

# Republic of South Sudan Country Operational Plan (COP) 2022

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## Strategic Direction Summary

May 20, 2022



## Abbreviations

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AGYW	Adolescent Girls and Young Women
ANC	Antenatal Clinic
APR	Annual Program Results
ART	Antiretroviral Therapy/Treatment
ARV	Antiretroviral
CALHIV	Children and Adolescents Living with HIV
CHW	Community Health Worker
COP	Country Operational Plan
CSOs	Civil Society Organizations
DHIS	District Health Management and Information System
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe partnership
DTG	Dolutegravir
EAC	Enhanced Adherence Counseling
ECHO	Extension for Community Healthcare Outcomes
EID	Early Infant Diagnosis
FSN	Foreign Service National
FSW	Female Sex Worker
FY	Fiscal Year
GBV	Gender-Based Violence
GF	Global Fund
GoSS	Government of South Sudan
HEI	HIV-Exposed Infant
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HPF	Health Pool Fund
HQ	Headquarters
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IDP	Internally Displaced Person
IPV	Intimate Partner Violence
KP	Key Population
IIT	Interruption in Treatment
MBC	Mother-Baby Care
MCH	Maternal and Child Health
MMD	Multi-Month Dispensing
MOH	Ministry of Health
MSM	Men who have sex with Men

NAE	Notifiable Adverse Event
NPHL	National Public Health Laboratory
OGAC	Office of Global AIDS Coordinator
OPD	Outpatient Department
OU	Operating Unit
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling
PLHIV	People living with HIV/AIDS
PLL	Planning Level Letter
PMTCT	Prevention of Mother-to-Child Transmission
PP	Priority Population
PrEP	Pre-Exposure Prophylaxis
QA	Quality Assurance
QI	Quality Improvement
RSS	Republic of South Sudan
SAPR	Semi-Annual Program Results
SI	Strategic Information
SID	Sustainability Index Dashboard
SNU	Sub-National Unit
TA	Technical Assistance
TB	Tuberculosis
TBAs	Trained Birth Attendants
TLD	Tenofovir Disoproxil Fumarate, Lamivudine and Dolutegravir
TWG	Technical Working Group
UNDP	United Nations Development Program
VL	Viral Load
VMMC	Voluntary Male Medical Circumcision
TPT	Tuberculosis Preventive Therapy
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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## 1.0 Goal Statement

The South Sudan PEPFAR program works in collaboration with the Ministry of Health, the Global Fund (GF), and other stakeholders including Civil Society Organizations (CSOs), to effectively and efficiently improve access to quality HIV prevention, care and treatment services in South Sudan. The Country Operational Plan 2022 (COP22) goals are to contribute to increased national ART coverage through improving the quality of HIV care and treatment services and retaining clients on life-long antiretroviral treatment (ART) for durable viral load (VL) suppression by the following activities:

1. Implementing a strategic mix of person-centered HTS to close 1st 95 gaps across subpopulations.
2. Improving on data systems at the national level, including strengthening DHIS2 and other systems to ensure appropriate testing, tracking and linkage to treatment and other services
3. Increased CSOs and CVOs engagement to appropriately tract and return clients to treatment using local best practices from other facilities and partners.
4. Improving diagnostics for VL, EID and TB by creating more demand for testing, conducting diagnostic network optimization and accelerating multiplex use of POC platforms for EID and VL among infants, children, and pregnant and breastfeeding women.

In fiscal year 2023 (FY 23) as part of COP22, this will be achieved through: aggressively scaling-up targeted approaches towards high volume and high yield testing, especially index testing and testing TB/TB presumptive cases; reaching under-reached groups such as men and youth; prioritizing and scaling-up work with key populations; innovative and data-driven efforts to monitor site level performance and track and retain patients on ART, including maintaining high coverage of six-month multi-month dispensing (MMD) achieved in COP-19 through COP-21.

Continued scale-up of VL coverage and improvement in VL suppression rates across populations; identification of children and adolescents living with HIV (C/ALHIV) for linkage to the orphan and vulnerable children (OVC) program to support ART adherence, retention and VL suppression, assessment of HIV exposed infants (HEI) for OVC program eligibility and support, and increasing by 75% identifying and assessing adolescent girls for Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) services; strengthened community engagement to improve client treatment literacy, retention, VL suppression and community-led monitoring as well as strengthened coordination and collaboration with stakeholders. Improvements in programmatic efficiency will continue to be made in FY23 through the consolidation of select implementing mechanisms.

Achieving sustained treatment growth with clients on uninterrupted lifelong ART will be one of the biggest priorities for PEPFAR South Sudan in COP-22. Specific targeted approaches are proposed to achieve this and other priorities.

Through these efforts, PEPFAR will assist the Republic of South Sudan (RSS) to move towards epidemic control, with the goal of 15,085 new HIV patients on ART and 64,724 total patients on ART by the end of FY 23 in twenty-three PEPFAR-supported counties and the military.

In COP22, PEPFAR will maintain support in the ten scale-up aggressive counties supported in COP21. These counties include Juba, Magwi, Yambio, Nzara, Ezo, Tambura, Rumbek Center, Yirol West, Yei and Wau. Based on 2022 Spectrum estimates and projection, 36% of all estimated people living with HIV (PLHIV) in South Sudan reside in these counties. Focusing resources on these scale-up aggressive SNUs with an estimated 64,978 PLHIV will result in 51,917 PLHIV on ART in these counties, translating to an average of 80% ART coverage by the end of FY23 in these counties. PEPFAR will support an additional 9,134 people on ART in sixteen sustained counties to reach the COP22 target of 64,724 PLHIV on treatment. This will represent significant progress in a country where only 27% of all PLHIV nationwide were on treatment in FY22. Efforts to improve adherence and retention will be undertaken with the goal of 95% of those on treatment virally suppressed by the end of FY 22.

South Sudan started using VL for treatment monitoring in FY17, with a continued increase in the number of facilities collecting samples for VL monitoring. Between FY21 and FY22 Q1, the number of PEPFAR supported facilities using VL for treatment monitoring increased from 69 to 80 out of the 86 PEPFAR supported ART facilities. VL coverage increased from 60% in FY21 Q4 to 66% in FY22Q1 while VL suppression stands at 86%. In COP22, South Sudan will aggressively focus efforts to improve both VL coverage and VL suppression to 70% and 90% respectively. The proposed strategies to improve VL suppression and VL coverage include enhancing demand creation and client literacy, use of electronic eligibility assessment tool, improving client tracing and community sample collection, integrating drug refill with sample collection, establishing multiple sample collection points, prioritizing pregnant and breastfeeding women, children and non-suppressed VL clients for near-point of care testing, creating children and adolescent friendly services, transitioning all children to pediatric DTG, ensuring all eligible patients are maintained on TLD, ensuring sufficient supply of ART at facilities through Last mile delivery, providing clients with six months of drugs; enhancing community drug refill activities; tracking patients for enhanced adherence counseling (EAC) and repeat VL testing; mentorship of clinic staff on EAC and non-suppressed client management; and data utilization for site level quality improvement (QI) activities.

PEPFAR will continue to support Key and Priority Populations in six counties. The implementing partner will collaborate and train local actors to consolidate and strengthen these services. Both the OVC and DREAMS programs will continue to support beneficiaries in one county. Support for OVCs in Juba County will continue to prioritize children living with HIV (C/ALHIV), and at least 90% of C/ALHIV on ART in Juba County will be provided an opportunity to enroll in OVC. The DREAMS program will focus on supporting adolescent girls and young women in Juba County to

remain HIV-negative through economic strengthening activities and supporting post-GBV referrals and strengthening post-GBV services. Whereas, the VMMC program will expand beyond the current facility-based delivery model to provide targeted mobile outreach services in select locations.

These efforts will be reinforced by complementary systems strengthening and oversight activities such as scaling up HIV/TB field supervisors from six to fifteen; a full re-alignment of human resources for health in accordance with site level needs; providing mentorship, site monitoring and management, and dissemination of best practices through Extension for Community Healthcare Outcomes (ECHO); strengthening the quality of HIV, VL and early infant diagnosis (EID) testing; enhancing collection and use of data for decision-making; and community-led monitoring.

In order to enhance programmatic impact, build consensus and move towards sustainability, PEPFAR will increase its engagement with and support for civil society and local communities. By working with and through CSOs/community-based organizations (CBOs), PEPFAR will gain better access to partners and children, including OVC of index patients; improve linkage to treatment; better trace those on treatment or facilitate getting them back on treatment; and facilitate adherence to treatment regimes, including through the promotion of treatment literacy. PEPFAR will continue to explore ways of engaging civil society and communities as the program matures to maximize its impact.

In order to maximize efficiencies and results, the South Sudan PEPFAR program continues to scrutinize and monitor programmatic expenditures, above-site level expenses and resource requirements of the program.

PEPFAR South Sudan in COP22 will continue to monitor, review and utilize site level performance data from weekly and monthly dashboards introduced in FY20 for site quality improvement (QI) and partner management, with a strong focus on accurate and quality data reporting from where the services are provided. The PEPFAR team will undertake Site Improvement through Monitoring Systems (SIMS), and work with stakeholders on joint field supervision and quarterly MOH-led review meetings. The actions above will help the program to understand its performance and issues for data-driven decision making.

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## 2.0 Epidemic, Response, and Program Context

### 2.1 Summary statistics, disease burden and country profile

The Republic of South Sudan (RSS) became an independent nation on July 9, 2011, after experiencing decades of civil war. However, it again descended into crisis in December 2013 and again in July 2016, adversely affecting the health system and access to health services. A peace agreement was signed in 2018 and a transitional government has now been formed. Despite the formation of a transitional government, the country remains caught in a web of fragility, economic stagnation, and instability as numerous intercommunal conflicts, flooding and Covid-19 are creating havoc to the already struggling state where all sectors are heavily supported by humanitarian assistance.

Population projections (2022) for the Republic of South Sudan are based on the pre-independence Sudan National Census of 2008, which are estimated to be about **14, 234977** adults and children. The December 2013 outbreak of war and the July 2016 crisis resulted in the displacement of about 4.26 million people, of which 1.87 million were internally displaced with some in Protection of Civilian (POC) camps and 2.27 million were forced out of the country as refugees<sup>1</sup>. Some of the displaced populations have returned to their villages while more returnees are expected once the Transitional Government is successfully implemented.

As recent events have shown, the South Sudan economy is especially vulnerable to weather, oil price, and conflict related shocks. The economy had picked up strongly before the COVID-19 pandemic, with gross domestic product (GDP) growth reaching 9.5 percent in FY2019/20.

The gross national income of RSS was \$20.17 billion in 2015, and the country's gross domestic product (GDP) per capita was about \$759. The national Human Development Index (HDI) value for 2016 was 0.418, putting the country in the low human development category at 181 out of 188 countries (Human Development Report 2016, United Nations Development Program). Outside the oil sector, livelihoods are concentrated in low productive, unpaid agriculture and pastoralists work, accounting for around 15% of GDP. In fact, 85% of the working population is engaged in non-wage work, chiefly in agriculture (78%).

Ongoing conflict has had a significant impact on South Sudan's economy; it has disrupted oil production – which accounts for 60% of its GDP – and lessened agriculture production, leading to a significant contraction of the economy. Extreme poverty has increased to 65%, and projections suggest that poverty will continue to rise as economic growth is likely surpassed by population growth.

The Government of South Sudan (GoSS)' Revised *National HIV and AIDS Strategic Plan 2021-2021* was developed to guide the multi-sectoral national response to the HIV epidemic for five years and details outcomes, outputs, indicators and priority interventions. The NSP is aligned to national and international frameworks, specifically Sustainable Development Goal (SDG) 3 which includes a

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<sup>1</sup> OCHA, January 2019

HIV/AIDS-related target: “By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.”

South Sudan has a generalized HIV epidemic with an adult prevalence of 2.1% (draft spectrum 2022). The epidemic is geographically concentrated in the former Equatoria States which comprise an estimated 46% (180,960 PLHIV) of the national estimate for 2022. The HIV prevalence based on 2021 routine ANC survey in these states is; 7.4% in Western Equatoria, 2.6% in Central Equatoria, 4.1 in Lake States, 0.6 in Western Bahr El Ghazal and 1.6% in Eastern Equatoria<sup>2</sup>. Based on 2021 Spectrum estimates, there are 180,960 PLHIV in RSS; only about 30% of these know their status (UNAIDS 2021, Global AIDS Monitoring Report). The 2022 Spectrum estimates indicated 80% of PLHIV are in 37 counties of which 23 are PEPFAR supported. The 2022 estimates for PLHIV distribution by county and PEPFAR-supported sites are illustrated in Figure 2.5.1 below.

Initiated under COP17, Test and Start is being implemented in all PEPFAR intervention areas. In addition, high yield testing modalities – particularly those focusing on index patients, TB/HIV co-infection, Provider Initiated Testing and Counselling (PITC), and malnutrition – are emphasized. Multi-month scripting as part of community-based treatment started under COP17 and through the SPLA with three-month prescription scripting. In COP19, this practice was successfully expanded to cover six-month dispensing for stable patients and when circumstances permit. Among the programmatic challenges preventing progress on epidemic control, improving yields and retaining patients on treatment (preventing loss to follow-up) continue to be among the most difficult to make progress on. Although improving, programs are still not maximizing differentiated treatment models to improve yields; this will continue to be an emphasis of COP22. In addition, the community engagement necessary to improve not only yield and loss to follow-up but also sustainability is not happening to the degree it should be although the program continues to make significant strides in COP21. This too will be prioritized. Reaching specific groups such as men and youth has also been a challenge, as has reaching men who have sex with men (MSM), because of the extreme stigma and lack of legal protections present in South Sudan.

The disease burden across age and sex is provided in the [Standard Table 2.1.1](#) below. Given that the South Sudan Spectrum data only provides data by the age groups <15 years and ≥ 15 years, we are not able to provide data for age group 15-24 years.

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<sup>2</sup> South Sudan Antenatal Care Clinics Sentinel Surveillance Report, MOH, 2017

Standard Table 2.1.1 Key National Demographic and Epidemiological Data

Table 2.1.1 Host Country Government Results											
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	14,234,977	100	3,522,265		3,568,654		3,444,439		3,699,659		2022 Projection, based on 2008 Sudan census
HIV Prevalence (%)		2.1		0.3%		0.3%		2.9%		1.7%	MOH 2022 HIV/AIDS Spectrum estimates
AIDS Deaths (per year)	8,900		990		1,010		3,900		3,000		MOH 2022 HIV/AIDS Spectrum estimates
# PLHIV	180,960		7,305		7,547		104,431		61,673		MOH 2022 HIV/AIDS Spectrum estimates
Incidence Rate (Yr)		1.21		NA		NA		NA		NA	MOH 2022 HIV/AIDS Spectrum estimates
New Infections (Yr)	16,534										MOH 2022 HIV/AIDS Spectrum estimates
Annual births	448,022	4.58									MOH 2022 HIV/AIDS Spectrum estimates, based on 2008 Sudan Census
% of Pregnant Women with at least one ANC visit	251,750	53.0	NA	NA			NA	NA			MOH 2014 HMIS Report

Pregnant women needing ARVs	5,177	52									MOH 2022 HIV/AIDS Spectrum estimates
Orphans (maternal, paternal, double)	114,154		NA		NA		NA		NA		MOH 2022 HIV/AIDS Spectrum Estimates
Notified TB cases (Yr)	8,730		NA		NA		NA		NA		MOH 2014 HMIS Report
% of TB cases that are HIV infected	(1,579) 11%	12.7	NA	NA	NA	NA	NA	NA	NA	NA	MOH South Sudan TB Data 2018
% of Males Circumcised	NA	NA			NA	NA			NA	NA	
Estimated Population Size of MSM*	201	NA									MOH 2016 SSAC MSM population size estimates
MSM HIV Prevalence	NA	NA									
Estimated Population Size of FSW	30,104	NA									Juba, Magwi, Rumbek, South Bor, Wau and Yambio-2020 FSWs size estimate and program data
FSW HIV Prevalence	16%	NA									2019 FSW survey, Wau and Yambio
Estimated Population Size of PWID	NA	NA									
PWID HIV Prevalence	NA	NA									
Estimated Size of Priority Populations (specify)	250,000	NA	NA	NA	NA	NA	NA	NA	NA	NA	2012 SPLA BBS
Estimated Size of Priority Populations Prevalence (specify)	NA	5.0	NA	NA	NA	NA	NA	NA	NA	NA	2012 SPLA BBS

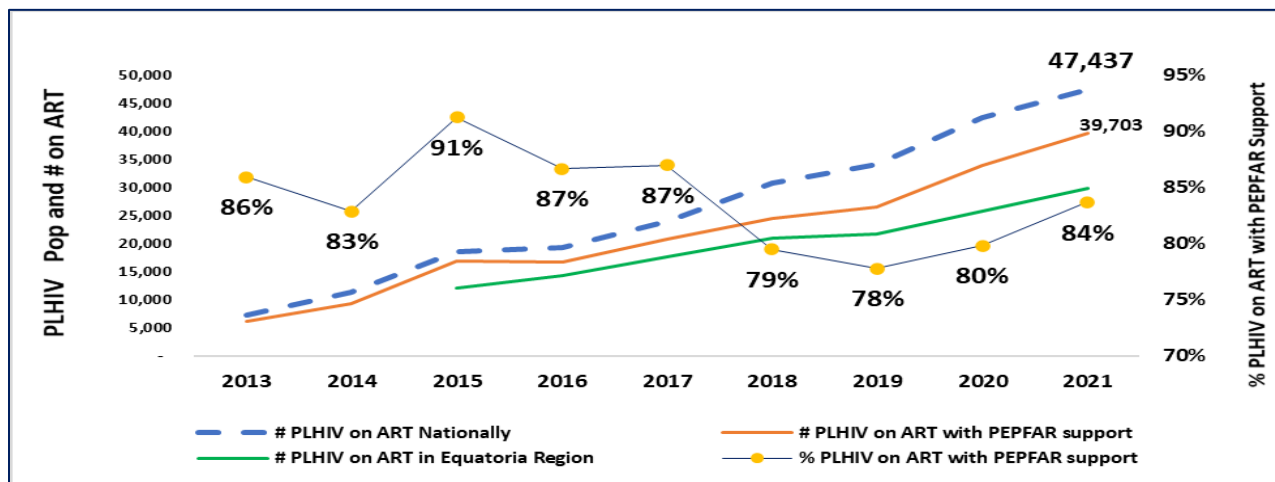
\*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources

**Standard Table 2.1.2 90-90-90 cascades: HIV diagnosis, treatment and viral suppression**

<b>Table 2.1.2 95-95-95 cascades: HIV diagnosis, treatment and viral suppression*</b>										
<b>Epidemiologic Data</b>					<b>HIV Treatment and Viral Suppression</b>			<b>HIV Testing and Linkage to ART Within the Last Year</b>		
	<b>Total Population Size Estimate (#)</b>	<b>HIV Prevalence (%)</b>	<b>Estimated Total PLHIV (#)</b>	<b>PLHIV diagnosed (#)</b>	<b>On ART (#)</b>	<b>ART Coverage (%)</b>	<b>Viral Suppression (%)</b>	<b>Tested for HIV (#)</b>	<b>Diagnosed HIV Positive (#)</b>	<b>Initiated on ART (#)</b>
Total population	14,234,977	2.1%	180,96	63,194	47,434	26%	64	377,61	15,331	15,27
Population <15 years	5,831,935	0.3%	14,594	4,939	2,428	16.6	62.5	33,186	812	754
Men 15-24 years	1,433,647	1.0%	8,739	2,534	1,508	12.7%	69.1	31,363	725	489
Men 25+ years	2684,319	-	56,262	16,310	13,024	23.9%	80.1%	83,574	5,196	4,189
Women 15-24 years		1.2%	16,806	3,849	5,529	33.6%	83.1%	90,648	2,957	2,154
Women 25+ years	2,764,447	-	84,085	32,679	22,853	24.0%	87.4%	138,845	6,923	6,660
MSM	-	-	-	-	-	-	-	-	-	-
FSW	15,010	16%			-	-	-	10,863	723	513
PWID	-	-	-	-	-	-	-	-	-	-
Priority Pop (specify)	250,000	-	-	-	-	-	-	4,462	191	171

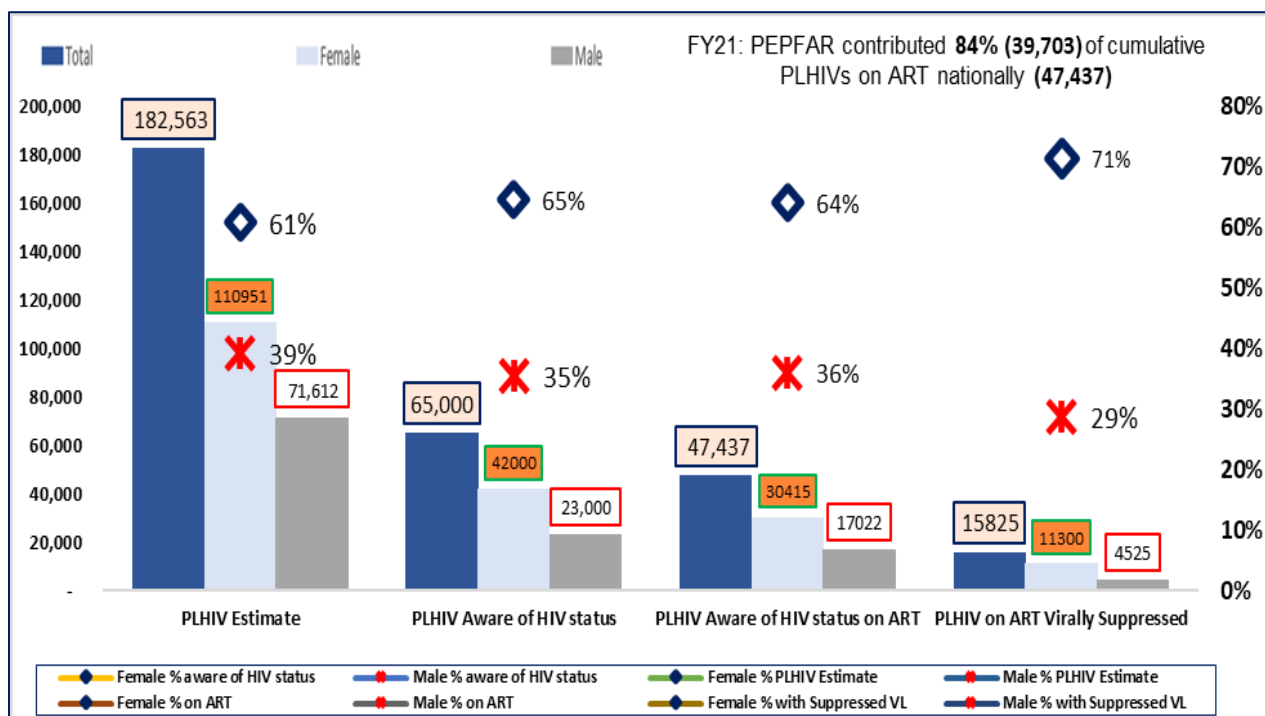
The ART program in South Sudan began in 2006 under the GF. PEPFAR involvement in treatment began in 2013 under treatment bridge funding and has since then become a major part of its major activities. PEPFAR support is focused in high disease burden counties mostly in the Equatoria region which is evident in the narrow difference between the national PLHIV on ART and those on ART with PEPFAR support as reflected in [Figure 2.1.1](#) below.

Figure 2.1.1 Updated National and PEPFAR Trend for Individuals currently on Treatment



Client loss from ART is a major problem for the South Sudan program. Although 94% of all HIV-positive cases identified in FY21 were linked on ART, the Treatment Net New between FY20Q4 and FY21Q4 remains low (Figure 2.1.3). Unless retention is addressed, it will be impossible to reach the FY23 treatment target of 60,808. Females are mostly lost between ages 15-29 years while men are lost at later age of 20-39 years. (Figure 2.1.3).

Figure 2.1.2 PEPFAR Contribution to 2021 National HIV Cascade FY2022

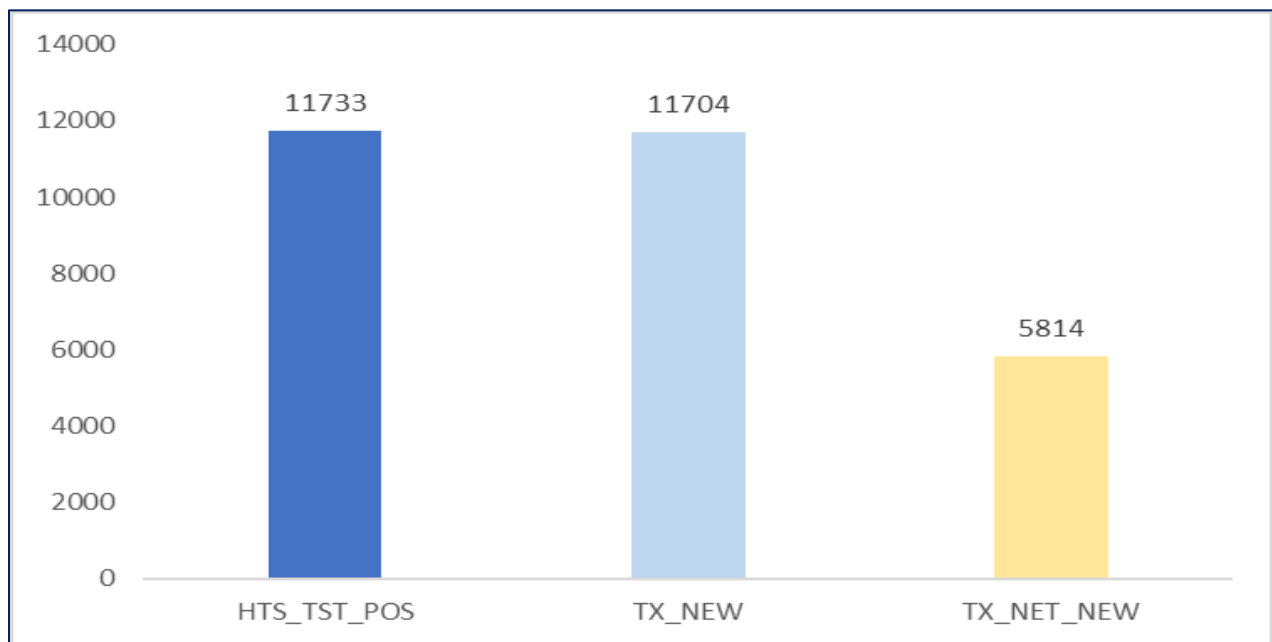


### Progress Retaining Individuals in Lifelong ART in FY22

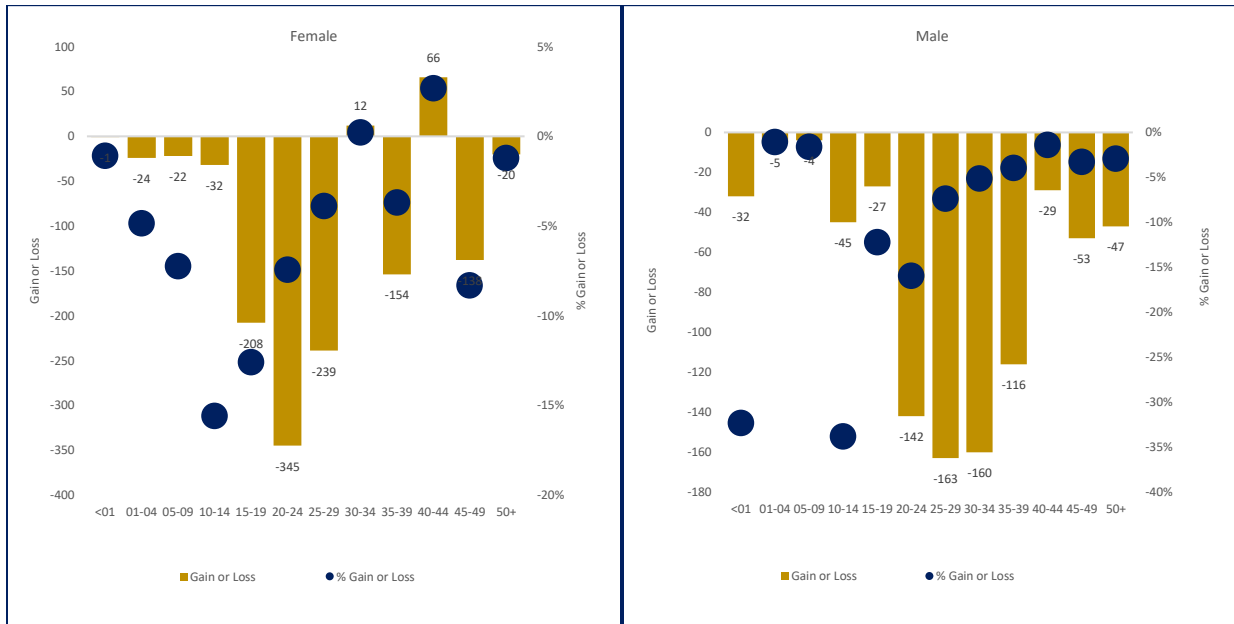
There were 11,021 clients who interrupted treatment in PEPFAR supported Anti-Retroviral Therapy (ART) facilities in South Sudan in FY21. Most of the interruptions in treatment were in Lake's state (5,031; 46%), Central Equatoria state (3,033; 28%) and Western Equatoria (1,594; 14%). During Q4 FY21, there were 2,686 clients that interrupted treatment in PEPFAR supported facilities; the majority (2,138) of clients who experienced an interruption in treatment (IIT) were on treatment for more than three months. Tracing efforts included phone calls by health facility staff coupled with home visits by community outreach volunteers, but facility teams and community volunteers could not locate these interruptions in treatment clients in the reporting period. The facilities with the highest number of clients who interrupted treatment during Q4FY21 were Yirol State Hospital (393), Mapourdit Hospital (300), Juba Teaching hospital (297), and Rumbek State Hospital (178)

Several efforts were put in place to address these challenges in treatment interruptions including strengthening community approaches and a proposed study to understand the factors associated with IIT. These efforts will enable the Ministry of Health and partners supporting the HIV program to design appropriate interventions to mitigate treatment interruption and improve treatment coverage in South Sudan.

**Figure 2.1.3 Progress Retaining Individuals in Lifelong ART in FY21**

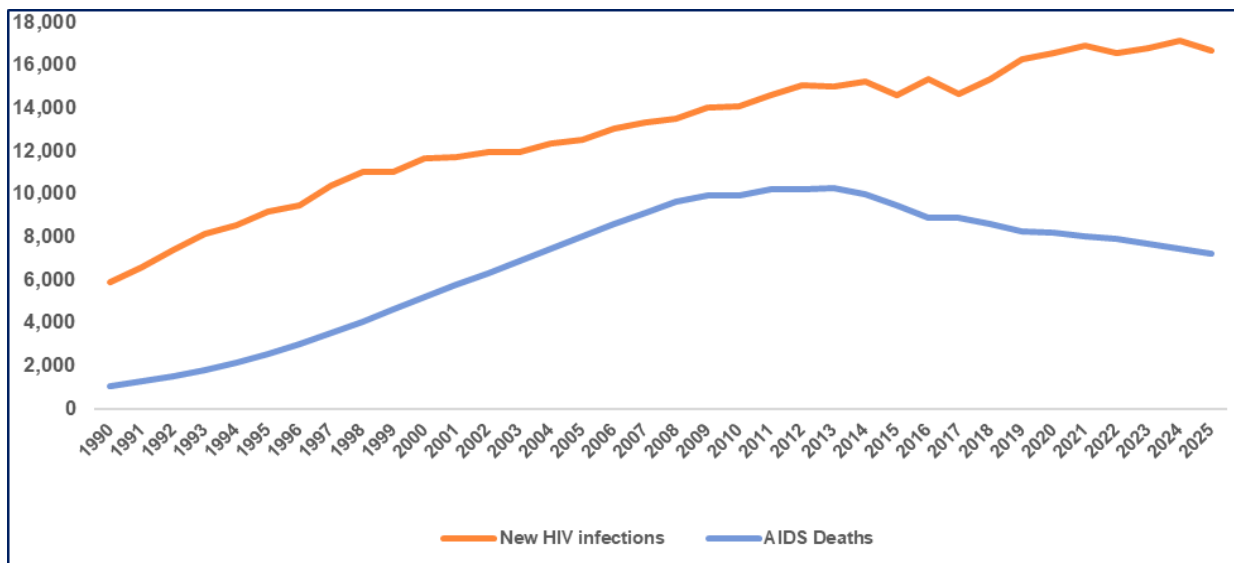


**Figure 2.1.3 Clients Gained/Lost from ART by Age/Sex, FY20 Q4**



While deaths among PLHIV due to all causes is on the decline, likely resulting from the expansion of treatment over the years as illustrated in the graph above, new infections continue to rise, dragging the country away from epidemic control ([Figure 2.1.4](#)).

**Figure 2.1.4 Trend of New Infections and All-Cause Mortality among PLHIV**





## **2.2 New Activities and Areas of Focus for COP22, Including Focus on Client Retention**

The new activities currently being prioritized in COP22 will be continue with focus on quality and scale.

### **Human Resources for Health (HRH)**

In COP20, PEPFAR undertook realignment of HRH, in accordance with needs at the site level based on HRH analysis conducted in the first quarter.

- These include:
  - Increasing field officers at sites.
  - Introducing field supervisors for each SNU.
  - Introducing standardized retention-specific cadre across all PEPFAR IPs to address new IIT patients, patients previously IIT, and patients with high viral load.
  - Decreasing incentivized staff, where possible.
  - Implementation of a regular, joint supervision schedule with MOH/Global Fund
  - Inclusion of Human Resource (HR) development component in Project ECHO
  - Establish IPV/GBV desk officers at high volume facilities to facilitate client referrals and provide advice.

### **Community-led Monitoring**

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organization(s) and host country governments. Community-led monitoring in COP22 will build on prior activities implemented in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM in COP22 will ensure indicators are defined by communities and health service users. CLM will endeavor to produce additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, the PEPFAR-supported community-led monitoring program will include an explicit focus on key populations. CLM will be utilized to advance equity and to support improvement in programs, especially for populations which have not yet fully experienced the benefits of HIV epidemic control. The OU will consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

### **OVC and DREAMS**

In COP22 the OU will maintain Orphans and Vulnerable Children (OVC) comprehensive services. The OVC program will continue prioritizing enrollment of C/ALHIV <18 on ART, especially ALHIV aged 15-17, C/ALHIV newly initiated on ART, C/ALHIV at highest risk of IIT, and who are virally unsuppressed. Expand OVC services to cover all facilities Juba Town with high volumes of C/ALHIV and poor pediatric (children and adolescents') clinical outcomes, to provide targeted

support for C/ALHIV and their families, with the goal of improving their clinical outcomes. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively supporting testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10–14-year-old girls and boys in regard to primary prevention of sexual violence and HIV. As of FY21 Q4, in Juba County, the OVC program had a proxy TX\_CURR <15 coverage of 107%, and a proxy TX\_CURR <20 coverage of 73%. p. All children in OVC-enrolled households with unknown HIV-status are being actively supported to test and those found positive linked to treatment. The program will continue to offer enrollment to at least 90% of C/ALHIV <18 on ART in Juba in COP22.

In COP22, the DREAMS program will expand targets to reach additional AGYW and expand DREAMS to other sites within Juba County to work towards reaching saturation in following years. In COP21, The AGYW-PREV target is 2300 and in COP22, it will be increased to 4,023. The project will continue to provide social asset building, and basic literacy and financial trainings to the AGYW and prepare them for long- and short- term training courses in areas informed by the market assessment in COP20. DREAMS will also support referrals to PrEP, basic education, and post-GBV services, including psychosocial support, and clinical services such as PEP, HIV testing, STI screening, and FP.

### **Scale up of Prevention and Clinical Services to improve retention**

See Section 4.0 on Client Centered Program Activities for Epidemic Control.

### **2.3 Investment Profile**

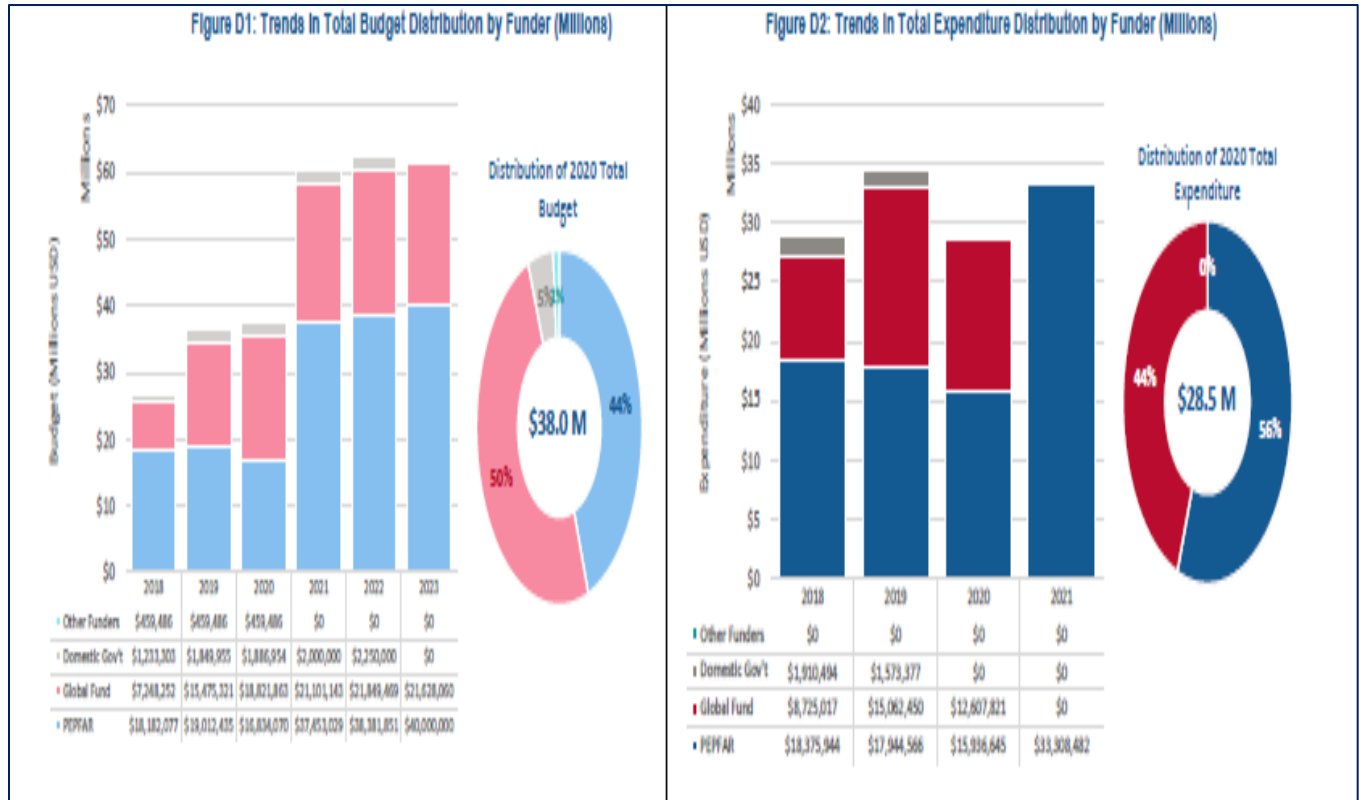
The Government of South Sudan (GoSS) recently increased its FY 23 budgets to about 9.0 % of its annual budget on health, but actual expenditures since the signing of the revitalized peace agreement in September 2018 are not clearly known. Therefore, specific health program funding remains uncertain and minimal. Previously, GoSS allocated a small budget of 2.0% to HIV annually; these funds were primarily spent on staff salaries. Due to the current economic crisis, PEPFAR does not anticipate any new funding from the GoSS for HIV programs.

The GF's current HIV/AIDS grant was approved for ~\$48,000 and will end by December 2023. The funding represents an overall increase from the previous grant valued at \$32,681,295 over three years (January 1, 2021 – December 31, 2023). These resources represent roughly 30% of the HIV budget for South Sudan. PEPFAR South Sudan and GF continue to collaborate to ensure all resources are used optimally, collaboratively and towards achievement of epidemic control.

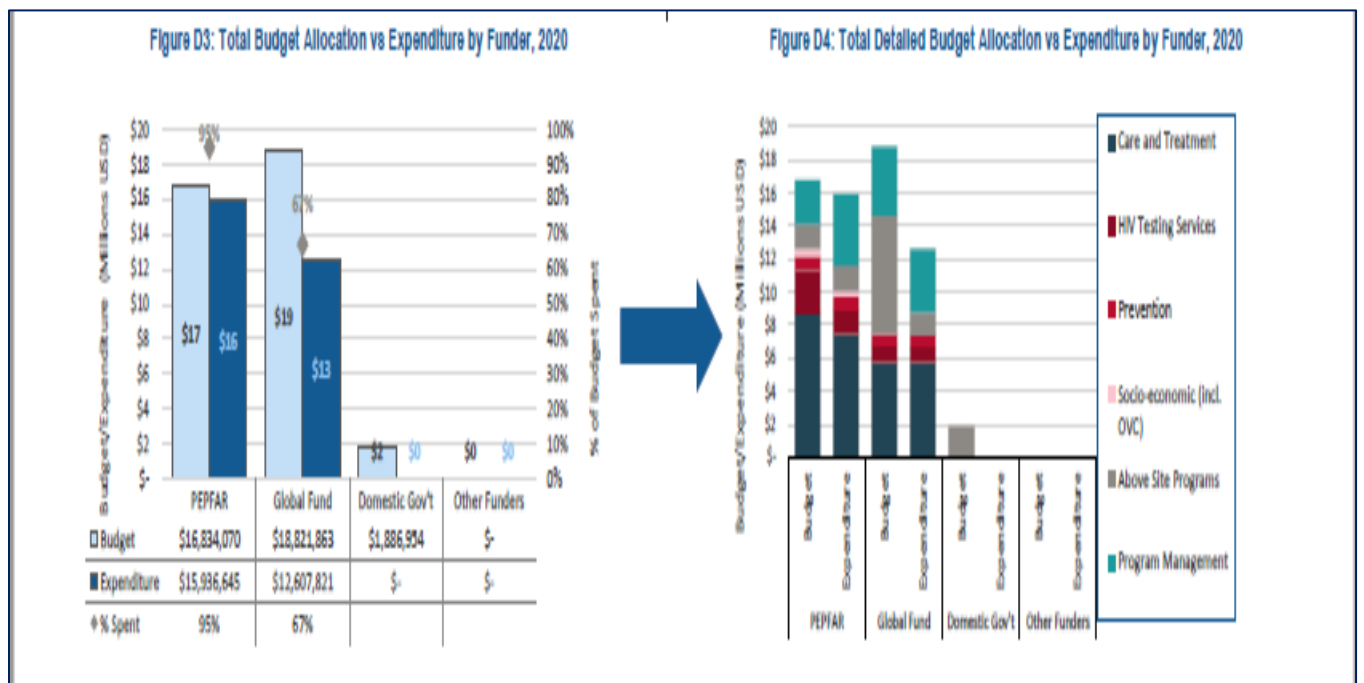
The MOH Department of HIV/AIDS has been understaffed since January 2018. UNDP, the GF Principal Recipient for the HIV/AIDS program, provides support at the national level which includes staffing support to the Department of HIV/AIDS.

The graphs below illustrate budget allocations and expenditures in 2019 by funding source.

**Figure 2.3.1 Trends in total Budget Distribution by funder versus Total Expenditure distribution by Funder, 2021**



**Figure 2.3.2 Total Budget Allocation versus Expenditure by Funder, 2021 and Total detailed budget allocation versus expenditure by funder 2021**



In COP22, PEPFAR will continue to coordinate closely with the GF to ensure complementarity and coordination of support. Joint coordination with MOH and GF will be crucial as GF will continue to procure all ARVs and other HIV-related commodities (such as HIV test kits, VL/EID reagents etc.) while PEPFAR will continue to provide technical guidance, through the TWGs and embedded IP staff, in planning, procurement, storage, quantification, forecasting and logistics management. PEPFAR will continue its technical assistance in COP22 to strengthen supply chain systems by continuing to support the two staff seconded to MOH and UNDP, multi-month dispensing and manage the complex transition from Lopinavir/ ritonavir to Dolutegravir 10mg for pediatrics. In COP 22, PEPFAR will also dedicate resources towards supporting last-mile delivery.

To achieve sustained control of the HIV/AIDS epidemic, it is essential that there is active and routine coordination and communication between stakeholders and partners who can provide valuable insights that improve the impact and accountability of programs. Key stakeholders including host country governments, bilateral donors, multilateral organizations, the private sector, civil society, and others, including faith-based organizations, play a critical role in supporting the mutual goal of HIV epidemic control. PEPFAR and the GF are committed to continually strengthening their partnership with host-country governments to ensure alignment of HIV investments with national priorities. Joint planning and coordination between stakeholders are critical to ensuring that prioritized interventions are scaled, geographic priorities are shared, and that all available resources for HIV/AIDS in the country are utilized optimally.

PEPFAR and the GF representing two of the largest donors in the global HIV response--in close partnership with host national governments and other stakeholders, accomplish bilateral program results and accelerate collective impact towards HIV epidemic control. Increased collaboration between PEPFAR and the GF during planning and budgeting processes helps ensure investments are strategically aligned to address gaps and solutions while maximizing transparency, efficiency, and accountability of their resources.

The GoSS's HIV response is expected to continue to be heavily reliant on PEPFAR, which currently supports over 80% of HIV treatment services in the country. Currently, there are no other development partners supporting core HIV programs in South Sudan.

**Table 2.3.1 Investment Profile (Budget Allocation) for HIV Program, 2021**

<b>Table 2.3.1 Investment Profile for HIV Program 2021</b>					
<b>Program Area</b>	<b>Total Expenditure</b>	<b>Domestic Govt</b>	<b>GF</b>	<b>PEPFAR</b>	<b>Other funders</b>
Care and Treatment	\$ 31,314,823	0%	44%	56%	0%
HIV Testing Services	\$4,814,614	0%	30%	70%	0%
Prevention	\$2,581,858	0%	14%	86%	0%
Socio-economic (incl. OVC)	\$1,662,208	0%	29%	71%	0%

Above Site Programs	\$21,685,150	0%	84%	16%	0%
Program Management	\$14,553,563	0%	36%	64%	0%
Total (Incl. commodities)	\$78,612,216	3%	31%	66%	0%
Commodities only	\$13,300,968	0%	100%	0%	0%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.

**Table 2.3.2 Investment profile (Budget Allocation) for HIV Commodities, 2021**

Table 2.3.2 Annual Procurement Profile for Key Commodities, 2021					
Commodity Category	Total Expenditure	Domestic Govt	GF	PEPFAR	Other
ARVs	\$4,413,209	0%	100%	0%	0%
Laboratory Supplies and Reagents	\$1,423,602	0%	100%	0%	0%
Medicines	\$2,093,211	0%	100%	0%	0%
Consumables	\$2,716,214	0%	100%	0%	0%
Health Equipment	\$245,178	0%	100%	0%	0%
PSM Costs	\$2,409,554	0%	100%	0%	0%
Total Commodities only	\$13,300,968	0%	98%	2%	0%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.

**Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration**

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$ 15,000,000	-	-	-	
USAID TB					
USAID Malaria					
Family Planning	\$ 4,000,000				
NIH					
CDC (Global Health Security)					
Peace Corps					

DOD Ebola					
MCC					
Other (COVID 19)	\$8,000,000				
<b>Total</b>	<b>\$ 27,000,000</b>				

**2.4 National Sustainability Profile Update**

As the world's newest country and a “fragile state”, implementing the revitalized peace agreement, the Republic of South Sudan (RSS) has nearly none of the critical elements in place to support a robust and transparent economy or government. The RSS HIV response remains almost entirely reliant on external donors; PEPFAR and the Global Fund are, in fact, responsible for nearly all the support for HIV/AIDS services nationwide. No areas of the HIV response in RSS are adequately covered in terms of finance, oversight, monitoring, or service delivery by the government. The Government of South Sudan (GoSS) prioritizes security infrastructure over health, education, and other sectors.

Since the last SID in COP 20, there have been some improvements in some SID elements. For example, planning and coordination among the HIV stakeholders have improved. There is an increased level of transparency among the HIV stakeholders. Also, PEPFAR has continued to bring additional civil society organizations representation into PEPFAR and COP planning and reporting processes for added accountability and transparency. The increased investment in DHIS2 has also added to the country’s capacity in data visibility under the Strategic Information element. In addition, PEPFAR has continued to capacitate IPs in producing, collecting, and using data for decision-making, particularly in tracking those who interrupted treatment (IIT).

There have also been some slight positive changes in the SID commodity security and supply chain since SID 2019, though this has remained red i.e., significant investment still required. The regular supply chain and commodities TWG meetings have ensured that commodities are tracked and monitored regularly to avoid stock outs.

The laboratory sustainability domains and elements for 2021 recorded a slight drop despite the investments in the provision of Viral Load and Early Infant Diagnosis (EID).

Although the peace partners are implementing the revitalized peace agreement, South Sudan is still a nation mired in conflict and insecurity, and has years, if not decades, before it can reach any reasonable level of sustainability in its HIV/AIDS response. Consequently, the PEPFAR program continues to be predominantly a direct service delivery model where the emphasis will remain on getting services to the people who need them. Global Fund essentially provides the only support for HIV commodities (ARVs, VL reagents etc.) procurement for the country’s HIV/AIDS response. For a country that allocates less than 2% of its annual budget to health, government contribution to HIV response is expected to be very limited. There are discussions to increase the allocated budget for health in the 2022 budget cycle.

In COP 22, PEPFAR South Sudan will continue to address some of the sustainability vulnerabilities identified during the SID process in 2021. These sustainability vulnerabilities include the following

- **Public Access to information** (2.0 **Red**): This score is lower than in SID 2019. The Country did not conduct further ANC surveillance and other studies. Information (studies, data) may be available to the stakeholders but not the public.
- **Service Delivery** (3.12 **Red**): South Sudan supports limited domestic workforce and local health systems. The country relies heavily on NGOs to provide health services at the facility level. This has affected scale up and expansion of services to new areas of high burden. There is a need to scale up services in all parts of the country.
- **Human Resources for Health** (2.68 **Red**): This element scored less than in SID 2019. South Sudan has continued to have insufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. The country has struggled to pay and retain health workers. Most staff at ART facilities are supported by NGOs and there is no strategy or plan for transitioning staff funded by donors. There are no sufficient staff and limited budget at the MOH.
- **Commodity security and supply chain** (2.43 **Red**): Though this showed some improvement from SID 2017 and SID 2019, more investment is required in this area since all HIV commodities are procured by one entity, i.e., Global Fund.
- **Quality Management**: (3.14 **Red**). This element dropped from SID 2019 (4.14 **yellow**). Quality Management/ Quality Improvement exists but needs to be formalized. No QI documents or structures seen at the national level.
- **Domestic resource Mobilization** (3.13 **Red**). The government only allocates about 2% of its annual budget to health. The MOH only supports some staff salaries at health facilities; no funds are allocated for commodities, training, or supportive supervision, among others.
- **Data for decision making ecosystem** (2.86 **Red**): The government demonstrates commitment to advancing the use of data in informing government decisions. Currently the country has introduced the use of DHIS2. However, there is limited capacity and resources put to operationalize this in all counties.

SID 2021 recorded a general improvement from SID 2019. The general need in the country is immense given that the government does not allocate resources for HIV response. As a result, the stakeholders prioritized the following elements, during the “Sustainability Planning” meeting.

- Government to strengthen planning and coordination of HIV response.
- Advocacy for legislation that gives legal protection to key population
- Conduct an objective assessment of the private sector knowledge and attitude to HIV/AIDS programming

- To institutionalize the current community volunteers (COVs) in to the Boma Health Initiative.
- Government allocation of resources for HIV/AIDS response (including commodities)
- Increase PEPFAR, GF and government support for health workforce.
- Strengthen the human resource information system (HRIS).
- Need to strengthen the logistic management system to improve on visualization of commodities and supply chain system. This should be accessible at national.
- Having a QI management system & having a person assigned for QI
- Transforming the current Granular Site Management (GSM) focal person at MOH to oversee QI.
- Need to develop a plan for QI/QM structure
- Expand the scope for management and monitoring of lab services.
- Improve viral load data availability through integration of VLSM and DHIS-2
- Increase PEPFAR, GF and government support for surveys/surveillance
- Establish strong survey & surveillance unit within the M&E directorate (for both general and key population)
- Increase the number of ANC sentinel sites in both rural and urban areas
- Consider conducting population-based surveys (Mini PHIA, and mini DHS)/ Undertake AIDS indicator survey to have population-based data to inform resource allocation
- Conduct IBBS in four major towns (Bor, Juba, Aweil, and Nimule)
- Develop procedural manuals and guidelines for surveillance and surveys in the health HIV/AIDS sub-sector
- Develop HIV/AIDS surveillance and surveys strategic plan
- Finalize and cost Health Information Management strategy
- Develop data quality review guidelines/SOPs
- Develop national HIV data quality assessment protocols and tools
- Develop annual plan for data quality strategy
- Establish a functional unique identifiers system in the country
- Conduct specific trainings to target health workforce capacity for QM/QI.
- Government to develop staff retention strategy and staff transitional plan.
- Improve communication and information sharing with the private sector.
- The government to develop and implement long term financing strategy for HIV response.
- National AIDS Spending Assessment (NASA) to be conducted every two years.
- Improve target/goal vs budget monitoring for domestic funds.
- Need to build evidence base for geographic burdens and document best practices for scaling interventions
- Scale up of the private sector involvement in HIV services

Funding targeting private sector for active engagement In COP 2022, PEPFAR will continue to prioritize the following actions:



- Service delivery – PEPFAR will work with its IPs to implement direct service delivery at the site level.
- Human resources for health – PEPFAR will increase support for human resources at the site level.
- Commodities and supply chain – PEPFAR will second two staffs to provide technical assistance and support to MOH and UNDP. These staffs will support supply chain management. PEPFAR will also continue to support through the commodities technical working groups and embedded IP staff.
- Data for decision making ecosystem – PEPFAR will support data for decision-making by enabling PEPFAR-MOH data alignment, DHIS-2 scale-up, PEPFAR dashboard utilization, PEPFAR quarterly reviews, and stakeholder consultations.

## **2.5 Alignment of PEPFAR Investments Geographically to Disease Burden**

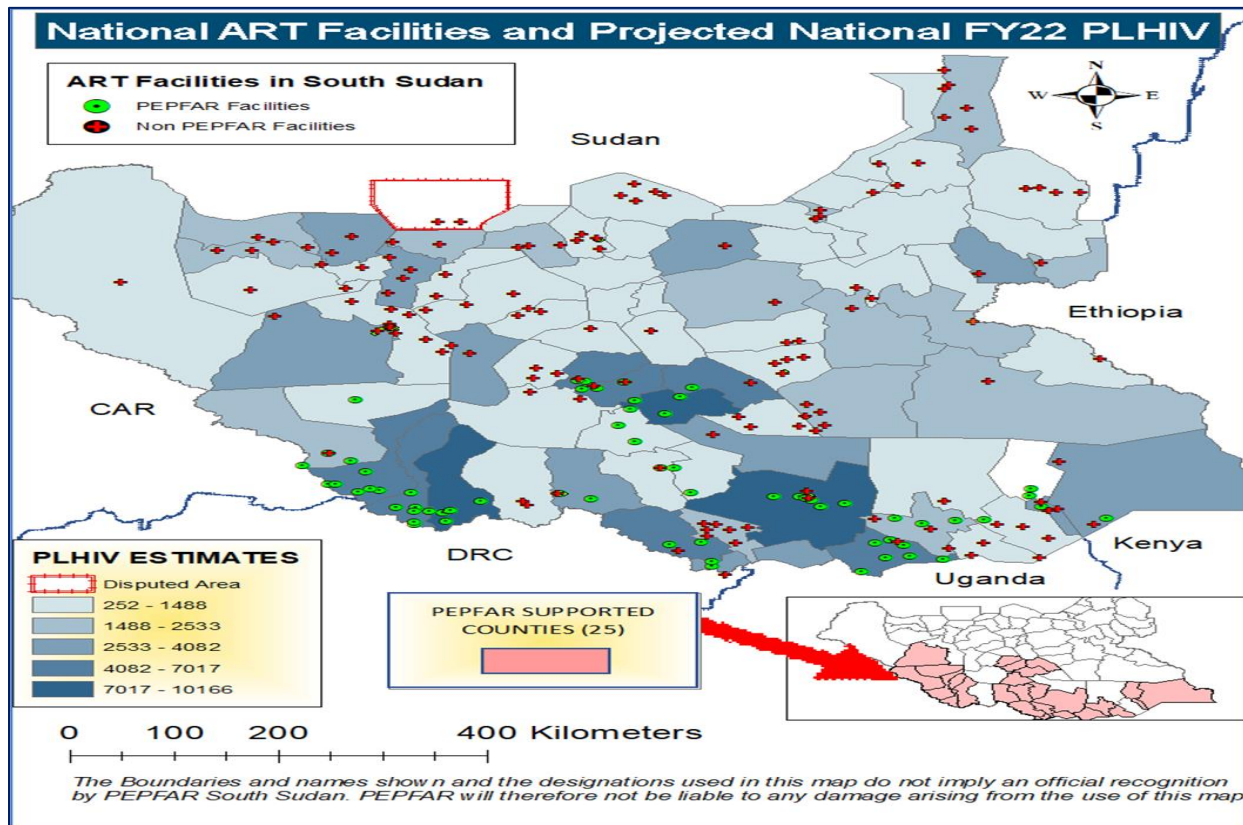
As in COP22, PEPFAR investments remain aligned geographically to 25 counties with the highest disease burden (Figure 2.4.1). These counties account for 58% (105,153) of the 180,960 PLHIV in the country based on 2022 Spectrum estimates. In FY20, there were 78 sites providing the full range of PEPFAR services including ART, the total number of sites for support in FY22 is 83 based on COP20 facility list.

Given the challenges in reaching sites, both for quality service provision and last mile delivery of commodities, PEPFAR will implement a tiered approach to service provision. The tier system categorization is transitional and flexible; the categorizations are meant to be reviewed regularly using data reported from sites at the point of service provision. PEPFAR South Sudan conducted a service quality and data quality assessment (SQA/DQA) at end of COP19 period, and the findings were used to determine the final site list and commensurate model of support at sites for COP20 which will be used for COP22 period.

In COP22 ten scale-up aggressive counties as in COP21 will be supported (Juba, Rumbek Center, Magwi, Yambio, Ezo, Nzara, Wau, Tambura Yirol West and Yei). These ten counties account for 36% (64,978) of all PLHIV in South Sudan. PEPFAR will also work in an additional fifteen sustained counties, up from twelve in COP21. The fifteen sustained counties (Ikotos, Kapoeta South, Maridi, Mundri East, Torit, Kapoeta North, Yirol East, Rumbek North, Mundri West, Mvolo, Morobo, Nagero, Kapoeta East, Lainya and Kajo-keji) account for 22% (40,175) of PLHIV in South Sudan and increase from 12% PLHIV in sustained units in COP22.

About 37% of PLHIV know their status in South Sudan (Spectrum 2022). The overall national ART coverage in 2020, based on MOH program data and 2020 Spectrum estimates, is 26%, of which 83% (39,498/47,437) are in PEPFAR-supported counties. Of all PLHIV currently on ART nationally, about 70% (33,073) are in the Equatoria regions. PEPFAR will continue to focus resources in the highest disease burden counties shown in the Figure 2.5.1.

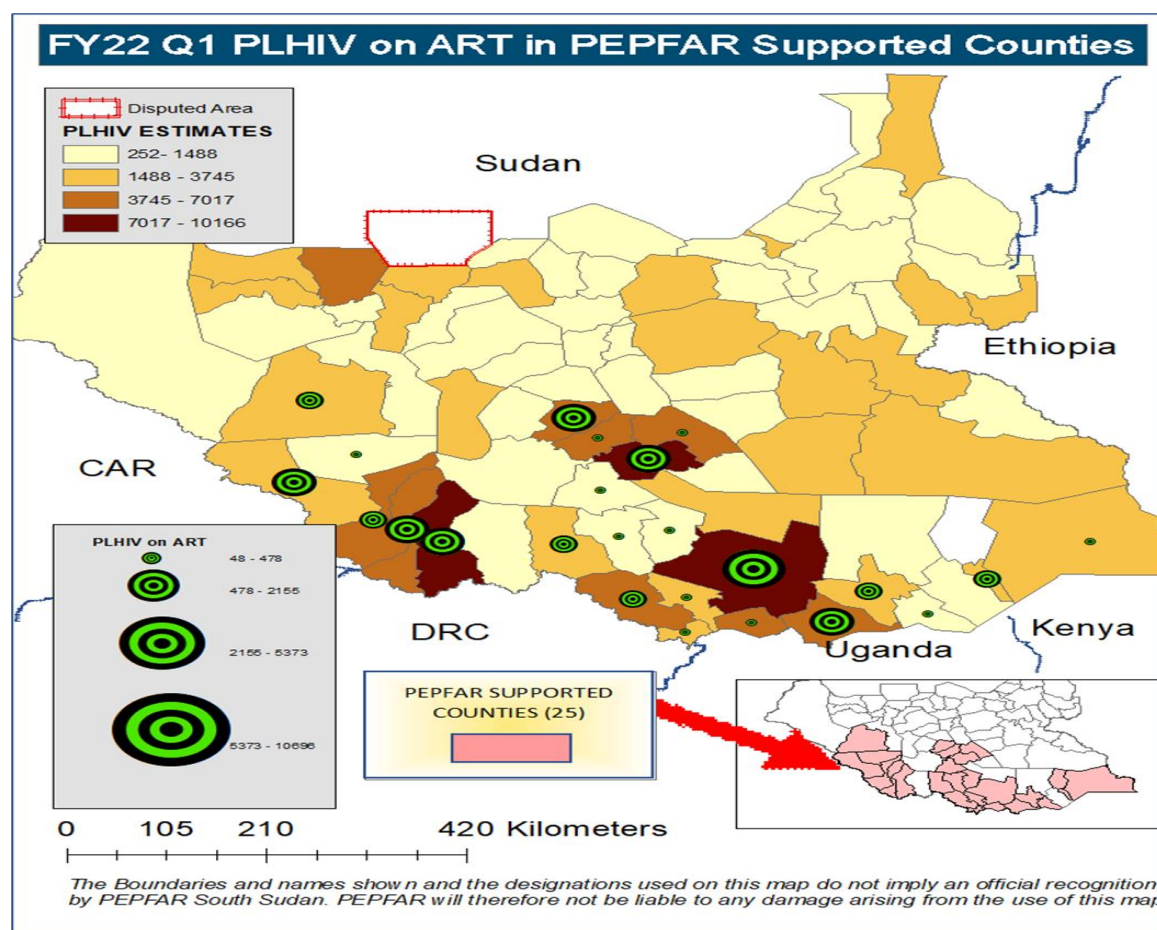
Figure 2.5.1 PEPFAR Investments by Geographic Burden of Disease



ART coverage in the ten PEPFAR prioritized scale up aggressive counties is on average 33% (34,688) in FY22Q1. The ART coverage varies across counties as shown on the map in Figure 2.5.1 and Table 2.5.1. ART coverage in the non-PEPFAR supported counties is close to 9%, with some counties not providing ART services. Based on the data and the coverage gaps in FY22, PEPFAR will continue to prioritize interventions in all the supported counties by working closely with stakeholders, including MOH in order to scale-up treatment services including viral load monitoring for assessing suppression status.

PEPFAR will continue to focus resources in the highest burden counties. Figure 2.4.2 shows the ART coverage. This is reflective of PEPFAR’s data-driven geographic prioritization of counties for scaling up ART coverage. Based on the data and the coverage gaps in FY22, PEPFAR will prioritize interventions in ten scale-up aggressive counties and sixteen sustained SNUs by working closely with stakeholders, including MOH in order to scale-up HIV testing, treatment and VL services.

Figure 2.4.2 FY21Q1 ART Coverage in PEPFAR Supported Counties



PEPFAR South Sudan will continue to align investment in highest disease burden areas, targeting sub-national units with the highest number of PLHIV and high unmet need. [Table 2.5.1](#) below shows ART coverage for all ages in Juba County. ART coverage for PLHIV under 40 years is below 80% for all age bands/sexes and ranges from 29% for ages 01-04 to 73% for 35-39 years. By targeting Juba and other similar SNUs, PEPFAR South Sudan will be addressing current gaps and ensure progress towards 90-90-90 for the supported SNUs.

Table 2.5.1 ART Coverage by County FY22Q1

SNU	PLHIV			TX_CURR FY22			TX_CURR FY23		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
_Military									
South Sudan	0	0	0	1,105	920	2,025	1,642	2,214	3,856
Ezo County	3,142	2,193	5,335	1,475	619	2,094	2,520	1,600	4,120
Ikotos County	528	334	862	199	109	308	416	265	681

Juba County	6,084	3,663	9,747	6,637	3,489	10,126	8,692	5,442	14,134
KajoKeji County	2,463	1,524	3,987	36	29	65	319	108	427
Kapoeta East County	1,924	1,224	3,148	17	10	27	401	153	554
Kapoeta North County	2,069	1,540	3,609				165	77	242
Kapoeta South County	1,933	1,228	3,161	406	363	769	675	451	1,126
Lainya County	1,520	967	2,487	15	13	28	139	46	185
Magwi County	4,151	2,866	7,017	1,506	801	2,307	2,408	1,564	3,972
Maridi County	1,794	1,141	2,935	568	224	792	796	522	1,318
Morobo County	1,765	1,120	2,885	88	55	143	176	123	299
Mundri East County	384	244	628	115	60	175	435	319	754
Mundri West County	520	331	851	137	53	190	200	122	322
Mvolo County	736	468	1,204	82	33	115	144	106	250
Nagero County	663	505	1,168	33	11	44	114	82	196
Nzara County	3,815	2,725	6,540	1,556	740	2,296	2,921	1,875	4,796
Rumbek Centre County	3,420	2,249	5,669	1,750	831	2,581	1,905	1,254	3,159
Rumbek East County	2,836	1,802	4,638	68	43	111	101	176	277
South Bor County	1,178	747	1,925				183	0	183
Tambura County	1,575	958	2,533	1,729	716	2,445	1,957	1,369	3,326
Torit County	1,389	940	2,329	555	421	976	847	669	1,516
Wau County	2,289	1,456	3,745	748	348	1,096	1,636	933	2,569
Yambio County	5,007	5,159	10,166	3,896	1,448	5,344	4,705	2,436	7,141
Yei County	3,202	2,185	5,387	1,039	637	1,676	1,851	1,239	3,090
Yirol East County	3,916	2,367	6,283	380	204	584	495	297	792
Yirol West County	5,182	3,657	8,839	2,173	1,215	3,388	3,426	2,182	5,608
<b>Total</b>	<b>63,485</b>	<b>43,593</b>	<b>107,078</b>	<b>26,313</b>	<b>13,392</b>	<b>39,705</b>	<b>39,269</b>	<b>25,624</b>	<b>64,893</b>

## PLHIV Burden and ART coverage by County and sex

SNU	PLHIV		PLHIV Total	TX_CURR		TX_CURR Total	FY21Q1	FY21Q1	FY21Q1	PLHIV in need of ART	PLHIV in need of ART Male	PLHIV in need of ART Total
	Female	Male		FY21Q1 Female	FY21Q1 Male		FY21Q1 Coverage Female	FY21Q1 Coverage Male	FY21Q1 Coverage average			
Tambura County	1,486	960	2,446	1,644	701	2,345	111%	73%	96%	-158	259	101
Maridi County	644	415	1,059	577	231	808	90%	56%	76%	67	184	251
Rumbek Centre County	1,485	960	2,445	1,190	573	1,763	80%	60%	72%	295	387	682
Torit County	757	489	1,246	468	326	794	62%	67%	64%	289	163	452
Juba County	8,043	5,191	13,234	5,382	3,041	8,423	67%	59%	64%	2,661	2,150	4,811
Wau County	1,552	1,002	2,554	723	325	1,048	47%	32%	41%	829	677	1,506
Ezo County	3,396	2,190	5,586	1,481	673	2,154	44%	31%	39%	1,915	1,517	3,432
Mundri West County	266	171	437	119	43	162	45%	25%	37%	147	128	275
Yei County	2,584	1,668	4,252	985	561	1,546	38%	34%	36%	1,599	1,107	2,706
Yambio County	8,863	5,720	14,583	3,547	1,372	4,919	40%	24%	34%	5,316	4,348	9,664
Yirol West County	6,505	4,197	10,702	2,214	1,200	3,414	34%	29%	32%	4,291	2,997	7,288
Nzara County	4,051	2,615	6,666	1,438	651	2,089	35%	25%	31%	2,613	1,964	4,577
Mundri East County	377	245	622	111	69	180	29%	28%	29%	266	176	442
Nagero County	77	52	129	25	10	35	32%	19%	27%	52	42	94
Magwi County	4,377	2,825	7,202	1,215	662	1,877	28%	23%	26%	3,162	2,163	5,325
Ikotos County	575	372	947	159	80	239	28%	22%	25%	416	292	708
Kapoeta South County	1,878	1,212	3,090	316	231	547	17%	19%	18%	1,562	981	2,543
Mvolo County	377	245	622	60	19	79	16%	8%	13%	317	226	543
Rumbek East County	1,191	768	1,959	42	23	65	4%	3%	3%	1,149	745	1,894
Yirol East County	4,263	2,751	7,014	121	50	171	3%	2%	2%	4,142	2,701	6,843
Morobo County	1,328	856	2,184	29	22	51	2%	3%	2%	1,299	834	2,133
Kapoeta North County	1,177	758	1,935			0	0%	0%	0%	1,177	758	1,935
	<b>55,252</b>	<b>35,662</b>	<b>90,914</b>	<b>21,846</b>	<b>10,863</b>	<b>32,709</b>	<b>40%</b>	<b>30%</b>	<b>36%</b>	<b>33,406</b>	<b>24,799</b>	<b>58,205</b>
Military South Sudan				1,783	36	1,819						

Source: COP22 Data Pack

## 2.6 Stakeholder Engagement

The PEPFAR South Sudan team has established a long-standing good relationship with the in-country stakeholders (including the host government MoH, Global fund and other multilateral donors, civil societies, and the community of the PLHIV). As early as January 2022, the Operating Unit (OU) started the preparation for COP22 Communication with the stakeholders regarding schedule for the COP/ROP2022 was established and continued till the first week of February 2022 when the Stakeholders consultative meeting was conducted virtually due to upsurge in COVID-19 cases and subsequently restrictions on in-person gathering in one place to an excess of 10 as per the directives of the MoH. PEPFAR continued the momentum from previous years with a variety of stakeholder engagements.

Prior to that, PEPFAR continued (though this time round, virtually) its tradition of holding quarterly IPs one-on-one performance review meetings followed by stakeholder meetings in preparation for quarterly PEPFAR Oversight, Accountability and Review Team (POART) meetings. This process is critical for understanding in-depth IP's performance trends and challenges and for facilitating transparency and accountability among stakeholders. PEPFAR also continued to engage stakeholders and participated in an ad-hoc consultations throughout the year to address specific issues items such as supply chain issues around roll-out of PrEP, pDTG10 and HIV Self Testing (HIVST) just to mention a few.

In addition, PEPFAR South Sudan conducted a formal, four-day stakeholders consultative meeting in Juba, South Sudan during the period from January 31 to February 4, 2022. Although this was a virtual meeting, there was an extensive engagement of key stakeholders' participants. Participants from all implementing partners, representatives from several CSOs, and UN agencies including UNDP, UNAIDS, WHO and MOH senior leadership, South Sudan HIV/AIDS Commission (SSAC) leadership, South Sudan S/GAC Chair and PPM were present in the meeting. The meeting proved to be highly productive for COP22 planning. During the meeting, in-depth presentations were made by the IPs on APR for COP20 and FY22 Q1 performance and by PEPFAR on COP21 programmatic priorities and the COP process/timing. The presentations were followed by two days of topical/thematic small group discussions to come up with COP20 challenges and solutions. The last day was devoted to finalizing how South Sudan would address COP21 priorities moving forward to COP22 implementation.

Furthermore, stakeholders were an important part of the COP22 Virtual Planning Meeting (VPM) held for four days from March 7-11, 2022. In line with COP22 focus on Equity in addition to Accountability, Transparency, and Impact as guiding principles for planning, the country team expanded its CSOs representation in the VPM from 4 to 7 to include youth and adolescents, KP and DREAM representatives to ensure inclusivity and advocate against the long-standing inequalities experienced by these groups.

Stakeholders' contributions to COP22 design were evident through their recommendations all the way from the retreat meeting to the VPM where they highlighted the need to standardize quality and package of HIV services across the country for equitable access by all PLHIV given the existing stark difference between PEPFAR and GF-supported sites. This also includes strengthening of the MoH HIV department to provide overall leadership and efficient coordination to the national HIV response, improve HIV data quality management and streamline all reporting through DHIS-2 system including all special programs (e.g., DREAM, OVC and VMMC). The need for improved coordination and complementarity between GF and PEPFAR was emphasized especially on HIV supplies chain management front. The team proposed that GF to consider adding VMMC commodities into their procurement list. Moreover, stakeholders identified PMTCT, especially EID as an area that is lagging and strongly recommended that MoH champions ANC/PMTCT integration efforts.

In their submission, CSOs identified high client stigma and discriminations, lack of nutritional support to PLHIV against severe economic meltdown, criminalization, and crackdown on KP activities, cultural and religious disapproval coupled with inadequate government institutions awareness on HIV policies as key challenges hindering treatment growth in the quest to reach epidemic control. They've advocated for comprehensive and meaningful engagement of CSOs to effectively implement and scale up all interventions linked to communities such as Community led Monitoring and advocacy, social mobilization, building linkages and coordination, Institutional capacity building and leadership development for sustainability. They also applauded PEPFAR for supporting CLM as an independent mechanism to ensure accountability and upholding quality

standards and urged for additional resources to scale it up and integrate documentation of HIV-related human rights violation, policy, and structural barriers as additional components.

Finally, CSOs networks pleaded all to work towards realizing a conducive environment for KP services and commit to building CSOs' capacity and supporting them as Prime recipients to promote sustainability and improve funding efficiency.

## **2.7 Stigma and Discrimination**

The level of HIV comprehensive knowledge in South Sudan is low, less than (40%) among the general population. General awareness of HIV and AIDS remains low, as well as social behavior change efforts are yet to reach the desired levels. The HIV prevention response to date has been insufficiently prioritized to populations at higher risk, and interventions have lacked the intensity quality and focused coverage to turn back the epidemic, while interventions are not yet fully multisectoral.

Stigma and discrimination continue to threaten the possibility of achieving the national strategic plan goals of reducing HIV new infections among the general population, vulnerable and key populations to achieving reducing mortality among women, children and men living with HIV. Similarly, stigma and discrimination have resulted in denying others dignity, respect, and the right to fully belong to their community. Stigma and discrimination have shown major negative impacts on treatment and care and support continuum; uptake of HIV prevention services and HTS; disclosure; treatment and support services; women and girls; and magnified effects among the socially vulnerable both at urban and rural settings.

The South Sudan Stigma Index report, 2015 showed that 52% of PLHIV had experienced shaming attitudes while 23% of PLHIV were excluded from social gatherings and 30% had experienced physical abuse while 18% experienced loss of job or source of income. In 2020 the Stigma Index study indicated 12.1% of PLHIV reported having experienced verbal abuse, 13.1% being gossiped by health workers and 28.5% by other service providers; 62% of PLHIV experienced various forms of stigma and discrimination.

### **Ongoing S&D reduction interventions**

SSAC in its capacity to ensure providing an enabling environment for KPs, PLHIV and Vulnerable populations through fostering leadership and policy and advocacy and training roles for HIV Prevention, Treatment, Care and Support programmed during the period and implementation scope through employing various methodologies and approaches including but not limited to:

- Undertake sensitization and engagement/advocacy sessions with general population (men and women) uniformed forces, local officials, cultural and religious leaders, health care workers, parliamentarians and others on stigma, discrimination and violence related and impacts mitigation.
- Sensitization training workshops on stigma and community, empowerment interventions, including legal and human rights literacy for PLHIV networks, key population groups and

CSOs to improve their capacity to challenge and be resilient to acts of stigma, discrimination and violence,

- Advocate to improve the capacity of legal service providers to offer legal advice and services to PLHIV and key populations who experience stigma, discrimination and violence in order to improve access to justice and redress.
- Reducing first the self-stigma in the clients and then the overall stigma in the community and families.
- Individuals continuous counselling and life testimonies of the Peer Counselors. NEPWU staff and data collectors has provided testimonies in the facilities and trainings and other community gatherings to saved lives of those who were dying without treatment due to stigma.

In COP22, the PEPFAR OU will continue to collaborate with the host government and other CSOs such as the networks of PLHIV to continue addressing stigma and discrimination among PLHIV.



### 3.0 Geographic and Population Prioritization

SNU prioritization for COP22 was determined by COP20 facility list and spectrum 22 estimates which is compared with previous year estimates.

Figure 2.4.1 above shows PLHIV estimates by county and the PEPFAR supported facilities. PEPFAR provides direct HIV services in 25 high disease burden counties in the five states of Central Equatoria, Western Equatoria, Eastern Equatoria, Lakes and Western Baher El-Ghazal. As of Dec 2022, there are 47,437 PLHIV on ART nationally, of which 87% are supported by PEPFAR.

Previously, PEPFAR South Sudan support was focused in the three highest HIV burden states of the Greater Equatoria region: Western Equatoria State (WES), Eastern Equatoria State (EES), and Central Equatoria State (CES); together, these three states represent 45% (81,799) of all PLHIV nationally. In COP18, PEPFAR started to implement comprehensive HIV services in Wau, Mapourdit and Rumbek Hospitals in the Western Bahr el Ghazal and Lakes States which will be maintained in COP22 and expanded to Rumbek East and Yirol East County facilities.

In COP21, HTS, TST, PMTCT, ART, VL services and health strengthening activities will continue at all PEPFAR sites. PEPFAR will cover 25 SNUs out of the total 80 SNUs in the country excluding the military SNU and South Bor. These 25 SNUs constitute approximately 59% of PLHIV (107,078) in the country. Among these 25 are ten scale-up aggressive SNUs and 15 sustained SNUs.

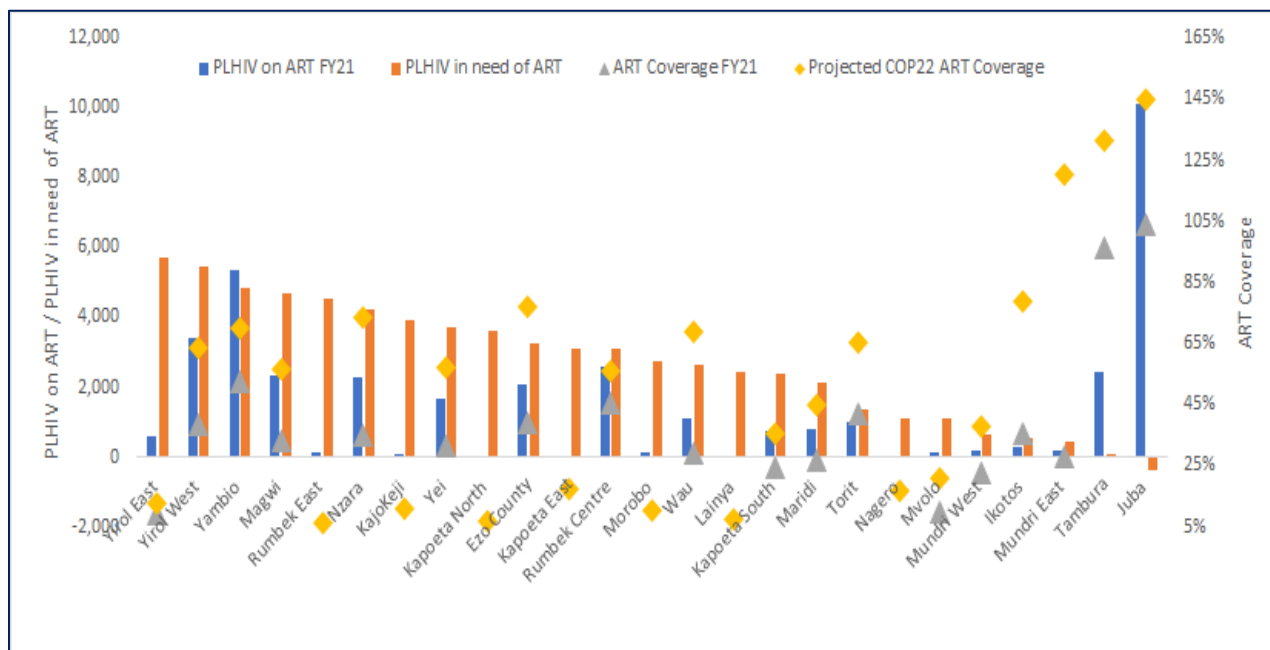
**Table 3.1 Current Status of ART Saturation**

<b>Table 3.1 Current Status of ART saturation</b>				
<b>Prioritization Area</b>	<b>Total PLHIV/% of all PLHIV for COP21</b>	<b># Current on ART (FY21)</b>	<b># of SNU COP20 (FY21)</b>	<b># of SNU COP22 (FY23)</b>
<b>Scale-up Aggressive</b>	<b>64,978 (38%)</b>	<b>33,353</b>	<b>10</b>	<b>10</b>
<b>Sustained</b>	<b>40,175 (22%)</b>	<b>4,327</b>	<b>12</b>	<b>16</b>
<b>Mil_SNU</b>		<b>1,722</b>	<b>1</b>	<b>1</b>

Figure 3.2 below shows the current levels of program saturation for PEPFAR supported SNUs as of 2021, as well as the expected FY23 coverage. PEPFAR continues to prioritize service delivery in the highest burden SNUs in order to increase ART coverage and have the highest impact on the epidemic. Thirteen of the PEPFAR-supported counties have ART coverage above the national ART coverage of 27%.

Based on FY21Q1 results and spectrum 2022 estimates the counties with highest PLHIV in need of ART include Yambio, Yirol East and West, Magwi, Juba, Nzara, Ezo and Yei counties. The ART coverage in Juba is 104%, Yambio 53% and Nzara 35%. PEPFAR will invest efforts in all these counties with high number of PLHIV in need of ART to increase ART coverage.

**Figure 3.2 Current Status of ART Saturation by SNU as of end of FY21 and Projected FY22 Coverage**



COP22 projected ART coverage in Juba is expected to reach 145% as Juba has the highest HIV prevalence in the country. In the scale up aggressive counties FY21 ART coverage ranged from 29% in Wau to 104% in Juba and the lowest expected ART coverage will be 57% in FY23. FY21 ART coverage in sustained counties ranged from 2% in Rumbek East County to 42% in Torit. In FY22, continued efforts will be undertaken to both increase and sustain ART coverage in various counties including counties where refugees are expected to return (Kapoeta South and North, Lainya, Kajo Keji and Morobo) as well is counties with low ART coverage in FY21.

Given the large ART coverage gap, PEPFAR South Sudan intends to apply 64% of its COP21 budget on care and treatment in order to scale-up ART coverage and provide ART to 60,808 people by the end of FY22.

PEPFAR South Sudan’s ability to achieve these targets will depend on programmatic and contextual factors including:

- Reaching the right populations through targeted approaches;
- Employing efficient testing modalities to increase yields;
- Enhancing linkage to treatment;
- Increasing retention rates and reducing interruption in treatment;
- Improving viral load suppression;

- Ensuring six-month multi-month drug dispensation;
- Addressing security and access issues in the Equatoria states;
- Leveraging Global Fund commodities.

Based on the above prioritizations, proposed SNU targets and budget earmarks, PEPFAR South Sudan proposes to increase overall ART coverage in PEPFAR supported SNUs from 72% in COP19 to 95% in COP22. With low treatment coverage overall in South Sudan, PEPFAR activities will continue to focus on the general population, along with specific programs for pregnant and lactating women, key populations and the military as described below.

Based on current program data, coverage rates are low among both men and women, and particularly low among adult men (20-49). The reach of services to adult men is low in high burden SNUs with both low testing volume and low yield. In COP22, PEPFAR will continue to employ approaches that will reach to adult men while also continuing to expand reach to women, especially adolescent girls and young women.

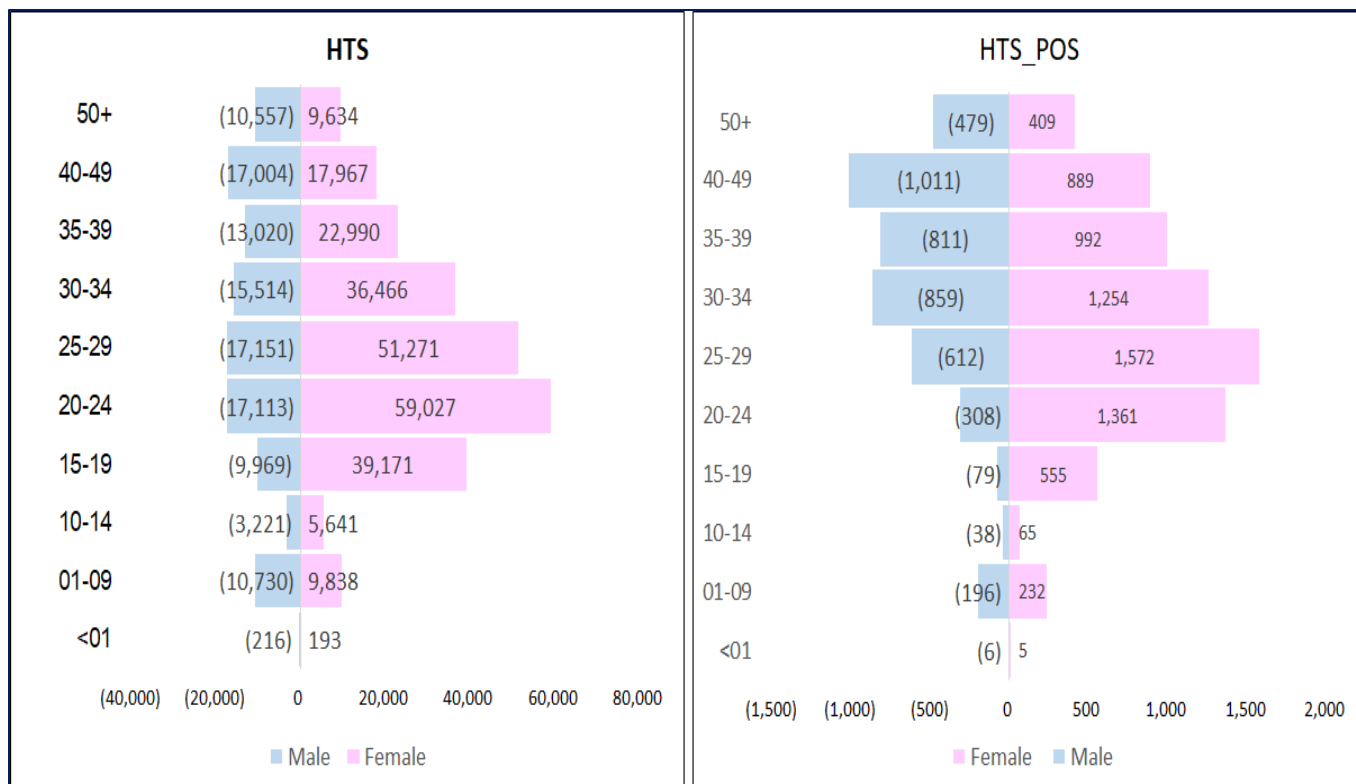
## 4.0 Client-Centered Program Activities for Epidemic Control

### 4.1 Finding the Missing, Getting Them on Treatment

Improvement in case finding remains key to scaling up HIV ART coverage in South Sudan. With an overall prevalence of <2.5% and only four in ten South Sudanese PLHIV knowing their status. The country has a long way to go to reach the 95,95,95 UNAIDS targets by 2030.

Age	Estimated PLHIV 2020			PLHIV Currently on ART			Current ART Coverage			PLHIV in Need of ART		
	PLHIV Female	PLHIV Male	PLHIV Total	Female	Male	Total	Female	Male	Average	Female	Male	Total
<01	608	375	983	294	48	342	48%	13%	35%	314	327	641
01-04	2433	1509	3942	592	345	937	24%	23%	24%	1841	1164	3005
05-09	2223	1375	3598	305	226	531	14%	16%	15%	1918	1149	3067
10-14	1910	1176	3086	263	221	484	14%	19%	16%	1647	955	2602
15-19	4601	1633	6234	1044	460	1504	23%	28%	24%	3557	1173	4730
20-24	12672	3618	16290	2734	874	3608	22%	24%	22%	9938	2744	12682
25-29	15836	5371	21207	4537	1225	5762	29%	23%	27%	11299	4146	15445
30-34	19332	6284	25616	5472	1780	7252	28%	28%	28%	13860	4504	18364
35-39	16325	6791	23116	5064	1781	6845	31%	26%	30%	11261	5010	16271
40-44	12675	5012	17687	3909	1208	5117	31%	24%	29%	8766	3804	12570
45-49	8613	3800	12413	2891	871	3762	34%	23%	30%	5722	2929	8651
50-54	4002	1558	5560	1185	444	1629	30%	28%	29%	2817	1114	3931
55-59	3293	1246	4539	950	350	1300	29%	28%	29%	2343	896	3239
60-64	2406	934	3340	704	260	964	29%	28%	29%	1702	674	2376
65+	1605	624	2229	471	172	643	29%	28%	29%	1134	452	1586
Total	108534	41306	149840	30415	10265	40680	28%	25%	27%	78119	31041	109160

In FY21, the country achieved just 41.3% (11,733/28,425) of its annual HTS\_POS target with an overall yield of 3.2%. Men aged 30 to 40 years, children age 10-14 and <1 year remained underserved (Figure below). There were only 26% of PLHIV on ART in 2021 and the highest coverage nationally at 28% were people aged 50 years and above, the country is missing everyone (Table 4.1.1 and figure 4.0.1).



High-yield modalities such as index testing and TB/TB presumptive struggled to scale up and remained low in volume. Contribution from Index testing dropped from 14% in FY21Q4 to 11% in FY22Q1. Close to 70% of all newly identified cases in PEPFAR-supported sites in FY21 came from just four modalities, namely:

1. Provider Initiated Counselling and testing (PITC)
2. Voluntary Counselling and Testing (VCT)
3. Inpatient Care
4. Prevention of Mother-to-Child Transmission (PMTCT)

The suboptimal performance in FY21 is largely attributed to two factors, Stigma, and distance from service points. The community engagement scaleup, designed to solve the distance problem in COP21 did not meet its full potential because of insecurity and community cadre capacity in many parts of the country. In COP22 there will be planned improvement of coordination of HTS services with other community-based interventions like OVC and DREAMS to ensure closing of any gaps.

In COP22 HTS will continue to focus on targeted demand generation and will implement strategic approaches of person-centered HTS to narrow 1<sup>st</sup> 95 gaps across sub-populations, targeting especially men age 30-40 years and children age 10-14 years, adolescent and young women as well as children below one year. While COVID-19 pandemic, remains a reality and threat to programming, a strategic mix of testing approaches that includes universal offer of safe and ethical index testing and implementation of facility and community-based approaches will be supported.

IPs will scale-up targeted HTS strategies to improve identification of PLHIV in communities and health facilities in scale-up counties, within the remits of COVID-19 guidelines.

### **Index testing**

Index Testing (and partner notification) – will continue to be aggressively scaled up across all PEPFAR-supported sites targeting sexual partners of index patients and their biological children less than 19 years. This will focus on patients with documented high viral load and newly diagnosed HIV positive patients. Active tracing of index contacts in the community shall be scaled up and CoV shall be trained to perform this in the most efficient way possible

To address issues of disclosure and partner notification, PEPFAR treatment partners will work closely with community outreach volunteers to ensure partner notifications are done ethically and in a confidential manner without any violence. Training and certification will be conducted to ensure adherence to standards to reduce risk of violence.

All sites shall implement index testing with fidelity while ensuring strict adherence to all the minimum standards. During the remaining two quarters of COP21, South Sudan will address gaps in index contact tracing and testing. The country will further scale up community index testing with special focus on tracing the sexual Contacts of index cases and biological children, because FY21 data shows that less than 60% of elicited clients were successfully traced but 95% of those traced were tested. The main bottle neck therefore is in tracing the contacts rather than testing them.

### **HIV Self Testing (HIVST)**

HIVST is now in the country's consolidated guidelines. The overall objective is to improve case finding among the hard-to-reach population which include men age 30-49 years, biological children of infected mothers and clients of female sex workers. South Sudan will develop and streamline methods that captures five critical indicators for the HIVST intervention.

1. Number of HIVST kits issued to clients in the facility and community
2. Number of HIVST done disaggregated by age and sex
3. Number HIVST result returned desegregated by age and sex
4. Number of HIVST reactive clients referred for confirmatory HTS\_TEST
5. Number of HIVST reactive clients confirmed positive.
6. Number of HIVST Clients confirmed positive and linked to care.

The PEPFAR South Sudan will coordinate with UNDP and implementing partners to ensure adequate supply of HIV self-testing kits and will explore ways of maximizing HIVST in the context of COVID-19

PEPFAR South Sudan plans to conduct over 9000 HIVST in COP22, this target will be equitably distributed across supported facilities. It took long for the country to accept HIVST as an intervention for fear of stigma and self-harm. For this reason the country adopted a phase approach

starting with select areas with relatively low stigma, higher media penetration and easy access. These areas include Juba, Magwi and Yambio Counties. Lessons learned here shall inform scale up to other parts of the country. In the remaining two quotas of FY21, the emphasis shall be on facility-based care giver assisted HIVST and eventually expand to the community. The Community outreach Volunteers (CoV) shall play a critical role in distributing the test kits and obtaining the results from the community. The CoV shall also Help clients with reactive HIVST result access confirmatory test either at home or anywhere convenient to the client.

The channels for delivery of HIVST services shall follow the target population listed above and shall complement the existing HTS models such as Provider Initiated Testing and Counselling (PITC), index testing services and PMTCT. The driving objective shall be to address gaps in HTS coverage. In other words, standard HTS takes precedence over HIVST at any opportunity of HIV testing services

a. Facility based

All clients seeking health services shall first be offered HTS services. HIVST shall be offered for those who declined HTS for any reason including stigma.

b. Community based

In the community, places where men congregate such as sports clubs, Gyms, and drinking Joints, shall be targeted for distribution of HIVST kits. backed up by mass information through radio and TV Jingles, men shall be informed of the availability of the kits in those locations and how to ask for them. Centers in KP-Hotspots shall also be availed with the HIVST kits for distribution to KPs and their Clients. Trained CoV shall deliver HIVST kits to schools, collages, and universities. They Shall team up with the institution management to provide the services to the young people in the institution. CoV shall be embedded with EPI workers during EPI campaigns to target Households with Elicited index contacts in the community

c. Private Sector

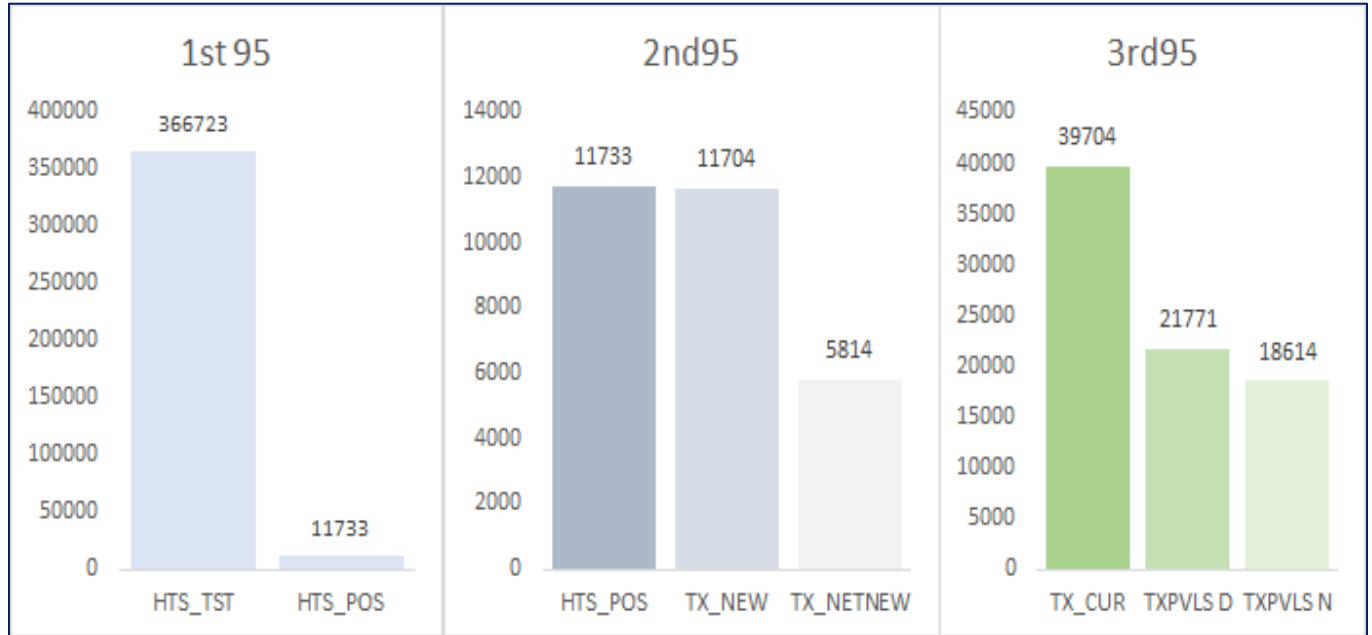
In COP22, PEPFAR will continue to provide VCT services at all PEPFAR-supported sites. VCT services will be integrated into the outpatient department (OPD). Trained CoV shall also provide these services in the community and market places alongside the HIVST services, a simple approach to screen out known PLHIV coming to retest shall be devised

Provider-Initiated Testing and Counselling (PITC) will be provided at all entry points in the facilities including TB; OPD; ANC; STI; malnutrition through therapeutic feeding centers (TFCs); medical and pediatric inpatient wards.

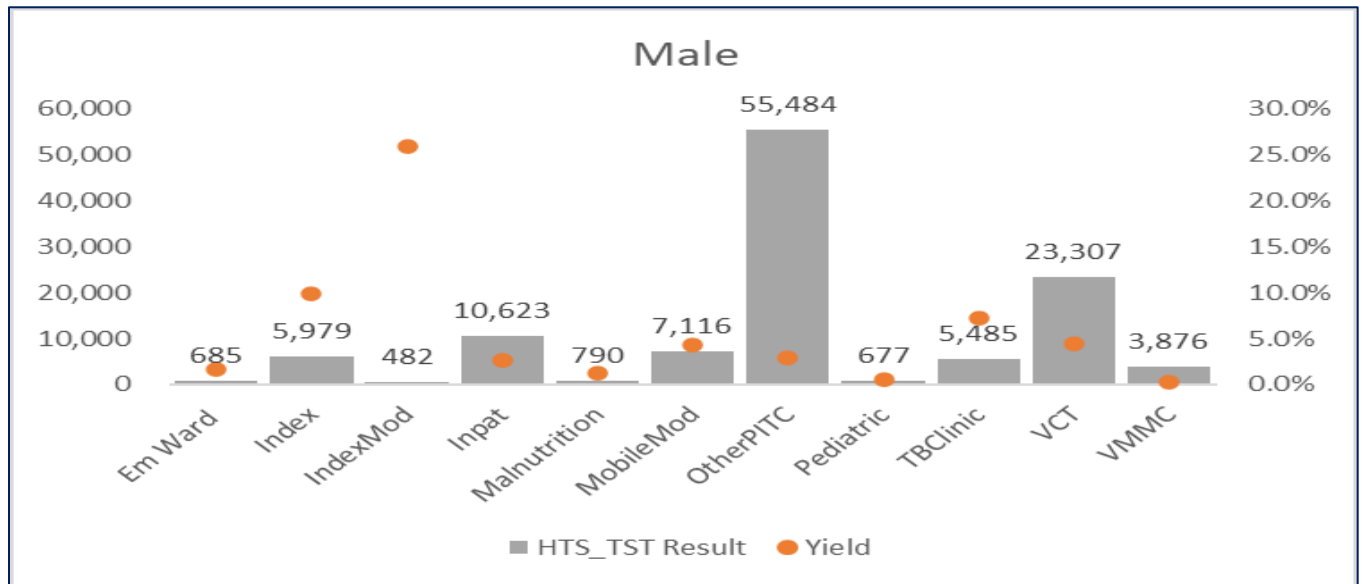
IPEPFAR will continue to scale-up HIV testing of presumptive TB patients, i.e., individuals with symptoms consistent with TB. PEPFAR-supported facilities will continue to identify presumptive TB patients using the TB symptom screening tool that is used both in the facility and in the community (by the community volunteers). PEPFAR clinical partners will continue to address

client flow issues that prevent TB presumptive patients from accessing HTS. Where feasible, partners shall integrate HTS within TB screening.

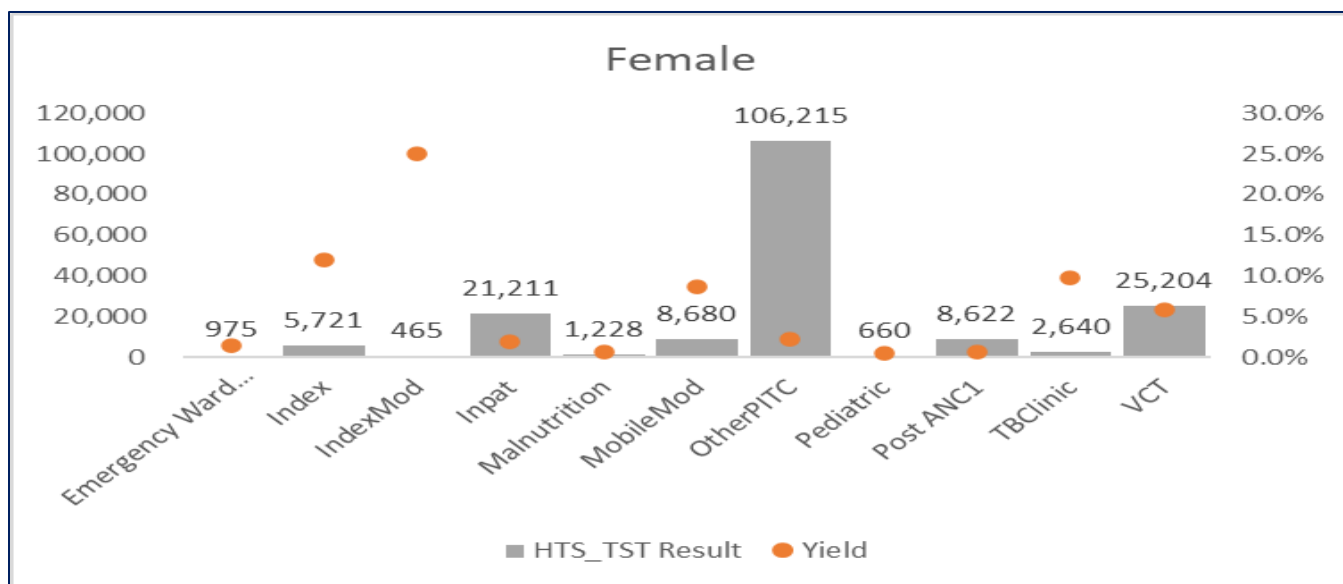
**Figure 4.1.1 Overview of 95/95/95 Cascade, FY21**



**Figure 4.1.2 Testing Volume and Yield by Modality and Age/Sex, FY21**







PEPFAR South Sudan will prioritize and maximize pediatric HIV testing, care and treatment, especially through the ANC/PMTCT and therapeutic feeding center programs.

At the end of Q4 FY21, 44 PEPFAR supported PMTCT facilities collected Dried Blood Spot (DBS) samples from infants that were either tested at the facility or sent them to the laboratory for EID. There were 53 facilities in South Sudan that collected samples for EID, and 24 out of the 53 facilities tested the samples on-site using near point of care GeneXpert instruments. By the end of FY21, a total of 3269 EID tests were done, and 58% were tested using near POCT at facilities.

By end of Q4 FY21, 273 testing points at 83 facilities participated in rapid HIV proficiency testing scheme and achieved 97% response rate and 100% pass rate. In FY23, PEPFAR South Sudan will distribute proficiency testing panels to individuals conducting HIV test and use it as a means of tester certification in order to improve the quality of HIV rapid testing. PEPFAR South Sudan will conduct tester training, certification of HIV testers (counselors); supportive supervision and mentorship and site certification using the Step-wise process for improving quality of HIV rapid testing (SPI-RT/RTRI) checklist.

## 4.2 Retaining Clients on Treatment and Ensuring Viral Suppression

### Linkage to Care and Treatment

In COP22, PEPFAR will continue with strategies ensuring effective linkage of HIV positive clients to treatment and support services in nearby facilities. This includes escorted linkage to ART clinics using community volunteers; follow-up and linkage of clients who decline same-day escort, using SMS reminders or phone calls; and use of two-way referral systems. Designated facility staff members will be responsible for receiving and tracking referrals from HTS and working closely with testing staff to proactively follow-up on expected new clients.

In COP22, PEPFAR South Sudan partners will continue to strengthen linkage to care and treatment and community services intended to improve treatment adherence and outcomes.

This will be done through:

- Continuing provision of “Test and Start” services to all individuals testing HIV positive
- Continued transitioning of pediatric clients to Dolutegravir based regimens and phasing out Lopinavir/ Ritonavir based regimens for children weighing 3-19.9kg
- Continuing implementation of differentiated models of service delivery (MMD for stable patients/those who are likely to travel, fast track ART refills, community ART refills, and family member refills). The military program will explore 9-12 months multi-month dispensing for service men and women on deployment to locations without ART services. There will be need to check status to ensure adherence. Similar MMD consideration will be given to clients who are stable on treatment but facing conflict situation with displacement affect normal services.
- Provision of integrated delivery of TB/HIV services, i.e., one stop shops to reduce waiting time
- Use of appointment registers (logbook and SMS), ART registers, missed appointment and Interruption in Treatment (IIT) registers and tracking systems (e.g., ART card and referral forms)
- Expanding access to ART through decentralization of ART services to all PEPFAR facilities including tier-3 sites, community ART provision or mobile outreach services for low-volume and remote areas
- Continued involvement of community outreach volunteers (COVs) on ART initiation/ refills and Viral Load Sample collection
- Greater involvement of PLHIV groups in index testing and linkages to facilities, quality assurance, adherence support/treatment literacy, and community-based distribution models
- Strengthening facility-community structures and linkages by utilizing CSOs and community networks, especially for tracing those patients who interrupted treatment
- Attaching newly diagnosed individuals to community outreach volunteers working in the same catchment area and conduct preventive follow up of newly initiated in the first 6 months by the COVs.
- Conducting “Return to care and Treatment campaigns” in the community targeting those who may have interrupted treatment
- Provision of “Back to care” package of services to returning clients who had interrupted treatment.
- Continuous health education and treatment literacy in the waiting rooms

PEPFAR will recommend these core components of linkage to HIV services:

- Escorting newly diagnosed individuals to HIV care Treatment navigation by expert clients or peer navigators
- Telephone follow-up, reminder calls, or text messaging
- Psychosocial support, informational/motivational counseling on the benefits of disclosure, testing of partners and biologic children, and ART initiation and adherence
- Use of risk assessment tool to mitigate real and perceived barriers to HIV care and retention
- Systematic monitoring and evaluation of enrollment in HIV care and ART initiation outcomes
- Interventions to link from testing to treatment services through implementation of linkage registers

Peer navigators and community volunteers support individuals who are living with HIV so they can enroll and remain in clinical care and on ART. The community outreach volunteers are trained individuals who are usually living with HIV themselves. They will strengthen the facility-community linkages by ensuring linkage and treatment initiation as well as support for drug distribution and adherence. They will work with patients and at-risk populations in their communities, facilitating care and treatment.

In COP22, PEPFAR will continue to work with partners to monitor and evaluate the implementation and scale up of rapid ART initiation and effective linkage-to-care and continuity in treatment strategies in all its supported sites. Continuity in treatment and viral load suppression will be closely monitored to ensure that patients initiated on ART maintain treatment coverage to achieve optimal treatment outcomes.

### Specific Continuity in Treatment Strategies

Since early COP17, the PEPFAR South Sudan team has consistently identified and highlighted program performance issues based on data at agency, SNU and partner levels. From Q2 of COP19, this was further refined to looking at granular data at the site level by use of the weekly dashboard and granular site management calls. During COP20 and COP21 Q1 implementation period, PEPFAR South Sudan continued to recognize interruption in treatment (IIT) as the biggest challenge in the South Sudan program. Interruption in treatment issues were cross cutting across all care and treatment implementing partners. The same has been highlighted in the COP22 planning level letter (PLL) with recommendations to prioritize this in COP22.

PEPFAR South Sudan recognizes continuity in treatment as a priority and proposes a range of interventions, some of which are currently being implemented.

These include:

1. Site-level data use for problem identification and use of continuity in treatment analysis tools at the IM/SNU level
2. Prioritization of sites based on scale and magnitude of the problem

3. Use of weekly and monthly dashboard and site-level treatment collaborative for root cause analysis and identifying remedial measures
4. Periodic data quality assessments and use of tools to look at data quality issues on a more frequent basis to ensure accurate reporting of data from the sites where services are provided
5. Continuity in treatment analysis using time-cohorts and site-level dynamics (transfer in, transfer out, death, true interruption in treatment, etc.) by age and sex
6. Facility team concept involving facility level staff/POCs, IP supervisors, MOH field officers and PEPFAR staff
7. Enhanced monitoring and reporting tools (e.g., checklists and supervision tools, client tracking register, missed appointment and Interruption in treatment registers)
8. Documented transfer-ins and transfer-outs and improve intra-facility patient referrals
9. Six-month multi-month dispensing to all patients on ART, regardless of stability criteria. For the uniform forces on deployment to areas without HIV services, clients may be given 12 months of ARVs.
10. Decentralized ART provision through six-month drug dispensation and community ARV dispensation using the community outreach volunteers
11. Continue with LPV/r to DTG 10mg transition for pediatrics
12. Enhanced site level supervision, mentoring and monitoring through Field Officers
13. Community interventions
  - a) Community outreach work through community volunteers
  - b) Treatment support groups
  - c) Engagement of support networks, including local community level PLHIV networks
14. Enhanced client treatment literacy and continuous patient education

In COP22, the PEPFAR South Sudan program will continue to focus on the quality of community interventions to address implementation issues around the cascade, with particular attention to continuity in treatment issues. With the goal of targeted demand generation at the community level, enhancing linkage to treatment and improving continuity in treatment, PEPFAR will continue to identify new and creative ways of scaling up community interventions across all its sites.

These will include, but not be limited to:

1. Working with indigenous county-level CSOs, CBOs, and FBOs
2. Direct partnerships with local, county-level PLHIV networks
3. Direct recruitment of community cadres of staff (e.g., outreach supervisors and outreach workers) and engaging community outreach volunteers

#### VL coverage and suppression:

In the past one year, the South Sudan program made improvements in VL coverage despite some challenges with reaching 95%. VL coverage increased from 57% in FY21Q1 to 60% in FY21Q4 and 66% in FY22Q1. VL suppression has stayed at an average of 85% during the past 4 quarters.

## **VL Suppression:**

VL suppression has been relatively good in the adult population at 85% in FY21Q4 but only 64% in children less than 15 years old. Some of the possible contributing factors for low VL suppression among children include absence of optimized pediatric ART regimens (pDTG), difficulty of administering ART to children due to taste and pill burden, limited or no clinical assessments, stigma in older children leading to absconding from clinic appointments, persistent absence of child/youth friendly environment at clinics, high transport costs preventing mothers from bringing children to clinic which leads to missed clinical assessments and hence low drug dosage and delayed or inadequate adherence counseling due to low provider or care-giver literacy levels.

In COP22, PEPFAR South Sudan will implement the following strategies to improve VL suppression:

1. For the children and adolescents.
  - ✓ South Sudan will continue advocating for optimization of treatment for children and transition of children to pediatric DTG regimen.
  - ✓ South Sudan will conduct provider and client literacy sessions at all facilities and communities with a focus on adherence to treatment. Field supervisors will monitor and mentor counselors on enhanced adherence counseling and management of non-suppressed clients.
  - ✓ The country will build capacity of community workers on pediatric ART dispensation and management. Community workers will be trained to follow-up children, conduct community drug refill and provide enhanced adherence counseling.
  - ✓ The country will continue to improve ART clinics to provide friendly and safe services to the children. This will include fast-tracking children and adolescents, creation of specific areas or week-end/after hour ART services and clubs that bring the youth together.
  - ✓ The PEPFAR team will continue to participate actively in commodity technical working groups in order to monitor consumption at facility and national level, conduct accurate projections and forecasting and collaborate with MoH partners for timely ordering of drugs.
2. For the General population.

South Sudan will conduct provider and client literacy sessions at all facilities and communities with a focus on adherence to treatment. Field supervisors will monitor and mentor counselors on enhanced adherence counseling and management of non-suppressed clients.

The country will strengthen the components of community drug refill to ensure drugs are taken close to the clients.

PEPFAR South Sudan will conduct active follow-up of unsuppressed clients through regular monitoring of HVL registers, appointment logs and physical tracing by community health volunteers. The community health volunteers will be trained on client counseling strategies, provided with the necessary job aids, SOPs and tools to be able to provide ethical and confidential services.

Through the Granular site management and weekly dashboard, the team will conduct weekly data review of VL site level data and implement quick actions at facility and community level. This will allow timely identification of missed appointments and initiate follow-up to return clients to treatment.

### **VL coverage:**

VL coverage has generally remained quite low in different populations and geographical areas. Although the average VL coverage stood at 66% in FY22Q1, the VL coverage in children under 15 years was at 60% and even lower for pregnant women at 59%

In order to improve VL coverage PEPFAR South Sudan has proposed the following strategies in COP22:

South Sudan will prioritize pregnant and breastfeeding women, children and adolescents and high VL clients for repeat VL after EAC for VL testing using near Point of care instruments at the treatment facilities to ensure access and timely results for action. By end of FY21 Q4, there were 15 facilities using GeneXpert instruments for testing PBFW, children and HVL clients with cumulative 1102 VL tests done.

One key rate limiting factor for progress on VL coverage is the process of identifying clients due for VL test in order to have them contacted or traced and provided VL services. In FY23, PEPFAR South Sudan plans to establish an electronic system that would ease the process of identifying clients who are eligible for VL and following them up for VL sample collection. One such tool that is being piloted is the *Vi* surge tool. *Vi* Surge tool was designed to simplify identification of clients eligible for VL load so that facility staff can easily contact them and trace them for VL services. It has automated the process of manually flipping through the ART register and patient files to identify eligible clients. Once ART clients who are active on treatment are entered in the system, the tool notifies the user when the client will be eligible for VL. It has the capacity to longitudinal track VL results, IIT status, recommend clinical evaluation and tracks client inter-facility movements. VL coverage is also impacted by low VL literacy and investments in provider capacity to deliver key information 'of what to anticipate and treatment is monitored.

In order to minimize missed opportunities for VL collection at other entry points, the PEPFAR program will strengthen its collaboration with other partners. More staff will be trained on sample collection at various entry points especially at PMTCT, OPD and Wards to collect VL samples.

South Sudan will also scale-up on demand creation for VL services at both facility and community level. This will be done by integrating VL information dissemination with other community activities. This activity requires development of patient education materials such as job aids.

In order to reach out to clients who cannot access the facilities, South Sudan will integrate VL sample collection into the community drug refill activities. Community outreach workers will be trained and mentored to be able to conduct client tracing, community VL sample collection and

proper documentation. The trainings will be conducted using standardized curriculum for health care workers and community volunteers.

In almost 98% of facilities, there is only one point for sample collection leading to clients leaving clinics before sample collection due to long waiting time and stigma related issues. PEPFAR South Sudan will put in place facility service improvement such as fast-tracking the adolescents for quicker service and introducing weekend and after hour ART services.

Sample transportation challenges also affect provision of VL tests to clients. Sample transportation is done by individual motor bike riders, commercial vehicle drivers or commercial flights. Absence of dedicated courier systems has several times led to delay in delivery of samples to the testing laboratory and hence rejection or loss of samples. The program reported a rejection rate of 1% in FY21 Q4. This is within the rejection limit of 5% set by the HIV reference laboratory. Other factors that have contributed to delay in delivery of samples for testing are lack of dedicated regional sample coordinators, insecurity, abrupt flight cancellations and absence of appropriate cold chain facilities at hubs. PEPFAR South Sudan will explore opportunities of engaging private registered companies to implement sample transportation in collaboration with regional or state transport coordinators. For facilities that do not have reliable transportation system, near point of care GeneXpert instruments will be used for conducting VL tests for all clients. The PEPFAR Lab implementing partner will contract transporters to transport of samples from sample collection sites to the testing laboratories.

Efforts to improve VL coverage was also affected by stock-out at facility level or testing laboratory. The supply chain advisor and commodity specialist together with HRL staff will actively monitor stock at facilities, generate weekly stock reports and support facilities to place timely orders for supplies. This will ensure there is adequate supplies for both capillary and venous sample collection, sample shipment and testing. PEPFAR South Sudan will identify resources for last mile delivery of supplies in order for facilities to have adequate stock at all times.

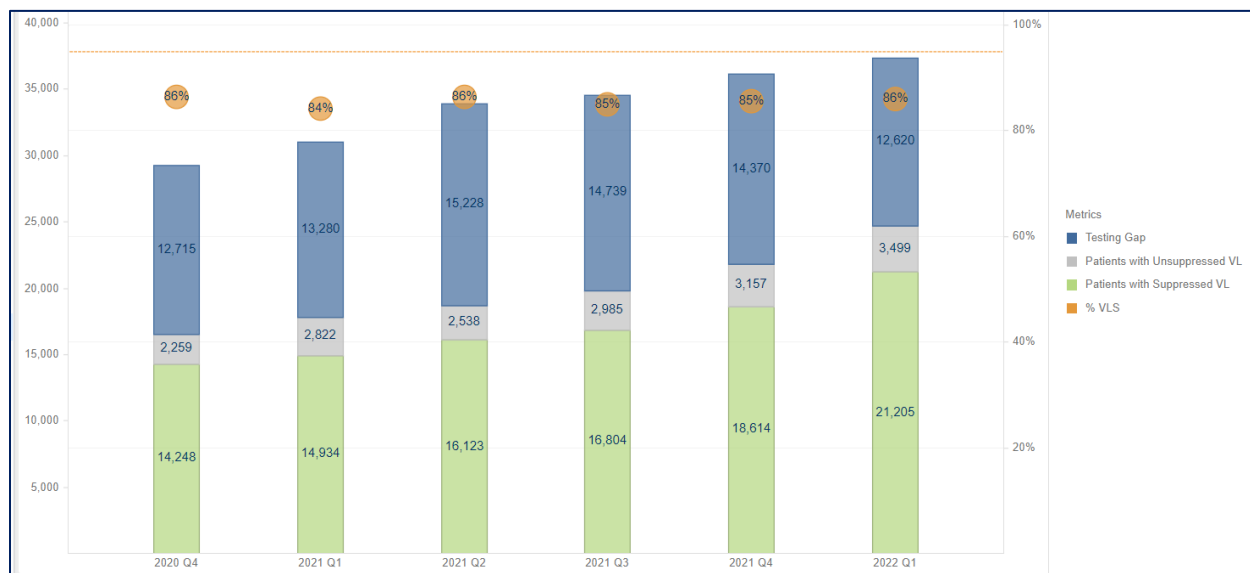
Testing of samples at HIV reference laboratory and Near Point of Care facilities and return of results require availability of reliable electricity at the testing laboratories, timely equipment maintenance, competent and dedicated human resource and availability of storage space for the much-needed supplies. PEPFAR South Sudan will continue liaising with UNDP to ensure the VL testing platforms are under optimum working conditions including supporting training of biomedical engineer and two super users to conduct basic equipment maintenance. PEPFAR will also provide fuel for generator, train and supervise staff in the testing laboratory and maintain appropriate and safe laboratory work environment.

Laboratory information systems also plays a part in the scale-up of VL services. The HIV Reference Laboratory currently uses VL sample management system (VLSM). The challenges experienced with the VLSM include unstable internet and recurrent system errors. In order to improve result transmission and accessibility, PEPFAR South Sudan will procure a stronger internet service,

finalize interoperability processes with DHIS2 and e-governance and provide mentorship to facility level staff on data entry and result access.

## Treatment and Viral Load Suppression

Figure 4.2.1 Viral Load Outcomes, FY21



### Adult ART

In COP22, PEPFAR will continue with the Lopinavir/ritonavir to Dolutegravir 10mg transition of children below 20 Kgs and continue to initiate adult patients on TLD, initiated under COP18, as the preferred option for ART for all adults (including women of reproductive potential) and adolescents weighing > 30kgs. Women of reproductive potential will be provided appropriate information to make informed decisions about their HIV treatment.

The government has adopted Dolutegravir-based regimens as preferred first line for adults and children and has just launched the January 2022 ART Guidelines to capture the new recommendations. South Sudan will continue to implement rapid ART initiation (Test and Start); TLD transition; differentiated service delivery models; and six-month MMD. PEPFAR will support training of ART providers in delivering consistent counseling messages (about Neural Tube Defects and all potential risks and benefits of available ART), so that a woman can choose from available ART options in South Sudan. Community volunteers/health workers will be engaged to provide current and up-to-date information on DTG. Patients receiving treatment for TB, with rifampin-containing regimens, will be provided additional DTG 50mg when taking TLD.

Additional activities to support adult ART will include the following:

- Ensuring provision of cotrimoxazole prophylaxis
- Screening and management of common Opportunistic Infections (OIs)
- Scaling up client literacy activities both at facilities and communities



- Developing and reviewing client literacy materials for demand creation
- Establishing multiple sample collection points within facilities to improve access and increase coverage
- Integrating VL sample collection into other community interventions
- Providing additional on-site training and mentoring for clinical and laboratory staff, including support to nurture a multidisciplinary team approach to patient management
- Engaging CSOs to conduct contact tracing and return clients to treatment
- Improving supply chain management of ARVs and OI drugs as well as laboratory supplies

In COP22, PEPFAR will continue to support one MOH and one UNDP staff to provide technical assistance to support quantification and forecasting; financial analysis and planning for Pediatric DTG/ pediatric ARV optimization and Test and Start. These supported staff will work with Implementing partner site focal persons to support facility level needs, including DHIS2.

With PEPFAR South Sudan support in both aggressive scale-up and sustained SNU, a total of 20,493 new patients will be initiated on treatment in FY 23. PEPFAR South Sudan will also provide treatment services at Protection of Civilian (POC) sites.

PEPFAR South Sudan will work to improve health care providers' capacity -- including at national and state levels -- to deliver high quality family-centered HIV care and treatment services to adults and children living with HIV.

To accomplish targeted scale up, ensure quality delivery of services, and build host country institutional capacities, PEPFAR will continue to strengthen systems investments at both national and facility levels. These include:

1. Supportive supervision and mentorship at the site level through Field Officers, who will build and strengthen the national field supervision program (this will be part of the HRH realignment efforts)
2. Maintain the 54 ECHO project sites. In COP21 and COP 22, the total number of ECHO sites will be maintained at 54. PEPFAR will maintain five additional sessions per month dedicated to continuous quality improvement practices, including data quality and human resource development across multiple cadres in the facility, lab and community.
3. Enhance national level capacities for program monitoring, data review and analysis, review of HIV/AIDS program at the national level, policy analysis and decision making and development of technical guidelines. PEPFAR will make systems investments at the MOH level and strengthen the national level HIV Department by providing direct technical assistance as well as staffing and technical support.
4. Support the Incident Management Structure (IMS) at HIV department -MOH
5. Support and strengthen the national M&E Technical Working Group to increase use of quality site-level granular data for data-based decision making
6. Support the Annual National HIV Care and Treatment Review and Planning Meeting, which includes the MOH, the State Ministries of Health, hospital directors, and ART providers in charge at each treatment site

7. Support NPHL to establish and scale up a lab quality assurance (QA) system across the HIV services cascade

PEPFAR-supported Field Officers will, in partnership with MOH staff, conduct working meetings with all staff at each ART/PMTCT site to review and discuss quality of treatment services using standards of care and to discuss progress, existing challenges, and ways to improve service delivery. The Field Officers will provide site level on-the-job training and mentorship to facility staff. They will discuss existing challenges in ensuring patient continuity in care and adherence to ART and identify the most suitable solutions.

### Pediatric and Adolescent Services, including ART

South Sudan has adopted optimized pediatrics ART regimens which have been integrated into the consolidated guidelines for ART. The country will transition Lopinavir/Ritonavir to Dolutegravir 10 mg, that is LPV/r to DTG 10 mg transition for children below 20kgs.

PEPFAR South Sudan will prioritize and maximize pediatric and adolescent HIV testing, care and treatment within a family-centered approach, in health facilities, the community and through the OVC program. This is aimed at increasing the ability to find and treat HIV positive children through PITC, PMTCT/EID and ART services.

In COP22, for pediatric and adolescent HIV services, PEPFAR South Sudan will continue to focus on:

1. Supporting the MOH with the optimized pediatric DTG transition Supporting scale up of index testing of biological children (below 19 years) of PLHIV
2. Supporting activities that widen access, utilization, and uptake by families and adolescents to testing
3. Increasing activities to support the needs of adolescents with HIV up to age 19 (prevention with PLHIV, support groups, support for transitioning into adult services, adherence support, reproductive health services, refer to the OVC program for adherence support, viral load monitoring, disclosure support, appointment tracking, and other support services)
4. Implementing partners will emphasize provision of differentiated Adolescents HIV clinical care to adolescents and young people living with HIV- Aged 10-19 years by implementing The Operation Triple Zero approach that will ensure adolescents and young people living with HIV commit to simple treatment goal of achieving “Three zeroes” i.e., Zero missed appointments, zero missed drugs/ medications and zero viral load. The three-pronged approach to operation triple zero, which includes i.e., empowerment of the Adolescent; the family care giver and the Health Care Worker will be rolled out through a series of activities that include, among others- establishment of teen clubs at facility and community level; Identification and training of Peer leaders, Training of Health Care workers and Care givers
5. Increasing pediatric ART coverage, continuity in treatment rates, monitoring, and quality of services, in addition to the provision of other pediatric care and support interventions

6. Increasing direct linkages to the community to improve communication between facilities and community services for HIV positive children and youth
7. Improving EID coverage through establishing integrated community service delivery with sample collection, recruiting, training and assigning dedicated mentor mothers to track mother-baby pair in the community, providing transportation incentives for referral of HIV exposed infants, strengthening collaboration between PMTCT and other child entry points e.g. immunization clinic, Nutrition, pediatric clinic, decentralize POC EID testing and establish multiple sample collection and testing points provision of literacy sessions for mothers, training and motivation of mentor mothers to trace HIV exposed infants, assigning of EID focal points at children entry points such as immunization and malnutrition units to identify HEI, strengthening maternity and postnatal and PMTCT collaboration, , provide in-kind or cash based incentives for mother-infant pairs and ensuring timely documentation of HEI.
8. Ensuring access to Cotrimoxazole prophylaxis for all HIV exposed and infected children
9. Enhancing linkage and continuity in treatment of children by reviewing the pediatric cascade from identification to continuity in treatment and follow-up of HIV exposed infants and children on ART
10. Facilitating provision of psychosocial support of children and adolescents, including age- and developmentally appropriate disclosure as described in the South Sudan guidelines
11. Supporting scale-up of adolescent HIV treatment by ensuring the provision of adolescent-friendly services in both facilities and communities
12. In-service training to building capacity of health workers to monitor, supervise and implement uninterrupted HIV treatment services from infancy to adolescents (including transition to adult services)
13. Improving linkages and referrals between facility and community services and ensuring adequate, bi-directional linkages between OVC and pediatric care and treatment services
14. Fast-tracking children for VL sample collection and non-suppression management
15. Improving VL coverage in children through use of near point-of-care GeneXpert devices
16. Ensuring TB preventive Therapy for all eligible children living with HIV.

#### **4.3 Prevention, Specifically Detailing Programs for Priority Programming**

- a. Orphans and Vulnerable Children
- b. Key Populations: Female Sex Workers
- c. Priority Populations: Clients of Female Sex Workers
- d. Voluntary Medical Male Circumcision
- e. DREAMS
- f. Pre-Exposure Prophylaxis

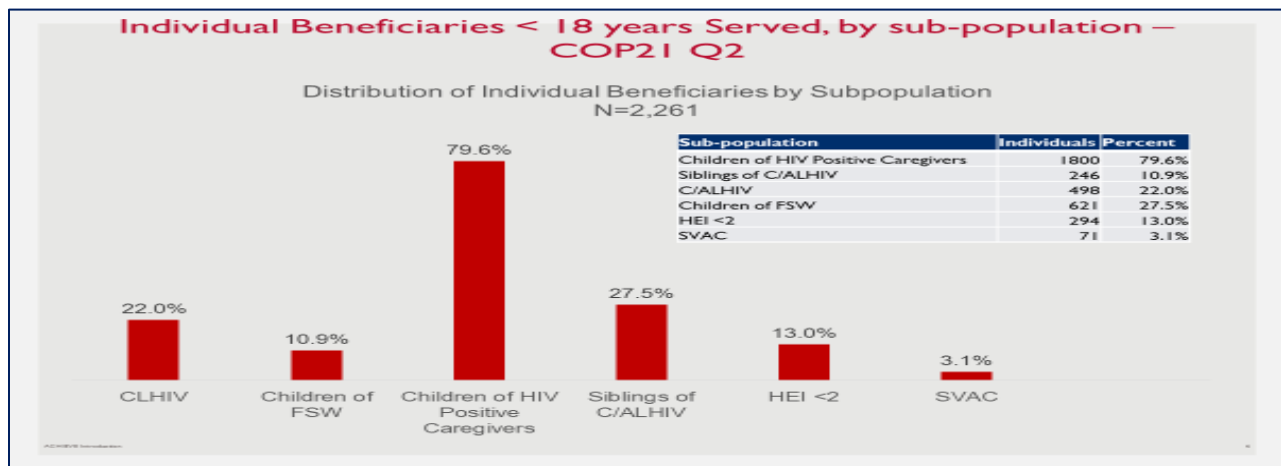
##### **a) Orphans and Vulnerable Children (OVC)**

From the start of COP19, the OVC program strongly prioritized enrollment of children and adolescents living with HIV (C/ALHIV) and their households, especially those who are newly on

treatment, IIT, or with poor viral suppression. The OVC program also prioritized children of HIV positive FSW and children of HIV positive women who are newly enrolled on treatment, IIT, or with poor viral suppression. The OVC program scaled up service provision within the current geographic location of Juba Town in COP20 to offer enrollment to 90% of TX\_CURR <18 . OVC beneficiaries are primarily identified through pediatric ART facility rosters as well as ANC, labor and delivery clinics, and referrals from the KP program. The OVC program provides a comprehensive package of services to children and caregivers, including adherence counseling; disclosure counseling, appointment tracking; viral load monitoring through clinical confirmation of viral load results; ART regimen tracking, MMD tracking; HIV testing referrals to ensure that siblings and caregivers of CLHIV know their status; transportation reimbursements to attend appointments; referrals to other clinical services; and other support such as education stipends or economic strengthening activities such as savings groups or income generating activities, as needed.

The OVC comprehensive program includes children aged 0 – 17 with a known risk factor (C/ALHIV, HEI at risk of IIT, biological children of HIV+ mothers, children of HIV+ FSW, sexual violence survivors, etc.), and their caregivers and siblings. These beneficiaries require routine support through home visits and case management. Children are identified via clinics, referrals from child welfare and community, and by index testing children of HIV+ parents to identify “well” children. These families are provided with socio-economic support and monitoring of case plans where participants are graduated from the program upon achievement of benchmarks around health and HIV outcomes, economic stability, child safety, and school enrollment.

**Figure 4.3.1 OVC beneficiaries’ distribution**



The OVC program will maintain their existing MOUs with clinical facilities in Juba and continue to ensure that a Clinic Community Coordinator (CCC) is based at each facility to ensure bi-directional referrals for testing, ART, VL and other services. These CCCs will support data sharing with OVC to help track missed appointments, monitor viral load test results, and conduct, at a minimum, monthly case conferencing meeting with OVC Community Case Workers to discuss beneficiaries with poor clinical outcomes and poor viral suppression. The CCCs will also work across clinical

areas to ensure that the OVC program is reaching beneficiaries through both pediatric and adult ART clinics, ANC, labor and delivery, and others.

In addition to a comprehensive package of services to support beneficiaries, in COP22 the OVC program will continue to collaborate with clinical programs to support index testing of biological children of HIV positive mothers and EID at risk of IIT. The OVC program and clinical partners will jointly develop SOPs, and the OVC program will support follow-up and tracing for index testing of biological children of HIV positive mothers and EID at greatest risk of IIT. The OVC program will prioritize these newly identified positive children and their households for enrollment and ensure that they are initiated on treatment and remain supported by the OVC program.

As for the COP22 activities, the OVC program will contribute to the three 95s as follows:

- 1<sup>st</sup> 95:  
HIV risk assessment, mobilization, and referrals to HTS. Stigma and discrimination reduction. Status disclosure counseling and clinic-community coordinators to continue as POCs in Facilities.
- 2<sup>nd</sup> 95:  
Assisted referrals to ART, CCCs monitoring of appointment attendance, monthly case conferencing with CCCs and Community Case Workers (CCWs). Home based ART adherence counseling, Household visits to promote treatment adherence and drug refill. Monitoring ART regimen and support status disclosure and continued retention.
- 3<sup>rd</sup> 95  
Caregiver and patient education on the importance of viral load suppression and monitoring incorporating the concept of Undetectable = Untransmissible (U = U). Defaulter tracking and tracing and reenrollment into care (caregivers and children in program catchment area). Monitoring of MMD status and monthly case conferencing with CCCs and CCWs on clients with poor outcomes. Monitoring VL status and supporting referrals to VL testing and ensuring results are received. Supporting those with high VL to complete enhanced adherence counseling at facility.

The OVC Comprehensive program will continue to provide the HIV and violence prevention curriculum, Sinovuyo Teen, as part of the comprehensive package of services for beneficiaries but will not specifically target additional beneficiaries ages 9-14 for prevention activities, per the COP22 Guidance. Starting from COP20, South Sudan has started implementing the DREAMS program and eligible DREAMS AGYW 15-24 will be considered for referral to OVC services. DREAMS beneficiaries that are identified to require OVC services (newly identified HIV+, or survivors of sexual violence) will be referred to the OVC comprehensive program for comprehensive services. DREAMS facilitators and mentors will also actively counsel and support demand generation for PrEP among AGYW. The AGYW that qualify for PrEP will get referred to receive these services from clinical partners starting in the last quarter of COP21 when commodities become available.

#### b) Key Populations: Female Sex Workers (FSWs)

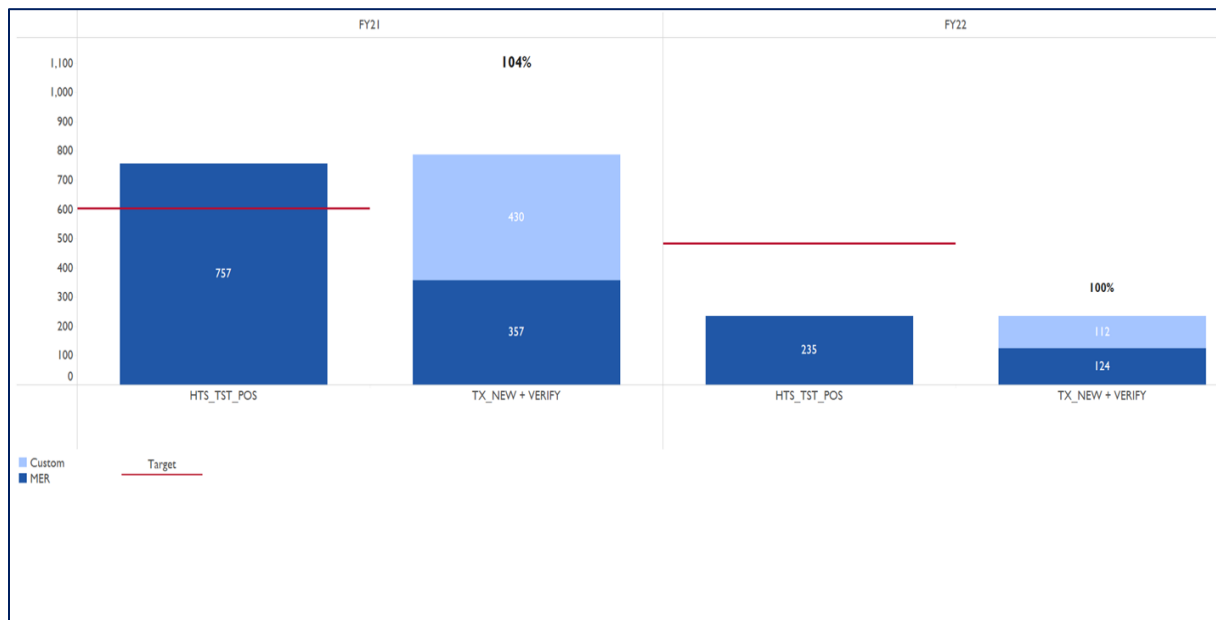
The Key Population program continues to contribute significantly to HIV prevention by aggressively targeting and reaching female sex workers and their clients, offering them a minimum package of HIV services that includes

- STI screening and referral for treatment,
- condom promotion and distribution including lubricants and
- GBV awareness raising and screening and referral for post GBV care
- Post Exposure Prophylaxis
- Family planning counselling and referrals.
- HIV testing and linkage to care and
- PrEP coming soon in COP21

The community-based HIV service delivery model has continued to grow enhancing the reach to FSWs and their clients across the six operational sites. During COP22 implementation, the program, will continue to follow the COVID-19 guidance and ensure community activities do not become risks for COVID-19 transmission especially at times when the country might experience upsurges.

In addition to current KP service package, PrEP will be offered to FSWs who test negative and accepts to initiate PrEP. The start of PrEP is anticipated in COP21 as commodities become available. The MOH has provided leadership and is working with a technical core team to ensure PrEP operational guideline, M&E tools, standard operating procedures and other materials are developed and trainings are conducted in preparation for readiness for the launch of PrEP anticipated in quarter 3 of FY22. Civil society is supportive and has offered to make critical contribution at this phase on preparation and readiness drive.

KP service package activities of prevention, and linkage to care were offered during COP20 and the program has demonstrated a strong performance reaching over 90 percent (8646/9416) of FSWs targeted for prevention activities, including testing 75 percent of FSWs targeted for HIV testing and identifying 757 accounting for 126% of that year's set target. The same trajectory of strong performance has been demonstrated in quarter one of FY22. And although the KP program is not mandated to report on treatment linkage and continuity in treatment across the six KP sites, it is important to note that that overall linkage among FSW was high with 100 percent cases linked to treatment across the three PEPFAR treatment partners ART sites as well as in one non PEPFAR ART site in BOR. The program is tracking all key indicators as mandated in MER and now includes the use of USAID designed Custom Indicators to track and verify treatment linkages, number of KPs currently on treatment and viral load services.



Viral load coverage among the KP has significantly improved at the start of COP21, with high volumes of samples collected for viral testing in quarter one of FY22. KP viral load suppression has remained high at around 88 percent, and coverage improved to 54 percent at the OU and 57 percent in Juba SNU. The implementation of viral load surge operations that started in quarter one of FY22 has brought VL services close to the community, supporting community-based viral load sample collection and logistical transportation to Juba national public health laboratory. This COVID-19 mitigation measure, funded under ARPA is one of the key factors attributed to these significant successes in KP viral load coverage. Viral load coverage and viral suppression is a key area of focus for the KP in COP21 and will continue to be so in COP22. Although the ARPA funding won't continue, the program will explore and scale up community-based viral load sample collection in collaboration with the national laboratory.

The Key Population program geographical focus remains the six current KP sites and during COP22, these will continue to be prioritized and served. The urban centers and towns in transport corridors, primarily in the Equatoria region where female sex work continues to take place, remains strong sites of KP services and the program will continue to consolidate activities in Wau, Bor and Rumbek. Periodic KP size estimates in the absence of recent biobehavioral surveys has continued to provide data for KP planning and target setting and have consistently shown increasing numbers of FSWs, including their clients, in other key towns and centers such as Wau, Rumbek and Bor where high prevalence has emerged.

Despite criminalization, commercial sex work continues to flourish in South Sudan and, a relative enabling environment for sex work continues. The economic situation remains dire, young, local girls and women continues to be driven into commercial sex work. The program has also noted a new wave of mostly younger FSWs coming from the neighboring countries and especially Uganda.

As South Sudan remains relatively stable, especially in urban centers and the transport corridors and with the emerging global and regional impact of COVID-19 to economies and livelihoods. Uganda which had one of the most stringent restrictions and only recently opened up, is believed to be experiencing a tough time, and hence the new arrivals could be attributed to these issues.

The Key Population program in South Sudan in COP21 and in COP22 continues to primarily target FSWs and their clients working in collaboration with DoD's program in major army barracks in Juba and Wau. It also incorporates new FSW "hot spots" in a few selected locations considered to be under-served, including the busy transport corridor between Juba and Nimule where services were previously interrupted due to violence. COP22 KP targets are a reflection on the continued good program performance and the annual KP scale up, the program has consistently supported. In COP22 while the program will support a comprehensive HIV package of prevention, testing and linkage to ART, including PrEP, a total of 11,715 FSWs and 8,622 clients are targeted for prevention activities. About 75% the FSWs reached with prevention services, will be eligible for testing and an estimated 702 newly identified HIV clients are expected to be linked to ART. The remaining 25% are expected to be composed of known positives and those who have been tested in the recent three months. With availability of PrEP services in country, those testing negative will now have an opportunity to enroll on PrEP to mitigate new HIV infection among the KPs. In COP22, 1,287 new PrEP initiations and 900 continuing PrEP from quarter 4 of COP21 are targeted.

The KP program has continued to collaborate and coordinate its implementation with the South Sudan AIDS Commission, UNAIDS, MOH, the Juba City Council and its affiliated law enforcement, and other security agencies and other governing authorities. Civil Society organizations are being brought onboard and have roles in providing key inputs and supporting new interventions such as PrEP and self-testing, as well as advocacy for KP rights to service initiatives, fighting stigma and discrimination, and raising awareness to support development of friendly policies that favor KP activities, and are being incorporated to overall KP and HIV response. In addition, the program will continue to work to support dialogue with MoH, SSAC, Global Fund and other key actors on implementation of PrEP which is already incorporated in the 2019 national ART guidelines that was launched this year (2022).

In Bor South where treatment is provided by a non-PEPFAR partner, USAID's Advancing HIV/AIDS Epidemic Control program has implemented successfully KP linkage to care activities there in collaboration with UNDP and MOH supported treatment partner to ensure ARV supplies for beneficiaries are always available. KP diagnosed at community level receive treatment at Bor state hospital which is directly supported by MOH with technical assistance coming through UNDP/GF funding. Implementation success in COP21 will continue during COP22 with the same model of service and collaboration.

#### c) Priority Populations: Clients of FSWs (cFSWs)

The KP program will continue in its fourth year to offer HIV prevention for and referral to ART care sites, clients of female sex workers who are disproportionately affected by HIV compared to the



general populations. During COP22, PP prevention and targets have been set for all 6 sites, with Juba, Nimule and Yambio having over 80 percent of the targets. In Juba, the program will continue its close collaboration with the DoD program to test military clients and those identified positive, will be linked to treatment, and integrated into the military program. In COP22, the KP program will work to identify clients in the general public, through PP network structures that have been established using similar model of the female sex workers. In addition, clients who are difficult to reach will be offered an alternative to self-screen using self-testing expected to be launched during COP21. During COP22 self-testing will continued to be scaled up among cFSW and opportunities for anonymous index testing, ensuring linkage to treatment for all HIV positive persons will also continue.

In COP22, the program intends to reach 8,622 clients of female sex workers in all sites and test at least 75 percent of those reached. With the projected 3-4% positivity of HIV among this group, 194 to 259 new cases are expected to be identified and referred for care and treatment.

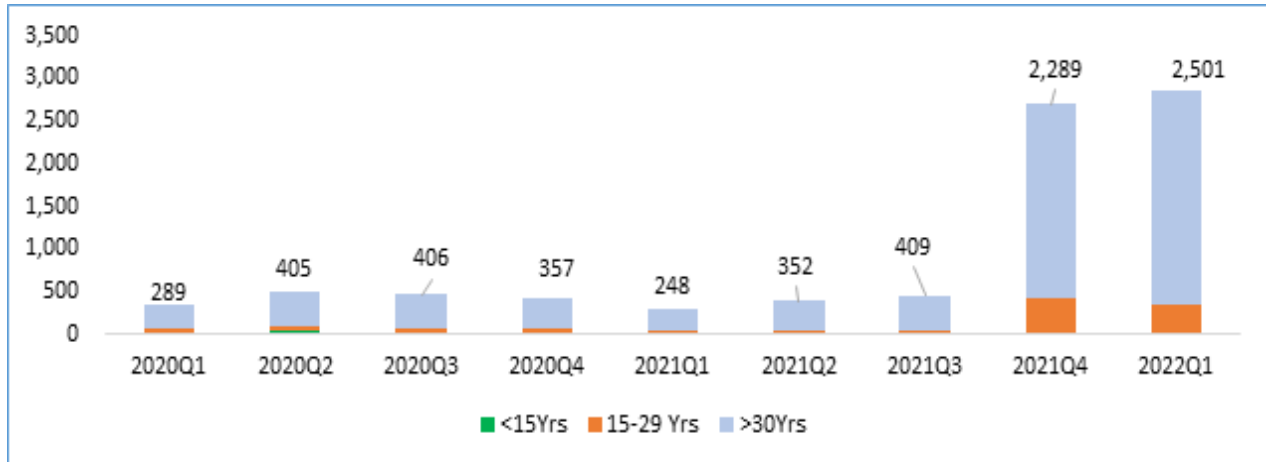
#### d) Voluntary Medical Male Circumcision (VMMC)

Provision of a comprehensive prevention package to the military is critical in addressing the challenge of new infections. Military leadership recognizes the importance of male circumcision as an important intervention for HIV prevention is prioritized in the inaugural SSPDF HIV Policy document and the SSPDF HIV/AIDS Strategic Plan (2018-2022). The commitment and political buy-in by military leadership prioritizing VMMC as a low-cost, one-time intervention to tackle the HIV epidemic among the organized forces is central to the program success recorded thus far.

Since COP19, PEPFAR South Sudan continued to support VMMC prioritizing the uniform forces who are responsible for up to 34.6% of all HIV new infections in the country as the main clients of Female Sex Workers (FSWs). By COP20, significant expansion has been made to the program in-term of geographic coverage into two new sites followed by additional expansion is surgical capacity of existing sites in the subsequent year (COP21). Currently, there are 3 PEPFAR-supported sites that provides VMMC services in 3 different locations (Juba, Bor town and Wau).

Despite initial slow start, FY21 results demonstrated a successful scale up of VMMC services mainly towards the last quarter with 84% increase in target achievement from the previous quarter (409→2289). The strategic reach among the key age band of 15-30-year-old males was also maintained as the program transitioned away from under-age (<15 years old) circumcision since Cop20 (Figure 4.3.3).

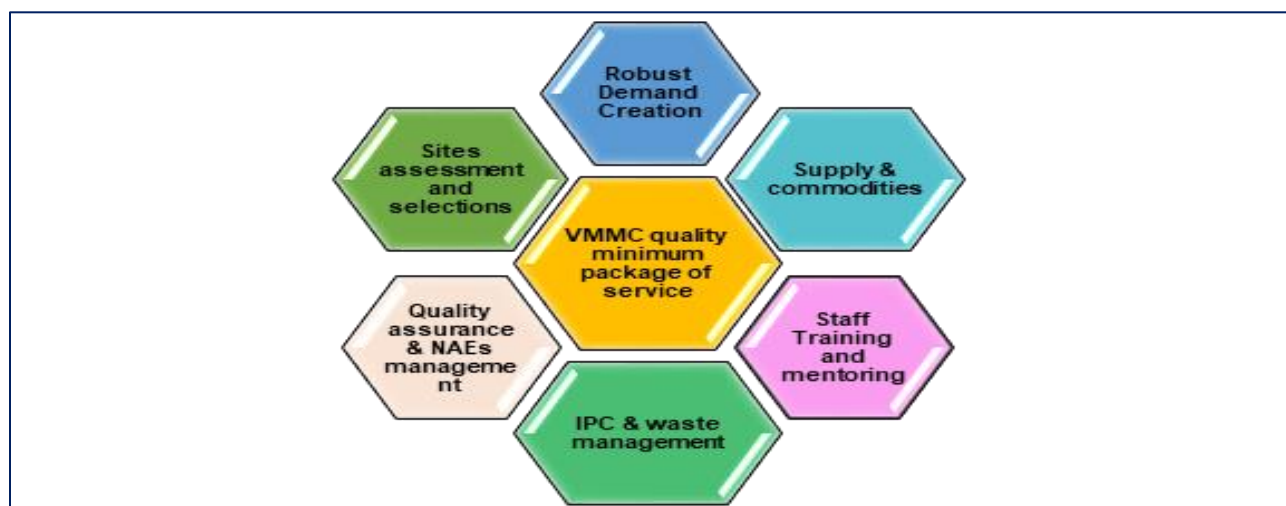
**Figure 4.3.3 VMMC Quarterly Trends by Age**



In Cop22 and in line with the PLL recommendation, the VMMC will expand beyond facility-based to provide mobile outreach services. the program will implement a low-cost hub and spoke service delivery model in addition to the current existing fixed sites. Because of poor road infrastructure condition in most part of the country coupled with the seasonal accessibility of some regions, existing fixed sites will be used as logistical hub from which trained and dedicated mobile team will be deployed periodically to some select locations based on agreed criteria using appropriate logistics means. Lessons learnt and best practices from sister programs in the regions will replicated to maximize community engagement and demand for services.

**VMMC Implementation framework in COP 22**

The implementation framework in COP22 will include 7 essential elements that represents core pillars of VMMC quality service delivery. These are highlighted below.



*VMMC implementation framework*

#### 1- Comprehensive minimum package of services:

In COP22, the VMMC will continue with minimum package that includes age-appropriate sexual education, testing and screening for Sexual Transmitted Infections (STIs) followed by linkage of all positives to treatment. Special emphasis will be put on post-operative counselling and clients follow up to reduce on Notifiable Adverse Events rates. Emphasis should be placed on moving away from blanket HIV testing in the VMMC program. This will be achieved through risk stratification prior to testing using a screening tool, nonetheless, testing would be made available on need and completely on voluntary basis. Positive clients will be prioritized for ART initiation and reappointed for medical circumcision in 3 months to reduce risk of disease transmission.

In addition to condom distribution, the program will also target high-risk negative clients for PrEP.

#### 2- Sustained Demand Creation

Robust demand creation remains key for sustained services uptake and targets achievement. This has been a key focus area with demonstrated successes in engaging commanders as VMMC champions leading a non-coercive sensitization campaign in their respective units. Given the anticipated shift in VMMC service delivery model in COP22, the program will update its communication strategy to explore more evidence-based methods and context specific interventions to adapt to the mobile outreach services. Insights from the ongoing VMMC service-situation analysis in COP21 will be used to inform demand creation strategies using appropriate platforms to develop and disseminate tailored age-appropriate and cultural-acceptable messaging. Involvement of CSOs, CBOs and community gatekeepers will be essential in mobile outreach settings. Strengthening synergies with the Key Population (KP) program will also be a key focus in COP 21 given the fact that military are known clients of FSWs. Demand generation plans will be extended to involve Peer navigators and active referral of FSW clients to VMMC services.

#### 3- Skilled and motivated staffing.

To minimize interruption of service in the main hubs, dedicated mobile outreach team will be trained and attached to a mother hub facility. Each team comprise of 10 individuals (including both technical and support staff) and will be led by team manager/supervisor who is an expert VMMC ToT to provide continuous technical mentorship to the team in addition to the administrative role. Addressing the long-standing military staff motivation issue is important in ensuring staff retention and continuity of service. Therefore, ongoing initiatives with UNDP/GF will be utilized to channel HRH support to VMMC providers. Similarly, cross-collaboration with the zoom-based video conferencing technology, ECHO project will be essential to develop in-service training curricula and continuous education for VMMC providers.

#### 4- Appropriate Site selection

Sites selection process for the mobile outreach will be guided by the following criteria:

- Population-rich Military barracks, training center and surrounding /host commodities
- Proximity to a facility with comprehensive HIV services to ensure linkage to treatment.
- Equity through regional consideration (Greater Upper Nile, Equatoria, and Bahr El Ghazal)

- Ease of access in the rainy seasons.
- Availability of pre-existing infrastructure (PHCC or PHCU) and clinician to be trained on VMMC postoperative follow up.

Potential sites will include established facilities, military training centers schools and other community centers as appropriate. The team will work closely with military leadership, local authorities, community leaders and health workers to ensure adequate mobilization, clients' education, safety, and appropriate post-operative follow-up.

#### 5- Effective commodities and supply chain:

Since COP20, the program has made a significant effort to maximize efficiencies and shift towards reusable MC Kits. In COP22, this will further be augmented with transition to smaller size needle (19mm inner cutter). Due to lack of central procurement mechanism, MC supplies will continue to be outsourced by the IP. However, ultimately the goal is to streamline all HIV commodities procurement to GF/ UNDP to focus on strengthening service delivery in line with stakeholders' recommendation.

#### 6- Quality assurance and improvement.

Since its inception, the VMMC program has prioritized patients' safety and invested significantly in trainings, development of SOPs and formation of Notifiable Adverse Event (NAEs) reporting mechanism and NAEs taskforce structures in partnership with the military and MOH. COVID-19 pandemic has further stressed the need to focus attention on site safety and prioritize both clients and health workers' safety. This was partially realized in COP20, and 21 through site-level investment in IPC measures including installation of hand washing facilities, continuous provision of basic personal protective equipment (PPE) and Soap/Alcohol-based Hand Rub (ABHR). To enhance safety and implement continuous Quality Improvement (CQI)/ Quality Assurance (QA) systems at all levels of VMMC service delivery in COP22, the VMMC program will consider the following interventions:

- Institutionalized regular internal program quality assessment followed by course correction.
- Identify and train dedicated QI/IPC staff in all sites including the mobile outreaches.
- Strengthen staff mentoring approaches and introduce VMMC QI virtual learning community in all the regional hubs.
- Strengthening of clients' education and quality counselling on post-operative wound care.
- Active monitoring, reporting and management of NAEs.

e) **Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS)**

From the start of COP20 (Oct 01, 2020), South Sudan began to implement DREAMS activities within Juba County as recommended in the COP22 PLL. Given the success of the DREAMS program thus far, the DREAMS program will expand targets by 75% within Juba County to reach additional AGYW in COP22. The DREAMS program prioritizes reaching AGYW ages 15-24 at greatest risk of HIV, especially those engaging in transactional sex. This include risk factors such as AGYW who are: out of school/never schooled, have multiple sexual partners, with frequent STIs, experience violence, inconsistently use condoms, or abuse alcohol. Entry points for the DREAMS program include ANC clinics for AGYW who are pregnant or already have a child, STIs clinics for those with frequent STIs, AGYW who are working in bars, restaurants, tea shops, and other high-risk sectors, as well as AGYW engaged with FSWs and refer peers that may be engaging in transactional sex more broadly. The project has been careful to ensure that IPs do not interpret transactional sex as commercial sex work only, but that they used a broader definition.

The DREAMS program primarily implements economic strengthening activities for AGYW ages 15-24. The economic strengthening package includes BRAC International's Empowerment and Livelihood for Adolescents (ELA) curriculum for financial literacy and social asset building. The ELA model will be facilitated by young women of similar age or slightly older than the AGYW enrolled, with demonstrated leadership, confidence, and experience. These groups are facilitated in safe spaces, wherever the groups of AGYW are comfortable, including homes, compounds of churches and mosques, mentoring groups, etc. This curriculum is supplemented with basic literacy education for those who need it (particularly numeracy literacy), provided either directly by the IP or through referrals to other basic literacy programs already being implemented in Juba.

Economic strengthening activities in COP20 included an assessment of business opportunities and labor market, as well as income generating activities and self-employment. Using this assessment, the DREAMS program has identified income generating activities and self-employment opportunities for enrolled AGYW, including short- and long-term training courses and internships. For AGYW who can receive start up support through other projects, the DREAMS program would provide follow-up and mentoring to support AGYW.

South Sudan currently has very limited post-GBV services, with a full-service package only available at two facilities, one UNFPA-supported clinic in a facility PEPFAR supported for HIV services and one private. The DREAMS program is working on strengthening both post-GBV referrals and post-GBV services. In COP21, the DREAMS program rolled out LIVES first line support training for DREAMS facilitators, mentors, and clinical focal points, and will maintain this in COP22. In addition to strengthening the post-GBV services provided at facilities, the DREAMS program will also continue to strengthen post-GBV referrals. This will include updating post-GBV referral service mapping for both clinical and non-clinical services such as psychosocial support; updating cards to hand out to AGYW with information on where to go and contact information; maintaining referral networks, providing escorted referrals and at the facility level to receive AGYW referrals and provide services; and providing transportation stipends for those who cannot afford to travel to post-GBV services. In COP22, the DREAMS program plans to provide more comprehensive

psychosocial support for AGYW experiencing violence as this has been identified as a gap during COP20/21 implementation.

Due to commodities delays, PrEP services has not yet started in COP21. However, once PrEP commodities arrive, the DREAMS facilitators and mentors will contribute to PrEP demand generation, counsel eligible AGYW, and refer AGYW for PrEP initiation with clinical partners.

For COP22, the DREAMS program will:

- Maintain current target population (AGYW ages 15-24 engaging in transactional sex or with highest risk factors for HIV)
- Maintain emphasis on economic strengthening activities and GBV referrals
  - BRAC ELA curriculum for life skills and economic strengthening/entrepreneurship skills
  - Ensure AGYW are linked to relevant employment/apprenticeship programs in areas highlighted in market assessment
  - Ensure AGYW are referred for relevant post-GBV services and can complete referrals (transportation stipends, accompaniment, etc.)
  - Conduct USAID's GEND\_GB V Site Monitoring Checklist with additional sites to identify additional referral sites for post-GBV services
- Continue to identify additional basic literacy programs to refer AGYW who have not completed/attended school
- Care and Treatment Partners:
  - Provide referrals to post-GBV services, including PEP, STI screening, HIV testing, and FP services
  - Provide referrals for HIV testing for AGYW who don't know their HIV status
  - Receive referrals from HTS partners of AGYW who test negative but may be at high risk
- OVC Comprehensive Program:
  - HIV+ AGYW will be referred to the OVC program
  - AGYW who are survivors of sexual violence will be referred to the OVC program
- Key Populations Program:
  - Receive referrals from the KP program of AGYW engaging in transactional sex.

#### f) Pre-Exposure Prophylaxis (PrEP)

Pre-Exposure Prophylaxis (PrEP) is an HIV prevention that is recommended for high-risk groups such as discordant couples, breast feeding, and pregnant mothers, Key populations and

adolescent women and young girls involved transactional sex. The South Sudan National ART Guideline provides the policy framework for implementation of PrEP. The ART guideline was officially launched this year (2022) and provides the policy background for implementation of PrEP in the country.

To ensure translation of policy into implementation, the MoH is working with a team of experts in developing PrEP operational guidelines, tools and job aids and demand creation materials including for training of providers. In COP21, PrEP will be launched once tools are ready and commodity is available. In COP21, 2,673 PrEP target was set but roll out delayed due to lack of commodities and initiations on PrEP are at least expected to start in quarter 3 of FY22.

In COP22, South Sudan has set a PrEP target of 3,922, for various high-risk sub-populations such as key populations: females sex workers, AGYW, military men, and discordant couples including pregnant and breast-feeding mothers. PrEP target for COP22 was increased by about 32 percent from COP21 targets and indicates the programs intention to scale up this key biomedical prevention interventions among the targeted sub-populations, to mitigate new HIV infections.

Discussions with UNDP and GF in COP20 and during COP21 were successful and led to the securing and ensuring sufficient PrEP commodities that will support that plans and ambitions of initiating and sustaining PrEP intervention in South Sudan. Over 60,000 doses of TDF/3TC are expected in country as the first shipment during quarter three of FY22. PEPFAR South Sudan will continue to collaborate and coordinate with UNDP and other key stakeholders with the leadership of the MOH to ensure a successful role out and sustenance of the program.

#### **4.4 Additional Country-Specific Priorities Listed in the Planning Level Letter**

Driven by data, national priorities and stakeholder recommendations, the strategic direction of PEPFAR South Sudan's program for COP21 is to maximize efficiencies by focusing resources on where the program can get the highest yield and volume (across populations and geography), with the overall goal of maximizing identification, linkage, and retention, and minimizing lost to treatment/follow-up. To accomplish this, in COP20, the PEPFAR South Sudan team will scale up HIV treatment services in high volume and high yield facilities, e.g. all hospital settings with high patient loads, and among the sickest newly identified PLHIV. The program will continue to focus on and use high-yield testing modalities, including index testing (focusing index testing on index case sexual partners), provider-initiated testing and counseling (PITC), e.g., at tuberculosis clinics. The community-based Key Population program will be scaled up and will also deepen its interventions in existing sites by, for example, providing community-based treatment; aligning interventions with military sites; and providing technical assistance in treatment and retention to Global Fund partners.

In order to improve performance and cost efficiencies, PEPFAR South Sudan will consolidate its portfolio of IMs: CDC will transition out sites from CMMB to ICAP in Western Equatoria to both address performance issues as well as consolidate care and treatment services to reduce program

management costs. USAID will consolidate its own portfolio in order to reduce costs and streamline operations; this move will combine its care and treatment and key populations portfolios into one complementary project in COP20.

In order to address high interruption in treatment and poor retention, PEPFAR South Sudan proposes an innovative cascade of strategies. Specific retention strategies listed under Section 4.1:

- Start with problem identification using site level Net\_New analysis; deep-dive into site level granular data and investigate unexplained loss by conducting site level analysis and three-month retention analysis.
- Conduct “surge operations” and intensive collection of accurate and complete data, use of data, facility team led weekly excel-based analysis of the data, monthly reviews with PEPFAR, and quarterly stakeholder-led reviews.
- Implement treatment collaboratives to identify challenges and possible solutions at facility level.
- Engage CSOs and community networks to strengthen linkage to treatment, treatment retention and tracking of LFTUs, targeted demand generation and partner notification.
- To enhance treatment adherence, COP20 will also continue differentiated service delivery models and six-month multi-month dispensing.

Finally, using an OU-wide approach, PEPFAR South Sudan made concerted efforts to address Index Testing scale-up with fidelity through the following steps:

1. Engagement with IPs to highlight index testing
  - Post COP19 Regional Planning Meetings USG agencies met with IPs and highlighted index testing as a priority.
  - PEPFAR gathered IP tools and resources used for index testing; these were reviewed and shared with Headquarters.
  - In order to consolidate and harmonize the approach, PEPFAR South Sudan drafted an index testing concept paper that was shared with the interagency and MOH for inputs.
2. Use of generic resources to conduct an ECHO session on index testing
  - Through ECHO, PEPFAR reviewed the concept of index testing with facility-based staff.
  - Approaches on index testing for sexual and biological contact were explained.
  - Explained how to identify eligibility for index testing at each clinical visit and develop a plan for testing sexual and biological contacts of index cases.

#### 4.4.1 Project ECHO

Cross-cutting with the goals of preventing, preparing and responding to coronavirus and mitigation of the impact of COVID-19 to ensure continuity of treatment services, virtual platforms for key program interventions are fundamental for granular site management for service delivery quality, performance review, training, mentorship and communication. The implementation of Project ECHO in South Sudan began in February 2018, with the aim of creating a community of practice amongst HIV service providers in South Sudan who were not reachable through traditional



methods for mentorship due to contextual conditions. The platform functions to build health care workers (HCW) capacity and knowledge across areas such as HIV management and data use and quality. It also helps build HCW confidence, allows for experience sharing, and alleviates the sense of alienation experienced by many health workers in remote facilities. It has provided a platform for mentorship, site monitoring/management, and dissemination of best practices. ECHO currently serves as the only source of continuing medical education in the country.

PEPFAR has adopted the field supervision initiative and granular site management, where field officers are assigned a fixed number of health facilities to improve service delivery across the HIV/TB cascade. Zoom technology has allowed for virtual interactions involving the health facility staff, field officers, USG staff, implementing partners/regional coordinators in multiple locations.

In COP21, PEPFAR South Sudan had scaled-up the Zoom-based platform to 54 sites, allowing for greater assurance of minimum site-level competencies across the HIV/TB cascade, including COVID-19 infection prevention, screening and case management as well and protection of PEPFAR services and gains made to date; opportunities for regular communication between site staff cadres (e.g., health providers, counselors, lab, M&E) community cadres, field officers, implementing partners, and USG to discuss regular performance review; quality improvement activities; and ensure best practices and lessons learned are shared more broadly and actions taken more expeditiously and efficiently. The advantages of the video-conferencing technology with its relatively simple hardware requirements via satellite internet connection will continue to be used. In addition to the weekly clinical mentorship sessions with subject matter experts at Juba Teaching Hospital, College of Physicians and Surgeons, additional opportunities for feasible virtual interactions will be carried out to support the continuity and quality of services. All PEPFAR treatment partners will have participating remote sites within the network and the effort is coordinated across USG. Monitoring and evaluation will be carried out through the regular documentation of session frequency, stakeholder participation, content discussed and site-specific action plans.

In COP 22, PEPFAR proposes to continue the ongoing bi-weekly HIV-ECHO with case-based sessions and expand to laboratory best practices and infection prevention and control (IPC) to address COVID-19. We also propose to offer quarterly “short course” training programs via the ECHO Zoom platform for specific Human Resource for Health (HRH) cadres in-country.

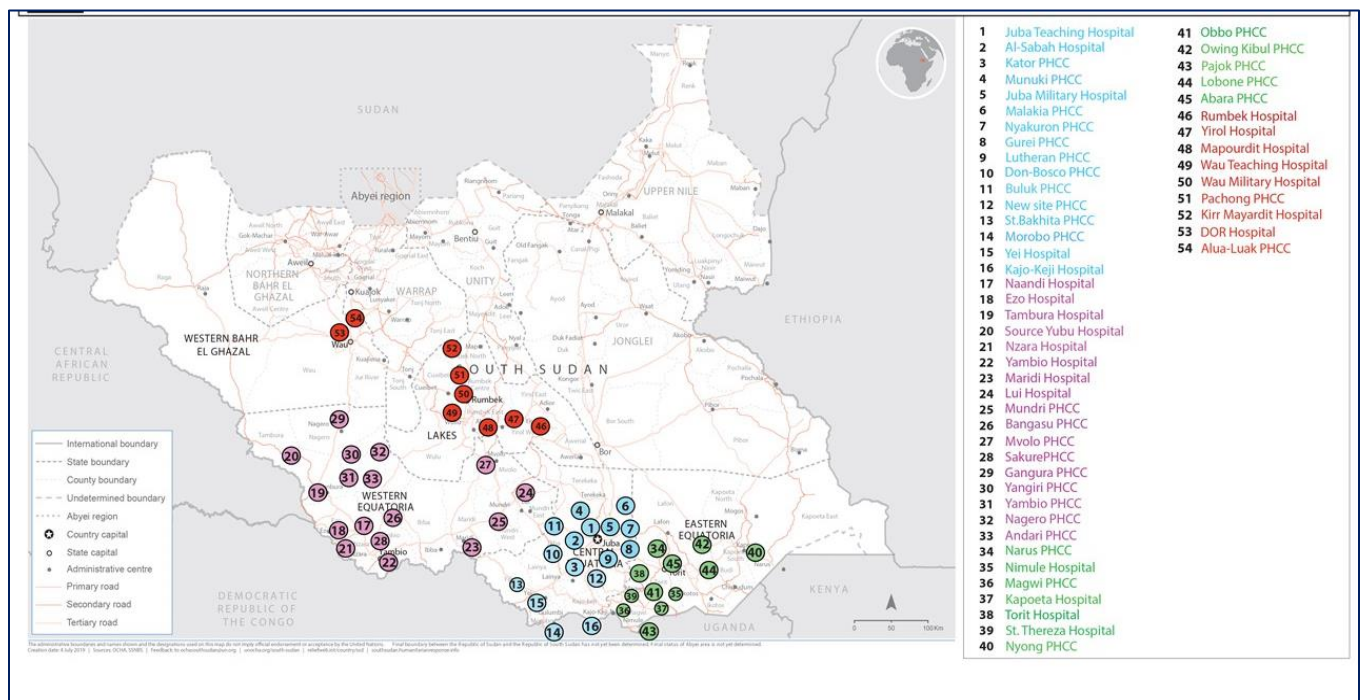
PEPFAR proposes to expand and add to the existing tele-mentoring initiative by focusing on the following five objectives.

**Objectives:**

1. To conduct a rapid needs assessment of healthcare workers and MOH officials on capacity gaps to identify short course topics
2. To establish a technical working group (TWG) including representatives from the MOH, medical professional associations, educational institutions and legal authorities to develop policies, competency frameworks and minimum standards for continuing education as well as a system for continuing professional development licensure

3. To develop a competency framework of skills required for various cadres in the South Sudan healthcare workforce to ensure health workers are 'fit for purpose' and fit for practice' for high priority health concerns
4. To develop three short courses in Year 1 to train frontline healthcare works in capacity gap areas identified through the needs assessment
5. To implement quarterly short course training programs for clinical officers, nurses, midwives and laboratory personnel to strengthen HR development, support the development of the short course training curriculum and certification program. The long-term goal for both of these proposed activities is to build a sustainable health system by training and capacitating a South Sudanese HRH workforce. By providing a system for continuing education, this program will support the technical expertise of in-country cadres to implement clinical care and will reduce the burden of a non-local workforce. PEPFAR will work in constant collaboration with the MOH to develop a framework for continuing professional development and licensure to ensure that the process is managed and implemented through a national owned system.

**Table 4.4.1: COP 21/ COP 22 Project ECHO Sites**



#### 4.4.2 Returning Refugees

According to the United Nations High Commissioner for Refugees (UNHCR), as of end of Feb 2021, there are an estimated 2.22 million South Sudanese refugees in the region. As shown in [Table 4.2.2](#), 39% of all refugees are in Uganda, followed by 37% in Sudan and 15% in Ethiopia. In addition, the number of internally displaced people (IDPs) is estimated to be nearly 1.4 million.

**Table 4.2.2 Number of South Sudanese Refugees by Country (Dec 31, 2019)**

	Country	Source	# of South Sudanese Refugees	Estimated PLHIV
1	Uganda	Office of Prime Minister	897,184	24,986
2	Sudan	UNHCR, IOM, SRCS, COR, HAC	762,288	No data
3	Ethiopia	UNHCR	363,309	No data
4	Kenya	UNHCR	127,412	3,476
5	Democratic Republic of the Congo (DRC)	UNHCR	54,899	2,557

Given the estimated number of PLHIV expected to return to South Sudan, especially from Uganda, Kenya and DRC, there will be a need to continue to attend to their HIV and TB-related needs and ensure the continuity of HIV/AIDS and TB prevention, care and treatment services during their return and reintegration.

Since conflict broke out in 2013, it is estimated that over four million people fled their homes. Based on early estimates, the number of PLHIV from the countries of Uganda, Kenya and DRC was around 31,019. Following the signing of the revitalized peace agreement, the country witnessed the formation of the Unity government in February 2020. As peace returns, there is a prospect of people returning from refugee camps in the neighboring countries of Uganda, Sudan, Kenya, Ethiopia, Democratic Republic of Congo (DRC), and Central African Republic (CAR) to their homeland. IDP, including those at protection of civilians (POC) sites in South Sudan, will also return to their homes and reintegrate into their communities of origin.

In COP20, PEPFAR, working with ICAP, has brought together Ministry of health, UNAIDS, IOM, UNHCR and national networks of people living with HIV on both sides of the South Sudan and Ugandan border to monitor return of refugees from Northern Ugandan. Pre-repatriation mobilization and dissemination of information on available services at entry points and destination points, mapping their final destinations and following up with active linkage upon arrival have been conducted. ICAP, in collaboration with state and county health departments, has conducted assessment of health facilities including Narus, Pajok, Lobone, Poge, Anjara PHCC, Pageri, Loa, Moli, Opari. The assessment has identified key gaps in human resource, infrastructure, training and

basic medical equipment capacities in destination health facilities. ICAP has procured package of basic medical equipment and furniture for health facilities.

ICAP staffs working in facilities close to destination such as Nimule hospital, Magwi PHCC, Kapoeta state hospital, Yei, Morobo and Kaya are providing on job training, supportive supervision, support in availing key recording and reporting tools and distribution of ARVs and other commodities.

In March and April 2021, ICAP in collaboration with Magwi country health department, relief and rehabilitation commission and other partners has conducted needs assessment for returnees in Pageri, Loa and Moli counties and joint action plan is under development.

In COP22 PEPFAR will continue to support demand generation for HIV/TB services during the pre-repatriation period and continue through the resettlement period. PEPFAR will work with and through national civil society organizations and beneficiary groups (e.g., South Sudan Network of People Living with HIV and Network of Positive Women United) and mobilize PLHIV to provide HIV services information for the continuation of HIV treatment upon return. PEPFAR South Sudan, through its partnership with national PLHIV networks, will support training and deployment of community outreach workers in the resettlement locations for continued mobilization and linkage to services.

Mobilization activities involving developing communication materials (brochures, flyers, audio messages, and posters) for refugee and IDP returnees with all the necessary HIV/TB messages, list of health facilities providing HIV/TB services in their destination locations as well as key actions to be taken before, during and after return. These materials will also be distributed to returnees throughout the refugee and IDP clinics. ICAP, through its partnership with national PLHIV networks and faith-based organizations, will support training and deployment of community outreach workers in the resettlement locations for continued mobilization and linkage to services.

In COP22, PEPFAR will continue to support human resource, training and direct service delivery support to facilities such as Narus, Kajo Keji, Pageri and Lanya, which are expected to have higher patient load. These locations had large number of clients, which were being served and got lost with the conflict and displacement.

#### 4.4.3 Enhanced Field Supervision and Monitoring/ GSM

In COP18 PEPFAR supported an HIV/TB Field Officers (FO) program to improve quality of HIV services at the sites. The number of FOs has increased from 6 in COP18 to 28 approved for COP21 which will be maintained in COP22. The FOs program was in response to limited SIMS visits conducted by the PEPFAR team and the small size of the PEPFAR country team coupled with no well-organized joint national supervision and mentorship plan as well as weak Sub-National level capacity to oversee HIV program delivery at the sites. This situation left implementing partners providing their own supervision with limited accountability. The FOs provide facility level mentorship and supportive supervision in all program areas from case identification, treatment, viral load, EID, community engagement and HIV data reporting through DHIS2. The FOs are

leading the Granular Site Management discussions, development of site improvement action plans as well as tracking of progress. The FOs also facilitate several trainings to the facility staff as well as support national and mini-Data Quality Assessments. The FOs work collaboratively with implementing partners and the PEPFAR team to address key program challenges at the facility which include, low case identification interruption in treatment and low viral load and EID testing coverages.

In COP22 the number of field officers will be maintained at 28. The PEPFAR team will work with MOH to ensure that the FOs support the operationalization of national HIV Incident Management system in which MOH coordinates stakeholders' efforts with focus at facility levels. The allocation of sites to PEPFAR MOH and four Global Fund funded Zonal HIV/TB officers will be reviewed by all stakeholders and the PEPFAR team will ensure that priority health facilities within PEPFAR supported counties are all adequately supported by the FOs. The FOs will provide mentorship and additional support to County and State HIV/TB officers through joint supportive supervision and sub-national program reviews with intention to strengthen capacity of the State and County health authorities to manage the HIV/TB services with the PEPFAR supported SNUs.

Direct PEPFAR team supportive supervision and oversight to facilities outside the capital Juba remains a challenge due to travel restrictions given insecurity in some parts of the country and poor access. The FOs program and virtual granular site management meetings will remain useful in ensuring that quality HIV services are delivered at the facilities and community interventions are properly implemented, monitored and supervised.

#### 4.4.4 Community/Civil Society Engagement

Up to 90% of South Sudan's population live in rural areas and 75% of whom live at least 5 KM from the nearest health facility (South Sudan census 2010). This has probably worsened over the years since independence as a result of the political and intercommunal strives that plagued the country since then. Long distance, seasonal population migration, insecurity, and its resultant population displacement, continued to be the major barriers to case finding, treatment continuity and program acceleration in the country, this scenario was further complicated with the outbreak of the COVID19 Pandemic at the start of FY20Q2. Facility centered HIV services captures less than 10% of the potential clients since only those who feel sick and have access to the health centers go for HTS services at the facility leaving out many PLHIV out there who do not know their status and live far away from health facilities. Scale up of community activity with the objective of taking services closer to the clients' home can mitigate this huddle but it did not achieve its intended target in the last two years due to the lock downs that came with the COVID 19 pandemic and upsurge of insecurities in many parts of the country,

In Cop21 the country set out to provide community level services across all the three 95s ; 1<sup>st</sup> 95 To optimize Community index testing 2<sup>nd</sup> 95 optimize patient treatment literacy and scale up community drug refill, for 3<sup>rd</sup> 95 optimize viral load sample collection in the community and reduce interruption in treatment through community EAC

With the waning of the COVID19 pandemic and gradual return of peace and stability across many parts of the country, the opportunity for PEPFAR South Sudan to scale up community engagement and improve performance across the three 95s is now a real possibility, for this reason, PEPFAR South Sudan will significantly expand its community footprints both in scale and scope of activities in COP22.

PEPFAR South Sudan will further align and coordinate its client-focused community engagement plan with the Government sanctioned BHI initiative, a community health program designed to bridge the gap between the facility and the community with particular focus on prevention and health promotion. PEPFAR South Sudan will, prioritize taking HIV/AIDS service to the community rather than wait for the community to come for the service at the facility. This strategy will entail training cadres of community outreach personnel with skills to provide HIV/AIDS services across the service cascade in the community. This will include prevention, demand creation, counselling, testing, linkage to treatment, referral from community to facility and referral from one community to another community. Also linking clients to other standalone services such as OVC, DREAMS, GBV and ANC. The community engagement plan will also develop ways of solving interstate silent transfer of clients which contribute to the largest chunk of interruption in treatment.

PEPFAR South Sudan will work to integrate HIV and COVID 19 community activities with the objective of saturating index contact tracing and testing in the community and concurrently seek to carefully blend EID services to EPI programs as a cover strategy for accessing HEI in highly stigmatize communities while adhering to the WHO 5c.

PEPFAR South Sudan will engage the private health sector, which has a wider community penetration compared to the public sector, as a strategy for reaching men who prefer the privacy of the private sector.

PEPFAR South Sudan will liaise with WFP to use food as an extra incentive for bringing clients especially HIV affected children to care at the facility.

PEPFAR South Sudan will prioritize engaging local CSOs to manage the community engagement and will task its prime partners to build the capacity of the local CSOs including key population-led groups.

In COP22, PEPFAR South Sudan will continue with regional rationalization of CSOs as a measure of creating order and a level of coordination among CSOs in the country. This approach will prevent duplication of activity, lessen rivalry, and create accountability by the CSOs. PEPFAR South Sudan will emphasize CSOs participation in the TWG at the national level which is an important platform for meaningfully engaging in national HIV/AIDS technical discussions.

PEPFAR South Sudan will Prioritize the recruitment of PLHIV as Community outreach Volunteers and Engage Traditional Birth attendance (TBAs), irrespective of their HIV status, as cadres for tracking PMTCT mothers in the community

PEPFAR South Sudan will recruit community Liaison officers (CLO) in all the facilities and Community HIV service officers. To create a seamless continuum between the facilities and the surrounding communities PEPFAR South Sudan will continue to implement and improve on the differentiated service delivery models for clinically stable clients and ensure choice between facility and community ART refill and pick-up locations. Peer-supported linkage and navigation extension support services will also be encouraged.

PEPFAR South Sudan will further strengthen the mechanism for identifying clients scheduled for clinic visit and those who missed their scheduled visit through a combination of both electronic records and the traditional paper-based methods we shall also streamline the flow of information between the facilities and the communities through a combination of methods including e-mails, wats up, SMS and paper-based delivery.

PEPFAR South Sudan will continue to recruit Community outreach volunteers and reach a CoV: Client ratio of 1:30. A special cadre of community outreach Volunteers will be trained to assist CHSO to conduct HTS, EAC and collect DBS for VL and EID

Because violence and intimidation of CSOs remain a significant problem in the country, PEPFAR South Sudan will coordinate with SSAC and other humanitarian actors such as UNAIDS, human rights activists, legal experts and global or regional networks of key populations to formulate approaches and identify best practices to mitigate risks to vulnerable groups and encourage the host governments to provide enabling environment for civil society participation.

PEPFAR South Sudan recognizes the well-structured faith communities with extensive networks in the country and will leverage it to accomplish two objectives: (1) To reach the remotest communities in a very targeted fashion to find people at risk of HIV and bring them back to care and treatment. (2) Build Faith communities of PLHIV from among the congregations and use them to deal with stigma related to index spouse disclosure and mitigate IPV.

#### 4.4.5 Community-Led Monitoring

Community led monitoring will remain a key strategy for ensuring quality and quantity of services in COP21. This strategy will supplement the PEPFAR SIMS assessment visits to facilities.

PEPFAR South Sudan will scale up community led monitoring to all the region and shall emphasize engagement of locally based CSOs to undertake the program and will establish a clear coordination mechanism to ensure set objectives are met.

PEPFAR South Sudan will use the following principles to guide this strategy:

- Emancipated PLHIV in a particular area will be organized, trained and empowered to independently monitor the quality of services in the facilities serving them using

standardized structured and targeted tools that probes quality of services, patient privacy, patient wait times, availability of commodities, user fees hindrance, poor provider attitudes and health and rights violations

- Regionally based CSOs shall be engaged to manage and coordinate these activities while the PEPFAR SIMS teams shall give them the technical support needed to do their Jobs.
- The CSO together with the PEPFAR SIMS team and the prime partners will regularly review the enablers and barriers to HIV/AIDS services identified by the community led monitoring teams in a manner that is productive, collaborative, respectful, and solutions-oriented with the objective to foster community ownership of the program.
- The ultimate beneficiaries of the community led monitoring initiative will be PLHIV groups.

#### 4.4.6 DTG 10mg; TLD and MMD Scale-Up

In COP 22, PEPFAR will continue with transitioning of LPV/r-based regimens to Dolutegravir 10 mg for pediatrics under 20kgs. The South Sudan ART guidelines have been revised to accommodate this new ART recommendation for pediatrics. All children below 20kgs will be transitioned to DTG 10mg while phasing out Lopinavir/ ritonavir regimens for this age group. DTG 10mg arrived in country earlier this year (2022) and the MOH officially issued a circular to all clinical partners, and the procurement partner, UNDP to facilitate the process of this transition. All PEPFAR clinical partners have trained their providers on the new regimens and provided guidance and SOPs rollout any time once a final decision is made by MOH on how to handle the remaining legacy LPV/r which at the moment is hindering DTG 10mg transition.

TLD transition was successful implemented and completed over the course of two years starting in 2019 and nearly 100 percent of all adult clients and children weighing 30kg and above are on TLD. Multi-months dispensing also improved significantly from three to six months and close to 100% of all adult clients are now on months multi-months dispensing ranging from three-six months. In COP22, PEPFAR South Sudan will explore 9-12 months multi-month dispensing for the military program to address high mobility and long deployments away from ART centers. Effort will be made to mitigate any adverse events associated with 12-month MMD specially impact on viral load testing and clients' monitoring. The longer MMD of 9-12 months was successfully used in 2021 to address needs of displaced clients in conflict setting that resulted in interruption of normal services in Tambura in Western Equatoria.

#### 4.4.7. TB/HIV

The 2020 WHO Global TB report estimates the incidence of TB disease in South Sudan at 232 /100,000 population, translating to TB burden of 26,000 (17,000-37,000) TB cases. Among PLHIV, TB incidence is 27/100,000 population, translating to 3,000 (1,900-4300) TB cases with TB mortality of 720 (450-1100) cases. In COP22, PEPFAR South Sudan shall focus on TB/HIV priorities that address the following challenges: poor-quality TB screening and low GXP MTB/RIF testing among PLHIV; limited provision of TPT services across facilities due to lack of commodities; data quality and documentation issues; and weak TB specimen referral system.



COP20 Q4, showed that 97 % of ART patients were screened for TB symptoms, and 3.6% screened positive, lower than the expected screen positive rate of 10-15% of newly enrolling, ART-naive patients and approximately 5-10% of previously enrolled ART patients. The low TB symptoms screening positive could be attributed to the low sensitivity of the WHO recommended four symptoms screening tool, inconsistency in screening, and/or poor documentation. Additionally, only 81% of the 1,115 PLHIV who screened TB symptom positive had specimens sent for diagnostic testing, mainly due to specimen referral logistical challenges. Of the specimens tested, only 78% were tested by GeneXpert, which is below the WHO target goal for GXP testing of at least 90%.

COP22 focuses on strengthening TB symptoms screening for PLHIV with prompt diagnostic evaluation of all TB presumptive.

Strategies to intensify TB symptom screening among PLHIV include:

- i. Strengthening TB symptom screening in multiple facility entry points, including nutrition units and in maternal child health, focused training and mentorship on quality TB symptom screening using the national screening tool, proper documentation in medical records, and integrated sputum collection.
- ii. Strengthening TB symptom screening among CLHIV using the OVC program.
- iii. TB symptom screening among children who are household contacts of PLHIV with TB disease using the community network for index testing.
- iv. Introduction of C-Reactive Protein (CRP) finger prick blood testing for adults and adolescents, a proxy for active TB infection in ART-naïve patients-to improve TB symptom screening. Discussions are ongoing with UNDP to include CRP kits during GF reprogramming.
- v. Strengthening TB/HIV data capture, recording, and reporting through supervision, mentorship, training by IP facility focal persons and field officers.
- vii. Integrating TB screening in PLHIV and COVID-19 patients in all PEPFAR supported facilities. All TB presumptive cases who also meet the COVID-19 case definition will be tested using Ag RDT for SARS-CoV-2. Development of a national algorithm for bi-directional C19-TB screening.

COP22 strategies for diagnostic evaluation of PLHIV who are presumptive for TB

- i. Improvement in TB case finding among PLHIV TB presumptive using GeneXpert MTB/RIF Ultra as an initial diagnostic test.
- ii. Strengthening the TB specimen referral network from spokes to GeneXpert sites and MTB rifampicin resistant specimens from GeneXpert sites to NPHL for culture and DST. Increasing frequency of specimen shipment to at least five times a week, Monday to Friday with integration of TB specimens with HIV and C-19 specimen referrals. Specimen referral

integration will begin with the top 10 high HIV volume sites and all GXP sites. Facilities at a radius of 5-10 kilometers should be integrated to the nearest hub (GXP site).

- iii. Scale-up of the use of urine-based point-of-care lateral flow LAM testing for all CLHIV <5 year as well as patients with advanced HIV disease who are at high risk of TB. With expected arrival of urine TB-LAM kits, testing will likely start in COP21Q4. Xpert testing will be carried out in parallel with LF-LAM for CLHIV <5.
- iv. HR support for GXP instrument uninterrupted testing with a minimum target of three runs per day per GXP site with four modular instruments.
- v. Continued work with UNDP to forecast reagents and other TB commodities to ensure adequate quantities for uninterrupted diagnostics.
- vi. Improvement in TB/HIV data capture, recording, and reporting through supervision, mentorship, training by IP facility focal persons and field officers along with reporting tools' updates.

Ending HIV-associated TB among PLHIV is possible through the combination of ART coverage, early TB identification and treatment, and TB preventive treatment (TPT). Over the past three years (FY19-21) of TPT implementation in the country, a total of 12,263 eligible PLHIV have been initiated on TPT and 8,536 completed, translating into overall initiation rate of 29.6% (12,263/41,462) and completion rate of 69.6% (8,536/12,263) among those initiated. The poor performance is attributable to inadequate and inconsistent TPT supplies in the country. For FY19, TPT started as a pilot in JTH, where only 54 eligible PLHIV were enrolled and 46 completed. In FY20, TPT supplies were procured through USAID procurement mechanism, this led to improved TPT enrollment (from 54 in FY19 to 9,347 in FY20). By FY21 Q2 and Q4, the country experienced INH stock outs, resulting in only 13.2% of the 21,604 TPT target achievement, but with very good completion rates of 99.8% (2,856/2862). For COP21, new stocks of TPT supplies from Global fund through UNDP have been received in country for approximately 11,000 clients, however pyridoxine tablet supplies are sufficient for only 2,500 clients, of which all eligible PLHIV in Juba County are being initiated on TPT.

In COP22, the 2nd 95 strategies shall focus on two main areas namely:

- Optimization of TB/HIV care and treatment
- Optimization of TB prevention among PLHIV.

CoP22 strategies for optimization of TB/HIV care and treatment shall include:

- Improving cross-referral of clients for both TB-HIV services across PEPFAR facilities. Clinicians at the ART and TB units work together to initiate TB-HIV co-infected clients on either TB or ART. Some quantities of TB-related drugs besides the TPT should be kept at the ART Unit. This should be implemented in the top 20 high volume sites providing both HIV and TB services- "One-Stop Shop" service delivery model for both TB and HIV services. The ART clinicians from the top20 high volume facilities should also be trained on M&E related to TB treatment.

- Improving client treatment literacy around TB symptoms, TPT, potential side effects, TB diagnosis and treatment options during facility health education sessions and use of the community outreach cadre for TB screening, diagnosis (specimen collection, referral) and treatment (adherence support, medication supply support). Facilities will generate line-list of eligible PLHIV who will be tracked by COVs for TPT initiation.
- Continue to collaborate with UNDP and through the commodities TWG to timely and improve quantification, procurement planning, tracking and utilization monitoring of GXP MTB/RIF ultra-kits, urine TB LAM test kits and sputum sample collection containers.
- Strengthening TB specimen referral, diagnostic network optimization and last mile delivery. TB specimen referral should be integrated with specimens for other diseases such as HIV and C-19, this should be done for all the GXP sites and from the GXP sites to NPHL. This is aimed at increasing frequency of specimen's shipment to at least 5 days a week (Monday-Friday) from the spokes to GXP sites.
- Continued monitoring of PLHIV on TB treatment with rifampin who are on ART with TLD to ensure an extra dose of dolutegravir (DTG) 50mg per day (taken 12 hours apart) is administered/taken for the duration of their TB treatment course (note PLHIV on TLD and three months isoniazid-rifampentine (3HP) do not need an extra dose of DTG).
- Continuous Quality Improvement (CQI) and SIMS for quality assurance and TB/HIV cascade performance improvement. PEPFAR clinical partners will be required to conduct bi-weekly TB cascade monitoring at TB clinics and performance review to identify issues to drive facility specific CQI activities with facilitation by the MOH HIV/TB field supervisors.

COP22 strategies for optimization of TB prevention among PLHIV shall include

- Continued work with UNDP and MoH to improve forecasting and quantification of TPT supplies to meet both adults and pediatric projected TB-Prev targets.
- Scale-up of quality TPT services to all 86 PEPFAR ART facilities and achieve universal TPT coverage for all eligible PLHIV including children with at least 90% completion rates. PEPFAR clinical partners will be required to report monthly TPT initiations using a standard template. Align TPT dispensing with ART MMD to ensure effective client management that supports adherence.
- Strengthen provider capacity to initiate, monitor and support clients on TPT at the community level using the COVs. This will require training of the COVs on tb symptoms screening and specimen collection, TPT initiation or client referral for TPT initiation along with M&E support. This should include the utilization of PLHIV networks to create demand for TPT services and community and client awareness to reduce stigma and discrimination around TB-HIV and increase knowledge about benefits of TPT among providers and patients.
- CQI for service delivery and the accurate and complete capture in TPT tools (facility and community-based), TPT registers, medical files including screening for presumptive TB, potential adverse events (AEs) and adherence during refills. (Note: discussion with UNDP and MoH to introduce the use of CTX/INH/B6 Fixed Dose Combination (FDC) for eligible

adults weighing >25 kg is ongoing. Since there is no pediatric FDC formulation and due to pill burden, we intend to initiate discussions on possibility of introducing the use of three months of weekly high-dose isoniazid and rifapentine (3HP) for children at least 2 years of age as an alternative to the current six months of isoniazid monotherapy). However, eligible PLHIV children weighing 14-25 kg would be given ½ tablet of FDC daily for six months.

#### 4.4.8 Facility Friendly Environment as an Intervention for Client-Centered Care

Retention is one of the main barriers to program growth in South Sudan. There are multiple factors that contribute to clients having their needs met which leads to an understanding of their disease and treatment plan. Overcoming the obstacles to retention, ART adherence, and service access requires the implementation of friendly client-centered services that make it easier for clients to continue their lifelong treatment. Through the implementation of strategies and interventions that lead to improvements at structural/physical, policy, individual and community levels, the program aims to provide site-level differentiated service delivery models that include optimized treatment, multi-month dispensing, convenient ARV pick up, and more informed process design that uses the feedback from individuals and communities' experiences and needs in a welcoming, responsive and supportive environment. Close and strengthened coordination between the facility, individuals and communities are pivotal to meeting the clients where they are. Through a cohesive framework that includes community-led monitoring and increased human resource investments, the implementation of specific activities and strategies are needed to create an enabling environment for the provision of quality services that will help address the current gaps and constraints faced.

In COP21, PEPFAR South Sudan proposes to emphasize and support client-friendly quality HIV care and treatment services. Being a largely direct service delivery program, PEPFAR in South Sudan has the opportunity to introduce site level impactful measures to accomplish the same. Long waiting hours, poor quality of care provided by the clinician, nurses, or ancillary healthcare staff, and lack of privacy are a few of the factors that lead to patient dissatisfaction. Many patients walk between two to four hours to reach the health centers. The absence of client-centered approaches may negatively impact the patients' willingness to return to care. Although there are no data to show the number of patients leaving select health facilities without being seen by a clinician/nurse or the decision to transfer their care to another facility due to poor treatment, evidence from SIMS and site visits reveal that in most of the PEPFAR-supported facilities, the average wait time in the PMTCT/ART clinic is over two hours.

With support from CDC, ICAP designed a conducive environment for the delivery of Enhanced Adherence Counseling, play area for children living with HIV, and the support of ART adherence clubs within JTH and ALS. Early experience of caretakers of the children attending care at these facilities revealed that such environments improve facility drug pick-up, family refills, tracking of ART defaulters, and male mobilization activities. Therefore, such friendly facility interventions are proposed for scale-up to all PEPFAR-supported facilities in South Sudan.

Proposed client friendly services are listed below. The proposed areas for intervention include the following:

1. Physical environment (e.g., space improvements for confidentiality)
2. Policy (e.g., client-centered, discrimination free policies)
3. Treatment literacy (revised quality counseling/messaging, delivery materials/patient education resources)
4. Processes (patient, data and sample flow), analysis and modifications
5. Sub-population (VL non-suppressed, men, children, adolescents, and PBFW) centered service delivery
6. Individual client supportive services
7. Service integration (SRH, OVC, GBV, nutrition, TB)
8. Demand creation activities
9. Patient experience enhancement – activities that are tied to feedback from community-led monitoring, institution of rapid feedback loops
10. Community – coordinated and strengthened community networks to ensure support for adherence retention, suppression

Specific activities/interventions under the different areas listed above are proposed below:

1. Establishing additional waiting areas (e.g., establishing tents next to EAC, VCT, PMTCT/ART clinic)
2. Creating enough space/filing cabinets/shelves for client record keeping/filing
3. Having additional data clerks to organize/update/retrieve patients files
4. Separating EAC and counseling rooms with minimum standards for client privacy
5. Partitioning/renovation of existing structures/facilities to create additional space to improve client privacy and confidentiality
6. Improving patient flow by rearranging areas for waiting, VCT service provision, health education and treatment literacy, ARV refills/pick-up, meeting areas for peer adherence services/clubs
7. Establishing a facility treatment collaborative
8. Scaling-up community care and ART refill services to improve the community network
9. Creating space within the facility setting for child, KP and youth friendly services and QI for children with high viral load
10. Training facility staff on key aspects of KP and youth friendly services
11. Procuring supplies for sub-population centered service delivery
12. Integrating GBV services with the HIV program

Funds proposed for PEPFAR-supported sites will be used towards the above activities and interventions for staffing, physical upgrades (where possible and feasible) and recommendations from community led activities.

#### 4.4.9 Prevention of Mother to Child Transmission of HIV (PMTCT)

In COP22, PEPFAR plans to provide PMTCT services in all PEPFAR-supported comprehensive HIV/AIDS service delivery sites. PEPFAR South Sudan will continue to integrate PMTCT services into ANC, Labor and Delivery (L&D) and

postnatal services, in all sites using models of integration of PMTCT services to ensure at least 95% of ANC clients are tested for HIV and 100% of those diagnosed as HIV positive are registered in care and have access to ART.

Routine HIV testing will be provided to all pregnant women at ANC 1 and L&D. Lactating mothers attending postnatal services, Expanded Program on Immunization (EPI) and under-five services will also be provided HTS. Mothers who test negative in the first trimester will be retested in the third trimester.

In COP22, PEPFAR South Sudan will strengthen Test and Start services to reach more women, their babies and spouses. All PEPFAR-supported PMTCT sites will be strengthened to provide EID/VL services. In FY23, PEPFAR will continue to improve coverage and quality of integrated PMTCT and EID, and better track newly enrolled maternal and infant outcomes.

PEPFAR IPs will:

1. Scale up PMTCT implementation, targeting pregnant and lactating women, HIV-exposed infants (HEI), male partners, and the community
2. Support HIV testing services for all pregnant and breastfeeding women and their partner(s), including first tests at ANC1 visits as well as additional tests conducted throughout the pregnancy and breastfeeding window
3. Support delivery of ARV prophylaxis for newborns and provide EID services to the infant
4. Train clinical and other personnel supporting PMTCT activities (e.g., lay counselors, mentor mother programs, data clerks) and services for HEI
5. Enhance facility-community linkages and utilize community support groups (mentor mothers, traditional birth attendance, etc.) to improve continuity in treatment through the use of appointment logs, phone reminders, active community follow-up and use of peer mothers as linkage facilitators, and family support groups
6. Support services to enhance initiation, adherence, continuity in treatment, clinical monitoring (including labs), contraceptive counseling, and Nutrition Assessment Counseling and Support (NACS) (including breastfeeding counseling) for HIV positive pregnant and breastfeeding women newly initiating ARVs
7. Build capacity of local PLHIV organizations to operationalize innovative approaches to enrolling HIV positive pregnant/lactating mothers, children and their spouses in care and treatment
8. Integrate HIV care and treatment for the mother-baby pair into maternal/child health  
(MCH) units until the baby attains 18 months of age (regardless of HIV status)
9. Monitor PMTCT program quality improvement at the site level by establishing monitoring and QI activities supportive of the continuum of care through

pregnancy, labor/delivery, and post-partum periods to ensure effective services uptake across the PMTCT cascade

10. Improve access to EID services for children less than two months 1) decentralizing point of care (POC) EID testing as well as establishing multiple sample collection and testing points; 2) tracking mother-baby pairs and ensuring mothers bring exposed infants back for testing
11. Enhance HIV exposed infant (HEI) identification at some entry points/clinics by 1) strengthening collaboration between PMTCT and other child entry points e.g., immunization clinic, nutrition, and pediatric clinic; 2) training and assigning staff for HEI identification and sample collection at entry points
12. Enhance client education through community structures, using tier one and two facilities for sample collection and use of point-of care-instruments at selected facilities
13. Conduct joint supportive supervision/mentorship with CHTs (County Health Teams), focusing on capacity building of midwives, nurses, and data clerks
14. Encourage male partner services, including HTS, linkage to VMMC services, sero discordant couple services and condom provision
15. Prioritize pregnant and breastfeeding mothers for viral load test within three months of ART initiation
16. Screen HIV positive pregnant and lactating mothers for TB using the TB screening questionnaire.

Screen HIV positive pregnant and lactating mothers for TB using the TB screening questionnaire.

#### 4.4.10 Data Quality Assessment (DQA)

In January 2019, PEPFAR supported a DQA in 13 high volume PEPFAR-supported sites contributing to 60% of PEPFAR supported PLHIV on ART. The 2020 and 2021 DQA were expanded to include none-PEPFAR supported sites. In 2021 the DQA was conducted in 22 sites contributing 75% of PLHIV on ART and 16 (73%) of the selected sites are PEPFAR supported. There was over reporting of TX\_CURR in DATIM by 3% in 2019, 2% in 2020 and 1% in 2021 reflecting an improvement in treatment data reporting. Discrepancy of treatment reporting in MOH DHIS2 is worse at 6% in 2020 and -17% in 2021 which requires attention to improve overall national treatment and other indicator reporting data. PEPFAR implementing partners and the Field Officers will do mini DQA in addition to the one planned national DQA.

#### 4.4.11 Human Resources for Health

Since independence, the South Sudan health sector has been run largely by international NGOs with funds from donors. Each NGO funds a program with specific objectives resulting into vertical programs with virtually no coordination. Also, each NGO recruits' staff with its own grading, salary scale and nomenclature, which often creates confusion. In COP18 the Government attempted to

standardize the nomenclature and the salary scale in the health sector; this was resisted by many facility staff which caused widespread strikes in facilities.

To successfully implement the differentiated care models and scale up MMD, PEPFAR South Sudan, together with the IP and MOH, analyzed the large human resource challenges facing the delivery of HIV services in the country. The exercise involved categorizing the existing staff by level: above site, site level and community. The cadres were linked to relevant MER indicators. It also involved establishing the minimum set of staff/numbers to fulfil establishment of a standalone facility and fulfill care and treatment service delivery functions. Recognizing continuing challenges in the HRH arena, an HRH analysis was undertaken in the first quarter of COP20 and accordingly staffing needs for COP20 were revised based on the above-mentioned HRH re-alignment activities, Field Officers' and other staff recommendations, data-driven needs and targets proposed. The size of a service delivery unit is now site-specific depending on the volume of PLHIV, targets and performance of a facility. At this point, PEPFAR South Sudan does not propose additional incentivized staff for COP22 on top of current COP21 plans. However, in COP 22, site-specific decisions will continue to be made based on the comprehensive HRH analysis and re-alignment recommendations and lessons learned from the COP 21 implementation.

#### **4.5 Commodities**

HIV commodities and supplies remain critical for the success of the PEPFAR program. In COP21 PEPFAR South Sudan USG staff and care and treatment partners continue to play a leading role in the commodities technical working group to ensure that HIV commodities such as test kits and optimized ARV regimens are appropriately quantified and planned to support MOH procurement through UNDP. Throughout COP21 implementation, South Sudan has continued to undertake key activities in support of multi-month dispensing, as well as pediatric ART optimization using DT10mg. In COP22, PEPFAR South Sudan will continue to work closely with MOH leadership, Global Fund, UNDP, and other key stakeholders to periodically review commodity needs and advocate for changes to procurement and supply plans that will ensure a consistent supply of HIV commodities.

The South Sudan 2020-2023 Global Fund grant did not fund all required commodities due to limited funding. In 2022 and 2023, Global Fund and UNDP will continue to coordinate and collaborate with key stakeholders, including PEPFAR South Sudan to ensure commodities such as PrEP, HIV-self testing, drugs and supplies required for advanced HIV care are aligned to national needs. Commodities like Isoniazid for TPT will be reviewed to ensure adequate quantities to support TPT targets and improved national coverage. The country is also exploring the possibility of updating Isoniazid to include Cotrimoxazole/Isoniazid/Pyridoxine fixed dose combination.

In COP22, South Sudan will continue to rely 100% on HIV commodities procured by UNDP under the Global Fund grant, apart from VMMC commodities, which will continue to be procured by the PEPFAR Implementing Partner directly. Although PEPFAR South Sudan does not procure HIV commodities, the PEPFAR program accounts for over 80% of the HIV commodities consumed. The



USAID South Sudan Supply Chain Specialist will lead PEPFAR South Sudan's efforts in coordinating supply chain stakeholders including MOH leadership, Global Fund, UNDP, and NPHL related to quantification and supply chain management activities. Issues related to consumption data collection and reporting persist.

### **Last Mile Delivery**

Last mile delivery has been a challenge affecting timely distribution of commodities including restocking to address stockouts. South Sudan has a challenging physical infrastructure and insecurity concerns that makes the use of road transportation impracticable. Because of this, humanitarian and development partners resort to the use of air transportation as the main means to manage logistics. With limited reliable air transport companies, the humanitarian air services, which are often very expensive, have been the main option used for commodities delivery. Despite it being the leading option, it has not been reliable and efficient in delivering commodities including last mile delivery.

In COP21, last mile delivery resources were distributed among all three PEPFAR care and treatment partners to conduct their own last mile delivery. This covers shipment from within Juba to health facilities, including transportation, storage, and handling, from regional hubs where UNDP ships commodities to their destination. In addition, resources were allocated to support human resources for TA on supply chain management, quantification and inventory support to enhance facility-level consumption data visibility, including TA for customization of DHIS-2 to allow for reporting, using that platform.

### **4.6 Collaboration, Integration and Monitoring**

During stakeholder meetings held in February 2022, pre-COP MOH consultations, and during the virtual COP consultations, several themes stood out as requiring continued work and efforts. These are:

1. Continued need for improvement in coordination across stakeholders particularly the need to get Global Fund/UNDP more engaged and involved in the national-level quarterly review meetings.
2. De-duplication of efforts and resources across MOH, GFATM and PEPFAR, specifically, to ensure that PEPFAR partners do not overlap their efforts and resources in support services at national and sub-national level by ensuring that PEPFAR IPs and GF primes de-duplicate their efforts.
3. Strengthening of collaboration with civil society and local NGO partners.
4. Ensuring all parties have a complete understanding of the data quality and service quality landscape at the site level.

For streamlined program planning, implementation and monitoring of HIV/AIDS program activities in South Sudan, the Ministry of Health has delegated the routine management and operations functions of HIV/AIDS program to the Department of HIV/AIDS, within the Directorate of Medical Services. All HIV/AIDS programs/interventions come under the purview of Department

of HIV/AIDS, headed by the Program Manager. PEPFAR has been supporting the Department complementing the interventions with Global Fund in a de-duplicated manner. In COP22, this support will continue to provide technical and management support to the Department for enhanced coordination and collaboration amongst the various partners and stakeholders. The goal of this support will be to ensure that PEPFAR and Global Fund supported interventions are complementary to each other and to support the Ministry of Health. It will ensure that the PEPFAR IPs and GF prime partners are supporting a common national plan rather than individual partner interests.

To ensure that the above goals are met, PEPFAR will:

1. Continue to engage with MOH and all stakeholders in program planning and designing during the COP processes through stakeholders' workshops and one-on-one interactions with different stakeholders.
2. Continue to support the HIV Incident Management System led by the MOH
3. Continue to schedule MOH- and stakeholder-led quarterly reviews of the PEPFAR program, with an emphasis on data and service delivery quality.
4. Participate in the MOH-led and convened Technical Working Groups for various thematic areas within the HIV/AIDS program.
5. Make efforts to engage the MOH and appropriate stakeholders in all technical discussions with partners that have programmatic impact of national importance.

#### Capacity Building of Civil Society organization

South Sudan lacks Human resource for health and technical capacity of the local CSO. Over the years, efforts to transition from international NGOs to local NGO were rendered impossible due to lack of capacity. In Cop21, PEPFAR South Sudan made a significant move by engaging nine local CSOs, however only one qualified as a prime partner the rest are sub-Prime

In Cop22 PEPFAR South Sudan shall embark on building the technical and managerial capacity of the local CSO. Each IP shall be tasked to set aside indicators for building the capacities of the CSO they engaged and gradually cede function to those CSOs. This shall begin with the community component of the programs. Where possible, expert CSOs and consultants will be engaged to organized structured trainings and workshops based on gaps identified with the CSOs engaged. The Target is to have most if not all of the local CSOs engaged as prime partners implementing the community engagement

#### Ministry of Health and Stakeholder-Led Review of PEPFAR Program

Since COP17 implementation, PEPFAR South Sudan has held a quarterly stakeholder-led review of PEPFAR IPs. During the two-day quarterly review, convened jointly by the Ministry of Health and UNAIDS, PEPFAR IPs present their program data for the preceding quarter. Each session is chaired and co-chaired by leadership representatives from MOH, CCM, WHO, UNDP, UNAIDS, IOM, SSAC and CSO representatives. Based on the data and performance against targets, the

stakeholders review the partner performance, issues and challenges are discussed openly and recommendations made. PEPFAR implementing agencies allow for the entire review process to be driven by the stakeholders. PEPFAR South Sudan will continue this practice in COP22 and continue to engage stakeholders at all levels in COP planning and implementation.

### Technical Working Groups

The Ministry of Health is reviewing its HIV response approach and adopting an incident management system (IMS) that will be led by MOH IMS chair who will be supported by four deputies. Five technical Working Groups (TWGs)-prevention, care and treatment, commodities and supply chain, strategic information and client led monitoring with discuss program implementation at national level and also engage with sub-national level and facility teams through GSM calls. PEPFAR USG staff and implementing partners staff will provide technical and operational support to the IMS and the TWGs.

In COP22, PEPFAR will continue to actively participate, provide technical support, leadership and guidance to the IMS and the TWGs as well as participate in the overall National M&E and Laboratory TWGs.

### PEPFAR Programming with Deduplication

As evident from the Sustainability Index Dashboard, several structural and contextual factors impact human resources for health in South Sudan. Ranging from low salaries to delayed payments, a dearth of trained staff and frequent turnover impact program implementation at all levels. PEPFAR continues to implement a direct service delivery model through implementing partners and provides clinical and lab staff as well as community level workers to implement different aspects of the program. Global Fund implements an incentive-based service delivery model wherein the existing staff from the MOH are supported with incentives to perform HIV/AIDS services. PEPFAR is carefully coordinating with the Global Fund to ensure there is no overlap or duplication of support. In addition, both donors build upon -- and deliver services through -- Health Pooled Fund (HPF) supported MOH facilities and thus, coordinate closely with HPF implementing NGOs.

The site-level rationalization exercise undertaken as part of the COP18 planning process is paying dividends, allowing for deduplication of resources by ensuring there is one implementing partner per SNU (county level). In order to increase efficiencies and decrease costs by ensuring one implementing partner per SNU and limit any multi-partner overlap at the SNU and State levels, PEPFAR South Sudan undertook a geographic rationalization exercise during the COP18 planning process, which is currently being executed with the following objectives:

1. Increase efficiency and decrease costs; limit IP monitoring and supervision costs by deduplicating multi-partner allocations to the same county/state
2. Improve accountability (have one IP take responsibility for the targets and results for the SNU)

3. Foster an IP to County/State MOH relationship and engagement by assigning dedicated IPs per County/State
4. Improve agency level partner management by adopting a more logical assignment of geographic areas by partners

This exercise has led to a reallocation of sites amongst the implementing partners. In consultation with Global Fund and MOH, site-by-site mapping of services and resources was undertaken, particularly for integration of TB-HIV services, which is a work in progress due to continued challenges with the TB program.

### Partner Management and Monitoring

Towards strengthening implementing partner management and monitoring and implementation of strategies across the cascade, the USG PEPFAR interagency team has a structured calendar and frequency of activities. The strategic direction of the PEPFAR program since COP19 is to maximize efficiencies by focusing resources, with attention to retention issues that stand out as the biggest challenge. Using accurate and complete site-level granular data, by volume, yield, testing modality, gender and age-band, PEPFAR proposes to identify and scale up to high volume and high yield interventions (across population and geography), maximize retention and minimize loss to treatment/follow-up with the goal of achieving the three 90s.

The partners will be reviewed periodically both by PEPFAR as well as through stakeholders' meetings as below:

1. At least quarterly one-on-one and more frequent IP review that is data driven, including site-level program performance, data quality, and fiscal data review to ensure all data are reported from the sites where services were provided along with a follow-up on action points from prior review/s.
2. Quarterly stakeholders' meetings that precede the interagency POART reviews and involve data-driven reviews of IPs along with external stakeholders.
3. Quarterly program performance reports as a narrative of the program performance submitted by the IP.
4. Field supervision and SIMS visits.

The quarterly administrative management visits will continue to be undertaken to review fiscal data and compare the same with program performance, i.e., results achieved against the targets set. Particular attention will be paid towards quarterly expenditure/spend-downs and forecasted annual spend-down to watch for possible over-outlays in order to identify and alert the partner as well as the agency of such possibility.

### Strengthen National Health Information System (HIS)

In October 2018 South Sudan introduced DHIS-2 reporting for all health data. PEPFAR in collaboration with other partners, mainly Global Fund and GAVI, has supported the DHIS-2 roll out process. PEPFAR focused its support at the national level to enhance coordination and resource

mobilization and at the county and site level in PEPFAR-supported counties to improve timeliness and completeness of reporting. By December 2021 complete DHIS-2 reporting at PEPFAR-supported sites was at 100%, compared to 68% at non-PEPFAR supported sites. Main challenges of the DHIS-2 roll out are inadequate, unskilled, unmotivated staff and high staff turnover at county and facility levels which results in poor data quality and incomplete reporting. In fracture challenges such as limited internet access result in late reporting. Inability of county teams to coordinate and supervise data management in all facilities within the county contributes to low timeliness and completeness in reporting even beyond HIV program indicators.

In COP22 PEPFAR will support MOH in ensuring availability of updated HIS policy and overall national M&E strategic plan as well as HIV specific national HIV M&E strategic plan. COP21 activities that will continue through COP22 include ensuring availability of data collection tools; providing targeted facility and county level joint support supervision and mentorship, including data quality; support improvement and maintenance DHIS2 and ensuring that monthly data submitted through DHIS2 are reviewed and feedback provided to State, County and facility levels. PEPFAR will support national HIV program review and state level HIV program performance reviews. PEPFAR will provide technical staff to support the national Ministry of health provide effective sub-national and facility level supportive supervision, mentorship and ability to collect quality data and utilize the data for decisions.

#### 4.7 Targets by population

About 86% of the COP21 Treatment New targets are expected to be achieved in scale-up aggressive counties. [Table 4.7.1](#) shows distribution of key targets in scale-up aggressive counties.

**Standard Table 4.7.1**

<b>Table 4.7.1 ART Targets by Prioritization for Epidemic Control</b>						
<b>Prioritization Area</b>	<b>Total PLHIV</b>	<b>Expected current on ART (APR FY21)</b>	<b>Additional patients required for 80% ART coverage</b>	<b>Target current on ART (APR FY22) TX_CURR</b>	<b>Newly initiated (APR FY22) TX_NEW</b>	<b>ART Coverage (APR 22)</b>
Attained	N/A					
Scale-Up Saturation	N/A					
Scale-Up Aggressive	69,670	36,243	19,493	50,918	15,912	73%
Sustained	21,127	4,666	12,232	6,377	1,796	30%
Military SNU	NA	2,604	NA	3,513	980	NA
Central Support	N/A					
Commodities (if not included in previous categories)	N/A					
<b>Total</b>	<b>90,797</b>	<b>43,513</b>	<b>29,125</b>	<b>60,808</b>	<b>18,688</b>	

The VMMC targets for COP21 in [Table 4.7.2](#) are only allocated to the military population. The targets for prevention among priority population (clients of FSW) and key population (FSW) in [Table 4.7.3](#) are assigned to the major towns in the scale-up aggressive counties of Juba, Magwi, Yambio and Wau.

**Standard Table 4.7.2**

Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	Target Populations	Population Size Estimate (SNU)	Current Coverage (date)	VMMC_CIRC (in FY22)	Expected Coverage (in FY22)
Military SNU	[15-39 years]	NA	NA	7,957	NA
	<b>Total/Average</b>				

**Standard Table 4.7.3**

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate* (SNU)	Disease Burden*	FY22 Target
AGYW at risk of HIV Juba County	36,081		2,300
KP_PREV (FSWs)- BBS surveys/program data	30,104	3,452	10,356
PP_PREV (Clients of FSW)			7,374
<b>TOTAL</b>	<b>66,185</b>	<b>3,452</b>	<b>20,030</b>

\*Include data sources in the text (i.e. not in the table itself)

**Standard Table 4.7.4 is required**

Table 4.7.4 Targets for OVC and Linkages to HIV Services					
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY22Target) OVC_SERV Comprehensive	Target # of OVC (FY22Target) OVC_SERV Preventative	Target # of active OVC (FY22Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY22 Target) OVC*
Juba County		3,637	0	1,274	2,941
<b>TOTAL</b>		<b>3,637</b>	<b>0</b>	<b>1,274</b>	<b>2,941</b>

## 4.8 Viral Load and Early Infant Diagnosis Optimization

In the past one year, the South Sudan program has made improvements in VL coverage despite some challenges with reaching 95% .VL coverage increased from 57% in FY21Q1 to 60% in FY21Q4. By FY22Q1, the VL coverage increased to 66%. VL coverage has generally remained quite low in different populations and geographical areas. Although the average VL coverage stood at 60% in FY21Q4, the VL coverage in children under 15 years was at 56% and even lower for pregnant women at 42%

VL suppression has stayed at an average of 85% during the past 4 quarters, with children under 15 years old having a low VL suppression of 64% in FY21 Q4.

The strategies for improving VL coverage and VL suppression have been described under section 4.2.

Early infant diagnosis in the 0-2months age group has not improved over time. By the end of FY21, the EID coverage for 0-2months was 48% but dropped to 46.% in FY22 Q1. The EID coverage for 2-12months was 88% at the end of FY21 and increased to 89% in FY22 Q1. These coverages are much lower than the expected EID coverage of 95% for both 0-2 and 2-12 months.

The main reasons that led to low EID coverage includes low literacy levels in the community, distance and costs associated with travel to facilities, delayed return of infants to facility, denial of positive HIV results by mothers, difficulty of identifying HEI at other facility points of entry and delivery of infants at home and private facilities.

The proposed strategies for improving EID coverage in COP22 include the following:

- Strengthening collaboration between PMTCT, Nutrition and EPI units to identify HEI at these entry points. This strategy will require the hiring and assignment of dedicated personnel to all entry points and training to identify HEI and link them to testing.
- The scaling up of Near Point of care instrument to improve access to EID services and reduce turn-around-time of EID results.
- Training, mentorship and remuneration of mentor mothers to trace, identify HEI, collect samples for EID and link positives to treatment.
- Provision of transport refund to mothers who bring their children to health facility for EID.
- Implement weekly data review of EID at facility level and weekly follow-up of HIV positive infants. HRL will also communicate with facilities to establish of PCR positive infants have been traced and started on ART

Complementary use of point of care (POC) and centralized instruments.

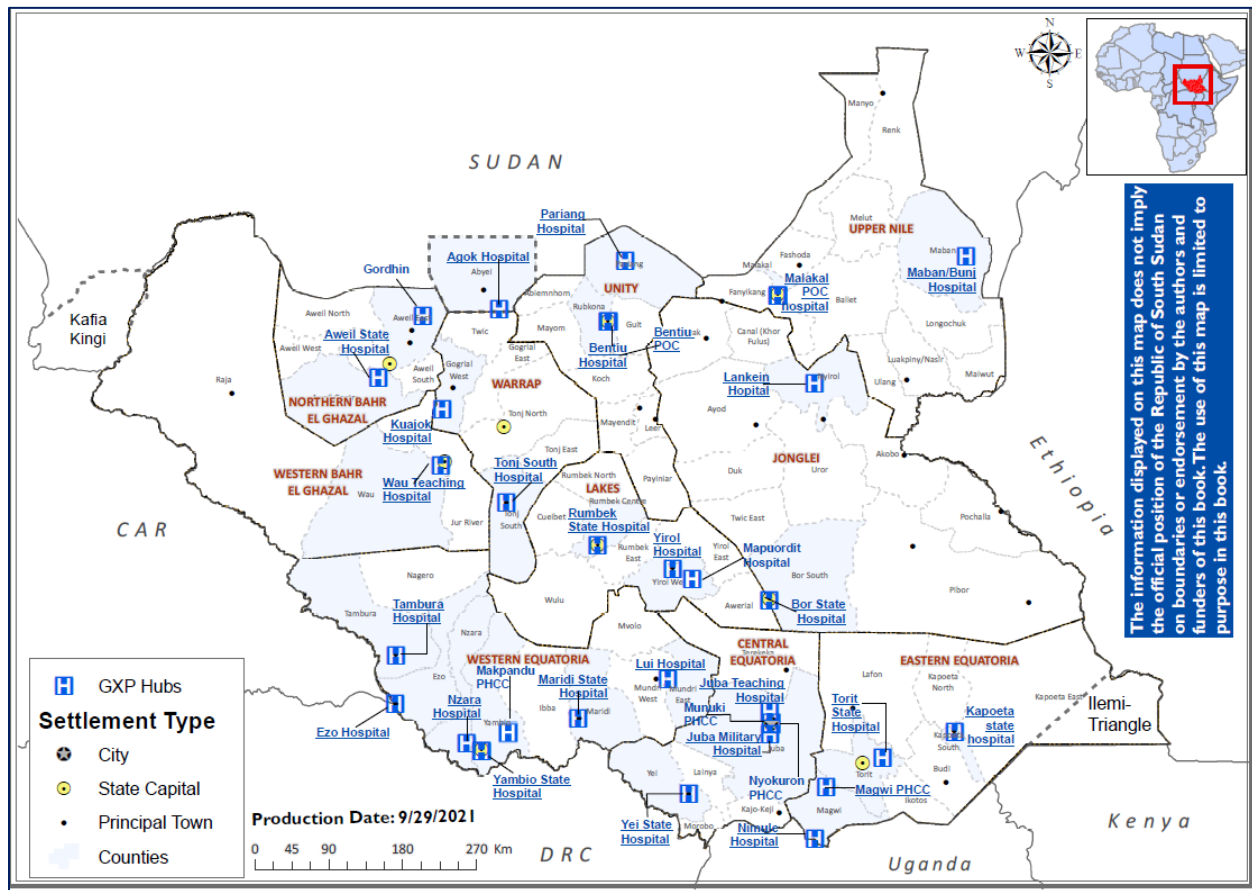
Testing of EID and VL samples and return of results are dependent on the availability and optimum performance of testing platforms, timely equipment maintenance, availability of reliable electricity, competent and dedicated human resource and availability of reagents and storage space for the much-needed supplies. There are currently two Abbott m2000sp/rt instruments that were procured by Global Fund. The first equipment was operationalized in May 2018 while the second equipment was installed in May 2021. Each of the Abbott instruments has a capacity to test 93 samples in 8 hrs. The theoretical capacity of the HIV reference laboratory is 89, 280 samples per day i.e. 4 runs per day at 100% efficiency. No laboratory operates at 100% efficiency. However, due to repeated breakdown of the instruments (e.g. the new Abbott equipment malfunctioned 4 times in 6 months), long response time of biomedical engineers, stock-out of reagents and limited hours of HRL operations (8-12hours), the HRL has been operating at an estimated efficiency of 50% (2 runs per day).

In COP22, the PEPFAR program expects to improve efficiency to 70% to allow an estimated number of 62,496 samples to be tested. To ensure optimum operations of the HIV testing laboratory, PEPFAR South Sudan will collaborate with UNDP to ensure timely equipment maintenance, fuel availability and appropriate and safe laboratory work environment. PEPFAR will continue to provide salary to the HRL staff, technical assistance including training, supervision and provision of all guidelines, tools and SOPs. In FY21, 96% of the VL samples (25207) were tested at HRL. As a back-up measure for uninterrupted VL testing, PEPFAR South Sudan has established memorandum of understanding South Sudan National Public Health Laboratory and Uganda National Health Laboratory Service. This South-South collaboration will continue into COP22. When resources become available PEPFAR will support establishing regional laboratory capacity to serve as an in-country back-up laboratory.

By end of FY21, there were 43 GeneXpert instruments in the country: 41 of them are four module and 2 are sixteen module instruments. 36 of the instruments are installed at the 34 facilities, 2 are installed at the HIV Reference Laboratory, 2 at the National TB reference laboratory and 1 sixteen modules at the Molecular laboratory. Installation of the GeneXpert instruments was possible because of laboratory infrastructural improvements that were supported by Global fund, UNHCR, IOM and MSF as a result of collaboration and engagement with PEPFAR South Sudan and MoH.



## Map showing locations of Near-Point of Care instruments



## Multiplexing

The GeneXpert instruments have been used for diagnosis of multiple conditions. In FY21, 15 instruments were used to test EID, VL, TB and COVID19, 9 were used for EID, TB and COVID19, 3 for TB and COVID19, 4 for only TB and 3 for only COVID19. The use of GeneXpert instruments complemented the testing capacity of Centralized testing of HIV, TB and COVID19. Multiplexing resulted into 1102 VL tests, 1902 EID tests, 7547 COVID19 tests and 10545 TB tests in FY21. The EID tests conducted using the GeneXpert contributed to 56% of the total EID tests done in the country but only 4.1% of VL tests.

There were 24 facilities using the GeneXpert instruments for HIV early infant diagnosis with more than 40 spokes. Through use of the near Point of care instruments the number of EID tests conducted using GeneXpert increased from 112 in FY21 Q1 to 1367 by the end of FY21. The total number of EID tests conducted via centralized and POC increased from 902 in FY21 Q1 to 3269 by end of FY21 Q4. We will continue optimizing use of the GeneXpert instruments and request for additional instruments for locations that do not have the instruments.

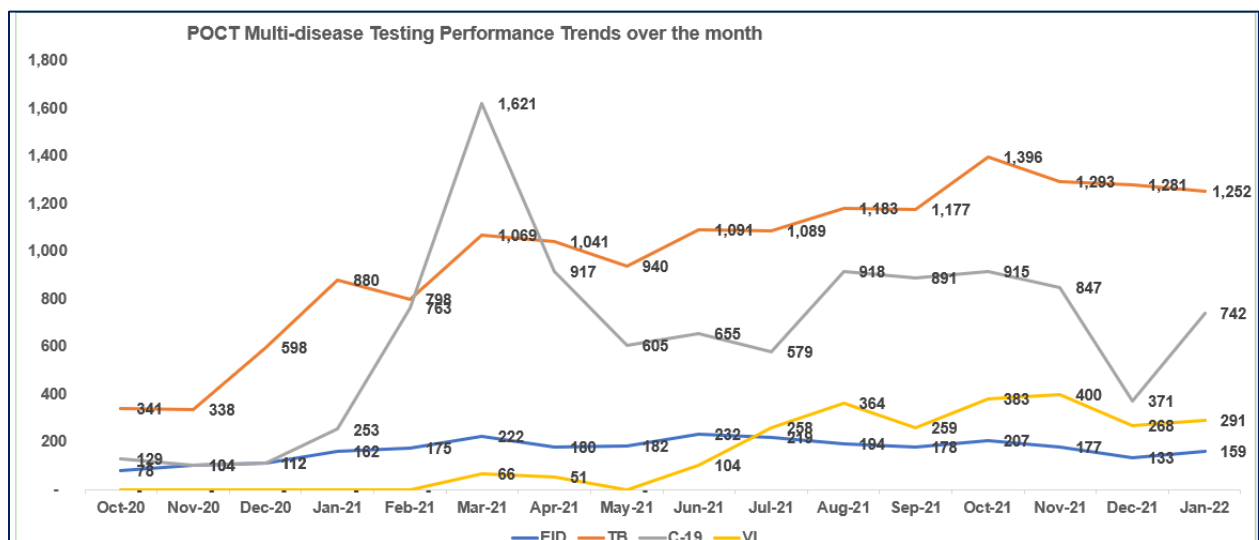
Currently, VL testing using GeneXpert instruments is prioritized for pregnant women, breastfeeding women, children and HVL patients. The facilities where VL testing is currently being

conducted at facility level are Ezo Hospital, Yirol State Hospital, Mapourdit Hospital, Yambio State Hospital, Nzara PHCC, Makpandu PHCC, Rumbek State Hospital, Wau Teaching Hospital, Kapoeta State Hospital, Torit State Hospital, Yei Civil Hospital, Nimule Hospital, Tambura Hospital, Maridi hospital and Lui hospital. All these facilities except Makpandu are CDC supported facilities. Facilities that have challenges with reliable transportation network e.g. Ezo, Mapuordit and Yirol test all clients using the GeneXpert near POCT. In FY22 Q1, 51.8 % of the VL POCT tests were for Pregnant and Breastfeeding mothers, 4.75% were for children, 10% were for HVL and 33.3% were for General population.

Due the existing challenges with access to VL services, PEPFAR will work with the MoH and Global fund to procure additional 16-module GeneXpert instruments through the all-inclusive pricing arrangement.

### TB/HIV diagnostic integration

Use of GeneXpert for TB diagnosis at health facilities was started in South Sudan in 2018. The phase 1 (2018) facilities in for TB diagnostics were Juba teaching hospital, Munuki PHCC, Torit state hospital, Nimule hospital, Aweil hospital, Malakal hospital and Bentiu hospital. In 2019, Rumbek state hospital, Yirol hospital, Tonj hospital, Gordhim hospital, Agok hospital, Nzara hospital and Pamir hospital also started using GeneXpert for TB diagnosis. Integration of TB and HIV testing on the same platform was started in FY20 Q3 (April-June 2020) at 4 facilities (Nzara hospital, Nimule hospital, Torit hospital and Makpandu. As of end of FY21, there are 24 facilities that have integrated TB and HIV testing on the same instrument. Diagnostic integration of TB and HIV has led to increase in number of TB tests conducted at the facilities as shown in the graph below. The country will continue to integrate VL testing onto the same GeneXpert instruments.



Successful integration requires availability of competent and dedicated staff who will require remuneration. Point of Care focal persons will be recruited to be responsible for ensuring maximum utilization of the instruments including demand creation, testing, stock management,

documentation and reporting. PEPFAR partners will support the training of users, results return, development of standard operating procedures and data collection tools and monitoring of equipment performance.

Use of data systems to alert patients of the availability of their test results

Laboratory information systems also play a role in scaling up of VL services. The HIV Reference Laboratory currently uses VL sample management system (VLSM). The VLSM, that was introduced in 2017 for VL, has been expanded to capture EID, COVID-19 and TB data. The VLSM has been installed at 3 laboratories (HRL Juba, Nimule hospital laboratory and Wau teaching hospital laboratory). The system has been improved to allow data entry and access from facilities via sim-card enabled tablets. The VLSM also communicates with the Abbott testing equipment and emails results to facility email addresses. The challenges experienced with the VLSM include unstable internet, recurrent errors and absence of dedicated IT technicians at Wau and Nimule. Because of limited phone connectivity, internet challenges, high stigma and high rates of intimate partner violence, the use of sms technology for result return to patients is not feasible in COP22. PEPFAR South Sudan will strengthen community systems to ensure that patients are notified of their result availability and provided with the right package of service. In order to improve result transmission and accessibility, PEPFAR South Sudan will improve internet service, recruit/assign 2 IT managers for Wau and Nimule, finalize interoperability processes with DHIS2 and e-governance, provide mentorship to facility level staff on data entry and result access and improve client literacy on areas of disclosure and stigma reduction.

## 5.0 Program Support Necessary to Achieve Sustained Epidemic Control

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COP22 proposes to identify and support systems investments that address:

1. System gaps as identified through SID, MER, SIMS and other sources.
2. Epidemic control priorities.
3. Systems strengthening by leveraging other development and MOH investments.

The system's investments are intended to supplement resources contributed by Global Fund and Ministry of Health towards epidemic control. The MOH contributes limited resources towards systems strengthening as reported in the Sustainability Index Dashboard, SID 4.0. PEPFAR will work in collaboration with the Global Fund and support the systems investments to leverage de-duplicated investments and maximize efficiency. While the ultimate goal is for the government to take ownership of the HIV program, the country is many years from that goal.

PEPFAR will provide institutional level technical assistance in implementing HIV/AIDS services. This will be in the form of technical support staff, training, mentoring and data management capacities support to the Department of HIV/AIDS in the Ministry of Health and the National Public Health Lab (NPHL) to build host country institutional capacities.

At the facility level HIV/AIDS interventions have three key aspects as identified under the three 95s, identification of PLHIVs, linkage and retention in treatment and viral load suppression. Accomplishing this at the facility level will require systems level investments to build current and sustainable capacity at an institutional level as well as technical assistance in policy making, developing guidelines, support for program monitoring and overall program management.

The Government of South Sudan does not have reliable population-based data, and program-based health data is limited with quality issues which make targeting PEPFAR interventions accurately and appropriately a challenge. The reporting of HIV indicators from health facilities through the MOH District Health Management and Information System (DHIS) is improving but not complete enough to provide realistic sub-national unit coverage figures.

The VL and EID testing program has gradually scaled up to 87 and 55 facilities respectively. As the programs scale-up to more facilities to meet the increasing targets and improve coverage, the National capacity to test samples needs to equally be improved. Successful improvement of coverage will require optimum utilization of the existing equipment, timely maintenance, reliable power supply, uninterrupted supply of reagents and consumables, sufficient storage capacity, adequate technical staff to conduct testing and accessible and stable laboratory information system to transmit results to the facilities timely. PEPFAR will continue to make systems investments in strengthening overall laboratory capacities both at the national level as well as site level to both scale up and improve HIV testing, EID, TB screening and viral load monitoring capacities.

In order to save costs, create efficiencies and minimize duplication of efforts, PEPFAR will strengthen coordination with MOH, other donors and implementing partners. PEPFAR will maintain laboratory technical advisor at NPHL to ensure that laboratory program tasks are implemented in a coordinated fashion. PEPFAR will lead technical assistance provision for laboratory services while Global Fund will procure the necessary reagents and supplies.

In FY19, PEPFAR established an integrated HIV and TB specimen transportation system. This system has enabled EID, VL and TB samples to be transported within a short time period. In COP22, resources will be required to strengthening the specimen referral system and ensure samples are transported from spokes to hubs and to HIV reference laboratory or outside South Sudan.

The critical systems investments identified in the above-site activities in Table 6/SRE-Tool primarily address key systems barriers related to laboratory, strategic information, and human resources, policy, planning and coordination at the national level as well as key populations, supportive supervision and mentorship.

Detailed below are the key systems barriers, COP22 activities to address them, COP22 benchmarks and expected outcomes.

**A. The laboratory key systems barriers and proposed COP22 activities include the following:**

**1. Inefficient specimen transportation and result transmission system for VL, EID and TB**

The planned COP22 activities to address the above barrier include:

- Transportation of samples from Spokes to Hubs and HRL and referral to back-up testing laboratories in the region or internationally
- Procurement of sample storage freezers and sample transportation containers
- Recruitment of regional sample transport focal persons to coordinate sample transportation
- Strengthening VLSM to expedite result transmission to facilities

The expected outcome for COP22 activities is a reliable and efficient system for specimen and result transmission that will ensure 100% of HIV and TB samples are transported by a nationally coordinated system and results delivered to caregivers within four weeks.

The COP22 benchmark is the establishment of a national specimen courier system and an electronic and automated system for remote access to results by clinics

**2. Inadequate implementation of Continuous Quality Improvement activities**

The COP22 activities plan to address the above barrier include:

- Implementation of laboratory Continuous quality improvement activities at ten laboratories e.g. LQMS trainings, mentorship visits and participation in proficiency testing schemes

- Conducting laboratory audits at HIV laboratory to support ISO 15189 accreditation
- Enrollment of 25 POCT laboratories in external quality assessment schemes
- Production and distribution of EQA materials
- Supporting equipment maintenance
- Supporting establishment of integrated electronic laboratory information management system.
- Supporting last mile delivery of supplies to facilities to ensure uninterrupted provision of services
- Strengthening systems for internal quality control at testing points
- Implementation the DTS EQA technology to monitor the quality of HIV RT
- Improvement and certification of sites using the Stepwise Process for Improving the Quality of HIV Rapid Testing (SPI-RT/RTRI) checklist
- Development of human resources through training, certification, and recruitment of in-country Quality Corp (Q-Corp) volunteers and officers
- Conducting post-marketing surveillance

The expected outcome for COP22 is an accredited HIV reference laboratory and improved quality of HIV rapid tests, EID, VL and TB diagnosis.

The COP22 benchmark is that the HIV laboratory will be accredited all POCT laboratories, all regional blood banks, regional hospital laboratories, TB and HIV reference laboratories are enrolled into external quality assessment scheme; ten labs are implementing quality improvement activities based on WHO AFRO Strengthening Lab Management towards Accreditation (SLMTA) program; and all HIV testers are participating in proficiency testing program for HIV rapid tests.

3. **Limited number of policies and guidelines to guide laboratory practice, and inadequate management and leadership structure to support broader lab services (Laboratory strategic plan is not costed, A laboratory department that has limited authority, insufficient staff and insufficient budget, no laboratory regulatory council)**

The COP22 activities planned to address the above barrier include:

- 
- Supporting establishment of a laboratory regulatory board through development of policies and guidelines
- Supporting monthly technical working groups to plan and monitor program implementation

The expected outcomes for COP22 are a functional laboratory regulatory body council over-see operations of 70% labs and POCT sites, a costed national laboratory strategic plan and a laboratory department/directorate that has sufficient capacity to coordinate National laboratory activities.

The COP22 benchmarks are the establishment of a lab regulatory body and initiation of licensing laboratory practice, a costed National lab strategic plan and participation of 4 senior laboratory directors and 10 heads of department in leadership and management training.

#### **4. Low coverage for EID and VL services**

The COP22 activities planned to address the above barrier include:

- Supportive supervision of facilities by program staff
- Procurement of storage containers for EID and VL supplies
- Bi-annual maintenance and calibration of minor equipment
- Provision of fuel for generator to provide power to the laboratory
- Improving the laboratory information management system to allow remote access and data visibility through a dashboard
- Printing and dissemination of laboratory-related EID and VL tools
- Recruitment of staff at POCT laboratories and HRL for day-to-day operations of the laboratory.
- Storage and transportation of used EID and VL GeneXpert cartridges

The expected outcome for COP22 is increased EID coverage for zero to two months to 80% and VL coverage of 90%.

The COP22 benchmark is 80% PMTCT\_EID coverage for zero to two months and 90% VL coverage.

#### **B. The strategic information key systems barrier and proposed COP21 activities include the following:**

##### **1. Limited reliable program data to track progress towards 90-90-90 and to guide program planning**

The COP21 activities planned to address the above barrier include:

- Continue to support roll out of DHIS-2 at county and facility level
- Continue routine ANC sentinel surveillance system
- Strengthen routine monitoring of HIV program
- Undertake routine data quality assessment
- Support quarterly and annual PEPFAR stakeholders' meetings

The expected outcome for COP20 is improved and reliable program data to track progress towards 90-90-90 and to guide program planning.

The COP21 benchmarks are that all facilities providing HIV services in PEPFAR-supported counties provide timely and complete data through DHIS-2 and conduct routine ANC sentinel surveillance.

**C. The human resources, supportive supervision and mentorship key systems barriers and proposed COP21 activities include the following:**

**1. Inadequate supportive supervision, mentorship and dissemination of best practices at national level**

The key COP21 activity to address the above barrier is to scale-up and maintain project ECHO at 24 facilities. The expected outcome for COP21 is an integrated national Project ECHO system that is used for mentorship and best practices dissemination. The COP21 benchmark is to enroll 13 more ART sites to ECHO and maintain the former eleven sites.

**2. Inadequate human resource and management structure to provide leadership to the HIV department at the national level to support HIV services provision**

The key COP21 activity is to support key positions at MOH HIV Department and National Public Health Laboratory. The expected outcome for COP21 is improved and capacitated human resource at the HIV Department leading to improved oversight and supportive supervision. The COP21 benchmark is that two technical staff will be supported, one at the MOH HIV Department and one at the National Public Health Laboratory.

**D. The Key Populations key systems barrier and proposed COP22 activities include the following:**

**1. Structural Obstacles: Laws and/or policies, including stigma and discrimination issues that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services.**

The COP22 activities planned to address the above barrier include:

- Continuation of coordination with MOH, SSAC, civil society organizations and UNAIDS for on-going advocacy among local governing authorities (e.g., the Mayor's Office and the Juba City Council) and the National Security and Police Forces (e.g., City Council affiliated Police Forces) in Juba and other locations impacted by these barriers.
- Raise awareness and foster support for provision of KP services, including involvement and stronger engagement of the civil society organizations to disseminate awareness messages.
- Conduct training for selected key actors on stigma and discrimination including on Human Rights and rights to accessing of services for all sub-populations including KPs.

The expected outcome for COP22 is that the Mayor's Office and the Juba City Council, and the National Security and Police Forces are receptive and collaborate to support the provision of KP services.

The COP22 benchmark is at least three advocacy meetings and trainings are conducted targeting Mayor's Office and the Juba City Council, members from the security and law enforcement agencies and are supportive of KP activities.



## **Surveys, Evaluation and Research**

South Sudan has no population-based HIV survey data and has rely on ANC sentinel survey data, PMTCT and ART data input into spectrum for estimations of PLHIV. PEPFAR has supported four rounds of periodic ANC sentinel surveys and two rounds of periodic ANC sentinel survey (2021 and 2022). In COP19 MOH and PEPFAR transition away from periodic ANC sentinel survey to routine ANC sentinel survey where ANC/PMTCT data are extracted for a given period from selected sites and used as a measure of disease burden in the country.

During COP20 PEPFAR South Sudan supported the completion of the first routine ANC sentinel survey which informed the 2020 spectrum HIV estimates. Currently, PEPFAR plans to support one rounds of the routine ANC sentinel survey in COP21 to build local capacity and improve quality of PMTCT data. After this, routine program data will be used with periodic data quality checks. PEPFAR will support and HIV drug resistance survey in COP21 to monitor effectiveness and any possible emergence of resistance to the current ART regimen mainly (LTD). The will be incorporated within the VL program.

## 6.0 USG Operations and Staffing Plan to Achieve Stated Goals

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### 6.1 Staffing Plan

PEPFAR South Sudan Program is implemented by three USG agencies: CDC, USAID and DoD. The program goal for COP22 is to strengthen HIV care and treatment services to improve case identification, yield, linkage, and retention and to scale up the OVC program. To achieve these, it is crucial to analyze and align PEPFAR South Sudan's staffing footprint to provide quality oversight to implementing partners as well as technical assistance to the MOH and other stakeholders.

Currently under COP 21, PEPFAR South Sudan has fourteen staff (filled positions) that include two USG Direct Hires (CDC Country Director and USAID Health Office Director) who provide overall leadership for technical, programmatic and management oversight of the program. Alongside the two direct hires, the DoD, LES program manager, also provides general leadership for technical, programmatic and management oversight to DoD PEPFAR portfolio. The other eleven filled locally employed filled positions include eight from CDC, and three from USAID. These locally employed staff provide support for budget and finance, administrative and logistics, care and treatment, prevention, HSS (laboratory and strategic information), KP, OVC, DREAMS and commodities management.

Besides, for COP22, two are vacant but approved LES positions, and two Direct Hire positions. one of the two LES are under CDC, and one is under USAID. The Direct Hire positions, one is for a PEPFAR Coordinator under State Department; and the other Direct Hire is for CDC Deputy Director, Public Health Advisor.

#### **CDC One Vacant, but Approved Position:**

In COP21, CDC has three approved positions, the Administrative Assistant, the Prevention Specialist, and a Deputy Director. The Administrative Assistant position is being filled. The prevention Position is in final stages of advertisement. The Deputy Director position is being advertised; and interviews are currently being conducted.

#### **USAID Two Vacant but Approved Positions:**

In COP19, two positions (Strategic Information Specialist, and Supply chain Manager) under USAID were approved. The Strategic Information position was filled in COP20.

The Supply Chain Advisor position is on process of recruitment following stalling of the first hiring process that came as a result of a sudden and last-minute decline by the previously selected candidate. The position was readvertised in December 2021 and interviews have been concluded. The expectation is the successful candidate will join the PEPFAR team between Q3 and Q4 of FY22.

In addition, USAID received an approval for a new position in COP22 to support Local Partner transition activities. Once COP22 is approved, the plan and process of recruiting for this new position will be taken forward to ensure this position is hired as soon as possible.

**State Department: One Vacant, but Approved Position:**

The PEPFAR Coordinator's position is a State Department Direct Hire. This has been approved by the front office, and recruitment is underway by the Department of State.

**COP22 PEPFAR Staffing Changes**

New staffing changes in COP22 will include one locally hired staff for the DoD. From COP19, the program, particularly the VMMC has significantly expanded in terms of budget from only \$150 to \$ 1.5 million in COP22. This was reflected in increased geographic coverage through additional sites but not necessarily new staffing structure.

Currently, the program is run by a single staff (program manager) who spread thin covering different program areas. There is a need to increase staffing bandwidth to meet the scaled-up program and ensure continuous USG technical support is accorded to the IPs and military HIV-secretariat. The new proposed staff will mainly focus on prevention (VMMC) but will also support Strategic Information (SI) and DoD data management systems. The interagency country team acknowledges this as a gap and has consensually agreed to move forward with it.

## **6.2 Cost of Doing Business**

The overall Cost of Doing Business (CODB) for PEPFAR South Sudan has increased by 8% compared to COP21. This increase is attributed to the additional USAID staff for local partnership; and a general increase in staff salaries and benefits due to the revision of the LES local compensation plan.

# APPENDIX A -- PRIORITIZATION

## Continuous Nature of SNU Prioritization to Reach Epidemic Control

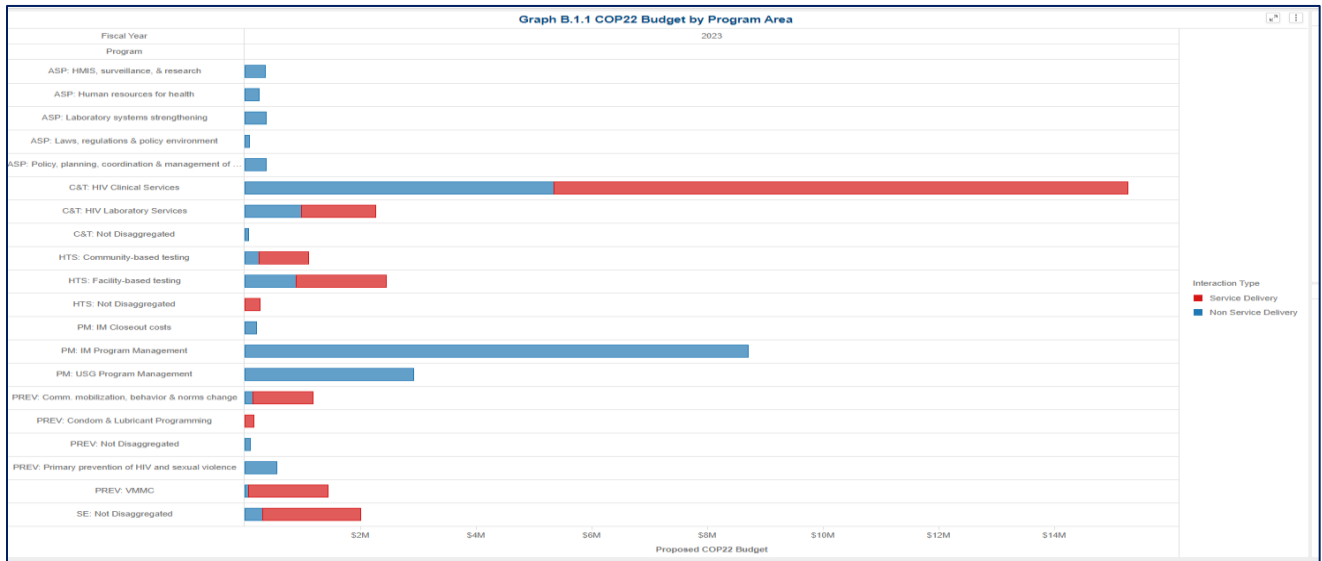
Table A.1

Prioritization	Prioritization	Prioritization	Results Reported	Attain 90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall																				Overall TX Coverage					
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44			45-49		50+		
				Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male		Female	Male	Female	Male	
Ezo	COP21	Scale-up Aggressive	Mar-20	18%	18%	32%	29%	19%	17%	18%	12%	48%	13%	59%	25%	50%	37%	45%	44%	43%	44%	34%	40%	35%	43%	25%	31%	32%	<div style="background-color: red; width: 10px; height: 10px; display: inline-block;"></div> <60 <div style="background-color: yellow; width: 10px; height: 10px; display: inline-block;"></div> 60-89 <div style="background-color: green; width: 10px; height: 10px; display: inline-block;"></div> >89
	COP22	Scale-up Aggressive	Mar-21	6%	22%	41%	35%	11%	21%	72%	7%	81%	8%	63%	28%	97%	37%	40%	35%	45%	35%	33%	27%	27%	29%	21%	12%	35%	
Ikotos	COP21	Sustained	Mar-20	10%	10%	19%	17%	11%	10%	11%	7%	38%	8%	35%	15%	29%	22%	26%	26%	25%	26%	20%	24%	20%	16%	15%	18%	19%	
	COP22	Sustained	Mar-21	0%	0%	28%	18%	10%	0%	36%	0%	100%	17%	46%	26%	32%	41%	28%	29%	46%	27%	20%	35%	40%	62%	46%	42%	30%	
Juba	COP21	Scale-up Aggressive	Mar-20	39%	38%	29%	28%	58%	57%	51%	47%	56%	37%	31%	49%	36%	67%	46%	87%	58%	99%	69%	112%	82%	130%	97%	60%	61%	
	COP22	Scale-up Aggressive	Mar-21	77%	56%	75%	71%	56%	54%	43%	19%	75%	12%	158%	38%	226%	85%	115%	154%	96%	109%	65%	154%	41%	99%	194%	94%	85%	
Kapoeta South	COP21	Sustained	Mar-20	7%	7%	13%	12%	7%	7%	7%	5%	19%	5%	24%	10%	20%	15%	18%	18%	17%	17%	19%	16%	14%	17%	10%	12%	13%	
	COP22	Sustained	Mar-21	0%	0%	18%	24%	6%	5%	10%	3%	33%	10%	38%	18%	28%	38%	22%	35%	14%	30%	14%	39%	16%	35%	48%	28%	21%	
Magwi	COP21	Scale-up Aggressive	Mar-20	12%	12%	22%	19%	6%	11%	12%	8%	32%	9%	39%	16%	33%	24%	30%	29%	28%	29%	22%	26%	23%	26%	23%	29%	21%	
	COP22	Scale-up Aggressive	Mar-21	9%	13%	26%	17%	6%	23%	25%	17%	17%	4%	37%	6%	81%	22%	38%	30%	38%	40%	23%	29%	28%	46%	25%	30%	27%	
Maridi	COP21	Sustained	Mar-20	39%	39%	72%	64%	6%	38%	40%	26%	108%	30%	132%	53%	111%	82%	100%	99%	96%	98%	75%	89%	78%	97%	53%	70%	72%	
	COP22	Sustained	Mar-21	0%	32%	33%	47%	6%	29%	28%	7%	28%	3%	39%	12%	37%	20%	35%	17%	38%	21%	23%	20%	31%	18%	15%	25%	24%	
Mundri East	COP21	Scale-up Aggressive	Mar-20	27%	27%	50%	44%	6%	26%	28%	18%	75%	21%	92%	38%	77%	57%	69%	68%	66%	67%	52%	61%	54%	67%	38%	48%	50%	
	COP22	Sustained	Mar-21	0%	0%	25%	24%	6%	81%	49%	16%	0%	36%	23%	10%	31%	6%	45%	22%	35%	24%	18%	23%	34%	28%	20%	46%	27%	
Nzara	COP21	Scale-up Aggressive	Mar-20	14%	14%	27%	24%	6%	14%	15%	10%	39%	11%	48%	20%	41%	30%	37%	36%	35%	36%	28%	33%	28%	35%	20%	26%	27%	
	COP22	Scale-up Aggressive	Mar-21	16%	9%	17%	23%	6%	17%	13%	14%	58%	30%	40%	26%	117%	32%	40%	31%	31%	36%	30%	17%	40%	30%	34%	21%	31%	
Rumbek Center	COP21	Scale-up Aggressive	Mar-20	32%	32%	59%	53%	6%	31%	33%	21%	88%	24%	109%	45%	91%	67%	82%	81%	78%	80%	62%	73%	64%	79%	45%	57%	59%	
	COP22	Scale-up Aggressive	Mar-21	17%	16%	26%	25%	6%	12%	16%	9%	68%	9%	61%	23%	47%	29%	57%	40%	53%	45%	50%	47%	52%	55%	47%	42%	36%	
Tambura	COP21	Scale-up Aggressive	Mar-20	41%	41%	76%	68%	6%	39%	42%	27%	113%	31%	139%	57%	116%	86%	105%	104%	100%	102%	79%	93%	81%	101%	58%	73%	76%	
	COP22	Scale-up Aggressive	Mar-21	16%	0%	142%	118%	6%	65%	73%	76%	73%	9%	64%	36%	184%	78%	146%	90%	138%	111%	121%	95%	127%	97%	64%	47%	86%	
Torit	COP21	Sustained	Mar-20	26%	28%	52%	46%	6%	27%	29%	19%	78%	21%	95%	39%	80%	59%	72%	71%	69%	70%	54%	64%	56%	70%	40%	50%	52%	
	COP22	Sustained	Mar-21	13%	13%	43%	51%	6%	10%	17%	0%	42%	16%	56%	20%	85%	49%	43%	48%	34%	56%	24%	43%	30%	71%	12%	48%	35%	
Wau	COP21	Scale-up Aggressive	Mar-20	23%	23%	42%	37%	24%	22%	23%	15%	62%	17%	76%	32%	64%	47%	58%	57%	55%	56%	43%	52%	45%	56%	32%	40%	42%	
	COP22	Scale-up Aggressive	Mar-21	0%	33%	30%	47%	14%	11%	19%	8%	37%	6%	38%	14%	38%	20%	37%	27%	37%	31%	26%	25%	32%	29%	18%	22%	25%	
Yambio	COP21	Scale-up Aggressive	Mar-20	18%	18%	33%	29%	19%	17%	18%	12%	49%	14%	60%	25%	50%	37%	46%	45%	43%	44%	34%	40%	35%	44%	25%	32%	33%	
	COP22	Scale-up Aggressive	Mar-21	25%	21%	16%	13%	14%	13%	25%	14%	84%	8%	102%	24%	227%	88%	82%	69%	79%	24%	51%	28%	57%	16%	60%	24%	48%	
Yei	COP21	Scale-up Aggressive	Mar-20	19%	19%	35%	31%	20%	18%	19%	13%	52%	14%	64%	26%	54%	40%	48%	48%	46%	47%	36%	43%	38%	47%	27%	34%	35%	
	COP22	Scale-up Aggressive	Mar-21	0%	0%	33%	34%	23%	26%	18%	23%	21%	0%	36%	15%	36%	24%	34%	32%	36%	36%	27%	37%	28%	35%	36%	31%	26%	
Yirol West	COP21	Scale-up Aggressive	Mar-20	14%	14%	25%	23%	14%	13%	14%	9%	38%	10%	46%	19%	39%	29%	35%	35%	33%	34%	26%	31%	27%	34%	19%	24%	25%	
	COP22	Scale-up Aggressive	Mar-21	25%	40%	40%	37%	18%	14%	16%	7%	80%	10%	58%	30%	103%	26%	36%	35%	39%	36%	26%	32%	29%	40%	29%	57%	36%	

# APPENDIX B – Budget Profile and Resource Projections

## B1. COP22 Planned Spending in alignment with planning level letter guidance

### Graph B.1.1 COP22 Budget by Program Area



### Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget			
		Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
<b>Total</b>			\$21,886,984	\$18,113,016	\$40,000,000	55%	45%	100%
C&T	<b>Total</b>		\$6,396,741	\$11,193,685	\$17,590,426	36%	64%	100%
	HIV Clinical Services		\$5,350,765	\$9,917,496	\$15,268,261	35%	65%	100%
	HIV Laboratory Services		\$980,976	\$1,276,189	\$2,257,165	43%	57%	100%
	Not Disaggregated		\$65,000	\$65,000	\$65,000	100%		100%
HTS	<b>Total</b>		\$1,134,310	\$2,651,970	\$3,786,280	30%	70%	100%
	Community-based testing		\$250,000	\$847,206	\$1,097,206	23%	77%	100%
	Facility-based testing		\$884,310	\$1,552,338	\$2,436,648	36%	64%	100%
	Not Disaggregated			\$252,426	\$252,426		100%	100%
PREV	<b>Total</b>		\$833,735	\$2,568,400	\$3,402,135	25%	75%	100%
	Comm. mobilization, behavior & norms change		\$135,000	\$1,038,400	\$1,173,400	12%	88%	100%
	Condom & Lubricant Programming			\$160,000	\$160,000		100%	100%
	Not Disaggregated		\$92,000		\$92,000	100%		100%
	Primary prevention of HIV and sexual violence		\$547,735		\$547,735	100%		100%
SE	<b>Total</b>		\$305,000	\$1,698,961	\$2,003,961	15%	85%	100%
	Not Disaggregated		\$305,000	\$1,698,961	\$2,003,961	15%	85%	100%
	VMMC		\$59,000	\$1,370,000	\$1,429,000	4%	96%	100%
ASP	<b>Total</b>		\$1,402,047		\$1,402,047	100%		100%
	HMIS, surveillance, & research		\$352,472		\$352,472	100%		100%
	Human resources for health		\$242,024		\$242,024	100%		100%
	Laboratory systems strengthening		\$368,210		\$368,210	100%		100%
	Laws, regulations & policy environment		\$70,000		\$70,000	100%		100%
	Policy, planning, coordination & management of disease control programs		\$369,341		\$369,341	100%		100%
	PM	<b>Total</b>		\$11,815,151		\$11,815,151	100%	
IM Closeout costs		\$200,000		\$200,000	100%		100%	
IM Program Management		\$8,705,657		\$8,705,657	100%		100%	
USG Program Management		\$2,909,494		\$2,909,494	100%		100%	

**Table B.1.3 COP22 Total Planning Level**

Table B.1.3 COP22 Total Planning Level				
Metrics	Proposed COP22 Budget			
Operating Unit	Applied Pipeline	New		Total
Total	\$654,029	\$39,465,971		\$40,120,000
South Sudan	\$654,029	\$39,465,971		\$40,120,000

**Table B.1.4 COP22 Resource Allocation by Program and Beneficiaries**

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary															
Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
South Sudan	Total	\$17,726,501	\$3,786,280	\$3,662,135	\$1,764,673	\$1,402,047	\$11,778,364	\$40,120,000	100%	100%	100%	100%	100%	100%	100%
	Females			\$1,052,735	\$1,075,000			\$2,127,735			29%	61%			5%
	Key Pops		\$295,982	\$548,000				\$843,982		8%	15%				2%
	Males		\$111,224	\$185,000				\$296,224		3%	5%				1%
	Non-Targeted Pop	\$14,621,051	\$2,524,779	\$307,400		\$1,402,047	\$11,565,151	\$30,420,428	82%	67%	8%		100%	98%	76%
	OVC			\$140,000	\$689,673		\$213,213	\$1,042,886			4%	39%		2%	3%
	Pregnant & Breastfeeding Women	\$2,067,713	\$601,869					\$2,669,582	12%	16%					7%
	Priority Pops	\$1,037,737	\$252,426	\$1,429,000				\$2,719,163	6%	7%	39%				7%

## B.2 Resource Projections

PEPFAR South Sudan used incremental and intervention-based budgeting methods. The technical team identified PEPFAR’s Fiscal Year 2023 priorities and goals to address PEPFAR South Sudan program challenges. Relevant interventions and initiatives were identified to achieve Fiscal Year 2023 goals and priorities. Based on Fiscal Year 2022 budget, Fiscal Year 2023 budgets are adjusted either upward or down for each program area.

There are three data sources used to project the Fiscal Year 2023 resources. The Annual Program Results (APR) was used to determine partners performance and ability to achieve results in Fiscal Year 2023. Based on this, resources were projected for the partners. Fiscal Year 2021 Expenditure Reporting (ER) guided the decision to adjust resources upward or downward to ensure resources are maximized for Direct Service Delivery (DSD), as opposed to Above-Site programs. Finally, COP21 interventions and budgets informed the decision on whether to continue or introduced an intervention that is relevant to PEPFAR South Sudan priorities, as stipulated in the Planning Level Letter (PLL).

## APPENDIX C – Tables and Systems Investments for Section 6.o

### Key System Barriers

Step 1: Select SID element	SID score (auto populated)	Step 2 - What is the outcome expected from investing in this element? (may duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed
10. Laboratory	8.6	Developed, approved, costed and implemented National Lab strategic plan	Lack of technical capacity	A strategic plan is the guiding document for implementing lab system strengthening activities. South Sudan National. The 2019-2023 strategic plan was developed but not costed. It can not therefore be used for resource mobilization. National Public health laboratory relies on technical and financial support from partners for majority of laboratory activities	1 year
10. Laboratory	8.6	An entity with sufficient authority, staff and budget	Lack of managerial capacity	There is no directorate at the Ministry of health responsible for laboratory services. Lab activities are over-seen by the national public health laboratory (NPHL). There are only 4 senior management staff that are in charge of the country-wide lab service delivery. This staff are inadequate in number, possess limited managerial capacity and unable to over-see lab operations in the country	4-5 years
10. Laboratory	8.6	An established lab regulatory council that over-sees operations of 70% labs and POCT sites	Legal, policy or regulatory constraint	South Sudan does not have an entity responsible for regulating the quality of laboratory services and practice. There is currently a laboratory	2-3 years

				professionals union that is mandated to protect professional integrity. Formation of a regulatory council requires an act of parliament and legal status in order to function	
10. Laboratory	8.6	Laboratories that are accredited and meeting international quality standards	Lack of Financial Resources	Continuous quality improvement activities are key in the provision of standard of lab services. There is no laboratory that is accredited in South Sudan. One lab (HRL) has been recommended to apply for accreditation. CQI requires financial resources to be able to meet quality indicators. The government does not provide funds for lab supplies, equipment maintenance, infrastructure improvement, personnel recruitment and salary, quality assurance procedures, provision of electricity and water, waste management, etc. Adequate resources are required for provision of quality lab services	2-3 years
10. Laboratory	8.6	Reliable, efficient, integrated sample transportation system	Underdeveloped private market	Sample transportation for HIV and TB samples is coordinated by ICAP on behalf of MoH. Sample movement is coordinated by one staff. There are no regional or state coordinators to ensure efficiency. Major challenges faced include insecurity, delayed payment of transporters, absence of coordinators, some non-HIV/TB samples are transported using a different mechanism.	2-3 years
14. Epidemiological and Health Data	5.7	Increased availability of accurate data on HIV epidemic in the country at national and subnational level to monitor the 95, 95, 95 cascade	Lack of sufficient HRH	Incomplete and unclear M&E staffing norm at the National, State and County levels. There is also inadequate skills and low motivation for government salaried staff due to low and irregular payments. This contributed to high staff turnover and need for continuous hirings and trainings.	6-9 years
16. Performance Data	6.6	Increased availability of accurate data on HIV epidemic in the country at national and subnational level to monitor the 95, 95, 95 cascade	Lack of sufficient HRH	Not adequate and skilled M&E staff at County and State level for complete and timely reporting of data through DHIS2 as well as limited capacity of County M&E teams to provide health data oversight, supportive supervision, and mentorship.	4-5 years



14. Epidemiological and Health Data	5.7	Increased health program M&E skills at National, State and county level	Lack of technical capacity	No trainings schools that generate data clerks and Health Information System staff. Most staff recruited to manage data have limited experience in health data management especially for HIV and requires trainings, mentorships especially at State, County and facility level. There is no strong in country capacity to manage and undertake HIS support including DHIS back end updates and creating inter-operable HIS such as Viral load information system, Logistics Management Information System and Human resource information management system	6-9 years
14. Epidemiological and Health Data	5.7	Increased availability of complete data through secure interoperable HIS	Physical infrastructure not complete/further investment needed by donors	While efforts have been made to provide some facilities with tablets and counties with computers to report health data, there is still need for additional infrastructure support in terms of tablets, computers, and internet connectivity	4-5 years
7. Human Resources for Health	6.8	Improved and capacitated human resource at the HIV department leading to improved oversight and supportive supervision	Inadequate human resource and management structure to provide leadership to the HIV department at the national level to support HIV services provision	Inadequate human resource and management structure to provide leadership to the HIV department at the national level to support HIV services provision	2-3 years
2. Policies and Governance	7	Mayor's Office & National Security and Police Forces are receptive and collaborate to support the provision of KP HIV services.	Legal, policy or regulatory constraint	Repeated harassment, arrests and unlawful detention of KP, often times with forced HIV testing and disclosure including denial of medications for KP on treatment.	4-5 years

**Table 6 Above Site Investments**

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	Barrier to Local Responsibility this activity addresses-3 (optional)	COP22 Activity Description	Intervention Start	Intervention End
\$6,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab policy, budgets, and strategic plans	10. Laboratory	6.22	5.64	Developed, approved, costed and implemented National Lab strategic plan	Lack of technical capacity	Lack of managerial capacity	Consultant fees, document reviews, consultations and workshops	COP22	COP23
\$20,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab policy, budgets, and strategic plans	10. Laboratory	6.22	5.64	An entity with sufficient authority, staff and budget	Lack of managerial capacity	Legal, policy or regulatory constraint	Support for National lab leadership workshops, management training, mentorship and support supervision, facilitate lab stakeholder and TWG meetings	Prior to COP 18	COP23
\$15,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	6.22	5.64	An established lab regulatory council that over-sees operations of 70% labs and POCT sites	Legal, policy or regulatory constraint	Lack of sufficient HRH	Supportive supervision, site and tester certification, development of SOPs, job aids and training materials, supplies	COP19	COP24
\$127,210	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab accreditation	10. Laboratory	6.22	5.64	HRL that should be accredited and 10 labs meeting international quality standards	Lack of Financial Resources	Lack of managerial capacity	Implementation of laboratory CQI at ten laboratories: LQMS trainings, mentorship visits, POCT EQA program, Integrated electronic LIMS, production and distribution of EQA materials, EQA lab supplies, equipment maintenance, sample transportation.	Prior to COP 18	COP24
\$200,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	6.22	5.64	Reliable, efficient, integrated sample transportation system	Physical infrastructure not complete/further investment needed by donors	It is not included in local HIV response plans	Transportation from spokes to hubs, and from hubs to National public health laboratory, Also support referral of samples to back-up in the region and internationally	COP19	COP24
\$242,024	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	3.19	2.68	Improved and capacitated human resource at the HIV department leading to	Inadequate human resource and management	Lack of managerial capacity	Support key positions at MOH HIV department and National Public Health Laboratory (NPHL)	Prior to COP 18	COP25
\$70,000	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	5.61	6.16	Mayor's Office & National Security and Police Forces are receptive and collaborate to support the provision of KP HIV services.	Legal, policy or regulatory constraint	Legal, policy or regulatory constraint	Engaging stakeholders within government and local community structures, such as law enforcement, judicial systems, religious and community leaders, and parliamentarians to link health programming with human rights, (including advocating for legal frameworks that decriminalize behaviors practiced by key populations)	COP18	COP24

## SRE-Tool Evaluation

COP22 Program Area	COP22 Beneficiary	COP22 Evaluation Budget	Evaluation Description	Filter Here - Select Evaluations
ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	\$ 6,000	Consultant fees, document reviews, consultations and workshops	Lab policy, budgets, and strategic plans
ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	\$ 20,000	Support for National lab leadership workshops, management training, mentorship and support supervision, facilitate lab stakeholder and TWG meetings	Lab policy, budgets, and strategic plans
ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	\$ 15,000	Supportive supervision, site and tester certification, development of SOPs, job aids and training materials, supplies	Lab quality improvement and assurance
ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	\$ 127,210	Implementation of laboratory CQI at ten laboratories: LQMS trainings, mentorship visits, POCT EQA program, Integrated electronic LIMS, production and distribution of EQA materials, EQA lab supplies, equipment maintenance, sample transportation.	Lab accreditation
ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	\$ 200,000	Transportation from spokes to hubs, and from hubs to National public health laboratory, Also support referral of samples to back-up in the region and internationally	Lab quality improvement and assurance
ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	\$ 242,024	Support key positions at MOH HIV department and National Public Health Laboratory (NPHL)	HRH recruitment and retention

ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	\$ 162,472	Support National DHIS reporting Revision and printing of HIV service reporting tools Integration of all HIV reporting into DHIS and provide technical support to ensure correct reporting, DHIS system management and data visualization and use	HMIS systems
ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	\$ 30,000	Conduct National HIV Data quality assessments and provide corrective action plans and follow up implementation of corrective actions Conduct min-data quality assessment at targeted facilities for select HIV program indicators.	Program and data quality management
ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	\$ 90,000	Support joint HIV program supportive supervisions to facility level for at 10 priority sites every quarter using standard MOH supportive supervision tool. These supportive supervisions will be undertaken together with National, State and County HIV program staff to enable them gain skills and also identifies success and problems at the facilities and ensure action items are generated from the supportive supervisions. Support bi-annual data review meetings	Training in HMIS systems or processes

ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	\$ 369,341	<p>Second technical staff to National MOH to ensure HIV program data is collected national wide and used for key National and Global reporting requirements and planning purpose</p> <p>Provide county and State technical support and mentorship on M&amp;E to enable them report and use program data</p> <p>Organize bi-annual State / County M&amp;E program data review and learning experience gathering.</p> <p>Updating of National SI related documents (National HIV strategic plan / M&amp;E Plan, update HMIS strategy, National M&amp;E and Surveillance and Survey plan)</p> <p>Support teams to conduct integrated joint supportive supervisions to facility level at least quarterly</p>	Program and data quality management
ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	\$ 70,000	<p>Expand selection of routine ANC sentinel survey sites (site assessment and selection)</p> <p>Conduct routine ANC sentinel survey, data analysis, report writing and support dissemination of findings</p>	Surveillance
ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	\$ 70,000	<p>Engaging stakeholders within government and local community structures, such as law enforcement, judicial systems, religious and community leaders, and parliamentarians to link health programming with human rights, (including advocating for legal frameworks that decriminalize behaviors practiced by key populations)</p>	Assessing impact of policies and regulations on HIV

## APPENDIX D – Minimum Program Requirements

Care and Treatment	Status
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Facility-based is ongoing with same day initiation in all PEPFAR supported facilities.
2. Rapid optimization of ART by offering TLD to all PLHIV weighing $\geq 30$ kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are $\geq 4$ weeks of age and weigh $\geq 3$ kg, and removal of all NVP- and EFV-based ART regimens.	As of November 30, 2021, over 98% of current patients have transitioned to TLD. pDTG arrived in country. pDTG tools-SOPs and job aids have been developed. pDTG roll out in FY 22 Q2.
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	As of October 2021, 98.9% of current clients on six-month MMD
4. All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	By FY21 Q2 and Q4, the country experienced INH stock out and only ICAP provided TPT services using FY20 facilities left stock, other IPs completed the TPT supplies in FY20. This interfered with our TPT initiation in FY21. As a result, only 13.2% of 21,604 TPT target denominator were achieved but with good completion rate of 99.8% (2,856/2862). No TPT for children started.
5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Currently, the country has 27 facilities with GeneXpert diagnostic platforms for TB and C-19 testing. By end of FY21Q4, 66% of the EID tests were conducted in 23 of 27 facilities and 12% of the VL tests done in 15 of the 27 facilities. POCT VL testing targeted Pregnant and Breastfeeding mothers, clients with HVL and children on ART. The overall utilization of the GXP

	diagnostic platforms was 50% for the four (TB, C-19, EID and VL) tests combined.
<b>Case Finding</b>	
1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Safe and ethical Index testing have been scaled up both in the facility and community level. HIVST commodities are projected to arrive end of January, but SOPs already developed.
<b>Prevention and OVC</b>	
1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	MoH with support from PEPFAR South Sudan, is working on a PrEP national manual to support PrEP launch and roll out when commodities become available.  About 2000 beneficiaries are targeted for the initial order projected to arrive in March.
2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	The OVC program continues to prioritize enrollment of C/ALHIV <18 on ART, as well as HEI, children of HIV+ FSW, and children of HIV+ caregivers at greatest risk of IIT, newly initiated on ART, and virally unsuppressed. OVC also supports index testing for siblings of HIV+ children and children of HIC+ caregivers, and linkage to clinical services for newly identified positives. HIV and sexual violence prevention curricula for 9-14s is provided as part of the package of services for OVC Comprehensive beneficiaries
<b>Policy &amp; Public Health Systems Support</b>	
1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	N/A
2. OUs assure program and site standards are met by integrating effective quality assurance and	SIMS implementation delayed due to COVID, but should resume soon in Juba. Other CQI-

Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.	like interventions are being implemented virtually in several facilities.
3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Client Treatment Literacy materials developed, printed, and disseminated to facilities and CSOs
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	The Community Led Monitoring award was granted to NEPWU, a local South Sudanese organization. The IntraHealth AHEC award has three local sub-grantees to which they are providing capacity building and have been assigned specific community-based activities for mentorship.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	N/A
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	N/A
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Initial sentinel surveillance activities begun. No progress on unique identifier



# APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

## 1. Misalignments between Investments and Outcomes

South Sudan's Landscape Analysis for Sustainability Tool (LAST) Lowest scoring elements are seen in:

1. Public Access to Information,
2. Human Resources for Health,
3. Commodity Security and Supply Chain,
4. Quality Management,
5. Data for Decision-Making Ecosystem.

PEPFAR South Sudan has invested in varying degree to address some of the SID elements listed above. These include four (public access to information, human resources for health, data for decision making and quality of management) of the above five elements. While the remaining one (commodity security and supply chain) never received any investment over the period analyzed (2017 to 2021). For the human resources for health, public access to information and data for decision making, the SID scores have seen little or no changes, staying in the red zone while Quality management improved slightly in 2019, and slid back again to low in 2021.

Human resource for health remains critical for the delivery of HIV service and non-service activities and sustaining this, is an important step towards achieving epidemic control. The MOH and the government of South Sudan continues to struggle with human resources for health management across the health portfolio, lacking funding to support, train and develop HR capacities across the different levels. PEPFAR South Sudan HIV program implements a direct service model and which requires it to supports full payment of salaries for staff that dedicated to direct and indirect service provision. Meanwhile the global fund model of paying incentives supports only payment to government employees as top ups to address gaps in the payment of government salaries that often delay for months and are insufficient. While these investments have allowed PEPFAR and the Global Fund to bridge gaps and temporarily address government inability to pay staff, this is a broad systemic issue that cannot be addressed sustainably these investments, hence the persistently low scores the SID have registered from year to year. The long-term solution is the MOH owning and managing the human resources including the organization and payment of all health workforce. While PEPFAR South Sudan continues to engage with the host partner government in this area, it's not realistic that the government will take up this responsibility.

Public access to information, quality management and data for decision making are other elements that have consistently remained low.

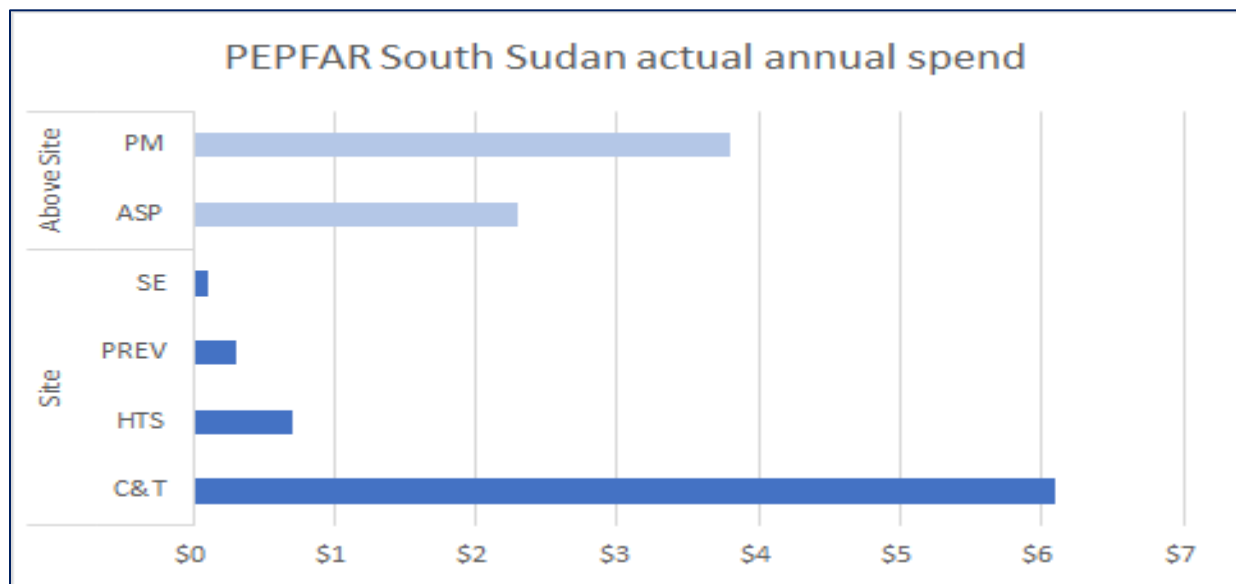
Commodity Security and Supply Chain, has not received any investment and remains one of the critical elements for supporting epidemic control. PEPFAR does not procurement comments and

while in the past few years planned supplementary budgets, investments were largely in in technical assistance.

**Figure E.1.1. Percent Primary Responsibility Ratings from Responsibility Matrix**

% Primary Responsibility Ratings from Responsibility Matrix			
Health Systems Area	Host Country	PEPFAR	Global Fund
HMIS	67%	48%	11%
Laboratory Systems	74%	44%	22%
Supply Chain	63%	37%	33%
HRH Systems	89%	15%	0%
Policy	93%	7%	4%
PFM	74%	30%	19%
Other Systems Support	74%	11%	4%
Health Workforce	26%	0%	0%

**Figure E.1.1: PEPFAR South Sudan Spending by program area**



## 2. Areas for Transition

In FY 22 Q2, PEPFAR South Sudan in collaboration with MOH, WHO and other stakeholders launched the Incident Management Structure (System). To ensure one national program for one country using one data system under one MOH, the Incident Management Structure is proposed to improve coordination of the national HIV/AIDS response, provide technical guidance and strategic leadership to the different donors and many partners and be able to address the challenges related to HIV implementation in South Sudan. The IMS is also proposed to ensure better response and accountability across all stakeholders and minimize duplication of efforts and resources. Additionally, the IMS is proposed to improve and strengthen coordination of HIV/AIDS response at sub-national level (State and County level) where the systems continue to be weak due to limited or absent human resources and limited resources and capacities. The IMS will effectively coordinate and manage the HIV response at all levels including at the site level using the Granular Site Management approach to service delivery. The HIV IMS will effectively link up available national capacity with the states and the counties for strong support to facilities.

Two key areas of coordination priorities that IMS will provide leadership to include:

1. National level coordination amongst multiple donors and partners involved with HIV/AIDS response activities
2. Site level program review for identification of issues, recommendation of remedial measures, using the granular site management (GSM) approach for program improvements at site levels.

In COP 22, PEPFAR South Sudan will continue to support and work with MOH to ensure the Incident Management Systems is strengthened for coordinated HIV response.

The Granular Site Management (GSM) system will also be transitioned and integrated into the Incident Management System. To effectively support facility teams, provide uniform and standard care based on national guidelines, there will be facility specific GSM team. The HF teams created will discuss facility specific HIV program issues and identify successes, challenges, barriers, and propose action plans to address identified issues. A lead for each facility team will be identified from the facility teams. National staff engaged in the HIV response from MOH, SSAC, PEPFAR, UN agencies, Civil society will be

State HIV/ TB coordinators, MOH Field Officers, implementing partners field staff will also be assigned to take lead of specific facility GSM discussions and response. Efforts will be undertaken to ensure that facility teams eventually take lead in organizing GSM discussion, developing action plans and monitor their implementation.

In COP 22, PEPFAR will continue to work closely with MOH to strengthen human resources development through the Expanded ECHO program by offering quarterly “short course” training programs via the ECHO Zoom platform for specific Human Resource for Health (HRH) cadres in-country. The human resource development effort will be led by MOH through the Incident Management system in collaboration with the directorate for training and human resource development.

### **3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response**

South Sudan is currently struggling to implement the revitalized peace agreement after nearly 9 years of civil war. The country has nearly none of the critical elements in place to support a robust and transparent economy or government. The HIV response remains almost entirely reliant on external donors. PEPFAR and the Global Fund are responsible for nearly all the support for HIV/AIDS services nationwide. No areas of the HIV response in the country are adequately covered in terms of finance, oversight, monitoring, or service delivery by the government.

Despite the increased health budget from 2% to 9% for 2023, very little is expected in terms of HIV service delivery. The PEPFAR program continues to be predominantly a direct service delivery model where the emphasis will remain on getting services to the people who need them. Global Fund essentially provides the only support for HIV commodities (ARVs, VL reagents etc.) procurement for the country's HIV/AIDS response. For a country that allocates less than 2% of its annual budget to health, government contribution to HIV response is expected to be very limited.

### **4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).**

NA