ARKANGELO ALI ASSOCIATION-AAA
South Sudan

GLOBAL FUND GC7 HIV/TB/RSSH YEAR 1 And C-19PO (COVID19) YEAR 4

ANNUAL REPORT 2024

Grant I
Global Fund GC7 HIV/TB/RSSH Year 1

SR Name
Arkangelo Ali Association - South Sudan

Report for implementation period
01/01/2024 to 31/12/2024

Funds Available:
Approved Budget (After the Amendment No. 1 to the SR Agreement with PR UNDP signed on 8, July 2024).
US Dollars 1,766,433.79

Funds Disbursed
US Dollars 1,766,433.79

Funds Utilized
US Dollars 1,735,212.58

Funds Balance
US Dollars 31,221.21.

Grant II
Global Fund UNDP C-19PO (COVID-19) Year 4

Report for implementation period
01/07/2024 to 31/12/2024

Funds Available:
Approved Budget (In line with Amendment No.4 to the 2021-2025 SR Agreement with the PR UNDP signed on 3, July 2024).
US Dollars 52,697.48

Funds Disbursed
US Dollars 52,697.48

Funds Utilized
US Dollars 48,185.31

Funds Balance
US Dollars 4,512.17

Project Areas

The project is operational in thirty one (31) counties, spread across five (5) out of the ten States of South Sudan, namely:

Northern Bahr el Ghazal State

1. **Aweil central County**
   - Aweil State Hospital
   - Aroyo PHCC
   - Aweil Prison PHCC

2. **Aweil East County**
   - Gordhim Hospital
   - Akuem PHCC
   - Malualkon PHCC
   - Wunyiik PHCC
   - Wanjok PHCC

3. **Aweil South County**
   - Panthou PHCC

4. **Aweil West County**
   - Nyamlell Hospital
   - Marialbaai PHCC
   - Udhum PHCC

5. **Aweil North County**
   - Gokmachar PHCC
   - Mayen Ulem

Western Bahr el Ghazal state

1. **Wau County**
   - Wau Teaching hospital
   - Grinty PHCC
   - Sikadid PHCC
   - Wau Prison PHCC
   - Agok PHCC
   - Aljeezera PHCC
   - Bezia Jedid PHCC
   - Hai Dinka PHCC
   - Hai Bafra PHCC
   - Lokoloko PHCC
   - Muktar PHCC

- St Daniel Comboni Hospital, Wau

2. **Raja County**
   - Raja Hospital
   - Deimzeibeir PHCC

3. **Jur River County**
   - Udici PHCC
   - Mapel PHCC
   - Kuarjiena PHCC
   - Thurkueng PHCC
   - Marialbaai PHCC
   - Achongchong PHCC
   - MaryHelp Hospital

Lakes State

1. **Awerial County**
   - Bunagok PHCC
   - Mingkaman PHCC

2. **Yirol East County**
   - Adior PHCC
   - Nyang PHCC

3. **Yirol West County**
   - St Joseph Hospital
   - Mapuordit Hospital
   - Aluakluak PHCC

4. **Cueibet County**
   - Agangrial Hospital
   - Cueibet Hospital
   - Abirieu PHCC
   - Citchok PHCC

5. **Rumbek Central County**
   - Rumbek State Hospital
   - Matangai PHCC

6. **Wulu County**
   - Wulu Hospital

7. **Rumbek East County**
   - Cueicok PHCC
   - Aduel PHCC

8. **Rumbek North County**
   - Maper PHCC

Western Equatoria State

1. **Yambio County**
   - Yambio State Hospital
   - Gangura PHCC
   - Yambio Prison PHCC

2. **Nzara County**
   - Nzara Hospital (St Theresa)

3. **Ezo County**
   - Ezo Hospital
   - Naandi PHCC
   - Yangiri PHCC

4. **Tambura County**
   - Tambura Hospital
   - Source Yubu PHCC
   - Mupoi PHCC

5. **Nagero County**
   - Nagero PHCC

6. **Maridi County**
   - Olo PHCC
   - Woko PHCC
   - Bethsaida ECS PHCC

7. **Ibba County**
   - Nabanga PHCC

8. **Mundri West**
   - Mundri Hospital

9. **Mvolo County**
   - Yeri PHCC

Warrap State

1. Gogrial West County

- Kuacjok State Hospital
- Gogrial PHCC
- Alek PHCC
- Akon PHCC

2. Gogrial East County

- Lounyaker PHCC
- Liethnom PHCC

3. Tonj North County

- Marial Lou,Comboni
- Mariallou Rural Hospital
- Warrap PHCC
- Aliek PHCC

4. Tonj South County

- Tonj Don Bosco
- Tonj Hospital

6. Tonj East County

- Rumabuth PHCC
- Ngapagok PHCC

7. Twic County

- St Mother Theresa Hospital
- Wunrok PHCC
- Mayen Abun PHCC

Contact persons

Mrs. Natalina Sala
AAA Director/Finance Director

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ACKNOWLEDGEMENT

The year 2024 was a strategic and fulfilling year for Arkangelo Ali Association (AAA) as one of the oldest partners in implementing the Global Fund grants in South Sudan in the fight against AIDS, Tuberculosis and Malaria. In South Sudan, the Global Fund marked their 20th anniversary in investing towards delivering health services linked with treatment, care and prevention of these three diseases that are the back-bone of their funding and support. Our organization, Arkangelo Ali Association (AAA) was part and parcel of this incredible journey since 2005 when we received our first grant under the Global fund to help fight Tuberculosis in South Sudan in partnership with the Republic of South Sudan - Ministry of Health (RoSS-MoH) under the leadership and oversight of the Country Coordinating Mechanism (CCM), the guidance of the National TB, Leprosy and Buruli Ulcers Control Program (NTLBP) and, through the management of the Principal Recipient - United Nations Development Programme (PR UNDP).

Through this 20-year incredible journey, Arkangelo Ali Association not only delivered remarkable results in the fight against Tuberculosis, but through this growth, we initiated new strategic shifts of going beyond the status quo to new frontiers of going Beyond TB and further joined in the combative efforts of fighting HIVAIDS through the integrated implementation of HIVTB grants under the Global Fund through the same grant stakeholders, and working towards the sustainability of the integration strategy.

In this first reporting year of the new Grant Cycle 7 (GC7), we achieved significant progress in our programme areas courtesy of the Optimization Plan which is a new strategy realized by the PR UNDP with a guide to invest more in high disease burdened sites for optimum results. Our achievements in 2024 reflect AAA's commitment and drive towards addressing South Sudan's health priorities and Universal Health Coverage (UHC) where the country has the lowest coverage and does not meet any of the three key elements of UHC. Throughout the year, AAA managed to notify 7805 new and relapse TB patients and 3707 HIV clients were current on treatment by the end of December. Through Community Health Workers, we provided comprehensive HIVTB prevention, treatment and care services (including DR-TB) to key and vulnerable populations through Expert Clients in collaboration with SSNeP+ , ensured early infant diagnosis and follow-up HIV testing for exposed infants through the support of Mentor Mothers in collaborative efforts with NEPWU which are HIVAIDS Networks in the country; and, worked towards reducing human rights-related barriers to HIV/TB services through Peer Navigators.

We remain steadfast in our commitment towards delivering progress for empowered, healthy and resilient communities. With optimism and determination, we are ready to confront today's challenges and expand our partnerships to deliver greater access to services and opportunities for the populations we serve through continued advocacy and investment in our institutional capacity, including our operational systems for optimal utilization of resources entrusted to us through continued collaboration with the State Ministry of Health (SMoH).

Finally, these accomplishments would not have been made possible without the dedication and unwavering support of our donors, our staff, implementing partners and communities we serve in the AAA's health cause. We look forward to an exciting 2025, where the past year's lessons will continue to shape our work and guide our mission. Our integrated approach, combined with the resilience and determination of our team, firmly positions us to continue making significant strides in the fight against TB, HIV, and other diseases.

ACRONYMS

AAA	Arkangelo Ali Association
BHI	Boma Health Initiative
BHW	Boma health Worker
CCM	Country Coordinating Mechanism
CoS	Continuity of services
C19RM	Covid 19 Resilient Mechanism
C19PO	Covid 19 Project Optimization
CTB DOTS	Community Based DOTS
DOTS	Directly Observed Therapy Short course
EID	Early Infant diagnosis
FR	Funding Request
GF	Global Fund
GC7	Grant Cycle 7
HCWs	Health Care Workers
HEI	HIV Exposed Infant
HIV	Human Immune deficiency virus
HHPs	Home health promoters
LMD	Last Mile Delivery
MDR-TB	Multi Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
MMD	Multi Month Dispensing
NFM	New Funding Model
NSP	National Strategic Programme
NTP	National TB Programme
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHCC	Primary Health Care Centre
RSS	Republic of South Sudan
RSSH	Resilient Sustainable System of Health
TB	Tuberculosis
TBMU	TB Management Unit
UNDP	United Nations Development Programme
VL	Viral load

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EXECUTIVE SUMMARY

Through the support of the Global Fund's grants to South Sudan, Arkangelo Ali Association (AAA) continues playing a crucial role in enhancing the sustainability of public health systems by filling gaps that exist in addressing HIVTB diseases in government-run health facilities and providing essential services, advocacy, and innovative solutions that can extend the reach and effectiveness of public health initiatives through collaborative efforts towards Resilient and Sustainable Systems for Health. Given our experience in the country, we operate with a deep understanding of local communities' needs, enabling us to address specific health issues that may not be completely addressed by broader public health strategies and are able to be innovative and nimble to deliver solutions to the communities' health challenges. AAA's priority is to ensure that its health services continue to benefit communities and providers in perpetuity bringing us closer to the Global plan of ending TB by 2030 and towards the UNAIDS 95-95-95 targets. In implementing Grant Cycle 7 (GC7), our approaches and impact continued being guided by the golden threads underpinned in the Global Fund's 2024 strategy which is to accelerate progress against HIV, tuberculosis, and malaria with focus on building strong health systems, using new tools, and innovation.

The Global Fund's Cycle 7 (GC7) TBHIV/RSSH goals are hinged on both the TB and HIV NSPs as below cited:

- Reduction of new HIV infections by 25% by 2026 (from 2022 levels).
- Reduction in AIDS-related deaths by 25% by 2026 (from 2022 levels).
- Reduced HIV-related stigma and discrimination towards PLHIV by <10%.
- Increase TB detection by 40% and reduce mortality rate by 35% by 2028 compared to 2022.

The Global Fund TBHIV/RSSH GC7 focuses the optimisation of services which is described as making what was then available work better in terms of increasing demand and uptake of HIV and TB services through strengthening investments in both facility-based and community-led activities so as to ensure maximum utilization of services in the existing facilities. This shift aims towards the reduction of mortality and morbidity caused by both TB and HIV diseases. This also remains a major focus of Arkangelo Ali Association (AAA) TB care and prevention Program. All interventions are based on the revised TB NSP 2023-2027 and HIV NSP 2021-2023 that identified gaps and defined appropriate strategies and has already been operationalized. The programs follow the Global Fund performance-based funding where specific indicators are used to monitor progress on quarterly basis. During the current reporting period, AAA met most of its set targets as shown in the table 1.4.

The strategies applied to meet the project goals include; training of X-ray technicians and other health care workers on the use of devices to increase TB case finding, Train and mentor HCWs on Continuous quality improvement of care through workshops, on Job training of laboratory assistants, training of health workers in all Primary Health Care, Psychosocial intervention of children and adolescents on ART training , Train and mentor HCWs on integrated testing of pregnant women for HIV, Syphilis and Hepatis B, strengthening of the PHCCs to be able to offer TB DOTs services so as to carry out sputum microscopy with an aim of increasing case finding and

promptly initiating them on treatment with supervised DOTs. AAA provided TA to the TB officers and the CHD staff on supportive supervision and monitoring of programme activities, streamlining and strengthening the logistics management information systems (LMIS) and forecasting and quantifications including the drug ordering system, maintaining minimum-maximum (min-max) levels and inventory maintenance. All forms of TB patients that were registered for treatment (new and relapse) were 7805 patients who were all notified to NTP. By end of December 2024 the PLHIV on current treatment were 3707.

The report further presents the performance indicators progress of our HIVTB programme in the 89 HIVTB sites courtesy of cross-cutting themes through the continued last mile project funded under COVID-19 Portfolio Optimization (C-19PO) grant as a complementary portfolio to our organization since October 2022 under COVID-19 response mechanism (C19RM) which is envisaged to continue up to 2025. The COVID-19 pandemic tested healthcare systems globally, strained resources and posed logistical difficulties and our organization was no exception. However, it also provided an opportunity to innovate and adapt our approaches to ensure the continued delivery of essential services as we rapidly integrated COVID-19 responses into our existing TB and HIV programmes, demonstrating the strength and flexibility of our integrated care model. This integration has reinforced our support of the communities we serve and the continued funding under C-19PO have been exceptional in last mile delivery of HIVTB health commodities and supplies to the health facilities within AAA's operational area.

To facilitate the contribution of the project goals and objectives, AAA has a team of passionate, dedicated and hard-working individuals who are responsible for executing the tasks and producing deliverables outlined in the project plan and schedule as directed by the project director and manager whose leadership and commitment over the past 20 years have been exemplary. None of our achievements would be possible without our staff, volunteers, and partners. The organizational structure illustrating this is shown in the organogram in page 16.

Looking ahead, we aim to provide holistic health support by offering a broader range of strategies aimed at addressing and improving service delivery and grant results. We will continue to empower the government health care workers at our disposal to enhance service delivery, work with the relevant grant stakeholders and partners to build a flexible workforce to adapt to evolving public health needs, and develop innovative solutions tailored to our communities. Ultimately, our vision is to enhance quality health services through continued partnerships with our funders, technical guidance and our partners in government, the civil society and the private sectors.

CHAPTER 1: INTRODUCTION

1.1: BACKGROUND

Arkangelo Ali Association (AAA) started as an indigenous South Sudanese Non-Governmental Organization (NGO) founded in November 2006 and registered under Relief and Rehabilitation Commission and the Ministry of Legal Affairs and Constitutional Development. AAA was upgraded to an International NGO on 27 January 2012 by the chief Registrar, Ministry of Justice following successful TB program collaboration and implementation in South Sudan (SSD). Internationally, AAA is a founder member of the Bakhita Consortium along with 7 other Italian organizations, Kenyan and South Sudanese NGOs/Associations that works for the development of South Sudan. The mission of AAA is to uplift dignity of disadvantaged people through provision of social services with respect of transparency, quality, equity, availability and accessibility with a vision of a community that believes in respect for human dignity. AAA has a regional office in Nairobi, Kenya under the umbrella of Verona Fathers (Comboni Missionaries Kenya Province) and a Country Office in Juba, South Sudan.

Starting in January 2024, UNDP took on responsibility for new Global Fund grants in South Sudan under the Grant Cycle 7 (GC7) allocation period from 2024-2026. These amounts include US$50 million for HIV, US$17 million for TB, US$24 million for RSSH, and US$23 million under the C19RM for pandemic preparedness and additional RSSH support. Following the successful securing of these resources, AAA was among the SRs selected by the PR UNDP to implement the project; thus, officiated a signed SR agreement on 8, February 2024 with a 3-year budget for 2024-2026 of USD 4,762,514. The assigned HIVTB Modules under this SR agreement are 11 (but only 10 are funded to AAA) and constitute of various interventions as stipulated below:

1. **Module: Differentiated HIV Testing Services**
   Intervention: Facility-based testing outside of Key Population (KP) and Adolescent Girls and Young Women (AGYW) programs.

2. **Module: Drug-resistant (DR)-TB diagnosis, treatment and care.**
   Intervention: Facility-based testing outside of key population (KP) and adolescent girls and young women (AGYW) programs.
   Intervention: DR-TB diagnosis/drug susceptibility testing (DST).
   Intervention: DR-TB treatment, care, and support.

3. **Module: Elimination of vertical transmission of HIV, syphilis and hepatitis B**
   Intervention: Integrated testing of pregnant women for HIV, syphilis, and hepatitis B.
   Intervention: Post-natal infant prophylaxis.

4. **Module: Key and vulnerable populations (KVP) – TB/DR-TB**
   Intervention: KVP - Children and adolescents.
   Intervention: KVP - Mobile population (migrants/refugees/IDPs).

5. **Module: Reducing human rights-related barriers to HIV/TB services**

Intervention: Eliminating stigma and discrimination in all settings.

6. **Module: RSSH/PP: Human resources for Health (HRH) and quality of care**
   Intervention: RSSH/PP: Community health workers: contracting, remuneration and retention.
   Intervention: RSSH/PP: Quality improvement and capacity building for quality of care.

7. **Module: TB diagnosis, treatment, and care**
   Intervention: TB screening and diagnosis.
   Intervention: TB treatment, care, and support.

8. **Module: TB/HIV**
   Intervention: TB/HIV - Collaborative interventions.
   Intervention: TB/HIV - Treatment and care.

9. **Module: Treatment, care, and support**
   intervention: HIV treatment and differentiated service delivery - adults (15 and above).
   Intervention: HIV treatment and differentiated service delivery - children (under 15).

10. **Module: Programme Management**
    Intervention: Grant Management.

Progressively, there was amendment No.1 to the SR Agreement between UNDP and AAA which was signed on 8, July 2024. The amendment officiated the updating of AAA's 2024-2026 GC7 budget from USD 4,762,514 to USD 5,160,428 to include additional activities in 3 budget lines. The inclusion entailed:

- Budget line 409 under the module RSSH/PP: Laboratory systems (including national and peripheral) for the intervention of RSSH/PP: Specimen referral and transport system.
- Budget line 41 under the module Elimination of vertical transmission of HIV, syphilis and hepatitis B in an added intervention of Early infant diagnosis and follow-up HIV testing for exposed infants. The activity linked to this is provision of Transport and Airtime to Mentor mothers which was retroactively approved from January 2024 for continuation up to end December 2026.
- Budget line 156 under the module Treatment, care and support in the intervention of HIV treatment and differentiated service delivery for adults, for an additional activity of providing Transport and airtime to Expert clients and outreach workers across the AAA supported facilities – also approved for retroactive payments from January 2024 for continuation up to end December 2026.

This actively increased the GC7 active modules assigned to AAA to 11.

It is worth noting that in the GC7 grant, AAA was assigned a budgetary obligation of remitting incentives to 60 mentor mothers and 84 Expert Patients. These cadres are not under AAA management but are directly engaged and supervised by their respective Networks NEPWU and

SSNeP+ as per the terms and conditions of signed MoUs and amendments between AAA and these implementing partners.

During the GC7 implementation; on 3, July 2024, AAA signed amendment No.4 to the 2021-2025 SR agreement with the PR UNDP for continued funding of COVID-19 module under COVID-19 Project Optimization (C-19PO) in intervention area of Health products & waste management systems. The purpose of the amendment was to update the grant end date for Covid-19Response Mechanism Portfolio Optimization (C19RM PO) from 2024 to 2025. The activities related to this are for continued strengthening of Last Mile Distribution (LMD) of COVID-19 and HIV/TB commodities as proposed in 2021 following the realized gap of last mile delivery after the related activities were paused or limited due to the COVID-19 pandemic declaration status by WHO on 11, March 2020. AAA formally started the implementation of the related activities in October 2022 and continued in 2023 in all the 83 TBHIV sites. Despite the continuation gap in January to June 2024, AAA embarked on the implementation of the linked activities after signing the amendment No.4 to the 2021-2025 SR agreement. These changes updated the AAA's budget for 2021-2025 from USD 3,632,817 to $3,783,748 thus, reflecting the revised C-19RM/PO funds approved to USD 463,671 from USD 312,740. The updated budget was approved to run for 2024 to 2025 for both last mile delivery activities and other essential enablers to support in service delivery as supported under the grant management intervention in the module of Program management. These include costs of one vehicle that was transferred to AAA from UNDP and was assigned to TBHIV Programme operations in Western Equitoria State – where a bigger gap of mobility had been realized following the transition of 6 HIVTB sites to AAA in the Eastern part of the State from July 2024. The sites are: Bethsaida, Woko and Olo PHCCs in Maridi County, Yeri PHCC in Mvolo County; Nabanga PHCC in Ibba County and Mundri County Hospital in Mundri West County.

Despite these amends, all the terms and conditions of the two SR Agreements remained unchanged.

AAA as a sub-recipient (SR) implemented the HIV/TB/RSSH and C-19PO interventions with GFATM funding support under the leadership of the Principal Recipient (PR) United Nations Development Program (UNDP). AAA implemented the 19 interventions in the TBHIV programme and 2 interventions in C-19PO and it managed to report data from 90 functional facilities that are spread across 31 counties in 5 out of 10 States of South Sudan.

In 2024, AAA took over 6 new health facilities in the Eastern part of Western Equatoria state. This happened after it had handed over to PEPFAR (ICAP) 10 facilities in Lakes State for HIV implementation.

Light microscopies, fluorescence or GeneXpert machines/TB LAM were put in use in the screening of 25445 presumptive TB patients.5157 were bacteriologically confirmed TB patients. There were 10,901 samples that were processed using GeneXpert machines. 2259 TB patients were diagnosed using GeneXpert machines. In total there were 7905 TB patients that were identified and 7805 were incidental TB (new and relapse) patients who were notified in the course of the year. There were 125 MDR TB patients that were identified and initiated on 2nd line treatment. There were 69 MDR-TB patients that were registered in the cohort of 2022 and their treatment evaluation

showed that 68 out of 69 (99%) were successfully treated. 6592 susceptible TB patients were registered in 2023 and had their treatment outcomes evaluated and 6066 TB patients had either cured or treatment completed giving a treatment success rate of 92%.

By the end of December 2024, the project area had 3707 PLHIV who were active on ARVs (TX CURR). The HTS had 94,277 clients who were counselled and tested for HIV and 1008 were diagnosed with HIV infections giving a yield of 1%. Out of the 1008 HIV infected clients, 818 were linked to care giving 81% as rate for linkage.

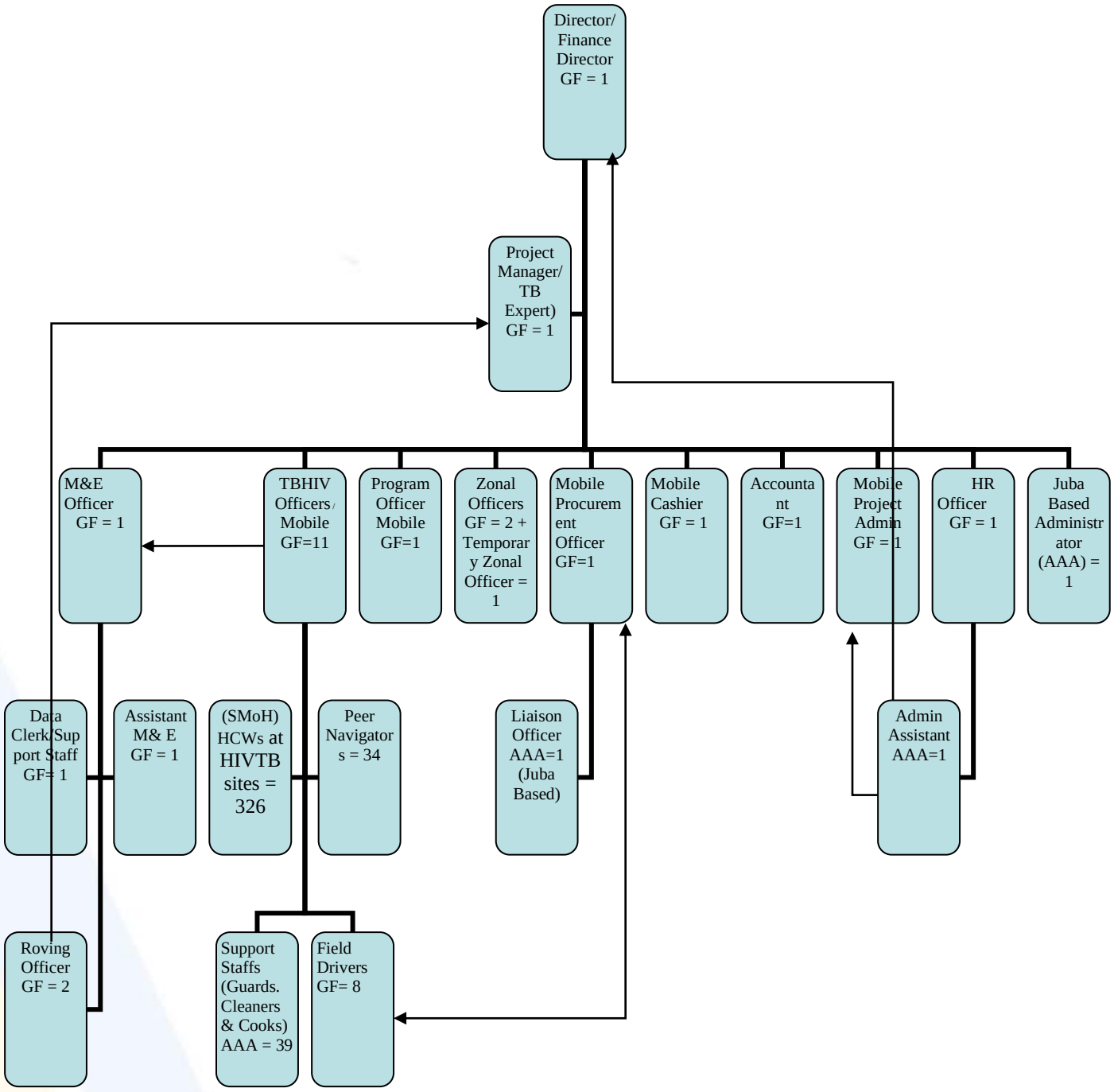
The grants implementation was in collaboration with the Ministry of Health where the interventions followed the standard Ministry of Health guidelines and protocols with the National Tuberculosis, Leprosy and Buruli Ulcer (NTLBP) Program and HIV departments providing the technical guidance and in close collaboration with the County Health Departments (CHD) and State level Ministries of Health in the States where AAA implements. The TBHIV project targets an estimated population of 3,824,109 which is within the AAA operation areas. This calculation is based on the South Sudan 2008 census result projection factoring in a growth rate of 3% per annum.

The Global Fund TBHIV/RSSH GC7 grant aims:

- Reduction of new HIV infections by 25% by 2026 (from 2022 levels).
- Reduction in AIDS-related deaths by 25% by 2026 (from 2022 levels).
- Reduced HIV-related stigma and discrimination towards PLHIV by <10%.
- Increase TB detection by 40% and reduce mortality rate by 35% by 2028 compared to 2022.

Focus is on the optimisation of services which is described as making what was then available work better in terms of increasing demand and uptake of HIV and TB services through strengthening investments in both facility-based and community-led activities so as to ensure maximum utilization of services in the existing facilities; whereas the C19-PO grant and activities aims at strengthening of the Last Mile Distribution (LMD) of COVID-19 and HIV/TB commodities. All these are pointed towards the reduction of mortality and morbidity caused by TBHIV and Covid 19. The implementation of the TBHIV and C-19PO interventions are carried out at various levels within the AAA organizational structure, right from the headquarters to the health facilities as shown in the organogram below in page 16.

AAA Organization Health Structure for HIVTB Programme & implementation of C-19PO activities in 2024:



NB: During the grant implementation, AAA was assigned a budgetary obligation of remitting incentives to 60 mentor mothers and 84 Expert Patients. These cadres are not under AAA management but are directly engaged and supervised by their respective Networks NEPWU and SSNeP+ as per the terms and conditions of signed MoUs and amendments between AAA and these IPs.

1. 2: OVERALL PROJECT GOAL AND SPECIAL GRANT AGREEMENT

The goals of the Global Fund GC7 HIV/TB/RSSH grant are:

- Reduction of new HIV infections by 25% by 2026 (from 2022 levels).
- Reduction in AIDS-related deaths by 25% by 2026 (from 2022 levels).
- Reduced HIV-related stigma and discrimination towards PLHIV by <10%.
- Increase TB detection by 40% and reduce mortality rate by 35% by 2028 compared to 2022.

As a cross-cutting theme, the C-19PO project is a COVID-19 response mechanism purposed to aid in strengthening the Last Mile Delivery (LMD) of COVID-19 and HIV/TB commodities - geared towards realization of the above Global Fund TBHIV/RSSH GC7 goals.

The Global Fund Agreement signed for the GC7 HIV/TB/RSSH grant between AAA and the Principal Recipient (PR) United Nations Development Programme (UNDP) was signed on the 2nd of February 2024 and officiated on 8 February, through the PR UNDP's signing. The total amount allocated to AAA for 2024 to 2026 GC7 TBHIV/RSSH is USD 4,762,514. The purpose of utilization towards running services in 90 facilities for both TB and HIV services. The target for ART sites was 69 but AAA managed to get data from 29 sites, HTS target was 69 sites but 57 sites reported data and PMTCT had a target of 65 sites but data was generated from 54 health facilities and TB had 65 as a target but reported from 78 sites.

As a cross-cutting aspect, AAA signed amendment No.2 to the SR agreement with the PR UNDP on 14th September 2022 for incorporation of COVID-19 module under the intervention area of Health products & waste management systems. The activities related to this are for strengthening of Last Mile Distribution (LMD) of COVID-19 and HIV/TB commodities as proposed in 2021 following the realized gap of last mile delivery after the related activities were paused or limited due to the COVID-19 pandemic declaration status by WHO on 11 March 2020. AAA formally started the implementation of the related activities in October 2022 and continued in 2023 in the then 83 TBHIV sites. These changes updated the AAA budget for 2021-2023 from USD 3,218,673 to USD 3,632,817. Progressively, in order to update the TBHIV activities' budget by presentation of the actual expenditure from January 2021 to September 2022 (Quarter 1 to Quarter 7) and as well as the forecast from October 2022 to December 2023 (Quarter 8 to Quarter 12) of the grant implementation, AAA signed amendment No.3 to the SR Agreement with UNDP on 16 December 2022. These occurrences, nevertheless did not in any way change AAA's final budget total annexed in amendment No.2 at US$3,632,817; and, C19RM budget was not updated in the process. On 3, July 2024, AAA signed Amendment No. 4 in order to include C19PO budget. These changes updated the grant period to 2021-2025 and AAA's budget from USD 3,632,817 to USD 3,783,748 thus, reflecting the revised C-19RM/PO funds approved to USD 463,671 from USD 312,740. The updated C-19PO budget was approved to run for 2024 to 2025. All other conditions remained the same as stipulated in the SR agreement with PR UNDP (Grant Agreement SSD-C-UNDP) signed on 27, January 2021 for the now updated period from 1, January 2021 to 31, December 2025.

1.3: STRATEGIES AND IMPLEMENTATION DURING THE REPORTING PERIOD

The goals of the GC7 TBHIV/RSSH Grant are:

- Reduction of new HIV infections by 25% by 2026 (from 2022 levels).
- Reduction in AIDS-related deaths by 25% by 2026 (from 2022 levels).
- Reduced HIV-related stigma and discrimination towards PLHIV by <10%.
- Increase TB detection by 40% and reduce mortality rate by 35% by 2028 compared to 2022.

Bearing the above goals in mind, specific strategies for TB and HIV were developed as so to meet the set objectives. The strategies employed by AAA in collaboration with the PR (UNDP) and the NTP and HIV/STI department during the reporting year so as to achieve the desired results include:

- Training on use of devices for better active case finding among mobile populations.
- Training of HCWs on Continuous quality improvement.
- Supportive supervision to ensure quality of HTS services in prioritized facilities
- Conduct of outreach activities in Mobile populations e.g. prisons, Refugee/returnees/IDP camps.
- Conduct the quarterly review meetings for DR TB patients requiring individualized SLD regimen.
- Conduct quarterly DR TB supportive supervision mission.
- Ensuring that all PLHIV were monitored through viral load for viral suppression.
- Conducted Annual State level review with mentor mothers in 5 States.
- Hired peer navigators so to create HIV/TB awareness so as HIV/TB- related stigma and discrimination is reduced.
- Engaged the HIV networks (NEPWU and SSNEP+) to trace the Lost to follow up, promote HTS and to assist with counselling and referrals.
- Strengthen linkage and referral processes to ensure that pregnant women who test HIV-positive are not lost-to-follow-up.
- MDR TB cohort review meetings that were clustered in 5 State level hubs.
- Capacity building of the health care workers on TB care and treatment.
- Behavior Change Communication (BCC) in the community and mobilization to increase demand for TB-DOTS services.
- Community TB-DOTs and promotion of treatment adherence through TB treatment supporters and TB clubs.
- Conducting TB awareness and health education campaigns.
- Contracting a Courier company for transporting samples from the facilities to the hubs and then shipment of the samples to the NPHL, Juba.
- Ensuring a good TB-HIV collaboration at community, facility, county, payam and boma levels, by engaging the HHPs.
- Supporting the TB-HIV co-infected cases while on treatment.
- Early retrieval of persons lost to follow up, through the establishment of TB clubs and the involvement of TB ambassadors.

- Conducting Door to Door health education and screening of contacts of smear positive TB patients and contacts of children under 5 years.
- Systematic TB screening among PLHIV and patients admitted in wards.
- Strengthening community DOTS in the continuation phase and follow up using the HHPs
- Mentoring the Home Health Promoters to link the community with respective PHCCs and PHCUs for TB care.
- Joint Supportive supervision and monitoring of programme activities by AAA TB Expert, M&E officer, the NTP and the PR for on-site training and data management and validations.
- Streamlining the drug ordering system and inventory to strengthen the LMIS, whereby all orders are placed at the beginning of every quarter.
- Health education in the community and mobilization to increase awareness and create self-referral and demand for TB-DOTS services. This included school health, mass media, community theatre and utilizing HHPs to educate the community in administrators' meetings, markets, local community courts and other organized gatherings.
- TBHIV sensitizations in congregate settings like prisons, military barracks, police cells, cattle camps, schools, churches and returnee/IDP camps.
- TB screening among patients admitted in wards and safe referral of sputum to laboratory for microscopy and relaying of results back to patients for treatment initiation within 48 hours.

As highlighted earlier, the C-19PO project is a COVID-19 response mechanism to aid in strengthening the Last Mile Delivery (LMD) of COVID-19 and HIV/TB commodities - geared towards realization of the above Global Fund GC7 goals; thus, specific strategies for were also employed so as to meet the grant objectives and goals. The strategies employed include:

- Continued use, reference and guidance of a detailed and clearly defined Distribution Strategic Paper in the implementation of the last mile activities which has clearcut details on creation of a distribution plan through understanding our target needs (patients), determining logistics by finding the most efficient and affordable way to transport the health commodities from the start up point to the last-mile for end-users, choosing distribution channels for reaching the end-users; and, evaluation and modification of the plan by assessing the distribution plan on a regular basis and make revisions in response to shifting conditions, end-user demands, and other elements that could affect the plan's success.
- Early preparations and projections of related activities. This was done at the earliest convenience; thus, enabling an ample and seamless mode of implementation. Early preparations included conducting mechanical assessments and researching of spare-parts quotations for repairing and servicing the existing vehicles and motorbikes and development of work plans for estimation of needed fuel for programme and last mile activities as well as researching favorable market prices.
- Engaging experienced and professional 3rd party road and air transport companies with good knowledge of our operating sites for route optimization.
- We ensured that our designated personnel continued adhering to the comprehensive written policies and procedures of handling pharmaceuticals as aligned with our environmental policy which is in line with the local regulations and global standards.

- We ensured staff training and education by conducting regular on-site mentorship sessions for healthcare personnel involved in drugs and supplies storage and handling.
- We ensured timely and accurate data was reported from our health facilities to enable our forecasting and ordering of health commodities.
- We ensured communication and coordination between stakeholders and key players where most issues were addressed in quarterly feedback meetings and capacity building sessions.

1.4: RESULTS

7.1 Programmatic GC7 TBHIV Year 1 (January-December 2024) TB indicators versus Targets

Indicator	Reporting Period	Target	Result	% Achievement
DOTS-1a: Number of notified cases of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapses	January to December	6137	7805	127%
DOTS-2a: Percentage of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among all new TB cases registered for treatment during a specified period	January to December	85%	6066/6692(92%)	108%
DOTS-3: Percentage of laboratories showing adequate performance in external quality assurance for smear microscopy among the total number of laboratories that undertake smear microscopy during the reporting period	January to December	86%	113/128(88%)	102%
TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register	January to December	93%	7661/7805(98%)	105%
TB/HIV-6(M) Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	January to December	90%	549/590(93%)	103%
TBDT-4 Percentage of new and	January to	40%		

relapse TB patients tested using WHO recommended rapid diagnostic (***mWRD***) tests at the time of diagnosis.	December		2738/7805(35%	88%
TB/HIV-7.1 Percentage of people living with HIV currently enrolled on antiretroviral therapy who started TB preventive treatment **(TPT**) during the reporting period	January to December	63%	1137/3707(31%)	49%
MDR TB-9 Treatment success rate of RR TB and/or MDR-TB: Percentage of cases with RR and/or MDR-TB successfully treated	January to December	83%	68/69(99%)	119%
MDR-TB 2 (M): Number of TB cases with Rifampicin-resistant (RR-TB) and/or MDR-TB notified	January to December	68	125	184%
MDR TB-3: Percentage of cases with drug resistant TB (RR-TB and/or MDR-TB) that began second-line treatment	January to December	94%	125/125(100%	106%
RSSH/PP M&E-1 Completeness of reporting: Percentage of expected monthly reports (for the reporting period) that are actually received	January to December	90%	78/78(100%	111%

HIV Indicators Versus Targets

Indicator	Reporting Period	Target	Result	% Achievement
TCS-10 Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of vertical transmission of HIV	January-December	4%	63/3617(1.7%)	45%
VT-2 Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth	January-December	1%	65/3617(1.8%)	179.7%
TCS-1.1(M) Percentage of people on ART among all people living with HIV at the end of the reporting period	January-December	2%	3707/168380(2.2%)	110%
TCS-1b Percentage of adults (15 and above) on ART among all adults living with HIV at	January-	2%	3478/154788(2.2%)	112%

the end of the reporting period	December			
TCS-1c Percentage of children (under 15) on ART among all children living with HIV at the end of the reporting period	January-December	1%	229/13592(1.7%)	168%

6.2 Status of Implementation of Approved work plan.

1. GC7 HIV/TB/RSSH

Activity	Year Planned	Status of Implementation	Concise description of the status/results/achievements and challenges
Training of HCWs on Continuous quality improvement	Year 2024	Conducted	▪ 100% attendance as 53 participants: ▪ 44 males ▪ 9 females
Training on use of devices for better active case finding among mobile populations	Year 2024	Conducted	**Achievements**: ▪ 100% attendance of 11 participants: ▪ 10 males ▪ 1 female
Supportive supervision to ensure quality of HTS services in prioritized facilities	Year 2024	Conducted	▪ 24 locations were supported in the course of the year.
Conduct of outreach activities in Mobile populations e.g. prisons, Refugees/returnees/IDP	Year 2024	Conducted	▪ 7 locations managed to carry out outreach activities among mobile populations. People reached with health educations messages were 5342 ▪ Number screened for TB symptoms: 5000 ▪ Number with signs and symptoms identified:752 ▪ Number with symptoms sent to the lab: 740 ▪ Number confirmed with TB: 51 ▪ Number identified with RR TB: 2 ▪ Number of other forms of TB identified: 12 ▪ Enrolled of 1st line drugs :63 ▪ Enrolled on 2nd line drugs: 2

Quarterly review meetings for DR TB patients requiring individualized SLD regimen	Year 204	Conducted	▪ 298 patients benefited from these review meetings
Quarterly DR TB supportive supervision mission	Year 2024	Conducted	▪ 13 locations were supported
TB contact screening with focus on bacteriologically confirmed TB cases	Year 2024	BHWs were involved in Contact investigations.	**Strengths/Achievements:** ▪ Number of bacteriologically confirmed TB patients on whom Contact Investigations were carried out: 995 ▪ Number of people found at home: 1974 ▪ Number of TB contacts screened:656 ▪ Number of contacts identified with TB symptoms:167 ▪ Number of sputum samples from symptomatic contacts tested in the lab:165 ▪ Number of TB contacts confirmed with TB: 34 ▪ Number confirmed with TB and initiated on treatment :33
Intensify TB case detection	Year 2024	Both Intensified and passive case finding approaches were employed during the quarter	**Strengths/Achievements:** ▪ Total of 7906 TB cases (caseload) were diagnosed and initiated on TB treatment. **Recommendations:** ▪ All index cases should always have their contacts screened for TB for at least 3 months.
EQA slide sampling	Year 2024	Done	**Strengths/achievements** **- 1280** slides were sampled from all the State facilities and sent to the NTRL for double-checking. 90 slides had discrepant results which resulted to an EQA result concordance of 88%.
Transporting DST samples from peripheral labs for	Year 2024	Done	**Strengths/Achievements:**

Gene-Xpert processing at the hub laboratories			▪ 98% (=N270 out of 276) samples were transported from retreatment patients to the nearby hub laboratories for Gene-Xpert processing. Out of these 125 DR-TB patients were diagnosed and all were initiated on SLD.
Commemorating World AIDS DAY on the 1th of December 2024 whose theme was "Take the Right Path"	Year 2024	Conducted	▪ World AIDS Day was marked in various state levels. Drama and other skits were performed and the state leaderships took the opportunity to sensitize the audience about HIV. More that 5000 people were reached with this HIV information.

II. C-19PO (COVID-19)

Activity	**Year Planned**	**Status of Implementation**	**Concise description of the status/results/achievements and challenges**
Last Mile Distribution (LMD) of COVID-19 and HIV/TB commodities	2024	All related and linked activities carried out.	**Strengths:** ▪ Experience from C19RM implementation. We tapped into the lessons learnt from the previous year of last mile implementation to try perfect and maneuver through the inevitable. ▪ Availability of resources courtesy of accountability. The dispatch of the C-19PO resources was timely and within the payment schedule by the PR UNDP. This was highly contributed by timely submission of both financial and technical reports at the end of each quarter. The timely dispatch of resources enabled our prior planning and projections and thus instantaneous payments of last mile delivery activities – which contributed

			to real-time and consistent flow of activities without any hitches or stagnation. ▪ Data Availability This was highly contributed by the use of the tablets assigned to the data focal persons in the health facilities for facilitation of DHIS2 reporting whose updated data is the basis of forecasting medical supplies from source for each health facility. Facilitation of internet bundles to the users also contributed to data collection and reporting. ▪ Project oversight, monitoring and evaluation. This was continuously carried out at the SR level by the technical staff not limited to the Project manager, the M&E Officer, the Zonal Officers, Program and the HIVTB Officers. It was effected through the usage of the Last Mile Strategic Paper developed at the LMD project start-up in 2022 as a reference tool for guidance and advising on areas of improvement that are basic and within the scope and power of the SR. At the strategic level of the grant management, this also continued courtesy of the PR and Central level MoH officials into various States thus contributing to improved implementation of last mile delivery from first to last mile. **Results/Achievements:** ▪ Improved TBHIV programmatic performance against the set targets for key indicators in the performance framework.

			A comparison of TBHIV data and reports verification in the previous quarters of the year as informed in the consecutive management letters by the PR UNDP to SR AAA applauded continued improvement and commendable programmatic performance against the set targets for key indicators in the performance framework. This was attributed to seamless flow of patient related activities like testing, screening, diagnostics, treatment etc in respect to availability of essential medicines and medical supplies. ▪ Access of health products like medicines, assorted lab products and other essentials was possible in all our 90 health facilities. Within the year, health commodities (1,124 bulky cartons weighing 11,264 kgs) were transported and distributed to our various hub points within the different states of our implementation coverage, by an outsourced transport company (Akoldit Transport Company) for further distribution up to last mile sites in for end-user/patient. To safeguard the vehicle transferred to the SR and placed in Western Equitoria following security concerns, we hired of one car to transport various cartons containing TBHIV commodities like drugs, assorted Lab materials, weighing scales etc for 7 health facilities in Tambura, Nagero and Ezo Counties in Western Equitoria State (WE) namely: Tambura and Ezo County Hospitals, Yangiri, Mupoi, Nagero. Source Yubu and Naandi PHCCs. The transportation period between the last mile of these health facilities took to 5 days inclusive of return to Yambio and the

			coverage journey was 625 KMs. ▪ Increased coverage for HIVTB service delivery. Access to 6 transitioned HIVTB sites in the far-end area of the Eastern part of Western Equitoria state for assessments, trainings, mentorships and supervisions was made possible. Most of these facilities were unreachable due to distance since there was no vehicle available in the state but under C-19PO budget, we were able to cater for the transferred vehicle's costs herein.

6.3 Financial (Income and Expenditure)

I. GC7 HIV/TB/RSSH

Module	Intervention	Budget Line	Activity Description	Cost Input	Year 1 (2024) Budget USD	Year 1 (2024) Expenditure USD	Year 1 (2024) Variance USD
Differentiated HIV Testing Services	Facility-based testing outside of key population (KP) and adolescent girls and young women (AGYW) programs	17	Supportive supervision to Ensure quality of HTS services in prioritized facilities - AAA	2.3 Supervision related per diems/transport/other costs	8,208.00	8,016.00	192.00
Drug-resistant (DR)-TB	DR-TB diagnosis/drug	209	Enhance mentoring and	2.3 Supervision related	6,524.80	6,520.00	4.80

diagnosis, treatment and care	susceptibility testing (DST)		supportive supervision for increased coverage and update of baseline investigations - DR supportive supervision quarterly for 5 days (7 inclusive of accommodation)-3 people - AAA	per diems/transport/other costs			
Drug-resistant (DR)-TB diagnosis, treatment and care	DR-TB treatment, care and support	216	Provision of package of practical support for individuals undergoing DR-TB - AAA	12.3 Cash incentives /transfer to patients/beneficiaries/counsellors/mediators	18,960.00	18,960.00	-
Drug-resistant (DR)-TB diagnosis, treatment and care	DR-TB treatment, care and support	218	Support quarterly review meetings for DR-TB patients requiring individualized SLD regimens - Concilium of experts - Quarterly 1-day meeting in 10 states -	2.4 Meeting/ Advocacy related per diems/transport/other costs	24,130.00	24,130.00	-

			AAA				
Elimination of vertical transmission of HIV, syphilis and hepatitis B	Early infant diagnosis and follow-up HIV testing for exposed infants	41	Provision of Transport and Airtime to Mentor mothers - AAA	12.3 Cash incentives /transfer to patients/beneficiaries/counsellors/mediators	18,000.00	18,000.00	-
Elimination of vertical transmission of HIV, syphilis and hepatitis B	Integrated testing of pregnant women for HIV, syphilis and hepatitis B	43	Train and mentor HCWs in prioritized facilities - AAA	2.1 Training related per diems/transport/other costs	49,880.00	49,880.00	-
Elimination of vertical transmission of HIV, syphilis and hepatitis B	Integrated testing of pregnant women for HIV, syphilis and hepatitis B	45	Incentives for Community outreach workers (mentor mothers) - AAA	1.6 Salaries - community-based, incl. Community Health Workers (CHWs) and outreach w	36,000.00	36,000.00	-
Elimination of vertical transmission of HIV, syphilis	Post-natal infant prophylaxis	58	Semi-annual regional meetings for mentors - AAA	2.4 Meeting/ Advocacy related per diems/transport/ot	9,520.00	9,520.00	-

and hepatitis B				her costs			
Key and vulnerable populations (KVP) – TB/DR-TB	KVP - Children and adolescents	240	Provide enablers (transport) to all DR-TB patients during care - AAA	12.3 Cash incentives /transfer to patients/beneficiaries/counsellors/mediators	22,680.00	22,680.00	-
Key and vulnerable populations (KVP) – TB/DR-TB	KVP - Children and adolescents	243	Provide enablers (nutrition) to all DR-TB patients during care - AAA	12.3 Cash incentives /transfer to patients/beneficiaries/counsellors/mediators	34,020.00	34,020.00	-
Key and vulnerable populations (KVP) – TB/DR-TB	KVP - Children and adolescents	246	Establish monthly follow-up clinics of DR-TB patients and track adverse events - AAA	12.3 Cash incentives /transfer to patients/beneficiaries/counsellors/mediators	3,960.00	3,960.00	-
Key and vulnerable populations (KVP) – TB/DR-TB	KVP - Mobile population (migrants/refugees/IDPs)	250	Training on use of devices for better active case finding among mobile populations - AAA	2.1 Training related per diems/transport/other costs	6,442.00	6,442.00	-

Key and vulnerable populations (KVP) – TB/DR-TB	KVP - Mobile population (migrants/refugees/IDPs)	251	Active case finding among mobile populations - 3 outreaches per year, each testing 200 people at each - AAA	2.5 Other Transportation costs	4,000.00	4,000.00	-
Reducing human rights-related barriers to HIV/TB services	Eliminating stigma and discrimination in all settings	263	Incentives for Community Volunteers/ / peer navigators TB-related stigma and discrimination - AAA	1.6 Salaries - community-based, incl. Community Health Workers (CHWs) and outreach w	20,400.00	15,300.00	5,100.00
RSSH: Monitoring and evaluation systems	Data quality	361	Incentive for County M&E Officers - AAA	1.7 Salaries - facility-based, including medical staff and other service providers	-	-	-
RSSH/PP: Human resources for health (HRH) and quality of care	RSSH/PP: Community health workers: contracting, remuneration and retention	152	Incentives for HCWs at ART, PMTCT and TB sites - AAA	1.7 Salaries - facility-based, including medical staff and other service	586,800.00	586,800.00	-

				providers			
RSSH/PP: Human resources for health (HRH) and quality of care	RSSH/PP: Community health workers: contracting, remuneration and retention	396	Equip BHWs with tools to support their functions - AAA	11.1 Office related costs	-	-	-
RSSH/PP: Human resources for health (HRH) and quality of care	RSSH/PP: Quality improvement and capacity building for quality of care	401	Train and mentor HCWs in prioritized facilities - 4 regional workshops x 40 people each x 4 days each - AAA	2.1 Training related per diems/transport/other costs	45,460.00	45,460.00	-
RSSH/PP: Laboratory systems (including national and peripheral)	RSSH/PP: Specimen referral and transport system	409	Provision of service contracts to courier companies for facilitation of sample transportation	3.4 Other external professional services	65,688.30	58,420.00	7,268.30

TB diagnosis, treatment and care	TB screening and diagnosis	185	Supportive supervision and mentorship to strengthening and maintain quality of care, monitoring and reporting - AAA	2.3 Supervision related per diems/transport/other costs	8,992.00	8,990.00	2.00
TB diagnosis, treatment and care	TB treatment, care and support	194	AAA Direct Programme Implementation HR cost (former BL354)	1.1 Salaries - program management	141,924.00	141,924.00	-
TB diagnosis, treatment and care	TB treatment, care and support	196	AAA Field level Direct Programme Implementation HR cost (former BL355)	1.7 Salaries - facility-based, including medical staff and other service providers	287,172.00	270,596.00	16,576.00
TB diagnosis, treatment and care	TB treatment, care and support	197	AAA Direct Programme Implementation Operational costs	11.1 Office related costs	36,236.80	36,227.00	9.80

TB/HIV	TB/HIV - Collaborative interventions	224	Incentives to support State HIV/TB coordinators - AAA	1.7 Salaries - facility-based, including medical staff and other service providers	12,000.00	12,000.00	-
TB/HIV	TB/HIV - Treatment and care	238	ToT on Piloting and scale-up of community-based/community-led HTS of presumptive TB cases in communities - AAA	2.1 Training related per diems/transport/other costs	12,038.00	12,038.00	-
Treatment, care and support	HIV treatment and differentiated service delivery - adults (15 and above)	150	Provide operational support to 130 facilities providing ART/PMTCT - Operating costs - AAA	11.1 Office related costs	21,520.00	21,520.00	-

Treatment, care and support	HIV treatment and differentiated service delivery - adults (15 and above)	151	Engagement event to strengthen community engagement and outreach interventions at prioritized facilities - AAA	2.1 Training related per diems/transport/other costs	23,400.00	23,400.00	-
Treatment, care and support	HIV treatment and differentiated service delivery - adults (15 and above)	153	Incentives for Expert patients and Outreach workers - AAA	1.6 Salaries - community-based, incl. Community Health Workers (CHWs) and outreach w	50,400.00	50,400.00	-
Treatment, care and support	HIV treatment and differentiated service delivery - adults (15 and above)	154	Provide operational support to facilities providing ART/PMTCT in 87 health facilities	11.1 Office related costs	64,400.00	64,374.00	26.00

Treatment, care and support	HIV treatment and differentiated service delivery - adults (15 and above)	156	Provision of Transport and airtime to Expert clients and outreach workers - AAA	12.3 Cash incentives /transfer to patients/beneficiaries/counsellors/mediators	25,200.00	25,200.00	-
Treatment, care and support	HIV treatment and differentiated service delivery - children (under 15)	162	Regional level workshop to sustain psycho-social interventions (camps/workshops) for children and adolescents on ART - AAA	2.4 Meeting/ Advocacy related per diems/transport/other costs	6,916.80	6,917.00	(0.20)
Program management	Grant management	500	AAA ICR - 7%	11.3 Indirect cost recovery (ICR) - % based	115,561.09	113,518.58	2,042.51
Total					**1,766,433.79**	**1,735,212.58**	**31,221.21**

***Notes to the Financial (Income and Expenditure) illustration for* GC7 HIV/TB/RSSH**

1. The overall budget variance for Year 1 is USD 31,221.21. This is projected for continued utilization in Year 2 of the grant in the activities where placed.

Explanations on Variances in the various Budget Lines for Budget VS Expenditure:

For Budget lines related to supervisions, there are slight positive variances due to 3rd participation by AAA in related supervision costs. These are:

- BL 17: Supportive supervision to Ensure quality of HTS services in prioritized facilities – AAA. This has been reported at a positive variance of USD 192. Annual/cumulative absorption is at 97.66%.

- BL 209: Enhance mentoring and supportive supervision for increased coverage and update of baseline investigations - DR supportive supervision quarterly for 5 days (7 inclusive of accommodation)-3 people – AAA. This is reported at a positive variance of USD 4.80. Annual/cumulative absorption is at 99.2%.

- BL 185: Supportive supervision and mentorship to strengthening and maintain quality of care, monitoring and reporting – AAA. This has been reported at a positive variance of USD 2. Annual/cumulative absorption is at 99.97%.

Other budget lines related to incentives and salaries that reported positive variances are:

- BL 263: Incentives for Community Volunteers// peer navigators TB-related stigma and discrimination – AAA. This has a positive variance of USD 5,100. As reported in the quarterly reports of year 1, the cadres involved in this activity were not engaged in Q1 due to reasons reported to the PR precedingly - these being: a short window of identifying, mentoring and enrolling them as contributed by the slight delay in signing the SR Agreement for GC7 as well as other important related programme activities linked to closure of the previous NFM3 grant e.g. external audits for FY2023, verification exercises by the LFA, closure of organizational assessment exercise for transition to new grant etc; thus, the budget allocated for the Q1 incentives remained unutilized hence retained as budget savings by end of Q4/2024. As these unspent resources will continue to remain open in the rest of the grant period unless reprogrammed, AAA looks forward to present a formal reprogramming proposition as the implementation of GC7 progresses in year 2 or during the next amendment phase in case it is envisaged. Annual/cumulative absorption is at 75%.

- BL 196: AAA Field level Direct Programme Implementation HR cost (former BL355). This has been reported at a positive variance of USD 16,576. The annual/cumulative absorption is at 94.22%. The positive variance is linked to the AAA field Technical HR and other service providers. The reasons for its existence are:

    - Pending payments of some TBHIV Officers (including mobile), which will be made time by time during their contract engagements and matured R&R.

    - Internal remuneration reviews for some cadres in case of casual engagements e.g. drivers due to partial use of some vehicles e.g. the one placed in Rumbek due to its continuous wear and tear following its exceeded useful use.

The forecast of the balance in this budget line has however been planned for utilization under the respective cadres as budgeted for and will be fully absorbed during the remaining grant period.

The rest of the budget lines with positive variances are linked to Sample transportation activities, operational costs due to 3rd participation by AAA towards some of these costs to the programme and 7% ICR for AAA as follows:

- BL 409: Provision of service contracts to courier companies for facilitation of sample transportation. This has been reported at a positive variance of USD 7,268.30. The remaining balance in herein was intentionally reserved for supporting the Year 2 implementation of this activity – reason being, the budget allocated for Years 2 and 3 is limited compared to what was allocated in Year 1; thus, this balance will enable the catering for some activities linked with sample collection and transmission of results e.g. airtime for sample coordination, supportive supervisions, mentorships and operational costs. The decision to have these resources reserved for the upcoming grant period projects a boost in improving the related indicators alongside the future budget allocated therein. Annual/cumulative absorption is at 88.93%.

- BL 197: AAA Direct Programme Implementation Operational costs. The positive variance is of USD 9.80 Annual/cumulative absorption is at 99.97%.

- BL 154: Provide operational support to facilities providing ART/PMTCT in 87 health facilities. The positive variance is of USD 26. Annual/cumulative absorption is at 99.95%.

- BL 500: AAA ICR - 7% with a positive variance of USD 2,042.51 at an annual/cumulative absorption of 98.23%. The 7% unutilized ICR by end of Year 1 is due to unused budgetary resources following the reasons/explanations in each budget line with positive variance above. It is projected to be recovered in Year 2 following envisaged utilization of the positive variances in the budget lines reported in Year 1.

- Lastly, the negative variance of USD (0.20) in BL 162 Regional level workshop to sustain psycho-social interventions (camps/workshops) for children and adolescents on ART was inevitable due to budgetary decimal points. It will be borne in Year 2 as there is a similar activity planned to take place therein.

II. C-19PO (COVID-19)

Module	Intervention	Budget Line	Activity Description	Cost Input	Year 4 (2024) Budget	Year 4 (2024) Expenditure	Year 4 (2024) Variance
COVID-19	Health products and waste management systems	83	Last Mile Distribution (LMD) of COVID-19 and HIV/TB commodities - AAA	7.4 In-country distribution cost	-	-	-
COVID-19	Health products and waste management systems	1209	Last Mile Distribution (LMD) of COVID-19 and HIV/TB commodities - AAA	7.4 In-country distribution cost	30,000.00	27,195.00	2,805.00
Program management	Grant management	291	AAA Programme Management Service ICR	11.3 Indirect cost recovery (ICR) - % based	-	-	-
Program management	Grant management	1303	Office-related costs (cost of vehicle transferred by UNDP and Bank charges for new banking arrangement)	11.1 Office related costs	19,249.98	17,838.00	1,411.98
Program management	Grant management	1308	ICR for AAA	11.3 Indirect cost recovery (ICR) - % based	3,447.50	3,152.31	295.19
Total					**52,697.48**	**48,185.31**	**4,512.17**

Notes to the Financial (Income and Expenditure) illustration for C-19PO (COVID-19)

1. The overall budget variance for Year 4 is USD 4,512.17 This is projected for continued utilization in Year 5 of the grant in the activities where placed.

Explanations on Variances in the various Budget Lines for Budget VS Expenditure:

- BL 1209: Last Mile Distribution (LMD) of COVID-19 and HIV/TB commodities – AAA. The positive variance is of USD 2,805 due to less consignment of health commodities received from the PR UNDP in Q16 (Q4.24). The positive variance is projected for utilization in Year 5 (2025) of the grant for payment of last mile delivery of the projected health commodities into the 90 health facilities in the 5 implementing States of AAA (WBeG, Warrap, NBeG, Lakes and WE). Annual/cumulative absorption at 90.65%.

- BL 1303: Office-related costs (cost of vehicle transferred by UNDP and Bank charges for new banking arrangement). The positive variance is of USD 1,411.98 due to AAA's 3rd participation to operational costs towards the programme. Further, with the good state of the vehicle transferred to AAA in Q15, there was little usage of resources towards its maintenance related costs. The positive variance is however projected for utilization in Year 5 (2025) of the grant. Annual/cumulative absorption at 92.66%.

- BL 1308: The 7% unutilized ICR of USD 295.19 by end of Year 4 (2024) of the grant is due to unused budgetary resources following the reasons/explanations in each budget line with positive variance above. It is projected to be recovered in Year 5 (2025) following envisaged utilization of the positive variances in the budget lines reported in Year 4.

Appendix on the Income & Expenditure:

AAA uses one Bank account for both GF UNDP Grants (GC7 and C-19PO) resources but accountability is distinct for each grant.

The bank balance reflected on the Bank Statement as of 31 December 2024 2024 is USD 35,734.07. For reconciliation purposes, the combined statement balance of USD 35,734.07 is split as:

- USD 31,221.21 - which is balance for the ongoing GF-UNDP_HIV/TB/RSSH_GC7 grant.
- USD 4,512.17 – which is balance for C-19PO grant.
- USD 0.69 – for AAA which serves as account retention balance before approval of new grant(s).

Third Participation:

As notified in the reasons for variances, there were instances where AAA contributed to the programme through 3rd participation. This was essential in order to supplement some financial gaps realized during the implementation of the grant especially in areas that were not funded by the Global Fund but deemed crucial for HIVTB and last mile service delivery, while at the same time, helping meet the grant objectives. For this reason, AAA sought financial aid from other well-wishers with the aim of supporting the programme. These additional funds were mobilized by AAA through fundraising hence regarded as third participation towards the programme implementation. Below is the summarized table showing the support rendered to the programme though AAA's contribution in 2024.

3rd Participation towards AAA's GC7_GF UNDP HIV/TB/RSSH and C-19PO Programme		
No.	**Area of Intervention**	**Amount in USD**
1	**Payment of Support Staff (Cooks/Cleaners** for intensive care patients to aid in treatment adherence and lab sterilization; **day and, night Guards** for safeguarding assets and other programme valuables and commodities) for AAA TBMUs, attached DCs/DTCs and **HIV** sites in WBeG, Warrap, NBeG and Lakes States. These support staff are crucial for supporting service delivery of GF TBHIV Programme but were not provided for in the GF budget.	40,452
2.	**Incentives for 1 HCW** (CO) in Nagero PHCC (TB site) attached to Tambura County Hospital in Western Equatoria State.	1,800
3.	**Technical Advising (TA)** related costs to the AAA TBHIV Programme in WE, NBeG WBeG and Warrap States through engagement of an external consultant.	9,151
4.	**Mobile Clinics** aligned with some programme activities in Aweil East County where we have **Gordhim PHCC** as a selected optimization HF. The mobile clinics aimed at aiding boost the improvement of lagging indicators, targets and grant results.	16,600
5.	**Renovations of health infrastructure for improved service delivery as follows:** a) Installation of solar system in **Gordhim PHCC** for lighting purposes and strengthening of power system for the GeneXpert machine. Support included provision of 10 batteries, 12 solar panels, 1 controller, cables and installation costs = $8,320. b) Provision of 1 piece of durable pole circuit breaker for **Gordhim PHCC** generator used for alternatively powering the GeneXpert machine. Cost included fixing labour; @ $260; and, provision of materials for repairing the	11,292

	pharmacy drug shelves to facilitate proper storage @$156 = $416. c) Repairs of TB/HIV clinic in **Wau Teaching Hospital** through provision of materials for flooring, wall works, painting and labour costs =$804. d) 1st part: Minor repair of the damaged fence in **St. Joseph TB/Lep Centre** through provision of materials and labour to reinforce security including for assets = $496. e) **Aroyo PHCC:** Rehabilitation to improve the status of the laboratory through provision of materials and labour cost @ $390. f) **Aluakluak PHCC:** Provision of furniture (1 plastic table and 2 plastic chairs) and installation of the sink in the laboratory (through materials and fixture costs) @ $370. g) **St. Joseph TB/Lep Centre:** Final part - Minor repair of the damaged fence in through provision of materials and labour to reinforce security including for assets @ $496.	
6.	**Vehicle repairs**: General repairs of AAA car plate No. SSD 921R stationed in Agangrial PHCC but servicing the AAA TBHIV programme in Cueibet County – Lakes State.	3,281
7.	**Support supervision** related costs for the TBHIV Programme through AAA Programme staff like Temporary Zonal Officer for Eastern part of WES, various TBHIV Officers and one Roving Officer	7,380
8	**General drugs for TB patients -** Provisions of these consumables were done in Gordhim and Agangrial PHCC.	17,400
9	**Last mile delivery/Transportation** of Q1 consignment for health commodities and supplies donated by PR UNDP – from drop-off points up to final destinations in the HFs. This was done before approval of C-19PO budget for Years 4 and 5.	3,111
	Total	**110,467**

Total 3rd Participation by AAA towards the Programme in 2024 was USD 110,467.

Procurement and supply management

The set standards of procedures by the Global Fund and PR UNDP are that the major assets and equipment should only be purchased directly by the PR, and issued in kind to the implementing partner. Therefore, depending on budget availability, AAA as an SR only procures minor purchases to aid in the operations and programme implementation. Examples of these purchases include consumables such as diesel, petrol, spare parts for the motor vehicles and motorbikes used in the various HIVTB sites, provisions of stationery and hygiene materials for ART, PMTCT, TB

sites etc. Within the reporting year, budgets for these consumable procurements were availed to AAA through operational costs under both GC7 and C-19PO grants.

The management of items supplies/purchased in the reporting year was well tended and was in accordance with AAA's Finance, Operational Policies and Procedures Manual under Procurement guideline/Procedures as well as in the standards expected and communicated by PR UNDP in workshops, management letters and during SR Reviews. From time to time, the manual is updated and upgraded with addendums depending on newly established systems, needs and/or requirements.

For pre-planning purposes, at the beginning of every year, AAA compiles a pre-qualified list of suppliers identified after a market/price surveys. This list is updated regularly by the Procurements/Logistics Officer through the review of the Project Manager and the Finance Director. This process was also effected in the reporting year. In 2024, the GC7 grant catered for emergency fuel and spare parts for some of the motor vehicles used in serving the TBHIV programme. There was also provisions of stationery and hygiene materials for use in the HIVTB sites. The budget for these needs was minimally provided in the budget lines linked to operational costs. The last mile delivery of various health commodities was facilitated by the C-19PO project budget together with costs linked to one vehicle that was transferred to AAA by PR UNDP and placed in Western Equitoria State. These were effected from July 2024 after signing amendment no.4 to the 2021-2025 SR agreement.

It is worth noting that the health commodities supplied to AAA under C-19PO were all donated/received in kind as were purchased directly by the PR UNDP; and, in most cases distributed from Juba to AAA drop-off points (hubs) in the five states of our operations for further distribution to various sites. The summary of commodities donated for each site was provided by the PR UNDP upon delivery of each consignment at the hub. This packing list is commonly referred to as a waybill and it is the guide that aids in sorting out the commodities for each site and/or health facility for last mile delivery. The original copy of the waybill also accompanies the commodities under distribution to each site whereas a copy copy is sent to the HQ for monitoring and follow-up of the distribution process or ground. Once at last mile, delivery note(s) by the designated receiving persons are signed as proof of last mile delivery.

For a successful execution of the TBHIV activities and last mile implementation in the year, AAA embarked on early preparations and projections of the linked activities to enable a successful procurement and supply chain management. The preparation ensued in early February and early July after signing the SR agreement and related amendments with PR UNDP in the reporting year. This facilitated a seamless flow of implementation from the start of project as time is of the essence. The preparations entailed:

- Conducting mechanical assessments and researching of spare-parts quotations for repairing and servicing the existing vehicles and motorbikes;
- Development of workplans for estimation of needed fuel and researching favorable market prices.

- Bidding of transport companies for last mile of the health supplies and commodities to the health facilities.
- Pre-orientation of field staff on the expected implementation of the grant's activities etc.

These preparations were continually adopted in the beginning of each quarter of the year and they contributed highly to a successful implementation of the programme activities, tangible aborption of grant resources, timely reporting and a successful end of year results.

The nature of procurement that took place includes:

- Spare parts and lubricants for general and minor repairs/maintenances and servicing of our motor-vehicles (cars and motorbikes) to enable their usage in the implementation of TBHIV Programme and last mile activities between Drop Point(s) (Hubs); main AAA HFs and various TBHIV sites in the peripheries within the 5 States.
- Diesel for active cars servicing the TBHIV programme including for last mile delivery.
- Petrol for active motorbikes servicing the TBHIV programme and last mile activities.
- Hiring third party transport companies for road transport of health commodities and supplies among other program items.
- Provisions of stationery and hygiene materials as part of providing operational support to facilities providing ART/PMTCT/TB.
- Additionally, from July 2024, AAA continued its involvement in the provision of service contracts to courier companies for facilitation of sample transportation under the RSSH/PP: Laboratory systems (including national and peripheral). Given its experience, effectiveness and efficiency, the contracted company for this service by the name Akoldit Transport Company Ltd was retained from 2023 under new agreement and revised/updated terms and conditions in 2024.

Through GC7 budget, there were also other forms of procurement that SR AAA was involved in such as payment of internal flights for the M&E officer and programme staff during back-and-forth movements for supervisions, mentorships and other related programme tasks and/or activities.

To enable an effective and efficient supply chain management of the above procurement and last mile activities, SR AAA effected the following:

- Continued use, reference and guidance of a detailed and clearly defined Distribution Strategic Paper in the implementation of the last mile activities which has clearcut details on creation of a distribution plan through understanding our target needs (patients), determining logistics by finding the most efficient and affordable way to transport the health commodities from the start up point to the last-mile for end-users, choosing distribution channels for reaching the end-users; and, evaluation and modification of the plan by assessing the distribution plan on a regular basis and make revisions in response to shifting conditions, end-user demands, and other elements

that could affect the plan's success. This tool was developed during the C19RM project start-up in October 2022.

To aid in achieving the grant objectives by filling in some monetary gaps, AAA made contributions to the programme through own resources/fundraising as shown in the table in page 41-42 of this report. Some of these costs were linked to minor procurement like vehicle maintenances, general drugs, infrastructure maintenance /rehabilitation of various structures related to TBHIV programme and some general running costs for the TBHIV sites.

It is worth noting that for all the procurement and supply chain management, regardless of The Global Fund or AAA's third participation resources, the same system stipulated in the AAA Finance and Operations manual and lessons learnt from continued mentorship by PR was applied. In brief, this is the applied process:

- In the usual procedures where procurement is involved, the Project Manager/TB Expert is the mandated person to analyze the procurement requisitions/work plans presented by the TBHIV Officers from different TBHIV sites. Upon analysis and approval, he liaises with the Finance Director who in accordance with the budget approves the procurement of the required requested items.
- In accordance with AAA's policy, spares are assessed by AAA's specialized consultant mechanic who signs besides the activity report.
- In cases where transport is involved, selection of the transport company is usually reached through scrutiny of various quotations from different companies for bid selection. Thereafter, the selected company signs a contract with AAA. The contract sights the expectations of the services and conditions to be adhered subject to payment.
- For renovations/rehabilitation of existing structures, AAA involves the selection of the available construction companies. The final decision is usually reached through scrutiny of various quotations from different companies for selection. Nonetheless, before any go ahead of the approvals of the renovations of the existing premises in the HFs e.g. storage houses, laboratories etc.; the Hospital or PHCC Head/Director(s) or linked CHD/SMoH must send an official endorsed letter highlighting and explaining on the dire need for renovations. This process in enforced to enhance transparency and collaborations with the state government partners and/or CHDs/SMoH.
- As far as hiring of transport companies and renovations/rehabilitation of existing structures is concerned, it is important to note that in the context of South Sudan especially in the remote areas where our programme is operational, there are not a variety of companies available for these services – majorly influenced by monopoly and/or poor infrastructure; thus, we select only the available existing and registered company(s) whereby a justification of selection is written to support the quotation.

- In regards to the stationery and hygiene materials purchases for the ART/PMTCT/TB sites, approval of the next procurement is done after checking the stock card to confirm if there is any sufficient balance from the previous purchase before replenishment. Once it is confirmed that there is need for procurement to take place, the Project Manager/TB Expert requests for various quotations for review with the logistics/procurement officer and the finance director for budget availability reference. The best one is selected based on availability of items, cost and convenience.
- After the quotation is selected, the Logistics/Procurement officer raises a purchase order to the selected supplier through the authorization of the Finance Director. An invoice follows thereafter. Upon provision and the delivery of the items in good order and condition, the supplier is paid by either cash or cheque and he provides a receipt.
- When the items are delivered to the requesting main health facility, they are recorded as in stock first and then distributed to the attached sites according to need through internal delivery notes.
- Monitoring of usage continues in order to ensure control, efficiency and efficacy.

In regards to fuel purchases, which are done on a regular basis as is a necessity for program implementation, approval is after checking the Logbooks to confirm if the usage is in tandem with the activities and distances covered. The supply system entails:

Fuel allocation to the TBHIV Programme:

The fuel allocation is supposedly for carrying out Programme activities such as:

1. Supportive and mentorship supervision visits.
2. Technical, monitoring and evaluation visits.
3. Tracing of patients lost to follow-up.
4. Last Mile Delivery of COVID-19, TBHIV commodities and other health products between Drop Point(s) (Hubs); main AAA TBMUs (HFs) and various TBHIV sites in the peripheries.
5. Running any other authorized/approved programmatic errands.

Prior to the approval of any new fuel procurement to the TBHIV sites, the Project Manager/TB Expert must have both copies of the Workplan and Logbook from the various TBHIV Officers.

- **Work Plan**: The document is a reflection of the TBHIV Officer's plan of action during a certain period (in this case quarterly) with specific information on activities, target groups, time frame, anticipated requirement and source of funding. Through this document, the Project Manager/TB Expert has insight on activities to be undertaken by the TBHIV officer and he can guide and add some input before approving the document.

- **Logbook:** This is a log sheet capturing the day-to-day movement of the motor vehicles with specific entries on mileage, fuel received, fuel used and purpose of travel. The movements of both cars and motorbikes must be either part of the work plan or sanctioned by the Director and Program Manager/TB Expert.

With both the Workplan & Logbook, the Project Manager/TB Expert will make analysis and determine the following:

- Whether the previous fuel allocation was utilized as per the preceding approved Workplan.
- Whether the amount of fuel reflected in the logbook in terms of consumption corresponds with the distance of the reflected trip /movement in the Log sheet.
- If the balance in stock is correct after deducting the total sum of fuel consumed from the initial balance in stock.
- Calculate total mileage verses the total fuel consumed in the preceding quarter in order to audit whether there was any loss or wastage in that period.
- Check entries in the logbook, which were not parts of the Workplan but were sanctioned by the Project Manager/TB Expert e.g. pick up of drugs donated by MoH/UNDP.
- Armed with the outcome of the above determinants plus the new Workplan, the Project Manager/TB Expert can come up with a projection of the number of liters to be allocated for that quarter and present to the Project Administrator/Director.
- The Finance Director will then present the figures to the Logistics/Procurement Officer for quotations from various suppliers.
- Upon receipt of the various quotations, the Finance Director will then approve the best quote based on the unit cost, quality, and reliability of the supplier, availability of the product and the mode of payment.
- The Project Manager/TB Expert and Finance Director will come up with the final allocation to the program after going through the available budget by the donor.
- Once the fuel is approved and distributed to the programme, they are recorded as in stock first and then distributed to the attached sites according to need through internal delivery notes.

ASSETS

In 2024, AAA received some assets donated by The Global Fund for use in supporting the TBHIV Programme. These are 109 weighing scales (Seca 755 Mechanic Scale) and 10 Laptops (Lenovo X 13 Gen 4). All these assets were distributed to the intended TBHIV sites and are under the care of assigned custodians.

To support the implementation of activities within the year, AAA continued using the old assets donated in 2017 by the Global Fund since 2005 and those formally transferred to the NFM2, NFM3 and GC7 grants even though their productive life-span is expired. These are 2 Vehicles, 26 Motorbikes and 110 Bicycles. Nonetheless, it is worth noting that AAA has maintained all the records of all these assets and focal persons remain in place as custodians. Even though old, these

assets remain distributed in the implementing locations as reflected in the Statement of Assets and Equipment which also reflects the net book value at Zero as of 31/12/2024. This statement is endorsed by signatures of both The PR UNDP and SR AAA.

Other assets that are available to AAA for the programme activities include:

- One Toyota Landcruiser donated by PR UNDP in 2021 and is placed in Gordhim location.
- One Toyota Landcruiser transferred by PR UNDP to AAA in August 2024 and is placed in Yambio location for supporting the TBHIV programme in Western Equitoria State.

Methods in place for safeguarding assets:

- AAA has no Global Fund/UNDP asset in Nairobi and Juba offices. All assets are in the field TBHIV Programme locations in South Sudan to facilitate the carrying out of project activities.
- All AAA vehicles provided have their fitted tracking devices on. As noted in the assets' preamble, appointment of focal persons responsible for safeguarding them is in place.
- Through regular physical verification of the assets in the field whereby the HQ always receives, updates on the asset list every 6 months per year (twice per year) from the field through the regional staff in charge but counter –signed by responsible national staff. Assets verification reports are kept in the H/Q for reference of next verification exercise.
- When the HQ staffs are in mobile for field visits regularly, they also conduct physical verifications of the assets in the locations they visit.
- During the assets verification in the field locations from the focal staff as per AAA policy, in the time of verification, the salaries are withheld until all assets are verified satisfactorily by the mandated verifying persons.
- There is updated Asset Register in place and register per each TBHIV Program location.
- Vehicles and motorbikes have logbooks sent monthly to the H/Q for analysis and verification.
- All the assets are comprehensively insurance through reliable insurance companies.

CHAPTER 2: CURRENT PROJECT MANAGEMENT ARRANGEMENT

Project Management:

The Global Fund GC7 grant and C-19PO last mile activities are managed by the Project Manager/TB Expert. He is the overall overseer of all Programme activities. This is made possible through the support of the field staff under the leadership of the TBHIV Officers. He is also involved in the decisions pertains the recruitment, retention and capacity building of staff. Additionally, he is responsible for forging alliances with other agencies involved in health care delivery in the areas of integration of TBHIV services in the health facilities; thus, is the focal contact person for the programme and the link between the donor agencies, PR UNDP, Ministry of Health (both Central and State levels), National bodies in charge TB and HIV services (NTLP and HIV departments) and the AAA TBHIV programme.

The Project Manager is responsible for monitoring the programme activities and ensuring that they are in line with the approved Workplan in order to achieve the set targets. This is with the support of the M&E Officer. The two are responsible for all the data collection, reporting and monitoring of activities to ensure that they are in accordance with the set Workplan(s); while prioritizing the activities as required, capacity building, verification and analysis of data and submission of the quarterly reports. Along with these tasks is also ensuring that the programme needs are met which may include; timely supply of drugs, availing the right equipment and offering technical assistance whenever need arises. Aligned with this, they ensure proper management of drugs and health commodities supplied as all the field TBHIV Officers prepares the drug orders using a standardized format which is submitted for verification and review. The Project Manager/TB Expert then submits the orders to the relevant MoH bodies at Central level with the PR UNDP, makes follow-up to ensure these are delivered; and, contacts the field officers regarding quantities and last mile deliveries. Further, he oversees the procurement of items as required; and, inventories from the field, consumption records etc as all are submitted to him for reviews.

To ensure smooth liaison operations, there is a national Administrator and 2 Liaison Officers based at the Country office in Juba. Further, the M&E Officer is also regularly placed in the Juba Country office for similar activities after his field visits and he is responsible for all the follow up of Programme issues at Central level (Juba) with the Ministry of Health, National TB and HIV bodies (NTLP and HIV departments), PR UNDP and other partners.

In the programme operational structure, AAA has a Finance Director who is responsible in managing all the Programme funds. The Finance Director in collaboration with the Project Manager/TB Expert ensures that the funds are utilized in accordance with the approved Workplan(s) to meet the expected end-deliverables. Approval of the expenditures is done in consultation between the two in close collaboration with the relevant departmental staff to aid in input.

In the field level, the TBHIV Officers and/or program officer are responsible for all the activity funds disbursed and there is a comprehensive accountability system in place, which involves at least two National staff to verify all the expenditures in conjunction with the assigned TBHIV Officer or Program Officer.

The TBHIV Officers/Program officer also performs various M&E activities such as data verification, ensuring that all staff understands the data collection tools, compiling data from the facilities and also offers some on-site mentorships, trainings and sensitizations on data collection and verification to lower cadres.

Follow - up of the programme matters (technically and financially is on a continuous daily basis) and reports submission is on a monthly basis for evaluations and feedback before the quarterly compilation for reporting to the PR UNDP within the set deadlines.

Finance Management:

The Finance Director is the head of Finance management.

As the Head of the Finance/Procurement, she works in close consultation with the Project Manager/TB Expert. The two parties are charged with the analysis of all the field requests before the approval and release of the funds for implementation of program activities in the field. Payments are made through online transfers and cheques; and, in accordance with the new requirements by the bank, they are accompanied with the approved copies of support documents (such as Cash Vouchers, Payrolls, Passport copies of the in charge etc). These support documents are prepared for projected payments after analysis and approval of the programme needs by the Finance Director and the Project Manager/TB Expert.

The programme resources are through electronic funds transfer from AAA's main bank (Citibank) to Ecobank Juba for later dispatch to various TBHIV sites as per approved needs and workplan.

Where cheques are involved, these are signed by two people – these being the Project Manager/TB Expert and an external person in Verona Fathers administration who is a Volunteer in the AAA setting but the administrator in the Verona Fathers' institution.

After the approval of the resources at the programme management level, the TBHIV Officers/Program officer are responsible for all the activity funds disbursed in the field and there is a comprehensive accountability system in place, which involves at least two National staff to verify all the expenditures in conjunction with the TBHIV Officers and/or Program officer.

Further, during the implementation, the Finance staff (under grant management) are in charge of monitoring that the funds are used in line with what they were approved for. They ensure this during their field visits to the sites where they verify the expenditures before submission of the original copies to the HQ for analysis and filing awaiting PR reviews and audits as only photocopies are retained in the field locations. The Project Manager/TB Expert together with the

M&E officer also assist in verifying that approved activities were actually implemented through the approved funds.

Usually, expenditure entry by the project accountant is on a daily basis following any occurrence of transactions. For control and quality assurances, a daily statement is sent by the bank. Accompanied by these are the monthly statements and the bank reconciliations which are prepared on monthly basis by the Project Accountant, reviewed by the Project Manager/TB Expert and approved by the Project Administrator/Director.

As such there were two sets of resources from The Global Fund (GC7 and C19PO grants) in 2024; AAA operated one bank account for these Global Fund donations; but, accountability, reporting and bank balance reconciliations for each grant was independently presented to the PR UNDP. This mode of operating one bank account specifically for the Global Fund resources continues to ensure transparency in the utilization of the funds as was always in the past.

There is quarterly review and approval of expenditure and FACE report by the PR before release of next disbursement. In addition, an external annual audit is conducted after every financial year by the audit firm selected by the PR.

All financial records are maintained by the Finance Director in conjunction with the other Finance Department staff who are charged with proper follow up of grant funds and preparation of financial reports. Additionally, regular back-ups are done in the information systems through external back-up disks that are stored safely in a secondary storage. Online back-up too takes place simultaneously through google online platform by all and for all staff.

Lastly, the Finance Director together with the Project Manager/TB Expert also oversees the Human Resource involved in the implementation of the Programme. In summary, see what is and was entailed under Human Resource within the year:

Human Resource:

AAA had an average of 437 (GF/AAA supported) staff, HCWs and CHWs involved in the TBHIV and last mile implementation in year 2024 as illustrated in the "organizational organogram" in page 16 These cadres service various AAA TBHIV sites situated in across (27) counties and located in five (5) out of the 10 established states in the Republic of South Sudan as stipulated under subtitle "Project areas".

As a way of strengthening and improving on the TBHIV interventions implementation, AAA continued with the engagement of two Zonal Officers to service the TBHIV Programme in four States these being Lakes, WBeG, NBeG and Warrap through general supervisions, advising on ways to continue strengthening the TBHIV activities, mentoring of the programme staff on TBHIV interventions among other duties. It is worth noting that some budgetary savings under Zonal Officers category were realized during the year's implementation - whereby in this case, one

position of a Zonal Officer was vacant in January and February 2024 as AAA was waiting for GC7 grant and budget approval. Following these unutilized resources, AAA reported to the PR that there was need to engage a temporary Zonal Officer for supporting the mentorship of HIVTB services in the 6 transitioned sites in the Eastern part of Western Equitoria State from 1st October 2024, as the assessment and supportive supervision visits/mission during and after the handover by former IP deemed the programme in a very wanting and dire state as detailed in the mission report which had been shared with the PR. This temporary engagement was essential towards setting a foundation in these "neglected" sites in this area and became a pathway of services improvement and results. The inclusion of this personnel is part of the total number of human resources noted above.

The standard procedure applied in HR Management is that the Program Manager/TB Expert with the help of the TBHIV Officers/Program officer are responsible for recruitment and retention of the staff. Jobs vacancies are advertised locally and the TBHIV Officers and SMoH through the CHDs have the mandate to select applicants for interviews, conduct interviews and thereafter share the outcome and all the applicants' documents with the Project Manager/TB Expert and Finance Director for approval. Each staff engaged in the year has either:

1. **Contracts:** These were directly employed by SR AAA to implement the programme after thoroughly capacitating them in order to retain and make them in charge of the programme. These are not under RoSS payroll. Originals of these are kept both in H/O and in the field under custody of TBHIV Officers.
2. **Incentives Agreements**: These are under RoSS payroll and only receive standardized incentives as approved in the budget. The SR maintains these agreements in order for them to offer their services and provide results to the TBHIV programme. Originals of these are kept both in H/O and in the field under custody of TBHIV Officers.
3. **Internal Arrangements with Internal Agreements:** These are for the Peer Navigators who only receive incentives. Their agreements are kept in the field under custody of TBHIV Officers as these cadres report directly to them.

Job descriptions are attached to the employment document of each staff or HCW.

Under normal circumstances, TBHIV Officers/Program officer are obligated to evaluate the staffs (through performance score) at the end of every contract period before their contracts are renewed by the Project Manager/TB Expert.

Each staff is required to sign the attendance sheet on daily basis. However, the Boma Health Workers (BHWs) sign the attendance sheet on monthly basis when they are submitting their monthly reports. In turn, these documents are shared with the Project Manager/TB Expert and Finance Director for approval of their payments.

Approval of salaries is bound on the TBHIV Officers submission of salary/incentives requisitions to the Finance Director for analysis. Thereafter, the HR Officer prepares the payrolls which are approved by the Project Manager/TB Expert and Project Administrator/Director.

Following the engagement of AAA to remit the incentives for HCWs at ART, PMTCT and TB sites from during the previous NFM3 grant, this continued too in GC7. As these HCWs are directly linked to the SMoH, AAA does not keep any agreements related to them. However, before enrolling the HCWs for incentives, AAA first does the verification of the actual number of HCWs at each allocated ART, PMTCT and TB site. The reference documents used during payment are:

- Copies of verified and approved forms with HCWs names and photos from the field HIV sites.
- Copies of approved attendance sheets from the field HIV sites as presented by the in-charge under SMoH and confirmed by the designated programme officers under AAA.

During the grant implementation, AAA was assigned a budgetary obligation of remitting incentives to 60 mentor mothers and 84 Expert Patients (Clients). These cadres are not under AAA management but are directly engaged and supervised by their respective Networks NEPWU and SSNeP+ as per the terms and conditions of signed MoUs and amendments between AAA and these IPs. In order to meet the budgetary obligation as provided for in the grant and for a continued cordial partnership with the Networks, AAA does the following:

- Retains the original copies of the payment sheets of the paid incentives.
- Provides the Central – Level - Juba office of the Networks with copies of the payment sheets of the paid incentives.
- Keeps copies of Attendance sheets and Monthly reports for these cadres as provided for by the Network focal people in the field as incentives payment support documents. The originals for these are maintained by the Networks since they are the cadres' direct engagers and supervisors.

An ongoing trait to improve on quality of work delivered by the programme's human resource entails capacity building. This is done by the Zonal Officers, TBHIV Officers/Program officer and the M&E Officer through continuous on-site mentorship of the health programme staff. The focus is on bench training of TBHIV Management, referral of presumptive TB cases to the nearby TB units and implementation and strengthening of last mile activities. For the grant management personnel, regular orientations through AAA resources are done for continued advocacy and investment in our institutional capacity, including our operational systems for optimal utilization of resources entrusted to us. This enables them understand the grant requirements and the importance of collaboration to achieve the desired goals and grant objectives together while confronting everyday's challenges and deliver greater access to services and opportunities for the populations we serve.

As illustrated and noted under "3rd participation"; in 2024, AAA realized that it was of paramount importance to continue seeking funds from well-wishers to fill in some gaps essential to aid in the

achievement of the expected grant results. This meant maintaining some crucial human resource that was not considered in the approved budget for GC7 like Support staff like (Cleaners for the Laboratories and TB wards, Cooks who prepare food for the intensive care TB patients to aid in treatment adherence and Guards who safeguard the storage facilities where drugs, programme commodities, assets etc., are kept). Through these resources, AAA was also able to engage 1 HCW (Clinical Officer) in Nagero PHCC attached to Tambura County Hospital's AAA TBHIV programme in Western Equitoria State. The same recruitment, management and reporting procedures applied for the staff and HCWs funded under Global fund grant were also applied in these staff supported through AAA's fundraised resources.

Additionally, AAA engaged an external consultant for Technical Advising (TA) of the AAA TBHIV Programme in the 5 states. The costs for this were catered for through AAA's fundraising as illustrated in the 3rd participation table.

Other forms of management that continued in the reporting year.

Provision of package of practical support for individuals undergoing DR-TB

In (GC7,) an additional activity in module Drug-resistant (DR)-TB diagnosis, treatment and care under the intervention DR-TB diagnosis/drug susceptibility testing (DST) was added to our scope of work. This activity was budgeted for under budget line 216.

As documented by WHO, Multidrug-resistant TB (MDR-TB) often inflicts the poorest and most marginalized members of a society. Their quality of life and financial situation are further aggravated by the disease, due to the adverse drug reactions produced by its treatment, the catastrophic costs they incur while seeking care and adhering to treatment, and the stigma attached to the disease and subsequent discrimination. The delivery of social support services is a must in any programmatic management of drug-resistant TB that is grounded in the consideration of human rights, ethical standards, financial risk protection and that pursues high effectiveness in efforts to prevent and treat MDR-TB. Social support may also contribute to improving the quality of life of patients. In many cases it also makes a difference to enable the patient and family to access health care.

Thus, through this activity, the patient-centered care approach to directly observation of therapy and the social support framework for programmatic management of drug-resistant TB, aimed at improving quality of life of MDR-TB patients and enabling their adherence to treatment.

For a successful treatment outcome and moral support to the DR patients, this activity ensured the engagement of a treatment supporter who was identified for each DR TB patient; he or she ought to be a person acceptable to, and chosen with, the patient. This could also be a family member of the client. For DR TB patients who live close to a health facility, the treatment supporter was one of the staff in the health facility, as this was the ideal choice if convenient to the patient. This social support granted the patient the perception and confirmation that he/she is

part of a social network that cares for him/her – as evidenced that social support is a predictor of health status and mortality.

The scope of support linked to this activity include:

- Informational support: This refers to any useful information that helps a person to solve problems and address sources of stress; it includes training and education. In the current grant, this will be tended under the DR-TB quarterly review meetings.
- Emotional support: This refers to all expressions of care that contribute to strengthen self-esteem through empathy, trust, encouragement and care, among others, and that helps to deal with the psychological challenges in life. This is part of our service delivery.
- Companionship support: This refers to the help that makes a person feel that he or she belongs to the social network, and that he or she can rely on it for certain needs. In the current grant, this will be tended under the DR-TB quarterly review meetings.
- Material support: This refers to all commodities, including financial products that a person receives through the assistance to deal with daily hurdles. This was tended through BL 216 practical support for individuals undergoing DR-TB whereby DR clients will be given USD 5 in every one-on-one meeting.

Thus, establishing an effective, age- and gender-sensitive mechanism for the TB control programme and other health-care providers to deliver; at least to the MDR-TB patients, the four social support functions described above are fundamental for a patient-centered approach to promote patient well-being, and to underpin DOT that ensures adherence to treatment.

Accountability:

- The Provision of package of practical support for individuals undergoing DR-TB is tended under BL 216 whereby DR clients is given USD 5 in every individualized meeting/visit with the in-charge officer or HCW.
- The number of individualized meetings are projected between an average of 3 to 15 per quarter depending on the number of months the patient is under treatment within the quarter. The calculated schedule estimate is normally attached to the payment cash voucher to act as a guide.
- The clients normally write their names in the payment sheets provided, sign and indicate the amount paid for the number of individualized meetings/visits undertaken.
- A report form showing each day the individualized meetings/visits undertaken for each client are filled in and the summary of details provided e.g. accompanying person (treatment supporter), issues discussed and general feedback/welfare of patient. A sample of this is provided too.

Management on provision of enablers (transport and nutrition) to all DR-TB patients during care:

Data gathering of the existing MDR-TB patients already enrolled for these enablers and any newly registered is usually a daily activity. This ensured updated records (tracking sheet) for reference of which patient is to be enabled and the enabling period too.

Upon the payment of the enablers, the receiving DR-patients fill their names and sign in a payment sheet, which is authenticated by key witnesses. Further, an attachment of lab results confirming that the patient is indeed drug resistant (DR) is provided by the referral health facility, which is also attached to the payment sheet as a supporting document.

Trainings Management:

In 2024, AAA continued with the implementation of the HIV/TB/RSSH trainings as part of the grant provisions. There were also review meetings and engagement events that took place.

All the Trainings, capacity building and feedback meetings were/are managed as follows:

- All were/are conducted are in line with the approved budget and topics sent by the PR UNDP in relation to the RoSS MoH policy and guidelines and facilitators are from the Ministry of Health (MoH) Central-Level in either HIV or TB Departments depending on module for training and intervention areas.
- The Project Manager/TB Expert shares with the facilitators of the trainings scheduled to be conducted within the quarter. He receives suggestions from them on the number of attendants that may benefit in each training (depending on ground needs and why) in order to factor in these whiles working on the trainings' schedules.
- After this engagement with the facilitators at the beginning of each quarter, if and where need be, the Project Manager/TB Expert sends to the technical team in the PR (UNDP) a detailed worksheet of the intended trainings to be conducted. This includes the no. of days earmarked for each training, no. of participants and the per diem rates of the participants.
- In the high-level trainings, the Project Manager/TB Expert with the M&E Officer develops concept notes and sends to the PR for review/approval prior to conducting the trainings.
- In some cases, even though it was not applicable in our 2024 trainings, at the inception phase of the trainings, an external ToT may be hired to capacitate the TBHIV Officers and other senior HCWs in the TBMUs in order to empower them train low cadres. Additionally, in complex trainings and state level meetings/workshops, an external consultant may also be hired based on experience and expertise.
- After reviewing, the facilitator's input for each projected training, the Project Manager/TB Expert dispatches the training schedules to the facilitators on ground. This document includes the type of training to be conducted, the TBHIV sites that will conduct the trainings, the period of training (not fixed as change in dates may occur during the preparation), the number of participants to attend the trainings and the per diem (DSA) each attendant will be facilitated with. As far per diems are concerned, the rates

established for paying out in each training are always within the range of AAA per diem policy. These costs cater for accommodation, meals, training materials, transport and DSA. AAA's training per diem rate is of USD 30 per day for the trainees and USD 50 for the SMoH facilitators in case of engagement events. For the National facilitators from Central level, the perdiem rate considered is of USD 68 per day within the approved national range.

- After dispatching the training schedules, The Project Manager/TB Expert with the support of the selected technical/finance team prepares the requisitions for the locations where trainings are to take place. The requisition is supported/accompanied by the Training Schedule (which has the type of training to be conducted, the period of training, the number of participants to attend the trainings and the per diem each attendant); and the instructions of how the trainings should be done and documented. The instructions are dispatched earlier to the facilitators for preparations.
- The Project Manager/TB Expert presents the above documents to the finance director for approval and authorization of the funds to conduct the trainings.
- There is follow up of how the trainings are being conducted by the facilitators. This includes ensuring involvement of the SMoH, STBHIV Coordinators and CHDs in selection of the participants to be trained and in identification of the qualified national facilitators to conduct the trainings. These key people (SMoH, STBHIV Coordinators and CHDs) are also involved in the payments as they co-sign the attendance lists and payment sheets for authentication. This boosts the collaborative efforts between SR AAA and the SMoH and it also creates the sense of programme ownership by the SMoH.
- Once the trainings are completed, the support documents are sent to the Project Manager/TB Expert and the finance director who together with the technical and selected finance team analyze and conduct internal audits and verification exercises.
- The reports are also sent upon completion of each training to the Project Manager and M&E Officer for review.
- The Original copies of the documents are retained in the HQ while replicas of all the trainings support documents are presented to the PR UNDP Office for their records.

CHAPTER 3: SUCCESSES AND ACHIEVEMENTS

The GC7 and C-19PO projects have managed to carry out the planned activities within the time frame and budget provided. The projects' successes were as a result of having clear terms of reference of the staff, proper delegation of the duties from the head office to the field staff, having specific staff responsible for certain activities, continued orientation of grant management staff and continuous mentoring of the national staff on programme management. The projects' hierarchy is also well established as per the organogram shown on page 16 and departmentally interlinked.

During the just ended year, AAA implemented the HIV/TB/RSSH and COVID-19 modules and interventions as mandated in the SR Agreements with PR UNDP and related amendments signed in the course of the year. All the approved modules, interventions and activities that were carried out.

As regards, transitioning of HIV implementation from the Global Fund (AAA) to PEPFAR (ICAP) support, AAA held series of meetings in Juba with the implementor (ICAP). It was agreed that transitioning of HIV services (from AAA to ICAP) was to take place during the October to December 2023 quarter. There was consensus that AAA was to keep on rendering HIV services in Lakes State up to end of December 2023, then from January 2024 onwards ICAP was to take full charge of the HIV implementation in the 18 (10 old and 8 new) facilities (see LIST below). However, the transition officially took place from 1, April 2024.

In summary it was agreed during the AAA and ICAP meetings that:

- AAA should share with ICAP a LIST of the staff getting Global Fund support per facility
- AAA should share with ICAP the Tx CURR for each ART site (End of December 2023)
- It was highlighted that AAA had been using the Government seconded staff to implement HIV services but ICAP was to follow its HR policy to advertise and recruit for all vacant positions in Lakes State facilities.
- That all assets e.g. microscopes were to remain under the custody of AAA as it was still running TB services in the 10 facilities that were to be handed over.

The HIV facilities in Lake State that were transferred from the financial support of Global Fund to PEPFAR support, hence AAA being allocated 6 additional facilities in Western Equatoria State.

Functional facilities-OLD		
SN	**County**	**Facility Name**
1	Awerial	Bunagok PHCC
2	Awerial	Mingkaman PHCC
3	Yirol East	Adior PHCC
4	Wulu	Wulu PHCC

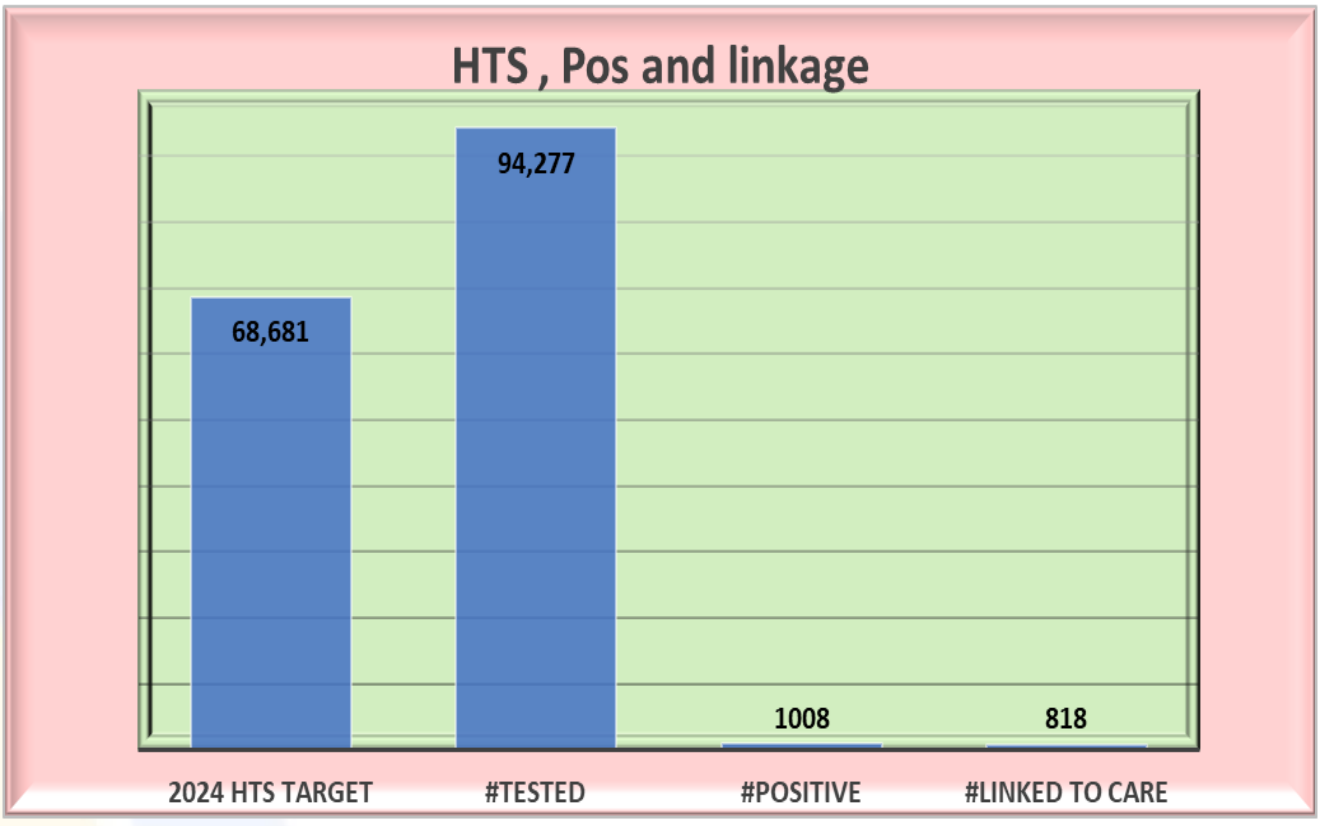
Newly proposed facilities-NEW		
SN	**County**	**Facility Name**
1	Wulu	Nuktamanga PHCU
2	Wulu	Makor PHCU
3	Cueibet	Agangrial PHCC
4	Rumbek North	Malueth PHCC

5	Rumbek East	Aduel PHCC
6	Rumbek East	Cueicok PHCC
7	Rumbek North	Maper PHCC
8	Rumbek central	Matangi PHCC
9	Cueibet	Cueibet Hospital
10	Ceuibet	Abirieu PHCC

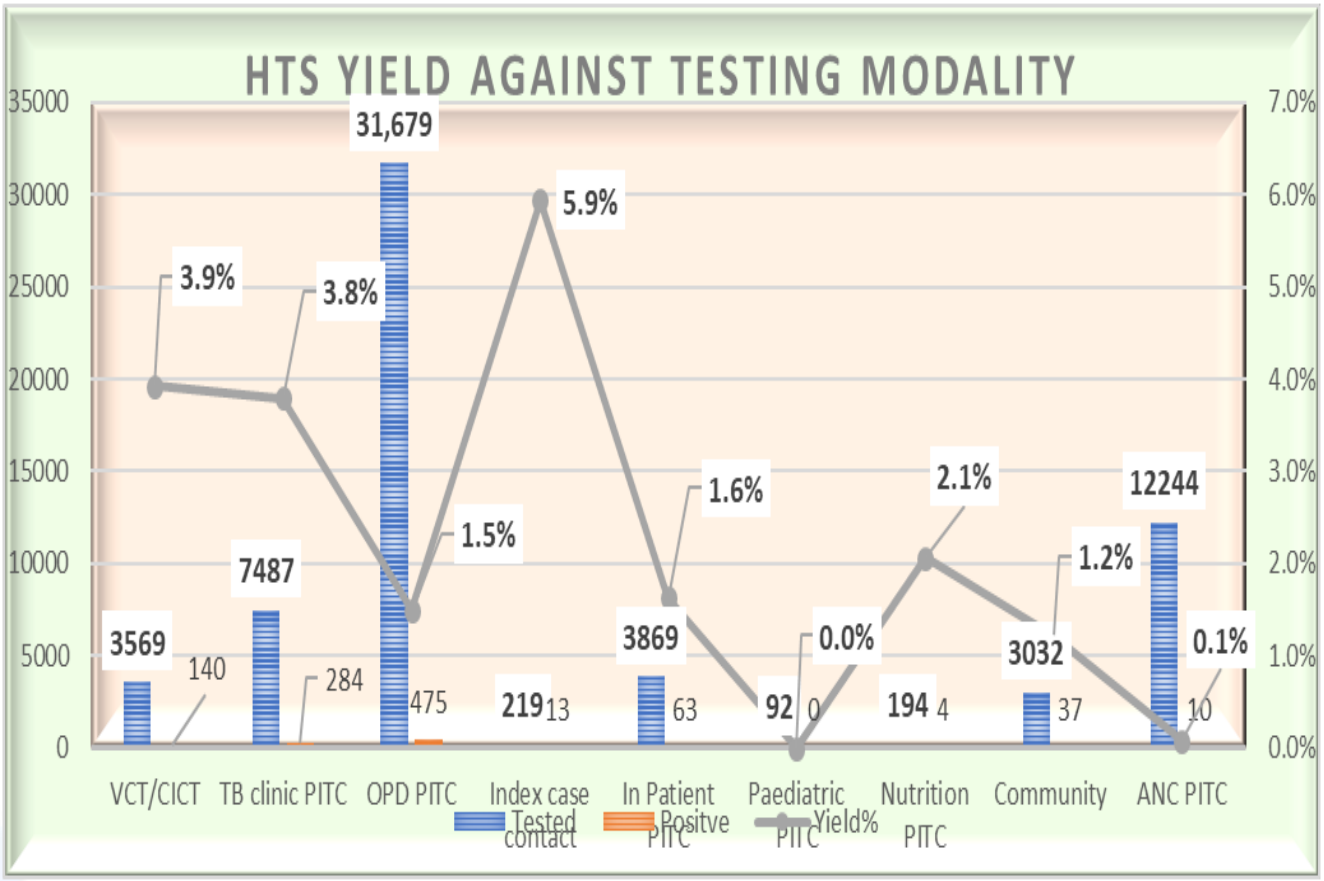
5	Rumbek Central	Amongpiny PHCC
6	Yirol East	Shambe PHCC
7	Yirol East	Thonabutkok PHCC
8	Rumbek East	Paloc PHCC

Under the Module of Differentiated HIV Testing Services; Intervention Area: Facility-based testing.

1st 95 target: There were 94,277 clients that were counselled and tested for HIV using various community and facility-based approaches, which gave an achievement of 109% of the set target of 86,681. There were 1,008 clients who were diagnosed with HIV infections giving a yield of 1%. 818 out of the 1,008 positive clients were linked to care giving 81% as the linkage percentage.

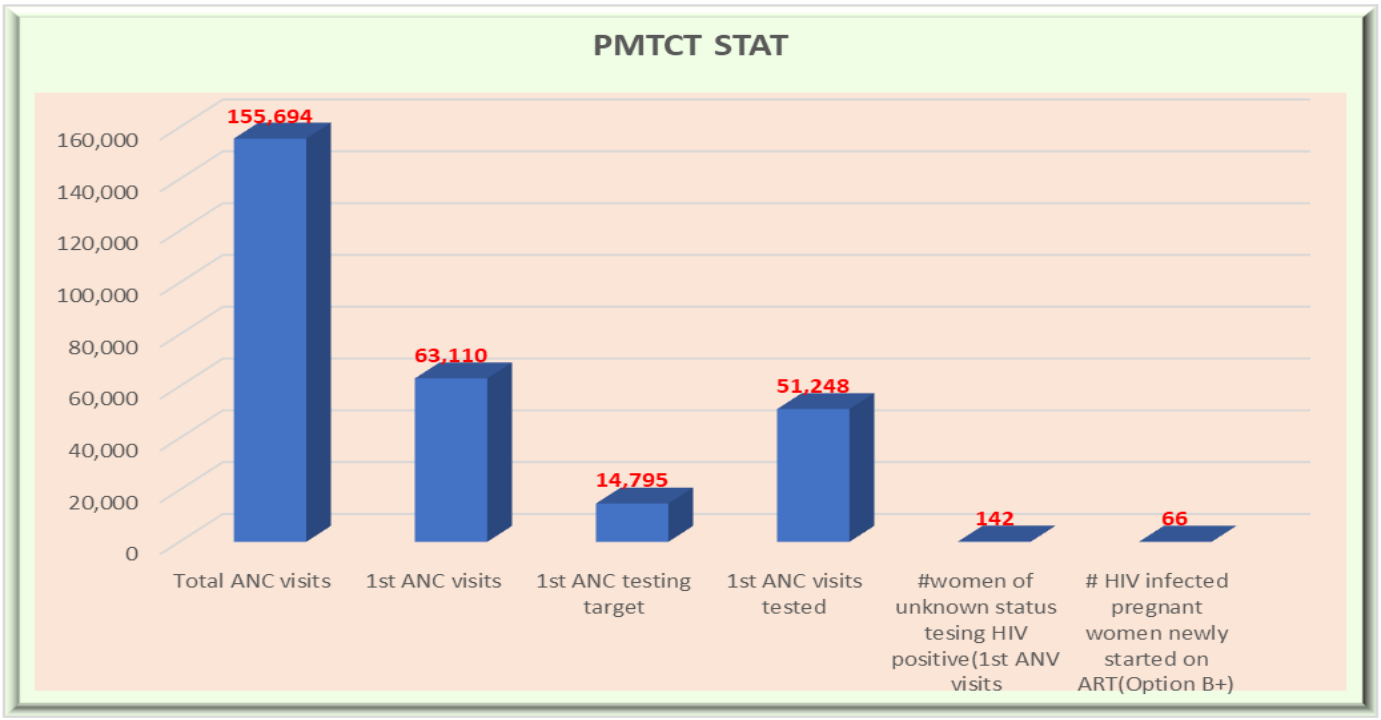


HTS positive and yield by Testing Modality



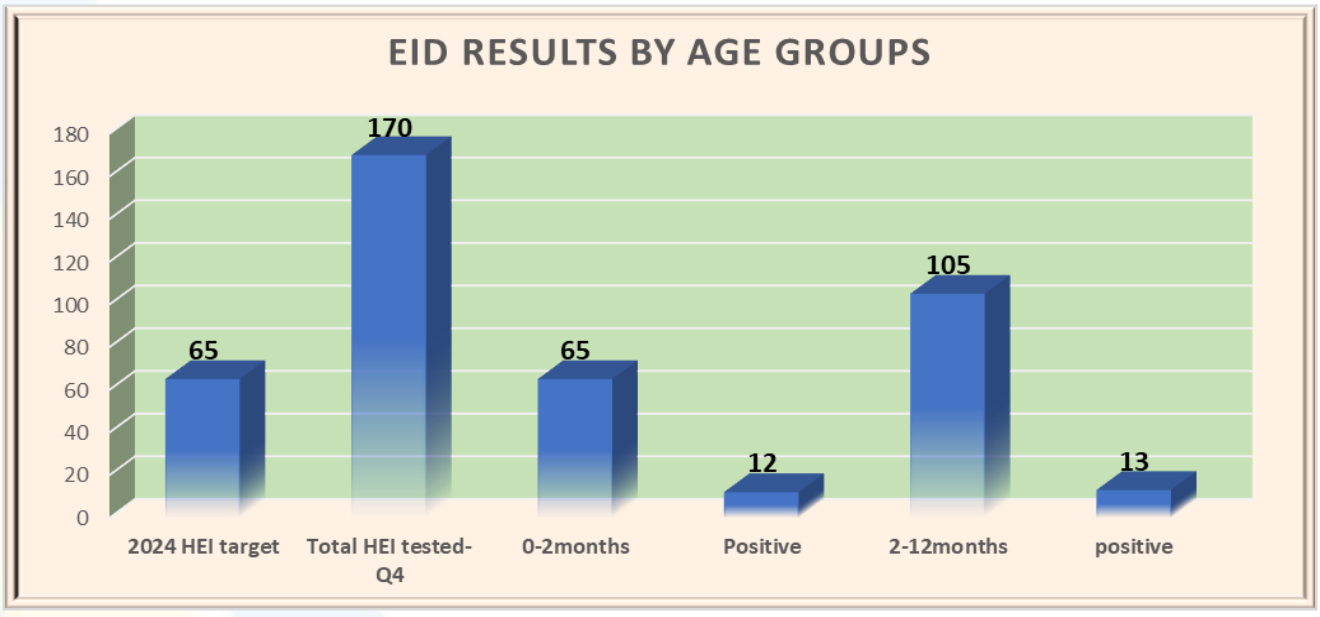
High HIV yield was realised in the following testing modalities: Index case contact (5.9%), PITC TB clinic (3.8%), VCT/CITC (3.9%), Community testing (3.6%), PITC OPD (1.5%), and PICT nutrition (2.1%),

The PMTCT ANC recorded a total of 155,694 women who attended ANC services the whole year. 63,110 were women who attended the 1st ANC services and 51,248,142 of these women were counselled and tested for HIV.
142 women of unknown status tested HIV positive (1st ANC Visits) giving a yield of 0.3%. 66 HIV infected pregnant women were newly started ART (Option B+). There were 82 women who were with known HIV positive status that were initiated on ART at entry into ANC. Total number of HIV Positive women attending ANC (new and old) were 247



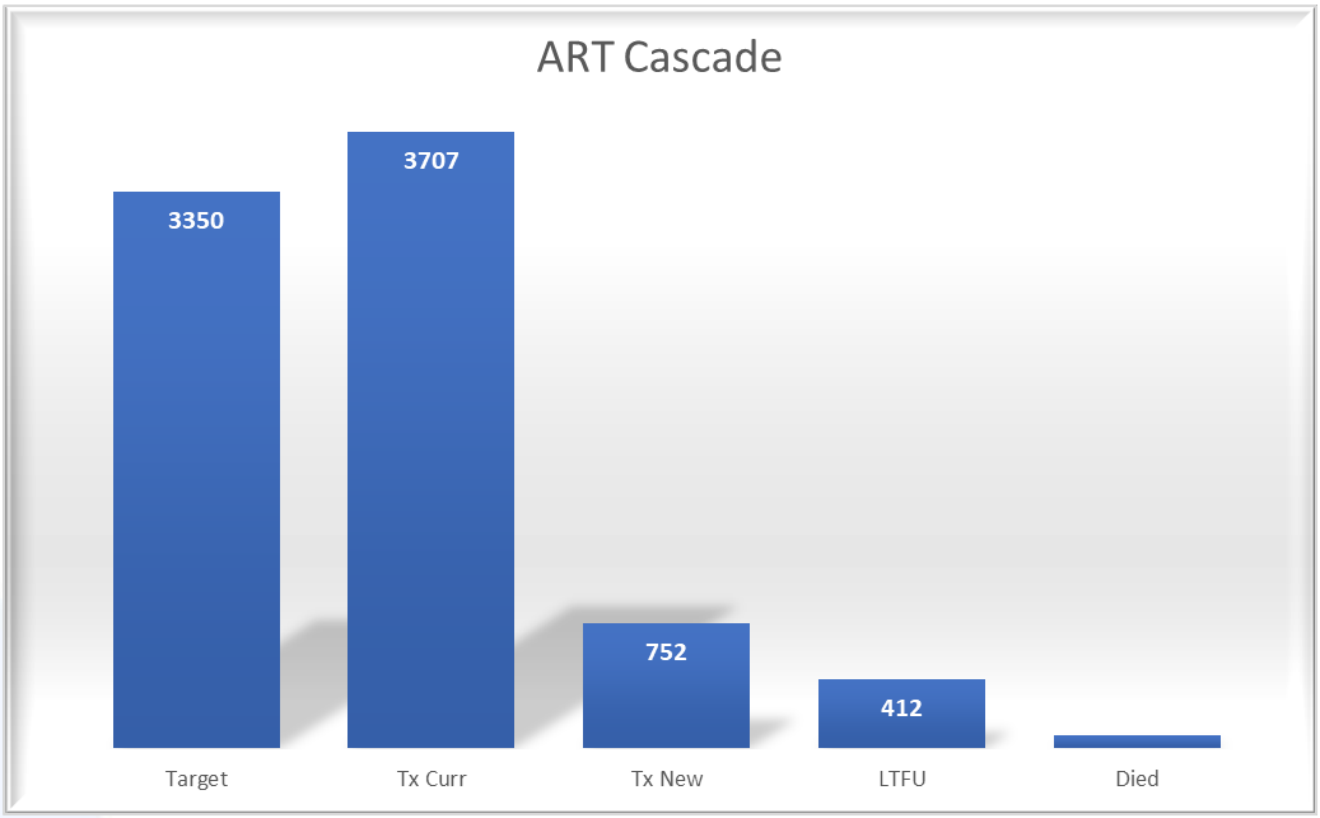
Under the Module of PMTCT EID; Intervention Area: Prong 3 - Preventing vertical HIV transmission.

Under this Module of PMTCT, the PR had allocated funds to AAA for Prong 3, which focuses on preventing HIV transmission from women living with HIV to their infants. 170 EID samples from the HIV exposed infants to the hub labs (Xpert sites) from the peripheral health facilities .65 samples were from the age group of 0-2months and 105 samples were collected from 2-12 months. there were 12 out of 65 HIV Exposed Infants (0-2months) and 105 samples screened from the 2-12months of age were HIV positive.

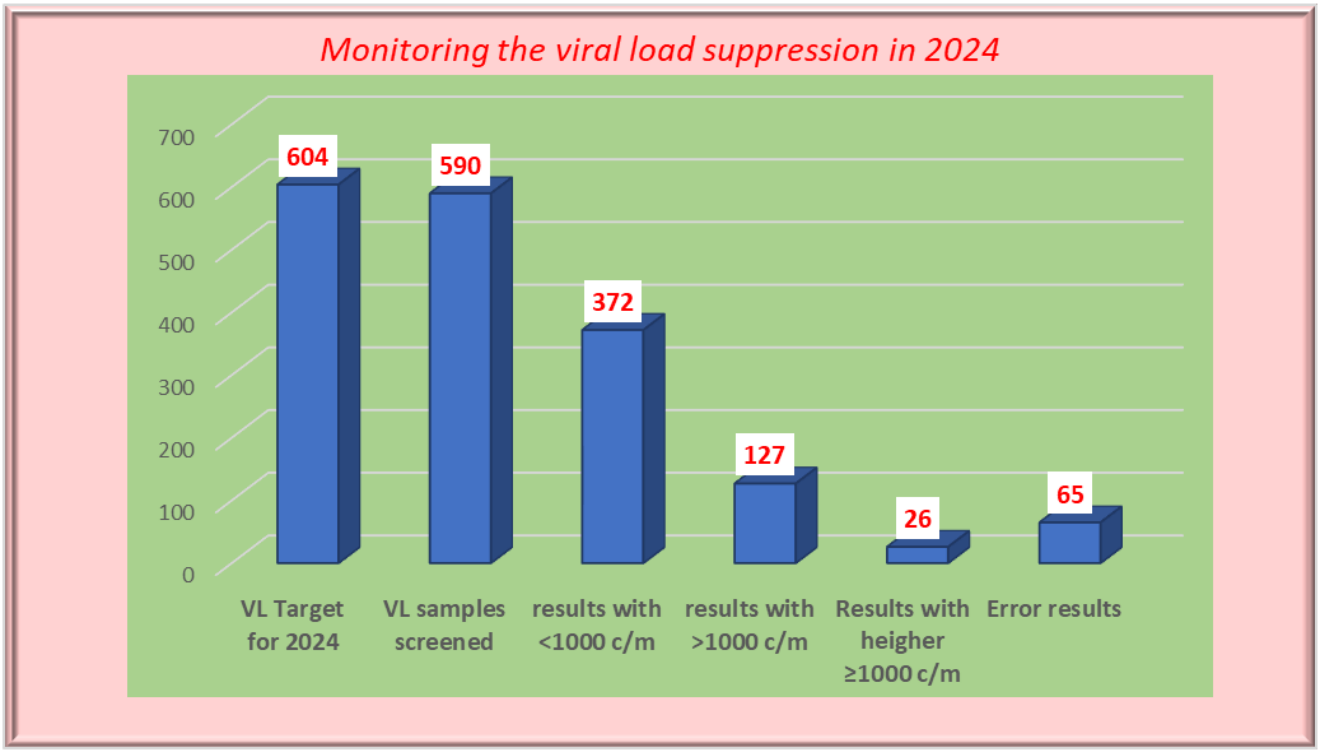


Under the Module of Treatment, care and support; Intervention Area:
Differentiated ART service delivery and HIV care.

The clients current on treatment (Tx-CURR) by end of December were 3707. There were 752 clients who were newly initiated on ART.
There were 76 clients who died while on treatment in the course of the year. The number of Lost to Follow up were 412 and this could be attributed non adherence to treatment.



Under 3rd 95 target, the PLHIV clients who were Alive and on ART but whose samples had not been previously assessed for viral loads had their 590 viral load samples collected and then shipped to the hubs for monitoring of the viral loads .372 had viral load results that were below 1000copies/ml among them 3 pregnant women and 127 viral load results had more than 1000 copies/ml and 26 samples (among them 1 pregnant woman) higher than 1000 copies/mls. These clients with higher viral loads results were immediately tracked by their respective mentor mothers for the counselling for the Enhanced Adherence Counselling (EAC) sessions. It is worth mentioning that 65 Viral load samples were rejected by the HRL citing various reasons e.g. missing request forms, clotted samples or samples



During the year, the programme activity focus was on the integration of TBHIV services where 2 facilities had the services integrated. High burden areas like Warrap State health facilities were targeted, the HHPs (BHWs) sensitized the general community on TBHIV and referred the presumptive TB cases to nearby units for diagnoses, mentoring the health care workers in public and private health facilities on TB suspicion, holding feedback meetings with HHPs (BHWs) during TB club meetings so that current and former TB patients could share experiences as a way of encouraging one another thus improved treatment adherence. The WFP was also engaged in the provision of food rations to the TB patients. The TB drug and reagent stock management was improved in all locations through updating of inventories/stock cards, the programme staff intensified Behaviour Change Communication(BCC) in the community, there was an establishment of Internal quality control system and most of the TB sites participated in the sampling and sending out of smear slides for EQA to the NTRL Juba, and the community opinion leaders were sensitized so as to solicit their backup for the TBHIV Control programme in their respective bomas and there was distribution of IEC materials that contained TB messages were successfully undertaken as support activities geared towards improvement of case detection and treatment outcomes. These above efforts above bore some good TB treatment outcomes as all forms of TB patients (new and relapse) in the 2022 where 6331 had their treatment outcomes evaluated as either cured or treatment completed and 5826 TB patient that showed a treatment success rate of 92% which is above the WHO End TB Strategy Standard.

- 270 out of 276 (93%) re-treatment cases that had been registered in the course of the year had their sputum samples processed by Gene-Xpert machines in various sites.
- 125 DR-TB patients were identified out of these samples and all of them were initiated on 2nd line treatment. 69 DR-TB patients that had been registered in the cohort of 2022 had their

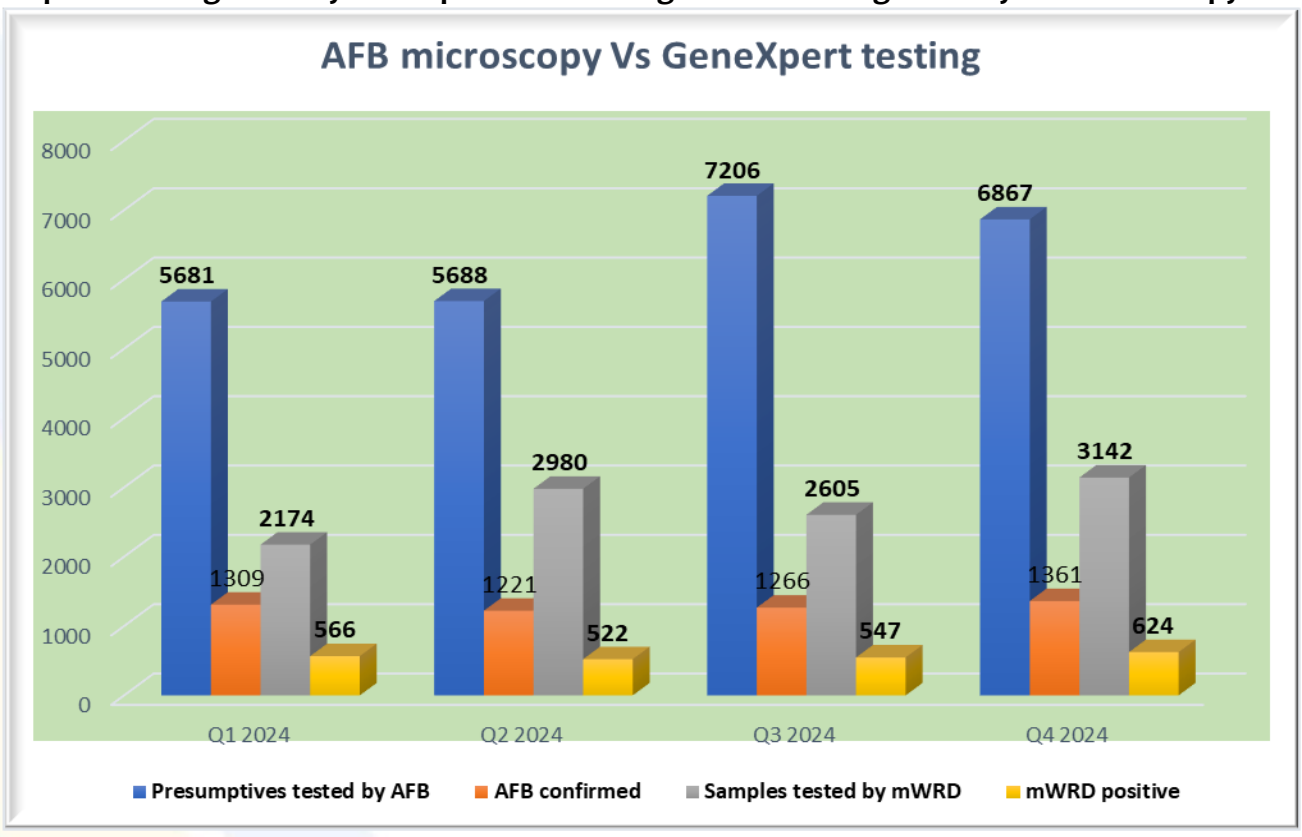
treatment outcomes evaluated and it showed that 68 patients had completed treatment giving 99% as the treatment success rate.

The project has specific TB and HIV indicators to measure its success, these indicators are used to ensure that project stays on track and program activities are prioritized.
During the 1st year TBHIV GC7 and C19RM Grants implementation, the following key successes recorded:

GeneXpert utilization per quarter in AAA supported in 2024

	INDICATORS	Q1	Q2	Q3	Q4	Grand Total
1	MTB Detected; RIF Resistance Not Detected (T)	541	490	507	596	**2134**
2	MTB Detected RIF Resistance Detected (RR)	25	32	40	28	**125**
3	MTB Detected RIF Resistance Indeterminate (TI)	60	42	67	71	**240**
4	MTB Not Detected (N)	1428	1643	1803	2082	**6956**
5	Error Results	105	63	47	110	**325**
6	Invalid Results	8	9	15	13	**45**
7	No Results	11	30	12	27	**80**
8	Total	2174	2980	2605	3142	**10901**

TB patients diagnosed by GeneXpert machines against those diagnosed by AFB microscopy



Name of Facility	TB Diagnostic Method	GenXpert	Smear microscopy	TB LAM	**Truenat	Xray, Clinically Diagnosed	Total Diagnosed using WHO RRD tests	Total New and relapse TB patients notified	% Diagnosed using WHO RRD tests
Aweil State Hospital	Breakdown of new and relapse TB cases by diagnostic method	454	4	5	0	49	459	512	90%
Aroyo PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	12	0	0	9	0	21	0%
Aweil Prison PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	40	0	0	1	0	41	0%
Gordhim PHCC	Breakdown of new and relapse TB cases by diagnostic method	485	72	34	0	175	519	766	68%
Akuem PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	31	0	0	11	0	42	0%
Panthou PHCC	Breakdown of new and relapse TB cases by diagnostic method	3	110	0	0	18	3	131	2%
Wanjyok PHCC	Breakdown of new and relapse TB cases by diagnostic method	1	4	0	0	1	1	6	17%
Malualkon Hospital	Breakdown of new and relapse TB cases by	0	7	0	0	0	0	7	0%

	diagnostic method								
Nyamlell Hospital	Breakdown of new and relapse TB cases by diagnostic method	65	35	0	0	12	65	112	58%
Marialbai PHCC	Breakdown of new and relapse TB cases by diagnostic method	8	27	0	0	6	8	41	20%
Mayen Ulem PHCC	Breakdown of new and relapse TB cases by diagnostic method	11	28	0	0	15	11	54	20%
Gokmachar PHCC	Breakdown of new and relapse TB cases by diagnostic method	5	39	0	0	6	5	50	10%
Udhum PHCC	Breakdown of new and relapse TB cases by diagnostic method	4	20	0	0	11	4	35	11%
Bunagok Hospital	Breakdown of new and relapse TB cases by diagnostic method	1	22	0	0	112	1	135	1%
Mingkaman PHCC	Breakdown of new and relapse TB cases by diagnostic method	1	42	0	0	150	1	193	1%
Agangrial PHCC	Breakdown of new and relapse TB cases by diagnostic method	3	61	17	0	82	20	163	12%
Cueibet Hospital	Breakdown of new and relapse TB cases by diagnostic method	8	36	4	0	45	12	93	13%
Abirieu PHCC	Breakdown of new and relapse TB cases by diagnostic method	1	17	0	0	6	1	24	4%

Luanyaker Hosp	Breakdown of new and relapse TB cases by diagnostic method	60	15	0	0	73	60	148	41%
Lietnom PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	66	0	0	103	0	169	0%
Warrap PHCC	Breakdown of new and relapse TB cases by diagnostic method	4	35	0	0	24	4	63	6%
Aliek PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	18	0	0	85	0	103	0%
Kuajok State Hospital	Breakdown of new and relapse TB cases by diagnostic method	144	62	0	0	150	144	356	40%
Alek PHCC	Breakdown of new and relapse TB cases by diagnostic method	3	47	0	0	74	3	124	2%
Akon PHCC	Breakdown of new and relapse TB cases by diagnostic method	1	255	0	0	53	1	309	0%
Gogrial PHCC	Breakdown of new and relapse TB cases by diagnostic method	3	60	0	0	231	3	294	1%
St Mother Theresa Hosp-Turalei	Breakdown of new and relapse TB cases by diagnostic method	55	19	0	0	24	55	98	56%
Mayen Abun PHCC	Breakdown of new and relapse TB cases by diagnostic method	103	124	0	0	148	103	375	27%
Wunrok PHCC	Breakdown of new and relapse TB cases by	3	15	0	0	52	3	70	4%

	diagnostic method								
Tambura Civil Hospital	Breakdown of new and relapse TB cases by diagnostic method	0	28	0	0	11	0	39	0%
Mupoi PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	7	0	0	6	0	13	0%
Source Yubu PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	2	0	0	22	0	24	0%
Nagero Hospital	Breakdown of new and relapse TB cases by diagnostic method	0	5	0	0	0	0	5	0%
Yambio State Hospital	Breakdown of new and relapse TB cases by diagnostic method	51	13	0	0	23	51	87	59%
Yambio Prison PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	43	0	0	3	0	46	0%
Gangura PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	25	0	0	40	0	65	0%
Nzara	Breakdown of new and relapse TB cases by diagnostic method	29	13	0	0	12	29	54	54%
Ezo Hospital	Breakdown of new and relapse TB cases by diagnostic method	5	14	0	0	14	5	33	15%
Naandi PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	15	0	0	0	0	15	0%
Yangiri PHCC	Breakdown of new and relapse TB	0	2	0	0	3	0	5	0%

	cases by diagnostic method								
Yeri PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	3	0	0	8	0	11	0%
Mundri Hospital	Breakdown of new and relapse TB cases by diagnostic method	0	16	0	0	1	0	17	0%
Olo PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	7	0	0	0	0	7	0%
Woko PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	7	0	0	0	0	7	0%
Bethsaida PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	2	0	0	0	0	2	0%
Nabanga PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	2	0	0	0	0	2	0%
Mariallou , Comboni	Breakdown of new and relapse TB cases by diagnostic method	0	25	0	0	30	0	55	0%
Ngapagok PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	11	0	0	12	0	23	0%
Mariallou Rural Hosp	Breakdown of new and relapse TB cases by diagnostic method	0	0	0	0	0	0	0	#DIV/0!
Rumabuth PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	10	0	0	10	0	20	0%

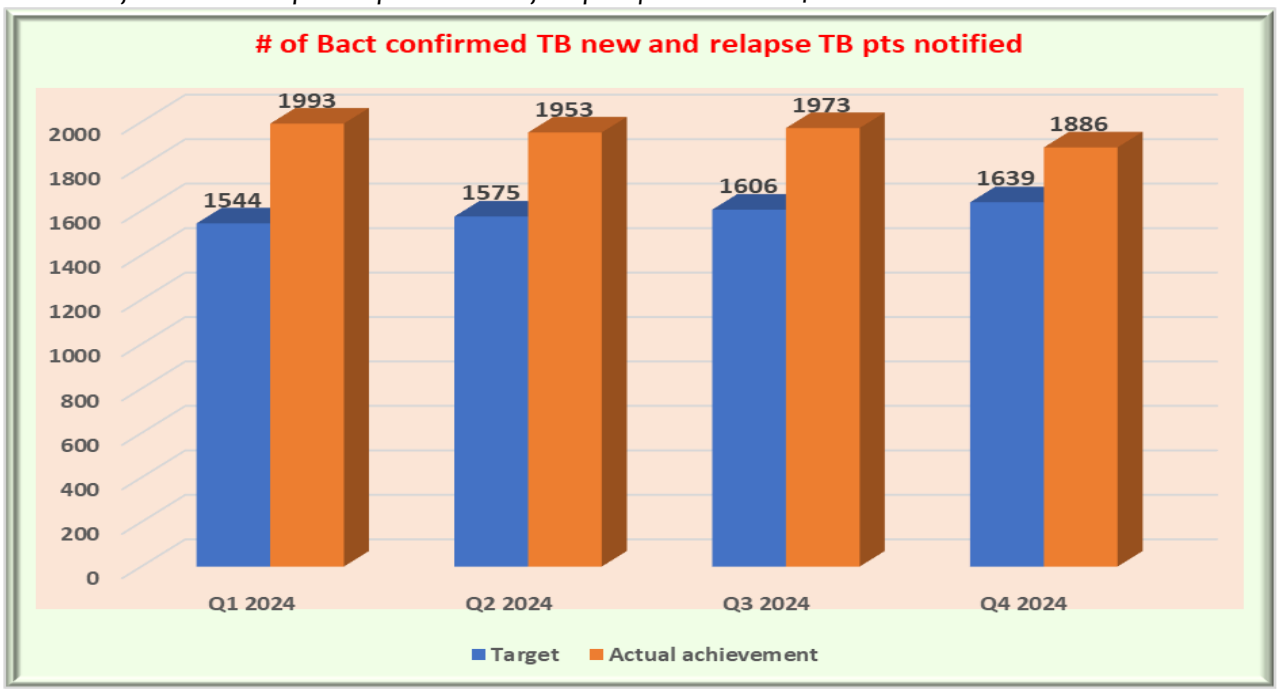
Tonj Don Bosco	Breakdown of new and relapse TB cases by diagnostic method	95	68	0	0	90	95	253	38%
Tonj Civil Hospital	Breakdown of new and relapse TB cases by diagnostic method	4	2	0	0	6	4	12	33%
Wau Teaching Hosp	Breakdown of new and relapse TB cases by diagnostic method	323	31	0	0	17	323	371	87%
Sikadid PHCC	Breakdown of new and relapse TB cases by diagnostic method	27	85	0	0	15	27	127	21%
MaryHelp Hospital	Breakdown of new and relapse TB cases by diagnostic method	4	103	0	0	26	4	133	3%
Agok PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	2	0	0	1	0	3	0%
Achongchong PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	5	0	0	2	0	7	0%
Wau Prison PHCC	Breakdown of new and relapse TB cases by diagnostic method	10	9	0	0	1	10	20	50%
Raja Hospital	Breakdown of new and relapse TB cases by diagnostic method	11	35	0	0	22	11	68	16%
Deimzeibeir PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	0	0	0	0	0	0	#DIV/0!
St. Daniel Comboni Hospital	Breakdown of new and relapse TB cases by	1	62	0	0	50	1	113	1%

	diagnostic method								
Marialbai PHCC-Jur	Breakdown of new and relapse TB cases by diagnostic method	8	26	0	0	7	8	41	20%
Mapel PHCC	Breakdown of new and relapse TB cases by diagnostic method	3	10	0	0	12	3	25	12%
Udici PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	53	0	0	0	0	53	0%
Grinty Hospital	Breakdown of new and relapse TB cases by diagnostic method	6	34	0	0	9	6	49	12%
Kuajina PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	5	0	0	4	0	9	0%
Adior Hospital	Breakdown of new and relapse TB cases by diagnostic method	2	18	0	0	23	2	43	5%
Nyang PHCC	Breakdown of new and relapse TB cases by diagnostic method	2	11	0	0	24	2	37	5%
St. Joseph Yirol	Breakdown of new and relapse TB cases by diagnostic method	4	31	6	0	138	10	179	6%
Yirol Hospital	Breakdown of new and relapse TB cases by diagnostic method	128	0	1	0	56	129	185	70%
Mapourdit	Breakdown of new and relapse TB	35	13	0	0	157	35	205	17%

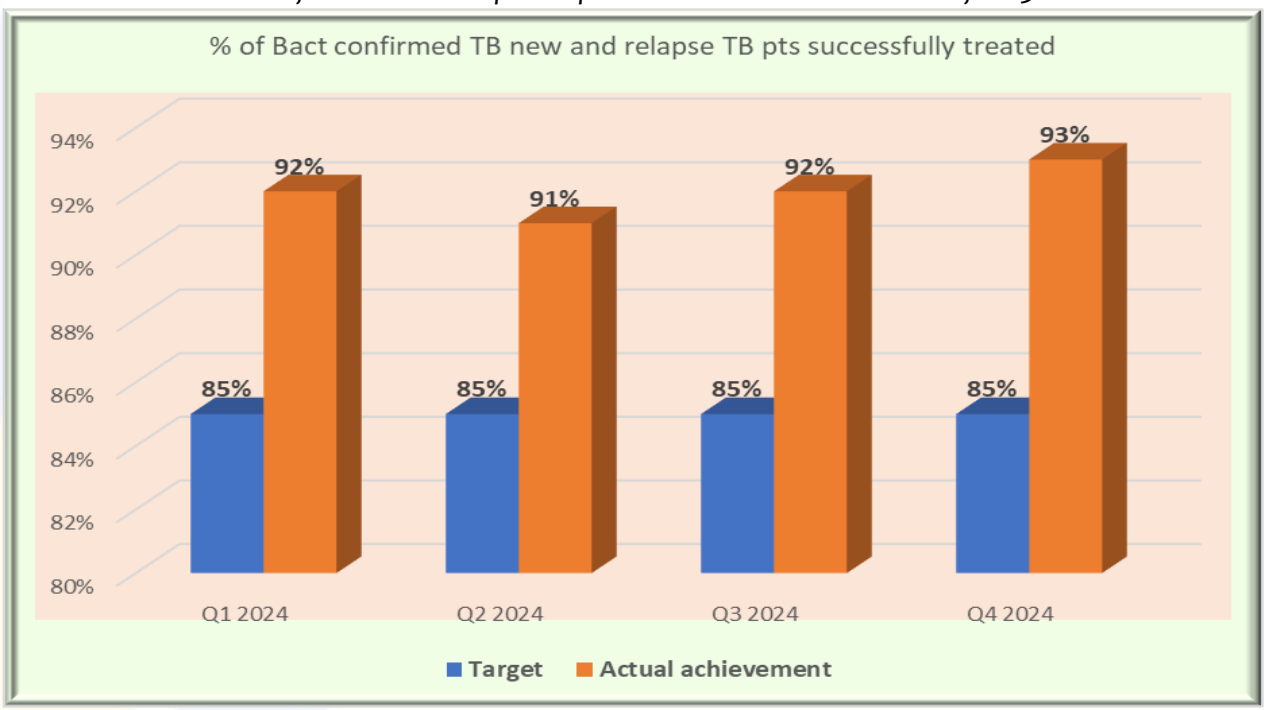
Hospital	cases by diagnostic method								
Aluaklua k PHCC	Breakdown of new and relapse TB cases by diagnostic method	1	10	0	0	61	1	72	1%
Rumbek State Hospital	Breakdown of new and relapse TB cases by diagnostic method	210	5	3	0	94	213	312	68%
Matangai PHCC	Breakdown of new and relapse TB cases by diagnostic method	249	9	0	0	19	249	277	90%
Wulu Hospital	Breakdown of new and relapse TB cases by diagnostic method	22	2	0	0	7	22	31	71%
Cueicok PHCC	Breakdown of new and relapse TB cases by diagnostic method	7	16	0	0	17	7	40	18%
Aduel PHCC	Breakdown of new and relapse TB cases by diagnostic method	2	29	0	0	31	2	62	3%
Maper PHCC	Breakdown of new and relapse TB cases by diagnostic method	0	8	3	0	2	3	13	23%
	Grand Total	**2665**	**2255**	**73**	**0**	**2812**	**2738**	7805	35%

TB Achievements by Target Versus Indicators

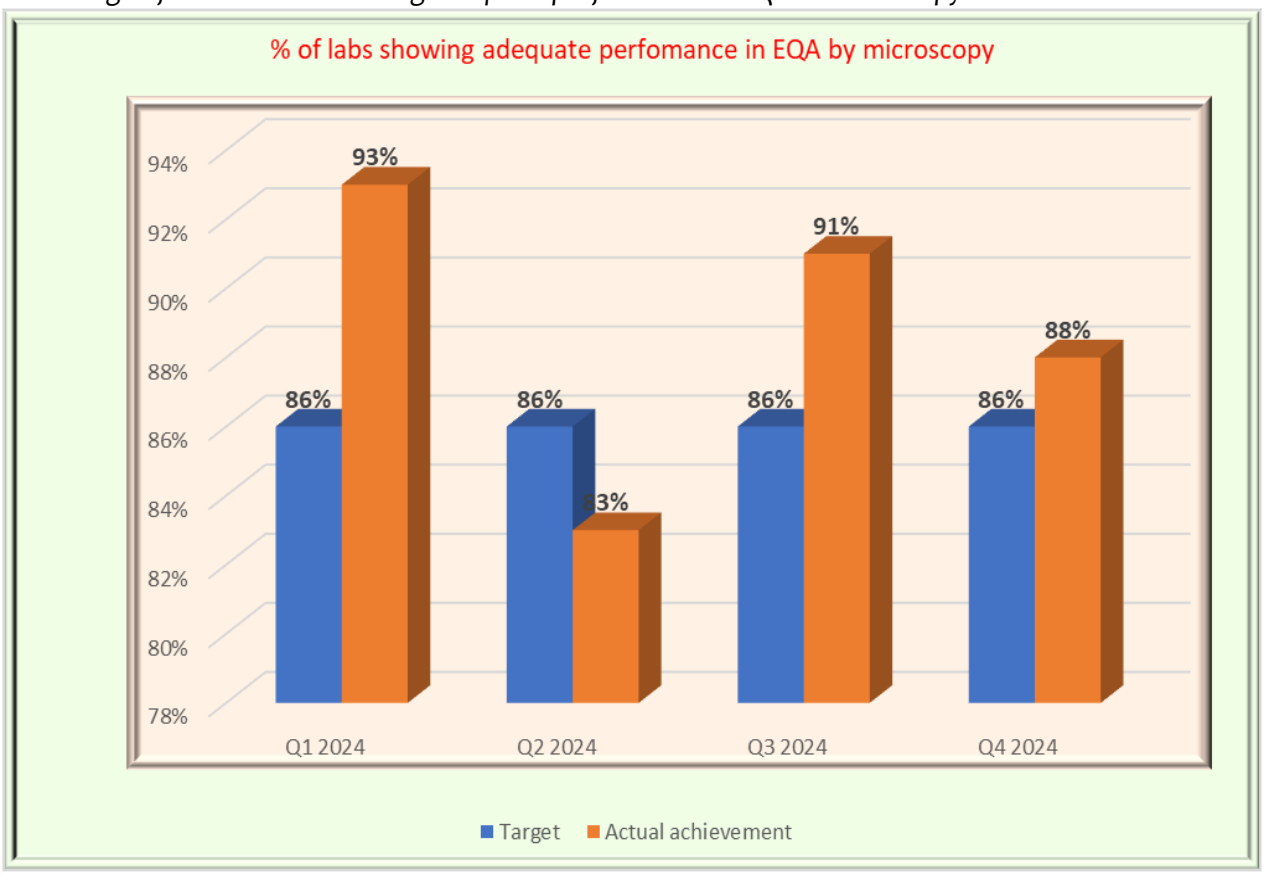
Number of New and relapse TB patients notified per quarter in 2024



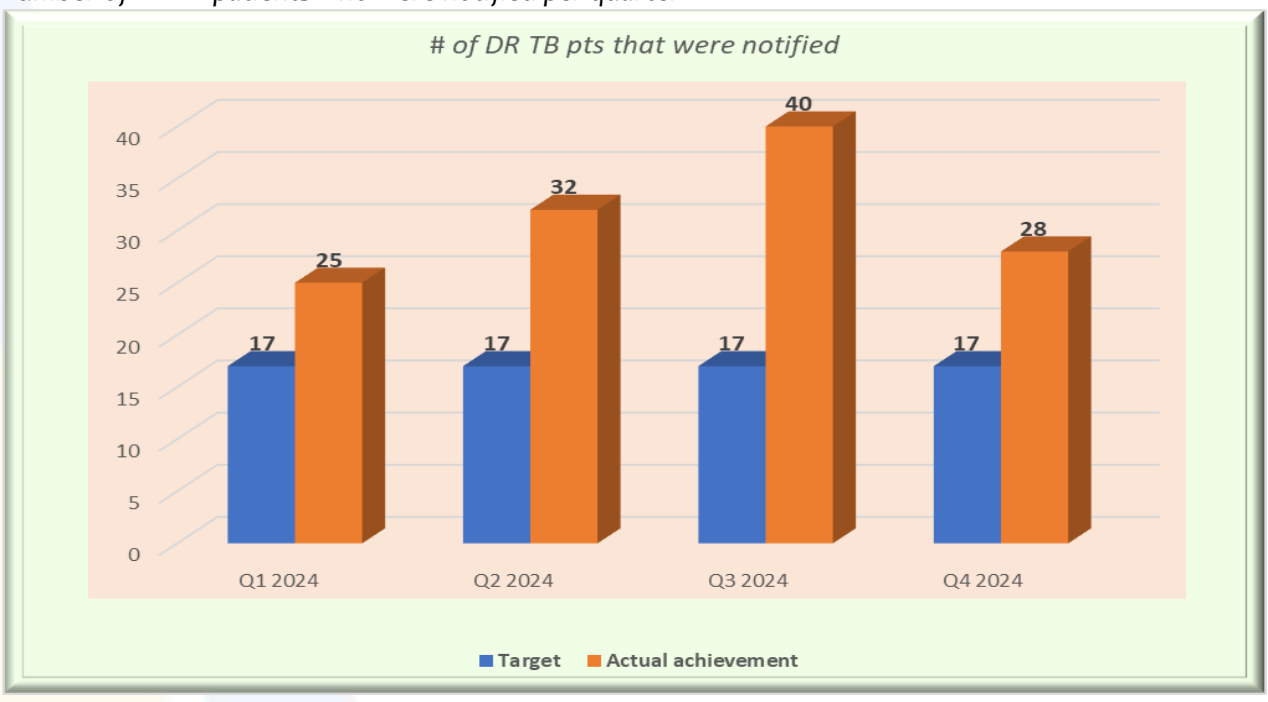
Treatment success rates for New and relapse TB patients enrolled in the cohort of 2023



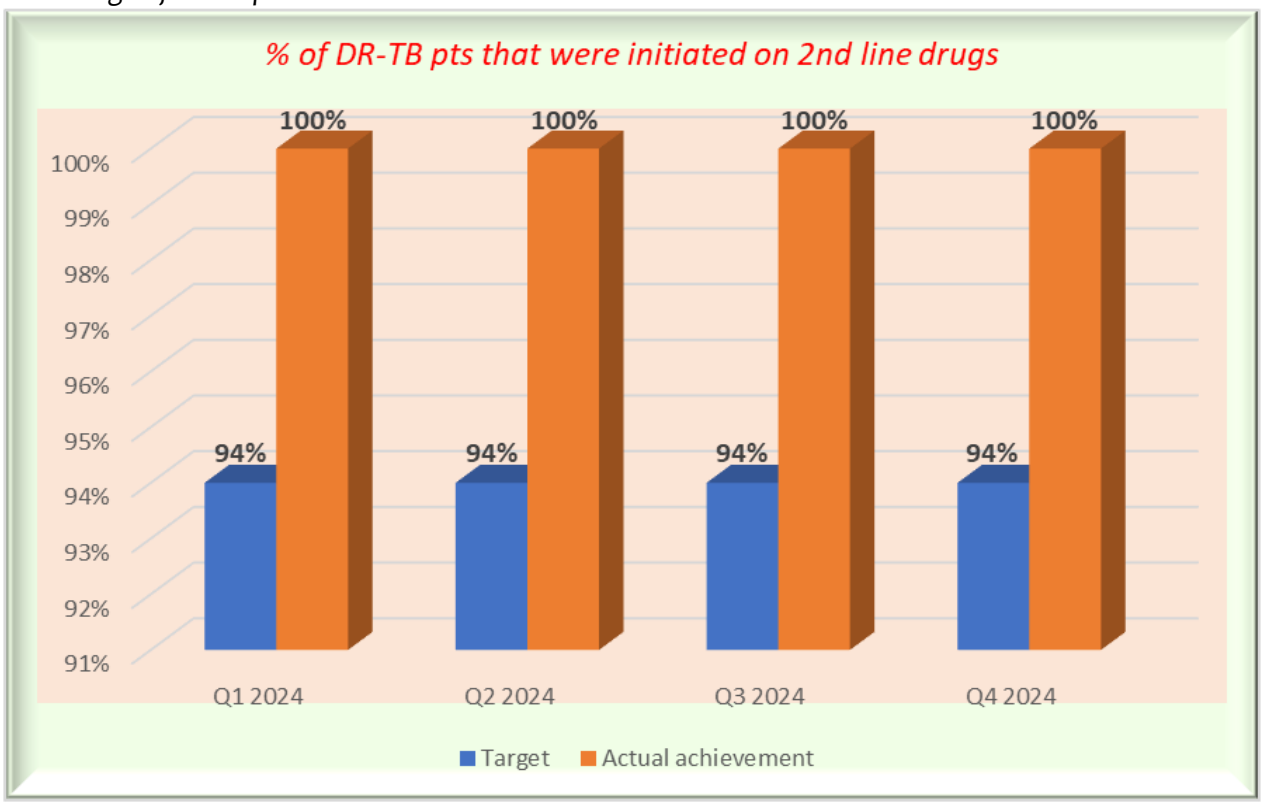
Percentage of laboratories showing adequate performance in EQA in microscopy



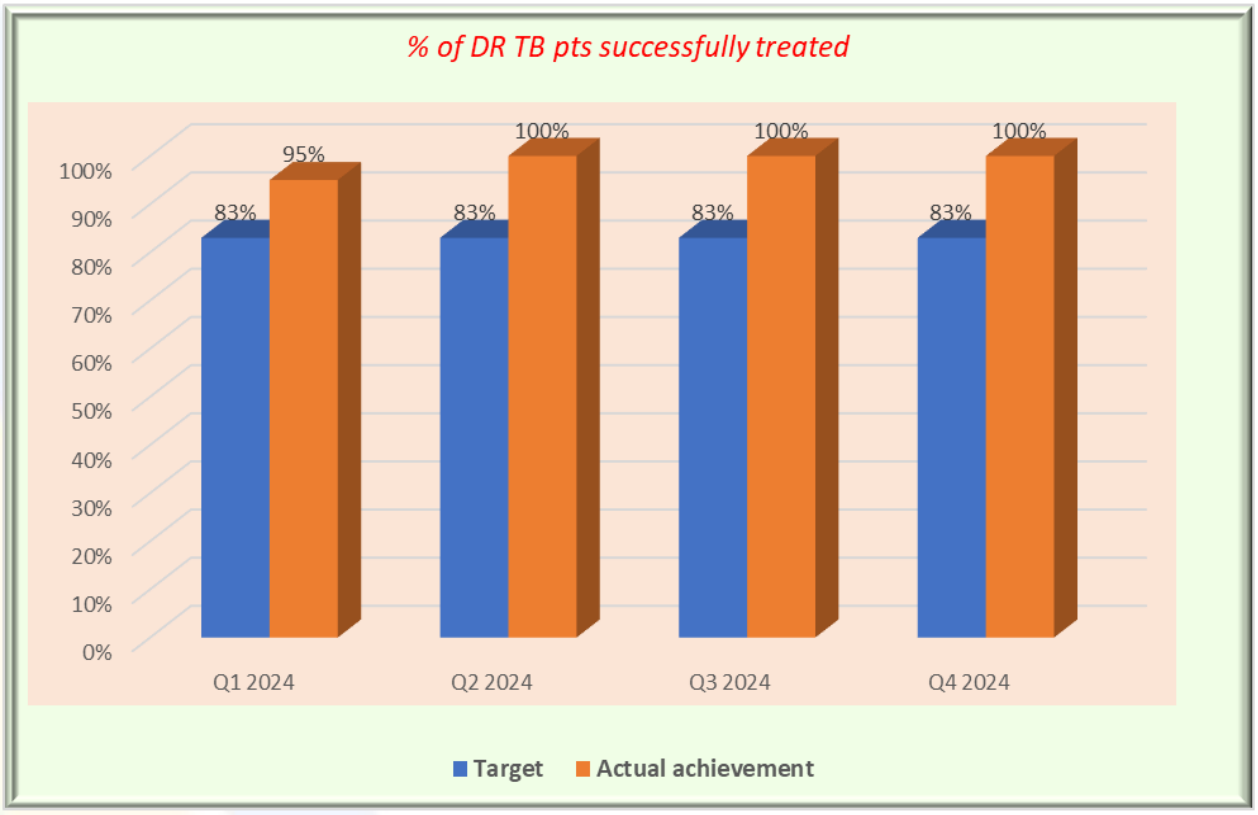
Number of DR-TB patients who were notified per quarter



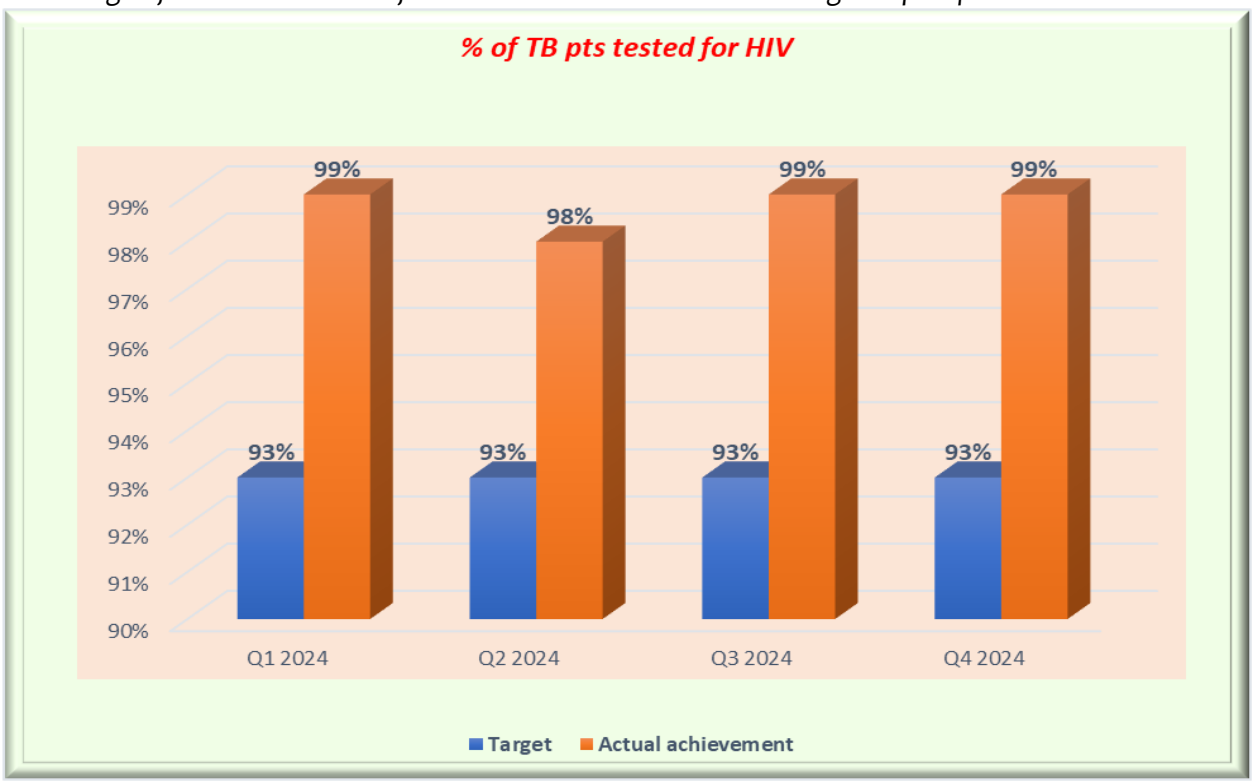
Percentage of DR-TB patients who were started on second line treatment.



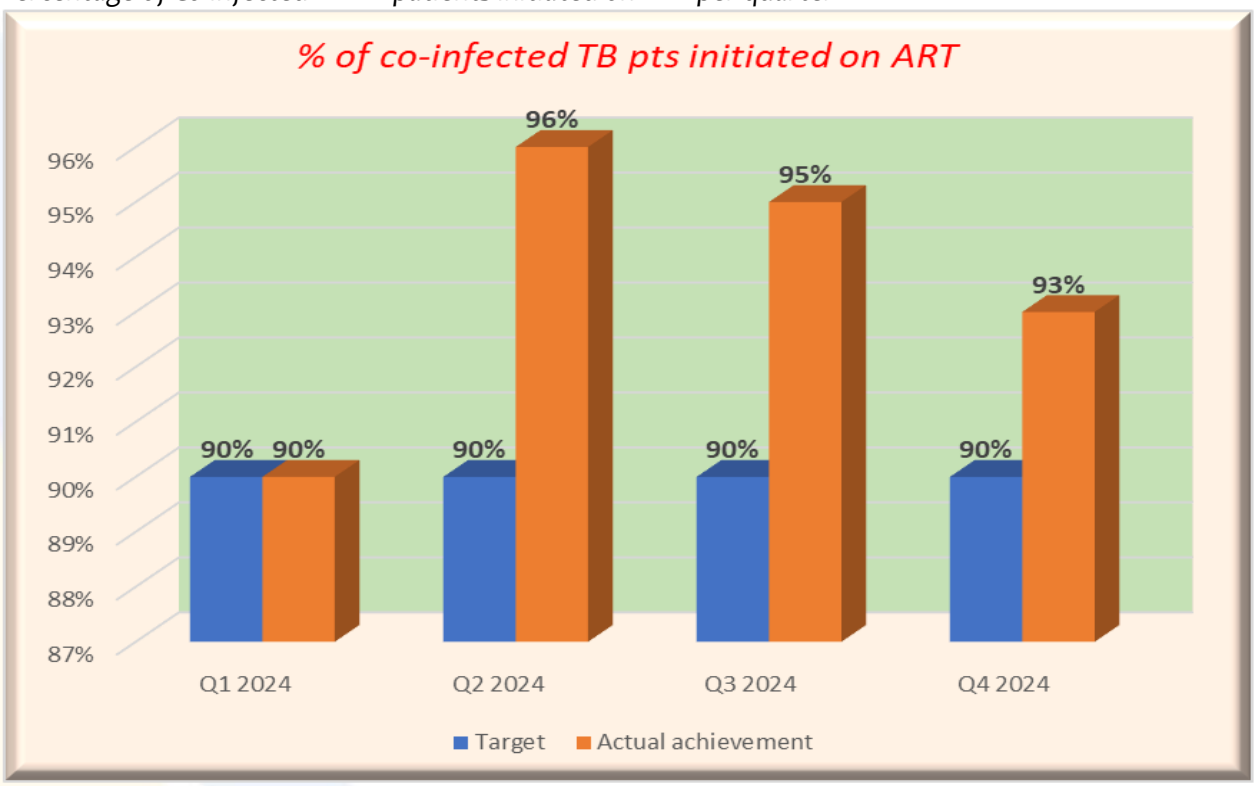
Percentage of DR-TB patients who were successfully treated



Percentage of TB Patients tested for HIV and results documented a register per quarter



Percentage of Co-infected TBHIV patients initiated on ART per quarter



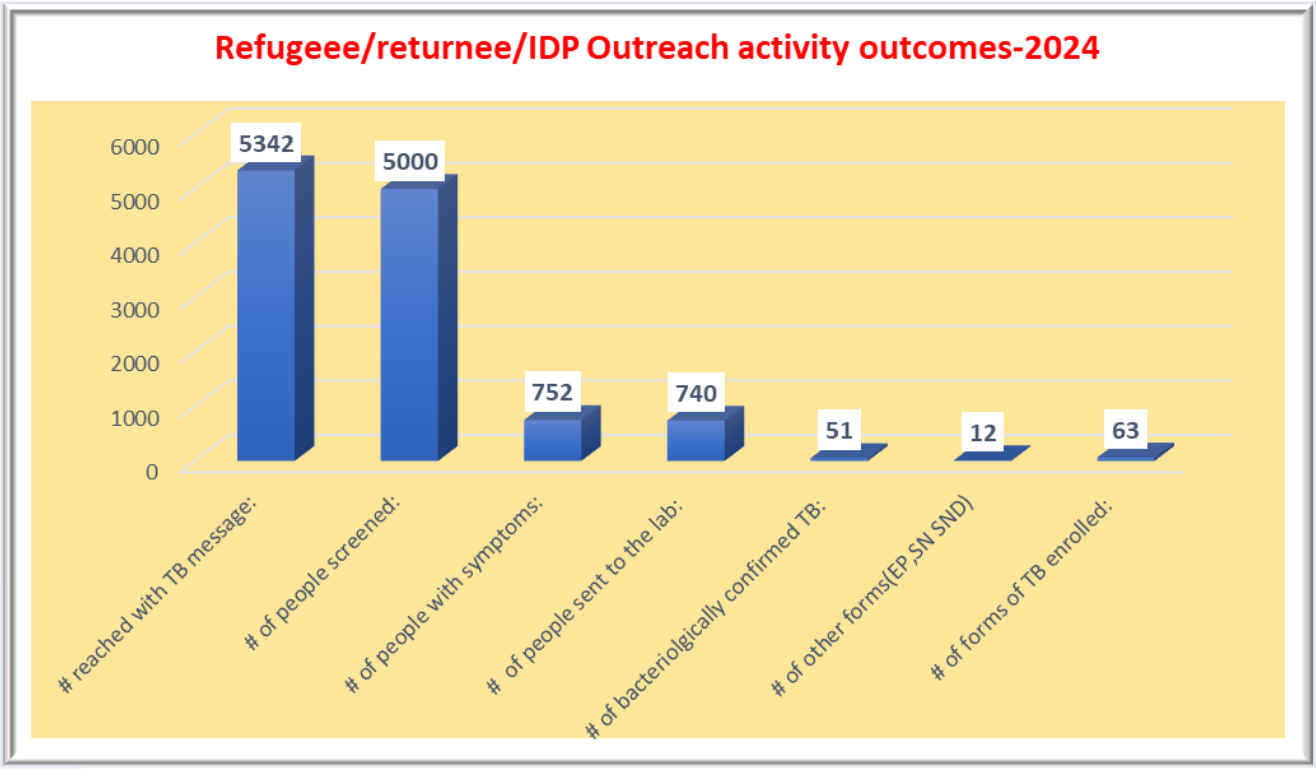
Deliverables	Achievements
# of supportive supervisions and mentorships conducted to the TBMU sites	4
# of Quality Assurance visits conducted from the main TB units to the peripheral health facilities	74

- 54 TB club/ambassador meetings were conducted to ensure early retrieval of treatment interrupters which led to adherence hence improved treatment success rates among all patients registered.
- There was commemoration of the annual **WORLD TB DAY** that was observed on the 24th of March, some of the AAA TB Sites managed to conduct some TB awareness activities to mark that day whose theme was **"Yes! We Can Yes! # End TB!"**


Marching in Aweil East county on the 24th of March 2024

- On the 1st of December 2024, most of the AAA supported States managed to commemorated the World AIDS DAY, whose theme for was Take the rights, My health, My Right".
- Semi Annual meetings for mentors were conducted in Aweil, Kuajok and Wau.
- STBHIV coordinators' supportive supervision visits were carried in 3 States
- Peer Navigators were recruited and assigned tasks in the community which included the sensitization, tracking of lost to follow up and drug refills. They were received their monthly incentives upto the end of December.
- In the 3rd quarter of the year, the PR reinstated the budget line for sample transportation, hence thus AAA had to contract a service courier company that supported the transportation of samples from the spokes to the hubs and then onward shipment to the NPHL Juba.
- There were 2 supportive supervision and mentorship missions in Rumbek and Yambio facilities.
- 144,245 people benefitted from the health education TBHIV messages that were passed in various avenues.

- 3 States had joint supportive supervision missions that had the following team members (UNDP, SMOH and AAA). All the mission findings were shared with AAA who immediately embarked on corrective measures in all the locations visited.
- 34 HIV sites were facilitated with quarterly operational costs which included procurement of the office stationery, patient files etc.
- Quality assurance visits from the main TB units to the peripheral facilities were conducted. Errors identified during these visits were corrected on the spot.
- There were outreach activities that were conducted in 5 locations in the course of the year. The yield for these outreaches that were conducted among mobile populations (Refugees, Returnees and IDPs) were as below tabulated:



- 15 MDR–TB treatment sites carried out monthly follow up clinic meetings for all the patients on 2nd line treatment.
- 5 STBHIV coordinators were jointly involved in the supervision visits of their respective state health facilities that were offering TBHIV services.
- The Courier Company was engaged in the 3rd quarter of the year so as to facilitate the sample transportation across AAA sites either from the spokes to the hubs or from the hubs to the NPHL.
- There were 20 quarterly MDR TB review meetings were conducted across all the MDR-TB sites so as to the review MDR-TB performance.
- One on One Review meeting via zoom was convened by the PR where by AAA had to share the activities under PMTCT.

- There were 34 supportive supervision visits that carried out by the AAA M&E officer in Western Barh Ghazal and Western Equatoria States.
- AAA was involved in the TB drug and HIV quantification exercise that was carried out in the 2nd quarter of 2024.
- AAA was represented in the revision of Indicator review and HMIS tools workshop.

In the course of the 2024, AAA was invited by the CCM and NTP so as to participate in the following:

- AAA was invited to participate in the Extraordinary CCM meeting.
- AAA was represented at the TBHIV programme review meetings in the course of the first semestre
- Progress update meetings with the HIV networks (NEPWU and SSNEP+) were conducted in the course of the year.

As far as the implementation of C-19PO LMD activities was concerned, the following were marked as also one of the key successes in addition to the achievements of TBHIV:

- Within the year, health commodities (1,124 bulky cartons weighing 11,264 kgs) were transported and distributed to our various hub points within the different states of our implementation coverage, by an outsourced transport company (Akoldit Transport Company) for further distribution up to last mile sites in for end-user/patient.

- Increased coverage for HIVTB service delivery as access to 6 transitioned HIVTB sites in the far-end area of the Eastern part of Western Equitoria state for assessments, trainings, mentorships and supervisions was made possible. Most of these facilities were unreachable due to distance since there was no vehicle available in the state but under C-19PO budget, we were able to cater for the transferred vehicle's costs herein.

In order to strengthen TBHIV and last mile activities and improve on the quality of the services rendered; AAA ensured that all the planned activities were timely carried out and also the gaps identified were addressed during supportive supervision visits. The staff were capacity built TBHIV improvement strategies , the engaged courier company managed to transport samples from the spokes to different hubs and then shipment to NPHL, the NPHL staff were engaged so as to conduct onsite mentorship in AAA supported facilities and the focus was EQA , IED and Viral load, there were intensified supportive supervision activities for mentorship and on-site trainings that were carried out by the M&E officer, the Project Manager/TB Expert and a Program Officer Mobile to ensure alignment to the South Sudan TB and HIV NSP and PMDT programmatic and treatment guidelines. The key staff ensured that all the heath commodities that were transported from Juba were temporarily stored at their respective State level warehouses before making the final transportation arrangement for the Last mile delivery.

The supportive supervisory activities included on-job training, assessment of the project activities, follow-up of the recommendations from the previous visits and discussions on the practical ways

of meeting the set targets and also strategies to accelerate implementation during the dry seasons prior to the prolonged rainy seasons. These supervisory visit activities were carried out following the approved MOH checklist. During the visits, on bench trainings were conducted with emphasis on proper data collection that encompasses complete and accurate recording in the various TBMU registers, compiling quarterly data, verification of the data and the filing of all support documents required.
A filing system was introduced in all the TB and HIV sites centers that ensure all the programmatic and financial reports were inter-linked to ensure that the budget is utilized as planned and create a clear account of the expenditures.

In conclusion, the programme staff made a lot of efforts so as to achieve the set targets in the ended year. The targets that were not met had to have the programme staff re-strategize so as to up the implementation in the first quarter of the first year; There were several mentorship exercises that were carried out among the programme staff and others in the private sector which helped in the TB HIV awareness creation. This led to a higher rate of referral of presumptive TB cases who were then examined in the laboratory for diagnosis. The last mile project also greatly boosted these results as the needed medicines and other health services were seamlessly made available to the end-users.

The BHWs and other community actors were engaged by being assigned patients in their respective catchment areas to ensure mother-bay pairs are returned to the facility for sample collection on time, the treatment interrupters are tracked and retrieved timely so as to reduce the lost to follow up, Door to Door visits were carried for index case contact screening and testing. AAA was involved in the orientation workshop on Diagnostic Network Assessment that covered most of the AAA supported facilities.

Success Story:

World TB Day commemoration on the 24th of March 2024 in Tambura.

During this occasion, Tambura CHD Director appreciated the efforts AAA in ensuring that there were TB control activities in Tambura and other counties. He further remarked that it was important that IEC materials were printed out in local dialects for the majority of the community to get the messages.

Mr David Yabira shared his TB story during the World TB Day commemoration in Tambura.

"My name is David Yabira a former TB patient from Loki in Tambura County. In 2021 I fell sick. It was a disease that had a toll on myself and my larger family. I suffered to the extent that I myself and my family had to lose hope as they tried all different types of medicines including the traditional (Pa Zande) treatment without any improvement.
My family decided to take me to Tambura Hospital. On arrival I was taken to the laboratory where sputum sample was examined in the laboratory. I was informed that I had TB of the lungs. After a

long session with the diktori, who informed me the type of disease I had and the treatment duration. Since I was seeing death, I accepted everything that the diktori was suggesting, as real I needed to be treated as I was suffering…
I was initiated on TB treatment for 6 months where I used to take the tablets every day, I remember going back to the laboratory after 2 months of treatment. When the sputum results were out, I was informed that there were no TB germs in my lungs but I had to remain on treatment for the remaining 4 months. I continued taking drugs and on the 5th month I went back to the laboratory and results still showed that I had no TB germs, so I was given drugs for one more month. When I went back to the laboratory, I was told that still I had no TB germs and that it was my last sputum follow up examination and I was cured of TB disease. Since then, I have been very fine as I am very healthy, as I always go to my farm and ride a bicycle to the market like any other person.
So, my advice to all of you and the entire community is that when you have a chronic cough, please go to Tambura Hospital and be treated for TB as it is treatable and curable.

If you don't take an early action for your life, then you will suffer like the way I suffered from TB and even up dying from TB. Remember that TB services are free of charge. I paid nothing to save my life and my life was saved for free.

I thank AAA and all the people supporting this TB program in Tambura and South Sudan.

God bless you."

David sharing his TB treatment story with the audience in Tambura

Lessons Learned:

Under GC7 implementation, the following lessons were learnt:

1. More resources should be allocated to facilitate the Index case contact testing, community-based HIV testing /Viral load and EID sample collection and community drug refills.
2. Key and vulnerable populations/communities in hard-to-reach areas should be served through outreach /mobile activities.
3. Reversing the high interruption in treatment rates (IIT), transport refund should be allocated for the community workers so as to timely track and retrieve the patients who interrupt treatment. Catchment areas are vast and movement on foot may remain a challenge.

During the implementation of C-19PO last mile activities, the following lessons were also learnt:

4. Continued communication is essential for good coordination among all involved partners to facilitate a smooth flow of last mile delivery.
5. There's need for continued resource mobilization and government contribution towards last mile initiatives and related activities as there's still much needed to be done to strengthen the health system in the country and to ensure that health services reach everyone in need.

CHAPTER 4: CHALLENGES and BOTTLENECKS

There were no major challenges in the project management as the system structures are well established and functional at Arkangelo Ali Association (AAA).

A comprehensive plan with the budget and targets is done during proposal development stage, with strict timelines to be followed. These are reviewed on a quarterly basis and underperforming activities that require strengthening are identified and way forward developed. However, some of the challenges encountered at the implementation stage of the TBHIV and last mile activities included:

1. Tablet holders having not been trained on DHIS2 use and assigned usernames and passwords.
2. The CHD M&E officers' reluctance to enter TBHIV data into the DHIS2, as they are haven't been receiving incentives.
3. Massive flooding in areas of operations that hampered the planned supportive supervisory visits.
4. Ordered HIV R&R tools were not always timely supplied to the field sites, as some facilities still lack crucial HIV R&R tools on ground, yet the orders had been placed.
5. Inadequate power (Backup)for the running of the GeneXpert machines e.g. in Yambio State Hospital and Tonj Hospital the GeneXpert machines were run only when there was a patient for operation. At times the operation is over before the samples are screened and therefore the generator was switched off, leading to many invalid/error GeneXpert results.
6. Gaps in data management whereby despite efforts to ensure reporting of data at the health facilities, sufficient training on usage of the reporting system continued to lack at last mile. Further, the DHIS2 system at central level was not well updated thus, output with missed or double reported data. Through this, visibility of essential logistics data such as consumption rates and patterns ought to be unstable because of the inconsistently captured and reported data hence bound to make it difficult to accurately forecast demand; make informed quantification and procurement decisions; and, thus, reduce stockouts and expiries.
7. Limited resources for last mile delivery. The activities that supported last mile delivery in the year accounted for limited resources in the form of limited capital to cover all costs associated with the linked activities and distribution operating costs. This continued to be felt especially because of our old vehicles and motorbikes which need regular repairs and maintenances with very little resources available in both GC7 and C-19PO grants. Further, during implementation, there was still room to do so much in activities like basic rehabilitation of service delivery rooms and storage structures, improving necessary conditions like ventilations, lighting etc., provision of storage furniture e.g. cabinets, shelves etc.; but the resources granted were limited – leaving so much undone as such crucial.
8. Issues with last mile coordination at various levels: In some instances, the SR was met with impromptu deliveries which somehow brought about confusion during inventory updates. In other instances, there was delayed release of commodities from the Juba warehouse especially towards the end of the year whereas in others there lacked provision and distribution of much needed commodities e.g. reporting tools.

9. A function of constraints caused by internal and external politics, economics, climate and infrastructure. This includes: unstable economy thus regular price fluctuations of commodities like fuel hence increased transport costs, inaccessible roads following insecurity due to inter-tribal clashes, poor technology causing communication breakdown sometimes; and, poor terrain and flooding, which made it difficult to access remote areas for last mile deliveries.

Way Forward

- C-19PO reprogramming should capture an expanded budget line for renovation of storage facilities
- The MOH HIV/STI department should prioritize the printing out of the HIV SOPS, Job Aids and most of the HIV sites have no SOPs displayed.
- The PR should think of additional incentives for the HR in facilities that had been targeted for TBHIV service integration.
- Backup solar systems should be procured by the PR for GeneXpert sites that have power challenges.
- The new tablet holders should be trained on how to use DHIS2 by the MOH/M&E, and then thereafter assign them usernames and passwords that will enable them to access the DHIS2 system and then timely enter TBHIV data.

CHAPTER 5: BEST PRACTICE

The Project Manager/TB Expert focused on improving communication with various locations as a way of ensuring that the programme activities were implemented according to the set work plan. Devising practical methods of meeting the needs of the programme such as transferring of experienced staff to locations where there are weaknesses and on-job mentorship of the national staff on programme management. The work plans were disseminated to all the locations with clear targets to be met in every quarter. There exists a strong link between the finance, logistics and program departments to ensure that all the activities are carried out according to the budget and work plan. There are both regional and national staffs working in these programs. Regional expatriate staffs had specific management duties and are deputized by the National staff.

The implementation of the programme activities followed strictly the set work plan and involved all the staff. Information sharing among the field staff and the Headquarters was excellent, despite the existing challenges. The implementation process involved advance planning of various activities at the field level, making requisitions for funds and supplies in advance analysis/approval by the project administrator and project manager and finally carrying out the activity and reporting.

Monitoring of these activities is carried out at various levels, the job descriptions of some of the staffs were revised to include monitoring and evaluation functions. Despite the added responsibility, their main activities remained supervision, data collection, verification, quality assurance of the procedures such as laboratory performance and clinical evaluation. A guideline for M&E was developed and a standardized checklist is available for supervision. The guideline and the checklist are both used in monitoring of these activities. The M&E officer provided regular feedback after the supervisory visits, always ensured that the tools for data collection were provided to all sites and performed on-job mentorship and trainings as required. The lessons learnt during the monitoring exercise are always used to improve the programme performance.

There is efficient data storage and archiving system. The system ensures availability and easy access of both aggregated and disaggregated data. Bi – annual supervision is done by the M&E officer and the project manager. Other best practice should be the door-to-door screening and referral of specimen and timely treatment initiation. We devolved finance management to the locations with budgeting and practical interventions being determined by the location staff. Transparency is ensured by cross-checking and countersigning by two persons the expenditure.

CHAPTER 6: RECOMMENDATIONS

As far as the implementation of TBHIV and LMD activities is concerned, the following are recommended:

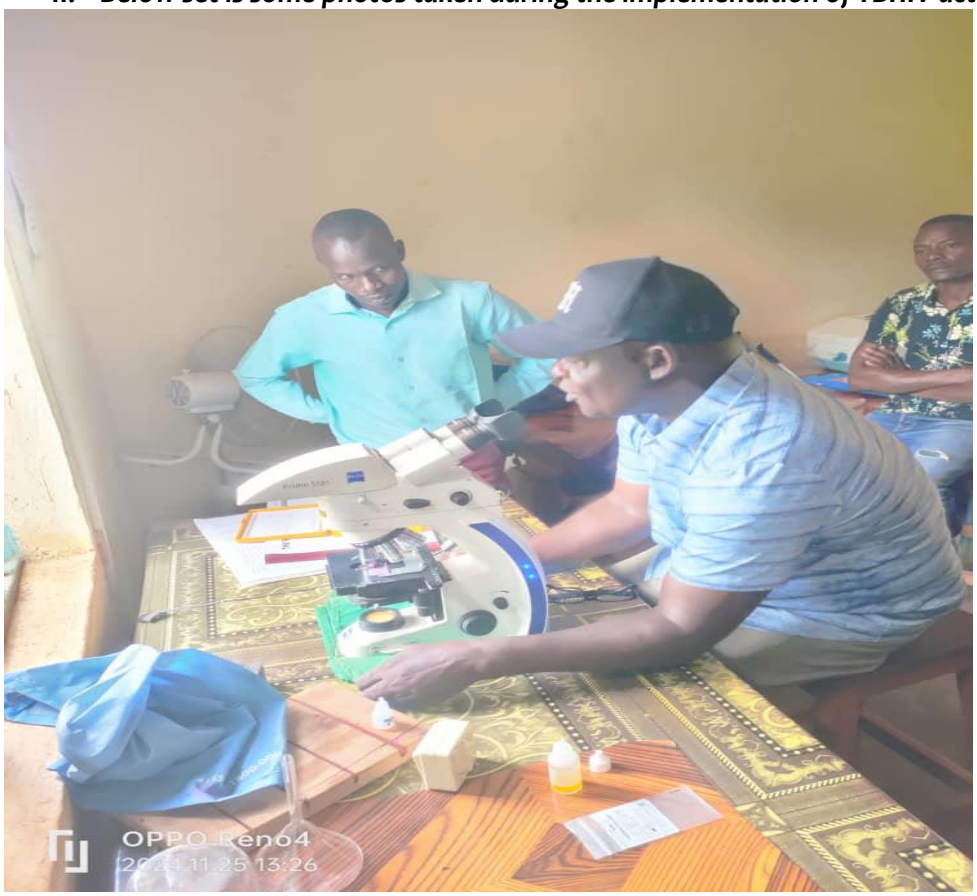
- The CHD M&E officers should be considered for incentives
- Printing out the M&E tools including the HIV SOPs, Job aids should be prioritized by the MOH.
- Data entry into the DHIS2 system has to be boosted by having the tablet holders trained by the MOH/M&E directorate and then assign usernames and passwords, to enable them have access to the DHIS2 hence enter data.
- Most of the TBHIV and C19RM commodities should be supplied from the medical Warehouse in Juba to the hubs during the dry season when accessibility to the facilities is good. This will make it easier for the LMD activities from the hubs to the health facilities in the periphery.
- The Zonal TBHIV coordinators should intensify supportive supervisory visits and onsite mentorship missions to all HIV sites, so as to improve the knowledge of the HIV staff.
- The government to continue diversifying collective and coordinated investments aimed at aiding, setting and boosting health priorities. This could be in form of government loans, multilateral donors, and unrestricted funding. Additionally, this should not only be limited to liquid funding but also in other forms like in-kind support including but not limited to professional skills like attached human resource from stable structured health systems in the world and TA in order to help.
- Continued support and extensive training is necessary for building local capacity to manage data collection, analysis and reporting at all levels of the supply chain and updating of the DHIS2 at the central level as that is the national reference system.
- C-19PO or an equivalent of Last mile project continuity/renewal in order for the SR to be able to continue implementing the areas that have fallen short due to budget constraints.
- SR AAA to continue advocating for motorvehicles with good conditions (new or second hand) from the PR UNDP to supplement the old existing ones to enable smooth programme implementation especially in Rumbek and Cueibet areas in Lakes State.

Annex 1: Some photos that were taken in 2024 when TBHIV and C-19PO last mile activities were being carried out:

An illustration of cargo handling from drop-off points in AAA Juba office, sorting and loading for last mile delivery.

Photo of vehicle transferred by UNDP to AAA and placed in Yambio station for AAA TBHIV Programme Western Equitoria State

II. Below set is some photos taken during the implementation of TBHIV activities…



AAA M&E officer going through the EQA slides in Bethsaida ECS lab

EMTCT training session in Maridi

Training participants pose for a group photo in Maridi
Dr Joseph Garang the PPMTCT senior inspector.as one of the facilitators

World AIDS Day commemoration on the 1st of December in WAU

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