South Sudan

Revised National HIV and AIDS Strategic Plan 2021 – 2023

Towards an
HIV and AIDS free South Sudan

August 2020

SOUTH SUDAN HIV/AIDS COMMISSION

The Republic of South Sudan
Ministry of Health

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List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
CBO	Community Based Organization
CDC	Centres for Diseases Control and Prevention
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
FSW	Female Sex Worker
GBV	Gender Based Violence
GOSS	Government of South Sudan
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IDPs	Internally Displaced Persons
IDUs	Injecting Drug Users
ILO	International Labour Organisation
IOM	International Organization for Migration
IPV	Intimate Partner Violence
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MOH	Ministry of Health
MOT	Modes of Transmission
MSM	Men-having-sex-with-men
NEPWU	National Empowerment of Positive Women United
NGO	Non-governmental organisation
NSP	National HIV and AIDS Strategic Plan
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention
PITC	Provider Initiated HIV testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
POC	Protection of Civilians sites
PrEP	Pre-exposure prophylaxis
RMNCH	Reproductive, maternal, new born, child health
SBCC	Social and Behaviour Change Communication
SGBV	Sexual and Gender Based Violence
SOP	Standard Operating Procedures
SRHR	Sexual and Reproductive Health and Rights
SSAC	South Sudan HIV/AIDS Commission
SSNeP+	South Sudan Network of People Living with HIV
STIs	Sexually Transmitted Infections(s)
TB	Tuberculosis
TTI	Transfusion-transmissible infection
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees

UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

FORWARD

Since its formation in 2011, the Government of South Sudan, in collaboration with its many partners, has made consistent efforts to address the challenge of HIV and AIDS for the population. Under the leadership of the Ministry of Health and the South Sudan HIV/AIDS Commission, partners from all sectors have worked together to reduce new HIV infections and AIDS-related deaths in order to move towards the global goal of ending AIDS as a public health threat by 2030. Yet despite the strength of this collaboration, progress has remained slow. In 2019 alone there were an estimated 19,000 new HIV infections, including 2,700 amongst infants and young children (0-14 years). In the same year there were an estimated 9,900 AIDS-related deaths among an estimated 194,000 adults and children living with HIV in South Sudan. Life-saving anti-retroviral treatment reached only 18% of those eligible to receive it. For infants and young children it was only 6%.

These stark realities prompted the South Sudan HIV/AIDS Commission to facilitate a reflection among the multi-sectoral HIV stakeholders on the relevance and sufficiency of the *National HIV and AIDS Strategic Plan 2018-2022*, the guiding policy document for the country's HIV response. What emerged from this dialogue was a realisation that, despite ongoing if slow progress to address the epidemic, our collective efforts remained insufficient to achieve the goals and targets we had set for ourselves. Many factors stood in the way, including the very challenging and complex operating environment for health programmes in the country, the evolving humanitarian crisis, the fragile state of the public health system, and the low levels of domestic investment in health.

As a result of this reflection, the South Sudan HIV/AIDS Commission, in collaboration with the Ministry of Health and its partners, undertook a revision of the National HIV and AIDS Strategic Plan to strengthen the ability of this important policy document to provide clearer guidance and support for a more robust and sustainable multi-sectoral HIV response. The revision was a highly participatory process and has occurred at a very timely moment when, on the one hand, major strides have been made towards peace and security for the country; and, on the other, new partner commitments have been made by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the United States President's Emergency Plan for AIDS Relief to significantly scale up the national HIV response.

I am delighted, then, to share with you the **Revised National HIV and AIDS Strategic Plan 2021-2023**. The revision strengthens our commitment to achieving ambitious national, regional and global level targets for HIV epidemic control while leaving no one behind. It remains aligned to the universal principles of human rights and gender equality, which are the foundation for health and prosperity for all; and the principle of meaningful involvement of people living with or closely affect by HIV, or, as it is often expressed, 'nothing for us, without us'. It also reinforces our HIV and health-related commitments under the United Nations 2016 Political Declaration on HIV and AIDS; the African Union's Catalytic Framework to End AIDS, TB and Eliminate Malaria by 2030; the Agenda 2063: The Africa We Want; and the Sustainable Development Goals.

I encourage all stakeholders, communities and individuals to continue to take up the challenge of HIV and AIDS in South Sudan and to use this revised plan to ensure that our

collective efforts remain focussed on achieving no new HIV infections and no AIDS-related deaths by 2030. The cost of achieving this, technically and financially, remains significant so I also encourage our many partners to sustain and scale-up their support and to use this revised plan to guide their contributions accordingly. Finally, I reaffirm the commitment of the Government of South Sudan to continue to provide leadership for the national multi-sectoral HIV response and to work to increase its own contribution, financially and otherwise, to bringing about an HIV and AIDS-free South Sudan.

Hon. Dr. Esterina Novello
Chairperson
South Sudan HIV/AIDS Commission

ACKNOWLEDGEMENTS

Many individuals and organisations contributed to this revision, through attending retreats and consultation meetings, by providing comments on drafts, and by sharing their reflections and insights through email and other means. For this we are truly grateful. Throughout the revision process there was an active participation of people living with HIV and representatives from other key-affected communities. We could not have undertaken this revision without your contributions.

Expert support and guidance was also provided by the Ministry of Health, particularly the staff of the HIV/AIDS, STI and Hepatitis Department, and by the United Nations Development Programme (UNDP), which contributed both financial and technical assistance with the support of the Global Fund to Fights AIDS, Tuberculosis and Malaria. Contributions were also received from the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organisation, and the Government of South Sudan. We express our heart-felt thanks for all of this assistance as it ensured a high quality, technically sound final product of the revision process.

At team of technical consultants participated in the revision process, including Russell Armstrong, International Consultant, Dr. Jervaise Ayat, National Consultant, and Qinani Dube, Costing Consultant. Additional contributions were provided by Arlette Campbell-White, Rhoda M. Lewa, and Dr. Emmanuel Lino. We acknowledge with gratitude the work of these highly qualified experts.

We acknowledge the contributions of the National Technical Working Group for the revision whose members provided strategic oversight and direction throughout the process.

Finally, we acknowledge and thank the staff of the South Sudan HIV/AIDS Commission for their usual dedication and commitment to the national HIV response and to the health of the people of South Sudan.

Hon. Achol Dor
Deputy Chairperson
South Sudan HIV/AIDS Commission

EXECUTIVE SUMMARY

Background and Rationale for the Revision

In 2017, the South Sudan HIV/AIDS Commission (SSAC) led a comprehensive, national process to develop the *National HIV and AIDS Strategic Plan 2018-2022*. Since then, the Plan has guided the multi-sectoral stakeholders leading the national HIV response in their joint efforts to provide critical health interventions to the population of the country.

Starting in 2019, the national HIV stakeholders began to look forward to the development of a new funding request to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and to a new commitment by the United States President's Emergency Plan for AIDS Relief (PEPFAR), the two primary funders of the country's HIV response. This prompted a comprehensive review of the National HIV Programme by the Ministry of Health (MOH) as well as a reflection led by SSAC on the quality and relevance of the National Strategic Plan.

Based on the results of these processes, at the end of 2019 SSAC commissioned a revision the Plan in order to improve its quality and relevance. The *Revised South Sudan National HIV and AIDS Strategic Plan 2021-2023* was subsequently prepared through consultative processes led by SSAC and with the support of an external technical expert.

Main Adjustments and Improvements

The main changes include the following:

- Revision of the Performance Framework to focus on outcome and impact level targets and results.
- Improved alignment with country priorities and the specific requirements for implementing a national HIV response in a challenging operating environment.
- A focus on strategic level objectives and interventions. Output level activities and results will be included in annual operational plans.
- Ensuring balance across prevention; treatment, care and support; and on addressing structural barriers and drivers of the HIV epidemic.
- Increased emphasis on the full engagement of communities and their unique resources and institutions.
- Increased emphasis on primary health care integration for improving the coverage, impact and sustainability of the national HIV response.
- Increased emphasis on country ownership and leadership.
- Recognition of a growing momentum towards peace-building, reconstruction, recovery and renewal.

Finally, the implementation period for the Plan has been adjusted to align with the next Global Fund funding cycle as well as to extend the time-frame for achieving desired outcome and impact level results for the national, multi-sectoral HIV response.

Revised Results Framework

Building on the progress made under the previous Plan, and taking into account the progress of the response at 2019, the implementation of the *Revised South Sudan National HIV and AIDS Strategic Plan 2021-2023* will be guided by the following vision, goals, thematic areas, strategic directions, and strategic outcomes.

Vision:

An AIDS-free South Sudan by 2030.

Goals:

- Reduction of new HIV infections by 50% by 2023 (from 2010 levels).
- Reduction of deaths among men, women and children living with HIV by 50% by 2023 (from 2010 levels).

Thematic Areas, Strategic Directions, Strategic Outcomes:

Thematic Area 1: Prevention of new HIV infections.	
Strategic Directions	**Strategic Outcomes**
1.0 Scale up combination HIV prevention interventions for priority populations.	1.1 Sexual transmission of HIV is reduced by 50%.
	1.2 Mother-to-child transmission of HIV is reduced by 50%.
	1.3 HIV transmission in health care settings is eliminated.
	1.4 Gender-based violence (in all its forms) is reduced.
	1.5 HIV-related stigma and discrimination is reduced.
	1.6 HIV-sensitive social protection is provided to the most vulnerable.
	1.7 Humanitarian responses integrate HIV programming.
Thematic Area 2: HIV treatment and care, and positive health and dignity for all PLHIV.	
Strategic Directions	**Strategic Outcomes**
2.0 Improve health outcomes for all PLHIV.	2.1 Proportion of PLHIV on ART increased to 50% by 2023.

	2.2 Viral suppression for PLHIV on ART maintained at >80% by 2023.
	2.3 Eligible PLHIV receive a defined package of social support to improve long term adherence on ART.
Thematic Area 3: Efficiency, integration and sustainability	
Strategic Directions	**Outcomes**
3.0 Strengthen the critical enablers supporting the multi-sectoral HIV response.	3.1 An enabling legal and policy environment is established.
	3.2 Strong health and community systems support the HIV response.
	3.3 The availability and use of strategic information is increased.
	3.4 Domestic financing and ownership is increased.
	3.5 Multi-sectoral coordination and accountability is improved.

Co-ordination and Implementation Arrangements

The revised Plan maintains SSAC as the lead strategic-level coordinating body for the national multi-sectoral response. The Ministry of Health remains the lead coordination and management entity for the technical and operational components of the national HIV response.

Monitoring and Evaluation

Based on the revised Performance Framework for the Plan, SSAC and the Ministry of Health will jointly prepare a revised National HIV Monitoring and Evaluation Plan 2021-2023.

Financing and Resource Mobilisation

The revised resource needs estimate for the Plan is **US$286 million**. Mobilising these resources will continue to be the responsibility of the Government of South Sudan in close collaboration with the many partners that currently provide more than 90% of the financing needed to provided life-saving HIV interventions to the population.

REVISED SOUTH SUDAN NATIONAL HIV AND AIDS STRATEGIC PLAN 2021-2023
AUGUST 2020

1. INTRODUCTION

In 2017, the South Sudan HIV/AIDS Commission (SSAC), with the support of its technical partners, led a comprehensive, national process to develop the *National HIV and AIDS Strategic Plan 2018-2022 (NSP)*. The NSP was based on performance reviews of the National HIV Programme and of the previous National HIV and AIDS Strategic Plan 2013-2017 conducted in 2016. The Plan was also based on the many insights and contributions of the multi-sectoral stakeholders collaborating to support a robust HIV response in one of the more complex and challenging operating environments in the East African region.

Starting in 2019, the national HIV stakeholders were looking forward to the development of a new funding request to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and to a new commitment by the United States President's Emergency Plan for AIDS Relief (PEPFAR), the two primary funders of the country's HIV response. This prompted a comprehensive review of the National HIV Programme by the Ministry of Health (MOH), as well as a reflection, led by SSAC ,on the quality and relevance of the 2018-2022 NSP. In this latter regard, it was determined to be unfinished in some respects, particularly the component of the Performance Framework. It was also deemed to contain a number of recommendations that, although in alignment with global guidance for evidence-based interventions, for example, were not suited to the unique context of the country and, as such, were neither relevant nor feasible for the stakeholders to implement.

1.1. Rationale for the Revision

To improve the quality and relevance of the 2018-2022 NSP, at the end of 2019 SSAC commissioned a revision using a consultative process, as well as the support of an external technical expert. The result is the *Revised South Sudan National HIV and AIDS Strategic Plan 2021-2023*. The implementation period for the plan was adjusted to align with the next Global Fund funding cycle as well as to extend the time-frame for achieving desired outcome and impact level results for the national, multi-sectoral HIV response.

1.2. Development of the Revised NSP

The development of this revised NSP involved retreats, national dialogues, a technical review, and a final, virtual process convened in August 2020. Representatives from a range of national stakeholders participated in these processes, including UN agencies, bilateral partners, government representatives, representatives from international non-governmental organisations (NGOs), civil society representatives, PLHIV and individuals from key and vulnerable populations.

1.3. Main Adjustments and Improvements

The main adjustments reflected in the revised NSP include:

- Revision of the Performance Framework to focus on outcome and impact level targets and results.

- Improved alignment with country priorities and the specific requirements for implementing a national HIV response in a challenging operating environment.

- A focus on strategic level objectives and interventions. Output level activities and results will be included in annual operational plans.

- Ensuring balance across prevention; treatment, care and support; and on addressing structural barriers and drivers that continue to place a substantial proportion of the population at risk of HIV infection, or at risk of early and untimely death due to late diagnosis and untreated HIV disease.

- Clarity about what can be addressing through the national HIV response and what the response can contribute to broader multi-sectoral efforts to address health and development challenges (such as gender-based violence, or extreme vulnerability, for example).

- Increased emphasis on the full engagement of communities and their unique resources and institutions. While re-investment and restoration of the public health system is ongoing in South Sudan, equal emphasis must be placed on leveraging community assets, such as local cultural, religious and social institutions and practices, upon which much of the population relies for its day-to-day health and well-being. Addressing HIV must be fully integrated across these entry points.

- Increased emphasis on primary health care integration for improving the coverage, impact and sustainability of the national HIV response. Wherever individuals encounter the health system, at facilities or in communities, there should be opportunities to receive or to be referred to HIV services.

- Increased emphasis on country ownership and leadership. While partners fulfil important mandates for development assistance across the national HIV response, the ultimate ownership and responsibility for leadership remains with the MOH and the Government of South Sudan (GOSS) on behalf of the population.

- Recognition of a growing momentum towards peace-building, reconstruction, recovery and renewal. At the time of the revision, major steps had been taken to secure long-term peace for the country. This represents an important opportunity for the renewal of the health sector and for strengthening and scaling up an integrated, national response to HIV.

1.4. Alignment with Regional and Global Commitments

The revised NSP maintains an alignment with South Sudan's regional and global commitments as expressed in:

- United Nations 2016 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight Against HIV and to Ending the AIDS Epidemic by 2030;

- African Union's Catalytic Framework to End AIDS, TB and Eliminate Malaria by 2030;

- Agenda 2030 for Sustainable Development;

- Agenda 2063: The Africa We Want;

- Political Declaration on Universal Health Coverage.

In addition to ending AIDS as a public health threat by 2030, these agreements also commit South Sudan to ensure healthy lives, to achieve gender equality, to reduce inequality, and to achieve a peaceful and just society the respects and protects human rights, while ensuring that no one is left behind. Strategic investments in the national HIV response will contribute to this broader progress for health and well-being for all South Sudanese people in all their diversity.

1.5. Guiding Principles

The implementation, monitoring, coordination and accountability mechanisms for the revised NSP will be aligned to the following principles:

- **Meaningful participation and inclusion of people living with HIV, and of members of key and vulnerable populations:** PLHIV, members of key and vulnerable populations as well as groups most affected by HIV will be fully involved in the planning, implementation, monitoring and accountability mechanisms of this plan from the central to the state and community levels.

- **Human-rights-based and gender transformative approaches:** The success of the national HIV response is dependent on protecting and promoting the rights of those who are socially excluded, marginalised and vulnerable. It is also dependent on transforming gender norms to reduce and eliminate gender-related vulnerabilities to HIV and other health challenges.

- **Country ownership and partnership:** All HIV stakeholders including the GOSS, development partners, private sector, international organisations, civil society organisations, communities of people living with HIV, members of key populations, and local communities have important roles and responsibilities for reducing the HIV burden in South Sudan and for achieving an AIDS-free society by 2030.

- **Multi-sectoral accountability:** The NSP sets out interventions and results for which multiple sectors are responsible and accountable. Every sector must play its part and be accountable for results if South Sudan is to effectively address and reverse the HIV epidemic.

- **Efficiency, effectiveness and innovation:** The national HIV response for South Sudan, with its unique and complex country context, must be driven by a full commitment to efficiency, effectiveness and innovation in the design of interventions that integrate within existing systems and resources for the health sector, from the central to the local levels.

- **Do-no-harm:** No individuals or groups must be put at risk of avoidable harm as a direct or indirect result of the development and implementation of the NSP.

- **Respect for personal dignity and autonomy:** *All* persons have the following fundamental rights guaranteed under international, regional and national laws: right to be free from discrimination; right to equality; right to be free from torture and cruel, inhuman and degrading treatment; right to dignity; right to security of the person; right to information; and, the right, including in prisons and other closed settings, to the highest attainable standard of health.

2. SITUATIONAL ANALYSIS

2.1. Evolving Epidemiology of HIV in South Sudan

By the end of 2019, South Sudan continued to have a generalised HIV epidemic, with some significant variations in prevalence and burden of disease by age, population and location. For 2019, the UNAIDS Spectrum model estimated an adult (15-49 years) HIV prevalence of 2.5%, ranging from 2.0% amongst adult males to 3.0% amongst adult females.[1] According to the 2017 Anti-Natal Care (ANC) Sentinel Surveillance Survey, HIV prevalence amongst women attending ANC was highest in Western, Central and Eastern Equatorial States, at 4.8%, 4.6% and 3.6% respectively,[2] and lowest in Warrap, Upper Nile, and Northern Bahr El-Gazal states, at 1.5%, 1.4% and 0.3%, respectively. Other data from the survey show that HIV prevalence increased from 2.0% amongst 15-19-year-olds to 3.5% amongst 30-35- year-olds, a period that marks peak child-bearing years for women in South Sudan. Additional disaggregated data on age and gender are not available.

A 2014 Modes of Transition (MOT) analysis estimated that most of the new HIV infections were among the clients of female sex workers (FSWs) (42.6%), children born to HIV infected mothers (15.7%), men and women involved in casual sexual relationships (14.5%), FSWs (11.2%), and couples in stable relationships (9%).[3] Other modes contributing to new infections include men-having-sex-with-other-men (MSM) (3.9%), partners of key and vulnerable populations (KVPs) (0.6%), and partners of those engaged in casual sex (1.6%). Medical injections and blood transfusion were estimated to contribute 0.02%. As of the end of 2019, however, a number stakeholders in the national HIV response had come to question the ongoing relevance of this analysis and to note that a new MOT analysis was needed.

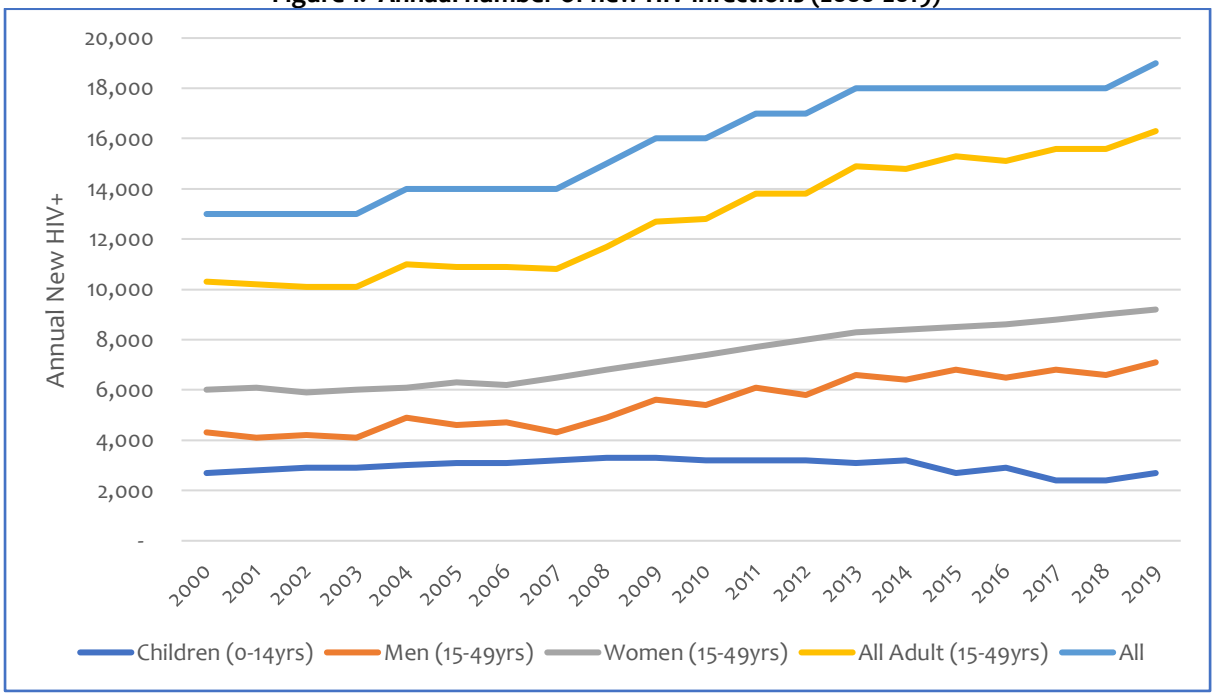
There have been more recent additions to strategic information on other populations in South Sudan, with some rates of HIV infection being higher than for the general population. In a survey conducted in 2017 of MSM, with participants largely from Juba but also from Nimule, Torit, Wau, Yambio, and Yei, 5 (3.0%) of 165 individuals tested positive for HIV. The study sample was too small to estimate an HIV prevalence to any minimal level of statistical significance.[4] A 2016 study involving 850 SW participants in Juba found an HIV prevalence of 38%.[5] New, as yet unreleased, HIV prevalence data for 2019 for FSWs in Wau and Yambio show figures of 6.75% and 13.6%, respectively.[6] Recent interventions in prisons, conducted by the South Sudan HIV/AIDS Commission (SSAC), included HIV testing. Of 278 inmates reached in four prisons in 2019 (Kapoeta, Kuajok, Renk and Yambio), two

[1] UNAIDS Spectrum Data 2020.
[2] These states border Uganda, Democratic Republic of Congo and Kenya where HIV prevalence ranges from 4% (DRC) to 6% (Uganda).
[3] MOH and UNAIDS. 2014. *HIV Prevention Response and Modes of Transmission Analysis*.
[4] MOH. 2018. *Formative Assessment, Mapping and Integrated Biological and Behavioural Surveillance (IBBS) Survey among Men who have Sex with Men (MSM) in South Sudan.*
[5] MOH. 2016. *A Bio-Behavioural HIV Survey of Female Sex Workers in South Sudan: The Eagle Survey Final Report.*
[6] Data from IBBS studies for Wau and Yambio included in IntraHealth International Strategic Information Project Update. COP 20 Planning. PowerPoint Presentation. No date.

men and three women tested HIV-positive.[7] Subnational HIV prevalence data show the overlap between areas where HIV is prevalent and sites where IDPs and refugees are located. Large numbers of refugees and IDPs are situated in regions with the highest HIV prevalence, such as Gbudwe and Boma, where HIV prevalence is 3% and 2.4%, respectively.[8] There is a general consensus amongst stakeholders that HIV prevalence is also elevated amongst members of uniformed services, and long-distance truck drivers; however, there are no current data to clarify these assumptions. Across the Eastern African region, these groups generally have higher prevalence so it may be reasonable to assume a similar situation in South Sudan.

By the end of 2019, it was estimated that there were 194,000 PLHIV in South Sudan (range=140,00-240,000), of which 16,000 (8.4%) were children (0-14 years). Approximately 56% of all adult PLHIV were female. Annual rates of new HIV infections are shown in **Figure 1**, below:

Figure 1: Annual number of new HIV infections (2000-2019)



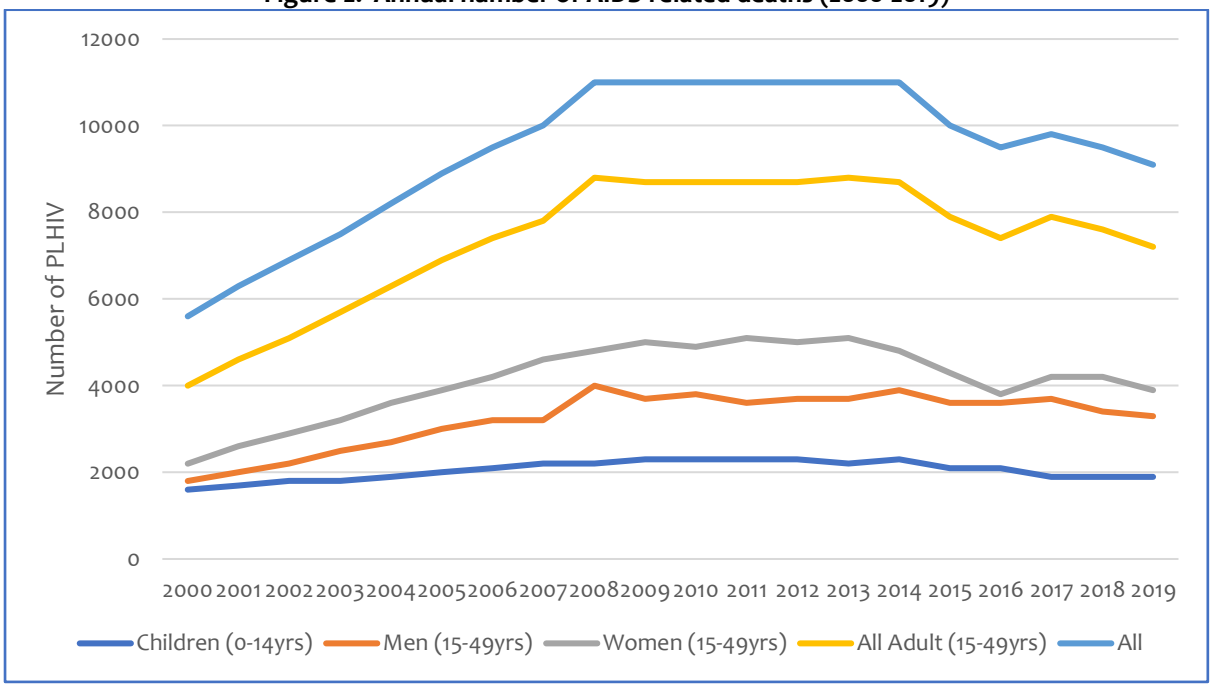
Source: UNAIDS Spectrum 2020

New HIV infections have continued to increase, year-over-year. Between 2010 and 2019, new HIV infections increased by 19%, at some distance from the global Fast-Track goal of a 75% decline from 2010 rates by 2020.[9] In 2019, there were an estimated 19,000 new HIV infections (all ages), 14% (2,700) amongst children (0-14 years). Amongst all new adult HIV infections (16,300), 56% (9,200) occurred amongst females. Between 2010 and 2019, HIV incidence (all ages) increased from 1.51/1,000 population to 1.56/1,000 population.

Trends in AIDS-related deaths are shown in **Figure 2**, below:

[7] Programme data from SSAC.
[8] UNHCR (2019), *op. cit.*
[9] United Nations. 2016. *Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.*

Figure 2: Annual number of AIDS-related deaths (2000-2019)



Source: UNAIDS Spectrum 2020

The annual rate of AIDS-related deaths has slowed over recent periods. Between 2010 and 2010, it declined by 17% but far from the Fast-Track target of a 75% reduction from 2010 levels by 2020. In 2019, there were 9,100 AIDS-related deaths (all ages), 21% (1,900) amongst children (0-14 years).

In 2019, the National TB Programme detected 16,232 cases (new and relapse), of which 90% (14,608) were screened for HIV. Of these, 12% (1,751) were found to be HIV-positive, and 90% (1,577) were linked to ART care.[10] In 2019, of PLHIV on ART, 67% (23,705/35,433) were screened for TB with 4% (848/23,705) subsequently starting TB treatment

2.2. Bio-behavioural and Structural Drivers of the HIV epidemic

Comprehensive data on the drivers of the HIV epidemic are scarce in South Sudan and what exists is now dated. Different sources identify a range of bio-behavioural and structural drivers (although many lack data to substantiate these claims). Amongst stakeholders participating in the revision of the NSP, the **bio-behavioural drivers** were identified as:

- Low knowledge and awareness about HIV across all population groups, but particularly amongst young people aged 15-30 years. This includes basic information about the sexual transmission of HIV and how to prevent it.

- Very low uptake and use of condoms, partly due to the complexity of making such commodities available country-wide on a reliable basis, but also due to socio-cultural

[10] MOH. 2019. *Comprehensive Review of the National TB Programme in South Sudan*.

attitudes and believes about condoms (they are a sign of 'immorality', for example, particularly in a cultural context that values high birth rates and large, sometimes polygamous families).

- Extremely high rates of sexual and gender-based violence (SGBV) linked to war and conflict as well as broader socio-cultural beliefs and practices that subordinate women and limit their agency and autonomy.[11]

- Low uptake of male circumcision for religious and cultural reasons (different tribal identities as well as different religious faiths--Muslim or Christian, for example).

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

The **structural drivers** were identified as:

- High levels of HIV-related stigma and discrimination linked to lack of comprehensive and accurate knowledge about the disease.

- War and conflict and the resulting impacts on livelihoods, including extreme poverty and food insecurity.

- High levels of illiteracy and low educational attainment beyond primary levels, with females much more affected in this regard than men.

- Weak or non-functioning health systems due to dilapidated or destroyed infrastructure (as a result of conflict), chronic underinvestment in the health sector, and severe shortages of health human resources.

- A legal environment that criminalises same-sex sexual behaviour, sex work and 'intentional' HIV transmission. This in turn fuels wide-spread discrimination, violence and abuse, including in the health sector, against PLHIV, MSM and FSW, amongst other groups.

Mounting an effective HIV response in the midst of this substantive range of epidemic drivers remains, for the country, challenging indeed.

2.3. Key Challenges and Gaps for the National HIV Response

Between 2017 and 2019, the national HIV response continue to be limited by the following challenges and gaps:

[11] See, for example: IOM. 2019. *Gender-Based Violence Knowledge, Attitudes, and Practices Survey in South Sudan.*

- Low level of domestic investment in the public health sector with critical health system weakness not addressed, including infrastructure, facilities and equipment, and health human resources recruitment and retention.

- Minimal domestic investment in the national HIV response (aside from infrequent salary payments to the health sector work force and the provision of facilities).

- An almost complete reliance on the financial, technical and operational capacity of international partners to deliver the national HIV response with inadequate coordination and leadership on the part of the MOH to guide these essential contributions.

- Low coverage of high-impact interventions, such as HIV testing services (HTS), condom promotion and distribution, prevention of mother-to-child transmission of HIV (PMTCT), and both adult and paediatric anti-retroviral treatment (ART) care and support.

- Unresolved challenges of recruitment and retention, as well as operational support, for critical technical and operational positions within the national HIV programme from the central to the facility levels.

- A complex and inadequately coordinated supply chain for essential HIV commodities, largely arising from the lack of MOH capacity to undertake this function and the absence of critical logistics and transport systems (in the absence of partners) to ensure a continuous, secure and responsive supply at service delivery levels.

- Significant gaps in operational data and strategic information to guide decision-making and quality improvement at both operational and strategic levels. This includes the ongoing inability of stakeholders to 'know the HIV epidemic' in significant detail to effectively prioritise investments where they will have the most impact.

- An insufficient investment in primary HIV prevention resulting in large technical and operational gaps and the absence in many localities across the country of any substantive prevention programming at all.

A number of these gaps and challenges did not only arise during the 2017-2019 period but have affected previous implementation periods and remain unresolved.

2.4. Adjustments to Address Challenges and Gaps

To address these challenges and gaps, the revise NSP will prioritise these strategic level shifts:

- **Ensuring balance across prevention; treatment, care and support; and on addressing structural barriers** and drivers that continue to place a substantial proportion of the population at risk of HIV infection, or at risk of early and untimely death due to late diagnosis and untreated HIV disease.

- **Increased emphasis on the full engagement of communities and their unique resources and institutions**. While re-investment and restoration of the public health system is ongoing in South Sudan, equal emphasis must be placed on leveraging community assets, such as local cultural, religious and social institutions and practices, upon which much of the population relies for its day-to-day health and well-being. Addressing HIV must be fully integrated across these critical foundations.

- **Increased emphasis on primary health care integration** for improving the coverage, impact and sustainability of the national HIV response. Wherever individuals encounter the health system, at facilities or in communities, there should be opportunities to receive or to be referred to HIV services.

- **Increased emphasis on country ownership and leadership**. While partners fulfil important mandates for development assistance across the national HIV response, the ultimate ownership and responsibility for leadership remains with the MOH and the GOSS on behalf of the population.

- **Recognition of a growing momentum towards peace-building, reconstruction, recovery and renewal**. At the time of the revision, major steps had been taken to secure long-term peace for the country. This represents an important opportunity for the renewal of the health sector and for strengthening and scaling up an integrated national response to HIV.

- **Reducing structural vulnerabilities, particularly insecurity, poverty and food insecurity** which affect a sizeable proportion of the population and create enormous barriers to progress to address HIV. This NSP, through its own investments, and through leveraging other health and social investments and development synergies, must contribute to reducing such vulnerabilities which are both cause and consequence of the HIV epidemic.

- **Shared accountability and transparency for results for the population**. The value of all efforts of all stakeholders in the national HIV response is measured by the extent to which individuals, families and communities receive benefits in terms of avoiding HIV infection or leading healthy and dignified lives with HIV. In addition, investments must be seen as 'belonging' to people of South Sudan and must be utilised for their maximum value in terms of delivering tangible health benefits to the population.

- **Capacity development and transition**. The national HIV response must contribute to capacity development and renewal and maintain a firm commitment of full transition of the national response to government and communities at the earliest opportunity.

2.5. Priority Populations for the National HIV Response

South Sudan's national, multi-sectoral HIV response is meant to reach all populations and locations and to leave no one behind in striving to end AIDS as a public health threat by 2030. However, in the midst of this broader effort, it is important that the response

prioritise those most at risk of HIV and those most left behind by current efforts. Through a consensus process led by SSAC, these priority populations were identified based on the following criteria:

- Highest risk of HIV infection;
- HIV incidence of HIV infection;
- Highest level of vulnerability to HIV infection or AIDS-related deaths;
- Least ability to control circumstances of vulnerability due to the influence of structural barriers, or to the unique circumstance in which these vulnerabilities are experienced (prisons, camps or other closed settings for example);
- Lowest access to HIV services based on human rights or other equity-related barriers.

The consensus process also took into account prevailing global categorisations of priority populations as adapted to the specific country context of South Sudan.[12] These included:

- **Key populations**--which are defined as groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. These populations generally include MSM, sex workers of all genders, transgender people, people who use or inject drugs, and people in prisons and other closed settings. Prioritising key populations is important to managing the dynamics of HIV epidemics. These individuals and groups are all essential partners in effective responses to the epidemic.
- **Vulnerable populations**--which are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities, refugees and internally displaced people, and migrant and mobile workers, among others. These populations are not affected by HIV uniformly across all countries and regions. Prioritising them in HIV responses depends on their particular circumstances within a country context.

One final consideration for prioritising populations in South Sudan was the lack of comprehensive, up-to-date evidence to a sufficient degree of disaggregation to guide such critical decisions. As a result, what is proposed below may evolve as such gaps in evidence are addressed over the implementation of the revised NSP.

The **priority populations** to be addressed under the revised NSP include:

Key populations	Vulnerable populations	Priority populations

[12] See WHO. 2016. *Comprehensive Guidelines on HIV Prevention, Diagnosis, Treatment and Care of Key Populations*. Available: https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/

▪ Sex workers ▪ MSM ▪ Prisoners ▪ People living with HIV	▪ Adolescents and young people, particularly adolescent girls and young women ▪ Refugees and returnees ▪ Internally displaced people ▪ Orphans and other vulnerable children ▪ People with disabilities ▪ Individuals facing extreme vulnerability due to socio-economic circumstances.	▪ Members of uniformed services ▪ Migrant and mobile populations

3. Revised South Sudan HIV and AIDS Strategic Plan 2021-2023

3.1. Vision and Goals

Building on the progress made under the previous NSP 2013 -2017, and taking into account the progress of the response at 2019, the implementation of the revised NSP 2021-2023 will be guided by the following vision and goals.

Vision:

An AIDS-free South Sudan by 2030.

Goals:

- Reduction of new HIV infections by 50% by 2023 (from 2010 levels).
- Reduction of deaths among men, women and children living with HIV by 50% by 2023 (from 2010 levels).

3.2. Thematic Areas, Strategic Directions, Strategic Outcomes

Thematic Area 1: Prevention of new HIV infections.	
Strategic Directions	**Strategic Outcomes**
1.0 Scale up combination HIV prevention interventions for priority populations.	1.1 Sexual transmission of HIV is reduced by 50%.
	1.2 Mother-to-child transmission of HIV is reduced by 50%.
	1.3 HIV transmission in health care settings is eliminated.
	1.4 Gender-based violence (in all its forms) is reduced.
	1.5 HIV-related stigma and discrimination is reduced.
	1.6 HIV-sensitive social protection is provided to the most vulnerable.
	1.7 Humanitarian responses integrate HIV programming.
Thematic Area 2: HIV treatment and care, and positive health and dignity for all PLHIV.	
Strategic Directions	**Strategic Outcomes**
2.0 Improve health outcomes for all PLHIV.	2.1 Proportion of PLHIV on ART increased to 50% by 2023.
	2.2 Viral suppression for PLHIV on ART maintained at >80% by 2023.
	2.3 Eligible PLHIV receive a defined package of social support to improve long term adherence on ART.

Thematic Area 3: Efficiency, Integration and Sustainability	
Strategic Directions	**Outcomes**
3.0 Strengthen the critical enablers supporting the multi-sectoral HIV response.	3.1 An enabling legal and policy environment is established.
	3.2 Strong health and community systems support the HIV response.
	3.3 The availability and use of strategic information is increased.
	3.4 Domestic financing and ownership is increased.
	3.5 Multi-sectoral coordination and accountability is improved.

4. THEMATIC AREA: PREVENTION OF NEW HIV INFECTIONS

Strategic Direction 1: Scale up combination HIV prevention interventions for priority populations

Context

South Sudan is continuing to see an increase in the annual number of new HIV infections across all age groups. Due largely to under investment in the national HIV response, interventions prioritising primary prevention of HIV remain minimal. Lessons learnt by the end of 2019, the mid-point of the 2018-2022 NSP, included:

- Many proposed interventions under HIV prevention were not implemented, either because they were not funded, or due to operational challenges for SSAC and the MOH at state levels. This included proposed interventions for social behaviour change communication (SBCC), condom promotion and distribution, and voluntary medical male circumcision (VMMC).

- Progress was achieved in other areas of prevention, notably the expansion of HTS through a wider range of modalities, particularly provider-initiated testing and counselling (PITC) in hospitals and in Primary Health Care Centre (PHCC) settings. The PMTCT programme also increased in scale, reaching approximately 56% of HIV-positive pregnant women by the end of 2018.

- Overall, uptake of prevention interventions continued to be inhibited by an ongoing lack of accurate knowledge regarding HIV across the population, and the consequent predominance of stigmatising and discriminatory beliefs, attitudes and behaviours, including self-stigma and fear amongst PLHIV themselves or those most at risk for HIV.

- There were a number of missed opportunities to further scale-up of prevention, including the lack of routine (opt out) HIV screening in sexually transmitted infection (STI), reproductive, maternal, new born and child health (RMNCH), and antenatal care (ANC) services, and poor integration of HIV prevention messages and interventions across primary health care and community health settings.

These lessons learnt have informed the following strategic shifts for the revision:

- Decentralisation and integration of HIV prevention components across the primary health care system.

- Integration of HIV awareness and prevention components within cultural, religious and other community level institutions. These must use context relevant approaches, taking into account oral traditions and low levels of literacy and numeracy across the population.

- Intensification of interventions within key and vulnerable populations.

- Full integration of HIV prevention within humanitarian responses.

- A comprehensive response to reducing stigma and discrimination, particularly within health care and community settings.

- Leveraging of HIV interventions for broader gains in sexual and reproductive health (SRH) programmes.

- Leveraging HIV interventions and investments to strengthen the multi-sectoral response to ending gender-based violence and to providing comprehensive care and support programmes to survivors.

- Leveraging HIV interventions and investments to strengthen the multi-sectoral response to other structural drivers of HIV vulnerability and new HIV infections, particularly poverty, food insecurity, and armed conflict and is aftermath.

Strategic Outcome 1.1: Sexual transmission of HIV is reduced by 50%

Social and Behaviour Change Communication

SBCC remains an important pillar for prevention within the national HIV response. Linked to the NSP, SSAC in 2017 led the development of an *HIV and AIDS Social Behaviour Change Strategy 2018-2020*. The strategy was extensive, and included a detailed roll-out plan. Neither the strategy nor the plan were costed, nor were they prioritised to indicate which components should roll-out first as resources became available. Although with limited gains to-date, SBCC continues to be prioritised. This revised approach places an emphasis on integration of SBCC interventions within primary and community level health initiatives as well as in communities more broadly. This will involve taking opportunities within current traditions, institutions and practices (cultural, religious, educational, recreational, for example) to improve HIV knowledge and understanding, and to encourage behaviour change using relevant and socially acceptable modalities.

Ref	Strategic Interventions	Responsibility
1.1.1	Design and implement culturally appropriate social and behaviour change communications activities that can be integrated within cultural, religious, recreational and other relevant traditions and events at community levels.	SSAC, MOH, Implementing partners
1.1.2	Mobilise and equip local leaders and influencers (religious, cultural, political, arts and music, for example) from national to community levels to champion HIV awareness and the importance of behaviour change to reduce HIV transmission.	SSAC, MOH, Implementing partners
1.1.3	Strengthen the operational and technical capacity of local institutions, including local CSOs and networks, to design, deliver and sustain HIV awareness and behaviour change interventions in communities	SSAC, Technical partners

1.1.4	Fully engage and support the involvement of PLHIV in communities as champions and change leaders for HIV awareness and for positive, health, dignity and prevention.	All stakeholders
1.1.5	Design and implement specific in- and out-of-school SBCC activities focussed on adolescents and young people with a view to ensuring comprehensive, age-appropriate knowledge regarding SRH and the importance of HIV prevention.	SSAC, MOH, other relevant Ministries, youth-led partners
1.1.6	Equip health care workers providing SRH services to adolescents and young people to deliver HIV prevention and risk reduction interventions in all their encounters.	MOH, technical partners
1.1.7	Review and revise the *National HIV and AIDS Social Behaviour Change Strategy* to guide the integration of combination HIV prevention interventions across all opportunities at community level.	SSAC, MOH

Condom Promotion and Distribution

Male and female condom promotion remains an important prevention pillar for South Sudan, despite significant challenges to implement and sustain relevant interventions to the extent that substantive public health benefits can be observed. In 2017, SSAC, in collaboration with the MOH, supported the development of the *National Comprehensive Condom Programming Strategy (NCCP) 2018-2022*. The strategy aimed to provide a more detailed action plan for strengthening the effectiveness and impact of condom programming. However, there was no specific implementation or monitoring of the strategy over the 2018-2019 period.

While male and female condoms were procured on a routine basis and distributed country-wide, significant technical, operational, and socio-cultural challenges limited the value of this important component of a high-impact response to HIV. This included the particular challenge of 'last mile delivery' to ensure that stocks of condoms reach health facilities. The revised NSP aims towards improving the integration of promotion and distribution of condoms across the primary health sector; improving the availability of condoms across all sectors; improving the range and quality of strategic information guiding condom programming; and achieving commodity security for condoms and all other essential commodities for family planning, and for SRH promotion.

Ref.	Strategic Interventions	Responsibility
1.1.8	Undertake a strategic mix of national and local level educational and promotional campaigns to increase knowledge and to create demand for male and female condoms for HIV prevention, family planning, and SRH.	SSAC, MOH, Implementing partners

1.1.9	Promote condom use for HIV-risk reduction as an integrated component of family planning, STI services, and youth-friendly services in health facilities.	MOH, Implementing partners
1.1.10	Design and implement tailored strategies for creating demand and improving condom uptake and use (including lubricants where relevant) amongst priority populations, including key populations, uniformed services, and sexually active young people.	SSAC, MOH, Implementing partners
1.1.11	Design and implement both general and differentiated (tailored approaches for priority populations) distribution strategies to improve the availability and accessibility of condoms across the public, private and NGO sectors.	SSAC, MOH, Implementing partners
1.1.12	Undertake routine procurement to achieve and maintain commodity security for condoms along with other essential family planning and sexual health commodities.	MOH, technical partners
1.1.13	Put in place systems and processes to increase the range and quality of strategic information regarding condom uptake and use.	MOH
1.1.14	Review and revise the *NCCP 2018-2022*.	SSAC

HIV Testing Services (HTS)

Within the framework of the *Guidelines on HIV Testing Services*, the national HIV response will continue to support a variety of access points and modalities for HIV testing. This will be combined with increased efforts in communities to create demand for HIV testing. Fuller integration of opportunities to request for and receive HTS will also be supported. Finally, referral and linkages mechanisms and modalities will also be strengthened to reduce to the greatest extent possible losses to follow-up for individuals who test HIV-positive.

Ref.	Strategic Interventions	Responsibility
1.1.15	Integrate HTS across the primary health care system, prioritising TB, family planning, STI services, RMNCH, ANC, adolescent-friendly services, and hospital-based out patient and in-patient services, among others.	MOH, Implementing partners
1.1.16	Design, roll-out and continuously review guidelines for prioritising HTS for individuals and groups with higher HIV risk, including routine opt-out modalities.	MOH, Technical partners

1.1.17	Develop and maintain effective referral mechanisms to improving referral linkages to HIV care, minimise losses to follow up and increase enrolment in HIV care for individuals who test HIV-positive.	MOH, Implementing partners
1.1.18	Continue to offer tailored HTS to priority populations, particularly key populations, members of uniformed services, prisoners, refugees and IDPs.	MOH, Implementing partners
1.1.19	Explore community provision of HTS (as part of the Boma Health Initiative roll-out, for example, or through CSOs) while ensuring effective follow up and referral for those who test HIV-positive.	MOH, Implementing partners
1.1.20	Engage CSOs and networks of PLHIV in communities to promote HTS and to assist with counselling and referral.	MOH, Implementing partners
1.1.21	Achieve and sustain commodity security for all HTS consumables.	MOH
1.1.22	Strengthen and maintain routine reporting of HTS results through DHIS2.	MOH
1.1.23	Continually pilot and, if effective, adopt new modalities of HTS, such as self-testing.	MOH, Technical and Implementing partners
1.1.24	Map and take advantage of opportunities in communities, such as religious or cultural events, recreational events, or political events, to promote HTS and the importance of 'know your status.'	MOH, Implementing partners

Voluntary Medical Male Circumcision

While VMMC remains a high impact prevention intervention globally and regionally, within South Sudan it has been implemented as a tailored programme for specific populations in specific locations. For example, in 2019, the United States Department of Defence, through RTI International, supported VMMC among the military as part of its overall HIV programme. Deeply entrenched and highly valued cultural traditions within the largely pastoralist society of South Sudan limit the applicability of this intervention as a broader strategy for HIV prevention. Additionally, health system challenges limit the feasibility of this intervention on a country-wide scale. While it will continue to be supported under the revised NSP, it will be focussed on populations and locations where significant coverage could be achieved to realise public health benefits.

Ref.	Strategic Interventions	Responsibility

1.1.25	Undertake a situational analysis of VMMC in South Sudan to more fully understand its socio-cultural significance and to identify barriers, enablers and opportunities for promoting it as a high-impact HIV prevention intervention.	SSAC, MOH
1.1.26	Based on the results of the assessment develop national guidelines and a scale-up plan.	SSAC, MOH
1.1.27	Undertake tailored demand creation and service provision for VMMC for priority populations (uniformed services for example, or amongst prisoners) where sufficient coverage could be achieved to obtain a public health benefit.	MOH, Implementing partners
1.1.28	Mobilise and equip cultural leaders to promote VMMC.	Implementing partners
1.1.29	Engage the cultural leadership to ensure that traditional circumcision practices do not create HIV-related risks.	MOH, Implementing partners
1.1.30	Strengthen the quality and availability of medical circumcision services within the primary health care system.	MOH

HIV Prevention for Key and Vulnerable Populations

This component of the national HIV response covers a range of populations and interventions, including those addressing key populations (FSW, MSM and prisoners); and vulnerable populations (uniformed services, adolescents and young people); and populations of humanitarian concern (refugees, IDPs and returnees). The intended outcomes for this component are knowledge about HIV and HIV risk reduction; improved coverage and uptake of tailored or 'friendly services' for HIV prevention, treatment, care and support; and increased community mobilisation to demand for HIV and other linked SRH interventions.

Ref.	Strategic Interventions	Responsibility
1.1.31	Design and deliver tailored combination HIV prevention interventions for key populations using globally-defined, evidence-based models adapted to the specific legal, socio-cultural and programming context for South Sudan.	MOH, Implementing partners
1.1.32	Invest in direct community mobilisation and empowerment interventions as part of combination HIV preventions interventions for key populations in order to create demand for services, and to build community ownership and resilience for sexual and reproductive health and rights.	Implementing partners
1.1.33	Provide comprehensive HIV programmes within uniformed services with a balanced emphasis on combination HIV	MOH, Ministry of Interior,

	prevention, HIV treatment care and support, and interventions to create enabling environments.	Implementing partners
1.1.34	Define and deliver a package of tailored interventions, differentiated by sub-groups, for adolescents and young people, balancing HIV prevention and sexual health promotion with HTS, and diagnosis and referral for HIV treatment	MOH
1.1.35	Fully integrate combination HIV prevention and sexual health promotion within existing efforts to offer adolescent-tailored health services in health facilities.	MOH
1.1.36	Mobilise young people in communities to design and deliver SBCC interventions, optimising the use of youth artists and other influencers in the delivery of such interventions.	Implementing partners

STI Screening, Diagnosis and Management

STI services in South Sudan represent missed opportunities for HIV testing and diagnosis for individuals with known high risks of infection. As of 2019, HIV screening was not routinely done for all patients, creating a considerable gap in efforts to diagnose and treat HIV. As with other primary health services, however, STI services struggled with insufficient or poorly motivated staff and stock-outs of key commodities, including STI screening tests. Under this revision, these gaps will be addressed through revising out-dated guidelines, providing additional training and mentorship to health care workers, achieving greater coordination and, where feasible, integration of HIV and STI services, and achieving commodity security for all essential STI consumables.

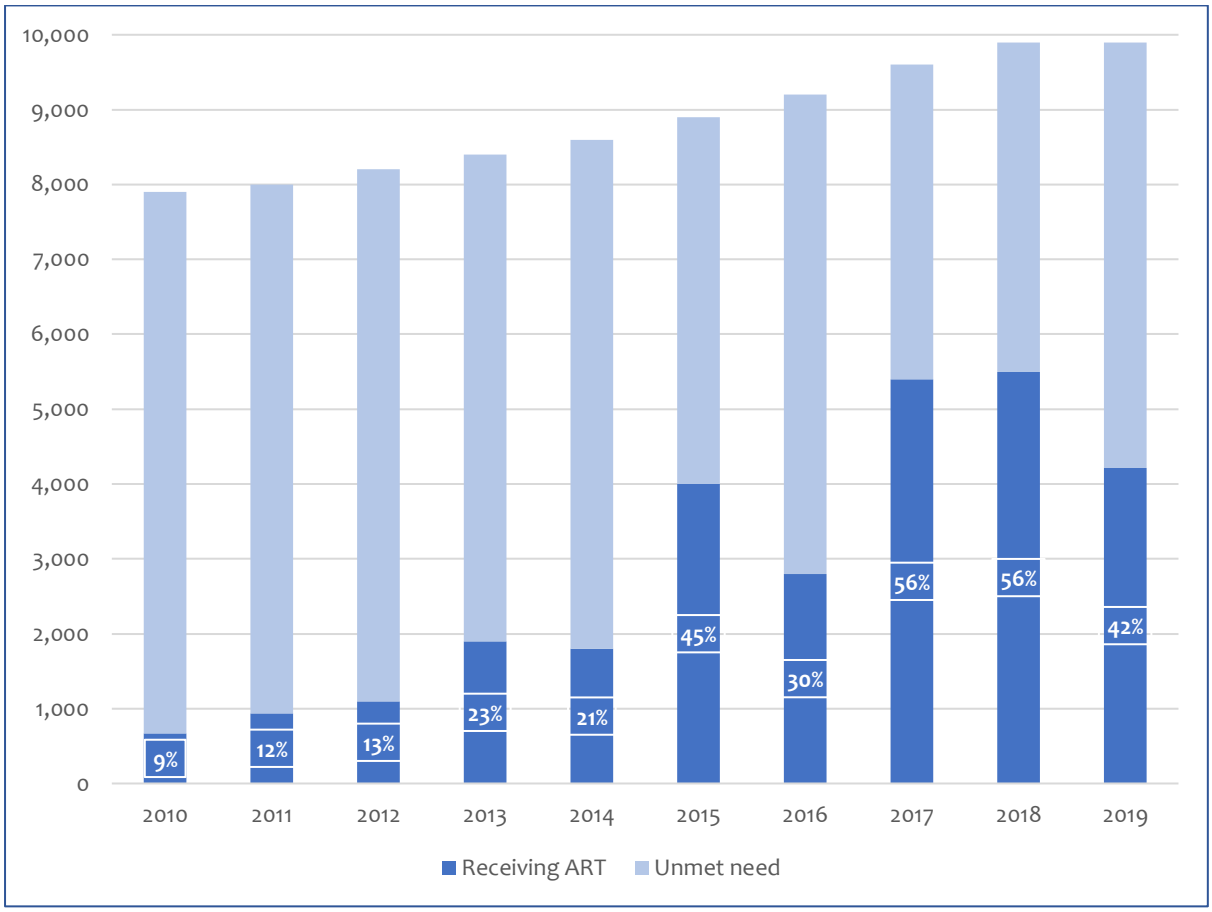
Ref.	Strategic Interventions	Responsibility
1.1.37	Review and revise national STI screening and management guidelines to include routine, opt-out HTS for all STI patients.	MOH
1.1.38	Train health care workers in STI and HIV programmes, in public and private sectors, on the revised guidelines; during the training address provider reluctance to offer routine HTS to all clients.	MOH
1.1.39	Integrate STI screening, treatment and/or referral within combination HIV prevention interventions for priority populations.	MOH, Implementing partners
1.1.40	Achieve and maintain commodity security for essential STI and sexual health commodities.	MOH
1.1.41	Strengthen STI surveillance and routine reporting through DHIS2.	MOH

Strategic Outcome 1.2: Mother-to-child transmission of HIV is reduced by 50%

By 2019, PMTCT was being offered in 109 facilities across the country, some of them co-located with ART services. However, early infant diagnosis (EID) was available in only 41 of these sites. National guidelines and standard operating procedures for PMTCT and EID supported the delivery of services.

Progress in coverage of PMTCT is shown in **Figure 3**, below.

Figure 3: PMTCT coverage 2010-2019



Source: UNAIDS Spectrum 2020 and MOH programme data

Internal conflict in 2016 significantly affected uptake of PMTCT service as well as routine reporting. Between 2017 and 2018, coverage remained stable at 56%; however, correction of reporting errors reduced the coverage to 42% in 2019. Early infant Diagnosis (EID) screening reached only 12% of exposed infants in 2019. UNAIDS estimated the vertical transmission rate at 27% in 2019, with 1,100 HIV infections averted and 80,000 infants born free of HIV. However, PMTCT coverage remained sub-optimal and far from achieving the global goal of eliminating vertical transmission of HIV while keeping mothers and their infants alive.

The PMTCT programme is a main pillar of the national HIV response. With strong support from technical partners, including the Global Fund, UNICEF and PEPFAR, the MOH has continued to expand the programme, with increasing coverage and uptake. The programme primarily focusses on Prongs 3 & 4 of the global PMTCT model.[13] There is limited investment in other components of the comprehensive PMTCT approach, such as primary prevention of HIV infection amongst women of child-bearing age, and for the prevention of unintended pregnancy for women PLHIV (Prongs 1 & 2). The revised NSP corrects this imbalance.

Ref.	Strategic Interventions	Responsibility
Prong 1: Prevent the sexual transmission of HIV amongst women of child-bearing age		
1.2.1	Scale up primary prevention of HIV among women of child-bearing age through integration of HIV prevention components (HIV awareness and risk reduction, access to HTS, referral for ART) across all primary health care services.	MOH
1.2.2	Fully integrate and promote routine HTS in ANC, RMNCH and family planning services for women across the health sector.	MOH
1.2.3	Train and equip traditional birth attendants to promote HTS and to refer women to health facilities for ANC and RMNCH services to know their HIV status.	MOH
Prong 2: Improve access and uptake for family planning services for women living with HIV		
1.2.4	Improve the accessibility and acceptability of family planning services for women living with HIV, through ANC and ART services, and as part of routine family planning services offered through health facilities.	MOH, Implementing partners
1.2.5	Address and resolve stigma and discrimination against women living HIV with regard to family planning and SRH across the health sector.	MOH, Implementing partners
1.2.6	Engage women living with HIV (as mentor mothers and community mobilisers) to promote family planning and to encourage full uptake and retention of women and children in PMTCT.	PLHIV networks
1.2.7	Undertake SRH literacy interventions, through ART centres and through CSOs and networks, for women living with HIV to empower them regarding their reproductive health choices, and to equip them to challenge and be resilient to stigma and discrimination in health services.	PLHIV networks

[13] WHO. 2017. *Global Guidance on Criteria and Processes for Validation. Elimination of Mother-to-Child Transmission of HIV and Syphilis*.

Prong 3: Prevent mother-to-child transmission of HIV		
1.2.8	Expand access to PMTCT through differentiated approaches, including facility-based, mobile services, and community-based components in order to reach all pregnant women.	MOH, Implementing partners
1.2.9	Increase the number of health facilities able to offer PMTCT services (including ART initiation and EID) through primary health care integration.	MOH
1.2.10	Strengthen and scale up community-led interventions (mentor mothers, for example) to support mothers and their children on ART for improved adherence, retention and overall health outcomes.	Implementing partners, PLHIV networks
1.2.11	Strengthen linkage and referral processes to ensure that pregnant women who test HIV-positive are not lost-to-follow-up.	MOH, Implementing partners, PLHIV networks
1.2.12	Provide adequate psycho-social counselling and support for newly diagnosed HIV-positive pregnant women to improve retention and adherence for them and their HIV-exposed infants.	MOH, Implementing partners, PLHIV networks
1.2.13	Improve the availability of EID services through decentralisation	MOH
Prong 4: Provide comprehensive HIV care, treatment and support for HIV-positive mothers, partners/spouses, and their children.		
1.2.14	Ensure strong linkages between facilities offering PMTCT and ART centres providing adult and paediatric HIV treatment and care to assure the quality and continuity of care and to avoid losses-to-follow-up.	MOH, PLHIV networks
1.2.15	Assist women living with HIV, using approaches to proactively identify and avoid risks of domestic violence and abuse, to engage their partners/spouses and children in HTS and, where relevant, enrolment in HIV care.	MOH, Implementing partners, PLHIV networks
1.2.16	Design and implement community-based strategies to engage men and boys in family planning, reproductive health, and PMTCT services.	Implementing partners, PLHIV networks

Strategic Outcome 1.3: HIV transmission in health care settings is eliminated

Preventing HIV transmission in health care settings involves implementation of infection control measures, including universal precautions; and the availability and adequacy of

policies and procedures for preventing and responding to occupational exposure to HIV, including the rapid administration of PEP. It also includes comprehensive blood safety, from donor recruitment and screening to safe storage, transport and utilisation of blood products. In 2019, within ART centres, standard operating procedures (SOPs) were in place to prevent occupational exposure, particularly within HTS. SOPs were also in place for the administration of PEP. No data were available, however, on use of PEP across the HIV programme. In some facilities where ART was provided, such as in PHCCs, the state of maintenance and upkeep of facilities significantly affected workplace safety, particularly with regards to TB exposure. Although AMREF was assisting the National Blood Service to improve blood safety, gaps still remained for the availability of safe blood products, donor recruitment, screening, testing and quality assurance of blood products, storage and transport. The revised NSP address these gaps in universal precautions and blood safety.

Ref.	Strategic Interventions	Responsibility
Improving the capacity of the health and health workers to observe universal precautions.		
1.3.1	Improve knowledge and adherence to national policies and guidelines on universal precautions across the health sector.	MOH
1.3.2	Establish and maintain commodity security for essential equipment and supplies for implementing universal precautions across the health sector.	MOH
1.3.3	Improve access to PEP, prioritising facilities and locations with growing prevalence of HIV across the population, and growing numbers of PLHIV using HIV and other health services.	MOH
1.3.4	Continue to provide education and awareness about PEP across all cadres of health care workers.	MOH
1.3.5	Improve monitoring and reporting of occupational exposure to HIV, including incident registries and data on uptake and outcomes of PEP.	MOH
1.3.6	Improve medical waste management equipment and procedures in all health facilities (including laboratories) offering HIV services.	MOH
Improving blood safety		
1.3.7	Establish and maintain a national, voluntary, non-remunerated blood donation programme that promotes retention of regular donors.	MOH, NBTS
1.3.8	Formulate, implement and continually review guidelines and SOPs for routine screening of donors and blood products for transfusion-transmissible infections (TTIs).	MOH, NBTS

1.3.9	Strengthen and sustain the capacity in clinical settings for the safe use of blood and blood products.	MOH, NBTS

Strategic Outcome 1.4: Gender-based violence is reduced

SGBV is a cross-cutting challenge in South Sudan. It is a criminal act in the country as well as a human rights violation. It affects most aspects of health and social development.[14] It has important links to the HIV response which is the rationale for its inclusion within the NSP. SGBV is a driver of HIV-related vulnerability and a contributor to new HIV infections for women and girls. To the extent that programmes and services to treat and support survivors are either not available, not accessible, or of poor quality, this represents missed opportunities, not only for comprehensive SGBV care, but also for HIV testing and referral for HIV interventions, especially PEP or ART. In addition, social cultural attitudes and practices regarding SGBV, particularly for the women and girls that are its victims, can perpetuate stigma and shame, and add to the already substantive barriers confronting these women to access and benefit from HIV services. Within the revised NSP what is prioritised are ensuring the national HIV response contributes to preventing and ending SGBV in South Sudan, and ensuring that access to HIV interventions, including HTS, PEP and ART, are routinely available within post-violence care interventions in all settings.

Ref.	Strategic Interventions	Responsibility
Leveraging HIV programming opportunities for preventing gender-based violence		
1.4.1	Integrate content on changing harmful gender norms and ending SGBV within HIV prevention and awareness interventions in communities.	MOH, Technical and Implementing partners
1.4.2	Ensure that content regarding harmful gender norms and SGBV is fully integrated within combination HIV prevention interventions for adolescents and young people.	MOH, Technical and Implementing partners
1.4.3	Ensure that interventions to prevent and respond to SGBV, including intimate partner violence, are included within comprehensive HIV prevention interventions for priority populations, particularly FSW, MSM, prisoners, uniformed services, and refugees and IDPs.	MOH, Technical and Implementing partners
1.4.4	Ensure that cultural, religions and political leaders and change agents address harmful gender norms and ending SGBV as part of their efforts to promote HIV awareness and social and behavioural change.	MOH, Technical and Implementing partners
1.4.5	Ensure that interventions in communities to engage men and boys in HIV and sexual health programmes include content on	MOH, Technical and

[14] UNFPA and IOM. 2017. *SBV Sub-Cluster Strategy South Sudan*; USAID/South Sudan. 2019. *Gender-Based Violence Prevention and Response Roadmap 2019*.

	changing harmful gender norms and eliminating SGBV in all its forms.	Implementing partners
Integrating HIV prevention and care within comprehensive post-violence care and support		
1.4.6	Ensure timely access to PEP for all survivors of SGBV.	MOH, Implementing partners
1.4.7	Ensure timely access to ART for survivors who need it.	MOH, Implementing partners
1.4.8	Train and equip health care workers providing HIV services to recognise and address the signs and symptoms of SGBV, and to provide compassionate care to survivors.	MOH
1.4.9	Ensure that comprehensive care and support for survivors of SGBV, including intimate partner violence, is integrated within HIV programming for key populations.	MOH, Implementing partners
Supporting multi-sectoral collaboration for ending GBV in all its forms		
1.4.10	Mobilise HIV stakeholders to participate in multi-sectoral efforts, from the central to the community levels, to end SGBV in all its forms.	SSAC

Strategic Objective 1.5: HIV-related stigma and discrimination is reduced

A new PLHIV Stigma and Vulnerability Index was completed by SSNeP+ and NEWPU in 2019. The findings reveal important details about the nature and extent of HIV-related stigma and its effects on PLHIV in communities. Most respondents felt that stigma and discrimination against PLHIV was largely motivated by lack of correct knowledge and fear of infection. HIV was known by many in communities but known in negative and derogatory terms. Approximately two-thirds (60%-70%) of survey respondents had disclosed their HIV status, however only 30% had done so in family settings. More than half experienced self-stigma, in the form of shame and guilt about their HIV status, and a similar proportion indicated that fear of stigma and shame prevented them for seeking an HIV test earlier in the course of their illness. The revised NSP proposes a combined programme of strategic intervention to reduce stigma and discrimination in all settings.

Ref.	Strategic Interventions	Responsibility
1.5.1	Finalise and enact the National HIV Policy as the guiding framework for addressing HIV-related stigma and discrimination across all sectors and in all settings.	SSAC, National Assembly
1.5.2	Design and deliver community-oriented, culturally competent interventions to address HIV-related stigma and discrimination within communities and families.	SSAC, PLHIV networks,

		Implementing partners
1.5.3	Improve the capacity of HIV stakeholders to understand and reduce HIV-related stigma and discrimination.	SSAC and partners
1.5.4	Conduct strategically focussed, broader campaigns regarding stigma and discrimination reduction. All of these efforts must be tailored to the country context of low literacy and limited formal channels for communication and information dissemination.	SSAC, PLHIV networks, Implementing partners
1.5.5	Map opportunities across primary health care services, political, religious and cultural events, as well as recreational activities in communities to integrate initiatives for stigma and discrimination reduction; develop an action plan to respond to the results of the mapping.	SSAC
1.5.6	Undertake sensitisation interventions with uniformed forces, including the police and the military, local officials, cultural and religious leaders, health care workers, parliamentarians and others, regarding the negative impacts of stigma, discrimination and violence against key populations on the country's efforts to address and resolve its HIV-related challenges.	SSAC, Implementing partners, PLHIV networks
1.5.7	Undertake community empowerment interventions, including legal and human rights literacy and other components of positive health, dignity and prevention, with PLHIV and key population groups to improve their capacity to challenge and be resilient to acts of stigma, discrimination and violence.	PLHIV networks, key and vulnerable population CSOs, other CSOs and networks.
1.5.8	Improve the capacity of legal service providers to offer legal advice and services to PLHIV and key populations who experience stigma, discrimination and violence in order to improve access to justice and redress.	SSAC and partners

Strategic Objective 1.6: HIV-sensitive social protection is provided to the most vulnerable

In 2019, South Sudan was ranked at 186 out of the 189 countries included in the Human Development Index.[15] Eight-three-percent of the population was rural, with 78% of households depending on crop farming or animal husbandry as their primary source of livelihood. Other standard socio-economic development indicators painted a bleak picture for the population and the country's near-term prospects for political, social and

[15] See: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/SSD.pdf

economic development. In 2019, 92% of the population lived in multi-dimensional poverty, with 74% considered to be in extreme poverty.[16] Although 63% of the adult population was considered to have some labour force participation (with participation in subsistence agriculture being the predominant form of 'employment'), 87% of the employed population was considered to be in highly vulnerable circumstances.

Socio-economic vulnerability linked to food insecurity are main drivers of vulnerability to disease, including HIV and TB. Shifting these structural vulnerabilities to a meaningful degree will take substantial investment sustained over a significant period. For the revised NSP, interventions have been prioritised to attempt to alleviate severe vulnerability, both for populations at high risk, such as orphans and vulnerable children and adolescent girls and young women, as well as HIV-affected households living in severe to extreme poverty.

Ref.	Strategic Interventions	Responsibility
1.6.1	Design and implement comprehensive social protection interventions to reduce the HIV-related vulnerabilities of adolescent girls and young women (including cash transfers, livelihoods development, empowerment training, and stronger legal and policy instruments to end early and forced marriage, SGBV, and sexual exploitation and abuse).	SSAC and partners
1.6.2	Strengthen and scale up social protection interventions for orphans and vulnerable children to reduce their HIV-related vulnerabilities.	SSAC and partners
1.6.3	Strengthen and scale up interventions to support the most socio-economically vulnerable PLHIV and their families.	SSAC, PLHIV networks, Technical partners

Strategic Objective 1.7: Humanitarian Responses Integrate HIV Programming

In 2019, Health services for IDPs in POCs, and refugees in camps and other locations, were provided by a number of partners, including IOM, the International Committee of the Red Cross (ICRC), UNHCR, and MSF, among others. Very little disaggregated data were available on these services. Given the size of these populations in South Sudan in 2019 (approximately 4 million) this information gap was very serious.[17] Anecdotal accounts from key stakeholders suggested that low awareness of HIV and high levels of stigma, discrimination and denial significantly affected the uptake, reach and effectiveness of efforts to provide HIV services. By the end of 2019, it was anticipated that, during 2020, a new government of national unity would be formed to secure peace for South Sudan and to initiate comprehensive efforts for reconstruction and renewal. As a result, the GOSS and partners were beginning to plan for repatriation of refugees and resettlement of IDPs

[16] See: http://hdr.undp.org/en/countries/profiles/SSD. All additional data in this paragraph is from this source unless otherwise indicated.
[17] OCHA. 2019. *South Sudan Humanitarian Response Plan 2020.*

in large numbers. Ensuring access to HIV services for prevention, treatment, care and support must be an important consideration in these processes. The revised NSP anticipates these developments.

Ref.	Strategic Interventions	Responsibility
1.7.1	Ensure that the law and policy context for health interventions in humanitarian settings mandate a minimum package of HIV interventions, particularly HTS, PMTCT, PEP in the context of responding to SGBV, HIV diagnosis and referral for ART, enrolment and retention on ART, community mobilisation and stigma reduction, and HIV risk reduction for humanitarian workers.	SSAC and humanitarian partners
1.7.2	Design and implement guidelines and interventions to ensure continuity of HIV care amongst refugees, asylum seekers and IDPs, particularly as part of emergency support and as part of resettlement.	SSAC and humanitarian partners
1.7.3	Develop and implement a prioritised, costed plan for comprehensive HIV service provision, through existing and new service points, for returning refugees as well as re-settled IDPs.	SSAC and humanitarian partners
1.7.4	Maintain a comprehensive data set on the coverage and outcomes of HIV interventions involving IDPs and refugees, prioritising HIV incidence, HIV diagnosis and enrolment on ART, adherence and retention on ART, transfers and referrals.	SSAC, MOH and humanitarian partners

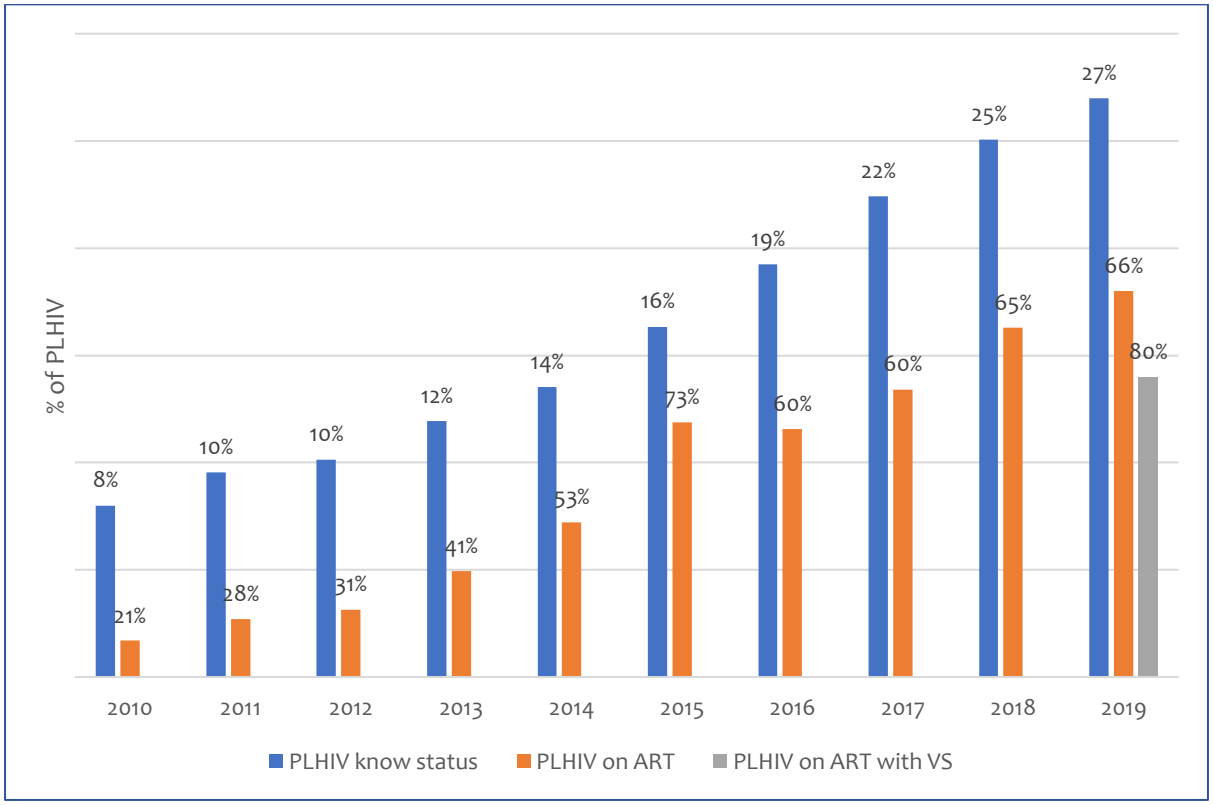
5. THEMATIC AREA: HIV TREATMENT, CARE AND SUPPORT

Strategic Direction 2: Improve health outcomes for all PLHIV

Context

The South Sudan HIV treatment programme was established in 2006. Since then, it has undergone numerous developments and changes, particularly during more recent times when internal conflict and population displacement created major challenges for continuity and access in many locations across the country. The most recent of these periods occurred in 2016 and, since then, the programme has been recovering and has continued to expand. The 'test and start' approach was introduced in 2017 and since 2018, viral load analysis has been available to a growing number of PLHIV and on ART. As of 2018, South Sudan's progress with regard to the global 90-90-90 targets is shown in **Figure 4**, below:

Figure 4: 90-90-90 results (2010-2018)



Source: UNAIDS Spectrum 2020 and MOH programme data

It is notable that, although the proportion of PLHIV (adult) who know their status has steadily increased over the 2010-2019, the proportion subsequently enrolled on ART has remained relatively stable, particularly between 2015-2019. The number of PLHIV newly enrolled on ART was significantly below the number of estimated new HIV infections annually, meaning that despite a year-over-year increase in number of PLHIV on ART, coverage of this life-saving intervention increased only incrementally. For the 2010-2018 period, no consolidated data were available on viral suppression. In 2019, out of a total

number of 13,486 samples tested, 10,798 returned a result of undetectable viral load, a proportion of 80%.[18]

Lessons learnt by the end of 2019, the mid-point of the implementation of the 2018-2022 NSP included:

- The 'test and start' approach has improved uptake and retention on ART for many PLHIV. Similarly, the introduction of easier to tolerate regimens (TLD) and multi-month scripting for stable PLHIV on ART has improved adherence and retention as well as the general satisfaction of PLHIV with the quality of their care.

- The engagement of networks of PLHIV in communities to enhance ART services, as treatment supporters, mentor mothers, counsellors, and for tracing patients lost-to-follow-up, has contributed to improved uptake and retention in HIV care, and has contributed to reengaging PLHIV on ART.

- The expansion of viral load screening has improved the quality of care for health care providers and for PLHIV on ART.

- However, despite improvements, there were significant retention and adherence challenges for those PLHIV who were initiated on ART. The 2018 HIV cascade analysis results showed wide variations between facilities with significant declines in retention beyond the 24-month period. Adherence was compromised for a number of PLHIV due to chronic food insecurity, severe poverty, long distances to ART sites, safety and security risks, and the burden of stigma, discrimination and fear. Some religious institutions were also promoting 'miracle cures' and thereby encouraging some PLHIV to stop their ART.

- Coverage of paediatric ART remained very low reflecting an overall challenge for South Sudan of children having access to health services. The low number of health care workers able to treat children, the limited number of ART sites offering paediatric ART, and the limited availability of EID services, also contributed to low coverage.

- The non-functionality of national procurement and supply management systems meant that partners used their own systems and process for the supply, management and distribution of essential commodities. This resulted, in some cases, in over-supply of commodities that subsequently expired, or under-supply of critical items due to an inability to accurately forecast demand.

- Similar, chronic and intractable weaknesses across the health system compromised most efforts to strengthen and extend HIV interventions to the sizeable proportion of the population that is still unable to access them, including 80% of more of the estimated number of PLHIV.

These lessons learnt have informed the following strategic shifts for the revision:

[18]PEPFPAR. 2020. *South Sudan Country Operational Plan 2020: Strategic Directions Summary*.

- A more intensive application of the differentiated service delivery (DSD) approach, including community-based delivery of HIV care, to provide more opportunities beyond health facilities to reach PLHIV with ART and other needed interventions to protect and promote their health.

- Continuing to strengthen the ART programme in health facilities, including using satellite facilities (smaller facilities linked to ART centres, for example), for HTS, same day ART start, and ART refills for stable patients.

- Intensifying efforts to diagnose, initiate and retain HIV-positive children in HIV treatment and care, through expansion of EID services, and through greater integration of HIV services within primary health care services, particularly ANC, RMNCH and family planning.

- Significant scale up the technical and operational investment in CSOs and networks of PLHIV working in communities to support all aspects of the national HIV programme.

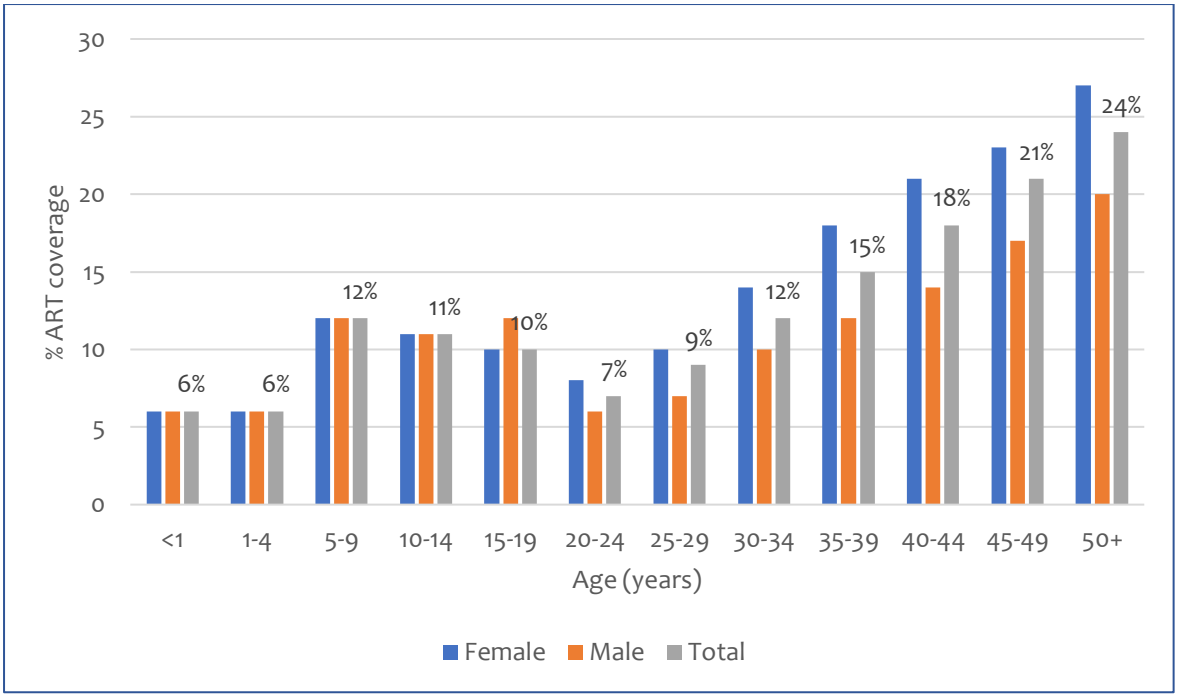
- Increased emphasis on integration of access to ART within primary health care services to achieve greater equity and sustainability.

Strategic Outcome 2.1: Increase proportion of all PLHIV enrolled and retained on ART

By the end of 2019, there were 34,988 PLHIV (all ages) on ART, 5,455 (16%) were adolescents and young people (15-24 years), and 1,789 (5%) were children (0-14 years).[19] There are substantial differences, however, in coverage of ART by age and sex, as shown in **Figure 5**, below.

Figure 5: ART coverage by age and sex (2019)

[19] National programme data as reported in PEPFPAR. 2020. *South Sudan Country Operational Plan 2020: Strategic Directions Summary*.



Source: MOH programme data

ART coverage is low overall. However, it is lowest for children <5 years (6%) and older adolescents and young adults (15-30 years, 7%-10%). Moreover, ART coverage is higher for women than men from age 20 onwards, indicating a need for concerted efforts to find older men to initiate them on ART.

During 2018-2019, access to ART through health facilities continued to expand, reaching 90 functional facilities by the end of 2019. However, 30 (26 were PEPFAR supported) of 90 facilities supported 90% of all PLHIV on ART. Volumes ranged from close to 3,500 active patients to four or less. Despite the three-fold expansion of ART access points in recent years, which significantly increased equity in terms of availability of ART to PLHIV, gains in uptake and coverage did not reflected a similar trend.

Under the revised NSP, continued efforts will be made to encourage all PLHIV to know their status and to be enrolled on ART. Stronger efforts will be made to identify and roll-out ways for PLHIV to access and remain on ART that compliment and extend the current facility-focussed approaches into more locations and communities across the country.

Ref.	Strategic Interventions	Responsibility
2.1.1	Design and roll-out a DSD strategy for rapid scale-up of ART services across all sectors and from the central to the community levels.	MOH, Implementing partners
2.1.2	Increase the number of entry points to HIV care and treatment through greater integration across the primary health care sector as well as through strengthening systems and process for effective referrals and linkages between services and facilities.	MOH, Implementing partners

2.1.3	Build and maintain the operational capacity of CSOs and networks in communities, particularly those led by PLHIV, to undertake community mobilisation to encourage HTS and to support more PLHIV to know their status and to be linked to HIV care.	MOH, Technical and Implementing partners
2.1.4	Expand access, uptake, coverage and retention in paediatric ART through greater integration within all ART service points and through creating more opportunities for entry into ART across ANC, RMNCH and other child health programmes.	MOH
2.1.5	Improve the prevention, diagnosis, treatment and cure rate for TB for PLHIV through greater integration of HIV and TB programmes and services from the central to the facility levels.	MOH, Technical and Implementing partners
2.1.6	Improve the prevention, diagnosis and treatment of HIV-related comorbidities through routine training and mentoring of health care providers, as well as through stronger linkages and integration of HIV care with other relevant health services.	MOH
2.1.7	Establish and sustain a country-wide system to monitor and swiftly address ART-related toxicities (integrated within the national pharmacovigilance system) and other adverse events arising from the treatment, care and support of PLHIV.	MOH, Technical partners
2.1.8	Routinely monitor, using early warning indicators, and address HIV-related drug resistance.	MOH, Technical partners

Strategic Objective 2.2: Increased proportion of PLHIV on ART with viral suppression.

Given the challenges for many PLHIV in the country to access ART, it is critical for those who do succeed that they are retained in care and supported to achieve life-long adherence and overall improved health and well-being. However, in 2019, twelve-month retention on ART reached only 57% with significant variations between facilities and Counties. PEPFAR partners estimated that, in 2019, for every 160 PLHIV that were initiated on ART, only **one** remained in care after 12 months.[20] Barriers included stigma, distance, costs of transport, HCWs' attitudes, inadequate adherence counselling, poverty, insecurity and lack of community-based and community-led interventions targeting new and old recruits to HIV care and treatment.[21]

Under the revised NSP, efforts will continue to address barriers to retention and adherence on ART, largely through increased investments in communities and through giving more attention to the psycho-social needs of PLHIV, including for mental health

[20] PEPFAR (2020), *COP20 SDS*, p. 14.
[21] USAID South Sudan. A Study to Understand Barriers and Enablers to Adherence to ART and Retention in Care Among HIV-Positive Clients in South Sudan. pp. 21-26.

support. Access to viral load testing will also be expanded. Additional emphasis will be placed on supporting PLHIV to address other barriers, such as food insecurity, poverty, and distance to health facilities offering ART, all of which are known to negatively affect retention and adherence.

Ref.	Strategic Interventions	Responsibility
2.2.1	Design and implement differentiated, 'person-centred' strategies (such as inclusion of ART regimens with low toxicities and side effects, multi-month dispensing, and decentralised ART refill access points in facilities and communities) to improve retention and adherence of all PLHIV on ART.	MOH, Technical partners
2.2.2	Design and implement tailored strategies to improve retention and adherence for children and adolescents on ART.	MOH, Implementing partners
2.2.3	Strengthen and scale-up community-based interventions, led by CSOs, networks and PLHIV, to support retention and adherence, including for tracing individuals lost-to-follow-up and for reengagement in HIV care.	MOH, Implementing partners
2.2.4	Provide enhanced psycho-social support, including primary-level mental health care, to eligible PLHIV on ART facing retention and adherence challenges.	MOH, Implementing partners
2.2.5	Strengthen systems for retention and adherence monitoring, including, where feasible, the use of electronic patient records, continuous registers reviews, automated reminders, and other modalities.	MOH, Implementing partners
2.2.6	Expand access to viral load monitoring through decentralisation and integration with TB diagnostic and monitoring facilities (utilising the GeneXpert platform, for example).	MOH, Implementing partners
2.2.7	Sustain, where relevant and effective, innovative approaches (such as public-private partnerships with transport service providers) to improve timely and reliable access to viral load monitoring for all PLHIV, including swift turn-around for results.	MOH, Implementing partners
2.2.8	Continue to improve the availability, accessibility and reliability or other clinical monitoring and diagnostic services for PLHIV, including hepatitis screening, cervical cancer screening, STI screening, and other relevant diagnostics.	MOH, Implementing partners
2.2.9	Achieve and sustain commodity security for all consumables required for the provision clinical monitoring of all PLHIV on ART.	MOH, Implementing partners

Strategic Objective 2.3: Sustain positive health, dignity and prevention for all PLHIV

In addition to life-long support for ART, PLHIV have other priorities to secure and maintain health and well-being. These include meaningful livelihoods, food security, adequate shelter, safety and security, and overall strength and resilience, particularly in contexts like South Sudan where much misinformation about HIV prevails along with high levels of stigma, discrimination and fear. Under the revised NSP, interventions are prioritised to ensure that the most vulnerable PLHIV receive a basic package of social protection interventions (to the extent that these are feasible and sustainable), and that greater efforts are made to empower PLHIV and their families in communities to provider for their own livelihoods and food security independent of external support.

Ref.	Strategic Interventions	Responsibility
2.3.1	Identify a relevant and feasible package of social protection services to make available to highly vulnerable PLHIV and their households.	MOH, PLHIV networks, Implementing partners
2.3.2	Strengthen the technical and operational capacity of CSOs and networks in communities, including those led by PLHIV, to provide social protection support, prioritising interventions for food security, and economic and social support needs.	MOH, PLHIV networks, Implementing partners
2.3.3	Strengthen the quality and coverage of therapeutic nutritional interventions for clinically malnourished PLHIV and their households.	MOH, Implementing partners
2.3.4	Scale-up and sustain social support interventions led by PLHIV to support long-term adherence, retention and positive health, dignity and prevention (PHDP) for PLHIV in all settings.	PLHIV networks
2.3.5	Equip CSOs and networks of PLHIV, from central to community level, to design and implement PHDP interventions.	PLHIV networks, Technical partners

6. THEMATIC AREA: EFFICIENCY, INTEGRATION AND SUSTAINABILITY

Strategic Direction 3: Strengthen the critical enablers for the multi-sectoral HIV response.

Context

An effective national response to HIV must be underpinned by laws, policies and systems across the health sector, and amongst the multi-sectoral stakeholders, in order to operative efficiently, effectively, and to be sustained long enough to achieve impact. While in 2019 there had been improvement in areas such as strategic information and some limited change in the health sector, significant gaps remained. These included:

- The absence of a supportive law and policy framework to entrench human rights and gender equity across the public health response to HIV;
- Ongoing gaps in health and community systems, particularly for adequate health human resources, functional and minimally equipped health facilities, procurement and supply management, and for accessibility to HIV services for a substantial proportion of the population;
- Ongoing gaps in the range and quality of strategic information needed to guide the national HIV response, particularly for prioritisation in a resource-constrained, challenging operating environment;
- Minimal domestic investment, both in the national HIV response, as well as for the health sector as a whole;
- Limited leadership for coordination, accountability and strategic guidance on the part of the MOH and SSAC.

As a result, the national HIV response remained largely a vertical programme, implemented mostly through external partners, and resulting in fragmentation, lack of consistency, inefficiencies, and sub-optimal value-for-money and impact. This was despite the good intentions and commitment of all stakeholders to rolling out an effective national HIV response in a challenging country context.

To addressed these challenges, the revised NSP has prioritised the following:

- Improving the law and policy environment for a human-rights-based and gender-transformative HIV response that is inclusive and leaves no one behind;
- Defining a clearly strategy for integration of the HIV programme within the primary health care system;
- Leveraging investments in HIV programmes for broader health and community system strengthening;

- Improving the range of quality of strategic information through continued technical and operational investments in data systems and research;

- Sustaining multi-sectoral engagement for greater domestic investment in the health sector, including for the national HIV response;

- Strengthening the technical and operational capacity of SSAC and the MOH to provide effective strategic, technical and operational leadership and coordination from the central to the community levels.

Strategic Outcome 3.1: An enabling legal and policy environment is established.

As noted previously, in 2019, a new PLHIV Stigma and Vulnerability Index was completed by SSNeP+, NEPWU and their technical partners. The findings revealed important details about the nature and extent of ongoing HIV-related stigma, discrimination and denial, and their effects on PLHIV in communities. Mechanisms for redress, including access to justice, remained unavailable. Challenges continued to be more serious for members of key population groups, particularly FSW and MSM. Sex work and same-sex sexual relations remained criminalised in South Sudan. Because of this, and fuelled by deeply held socio-cultural and gender norms rejecting such individuals and behaviours, rates of verbal, physical and sexual violence and abuse against these individuals, including on the part of public officials and uniformed services, remained high. To address this, the revised NSP prioritises the following strategic interventions.

Ref.	Strategic Interventions	Responsibility
3.1.1	Routinely assess the legal, regulatory and policy environment for the national HIV response to ensure that it supports a human-rights-based, gender-transformative public health response to HIV and other public health priorities.	SSAC
3.1.2	Enact and continuously review the National HIV Policy to ensure that it supports a human-rights-based, gender-transformative public health response to HIV for all HIV-affected populations, in all their diversity.	SSAC
	Repeal legal provisions criminalising same-sex sexual relations, sex work, and 'intentional' transmission of HIV.	SSAC
3.1.3	Improve protective measures for key and vulnerable populations to ensure their full access, uptake and long-term retention in HIV services.	SSAC

Strategic Outcome 3.2: Strong health and community systems support the HIV response.

In 2019, the performance of the national HIV programme continued to be negatively affected by health human resource challenges from the central to the facility levels. Across the public health sector, including at the central programme management levels, the value of salaries had depreciated to barely above subsistence level because of currency devaluation and rising inflation. This was also the case across the national HIV programme and it contributed to chronic turn-over as individuals moved to positions within partner organisations or left the country entirely. It also led to low motivation and poor performance. Through partners, retention incentives were paid across central, state and facility levels which were meant to attempt to stabilise staffing and to ensure that core HIV programmes remained viable. While some partners invested in community systems, including CSOs and PLHIV networks to promote HTS, to identify and refer PLHIV for diagnosis and treatment, and for retention and adherence, for example, overall investment remained low and represented significant missed opportunities for scaling up and extending the national HIV response into the many communities that it does not yet reach. To address this, the revised NSP prioritises the following interventions.

Ref.	Strategic Interventions	Responsibility
3.2.1	Continue to mobilise system strengthening investments, both financial and technical, prioritising health management information systems (HMIS), procurement and supply management (PSM), and the decentralisation of clinical monitoring and diagnostic services.	MOH
3.2.2	Define a consistent approach to the retention of health workers and programme staff that is aligned to broader health sector agreements and that reduces to the greatest extent possible avoidable differences in remuneration rates and retention schemes.	MOH, Implementing partners
3.2.3	Develop and implement an integration strategy for HIV services across the primary health care sector as defined in Basic Package of Health and Nutrition Services	MOH
3.2.4	Significantly scale up technical and operational investments in CSOs and networks of PLHIV working in communities to support all aspects of the national HIV programme.	SSAC, Technical partners, funders, CSOs
3.2.5	Integrate the systems strengthening needs of the national HIV response within health sector development plans, strategies and partnerships.	MOH, Technical partners
3.2.6	Leverage the roll-out of the Boma Health Initiative for the integration of community-level HIV interventions, particularly for promoting HIV awareness, reducing stigma and	MOH

	discrimination, promoting behaviour change, and mobilising demand for HIV services.	
3.2.7	Leverage HIV-specific investments in health and community systems strengthening for broader system strengthening gains in the context of integration.	MOH, technical partners
3.2.8	Align recruitment and retention schemes for HIV programmes with the broader health sector policies and practices as set down by MOH. Ensure that these policies and practices incorporate and address the needs of the national HIV response.	MOH, Implementing partners
3.2.9	Undertake a comprehensive capacity assessment of community and civil society organisations active in the national HIV response. Based on the findings, design and deliver a multi-year institutional capacity development strategy.	SSAC
3.2.10	Build and maintain the Technical and operational capacity of CSOs and networks led by or working with PLHIV and priority populations in communities.	SSAC, technical partners

Strategic Outcome 3.3: The availability and use of strategic information is increased.

By 2019, significant investments had been made to strengthen the systems and processes for generating accurate and timely strategic information to guide the implementation of the national HIV response. This included an extensive, country-wide effort to up-grade the HMIS from DHIS1.4 to 2.0. The HIV Strategic Information Sub-Technical Working Group provided some degree of oversight and coordination for these efforts. Both the Global Fund and PEPFAR programmes provided financial and technical support. Other achievements included completion of surveillance and research interventions, such as the ANC sentinel surveillance survey, IBBS surveys for MSM and FSW, and participation in the a regional STI study led by the East Africa Community. To sustain this momentum towards addressing and closing critical gaps in systems and data, the revised NSP prioritises the following strategic interventions.

Ref.	Strategic Interventions	Responsibility
3.3.1	Continue to invest in the quality and reach of the DHIS2 system to position it as the main data collection and dissemination modality for the national HIV response for *all* partners.	MOH, Technical partners
3.3.2	Develop a prioritised, national HIV research plan and conduct applied, multi-disciplinary HIV research on a routine basis.	SSAC, MOH, partners
3.3.3	Widely disseminate and promote the results of HIV research, using different formats, modalities and targeting different	SSAC, MOH partners

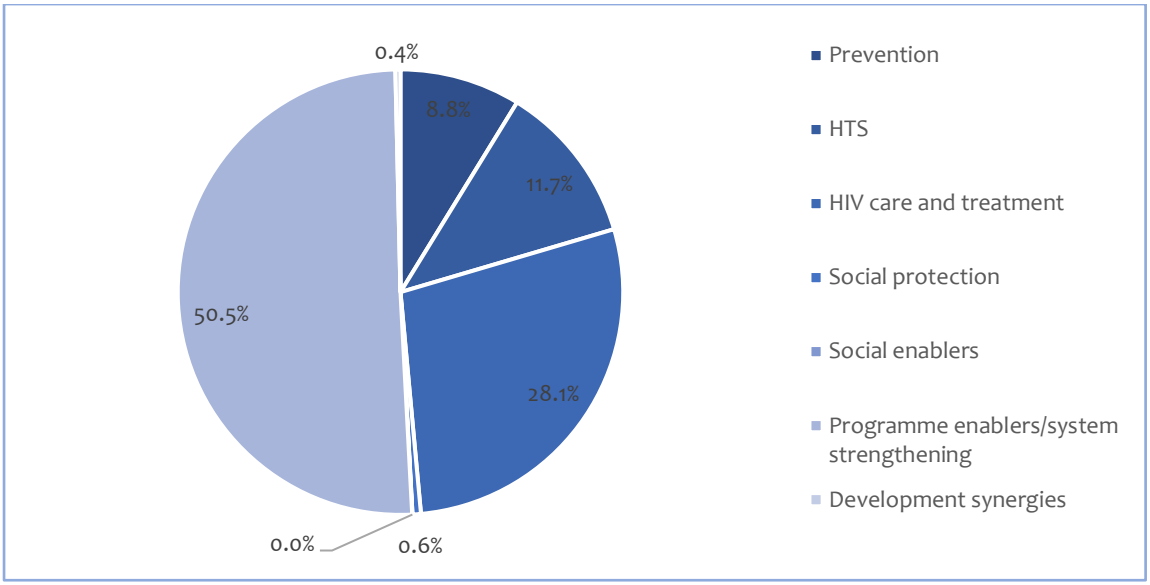
	audiences, in order to encourage uptake and use of research findings.	
3.3.4	Strengthen the capacity of research governance bodies and research institutions to undertake and assure the quality of routine HIV research.	MOH, Technical partners
3.3.5	Conduct annual joint reviews (and produce an annual report) on the state of the national HIV response engaging all stakeholders from all sectors and from central to community levels.	SSAC, MOH and partners
3.3.6	Build and sustain community-based monitoring mechanisms for accessible, available, acceptable and quality-assured HIV programmes in communities.	SSAC, CSOs
3.3.7	Perform routine data quality audits and develop improvement plans to address results.	SSAC, MOH
3.3.8	Conduct an end-term evaluation of the NSP and widely disseminate the findings.	SSAC

Strategic Outcome 3.4: Domestic financing and ownership is increased.

During 2019, a new National AIDS Spending Assessment (NASA) was conducted, covering the three financial years from 2015/2016 to 2017/2018 (the previous NASA dated from 2012). The findings offered a detailed picture of how the national HIV programme was financed and how these resources were used. In 2017/2018, spending on HIV/AIDS programmes totalled USD41 million which represented a 9% decrease over the previous period (largely arising from a decrease in the Global Fund allocation over previous years). In the same financial year, the United States government contributed USD26 million or 63.5% of all resources, while the Global Fund contributed USD10 million or 24.6%. It was estimated that the GRSS contributed USD4 million or 9.6%, almost exclusively in the form of salaries for health workers. Over the full three-year period of analysis, the NASA found that external financing supported 92% of all expenditure.

Figure 6, below shows programme expenditure for 2017/2018 across the NASA programme categories.

Figure 6: 2017/2018 expenditure by NASA programme category



Programme enablers/system strengthening represented the largest expenditure category. It included USD10 million in programme management expenses and USD6 million for 'non-disaggregated' system strengthening costs. HIV care and treatment was the next largest expenditure category, which included USD4 million in salary support (the largest component of which is partner-supported staff in ART facilities). Spending on prevention activities, including PMTCT, amounted to only 8.8% of total expenditure. Spending on social protection and social enablers, including efforts to address enabling environment issues for key populations, represent only 1% of the total.

With regards to sustainability, the analysis makes clear that South Sudan is far from being able to take up a reasonable share of HIV programme expenditure beyond what it currently contributes on the human resources side. At the moment, the GRSS contribution to direct programme costs is negligible if non-existent. To improve this situation, the revised NSP prioritises the following strategic interventions:

Ref.	Strategic Interventions	Responsibility
3.4.1	Expedite the implementation the Global Fund-supported Capacity Development and Transition Plan for the MOH to address and resolve its critical gaps in financial and programmatic management, coordination and leadership of the national HIV response.	MOH
3.4.2	Develop an HIV investment case for South Sudan. Ensure that it reflects a balanced, strategic orientation for the national HIV response that gives equal emphasis to combination HIV prevention as well as to provision of ART.	SSAC
3.4.3	Based on the investment case, identify short, medium and long-term opportunities for progressively increasing the domestic contribution to the national HIV response.	SSAC

3.4.4	Linked to the investment case, develop a short, medium and long-term resource mobilisation strategy including both domestic and external opportunities across all sectors and sources.	SSAC
3.4.5	Increase the value-for-money of investments in the national HIV response through undertaking routine analyses of allocative and technical efficiency and taking action on the results.	SSAC, MOH, Technical partners
3.4.6	Develop policy guidance for external partners on acceptable financing arrangements, including ceilings for programme management costs.	SSAC, MOH
3.4.7	Mobilise the multi-sectoral stakeholders to advocate for increased domestic investment in the health sector.	SSAC
3.4.8	Routinely conduct NASAs in order to measure progress for increasing the domestic financial commitment to the national HIV response.	SSAC

Strategic Outcome 3.5: Multi-sectoral coordination and collaboration is improved.

As noted at several points throughout this revised NSP, there are numerous partners that work with the national HIV programme and, effectively, deliver much of the programme's mandate across the country.[22] Indeed, in the current country context, the programme would be inoperable without this support. And while it is of great benefit to the people of South Sudan, particularly those who rely on HIV interventions for their health and well-being, it has come to create significant challenges for coordination and harmonisation to the extent that it affects the stability and viability of the programme. Due to the severity of health system challenges, as well as the complex nature of the country's terrain (including the numerous safety and security risks), many partners use their own systems for programme delivery, including PSM, commodity transport and storage, and last-mile delivery to health facilities. As noted above, some partners also recruit dedicated staff to deliver services, often along side or in close proximity to public sector health workers.

In the midst of this complex situation, the MOH has not succeeded in playing an effective role to coordinate the partners and to direct their contribution within one overall framework or vision for the national HIV programme. Similarly, due mainly to the limited domestic investment in the national HIV response, the functional capacity of SSAC to perform its strategic level leadership and coordination role has become severely constrained and largely non-functional beyond the central level. To address this situation, particularly within an ongoing context of resource constraints and many competing

[22] In a recent analysis, the PEPFAR programme identified 85 entities working in some capacity within the national HIV response and affiliated health programmes, such as laboratory services, blood bank, or supply chain management. PEPFAR. 2020. COP20 Priorities. PowerPoint Presentation. January 28, 2020.

priorities for resources for the HIV response, the revised NSP prioritises the following strategic interventions:

Ref.	Strategic Interventions	Responsibility
3.5.1	Conduct a functional review of current coordination mechanisms at central, state and county levels with a view to identifying more sustainable and effective modalities given the strategic direction of integration.	SSAC, Technical partners
3.5.2	Design and implement a revised coordination mechanism, from the central to the state and community levels, that to the extent relevant and feasible integrates HIV coordination needs within existing structures and mechanisms for the health sector.	SSAC, Technical partners
3.5.3	Establish a comprehensive partnership forum and framework for the national HIV programme that sets out a clear strategic direction, and monitoring and accountability mechanisms, for all partners contributing to the national HIV response.	SSAC
3.5.4	Hold routine central and state level joint review forums (at least annually) to reflect on the progress of the national HIV response.	SSAC

7. PERFORMANCE FRAMEWORK

The revised Performance Framework for this NSP is shown below:

Overall NSP				Baseline year 2019		Targets		
Ref	**Impact**	**Ref**	**Indicators**	**Source**	**Value**	**2021**	**2022**	**2023**
O1	Reduction in new HIV infections by 50%.	O1.1	Annual new HIV infections (all ages).	Spectrum (2010)	14,000	12,000	9,000	7,000
O2	Reduction in AIDS-related deaths by 50%.	O2.1	Annual number of AIDS-related deaths (all)	Spectrum (2010)	9,800	7,840	6,370	4,850

Prevention				Baseline year 2019		Targets		
Ref	**Outcomes**	**Ref**	**Indicators**	**Source**	**Value**	**2021**		**2023**
P1	Reduction of sexual transmission of HIV.	P1.1	HIV incidence per 1000 population.	Spectrum (2010)	1.51 (all)	1.30	1.0	0.75
		P1.2	% of adults who correctly reject the two most common local misconceptions about HIV transmission or prevention, and who know that a healthy-looking person can transmit HIV.	No current source	No data	25%	40%	60%
		P1.3	Percentage of young women and men aged 15-24 years who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission.	No current source	No data	25%	40%	60%
		P1.4	Percentage of young people aged 10–24 years attending school reached by comprehensive sexuality education and/or life skills–based HIV education in schools.	Programme data	0%	15%	30%	50%
		P1.5	Percentage of young people aged 10–24 years out of school reached by comprehensive sexuality education and/or life skills–based HIV education.	Programme data	0%	10%	15%	25%

		P1.6	Percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months.	No current source	No data	10%	20%	30%
		P1.7	Percentage of key and priority populations 15-49 years reporting the use of a condom at last high-risk sex.	MSM FA and IBBS 2018 Eagle Survey 2016	MSM 29% FSW 72%	50%	70%	80%
		P1.8	Percentage of women and men (15-49 years) who tested for HIV in the last 12 months and know their results.	No current source	No data	15%	25%	40%
		P1.9	Percentage of key and priority populations 15-49 who tested for HIV in the last 12 months and know their results.	MSM FA and IBBS 2018 Eagle Survey 2016 (ever tested)	MSM 76% FSW 78%	60%	65%	70%
		P1.10	Percentage of people living with HIV who know their status.	Estimate	27%	35%	50%	60%
		P1.11	Percentage of key and priority populations reached with HIV prevention programs - defined package of services.	MSM FA and IBBS 2018 Eagle Survey 2016	MSM 26% FSW 38%	60%	65%	70%
		P1.12	Number of medical male circumcisions performed according to national standards.	Programme data	1,453	2,000	3,000	4,000
P2	Reduce mother-to-child transmission of HIV.	P2.1	Percentage of HIV-positive pregnant women attending ANC who know their HIV status.	Programme data	43%	50%	60%	70%
		P2.2	Percentage of HIV-positive pregnant women who receive antiretroviral drugs to reduce risk of mother-to-child transmission of HIV.	Estimate (4352/9977)	43%	55%	65%	70%
		P2.3	Percentage of HIV-exposed infants receiving a virological	Programme data.	12%	55%	65%	70%

			test for HIV within 2 months of birth.					
		P2.4	Percentage of antenatal care attendees tested for syphilis.	No current data.	No data	15%	25%	50%
P3	Reduce HIV transmission in health care settings by 2023.	P3.1	Percentage of donated blood units in the country that have been adequately screened for HIV according to national or WHO guidelines during the past 12 months.	Blood bank data	No availab le data.	100%	100%	100%
	Gender-based violence reduced.	P3.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.	No current data except IOM 2017 which is 47% (not disaggre gated by marital status)	47%	40%	30%	25%
	Reduced HIV-related stigma and discrimination in all settings.	P3.3	Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV.	No current data source	No data			<10%
		P3.4	Percentage of people living with HIV who report experiences of HIV-related discrimination in health-care settings.	2019 Stigma index (p56)	13% (HIV care) 28.5% (non-HIV care)	20%	15%	<10%
		P3.5	Percentage of people living with HIV reporting their rights were violated who sought legal redress.	2019 Stigma index	0%	25%	50%	75%
		P3.6	Percentage of key populations who avoid health care because of stigma and discrimination.	MSM FA and IBBS 2018	MSM 22%	15%	10%	<5%

HIV treatment, care and support				**Baseline year 2019**		**Targets**		
Ref	**Outcomes**	**Ref**	**Indicators**	**Source**	**Value**	**2021**	**2022**	**2023**
T1	Percentage of adults and	T1.1	Percentage of people on ART among all	Spectru m/	19.5%	30%	40%	50%

	children living with HIV (disaggregated by age group, sex and State) currently receiving antiretroviral therapy.		people living with HIV at the end of the reporting period.	program me data				
		T1.2	Percent of PLHIV on ART that had a viral load test done in the last 12 months.	Program me data	52%	60%	70%	80%
		T1.3	Percentage of people living with HIV and on ART, who have a suppressed viral load at 12 months (<1000 copies/ml).	Program me data (based on 52% of PLHIV screened)	80%	90%	90%	90%
		T1.4	Percentage of registered new and relapse TB patients with documented HIV status.	TB program me data	90%	90%	95%	95%
		T1.5	Percentage of HIV-positive new and relapse TB patients on ART during TB treatment.	TB program me data	90%	90%	90%	90%
		T1.6	Percentage of people living with HIV initiated on ART who are screened for TB in HIV treatment settings.	HIV program me data	69%	90%	95%	95%
		T1.7	Percentage of PLHIV on ART who initiated TB preventive therapy.	HIV program me data	No data	80%	90%	100%

Enabling environment				**Baseline year 2019**		**Targets**		
Ref	**Outcomes**	**Ref**	**Indicators**	**Source**	**Value**	**2021**	**2022**	**2023**
E1	An enabling legal and policy environment is established.	E1.1	Number of non-discrimination laws that specify protections for key populations and people living with and affected by HIV (legal and policy documents).	NCPI	TBD (LEA to be done in 2021)	1 (HIV policy)	TBD	TBD
		E1.2	Number of laws and/or policies that present barriers to the delivery of HIV prevention, testing and treatment services or the accessibility of these services (legal and policy documents).	NCP	TBD (LEA to be done in 2021)	TBD	TBD	TBD

E2	Strong health and community systems support the HIV response.	E2.1	Percentage of total funding for HIV managed by local registered NGOs/CBOs.	NASA	To be included in next NASA	5%	10%	15%
		E2.2	Percentage of national budget allocated to health.	NASA	1%	5%	10%	15%
E3	Sustainable financing for the HIV response.	E3.1	Domestic and international HIV expenditure by programme categories and financing sources.	NASA Total external support	98%	95%	90%	85%
E4	Multi-sectoral coordination and collaboration is improved.	E4.1	Proportion of line ministries at central and state levels having mainstreamed HIV.	NCPI	TBD (audit to be done in 2021)	TBD	TBD	TBD

8. MANAGEMENT AND IMPLEMENTATION ARRANGEMENTS

This section of the revised NSP addresses management and implementation arrangements taking into account a strategic direction towards primary health care integration of the national HIV response, and a significantly scaled-up investment in various communities. It also takes into account the reality of constrained resources and the need to prioritise these as much as possible towards programme implementation and systems strengthening, and to maximising synergies with other health and development programmes.

8.1. Response Coordination

There are different domains and levels of coordination for the national HIV response. Coordination addresses the division of roles and responsibilities for strategic, technical and operational issues. It also addresses the different levels of operations from the central to the community levels. For the revised NSP, the focus is on *strategic level* coordination. It is the mandate of the MOH to coordinate and lead technical and operational aspects of health programme implementation for the country.

Overall Coordination and Leadership

Under the revised NSP, the GOSS will continue to lead the overall coordination of the national HIV response working through the office of His Excellency the President, the National Transitional Legislative Assembly (NTLA) committees; the Office of Cabinet; and SSAC.

In addition to Government stakeholders, the overall coordination of the national HIV response will involve development and technical partners, PLHIV, members of key and vulnerable populations, civil society, the private sector and other non-state actors through the following structures.

National Multi-Sectoral Coordination

As per the GOSS's Presidential Decree No. 55/2006 of June 27, 2006, and by virtue of the *Establishment Act of the HIV/AIDS Commission* in 2006 (as amended in 2013), SSAC, along with 10 State HIV/AIDS Commissions and 20 County HIV/AIDS Commissions, shall continue to exercise the mandate of overall coordination of the multi-sectoral national response to HIV in the country. This mandate will ensure that all actors contribute to achieving the results and targets set out in this revised NSP.

National Technical Working Groups

The HIV and AIDS National Technical Working Group (TWG) co-chaired by SSAC and the MOH, and its thematically aligned clusters, shall continue to support the technical aspects of coordination. The TWG will continue to involve members from all sectors and different categories of stakeholders, including from civil society, PLHIV networks and key and vulnerable population groups. The TWG shall convene quarterly to review and reach consensus on the progress of the national response, validate findings of surveys, studies and other HIV-related research, and discuss emerging issues and priorities.

National Stakeholders' Forum

SSAC will convene an annual National Stakeholders Forum to review the performance of the multi-sectoral HIV response, to share best practices, and to follow the implementation of an annually endorsed priority action plan (derived from the revised NSP). The Forum will identify and advocate for emerging needs and priorities and seek to build consensus on way-forward recommendations and actions. The Forum will also seek to enhance the collaboration, transparency and accountability of all partners involved in the national HIV response. A report from the Forum shall be prepared by the SSAC Secretariat and widely shared and promoted.

State and County Level Coordination

At the time of the revision of the NSP, this level of coordination for SSAC was no longer functioning due to resource constraints. Under the revised NSP, SSAC will work with the MOH to integrate coordination of the national HIV response at the state and county levels within existing governance structures for the health sector and for the national HIV programme.

Sectoral Coordination

SSAC will continue to work with relevant sectors to strengthen and sustain coordination mechanisms, including self-coordination mechanisms.

Civil Society Coordination and Community Engagement

Under the revised NSP, civil society partners will maintain their respective self-coordinating entities and shall engage at national, state, county and community levels of the response. They will coordinate with Government and development partners through the structures described above.

Development Partner Coordination

Development partners providing funding, offering technical assistance, implementing or providing services within national HIV response will be coordinated under the existing United Nations agencies Joint Team on HIV and AIDS (JUNTA) and the wider development partner forum normally coordinated by UNAIDS.

8.2. Monitoring and Evaluation of the Response

Based on the revised Performance Framework, SSAC in collaboration with the MOH will prepared a revised National M&E Plan for the 2021-2023 period. Based on this revised Plan, the performance of the national HIV response will be continuously monitored and assessed by SSAC, at annual, mid-term and end-term intervals. During the implementation period for the NSP, data for monitoring and evaluating performance will be generated from different sources. The M&E Plan will provide a description of the different categories of data sources, and will contain provisions regarding data quality, data analysis, and actions need to ensure effective uptake and use of data for decision-making.

9. RESOURCE NEEDS

Thematic Area	Strategic Direction	Strategic Objective	Component	2021	2022	2023	Total
Prevention of new HIV infections.	Scale up combination HIV prevention interventions for key and priority populations.	1.1 Sexual transmission of HIV is reduced by 50%.	Social and Behaviour Change Communication	3 599 184	3 985 848	3 789 184	11 374 216
			HTS	9 200 340	15 333 900	30 667 800	55 202 040
			Condoms	2 860 251	2 767 573	3 044 330	8 672 154
			VMMC	369 600	554 400	1 108 800	2 032 800
			KPs	6 378 159	6 640 886	6 928 795	19 947 841
		1.2 Mother-to-child transmission of HIV is reduced by 50%.	PMTCT	2 668 020	3 118 280	4 018 530	9 804 830
		1.3 HIV transmission in health care settings is eliminated.	PEP, IC, NBTS	1 369 179	1 369 179	1 369 179	4 107 537
		1.4 Gender-based violence (in all its forms) is reduced.		991 684	997 500	1 047 375	3 036 559
		1.5 HIV-related stigma and discrimination is reduced.		1 019 350	997 500	1 047 375	3 064 225
		1.6 HIV-sensitive social protection is provided to the most vulnerable.		3 200 000	3 360 000	3 528 000	10 088 000
		1.7 Humanitarian responses integrate HIV programming.		72 334	125 000	125 000	322 334
	Subtotal			31 728 101	39 250 066	56 674 368	127 652 536
HIV treatment and care, and positive health and dignity for all PLHIV.	Improve health outcomes for all PLHIV.	2.1 Proportion of PLHIV on ART increased to 50% by 2023.	ART (ARVs and Lab monitoring)	8 590 553	10 882 009	14 612 100	34 084 662
			ART (programme costs)	6 582 506	9 009 865	11 677 599	27 269 969
			TB treatment for PLHIV	397 951	544 571	713 641	1 656 164
		2.2 Viral suppression for PLHIV on ART maintained at >80% by 2023.	Adherence support (costed in ART and also in PHDP)	-	-	-	-
		2.3 Eligible PLHIV receive a defined package of social support to improve long term adherence on ART.	PHDP	2 874 132	3 870 780	4 961 928	11 706 840
	Subtotal			18 445 142	24 307 225	31 965 268	74 717 635
Efficiency, integration and sustainability	Strengthen the critical enablers supporting the multi-sectoral HIV response.	3.1 An enabling legal and policy environment is established.	Human rights	1 465 394	1 338 888	1 251 608	4 055 890
		3.2 Strong health and community systems support the HIV response.	HSS/CSS	3 813 420	5 396 350	3 878 818	13 088 588
		3.3 The availability and use of strategic information is increased.	HMIS (7.5%) *	4 158 904	5 271 940	7 032 755	16 463 599
		3.4 Domestic financing and ownership is increased.	Financing (1%)**	596 110	755 645	1 008 028	2 359 782
		3.5 Multi-sectoral coordination and collaboration is improved.	Coordination/ Programme Management (@20%)***	12 041 414	15 264 023	20 362 169	47 667 606
	Subtotal			22 075 242	28 026 845	33 533 378	83 635 465
	TOTAL			72 248 486	91 584 136	122 173 015	286 005 636

*7.5% of all programme costs excluding programme management and domestic financing interventions;**1% of all programme costs excluding programme management and domestic financing interventions; ***20% of all other budgeted costs. This is the estimated cost of managing the national programme.

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