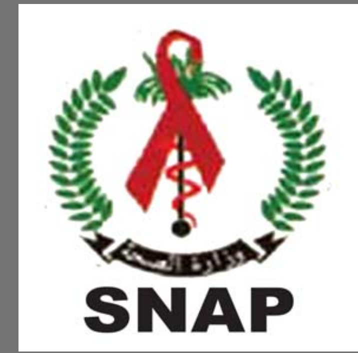
2010



Sudan National AIDS Control Programme

United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Report 2008 – 2009

NORTH SUDAN

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FEDERAL MINISTRY OF HEALTH

2010 UNGASS REPORT

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ANNEXES

A. NCPI Questionnaire

Acronym

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral Therapy
CBOs	Community-Based Organizations
BCC	Behaviour Change Communication
CCM	Country Coordination Mechanism
CDC	Centers for Disease Control and Prevention (United States)
COMBI	The Communication for Behaviour Impact
CPA	Comprehensive Peace Agreement
CT	Counseling and Testing
CSOs	Civil Society Organizations
DIFD	United Kingdom Department for International Development
FMoH	Federal Ministry of Health
FSM	Female Sex Worker
GDoP	General Directorate of Pharmacy
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoNU	Government of National Unity
GoS	Government of Sudan
GoSS	Government of Southern Sudan
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HTC	HIV Testing & Counseling
IATT	Inter-Agency Task Team
IBBS	Integrated Biological and Behavioral Survey
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
IMAI	Integrated Management of Adult Illness
M&E	Monitoring and Evaluation
MARPs	Most-at-risk Populations
MoH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Council
NCPI	National Composite Policy Index
NECHA	National Executive Council on HIV and AIDS
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NTC	National Telecommunication Corporation
OI	Opportunistic Infections
OVC	Orphans and other Vulnerable Children
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PSM	Procurement and Supplies Management
SAN	Sudan AIDS Network
SHHS	Sudan Household Health Survey
SECS	Sudanese Environmental Conservation Society
SNAP	Sudan National AIDS Control Programme
STI	Sexually Transmitted Infections
TB	Tuberculosis

UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nation High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNMIS	United Nations Mission in Sudan
VCT	Voluntary Counseling and Testing (for HIV)
WHO	World Health Organization
WFP	World Food Program

1. Status at a Glance

This is the 2010 UNGASS report of North Sudan highlighting the progress made during the reporting period 2008-9. The report has been prepared following the UNGASS 2010 guideline and based on reporting the core UNGASS indicators applicable to the country context and availability of most recent data. It is important to note that during the reporting period ANC surveillance carried out in 2009 and no other national survey was carried out. However, there is an on-going Sudan Health Household Survey (SHHS) and a major integrated bio-behavioural survey among female sex workers and men having sex with men is planned in 2010, it will greatly improve the knowledge on the status of epidemic in North Sudan as well as updated information on key UNGASS indicators.

1.1 The inclusiveness of the stakeholders in the report writing process

Attempts have been made to make the process to the extent possible participatory while preparing the country progress report on monitoring the follow up to the Declaration of Commitment on HIV and AIDS in North Sudan. With the leadership from Sudan National AIDS Control Program (SNAP) and technical support from Monitoring and Evaluation Technical Working Group, stakeholders from government such as the Ministry of Health, Ministry of Defense, Ministry of Interior and Ministry of Higher Education, Civil Society organizations, PLHIV associations and networks, the United Nations' Agencies were engaged and contacted for providing information on the progress made and the challenges encountered. The draft report was discussed in a wider forum comprising stakeholders of all levels as part of the consensus building as well as to ensure their inputs into the UNGASS report. The comments from the stakeholder meeting were incorporated to make improvements and finalization of the overall report.

The UNGASS reporting process also included a training workshop focusing on UNGASS reporting and overall M&E system with the support of UNAIDS Regional Office. This was held in Beirut in November 2009 and attended by two national experts from Sudan (one each from North and South) who eventually worked as national consultants to prepare the UNGASS report for Sudan. Finally the document was peer reviewed by the experts at the regional level also with the support from UNAIDS Regional Office in MENA.

1.2 The status of the epidemic

The AIDS epidemic in Sudan is uneven and according to recent MENA synthesis report the epidemic is concentrated in the Southern part of the country[1]. Years of civil war and limited epidemiological data in Sudan makes it rather difficult for a proper assessment of the nature and dynamics of the epidemic. In 2008 UNAIDS estimated a prevalence of 1.4 percent with 320,000 people living with HIV, however no separate estimates were produced for urban/rural or northern/southern.

[1] Time for Focus: Characterizing the HIV/AIDS Epidemiology in the Middle East and North Africa, Middle East and North Africa HIV/AIDS Epidemiology Synthesis Project, 2010

According to the recent epidemiological and behavioural review on the HIV situation in Sudan (August, 2009)[2], the overall HIV prevalence is estimated at 1.1% (0.67% in the North) while it is expected to gradually increase up to 2.2% in 2015 (1.2% for North). Data from the estimation and projection[3] for this reporting period for the North Sudan showed that in 2009, total number of adults and children living with HIV is about 122,216; AIDS orphans (ages 0-17) currently living (27,888); adults deaths, 6,301 (4,771 adults and 1530 children). Number of new HIV infections 23,766 (21,416 adults; 2,351 children). Need for ART - adult (15+) 18,423, children 2,981, while mothers needing PMTCT is estimated at 6,715.[4]

1.3 The policy and programmatic response

The response to AIDS in North Sudan is multi-sectoral and decentralized, coordinated by SNAP that is located within the Federal Ministry of Health. SNAP was established in 1987 soon after the official declaration of first case of HIV in 1986. Other than MoH, there are at least eight key line ministries involved in the national response on specific areas (General education, higher education, defense, interior, guidance, youth and social welfare). During the reporting period SNAP has strengthened its decentralized response by deploying additional human resources particularly in the area of surveillance and M&E at the state level. Efforts are continued to strengthen the response beyond the state (at locality level).

The Government of Sudan as early as in 2005 drafted a legislation/Act on HIV/AIDS to protect the rights of PLHIV and other vulnerable population groups; however the Act is awaiting final approval from Ministry of Justice before placing it to the Cabinet for endorsement.

SNAP is currently developing its second strategic plan for 2010-14 (NSP II) which is a work in progress and expected to be finalized by 31 March 2010. The previous NSP (2004-9) focused in maintaining the prevalence of HIV (less than 2%) in general population, while the new one prioritizes and targets most-at-risk population by ensuring that HIV interventions are evidence based; addressing relevant gaps that are likely to hinder provision of HIV services, and building capacity of coordination, management and implementation structures to sustain the national response.

The priority interventions those were implemented during the reporting period included prevention programmes targeting general population with increased number of VCT, and PMTCT sites, condom distribution outlets, and increased production and distribution of BCC/IEC materials. The most-at-risk populations were reached through outreach services including VCT, peer education, condom distribution and mapping and bio-behavioural researches conducted. Care and treatment programme expanded in all states with increased number of ART and TB/HIV centers, nutritional support for PLHIV and their families and empowering PLHIV associations.

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[2] SNAP (2009). Review of HIV Epidemic in Northern Sudan: Situation Analysis by Dr. Jesus M. Garcia Calleja, August 2-8, 2009, Khartoum.

[3] In 2009 Sudan conducted Estimation and Projection of epidemic using 2004, 2005, and 2007 ANC data from North and 2006 ANC data from South applying UNAIDS/WHO recommended software EPP/Spectrum.

[4] Although it is not possible to get separate estimates of North and South on different parameters using Spectrum, but from the EPP outputs, the proportion of infection is used to determine the values of the parameters separately for North and South Sudan.

1.4 The UNGASS Indicator Data Overview Table

Table 1: Core Indicators for the Declaration of Commitment Implementation (UNGASS) 2010 reporting

Indicators	Indicator Value	Comments
National Commitment and Action		
Expenditures		
1. Domestic and international AIDS spending by categories and financing sources	No data	Data collection for both North and South ongoing
Policy Development and Implementation Status		
2. National Composite Policy Index	Reported	Attached
Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation		
National Programmes: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education.		
3. Percentage of donated blood units screened for HIV in a quality assured manner	0%	All blood banks have SOP for HIV testing. In 2009 total units screened were 250,000 in North and 3,825 in South. There is no schemes for external quality assurance
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	2.97% (2008) [N=38,764] 4.39% (2009) [N=45,466]	Numerators are only from North Sudan (1151 in 2008 and 1996 in 2009). Denominators are estimated from Spectrum 2009 for entire Sudan
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	0.87% (2008) [N=12,521] 1.72% (2009) [N=14,263]	Numerators are from both North and South as: North (2008/9): 59/90 South (2008/9)=50/155
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	8.29% [N=9,927]	Total estimated number of incident TB cases for PLHIV is 9927 for entire Sudan according to WHO (2007) The numerator for North and South is 648 and 175 respectively
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	28.7% [N=2,464]	The data is from three towns in Southern Sudan from study conducted by MoH/FHI (ROADS Project 2009). No available estimate for countrywide. The 2010 Sudan Household Health Survey is expected to produce this indicator value.
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	FSW 6.5% (2008) [<25=5.7%, 25+=7.2%] [N=321]	This indicator is calculated from an RDS study among FSW in Khartoum in 2008.
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	FSW 1.5% (2008) [N=321]	Data source is same as above. The question used to estimate coverage differs from UNGASS guideline and mentioned details in UNGASS on data

Indicators	Indicator Value	Comments
		tool
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	N/A	Not applicable for Sudan
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	12.8% [N=17,400]	This indicator is calculated from data in North Sudan only. A total of 2,223 schools reached. The source of denominator is Ministry of General Education.
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14*	53.5% (part A) [Male 55.1%, Female 53.2%] 66.8% (part B) [Male 71.1%, Female 65.2%]	The source of this data is Sudan Health Household Survey (2006).
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*	7.3%	The data source is SHHS 2006 conducted among 15-49 years women in Sudan. The indicator was calculated based on two effective ways to prevent HIV. However, The SHHS 2010 included questions matching with the UNGASS guideline to accurately measure this 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	FSW 25.4% (2008) [N=321]	The data source is same as indicator 8 and only for North
15. Percentage of young women and men who have had sexual intercourse before the age of 15	40.8% [N=1,035]	Data source is same as indicator 7. It can be noted that there is a survey done in 2009 among university students and also among out-of schools in North, report not available yet.
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	7.96% [N= 1,331]	The data source is same as indicator 7 and only for South.
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	No data	There is no data.
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	FSW 45% (2008) [<25=46.4%, 25+=43.4%]	The data source is same as indicator 8 and only for North
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No data	There is an RDS bio-behavioral survey among 415 MSM done in 2008 in Khartoum. Data analysis is in progress
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	No data	No data available

Indicators	Indicator Value	Comments
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	No data	No data available
Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected*	North Sudan 0.31% (2007), N=3,524 South Sudan[5] 3.65% (2007), N=2,604	ANC Surveillance is conducted independently in North and South as such there is no compiled figure for Sudan.
23. Percentage of most-at-risk populations who are HIV infected	FSW 0.91% (2008) [N=328]	Data source is same as indicator 8 and only for North
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	56.54% (2008) [N=428]	This indicator is calculated from Cohort studies in North Sudan in 2008
25. Percentage of infants born to HIV infected mothers who are infected	29.75% [N=14,263]	HIV estimation using Spectrum 2009.

*Millennium Development Goals indicator

[5] Southern Sudan ANC Sentinel Surveillance Report (2007). US Centers for Disease Control and Prevention (CDC) on behalf of GOSS MOH and SSAC.

2. Overview of the AIDS Epidemic

2.1 Country Context

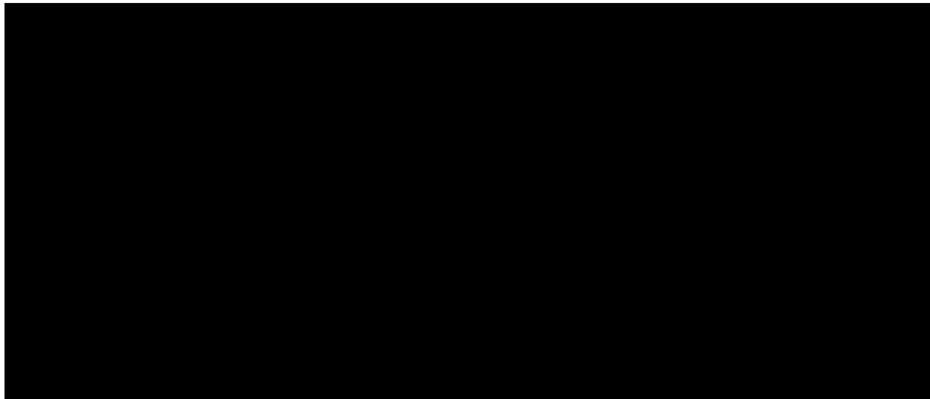
Located in north-eastern Africa, the Republic of the Sudan is the largest country in Africa (2 505 000 sq km). It is 2,100 kilometers long and 1,600 kilometers wide at the extreme, with international boundaries traversing more than 7,000 kilometers circumscribing it from nine neighboring countries five of which border Southern Sudan. According to the available Sudan's 5th Population and Housing Census data, Sudan's total population in 2008 stands at 39,154,490 (Northern Sudan is 30,894,000 and Southern Sudan is 8,260,490). The census results also revealed that Sudan's overall population has increased by about 14 million since the 4th Population Census (1993). The life expectancy is estimated at 56 years for males and 60 years for females.

Sudan is a vast country presenting wide religious, ethnic, linguistic and cultural diversity. Despite the diversity of the Sudanese people, environment and the richness of resources such as oil, poverty is widespread in Sudan, and the poorest regions are those of Darfur, Kordofan as well as Blue Nile and rural Red Sea.

Administratively, the country is divided into 25 states and corresponding local governance systems. The North Sudan (1.45 million square kilometers) comprises of the following 15 States: Khartoum, Northern, River Nile, Red Sea, North Darfur, West Darfur, South Darfur, North Kordofan, South Kordofan, White Nile, Blue Nile, Gezira, Sennar, Gedarif and Kassala. Under the CPA, a unity government under the presidency of the Government of National Unity (GoNU) was established in 2005 with more autonomy delegated to the Government of Southern Sudan (GoSS). Whereas the CPA has resulted in stability and security to the people, conflict and post-conflict within the context of HIV pose a major challenge that could undermine the development and reconstruction of the country.

1.2 The AIDS Epidemic

In 2008, UNAIDS estimated prevalence of 1.4 percent with 320,000 people living with HIV. However, it is noticeable that Sudan faces two distinct and concurrent epidemics. The epidemic in South Sudan is mostly of a generalized type while it is of low level in the North. In 2007 an ANC sentinel sero-surveillance survey was conducted in the 15 Northern States of the country, where a total of 9,164 blood specimens were collected from 26 different ANC sites. The overall HIV prevalence was found to be at 0.19%. Out of 3524 ANC attendees aged 15-24 years, 11 tested positive for HIV (0.31%). Average prevalence among 15-19 and 20-24 years ANC attendees was 0.27% and 0.33% respectively [2007 ANC SS survey].



In 2008, 4 bio-behavioural surveys among FSW, MSM and truck drivers were conducted in Khartoum and Gezira states using Respondent driven sampling (FSW and MSM) and Time-location sampling (Truck drivers). Prevalence among FSW in Khartoum was 0.9% (N= 321) while it was 0.1% in Gezira (N= 267). On the other hand, prevalence of HIV among 450 MSM was 2.3% while it was 0.3% among truck drivers (N=570).

In 2009 Sudan produced its first estimate based on three rounds of HIV surveillance in the North and 2006 surveillance of south, which shows that overall national HIV prevalence is expected to gradually increase from 1.1% in 2009 to 2.2% in 2015. In 2009, prevalence is estimated at 0.67% in North Sudan.

In 2008 and 2009, the overall number of people living with HIV is estimated to be 223,683 [154,044 – 311,922] and 259,610 [168,073 – 384,692] respectively. In addition, the estimated number of new infections among children is 4,383 in 2008 and 4,993 in 2009.

By the end of this year, new epidemiological data will be available from the Sudan Household Health Survey and the 2009 ANC sentinel sero-surveillance surveys in North and South Sudan. These data are expected to improve the overall HIV estimations in Sudan.

3. **National Response to the AIDS Epidemic**

3.1 Planning and Coordination

National AIDS Council (NAC) represents the highest level policy and advisory body on all issues related to HIV/AIDS with State AIDS Council headed by the ***Wali*** (Governor) providing leadership at the states level. On the other hand, the National Executive Council on HIV/AIDS (NECHA) chaired by the Undersecretary of the Federal Ministry of Health is the body responsible for execution, coordination and overall management of the national response. Its membership includes the United Nations Agencies, public and private sectors; national and international stakeholders. Sub-committees were established within the NECHA to support interventions in specific areas.

The Sudan National AIDS Control Programme (SNAP) is the technical department with the responsibility for national level policy, planning and coordination. It liaises and works with the different sectors, including the Ministries of Defense, Interior, Education, Higher Education, Information and Communication, Ministry of Labour, Ministry of Culture, Youth and Sports; and Ministry of Social Welfare, Women and Child Affairs.

3.2 Review of National Response

During the development process of NSP II, a review of HIV programme was carried out to identify achievements made in the last four years and gaps in HIV programme implementation. The review was carried out by technical working groups comprising technical experts in specific programmatic areas and stakeholders from all sectors involved in the national response. The followings are the highlights of the review findings of national response considered for developing appropriate strategy:

- **Increased focus on targeted interventions for population at risk and other vulnerable population groups**: National response should focus as well as expand its coverage to most-at-risk population groups and vulnerable populations. Key most-at-risk populations should include FSWs, MSMs. The vulnerable populations those are considered for interventions include tea sellers, military personnel, youth in and out of school, truck drivers and populations of humanitarian concerns.

- **Effective targeting of programmes**: The current programmes aim at covering all the 15 states in Northern Sudan. However, evidence from the epidemic analysis shows the need to priorities certain regions where there is greater need for services than other areas. For instance, regions with higher HIV prevalence should be prioritized. Likewise, “hotspots” where FSWs and MSMs and populations of humanitarian concern should be targeted.

- **Renewed focus on HIV prevention**: Given the low HIV prevalence combined with high level of risky sexual behaviour especially among high-risk and vulnerable populations, HIV prevention should be prioritized.

- **Generate strategic information for focused intervention**: There is a need to generate recent data particularly on size and behavioural aspects of MARPs and vulnerable population in addition to population-based estimate of HIV prevalence and other behavioural data for general population in North Sudan.

- **Integration of HIV services**: Most of the HIV services are provided with limited linkage to others and outside the health system. This strategic plan prioritizes integration of HIV services in the health systems as well as provision of a comprehensive package of services.

- **Quality improvement**: While the programme is sufficiently scaled up but due to poor quality interventions the efforts might not yield high impact. Quality improvement across all services and at coordination, managerial and technical levels is necessary.

- **Need driven capacity building**: There is demand for capacity building to support the implementation of NSP II.. Some of the priority areas for capacity building include PSM, HIV surveillance, health systems strengthening and CSOs capacity development.

3.3 HIV Prevention

The HIV prevention programmes in North Sudan implemented during the reporting period include Counseling and Testing, Prevention of Mother to Child Transmission of HIV, Information, Education and Communication (IEC) and blood safety, and Sexually Transmitted Infections. Following is the description of progress made:

HIV Testing and Counseling (HTC): During the reporting period HTC programme has been scaled up. At the end of 2007 there were 55 VCT centers that have increased to 113 in 2008 and 132 in 2009. In 2009 a total number of 32,500 people tested in these VCT centers while a total of 52,770 people were tested in all HTCs in 2009. Although the overall number of people tested and counseled is showing an increasing trend, however there is no population-based estimate on the coverage of HTC in North Sudan.

Services	2007	2008	2009
# VCT centers	55	113	132
# ART centers	21	30	32
# PMTCT sites	7	20	27
# people tested in HTC	14,000	28,376	52,770
# pregnant women tested	1,608	7,515	19,980
# PLHIV on treatment	-	1,151	1,996

Source: SNAP Database 2009

Prevention of Mother to Child Transmission of HIV (PMTCT) services: During reporting period total number of facilities providing PMTCT services have increased from 7 facilities in 2007 to 20 in 2008 and 27 in 2009 resulting in increased number of pregnant women accessing HIV testing and counseling.

Behavioral Change and Communication (BCC): There is no recent data on the overall knowledge of HIV transmission and misconception among general population in Sudan. According to 2006 SHHS more than 70 percent of women in the 15-49 age group in Sudan had heard about AIDS and only half of them knew that it could be transmitted by sexual intercourse and just around 7.5 percent identified use of condom as a preventive measure. In addition, the percentage of women who knew two of the most effective ways (i.e. having one uninfected partner and using a condom correctly every time) of preventing HIV transmission was also fairly low (8 per cent) Although the SHHS did not include men in the survey, men's knowledge about AIDS is also assumed to be at low level.

BCC programmes are targeted to improve awareness of HIV among general population including youth. HIV education has also been included in the school curriculum in 2008. A total of 2,223 schools have been reached and teachers are trained to implement the HIV curriculum. It is expected that full implementation of all the BCC interventions would improve the knowledge of HIV in Sudan.

STI Intervention: The management of STI has been integrated in the primary health care service delivery points in all the States to ensure wider coverage using the syndromic approach. In 2009 the treatment protocol was reviewed and updated. During the course of this reporting year, 180 health care providers were trained; 35,263 clients were reported to have been treated for STI in more than 300 sites.

Condom distribution: Condom is distributed free of charges mainly through different health outlets (VCT, PMTCT, ART, STIs, family planning and TB facilities) and outreach interventions for MARPs. In 2009, more than 1 million pieces of condoms were distributed through health outlets and 304,290 to MARPs. Also in 2009 initiative has been taken to implement a comprehensive condom programming (CCP).

Blood Safety: There are 280 blood banks and 9 reference laboratories in North. Data from 215 blood banks showed that 100% of blood units are screened for HIV while the issue of external quality assurance needs further assessment. Northern Sudan collects about 250,000 units of blood annually, of which 15% are collected from voluntary donors. In order to strengthen quality assurance system, SOPs were developed and implemented and in addition 50 staffs have been trained on international standards for blood quality assurance in collaboration with WHO.

MARPS and Vulnerable Groups: During the reporting period marked improvement of interventions and services targeting most at risk and vulnerable population was achieved. Standard service package, guidelines and manuals have been developed for targeted interventions. Services are offered through outreach activities provided by more than 25 NGOs in 10 States. Interventions are mainly targeting FSW, Tea sellers, Prisoners, Truck Drivers and recently MSM. Interventions have been scaled up in most of the 10 states. In addition about 1,300 MARPs were counseled and tested in 2009.

Although coverage of these interventions is still limited to capital cities of states and major town, there is steady improvement in knowledge and behavior indicators particularly among female sex workers. For example, the RDS study in Khartoum among FSW in 2008 showed a comprehensive knowledge of 25.4%, knowledge about place of HIV testing (75.2%), HTC voluntary seeking behavior (6.5%) and condom use with last client of 45.0%.

The new strategic plan (2010-2014) has prioritized to address MARPs and vulnerable populations and considered critical for intervention. In 2010 a comprehensive IBBS combined with Population Size Estimation (PSE) will be conducted among FSW and MSM. Provision of testing and counseling through outreach HTC will be scaled up.

During the reporting period, the country continued with implementation of the specific interventions for out-of-school youth supported to implement life-skills activities and to reach others through peer education and awareness-raising sessions. About 315,000 young people were reached in 11 states; one youth friendly centre was identified for rehabilitation in 4 states to ensure access to youth-friendly HIV and AIDS services through partnership with existing youth structures. Furthermore, mass media was used as a channel to reach young people in 10 States. It is estimated that, approximately 11.3 million young people from the above States were reached through state radio and community radios. This was complemented by the mass media campaigns, including radio and television spots and programmes that were broadcasted in form of drama series and songs in the local languages. A formal agreement was signed by Undersecretary Ministry of Health and the Minister of Communication, which entitled SNAP free airtime for 3 HIV/AIDS spots and granted the national Radio and Television the sole production rights.

3.4 Treatment, Care and Support

The national policy on HIV and AIDS as well as the national strategic plan highlight treatment, care and support as priority interventions in the national response within North Sudan. The HIV and AIDS treatment care and support services have been introduced in all the 15 States of North Sudan and there is deliberate effort to scale up within the individual states. Total numbers of ART centers have also increased in this reporting period from 21 in 2007 to 32 in 2009. Although more than 3,000 PLHIV ever started on treatment there are currently 1,996 PLHIV on ART in 2009 compared to 1,151 in 2008. The cohort study conducted in selected ART centers in Khartoum and Gaderif documented noticeable improvement on the proportion of PLHIV who discontinue treatment or lost to follow-up (56.54% in 2008 compared to 42% in 2007 are on ART after 12 months).

Care services have been also scaled up. About 5,710 patients are provided with cotrimoxazole prophylaxis. Efforts have been made to improve the quality of treatment and care services; the CD4 monitoring coverage has been improved by providing at least one machine per state. A nutrition programme targeting PLHIV has been initiated: PLHIV on ART in 5 states are being provided with food support. In addition, a capacity building interventions to strengthen treatment and care programme are on-going. The process of integrating ART clinics into the health system has been initiated. However, the treatment programme is highly dependent on external resources and there is a need for increased contribution from government.

During 2008-2009 there has been marked improvement in TB/HIV collaborative activities. The TB/HIV services have been expanded to all states with minimum one center per state. In 2009, 648 TB/HIV patients were brought under ARV programme. The overall coverage of TB/HIV is estimated to be 8% in Sudan.

During the reporting period, the guidelines for Post Exposure Prophylaxis (PEP) went through a series of discussions before being finalized and adopted. The services for post-exposure prophylaxis are now available for occupational and non-occupational exposures such as after incidents of sexual violence. Training modules were developed and used to conduct sensitization as well as training of officers at federal and State levels. PEP kits are made available in 21 sites covering all the 15 States in North.

3.5 Involvement of People Living with HIV

The involvement of people living with HIV is one of the key elements that determine success of the national response. The Sudanese Association of People Living with HIV was formed in 1990s and played key role in overall response in the country. The PLHIV Association is represented in all decision making forum (at Federal and State level) and coordinating bodies including National AIDS Council, CCM, SAN and key steering committees. The association has active branches in 13 northern states. PLHIV has also been actively involved in the development of the HIV/AIDS Act. In 2009, PLHIV association supported 12 service delivery centers for the chronically ill and families affected by HIV/AIDS.

4 Best Practices

4.1 Adoption of School Curriculum for HIV and mainstreaming HIV in education sector

The Ministry of General Education approved HIV curriculum in 2008 and printed textbooks and trained 3,373 teachers across Sudan .The curriculum was launched by the presidential advisor of Sudan. The curriculum placed emphasis on the participatory learning methodologies such as group discussions, role playing and games that carry messages on how the disease spreads, its misconception as well as the danger of stigma and discrimination. A total of 3,373 specialists were trained to deliver youth education including trainers, school teachers and counselors of drop-in-center.

In addition, a total of 2,223 schools and drop-in centers providing life-based HIV/AIDS education; HIV/AIDS education in Out-of-School settings using GFATM resources was provided to 239,747 young people; HIV/AIDS education reached 420,494 young people in school settings.

In October 2009, UNESCO held a consultative meeting in North Sudan to pilot test the draft Toolkit on Mainstreaming HIV in Education Sector Responses during Emergencies. The draft Toolkit has been developed by the Task Team on HIV and Education in Emergencies, which comprises members from the International Network for Education in Emergencies (INEE) and the Inter-Agency Task Team (IATT) on Education UNESCO, UNICEF and UNHCR piloted the toolkit in selected countries, including Sudan, to make it more field-friendly. The consultation was carried out in collaboration with the Sudanese National AIDS Control Programme, the Ministry of Education, UNICEF and UNHCR. Participants involved in the consultation were from 3 Darfur States, 4 Eastern Sudan States, as well as representatives from NGOs, Ministry of General Education, Ministry of Higher Education, and the Ministry of Humanitarian Affairs.

4.2 Khartoum Declaration of Commitment on HIV/AIDS by Religious Leaders

Experience from elsewhere and particularly in MENA suggests that religious leaders can play an important role in disseminating key HIV messages and improving access to available HIV services and interventions. Religious leaders, if successfully engaged, can contribute in the reduction of stigma and discrimination and enhance positive attitude towards AIDS workers and PLHIV. Understanding the importance of involving religious leaders in the national response, the Ministry of Guidance and Endowment and SNAP planned to organize religious leaders from different faiths to discuss about HIV issues. In February 2008, a technical meeting for key religious leaders comprising top 50 Muslim and Christian leaders was organized in Khartoum. They produced a progressive Declaration of commitment on HIV/AIDS which emphasizes the urgency of responding to the AIDS epidemic, calling for awareness campaigns, outreach to vulnerable groups, treatment and care for those infected and affected by the virus.

The core value of this event has resulted in the development of two HIV training manuals written by and for Muslim and Christian religious leaders which is now being used for the training of mid-level and grass-roots level religious leaders all over the country. They contain

suggested material for sermons and religious lessons on HIV related issues, which integrate fact-based messages from not only the medical but also the broader development perspective, and human rights based approach with appropriate references from the Koran and *Hadith*, or the Bible and its scriptures.

Since then, the Declaration has been endorsed by thousands of Muslim Imams and Christian Ministers in the country. It has been described as revolutionary by HIV/AIDS stakeholders which opens the door for action not only to other religious leaders but to all stakeholders involved in the response to HIV/AIDS from the government to the civil society.

4.3 Messages from the President on HIV

During 2009 World AIDS Day a delegation comprising of SNAP, PLHIV, UN and NGOs met HE President of Sudan and shared with him key HIV messages from HE President to be used for media campaign. The President appreciated the effort and approved messages developed for raising awareness on HIV/AIDS for the use in print and electronic media. The messages focused on the benefit of abstinence until marriage, encourage people to go for HIV testing through VCT centers and respect and dignity for PLHIV to address stigma and discrimination. It can be noted that these messages are currently being aired in TV/Radio and publicized in different print media. In this occasion, the PLHIV association presented HE President a certificate of appreciation as a token for his continued leadership and patronization. HE president in his discussion assured that his government will continue to play its positive role to support HIV activities and he further assured that the rights of the PLHIV and other affected groups will be protected.

4.4 Inclusion of HIV Modules in Sudan Health Household Survey (SHHS) 2010

Given the coverage of ANC surveillance is limited and also the need to generate population-based estimates of HIV and other behavioural parameters in North and South Sudan, SNAP and SSAC with support from all partners planned to conduct a nation-wide survey. However as the cost of survey was very high it was not possible to implement the population-based bio-behavioural survey.

Following the 2006 SHHS, in 2010 Sudan planned to conduct the SHHS II and both SNAP and SSAC took this advantage and advocated to include HIV module in this survey for generating population-based HIV estimates. The previous SHHS only measured knowledge of HIV as that was focused more for Health and Nutrition. The key HIV indicators included in SHHS II are those in UNGASS such as: HIV testing, knowledge, age at first sex, multiple partners and condom use among others in addition to HIV prevalence. However some of the sensitive behavioural questions were excluded for women in SHHS II.

This is a good example of aligning population-based surveys to minimize efforts and costs.

4.5 Increased Partnership with Civil Society

In Sudan Civil Society Organizations including NGOs, PLHIV associations are key partners in the national response. Under the network of more than 50 NGOs, the Sudan AID Network (SAN) are organized and represented in the highest decision and policy making forums and coordinating bodies. Currently SAN is the Vice-Chair of CCM and key member of Tasks Force and Steering Committee to develop Strategic Plan. CSOs in Sudan are heavily involved in delivering and scaling up outreach services to MARPs. In addition, some NGOs are sub-recipients of Global Fund to implement HIV interventions. Several partnerships between NGOs and line ministries exists, e.g., the Family Planning Association in partnership with Ministry of Interior is responsible for delivery HIV services among prisoners.

5 Major Challenges and Remedial Actions

5.1 Progress made on key challenges identified in 2008 UNGASS Report

The 2008 UNGASS country progress report from North Sudan highlighted several challenges that were identified as bottle-necks to the successful implementation of HIV and AIDS interventions.

Challenges during the 2006 – 2007 period:	Progress made by 2009
1. Low uptake of services	In order to increase service uptake: (a) HTC, PMTC and ART centers have been increased (b) Introduction of PITC in all facilities providing HTC (PMTCT, TB/HIV and STIs) (c) Expansion of geographical coverage
2. Limited integration of HIV/AIDS services into the existing PHC services	Following are integration and collaborative efforts: (a) Efforts are underway to integrate PMTCT within broad RH programme in collaboration with RH department (b) Strengthened collaboration between TB and HIV through establishing the committee, TB/HIV guidelines and workplan (c) In collaboration with Nutrition Program, MCH at the FMOH a Food, Nutrition and HIV strategic plan has been developed. (d) Integration of STI in PHC
3. Weak decentralized structure	(a) Strengthening of state level HIV structure (b)Decentralization of HIV services to locality level (district level)
4. Limited allocation of funds by government	As still the government contribution is nascent compared to external resources, this issue needs further policy advocacy. The currently ongoing National AIDS Spending Assessment (NASA) exercise findings will be used for greater policy attention to address resource allocation to priority programme areas.
5. Deficiency in strategic information and documentation	(a) Reasonable progress has been observed in improving strategic information particularly in the area of collection of regular programme monitoring data and its use in improving interventions. (b) Regular quarterly meetings were organized with all the state-level programme managers that also allowed opportunity to improve data quality. (c) Surveillance system has improved in terms of (i) expansion of ANC sites as well as quality

	of data; (ii) SHHS II included AIDS module to measure a number of key indicators of UNGASS including a population-based estimate of HIV prevalence; (iii) Plan for IBBS among FSW and MSM (d) National database including CRIS3 under planning stage and will be implemented in 2010
6. Limited promotion of condoms	(a) Initiatives taken for Comprehensive Condom Programming (CCP) (b) Expanding free distribution outlets through wide range of health facilities (RH, FP, TB, STIs, VCT, PMTCT) (c) Targeted free distribution and promotion for MARPs through outreach and non-traditional outlets. (d) Intensify promotion of condom use through IEC/BCC (e) Introduction of female condoms

5.2 Challenges in 2008-9 and Proposed Remedial Actions

5.2.1 Policy and management issues

- The previous strategic planning lacked the operational plan thus limiting the coordination of support and resource mobilization strategies and targets. While the new NSP is almost finalized, efforts should be taken for urgently develop the costed operationalization plan.
- The consistency and sustainability of the services remains a huge challenge for large country like Sudan. Often initiatives are either for a short duration and cover small areas thus limiting their impact. More results oriented focus is required for long-term impact.
- The overall capacity of SNAP to effectively coordinate the multisectoral response particularly at state and below is limited and needs to be strengthened.
- The HIV programme is largely donor dependent with token government contribution in terms of resources that needs to be taken care of for the future sustainability and ownership of the national response.

5.2.2 Prevention

- The coverage of prevention programme is still not sufficient to make a significant impact on overall HIV situation. In addition, the current HIV interventions are not effectively targeting the high-risk and vulnerable populations as well. There is a need for scaled up and sustained response to address HIV among MARPs and vulnerable population as prioritized in the draft Strategic Plan (2010-14).

- There is inadequate information about MARPs and vulnerable population size, location and behavior. The planned IBBS in 2010 should be prioritized for implementation to provide estimates on the size, HIV prevalence and behavioral data of the MARPs.

5.2.3 The involvement of civil society

- The capacity of civil society is limited for a scaled up response and requires technical support in priority areas.
- The civil society response is largely donor driven and reliance on external support lacking sustainability of the response. CSOs should be encouraged to mobilize resources.

5.2.4 Access to treatment

- The ART programme currently faces challenges in enrolling PLHIV on ART. There is an urgent need to improve access to treatment and care by PLHIV to achieve UA targets.
- There is considerable gap in the number of patients ever started on ART and those who are currently on treatment. In order to improve the situation there is a need to address the retention and patient-tracking.
- Linkages and referral between various HIV services is weak. Efforts needs to be taken to improve coordination between different services and establishment of clear referral mechanisms
- The management of ART sites outside of the health care system is hindering sustainability. Integration of services within the health care system is a priority.

6 Support from the Country's Development Partners

6.1 **Areas of support**

The support from Development Partners has been one of the critical strengths behind the national AIDS response in the Republic of Sudan. The major input was from the multilateral agencies such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM); the United Nations' Agencies comprising mainly of UNAIDS, WHO, UNICEF, UNFPA, WFP and UNMIS; as well as from the bilateral agencies, specifically the United Kingdom Department for International Development (DFID), the Swedish government, the Spanish government and government of the Netherlands. The support provided covered the following key areas:

- Procurement of equipment and logistics as a component of the operational support to programmes
- Building capacity of service providers through training in the different thematic areas
- Technical support
- Direct financial support from the bilateral agencies for specific programme or thematic areas

6.2 Actions for the Development Partners

The recommended critical actions that need to be taken by the Development Partners in order to ensure that the country remains on course towards achievement of the UNGASS targets include the following:

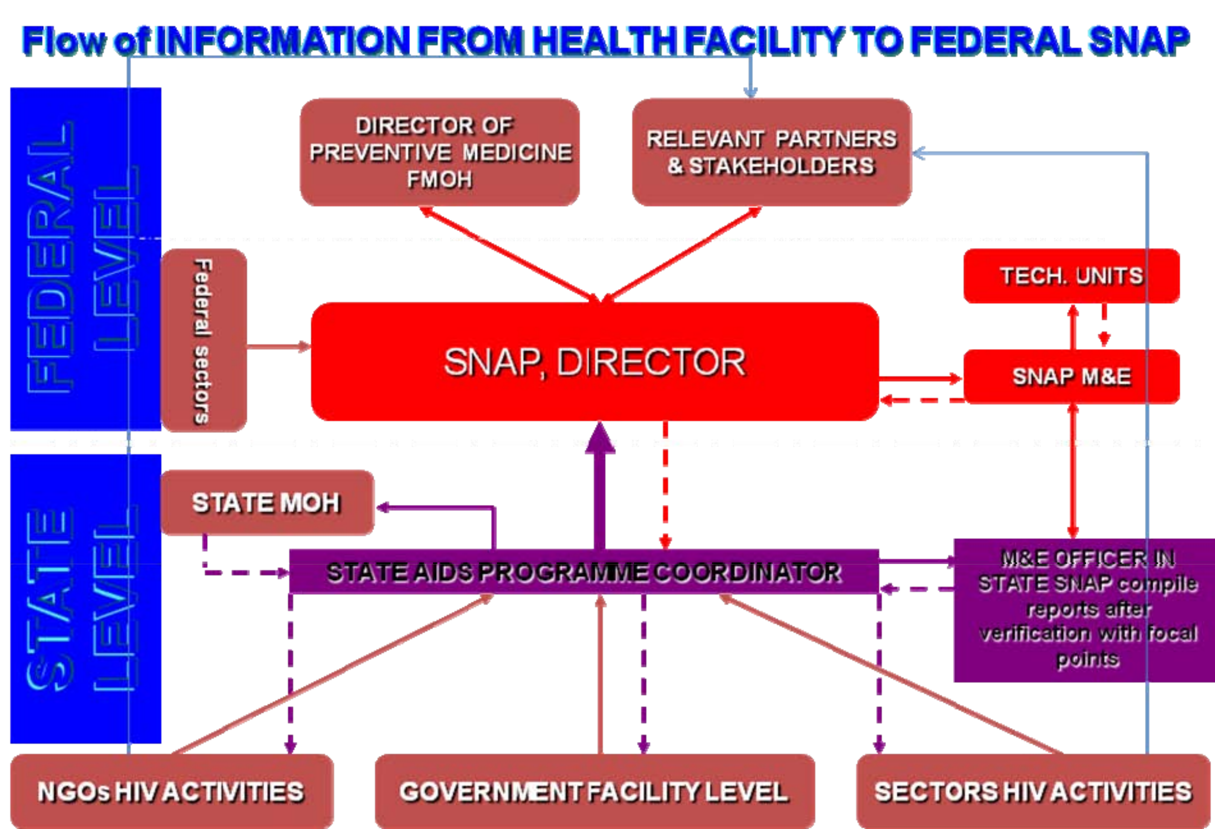
- Facilitate the national response and align the support in priority areas and gaps as per National Strategic Plan.
- Continue advocacy with high-level policy makers to prioritize HIV response.
- Advocate for mobilization of resources from both internal and external sources.
- Provide technical assistance and capacity building particularly in the area of system strengthening
- Technical support in the areas of M&E and strategic information.

7 Monitoring and Evaluation Environment

7.1 Overview of the Monitoring and Evaluation System

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

- The current M&E Framework (although will be revised) has 62 core indicators based on which all partners are reporting on quarterly basis
- SNAP has an M&E Unit and Chairs the M&E TWG that includes stakeholders from all key partners including government, NGOs, UN and PLHIV
- In addition to M&E Unit at Federal level, each state has an M&E and Surveillance focal person to coordinate M&E activities.
- At the central level M&E activities are coordinated by M&E TWG while at the state level and Federal level there are regular quarterly review meetings to share information



7.2 Challenges and Remedial Actions

- High turn-over among trained M&E officers at SNAP and state level in addition to limited number of human resources. In order to strengthen the M&E unit fund has been secured to recruit additional staff in 2010.
- Inadequate resources are allocated to the monitoring and evaluation component of the programme. In future plans at least 10% of total budget will be allocated from M&E.
- Currently there is no database/online data entry system limiting the analysis and timely generation of indicators and feedback. Funds are allocated for the

- The current M&E Framework has 65 core indicators. As the new M&E plan will be developed based on NSP II (2010-14), there will be a review of core indicators in line with UNGASS and UA indicators.

7.3 M&E Technical Assistance Needed

- Long term professional training and short-term courses for M&E officers at state and federal level including civil society and people living with HIV/AIDS.
- Study tours to other countries for shared learning on national data flow system for improving programme monitoring.
- Technical assistance in specific aspects of M&E such as research and evaluation
- Technical assistance for establishing a resource tracking system and build local capacity in this area

ANNEX 1 National Composite Policy Index

NCPI Data Gathering and Validation Process

The survey to compile the National Composite Policy Index (NCPI) was carried out in the month of March 2010 using the NCPI Instruments given in the Guidelines on Construction of Core Indicators: 2010 Reporting. Identification of key stakeholder organizations was done by the consulting organization in collaboration with SNAP. One research assistants with prior experience in key informant interviewing underwent two days of training. Pre-testing was carried out, only for familiarization, as no alteration of the instrument was intended. Continuous process progress was reported in the SNAP M&E Technical Working Group and no alterations to the process were suggested. Out of the 16 stakeholders identified, successful interviews were held with representatives of 3 government ministries and agencies and 5 UN, bilateral or civil society organizations.

NCPI Respondents

NCPI - PART A [administered to government officials]

Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V
SNAP	Dr.Ezzelding/ head Treatment & Care					
SNAP	Dr. Siham Jaber, Head Sectors					
SNAP						
MINISTRY OF JUSTICE						

NCPI - PART B [Administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	Respondents to Part B

		[indicate which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	BV
Health Alliance	Dr. Wisal					
UNICEF	Dr. Elfatih					
PLHIV	Mr. Peter, Head Mr. Omer, Deputy					
Sudan AIDS Network, SAN	Dr. Amel Salih, Directir					

National Composite Policy Index (NCPI) questionnaire
Part A
[Administered to government officials]

STRATEGIC PLAN

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

Yes	No	Not Applicable

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

Sectors	Included in strategy		Earmarked budget	
Health	Yes	No	Yes	No
Education	Yes	No	Yes	No
Labor	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Military/Police	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young people	Yes	No	Yes	No
Other*				

1.3 Does the multispectral strategy address the following target populations, settings and crosscutting issues?

Target populations			
a. Women and girls	a.	Yes	No
b. Young women/young men	b.	Yes	No
c. Injecting drug users (Not applicable in Sudan)	c.	Yes	No
d. Men who have sex with men	d.	Yes	No
e. Sex workers	e.	Yes	No
f. Orphans and other vulnerable children	f.	Yes	No
g. Other specific vulnerable subpopulations*	g.	Yes	No
Settings			

h. Workplace	h. Yes	No
i. Schools	i. Yes	No
j. Prisons	j. Yes	No
Cross-cutting issues		
k. HIV and poverty	k. Yes	No
l. Human rights protection	l. Yes	No
m. Involvement of people living with HIV	m. Yes	No
n. Addressing stigma and discrimination	n. Yes	No
o. Gender empowerment and/or gender equality	o. Yes	No

1.7 Does the multispectral strategy or operational plan include?

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

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

Yes	No

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

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

HIV prevention	Yes	No
Treatment for opportunistic infections	Yes	No
Antiretroviral treatment	Yes	No
Care and support (including social security or other schemes)	Yes	No
HIV impact alleviation	Yes	No
Reduction of *gender* inequalities as they relate to HIV prevention/ treatment, care and/or support	Yes	No
Reduction of *income* inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No
Reduction of stigma and discrimination	Yes	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No
Other: *[write in]*	Yes	No

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? low | 1 | 2 | 3 | 4 | 5 | high			
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	No	
Condom provision	Yes	No	
HIV testing and counseling	Yes	No	
Sexually transmitted infection services	Yes	No	
Antiretroviral treatment	Yes	No	
Care and support	Yes	No	
Others: *[write in]*	Yes	No	

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

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

Yes	No

6. 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

6.1 ***IF YES,*** for which subpopulations?		
a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers	Yes	No

f. Prison inmates	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other: *[write in]*		

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

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

V. poor	1	2	3	4	5	6	7	8√	9	10	Excellent

Since 2007, what have been key achievements in this area? Law drafted
What are remaining challenges in this area: law enforcement, protection of the rights of MARPs and vulnerable population groups

II. POLITICAL SUPPORT

1. Do high officials speak publicly and favorably about HIV efforts in major domestic forums at least twice a year? President/Head of government Yes No Other high officials		Yes	No
Other officials in regions and/or districts		Yes	No
2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?		Yes	No
IF NO, briefly explain why not and how AIDS programmes are being managed:			
2.1 ***IF YES***, when was it created? Year: *[write in]*	2003		
2.2 ***IF YES***, who is the Chair? Name: Position/Title: *[write in]*	Federal Minister for Health		
2.3 ***IF YES***, does the national multisectoral AIDS coordination body: have terms of reference?		Yes	No
Have active government leadership and participation?		Yes	No
have a defined membership?		Yes	No

IF YES, how many members? *[write in*		Yes	No
] include civil society representatives? ***IF YES***, how many? *[write in]*		Yes	No
Include people living with HIV? ***IF YES***, how many? *[write in]*		Yes	No
Include the private sector?		Yes	No
Have an action plan?		Yes	No
Have a functional Secretariat?		Yes	No
Meet at least quarterly?		Yes	No
Review actions on policy decisions regularly?		Yes	No
Actively promote policy decisions?		Yes	No
Provide opportunity for civil society to influence decision-making?		Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?		Yes	No
3. 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: Briefly describe the main challenges:	NAC met in 2009		
4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?			

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	No
Technical guidance		Yes	No1
Procurement and distribution of drugs or other supplies		Yes	No
Coordination with other implementing partners		Yes	No

Capacity-building		Yes	No
Other: *[write in*		yes	No
6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?		yes	No

Overall, how would you rate the *political support* for the HIV programme in 2009?
2009 Moderate Excellent: 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area? President approved HIV messaged to be used for advocacy, High level participation during World AIDS Day
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			
c. Be faithful	Yes		
d. Reduce the number of sexual partners			
e. Use condoms consistently			
f. Engage in safe(r) sex			
g. Avoid commercial sex			
h. Abstain from injecting drugs			
i. Use clean needles and syringes			
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		
m. Males to get circumcised under medical supervision		
n. Know your HIV status	Yes	
o. Prevent mother-to-child transmission of HIV	Yes	
Other: *[write in]*		
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	No
secondary schools?	Yes	No
teacher training?	Yes	No
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?	Addressed and recognized in NSP	
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:		
3.1 ***IF YES***, *which populations* and *what elements of HIV prevention* do the policy/strategy address?		

Overall, how would you rate policy efforts in support of HIV prevention in 2009? 2009 Moderate Excellent: 0 1 2 **3** 4 5 6 **7** 8 9 10

Since 2007, what have been key achievements in this area? Law drafted
What are remaining challenges in this area: law to be endorsed

4. Has the country identified specific needs for HIV prevention programmes? Yes1-

IF YES, how were these specific needs determined? Through recommendation of SNAP, UN and other civil society

Some parts of practices methods are not accepted socially (condoms)

4.1 To what extent has HIV prevention been implemented?

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

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?											
2009 Very poor											Excellent
	0	1	2	3	4	5	★	7	8	9	10

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).

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

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

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

IF YES, how were these determined?

Through plans and proposals

Reported cases

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 acces		
Antiretroviral therapy	Agree ✦	Don't Agree	N/A
Nutritional care	Agree	Don't Agree ✦	N/A
Paediatric AIDS treatment	Agree ✦	Don't Agree	N/A
Sexually transmitted infection management	Agree ✦	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree ✦	Don't Agree	N/A
Home-based care	Agree ✦	Don't Agree	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't Agree ✦	N/A
HIV testing and counselling for TB patients	Agree ✦	Don't Agree	N/A
TB screening for HIV-infected people	Agree ✦	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree ✦	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree ✦	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree ✦	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree ✦	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree ✦	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree ✦	N/A
Other: *[write in]*	Agree	Don't Agree	N/A

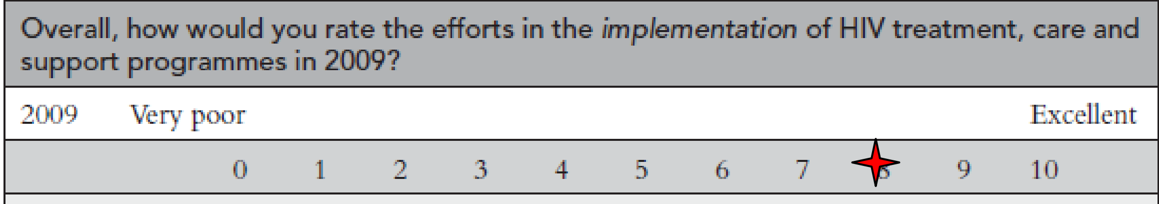
3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes ✦	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?

Yes ✦	No

IF YES, for which commodities?: *[write in]*



Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes 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?

VCT, ART Centers, in All States

Sustainable supply of ART services

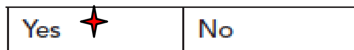
What are remaining challenges in this area:

Awareness, Stigma, Funding, High staff turnovers

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

Yes	No	N/A

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



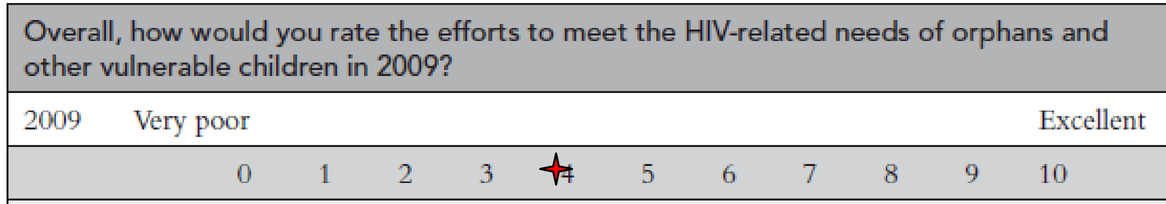
Yes	No

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

Yes	No

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

Yes	No



Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children 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: National committee for Orphans

What are remaining challenges in this area: lack of funds, scaling up of the interventions

V. MONITORING AND EVALUATION

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

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

National Composite Policy Index (NCPI) questionnaire

Part B

[Administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

HUMAN RIGHTS

QUESTION	YES	NO
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.)	X	
2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?		X
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?	X	
4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?	X	
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?		X
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?	X	
7. Does the country have a policy of free services for the following?		
a. HIV prevention services	X	
b. Antiretroviral treatment	X	
c. HIV-related care and support interventions	X	
8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?	X	
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?	X	

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?	X	
10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination)?		X
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?	X	
12. Does the country have the following human rights monitoring and enforcement mechanisms?		
	YES	**NO**
Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work [There is commission but not specifically for HIV]		X
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		X
Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts		X
13. In the last 2 years, have members of the judiciary (including labor courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?	X	
– Legal aid systems for HIV casework		X
– Private sector law firms or university-based centers to provide free or reduced-cost legal services to people living with HIV		X
– Programmes to educate, raise awareness among people living with HIV concerning their rights	X	
15. Are there programmes in place to reduce HIV-related stigma and discrimination?	X	

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

V. poor	1	2	3	4√	5	6	7	8	9	10	Excellent

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?

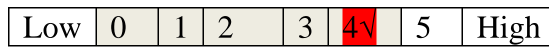
V. poor	1	2	3	4	5√	6	7	8	9	10	Excellent

Part B

[Administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

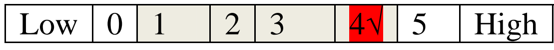
CEVIL SOCIETY PARTICIPATION

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



Low	0	1	2	3	4√	5	High

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	0	1	2	3	4√	5	High

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	0	1	2	3√	4	High

b) The national AIDS budget?

Low	0	1	2	3√	4	High

c) National AIDS reports?

Low	0	1	2	3√	4	High

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

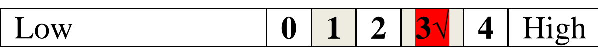
a. developing the national M&E plan?

Low	0	1	2	3√	4	High

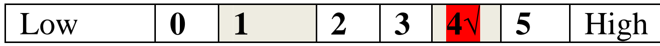
b. participating in the national M&E committee / working group responsible for coordination

Low	0	1	2	3√	4	5	High

c. M&E efforts at local level?

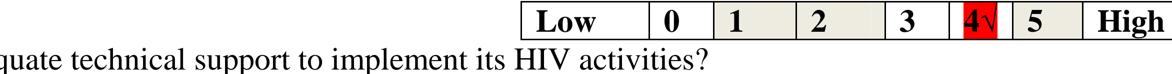


5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?



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

a. adequate financial support to implement its HIV activities?



b. adequate technical support to implement its HIV activities?

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

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

Prevention for most-at-risk-populations				
Injecting drug users (Not applicable)	<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 Counseling	<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%

Overall, how would you rate the efforts to increase *civil society participation* in 2009?

V. poor	1	2	3	4	5	6	7	8	9	10	Excellent

Part B

[Administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

PREVENTION

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

Yes NO

1.1 To what extent has HIV prevention been implemented?

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

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

V. poor	1	2	3	4	5	6√	7	8	9	10	Excellent

Part B

[Administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

TREATMENT, CAR AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services? Yes NO

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	Agree	Don't Agree (2)	N/A
Nutritional care	Agree	Don't Agree	N/A
Pediatric AIDS treatment	Agree	Don't Agree	N/A
Sexually transmitted infection management	Agree	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree	Don't Agree	N/A
Home-based care	Agree	Don't Agree	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't Agree	N/A
HIV testing and counseling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected People	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree	N/A
Other programmes: *[write in]*	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

V. poor	1	2	3	4	5	6√	7	8	9	10	Excellent

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

V. poor	1	2	3	4	5	6√	7	8	9	10	Excellent

HIV/AIDS IN SOUTHERN SUDAN

SOUTHERN SUDAN

UNGASS Progress Report (2008-2009)

March, 2010

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ADRA	Adventist Development and Relief Agency
ARC	America Refugee Committee
ARV	Anti-retroviral
BCC	Behaviour Change Communication
BTS	Blood Transfusion Services
CBOs	Community Based Organizations
CDC	Centre for Diseases Control and Prevention
CPA	Comprehensive Peace Agreement
CSO	Civil Society Organisations
DFID	Department for International Development
FBO	Faith Based Organisations
FHI	Family Health International
FSWs	Female Sex Workers
GFATM	Global Fund for AIDS, Tuberculosis & Malaria
GOSS	Government of South Sudan
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HCT	HIV Counselling and Testing
IDPs	Internal Displaced Persons
IDUs	Injecting Drugs Users
IEC	Information, Education and Communication
IMC	International Medical Corps
M&E	Monitoring and Evaluation
MDTF	Multi Donor Trust Fund
MOH	Ministry of Health
MSM	Men who have sex with Men
NGOs	Non-governmental Organisations
NSF	National Strategic Framework
OVCs	Orphans and Vulnerable children
PEP	Post Exposure Prophylaxis
PHCC	Primary Health Care Centre
PLHIV	People Living with HIV

PMTCT	Prevention of Mother-to–Child Transmission (of HIV)
PSI	Population Services International
SCC	Sudan Council of Churches
SMI	Safe Motherhood Initiative
SPLM/A	Sudan People Liberation Movement/Army
SSHASF	Southern Sudan HIV/AIDS Strategic Framework
SSNeP+	Southern Sudan Network of People Living with HIV
SSOPO	Southern Sudan Older People's Organisation
STIs	Sexually Transmitted Infection(s)
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WAD	World AIDS Day
WFP	World Food Programme
WHO	World Health Organization

Acknowledgement

On behalf of the Government of Southern Sudan, the Southern Sudan AIDS Commission (SSAC) would like to appreciate the input and efforts of UNAIDS and its donors for making it possible to put together this UNGASS Report. Albeit the challenges posited in this Report, it has uncovered a number of issues and provided direction on how to harness the response in a manner that all partners play well coordinated roles. In addition, SSAC candidly recognizes the input by all partners listed in Appendix 1, whether in responding to the National Composite Policy Index Questionnaire, or providing raw data or participating in reviewing and validating the Report. SSAC dedicates special thanks to the efforts of the Consultant, Mr. Laila B Lokosang for bearing with all hiccups and hustles in collecting the data and information that provided the basis of the Report.

Foreword

The biennial compilation of the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Country Report is partially a response to the Declaration of Commitments (DoC) by the UN member countries. That is, to monitor and evaluate progress towards the 25 UNGASS indicators in the response to combating the pandemic. Southern Sudan's compliance to this global task was to produce the last two reports of 2005-2006 and 2008-2009. Southern Sudan realised a semi-autonomous governance status in 2005; which explains why it did not contribute to production of the first report.

The first step of Southern Sudan's response was to establish the Southern Sudan AIDS Commission in 2005 followed by the establishment of the HIV and AIDS Directorate of the Ministry of Health of the Government of Southern Sudan (GOSS). The Southern Sudan AIDS Strategic Framework was produced in 2008 with joint efforts of key stakeholders n adherence to the 'three ones' principle. The Framework addressed the response through six thematic areas: Enabling Environment; Prevention; AIDS Treatment, Care, Support and Impact Mitigation, Capacity Building; Post-conflict Focus (uniformed forces; prisons and detention services; cross-border populations and IDPs) and; Monitoring and Evaluation.

Although some progress was made in the two preceding reporting periods, a complex of factors presented challenges that limited the region's capacity to respond efficiently. Chief among the hurdles were limited implementation and coordination capacities, poor and incoherent monitoring and evaluation efforts (that resulted in scarce and scanty data), lack of knowledge of the epidemic in its scope and, acute shortage of health facilities, skilled and professional human resources, poor coverage by service delivery due to the vastness of territory and too many administrative layers of government.

Nevertheless, the 2009 UNGASS report, compiled with joint collaboration of key stakeholders, has managed to identify gaps and instigated re-prioritization of activities and interventions. The process was delayed due to lack of data in many sources. It is hoped that the next process will start early and that adherence to completion of NASA forms would be taken seriously.

Vianna Kakuli

ACTING CHAIRPERSON

Southern Sudan AIDS Commission

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II. Status at a Glance

2.1 Stakeholder involvement

This is the UNGASS 2010 report for Southern Sudan. This report presents the inputs from all the key stakeholders involved in AIDS response in Southern Sudan including:

- Ministry of Health
- Southern Sudan AIDS Commission
- Southern Sudan Human Rights Commission
- UNDP/Global Fund for HIV, Malaria and Tuberculosis
- World Health Organisation
- UNICEF
- UNFPA
- UNHCR
- Family Health International
- International HIV/AIDS Alliance
- Population Services International
- Southern Sudan Older People's Organisation (SSOPO)
- Intra-Health

Efforts were made to collect data for the recommended indicators of UNGASS including the National AIDS Spending Assessment (NASA) to highlight the progress made during the reporting period of 2008-9.

The draft report was discussed in a wider forum comprising stakeholders of all levels as part of the consensus building as well as to ensure their inputs into the UNGASS report. The comments from the discussion meeting were incorporated to make improvements and finalization of the overall report.

The UNGASS reporting process also included a training workshop focusing on UNGASS reporting and overall M&E system with the support of UNAIDS Regional Office. This was held in Beirut in November 2009 and attended by two national experts from Sudan (one each from North and South) who eventually worked as national consultants to prepare the UNGASS report for Sudan. Finally, the document was peer-reviewed by the experts at the regional level; also with the support from UNAIDS Regional Office in the MENA Region.

2.2 The status of the epidemic in Southern Sudan

Lack of availability of data on HIV prevalence remained a major challenge through 2009. HIV Programmes in Southern Sudan continued to use the 2007 estimate of 3.1, which made the region to be classified as a generalised low epidemic.

As Southern Sudan continues to suffer the setback of low literacy, especially among women, knowledge of HIV in rural communities remained unacceptably very low. In 2006 the Sudan Household Health Survey, applying the Multi-Indicator Cluster Survey (MICS) methodology, found out that knowledge of all three methods of prevention of HIV, also known as the ABC principle (i.e., abstinence from sex, having only one faithful uninfected partner and using a condom every time), was on the average 9.8 per cent in Southern Sudan (see Figure 1). This percentage was unlikely to have improved over the last three years, as the packaging of health services to rural areas continued to be largely curtailed by road inaccessibility and insecurity.

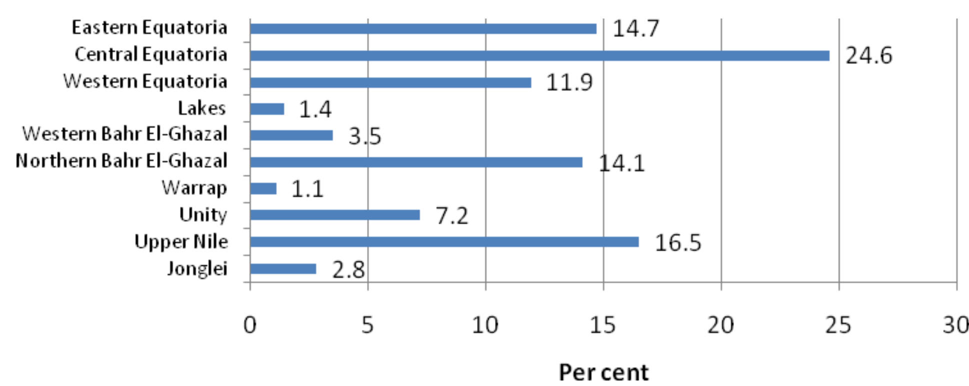

Figure 1: Knowledge of all three ways of HIV transmission, Southern Sudan, 2006 (SHHS, 2006)

In view of these fears, there is no doubt that the task remained enormous for arresting HIV from exploding into a widespread crisis. It seemed, therefore, that the HIV and AIDS partners had to start doubling their efforts by aggressively implementing preventive programmes to targeted populations. One of the programmes widely ignored, if not shied away from, was the planning and implementation of most-at-risk populations (MARP) strategies for containment of the epidemic.

2.3 The policy and programmatic response

The Southern Sudan AIDS Strategic Framework 2008 outlined the policy for HIV and AIDS implementation and the response to the Declaration of Commitments. The Framework underlined six thematic areas of responding to the epidemic by partners involved[1].

The challenge, however, was in the coordination and implementation of this policy, as categorically confirmed by the National Composite Policy Index (NCPI). The Southern Sudan AIDS Commission (SSAC) was the body charged with coordinating the efforts for controlling the epidemic. However, its weak institutional capacity, as many technical positions were not filled, rendered its capability to follow up on passing of policy guidelines, including the National Strategic Framework itself, very limited. It was further reported that the public lacked awareness about existence of policy documents, as the documents were not launched or disseminated.

Human rights policies, especially those inclined toward protection of people living with HIV and other vulnerable groups were either still in draft form or no mechanisms put in place for their implementation. The Human Rights Commission, a government body, lacked the autonomous power to enforce laws. It had no set up HIV focal position with clear mandate, resources and budget. Therefore, issues heavily leaning on human rights statutes, such as safeguarding the rights of most-at-risk-populations, remained invisible.

Although a number of civil society organisations (CSOs) played their part during the development of the Southern Sudan AIDS Strategic Framework, their contribution to policy implementation remained very limited. There were no mechanisms established for proactively garnering the voices of civil society organisations as a united front for lobbying the legislative institutions to pass policy documents. A parliamentary committee, whose functions included HIV, functioned with limited capacity and technical support.

As the planning apparatus of the HIV and AIDS coordinating body and monitoring and evaluation of the epidemic and response remained largely dormant in 2009, there were no policy briefs to provoke Southern Sudan's legislative, executive and judicial bodies into taking a more proactive stance towards HIV policy implementation.

---

[1] The six thematic areas are: (i) Enabling Environment; (ii) Post-conflict Focus; (iii) Prevention; (iv) Care, Treatment, Support and Impact Mitigation; (v) Capacity Building and; (vi) Monitoring and Evaluation.

Notable of the main achievements in 2009, was the establishment of sectoral HIV focal units in key line ministries of the Government of Southern Sudan (GoSS). However, the realisation of this milestone became a real challenge, as funding from the Global Fund was limited. If sector focal units in the Government Ministries of Agriculture, Education and Roads and Transport could become more functional, sensitisation messages of prevention could have benefited large target groups through teachers, extension workers, road construction workers and others. With such set ups in place, there was a great need for reinforcing the coordination of the response by reviewing its structures and capabilities.

There were adequate reasons to believe that the efforts targeting uniformed services through funding from USAID and PEPFAR were creating a difference in this special high risk group. However, with only one civil society (Intra-Health) being in the forefront and operating with limited resources, both human and material, the impact of the response could not have risen to the expected level.

2.4 The UNGASS indicator overview

The resulting list of 25 core indicators for the implementation of declaration of commitments on HIV and AIDS is, as presented in Table 1, reflected some mixed performance in the response.

Table 1: Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS 2010 reporting

Indicators	Indicator Value	Comments
National Commitment and Action		
Expenditures		
1. Domestic and international AIDS spending by categories and financing sources	No data	Data collection for both North and South ongoing
Policy Development and Implementation Status		
2. National Composite Policy Index	Reported	Attached
Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation		
National Programmes: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education.		
3. Percentage of donated blood units screened for HIV in a quality assured manner	0%	All blood banks have SOP for HIV testing. In 2009 total units screened were 250,000 in North and 3,825 in South. There is no schemes for external quality assurance

Indicators	Indicator Value	Comments
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	2.97% (2008) [N=38,764] 4.39% (2009) [N=45,466]	Numerators are only from North Sudan (1151 in 2008 and 1996 in 2009). Denominators are estimated from Spectrum 2009 for entire Sudan
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	0.87% (2008) [N=12,521] 1.72% (2009) [N=14,263]	Numerators are from both North and South as: North (2008/9): 59/90 South (2008/9)=50/155
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	8.29% [N=9,927]	Total estimated number of incident TB cases for PLHIV is 9927 for entire Sudan according to WHO (2007) The numerator for North and South is 648 and 175 respectively
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	28.7% [N=2,464]	The data is from three towns in Southern Sudan from study conducted by MoH/FHI (ROADS Project 2009). No available estimate for countrywide. The 2010 Sudan Household Health Survey is expected to produce this indicator value.
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	FSW 6.5% (2008) [<25=5.7%, 25+=7.2%] [N=321]	This indicator is calculated from an RDS study among FSW in Khartoum in 2008.
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	FSW 1.5% (2008) [N=321]	Data source is same as above. The question used to estimate coverage differs from UNGASS guideline and mentioned details in UNGASS on data tool
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	N/A	Not applicable for Sudan
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	12.8% [N=17,400]	This indicator is calculated from data in North Sudan only. A total of 2,223 schools reached. The source of denominator is Ministry of General Education.
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14*	53.5% (part A) [Male 55.1%, Female	The source of this data is Sudan Health Household Survey (2006).

Indicators	Indicator Value	Comments
	53.2%] 66.8% (part B) [Male 71.1%, Female 65.2%]	
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*	7.3%	The data source is SHHS 2006 conducted among 15-49 years women in Sudan. The indicator was calculated based on two effective ways to prevent HIV. However, The SHHS 2010 included questions matching with the UNGASS guideline to accurately measure this 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	FSW 25.4% (2008) [N=321]	The data source is same as indicator 8 and only for North
15. Percentage of young women and men who have had sexual intercourse before the age of 15	40.8% [N=1,035]	Data source is same as indicator 7. It can be noted that there is a survey done in 2009 among university students and also among out-of schools in North, report not available yet.
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	7.96% [N= 1,331]	The data source is same as indicator 7 and only for South.
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	No data	There is no data.
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	FSW 45% (2008) [<25=46.4%, 25+=43.4%]	The data source is same as indicator 8 and only for North
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No data	There is an RDS bio-behavioral survey among 415 MSM done in 2008 in Khartoum. Data analysis is in progress
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	No data	No data available
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	No data	No data available
Impact		

Indicators	Indicator Value	Comments
22. Percentage of young women and men aged 15–24 who are HIV infected*	North Sudan 0.31% (2007), N=3,524 South Sudan[2] 3.65% (2007), N=2,604	ANC Surveillance is conducted independently in North and South as such there is no compiled figure for Sudan.
23. Percentage of most-at-risk populations who are HIV infected	FSW 0.91% (2008) [N=328]	Data source is same as indicator 8 and only for North
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	56.54% (2008) [N=428]	This indicator is calculated from Cohort studies in North Sudan in 2008
25. Percentage of infants born to HIV infected mothers who are infected	29.75% [N=14,263]	HIV estimation using Spectrum 2009.

*Millennium Development Goals indicator

[2] Southern Sudan ANC Sentinel Surveillance Report (2007). US Centers for Disease Control and Prevention (CDC) on behalf of GOSS MOH and SSAC.

III. Overview of the AIDS Epidemic

Sudan is described as a generalised low epidemic country. There was no recent data on the HIV prevalence of Southern Sudan except the 2006-7 ANC surveillance conducted in 11 sites of Southern Sudan that had an average HIV prevalence rate of 3.1% among pregnant women. During 2009 Southern Sudan conducted its second ANC surveillance with technical support from CDC covering a wider geographical area, however the results of the surveillance were not yet officially declared.

Southern Sudan bordered by countries with high prevalence of HIV and possible increasing cross activity and movements, as the period of relative peace extended to more than five years, there were well placed fears that new HIV infections were on the rise and thus expected rising caseload of people living with the virus. A small sentinel site survey conducted by the Centres for Disease Control in August 2007 determined that the percentage of 3.7 per cent of adults – with a range of 0.9 per cent to 11.5 per cent – was infected. Data were not available of 2009 since no relevant studies were conducted in the period. Western Equatoria State was reported to be the region of high epidemic in terms of both prevalence and rate of new infections.

By the time of submission of this report Sudan was conducting a nationally representative, population-based, survey as a part of the Second Sudan Household Health Survey (SHHS-II), which was designed to obtain national and state level data on the prevalence of HIV and its social and demographic variations. The survey was also designed to obtain information on knowledge, attitudes, and sexual behaviour regarding HIV/AIDS.

The fourth UNGASS indicator showed no change in the proportion of people with advanced HIV infection who received antiretroviral therapy (1.2 per cent). This proportion was alarmingly low, as it indicated that not many infected people (adults and children) cared to check their HIV status and receive ART to reduce the risk of the virus progressing to an advanced stage.

As stated in the preceding chapter, the generally low knowledge of HIV was in itself a risk and a potential factor for the disease to break out into a full blown epidemic. Without empirical data and documentary evidence strategically disseminated to the public, ignorance could result in no behavioural change and indulgence in practices long advocated against. There was no question that the rural population remained by far more disadvantaged, as their radio listenership continued to be very low in 2009.

IV. National Response to the AIDS Epidemic

4.1 National commitment and action

Southern Sudan developed its National Strategic Framework with involvement of most of the partners in the response to HIV pandemic. The process was launched by the Vice President in 2007 and the final document produced in mid-2008. The Government of Southern Sudan committed funds in annual budgets for funding activities of the Southern Sudan AIDS Commission (SSAC) and the Ministry of Health, for coordination and health response respectively. In 2008, the Government set up the Directorate of HIV and AIDS 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 replicate the activities of the GO SS Ministry of Health and monitor and report the cases of infections.

The leadership of the armed forces (the Sudan People's Liberation Army) of the Government of Southern Sudan, with formidable support from USAID/PEPFAR and GFTAM, established an AIDS implementing unit known as the SPLM HIV Secretariat that was implementing HIV-preventive and treatment, care and support activities. However, proportionate to the size of the region and all the government administrative structures, the committed funds and human resources were far inadequate for a resounding response addressing all units of the army and other uniformed services. With 80 counties each with two other administrative layers, the region faced a major challenge in reaching rural communities.

An area where the national response did well was the support to the establishment of the network of associations of people living with HIV known as Southern Sudan Network of People Living with HIV (or SSNeP+ in short). This support included temporary accommodation in a prefabricated house and a vehicle by Government. However, the Network was yet to effectively help establish associations throughout Southern Sudan and produce a comprehensive plan of action for coordinating its affiliate associations.

4.2 National spending assessment

<work in progress to collect NASA data>

4.3 Development of a national multisectoral strategy

Ever since the development of the National Strategic Framework, the Government had not developed a multisectoral strategy to respond to HIV. However, the Southern Sudan AIDS Commission coordinated the appointment of Focal Persons in 19 line ministries (See Annex IV). The Commission was working to support, through the Multi-Donor Trust Fund, the newly established focal points. The funding programme was planned to start with the Ministry of SPLA Affairs and the Ministry of Internal Affairs at its first phase. Ministry of Education and Youth and Sports were to follow later in a second phase. There were no written plans of action to support these statements from the Acting Executive Director of SSAC. The Southern Sudan HIV and AIDS Strategic Framework (SSHASF) spelled out the need for targeting specific populations in a multisectoral 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.

The international partners and in particular the United Nations system helped Southern Sudan integrate HIV plans into the United Nations Development Assistance Framework (UNDAF) for 2008-2010. The plan covered all HIV-related activities: prevention, treatment, care and support, HIV impact alleviation, reduction of stigma and discrimination and women economic empowerment.

With funding from USAID/PEPFAR through its agency Intra-Health, Southern Sudan had developed a formidable strategy for addressing HIV issues among its uniformed services with the Sudan People's Liberation Army (SPLA) topping the list. The strategy targeted implementation of the programmes: behavioural change, condom distribution, voluntary counselling and testing, sexually transmitted infection services, antiretroviral treatment, care and support for PLHIV.

There were no known laws and regulations that posed as obstacles to HIV preventive programmes, treatment care and support of vulnerable populations. The region, however, lacked the watchdog bodies for enforcement and safeguarding the rights of the vulnerable populations.

Overall, Southern Sudan did not do well in its strategy planning efforts for HIV programmes in 2009. With a rating of 6 on a scale of 10, the region actually did worse than in 2007 when the rating was 7 on the same scale[3].

4.4 Political support

The high commitment of the President of Southern Sudan, who was also the Vice President of the Republic, to the eradication of the AIDS epidemic and the fight against stigma and discrimination, was well documented. The World AIDS Day presented the main forum for the Head of Government, state Governors and county Commissioners who pronounced HIV to be 'the next enemy' to be fought at all costs in Southern Sudan, as it presented a real threat to depopulating and retarding the progress of Southern Sudan. Prominent personalities spoke as main guests on radio and television, highlighting the potential threats of HIV and the need to fight it through all prevention avenues.

Southern Sudan had a Country Coordinating Mechanism (CCM), which coordinated all the response to HIV and AIDS. Created in 2006, the CCM coordinated 25 members at both the federal and state level, who were government institutions, UN agencies (WHO, UNDP, UNICEF and UNFPA), other bilateral partners, international non-governmental organisations, civil society organisations, the private sector and faith-based organisations. The CCM was chaired by the by Director General for External Assistance of the MOH in the Government of Southern Sudan. The structure had existed prior to the signing of the Comprehensive Peace Agreement (CPA), which ended war and hostilities between the north and South.

The Southern Sudan AIDS Commission, was the official Government multisectorol AIDS coordinating body with eight members representing the Chairperson, Deputy Chairperson, the Executive Secretary (as Secretary of the Board), Chairperson of the Network of PLHIV (SSNeP+), representative of youth organisation (Youth Desk, representative of women groups (Women Desk) and representative of civil society organisations. However, this body that did not include a private sector representative existed in name only. Its Board was yet to start its initial formal meeting with clear agenda and mechanism for documentation and reporting of proceedings. Without this mechanism put to functioning, it presented a major weakness in SSAC living up to its expectations.

[3] The rating was concurrently done by the two key informants of the Ministry of Health of the Government of Southern Sudan and the Southern Sudan AIDS Commission.

One of the leading challenges threatening to jeopardise the response to the effects of HIV and AIDS in Southern Sudan, was the low spending level (... per cent; see NASA), manifested in poor capacity and weak financial structures to manage and report large amounts of funds; inclusive of accounts and cost centres across all government administrative levels and spanning to principle recipients, sub-recipients and sub-sub-recipients. The SSAC provided some limited support to civil society organisations in all forms except procurement and distribution of drugs and other supplies. Notable of its support in 2009, was its facilitation of full establishment and provision of office accommodation to the Network of Association of People Living with HIV (SSNeP+).

Review of national policies and laws to determine their consistency with its Framework, was in the form of review of tools, guidelines and funding mechanisms by source. There was also internal and external monitoring and evaluation workshops attended by a cross section of SSAC and Ministry of Health officials. The SSAC also coordinated fundraising activities of the Network of Associations of People Living with HIV that resulted in the President of Southern Sudan donating a 4x4 vehicle for the Network.

Overall rating of the highest Government authorities' support was seven on a scale of ten points. Government of Southern Sudan's allocation of funds for some SSAC and Ministry of Health HIV and AIDS activities, the response to some of the needs of SSNeP+, important positive pronouncements and declarations of the President and Governors in World AIDS Day forums, presented the basis for this modest rating. However, lack of effective commitment by the heads of public sector organisations fell below expectations. Partners were widely concerned about the poor response by the private sector and some private sector organisations in mobilising their affiliated organisations and resources to resonate the commitment of the top leadership in Southern Sudan.

4.2 National programme implementation/indicators

The overall weaknesses and dysfunctionality of the HIV monitoring and evaluation system in Southern Sudan could be attributable to the lack of data required for generating the indicators for assessment of UNGASS commitment. Establishment of a central database or central repository of information could have provided ready data for the indicators and reduce time of run-around for collecting disjointed data from partners. Even these last efforts would not suffice the relative large size of Southern Sudan and massive logistical requirements for reaching ten states. Lack of interventions for most-at-risk populations and HIV-related orphans and other vulnerable children also translated to absence of data for generating six indicators (8, 9, 10, 12, 14 and 18). For this reason, the list of indicators in Table 1 contained few indicators and did not provide any significant improvement from that of 2007.

4.2.1 Prevention

Southern Sudan considered prevention as its flag bearer, given that there were notable factors that might lead to HIV becoming a leading cause of morbidity and mortality. This effort was manifest in the budgetary allocations to preventive activities of 50 per cent and above. All HIV partners supported prevention interventions including those targeting most-at-risk populations: injecting drug users, commercial sex workers and male circumcision as done in many countries.

Lack of clear policy on MARPs could be responsible for the lapse in the response. There were seldom any interventions targeting unfavourable cultural practices and attitudes promoting stigma and discrimination. Inevitably, these attitudes discourage many people from seeking voluntary counselling and testing services and treatment, care and support. There was, therefore, a possible high unmet need for the range of available VCT services in Southern Sudan due to ignorance and fear of stigma, stereotype and discrimination. Moreover, Southern Sudan was ground for peculiar hindrances to HIV prevention efforts. Polygamy wife inheritance, tribal marks, cultural tooth extraction and tattooing, were among cultural barriers for interventions of behavioural change and communication (BCC).

A major gap in the delivery of prevention activities was irregular and inaccurate reporting of the dynamics and threat of the virus and AIDS by media houses. There was no planned or implemented intervention to train and sensitise media people on how to report HIV without causing unnecessary fear of discrimination. It was reported that some media instruments still referred to infected people as 'HIV victims' rather than 'clients'.

HIV-related reproductive and sexual health education for young people was implemented with funding through mainly UNICEF, UNFPA and Population Services International (PSI). Some of these funds went to mainstreaming of HIV education into secondary school and teacher education curricula, which was also aimed to address both genders of the learners.

There was notable increase in VCT and PMTCT attendances and condom consumption in 2009 (see related indicators). As indicated earlier, the range of services offered to uniformed services – identified as specific area of need for HIV prevention – are noteworthy. In the post-conflict setting of Southern Sudan, the uniformed services, dominated by ex-combatants and guerrilla fighters, could be treated as a special group of most-at-risk populations. This highly mobile population group poses as potential area of the epidemic erupting. Added to the achievements in prevention were the efforts in promoting PMTCT to become a full-fledged programme, production of blood safety guidelines and VCT, STI and ART guidelines. The development of HIV Policy and BCC Strategy set a remarkable pace to prevention efforts. Obviously, the challenge remained of how to translate the policies and guidelines into activities, outputs and outcomes.

Furthermore, government key informants unanimously agreed that blood safety measures were to some extent accessed by the majority of people in need. These included:

- Universal precautions in health care settings
- Prevention of mother-to-child transmission of HIV
- Information on reduction of stigma and discrimination
- HIV testing and counselling
- Risk reduction for commercial sex workers
- Streamlining of HIV into reproductive health services
- HIV prevention in the workplace

In as far as the development of guidelines, behavioural change and communication strategy, integration of HIV into the health education package, establishment of new VCT centres and provision of ART through the Global Fund support, stood out as key 2009 achievements, there was favourable rating of the efforts for implementation of the HIV prevention programme. The main challenge in 2009 was inadequate funding for sub-state levels (i.e. counties and payams). Additionally, partners in the HIV response believed there was high resistance to change in use of condoms by rural people. Misunderstanding of the benefit of using condom and stereotype were the main reasons for the lack of compliance. An aggressive BCC and school education programme, which was very weak, could offer the solution for this dilemma.

As most-at-risk populations remained invisible and unmapped, the HIV virus would not be contained as an epidemic and future efforts might come too late. There was therefore, an urgency for a mapping intervention that goes in tandem with WHO and UNAID's guidelines for monitoring of HIV in concentrated epidemic settings. Due to very low literacy, information, education and communication materials would not be effective in changing knowledge, attitudes and practices.

A number of challenges were encountered. First, Southern Sudan's lack of clear policy and guidelines for most-at-risk populations and other vulnerable people culminated in near total absence of interventions for these groups. There were semblances or low key interventions by one civil society organisation, HIV/AIDS Alliance International in form of support to community-based organisations working with sex workers. Due to unaddressed stigma and discrimination issues, the bulk of most-at-risk groups remained invisible. For these reasons and other, government key informants rated overall prevention efforts as five (average) on a scale of 10.

Secondly, it was feared that the generally unsatisfactory performance in prevention services could have been due to the unfilled position of the head of Prevention Department in the Southern Sudan AIDS Commission for two years. Although another line manager had been

acting in that capacity, prevention is a massive intervention and should have had a proportionately large department with a range of specialists. The post, which fell vacant when the Director for Preventive Services resigned, should have been filled as a matter of urgency. Third, it was reported that that there was low awareness raising campaigns, especially those targeting community groups. Coupled with inadequate advocacy and sensitisation of policy makers, the obscurity could have translated into the reported cases of resistance to change and resurgence of negative attitudes in the society.

4.2.1.1 Blood safety

The Government of Southern Sudan records show that the total number of donated and screened blood units was 3,825. This represented a 100 per cent rate and indeed a good adherence to the Blood Safety Guidelines, which state that all donated blood must be screened before transfusion. Southern Sudan lacked blood banks and associations for blood donor campaigns. There was very limited number of facilities that had blood transfusion services, as it was the case in 2007.

4.2.1.2 Most-at-risk populations: Prevention programmes

Targeting of most-at-risk populations is the grey but the most dangerous area that is largely not intervened to, even to establish what the true image is. One way or the other, the lack of information to know the size of MARPs and programming appropriately to contain the threat of the concentrated epidemic in those groups, is potentially dangerous. There were some scanty efforts reported in 2009 done through community-based organisations toward sex workers. As human rights laws and institutions remained invisible and passive, it could not be ascertained whether the most-at-risk population groups would surface and demand services in a more overt manner. There are justified worries that demand creation for preventive services for most-at-risk population would become too late, too little.

4.2.1.3 Prevention of mother-to-child transmission (PMTCT)

A UNICEF and other donor-agency-funded Multi-Indicator Cluster Survey (MICS), the Sudan Household Health Survey, determined that maternal mortality ratio put Southern Sudan into the second worse country with over two thousand maternal deaths in every 100,000 live births. Translating to two deaths out of every fifty live births, the finding led to declaration of maternal health as an emergency in Southern Sudan.

There has been tremendous progress in the implementation of the PMTCT programme in 2009 despite some challenges. Under the leadership of the Ministry of Health, PMTCT guidelines

were developed and finalised. The development of the guidelines facilitated the implementation of PMTCT services in Southern Sudan.

PMTCT service Provision was supported by two major partners: Intra Health and UNICEF, who worked in collaboration with the Ministry of Health GoSS and other partners to increase access to the services. By the end of 2009, there were 19 health facilities where a minimum package of PMTCT was provided. These facilities provided testing to 13,141 pregnant women of which 265 tested HIV positive and 155 (59 per cent) received ARV prophylaxis in form of single dose Nevirapine. In 2008, only three PMTCT sites were functional and 3,089 pregnant women got tested for HIV, of which 50 were HIV positive and received ARV prophylaxis. The provision of PMTCT in Southern Sudan was slow in scaling up due to challenges; including limited human resource capacity, lack of appropriate infrastructure to provide quality PMTCT services, limited capacity of health facilities to offer combined ARV prophylaxis and ANC revisit rate and health facility delivery.

4.2.1.4 HIV testing

Southern Sudan saw a remarkable achievement in the number of VCT sites. There was steady increase between 2006 and 2008 and then a sharp rise in 2009 (see Figure 2). The increase from 2008 to 2009 was 138 per cent – from 13 in 2008 to 31 in 2009.

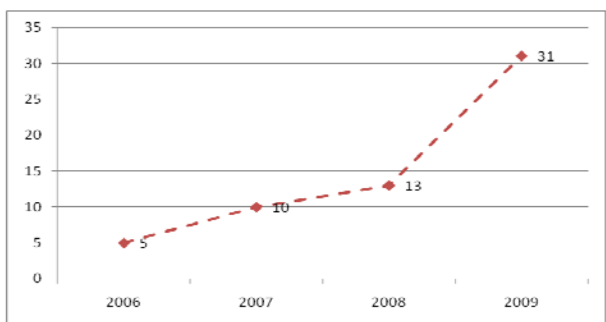

Figure 2: Increasing annual trend of VCT sites in Southern Sudan (MOH-GOSS, 2006-2009)

It is quite satisfying to note that the increase in number of VCT sites caused a corresponding increase in the number of people tested at VCT sites for HIV since 2005. As shown by Figure 3, the trend line peaked in 2008 and 2009. The Figures were collected from the MOH HIV/AIDS Directorate courtesy of FHI/ROADS Project, UNICEF and Intrahealth HIV Programmes.

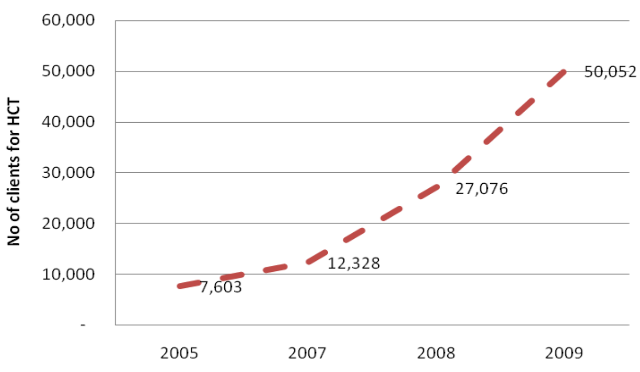

Figure 3: **Number of HIV counselling and testing clients (MOH-GOSS, 2005-9)**

Despite this gradual achievement in number of people counselled and tested for HIV, some specialists observed that that the number of clients reached was low and that very low literacy rates, especially among women, deprived many people from seeking the services. It was also observed that the uneven distribution of functional VCT sites by state and county, translated into many potential clients not getting the service (i.e. high unmet need). Therefore, even though lack of survey data made it impossible to calculate the seventh UNGASS Indicator, it could be a foregone conclusion that the percentage of women and men aged 15 to 49 who received an HIV test in 2009 and who knew their results would be very low. As per guidelines, this indicator serves to motivate BCC programmes to double their efforts in encouraging young people to seek VCT services. There is no doubt that the BCC programmes were still lagging behind in approach and information, as the epidemic remained relatively unknown.

The August 2009 Behavioural and Monitoring Survey for a special group of defined most-at-risk population, arrived at the results shown in Figure 4 below. If testing for HIV by a group to be identified as most-at-risk was as low as below 50 per cent, what could be of the general population? HIV testing for this group was calculated to be 28.7 per cent.

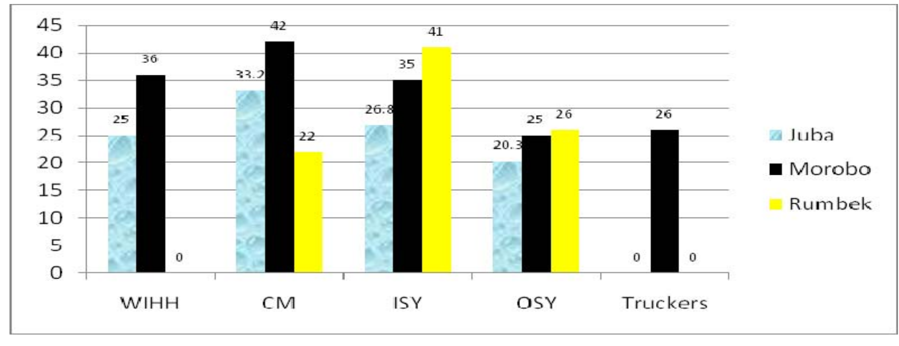

Figure 4: **Percent distribution of respondents ever tested for HIV (MOH-GOSS and FHI, 2009)**

4.2.1.5 Young people's knowledge about HIV prevention

There was no latest statistics regarding young people's knowledge of HIV. The only available information was the one from the 2006 Sudan Household Health Survey shown in Figure 1. Key informants were concurrent that knowledge of HIV still remained very poor in Southern Sudan, as the level of education was low, many people still lived in denial of the risk, infrastructure was in poor state and there was little behavioural change and communication work, especially at the community level.

Southern Sudan persistently organised World AIDS Day events (every fifth of December) since 2005 with high involvement of stakeholders in planning, resourcing, organisation and participation. Usually there was high level participation of the President of Southern Sudan and other dignitaries. The last World AIDS Day was staged in Yambio, the administrative capital of Western Equatoria State. The event, usually organised in open air public arena, drew a large audience from a cross section of the public. The public was rallied through the media and the colourful event was covered life using public address system, different radio channels and television. Health education materials were largely distributed which included banners, posters, head caps, T-shirts and umbrellas. School children, the youth and the organised uniformed services (army, police, prison warders and wildlife forces) usually paraded in great aplomb to add colour and entertainment to the public event. The Network of Association of People Living with HIV usually played part in addressing the public, expressed their concerns to the leadership and giving personal testimonies about positive living with the virus. This single annual event provided the opportunity for the HIV and AIDS community to reiterate the dangers of the epidemic and of ignoring it. There is no doubt, therefore, that many people and leaders came to learn about the many facets of HIV, the implications of denial, stigma and discrimination.

That Sudan remained a generalised low epidemic country played negatively in attracting both wide international and national attention. The post conflict situation of the country also made many of the people and organisations concerned with recovery, reintegration, reconstruction and insecurity agenda. It also meant there was acute shortage of local expertise in healthcare and delivery, poorly resourced and sparse health facilities.

As many young people did not read, printed messages on behavioural change could not give much impetus to health education and prevention efforts. The print and listening media could not give better access, as fewer people read newspapers and listened to the radio (various behavioural and communication studies). The only effective avenue of communication, therefore, would be public and community interactive forums and open-air campaigns. Peer education and youth group forums could also provide effective ways for creating positive

impact of BCC activities. There were a number of efforts by civil society organisation such as Population Services International (PSI), International HIV and AIDS Alliance and others, working through community based organisations that were in the form of peer education and training and awareness raising community forums.

4.2.1.6 Most-at-risk populations' knowledge about HIV prevention

Interventions for most-at-risk populations became the major shady area in Southern Sudan that rendered the epidemic unknown and thereby obscuring knowledge of the potential risk. In 2007 it was reported that the most-at-risk population groups were unmapped and lacked information. In August 2009, the Ministry of Health and Family Health International (under the ROADS Project) conducted a Behavioural Monitoring Survey of most-at-risk populations with funding from USAID. The study was, however, limited to three towns and two states[4]. Four groups of MARPs were identified although not all surveyed areas included them. The study provided some substantive information on the risk and epidemiology of HIV and AIDS in these population groups (in-school youth, out-of-school youth, women aged 15-49 exposed to dangerous social behaviours). Although dented with incomplete data, the study reported relatively poor knowledge of all three, widely advocated, methods for preventing HIV infection (Table 2). It is a known fact that hearing of the disease alone would not translate into knowing the basic facts. This is reinforced by the fact that over half of the women in Juba and Morobo towns did not get the facts about PMTCT right.

It could be noted that definition most-at-risk populations in the study left a number of questions unanswered. At the very top is the fact that the sample was inclusive of people who answered 'no' to the question on whether they used sex for livelihood purposes or not; whether they used drugs or not. Indeed the target population could be followed up and determined for programmatic intervention.

[4] Juba (Central Equatoria State; sample size=1,339); Morobo (Central Equatoria State; sample size=1,484); Rumbek (Lakes State; sample size=503)

Table 2: Knowledge of HIV/AIDS and prevention methods (Juba, Morobo and Rumbek, 2009)

	Site	Women (15-49 years)	Men (25 years +)	In-school youth (15-24 years)	Out-of-school youth (15-24 years)	Truck drivers
Heard of HIV and AIDS	Juba	91.8%	90.9%	96.4%	88.0%	No data
	Morobo	92.4%	97.7%	75.6%	81.8%	91.2%
	Rumbek	No data	No data	No data	No data	No data
Knew all three methods of preventing HIV[5]	Juba	25.7%	42.1%	43.4%	36.7%	No data
	Morobo	40.3%	48.9%	19.0%	38.6%	35.5%
	Rumbek	No data	16.0%	10.0%	25.0%	No data
Knew that an infected pregnant woman can transmit HIV to her unborn baby (PMTCT)	Juba	49.8%	66.7%	49.9%	52.9%	No data
	Morobo	41.0%	57.2%	77.1%	53.9%	22.1%
	Rumbek	No data	No data	No data	No data	No data

In 2007 it was reported that Southern Sudan justifiably defined another most-at-risk population group – the Sudan People's Liberation Army (SPLA). The special setting of Sothern Sudan (due to its post conflict environment) warranted the main organised ex-fighter group to qualify as a most-at-risk population. However, even with this understanding, there was no information on the number of SPLA soldiers who could identify correctly three ways of prevention from HIV.

4.2.1.7 Sex before the age of 15

This indicator was determined using data from household behavioural surveys or school based surveys. The behavioural survey mentioned in section 4.2.11 provided some results of the mean age of sexual debut of in-school youth and out-of-school youth aged 15-24 years.

Table 3: Mean age of youth respondents at sexual debut (Juba, Morobo and Rumbek, 2009)

Age group	Gender	Juba	Morobo	Rumbek
In-school youth	Male	16.2	13.3	15.8
	Female	16.4	13.5	14.5
Out-of-school youth	Male	16.9	14.7	16.1
	Female	16.7	16.7	15.8

The survey showed that youth in Morobo on the average started indulging in sexual activities early with in-school males and females averaging just below 14 years and out-of-school youth just below 15. In Juba, however, sexual debut was delayed up to the age of 17. With Morobo as an exception, there was no significant difference between males and females in the mean age

[5] The ABC (abstinence, faithfulness to one partner and condom use) prevention methods

of sexual debut. The survey (Table 4) also investigated the proportion of youth who started sex at 15 years and below.

Table 4: Percentage of youth who had sex latest by age of 15 (Juba, Morobo and Rumbek, 2009)

Age group	Gender	Juba	Morobo	Rumbek
In-school youth (%)	Male	29.4	68.8	38.4
	Female	28.0	26.9	90.0
	Total	**28.8**	**60.9**	**43.1**
Out-of-school youth (%)	Male	41.4	48.6	37.4
	Female	27.1	21.9	58.3
	Total	**37.6**	**41.8**	**39.8**

It was shown that the majority (61 per cent) of Morobo in-school youth had started engaging in sex by the age of 15 with males (69 per cent) dominating in this group. The Rumbek figures for females are, however, questionable (appear in parenthesis in the source report), having emanated from a very small sample (too many missing values or "don't know" responses). In general, sexual debut was rather early for most male youth. Meta analysis showed that 41 per cent of the youth of all groups and both sexes had sex by the age of 15.

4.2.1.8 Condom use during higher-risk sex

The behavioural monitoring survey cited above reported the use of condoms among most-at-risk people who had sex with more than one partner. However, it only reported "proportion of sexually active youth who have ever used a condom (male/female) at different points in time". Per cent of youth identified as most-at-risk populations were determined by the Behavioural and Monitoring Survey of 2009 (see Figure 5) to be generally low (range. 15.4 to 50 per cent).

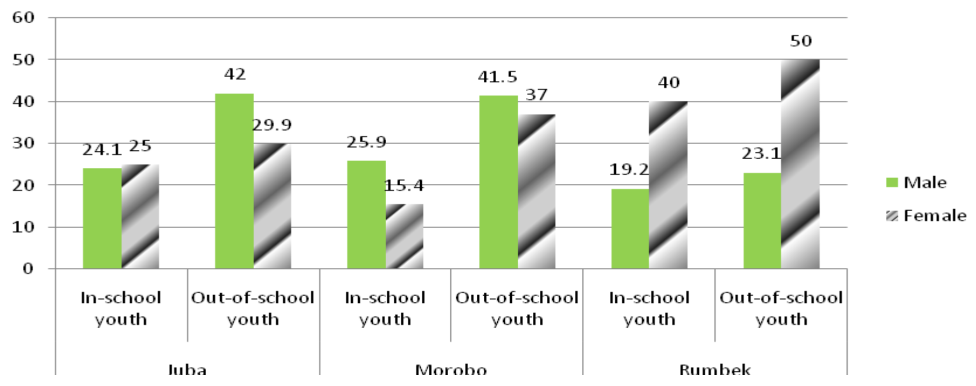

Figure 5: Per cent distribution of in-school and out-of-school youth who ever used condom (MOH/FHI BCC Survey, 2009)

4.2.1.9 Men who have sex with men: condom use

Interventions targeting MSMs remained invisible in Southern Sudan. The laws of the Sudan did not allow this group of MARPs to be recognised and operate in an overt manner. This would, therefore, make it difficult for organisations to target them. Moreover, the available organisations seemed to lack the relevant expertise for identification and mapping of MSMs. For this reason, there was no data to support determination of the indicator.

4.2.1.10 Injecting drug users: condom use

The population of injecting drugs users is not known and not mapped. It is possible that the phenomenon or practice did not exist in Southern Sudan due to unavailability of the substance for injection in the local markets. The cost of the substance could also be too prohibitive for the generally poor and far less sophisticated population. The presence of locally produced drugs like cannabis, marijuana or Indian hemp, could also mean users had cheaper alternatives to injectable drugs. In general, use of injecting drugs was not common in Southern Sudan until December 2009, as there were no criminal records on the phenomenon. Therefore, the indicator could not be applicable in the context of Southern Sudan.

4.2.1.11 Injecting drug users: safe injecting practices

As in 4.2.1.10 above.

4.2.2 Treatment, care and support

Key respondents to the treatment, care and support NCPI questionnaire were the Ministry of Health of the Government of Southern Sudan (GoSS) and the World Health Organisation (WHO). Both organisations concurred that the specific needs for HIV treatment, care and support were identified although not comprehensive, especially in addressing barriers for women and most-at-risk populations. Estimation of people living with HIV was done using WHO/UNAIDS models. This was through data from HIV testing facilities and estimates of people in need of ART (about 23,000 and estimated number of Southern Sudanese who are living with HIV is 137,000). Key informants were also concurrent in that the majority of people living with HIV did not have access to:

- Antiretroviral therapy
- Paediatric AIDS treatment
- Sexually transmitted infection management
- Psychosocial support (for PLHIV and their families)

- Home-based care
- Palliative care and treatment of common HIV-related infections
- Post-exposure prophylaxis for in HIV infected people
- HIV treatment services in the workplace for treatment referral system through the workplace
- HIV care and support in the workplace

Conversely, there was agreement that majority of people in need had access to the following:

- HIV counselling and testing for TBA patients
- TB screening for HIV infected people
- TB infection control in HIV treatment and care facilities
- Cotrimoxazole prophylaxis

Southern Sudan developed protocols and guidelines for using generic drugs. However, the region did not have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms and substitution drugs.

Overall efforts in the implementation of treatment, care and support programmes in 2009 were rated as average (5 on a scale of 0 to 10). This was largely due to unresolved challenges such as:

- Lack of staff in the procurement and supply chain management involving the facilities and the Ministry of Health
- Slow expansion rate of treatment centres
- Lack of proper delivery of nutrition support to people on ART treatment
- Inadequate implementation of home-based care activities
- Limited overall health service coverage by ART services (wide unmet need)
- Inadequate trained human resource for ART centres

However, there were some remarkable achievements in 2009 in form of high increase in the number of people in HIV care. By December 2009, people on ART treatment increased from 374 (in 2007) to 1,900. Also by December 2009, number of people enrolled for HIV care increased to 6,406; up from 546 in December 2007. Furthermore, there was a rise in number of HIV paediatric care cases of 176 cases in 2009.

Southern Sudan AIDS Strategic Framework 2008 included a policy for addressing the HIV-related needs of orphans and other vulnerable children (OVC). However, there was no operational plan in 2009 for delivering services to OVCs. Although an operation UNICEF and international definition for OVCs was adopted, the Ministry of Gender, Social Welfare and

Religious Affairs, did not come out with an operational plan for OVC support. Lack of coordination could be blamed for this shortfall. Moreover, there was no intervention for mapping or estimating the number of orphans and vulnerable children due to HIV and AIDS. This could explain why the problem remained unknown. Subsequently, there could be no doubt as to why the overall 2009 efforts in meeting the HIV-related needs of orphans and other vulnerable children were rated as below average (4 on a scale of 0 to 10).

4.2.2.1 HIV treatment: Antiretroviral therapy

The proportion of adults and children with advanced HIV infection had not changed in 2009 from that of 2009; it remained 1.3 percent. However, as stated elsewhere above, the number of people on ART treatment went up quite significantly to nearly 1,900 clients; up from 374. This was largely due to expansion of ART treatment sites and the more proactive interventions for unformed services.

4.2.2.2 Co-management of tuberculosis and HIV treatment

With support from the mainly the World Health Organisation, co-management of tuberculosis and HIV was delivered through 2009. One of the main reasons for encouraging people to seek voluntary counselling and testing services, is to prevent infection with tuberculosis if found with HIV and receive earlier care and treatment. All TB cases are supposed to be investigated for HIV and vice versa. Antiretroviral sites and TB diagnoses and treatment facilities were limited to the few (less than seven) hospitals that also lack comprehensive diagnostic, treatment and care services. The ART sites reported 99 HIV cases on TB treatment, giving 2.7 per cent, which is by far a worrying indicator, meaning the unmet need was tremendous.

4.2.2.3 Support for children affected by HIV and AIDS

The Ministry of Gender, Social Welfare and Religious Affairs of the Government of Southern Sudan, established a focal point for HIV and AIDS under the Directorate of Child Welfare. This is the line ministry that is supposed to lead in implementation of activities for the welfare of orphans and other vulnerable children including AIDS-related orphans. However, due to capacity gaps, the Ministry could not develop a project for support and care of AIDS-related orphans and other vulnerable children.

In the Southern Sudan AIDS Commission, the Directorate of Treatment, Care and Support is supposed to lead in the coordination of all support activities including OVCs. However, acute shortage of staff posed as major hindrance to implementation of strategies and plans as contained in the Southern Sudan HIV and AIDS Strategic Framework.

With the epidemic remaining unknown in magnitude and degree, proposing any project for orphan care and support could be likened to shooting a target in the dark. By December 2009, neither the Ministry of Gender, Social Welfare and Religious Affairs nor the Southern Sudan AIDS Commission had set up capacity for monitoring OVCs-related activities. It was not surprising, therefore, that the visibility of OVCs was obscured. AIDS-related orphans for 2009 were estimated to be about 31,000 in Southern Sudan. However, this estimation was done towards the end of 2009.

4.2.2.4 Life skills-based HIV education in schools

Life skills-based HIV education is programme intended to make children grow knowing the dynamics of the epidemic. It not only enriches knowledge but also encourages young people act as change agents while participating openly as peer educators in community-based activities. The Ministry of Education was supposed to be the leading implementing agency in establishing, overseeing and resourcing this programme. Unfortunately, efforts for promoting the programme were far from convincing. Still inadequately resourced, the HIV Focal point in the Ministry of Education did not carry out any mapping exercise to generate the required data for determining the number of schools with life skills-based HIV education.

4.2.2.5 Orphans' school attendance

A civil society organisation, Southern Sudan Older People's Organisation (SSOPO) was leading in 2008 and 2009 with a programme for identification and support of HIV and AIDS-related orphans and other vulnerable children. The support came in form of enrolment in schools and payment of fees using funds received from international partners, mainly HelpAge International. SSOPO collaborated with the Network of People Living with HIV to identify the OVCs and document them. Until 2008 the programme supported 490 OVCs in schools, but in 2009, when HelpAge International wrapped up work in Sudan, the organisation could not enrol new OVCs except for some 20.

With an estimated 31,351 AIDS orphans, the number of orphans served was a drop in a drum. It represented coverage of 1.6 per cent. It is possible that lack of statistics made it difficult for organisations to know the epidemic and the effects associated with it. Subsequently, programmes could not use the required evidence to convince donor agencies of the issue was of urgency. If only the HIV and AIDS partners could dedicate more efforts to collecting reliable data, programming, targeting and attracting funding would be possible. The proportion of nearly two AIDS-related orphans of 100 receiving educational support could mean about 98 per cent were either out of school or supported through the extended family system.

4.3 Trend analysis on the key NCPI data

Generally efforts for the response to HIV and implementation of programmes had worsened in 2009 compared to 2007. The momentum reached in 2007 simply slackened. Given the circumstances that were feared to increase infections in Southern Sudan's relatively young population, one would anticipate an increase in prevention efforts. However, key informants maintained that efforts for prevention policy support did not improve and remained average (Table 5). Similarly, efforts for implementation of prevention programmes could not pick up. It could be possible that lack of coordination and evidence-based planning of prevention programmes could be blamed for the non-improving three-year trend of prevention rating.

Table 5: Trend analysis of overall rating of efforts by government and partners in the HIV response

	NCPI response context	**Rating (0=very poor; 10=excellent)**		
		2005	2007	2009
1	Efforts for strategy planning	4	7	6
2	Efforts for political support	6	8	7
3	Efforts for policy in support of prevention	4	5	5
4	Efforts in the implementation of HIV prevention programmes	3	5	6
5	Efforts in the implementation of HIV treatment, care and support programmes	No data	No data	5
6	Efforts to meet the HIV-related needs of orphans and other vulnerable children	3	3	4
7	M&E efforts of the HIV programme	3	5	4

V. Best Practices

5.1 High level participation in World AIDS Day

The World AIDS Day remained a single annual event that was persistently used to sensitise thousands of people in one public arena. The President of Southern Sudan, Lieutenant-General Salva Kiir Mayardit, was on mark to have officiated all five World AIDS Day events since December 2005. This in itself is an exemplary commitment from the highest office in the region. The presence of the President provided an opportunity for live radio and television coverage and wide coverage other mass media. The occasion also provided a ground to prominent personalities from the HIV and AIDS fraternity to give remarks and educate the public about HIV and AIDS through panel interviews and discussions. In the last World AIDS Celebration, which took place in Yambio, Western Equatoria State, President Kiir made remarkable commitment toward the Network of People Living with HIV by donating a vehicle.

5.2 An aggressive programme for the military

There was adequate evidence suggesting that the most aggressive and progressive HIV programme was the one implemented for the military, which in the context of Southern Sudan, are the Sudan People's Liberation Army (SPLA) units. The programme experienced some notable expansion in its service delivery package since its establishment around 2007. By the end of 2009, the programme became a major partner in the response to HIV and AIDS, thanks to funding from PEPFAR. One of its remarkable achievements was its involvement of senior military officers in running its operations and in rallying their forces in sensitisation campaigns and playing role models in voluntary counselling and testing activities.

5.3 Focal points in line ministries

In 2009, Southern Sudan scored a landmark in identifying and recruiting focal points in 19 line ministries and specialised commissions (see Annex IV). The effort, if well coordinated and supported, would go a long way in not only making the response more visible, but also in influencing implementation of work-related HIV policy regarding protection of rights of infected and affected people. It was hoped that the programme would have strategies for scaling up and standard reporting. Confinement of the programme to Government of Southern Sudan Ministries without replication of efforts at the state level and the private sector would be counterproductive in that the bulk of the working class would be missed out.

VI. Major Challenges and Remedial Actions

The list of challenges (Table 6), compiled with inputs and insights from key informants, could not be exhaustive. However, if the few challenge identified below could find solutions, the situation and efforts for managing and monitoring the epidemic and the response to it could improve.

Table 6: Challenges, progress, remaining issues and remedial action

	Key challenges reported in the 2007 UNGASS Country Report	Progress made on key challenges as per 2007 Report	What remains to be done	Remedial actions
1	Coordination of stakeholder planning and budgeting activities	Very limited progress made	Establishment and strengthening of the SSAC Board	Inclusion of activation of SSAC Board in the National Action Plan
2	Limited communication of coordinating body with implementing partners	Very limited progress made. There was email discussion forum. However, it lacks outputs	Establishment of a functional (physical) coordinating HIV and AIDS Forum. Creation of a Secretariat for the Forum	Development of TORs for the Forum Secretariat with clear and distinct responsibilities and work plans
3	General poor implementation capacity	Very limited	Review the existing organisational structure of each line department based on expected outputs/results	• Competitive recruitment of technical officers. • Attractive remuneration package for professional and technical personnel • Need and performance based training • Reviewing of the financial and human resource management capacities
4	Dysfunctional monitoring and evaluations system	Addition of two new officers at SSAC. A number of CSOs had their own M&E staff and systems	Full implementation of the AIDS M&E Framework	• Resident technical support at the central level for establishment of M&E system • Reactivation of the M&E Forum with clear TORs
5	Lack of knowledge of the real drivers of the epidemic and therefore inappropriate planning and programming	Very limited. MOH and Family Health International conducted a study on MARPs in 3 states	Accelerate the process of conducting the sero-behavioural survey	Funding of a BCC study
6	General poor attitudes toward risk of HIV and denial	Very limited. There are some scanty efforts by some CBOs on stigma, denial and	Well coordinated joint BCC programme for aggressive response to the poor attitudes of	Development of special BCC strategy and programme for joint implementation by key stakeholders

	Key challenges reported in the 2007 UNGASS Country Report	Progress made on key challenges as per 2007 Report	What remains to be done	Remedial actions
		discrimination reduction	denial and stigmatisation	

VII. Support from Development Partners

7.1 The body of development partners

Over twenty development partners served in Southern Sudan in 2009. Most of the partners had been in Sudan prior to and since the establishment of the Government of Southern Sudan in 2005. Major sources of funds were (a) multilateral partners: The Global Fund (GFTAM), the Multi-Donor Trust Fund (MDTF) and UN principal recipients such as WHO, UNFPA, UNICEF and UNHCR and (b) bilateral partners: United States Agency for International Development (PEPFAR) and others. International civil society organisations mainly acting as sub-recipients of funds for HIV and AIDS were the frontline implementers of activities but unfortunately not according to a National Operational Plan as per international guidelines and the 'three-ones' recommendation in the UN Declaration of Commitment. Six leading partner civil society organisations were identified as key informants to the NCPI section titled 'Civil Society Participation'. Below are their perspectives and insights.

7.2 Contribution to political commitment strengthening

As shown by the median rating of 2 on a scale of 0 to 5 (Table 7), the six CSO's demonstrated overall low contribution to strengthening of political commitment of top leaders and national strategy or policy formulation. Contribution of CSOs was mostly limited to development of guidelines and the development of the National Strategic Framework. As asserted by two of the CSOs, poor capacity and coming together of the CSOs as one lobby group, were among the reasons for the poor CSO participation in rallying effective political commitment.

Table 7: Assessment of contribution of civil society organisations

	Organisation	**Rating (0=low; 5=high)**	**Comments and examples**
1	FHI	2	▪ Capacity of CSO had not been built and was very limited. ▪ CSOs not coming together as a lobby group to influence active leadership commitment
2	International HIV/AIDS Alliance	2	▪ Lack of CBOs capacity for making positive contribution toward policy and strategy ▪ No link between community and policy making bodies ▪ Most CSOs constrained by internal regulations for protection of the organisation's image or fear of making a 'politically incorrect' step
3	PSI	3	Participated in development of the NSF, HIV coordination meetings and HIV guidelines document reviews

	Organisation	Rating (0=low; 5=high)	Comments and examples
4	SSOPO	2	Met the Minister if Gender and Social Welfare to seek assistance for OVCs. There was promise to lobby donors to support OVCs in orphanages
5	Intra-Health	3	▪ Contributed to development of VCT guidelines and drafting of PMTCT guidelines ▪ Contributed to production of SPLA HIV Strategic AIDS Plan ▪ Supported the Ministry of Internal Affairs and its different organs with development of HIV Policy statements addressing uniformed services
6	SSNeP+	2	▪ SSNeP+ fully participated in development of the NSF 2008 ▪ Concerns of PLHIV were formally forwarded to the President through a written memo by SSNeP+. These granting of incentives to PLHIV on awareness raising tasks. There was positive response from the President

7.3 Civil society involvement in planning for National Strategic Plan

There was mixed reaction to the question of involvement of CSO in NSP planning and budgeting (Table 8). CSOs were on either end of the scoring scale where two NGOs had no contribution and three had good level or full involvement. This tells of lack of proper coordination of the organisations using an effective communication strategy. It seemed smaller CSOs were the ones that were disadvantaged in being involved in national planning and budgeting processes.

Table 8: Assessment of their involvement in planning and budgeting for National Strategic Plans

	Organisation	Rating (0=low; 5=high)	Comments and examples
1	FHI	5	▪ FHI was fully involved in planning, budgeting, development of resources and dissemination of materials
2	Alliance	4	▪ MOH and SSAC invited stakeholders to document reviews, planning and budgeting meetings
3	PSI	3	▪ Participated in budget working sessions ▪ Participated in Global Fund Round 8 budget activities even though CSO did not succeed to receive funding from this source
4	SSOPO	0	CSO did not participate in any planning and budgeting process for the NSP
5	Intra-Health	0	CSO did not participate in any planning and budgeting process for the NSP

	Organisation	Rating (0=low; 5=high)	Comments and examples
6	SSNeP+	4	▪ Participated in development of plans and budgets under MDTF and GFTAM

7.4 Inclusion of CSO prevention, treatment, care and support services in National AIDS Strategy, budget and reports

There were mixed feelings with regard to CSOs' inclusion of prevention, treatment, care and support services in national AIDS strategy, budgets and reports (see Table 9). Family Health International was the only one that included its range of services, to almost a full extent, to be reflected in the National Strategy, Budget and Reports. Likewise, PSI did relatively well. On the contrary, SSOPO's activities remained obscured in the NSP, budget and reports (although it is known that no national report was produced in 2009 or the previous years).

Table 9: Inclusion of prevention, treatment, care and support services in CSO's strategies, budgets and reports

	Organisation	Rating (0=low; 5=high)			Comments and examples
		Strategy	Budget	Reports	
1	FHI	5	4	4	FHI contributed with the section of Counselling and Testing in the World AIDS Day Report 2009
2	Alliance	4	3	0	▪ Never asked to submit a report to SSAC. However, a report was being compiled to be submitted to the Office of the Vice President of GoSS through SSAC ▪ Alliance's budget for 2009 was incorporated in the overall figures of the Directorate of External Relations of MOH. However, SSAC's budget did not reflect those figures.
3	PSI	3	3	4	▪ PSI did not follow the National AIDS Strategy ▪ PSI conducted a joint plan with Alliance and FHI ▪ Reports of PSI were submitted to SSAC and MOH but no feed back in form of one national report
4	SSOPO	1	1	1	▪ Not asked to supply budget figures by SSAC ▪ Organisation submitted its plans and budget to its donors directly

	Organisation	Rating (0=low; 5=high)			Comments and examples
		Strategy	Budget	Reports	
5	Intra-Health	5	0	3	▪ Organisation was not asked to provide its budget for incorporation into the National Budget ▪ Circulated its annual report to partners but did not get feedback
6	SSNeP+	3	3	2	▪ Organisation did not have its own strategy ▪ However, it was earmarked as sub-recipient of Global Fund Round 9 and did receive some funds ▪ Organisation did not compile any annual report in previous years, as it was not asked to do so (it was in the process of compiling its Annual Progress Report)

7.5 CSO's inclusion in the monitoring and evaluation of the HIV response

Inclusion of civil society organisations in the monitoring and evaluation of the HIV response varied according to size and nature. It was clear that the international CSOs participated the more in development of the national M&E plans, M&E committees and working groups and had their own M&E efforts. As shown in Table 10, the smaller and national CSOs played relatively low role in this area.

Table 10: Inclusion of prevention, treatment, care and support services in CSO's strategies, budgets and reports

	Organisation	Rating (0=low; 5=high)			Comments and examples
		Strategy	Budget	Reports	
1	FHI	4	4	4	▪ FHI used the national M&E tools for data collection and reporting. It reported at Southern Sudan, state and county levels ▪ FHI participated in M&E meetings
2	Alliance	5	4	4	▪ Alliance were fully involved in the process of developing of the Southern Sudan M&E Framework ▪ Alliance was initially involved in M&E Technical Working Groups before meetings faded out ▪ No indicators, baselines and targets provided for planning by CSOs ▪ Alliance had its own M&E plans and tools, developed with its implementing CBOs and has indicators for each of its projects. The tools were reviewed annually.

	Organisation	Rating (0=low; 5=high)			Comments and examples
		Strategy	Budget	Reports	
3	PSI	4	4	4	▪ PSI M&E Department was still new but PSI was actively involved in the development of the national HIV and AIDS indicators ▪ PSI had data flow policy that are in tandem with those of Southern Sudan HIV M&E framework
4	SSOPO	2	0	4	▪ Not asked to provide data. However, in 2009 SSOPO attended one review and planning workshop ▪ Not part of M&E Technical Working Group ▪ Adopted a results-based reporting system using various tools for data collection
5	Intra-Health	5	3	-	▪ All Intra-Health forms were reviewed and adopted during the Southern Sudan HIV M&E Framework development ▪ The M&E TWG never met in 2009
6	SSNeP+	1	1	1	▪ SSNeP+ did not participate in development of the Southern Sudan HIV M&E Framework and only attended an M&E meeting once

7.6 Inclusiveness of the civil society sector of special interest groups

There was reasonable level of involvement of special HIV response organisations (the Network of PLHIV and faith-based organisations) in activities of CSOs (Table 11). However, sex workers and other most-at-risk population groups remained invisible due to lack of interventions targeting them. The comments by International HIV/AIDS Alliance (Sudan) that assert that some partner organisations found it difficult to work with MARPs such as female sex workers, should be noted. This could be the main reason why there were very limited or no interventions targeting MARPs. The fear of failure and losing reputation could not be overlooked.

The sentiment expressed by one CSO that networking among CSOs was not strong and persistent, also need not be downplayed. This could also provide evidence of poor coordination and the reason why there were no concerted efforts to uniformly outline priorities or lining up common approach to challenges. Otherwise, it could also reflect some competition among CSOs in what is known as ‘territorial claims’ – a phenomenon that might defeat the purpose of the Declaration of Commitments and the ‘three ones’ principle.

Table 11: Assessment of CSO involvement in planning and budgeting for National Strategic Plans

	Organisation	Rating (0=low; 5=high)	Comments and examples
1	FHI	4	▪ CSO worked in partnership with other international organisations and national CBOs in a consortium fashion
2	Alliance	3	▪ Not all key population groups were involved e.g. not all organisations worked with FBOs and FSWs ▪ Alliance worked with sex workers while some CSOs found it difficult to work with FSWs, especially Sudanese FSWs who fear stigma and discrimination
3	PSI	4	▪ Worked very closely with CBOs and implemented activities through CBOs e.g. youth and women groups, FBOs and the uniformed services other than SPLA
4	SSOPO	4	▪ SSOPO worked very closely with the associations of PLHIV, including identification of OVCs and extending support to them ▪ An income-generating programme was implemented for support of vulnerable PLHIV in collaboration with associations of PLHIV
5	Intra-Health	3	Level of commitment of some CSOs to networking and partnership was not so strong. For example attendance of meetings was not persistent and different people from organisations concerned attended
6	SSNeP+	4	SSNeP+ invited CBOs and FBOs to their meetings and coordination activities, especially PLHIV associations activities

7.7 Civil Society's access to financial and technical support

It is evident from the data shown in Table 12 below that technical support was adequately received by CSOs, especially from their head offices abroad. Even the national CSOs received fairly good amount of technical support. Opposed to this, CSOs found financial support as inadequate. The geographical situation of Southern Sudan and the special needs of the region (such as high market prices of basic services), were largely to blame for the low coverage, as far as funding is concerned. This finding clearly reflected that, under current global challenges, no amount of funding would be adequate to create a major impact. There was need for a viable strategy for division of responsibilities according to needs and specialisation of CSOs. Probably there could be need for establishing consortiums for HIV-related service delivery.

Table 12: Assessment of support received by civil society organisations for HIV-related programmes

	Organisation	Rating of access to support (0=low; 5=high)		Comments and examples
		Financial	Technical	
1	FHI	4	4	▪ FHI got technical support from MOH, consultants and donors
2	Alliance	2	4	▪ Very low financial support for CBOs. Majority of CSOs shied away from supporting CBOs as a link to communities. They did not encourage communities to do thing by and for themselves. Lack of capacity, leadership and other circumstances were always claimed by CSOs ▪ Alliance accessed adequate technical support from their HQs in Brighton, UK and their Technical Support Hubs. This technical support was extended to the CBOs it worked with
3	PSI	3	3	▪ Demand for services had been increasing. Know of HIV still very low and coverage very limited. PSI was, therefore, obliged to select few counties due to limited funding. Consequently, there were very limited outreach programmes and support to the increasing number of CBOs in 2009 ▪ PSI staff gained professional development support from their regional offices
4	SSOPO	1	5	▪ In April 2009 SSOPO's financial support came from HelpAge International but that since ceased. ▪ In 2009 SSOPO received funding from CAFOD and HIV Alliance. However, the funds were inadequate. ▪ HIV Alliance gave training to SSOPO in 2009
5	Intra-Health	2	5	▪ Needs for Sudan were enormous, as the region is vast. This translated to wide coverage area and outstretching resources ▪ Intra-Health received technical support from its HQs and Centers for Disease Control (CDC)
6	SSNeP+	1	3	▪ SSNeP+ had been in operation for only one year. Therefore, donors still doubted the capacity of the organisation to deliver, especially lack of financial capacity ▪ Due to lack of funding SSNeP+ could not recruit any professional staff to meet its challenging roles

	Organisation	Rating of access to support (0=low; 5=high)		Comments and examples
		Financial	Technical	
				▪ SSNeP+ received technical support from the Technical Advisor Board (TAB) for its planning and budgeting tasks

7.8 Civil Society's contribution to provision of HIV and AIDS-related services

Civil society organisations were fairly distributed in terms of provision of HIV and AIDS-related services in 2009. No CSO specialised in providing one type of service, although PSI was understandably was more on the prevention side. Three out of six CSOs provided 51 to 75 per cent of prevention services for the youth. HIV affected orphans and other vulnerable children (OVCs) were largely the under-served group. Home-based care (HBC) was also mainly limited to SSNeP+, which reported to deliver 51-75% of HBC services and this is definitely to its own members (PLHIV). This is explained by the low prevalence rate or the huge number of unreported cases of infections and OVCs. One would have, therefore, expected the area of VCT to be well intervened to. In general, Table 13 presents interesting results for strategising. If the responses presented are anything to go by, it shows how polarised were the range of services offered. It could also reinforce the concerns about coverage, organisational capacities and inadequate coordination.

Table 13: Percentage of HIV services provided by civil society organisations

Organisation	Category of service delivery (estimated per cent of services provided)						
	Prevention for youth	M.A.R.P. prevention: SWs	Testing & counselling	Stigma and discrimination reduction	ART/OIs	HBC	OVCs
FHI	51-75%	25-50%	25-50%	<25%	<25%	25-50%	<25%
Alliance	25-50%	25-50%	51-75%	51-75%	<25%	25-50%	<25%
PSI	51-75%	51-75%	NA	25-50%	NA	NA	NA
SSOPO	<25%	25-50%	25-50%	>75%	>75%	25-50%	>75%
Intra-Health	<25%	<25%	>75%	>75%	51-75%	<25%	NA
SSNeP+	51-75%	51-75%	25-50%	51-75%	25-50%	51-75%	<25%

Activities carried out or efforts exerted by individual CSOs were as outlined in Table 14.

Table 14: Some key services or programmes delivered by CSOs in 2009

Organisation	Programme/Services
FHI	
Alliance	▪ Work with zones of Juba city street kids (users of inhalable drugs) through SSOPO ▪ Targeting of MSMs through partner CBOs that collect commodities from Alliance office ▪ Giving sub-grants for two OVC serving organisations ▪ Training of community mobilisers for VCT. These do counselling and referral to VCT centres ▪ Giving sub-grants to PLHIV associations for HBC activities ▪ Stigma reduction training for 22 trainers in Yei, Yambio, Morobo, Lainya, Juba, Magwi, Nimule, Torit and Kapoeta Counties in the Greater Equatoria Region
PSI	Organisation of youth campaigns e.g. the 13-25 years programme Dissemination of information and distribution of condoms to sex workers through peer educators Provision of basic health care package to PLHIV[6] Implementation of the ROADS project[7]
SSOPO	▪ Peer educator training ▪ Home-based care
Intra-Health	▪ Establishment, equipping and supplying of ART centre at military HQs ▪ Preventive services for army and other uniformed services
SSNeP+	▪ Trained counsellors and delivering HBC package to PLHIV ▪ One PLHIV targeted sex workers with a range services ▪ Advocacy for provision/supply of ARVs and drugs for OIs

7.9 Civil society perceptions regarding their level of participation

There was fairly good rating of the overall amount of efforts civil society organisations exerted in 2009 (Table 15). A number of achievements by each of the organisations were outlined that motivated this high rating (median=7.5). Surely, everyone would like to report a success. However, it would be more satisfying to see the success stories supported by more empirical evidence such as outcome indicators. Special attention needs to be given to the comments

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[6] A kit containing mosquito net, Water Guard/purifier tablets, jerry can, filter cloth and information leaflet for healthy life.

[7] Regional Outreach Addressing AIDS through Development Strategies (a peer educator programme)

about 'remaining challenges' or what could pose as obstacles in the coming periods. This could enable better strategising, planning, prioritisation and commitment of resources.

Table 15: Assessment of their involvement in planning and budgeting for National Strategic Plans

	Organisation	Rating (0=low; 5=high)	Comments and examples
1	FHI	8	▪ Achievements in 2009: o Capacity building of CBOs in six counties o Working with 36 CBOs in the six counties ▪ Remaining challenges: o Limited funding o Delay in carrying out the Sudan AIDS indicator survey caused difficulties in setting targets o Systems and structures were not properly set up at the national level o Lack of policy documents e.g. condom policy o Non-harmonised reporting tools/formats
2	Alliance	7	▪ Achievements in 2009: o Government recognised the importance of CSOs and Alliance was asked to invite more CBOs to participate in national activities such as the WAD, training and document validations ▪ Remaining challenges: o No HBC guidelines, training tools for care givers and kits
3	PSI	8	▪ Achievements in 2009: o Increase in people's perception of risk due to increased education and BCC strategies. Previously, risk of HIV was perceived to be associated with foreigners o There was more open discussion and participation about HIV and AIDS o Substantial increase in use, distribution and acceptance of HIV commodities ▪ Remaining challenges: o Lack of incentives for peer educators, which makes them not to be proactive o Cultures and believes pose as barriers to community interventions

	Organisation	Rating (0=low; 5=high)	Comments and examples
4	SSOPO	10	▪ Achievements in 2009: o Training of peer educators, group dynamics, HBC, awareness raising for community leaders and other groups and radio talk shows were done ▪ Remaining Challenges: o Poor attitude toward HIV and AIDS listenership during outreach campaigns o Stigma surrounding the use of condoms and VCT o Poor sex attitudes among street kids e.g. indulging in sex without the use of condoms o Lack of follow up by counsellors of VCT clients tested positive o Lack of laws and enforcement of laws guiding the practice of prostitution or controlling the practice
5	Intra-Health	7	▪ Achievements in 2009: o Development of HIV and AIDS Strategic Framework for the military o Start of ART centre at SPLA General Headquarters ▪ Remaining challenges: o Poor AIDS coordination o Inadequate resources
6	SSNeP+	7	▪ Achievements in 2009: o Having an established and functional office o Received a grant for the affiliated associations to carry out their work o Organised coordination meeting for all affiliated associations ▪ Remaining challenges: o Lack of funds for carrying out planned activities o Lack of human resources for the key staffing requirements of the Network o Lack office accommodation for many of the PLHIV associations o Lack of monitoring system for effects of ARVs on takers o PLHIV lack second-line drugs

VIII. Monitoring and Evaluation Environment

8.1 Current Status and Progress

In compliance with the last of the ‘three ones’ principle of the Global Declaration of Commitments, Southern Sudan established a Monitoring and Evaluation (M&E) Directorate in the Southern Sudan AIDS Commission. The Directorate had four officers in 2009 but three were on post for greater part of the year. Two of the senior M&E Officers attended short courses in M&E internally and abroad.

In 2008 Southern Sudan produced its first AIDS M&E Framework, which outlined among other things the requirements for a functional M&E unit. The Framework outlined mechanisms for ensuring that implementing partners submitted their M&E data and reports for its consolidation and dissemination through a central database and website. The M&E Framework provided roles and responsibilities for each partner and specified a structure for data and information flow.

An M&E Technical Working Group (TWG) was formed with good representation of civil society organisations[8], although it rarely met. The M&E TWG had representation of SSAC, MOH HIV/AIDS Directorate, international development partners and representatives of CSOs. The main mandate of the M&E Working Group was to meet quarterly to review reports and recommend solutions to challenges in achievement of results.

Also of good note were capacity building efforts supported by partners to reinforce the HIV M&E system at Government of Southern Sudan level. External and internal trainings were attended by a number of government M&E officers that benefited up to 43 persons. Also noteworthy was the finalisation of nationally approved HIV M&E tools.

However, the M&E system encountered a number of challenges, with dire consequences in form of scanty data, uncoordinated data collection and processing efforts and difficult access of information, as witnessed during the UNGASS 2010 reporting process. First, the recommended establishment of an M&E system did not materialise. This gap curtailed the set up and

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[8] CSOs represented were: HIV/AIDS Alliance, Family Health International (FHI), Population Services International (PSI), Southern Sudan Order People’s Organisation (SSOPO), Adventist Development and Relief Agency (ADRA) and International Rescue Committee.

preparation of the M&E Directorate in playing its role efficiently and achieving the planned strategic objectives of the HIV and AIDS M&E Framework. In fact, the M&E Framework 2008 was not launched and not disseminated to the stakeholders.

Second, inadequate M&E capacity at the Southern Sudan level resulted in poor coordination of planning efforts, poor attendance of meetings, lack of inter-departmental rapport and lack of consolidated HIV reports on regular basis. Despite absorbing two new officers to a team that already had two other officers, the M&E unit was insufficiently equipped, inadequately resourced and improperly capacitated team. A glaring consequence of this organisational weakness was lack of one monitoring and evaluation plan during the entire year of 2009. The Southern Sudan AIDS Commission (SSAC) and Ministry of Health HIV Directorate had budgets for M&E activities but neither organisation was fully funded for their M&E components. The SSAC M&E unit reported it was not even made aware as to when funds became available and at its disposal. Therefore, despite the set priorities for the unit to function smoothly and fulfil its mandate, it had not conducted any national M&E assessment, to measure progress towards performance using the agreed indicators.

Third, lack of nationalised HIV surveillance was a major gap which rendered data not to be available at the national level. This was the main reason why determination of indicators remained a big challenge to programme planners and reviewers. This grim picture led to disintegrated and uncoordinated M&E efforts by civil society organisations in Southern Sudan. Key informants in the UNGASS reporting process rated the overall M&E efforts as very low (1 on a scale of 0 to 5). The HIV M&E system hardly supported use of data for reviewing the AIDS strategy, resource allocation and intervention.

8.2 Challenges and Gaps

This section outlines (Table 16) the major challenges and gaps to implementation of a robust national M&E system in Southern Sudan. Also outlined are recommendations for possible remedial action.

Table 16: Major challenges and recommended remedial measures for a functional national M&E system

	Key challenge	Recommended remedial action
1	Weak M&E structure/system	▪ Provision of long term technical support to the M&E Unit at SSAC to help draw up a programme, mentor the technical staff and give technical support in data management and reporting. ▪ Commitment to the recruitment of competent M&E officers through a competitive procurement processes
2	Irregular reporting of the AIDS epidemic and the response and low public awareness of the magnitude of the problem	Strengthening of the TWG in order to consolidate information and report the epidemic using quarterly bulletins and to plan and implement an aggressive data collection and reporting system based on the M&E Indicator Framework
3	Disjointed and unharmonised data collection and reporting of HIV-related activities by partner organisations	Establishment of HIV management information system with mechanisms for regular submission of indicator-related data to the M&E unit at SSAC as per the Southern Sudan HIV Framework (information flow conceptual framework)
4	Inadequately resourced M&E unit and system	Advocate for implementation of the recommended 10% of national AIDS budget for M&E activities and commitment implementation of an M&E plan
5	Non-recognition of M&E as a driving force of the response to HIV and AIDS	UNAIDS Sudan to play its prime responsibility of supporting and strengthening the country's M&E system. There is need to provide long term support to the HIV M&E system for effective implementation of the HIV M&E Framework

ANNEXES

ANNEX I

Consultation/preparation process for the country report

The process for preparing the UNGASS Country Report started when UNAIDS set aside a budget for the Southern Sudan AIDS Commission (SSAC) to carry out the activity. Two officers were identified and sent to attend two separate trainings in Cairo Egypt and Beirut Lebanon for the NASA and UNGASS Report respectively. One of the officers was engaged by SSAC as a Consultant for the exercise in mid-December 2009 with specific terms of reference. The officer trained on NASA in Cairo was assigned as a NASA Focal Person. The two national officers were supervised by SSAC and technically assisted by the UNAIDS Sudan M&E Officer. The first task was to organise an orientation workshop for potential key informants from identified implementing partners on the UNGASS reporting process, the National AIDS Spending Assessment and UNGASS Indicators. However, the Workshop could not take place due to heavy implementing partner involvement in planning and budgeting for the financial year 2010[9]. Moreover, most expatriate heads of implementing partners were leaving the country for the Christmas holidays. With the advent of the Second Sudan Household Health Survey series of meetings in December and January 2010, it meant many HIV and AIDS programme managers were not found in their offices most of the time. This important exercise had therefore been skipped and the Consultant and the SSAC M&E team embarked on data collection and conducting interviews for the NCPI. This was done according to the list of identified key informants.

During the NCPI interviewing process, the UNGASS Reporting Consultant gave the key informants a brief overview of UNGASS Reporting process and the importance of information provided for compiling the report. Key informants were also informed that they would be invited to a Validation Workshop supposedly by mid-February. The response rate for the NCPI interview was 12 out of 18 key informants (66.7 per cent) and this was mainly due to unavailability of some key informants in South Sudan. These included very important key informants who could not be left out due to their leading roles in the response to HIV and AIDS. These were officers from Government and leading multilateral organisations. The exercise, therefore, dragged unnecessarily for too long. Data collection for the indicators was done alongside the NCPI interviews. Due to scattered and unprocessed data and responsible officers being in other official duties, the Consultants encountered difficult time in processing the data

[9] The Fiscal Year in Sudan coincides with the calendar year.

within a reasonable time frame. This problem was worsened by lack of appreciated by the relatively officers in partner organisations, who were not present during the preparation of the last UNGASS Report (2006-7).

The most difficult task in the whole process was collection of the NASA data. Most of the implementing partners lacked competency for doing the exercise, could not appreciate its importance, were not having the relevant financial officers present, lacked ready data or undermined its importance. For this reason it was thought worthwhile to conduct a rapid orientation of concerned implementing partners with participation of two officers from each organisation. A one day orientation session on the NASA process using extracts from the last NASA training in Cairo was conducted. After that workshop, the turnover rate increased. However, that gave unnecessary pressure to the Consultant and the NASA Focal Person.

After the data compilation and the UNGASS narrative were almost complete, implementing partners were invited to a one-day Validation Workshop at SSAC. Most of the invited were in attendance. In the workshop, participants were divided into three groups: Prevention; Care, Treatment and Support and Monitoring and Evaluation and Policy. The workshop succeeded to gather good comments and recommendations for improving the Report and Indicators. Some participants contributed by sending data and comments by emails to the Consultant. Most of the comments and additions were included in the Report, which was unanimously endorsed in the Validation Workshop (see list of participants of the Validation Workshop in Annex V).

The draft UNGASS Report for South Sudan was submitted officially by the SSAC Senior Management to UNAIDS in electronic form. The UNAIDS M&E officer completed the UNGASS Online Forms using the Country Response Information System (CRIS) just before the deadline for submission.

ANNEX II

National Composite Policy Index questionnaire

NCPI Respondents

[Indicate all respondents whose responses were compiled to fill out (parts of) the NCPI in the below table;

add as many rows as needed]

NCPI - PART A [to be administered to government officials]

		Respondents to Part A [indicate which parts each respondent was queried on]				
Organization	**Name/Position**	**A.1**	**A.11**	**A.111**	**A.1V**	**A.V**
Ministry of Health, GOSS (Directorate of HIV/AIDS)	**Dr. Emmanuel Lino, Deputy Director, Clinical Management**	✓	✓	✓	✓	✓
Southern Sudan AIDS Commission	**1. Dr. Esterina Novello, Acting Executive Director**	✓	✓		✓	
	2. Mr. James Rondyang, Director for VCT			✓		
	3. Mr. Maika Lisok, Deputy Director for M&E					✓

Add details for <u>all</u> respondents

National Composite Policy Index questionnaire

Part A

[to be administered to government officials]

I. Strategic plan

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

   (Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	No ✓	Not Applicable (N/A)

IF NO or NOT APPLICABLE, briefly explain why. - *There were intentions for the activity to be planned for 2010 with financial support from the Multi-Donor Trust Fund (MDTF).* - *Focal persons were appointed in key line ministries of the Government of Southern Sudan, i.e., SPLA Affaires (Defence); Education; Gender; Internal Affairs and; Youth and Sports*

***IF YES*, complete questions 1.1 through 1.10; otherwise, go to question 2.**

1.1 How long has the country had a multisectoral strategy?

Number of Years: *[write in]*

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	No	Yes	No
Education	Yes	No	Yes	No

Labour	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Military/Police	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young people	Yes	No	Yes	No
Other[*]: *[write in]*	Yes	No	Yes	No
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?				

1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	a. Yes No
b. Young women/young men	b. Yes No
c. Injecting drug users	c. Yes No
d. Men who have sex with men	d. Yes No
e. Sex workers	e. Yes No
f. Orphans and other vulnerable children Settings	f. Yes No
g. Other specific vulnerable sub- populations*	g. Yes No
Settings	
h. Workplace	h. Yes No
i. Schools	i. Yes No
j. Prisons	j. Yes No
Cross-cutting issues	
k. HIV and poverty	k. Yes No
l. Human rights protection	l. Yes No
m. Involvement of people living with HIV	m. Yes No
n. Addressing stigma and discrimination	n. Yes No
o. Gender empowerment and/or gender equality	o. Yes No

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

Yes	No ✓

IF YES, when was this needs assessment conducted?

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

Year: *multiple* *[write in]*

IF NO, explain how were target populations identified? *The needs assessment has not been comprehensive but the development of Strategic Framewrok involved desk review of existing information and studies regarding the target population*

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

[write in]

The whole population is targeted but programmes are tailored according to their specific needs

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	No
b. Clear targets and/or milestones?	Yes	No
c. Detailed budget of costs per programmatic area?	Yes	No
d. An indications of funding sources to support programme implementation?	Yes	No
e. Monitoring and Evaluation framework?	Yes	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**

If ***active involvement***, briefly explain how this was done?

IF NO or MODERATE involvement, briefly explain why this was the case: *No multi-sectoral strategy was developed that covered planned activities for Health, Education, Labour, etc.*

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

Yes	No

1.10 Have external Development Partners aligned and harmonized their HIV- related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No

IF SOME or NO, briefly explain which areas there is no alignment / harmonization and why?

2. Has the country integrated HIV and AIDS into its general development plans such as in: a) National Development Plan; b) Common Country Assessment/ UN Development Assistance Framework; 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	No	N/A✓
b. Common Country Assessment / UN Development Assistance Framework	Yes✓	No	N/A
c. Poverty Reduction Strategy	Yes	No	N/A✓
d. Sector-wide approach	Yes	No	N/A✓
e. Other: ***National Strategic Framework*** *[write in]*	Yes✓	No	N/A

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✓	No

Treatment for opportunistic infections	Yes✓	No
Antiretroviral treatment	Yes✓	No
Care and support (including social security or other schemes)	Yes✓	No
HIV impact alleviation	Yes✓	No
Reduction of *gender* inequalities as they relate to HIV prevention/ treatment, care and / or support	Yes✓	No
Reduction of *income* inequalities as they relate to HIV prevention/ treatment, care and / or support	Yes✓	No
Reduction of stigma and discrimination	Yes	No✓
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes✓	No
Other: *[write in]*	Yes	No

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?

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 ✓	No
Condom provision	Yes ✓	No
HIV testing and counselling	Yes ✓	No
Sexually transmitted infection services	Yes✓	No
Antiretroviral treatment	Yes✓	No
Care and support	Yes✓	No
Others: *[write in]*	Yes	No

If HIV testing and counselling is provided to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g. indicate if HIV testing is voluntary or mandatory) - *Voluntary VCT* - *VCT centres included in military garrisons/units* - *Involvement of military officers* - *High level commitment of high ranking officers*

6. 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✓

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

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex workers	Yes	No
f. Prison inmates	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other: *[write in]*	Yes	No

IF YES, briefly describe the content of these laws, regulations or policies: Briefly comment on how they pose barriers:

7. Has the county 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

IF YES, for which population groups?

- *Estimates of people in need of treatment were made but not reliable (not based on survey)*
- *Plans are in place to do actual estimates, based on Sudan Household Health results as after March 2010. The survey was designed to include HIV.*
- *There was information on VCT, ART, blood safety and STI, which was disaggregated by age and sex and these were collected under supervision of the Ministry of Health.*

Briefly explain how this information is used:

- *This information helped the MOH in planning for the needs of those affected and*

infected with HIV and it is also shared with international partners when needed.

(c) Is coverage monitored by geographical area?

Yes ✓	No

IF YES, at which geographical levels (province, district, others)?

This happened mostly at state level with scattered monitoring efforts at county level

Briefly explain how this information is used:

This information was used to plan for expansion of service coverage to new areas and strengthening existing ones.

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 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: 1. *Health sector operational plan completed although not costed.* 2. *Four guidelines (Counselling and testing, STI, treatment and blood safety) produced but not disseminated.* 3. *An additional VCT centre was opened.* 4. *Treatment of STI scaled up* 5. *ANC surveillance undertaken (reports expected in March/April 2010)* *What are the remaining challenges in this area:* 1. Proper establishment of MOH state offices for HIV 2. Recruitment of key staff at the Directorate and state levels 3. Mobilisation of funds to address the strategies outlined in the operational plan.

4. Slow disbursement of funds from Global Fund affects running of establishment of ART service centres.

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 major domestic forums at least twice a year?

President/Head of government	Yes ✓	No
Other high officials	Yes ✓	No
Other officials in regions and/or districts	Yes ✓	No

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

Yes ✓	No

IF NO, briefly explain why not and how AIDS programmes are being managed:

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

Year: *2006* *[write in]*

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

Name: *Dr. Bellario Ahoy* Position/Title: *Chairperson* *[write in]*

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

have terms of reference?	Yes ✓	No
have active government leadership and participation?	Yes ✓	No
have a defined membership? **IF YES**, how many members? 8 *[write in]*	Yes ✓	No
include civil society representatives? **IF YES**, how many? 1 *[write in]*	Yes ✓	No
include people living with HIV?	Yes ✓	No

IF YES, how many? 1 [write in]		
include the private sector?	Yes✓	No
have an action plan?	Yes ✓	No
have a functional secretariat?	Yes ✓	No
meet at least quarterly?	Yes ✓	No
review actions on policy decisions regularly?	Yes ✓	No
actively promote policy decisions?	Yes ✓	No
provide opportunity for civil society to influence decision-making?	Yes ✓	No
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes ✓	No

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

Yes ✓	No	N/A

IF YES, briefly describe the main achievements:

There is Country Coordinating Mechanism; but it needs more improvement and CSOs need room to advocate or even check the performance of the government institutions (SSAC, Line Ministries) with HIV programmes.

Briefly describe the main challenges:

Weak coordinating body

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

Percentage: *Unspecified*

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

Information on priority needs	Yes✓	No
Technical guidance	Yes✓	No
Procurement and distribution of drugs or other supplies	Yes✓	No
Coordination with other implementing partners	Yes✓	No
Capacity-building	Yes✓	No
Other: *Office accommodation for PLHIV* *[write in]*	Yes✓	No

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

IF YES, name and describe how the policies/laws were amended:

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

<table>
<tr><th colspan="3">Overall, how would you rate the political support for the HIV programme in 2009?</th></tr>
<tr><td>2009</td><td>Very poor</td><td>Excellent</td></tr>
<tr><td colspan="3">0 1 2 3 4 5 6 7✓ 8 9 10</td></tr>
<tr><td colspan="3">Since 2007, what have been key achievements in this area:
- Formation of the HIV/AIDS Directorate in Ministry of Health
- Government budgetary allocations for HIV and AIDS core activities
- President of GOSS donated vehicle for PLHIV
- President and top leadership persistent participation in World AIDS Day events

What are the remaining challenges in this area:
- Lack of actual commitment by sectoral constitutional heads (i.e. they do not include HIV issues in their plans)</td></tr>
</table>

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	✓
b. Delay sexual debut	✓
c. Be faithful	✓
d. Reduce the number of sexual partners	✓
e. Use condoms consistently	✓
f. Engage in safe(r) sex	✓
g. Avoid commercial sex	✓
h. Abstain from injecting drugs	✓
i. Use clean needles and syringes	✓
j. Fight against violence against women	✓
k. Greater acceptance and involvement of people living with HIV	✓
l. Greater involvement of men in reproductive health programmes	✓
m. Males to get circumcised under medical supervision	✓
n. Know your HIV status	✓
o. Prevent mother to child transmission of HIV	✓
Other: Addressing polygamy, wife inheritance, tribal marks, traditional tooth Extraction and tattooing *[write in]*	✓

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

2.1 Is HIV education part of the curriculum in:

primary school?	Yes	No✓
secondary school?	Yes✓	No
teacher training?	Yes✓	No

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 vulnerable sub-populations?

Yes	No✓

IF NO, briefly explain:

3.1 **IF YES**, which populations and what elements of HIV prevention do the policy/ strategy address?

✓ Check which specific populations and elements are included in the policy/strategy?

	IDU*	MSM*	Sex workers	Clients of sex workers	Prison inmates	Other sub-populations [write in]
Targeted information on risk reduction and HIV prevention						
Stigma and discrimination reduction						
Condom promotion						
HIV testing and counselling						
Reproductive health, including sexually transmitted infections prevention and treatment						
Vulnerability reduction (e.g. income generation)	N/A	N/A		N/A	N/A	
Drug substitution therapy		N/A	N/A	N/A	N/A	
Needle & syringe exchange		N/A	N/A	N/A	N/A	

Overall, how would you rate the policy efforts in support of prevention 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:

- *Increased VCT attendance*
- *Increased PMTCT attendance*
- *Increased condom consumption*
- *Increased VCT sites*
- *BCC Strategy developed*

What are remaining challenges in this area?

- *Position of the head of Prevention Programme remained vacant through resignation since 2008.*
- *Low awareness raising campaigns from policy makers*
- *There were no policies to address specific areas within the general population.*

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

Yes ✓	No

IF YES, how were these specific needs determined?
• *Aggressive programme targeting uniformed services (regarded as potential vehicles for the epidemic errapting)* • *PMTCT was being promoted* • *Blood safety guidelines produced* • *VCT, STI, ART guidelines produced.* • *STI treatment improved* • *BCC programmes scaled up*

IF NO, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

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

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

- *Relevant HIV prevention-related guidelines developed*
- *New VCT centres and ART stocks with support from the Global Fund*
- *Some scattered efforts by implementing partners such as PSI in condom promotion while other partners were scaled up testing and counselling services*

What are remaining challenges in this area:

- *The largest portion of the population had not come into contact with any of the mentioned interventions*
- *Inadequate funds for state and sub-state level service delivery*

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

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

Yes ✓	No

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

Yes ✓	No

IF YES, how were these determined?
This was done through data from HIV testing facilities and estimates of those who were supposed to be in need of ART, which were about 23,000. Estimated number of Southern Sudanese who were living with HIV was about 150,000

IF NO, how are HIV treatment, care and support services being scaled-up?

2.1 to what extent have the following HIV treatment, care and support service been implemented?

HIV treatment, care and support services	The majority of people in need have access		
Antiretroviral therapy	Agree	Don't Agree ✓	N/A
Nutritional care	Agree	Don't Agree ✓	N/A
Paediatric AIDS treatment	Agree	Don't Agree ✓	N/A
Sexually transmitted infection management	Agree	Don't Agree ✓	N/A
Psychosocial support for PLHIV and their families	Agree	Don't Agree ✓	N/A

Home-based care	Agree	Don't Agree ✓	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't Agree ✓	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree✓	N/A
TB screening for HIV infected people	Agree✓	Don't Agree	N/A
TB preventive therapy for HIV infected people	Agree	Don't Agree	N/A✓
TB infection control in HIV treatment and care facilities	Agree✓	Don't Agree	N/A
Cotrimoxazole prophylaxis for HIV infected people	Agree✓	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposure to HIV, rape)	Agree	Don't Agree✓	N/A
HIV treatment services in the workplace for treatment referral system through the workplace	Agree	Don't Agree✓	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree✓	N/A
Other: *[write in]*	Agree	Don't Agree	N/A

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

Yes	No ✓

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

Yes	No ✓

4.1 ***IF YES***, for which commodities?: *[write in]*

Overall, how would you rate the *efforts in the implementation of HIV* treatment, care and support programmes 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:

The number of clients in HIV/AIDS care doubled from that in 2007 to the current figures of about 5,500 in care and nearly 2,000 on ART and increase in paediatrics care to 176.

What are remaining challenges in this area:

1. Procurement and supply chain management involving the facilitators and the Ministry of Health GOSS (lack of staff)

2. Expansion rate of treatment centres is very slow
3. Improper nutritional support delivered
4. HBC activities not well implemented

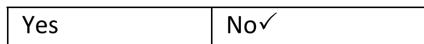
5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children (OVC)?

Yes✓	No	N/A

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

Yes✓	No

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

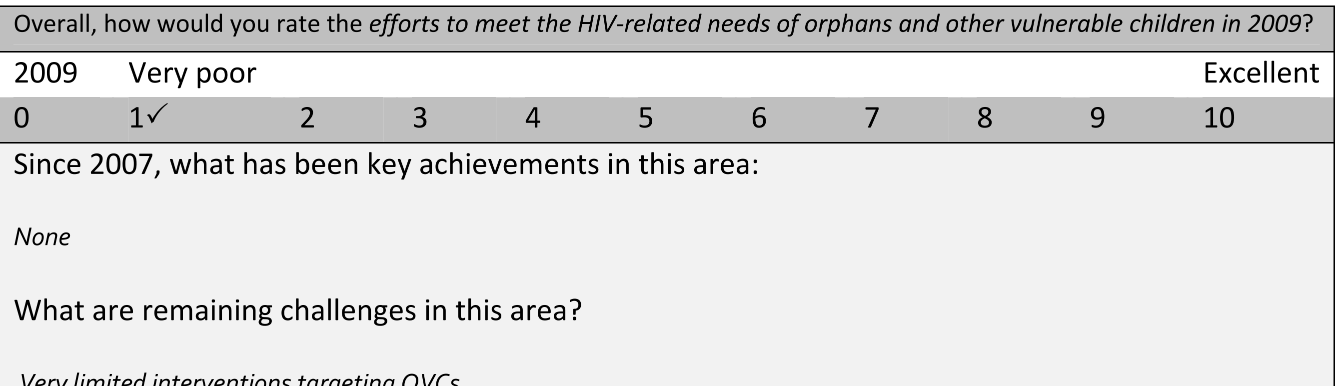


Yes	No✓

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

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? % *[write in]*



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

Since 2007, what has been key achievements in this area:

None

What are remaining challenges in this area?

Very limited interventions targeting OVCs

V. Monitoring and evaluation

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

Yes	In progress	No ✓

IF NO, briefly describe the challenges:

- *Inadequate coordination (no common planning workshop)*
- *Weekly departmental meetings planned but poorly attended*
- *The SSAC Planning and Policy Directorate did not liaise with the M&E Directorate*
- *The new head of M&E was not satisfactorily oriented on his job*
- *HIV M&E Framework was not launched and implemented (not even printed)*
- *Lack of driving power for the M&E system*

1.1 ***IF YES***, years covered? *[write in]*

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

Yes	No

1.3 ***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:

2. Does the national Monitoring and Evaluation plan include?

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

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

Yes ✓	In progress	No

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

% (*unspecified*) *[write in]*

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

Yes	No ✓

IF NO, briefly describe the challenges: *Department was not kept aware as to when budgeted funds were available (released).* *Lack of transport means for M&E activities*

3.3 *IF YES*, are M&E expenditures being monitored?

Yes	No✓

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

Yes✓	No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves: *Due to above mentioned reasons, there was no national M&E assessment carried out.*

IF NO, briefly describe how priorities for M&E are determined?

5. Is there a functional national M&E unit

Yes ✓	In progress	No

IF NO, what are the main obstacles to establishing functional M&E unit?

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

in the Nationalo AIDS Commission (or equivalent)?	Yes ✓	No
in the Ministry of Health?	Yes	No ✓
elsewhere? *[write in]*	Yes	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: *4* *[write in]*	**Full time / part time?**	**Since when?:**
Position: *Deputy Director* *[write in]*	**Full time / part time?**	**Since when?:**
[add as many as needed] *M&E Officer* *M&E Officer*	 *Full time* *Full time*	 *August, 2008* *October, 2007*
Number of temporary staff:		

Position: *[write in]*	**Full time / part time?**	**Since when?:**
Position: *[write in]*	**Full time / part time?**	**Since when?:**
[add as many as needed]		

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:

As described in the National HIV and AIDS M&E Framework with roles and responsibilities of implementing partners specified.

What are the major challenges?

- *Coordination: accessibility to allocated funds; inadequate capacity of some staff at SSAC*
- *M&E Unit ill-equipped; not technically backstopped*
- *M&E Framework not widely circulated abd not fully implemented*

6. Is there a national M&E committee or working group that meets regularly to coordinate M&E activities?

No	Yes, but meets irregularly ✓	Yes, meets regularly

6.1 Does it include representation from civil society?

Yes ✓	No

IF YES, briefly describe who the representatives from civil society are and what their role is:

CSOs were: *International HIV/AIDS Alliance; FHI; PSI; SSOPO; ADRA; ARC; SRC; etc.*

Role: *to bring out challenges of M&E; review quarterly reports; receive instant feedback*

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

Yes	No ✓

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

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)? *[write in]*	Yes	No✓

*(*regularly reporting data from health facilities which are aggregated at district level 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?

Yes	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:

What are the main challenges, if any?

9.2 for resource allocation?:

Low					High
0	1✓	2	3	4	5

Provide a specific example:

CSO-related M&E generated ART-data used in determination of ARV needs.

What are the main challenges, if any?

- *Lack of defined roles and facilities for collecting data*
- *Inadequate technical capacity*
- *Lack of central HIV database*

9.3 for programme improvement?:

Low					High
0	1✓	2	3	4	5

Provide a specific example:

- *CSO-related data*
- *What are the main challenges, if any?*
- *CSO-related data*

10. Is there a plan for increasing human capacity in M&E at national, subnational 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:		[write in]
At sub-national level	Yes	No ✓
IF YES, number trained:		[write in]
At service delivery level including civil society?	Yes ✓	No
IF YES, number trained: 25		[write in]

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

Yes ✓	No

IF YES, describe what type of activities: [write in]

Overall, how would you rate the *M&E efforts* of the HIV programme 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:*

- *Availability of HIV M&E data collection tools*
- *Availability of M&E Framework*

What are remaining challenges in this area:

- *Inadequate implementation capacity*

ANNEX III

List of Key Informants to the NCPI Questionnaire

	Organisation	Name of respondents	
1	Ministry of Health	1. Dr. Emmanuel Lino	Director for Care, Treatment & Support
2	Southern Sudan AIDS Commission (SSAC)	2. Dr. Esterina Novello 3. Mr. James Rondyang 4. Mr. Maika Lisok	Acting Executive Director Director for VCT Deputy Director for M&E
3	International HIV/AIDS Alliance	5. Ms. Florence Bayoa 6. Dr. Ally Ahmed Ramadhan	Country Director M&E Officer
4	Family Health International (FHI)	7. Ms. Youniter Mutsungah	Senior Technical Officer, HTC
5	Intra-Health	8. Ms. Carol Karutu	Project Director
6	Population Services International (PSI)	9. Ms. Tonee Mwangi 10. Ms. Theresa Angelo	Deputy Country Representative ROADS Programme Manager
7	Southern Sudan Older Peoples Organisation (SSOPO)	11. Mr. Donato Ochan 12. Ms. Asunta Santino Gore	Director HIV Programme Manager
8	Southern Sudan Human Rights Commission	13. Mr. Victor Lado Ceasar 14. Mr. Mathias Donas Tombe	Executive Director HIV Focal Person
9	Southern Sudan Network of People Living with HIV (SSNEP+)	15. Mr. Lole Laila Lole 16. Ms. Evelyn Letio	Chairperson Deputy Chairperson
10	UNICEF	17. Ms. Joyce Mphaya	HIV and Safe Motherhood Programme Offcer
11	UNFPA	18. Mr. Patrick Wambua	HIV/AIDS Programme Officer
12	WHO	19. Dr. Busulwa Rogers 20. Dr. Wilma Juma	HIV/AIDS Programme Officer

ANNEX IV

List of List of Ministries & Commissions with appointed focal persons

S/N	Ministry /Commission
1	Ministry of Culture , Youth & Sports
2	Commerce & Industry
3	Telecommunication & Postal service
4	Parliamentary Affairs
5	Environment, Wildlife Conservation & Tourism
6	Internal Affairs
7	Gender, Social Welfare & Religious Affairs
8	Information & Broadcasting
9	Housing, Physical Planning & Environment
10	Agriculture & Forestry
11	SPLA Affairs
12	Animal Resources & Fisheries
13	Education Science & Technology
14	Human Rights Commission
15	Civil Service Commission
16	Centre for Census, Statistics & Evaluation
17	Ministry of Cooperative & Rural Development
18	Local Government Board
19	War Disabled, Widows & Orphan

ANNEX IV

List of participants in the UNGASS 2010 Report

S/N	Name	Organisation	Email
1	Vianna Kakuli	SSAC	kakuliaggrey@gmail.com
2	Esterina Novello	SSAC	enyilok@gmail.com
3	Maha Marghani	SSAC	maha.marghani@yahoo.com
4	Maika Lisok	SSAC	maikalisok@yahoo.co.uk
5	Gabriel Atillio	SSAC	gabrielatillio@yahoo.com
6	Bol Majok Yal Bol	SSAC	Bolmajok78@yahoo.com
7	Joseph Elisa Jibi	UNAIDS	jibielisa@yahoo.com
8	Mohammed Bhuyan	UNAIDS	Bhuyanm@unaids.org
9	Joy Theophilus	UNFPA	theophilus@unfpa.org
10	Patrick Buruga	Intra-Health	pburuga@intrahealth.org
11	Wilma Alphonse	WHO	jumawilma@yahoo.com
12	Rogers Busulwa	WHO	busulwar@sud-emro.who.int
13	Tereza Angelo	PSI	tlangelok@yahoo.com
14	Daniel Majok	SSAC	Majokkuol205@yahoo.com
15	Ally Ahmed Ramadhan Lasu	IHAA	allyahmedr@yahoo.co.uk
16	Catherine L Duku	SSAC	catherineduku@yahoo.com
17	Becky Ben Ondoa	UNHCR	ondoa@unhcr.org
18	Mary Michael	SSAC	marylobojo@yahoo.com
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23	Youniter Mutsungah	FHI	ymutsungah@fhi.org
24	Nkangabwa James	SSAC/UNDP	James.nkangabwa@undp.org
25	Laila B Lokosang	SSAC	lailalokosang@yahoo.co.uk