TODAY'S CHALLENGES, TOMORROW'S POTENTIAL

Findings from a Rapid Population and Reproductive Health Analysis for Sudan

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Executive Summary

Background

Sudan is a politically and culturally diverse country. The Comprehensive Peace Agreement, signed in January 2005, has brought hope for peaceful coexistence between North and South Sudan, after a long and devastating war. Recent conflicts in Darfur (Western Sudan) and long-simmering tensions in the East, however, have created a complex political landscape and increased human suffering. As a result, attention has been diverted from the development and strengthening of health systems in Sudan.

Columbia University conducted a study in 2006, at the request of UNFPA, to present a broad overview of Reproductive Health issues in Sudan. This investigation did not include analysis of needs or programming in the Darfur as the Country Office indicated that significant information was already available for this region. As a Population and Reproductive Health Analysis (PRHA) for Sudan, its qualitative findings are intended to complement the quantitative data soon to be available from the Sudan Household Health Survey. Together, these data will inform the strategy for UNFPA Sudan's 2008-11 Country Program.

Key Findings

Reproductive health in Sudan suffers from a shortage of education, equipment and supplies, and skilled health personnel. In the general population, misinformation about reproductive health options is widespread. Low literacy levels hamper training of skilled medical workers, particularly midwives. Additionally, there is a lack of standardized population-based statistics to guide program planning and baseline data to facilitate effective evaluation of progress.

In the **North** and **East**, conservatism presents challenges for reproductive health programming, though institutions such as Ahfad University for Women offer promising strategies for approaching these cultures on their own terms. In the **South**, there is extremely limited physical and political infrastructure, but hope that a more stable and prosperous Southern system can be developed.

Sudan is characterized by extremely high rates of **maternal mortality** (especially in the South), making midwifery training and upgrading of emergency obstetric facilities a priority. In the area of **gender-based violence,** most programming has been overshadowed by the emergency responses to violence in Darfur. UNFPA could build upon its extensive efforts to coordinate GBV response in Darfur to focus added attention on GBV concerns in other regions of the country. Extremely high levels of female genital mutilation/cutting persist in the North, despite some existing eradication activities. The response to **HIV/AIDS** has been disappointing and uncoordinated. Significant efforts are needed in education, awareness, testing, and treatment. **Family planning** in Sudan is characterized by low contraceptive prevalence rates, cultural and political barriers to family planning methods, and high numbers of unwanted pregnancies. There is a reliance on oral contraceptives rather than condoms. Finally, **adolescent reproductive health**

programming is largely absent in Sudan, and there is a need for programs that address the particular vulnerabilities of adolescents.

UNFPA's Sudan Country Office has made significant progress during its current Country Planning cycle; notable achievements include the development of training modules for midwives in both Northern and Southern Sudan, increasing the availability of RH supplies and equipment, and playing a leadership role in the context of UN HIV/AIDS Country Team activities. By expanding its efforts in the South, examining programming possibilities in the East, and focusing on a few key issues in the North, UNFPA can make some broad improvements to reproductive health in Sudan. Strengthened coordination and joint planning could bring greater coherence to certain programs, and promote local ownership by government actors, while also emphasizing greater accountability. UNFPA can reinforce existing collaborations and build new partnerships to encourage the development of more community-based interventions, tailor its distribution activities to varied local contexts, and position itself as the central point for information on reproductive health activities in Sudan.

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i. List of Acronyms

ACORD	Agency for Co-operation and Research in Development
AIDS	Acquired Immune-Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ARC	American Refugee Committee
AU	African Union
ARV	Anti-Retroviral Drugs
ART	Anti-Retroviral Treatment
BCC	Behavior Change Communication
CBO	Community Based Organization
CMT	Community Midwife Training
CPA	Comprehensive Peace Agreement
CU	Columbia University
DASECA	Division for Arab States, Europe and Central Asia
EmOC	Emergency Obstetric Care
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GoS	Government of Sudan
GNU	Government of National Unity
GoSS	Government of Southern Sudan
HIV	Human Immunodeficiency Virus
HRU	Humanitarian Response Unit
ICPD	International Conference on Population and Development
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
IEC	Information Education Communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IGP	Income Generating Project
INGO	International Non-Governmental Organization
IO	International Organization
IRC	International Rescue Committee
LNGO	Local Non-Governmental Organization
MICS	Multiple Index Cluster Survey
MoH	Ministry of Health
MMR	Maternal Mortality Ratio
MSF	Médecins Sans Frontières
NGO	Non-governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PAPFAM	Pan-Arab Project for Family Health
PHCC	Primary Health Care Centers
PHCU	Primary Health Care Units
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PRHA	Population and Reproductive Health Analysis
RH	Reproductive Health
SCC	Sudan Council of Churches
SGBV	Sexual and Gender-Based Violence
SIPA	School of International and Public Affairs
SNAP	Sudanese National AIDS Program
SNCTP	Sudanese National Council on Harmful Traditional Practices
SPLA	Sudan People's Liberation Army
SPLM	Sudan People's Liberation Movement
SRC	Sudanese Red Crescent Society
STI	Sexually Transmitted Infection
SUNAF	Sudanese Network for the Abolition of Female Genital Mutilation
UN	United Nations
TB	Tuberculosis
TBA	Traditional Birth Attendant
ToT	Training of Trainers
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNMIS	United Nations Mission in Sudan
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

ii Map of Sudan

Map available online from UN Cartographic Section, at:
http://www.un.org/Depts/Cartographic/map/profile/sudan.pdf

iii. Acknowledgements

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The team would also like to thank the Economic and Political Development (EPD) Program at SIPA, through which this workshop project was organized. We are grateful for the overall organizational framework that EPD provided and for the program's efforts to prepare and support workshop participants.

1. Project Background

1.1 The Client Agency

The United Nations Population Fund (UNFPA) works with governments and non-governmental organizations (NGOs) to support programs that help women, men, and young people to plan their families and avoid unwanted pregnancies; to improve the safety of pregnancy and childbirth; to avoid sexually transmitted infections (STIs) including HIV; and to combat violence against women.[1] The Program of Action adopted at the 1994 International Conference on Population and Development (ICPD), and the Millennium Development Goals, guide UNFPA's work. UNFPA also emphasizes the promotion of gender equality in order to improve health and advance development.

UNFPA formalized its Humanitarian Response Unit (HRU) in 2002 to better respond to reproductive health (RH) needs in conflict and post-conflict settings. In Sudan, the agency is currently supporting RH programs and services in the North, West, East and South — settings with varied contexts: development; conflict; pre-crisis; and transitional.

1.2 Columbia University and UNFPA

The relationship between the Humanitarian Response Unit at UNFPA in New York and the Humanitarian Affairs Program at Columbia University's School of International and Public Affairs (SIPA) began in 2003-2004, when SIPA provided UNFPA with a team of graduate consultants to evaluate the agency's HIV/AIDS programming in Sierra Leone. In 2004-2005, a second SIPA team mapped HIV/AIDS and sexual and gender-based violence (SGBV) programming in Liberia. The success of these partnerships led UNFPA to request a SIPA team in 2005-2006 to consult on RH issues and programming in Sudan. The Sudan team, comprised of seven graduate students from diverse professional and academic backgrounds, participated in the study as part of a Workshop in Applied Development at SIPA's Economic and Political Development Program. The Program's objectives include improving the quality of humanitarian action in the field, and placing humanitarian affairs in the broader development and geo-political context.

1.3 Project Rationale

The political situation in Sudan presents both opportunities and challenges. There is peace between the North and South after a long war, but conflict in the West (Darfur) and unrest in the East. Taking account of both public health need and political realities, UNFPA must decide how to prioritize its resources in this complex setting.

1.4 Development of Project Objectives and Deliverables

The Columbia University (CU) team, which included graduate students with professional experience in public health, humanitarian aid, international development, and journalism, began work on the project in December 2005. In consultation with UNFPA (DASECA, HRU and the UNFPA Sudan Country Office), the team set out to conduct a Population and Reproductive Health Analysis (PRHA) for Sudan, as the UNFPA Sudan Country

[1] See www.unfpa.org for more details.

Office identified the need for a broad overview of national RH issues and activities to inform development of the 2008-2011 Country Program. The Sudan Household Health Survey, which is currently being conducted, is expected to provide population-based statistics for many of the issues considered here. This PRHA is designed to add qualitative data to help in the interpretation of the survey's quantitative findings.

To ensure a useful and informative analysis of Sudan - Africa's largest nation - regional and topical areas of focus were defined. Minimal time was devoted to Darfur as some observers have indicated that there are already significant assessment and programming efforts being directed towards the Western region of the country. The transitional areas also were not emphasized. Due to the quickly changing situations in Darfur and in transitional areas, these regions were not included in depth since the primary goal of this report is to inform planning for the next Country Program, which will not begin until 2008. Field visits were organized from Khartoum to the East, where UNFPA has limited activity, and to the South, where the peace agreement has presented both local and international actors with promising new opportunities.

The team set out to map the needs and actors in RH in Sudan so as to provide UNFPA with information necessary to better distribute their own resources and efforts. The team produced both an interim literature review (which contains more references to the team's information sources and statistical data) and this final report with findings and recommendations for UNFPA Headquarters Offices and the Sudan Country Office.

2. Country Background

2.1 The Republic of Sudan is the largest country in Africa. Located in northern Africa, it covers approximately 2.5 million square kilometers and is home to a widely dispersed population of roughly 36 million people. The physical terrain varies significantly. It is dominated by the Nile and its two tributaries, which join forces at Khartoum, the capital in the North. Oil fields located mostly in the South and in transitional areas produce significant revenue for the government.

2.2 Sudan's multiple identities stretch far back into history.[2] Ethnic divisions were sharpened by Britain, the dominant partner in an Anglo-Egyptian condominium from 1898 onwards. The British later ruled Sudan as a colonial possession, the North as an Arab-Muslim society and the South as an African society that was subject to Western influences, but largely denied access to colonial education or economic development initiatives. Southern opposition to Northern domination started even before independence in 1956, and conflict continued until the Addis Ababa Agreement of 1972. War resumed in 1983 and continued until the current peace was established by the Comprehensive Peace Agreement (CPA), signed in January 2005.

[2] See, for example, Deng, F.M. War of Visions: Conflict of Identities in the Sudan. Brookings Institution, Washington, D.C. 1995.; and Johnson, D.H. The Root Causes of Sudan's Civil Wars. International African Institute. Oxford, UK. 2003.

2.3 The CPA defines a federal system, embodied by the phrase "One Country, Two Systems." The Government of Sudan (GoS) in the North was renamed the Government of National Unity (GNU) and the rebel movement in the South (the Sudan People's Liberation Movement / Sudan People's Liberation Army (SPLM/SPLA)) formed the basis for the Government of Southern Sudan (GoSS). The peace agreement grants the GoSS autonomy for 6 years, after which a referendum on independence will be held. Approximately one third of Sudan's population lives in the area now administered by the GoSS.

2.4 The GoSS has begun establishing itself in Juba, the newly designated capital of Southern Sudan. A former garrison town, Juba did not previously have a large international presence. At present, most agencies operating in Southern Sudan are in the process of moving their central operations to Juba from their current locations in Rumbek (Southern Sudan), Nairobi (Kenya) or Kampala (Uganda). Accommodation, office space, telecommunications, and transportation are extremely limited in this transitional setting.

2.5 The peace agreement is expected to encourage many refugees and internally displaced persons (IDPs) to return to their homes in the South. Over 2 million IDPs are estimated to live on the outskirts of the Northern capital, Khartoum, alone. Many of them have lived there for 15 or more years, in areas that continue to have negligible infrastructure and social services. Another 1.7 million people are thought to be displaced within Southern Sudan.

2.6 Meanwhile, tensions in Darfur, Western Sudan, flared into systematic violence against civilians in 2003. Some observers believe that the North–South and North–West conflicts share a common theme: the refusal of Khartoum to cede significant financial or political control to the periphery.[3]

2.7 The fragility of the North–South agreement has led the UN and many other countries to tread more carefully than they might have otherwise when reacting to the Darfur crisis. The international community stakes a great deal on maintaining the North–South peace, giving the GNU considerable leverage in Darfur. Although a UN peacekeeping force (UNMIS) is operating in the South, the GNU has allowed only African Union (AU) forces to provide security in Darfur. However, the UN is widely expected to take over the operation by the end of this year, now that a comprehensive peace accord has been signed in early May 2006 by the government and the largest rebel group, concluding a lengthy process of peace talks brokered by the African Union.

2.8 The position of many NGOs in Sudan is also precarious. The GNU places significant bureaucratic barriers in the way of day-to-day operations, as it objects to any potential external source of criticism. In the South, efforts to build the administrative authority of the GoSS are expected to include a new regulatory framework for all NGOs operating in Southern Sudan to improve accountability.

[3] Prunier, G. Darfur: The Ambiguous Genocide. Cornell University Press, Ithaca, NY. 2005.

3. Methodology

In undertaking the Population and Reproductive Health Analysis, the Columbia team relied on a combination of qualitative and participatory methods. Combined with our preliminary desk review, this methodological approach allowed the team to triangulate and contextualize our findings. As mentioned above, the study was framed to focus on Northern Sudan, including Khartoum and eastern regions as well as Southern Sudan. Where information on Darfur and transitional areas was readily available, it has been incorporated in relevant sections of the report.

A. Phase 1 – Preliminary Data Collection

1. In-depth Interviews

The Columbia team conducted a series of in-depth interviews with NGO staff, UN staff, and academics in New York with expertise in reproductive health and emergency assistance as well as field experience in Sudan. The team designed an interview guide and coded interview notes, which informed a preliminary literature review. Interviews were also helpful in soliciting background materials and reports for the literature review.

2. Existing reports and documents

The team identified and collected reports, evaluations, proposals, surveys, field studies, articles, and other literature relevant to the PRHA. Collected materials were analyzed in an initial attempt to identify overarching issues, current operations in the field and key gaps and challenges.

3. Identification and contacting of relevant organizations for field visits

Through interviews with key stakeholders, consultations with UNFPA, and outside research, the team identified the main actors working in reproductive health on the ground in Sudan. The team created and prioritized a database of contacts and established a timeline for the overall analysis.

B. Phase 2 – Field Data Collection

1. Site visits, Meetings and Workshops

While in Sudan, the team visited and observed a variety of public and private facilities to get a sense of health service and training facilities in different communities. These included hospitals, clinics, universities, a midwifery school and an IDP camp's health facilities. The team also attended a series of workshops and meetings, which helped us get a picture of coordination efforts, current priority issues, and an overall view of how organizations are operating on the ground. The UNFPA Country Office staff in Khartoum

and Juba were instrumental in assisting in the identification of key stakeholders and supporting the logistical arrangements of the information gathering process in the field.

2. In-depth interviews

The Columbia team designed interview guides for NGOs, UN and government facilities and met with over 60 individuals. For a complete list of individual interviews, please see Appendix II. To maximize effectiveness, interviews were conducted individually or in teams of two.

3. Focus groups

The Columbia team conducted a total of 9 focus groups in the North and the South. Limited resources and logistical constraints prevented the team from conducting focus groups in the East. Separate groups were convened with young women, young men, and women of childbearing age. The team trained a total of 6 local men and women in focus group methodology. We then relied on these individuals to pre-test our focus group guides and assist with focus group facilitation, note taking and translation. In all cases, verbal consent of participants was obtained. We also relied on local staff and volunteers to be our cultural guides, helping us to collect information in a manner that was sensitive to local understandings and practices related to gender, tribal/religious affiliation, and social norms.

C. Limitations

The Columbia team hopes and expects that this initial PRHA will be expanded and informed by additional analyses that are specific to certain geographic and thematic foci. Although we have been able to collect and analyze a significant amount of information, we acknowledge a number of important limitations to our work.

1. Time Constraints

Our single biggest constraint was time. Sudan is an enormous country with a complex history and dramatic regional variation. Attempting to conduct a comprehensive PRHA for the entire country in a little over 4 months, with just over two weeks in country, was a significant challenge and clearly limited the extent to which we were able to assess relevant issues in great depth. Additionally, high staff turnover, frequent travel and the fact that many agency staff working on Southern Sudan are still based in Nairobi proved problematic. Although the team managed to conduct a significant number of interviews, there were some important stakeholders that the team was only able to contact via email, telephone or not at all.

2. Logistical and Security Constraints

Although we would have liked to have seen as much of the surrounding areas as possible, the team was restricted to a few areas due to logistical and security constraints. The East

and South were considered to be at Phase II and Phase III security levels, respectively. Limited time and travel authorization requirements restricted our travel in the North to Khartoum and in the East to Kassala. In the South, security concerns as well as poor infrastructure and recent rainfall made travel outside of Juba impossible. As a result, information gathered from focus groups and site visits is not representative or exhaustive. This analysis may point to specific issues that warrant further research.

3. Language and Socio-cultural Barriers

A final limitation is the fact that none of the CU team members speak Arabic or any other language indigenous to Sudan. We relied heavily on translators for focus groups and some site visits. As a result, some information was surely lost and bias may have been introduced through the use of translators with limited training. At the same time, there may have been information that focus group participants withheld from us or emphasized given the presence of outsiders associated with an American university and a UN agency. Although the team tried to create a comfortable space for sharing sensitive information by matching male translators with male groups, female translators with female groups and pre-testing the focus group questionnaires, there was some question as to the extent to which the participants felt comfortable revealing intimate personal and sexual details.

4. Reproductive Health in Sudan

Broad observations about the Sudanese health system generally and reproductive health in particular are presented below. A more detailed description of health system statistics can be found in the SIPA team's Preliminary Desk Review Findings.

4.1 There is a general **lack of supplies, staff, and services** in all areas of reproductive health.

4.2 Sound population-based statistics are lacking for many reproductive health indicators. This lack of reliable baseline data has made it nearly impossible to effectively measure program impact. The situation should be improved, however, by quantitative data generated by the Sudan Household Health Survey, which is currently being conducted in all states.[4]

4.3 Many aspects of reproductive health are politically or culturally sensitive in Sudan. Family planning is seen by some in the GNU as part of a Western strategy to decrease the population size and thus prevent recovery from the casualties of war. The existence of gender-based violence is often denied, and steps taken to address it may clash with gender norms. HIV/AIDS programs require condoms, which are controversial

[4] This survey was originally two different processes — a Multiple Index Cluster Survey (MICS) survey (originally planned for the South only) and a Pan-Arab Project for Family Health (PAPFAM) survey (originally to cover reproductive health in the north) — but the projects were combined after the peace agreement.

because of their commonly held association with promiscuity and sexual activity outside of marriage. Perhaps least controversial is safe motherhood, yet there is still some disagreement over the most appropriate strategies, in particular the role of traditional birth attendants (TBAs) in comprehensive reproductive health systems. While policymakers and health providers repeatedly stated that there is no evidence that TBA interventions reduce maternal mortality, other providers maintained that there is a role for TBAs to play in the context of limited qualified health personnel. One provider told us, *"The TBAs are our eyes outside."*

4.4 Turnover or rotation rate of staff at NGOs, international organizations (IOs), and government agencies is high, and some staff lack technical expertise. The difficulties of working in Sudan mean that most international humanitarian and development workers stay for only 1 or at most 2 years. In some locations, such as Juba, many international staff may stay only four to six months, due to very basic living conditions. Those with the most experience are drawn to less challenging locations. Qualified national staff are often drawn from government ministries and health facilities to work for international agencies. This constant turnover limits institutional memory and poses serious coordination challenges. One INGO provider said, *"Resources and time are spent training people who may or may not be right for the job, and who may or may not stay on in the position."*

4.5 Coordination meetings are useful for exchanging operational plans and progress, but not for devising a common country strategy. Agency representatives generally come to these meetings with their plans already set, making it impossible to devise truly collaborative strategies. Both the UN agencies and government appear to think that the other should be taking more of a lead in forming this common strategy. With so many IOs and NGOs present in the country, there seems to be a common misperception amongst many Sudanese that service provision is the job of NGOs and UN agencies rather than of government.

4.6 In spite of some strong initiatives to provide training to health personnel, there is limited systematic supervision or monitoring. The impact of provider training on expansion of services and quality improvement is thus difficult to measure.

4.7 Sudan has an abundance of studies that describe the broad gaps in services, but too few implementation plans. Some actors suggested that detailed plans and costing of reproductive health programs, developed in collaboration with the GNU and GoSS, would create a more realistic path forward for government and other actors.

4.8 Although UNFPA, UNICEF and INGOs are collaborating with the MoH and LNGOs to develop policy and facilitate service delivery, infrastructure development seems to be divorced from the health sector. The Multi Donor Trust Fund, administered by the World Bank, has been established as a common pool of funds for implementing agencies. Nevertheless, the role of the World Bank in health sector planning was unclear during our field visit. The World Bank has the capacity to contribute to functioning logistics systems and infrastructure that are prerequisites for an

effective health system; there is room for more joint planning by the different agencies.

A - Reproductive Health in Northern Sudan

4.9 The health system in Sudan is overly centralized and heavily skewed towards tertiary care. Financial and human resources have been disproportionately invested towards referral level care. In the North, only 40% of primary health care units have qualified staff.[5]

4.10 The Federal Ministry of Health has been slow to implement its own policies. UN agencies and INGOs are developing policies in consultation with the MoH, but once developed these policies do not always find a champion in other units of the MoH and in other ministries.

4.11 Return strategies may leave poorer IDPs without services. At least a third of the 6 million people in Khartoum state are IDPs displaced by drought, famine, and conflict. Donors and INGOs do not wish to interfere with the return of IDPs from the South, and are therefore wary of providing services in the North that would dissuade IDPs from returning to the South. With little or no assistance available for the return process, however, many of the IDPs left behind tend to be poorer. Unable to afford the return, and lacking in basic services, they are in a particularly precarious position. Other IDPs may not be inclined to return. Many IDPs were born in the camps and have been able to access education and livelihood opportunities in Khartoum that may not be available to them in the regions of their parents' origin. Furthermore, IDPs from Darfur are unable to return due to ongoing conflict.

4.12 Ahfad University for Women is a valuable partner for UNFPA and can help advocate in a more locally relevant way, provided that its efforts are not stretched too thin. UNFPA already has several programs with Ahfad. The University has a vital role to play in pulling together evidence of particular reproductive health needs and in marshalling evidence that is Sudanese in origin. These efforts include conducting research in Sudan and providing data related to religious and cultural beliefs which impact reproductive health. This is an evidence base that can be more relevant to the GNU than some studies conducted by international actors, even if the respected institution cannot make some of the difficult arguments that international agencies like MSF have made.

4.13 Although health centers in Khartoum offer varying degrees of reproductive health services, a comprehensive package has not yet been integrated into primary health care. Basic levels of antenatal care and limited family planning services (pills, injectables, and condoms) seem to be offered at most health clinics, although PMTCT and other services are not part of the standard package. Even the small health facilities

[5]United Nations. Joint Assessment Mission, *Northern Sudan Health Sector Draft Working Paper*, 2004.

that offer maternal and child health (MCH) and family planning services often address these areas separately, with distinct facilities for each service area. Because these facilities are often understaffed, clients have to make frequent trips to receive required services, often resulting in lost time and additional fees, if centers charge for consultations.

B - Reproductive Health in Southern Sudan

4.15 Public infrastructure in the South is severely lacking. As noted in one report, "the historical neglect of development activities in the south of the country, coupled with the diversion of public resources to support the pursuit of war and the deliberate destruction of infrastructure as a tactic of war have left public services in Southern Sudan in a shambles."[6]

In Southern Sudan, it is estimated that only 25% of the population have access to health facilities.[7] The health system is limited to 19 hospitals, 103 Primary Health Care Centers (PHCC), and 554 Primary Health Care Units (PHCU).[8] None of these hospitals are thought to operate at a tertiary level. The great majority of these facilities are supported by INGOs with a single NGO generally taking responsibility for a particular geographic area and supporting a number of PHCC and PHCU facilities including regional health training centers and in some cases mobile health units. For example, the International Rescue Committee, one of the few agencies providing EmOC (at three facilities), operates 41 PHCC and PHCUs.

4.16 The GoSS is an active partner in efforts to expand reproductive health services but lacks capacity and continuity. Health services in Southern Sudan are still primarily delivered by UN agencies, non-governmental organizations (NGOs) and faith-based organizations with limited coordination and oversight. Few common policies and guidelines for care exist. The regions of Upper Nile and Bahr el Ghazal in particular have very low ratios of health facilities to population.[9]

4.17 Operational costs have been very high in part due to the vastness of the region and inefficiencies in the system. Transportation of personnel, patients, equipment, and supplies by plane is often necessary due to the absence or insecurity of roads. Basic communications systems also inhibit sharing of information and referral systems.

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[6] Purdin, S. A Reproductive Health Strategy for Southern Sudan. Background Paper for the David and Lucile Packard Foundation. 2005.
[7] GNU/GoSS. Framework for Sustained Peace, Development and Poverty Eradication: Progress Monitoring Note. February 2006.
[8] African Medical and Research Foundation (AMREF). Proposal for Development of Curriculum for Training Community Midwives in South Sudan. October 2005.
[9] United Nations. *Joint Assessment Mission, Southern Sudan. Health Sector Working Paper*. October 2004.

C - Reproductive Health in Eastern Sudan

4.18 Eastern Sudan is also a challenging environment in which to implement reproductive health programs. [10] Kassala state has a history of insecurity and disaster, accommodating waves of refugees and IDPs and faced with periodic severe flooding to the area. The large number of displaced persons has increased the population of Kassala state to 1.2 million. Military presence in the National Democratic Alliance (NDA) controlled territories, historical grievances, feelings of exclusion and marginalization, demands for fair power sharing, inequitable distribution of economic resources and benefits compounded by underdevelopment and the lack of a genuine democratic process have all contributed to the insecurity in the East.[11] While the CPA signed in 2005 addresses SPLM's presence in Eastern Sudan and stipulates the withdrawal of its military forces by January 2006, the lack of a mechanism for transferring authority of the opposition controlled areas as well as the delay in the withdrawal of the SPLM forces has led to heightened insecurity especially in NDA controlled towns such as Hamish Koreib.[12]

4.19 While there are hospitals with adequate facilities in major towns, **65% of the population resides in rural areas**, including villages, refugee camps, IDP camps and settlements that are a significant distance from urban areas. Populations are widely dispersed, and clinics are not readily accessible to much of the rural populace.

4.20 Refugees have been in Kassala state for 20-40 years. 99% of the refugees are Eritrean (as of 2002, Ethiopians are no longer considered to be refugees). There are approximately 10-12 IDP camps and settlements, and approximately 60-75,000 IDPs in Kassala. There is little cultural distinction between the IDPs and the local population. The main IDP and local tribes served by clinics in Kassala are the Beni-Amer, Hadendowa, and Howsa. [13] There are 12 refugee camps of varying sizes, hosting 110,000 refugees and managed by UNHCR in Showak, and an additional 10-15,000 who live in urban areas and are fully integrated.

4.21 There are limited reproductive health programs in Eastern Sudan, and few reproductive health education initiatives. The two main actors in reproductive health in the East are GOAL and the Sudanese Red Crescent (SRC). Some NGOs are actively conducting daily health education outreach, but these efforts reach very few people. This work is especially critical in the East, as Kassala and Port Sudan are both positioned on

[10] Eastern Sudan is generally considered to consist of the three states of Kassala, Red Sea and Gedaref.
[11] In the mid 1990s, the Beja Congress (one of the oldest political parties in Sudan) joined the National Democratic Alliance (NDA), a coalition of northern opposition parties also consisting of the SPLM/A.
[12] For further information: International Crisis Group. Sudan: Saving Peace in the East. January 2006.
[13] The majority of the population in the region is Beja. The Beja are a confederation of tribes whose three main groups are the Bishariyyn, the Amar'ar and the Hadendowa. Another group, the Beni Amer are considered by many to be Beja although they speak another language. The region is also inhabited by another pastoral group, the Rashaida who are found mostly in the Kassala area.

major highways, and large transport hubs are historically associated with a higher risk of HIV/AIDS.[14]

5. Safe Motherhood

5.1 The Maternal Mortality Ratio (MMR) ranges from high in the North (509/100,000 live births) to extremely high in the South (1,700/100,000). The latter figure translates into 1 in 9 women dying in pregnancy or childbirth. Current evidence suggests that three interventions are necessary for reducing maternal mortality: skilled attendance at birth, family planning, and Emergency Obstetric Care (EmOC), all of which are in short supply in Sudan as a whole.

5.2 There are three common delays that limit access to emergency obstetric care (EmOC): 1) the delay in deciding to seek care, 2) the delay in identifying and reaching a health facility, and 3) the delay in receiving appropriate care at health facilities; **These three delays are widespread across Sudan.** The first delay is likely to occur for reasons such as the lack of knowledge among women, their family, and those attending their births in how to identify danger signs; or the need for permission from husbands to seek medical care. The second delay reflects the geographic vastness of Sudan: the dearth of peripheral health facilities and proximity to such services pose major challenges for rural women. Transportation is often not available for poor families—even in the Khartoum area—due to the lack of money or means of transport. The third delay is often a result of the lack of equipment, resources, and trained medical personnel, as there is a shortage of doctors, trained midwives, and nurses in public health facilities. In the South for example, there is estimated to be only one doctor per 100,000 people and one primary health care center for every 79,500.[15] Few facilities outside of Khartoum are equipped to provide either basic or comprehensive EmOC. A 2002 situational analysis of 175 health facilities in the North found that basic delivery services are available in 87% and only 33% of the surveyed hospitals and health centers, respectively.[16]

5.3 Both service providers and policy-oriented organizations voiced concern over how to address the issue of TBA training. Some service providers noted that young TBAs could be trained to become village or community midwives where midwives were non-existent. In the East, however, there are well-trained TBAs, many of whom are older and illiterate, and thus would not qualify for MoH midwife training. NGOs currently support many of these TBAs by restocking their delivery kits but, based on current guidelines, after handover of services to the MoH, this support to TBAs will cease. There is some concern amongst NGOs that this will result in a severe decrease in able birth attendants.

[14] Ockenden International. Combating HIV/AIDS in Eastern Sudan: The Case for Preventative Action. February 2005.
[15] See: UNFPA/CU Initiative. "Preliminary Desk Review Findings," 6.
[16] National Reproductive Health Directorate, *Summary Plan of Action 2004-2005*, Khartoum: Federal Ministry of Health, 2004.

5.4 UNFPA's clean delivery kits and other reproductive health kits are very popular among service providers, especially INGOs. Some organizations noted that supplies are not constant, and others mentioned that they would appreciate a more clearly defined procurement process (with appropriate distribution and monitoring mechanisms).

A - Safe Motherhood in Northern Sudan

5.5 Availability of pregnancy-related services varies significantly by agency and facility. Although hospitals are better equipped and staffed to provide comprehensive services, smaller health centers and clinics that offer maternal-child health services (both local and INGO-operated) only offer antenatal and/or postnatal care, not EmOC or testing services. Doctors, obstetricians, nurses, and midwives are either absent or are only present on certain days of the week in these facilities, and antenatal care services (including supplementation for vitamin A) are not uniformly provided, but provision is determined by facility capacity. Fees for consultations, medicines, and lab tests are charged by some small clinics, including those servicing IDPs (if they indeed have testing capacity or can refer samples to other labs). Better-funded clinics generally offer various services for free, including antenatal care, routine check-ups for infants, and immunizations for children.

5.6 Female Genital Mutilation (FGM)/Female Genital Cutting (FGC) was identified by young women to be a leading cause of obstetric complications. As FGM/FGC incisions heal, they form scars that can act as a physical barrier during childbirth, thus increasing the risk of obstructed labor. Defibulation (the cutting of this scar tissue) can reduce this risk, but is available at few sites.

5.7 Lack of supervision of new village midwives and formerly trained village midwives is a barrier to ensuring quality of care. Only those midwives working in Khartoum State are currently thought to be supervised by the MoH; the rest are not monitored, despite the Khartoum North Midwifery School and other schools graduating assistant health visitors (who act as federally sponsored midwifery supervisors) annually. Refresher trainings for practicing midwives have also not been provided by the MoH, due to financial constraints (UNFPA is currently looking into supporting such initiatives via MoH). This lack of supervision allows dangerous practices to persist. While the Khartoum North Midwifery School, for example, instructs against the practice of FGM, the Sudanese National Council on Harmful Traditional Practices (SNCTP) identified re-circumcision as a significant source of income for midwives, and FGM practices continue to be widespread, especially in rural areas.

5.8 The new national policy on village midwifery training is expected to enhance quality of care and reduce turnover at the rural level, but foreseeable problems still need to be addressed. The enhanced 18-month midwifery training curriculum, plus the FMoH requirements that the midwives are elected from her community and will return to her community upon completion of the program, are key developments to realizing the

"one midwife for every village" goal. However, the new literacy requirement poses problems for potential applicants to all 38 federally-sponsored midwifery schools, as illiteracy has been acknowledged by key stakeholders as an existing barrier to training. Moreover, village midwives are not currently paid by the under-funded MoH, a factor that leads to low morale and a lack of quality control. The MoH, UNFPA, and other key stakeholders have recognized this problem and are discussing plans to **integrate village midwives into the salaried health system**, so that those trained will have incentives (other than the mandatory regulations of the new national policy) to remain in rural areas. Mechanisms of supervision, monitoring and evaluation, and replenishments of distributed midwifery kits (i.e., logistics) will also need to be addressed, as follow-up to training will be a key determinant of the success and effectiveness of the new policy. One agency staff member stressed the importance of community involvement in the selection of community midwives. **"***The challenge is definitely present and recognized. If there is no financial support from the community or if the midwife is unmarried and later marries into another community, then she might not go back to her community… The selection should not be made by the DG but should be made by the community at the grass roots level as they are the best judges."*

5.9 Demand for fistula repair surgery is expected to be better met in Khartoum. This is based on the expansion of Dr. Abbo's Centre for Fistula and Urogynaecology, one of the two[17] centers offering fistula repair services in all of Sudan. Three new operating tables (previously only one) and 16 extra beds are expected to improve the current situation. Until now, there was only one operation per day and a six month waiting list.[18] In addition, the centre plans to train 18 junior and specialized doctors a year in fistula repair, and aims to establish itself as a major training ground for fistula repair surgery worldwide.

B - Safe Motherhood in Southern Sudan

5.10 Very few health facilities offer basic or comprehensive emergency obstetric care. One service provider estimated that only five referral facilities exist in all of Southern Sudan and even these may not be fully functional. The lack of trained physicians (1 per 100,000 population) and other health personnel, the paucity of primary health care centers, logistical challenges, and the absence of transportation infrastructure are factors that limit access to emergency obstetric care and contribute to the extremely high rate of maternal mortality (1700/100,000 live births) in Southern Sudan. A lack of ambulances and communications systems inhibits the ability of women to reach existing EmOC facilities. Even Juba Hospital, one of the few referral facilities has just one ambulance and it is reported to be in poor condition.

[17] Plans to equip Juba with facilities to perform fistula repair are underway; with that addition, there will be three centers in total.

[18] 86% of the cases seen at the Abbo Centre are due to obstructed labor; only one known case of traumatic fistula has been treated in the past.

5.11 Community midwife training (CMT) has been identified as the key strategy for expanding coverage of skilled attendance at birth in order to reduce maternal mortality. The estimated proportion of pregnant women in the population who will develop an obstetric complication serious enough to require medical care is 15%,[19] and it is not possible to predict ahead of time which women will be in this 15%, yet only 5% of births in Southern Sudan are attended by skilled care. A collaborative effort to train 5000 community midwives in at least three health training institutes is underway.[20] Despite strong collaboration on this initiative from the government, UNFPA, AMREF and service providers, it will take time to build capacity to provide skilled care.

5.12 High illiteracy rates, especially among women (above 80%), reduce the number of candidates for community midwife and other health personnel training programs. One staff member of an NGO noted that at the last training course offered by the NGO, just 18 of 135 attendees were female. "Induction" training of 3 to 6 months, to be offered as part of the CMT program, will facilitate the participation of women who may need to strengthen their basic reading, math, and science skills. Nevertheless, many traditional birth attendants will remain ineligible if they have not attended a minimum of five years of schooling. In addition, most health training programs are offered in English, another barrier for many women. Only Hakima Training Centre in Nuba Mountains uses Arabic as the language of instruction.

5.13 Some agencies view training and supplying traditional birth attendants as an important intervention given the current lack of trained midwifes. TBAs are seen as a vital link between communities and health facilities. Training of TBAs has long been a popular intervention in Southern Sudan in a context where the population is dispersed and few facilities are fully operational or accessible. There does not appear to be a coordinated plan for phasing out TBAs or incorporating them into the health system as community health workers or as another cadre of health worker. UNICEF, IRC, ARC, and World Relief are just some of the organizations that conduct TBA training.

5.14 The Government of Southern Sudan's Ministry of Health appears to be strongly committed to reducing maternal mortality but their current operational capacity is very low. Maternal health services are mentioned as a top priority within the package of basic health services defined by the SPLM Secretariat of Health, which has now been transformed into the GoSS Ministry of Health.[21] There is a strong emphasis on upgrading and training of staff as the primary means of improving available services. The GoSS Ministry of Health has been working collaboratively with UNFPA and other partners to set guidelines and priorities for health personnel training. A great deal of attention has been focused on building the capacity of the new Ministry, but it was noted that staff turnover is high, limiting the effectiveness of these efforts. Some county level

[19] UNICEF/WHO/UNFPA. Guidelines for Monitoring the Availability and Use of Obstetric services. UNICEF. New York: NY, 1997.

[20] AMREF's Maridi Health Training center in Equatoria will serve as one of these training sites. Save the Children-US has also started a training facility in the Nuba Mountains, which will be supported by AMREF.

[21] SPLM Health Secretariat. Laying the Grounds for the Recovery of the Health Sector in a Post-Conflict Southern Sudan. March 2004.

health departments do function and collect facility data but their capacity for supervision and monitoring is considered to be quite low.

5.15 There is poor antenatal and postnatal care, resulting in limited opportunities for reproductive health and safe motherhood education. ANC coverage is estimated at 16%, including care provided by TBAs, but this figure varies widely by region.[22] Although a number of clinics and hospitals do offer antenatal care services, testing for syphilis is not routine. Some PHCCs that do provide ANC may lack reagents for syphilis and hemoglobin testing.[23] Many health care facilities, especially in underserved areas, provide only basic services such as treatment for malaria and diarrhea.

5.16 Service providers expressed a need for assistance with reproductive health kits, supplies and equipment. UNFPA currently has memorandums of understanding with 6 agencies to supply reproductive health kits, but a workable distribution and monitoring system has yet to be realized. Some confusion about the process of procurement seems to exist. The logistical challenges of supplying to locations in Southern Sudan demand constant attention and the expense can be substantial. Supply lines for most NGO operations in Southern Sudan involve transport through Nairobi or Kampala, rather than Khartoum, yet UNFPA supplies arrive via Khartoum.

5.17 The projected returnees will demand rapid expansion of facilities and trained personnel. Upgrading and scaling up of health facilities will be essential for reducing maternal mortality but may receive less attention due to some agency policies prohibiting support for construction and renovation. Service providers suggested that improved monitoring and supervision is necessary to ensure the effectiveness and sustainability of health training activities.

5.18 The high prevalence of early marriage and pregnancy in Southern Sudan is a key concern for reducing maternal mortality and morbidity. Young women, especially those under 15 years of age, are especially at risk for pregnancy complications.[24] One of the conditions commonly associated with early pregnancy is fistula. Until now there has been no facility in Southern Sudan capable of repairing fistula, although the ICRC was transporting women to Lokichokio in Northern Kenya for fistula repair. UNFPA is now in the process of equipping and training staff at Juba Hospital to perform fistula repair.

5.19 Resistance to family planning is another constraint to implementation of effective and integrated Safe Motherhood programs. Promotion of family planning for birth spacing is discussed in the family planning section of this report; however, it is important to note here that the extraordinarily low contraceptive prevalence rate (<1%)

[22] ANC coverage is thought to be much higher in Western Equatoria but extremely low in Bahr al Ghazal and Upper Nile. Coverage trends for tetanus vaccination are similar. See: New Sudan Centre for Statistics and Evaluation/ UNICEF. Towards a Baseline. Best Estimates of Social Indicators for Southern Sudan. May 2004.

[23] Nyabega, Maryline. Safe Motherhood Training at Awada Training Centre. January-February 2006.

[24] WHO/UNFPA/UNHCR. Reproductive Health in Refugee Situations: An inter-agency field manual. Geneva: UNHCR, 1999.

inhibits birth spacing, a key element in the prevention of maternal mortality and morbidity. Most providers emphasized that birth spacing and disease prevention may be the best promotion strategies for contraception.

5.20 Given the many competing priorities, post-abortion care appears to have received little attention, although it is included in the competencies defined for the community midwife. Despite non-acceptance of abortion, our focus groups indicated that women are terminating pregnancies, but the safety and efficacy of existing informal services are highly questionable. It was suggested that local women might go to local practitioners for abortion with use of herbs and that some might even go to a clinic to seek help for an unwanted pregnancy.

5.21 Both money and the limited decision making power of women in the household may delay access to care, even in an emergency. Wider efforts will be needed to address these challenges. Programs that provide livelihoods opportunities to women, for example, may empower them both to earn money and to play a stronger role in household-level decision-making.

C - Safe Motherhood in Eastern Sudan

5.22 The rate of maternal mortality is higher in Eastern than in Northern Sudan. In 2005, maternal mortality ratios peaked at 644 and 561 per 100,000 live births in Gedaref and Kassala States, respectively.[25] Contributing factors include malaria,[26] distance, poorly equipped health facilities, and few skilled birth attendants.

5.23 Many face difficulties in accessing local clinics and hospitals due to the remoteness of some villages and lack of available transportation. NGOs have very limited numbers of vehicles for emergency transport to health facilities. GOAL has vehicles to drive women to the hospital on an emergency basis, and the Sudanese Red Crescent (SRC) only has one vehicle for all of the IDP camps. As a result, according to one NGO, home births conducted by either TBAs or midwives are the norm in the IDP camps, and referring women with complications is difficult from the refugee camps. The ease of access depends on the season and the availability of emergency transport.

5.24 Existing delivery facilities at the PHC Level are limited. This is particularly the case in the refugee camp health care facilities. According to one agency in Showak, the current refugee camp facilities are "obsolete" and lack delivery beds.

[25] United Nations and Partners, 2006 *Workplan for Sudan*, p. 93.

[26] As a recent study at the New Haifa Teaching Hospital in Kassala State revealed, there is a high prevalence (13.7%) of *P. falciparum* malaria amongst pregnant women, who are more susceptible to the disease: Adam, Isag et al. "Prevalence and Risk Factors for Plasmodium falciparum Malaria in Pregnant Women of Eastern Sudan"; *Malaria Journal* 2005, 4:18.

5.25 There are few trained midwives and it is difficult to train TBAs to become midwives. A new MoH directive requires the hiring of community midwives in lieu of TBAs. According to NGO representatives in Kassala, most of the TBAs currently in the area are in their fifties, unable to read and write, and are unable to be trained as midwives in accordance with the MoH policy. One Showak agency also noted a lack of midwives working in the refugee camps.

5.26 There is a notable shortage of medical doctors at health facilities. Clinics and some hospitals are staffed only by medical assistants. This is of concern particularly when there are complications in pregnancy that require immediate surgery, as the nearest hospital may be over an hour away. There is a large hospital in Hamish Koreib, but no consistent presence of doctors due to insecurity in the region.

5.27 Some women from more conservative tribal cultures refuse treatment by a male doctor. This attitude is slowly changing, particularly in the areas more immediately surrounding Kassala town, but it is a pervasive attitude in the rural areas.

5.28 Some NGO clinics are functioning well, and are preparing to be taken over by the MoH. GOAL and SRC run clinics that currently function well, according to representatives from these agencies. These NGOs are currently charging nominal fees and modeling their operations on MoH standards to prepare clients for the transfer of clinic operations to the MoH. It is the opinion of these NGOs that this transition to MoH takeover will happen smoothly, as a result of this preparation, although staffing and payment of staff may be a concern. Only two of the SRC clinics in the refugee and IDP communities will be transferred to the MoH; the others will continue to be managed by SRC.

5.29 Security conditions continue to affect service delivery in some regions. Certain areas that border Ethiopia and Eritrea, particularly the northern zone surrounding Hamish Koreib, are very unstable and pose a major security risk for all who are working in the region. It remains a challenge to ensure that trained midwives and other health care workers will continue to be able to work in such areas of insecurity, which are also marked by limited resources due to low NGO presence.

6. Gender-Based Violence

6.1 There are few data on gender-based violence in Sudan. Male-biased gender roles, an unsupportive legal environment, persecution of victims, and a lack of sensitivity to the idea of GBV all contribute to a culture of silence around GBV in Sudan. Without documentation of cases, denial continues to be a problem among some politicians.

A - Gender-based violence in Northern Sudan

6.2 Although FGM/FGC prevalence has remained at over 90% in the North, civil society has continued to advocate for FGM abolition for three decades, with some success. Recent developments have included expanded research on the implications of FGM/FGC and advocacy against the practice by local NGOs such as the Sudanese National Committee on Harmful Traditional Practices (SNCTP); and the formation of umbrella networks including the Sudanese Network for the Abolition of Female Genital Mutilation (SUNAF), which was established in 2002 to create a unified front against government counterattacks on the abolition of FGM/FGC. However, competition and sensitivities impede collaboration between the network organizations and larger NGOs. Strategies to abolish FGM/FGC also vary by organization, from low-profile community outreach to international media campaigns and publicized marches, and such differences in approach also seem to contribute to the existing frictions between certain groups. Despite these challenges, all interviewed organizations noted that they would enjoy strengthened partnerships with UNFPA in terms of monetary support for advocacy campaigns and the creation of a data center on FGM/FGC, technical training on networking and coordination processes, or knowledge/experience sharing on effective strategies to prevent FGM at the grassroots level.

6.3 GBV interventions by the UN and INGOs mostly address rape or FGM/FGC; little attention is paid to domestic violence. Most international agencies addressing GBV implement projects in the North as an extension of their Darfur programming. There is less focus on non-sexual forms of violence, which are often regarded as non-emergency issues.

6.4 Local GBV initiatives are focused on research, raising awareness and capacity building, with less emphasis on service provision. While more and more local organizations are addressing issues such as domestic violence, the dearth of counseling and psychosocial services was raised as a concern by organizations interviewed and young women. In the context of rape, it is unclear whether survivors would indeed seek such services, however, given the sensitivity of the issue: Young women in focus groups noted that, if raped, they would not inform anybody, or at most their close friends and perhaps their mother.

B - Gender-based violence in Southern Sudan

6.6 Very little data exists on gender-based violence in Southern Sudan. The limited information that is available indicates that GBV is often linked to the socio-cultural practices of the ethnic groups that reside in the region.[27] Domestic violence, early/forced marriage, wife inheritance, lack of property rights, exclusion from education and FGM/FGC have all been documented.[28] [29]. In interviews with international agencies, we

[27] UNFPA, *Sudan Country Office 2005 Annual Report*, January 2006, p 3
[28] USAID, *Report of a Preliminary Assessment of Gender Based Violence in Rumbek, Aweils (East and West) and Rashad County, Nuba Mountains,* March 2005, p. 3.
[29] IRC, *Freedom from Fear*, April 2004, p. 38.

were informed that survivors of sexual assault who seek assistance from the local police stations might be required to provide evidence of rape. Failure to provide such evidence may result in detention. Sometimes survivors may even be accused of having had extra-marital relations with the rapist, leading to rejection by the family or community. Profound stigmatization of rape survivors appears to prevent many survivors from reporting sexual violence to police and receiving appropriate treatment. Sudan's protracted civil war has exacerbated gender-based violence, including rape, sexual coercion and abduction of Southern Sudanese women.[30]

6.7 Domestic violence is seen by many in Southern Sudan as a normal way to discipline a wife. This problem remains prevalent and largely unchallenged within the community.[31] Tolerance of domestic violence is likely related to dowry (bride price) customs, which in Southern Sudan generally entail that a woman's family returns the dowry to the husband in the event of a divorce. This practice may serve as a strong disincentive for women to leave abusive marriages. As mentioned in the section on family planning, the issue of domestic violence came up repeatedly in focus groups in conjunction with condom negotiation. Women feared that asking their husbands to use a condom would result in a beating. Women also claimed that their husbands might beat them if their daughters were impregnated before marriage. As one woman described, *"Some [husbands] beat the wife for not looking after the daughter properly. The father would beat the mother."*

6.8 FGM/FGC is significantly less prevalent in Southern Sudan when compared with other areas of the country. None of the service providers with whom we spoke identified FGM/FGC as a priority issue as it is considered a practice that is very limited in Southern Sudan. However, a study by Norwegian Church Aid on the prevalence of FGM/FGC in the Nuba Mountains, South Kordofan state, a transitional area, found a prevalence rate of over 74%.[32] There is also some concern that IDPs in the North will bring these practices to the south when they return to their states of origin.

6.9 War-related rape has reportedly been committed by all armed groups including SPLA and GoS troops. Soldiers and militia often have taken advantage of the culture of silence surrounding rape and the lack of mechanisms for handling rape allegations.[33] Performing traditional tasks such as gathering firewood and water and cultivating crops has put women at greater risk of both rape and kidnapping.[34] [35] **Throughout the conflict, women and girls have been vulnerable to abduction by armed forces, including the**

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[30] UNFPA(2006). Population, Reproductive Health, HIV/AIDS and Gender: A Situational Analysis of South Sudan."

[31] AMREF, *Rapid Needs Assessment for Midwifery and Reproductive Health Training in South Sudan*, 2005, p. 11.

[32] USAID, *Gender Assessment*, March 2003, p. 15.

[33] WomenWarPeace.org. *Gender Profile of the Conflict in South Sudan*, http://www.womenwarpeace.org/sudan/docs/sudan_pfv.pdf

[34] Report of the Representative of the Secretary-General on internally displaced persons, Mr. Francis Deng January 2003.http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/6b07acea57ed27f0c1256cda0045861b/$FILE/G0310215.pdf

[35] USAID, *Gender Assessment*, 2003, p. 7.

Lord's Resistance Army (LRA), which continues to enter Southern Sudanese territory from Northern Uganda.[36] Many women have been separated from their families and communities after being abducted to distant regions of the country. Although women in our focus groups identified rape as an ongoing concern for women, the young men in our focus groups felt that rape was no longer a major problem since the end of the war. One woman said, *"There are some people with guns or weapons in the bush who may force you to have sex. It is happening in the bush there when they go to collect firewood. Mostly it is happening with soldiers."*

6.10 Among female returnees, increased prostitution and exploitation have been noted due to a lack of resources upon return, reduced access to property, and limited community support. Women returnees are thought to be at risk of community reprisals for their perceived modernity and disrespect of traditions.[37] Increasing numbers of women-headed households exist in the south, in the refugee camps, and amongst IDPs, and their needs must be considered in planning for social services.

In Juba, all of the focus groups reported that girls and women have sex in exchange for food, money or protection. As one woman remarked, *"Mostly this is happening right now because of peace. Since the roads are open, people come from different places and girls have sex for money with traders and others."* Another woman explained, *"some girls are orphans and do not have parents. They have sex to get money for food and for clothing. These girls will go with any person who is having a lot of money. They go to the rich ones."*

Prostitution and sexual exploitation may be particularly prevalent in former garrison towns, and in proximity to SPLA barracks, with single mothers and widows being especially vulnerable. [38] Soldiers, with regular access to salaries and who are stationed apart from their wives and families, wield significant power in the context of very high unemployment and particularly limited income generating opportunities for women. Such marked income disparities may fuel transactional sexual encounters and relationships, often characterized by women's limited power to negotiate safer sex.

6.11 Most women associated with armed groups by marriage are thought to be at increased risk of domestic and sexual violence. Additionally, an audit carried out by UNICEF and the SPLA in 2004 estimated that there were 3178 women associated with the SPLA, 1824 female combatants, and 545 women veterans. These figures are believed to underestimate the actual numbers by at least 20%.[39] Although referred to as marriages, these relationships generally did not involve the payment of a dowry, and in many cases were against the wishes of one of the two families. Accordingly, current DDR planning

[36] Report of the Representative of the Secretary-General on internally displaced persons, Mr. Francis Deng, January 2003. http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/6b07acea57ed27f0c1256cda0045861b /$FILE/G0310215.pdf
[37] USAID, *Gender Assessment*, March 2003, p. 19.
[38] USAID, *Gender Assessment*, March 2005, p. 18.
[39] Assessment of Women Associated with the SPLA and Female Combatants in the SPLA, October 2005.

efforts aim to consider the special needs and concerns facing women associated with armed forces.

6.12 Our research and a 2005 USAID study found little programming that specifically targets GBV in Southern Sudan. The USAID study identified advocacy work undertaken by the Women in Law Project in Rumbek as the only gender-specific activity underway at the time of the study.[40] Past activities have included information, [41] protection,[42] and legal[43] programs.

6.13 There are a few important emerging initiatives targeting GBV. March 2006 saw the formation of the Inter-Agency Working Group on Sexual and Gender Based Violence. This group is based in Juba and includes representatives from UNFPA, UNIFEM, UNMIS, UNHCR, UNDP, and OCHA.[44] Although this group is in its infancy, it has the potential to make some important headway on issues of SGBV if it receives adequate financial and institutional support.

Awareness-raising of GBV among armed forces and police has been identified as a key strategy to reduce GBV. UNMIS Police in Juba intend to train all 10,000 local police personnel in the coming months on issues of domestic violence, gender-based violence, HIV/AIDS, child protection, human rights and rule of law. They have submitted a project proposal to UNFPA, which is currently under review. A variety of other GBV activities have been planned for 2006. Proposed activities include:

- **UNDP**: National training of trainers on GBV policing;
- **UNICEF**: Life skills based education to ensure that school aged girls, OVCs, boys, and young people both in and outside school have the life skills to prevent HIV and GBV in the 10 states of Southern Sudan;
- **ADEO**: "Primary Health Care Provision to Host Communities and Returnees in Yambio County," which consists of building the capacity of ten community-based organizations (CBOs) in the prevention and mitigation of HIV and GBV;
- **UNFPA**: "Integrated reproductive health services and information for Southern Sudan," which advocates for RH services by convincing policy makers on certain sensitive topics such as Family Planning and GBV and uses community and religious leaders to increase accessibility to services;

[40] USAID, March 2005, p. 43.
[41] Sudan Women's Voice for Peace conducted informational campaigns on early marriage in the Upper Nile. USAID, March 2005, p. 20.
[42] The Civilian Protection Monitoring Team (CPMT) in Rumbek investigated and reported alleged incidents of attacks against civilians, an estimated 30% of which involved sexual violence against women by GoS soldiers.
[43] The New Sudanese Women's Foundation hired and trained 60 paralegal aid officers and opened legal aid clinics in nine counties addressing complaints regarding GBV, especially domestic violence. USAID, March 2005, p. 20.
[44] The objectives are to enable participating UN and related agencies to coordinate their support to ending SGBV in Southern Sudan through (1) the exchange of information on ongoing and planned activities, (2) coordination and complementing activities, (3) formulating and implementing collaborative activities, (4) advocacy, and (5) building capacity.

- **UNHCR**: Establishment of Community Based Protection Networks in main areas of return, whereby UNHCR organizes six one-week-long workshops for local authorities, community representatives, NGOs and UN agencies on protection principles, human rights, women's rights and GBV, children's rights, IDP, refugee and returnee principles, HIV/AIDS awareness and protection incident reporting guidelines.

C - Gender-based violence in Eastern Sudan

6.14 Female Genital Mutilation/ Female Genital Cutting is almost universal in Eastern Sudan, affecting girls as young as 4 or 5 years of age. It is likely that 98% of girls in the refugee camps have undergone FGM/FGC, according to an agency in Showak. Other NGO staff members stated that the prevalence of FGM/FGC is 95% or higher among the local and IDP populations. An NGO staff member noted that it was "very rare to find girls who are not exposed to FGM/FGC." Infibulation, the most severe form of FGM/FGC, is the typical form of FGM/FGC that is carried out on the girls; however recent trends do include a shift away from infibulation, to the "minor" forms of FGM/C termed *sunna*. [45] NGOs have conducted some awareness-raising activities on this issue, but the impact has been limited.

6.15 Stigma and lack of social acceptance have impeded the reporting of rape. Rape is very rarely discussed openly in the community or reported to the authorities. Stigma causes rape to be quickly "hushed up" in the community, leading to impunity for the perpetrators. In 2005, only 8 cases of rape were reported in the refugee camps in Kassala State. No statistics on rape were available for the IDP population in Eastern Sudan. Local women believe that among the Muslim IDPs, the women who are raped might be pressured by her family and the community to marry the rapist as a means of resolving the issue.

6.16 No formal statistics were found on unwanted pregnancies. Only anecdotal evidence was presented on this topic. Local women reported that in the refugee communities, the families often first try to resolve the issue amongst themselves. Options can include marriage or monetary compensation from the father to the mother's family. If the families cannot resolve the issue, the matter is referred to the elders' committee to be discussed between the tribal heads, and then to the camp manager (a member of the Sudanese government Commission on Refugees).

In the local community, unmarried girls who find themselves pregnant might resort to induced abortions to escape the stigma and shame. Traditionally among the Beja community, unwanted pregnancies are punishable by death. Limited services are being provided in Kassala town for girls who want to give up newly born babies for adoption.[46]

[45] Compared to infibulation that can involve removal of part or all of the external genitalia, sunna generally involves removal of the clitoral head with or without all or part of the clitoris.

[46] The MoH Council for Child Welfare runs a center within Kassala hospital where girls can give up their babies for adoption. On an annual basis, 50-60 babies are received by this facility.

6.17 GBV statistics are lacking, which reflects the traditionally secluded life led by Beja women. Beja and Rashaida women are among the most socially marginalized and secluded groups in the country. In many of these communities, women are not allowed access to public places. In some towns such as Hamish Koreib, men and women live in separate quarters. Men can only visit the women's quarters between certain hours of the day and have to leave by 6 pm.

6.18 Medical, psychosocial, and legal GBV services are limited. Psychosocial services are almost non-existent in the region. Local police and legal practitioners do not appear to be trained or equipped to handle cases of GBV, including domestic violence. The Khartoum-based Ahfad University for Women conducted a recent study, in conjunction with a UN Agency, on attitudes of refugees towards GBV, FGM/FGC, HIV/AIDS and general reproductive health. The findings, yet to be finalized, will be used by the NGO to design training programs on psychosocial support.

7. HIV/AIDS and STIs

7.1 HIV surveillance has been limited, with most studies citing a 2002 Situation Analysis conducted amongst various sub-groups in the North. The national prevalence of HIV is now estimated at 2.3% [confidence interval: 0.7-7.2%].[47]

7.2 Although most people have heard of AIDS, there is widespread misinformation about modes of transmission and prevention methods. The presence of many mistaken beliefs indicates large scope for discrimination against and exclusion of people living with HIV/AIDS.[48] [49]

7.3 There is very limited testing for HIV. A total of 21 Voluntary Counseling and Testing (VCT) centers were functioning nationwide in 2005, resulting in 4,134 tests being administered.[50] Only five sites (all teaching hospitals) have programs for Prevention of Mother to Child Transmission (PMTCT).

7.4 Very few are receiving antiretroviral treatment (ART). Ambitious targets for the 3 x 5 initiative (20,000 receiving ART by the end of 2005) have not been met. Between 50,000 (December 2004 estimate) and 80,000 (UNAIDS estimate[51]) people were in need of antiretroviral therapy, but only 400 individuals were receiving treatment in 2005. [52]

[47] WHO/UNAIDS. Epidemiologic Fact Sheets on HIV/AIDS: Sudan. 2004.
[48] Multiple Indicators Cluster Survey, 2000 – World Bank report No 24620-S, cited by Sudan Joint Assessment Mission.
[49] WHO/UNAIDS. AIDS Epidemic Update: December 2005.
[50] Sudan National AIDS Programme and UNFPA. HIV/AIDS Integrated Report, North Sudan, 2004-2005. United Nations General Assembly Special Session on HIV/AIDS Indicators. February 2006.
[51] Sudan National AIDS Programme and UNFPA. HIV/AIDS Integrated Report, North Sudan, 2004-2005. United Nations General Assembly Special Session on HIV/AIDS Indicators. February 2006.
[52] WHO. *HIV/AIDS Treatment Scale-Up Plan for the Republic of Sudan 2005-2009.* August 2005 draft.

A - HIV/AIDS and STIs in Northern Sudan

7.5 There have been promises but little action in HIV programming. The 1987 formation of the Sudanese National AIDS Program (SNAP) brought limited action until a 2002 Situation Analysis and a 2004 study tour to Uganda. SNAP developed a National Strategic Plan 2003-2007. Unrest in the South and Darfur has, however, distracted attention from HIV/AIDS awareness and prevention programs.

7.6 HIV testing is limited in the North. Service providers were familiar with only 2 VCT sites in the greater Khartoum area. They stated that most individuals who get tested for HIV are referred by health service providers based on signs of advanced disease, rather than voluntarily seeking testing. The VCT clinic at Omdurman hospital is funded by the Global Fund for AIDS, TB and Malaria. WHO and partners reported that there are issues with sustainability of VCT clinics throughout Northern Sudan. Stigma is also a significant factor that limits VCT utilization. One NGO member recommended adding VCT services to health care clinics providing ANC to mothers as a measure to reduce stigma.

7.7 STI but not HIV testing is available during antenatal care. Clinics such as the Ahfad University affiliated antenatal clinic have STI but not HIV testing. Most women are not getting tested because of a lack of testing sites, but stigma may also keep the numbers low.[53]

7.8 HIV/AIDS is commonly associated with displaced persons and is not acknowledged by most populations in the North as a serious problem. Denial and stigma remain pervasive throughout the North because the overall level of HIV/AIDS awareness is low. SNAP and UNAIDS conducted a survey on HIV/AIDS in North Sudan (2004-2005) showing that the majority of respondents exhibited multiple stigmatizing and discriminatory feelings towards PLHIV.[54] SNAP has expressed interest in offering mobile VCT services, which could be combined with general health services as a means of reducing stigma.

7.9 There is a lack of policy coordination among service providers. A significant number of UN organizations, INGOs and LNGOs fail to coordinate their HIV/AIDS activities with each other and with SNAP. Since service provision remains unmapped no one understands who is doing what and where. This creates an increased possibility of program duplication and overlap, as well as the risk that some areas and populations could remain underserved. Behavior Change Communication (BCC) is not well mapped or systematic as each agency has its own approach.

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[53]Sudan National AIDS Programme and UNFPA. HIV/AIDS Integrated Report, North Sudan, 2004-2005. United Nations General Assembly Special Session on HIV/AIDS Indicators. February 2006.

[54]Sudan National AIDS Programme and UNFPA. HIV/AIDS Integrated Report, North Sudan, 2004-2005. United Nations General Assembly Special Session on HIV/AIDS Indicators. February 2006.

7.10 It is not clear which agency is taking the lead on HIV efforts. The overlapping mandates of WHO, UNAIDS, UNFPA and others have left a leadership gap for HIV/AIDS activities in Northern Sudan.

7.11 The necessary multi-sectoral approach to combating HIV/AIDS is not being taken. A full response to HIV/AIDS requires involvement of religious, political, socioeconomic and education actors. Behaviors and attitudes are influenced by strongly ingrained cultural beliefs and religious convictions. There has been some attempt to include religious leaders, but these efforts appear to be limited to awareness-raising workshops. One provider explained, "*Addressing abstinence and being faithful – this is easy to do, as religious leaders find it easy to talk about… Promoting condom use by community leaders needs to happen more. It used to be forbidden, but now people are discussing some."*

B - HIV/AIDS and STIs in Southern Sudan

7.12 HIV prevalence rates in the South may be significantly higher than the national prevalence rate. Existing data for Southern Sudan show varied prevalence rates: 0.9% in Rumbek (2003), 7.2% in Yambio, and 2.7% in Yei county (2003).[55]

7.13 Low condom use and high prevalence of multiple partners, discussed by service providers and in focus groups, put this population at high risk for HIV and other STIs. Sudan has a generalized HIV epidemic with surveillance data demonstrating that most infections are acquired through heterosexual transmission.

7.14 WHO reports that there are neither blood bank facilities nor regulations for blood testing in the South.[56] Providers report that most hospital patients bring a relative to donate blood due to concern over transmission via blood transfusion. Still, donations organized by patients are not tested.

7.15 The peace agreement brings with it the risk that increased population mobility from neighboring countries of higher prevalence may increase HIV transmission.[57] The war and resulting isolation of populations is thought to have limited the spread of HIV in Southern Sudan. Peace is expected to bring increased mobility and trans-border trade. This could promote transmission in the absence of adequate prevention measures including behavior change communication (BCC) interventions and access to voluntary counseling and testing (VCT) services.

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[55] WHO. Summary Country Profile for HIV/AIDS Treatment Scale-Up: Sudan. June 2005.
[56] WHO. Summary Country Profile for HIV/AIDS Treatment Scale-Up: Sudan. June 2005.
[57] Sudan: HIV/AIDS swell feared when refugees return – UNFPA at http://www.reliefweb.int/rw/rwb.nsf/AllDocsByUNID/36b1063f60c7402fc1256f3100242459 and With Peace Expected In Sudan, HIV/AIDS Threat Looms at http://medilinkz.org/news/news2.asp?NewsID=4367

7.16 Refugees are likely to have had access to HIV/AIDS awareness campaigns in host countries and levels of knowledge may be much higher among these returnees. Some may return with expertise in peer education and community outreach — skills that could be tapped in order to expand BCC and VCT activities.

7.17 HIV awareness is generally low and stigma high while VCT coverage is limited to a few locations. In Juba there is still only one site for VCT services and no established surveillance system. WHO, ARC, IRC, ZOA Refugee Care are all operating VCT sites in Southern Sudan. In more than one instance, NGO representatives noted the need to increase the number of VCT sites, particularly in more remote areas. This would include training of counselors to be deployed to these new sites. Awareness of HIV/AIDS and prevention measures appears to be low in many parts of South Sudan despite some promising IEC initiatives run by ACORD, SCC, ARC, IRC, HelpAge International and their local partners. Behavioral surveillance studies specific to Southern Sudan are lacking; however, the 2004 survey of the then GoS-controlled towns, including Juba, indicated very poor knowledge of HIV/AIDS.[58] Members of focus groups reported accessing some basic HIV/AIDS education, but had some misconceptions about modes of transmission, and did not mention the possibility that HIV could be transmitted from mother to child.

7.18 One service provider suggested that one in five women might have an STI. Some providers also provided anecdotal reports of high levels of infertility, a probable result of untreated STIs. Routine syphilis screening for pregnant women was not reported. Improved antenatal care is needed to begin implementation of routine syphilis testing for women. Such services may also serve as an effective entry point for male partners of infected women.

7.19 ART treatment became available at one site in Juba in early 2006. This ART site is thought to be the only site providing ART in Southern Sudan. Although the ART program, managed by WHO, has just begun, collaborative efforts at this site between government, UN, and community based organizations are providing comprehensive counseling, treatment, and support services (including home visits, food aid, and school fees for children) to a limited number of people identified as living with HIV/AIDS. The Juba Association of People Living with HIV/AIDS has been instrumental in creating community awareness and advocating for ART. It is also vital that continuity of treatment be assured for HIV+ individuals returning from other countries where they have initiated treatment. At present, AMREF is developing a cross-border, Kenya/ Sudan ART program to address this concern.

7.20 PMTCT activities are still at the pilot stage. UNICEF is the key partner initiating PMTCT services but it is not clear to what extent services are operational. There is no apparent integration of VCT and PMTCT services.

7.21 Service providers and focus groups identified widespread polygamy and extra-marital sex as factors that make women particularly vulnerable to HIV. This

[58] UNAIDS/WHO. AIDS Epidemic Update: December 2005.

concern was raised by women in focus groups. As one woman put it, "You have just one sexual partner. You stay with your husband. You don't move with other men. Men they move with other women. It is a big problem. If you tell your husband not to move with other women he may even beat you."

7.22 The suspected high prevalence of transactional or survival sex may also increase HIV risk for women. Focus groups members suggested that commercial sex workers may be able to negotiate condom use. But women and especially girls who have sex for money or basic support may have less bargaining power, reducing their ability to negotiate safer sex. Women need to be empowered economically in addition to receiving information and access to services, but integrated programming has not yet been realized. Armed groups have also been documented as having higher prevalence rates, so women associated with the armed forces may be at particular risk. Planning for DDR has included HIV/AIDS prevention activities.

7.23 UN partners are directing efforts towards capacity building of government ministries but may be overextending the capacity of these personnel at the central administrative level. Constant meetings, training, and study trips may take these key people away from the day-to-day responsibilities of their offices. UNDP is focusing on building the capacities of state-level AIDS councils in an effort to implement decentralization. The mechanisms for coordination between AIDS councils and service delivery of BCC activities and HIV clinical interventions, to be funded through Global Fund money, remain unclear however.

7.24 Collaboration with community leaders has been instrumental to effective sensitizations efforts. HelpAge International, active for several years in Juba, has successfully reached rural communities by building long-term relationships with elders' committees. By demonstrating their loyalty and providing an array of services to these communities in partnership with other agencies, HelpAge has been able to overcome resistance to condom demonstrations and sensitization activities.

C - HIV/AIDS and STIs in Eastern Sudan

7.25 HIV/AIDS prevalence levels in the East may be higher than in the North of Sudan. Data collected from 4 sites[59] through the Sentinel Sero-Surveillance system in 2004 indicated that Red Sea had the highest prevalence rate (1.5%) among pregnant women attending ANC.

7.26 Levels of knowledge about HIV/AIDS and its transmission mechanisms are low. This is especially true for women in rural areas. Limited awareness-raising activities are currently being conducted beyond Kassala town. Ockenden is scaling down its HIV/AIDS Awareness Raising and Prevention Program in Kassala and Red Sea states

[59] The four sites included the states of Red Sea, Gedaref, Khartoum as well as the displaced camps around Khartoum. Sudan National AIDS Programme and UNFPA. HIV/AIDS Integrated Report, North Sudan, 2004-2005. United Nations General Assembly Special Session on HIV/AIDS Indicators. February 2006.

due to funding difficulties.[60] Through the program, Ockenden had previously conducted IEC activities such as workshops, lectures, production of materials (billboards, posters and leaflets), school drama groups, youth activities, and radio and T.V programs. GOAL has recently started a participatory rural appraisal to assess the level of knowledge about transmission mechanisms among female IDPs and women in the local community.

7.27 Condom distribution is linked by the local communities to premarital or promiscuous sex, inhibiting widespread condom usage. There was a cultural backlash recently against condoms, targeting the NGO community. An anonymous letter was sent to the NGO community and UN agencies protesting against condom distribution in the area. However, interviewees stated that the local communities do recognize condoms as a means of prevention of the transmission of HIV/AIDS and STIs, especially due to the awareness activities carried out on the role of condoms in HIV/AIDS prevention.[61]

7.28 Denial and stigma are pervasive in the East. The local population considers HIV/AIDS to be a disease prevalent especially among the refugees, and which is spread by the refugees to the host communities. Local women suggested that the presence of VCT centers at the entrance of refugee camps would act as a screening mechanism to prevent disease from spreading out from the camps.

7.29 HIV testing services are poorly used. VCT is provided primarily at Kassala Teaching Hospital, and to a lesser degree at two other VCT centers in the region. The local population is aware of the Kassala VCT site, but the site's separate entrance and the resulting fear of lack of confidentiality and stigma have limited utilization. In 2005, only 112 cases were tested at the center, out of which 58 cases tested positive. Most cases are referred by clinicians who suspect symptomatic AIDS.

7.30 Health professionals at the health centers lack training necessary to recognize AIDS cases and treat opportunistic infections. In many cases, the patients at the IDP health centers are not referred by the medical assistants to the VCT centers until they are at an advanced stage of HIV infection. Furthermore, no ARVs are available and PMTCT services are limited.

8. Family Planning

8.1 Sudan is characterized by low contraceptive prevalence rates, cultural and political suspicion about family planning methods, and high numbers of unwanted pregnancies. Although these factors vary in their severity by region, they are common themes nationwide. Condoms are also generally less popular than oral contraceptive pills

[60] Through e-mail communication with Ockenden International, Kassala Office
[61] See, for example, "Combating HIV/AIDS in Eastern Sudan: The Case for Preventative Action" at http://www.ockenden.org.uk/index.asp?id=1250

and injections (Depo-Provera), leading to a greater reliance on these other methods of family planning.

A - Family Planning in Northern Sudan

8.2 Education and access issues together result in high numbers of unwanted pregnancies. Many women do not receive the necessary education about reproductive health and contraceptive choices. One patient, for example, stated to a doctor that if you take oral contraceptive pills you will get fat and lose your hair. Even with education, women often lack access to family planning services. Furthermore, in areas where condoms are available they are not always used because of the unpopularity of this method among men.

8.3 Limited data about family planning practices hinders appropriate programming. There is no comprehensive data collection system on family planning practices in Sudan so knowledge of the variability of family planning practices across North Sudan is very low. Limited sharing of information between agencies providing family planning services also impedes the availability of appropriate programming.

8.4 Culture and beliefs strongly influence attitudes to family planning practices and services. Staff at a family planning clinic said that the influence of cultural beliefs was a challenge they faced in the provision of family planning services. Several women stated that the more children you have the better because children are blessings and valuable to the social security of the family.

8.5 There is limited knowledge of the extent to which abortion is practiced. There are few options if a woman has an unwanted pregnancy. Unmarried girls or women who become pregnant can be kicked out of the home or even killed because they dishonored their families. Elective abortion is an illegal practice in Sudan — legally, abortions can only be performed to save the life of the mother. Women in our focus groups reported, however, that in Khartoum there are doctors and clinics that will perform abortions and in the surrounding areas women can go to midwives for pregnancy termination. This availability of abortion services suggests that the demand for family planning services is not being met. Opinions differed on the extent to which abortion is practiced.

8.6 There is a lack of initiatives to involve men in family planning programming. Reproductive health issues are perceived by many as concerning only women. In a very male-dominated society, however, men are often the decision-makers on issues of family planning and can even hinder access to health services for women. Service providers have recently recognized the value of including men in family planning programming, but few, if any, have made attempts to target the male population. As a result, education and training sessions were reportedly attended by women only, as were the family planning clinics and reproductive health services.

B - Family Planning in Southern Sudan

8.7 Family planning is extremely poorly used in Southern Sudan. It is estimated that the total fertility rate in Southern Sudan is 6.7 live births per woman with a contraceptive prevalence rate of less than 1%.[62] These figures are extreme, even in comparison to other African countries.

8.8 There is resistance to family planning methods in Southern Sudan. A high value is placed on fertility.[63] Some argue that there is no need for population control since the country has large tracts of unoccupied land. Even more common is the perceived need to "replace" those lost in the war.[64] Although some providers stressed the importance of family planning, at least one said the population was not yet ready. There is little political will for family planning and there have been reports of community leaders condemning the use of contraception.[65]

8.9 There is poor access to family planning. Many women simply lack access to any health care facility, and family planning distribution points and stock have been limited and distribution inconsistent. IRC and ARC distributed condoms in South Sudan at various points but, as of 2005, 100% of public sector family planning commodities are being provided by UNFPA. Using these commodities, 63% of rural hospitals in about 75% of localities are providing family planning. The package provided by UNFPA includes training of service providers in family planning services and counseling according to WHO criteria.[66]

8.10 Age affects ability to access family planning methods. Within Juba, adult focus group participants claimed that they were able to access family planning methods – namely condoms and the pill – at the hospital, clinics, pharmacies and family planning centers. Girls in the focus groups stated that family planning methods are only for adults and that they did not know how to access contraceptives for themselves.

8.11 Family planning education and distribution points are inadequate. For example, the recent closure of the Integrated Reproductive Health Center, a collaboration between Juba Teaching Hospital and the Sudan Family Planning Association, has reduced the already limited availability of contraceptives. Women claimed that contraception was free in at least one family planning center but not at other distribution points. There was a general lack of knowledge about condom use and other methods of family planning. Community health workers at a recent safe motherhood training in Bahr

[62] New Sudan Center for Statistics and Evaluation, Towards A Baseline: Best estimates of social indicators for Southern Sudan, UNICEF, May 2004.
[63] UNFPA. Population, Reproductive Health, HIV/AIDS and Gender: A Situational Analysis of South Sudan. 2006.
[64] AMREF, *Rapid Needs Assessment for Midwifery and Reproductive Health Training in South Sudan,* 2005.
[65] Purdin, S. *Reproductive Health Strategy for Southern Sudan.* A Background Paper for the David and Lucile Packard Foundation. 2000.
[66] UNFPA Sudan Country Office. 2005 Annual Report.

al Ghazal sponsored by IRC also noted that not all PHCCs and PHCUs were stocked with family planning supplies.

8.12 Negotiating family planning use creates friction between women and their partners. Both men and women in our focus groups emphasized this point. Men frequently reported that their partners did not want them to use a condom as that symbolized distrust and potential infidelity. One young man offered, "A lady might say, 'Do you think I am a prostitute?' They will refuse you even." Women also described difficulties in negotiating condom use with their partner, indicating that a woman's request for her husband to wear a condom was sure to result in domestic abuse. As one woman cautioned, "If you do not arrange [using a family planning method] with your husband, he may beat you." In one focus group, women expressed curiosity about the female condom and believed that access to this method of family planning might empower them to be the decision-makers.

8.13 Several researchers have reported, however, that at least some people do want to use family planning – some for delaying first birth, some for birth spacing and some to prevent having any more children.

Many girls in the community have unwanted pregnancies, according to focus group participants. Focus groups indicated that unwanted pregnancies were handled differently depending on the tribe. For example, an unmarried Bari girl who became pregnant might be chased from her home or driven to suicide. At the same time, a Moroe girl in the same situation might be cared for by her parents.

8.14 Termination of pregnancy is performed in the community both by "traditional" means and even by health providers, according to focus groups and interviews. Although there is a widespread feeling that abortion is a sin, it was suggested as one way to deal with an unwanted pregnancy. One ethnographic study reported that conception due to social pressure followed by induced abortion might be common among Dinka women.[67]

C - Family Planning in Eastern Sudan

8.15 The conservative cultures of the East have made family planning awareness-raising activities very difficult for NGOs. In some very conservative communities such as those in the area of Hamish Koreib, the men and women live in separate quarters, with men visiting the women during specified hours only. In many of the Beja communities, the women rarely go out of their homes, apart from visits to the homes of relatives. This has made NGO outreach and awareness-raising activities targeting women quite difficult. In addition, communities are accustomed to women having up to 7-11 children each.

[67] In a population of 23,000, 130 miscarriages and terminated pregnancies were counted in 1.5 years; and during an eight-month period within that time, seven women died as a result of unsafe abortions. While it is not known how extensive such practices are, further research is warranted. See, for details, Jok, Jok Madut, *Militarism, Gender and Reproductive Risk: The Case of Abortion in South Sudan*, 1996.

There has also been active resistance recently to family planning activities. An anonymous letter was sent to all NGOs in the area, stating that the distribution of condoms was offensive to Islam, as it instills corruption and infringes upon traditional values and customs.

8.16 Distribution of condoms is less contentious than it was previously, but still resisted. Condom distribution in the refugee camps was problematic a few years ago, but the stigma has been reduced to some degree. According to one NGO in Kassala, refugees are "ordering" them to distribute more condoms in the refugee camps. There is, however, still significant resistance to condom distribution in the local community and in the IDP camps. To the local and IDP communities, condoms are associated with promiscuity and "illegal sex", and used to prevent pregnancy in extra-marital affairs. Limited awareness-raising activities are conducted surrounding condom usage as a family planning tool.

8.17 Condoms are viewed and used as a tool for HIV/AIDS prevention, not for family planning. Peer educators do carry out some awareness-raising activities surrounding family planning and other issues in the refugee camps, but such activities are conducted to a much lesser degree in the host community villages and in IDP camps.

8.18 There is a shortage and/or an inconsistency of delivery of family planning supplies. There has reportedly been a problem in the East with the availability of condoms and other family planning supplies, including birth control pills and injectables. A lack of supplies or an irregular pattern of delivery was noted by both the NGOs in Kassala and an agency in Showak.

9. Adolescent Reproductive Health[68]

9.1 The reproductive health needs of young people and adolescents include safe motherhood, family planning, HIV and STIs, and GBV. The particular vulnerabilities of adolescents warrant an approach that addresses their multi-dimensional needs and factors that may limit their ability to take advantage of existing services.

9.2 Adolescent reproductive health programming is largely absent in Sudan. The greatest need is for education efforts to improve health literacy to bring about positive behavior change.

A - Adolescent Reproductive Health in Northern Sudan

[68] According to UN agencies, adolescents are 10-19 years of age and young people are 10-24 years of age. See: WHO/UNFPA/UNHCR. Reproductive Health in Refugee Situations: An inter-agency field manual. Geneva: UNHCR, 1999.

9.3 Sexual activity among adolescents is higher than is generally acknowledged. Focus groups with young women revealed that sexual initiation can be as young as 13 for boys. Moreover, adolescent boys aged 14-16 and young men are frequenting commercial sex workers "for fun" and for reasons such as: "If they can't find sex with friends they will go out and find it". Even for older adolescents in steady relationships, motivations for extramarital sex included "whatever is forbidden is wanted". As for girls engaging in premarital sex, economic reasons were cited as a key motivating factor.

9.4 Contraceptive prevalence is presumed to be low among sexually active adolescents/youth, although accessibility is not the main barrier in Khartoum. Although male condoms were identified as the most widely used method of contraception among young people, resistance to condom use is seen to be high in the general population. Young women mentioned that most boys do not perceive the need to use condoms in steady relationships, although they may choose to do so for commercial sex.

Pharmacies were identified as the number one place to obtain condoms in and around Khartoum. Some young women voiced concern that unmarried people are culturally forbidden to purchase condoms, but they noted that pharmacists would sell it to them without identification requirements so long as they "look[ed] old". The availability and cost of condoms were not perceived to pose significant problems in the Khartoum area, although this is questionable for the less wealthy and more marginalized populations. Our information on this issue came from focus groups with relatively advantaged groups of students from Ahfad University.

9.5 Knowledge about contraceptive methods and HIV/AIDS is low among adolescents/youth outside of Khartoum. Educated adolescents/youth in Khartoum receive sexual education before or in high school and are aware that their generation has a high risk of HIV/AIDS "because they [young people] have sex more often." But youth outreach program participants noted that knowledge of condom usage is minimal in rural areas,[69] and HIV/AIDS transmission routes even less well understood.

9.6 Youth outreach programs are contributing to knowledge dissemination in schools and in rural areas. Outreach programs have been highly successful in mobilizing young people and raising awareness among populations with less access to information and services. These programs are run by Ahfad University for Women and other peer education initiatives including the Community Animator Friendly Association, an 800-member volunteer organization that conveys messages on family planning, HIV/AIDS, FGM/FGC and other issues through drama, music, and performance to IDP communities in Omdurman.

9.7 There remains a lack of adolescent/youth involvement in program planning and design, despite the potential of adolescent participation to improve the efficacy of programming. Service providers noted that they would like to know more about adolescent/youth reproductive health practices, their needs, and their beliefs in order to

[69] Myths among boys in rural areas involving condoms, including beliefs that condoms are a source of disease, were raised by Ahfad students who have completed their field extension program.

commence or enhance programming for the age group; yet, young people have rarely been involved in the planning, design, implementation, and evaluation of UN and INGO interventions.

B - Adolescent Reproductive Health in Southern Sudan

9.8 Early and forced marriage and teen pregnancy were identified as major threats to adolescent health and well-being. The lack of education, livelihood, and recreation opportunities for young people in Southern Sudan is a key factor in early marriage and early onset of sexual activity. Poverty and breakdown of family support systems may be related to widespread "survival" or transactional sex among girls and young women as well as forced marriages to older men.

9.9 Early pregnancy has serious physical and social consequences for these young people. A girl who became pregnant would likely be forced to leave school. The child's father would likely also leave school either by expulsion or to earn money to support and perhaps marry the girl. One young man explained, *"You may not continue with your studies. It [pregnancy] leads to economic problems. You don't have money for medicine if the child gets sick or for food."* Some communities may expel a girl who has become pregnant outside of marriage. Unsafe abortion is also seen as an alternative for some young women who are pregnant but not married.

Customs of early marriage—including friendship marriages where marriages are arranged before a girl is even born—have been reinforced by conflict and poor economic conditions, where fathers are marrying their daughters off at an earlier age than prior to the conflict. In many cases, young girls have been married to very old men, as they are the ones who are able to pay a larger bride price.[70] In Juba, girls identified this as one of the main problems in their community as *"the father may force the girl to marry and she doesn't want to. This is usually when she is 15 or 16 years old."*

9.10 Broader livelihoods and gender empowerment strategies may be necessary to reduce risky sexual activity. The suspected high rate of transactional or survival sex among young women is of particular concern since they may have limited power in these relationships to negotiate condom use. It is a complex phenomenon, however, which cannot only be addressed through education of young women but which must address the largely economic factors that compel women to engage in risky sexual activity.

9.11 There appears to be a near total lack of formal reproductive health education for adolescents and young people in much of Southern Sudan. Life skills and HIV/AIDS education programs targeting young people are limited to individual, small-scale programs, although UNICEF is projected to expand their efforts. Misconceptions about pregnancy, contraception, and HIV are prevalent, though again, reliable

[70] USAID, March 2005, p 18.

quantitative data are not available. Some incorrect knowledge about the biology of reproduction and contraceptive methods was shared during focus groups in Juba. Use of drugs, like aspirin or paracetamol, was suggested as a way that one could try to prevent a pregnancy in addition to condoms, pills, injectables, the rhythm method, and indigenous methods, for example a solution made of banana leaves. Qualitative data suggest that young people associate condoms with a lack of commitment and mistrust of a partner, and that they lack knowledge about how to correctly use condoms.

9.12 Incorporation of reproductive health education into the school curriculum was mentioned by some service providers as a promising strategy. Providers and community members indicated a lack of basic reproductive health knowledge, even among young men and women in secondary school. Such an effort would demand collaboration between many partners, particularly the Ministry of Education. The education sector is thought to be well funded since it has been identified by the GoSS as the top priority for rebuilding Southern Sudan.

9.13 Health center fees and age are barriers to adolescent utilization of existing reproductive health services. Young people we spoke to suggested that providers would refuse them services if they were less than 17 years of age. The specific reproductive health needs of adolescents have yet to be addressed in a coherent program that tackles the environmental factors that contribute to the reproductive health challenges of young people, particularly girls. UNICEF, Save the Children UK, Sudan Council of Churches (SCC) and others are working to improve education opportunities for girls. There are also a few HIV/AIDS education efforts that reach young people, but there do not appear to be any programs focusing on improving access to clinical services for young people.

C - Adolescent Reproductive Health in Eastern Sudan

9.14 Early marriage is very common for adolescent girls (as young as 14) in rural areas of the East. In more urban areas, it is more the norm for girls to marry between the ages of 18-20 years. Early marriage is also associated with early drop out in schools at grade 7 or 8 (13-14 years of age). Early drop-out of adolescent girls contributes to low literacy levels in the region; illiteracy is pervasive in the East, ranging from an average of 50% to as high as 89% in some areas.[71]

9.15 There is a lack of basic RH knowledge and minimal RH awareness-raising activities targeting adolescents. The small scale programming has included peer counseling in Kassala town,[72] youth counseling in an IDP camp,[73] and the possibility of

[71] Pantuliano, Sara. "Comprehensive Peace? Causes and Consequences of Underdevelopment in Eastern Sudan"; September, 2005, p. 8.

[72] GOAL initiated peer counseling activities for youth in Kassala town, targeting a small number of school-going boys and girls (gender segregated).

[73] In one IDP camp, youth counseling activities were initiated by GOAL and were targeting out-of-school youth, but the adolescent boys stopped attending the sessions, possibly due to pressures to seek employment.

three youth centers for RH education.[74] According to a Kassala-based NGO, youth are participating in early sexual activity, and there is a need to educate adolescents on risks and prevention methods.

9.16 HIV/AIDS awareness-raising activities have been limited to only a few communities, and are targeting a very limited number of adolescents. Both GOAL and SRC have conducted limited outreach activities on HIV/AIDS with adolescents. The adolescents are trained as peer and door-to-door educators or have participated in HIV/AIDS awareness trainings. According to NGOs in Kassala, HIV/AIDS awareness levels are especially low among adolescents living in rural areas and in the IDP camps. The MoH – Council for Child Welfare also conducts awareness-raising activities on HIV/AIDS in the secondary schools in Kassala town. These gender-segregated workshops, which target a limited number of students, focus on prevention methods including condom usage.

[74] In Kassala town, SRC has submitted a proposal to PPFA to restore 3 youth centers for VCT, condom promotion, and general RH education and awareness for youth.

11. Recommendations

The need for reproductive health services in Sudan is immense and there are many areas in which UNFPA can play a significant and valuable role. Taking into consideration the diverse needs in Sudan, the recommendations are region specific, rather than theme based.

Overarching Recommendations

1. UNFPA should continue to build the capacity of health personnel and health facilities through training, and technical assistance, with special emphasis on:

- Sustained supervision, monitoring and evaluation.
- Developing detailed costed implementation plans with government and NGO partners in order to prioritize interventions and improve integration of reproductive health services into primary health care.

2. To help health actors to find their place in the complex environment of reproductive health in Sudan, UNFPA can act as a central information point for reproductive health activities through:

- Building and maintaining a database of reproductive health activities, which could be updated via periodic meetings and simple questionnaire forms.
- Periodically disseminating the contents of this database to concerned parties so that they can better coordinate their activities.

3. UNFPA should expand collaboration with local and international NGOs and other community-based groups to enhance ownership of reproductive health policies and programs at the community level. Specific approaches include:

- Targeting men in reproductive health programs, particularly in family planning, so as to raise awareness of reproductive health as a common issue affecting both men and women.
- Using the untapped potential of adolescents and youth, since they can often be their own agents of change.

4. Monitoring of programs and distributed goods and the management of data have been identified as significant programming gaps. As a result, UNFPA should:

- Ensure that mechanisms for distribution of reproductive health kits are tailored to the differing operational contexts in Sudan.
- Develop a comprehensive data collection system for RH commodities to track distribution and utilization.
- Develop a reporting mechanism to encourage transparency and accountability of UNFPA funding recipients – both government and NGO. Continued funding should be contingent on successful achievement of specified program outcomes.

North

5. UNFPA should continue to play a leading role in efforts to enhance skilled attendance at birth through:

- Assisting the FMoH in operationalizing the new village midwifery training curriculum policy.
- Developing supervision, monitoring and evaluation, and logistics systems in conjunction with the FMoH to help sustain efforts to increase the number of trained midwives in rural areas.
- Facilitating the integration of trained midwives into the nation's health care payroll system so as to ensure better quality of care, supervision of practices, and adequate support and follow-up. Efforts should be taken to identify new roles for TBA's (i.e. community health workers).

6. There are many methods by which UNFPA can tap into local resources and better liaise with local organizations:

- Use existing resources and information generated by local academia and community-based organizations to inform program planning. Much research has been generated by local NGOs and by university students, especially by those at Ahfad University on cultural and behavioral practices related to family planning and adolescent sexual health; UNFPA can tap into such resources for KAP data and for ongoing technical assistance.
- Assist youth outreach and peer education initiatives that conduct BCC activities in rural areas, since young people, particularly students, have expressed willingness to enhance the knowledge and skills level of their peers.
- Enhance public relations strategies to better advocate UNFPA's strengths and activities to potential NGO partners, as some were not aware of how to approach UNFPA.

7. Local organizations in the North that have expressed interest in partnering or strengthening partnerships include:

- **Sudanese Network for the Abolition of FGM/FGC** (SUNAF): The network has stated that it would benefit from financial support for the creation of a databank on FGM/FGC and technical training.
- **Sudanese National Committee on Harmful Traditional Practices** (SNCTP): The Executive Director has explicitly expressed her wish to partner with UNFPA and attend its events for information and experience-sharing purposes.
- VCT Center at **Omdurman Hospital**: With funds from the Global Fund reaching Omdurman Hospital and other hospitals providing ARVs, UNFPA can concentrate on raising awareness of HIV/AIDS so testing is targeted to the general population in addition to clinical referrals.

8. To clarify roles and responsibilities regarding HIV/AIDS, UNFPA should work with the MoH and SNAP to:

- Expand the availability of HIV/AIDS and STI testing centers both in terms of technical support for capacity-building and financial resources.

- Promote the inclusion of PMTCT interventions in the antenatal care protocol.
- Work with SNAP to better coordinate the activities and policies of HIV/AIDS service providers and UN organizations so as to avoid overlap in service provision and gaps in resources.

South

9. As community education and awareness-raising on reproductive health issues is nearly non-existent beyond basic HIV/AIDS sensitization, especially for adolescents, UNFPA should prioritize BCC activities to:

- Support curriculum development, TOT workshops, and serve as a coordinating agency for such activities.
- Partner with schools, women's associations, and organizations with strong community-based networks such as Help Age International, PACT, and IRC. Activities should be expanded beyond Juba through contracting with active and reliable local and international NGOs.
- Address cultural appropriateness of interventions. Help Age has been successful at integrating condom education into their outreach activities; their strategy, based on developing relationships with village elder committees, should be shared as a local best practice for future scale-up.

10. The need to link reproductive health education and services with empowerment programming such as micro-credit or income generating projects (IGPs) has been increasingly acknowledged by service providers as a means of preventing sexually risky behavior among poor women; hence, UNFPA should:

- Support 'linked' programs through seeking partners with experience in IGPs such as ARC.
- Spearhead the development of programming in Southern Sudan that integrates reproductive health services and economic empowerment.

11. To continue to build the capacity of health personnel, particularly at peripheral health centers, UNFPA should:

- Efforts to equip and train local health service providers, such as the upcoming fistula training at Juba Teaching Hospital, should be prioritized in tandem with efforts to expand government capacity in the areas of health and gender.
- Use its technical expertise in reproductive health to pilot supervision and monitoring tools for use at public and private facilities.

12. To continue to meet the demands for reproductive health equipment and supplies UNFPA should:

- Examine its capacity to play a leading role in support of PHC centers, PHC units, and hospital facilities providing RH services.
- Work with key partners in the reproductive health coordinating group to establish a system to monitor the use of RH commodities in order to determine whether scaling up distribution is feasible.

- Reexamine the current RH commodity pipeline and distribution system in order to address logistical constraints and ensure a constant supply of equipment and commodities. (For instance, would it possible to procure and transport RH kits from Kenya into South Sudan as most NGOs do with their supplies?)

13. The enormous need and lack of services throughout Southern Sudan warrants increased funding allocations for the expansion of programming and personnel:

- UNFPA is involved in forward-thinking coordination efforts such as the newly established SGBV working group; such work should be adequately supported.
- Support to the UNFPA office in Juba should reflect the reality that Southern Sudan is still largely operating in an emergency context; hence, quick impact projects should be encouraged as a complement to longer term capacity building efforts.

East

14. To better understanding the context, services, gaps, and possibilities for collaboration in the East, UNFPA should:

- Conduct a detailed survey on the above in clinics in the refugee camps, IDP camps, and rural and urban host communities.
- Work towards establishment of a physical presence in the region in order to more effectively implement and monitor programs.

15. Regarding Safe Motherhood initiatives, UNFPA can assist and collaborate with partners to:

- Provide NGOs with additional vehicles to increase capacity for emergency transportation.
- Provide delivery beds to UNHCR and NGOs to improve health facilities in the refugee camps.
- Identify workable solutions to the midwife/TBA issue.

16. For UNFPA to enhance contraceptive prevalence and reduce resistance to contraceptive use, it should:

- Collaborate with NGOs to identify solutions for targeted outreach and awareness raising on family planning methods within the context of a culturally conservative society.
- Increase the level of coordination with NGOs on provision and distribution of condoms, birth control pills, and injectables.

17. To improve the availability of HIV/AIDS-related services in the East, UNFPA could:

- Provide technical guidelines for operating VCT centers with minimum standards in regards to physical location, staffing, and standing operating procedures.
- Identify partner agencies for the establishment and maintenance of VCT centers integrated into the health care system.

- Partner to raise awareness among rural populations of mechanisms of HIV/AIDS transmission and prevention. The development and adaptation of a curriculum for including HIV/AIDS in the basic and secondary schools as well as activities for raising awareness among religious leaders are needed.

18. If FGM/FGC and GBV are to be adequately addressed in the conservative East, awareness-raising activities must precede or work alongside behavior change programs; hence, UNFPA should:

- Partner with NGOs to conduct awareness raising on the impact of FGM/FGC and its implications for safe motherhood.
- Develop training manuals to sensitize local judicial mechanisms on GBV issues.
- Conduct an assessment to investigate the prevalence and consequences of GBV in Eastern Sudan.

19. UNFPA can provide support to NGOs to expand the level of outreach and training of adolescents on RH issues by:

- Ensuring that outreach is expanded not only in terms of the number of youth targeted, but also by the number of regions covered, particularly reaching the IDP camps and host community villages outside of Kassala town.
- Working with the school system, as this will reach more adolescents than the use of outreach workers.

ANNEX I — Mapping Matrix

The following pages display the matrixes of which organizations (of those interviewed in each region) are involved in what kinds of activities in the North, South, and East. This analysis is not intended to serve as a comprehensive or exhaustive list of the programming, but is based on information collected during the literature review and interviews. Some remaining points of uncertainly are represented by question marks. The mapping matrices are not indicative exclusively of the geographical location of programs, as some agencies (particularly those with headquarters based in Khartoum) may be coordinating programs elsewhere in the country (e.g. Darfur, Southern Sudan).

NORTHERN SUDAN PROGRAMS																	
Organization	Type	Services					Awareness-Raising					Training					Other
		Safe M'hood	FP	Adol RH	HIV/ AIDS	Gend / GBV	Safe M'hood	FP	Adol RH	HIV/ AIDS	Gend /GBV	Safe M'hood	FP	Adol RH	HIV/ AIDS	Gend /GBV	
Ahfad University	ACAD	X	X				X	X			X						
ARC	INGO	X	X	X		X	X	X			X	X	X				
BBSAW	LNGO						X	X			X					X	
CARE	INGO	X	X				X	X			X					X	
DAAWA	LNGO	X	X					X					X				
FMoH, Int'l Directorate	GOV		?									?	?				
FMoH, National RH Directorate	GOV		?									X	X				
GOAL	INGO	X	X				X	X									
ICRC	UN	X	X					X					X				
IRC	INGO	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Islamic World Relief	LNGO	X	X														
Japanese Mission	GOV																
MEDAIR	INGO	X	X				X	X				X	X				
NPC	LNGO								X					X			
SRC (at Al Salaam Camp)	LNGO	X	X														
SNAP	GOV				X			X		X		X			X		
SNCTP	LNGO					X					X					X	
SUNAF	LNGO										X					X	
UNICEF	UN						X					X					
UNIFEM	UN								X	X	X					X	
UNMIS	UN									X	X				X	X	
WHO	UN																X

SOUTHERN SUDAN PROGRAMS																	
Organization	Type	Services					Awareness-Raising					Training					Other
		Safe M'hood	FP	Adol RH	HIV/ AIDS	Gend/GBV	Safe M'hood	FP	Adol RH	HIV/ AIDS	Gend/ GBV	Safe M'hood	FP	Adol RH	HIV/ AIDS	Gend/GBV	
AMREF	INGO											X	X		X		
Association of People Living with HIV/AIDS	LNGO				X					X					X		
CDC	GOV				X										X		
Help Age International	LNGO				X			X		X			X		X		
ICRC	INGO	X										X					
IOM	INGO																X
JSI	INGO						X					X			X	X	
Juba Hospital	GOV	X	X		X							X	X				
Save the Children - UK	INGO					X			X		X						
SSRRC	GOV																X
SCC	LNGO				X					X					X		
UNDP	UN				X					X					X		
UNHCR	UN	X															X
UNICEF	UN	X		X	X		X					X			X		
VCT Center	GOV		X		X					X					X		
WHO	UN		X		X					X					X		X
World Relief Int'l	INGO	X					X					X					

EASTERN SUDAN PROGRAMS																	
Organization	Type	Services					Awareness-Raising					Training					Other
		Safe M'hood	FP	Adol RH	HIV/ AIDS	Gend/GBV	Safe Mother-hood	FP	Adol RH	HIV/ AIDS	Gend/ GBV	Safe M'hood	FP	Adol RH	HIV/ AIDS	Gend/ GBV	
MoH, Council for Child Welfare	GOV	X	X						X	X				X	X		
GOAL	INGO	X	X	X			X	X	X	X		X		X	X		
SRC	LNGO	X	X					X	X	X	X	X		X	X		
UNHCR (Showak)	UN								X	X	X	X		X	X		
UNOCHA	UN																X

ANNEX II — Organization Summaries

A - Northern Sudan

Ahfad University	
Date and Location of Meeting	14 March 06 Ahfad University, Khartoum
Contact Person	Dr. Amna Badri, Director of Ahfad University; Dr. Nafisa Badri, Network for RH and Population; Teacher in Family Science
Email Address	
Focus Activities	Women's issues, gender, reproductive health
What, Where	o Strategy: hold workshops and conferences, produce IEC materials on reproductive health and FGM/FGC o Educating the media on RH issues o Mapping of organizations working on RH in Khartoum state (currently in production) o Policy forums: Aim to promote discussion of RH issues o Disseminate information amongst RH organizations o Advocacy role towards government, religious organizations and donors

American Refugee Committee (ARC)	
Date and Location of Meeting	14 March 06 ARC
Contact Person	Jerry Farrell, Country Director
Email Address	arcsudan@yahoo.com
Focus Activities	Primary health care, training
What, Where	o Operating in S. Sudan out of Kampala since 1994 o Operating in S. Darfur since Aug. 2004 o Operating in urban and rural areas where IDPs live. Clinics are located in areas 200kms S. of Nyala. o Primary health care program in Nyala and surrounding areas: 12 primary healthcare clinics, and in women's prison in Nyala. o Full RH services in all clinics—can handle any kind of delivery except C-section. o Basic EMOC in Nyala, and are training staff to do rural work. o Train TBAs, midwives, and sponsor a midwife school in Nyala. o Provide posters on GBV, and have theatrical performances about reducing FGM/FGC. o Income generating activities (e.g. making clean delivery kits). o Wat-san and agricultural projects

Babiker Badri Scientific Association for Women's Studies (BBSAWS)	
Date and Location of Meeting	22 March 2006 University of Khartoum
Contact Person	Dr. Sidiga Washi, Associate Professor, Dean of School of Family Sciences Wifag Salah A. Mabrouk, School of Family Science
Email Address	sidiga@gmail.com; wifag_mabrouk@yahoo.com
Focus Activities	Women's Issues, Gender, GBV
What, Where	o Working on combating harmful practices against the health and status of women, as well as building capacity of women at the various levels (grassroots included). o Creates publications such as posters and pamphlets, conducts training and research, and examines the legal aspect of gender issues. o Awareness raising of women and domestic violence or GBV. o Current activities: BBSAWS is involved in a project in Darfur, wrote a proposal for UNIFEM and is doing research on GBV. Also working on capacity building for the organizations in Darfur—community based organizations. Active in counseling women affected by violence—end of April is end of the project. o Designed a training program for media people covering Darfur. Also designed training for CBOs down in Darfur—West Darfur and South Darfur. Now designing a policy training for those working in Darfur. o Advocacy—publications, forums, policy trainings o Capacity-building for local organizations working on gender issues

CARE	
Date and Location of Meeting	15 and 21 March 06 CARE Office
Contact Person	Rabab Baldo, Gender Coordinator, and Ekramul Kabir, Project Manager
Email Address	rabab@sud.care.org, ekramul@sdn.care.org
Focus Activities	Health and nutrition services
What, Where	o Programs in Northern Sudan, Unity State, and Eastern Sudan, and IDP camps, including: As Salaam, Wad El Beshir, Mayo, and Jebel Marra. o Funds a nutrition program for Khartoum IDP Camp o Funds a program for pregnant and lactating mothers: three centers in Omdurman that provide services to pregnant and lactating mothers; 2 centers in Al Salaam that offer services to pregnant and lactating mothers and under 5 children; 1 center in Mayo and 1 center in Jebel Marra that service mothers and under 5 children. o Food-for-work and Food-for-training are offered in the camps. o Provides food and technical data to 4 partner NGOs including Medair. o Most women stay three months, during their third trimester of pregnancy. After delivery, they stay for 45 days. Lactating mothers receive care for 4 to 5 months. o The centers see approximately 1,000 children per month, and 1,950 pregnant and lactating mothers per month. o There are kindergarten/child care centers for 2-6 year old children. o Care has five health clinics offering basic health services in Unity State.

	Only basic services such as treatment for malaria, diarrhea, and respiratory infections are offered. Medicines are provided for free, although with 50,000 people expected to return, the hospital capacity has already met its limits. o Screening for STIs takes place at the clinics, although HIV/AIDS testing is not offered. o Health education programs are also offered at the clinics. o Care also runs a 24-hour mother-child hospital in rural Unity State. It is the only running hospital since the hospitals that oil companies have build have not been sustained. Other agencies operating in Unity State include MSF France (TB and other disease) and ACF (nutritional activities). o In 2000, Care, in partnership with UNICEF, and created water treatment plants. However, demand exceeds supply.

Federal Ministry of Health, International Health Directorate	
Date and Location of Meeting	16 March 06 Federal Ministry of Health, Khartoum
Contact Person	Isameldin M. Abdella, Director General Dr. Saad El-din Hussein Hassan, Director of Emergency and Humanitarian Action
Email Address	unagencies@hotmail.com; isameldin99@yahoo.com
Focus Activities	Health and humanitarian action
What, Where	o International Health Directorate established in 2003 o Liaison office between assistance organizations working in health and other directorates o MOH is trying to standardize emergency services provided, especially in the IDP camps. They are working with the RH Directorate to try to improve the standard of the clinical management of rape, GBV and raise capacity of staff to manage such issues. The main focus of this emergency group is in Darfur at the moment. o The government tried to set some standards for health delivery at the camps. Since 2001, there is a Federal Health Coordinator in each of the Darfur states and a Health Camp Coordinator in each of the big camps. o Building capacity of the MOH on the state level.

Federal Ministry of Health, National Reproductive Health Directorate	
Date and Location of Meeting	22 March 06 RH Directorate, Khartoum
Contact Person	Dr. Igbal Ahmed Bashir, Reproductive Health Director
Email Address	
Focus Activities	Safe Motherhood, Reproductive Health (general)
What, Where	o Rapid mapping of the RH services in the 15 Northern states as well as the 3 garrison towns of Juba, Malakal and Wau. Confined to the North as done before the signing of the CPA. The mapping was carried out in conjunction with UNFPA and a report was produced following the mapping exercise. o Rapid assessment of the midwifery services carried out in conjunction

	with UNFPA. A consultant from UNFPA's regional office aided in the process. Based on the mapping exercise, the RH directorate has formulated the activities for 2006. The new policy of the RH Directorate to focus on trained community midwives as the first level of care. The TBAs who had earlier been providing health services to the community are not prepared to deal with complications of birth leading to a high maternal mortality. o Under MoH's new policy, training will be provided at the 38 midwifery schools (more than 1 school in each state).

Global Health Foundation (Formerly DAAWA)	
Date and Location of Meeting	14 March 2006 Al-Salaam IDP Camp, Omdurman
Contact Person	
Email Address	
Focus Activities	Primary Health Care, Medical Clinic, Health Education, Family Planning
What, Where	o Services offered: comprehensive MCH, CHW, pregnancy testing, immunizations, lab work as well as follow up in the community with health educators o Family Planning methods offered: free condoms, oral birth control pills provided by the state MoH

GOAL	
Date and Location of Meeting	18 March 2006 GOAL
Contact Person	Bronwen Williams, Health Coordinator
Email Address	bwilliams@goalsudan.com
Focus Activities	Primary health care, RH, watsan
What, Where	o 4 locations: N. Darfur, Kassala, Malakal, Abiyei o Main work is in Primary Health Care reproductive health, watsan, quality of life o Primary health care services: Epi, growth monitoring, lab work, reproductive health o 500,000 served o 17-18% of beneficiaries receive reproductive health services

International Committee of the Red Cross (ICRC)	
Date and Location of Meeting	21 March 06 ICRC, Khartoum
Contact Person	Yasmeen Abdu Majid, Assistant to Medical Coordinator Adil Sharif, Assistant Head of Delegation
Email Address	khartoum.kha@icrc.org
Focus Activities	Primary Health Care (PHC), Expanded Program on Immunization (EPI), Reproductive Health, Hospital Support, Surgical Activities
What, Where	o ICRC has PHC centers in Darfur, and hospital and orthopedic services in South Sudan and in Kenya (for S. Sudanese refugees) o PHC activities include EPI (polio and other immunizations during outbreaks), MCH, and community awareness, capacity awareness,

	among others. o ICRC in Darfur: PHC, surgical activities, first aid, and ad hoc vaccination campaigns. It also addresses protection issues through the use of international humanitarian law (IHL). o In Gareida (S. Darfur), the ICRC provides antenatal care; in Silia (W. Darfur), MCH; and in Nena (N. Darfur), MCH. o ICRC in S. Sudan: one medical doctor in Gereida (S, Sudan), the clinic inside the IDP camp and a midwife. In Juba, the ICRC plays a supportive role to MoH. The Water and Habitat Team of the ICRC also works with Juba Teaching Hospital. Supplies medical and surgical equipment, fuel, maintenance, food for patients, and food incentives to 850 staff. Juba Nursing School has a maternity ward; the Juba Hospital is a district hospital meant for war surgery. o ICRC in other areas: There is currently a protection delegate in the East. In Kadugli, there is a field delegate and orthopedic services o ICRC RH Services: follows the national protocol for family planning. The organization does not administer PEP because it is not in the national legislation. PEP also needs follow-up, which is another reason the ICRC does not offer it. IUDs and other contraceptives are provided, although injectables and tablets are not. STI testing is available, although no VCT services are provided. ARVs are also not available. Services are free, although medicines are charged in some places (e.g. Abata, W. Darfur) for cost-recovery purposes. Field surgical teams also intervene in extreme obstetric emergencies.

International Rescue Committee (IRC)	
Date and Location of Meeting	13 and 23 March, 2006 IRC, Khartoum
Contact Person	Aisling Swaine, Women's Health Coordinator in Darfur; Amal Dirar, GBV Specialist; Muawia Gorti, Health Advisor
Email Address	aisling@theirc.org, amal@theirc.org, muawia@theirc.org
Focus Activities	GBV, reproductive health, psychosocial, women's centers, health clinics
What, Where	o In Darfur, IRC is operating women's centers as well as health clinics. Women's centers are located in all states of Darfur: Nyala (South Darfur)-1; West Darfur-2; El Fasher (N Darfur)-3; East Darfur-2. o In South Darfur IRC is located at Kalma and Otash camps, and in North Darfur-Abu Shok camp. o Eastern Sudan: IRC has an agreement with the MoH to construct health centers, train staff and then handover to the MoH. IRC is also providing the initial drug supply. Ten health centers have been constructed in Kassala with six others in Port Sudan. o Women's centers in Darfur: The women and girls who come to the health centers range from age 10 and upward. The different activities held at the health centers are: literacy classes; health education classes-through outreach to community and at the women's centers, covering FP, nutrition, and antenatal services; recreational activities, IGAs, psychosocial counseling o Information about the health clinics is disseminated through outreach. Women are referred to the health clinics by the women's centers. o Clinic activities: treatment of rape victims including post rape kits and PEP kits; labor and delivery. In case of complications, the women are

	referred to the nearest hospital (Nyala hospital in South Darfur). The IRC usually does not help in transportation. o Construction of health centers and staff training

Japanese Mission	
Date and Location of Meeting	21 March 06 Japanese Mission, Khartoum
Contact Person	Yoichiro Toda, Attache
Email Address	Yoichiro.toda@mofa.go.jp
Focus Activities	Primary Health Care, Immunizations, communicable diseases, Infrastructure, Water/Sanitation
What, Where	o Funds WHO and UNICEF in their immunization campaigns for children; and a few health-related grassroots activities o Emphasis placed on infrastructure development in Southern Sudan

Islamic World Relief (IWR)	
Date and Location of Meeting	20 March 2006 Islamic World Relief
Contact Person	Ibrahim Mohammed
Email Address	
Focus Activities	Health, social issues (e.g. education), water, environment
What, Where	o In West Darfur, IWR has 6 clinics o In South Kordofan, IWR has 3 labs, White Nile 2 labs, North Darfur 2 labs, Juba 2 labs, Malakal 3 labs, Wau 4 labs, Atbana 3 labs, Kassala 3 labs. Labs currently test for malaria etc., but not HIV. o Antenatal care and postnatal care are offered at the PHC centers. Contraceptives (pill, condoms) are provided for free. o IWR provides services to orphans, widows, and the disabled, including leprosy patients. o With WFP, IWR offers food-for-work in North Darfur, and works with UNICEF on a water project.

MEDAIR	
Date and Location of Meeting	15 March 2006 Al-Salaam IDP Camp, Omdurman
Contact Person	Agnes Konga Adde, General Medical Assistant and Supervisor of Medair Clinic
Email Address	
Focus Activities	Primary Health Care, Reproductive Health
What, Where	o Runs a clinic serving members of the IDP camp and surrounding area o Approximately 14, 342 beneficiaries; open 8-4pm closed on Sunday o 45 patients/medical assistant/day, 4 medical assistants total o Clinical rooms: Registration, ORS, Medical Consult, Pharmacy, Dressing and Injection, Immunizations o Clinic was started by MSF France in 1996 and Medair took over in 2000 o RH: pregnancy and lactation class is well-attended o If a patient is very ill and admitted to the recovery room payment is

	not compulsory; these patients are referred to Omdurman hospital and is escorted by a nurse, Medair provides a car when possible o Referrals: about 1-2/week, approx. 10/month o 12 total TBAs, trained by the Ministry of Health; hold office hours at clinics—only one TBA at a time; TBAs can refer if the birth is difficult o Offers a pregnancy and lactation class for women

National Population Council (NPC)	
Date and Location of Meeting	23 March 2006 NPC
Contact Person	Dr. Wisal Hussein
Email Address	
Focus Activities	Population policy, monitoring, and evaluation
What, Where	o 16 branches of NPC in 16 states, but each NPC functions independently, with the Khartoum office as the central coordinating office. o Conduct advocacy workshops on RH, concentrating on youth (in Khartoum). 15 workshops/year conducted. o Conduct a survey of RH for the whole country for the census (not just South). o Are developing 2 curriculums for RH for youth in the military o Are requesting that the Youth Minister endorse the Declaration on Youth and lobbying for Sudan to adopt the idea of having a center for youth in Khartoum.

Sudanese Network for Abolition of FGM (SUNAF)	
Date and Location of Meeting	21 March 06 SUNAF office, Khartoum
Contact Person	Nahid Gabralla, Media and Public Relations for SUNAF (also Technical Advisor on FGM for UNICEF)
Email Address	
Focus Activities	GBV, Female Genital Mutilation (FGM)
What, Where	o Established in 2002 as a national network (no operations in the South) in response to counterattacks on eradicating FGM/FGC. There were 25 organizations in the beginning. Currently there are 31 national organizations. o The member NGOs are engaged in different activities directly or indirectly related to FGM/FGC (health, HR, etc.) o Works at the level of strategies, polities, and building capacities. o The Network advocates for the eradication of all forms of FGM/FGC. o Media activities include radio programs, specialized pages/articles in newspapers. o Celebration of 6 Feb. International Day of Zero Tolerance of Female Genital Mutilation, 16-day event on FGM, March on FGM etc. o Capacity-building activities: technical issues, training for media personnel, member NGOs, doctors, etc. o Campaigned two years ago to stop a law promoting FGM.

Sudanese Red Crescent (SRC)	
Date and Location of Meeting	15 March 2006 SRC Clinic, Omdurman IDP Camp
Contact Person	Medical Assistant
Email Address	
Focus Activities	Primary health care, ante-natal care
What, Where	o Ante-natal clinic is open 3 days a week o General out-patient care (50 dinars/visit plus meds) o Distributes condoms, pills, and injections o STI testing for pregnant women is done but not HIV (even this is questionable, given the capacity). HIV testing is done at a lab, but according to the Medical assistant, there is no counseling. These services are not free o There is one Medical Assistant and one laboratory technician that come everyday. The midwife and immunization person come in three times a week (Saturday, Monday, Thursday). On days that they are not at the center, they conduct home visits.

Sudan National AIDS Program (SNAP)	
Date and Location of Meeting	22 March 2006 SNAP Office
Contact Person	Mohammed Siddieg
Email Address	mohsnap@yahoo.com
Focus Activities	HIV/AIDS policy, advocacy, awareness-raising
What, Where	o Care, management and treatment of STIs (treatment based on symptoms, not lab tests) o 3 CD4s—Juba, Wau, and Omdurman for starting treatment and follow-up every 6 months o Coordination with religious leaders o Curriculum development with MOH on HIV/AIDS—to move beyond the "fear approach" o VCT centers in each state (19 in KRT) o Peer education o Counseling and testing o Awareness raising: distribute materials in neighborhoods, at sport clubs, student camps, etc. Show videotapes in waiting rooms of clinics and hospitals. Distribute materials to health counselors, medical personnel, NGOs o Focus group discussions o Promote condom distribution o Support and train midwives, teach them how to use sterile equipment, how to avoid mother to child transmission, etc. o SNAP will play a major part in the formulation and implementation of the HIV/DDR strategy o Working with government to put HIV/AIDS on the school curriculum to make more comprehensive

Sudan National Committee on Harmful Traditional Practices (SNCTP)	
Date and Location of Meeting	21 March 2006 SNCTP
Contact Person	Amna Abdel Rahman Hassan, Executive Secretary
Email Address	snctpiac5@hotmail.com
Focus Activities	Addressing FGM
What, Where	o 15 branches in 15 states of Sudan. o SNCTP advocates for "zero tolerance of FGM". It also advocates for the abolition of early and forced marriages, tribal face marks (men), among other traditional practices. o Work to include FGM in community-based organizing; addresses general hygiene and other reproductive health issues, which have increased # of people coming to clinics for antenatal care. o Makes home visits to examine girls to see whether they have been circumcised. o Has worked for 10 years to sensitize school directors on FGM. UNFPA and UNICEF have since come on board to incorporate training into school curricula. o Conducts training to women at all levels.

UNICEF	
Date and Location of Meeting	16 and 23 March 2006 UNICEF
Contact Person	Haydar Nasser, Health Coordinator for Darfur Dr. Emmanuel Ija Baya, Project Officer, Health
Email Address	hnassar@unicef.org, ebaya@unicef.org
Focus Activities	Primary health care, immunization, emergency response.
What, Where	o Main office in Khartoum, with related sub-offices. Darfur falls under northern activities. o Prior to the peace agreement, UNICEF (north) was supporting activities in Malakal, Wau and Juba. The UNICEF office in the South has still not built up its capacities to take over the activities for the South. o For the neglected areas (South Kordofan, South Blue Nile, Red Sea, Gedaref, Kassala), the programming will take into account its emergency status- i.e. will be regular programming but focused considering their emergency conditions. o Conducted rapid assessment on EmOC in Northern states as well as in the garrison towns. Results indicated poor condition of obstetric care. Lack of good EmOC facilities. o Is currently funding program training village midwives and doctors in EmOC as well training health visitors. The training is conducted for 12 months using the curriculum set by the RH directorate of the MoH. Currently 1069 midwives are being trained at the midwifery schools. Out of this number, 267 midwives are being funded by UNICEF o 30 communities in Kassala state are provided with solar powered radios funded by UNICEF, which disseminate info on health, hygiene, education etc. This activity is under the information, communication and advocacy section of UNICEF. The health-related messages focus on the problems of delay in seeking health care, hygiene, and pregnancy related anemia.

UNIFEM	
Date and Location of Meeting	16 March 06 UNFPA-Sudan office, Khartoum
Contact Person	Dr. Ruth Kibiti, Programme Officer
Email Address	ruth.kibiti@undp.org
Focus Activities	Women's Issues, UN Security Council Resolution 1325 on Women, Peace and Security
What, Where	o Operates in Darfur, Nuba Mountains (3 projects); UNIFEM is negotiating to work with an indigenous organization in the Kurmouk area. o Gender and HIV awareness workshops around the Gedaref area in Eastern Sudan. o UNFEM works to realize Security Council Resolution 1325. Supports women in taking part in peace negotiations and peacebuilding activities; gender balance; GBV including domestic violence, FGM, honor killings, early marriages, forced marriages; governance

	programs: women governmental forum; exchange between East African parliaments o UNIFEM is concentrating on the peace-building processes in Abuja in Darfur and in Eastern Sudan o Also creating awareness for HR issues in Darfur. o The Violence Against Women Trust Fund mandated by UNIFEM looks at GBV, particularly at sexual violence in communities, wife inheritance, etc. o Assistance to Government: works with the Ministry of Welfare, Women and Child Affairs; technical assistance to General Directorate for women so that the government can engage positively on women's issues; facilitating IGAD to run a national women's conference to form a national NGO.

UNMIS	
Date and Location of Meeting	21 March 06 UNMIS, Khartoum
Contact Person	Amina Adam, Senior Gender Advisor, Chief of Gender Unit
Email Address	adama@un.org
Focus Activities	UN Security Council Resolution 1325
What, Where	o Works in Kassala, Kadubli, Juba, Marakal, Wau, Edamazir, Afasher, Khartoum, etc. o Builds the capacity of and provides technical assistance to the gender focal points in the Sudanese government on federal, state and local levels o The Gender Unit conducts training for military contingents on conduct, culture, expectations, gender awareness, and HIV/AIDS in Darfur and Juba. It will soon go to Abeyei to conduct HIV/AIDS training. o Provides capacity building for the police so that they understand the issue of GBV. In South Sudan, the police have established Women and Juvenile Centers within their system. o There are state committees on GBV (Walli's Commission) in Nyala in the south of Darfur. The Unit works with them and trains them. o The Unit works with the Ministry of Justice and Ministry of Social Welfare, and attempts to work with the other ministers (including the Director of Women, Child, and Family).

World Health Organization (WHO)	
Date and Location of Meeting	19 March 06 WHO, Khartoum
Contact Person	Dr. Stefania Pace-Shanklin, Emergency and Humanitarian Coordinator Dr. Ahmed El Ganiny, Darfur Program Coordinator
Email Address	paces@sud.emro.who.int; elganinya@sud.emro.who.int
Focus Activities	General health, information management, communicable diseases
What, Where	o Provides technical assistance to international, national and local implementing agencies o Building capacity of health intervention coordination o Emergency program in Darfur

	o Target populations: IDPs and conflict-affected populations; i.e. vulnerable populations

B – Southern Sudan

African Medical and Research Foundation (AMREF)	
Date and Location of Meeting	16 March 2006 UNFPA Juba office
Contact Person	Margaret Itto, Sudan Program Advisor
Email Address	MargaretI@amrefhq.org
Focus Activities	Training/capacity building, advocacy, and research to address the high maternal mortality rate Health personnel training: community midwifes, clinical officers, CHWs, Maternal and child health workers, nurses, lab technicians
What, Where	o Conducted Midwifery Training Needs Assessment o Maridi: Health training Center – trains 80 clinical officers each year o Community Midwife training: curriculum development

Center for Disease Control (CDC)	
Date and Location of Meeting	20 March 06 USAID compound
Contact Person	Tom Booh
Email Address	
Focus Activities	HIV/AIDS coordination, PMTCT and sentinel surveillance
What, Where	o Trained people in 11 antenatal sites, 4 of which are UNICEF sites (Yei, Maridi, Rumbek, Aveyo West) o Setting up sites for antenatal data collection. Collection has been limited so far with only 400 samples collected. o Providing funding to partners such as Save the Children and Intrahealth to do community-based prevention education, capacity building and training in VCT and to provide basic services like clean water to PLWHA when ARVs are not available.

John Snow International (JSI)	
Date and Location of Meeting	20 March 06 UNFPA offices
Contact Person	Elizabeth Ojaba
Email Address	
Focus Activities	Supports the MoH providing primary health care services
What, Where	o Currently implementing programs in 6 counties. o Capacity building with the ministry o JSI is looking at antenatal care attendance and vaccinations. o Although RH is not an overall focus, though they are funding Save the Children to train community midwives next year. o Have conducted trainings for HIV surveillance o Also have training for safe motherhood data collection and conducted a recent training for the SPLA on HIV and GBV

HelpAge International	
Date and Location of Meeting	20 March 06 HelpAge Offices
Contact Person	Michael Wani Max, Deputy Program Coordinator
Email Address	
Focus Activities	Programs include HIV programs, provision of non-food items, family tracing and reunification, and conflict resolution programming
What, Where	o HelpAge works in 12 clusters in 65 villages outside Juba and works in 4 states in Southern Sudan – Lakes State, Jonglei, Equatoria and Bahr El Ghazal o Sent elderly community women for TBA training. o Awareness-raising activities for HIV/AIDS including community drama, singing, and radio shows. o Support PLWHA caregivers including helping with housing renovations, medications, income-generating projects and training caregivers to help with the awareness raising. o Utilize older people in the community to address sensitive topics like condom use.

International Committee of the Red Cross (ICRC)	
Date and Location of Meeting	21 March 2006
Contact Person	Maureen, Head Nurse
Email Address	
Focus Activities	Health care, tracing
What, Where	o War/ trauma surgery o Tracing o Support of nursing school – renovation, training, and curriculum o Provision of food, clean water and medical supplies to Juba Teaching Hospital o Support to Sudanese Red Cross Society

Juba Association of People Living with HIV/AIDS	
Date and Location of Meeting	20 March 2006 UNFPA Juba Office
Contact Person	Lola Laila Lole, Chairman
Email Address	
Focus Activities	Support for PLWHA HIV/AIDS Awareness Program Education program for orphans and vulnerable children (OVC)
What, Where	o Conduct HIV/AIDS awareness activities in markets, streets o Holds monthly meetings for PLWHA (~125 members) o Distributes WFP supplemental food rations to OVC and PLWHA o Pays school fees for OVC o Partners with ACCORD, SCC, HelpAge International, SSOPO, Seventh Day Adventists o Funded by UNAIDS

Save the Children, UK	
Date and Location of Meeting	March 2006 UNFPA Juba office
Contact Person	Rosmarie-Connie, Program Manager for South Sudan
Email Address	
Focus Activities	Child protection, education, food security and livelihoods and health (water, san, and hygiene).
What, Where	o Working in 5 States and 10 counties in Upper Nile and Bahr El Ghazal. Under education doing school construction, providing supplies, teacher training, looking at girl child education. o Looking at protection issues where girls afraid to walk to school. o Also addressing protection concerns by putting water in community - girls do not have to travel long distances. o Raising awareness about early marriage. o Training more female teachers to be role models. o HIV education is mainstreamed into the current curriculum.

Southern Sudan Relief and Rehabilitation Commission (SSRRC)	
Date and Location of Meeting	17 March 2006
Contact Person	Stans Yatta, Director, Central Equatoria State
Email Address	
Focus Activities	GoSS coordinating body for relief and development activities
What, Where	o 10 state offices coordinate local relief and development activities o Working closely with UNHCR to coordinate returns o Developing registration/ monitoring processes for NGOs

UNDP	
Date and Location of Meeting	21 March 2006 UNDP Juba offices
Contact Person	Madelena Monoja, National Program Officer for HIV/AIDS
Email Address	
Focus Activities	HIV Mainstreaming, Capacity-building of New Sudan National AIDS Council
What, Where	o Supporting 10 state level AIDS Councils (offices, salaries) in order to help decentralization of HIV/AIDS activities from central to the state, county, and payam levels. o Leadership training has begun with 100 people – Equatoria, Upper Nile, Bahr al Ghazal o The New Sudan National AIDS Council was founded in 2002 but has had limited capacity. Only 5 county level councils existed when UNDP's activities began in October 2005.

UNHCR	
Date and Location of Meeting	21 March 2006 UNHCR Juba Sub-office
Contact Person	Ann Encontre, Head of Juba Sub-office
Email Address	
Focus Activities	Community-based Reintegration Projects targeting returnees and their communities
What, Where	o Programs in Yei, Tambora aim to even out balance between communities that are receiving returnees and those that are not by providing services and non-food items to communities rather than individuals. o Current partners include the Sudanese Red Crescent, Windle Trust, SSRRC, and local chiefs o Providing health services through mobile clinics and existing primary health care centers o 20 boreholes built

UNICEF	
Date and Location of Meeting	17 March 2006
Contact Person	Romanus Mkerenga, Chief, Health and Nutrition, Southern Sudan
Email Address	
Focus Activities	Child health – immunization Nutrition Adolescent and Maternal health
What, Where	o Working in 7 Zones in the south (15% of the country) o Support to health facilities NGOs – equipment, training o Direct implementation (i.e. immunization) o TBA training

UNMIS Police	
Date and Location of Meeting	20 March 2006 UNFPA Juba office
Contact Person	Florence Arthur, Trainer
Email Address	
Focus Activities	Training of UNMIS police in Rule of Law, Human Rights and Gender Based Violence.
What, Where	o UNMIS Police's target is to train all 10,000 local police personnel in the coming months on issues of domestic violence, gender based violence, HIV/AIDS, child protection, human rights and rule of law. o They also want to set up special units on SGBV for women and children in the local police stations. As of now, everyone is kept in one room (boys, men, women and girls). There is no separate space for women and their children.

C – Eastern Sudan

Ministry of Health, Council for Child Welfare	
Date and Location of Meeting	21 March 06 UNDP Guesthouse, Kassala
Contact Person	Buthina
Email Address	
Focus Activities	Child welfare, awareness raising on HIV/AIDS
What, Where	o Adoption program run out of Kassala Hospital for unwanted babies o Awareness-raising activities in secondary schools on HIV/AIDS prevention in closed workshops (20-30 students, gender segregated). o Awareness-raising with community leaders and religious leaders, who then disseminate messages about HIV in the community and at the mosques.

GOAL	
Date and Location of Meeting	20 March 06 GOAL, Kassala
Contact Person	Brid Corr, Area Coordinator for Eastern Sudan
Email Address	bcorr@goalsudan.com
Focus Activities	Primary health care, HIV/AIDS awareness
What, Where	o 6 clinics and 6 outreach programs in Kassala-area spanning 100 km. The clinics will be handed over soon to the MoH, and GOAL will then coordinate from Khartoum. o Clinic services include: antenatal care, postnatal care, family planning-injections, oral birth control pills, and condoms. o One midwife in each clinic responsible for 4-5 TBAs that work in the community providing ante and postnatal care. o Provides an annual refresher course to TBAs, and restocks their clean delivery kits. Once the handover of the health facilities occur, GOAL will no longer restock the health kits.

	o HIV/AIDS awareness raising through peer education. Peer educators are trained about HIV and then disseminate information to the community. They recently completed a program in one community with 6 girls between 15-20 years old, mostly girl students. Weekly meetings are held with the educators for reporting and follow-up on activities. Another program will start in Kadugli IDP camp in March with 13 females. o Health promotion activities through community based organization. o Child to child education focusing on EPI and environmental health primarily hygiene o Participatory health promoter (PHP)- train health promoters with health messages identified by the GOAL office and which are disseminated among the local population.

Sudanese Red Crescent (SRC)	
Date and Location of Meeting	20 March 06 SRC, Kassala
Contact Person	Taha Hussein Ahmad, Youth Programme Officer
Email Address	Adaroob_src@yahoo.co.uk
Focus Activities	Primary health care (including RH), relief/emergency response, income generation
What, Where	o Refugee camp activities: Wad Sharife-- 1 hospital, 3 clinics; Abuda-- 1 hospital. RH activities: pregnancy delivery, family planning commodities (pills, condoms, etc), awareness lectures about advantages of family planning, HIV awareness and stigma reduction, training for TBAs o IDP community activities: 7 clinics for PHC (includes MCH). RH (and other health) activities: training for TBAs, examinations, drugs, supplementary feeding, family planning, ORT, home visiting, TBA advisors (in the clinic) o In 2005, 3 peer educator trainings on RH concentrating on HIV/AIDS attended by 50-60 youth volunteers ages 17-24 years old. o Clinic inside Kassala: Marabat clinic—have surgeries, obstetric care. Other clinics: Barat clinic and 1 clinic in Halfa o Involve youth in home visits to raise awareness—going door to door to talk about HIV/AIDS o Awareness-raising on health: every week people gather in the 3 clinics in refugee camps (~60-70 women) for a lecture and video on topics including FGM, HIV, Family Planning, Diarrhea, Malaria, etc. o Home visitors speak to families about FGM and other issues in IDP and refugee camps. o Tracing services (with ICRC): sending messages and receiving, tracing individuals o Training of volunteers on first aid, primary health care, HIV/AIDS, development activities (income generation including handicrafts, construction mechanisms, metal smiths o Mine action/risk education since 1999 o Food security: targeting drought effectiveness, giving emergency food and goats to most vulnerable o Watsan- teaching people sanitation methods o 45,000 volunteers trained, 10,000 active volunteers

UNHCR Showak	
Date and Location of Meeting	19 March 2006 UNHCR Showak
Contact Person	Fatima Sherif-Nor, Head of Sub-office
Email Address	sherif@unhcr.org
Focus Activities	Refugee relief
What, Where	o Provide funding to the main health facilities in the refugee camps o Capacity Building of medical staff on STIs, HIV/AIDS. Three types of training were conducted in 2004. Medical staffs were trained on syndromic training on HIV/AIDS. MoH was the facilitating partner. o Strengthening health information systems o Training of 24 midwives who were recruited from among the refugees. o Awareness-raising in the community on issues of GBV (primarily FGM), and HIV/AIDS. Peer educators from the refugee community (between the ages of 17-30) carry out awareness raising sessions at the local schools, mosques, and camp clinic.

UNOCHA	
Date and Location of Meeting	20 March 06 OCHA, Kassala
Contact Person	Elisa Cavacece
Email Address	cavacece@un.org
Focus Activities	Coordination
What, Where	o Coordination; no direct programming implementation or funding of programmes. o Information provision o Regular involvement in the interagency coordination meetings as well as sectoral meetings o Organize health coordination meetings involving HAC, UN agencies, local and international NGOs. o Ensure proper distribution of funding o Work in partnership with ACCORD (training) and WFP (food for training).

ANNEX III — Site visits

A – Northern Sudan

Abdo Fistula Center	
Date and Location of Meeting	23 March 06 Dr. Abbo's Center for Fistula and Urogynaecology Khartoum
Contact Person	Dr. A/Rahman A. Eltayeb, Director Dr. Ali G. Mohammed, Physician
Email Address	
Focus Activities	Fistula Repair
What, Where	o Conducts fistula repair surgery to women from all of Sudan o Offers comprehensive services through use of psychologists and social workers o Trains junior doctors, and specialized doctors in fistula repair o Three new operating tables and additional beds have been added to the center; facility expansion expected to increase the 6 operations/week pace.

El Salaam IDP Camp	
Date and Location of Meeting	15 March 06 El Salaam IDP Camp Omdurman
Contact Person	Organizations visited: Medair, Global Health Foundation (DAAWA), Red Crescent
Email Address	
Focus Activities	Primary health care and reproductive health care
What, Where	o Population served: IDP camp and surrounding area o IDPs from Southern Sudan o Met with beneficiaries of Medair clinic, Red Crescent clinic o Interviews with clinic workers

Khartoum North Midwifery School	
Date and Location of Meeting	23 March 06 Khartoum North Midwifery School
Contact Person	Director, Trainers, Federal Ministry of Health Officials
Email Address	
Focus Activities	Midwifery training
What, Where	o Trains village midwives and assistant health visitors in midwifery skills o Observed demonstration of mock birth by student o Graduates over 150 students per year

Omdurman Hospital: VCT Center; Emergency Room	
Date and Location of Meeting	23 March 06 Omdurman Hospital Omdurman, Sudan
Contact Person	VCT Center Staff
Email Address	
Focus Activities	HIV/AIDS testing; emergency care
What, Where	o Provides VCT services to referred patients and others o Provides ARVs to 250 patients o Tour of VCT center and emergency rooms o -Most testing done for referred cases; voluntary testing is minimal. o In 2005, 29 cases were seen for AIDS. o ARVs provided by the Global Fund. o Does not offer PMTCT since there is no obstetrics department. Another hospital does, but there is a problem with drug sustainability.

B – Southern Sudan

Juba Police Hospital	
Date and Location of Meeting	18 March 06 Police Hospital, Juba
Contact Person	Dr. John and hospital midwives and medical assistants
Email Address	
Focus Activities	Primary health care
What, Where	o There is only one doctor in this facility and he is a gynecologist. There is limited manpower and all surgeries are referred to Juba Teaching Hospital. o They test for syphilis, but for HIV testing, they refer people to Juba VCT Clinic. o Provide limited pre-natal and antenatal care. o Can perform normal deliveries, but for complications, they send to other hospitals. o They do not provide any family planning methods.

Juba Teaching Hospital	
Date and Location of Meeting	20 March 2006 Juba Teaching Hospital
Contact Person	Dr. Hassan Jamal, Dr. Samuel Salyi, Dr. Wahab Sa'ad
Email Address	
Focus Activities	In-patient and outpatient care
What, Where	o Provide emergency obstetric care, c-sections, normal deliveries, hysterectomies, removal of cysts, etc. o Test for syphilis and HIV if suspected case (no routine testing). o Refer patients to reference lab for VCT services. o Provides contraceptives – 2 types of pills, condoms, and depo injections. Pills are most popular and fees are low compared with pharmacy prices. Stock comes from the Sudan Council of Family

	Planning and there have been no reported supply shortages.

Juba VCT Centre	
Date and Location of Meeting	20 March 2006 Juba VCT Centre
Contact Person	Benjamin Lokio Lemi, VCT Counselor Adelinda Drasa David, Lab technician. Counselor
Email Address	
Focus Activities	Voluntary counseling and testing for HIV, Anti-retroviral treatment for AIDS, HIV Awareness raising activities
What, Where	o 6 Counselors and 2 technicians provide VCT services to Juba and surrounding communities since 2000. Testing done on-site since April 2004 o Providing ART to X people since February 2006 o Awareness raising sessions at schools, ANC centers, churches and in the community since 1999 o Condoms provided o 45 "at-large" counselors follow up ART patients in their communities

ANNEX IV — Research Instruments

UNFPA/CU Sudan Initiative

Focus Group Discussion Guide for Adolescents[75]

Date:	Location:
Facilitator (note gender):	Translator (note gender):
Number of Participants:	Gender of participants:
Age range of participants;	Place of origin of participants:

INTRODUCTION:

INTRODUCE YOURSELF AND THE MODERATORS

(To be read to participants): *We are interested in learning about some of the health needs and services for adolescents and youth in your community. I would like your permission to ask you some questions about health care and issues related to health. Your participation is voluntary. You do not have to participate and you are not required to answer any questions. We will discuss some topics that are sensitive or that may be difficult to talk about but we will not record your names. We ask that you respect the privacy of other members of the group and do not share what other people say after you leave today. The information will help us to learn more about the health and wellbeing of young people in your community but it may not necessarily result in new programs being started in your community. I expect our conversation to last between one and a half and two hours. I will ask questions and we will discuss your responses. There are no right or wrong answers and it is okay if some of you disagree. Does everyone agree to participate?*

ASK ALL PARTICIPANTS TO INTRODUCE THEMSELVES TO EACH OTHER SO THAT EVERYONE FEELS COMFORTABLE. ASK THEM TO SHARE THEIR FIRST NAME, AGE, WHERE THEY ARE FROM, AND HOW LONG THEY HAVE LIVED IN THE AREA.

- **DAILY ACTIVITIES**

I will start off by asking you some questions about your daily activities.

1. Do you go to school?

[75] This guide is modeled on the Focus Group Discussion Guide for Adolescents/ Youth in the Reproductive Health Response in Conflict Consortium's Monitoring and Evaluation Toolkit (2005).

2. What are some of the reasons that boys/ girls would not go to school or would stop going to school?

3. What activities are available to boys or girls?
   Probe: What are the kinds of things you do in your free time?
   Probe: Are you a member of a youth group?

- **GENERAL WELLBEING**

4. What are the main problems that young people in your community are facing?

- **HEALTH SERVICES**

Now I would like to ask you about health services in your community.

5. Where in your community are health services available?
   Probe: Are there any other places in the community?

6. Are they provided free?
   Probe: Do you think the cost prevents young people in your community from using these services?

7. Have you used any of these services?
   Probe: Did you think the services provided were of good quality?
   Probe: Who are the health providers?
   Probe: How did you feel about the health providers?

Now I am going to ask you some questions about relationships.

- **RELATIONSHIPS**

8. Can you tell me about friendships between boys and girls in your community?
   Probe: How about relationships?

9. At what age do people usually marry?
   Probe: Has this changed for people who have been displaced from their homes?

10. Do girls and boys in your community usually wait until after marriage to have sex?
    Probe: Has this changed for girls/ boys who have been displaced from their homes?

11. At what age do people usually start having sex?
    Probe: Has this changed for boys or girls who have been displaced from their homes?
    Probe: How are sexual relationships before marriage viewed by the family and the community?

12. What happens if a girl is not married but she gets pregnant?

HEALTH AND SEXUALITY
Now I am going to ask you some questions about health and sexuality.

13. If you had a health problem, what would you do first?
    Probe: Who else would you see?

14. What if the problem concerned sex or pregnancy?
    Probe: What would you do first?
    Probe: Who would you talk to about it?

15. From who did you first learn about sex?
    Probe: Did you learn about sexuality in school?

16. Do you know of girls/ boys who have sex for money, protection or food?
    Probe: With whom do they have sex?
    Probe: What do you think of this kind of situation?

17. In some communities men have sex with men. Are there boys who have sex with boys in your community?
    Probe: What do you think about this?

18. If a girl/ boy is having sex and does not want the girl to become pregnant what does he/ she do?
    Probe: What are the modern ways?
    Probe: Traditional ways?

19. Sometimes girls are pregnant but they don't want to be. What do girls do when they are pregnant but do not want to be?

20. [If condoms have not yet been discussed] Do know what a condom is?

21. Where would a young person in your community go to get condoms or other contraceptives?

    Probe: Is it difficult or easy to get contraceptives?

22. Are condoms available to young people who are having sex?
    Probe: If so, from where?
    Probe: Are young people using them?

HIV/AIDS/STIs
Now I would like to get your thoughts about HI/AIDS.

23. Have you heard of AIDS?

Probe: What have you heard?

24. Tell me about all the ways a person can get AIDS.
    Probe: Are there any other ways?

25. Do you think your friends are at risk of getting AIDS?

26. What are the ways that a person can prevent AIDS?

GBV *Now I am going to ask you some questions about violence against women.*

27. Do you know of girls who were forced to have sex?
    Probe: Who forced them to have sex? (soldiers, teachers, or other in positions of authority)?

28. If a girl or boy was forced to have sex, who would s/he tell?
    Probe: Who would s/he go to for help?

- **SERVICES FOR YOUTH**

29. Are there any centers that are just for adolescents/ youth?

30. Have you ever visited a center that is specifically targeted for youth? If yes, what attracts you to the center?

31. Are there any services that you think should be made available to youth?

32. How could services or information be made appealing or attractive to youth?

CONCLUSION
Thank you so much for your ideas, we realize that these are difficult subjects to talk about. Thank you for speaking with us. You have given us some very useful information.

Do you have any questions for us about any of these issues or about what we do?
Is there anything more you would like to say?

Thanks very much.

UNFPA/CU Sudan Initiative

Focus Group Discussion Guide for Women of Childbearing Age[76]

Date:	Location:
Facilitator (note gender):	Translator (note gender):
Number of Participants:	Gender of participants:
Age range of participants;	Place of origin:

INTRODUCTION:

INTRODUCE YOURSELF AND THE MODERATORS

(To be read to participants): *We are interested in learning about some of the health needs and services for women in your community. I would like your permission to ask you some questions about health care and issues related to health. Your participation is voluntary. You do not have to participate and you are not required to answer any questions. We will discuss some topics that are sensitive or that may be difficult to talk about but we will not share your names. We ask that you respect the privacy of other members of the group and do not share what other people say after you leave today. The information will help us to learn more about the health and wellbeing of women in your community but it may not necessarily result in new programs being started in your community. I expect our conversation to last between one and a half and two hours. I will ask questions and we will discuss your answers. There are no right or wrong answers and it is okay if some of you disagree. Does everyone agree to participate?*

ASK ALL PARTICIPANTS TO INTRODUCE THEMSELVES TO EACH OTHER SO THAT EVERYONE FEELS COMFORTABLE. ASK THEM TO SHARE THEIR FIRST NAME, AGE, WHERE THEY ARE FROM, AND HOW LONG THEY HAVE LIVED IN THE AREA.

- **GENERAL WELLBEING**

1. What are the main problems that women in your community are facing?

- **HEALTH SERVICES**

Now I would like to ask you about health services in your community.

[76] This guide is modeled on the Focus Group Discussion Guide for Adolescents/ Youth in the Reproductive Health Response in Conflict Consortium's Monitoring and Evaluation Toolkit (2005).

2. Where in your community are health services available?

3. Are they provided free?
   Probe: Do you think the cost prevents women in your community from using these services?

4. Have you used any of these services?
   Probe: Did you think the services provided were of good quality?
   Probe: Who were the health providers?
   Probe: How did you feel about the health providers?

Now I am going to ask you some questions about relationships.

- **RELATIONSHIPS**

5. At what age do people usually marry?
   Probe: Has this changed for people who have been displaced from their homes?

6. Do girls and boys in your community usually wait until after marriage to have sex?
   Probe: Has this changed for girls/ boys who have been displaced from their homes?

7. At what age do people start having sex?
   Probe: Has this changed for boys or girls who have been displaced from their homes?
   Probe: How are these relationships viewed by the family and the community?

8. What happens if a girl or woman is not married but she gets pregnant?

HEALTH AND SEXUALITY

Now I am going to ask you some questions about health and sexuality.

9. If you had a health problem, what would you do first?
   Probe: Who else would you see?

10. What if the problem concerned sex or pregnancy?
   Probe: What would you do?
   Probe: Who would you talk to about it?

11. Who first told you about sex?
   Probe: Did anyone else talk to you about sex?

12. Do you know of girls/ boys / women who have sex for money, protection or food?
   Probe: With whom do they have sex?
   Probe: What do you think of this kind of situation?

13. In some communities men have sex with men. Are there men who have sex with men in your community?

Probe: What do you think about this?

14. If a woman doesn't want to get pregnant, what does she do?

Probe: What are the modern ways?
Probe: Traditional ways?

15. Sometimes women are pregnant but they don't want to be. What do women do when they are pregnant but do not want to be?

16.[SKIP if condoms have already been discussed] Do know what a condom is?

17. Where would a woman in your community go to get condoms or other contraceptives?

Probe: Is it difficult or easy to get contraceptives?
Probe: What contraceptives are available?
Probe: Are there any contraceptives that are not available?

Safe Motherhood

18. What are some of the things that can go wrong when a woman gives birth?

19. What should be done if a woman experiences one of these problems?

Probe: Who can help her? [in the community]
Probe: Where would she be taken first?

20. If a woman has a problem during childbirth, who makes the decision to seek help?

Probe: Who are the other decision-makers?
Probe: Anyone else?

21. How does she decide whether or not to go to a health facility?

Probe: Money? Transport? Gender of the doctor? Risk that woman or baby will die?
Probe: Which of these makes it more likely that you will go?
Probe: Which factors make it less likely that you will go?
Probe: Is there a place equipped to handle emergencies during childbirth? Where is it?

22. What are some reasons to go there?

23. What are some reasons ***not*** to go there?

24. Are there other health facilities in the area where you might take a woman who has a problem?

25. What are the costs involved in going to the health facility?
    Probe: How would the family obtain the money for this? What would be done if they cannot get the money?

HIV/AIDS/STIs
Now I would like to get your thoughts about HIV/AIDS.

26. Have you heard of AIDS?
    Probe: What have you heard?

27. Tell me about all the ways a person can get AIDS.

28. Do you think women in your community are at risk of getting AIDS? Why or why not?

29. What are the ways that a person can prevent AIDS?

GBV
Now I am going to ask you some questions about violence against women.

30. Do you know of women who were forced to have sex?
    Probe: Who forced them?
    Probe: (soldiers, teachers, or other in positions of authority)?

31. If a woman was forced to have sex, who would s/he tell?
    Probe: Who would s/he go to for help?

30. Are there any services in your community to help a woman who has been forced to have sex?

31. Can you tell us about those services?

Today we have talked about many women's health issues. We have also talked about health services for women.

31. How would you like to see services improved?

32. What additional services would you like to have available to you?

CONCLUSION

Thank you so much for your ideas, we realize that these are difficult subjects to talk about. Thank you for speaking with us. You have given us some very useful information.

Do you have any questions for us about any of these issues or about what we do?
Is there anything more you would like to say?

Thanks very much.

Interview Guide: General Questions for UN, Government, and NGO Staff

NOTE TO INTERVIEWER:

- POINTS IN CAPITAL LETTERS ARE INSTRUCTIONS AND FOR YOUR REFERENCE ONLY; DO NOT READ TO RESPONDENTS DURING ACTUAL INTERVIEW.
- FOR EACH QUESTION, READ UNTIL YOU REACH AN END PUNCTUATION (NORMALLY A QUESTION MARK). THEN FILL IN BLANKS OR CIRCLE APPROPRIATE NUMBER.
- IF INSTRUCTIONS SAY "ASK a" OR "SKIP TO Q2," THEN DO SO. WHEN NO INSTRUCTIONS ARE PRESENT, GO ON TO THE NEXT QUESTION.
- MENTIONED/NOT MENTIONED QUESTIONS ARE FOR RESPONDENTS TO OFFER ANSWERS. PLEASE CIRCLE NEAREST OPTION(S); OTHERWISE SPECIFY IN "OTHER".
- CIRCLE **7** (**INAP**) FOR UNANSWERABLE QUESTIONS DUE TO SKIP PATTERN.
- CIRCLE **8** (**DK**), OR "DON'T KNOW" FOR QUESTIONS THE RESPONDENT IS UNABLE TO ANSWER.
- CIRCLE **9** (**NR**), OR "NO RESPONSE" FOR QUESTIONS THE RESPONDENT FAILS TO ANSWER.
- FOR OPEN-ENDED QUESTIONS, WRITE DOWN AS MUCH AS YOU CAN.
- ONCE THE INTERVIEW IS OVER, GO THROUGH ANSWER SHEET TO FILL EMPTY SPACES AND COMPARE NOTES WITH OTHER INTERVIEWERS.

Date: Location:
Name and Title of Interviewee(s):
Name of Organization:
Name of Interviewer(s):

I. INTRODUCTION

- Who we are
- Our purpose here with UNFPA
- Purpose of our meeting with them
- How the information will be used

OR, IF YOU FEEL MORE COMFORTABLE, READ THE FOLLOWING:
[Our names are xx and xx and we are consultants from Columbia University in New York. We are here to help the United Nations Population Fund (UNFPA) understand how it can best adapt its activities to the population and reproductive health needs in Sudan. The purpose of this interview is to learn about your agency; to do this we would like to

conduct a brief interview. We would very much appreciate it if you could be honest in your response so that we can make appropriate suggestions and recommendations to UNFPA. You should feel free to skip any questions that you do not wish to answer.]

II. ORGANIZATION AND PLANNING

1) We want to start by finding out a bit more about your organization's operations here in Sudan. Can you tell us a bit about how long your organization has been operating here and where in Sudan you have offices and programs?

2) Does your organization have an overarching mission or objective for its work in Sudan?

3) Can you tell us what, if any, reproductive health activities your agency is implementing in Sudan? Can you tell us a bit about these programs and where they are operating?

Location/Activity:

Location/Activity:

Location/Activity:

(PROBE IF NOT MENTIONED: Do you offer any programs related to family planning? Safe Motherhood? Adolescent Health?)

4) How many international and national staff do you have?

National _____ (Number)
International _____ (Number)

a) How many of those staff members are clinical professionals? (i.e. doctors, nurses, midwives, TBA's)

5) What factors have influenced your program activities and locations?

PROBE: Are there any other factors that have influenced your programming?

[USE AS PROMPTS IF NECESSARY]

	Mentioned	Not Men	INAP	DK	NR
(a) Need	1 (ASK c)	2	7	8	9
(b) Funding	1 (SKIP TO d)	2	7	8	9
(c) Organizational Mandate	1 (SKIP TO d)	2	7	8	9
(d) Political Considerations	1 (SKIP TO d)	2	7	8	9

(e) Security Considerations	1 (SKIP TO d)	2	7	8	9
(f) Coordination/Partners	1 (SKIP TO d)	2	7	8	9
(g) Logistical constraints	1 (SKIP TO d)	2	7	8	9
(f) Other (Specify: _____)	1 (SKIP TO d)	2	7	8	9

6) What methods does your agency use to assess need for programming?

[USE AS PROMPTS IF NECESSARY]

	Mentioned	Not Men	INAP	DK	NR
(a) Literature Review	1	2	7	8	9
(b) Focus Group Discussions	1	2	7	8	9
(c) Interviews with target population	1	2	7	8	9
(d) Quantitative Data Collection Methods	1	2	7	8	9
(e) Discussions with key stakeholders	1	2	7	8	9
(f) Other (Specify: _____)	1	2	7	8	9

7) Who are the main target groups for your program(s)?

[USE AS PROMPTS IF NECESSARY]

	Mentioned	Not Men	INAP	DK	NR
(a) Refugees (Specify: _____)	1	2	7	8	9
(b) IDPs (Specify: _____)	1	2	7	8	9
(c) Local Population (Specify: _____)	1	2	7	8	9
(d) Men	1	2	7	8	9
(e) Women	1	2	7	8	9
(f) Armed forces	1	2	7	8	9
(g) Other (Specify: _____)	1	2	7	8	9

8) Why have you focused on these groups?

SEE ANNEXED QUESTIONS FOR EACH PROGRAMATTIC AREA. ASK ADDITIONAL QUESTIONS IF SPECIFICITY IS REQUIRED.

9) How many beneficiaries would you estimate that your different programs serve in total on average per month?

_____ (Program) _____ (Number per month)

_____ (Program) _____ (Number per month)

_____ (Program) _____ (Number per month)

10) What would you identify as the main strengths of the program(s) which you are currently operating?

PROBE: Any other strengths?

11) What would you identify as the main weaknesses or challenges of the program(s) which you are currently operating?

PROBE: Any other weaknesses or challenges?

12) Can you tell us a bit about how you monitor and evaluate your programs?

PROBE: What indicators do you measure, and how do you obtain your information?

PROBE: To whom, and in what form, do you regularly report program progress? (i.e. headquarters, donors, UN)

II. REPRODUCTIVE HEALTH

1) What do perceive to be the most important reproductive health issues in the geographical areas you serve?

2) What do you think are some of the root causes of these repro health issues?

PROBE: What are other obstacles you see that prevent meeting reproductive health needs?

3) Are there geographical areas or target groups that are particularly underserved?
PROBE: Are there specific challenges to working in these areas or with these groups?

4) How do current mechanisms for coordination affect reproductive health planning in Sudan?

III. PARTNERSHIPS

1) Do you partner with local or international organizations in planning and/or delivering your programs? (IF 'NO,' SKIP TO FUNDING AND OTHER ISSUES)

a) Which organization(s)?

_____ (Name of local partner organizations)

_____ (Name of international partner organizations)

b) Can you describe how you work with these partner agenc(y/ies)?

c) What led you to partner with (this group/these groups)?

[USE AS PROMPTS IF NECESSARY]

	Mentioned	Not Men	INAP	DK	NR
(a) Similar Operational Areas	1	2	7	8	9
(b) Funding	1	2	7	8	9
(c) Capacity	1	2	7	8	9
(d) Access to Target Population	1	2	7	8	9
(e) Prior experience with Agency	1	2	7	8	9
(f) Other (Specify: _____)	1	2	7	8	9

d) Is capacity building part of this partnership? What kind of support do you [provide to/receive from] your partners?

[USE AS PROMPTS IF NECESSARY]

	Mentioned	Not Men	INAP	DK	NR
(a) Financial	1	2	7	8	9
(b) In-kind	1	2	7	8	9
(c) Training	1	2	7	8	9
(d) Technical Assistance	1	2	7	8	9
(e) Other (Specify: _____)	1	2	7	8	9

e) What kind of support would you *like* to [receive from/provide to] your partners?

[USE AS PROMPTS IF NECESSARY]

	Mentioned	Not Men	INAP	DK	NR
(a) Financial	1	2	7	8	9
(b) In-kind	1	2	7	8	9
(c) Training	1	2	7	8	9
(d) Technical Assistance	1	2	7	8	9
(e) Other (Specify: _____)	1	2	7	8	9

IV. FUNDING AND OTHER ISSUES

1) What is your rough program budget for all of your reproductive health projects?

Overall budget:

It would be great if you could breakdown budget by program.

Program	Amount (USD)

a) What areas are most costly for your agency?

[USE AS PROMPTS IF NECESSARY]

	Mentioned	Not Men	INAP	DK	NR
(a) Staff Development	1	2	7	8	9
(b) Staff Salary	1	2	7	8	9
(c) Commodity Procurement	1	2	7	8	9
(d) Monitoring and Evaluation	1	2	7	8	9
(e) Administration	1	2	7	8	9
(f) Other (Specify: _____)	1	2	7	8	

b) If funding was increased, what would your priorities be?

[USE AS PROMPTS IF NECESSARY]

	Mentioned	Not Men	INAP	DK	NR
(a) Program Development	1	2	7	8	9
(b) Program Expansion	1	2	7	8	9
(c) Staff Development	1	2	7	8	9
(d) Staff Salary	1	2	7	8	9
(e) Organizational Restructuring	1	2	7	8	9
(f) Commodity Procurement	1	2	7	8	9
(g) Monitoring and Evaluation	1	2	7	8	9
(h) Other (Specify: _____)	1	2	7	8	9

2) What would you identify as the major challenges you have faced in starting up, delivering, and sustaining your programs? Please describe both overall and program-specific challenges.

3) What kind of strategies have you found useful in dealing with these challenges?

PROBE: What other strategies might you employ in the future?

4) What are your programming priorities for the next 12-24 months?

PROBE: Do you see your programs shifting based on projected returns of refugees and/or IDPs? If so, how?

5) Are there other program areas in RH, which you would like to enter?

Yes (ASK a) 1
No (SKIP TO NEXT Q8)

a) What areas specifically?

	Mentioned	Not Mentioned	DK	NR
(a) Safe Motherhood	1	2	8	9
(b) Family Planning	1	2	8	9
(c) Adolescent Repro Health	1	2	8	9
(d) GBV	1	2	8	9
(e) HIV/AIDS and STIs	1	2	8	9
(f) Integration of RH into PMC	1	2	8	9
(g) Other (Specify: _____)	1	2	8	9

PROBE EACH AREA MENTIONED: Can you tell us a bit more about that? What specifically would you include within that type of program?

6) Now I would like to ask you some questions about UNFPA. How do you perceive UNFPA's presence in your area of work?

7) Do you currently have a working relationship with UNFPA?

Yes (ASK a-c) 1
No (SKIP TO b)

a) In what ways are you working with UNFPA?

b) Can you think of things that UNFPA does really well?

c) Can you think of any ways that UNFPA could support your work?

8) What, if any, trends have you identified in repro health programming in Sudan?

9) Finally, what services should be prioritized for expansion?

10) Is there anything else you would like to say—either what we did not ask, or that you would like to add?

Thank you very much for your time and cooperation.

**** If reports or documents came up in the discussion, make sure to get these before leaving. If not, ask if they have any reports or documents that they think would help inform our work…**

ANNEX V — Documents Reviewed

Dr. Abbo's Centre for Fistula and Urogynaecology. *Fistula in Sudan*, 2005.

Abdallah, Manal Mohammed. *Maternal Mortality Levels and Causes in Northern Kordofan State*. Thesis submitted to Gezira University Faculty of Economics and Rural Development, Population Studies Centre, Jan. 2005.

Abu-Nuwar, Abdul Muniem, Abdelaziz Farah and Abdallah Abdelaziz Zou'bi. *Technical Assistance Report for UNFPA Country Office in Sudan.* Mid-Term Review, July 2005.

Adam, Isag et al. "Prevalence and Risk Factors for Plasmodium falciparum Malaria in Pregnant Women of Eastern Sudan." *Malaria Journal* 4, no. 18. 2005.

Adam, Suzana. Title Unknown. Thesis submitted to Afhad University for Women, 2006.

*Administrative, Geographic and Ethnic Regions.*STARBASE Statistical Tables Version 1, November 2004. Available at: http://www.unsudanig.org

African Medical and Research Foundation, Directorate of Learning Systems. *Rapid Needs Assessment for Midwifery and Reproductive Health Training in South Sudan.*

African Medical and Research Foundation. "Community Midwifery Training in South Sudan Consultation Workshop." Consultation Workshop, Nairobi, Kenya, 4-9 May 2005.

African Medical and Research Foundation. *Proposal for Development of Curriculum for Training Community Midwives in South Sudan.* Submitted to UNFPA Sudan, October 2005.

Agreement Between the Government of Sudan and SPLM on Implementation Modalities of the Protocols and Agreements. 31 December 2004.

Agreement Between the Government of Sweden and UNFPA on Support to UN Work Plan for Sudan 2005. Ref 2005-1929, Component 7400282601. 2005.

Ahfad University for Women and UNHCR. *A Survey on Female Genital Mutilation Targeting Male Population in Refugee Camps in East of Sudan.* 2006

American Refugee Committee (ARC) International - Sudan. *Final Program Report for Reducing HIV/AIDS Transmission and Improving Related Reproductive Health Practices in Yei and Rumbek Counties, Southern Sudan.* May 2005.

Angagaw, Dee Dee. *End of Assignment Report.* UNFPA South Sudan, September 2005.

Arrangement Between the Netherlands Minister for Development Co-operation and the United Nations Population Fund. 4 April 2005.

Assessment of Women Associated with the SPLA and Female Combatants in the SPLA. Southern DDR Interim Authority, UN DDR Unit and the Southern Sudan Psychosocial Programme. Southern Sudan, October 2005.

Ati, Hassan A. Abdel and Abdel Lateef Egemi. *An Analysis of Food Security Constraints and Potentials in the Red Sea and Kassala States, Eastern Sudan.*UNDP Sudan, April 2005.

Ati, Hassan A. Abdel. T*raditional Tribal Systems and Customary Law in Eastern Sudan.* UNDP Rule of Law Unit, January 2006.

"Building Health Capacity in Sudan." *CSIS Insights.* November/December 2003. Accessed online 31 January 2005. Available at: http://www.unsudanig.org/JAM/clusters/social/background-docs/CSIS_health_2003.pdf

Centre for Strategic and International Studies.Health in Post-Conflict Sudan: Building Capacity to Fight Disease. Belgium: November/December 2003.

Conroy, Colleen. Final Report: Sudan Health Transition Project (SHTP), South Sudan - Maternal Health Consultant. 2005.

Deng, Francis. *Report of the Representative of the Secretary-General on Internally Displaced Persons.* January 2003.

Eltayeb, Mohamed S.M. and Balghis Y. Badri. Reproductive Health Rights of Adolescents and Women in Sudan. Ahfad University for Women: institute for Women, Gender, and Development Studies. April 2004.

Ertürk, Yakin. "Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women--The Due Diligence Standard as a Tool for the Elimination of Violence Against Women." *Report of the Special Rapporteur on Violence Against Women, Its Causes and Consequences.* Commission on Human Rights Sixty-second session. E/CN.4/2006/61. 20 January 2006.

Federal Ministry of Health Omdurman Teaching Hospital. *Annual Report*, 2005.

Federal Ministry of Health of the Republic of Sudan. *Making Pregnancy Safer Strategy.* Khartoum: 2001.

Federal Ministry of Health of the Republic of Sudan. *National Policy on Reproductive Health.* Khartoum: 2004.

Forced Migration Review. *Sudan: Prospects for Peace.* November 2005 special issue.

Government of Sudan. *Progress Report on Sudan Household Health Survey.* March 2006.

GNU/GoSS. Framework for Sustained Peace, Development and Poverty Eradication: Progress Monitoring Note. February 2006.

*Inter-Agency Standing Committee Guidelines for Gender-Based Violence Interventions in Humanitarian Settings.*September 2005.

Inter-Agency Standing Committee Guidelines for HIV/AIDS Interventions in Emergency Settings. 2005.

International Crisis Group. "Sudan: Saving Peace in the East." *Africa Report* No.102, 5 January 2006.

International Organisation for Migration."IDP Intentions Concerning Return to Their Places of Origin: Sample Survey of Khartoum, North, East, Central Sudan and Nuba." *Report on Survey Results 1.* Khartoum: June 2005.

International Rescue Committee. *Freedom from Fear: Promoting Human Security for the Return and Reintegration of Displaced Persons.* May 2004.

International Rescue Committee. *GBV Mapping: Who Does What Where in North, South and West Darfur.* March 2006.

International Rescue Committee - Southern Sudan. 2005 Annual Report. 2006.

Jok, Jok Madut, *Militarism, Gender and Reproductive Risk: The Case of Abortion in South Sudan*, 1996.

Krause, Sandra, Rachel Jones, Susan Purdin. "Programmatic Responses to Refugees' Reproductive Health Needs." *International Family Planning Perspectives,* Vol. 26, No. 4. December 2000. pp.181-187.

Krause, Sandy. *Briefing Noted on Darfur: MISP.* Assessment, 16 September 2005.

Memorandum of Understanding Between the United Nations Office for the Coordination of Humanitarian Affairs and the United Nations Population Fund. 26 October 2005.

Memorandum of Understanding Between the United Nations Population Fund and the Secretariat of Health of the Government of South Sudan. 31 October 2005.

Ministry of Health of the Government of South Sudan and UNFPA. *Policy and Standards of Community Midwifery Training in South Sudan.* November 2005.

Mohammed, Zamzam Mukhtar. *Knowledge, Attitude and Practice of Family Planning: A Case Study in Eltebaib Village--Gezira State*. Thesis submitted to University of Gezira Faculty of Economics and Rural Development, Population Studies Center, Sept. 2005.

Narrative and Financial Report: Netherlands' Allocations for UNFPA Sudan Projects-- Integrated Reproductive Health Services for Southern Sudan and Expanding Community Midwifery Training in the Southern Sudan. Netherlands' Identification Activity Number 11767. UNFPA Sudan Country Office, Khartoum, December 2005.

*National Transitional Government of Liberia: Results Focused Transitional Framework.*United Nations and the World Bank. April 2005.

Nyabega, Maryline. Safe Motherhood Training at Awada Training Centre. January-February 2006.

New Sudan Centre for Statistics and Evaluation/ UNICEF. Towards a Baseline: Best Estimates of Social Indicators for Southern Sudan. May 2004.

OCHA. *Humanitarian Appeal 2006.* November 2005. Accessed online 31 January 2006. Available at http://ochadms.unog.ch/quickplace/cap/main.nsf/h_Index/CAP_2006_Humanitarian_Appeal/$FILE/CAP_2006_Humanitarian_Appeal_SCREEN.pdf?OpenElement

Ockenden International. *Combating HIV/AIDS in Eastern Sudan: The Case for Preventative Action.* February 2005.

Palmer, Celia. Rapid Appraisal of Needs in Reproductive Health Care in Southern Sudan: Qualitative Study. British Medical Journal vol 319, pp743-748 (1999).

Pantuliano, Sara. *Comprehensive Peace? Causes and Consequences of Underdevelopment in Eastern Sudan.* NGO Paper, September 2005.

Purdin, Susan. "Reproductive Health Strategy for Southern Sudan." Background paper for the David and Lucile Packard Foundation. Presented to Centre for African Family Studies, November 2000.

Republic of Sudan National AIDS Council. *Sudan National Strategic Plan and Sectoral Plans on HIV/AIDS 2004-2009.*

SOH/GOSS and UNFPA. *Policy and Standards of Community Midwifery Training in South Sudan.* October 2005.

SPLM Health Secretariat. *Laying the Grounds for the Recovery of the Health Sector in Post-Conflict Southern Sudan.* 2nd Draft. 17 March 2004.

SPLM Women delegates to the Sudanese Peace Talks at Naivasha on Power Sharing and the Three Areas. *A Concept Paper on Empowerment of Women for Ownership and Effective Participation in the Implementation of the Sudanese Peace Agreement.* June 2004.

Sudan National AIDS Programme and UNFPA. *HIV/AIDS Integrated Report, North Sudan, 2004-2005.* United Nations General Assembly Special Session on HIV/AIDS Indicators. February 2006.

Sudan National AIDS Programme and the New Sudan National AIDS Council. *Sudan: HIV/AIDS Integrated Report (2004-2005).* United Nations General Assembly Special Session on HIV/AIDS Indicators. February 2006.

Sudan National Reproductive Health Directorate. *Summary Plan of Action 2004-2005.* Federal Ministry of Health of the Republic of Sudan. Khartoum, 2003.

UN Office for the Coordination of Humanitarian Affairs. *Humanitarian Appeal 2006.* November 2005.

UN Office for the Coordination of Humanitarian Affairs. *Rapid Assessment to Hamesh Koreib town.* 6-7 February 2006.

UN Office for the Coordination of Humanitarian Affairs. *Sudan Humanitarian Overview* 1 no. 4, 15 November – 1 December, 2005.

UN Office of the Resident and Humanitarian Coordinator for the Sudan. *2006 Work Plan for Sudan.*

UN Office of the Resident and Humanitarian Coordinator for the Sudan. *2006 Work Plan for Sudan--Funding Overview.* Resource Tracking Service. 13 March 2006.

UN Office of the Resident and Humanitarian Coordinator for the Sudan. *2006 Work Plan for Sudan--Objective Indicators for Health and HIV/AIDS.* 13 March 2006.

UN Office of the Resident and Humanitarian Coordinator for the Sudan. *Sudan Transition & Recovery Database: Kassala State.* Version 2, 1 July 2004. Available at: http://www.unsudanig.org

UN Office of the Resident and Humanitarian Coordinator for the Sudan. *Sudan Transition & Recovery Database: Report on Red Sea State.* 22 July 2003. Available at: http://www.unsudanig.org

UNFPA and UNICEF. *The Effects of Conflict on Health and Well-being of Women and Girls in Darfur: Situational Analysis Report.* September 2005.

UNFPA Sudan Country Office. "Multi-sectoral, Multi-partnership, Multi-disciplinary Gender Based Violence Prevention and Response Program in Darfur." Draft report from the GBV Strategy Workshop, El Fasher,14-15 February 2006.

UNFPA Sudan Country Office. *2005 Annual Technical Report North Darfur.* El Fasher Sub-Office. 2005.
UNFPA Sudan Country Office. *2005 Annual Technical Report: West Darfur.* Genenina Field Office. 11 January 2006.
UNFPA Sudan Country Office. *2005 Sudan Country Office Annual Report.* RDEF Annual Report Submission. 9 February 2006.
UNFPA Sudan Country Office. *Annual Report 2005: South Darfur.* 2006.
UNFPA Sudan Country Office. *Briefing Note on Sudan.* February 2006.
UNFPA Sudan Country Office. Concept Paper on Integrated Reproductive Health Services for Southern Sudan. Sudan UN WP 05 Code: SUD-05/H18. 2005.
UNFPA Sudan Country Office. *Concept Paper on Expanding Community Midwifery Training in the Southern Sudan.* Sudan UN WP 05 Code: SUD-05/H16. 2005.
UNFPA Sudan Country Office. *Country Programme Analysis.* October 2005.
UNFPA Sudan Country Office. *Status of Funds Raised Locally in Addition to Country Office Ceiling (Regular Resources).* 29 October 2005.
UNFPA Sudan Country Office. *Trip Report on Reproductive Health Workshop in Nyala 12-15 February 2006.* March 2006.
UNFPA Sudan Country Office. *Work Plan and Budget for 2005.* 29 December 2004.
UNFPA. "Population and Reproductive Health Analysis," in *Policy and Procedures: Programme III,* June 2003.
UNFPA. *Country Population Assessment--Sudan.*
UNFPA. Population, Reproductive Health, HIV/AIDS and Gender: A Situational Analysis of South Sudan. 2006.
UNFPA. *Reduction of Maternal Mortality in Sudan.* 2003.
UNFPA. *Safe Motherhood Survey National Report.* 1999.
UNFPA. *South Kordofan/Nuba Mountains Safe Motherhood Proposal.* 17 October 2005.
UNFPA. *Sudan Annual Health Statistical Report.* 2003.
UNFPA. *Supporting the Recovery of the Southern Sudanese Health Sector.* Mapping Exercise. 18 March 2004.
UNHCR. Global Appeal 2006. 2006.
UNHCR. *Sudan Operations: Sudan/Chad Situation Update 43.* 9 January 2006.
UNICEF. "Humanitarian Action Sudan in 2006." *Humanitarian Action Report.* 2006
UNICEF. *But You Know…Darkness is a Big Thing…A Background Report on Family Attitudes and Sexual Behaviour in the Southern Sudan as a Basis for HIV/AIDS Awareness.* 2001.
UNICEF. *Southern Sudan Monthly Report.* October 2005.
UNIFEM. *Guidelines for Mainstreaming Gender in Joint Assessment Mission for Sudan*, 2005. Accessed online: 31 January 2005. Available at: http://www.unsudanig.org/JAM/clusters/cross-cutting/mainstreamingguidelines.doc
UNIFEM. *Joint Assessment Mission Report on Gender Situation and Priorities-- North Sudan.* Draft 2 of 2005. Accessed 31 January 2006. Available at: http://www.unsudanig.org/JAM/clusters/cross-cutting/gendersituation-north-sudan.doc
UNIFEM. *Report on Gender Situation and Priorities--North Sudan.* Draft. February 2005.
United Nations and the World Bank. *Joint Assessment Mission in the Sudan.* Volumes 1-3.
United Nations. *Joint Assessment Mission, Northern Sudan. Health Sector Working Paper.* October 2004.
United Nations. *Joint Assessment Mission, Southern Sudan. Health Sector Working Paper.* October 2004.
United Nations. *Joint Assessment Mission, HIV/AIDS Suggested Priorities per JAM Cluster*, 2004.
United Nations Development Programme Sudan. *Rule of Law Seminar Report: Promotion of Rule of Law in Kassala State.* November 2005.

United Nations Development Programme Sudan. *Rule of Law Seminar Report: The Role of Traditional Leaders in Promoting the Rule of Law and Sustainable Peace in Kassala State.* 13 December 2005.

United Nations Development Programme Sudan. *Traditional Tribal Systems and Customary Law in Eastern Sudan.*January 2006.

United Nations. *Joint HAC/SRRC Policy Framework for the Return of Displaced Persons in a Post-Conflict Sudan.* July 2004.

United Nations. *Joint HAC/SRRC Policy Framework for the Return of Displaced Persons in a Post-Conflict Sudan: Support for Spontaneous Returns 1--5/2006 Operational Plan.* Version 2, 27 February 2006.

USAID. *Health Assessment 2003: South Sudan.* 2003.

USAID/REDSO/ESA. *Gender Assessment Sudan ISP: 2003-2005.* March 2003.

Wahab, Saad Abdel. Treatment of Infertility Caused of Tubal Occlusion by Hydrotubation Technique. Juba Teaching Hospital and Integrated Reproductive Health Center. 2005.

Wahab, Saad Abdel. Treatment of Infertility Caused of Tubal Occlusion by Hydrotubation Technique. Juba Teaching Hospital and Integrated Reproductive Health Center. 2005.Ward, Jeanne. *Report of a Preliminary Assessment of Gender-Based Violence in Rumbek, Aweils (East and West), and Rashad County, Nuba Mountains.* International Rescue Committee, funded by USAID and USDA, March 2005.

Women's Commission. *Only Through Peace: Hope for Breaking the Cycle of Famine and War in Sudan.* 1999.

World Health Organization. *Consolidated Appeal 2006: Sudan.*2006.

World Health Organization. *HIV/AIDS Treatment Scale-Up Plan for the Republic of Sudan 2005-2009.* August 2005 draft.

World Health Organization. *Summary Country Profile for HIV/AIDS Treatment Scale-Up--Sudan.* 2005.

WHO/UNAIDS. AIDS Epidemic Update: December 2005.

WHO/UNAIDS. Epidemiologic Fact Sheets on HIV/AIDS: Sudan. 2004.

WHO/UNFPA/UNHCR. Reproductive Health in Refugee Situations: An inter-agency field manual. Geneva: UNHCR, 1999.

World Vision International. *A Study of Customary Law in Contemporary Southern Sudan.* March 2004.