

Summary

This concept note summarizes the rationale for the Republic of South Sudan’s funding request to the Global Fund. Anchored on the overall national development strategy, updated South Sudan National HIV and AIDS Strategic Plan 2013-2017, Health Sector Development Plan 2012-2016 and supporting documents, it highlights technical data backing prioritized high impact and cost-effective modules and their proposed implementation strategies. In addition, it outlines why the comprehensive country dialogue for national strategy review and concept note deemed this overall approach the most optimal and effective. The concept note further describes the implementation approach, management arrangements for the proposed modules and interventions, risk management and methods for measuring, reporting on and improving achievement of the outcomes. It is divided into four sections:

Section 1 describes South Sudan’s epidemiological situation, country context, including health and community systems, human rights context, barriers to access, and the national response.

Section 2 details the national funding landscape and sustainability arrangements.

Section 3 summarizes the funding request to the Global Fund, providing a programmatic gap, rationale and description, and the modular template.

Section 4 introduces implementation arrangements, risk assessment and management strategies.

*IMPORTANT NOTE:* The process of completing this template relied on Standard Concept Note Instructions provided by the Global Fund to fight AIDS, TB and malaria.

Republic of South Sudan HIV and AIDS Program: Standard Concept Note

Investing Towards Impact against HIV and AIDS in South Sudan

February 13, 2014

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| SUMMARY INFORMATION | | | |
| Applicant Information | | | |
| Country | South Sudan | Component | HIV |
| Funding Request Start Date | 2015  (June 1, 2015) | Funding Request  End Date | 2017/  (December 31, 2017) |
| Principal Recipient(s) | UNDP (under Global Fund Additional Safeguards Policy)  and multi-track sub-recipients (Government, CSO & DPH) | | |

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| Funding Request Summary Table |

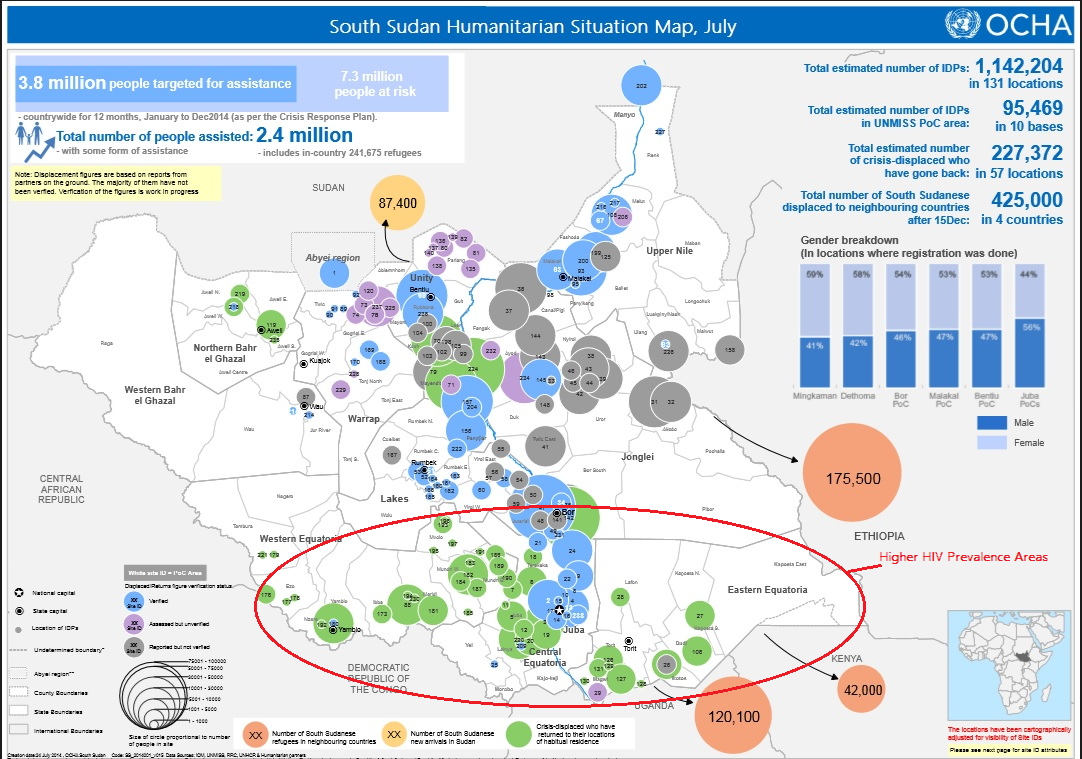
A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.



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| SECTION 1: COUNTRY CONTEXT |
| This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions. |

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| 1.1 Country Disease, Health and Community Systems Context |
| With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:   1. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence. 2. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality. 3. Key human rights barriers and gender inequalities that may impede access to health services. 4. The health systems and community systems context in the country, including any constraints. |
| 1. Epidemiology and Profile of HIV and AIDS in South Sudan   This section summarizes South Sudan’s epidemiological situation, country context (including health and community systems), human rights context, barriers to access, and the national response. It draws this information from key national documents, including the South Sudan National HIV and AIDS Strategic Plan 2013-2017 (‘NSP’ Section 3, pages 16-33, Annex 5); South Sudan Global AIDS Response Progress Report 2013, (‘GARPR’ Section 2, pages 16-32, Annex 6); the South Sudan HIV Prevention Response and Modes of Transmission Analysis 2013 (‘MoT’ Chapter 3, pages 17-74- Annex 7), the Health Sector Development Plan 2012-2016 (Annex 9) ; the South Sudan Development Plan (Annex 12) and other validated documents.  The Republic of South Sudan has one of the world’s most underfunded HIV programs,[[1]](#footnote-1) where the ratio of new adult and child infections (16,000) to average newly initiated on treatment since inception (800)[[2]](#footnote-2) is 20:1. Despite highly improved numbers newly initiated in 2013 the ratio remains low, at about 4:1, while the average in Africa is estimated at 1.93:1. There is scanty coverage of general and key populations. South Sudan has a mixed HIV epidemic, with pockets of hyperendemicity and concentration among key populations[[3]](#footnote-3) and within the country’s southern region, while the epidemic is generalized within the wider population. Antenatal clinic surveys (ANC Surveys, Annexes 15 and 51) reported national prevalence of 2.6% in 2012[[4]](#footnote-4), from 3.0% in 2009 and 3.7% in 2007. GARPR (2013- Annex 6) gives modelled estimates for 2013 as 2.2%.[[5]](#footnote-5) About 153,000 people, including 20,000 children were estimated to be living with HIV in 2013 (Spectrum Estimates.)**.** Higher prevalence has been estimated among women (2.6% prevalence or 90,000 females and 1.8% prevalence or 63,000 males)[[6]](#footnote-6) and certain age groups, including 20-24 and 25-29 years. This variance is explained by a range of social, cultural, economic and risk factors disfavouring women and girls. About 13000 people die from AIDS related causes annually, and prevalence trends indicate that the majority could be women (Spectrum estimates, 2013). South Sudan’s Maternal Mortality Ratio is the world’s highest, at 2054 per 100,000. The livelihoods of a large proportion of the 10.8 million population (2012 Estimates)[[7]](#footnote-7) are threatened by political conflict mostly in the three northern states of Jonglei, Unity and Upper Nile, which have aggravated a humanitarian crisis. This crisis has led to 1.5 Million South Sudanese being either internally displaced (IDPs) or refugees living in camps around the country- with poor access to health care, and a sharply elevated probability of HIV transmission.[[8]](#footnote-8) Up to 7 Million individuals have been directly or indirectly affected by the crisis, which has constrained service delivery and access. Demographic and epidemiological transitions are yet to occur. Life expectancy is 42 years; infant mortality rate is one of the highest in the world, at nearly 90 deaths per 1,000 live births while communicable diseases, many of them also HIV opportunistic infections, constitute the main health problem in the general population.  Sex workers and their clients, including the military, account for at least 63%% of new adult infections (MoT, Annex 7). Prevalence within the military is 5%[[9]](#footnote-9), about twice that of the general population, and at least six times higher than the general population for sex workers.  While much progress has been made within the HIV response in South Sudan, such as improving coordination, (GARPR, 2013) the number of AIDS-related deaths is rising. Service coverage levels are strikingly low. Less than 5% of all adults and 3% of all children living with HIV are on treatment. Incidence has generally stabilized within specific populations and in a few sentinel sites since the year 2000, and the country is set to miss previous HLM and NSP targets. A few ANC sentinel surveillance sites including Akobo, Leer, Kajo Keji and Maridi hospitals in Jonglei, Unity, Central and Western Equatoria states respectively have registered a rise in prevalence since 2007. Figure: Trends in adult (15-49) incidence and deaths 1990 – 2017 (UNAIDS/ Spectrum Estimates 2014, Annex 10) Geographical, Gender and Age Disparities:  Geography: The epidemic is geographically concentrated in the southern states. In 2011, Western Equatoria had about 7.2% HIV prevalence, Central Equatoria 3.9% and Eastern Equatoria 3.4% (MoT 2013, GARPR 2014 p.19- Annexes 6 and 7); while in 2012 ANC prevalence was recorded at 6.8%, 3.4% and 2.6% for the three states respectively. Sixty percent of all new infections[[10]](#footnote-10) and most of the 175,000 cumulative AIDS related deaths have occurred within the three Equatoria states to the south, bordering Central African Republic, Democratic Republic of Congo, Ethiopia, Kenya and Uganda, which have higher numbers of people living with HIV (Spectrum Estimates). A prevalence map by geography is included below). Markedly higher prevalence has been observed in sentinel sites and hotspots within these states. The hotspots include communities living close to bars, trade centers, cross border points and transport corridors; where sentinel sites have registered prevalence as high as 15.5% (Yambio hospital) - much higher than in remote and inaccessible areas. In contrast, Northern Bahr Ghazal recorded prevalence slightly above zero, while Warrap State recorded 0.7%. Syphilis prevalence has been recorded at 9.9%, as low as 4.3% in Warrap and as high as 13.3% in Western Equatoria. Interestingly, the high prevalence states are also home to the highest malaria parasite prevalence greater than 40%, posing a significant threat, especially to children under 5, while Central Equatoria, with its high population also has the highest notified TB incidence, at 59.1/100,000. The River Nile, Africa’s largest, also flows through the region, which also has a high burden of water-borne diseases including diarrhea, cholera and typhoid. Malaria co-morbidities are high. There is a strong case to prioritize scale up for the southern states as advanced in this document, and integrate scale up of prevention and treatment interventions for HIV with those of malaria and TB in phases, beginning with the utilization of the same community level platforms and integration of HIV in TB treatment sites as advanced in section 3.2 of this document.  **Figure: ANC Prevalence by state (2012)**    Gender and Age: Prevalence and incidence among women and girls is higher than that of boys and men; and incidence is higher than average between ages 20-24.[[11]](#footnote-11) Syphilis and HIV prevalence has been found to be inversely proportionate to education levels especially among women. There is need to provide youth focused BCC to promote safe sex and delayed sexual debut, along with other preventive interventions, linkages to the family planning program run by MOH, UNFPA, HPF and others, emphasis on MTCT linkages to avoidance of unintended pregnancies, and include targets for the youth in preventive and treatment modules as advanced in this concept note. Sources of New Infections Epidemiological projections reported in MoT (2013- Annex 7) reveal that the main channel of transmission in South Sudan is sexual. More than 13,000 new infections occurred during the last year among adults aged 15-49, while epidemiological projections reveal that more than 2,400 newborns were infected through MTCT. Sex workers and their clients contribute 8,468 (63%), or nearly two thirds of all new adult infections. Within the general population, men and women engaged in casual sexual relations and those in stable polygamous relationships contributed 27% (17% and 10% respectively), of all new infections. The probability of getting infected is about five times higher for partners in polygamous but stable relationships than for the monogamous. Men who have sex with men comprised 610 cases or 5% of all new infections. Women and girls are twice as likely as men and boys to get infected with HIV in South Sudan.  This evidence suggests that the response should prioritize packages of integrated high impact combination prevention for key populations especially sex workers and their clients, beginning in geographical areas of high endemicity and concentration such as transport corridors, trade centres and other hotspots in the three equatorial states, followed by Lakes State and IDP/refugee settlements especially refugee camps surrounding the equatoria states, where vulnerability to infection for women, girls, sex workers and their partners is catalyzed. Within the general population, BCC including condom promotion interventions, accelerated HTC campaigns and an integrated package of high impact combination prevention interventions should be targeted to youth involved in casual sex and partners in polygamous relationships should be provided Couple HIV Counseling and Testing, and HIV positive discordant partners among them prioritized for treatment. Treatment should be prioritized in high prevalence states with high numbers of PLHIV, and high yield settings. Priority should also be given to tracing, evaluating and treating about 1140 ART clients lost to follow up in the crisis hit states.  Table: Sources of new adult infections 2012 (MoT 2013)   |  |  |  | | --- | --- | --- | | Risk Group | Number | % | | a. Female Sex Workers and their clients |  |  | | Uniformed services | 4,689 | 35% | | Female sex workers | 1,766 | 13% | | Other clients | 1,247 | 9% | | Boda boda (transporters by cycle) | 736 | 6% | | Long-distance truck drivers | 20 | 0% | | Total FSW and Clients | 8,458 | 63% | | b. Other key populations |  |  | | Men who have sex with men | 610 | 5% | | Female Partners of MSM and other MARPS | 96 | 1% | | Total MSM, female partners of MARPS | 706 | 6% | | TOTAL (KEY POPULATIONS) | 9,164 | 69% | | c. General population |  |  | | Men and women engaged in casual sex | 2286 | 17% | | [[12]](#footnote-12)Partners of men and women engaged in casual sex [1] | 251 | 2% | | [[13]](#footnote-13)Men and women in stable polygamous relationships[2] | 1,311 | 10% | | Men and women in stable monogamous relationships | 234 | 2% | | TOTAL (GENERAL POPULATION) | 4082 | 31% | | d. Blood transfusions and medical injections | 3 | 0% | |  | | | | Grand Total New Adult Infections | 13,246 | 100% | | PLHIV in IDP and Refugee Settlements 2014 | 25,000 |  |   Data from NSP 2013-2017, MoT 2013 and GARPR 2013 has been analyzed and consolidated to arrive at this table. Initial table from the MoT slightly differs.  Key Drivers and Determinants of HIV Transmission in South Sudan  Factors determining HIV transmission in South Sudan are behavioral, social (including gender factors), biomedical and structural (including health systems weaknesses and human rights issues). The dire humanitarian situation, its causes and consequences such as insecurity, population mobility, psychological stress, military activity, and loss of livelihoods amplify most of these factors.[[14]](#footnote-14) Section 3.8.5 of the National Strategic Plan (Annex 5, page 30) elaborates on the factors increasing vulnerability to HIV infection. These are summarized below:  Table: Factors determining HIV transmission in South Sudan (Sources: Technical Expert Synthesis from National Strategic Plan, p.30; GARPR 2013; MoT 2013; Humanitarian Reports; BSS, Household Survey, Special Surveys and others - in June 2014)   |  |  |  |  | | --- | --- | --- | --- | | Behavioral | Social | Biomedical | Structural | | Low knowledge and misconceptions (only 11.4% of young people know HIV prevention modes, only 9% of women have been tested)  Low rates of condom use; transactional sex and other high risk behavior; high rates of multiple, concurrent sexual partnerships[[15]](#footnote-15) | Increasing transactional sex, male-dominated gender norms, Gender based violence (20% of women battered by husbands); high poverty rate (51%), peer pressure (10% of girls debut sex before age 15), inter-generational sex, high stigma, discrimination, harmful cultural practices such as polygamy, widow inheritance; Low literacy esp. among women (28%)[[16]](#footnote-16) [[17]](#footnote-17); gender inequality, humanitarian (mobility, migration), and economic factors such as poverty and income level disparities[[18]](#footnote-18) [[19]](#footnote-19) | Along with early sexual debut, make girls more susceptible to infection; high rates of syphilis[[20]](#footnote-20) and high viral load levels;[[21]](#footnote-21) poor nutritional status; anal sex, low ART and OI management coverage; Low uptake of PMTCT, and VCT. Low condom coverage, low circumcision rates in higher prevalence regions. [[22]](#footnote-22) | Human rights violations and policy barriers against sex workers, MSM and other marginalized populations; Health systems weaknesses[[23]](#footnote-23) | | Humanitarian factors restrict service delivery and access, and can further catalyze transmission. | | | |  b. i. HIV epidemiology within Key Populations  1. Key Populations   **Definition:** Key Populations are distinct sub-groups within the general population who are at higher risk of exposure to HIV, and have high HIV prevalence. Within the context of South Sudan, these include Female Sex Workers and their clients (mainly from SPLA and other uniformed services, boda boda riders and truckers within the transport corridor), and MSM in the context of having a higher risk of infection.  Most-at-Risk populations are vulnerable populations that are disproportionately at higher risk of acquiring or transmitting HIV because they engage in high risk sexual behaviour. Within the South Sudan context these include Female Sex Workers and their clients, MSM, and sero discordant couples.  Studies have indicated that the majority of female sex workers are actually migrants from neighbouring countries of Kenya, Uganda, DRC, Ethiopia, Eritrea and Rwanda. In addition, MSM have been newly identified as a key population at higher risk. Groups exhibiting higher vulnerability to infection include other uniformed groups, and clients of sex workers.  **General Legal, Humanitarian, Systemic and Data Issues facing Key Affected Populations**  PLHIV within the general and humanitarian context are also highly vulnerable to disease progression, especially due to low commodity access and malnutrition. In addition to political conflict, weak health and community systems and criminalization of FSW, MSM, including those among them who migrate from neighboring countries has hitherto made it untenable to map some key populations, let alone provide service packages tailored to their needs. Coverage of services for key populations is therefore incomprehensive and limited. National level denominators are not available FSW, MSM and clients beyond the military. While other evidence points to much higher HIV prevalence among them, scientific prevalence data, and denominators are not optimally available for FSW, MSM and some key affected populations. MSM data, from mapping to prevalence, and service quality, is difficult to come by beyond the organizations directly working with them. Moreover, many key actors do not report under a single M&E framework. Data gathering, quality assurance and harmonization for key populations are planned during grant implementation.  **Uniformed services**  Of the estimated 13,246 new annual adult HIV infections, 4,689 (35%) occur within the uniformed services, who are among the key clients of sex workers at higher risk. Prevalence among soldiers is 5%, nearly twice the national average (SPLA Bio-Behavioural Survey, 2010 & 2012,as quoted in the Modes of Transmission Analysis, Annex 7, pp. 89-90) Data from a cross sectional survey of 1063 randomly selected soldiers from 13 SPLA bases (55% in/around Juba) three sites in Central Equatoria (Bilfam, Mogiri, Joint Integrated Unit [JIU]), five in Western Equatoria (WE) (Yambio, Nzara, Tambura, Ezo, Maridi), one in Unity State (Duar), one in Upper Nile State (Renk) and one each in Western Bahr el Ghazal (Mapel), Northern Bahr el Ghazal (Wutnyiek), and Eastern Equatoria (Owiny Kibul) was conducted in two phases in 2010 and 2012 with an overall HIV prevalence in the sample (final sample n=1058) found to be 5% (CI 3.6-6.9l) weighted data. Female prevalence was found to be (9.86%), though inferences cannot be made conclusively since the female sample was relatively much smaller (n=43). Prevalence is also highest (7.65%) within the 30-35 age group and with those of higher rank. Uniformed services include the military (about 250,000 individuals), police, and prison and wildlife officers, among others comprising about 100,000 people. Prevention programmes are currently limited to the SPLA. Soldiers frequently migrate within the country. Evidence points to behavioural, biomedical and social determinants of this high infection. Some sex workers report an aversion to condom use among soldiers, who offer to pay more for unprotected sex, or force them to have unprotected, often violent, unpaid or with simultaneous multiple partners.[[24]](#footnote-24) New recruits have little formal education (SPLA Bio-Behavioural Survey, 2010) and only 5% know how HIV is transmitted. Less than half (44%) ever used a condom. An analysis of beliefs revealed high levels of stigma (87%). Biomedically, only 46% had been circumcised even in states such as Western Bahr Ghazal which is home to some tribes known to circumcise traditionally. A sero-survey is planned to ascertain the exact prevalence across the entire military. Similar to other groups, interventions in this concept note provide a package of interventions targeted at uniformed services and other clients, including HTC, BCC, Condoms, Human Rights and GBV Package (Including rape prevention), and linkages to VMMC. These interventions will be planned and closely coordinated with those of sex workers.  **Sex workers**  Prevalence among sex workers has not been scientifically established, but was estimated for the East African region using Bayesian methodology to be at least five times the national average (at least 12%)[[25]](#footnote-25) and possibly many times higher. Much earlier, in 1995 an assessment among female sex workers was conducted in Juba, indicating HIV prevalence of 16%; and in the same study HIV prevalence of 14% for clients of sex workers. Another study conducted at STD clinic attendees in 2006 reported an HIV epidemic of 5.8%, whereas a VCT clinic attendee’s study conducted in the same year indicated an HIV prevalence of 17%.[[26]](#footnote-26) In some ANC sites, prevalence among women has been found to be as high as 15%, indicating possibility of significantly higher rates for the Female Sex Worker population around these areas. Although data on HIV prevalence, size estimation and risk dynamics of female sex workers is limited, findings from various surveys show high incidence of unsafe sex, while studies in two southern states found six typologies of sex workers based on place of work, ranging from streets and homes to motels, gambling sites and bars.[[27]](#footnote-27) Juba, Nimule, Yei, Yambio, Morobo, Maridi and Kaya towns in the equatoria region have been found to have highest estimated numbers of sex workers and clients.[[28]](#footnote-28)  Decades of war and population migration across borders may have facilitated the spread of the virus from high to low prevalence areas. Sex workers in South Sudan are not a homogenous group. Origin, location, age, knowledge and educational levels should be anticipated determinants of program outcomes. A study conducted in 2013[[29]](#footnote-29) suggested that the majority of sex workers in South Sudan are actually migrants from neighbouring countries (Uganda, Kenya, Ethiopia, DRC, CAR and Eritrea). Yet, the humanitarian context, chronic poverty, and disintegration of traditional social structures have increasingly encouraged sex work among local South Sudanese women and girls as a means of survival. HIV knowledge levels are higher among those from neighbouring countries, who include external university graduates unable to find alternative work.[[30]](#footnote-30) Previous studies **[[31]](#footnote-31)** **[[32]](#footnote-32) [[33]](#footnote-33) [[34]](#footnote-34)** found that two-thirds of theFSWs were divorced, separated, or widowed with only 7% being married, but almost 90% of them were the primary bread winners. Nearly all the 2,000 to 2,800 sex workers in Juba reported multiple daily clients; while up to 20% were underage (mostly South Sudanese) hence exposed to abuse and biomedical risks. Only 25% negotiated condom use with their clients. Majority of the clients are migrant workers such as long distance truck drivers and local South Sudanese men, who included the military, police, immigration officers, other government officials, settlers in IDP camps and migrants within the transport corridor, mostly in Eastern, Central and Western Equatoria, and the other states. Sex workers are found mainly in towns and within hotspots. Knowledge of HIV among FSWs is mixed, but generally low among migrants within the transport corridor, mostly in Eastern, Central and Western Equatoria, and the other states. A venue-based mapping[[35]](#footnote-35) in three states found a total of 1,005 hotspots (bars, lodges and brothels) and 52 truck stops where a majority of sex workers operating within the southern states may be reached with a package of high impact interventions outlined within the first module in section 3.2 of this document.  **Truck drivers, traders and boda boda riders:**  Data on HIV prevalence and population size estimation of truck drivers is lacking though there is evidence of high incidence of unsafe sex among this population. The Behavioural Monitoring Survey in 2008 which analyzed a group of truck drivers in Morobo found that in the preceding six months, 39% of the group had paid for sex, and while 70% knew about male condoms, only one-third were aware of any other means of HIV protection[[36]](#footnote-36). The MoT 2013 (Annex 7, p. xv)i, and GARPR 2013 (Annex 6 pp.31 & 59) and a USAID 2011 Formative Assessment of Most at Risk Populations (Annex 18, pp.3, 26-59[[37]](#footnote-37)) elaborate further information on truck drivers, traders and boda boda riders.  Interventions planned for sex workers and their clients with allocated and above allocated funding include planning, mapping to enhance coordinated scale up for sex worker prevention programs; Customized behavioral change communication for sex workers and their clients delivered through peer-led programs, condoms with compatible lubricants; Diagnosis and treatment of STIs (sex workers and their clients); Harm reduction (SGBV and rape prevention) for sex workers and their clients, HIV testing and counseling, a human rights package including addressing barriers to access, as well as linkages to the unfolding VMMC program.  **MSM**  Data on the MSM populations is sparse. The population is yet to be mapped, is highly criminalized and marginalized. 610 or 4.5% of new infections annually are estimated to occur among MSM. The renewed response to HIV in South Sudan has been customized to address the factors increasing MSM and their partners’ vulnerability to infection, and issues limiting their access and utilization of prevention, treatment and care services.   1. **Vulnerable Groups:**   **Definition:** Vulnerable Populations are groups of people that enjoy less legal, political, social, economic or policy protection, which places them at a disadvantage compared to the general population and limit their ability to access or use HIV prevention and treatment services. Within the South Sudan context, these include youth (adolescents) engaged in casual sex, young girls and women, discordant couples especially those in polygamous relationships, people infected with TB, prisoners and Populations of Humanitarian Concern (Internally Displaced Persons and Refugees),  Populations of Humanitarian Concern[[38]](#footnote-38)  The United Nations Secretary General's Report on South Sudan to the United Nations Security Council (October 2014) - Annex 30 provides an updated and comprehensive overview of the humanitarian, security and political situation in the country. By August 2014, 1.3 Million South Sudanese (About 10% of the country’s population) had been internally displaced as a result of the armed conflict within the governing party which has spilled over to various regions of the country. An additional 448,000 people have sought refuge in neighboring countries (Uganda, Kenya, Ethiopia and Sudan). Given the intractable nature of the conflict and the gap which exists between the warring parties with respect to the substantive issues at stake, a state of lower-intensity civil warfare is expected to persist in the country for the foreseeable future. This will significantly and durably affect the delivery of HIV services to populations deemed of humanitarian concern, currently estimated at 4.7 million people by OCHA.[[39]](#footnote-39) According to UNICEF, 250,000 children, are at risk of famine, especially in the Upper Nile, Unity and Jonglei, where the conflict has prevented land cultivation. Less than half of this population may have been covered by health services, but emergency services are being provided by international NGOs working with IOM and UNHCR as humanitarian partners.  Currently dispatched across 179 sites throughout the country (as of August 2014), the IDP population ought to be given priority with regards to HIV prevention activities implemented during the coming months and years. Indeed, displaced populations tend to be more vulnerable to HIV because of a number of factors. These include: family separation as many families have been displaced into different camps and localities leads to a breakdown of social norms that govern distress coping mechanisms and sexual behaviors, especially among young people; a lack access to basic services such as food, water, shelter, health and education as well as security in the IDP site; and transactional sex, sexual exploitation and abuse. In the South Sudanese context, these factors are compounded by the use of rape as a weapon of war by both sides of the conflict. Although rape kits, including post-exposure prophylaxis (PEP), are available among health partners responding to the emergency, most survivors are not presenting at health facilities for a variety of reasons such as stigma, perpetrator impunity, fear of retribution from the community, and lack of information and/or knowledge. With the majority of the internally displaced persons being women and children, issues of sexual exploitation and abuse are of further concern. The health risks associated with sexual violence are numerous including unwanted pregnancies and sexually transmitted infections and HIV. The destitution of most of the affected populations puts the most vulnerable (women and girls), at risk of engaging in risky behaviors for survival, i.e. transactional/survival sex.  The conflict has had far reaching adverse consequences on the HIV epidemic and response in the country. The three ART centers in the conflict states remain closed and the majority of the 1,140 PLHIV enrolled on treatment in these three sites have been lost to follow-up. In February 2014, UNAIDS estimated that 25,000[[40]](#footnote-40) PLHIV have been directly impacted by the crisis, putting further strain on the need for treatment, care and support services. This number has only grown with time, as a tenuous security situation has forced more people from their homes. Efforts to provide treatment services have been impeded by issues of access, lack of presence of trained personnel in the affected areas, and refusal of some affected populations to receive services from a government apparatus they perceive as actively pursuing them.  Men and boys are at risk of being conscripted into the war. Uniformed services are the population group at highest risk of HIV infection in South Sudan as 35% of new infections come from within their ranks.[[41]](#footnote-41) This is particularly linked to uniformed service members patronage of sex work, including sexual abuse of female sex workers, and very low condom use. Among young men in IDP settlements, which is an increasingly large community due to fear of being conscripted or killed, humanitarian partners have witnessed increasing violent physical behavior linked to poor coping mechanism such as early and frequent engagement in substance abuse. Alcohol and drug abuse impedes an individual’s ability to engage in safe sex practices and often leads to physical violence against women and girls.  Figure: Please see map of POCs and summary of Humanitarian Situation in South Sudan (Source: OCHA, map as of July 2014 at the end of this section 1.1)  **Women and girls**  While comprising slightly over 50% of the population, HIV prevalence among women and girls in South Sudan is higher than that of men and boys, and various studies within key populations at sentinel sites have found even higher discrepancies. The new response in South Sudan is anchored on interventions addressing the structural, social, biomedical and behavioural factors causing higher vulnerability among women and girls. About 20% of women within the general population are victims of gender violence, and female sex workers report higher or more intense rates of physical and psychological violence from their clients.[[42]](#footnote-42) About 40% of women have reported some form of violence. [[43]](#footnote-43) Economic gender inequalities are rife. Most (98%) of the country’s revenue originates from the oil sector (World Bank, 2013), where female workers feature very little, and most are either unemployed or underemployed, leading to forms of economic subjugation. Among female sex workers from South Sudan and neighbouring countries, who are already criminalized, their prime economic activity is conducted at the constant risk of abuse or in some cases death, with very few linkages to medical care, trained/friendly personnel, judicial support and no medico-legal linkages. To address these and other issues, this concept note proposes a number of interventions found to be successful in other similar settings, under modules for sex workers and their clients and vulnerable populations, including populations of humanitarian concern (Section 3.2).  **Prisoners / Incarcerated Population**  There are around 7000 prisoners in 80 prisons in South Sudan and around 70 county prisons[[44]](#footnote-44) [[45]](#footnote-45) [[46]](#footnote-46) A 2013 survey[[47]](#footnote-47) of prisoners in three state prisons found an HIV prevalence of 11.7% in Juba and 7.5% in Malakal. TB prevalence is assumed to be about 10 times above the general population. However, these assessment methods did not use biological samples, hence should be inferred with care. There is need for serological screening that will ascertain more exact prevalence for HIV among prisoners. Prisoners are not screened for HIV or tuberculosis as part of their medical examination at entry. There are no voluntary counselling services in prisons and no significant data on HIV. However, a limited number of prisoners living with HIV access ART directly from the Ministry of Health, through Global Fund support. Stigma prevents many prisoners and prison officers from revealing their status to others, and is therefore a barrier to HIV testing and treatment. There is also no linkage between the existing National Tuberculosis Programme and the prison system. However, some NGOs conduct TB screening in prisons. These are planned and highlighted under section 3.2 below.  **Young People**  South Sudan has a young population with 72% being under the age of 30 years and 51% under the age of 18 years. HIV vulnerability of young people is well documented and includes lack of access to information, low condom use, early sexual debut, especially among girls and limited access to HIV and SRH services. Inter-generational sex and gender-based violence are common among young people, especially young women. Forty-nine percent (49%) of female respondents in the 2010 Household Health Survey (Annex 16b) had experienced some form of GBV.  Comprehensive knowledge of HIV among young people (15-24 years) was 11.3% in 2010 (Household Survey- Annex 72). Knowledge, attitude, practice and coverage (Annex 22) study among young people in the Greater Equatoria states indicates an improvement in knowledge among the younger age group (10-14 years), especially on HIV transmission from mother to child, due to the introduction of HIV/SRH modules in schools. However, practice is still a challenge with one of every five (21%) of the children interviewed having had sex with a mean age of 10.75 and only 31% of the young people reporting to know how to use condoms correctly[[48]](#footnote-48).  It is estimated that 20,000 young people are living with HIV and access to treatment is still very low. Young people are also unable to access SRH services due to unavailability of youth friendly services in most health facilities. Only three youth friendly centres have been established in the three Greater Equatoria states providing BCC, SRH and HCT services. More are required, including integration of youth friendly services in health facilities for easy access by young people. One module is partially dedicated to providing a package of high impact interventions to young people.  **TB and TB/HIV co-infections**  Consistent data from the National Tuberculosis Programme (NTP) and a survey carried out in 10 states in 2011; suggest that the prevalence of HIV infection in patients with TB is approximately 15%.[[49]](#footnote-49) A cohort analysis of TB/HIV who were treated for TB within the existing NTP network indicates that the death rate was 11% in 2012. Tuberculosis (TB) is a major public health problem in South Sudan. TB prevalence was 257 per 100,000 population in 2012 (WHO), while 16,000 were newly affected, indicating an incidence of 146 new TB cases per 100,000 population. 3,200 TB related deaths were registered; a mortality rate of 30 deaths from TB per 100,000 population. According to the National TB Program (NTP), notification increased from 2,955 in 2008 to 8,403 in 2012. Routine data (2012) indicate the following demographics among newly infected TB patients: 67% are males, which indicates a sex ratio of 2 males per female; about one third are men and women aged 25-34, while 77% are aged less than 45 years for either men or women. Four of the ten states comprised two thirds of smear-positive pulmonary TB patients notified in South Sudan in 2012. These were: Central Equatoria State, Upper Nile State (14%), Northern Bahr El Ghazal State (14%) and Warrap State (10%). There are about 45 TB treatment sites in the country, compared to less than 20 functional ART sites. A major health systems component of the South Sudan TB, HIV and HSS concept notes is the renovation of TB sites in order to meet increased demand for ART especially in areas of high HIV prevalence. The burden of multidrug-resistant TB (MDR-TB) among notified pulmonary TB was 250 MDR-TB cases in 2012[[50]](#footnote-50). WHO estimates that the prevalence of MDR-TB among new TB cases and retreatment TB cases is 1.8% and 19% respectively.  TB identification in PLHIV is insufficient because of low HTC capacity and coverage especially of key populations (only 5.7% coverage despite comprising 70% of new infections) and low coverage of TB screening in health facilities providing HIV and AIDS services. In 2012, 4,476 TB screening procedures were carried out among PLHIV. The maximum proportion of PLHIV screened for TB was 7%, but most likely lower since this percentage constitutes multiple screenings for some patients. The three disease programs and the health system have converged to intensify provider-initiated and community level HIV testing and OI screening through this new funding model.  c. Human rights and gender constraints Gender Factors Gender factors expose both men and women to HIV infection; hence women and girls are twice as likely to be infected. MSM and their partners are nearly; if not totally cut out from their required specialized health services in South Sudan. Soldiers who are mostly male often travel far from their partners and engage in unprotected sex. Female soldiers are also known to be significantly more vulnerable to infection. Socio cultural and bio-medical factors place women and girls at a higher risk of infection. Women have a low rate of literacy at 16% and high rate of maternal mortality at 2054 per 100,000 live births one of the highest in the world. Health seeking behavior beyond the community is remarkably low even by regional standards. While 48% of pregnant women attend one Ante Natal Care (ANC) visit, only 19.4% births assisted by skilled personnel. The prevalence rate of modern contraceptives is less than 3%. Women have limited knowledge of sexual HIV transmission and transmission of HIV from mother to child. Other vulnerability factors include early sex debut among girls (about 10% of girls debut sex before age 15), harmful traditional practices, and vulnerability to sexual and gender based violence (SGBV). About 20% of women are battered by their husbands. Most women are in polygamous or unfaithful marriages. All these factors expose women to the risk of HIV infection. The MoT and NSP provide indicators demonstrating the factors that drive women’s vulnerability to HIV infection.  The US Department of State’s Country Report on Human Rights 2013 [[51]](#footnote-51) describes arbitrary killings, disappearance, torture, arbitrary arrests, imprisonment under inhumane conditions; all of which were corroborated by various groups during country dialogue; including key populations.  Other human rights issues: Inadequate coverage and reach of key populations, their criminalization and marginalization (sex workers, MSM) and high levels of stigma against PLHIV /TB limit their access to services. In addition, some areas especially those in the north are underserved by health services. There is in addition a lack of policy protection for PLHIV. The latter also face significant drug and commodity stock outs and poor monitoring. High levels of abuse and violence against sex workers and difficulty in access to justice and law enforcement requires concerted and innovative methods to address, such as scaling up best practice / signature programs such as the SPLA-sex worker program; developing medico-legal linkages for post GBV victims and improving health worker attitudes and awareness. There is need to finance distribution of commodities for sex workers and MSM beyond the last mile (community level) and address the high levels of stigma and discrimination prevailing throughout the country. The HIV Policy requires updating to provide a change platform in addressing issues for PLHIV, Key Populations and Humanitarian concern.  d. Country Health and Community Systems Context  Sections 3.10 and 3.11 of the updated National HIV and AIDS Strategic Plan (Annex 5, pages 39-45), refers to the Health Sector Development Plan 2012-2016 (Annex 9), elaborating health systems and community systems weaknesses affecting the HIV programme. This section merely highlights health and community systems-related constraints at the national, sub-national and community levels, which scale-up through this funding request pre-supposes. Information on gaps at community level, including those affecting key populations previously not studied, was triangulated during country dialogue for this concept note’s development, and supplementary data was collected using a customized gap analysis tool developed in line with the Global Fund Community Systems Strengthening (CSS) Framework. Health Systems With her health system decimated by decades of war and marginalization; and only three years into independence, South Sudan registers among the worst health outcome indicators globally, with less than half of her population effectively covered by health services. These weaknesses are exacerbated by insecurity, humanitarian crisis, a vast, sparsely populated terrain, poverty and other economic woes. Maternal Mortality Ratio (MMR) is estimated at 2,054 deaths per 100,000 live births, while the Infant Mortality Rate (IMR) is estimated at 102 deaths per 1,000 live births. 25% of all children under five are stunted, and even neglected tropical disease considered globally eradicated are still present in South Sudan.[[52]](#footnote-52) These constitute some of the world’s worst heath indicators. Scale up of HIV prevention, treatment and care services can only attain targets if the national response is delivered through an innovative, integrated and well coordinated partnership where government, communities/ civil society, development partners and humanitarian partners strengthen the shared health and community systems and focus on covering certain proportions of beneficiaries in different localities.  Health Service Delivery  Only 44% of the population is settled within a 5 kilometer radius of a functional health facility (HFM 2011, quoted and updated in HFS 2013)[[53]](#footnote-53) and hence access to PHCCs is also low (HFS 2013- Annex 69.). Within the northern region, some communities live as far as 200 kilometers from the nearest health facility[[54]](#footnote-54), while incessant conflict has reversed investments in health infrastructure[[55]](#footnote-55). 1,147 out of 1,487 health facilities in the 10 States are functional, due to shortage of staff at national and county hospitals, unavailability of equipment and supplies (50% of facilities experience stock outs), poor management and dilapidation. Only 22 (2%) of these functional facilities were ready to provide ART treatment by December 2013, but the conflict has reduced these to 16 after Bentiu, Renk and Malakal sites were closed while others reported reduced patient flow due to commodity instability. 1140 individuals previously on ART have been lost to follow up due to this conflict. There is very low availability of ARTs. Scale up should be a high priority with expansion of sites offering ART (in high prev settings), decentralization; integration and examination of service delivery models (e.g. task shifting). These measures are all planned and highlighted in section 3.2. Site expansion in high prevalence states including the equatorias and Lakes is set to begin through integration of ART into existing TB sites. It will be challenging to scale up ART from 5% to 35% of the population as targeted in the NSP 2013-2017 (of all people living with HIV (new UNGASS High Level Meeting Denominator), but the following steps could provide a critical first step as and before the country (re)builds infrastructure:   * + Optimizing quality of services at existing ART sites to allow for scale-up to maximum capacity, and then replicating/ expanding to other site; includes strengthening the weak PSM systems, and alleviating difficulties in tracking patients due to the weak information system. The community system will be used for follow up and linked better with the primary health centres; 750 community health workers enrolled under the malaria program will be trained on HIV and TB treatment literacy, HIV testing and counseling, SGBV, and ART adherence follow up.   + Integrating and pairing ART services with TB, malaria and other interventions: About 80 (6%) of sites provide TB treatment; other scale up opportunities exist if HIV services (PMTCT, SRH, TB, STI, HCT, VMMC, others) are integrated together with RMNCH[[56]](#footnote-56) from primary to tertiary levels since about 35% of health facilities provide immunization services, and 20% provide laboratory services for common tests. Forty five health facilities in high prevalence sites offering TB services will be expanded to add more rooms for ART initiation and HTC, bringing the total to about 65 facilities offering ART.   + Task sharing among health workers at different cadres as described in section 3.2 of this concept note,   + Massively task shifting much of HTC, adherence support and referrals to the community level, and sharing community health workers enrolled by the malaria program.   + Diversifying implementation structures, for example by using the humanitarian implementation mechanisms and development partner structures, especially for ART.   + Establishing and rolling out a quality assurance system across the entire ART program for all implementers: Supervision and follow up by MOH staff is infrequent, irregular and not up to global quality standards.   + Adopting strategies that lower costs: Service delivery is further hindered by high operational costs, and efficiency opportunities as stipulated in the NSP (Annex 5) and Health Systems 20/20 sustainability report (Annex 49) are yet to be fully exploited. These include decentralization, which is planned in section 3.2.   + Applying new technologies: There is need for application of new technologies including the single pill a day, remote diagnosis, use of Point of Care diagnostics, among others. Feasible technologies including the single daily pill, Gene Xpert and others have been adopted in the revised NSP (Annex 5) and in this concept note.   A significant proportion of newly allocated and pipeline funding for HIV, TB, malaria and HSS grants is aimed at addressing some of these challenges. Still, service beneficiary targets need to be distributed across sectors and partners. Based on recent scale up rates for treatment (more than 4000 individuals newly placed on treatment in 2013), and the high number of people on ART ‘waiting lists/ pre-ART, South Sudan is capable of scaling up both testing and treatment at the rates envisioned in this concept note. However scale up will require significant task shifting between various medical cadres and task sharing across disease staff in order to obtain optimal results. Several cadres of staff will be required to assure quality and effectively deliver services, hence HR needs are described under each module in section 3.2.  Health Information System and Community Health Information System  Although vastly improved within the last few years, generation and use of strategic information for HIV planning and resource allocation has previously been limited. Health Information Systems remain fragmented and not adequately effective. Some non government partners do not report to the Health Management Information System (HMIS), while it faces issues of accuracy, completeness of reporting, reliability, timeliness and consistency and overall quality. (Ministry of Health HMIS Data Quality Report 2012, Annex 19, p.11; Global Fund On Site Data Verification Feedback 2013- Annex 63c) Disease surveillance is still at a nascent stage while vital statistics cover only a section of the country. Several data quality issues have been reported by the Global Fund and within country reports[[57]](#footnote-57). The use of strategic information for planning and resource allocation has previously been limited. The MOH is in the process of developing and having a fully operationalizing a Health Management Information System that can provide routine reports for the HIV Program. There is need to link the Health Management Information System to a Community Health Information System which can generate and analyze strategic information for PSM and HMIS more frequently. DHIS (District Health Information Systems) implementation is also planned to support ART, PMTCT and HCT scale up, integration and linkages with other programs. Strengthening of Logistical Management Information Systems (LMIS) is also planned, as well as the use of electronic and mobile systems for patient tracking, reminders and data base automation as part of adherence support and strengthening the supply chain management system.  Medical products, vaccines and technologies  A high number of facilities experienced stock outs of HIV related commodities within the last 3 months (NSP 2013-2017; HSDP 2012-2016 and Country Dialogue Meetings with PLHIV, May 2014). Many PLHIV lacked commodities; CD4, test kits, viral load tests, ARVs for extended periods, and the few available viral diagnostic equipment malfunctioned. [[58]](#footnote-58)  The severity of these issues was corroborated by a Rapid Service Quality Assessment (RSQA) (Annex 36) by the Global Fund for 2013. In addition, lack of electricity supply in most areas of the country renders most electric power-reliant machinery redundant. However, this lack was not general, as there were laboratory services for EID, HIV testing, EID, CD4, VL, Xpert in a limited number of sites. Laboratory support to fill gaps and support scale up is planned under the Health Systems Strengthening concept note, and to some extent in section 3.2 of the TB concept note. Most HIV commodities are procured and supplied through the UN System. The Global Fund, Health Pooled Fund, PEPFAR and others operate parallel procurement systems coordinating with the government on a needs basis at different points in time. None possesses the number of qualified pharmaceutical staff, forecasting, procurement and distribution infrastructure, or push and pull information to scale up the programme on its own; but each has developed dependable innovations. The country has agreed to strengthen PSM coordination under the Ministry of Health and consider a joint PSM strengthening plan. In addition, these issues will be addressed under the HSS grant, in collaboration with other partners.  Health Financing  More than 90% of the HIV response is funded by development partners, mainly the United States Government and the Global Fund to fight AIDS, Tuberculosis and Malaria. Still, South Sudan has one of the most underfunded HIV programs in the developing world. The government budget allocated to the health sector in 2011/2012 was 2.6% of the total.[[59]](#footnote-59) However, actual public expenditure on the HIV Programme was 6.5% in 2010/2011, increasing to 8% in 2011/2012.[[60]](#footnote-60) A previously approved parliamentary motion doubling HIV Program allocations from 15 to 35 Million South Sudanese pounds has been undermined by conflict and the humanitarian crisis, which have slowed funds flow to all sectors including health. Less than 30% of required funding for humanitarian issues had been pledged by April 2014. HIV is currently competing for funding with food, security and other critical budget items. Section 9.3 of the NSP 2013-2017, (Annex 5, page 116) recommends a few efficiency and sustainability strategies to be adopted during service delivery, while pages 104 and 105 outlines macroeconomic and political risk management measures to be taken at this time when the HIV program is faced with financing, oversight, sustainability, political and macroeconomic challenges.  Table: Partner Financing to South Sudan’s Health System   |  |  |  | | --- | --- | --- | | Partner | Health System Area Supported[[61]](#footnote-61) | | | US Govt. (PEPFAR)[[62]](#footnote-62) | Health Information Systems: In collaboration with Government of South Sudan, the US Government (PEPFAR) currently funds part of the Health Management Information System, and the generation of strategic information. USG also partly funds; supportive supervision and data quality assessments in states, countries and facilities. | | Global Fund Round 9 | Human Resources and Infrastructure: 3 teaching institutions renovated and equipped some institutions and supported the MOH in selection of students. In addition, it recruited 8 international tutors for the training institutes; Renovated and equipped one warehouse in Juba, and additional warehouse will be renovated and equipped in Juba.  PSM: Trained 145 health workers for 3 days each on pharmaceutical management; Procured and installed 6 pharmaceutical waste incinerators in state hospitals; 84 waste collection boxes for distribution and conducted training in Logistical Management Information Systems (LMIS)  HIS: 20,000 HMIS tools printed and distributed; 175 national, state and county and facility M&E focal persons trained on use of HMIS tools; 8 State M&E offices strengthened through renovation; IT equipment, furniture and support provided.  Service Delivery/ HR: Trained 579 Health workers and auxiliary staff in health facilities on universal precautions; 387 health workers trained on MNCH and PMTCT for 30 days; 15 ANC clinics and 5 maternity wards were renovated and equipped, and four community resource structures rehabilitated and supported. | | World Bank | The World Bank funded Interfaith Medical Assistants (IMA) to roll out DHIS up to the CHD levels; trained M&E/ Surveillance officers; provided two laptops per county; seconded two M&E officers to MOH. It also funded Liverpool Associates in Tropical Health (LATH) to conduct health facility survey; carry out HIS review meetings, review support Supervision tools and conducting LOT Quality Assurance Sampling (LQAS) | | GAVI  Grant to World Health Organization and UNICEF | Training of state Directors General on leadership, governance and management and county health management teams on the Basic Package of Health and Nutritional Services (BPHNS)[[63]](#footnote-63) the district and health team on leadership modules; printed IEC materials for the campaign for children and mothers’ health; Production and publishing of the Health Sector Development Plan (HSDP) and BPHNS; renovation of the national vaccine store and cold rooms; provision of motorboats and motorcycles to support EPI activities in states; and provision of cold chain equipment (Refrigerator and cold boxes, among others) | | Health Pooled Fund (HPF) | Conducted Health Systems Assessment in six states, identified gaps and developed a work plan. The HPF has also co-funded a leadership management program design, beginning with joint planning exercise including 39 County Health Departments (CHDs), implementing partners and other NGOs. It has also supported aspects of the PSM system for drugs in 39 counties. | | Abt Associates | Supported Very Small Aperture Technology (VSAT ), a two-way satellite communication system for Internet Connectivity; HMIS/ DHIS training to County Health Department M&E Focal Persons; Supportive supervision to County Health Departments and health facilities, among others. | | Intra Health International | Supported MOH in HIV/AIDS data management and development of earlier version of National Strategic Plan; Supported MOH in reviewing HIV/AIDS tools; Seconded one staff to MOH, based at HIV department and provided other operational support to MOH. | | UNAIDS | Supported the development of National Strategy Documents including the updated NSP, and generation of strategic information; as well as leadership of the HIV program, and collaboration with the humanitarian / peace and security program, as well as among development partners in health. |   Leadership and Governance  The government has led the development of the South Sudan Development Plan (SSDP), Health Sector Development Plan (HSDP) 2012 -2016 and health sector financing strategy, in collaboration with various partners. These provide a basis for additionality and alignment of partner support to the health sector and HIV response. However, the country faces challenges in leadership and governance of the health sector and national response, including shortage of skilled management and administrative staff at all levels; Lack of tools, guidelines and procedures for health planning and management; Lack of laws, policies and regulations- resulting sub-standard services and weak coordination between the three levels – national, state and county- severely impaired by poor planning, lack of guidelines, poor communication, irregular reporting and non-functioning stakeholder coordination mechanisms especially at the community level. Effective scale up requires a strengthening of the health system, the community system and their coordination. Module 7 in Section 3.2 of this document highlights various interventions and activities for improving health sector, including HIV Program leadership and governance. Community Systems Strengthening Needs Community systems assessments[[64]](#footnote-64) and country dialogue have illustrated technical capacity, institutional gaps and other weaknesses within the community system. These included inadequate funding, gaps in Human Resources for Health, and governance issues, among others. Strengthening these systems to promote health seeking behaviour and HIV service and commodity delivery will undoubtedly be required prior to acceleration of scale up for HTC and ART services, which are key to meeting the NSP 2013-2017 goals. Again key populations and Populations of Humanitarian Concern cannot all be reached effectively by government due to structural and other reasons, including lack of data, inadequate technical capacity, criminalization, lack of legal mandate, and fear of stigma or arrest.[[65]](#footnote-65) These key populations include Sex Workers, MSM, and some Populations of Humanitarian Concern within the conflict areas. Community service delivery, capacity building, provision of resources, improving community networks, linkages, partnerships and coordination with government, advocacy, leadership strengthening and creating linkages between a CHIS and HMIS are a few of the areas prioritized for strengthening. This Concept Note plans training for 750 Community Health Workers already enrolled under the malaria programme, in HTC, adherence and treatment literacy, as well as TB case management at community level, and referral. These community health workers will be linked to the community and supervisory systems of the health sector, and knowledge generated will be shared at the HIV partnership fora and heath fora to help improve on the program design, as well as facilities and communities supported by the Heath Pooled Fund (HPF) to optimize service delivery, especially in states supported by HPF partners, USG and this grant, such as Eastern Equatoria. [[66]](#footnote-66) [[67]](#footnote-67) Non- Governmental Organizations play an important role in South Sudan’s health system, and a mapping of health cluster partners by WHO (Annex 61, pp.1-3) has highlighted current engagements by more than 50 civil society partners in various aspects of the health system. Section 3.2 of this document envisages continued engagement and institutional strengthening of NGOs and Community Based Organizations to provide between 25% and 40% of planned interventions, through service delivery, supervision, referral, mapping of key populations, monitoring, ensuring accountability, and other roles. |

Figure: Map of POCs and summary of Humanitarian Situation in South Sudan (Source: OCHA, July 2014, Red circle denotes high HIV prevalence area)



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| 1.2 National Disease Strategic Plans |
| With clear references to the current national disease strategic plan(s) and supporting documentation (include the name of the document and specific page reference), briefly summarize:   1. The key goals, objectives and priority program areas. 2. Implementation to date, including the main outcomes and impact achieved. 3. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed. 4. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes. 5. For standard HIV or TB funding requests[[68]](#footnote-68), describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes. 6. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged. |
| a. Goals, Objectives, Priority Programs and Strategies of the Updated National HIV and AIDS Strategic Plan 2013-2017.  The South Sudan National HIV and AIDS Strategic Plan 2013 – 2017 has been revised based on new evidence from the modes of transmission study, JANS Review, a review by the Global Fund, humanitarian partners and the Global AIDS Response Program Report for South Sudan, among others. Section 4 of the NSP 2013-2017, pp.46-50 outlines the vision, goals, and overarching priorities for the national response. Desired strategic results and interventions (modules) are outlined from Sections 4-9, pages 46-109. Investment priorities have also referred to UNAIDS, Global Fund, WHO, PEPFAR and other partners’ Strategic Investment Frameworks, guidelines and information notes.[[69]](#footnote-69) [[70]](#footnote-70) [[71]](#footnote-71)  Vision  The NSP envisions the global HLM push towards Zero new Infections, Zero AIDS related deaths, and Zero Stigma and Discrimination, by 2030. It provides a roadmap towards achieving this vision by guiding the national response towards the point where the epidemic begins to reverse (“tipping the scale”) on new infections and AIDS related mortality by 2017.  National Strategic Plan Goals  The main goals of the NSP 2013-2017 are:   1. To reduce new HIV infections by 50% by 2017 (From 13000 in 2013 to 6500 by 2017) 2. To reduce mortality among men, women and children living with HIV by 50% by 2017 (From 13,000 to 6,500)   To reach the point where the epidemic begins to reverse, the NSP seeks to achieve a ratio where those newly placed on treatment exced the number of newly infected each year, from the current average of 20:1, (16,000: 800) or 2013 ratio of 4:1, through integrated combination prevention and rights based approaches implemented by a multiplicity of partners (Government, Development Partners, Civil Society, the Private sector and humanitarian implementers). These will be scaled up simultaenously at facility, community level and humanitarian spaces of work beginning with hotspots and spaces located in high prevalence states.  Impact Results for Proposed Funding (2015-2017)  To reduce new HIV infections by 50% by 2017 (From 13000 in 2013 to 6500 by 2017)  To reduce mortality among men, women and children living with HIV by 30%? by 2017 (From 13,000 to ?)  However, due to funding and feasibility constraints, the allocated funding proposed in this Concept Note is only able to attain the above proportion of the national impact results.  Program Areas and Strategic Results  The NSP 2013-2017 seeks to scale up through three main program areas:   * Prevention of new HIV Infections * HIV Treatment, Care, Support and Socio-economic Impact Mitigation * Enabling Environment: Improving the legal and policy framework; strengthening PSM systems, resource mobilisation and financing; management and leadership; coordination and partnerships; accountability and; generation, management and utilisation of strategic information for the national response.   The following page summarizes results based strategies that are the focus of this concept note from those presented in the NSP 2013-2017, Sections 4-9, pages 46-109.  Priorities:  To achieve the above goals, the NSP is prioritized through four main dimensions:   1. High impact interventions: Core program: High Impact Interventions in the NSP: Prevention interventions for key populations; Elimination of Mother to Child Transmission; Antiretroviral Therapy; Behavior Change Communication; and Voluntary Medical Male Circumcision (VMMC – which has never been rolled out officially);   Enablers:  HIV Testing and Counseling as a gateway to scaling up the response;  Community Systems Strengthening (M&E, Advocacy, Demand creation and adherence support)  and Health Systems Strengthening(PSM, HR, Information System) ; and  Stigma reduction.   1. Prioritization of key populations based on evidence of sources, risk, drivers of the epidemic and coverage gaps: sex workers & clients especially uniformed groups and boda boda riders, MSMs; and of vulnerable populations such as Populations of Humanitarian Concern (Refugees and IDPs), women and girls, young people , PLHIV/ TB due to low coverage, and especially those PLHIV on ART waiting lists (who number over 17,000) 2. Prioritization of geographic locations such as high prevalence states and sites, hotspots, and targeting based on prevalence, incidence, coverage (or lack thereof) and determinants of transmission in specific areas:  * Greater Equatoria region (the three equatorial states) due to high numbers of PLHIV and key populations, incidence, significantly high proportion of population not covered by ART; and presence of hotspots, transport corridor and trade centers with high numbers of key affected populations, economies of scale and cost-effectiveness of HTC and eMTCT. * Humanitarian settlements – due to high population density and transmission factors; Gender factors, GBV and potential operational efficiency and service integration; economies of scale and scope (potential for service integration and efficiency due to low transport costs) * Hotspots: HIV epidemic in South Sudan is concentrated along transport corridors, cross border points and trading centers. The prevalence tends to reduce as distance from the transport network reduces. * Other areas - low knowledge and low access to services  1. Humanitarian settlements/ Protection of Civilian Sites /spaces of work for Internally Displaced Persons, refugees, vulnerable returnees; populations facing human rights violations including gender based and systemic barriers to service delivery and commodity access including those living far from hospitals, the marginalized and persons with disabilities.   b. Main Implementation Outcomes  Prevention of New HIV Infections  Outcome 1: Reduction of risky sexual behaviour with special focus on key populations at higher risk. Within the general population, it will focus on coupes in polygamous relationships and populations of humanitarian concern :  This outcome integrates a package of combined prevention interventions with HTC as a gateway to the national treatment and prevention with positives program :   * Providing HTC to targeted populations (FSW, uniformed forces, business community, youth, communities living around hotspots), and * Scale up of Provider Initiated Testing and Counseling * Peer led BCC/ presentation package for Key population (FSW) including condom promotion with compatible lubricants * Couple testing and counseling aimed at people in polygamous relationships) * Identification of MSM through FSW and other identifiable networks coupled with provision on HTC * Integrating PITC, community based HTC and HIV prevention packages into GBV, TB/HIV, VMMC, STI, with RMNCH, Condoms and compatible lubricants, management of TB and viral hepatitis and pre and post exposure prophylaxis – during health and community based worker training, service delivery and reporting.   Informed by evidence from the MoT (2013), this outcome focuses on a prevention package for three major population groups:   * Key Populations, * Vulnerable Populations (prioritizing prevention among polygamous / discordant couples and youth engaged in casual relationships) * Populations of Humanitarian Concern.   The objective is to provide a peer-led prevention package for Key Populations, within the general population and for populations of humanitarian concern, which also includes eMTCT under prong three and gaps in the other prongs within humanitarian spaces of work and hotspots. Other prevention interventions prescribed by this outcome include: Voluntary Medical Male Circumcision (VMMC) which are just beginning in South Sudan; and Condom Distribution under a scaled up program for behavior change.  Outcome 2: Reduction of Mother to Child Transmission  The second National Strategic Plan outcome seeks to reduce Mother to Child transmission through the four prongs, by 2017. The concept note will target a proportion of national strategic plan targets, to decrease MTCT from (29%) currently to less than 5% by 2017. Primary prevention (prong 1) is addressed in outcome 1 above, while family planning (prong 2) is funded by other partners such as UNFPA, and the Health Pooled Fund. Support from the Global Fund will cover Early Infant Diagnosis (EID) and follow up through final status (prong 3), and ongoing care and treatment (prong 4). The National Strategic Plan seeks to reach 87% (approximately) 90% coverage (comprising 7600) women by 2017. This seemingly high target has been interrogated severally. Currently, 42% of the target is being funded by other donors, and Global Fund allocation support will enable an increase by 34% number of HIV-infected pregnant women receiving ARVs for PMTCT from 717 in 2012 to 3000 women by 2017 ( 34% of national target, raising the total coverage by Global Fund, USG and other partners to 76%). In addition, funding will enable strengthening and integrating Early Infant Diagnosis of HIV in all PMTCT sites by 2017 and to establish linkages between RMNCH, SRH, PMTCT, HCT, immunization and ANC. Besides contributing to an over 60% reduction in new infections by 2017, the following outcomes are expected from the Global Fund grant:  1. Enable the country transit into Option B+ and Strengthen EID. 2. Community mobilization and couple testing 3. Program quality improvement 4. Strengthening referral and integrating PMTCT with other interventions   HIV Treatment, Care, Support and Socio-economic Impact Mitigation  Outcome 4: Proportion of PLHIV on ART increased from 6,500 (2012, being 5% (adults) and 240 (3%, children) to 35% (65,000) by 2017 (under review)  Out of this national target, the funding allocated seeks to cover 35,637 individuals by 2017. (Figures for adults and children  Outcome 6: Strengthened Peer Group Support for prevention and treatment and improved access of people infected and affected by HIV to in-come generating activities  Enabling Environment  The below outcomes, related strategies, interventions and activities are comprehensively justified and described in section 7 of the National Strategic Plan 2013-2017, pp. 92-105.  Outcome 7: Improved policy environment for an effective national response to HIV epidemic  Outcome 8: Funding gap for HIV/AIDS response reduced by 85% by 2017  Outcome 9: *A*ll individuals in need of quality HIV and AIDS prevention, treatment and care commodities have timely and continuous access  Outcome 10: Functional coordination structures and improved leadership commitment at national, state and county levels  Outcome 11: Effective programme and financial accountability for HIV/AIDS interventions  Outcome 12: Increased generation and utilization of Strategic Information for policy formulation, planning and management of the HIV response in South Sudan.  Outcome 13: Community Systems Strengthening  Six prioritized interventions discussed at length and found to be fundamental to the achievement and consolidation of impact within the HIV disease program are described on section 3.2 of this concept note, while others that contribute to impact beyond the HIV program have been summarized on the HSS concept note. The important outcomes 9, 10 and 12, along with the HSDP 2012-2016, therefore form the basis for the HSS Concept, while a few critical but HIV program specific activities have been included in section 3.2 of this concept note.  b. Summary of the response to date (Main outcomes and impact):  National Strategic Plan 2013-2017, (Annex 5, Section 3.9, pages 33-42) elaborates on outcomes and impact to date, while the Global AIDS Response Program Report for South Sudan 2013, (Annex 6. pages 33-64) provides an in-depth review of progress in reaching targets set out in the previous NSP, most of which act as a baseline for the new plan period. It would be prudent to review previous results for the South Sudanese response against the challenging political, humanitarian and health systems context. The country is only three years old, and at independence, inherited a previously marginalized and underdeveloped health system. Service delivery and commodity distribution are performed under a difficult macroeconomic, political, security and humanitarian context. Some of the remarkable achievements include the establishment of a coordinated, coherent, and decentralized National HIV and AIDS Response informed by evidence; increasing ART coverage, and reduction in mother to child transmission. However, the response in South Sudan has been severely underfunded, and challenging, hence the mixed results when progress is reviewed against some NSP outcomes and HLM commitments. For instance, AIDS-related mortality, at 13,000 is still remarkably high, nearly a 1:1 ratio with new adult infections. A few impact and outcome results are summarized below :  Summary of progress on impact and key outcomes (GARPR, 2013)   |  |  |  |  |  | | --- | --- | --- | --- | --- | | TARGET / INDICATOR | 2011 | 2012 | 2013 | Progress | |  |  |  |  |  | | Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015 |  |  |  |  | | 1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | 7.30% | 11% |  | ·Scaled up targeted community awareness activities in schools  ·Awareness on uptake of HIV Counseling and testing services; Training of peers educators on BCC activities; Free condom distribution activities being scaled up (2,613,592 in 2011, 2,848,104 in 2012 and 1,584,976 in 2013 ) | | 1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 | 31% w 41% m | 23.3% w 29% m |  |  | | 1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months | 7.96% m | 6.8% w 27% m |  | Risk perception in general population is poor. Response to continue focus on BCC , youth engaged in casual sex and stable polygamous re relationships | | 1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse |  | 2.6% w 7.4% m |  |  | | 1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results | 28.70% | 41% |  |  | | 1.6 Percentage of young people aged 15-24 who are living with HIV | 3.05% | 12% |  |  | | 1.7 Percentage of sex-workers reached with HIV prevention programmes  There is no data on the following (indicators 1.8-1.10) for sex workers on a national scale, which will be collected during grant implementation: condom use, testing among sex workers; and FSW prevalence. | 0.91% -2008 | no natl. data |  | Mapping & beh. Survey in over 1000 hotspots around high prevalence areas completed (PSI- Annex 17); WHO/ SSAC (2012) – estimate based on available funding shows about 5.7%; 25% for condom use in some localized studies, e.g. with military. | | 1.11 Percentage of men who have sex with men reached with HIV prevention programmes; data to be collected on this and indicators 1.12-.1.14 on MSM condom use, testing and prevalence | No data; to be collected |  |  | Huge % of men and women in gen. population engage in multiple, unprotected sex and have low knowledge of HIV transmission. | | Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths |  |  |  |  | | 3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission | 8.30% | 9.50% | 21% | •  PMTCT guidelines developed and validated •  PMTCT scale up plan developed •  Mentorship programme initiated •  Mother to mother support groups created | | 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth | No data | No data | 7.30% |  | | 3.3 Mother-to-child transmission of HIV (modelled) | 30% | 30% | 30% |  | | Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015 |  |  |  |  | | 4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy [[72]](#footnote-72) | 7% | 6.50% | 9.45%/ 4.52% | Retention of adults and children with HIV known to be on treatment after 12 months since initiation of ART has tremendously increased to 78.4% during the current reporting period from 62.5% in 2011 and 70.8% in 2012. | |  |  |  |  | The retention rate after 24 months and 60 months was 65.8% and 44.7% respectively. | | 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | 62.51% | 70.80% | 78.40% |  | | ·         24 months |  |  | 65.80% |  | | ·         60 months |  |  | 44.70% |  | | Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015 |  |  |  |  | | 5.1 Co-management of tuberculosis and HIV treatment (Global Fund RSQA 2013- Annex 36[[73]](#footnote-73) has found that TB and HIV collaborative services are functional) | 8.29% | 27.50% | 86.30% | Results for the current reporting period have been very impressive registering 86.3% at the end of the reporting period. | |  |  |  |  | Previous progress has been also progressively satisfactory. Reporting 8.29% in 2011 and 27.5% in 2012. | |  |  |  |  |  | | Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22–24 billion in low- and middle-income countries |  |  |  |  | | 6.1 AIDS spending | 6% | 10% |  | § NASA analysis indicates that domestic AIDS spending is wanting in spite of increasing from 6% in 2011 to 10% in 2012. | |  |  |  |  | § There exists a wide gap between domestic AIDS spending and total spending, a situation which may impede the mobilization of resources to the current NSP. | | Target 7: Eliminating gender inequalities |  |  |  |  | | 7.1 Prevalence rate of recent intimate partner violence | No data | No data | No data | § Gender and human rights sensitive programming and elimination of the Gender Based Violence (GBV) should address the vulnerability of women and other groups to HIV infection. | | Target 8: Eliminating stigma and discrimination |  |  |  |  | | 8.1 Discriminatory attitudes towards people living with HIV | No data | No data | No data | Conducted Stigma Index Survey 2012/2013– SSNEP/ Alliance. Follow up to complete this process required. | |  |  |  |  | § Training of Anti Stigma trainers (33)-22 Males and 11 Females – Alliance/SSAC 2013 | | Target 10: Strengthening HIV integration |  |  |  |  | | 10.2 External economic support to the poorest households who received external economic support in the past 3 months | No data | No data | No data | There is great need for the support of vulnerable and poor households in the country as reported in the SSHH surveys of 2006 and 2010. However, there is no evidence that much support is invested in these populations from either domestic or external sources. |   c. Summary of obstacles or limitations to the implementation of the NSP  Annex 6, Pages 33-64 of the Global AIDS Response Program Report for South Sudan (2013) detail in depth the obstacles and limitations to reaching targets set out in the previous NSP, most of which were inherited by the current NSP. In addition to the stated political, humanitarian, security, health system and macroeconomic challenges (World Bank Country Survey 2013 Annex 20, pp. 10-11), the previous response was planned against a background of unavailable evidence; hence a slight mismatch between the epidemic and response. Internal to the HIV program an analysis of the above documents emerges with the following cross-cutting challenges: inadequate funding; weak Health System (HIS, PSM, Human Resources); Weak Community System, the humanitarian crisis, poor infrastructure, high operational costs and a weak policy and legal environment are a few of the debilitating challenges facing the HIV program.  Where some NSP targets are ambitious given the current health system and scarcity of resources, this Concept Note helps to further prioritize the NSP, and targets populations key in incidence and mortality to begin registering positive results in the short to medium terms, and tip the epidemic by 2018.  d. Linkages between NSP and the national health strategy  Though the two national strategies were developed at slightly different periods, both are well aligned and use the same data to describe the HIV situation. The HSDP 2012-2016 elaborates the health sector interventions in the overall HIV response. Highlights HIV and AIDS as one of the priority diseases to tackle (cf 2.3.5, pg 6 of HSDP 2012-2016). The HSDP broadly summarizes the key health sector responses and expected results/outcomes. The HSDP mentions the health system as key area for strengthening in order to obtain appropriate health outcomes at programmatic level including HIV. HIV is included in objective one ‘To increase the utilisation and quality of health services’, with an outcome ‘HIV prevalence among 15-24 years old female population remains stable at 3% by 2015. Systems strengthening needs from the HIV program are also reflected in national plans, and the country dialogue process for PSM and HIC resolved to strengthen these systems under a joint plan under the aegis of the Ministry of Health.  e. Scope and status of ongoing TB/HIV collaborative activities  While TB and HIV collaborative activities occur in some locations and among some partners, formal collaboration is strengthening. The TB hotspots, TB case detection map will be superimposed on the HIV prevalence map to enable partners determine the direction of HIV program scale up. During disease program split discussions, $2 Million was taken from the HIV program allocation and allocated to the TB program. The following TB/HIV Collaborative activities are planned and costed under the TB Concept Note:   * + - * Initiate Early Antiretroviral Therapy (ART) For HIV Patients Co-Infected With TB. All TB patients testing HIV positive will be put on ART by establishing a referral system for these patients to the ART sites, and integrating ART in TB treatment sites, among other measures.       * Scaling up TB Screening Amongst PLHIV Through Intensified Case Finding; Screening and referral of PLHIV to TB diagnostic sites including diagnosis of (Multidrug Resistance) MDR TB.       * Scaling up Cotrimoxazole Prophylaxis Therapy (CPT) For HIV Positive TB Patients       * Intensify TB/HIV Case Finding among Population Of Humanitarian Concern especially the high risk and Hard To Reach Populations       * Strengthen the Surveillance, Monitoring & Evaluation System For both TB and HIV To ensure complimentarily       * Scale Up access To Quality Laboratory And Other Diagnostic Services For TB and HIV       * Promoting operational Research and Quality Assurance * Elaboration/details for TB/HIV collaborative activities are found in “Recommended strategic interventions for improved collaboration and coordination of TB and HIV service delivery – September 2014”   + - * Strengthen coordination between HIV and TB programmes through joint meetings, and integrated M&E at various service delivery levels     f. Review and Planning Cycle of NSP; Results of recent Program and JANS Review[[74]](#footnote-74) and how findings were used. The (GARPR, MOH and TWG Report);  This concept note is aligned to the current NSP, which runs from July 2013 to June 2018. Following the completion of the NSP, a Technical Review Panel was formed by the Country Coordinating Mechanism, including TB representatives and specialists from different HIV interventions, financing and management, and development partners. Facilitated by the UNAIDS Regional Support Team and Technical Support Facility, they were trained and facilitated to conduct a JANS Review, concurrent with a review by the Global Fund. Outcomes of the JANS Review (attached to this concept note) were used to strengthen the NSP further. Upon completion it was subjected to four stages of review towards further prioritization and experts in humanitarian, human rights, persons with disabilities, impact modeling, costing an others. The Global Fund team was also provided a final set of comments which were spread across both the NSP and Concept Note.[[75]](#footnote-75) |
| SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY |
| To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources which are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year. |

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| 2.1 Overall Funding Landscape for Upcoming Implementation Period |
| In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe:   1. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund). 2. How the proposed Global Fund investment has leveraged other donor resources. 3. For program areas that have significant funding gaps, planned actions to address these gaps. |
| 1. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).   According to the South Sudan NASA 2010/11 – 2011/12[[76]](#footnote-76), and the GARPR there are several sources of financing for HIV activities. These include the Government of South Sudan (GOSS), Government of United States (USG), Multi-Donor Trust Fund (MDTF), the Health Pooled Fund; GFATM and United Nations Agencies. However, the MDTF programme is closed[[77]](#footnote-77). Total expenditure in the various HIV and AIDS interventions was about US$ 28.71 million in 2011/12. USG (all the agencies) contributed the largest share (42.8%) of the total expenditure MDTF (21.4%), GFATM (13%), UN agencies (11.7%) and GOSS (8%). Overall, the financing of the HIV remains domain of international partners, accounting about 92% of the total expenditure.  Planning, coordination and programme management accounted for the largest share (52%) of the total expenditure in 2011/12. This was followed by prevention (29%), social protection (8.8%), and care and treatment (8.6%). The specifically identified interventions currently being financed in under prevention of new infections are communication for social and behavioural change, community mobilization, voluntary counseling and testing (VCT), risk-reduction for vulnerable and accessible populations, prevention – youth in school, prevention – youth out-of-school, prevention programmes for sex workers and their clients, prevention programmes in the workplace, public and commercial sector male condom provision, Prevention, diagnosis and treatment of sexually transmitted infections (STI), prevention of mother-to-child transmission (PMTCT), blood safety, and universal precautions. In the treatment, care and support pillar, and antiretroviral therapy, and home-based care. Other interventions include OVC, programme management and administration, human resources, social protection and services and enabling environment. The earlier NSP budget was generally not well aligned with evidence and this concept note, as well the updated NSP which it supports, have mobilized partners towards a more strategic and focused response to the evidence.  In this concept note, six service delivery and three program support modules have been prioritized. These include:  Module 1: Prevention for Sex Workers and their clients;  Module 2: Prevention for MSM  Module 3: PMTCT;  Module 4: Treatment, Care and Support  Module 5:Prevention programs for the general population (Young women and girls, discordan couples / polygamous and others.  Module 6: Prevention programs for Vulnerable Populations (Refugees and Internally Displaced Persons)  (Populations of Humanitarian Concern [POHC] and the general population [Module 7: CSS (Community Based Reporting and Accountability; Stigma Reduction  Module 8: Program Support (Including Grant Management)  Module 9: Strategic Information and M&E  Funding for these programme areas, less programme management and administrative costs, are summarized on the below table. The table shows that the estimate of available funds from sources (mainly the USG PEPFAR program) will not be adequate to finance each of the five priority modules identified in the country.  Condoms and Prong 2 of PMTCT are adequately funded. However, BCC, HTC, ART, STI treatment for key populations, the prevention package for key populations and all others proposed in section 3 of this concept note face significant funding gaps. Funders supporting specific interventions are indicated on the financial (Table 3) and programmatic gap analyses. (Table 2), annexed to this concept note. A financial gap analysis has been performed for each intervention and module (see Annex 1- Table 1, MS Excel Sheet on Financial Gap analysis and counterpart financing). Available funding over the 4 year period is approximately US$ 83 Million. Global Fund investment will therefore be significant in plugging this huge financing gap in the high impact modules. Priority program areas that are expected to be significantly funded hence not costed in the concept note include VMMC (United States Government, Ministry of Health) for the general population and PMTCT Prong 2 on avoidance of unintended pregnancies (UNFPA, MOH and Health Pooled Fund for family planning). However there will be need to fund the development of normative documents to guide the scale up of VMMC services, especially for clients of sex workers and the general population. Besides Hepatitis B management for key populations, most other STIs have been funded by other partners, including government. The table on section 2b further below provides sources of leveraged funding.  The below table provides a summary of funding amounts available and projected for each module through 2017. Beyond 2015, GOSS, USG and other partners’ funding are estimated projections based on current support[[78]](#footnote-78) where the partner has not indicated a definite end date to funding.  Table: Availability of funds by program area and sources of funding   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Programme areas / Modules | Total cost (US$) for service delivery only based on NSP costing 2014-2017 per module | Funding available for service delivery only (programme administration and management excluded (US$) | | | | Sources | Financing gap 2014-17 (US$) | | 2014 | 2015 | 2016 | 2017 |  |  | | PMTCT (HTC, ARV, SRH, EID) | 12,910,041 | 1,506,704 | 2,268,142 | 2,268,142 | 2,268,142 | USG -PEPFAR | 4,598,911 | | FSW (BCC, HTC, STI, GBV, condoms, SRH, SGBV) | 5,584,513 | 586,191 | 299,476 | 299,476 | 299,476 | USG -PEPFAR | 4,099,894 | | Other Key populations (BCC, HTC, STI, GBV, condoms, SRH, MC) | 10,211,480 | 1,306,391 | 571,571 | 571,571 | 571,571 | USG -PEPFAR | 7,190,376 | | General population (BCC, HTC, STI, GBV, condoms, SRH, MC) | 47,297,279 | 2,196,404 | 3,727,854 | 2,789,610 | 3,339,220 | USG -PEPFAR, UNPFA, GOSS | 28,990,487 | | 371,419 | 371,419 | 459,486 | 459,486 | UNPFA | | 1,065,374 | 1,118,642 | 1,174,575 | 1,233,303 | GOSS | | Treatment and care (Pre-ART, ART, TB/HIV, lab, OI treatment, OI prophylaxis | 35,860,408 | 2,737,571 | 2,335,516 | 2,317,482 | 2,153,550 | USG -PEPFAR | 26,316,290 | | CSS (livelihood support, accountability and services) | 12,000,000 | - | - | - | - |  | 12,000,000 | | TOTALS | 123,863,722 | 9,770,053 | 10,692,620 | 9,880,342 | 10,324,748 |  | 83,195,959 |   It should be noted that data on programmatic coverage was scarce and cumbersome to disaggregate, since most partners including PEPFAR, World Bank and HPF rarely plan based on the numbers of intended beneficiaries (with the exception of ART, counselors to be trained, etc.). To generate financing gaps, the concept note relied on a mix of accounting and economic methods.   1. How the proposed Global Fund investment has leveraged other donor resources.   Partners in South Sudan have been providing selected services in various geographies, for example USG in the Equatoria region, and HPF in some designated states. However, funding has not been previously scaled up. Global Fund support will complement resources from other donors, especially PEPFAR, the HPF, World Bank, UN agencies, GOSS and civil society members of the health cluster, and others providing specialized HIV services. In addition, GOSS has during country dialogue for concept note development, committed to increasing its contribution to the HIV program. Existing systems and funding from development partners will be leveraged by Global Fund support to promote joint targeting of beneficiaries. The development of a resource mobilization strategy is planned. Partners will be requested to complement scale-up of high impact interventions, and integration at health facility and community level. The government is increasing commitment to the program.   |  |  |  | | --- | --- | --- | | Partner | Funding Areas Leveraged | NSP result area supported;  Funding Amounts, Geographical focus | |  |  |  | | The World Bank | The Multi-Donor Trust Fund managed by the World Bank (with contributions from more than 12 countries including the European Union) previously supported SSAC as the mandated coordinator of the national response. The MDTF supported SSAC’s infrastructure, activities, and some salaries. Most of the integration, reporting and policymaking will be undertaken through SSAC. The World Bank also supports interventions such as PMTCT. Global Fund support will be used to fill gaps in service delivery and numbers reached, as well as promote demand from the community level. |  | | The Health Pooled Fund (19 development partners supporting GOSS and county health departments | Areas to be partly supported through HPF which is set to lapse in December 2015 include training of counselors, some PMTCT prongs and numerous HSS activities. To illustrate, much of the PMTCT gap has been partially filled. The allocated funding from Global Fund will contribute to 32% of national PMTCT funding needs, which comprises the entire gap. | 39 Counties at Primary Health Care Centre Level (HTC, BCC, PMTCT, STI; Training in Warrap, NBEG, WBEG, EES, Lakes States. | | United States Government (USAID/ CDC[[79]](#footnote-79)/PEPFAR/DOD) | Global Fund support will complement USG support for HTC (including PITC) BCC, PMTCT, ARTs for about 10,000 individuals each year 2014 and 2015, Key Populations, HSS and civil society/ CSS, Strategic Information and some procurement, including condoms, test kits and others. Global Fund support will be used to close the HTC and PITC gap and well as the entire PMTCT gap. ART funding will complement Global Fund support, together targeting a total of 11,000 individuals on treatment in the 2014 fiscal year and 15,000 in 2015. It is projected that these funding levels will remain stable through 2017. Global Fund support will intensify prevention, treatment and adherence support in high prevalence/ priority areas. Similar complementarily to reach targets in specific areas is expected in other interventions including BCC and CSS. USG is also expected to benefit from Health Systems Strengthening, particularly Procurement and Supply Chain Management, Health workers and strengthened information system supported by the Global Fund, Plans are underway to develop a joint PSM plan, while the Strategic Information Plan[[80]](#footnote-80) has been reviewed for complementarity. | Support in high impact areas; USG currently covers between 4 and 6% of key populations in Eastern, Western and Central Equatoria in several regions. | | IGAD | Funding for POHC will complement regional IGAD group’s funding for cross-border and mobile populations and HIVAIDS related issues, as well as those of IOM and UNHCR. | Supports humanitarian partners and funds a portion of M&E and HSS activities. | | Humanitarian partners (UNHCR, IOM and others) | Humanitarian partners will provide services to between 10% and 15% of national targets. IOM provides emergency primary health care services, including curative and preventative consultations, EPI, Reproductive Health Care and health education. IOM has trained 30 counselors and is looking to train more. Global Fund will complement humanitarian partners’ efforts in the six priority areas. | Humanitarian partners assist in protection of civilian sites covering a population of about 1.5 Million around the conflict prone states and in the border areas. | | The United Nations system (UNICEF, WHO, UNFPA, UNAIDS, UNMISS, WFP, UNESCO, UNHCR, IOM and others): | Requested funding will leverage the UN system’s implementation, financial, technical and oversight support in areas such as policies and guideline formulation and implementation, scale-up, coverage of Populations of Humanitarian Concern, capacity building and resource mobilization. UNFPA will provide the total condom need of 110 M pieces including about 30 Million in 2016/17. Only specialized MSM and sex worker condoms and/ or compatible lubricants may need to be purchased through the Global Fund. | Spread out geographically; supporting small percentage of high impact targets; very strong institutional, governance, leadership, policy and technical support. | | Civil society in the health cluster[[81]](#footnote-81) | While few provide HIV prevention and care services, health cluster partners (mostly civil society) support the implementation environment and easily integrated services including: immunization, STI, TB treatment, prevention of SGBV, and primary health care/ community based services. These partnerships will be called upon to implement between 25% and 40% of the required target through community structures, and to reach key populations effectively. | Civil society partners support implementation and numerous raise between 5 – 10% counterpart financing to support activities in each state. However, many are yet to shift from humanitarian to devt. approach. | | The Government | GOSS will strengthen the health system, including human resources, policy leadership and coordination with partners/ civil society, health facilities to provide ART services in conjunction with HPF, the Global Fund, the World Bank and other partners. |  | | The Private Sector | Private sector support is still minimal (98% of national revenue is oil based, an export industry) and efforts will be made to train and accredit good service providers especially in HTC, and work with them to identify and reach risk groups (clients such as boda boda riders and truck drivers) within the transport corridor) and to provide condoms through the social marketing approach where applicable, as well as reach venue-based sex workers. |  |   USG will support a portion of targets for BCC, HTC/ PITC, key populations and condom distribution.  UNFPA will support up to 30 Million condoms in 2016 and 2017.  PEPFAR had planned through the transitional funding mechanism to support 10,000 patients on ART in 2 years 2014-2015. The plan is to transition these patients for Global Fund support because of the inability of partners to enroll new patients.   1. For program areas that have significant funding gaps, planned actions to address these gaps   Most donors highlighted in section 2.1 (b) above will be approached through a Development partners in Health Forum to consider increasing their contributions in line with the NSP scale up targets and funding gap. A resource mobilization plan is being drafted to draw support for priority areas with large gaps.  The three diseases will each contribute $2 Million from their allocated funding to strengthen the health system and allocate additional funds towards community support for health service delivery.  GOSS and the HPF will support significant portions of the health system, while a HSS/ CSS concept note accompanying this plan will be drafted to strengthen the system with a view to supporting scale up of the three disease programs. GOSS through Ministry of Health will also continue to support a portion of STI services.  UN agencies are expected to continue with the above support, while IOM, UNHCR, WFP and other humanitarian lead partners will support implementation within the humanitarian spaces of work, targeting IDPs and refugees.  The Health Pooled Fund will continue supporting aspects of HSS, including testing counselor training, facility level support, and some PMTCT prongs, among others.  The following section (3) outlines priority funding gaps to be filled with allocated funding, while section 4 outlines measures to address funding shortfall risks. |

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| 2.2 Counterpart Financing Requirements | | |
| Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.   1. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance. | | |
| Counterpart Financing Requirements | Compliant? | If not, provide a brief justification and planned actions |
| 1. Availability of reliable data to assess compliance | ☐ Yes | N/A |
| 1. Minimum threshold government contribution to disease program (low income-5%) | ☐ Yes  (10%)[[82]](#footnote-82), Table 1 | N/A |
| 1. Increasing government contribution to disease program | ☐Yes  (5% annual increase estimated across the health sector) | N/A |
| 1. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported. 2. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures. | | |
| 1. The total financial requirement for the South Sudan AIDS Strategic Plan 2013-17 is US$ 273 million during the five-year period of the strategy. The government fiscal years for which the funding request from the Global Fund will be applicable are 2014/15, 2015/16, 2016/17 and 2017/18. These years constitute the last four of the strategic plan. Total planned financial requirements in these four fiscal years will be US$ 242 million. Government intends to spend total of US$ 14 million within the period of the funding request, consisting US$ 2.5 million in 2014/15, US$ 2.8 million in 2015/16, US$ 2.9 million US$ 8 in 2016/17, and US$ 3.1 million in 2017/18. This translates to an average of about US$ 2.8 million annually in the four years. However, this amount will be geared towards programme administration and coordination in terms of support to SSAC, HIV Department in the Ministry of Health, SPLA secretariat, and workplace activities at government ministries and agencies/ secretariat including the Ministry of Interior and Wildlife Conservation HIV/AIDS secretariat.   While the country plans to institutionalize an expenditure tracking system, spending by government will be availed through the Ministry of Finance expenditure reporting in each of the years. The CCM is committed to endure that the expenditure data will be available. Additionally, NASA survey will be carried out in early 2016. This will provide government expenditure for the periods 2013/14 and 2014/15, which can be used to assess compliance. As shown in the financing gap analysis, government financial contribution to the HIV response will be increasing steadily over the period of funding. In terms of the overall health sector, the health strategy, government allocation to health shows an increasing trend in the period 2014 to 2017.  The total country’s allocation for the three years 2015, 2016, and 2017 is US$ 46 million, with an average of US$ 15.38 million. The South Sudan NASA placed government expenditure at about US$ 4 million in the period 2010/11 and 2011/12, with an average expenditure of US$ 2 million annually. Given government projected expenditure of US$2.5 million for HIV in the year 2014/16, the estimated average government expenditure in the HIV response in the last two years and the current year is about US$ 2.42 million. Considering the average amount of request of US$ 15.38 million from the Global Fund, counterpart financing is 14%, when existing funding and allocation are considered. This percentage is above the required 5% for South Sudan as a low income country. Additionally, counterpart financing based on Global Fund existing funding and total request (including above allocation funding) is 7%.  Willingness-to-pay  During the Global Fund review meeting on October 8, 2014, the government committed to fund an additional 5% of the health program. These funds, while not yet committed to any specific intervention, will be added to health systems strengthening efforts that support impact on the three diseases.   1. Data Reliability:   While most development partners use the economic costing method to determine coverage and unit costs based on the amount of funding available, the Global Fund relies on the accounting method which arrives at funding allocated based on the disease burden, number of people to be reached multiplied by unit costs. Data on programmatic coverage was scarce and cumbersome to disaggregate, since most partners including PEPFAR, World Bank and HPF rarely plan based on the numbers of intended beneficiaries (with the exception of ART, counselors to be trained, etc.). To generate financing gaps, the concept note mostly relied on unit costs from the NSP 2013-2017, rationalized with partner unit costs where these varied widely. Programme gaps in this case were reached through the economic costing method, by dividing total funding  Data collected is accurate to standard margins of error. USG figures beyond the actual expenditures and current financial year are projected estimates. All current financial year figures are actual commitments from GOSS and other partners. Future financial figures are estimates and are most reliable among partners such as the UN.  To correct for any eventualities, the estimates and commitments, until actually received should be considered as accounts receivable, and corrected once funds are actually received. | | |

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| SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND |
| This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems. It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs. |

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| 3.1 Programmatic Gap Analysis |
| A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant’s funding request.  Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant’s funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).  For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps. |
| *Please see Annex 2 on the Programmatic Gap Analysis (MS Excel Sheets) for gaps on the six modules.*  The annexes list: Total population in need; Country targets; Population already covered, and the source of funding; Expected gaps; and How Global Fund allocation and above support will address some of these gaps.  Community Systems Strengthening and Program Management are not service delivery modules. However, the interventions they comprise include:   * Social mobilization, building community linkages, collaboration and coordination * Community-based monitoring for accountability * Advocacy for social accountability * Institutional capacity building, planning and leadership development   Program Management will comprise:   * Grant management * Policy, planning, coordination and management * Routine reporting * Surveys * Analysis, review and transparency.   These are further described in section 3.2 below. |
| 3.2 Applicant Funding Request |
| Provide a strategic overview of the applicant’s funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact. |

The main goal of the national strategic response in South Sudan is to halve the number of new infections, while at the same time halving the number of deaths through accelerated ART scale up. However, the allocated funding in this request can only achieve a proportion of these results. This funding request proposes high impact interventions prioritized under four dimensions, but mainly for the populations considered at highest risk of infection. Evidence suggests that a ratio of at least 16000 net new HIV patients on treatment and reducing new infections below 13,000 will result in a programmatic tipping point of the epidemic in South Sudan. Given the current low scale of activities, level or underfunding, and the humanitarian crisis, a tipping point is possible if more funding is allocated by 2018. Furthermore, if targets are met, rudimentary modeling shows that it is possible to reduce new infections to Zero by 2026 onwards, through a mix of integrated, high impact combination prevention interventions which target sources of new infections directly (while utilizing the preventive combination of ART, BCC: Condom use, VMMC, eMTCT and others.)

General Assumptions:

Realistically, this accelerated scale up of high impact interventions is only achievable under certain assumptions:

* The health system, particularly the workforce, PSM and HIS are strengthened to a minimum acceptable staffing level.
* Service delivery is effectively integrated, and priority is given to increasing operational efficiency as prescribed in the NSP 2013-2017.
* Partners share targets across government and non government implementers, including at the community level
* Scale up begins from prioritized populations and geographical areas, including sex workers and their clients, MSM, populations of humanitarian concern (IDPs and Refugees), women and girls, and high yield populations for ART (TB patients, inpatients at health facilities, prisoners, women and girls, youth engaged in casual sex, partners in polygamous relationships and populations of humanitarian concern, and malnourished children.)
* Geographical priorities include hotspots around the transport corridor, Western Equatoria, Eastern Equatoria, Central Equatoria, Lakes States and areas inhabited by Populations of Humanitarian Concern.

Overall Scale Up Acceleration Model:

The appropriate model of acceleration is one that additionally considers the strengthening needs of health and community systems, within the broader context of South Sudan. The figure below presents the selected scenario for scaling up the response and beginning to tip the epidemic. Maintaining current investment levels equates to maintaining the status quo in terms of rate of increase for new infections and newly placed on treatment. Such scenarios can only worsen the epidemic in South Sudan and reach a tipping point only in 2023 despite opportunities to begin tipping the epidemic by 2018. By 2023 under current scenarios, nearly 60,000 more individuals will have been newly infected, while thousands will needlessly die. Later investments will then have a lower impact, and may prove less efficient or unsustainable. Apart from maintaining the status quo, another improbable scenario is one of immediate, accelerated scale up, since sustained results require an accompanying strengthening of the health and community system. The most realistic investment option is one where scale up begins in moderation, while the health and community system are strengthened, and rapidly begins to accelerate, and is targeted at specific activities, populations and geographies evidenced as key to the epidemic. In this scenario, the epidemic tips and begins to reverse by mid 2018.

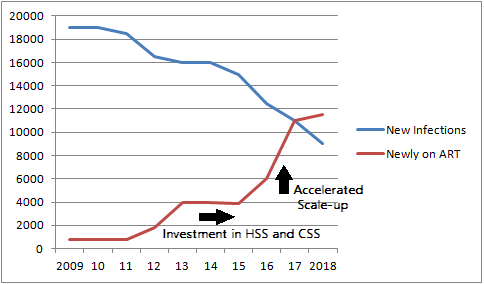
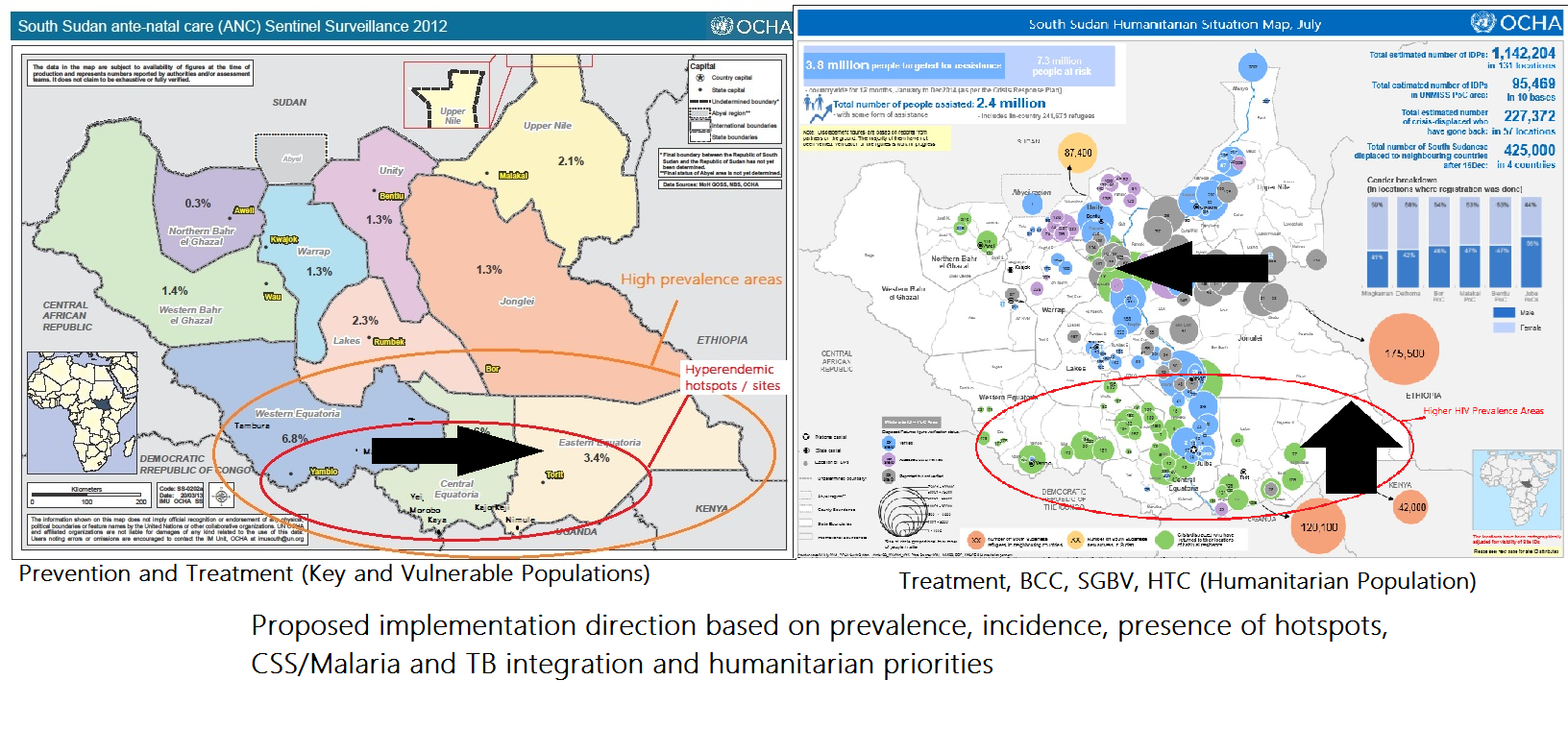


Figure: HIV Incidence versus ART (combination prevention) scenarios showing possible epidemic tipping points with rapid scale up, before and after HSS and CSS for South Sudan. (Source: NSP Modeling on current situation versus desired goals)The entire funding will be invested in high impact interventions accelerating progress in preventing the most deaths and new infections, across prioritized modules. It targets key and most-affected populations, and prioritizes highly endemic zones. The figures below show the proposed geographic scale up direction.



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| --- | --- | --- | --- | --- | --- | --- |
| Summary of Funding Request, Performance Framework and Rationale | | | | | | |
| Goals, Objectives, Outcomes, Modules and Indicators | | Funding ($ Millions) | | | | Rationale  Summary:  Revised and reprioritized NSP ; MoT – Matching Response to Epidemic Drivers; High impact interventions, targeted to relevant populations; Investment approach, Country  Dialogue and Equity Considerations;  Modules & interventions where significant gaps exist; Available budget ceiling versus NSP need; Need for acceleration versus grant performance  Risk management (humanitarian; political); Lessons learned from previous program and Global Fund grants. |
| Allocated | | Above Allocated | |
| National Strategic Plan (NSP) Goals: | |  | |  | |  |
|  | NSP Goal 1: To reduce new HIV infections by 50% by 2017 (From 16000 in 2013 to less than 8000 in 2017) | | | | | |
|  | NSP Goal 2: To reduce mortality among men, women and children living with HIV by 50% by 2017 (From 13,000 to 6,500) | | | | | |
| Objective 1: To intensify HIV prevention efforts across key populations, vulnerable populations and populations of humanitarian concern | | | | | | |
| Module 1: Prevention programs for sex workers and their clients | |  | |  | |  |
|  | National Strategic Plan (NSP) Outcome (1): To provide a combination prevention package for female sex workers |  | |  | | Female Sex Workers are the no. 1 driver of transmission (MoT 2013 p.xvi); and # 1 priority of the revised NSP; They are pivotal in about 63% of new infections annually; currently only about 5% of FSW are covered by the national HIV program. The modular impact is one of the highest, but there is need to match South Sudan’s response to the epidemic as guided by the revised National Strategic Plan. In addition, FSW are criminalized hence reaching them at scale effectively requires direct strategies through CSOs and indirect strategies through their core clients such as (boda boda) bicycle/ motorcycle riders and the SPLA/ military who have worked successfully with them on a lower scale. The allocated funding will reach of the sex worker population by year 3, while the above allocated funding should reach by the same year, with a WHO[[83]](#footnote-83) -recommended and nationally customized package of prevention, treatment and protection interventions. Modeled modular impact is very high; there is a likelihood of reducing incidence by between 15% and 30% with both allocated and above allocated funding. The AIDS program in South Sudan is grossly underfunded hence divided with a high number of patients on pre-ART care, PMTCT needs and others. Budget lines have been delineated between sex workers and their clients to ensure that the entire prescribed package is available for each FSW. Above allocated funding seeks to reach a further FSW in year 1 and by year 3 to enhance the probability of halving new infections nationally by 2018 and tipping the epidemic. |
|  | Outcome Indicator: HIV O-5: Percentage of sex workers reporting the use of a condom with their most recent client (disaggregated by sex male, female) |
|  | NSP Outcome 2: Reduce risky sexual behaviour with special focus on key populations at higher risk (Clients of Females Workers) |  | |  | | Clients of FSW constitute 50% of new infections; 94% gap in coverage exists for uniformed services, bodaboda riders/ traders. Involving uniformed services (who constitute 63% of clients and 35% new infections) is key immediate strategy for circumventing politico-legal barriers to reaching FSW and populations of humanitarian concern; partially manages risk in securing health delivery sites, and offers an avenue for logistical support in secure commodity delivery, besides promising high modeled impact. |
|  | Outcome indicator 2: HIV O-3: Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (disaggregated by 15-19 ; 20-24 years) |
| Module 2: Prevention among MSMs | | | | | | |
|  | Outcome indicator 3: HIV O-4a: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner |  | |  | | MSM constitute nearly 5% of new infections; are highly criminalized; need to stall epidemic among MSM- could be very high; no national program exists; need to map, survey and link to prevention and treatment. Currently, less than 100 are covered by the HIV program. Allocated funding seeks to nearly quadruple the number of MSMs reached by year 3 (from 54 currently to 200) with a package of interventions even as work on policy legal change is ongoing. |
| Module 3: Prevention of Mother to Child Transmission (PMTCT) | | | | | | |
|  | NSP Outcome: Reduced Mother to Child Transmission of HIV from 30% to less than 5% by 2017 |  | |  | | Annually 2,476 new infections are due to children born to HIV-infected mothers (UNAIDS Spectrum EPP Model); Less than 3% of children living with HIV are receiving treatment. PMTCT key in leveraging community support; allocated funding covers entire gap, but challenge is in integrating and promoting health-seeking behavior within community. |
|  | Outcome indicator: Percentage of infants born to HIV positive mothers who are HIV positive |
| Module 4: Prevention programs for other vulnerable populations (Young women and girls, TB infected, discordant couples, with focus on polygamous, and others) | | | | | | |
|  | NSP Outcome: Reduced risky sexual behavior among vulnerable populations (youth engaged in casual sex, stable polygamous partners, TB patients, women and girls.)  Outcome indicator: Percentage of men and women 15+ years with comprehensive and correct knowledge about HIV prevention |  |  | | Central, Eastern, and Western Equatoria, just three of the ten states, contribute 60% of new infections. There is very low knowledge of HIV (11%), while girls of some ages are nearly twice more likely to contract HIV than boys. This funding targets communities surrounding hotspots and , youth, engaged in casual sex, women and girls, as well as discordant (especially polygamous) couples in communities surrounding high prevalence sites, including persons living with disability among these groups. Interventions include BCC, PEP, prevention of syphilis and medico-legal linkages to address and prevent cultural practices which make individuals vulnerable to HIV such as substance abuse and GBV, and prevention of STI, implications on the health of the individual and treatment; Scarcity of funding has forced a huge trade off between epidemiological and humanitarian goals where the former wins; Political risk places huge proportion of program at risk; it is critical to engage humanitarian community in service delivery esp. in areas where govt. and opposition/ rebels do not access; Youth engaged in casual sex and polygamous relationships constitute 28% of new infections. | |
|  | Outcome indicator: Percentage of men and women 15+ years with comprehensive and correct knowledge about HIV prevention |  |  | |  | |
| Module 5: Prevention programs for other vulnerable populations (Populations of Humanitarian Concern- Refugees and IDPs) | | | | | | |
|  | Populations of Humanitarian Concern (Border areas around Equatoria; Jonglei, Upper Nile, Unity and Spaces of Work in high prevalence border areas and POC sites) |  |  | | Populations of humanitarian concern in the crisis areas are critical in South Sudan’s context, and comprise about 15% of the total. In times of peace, 20% of women have reported having been battered by their husbands, while in times of war, 40% of women report having faced some form of violence, including SGBV. There is difficulty in accessing services among the 1.5 Million refugees and IDPs, including in border areas and those around high prevalence sites. HIV infection has been recorded in some Protection of Civilian sites, while 1140 people have been lost to follow up from the crisis states. This module seeks to | |
| Objective 2: To increase access to and improve quality of HIV care and treatment as prevention and TB/HIV collaboration across key, general and humanitarian populations | | | | | | |
| Module 6: Treatment, Care and Support | | | | | | |
|  | NSP Outcome |  |  | | Module has highest potential for impact in terms of reduction in mortality and combination of above modules (which present high yield/ ‘low-hanging fruits' for the care and treatment program) with treatment compounds impact on disease. Allocation moves GF funding to about of target; and above allocation - Hence, for sustainability and feasibility (adherence, reach, retention) purposes, not all has been placed under allocation. | |
|  | Outcome indicator: HIV O-1: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (disaggregated by age <15, 15+, sex, with 24 and 36 month data) |  |  | |
| Objective 3: To create a sustainable, enabling environment for intensified HIV prevention, treatment, care and management | | | | | | |
| Module 7: Community Systems Strengthening | | | | | | |
|  | NSP Outcome |  |  | | According to NSP (Annex 5) accelerated scale up of high impact interventions is only achievable if community system (workforce, PSM and HIS are strengthened to a minimum acceptable level by Jan. 2016. | |
|  | Community Systems Strengthening : Outcome indicator: HSS O-1: Percentage of women attending antenatal care |
| Module 8: Program Management | | | | | | |
|  | Programme Management (National Leadership, Coordination and Reporting- South Sudan AIDS Commission and Partners) |  |  | | Due to perennial underfunding of the AIDS Response in South Sudan, and the recent civil war that has constrained government resources, funding for programme management and coordination has been reduced and is often paid late. One key success of the South Sudan program between 2007 and 2012 was the establishment of a single coordination mechanism (The South Sudan AIDS Commission.) However, the commission is now unable to keep much of its Managerial and Program Coordination Staff. This funding crisis is coming at a time when South Sudan’s response is being scaled up, hence in need of stronger coordination. The renewed response has alsoallocated funding to increasing prevention and treatment targets attained through community systems under the leadership of 60 PLHIV associations. These associations will need to be closely coordinated, trained, quality assured and able to report results, alongside other strategic information. Presently, the key PLHIV networks (SSNeP+ and PNEWU) are sparsely funded; hence a proportion of funding is sought to staff and strengthen their capacity. The change in the AIDS response and funding levels requires increased leadership and coordination below the national level, to address issues raised in the NSP, coordinate and increase achievements. | |
|  | Grant Management (PR and SR Costs) | 5.00 |  | | UNDP is a PR under additional safeguards policy; it charges a statutory 7% fee besides operational costs. At least 4 sub-recipients representing each core constituency will be selected. | |
| Module 9: Health information Systems and M&E | | | | | | |
|  | Surveys, analysis, review and transparency  Routine Reporting and HMIS |  |  | | This grant will contribute majorly to matching the response to the epidemic. There is need to increase generation and utilization of Strategic Information for policy formulation, planning & management of the HIV response in South Sudan. There is also need to address shortage of qualified personnel at all levels, and operationalize data collection and analysis. Again data is required on several key populations; and no AIDS Indicator survey has been conducted so far to scientifically establish HIV prevalence and behavioral related factors. The allocated funds will contribute between 5% and 60% of various studies ranging from Modes of Transmission Study, Behavioral Surveys, NASA (Financial Tracking), the AIDS Indicator Survey and MSM Mapping. Sub national level capacity to carry out routine HMIS will also be strengthened, and will be complemented by the HSS and other disease grants. | |
|  | Total | 36.5 |  | |  | |

Summary of Cross-cutting High- Impact and Enabling Interventions:

* HIV Testing and Counseling: As one of the main gateways to HIV treatment, behavior change and integration, HIV testing and counseling will be scaled up rapidly to reach about 2.1 Million individuals (additionally more than20%), based on an updated version of the HIV Testing and Counseling Guidelines[[84]](#footnote-84) across the prevention and treatment modules through the allocated funding.
* Antiretroviral Treatment and adherence support: For key populations (sex workers, their clients, MSM), expectant mothers living with HIV and similar discordant partners in stable polygamous relationships), as well as TB patients and in patients, treatment will be accelerated for all who test positive. Populations placed on treatment will be capacitated to lead prevention, stigma reduction and voluntary disclosure programs. Emerging evidence (UNDP, 2013[[85]](#footnote-85); UNAIDS 2012; WHO 2012) illustrates that this is more efficient; and that stigma reduction, the rate of educated disclosure, reduced transmission and increased demand for HIV (health) services are directly proportional.
* Behavior change communication will accompany all aspects of the prevention program. Behavior change and increased provision and use of condoms will be key messages for populations.
* Condom promotion will accompany behavior change communication to various degrees, customized for highly mobile and immobile populations.
* PMTCT & RMNCH linkages: PMTCT will as far as possible be integrated with RMNCH, TB and the ART program, beginning in hyper endemic sites and moving towards areas of lower prevalence.
* Programme Support; Community Systems strengthening; Rights based programmes, including stigma reduction and enabling access to services and commodities.
* Sexual and Gender Based Violence elimination: This will be targeted to populations of humanitarian concern and female sex workers will also emphasize prevention of SGBV, legal support and nutrition as part of adherence support and treatment efficacy.
* Voluntary Medical Male Circumcision: Following the formal rollout of the VMMC program (currently at strategic planning stage), advocacy and other support will be provided to ensure it is targeted to clients of sex workers, men in stable polygamous relationships and young men engaged in casual sex, in non-circumcising communities within the four highest prevalence states (WE, EE, CE and Lakes).

Normative/ Guidance Documents and Tools: The country has developed various strategies and has been engaged in updating them for each of the interventions above, including a scale up plan for ART and PMTCT, revised testing protocols, BCC strategies including for key populations; while Civil Society has developed toolkits for SGBV and Stigma Reduction, which will continue to be used and adopted nationally. Any documents requiring updating prior to scale up are mentioned and costed under each intervention.

General Implementation Approach and Geographical Targeting:

Harnessing impact, economies of scope and scale through efficient implementation and phasing: Implementation for key populations will begin in hotspots within Western Equatoria, followed by those in Eastern and Central Equatoria respectively. For the treatment program, a sizable population is already under the care/pre-ART program, and will be enrolled into ART. HTC and ART Services will be interlined through referral from community and linkages of PITC sites to ART sites. Service provision will begin with high yield sub populations or low hanging fruit”. These ‘Easier’ targets are found within high prevalence sites and populations, and can thereafter be reached by using the same services to extend to their clients and vulnerable populations in surrounding communities. Programs beginning in the southern part of the country will provide a largely similar package of interventions (with the exception of SGBV and STI, which is focused in sex workers, civilians in protected sites and PMTCT). The provision of varied interventions, to varied populations through one group of implementers will ensure economies of scope, while higher yield in these sites will ensure economies of scale (higher numbers reached by any group of implementers). Programs focused on Populations of Humanitarian Concern will emphasize tracing those lost to follow up, BCC, service demand creation, reduction of SGBV and stigma reduction. Protection of Civilian sites offers high population density within a small area, with low logistical costs. For example, the three refugee sites around the equatoria border with Kenya, Uganda and at the Jonglei border with Ethiopia (Gambela), offer within a few square kilometers, a population of over 300,000 that can be reached with minimal transport costs, with HTC, BCC, condoms and other combined services. Significantly low levels of HIV knowledge (11.5%) relative to the region justify increased investment in knowledge and awareness creation.

Integrating a common service delivery platform for all three diseases: A Rapid Service Quality Assurance by the Global Fund in 2013 found that TB / HIV collaborative activities were functional. Leveraging HSS Funding, the health sector partners now propose to integrate ART within 45 TB sites, for a total of more than 60 ART sites, up from the less than 20. This will enhance service provision for HIV, TB and Malaria. Service delivery integration will also occur through the antenatal care platform and PMTCT prongs. The integration of EID and RMNCH into the 79 and additional ANC sites will also see the concurrent and faster provision of malaria diagnostic and treatment services. The country is also moving towards strengthening integrated community case management. A key introduction will be the training of 750 out of the 1200 community health workers enrolled by the malaria program in HTC, Treatment Adherence and literacy by the HIV Program, and training in community case management and follow up by the TB program. While this may require transport and other low cost incentives for the additional work, they will vastly expand the HIV and TB implementation platform into the community and lead to the coverage necessary to halve morbidity and incidence.

Programmed Coordination: Coordination by SSAC, MOH, Civil Society leads and Development Partners in Health will be critical to ensuring that this coordination happens effectively. A set of activities, some of whose funding is requested here, has been described in the HSDP and NSP to ensure that the coordination is effective.

Implementation strategies for obtaining each desired result:

Coordination, strategic and implementation planning will require a participatory approach with partnership forums for dialogue held at national, state and county level; while provisioning targets to various stakeholders will be based on expert approaches, including targets setting based on implementer capacities vis-à-vis needs. Behavior change, stigma and discrimination reduction and other areas requiring community acceptance or culture change will rely on community participatory and educative strategies. Efforts to change policies and laws will require a mix of negotiation, educative and participatory strategies, such as advocacy, training policymakers on effects of key populations’ criminalization and the participation of actual enforcers such as police in direct contact with key populations. Changes in structures including civil society and SSAC institutional strengthening will employ directive and expert strategies including engagement of technical assistance and obtaining directives from senior levels of government or institutions. M&E and Strategic Information including gap analyses will require expert and participatory as well as educative approaches. Effectively reaching key populations considered illegal and TB-HIV collaboration will require negotiations, expert, directive and participatory approaches; while shifting of tasks and roles between various cadres, levels and individuals will require directive, participatory and educative approaches, including training on these new roles. These implementation strategies and the sustainability analysis (Annex 49), and cost-effectiveness analysis of previous implementation approaches in the NSP 2013-2017 (Annex 5, page 116) form the basis for the interventions and activities outlined in this section.

Please Note: With the exception of the PMTCT Module where the complete funding gap is filled, due to the significant gaps, above allocated funding is dedicated to increasing coverage to ensure more impact. Non priority items have been left out altogether during the nearly year-long planning process.

Table: PRIORITIZED IMPLEMENTATION CHART

|  |  |  |  |
| --- | --- | --- | --- |
| KEY | Priority: Phase 1  (Year 1-1.5) | Phase 2; Indicated interventions to be delivered during  Phase 1 | Non-priority, consider, during phase 2, with emerging data |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Targeted Numbers/ % by State (Where Applicable/ Available) | | | | | | | | | | |
|  | WE | EE | CE | WBG | NBG | Lakes | U.Nile | Jonglei | Warrap | Unity |
| Sex Workers | Venue based services in 6 key venues; hotspots in Juba, Nimule, Yei .Yambio, Maridi, Kaya and  other parts of transport corridor | | |  |  | Phase 2 |  |  |  |  |
| Sex Worker Clients &  Other key Populations | 40% |  |  | Policy | Policy, SGBV | Policy | SGBV | Policy | SGBV | Policy |
| PMTCT as per MOH (2014) Consolidated  ART Guidelines for Treatment and Prevention (Annex 55, Chapters 4, 6 and 7, and PMTCT guidelines/ scale up plan.) | Prongs 1, 3&4 | Prongs 1,  3&4 | Prongs 1,  3&4 | Integration SGBV & comm.. demand creation) | Integration SGBV & comm.. demand creation) | Prongs 1,  3&4 | ANC (HCT, Opt.B+, Integration & comm.. demand creation) | ANC (HCT, Opt.B+, Integration &demand creation) | ANC (HCT, Opt B+, Integration & comm.. demand creation) | ANC (HCT, Opt.B+, Integration & demand creation) |
| Services for POHC |  |  |  |  |  |  |  | 40%? |  |  |
| BCC for youth, women and girls, and Polygamous / discordant  couples, and high yield settings within general population (Based on an updated version of the BCC Strategy[[86]](#footnote-86)) |  |  |  | Knowledge | Knowledge |  | Knowledge | Knowledge | Knowledge | Knowledge |
| ART as per MOH (2014) Consolidated  ART Guidelines for Treatment and Prevention (Annex 55, Chapters 3-11) |  |  |  |  |  |  |  |  |  |  |
| HTC as per MOH (2014) Consolidated  ART Guidelines for Treatment and Prevention (Annex 55, Chapter 2) |  |  |  |  |  |  |  |  |  |  |
| CSS |  |  |  |  |  |  |  |  |  |  |
| Stigma reduction |  |  |  |  |  |  |  |  |  |  |
| VMMC (Planning, Advocacy and Linkages) |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- |
| Module 1a.: | Allocation $M | Above allocation $M |
| HIV Prevention for Sex Workers and Clients (Female SW) |  |  |
|  |  |  |

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| 3.3 Modular Template |
| Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:   1. Explain the rationale for the selection and prioritization of modules and interventions. 2. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount. |
| 1. Explain the rationale for the selection and prioritization of the modules and interventions for the allocated amount and the request above the allocated amount (for example, existing programmatic gaps, program effectiveness, etc.)   Rationale for the Prioritization Process:  The prioritization process began with country dialogue following a CCM meeting in February; and a review of the NSP 2013-2017 to include new evidence from MoT 2013, GARPR and epidemiological projections. The CCM outlined a few priorities. The Technical Working Group reviewed the roadmap and developed one that included review of NSP against the JANS Tool and new evidence. NSP was reviewed and updated. Prioritization was based on five issues:   * Programmatic: Prioritization of high impact interventions and associated target populations based on efficiency of approach in reducing mortality and new infections. Grounded on known scientific efficacy of combination prevention interventions, by each source of new infection. * Population: Targeting of key affected populations based on evidence of sources and drivers of the epidemic * Geographical: Targeting geographic locations based on prevalence, incidence, coverage (or lack thereof) in certain areas * Rights Based: Humanitarian considerations based on the high number of internally displaced persons, vulnerable returnees; and barriers to service delivery and commodity access. * Costs and funding gaps: Relative costs and funding gaps in the NSP: Amounts to allocate each module was rationalized against their relative costs and funding gaps in the NSP. Above indicative allocation considers feasibility/ funds utilization / burn rate within the time. (Overall expenditure for entire program (besides out of pocket) is $28 Million annually on average.   Steps in the Prioritization Process:   1. Prioritization based on high impact interventions: The Strategic Investment Framework and Successful Regional Strategies, UNAIDS, WHO, PEPFAR, guidelines used to focus only on high impact interventions:   Other guidance obtained from Global Fund information and guidance on Human rights, PEPFAR/CDC/WHO and UNAIDS Models as well as Revised National HIV and AIDS Strategic Plan   1. Evidence and guidance on sources of new infections and broad targets was obtained from the MoT 2013; Spectrum data (Annex 10) and EPP Projections; NASA (proportionate financing by area) and Rationalization during NSP review. 2. Current programmatic coverage, unmet need and initial gaps obtained from NSP, GARPR and primary sources including country dialogue to triangulate and fill information gaps 3. Prioritization at intervention level was guided by:   Previous research and efficiency/ sustainability analyses by Health Systems 2020; Country Dialogue within the NSP review and CN processes; MoT 2013; recommendations of GARPR 2013.   1. Regarding HSS and CSS:   At disease level prioritization of HSS issues to accompany the HIV concept note was guided by:   * How severely they constrain HIV program, * Their possible impact on the coverage and quality * The feasibility of scale scale-up. * Useful information sources included: HSDP; MoH Reviews, Country Dialogue, TWGs on CN, PSM, HMIS, and CSS.   Emerging priorities after these exercises were at least 65% in conformity with earlier CCM suggested priorities.  Section 4.2, pp. 52-56 of the NSP 2013-2017 further describes the NSP prioritization process.   1. Explain the expected impact and outcomes for the allocated amount and the request above the allocated amount. Describe how the impact and outcomes have been estimated, including the sources of data used and any modeling or survey results, and refer to available evidence of effectiveness. For the request above the allocated amount, highlight the additional gains expected and analyze the additional expected coverage and/or plans for scale-up.   Scenario modeling of impact:  Scenario modeling is ongoing to determine outcomes and impact and how much will be allocated above indicative funding. Current assumptions on efficacy used to model economies of scale and scope for the proposed interventions are:  ART -96% efficacy  PMTCT – 95% efficacy  Condoms – 95% efficacy x factor of efficacy/use and cost effectiveness  BCC service delivery modes dependent on informed targeting.  Efficacy of targeting key populations and geographies.  (References: CDC (Blandford), Stover (Futures) + Goals, and UNITAID models, World Bank./ UNFPA study on sex work and efficacy of programmes)  Questions guiding prioritization and scenario modeling   1. Basic Scenarios: 2. What combinations of the prioritized interventions ensure that South Sudan attains the impact targets fastest? i. Assuming HSS and CSS gaps have / have not been addressed (iii) Assuming that it takes at least 12 months to put in place a robust foundation for PSM, HIS, HR, Community Systems, etc.) prior to scale up? 3. Under scenarios I and iii, what proportion of the targets will have been met by June 2018?   2. Effectiveness and Reaching Tipping Point (Point of Epidemic Reversal)  a. Under each scenario above, when will the country reach the tipping point\* for the epidemic using a combination prevention approach (the point at which the ratio of number newly on treatment exceeds the number of new infections becomes )  b. Under the current (2013) scenario of 16,000 new infections reducing at the rate of 1500 a year, and 6900 on treatment with 800 newly placed on treatment each year, when will the country reach the tipping point and begin reversing the epidemic?  c. How much does the country save in terms of averted treatment needs savings (and DALYs saved if available)?  3. Efficiency gains: Impact & Economies of Scale versus Economies of Scope  a. Scale:   1. Which individual interventions (ART, eMTCT, Key Populations, BCC) would achieve the most impact when scaled up? 2. What is the impact expected from scaling up each of the interventions separately?   b. Scope:   1. Would the country achieve more impact on scaling up either ART (+ HTC) alone, or combining ART, eMTCT, and Key Population interventions and Condoms? 2. Which combination of 3 interventions would achieve the most impact in the South Sudan context? 3. In addition to the three interventions that generate the greatest impact, what interventions within 6 prioritized modules will also maximize impact? 4. What therefore is the optimal combination ratio for the interventions, if any?   Summary of the Country Dialogue Process for Prioritization  To ensure prioritization of goals, strategy, module to activities.   * CCM Meeting for Initial Prioritization, February 2014 * TWG HIV and TB Training, Roadmap and NSP JANS Review, Concept Note Mar 31- April 2 * Review of Modes of Transmission & Other Literature * Roadmap, issues reviewed with GF, early April * Detailed Roadmap approved by CCM April 24 * Dialogue with People Living with HIV on May 21, and continuously through October 2014 * Uniformed services on May 22 * Sex Workers (inc. representatives of MSM groups) on May 23 * Global targets validated by SSAC May, 2014 * Separate gap analysis meetings on May 28, 2014 * Civil Society Organizations on May 29. * Meeting with Private Sector on May 30 * Initial meeting with Government on June 5, 2014. * Meetings with groups Sex Workers, Uniformed Services, others in states between May 26 and June 17. * TWG meeting to review and pre-validate updated NSP priorities, June 20 * Strategic Information Plan Committee –May-June 2014 * Multisectoral committee updating PSM Plan – June 21, 2014 and thereafter * National Health Stakeholders’ Conference (Malaria, TB, HIV, DPH, States and others- June 26-27) * Separate Meetings with DPH (UNESCO, UNAIDS, USG, WHO, IOM, WFP, HPF)- May 14-October 9 * Discussions on Willingness to Pay initiated in June * Strategy meeting for uniformed services July 3&4 2014 * July 7 Meeting with GF & LFA Team (Later: First Reviews of NSP/CN) * Harmonization Meeting with TB TWG and Partners (HPF) , August 11 * August Meeting with GF inc. LFA Team & * Sept.4,6 &11 TWG Meeting * UNAIDS Regional Support Team Mock Review, September 24- 26, received October 5 * HSS Review Meeting October 3 * Global Fund Review Meeting October 7-8 |

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| 3.4 Focus on Key Populations and/or Highest-impact Interventions |
| This question is not applicable for low-income countries. |
| Describe whether the focus of the funding request meets the Global Fund’s Eligibility and Counterpart Financing Policy requirements as listed below:   1. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions. 2. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions. |
| Not applicable for South Sudan, a low income economy. However, close to 75% of the budget is focused on key and underserved populations.  However, despite comprising only 5% of the total national population, key populations (sex workers and their clients) have received 43% of the prevention budget, and will comprise 60% of people on treatment, hence a similar proportion of the treatment budget.  In total, the budget ascribed to prevention and treatment for key populations is 41%, while that for vulnerable populations is 31%. |

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| SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT |
| 4.1 Overview of Implementation Arrangements |
| Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:   1. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s). 2. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients. 3. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified. 4. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients. 5. How representatives of women’s organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request. |
| Overview of proposed implementation arrangements:  Contributions by the Global Fund to the national HIV program will be managed by a Principal Recipient, currently the United Nations Development Program (UNDP), while implementation will be managed through a matrix (as opposed to a functional) implementation management model as shown on the above diagram. Implementation scale-up will begin in hotspots inside prioritized locations, first intervening with prioritized populations (key and vulnerable populations) and spreading to lower prevalence areas and the general population. Prioritized locations include areas of high TB detection within the equatorial states and settlements/ spaces for IDPs and refugees.  While some NSP targets are low, others are reasonably ambitious. Based on average allocation of the $46 Million allocated to each of the NSP priority areas and the portion of programmatic targets it is expected to meet, the Global Fund grant will contribute to meeting about 35% of national targets, which is a significant amount. However, given the weak health and community system, and coverage of only 40% of the health system, no single partner can deliver the targets alone. The IDPs and refugee population is between 10 and 15%, and cannot be reached through the formal health and community systems, hence are best reached by humanitarian partners.   1. Figure: Flow of Funds and Commodities versus reporting, oversight, national coordination and technical support     Government Sub Recipients and government run facilities will be apportioned between 30% to 40% of the targets commensurate with health sector coverage (44%). Still, only 2% of facilities provide ARTs, and this is expected to increase massively. A key government strategy will be to integrate HIV services into the general health sector and interventions such as TB, RMNCH and the humanitarian program such that ART and HTC indicators *seek to* achieve parity with, *or surpass* immunization indicators, while facilities with the capacity to offer ART increase to more than 200 within the first year of funding.  Civil society and the community will be apportioned between 20% and 40% of the targets (including general and criminalized key populations);  Development partners including donors and their partnering implementers will be apportioned between 10% and 30% of the targets (including general and key populations).  Humanitarian partners working with IDPs, refugees and the malnourished will initially be allocated between 10% and 25% of the NSP targets.  Besides multi-sectoral clustering, some partners have been apportioned certain geographies to implement specific interventions. Implementation of high impact integrated strategies in this plan is therefore proposed to be managed under a well coordinated matrix structure where health and community systems (HR, information systems, infrastructure and equipment, financing, procurement and supply management systems, referral, management structures, and community systems) are shared across the platform by all stakeholders.  This implementation management structure emphasizes beneficiaries and enables sharing of technical support across the entire health sector. The holistic matrix model will also enable continuity towards universal targets and during situations of conflict. Management of implementation in this manner will also enable a more rapid achievement of targets, flexibility and efficient utilization of resources. However, the design requires efficient co-ordination and well delegated division of authority and responsibility across clusters.  Reports will be collected and analyzed from beneficiary level by SRs and consolidated at PR level. The PR will then report to the CCM on main indicators and share these reports with the SSAC national HIV advisory committee, who will review and consolidate a national report in collaboration with MoH and other partners. SRs will coordinate with members of the same output cluster and a lead SR will be nominated for each constituency. SRs will also encourage beneficiaries to participate in output clusters with a view to sharing experiences, technical support, and health system inputs outside of the Global Fund supported program. SRs will also participate in clusters and working groups.   1. Reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement: South Sudan remained under the Global Fund’s Additional Safeguards Policy (ASP), following independence in 2011. United Nations Development Program was the PR for previous Global Fund grants (Rounds 4, 5, 7 and the TFM). Under the ASP, UNDP was nominated by the Global Fund, and it works under the general guidance of the CCM. The PR is responsible for programme management, financial accountability, procurement of goods & services and Monitoring and Evaluation. To avoid disruption, it is anticipated that some current institutional arrangement will continue during the life of the grant. However, given the worsening humanitarian situation and new evidence (MOT 2013, Spectrum (Annex 10) Projections, and surveys) showing that incidence is now mainly driven by key populations such as Female Sex Workers and their clients; that a majority of the population is affected by the humanitarian crisis and that about 10% of the population are either IDPs and Refugees; and that women are twice as likely than men to get infected, there is strong justification for additional sub recipients to represent the key clusters of vulnerable populations; financing for greater gender responsiveness responses; and better geographical prioritization. Currently, government and national civil society institutions require further capacity building, while the health sector only covers about 40% of the population. New implementation structures should focus on strengthening technical and institutional capacity to meet or surpass Global Fund standards 2. Only one Principal Recipient has been designated currently under the Global Fund’s Additional Safeguards Policy, hence coordination between PRs has not been discussed. 3. Type of sub-recipient management arrangements likely to be put into place and whether sub-recipient(s) have been identified:   Sub recipients will be identified during the grant-making stage, using the criteria described in this section. The following Sub-recipients (SRs) were involved in implementation of Round 4 of the GF Grant for HIV and AIDS: UNICEF; WHO; South Sudan AIDS Commission SSAC); Community and Public Health Directorate; Catholic Diocese Torit (CDOT) and Ministry of Health (MOH-GOSS) respectively. Given that the country has decided to massively scale up the HIV and AIDS programmes through active involvement of civil society organizations and mainly community health systems (to achieving national commitment towards Zero new Infections, Zero HIV-related deaths, and Zero stigma and discrimination, by 2030), it is expected that SRs will be nominate more implementers/ sub sub recipients to play key rolles in the scale up process at various levels and represenation. SSAC and the Ministry of health through its established health facilities and staff are expected to re-focus the HIV and AIDS response towards greater involvement of people community level participation ( primary care services) and integration; while partners working with key populations will train them to lead aspects of the program. To deterrmine the type and role of SRs to be involved in implementation below criteria will be used to identify and nominate SRs.    Current SR management arrangements in place include; financial, programmatic, procurement and monitoring and evaluation procedures.   * Programmatic arrangements include routine OSDV visits, discussion of reports in CCM meetings and action plans drawn. In addition, the PR will have standing arrangements of regular meetings with each SR on a monthly basis. With the NTP, more regular meetings (monthly) will be instituted in the context of the ongoing capacity development and transition of PR role in the near future. * Routine reporting. SRs are required to fill PUDR quarterly. These reports include financial reports, target achievement and reasons for any deviation. * Regular joint monitoring and supervision to states and health facilities.   The following processes have been planned during the CN period:  The SRs will develop activity plans/work plans and finalize budgets, which will be submitted to the PR. The PR will then organize a work plan meeting with SSAC, MOH, CCM, all SRs and relevant stakeholders to review all work plans and integrate SR plans into a National Global Fund New Funding Model implementation plan. Once finalized, this will be presented at the CCM for review and endorsement. Budgets will be submitted to the Global Fund for review and endorsement. After this, the PR will enter into contractual agreements with each sub-recipient of project funds. The agreement will be based on the approved work plan, M&E plan and budgets, and will include a strategy for corrective action if targets are not being met. The work plan will specify the amount and purpose of the grant and the terms and conditions to be adhered to. The PR will release additional funds on the basis of performance against approved work plans and budgets.   1. Identification and management of sub-recipients:   The context in which the CCM will nominate the SRs is based on the following justification:  i). The country’s HIV epidemiological trend backed by new studies and surveys;  ii). Geographical and cross-border HIV dimension in which recent studies have demonstrated higher than national HIV incidents on the Western, Central and South-eastern SS States bordering neighboring countries;  iii) Key population identified as key drivers of HIV in SS- consideration the roles of CSOs towards scaling up HIV interventions across key population;  iv). The role of Ministry of Health in the context of implementation of basic HIV programmes as well as strengthening key enablers of HIV programmes to facilitate scale up of interventions to community level;  v). Humanitarian context in view of high numbers of refugees, returnees and IDPs and;  vi). Addressing issues of other key vulnerable population such as military, police and other security personnel and;  vii). Representation of gender and other vulnerable and affected groups.  viii). The role of community systems in the scale up of all critical HIV interventions.  ix) The different change management strategies utilized and required for key populations- ranging from directives from the military’s top brass; negotiations among development partners; and participative implementation with key populations, communities and populations of humanitarian concern.  Given that the existing grant approved under the GF’s transitional fund’s mechanism (TFM) that supports the HSS components of the MOH is almost exhausted, it will not be consolidated with the new grant, and reprogramming is therefore unnecessary. Besides being PR for the Global Fund, UNDP will continue to play a major role in coordination with other donors to build on economies of scale (efficiently achieve impact through increased numbers) and technical support planning to optimize economies of scope (efficiently achieve impact through the correct variation and mix of interventions for each key area and population). The arrangements will also help avoid duplication and maximize the impact interventions within the framework of both government and donor resources. UNDP Country Office will build on existing coordination mechanisms with government, bilateral development partners, civil society and the private sector to encourage coordination, and technical support.  To strengthen national capacity across components of GF implementation, UNDP Country Office will work with all stakeholders and implementers through proposed SRs (2 CSO, 2 Government, 1 DPH/ Humanitarian), donors and in-country bi-lateral partners such as UNAIDS, UNICEF, WHO, Humanitarian agencies, US Government (CDC, PEPFAR), UNFPA, ILO and WHO). The CCM will continue to perform its oversight role and will approve all major changes in implementation plans as necessary.  Funds flow diagram, indicating reporting process  The above chart shows how funds will flow from the PR to entities receiving funding, and playing a role in program implementation. It also shows the reporting/ data flow from beneficiary level to SRs, to the PR and coordination relationships within the national HIV program under SSAC’s coordination (output and outcome clusters; technical working groups the National HIV Advisory Committee of SSAC), and between the entities. Entities’ roles in implementation are currently divided by beneficiaries (meaning that service provision will be integrated and aimed at reaching the most beneficiaries, rather than focusing on the functions of each SR . Among SRs from each constituency, targets and program areas will be divided along the lines agreed at the national coordination level as described in section 8.3 of the National Strategic Plan (Section 8.3, pp.107-112). The exact identities of each SR portrayed on the chart will be defined prior to grant signing.   1. How representatives of women’s organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.   PLHIV, women and girls are among the key affected populations and are more vulnerable to infection. SRs from civil society will include organizations focusing on women and girls. PLHIV networks such as SSNEP+ are already recipients and their capacity will be built to achieve higher targets. Organizations working with MSM and along hotspots; as well as the SPLA secretariat are also proposed. Organizations working with MSM have been part of the concept note development process since inception, and will be involved in planning for mapping and scale up. The SPLA will be involved as a key sub-recipient through the Ministry of Interior.  Scale up will be performed in collaboration with the TB and malaria programs; which will help determine the final directional scale up plan based on a consolidated overview of areas of high endemicity or caseload for each of the diseases.  Similar to the malaria concept note, and working with some of these regions, local NGOs and community organizations such as women groups support the provision some basic services and health education. They will be involved 1) Through participation as SRs for the implementation of malaria activities and 2) Through partnerships with SRs implementing activities. For example, women groups have been engaged as community health workers by SRs implementing community interventions where access to public health services is very low. |

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| 4.2 Ensuring Implementation Efficiencies |
| Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants. |
| Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.  In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities. |
| Complementarity between the HIV and the malaria concept notes have been observed within 3 modules, particularly those focusing on service delivery at the community level. There is high complementarily with the emerging TB concept note, which were drafted alongside each other. Review of resources, staffing, training, monitoring and evaluation; and supervision was performed jointly between the three disease programs beginning with Malaria in May, and finalized with TB and HSS in October 2014.  Human Resources: To avoid duplicating services at the community level, HIV primary services at the community level will utilize, facilitate work and provide additional training to 750 of the 1200 Community Health Workers planned under the malaria concept note submitted in July 2014. These will be trained on HTC, adherence and treatment literacy, as well as other integrated service follow-up.  The process of deciding on HSS Modules revisited the malaria program, and joint meetings were held at several points between July and October 2014 between HSS, TB and HIV teams to harmonize HSS needs, and agree on TB and HIV collaborative activities.  Information Systems: All shared information systems including training and equipment, for HMIS and DHIS will be strengthened from the health sector level, with only community based reporting in areas not prioritized by all diseases being strengthened at disease program level.  Service delivery: A referral system from the state to tertiary hospitals, will be established to integrate RMNCH/TB/ HIV/OI services, and this has been agreed at the ministerial level, with all disease programs. |

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| 4.3 Minimum Standards for Principal Recipients and Program Delivery | | | |
| Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions. | | | |
| PR 1 Name | UNDP | Sector | Development Partners / GF Technical Partner |
| Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)? | | ☐Yes | |
| Minimum Standards | | CCM assessment | |
| 1. The Principal Recipient demonstrates effective management structures and planning | | Overall performance assessment for PR Minimum Standards undertaken in October 2009 and December 2010 gave B1 and B2 ratings respectively for the current PR (UNDP) in all aspects of grant management across all the following disease components and cross-cutting HSS grant:  i. The PR has strong Management Systems/Structures and processes in place built with the Global Fund assistance, and are working. | |
| 1. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients) | | The PR was found to have capacity and systems for this component. | |
| 1. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud | | PR internal control systems were found to be effective | |
| 1. The financial management system of the Principal Recipient is effective and accurate | | Based on assessments available the PR has strong financial systems in place, and demonstrated good financial management systems. | |
| 1. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products | | The PR has well equipped and functional supply chain management system undertaken by a qualified PSM Manager; | |
| 1. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions | | The PR candidate has logistical management systems in place, except there have been gaps in the delivery system due to security and poor distribution system at county and lower levels, For example, there have been instances of commodity stock-outs at county levels despite adequate stocks at central level. | |
| 1. Data-collection capacity and tools are in place to monitor program performance | | The PR was scored high rating under this requirement because:  i.The PR has an updated Health Management Information System (HMIS) in place which has defined relevant indictors used to routinely monitor interventions and the targets presented in various program Performance Frameworks (PF).  HMIS need updating to be fully rolled out in all the States and county level as well as the rolling out of the internet connectivity to all the States to ensure effective usage of the HMIS, which is a web based application. | |
| 1. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately | | Routine reporting at national level was found to be functional however, The DHIS and HMIS systems need to developed and rolled out to State and county levels to facilitate project monitoring and timely reporting. | |
| 1. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain | | The PR was scored highly on this requirement, PR conducted several capacity building and training for SRs and implementers compliance with quality requirements including monitoring product quality. | |

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| 4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance |
| 1. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers’ capacity, and past and current performance issues. 2. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request. |
| The updated National HIV and AIDS Strategic Plan 2013-2017, Section 8.5, pages 103-105 assesses various program level risks (current and anticipated) and offers several risk management recommendations. These will generally be adapted by coordinators and implementers of the national HIV program. In addition, at the implementation level, UNDP has completed the Grant Risk Assessment and Management Tool (attachment X) which will assist with identifying and addressing implementation level risks. The proposed PR and SRs will rely on the Global Fund approach to risk management. The below table summarizes the major risks, their impact as a product of probability of occurrence and severity; as well as the mitigation measures proposed as guided by the NSP.   |  |  |  | | --- | --- | --- | | RISK  L=Low M=Medium H=High | IMPACT | RISK MANAGEMENT AND MITIGATION MEASURES | | Program Risks |  |  | | Strategic Planning and timing : Many targets for Y1 have not been financed | Medium | -Accelerate implementation of resource mobilization plan  -Consolidate non-cumulative targets and accelerate implementation later  -Consider reviewing the targets | | Targeting is highly ambitious relative to baselines | Low | - Prioritize high impact interventions  - Scale and scope up HIV Testing and BCC from geographical areas of high prevalence to areas of low prevalence; balance stigma reduction and prevention education and treatment across the country  - Strengthen multi-sectoral model of service delivery (assign each targets)  - Increase community level targets and assign targets to POHC partners | | Inadequate and untimely financing | High | Focus on high impact interventions ; share targets across partners; implement  Cost-effective interventions prioritized in NSP sustainability section; assign specific targets to partners; accelerate plans for HIV and AIDS Pooled Fund and propose multi-currency account; frontload willingness to pay discussions to ensure money is availed in the first year of scale up; and implement HIV/AIDS resource mobilization strategy. | | Organizational Risks |  |  | | Inadequate implementation capacity- | Medium | -Institute upfront capacity and risk assessment using partner tools ; strengthening for implementers through local organizations and partners  - Appoint lead implementers across sectors to promote coordination,  technical support sharing, timely, consistent and accurate reporting.  - Implement joint technical capacity building strategy and plan across  program. | | Inadequate funding for SSAC | High | Prioritize SACC and Partner coordination funding to enable monitoring of targets and identification and coordination of technical support across board; as well as update of contingency planning for HIV[[87]](#footnote-87) | | Contextual Risks |  |  | | Political risks; Insecurity and worsening humanitarian situation | High | - Accelerate integration of HIV into Humanitarian Program; Implement humanitarian contingency plan;  - Appoint government, civil society, private sector, humanitarian and development partner lead for each cluster;  -Adopt matrix implementation management structure focused on beneficiaries in different locations rather than functions; assign flexible targets and funding to humanitarian partners based on number of IDPs and refugees  -Apply for additional funding based on the current humanitarian need  -Integrate nutrition into the humanitarian aspect of the program | | Insecurity and related emerging risks: Destruction of and continuing attacks on medical facilities (5 treatment sites destroyed thus far) | High | * + Implement contingency plan through humanitarian partners   + Security support for selected Medical Centers   + Work with UNMISS and others to secure sites   + Develop standard referral system for patients from crisis prone sites | | Macroeconomic Risks: Foreign exchange exposure due to SS Pound volatility against US Dollar; Narrow fiscal space due to falling revenue, stagnant growth forecast | High | Negotiate use of internal and external exchange risk management techniques; e.g. forward contracting or other acceptable derivatives; multicurrency accounts, swaps; invoicing currency, etc.  - Increase targets for lower cost implementers at community level  -Frontload willingness to pay discussions and develop resource mobilization strategy;  -Hold funds in multi-currency accounts and negotiate fixed rates | | Health and community system weaknesses constraining program scale up and access: HR, PSM, HIS, Financing, Service delivery • and CSS | High | -Integrate interventions; conduct integrated package of training on HTC, SRH,  MNCH, STI, HCT, PMTCT, TB,ARV initiation for same workers at different times  - Replace transport costs through use of new technologies as per NSP; accelerate linking of all national diagnoses to new laboratory;  - Conduct joint PSM planning and strengthening for all partners  - Increase supervision at facility level; Implement NSP accountability measures | |

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| CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE |
| Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so. |

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| ☐ | Table 1: Financial Gap Analysis and Counterpart Financing Table |
| ☐ | Table 2a-f: 6 Programmatic Gap Table(s) |
| ☐ | Table 3: Modular Template |
| ☐ | Table 4: List of Abbreviations and Annexes |
| ☐ | CCM Eligibility Requirements |
| ☐ | CCM Endorsement of Concept Note |

1. Average ratio of newly infected to newly placed on treatment in 16 African States is 1.93: 1. Source: PEPFAR (2013) The Opportunity Proposition: Illustrative Country Scenarios for Accelerated Progress toward Achieving an AIDS-free Generation (Annex 8, p.1) [↑](#footnote-ref-1)
2. This number reflects an average since the onset of the ART program. In recent times, average numbers newly placed on treatment annually have increased. In 2013, PLHIV on ART increased from 4650 to 6899. This excludes those LTFU and deaths. [↑](#footnote-ref-2)
3. Commercial sex workers and clients (uniformed services, long distance truck drivers and boda boda riders in the transport corridor) [↑](#footnote-ref-3)
4. MOH ANC report, 2012 (Annexes 15 and 51) [↑](#footnote-ref-4)
5. Boundaries for these estimates are 0.9-5.2, signifying a stable prevalence [↑](#footnote-ref-5)
6. Spectrum modeled estimates 2013. [↑](#footnote-ref-6)
7. *MOH HMIS Report 2012 (Projections based on the 5th Sudan Population and Housing Census, 2008 (Annex 11)*  [↑](#footnote-ref-7)
8. Kaiser R, Kedamo T, Lane J, Kessia G, Downing R, et al. (2006) HIV, syphilis, herpes simplex virus 2, and behavioral surveillance among conflict-affected populations in Yei and Rumbek, Southern Sudan. Aids 20: (Annex 13, 942-944).; Spiegel PB (2004 HIV/AIDS among conflict-affected and displaced populations: Dispelling myths and taking action. Disasters, Annex 14 28(3):322-339 (Annex 13) [↑](#footnote-ref-8)
9. SPLA Behavioral Surveillance Survey [↑](#footnote-ref-9)
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11. Global AIDS Review Progress Report for South Sudan (2013) [↑](#footnote-ref-11)
12. [↑](#footnote-ref-12)
13. [↑](#footnote-ref-13)
14. MoT (2013), p.69 (Annex 7) [↑](#footnote-ref-14)
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18. National HIV and AIDS Strategic Plan 2013-2017, (Annex 5, p30) [↑](#footnote-ref-18)
19. South Sudan National Action Plan on UNSCR 1325 on Women, Peace and Security 2014-2015 (Annex. 50, pp.11-16, 18-38) [↑](#footnote-ref-19)
20. Some high prevalence areas/ sentinel sites register syphilisprevalence rates as high as 15% among pregnant women, and among sex workers prevalence is likely much higher. This is statistically significant in HIV transmission around key populations and certain geographical areas, even though in the general population syphilis may be insignificant. Syphilis treatment should be included in prevention packages targeting key populations, one PMTCT prong, people in stable polygamous relationships and youth engaged in casual sex. [↑](#footnote-ref-20)
21. Yet to be verified, but high AIDS-related mortality and low coverage of pre-ART and ART program support this assertion [↑](#footnote-ref-21)
22. South Sudan NSP 2013-2017 [↑](#footnote-ref-22)
23. Country Dialogue with Sex Workers and MSM Groups, May 2014 (Annex 24); HSDP 2012-2016 (Annex 9) [↑](#footnote-ref-23)
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37. USAID 2011 Formative Assessment of Most at Risk Populations in South Sudan (Annex 18, pp.3, 26-59) [↑](#footnote-ref-37)
38. Annex 30- United Nations Security Council (2014) Secretary General's Report on South Sudan(pp. 1, 3-7) [↑](#footnote-ref-38)
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40. This estimate is based on the national HIV prevalence and the number of people displaced across the country; revised downwards from an earlier figure of 40,000 estimated in the UN Crisis Response Plan 2014 (Annex 31). [↑](#footnote-ref-40)
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60. South Sudan National AIDS Spending Assessment 2010/2011-2011/2012, May 2014. [↑](#footnote-ref-60)
61. Source: Partner Reports Consolidated in the MOH Summary Presentation at the Global Fund Mock TRP Review, October 2014 [↑](#footnote-ref-61)
62. PEPFAR 2013 South Sudan Operational Plan Report(Annex 27- pp. 8-27) [↑](#footnote-ref-62)
63. Annex 56 - MOH (2011) Basic Package for Nutrition and Health Services [↑](#footnote-ref-63)
64. International HIV and AIDS Alliance, 2011-2012 Assessment. [↑](#footnote-ref-64)
65. Country dialogue with key populations and humanitarian implementation partners 2014 (Annex 24) [↑](#footnote-ref-65)
66. Health Pooled Fund (2013) Inception Report and 12 Month Work plan (Annex 39, pp.31-38) [↑](#footnote-ref-66)
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68. Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB. [↑](#footnote-ref-68)
69. UNAIDS TSF (2014) NSP Pre update JANS Review and TWG Concept Note Meeting Report - April 2014 pp.25-33 [↑](#footnote-ref-69)
70. The Global Fund Strategy 2012-2016 Investing for Impact pp.5-11 [↑](#footnote-ref-70)
71. UNAIDS (2012) Investing for results. Results for people- A People Centered Investment Tool Towards Ending AIDS pp. 8-27 [↑](#footnote-ref-71)
72. Percentages on ART are now lower than GARPR 2013 figures since the country has adopted the Global HLM denominator of placing every PLHIV on treatment. [↑](#footnote-ref-72)
73. Please request from GF Secretariat Geneva [↑](#footnote-ref-73)
74. Annex 40 -UNAIDS TSF (2014) NSP Pre update JANS Review and TWG Concept Note Meeting Report - April 2014 [↑](#footnote-ref-74)
75. Annex 62, Compendium of Comments. [↑](#footnote-ref-75)
76. Annex 47- UNAIDS, SSAC South Sudan National AIDS Spending Assessment 2010/11–2011/12 [↑](#footnote-ref-76)
77. Annex 46- MDTF (2012) HIV AIDS Project Completion Implementation Report [↑](#footnote-ref-77)
78. Annex 32- Ministry of Health Budget 2013-2014. [↑](#footnote-ref-78)
79. CDC South Sudan DGHA Country Profile August 2014 (Annex 26 p1) [↑](#footnote-ref-79)
80. Draft South Sudan HIV NSP Strategic Information (M&E) Plan- Annex 53 [↑](#footnote-ref-80)
81. WHO (2014) South Sudan Mapping of Health Cluster Partners [↑](#footnote-ref-81)
82. National AIDS Spending Assessment 2010/11-2011/12 Report (May 2014), Annex 47. p.16,17-31; Please see “Annex 1” on mandatory financial gap analysis and counterpart financing table – assumes 5% increase in government expenditure for HIV programme. [↑](#footnote-ref-82)
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86. Annex 60- South Sudan HIV & AIDS Communication (BCC) Strategy 2008-2012 [↑](#footnote-ref-86)
87. Annex 67b [↑](#footnote-ref-87)