Republic of South Sudan

South Sudan AIDS Commission and Ministry of Health, June 2015

ACKNOWLEDGEMENTS

The development of the South Sudan's 2014 Global AIDS Response Country Progress Report was led by the South AIDS Commission and the Ministry of Health. Partners through South Sudan HIV/AIDS technical working provided technical and some financial assistance.

The HIV/AIDS technical working group is comprised of key governmental, non-governmental, bilateral and multilateral stakeholders in the multi-sectoral response to HIV and AIDS in South Sudan and they collectively undertook the collection, analysis, interpretation of data as well as drafting the narrative report. No consultant was hired. UNAIDS provided funding and secretarial coordination of the stakeholders. SSAC coordinated consultative meetings and Ministry of Health coordinated data collection and analysis from partners and facilities.

Representatives from civil society organizations, Development Partners and line ministries gave their time and experience to ensure that all perspectives on the country's achievements in addressing HIV and AIDS in the year 2014 were profiled and benchmarked with NSP, HLM and 90 90 90. This was equally true for the country's ongoing challenges during 2014 after many negative consequences of its ongoing political conflict.

South Sudan Country Progress Report has once again been enriched by the voices of key populations who continue to have difficulty having their needs for HIV prevention, treatment and care both recognized and addressed. In the course of the development of the report Female Sex Workers and People living with HIV aired their perspective on the response in 2014 through guided focus group discussions facilitated by UNAIDS.

To all organizations and individuals that have contributed to the development of this report, and continue to join hands in the country's effort to contain and reverse the HIV epidemic, we give our sincere thanks on behalf the people and leadership of South Sudan.

Dr. Esterina Novello Nyilok
Chairperson,
South Sudan AIDS Commission.
Juba, South Sudan.
June, 2015.

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LIST OF ABBREVIATIONS

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
FSWs	Female Sex Workers
GARPR	Global AIDS Response Progress Report
GBV	Gender based violence
GFATM	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
MTMSG	Mother to Mother Support Groups
NEPWU	Network of Positive Women United
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OVCs	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHCC	Primary Health Care Center
POHC	Populations of Humanitarian Concern
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SSAC	South Sudan AIDS Commission
SPLM/A	Sudan People's 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
VMMC	Voluntary Medical Male Circumcision
WAD	World AIDS Day
WHO	World Health Organization

ABOUT GLOBAL AIDS RESPONSE PROGRESS REPORTING

In 2011 the United Nations High Level Meeting on AIDS (HLM) took place from 8 to 10 June 2011 at the general Assembly in New York. A new declaration, entitled Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS was unanimously adopted by member states on 10 June. The Declaration set new targets and called on Member States to redouble efforts to achieve, by 2015, universal access, with a view to attaining Millennium Development Goal 6. The Declaration also recognized key populations at higher risk of HIV infection—men who have sex with men, people who inject drugs and sex workers.

HIGH LEVEL MEETING COMMITMENTS AND MONITORING OF HLM

On June 10th 2011, World Leaders under the technical guidance of UNAIDS set bold targets at the United Nations General Assembly High Level Meeting on AIDS in New York. The attendance was by Heads of State or Governments. The targets were aimed to be achieved in 2015. There was also the most unprecedented participation by heads of states during formulation of the commitments, targets and positioning the momentum. A framework consisting of targets towards reducing sexual transmission of HIV and halving HIV infection among people who inject drugs by 2015, eliminating new HIV infections among children in five years, increasing the number of people on life saving treatment to 15 million as well as reduce tuberculosis related deaths in people living with HIV by half by 2015 were set and adopted.

Figure 1. HE The President of the Republic of South Sudan Salva Kiir welcoming AU mission escorted by Dr Esterina Novello the Chair of AIDS Commission at commemoration of WAD in 2013

This declaration was christened Political Declaration on HIV/AIDS: Intensifying our Efforts to eliminate HIV/AIDS and 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 General Assembly to support countries monitor progress of the HLM implementation and report periodically as planned to the General Assembly.

In the new declaration, entitled *Political Declaration on HIV and AIDS, the following targets were reaffirmed:*

- *Reduce sexual transmission of HIV by 50 per cent by 2015;*
- *Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015;*
- *Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths;*
- *Halve 15 million people living with HIV on antiretroviral by 2015;*
- *Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015;*
- *Reach a significant level of annual global expenditure in low and middle income countries;*
- *Critical enablers and synergies with development sectors.*

SOUTH SUDAN ALIGNMENT OF THE NATIONAL STRATEGIC PLAN TO THE HLM COMMITMENTS

Following the Global political declaration, South Sudan domesticated the political declaration through the following targets of the national strategic plan 2013/14-2017/18

1. Reduction of new HIV infections by 50% by 2017; this area has three outcomes and aims to scale up services, especially among key population groups, to minimize the risk of new infections across the country.
   i. Reduction of risky sexual behavior among prioritized populations;
   ii. Mother to child transmission of HIV reduced from 30% to less than 10% by 2017;
   iii. HIV transmission in health care settings eliminated by 2017.

2. Reduction of mortality among men, women and children living with HIV by 50% by 2017; this area has three outcomes and aims to scale up HIV treatment, care and support services to improve the quality of life of PLHIV and their families.

   i. PLHIV in need of on ART increased from 10% to 80% (adults) &, from 3% to 50% (children) by 2017;
   ii. Improved retention on care and treatment;
   iii. Improved access to social protection and safety nets for PLHIV and HIV affected households.

3. The third pillar aims to create an enabling environment for the national HIV response through 6 outcomes:
   i. Improved policy environment for an effective national HIV response;
   ii. Reduction in funding gap for the HIV response by 85% by 2017;
   iii. Functional coordination structures and leadership commitment at all levels;
   iv. Effective programme and financial accountability for HIV interventions;
   v. Increased generation and utilization of strategic information for policy formulation, planning and management of the HIV response;
   vi. All individuals in need of quality HIV commodities have timely and continuous access.

REPORT WRITING PROCESS

The HIV/TWG reviewed all relevant documents (key reports, national guidelines and policies pertaining to all the GARPR targets) to incorporate in the reports. Estimate progress and achievements preceding global declarations through quantitative (GARPR indicators and qualitative data focus group discussions with sex workers and people living with HIV).

The roadmap below was used developed and utilized as a guide to mobilize the technical working to construct the report. UNAIDS provided funding and secretarial coordination of the stakeholders writing follow up, consolidation and editing. SSAC coordinated consultative meetings and Ministry of Health coordinated data collection and analysis from partners and facilities. Stakeholders that participated in the writing process include government officials, civil society technical and leadership representatives

ROAD MAP TOWARDS DEVELOPING THE GARPR

- 30 April 2015 General meeting to Launch the GARPR report Writing
- 13th May 2015 Review of the report
- 25th May 2015 First consolidated Draft
- 3rd June 2015 Validation meeting
- 4th June 2015 Editing and Finalization
- 10th June Final GARPR report
- 15thJune 2015 Submission

DIVISION OF LABOR AMONG THE HIV/AIDS TECHNICAL WORKING GROUP

1. **Prevention** (Sexual prevention , STIs , CT , PMTCT,PEP) –
   (**Dr. Ally Ahmed** ,Jane Muraa, Patrick Buruga , Richard Jele, Gerald Kimondo, Gabriel Atillio , Simon Dada, Venansio Akol , Joseph Celestino, Alex Bolek, John Mondi, Joy Zakaria,)
   a. Targets for prevention (source is NSP & SIP)
   b. Achievements by targets
   c. Challenges and Emerging issues
   d. Priority Areas for 2015
   e. Best practices

2. **Care and Treatment** (HIV Care ,ART, TB/HIV ,OVCs, Nutrition ,IGAs, Support Groups)

   (**Dr. Moses Mutebi,** Gerald Kimondo , David Lukudu, Shambel Aragaw, Wubaye , Ajak Panther , Margaret Semira, Evelyn Letio, Lino Baba)

   a. Targets for Treatment (source is NSP & SIP)
   b. Achievements by targets
   c. Challenges and Emerging issues
   d. Priority Areas for 2015
   e. Best practices

3. **Enabling Environment**: (Coordination and Leadership , Financing /Funding Policy , accountability, Commodities, Stigma and Discrimination, Community Systems, CSOs and M&E) – **Boaz Cheluget**, Habib Dafalla, Silvano Koribe, Acaga Taban, Alfred Okiria, Florance Bayoa, Maika Lisok, Alex Bolo, Denis Mali, 65James65James Rondyang, Gune Cicily , Karin Natsheya, Jeanne Bushayija, Dassan Hategekimana)

   a. Targets for Enabling Environment (source is NSP & SIP)
   b. Achievements by targets
   c. Challenges and Emerging issues
   d. Priority Areas for 2015
   e. Best practices

4. Voices of the beneficiaries

1. PLHIV (Boaz cheluget, Betty Araba and Evelyn Letio)
2. CSWs (Boaz cheluget and Mary)
3. MSM (Boaz cheluget and Aboi Talib)

OVERVIEW OF PROGRESS TOWARDS HLM TARGETS

Table 1: Summary progress in 2014 by indicators and targets

TARGET / INDICATOR	2011	2012	2013	2014	NSP Targets for 2015	Progress in 2014
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%	No new data	No New data	20 % for both sexes	• 8122 youths reached with HIV prevention messages through peer education. • 58 officials from Ministries of Education, Health, Gender and Youth trained on comprehensive Sexuality education(CSE) and HIV • School curriculum revised to include CSE. • Strategic Plan and Education management information revised to include CSE. • 45 Media practitioners trained on (CSE) and HIV/AIDS.
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	No New data	No New data	M:20% F:15%	
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	No New data	No New data	6% (M: 12%, F: 1%	• 2,173,595 male condoms distributed in 2014. • 221,000 Refugees and IDPs were provided with BCC messages. • 89,733 Individuals were counselled and tested in HTC settings (excluding pregnant women) in 2014 and 7,707 (8.5%) were HIV positive and were referred and linked to HIV Care. • 9,129 tested for HIV during World AIDS day HTC campaign. • 82,509 pregnant women counselled and tested. 2261 found HIV positive - Prevalence – 2.7%
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	No New data	No New data	20 %	
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%	No New data	No New data	TBD	
1.6 Percentage of young people aged 15-24 who are living with HIV	3.05%	12%	No New data	No New data	M:0.5 F:0.9	
1.7 Percentage of sex-workers reached with HIV prevention programmes	0.91% (2008)	no data				• 300 Sex workers in Nimule provided HIV prevention packages • 764 sex workers tested where 221 FSW tested positive.
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	M: 4.91% F: 9.18%				45 %	

TARGET / INDICATOR	2011	2012	2013	2014	NSP Targets for 2015	Progress in 2014
	GBV in SS 2010					• 1,755,000 condoms distributed through sex workers • Uniformed forces HIV program conducts regular prevention work around garrisons. • IBSS for FSW ongoing in Juba and Yambio cities. • USD 8 million mobilized through GF for Mapping and prevention programing among FSW and their clients.
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No data	No data	No data	No data	No target	
1.10 Percentage of sex workers who are living with HIV	12 %	No data	No data	No data	No target	
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				▪	▪	▪ USD 800, 000 mobilized through GF for mapping, IBBS and prevention programing among MSM
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 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths						
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	8.3%	9.5%	21%	18%		• PMTCT guidelines and scale up plan finalized. • Mentorship programme ongoing • 8 Mother to mother support groups trained followed up PMTCT mothers and linked them to care & treatment. • 1793 provided with ART for PMTCT, 521 initiated on B+, 230 were already on ART, 1042 provided with AZT • Coverage 18% using spectrum estimates • 44% of 82,509 PMTCT beneficiaries are from Western equatorial.
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%	No data	3,800	
3.3 Mother-to-child transmission of HIV (modelled)	30%	30%	29%	Read spectrum	10 %	
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015						

TARGET / INDICATOR	2011	2012	2013	2014	NSP Targets for 2015	Progress in 2014
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy	7%	6.5%	(9.45 %) 4.52 %*	6%[1] (Adults 3% - Childre n	22750	▪ 6,021 people newly initiated on treatment resulting to 11,310 PLHIV on ART as of December 2014. ▪ Newly initiated distributed as M; 1901 and F: 4120. ▪ Among the total enrolled, M:3463 and F:7846 ▪ Coverage indicators has been changing from CD4<200 to CD4<350 then CD4< 500 to now all HIV+ ▪ Retention improved through strengthened community systems and mentorship of clinical service providers. ▪ ART coverage for Adults 6% and 3% for children using spectrum estimates
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 %	12 months : 74.8 % 24 months :67.1 % 60 months : 41.8 %	12 months: 78 % 24 months:70 % 60 months: 63 %	
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015						
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	8.29 %	27.5%	57%	57 %	90 %	▪ 428 out of 751 TB patients were provided with ARVs
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	Gov=5 % (estima ted 2010) DPs= 95% (est. 2010)	10%	No data	No data	Gov=15% DPs = 85%	▪ In 2014 the country has submitted concept note and 40.7 million USD has been approved by the GFATM. The Government has committed 5% of the approved NFM concept note budget for the year 2015-2017. ▪ The country also submitted a proposal for the GF through ANECA and IGAD in 2014. The proposal for ANECA has been approved and the

[1] The Denominator has varied over the years. Current denominator is all PLHIV

TARGET / INDICATOR	2011	2012	2013	2014	NSP Targets for 2015	Progress in 2014
						IGAD proposal is still in process. ▪
Target 7: Eliminating gender inequalities						
7.1 Prevalence rate of recent intimate partner violence	No data	No data	No data	No data	No NSP target	▪ Accelerated Agenda Country Action (AACA) for girls and women has been developed and validated by partners and SSAC with the support of UN Women. .
Target 8: Eliminating stigma and discrimination						
8.1 Discriminatory attitudes towards people living with HIV	No data	No data	No data	No data	•	• Resource has been mobilized to undertake stigma and discrimination index for the three Greater Equatoria states. Advocacy has been done for the three Greater Equatoria states. ▪ 764 sex workers were counseled and tested for HIV and 210 positives were linked to HIV care and treatment centers. ▪ 1,755,000 condoms were distributed to sex workers ▪
Target 9: Eliminate Travel restrictions (not tracked in South Sudan due to clear government policy)						• South Sudan has imbedded in its constitution the nondiscrimination of PLHIV coming in or going out of the country and therefore there is no need to track this target.
Target 10: Strengthening HIV integration						
10.1 Orphans school attendance	No data	No data	No data	No data	TBD	▪ 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

TARGET / INDICATOR	2011	2012	2013	2014	NSP Targets for 2015	Progress in 2014
						vagaries of poverty and from infection of HIV ▪ In South Sudan 3.6% of children aged 10-14 have lost both parents and only 26% of these children attend school. ▪ The government spent 80,000 USD for orphans school fees and scholastic materials ▪ IGAD also contributed to OVC related activities
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	No data	TBD	▪ 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, not much support is invested in these populations either from domestic sources or external sources.

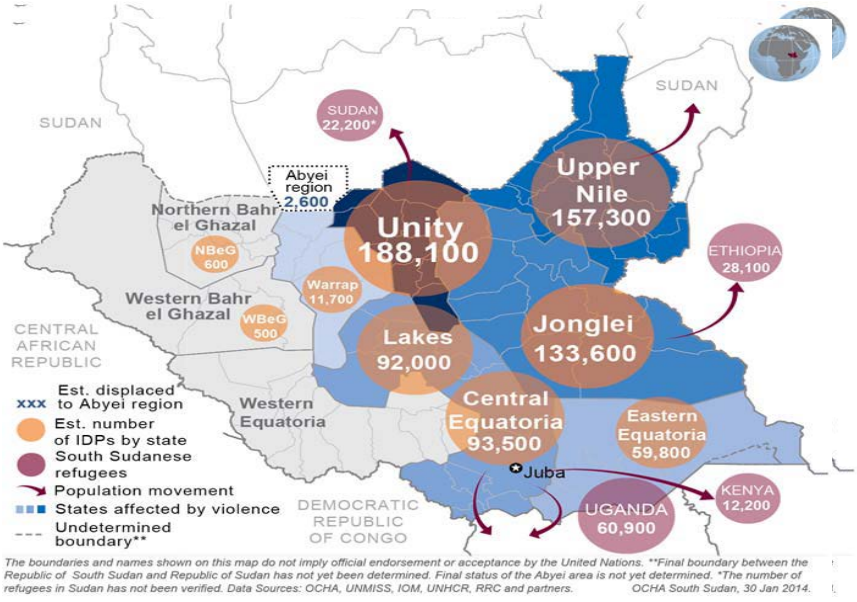
OVERVIEW OF THE AIDS EPIDEMIC

COUNTRY POLITICAL AND GOVERNANCE LANDSCAPE AT A GLANCE

Shortly after Sudan gained independence in 1956, the north and the south engaged in a prolonged civil war that caused over 2 million deaths, displaced more than 4 million, and drove over 500,000 people into refuge in other countries. The Civil war ended in January 9, 2005 when the government of the National Congress Party (NCP) and the Sudan People's Liberation Movement (SPLM) signed the Comprehensive Peace Agreement (CPA) bringing to an end decades of hostilities between the North and the South.

Even after the Republic of South Sudan having attained its Independence in 2011, the health infrastructure remains rudimentary and fragmented. Decades of neglect and years of devastation from wars have contributed to poor health status of South Sudanese. To address the new country's poor health indicators, the government has set clear priorities for many health areas. Several key policies provide important strategic direction and guidance for engagement in the health sector, and in particular efforts to ensure access to primary health care.

From 2005 onwards the Government of South Sudan (GoSS) began to create new administrative entities and government departments that would function in the post-conflict period. In the area of HIV/AIDS, the GoSS established the South Sudan AIDS Commission (SSAC) in 2006, with the mandate to provide leadership in coordination and management of the national multi-sectoral HIV/AIDS response through resource mobilization, advocacy, joint planning, monitoring and



evaluation. In 2008, the Government set up the Directorate of HIV and AIDS in the Ministry of Health (MOH) to implement the HIV and AIDS programmes such as antiretroviral treatment, care and support, blood screening for HIV and sexually transmitted infections (STIs) and management and reporting of opportunistic infections. The Ministries of Health in the ten states of Southern Sudan also set up focal offices for HIV to coordinate the activities of the MOH and monitor and report new cases of infections (Southern Sudan AIDS Commission, 2011).

In December 2013, national and international community experienced an armed political conflict that continued to evolve until now. By January 2014, some 740,000 had been internally displaced and another 123,400 people crossing to neighboring countries. These figures have continued to grow as comprehensive political solution is being sought through regional mechanisms.

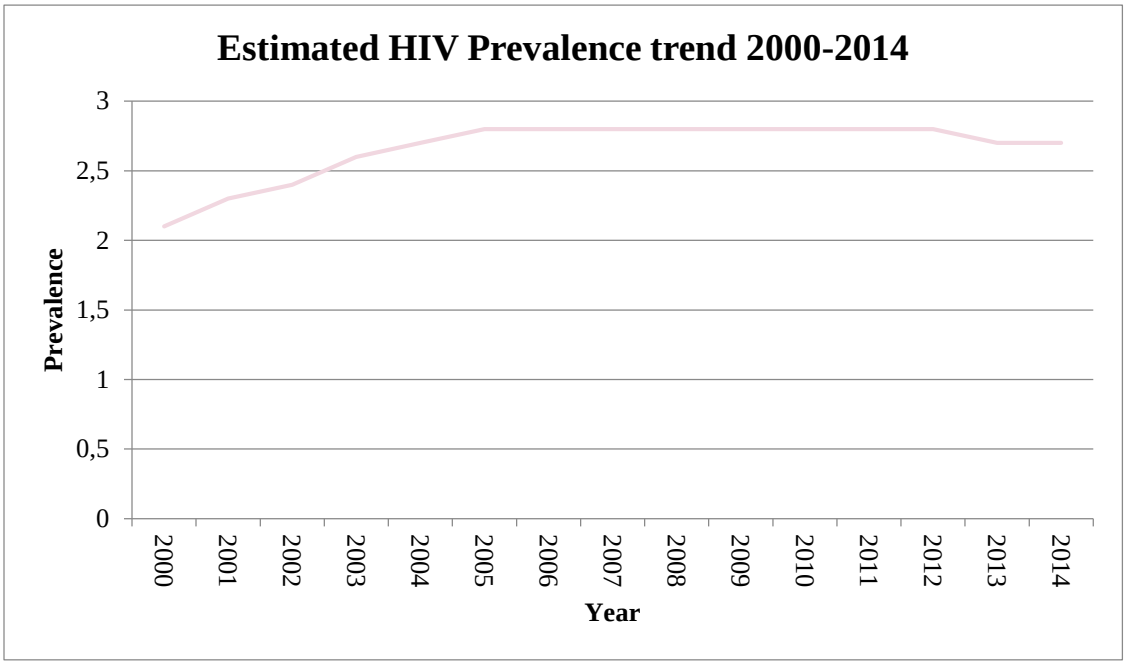
The crisis from the 15th December 2013 affected more than half of the country (map above) with the displaced populations hosted in over 100 locations, with 18 sites hosting over 10,000 people each. The key areas of displacement include: UNMISS bases in Bentiu, Bor, Juba, and Malakal, Awerial in Lakes state, Mayom in Unity state and Twic county in Warrap state, Nimule in Magwi County. Across all these areas, there is an urgent need for humanitarian assistance including addressing needs for prevention, treatment, care and support for HIV.

THE PREVALENCE OF HIV IN SOUTH SUDAN

The prevalence of HIV estimated from pregnant women monitored through ANC surveys appears to have been stabilized from 3.7% in 2007 to 3.0% in 2009 and 2.6% in 2012[2] and currently estimated 2.7%[3] and the trend is as in the Chart below. The difference between 2007 and 2009 is statistically significant, whereas further decrease to 2.6% in 2012 is not significant but substantia[4]. Due to limited data in South Sudan, the estimate has wide plausibility boundaries leading to uncertainty on the estimates. This will improve once population based data is collected and analyzed.

[2] Republic of South Sudan (2012) ' Sentinel Surveillance Report, Ministry of Health
[3] Republic of South Sudan (2015) 'National Spectrum Estimates Report', Ministry of Health and South Sudan AIDS Commission.
[4] Republic of South Sudan (2012) ' Sentinel Surveillance Report, Ministry of Health

Chart 1: Estimated HIV Prevalence in South Sudan 2000-2014



The prevalence decline is supported by (proxy incidence) incident prevalence in young pregnant women (15-19) and (20-24) years. It is very clear from the data that incident cases are progressively declining every successive year of ANC survey in both age groups and it is apparent that the annual decrease in each age group is not ordinary. For the younger age group (15-19) years the prevalence decreased by 0.4% from 2007 to 2009, and by 0.8% from 2009 to 2012. In the age group (20-24) it decreased by 0.5% and 0.7% in respective periods[5]

Table 2: Trends of HIV and syphilis prevalence among ANC pregnant women in South Sudan (2007 – 2012)

YEAR	No. of sites	No. tested for HIV	HIV prevalence	No. tested for STIs
2007	10	4,710	P1 = 3.7	3,372
2009	24	5,913	P2 = 3	6,175
2012	33	11,134	P3 = 2.6	11,033

[5] Republic of South Sudan (2014) 'Global AIDS Response Progress Report' Ministry of Health and South Sudan AIDS Commission.

Statistical comparison HIV and STI prevalence for 2007, 2009 and 2012			
	Comparison	**Hypothesis**	**P-value (significance)**
1	2007/ 2009 HIV	Ho: P1=P2 H1: P1≠P2	Z=2.00, P=0.02 Reject Ho:
	2007/ 2009 STI	Ho: P1=P2 H1: P1≠P2	Z=1.69, P=0.05 Reject Ho:
2	2009 – 2012 HIV	Ho: P2=P3 H1: P2≠P3	Z=1.52, P=0.06 Not sign.
	2009 – 2012 STI	Ho: P2=P3 H1: P2≠P3	Z=3.54, P=0.00020 Reject Ho:

The HIV prevalence in 2009 was significantly lower compared to 2007. Similarly, the STI prevalence in 2009 is also significantly lower that of 2007. The HIV prevalence in 2012 is not significantly lower than of 2009. However, the STI prevalence in 2012 is greatly lower that of 2009.

One major problem that has attended the ANC sentinel surveys from the very beginning in 2007 when only ten sites from five out of 10 States were included in the ANC survey of that year, and followed by subsequent changes or expansion of the sample of sites and sample size of pregnant women participating in the surveys is the representativeness of the samples. Each time the sites have been increased, the prevalence has decreased and this could be the phenomenon that is being observed rather than the real prevalence decrease. The problem could be lack of representativeness of the data, which could be coming from easy to access service delivery points without proper rural-urban mix. Some States are represented by only one ANC site to which again the State prevalence is based. Therefore caution is needed in interpretation of these findings.

Overall the current adult prevalence is estimated at 2.7 in 2014 and probably due to rapid scale up of ART in 2014[6] which translates to 190, 000 PLHIV in the country of which 170,000 are adults whereas 20,000 are children below 15 years. Annually 0.16 % of the adult population becomes infected – approximately 18,000 new cases of HIV occurred in South Sudan in 2014, translating to about 50 people infected each day.

[6] Republic of South Sudan (2015) 'National Spectrum Estimates Report', Ministry of Health and South Sudan AIDS Commission

Most ANC facilities in South Sudan are found mainly in accessible locales and not uniformly and homogeneously distributed throughout the country. In such situations, the UNAIDS Advisory Committee/Group has advised for the recalibration of ANC prevalence with a factor of approximately 0.80 when making estimates of national HIV prevalence in countries without specific local population based estimates to support ANC findings. Because of the complexities involved in the selection ANC surveys and representativeness of samples, the rural - urban mix and design problems, it is hypothesized that the true HIV prevalence in South Sudan could have been between 1.5% and 2.0% at the end of 2012[7].

The 2010 household survey data show that only 53 percent of women 15-49 years old have ever heard of HIV or AIDS, and only 19.3 percent know of a place to get tested. In addition, only 15 percent of women who give birth two years prior to the study and had access to ANC services received HIV counseling and testing, while only 9 percent of these women were tested for HIV while seeking antenatal care.

HETEROGENEITY

The patterns of HIV prevalence and heterogeneity of the epidemic – by age, gender, geography, education level, marital status and States of residence is common in South Sudan. Overall, the level of heterogeneity of the epidemic is striking and the general impression is that the epidemic is not spread evenly in all regions and sub populations but it is concentrated in the southern States where in 2012 Western Equatoria reported the highest prevalence with about 6.8% followed by Eastern Equatoria 3.4% and Central Equatoria at 2.6%. These results show that in general the epidemic is worse in the southern part of the country and in Juba the capital city, with those states on the southern borders with Uganda and Democratic Republic of Congo having the highest HIV prevalence. Conversely, the lowest prevalence is found in the more remote northwestern states – Northern, Western Bahr Ghazal and Warrap. Urban/rural differences seem to be of less importance than geographical location, for example, Nimule is a rural location with a high prevalence, but close to the Ugandan border, whereas Awiel and Kuajok are both urban, but located in a Northern

[7] Republic of South Sudan (2014) 'Global AIDS Response Progress Report' Ministry of Health and South Sudan AIDS Commission.

low prevalence state, and Yambio (urban) and Tambura (rural) both are in Western Equatoria, where the prevalence is generally high.

According to the 2012 Antenatal Care Sentinel Surveillance, women aged 25 – 29 years old had the highest prevalence of HIV at 2.9% (2.3 – 3.5) while those aged 15 – 19 years old had the lowest prevalence at 1.9 (1.4 - 2.5). However there were no substantial differences in the prevalence of HIV in pregnant women aged 20 – 24 years and women aged 25 - 29 years (Odds Ratio, OR [95% C.I], p-value: 1 [0.7-1.4] p<0.059). (Ministry of Health, 2013) This corresponds to age specific HIV prevalence for the antenatal clinic clients in 2007, in this survey the highest prevalence levels were found in the 20-34 year population, although it is interesting that the highest levels are in the 20-24 year old group – in most countries with a generalized epidemic, the highest levels are found in the older women of reproductive age – the 30-35 year olds, which may imply a more recent arrival of HIV in the country. However the confidence intervals for the three groups 20-24, 25-29 and 30-34 largely overlap, so there may not be a significant difference in the prevalence levels between the different ages 20-34. One factor that may explain this is the fact that more than 50% of South Sudanese women are sexually active by age 16 (Southern Sudan AIDS Commission, 2011).

The 2010 Household survey (Government of South Sudan, 2010) found that a very low percentage of sexually active women use condoms or any other means of birth control, and that 90% of the women surveyed had given birth, implying that first pregnancies probably occur between the ages of 15 and 19, which is younger than in many other African countries. For antenatal clinic clients in 2009, what is notable is that the prevalence in the 15-19 year olds has stabilized (with whatever changes not being significant), the higher levels seen in the 20-24 year group in 2007 are no longer seen, and the prevalence is essentially the same for all three age groups between 20 and 35 years, which would imply the continued maturation of the epidemic from the results seen in 2007 – with new incidence in the 15-19 group and a stable prevalence in the older groups. This implies a continued incidence of new infections as well as mortality in those previously infected[8].

Results of the three surveys reveal that antenatal HIV prevalence does not vary by marital status. There is essentially no difference between the prevalence levels in women who are married, either

[8] Southern Sudan (2011) 'HIV epidemic and Response Review Report', Southern Sudan AIDS Commission.

in monogamous or polygamous marriages, and single women. One might be tempted to draw conclusions about the high prevalence (16.7% in 2009, 4.6 in 2012) in those who were widowed (husbands having died of HIV, or perhaps women turning to high-risk survival sex as a result of widowhood) but the small sample size does not give weight to these hypotheses9.

SOURCES OF NEW INFECTIONS

Epidemiological pprojections[10] reported in MoT (2013- Annex 7) reveal that the main channel of transmission in South Sudan is sexual. More than 13,000 new infections occurred during the last year among adults aged 15-49, while epidemiological projections reveal that more than 2,476 newborns were infected through MTCT. Sex workers and their clients contribute 8,468 (63%), or nearly two thirds of all new adult infections. Within the general population, men and women engaged in casual sexual relations and those in stable polygamous relationships contributed 27% (17% and 10% respectively), of all new infections. The probability of getting infected is about five times higher for partners in polygamous but stable relationships than for the monogamous. Men who have sex with men contribute about 610 cases of new infections annually or five 5% of all new adult infections.

This evidence suggests that the response should prioritize packages of integrated high impact combination prevention for key populations especially sex workers and their clients, beginning in geographical areas of high endemicity and concentration such as transport corridors, trade centres and other hotspots in the three equatorial states, followed by Lakes State and IDP/refugee settlements especially refugee camps surrounding the Equatoria states, where vulnerability to infection for women, girls, sex workers and their partners is catalyzed. Within the general population, BCC including condom promotion interventions, accelerated HTC campaigns and an integrated package of high impact combination prevention interventions should be targeted to youth involved in casual sex and partners in polygamous relationships should be provided Couple HIV Counseling and Testing, and HIV positive discordant partners among them prioritized for treatment. Treatment should be prioritized in high prevalence states with high numbers of PLHIV,

[9] Republic of South Sudan (2014) 'Modes of Transmission Study', South Sudan AIDS Commission.
[10] Republic of South Sudan (2014) 'Modes of Transmission Study', South Sudan AIDS Commission.

and high yield settings. Priority should also be given to tracing, evaluating and treating about 1140 ART clients lost to follow up in the crisis hit states.

Table 3: Sources of new adult infections 2012 (MoT 2013)

Risk Group	Number	%
a. Female Sex Workers and their clients		
Uniformed services	4,689	35%
Female sex workers	1,766	13%
Other clients	1,247	9%
Boda boda (transporters by cycle)	736	6%
Long-distance truck drivers	20	0%
Total FSW and Clients	8,458	63%
b. Other key populations		
Men who have sex with men	610	5%
Female Partners of MSM and other MARPS	96	1%
Total MSM, female partners of MARPS	706	6%
TOTAL (KEY POPULATIONS)	9,164	69%
c. General population		
Men and women engaged in casual sex	2286	17%
Partners of men and women engaged in casual sex [1]	251	2%
Men and women in stable polygamous relationships[2]	1,311	10%
Men and women in stable monogamous relationships	234	2%

Republic of South Sudan (2015) 'Spectrum Estimates Results report' Ministry of Health and South Sudan AIDS Commission

TOTAL (GENERAL POPULATION)	4082	31%
d. Blood transfusions and medical injections	3	0%
Grand Total New Adult Infections	13,246	100%

Data from NSP 2013-2017, MoT 2013 and GARPR 2013 has been analyzed and consolidated to arrive at this table.

FACTORS ASSOCIATED WITH HIV TRANSMISSION

There has been little Solid data in South Sudan to inform programmes on the factors associated with transmission of HIV in South Sudan. Adequate data around individual level factors – marriage, sexual debut and behavior, male circumcision, multiple concurrent partners, condom use, and STIs is largely not available. Some data is available in Household Surveys of 2006 and 2010 coupled with small surveys covering small geographic areas and some populations. These data is summarized below:

MARITAL STATUS

Generally about 65% of the population of adults (15 – 49) in South Sudan are married or in union. Sixty percent of married women (15- 49 years) are in monogamous union while 40 percent are in polygamous union. Of married women (15 – 49 years), 16.7 percent got married before the age of 15 and 48 percent of women (15 – 19) years of age got marries before the age of 15 years. In South Sudan, more women than men are divorced, separated or widowed. The mean age at first marriage is 19.1 years (men 21.5 years; women 17.7 years). (UNAIDS, 2013). The main question remains though - Is marriage protective against HIV? Different studies have made different observations: In Africa there is increasing evidence that a large proportion of new HIV infections occur in cohabitating couples (Dunkle KL, 2008[11] and Guthrie BL, 2007[12]), who in many cases are unaware of both partners' sero-status. In East Africa, 40–50% of married or cohabitating HIV-infected persons are in an HIV-discordant partnership (Bunnell R, 2006[13]). In Kenya, Uganda and Malawi, over 80% of all unprotected sex acts by HIV-infected persons occur with spouses or cohabitating partners (Bunnell R, 2008[14]). Consequently, a high proportion of incident HIV

[11] Dunkle KL, et al. (Lancet 2008); New heterosexually transmitted HIV infections in married or cohabiting couples in urban Zambia and Rwanda: an analysis of survey and clinical data.
[12] Guthrie BL, de Bruyn G, Farquhar C, 2007. Current HIV research 2007; HIV-1-discordant couples in sub-Saharan Africa: explanations and implications for high rates of discordancy.
[13] Bunnell R, et al. AIDS 2006; Changes in sexual behavior and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda.
[14] Bunnell R, et al. AIDS 2008; HIV transmission risk behavior among HIV-infected adults in Uganda: results of a nationally representative survey

infections occur within married or cohabitating heterosexual couples, e.g., in Uganda 65% (2004–5) and in Zambia (2001–2) and Rwanda in 2005, an estimated 52–93% (Dunkle KL, 2008[15]).

AGE AT FIRST SEXUAL INTERCOURSE

When sex occurs early and before marriage, it is associated with longer exposure to sexual activity and higher likelihood of accumulating sexual partners. A study done in Zimbabwe revealed that early coital debut is a significant predictor of prevalent HIV infection independent of other factors. HIV prevention strategies should include delaying the age of first coitus and should address the barriers that may prevent young people from so doing (Pettifor AE, 2004). In South Sudan, one third of the 15-19 year old females have started childbearing, 30% have had a live birth and 5.3% are pregnant with their first child. Women ages 15-19 with no formal education were more likely to already have had a live birth (32.6%) than women with either a primary (19.4%) or a secondary education (12.9%).

The 2010 Household survey also confirmed the early age of onset of sexual activity. Of the 3300 men who answered the question, 29% had initiated sex by age 14 and 52% were sexually active by age 16. Of the 6900 females who answered the question, 23.3 % had sex by age 14 and 50.2% were sexually active by age 16. Only 4% of men and 1.8% of women stated that they had used a condom at first sex, and only 7.4% of men and 2.6% of women stated that they had used a condom during their last sex (although more than 90% of both men and women said that their last sex was with their wife, girlfriend/fiancée or current cohabiting partner (Government of South Sudan, 2010).

MALE CIRCUMCISION

According to WHO there is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. The role of male circumcision as an important factor in reducing the risk of HIV transmission has been well-established as a result of the three randomized controlled trials in South Africa, Uganda, and Kenya. (WHO, 2014[16])).

[15] Ibid. 11
[16] http://www.who.int/hiv/topics/malecircumcision/en/, 2014

In one study in South Sudan, only 9.4% of the men interviewed reported having been circumcised (IGAD-UNHCR, 2010). A third of these men were circumcised before their 10th birthday and a quarter were circumcised after the age of 20 years. The mean age at circumcision was 18.7 years. Of the uncircumcised men 39.5% were willing to be circumcised if it was affordable and safe. Female circumcision did not appear to be a common practice among the residents of Kajo Keji, as only 0.5% of women interviewed reported having been circumcised and in all cases it occurred before the age of 10 years. Regarding preference for a circumcised partner, almost an equal percentage of men (12.2%) and women (12.3%) indicated they would prefer a circumcised partner. However, the majority of men (78.9%) and women (70.5%) indicated that they would rather have a partner that is not circumcised.

Most men in Southern Sudan who are not Muslim are not circumcised – A UNHCR survey in Juba in 2008 showed that among the non-Muslim men, 60% were not circumcised (UNHCR, 2008[17]). The prevalence of male circumcision is probably lower in the rural areas away from towns where Islam is practiced by segment of the population that resides in these towns. Generalizing from the above limited data, it could be argued that if approximately 60% of the non-Muslim male population of South Sudan is not circumcised, that could be one of the important factors contributing the higher prevalence of HIV in the South. Given that the available data is from urban Juba, it is possible that the rates of male non-circumcision in the more outlying areas are even higher.

MULTIPLE, CONCURRENT SEXUAL PARTNERS

Individuals who have multiple sexual partners increase their risk of contracting HIV as each new relationship introduces another pathway for HIV transmission. Concurrent sexual partnerships, defined as having two or more partnerships that overlap in time, also increase risk and have been recently identified as a likely driver of the spread of HIV.

In the Household Health Survey 2010 (Government of South Sudan, 2010), 75% of the men who answered the question admitted to having two or more wives or other sexual partners, and 43.2%

[17] UNHCR, 2008; HIV Behavioural Surveillance Survey, Juba Municipality, South Sudan

of the women said that their husbands had other wives. More than 27% of men had sex with more than one partner in the past 12 months, and of these, almost half had three or more partners. A report by UNICEF recorded on its fact sheet on HIV and AIDS in the Republic of South Sudan showed that casual sex partners were most common among unmarried men (19 percent) and those under the age of 25 (16 percent). Few women reported a casual sex in the past 12 months. Although the figures are low it is troubling, especially given the elevated risk that each of the members of any given group of sexual partners (sexual network) is exposed to over time. That is, as one person may have two to three sexual partners, so too could each of those partners have sexual relations with two or three additional people. Thus, a sex network process is created with single individual who may be linked to a large number of unknown sexual "partners", and as soon as one person in the network is infected, the risk to all others is increased.

CONDOM AVAILABILITY AND USE

According to the Sudan Household Survey Report (Government of South Sudan, 2010), the mean rate of contraception use is only 3.5% (Government of South Sudan, 2010[18]). The rate is highest in Central Equatoria (8%), followed by Northern Bahr El Ghazal, Eastern Equatoria and Upper Nile (about 5%). Figures are lowest in Western Equatoria, where only 1.4% of women said they or their partners used any form of contraception. The highest proportion of women ages 15-49 who reported use of condom as a contraception method was 2.3% in Northern Bahr El Ghazal State.

Sex workers reported that condoms were plentiful and inexpensive. No one reported not using a condom because of cost or availability. In places like Juba, SWs reported that they bought condoms from government facilities. Although condoms were said to be readily available, SWs at all the sites emphasized that clients did not like using them, especially South Sudanese clients

[18] Government of South Sudan, 2010; Sudan Household Survey Report

SEXUALLY TRANSMITTED INFECTIONS

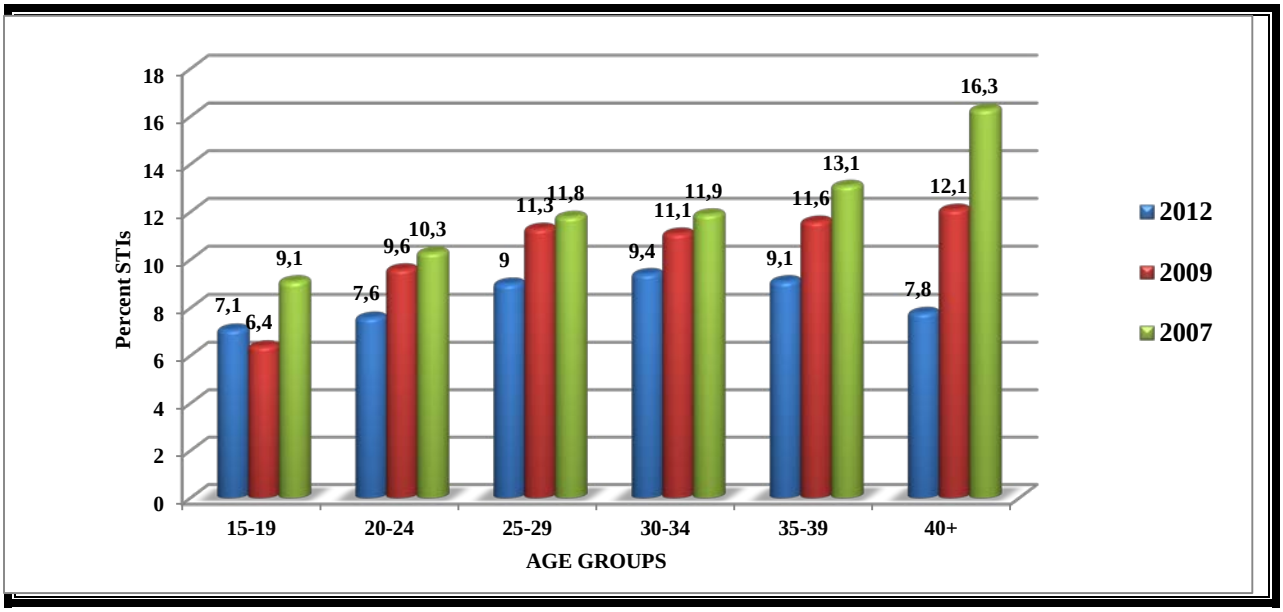
The predominant mode of transmission of both HIV and other STIs is sexual intercourse. Measures for preventing sexual transmission of HIV and STIs are the same, as are the target audiences for interventions. In addition, strong evidence supports several biological mechanisms through which STIs facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility. Thus, detection and treatment of individuals with STIs is an important part of an HIV control strategy (UNAIDS, 2004[19]).

The Household Health Survey 2010 reports that upwards of 10% of the population have had symptoms of an STI, and antenatal surveillance and other reports show an extremely high rate of positive tests for syphilis in both males and females. These results are similar to the findings in the Behavioural Surveillance Survey carried out in Kajo Keji County in 2009, which found that 12.7% percent of the men and 19.2% of the women aged 15-49 who were surveyed had an STI symptom in the past 12 months and had sought treatment at a health facility (which implies that a higher percentage may have had symptoms which were treated elsewhere) (IGAD-UNHCR, 2010[20]). These levels of syphilis are comparable to a study that was done amongst Sudanese refugees in Ethiopia, which found prevalence levels of 11% in the female and 26% in the male populations studied.

[19] UNAIDS, 2004; Report on the global AIDS epidemic

[20] IGAD-UNHCR, 2010; HIV Behavioural Surveillance Survey in Kajo Keji County, Central Equatoria State, Southern Sudan

Chart 2: STIs Trends by age and year of ANC survey in South Sudan (2007, 2009 & 2012)



The prevalence of STIs was highest during the 2007 ANC sentinel surveillance of pregnant women and started declining in every successive year. By 2012 STIs had declined most for the age group 40 and above, decreasing from 16.3% in 2007 to 7.8% in 2012.

POPULATIONS AT RISK

Although South Sudan experiences a generalized epidemic with apparently high HIV prevalence in the population, some socioeconomic sub-populations are particularly prone to HIV infection due to higher risk behaviors. Most-at-risk populations (MARPs) are defined as populations in which there is a concentration of risk behaviors that lends to efficient HIV transmission that may then drive the majority of new infections. Behaviors 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.

SEX WORKERS

Commercial sex work is common in South Sudan and is practiced in both rural and urban areas throughout the country as reported in the UNGASS Report 2008-2009. 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 (Irin news, 2011[21]). 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. In the Behavioural Monitoring Study of 2008, 10% of the women surveyed in Juba and 13% in Morobo stated that they had sex in exchange for money in the past twelve months (and presumably they were the supply side in most of the transactions).

Only one detailed study of CSWs has been done in recent years in Juba, South Sudan (Irin news, 2011). The study noted that two-thirds of the CSWs in Juba were either divorced, separated, or widowed with only 7% being married, but almost 90% of them were the primary bread winners of their families, which numbered six to seven, on average.

More than 90% of the CSWs were working individually and not through mediators or organized sex work. They reported about two clients per day, and 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 CSWs".

UNIFORMED PERSONNEL

Uniformed services personnel, such as the military and police, are vulnerable to HIV due in part to their age, environment and inclination towards risky sexual behavior while out of their communities. This population is highly mobile and may be away from their regular partners for extended periods of time, which also serves to increase risk. In peacetime, STI rates among armed forces are generally two to five times higher than in civilian populations, while in times of conflict this disparity can be much higher.

The HIV infection rate among soldiers in the South Sudanese army is nearly twice as the national average, this is according to recently released 2012 HIV-Bio Behavioral surveillance findings in which the rate of 5% was reported against the national average of 2.6% (SPLA, 2013[22]). Another survey found a prevalence of 2.9% in Yei town and 0.8% in Rumbek town among military

[21] Irin news, 2011; SOUTH SUDAN: Sex workers risk violence, HIV in Juba's brothels

[22] SPLA 2013, HIV Bio behavioral surveillance in the Sudan people's liberation Army

personnel and soldiers (UNAIDS 2006[23]). A number of sex-workers, including some living with HIV, have reported that soldiers refuse to use condoms, and ready to pay more for not using, because condoms prevent them from re-populating.

TRUCK DRIVERS (TD)

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. As commerce and trade continue to increase in South Sudan and barriers hindering the transport of goods across borders diminish, concern about the spread of HIV along these corridors has increased. This network of highways, however, links South Sudan, a relatively low HIV prevalence, to a region that has the second highest prevalence of HIV in the world. HIV risk among TDs is of particular concern because they travel frequently from areas of high HIV and are away from home for long periods, during which they have sex with multiple partners, including SWs. Infected TDs and their assistants have also been linked with the spread of the virus to their regular partners in their home communities. (IOM/UNAIDS, 2006[24])

One study on TDs conducted along the Kampala-Juba transport route found that TDs, and their SWs partners are at particularly high risk for HIV due to the lack of HIV services, especially prevention and counseling and testing; sex with multiple partners; low condom use; and high levels of STIs. One behavioral monitoring study conducted in Juba, Rumbek, and Morobo in 2008 and 2009 found that slightly more than 37% of TDs had had sex with multiple paid partners in the previous six months and had little knowledge about HIV: 36% were familiar with ABC methods of HIV prevention, but only 3% had comprehensive knowledge of HIV. Truckers knew little about

[23] UNAIDS, 2006; Report on the global AIDS epidemic

[24] IOM/UNAIDS, 2006; HIV/AIDS and Populations Mobility, Overview of the IOM Global HIV/AIDS Programme

STIs, with only 3% able to name three STI symptoms. Despite their elevated risk, only 26% had been tested for HIV. (Kitungulu, 2009[25])

BODA-BODA DRIVERS

The Crane report (Makerere University, 2009[26]) 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. 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 partners. 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.

Motorcycle taxi drivers are ubiquitous in sub-Saharan Africa. As in most other places, South Sudan's version of motorcycle taxi operators, called boda boda drivers, are mostly young, active males who share a set of high-risk behaviors, including multiple sex partners, low condom use, and low levels of knowledge about HIV and STIs that clearly identify them as a most-at-risk population. Despite their large numbers, few studies (none in South Sudan) have investigated these factors that put BBDs at risk for contracting HIV. One study conducted in Kampala showed that 10% bought sex from a sex worker in the last 6 months, and of those, 78% bought sex at least

[25] Kitungulu B, Tegang S, Suji O, Jervase A. Behavioral Monitoring Survey for HIV/STI/FP/Malaria/GBV in Juba, Morobo and Rumbek Southern Sudan. Nairobi: Family Health International; 2009

[26] The Crane Survey Report: High risk group surveys conducted in 2008/9, Kampala, Uganda

twice. Only 33% used a condom at last sex. HIV prevalence among this group of BBDs was 7.5%, with BBDs 25 years of age and older having significantly higher rates (10.9%) of HIV infection.

COLLECTIVE PROGRESS IN MADE IN 2014 RESPONDING TO HIV/AIDS EPIDEMIC IN SOUTH SUDAN.

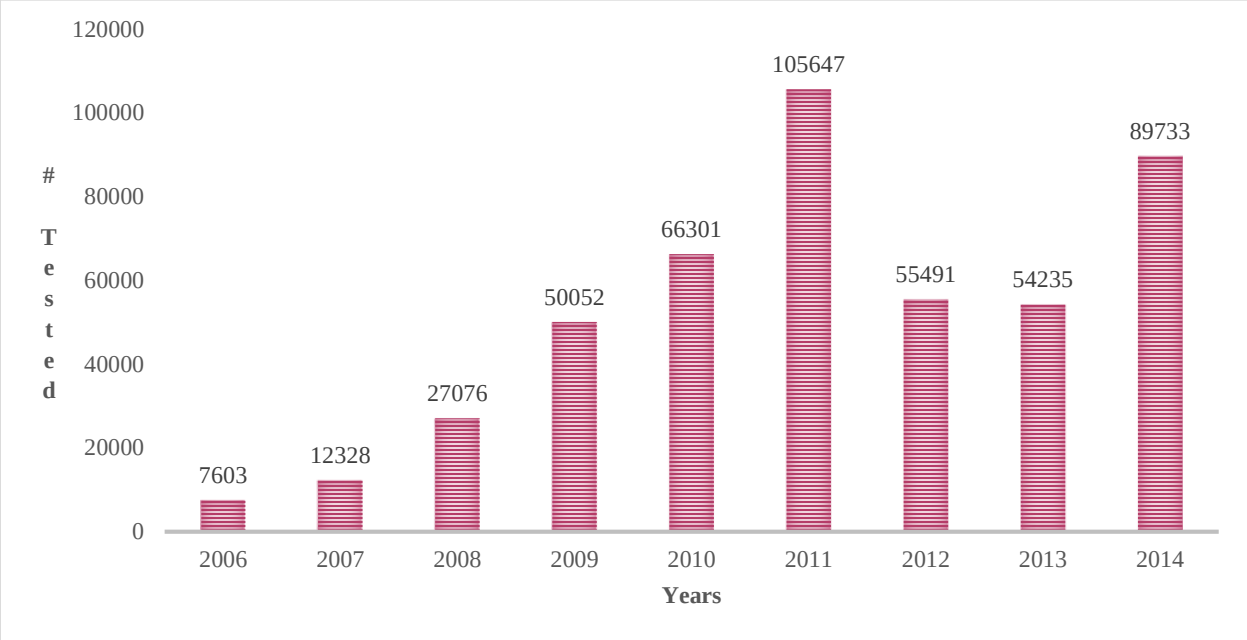
REDUCTION OF NEW HIV INFECTIONS BY 50% BY 2017

South Sudan has prioritized reduction of new infections among the general and key populations in its strategic Plan as the first priority. It aims to reduce new HIV infections by 50% by 2017 through achieving increased utilization of prevention services by general population and especially key populations, reduced risk of getting infections among the general population and also key populations at risk as well as reducing mother to child HIV transmission. South Sudan has planned to reduce mother to child transmission from 30 % to 10 % in 2017 in line with the HLM commitment. The strategies adopted include increasing the number of women and men above 15 years who know their HIV status, provision of targeted preventive interventions to key populations (Sex workers, uniformed services, truck drivers, MSM, girls and boys around hotspots), provision of combination prevention (including treatment and care) services to Populations of Humanitarian Concern, providing knowledge of HIV prevention among men and women between 15-49 years, provision of condoms to key population at risk and strategic general population as well as introducing voluntary medical male circumcision.

ACHIEVEMENTS IN 2014

- In 2014, a total of 114 health facilities provided HTC and PMTCT services.
- 172,242 individuals were counselled and tested for HIV in which 89733 were tested in HCT settings and 82,509 pregnant women were tested under the ANC. The number tested represents 38% of the National Strategic Plan target (450000).
- The number tested HIV positive was 7707.
- HIV prevalence (at HTC) was 8.5% and at ANC was 2.7% of 82,509;

Chart 3: Number of individuals tested for HIV at HCT sites (excluding pregnant women) in South Sudan 2006-2014

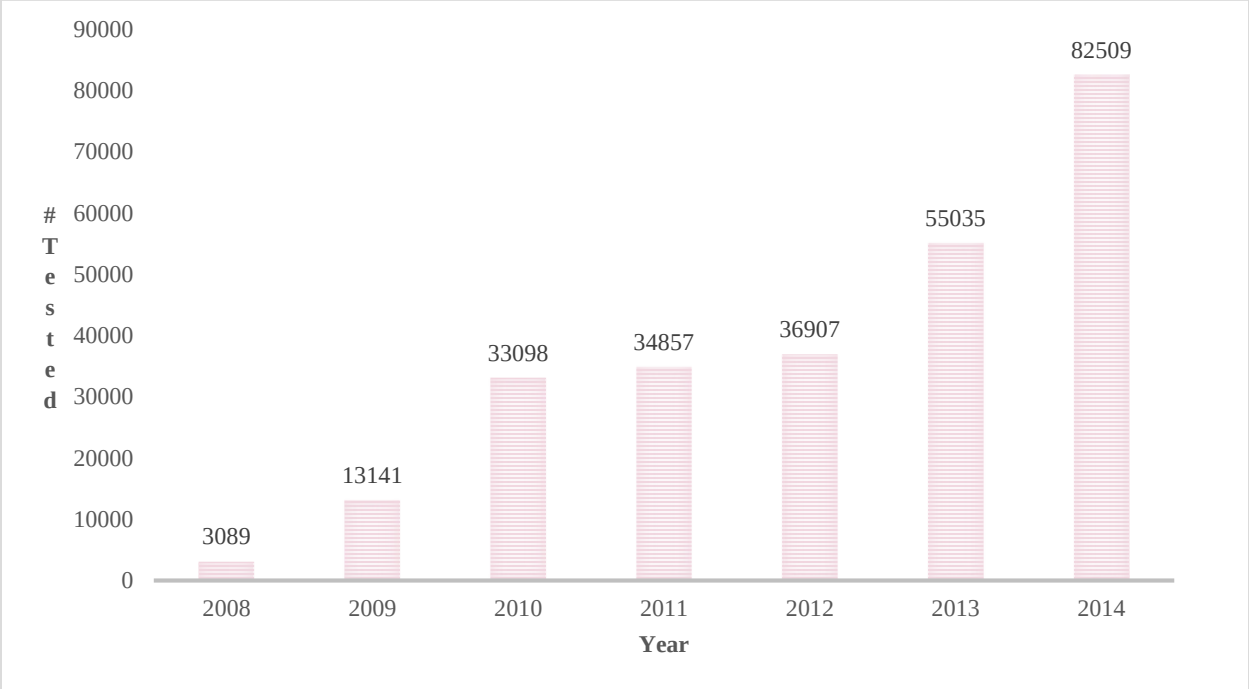


- Different partners such as UN agencies and NGOs contributed to the HTC results reached in 2014. They are Intrahealth, PEPFAR supported with some Test kits, UNAIDS mobilized funding for WAD 2014 to support incentives for counsellors while MoH conducted coordination of sites mapping for HTC and SSAC coordinated resource mobilization for HTC campaign (WAD, 2014)
- Intrahealth through the CDC prevention provided some prevention packages targeting FSW Nimule.
- SPLA HIV program conducted regular prevention work with FSW around the garrisons. These activities included massive HIV awareness, risk identification and reduction, HIV counselling and testing, condom education and distribution and referral to ART services after HTC services in which more than 300 FSW were reached with services in 2014;
- UNICEF supported some Community based and international Organizations (Sports for Hope (SHS) and AIDS Resistance Trust (ART) and Greater Yirol AIDS Awareness program (GYAAP) including Juba teaching Hospital (JTH and IRC) to reach 52,948

young people/IDPs with HIV messages in the Tongping, Juba 3 and Mahad displaced camp in Juba, Mingkaman in Awerial County.

- UNICEF also provided PMTCT services in Malakal and Bentiu Protection of Civilian sites (PoCs) at UNMISS in 2,713 women were tested for HIV out of which 33 were found HIV positive. All the 33 HIV positive women were provided long term ART for prevention of mother to child transmission of HIV and for their own health.
- UNAIDS, USAID and CDC provided financial and technical support to SSNeP+, IOM, IMC and Health Link South Sudan to provide BCC interventions to over 200,000 IDPs in 6 priority sites.

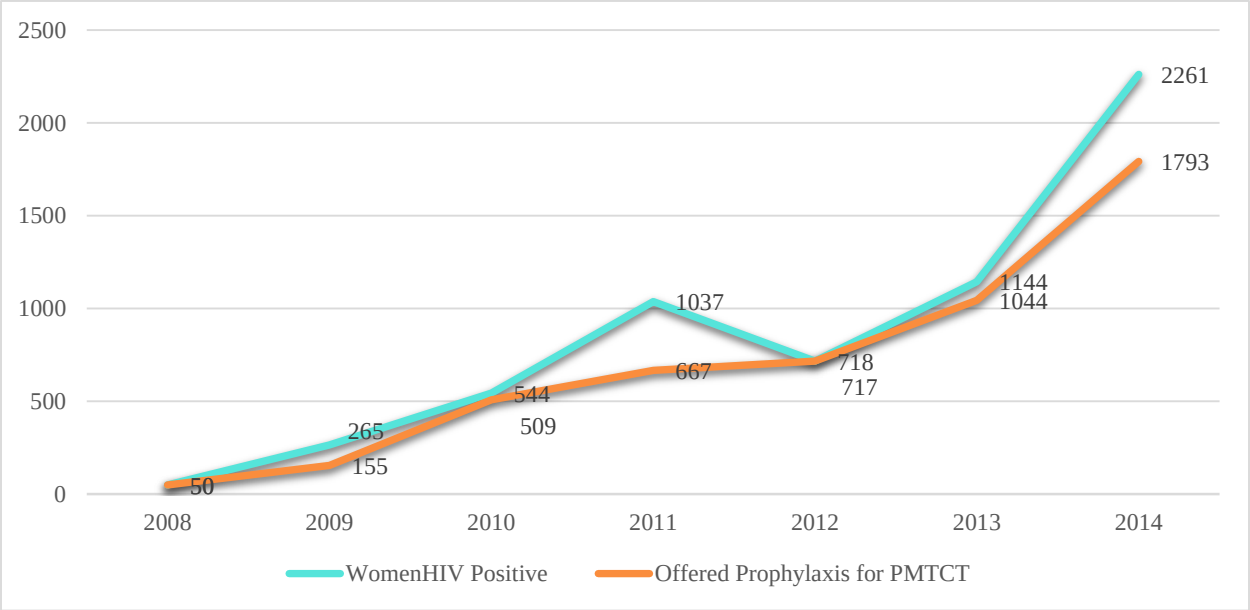
Chart 4: Number of Women counselled and Tested at ANC, Maternity and Post Natal Care, South Sudan 2008 - 2014



- At the same time, 2203 young persons aged 15 to 49 years were counselled and tested for HIV and 70 were identified to be HIV positive and referred for treatment.

- UNESCO and UNICEF have continued to take the lead in mainstreaming HIV education in educational institution such as primary and secondary school curriculums.
- UNAIDS, UNFPA, UNESCO, SSAC and UN Women conducted training for media houses to increase HIV knowledge on prevention.
- BCC program for POHC and persons with disabilities-(Light the World and Handicap International) was conducted.
- A total of 75 health facilities provided PMTCT services in the country in 2014.
- 203,613 pregnant women attended the 1st ANC visit in 2014.
- 82,509 pregnant women were counselled and tested for HIV at ANC and maternal clinics in the 2014 reporting period. The total number tested was 72% of the total NSP target (114,000).
- Out of the total 82,509 tested, 2,261 pregnant mothers tested HIV positive, representing a prevalence of 2.7%.
- The number of HIV positive pregnant women who received prophylaxis was 1,793 – 79.3% of those HIV positive and 521 were initiated on option B+.
- 159 health care providers trained on integrated PMTCT/EID from 42 health facilities

Chart 5: ART Prophylaxis for Women at PMTCT Sites, South Sudan 2008 – 2014.



- MoH with support from UNICEF and UNAIDS developed PMTCT scale up plan and mother-to-mother support group operational guidelines.

- Training of health workers on Early Infant Diagnosis was incorporated together with prevention of-mother-to child transmission of HIV. The piloting of EID did not start in 2013 as planned because work on installation of the testing Polymerase Chain Reaction (PCR) machines at the national reference laboratory has not been completed to date.

- PMTCT has been partially integrated into maternal neonatal child health (MNCH) and ART services, thus increased access to PMTCT at ANC, maternity, and delivery.

CHALLENGES EXPERIENCED IN 2014 WHILE DELIVERING PREVENTION SERVICES TO GENERAL POPULATION, KEY POPULATION AND PREGNANT WOMEN.

- Limited awareness programs about HIV in the communities due to inadequate financial resources, poor accessibility, insecurity and poor road networks
- Frequent stock-out of test kits, condoms, STI drugs resulting to interruption of services.
- Most HTC services are located in southern part of the country and much of the rest of the country have few or non-existent HTC services.
- High HIV-related stigma and discrimination
- There is still criminalisation of key populations (FSW and MSM) in South Sudan, leading to difficulty in reaching this sub-population with services.
- Inadequate funding for comprehensive programming for key populations and Populations of Humanitarian Concern (PoHC).
- Inadequate coordination for HIV/AIDS services for PoHC
- Language barriers, illiteracy and limited media coverage affected HIV educational programs
- Myths, beliefs and misconceptions about HIV are barriers to engaging the communities.
- No taskforce for condom programming.
- Poor condom-distribution systems.
- No policy and guidelines developed for condoms and voluntary medical male circumcision

From Sex Workers perspective

- *'Men in South Sudan are not willing to use condoms. We would like your organization to assist us in this part. If they find you with a condom they arrest you'*
- *'They arrest people distributing condoms and your photograph is put on the newspaper'.*
- *'In South Sudan a condom is an offence. They are not put in hotels and lodgings. So this people force you to have sex with them without using condoms. Even in hotel toilets condom are not put in. Condoms are not allowed in South Sudan'*
- *'The men who work in the UN don't force the ladies. They don't force you to have sex without condoms. They don't force us. They pay you good money. They give good services. The money you agree on is what they give you. We salute this men'.*
- *'We prefer the guys in sleepers than the guys in suits* ***(Zol Kabir)****. The one in suits are very cruel. The young once of say 25 years accept to use' condoms without a problem. The older ones of 30 years do not accept'*

- Limited PEP services Low coverage of PEP in most of the health facilities.
- Low knowledge on PEP and standard precaution for the health workers.
- High Sexual and Gender-Based Violence (SGBV) and impunity in communities. Unreported cases of rape, and SGBV within the community.

PRIORITIES FORFOR 2015

- Development of Prevention strategy for the Country.
- Strengthening capacities of health facilities to provide HTC services through PITC.
- Conduct targeted mass HIV Testing and counseling at community level.
- Effective procurement and supply chain management for HIV prevention and STI commodities.
- Effective targeting and scale up of HIV prevention targeting key populations at higher risk and People living with HIV.
- Effective targeting of condom programming distribution to key population, young people and the general population.
- Humanitarian settlements/ Protection of Civilian Sites /spaces of work for Internally Displaced Persons, refugees, vulnerable returnees; populations facing human rights violations including gender based and systemic barriers to service delivery and commodity access including those living far from hospitals, the marginalized and persons with disabilities.
- Provision of integrated combination prevention interventions (HTC, TB/HIV, STI, BCC, Condoms, elimination of GBV, RMNCH, VMMC, ART) to key and vulnerable populations.
- Conduct a VMMC situational analysis.
- Develop a VMMC strategy.
- Advocate for VMMC awareness among the policy makers and community.
- Scale up PMTCT services (training, infrastructure, etc.).
- Strengthen mother-to-mother support groups (MtMSG) for PMTCT service uptake to improve adherence.
- Improve procurement, and supply chain management.

- Initiate the Transition from option A to option B+ in all facilities offering PMTCT.
- Improve data collection and reporting at PMTCT sites.
- Improve Screening, treatment, recording and reporting of STI routine data and surveillance of STI.
- Improve recording and reporting of STI routine data and surveillance.
- Training of for the health workers on PEP and universal standard precautions for health workers.

REDUCTION OF MORTALITY AMONG MEN, WOMEN AND CHILDREN LIVING WITH HIV BY 50% BY 2017

South Sudan prioritized in its strategic plan reduction of mortality among men, women and children living with HIV by 50% by 2017 along the HLM vision but taking into consideration its limitations in terms of the availability health, infrastructure, trained personnel, health service utilization levels, access to populations due to terrains, cultural perceptions and security. South Sudan therefore focus increasing proportion of PLHIV on ART to 80% (adults) & from 3% to 50% (children) by 2017, improving retention on care and treatment as well as improving access to social protection and safety nets for PLHIV and HIV affected households.

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV

The burden of HIV in South Sudan has been increasing over the years. The estimated number of PLHIV as table 4 below shows, has increased from 170,000 in 2010 to 190,000 in 2014. Out of the 190,000 PLHIV in 2014, about 170,000 are adults. While about 100,000 of PLHIV in 2014 were women of 15 years and above.

Table 4: Number PLHIV by CD4 threshold 2010-2014 (HIV spectrum estimates 2014)

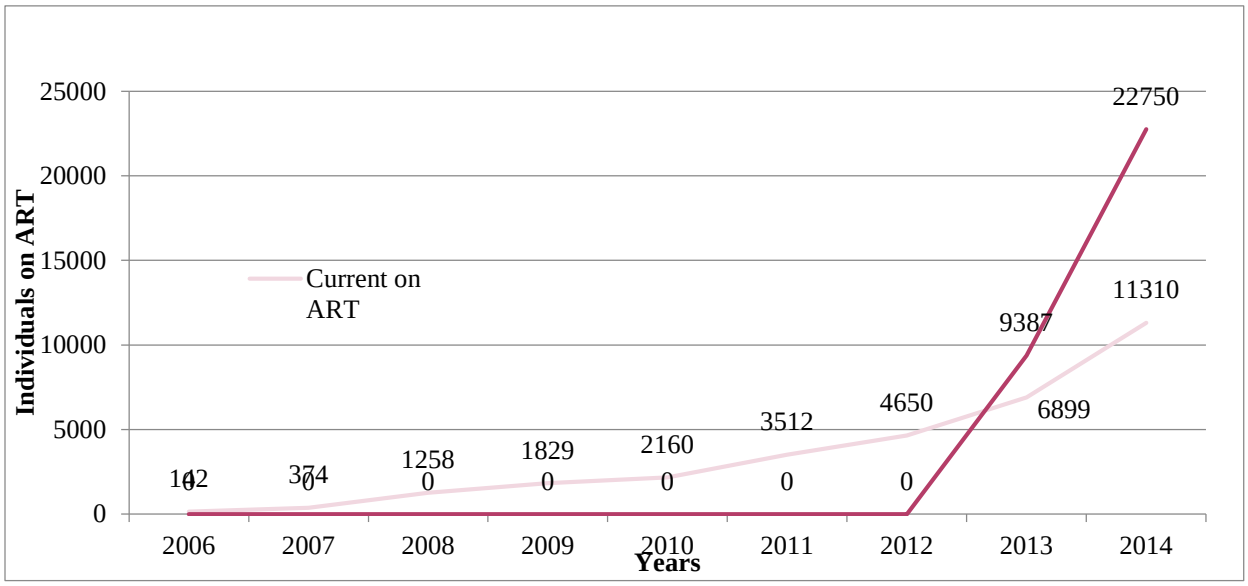
	2010	2011	2012	2013	2014
Estimated number of people living with HIV	170,000	170,000	180,000	190,000	190,000
Estimated number of Adults 15+ living with HIV	150,000	160,000	160,000	170,000	170,000
CD4 threshold	<200	<350	<350	<350	<500

SCALE UP HIV CARE AND TREATMENT

The scaling up of HIV treatment across the country is one of the most remarkable achievements in the HIV response in 2014 despite the crisis that affected country. At the end of 2014, 11310 people living with HIV were receiving ART in the country, representing about 48% (11310/22750) of the national target set for 2014 in the NSP as chart 6 below shows. The number of people receiving ART rose by about 40% compared with the previous year of 2013, making it the largest

annual increase ever. However the coverage of ART according to current estimated number of people living with HIV remains very low at about 6%.

Chart 6: Number of individuals currently on ART vs NSP Targets, 2006 - 2014

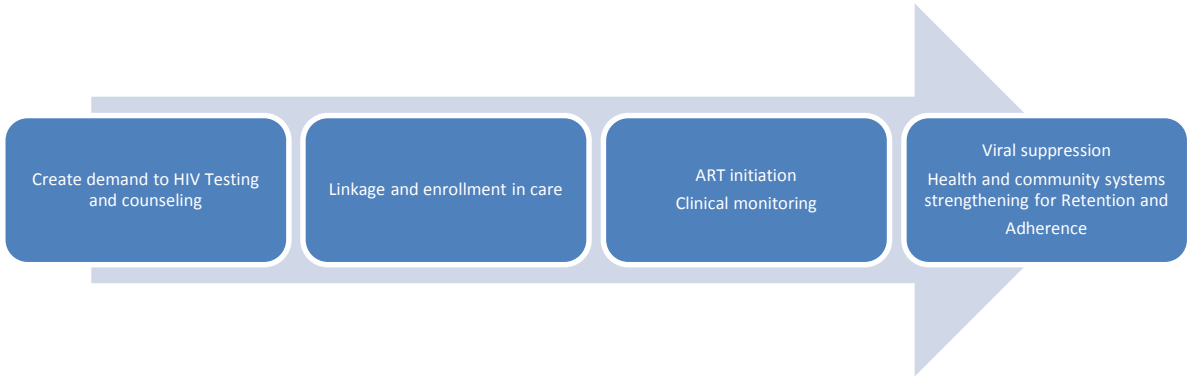


This rapid expansion of access to ART in 2014 is as a result of implementation of the WHO recommendations in the newly adapted national consolidated clinical guidelines for antiretroviral use for treatment and prevention of HIV. This progress is as a result of the strong political commitment from government and implementing partners, commitment from the international community funding the response (Global and PEPFAR) to accommodate the increased numbers, coordination between partners to ensure sustained scale up, the commitment of health care workers, community mobilization including people living with HIV and the application of new technologies especially Point-of-Care (PIMA) in identification of PLHIV eligible for ART.

This increase comes against a backdrop by the effects of the post December 2013 political crisis that resulted in extensive displacement of populations including health workers and closure of some health facilities in the conflict affected areas. More than one-third of the country was grossly affected by the civil war and >90 of PLHIV in these areas remain unaccounted for. Relative peace in rest of the country allowed partial scale up which coincidentally has the greatest burden of HIV

PROGRESS TOWARDS ACHIEVING NATIONAL TARGETS

The test-treatment-retain cascade provides a framework for assessing progress in programme implementation achieved at each step of the continuum of care, from HIV testing to achieving and maintaining viral load suppression.



PROVIDER INITIATED HIV TESTING AND LINKING PEOPLE TO CARE

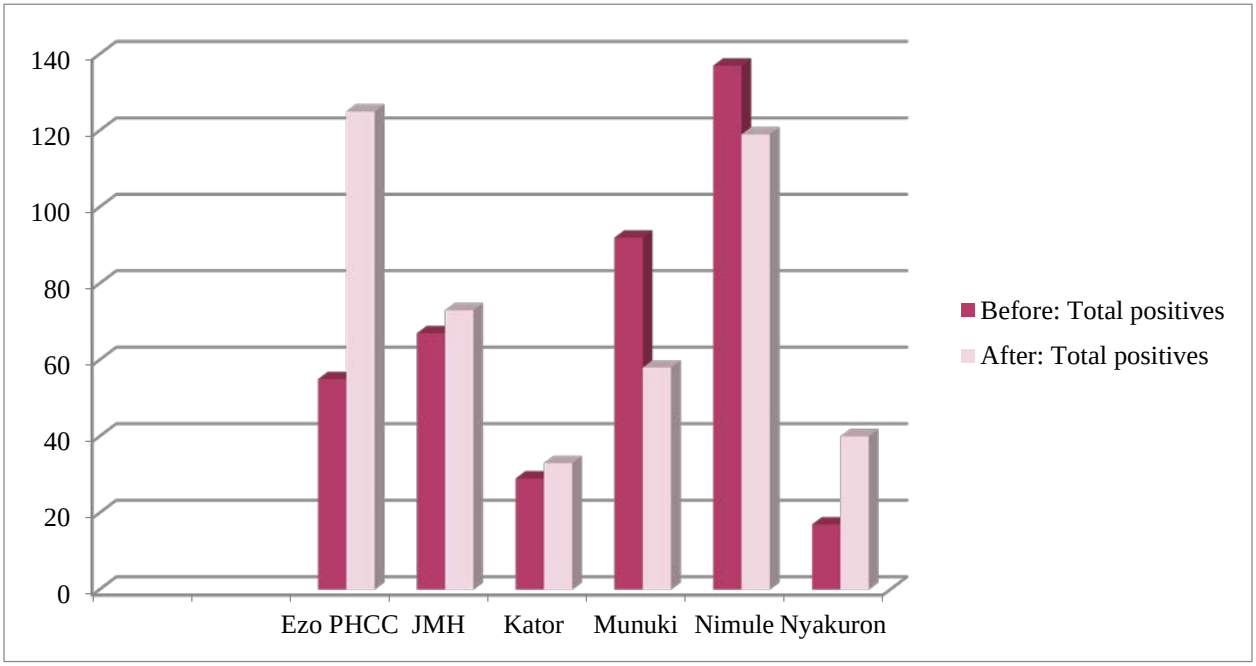
The national consolidated clinical guidelines for ARV use for HIV treatment and prevention defines the approaches and modes to HIV testing in the country. HIV testing and counseling (HTC) is provided through two main approaches: client initiated testing and counseling (CITC) routinely performed among self-referred clients who want to know their status and provider initiated testing and counselling (PITC), using either the facility-based model (at health facilities, stand-alone sites), or community-based models in different settings such as Home-based door-to-door testing, mobile and outreach, work-place, educational institutions and campaigns. In general there is lack of resources for scale up for HIV interventions HIV testing inclusive, therefore the need to effectively utilize the available resources.

Recognizing the need to maximize resources, the MoH and US Government PEPFAR program piloted the HIV Provider Initiated Testing and Counseling (PITC) in six selected health facilities. The PITC is implemented with the aim of Reaching more persons with HIV testing; Identifying more HIV positive persons and discordant couples; Providing more efficient linkages with follow-up prevention, care, and treatment services; and Routinizing HTC as part of standard healthcare services to build MOH capacity, integrate with MOH systems, and provide more sustainable

services. The PITC is offered in outpatient General OPD, STI clinic, TB Clinic, Ante natal, Post-natal and Family planning clinics and In-patients (particularly medical and pediatric wards).

Results from this pilot indicate a general increase in the number of people testing for HIV with the introduction of PITC, increased proportion of HIV positive results and more females accessing HCT services compared to males-both before and after the PITC introduction. Some facilities also reported improved linkage of those testing positive to care and treatment.

Chart 7: Total number of HIV positive individuals before and after introduction of PITC



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The limited HIV testing makes linking the people diagnosed with HIV extremely vital in order to sustain the scale up of HIV treatment. The national programme with support from partners developed referral guidelines and tools and trained health care providers on referral between HCT and treatment service points. Due to limited funding implementation was systematically conducted by a few NGO supported facilities especially PEPFAR-funded partners. These partners report >95% of people are linked between testing and enrollment in HIV care. However numerous challenges have been cited as deterrents to effective linkage, these include Stigma and discrimination, prohibitive distances between HIV testing and HIV care/treatment centers, weak

integration and coordination of services, and weak community and health care systems to ensure referral.

Enrollment into pre-ART HIV care

Performing the right interventions at enrollment and during pre-ART HIV care is extremely important for determining survival for PLHIV before they start ART. A number of interventions are spelt out in the national clinical guidelines and routinely performed by many health providers at facilities providing HIV care; these include HIV counselling and patient education, providing co-trimoxazole prophylaxis, community/home visits, treatment of Opportunistic infections, screening for cancers and opportunistic infections and conducting CD4 testing to determine eligibility.

Overall, the total number of HIV-infected people enrolled into HIV care in the 19 ART/HIV care functioning sites from Jan – Dec 2014 was 6885 (4115 F and 2770 M). This probably leads us to a conclusion that female are more likely to be enrolled than male. Reasons may be attributable to greater encounter with the health system e.g. through MCH/PMTCT, opportunity arising by care for children and higher acceptance of women for health services. By the end of 2014, 18671 people living with HIV were receiving HIV care, this represented 25% (18671/75400) of the national target set for 2014 in the NSP. In 2014, the programme adapted the consolidated clinical guidelines which include guidance on prevention, diagnosis and management of common opportunistic infections and cancers. Health workers were trained on clinical management and guidelines distributed for use.

In the same year, Point-of-care CD 4 testing was introduced with support from PEPFAR and GFATM. To avoid unnecessary delays in assessing Pre-ART clients for eligibility to ART and to ease monitoring while on treatment, 22 PIMA instruments were procured by CDC and 10 by GFATM, all machines were distributed to health facilities providing ART. PIMA complimented the PARTEC CD4 machines which are well suited for the high volume sites. Overall,

From Sex Workers and MSM words

- 'The South Sudan Military, the Ugandan military and Kenya military help sex workers with supply of HIV/AIDS and TB drugs. As we are talking some of us are taking our medication with the supply of these good people'. .
- 'My third point is on treatment and care we find the medicine very expensive. Last one month ago they were arresting some ladies over the issue of drugs (ARV's) when they arrest you they make you pay like 250 South Sudanese pounds. They just stop all the buses and taxis and check everybody if you have they take them. They confiscate all the drugs found in our bags. They take them and throw them away'.

the total number of CD4 tests performed between Jan- Dec 2014 short up but due to lack of quality data, the programme hasn't been able to document the magnitude. As well the total number of HIV-infected people who had at least one CD4 test between Jan- Dec 2014 markedly improved to 95% in some facilities. There is no doubt that the access to CD4 testing has greatly contributed to the rapid expansion of ART in 2014.

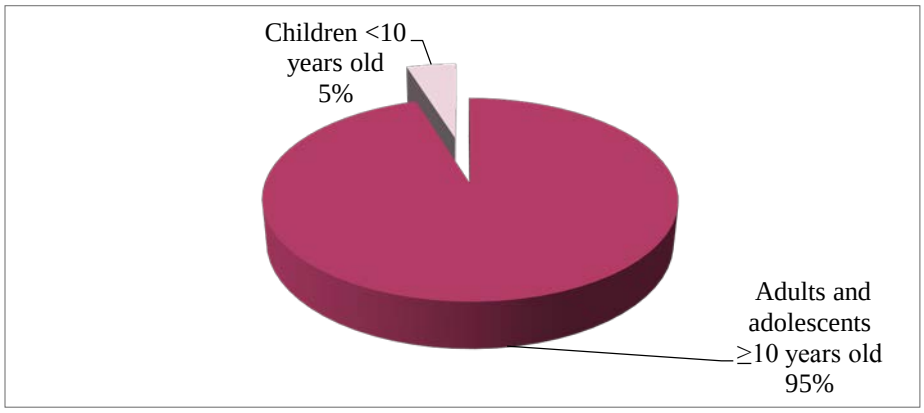
Expansion of HIV treatment in adults and children

The newly adapted consolidated clinical guidelines for ARV use for HIV prevention and treatment introduced policies for earlier initiation of ART to people with a CD4 count ≤500 cells/mm3, providing ART to the HIV-positive partners in serodiscordant couples, implementing lifelong ART for pregnant women living with HIV (Option B+), initiation of ART irrespective CD4 count for co-infected individuals with TB and Hepatitis B and in children below 5 years. This new criteria provided enormous opportunity for initiating PLHIV onto ART hence majorly contributing to the rapid scale up.

The consolidated guidelines were further simplified and operationalized into Integrated Management of Adult Illness (IMAI) training materials for health providers. The IMAI guidelines were used to train over 200 multidisciplinary health care providers in 19 old facilities and 8 new satellite facilities. Treatment and care was expanded and decentralized to Primary Health Care Centres in WES (Source Yubu, Nandi, Ibba), Lakes state (Yirol hospital), Warrap (Tonj South, Kuajok), CES (Munuki, Nyakuron, KatorKator) and GBEG (Sikka Hadid and Comboni). The new guidance and decentralization of services contributed enormously to the rapid scale up of ART where six thousand twenty (6020) PLHIV were initiated on ART in 2014. Majority of PLHIV initiated were female 4119 while 1901 Male. Of the 6020 newly initiated 5640 were >15 years whereas 380 were <15 years, WES enrolled the biggest number of 2721 on to HIV treatment, CES initiated 2433 followed by EES and NBEG at 519 and 251 respectively. Some of those initiated were LTFU or died and leaving a total of 11310 receiving ART by the end of 2014.

About 99% (11277/11310) of HIV-infected adults and children on treatment are still on 1st line ARV regimens while the rest is on 2nd line AR therapy. PLHIV on 2nd line have remained few due to lack of monitoring facilities for treatment failure i.e. Viral Load. Children comprise of about 5% (542/11310) while 95% (10768/11310) are adolescents and adults

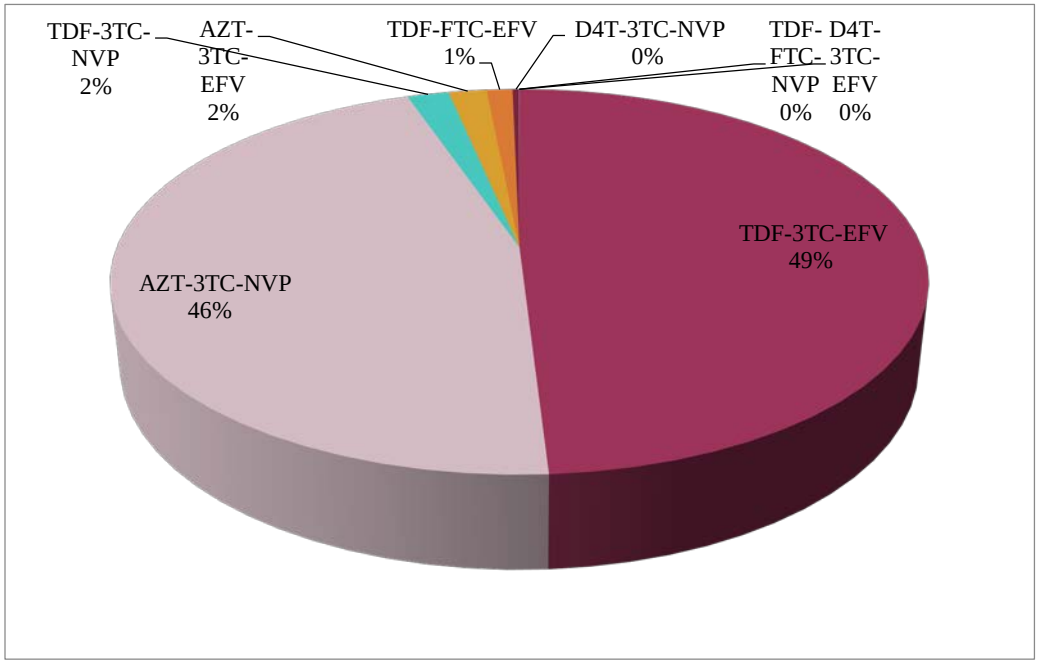
Chart 8: Percentage of Individuals currently on ART by age groups (<10 and ≥10), 2014



ART regimens in Adults and Adolescents

At the end of 2014, 49% and 46% of the HIV-infected adults and adolescents ≥10 years old were on TDF-3TC-EFV and AZT-3TC-NVP regimens respectively. <0.3% was on d4T-based regimens, these are mainly children.

Chart 9: Percentage of adult patients by current treatment regimens



This is in line with the current consolidated clinical guidelines where the preferred ART regimen for all populations is TDF-3TC (FTC)-EFV whereas d4T was phased out.

AZT-3TC-NVP is an alternative regimen still often used since it was preferred regimen before adaptation of the consolidated guidelines.

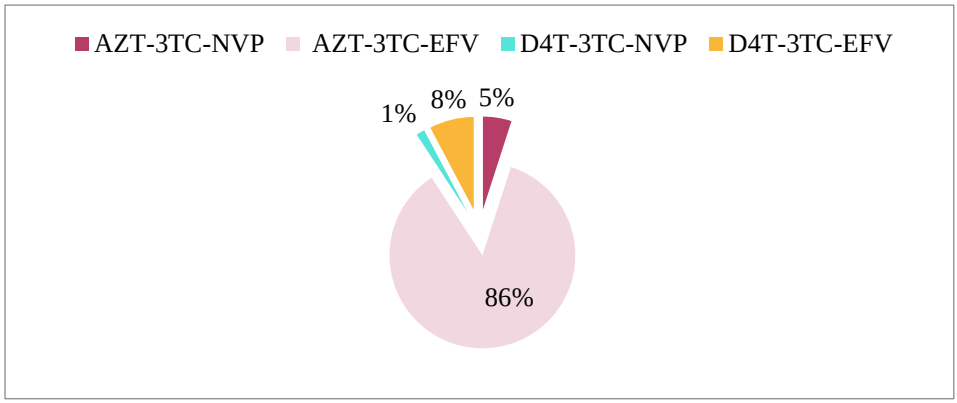
HIV treatment among children living with HIV

Children represented only about 5% (542/11310) of the overall PLHIV on treatment. 90% (493/542) of HIV-infected children were on AZT-based regimens while the rest were on d4T-based regimens. The programme has a plan of transitioning those on d4T-based regimens to AZT for children <10 years and TDF-based regimens for those >10 years. Numbers of children have persistently remained low due to lack of EID services. The programme has now developed an operational plan and tools for Early Infant Diagnosis (EID) to guide the scale up of ART services among children; procured PCR machine and in process of remodeling the National Reference Laboratory. Capacity is needed to initiate collection, transportation and processing of DBS samples. Linking of the MCH and HIV programmes is needed to continuously identify children who need treatment.

From PLHIV in South Sudan

- 'There is very high stigma and discrimination against us at home in the family, community and by Health Workers'.
- 'When we are being provided with services, there is no confidentiality things are done in a verandah where there is a lot of congestion.
- 'Health workers in South Sudan are the worst source of stigma and discrimination especially the midwives'.
- We feel the health workers are inadequately trained to provide HIV/AIDS treatment services. Train PLHIV health professionals to replace hostile health workers'

Chart 10: Percentage of children living with HIV by current treatment regimens.



Decentralization of ART services (coverage by state)

Decentralization of HIV treatment and care services is underway; 4 regional IMAI trainings conducted included health care providers from newly established ART sites. The trainings and expansion of ART facilities to satellite facilities offered opportunity scale up treatment to communities beyond the current 19 functional ART facilities. Currently, mo st facilities providing HIV treatment are located in urban or semi-urban settings (state, county hospitals and few PHCC's). 90% of PLHIV on ART by end of 2014 were found in the greater equatorial region where the burden is about 60%. With approval of the GFATM/ New Funding Model grant, the programme plans to more equitably expand treatment to the entire country.

Quality of HIV care services

In this rapid scale up, quality of services are likely to be compromised therefore significant investments were injected into *improving quality of ART services* through supervision and mentorship, improving Procurement and Supply Management systems, improving data management, strengthening community systems for referral and follow up of clients, infrastructure improvement including equipping facilities with the necessary machines for monitoring HIV treatment response. A number of partners (WHO, UNDP, ICAP, IHI, DoD) worked alongside the MoH to develop mentorship and Quality Improvement tools including Standards of Care (SOC) and conduct mentorship. MoH, WHO, UNDP, IHI and ICAP worked together to enhance quality data collection and reporting

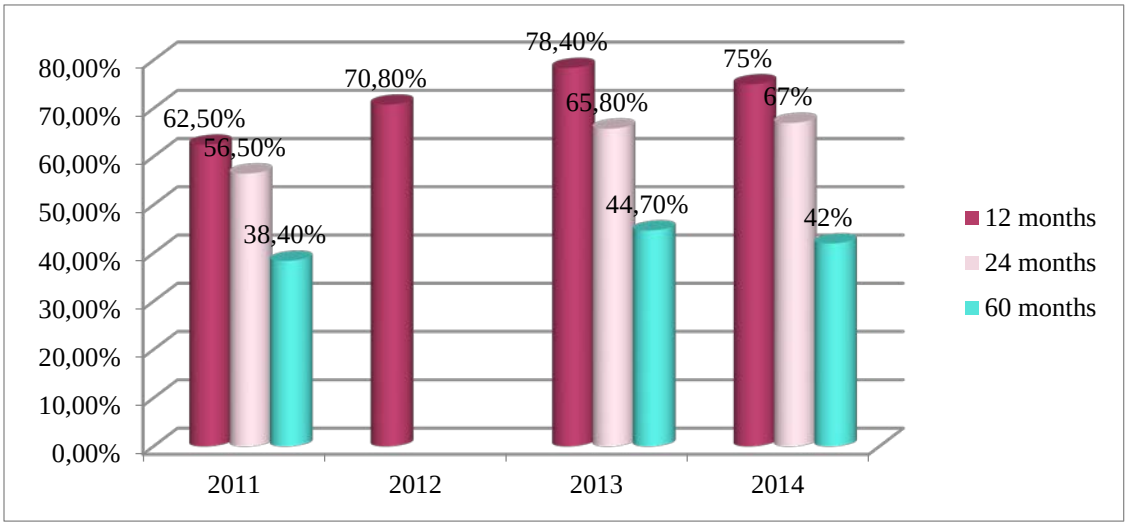
PREVENTING TB AMONG PEOPLE LIVING WITH HIV AND PROVIDING CARE FOR PLHIV THAT ACQUIRE TB

HIV programme should work closely with the TB programme, by holding joint planning and implementation meetings, conducting research, M&E and management of co-infected individuals. The tasks are divided between the two programmes. *HIV programme* - The national guidelines recommend that everyone living with HIV be screened for symptoms of TB on every visit, using a simple screening tool for intensified case finding for active TB in PLHIV. This tool was updated in 2014, and made available to providers in the consolidated guidelines and job aides for easy reference during consultations. The screening information is reported routinely through monthly reports to the national programme and data is used for planning. In 2014, 18641 PLHIV were screened for TB at least once in the year. Isoniazid preventive therapy isn't yet policy in South Sudan and hence IPT isn't recommended for prophylaxis. The TB and HIV programmes also finalized operational guidelines for infection prevention in healthcare settings to minimize transmission of TB. *TB programme* - According to the national guidelines, TB clients should routinely be screened for HIV, and everyone co-infected with TB and HIV should receive co-trimoxazole preventive therapy and immediately be initiated on ART, regardless of CD4 count. By end 2014, the coverage of TB clients screened for HIV, individuals co-infected who receive CTX and coverage of ART among people with TB was found to be 68%, 91% and 57% respectively. Two of the indicators are significantly below the target of 90% by 2017.

RETENTION ON ART

Retaining people living with HIV across the continuum of care is essential for optimal health outcomes. Retention at all steps in the continuum i.e. from HIV testing to viral suppression is essential for sustained scale up of treatment.

Chart 11: Percentage of ART patients retained on treatment at 12, 24 and 60 months.



In 2014, retention on ART study conducted revealed a mean retention at 12 months of 75%, gradually declining to 67% at 24 months and 42% at 60 months.

Comparing retention outcomes of 2014 with the previous year, despite the crisis that resulted into massive displacements there seems not to have been any significant decline. Also comparing with the national targets (NSP) of 82%, 79% and 75% for 12 months, 24 months and 36 months respectively by 2017, we realize that huge efforts are needed for improvement.

Some lessons were learnt from the crisis response in 2014 that avoided stock out of ARV drugs and innovative ways of ensuring continuous supply of ARV drugs and other essential HIV commodities during the period of crisis. These included maintaining communication with providers of HIV services, quickly reopening of health facilities for access of ARVs in areas not directly affected by war; dispensing huge quantities (at least 3 months of supply to patients); partnerships by MoH, GFATM, UNDP, WHO and WFP working together to ensure emergency supplies and alternative storage and fast-tracking of supplies by air transport to provinces/states; and re-establishment of HIV essential services including supply of ARVs to displaced populations in IDP camps.

Mechanisms for improving retention included ensuring food supply by WFP to especially displaced populations and those clinically very sick. Nutrition education continued to be central to patient education programs at facility level and adherence support through community/home care teams was conducted by some NGO's/CBO's e.g. CECE in Nimule. The HIV programme is working with partners on plan to improve retention including contingent planning during crisis, investment in improving adherence including monitoring adherence as part of essential performance indicators in MoH, support for community/home care teams and workforce e.g. Mother to Mother (M2M) support groups, community midwives and PLHIV networks, improving patient monitoring systems at facility level, introduction of new technologies such as routine viral load and sending of sms as reminders where available. Other measures include strengthening skills of health workforce and ensuring availability and strengthening road transport systems for patient referral and follow up.

CHALLENGES IN DELIVERY OF HIV TREATMENT, CARE AND SUPPORT SERVICES

a. PITC and linkages to enrollment into HIV care
   i) Stigma and discrimination
   ii) Prohibitive distances between HTC and care and sometimes lack of transport
   iii) Weak integration and coordination of services
   iv) Weak community and health care systems to ensure referral
b. ART initiation and scale up
   i) Few Health facilities offering ART/HIV care
   ii) Frequent breakdown of CD4 machines
   iii) No VL for monitoring treatment response
   iv) Dilapidated infrastructure
   v) Quality of treatment monitoring – poor maintenance of Lab equipment to perform Clinical chemistry, hematology etc.
   vi) Inadequate suitably qualified staff, skills and poorly motivated health workforce
   vii) EID – Equipment no yet installed; affects enrollment for paediatric treatment
c. TB and HIV programming
   i) Leadership to foster joint planning, review meetings, joint trainings and supervisions for HIV and TB
   ii) Lack of a common platform for M&E and sharing of information

d. Patient retention on ART

i) Inadequate funding support for Community initiatives and tools for patient education, information and adherence counseling

ii) Healthcare workers not trained on ART adherence counselling and ethics in order to address stigmatization and staff attitudes towards HIV positive persons and improve interactions with patients

iii) Poor collaboration between food supply (WFP) for PLHIV and MOH/SMOH/clinics offering ART

iv) Insecurity in some parts of the country

PRIORITY AREAS FOR 2015 - HIV TREATMENT, CARE AND SUPPORT

i) Expansion of HF's providing HIV care and treatment - Decentralizing treatment and care services

ii) Integrated ART/PMTCT training – clinical skills, PSM, M&E

iii) Establish PCR and VL testing to facilitate EID and treatment monitoring

iv) Acceleration of treatment for children and pregnant mothers (Option B+)

v) Revitalization of joint programming for HIV & TB

vi) Establishing services for Population Of Humanitarian Concern

vii) Integrated community systems for delivery of HIV Prevention and adherence HIV treatment

viii) Private sector engagement to expand care in Big cities

ix) Reaching Key populations – prisons, FSWs

ENABLING ENVIRONMENT FOR EFFECTIVE NATIONAL HIV RESPONSE

South Sudan recognize that there is need to create an enabling environment for the national response to thrive. It prioritized therefore in the next five year improving the policy environment for an effective national response, reduction of the funding gap for the HIV/AIDS response to 15 % 2017, ensuring that there are functional coordination structures at all levels as forging leadership commitment. Effective programme and financial accountability for HIV interventions mechanisms put in place as well as strengthening system to generate and utilize strategic information for policy formulation, planning and management of the HIV response. The issue of ensuring that quality HIV commodities are available in a timely manner was prioritized and housed in the enabling environment pillar.

ACHIEVEMENTS IN 2014

POLICY ENVIRONMENT

In the year 2014, SSAC, UNAIDS and UNFPA mobilized financial and technical resources for the review of HIV policy and work place policy which is still on going. WHO, UNDP and Intrahealth Contributed to the development of HIS Policy and HMIS Strategy in 2014. PMTCT scale plan, operational guidelines and tools for PMTCT with support from UNICEF and UNAIDS.

In line with improving the policy environment, development of the Accelerated Agenda Country Action (AACA) for women, girls, gender equality, disability equality and HIV and AIDS was initiated with the support of UN Women, UNAIDS, SSAC and many partners are being engaged in the process. The policy is now in the final stage. Ministry of Education and Ministry of Gender, Social Welfare, Religious affairs and disaster management were also engaged by the HIV/AIDS partnership to incorporate into the school curriculum HIV/AIDS lessons.

INCREASING DOMESTIC AND EXTERNAL FUNDING FOR THE NATIONAL HIV RESPONSE

The total financial requirement for the South Sudan AIDS Strategic Plan 2013-17 is US$ 273 million during the five-year period of the strategy. The Government intends to spend total of US$ 14 million within the period of the funding request, consisting US$ 2.5 million in 2014/15, US$ 2.8 million in 2015/16, US$ 2.9 million US$ 8 in 2016/17, and US$ 3.1 million in 2017/18. This translates to an average of about US$ 2.8 million annually in the four years and unable to fill the required financial resources. Moreover, this amount will be geared towards programme administration and coordination in terms of support to SSAC, HIV Department in the Ministry of Health, SPLA HIV secretariat, and workplace activities at government ministries and agencies/ secretariat including the Ministry of Interior and Wildlife Conservation HIV/AIDS secretariat.

The country was under crisis in 2014 and many development partners shifted their attention to humanitarian services and attention to developmental initiatives. Although resource mobilization strategy had been planned to be completed in 2014, it was not possible because of the crisis which caused the evacuation of the consultant. UNAIDS and UNFPA is negotiating with the consultant to come back and finalize the development of the strategy.

The country HIV/AIDS partners through the HIV/AIDS technical working group developed the Global Fund new funding model concept note to access Global Fund resources. The process involved development of the concept note through dialogue processes. The technical working group developed a concept note worth USD 60,072, 070 with 36,565,788 being an allocation that had been defined by the Global Fund during the call of the proposal and 23,506, 282 being the amount that the technical working developed for quality and program acceleration as an above allocation. The technical review board of the Global Fund approved all the amount of 60,072,070 but requested a clear strategy on how to absorb the above allocation amounts given the consumption rate in the history of the other grants. The New Funding Model concept note is now in the grant making stage with the aim to start the programme in October 2015.

Many other partners mobilized other resources in the year 2014 and include the UN joint Team, PEPFAR through the Country Operational Plan 2014. UNAIDS mobilized over half a million USD for initiating HIV/AIDS activities for the persons displaced during the crisis.

During the Global Fund review meeting on October 8, 2014, the government also committed to fund an additional 5% of the approved GF budget for the period of 2015-2017.. These funds, while not yet committed to any specific intervention, will be added to health systems strengthening efforts that support impact on the three diseases. During this period also, an operational plan with clear targets was developed for Ministry of Health, SSAC, Ministry of Defense, NEPWU and SNEP+.

MAKING AVAILABLE QUALITY HIV AND AIDS PREVENTION, TREATMENT AND CARE COMMODITIES HAVE TIMELY AND CONTINUOUS ACCESS.

In bid to improve the making available supplies to the centers, regular meetings for forecasting of OI, ARVs and STI commodities have been taking place resulting on reliable forecasting and distribution especially on the Global Fund sites. With Global Fund support, storage and distribution to the lower units has been improved with CCM oversight committee visiting warehouse for PSI. PSM trainings were conducted for 21 pharmacists/dispensers/ storekeepers from the ART sites on recording, ordering and quantification of supplies in the facilities through the support from UNDP GF project.

In 2014, about 23 Pima machines with cadridges for ART monitoring were procured, condoms, rapid test kits and ARVs were also procured by PEPFAR and Global fund. Drugs for opportunistic infections, STI's, lab reagents and AIDS therapy were also procured by partners. UNFPA procured condoms and reproductive health commodities in support of reproductive health and HIV interventions. Currently, PCR machine has been procured and delivered in country by GF through UNDP with training on Training on PIMA machines undertaken. It is to be noted that the drug and food authority control has been established with support from World Bank to undertake quality monitoring of the foods and drugs.

FUNCTIONAL COORDINATION STRUCTURES AND IMPROVED LEADERSHIP COMMITMENT AT NATIONAL, STATE AND COUNTY LEVELS

In terms of coordination, SSAC and Ministry of Health continued coordinating partners towards addressing issues as arose. Many adhoc coordination meetings were held that included for the review of the strategic plan, development of the of the strategic information plan, development of

the concept note and many other policy guidelines and documents to guide the implementation of the programs and interventions. Currently there are several partnership arrangements that meet regularly in 2014. These include Health Sector Partners, HIV Technical Working group, HIV M&E technical working group, PMTCT technical committee. The TWGs at state and county level have not been established and attention will be given in 2015.

UNAIDS supported to develop and mobilize resources for holding a national holding partnership forum as a platform for collective review of the progress, identification of implementation bottle necks and formulation of corrective solutions and monitoring of the corrective measures. The concept note was adopted by the HIV/AIDS technical working group but could be held because the country partnership got over involved with the Global Fund concept note development. UNAIDS volunteered seed money but was not utilized.

Increased generation and utilization of Strategic Information for policy formulation, planning and management of the HIV response in South Sudan.South Sudan HIV/AIDS technical working group comprising of partners, continued to Strengthened leadership, organization and coordination of HIV and AIDS Strategic information generation and management at national and state level.

PROGRESS/ACHIEVEMENTS REALIZED IN 2014 INCLUDED THE FOLLOWING:

- HIV Strategic Information plan 2013-2017 developed;
- HIV estimation undertaken and utilized in the Global fund new funding model;
- Modes of Transmission Study was finalized;
- NASA data analysis and report development was undertaken;
- Finalized the printing and distribution of revised HIV Tools (HTC, ART and PMTCT);
- Finalized Health sector Strategic Information Plan;
- MOH HIV annual report finalized
- GARPR report developed and submitted
- Formative assessment on HIV/AIDS for people in correctional services and female sex workers undertaken;
- KAP survey conducted for young people from age 10-24yrs in four states (Warrap, Nothern Bahr El Ghazal ,Western Bahr El Ghazal and Lakes State);

- Training of data clerks from all the 22 ART sites
- Training of 18 State HIV Directors and M&E Officers on Basic M&E skills and competencies;
- On Job training for HIV department in MOH financial officer conducted on reporting.
- Financial officers trained on financial management soft ware
- Trained 50 heath facility staff on the revised HIV/AIDS data collection and reporting tools
- Conducted training for data collection analysis, interpretation and use for 40 state and county M&E officers
- 3 staff were seconded to MOH to support HIV M&E activities

CHALLENGES

- Laws and Policies on availability and access of HIV/AIDs service for Sex Workers and MSM lacking. The services include partnership formation, protection, testing, and access to information, treatment, care and support.
- Coordination, policies and resources for PSM inadequate.
- Guidelines, human resource for oversight and supervision.
- National drug regulatory authority (Registration and pre-qualification) lacking.
- No capacity and equipment's to ensure application of international quality standards for the respective product (Quality Control).
- High levels of stigma and discrimination in the country including politicians and other policy makers which affects the formulation, passing and implementation of legislations and policies.
- Inadequate HIV mainstreaming in the various sectors and gender inequality.
- No forum for sharing the work plans and performance review held in 2014.
- Obtaining technical assistance for contract negotiations for lab equipment (or lease options) and related commodities (consumables, S&M) to improve performance of the CD4 monitoring machine.
- There have never been a functioning PCR machine for early infant HIV diagnosis.
- The country currently relies on WFP for transportation of commodities to states. PEPFAR can only bring commodities to the country and partners collect leading to irregular and unreliable distribution of commodities to the last mile before consumption by the beneficiaries.

- There is no strong HIV TWG at state and county level.
    i. Inadequate national, state and counties HIV Units with active focal points for Civil Society, Faith-Based Organizations, PLHIV and Disabled People's
- There is limited human resource capacity especially in the area of M & E at all levels;
- There is no comprehensive database for HIV related activities at SSAC
- There is no system to capture data at community level
- Staffs have not been trained on the use of the revised HIV tools at facility level;
- Limited and inadequate funds for survey, training and supportive supervision;
- Insecurity and inaccessibility in some states.
- No information on grandmothers who are care givers and heading orphans households
- High staff turnover in MOH/SSAC at all levels

PRIORITY FOR 2015

- Finalize the policies and strategies that include HMIS, HIV, AACA, resource mobilization and disseminate to all stakeholders.
- Provide technical support to Global Fund new funding model implementation in oversight, supervision and periodical review.
- Establish forum to share work plans and performance reports among partners implementing the national response and continue building capacity of partners and sectors to develop work plans and performance reports.
- Assess and improve the robustness of Forecasting and Quantification processes (population versus consumption), software and services at national level, and feedback procedures from state and lower levels.
- Improve the distribution schedule to cover distribution "Beyond the last mile" up to community level, to reach key populations, POHC, Persons with Disabilities and others;
- Advocate for funds and technical assistance to enable quality control standards for HIV/AIDS commodities, drugs and equipment;

- Advocate and support SSAC with technical and financial assistance to hold partnership forum in September this year and to develop end of financial year report on progress, bottlenecks and next steps;
- Mobilization of resources for 2016 NASA; review meetings at state level, capacity building, supervision visits, MOT, Cities project Yambio and Juba.
- Plan to hold bi annual review meetings at the national and state level;
- To integrate survey for grandmothers who are care givers and heading orphans households on population based surveys.

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

More than 90% of the HIV response is funded by development partners, mainly the United States Government and the Global Fund to fight AIDS, Tuberculosis and Malaria. The government budget allocated to the health sector in 2011/2012 was 2.6% of the total.[27] However, actual public expenditure on the HIV Programme was 6.5% in 2010/2011, increasing to 8% in 2011/2012.[28] A previously approved parliamentary motion doubling HIV Program allocations from 15 to 35 Million South Sudanese pounds has been undermined by conflict and the humanitarian crisis, which have slowed funds flow to all sectors including health. Less than 30% of required funding for humanitarian issues had been pledged by April 2014. HIV is currently competing for funding with food, security and other critical budget items.

The table provide the list of development partners and the areas they support in South Sudan as collected during Global Fund Concept note development in early 2015

Table: List of development partners and areas they support as early 2015

Partner	Health System Area Supported[29]
US Govt. (PEPFAR)[30]	Health Information Systems: In collaboration with Government of South Sudan, the US Government (PEPFAR) currently funds part of the Health Management Information System, and the generation of strategic information. USG also partly funds; supportive supervision and data quality assessments in states, countries and facilities.
Global Fund Round 9	Human Resources and Infrastructure: 3 teaching institutions renovated and equipped some institutions and supported the MOH in selection of students. In addition, it recruited 8 international tutors for the training institutes; Renovated and equipped one warehouse in Juba, and some in Nassir being completed PSM: Trained 145 health workers for 3 days each on pharmaceutical management; Procured and installed 6 pharmaceutical waste incinerators in state hospitals; 84 waste collection boxes for distribution and conducted training in Logistical Management Information Systems (LMIS) HIS: 20,000 HMIS tools printed and distributed; 175 national, state and county and facility M&E focal persons trained on use of HMIS tools; 5 State M&E offices strengthened through renovation; IT equipment, furniture and support provided. Service Delivery/ HR: Trained 579 Health workers and auxiliary staff in health facilities on universal precautions; 387 health workers trained on MNCH and PMTCT for 30 days; health service delivered and four community resource structures supported.
World Bank	The World Bank funded Interfaith Medical Assistants (IMA) to roll out DHIS up to the CHD levels; trained M&E/ Surveillance officers; provided two laptops per county; seconded two M&E officers to MOH. It also funded Liverpool Associates in Tropical Health (LATH) to conduct health facility survey;

[27] Annex 37- MoF (2012) Approved Budget Book 2012-13
[28] South Sudan National AIDS Spending Assessment 2010/2011-2011/2012, May 2014.
[29] Source: Partner Reports Consolidated in the MOH Summary Presentation at the Global Fund Mock TRP Review, October 2014
[30] PEPFAR 2013 South Sudan Operational Plan Report(Annex 27- pp. 8-27)

	carry out HIS review meetings, review support Supervision tools and conducting LOT Quality Assurance Sampling (LQAS)
GAVI Grant to World Health Organization and UNICEF	Training of state Directors General on leadership, governance and management and county health management teams on the Basic Package of Health and Nutritional Services (BPHNS)31 the district and health team on leadership modules; printed IEC materials for the campaign for children and mothers' health; Production and publishing of the Health Sector Development Plan (HSDP) and BPHNS; renovation of the national vaccine store and cold rooms; provision of motorboats and motorcycles to support EPI activities in states; and provision of cold chain equipment (Refrigerator and cold boxes, among others)
Health Pooled Fund (HPF)	Conducted Health Systems Assessment in six states, identified gaps and developed a work plan. The HPF has also co-funded a leadership management program design, beginning with joint planning exercise including 39 County Health Departments (CHDs), implementing partners and other NGOs. It has also supported aspects of the PSM system for drugs in 39 counties.
Abt Associates	Supported Very Small Aperture Technology (VSAT), a two-way satellite communication system for Internet Connectivity; HMIS/ DHIS training to County Health Department M&E Focal Persons; Supportive supervision to County Health Departments and health facilities, among others.
Intra Health International	Supported MOH in HIV/AIDS data management and development of earlier version of National Strategic Plan; development of the Health Sector Strategic Information and capacity strengthening Plan. Supported MOH in revising, printing, and distribution and training 50 facility staff on revised HIV/AIDS data collection and reporting tools; Conducted training for Data collection analysis interpretation and use in which 40 state and county M&E officers benefitted. Seconded one staff to MOH based at HIV department and two staff to the State MOH in the greater Equatoria. Supported the MOH in the development of the HMIS policy and strategy. Also supported the Global Fund New Funding Model application process and provided other operational support to MOH.
UNAIDS	Supported the development of National Strategy Documents including the updated NSP, and generation of strategic information; as well as leadership of the HIV program, and collaboration with the humanitarian / peace and security program, as well as among development partners in health.

[31] Annex 56 - MOH (2011) Basic Package for Nutrition and Health Services

LIST OF PARTICIPATING PARTNERS AND INDIVIDUALS

s/no	Name	Organization	Type of Organization
1	Jeanne Bughasiya	UN Women	Multilateral
2	Moses Mutebi N	WHO	Multilateral
3	Danssan Hategekimana	WFP	Multilateral
4	Asantewaa E Lo-liyong	UNFPA	Multilateral
5	Roseline Mary	BEDN	CSO
6	Loiske Albert Koteen	OPRD	CSO
7	James Odinga	WAYEI	CSO
8	Maika Lisok	SSAC	Government
9	Caesar Lohom	SSAC	Government
10	Mary Lobojo	SSAC	Government
11	Catherine L Duku	SSAC	Government
12	James Nyawello	SSAC	Government
13	Mary Yor Lual	MSO	CSO
14	Lino Baba Diye	CA	CSO
15	Victoria Achut	MOH	Government
16	Boaz Cheluget	UNAIDS	Multilateral
17	Gerald Kimondo	MOH/JSI	Government/CSO
18	Temesgen Berara	UNDP/GF	Multilateral
19	Acaga Taban	MOH/IHI	Government/CSO
20	Gabriel Atillio	SSAC	Government
21	Justin Okeny	SSAC	Government
22	Dr.Wubaya Walelgne	ICAP	CSO
23	Alex Bolek	JUPIEGO	CSO
24	Daniel Loro	SSAC	Government
25	Henry Waye	UNAIDS	Multilateral
26	Joseph Celestino	UNIEF	Multilateral

27	Venansio Joseph	MOH/HIV	Government
28	Muntaz Mia	UNAIDS	Multilateral
29	Oyum Daniel	UNESCO/CLUB SS	Multilateral
30	David Lukudu	WHO	Multilateral
31	Philip Lokudu	SSAC	Government
32	Everline Letio	NEPWU and SNEP+	CSO
33	Lole L Lole	SNEP+	CSO
34	Habib Daffala	SSAC	Government
35	Richard Jele	SSAC	Government
36	Joy Zakaria	UN Women	Multilateral
37	Alex Bolo	CDC	Multilateral
38	Ally Ahmed	DOD	Bilateral
39	Betty Araba	UNAIDS	Multilateral
40	Panther Ajak	MOH	Government