GLOBAL AIDS RESPONSE PROGRESS REPORT

COUNTRY: SOUTH SUDAN

March 2014

Reporting Period: 2012 - 2013

LIST OF ACRONYMS

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

Acknowledgement

The South Sudan 2013 Global AIDS Response Country Progress Report development was led by South Sudan AIDS Commission and Ministry of Health with financial and technical support from UNAIDS among many other partners.

A Technical Working Group comprised of key governmental and non-governmental organizations in the multi-sectorial response to HIV and AIDS guided the collection, analysis, interpretation and formulation of the narrative report and collectively validated the draft report.

Representatives from Civil Society Organizations, development partners and Line Ministries generously spared time and experience to ensure that all their perspectives on the countries response since 2012 were completely and accurately profiled. The ongoing political and economic challenges facing the country has inevitably affected peace, security and delivery of services to the people of South Sudan and is threatening to roll back the foundation that is being laid to ensure achievement of the country leadership vision of zero new infections, Zero AIDS related deaths and Zero Discrimination in line with the HLM targets.

The South Sudan Country progress report has been enriched by voices of the civil societies and service providers of the key populations at risk who are increasingly seeking more quality services.

To all organizations and individuals that have contributed to the development of this report, and continue to join hands in the country's efforts to achieve elimination of HIV and AIDS in the next few decades, we give sincere thanks on behalf of the Government of the Republic of South Sudan.

Hon. Dr. Esterina Novello Nyilok
Chairperson,
South Sudan AIDS Commission
Republic of South Sudan
Email: enyilok@gmail.com
Mibile: +211 955 946 062

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1. STATUS AT A GLANCE

1.1 Introduction

South Sudan is a landlocked country bordering Sudan to the north, Ethiopia to the East, Kenya, Uganda and the Democratic Republic of the Congo to the South and the Central African Republic to the West. The country has a land area of 644,329 square kilometres and is administratively divided into ten states and 79 counties[1].

South Sudan is the newest state in Africa still recovering from a protracted civil war spanning over four decades. The war destroyed the social fabric, physical infrastructure and caused massive displacement of an estimated four million people[2]. Given the long period of under-development, the country faces major challenges ranging from establishing peace and stability, developing infrastructure, management of massive population movements and displacement,, ensuring food security, human resource development, establishing and building governance structures and systems, provision of education, delivery of health and HIV and AIDS services as well as water and sanitation services.

South Sudan has an estimated population of 10.9 Million[3] (Table 2), of which 83% lives in rural areas. Females constitute 52% of the population while males account for 48%. By the last census in 2008, about 51% is below the age of eighteen and 72% below age thirty.

The population growth rate is estimated at 3%, fertility rate at 6.7 and had a population density of 13 persons per sq.km in 2008. The density is now estimated to be about 17 persons per sq as per 2012 projections. There are notable wide variations in population distribution among states.

Table: 1: South Sudan Population by State; 2012

State	Population
1. Upper Nile	1,259,306
2. Jonglei	1,740,564
3. Unity	832,764
4. Warrap	1,269,206
5. Northern Bahr El Ghazal	987563
6. Western Bahr El Ghazal	445,733
7. Lakes	898,071
8. Western Equatoria	785,569
9. Central Equatoria	1,494,116
10. Eastern Equatoria	1,159,255
South Sudan Total	**10,872,147**

***Source**: MOH HMIS Report 2012 (Projections based on the 5th Sudan Population and Housing Census, 2008)*

Rapid changes in the demographic structure have been taking place following the signing of the CPA in 2005 due to an influx of a large number of returnees and increased household formation. It is estimated that in 2013, there are 4.2 million people in need of humanitarian assistance, of whom 70,000 are returnees, and 125,000 are IDPs and 263,000 are refugees in South Sudan[4].

Provision of HIV services particularly should take into account the majority population of young people, population displacement and mobility and the population distribution among states.

[1] South Sudan Statistical Year Book, 2010
[2] Sudan Development Plan 2011-2013
[3] 5th Sudan Population and Housing Census, 2008; MOH HMIS Report 2012 Projections
[4] South Sudan CAP 2013 Mid-Year Review, June

Fifty-one percent (51%) of the population lives below the national consumption poverty line. Poverty is significantly lower in urban areas where only 24% of population lives below poverty line compared to 55% in rural areas. Poverty index is higher in female-headed households, rated at 57%, compared to 48% for men headed households. The vast majority of the population is engaged in rural subsistence farming and cattle herding.

Education is a key determinant of poverty with 11% of households with a head having post-secondary education living in poverty compared to 57% of household where the head has no education[5]. Given that poverty is a key determinant in access to health services, households headed by women and people with no education are likely to have difficulties accessing HIV services.

In addition to high levels of poverty, South Sudan has a high disease burden and low levels of education, thus ranking as one of the poorest countries in the world.

Only 27% of population 15 years and above is literate. Literacy levels are higher among men (40%) compared to women (16%) and in urban areas (at 53%) compared to rural areas (22%). The situation is worse among the youth 15-24 years where literacy rates are 55% among young men compared to 28% among young women[6].

Literacy is a key factor in providing HIV services especially awareness and knowledge of HIV and in behaviour change communication. The national response will need to adopt communication strategies responsive to the literacy levels in the country.

Health outcomes in South Sudan are generally low. Based on the SSHH (2010), infant mortality rate in 2010 was 75 per 1000 live births, child mortality 105; children under 2 years immunized 6.3%; births attended by skilled personnel 19.4%. In the 2006, the maternal mortality ratio was 2054 per 100,000 live births, rated the highest in the world.

These health outcomes reflect a not very effective health system. What is instructive is that the HIV epidemic is happening within this context of multiple challenges and needs.

HIV prevalence among persons 15-49 year is currently estimated at 2.3% in 2013. Approximately 153,000 people are living with HIV (135,000 adults and 18,000 children under 15 years of age) in 2013. Coverage for services is 21% for PMTCT and 9.5 % using currently eligible. A cumulative 144,000 people have died in South Sudan due to HIV and AIDS and 12,500 died in 2013. Need for ART is estimated at 72,000 people.

An estimated 15,400 new infections occurred in 2013[7] in the general population and 12,000 among 15-49 years. Surveillance showed marked heterogeneity of the epidemic, with significant differences between sites with lowest and highest prevalence. Figure 2 below shows HIV prevalence based on ANC data from the MOH 2012 report.

The HIV prevalence is higher along the borders with Democratic Republic of Congo (DRC), Uganda and in Juba, the capital city. Urban and rural divide seems to be less important than geographical

[5] National Baseline Household Survey, 2009
[6] National Baseline Household Survey, 2009
[7] SSAC; Universal Access Report 2010, Scaling Up HIV/AIDS Response, South Sudan

location. For instance, Nimule is a rural location with a high prevalence, while Aweil and Kuajok are urban centres but with low prevalence. Areas located along road networks and trading centres, however, tend to have higher HIV prevalence.

South Sudan participated in the past three reporting of Global AIDS Response Progress Report (GARPR) starting in 2010, 2012 and 2013.South Sudan joined the Global community at the 2011 United Nations General assembly political declaration on HIV and AIDS where countries committed to accelerating HIV and AIDS response to achieve globally agreed targets. Thus, South Sudan participated in the U***nprecedented global participation at UN General Assembly High Level Meeting on AIDS that led to new commitments, targets, and momentum in the AIDS response through the political declaration*.**

The declaration included the targets that are time bound and set a clear and workable roadmap, not only for the next five years but also beyond with set clear goals.

These far reaching goals are set in the Political Declaration on HIV/AIDS: Intensifying our Efforts to eliminate HIV/AIDS adopted by the General Assembly on 10 June, 2011. The declaration notes that HIV prevention strategies inadequately focus on populations at higher risk—specifically men who have sex with men, people who inject drugs and sex workers, and calls on countries to focus their response based on epidemiological and national contexts.

UNAIDS was tasked by the United Nations General Assembly to support countries to be able to monitor and evaluate the implementation of this political declaration.

The targets set for 2015 are as follows:

1. Reducing sexual transmission of HIV by 50 % by 2015
2. Reduce transmission of HIV among people who inject drugs by 50% by 2015
3. Eliminate mother-to-child-transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths
4. Reach 15 million people living with HIV on antiretroviral treatment by 2015
5. Elimination of New Infections Among Children by 2015 and Keeping their Mothers Alive
6. Reducing TB deaths in PLHIV by 50% by 2015Avoiding TB deaths
7. Closing the resource gap by 2015
8. Eliminating gender inequalities and Gender-based abuse and violence
9. Eliminating stigma and discrimination, and
10. Strengthening HIV integration.

The government of South Sudan has demonstrated its commitment to fight the HIV/AIDS epidemic since its formation. The current National Strategic Plan on HIV and AIDS (NSP 2013-2017) describes the national response under the stewardship of the government of South Sudan through the HIV and AIDS Commission and stipulates strategic direction and actions on how the unique challenges that HIV and AIDS poses to the welfare of the South Sudanese population will be addressed.

1.2 The Report Writing Process

Technical Assistance was provided by the UNAIDS Country Team. For the development of this report, a consultant was engaged by the UN Joint Programme on AIDS (UNAIDS) through the Technical Support Facility (TSF) Southern Africa and given the following Terms of Reference:

To develop the report, review of relevant documents (key reports, national guidelines and policies) pertaining to all the GARPR targets with exception on the target focusing on elimination of travel restrictions was undertaken. Progress and achievements preceding global declarations through quantitative (GARPR indicators and qualitative data (NCPI) was determined.

Short term priority actions were identified for sustained and integrated multi-sectorial AIDS responses with focus on articulating commitments that include financing and promotes shared accountability through increasing country ownership, strengthened civil society leadership and locally driven priority-setting, as well as enhanced monitoring of progress, based on the know your epidemic/know.

To consolidate the report, the following activities were undertaken:

1. consultation reports from the Technical Planning Groups;
2. Review data on indicators for HLM targets (including GARPR and UA indicators);
3. Collect NCPI data based on the list provided by the TWG;
4. Hold consultations with key partners on availability and quality of data and information products;
5. Facilitate a national stakeholders consensus workshop;
6. Develop final report and be approved by the National AIDS Commission Steering committee for submission before 31st March 2014.
7. Produce a national progress report in respect to GARPR and NOP targets.

The NCPI report data gathering and validation involved desk reviews, consultations with public sector agencies, civil society organization (CSO) networks and bilateral agencies, United Nations (UN) organizations and other development partners during which the questionnaire Part A (for Government) and Part B (for CSOs, Bilateral Agencies and UN Organizations) were administered to the targeted respondents as indicated in Annex I through a consensus workshop. Questionnaires were synthesized by the consultants and the generated draft report was first reviewed by the National HIV/AIDS Monitoring and Evaluation (M&E) Technical Working Group (TWG) and finally validated at a national stakeholder's workshop.

The report writing process was guided by South Sudan AIDS Commission (SSAC) and The Joint United Nations Programme on HIV and AIDS (UNAIDS) and the M&E-TWG. A Validation Workshop was held (March 25, 2014) to discuss the first Draft Report. The stakeholders included a wide cross-section of participants from central and local governments, development partners, members of PLHIV networks, faith based organizations, private sector and media, national and state based NGOs/CBOs.

1.3 The Status of the Epidemic

In an ANC survey that was carried out in 2007 HIV prevalence was estimated to be 3.7% and in subsequent ANC surveys HIV prevalence declined to 3.0% in 2009 and 2.6% in 2012. The current overall adult prevalence of 2.3% (Spectrum estimate in 2013), translated to 153,000 PLHIV in the country of which 135,000 were adults whereas 18,000 were children below 15 years. Annually 0.23% of the adult 15-49 years becomes infected translating to 37 people getting infected each day (Table 1).

Table 2: Epidemiology of HIV in South Sudan: Key Indicators (15-49)

	2012	2013
National prevalence rate of HIV	2.6	2.3
Estimated number of PLWHIV (adults)	132,000	135,000
Estimated number of children (< 15 years)	20,000	18 ,000
Number of people requiring ART (adults and children)	83,000	72,000
New HIV Infections (adults) – source MOT*	13,616	12,000

The Policy and Programmatic Response

At the national level, the Government of the Republic of South Sudan is playing an active leadership role in HIV and AIDS impact alleviation particularly through the development of the South Sudan Development Plan (SSDP), the Health Sector Development Plan (HSDP) 2012 -2016 and health sector financing strategy. These plans have provided a basis for harmonization and alignment of the country resources and development partners' support to the health sector and the response to HIV. The government leads the alignment process by engaging with development partners to ensure support provided contributed to achievements of the overall health outcomes.

The South Sudan government has been pro-active in its efforts to confront the HIV scourge with its overarching strategy elaborated in the bottom-up poly-stakeholder and multisectoral.

National Strategic Plan (NSP)

The NSP is derived from the architecture of the **National Strategic Framework 2013-17**(NSF II) and has targets to halt and begin to reverse the spread of HIV infection, as well as mitigate the impact of HIV/AIDS, by 2017. With the condition that where appropriate, the targets of the NSP should be population-based, the government of South Sudan implicitly recognizes HIV care and treatment as a national public health good. To this effect, the NSF II was developed to provide direction and ensure consistency in the development of the strategic plans by all stakeholders including all the 10 states that constitute the government of South Sudan.

Most Government Ministries, Departments and Agencies (MDAs) and the constituent coordinating entities of Civil Society Organization (CSOs) Networks are involved. The NSF II, unlike the NSF 2008-12 (NSF I), is linked to Universal and MDG targets and has an overriding emphasis on HIV prevention.

The Response Analysis of the preceding NSF 2008-2012, together with input from over 30 stakeholders from public, private and civil society sectors and development partners provided the evidence for findings and recommendations that guided the NSF II.

The NSF II builds on the National HIV Policy and provides a broad structural framework for the implementation of this policy. Considerations that informed the development of this framework include the burden of HIV/AIDS in the country, the public health challenge of HIV/AIDS, comprehensive HIV/AIDS services, feminization of the epidemic and strategy for gender streaming, young people, MARPs, modes of HIV transmission, drivers of the epidemic, stigma and discrimination, cultures, traditions and religion, human rights and multisectoral partnership. The current SSNSP II is better placed to address the national response and make progress on the GARP than the previous strategic plan.

Programmatic Response

Based on commitments to secure significantly increased resources (human, material, financial and technical) for the national HIV/AIDS response from both domestic and international sources, South Sudan has set ambitious country specific targets to monitor progress towards Universal Access to HIV/AIDS Interventions and achieve Global AIDS response progress as by the commitments and declaration pronounced at the United Nation's High Level Meeting (HLM). A number of interventions were identified as critical to the success of progress towards the universal access goal. These interventions included gender mainstreaming, advocacy at all levels, capacity building including training and skills development, increased access to material goods, technical assistance and sustainable funding addressing in all the ten target areas.

To ensure effective response and management planning, structures for coordination was to be strengthened and sustained at national, state and county levels under the leadership of the South Sudan HIV and AIDS Commission (SSAC). Sectoral coordination was to happen under the auspices of the relevant line ministries. At each of these levels, stakeholders were envisaged to be brought together in a respective HIV partnership forum.

Self-coordinating entities that bring together stakeholders of different specific categories in the respective constituencies to continue to function with support from all partners to include particularly the networks - PLHIV (South Sudan Network of people living with HIV), civil society organizations, faith based organizations and the private sector. To a large extent good progress is being made in various target areas such as PMTCT and ART.

1.4 South Sudan AIDS Response Country Summary Progress (SSGARPR) 2013

The status of South Sudan national, multi-sectorial HIV and AIDS response in relation to the key country level targets of 2011 Political Declaration on HIV and AIDS is shown in Table 2 below. Details on these achievements are as in the table below.

Table 3: Global AIDS Response Progress Indicators

TARGET / INDICATOR	2011	2012	2013	Progress
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015				
1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	7.3%	11%		• Scaled up targeted community awareness activities in schools • Awareness on uptake of HIV Counselling and testing services • Training of peers educators on BCC activities • Free condom distribution activities being scaled up (2,613,592 in 2011, 2,848,104 in 2012 and 1,584,976 in 2013 by PSI)
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	30.5% w 40.8% m	23.3% w 29% m		

1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	W 7.96% Both m	6.8% w 27% m		▪ Risk perception among the general population is poor. It is therefore important that the response continues to focus on the general population as it also enhances reaching the key populations.
1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse		2.6% w 7.4% m		
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	28.7%	41%		
1.6 Percentage of young people aged 15-24 who are living with HIV	3.05%	12%		
1.7 Percentage of sex-workers reached with HIV prevention programmes	0.91% (2008)	no data		
1.8 Percentage of sex workers reporting the use of a condom with their most recent client				
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results				
1.10 Percentage of sex workers who are living with HIV				
1.11 Percentage of men who have sex with men reached with HIV prevention programmes				
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner				▪ A huge percentage of men and women in the general population have multiple sexual partners, engage in unprotected sex and have low knowledge of HIV transmission.
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results				
1.14 Percentage of *men who have sex with men* who are living with HIV				
Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015 (currently no interventions and therefore not yet a priority; still invisible or minimal population):				
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths				
3.1 Percentage of HIV-positive				• PMTCT guidelines developed and

pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	8.3%	9.5%	21%	validated • PMTCT scale up plan developed • Mentorship programme initiated • Mother to mother support groups created
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	No data	No data	7.3%	
3.3 Mother-to-child transmission of HIV (modelled)	30%	30%	30%	
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015				
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy	7%	6.5%	(9.45%) 4.52%*	▪ Retention of adults and children with HIV known to be on treatment after 12 months since initiation of ART has tremendously increased to 78.4% during the current reporting period from 62.5% in 2011 and 70.8% in 2012. ▪ The retention rate after 24 months and 60 months was 65.8% and 44.7% respectively.
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy • 24 months • 60 months	62.51%	70.8%	78.4% 65.8% 44.7%	
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015				
5.1 Co-management of tuberculosis and HIV treatment	8.29%	27.5%	86.3%	▪ Results for the current reporting period have been very impressive registering 86.3% at the end of the reporting period. ▪ Previous progress has been also progressively satisfactory. Reporting 8.29% in 2011 and 27.5% in 2012.
Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22–24 billion in low- and middle-income countries				
6.1 AIDS spending	6%	10%		▪ NASA analysis indicates that domestic AIDS spending is wanting in spite of increasing from 6% in 2011 to 10% in 2012. ▪ There exists a wide gap between domestic AIDS spending and total spending, a situation which may impede the mobilization of resources to the current NSP.
Target 7: Eliminating gender inequalities				

7.1 Prevalence rate of recent intimate partner violence	No data	No data	No data	▪ Gender and human rights sensitive programming and elimination of the Gender Based Violence (GBV) should address the vulnerability of women and other groups to HIV infection.
Target 8: Eliminating stigma and discrimination				
8.1 Discriminatory attitudes towards people living with HIV	No data	No data	No data	• Conducted Stigma Index Survey 2012/2013– SSNEP/Alliance Follow up to complete this process required. ▪ Training of Anti Stigma trainers (33)- 22 Males and 11 Females – Alliance/SSAC 2013
Target 9: Eliminate Travel restrictions (not tracked in South Sudan due to clear government policy) South Sudan has imbedded in its constitution the legal policy of nondiscrimination of PLHIV coming in or going out of the country and therefore there is no need to track this target as it is guided by law.				
Target 10: Strengthening HIV integration				
10.1 Orphans school attendance	No data	No data	No data	▪ The country has a huge bulk of OVCs exceeding 70,000 but there is no evidence that much is taking place to protect them from the vagaries of poverty and from infections of HIV ▪ In South Sudan 3.6% of children aged 10-14 have lost both parents and only 26% of these children attend school.
10.2 External economic support to the poorest households who received external economic support in the past 3 months	No data	No data	No data	▪ There is great need for the support of vulnerable and poor households in the country as reported in the SSHH surveys of 2006 and 2010. However, there is no evidence that much support is invested in these populations from either domestic or external sources.

2. OVERVIEW OF THE AIDS EPIDEMIC

2.1 HIV Prevalence

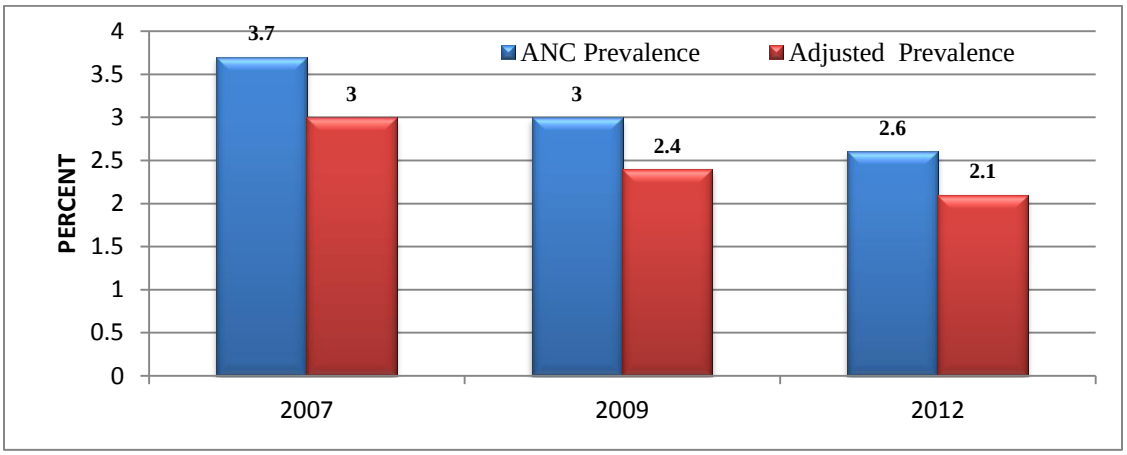
The HIV prevalence is higher along the borders with Democratic Republic of Congo (DRC), Uganda and in Juba, the capital city. Urban and rural divide seems to be less important than geographical location[8]. For instance, Nimule is a rural location with a high prevalence, while Aweil and Kuajok are urban centres but with low prevalence. Areas located along road networks and trading centres, however, tend to have higher HIV prevalence.

Table 3 presents UNAIDS estimation of the HIV situation in the Southern Sudan region between 2009 and 2010[9]. UNAIDS figured that HIV prevalence in the region of Southern Sudan by 2010 was 3.54% in the adults (15-49) age group[10]. The World Health Organization (WHO) and UNAIDS reported steady increasing of HIV prevalence in Sudan over the years and probably much more in Southern Sudan than Northern Sudan on the account of the Southern Sudan being surrounded by neighbours experiencing higher HIV prevalence.

2.1.1 HIV Prevalence Trends

Figure 1 below presents HIV prevalence as estimated from ANC sentinel surveillance from 2007 to 2012[11]in the age group 15 - 49 for South Sudan. The HIV prevalence trend is giving hope to South Sudan of reducing sexual transmission of HIV by 50% in the near future although not by 2015 but possibly by 2017.

Figure 1: Comparison of ANC and ANC-Adjusted HIV prevalence in South Sudan.



8. UNAIDS Report on the Global AIDS Epidemic (2012)
9. Government of Sudan Millennium Development Goals Interim Unified Report, 2010.
10. Government of Sudan, National HIV/AIDS Strategic Plan, 2009.
11 GOSS ANC Sentinel surveillance of 2009 and 2012

2.1.2 Heterogeneity of HIV prevalence trends

Overall, the level of *heterogeneity* of the epidemic is striking, the general impression is that the epidemic is not spread evenly in all regions and sub populations but it is concentrated in the Greater Equatoria States, rural populations and Most-At-Risk Populations (MARPS).

2.1.2.1 Age-Related Heterogeneity

Table 4 present the age specific HIV prevalence for the antenatal clinic clients in 2007 and shows that the highest prevalence rates were found in the 20-24 year population instead of the expected (30 – 34) year age group as depicted from most sub Saharan African countries with a generalised mature epidemic[7]. Age at first sexual intercourse, when it is before marriage, is associated with longer exposure to sexual activity and higher likelihood of accumulating sexual partners[12] . Individuals are most likely to have multiple partners during the period between the first intercourse and first marriage[13]. This process unnecessarily exposes the young women and men to sexual infection with HIV that could have been avoided.

12. E. Y. Tenkorang and E. Maticka-Tyndale, "Factors influencing the timing of first sexual intercourse among young people in Nyanza, Kenya," International Family Planning Perspectives, vol. 34, no. 4, pp. 177–188, 2008. View at Publisher · View at Google Scholar · View at Scopus
13. R. Stephenson, "Community influences on young people's sexual behavior in 3 African countries," American Journal of Public Health, vol. 99, no. 1, pp. 102–109, 2009. View at Publisher · View at Google Scholar · View at Scopus

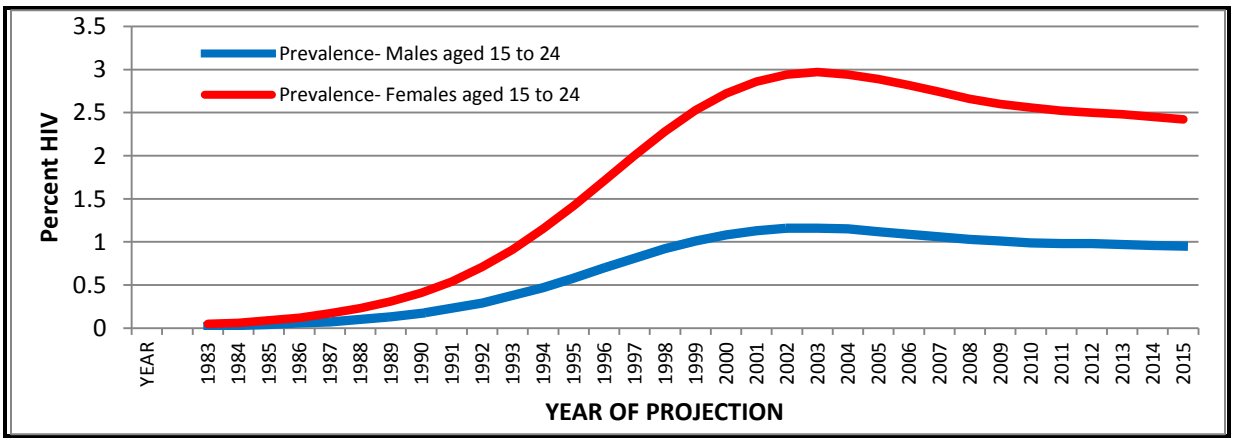
Table 4: Age specific HIV prevalence for first ANC respondent

AGE	Number Tested	Number HIV positive (%)
<19	976	30 (3.1)
20 – 24	1,628	65 (4.0)
25 – 29	1,549	53 (3.4)
30 – 34	844	28 (3.3)
35 – 39	480	13 (2.7)
40+	54	2 (3.7)
Total	**5,401**	**197 (3.5)**

2.1.2.2 Gender-Related Heterogeneity

Figure 2 below presents projected (EPP) prevalence of HIV among pregnant women and indicates that like many other countries in the sub Saharan region, HIV is higher in females than in men. The ratio, according to the projected data is 1:2 (male to female)[7].

Figure 2: Projected HIV prevalence by year and gender in South Sudan (1984-2015)



2.1.2.3 Heterogeneity of HIV Distribution by Education Levels

The distribution of HIV and syphilis by educational status was recorded only for 2012 in South Sudan sentinel surveillance[7]. Women were found with lesser syphilis prevalence as they increased in educational levels. The high level of educational attainment had a clear effect of protectiveness against STIs. Compared to those with elementary education, women with no formal education were almost twice more likely to have syphilis infection.

2.1.2.4 Heterogeneity of HIV and STIs Prevalence by Marital Status in South Sudan

The distribution of HIV and syphilis by marital status among ANC pregnant women that participated in the 2009 and 2012 ANC surveys produced very high rates of syphilis showing among widowed women and presented such high HIV prevalence of 16.7%. For the year 2009 the prevalence of HIV and syphilis were both low by all marital status categories excepting for the HIV in the widowed women. The overall prevalence rates for HIV and syphilis during the year 2009 was 3.5% and 9.9% respectively[7].

2.1.2.5 Heterogeneity of HIV Prevalence in Urban Vs. Rural Settings in South Sudan

The distribution of HIV and STIs prevalence by urban and rural populations have tended to be significantly higher in urban than in rural areas in both the population-based surveys and ANC sentinel surveillance surveys in sub Saharan Africa. However, the distribution of HIV and other STIs in South Sudan shows preponderance among the rural populations than urban ones.

2.1.2.6 HIV Heterogeneity by Geographic Regions or States

According to antenatal surveillance data in South Sudan, **the overall HIV prevalence among adults aged 15-49 in 2009 was estimated to be about 3%.** However, the drop from 3% reported in 2009 to 2.6% reported in 2012 was a considerable achievement in the prevention and control of the epidemic in South Sudan.

The wide variations observed are geographical (with **Western Equatoria** having the highest State prevalence of **7.2% in 2011 while Northern Bahr Ghazal had a HIV prevalence of zero and 0.7% for Warrap.** At the site level, prevalence was highest at Yambio Hospital at 15.5%. Syphilis prevalence was also very high at 9.9%, ranging from 4.3% in Warrap to 13.3% in Western Equatoria.

2.2 Incidence of HIV Infection

Information on the sources of new HIV infections is critical for guiding and refocusing HIV prevention policies and programming in South Sudan. To do this a simple mathematical model known as the "Modes of Transmission" model (MoT) that was first developed by the UNAIDS Reference Group on Estimates, Modeling and Projections was used[14].

[14] Brown T. et. al., 2008. Progress and challenges in modelling country-level HIV/AIDS epidemics: the UNAIDS Estimation and Projection Package 2007. Sex Transm Infect 2008;84(Suppl I):i5–i10. doi:10.1136/sti.2008.030437.

HIV incidence data are not readily available in South Sudan and in many developing economies. Therefore, it is important to investigate and understand HIV incidence trends using proxy and modeled data, in the absence of actual incidence data is critical. The **UNAIDS HIV Incidence Model** enabled the estimation of the new HIV incidence in South Sudan as indicated in table 5 and figure 5 below. The risk group contributing the most new cases of HIV were Clients of Female Sex Workers comprising of men in uniformed services (4,689 ,or 34.6%), other clients of FSW (1,247 or 9.2%), Boda-Boda riders (736 or 5.4%) and Long Distance Truck drivers (20 or 0.2%) totaling 6,692 new cases which makes up 42.5% of all new adult infections in 2013[7]. Men and women who engaged in casual sexual relations contributed the second highest number of new adult infections amounting to 2,286 (16.9%) followed by Female sex workers who contributed 1,766 (13.0%) new adult infections.

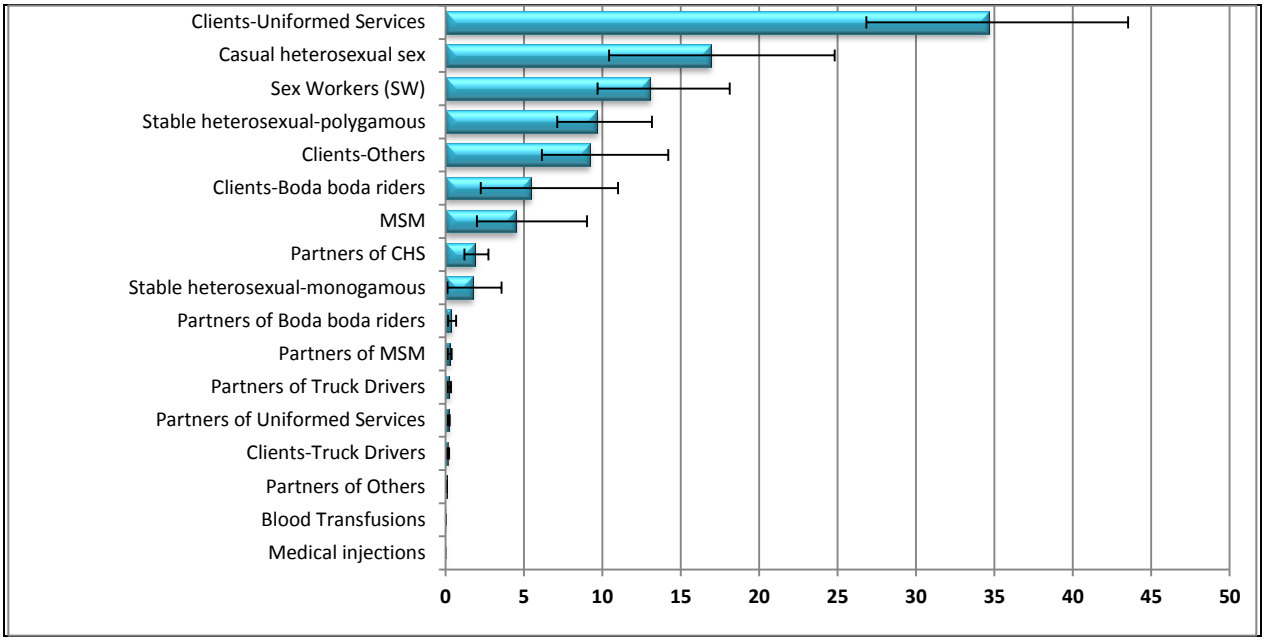
Men and women in unions or stable relationships (monogamous and polygamous) contributed 1,545 (11.4%) new infections with polygamous relationships alone contributing the most infections of 1,311 (9.7%) cases. Men who have sex with men contributed 610 (4.5%) and other behavioural risk groups comprising of female partners of all MARPS contributed 96 (0.6) while partners of men and women who engage in casual sex contributed 241 (1.7%) of new cases in 2013. Other risk groups comprising blood transfusions, medical injections and no risk, contributed near zero new infections.

2.2.1 Main sources of new HIV infections (heterosexual transmission)

Table 5: New infections by Risk group (2013) in South Sudan

Adult Risk Behaviour (15-49 years)	Incidence	% incidence
FSW Clients - Uniformed Services	**4689**	**34.6**
Casual heterosexual sex (CHS; Multiple partners)	**2286**	**16.9**
Female Sex Workers (FSW)	**1766**	**13.0**
Stable heterosexual-polygamous	**1311**	**9.7**
Other Clients of FSW	**1247**	**9.2**
FSW Clients - Boda boda riders	736	5.4
MSM	610	4.5
Partners of CHS	251	1.9
Stable heterosexual-monogamous	234	1.7
Partners of Boda boda riders	50	0.4
Partners of MSM	32	0.2
Partners of Truck Drivers	31	0.2
Partners of Uniformed Services	25	0.2
FSW Clients - Truck Drivers	20	0.2
Partners of Others	9	0.1
Blood Transfusions	3	0.02
Medical injections	0	0.00
Total	**13,540**	

Figure 3: Percent of New Infections by Specific Risk Groups



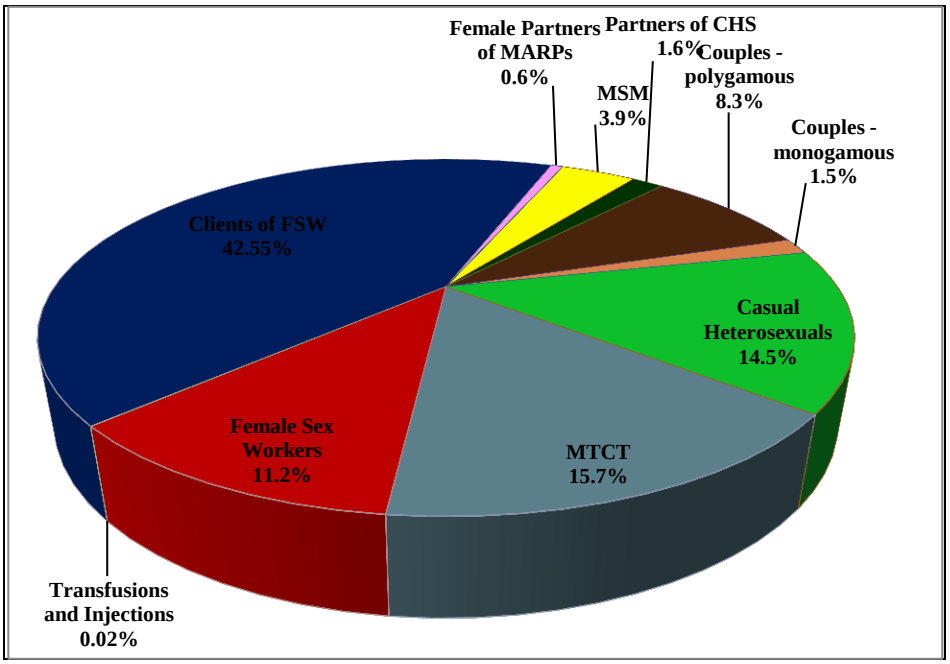
2.2.2 Visualizing the epidemic in adults and children

The UNAIDS spectrum EPP[15] model estimated 2,476 new infections in children through mother to child transmission (MTCT) in 2013 in South Sudan. Combined with the incidence model estimates of new infections in adults of 13,540 in 2013 the total number of infections in children and adults in South Sudan amount to 16,016 cases. **Figure 4 shows the proportional distribution of new infections among children and adults in 2013**. **The groups which are most affected by the epidemic are Clients of Sex Workers (42.6%), children born by HIV infected mothers (15.7%), Men and women involved in casual sexual relationships (14.5%), Female Sex Workers (11.2%) and couples in polygamous unions (8.3%)** and those in monogamous unions (1.5%). Other modes which are contributing to new infections are Men who have Sex with men (3.9%), Partners of those who engage in risky behaviors (MARPS) contributed 0.6%, partners of who engage in casual sex (1.6%). Medical injections and blood transfusions contribute 0.02% of new cases of HIV into the South Sudan population[7].

[15] UNAIDS Spectrum EEP for South Sudan 2012

In view of the findings of the MoT, HIV response and programming in South Sudan needs to focus on the key groups at risk of HIV infection (HIV epidemic key drivers): IDUs, MSM, and FSWs and their clients. Injecting drug users have not been included in the NSP (3013 – 2017), but no studies or situation assessments have been conducted to show that this group does not exist in the country. HIV testing and treatment must be very aggressively expanded among these population groups and development of awareness programs regarding condom use is warranted. Also, with a geographically heterogeneous HIV transmission, HIV response needs to be tailored to the nature of HIV transmission across the different parts of the country with a priority given to risk groups and geographic settings where HIV is already endemic but still not neglecting the general population which is also at risk as demonstrated by the high incidence of married couples.

Figure 4: Proportion of New cases by risk groupings in South Sudan, 2013



2.3. Factors Influencing the Transmission of HIV in South Sudan

2.3.1 Sexual Transmission

This section summarizes the risk behaviours and related factors known about each population in general and specifically in South Sudan, as well as changes over time. Household surveys of 2010 and Kajo Keji BBS of 2009 demonstrated that there are several biological and behavioural factors that may be contributing to the continuing HIV incidence in South Sudan. These factors include:

- A high rate of sexually transmitted infections (STIs);
- Most men in South Sudan who are not Muslims are not circumcised;
- Early age of sex debut and low level of use of condoms;
- Multiple sexual partners;
- A low level of knowledge in both men and women about the means of transmission of HIV and how to protect themselves;
- A high level of stigma and discrimination against people who might be HIV positive.

Sexually transmitted infections

Self-reported STI symptoms are very common in South Sudan, for example in the 2009 Kajo Keji County BSS, 24.9% of men and 35.3% of women reported an unusual genital discharge in the 12 months before the survey. Genital ulcers or sores were reported by 26.8% of men and 41.5% of women in the same time period. Of those with symptoms of an STI, only 26.4% sought treatment, with 71.1% first seeking treatment at a public health facility and 27.3% first going to a private clinic. The implication of STIs to the transmission of HIV is obvious as HIV is a STIs.

Sex workers

Sex work is common in South Sudan and tends to be lodge or brothel-based. The majority of sex workers are foreigners. South Sudanese sex workers tend to be among the youngest. Despite having many sexual partners and inconsistently using condoms, most sex workers do not view themselves as being at risk for HIV. Nevertheless, there is a high demand among sex workers for greater access to HIV and STI services. However, no recent biological data exist for sex workers.

Sexual behavior and condom use

According to a 2007 mixed-method hot spot mapping and situational analysis conducted along the Kampala-Juba transport route, sex workers are mobile. Only 17.2% spent every night of the survey period in the same location. Of the 2,588 women-nights recorded, 78% were spent in the location at which participants were recruited. The median number of clients per month among the 93 female sex workers who participated was 19, with a range of 1 to 34. Twenty-eight percent of their clients were truckers, revealing that many local men also engage sex workers.

HIV-related knowledge

Little data exist on sex work, a highly stigmatized and illegal practice, in South Sudan.

Qualitative research conducted in 2011 among sex workers in five towns suggests that most sex acts involve vaginal sex as very few women engage in or know someone who engages in anal sex. Similar results were found in the 2009 Kajo Keji survey of the general population.

While South Sudanese women seem to comprise a minority of sex workers, they are also on the younger end of the spectrum, with many below the age of 18 years. This is particularly true in Juba. Thus, sex work is a major contributing factor to the continuous flow if incident HIV infections in the population and as recently confirmed by the mode of transmission study (MOT), female sex workers and their clients are the leading contributors of new HIV infections into the South Sudan population.

2.3.2 Transmission through injecting drugs

Injection drug use-related HIV infection accounts for a substantial and growing fraction of the total cases of HIV in the countries where it is one of the leading modes of HIV transmission and even in some countries in sub Saharan Africa. Risk factors for HIV infection among injection drug users (IDUs) include demographic characteristics and practices that increase sexual transmission and parenteral exposure to infected blood. This mode of HIV transmission is reported to be insignificant to nonexistent in South Sudan, therefore it has been left out of the NSP, although there are no scientific studies or situation analyses that have documented its absence in South Sudan.

Condom distribution

Condom distribution is key strategy for prevention of new HIV infections. Condoms are distributed through the social marketing programme, health facilities and outreach activities. About 10 million condoms are distributed annually.

Condom distribution is constrained by the negative attitude towards condom use among men and women, inadequate number of condoms procured and distributed in the country and use of traditional distribution outlets which do not adequately reach priority populations such as sex workers, truck drivers and the young people.

A comprehensive condom strategy is in its final stage of development to guide implementation of the national condom programme. Currently, the number of condoms procured is determined by available funding and the implementing organizations have segmented the population based on their capacity to distribute condoms.

2.3.3 Mother to child transmission

- Mother to Child Transmission (MTCT) still remains the second major mode of transmission of HIV in South Sudan. MTCT is the main source of infection to children less than 5 years of age.
- Without PMTCT, the risk transmission of HIV during pregnancy and delivery is estimated at 15-30% and the additional risk through breast feeding is estimated at 10-20%. With PMTCT interventions, the risk in the breast feeding population reduces to less than 5% and in the non-breast feeding population to less than 2%.
- The PMTCT program aims for virtual elimination of HIV transmission from mother to child and reduction in mortality and morbidity among women living with HIV and among exposed and infected infants.

Ensuring that no baby is born with HIV is an essential step towards achieving an AIDS-free generation. Prevention of mother-to-child transmission of HIV," or PMTCT, provides drugs, counselling and psychological support to help mothers safeguard their infants against the virus. Ensuring PMTCT is provided to all women that need it is our most effective way to eliminating new HIV infections among children and keeping their mothers alive by 2015. As increasingly more pregnant women living with HIV

receive access to antiretroviral treatment, fewer children are being newly infected with HIV. Whether HIV-infected or not, children born to women living with HIV, have increased risk of morbidity and mortality. And poverty, isolation and distance from health care facilities can place them beyond the reach of life-saving care. Partners must also work together so that HIV exposed children are identified early and provided with follow-up treatment, care and support throughout childhood, and into adolescence and adulthood.

By making things work as simple as possible, UNICEF South Sudan aims to reach more women and children, even in a rural clinics with no doctors. Offering an HIV test that gives a rapid result in just a few minutes as part of the first visit for routine antenatal care for pregnant women is a first step. Then, for women who test HIV positive, offering them treatment – "one pill, once per day" – starting as early as possible – is key. This approach puts the health of the mother at the centre. Treatment not only protects the health of the mother living with HIV, but also prevents transmission to her child – in utero, during delivery or during the breastfeeding period. And treatment also prevents sexual transmission among discordant couples – where one partner is HIV positive and the other is HIV negative. To ensure that children living with the virus receive the care they need, UNICEF also works to scale up early infant diagnosis and provide simplified HIV treatment for children.

However, South Sudan still has a long way to go in preventing new infections especially in children. Despite the 2.6% HIV prevalence in 2012 in the country, very few mothers get tested for HIV during their pregnancy and even fewer women access antenatal care, and thus increasing the chances of infecting their newborns.

2.3.4 ART Coverage

There are 22 ART sites in the country located mainly in tertiary and secondary hospitals. Overall, about 10% of those in need of ART services are currently on ART using the need and <350 CD4 criteria and about 8.5% of the HIV positive TB patients are on ART.

HIV treatment, care and support, and socio-economic impact mitigation programme in South Sudan is at its nascent stage when compared to other programmes in Sub Saharan Africa. Constraints facing this programme include:

- HIV treatment, care and support, and socio-economic impact mitigation programme in South Sudan is at its nascent stage when compared to other programmes in Sub Saharan Africa. Constraints facing this programme include:
- Inaccessibility of the ART service given that sites are located in hospitals and clients have to incur huge transport costs to reach the sites.
- Assessment of eligibility for ART is sub-optimal in many facilities providing ART due to frequent breakdown of CD4 instruments
- Low ART retention rate. For instance, ART retention rate in 2012 was 62.5%. This is attributed to weak monitoring of adherence to ART because of inadequate numbers and capacity of staff, inadequate laboratory support and weak patient referral system.
- Weak community and family networks that can follow up, refer and link up patients in communities with health facilities

- Weak linkage between treatment centres, and community support groups that provide ART services, psychosocial, spiritual and moral support to PLHIV.
- Funding constraints. For instance the programme has not scaled up enrolment of PLHIV on ART for lack of funds since December 2011.
- Low uptake of HIV counselling and testing which limits the enrolment of PLHIV on ART. The coverage of HCT services is inadequate. There is a weak linkage between HIV testing and treatment services.
- Awareness among communities on HIV in children and the need to seek HIV testing and treatment for children is low
- A robust programme to care for OVCs and other persons affected by HIV and AIDS is yet to be established.
- Rate in 2012 was 62.5%. This is attributed to weak monitoring of adherence to ART because of inadequate numbers and capacity of staff, inadequate laboratory support and weak patient referral system.
- Weak community and family networks that can follow up, refer and link up patients in communities with health facilities
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2.3.5 Reduction of TB deaths in PLHIV

MOH is working on the integration of TB and HIV services with updating strategy and using tools for intensified case finding for active Tuberculosis in PLHIV. This will be achieved through screening and referral of PLHIV to TB diagnostic sites including diagnosis of (Multidrug Resistance) MDR TB. Provide HIV treatment HIV positive TB cases. All TB patients testing HIV positive will be put on ART by establishing a referral system for these patients to the ART sites.

Conduct consultative meetings to explore implementation of Isoniazid Preventive Therapy and operationalize guidelines for infection prevention in healthcare settings to minimize transmission of TB.

Conduct periodic (quarterly) national and state surveillance of HIV and TB and conduct joint planning and reviews of HIV/TB programmes.

2.3.6 Increasing AIDS Spending

The government budget allocated to the health sector in 2011/2012 was 2.6%. Government funding of the HIV programme is about 5% of the total funds available. Thus, the country relies heavily on development partners for funding of the national response to HIV. It is projected that development partners will continue to play a key role in financing the HIV programme for the implementation of the current NSP.

2.3.7 Eliminating gender inequalities

HIV interventions should support gender and human rights sensitive programming and elimination of the Gender Based Violence (GBV) to address the vulnerability of women and other minority groups to HIV infection.

2.3.8 Eliminating stigma and discrimination

HIV stigma is a barrier to the uptake of HIV services. The South Sudan Household Survey of 2010 revealed that among the women aged 15-49:

- 92% expressed at least one accepting attitude;
- Only 10.3% expressed acceptance of all four indicators on stigma while;
- 86.1% could care for a family member living with HIV;
- Only 57% cannot keep AIDS a secret were 57%);
- Only 36.6 were agreeable to teachers living with HIV to teach their children;
- 37.6% could buy produce from a vendor with AIDS virus;
- There is greater acceptance of persons living with HIV among urban residents than rural (14.7% versus 8.1%) and among highest wealth quintile (15.1%) compared to those in the lowest quintile (4.1%).

Overall, HIV stigma pervades through all sections of society in South Sudan.

2.3.9 Eliminate Travel restrictions

Since the beginning of the HIV epidemic, governments and the private sector have not implemented travel restrictions with regard to HIV positive people wishing to enter or remain in a country for a short stay (e.g. business, personal visits, tourism) or for longer periods (e.g. asylum, employment, immigration, refugee resettlement, or study).

UNAIDS has set up an international task team to heighten attention to the issue of HIV-related travel restrictions (both short-term and long-term) on international and national agendas and move towards their elimination. In South Sudan this is not a problem to tracked as the country prohibits such restrictions in its constitution.

2.3.10 Strengthening HIV integration

Integration and mainstreaming of HIV services including comprehensive HIV services (prevention, care treatment and support) into the existing health care system, non health sectors and in humanitarian efforts is the way forward for seamless provision of health services. Integration of HIV services will minimize stand alone programmes, fragmentation of activities, duplication and waste of resources. For instance, HIV counselling and testing and prevention of mother to child transmission of HIV will be integrated into STI, ANC and reproductive health services. The co-management of TB and HIV would perform better if it were integrated at the same service delivery point.

2.3.11 Provision of HIV services in a humanitarian settings

South Sudan is still in a complex emergency situation with large population movements of returnees, refugees and IDPs. There are also pockets of conflict areas resulting in new waves of internally displaced persons and refugees. The disarmament, demobilization and reintegration (DDR) of ex-combatants adds another layer to this already complex context. Progress made in providing HIV services in this setting includes:

- Sensitization of refugees, IDPs and returnees, surrounding host communities on HIV prevention
- Provision of HIV counselling and testing services and condoms to the targeted populations.
- Development and implementation of an HIV programme targeting the Military and ex-combatants. This programme provides HIV awareness, counselling and testing, condom distribution and treatment and care services to military personnel.
- Challenges and gaps remain, which will inform future programmes in humanitarian settings:
- HIV programming is not an immediate priority in a humanitarian setting where emergency issues such as food insecurity and disease outbreaks often take precedence
- A recent assessment on HIV programmes in humanitarian settings in 3 states found that current programmes are limited and fragmented, with little accountability and reporting mechanism in place
- Limited data on the risk factors and prevalence of HIV among the PoHC that can be used to develop effective programmes
- There is limited funding and capacity for HIV programming among humanitarian agencies.
- Integration of HIV programmes with other relevant sectors such as protection, GBV and nutrition is limited.

2.3.1.2 Sex workers and their clients

Sex workers are found mainly in towns. A significant proportion of the sex workers are migrants from neighbouring countries. A study carried out in Juba found that two-third of the FSWs were divorced, separated, or widowed with only 7% being married, but almost 90% of them were the primary bread winners of their families.

Only about 25% negotiated condom use with their clients, fearing that "insistence on the use of condoms would upset customers and may result in clients leaving them for other FSWs". Majority of the clients are local South Sudanese men, who included the military, police, migrant workers, immigration officers, and other government officials. Knowledge of HIV among FSWs is mixed – the understanding that condoms can protect one from HIV infection and that HIV can be transmitted from mother child is high, but there are also misconceptions such as spread of HIV through mosquito bites.

Despite the knowledge of importance of use of a condom, condom use among female sex workers is low. Although data on HIV prevalence and size estimation of female sex workers is limited, findings of various surveys show high incidence of unsafe sex among the female sex workers which increases the risk to HIV infection among both female sex workers and their clients.

2.3.2 Factors at the Individual and Couple Level That Impact the Risk of Heterosexual Transmission

The risk of acquiring HIV through sexual intercourse at the individual level is mostly related to s**exual practices[16]:**

- The risk of HIV transmission from female to male is 2-3 times higher during menstruation[17];
- For monogamous HIV discordant couples there is a relatively low risk of HIV transmission percoital act (1 in 2000 to 1 in 384);
- The risk of HIV transmission during anal sex is higher than vaginal sex, and is estimated to be 1.3 times higher risk for the insertive partner, but 10 or more times higher for the receptive partner;
- The risk of HIV transmission during oral sex is extremely low;
- Data from South Sudan on important individual level factors – marriage, sexual debut and behaviour, male circumcision, multiple partners, condom use, and STIs – are very scarce although some can be extracted from the two household surveys of 2006 and 2010[18, 19].

2.3.3 Sexual behaviour in key sub-populations at risk of HIV

Although South Sudan experiences a low generalized epidemic with apparently high population prevalence, some socioeconomic sub-populations are particularly prone to HIV infection due to higher risk behaviours[20]. **Most-at-risk populations** (MARPs) are defined as populations in which there is a concentration of risk behaviours that lends to efficient HIV transmission that may then drive the majority of new infections[21]. Behaviours that put people at greater risk of HIV infection include unprotected sex with multiple partners, receptive anal sex, and injecting drugs with shared equipment and drug preparations.

16. Benedicte Leynaert, Angela M. Downs, and Isabelle de Vincenzi (1998) for the European Study Group on Heterosexual Transmission of HIV. American Journal of Epidemiology; Vol. 148, No. 1

17. Campo J, Perea MA, del Romero J, Cano J, Hernando V, Bascones A. Oral transmission of HIV, reality or fiction? An update. Oral Dis. 2006 May;12(3):219-28.

18 SSHH Survey 2006

19 SSHH Survey 2010

20. SNAP/UNICEF/UNAIDS (2005) Baseline study on knowledge, attitudes, and practices on sexual behaviors and HIV/AIDS prevention amongst young people in selected states in Sudan. HIV/AIDS KAPB Report. Projects and Research Department (AFROCENTER Group). quoted in Abu-Raddad et al

21 Timothy, L Mah & Daniel, T. Halperin, 2008, Concurrent Sexual Partnerships and the HIV Epidemics in Africa. Evidence to move forward. (SAfAIDS)

2.3.3.1 Female Sex Workers

Commercial sex work is common in South Sudan and is practiced in both rural and urban areas throughout the county. It is especially concentrated in border towns, larger cities such as Juba, and at truck stops along the Kampala-Juba transport corridor. One study estimates the number of SWs in Juba to be between 2,000 and 2,800, with 400, or between 15% and 20%, underage[22]. According to this study, almost all underage SWs in Juba are South Sudanese. Though SW risk behaviors have been well studied and understood globally, few studies have investigated the dynamics of HIV risk among SWs in South Sudan. Several political and historical factors unique to the South Sudanese context may have shaped the epidemiological profile of the epidemic in ways that differ from other East African countries. For example, the decades of war and the massive movement of refugees back and forth across the border may have facilitated the spread of the virus to areas of low HIV prevalence. Deep poverty and the disintegration of traditional family and social structures may have encouraged the practice of "survival sex" among South Sudanese women and girls.

2.2.3.2 Uniformed Personnel

The HIV infection rate among soldiers in the South Sudanese army is nearly twice the national average[23]; this is according to recently released 2012 sentinel surveillance findings in which the rate of 5% was reported against the national average of 2.6%.

A survey found a prevalence of 2.9% in Yei town and 0.8% in Rumbek town among military personnel and soldiers. In another pan-Sudan study, 39.6% of sexually active military personnel reported to have had one sexual partner, 13.4% had two partners, 12.5% had % had three partners, and almost ONE THIRD (31.2%) had more than 3 sexual partners in the preceding six months[24]. These rates are about the same, or even lower than the general population data that is available, leading one to question whether the military and uniformed services should be included amongst the populations at higher risk.

2.2.3.3 Mobile Populations

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

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22 McCarthy MC, Khalid IO, El Tigani A (1995) HIV-1 infection in Juba, southern Sudan. J Med Virol 46: 18-20. quoted in Abu-Rabbad et al.

23 23. Esterina Novello Nyliok, the head of the South Sudan AIDS Commission, said data from 2012 show the HIV rate in the SPLA, the South Sudanese army.

24 24. ACCORD (2005) Socio Economic Research on HIV/AIDS Prevention among Informal Sex Workers. Agency for Co-operation and Research in Development. Federal Ministry of Health, Sudan National AIDS Control Program, and the World Health Organization, quoted in Abu-Raddad et al

2.2.3.4 Truck Drivers (TD)

A study of truck drivers in Khartoum State showed a prevalence of about 1% in truck drivers. But of these drivers, 10.8% reported three partners in the past six months, and 13.4% reported more than three partners[25]. As noted earlier, these North Sudanese truck drivers were probably mainly Muslim and circumcised. If the number of casual partners in the mainly uncircumcised Southern drivers was similar, one would expect a higher HIV prevalence. Unfortunately data does not exist on the HIV prevalence in South Sudanese truck drivers is not yet available.

Currently, much attention is being focused on HIV risk and prevalence among long distance TDs and their assistants, known as turn boys. TDs have been linked to the spread of HIV throughout East Africa since the earliest days of the epidemic. Studies mapping the incidence of HIV show concentrations along roads heavily trafficked by commercial vehicles, particularly the network of large interstate highways crosscutting East, South, and Central Africa.

2.2.3.5 Boda-Boda Riders

The Crane report based on a study population in Kampala, Uganda, exposes a culture of very risky sex involving buying and selling sex with both women and men and casual sex involving multiple partners with low condom use[26]. The report states that eighty-four percent of the study population identified themselves as straight/heterosexual, 12% as bisexual and 4% as homosexual. Seven percent of participants reported having had sex with at least two male casual sex partners, while 8% reported sex with two steady male sex partners in the past six months. Ten percent had had one or more casual male sexual partners and 15% had more than one steady male partner. Twenty-one percent of boda riders reported having sold sex to at least two women while 78% bought sex from at least two women. Ten percent of the sampled boda-boda riders reported buying sex from women in the past six months. Of these, more than three quarters (78%) had bought sex from two or more women. Condom use was low ranging from 33% to 36%. Drug use was relatively high with more than half (54%) of the boda boda riders reporting ever drinking alcohol, and 12% having drunk it in the last 30 days. Sixteen percent ever used illegal drugs, and 2 % had ever injected drugs. HIV and STI prevalence among this group was 7.5% and 6.1% with those who are 25years and above exhibiting of 10%, three times higher than their younger counterparts.

2.3.3.6 Conflicts/Refugees and IDPs

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

[25] 25 Farah MS, Hussein S (2006) HIV Prevalence, Knowledge, Attitude, Practices and Risk Factors among Truck Drivers in Karthoum State. quoted in Abu-Raddad et al

[26] 26. School of Public Health, Makerere University, 2009. The Crane Survey Report: High Risk Group Surveys in Kampala Uganda. MOH, CDC/Pepfar, 2009.

South Sudan is characterized by constant population mobility which makes it one of the most mobile populations in the region. Traditionally South Sudanese have three abodes: the principal home in the village, the cattle camps for pastoral farming, and the arable lands for farming. With increasing urbanization some people have a fourth home in an urban area[27]. For several years people have shuttled between these domiciles in a complex pattern varying across seasons and stages of individuals' life cycles[28]. An additional source of the high population mobility in the country is the repatriation of refugees/returnees from neighbouring countries and large groups of internally displaced populations. It is therefore not uncommon for married couples to live separately for long periods of time, and for young people to live away from their parental guidance.

2.3.3.7 Extremely low knowledge about HIV/AIDS

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

2.3.3.8 Transmission during Sex between Men Who Have sex with Other Men

In South Sudan, there are probably more men engaging in MSM activities than has been appreciated, and there is some evidence for this[29]. In the few studies that have taken place (mainly in the North), 2% of males among mainly rural populations reported homosexual contacts and among truck drivers, 0.2% reported having had sexual relations with both sexes, and 0.5% reported having had sex only with males.[30] Among prisoners, 2.2% reported having homosexual contacts. Evidence of same activities have been reported by field workers but there is strenuous denial from the centre, such that people are not talking about it and the MSM themselves may have gone underground due to non conducive and unwelcoming environment.

3. NATIONAL RESPONSE

3.1 Review of Response from January 2013 to December 2013

This section presents the findings of the review analysis of the progress since January 2013 to December 2013 by South Sudan HLM targets and commitments. The findings are presented into two main sections: the narrative summary of the findings and the detailed presentation, including quantitative analysis according to HLM areas of commitments with respect to: restatement of the particular HLM Target, the tracking indicators and value figures for progress or status trend analysis and the duly filled Stocktaking tool/matrix for assessing the overall progress of targets and indicators.

[27] 27. Kitingulu B, Tegang SP, Suji O, Jervase A; Behavioral Monitoring Survey for HIV/STI/FP/Malaria/GBV in Juba, and Rumbek, Southern Sudan; FHI/USAID/MOH: 2009

[28] 28Zwi AB, Cabral AJ. Identifying 'high risk situations' for preventing AIDS. BMJ. 1991 Dec 14;303 (6816):1527-9.

29. Elrashied S (2006) Draft Report: Generating Strategic Information and Assessing HIV/AIDS Knowledge, Attitude and Behaviour and Practices as well as Prevalence of HIV 1 among MSM in Khartoum State, 2005. Khartoum., quoted in Abu-Raddad et al

30. Aceijas C, Friedman SR, Cooper HL, Wiessing L, Stimson GV, et al. (2006) Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution. Sex Transm Infect 82 Suppl 3: iii10-17 quoted in Abu-Raddad et al 153

It is hoped that if South Sudan continue to with recommended intervention that are found in the new NSP (2013 – 2017), HIV prevalence could drop to 1.5% by 2015 or by 2017, all depended on the ramification of the ongoing socio- political hiccups in the country.

3.2 Country Progress 2013

This section highlights the country progress attained during the reporting period.

3.2.1 Target 1: Reducing sexual transmission of HIV by 50% by 2015.

Significant progress has been achieved in regard to reduction of new HIV infection taking place per year. It was estimated that new infection was estimated 16000 in 2010 and 15000 in 2012 and 13000 in 2013. South Sudan target for 2015 is 8000 annual new infections. Although it is unlikely that SS can achieve this HLM target, the following were efforts done to achieve the targets amid numerous challenges inherent in the country.

Target 1: Reducing Sexual Transmission

Progress during reporting period <January – December 2013>:

- Scaled up targeted community awareness activities in schools;
- Awareness on uptake of HIV Counselling and testing services;
- Training of peers educators on BCC ;
- Scaled up targeted community awareness activities in schools;
- Awareness on uptake of HIV Counselling and testing services;
- Training of peers educators on BCC activities;
- Free condom distribution activities being scaled up (2,613,592 in **2011,** 2,848,104 in **2012** and 1,584,976 in **2013** by PSI); UNFPA supplied 10,000,000 condoms in 2013;
- Condom social marketing distribution was 560,196 in **2011**, 1,287,792 in **2012** and 1,396, 304 in **2013** by PSI);
- National ToT training with implementing partners on IEC materials conducted by UNAIDS;
- National KAPC training on SRH among young people (10-24) conducted by UNFPA/SSAC/Alliance;
- Dialogue meetings with community leaders on adolescence sexual and reproductive health;
- Scaling up safe voluntary male circumcision awareness;
- Collaboration with partners on prevention activities;
- SMMVC happening but no records;
- Training of health workers on PICT/ PMTCT option B+;
- Training of HCT counselors at various health facilities (ADRA).

Challenges:

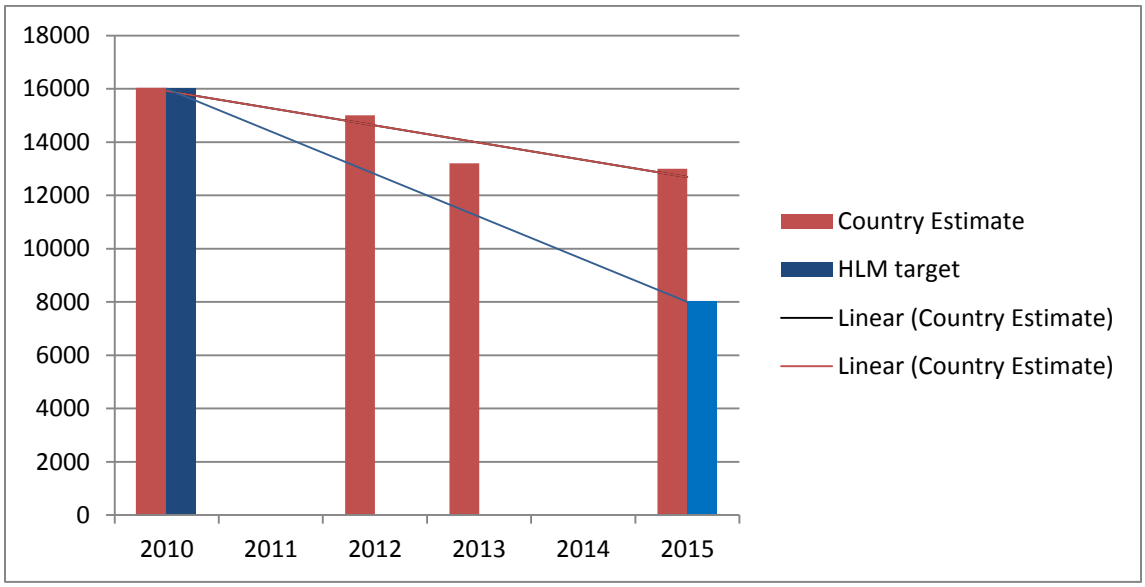
- Not much quantitative data for 2013;
- Lack of baseline data for tracking progress;
- Unclear reporting frame work (timeliness, data flow from bottom to top);
- Un harmonized data collection tools (different reporting tools exist, no specific tools to capture community activities);

- Short fall in funding;
- High levels of cultural misconceptions in the communities;
- Low capacity in reporting data at various levels;
- Stock out of HCT test kits;
- Limited access to HCT sites (some sites closed up or nonexistence);
- High levels of insecurity driving many populations into IDP camps/refugees settings;
- Poor road infrastructures limiting access to health facilities;
- Lack of storage facilities at state levels;
- Limited use of media houses to disseminate HIV basic information;
- Low level of knowledge or misconceptions on condom use among clients of sex workers;
- Limited access to HCT services by sex workers;
- Low level of knowledge on use of female condoms;
- There is no coordination with the private sector on HIV interventions.

Remedial Actions in the next one year:

- SSAC to consult with MoH and provide data for 2013 and regularize reporting of data;
- MOH/SSAC to conduct regular baseline data for tracking progress;
- MoH/SSAC/partners to harmonize reporting frame work (timeliness, data flow from bottom to top);
- Standardize data collection tools (different reporting tools exist, no specific tools to capture community activities);
- Need for domestic and donor long term funding into HIV interventions;
- Partners to scale up community awareness campaigns;
- Need for training staff on reporting of HIV data at various levels;
- MoH/SSAC to forecast testing supplies;
- Scale up integration of HCT services;
- MoH/SSAC/partners High level of involvement of media houses to disseminate HIV basic information;
- Need for partners to scale up targeted outreach HCT services for sex workers;
- Partners to scale targeted awareness campaigns at all levels;
- MoH to foster a strong coordination with the private sector on all HIV interventions.

Figure 5: Estimated new annual HIV infections compared with HLM target



There exists ongoing investments or making of investment case and new strategic actions likely to have positive bearing on the rate of reduction in the form of the new emphasis on prevention in the new NSP II (2013 – 2017); identification and focus on planning for new most-at-risk populations recently identified through mode of transmission (MOT) in December 2013. These MAR Populations, which include SWs, CHS group, polygamy MSM and many clients of FSWs had been left out of the programming in the NSP I (2008 – 2012) and are now included in the second NSP (2013 – 2017). Other key populations included in the NSP II that could have a bearing on the reduction of sexual transmission of HIV include populations of humanitarian concern and generally improving coordination of prevention coordination. All these were achieved in the year 2013. The analysis report (table 6) presents summary achievements that were attained in the area of reducing sexual transmission of HIV during the reporting period.

Review Questions	Performance, current status and proposed strategic actions, new investments and changes in policy & other enabling environment.
1. Is this a priority target in South Sudan? Yes. Prevention of new infections the leading and most important priority of all priorities for the NSP (2013 – 2017).	
2. Does the NSP address this target? How aligned to the HLM commitments is the National Response Programming as illustrated by the NSP?	

- Yes.
- The NSP has targets for prevalence and new infections to be reduced by 50% by 2017.

3. What actions, investments have been undertaken towards the HLM target and what progress (achievements has been made)?

- Increased knowledge and awareness of SWs, and other most-at-risk populations including the general populations,
- Increased condom use and distribution to PLHIV.

4. What are the challenges and constraints to attaining the HLM target?

- Weak health and service delivery persist
- Low literacy rates and low knowledge of ways of preventing HIV transmission and rejection of of misconception about HIV transmission.
- Gender factors and inequality still persists and very little is being done in terms of interventions
- High HIV stigma is still high.
- Uptake of HCT services still remains low and is even going down..

5. Is the country on track (or not) to attain the HLM target? No.

6. What programmatic actions are needed to stay on course/track to reach the target?

- Scaling up of HIV voluntary counseling and testing among young people and key populations, including in humanitarian settings;
- Improve HIV prevention coordination at national level
- Scaling up of Provider Initiated Testing and Counseling (PITC) in all health facilities
- Run comprehensive condom programming
- Initiation of house-based counseling and testing

7. What policy enabling environment changes are necessary to stay on course/track or reach the target?

- Develop and utilize HIV prevention programming guidelines for young people, sex workers, transporters and prison settings;
- Policies and guideline to regulate cultural and traditional practices
- The draft policy requires approval of the legislature to provide power to the strategies being used
- Male circumcision policy needs to be developed and implemented.

8. What new investments are necessary to stay on course/track or reach the target.

- Investment approach/case to sustain the response is being developed which will bridge the resource gap with prevention at the centre of it.
- Initiation of youth support (training of peers).

9. What should be done/recommendations to ensure that the actions /changes needed are implemented?

- There is need for stakeholders having a forum once a year to review progress, challenges, good practices and lessons learnt.
- Develop coordination mechanism that focuses on young people.
- Capacity building for service providers
-

10. What are the recommendations to ensure that the progress is sustained beyond 2015?

- Build national capacity and increase national budget for HIV/AIDS
- Carry on continuous resource mobilization.

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

Although South Sudan has not included Injecting use of drugs in the NSP, and in the modes of transmission, no studies have been done to ascertain the existence or absence of IDUs in the country, this decision was not was not evidence informed to exclude from the NSP.

3.2.3 Target 3: Elimination of new infections among Children by 2015 and keeping their mothers alive

Elimination of Mother to Child Transmission of HIV is a high priority for all, given the persistence of HIV related maternal, newborn and child morbidity and mortality in African countries, South Sudan included. It is one of the major concerns addressed by a high level Global Task Team that was convened by UNAIDS in New York in June 2011, to commit African countries to work towards the elimination of mother-to-child transmission of HIV by 2015 and substantially reducing AIDS-related maternal deaths

The Government of South Sudan has made significant strides towards expanding PMTCT services in RCH clinics guided by the Health Sector Development plan despite the existing health system challenges.

Currently PMTCT services are provided in 52 RCH clinics out of 458 and the government of South Sudan is committed to sustain the momentum gained and together with its development partners are striding to make considerable progress towards health MDG 4, 5 and 6.

PMTCT scale up has been developed in the light of the elimination agenda of which South Sudan has committed herself by signing a political declaration. As such the plan provides a platform for elimination of mother to child (eMTCT) of HIV and fewer efforts will be utilized to upgrade it to suit such purpose. This plan has been developed to provide guidance on critical interventions, targets and resources required at all levels. It has been developed as a result of joint collaboration between the Government through the South Sudan HIV/AIDS Commission, the Ministry of Health and partners supporting maternal and Child.

Table 6: Tracking indicators and indicator values over time (2009-2013)

	Available Data			NSP Targets
Key Tracking Indicators	**Value and Year 2011**	**Value and Year 2012**	**Value and Year 2013**	
Percentage of infants born to HIV positive mothers who are HIV positive	**30% (spectrum 2009)**	**29%**	**28%**	**20% in 2015 <10% in 2017**
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission (PMTCT coverage)	8.3%	9.5%	21%	
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	No data	No data	7.3%	
3.3 Mother-to-child transmission of HIV (modelled)	30%	30%	29%	

Although South Sudan is making progress towards elimination of HIV infections to children, the current progress will not lead to achievement of HLM target in 2015 as reflected in the figures 6 and 7 below. However several achievements were made in 2013 that include:

- PMTCT guidelines developed and validated ;
- PMTCT scale up plan developed;

- Mentorship program initiated;
- Mother to mother support groups;
- Number of PMTCT sites increased from 50 to 75 sites ;
- Trainings (Mentorship, PMTCT, EID, PIMA).
- No progress has been made in reducing mother-to-child transmission of HIV during the period 2011 – 2013 and has remained at 30% since 2011.
- South Sudan may not attain the 2015 HLM target of eliminating the MTCT given the wide variance by 2015 as indicated in figure 3.3 above if the progress in reducing the transmission rate remains at a slow pace of reducing one percentage point per year.
- There are quite a number of important planned investments and strategic actions in the PMTCT scale up plan that include: increasing service providers, decentralization and expansion of PMTCT services; supporting outreach services, targeting marginalized groups, improving ANC coverage, developing eMTCT communication strategy; strong supervision and social mobilization. These may have a potential for accelerating the reduction rate and thus observed variance or even attain the target.

Challenges:

- High turnover of health care providers;
- Limited funding ;
- Inadequate supervision;
- Loss to follow up;
- Very low coverage;
- Inadequate level of integration of HIV/AIDS services into PHC;
- Irregular supplies of HIV commodities;
- Stigma and discrimination;
- Low level of support (family, community etc).

Remedial Actions:

- Scale up Early Infant Diagnostics (EID) among EID focal persons and initiate paediatric ART service;
- Decentralize/expand PMTCT services including support for outreach services on PMTCT for social mobilization including utilization of media;
- Improve ANC coverage and hence PMTCT;
- Supervision visits, training health workers;
- Mobilizing couples to be counseled and tested together during the ANC visit;s
- Approaches to provide services to key populations (SWs), PoHC and other marginalized groups;
- Strengthen mother to mother support groups;
- Training of midwives on HIV related referrals.

Figure 6: PMTCT coverage versus HLM target in South Sudan

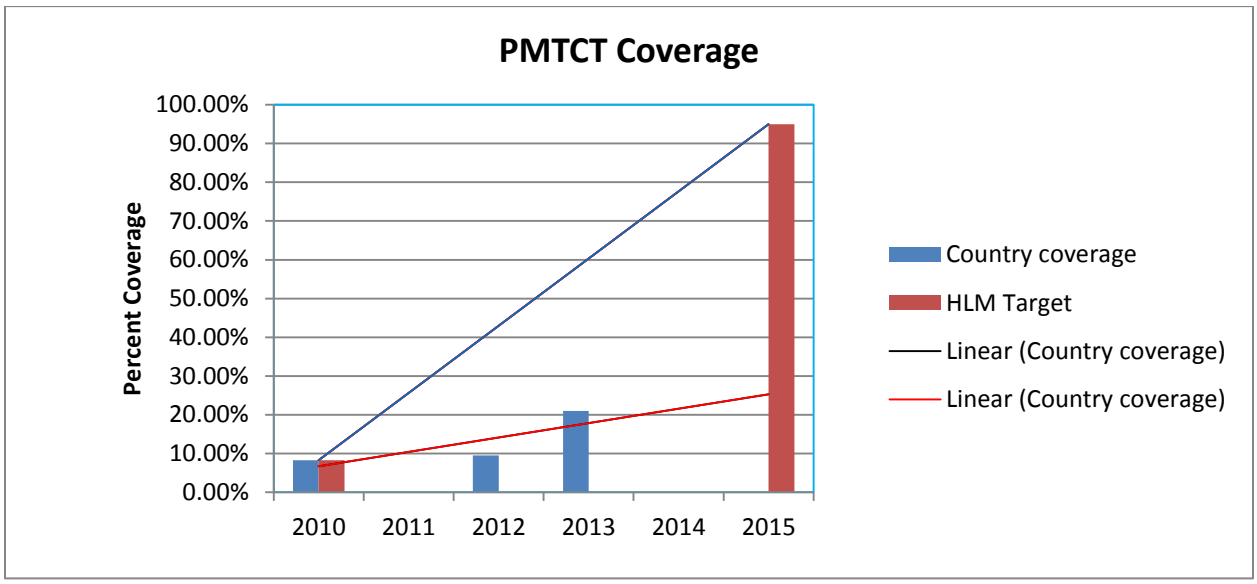
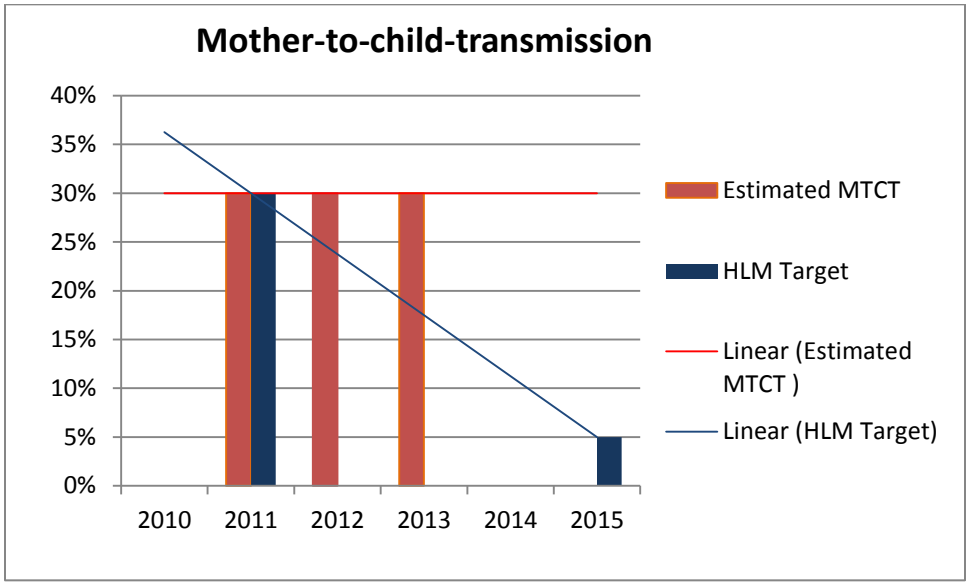


Figure 7: Achievement of MTCT rate versus HLM target in South Sudan



Review Questions	Performance, current status and proposed strategic actions, new investments and changes in policy & other enabling environment.
1. Is this a priority target for South Sudan? ▪ Yes	
2. Does the NSP address this target? How aligned to the HLM commitments is the National Response Programming as illustrated by the NSP? ▪ Yes, ▪ PMTCT is one of the NSP Outcome areas	
3. What actions, investments have been undertaken towards the HLM target and what progress (achievements) has been made? ▪ Expanded facilities providing PMTCT services; training of HCPs ▪ Pregnant women were provided utilized HIV testing and counselling services, received ARV prophylaxis;HIV treatment eligible mothers received ART exposed infants received cotrimoxazole and ARVs prophylaxis; confirmed HIV positive infants and children received ART ▪ HIV positive children were provided with basic and psychosocial support	
4. What are the challenges and constraints to attaining the HLM target? ▪ The 73 sites currently providing PMTCT services are grossly few for the HCT services; ▪ Insufficient HR as well low capacity by the available staff; ▪ , Frequent shortages of test kits; ▪ Low uptake of ANC due to lack of awareness ▪ High illiteracy rate of pregnant mothers ▪ Poor follow up of positive mothers and exposed infants	
5. Is the Country on track (or not) to attain the HLM target? ▪ No	
6. What programmatic actions are needed to stay on course/track of reach the target? ▪ Scale up Early Infant Diagnostics (EID) among EID focal persons and initiate paediatric ART service; ▪ Decentralize/expand PMTCT services including support for outreach services on PMTCT for social mobilization including utilization of media; ▪ Improve ANC coverage and hence PMTCT ▪ Supervision visits, training health workers ▪ Mobilizing couples to be counseled and tested together during the ANC visits ▪ Approaches to provide services to key populations (SWs), PoHC and other marginalized groups ▪ Strengthen mother to mother support groups ▪ Training of midwives on HIV related referrals	
7. What Policy/ enabling environment changes are necessary to stay on course/track or reach the target? ▪ Update PMTCT guidelines and protocol including Develop mother-to-mother support group guideline and tools in accordance to WHO comprehensive PMTCT package 2012 and WHO consolidated guidelines 2013 ▪ Consider policy change to Option B/B+ ▪ Develop and support implementation of EID Strategy and Referral Register ▪ Develop an operational plan and tools for Early Infant Diagnosis (EID) to guide the scale up of ART services among children	
8. What new investments are necessary to stay on course/track or reach the target? ▪ In introduce PoC CD4 technologies to improve diagnosis and treatment monitoring of pregnant mothers; coordination and referral	

What should be done / recommendations to ensure that the actions/changes needed are implemented? ▪ Need to increase advocacy and coordination for EMTCT services
10. What are the recommendations to ensure that the progress is sustained beyond 2015? ▪ Investment for eMTCT, resource mobilization needed, training and capacity building of local staff ▪ Increase government budget allocation to HIV/AIDS

3.2.4 Target 4: 15 MILLION PLHIV ACCESSING TREATMENTS BY 2015

One of the major objectives of the Ministry of Health is to provide greater care, support and treatment to the larger number of PLHIV estimated at about 152,000 in South Sudan, with ultimate goal of universal access for all those who need it. The Care, Support and Treatment component of the HIV/AIDS Division aims to provide comprehensive management to PLHIV with respect to prevention and treatment of Opportunistic Infections including TB, Anti-retroviral Therapy (ART), psychosocial support, home-based care, positive prevention and impact mitigation.

Anti-retroviral Therapy (ART) for eligible persons living with HIV/AIDS was launched in 2006 in three hospitals. Since then, the programme has been scaled up both in terms of facilities for treatment to 22 and number of beneficiaries seeking ART. The main services provided to PLHIV under care, support and treatment include:

- Registration of PLHIV for ART and pre-ART services;
- Assessment of eligibility of ART based on clinical examination and CD4 count;
- Provision of first line ART to all eligible PLHA and CLHA;
- Follow-up of patients on ART by assessing drug adherence, regularity of visits and periodic examination and CD4 count (every 6 months) ;
- Care, support and home-based services;
- Treatment of opportunistic infections; and
- Provision of alternate first line and second-line ART to those experiencing drug toxicities and treatment failure, respectively.

Progress Made in 2013

- Consolidated ART guidelines developed and is waiting roll-out;
- ART Scale up plan developed;
- 22 ART sites operational;
- More people enrolled on ART (more info needed from MOH & WHO)
- Improved retention (71% in 2012 to 78% in 2013) as indicated in the table below.

Challenges:

- Financial constraints – inadequate funds to scale up (perennial);
- Sub-optimal HIV testing (VCT, PMTCT, TB, key populations)
- Health systems weaknesses – Shortage of skilled and suitably qualified health work force/same as last reporting;
- Weak service delivery systems i.e infrastructure, logistics, integration and linkages; supply management for medical products (e.g. test kits, ARVs, OIs etc), information systems for treatment monitoring; weak management systems especially at service delivery levels/same as last reporting;

- Community systems – lack of networks at community level, peer PLHIV groups/CBO's to support treatment adherence and retention (paramount but not adequate).

Remedial Actions

- Increase number of ART centres, prophylaxis and treatment of opportunistic infections among PLHIV/same as last reporting;
- Expand targeted HCT (PICT)/still a requirement;
- Strengthen integration and management of ART programme: linkages HIV counseling and testing services with treatment programme and between treatment centres, logistical management; strengthened community & peer support groups to enhance uptake, referral follow up and adherence/still ongoing but very slow;
- Strengthen linkages between VCT, PMTCT, EID and ART services to ensure effective follow up on children born to HIV positive mothers and scale up early diagnosis of the children/poor follow up;
- Improve livelihood and nutritional care and support to enhance treatment effectiveness and adherence/slow implementation.
    - Provide training and mentoring to health service providers to improve the quality of ART services (continuous requirement).

Table 7: Tracking indicators and indicator values over time (2009-2013)

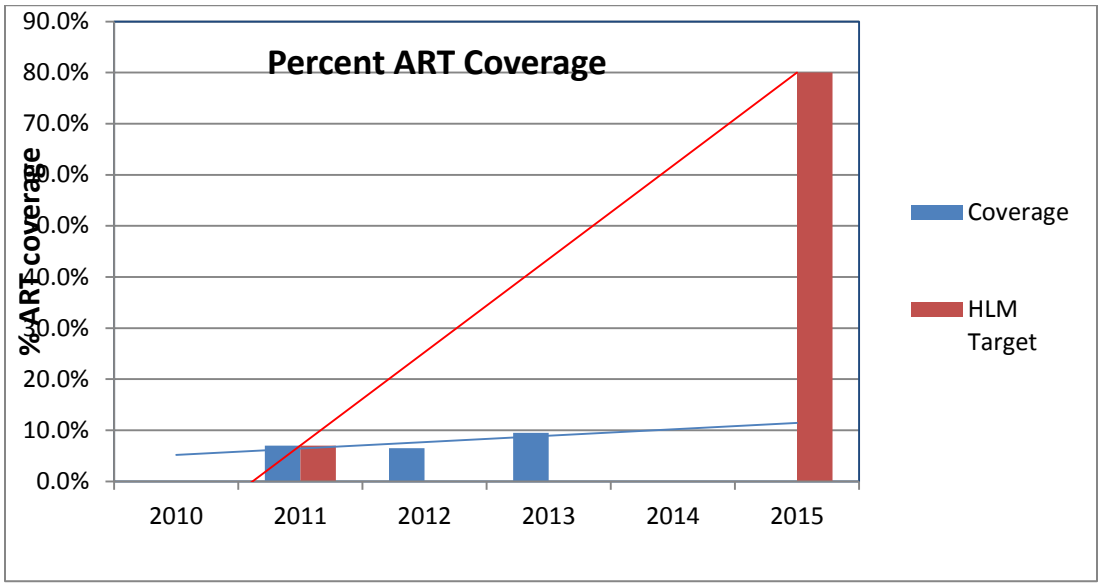
	Available Data			NSP Targets
Key Tracking Indicators	**Value and Year 2011**	**Value and Year 2012**	**Value and Year 2013**	
NSP 2.1.1: Number of eligible adults and children enrolled on ART 3512 in 2011 (GARPR) A: 4486; C: 164 4650 in 2012 9,387 in 2013		3512 in 2011 (GARPR)	A: 4486; C: 164 4650 in 2012 6899 in 2013	▪ 9,387 in 2013 ▪ 23,387 in 2015
NSP 2.1A: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy				A. - 6 %, C - 1% in 2012 (% reduced due to change in estimation methodology)

Table 8: Treatment retention

	Available Data			NSP Targets
Key Tracking Indicators	**Value and Year 2011**	**Value and Year 2012**	**Value and Year 2013**	
2.2a: Percentage of adults and children known to be on treatment in 12 months after initiation of ART	56.5%	62.5%	78.48%	75% (2015)

2.2b: Percentage of adults and children known to be on treatment in 24 months after initiation of ART		55% (2011)	65.8%	70% (2015)
2.2c: Percentage of adults and children known to be on treatment in 60 months after initiation of ART		38% (2011)	44.7%	63% (2015)

Figure 8: Number of Eligible persons on treatment



Progress has been made increasing the number of eligible persons on treatment between 2011 and 2013 from about 3512 (7%) to 4650 (6%) and estimated to reach 9387 in 2013 (20%). Note the % from 7% to 6% in the indicator table above is due to change in denominator for estimation of the rate.

South Sudan may not attain the 2015 HLM target of having all on treatment by 2015 given the wide variance in what was feasible targets of 23,387 (NSP target of 60%) persons in 2015 in NSP against an estimated 38978 in need in 2015 if the rate of progress rate remains the current pace.

Percentage of adults and children known to be on treatment in 12 months after initiation of ART has also been increasing over the past 3 years as indicated by 62.5% in 2012 and 70.8% in 2013 (MOH Programme data).

- There are quite a number of important planned investments and strategic actions including:
- Increase number of ART centres, prophylaxis and treatment of opportunistic infections among PLHIV (still needed)
- Strengthen integration and management of ART programme: linkages HIV counseling and testing services with treatment programme and between treatment centres, logistical management;

strengthened community & peer support groups to enhance uptake, referral follow up and adherence (still needed)

- Strengthen linkages between VCT, PMTCT, EID and ART services to ensure effective follow up on children born to HIV positive mothers and scale up early diagnosis of the children
- Improve livelihood and nutritional care and support to enhance treatment effectiveness and adherence (still required)
- Provide training and mentoring to health service providers to improve the quality of ART services (not yet achieved)

Review Questions	Performance, current status and proposed strategic actions, new investments and changes in policy & other enabling environment.
1. s this a priority target for South Sudan? ▪ Yes	
2. Does the NSP address this target? How aligned to the HLM commitments is the National Response Programming as illustrated by the NSP? ▪ Yes ▪ o As one of the outcomes of the planned in NSP: PLHIV on ART increased from 10% (adults) and 3% (children) to 80% (adults) and 50% (children) in need of ART by 2017	
3. What actions, investments have been undertaken towards the HLM target and what progress (achievements) has been made? ▪ Increase in the number of ART sites from 16 in July 2011 to 22 in 2013 ▪ Number of PLHIV on ART increased from 3512 in 2011 to 4650and 6899 in 2013 are on care. ▪ Training and mentoring HCPs, update of treatment protocols according to WHO 2010 guidelines ▪ Updated PMTCT guidelines and job aides in line with WHO/UNICEF eMTCT global guidelines.	
4. What are the challenges and constraints to attaining the HLM target? ▪ Financial constraints – inadequate funds to scale up (perennial); ▪ Sub-optimal HIV testing (VCT, PMTCT, TB, key populations) ▪ Health systems weaknesses – Shortage of skilled and suitably qualified health work force/same as last reporting; ▪ Weak service delivery systems i.e infrastructure, logistics, integration and linkages; supply management for medical products (e.g. test kits, ARVs, OIs etc), information systems for treatment monitoring; weak management systems especially at service delivery levels/same as last reporting; ▪ Community systems – lack of networks at community level, peer PLHIV groups/CBO's to support treatment adherence and retention (paramount but not adequate).	
5. Is the Country on track (or not) to attain the HLM target? ▪ No	
6. What programmatic actions are needed to stay on course/track of reach the target? ▪ Increase number of ART centres, prophylaxis and treatment of opportunistic infections among PLHIV/same as last reporting; ▪ Expand targeted HCT (PICT)/still a requirement; ▪ Strengthen integration and management of ART programme: linkages HIV counseling and testing services with treatment programme and between treatment centres, logistical management; strengthened community & peer support groups to enhance uptake, referral follow up and adherence/still ongoing but very slow; ▪ Strengthen linkages between VCT, PMTCT, EID and ART services to ensure effective follow up on children born to HIV positive mothers and scale up early diagnosis of the children/poor follow up; ▪ Improve livelihood and nutritional care and support to enhance treatment effectiveness and adherence/slow implementation; ▪ Provide training and mentoring to health service providers to improve the quality of ART services (continuous requirement);	
7. What Policy/ enabling environment changes are necessary to stay on course/track or reach the target? ▪ Update the national HIV policies and protocols in line with WHO global guidelines 2013/ongoing;	

8. What new investments are necessary to stay on course/track or reach the target? ▪ Simplified and reliable CD4 technologies (point-of-care) for assessment of eligibility and monitoring of PLHIV on ART; Viral Load (VL) machines to track viral suppression and evaluation of treatment failure; comprehensive human capacity development/eligibility not required but status is important;
9. What should be done / recommendations to ensure that the actions/changes needed are implemented? ▪ Strengthen coordination and integration, support supervision and monitoring. Resource mobilization – NSP, treatment acceleration plan/ongoing but taking time;
10. What are the recommendations to ensure that the progress is sustained beyond 2015? ▪ Increase financial allocation by the government, development partners and the private sector/domestic aids spending to increase considerably if impact has to be felt on the ground; ▪ Develop public private partnership (PPP)/not visible; ▪ Strengthen Human resources, management and logistical capacity for ART/remains a requirement;

3.2.5 COMMITMENT 5: AVOID TB DEATHS

Target 5: Reducing TB deaths in PLHIV by 50% by 2015 - Avoiding TB deaths

Tuberculosis (TB) diagnoses and treatment facilities are limited to the few (less than seven) hospitals. On the other hand, in 2010, according to the Universal Access report, ART sites reported 99 HIV cases on TB treatment, representing a lowly 2.7% of TB patients on HIV treatment. The plan is to scale up enrolment of HIV positive TB patients to reach 90% by 2017. The programmes (TB and HIV) are collaborating through the diagnosis of the other condition in their respective facilities and TB/HIV co-infected who were initiated on ART (proper linkages).

Progress achieved:

Progress has been made increasing the number and percentage of the HIV positive TB patients are on ART between 2010 (2.7%) and 2012 (8.5%) and 27.5% in 2013.

- Not on Track: South Sudan may not attain the 2015 HLM target of reducing the TB death among PLHIV by 50% but if concerted effort is invested, this could be realized in 2017.
- The Estimated PLHIV deaths due to TB are from modeling (UNAIDS) done for all states.
- UNAIDS (2011- 2015 Global Strategy) estimates that of the globally estimated 1.8 million people who died from TB in 2008, more than 25% were living with HIV. Using this proportional factor and the estimated number of PLHV death for Sudan, the estimated number of PLHIV deaths due to TB was derived.

Challenges:

- Though not on targets directly on TB deaths;
- Not being achieved due to parallel systems and use of referrals rather than integrated services;
- TB strategic plan still in process of development
- Integration not yet realized.

Remedial Actions:

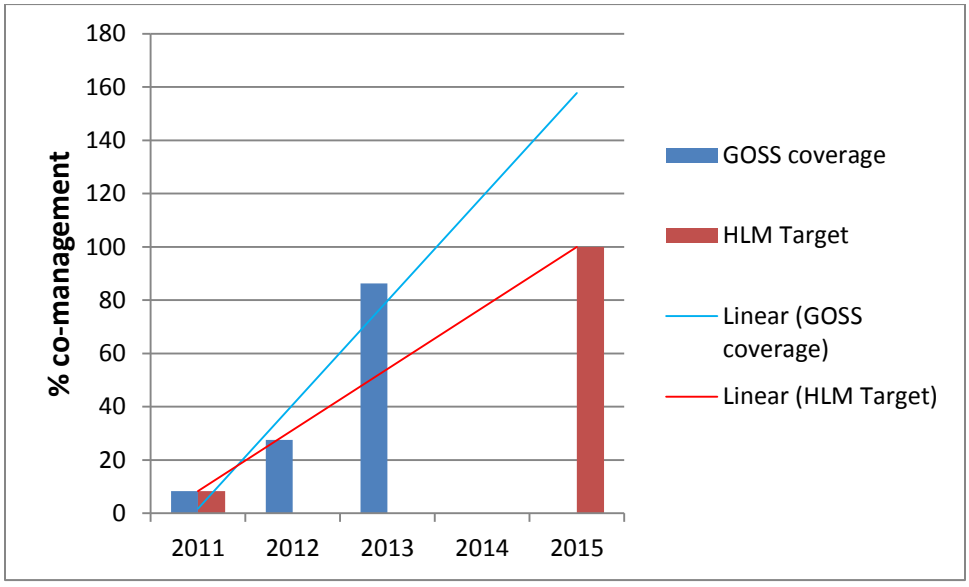
There are quite a number of important planned investments and strategic actions including:

- Advocate and facilitate collaboration between stakeholders providing HTC, SRH, TB, MCHN and treatment; including collaborative TB/HIV activities;
- Design and establish integrated patient tracking systems to facilitate referral and linkages;
- Integrate and conduct training for CSOs and HCPs on referral (4 states in 2013);
- Intensified case finding – revision/update of protocols - Infection control – implement in congregate settings, health facilities.

Table 9: Progress made in TB and HIV co-management

	Available Data			NSP Targets
TB - ART Indicators	**Value and Year 2011**	**Value and Year 2012**	**Value and Year 2013**	
NSP Targets % of those with TB on ART		2012	27.5%	
		2015		70%
		2017		90%
% of those with TB tested for HIV		2012		51%
		2015		
		2017		100%

Figure 9: Co-management of TB and HIV by national achievement and HLM target



Review Questions	Performance, current status and proposed strategic actions, new investments and changes in policy & other enabling environment.
1. Is this a priority target for South Sudan? ▪ Yes	
2. Does the NSP address this target? How aligned to the HLM commitments is the National Response Programming as illustrated by the NSP? ▪ Yes. ▪ Though not on targets directly on TB deaths ▪ Not being achieved due to parallel systems and use of referrals rather than integrated services; ▪ TB strategic plan now in process of development;	
3. What actions, investments have been undertaken towards the HLM target and what progress (achievements) has been made? ▪ Revive and strengthen TB and HIV coordinating body that undertakes joint TB/HIV planning/not rigorous; ▪ Conducted surveillance of HIV among TB clients/continuous; ▪ TB/HIV M&E: indicators, tools and tracking/not satisfactory; ▪ Develop tools for TB case finding in HIV clinics/required in not yet available; ▪ Infection control for TB in health care settings: guidelines and implementation/needed; ▪ Developed guidelines and trained HCPs on TB&HIV co-management/still needed; ▪ Provided ART and Cotrimoxazole prophylaxis for TB&HIV co-infected individuals/ongoing;	
4. What are the challenges and constraints to attaining the HLM target? ▪ Considerable and already mentioned above;	
5. Is the Country on track (or not) to attain the HLM target? ▪ No, too many constraints to be overcome;	
6. What programmatic actions are needed to stay on course/track of reach the target? ▪ Advocate and facilitate collaboration between stakeholders providing TB and HIV/needed and urgent; ▪ Design and establish integrated patient tracking systems to facilitate referral and linkages/not working smoothly, confusion still arises on either side on numbers; ▪ Integrate and conduct training for CSOs, and HCPs in public and private institutions on referral and management Intensified case finding – revision/update of protocols; ▪ Total integration the only solution; ▪ Infection control – implement in congregate settings, health facilities/ a requirement;	
7. What Policy/ enabling environment changes are necessary to stay on course/track or reach the target? ▪ Update/adapt national protocols and guidelines on TB-HIV co-management Institutionalizing TB and HIV collaboration	
8. What new investments are necessary to stay on course/track or reach the target? ▪ Conduct studies on Isoniazid Preventive Therapy (IPT) to inform policy change/still undone; ▪ Provide additional funding to support TB/HIV collaborative interventions	
9. What should be done / recommendations to ensure that the actions/changes needed are implemented? ▪ Resource mobilization/to continue ▪ Advocacy at all levels/ongoing;	
10. What are the recommendations to ensure that the progress is sustained beyond 2015? ▪ Increase financial allocation by government, development partners and private sector required but still doubtful; ▪ Develop Public private partnership (PPP)	

3.2.6 Target 6: CLOSING THE RESOURCE GAP BY 201

Adequate funding is a key constraint facing South Sudan in the provision of HIV services. Funding for the national response is largely from external sources (over 95%) while domestic funding by Government has been limited by the severe austerity measures currently being implemented. The ambitious targets set out in the strategic plan can only be realized if adequate funding is available. The country aims to reduce

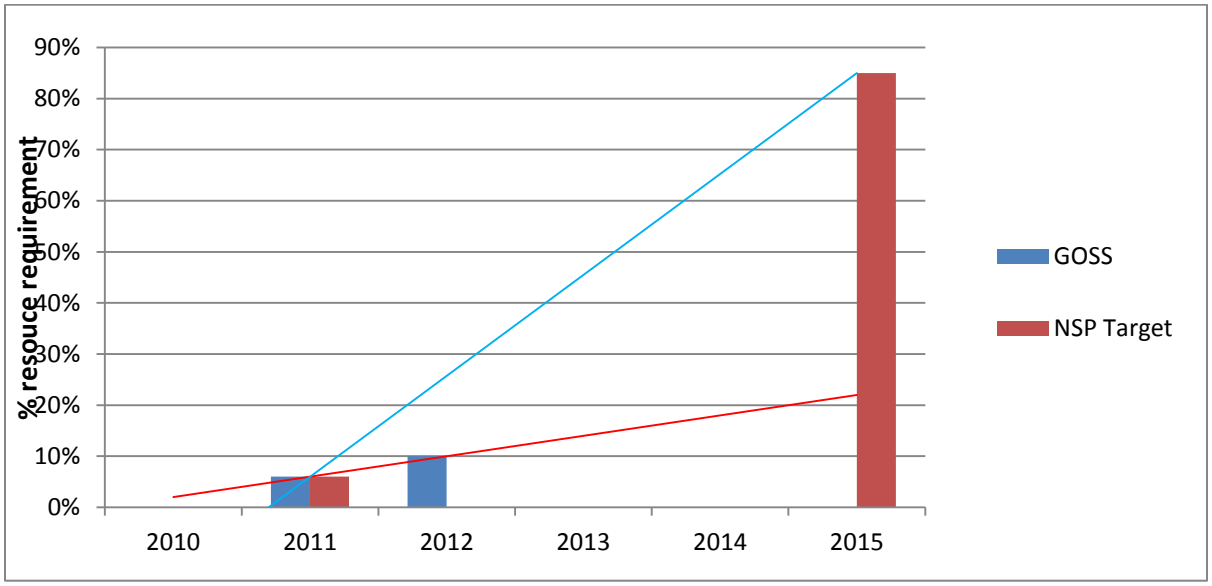
the funding gap by 85% over the next five years through increase domestic and external funding within the spirit of shared responsibility.

Table 10: Tracking indicators and indicator values for target 6 over time (2011/12-2012/13)

	Available Data			NSP Targets
Key Tracking Indicators	**Value and Year 2011**	**Value and Year 2012**	**Value and Year 2013**	
UNAIDS GARPR 2013: Domestic and international AIDS spending by categories and financing Sources	USD 31,238,878 (94%) External 6% domestic funding	USD 24,154,614 90% External 10% domestic funding	To be determined	
Amount and % of required annual funding mobilized; Funding gaps as a % of estimated annual funding requirements			Allocation of GovtSSP35 million (US$12 million) year 2011/2012	
NSP 3.1a Domestic AIDS financing				10% in 2013 40% in 2015
NSP 3.2b Proportion of funding of the national HIV response by funding source (SSAC:	Government=6% (actual 2010) Extern al sources= 94% (actual 2010/11)	Government 10% actual External 90% (2012)		NSP 2015 □ Gvt=15% □ DPs = 85%

Progress for Target 6

Figure 10: HIV and AIDS response resource by government versus NSP target



Review Questions	Performance, current status and proposed strategic actions, new investments and changes in policy & other enabling environment.
1. Is this a priority target for South Sudan? ▪ Disbursement mechanisms are not efficient. ▪ Actual allocation is much less than the pledged funds ▪ Insufficient data resulted to improper projection of resources	
2. Does the NSP address this target t? How aligned to the HLM commitments is the National Response Programming as illustrated by the NSP? ▪ Yes	
3. What actions, investments have been undertaken towards the HLM target and what progress (achievements) has been made? ▪ Allocation of SSP35 million (US$12 million) for the HIV response in the financial year 2011/2012 by the government of South Sudan ▪ Advocacy was undertaken by SSAC, MOH and partners to lobby members of the national assembly to increase budget for national AIDS response from government. o A steering committee was formed by SSAC to identify and advocate for government to increase domestic funding for HIV and AIDS. ▪ A concept note was developed and tabled for steering committee on the identifying options for sustainable financing of HIV response in South Sudan. ▪ The NSP 2013-2017 has included a comprehensive costed need assessment	
4. What are the challenges and constraints to attaining the HLM target? ▪ National budget reduced drastically due to austerity measures related to suspension of export of oil. ▪ Political and policy level support to the national response has not been matched with resource allocation and capacity building ▪ Weak funds absorptive capacity: The expenditure rate for funds allocated to HIV especially by MDTF and Global Fund has remained low ▪ Lack of data on the source of funding and the amount	

▪ Disbursement mechanisms are not efficient. ▪ Actual allocation is much less than the pledged funds ▪ Insufficient data resulted to improper projection of resources	
5. Is the Country on track (or not) to attain the HLM target? ▪ No	
6. What programmatic actions are needed to stay on course/track of reach the target? ▪ SSAC and MOH to identify and utilize sustainable financing options e.g develop resource mobilization strategy ▪ Create awareness on the NSP especially targeting policy makers e.g. executive and members of National and State Legislative Assembly. ▪ Strengthen national data collection and reporting system for effective resource mobilization (develop national data base) ▪ Strengthen coordination of stakeholders activities for effective resource utilization ▪ Support establishment of vibrant private sector involvement in AIDS response.	
7. What Policy/ enabling environment changes are necessary to stay on course/track or reach the target?	▪ Allocate 15% of national revenue for health and HIV/AIDS (abide by the Abuja declaration) ▪ Diversify government revenue to increase include domestic funding
8. What new investments are necessary to stay on course/track or reach the target?	▪ Invest in capacity building to effectively manage domestic and donor resources ▪ Strengthen financial accountability systems to minimize wastage of resources
9. What should be done / recommendations to ensure that the actions/changes needed are implemented? ▪ GOSS and SSAC to have a strong management and leadership role for proper oversight and accountability for all government sectors including stakeholders.	
10. What are the recommendations to ensure that the progress is sustained beyond 2015? ▪ Annual progress reviews ▪ MOU and LOU between SSAC and stakeholders to track progress./ to be done continuously and with at least one forum of implementors once a year for the review of progress and challenges.	

3.2.7 Target 7: ELIMINATE GENDER INEQUALITIES AND GENDER-BASED ABUSE AND VIOLENCE

The magnitude of GBV is not known, but there are isolated studies covering different areas.
A survey conducted in Juba, Morobo and Rumbek, showed that 51% of women in households in Juba had suffered gender based violence. In Morobo, 37% of women in households had ever been abused, including 21% who had had forced sex. However, the study did not provide statistical information in Rumbek on GBV. Hence, it makes it difficult to present a comparative analysis.

This calls for a national prevalence study to be conducted. SGBV manifestations could differ from state to state due to the various cultural differences. Common forms of SGBV include physical such as rape, battery, abductions and jailing of women is some states; economic violence such as auctioning of girls, deprivation of property and psychosocial abuse.

Addressing sexual and gender based violence in the context of HIV appears to be weak. The police form 8 is used to record incidents of injuries which occurred as a result of rape, physical battery or assault. However, access to police form 8 is a challenge, as there are a number of procedures to be undertaken, which consume a lot of time. These could impact on the ability to access health care, including PEP.

Progress in 2013

Table 11: Key Tracking Indicators for Target 7

	Available Data			NSP Targets
Key Tracking Indicators	**Value and Year 2011**	**Value and Year 2012**	**Value and Year 2013**	
UNAIDS GARPR 2013: Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Not available	Not available	Not available	
Proportion of women 15-49 who reported having suffered physical violence (specifically beaten by their partners/ husband)	21.60% in 2006	Ministry of gender to report	Ministry of Gender to report	
All indicators with sex-disaggregated data can be used to measure progress towards target 7	ok	ok	ok	
Literacy levels are higher among men (40%) compared to women (16%) among the population 15 years and above	M-40%; F-16%; National Baseline Household Survey, 2009	No recent survey data	No recent survey data	
Comprehensive knowledge about HIV prevention among young people (women 15-24 years)	Requires new surveys	Requires new surveys	Requires new surveys	
Poverty index of female-headed households	11.30% SSSHS 2010	No study	No study	
	F- 57%, M- 48% in 2009	No study	No study	

Review Questions	Performance, current status and proposed strategic actions, new investments and changes in policy & other enabling environment.
1. Is this a priority target for South Sudan? ▪ Yes.	
2. Does the NSP address this target? How aligned to the HLM commitments is the National Response Programming as illustrated by the NSP? ▪ Yes ▪ NSP has gender disaggregated indicators relating to prevalence and service access/utilization	
3. What actions, investments have been undertaken towards the HLM target and what progress (achievements) has been made? ▪ Included in the National Gender Policy and Strategic Plan ▪ Gender based violence Standard Operating guidelines developed ▪ South Sudan Child Act 2008 now the African Charter of Child protection ratified by the government of South Sudan. ▪ UNSC 1325 domestication	
4. What are the challenges and constraints to attaining the HLM target? ▪ Gender analysis not adequate in all sectors/same situation persists ▪ Socio-cultural context, low literacy/same ▪ Statutory Laws not implemented/same ▪ Contradiction between Statutory and Customary Laws/persist;	

5. Is the Country on track (or not) to attain the HLM target? ▪ No, but making progress;
6. What programmatic actions are needed to stay on course/track of reach the target? ▪ Develop costed and resourced plan of action on women, girls, gender equality and HIV for planning and budgeting ▪ Generate data to monitor situation and track progress ▪ Implement Gender Policy and Strategic Plan/yet to be done
7. What Policy/ enabling environment changes are necessary to stay on course/track or reach the target? ▪ Develop and implement Family Law and GBV Policy/critical ▪ Mainstream gender (and HIV) in existing policies and programs/problematic
8. What new investments are necessary to stay on course/track or reach the target? ▪ Develop and implement a resource mobilization strategy/developed ▪ Capacity building for implementation of Agenda for Accelerated Country Action for Women and Girls (AACA), Gender Policy, GBV Policy ▪ Advocacy and awareness creation among leadership and
9. What should be done / recommendations to ensure that the actions/changes needed are implemented? ▪ To ensure more engagement at policy level and community levels ▪ HIV to be prioritized across all development sectors ▪ Awareness and advocacy through media ▪ Identify Champions for HIV response
10. What are the recommendations to ensure that the progress is sustained beyond 2015? ▪ Government ownership and domestic financing ▪ Mutual accountability among all partners including communities ▪ Create database and indicators for monitoring and evaluation

3.2.8 Target 8: ELIMINATE STIGMA AND DISCRIMINATION

Review Questions	Performance, current status and proposed strategic actions, new investments and changes in policy & other enabling environment.
1. Is this a priority target for South Sudan? ▪ Yes	
2. Does the NSP address this target t? How aligned to the HLM commitments is the National Response Programming as illustrated by the NSP? ▪ Yes through BCC interventions/same	
3. What actions, investments have been undertaken towards the HLM target and what progress (achievements) has been made? ▪ Targeted Behavior Change Communications (BCC) programmes/ campaigns including the champions initiative/needed; ▪ Formation of Sudan Network of People Living with HIV (SSNeP+),	
4. What are the challenges and constraints to attaining the HLM target? ▪ Stigma Index not available/same; ▪ Low knowledge on HIV/same; ▪ Attitudes and socio-cultural practices	
5. Is the Country on track (or not) to attain the HLM target? ▪ No/same;	
6. What programmatic actions are needed to stay on course/track of reach the target? ▪ Conduct stigma index study/not yet conducted; ▪ BCC based on evidence (Stigma Index). No, but stigma is very high and obvious; ▪ Strengthen capacity of PLHIV to advocate for their rights/needed;	
7. What Policy/ enabling environment changes are necessary to stay on course/track or reach the target?	

▪ Develop HIV Policy (to also address stigma and discrimination)/on- going since 2007; ▪ Develop South Sudan Workplace Policy/not yet; ▪ Mainstreaming HIV into sectors and programs (internal and external)/ongoing;
8. What new investments are necessary to stay on course/track or reach the target? ▪ Resource mobilization strategy/resource being mobilized but not aware of strategy development for the same; ▪ Advocacy and capacity building/continuous;
9. What should be done / recommendations to ensure that the actions/changes needed are implemented? ▪ HIV to be prioritized across all development sectors ▪ Awareness and advocacy through media/attempts being made, media trainings taking place; ▪ Identify Champions for HIV response/ongoing;
10. What are the recommendations to ensure that the progress is sustained beyond 2015? ▪ Government ownership and domestic financing/imperative; ▪ Mutual accountability among all partners including communities/necessary; ▪ SSAC to Create database and indicators for monitoring and evaluation/extremely important and urgent.

3.2.9 TARGET 9: ELIMINATE HIV RELATED TRAVEL RESTRICTIONS

South Sudan has written document inform of government resolution stating no travel restriction of any form whatsoever on people living with HIV and AIDS be it a South Sudanese citizen or foreign citizen travelling from and to the Country.

Review Questions	Performance, current status and proposed strategic actions, new investments and changes in policy & other enabling environment.
1. Is this a priority target for South Sudan? ▪ No	
2.Does the NSP address this target? How aligned to the HLM commitments is the National Response Programming as illustrated by the NSP? ▪ No	
3. What actions, investments have been undertaken towards the HLM target and what progress (achievements) has been made? ▪ The Republic of South Sudan does not impose any travel restrictions whatsoever on PLHIV .	
4. What are the challenges and constraints to attaining the HLM target? ▪ Government of the Republic of South Sudan issued a resolution to reaffirm no travel restrictions whatsoever on PLHIV	
5. Is the Country on track (or not) to attain the HLM target? ▪ No challenges being faced so far.	
6. What programmatic actions are needed to stay on course/track of reach the target? ▪ Yes	
▪ 8	
7. What new investments are necessary to stay on course/track or reach the target? ▪ Update the draft HIV and AIDS National Policy to incorporate the no restriction on PLHIV resolution	
9. What should be done / recommendations to ensure that the actions/changes needed are implemented? ▪ Sensitize immigration officials on the no-travel restriction resolution ▪ Sensitize PLHIV on HIV and AIDS National Policy	
10. What are the recommendations to ensure that the progress is sustained beyond 2015? ▪ Advocate for and implement the National HIV and AIDS policy	

3.2.10 TARGET 10: STRENGTHEN HIV INTEGRATION

Key Tracking Indicators Focus:

The HLM commitment is to eliminate parallel systems in HIV services as part of integration of AIDS response in Global Health and development efforts. The integration of HIV was assessed from the perspective of increased intra HIV & AIDS response coordination, linkages and synchronization of related services and mainstreaming into existing institutional set up and programming framework.

South Sudan has not collected data to track this indicator and should be included when a national population based survey is undertaken.

Table 12: Tracking Indicator for target 10

	Available Data			NSP Targets
Key Tracking Indicators	**Value and Year 2011**	**Value and Year 2012**	**Value and Year 2013**	
The indicators provided by the UNAIDS GARPR below are not adequate indicators to track this progress				
UNAIDS GARPR 2013: Current school attendance among orphans and non-orphans aged 10–14*				
UNAIDS GARPR 2013: Proportion of the poorest households who received external economic support in the last 3 months	Not relevant indicator??			

Review Questions	Performance, current status and proposed strategic actions, new investments and changes in policy & other enabling environment.
1. Is this a priority target for South Sudan? ▪ Yes	
2. Does the NSP address this target t? How aligned to the HLM commitments is the National Response Programming as illustrated by the NSP? ▪ Yes ▪ As part of Enabling environment, the NSP focuses on HIV/AIDS Mainstreaming and enhanced coordination to reduce parallel HIV services/ actions	
3. What actions, investments have been undertaken towards the HLM target and what progress (achievements) has been made? ▪ Development and implementation of service delivery protocols and guidelines that promote service integration is between prevention services like HIV community and institutional level mobilization and sensitization, HCT, ANC and PMTCT and ART. ▪ Development of national HIV and AIDS coordination guidelines in 2010/2011/continuous refinement of NSP II; ▪ Development and implementation of Multi-sectoral National Strategic Plan (NSP- 2013-2017) and 2 year Operational plans/ Workplans/ongoing although completed;. ▪ Structures to coordinate the response to HIV have been established at the national level and in all 10 states. A stakeholders' forum bringing together all stakeholders is held at national and state levels. SSAC has also established structures to coordinate civil society organizations which include South Sudan HIV/AIDS NGOs Network (SSHAN), South Sudan HIV/AIDS Interfaith Network (SSHIN) and South Sudan Network of People Living positively (SSNeP+)/structures are in place;. ▪ HIV/AIDS Interventions are mainstreamed/integrated in strategic/ investment and plans and core programmes of implementing agencies in different sectors —Government Ministries, Departments and Agencies (MDAs) such as Health, Education, Youth and Culture, Gender, Agriculture, Interior and Defense at National; State, Counties levels;	

development partners and NGOs country strategies and programmes; formation of multi-sectoral working groups. The multi-sectoral HIV technical working groups/ongoing process; ▪ National AIDS bill was reviewed with support of SSAC to the National parliament and passed into law by enacting the "National AIDS Act". ▪ SSAC and Directorate of HIV/AIDS in the Ministry of Health MOH) has decentralized HIV/AIDS coordinating/ implementing structures at the State and County levels/still unaccomplished;	
4. What are the challenges and constraints to attaining the HLM target? ▪ Weak leadership and political commitment to the HIV response in some sectors, at state and county levels. Some line ministries have not appointed focal persons while, of those focal persons in place, not all are active. 80% of the states have operationalized the HIV coordination structures/same; ▪ A system to comprehensively track all actors implementing HIV activities at the national and state levels is not yet in place. A mechanism to know and track who is doing what and where is not yet in place/ a must, but not yet in place;. ▪ Structures to coordinate the response to HIV are relatively weak at the lower structures of the government due to inadequate financial and qualified human resources/situation same;	
5. Is the Country on track (or not) to attain the HLM target?	▪ Yes, but doubtful due to the non progress so far;
6. What programmatic actions are needed to stay on course/track of reach the target? ▪ Develop HIV/AIDS Planning guidelines (including: Strategic, Operational, sectoral, decentralized and community level for public, development partners, NGO and private actors)/some have been developed, and others in progress of being developed; ▪ Strengthen the functioning of the National HIV and AIDS Partnership forum and coordination and tools and the decentralization of AIDS response and improve functioning of AIDS committees as part of the state and county structures/not smooth, some hiccups being experienced; ▪ Build capacity of public and non public sector implementing organizations to internally and externally mainstream HIV/AIDS in their work/being considered and in progress;	
7. What Policy/ enabling environment changes are necessary to stay on course/track or reach the target? ▪ Disseminate the newly enacted "National AIDS Act"/there is no act enacted yet ready for dissemination; ▪ Development and implementation of integrated HIV & AIDS Workplans at overall national level multi-national level sectoral; Self Coordinating Entities (SCE) (ie CSO, Faith Based, PLHIV network, Research institutions); State and Counties. ▪ Develop funding and monitoring/appraisal guidelines underpinned by/ using mainstreaming principle in support of the NSP/ongoing;	
8. What new investments are necessary to stay on course/track or reach the target? ▪ Strengthen institutional and human resources capacity of SSAC and MOH at all levels/ongoing but problematic due to high turnover; ▪ Implement the coordination guidelines developed ▪ Develop resource mobilization strategy to fully support implementation and sustainability of HIV and AIDS services/ongoing;	
9. What should be done / recommendations to ensure that the actions/changes needed are implemented? ▪ Strengthen the national HIV and AIDS partnership forum/needed;	
10.. What are the recommendations to ensure that the progress is sustained beyond 2015? ▪ Ensure pragmatic and policy backed mainstreaming/policy need to be in place;	

3.2.11 HIV and CRISIS in South Sudan

A deadly surge of violence in South Sudan resulted in massive population displacement, leaving tens of thousands in dire need of emergency medical care. Thus, the UNAIDS is concerned about the dire situation faced by the growing Sudanese refugee population in IDP camps/clusters inside the country. The UNJP remains deeply committed to meeting the humanitarian needs of the people of South Sudan, and urge the international community and other stakeholders to join in the efforts to curtail the imminent

deterioration of the HIV and AIDS situation in the country and assist those infected and affected by HIV and AIDS amidst the on-going violence.

It is now known that an estimated almost 1,000,000 (almost 10% of the entire population) people are displaced inside South Sudan, with the largest increase in Unity State. Another 123,400 people have fled to neighboring countries (Red Cross South Sudan, 2014).

Clashes were reported in Jonglei[31], Lakes and Unity states, with displacement increasing in Koch and Leer counties. These numbers continue to increase by day and week in spite of the a cessation of hostilities agreement which was signed for South Sudan, unrest in southern Unity state has forced thousands to flee into the bush[32]. As we understand it, this situation of uncertainty may continue for unpredictable period of time and may go on for months and years before the situation is resolved.

People displaced are hosted in over 100 locations, with 18 sites hosting over 10,000 people each. Aid organizations have assisted nearly 300,000 people so far; the majority outside UN bases in rural areas.The needs is already dire. So far, just 302,500 of the internally displaced — fewer than half of the total — have been reached by some assistance and mostly HIV not included.

Achievements in addressing HIV in humanitarian and IDP poplations

- HIV strategy for humanitarian population has been developed;
- Seed funding to the sum of around 300,000 USD mobilized to cater for HIV services for the IDP populations;
- IEC materials developed and disseminated to key actors in the IDP locations and humanitarian populations;
- Several assessments have been undertaken to determine the needs of the humanitarian and IDP populations.

Recommendation:

- Improve coordination and leadership of HIV in Emergencies;
- Undertake needs assessments, information management, monitoring and evaluation around HIV and AIDS in the IDP and humanitarian populations;
- Improve funding base for HIV interventions in Emergencies.

[31]

[32]International medical aid group Doctors Without Borders (MSF)

CONCLUSION:

Accelerated way forward: 2013-2015 and beyond the government of South Sudan continues to demonstrate strong commitment to the national AIDS response. The current National Strategic Plan on HIV and AIDS (NSP 2013-2017) describes the national response under the stewardship of the government of the Republic of South Sudan and stipulates strategic directions and action on how the unique challenges that HIV and AIDS pose to the welfare of the South Sudanese population will be addressed.

Implementation of the recommended key actions, investments, policy and other enabling changes is paramount. The South Sudan HIV/AIDS National Strategic Plan is guided by the HLM commitments and targets and has set matching inspiring targets.

4. BEST PRACTICES

4.1 Introduction

The purpose of this section is to share lessons learned from one or more of the key areas such as political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation; capacity building; and infrastructure development in the South Sudan HIV and AIDS prevention and control environment.

4.2 Best Practices

4.2.1 National strategic plan II (2013 – 2017) developed. The current strategy is much improved in relation to the NSP I (2008 – 2012) both in scope and content.

The NSP development process was aligned to the HLM targets for 2015, South Sudan Development plan and the National Heath sector strategy and Policy. Key interventions in the current NSP have been added to include male circumcision (VMMC). Medical male circumcision reduces the risk of female-to-male sexual transmission of HIV by approximately 60%. A one-time intervention, medical male circumcision provides men life-long partial protection against HIV as well as other sexually transmitted infections. It should always be considered as part of a comprehensive HIV prevention package of services and be used in conjunction with other methods of prevention, such as female and male condoms. Other populations of concern added to the SSNSP II include cross boarder mobile populations, men who have sex with men and Population of Humanitarian Concern. Priorities and goals of the NSP have been reduced so as to be more focused and effective. It is now more evidence informed through utilization of epidemiological analysis and key informants. Components of Health Systems Strengthening and Community Systems Strengthening have been introduced and civil society was involved during consultative meetings and validation of the National strategic Plan (NSP), NSP Operational Plan and National Strategic Information (SIP).

4.2.2 Identification of specific needs for HIV prevention programmes

A number of critical assessments and studies have been carried out through which specific needs have come to fore requiring urgent inclusion into the strategic plans. The country has conducted sex workers mapping which has clarified on the magnitude of the problem and geographic locations in the country and habitat these are operational.

The mode of transmission study (MOT) has provided the estimation of HIV incidence and of mixed types of categories of groups including uniformed personnel, migrant population, Boda Boda. All these are clients of FSWs. Casual heterosexual sex (CHS) group and MSM together with SW are the key drivers of HIV in Sudan. Gender assessment and the national AIDS spending assessment (NASA) was carried out for the first time in South Sudan late 2013 and identified that more than 90% of the HIV and AIDS strategic plan was being funded from international sources and also provided expenditures by programme.

Health services have scaled up in terms of quality and number of facilities/sites (PMTCT, ART, ANC, HCT), human resource have been trained and more health worker providers have been allocated to various sites, equipment procured and the chain management and logistics for commodities supply have improved through better warehouses constructed and equipped with good cold chain facilities, well coordinated distribution mechanism for commodities are in place; improved monitoring and quantifications of commodities has also been realized.

4.2.3 Strengthening of health systems

South Sudan faces a severe shortage of all categories of trained HRH professionals, including physicians (1 per 65,574 populations) and midwives (1 per 39,088 populations). Due to these severe shortages in HRH, the country relies on inadequately trained or low skilled health workers. There is also an inequitable distribution of health workers both among the states, with Central Equatoria having the highest number of health workers, and between urban and rural areas, where the majority of the population lives (Health Strategic Plan (2011-2015) Government of South Sudan Ministry of Health).

In the face of these difficulties, achievements have been made by the MoH, including:

- Creation of a Health Sector Development Plan (2011-2015) that emphasizes HRH as a determinant of all 3 of the Plan's objectives
- A Strategic Plan for Human Resources for Health 2007-2017
- A draft national HRH policy 2011-2015
- A Basic Packages for Health plan (draft).

Several HRH-specific projects also have been implemented during the past 2 years with the support of partners. Achievements include: the establishment of the Juba College of Nursing and Midwifery; creation of an HRH information system; the rehabilitation of health care training schools; and review of health care curriculum.

Currently South Sudan has on-going participation in the CCF phases 1 to 3. NGOs, both international and faith-based, comprise the majority of the health care employers. They are also the primary stakeholders involved in the CCF process.

Through the catalytic support of the Alliance, the Republic of South Sudan has been able to expand the capacity and membership of its HRH committee, and conducted a new workshop of stakeholders on the CCF process that included participants from: the MoH; stakeholders; and for the first time, representatives from the 10 states including the Ministries of education, civil services, and training institutions.

The HRH situation analysis was made and the stakeholders provided inputs on the draft HRH policy, a draft Strategic Plan, and the 2012 operational plan, all linked with the health sector development plan.

5. MAJOR CHALLENGES

5.1 Introduction

This section presents the challenges submitted in the 2012 report and reports on the progress made regarding the identified challenges. Challenges encountered in the current reporting period and proposed remedial actions to address the challenges are also captured.

	TARGETS	PROGRESS, CHALLENGES AND REMEDIAL ACTIONS
	Target 1. Reduce sexual transmission of HIV by 50% by 2015 CHALLENGES: • Not much data for 2013 • Lack of baseline data for tracking progress • Unclear reporting frame work (timeliness, data flow from bottom to top) • Un harmonized data collection tools (different reporting tools exist, no specific tools to capture community activities) • Short fall in funding • High levels of cultural misconceptions in the communities • Low capacity in reporting data at various levels • Stock out of HCT test kits • Limited access to HCT sites (some sites closed up or nonexistence) • High levels of insecurity driving many populations into IDP camps/refugees settings • Poor road infrastructures limiting access to health facilities • Lack of storage facilities at state levels • Limited use of media houses to disseminate HIV basic information • Low level of knowledge or misconceptions on condom use among clients of sex workers • Limited access to HCT services by sex workers • Low level of knowledge on use of female condoms	

	• There is no coordination with the private sector on HIV interventions REMEDIAL ACTIONS: In Africa, including South Sudan, HIV is mainly transmitted through heterosexual sex. The GOSS from the highest political levels, should take urgent action to provide education and services to prevent the transmission of all forms of sexually transmitted diseases and HIV • SSAC to consult with MoH and provide data for 2013 and regularize reporting of data • MOH/SSAC to conduct regular baseline data for tracking progress • MoH/SSAC/partners to harmonize reporting frame work (timeliness, data flow from bottom to top) • Standardize data collection tools (different reporting tools exist, no specific tools to capture community activities) • Need for domestic and donor long term funding into HIV interventions • Partners to scale up community awareness campaigns • Need for training staff on reporting of HIV data at various levels • MoH/SSAC to forecast testing supplies • Scale up integration of HCT services • There is need for MoH to provide adequate storage facilities at state level • MoH/SSAC/partners High level of involvement of media houses to disseminate HIV basic information • Need for partners to scale up targeted outreach HCT services for sex workers • Partners to scale targeted awareness campaigns at all levels • MoH to foster a strong coordination with the private sector on all HIV interventions
2.	**Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015** N/A
3.	**Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce** CHALLENGES: Major challenges for this target in South Sudan are: • High turnover of health care providers • Limited funding • Inadequate supervision • Loss to follow up • Very low coverage • Inadequate level of integration of HIV/AIDS services into PHC • Irregular supplies of HIV commodities • Stigma and discrimination ▪ Lack of support (family, etc) .REMEDIAL ACTIONS: • Increase the number of PMTCT sites • Integrate PMTCT in all aspects of PHC • Train more health workers on PMTCT and Integrate PMTCT into all health trainings • Organize and strengthen mother to mother support networks • Improve support supervision
4.	**Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015**

	CHALLENGES: The major challenge in regard to this specific target as to all other targets is financial and human resource required for implementing a scaled up strategy for the achievement of the UNGASS commitments and declaration. Other challenges include: • Lack of finances to meet transport costs to and from health facilities; • Stigma very serious impediment from the community; • Frequent drug stock outs in health facilities; • ARV related side effects; • Long distance from health facilities; • Very acute shortage of trained health workers in South Sudan to offer treatment, care and support to PLHIV. • Patient provider ration still unacceptably very high; • Lack of home-based support to continues to be critical barrier to retention and adherence in ART programmes and, • Heavy alcohol consumption by some patients. REMEDIAL ACTIONS: Need to find a feasible follow up system in the context of South Sudan. Most PLWHIV who are receiving ART are lost to follow up and deaths. Other remedial actions are: Strengthening the ARV drug stocks and logistics supply chain management in order to off-set shortages and stock outs caused by the inefficiencies of the National Medical stores. • The development of human resource capacity for health in their catchment areas • Increased community engagement and expansion of training and deployment and motivation of community health workers. • Intensifying strategies to fight stigma and discrimination at all levels • Improvement of health care infrastructure & equipment; and • Provision of electronic systems for data management at health unit level.
5.	**Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015** CHALLENGES: • Increasing number of women living with HIV, especially women under theage of 24, are becoming ill with TB • Discrimination against people with HIV/AIDS • Economic impact of HIV/AIDS and Cost of HIV treatment • HIV/AIDS denialism • Media portrayal of HIV/AIDS • Accessing the slums and informal settlements to captured these populations in health statistics that define disease epidemiology but not reached; • Inequity of opportunities to access slum and informal settlement dwellers equal to the rest of the population to access proven intervention; • Growing international attention to the plight of slum dwellers and informal settlers; • Structural and intermediate determinants of poor health in these settings, require broad and integrated interventions that address the underlying causes of inequity that result in poorer health and worse health outcomes for the urban poor who make the majority of the population that is infected with the two diseases. REMEDIAL ACTIONS: Prevention of HIV is the prevention of TB. Remedial actions needed are: • **Make health services more widely available.** • Screening programmes should provide testing for both infections to everyone in the population every three years. • All people who test positive for HIV and are also found to have TB should start TB treatment immediately while those who do not have active TB should begin ART. • People living with HIV who are routinely exposed to TB should be protected against becoming ill with TB by providing cheap and simple protection —a daily dose of isoniazid.

	• People living with HIV should receive ART as soon as blood tests show their positive HIV status; • HIV control and prevention needs bold political leadership to integrate HIV and TB services at every level of the health system and carefully develop and fully fund plans; • Need for good systems for quickly tracking the numbers of people living with HIV who are becoming ill with TB, as an important step to improving programmes. • Take measures to reduce TB exposure in places where people living with HIV may be concentrated, such as clinics, hospital wards and prisons; • Provide couples HIV counseling and testing and ART for discordant HIV status; • TB cases detected amongpeople living with HIV • New child-friendly diagnostic methods and treatment regimens are urgently needed.
6.	**Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22–24 billion in low- and middle-income countries** CHALLENGES: Competing needs and priorities ensure that GOSS is thinly spread on the ground where no sufficient financial resource is invested on the HIV programme. REMEDIAL ACTIONS: Increase the current public spending on HIV programme to about 45% or above as a top priority to ensure the achievement of the global commitments and UNGASS declaration.
7.	**Target 7: Eliminating gender inequalities** CHALLENGES: Funding and implementing of the gender strategy and plans is paramount as there are signs that this area requires urgent attention of the programme. Major challenges in South Sudan include: ▪ Limited funding ▪ Inadequate number of trained personnel ▪ Its new and not rolled country wide (Its still a pilot project) ▪ Limited technical knowhow on how to develop this initiative ▪ Only a pilot project targeting the PLHIV in four states (WBG, Equatoria) ▪ Volunteers without incentives ▪ Not sustainable ▪ In adequate number trained ▪ Poor quality of services ▪ Traveling of long distances to attend meetings by members. ▪ Traveling of long distances to attend meetings by members. ▪ Disparities/Doctrines within the FBO REMEDIAL ACTIONS: • Widening scope of understanding about gender by all actors • Advocate for equitable distribution of resources. • Gender responsive budgeting • Training of the uniformed forces in gender issues • Training of para legals in gender • Sensitization of community leaders • Training of staff • Institutional capacity strengthening • Strengthen gender machinery • Enabling working environment

8.	**Target 8: Eliminating stigma and discrimination** CHALLENGES: ▪ Limited funding ▪ Inadequate number of trained personnel ▪ Its new and not rolled country wide (Its still a pilot phase) ▪ Limited technical knowhow on how to develop this initiative ▪ Only a pilot project targeting the PLHIV in four states (WBG, Equatoria) ▪ Volunteers without incentives ▪ Not sustainable ▪ In adequate number trained ▪ Poor quality of services ▪ Traveling of long distances to attend meetings by members. ▪ Disparities/Doctrines within the FBO REMEDIAL ACTIONS: ▪ Follow up to complete this process ▪ Advocate for funding ▪ Need to train more ▪ Strengthen capacity ▪ Adopt it country wide ▪ Roll it out national wide ▪ Continued funding and training to ensure sustainability ▪ Provide motivational support ▪ Train more community counselors ▪ Harmonization of doctrines, cultures
9.	**Target 9: Eliminate Travel restrictions** N/A
10.	**Target 10: Strengthening HIV integration** **Integrating HIV Services into Community-based FP Programs** CHALLENGES: • Community-based FP workers could have limited backgrounds in HIV services, thus requiring additional training, monitoring, and supervision to provide HIV counseling and communicate with clients about dual method use and dual protection when discussing condoms. • Integrating services adds time to an already full schedule REMEDIAL ACTIONS: • Integrate HIV services to leverage existing community FP services (for example, community- based promoters and distributors) to add HIV counseling and referrals; • Ensure that community-based FP workers already provide some information on HIV, AIDS, and STIs; • Integrate HIV services to provide the opportunity to promote correct and consistent condom use for dual protection against HIV/STI infection and unintended pregnancy; • Integrate services to addthe opportunity for HIV prevention counseling for women of reproductive age, including married women who might underestimate their risk of HIV; and • Uptake of HIV services, particularly CT services, among FP clients are likely to increase.

6. SUPPORT FROM DEVELOPING PARTNERS

6.1 Introduction

The multi-sectoral nature of the epidemic requires all relevant stakeholders to make their fair share of the contribution towards the fight against the epidemic. South Sudan just emerged out of a long protracted civil war and requires massive assistance as it there is a plethora of competing priorities for the nascent state. Even though South Sudan government has resources from its oil revenues, development partners are important players in the national response to the HIV and AIDS epidemic against competing humanitarian and peace building interventions. Partners supporting HIV and AIDS response in South Sudan include PEPFAR, UNJT, Global Fund, International and National NGOs with Faith Based organizations, private sector and regional initiatives among them IGAD and .

The table below provides the summary of the support from the development partners to the national response in South Sudan.

Development Partners and Support to the National Response in South Sudan

The South Sudan medical programs and HIV and AIDS programs have received number of donors funding and the following have been the main ones:

6.1.1 World Bank – through the **Multi-Donor Trust Fund** (contributions from more than 12 countries including the European Union) to support the HIV/AIDS component. Funds were provided to support the SSAC infrastructure and some of its activities.

6.1.2 Global Fund - Fight AIDS, Tuberculosis and Malaria (GFATM)

GFATM implemented by its principal recipient the United Nations Development Programme (UNDP) has been the main funder of HIV programs in South Sudan since the initial Round 4 award in 2006 and has been the only funder for HIV treatment drugs.

6.1.3 United States Government (USAID/ CDC/PEPFAR/DOD)

The United States Government has been a substantial funder of HIV/AIDS programmes in South Sudan, Ministry of Health, South Sudan HIV/AIDS Commission and to the military (SPLA). One of the USG project funded through USAID was the "South Sudan HIV/AIDS Project" which was five year project and initially implemented by FHI and later by PSI, the International HIV/AIDS Alliance and Howard University. Another PEPFAR project was the Roads Project which ran until 2009 and was an attempt to develop HIV outreach activities through other development strategies. PEPFAR continues to fund numerous projects and programmes in South Sudan. Existing PEPFAR projects are described in the South Sudan Country Operational Plan 2011 and 2012 reports, which illustrates the various programs, planned activities, implementing partners as well as their funding agencies from three state agencies (DOD, CDC and USAID).

6.1.4 IGAD – the Regional IGAD group has funding projects on cross-border and mobile populations as well as the IRAP Project on HIV/AIDS related issues.

6.1.5 UNICEF, WHO, UNFPA, UNAIDS, UNMIS, IOM have been involved as donors, implementing partners, oversight and technical support provision in numerous projects and HIV and AIDS activities in the country. The UN through the Joint Team on AIDS supports the government

initiate on the AIDS response through provision of funding and technical assistance and capacity building for scaling up of HIV/AIDS services. Recent outputs from this support include guidelines for PMTCT and ART together with their scale up plans, strategic information analysis and use as well resource mobilization initiatives.

One significant achievement of the South Sudan HIV and AIDS response actors has been successful in mobilizing both local and International Civil Societies Organizations (CSO) which have in turn mobilized a number of Community Based Organisation (CBOs) into the National HIV response. Some CSOs which have been playing significant roles are the International HIV/AIDS Alliance, Merlin, IntraHealth International, CAFOD, CMMB, ICAP, Help Age International, Family Health International, Population Services International (PSI) to mention a few.

SSAC coordinated the process of setting up a number of HIV/AIDS NGOs networks such as the Southern Sudan HIV/AIDS NGOs Network (SSHAN) and the Southern Sudan Interfaith HIV/AIDS network (SSIHAN) and CBOs like Widows Orphans and People Living with HIV/AIDS (WOPHA) and many others.

RSS has received six HIV/AIDS GFATM grants on behalf of the people and Government of Southern Sudan, with Round 2 TB (SUD-202-G02-T) and Round 2 Malaria (SUD-202-G01-M) which ended in March 2010. There are four active grants; Round 4 HIV/AIDS (SUD-405-G05-H); Round 5 TB/HIV (SUD-506-G06-T); Round 7 TB (SUD-708-G11-T); and Round 9 Health Systems Strengthening (SUD-910-G13-S), which were officially signed in September 2010. The first three grants are focused on the delivery of health services, the recently signed HSS grant is focused on supporting an integrated approach to health systems delivery and the construction and renovation of health facilities to ensure access to health services. The HSS provides an opportunity to enhance institutional capacity and delivery of basic health services in Southern Sudan. The grants are being implemented by UNICEF, WHO, SSAC and PSI, and are targeting "Soldiers, sex workers, returnees, IDPs, transporters, cattle traders, unaccompanied children, female and child headed households, PLWHA, Youth, and children in and out of school."[33]

Round 4 HIV/AIDS (SUD-405-G05-H) amounting to US$ 26,935,365 was the main grant for HIV Prevention and Treatment commenced on 1 August 2006. This funding has been utilized to scale up the national response for HIV prevention and treatment, treatment and care services, strengthening the SSAC and BCC strategies in prevention.

The overall goal of the funding was to halt and begin to reverse the spread of HIVIAIDS in the Southern Sector of Sudan by 2015by reducing HIVIAIDS transmission, reduce morbidity and mortality and minimizing the personal and societal impacts HIV/AIDS.

The main activities which would be undertaken by the program were expected to have the following impacts and outcomes:

- Reduction in HIV prevalence among the adult population (ages 15 - 49);
- Reduction in the proportion of HIV infection among young people (ages 15 - 24);
- Reduction in HIV infection among MARPs;
- Reduction in HIV-infected infants born to HIV-infected mothers;

[33] . UNDP: 2010 Annual Report Global Fund Grants in Southern Sudan

- Increase in the proportion of young people aged reporting the use of condoms during sexual intercourse;
- Increase in proportion of high risk groups that have adopted safe behavior; and
- Increase in adherence to HIV treatment

The program targeted high risk and vulnerable groups comprising female sex workers, internally displaced persons, military personnel and truck drivers; People living with HIV/AIDS; and the general population at risk of HIVIAIDS.

The main programming strategies planned were Behavioral change communication through mass media, community outreach programs, youth education and prevention, programs for specific groups, counseling and testing, and STI diagnosis and treatment; treatment, care and support services comprising prevention of mother to child transmission, antiretroviral treatment and monitoring, blood safety and universal precautions; and strengthening the capacity of national institutions in monitoring and evaluation through operations research, procurement and supply management capacity building.

Due to some initial challenges, the program experienced a very slow start and received a one year extension due to security and fund management issues. However, once these issues were resolved the program was able to accelerate implementation and at the time of Phase 2 review the program is demonstrating satisfactory results overall. The program reported good progress in its Behaviour change program, HIV education out of school youth, ARV treatment, HIV counseling and testing and treatment for STI's.

Some achievements with GFATM support[34]

MoH has develop standardized reporting tools and systems, which led to the development of a PMTCT and HCT database at MoH. This data has been useful in decision making on services and program improvement. The support has enabled coordination meeting and activities to improved implementation, management and achievement of results. Through this coordination support partners have been able to scale up HIV testing services through outreach provision and intensified community mobilization activities.

Life Skills Based Education was successfully introduced in schools. Activities have comprised entertainment, sports, and peer education activities have served as vehicles for disseminating information and increasing access to condoms. Round 4 HIV/AIDS has contributed to the strengthening of SSAC at GoSS and state level through the provision of financial and technical support to monitor and coordinate HIV activities in the states on quarterly basis. ART services have been expanded to 7 of the 10 states of Southern Sudan and have increased access to ART services for PLWHA. By the end of 2010, 7 new ART sites were opened in Mapuordit and Rumbek (Lakes state), Yambio and Maridi (WES) Torit and Kapoeta (EES) and Bor in Jonglei state respectively. The budgeting lines submitted and approved for funding are showed on Table 4.4 below.

Global Fund Grant SUD-405-G05-H submitted budget lines

PROGRAMS	Year 3	Year 4	Year 5	Total
Prevention				
BCC- Mass media	987,881	405,077	363,614	**1,756,572**

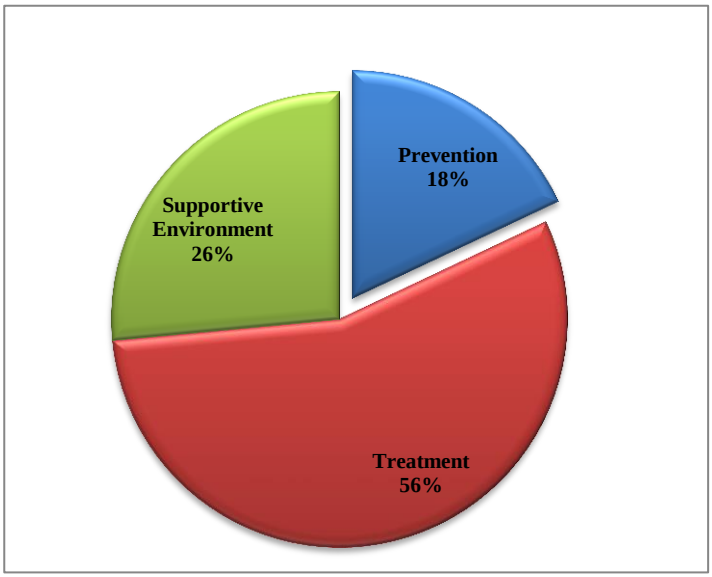
[34] . UNDP: 2010 Annual Report Global Fund Grants in Southern Sudan

Youth Education	87,978	81,734	92,893	**261,705**
Programs for specific groups	86,756	86,756	74,128	**247,640**
Counseling and testing	443,248	357,469	357,469	**1,158,206**
STI diagnosis and treatment	130,766	133,067	133,107	**396,940**
Treatment				
ARV Treatment and medication	2,609,853	3,121,431	3,752,611	**9,483,895**
Blood safety and universal precaution	571,032	296,014	338,901	**1,205,947**
Supportive environment				
M&E	570,773	514,174	600,394	**1,685,341**
Procurement and supplies	106,632	83,718	88,464	**278,814**
Management and administration	1,078,339	1,014,218	1,043,368	**3,135,924**
Total	**6,673,258**	**6,093,658**	**6,487,480**	**19,254,396**

Source: Program grant agreement between GFATM and UNDP SUD-405-G05-H modification 4 (Phase 2 Amendment)

Figure 12 gives an indication of the distribution of funding in the three programmatic categories as requested by GOSS in 2006. At the time GOSS allocated bulk of its funding request (56%) to supporting treatment programs, 26% to the provision of supportive environment and only 18% to Prevention programs.

Global Fund GFATM HIV FUNDING



6.1.7 United States Government HIV Funding through PEPFAR

The PEPFAR program began in Sudan in 2006, after the signing of the Comprehensive Peace Agreement (CPA). The PEPFAR Sudan country team engaged the GoSS Ministry of Health in planning and implementation of its HIV/AIDS strategy and activities, ensuring alignment of the PEPFAR program with the MoH's activities. Through DOD and it two sister agencies of USAID and CDC, PEPFAR Sudan has been working with other civil society partners provision of targeted HIV prevention services, care and support services, health and welfare of HIV+ patients, technical support in developing national strategic policies and guidance documents, provision of support for

HIV surveillance and laboratory services. Recently, PEPFAR Sudan was instrumental in helping to design and develop a National Medical Laboratory Policy and Strategic Plan (NLP & NSP) with the MoH.

In its 2011 Country Operational Plan (COP), PEPFAR planned to strengthen coordination with GoSS, support technical working groups and participate the Global Fund's Country Coordinating Mechanism (CCM). Among its programs were plans to develop GOSS individual, scientific, technological, organizational, and institutional capacity. PEPFAR Sudan programmes have shown significant success attributable to its ability to work as a coordinated team across USG agencies, GOSS institutions, with other International organizations and implementing partners. In recognition for strong interagency and donor coordination and ability for effective response, PEPFAR Sudan received the Major Joe Haydon award from OGAC in 2010.

In 2011 through its Country Operational Plan (COP)[35], PEPFAR South Sudan set aside funding to support the GoSS in six key areas:

1. Prevention
   Reduce the number of new infections by focusing prevention efforts on MARPs (PLHIV, discordant couples, commercial sex workers and their clients and partners, long distance truckers, returning refugees and members of the uniformed services); and activities to support prevention of mother-to-child transmission (PMTCT) services. Additionally prevention programs will also include Abstinence/Be Faithful in IEC/BCC strategy increased awareness of HIV/AIDS and sexually transmitted infections (STIs), VCT including risk-reduction counseling, reduced stigma and discrimination, use of support services, promotion of positive reproductive health behaviors, emphasis on harmful male norms, and alcohol reduction, promotion of abstinence and delay of sexual debut, and multiple/concurrent partner reduction among MARPs. PEPFAR's military program planned to target education and mobilization of military commanders, military personnel and their families, demobilized soldiers, and community leaders and in and out of school youth.

2. Strategic Information and M&E.
   In alignment with SSAC/GOSS goal of strengthening evidenced-based management of national multi-sectoral HIV response at all levels (SSHASF 2008-2012)[36], PEPFAR would support GoSS efforts in understanding the HIV epidemic, including its drivers, by strengthening the capacity to collect, use, and disseminate quality data to support evidence-based decision making for policy-making, programming, and strengthening programs. This is in alignment with the SSHASF's.

3. Laboratory Systems Strengthening.
   Through provision of technical assistance and training in HIV diagnostic and clinical monitoring services and building technical and managerial capacity of personnel to provide and deliver quality laboratory services, PEPFAR will provide support to improve capacity, quality, availability of diagnostic services and systems for HIV and related opportunistic infections in South Sudan. This would include the implementation of the NLP and NSP strengthening laboratory capacity through training in procedures for performing HIV ELISA testing on dried blood spots (DBS). Through the Operational plan 2011, PEPFAR Sudan

[35]. PEPFAR Country Operational Plan Report FY 2011
[36]. National HIV/AIDS Strategic Framework (SSHASF 2008-2012)

committed to continue provision of reagents and laboratory supplies for quality assurance at HTC and PMTCT sites and work to identify and lease storage space in Juba to ease logistical challenges in management, procurement, and distribution of test kits and laboratory supplies in Southern Sudan.

4. Health Systems Strengthening
   Support health system strengthening through human resource capacity building for the achievement of quality health services at all levels, including training of new personnel, improved retention, and improved management of existing and future personnel and building GoSS institutional capacity in governance, leadership, policy, and finance through implementation of policies, guidelines, and protocols to better coordinate HIV programming in Southern Sudan

5. Community Capacity Building
   Strengthen the capacity of community-based organizations (CBOs) to provide information and services to most-at-risk populations (MARPs) and PLHIV.

6. Treatment, Care and Support.
   PEPFAR committed to support the development of two HIV ARV treatment demonstration sites for comprehensive HIV/AIDS care, treatment, and support. Additional, support was budgeted to provide ARV treatment to five PMTCT sites for demonstration of model care. Other treatment care programs comprising comprehensive clinical, preventive, and support programs were set to continue. These comprise clinical services provided to HIV+ individuals at facility, community and home settings including: initial WHO staging, prevention, diagnosis and treatment of opportunistic infections, cotrimoxazole prophylaxis, CD4 testing, and TB screening. Prevention with Positives (PwP), access to and increased consistent and correct use of condoms, HIV testing for sex partners and family members, early diagnosis and management of STIs, tuberculosis (TB) screening and treatment of HIV infected patients at the facility level, family planning and adherence to treatment through counseling and home-based visits support TB programs to include HIV testing in TB clinics, training of TB attendants in HTC, and screening and treatment of HIV patients for TB.

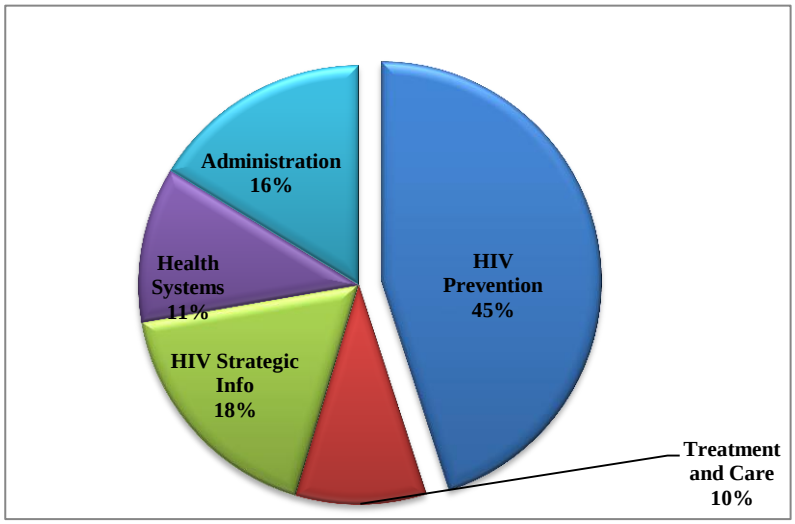
Table 22 and Figure 14 below, provides the specific amounts and the distribution budgets into various programmatic categories as described in the PEPFAR operational plan for 2011-2012. It is important to note that by allocating 45% of the budget to HIV prevention, PEPFAR is recognizing the strategic importance of prevention programming activities in managing the epidemic.

Summary of planned funding by budget and agency for the year 2011-2012.

	Agency (USD)			
	DOD	**HHS/CDC**	**USAID**	**Total (USD)**
Prevention Support				
Abstinence/Be Faithful		306,800	510,000	**816,800**
Other sexual prevention	130,000	425,200	1,513,000	**2,068,200**
Testing and counseling		1,069,900	1,164,000	**2,233,900**
PMTCT		628,900	790,000	**1,418,900**
Treatment and Care				
Adult Care and Support	60,000	659,900	490,000	**1,209,900**
Adult Treatment		0		**0**

TB/HIV	25,000	12,500	150,000	**187,500**
Monitoring				
Strategic Information	275,000	1,670,700	615,000	**2,560,700**
Infrastructure and development				
Laboratory Infrastructure	117,500	440,000		**557,500**
Health Systems Strengthening	125,000	267,600	710,000	**1,102,600**
Administration				
Management and Operations	172,800	1,226,884	965,316	**2,365,000**
TOTAL (US$)	**905,300**	**6,708,384**	**6,907,316**	**14,521,000**

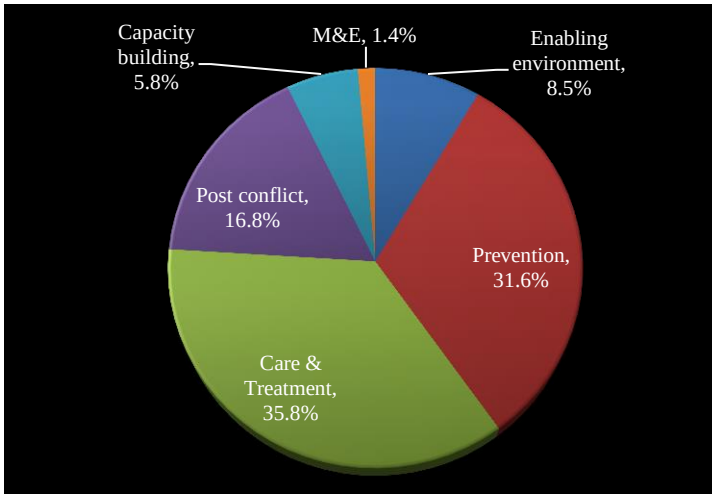
PEPFAR budgets by activity area (%)



6.1.8 SSAHSF 2008-2012 Funding Allocation

The Southern Sudan HIV and AIDS Strategic Framework 2008-2012 was based on six pillars namely Enabling environment, Prevention, Care, Treatment and Support, Capacity Building, Post Conflict and Monitoring and Evaluation. The total budget for the five years of the plan amounted to USD 656.12 million which was allocated to the various pillars as indicated in Figure 4.10 below. Bulk of the allocation went to Treatment and Care (35%), Prevention (31.6%), 8.5% and 5.8% were allocated to enabling environment and Capacity building respectively and Monitoring and evaluation received the least amount (1.4%). The funding allocation for prevention in the SSHASF budget is indicative of sufficient prioritization comparable to other programs including treatment and care program (refer to figure 4.10 below). However, given that SSHASF was the first strategic plan, developed in a context where statistical data was scarce, M&E should have been prioritized and allocated more funding.

Estimation of funding requirement for HIV and AIDS Response SSAHF 2008-2012



6.2 Challenges experienced in 2013

The 2012 UNGASS Progress Report highlighted several challenges. The current challenges and progress in this area are highlighted below:

- Over 95 % of the national response is externally funded and pose high risk in terms of sustainability of the response in the absence of the external support.
- There are frequent political and peace crisis in the country hampering continuous presence of external actors in the response;
- Development partners forum in South Sudan have not included HIV support on their standing agenda;
- Weak policy environment to allow partners provide support to interventions for some key at risk populations and modern initiatives such as VMMC;
- Limited strategic information for advocacy use with development partners as well in planning evidence informed interventions.

7. MONITORING AND EVALUATION ENVIRONMENT

7.1 Overview of Current Monitoring and Evaluation System

The routine reports generated by the Ministry of Health are the main source of data on the monitoring of the HIV and AIDS response. The MOH is in the process of developing and having a fully operational Health Information System. Progress made includes construction and equipping of M&E office blocks in states, training of health workers in District Health Information System (DHIS) software and tools and deployment of M&E specialists at central level and in four states to support the HIS.

SSAC and MOH with support from development partners achieved the following in the last one year

- Undertaking of NASA
- Carried out MOT analysis
- Assessments in prison, gender, population of humanitarian concern undertaken
- Sex workers and truck drivers mapping carried
- Strategic Information Plan for both national and health sector undertaken
- HLM and NSP reviews carried out
- Capacity building for personnel in terms of trainings in M&E;
- Revitalization of the M&E TWG
- Implementer partners mapping
- Estimates reports that include sub national estimates (SPECTRUM)

7.2 Challenges in Implementation of Monitoring & Evaluation System

The HIS still remains fragmented and not as effective as is intended. There are several parallel information systems of vertical programs and non-government partners that do not report to the national health information system.

The HMIS is not fully functioning. Data from health facilities are not always complete or very reliable. Often reporting is delayed. Disease surveillance is still at infancy. The registration of vital events (births, deaths) does not cover the whole country.

The use of data for planning at all levels (from health facilities to the national level) is limited. As a result, resources cannot be allocated to where they would be needed most. These challenges impact on the effectiveness of all programmes including HIV.

Key **challenges** in the area of monitoring and evaluation include the following:

(i) **Poor reporting**: Data for several indicators on the UNGASS are not available. M&E officers in the 10 states have difficulties collecting data due to poor communication and road networks in some of the rural settings. The linkages and coordination between national M&E units and data collection points is weak and the flow of data is not regular. Poor reporting has contributed to disintegrated and uncoordinated efforts by civil society organizations in South Sudan.

(ii) **M&E Framework has not been fully operationalized**: The failure to operationalize the M&E framework is a major hurdle. Majority of stakeholders have not been exposed to the framework nor have not used it.

(iii) progress towards performance using agreed indicators.

(iv) **Inadequate resources**: There are inadequate human and financial resources to effectively implement the HIV and AIDS national M&E system.

(v) There is **no explicit** HIV and AIDS **evaluation and research agenda**.

(vi) Limited functioning of the **decentralized M&E** structures and function

(vii) Acute lack of population based data on HIV and AIDS to improve targeting of the response.

(viii) Population based survey funding;

(ix) Key BSS for populations at risk;

(x) Partnership forum for national response to be strengthened at national and sub national level to cause reporting and data use.

7.3 Planned and Ongoing Remedial Actions

The SSAC is the custodian of the "One Monitoring and Evaluation System" for the national response. SSAC is working closely with all sectors (especially SMOH) to:

- Ensure a monitoring plan for the current strategic plan is developed.
- The monitoring system is reviewed and updated to provide required information.
- Research is integrated to the M&E system to provide strategic information. This will include operational research, population size estimation and evaluations.
- Build the capacity required for effective M&E including human resources and equipment.
- Establish or strengthen information management systems at all levels.
- It is imperative to establish and develop database for SSAC if it has to effectively manage, lead and track the GARPR targets.
- SSAC must play its central role of being the guardian of "the Three 1" and all stakeholders have to support this arrangement to make it easier not only for SSAC but for everybody involved.

7.4 M&E Technical Assistance and Capacity Building Needed

The capacity development of GOSS departments by development partners and agencies is key aspect of GOSS partnership with focus on strategic planning, project management and monitoring and evaluation among national counterparts as well as specific technical areas such as clinical, laboratory and Pharmaceutical trainings for health personnel.

MOH GOSS is tasked with monitoring and evaluation of the quality of the services provided while exploring continued opportunities for health workers trainings at the same time. In 2011/12 GFATM contributed to the strengthening of national institutions such as SSAC and to GOSS at state level through the provision of financial and technical support to monitor and coordinate HIV activities in the states. UNICEF has worked closely with MoH to develop and train health workers at service delivery points and also standardized guidelines, registers, and reporting tools for VCT and PMTCT programmes which has contributed to an improvement in the quality and reporting for these programmes.

ANNEX 3: LIST OF KEY REFERENCE MATERIALS REVIEWED

1. Ministry of Health 2012; Health Sector Development Plan 2012 – 2016;
2. Ministry of Health 2013; HIV and AIDS Division Annual Report July 2011- June 2012
3. South Sudan AIDS Commission (SSAC);); 2008; South Sudan Draft South Sudan National HIV and AIDS Strategic Framework (NSP 2008- 2012
4. South Sudan AIDS Commission (SSAC); March 2013; South Sudan Draft South Sudan National HIV and AIDS Strategic Framework (NSP 2013- 2017);
5. South Sudan AIDS Commission (SSAC); March 2013; South Sudan Draft National HIV and AIDS Strategic Information Plan (SIP 2013- 2017);
6. South Sudan AIDS Commission (SSAC); March 2013; South Sudan Global AIDS Reporting Progress Report (GARPR);
7. SSAC; Universal Access Report 2010, Scaling Up HIV/AIDS Response, South Sudan
8. The United Nations General Assembly 2011 Political Declaration on HIV and AIDS
9. UNAIDS February 2013; Technical Brief; Closing the gap: a midterm review at the country level
10. UNAIDS: Modeling Report; 2013: Estimating HIV and AIDS Response Needs of the States