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Global Fund Project for South Sudan
2016 Annual Report

May 2017

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

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Project Summary	**Country: South Sudan** **Project Duration:** 1. HIV NFM (1 October 2015 to 31 December 2017) 2. TB NFM (1 June 2015 to 31 December 2017) 3. R9 HSS (1 October 2010 to 30 September 2016) **Project Current Budget:** 1. HIV NFM ($ 19,165,240), Expenditure ($ 12,327,287) 2. TB NFM ($ 6,469,831), Expenditure ($ 3,306,410) 3. R9 HSS ($ 8,566,711), Expenditure ($ 5,726,911) **Donor:** The Global Fund to Fight AIDS, Tuberculosis and Malaria **Contact Person:** Blaise Karibushi Global Fund Portfolio Coordinator Advisor Tel. (+211) 954319630 Email: blaise.karibushi@undp.org
Responsible Sub Recipients: *South Sudan AIDS Commission (SSAC), Ministry of Health (MOH), World Health Organization (WHO), IMA, IOM, National Tuberculosis Programme (NTLBP), Arkangelo Ali Association (AAA), Cordaid, IMC.*	

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

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Acronyms

AAA	Arkangelo Ali Association
AIDS	Acquired Immunodeficiency Syndrome
AFB	Acid Fast Bacillus
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCM	Country Coordination Mechanism
CD4	Cluster of Differentiation 4
CPT	Co-trimoxazole Preventive Therapy
DHIS	District Health Information System
DOTS	Directly Observed Treatment Short-course
DST	Drug Susceptibility Test
EID	Early Infant Diagnosis
EmONC	Emergency Obstetrics and Neonatal Care
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HEI	HIV Exposed Infant
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSS	Health System Strengthening
IDP	Internally Displaced People
IMAI	Integrated Management on Adults and Childhood Illnesses
LMIS	Logistics Management Information System
LoA	Letter of Agreement
MDRTB	Multi Drug Resistance Tuberculosis
M&E	Monitoring and Evaluation
MNCH	Maternal Newborn and Child Health
MoH	Ministry of Health
MSG	Mother to Mother Support Group
NFM	New Funding Model
NTP	National TB Control Programme
OI	Opportunistic Infections
OSDV	Onsite Data Verification
PCR machine	Polymerase Chain Reaction machine
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipient
RSQA	Rapid Service Quality Assessment
RSS	Republic of South Sudan
SMoH	State Ministry of Health
SR	Sub-Recipient
TB	Tuberculosis
TFM	Transitional Funding Mechanism
NFM	New Funding Mechanism
UNICEF	United Nations Children’s Fund
WHO	World Health Organization
UNDP	United Nations Development Programme

1. Executive Summary

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been supporting the Government of South Sudan since 2004, providing resources to fight three devastating diseases: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), Tuberculosis (TB), and Malaria. In 2016, the United Nations Development Programme (UNDP) continued to serve as the Principal Recipient (PR) of the last resort on behalf of the Government for three GF grants - the Round 9 Health System Strengthening (HSS) (SSD-910-G13-S), New Funding Models (NFM) for HIV (SSD-H-UNDP), and NFM for Tuberculosis (SSD-T-UNDP). UNDP played a management role of the grants, including procurement and management of supplies, financing of all activities, and ensuring grant implementation in accordance with the approved work plan and internationally acceptable procedures. This annual report (2016) presents a description of the key achievements, challenges and lessons learned between January and December 2016 for the mentioned HIV, TB and HSS grants.

The military conflict that erupted in the country during the reporting period (July 2016) greatly hindered the smooth implementation of Global Fund grant programs in the reporting period. The planned AIDS Indicator Survey (AIS), Antenatal Care (ANC) Surveillance, Integrated Bio-Behavioural Survey (IBBS) for Female Sex Workers (FSWs), Men Having Sex with Men (MSM) mapping and others were delayed. Additionally, a significant number of health facilities stopped providing services to the population. Of 40 health facilities, only 23 (57.5%) were able to provide ART/HIV care with functional community care teams. However, the PR (UNDP) and SRs of this grant (South Sudan AIDS Commission, Ministry of Health, World Health Organization, IMA, and IOM) managed to implement grant activities with the intention of reaching the relevant targets (some targets were reduced in the PF to make it more realistic to reach those given the insecurity conditions in the country).

Thus, in the reporting period of Jan-Dec 2016, the number of people living with HIV receiving antiretroviral therapy reached 19,679, making 11 percent of the estimated number of PLHIV, and 89% of the relevant target (22,000). 26.8 percent of the estimated number of HIV+ pregnant women (2321) received ART prophylaxis to prevent Mother to Child transmission of HIV Transmission, which is slightly higher than the target of 23 percent. Cohort data analysis by the World Health Organization (WHO) depicted a 68.3 percent survival rate of ART patients after 12 months of initiation of treatment; an improvement from the survival rate of 62.5 percent reported in 2012.

Additionally, 421,440 women (12.5% of all women) had (at least one) ANC visits in 2016, and 137,228 people received an HIV test, and 80,691 pregnant women knew their HIV status. In the reporting period the SRs were able to implement HIV

prevention activates: 9,690 sex workers (12.6% of the estimated number of SWs in the country) were reached with HIV prevention programs - defined package of services, making 84% of the target. Moreover, 10.6 percent of estimated number of sex workers received HIV test during the reporting period (with known test results), which makes 71 percent of the target (as per revised PF). The SRs performed well also in terms of reaching other vulnerable populations and the clients of sex workers. In the reporting period 21,189 clients of SWs were reached, making 77 percent of the target; and 91,867 representatives of other vulnerable populations, such as IDPs, were reached with HIV prevention programs (39% of target). The latter is low due to the crisis, which affected the outreach activities in many areas of the country.

In the reporting period the TB/HIV collaborative activities were successfully implemented. In the first semester of year 77 percent, and in the 2nd semester – 75 percent of TB patients were tested for HIV (with test results recorded in the TB register), which are significant achievements (96% and 94% respectively) in comparisons with the targets (80% in each semester). 64 percent of HIV+ TB patients in the 1st semester, and 76 percent of those in the 2nd semester were provided with ARV therapy, meeting the targets by 92% and 109% respectively. In the 1st semester 79 percent, and in the 2nd semester 77 percent of HIV-positive patients were screened for TB in HIV care or treatment settings, which make 87 percent and 85 percent of targets respectively.

2. Progress towards Development Results

2.1 Progress towards Country Programme Action Plan (CPAP) outcome targets

Relevant CPAP Outcome 3: Key service delivery systems are in place

UNDP continued to support the National Blood Transfusion Centres in Juba and Wau as well as the establishment of the National public health reference laboratory. The support to the National Public Health Laboratory has greatly improved diagnostic capacity and turn around and quality of care for patients. As a result, some key laboratory tests (such as GeneXpert for TB) are now being carried out in-country as opposed to the transportation of samples to neighbouring countries (Kenya and Uganda) or outsourcing of testing to private laboratories.

During the reporting period the GF project supplied medicines and diagnostics to all 87 TB and 26 ART sites and 70 percent of 72 Prevention of Mother to Child Transmission (PMTCT). This enabled over 19,000 People Living with HIV (PLHIV) and 10,613 TB patients to receive treatment. Moreover, forty one percent of the estimated 9,000 HIV+ pregnant women received ART prophylaxis to prevent Mother to Child transmission of HIV.

In 2016, UNDP trained 1822 health workers strengthening their capacity on TB, HIV, maternal health, and management of drugs, record keeping and reporting, raising service uptake. Cumulatively, the UNDP has supported capacity building over 3,279 health workers since 2013. Additionally, 46 M&E staff improved their use of Health Management Information Systems and District Health Information Software. As a result, completeness of reporting at county level has increased from 42% in 2012 to above 87% in 2016.

Targeting key population: HIV/AIDS and TB programs continued to target key affected populations including female sex workers, Men having Sex with Men, IDPs, truck drivers and people living in congregate settings like prisons.

Sustainability: All health programmes are based on national needs and priorities which are aligned to the National Health Sector Development Plan (HSDP). Hence, in the New Funding Model proposals, all the interventions and outcomes of the interventions are based on the nationally approved strategic plans and all the benefits of the achieved results have the potential to last beyond the duration of UNDP support.

National capacities: During the reporting period 1822 health workers (1254 male and 568 female) were trained on different health topics including TB and HIV in collaboration with the different directorates of the Ministry of Health in an effort to improve the capacity of the MoH and the quality of services at health facility level. UNDP also seconded one M&E analyst to the M&E Directorate in the Ministry of Health to manage the HMIS/DHIS. Consequently, the MoH managed to produce monthly reports regularly. Building the capacity of M&E Directorate resulted in the

use of the data for evidence-based decision making, for example during development of New Funding Request we used data generated from TB and HIV programs for 2016 which were used to set the baseline and calculate the targets. UNDP also supported the Ministry of Health to develop Health Information System policy and guideline which is expected to be endorsed in late 2017 or early 2018.

2.2 Progress towards GFATM key performance indicators and WP targets

2.2.1 New Funding Model (NFM) for HIV Grant (SSD-H-UNDP)

The NFM grant entitled "Investing Towards Impact for HIV and AIDS in South Sudan" is implemented by UNDP South Sudan as the main Principal Recipient (PR), with the involvement of the following Sub-Recipient (SR) organizations: the Ministry of Health (MoH), South Sudan HIV and AIDS Commission (SSAC), World Health Organization (WHO), International Organization for Migration (IOM), and Inter-Church Medical Assistant (IMA) World Health.

This grant aims to reduce new adult HIV infections and mortality among adults and children living with HIV by 50% by 2017. The objectives are: 1) to intensify HIV prevention efforts across key populations, vulnerable populations and populations of humanitarian concern; 2) To increase access to and improve quality of HIV care, treatment, treatment as prevention, and TB/HIV collaboration across key general and humanitarian populations; and 3) To create a sustainable, enabling environment for intensified HIV prevention, treatment, care and management.

The NFM grant provides an opportunity for comprehensive HIV/AIDS interventions including prevention programmes for Sex Workers and their clients, MSM, populations of humanitarian concern (IDPs and refugees), HCT and PMTCT. The NFM grant also supports the expansion of quality HIV care and treatment services, community systems strengthening, programme management, HSS, and HIS and M&E.

The HIV NFM grant started on 1 October 2015 and will end on 31 December 2017. The NFM grant continues the activities of the R4 HIV/AIDS and R5 HIV/TB grants. The country has implemented the continuation of service (COS) and TFM grants from December 2011 to September 2015. The COS and TFM grants were of limited scope and only supported the provision of comprehensive ART and PMTCT services.

The total budget of NFM HIV grant (for NFM period of 1 Oct 2015- 31 Dec 2017) is USD 42,464,597 of which USD 19,165,240 is for the reporting period (1 Jan – 31 Dec 2016).

NFM HIV project performance of key impact/outcome indicators

The military conflict that erupted in the country in July 2016 greatly hindered the smooth implementation of this grant program in the reporting period (January-December 2016). It created difficulties in providing quality health services, HIV prevention activities, and relevant M&E/supervision in many regions of the country. The planned surveys (AIS, ANC Surveillance, IBBS for FSWs, MSM mapping, etc.) were delayed. Thus, there are no data/results to report for most of the impact/outcome indicators in the reporting period.

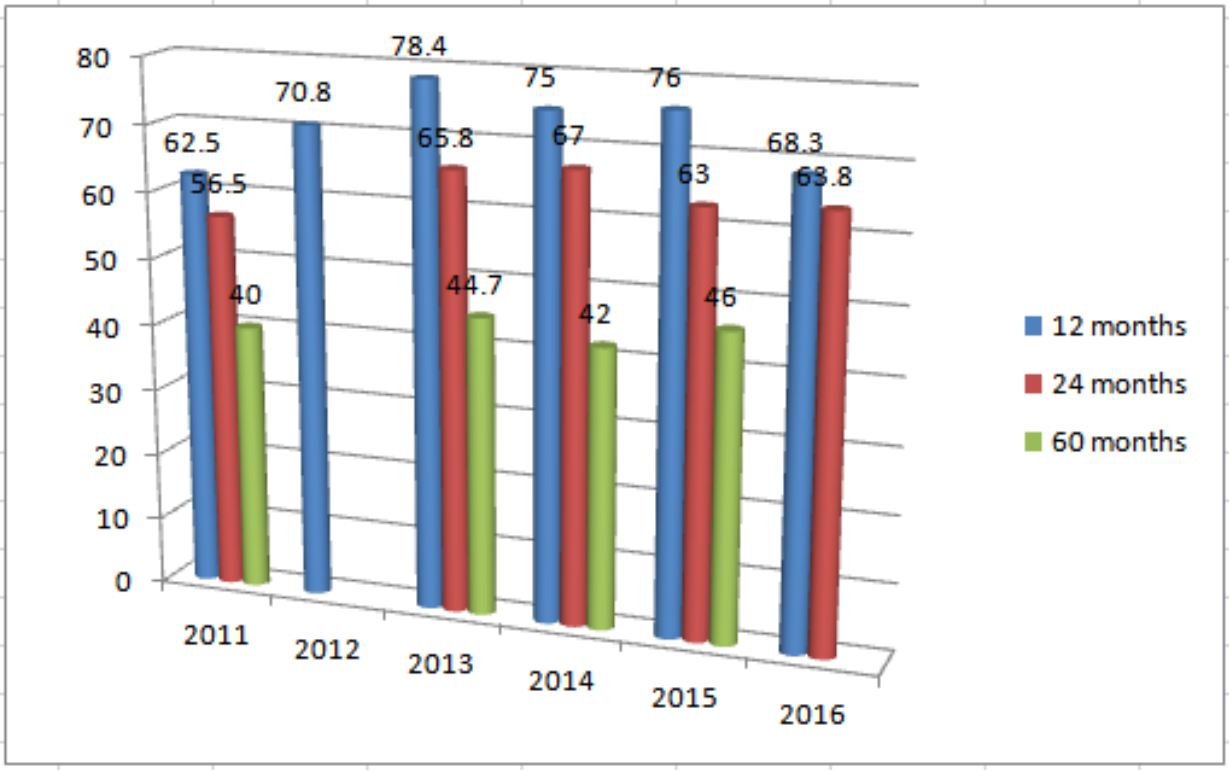
According to UNAIDS Global HIV/AIDS 2015 report, the estimated percentage of child infections from HIV-infected women delivering in the past 12 months (estimated mother-to-child transmission) was at 21% in 2015 down from 29% in 2014. The 2015 LQAS Report shows that mothers who had at least one ANC visit and were attended by skilled health personnel during the last pregnancy was at 53.9%. More data for 2016 will become available once the LQAS Report for 2016 is made available.

The total number of women who attended at least one ANC visit in 2016 is 295397. And per the estimated annual pregnancies for 2016 from the DHIS is 589441, Thus 50% of women attended antenatal care in 2016

The total number of women who attended at least one ANC visit in 2016 is 421,440. As per UN data, there are 3,361,739 women aged 15-64 in South Sudan, thus, 12.5% of women attended antenatal care in 2016, which makes 23% of target.

Retaining people living with HIV across the continuum of care is essential for optimal health outcomes. The mean retention at 12 months was 68.3 percent. Multiple factors relating to the humanitarian situation in the country, health care delivery systems and patients specific factors were noted to facilitate or hinder retention on ART. Given the broad range of challenges across different geographical areas and settings, multiple approaches are in use and other strategies recommended to address the issues. For the details on ART retention trend analysis see the graph below.

Figure 1 Graph Showing Trends in ART retention (in %), 2011-2016



Most impact and outcome indicators should be measured through national surveys every 3-5 years. Due to the South Sudan country context, the national IBBS for Sex Workers (SWs) could not be conducted earlier. An IBBS survey for SWs was planned in 2016 but only completed in Juba and Nimule. The survey in Yambio was delayed due to insecurity. The final results from the IBSS study (implemented by Intrahealth) have not yet been cleared by the Ministry of Health and will be reported upon clearance.

The country plans to conduct AIDS Indicator Survey (AIS) in 2018 and preparatory works have already started with financial support from the GF and other partners. Due to lack of data for the impact and outcome indicators from population based surveys, the program has majorly relied on the 2015 HIV Spectrum estimates which might not be a true representation of the country's real epidemiologic situation.

Table 1. Performance of NFM HIV project impact/outcome indicators, 2016

Impact/outcome indicators[1]	2016 Target	2016 Achievement	% Achievement
HIV I-4: AIDS related mortality per 100,000 population	75	98.5 (2016)	UNAIDS estimates for year 2016.

[1] The list of indicators is presented as per modified grant Performance Framework dated 10.03.2017.

Impact/outcome indicators[1]	2016 Target	2016 Achievement	% Achievement
		Data for 2016 not available yet	
HIV I-6: Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	10%	12% (2016)	UNAIDS estimates for year 2016
HIV O-1: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	80% (12 Months); 65% (24 Months); 50% (60 Months)	68.3%[2] (12 Months) 63.8% (24 Months)	85%(12 Months) 98%(24 Months)
HSS O-1: Percentage of women attending antenatal care	55%	50%	23% LQAS Report for 2016 is not available yet.

The percentage of child HIV infections from HIV-positive women has been reduced to 12% (data of year 2016) as compared to the baseline of 29%.

NFM HIV project performance of key output indicators

Following the reprogramming done in early 2017, the targets of 5 indicators in the Performance Framework (PF) were significantly reduced for the reporting period taking into consideration the challenges in implementation of activities due to insecurity situation in the country. Based on the revised PF, there are 13 output indicators with targets for the reporting period ending on 31 December, 2016. The average target achievement ratio as per the targets in the revised PF is 88% (B1), with 5 indicators exceeding the expectations (>100%), one meeting the expectations (94%-98%), 6 indicators with adequate performance (71%-89%), and only one - "KP-1e: % of other vulnerable populations reached with HIV prevention programs" with inadequate performance (39%).

Similar to the progress in the previous year of grant implementation, South Sudan has performed well in achieving targets related to ART and PMTCT programme.

Table 2. Performance of NFM HIV coverage (output) indicators, 2016

[2] Data from 3 facilities (Yei, Aweil and Wau) are missing (not included in the results).

Coverage/output indicators	2016 Target	2016 Achievement	% Achievement
KP-1c: Percentage of sex workers reached with HIV prevention programs - defined package of services	11,500 /76,691 15%[3]	9,690 /76,691 12.6%	84%
KP-3c: Percentage of sex workers that have received an HIV test during the reporting period and know their results	11,500 /76,691 15%[4]	8,171 /76,691 10.6%	71%
KP- (other) - Percentage of sex workers clients reached with standardized HIV prevention interventions	27,393 /400,000 6.8%	22,189 /400,000 5.5%	81%
KP-1e: Percentage of other vulnerable populations reached with HIV prevention programs - defined package of services	234,989 /1,662,647 14%	91,867 /1,662,647 5.5%	39%
PMTCT-1: Percentage of pregnant women who know their HIV status	80,000 /392,909 20%[5]	80,691 /392,909 20.5%	102%
PMTCT-2.1: Percentage of HIV-positive pregnant women who received ART during pregnancy	2,000/ 8,644 23%	2,321 /8,644 26.8%	116%
TCS-1: Percentage of people living with HIV currently receiving antiretroviral therapy	22,000 /177,277 12%	19,679 /177,277 11.1%	89%
GP-1.1: Number of people who were tested for HIV and received their results during the reporting period	140,000[6]	137,228	98%
Number and Percentage of health facilities providing ART/HIV care with functional community care teams	30/40 75%	23/40 57.5%	77%
M&E-1: Percentage of HMIS or other routine reporting units submitting timely reports according to national guidelines	60/70 85%	53/63 84%	98.5%
TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register	8936/11172 80%	9216/11701 79%	98.5%
TB/HIV-2: Percentage of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment	938/1340 70%	758/1084 70%	100.5%
TB/HIV-3: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	36900/41000 90%	29965/37649 80%	88%

[3] During the reprogramming [late 2016 & early 2017], the original targets were halved [50% reduction from 30% to 15%] for the period 2016 & 2017 because of difficulties in implementation of activities due to insecurity situation in-country

[4] During the reprogramming [late 2016 & early 2017], the original targets were halved [50% reduction from 30% to 15%] for the period 2016 & 2017 because of difficulties in implementation of activities due to insecurity situation in-country

[5] During the reprogramming [late 2016 & early 2017], the targets were adjusted from 25% to 20% in 2016 and 38% to 25% in 2017 because of difficulties in implementation of activities due to insecurity situation in-country

[6] During the reprogramming [late 2016 & early 2017], the original targets were halved [50% reduction from annual figure of 560,000 to 280,000 in 2016 and from annual figure of 700,000 to 350,000 in 2017] because of difficulties in implementation of activities due to insecurity situation in-country

Module 1: Prevention programs for sex workers and their clients

A total number of 9690 sex workers were reached with HIV prevention programs in 2016 (cumulative period). The prevention program included peer education, condom promotion and distribution or HIV testing and counselling. The two partners involved in the prevention programmes are IOM and IntraHealth International. IOM started implementation of activities in April 2016. And were just finalizing agreements with SSRs for implementation of planned activities when the military conflict in Juba erupted and the staff had to be evacuated. The speed of implementation continued to be affected in the subsequent months because of limited staff within the SR, SSRs and other partners.

During the reprogramming the original targets were halved from 22,935 to 11,500 after taking into consideration the difficulties in implementation of activities due to insecurity situation in the country. The achievement obtained as per the new Performance Framework is therefore 84% (the percentage of result is 12.6% against the target of 15% for the year).

In addition, the targets for this module were set based on the HIV spectrum estimates which are high compared to the real context in South Sudan. Additionally, the targets were set from the NSP, which are over ambitious and unrealistic to reach. The figures will be revised after IntraHealth completes the IBBS and size estimations for sex workers in hot spot areas of Juba, Nimule, and Yambio. The actual results from the IBSS study (implemented by Intrahealth) have not yet been cleared by the Ministry of Health and will be reported upon clearance.

In order to improve access to the prevention packages to sex workers and their clients (and thus, also improve the result of this indicator), the PR and SRs propose to: (i) engage with additional SSRs in order to reach out to more sex workers and clients; (ii) improve the state and county-level support to the SSRs (iii) engage the military to reach more sex workers' clients and (iv) use other partners, such as IntraHealth and other PEPFAR partners to closely work with SSRs in reaching more clients and KPs.

Module 4: Prevention programs for other vulnerable populations

Due to late signing of agreements with the SR and SSRs, and due to the conflict, that erupted in 2016, no results were achieved for this indicator in the first semester of 2016. However, IOM started reaching other vulnerable populations (refugees and internally displaced people) in July 2016, but the activities were interrupted for almost three months. IOM in collaboration with UNHCR carried out assessments in various refugee and IDP camps after security stabilized in the country. By Dec 31, 2016, the program reached 91,867 vulnerable population, which makes 5.5% of estimated size of this population, or 39% of target (5.5%/14%). Going forward, IOM, UNHCR, and collaborating partners are expanding HIV prevention services

among the Key Populations (refugees and IDPs) and it is anticipated that the target will be met in the next reporting period.

Module 5: Prevention of Mother to Child Transmission of HIV (PMTCT)

In 2016, 2321 HIV-positive pregnant women received ARV prophylaxis to prevent mother to child transmission of HIV. This represents 27 percent of estimated number of HIV positive women (2,321/8,644) in the country. This achievement exceeded the set target by 16 percent.

In 2016, 80,691 women were tested and knew their HIV status. This makes 20.5% of target population, or 101% of target for this indicator (20.5%/20.4%) as per the target in the revised performance framework (after reprogramming).

The expansion of PMTCT services being carried out by IMA and other partners will enhance the result of this indicator in the next reporting period.

Participants acting out a play related to PMTCT in front of the Directors on the closing day in Yambio

Module 6: Treatment, care and support

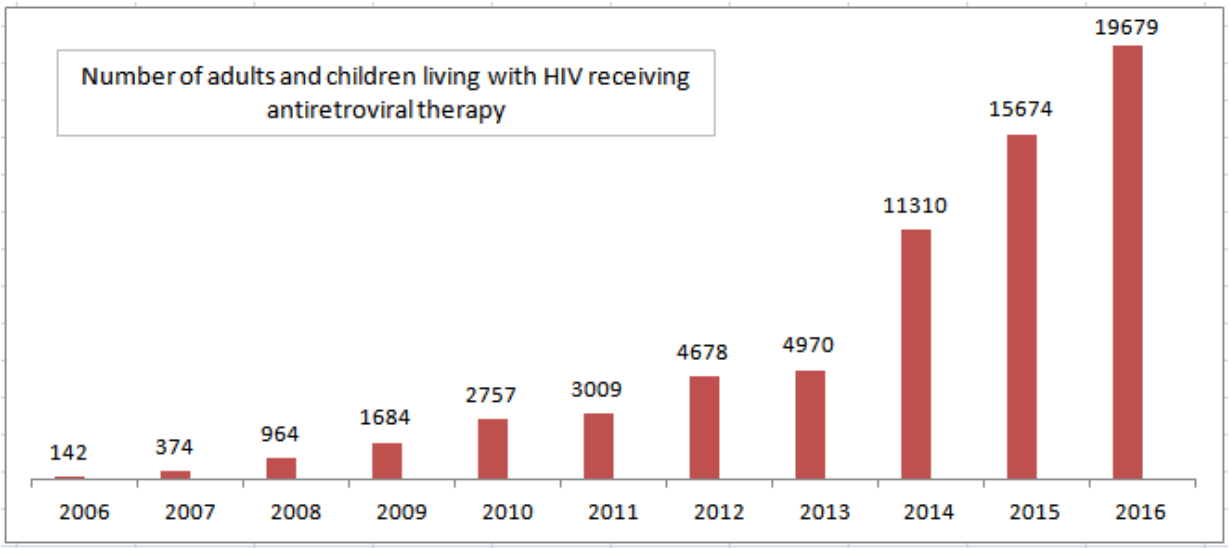
As of 31 December, 2016, a total of 19,679 adults and children living with HIV were receiving antiretroviral therapy as compared to the set target of 22,000 for the reporting period. This includes 17,975 on ART (non-PMTCT) and 1,704 on PMTCT (Option B+). The reported result represents 11 percent of estimated number of

people living with HIV, and it makes 89 percent of the set target. Due to the conflict in the country, a significant number of people living with HIV were cut off from accessing health care services, including ART.

The target for the reporting period has been achieved although the ART coverage in general is low (11%) including those on PMTCT. With implementation of the new WHO guidelines recently adapted by South Sudan, in all ART facilities and majority of PMTCT facilities have started initiating treatment at CD4 <500. TB patients and children at <5 years irrespective of CD4 and all pregnant women irrespective of CD4 count (Option B+) are being enrolled in treatment.

The number of people that newly initiated antiretroviral therapy (ART) has increased since 2014, and it is expected to increase as funds become available and new facilities are opened during the NFM. Necessary measures need to be put in place to retain the increased load while maintaining the quality of care. Two consultative meetings were held with UNHCR for the agencies that can partner with the PR to initiate HIV/AIDS services in the refugee camps for the refugees and host communities. In addition, the PR is in discussion with potential partners (such as MSF, AAA, IOM) already working in the POC sites in order to commence ART services the soonest possible time.

Figure 2 Trends in ART uptake (years 2006 -2016)



In January-June 2016 only 66,582 women and men aged 15+ were tested for HIV and knew their status (HTC sites - 25,004, pregnant women - 33,932, TB - 4,525, and FSWs - 3,121). In July-December 2016 twice higher, 137,228 men and women aged 15+ were tested for HIV and knew their test results. The target (as per the revised PF) was met by 98 percent (137,228/140,000). The reported figure includes individuals counselled and tested for HIV in HTC settings, patients tested in TB

settings, FSWs tested, and pregnant women tested in PMTCT sites. Following the reprogramming, the target for July-December 2016 was reduced from 280,000 to 140,000 taking into consideration the challenges in implementation of activities due to insecurity situation in the country.

In addition to revising the target, the strategies of expanding PITC in all health care settings, reaching out to more refugees, IDPs, FSWs and their clients for HIV testing is expected to improve the result of the indicator in the next reporting period.

Module 7: Community systems strengthening

The number and percentage of health facilities providing ART/HIV care with functional community care teams was initially low in the first half of the year due to delays in signing the agreements. However, steps were taken during the second half of the year that enabled the SR (IMA) to reach about 77 percent of the target. The facilities assessed were Maridi Hospital, Wau Teaching Hospital, Aweil State Hospital, Kuajok Hospital, Bor Hospital, Nyong PHCC and Torit Hospital, Yambio State Hospital, Yambio PHCC, Kapoeta Mission Hospital, St Daniel Comboni Hospital, Nimule Hospital, Juba Teaching Hospital, Kimu PHCC, Munuki PHCC, Gurei PHCC, Malakia PHCC, Nyokuron PHCC, Kator PHCC, Lolugo PHCC, Kajokeji Hospital, Jalimo PHCC and Nzara PHCC.

In the period of January-June 2016 community care teams were established in only two ART sites by IMA, which gave the cumulative number of functional care teams to 8. In the cumulative period (Jan-Dec 2016) the total number of care teams increased to 23, which makes 77 percent of target.

The reasons for relatively modest achievement are several: (i) a few health facilities were monitored by IMA to identify the existence of community care teams because of delayed recruitment of project staff; (ii) insecurity in most states was a setback to implementation and coordination; (iii) delayed commencement of the activity because of delayed PCA signing with IMA; and (v) delayed handover of facilities from the previous implementing partner (UNICEF). While insecurity remains a major deterring factor, the PR and the SR will continuously monitor security situations and get on board as many community care teams as possible in collaboration with state level MoH and partners.

Participants during the community training of trainers in Aweil

Module 10: HSS - Health information systems and M&E

The total number of health facilities providing ART in 2016 increased from 27 (reported in the 1st semester of 2016) to 36. Despite the military conflict that erupted in the country in July 2016, 86 percent (31/36) of ART sites reported in time, which is slightly higher than the target of 85%. Renk, Malakal & Bentiu ART sites are not providing the services due to prevailing crisis.

Module 11: TB/HIV

In Jan-June 2016 a total of 5,880 TB cases (all forms) were notified and 4,525 (77%) of them were tested for HIV. In July-Dec 2016 a total of 5,814 TB cases (all forms) were notified, and 4,375 of those (75%) were tested for HIV. The targets for this non-cumulative indicator are 80% in each reporting period, thus, the achievements are 96 percent and 94 percent respectively.

In Jan-June 2016 there were 559 HIV-positive registered TB patients and 364 (65%) of them were provided with anti-retroviral therapy. A major reason for the slightly lower achievement of the target in the first semester of the reporting period was the delay in the opening of new ART sites due to the civil unrest which decreased patients' access to ART. However, in the second semester (July-Dec 2016) the result was higher as 401 of 525 (76%) HIV positive registered TB patients were enrolled in ART. This is explained by the good linkage between the TB and HIV service units, especially in those health facilities where they co-existed together.

In Jan-June 2016, 79 percent (15,210/19,349) and in July-Dec 77 percent (14,628/19,063) of HIV-positive patients were screened for TB in HIV care and treatment settings. The significant achievement of this indicator's targets in the reporting period is due to continuous mentoring of clinicians in ART sites, which is now a standard follow up procedure in most ART sites.

2.2.2 New Funding Model (NFM) for TB Grant (SSD-T-UNDP)

Tuberculosis (TB) is a major public health problem in South Sudan. Round 7 TB grant began in January 2009 and ended in December 2013. TFM for TB started in January 2014 and ended in July 2015. The goal of the TFM was to continue contributing to the improvement of the quality of life of the people of South Sudan by reducing dramatically the burden of the TB by 2015 in line with the MDGs and Stop TB partnership targets.

The Global Fund has been the most important partner in TB control in South Sudan by providing three TB-related grants (Rounds 2, 5 and 7). The country has successfully applied for the GF New Funding Model (NFM) which will cover a period of two and half years (June 2015 to December 2017). With a total budget of 16 million USD, the NFM is expected to cover the existing gaps in financing the TB control efforts in the country while at the same time expanding services to additional 30 facilities in the course of implementation.

The TB NFM grant will contribute towards the reduction of TB prevalence from 257/100,000 (WHO estimate 2012) to 180/100,000 (30%) by 2030. The objectives of this grant include the following: 1) to increase the number of detected Tuberculosis cases to 15,150 by 2017; 2) increase the treatment success rate from 72% to 85%; 3) decrease death rate from 11% to 5% in HIV co-infected Tuberculosis patients; 4) to enrol in second line treatment 15 MDR TB patients by 2017; and 5) to improve and reinforce the technical and managerial capacities of the national program.

Some targets in the revised Performance Framework ("M&E-1: Percentage of HMIS or other routine reporting units submitting timely reports according to national guidelines" and "MDR TB-6: Percentage of TB patients with DST result for at least Rifampicin among the total number of notified (new and retreatment) cases in the same year") were slightly reduced for the reporting period, and two others ("DOTS-1b: Number of notified cases of bacteriologically confirmed TB, new and relapses" and "DOTS-2b: Percentage of bacteriologically confirmed TB cases successfully treated (cured plus completed treatment) among the bacteriologically confirmed TB cases registered during a specified period") were removed taking into consideration the challenges in implementation of activities due to insecurity situation in the country.

TB project performance of key impact/outcome indicators

According to the latest (year 2015) estimates of WHO, the estimated incidence, prevalence and mortality rate for South Sudan are at 146, 319, and 29 per 100,000 population respectively. Incidence of MDR/RR-TB was 6.2 per 100,000 (760 cases).

The table below summarises details on TB impact/outcome indicators including case notification rate and treatment success rate for all forms of TB.

Table 3. Performance of Key TB Impact/Outcome Indicators

Impact/outcome indicators	2016 Target	2016 Achievement	% achievement
TB I-1: TB prevalence rate (per 100,000 population)	TBC	319 (2015)	N/A
TB O-1a: Case notification rate of all forms of TB per 100,000 population - bacteriologically confirmed plus clinically diagnosed, new and relapse cases	112	95	85%
TB O-2a: Treatment success rate - all forms of TB	82%	8296/10211 81%	99%
Death rate in TB/HIV patients on TB treatment	9%	110/1072 10.3%	88%
TB O-6: Notification of RR-TB and/or MDR-TB cases – Percentage of notified cases of bacteriologically confirmed, drug resistant RR-TB and/or MDR-TB* as a proportion of all estimated RR-TB and/or MDR-TB cases . **RR= rifampicin-resistant; MDR = multidrug-resistant	1%	0%	0%

South Sudan has not carried out TB prevalence survey, thus, WHO annual estimate is used for monitoring prevalence. According to the 2015 WHO report, the prevalence rate of TB for South Sudan was at 319 per 100,000 population.

In the reporting year 2016, the TB case notification rate (Case notification rate of all forms of TB per 100,000 population - bacteriologically confirmed plus clinically diagnosed, new and relapse cases) is estimated at 95 per 100,000 population based on the National TB Program data on the actual number of notified TB cases (all forms), which is 11,694, and the World Bank estimate for year 2015 population of country (12.34 million). The reported case notification rate makes 85 percent of target (95/112). The relatively lower achievement of the target can be attributed to the interruption of services and the delay in expansion of TB services to new health facilities caused by the military conflict in the country.

In the reporting period, the treatment success rate for all forms of TB patients (cured plus completed) is 81 percent (8,296 TB patients were successfully treated

(cured + treatment completed) out of 10,211 TB patients). As for the death rate in TB/HIV patients on TB treatment, we note that 1,072 TB/HIV co-infected patients were evaluated for outcomes in the reporting period, and 110 of those (10%) were declared as "died".

The target of outcome indicator "TB O-6: Notification of RR-TB and/or MDR-TB cases" was not achieved in the reporting period. It is due to delay in MDR-TB management program. The construction of the MDR-TB facility was not materialized. The site where the facility was to be constructed in Juba teaching hospital was given for another service. Another site (within Kator PHCC) has been identified, an engineer was contracted by WHO for a design and BOQs. The design is now finalized and BoQs being developed. Given the protracted delay and as per WHO's recommendation of ambulatory treatment as a good option in PMDT, the country has decided to go for ambulatory management. Health care workers in Juba teaching hospital and laboratory technicians in the reference laboratory are now trained. The next steps are to map MDR-TB patients in Juba city and update the guidelines accordingly for an immediate start up of treatment.

NFM TB project performance of key output indicators

There are 9 output indicators with set targets for the reporting period, and in the 1st semester three exceeded the set targets, five met the expectations, and only one ("MDR TB-3(M): Number of cases with (RR-TB and/or MDR-TB) that began second-line treatment") had zero achievement. The latter has symbolic/law targets (2 in S1 and 3 in S2) which were not achieved due to the delay in starting of the MDR treatment program. In the 2nd semester (July-December 2016) three indicators exceeded the targets, three met the expectations (with 90%-100% target achievement ratio), one ("TB/HIV-3.1: Percentage of people living with HIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings") significantly achieved the target, one ("MDR TB-6: Percentage of TB patients with DST result for at least Rifampicin among the total number of notified (new and retreatment) cases in the same year. DST coverage includes results from molecular (example Xpert MTB/RIF) as well as conventional phenotypic DST results]") has relatively lower (58%) target achievement ratio, and one ("MDR TB-3(M): Number of cases with (RR-TB and/or MDR-TB) that began second-line treatment") had zero achievement.

Overall, the grant continued to demonstrate good results. The average performance of all indicators is B1 (90% in S1 and 84% in S2).

Table 4. Performance of key NFM TB output indicators, 2016

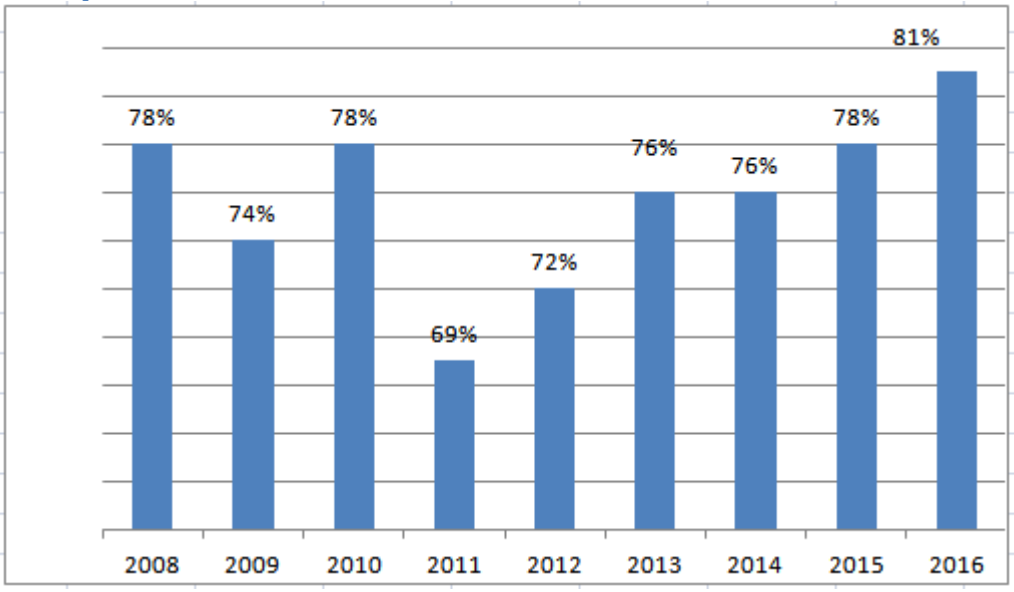
Output indicators	2016 Targets	2016 Achievement	% Achievement
TCP-1(M): Number of notified cases of all forms of TB-(i.e. bacteriologically confirmed + clinically diagnosed) Includes new and relapse cases	S1: 5586 S2: 5586	S1: 5880 S2: 5821	S1: 105% S2: 104%
TCP-2(M): Treatment success rate- all forms: Percentage of all forms of TB cases (i.e. bacteriologically confirmed plus clinically diagnosed) successfully treated (cured plus treatment completed) among all forms of TB cases registered for treatment during a specified period Includes new and relapse cases.	S1: 4233/5162 82% S2: 4233/5162 82%	S1: 4177/5178 80.7% S2: 4119/5033 82%	S1: 98% S2: 100%
TCP-3: Percentage of laboratories showing adequate performance in external quality assurance for smear microscopy among the total number of laboratories that undertake smear microscopy during the reporting period	S1: 57/60 95% S2: 76/80 95%	S1: 75/88 85% S2: 33/37 89.2%	S1: 90% S2: 93.8%
TB/HIV-5: Percentage of registered new and relapse TB patients with documented HIV status	S1: 4468/5586 80% S2: 4468/5586 80%	S1: 4525/5880 77% S2: 4,691/5,821 80.6%	S1:96% S2: 100.7%
TB/HIV-6: Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	S1: 469/670 70% S2: 469/670 70%	S1:359/559 64% S2: 399/525 76%	S1: 92% S2: 109%
TB/HIV-3.1: Percentage of people living with HIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings	S1: 9,876 /19,752 50% S2: 19,800 /22,000 90%	S1:15,210 /19,349 78.6% S2: 14,755/ 18,300 80.6%	S1: 120% S2:90%
MDR TB-6: Percentage of TB patients with DST result for at least Rifampicin among the total number of notified (new and retreatment) cases in the same year. *DST coverage includes results from molecular (example Xpert MTB/RIF) as well as conventional phenotypic DST results].	S1: 126/315 40% S2: 126/315 40%	S1: 99/273 36.3% S2: 105/264 39.8%	S1: 91% S2: 99.5%
MDR TB-3(M): Number of cases with (RR-TB and/or MDR-TB) that began second-line treatment	S1: 2 S2: 3	S1: 0 S2: 0	S1: 0% S2: 0%
M&E-1: Percentage of HMIS or other routine reporting units submitting timely reports according to national guidelines	S1:148/174 85% S2: 199/234 85%	S1: 147/150 98% S2: 147/148 99.3%	S1: 115% S2: 116%

Module 1: TB care and prevention (TCP)

The notification rate for all forms of TB (i.e. bacteriologically confirmed + clinically diagnosed) has been high in 2016: 5,880 in the 1st semester and 5,814 in the 2nd semester, with 105% and 104% target achievement ratio respectively.

The treatment success rate for all forms of TB in the 1st semester of the reporting period (Jan-June 2016) is 81% (4177/5178) and it is 82% (4,119/5,033) in the 2nd semester (July-Dec 2016). The target achievement ratio is 98% and 100% respectively. In TB control programme, treatment success rate is one of the indicators used to measure the status of the interventions at outcome level. The treatment success rate is slightly lower that the WHO standard rate of at least 85%. However, the success rate in 2016 was as significant improvement from 78% reported in 2015.

Figure 3 Graph Showing Trends in treatment success rate by year (2008 – 2016)



In 2016, 88 TB diagnostic facilities underwent external quality assurance, and 75 of them (85%) showed adequate performance (attained 95 - 100% concordance at EQA). The slightly lower performance is due to inappropriate preparation of reagents (transporting prepared reagents from the reference laboratory to peripheral laboratories has been challenging), issues with microscopy, inadequate internal control, and the skills of lab personnel (due to high staff turnover). In addition, the pulling out of Challenge TB project with regards to the technical assistance for quality assurance of laboratories outside Juba city also negatively affected the performance. The NTP and SRs will target those health facilities where concordance rate is low aiming at providing more training and mentorships. In

addition, preparation of reagents will be more streamlined and monitored for better results.

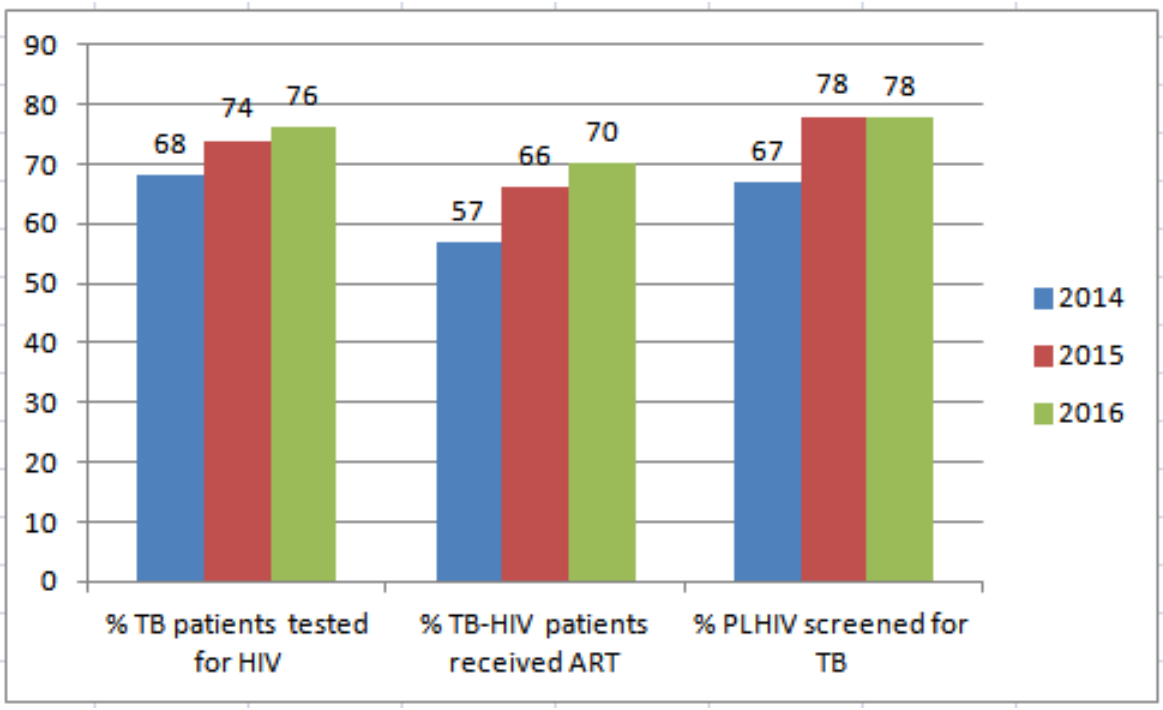
Module 2: TB/HIV

In Jan-June 2016 a total of 5,880 TB cases (all forms) were notified and 4,525 (77%) of them were tested for HIV. In July-Dec 2016 a total of 5,814 TB cases (all forms) were notified, and 4,375 of those (75%) were tested for HIV. The targets for this non-cumulative indicator are 80% in each of mentioned reporting periods, thus, the achievements are 96% and 94% respectively.

In Jan-June 2016 there were 559 HIV-positive registered TB patients and 364 (65%) of them were provided with anti-retroviral therapy. A major reason for the slightly lower achievement of the target in the first semester of the reporting period was the delay in the opening of new ART sites due to the civil unrest which decreased patients' access to ART. However, in the next/second semester (July-Dec 2016) the result was higher – 76 percent (with 109% target achievement ratio), as 401 of 525 HIV positive registered TB patients (new and relapse) were enrolled in ART. The percentage of HIV positive registered TB patients who received ART treatment increased from 66% in 2015 to 70 % in 2016. This is explained by the good linkage between the TB and HIV service units, especially in those health facilities where they co-existed together.

In Jan-June 2016, 79 percent (15,210/19,349) and in July-Dec 77 percent (14,628/19,063) of HIV-positive patients were screened for TB in HIV care and treatment settings. This achievement significantly surpassed the set targets for the period. The significant achievement of this indicator's targets in the reporting period is due to continuous mentoring of clinicians in ART sites, which is now a standard follow up procedure in most ART sites.

Figure 4 Graph showing Performance of TB/HIV collaborative activities (2014 -2016).



Module 3: MDR-TB

In the 1st semester of 2016, 99 samples out of 273 (36%) TB re-treatment cases (bacteriologically positive only) were collected and submitted for DST. In the 2nd semester 62 samples out of 266 (23%) TB re-treatment cases were collected and submitted for DST. The target achievement ratio (as per the revised PF, where the target is 40% vs. 50% in the original PF) is 91% and 58% respectively. Such a low performance in the 2nd semester is due to the crisis (widespread insecurity in most parts of the country) as there were challenges in transporting sputum samples from various TB sites due to inaccessibility by road and air of many sites on a daily basis. The collaboration with Challenge TB in getting sputum samples from patients in the community (for example using motor cycles 'boda bodas' in Juba city) will significantly contribute to an improvement of the indicator result.

No cases of (RR-TB and/or MDR-TB) began second-line treatment during the reporting period due to the delay in initiation of MDR treatment program, through there were 6 MDR-TB patients laboratory confirmed during this reporting period. National treatment guidelines have been developed and the staff has been trained on MDR-TB to start up the services. NTP is in the process of establishing MDR-TB facility in Kator PHCC. The facility is planned to be renovated with the support of WHO and the Global Fund. A PMDT officer at the National TB Control Program was recruited but he recently left NTP due to the low salary. However, WHO has contracted MDR-TB specialist to provide technical assistance to the team of clinicians in managing MDR-TB patients. Second line anti-TB drugs were delivered

and new NTP laboratory staff at the NRL have been trained on relevant topics. An operational plan was developed. Mapping of MDR-TB patients available in Juba is being carried out and patients will start treatment using ambulatory short course regimen (new regimen) by the beginning of April 2017. An indeed, MDR-TB treatment has started on the 5th of April 2017 with 11 patients, 6 patients from Kator PHCC, 3 from Munuki and 2 patients from Juba Teaching Hospital.

Module 5: HSS - Health information systems and M&E

The assumption was to have 87 functional TB facilities at the end of June 2016, and that each facility would submit a report on quarterly basis. However, as shown in the Table 5 below, at the end of the 1st semester there were only 75 functional TB facilities due to insecurity and delay in the expansion. In the 1st semester 147 TB quarterly reports were received out of the expected 150 quarterly reports from the existing functional TB facilities (98%).

Table 5. Percentage Completeness of Reports by quarter, 2016

TB Facilities	2016	
	Q1-Q2	Q3-Q4
Total # of reports received	147	67
Total # of TB units	87	46
Total # of functional TB units	75	34
Completeness from all	**84.5%**	**72.8%**
Completeness from functional	**98%**	**98.5%**

In the second semester there were only 34 functional TB units (due to the conflict), and in the reporting period 67 out of 68 (98.5%) expected reports were received from those facilities.

2.2.3 R9 Health Systems Strengthening Grant (SSD-910-G13-HSS)

The Round 9 HSS Phase 2 grant started in October 2012 and ended (after one year of no-cost extension) on 30 September 2016. The grant was aimed at addressing the main constraints identified by the National Health Policy: lack of appropriate equipment and supplies; lack of well-functioning disease surveillance and response systems; and poor infrastructure and support services. The goal was to strengthen the health system of South Sudan to scale up HIV/AIDS, TB, and Malaria services. The last progress update report for this grant (covering 1 April – 30 September 2016 period) was submitted to the GF in November 2016.

R9 HSS project performance of key impact/outcome indicators

In the reporting period (1 April – 30 September, 2016) results for only three impact/outcome indicators were reported due to delays in surveys and studies which were meant to provide data for reporting.

The target of the outcome indicator "General Service readiness score for health facilities" was achieved by 91 percent (73%/80%) in the previous reporting period (October 2015 - March 2016). WHO was planning to conduct SARA survey through GAVI financing, which was postponed. Therefore, there is no data reported in this reporting semester.

The Ratio of Nurse/Midwives per 10,000 population was reported in the PUDR for October 2015 to March 2016, within the HSS end of project evaluation. WHO's plan to conduct the SARA survey through GAVI financing has been postponed, and there is no data reported in this reporting semester.

According to the draft HMIS annual report (MOH 2015) , the proportion of births attended in health facilities by skilled birth professionals is 8 percent, an improvement by 1% from 2014, but it is far below the set target of 30%. The baseline was also set based on the data from Sudan Household survey which was conducted in 2010 and may not be true representative of the skilled birth attendance rate for South Sudan. Additional population based data will be collected through the national expanded maternal mortality (EMMR) survey, which is currently in progress (the TOR, budgets and timelines EMMR survey have been shared with the Global Fund). The PR will update the Global Fund on the status of the EMMR survey.

Table 6. Performance of key HSS impact/outcome indicators, 2016

Indicator Description	Year 5 (2015) Target	Achievement	% Achievement
Proportion of births attended in health facility by skilled birth professionals	30%	8%	27%
% of pregnant women attending at least 4 ANC visits in Health facilities	40%	27%	67.5%
Outpatient health facility attendance - Number of people seeking services at outpatient departments per 10 000 population	1	0.9	90%

According to the draft HMIS annual report (MOH 2015), the percentage of pregnant women attending at least 4 ANC visits in health facilities is 27 percent, an improvement by 3 percent points from 2014.

The percentage of outpatient health facility attendance is 0.9, which is close to the HSDP target of 1. This is an improvement by 0.3 as compared to the HMIS report of 2014.

R9 HSS project performance of key output indicators

According to the recent GF grant performance assessment for April to September 2016, the final period of the grant demonstrated good results and reached a Quantitative Indicator rating of A2 (overall achievement of 90-98%). Of the three indicators for the reporting period, one ("Number and Percentage of Counties submitting complete and timely reports to the national level HMIS") exceeded the target, the other ("Number of Pharmaceutical and Hospital Waste Incinerators installed") met the target, and the other ("Number of Health Workers trained on Pharmaceutical Management") did not meet the target.

Table 7. Performance of key HSS output indicators, April 1, 2016 – Sept 30, 2016

Output indicators	Target	Actual Result	%
Number of Teaching Institutions renovated	N/A	N/A	
Number of Health Workers trained on Pharmaceutical Management	25	0	0%
Number of Pharmaceutical and Hospital Waste Incinerators installed	1	1	100%
Number of State M&E Officers trained on HMIS	N/A	N/A	
Number of State M&E offices renovated	N/A	N/A	
Number of State Laboratories renovated	N/A	N/A	

Output indicators	Target	Actual Result	%
Number and Percentage of Counties submitting complete and timely reports to the national level HMIS	64/80 (80%)	68/80 (85%)	106%

SDA 1: HSS - Health Workforce

The PSCM taskforce consisting of GF, WHO, PEPFAR, MSF, MoH, ICAP, etc. developed the training materials, i.e. SOPs and the training module, as well as the tools for dissemination once the training was nearing completion. The validation of the SOPs for supply chain management of HIV commodities is awaiting endorsement by the Under-secretary for Health.

The training was scheduled in August 2016, however due to the July 2016 conflict and subsequent relocation of staff, the PR and MOH were unable to carry out the trainings as planned. The training has been included in the HSS reprogramming and rescheduled to the 1st quarter of 2017. And indeed, it was conducted 17th of March, 2017

SDA 2: HSS - Access to safe and effective drugs

One pharmaceutical waste incinator was installed in the national public health reference laboratory in 2016, and now it is functional. The installation of incinerators, commissioning and training has been completed in Juba, Bor, Wau, Rumbek and Torit. However, there are some parts that are currently being procured for Rumbek and Torit. Renk and Malakal have not been commissioned because they are in the conflict affected areas.

The renovation of the Riverside warehouse annexture and office block is substantially completed.

With the exception of the PCR machine, all TB and PCR lab equipment have been installed at the NPHL. Lab equipment for Torit and Kuajok minor labs have also been installed and they are not functional. Activities for the Boma Health Initiative require an NGO SR to implement them, one that is already operating at community level. Therefore, AAA has been identified to implement the activities and is included in the reprogrammed budget submitted to the Global Fund.

SDA 3: HSS – Health Information system

In this reporting period the average completeness and timeliness of HMIS report was 84 percent surpassing the set target of 80 percent for the reporting semester

(106 percent achievement). The current achievement would have been much higher were it not for the current conflict in Jonglei and Upper Nile states.

SDA 4: HSS – Health systems related service deliveries

South Sudan's first blood bank and the national and regional public health laboratories were opened in 2014 and staff salaries were supported by the HSS grant in 2015. Additionally, this grant supported procurement and distribution of reagents for national reference laboratory, the two blood banks (Wau and Juba), as well as the state labs. The renovations of Torit and Kuajok state laboratories have been completed and handed over to the state MoH during the reporting period. Unfortunately, the Malakal lab and blood bank are still non-functional due to the conflict that resulted in vandalization of these structures and looting of the equipment.

The construction of five ANC clinics (Imatari in Eastern Equatoria; Warrap, in Warrap state; Aduel, in Lakes state; Cueicok; and Raja in Western Bar el Ghazal state also in Lakes state) have been completed in December 2015. Additionally, the construction works of five maternity wards (Aduel in Lakes; Cueicok in Lakes; Mapel in Western Bar el Ghazal; Wanjok, in Northern Bar el Ghazal state and Deim Zubeir, in Western Bar el Ghazal states) have been completed including Mayen Abun, in Warrap State.

3. Procurement and Supply Chain Management (PSM)

In 2016, the PSM activities were carried out in the midst of complex environment characterized by an outbreak of conflict in the capital city and intensified fighting and insecurity widespread across the country that hindered supply chain operations on several occasions. There were extensive procurement activities for both HIV and TB drugs and consumables as a result of the new funding model which catered for expansion of services – unlike the previous transitional funding mechanism in 2015. In the reporting period UNDP as a Principal Recipient for the GF, managed to store and manage TB and HIV commodities worth an average 3.9 million USD. In addition, the warehouse continued to provide support to 26 ART, 72 PMTCT, 87 TB, and 9 state laboratories, 2 blood banks and the national public health reference lab with regular deliveries of TB, HIV and lab commodities worth approximately 3.9 million USD.

UNDP South Sudan managed to make use of Long Term Agreements set up by the UNDP and manufacturers of Tenofovir, Lamuvidine, Efavirenz (TLE) fixed dose combination to secure very competitive prices for the products and achieve savings that were reprogrammed for other activities.

In an effort to streamline procurement processes and improve efficiency and lead-times, the Procurement unit develops a consolidated Procurement plan for all the grants. Adherence to the execution of this plan has helped to improve procurement efficiency and support programme implementation. During the reporting period, UNDP managed to procure TB and HIV commodities worth 2.6 million USD which were delivered to the country. UNDP continued to monitor the quality of the products supplied by the grants by submitting samples of TB and HIV commodities for Quality Control checks with a WHO prequalified laboratory in Zimbabwe. All the samples assessed were found to be compliant.

Substantial efforts were made to improve the capacity of the TB and HIV programmes through participation in training and networking events such as the 1 week UNDP PSM Training held in Goa, India where 2 PMU and 2 MoH staff as well as on-the-job mentoring for staff in facilities in Juba. Support was provided with setting up an HIV Supply Chain Working Group with relevant stakeholders. The working group under the auspices of the Pharmaceutical Technical Working Group was responsible for monitoring the stock situation in facilities (through the support of ICAP), review of orders and distribution of commodities as well as commencing the revision of Standard Operating procedures and relevant tools for the management of commodities.

4. Partnerships

UNDP as a Principal Recipient for the Global Fund implemented all activities in partnerships with MoH, SSAC, AAA, WHO, IOM, IMA, Cordaid, and IMC. UNDP involved these organizations during project planning, implementation, monitoring, and evaluation. The partners also participated in the reprogramming of the grants due to the change in the context of the country from July 2016. UNDP provided technical support and timely disbursement of funds to execute and enhance programme delivery based on the project work plan.

The Principal Recipient has been also working with CCM and LFA in the implementation of the grants. The Principal Recipient is fully participating and supporting MoH in different TWGs including HIV, TB, M&E, HSS and PSM. The PR also works with CDC/PEPFAR, ICAP, and USAID/MSH to maximize a synergy between the two partners working in the area of HIV/AIDS and TB.

5. Monitoring and Evaluation

UNDP in collaboration with Directorate of Policy, Planning and Budgeting Department in MoH conducted a comprehensive and systemic annual review meeting in Juba from 28-30th September 2015. In total, 50 participants drawn from SRs, MoH-RSS, partners and state MoH (DGs, M&E coordinators, HIV directors and TB coordinators) participated in the review. The meeting assessed the achievement of TB, HIV, TB/HIV and HSS grants at Principal Recipient and SRs levels. Additionally, the meeting also contributed to the development of operational plan for TB, HIV and HMIS/M&E for state MoH. UNDP M&E participated in TB and TB/HIV training for Health Workers in states namely CES (Juba), EES (Torit and Nimule), and NBGS (Aweil).

As part of routine M&E activities, several supervisory visits and routine data quality assessments to GF supported TB, ART and PMTCT sites were carried out by the PMU team jointly with government counterparts despite the challenges of security in most of the states. The performance of some of the sub-recipients has been assessed through site and office visits. Feedback on programme and finance reports was also provided to the SRs and TB/HIV facilities that reported during this period. The joint quarterly M&E visits contributed to an improvement in the accuracy of TB reports.

The Local Fund Agents (LFA) conducted an on-site data verification (OSDV) in selected TB, ART and PMTCT facilities in Central Equatoria, Western Behr El Ghazel and Warrap states. Nine TB and HIV sites were selected and verification was undertaken for results reported for the period of 1 January – 30 June 2015. Key

HIV and TB (three each) performance indicators were selected. Based on the findings of each of the assessed indicators, the data quality was overall good except for PMTCT indicator, which was below the GF standard. There was under reporting by most of the PMTCT sites due to the delay in the transition from Option A to Option B+. Some facilities were updating the monthly report at facility level after submission to the next level.

The project provided technical assistance to the MoH in strengthening the HMIS in producing the monthly HMIS bulletin; coordination and facilitation of the monthly M&E TWG; cleaning of District Health Information Software (DHIS) data; on the job training of health facilities' staff on DHIS and HMIS tools; MMR survey TWG and financially supported the MMR survey in pretesting of the survey tools. UNDP supported the MoH in revising the HIV and TB recording and reporting tools based on the WHO recommendations, TB data were updated in the DHIS 2 software. TB policy, guideline, recording and reporting tools are in the process of revision and will be fully implemented in 2016. UNDP in collaboration with WHO and partners supported MoH in printing and distribution of patient monitoring tools and clinical guidelines. Capacity building through visits and formal trainings needs to continue to ensure proficiency in use of the tools.

6. Challenges / Issues

While insecurity in the country was already widespread, the incident of July 2016 in Juba escalated fighting and insecurity to most states including states which were relatively peaceful before the incident (such as former Central Equatoria, Eastern Equatoria, and Western Bahr El Ghazal). This tremendously disrupted the provision of services at facility level and the delivery of essential drugs and consumables to the facilities. Patients had to flee to the neighbouring countries and other, more secure places, discontinuing their treatment.

The economic situation in the country worsened more than ever. The devaluation of the local currency and the inflation reduced the real income of MoH TB and HIV program staff. This resulted in very high staff turnover, and the key/experienced technical and managerial staff in those programmes left the Ministry.

Although molecular biology testing for TB (and MDR-TB) was initiated, the new PCR machine for HIV has not been delivered and the delay in implementation of EID activities negatively affected the testing of HIV exposed infants. UNDP has been supporting the MoH in the finalization of the set-up of the molecular laboratory and launch of EID activities in June 2017.

Challenges related to infrastructure also remain a major constraint in the distribution of drugs and commodities, besides the ongoing crisis. Due to the poor

conditions of roads, there is an increased reliance on WFP's humanitarian air services, although these are also limited by the volume and category of supplies they can carry (for instance, WFP does not carry laboratory reagents/liquids).

The lack of a functional Logistics Management Information System (LMIS) to gather consumption and stock on hand data from sites has proved to be a challenge. This has made it difficult to monitor stock status of commodities at the site level.

7. Lessons Learned and Way Forward

1. **Expanding access to HIV and TB services** – The support from the new funding model of HIV and TB presented an opportunity to increase access to HIV and TB services, however, the widespread insecurity did not permit the expansion plan. Targeted expansion – for example IDP POCs, refugee camps, prisons, uniform population and urban centres will improve access.

2. **Implementation through partnership – tapping into non-GF implementing partners' resources**. The opportunities presented from humanitarian agencies, such as UNHCR and its implementing partners; WFP, IOM, and PEPFAR partners, have to a certain extent synergized the efforts of the Global Fund resources. The partnership is yet to be strengthened and streamlined in the coming years.

3. **Lack of health service integration** – The root causes of delay in seeking medical attention for coughs among females having presumptive TB at various TB units in AAA locations were lack of integration of TB service in the existing PHC facilities and distance to be covered by medical care seekers (coughers). Hence, integration of TB services in the general health services reduces the distance travelled to health facilities, increasing the chance of early diagnosis and treatment.

4. **Community involvement** – Community engagement for early retrieval of persons interrupting TB treatment by home health promoters, TB club and TB ambassadors for patient follow-ups and monthly feedback meetings and enhancement of community DOT through treatment support promoted adherence to achieve 91 percent treatment success rate.

8. Risks and Mitigation Measures

Risks	Mitigation Measures
HIV	
Delayed expansion of HIV services	I) Expand services into POCs/IDP camps and refugee camps; ii) Expand services into Prison health canters; iii) Integrate with primary health care services using PHC implementers.
Delayed functionality of Central PCR Reference Laboratory will delay early infant diagnosis.	i) PCR machine to be leased for a limited period from renowned international Laboratory company; ii) Biosafety Level 3 laboratory established – with the remaining PCR machine leasing; iii) All minor & major equipment, accessories & consumables received.
TB/HIV collaborative activities weakened: imbalance in the number of HIV and TB facilities	i) Ensure provision of non-interrupted provision of CPT to TB centres, liaise with other donors to provide HIV test kits; ii) Coordinate with state HIV coordinators to strengthen collaborative work; and iii) Expedite the implementation of the New Funding Model (NFM) from both TB and HIV grants.
TB	
Delayed expansion of TB services	I) Expand services into POCs/IDP camps and refugee camps; ii) Expand services into prison health canters; iii) Integrate with primary health care services.
Delayed functionality of Central TB Reference Laboratory.	i) Savings under R9 HSS grant identified to cover costs of renovation and budget re-programmed for the remodelling of the reference lab; ii) Biomedical Engineer on board and civil work and air handling system completed; iii) The PMU is waiting for furniture and equipment from PSO.
Community TB Care not fully delivered	i) The project tried to identify CBOs already operating in the villages; ii) The Principal Recipient worked with partners like MSH TB challenge that are implementing community TB programme through CBOs; iii) The Principal Recipient in collaboration with NTP is expediting the selection of Sub-recipients to implement NFM activities, including community TB.

9. Financial Summary

Table. Cumulative Financial Summary by Grants, December 2016

Modules	2016		
	Budget	Expenditure and Commitments	Variance
HIV NFM			
Module 1 Prevention programs for MSM and TGs	620,385	117,201	503,184
Module 2 Prevention programs for sex workers and their clients	819,813	520,775	299,038
Module 3 Prevention programs for other vulnerable populations	1,946,930	88,359	1,858,571
Module 4 PMTCT	767,314	639,534	127,780
Module 5 Treatment, care and support	6,656,109	6,542,478	113,631
Module 6 HSS - Health information systems and M&E	1,675,944	30,867	1,645,077
Module 7 HSS - Health and community workforce	864,000	329,815	534,185
Module 8 HSS - Financial management	50,000	51,187	-1,187
Module 9 HSS - Policy and governance	729,431	212,734	516,697
Module 10 Community systems strengthening	217,500	72,655	144,845
Module 11 Programme management	4,817,814	3,721,682	1,096,132
PMU	9,226,517	8,907,340	319,177
Total	**19,165,240**	**12,327,287**	**6,837,953**
TB NFM			
Module 1 TB care and prevention	2,523,318	906,429	1,616,889
Module 2 TB/HIV	300,878	137,832	163,045
Module 3 MDR-TB	58,767	61,533	-2,766
Module 4 HSS - Health information systems and M&E	163,321	81,735	81,586
Module 5 Programme management	3,423,547	2,118,880	1,304,667
PMU	3,469,334	1,924,440	1,544,893
Total	**6,469,831**	**3,306,410**	**3,163,421**
R9 HSS Grant[7]			
SDA1:HSS Health Workforce	1,400,829	632,224	768,604
SDA2:HSS Medical Products, vaccines and technology	0	0	0
SDA3:HSS Information System	564,561	92,100	472,461
SDA4:HSS Service Delivery	6,601,322	5,002,586	1,598,735
Total	**8,566,711**	**5,726,911**	**2,839,801**

[7] The budget and expenditure figures refer to 1 Oct 2015 – 30 Sept 2016 period of this grant.

Grand Total (All Grants)	**34,201,782**	**21,360,608**	**12,841,175**