South Sudan

Country Operational Plan

(COP/ROP) 2023

Strategic Direction Summary

May 17, 2023

Table of Contents

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Executive Summary of PEPFAR's strategy in South Sudan in support of the COP23 plan.

Introduction

South Sudan is a country in a protracted crisis. It has been plagued by conflict, flooding, corruption, poor governance, economic mismanagement, and increasing dependency on donor assistance since its independence in 2011. The United States has been a strong supporter of South Sudan, providing over $6.6 billion in humanitarian aid and development assistance since 2011 and helping to broker peace agreements. South Sudan is facing several challenges making it difficult for the country to recover from the conflict and build a stable and prosperous future. Broader systemic issues continually upend the efforts and investments into the public health landscape of the country, such as high poverty levels, lack of or deteriorating infrastructure, and sexual and gender-based violence directed at women and girls. Limited to weak service delivery and health systems directly and negatively impact PEPFAR program implementation, limiting the trajectory towards achieving epidemic control. Poor domestic allocation, and weak coordination have led to a fragmented approach to service delivery, including duplication of resources and investments.

Due to legal and policy restrictions limiting direct assistance to the South Sudanese government, PEPFAR South Sudan works with a parallel set of non-governmental health educators, providers, and facilities to deliver direct service while collaborating with the South Sudan Ministry of Health. PEPFAR is working to ensure the provision of HIV prevention, testing, and treatment services in this complex working environment by coordinating with the Global Fund and our NGO, CSO, and FBO partners. In addition to current adjustments in COP23, the team is updating its approach in a country where meeting the 95-95-95 goals by 2030 is highly unlikely, and achieving sustainability as defined by Pillar II (Sustaining the Response) of the PEPFAR Strategic Vision is unachievable anytime soon under current circumstances. PEPFAR South Sudan's efforts are to prevent initial infection and provide treatment to those who have tested HIV-positive. Within this construct, PEPFAR South Sudan focuses on maintaining program coordination and oversight of US-funded activities to ensure coverage, equity, and quality.

On behalf of U.S. Embassy Juba, we are submitting COP23 for the Republic of South Sudan. This is the twelfth PEPFAR COP submission and 17th year of PEPFAR implementation in South Sudan. PEPFAR continues to provide unwavering support to the South Sudanese people, demonstrated once again by continued resources towards saving precious lives of those living with HIV. Of the approximately 53,000 people living with HIV on treatment countrywide, 91% are receiving treatment supported by the generosity of the American people.

We acknowledge the involvement of the Ministry of Health and their various levels of engagement in the planning process this year. Our hope is that in the future we will see even more participation by senior officials, and financial contributions by the Government of South Sudan to sustain the gains been made by the United States to prevent the spread of this virus in the country.

PEPFAR South Sudan looks forward to continuing successful approaches while also pivoting the program to accelerate progress. For example:

- Investments in the DREAMS program will continue empowering the most disadvantaged groups such as adolescent girls and young women with an appropriate package of services to address inequity and reducing stigma, discrimination, and violence.
- PEPFAR acknowledges that many young women become infected through violent encounters with older men, and we will work to implement community norms change activities focusing on gender-based violence prevention and HIV awareness among men and the broader community, with a goal to break this cycle.
- In COP23, PEPFAR South Sudan will address the obstacles that communal conflict and insecurity have on the health system's performance and capacity to deliver essential health services. In Lakes State, PEPFAR will increase services to 18 new sites to reach nomadic communities and communities displaced by conflict and insecurity through innovative service delivery models.
- In this COP PEPFAR South Sudan will implement multiple Bio-Behavioral Surveys for Key Populations in country. The new information derived from these surveys will inform future programming and help close equity gaps among underserved populations.
- We are excited that PEPFAR intends to incorporate Social and Behavior Change activities along the HIV continuum of care as well as increase engagement of community service organizations (CSOs) and faith-based organizations (FBOs), to deliver evidence prevention and treatment messages, driving community mobilization by faith-based community champions.
- Through the LIFT Equity Incentive Initiative, PEPFAR will implement an approach to reach children and caregivers to address equity gaps for treatment outcomes through a special project that uses targeted behavior change activities and small grants to FBOs and CBOs to provide services that will benefit and facilitate children's access to care.
- Additionally, PEPFAR provides support 13 CSOs either directly or through sub-grantees. The role played by these civil society organizations in community led monitoring is critical for the success of the PEPFAR program. This year we welcome a plan that sees the inclusion of FBOs as well. Together with both CSO and FBO participation we will be able to deliver HIV prevention, care, and treatment services to the doorsteps of our clients and ensure many more people are retained on treatment.
- PEPFAR South Sudan would like to emphasize that a conducive policy environment that ensures and respects the rights of all, including LGBTI, is paramount. We hope that this is considered by the stakeholders and translated into a clear action plan including the safe implementation of men-who-have-sex-with-men (MSM) sections of the national HIV/AIDS survey.

Finally, we appreciate S/GAC leadership for the support to the South Sudan PEPFAR program, especially for the recognition of the difficulties being faced on implementing the PEPFAR strategy in a complex and fragile context where the country is trying to recover from communal violence and build a stable and prosperous future. The successful implementation of COP23 will require concerted efforts from all, including:

- Local ownership and increased domestic funding for health, ensuring that health care workers are paid proportionally and regularly.
- As well as improved coordination and collaboration at all levels.

Summary statistics, disease burden and country profile.

Population projections (2022) for the Republic of South Sudan are based on the pre-independence Sudan National Census of 2008, which are estimated to be about 14,489,096 adults and children. The December 2013 outbreak of war and the July 2016 crisis resulted in the displacement of about 4.26 million people, of which 1.87 million were internally displaced with some in Protection of Civilian (POC) camps and 2.27 million were forced out of the country as refugees. The national Human Development Index (HDI) value for 2016 was 0.418, putting the country in the low human development category at 181 out of 188 countries (Human Development Report 2016, United Nations Development Program). Extreme poverty has increased to 65%, and projections suggest that poverty will continue to rise as economic growth is likely surpassed by population growth.

South Sudan has a generalized HIV epidemic with an adult prevalence of 1.9% (Spectrum 2022). The epidemic is geographically concentrated in the former Equatoria States which comprise an estimated 46% of the national estimate for 2022. The HIV prevalence based on 2021 routine ANC survey in these states is 7.4% in Western Equatoria, 2.6% in Central Equatoria, 4.1 in Lake States, 0.6 in Western Bahr El Ghazal and 1.6% in Eastern Equatoria 2. Based on 2023 Spectrum estimates, there are 164,453 PLHIV in RSS; only about 30% of these know their status (UNAIDS 2021, Global AIDS Monitoring Report). The 2022 Spectrum estimates indicated 80% of PLHIV are in 37 counties of which 23 are PEPFAR supported. The 2023 estimates for disease burden across age and sex is provided in the Standard Table 1.1 below.

Table 1.1: 95-95-95 Cascade: HIV Diagnosis, Treatment, and Viral Suppression

Table 1.1 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression (FY24)			HIV Testing and Linkage to ART Within the Last Year (FY22)		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV Diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	on ART (#)
Total population	**14,489,096**	**1.9**	**164,453**	**63,592**	**68,566**	**41.7%**	**94%**	**465,997**	**12,554**	**12,835**
Population <15 years	6,413,246	0.20	14,750	2,607	6,963	47%	92%	40,367	567	678
Men 15-24 years	218,312	3.68	7,299	N/A	3,122	43%	95%	40,430	418	414
Men 25+ years	2,729,737	1.89	46,883	17,764	20,482	44%	94%	100,049	4,230	4,395
Women 15-24 years	814,087	1.91	14,094	N/A	5,980	42%	95%	120,052	1,857	1,741
Women 25+ years	4,313,714	2.08	81,427	43,220	32,019	39%	94%	165,099	5,482	5,607
MSM	0	0	0	0	0	0	0	0	0	0
FSW	50,000	12	5997	0	2,188	37%	85%	8785	702	360
PWID	0	0	0	0	0	0	0	0	0	0
Priority Pop (specify)	0	0	0	0	0	0	0	0	0	0

*These should be national data; if the data does not exist, PEPFAR data may be used if relevant.

Figure 1.1, below, displays total PLHIV population, treatment coverage among PLHIV population, and viral load coverage by SNU. Please note that because of inconsistent viral load data reporting through DHIS-2, the viral load testing coverage shown in Figure 1.1 is for PEPFAR supported SNUs.

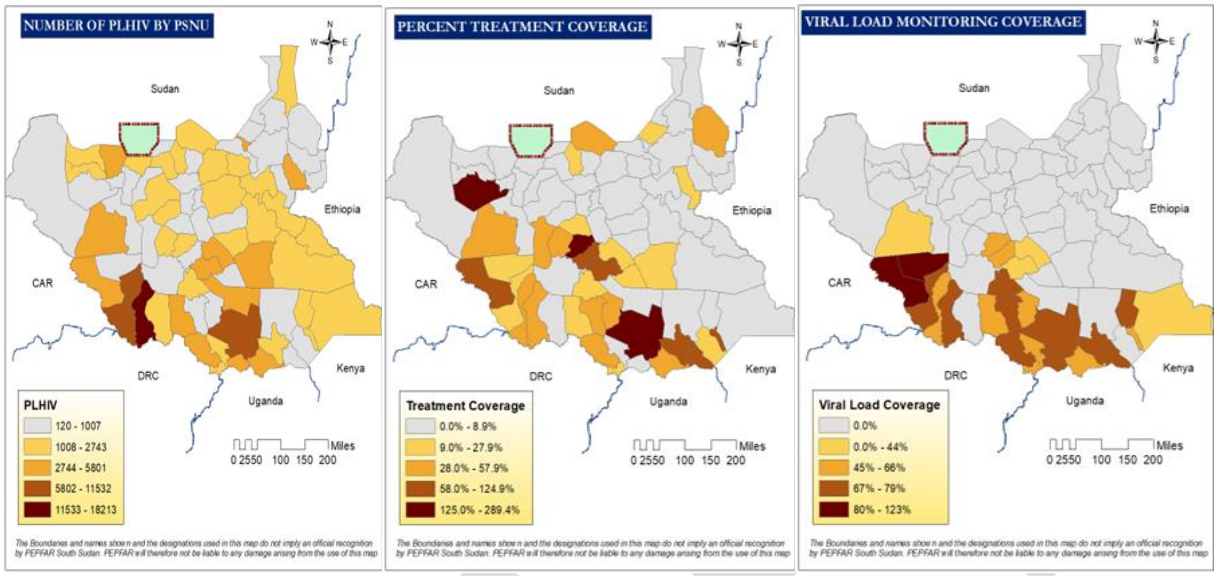


Figure 1.1: Total PLHIV population, treatment coverage among PLHIV population, and viral load coverage by SNU

Table 1.2 below shows the status of ART saturation and progress towards 95/95/95 across all SNUs as applicable.

Table 1.2 Current Status of ART Saturation				
Prioritization Area	Total PLHIV/% of all PLHIV for COP23	# Current on ART (FY22)	# of SNU COP22 (FY23)	# of SNU COP23 (FY24)
Attained	0	0	0	0
Scale-up: Saturation	0	0	0	
Scale-up: Aggressive	77,791	39,299	51,917	53,049
Sustained	42,265	5,881	8,951	11,461
Central Support	0	2,597	3,856	
No Prioritization	0	0	0	4,056
Total National	**109,895**	**47,777**	**64,724**	**68,566**

Pillar 1: Health Equity for Priority Populations

Health Equity for Priority Populations

Introduction to Priority Populations in South Sudan

South Sudan is far from reaching epidemic control according to the 2022 spectrum estimates. There were 11,893 new HIV infections and 7,323 AIDS related deaths. Health equity for priority populations is crucial to ensure no populations are left behind as progress is made towards epidemic control. By the end of 2022, it was estimated that 164,500 people were living with HIV in South Sudan, of which 14,750 (8.9%) were children (0-14 years), 14,094 (8.5%) adolescent girls and young women. Approximately 64% of all adult PLHIV were female, and only 37% of PLHIV aged >15 years knew their HIV status (40% among women and 33% among men). The 2022 Spectrum estimates indicate that more females (3.5 percent) than males (1.9%) in the age bracket of 25+years were infected. More specifically, the Juba County results showed that HIV disproportionately affected females (5.0 percent), more than males (3.1%) in the same age bracket of 25 - 45 years. In the age bracket of 15 - 24 years, females had a higher HIV prevalence of 1.8% compared to 0.8% among males of the same age group. Only 28% of PLHIV are on treatment (30% among women and 26% among men). In 2022 alone, more than 17,000 people were newly infected with HIV and more than 9,000 people died of AIDS related causes. Eight thousand people were initiated on ARVs, and more than half interrupted their treatment within the first 3-5 months of starting treatment, especially among the women. Only 70% of the people on treatment had their viral load checked and 87% of them were virally suppressed (FY22 statistics by age and sex).

Table 2.1: PLHIV Estimates by Priority Population

Priority Population	PLHIV Estimate	PLHIV on ART FY22	FY22 ART Coverage	PLHIV on ART FY24	FY24 ART Coverage
Children <15	14,750	2,146	27%	6,963	47%
AGYW (15-24)	14,094	6,272	45%	5,980	42%
ABYM (15-24)	7,299	1,251	17%	3,122	43%
Female (25-34)	27,558	12,471	45%	15,012	54%
Female (35 - 49)	40,321	9,289	23%	12,923	32%
Male (25-34)	14,286	5,485	38%	8,746	61%
Male (35 - 49)	24,275	6,963	29%	8,750	36%
Others (male and female 50+)	21,870	3,737	17%	7,070	32%
Total	**164,453**	**20,673**	**28%**	**68,566**	**42%**

Table 2.2: Access to testing services.

	HTS_TST Results		HTS_TST Achieved (%)		HTS_TST_POS Results		HTS_TST_POS Achieved (%)	
Age	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
01-04	7,723	7,867	63%	64%	152	124	29%	22%
05-09	5,826	5,751	43%	37%	91	78	13%	11%
10-14	7,912	5,082	143%	54%	81	39	25%	8%
15-19	48,872	16,664	429%	219%	500	100	291%	22%
20-24	71,180	23,766	344%	185%	1,357	318	396%	41%
25-29	60,072	23,572	131%	361%	1,570	684	182%	147%
30-34	42,458	21,534	113%	323%	1,407	883	160%	157%
35-39	27,818	16,978	106%	124%	1,050	884	66%	81%
40-44	13,940	13,436	49%	92%	646	732	32%	58%
45-49	8,787	9,674	38%	150%	421	489	32%	84%
50+	12,024	14,855	31%	65%	388	558	16%	39%
Total	**306,612**	**159,179**	**116%**	**124%**	**7,663**	**4,889**	**69%**	**58%**

Overall, the country exceeded its HIV Testing Services (HTS) targets for FY22, nonetheless some age categories were not optimally reached with the testing services. There were significantly lower testing rates for children below 10 years and for women above 40 years.

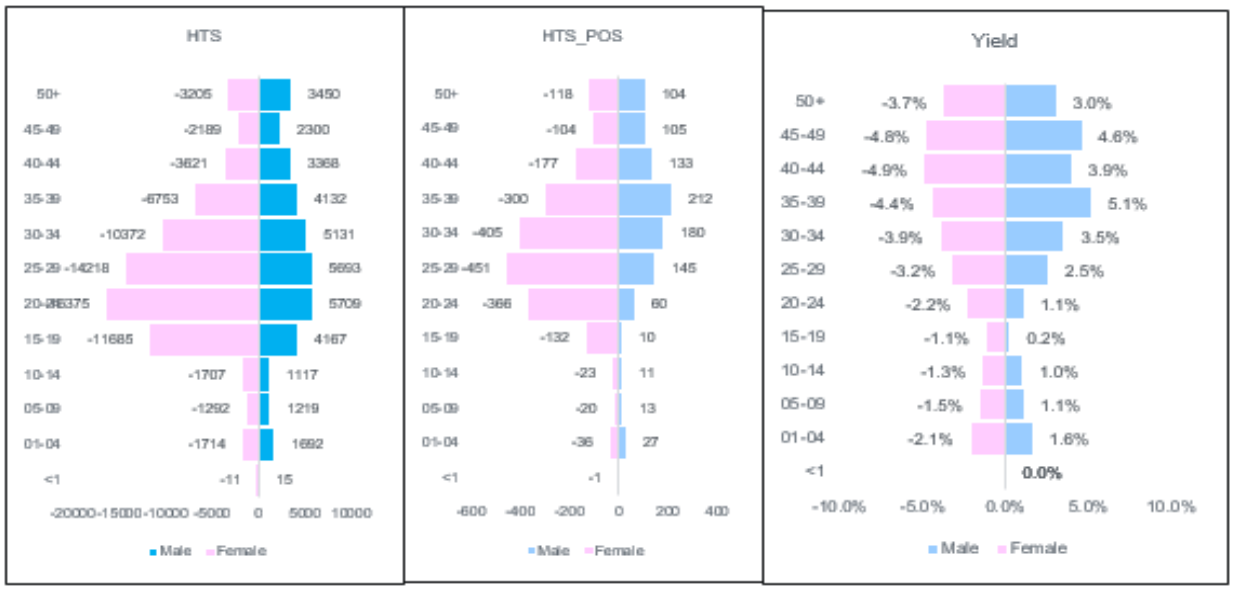


Figure 2.1: HIV Testing Services Summary

Infants and children <14 years, men ages of 35-39 and women 35-40 were not equitably reached with HTS services despite the higher positivity.

Considering the shift in the disease dynamic over the last few years, the response has not been equitably considered. For instance, a significant proportion of the HTS_POS in FY22 comes from the Lake's region and a significant proportion of the interruption in treatment (IIT) comes from the same region. Part of this can be attributed to the nomadic nature of some of the population, complicated by inter-communal strife and low level of HIV awareness and treatment literacy.

Drivers of inequities include:

- Low knowledge and awareness about HIV across all population groups, but particularly among young people aged 15-24 years. This includes basic knowledge on HIV, modes of transmission and how to prevent it.

- Very low uptake and use of condoms, partly due to socio-cultural attitudes and beliefs that regard condom use as a sign of 'immorality' and the prevailing cultural beliefs that value high birth rates, that use of condoms negatively impacts.

- High rates of SGBV linked to war and conflict as well as socio-cultural and socio-economic dynamics that place women as subordinates, with limited autonomy and decision-making power, impacting sexual and reproductive health.

- Low uptake of male circumcision for religious and cultural reasons (different tribal a identities and religious beliefs.).

- Elevated rates of transactional sex and sex work linked to extreme poverty and negative gender and social norms, as well as war and conflict, particularly for adolescent girls and young women.

- High levels of HIV-related stigma and discrimination linked to negative social and cultural norms particularly in remote areas.

- Weak or non-functioning health systems due to conflict, chronic underinvestment in the public health sector, leading to severe shortages of human resources and poor infrastructure.

- Poor health seeking in general and for HIV services, where PLHIVs do not feel sick and hence do not seek care. The passive model of waiting for those seeking health services in the health facilities does not work for HIV/AIDS services, as there is no motivation to visit any health care center.

- A social and political environment that heavily penalizes sex workers and men who have sex with men (MSM). This fuels wide-spread stigma and discrimination, violence, and abuse of KPs, driving the MSM underground making it hard to reach, test and treat these priority populations.

Mounting an effective HIV response amid this substantive range of factors and barriers remains challenging for the country and this is partly responsible for South Sudan's epidemic control standings globally and drives the increase in new HIV infections across age groups over the last four years as shown by UNAIDS data.

COP23 Strategy

During COP23, South Sudan will specifically target key populations, children, adolescent girls and boys, young women and young men, breastfeeding, and pregnant women, and the military populations to narrow gaps across 95, 95, 95 cascades with a keen focus on early infant diagnosis, reducing interruption in treatment and retaining people in care. The gap in reaching men is also wide and a focus will be placed in finding and treating men. To ensure community engagement, PEPFAR will work with CSOs to utilize community-led monitoring, to increase awareness, sensitization, and advocacy for addressing gaps in HIV programming in South Sudan, particularly in strengthening PEPFAR's programmatic responsiveness to community identified gaps.

There will be a reinforced focus on strengthening the community network and ensuring that all clients on treatment are verifiably linked to a community outreach volunteer (CoV). This will guarantee that all clients who interrupt treatment are effectively traced and brought back to care. Clients with unsuppressed viral load shall be placed on the priority list for the respective CoV to trace. South Sudan shall adopt a balanced approach in combination HIV prevention with proportional investments in primary prevention (structural and behavioral interventions) on the one hand, and the biomedical interventions (PrEP, PEP, VMMC) and continue to implement DREAMS activity in Juba County, on the other hand. The primary prevention strategy shall involve generating demand through evidence-based social and behavioral change (SBC) interventions that address relevant individual and social level barriers and motivators. In locations where PrEP will be available, status neutral testing will be offered where clients will be supported to identify any social or structural barriers that might impede enrolment and compliance on PrEP. By doing so all clients who test negative would have received support to enroll and adhere to PrEP. Faith-based organizations (FBOs) play a critical role in supporting HIV epidemic control by providing HIV education including "U=U" messaging to PLHIV, and encouraging HIV prevention, care and treatment services among those at risk of HIV infection by leveraging their social, spiritual and access capital within local communities. PEPFAR South Sudan will collaborate with multilateral partners operating in the country to create a mutually supportive synergistic system. For instance, PEPFAR South Sudan will partner with United Nations Children's Fund (UNICEF) in the Expanded Programme on Immunization (EPI) to ensure all HIV-Exposed Infants (HEI) have Early Infant Diagnosis (EID) at EPI access points both in the facility and the community. This shall increase case identification (EID coverage for children < 5yrs).

PEPFAR will advocate for inclusion of evidence-based SBC approaches that address underlying barriers and drivers, and partner with the World Health Organization (WHO) and Ministry of Health (MoH) to ensure inclusion of HIV prevention and treatment into the primary health care health package.

PEPFAR will also partner with the Global Fund to ensure TB/HIV programs are well coordinated and eventually integrated by ensuring all TB registers capture HIV status, all HIV registers capture TB status and training TB service providers to do HTS and link clients to treatment and train and support HIV service providers to screen, diagnose and link clients to TB treatment.

PEPFAR South Sudan will continue to balance a strategic mix of case finding approaches maximizing high volume and high yield modalities offering index testing to 100% of the patient population, prioritizing newly individuals diagnosed or with unsuppressed viral loads. Additionally, PEPFAR will continue to scale

up distribution of HIV self-test at the community and facility level; offering HIV self-test to index clients for partners and biological children >2 years of age and making them available for high-risk PBFW.

PEPFAR will work with networks of people living with HIV to build treatment support groups, faith-based organizations, CSOs, and other stakeholders to ensure optimal commodities, capacity building, advocacy, dissemination of best practices, and support for the elimination of mother-to-child transmission, increase access to the delivery of adult and pediatric/adolescent HIV prevention and treatment services, adherence, and viral suppression.

In COP23 we will engage with community norms change activities (such as SASA or Stepping Stones) focusing on GBV prevention and HIV awareness among AGYW and the broader community. We will also expand support and quality of clinical care for survivors of violence with special focus on AGYW. In this operational plan we see the scale up of PrEP, demand creation for other combination prevention services, and strengthening integration of family planning services for AGYW. We will work with clinical IPs to ensure that clinical staff do not refuse to dispense PrEP and PEP to AGYW and FSW who identify as high risk. And we will advocate for the review of the PrEP guideline to lower the age of consent for HIV and PrEP services. Finally, we will provide adolescent youth friendly services training for health care providers focusing on empathy building to foster trust and address implicit biases providers may have with respect to AGYW being sexually active.

Implementing partners will emphasize provision of differentiated adolescents HIV clinical care to adolescents and young people living with HIV, aged 10-19 years by implementing "The Operation Triple Zero" (OTZ) approach that works with adolescents and young people living with HIV to commit to the simple treatment goal of achieving "Three zeroes" i.e., zero missed appointments, zero missed drugs/ medications and zero viral load. The three-pronged approach to OTZ, which includes empowerment of the adolescent, the family care giver, and the Health Care Worker will be rolled out through a series of activities that include the establishment of teen clubs at the facility and community levels, identification and training of peer leaders, and the training of health care workers and caregivers.

PEPFAR South Sudan plans to improve access to HIV/AIDS services for children through nutrition and young child clinics. PEPFAR South Sudan will increase emphasis on connecting mother-infant pairs to mentor mothers and Community Outreach Volunteers as well as increasing child-focused HIV testing services in the community which would include scale-up of index testing of biological children and siblings <19 years old of HIV positive mothers. Improvements in VL testing will be done through VL samples collection by CoVs and mentor mothers, and on a case by case, refunding transport money to mothers who bring their children for reviews in the health centers.

PEPFAR South Sudan shall dedicate an equitable amount of time and resources to counter the changing dynamics in Lakes State, where in COP21, 3620 tested HIV positive; 74 infants born to HIV mothers tested positive; 5097 total unexplained losses and proxy VL coverage of only 43% were recorded. Activities to improve performance in Lakes State shall include:

- Improving treatment literacy through evidence-based SBC interventions that include essential knowledge, but also address relevant emotional drivers that will motivate individuals to get tested, initiate, and stay on treatment.

- Strengthening Decentralized Drug Distribution (DDD) / Community ARV refill groups.
- Strengthening continuous patient education / counseling to reinforce the concept of undetectable = un-transmissible (U=U) messaging.
- Expansion of adolescent OTZ programs to the Lakes region.
- Establish weekend clinics in peri-urban settings.
- Engage cattle camp leaders for provision of HIV services (HTS and ART / VL sample collection) in cattle camps.
- Work with Community leaders / COVs to map cattle camps & their seasonal migration routes and assign COVs to track them and provide services.
- Expand the number of ART supported sites in Lakes Region. Strengthening State / County Leadership and Coordination.
- Expand community-led monitoring through CSOs to make the government, partners, and providers accountable.

LIFT Equity Incentive Initiative

PEPFAR South Sudan is a successful applicant for the **PEPFAR LIFT Equity Incentive Initiative** and will be receiving an additional $800,000 in COP23. We will implement an innovative approach to reach children and caregivers to address equity gaps for treatment outcomes through a special project that uses targeted behavior change activities and small grants to FBOs and CBOs that will provide services to benefit and facilitate children's access to care.

Children <15 have the lowest achievement across the three 95s of any population in South Sudan. Based on the UNAIDS 2022 Spectrum estimates, against the three 95's, children have only 15% known status, 15% on ART, and per UNAIDS 2021, only 36% viral suppression. Stigma and non-disclosure around HIV are high throughout South Sudan, and the PEPFAR team has received reports of children being abandoned after testing positive for HIV, particularly in Lakes State. Given the cultural context in South Sudan, men have a strong influence over their female partners and children. This may hinder their ability to access services or adhere to treatment. Meanwhile, high levels of GBV, particularly among the military, increase children's risk of acquiring HIV. Children rely on their caregivers for accompaniment to HIV clinical services, and young children rely on caregivers to administer medication. Adolescents have more agency over their medication adherence, but still rely on caregivers to accompany them to facility visits or refill prescriptions. However, in the absence of disclosure to households, adolescents may hide their medication and therefore have insufficient environmental cues and reminders to build or sustain their daily pill-taking habit. Because of this, activities targeting clinical outcomes for children must also target caregivers.

PEPFAR will engage in the following activities:

Development of SBC Materials. (40% of LIFT Incentive Fund). PEPFAR South Sudan will use segmentation analyses and human centered design to co-create behavioral science/SBC solutions tailored to specific populations that can be implemented across the interagency PEPFAR portfolio through IPs, FBOs, and CBOs at facility and community level. This will fill critical gaps by collecting data on barriers and drivers among children and their parents and caregivers that influence key behaviors underpinning prevention and treatment outcomes. FBOs, CBOs, faith and community leaders, and the military will be among the stakeholders involved in co-creation to ensure ownership and engagement. They will be oriented on how to roll out the tools and materials in their respective communities. Materials for clinical and community health care workers will also be developed, adapted, and translated into local languages. This could include materials for tailored adherence counseling for the caretakers and clients and empathy and trust-building tools with adolescents. This will allow care and treatment programs to implement updated, targeted materials, which can be used for future programming after this one-time funding has ended.

These activities will be programmed through the Meeting Targets and Maintaining Epidemic Control (EpiC) mechanism which includes SBC expertise through FHI360. EpiC is available to provide technical support to conduct research, improve SBC implementation, and scale-up.

Small Grants Program for FBOs and CBOs. (60% of LIFT Incentive Fund). The Equity Fund will also provide direct support to FBOs and CBOs to develop targeted, community-led approaches to better reach children. This will require targeting the caregivers who are responsible for accompanying children to testing and clinical services, disclosing status to children, picking up ART refills, and supporting adherence through reminders and cues, as well as the household decision makers (often men) who may inhibit children's access to those services. FBOs and CBOs will be supported both to roll out the SBC approaches identified and adapted through the SBC activity and will be encouraged to identify innovative approaches most relevant to their local context and the specific needs of the community. These grants will allow for direct implementation by faith and community-based organizations, including community outputs or similar models. In addition to supporting the needs of families and communities, these small grants will take existing national partner capacity building efforts to the next level, by directly funding national FBOs and CBOs. FBOs and CBOs will be supported across all PEPFAR-supported geographic areas, with particular emphasis in areas with the greatest 95-95-95 gaps, such as the Lakes State.

To maximize efficiency with limited funding, the FBO and CBO small grants will be programmed through UNAIDS. This has the lowest overhead costs compared to agency-specific implementing partners. UNAIDS also has existing staff and consultants in South Sudan with strong experience in working with FBOs and CBOs and will be able to manage this activity well. Expanding the partnership with UNAIDS and national partners promotes the PEPFAR 5x3 strategy through transformative partnerships.

The table below shows some selected priority population targets for COP23.

Table 2.3: HIV Testing/Treatment Targets by Priority Population

Priority Population	Pop. Estimate	New Infection	PLHIV Est	HTS_POS	TX_NEW	TX_CURR	TX_PVLS	ART Coverage
Children <15	6,413,246	3,835	14,750	857	1,758	6,963	5,295	47%
Key Population (FSW)	50,000		5,997	769	416	2198	2022	37%
Men	7,190,552	5161	61675	4472	5,474	27,091	20,262	44%

Plans to close gaps in Key Populations:

Female sex workers (FSW) and their sexual partners are a leading contributor to new HIV infections globally and in South Sudan. While no recent surveys have been conducted, the 2014 HIV mode of transmission studies showed 42.6% new infections were attributed to FSWs1. Female sex workers fall under high-risk groups because of behavioral aspects like frequent condomless sex, lack of access to combination prevention services, stigma and discrimination, behavioral determinants such as gender power dynamics, unfavorable social norms, and lack of skills to negotiate safe sex.

1 https://comms.southsudanngoforum.org

Key Populations remain a priority for HIV prevention and narrowing the gap of new infection among the general population as progress is made toward epidemic control. Since 2015, PEPFAR has supported South Sudan in planning and responding to the HIV epidemic among Key Populations, specifically targeting FSWs and their clients. While MSM were targeted, by programs in the past, since 2018, services have ceased due to a harsh operating environment that stigmatizes, discriminates against, and violently cracks down on them. Many activities geared toward MSM have been shut down by the authorities. This has resulted in the MSM community operating underground due to fear of crackdown and incarceration. There are anecdotal accounts of people who inject drugs (PWID) active in some towns such as Juba, but there are no data to confirm this. There is a need for formative research to assess the presence and size of this population.

PEPFAR continues to invest in creating an enabling environment for KP service delivery, and COP23 will continue to support and strengthen routine community based KP service delivery. Effective strategies such as enhanced peer outreach approach, social network strategy, and risk network referral already applied in South Sudan are reaching and testing FSWs in existing and new community hotspots. Although PEPFAR interventions have continued to reach and serve KP amid challenging structural and social barriers, and making significant annual progress, the national KP program still suffers from a lack of adequate data to assess the country's progress towards 95, 95, 95 and for planning. Since 2016, PEPFAR has invested in four integrated biobehavioral surveys (IBBS) in four major towns of Juba (2016), Nimule (2017), Wau and Yambio (2019); all these surveys are now outdated. In the absence of good national routine KP and survey data, PEPFAR program has relied on KP program data, for size estimation and FSW hotspots mapping. In 2022, South Sudan spectrum estimated the size of FSWs, using a limited routine KP data to be 50,000.

Despite a lack of data on the size of key populations, the table below shows consistent progress with interventions.

Table 2.4: MERS Indicators by Key Population

Indicator	Disagg_type / Definition	FY2021 Results	FY2022 Results	FY2023 Target	FY2024 Target	2021 % Achievement	2022 % Achievement	2023 % Achievement
KP_ESTIMATES (FSW)	Total Size Estimate	-	-	-	50,000	-	-	-
HTS_TST	Key Pop/Result	8,680	8,877	7633	8,047	115%	132%	29%
HTS_TST_POS	Key Pop/Result	757	761	597	769	126%	157%	31%
KP_PREV	Key Pop	8,646	11,665	11,715	12,312	92%	112%	-
PrEP_CT	Key Pop	-	-	599	599	-	0%	0%
PrEP_NEW	Key Pop	-	-	1,093	1,392	-	0%	0%

TX_CURR	Key Pop/HIV Status	1,046	1,450	1,876	2,198	-	-	95%
TX_NEW	Key Pop/HIV Status	357	394	367	416	-	-	32%
TX_PVLS(D) KP	Key Pop/HIV Status	-	-	1,595	2,022	-	-	77%
TX_PVLS.N.KP	Key Pop/HIV Status	-	-	1,515	1,719	-	-	73%
KP Linkage %	KP.POS/ TX_NEW	47%	52%	53%	54%	-	-	-
Proxy VLC %	TX_PVLS_D / TX_CURR	-	-	85%	92%	-	-	-
VLS %	TX_PVLS_N / TX_PVLS_D	-	-	85%	85%	-	-	--

Key Populations strategy for COP23

Based on program data provided by the Ministry of Health, in COP23 PEPFAR South Sudan will make a strategic shift to increase integrated community KP services focusing on the Lakes, in one site (Bor) in Jonglei and Western Bahr El Ghazel regions, while consolidating gains made in Juba, Yambio and Nimule. Out of the ***SPECTRUM*** model estimated 50,000 FSWs, 12,312 are targeted to be reached, with 2,198 knowing their positive HIV status and on treatment. Ninety two percent of TX_CURR will be tested for viral load.

During COP23, PEPFAR proposes to undertake the following:

- Increased focus on Lakes, Jonglei (Bor) and Western Bahr El Ghazal, towns of Rumbek, Bor and Wau.
    - Addition of new service sites, including community systems for expanding KP services and absorbing newer hotspots under the program.
    - Increased engagement with KP-led organizations to ensure local transfer of skills and capacity. This will also mean identifying leaders for mentorship to champion KP causes.
    - Continue direct implementation with one CSO while ensuring capacity building and technical skills improvement.
- Address access barriers by improving quality of services to ensure KP programming continues to be friendly and uninterrupted.
    - Review facility practices to eliminate provider related stigma, including sensitization and training of health workers.
    - Amplify the voices of KPs, through community-led monitoring.
    - Consult with KPs, UNAIDS and SSAC to conduct advocacy workshops with key decision makers.
    - Continue to offer GBV case identification and response and provide clinical and non-clinical services to survivors of violence.

The Key Populations program in South Sudan in COP22 and in COP23 will continue to primarily target FSWs and their clients while collaborating with DoD's program in army barracks in Juba and Wau, where clients of FSWs are men in uniform. Targeting to scale up KP interventions in Rumbek and Bor is a major consideration. PEPFAR South Sudan will ensure new and existing FSW "hot spots" in locations within Bor and Rumbek are served, freeing up resources that GF sub-recipients can use in other locations.

Key Populations Service Package

Key Population needs are unique, and demand driven. South Sudan does not provide all the recommended WHO packages, however the minimum package provided addresses most of the needs of KPs. Only few services (cervical cancer and hepatitis screening) are missing. Below is the summary of service offered in the package that will be continued under COP23.

- Sexually transmitted infection screening and referral for treatment.
- Condom promotion and distribution including lubricants.
- Gender-based violence awareness, screening, and post GBV care.
- Post Exposure Prophylaxis
- Family planning counseling and referrals.
- HIV testing and linkage to treatment and prevention service.
- Pre-Exposure Prophylaxis (PrEP) recently added.

In addition to the FSW service package, male clients of the FSWs are also actively reached, tested, and linked to care and viral load services. Other services offered to male clients include access to condoms and promoting condom use.

HIV Prevention: Combination interventions are key for KP HIV prevention, South Sudan has predominantly been supporting condom use and over 2.7 million male condoms were distributed across the six KP supported sites in 2022 alone. Pre exposure prophylaxis was added to the package of care recently following its launch during World AIDS Day 2022, officially marking the start of this new biomedical intervention. All PEPFAR-supported implementing partners received PrEP commodities and started enrolment across the supported sites. A delay of over six months attributed to the late arrival of commodities impacted the earlier plan to kickstart PrEP. While preliminary COP22 PrEP results were far from the projected performance, PrEP scale-up has been prioritized across the six KP locations. Of the COP22, 6,572 targeted PrEP beneficiaries, about 26% (1692) are allocated to KPs. In COP23 while the program will support a comprehensive HIV package of prevention, testing and linkage to ART, including 1,392, PrEP_NEW and 599 PrEP_CT targets, a total of 12,312 FSWs and 9,068 clients will be targeted for prevention activities. About 75% of the FSWs reached will be eligible for testing, and an estimated 659 newly identified HIV clients are expected to be linked to ART.

PrEP demand generation: South Sudan has just started PrEP implementation, and the program will be applying evidence-based behavior change and exploring alternative delivery models to facilitate increased uptake of testing (inc. self-testing) and prevention – that are primarily aimed at closing equity gaps and scale-up PrEP intervention. Currently, PrEP is only available through health facilities limiting the ability of Key Populations to access it. South Sudan is already working with KP headquarters ISMES in 2023 to review

and adopt other models of delivery such as community models that have been shown to be effective in PrEP intervention in some countries within the region.

HIV Testing, Linkage to Care and Prevention.

South Sudan does not have drop-in centers or KP-friendly or special facilities for KP care; the community-based HIV service delivery model is the primary service delivery model, and that has continued to be robust, progressively reaching and testing more FSWs and their clients across the six supported sites. Despite the COVID-19 situation in the past years, the program remained resilient, applying innovations that ensured community services continued. While COVID-19 restrictions banned physical gatherings, the program continued to serve KP in smaller recommended numbers ensuring services were uninterrupted. While many FSWs tested negative, the only available prevention intervention was condoms. With PrEP, FSWs who test negative now have the option of enrolling in PrEP an additional prevention intervention.

COP21 demonstrated a stronger KP performance reaching over 100% (11,665/10,356) of the targeted beneficiaries, way over the COP20 numbers (8646/9416), targeted for preventative activities and testing (8,877/7,505), compared to 75% of the HIV testing achieved in COP20. During COP21, over 100% (761/563) of the targeted positive cases were identified, slightly above the COP20 results of 757. The performance trajectory for COP22 is on course to achieve PEPFAR targets as shown by quarter one data of FY22. KP treatment linkages are reported in limited locations in Juba only where the KP partner directly provides services. Elsewhere, program data does track linkages and continuity on treatment of KPs across the remaining five locations of PEPFAR support. Over 95% of linkages were reported in all six locations and 3,689 FSWs were currently receiving treatment in nineteen ART facilities across all six KP sites, where a global fund supported, a private facility and a faith-based clinic were among the facilities providing ART for KPs. In Bor South where treatment has been provided by the GF partner, USAID will integrate services at the Bor hospital ensuring both general population and KPs receive high quality care.

The KP program has continued to collaborate and coordinate implementation of services with the South Sudan AIDS Commission, UNAIDS, MOH, the Juba City Council and its affiliated law enforcement, other security agencies and other governing authorities. Civil society organizations continue to have more significant roles, providing critical program feedback, advocating for KP rights for services, and demanding KP friendly space, including demanding KP service providers be nonjudgmental and adapting behaviors that fight stigma and discrimination. In addition, the program will continue to work to support dialogue with MoH, SSAC, Global Fund and other key actors on implementation of PrEP which kicked off in December 2022, including review and ensuring providers interpretation of the national ART guidelines does not become a barrier in enrolling young women who might be at higher HIV risk.

Plans to close gaps in the pediatric cascade.

Children (<15)

Children <15 have been difficult to reach due to high levels of stigma that impact caregivers' behaviors of getting children to care facilities, limited ART sites across the country, negative provider behaviors, and socio-cultural and economic factors that impede women from accessing care.

To address the gap among children under the age of 15 years, PEPFAR South Sudan increased the target on treatment current, ambitiously aiming to cover 43%, slightly above the general population coverage. The upward adjustment of the target is in line with current strategies to address some equity barriers such as high levels of stigma that impacts caregivers' behaviors, and limited sites of comprehensive ART. Furthermore, C/ALHIV, especially those <5 have a disproportionately higher mortality rate and poor outcomes compared to older PLHIV even after linkage to ART. In response, PEPFAR South Sudan will focus on integration HIV services with MCH and other pediatric services to ensure CLHIV receive all the complementary services they need like OVC, TPT, cotrimoxazole, etc. are critical to help reduce these inequities.

Unlike adults who transitioned much earlier to optimized regimens, children below the weight of 25kg have recently started getting DTG 10mg. While viral load coverage and suppression has improved country-wide, that has not been commensurate for children. However, during COP22 all eligible children would have been transitioned to DTG10mg, except those who may have interrupted treatment. There is progress and improvement with viral suppression among children who have transitioned and been on treatment for over 6 months. PEPPFAR will continue to target and address IIT among children and ensure all returning children are immediately placed on the optimized regimen.

Orphans and Vulnerable Children

The OVC program will maintain their existing MOUs with clinical facilities in Juba and continue to ensure that Clinic Community Coordinators (CCCs) are based at each facility to facilitate bi-directional referrals for testing, ART, VL and other services. These CCCs will support data sharing between the clinical and OVC programs to help track missed appointments, monitor viral load test results, and conduct, at a minimum, monthly case conferencing meetings with OVC Community Case Workers (CCWs) to discuss beneficiaries with unknown or poor viral suppression. The CCCs will also work across clinical areas to ensure that the OVC activity is reaching beneficiaries through both pediatric and adult ART clinics, ANC, labor and delivery, and others.

In addition to providing a comprehensive package of services to support beneficiaries, in COP23, the OVC activity will continue to collaborate with clinical programs using existing SOPs, and support follow-up and tracing for index testing of biological children less than 19 y/o of HIV positive mothers and HEI at most significant risk of IIT. The OVC activity will continue to prioritize newly identified positive children and their households for enrollment and ensure that they are initiated on treatment and remain supported by the OVC activity.

For COP23, the OVC activity will contribute to the three 95s as follows:

- 1st 95:
    - SBC interventions to improve HIV and treatment literacy and other relevant behavioral determinants, HIV risk assessment, mobilization, and referrals to HTS, with transportation refunds as needed.
    - Stigma and discrimination reduction. Status disclosure counseling to reduce stigma and discrimination affecting disclosure.
- 2nd 95:

- Support those who test positive for HIV to initiate on ART. Provide transportation reimbursements, as needed, for visits to facilities. The CCCs will continue monitoring appointment attendance and will conduct monthly case conferences with CCCs and CCWs. CCWs will provide home-based ART adherence counseling and household visits to promote treatment adherence and drug refill. The activity will continue to monitor ART regimens and support status disclosure to ensure continued retention. The activity will continue to collaborate with clinical partners to provide peer support through community and adolescent treatment supporters (CATS) using the Zvandiri model and will coordinate with the CCWs to maintain good clinical outcomes for OVC-enrolled CALHIV COP23 moving forward.

- 3rd 95
  - Caregivers and parents are educated on the importance of viral load suppression and incorporating the concept of Undetectable = Un-transmissible (U = U). Default tracking, tracing, and re-enrollment into care for caregivers and children in the program catchment area. Monitoring of multi month dispensing (MMD) status and monthly case conferencing with CCCs and CCWs on clients with poor or unknown clinical outcomes. Monitoring VL status and supporting referrals to VL testing and ensuring results are received. Supporting those with high VL to complete enhanced adherence counseling at the facility.

The OVC Comprehensive program will continue to provide the HIV and violence prevention curriculum, Sinovuyo Teen, for boys and girls ages 10-14 and their caregivers as part of the comprehensive package of services for beneficiaries.

There will also be continued services in terms of counseling and psychosocial support to caregivers and their children to facilitate and strengthen the skills of parents in providing effective parenting to their children and adolescents.

The OVC activity will continue to provide technical support for savings and internal lending communities (SILCs) to get formed by the caregivers of the OVC at their localities. This will lead to economic strengthening of those families participating and ensures they were able to provide strong support to their children and achieve expected clinical outcomes of viral suppression for the CALHIV on ART.

In line with the schooled domain of the OVC services, the activity will ensure that those children and adolescents in school who are eligible (especially girls and young women) to get school support, gets it to ensure they improve educational access, progression, and completion.

Adolescent Girls and Young Women and Adolescent Boys and Young Men

New WHO and partners data shows that, globally, violence against women remains devastatingly pervasive and starts at a young age. In South Sudan, women and girls suffer among the highest levels of physical and sexual violence in the world. For instance, out of the 2,244 women interviewed by Ellsberg

et al[2], 50% reported experiencing either physical or sexual violence from a partner or non-partner during their lifetimes; Approximately 35% of respondents experienced rape, attempted rape or other forms of sexual violence by a non-partner during their lifetime. Restrictive marital practices and gender norms, and experiences of conflict were major drivers of both partner and non-partner violence[3]. PEPFAR South Sudan has made significant progress in providing services to AGYW. The Determined, Resilient, Empowered, AIDS Free, Mentored and Safe (DREAMS) initiative started in South Sudan in FY21 to support AGYW to prevent new HIV infections among this disproportionately affected population, and to fast track the country's efforts to reach epidemic control by 2025. According to the 2021 Global UNAIDS report on HIV, adolescent girls in the ages 15 - 19 years, make up 52 percent of all new HIV infections.4 This requires a significant, targeted expansion of HIV prevention services (including pre-exposure prophylaxis [PrEP], post-exposure prophylaxis [PEP], and condoms and lubricants), HIV testing services (HTS) and uninterrupted access and adherence to antiretroviral therapy (ART) to this population.

While many people living with HIV (PLHIV) are now able to stay alive and take care of their families because of antiretroviral therapy, lingering effects of the epidemic's past high mortality remain. About 2.6% of children aged 0-14 years are orphaned. The impact of HIV disrupted and destabilized families and communal support systems, exacerbated by civil wars, food insecurity, and widespread poverty.

While current DREAMS activities target AGYW due to persistent inequities for AGYW, adolescent boys and young men (ABYM) are currently supported through OVC and broadly through clinical services. The OVC program supports adolescent boys <18, particularly through HIV and violence prevention curricula for teens and their caregivers. OVC also supports young men as caregivers for CALHIV and their siblings. In COP23, the DREAMS activity will expand to incorporate community norms change activity targeting AGYW and their communities, particularly ABYM, which will address GBV and other forms of violences that AGYW face.

Plans for AGYW services.

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

From the start of COP20, South Sudan began to implement DREAMS activities within Juba County. As recommended in the COP23 PLL and given the success of the DREAMS activity thus far, the DREAMS activity will be maintained in Juba County. The DREAMS activity will prioritize reaching AGYW ages 15-24 at greatest risk of HIV, especially those engaging in transactional sex. This includes risk factors such as AGYW who are: out of school/never schooled, have multiple sexual partners, with frequent STIs, experience violence, inconsistently use condoms, or abuse alcohol. Entry points for the DREAMS activity include ANC clinics for AG who are pregnant or already have a child, STI clinics for those with frequent STIs, AGYW who are working in bars, restaurants, tea shops, and other activities of high-risk, as well as AGYW engaged with FSWs and refer peers that may be engaging in transactional sex more broadly. The activity has been careful to ensure that IPs do not interpret transactional sex as commercial sex work only, but that they used a broader definition. The activity will not be expanded out of the current geographic location but will continue to work towards saturation in Juba County.

2 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0237965
[3]https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence
[4]https://reliefweb.int/report/world/2021-unaids-global-aids-update-confronting-inequalities-lessons-pandemic-responses-40

The DREAMS activity primarily implements economic strengthening activities for AGYW ages 15-24. The economic strengthening package includes BRAC's Empowerment and Livelihood for Adolescents (ELA) curriculum for financial literacy and social asset building. The ELA model is facilitated by young women of similar age or slightly older than the AGYW enrolled, with demonstrated leadership, confidence, and experience. These groups are facilitated in safe spaces, wherever the groups of AGYW are comfortable, including homes that are accepting to provide their compound spaces for this activity, compounds of churches and mosques, community compounds, etc. This curriculum is supplemented with functional literacy education for those who need it (particularly numeracy literacy), provided either directly by the IP or through referrals to other basic literacy programs already being implemented in Juba. Moving forward, the DREAMS activity will leverage the USAID funded Youth Empowerment Activity (YEA) that will start to implement activities in Juba County in early 2024 to increase reach and synergistically provide the most needed services to the most vulnerable youth and, AGYW. In collaboration with YEA, the DREAMS activity will work with youth-led and local organizations to ensure AGYW who complete their DREAMS package are supported to find employment. For example, DREAMS will continue its ongoing collaboration with the Radisson Blu hotel, which supports a rotating cohort of AGYW to complete internships at Radisson Blu, with potential for ongoing employment after the internship.

Economic strengthening activities in COP23 will continue the current activities including income generating activities and self-employment start up support. This will be based on the reassessment of the market and employment opportunities done in COP22. The DREAMS activity has identified income generating activities and self-employment opportunities for enrolled AGYW, including short- and long-term training courses and internships. For AGYW who can receive start-up support through other projects, the DREAMS activity will continue to provide follow-up and mentoring to support AGYW who enter self-employment activities.

South Sudan currently has very limited post-GBV services in Juba, with a full-service package only available in one facility supported by UNFPA. The DREAMS activity will continue to strengthen both post-GBV referrals and post-GBV services. In COP23, DREAMS will continue to offer LIVES first line support training for DREAMS facilitators, mentors, and clinical focal points. In addition to strengthening the post-GBV services provided at facilities, the DREAMS activity will also continue to strengthen post-GBV referrals. DREAMS will work in collaboration with relevant stakeholders on updating post-GBV referral service mapping for both clinical and non-clinical services such as psychosocial support; updating cards to hand out to AGYW with information on where to go and contact information; maintaining referral networks, providing escorted referrals and at the facility level to receive AGYW referrals and provide services; and providing transportation stipends for those who cannot afford to travel to post-GBV services.

Due to commodity delays, PrEP services started in December of COP22. However, the DREAMS facilitators and mentors have contributed a lot by creating demand for PrEP among AGYW, counseling eligible AGYW, and referring AGYW for PrEP initiation with clinical partners.

For COP23, DREAMS will:

- Maintain current target population (AGYW ages 15-24 engaging in transactional sex or with highest risk factors for HIV).
- Maintain emphasis on knowing HIV status, economic strengthening activities and GBV referrals.
- Use BRAC ELA curriculum for life skills and economic strengthening/entrepreneurship skills.
- Ensure AGYW are linked to relevant long-term training/internship, employment/apprenticeship programs in areas highlighted in market assessment.

- Ensure AGYW are referred for HIV testing (for those who need to know their status), relevant post-GBV services and can complete referrals (transportation stipends, accompaniment, etc.)
- Conduct USAID's GEND_GBV Site Monitoring Checklist with additional sites to identify opportunities for post-GBV service quality improvement.
- Continue to identify additional basic literacy programs to refer AGYW who have not completed/attended school.
- Will advocate for distribution and use of HIVST kits in the community so that AGYW who fear to go to the facility can screen themselves using the HIVST kit.
- Include community norms change activity (such as SASA! or Stepping Stones) to ensure AGYW and their communities, including adolescent boys and young men, are reached with GBV and HIV prevention messages. Given the influence that ABYM have in the lives of AGYW, and their prominent role as decision-makers in the family, community leaders, as well as perpetrators of violence, engaging men in these community norms change activities is critical to ensuring an enabling environment for AGYW to access necessary services and thrive.
- Provide referrals to relevant clinical IP(s) for post-GBV services, including PrEP, PEP, STI screening, HIV testing, and FP services.
- Provide referrals for HIV testing for AGYW who don't know their HIV status.
- Receive referrals from HTS partners for AGYW who test negative and are at high risk. HIV+ AGYW ages 15-17, will be referred to the OVC activity.
- AGYW ages 15-17 who are survivors of sexual violence will be referred to the OVC activity.

Plans to close gaps in the Military Population.

In the context of South Sudan, the military is considered a priority population that continues to drive and shape the HIV epidemic. The last Integrated Bio-Behavioral Survey[5] (IBBS) in 2010 estimated the prevalence rate among this group at 5% (twice the general population's). While still significant, the country has since experienced cycles of reoccurring conflict followed by peace treaties during which the size of troops has significantly grown and HIV vulnerabilities increased, it is therefore plausible that the situation has worsened. As the main clients of FSWs, the military contributes up to 42.6% of all new infections[6]

Low knowledge and awareness, excessive alcohol use, and high-risk sexual behaviors with multiple concurrent sexual partners, low condom usage and entrenched GBV practices are all established main drivers of the epidemic among the military.

Hence, provision of a comprehensive HIV treatment and prevention package to the military is critical in addressing the challenge of new infections. Realizing this, PEPFAR South Sudan through the US Department of Defense (DoD) program has been supporting the response in this priority population in collaboration with the Military HIV-Secretariat. Extending critical technical and operational support to military sites to provide HIV testing, Care and treatment and prevention services targeting primarily military personnels, and their families but also civilians associated with militaries (CAM). System-level

5 HIV prevalence and behavioral risk factors in the Sudan People's Liberation Army: Data from South Sudan https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0187689
6 South Sudan HIV/AIDS Commission HIV Modes of Transmission Study Draft Concept Note and Terms of Reference. Available at https://comms.southsudanngoforum.org

investments include strengthening the HIV-Secretariat's institutional capacity to provide sustainable stewardship, oversight, and coordination of the response.

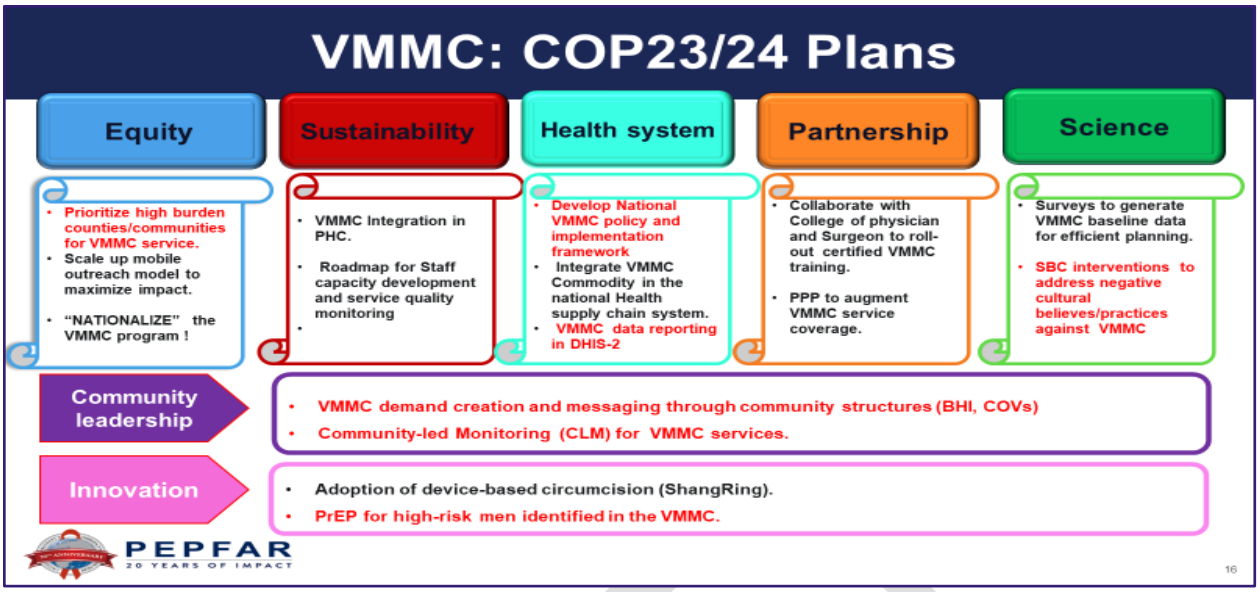
To address the equity gap, in COP 23, PEPFAR South Sudan proposes a "break the cycle" approach which seeks to identify key drivers of inequities in HIV treatment outcomes across the different priority populations and then prioritize effective and transformative interventions to tackle them. Specific to the military, the Voluntary Medical Male Circumcision (VMMC) is a primary intervention.

VMMC remains a cost-effective one-time prevention measure that reduces HIV risk transmission by 60% among heterosexuals. As one of the 15 identified priority countries for VMMC globally, South Sudan had only started implementing VMMC in COP17 and therefore missed out on the 2020 VMMC Fast-Track Target. However, in the roll out phase, implementation was only limited to the military as a priority population. Over the years, the program has demonstrated successes in creating high demand and achieving beyond set targets which resulted in further program expansion to new sites and geographical areas.

Currently, the facility-based approach includes 3 sites in Juba, Bor and Wau towns. In COP22 the mobile outreach approach was introduced to address gaps in services coverage. This has quickly proved instrumental in extending services to high-burdened populations/communities. Despite this, numerous challenges still stand in the way to realize GPC targets for the country, from unavailable baseline data for effective planning, limited program coverage, lack of policy framework, commodities procurement, and sustainability issues to negative cultural barriers and beliefs against VMMC uptakes.

To align with the new PEPFAR 5x3 strategy the VMMC program will adopt a new implementation framework in COP23 and subsequent COP24 focusing on:

- Redirecting services towards high-burden population/regions to maximize impact and ensure equitable access to services.
- Applying system strengthening lens in implementation by prioritizing activities in support of establishing and strengthening VMMC policy framework and systems.
- Streamlining VMMC training, capacity building and seeking durable partnership with academic institutions and private sector for sustainable and quality service delivery.
- Conducting operation research to understand barriers and enablers to service uptake and design appropriate interventions to tackle them.
- Foster community engagement and ownership of the program for sustainability through Community-led Monitoring and Community-led VMMC demand generation.



In COP23, the VMMC program will continue with the dual implementation approach of both facility and mobile outreach models. For the mobile outreaches, existing fixed sites will be used as logistical hubs from which trained and dedicated mobile teams will be deployed periodically to some select locations based on agreed criteria using appropriate logistics means (hub and spoke). Lessons learnt and best practices from COP22 implementation will be applied to maximize community engagement and demand for services and improve reach.

To ensure quality service delivery, the VMMC program will continue to prioritize the following seven essential elements.

1- Comprehensive minimum package of services.

This will include age-appropriate sexual education, testing and screening for sexual transmitted infections (STIs) followed by linkage of all positives to treatment. Special emphasis will be put on post-operative counseling and clients follow up to reduce Notifiable Adverse Events (NAEs) rates. While not a requirement, HIV testing would be made available on need and completely voluntary basis. Where possible, HIV self-testing would be utilized to generate demand and identify high risk groups. Positive clients will be prioritized for ART initiation and reappointed for medical circumcision in 3 months to reduce risk of disease transmission. In addition to condom distribution, the program will also target high-risk negative clients for PrEP.

2- Sustained Demand Creation.

Robust demand creation remains key for sustained services uptake and targets achievement. This has been an area of strength with demonstrated successes in engaging opinion leaders and military commanders as champions leading a non-coercive sensitization campaign in their respective units.

In COP22, demand creation strategy has been updated with critical components that cater for the mobile outreach models outlining different platforms to develop and disseminate tailored age-appropriate and culturally acceptable messaging. While it seems to be working perfectly, in COP 23 institutionalizing demand creation for VMMC through existing community structures will be prioritized to ensure community ownership and sustainability in line with the new PEPFAR strategy.

3- Skilled and motivated staffing.

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

4- Appropriate Site selection.

Sites selection for mobile outreaches will be prioritized based on the following criteria:

- HIV High-burden and low circumcision rates.
- Population-rich military barracks, training centers and surrounding /host community.
- Proximity to a facility with comprehensive HIV services to ensure linkage to treatment.
- Equity considerations.
- Availability of pre-existing infrastructure (PHCC or PHCU) and clinician to be trained on VMMC postoperative follow up.

Potential sites will include previous outreach sites with existing high demand, established facilities, military training centers, schools and other community centers as appropriate. The team will work closely with military leadership, local authorities, community leaders and health workers to ensure adequate mobilization, client education, safety, and appropriate postoperative follow-up.

5- Effective commodities and supply chain.

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

6- Quality assurance and improvement.

- To enhance safety and implement continuous Quality Improvement (CQI)/ Quality Assurance (QA) systems at all levels of VMMC service delivery in COP23, the VMMC program will Institutionalize regular internal program quality assessment followed by course correction.
- Identify and train dedicated QI/IPC staff in all sites including the mobile outreaches.
- Strengthen staff mentoring approaches and introduce VMMC QI virtual learning community in all the regional hubs. Strengthening of clients' education and quality counseling on post-operative wound care. Periodic training on management and reporting of NAEs will be prioritized especially for the mobile outreach models.

Plans to close gaps among Pregnant, and Breast-Feeding Women and HIV Exposed Infants.

In South Sudan, the Prevention of Mother to child transmission (PMTCT) program for pregnant and breastfeeding women (PBFW) is facing challenges across the three 95s. According to the draft South Sudan National HIV strategic plan 2024-2026 ANC 1 attendance is only at 46.7% and institutional delivery at 12.3% which restricts delivery of PMTCT services. By the end of 2022, 73% of the pregnant women received HIV test at first antenatal care (ANC1) visit, 53% were on antiretroviral treatment (ART) for PMTCT, over 7,000 mothers needed ART with 26% transmission rate during breastfeeding period. Program data shows that in PEPFAR supported sites, knowledge of status at ANC1, linkage to ART, and viral suppression in FY23 Q1 were 97.9%, 98.7% and 88%, respectively. However, viral load testing coverage among pregnant women remains low (58%). Similarly, early infant diagnosis (EID) in the 0-2 months age group has not improved over time. By the end of FY23 Q1, the EID coverage for 0-2 months was 64% and for 0-12 months was 34%. These coverages are much lower than the expected EID coverage of 95% for both 0-2 and at 0-12 months.

The main reasons for low EID coverage include low ANC attendance, home-birth delivery, limited EID sample collection points at health facilities, low literacy levels in the community, and delayed return of infants to health facilities. Other gaps in PMTCT and EID include:

- Poor Linkage to ART treatment for PBFW and HEIs especially in Lakes State areas.
- Poor client Community Outreach Volunteer (COV) linkage and lack of systematic tracing and tracking of clients in the community.
- Poor tracking and documentation of the final HIV status outcome for HEIs (registered in a birth cohort) at 18 months (about 1 and a half years).

In COP23, PEPFAR South Sudan plans to provide PMTCT services in 57 PEPFAR supported comprehensive HIV/AIDS service delivery sites. Of these sites, 43 will be in the 10 aggressive scale-up counties, and 14 will be in the 15 sustained SNUs.

PEPFAR South Sudan will continue to work with implementing partners (IPs) to improve coverage and quality of integrated PMTCT and EID services. PEPFAR IPs will:

1. Coordinate between community based FSW and PMTCT/EID programs to facilitate successful linkage of pregnant FSW to antenatal services to support PMTCT efforts.
2. Scale-up routine HIV testing services to all pregnant women at ANC 1, and L&D, and at the EPI, pediatric in-patient ward, and malnutrition unit.
3. Implement integrated services at ANC/PMTCT units (e.g., HIV/STI/HBV) and optimize repeat testing for mothers who test negative in the first trimester.
4. Link HIV negative women and PBFW to PrEP to reduce HIV acquisition during pregnancy and breastfeeding stages and monitor utilization of PrEP commodities.
5. Offer HIV self-test to PBFW.
6. Use the SBC interventions to address the relevant barriers and motivators to support demand for ANC attendance, rapid ART initiation and treatment adherence for PMTCT mothers.
7. Optimize EID at 2 months and viral load sample collection through mother-baby pair tracing & use point of care testing (POCT) instruments to improve access to EID services and reduce turn-around-time (TAT) of EID results.
8. Case management of mother-baby pairs in which mothers' appointment dates are aligned with their babies and their files kept together at the health facilities.
9. Establish integrated community drug refills and EID/VL sample collection.
10. PMTCT program monitoring and quality improvement at the site level by building capacity of community volunteers, clinicians, mentor mothers and nurses, establishing monitoring and QI activities supportive of the continuum of care through pregnancy, labor/delivery, and post-partum periods to ensure effective services delivery across the PMTCT_EID cascade.
11. Enhance facility-community linkages and utilize community support groups (mentor mothers, traditional birth attendance, OVC program, etc.) to improve retention through use of appointment logs, phone reminders, active community follow-up and use of peer mothers as linkage facilitators, and family support groups.
12. Increase EID sample collection points at high volume facilities to include EPI and malnutrition units.
13. Demand creation through increased community-based SBC interventions and intense client tracing.

Plans to address Stigma, Discrimination, Human Rights, and structural barriers.

According to the "stigma index and vulnerability study" conducted in 2020, denial and lack of accurate information about HIV transmission are responsible for discriminatory attitudes some of the community

members harbor towards PLHIV. Some people fear that casual contact can lead to transmission, while others fear that if their close associates' HIV status (e.g., spouses, children) is disclosed, they will also be branded or known to be HIV positive. These discriminatory practices were reported particularly at the family and community level, and among sexual partners. Such prejudices emanate from fear of contracting HIV from an index person and feeling of a sense of shame having a family member "bring" HIV to the family.

The South Sudan HIV/AIDS Commission (SSAC) is at the forefront and continues to champion and provide leadership in inclusivity, human rights, dignity, and respect for PLHIV. SSAC has also been advocate for creation of an enabling environment for key and vulnerable populations (KVP), PLHIV as per South Sudan's definition including (MSM, sex workers of all genders, transgender people, people who use or inject drugs, and people in prisons and other closed settings, and adolescents particularly adolescent girls in sub-Saharan Africa, orphans, street children, people with disabilities, refugees and internally displaced people, and migrant and mobile workers, among others) through advocacy, fostering leadership and policy development, and training roles for HIV prevention, treatment, care and support program. SSAC employs various methodologies and approaches including but not limited to:

- Undertake sensitization and engagement/advocacy sessions with the general population (men and women), uniformed forces, local officials, cultural and religious leaders, health care workers, parliamentarians, and others, on stigma, discrimination, and violence impacts mitigation.
- Sensitization workshops on stigma and community empowerment interventions, including legal and human rights literacy for PLHIV networks, KVP groups and CSOs to improve their capacity to challenge and be resilient to acts of stigma, discrimination, and violence.
- Advocate to improve the capacity of legal service providers to offer legal advice and services to PLHIV and key populations who experience stigma, discrimination, and violence to improve access to justice and redress.
- Reducing self-stigma in the clients and then the overall stigma in the community and families while also introducing trust and empathy building tools such as Empathways.
- Individual continuous counseling and life testimonies of the Peer Counselors.

South Sudan criminalizes various aspects of sex work including procuring; keeping a brothel; living on earning of prostitution; and loitering or soliciting in a public place for purposes of [prostitution. Sex workers in South Sudan face significant risks to their safety, health, and human rights because of criminalization of sex work. There are high levels of HIV-related stigma and discrimination among females 72% (2020 PLHIV Stigma Index Survey).

The 2022, ***Legal Environment Assessment*** recommended the following corrective actions:

- Create mechanisms in consultation with sex workers to eliminate and address unlawful arrests and detention; state-sanctioned violence; and impunity for acts of violence against sex workers.
- Enact strict non-discriminations laws for protection of sex workers.
- Provide pre- and in-service training for National Police Service members on human rights-based policing which respects the human rights of all, including sex workers.

- Create mechanisms in meaningful consultation with sex workers to monitor and provide training for healthcare workers on human rights-based approach to provision of services.
- Ensure all health services, including sexual and reproductive health services are available in a confidential, respectful, and non-judgmental manner.
- Increase the roll-out of comprehensive, rights based, community-led SRHR services in areas and venues known to be places of work for sex workers, ensuring the involvement of sex worker organizations in the design, implementation and evaluation of such services and programs.
- Ensure accessible and affordable sexual and reproductive healthcare, services and information are available for all, without discrimination and persecution for their age, gender identity, sexual orientation, and profession.
- Improve the frequency and geographic coverage of data collection on population sizes and HIV prevalence amongst the populations "being left behind"—including sex workers—to ensure that the national HIV response is informed by the best available scientific evidence.

While the issues are wide ranging and complex, requiring a multi-sectoral approach, PEPFAR will work closely with key stakeholders e.g., SSAC, UNAIDS to champion the cause and advocate for KP rights to services and the public health importance of addressing HIV among the KPs. In COP23, PEPFAR will continue to collaborate with the leadership of SSAC to promote stigma and discrimination reduction through; a) addressing providers behaviors and b) deploying social behavior change approaches to address targeted community barriers that influence stigma and discrimination. To achieve these aspirations, South Sudan will work with CSOs such as the networks of PLHIV and intentionally with FBOs tapping into their established community structures for messaging that can support creation of enabling environment.
The following issues will be targeted using SBC.

- IIT mitigation through more meaningful messaging including U=U
- Key messaging to caregivers and parents to improve Children's access of HIV services including EID.

Pillar 2: Sustaining the Response

2.0 Sustaining the Response

South Sudan is still a nation mired in conflict and insecurity, and has years, if not decades, before it can reach any reasonable level of sustainability in its HIV/AIDS response. Consequently, the PEPFAR program has been predominantly a direct service delivery model where the emphasis remains on getting HIV services to the people who need them. However, under the new PEPFAR five-year strategy, COP23 affords PEPFAR South Sudan and HIV stakeholders, particularly the MOH, to begin the process of concretizing a sustainability roadmap that can guide country efforts in the following key areas of the response domestic fiscal leadership, programmatic leadership, the health workforce, and local ownership.

2.1 Context

More than a decade after independence, South Sudan remains impacted by fragility, economic stagnation, and instability. Furthermore, pervasive corruption and weak governance and weak systems continually jeopardize development efforts. Poverty is ubiquitous, exacerbated by conflict, displacement, natural disaster due to climate change, and external shocks. Thus, national priorities remain focused on peace building, economic recovery, and emergency response with limited outlook on system strengthening, particularly for health. The signing of the Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan (R-ARCSS) in September 2018 and the formation of a Transitional Government of National Unity (TGNU) in February 2020 have attempted to contribute to recovery and peacebuilding. A series of encouraging reforms have been undertaken to support longer term stability and development outcomes. However, residual effects of COVID-19, global inflation, and production bottlenecks in the oil sector, cloud South Sudan's economic outlook. South Sudan's vulnerability to climate change and natural disasters compounds the country's humanitarian situation, jeopardizes recovery, and undermines development efforts. South Sudan remains in a serious humanitarian crisis. Some 9.4 million people, 76% of the population, are estimated to need humanitarian assistance in 2023, an increase of half a million people compared to 2022. Women and children continue to be the most affected.

It's within this complex environment that the health system struggles to provide the most basic services to the population. The overall general service availability score is low at 30.4%, with the health infrastructure and service utilization indices at 43.2% and 15.05%, respectively. The health workforce stock is far below the recommended to attain universal health coverage. As a result, the country has poor health indicators. South Sudan's maternal, infant and child mortality rates are some of the highest in the world and life expectancy is low, at 56.5 years.

Going forward, upholding, and fast-tracking the implementation of the peace agreement, strengthening service delivery institutions, governance, and economic and public financial management systems will prove critical as the country seeks to build resilience against future shocks and lay down the building blocks for a diversified, inclusive, and sustainable growth path. While these actions are within the government's control, there has been limited evidence of good public health stewardship and leadership over the past year as evidenced by limited investments in health, unpaid salaries affecting health worker performance, poor coordination of donor funding, and limited health governance.

2.2 Partner Country Government Investment- Domestic Fiscal Leadership

Health sector allocation of the national budget has remained below 2% for the last five years, with the country disproportionately depending on international development assistance for health at over 90% of its total health expenditure. PEPFAR and the Global Fund has supported 100% of HIV services since program began in 2006. Of note, the Revitalized Transitional Government of National Unity (R-TGNU) prioritizes security infrastructure over health, education, and other sectors. Public financing for procuring essential medicines has diminished, procurements are opportunities for corruption, and regulatory capacity is weak. The health sector budgetary allocation increased to 7.9% of the national budget for the 2021/2022 fiscal year, but actual expenditures since the signing of the revitalized peace agreement in September 2018 are not known, and salaries remain unpaid for the most part. Therefore, specific health program funding remains uncertain and minimal. Previously, the R-TGNU allocated a small budget of 2.0%

to HIV annually; these funds were primarily spent on staff salaries. No funds have been allocated for commodities, training, or supportive supervision, among others.

PEPFAR does not anticipate any new funding from the R-TGNU for HIV, TB, and Malaria programs despite the continued advocacy by South Sudan AIDS Commission (SSAC), Ministry of Health (MOH), and other stakeholders. The HIV response is expected to continue to be solely reliant on PEPFAR and GF, with PEPFAR currently supporting about 92% of the national PLHIV population on ART. Currently, there are no other development partners supporting core HIV programs in South Sudan.

The Global Fund (GF) is in the process of approving a new three-year HIV/AIDS grant of $68,125,558 that ends in December 2025. The funding represents an overall increase from the previous grant valued at $48,000,000 over three years (January 1, 2021 – December 31, 2023). About 68% of the GF resources will go towards treatment, care, and support, covering mostly commodities. PEPFAR and GF continue to collaborate to ensure all resources are used optimally, collaboratively and towards achievement of epidemic control.

Due to funding and staff retention issues, the MOH Department of HIV/AIDS remains understaffed. PEPFAR does not support salary or incentives to MOH staff.

The figures below illustrate trends in total budget by funder 2018-2024, funding landscape and trends in budgets versus expenditures.

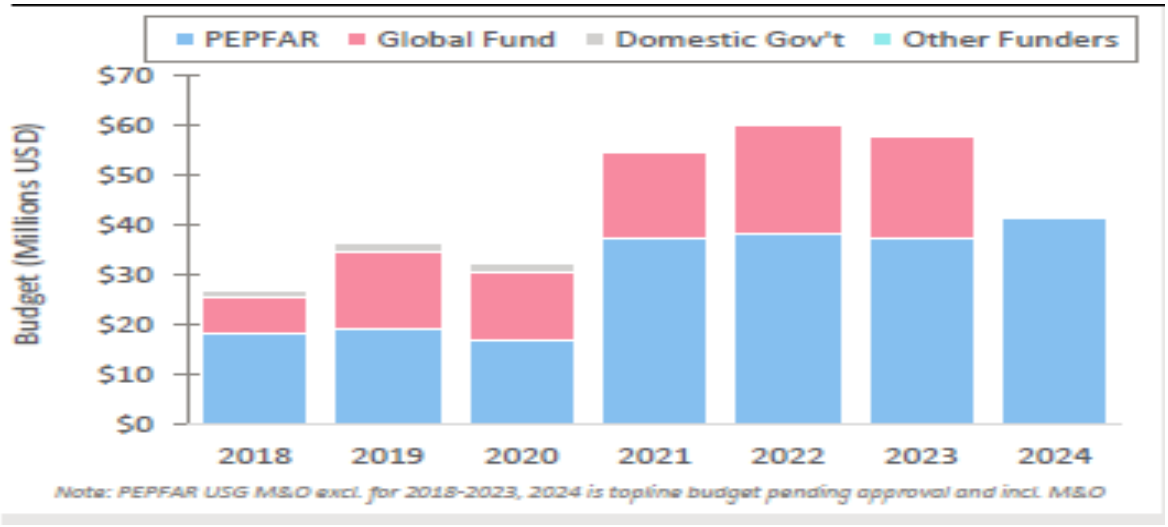


Figure 3.1: Trends in total Budget by funder 2018-2024

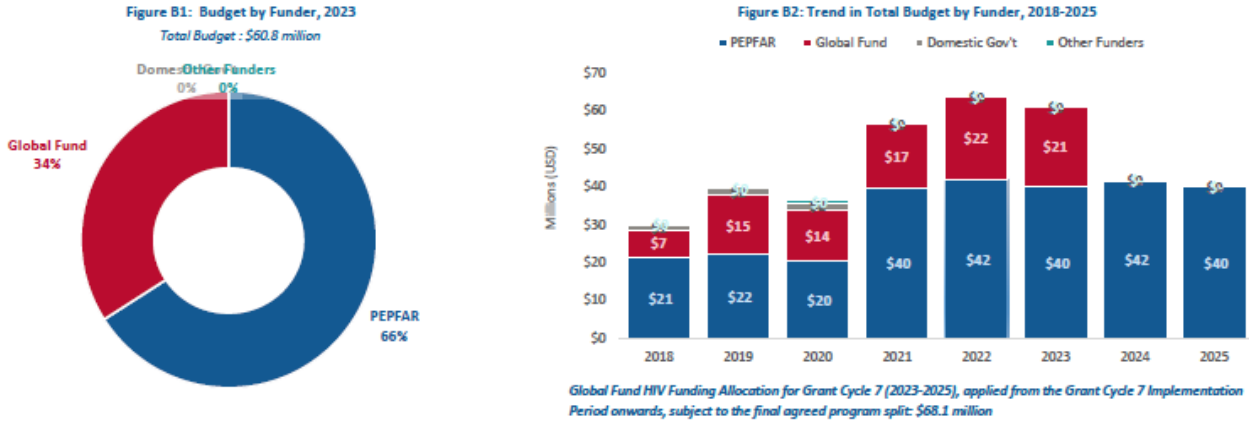


Figure 3.2: Funding landscape-planned budgets by funder 2023

	PEPFAR			Global Fund			Domestic Gov't			Other Funders		
Year	Budget	Expenditure	% Spent	Budget	Expenditure	% Spent	Budget	Expenditure	% Spent	Budget	Expenditure	% Spent
2018	$18,182,077	$18,375,944	101%	$7,246,252	$8,725,017	120%	$1,233,303			$459,486		
2019	$19,012,435	$17,944,566	94%	$15,475,321	$15,062,450	97%	$1,849,955			$459,486		
2020	$16,834,070	$15,936,645	95%	$13,608,270	$12,607,821	93%	$1,886,954			$459,486		
2021	$37,453,029	$33,308,482	89%	$16,934,027	$17,042,764	101%						
2022	$38,381,851	$35,077,801	91%	$21,624,782								
2023	$37,210,506			$20,716,567								

Figure 3.3: Trends in total budget and Expenditure by Funder, 2018-2023

In COP23, PEPFAR will continue to coordinate closely with the GF and MOH to maximize efficiencies GF will continue to procure all ARVs and other HIV-related commodities (such as HIV test kits, VL/EID reagents etc.) while PEPFAR will continue to provide technical guidance, through the Incident Management System (IMS), technical working groups (TWGs) and embedded technical staff to MOH, in planning, procurement, storage, quantification, forecasting and logistics management. PEPFAR will continue to dedicate resources towards supporting last-mile delivery.

To strengthen the HIV/AIDS response, PEPFAR/GF/MOH and other stakeholders will refocus and realign coordination and communication among themselves to improve efficiencies, impact, and accountability of programs. While key stakeholders such as the MOH, bilateral donors, multilateral organizations will need to shift to new approaches proven to accelerate gains towards reaching the 95-95-95, further gains will depend on increased engagement with the private sector, civil society, and others, including faith-based organizations. PEPFAR/ GF and other partners are committed to continually strengthening their partnership with host-country governments to ensure alignment of HIV investments with the National Strategic Plan (NSP) In COP 23, PEPFAR, GF and partners will continue joint planning and coordination to ensure that prioritized interventions are scaled up, geographic priorities like the Lakes state strategies are shared, and that all available resources for HIV/AIDS in the country are utilized optimally. Increased collaboration between the MOH, PEPFAR and the GF during planning, budgeting processes and joint quarterly program reviews help ensure investments are strategically aligned to address gaps and solutions while maximizing transparency, efficiency, and accountability of their resources. For COP23, PEPFAR will advocate to strengthen the framework and process of the joint quarterly program reviews to ensure

progress in addressing findings and roadblocks. During COP23, PEPFAR and GF will also continue alignment discussions focused on TB/HIV integration, alignment of staff salaries and incentives, and health systems strengthening investments.

Looking forward and keeping in mind the current challenges facing South Sudan in the fiscal space, there are opportunities for increasing the domestic fiscal envelope. During the Juba Stakeholders Meeting that took place in February, participants highlighted lack of health funding as one of the key impediments for reaching 95-95-95. However, many felt there was an opportunity to increase the funding envelope for HIV through advocacy with the Ministry of Finance, public financial management (i.e., expenditure tracking), engagement with the private sector, and finding efficiencies in program implementation and spending (i.e., integration). Further discussions that took place during the Johannesburg and Second Juba Stakeholders Meeting, resulted in the following action items and/or topic for further discussion:

- Abuja Advocacy Platform: PEPFAR South Sudan, MOH, and key stakeholders join SSAC in pushing forward an advocacy platform to increase the budget allocation for the HIV program. Furthermore, the HIV community should combine strategies with other health actors to advocate the Ministry of Finance to increase the overall allocation for health to 15% as outlined by the Abuja Declaration. PEPFAR South Sudan and HIV stakeholders should align advocacy efforts with those of the Health Pool Fund (HPF) donors, which are currently undergoing discussions to design the next iteration of the HPF. To derive accurate financing needs, it is recommended that the Ministry of Health develop and implement a long-term financing strategy for the HIV response. As part of these efforts in COP23, PEPFAR South Sudan will work with the Ministry of Health and SSAC to initiate the process of developing the Sustainability Vision, Roadmap, and Implementation Plan.
- Implementation of Transparent Public Financial Management Processes: Given limited resources in the HIV program and need to optimize investments, it's critical to have transparent systems for tracking the allocation and expenditures of funds directed at the HIV program. UNAIDS and the MOH are in the process of developing and launching an expenditure tracking tool for the HIV program. This presents an opportunity to include expenditure tracking as part of the Ministry of Health's HIV program reviews.
- Engagement with the Private Sector: While South Sudan doesn't have a robust private sector, there is still potential for leveraging this growing sector, including private health providers for the delivery of HIV services. The Ministry of Health is committed to reinitiating discussions on their private sector engagement strategy. PEPFAR South Sudan remains committed to engaging the private sector to accelerate outreach efforts by exploring partnerships with private providers and pharmacies in COP23.
- Finding Efficiencies and Integration: Vertical programming in South Sudan is ubiquitous but not cost-effective. The HIV National strategic plan includes integration to optimize efficiencies. Under COP23, PEPFAR South Sudan will exert efforts to integrate HIV and other health programming, particularly leveraging USG programming in the maternal and child health, family planning, youth, and humanitarian spaces. The focus will be on TB/HIV integration with the goal of outlining a roadmap for full integration by 2025.

Partner government Sustainability of HIV Response

South Sudan has nearly none of the critical elements in place to support a robust and transparent economy or government. The government's HIV response remains entirely reliant on PEPFAR and the Global Fund that are responsible for nearly all the support for HIV/AIDS services nationwide. No areas of the HIV response in RSS are adequately covered in terms of finance, oversight, monitoring, or service delivery by the government. The government prioritizes security infrastructure over health, education, and other sectors.

2.4 Programmatic Leadership

To achieve sustained control of the HIV/AIDS epidemic, it is essential that the Ministry of Health be the owner and steward of the HIV program. During the Juba and Johannesburg stakeholder meetings, participants indicated that coordination both at the national and sub-national level was a hindrance to effective program implementation. However, participants also highlighted the following opportunities and actions for strengthening the Ministry's role as the lead and steward of the HIV program:

- Institutionalize the HIV/TB Incident Management System (IMS): PEPFAR South Sudan in collaboration with MOH, WHO and other stakeholders launched the IMS, which is intended to improve coordination of the national TB and HIV/AIDS response, provide technical guidance and strategic leadership to the different donors and many partners and be able to address the challenges related to HIV implementation in South Sudan. The IMS is also intended to ensure better response and accountability across all stakeholders and minimize duplication of efforts and resources. Additionally, the IMS is proposed to improve and strengthen coordination of HIV/AIDS response at sub-national level (State and County level) where the systems continue to be weak due to limited or absent human resources and limited resources and capacities. In COP 23. PEPFAR will continue to support the IMS through a variety of capacity building activities including monitoring and oversight of facility performance; strategic use of information, particularly DHIS2 implementation to improve data visibility; supply chain and commodities to ensure that commodities are tracked and monitored regularly to avoid stock outs. PEPFAR will facilitate the MOH sustain regular monthly technical working groups and priorities topics along the continuum of care that are critical and impactful to the HIV response.
- Program Management- Defining Roles and Responsibilities: During the three stakeholder engagements, participants articulated a need for defining roles and responsibilities between national and sub-national level to streamline coordination and building capacity of management human resources. Furthermore, sub-national managers could benefit from better clarity on the roles and responsibilities of MOH and SSAC, including the responsibilities of State AIDS commission (SAC) and County AIDS commission (CAC) officers.
- Sub-national Engagement and Capacity Building- Sub-national entities play a critical role in the success of the national HIV program. In this vein, stakeholders agree that intentional and targeted engagement with sub-national entities in the planning, implementation, and monitoring is important to ownership and inevitable stewardship of the response at the sub-national level. In COP 23, PEPFAR will strengthen coordination with sub-national level MOH leaders and program

managers, including co-locating the TB/HIV and M&E state and county field officers within government offices.

2.5 Health Workforce

An adequately staffed, trained, motivated, efficient, and effective health workforce is critical to attaining epidemic control. However, several structural and contextual factors impact human resources for health in South Sudan ranging from low salaries to delayed payments, a dearth of trained staff, and frequent turnover. Over the past couple of years, the country has struggled to pay and retain health workers leading to staff demotivation and high turnover. The MOH Department of HIV/AIDS has been chronically understaffed because of poor domestic financing. UNDP, the GF Principal Recipient for the HIV/AIDS program, provides support at the national level which includes staffing support to the Department of HIV/AIDS. Most staff at ART facilities are supported by PEPFAR through IPs (i.e., salary payments) and GF through UNDP through incentives. During the Juba and Johannesburg stakeholder meetings, participants indicated high turnover, low job dissatisfaction due to inconsistent salary payments, parallel functions across various positions, poor efficiency to perform job functions, and weak skill alignment to job function as notable issues impacting the effectiveness of human resources. The following opportunities and action items were identified:

- In-Service and Pre-Service Training: Develop a standardized HIV training and mentoring plan to ensure HIV staff knowledge and skills sets are continually improved. If feasible, ensure trainings such as PrEP, VMMC, and HST are incorporated into pre- service or in-service trainings under the National Health Institute. Given the high turnover of staff, in-service trainings should include modules focused on program management and leadership. In COP 23, PEPFAR will continue to coordinate training with MOH, including building capacity of trainers, particularly focusing on capacitating a health care workforce skilled in prevention and PrEP services. PEPFAR will also focus on post training quality assurance for effectiveness, performance monitoring and mentoring to further strengthen adoption of new skills and improvement of quality service delivery.
- Harmonized Salary Incentives: One of the main causes of low job satisfaction and high turnover is fluctuations in salary payments and incentives across implementing entities. During the last stakeholder meeting in Juba, the MOH committed to updating the salary table and disseminating via circular. In COP 23, PEPFAR work with GF to harmonize salaries and incentives with the goal of aligning salaries and incentives to the MOH's salary table by 2025.
- Standardizing Recruitment Process: To address the issue of 'poor fit for job', stakeholders recommended that the MOH standardize the recruitment process to ensure transparency and appropriate fit when filling government positions. This should also include review and revision of position descriptions to ensure alignment to roles and responsibilities of the position. In the long-run and as part of the sustainability plan that will be developed during the implementation of COP 23, the MOH should lead the development of a staff retention strategy and implementation plan, including strengthening of the existing human resource information system. In COP 23, PEPFAR will IP employment terms with government recognized cadres, pay scales and qualifications, and ensure optimized PEPFAR human resources for health staff investments complement government and private sector staffing availability and needs.

2.6 Local Ownership

A critical factor for sustaining the response in South Sudan, given low resource allocation, and limited human resources, is the engagement of civil society organizations (CSO) and faith-based organizations (FBO). PEPFAR has continued to expand civil society representation into PEPFAR COP planning, implementation, and reporting processes for added ownership, accountability, and transparency. To date, the engagement has been beneficial to the response, particularly for elevating the rights of KPs and ensuring a conducive environment for accessing services.

During the three different stakeholder meetings between February and March 2023, stakeholders emphasized the need to fill the gap for building CSO/FBO capacity to both advocate for and implement services for PLHIV. The following recommendations were incorporated into COP23:

- Strengthen CSO/FBO Coordination Forum: Currently, the network of AIDS service organization in South Sudan (NASSOS) serves the role of CSO/FBO coordination for HIV programming in South Sudan. NASSOS currently functions on a volunteer basis and the limited grants they manage are short-term and inconsistent. In COP23, PEPFAR will provide capacity building support to strengthen NASSOS's organizational capacity, focusing on resource mobilization to coordinate the forum. Additionally, PEPFAR South Sudan will continue to advocate for CSO/FBO participation in all HIV platforms, including technical working groups.
- Organizational and Technical Capacity Building: PEPFAR South Sudan's long-term vision is to strengthen CSO/FBO capacity and exposure to managing USG grants and cooperative agreements, with the goal of increasing the number of local recipients of direct PEPFAR awards. In COP 23, PEPFAR South Sudan will continue to prioritize engaging local CSOs/FBOs to manage the community engagement components of the program (service delivery, social behavior change, etc.) and will task its prime partners to build the capacity of the local CSOs/FBOs including KPs. Furthermore, PEPFAR will provide individualized capacity building support to sub-grantees and leverage the NASSOS platform to provide virtual and one-off capacity building activities (i.e., workshops, seminars, communities of practice) that can be accessed by the wider network of CSOs/FBOs.
- Increase in Funding Opportunities: Given the limited funding envelope and tendency of HIV donors to use INGOs to implement activities, there are limited opportunities for CSOs/FBOs to competitively apply for funding opportunities. To increase the number of awards managed by CSOs/FBOs, PEPFAR South Sudan will increase the number of funding opportunities (i.e., cooperative agreements, grants) for CSOs/FBOs, including incorporating transition modalities into existing mechanisms.

In COP23 PEPFAR South Sudan will continue to invest in the above identified areas of human resource for health which remains critical for the delivery of HIV service and non-service activities and sustaining this, is an important step towards achieving epidemic control. The MOH and the government of South Sudan continues to struggle with human resources for health management across the health portfolio, lacking funding to support, train and develop HR capacities across the different levels. Public access to information, quality management and data for decision making are other elements that have consistently remained low but some of these will be addressed with activities indicated in the PASIT.

Pillar 3: Public Health Systems and Security

Leveraging PEPFAR Resources to Support Public Health Security.

The new PEPFAR pillar "Public Health Systems Strengthening and Health Security" comes at a time when the world is coming out of pandemic. During the COVID-19 pandemic PEPFAR countries were able to leverage its investments in HIV prevention, care and treatment and laboratory to provide a platform for infectious disease response. The PEPFAR supported DHIS-2 platform in South Sudan rapidly stood up a surveillance tracker and vaccine module in <6 months to capture hotline surveillance, laboratory, contact tracing, case management, border health and vaccination data. Years of PEPFAR and Global Fund support at the National Public Health Laboratory allowed for rapid initiation and expansion of in-country COVID-19 testing capabilities within a few weeks of the COVID-19 pandemic enabling a transformative approach to partnership. Forty GeneXpert testing sites, a field level PCR lab with staff training, mentorship, and support from US CDC to undertake TB, HIV/EID, COVID19 testing at state and county level was provided. PEPFAR Quality Management System supported activities in the Health Reference Lab was used as a framework for the COVID-19 lab at NPHL and private facilities. The PEPFAR supported ECHO platform based virtual site visits, remote training expedited rolling out of virtual GSM for site level improvements. Congress American Recovery Plan supplement supported improvement of Infection Prevention and Control measures and COVID-19 mitigation measures. PEPFAR supported NPHL leveraged for Ebola sample collection and transport, Rapid Response Teams supported the Incident Management Structure for Ebola Preparedness. Border Health Screenings for both COVID19 and Ebola (Juba International Airport and Nimule Land Border).

Hence the timeliness of this cannot be understated as PEPFAR has for years been building health systems in some of the most challenging and austere working environments. Such is the story of South Sudan; a country recovering many years of conflicts plagued by natural disasters, acute food insecurity; famine and on-going inter-communal clashes with limited access to fragmented primary healthcare. Health systems in PEPFAR are characterized by service delivery and community systems, public health systems and public health institutions. The core of this triangle is Governance, Ownership and Leadership. In the context of South Sudan with the entirety of HIV services and 99% of the Healthcare services in-country is donor funded with very limited Government of South Sudan ownership and leadership compiled with poor governance the sustainability of any investments in systems work need to be strategically placed. Critical health system building priorities include strategic information and data systems, laboratory health systems, workforce capacity through ECHO, supply chain systems, pandemic preparedness, and response.

Pandemic preparedness and response.

The current Incident Management System (IMS) sits at the public health emergency operations center. HIV IMS under HIV Directorate. HIV IMS Technical Working Groups are in nascent stage, weak and require further support to invigorate and manage issues as they arise. Lessons from the more functional Laboratory Working Group and Supply Chain Working Groups should be incorporated for care and treatment. HIV IMS should support the Joint Programmatic Reviews which should provide a more

thorough systemic approach into PEPFAR stakeholder consultations and Country Operational Planning process. The same system should be applied to improve trigger decisions for public health preparedness and emergency response for other diseases. The current National Steering Committee remains weak in implementation of emergency management measures with limited rapid response teams and capacity to investigate alerts arising from the community. The community piece in a fragmented system is critical to build surveillance capacity to monitor events. Community based surveillance requires a functional event-based surveillance system with adequate epidemiological workforce.

Investments in the Laboratory in providing technical support at the National level, increasing the number of accredited Laboratories in the country will contribute to improving the preparedness of the National Laboratory system to investigate any outbreak. Sustaining the support for health data systems and providing technical support at the National, States and County level in overall health data collection, reporting, analysis, and use will empower local capacities for prevention of outbreaks, early detection, and response. While the supply chain support will ensure an efficient supply chain system that can deliver the required supplies rapidly during outbreaks.

Health Information Systems.

In line with the draft South Sudan HIS Strategic Plan 2023-2028, PEPFAR program will support establishment one secure data system. PEPFAR will continue to support management and use of DHIS2 which proved for COVID19 surveillance tracking. PEPFAR will support data management and use at national, state and county level for timely and complete health reporting and early detection of epidemics. Support for HIS will enable MOH monitor the implementation of the National Health Strategic Plan as well as the National HIV strategic plan and share health information with stakeholders as well as meet global health reporting requirements. Details on HIS strengthening and data use as well as surveillance is provided under pillar 5 (follow the science) and Enablers (leading with data).

Strengthen HIV commodities supply planning management.

PEPFAR South Sudan in COP23 will continue to work closely with MOH leadership, Global Fund/UNDP, and key stakeholders to improve commodities and supply chain needs and advocate for changes to procurement and supply plans that will ensure a consistent supply of HIV commodities for the success of PEPFAR program.

HIV commodities and supplies remain critical for the success of the PEPFAR program, in COP23 PEPFAR will liaise with MOH and Global Fund/UNDP to ensure all HIV commodities are quantified correctly, budgeted adequately, and procured in a timely manner to avoid any stockouts. PEPFAR will provide technical assistance to improve operational capacity and performance in South Sudan's national quantification and forecasting of HIV/AIDS commodities and supplies as a key area identified as a gap in the supply chain system. PEPFAR will continue to work closely with the national supply chain technical working group to strengthen the MOH department of pharmaceuticals' capacity for forecasting and supply planning, procurement, distribution, policy, and governance.

PEPFAR will continue to participate in the commodities technical working group in the HIV Incident Management System (IMS) to ensure that HIV commodities such as PrEP, rapid-test kits and self-test kits, pediatric ARV formulations, fixed dose TB coinfection Preventive Therapy (TPT) for both adults and children and drugs and supplies required for advanced HIV care are appropriately quantified and planned to support MOH procurement through UNDP.

In COP23 South Sudan will continue to rely 100% on HIV commodities procured by UNDP under the Global Fund grant 7 (GC7), apart from VMMC commodities, which will continue to be procured by the PEPFAR Implementing Partner directly. Although PEPFAR South Sudan does not procure HIV commodities, the PEPFAR program accounts for over 80% of the HIV commodities consumed. The USAID South Sudan Supply Chain Specialist will lead PEPFAR South Sudan's efforts in coordinating supply chain stakeholders including MOH leadership, Global Fund, UNDP, and NPHL related to quantification and supply chain management activities.

Issues related to consumption data collection, reporting and visibility persist, the Global Fund through MOH and UNDP will continue to support the Supply Chain System strengthening under RSSH-Health Products Management Systems to establish sustained central level storage and distribution capacity, system responsiveness, accelerate supply chain integration (legal and regulatory framework), strengthen supply chain governance, supply chain information systems (eLMIS), increase Drug and Food Control Authority (DFCA) capacity for quality assurance/safety, scale up/strengthen pharmacovigilance and improve environmental controls across the supply chain.

Last Mile Delivery.

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

In COP23, last mile delivery resources will be available to the three PEPFAR care and treatment partners to ensure commodities reach the last mile in the most challenging and most critical supported areas. In COP23 PEPFAR through IPs will make significant advances to improve the ability for commodities to reach the service delivery point and ultimately patients. PEPFAR will continue to address last mile delivery challenges to ensure timely distribution of commodities to the PEPFAR supported sites and KP sites, including restocking in close collaboration with Global Fund, and other stakeholders. A combination of aircraft, vehicles, motorcycles, and bicycles will be utilized to ensure that essential commodities—condoms, ARVs, HIV test kits, opportunistic infection medication, lab supplies, and PrEP reach the population.

Additionally, PEPFAR through IPs will build capacity of the facility staff (supply chain focal persons and storekeepers) in supply chain management through training, onsite mentorship, and coaching sessions to

improve the timely updating of stock cards, timely ordering of drugs and other supplies, minimize stock-outs of key commodities and support and track HIV commodity consumption reporting through DHIS2.

The newly hired Supply Chain Advisor will lead PEPFAR South Sudan's effort to coordinate with commodity and supply chain stakeholders including MOH, UNDP, NPHL and others to ensure all issues related to supplies are managed in a timely manner.

Laboratory systems.

a. Viral load

South Sudan's VL coverage has generally remained at an average of 68% in the past one year with the lowest being observed in children under 15 years (57% in FY23 Q1) and pregnant women (60%). VL suppression was 87% in the general population in FY23Q1 with a slight improvement in children under 15 years old from 65% in FY22 Q1 to 73% in FY23 Q1.

The low VL coverage has been attributed to low demand creation, low VL literacy among clients and providers, client treatment interruption, challenges with accessing health facilities, long waiting time at facilities, etc.

The proposed strategies for improving VL coverage include:

- Improving client and clinician VL literacy: Low VL literacy among service providers at facility and community levels have negatively impacted the improvement of VL services. South Sudan will improve demand creation for VL services at both facility and community level through various VL information dissemination activities including an SBC approach.
- Integration of community drug refill & sample collection: To reach out to clients who cannot access the facilities, South Sudan will continue to integrate VL sample collection into the community drug refill activities. Community outreach workers will be trained and mentored to be able to conduct client tracing, community VL sample collection and proper documentation. The training will be conducted using standardized curriculum for health care workers and community volunteers.
- Scaling-up viral load services in ART sites and increasing sample collection points at high volume facilities. There are 116 out of 179 ART facilities that have services for VL sample collection. Personnel at the remaining ART facilities will be trained, provided with tools, and supplies to initiate VL sample collection services. To minimize missed opportunities for VL sample collection at other entry points, the PEPFAR program will strengthen its collaboration with other partners supporting health facilities e.g., UNICEF, Health Pooled Fund, CORDAID, etc. More staff will be trained on sample collection at various entry points especially at PMTCT, OPD and Wards to collect VL samples. PEPFAR South Sudan will continue to support facility service improvement such as fast- tracking of clients for quicker service and weekend ART services especially for the adolescents.

- Decentralization of VL testing: South Sudan has 66 GeneXpert instruments (11 are 16-modules, 55 are 4-modules). 18 of these instruments are used for VL testing at various facilities and 21 of them are pending installation. In FY23 Q1, pregnant and breast-feeding mothers and children contributed 58% (440) and 21% (163) of the VL tests done at the POCT laboratories respectively. These volumes are much lower than the number of VL eligible pregnant women and children. South Sudan will continue to use the instruments for VL testing of eligible clients especially pregnant and breastfeeding women, children, and adolescents and high VL clients.
- Improving VL instrument utilization. Testing of samples at the HIV reference laboratory and decentralized laboratories and return of results require availability of reliable electricity at the testing laboratories, timely equipment maintenance, competent and dedicated human resource and availability of storage space for the much-needed supplies. PEPFAR South Sudan will continue working with UNDP to ensure that VL testing platforms are under optimum working conditions. PEPFAR will also support training of laboratory technicians and instrument super-users to conduct basic GeneXpert platforms maintenance, calibration, and troubleshooting, provide refrigerators at hubs, install additional solar energy at selected facilities and provide routine mentorship and quality assurance.

b. Diagnostic network optimization and multi-disease diagnosis

By the end of FY23 Q1, there were 66 GeneXpert instruments in the country (55 of them are four modules and 11 are sixteen modules' instruments). Thirty-nine of the instruments are installed at 37 health facilities, 1 installed at the HIV Reference Laboratory (HRL), 2 at the National TB Reference Laboratory and 1 sixteen modules at the Molecular laboratory. 9 sixteen modules and 12 four modules are pending installation and 2 are faulty. The country also has two Abbott m2000 instruments placed at the HRL for VL testing.

The GeneXpert instruments are being used for multi-disease testing. In FY22, 19 facilities tested for COVID19, EID, TB and VL on one platform, 10 facilities tested for EID, TB and COVID19, 3 facilities tested for TB and COVID19, 5 tested for only TB and 1 tested for only COVID19. With the use of POCT, more tests are being done at facility level. There are 18 facilities doing VL testing using the POCT, 23 for EID, 35 for TB and 32 for COVID19. In FY23Q1, out of the total tests done at POCT laboratories, 70% of tests were TB, 19% VL tests and 8% EID tests. COVID19 testing significantly dropped due to the roll-out of antigen-based (Ag) rapid diagnostic test (RDT) kits. In FY23 Q1, 58% of EID tests and 14% of VL tests were done at decentralized laboratories.

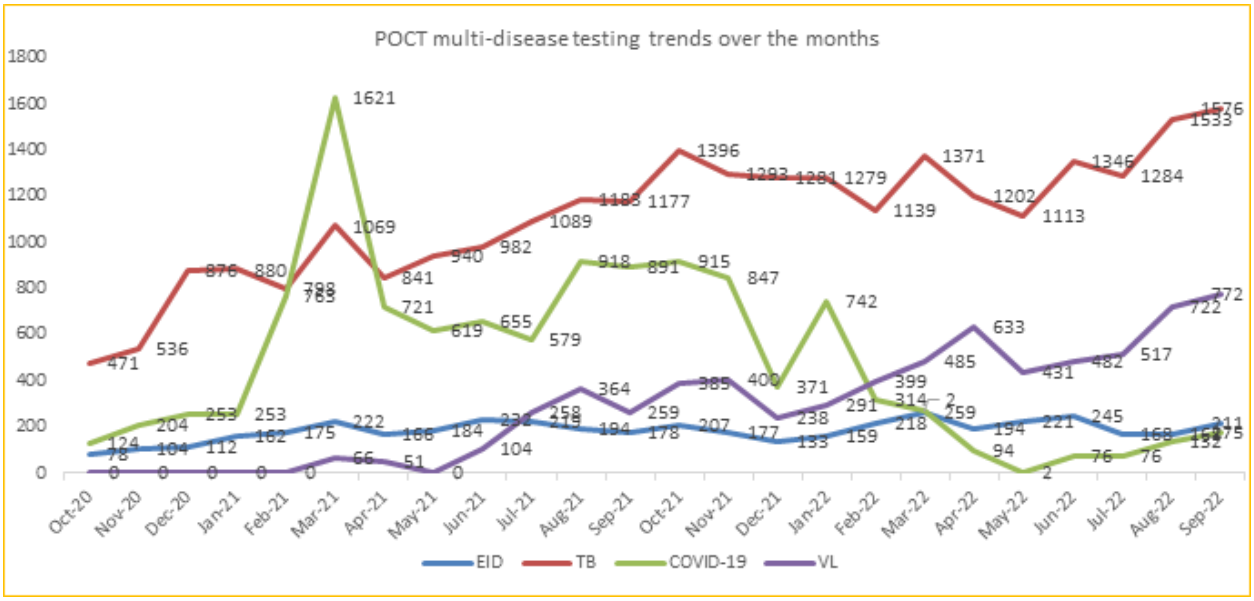


Figure 4.1: Multi-disease testing trends

Multi-disease testing and instrument utilization is hindered by several factors including power interruptions, instrument breakdowns, delayed maintenance of instruments, delayed and inappropriate supply chain systems, inappropriate infrastructure, and low demand for services.

To improve multi-disease testing and instrument utilization, PEPFAR South Sudan will implement the following interventions:

- Train and certify more testing personnel to address attrition.
- Enhance demand creation at facility and community.
- Conduct maintenance of laboratory utilities such as air-conditioners
- Build capacity of more technicians as super-users to ensure timely instrument maintenance.
- Conduct supportive supervision and mentorship to laboratory technicians.
- Develop, print, and disseminate guidelines, tools and job aids.
- Coordinate external quality assurance activities for near POCT.
- Improve data capture and quality at site and central level through training and ensuring functionality of the laboratory information management systems.

c. Continuous quality improvement and accreditation

South Sudan is implementing laboratory continuous quality improvement (LCQI) activities at six hospital laboratories using the Strengthening Laboratory Management Towards Accreditation (SLMTA) model. The six laboratories are Juba teaching hospital (JTH), Al-Sabah hospital (ASH), Torit state hospital (TSH), Yambio state hospital (YSH), Wau state hospital (WTH) and Juba military hospital (JMH). Over the past two years, the laboratories have shown some progress in LCQI. Using the WHO AFRO ASLM Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA) checklist, JTH and ASH attained 3 stars, TSH attained 2 stars, YSH and WTH attained 1 star. JMH was enrolled in FY23Q1 and has not yet been audited.

The HIV Reference Laboratory (HRL) started the process towards accreditation in FY18 and received ISO 15189 accreditation from Kenya Accreditation Service (KENAS) for EID and VL testing in October 2022. This is the only internationally accredited laboratory in South Sudan.

South Sudan has 100 HIV testing facilities each with at least 3 testing points that participate in HIV rapid test proficiency testing (PT) scheme, 24 laboratories participating in EID near POCT PT and 19 laboratories participating in VL near POCT PT schemes.

Implementation of LCQI is faced with many challenges including understaffed laboratories, unpaid technical staff, poorly equipped laboratories, absence of or delayed equipment maintenance, lack of reagents, poorly designed laboratories, no national laboratory accreditation plans, limited external quality assessment programs and inadequately staffed EQA department.

To proceed with quality laboratory services, PEPFAR South Sudan will support capacity building of technical staff through trainings on LQMS, SLMTA, EQA, biosafety and biosecurity; mentorship, infrastructure improvement to ensure safety of personnel and optimum laboratory processes, ensure essential equipment maintenance and calibration and develop and disseminate quality policies, tools, and guidelines. In FY24, South Sudan plans to expand LCQI activities to 4 additional laboratories, extend HIV rapid testing to community testers, increase EQA PT panels to TB, Syphilis and Hepatitis B especially at antenatal clinics, continue with HIV rapid test site and tester certification, automating EQA result management and collaborating with global fund and other partners on establishing regional laboratories for timely investigation of future outbreaks. The program will also initiate the accreditation process for one hospital laboratory and finalize an accreditation maintenance plan for the HRL and any other laboratory that gets accredited.

d. Biosafety and waste management

South Sudan is still struggling with hospital and laboratory waste management. Several facilities do not have established procedures, guidelines, equipment, and skilled personnel to handle waste. The only high temperature incinerators capable of incinerating GeneXpert EID, COVID19 and VL cartridges containing guanidinium thiocyanate (GTC) are installed in Juba and Wau. All used cartridges are transported to Juba by road at a high cost. There are approved guidelines for management and disposal of medical waste including liquid wastes generated by laboratories.

In COP23, the country proposes to develop national guidelines on waste management, strengthen implementation of waste management policy at national and sub-national levels, continue packaging and shipping of GTC containing cartridges for proper disposal and train facility staff on waste management.

e. Sample transportation system.

Sample transportation is partially integrated for HIV and TB. HIV and TB samples from PEPFAR supported facilities are transported using one system, samples from non-PEPFAR supported sites are transported by global fund partners e.g., Arkangelo Ali Association (AAA) and samples for suspected outbreaks (e.g.,

Measles, Polio, Rubella, Cholera, Meningitis, VHF, SARS-CoV-2) are referred using the WHO Integrated disease surveillance system (IDSR).

The sample transportation system is coordinated by a Sample Transport Coordinator who is based at the National Public Health Laboratory (NPHL). Within Juba County, sample movement from facilities to HRL for testing is facilitated by an ICAP hired sample transporter riding an ICAP provided motorbike. The transporter visits the sites thrice a week to pick the specimen while dropping any available results from the HRL. The transporter further transports all specimens shipped through commercial airlines or taxis from distant sites to HRL based on their availability. For facilities outside Juba County, specimen movement is facilitated by locally hired private motorbike riders. Specimens are picked at spoke facilities, transported to the hubs and then for onward shipping to HRL based on a defined transportation schedule designed for each facility, state and region using commercial airlines, UNHAS flights or commercial vehicles.
Sample transportation is a very costly activity in South Sudan due to poor road network, limited road transport operators and insecurity and floods. Other observed gaps include absence of dedicated courier companies, distance between hubs and spokes, reliance on individuals and commercial flights, absence of dedicated sample coordinators in the regions and inefficient payment systems leading to delay in sample movement.

In FY24, PEPFAR South Sudan will collaborate with other donors such as Global Fund to fully integrate movement of all HIV and TB samples within one-centrally coordinated network to maximize use of resources. PEPFAR will build capacity of personnel involved in specimen movement on sample handling, packaging, documentation, and safety, develop tools and standardized indicators to track and monitor effectiveness of the system, identify sample transport coordinators, and establish appropriate storage facilities e.g., refrigerators for samples at hubs to prevent loss of sample integrity and quality.

f. Result transmission

There are two laboratory information management systems (LIMS) at National Public Health Laboratory – Viral Load Sample Management System (VLSM) and TB Laboratory Information System (LIS). The others are e-governance for COVID19 travelers test data and WHO LIMS for NPHL reference laboratories. The VLSM was introduced in 2017 for VL, but now expanded to capture EID, COVID-19 and being configured for TB data. The VLSM has been installed at 3 laboratories (HRL, Nimule hospital laboratory and Wau teaching hospital laboratory). The system has since been upgraded to include a cloud-based VL sample tracking system (VLST) and Android module used on sim-card enabled tablets for 24 POCT laboratories to enter data and access results. The VLSM is also interoperable with the Abbott and GeneXpert testing equipment. Efforts are ongoing to finalize integration of VLSM with DHIS2 to ensure availability of VL data in DHIS2 for use in national reports and generation of DHIS2 dashboards for use at facility, county, and state level.

HIV EID and HIV VL results for facilities in Juba County are delivered as hard copy by a sample transporter and results for facilities outside Juba are sent by email to facility focal persons. Results of EID and VL tests done at decentralized laboratories are entered into the android tablets that get synchronized via the cloud based VLST system with the VLSM. The current mechanism for results transmission has let to delays in

returning results to service providers to initiate clinical actions.

Despite the improvements on LIMS, there are still gaps that delay return of results to patients and access to data for decision making. The main challenges include lack of a national laboratory Information system and dashboard, limited internet and phone coverage, few human resources for data entry and absence of national policy on record management and archiving.

To enhance laboratory information systems, PEPFAR will continue to ensure the functionality of VL sample management system (VLSM) through supporting internet services, training VLSM users, on-going monitoring of the system functionality, finalizing interoperability with DHIS2 and laboratory instruments, maintain a VLSM system manager and provide mentorship to facility level staff on data entry, result access, result utilization and data quality assurance.

TB/HIV

The 2022 WHO Global TB report estimates the incidence of TB disease in South Sudan at 227/100,000 population, translating to 24,000 (16,000-35,000) new TB cases in 2021. Among PLHIV, TB incidence was 30/100,000 population, translating to 3,200 (2,000-4600) TB cases in 2021 with an estimated 910 (590-1300) TB-associated deaths among PLHIV. COP21 Q4, showed that 93.6 % of ART patients were screened for TB symptoms, and 3.4% screened positive, lower than the expected screen positive rate of 10-15% of newly enrolling, ART-naive patients and approximately 5-10% of previously enrolled ART patients. The low percentage of people screening positive for TB symptoms could be attributed to the low sensitivity of the WHO recommended four symptoms screening (W4SS) tool, inconsistency in screening, and/or poor documentation practices. Additionally, only 56% of the 1,115 PLHIV who screened positive for TB symptoms had specimens sent for diagnostic testing, mainly due to logistical challenges with specimen referral, we hope to address this through introduction of Truenat platform through Global Fund support. Of the specimens tested, 97% were tested by GeneXpert, which exceeded the WHO target goal of at least 90%.

In COP23, PEPFAR South Sudan shall focus on the following regarding TB among PLHIV:

Strategies to intensify TB symptoms screening among all PLHIV.

i. Scaling up TB symptom screening in multiple high volume facility entry points, including nutrition units and in maternal child health, focused training and mentorship on quality TB symptom screening using the WHO 4 Symptom Screen (W4SS), proper documentation in medical records, and integrated sputum collection for those who screen positive.

ii. Scale up community TB screening among all PLHIV, including screening children who are household contacts of PLHIV with TB disease using the community network for index testing and using the OVC and Key Population programs. Start community sputum samples collection for those who screen positive and transportation to facilities implementing molecular WHO Recommended Rapid Diagnostics (mWRDs). Through collaboration with Global Fund (GF) and other partners, PEPFAR will advocate for barcoding or e-system for sample registration and tracking to ensure linkage of collected samples and their patients to

services without loss Also PEPFAR will engage UNDP to provide cold chain system to ensure collected samples from the community are transported and kept under appropriate cold condition. iii. Introduction of C-Reactive Protein (CRP) finger prick point-of-care blood testing for adults and adolescents—an indicator of active TB disease in ART-naïve patients—to improve TB symptom screening as per the new national TB diagnostic algorithm. Engage UNDP to include CRP kits and readers during GF reprogramming.

iv. Strengthening TB/HIV data capture, recording, and reporting through supervision, mentorship, training by IP facility focal persons and field officers.

v. Refresher training on W4SS to improve screening quality and documentation. Also, training and mentorship on using the new national TB diagnostic algorithms.

Strategies for diagnostic evaluation of PLHIV who are presumptive for TB.

i. Improve TB case findings among all PLHIV who are presumptive for TB by using GeneXpert platform with MTB/RIF Ultra kit as an initial diagnostic test. The new national algorithm for tuberculosis diagnosis among PLHIV using Lateral Flow Lipoarabinomannan (LF LAM) should be implemented in all PEPFAR supported sites for all PLHIV with TB signs and symptoms, all PLHIV with AHD or seriously ill regardless of TB signs and symptoms and CD4 count of less than 200cells/µL, all PLHIV children less than 5 years who are TB presumptive. TB LAM TEST should be done in parallel with routine mWRDs for PLHIV that are TB presumptive and those with AHD to improve TB case finding, including seriously ill individuals who are hospitalized as per the national TB LAM algorithm. All PLHIV with AHD and those screening positive for TB symptoms should have quality samples collected for testing as per the national algorithm.

ii. Integrate TB specimen referral with HIV viral load testing and EID for all PEPFAR supported sites. TB samples should be shipped under appropriate pre-test conditions together with HIV samples from spokes to GeneXpert sites and MTB rifampicin resistant specimens from GeneXpert sites to NPHL for culture and DST. The frequency of specimen shipments should be increased to at least three times a week. Specimen referral integration should happen in all GXP sites under PEPFAR. Facilities at a radius of 10-20 kilometers should be integrated to the nearest hub (GXP site). For effectiveness the integration of sample referral shall be monitored using key indicators such as turnaround time from date of samples collection to date of results return among other indicators.

iii. Scale-up of the use of urine-based point-of-care lateral flow LAM testing for all PLHIV including CLHIV <5 years as well as patients with advanced HIV disease as they are at higher risk of TB. GXP testing will be carried out in parallel with LF-LAM following the newly developed national TB-LAM algorithm. Partners are required to implement quality assurance activities to ensure all testers are trained and their competency assessed semi-annually as TB LAM is scaled up. Other activities include quarterly and targeted supervisory visits and enrolling testers on the EQA scheme.

iv. Continue working with UNDP to forecast reagents and other TB commodities (GXP ultra cartridges, TB LAM kits and consumables) to ensure adequate quantities for uninterrupted testing.

v. Improve TB/HIV data capture, recording, and reporting through supervision, mentorship, and training by IP facility focal persons along with reporting tools' updates. PEPFAR implementing partners are also

required to monthly monitoring the TB LAM diagnostic cascade from patients eligible through to tested, tested positive and treated-as well as the quality status of the testers and testing sites.

Ending HIV-associated TB among PLHIV is possible through the combination of ART coverage, early TB identification and treatment, and TB preventive treatment (TPT). Over the past four years (FY19-21) of TPT implementation in the country, a total of 12,263 eligible PLHIV have been initiated on TPT and 8,536 completed, translating into an overall initiation rate of 29.6% (12,263/41,462) and completion rate of 69.6% (8,536/12,263) among those initiated. The poor performance is attributable, in part, to inadequate and inconsistent TPT supplies in the country.

In COP23, the 2nd 95 strategies shall focus on two main areas namely:

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

Strategies for optimization of TB/HIV care and treatment

- Improving cross-referral of clients for both TB and HIV services across PEPFAR facilities. Clinicians at the ART and TB units work together to initiate TB-HIV co-infected clients on TB treatment and ART. Some quantities of TB-related drugs in addition to the TPT medicines should be kept at the ART Unit or drug store. This should be implemented in the top 20 high volume PEPFAR sites providing both HIV and TB services -- "One-Stop Shop" service delivery model for both TB and HIV services. The ART clinicians from the top 20 high volume facilities should also be trained on M&E related to TB treatment.
- Improving client treatment literacy around TB symptoms, TPT, potential side effects of TPT and TB treatment, TB diagnosis, and TB treatment options during facility health education sessions and use of the community outreach cadre for treatment (adherence support, medication supply support). Facilities should generate line-lists of eligible PLHIV who will be tracked by community volunteers for TPT initiation.
- Continue to collaborate with UNDP and through the commodities TWG to timely and improve quantification, procurement planning, tracking and utilization monitoring of GXP MTB/RIF ultra-kits, urine TB LAM test kits and sputum sample collection containers.
- Continuous Quality Improvement (CQI) and SIMS for quality assurance and TB/HIV cascade performance improvement. PEPFAR clinical partners will be required to conduct monthly TB cascade monitoring at TB clinics and performance review to identify issues to drive facility specific CQI activities with facilitation by the MOH HIV/TB field supervisors.

Strategies for optimization of TB prevention among PLHIV

- Continue working with UNDP and MoH to improve forecasting and quantification of TPT supplies to meet both adults and pediatric projected TB_Prev targets.

- Close supply chain gaps to ensure PLHIV of all age groups including CLHIV <15 have access to effective TPT.

- Scale-up of quality TPT services to all 86 PEPFAR ART facilities and achieve universal TPT coverage for all eligible PLHIV including children with at least 90% completion rates. PEPFAR clinical partners should monitor and review TPT initiations monthly. Align TPT dispensing with ART MMD to ensure effective client management that supports adherence.

- Strengthen provider capacity to initiate, monitor and support clients on TPT at the community level using the community volunteers (COVs). This will require training of the COVs on TB symptoms screening and specimen collection supervision, client referral for TPT initiation along with M&E support. This should include the utilization of PLHIV networks to create demand for TPT services and community and client awareness to reduce stigma and discrimination around TB-HIV and increase knowledge about benefits of TPT among providers and patients.

- TB prevention Quality assurance and Quality improvement should be implemented across all TB/HIV services at health facilities. The Clinic-Lab Interface Continuous Quality Improvement (CLICQ) approach should be adopted to guide healthcare workers and laboratory staff through review of their clinic-laboratory data and identify gaps within their TB patient cascade. Participants should be trained on continuous quality improvement (CQI) practices and data review. Site-specific improvement projects should be developed that target prioritized gaps for closure and monitored for progress.

Diagnose and treat people with advanced HIV disease (AHD)

Despite increasing ART coverage globally, mortality from HIV/AIDS continues to pose a challenge as 50% of newly diagnosed individuals present with Advanced HIV Disease (AHD). In 2022, death among PLHIV in South Sudan was 8,000. In 2021, TB accounted for 3200 deaths among PLHIV. It is for this reason that PEPFAR in the last couple of years is shifting focus on expanding access to CD4 testing for PLHIV since this is an objective and quantitative measure of the degree of immunosuppression and the likelihood of opportunistic infection and death from HIV compared to the use of WHO clinical staging. CD4 testing is supported by PEPFAR to identify individuals with Advanced HIV Disease (AHD); however, all CLHIV <5 not stable on ART are considered to have AHD regardless of CD4 testing. CD4 is not to be used for determining eligibility for ART or monitoring response to ART. HIV Viral load (VL) testing remains the primary method used to monitor the effectiveness of treatment. A CD4 may be obtained anytime within the first weeks of initiating or re-initiating therapy. Priority PLHIV that should receive CD4 testing in PEPFAR-supported sites and as per the Comprehensive HIV prevention, Care and Treatment guidelines of Jan 2022 include:

  - All TX-NEW.
  - All PLHIV re-engaging in treatment after an interruption of ≥1 year.
  - All PLHIV who are virally unsuppressed for ≥1 years.
  - All PLHIV presenting sick to the clinic.

Between November and December 2022, ICAP in South Sudan with Visitect CD4 RDT donated by Omega Diagnostics, tested 81 PLHIV for AHD and 36 of these had a positive diagnosis. 18 of the 36 were also found to have tuberculosis disease. None of the 36 PLHIV with AHD were tested using CrAg test to rule out cryptococcal infection.

Cryptococcal disease accounts for 15% of all HIV/AIDS related deaths. Screening, diagnosis, and treatment are integral parts of AHD management. Unfortunately, there is no data to quantify the contribution of cryptococcal disease to HIV deaths in South Sudan due to the historic lack of diagnostic testing availability. Through the current global fund grant writing (2024-2026) application, CrAg testing commodities and CD4 RDTs have been included for procurement. Therefore, in COP23, PEPFAR implementing partners should implement a package to screen and diagnose AHD and interventions that reduce morbidity and mortality in individuals with advanced HIV disease, which includes the following:

CD4 testing in all 86 PEPFAR supported sites using WHO-prequalified Omega Diagnostics VISITECT CD4 Advanced Disease test by lab staff who have been trained, with quarterly supervision and mentorship for quality assurance. All Testers will be enrolled in the EQA scheme. High volume sites will require a cold chain system for sample storage. Screening for cryptococcal disease with cryptococcal antigen (CrAg) testing with appropriate treatment as per national guidelines. Lab staff would need to be trained in the performance of quality CrAg testing.

Robust implementation of a quality assurance package for Visitect CD4, LF-LAM, and CrAg RDT across PEPFAR-supported sites to ensure screening and diagnostic quality testing using RTCQI+

Pillar 4: Transformative Partnerships

In a country like South Sudan where the host country government provides less than 2% of domestic financing to the health sector, partnerships of all kinds is essential in the fight against HIV and AIDS. Historically, bilateral, and multilateral donors have been at the forefront of providing development and humanitarian assistance. PEPFAR and the Global Fund represent the two primary donors for HIV in close partnership with the Ministry of Health and other stakeholders such as WHO, UNAIDS, civil society and faith-based organizations.

As PEPFAR we recognize that there are opportunities when looking across the health development and humanitarian landscape in South Sudan to work with new donor and implementing partners that have complementary programmatic priorities. For example, we can leverage the service delivery infrastructure of the primary care Health Pooled Fund and World Bank programs to strengthen referrals to HIV/AIDS related programming. There are also significant resources to leverage from cross-cutting USG programs in Economic Growth, Education, Humanitarian Affairs, and Democracy & Governance.

In addition to the Global Fund, we currently work very closely with other multilaterals such as WHO and UNAIDS on the HIV response. We leverage UNAIDS South Sudan's expertise on legal frameworks and the enabling environment, stigma and discrimination, human rights and CSO, including FBO, capacity building. WHO provides significant technical assistance support to the government on the regulatory and policy front as well as provides technical guidance and coordination support. Our work with UNFPA is indirect as they manage the quantification and procurement of male and female condoms as part of the country's family planning program which are integrated for use in the HIV program. PEPFAR IPs also refer women and girls to the UNFPA sponsored GBV one-stop center at the Juba Teaching Hospital. In COP23, the new multilateral partners that we will reach out to are a) UNICEF to explore integration of MCH/ANC and PMTCT, violence against children and protection and nutrition; and b) UNESCO for comprehensive sexuality education and prevention.

On the non-governmental front, PEPFAR will work with civil society and faith-based partners to build their capacity to take on more responsibility of program implementation in a phased approach. We will seek to transform key population (KP) service delivery through local KP-led and KP-competent organizations. We will provide sub-grants to local FBOs and CSO for service delivery and SBC outreach. Additionally, a key focus will be on engaging young people more meaningfully through all interventions beyond DREAMS and the OVC programs. Private sector providers and pharmacies will be engaged to support PrEP scale-up.

In COP23, PEPFAR will continue to seek and identify additional, diverse partners that provide humanitarian assistance and that are in the private sector, philanthropies, and American institutions to fill gaps, complement our program and scale up best practices where our resources are limited.

Pillar 5: Follow the Science

Status of Evidence for HIV response

South Sudan HIV epidemic estimates from the UNAIDS Spectrum model are based on program results, ANC sentinel surveys and FSWs biobehavioral surveys. Inputs into the spectrum models have limitations of data quality and include outdated BBS survey results (Juba 2016, Nimule 2017, Yambio and Wau 2019), low quality of ANC survey results from some facilities, as well as limited national ANC survey representation. County level estimates have not matched program implementation findings. For example, low HIV testing yield in Western Equatoria counties have been observed in what the model identifies as a high disease burden region, and ART coverage greater than 100% in Juba County. Generating sub-national PLHIV estimates has remained a challenge without population-based HIV surveys. Growth of the treatment program has been slow due to several factors including low access to HIV services, limited awareness, and demand for HIV testing, stigma, and interruptions in treatment.

To determine the HIV response gap by geography and population, PEPFAR in the COP23 period will support BBS survey in FSWs and continue the support for ANC surveys. Also, the PEPFAR program will monitor the effect of streamlining engagement with Faith Based Organizations on stigma, case finding and interruptions in treatment as well as how HIV service expansion in the Lakes region and expansion of community-based HIV services improve the National HIV cascade performance.

Behavioral Science and Implementation Science

The PEPFAR program in South Sudan intends to incorporate Social and Behavior Change (SBC) activities along the HIV continuum of care as well as increase engagement of CSOs and FBOs. The program will develop tools and plan to monitor the impact of these interventions. Data collection for behavioral science and implementation science work will be minimized and conducted using existing program staff. Some of the activities include:

- Integrating intermediate outcomes such as knowledge, attitudes and self-efficacy, norms, and other relevant factors as well as exposure to SBC efforts so that we can do course-corrections and improve interventions.
- Monitoring the outcomes of FBO engagement on case identification and treatment continuity.
- Measuring the outcomes of community-based HIV testing services on HIV case finding for men, adolescents, and young women.
- Integrating intermediate outcomes along the HIV continuum of care such as knowledge, attitudes and self-efficacy norms and other relevant factors that may be determined during program implementation as well as exposure to SBC efforts for purpose of course-correction and intervention improvement.
- Monitor HIV proficiency test results for community and facility-based testers to ensure that quality HIV testing is provided and provide targeted training / mentorship to staff from underperforming testing sites to achieve acceptable proficiency test results.
- Systematically capturing and tracking root causes of interruptions in treatment, especially in Lake's state by sub-national unit, facility, and age, and identifying and document interventions

that mitigate interruptions, return clients who interrupted treatment and identify successful interventions that can be rolled out to other counties.

- Currently South Sudan is undertaking laboratory verification of the three test HIV algorithm which will be piloted in COP23 period and eventually rolled out. This will require updating of the HTS tools and training of providers.
- TB diagnosis in children is currently through sputum and chest x-ray for the general population. For children living with HIV besides sputum and chest x-ray is also TB urine LAM-RDT. To improve on TB case finding in children living with HIV, PEPFAR will support in COP23 verification of stool samples for TB diagnosis using gene-Xpert.

Surveillance and Surveys

- Support three biobehavioral surveys in 3 towns that will be determined by the BBS survey steering committee based on population of town, time since previous BBS survey, population movement activity in the town, existing information on HIV burden in the county where the town is located, and HIV program information indicating increased HIV cases in the town. The main purpose of the BBS survey will be to determine HIV burden in FSWs, determine the 95,95,95 cascade of care, estimate PLHIV numbers, and changes in key behavioral determinants (barriers and motivators) and exposure to SBC interventions. HIV positive survey participant samples may also be tested for recent HIV infections.
- Expand the site participating in routine ANC sentinel survey from the current 79 sites and improve county representation. Dedicate efforts to improve the quality of routine ANC data in selected sentinel sites through monthly data review with the site staff, quarterly data analysis and use, and site mentorship through the County / State health management information system (HMIS) mentors.

Given ART coverage in South Sudan is still low at about 40%, resource constraints, and the absence of an Electronic Medical Record system, PEPFAR will not allocate resources towards the establishment of HIV case surveillance and recent infection surveillance.

Strategic Enablers

Community Leadership

Community Lead Monitoring. In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent (not implementing any PEPFAR supported/financed activity), local civil society/organization(s) and host country governments. Community-led monitoring in COP23 will build on prior activities implemented in COP22 and be designed to help PEPFAR program and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM in COP23 will ensure indicators are defined by communities and health service users. Through the CLM process, PEPFAR SS will endeavor to produce additive and not a duplicate collection of routine data already available to

PEPFAR through MER or SIMS. New in COP22, the existing PEPFAR-supported community-led monitoring activity, which monitors the quality of care for various HIV services target populations has included a dedicated data collection tool for key populations, but of course, there are many other focuses of the CLM activity.

In COP21, the CLM activity was able to identify several qualities of services issues in many of the facilities monitored and most of those facilities showed improvements in most of their areas of quality improvement including (facility toilet improvement, filing cabinets improvements, change of attitude of health workers towards the beneficiaries) by the time of reassessing them. The CLM process will be utilized to advance equity and to support improvement in programs, especially for populations which have not yet fully experienced the benefits of HIV epidemic control. Through the CLM process, relevant stakeholders such as CSO's, FBOs, UNAIDS, MOH and SSAC will provide input on the data collection tools, which are used to measure and track the quality of services from the community perspectives. This process and approach will ensure accountability of services providers and those supporting them to the beneficiaries of services including among others child, adolescent, key populations, and pregnant women. The CLM process will monitor and improve provision of HIV services in a family-centered care approach.

During COP22 CLM activities included specific focus on FSW but did not include VMMC service monitoring. In COP23, the CLM activity will be requested to intentionally monitor outcomes for voluntary male medical circumcision (VMMC).

Community Leadership and FBO Engagement

Historically faith and community leaders played a key role in providing humanitarian assistance during South Sudan's 21-year struggle for independence. Amid destruction and failed politics in the post-independence period, Faith leaders emerged as key gatekeepers with credible influence on communities, as well as individuals, as most people are members of different faith-based denominations. This social capital enabled them to effectively broker peace between communities torn apart by war and ethnic strife.

The faith community also provides health services in many parts of the country, especially in rural areas, both in facility and community settings. They have become crucial as government investment in the health sector has dwindled.

COP23 plans:

PEPFAR recognizes the potential of engaging the community and faith leaders in the fight against HIV/AIDS and In line with the COP/ROP23 guidelines of engaging community-based organizations. We shall build and support a coordination mechanism that will bring together all the CSOs active in the HIV program under one umbrella. This shall ensure uniformity of messaging, synergy of efforts and effective advocacy on behalf of the vulnerable population of PLHIV.

PEPFAR South Sudan shall engage the faith based and community leaders as a cross cutting enabler to

support and advance HIV/AIDS messages in the community in a more structured, effective, and measurable way.

PEPFAR South Sudan shall use the faith and community groups to address equity gaps and reach sustainable HIV epidemic control through accelerated uptake of optimized testing, enhanced differentiated service delivery, and achieve durable viral suppression.

PEPFAR South Sudan shall gradually build the capacities of locally owned, led, and operated organizations and position them to become prime recipients of PEPFAR funds. This shall begin with building their organizational and managerial capacity through the Accelerating Support to Advance Local Partners II (ASAP II) mechanism and eventual follow-on. We shall task international implementing partners to build local partner technical capacities to deliver HIV/AIDS services in their communities.

In COP23, PEPFAR South Sudan shall adopt and adapt community intervention models that have demonstrated success in other countries, such as. the Circle of Hope faith engaged community post model, which engages community faith leaders to provide decentralized HIV care and treatment services at Community Posts (CPs). By leveraging the existing partnership and community footprint of a faith-based organization in Western Equatoria State, the STAR Group, the Community Posts will expand service delivery to increase HIV case identification and close gaps in linkage to treatment at the community-level.

PEPFAR South Sudan in collaboration with the care and treatment IP and FBO will conduct a landscape analysis to determine hotspots to integrate Community Posts that will be operated by faith leaders and trained staff to offer HIV testing, care, and treatment services. Findings from the landscape analysis will inform the number and location of the Community Posts. The outcomes during this pilot will determine the feasibility and scalability of decentralizing HIV service delivery through faith engaged community posts.

Throughout the pilot implementation phase, in-person and virtual technical assistance will be provided by international subject matter experts (SMEs) on how to replicate the community intervention with fidelity factoring in country context adaptations. During this phase, faith and community leaders will be trained to build their capacity to replicate faith-based models that have demonstrated success in closing the 95-95-95 gaps for pediatrics, adolescents, men, and women, and strengthening the 10-10-10 stigma reduction cascade.

Social Behavior Change strategies will be integrated within the faith-engaged community post service delivery model to address behavioral barriers to increasing testing, initiating, and adhering to treatment among prioritized populations.

Guided by findings from the SBC formative assessment, the PEPFAR South Sudan Program shall formulate segmented and targeted value-based messages that incorporate messages of hope to drive demand creation and community mobilization by the faith community champions.

PEPFAR South Sudan shall leverage the existing structures and community level platforms of the faith and community organization to improve HIV/AIDS services across the continuum of care and shall

package prevention strategies informed by social behavioral change communication messaging techniques to bring services to hard-to-reach populations.

As an example, in the context of the military, the program will tap into the existing and well-developed chaplaincy structures to penetrate behavioral and structural barriers that drive negative and undesirable treatment outcomes among the military. Training of chaplains on HIV counseling, HIV prevention messaging using evidenced-based SBC materials and ultimately engaging them in HIV service delivery both at facility and community shall prove instrumental leveraging on their influence and religious authority. Since COP20, the military program has been implementing the Champion Commander Campaign (CCC), an SBC model focusing on sensitizing division commanders to champion and generate demand among troops for uptake of HIV prevention services, such as VMMC. While successful thus far, in COP 23, the chaplaincy shall play a central role in this initiative and will be expanded to cover comprehensive messaging on HIV continuum of care.

Innovation

Project ECHO/ Next Generation ECHO (Short Courses).

In South Sudan, workforce development and capacity building are an on-going challenge to the prevention of diseases e.g., HIV/AIDS; effective care and treatment, and health system strengthening throughout the country. Lack of continuing medical and nursing professional education and development, on-site technical assistance (TA), mentorship, and supportive supervision at the site level have negatively impacted the capacity of healthcare providers to provide quality HIV services. With constantly new knowledge in the medical field, it is imperative that the health workforce has access to high quality continuing education.

The implementation of Project ECHO in South Sudan began in February 2018, with the aim of creating a community of practice amongst HIV service providers in South Sudan who were not reachable through traditional methods for mentorship due to contextual conditions. The platform functions to build health care workers (HCW) capacity and knowledge across areas such as HIV management and data use and quality. It also helps build HCW confidence, allows for experience sharing, and alleviates the sense of alienation experienced by many health workers in remote facilities. It has provided a platform for mentorship, site monitoring/management, and dissemination of best practices. ECHO currently serves as the only source for continuing medical education in the country.

In COP21, PEPFAR South Sudan scaled-up the Zoom-based platform to 54 sites. In COP 22, one facility, -Malual Chat was added for the military program, bringing the total number to 55 sites. This allows for greater assurance of minimum site-level competencies across the HIV/TB cascade, including COVID-19 infection prevention and control, screening and case management as well and protection of PEPFAR-supported services and gains made to date; opportunities for regular communication between site staff cadres (e.g., health providers, counselors, lab, M&E) community cadres, field officers, implementing partners, and USG to discuss regular performance review; quality improvement activities; and ensure best practices and lessons learned are shared more broadly and actions taken more expeditiously and

efficiently. The advantages of the video-conferencing technology with its relatively simple hardware requirements via satellite internet connection will continue to be used.

In COP23, PEPFAR will continue to leverage its extensive HIV ECHO internet platform to implement the proposed capacity building activities targeting health care workers (HCWs) across 54 health facilities with ECHO infrastructure and continue providing the ongoing bi-weekly HIV-ECHO with case-based sessions and strengthen the laboratory best practices and infection prevention and control (IPC) to address COVID-19. We will also strengthen the "short course" training programs via the ECHO Zoom platform for specific Human Resource for Health (HRH) cadres in-country.

To strengthen the existing tele-mentoring initiative, PEPFAR will continue to focus on the following:

- Strengthening the technical working group (TWG) including representatives from the MOH, medical professional associations, educational institutions, and legal authorities to develop policies, competency frameworks and minimum standards for continuing education as well as a system for continuing professional development licensure.
- To continue to develop a competency framework of skills required for various cadres in the South Sudan healthcare workforce to ensure health workers are 'fit for purpose' and fit for practice' for high priority health concerns.
- Continue to train frontline healthcare workers to build their capacity through the quarterly short course training programs for clinical officers, nurses, midwives, and laboratory personnel to strengthen HR development.

By providing a system for continuing education, this program will support the technical expertise of in-country cadres to implement quality clinical care. PEPFAR will work in constant collaboration with the MOH to ensure MOH leadership and oversight. The ECHO platform will also continue to support the Incident Management System (IMS) led by MOH to review facility performance.

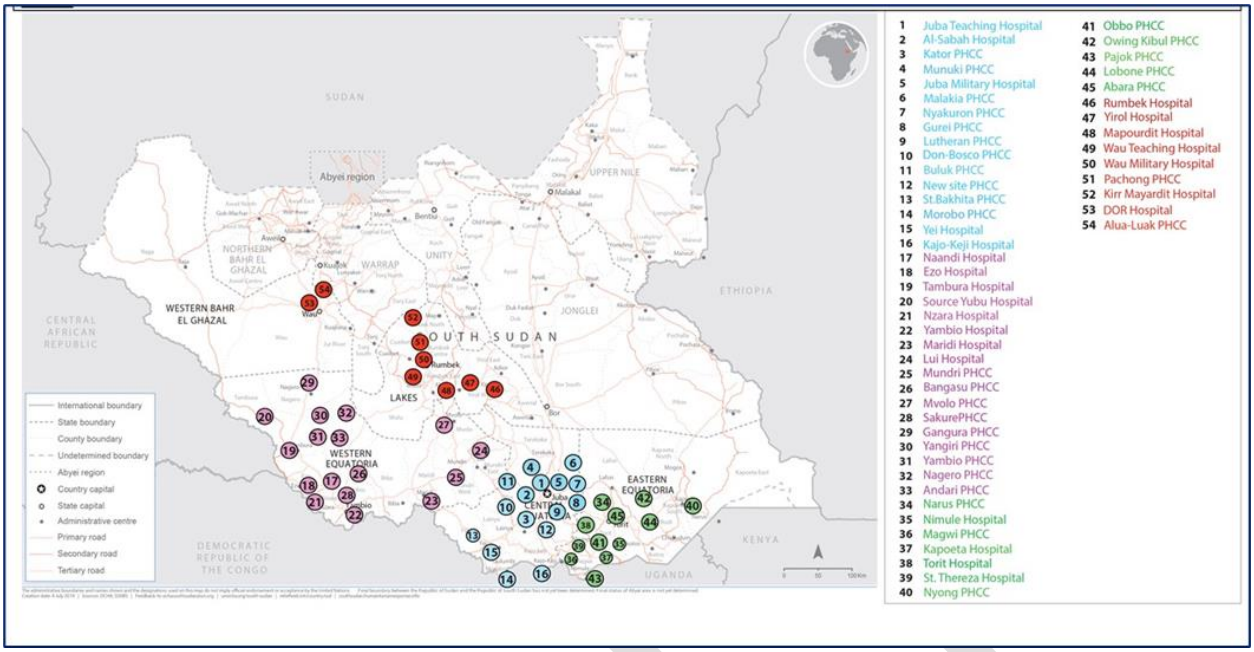


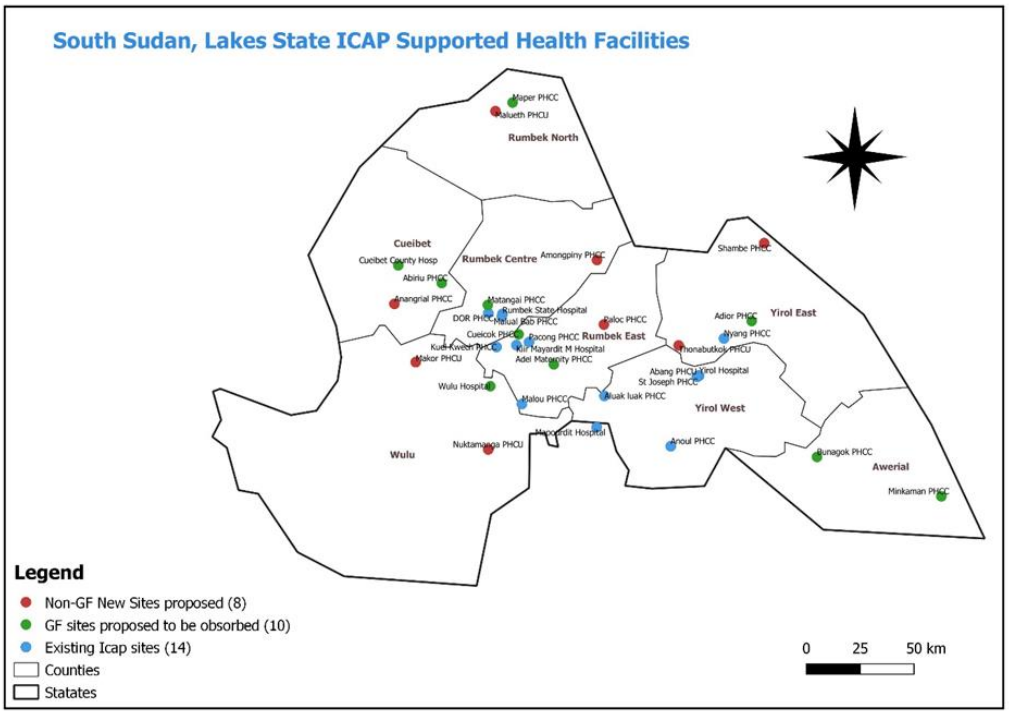
Figure 7.1: COP 22 Project ECHO Sites

Malual Chat- for DOD was added in COP 22. Total number of sites is 55 sites.

Lakes State Strategy

Lakes State has a long experience with communal conflict and insecurity and the consequent displacement of the community and implications on the socioeconomic situation have negatively impacted the health system's performance and capacity to deliver essential health services. This occurs at a time when MOH program data are showing increases in the number of people seeking HIV services and AIDS treatment.

In the Lakes State, insecurity and flooding resulted in the displacement of communities. In some areas, the population is nomadic and hard-to-reach. Long distances to facilities offering HIV services negatively impact access to HIV services. Low literacy levels have led to increased stigma/ discrimination and non-disclosure. The combination of illiteracy, a largely nomadic population, and the need to further address fear, stigma and discrimination continue as overarching challenges in this region.



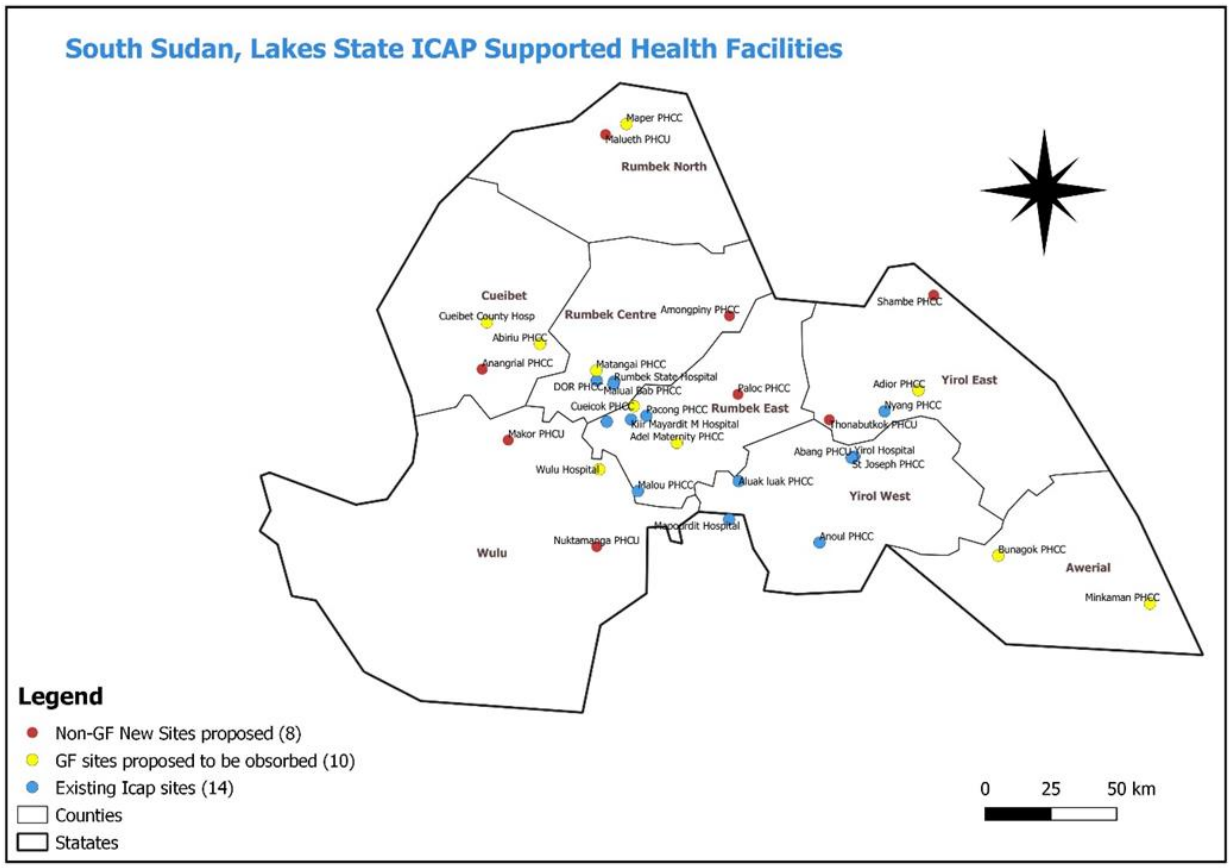


Figure 7.2 and 7.3 above: Map of PEPFAR supported facilities (blue), Global fund supported facilities (Green) and health facilities without support for HIV services.

While these facilities are centered around higher population areas, the map clearly shows the very large land area without ready access to service. In addition, while community outreach services have been developed with the goal of supporting treatment retention and virologic suppression, among other aspects of the HIV cascade, there is a need to further respond to the unique needs of the nomadic communities through innovative mobile and identified meeting points of service, i.e., community posts.

In COP 22, CDC/ICAP supports a total of 14 ART sites, GF supports 10 facilities. At the end of Q4 of FY22, about 30% (9500) of ICAP's TX_CURR (35,000) were accessing HIV care and treatment services in facilities in the Lakes region. Since October 2019, ICAP has been working closely with the Consortium of Medical Care (CMC), a Civil Society Organization that has a network of about 200 community volunteers to provide a range of differentiated services, including targeted HIV testing (index testing), community ART refill, viral load sample collection, and patient tracing.

To improve case finding, continuity in treatment and viral load suppression, CDC/ICAP initiated a Lakes State Strategy. Some planned activities to improve performance towards 95-95-95 across the continuum of care include the following:

- Increase HIV awareness through engagement of community and faith leaders, youth champions during public events like wrestling matches.
- Strengthen Decentralized Drug Distribution (DDD) / Community ARV refill groups.
- Strengthen continuous patient education/ counselling (Reinforce U=U messaging)
- Expansion of adolescent OTZ programs
- Establish weekend clinics in peri-urban settings.
- Human Resource Investments including trainings.
- Engage Cattle Camp leaders to advocate for the provision of HIV services (HTS and ART / VL sample collection) in cattle camps.
- Work with Community leaders / COVs to map cattle camps and assign COVs.
- Re-distribute COVs based on need / Train COVs to provide ART refill based on client consent.
- Expand the number of ART supported site in Lakes Region from the 14 sites to 32 sites.
- Strengthen State / County Leadership and Coordination (strengthen technical support)
- MOH HIV IMS to Priorities reviews and support for Lakes State facilities (Monthly/ Quarterly Reviews?)
- Expand community-led monitoring through CSOs to make the government, partners, and providers accountable.
- Scale up of innovative client-centered strategies such as facility adjacent waiting areas for expectant mothers, mobile services and migratory service points aligned to cattle routes to further facilitate access to care.
- Scale up index testing and access to HIV self-test.
- Produce and disseminate client literacy materials in appropriate languages.
- In partnership with the SSAC and the State MoH, coordinate and support PLHIVs to form peer-led support groups to scale up health promotion activities.
- Collaborate with youth opinion leaders (such as music artists; successful and credible young persons (influencers) from the Lakes region who agree to serve as youth champions for health.

- Engage the MOH community approach I.e., the Boma Health Initiative to leverage their presence and improve available HRH for HIV services at the community level.

For COP 23, as part of Lakes State Strategy for HIV/AIDS programming, PEPFAR proposes to:

1. **Transition ten (10) GF supported sites to PEPFAR/CDC that include seven sites as DSD model and three sites as TA model with community ART refill sites.**
2. **Integrate additional 8 sites. 5 sites as DSD and rest as ART refill sites.**

The current GF supported facilities in Lakes State that are providing HIV services that are considered for PEPFAR to transition into during COP 23 include Cueibet County Hosp; Abiriu PHCC; Minkaman PHCC; Bunagok PHCC; Wulu PHCC; Matangai PHCC; Maper PHCC; Ton Aduel PHCC; Cueicok PHCC and Adior PHCC.

The eight additional facilities proposed for scale up in Lakes State as part of the Lakes State Strategy include Amongpiny PHCC; Paloc PHCC; Nuktamanga PHCC; Makor PHCU; Malueth PHCC; Shambe PHCC; Thonabutkok PHCU and Anangrial PHCC

The DSD sites will provide the full range of HIV services, across the continuum of care, at the facility on daily basis. Six facilities, three from each category will have a technical assistance (TA) model/ strategy. This model will provide HIV services on designated days. Below is a summary of the TA model.

1. The package of care (services) will include PrEP, ART refill; Community testing including index and Community VL sample collection.
2. The human resources will consist of a site focal person; COVs; community mobilization team and Community leaders/Champions.
3. Infrastructural requirements: Space for minimum HIV RTKS and ARVS stocks.
4. The operational considerations will include:
    a. Monthly scheduled ARV refill, Viral sample collection and HIV testing by the team from a nearby health facility.
    b. Communication and Mobilization of clients and contacts by COVs and focal points
    c. Documentation and reporting will be done in the nearby facility.

Leading with Data

Current HIS landscape.

A well-functioning Health Information System (HIS) is important for monitoring health status of the population and implementation of the National Health Strategic plan as well as the HIV National strategic plan. South Sudan has developed a HIS policy whose mission is to enable production of timely, reliable, accurate and accessible health information for evidence-based decision making. PEPFAR will support building of a national data system that meets the needs of MOH and all stakeholders including PEPFAR program needs. A DHIS2 server assessment report conducted in January 2023 recommended increasing servers to two, upgrading the operating system for improved security, strengthening the DHIS2 backup, establishing regular maintenance and governance structures. Major HMIS gaps include only about 50% completeness of health data reporting into DHIS2, weak data use, limited motivated skilled workers, parallel reporting systems given multiple health partners operating in South Sudan and poor data quality. In COP23, PEPFAR will support MOH data systems as well as data use.

Strengthen Secure and Integrated Data Systems.

Since 2018 South Sudan has established DHIS2 as the National health data reporting system. Data is entered into the DHIS2 either at the facility level for some hospitals and some Primary Health care centers or at the County Office level for facilities without computers / Tables and internet connectivity. PEPFAR will continue to support the existing DHIS2 for overall health data reporting through providing:

- Technical support for DHIS2 system maintenance, updating reporting tools, creating program monitoring dashboards by working through Health Information Systems Program (HISP) Tanzania. The support through HISP Tanzania will be defined in a memorandum of understanding that will be signed by HISP Tanzania South Sudan MOH and the implementing partner.
- Support MOH in establishing, maintaining, and monitoring standards of data security, data retention and data exchange with stakeholders.
- Support HIV paper-based reporting through production and distribution of HIV reporting tools registers and monthly reporting forms to all health facilities in South Sudan providing HIV services integrate other reporting systems such as Logistics Management Information System (LMIS), Viral Load Sample Management (VLSM) the Early Warning Alert and Response System (EWARS) within the DHIS2 and improve dashboard outputs for use by MOH and stakeholders.
- Support facility and County DHIS2 system and connectivity to enable timely reporting of data to the national level.
- Strengthen systems for tracking and reporting on continuity of ART clients on treatment, managing referrals and detecting and tracking treatment Interruptions as interim measure in the absence of an Electronic Medical record system.

Improving Health Data Use.

- Provide technical support at National, State and County levels. The technical support at State and County level will involve assigning HMIS mentors (10 states / 3 administrative areas and 26 PEPFAR focus counties) to support and strengthen skills of State and County M&E officers and provide mentorship to facility teams for correct data collection and reporting. The mentors will also support sub-national teams in data analysis and its use for program improvement.
- Promote data use through supporting National and State level HIV/TB quarterly program review meetings where data is used to assess overall program performance for generation of action.
- Support generation of National quarterly / Annual health bulletin that include HIV program performance.
- Improve DHIS2 HIV program related dashboards for use by County and State teams as well as the HIV Incident Management System and HIV program technical working groups.

Target Tables

Table 1 below shows the pre-populated targets on key indicators for COP22 and the projected targets for COP23 by prioritization for epidemic control.

Table 8.1: COP23 Targets

Target Table 1 ART Targets by Prioritization for Epidemic Control							
Prioritization Area	**Total PLHIV (FY23)**	**New Infections (FY23)**	**Expected Current on ART (FY23)**	**Current on ART Target (FY24) *TX_CURR***	**Newly Initiated Target (FY24) *TX_NEW***	**ART Coverage (FY24)**	**ART Coverage (FY25)**
Attained	**0**	**0**	**0**	**0**	**0**	**0**	[redacted]
Scale-Up Saturation	**0**	**0**	**0**	**0**	**0**	**0**	
Scale-Up Aggressive	**64,978**	**4,604**	**51,917**	**53,049**	**11,972**	**68%**	
Sustained	**42,100**	**1,932**	**10,589**	**11,461**	**2,086**	**33%**	
Central Support	**0**	**0**	**0**	**0**	**0**		
Commodities (if not included in previous categories)	**0**	**0**	**0**	**0**	**0**	**0**	
No Prioritization	**73,882**	**4,412**	**3,856**	**4,056**	**1,054**	**7%**	
Total	**180,960**	**10,948**	**66,362**	**68,566**	**15,112**	**39%**	

Table 8.2: Projected VMMC targets for COP23 and COP24 in Scale-PSNU

Target Table 2 VMMC Coverage and Targets by Age Bracket in Scale-up PSNU							
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (date)**	**VMMC_CIRC (in FY24)**	**Expected Coverage (in FY24)**	**VMMC_CIRC (in FY25)**	**Expected Coverage (in FY25)**
	[Specify age bands for focus]	2,059,190	0.5%	11,932	1.0%	13,125	1.2%

	Total/ Average	2,059,190	0.5	11,932	1.0%	13,125	1.2%

Table 8.3: COP23 target projection on key indicators for KP, PP and AGYW

Target Table 3 Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Target Populations	**Population Size Estimate* (SNUs)**	**Disease Burden***	**FY24 Target**	**FY25 Target**
KP_PREV	**50,000**	11.8%	12,312	**12,312**
PP_PREV,	**-**	**-**	9,068	9,068
AGYW_PREV	**81,4087**	**1.91%**	2,822	2,822
TOTAL			24,202	24,202

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

Table 8.4: COP23 target projection on key indicators for OVC program

Target Table 4 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC OVC_SERV Comprehensive**	**Target # of OVC OVC_SERV Preventative**	**Target # of active OVC OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files. OVC_HIVSTAT**
[Specify SNUs for focus in FY24]	**6,350**	**3,637**	**0**	**1,274**	**4,911**
FY24 TOTAL	**6,350**	**3,637**	**0**	**1,274**	**4.911**
FY25 TOTAL					

Core Standards

1. **Offer safe and ethical index testing to all eligible people and expand access to self-testing**. Ensure that all HIV testing services are aligned with WHO's 5 Cs. Index testing services should include assessment of and appropriate follow-up for intimate partner violence. Offer HIV testing to every child under age 19 years with a biological parent or biological sibling living with HIV.
    - All HIV testing, including Index Testing must meet the following standards i.e., consent, counselling, confidentiality, correct test results, and connection to HIV prevention, care, and treatment services.
    - Index testing shall be client-centered and focused on the needs and safety of the index client and his/her sexual partner (s) and children.
    - All persons recently testing positive or with recent unsuppressed viral load shall be provided with all available HIV prevention, care, and treatment services regardless of their decision to participate in partner notification services.
    - Eligible people are accessing safe and ethical index testing both in the community and facility.
    - All partners of index clients are screened for intimate partner violence.
    - HIV Self testing services started in April 2022 and currently available in all five states where PEPFAR is present.
    - All IPs trainer providers on safe and ethical index testing.

2. **Fully implement "test-and-start" policies.** Across all age, sex, and risk groups, over 95% of people newly identified with HIV infection should experience direct and immediate linkage from testing to uninterrupted treatment.
    - "Test and start" has been fully implemented since 2016.
    - All HIV positive clients, through the treatment navigators, are linked to ART on the same day or within 7 days of HIV positive diagnosis.

3. **Directly and immediately offer HIV-prevention services to people at higher risk that test negative for HIV.** People at risk of acquiring HIV must be directly and immediately linked with prevention services aimed at keeping them HIV-free, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).
    - We assess for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices.
    - Eligible young men are offered VMMC services though confined to military setting.
    - Young girls and women are linked to DREAMS program, where empowerment activities are supported to mitigate risk of HIV infections e.g., income generation.
    - PrEP services available in all the five states where PEPFAR operates.
    - PEP services are available in most facilities across the five states and offered in post GBV package.

4. **Provide orphans and vulnerable children (OVC) and their families with case management and access to socioeconomic interventions in support of HIV prevention and treatment outcomes**.

Provide evidence-based sexual violence and HIV prevention interventions to young adolescents (aged 10-14).

- The OVC program continues to prioritize enrollment of C/ALHIV <18 on ART, as well as HEI, children of HIV+ FSW, and children of HIV+ caregivers at greatest risk of IIT, newly initiated on ART, and virally unsuppressed. OVC also supports index testing for siblings of HIV+ children and children of HIC+ caregivers, and linkage to clinical services for newly identified positives. HIV and sexual violence prevention curricula for 9-14s is provided as part of the package of services for OVC Comprehensive beneficiaries.
- The OVC activity will continue to support OVCs, and their families are supported with case management and access to socioeconomic interventions to support them for an HIV prevention and great clinical treatment outcome including viral suppression.
- OVC families participate in savings and internal lending communities (SILC) programming which are meant to capacitate and strengthen the economic status of the OVC families.
- 10–14-year-olds receive the Sinovuyo curriculum and their parents and parenting skills to create effective family relationships.
- Adolescent girls aged 15 - 17 who experience sexual violence identified in the DREAMS safe clubs, are referred to the OVC program for psychosocial support.
- The activity will continue to provide scholastic materials to eligible children.

5. **Ensure HIV services at PEPFAR-supported sites are free to the public.** Access to HIV services, medications, and related services (e.g., ART, cotrimoxazole, ANC, TB, cervical cancer, PrEP and routine clinical services for HIV testing and treatment and prevention) must not have any formal or informal user fees in the public sector.
    - All HIV services provided at PEPFAR supported sites will continue to be provided free of charge. This also includes services provided at the community level. There are no user fees.

6. **Eliminate harmful laws, policies, and practices that fuel stigma and discrimination, and make consistent progress toward equity**. Programs must consistently advance equity, repudiate stigma and discrimination, and promote human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, children, and other vulnerable groups. This progress must be evidence-based, documented, and included in program evaluation reports.
    - PEPFAR will continue to strengthen the following activities:
        i. Reduce self-stigma among clients and in the general community.
        ii. Undertake sensitization and engagement/advocacy sessions with general population (men and women) uniformed forces, local officials, cultural and religious leaders, health care workers, parliamentarians and others on stigma, discrimination and violence related and impacts mitigation.
        iii. Sensitization training workshops on stigma and community, empowerment interventions, including legal and human rights literacy for PLHIV networks, key population groups and CSOs to improve their capacity to challenge and be resilient to acts of stigma, discrimination, and violence.
        iv. Continued collaboration with South Sudan AIDS Commission to advocate for enabling policies.
        v. PEPFAR directly supports continuous advocacy and awareness creation to support enabling environment for KP services.

vi. Engagement with CSOs including NASOSS to champion advocacy for rights for all population discriminated against.

7. **Optimize and standardize ART regimens.** Offer DTG-based regimens to all people living with HIV (including adolescents, women of childbearing potential, and children) four weeks of age and older.
    - All adults are on TLD optimized regimens.
    - All active children on ART four weeks of age and older have been on transitioned to DTG10mg.
    - Remaining pediatric IIT to go optimized regimens as they get restarted on care.

8. **Offer differentiated service delivery models**. All people with HIV must have access to differentiated service delivery models to simplify HIV care, including 6-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve ART coverage and continuity for different demographic and risk groups and to integrate with national health systems and services.
    - All adults on ART are provided 6 months multi-month dispensing since 2021.
    - The program will continue to provide ARVs through the community ART groups.
    - All eligible clients are on MDD 6 and MDD3.
    - Clinic days are extended to weekends.
    - Decentralized drug refills supported including through community ART groups.
    - Fast tracking of PMTCT clients for ARV dispensing and refills.

9. **Integrate tuberculosis (TB) care**. Routinely screen all people living with HIV for TB disease. Standardized symptom screen alone is not sufficient for TB screening among people living with HIV and should be complemented with more-sensitive and setting-specific, WHO-recommended screening tools. Ensure all people living with HIV who screen positive for TB receive molecular WHO-recommended diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - All PEPFAR sites routinely screened PLHILV for TB using W4SS and molecular testing is offered for those who screened positive.
    - TPT is provided for all TB negative PLHIV (via screening and molecular testing).
    - All PLHIV are screened for TB using the 4-question screening tool, Positive clients are sent for diagnostic workout using the GXpert machine and negative clients are provided with TB prophylactic therapy.
    - Client testing positive for TB are linked to TB treatment.

10. **Diagnose and treat people with advanced HIV disease (AHD).** People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The WHO-recommended and PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.
    - PEPFAR supported facilities conduct clinical base-line assessment, TB screening every clinic visit. In COP23, CD4 testing will be supported in all 86 PEPFAR supported sites using WHO-prequalified Omega Diagnostics VISITECT CD4 Advanced Disease test.

- Screening for cryptococcal disease with cryptococcal antigen (CrAg) testing will be introduced as per national guidelines. Lab staff would be trained in the performance of quality CrAg testing.

11. **Optimize diagnostic networks for VL/EID, TB, and other coinfections**. In Coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multiplex testing to address multiple diseases. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time.
    - South Sudan has two Abbott m2000 instruments for VL testing and 66 GeneXpert instruments: 11 are sixteen modules and 55 are four modules. 39 of these instruments are placed at 37 laboratories for multi-disease diagnosis.
    - 24 facilities are using GeneXpert for EID testing and 18 facilities are using GeneXpert for VL testing.
    - More than 50% of the GeneXpert (19) are used for testing EID, VL, TB and COVID19.
    - South Sudan conducted a DNO during COP20. The next DNO will be implemented this year with support from Global fund.

12. **Integrate effective quality assurance (QA) and continuous quality improvement (CQI) practices into site and program management.** Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementing partner agreements and work plans should align with national policy in support of QA/CQI.
    - Robust implementation of a quality assurance package for Visitect CD4, LF-LAM, and CrAg RDT across PEPFAR-supported sites to ensure screening and diagnostic quality testing using RTCQI+ will be prioritized for COP23.

13. **Offer treatment and viral-load literacy**. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. Undetectable=Untransmittable (U=U) messaging and other messaging that reduces stigma and encourages HIV testing, prevention, and treatment should reach the general population and health care providers.
    - IPs to support some facility-based SBC messaging to address barriers across continuum of care, including U=U.

14. **Enhance local capacity for a sustainable HIV response**. There should be progress toward program leadership by local organizations, including governments, public health institutions, and NGOs. Programs should advance direct funding of local partners and increase funding of organizations led by members of affected communities, including KP-led and women-led organizations.
    - CSO's currently receiving sub-grants from IPs are receiving capacity development support through NUPAS assessments, capacity building plans, and technical support.
    - CSO awarded a 3-year grant to conduct community led monitoring.
    - IMS established and in the process of being institutionalized.

15. **Increase partner government leadership**. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects

of the HIV response—including political commitment, building program capacities and capabilities, and financial planning and expenditure.

- The HIV program in the country is largely donor dependent (PEPFAR and Global Fund resources) with very little commitment from the government.
- PEPFAR is supporting MOH take leadership in HIV program implementation through establishment of HIV Incident management system.

16. **Monitor morbidity and mortality outcome**. Aligned with national policies and systems, collect, and use data on infectious and non-infectious causes of morbidity and mortality among people living with HIV, to improve national HIV programs and public health response.
    - HIV related mortality is reported in the National DHIS2 reporting system. Some of the community deaths of PLHIV are reported by community volunteers and the data then entered client's registers/files and then entered into the DHIS2.
    - PLHIV on ART who develop TB are tracked through the DHIS2 reporting system. However, other morbidities are not tracked separately from the general reporting of morbidity using OPD and in-patient records.

17. **Adopt and institutionalize best practices for public health case surveillance**. Transfer/deduplication processes and a secure person-based record should be in place for all people served across all sites. Unique identifiers should also be in place, or a plan and firm, agreed-upon timeline for scale-up to completion should be established.
    - Case Based HIV reporting, or surveillance has not been established. South Sudan has not established any Patient-based Electronic Medical Reporting system or any unique identifier system. PEPFAR will engage with other stakeholders to develop plans for case-based reporting / surveillance and provide details when resources are identified, and timeline of implementation established.
    - Newly identified HIV positive client's records are maintained in HTS registers and clients are linked to ART. Clients on ART are currently provided ART numbers and paper-based records including registers, patient files are kept securely at the sites providing services.

USG Operations and Staffing Plan to Achieve Stated Goals

Three USG agencies, CDC, USAID, and DoD, implement the PEPFAR program in South Sudan. The eventual program goal for COP23 is to continue to move towards the achievement of UNAIDS target of 95-95-95. Within the context of South Sudan, this is likely to take much longer than 2030. However, by strengthening HIV care and treatment services to improve case identification, yield, linkage, and retention, scale up prevention programs and aligning the HIV responses to the PEPFAR 5x3 Strategy progress can be made.

Structuring PEPFAR South Sudan management and operations to achieve the HIV goals remains critical. The PEPFAR South Sudan interagency analyzed and aligned the staffing footprint to ensure quality programmatic oversight to the implementing partners, provision of technical assistance to the Ministry of Health, building of transformational partnerships with CSOs, FBO and multilateral stakeholders.

At the beginning of COP 22, PEPFAR South Sudan had fifteen staff (filled positions) that included two US Direct Hires (CDC Country Director and USAID Health Office Director) who provided overall leadership for technical, programmatic and management oversight of the program. Alongside the two direct hires, the DoD FSN Program Manager also provided general leadership to the technical, programmatic and management oversight of DoD's PEPFAR portfolio. The other eleven locally employed filled positions include eight from CDC, and three from USAID. These locally employed staff provide support for budget and finance, administrative and logistics, care and treatment, prevention, HSS (laboratory and strategic information), KP, OVC, DREAMS and commodities management. With the limited USDH and LES staffing footprint, staff were spread thin and other key roles such that of the PEPFAR Coordinator had to be performed by the agency leads of DOD, USAID, and CDC on a rotational basis. Based on identified technical and operational gaps, the PEPFAR team identified some key positions that needed to be filled. A couple of months into COP22, the position of the PEPFAR coordinator was filled along with the positions of the CDC Deputy Country Director and the USAID Health Team Deputy/HIV Team Lead. Additionally, the USAID Supply Chain Manager and the CDC Administrative Assistant were also filled. These changes in the staffing footprint and the interagency staffing structure shall enable efficient and effective implementation of the PEPFAR Program to achieve program priorities across PEPFAR's strategic pillars.

Explain Long-term Vacant Positions

There are three FSN vacant but approved positions in COP22. One of these positions is under CDC, the other one under USAID and the third under DOD. Space constraints have been the primary factor delaying hiring actions.

CDC One Vacant, but Approved Position:

Prevention Specialist: This position was approved in COP21. The prevention position is finalized and ready for advertisement, however, space issue remains a challenge at the Embassy which has been causing significant delays. With the COP23 emphasis on prevention strategies, this position should be maintained even if unfilled.

USAID one Vacant but Approved Position:

Local Capacity Development Specialist: This position was approved in COP21. The position has been approved by USAID but will not be advertised until there is resolution on the office space issues. Given the increased focus on CSO and FBO capacity building support, this position should be maintained even if unfilled.

DOD one Vacant but Approved Position

HIV program specialist: This position was approved in COP22 owing to the significant increase in DoD program budget and activities from COP20 to 22.

Justification for Proposed New Position

CDC Proposed New Position: Driver:

CDC manages a large PEPFAR Care & Treatment portfolio with over 60 sites which are expected to increase in COP23. CDC heavily relies on HQ TDYer support which adds to the logistics burden at post. Movement logistics for USG staff remain a challenge. In addition, CDC is the only agency at post without a dedicated vehicle despite its footprint of PEPFAR. The US Government is only allowed to travel in Fully Armored Vehicles (FAVs). Discussions on options for having a designated vehicle have occurred with the agreed upon decision being that CDC utilize its authority under the 14 FAM to procure a separate vehicle along with a driver.

The dedicated vehicle and driver would enable CDC to maintain its commitments under the cooperative agreements with its partners, the Ministry of Health (MOH) and other stakeholders. The proposed driver will be dedicated to support CDC and Inter-Agency PEPFAR program movements for an effective engagement with stakeholders. This position does not require a working space and thus would not hinder the space management plans.

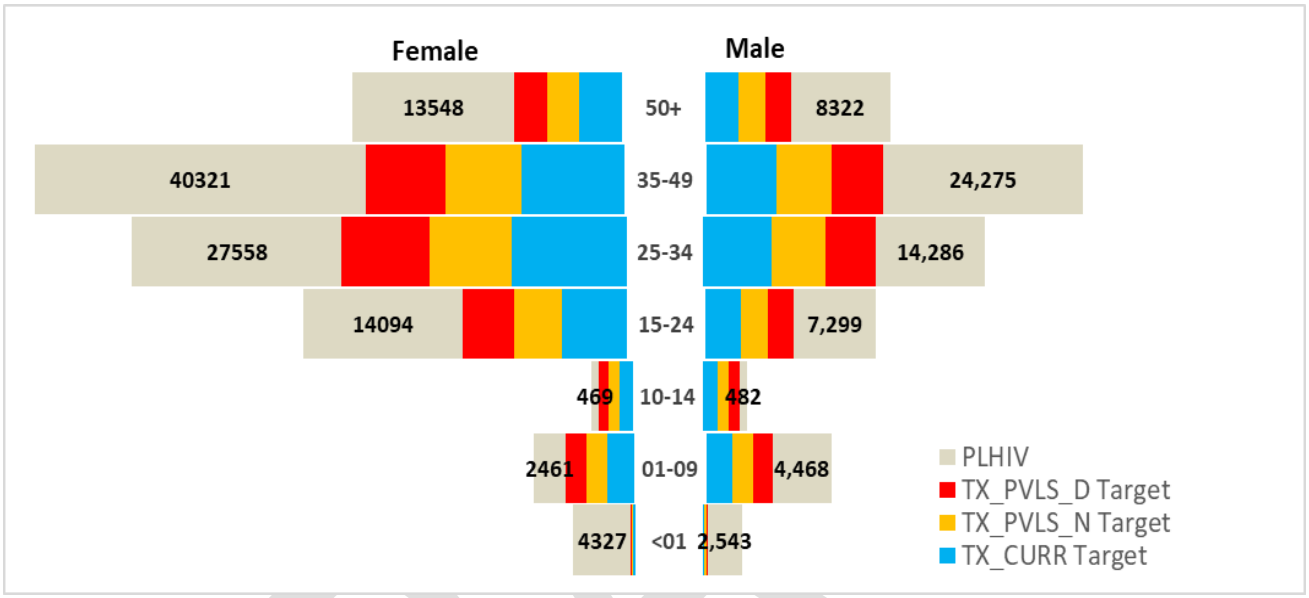
Cost of Doing Business

The overall COP23 Cost of Doing Business (CODB) for PEPFAR South Sudan has increased by 24% compared to COP22. This increase is attributed to annual increase in staff salaries and benefits, increase in ICASS cost, and Overseas Building Operation taxes for the New Embassy Compound construction. U.S. Embassy staff who travel outside of Juba generally must use United Nations Humanitarian Air Service flights and be accompanied by Embassy security personnel. Costs for this security support has also increased.

APPENDIX A -- PRIORITIZATION REQUIRED

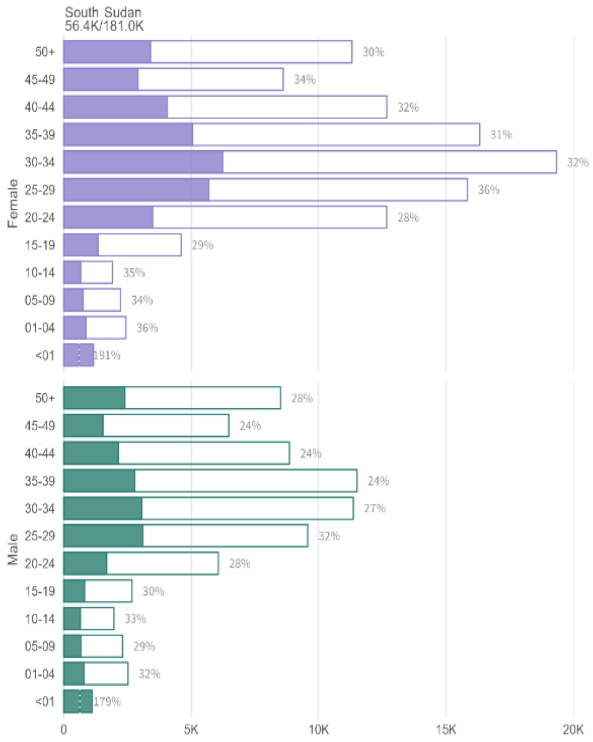
Epidemic Cascade Age/Sex Pyramid

Figure A.1 below shows the PLHIV population, PLHIV on ART and Viral Load suppression targets for COP23.



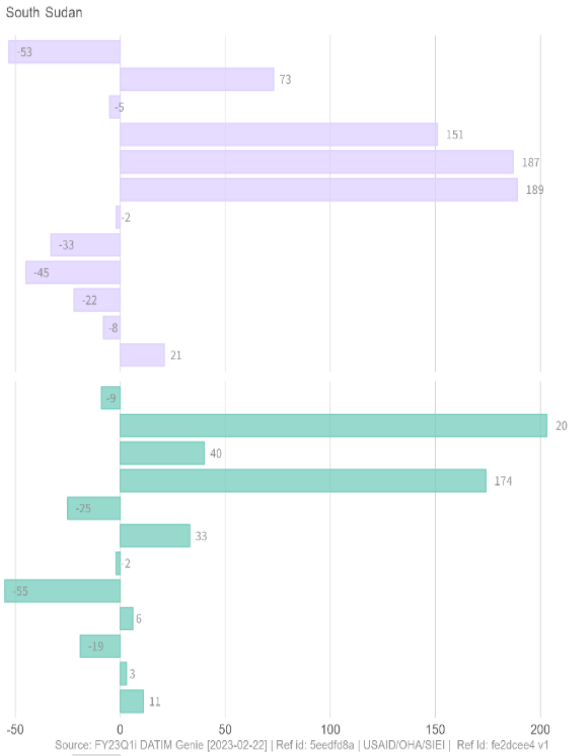
FY22 South Sudan Treatment Coverage Gaps

TX_CURR_SUBNAT coverage of PLHIV by age and sex



FY23Q1 PEPFAR/South Sudan Quarterly Net Change in Patients on ART

TX_NET_NEW by age and sex



APPENDIX B – Budget Profile and Resource Projections REQUIRED

Please note that COP 23/FY 25 budget profile and resource projections are only available for bilateral, not regional, programs. Regional OUs will include only FY 24 information.

Tables B.1.1-B.1.4 can be generated from the SDS Appendix B chapter of the COP 23 FAST Dossier in PAW.

Table B.1.1 COP 22, COP 23/FY 24, COP 23/FY 25 Budget by Intervention

Operating Unit	Country	Intervention	Budget		
			2023	2024	2025
Total			**$40,120,000**	**$41,520,000**	**$41,924,702**
South Sudan	**Total**		**$40,120,000**	**$41,520,000**	**$41,924,702**
	South Sudan	ASP>Health Management Information Systems (HMIS)>Non Service Delivery>Non-Targeted Populations		$849,200	$849,200
		ASP>HMIS, surveillance, & research>Non Service Delivery>Non-Targeted Populations	$352,472		
		ASP>Human resources for health>Non Service Delivery>Non-Targeted Populations	$242,024		
		ASP>Laboratory systems strengthening>Non Service Delivery>Non-Targeted Populations	$368,210	$458,054	$458,054
		ASP>Laws, regulations & policy environment>Non Service Delivery>Non-Targeted Populations	$490,000	$70,000	$137,640
		ASP>Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations		$100,000	$100,000
		ASP>Policy, planning, coordination & management of disease control programs>Non Service Delivery>Non-Targeted Populations	$369,341		
		ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Key Populations		$1,400,000	$1,352,794
		ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Pregnant & Breastfeeding Women		$200,000	$200,000
		C&T>HIV Clinical Services>Non Service Delivery>Children		$160,000	$154,605
		C&T>HIV Clinical Services>Non Service Delivery>Key Populations		$77,521	$77,521
		C&T>HIV Clinical Services>Non Service Delivery>Military	$180,425	$180,425	$174,341
		C&T>HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	$5,020,340	$3,083,584	$3,044,547
		C&T>HIV Clinical Services>Non Service Delivery>Pregnant & Breastfeeding Women	$150,000	$125,000	$125,000
		C&T>HIV Clinical Services>Service Delivery>Military	$822,312	$822,312	$794,585
		C&T>HIV Clinical Services>Service Delivery>Non-Targeted Populations	$7,313,546	$10,185,337	$10,080,970
		C&T>HIV Clinical Services>Service Delivery>Pregnant & Breastfeeding Women	$1,917,713	$870,000	$870,000
		C&T>HIV Laboratory Services>Non Service Delivery>Non-Targeted Populations	$980,976	$432,414	$432,414
		C&T>HIV Laboratory Services>Service Delivery>Non-Targeted Populations	$1,276,189	$1,026,608	$1,026,608
		C&T>Not Disaggregated>Non Service Delivery>Military	$35,000	$40,000	$38,651
		C&T>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$30,000		

Operating Unit	Country	Intervention	Budget		
			2023	2024	2025
		HTS>Facility-based testing>Non Service Delivery>Non-Targeted Populations	$784,310	$130,000	$130,000
		HTS>Facility-based testing>Non Service Delivery>Pregnant & Breastfeeding Women	$100,000	$70,000	$70,000
		HTS>Facility-based testing>Service Delivery>Non-Targeted Populations	$1,050,469	$713,000	$690,500
		HTS>Facility-based testing>Service Delivery>Pregnant & Breastfeeding Women	$501,869	$372,000	$632,941
		HTS>Not Disaggregated>Service Delivery>Military	$252,426	$252,426	$243,915
		PM>IM Closeout costs>Non Service Delivery>AGYW		$25,000	$24,157
		PM>IM Closeout costs>Non Service Delivery>Non-Targeted Populations	$0		$220,000
		PM>IM Closeout costs>Non Service Delivery>OVC		$13,000	$12,562
		PM>IM Program Management>Non Service Delivery>Non-Targeted Populations	$8,505,657	$8,341,644	$8,343,624
		PM>IM Program Management>Non Service Delivery>OVC	$213,213	$240,213	$290,808
		PM>USG Program Management>Non Service Delivery>Non-Targeted Populations	$2,639,494	$4,327,763	$4,263,933
		PREV>Comm. mobilization, behavior & norms change>Non Service Delivery>AGYW	$135,000		
		PREV>Comm. mobilization, behavior & norms change>Service Delivery>AGYW	$250,000		
		PREV>Comm. mobilization, behavior & norms change>Service Delivery>Key Populations	$323,000		
		PREV>Comm. mobilization, behavior & norms change>Service Delivery>Non-Targeted Populations	$465,400		
		PREV>Condom & Lubricant Programming>Service Delivery>Key Populations	$160,000	$100,000	$100,000
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>AGYW		$89,600	$86,579
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Key Populations		$337,305	$337,305
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Non-Targeted Populations		$300,000	$300,000
		PREV>Non-Biomedical HIV Prevention>Service Delivery>AGYW		$292,600	$385,000
		PREV>Not Disaggregated>Non Service Delivery>Key Populations	$65,000	$65,000	$65,000
		PREV>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$27,000	$25,000	$48,000
		PREV>Not Disaggregated>Service Delivery>Non-Targeted Populations		$510,000	$510,000
		PREV>PrEP>Service Delivery>Non-Targeted Populations		$280,000	$260,000
		PREV>Primary prevention of HIV and sexual violence>Non Service Delivery>AGYW	$667,735		
		PREV>Primary prevention of HIV and sexual violence>Non Service Delivery>OVC	$60,000		

Operating Unit	Country	Intervention	Budget		
			2023	2024	2025
		PREV>Violence Prevention and Response>Non Service Delivery>OVC		$75,000	$74,494
		PREV>Violence Prevention and Response>Service Delivery>OVC		$100,000	$109,448
		PREV>VMMC>Non Service Delivery>Military	$59,000	$59,000	$57,011
		PREV>VMMC>Service Delivery>Military	$1,370,000	$1,370,000	$1,323,805
		SE>Case Management>Non Service Delivery>OVC		$52,351	$91,919
		SE>Case Management>Service Delivery>OVC		$450,000	$506,291
		SE>Economic strengthening>Service Delivery>AGYW		$795,400	$949,045
		SE>Economic strengthening>Service Delivery>OVC		$206,873	$250,651
		SE>Not Disaggregated>Non Service Delivery>AGYW	$265,000		
		SE>Not Disaggregated>Non Service Delivery>OVC	$80,000		
		SE>Not Disaggregated>Service Delivery>AGYW	$810,000		
		SE>Not Disaggregated>Service Delivery>OVC	$609,673		
		SE>Psychosocial support>Non Service Delivery>AGYW		$80,933	$113,474
		SE>Psychosocial support>Service Delivery>AGYW		$188,667	$242,981

Table B.1.2 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Program Area

Table B.1.2: COP22, COP23/FY 24, COP 23/FY25 Budget by Program Area

Operating Unit	Country	Program	Budget		
			2023	2024	2025
Total			**$40,120,000**	**$41,520,000**	**$41,924,702**
South Sudan	**Total**		**$40,120,000**	**$41,520,000**	**$41,924,702**
	South Sudan	C&T	$17,726,501	$17,003,201	$16,819,242
		HTS	$3,786,280	$3,101,396	$3,022,885
		PREV	$3,662,135	$3,616,305	$3,675,442
		SE	$1,764,673	$1,774,224	$2,154,361
		ASP	$1,822,047	$3,077,254	$3,097,688
		PM	$11,358,364	$12,947,620	$13,155,084

Table B.1.3 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Beneficiary

COP23 & Year 2 FAST Dossier SDS Appendix B - B.1.3 Beneficiary - Table B.1.3: COP22, COP23/FY 2...

Operating Unit	Country	Targeted Beneficiary	Budget		
			2023	2024	2025
Total			**$40,120,000**	**$41,520,000**	**$41,924,702**
South Sudan	**Total**		**$40,120,000**	**$41,520,000**	**$41,924,702**
	South Sudan	AGYW	$2,127,735	$1,472,200	$1,801,236
		Children		$160,000	$154,605
		Key Populations	$843,982	$2,507,747	$2,574,137
		Military	$2,719,163	$2,724,163	$2,632,308
		Non-Targeted Populations	$30,716,652	$31,881,453	$31,528,302
		OVC	$1,042,886	$1,137,437	$1,336,173
		Pregnant & Breastfeeding Women	$2,669,582	$1,637,000	$1,897,941

Table B.1.4 COP 22, COP 23/FY 24, COP 23/FY 25 Budget by Initiative

Operating Unit	Country	Initiative Name	Budget		
			2023	2024	2025
Total			**$40,120,000**	**$41,520,000**	**$41,924,702**
South Sudan	**Total**		**$40,120,000**	**$41,520,000**	**$41,924,702**
	South Sudan	Community-Led Monitoring	$350,000	$350,000	$350,000
		Core Program	$35,680,327	$35,430,776	$35,376,164
		DREAMS	$1,760,000	$1,760,000	$2,168,350
		KP Survey		$1,400,000	$1,352,794
		OVC (Non-DREAMS)	$829,673	$884,224	$1,032,803
		Surveillance and Public Health Response		$200,000	$200,000
		VMMC	$1,500,000	$1,495,000	$1,444,591

B.2 Resource Projections

PEPFAR South Sudan used incremental and intervention-based budgeting methods. The technical team identified PEPFAR's Fiscal Year 2024 priorities and goals to address PEPFAR South Sudan program challenges. Relevant interventions and initiatives were identified to achieve Fiscal Year 2024 goals and priorities. Based on the Fiscal Year 2023 budget, Fiscal Year 2024 budgets are adjusted either upward or down for each program area.

There are three data sources used to project the Fiscal Year 2024 resources. The Annual Program Results (APR) was used to determine partners performance and ability to achieve results. Based on this, resources

were projected for the partners. Fiscal Year 2022 Expenditure Reporting (ER) guided the decision to adjust resources upward or downward to ensure resources are maximized for Direct Service Delivery (DSD). Finally, COP23 interventions and budgets informed the decision on whether to continue or introduce an intervention that is relevant to PEPFAR South Sudan priorities, as stipulated in the Planning Level Letter (PLL).

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APPENDIX C – Above site and Systems Investments from PASIT and SRE REQUIRED

Identified Priority Health Systems Support

The above site systems that were identified for support include Health Information System (HIS), Laboratory strengthening and dealing with FSWs operating environment laws and regulations. HIS and Laboratory are cross curing systems that benefit not only the HIV program but the overall health program. HIS was identified as a priority given many data gaps in the country in defining the HIV epidemic and gaps in monitoring of the HIV response. A strong HIS contributes to early detection of epidemics and effective monitoring of response. The laboratory is critical in ensuring correct diagnosis of HIV cases, proper monitoring of treatment response as being useful in confirmation of any outbreak. Key populations in South Sudan face repeated risk of discrimination and arrest due to the existence of punitive laws requiring engagement of leaders and lawmakers. These systems were identified for support during the pre-Johannesburg stakeholders meeting as well as during the Johannesburg COP 23 planning meeting. PEPFAR will engage with Global Fund, WHO and MOH to ensure that these systems support are coordinated without resource duplication.

Key Health System Gaps

The HIS and surveillance related system gaps include inaccurate spectrum PLHIV estimates, low health data reporting rates through DHIS2, Weak MOH sub-national capacity for HMIS for accurate data collection and reporting, outdated IBBs data for KP planning. Also, there is inability of MOH to effectively lead HIV implementing partners program reviews and coordination of activities. Supporting the HIS and surveillance priorities would result in increased availability of complete and timely health data in DHIS2 to support national health program monitoring and global reporting needs such as PEPFAR / MOH annual data alignment and generation of better Global AIDS Monitoring reports. Data availability will improve HIV cascade monitoring. Updated KP BBS results will improve KP service programing and prevention of new infections while improved routine ANC sentinel survey data will improve the spectrum PLHIV estimates for better targeting of HIV services.

The laboratory systems gaps include limited and outdated national lab documents, inefficient specimen and result referral, inadequate implementation of CQI activities and only one accredited lab in the country. The laboratory systems support will improve the capacity of MoH to regulate laboratory practice and ensure adherence to National laboratory policy, strategic plan, and guidelines for delivery of laboratory service. It will also reduce turn-around-time and result in cost-efficiency of the integrated national sample and result referral system. The Laboratory support will improve CQI and EQA activities and result in two laboratories accredited by 2025.

While gaps in the KP operating environment include occurrences of harassment, arrests and unlawful detentions including reduction of forced HIV testing. This engagement will result in regulatory offices such as the Mayor's Office and law enforcement bodies to be receptive and collaborate to support the provision of KP HIV services.

Leveraging Host Country Government and other stakeholders' resources for Health systems strengthening

South Sudan health systems support is heavily donor reliant. PEPFAR will work with other stakeholders mainly Global Fund, World Bank and GAVI to ensure that resources are not duplicated, and not parallel systems are supported. WHO as technical partner to the MOH will also be engaged in the health systems support arrangement. PEPFAR will coordinate with these stakeholders all its health systems supported d activities.

PASIT

Funding Agency	Prime Partner	Sub-Program Area	Activity Category	COP 23 Beneficiary	Status of Activity	Activity Implementation Start	Short Activity Description	Activity Budget	Measurable Expected Outcome from Activity
USAID	INTRAHEALTH INTERNATIONAL, INC.	ASP: Laws, regulations & policy environment	Information and sensitization for public and government officials	Non-Targeted Populations	Continuing	FY19/C/ROP18	Conduct workshops convening key policy stakeholders to create awareness and share information on public health importance of addressing HIV/AIDS among Key Populations. The aim is to create an enabling environment that supports KP services, while advocating for rights of KPs.	$70,000	Mayor's Office & National Security and Police Forces are receptive and collaborate to support the provision of KP HIV services.
USAID	INTRAHEALTH INTERNATIONAL, INC.	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveys	Key Populations	New	FY24/C/ROP23	The goal of the BBS is to collect a representative biobehavioral information from Female Sex Worker in three towns using respondent driven sampling.	$1,400,000	A final Biobehvaioural Survey Report detailing key characteristics of the FSWs across the three towns, including HIV prevalence, cascade, size estimate and others.
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveys	Pregnant & Breastfeeding Women	Continuing	FY19/C/ROP18	Support and strengthened expanded coverage quality routine ANC sentinel survey from 70 sites to 90 sites. Support quarterly sentinel survey site mentorship for quality data reporting, deployment of data extraction teams; support data analysis and dissemination.	$200,000	HIV prevalence trend in pregnant women tracked; MOH and partners use data to inform plans for PMTCT services in the country

HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	Non-Targeted Populations	Continuing	Prior to C/ROP15	National DHIS2 system update/maintenance through Health Information System Project (Tanzania); Integration of other systems with DHIS2; Improve National, state / county level DHIS2 system hardware / connectivity; Review and improve DHIS2 dashboards for facility, county, state and national level to improve data use.	$250,000	Increased availability of health data in DHIS2; Increase completeness and timeliness of HIV program data reporting through DHIS2 from 75% to 95%
USAID	INTRAHEALTH INTERNATIONAL, INC.	ASP: Management of disease control programs	Civil society engagement	Non-Targeted Populations	Final Year	FY23/C/ROP22	Provide capacity development support to CSOs and FBOs currently implementing sub-grants under PEPFAR INGOs. Support includes institutional assessments, capacity building strategies/plans, and technical assistance.	$58,141	1) Increased institutional capacity of CSOs and FBOs; 2) At least 1 CSO receiving TA applies for and is awarded a direct award