Document of
The World Bank

Report No: ICR2638

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(P106927)

IN THE AMOUNT OF US$36.75 MILLION

TO THE
GOVERNMENT OF SOUTH SUDAN

FOR A
SOUTH SUDAN MULTI-DONOR TRUST FUND HIV/AIDS PROJECT (P106927)

June 20, 2013

Human Development Network
AFTHE
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective June 2012)

Currency Unit	=	USD
SDR 1	=	US$ 1.51
US$ 1	=	SDR 0.66

FISCAL YEAR

July 1 – June 30

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral Drugs
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CSO	Civil Society Organization
FBO	Faith Based Organization
GDP	Gross Domestic Product
Global Fund	Global Fund to Fight AIDS, TB and Malaria
GoSS	Government of South Sudan
HIV	Human Immunodeficiency virus
HMIS	Health Management Information System
HMSF	HIV/AIDS Multisectoral Strategic Framework
IDA	International Development Association
ISR	Implementation Status Report
JAM	Joint Assessment Mission
M&E	Monitoring and Evaluation
MAP	Multi-Country AIDS Project in Africa Region
MARP	Most at Risk Population
MDTF	Multi Donor Trust Fund
MoH	Ministry of Health
NGO	Non-Governmental Organization
PEPFAR	President's Emergency Plan for HIV/AIDS Relief
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV Infection
SSAC	South Sudan HIV/AIDS Commission
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
THM	Transitional Health Funds from GFATM
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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SOUTH SUDAN MULTI-DONOR TRUST FUND HIV/AIDS PROJECT

CONTENTS

A. Basic Information			
Country:	South Sudan	Project Name:	South Sudan Multi-Donor Trust Fund HIV/AIDS Project
Project ID:	P106927	L/C/TF Number(s):	TF-91518
ICR Date:	April 23, 2013	ICR Type:	Core ICR
Lending Instrument:	ERL	Borrower:	Government of South Sudan
Original Total Commitment:	US$36.75M		
Revised Amount:	US$ 17.6M	Disbursed Amount:	US$ 17.6M
Environmental Category: C			
Implementing Agencies: SSAC, MOH, Selected Line Ministries, CBOs, International NGOs			
Co-financiers and Other External Partners: None			

B. Key Dates				
Process	**Date**	**Process**	**Original Date**	**Revised / Actual Date(s)**
Concept Review:	07/12/2007	Effectiveness:	02/29/2008	02/29/2008
Appraisal:	11/06/2007	Restructuring:		06/06/2011
Approval:	02/29/2008	Mid-term Review:	None	
		Closing:	06/30/2011	06/30/2012

C. Ratings Summary	
C.1 Performance Rating by ICR	
Outcomes:	Moderately Unsatisfactory
Risk to Development Outcome:	Significant
Bank Performance:	Moderately Satisfactory
Borrower Performance:	Moderately Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)			
Bank	**Ratings**	**Borrower**	**Ratings**
Quality at Entry:	Moderately Unsatisfactory	Government:	Moderately Satisfactory
Quality of Supervision:	Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	***Moderately Satisfactory***	**Overall Borrower Performance:**	***Moderately Satisfactory***

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	Y	Quality at Entry (QEA):	NA
Problem Project at any time (Yes/No):	Y	Quality of Supervision (QSA):	NA
DO rating before Closing/Inactive status:	MS	QALP rating	NA

D. Sector and Theme Codes		
	Original	**Actual**
Sector Code (as % of total Bank financing)		
Central government administration	25	25
Health	35	35
Sub-national government administration	25	25
Other social services	15	15

Theme Code (as % of total Bank financing)		
HIV/AIDS	67	67
Population and reproductive health	33	33

E. Bank Staff		
Positions	**At ICR**	**At Approval**
Vice President:	Makhtar Diop	Obiageli Ezekwesili
Country Director:	Bella Bird	Ian Bannon
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F. Results Framework Analysis

Project Development Objectives

The Project Appraisal Document (PAD) stated that the project development objectives were to: (i) strengthen the capacity of the South Sudan HIV/AIDS Commission (SSAC) to plan, coordinate and monitor the Government of South Sudan (GOSS) response to HIV/AIDS, (ii) increase community access to comprehensive HIV/AIDS services, and (iii) create awareness and encourage measurable behavior change regarding HIV/AIDS.

The original PAD included the expected ladder of achievements under the project, and later in 2009, the client with the support of the Bank team identified the following measurable indicators to assess progress towards these achievements. The ladder of achievements contained in the PAD and the indicators developed later to measure these achievements did not aim to measure progress towards reduction in HIV prevalence or incidence.

(a) PDO Indicator(s)

Indicator	Baseline Value	Target Values	Actual Value Achieved at Completion
PDO 1: Strengthen the capacity of the SSAC			
1.1: Number of states with functional AIDS commission (15%)			
Value	0	10	10
Date achieved	17-Dec-2008	29-Jun-2012	30-March-2012
Comments: Target was achieved-10 state AIDS commission and 20 County AIDS Commissions were established and strengthened with the support of the project.			
1.2: Number of Ministry action plans implemented			
Value	0	5	6
Date achieved	23-Dec-2008	29-Jun-2012	30-March-2012
Comments: Original goal was 10 ministries, but this was scaled back to 6 in 2009. The purpose of the scaling down was to prioritize those line ministries which could focus on highly vulnerable groups such as men in uniform, prisoners, school and out of school children, etc. This target was partially achieved: five out the agreed six line ministries (health, Education, Army, Internal Affairs and Youth) implementing their respective action plans.			
1.3: Number of sectoral policies established			
Value	0	4	5
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: Target was achieved. At project appraisal, the country did not have documented strategy to deal with the HIV/AIDS challenge. The national strategic HIV/ framework was at the earliest stage of conceptualization. The project supported the finalization of the national strategic plan and other essential documents such the HIV/AIDS M&E framework and operational plan, condom promotion and distribution guidelines, and ART, PMTCT, HRT guidelines.			
PDO 2: Increase community access to comprehensive HIV/AIDS services			
2.1 Number of CSW reached by HIV/AIDS prevention and care (22%)			
Value	0	5,000	9,152
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: Target achieved - Incrementally, about 9000 CSWs reached in the areas supported by the			

Indicator	Baseline Value	Target Values	Actual Value Achieved at Completion
project, in addition 8200 high risk men (2, 366 truck drivers, and 5, 916 clients of CSWs) were reached.			
2.2: Pregnant women living with HIV who received antiretroviral to reduce the risk of MTCT (10%)			
Value	0	1650	662
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: Target achieved - In 2008, provision of PMTCT service was limited to one health center in Juba, the project supported the expansion of availability and the utilization of PMTCT services.			
2.3: Adults and children with HIV receiving antiretroviral combination therapy (8%)			
Value	0	2500	3492
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: Target achieved. At project appraisal, availability and utilization of ART treatment was limited to Juba town, the project supported the expansion of availability and the utilization of ART services.			
2.4: Number of health facilities providing PMTCT services			
Value	9	20	62
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: Target achieved.			
2.5: Number of health facilities providing ART treatment			
Value	1	15	22
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: Target achieved.			
2.6: Number of health facilities providing VCT, including tuberculosis centers			
Value	10	30	164
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: At project appraisal, the VCT services were available in Juba, the project supported expansion of the availability of VCT service.			
2.7: Number of CSO subprojects funded			
Value	0	50	101
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: Target achieved, the objective was to support 5 CSOs per state and at least one focusing on women. Total of 101 additional CSOs enrolled during project implementation.			
PDO 3: Create awareness and measurable behavior change regarding HIV/AIDS			
3.1: Number of person counseled, tested and knowing their HIV status			
Value	0	35000	83890
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: Target achieved.			
3.2: Number of pregnant women attending prenatal consultation and tested for HIV			
Value	0	35000	49691
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments: Target achieved.			
3.3: Number of condoms distributed (5%)			
Value	0	1, 042, 000	1, 525, 158
Date achieved	24-Dec-2008	29-Jun-2012	30-Sept-2012
Comments	Target achieved. The condoms distributed were mostly financed by UNFPA but the promotion and distribution were implemented by the project.		

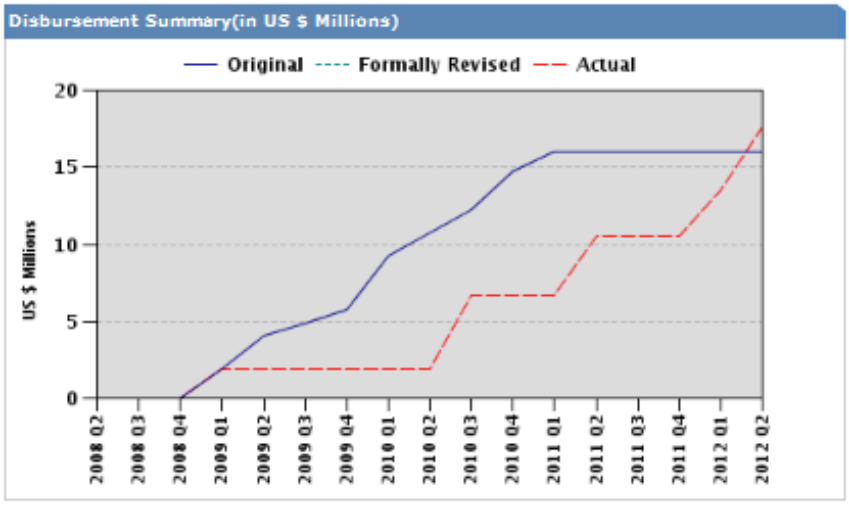
G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	
1	06/30/2008	Satisfactory	Satisfactory	0.00
2	12/28/2008	Moderately Satisfactory	Moderately Satisfactory	1.89
3	06/29/2009	Moderately Unsatisfactory	Moderately Unsatisfactory	1.89
4	12/22/2009	Moderately Unsatisfactory	Moderately Unsatisfactory	1.89
5	06/28/2010	Moderately Unsatisfactory	Moderately Satisfactory	6.64
6	12/22/2010	Moderately Unsatisfactory	Satisfactory	6.64
7	03/17/2011	Moderately Satisfactory	Satisfactory	10.50
8	12/06/2011	Moderately Satisfactory	Satisfactory	17.60
9	06/15/2012	Moderately Satisfactory	Satisfactory	17.60

H. Restructuring

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions	Reason for Restructuring & Key Changes Made
		DO	IP		
06/6/2011	No	MS	MS	66%	Extension of the closing date from June 30, 2011 to June 30, 2012 for successful implementation of planned activities. A new result framework agreed with the client in 2009 was approved.

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1. The Southern Sudan Multi-Donor Trust Fund (MDTF) HIV/AIDS Project was approved on November 6, 2007 and became effective on February 29, 2008. This multisectoral project aimed to strengthen a coordinated national response to HIV/AIDS by building capacity at the Government of South Sudan (GoSS), State and County levels of South Sudan, and to scale up delivery of comprehensive HIV/AIDS services. The total committed amount for this project was US$36.7 million over five years (2008-2012) with the MDTF financing US$31.75 million (86.7% of the total cost) and the GoSS financing US $5 million (13.6% of the total cost). Importantly, the project was a trust fund, jointly funded by multiple donors and the GoSS; and not an IDA credit or grant to the government.

1.1 Context at Appraisal

2. The Republic of South Sudan has an estimated population of about 8 million people in a country of approximately 640,000 square kilometers. The population is largely rural based (90%) and more than half the population lives below the poverty line. At appraisal, it was a nation that had just become autonomous in 2005 following the Comprehensive Peace Agreement and later became independent from Sudan in July 2011. The economy is predominantly rural and relies on farming. The country has suffered from serious conflict, including civil wars as part of the struggle for independence from Sudan. As a result, many people were displaced or killed and the country made little development progress. At ICR, South Sudan remains a fragile state with ongoing conflicts with various smaller armed groups. Some disputes with Sudan still arise, for example over sharing of petroleum revenues.

3. The long civil war had a negative impact on the health care system; and the health status of the population was alarmingly poor. The estimate for maternal mortality (2,054 per 100,000 live births) was the highest in the world and the coverage of preventive services such as immunization was among the lowest. Malnutrition was widespread and tropical diseases, largely controlled in other countries, accounted for a large proportion of the total burden of disease. A comparison of key health indicators in South Sudan, North Sudan, and Sub-Saharan Africa is presented in the table below.

Table 1: Key Health Indicators for South Sudan and its Comparators

Indicator	South Sudan[1]	North Sudan[1]	Sub-Saharan Africa[2]
Infant Mortality Rate (per 1,000 live births)	102.4	71.0	95
Maternal Mortality Ratio (per 100,000 live births)	2,054	534	920
DPT3 vaccination coverage rate (%)	24.6	70.5	72

1 Source: Sudan Household Health Survey (SHHS) 2006
2 Source: UNICEF State of the World's Children, 2008 (data are for 2006)

4. The organization of health services in South Sudan was, as is the case in many post conflict settings, under the control of international NGO's which were not fully aligned with government strategy in terms of ensuring equitable geographical focus in service delivery. As a

consequence, the distribution of supported services was biased towards urban areas and along the main roads. It is important to mention that the majority of the mainly rural based and remote population had no access to health services. Even those areas receiving external support often lacked sufficient funds to improve the delivery of PHC as a whole either because assistance was focused on only a few of the payams or because it was concentrated on supporting vertical programs.

5. At appraisal, it was believed that new and prevalent HIV infections were lower in South Sudan than in neighboring countries because the long civil war had restricted migration, trade and travel and thus reduced HIV transmission. However, at appraisal it was known that the average HIV prevalence among adults aged 15-49 years of the seven countries surrounding South Sudan was already over 4%.[1]Moreover, expectations of large migration from returning displaced peoples after the end of the civil war, low levels of literacy (particularly among females), near non-existent health services and low status of women and girls were feared as likely to contribute to an explosive increase in HIV infections.

6. Rationale for the Bank involvement included its comparative advantage versus other donors to pull together countries and partners, especially in the context of AIDS programming; its ability to work across various line ministries and sectors; and the fact that spread of HIV was a threat to human capital, economic growth and poverty reduction.

7. The GoSS established the South Sudan HIV/AIDS Commission (SSAC) in 2006 to coordinate its response. The SSAC developed a MDTF funded HIV/AIDS project proposal in consultation with representatives of GoSS, UN Agencies, Civil Society and other key development partners, including the Bank. The GoSS strategic objective for this project was to ensure an effective response to the HIV/AIDS epidemic through a multisectoral approach that included Government and Civil Society.

1.2 Original Project Development Objectives (PDOs) and Key Indicators

8. The Project Appraisal Document (PAD) lists three project development objectives:
   a. Strengthen the capacity of the SSAC to plan, coordinate and monitor the GoSS response to HIV/AIDS;
   b. Increase community access to comprehensive HIV/AIDS services; and
   c. Create awareness and encourage measurable behavior change regarding HIV/AIDS.

9. During its five-year implementation period, the project sought to achieve its development objectives through:
   a. Incremental strengthening of the SSAC at all levels;
   b. Phased expansion of the geographic coverage of successful approaches to all States of South Sudan;
   c. Phased mainstreaming of HIV/AIDS into priority Government sectors; and

[1]UNAIDS Annual Report 2012, UNAIDS, www.unaids.gov

d. Phased expansion of the scope of programs toward the achievement of comprehensive service provision.

10. Tools for measuring the achievement of the original PDOs were not specified in the PAD by detailed indicators or a Results Framework. However, the PAD did provide a ladder of achievement (page 20) with annual goals. The expected outcomes at the completion of the project were:

a. AIDS Commission offices at the GoSS, State and County levels would be in place, with a clear mandate, institutional capacity and human resources to effectively coordinate and monitor the multisectoral response to HIV/AIDS;
b. The capacity of SSAC will be more strategic allowing prioritization of activities that will have greatest impact on the epidemic;
c. Budgeted HIV/AIDS Strategic Plans will be in place at GoSS and State levels and will respond to local priorities;
d. An HIV/AIDS Monitoring and Evaluation System will be in place, and will collect strategic information at all levels for decision making by all stakeholders;
e. There will be increased capacity among Government Ministries and Civil Society Organizations to deliver comprehensive HIV/AIDS services;
f. There will be increased population coverage of accessible, affordable and sustainable prevention, care, support and treatment services;
g. HIV/AIDS will be integrated into the policies, work plans and budgets of priority Line Ministries and Departments at the GoSS and State levels; and
h. The capacity of the Ministry of Health to respond to HIV/AIDS will be increased at the GoSS and State levels.

11. The initial ISR included the following indicators for which the baseline data as well the targets were defined.

PDO indicators:

a. Number of states with functional AIDS commissions;
b. Number of Ministry action plans implemented;
c. Increased knowledge of HIV/AIDS; and
d. Number of services sites established.

Intermediate outcome indicators:

a. % of resources disbursed by category;
b. Number of CSO subproject funded;
c. % of MARPS reached by interventions; and
d. Number of sectoral policies established.

12. In November 2009, the client revised the result framework, the ISR was updated and a set of measurable indicators to monitor progress of the above mentioned ladder of project achievement was added; these were formalized during the restructuring of the project in June 2011.

1.3 Revised PDO and Key Indicators

13. There were no changes to the PDOs.

14. As noted below in the discussion on implementation, the project underperformed for the early two years, with a number of unsatisfactory ratings on PDOs and IP in ISRs. From November 2009 a substantial effort to reshape the project began, with the main changes of the restructuring described in the June 2011 restructuring document. The changes, beginning in December 2009 involved the following elements:

a. *Reduced grant size*. In July 2009, following very slow implementation progress and disbursements (with only about US$2 million spent) and the need for resources to fund other priority programs, the Oversight Committee of the MDTF decided to reduce their contribution to the project by half. The SSAC was not supportive of this decision. Due to the financial crisis, the GoSS contribution was limited to US$1 million. Therefore the total project budget was reduced to $18.6 million of which $17.6 million came from MDTF and $1.0 million from GoSS. The allocation by component before and budget reduction is presented in Table 2. The proportional funding for institutional capacity building was slightly raised, and the other three components were slightly cut.

b. *Agreed specific actions to speed implementation:* a) Recruitment of Lead agencies (NGOs/firms) to support the state SSACs and to focus on: (i) improving the delivery of HIV/AIDS prevention and treatment services on the ground; (ii) building the capacity of the State SSACs and State MOH HIV/AIDS departments; and (iii) strengthening the ability of local CSOs/NGOs to deliver HIV services; b) Prioritizing line ministries being financed to those that are most strategic (Education, Gender, Internal affairs, Defense, Youth, and Health); c) Strengthening M&E and improving the availability of data through the inclusion of an HIV/AIDS module into the planned population based survey under the Umbrella Health Project, to incorporate the collection of HIV/AIDS related activities into the revised HMIS and to undertake review of the HIV epidemic and responses; d) Strengthening the fiduciary capacities of the SSAC by accelerating the recruitment of a Financial Management Specialist.

c. *Adopt and update a formal Results Framework.* The revised indicators from the Results Framework are given in Section F above and discussed further below.

d. Extend the project closing date by one year from June 30, 2011 to June 30, 2012.

Table 2. Original and Revised cost by components in US dollars

Component	Original cost	Revised cost
Institutional and capacity building of the SSAC	$9,187,500 (25%)	$6,700,000 (36%)
Line Ministries' responses	$3,675,000 (10%)	$1,400,000 (7.5%)
Civil Society Response:	$18,375,000 (50%)	$9,000,000 (48.4%)
Health Sector Response:	$5,512,000 (15%)	$1,500,000 (8.6%)
TOTAL	**$36,750,000 (100%)**	**$18,600,000 (100%)**

1.4 Main Beneficiaries

15. The original PAD listed the following direct beneficiaries: (i) populations at high risk of HIV transmission, including IDPs, returnees, youth and women including most-at risk populations (MARPs); (ii) people living with HIV and AIDS (PLWHA); (iii) orphans and vulnerable children; and (iv) the general population.

1.5 Original Components: The project had four main components.

16. **Component 1: Institutional and Capacity Building of the SSAC at all levels (Originally US$9.1 million; revised US$6.7 million, or 36% of revised total).** This component proposed to build capacity at the GoSS, State and County levels in the following strategic areas: (a) Human resources: The Project aimed to support institutional, managerial and technical capacity building of the SSAC in a phased approach, prioritizing the GoSS level and then supporting State and County HIV/AIDS Commissions; (b) Policy and planning: The project aimed to support SSAC in further development of the HIV/AIDS Multisectoral Strategic Framework (HMSF) and GoSS HIV/AIDS Policy by supporting the development of annual action plans at national and state levels, and the dissemination of the HMSF and State HIV/AIDS Strategic Action Plans (SAP) in all counties. The Project also aimed to provide technical assistance in the development of evidence-based County HIV/AIDS work plans and proposal writing in line with the HMSF and SAPs; (c) Infrastructure: The Project aimed to support provision of communication equipment (VSAT) to improve communication with counties and the national level; vehicles and bicycles and/or motorcycles for focal persons. (d) Monitoring and Evaluation (M&E): The Project aimed to provide technical support to complement M&E activities and support the establishment of M&E support teams in the SSAC at GoSS and state levels, and an overall M&E framework and implementation plan. The system aimed to strengthen the coordination of M&E-related data flows and easy access, and use of information for evidence-based decision making; and (e) Project management: The Project aimed to train staff at GoSS and state levels on World Bank and/or GoSS procurement and financial management guidelines and procedures. In addition staff at all levels was to receive training in project planning, budgeting and financial management.

17. **Component 2: Line Ministries' Response (Originally US$9.6 million; revised US$1.4 million, or 7.5% of revised total).** The component undertook to provide technical and financial support to mainstream HIV/AIDS in policies, development plans and budgets of strategic sector Ministries at the GoSS and state level, and strategic government departments at county level in line with the HMSF and National HIV/AIDS Policy. There are 23 line ministries and 16 independent commissions and chambers in the GoSS. The sectors were at varying stages of integrating HIV/AIDS into their core business. Eventually, this component was revised from 14 to only six ministries. The overall objective was that this component would expand awareness of HIV/AIDS.

18. **Component 3: Civil Society Response (Originally US$18.3 million, revised US$9.0 million, or 48.4% of revised total).** During the war, most health services at the community level were supported by local, regional, and international NGOs, some of which have significant skills in community service delivery. Thus, at the community level, the Project aimed to promote and

support existing, and develop new, partnerships between government institutions, civil society, and international organizations to scale up the coverage of prevention, care, treatment and support services for MARP groups and the general population. Services would build on, complement, and strengthen existing programs. The overall objective of this component was to expand community access to essential HIV/AIDS prevention services. In addition to community-based programs and services, the Project aimed to support delivery of specific services targeting MARPs including, but are not limited to, programs for: CSWs, PLWHA; young people; women and girls; orphans and vulnerable children; (returning) refugees, including repatriation corridors and cross-border programs; uniformed personnel; truck drivers and other mobile populations; condom social marketing; mass media interventions; policy and legal advocacy; human rights; stigma and discrimination; traditional and political leaders; traditional healers; as well as mainstreaming gender in all programs. Implementation of these programs was to be contracted out to individual organizations or consortia of NGOs, CBOs, FBOs, and UN and/or government organizations.

19. **Component 4: Health Sector Response (Originally US$5.5 million, revised US$1.5 million, or 8.6% of revised total).** This component aimed to strengthen MOH capacity to deliver HIV/AIDS services at all levels in a phased approach, starting with building capacity at the GoSS and state levels and subsequently at county levels. The goal was to be strategic and selective in strengthening institutional capacity through the recruitment, and technical training of focal persons in the HIV/AIDS and TB directorates and health workers in general. The Project supported complement activities financed by the World Bank Regional HIV/AIDS Partnership Program that aimed to improve HIV/AIDS prevention, care, treatment and mitigation programs for cross border and mobile populations, refugees and returnees in a few selected counties in South Sudan.

1.6 Revised Components and Changes

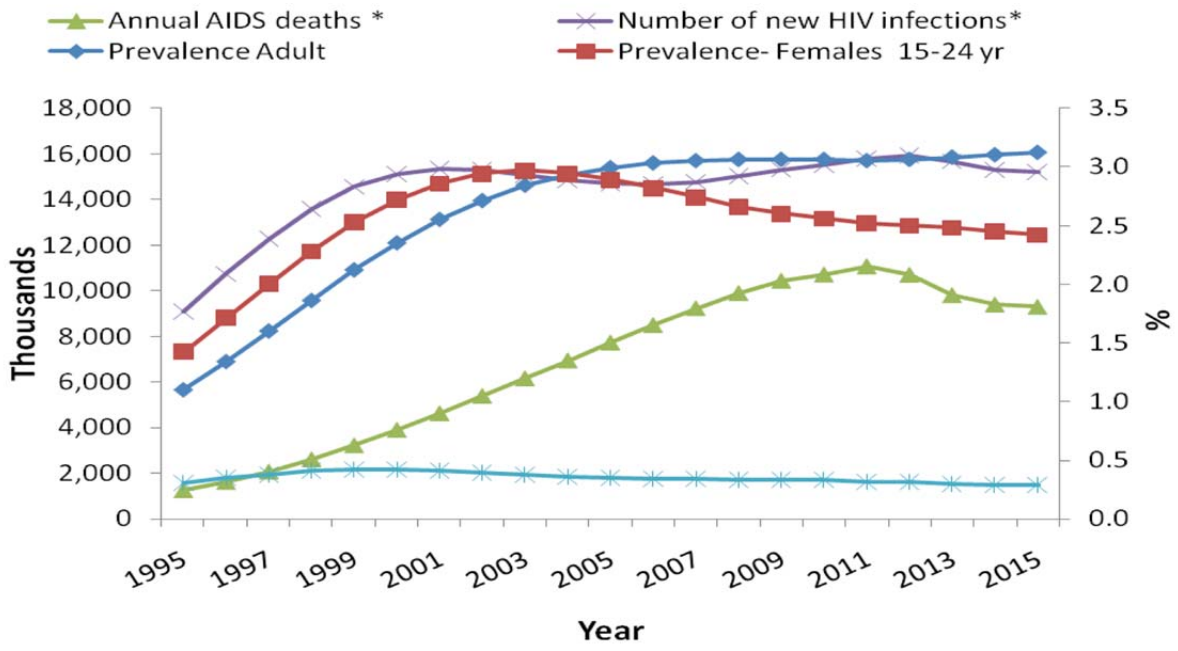
20. There were no other significant changes to components.

2. Key Factors Affecting Implementation and Outcomes

2.1 Results Chain, Baseline and Counterfactual Scenario

21. **Epidemiological scenario:** Baseline data to determine the levels and trends of HIV infection, treatment needs and other outcomes were unavailable at Appraisal. Thus the main reliance was on UNAIDS and other technical reports using model-based projections. Figure 1 summarizes the UNAIDS "Spectrum" model which suggests about 3% of adult were infected in South Sudan, and which predicted modest declines in incidence (which is difficult to measure) and prevalence in females aged 15-24 years (which is proxy for new infections and which can be measured more easily by testing in young pregnant women) over the project period. Earlier data from behavioral surveys and from other settings in Africa had determined that most new infections arose from CSW to male clients, and onward to regular partners. The design of the project sought to reach these MARPs via a broad response with various ministries engaged, care and testing services via MoH run facilities, and use of NGOs and CBOs to reach CSWs and other MARPs.

Figure 1. UNAIDS model-based trends in HIV prevalence, new infections and AIDS deaths, 1995-2011



Notes: Annual AIDS deaths and number of new infections use the Y-axis on the left in thousands; the remaining trends are prevalence using the Y-axis on the right in %.[2]

[2] Courtesy of Boaz Kiprop Cheluget and Peter Ghys, UNAIDS, Unpublished data from UNAIDS Spectrum model 2012.

22. **Results Chain and Counterfactual Scenario:** Previous experience and the project's "ladder of achievement" had a logical results chain leading from inputs to increase SSAC and SACs capacity, engage other ministries, increase civil society response, to expanded services, and increased awareness of HIV/AIDS. Outcomes were to include: increased safe sexual practices, increased knowledge of HIV and accepting attitudes towards PLWHA. The PAD stopped short of claims on impact (reduction in HIV or other STIs), and as noted, the M&E framework did not have sufficient plans for behavioral surveys or other methods to measure progress. The basic results chain was unchanged with the adoption of revised Results Framework of June 2011, though weakness in surveillance continued, there were efforts to include some questions on aspects of HIV/AIDS behavior in surveys supported by the Umbrella Health project. The counterfactual scenario was not one of elimination of new infections or turning the trajectory of HIV sharply downward. While some other African countries have seen sharp declines in HIV infections among young pregnant women, this was not the counterfactual scenario in South Sudan. A realistic counterfactual was that the HIV epidemic growth (i.e., new HIV infections) would slow or would be prevented from exploding.

2.2 Project Preparation, Design and Quality at Entry

23. **Project preparation:** The project was prepared in 6 months, including the time from Concept Review (June 2007) to Board approval (November 2007) and was effective by February 2008. The project preparation was supported by the Multi Donors Trust Funds. There was no change in the original date of grant effectiveness set for March 1, 2008. The conditions for effectiveness were quite achievable involving development of a multisectoral framework and hiring staff for financial management.

24. **Stakeholder involvement and review of African lessons:** The HIV/AIDS project was prepared in the context of a post conflict country with limited capacity and available data on HIV/AIDS. During preparation as well implementation, regular consultation under the coordination of SSAC was held to monitor the progress of national HIV/AIDS response. The Bank team consulted widely with partners including UNAIDS, UNDP, CDC, GFATM, and WHO among others. This led to the MDTF being instrumental to the early efforts by the new GoSS. The future promise of oil revenues also suggested that funds would be available to GoSS to sustain these activities. The World Bank was in charge of the management (technical and financial responsibility) of the MDTF, and the Oversight Committee that was composed of representative of government and donor countries was responsible for allocation and use of funds.

25. **The division of labor between donors, mainly between the World Bank and Global Fund, was defined by SSAC**. The MDTF project would support the establishment of VCT, PMTCT, ART (infrastructure, equipment, human resources, supervision) and creation of demand through civil society association. The GF would provide reagents and ARV drugs. For ARV delivery, GFATM or Transitional Health Funds (THM) financed the drugs, with the Trust fund proportion paying to establish 22 treatment sites (infrastructure, appointment and training of health worker, community mobilization, etc.). USAID also provided some support for these centers. Condoms were mostly procured and supplied by UNFPA but distributed through MOH and the NGOs and CBOs contracted under this project.

26. **Lessons from other experiences in the region**: Moreover, the Bank drew from experience in African countries and a World Bank report on HIV/AIDS developmental assistance. This included realistic assessments that simple designs were needed when implementation capacity was low, the need to ensure NGOs had capacity to assess their target groups of marginalized populations. However, while their importance was already established, the project probably paid less attention to baseline and monitoring data, the need for SSAC leadership to ensure other sectors worked well on HIV, and the need to ensure capacity in new implementing partners, and finally to the transition to GoSS to fund and sustain HIV/AIDS programming.

27. **Adequate attention to financial management and project supervision:** The project invested a considerable amount of attention to ensure financial management and reporting was robust from the start. This included requiring financial consultants to be in place as a condition of effectiveness, and other capacity building efforts. Similar, project supervision had identified this as high-risk project and suggested quarterly financial reporting. There was a detailed and realistic risk assessment, which identified the problems expected with a new GoSS administration and the coordination problems expected across ministries.

28. **Project design.** The project adopted a broad multi-sectoral approach, which was recommended by UNAIDS and other partners at that time, including provision to reach MARPs, expanding ARV treatment and other components. However, the ambition to have various parts of GoSS working together in an inter-sectoral manner was an overly lofty goal given that the GoSS was, and still is, a new government with various challenges of establishing structures for effective management of the country. The design underestimated the amount of attention and coordination needed to manage such action across sectors. The project appropriately sought to avoid new structures, and as much as possible work within the GoSS structures.

29. **Limited project inputs on monitoring and evaluation: The M&E component was not well developed in the project design.** The PAD had no Results Framework, only a ladder of achievements. Though late, the team worked to have a Results Framework identified in November 2009 and formalized in June 2011. The project investments did not specifically fund surveillance in antenatal clinic populations, mapping of high-risk groups, repeat behavioral surveys or other key inputs, as recommended in the external consultant report of April 2011.[3]

30. **Risk assessment of the results chain.** The Project was rated as high-risk for appropriate reasons. Several of the identified risks were realistic, in particular, those related to the financial and procurement arrangements, and these also had reasonable mitigation strategies. However, risk assessment was absent on other Ministries besides MOH having the necessary know how to reduce HIV, and the risk assessment could have better identified how MDTF-financed inputs would relate to the eventual reductions in HIV/AIDS in the general population, that is, to identify a clear results chain and identify the risky components within it.

[3] Gelmon L. Southern Sudan: HIV Epidemic and Response Review Report issued in April 2011

31. **High reliance on a new organization (SSAC) with minimal transition strategy.** The project began on an emergency, humanitarian basis, which was appropriate to the country scenario. A clear transition strategy, moving away from reliance on international NGOs to GoSS for delivery of services was not developed. The creation of SACs at the national and state levels emphasized form over function, with very few specifications of which functions, staffing needs, job descriptions, and other aspects of capacity building could be transferred to GoSS within a feasible timeframe.

2.3 Implementation

32. For almost two years the project was not able to make expected progress and disbursement was very slow, with the eventual diminution of project amount by half. The main reason for slow implementation included the internal management struggles between the chairperson of the SSAC and the executive director that lead to significantly delayed recruitment of core staff such as fiduciary specialists, M&E specialist, etc. The issues were resolved with the appointment of the new executive director. In November 2009, the Bank's supervision mission assessed the main constraints and identified the way forward aiming to revitalize the project. This included:

a. Strengthening the fiduciary capacities of the SSAC through the recruitment of a Financial Management Specialist and Procurement Specialist;
b. Contracting Lead agencies (NGOs/firms) to support the state SSACs with the aims of: improving the delivery of HIV/AIDS prevention and treatment services on the ground; building the capacity of the State SSACs and State MOH departments; and strengthening the ability of local CSOs/NGOs to deliver HIV services;
c. Prioritizing line ministries to those that are most importantly strategic such as Education, Gender, Internal affairs, Defense, Youth, and Health;
d. Strengthening M&E and improving the availability of data by: including an HIV/AIDS module into upcoming household surveys; recruit M&E specialist to carry out the epidemiological synthesis of HIV/AIDS epidemic and response; and review and update the result framework.

33. Work and procurement plans were updated in order to reflect the actions above. These changes were summarized in the December 2009 ISR, and formalized, as noted above in the Board restructuring document of June 2011. The project succeeded in delivering most of the outputs under the three components and mostly achieving or partially achieving its expected outcomes after the formal restructuring of January 2010 (see details in Annex 2, Section 3.2, and Data sheet). There were positive and more challenging factors that played a role in implementation:

34. **Intensive supervision.** After a change in project supervision team by the Bank in late 2009, project performance improved considerably. This included more effective dialogue on the need to change SSAC leadership and staffing. While the cut was unforeseen, the reduction in project cost did convey the seriousness of the situation to GoSS, who responded with improved staffing. The Bank team made considerable efforts to support accelerated contracting of the large umbrella NGOs, organized monthly roundtables of key partners, and commissioning of specific studies. All of these efforts led to an emphasis on delivery of activities under the various project

components. The GoSS worked to reduce 15 different ministries or line authorities in GoSS to 6 ministries. The GoSS commissioned an external expert to review the epidemiological status and program response[4], and the HIV/AIDS Alliance was able to conduct mapping of likely sex workers in only two parts of South Sudan[5]. A CDC report on the epidemiology of HIV was issued in 2012.[6]

2.4 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

35. Overall, the design, implementation and utilization of M&E was *unsatisfactory* for the following reasons:

36. **M&E Design:** The PAD had no formal indicators, only a ladder of achievement and broad goals by the end of the project. Specific efforts to expand surveillance among pregnant women were mentioned, but it was hoped that these would be achieved with the support of other agencies including WHO and CDC.

37. **M&E Implementation:** The project supported a detailed and high quality review of all existing epidemiological data including the 2010 Household Survey with the aim of better understanding the epidemiology of HIV/AIDS in South Sudan and the nature of the response. The draft report has been widely circulated, discussed and validated by SSAC and stakeholders. In addition, in order to improve the availability of HIV/AIDS services, the SSAC with the support of the project completed the following activities: (i) Integration of health related HIV/AIDS data (PMTCT, ART treatment, VCT, etc.) into the Ministry of Health's national Health Management Information System (HMIS); (ii) Integration of HIV/AIDS module into the Health Facility survey to identify availability and use of VCT, PMTCT and ART treatment; (iii) Integration of HIV/AIDS module (Knowledge of HIV status, knowledge about the means of transmission of HIV and protection) into the LQAS survey conducted in June 2011. Some of the recommendations of the external consultant on M&E were not fully implemented and the mapping of sex workers was only partially implemented. The sentinel surveillance of pregnant women was always under the responsibility of MOH and supported by other partners such WHO, CDC, etc. Despite these efforts, lack of robust data remains a problem to date. The UNAIDS spectrum model continues to be the major basis for quantitative decision making, but primary data on trends is required to validate and update this model.

38. **M&E Utilization:** The lack of early M&E indicators and of robust surveillance data contributed to a lack of clarity by SSAC on which actions to prioritize, and how to best advise which interventions (beyond general awareness) that could be pursued by other line ministries. Even now, there is insufficient use of sentinel surveillance data conducted to inform subsequent project strategic priorities, the actions of NGOs or other efforts. Similarly, capacity building to sustain sentinel surveillance by GoSS is limited.

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[4] Gelmon L. 2011 ibid
[5] HIV/Alliance Report to SSAC on Final implementation status, Sept 2012.
[6] Hakim A et al. 2012 South Sudan HIV/AIDS Epidemiologic Profile, Integrated Epidemiologic Profile for HIV/AIDS Prevention, Care and Treatment, and Strategic Information. US CDC, March 2012

2.5 Safeguards and Fiduciary Compliance

39. **Safeguards implementation** was ***satisfactory*** throughout project implementation. The environmental impact of the project was rated C, therefore, no environmental assessment was required.

40. **Financial Management** was ***satisfactory*** throughout project implementation. The project invested substantial amount of attention and staffing for sound financial management. Project audits were conducted annually, with the audit reports submitted to the Bank by due dates. Subsequent audit reports and management letters did not raise any major issues.

41. **Procurement was *satisfactory*** throughout project implementation. Independent procurement reviews were carried out regularly by the Bank team as well by the independent team hired by the World Bank to review procurement of all MDTF supported projects.

2.6 Post-completion Operation/Next Phase

42. **Funding for HIV/AIDS has stalled in the region as a whole, is focused on ARV treatment and remains driven by external sources.** This is also true for South Sudan where funding has also stalled due to austerity measures adopted by the GoSS following the closure of oil production and the long list of development priorities that face the new country. The GoSS has obtained several rounds of funding for HIV/AIDS from the Global Fund as shown in Table 3.

Table 3. Sources, time periods and amounts of non-MDTF funding for HIV/AIDS in South Sudan

Source	Time period	Amount
GF R4	ended Nov 2011	$26,935,365
GF R5 for TB/HIV	ended September, 2011	$21,613,754
GF R9 for HSS	ended September 2012	$24,507,104
GF R9 for HSS phase 2	ends 2015	$12,563,604
GF CoS for HIV	2011-13	$8,473,110
GF CoS for TB/HIV	2011-13	$6,600,951
TFM for HIV	2013-14	$11,918,939
TFM for TB/HIV	2013-14	$9,345,111
MDTF-UPHSD 2	2012-13	$0.7 Million
GoSS for ARV	2013	6 Million SSP (about $1.5 M)

43. The GFATM rounds including Transitional Funds (TFM) focus on provision of ARV treatment, and not so much on outreach programs to reduce HIV transmission from MARPs. USAID and CDC are planning some additional programs funded by PEPFAR, but these will focus mostly on sustaining the 22 ART sites plus some surveillance. For the most recent budget, the GoSS funded the SSAC by about $3 million to keep their operations going, but provides limited funding for outreach activities. The GoSS austerity measures cut the SSAC funding from about $12 million/year, and austerity is expected to continue to at least 2014. Presumably, once petroleum production increases, additional funds will become available. The ongoing Bank supported health project (Health Rapid Results Project) which covers two states (Jonglei and Upper Nile) will sustain some of the existing VCT, PMTCT and ART services developed under the HIV/AIDS project.

44. **High levels of uncovered populations persist**. The UNAIDS survey of various data sources and the results of the 2010 and 2011 surveys on HIV/AIDS awareness[7] reveal there are still large gaps in coverage for most of the UNAIDS-defined components in a multi-sectoral response. The following reports from UNAIDS suggest the following gaps as of September 2012:

a. Comprehensive knowledge on HIV prevention is only about 10% for women and 11% for young people, with little change between the 2010/11 surveys and the earlier 2006 national survey.[8] However, the methodologies for these surveys are not standardized, so some of the lack of awareness might be due to different survey designs;
b. Only about 1,600 HIV positive pregnant women are reached annually for PMTCT, as opposed to estimated 8000 HIV positive pregnant in need;
c. About 73,000 pregnant women utilized HIV testing and counseling services, out of total pregnancies estimated at 300,000;
d. Only about 14% (11,000) of PLWHA in need of treatment receive it; 83,000 are in need of ARV using the WHO's new criteria of treating at higher levels of immune suppression (CD4 counts>350).
e. Condom needs have not been estimated but only about 2.5 million condoms are distributed, mostly with support from UNFPA. Condom use with last non-regular partner among CSWs is estimated at 50-74%, well below levels seen in countries such as Senegal or Cote d'Ivoire.[9]
f. UNAIDS unfortunately does not do estimates of CSW population size, and the project did not do any national mapping of the number of CSWs. Crudely, using the prevalence of CSWs to be the median of estimates from a worldwide review[10], of about 2% (i.e. between 0.4% and 4.3%), would imply about 40,000 of South Sudan's 2 million adult women aged 15-49 years are engaged in part time or full time sex work. Currently only about 9,000 (20-25%) are reached via CSW interventions.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation
Rating: *Modest*

45. At the time of the ICR, the relevance of the project's original objectives to the current epidemiological challenges are rated *high* for several reasons: (i) HIV transmission in the country continues to be driven mostly by MARPs, with new infections stabilizing at about 13,000 per year; (ii) UNAIDS computer-based projections suggest that the growth of HIV has not yet stabilized in South Sudan (see Figure 1 and Annex 3) and there are insufficient sentinel surveillance data to report if there are plateaus in HIV infections in pregnant women or in specific high risk populations, as noted in other parts of Africa;[11] (iii) There is an ongoing need

[7] GoSS: The Sudan Household Health Survey (SHHS), 2010 and GoSS, Report of the Community-based LQAS Survey Conducted in South Sudan, 2011
[8] GoSS. Sudan Household Health Survey (SHHS). 2006
[9] UNAIDS 2012, ibid
[10] Talbott JR. 2007. Size Matters: The Number of Prostitutes and the Global HIV/AIDS Pandemic. PLoS ONE 2(6): e543. doi:10.1371/journal.pone.0000543
[11] Gregson et al, 2008, ibid

for modern public health institutions within GoSS; and (iv) HIV control has been a key aspect of poverty reduction and the Bank's overall assistance strategy in the Africa region.

46. The relevance of the design focusing on inter-sectoral response is rated *modest*, especially in view of the insufficient capacity of the GOSS at that time. While this evaluation is being made at the time of the ICR, it is important to note that the inter-sectoral approach in the design of the HIV/AIDS project was in line with the HIV/AIDS MAP recommendation at that time. It is also important that the team recognized the deficiency in the original design and in 2009 the number of line ministries involved in the project was reduced to six to target highly vulnerable groups (uniformed personals, prisoners, in and out of school children) which could not be reached through civil society response.

47. The relevance of the implementation arrangements is rated *modest*. A strong feature of the project was to focus on a SSAC that would work across ministries, and indeed capacity has improved nationally and in all 10 states. The financial management and procurement aspects appear to have gone well. However, the key lack of technical inputs and ability to mobilize expertise on HIV prevention to lever other ministries remains weak. Finally, the lack of an exit or transition strategy to GoSS funding and stronger stewardship of HIV/AIDS prevention and treatment remains.

3.2 Achievement of Overall Project Development Objectives

48. The evaluation of outcomes against the original PDOs is not easy given that meaningful measurement can only be made against indicators in the Results Framework agreed in November 2009 and formalized in June 2011. Evaluated against these indicators, the project has achieved most of the key benchmarks (see Results Framework in Section F above). The 13 indicators for project development objectives are specified in Section F above and these ranged from increasing community access to HIV/AIDS services to the numbers of CSWs reached. These were important indicators given the epidemiological importance of new infections arising from CSW-male client transactional sex in most parts of Africa.[12] Overall, 9 of the 13 project indicators were achieved or exceeded. Three indicators (children/adults receiving ARV, pregnant women receiving PMTCT and condoms distributed) were funded partially (through procurement of commodities) by GFATM and UNFPA so achievements are not only attributed to the project. One indicator was partially achieved (5 out of 6 planned line ministries have implemented their respective plans.

49. **Achievement of PDO 1 (Strengthening the capacity of the SSAC to plan, coordinate and monitor the GOSS response to HIV/AIDS) is rated *moderately satisfactory*.** The relevance of this objective remains high, and the project made important progress towards its achievement. By the end of the Project, state-level SSACs were established in 10 states and in 20 major more populated counties. All four lead agencies worked with the SSAC to strengthen the delivery of HIV/AIDS prevention and treatment services, building the capacity of the State SSACs and State MOH departments, and strengthening the ability of local CSOs/NGOs. Though

[12] Chen et al, Consistency of sexual risk factors for HIV infection in early and advanced HIV epidemics in sub-Saharan Africa: systematic overview of 68 epidemiological studies PLoS One. 2007; 2(10): e1001; Tallbot, 2012, ibid, Gelmon 2011, ibid.

emphasis was on expansion and scaling up of VCT, PMTCT and ART services in the states, the capacity building of SSAC formed a critical component of the activities undertaken by lead agencies. All the four agencies supported the State AIDS Commissions (SACs) and MOH/HIV department State level (SMoH) to lead and manage the HIV/AIDS response in close collaboration with local County Health Departments (CHD) and the County AIDS Commissions (CACs), while in parallel appropriate technical and financial resources were channeled to an array of PHCCs and community based organizations (CBOs) and other groups like PLHIV networks.

50. The focus was on improvement of leadership capacity, building key technical and managerial skills; ensuring coordination and building partnerships between civil society, the community and local government, as well as between the HIV subsector and other social sectors such as health, education and the private sector; strengthening the states and community systems upon which HIV/AIDS service delivery relies so as to ensure that SACs are able to target populations that are most at risk for HIV (MARPs). Some of the activities that were necessary at that time and were necessary to enable strong functioning of SACs included Mapping of health facilities (PHCC & hospitals) providing HIV/AIDS services; Community Based Organizations capacity assessment with the aim of examining existing SACs, CACs, CBOs and FBOs in order to identify their organizational and institutional capacity needs and gaps. A rapid assessment of the Most at Risk Population was carried out in the two States of Central Equatoria and Eastern Equatoria, and the lead agencies supported the development of communication strategies. The project supported the physical setup of the SACs including purchase of furniture, training of influential persons in the community; health care managers; VCT/PMTCT Counselors; Peer educators; TBAs; HBC Facilitators; and other Trainers, promoters, mobilizers and effective referral sources for PMTCT services.

51. The project supported managerial and technical capacity building through structured short term training workshops/courses, regional trainings, hands on Technical Assistance and joint reviews. Some of the training that was provided included: i) Organization and implementation of HIV/AIDS intervention; ii) Strategic targeting and programming service delivery; iii) Participatory methods and Basic Management of M&E; iv) Effective HIV/AIDS BCC, advocacy and social mobilization; v) Positive Prevention Practice Model; and vi) Technical service concepts on Home Based Care, Positive Prevention Practice and ASRH. For example, peer education in Western Equatoria and Lakes included: i) 58 persons from Greater Yirol HIV/AIDS Awareness Program [GYAAP] who received training for in-school and out-of-school youth; ii) 68 SPL Youth League in Rumbek; iii) 30 Good News Radio Programs; iv) 50 peer educators for YMCA Yambio including additional provision of large scale communication equipment; v) 42 ECS from Diocese of Nzara.

52. An important part of building State capacity to respond was to build the capacity of smaller NGOs as was accomplished in Jonglei State where Jonglei Women's Association, Back Home, Pochalla Youth Association and Fangak Women's Association formed part of the implementation of the project in the State. These NGOs were trained in Community mobilization and sensitization, health education on VCT, PMTCT and other HIV/AIDS services, and distribution of condoms and IEC materials.

53. However, weakness in technical inputs for targeted interventions to high-risk groups, and the use of M&E and surveillance are notable. The project was partially able to support responses from line ministries, since, by the end of the Project, five of the six line ministries (Health, Education, Army, Internal Affairs and Youth) had implemented specific plans but one (Gender) had not. Detractions from a higher rating include poor alignment of project inputs (goods and services) to each Ministry's actions and to reductions in new HIV infections, and the capacity of the SSAC to implement change was limited.

54. **Achievement of PDO 2 (Increasing community access to comprehensive HIV/AIDS services) is rated as *satisfactory*.** The project supported recruitment of four lead agencies which were recruited to support over 100 smaller NGOs on provision of services and care and support. This led to a substantial increase in VCT, and in peer based services to high-risk groups. However, as noted, there is still no reliable denominator of the size of these groups, and surveillance continues to be poor and poorly connected with decision-making by NGOs. Despite these limitations, the coverage of CSWs and other high-risk groups has likely yielded large returns on investment (see Annex 3 for economic analyses). Activities under component 4 which supported a health sector response and hence contributed to increasing access to comprehensive services were implemented in a satisfactory manner; these activities were relevant to the overall achievement of project objectives. The project supported a rapid expansion of the number of health care facilities providing various services such as VCT, prevention of mother to child transmission and adult antiretroviral therapies.

55. Some of the activities that were supported by the project and directly link to the achievement of this PDO include: improvement of quality VCT and PMTCT services through physical infrastructure development of facilities; and building the capacity for effective management of HIV/AIDS programming, as well as service delivery. The project also supported the introduction and testing of models to improve access to services including outreach model to provision of HCT for hard to reach areas, the scaling up frontiers like TBAs in PMTCT promotion, education and referral, and the Home Based Care model of transferring skills to primary care givers, and MH-HIV integration model. The project supported the Extension of VCT and PMTCT Services and improved access to, and utilization of, VCT and PMTCT services; it also supported the expansion of ART services and use, including supporting ART training. In Jonglei State for example, the project supported strengthening of provision of HIV/AIDS services (VCT, PMTCT and ART) through upgrading and/or adding facilities, providing equipment/ supplies, training of healthcare workers and provision of supportive supervision. An example of infrastructure improvement includes the renovation and furnishing of a new ART Center and VCT at Civil Hospital Bor. The responsible leading agency for Jonglei (IMA) provided assistance in refurbishment and/ or equipping new VCT centers in 5 counties of the State, 3 of which carried out PMTCT services; and in addition 2 new VCT centers were constructed in Uror and Pochalla with the provision of equipment/ furniture to ensure these facilities are functional.

56. The main weakness remains attribution of these efforts to the MDTF versus to GFATM or other sources of funds.

57. **Achievement of PDO 3 (Creating awareness and measureable behavior change regarding HIV) has been rated *moderately unsatisfactory*.** The project supported awareness raising activities and it is likely that these contributed to some behavior change. The project supported counseling and testing for pregnant women attending prenatal care services. The project also supported the distribution of condoms though these were financed by other agencies including UNFPA. The project also supported awareness building efforts through line ministries as mentioned above, and in addition some NGOs that represented vulnerable groups such People Living with HIV, Commercial Sex Workers, etc. undertook outreach activities to improve knowledge, awareness and demand for and use of HIV/ADS prevention services. These activities contributed to identifying and delivery of prevention services to Most At Risk Population such as PLHIV (72), CSW (9152), 5, 916 clients of CSWs, Long distance drivers (2366) and MSM (98). As section F shows, services such as Voluntary Counseling & Testing have reached more than 80,000 persons that have been tested and know their HIV status. There is however no evidence that supported activities have not induced expected change (comparison of 2006/2010 household survey):

a. A low level of knowledge in both men and women about the means of transmission of HIV and how to protect themselves;
b. A high level of stigma and discrimination against people who might be HIV-positive;
c. Multiple sexual partners: In the Household Health Survey 2010, 75% of the men who answered the question admitted to having two or more wives or other sexual partners, and 43.2% of the women said that their husbands had other wives. More than 27% of men had sex with more than one partner in the past 12 months, and of these, almost half had three or more partners; and
d. Early age of first sex and a low level use of condoms: In the Household Health Survey 2010 more than 50% of both young men and young women had initiated sexual activity by age 16, with a very low level of condom use at either first sex or thereafter.

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3.3 Overall Project Efficiency

Rating: *Modest (but Substantial for Civil society response)*

58. The original economic analysis conducted at appraisal was done as part of the Multi-Country HIV/AIDS Program (MAP) for the Africa Region-Report no 20727, paragraphs 76-78[13]. This included an overall assessment of the impact of HIV/AIDS on economic development and poverty, and a cost-benefit analysis of HIV/AIDS interventions. The HIV/AIDS epidemic in Africa has gone beyond the health sector and has become a serious socioeconomic development issue. HIV/AIDS affects a country's economy through reduced productivity, domestic savings and economic growth; and increasing the costs of treatment and care for both affected households and society as a whole. Some of the earlier estimates from MAP on the impact on GDP growth now appear to be have been overstated. However, there is little doubt AIDS strikes people in their most productive age, reducing both the size and growth of the nation's labor force. Care and treatment for AIDS impose enormous costs on households and society at large.

59. The expected benefits of the project were multifold and the fiscal impact of the interventions was expected to be small. However, this assumed that GoSS would assume

[13] Multi-country AIDS Project, World Bank, Africa Region, 2006

responsibility for the maintenance of project investments after the closure of the project, which is clearly not the case. And as must be noted, the cost structure using international NGOs is not sustainable.

60. The economic analyses of the project focused on HIV infections likely averted from the CSW and client interventions, which were reasonably specific to the project. With various simple assumptions (see Annex 3), the project estimates about 2000 infections were averted over the project period (or only about 3% of the UNAIDS estimates of new HIV infections over the 5 years). If each infection averted leads to about 22 years of healthy life lost and these are valued at between 1 to 3 times of GDP[14], then a comparison to the project costs using a discount rate of 3% can yield an approximate cost-benefit (Table 4).

Table 4. Estimated cost-benefit/cost-effectiveness of the project

Indicator	Value@1 X GDP in 000s, USD	Value @ 3 X GDP in 000s, USD
Project cost, discounted	$14,142	$14,142
Net benefits	67,680	231,322
Net present value	$12,290	$57,380
Internal rate of return	30%	89%
Cost effectiveness (US$ per healthy year of life)	$321	$321

61. The overall favorable cost-benefit and cost-effectiveness of the project and the large rates on investment is mostly a function of the extraordinarily large reductions in HIV possible with CSW interventions, and should not be viewed as efficiencies in delivery of these services (done through generally high cost international NGOs). The relative cost-ineffectiveness of some of the other interventions (such as youth programs or VCT) is not an argument to focus narrowly only on CSW interventions in future investments. Indeed, creating an enabling environment with wide scale awareness is required for most programs, particularly when prostitution is illegal, as is the case in South Sudan. Finally, the current unit costs are high, so that it would be prohibitively expensive to scale up to wider coverage (most importantly expanding the coverage of CSWs to well over 50% from the estimated 20-25% currently).

3.4 Justification of Overall Outcome Rating

Rating: *Moderately Unsatisfactory*

62. The ICR rated the quality of design of the project as relatively weak; the project was overly complex for a new government coming out of many years of conflict; the M&E design and utilization is also rated *Unsatisfactory* by the ICR. Implementation was *Marginally Unsatisfactory* for a larger section of implementation period. The ICR rates overall relevance of the project as *modest* after combining relevance of objectives, design and implementation. Effectiveness is rated as *modest* except for the objective of expanding access which is rated *high*. Efficiency is rated as *modest* overall, but as discussed above, the substantial cost benefit and cost-effectiveness of the CSW interventions have a major impact on the overall project. The

[14] Bertozzi et al, HIV/AIDS Prevention and Treatment, in Jamison D.T. et al, Disease Control Priorities in Developing Countries, 2nd Edition, World Bank, Oxford University Press, 2006, Chapter 18.

achievement of PDO 3 is difficult to measure. NGO funded efforts to reach CSWs were almost exclusively funded by the Bank and this component is the most cost-beneficial, hence the economic analyses of returns on investment can be reasonably attributable to Bank-specific inputs. These together with the Moderately Satisfactory rating for PDO1; Satisfactory rating for PDO2 and Moderately Unsatisfactory rating for PDO3 yield an overall outcome rating of ***Moderately Unsatisfactory***.

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

63. Although the project did not have a specific poverty focus, the literature on HIV/AIDS, including literature from the Africa region, has established that programs that decrease transmission help reduce the number of poor households which have to resort to more expensive HIV treatments. Similarly, while the project did not have an explicit gender aspect, empowering of SWs, and targeted interventions does enable better economic opportunities for these women since marginalized groups face considerable difficulty in the country. The gains in awareness among females about HIV prevention were probably small, but did vary considerably across the states of South Sudan. In part this slow progress reflects high rates of illiteracy and ongoing civil disruption from wars and conflict.

(b) Institutional development impact

64. This project began implementation with a major constraint of lack of capacity in the newly created SSAC and for almost 2 years, the project was not able to make the expected progress. However, by project close the capacity of the SSAC to plan, coordinate and monitor national HIV/AIDS response had been significantly strengthened and with continuous support of the project, the newly established SSAC is coordinating the national HIV/AIDS response at state level and central level. The core staff composed of the Deputy Chairperson, CSO coordinator, and head of M&E department do conduct supervision of AIDS commissions that are now established in each of the 10 states. In addition, capacity was also built at the state level HIV/AIDS Directorates of the MOH who coordinate and monitor the delivery of HIV/AIDS services at local level. The SSAC has also incrementally built its capacity for planning for HIV/AIDS data for policy makers. The project financed significant investments in state level SSACs, and these are now in place and funded by GoSS. However, a weakness has been the lack of coordination of ongoing surveillance activities implemented by different partners (MOH, NGO's, etc.); of expansion of surveillance and actual use of the data available for project monitoring and evaluation.

(c) Other unintended outcomes and impacts: none.

4. Assessment of Risk to Development Outcome

Rating: *Significant*

65. The risk at the time of the ICR to development outcomes is considered significant for the following reasons:

a. The main drivers of new HIV infections in South Sudan continue to be high-risk groups, and it is unlikely that even with marked expansion of ARV treatment this will be able to keep up with new infections. For this reason, the UNAIDS projections suggest no major decrease in the prevalence among adults in South Sudan for the next few years;
b. High-risk groups have benefitted from specific attention and the civil society component, although the weakness from lack of reliable denominators of such groups remains. Specifically, the reliable measurement of the number, mapping and practice patterns of MARPs continues to be a gap and is not covered under the sentinel surveillance. There is little technical assistance underway to meet these gaps;
c. Future explosive HIV growth in South Sudan is unknown for several reasons. First, many African countries, including neighboring countries have seen declines in HIV, which reduces HIV prevalence among CSWs or male migrant populations coming to South Sudan[15]. Second, some broad awareness of HIV, while not measured yet through reliable national behavioral surveys, is bound to rise from the unusually low levels recorded in the 2006/10 surveys. This may arise from increases in education levels. This in turn should influence condom use practices, particularly among MARPs. Finally, there are unexplained reasons for the decline in HIV in many parts of SSA, and these factors are likely to be in play in South Sudan[16];
d. However, the countervailing trends involve projected ongoing male migration (including for a booming construction industry), expanding access to ART treatment potentially disinhibiting the use of condoms in transactional or high-risk sex. Higher income expected is no guarantee of reductions in HIV, especially if sole male migration is a main source of income growth. Already, the discrepancies seen in HIV risk patterns across the states are likely to be exacerbated. The stakes are large- even a 10% increase in incidence in the UNAIDS model based projections would mean an extra 1500 South Sudanese being infected per year or a loss of over 33,000 healthy life years;
e. The project's the lack of an "exit" or transition strategy to move to GoSS delivered services, insufficient resources for HIV/AIDS, weak surveillance and M&E; and inadequate planning and management are a concern. As noted below in the lessons learned, there might be opportunities for GoSS and the Bank to mitigate these risks through forthcoming investments in the health sector.

[15] UNAIDS, 2012, ibid, Gregson et al, 2008 ibid.
[16] Nagelkerke, et al Heterogeneity in host HIV susceptibility as a potential contributor to recent HIV prevalence declines in Africa. AIDS. 2009 Jan 2;23(1):125-30.

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry
Rating: ***Moderately Unsatisfactory***

66. The project design built on the findings of earlier sector work in the region and incorporated a number of important lessons learnt. The preparation was also strong on donor coordination, and adequate attention to financial supervision. However, there were important gaps in ensuring readiness for implementation of a new agency (SSACs), including insufficient Bank attention to the high risks from technical inputs of the project at the outset and undue emphasis on action across many ministries which was overly complex. No specific assessment of the institutional and governance arrangements for the SSACs took place prior to project or during the planned reduction in budget by half. Importantly, the original monitoring framework was weak, and only strengthened in 2011. Finally, a clear exit strategy or transition strategy to GoSS was not outlined. At appraisal, it was known that South Sudan would have substantial revenues from petroleum production, and a dialogue to transit funding to GoSS would have been appropriate. All these collectively led to delays in the start-up of the project and slow implementation during the first two years.

(b) Quality of Supervision
Rating: ***Satisfactory***

67. Due to the high-risk of the project, the Bank team closely monitored project implementation through regular joint missions with partners, participated in major consensus building via the Oversight Committee of the MDTF, and focused on financial management. After the first two years, when the project was underperforming, specific inputs such as technical consultants, reworked Results Framework and other efforts to expedite the project appear to have been successful with increases in capacity, disbursement and project outputs. No formal mid-Term Review was done, but the major project review meetings in 2010-12 and active management by the Bank team improved the project's performance substantially in the latter two years. The Bank supervision team worked diligently after November 2009 to improve the performance and the PDO and IP ratings improved before the formal restructuring of June 2011.

(c) Justification of Rating for Overall Bank Performance
Rating: ***Moderately Satisfactory***

68. The overall Bank performance rating was assigned on the basis of the overall design at entry, ensuing delays in implementation, weak initial indicators, and strong supervision at the later stages. The Bank recognized problems during implementation and made attempts to improve performance. By the end of the project, there had been substantial improvements in progress towards goals, functioning SSACs in the states and major urban areas, and efforts to ensure that umbrella NGOs were funded to reach MARPs.

5.2 Recipient Performance
Rating: ***Moderately Satisfactory***

a. GoSS ***Moderately Satisfactory***

69. Since its formal establishment, the GoSS recognized the threat of HIV/AIDS to the country and committed itself to fight HIV/AIDS. Establishment of the HIV/AIDS Commission to coordinate the national response to the HIV/AIDS epidemic was the first step toward this objective. It is important to mention that HIV/AIDS control was already the priority of the SPLM, the freedom fighting predecessor to the GoSS. The GoSS allocation to the project was also a confirmation of the political commitment to fight HIV. The significant action taken at the higher level by the government to solve the emerged managerial problems within the commission was appreciated by the donor community.

b. SSAC Performance ***Moderately Satisfactory***

70. There were substantial initial delays in SSAC activities in the first year. As mentioned above, the difficult start was due to internal managerial problems within the SSAC but the GoSS took significant action to solve these internal problems. Following this decision in late 2009, the SSAC saw accelerated implementation of the project through the mobilization of technical assistance on effective strategies, approaches to reach high-risk groups and the change in the number of line ministries for the multi-sectoral response. The country now has functional SSAC offices at the local level, which have the ability to implement and support HIV prevention and care services, but not sufficient funding to do so.

6. Lessons Learned

71. **International NGOs might be faster in service delivery but not sustainable over the long term.** Despite the overall project likely being cost-effective and cost-beneficial, it will not be financially or managerially sustainable for the GoSS to deliver services at high marginal unit costs via international NGOs. Per person reached costs might be higher under international NGO delivery models than others and a high per person cost is simply not sustainable. A limitation of the current project was that it did not explicitly design an “exit” or “handover” strategy from use of international NGOs.

72. **Engage early on capacity building and use other avenues and partners to reach goals.** Given it’s convening role, the Bank is well placed to now lead on dialogue with GoSS about strategies to build capacity such that the GoSS can fund and deliver HIV/AIDS services (mostly via the traditional public sector but also by use of NGO/CBO contracting or other private delivery) over the next few years. Experience from the transition of the Gates-funded prevention program to the Government of India can be brought to bear in this effort.

73. **Realistic results-based indicators are essential at the outset.** The project has proved once again the need for (i) objectives and performance indicators to be carefully selected at the outset; (ii) an adequately designed M&E system to be in place at the start of implementation; (iii)

appropriate arrangements to be in place to ensure that information is used strategically for decision making; and (iv) surveillance activities for HIV/AIDS including estimation of denominators of target groups needs to be a funded activity with strong technical assistance.

74. **Undue emphasis on inter-sectoral action on HIV/AIDS should be avoided in low capacity systems**. While it is important to build constituencies across various ministries, complex implementation arrangements that involve various line ministries spreading awareness of HIV are unlikely to be successful. Specific action, mostly led by MOH and NGOs is needed for peer-based interventions to decrease HIV transmission and to provide specific supportive services such as VCTC.

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

(a) Recipient/implementing agencies

75. The South Sudan HIV/AIDS proejct supported by the World Bank contributed to establish the fundation for a comphensive and coordianted reponse to HIV epidemic in the country. The project contributed to the strengthening of the South Sudan AIDS commission at the central level and the state level. The project channeled substantial amount of its resources to HIV/AIDS affected people as well as people who can help in preventing others from getting infected. This was directly through community initiatives involving local Non-Government Organizations (NGOs), Civil Society Organizations (CSOs), religious groups, the private sector and other groups. The project allowed the introduction of a performance-based contract approach in the country in which the implementing agencies were paid against achieved results. Despite the challenges encountered at the start of the project, the achievements of the projects are encouraging: i) improved availability and use of essential HIV/AIDS services; ii) improved knowledge of HIV, although the measurable behavioral change is limited; iii) better knowledge of the dynamic of the HIV epidemic.

76. Five line ministries and four lead agencies were involved in the implementation of the project- According to the line ministries, the project contributed to introduce the HIV agenda into their respective ministry with the establishment of HIV unit in charge of coordinating and monitoring activities. In addition, the project also helped to increase awareness and improve access to essential HIV/AIDS services for specific categories of High risk group which could not reached by NGO's. For the four lead agencies, despite being very challenging to produce tangible results in a very short period of time, the project contributed to bring HIV/AIDS services to the community.

Annex 1: Project Costs and Financing

(a) Project Cost by Component

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Institutional and capacity building of the SSAC	$9,187,500 (25%)	$6,700,000 (36%)	73%
Line Ministries' responses	$3,675,000 (10%)	$1,400,000 (7.5%)	38%
Civil Society Response:	$18,375,000 (50%)	$9,000,000 (48.4%)	48%
Health Sector Response:	$5,512,000 (15%)	$1,500,000 (8.6%)	27%
TOTAL	**$36,750,000 (100%)**	**$18,600,000 (100%)**	**51%**

(b) Financing

Source of Funds	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Borrower/Recipient	31,750,000.00	17,600,000.00	86,4%
IDA Grant	5,000,000.00	1,000,000.00	13,6%
Total	**36,750,000.00**	**18,600,000.00**	**100%**

(c) Project Cost by Category

Categories	Appraisal Estimate (USD millions)	Actual Disbursement (USD millions)	Percentage of Appraisal
(1) Goods works and services, including Training and Operating Costs	8, 600, 000	17, 600, 000	204%
(2) Sub-grants	4, 400, 000	0	0%
(3) Unallocated	3, 000, 000	0	0%
Total Amount Disbursed	**17, 600, 000**	**17, 600, 00**	**100%**

Annex 2: Outputs by Component

Output under Component 1: Institutional and capacity building of the SSAC.

77. The project supported the strengthening of newly established South Sudan HIV/AIDS Commission as follow:

a. Establishment of office spaces for the HIV/AIDS commission. The project supported procurement of prefabricated offices, procurement and installation of generators, procurement of transport and communication means, procurement of office equipment, etc.
b. Recruitment of core staff for the HIV/AIDS commission: At central level, the project supported the recruitment of procurement specialist, financial specialist, M&E specialist, CSO coordination and line ministry coordinator. At the state level, the project supported the recruitment of SACC coordinator, head of Administrative and financial department and M&E specialist. By the closing of the project, all this personals were shifted to the government payroll and continue to serve the HIV/AIDS Commission. In addition, the project supported the training of staff including those from the line ministries (The project facilitated and supported the training of three in Project management and M&E in Uganda and Ethiopia.
c. Development and dissemination of HIV related policy documents and guidelines: The project supported the national HIV/AIDS commission to develop, validate and disseminate key policy documents such as national HIV/AIDS strategic pan, the HIV/AIDS M&E framework and operational plan, different guidelines (VCT, PMTCT, ART, etc.).
d. Support the operationalization of SSAC's as well the implementation of the project: At the time of appraisal, the government budget allocated to the SSAC's was very limited, therefore in agreement with the government, the project support the operational cost of the SSAC's as well the implementation of the project.
e. Elaboration and implementation of M&E framework: At the time of the project appraisal, the availability of reliable HIV/AIDS data to inform an evidence based data was very limited and fragmented. In 2009, the client with the support of the Bank agreed of the following activities to contribute the data availability and utilization: i) conduct HIV epidemic and response review in South Sudan (Report was validated and disseminated in April 2011); ii) integration into the routine HMIS developed by bank supported health, collection of data on health related activities (VCT, PMTCT, ART, TB/HIV, Condom distribution, etc.). The first monthly HMIS report published by the MOH in February 2012 contains data on availability and utilization of VCT, PMTCT, TB/HIV, etc. Besides that, the project successfully supported SSAC's to include HIV/AIDS in 2 population based surveys: 2009/2010 household survey and 2011 LQAS survey.

78. The establishment of these institutions contributed to the decentralized management and coordination of HIV/AIDS response. The State HIV/AIDS commissions, with the support of lead agencies were coordinating the implementation of HIV/AIDS activities by different implementers and were submitting regularly a monthly report which summarizes the ongoing HIV/AIDS activities and their achievements.

Table 5: Activities under component 1 and their costs.

Activities	Cost
Establishment of SSAC's offices and procurement of office equipment	**3,057,613.00**
Recruitment of core staff for the HIV/AIDS commission; capacity building of staff including those from the line ministries trough in job training as well specific training such master degree training in M&E and project management	1,124,000.00
Development and dissemination of HIV related policy documents and guidelines.	415,700.00
Elaboration and implementation of M&E framework	1,055,000.00
Support the operationalization of SSAC's as well the implementation of the project	1,047,687.00
TOTAL	6,700,000.00

Output under Component 2: Line Ministries Response

79. The project supported the response of line ministries as follows: Five (Health, Education, Army, Internal Affairs, and Youth) out of the planned earlier six line ministries (health, Education, Army, Internal Affairs, Gender and Youth) have implemented their respective plans and have disbursed the allocated funds. It is important to note that in response to the weak capacities of most of the line ministries to develop and implement HIV/AIDS specific activities, SSAC encouraged those line ministries to seek the support of international NGO operating in the country which had the needed expertise. Thus, Education, Army, Internal Affairs ministries were supported by different NGO's to implement their respective plans. The Gender's Ministry was not able to submit a work plan to the SSAC despite the support received from SSAC and the Task team to elaborate the plan. The failure was due to the internal challenges within the Ministry itself.

80. The target populations of theses ministries included uniformed personnel and their family, staff of the ministries and their dependents, school and out school children and prisoners (Ministry of Internal Affairs). Identified and implemented activities aimed to increase awareness and induce safe sexual behavior, promote condom use and make them accessible and improve access to the VCT through HIV test campaign. The support to the Ministry of Education aimed to complement the ongoing effort from other partners such as UNFPA to introduce HIV/AIDS module in the school curriculum. The project supported the establishment of 35 anti AIDS clubs which targeted more than 50, 000 school children. The Ministry of Defense and the Ministry of Interior implemented their respective action plans on national scale and were aiming to improve the knowledge; the attitudes toward HIV infected people and promotion of safer sexual behavior.

Output under Component 3: Civil Society Response

81. The civil society response was implemented with the support of four Lead Agencies and following activities were implemented:

a. Support to HIV/AIDS commission and MOH/HIV directorate at the state level with the objective of ensuring functional state offices in order to efficiently and effectively coordinate, supervise and monitor HIV/AIDS. The lead agencies conducted analysis of the

portfolio of HIV/AIDS stand-alone projects as well as projects with HIV/AIDS components being implemented in respective states and identified gaps;

b. Extension of health related HIV/AIDS services such as VCT, PMTCT, ART services in the states. Under the leadership of the state SSAC's and state MOH HIV directorate, the lead agencies undertook rapid assessment of availability of existing VCT, PMTCT and STI services in the states, based on the outcomes of the assessment develop and implement extension plan of these services by at least 30% and increase the use of these services by the population through ICC and behavioral change activities implemented by local CSOs;
c. Increase community activities and involvement with the objective to facilitate the participation of communities in the design and delivery of HIV/AIDS and STI prevention and care services. For this purpose, each lead agency:
    i. Undertook a comprehensive inventory of all NGOs/CSOs/CBOs/FBOs, assessed respective capacity needs of the CSOs;
    ii. Provided analysis of the portfolio of HIV/AIDS stand-alone projects as well as projects with HIV/AIDS components currently being implemented, identifying gaps. Commented on the technical capabilities of NGOs/CBOs to implement HIV/AIDS projects.
    iii. Provided a matrix showing which high-risk groups are being served by which NGOs/CBOs per geographic area.
    iv. Assessed capacity needs of the CSOs and provided concrete capacity building support to the local indigenous NGOs
    v. Involved trained local NGOs in the provision of HIV/AIDS prevention services mainly for the Most at Risk Population through small grants system;
    vi. A rapid assessment of the Most at Risk population was carried to identify their number, the challenges and risk factors. Based on the outcomes of this assessment identify and coordinate implementation of HIV/AIDS prevention and care services targeting these groups.

82. The table below summarizes the contribution of the lead agencies and civil society organizations to the achievement of the project: (i) More than 50% of newly established VCT services; (ii) 54.8% of PMTCT newly established services and (iii) Third of new established ART services.

Table 6: Lead agencies contribution to the project's achievements.

Activities	Project achievement	CSO/ Lead agency's contribution
Improve availability of health related HIV/AIDS services:		
VCT	164	86 (52.4%)
PMTCT	62	34(54.8%)
ART	22	7 (31.8%)
Improve access and utilization to health related HIV/AIDS services		
VCT	83890	43075 (51.6%)
PMTCT	49691	36323 (73.09%)
ART	3492	1345(38.51%)
Number of CSO selected, trained and received small grants from the project to implement HIV prevention activities	101	NA

Number and category of Most at Risk Population reached by the project: CSW CSW's clients MSM Long distance drivers PLIHV Orphans and other vulnerable children	 9152 5196 98 2366 72 3491	 9152 5196 98 2366 72 3491

83. Approximately 101 CSOs have been trained and given grants to support the provision of HIV/AIDS prevention and care services. Some of these NGOs were from vulnerable groups such People Living with HIV, Commercial Sex Workers, etc. The involvement of the CSO's helped the project to achieve even greater results than expected. Thus, improved knowledge and awareness has increased the demand for and use of HIV/ADS prevention services such as Voluntary Counseling & Testing (83,890 persons have been tested and know their HIV status). The implication of the involvement of CSOs has also contributed to identify and deliver prevention services (Peer education, condoms distribution, etc., to Most At Risk Population such as PLHIV (72), CSW (9152), 5, 916 clients of CSWs, Long distance drivers (2366) and MSM (98).

Outputs under Component 4: Heath Sector Response

84. The HIV/AIDS Directorate of the Ministry of Health was in charge of coordinating the health sector response. The purpose of this component was to increase availability and use of HIV/AIDS services through integration of HIV/AIDS prevention and care activities in health facilities. For this purpose, the HIV/AIDS directorate coordinated the conduct of a rapid assessment of available health related HIV/AIDS services and based on the outcomes of the assessment developed and coordinated the implementation or/and implemented directly the extension plan of these services.

85. The achieved results in term of availability and use of VCT, PMTC and ART services have increased: 78 new VCT centers, 28 new PMTCT centers and 15 ART centers were established with the support of the project and as consequence the utilization of these services has increased (See table below)

Table 7: Ministry of health contribution to the project's achievements.

Activities	Project achievement	MOH (Health sector component) achievement
Improve availability of health related HIV/AIDS services: VCT PMTCT ART	 164 62 22	 78 (47.6%) 28(45.2%) 15(58.2%)
Improve access and utilization to health related HIV/AIDS services VCT	 83890	 40815 (48.7%)

PMTCT	49691	13368 (26.9%)
ART	3492	2057(58.9%)

86. The health sector response was instrumental to the project achievement in the area of availability and utilization of health related HIV/AIDS essential prevention and treatment services. In addition to supporting the establishment of above mentioned services managed by the MOH, the component was instrumental to the achievements of lead agency in the same area. The health sector response and the civil society response worked closely and complemented each other. The MOH, HIV/AIDS directorate supported and provided required technical expertise to the HIV/AIDS commission in the development of policy documents on VCT, PMTCT, ART treatment, etc. The Component also supported the integration of HIV/AIDS modules into the planned and executed by the MOH, M&E activities such as population based survey, HMIS, Health facility survey.

Annex 3. Economic and Financial Analysis

Epidemiological Scenario:

87. The overall epidemiological scenario in the region suggests that the absolute levels of HIV infection will continue to increase. UNAIDS projections for the region, based on the Spectrum Model predict modest ongoing growth of HIV South Sudan among adults, stabilizing around 2010-2015 (Annex 3, Table 1).[17] Unfortunately, the UNAIDS models cannot be reliably verified by direct surveillance data from South Sudan as the number of pregnant women tested or other surveillance efforts has been limited to less than 2-3 sites over a few years. The results from these limited sites also suggest a plateauing of the prevalence of HIV, and as yet no major declines in infection among pregnant women.

88. The UNAIDS model estimates also suggest that the absolute number of new infections will stabilize at about 13,000 per year. The number of new infection estimates is especially important as it suggests how many of these need to be prevented in order to growth in HIV. As noted, the number of female sex workers in Juba alone has been estimated to be about 3500 to 10000 alone, with uncertain estimates for how many CSWs live in the country (but an approximation of about 30,000 based on 2% prevalence in adult women seems reasonable). This implies that further increases in coverage of CSWs would be needed to have a meaningful dent in the total number of new infections. Various epidemiological studies in Africa[18] have suggested that most new infections are from downstream transmission from CSWs and male clients, and South Sudan appears to be no different. Conservatively, even if half of the 13,000 annual new infections are due to CSWs based transmission, then this would suggest that the number of CSWs enrolled in peer-led condom programs needs to rise substantially from a few hundred to several thousand to impact HIV incidence meaningfully in South Sudan. The current project has shown that even modest expansion to a few hundred CSWs is possible and is cost-effective, and has provided the institutional structures with the SSACs and NGOs to do so. The major challenge to slow growth of the overall HIV epidemic in South Sudan will thus require major scale up in CSW coverage.

89. Consistent with this increase in CSW coverage will be the need to expand surveillance and other supportive services, such as good access to condoms, STI treatment, lowering stigma and police harassment of CSWs and other steps.

Economic and Financial Analysis:

90. The PAD had no direct an economic analysis with estimated rate of return. The estimates made were from the regional MAP about broad benefits of HIV/AIDS control. Thus, no comparison to baseline estimates of economic return is possible. However, very crudely, if the project covered (conservatively) about 9000 CSWs and 8000 high-risk men, these would, based on the literature, represent about 4000 new HIV cases avoided of which half were assumed to be using condoms and having safe sex prior to the project. Thus, the 2000 avoided HIV cases from

[17] UNAIDS 2012, ibid
[18] Chen, PLOS One, 2009, ibid, Gregson et al, 2008 ibid

the project represent about 22 years of Disability Adjusted Life Years (DALY; weighted by age preference and a discount rate of 3 percent), or about 44,000 DALYs saved over a 20-year period. If each DALY is valued (again conservatively) at between 1 to 3 times the South Sudan average GDP of US$1500/capita (adjusted for a 5 percent annual income growth), then the discounted value would be US$67 to US$ 230 million. The discounted project costs are about US$14 million (assuming an inflation rate of 13 percent). Thus, in crude terms, the total economic benefit exceeds the projected costs. This further suggests that high coverage of high-risk groups might have made the economic returns from the project even greater. However, the estimation is not sensitive to discount or inflation rates, but is sensitive to the value of life- if each healthy year of life is valued only at average per capita income, then the project is far less cost-beneficial. Finally, the lack of alignment of outputs of the project with the reduced HIV transmission effectively means that it is quite difficult, if not impossible, to assess the economic returns from the rest of the project. Surveillance activities generate important information effects and as public goods, it is hard to evaluate the returns from such information. Similarly, the efficiencies from having a SSAC active in each state are difficult to assess. That is not to state that the economic returns from the rest of the small grants program would be zero. A recommendation from this ICR is to organize a formal economic analysis of the project.

91. Finally, a full fiscal impact is not undertaken here. The costs of running the SSACs can be easily incorporated into South Sudan's annual health budgets (as noted in earlier analyses by the Bank). The major recurrent cost liabilities are those of ARV drugs and supplies for treatment of the health facilities. However, these are small in comparison to the overall MOH budget in South Sudan at current levels of coverage. In this case, the overall fiscal burden associated with the project is small. That is not to state that the costs for ARV treatment are small and if the true numbers of patients estimated by UNAIDS (see table 8 below) were to avail of ARV treatment, then the costs would be much higher and likely well beyond the affordability of the GoSS. A greater discussion of these costs in the African setting has been recently described by Over and colleagues.[19]

[19] Over M. 2008. "Opportunities for Presidential Leadership on AIDS: From an 'Emergency Plan' to a Sustainable Policy." In The White House and the World: A Global Development Agenda for the Next U.S. President. Center for Global Development

Table 8.UNAIDS Spectrum Past estimates of HIV prevalence, new infections, AIDS deaths and other indicators for 1995, 2000, 2005, 2010 and forward projections from 2011-2015.

Summary Table Extended

	1995	2000	2005	2010	2011	2012	2013	2014	2015
Prevalence Adult									
Lower 2.50%	0.03	0.67	2.03	2.11	2.08	2	2.02	2.04	2.05
Median 50%	1.1	2.35	2.99	3.06	3.05	3.06	3.08	3.1	3.12
Upper 97.50%	1.69	3.37	4.09	4.1	4.1	4.12	4.16	4.2	4.22
New HIV infections- Adult									
Lower 2.50%	965	6,937	7,543	8,196	8,511	8,730	8,687	8,583	8,729
Median 50%	8,259	13,242	12,157	12,758	13,064	13,316	13,200	12,923	12,958
Upper 97.50%	30,666	28,415	18,862	17,806	18,308	18,737	18,451	17,742	17,782
Annual AIDS deaths									
Lower 2.50%	16	329	2,971	7,286	7,563	7,381	6,829	6,541	6,447
Median 50%	1,243	3,902	7,736	10,724	11,087	10,714	9,819	9,406	9,305
Upper 97.50%	5,289	5,922	10,640	15,112	15,517	14,771	13,396	12,821	12,677
Mothers needing PMTCT									
Lower 2.50%	49	1,277	4,673	5,171	5,144	5,119	5,080	5,054	5,023
Median 50%	2,363	5,470	7,306	7,825	7,839	7,846	7,877	7,924	7,950
Upper 97.50%	4,071	8,017	10,776	10,954	10,954	10,934	11,064	11,076	11,082
HIV population (15-49)									
Lower 2.50%	856	21,531	71,917	85,454	86,365	86,074	89,247	92,499	95,792
Median 50%	31,838	75,238	105,014	123,287	126,650	130,560	135,071	139,563	144,044
Upper 97.50%	48,773	107,745	143,867	164,886	169,267	174,893	181,210	187,755	194,207
Number of new HIV infections									
Lower 2.50%	881	8,509	9,426	9,987	10,221	10,365	10,279	10,159	10,214
Median 50%	9,087	15,123	14,716	15,524	15,795	15,929	15,676	15,288	15,209
Upper 97.50%	28,161	28,993	21,608	21,694	22,118	22,219	21,709	20,864	20,777

Table 9. Project Costs, Benefits, and Internal Rate of Return (all costs in thousands)

Year	MDTF Disbursements (000s)	Inflation	Total costs (000) Real, 2011 terms	Nominal Benefits (DALYs averted): 1 X GDP estimate (000s)	DALY discount	Discounted Benefits (DALYs averted): 1 X GDP estimate (000s)	Nominal Benefits (DALYs averted): 3 X GDP estimate (000s)	Discounted Benefits (DALYs averted): 3 X GDP estimate (000s)	Net benefits, real Low, 000s	Net benefits, real High, 000s
2008	2,000	1.00	2,000	-	1.00		-		(2,000)	(2,000)
2009	4,000	0.89	3,556	693	0.97	673	2,079	2,018	(2,883)	(1,537)
2010	5,000	0.79	3,951	1,819	0.94	1,715	5,457	5,144	(2,236)	1,193
2011	6,600	0.70	4,635	2,865	0.92	2,622	8,595	7,866	(2,013)	3,231
2012		0.62	-	4,011	0.89	3,564	12,034	10,692	3,564	10,692
2013		0.55	-	4,859	0.86	4,192	14,578	12,575	4,192	12,575
2014	-	0.49	-	5,102	0.84	4,273	15,307	12,819	4,273	12,819
2015	-	0.44	-	5,357	0.81	4,356	16,072	13,068	4,356	13,068
2016	-	0.39	-	5,603	0.79	4,423	16,809	13,269	4,423	13,269
2017	-	0.35	-	6,023	0.77	4,616	18,068	13,848	4,616	13,848
2018	-	0.31	-	6,324	0.74	4,706	18,972	14,117	4,706	14,117
2019	-	0.27	-	6,640	0.72	4,797	19,920	14,391	4,797	14,391
2020	-	0.24	-	6,972	0.70	4,890	20,916	14,670	4,890	14,670
2021	-	0.22	-	7,321	0.68	4,985	21,962	14,955	4,985	14,955
2022	-	0.19	-	7,687	0.66	5,082	23,060	15,246	5,082	15,246
2023	-	0.17	-	8,071	0.64	5,181	24,213	15,542	5,181	15,542
2024	-	0.15	-	8,475	0.62	5,281	25,424	15,843	5,281	15,843
2025	-	0.14	-	8,898	0.61	5,384	26,695	16,151	5,384	16,151
2026	-	0.12	-	9,343	0.59	5,488	28,030	16,465	5,488	16,465
2027	-	0.11	-	9,811	0.57	5,595	29,432	16,784	5,595	16,784
Totals	**$17,600**		**$14,142**	**115,875**		**81,821**	**347,625**	**245,464**	67,680	**231,322**
								NPV	$12,290	$57,380
								IRR	**30%**	**89%**

Assumptions: Inflation rate of 13%, Discount rate of 3%, GDP growth of 5%
Cost-effectiveness: Cost $14,142; DALYS saved 44,000, Ratio: $321 per DALY. This ratio is considered cost-effective.

Year	HIV infections averted	DALYs averted (000s)	GDP (2011 terms) per capita	Low: 1 DALY= 1 X per capita GDP (in 000s)	High: 1 DALY= 3 X per capita GDP (in 000s)
2009		-	1,500	-	-
2010	250	0.44	1,575	693	2,079
2011	350	1.10	1,654	1,819	5,457
2012	600	1.65	1,736	2,865	8,595
2013	800	2.20	1,823	4,011	12,034
2014		2.54	1,914	4,859	14,578
2015		2.54	2,010	5,102	15,307
2016		2.54	2,111	5,357	16,072
2017		2.53	2,216	5,603	16,809
2018		2.59	2,327	6,023	18,068
2019		2.59	2,443	6,324	18,972
2020		2.59	2,566	6,640	19,920
2021		2.59	2,694	6,972	20,916
2022		2.59	2,828	7,321	21,962
2023		2.59	2,970	7,687	23,060
2024		2.59	3,118	8,071	24,213
2025		2.59	3,274	8,475	25,424
2026		2.59	3,438	8,898	26,695
2027		2.59	3,610	9,343	28,030
2028		2.59	3,790	9,811	29,432
SUM	2,000	**44.00**		**115,875**	**347,625**

Assumptions	No	Source
CSW reached	10000	M&E reports
No partner/CSW/year	240	CDC report
Transmission rate	0.002	Literature, assuming co infections
Prevalence in CSW	15%	Assume 5 times general population prevalence
New infections over 5 years	3600	
Clients reached	8200	M&E reports
No partners per year	100	CDC report/assume 2 CSWs per week
Transmission rate	0.001	Literature, assuming less efficient female to male transmission
Prevalence in clients	9%	Assume 3 times general population prevalence
No of new infections over 5 years	369	
Assumed total	~4000 of which 50% already use condoms, so ~2000 new infections prevented by the project	

Starting GDP at $1500 GDP growth of 5% a year

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit	Responsibility/ Specialty
Lending			
Khama Odera Rogo	Lead Health Specialist	ATTHE	TTL
Pascal Tegwa	Senior Procurement Specialist	AFTPE	
Mohamed Yahia	Sr. Financial management Specialist	MNAFM	
Amy Ba	Team Assistant	AFTHE	
Supervision/ICR			
Mohamed Ali Kamil	Senior Health Specialist	AFTHE	TTL
Benjamin Loevinsohn	Lead Health Specialist	AFTHE	Cluster leader
Noriko Oe	Consultant	AFTHE	
Prosper Nindorera	Senior Procurement Specialist	LCSPT	
Anjani Kumar	Senior Procurement Specialist	AFTPE	
Adenike Sherifat Oyeyiola	Sr. Financial management Specialist	AFTME	
Joyce Wani Gamba	Team Assistant	AFMJB	

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY07		74,103.45
Supervision/ICR		
FY08		
FY09		
FY10		
FY11		
FY12		
FY13		
Total:		**276,375.48**

Annex 5: Beneficiary Survey Results

N/A

Annex 6: Stakeholder Workshop Report and Results

N/A

Annex 7: Summary of Recipient's ICR

Introduction and Context

92. According to UNAIDS estimates HIV prevalance in South Sudan is estimated at 3% among adult population but the country shares borders with countries reported to have high rates of HIV/AIDS (Uganda 6.5%, Kenya, 6.3%, Ethiopia, 1.1%, DRC 3.4%, Central African Republic 4.9%). The nature of the epidemic is generalized low although there are "hot spots" where it has matured and is grounded. With increased population movement and interaction across borders since the signing of the Comprehensive Peace Agreement and the independence to a sovereign state of the Republic of South Sudan, there is potential for the epidemic to blow-up. Access to health care is limited and the available health facilities are poorly resourced with frequent stock outs of drugs and shortage of trained health workers. According to national surveillance report of 2010 the HIV prevalence is estimated to be 5.7% and conditions for rapid spread of the disease is high given the high illiteracy levels, polygamous families and high traditional heterosexual behaviors which could potentiate rapid HIV transmission. As part of the project start-up activities, through a consultative process key stakeholders in each state participated in a rapid assessment and mapping of HIV/AIDS interventions to establish the gap. From this exercise it was evident that there are very few HIV/AIDS services in each respective state to meet the needs of the growing epidemic.

Project Context, Development Objectives and Design

93. A rapid response to the HIV/AIDS epidemic was proposed and expected to succeed through direct involvement of the communities. Thus, the project channeled substantial amount of its resources to HIV/AIDS affected people as well as people who can help in preventing others from getting infected. This was directly through community initiatives involving local Non-Government Organizations (NGOs), Civil Society Organizations (CSOs), religious groups, the private sector and other groups. This was the basis for a performance-based contract in which Lead Agencies were given the responsibility and are held accountable for: (i) improving the delivery of a basic package of HIV/AIDS prevention, care, and treatment services especially in urban areas and among most at risk groups (MARGs) with an initial focus on behavior change communications, VCT, PMTCT, and ART services; and (ii) strengthening the key stewardship functions of the SSAC and MOH/HIV directorate at state level, with an initial focus on improving the coordination and supervision of HIV/AIDS services, monitoring and evaluation, and building the capacities of local civil society organizations.

94. The Government of South Sudan secured funding from the World Bank and other donors to implement the Southern Sudan HIV/AIDS Project. Under the funding the Government undertook actions to address the issues related to HIV/AIDS through Line Ministries, the South Sudan AIDS Commission (SSAC), the Ministry of Health (MOH), Civil Society Organizations and the civil society at large. The project was recognized as a multi-sectoral response to HIV/AIDS. It was designed as a rapid response to the HIV/AIDS epidemic through direct involvement of the communities with funding channeled through the following Lead Agencies: Christian Health Association of Sudan (CHAS) (covering Western Equatoria and Lakes), International HIV/AIDs Alliance (covering Central and Eastern Equatoria), IMA (covering

Jonglei and Upper Nile) and HealthNetTPO (covering Western Bahr el Ghazal, Northern Bahr el Ghazal, Unity and Warap) which were assigned to support interventions in the states of South Sudan. The objectives of the assignment for Lead Agencies was to strengthen the delivery of HIV/AIDS prevention and treatment services, building the capacity of the State SSACs and State MOH departments, and strengthening the ability of local CSOs/NGOs. The emphasis was expansion and scaling up of VCT, PMTCT and ART services in the states.

Key Factors Affecting Implementation and Outcomes:

a. There was significant delay in the transfer of the additional fund into the LA's accounts in some instances though the transfer process was completed earlier enough from the office of SSAC. This has impacted the implementation of activities.
b. Shortage of test kits throughout the project period. This has resulted in some of the existing VCT and PMTCT sites not to provide services for the community.
c. Recruitment of companies to carry out construction and renovation of the facilities in some states was a major challenge.
d. Insecurity and heavy rains in some states has been a challenge and has affected project implementation. Poor infrastructure, roads and lack of telephone lines have all been a challenge in reaching to the partners, providing TA and supervision and monitoring
e. Shortage of condoms both the generic and the marketed condoms. Demand has been created through the IEC/BCC awareness and supply was not there. This is caused beneficiaries to start questioning why the project is promoting use of condoms and test when services are not available (no condoms and no test kits).
f. Poor documentation of activities by the partners despite training and TA provided.
g. High expectation from this project from the local authority, the community leaders and beneficiaries despite project objectives and deliverables has been clearly discussed and shared with all.
h. High staff turnover in implementing the project activities. Staffs are trained and they leave or move to another location leaving gaps and calls for more training and capacity building.

Assessment of Outcomes

The following are examples of achievements by the various lead agencies:

95. **International HIV/AIDs Alliance:** The international HIV/AIDS Alliance was lead Agency for East and Central Equatoria States an arrangement that aimed to address challenges in a decentralized manner; strengthening state government response to HIV/AIDS; intensive and participatory capacity building approach at three levels: State (initially and later extend to counties), facilities (PHCCs) and community. The project supported the State AIDS Commissions (SACs) and MOH/HIV department State level (SMoH) to lead and manage the HIV/AIDS response in close collaboration with local County Health Departments (CHD) and the County AIDS Commissions (CACs), while in parallel appropriate technical and financial resources were channeled to an array of PHCCs and community based organizations (CBOs) and other groups like PLHIV networks. The approach was to improve the delivery of high quality comprehensive HIV/AIDS services for PLHIV through: Improvement of leadership

skills, Strengthening the community systems upon which HIV/AIDS service delivery relies, Building key technical and managerial skills where they are needed, Ensuring coordination and building partnership between civil society, the community and local government, as well as between the HIV sector and other social sectors such as health, education and the private sector, and targeting of the populations that are most at risk for HIV (MARPs) and areas with high prevalence.

96. The lead agency conducted key assessments and surveys in initial phase of the project including: Health facilities mapping; Community Based Organizations capacity assessment; and rapid assessment of the Most at Risk population. Target beneficiaries and clients reached included: 254, 000 youth, men, women, CSWs, MSM, OVC, PLHIV and truck drivers. Lead agency also provided training and capacity building of implementing partners and health workers including training in ART and IMAI training for clinicians and health workers on Integrated Management of Adolescent and Adults (IMAI) and ART; PMTCT training for midwives and county supervisors. The Alliance also provided support that included support to seven (7) CBOs with assets such as tables, office chairs, desk top computers, printers, generators, motor bikes and a cameras. A select list of achievements of the implementing partners of the Alliance (by end of the project) in Central Equatoria State: Number of OVC aged 0 - 17 whose household received free basic external support in caring for the child: 533 OVC received support in forms of food, cash, and scholastic materials in CES; Number of women reached with HIV/AIDS IEC/BCC programs was 50,091 includes young girls reached through IEC/BCC. 59 Number of MSM reached with HIV/AIDS IEC/BCC programs. In Eastern Equatoria State: 3001 women referred to PMTCT services; 7129 Number of people mobilized and educated on HCT, care and treatment services.

97. **Christian Health Association of Sudan (CHAS**): Conducted Baseline Assessments in collaboration with SSAC, SMOH and development partners operating in target States, including rapid assessment and mapping of current HIV prevention and treatment services; a simple household cluster survey using LQAS methodology to establish current knowledge, attitudes, and HIV prevention practices of men, women, young people, PLHIVs and Orphans in a sample of one urban county in each state; institutional capacity assessment of NGOs/CBOs selected to deliver HIV interventions under this project; rapid facility assessment to determine potential to serve as VCT, PMTCT and ART site, and gaps in technical capacity, systems and quality assurance. The project also supported Behaviour Change Communication to increase knowledge of problem and modes of transmission, PMTCT, HCT, ART; Community HIV/AIDS prevention education and service promotion through radio programs, bill boards, IEC material distribution, religious leaders, school programs, local theatre events; Community HIV/AIDS prevention education and service promotion targeting in-school and out-of-school young people through peer education, radio programs, support groups/clubs; HIV/AIDS prevention education and service promotion targeting the military, IDP and returnees through IEC material distribution, group education sessions, religious leaders and local radio programs; Education of Positive Prevention Practice model targeting PLHIV associations, through peer support meetings, status disclosure events, world AIDS day campaign events; Promotion of condom acceptance, use and distribution among PLHIVs, CSW, truck drivers and general adult population. The lead agency most importantly supported Extension of VCT and PMTCT Services: The project increased access to and utilization of VCT and PMTCT service in both

Western Equatoria and Lakes states in the following ways: Introduced outreach system; Refurbished PHCCs and PHCUs; Trained VCT/PMTCT counsellors; and trained TBAs and educators, promoters, mobilizers and effective referral sources for PMTCT services. It provided 1,200,000 HIV testing kits as the country was experiencing a six months stock out. They also supported the expansion of ART: sponsored ART training for 10 service providers from two sites selected for expansion of ART services; worked in close collaborations with South Sudan Network of People Living with HIV (SSNeP+) eleven (11) PLHIV associations, 10 in Western Equatoria and one in Lakes state were supported to increase effective referrals for ARV uptake. Funds were provided to support transportation of clients for ARV follow-up visits and nutrition support for clients on ARV but desperate for basic food.

98. **Interchurch Medical Assistance (IMA):** The LA carried out the mapping of HIV/AIDS services within the different health care facilities as well as mapping of the CBOs implementing HIV/AIDS activities in the states. A thorough capacity assessment of the CBOs was conducted, after the preliminary results of the assessment, the Lead Agency called for proposals to scale up BCC activities in the selected counties. In collaboration with the SMoH, health facilities were identified where LA would support HIV/AIDS services. Assessment of health facilities in terms of infrastructure, staffing and training was undertaken. Mapping of the MARPS (Most at risk populations for HIV), especially the Commercial sex workers (CSWs)in urban areas such Bor Town and Border points such as Pochalla were conducted in early 2011. The project supported Behavior Change Communication (BCC) targeting the general population as well as MARPS. A total of 4 CBOs were selected and were sub-contracted to implement BCC activities in 6 counties with some activities carried out in the health facilities including Jonglei Women's Association; Back Home; Pochalla Youth Association; Fangak Women's Association**.** The main activities carried out by the sub- contracted CBOs included: Community mobilization and sensitization, health education on VCT, PMTCT and other HIV/AIDS services, distribution of condoms and IEC materials. Examples of communication activities included: workshops with Government officials; Radio Coverage: HIV /AIDs radio talk shows on radio Jonglei FM covered topics such as ways of preventing HIV, modes of transmission, promotion of condom use and promotion of HIV service utilization. The program highlighted VCT, PMTCT and ART services in Bor state Hospital. Outreach activities organized for the Jonglei state prisons, reaching 268 prisoners conveying HIV prevention messages both to prisoners and Prison Officers; where 500 condoms were distributed, 23 people were tested for HIV where 3 were found positive; 2 men and 1 female and referred to ART clinic for care and treatment. Condom promotion and distribution was continued through County Health departments (CHDs) and facilities supported by International and National organizations in where a t total of about 95,520 condoms distributed through project activities. Provision of HIV/AIDS services (VCT, PMTCT and ART) in Jonglei State was strengthened and expanded through upgrading and/or adding facilities, providing equipment/ supplies, training of healthcare workers and provision of supportive supervision. At the onset of the project, there were 4 facilities providing quality HIV counseling and testing and 3 PMTCT services. By the end of the project, the number of service-providing facilities had reach more than doubled for each type of service. One of the infrastructure improvement projects was the renovation and furnishing of a new ART Center and VCT at Civil Hospital Bor. IMA provided assistance in refurbishment and/ or equipping new VCT centers in 5 counties of the State, 3 of which carried out PMTCT services. 2 new VCT centers were constructed in Uror and Pochalla with the provision of equipment/ furniture

to ensure these facilities are functional. VCT counselors were trained prior to the completion of the construction work. On Training**:** The LA in collaboration with SAC and SMoH organized and conducted various types of training for different categories of practitioners and stakeholders including Clinicians, nurses, and individuals from ministries, schools, the private sector etc. Achievements of the campaign: 4772 people were reached with HIV/AIDS messages & informed about the availability of HCT, PMTCT and ART services; 4450 male condoms were distributed; A total of 1746 people were screened for HIV comprising of 1120 males (64%) and 626 females (36%) out of which the key findings were: 71.5% were married and 28.5% singles; Most of the beneficiaries were between the age of 20 – 29 years accounting for 47% of the total. The LA also supported Capacity building of selected NGOs /CBOs. 42 participants from various CBOs trained on intensive management training; Ongoing technical support to 4 CBOs sub-contracted to carry out BCC activities in the 6 assigned counties; Institutional capacity building for the selected CBOs through provision of vital office equipment, furniture etc. Capacity Building of SSAC and SMoH: included Joint operational activities such as organization and conduction of basic HIV/AIDS and PMTCT training of focal persons from the Line Ministries, Commissions and the private sector, involvement in the evaluation of CBOs proposals for BCC/IEC activities, outreach activities as for the prisons ant MARPs Targeted training of some staff enrolled in 3 months of basic computer training, 2 SSAC training in management training course, 4 senior staff from SSAC and SMoH trained on District Health Information Software (DHIS); Joint supportive supervision; Coordination; Facilities/ infrastructure improvement or development;

99. **Healthnet TPO**: Supported the project in Western Bahr el Ghazal, Northern Bahr el Ghazal states, Unity and Warap states. As with the other agencies the start was with Baseline assessment which found, for example, that the combined VCT, PMTCT & ART services delivery sites were very limited and concentrated to the state capital; VCT, PMTCT & ART services are predominantly delivered in health facilities; however, the integration of HIV/AIDS service provision in the Basic Package of Health Services (BPHS) was weak; VCT services were being delivered in the health facility and as an outreach; Provider initiated counseling and testing (PICT) was not systematically integrated in the health facilities; Weak referral system to link clients diagnosed to be HIV positive from different VCT, PMTCT and TB centers to Wau Teaching Hospital ART clinic; Weak coordination of all stakeholders supporting HIV services; Diagnostic testing and counseling is provided in 9 out of 13 TB treatment centers in the 4 states and that the monitoring and evaluation system was weak. The agency carried out the following at central level including Coordination meetings with other Lead Agencies; Meetings at SSAC. They supported the development of Template for Sub-contracting; Assessment of NGOs/CBOs proposals CBOs/NGOs proposals and development of BCC intervention strategy. Activities implemented at State level in Western Bahr El Ghazal included facilitation of various coordinating mechanisms; and reviews of strategies on BCC Strategy and IEC/BCC Materials and the State BCC Intervention strategy was shared with SAC and SMOH for their input and comments. In Northern Bahr El Ghazal supported activities that included conducting Training Needs Assessment of SAC/SMOH: The main capacity gaps identified were in the areas of computer literacy, monitoring and evaluation, planning and financial management, and conceptualisation of Job Descriptions. Conducted mapping of health providers and CSOs: The mapping identified seven (7) health providers namely 5 hospitals and 2 PHCCs; and fourteen (14) CSOs which include 3 INGOs and 11 CBOs in Aweil West, Aweil East, Aweil South and

Aweil Central. In Unity improvement of HIV/AIDS Clinical Services: HealthNet TPO together with SAC and SMOH made a joint visit to Bentiu hospital to assess the PMTCT and ART services. In Warrap, establishment of a State coordination mechanism among all the various stakeholders active in HIV/AIDS in the region. This lead agency supported Capacity Building of Implementing Partners: The training of sub-contracted CBOs/NGOs on various topics related to HIV/AIDS and financial management. Identification of new VCT and PMTCT sites. In Northern Bahr-El Ghazal State: Scaling up VCT and PMTCT services: The expansion of VCT and PMTCT services with establishment of three new VCT sites in the following Health facilities: Aweil Civil hospital in Aweil Central; Nyamlell PHCC in Aweil West and a new VCT and PMTCT in Gordhim Hospital in Aweil East. 20 Peer educators were also trained to promote the sites and provide referrals to VCT/STI Services. 43 clients are already counselled and tested and received test result, two (2) clients confirmed positive. In Western Bahr- El Ghazal: 5 existing PMTCT and 3 existing VCT were strengthened. In Warrap State setting up of new VCT site, peer education training, regular coordination meetings, routine monitoring of VCT and PMTCT services and Commemoration of the WAD 2011. The following is the description of progress made: Setting up of VCT centre in Mariallou hospital Tonj North County Making voluntary counselling and testing (VCT) services available has been proved to encourage people to determine their HIV status and to take the appropriate measures to prevent the transmission of HIV. As part of efforts to increase number of VCT and PMTCT services at the state, HealthNet supported expansion of the number of health facilities providing quality HIV counseling and testing to 5 VCT and 6 PMTCT sites, and Set up a new HIV testing and counselling site in Mariallou hospital Tonj North County in Warrap.

Selected Lessons learnt

100. High expectation from this project and Project duration was short. The project scope of work was wide from IEC/BCC to capacity building and service delivery. There are many challenges in South Sudan as a new country which affects implementation of projects. It is recommended that future similar projects should be for three years to have long term and allow enough time for completion of activities.

101. Involvement of Country Aids Commission and State Aids Commission in direct supervision of the implementing partners has improved the support and quality of project implemented by the partners. This was in form of coordination meetings, Technical assistance, report collection and monitoring of activities in the community. And also it has covered the gap that is been created by very mobile management of some of the organizations.

102. Future projects should also focus on capacity building and training of state leadership and authorities such as chiefs, Payam administrators, County commissioners, and honorable members of local Parliament. The local people listen more to their leaders therefore equipping their leaders with HIV knowledge will greatly help change the negative attitude and stigma towards HIV and PLHIV.

103. Ensure design of future programs consider some of the external factors that weakened the design of MDTF such as longer timeframe, better targeting of population, commodity allocation, achievable and relevant indicators and also line budgets for commodities.

104. Outreach and mobile services has worked well and many people are utilizing services than when static facilities. This is due to the fact that services are closer to the people. Future projects should take this into consideration and ensure more outreach services as more staff are been recruited, trained and facilities been scale up.

105. Media coverage in raising community awareness on HIV/AIDS- the involvement of the media was one of the key strategies for raising of community awareness on HIV/AIDS as well as community mobilization and promotion advocacy for scaling up HIV/AIDS activities in the community with special focus on the youth groups through visual dimension on HIV prevention, condom use promotion, capacity building, peer education with vulnerable populations such as youth, women and the local communities through TV (Straight Talk Network) and Radio (Heavens Lights the World) program activities.

106. Mainstreaming of HIV/AIDS into Line Ministries- under the project, the Government undertook actions to address the issues related to HIV/AIDS through Line Ministries and the civil society at large. The key objective of the funds was aimed at: i) Provision of technical and financial support to mainstream HIV/AIDS policies, development of plans and budgets at GoSS and state levels and strategic Government departments at county level in line with HIV/AIDS policy; and ii) Support the establishment of HIV/AIDS focal points in Line Ministries. Some of the Line Ministries which benefited from the funds from the period of July 2010 to September 2012 are i) Ministry of SPLA Affairs; ii) Ministry of Health; iii) Ministry of Internal Affairs; iv) Ministry of Education and v) Ministry of Youth Culture and Sports.

Sustainability

107. This end-of project review of the project provides concrete recommendations for improvements in the design and execution of similar undertakings in the revised National HIV/AIDS Strategic Framework for South Sudan. It will enhance higher probability of sustainable impact of future programs. The impact of this project is the reduction of new HIV/AIDS infections particularly in “hot spots” like Western Equatoria where the prevalence is significantly higher than any other place in South Sudan. Sustainability and feasibility of scale-up of community based interventions aimed at empowering the community for sustained knowledge and preventive actions for HIV/AIDS prevention and was therefore considered by this project from the outset in the program design.

108. This review therefore appraises sustainability by focusing on two specific elements of program sustainability; capacity for continuity and community participation and contribution to long-term solutions for resolving long-term problem. This is in line with the idea that production of health begins or happens mostly at the household level. Parameters of the extent to which interventions initiated by the project will be sustained beyond the life of this project is evident in sustainability strategies embedded both in the design and implementation approaches applied. These include: i) Interventions are locally managed by local organizations operating in

the area, local government departments and by community residents; ii) Incorporation or/and integration of interventions initiated or supported by the project in the States' HIV/AIDS response; iii) Incorporated adequate human resource development; iv) Sustained government involvement; v) Integrated in the broad national HIV/AIDS Strategic Framework of ROSS; vi) Inclusion of stakeholders in the design and oversight; vii) Sustenance of behaviors change.

109. On the overall the design of this project lends itself to successful attainment of sustainability aspects listed above. However the extent to which each of these aspects has been addressed varies state by state and also the level of attainment varies.

a. In all countries the project is co-managed by a local team comprising of staff from FBOs, CBOs, NOGs and PLHIV associations. Government counterparts from SAC and SMOH are fully engaged or significantly involved;
b. In both states activities under this project been incorporated in the State plans including the annual operational plans (AOP). The interpretation is that the projects formed part of the State priorities and are likely to receive budgetary support from the Government and other partners;
c. Project allocated significant resource to human capacity building with good number of the relevant workforce having been trained in HIV/AIDS programming, managing, advocating, monitoring and evaluation. Various technical teams of local residents exist in target communities;
d. Sustaining change or results in behaviors and practices takes from an evidence-based communication and advocacy strategy and fortunately the SSMHA project supported development of messages based on research findings.

Recommendations:

a. The key challenges/ constraints mentioned above needs to be addressed adequately in future project interventions for sustainable and effective project with a clear exit strategy;
b. Future similar projects should consider supporting a community advocacy strategy to influence strong social and cultural impediments to achieving the reduction of New HIV infections. Current social/cultural environment the supports wife inheritance, early/arranged marriages, cross generation sexual relationships and prolonged separation among married undermine all HIV prevention efforts;
c. Increasing access and utilization of HIV/AIDS services for the hard to reach populations like IDPs, returnees, and some tribes , call for the redesign of the project, factoring in the consideration of the nomadic lifestyle, the pattern of population movement, settlement and the shifting influence of the weather conditions;
d. Further expansion of the community component of PMTCT with mother to mother care groups and TBAs as frontiers for high impact PMTCT. PMTCT investments should be measured in terms of final outcome rather than number of positive mothers

enrolled. This approach will pursue and monitor the specific outcome indicators of HIV negative babies born to HIV positive mothers;

e. There is need for similar future project to support introducing of a reliable community information system including an information system for the network of PLHIV. This would formalize or institutionalize capturing of specific contributions from the community response or community-based efforts. This should be a collaborative effort between SSAC and MOH;
f. The system should include: i) Defined catchment areas/units that specify demographic information per unit; ii) Registration of PLHIVs in high prevalence states for better monitoring of sustained impact of treatment care and support; iii) Documentation of benefits from referral systems;
g. For effective monitoring and learning, it is recommended that SSAC considers formalizing structures for supervision and monitoring as well as introducing approaches for monitoring outcomes on a regular basis that would provide county specific data which is critical for facilitating improvements in programs and increasing efficiency;
h. There is need for further strengthening of the technical and managerial capacities SACs and this should be done through provision of guidelines, mentorship programs, service aids, e-learning, teleconferencing/discussions, e-health, and back up by a technically competent M&E team at HQs;
i. The design of the project was complex, with many components and many diverse types of target populations. Given the fact that the whole project started in the third year of the entire South Sudan MDTF, there was both time and resource limitations and therefore a logical concentration on component three; Civil Society Response;
j. More HIV/AIDS are needed in all the states to increase uptake of services nearer to the people;
k. Targeted HIV prevention activities that address the Youth and adolescents as they the most affected;
l. Empowerment of women especially the young to delay the initiation of sex and/ be in position to negotiate for safer sex.

Annex 8: Comments of Co-financiers and Other Partners/Stakeholders

As stated in Section 7 (b) of the main text, when provided the draft ICR for comments, DFID raised no issues and expressed its agreement with the content of the document.

Annex 9: List of Supporting Documents

1. South Sudan HIV Project – PAD – 2008
2. Implementation Status Reports (2008-2012);
3. Jha P. et al. The evidence base for interventions to prevent HIV infection in low and middle-income countries. Commission on Macroeconomics and Health, Working Group 5 Paper no.24;
4. Project Aide Memoires (2007-2012);
5. Over M. 2008. "Opportunities for Presidential Leadership on AIDS: From an 'Emergency Plan' to a Sustainable Policy." In The White House and the World: A Global Development Agenda for the Next U.S. President. Center for Global Development
6. Multi-country AIDS Project, World Bank, Africa Region, 2006
7. Nagelkerke, et al Heterogeneity in host HIV susceptibility as a potential contributor to recent HIV prevalence declines in Africa. AIDS. 2009 Jan 2;23(1):125-30.
8. Bertozzi et al, HIV/AIDS Prevention and Treatment, in Jamison D.T. et al, Disease Control Priorities in Developing Countries, 2nd Edition, World Bank, Oxford University Press, 2006, Chapter 18.
9. Chen et al, Consistency of sexual risk factors for HIV infection in early and advanced HIV epidemics in sub-Saharan Africa: systematic overview of 68 epidemiological studies PLoS One. 2007
10. Client/Government ICR
11. GoSS: The Sudan Household Health Survey (SHHS), 2010 and GoSS, Report of the Community-based LQAS Survey Conducted in South Sudan, 2011
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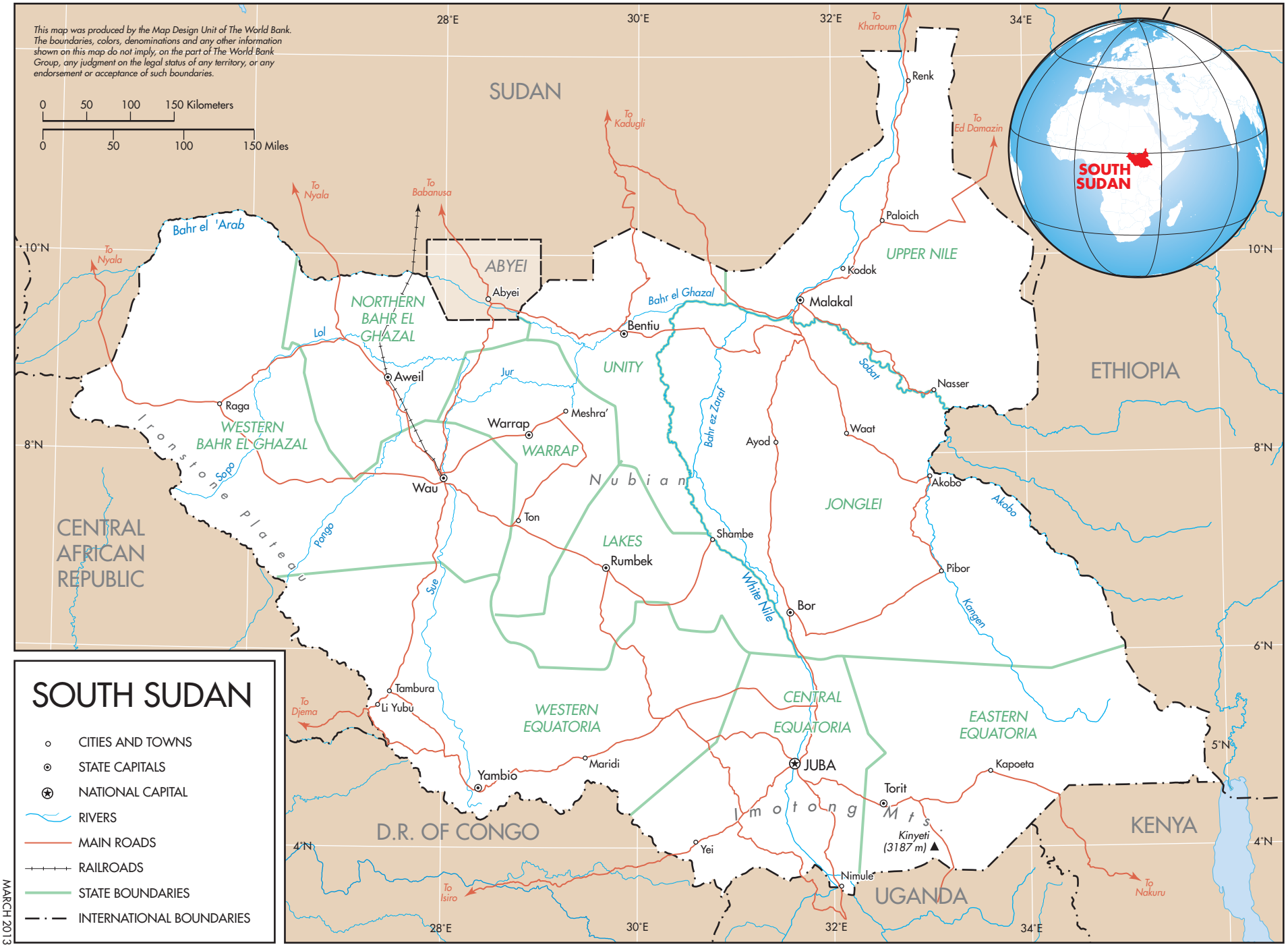
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0 50 100 150 Kilometers
0 50 100 150 Miles
SUDAN
ETHIOPIA
CENTRAL AFRICAN REPUBLIC
D.R. OF CONGO
KENYA
UGANDA
SOUTH SUDAN
ABYEI
NORTHERN BAHR EL GHAZAL
WESTERN BAHR EL GHAZAL
UNITY
UPPER NILE
WARRAP
LAKES
JONGLEI
WESTERN EQUATORIA
CENTRAL EQUATORIA
EASTERN EQUATORIA
Nubian
Imotong Mts.
Ironstone Plateau
Bahr el 'Arab
Bahr el Ghazal
Bahr ez Zaraf
White Nile
Sobat
Akobo
Kangen
Jur
Lol
Sopo
Pongo
Sue
Abyei
Aweil
Raga
Wau
Warrap
Meshra'
Ton
Rumbek
Bentiu
Malakal
Kodok
Paloich
Renk
Nasser
Waat
Ayod
Akobo
Pibor
Bor
Shambe
JUBA
Torit
Kapoeta
Kinyeti (3187 m)
Nimule
Yei
Maridi
Yambio
Tambura
Li Yubu
To Khartoum
To Kadugli
To Ed Damazin
To Nyala
To Babanusa
To Djema
To Isiro
To Nakuru
28°E
30°E
32°E
34°E
10°N
8°N
6°N
4°N
5°N
SOUTH SUDAN
CITIES AND TOWNS
STATE CAPITALS
NATIONAL CAPITAL
RIVERS
MAIN ROADS
RAILROADS
STATE BOUNDARIES
INTERNATIONAL BOUNDARIES
MARCH 2013
IBRD 38572R