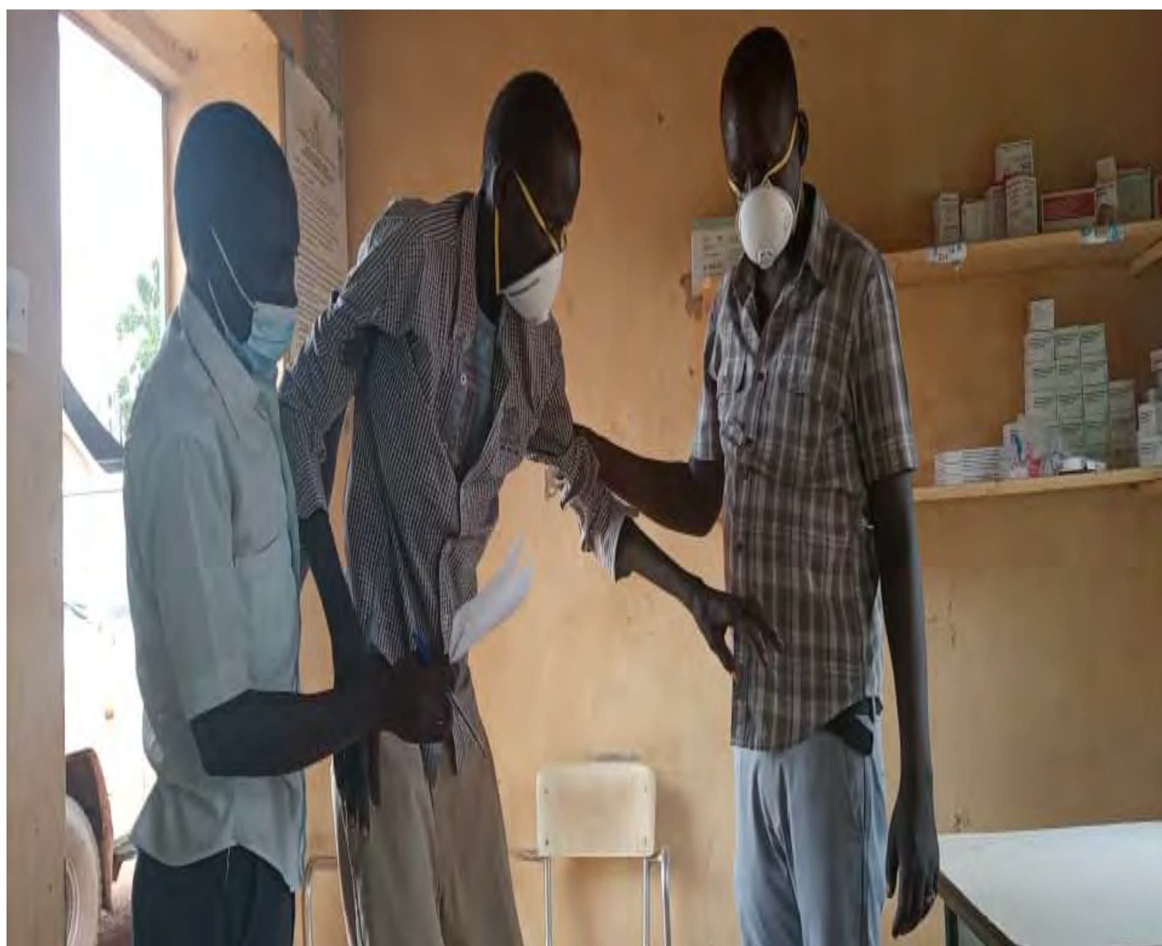
ARKANGELO ALI ASSOCIATION-AAA

SOUTH SUDAN

GLOBAL FUND TBHIV NFM3 ANNUAL REPORT 2021



A weak TB patient being supported by relatives in Aweil State Hospital TB unit

Grant
Global Fund UNDP TBHIV NFM3 Year 1

SR Name
Arkangelo Ali Association - South Sudan

Report for implementation period
01/01/2021 to 31/12/2021

Funds Available:

Approved Budget (After the Amendment No. 1 to the SR Agreement with the PR UNDP in September 2021)
US Dollars 843,060.45

Funds Disbursed
US Dollars 843,059.74
Note: USD 0.71 was not disbursed to AAA as it was under rounded decimal points in quarterly disbursements.

Funds Utilized
US Dollars 776,867.17

Funds Balance
US Dollars 66,192.57

Project Areas

The project is operational in twenty six (26) 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

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. Tambura County

- Tambura Hospital
- Source Yubu PHCC
- Mupoi PHCC

4. Nagero County

- Nagero 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

5. Tonj East County

- Rumabuth PHCC
- Ngapagok PHCC

6. Twic County

- St Mother Theresa Hospital
- Wunrok PHCC

Contact persons

Mrs. Natalina Sala
AAA Director/Finance Director

Dr Callixte Minani
Project Manager (TB Expert)

ACKNOWLEDGEMENT

The current NFM3 TBHIV programme achievements entitled "Integrating Services for Maximum Impact" have been realized because of the financial support and assistance from the Global Fund (GF) and implementation collaboration with the PR UNDP, the Ministry of Health –RoSS - specifically the National TB, Leprosy and Buruli Ulcers Control Program and HIV departments together with the Country Coordinating Mechanism (CCM). AAA appreciates the valuable and worthy partnership with these stakeholders currently as was in the past.

To supplement the financial gaps realized during the implementation of the grant in the course of the year in areas that were not funded by the Global but deemed crucial for TBHIV service delivery, AAA sought financial aid from other well-wishers who stretched their hands with the aim of supporting the programme. For their kindness and generosity towards our course, we say thank you.

Arkangelo Ali Association (AAA) would also like to extend sincere gratitude to individuals and agencies who have contributed towards the attainment of targets for the program. Special thanks go to the SMoH, County Health Departments in all the AAA areas of operation, NPHL at Central level, the Non-governmental organizations supporting Primary Health Care activities and the AAA dedicated members of staff who have been providing essential services to diagnose and initiate TBHIV treatment promptly. Without their crucial support and commitment, many more lives could have been lost.

ACRONYMS

AAA	Arkangelo Ali Association
BHW	Boma health Worker
CCM	Country Coordinating Mechanism
CoS	Continuity of services
CTB DOTS	Community Based DOTS
DOTS	Directly Observed Therapy Short course
EID	Early Infant diagnosis
GF	Global Fund
HCWs	Health Care Workers
HEI	HIV Exposed Infant
HIV	Human Immune deficiency virus
HHPs	Home health promoters
MDR-TB	Multi Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
NFM	New Funding Model
NSP	National Strategic Programme
NTP	National TB Programme
PHC	Primary Health Care
PHCC	Primary Health Care Centre
RSS	Republic of South Sudan
TB	Tuberculosis
TBMU	TB Management Unit
UNDP	United Nations Development Programme
VL	Viral load

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EXECUTIVE SUMMARY

The Global Fund TBHIV NFM Grant focuses on maintaining the TBHIV services in the existing TB diagnostic and treatment centers by pursuing high quality DOTS expansion, addressing challenges related to multidrug-resistant TB (MDR TB) and strengthening the national management capacity by establishing a National TB care and prevention department in the Ministry of Health in the Republic of South Sudan. All these are aimed towards the reduction of mortality and morbidity caused by both 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 2020-2024 and HIV NSP 2020-2023 that identified gaps and defined appropriate strategies and has already been operationalized operational. 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; on Job training of laboratory assistants, training of health workers in all Primary Health Care , training of Prison health person on TB care and management and 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.

AAA has a team of dedicated staff for TB intervention programs with clear terms of reference and functions. The organizational structure is shown in the organogram below.

All forms of TB cases registered for treatment in the year 2021 were 5820 out of which 5746 were incidental TB cases that were notified to NTP.

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 International NGO on 27th 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.

The South Sudan GF TBHIV NFM3 grant was allocated USD 71,526,259 for 3 years (201-2023). AAA signed an SR agreement with PR UNDP on 27/01/2021 with a 3-year budget (2021-2023) of USD 2,239,426. The coverage focused on four Modules of the NFM3 as below cited:

1. TB Care and Prevention; Intervention Area: Case detection and diagnosis.
2. TBHIV; Intervention Area: Engaging all care providers.
3. MDR TB; Intervention Area: Treatment.
4. Program Management; Intervention Area: Grant management.

On 13th of September 2021, AAA further signed the Amendment No.1 to the SR agreement with the PR UNDP increasing the 3 - year budget (2021-2023) from USD 2,239,426 to USD 3,218,673. These changes were effected in order to include activities related to the HIV interventions to ensure TB/HIV integration at health facility and community outreach level. AAA was additionally expected to engage in four additional HIV modules and interventions as from 1st October 2021 (Q4/21). The additional Modules related to HIV were:

1. Differentiated HIV Testing Services; Intervention Area: Facility-based testing.
2. PMTCT; Intervention Area: Prong 3 - Preventing vertical HIV transmission.
3. RSSH: Laboratory systems; Intervention Area: Information systems and integrated specimen transport networks.
4. Treatment, care and support; Intervention Area: Differentiated ART service delivery and HIV care.

The budget allocated to AAA is to facilitate the running of the programme in the then existing 66 TB units by end of 2023 and then integrate and expand TBHIV Treatment services into 14 new health facilities by the end of the 2021-2023 grant. At the end of this year, AAA has managed to have 12 health facilities integrated with TBHIV services as a way of expanding TB DOTs in the AAA catchment areas and are all functional.

AAA as a sub-recipient (SR) implemented the TB and TBHIV interventions with GFATM funding support under the leadership of the Principal Recipient (PR) United Nations Development Program (UNDP). AAA implemented the eight interventions in the TBHIV programme and it managed to report data from 59 functional diagnostic and treatment centers that are spread across 26 counties in 5 States of South Sudan.

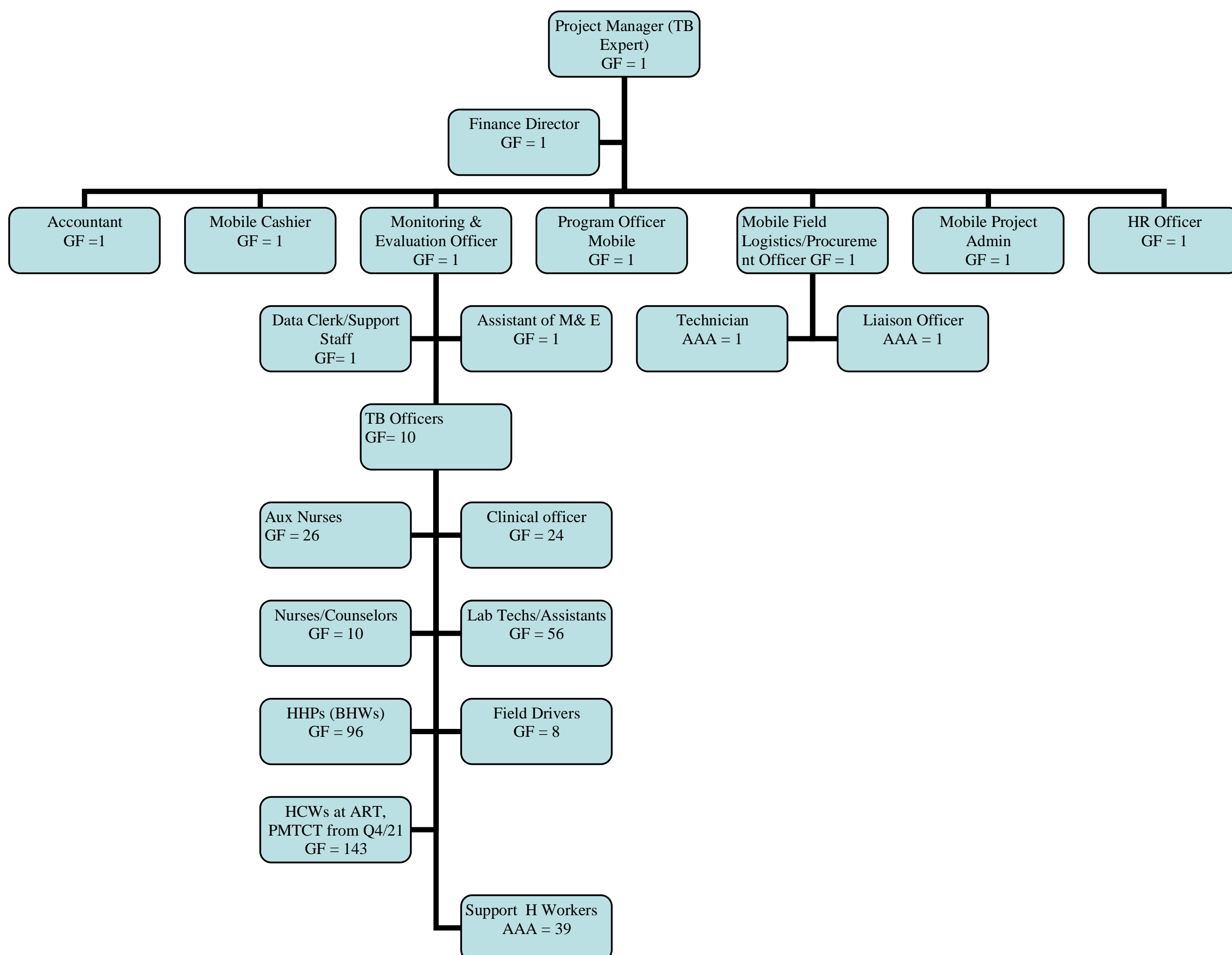
In 2021, AAA integrated and strengthened TBHIV services in 12 health facilities (i.e *St Theresa Nzara Hospital in Nzara county,Sikadid PHCC in Wau county, Mary Help Hospital in Jur River county, Awei, Prison PHCC in Aweil Central county,Nyang PHCC innYirol East county, ,Wunrok PHCC in Twic County, Gnangura PHCCin Yambio County, Wau Prison PHCC in Wau,Marialbaai PHCC Jur River county, Achongchong PHCC in Jur River county, Abirieu PHCC in Cuiebet County and Yambio Prison PHCC in Yambio county*)

An evaluation of the TB patients who had been initiated on TB therapy in 2020 was conducted and out of 4980 patients registered ,4608 patients had either cured or treatment completed giving a treatment success rate of 93% which is above the recommended WHO target of 90:90:90.

This grant implementation was in collaboration with the Ministry of Health where the interventions follow 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 3,499,601, which is within the AAA catchment 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 NFM3 grant aims to expand TB treatment coverage but at the same time pursuing high quality DOTS expansion and enhancement, addressing challenges related to multidrug-resistant TB and strengthening the national management capacity by strengthening a National TB care and prevention department in the Ministry of Health of South Sudan. All these are aimed towards the reduction of mortality and morbidity caused by TBHIV. The implementation of the TBHIV interventions is carried out at various levels within the AAA organizational structure, right from the headquarters to the health facilities as shown in the organogram below.

AAA Organization Structure for TBHIV Programme:



1. 2: OVERALL PROJECT GOAL AND SPECIAL GRANT AGREEMENT

The goals of the Global Fund TBHIV NFM3 Grant are:

1 Reduction of new HIV infections by 50% by 2023 (from 2010 levels)

2. Reduction of deaths among men, women and children living with HV by 50% by 2023 (from 2010 levels)

3. Reduce TB incidence by at least 30% (relative to the 146/100,000 population in 2019) to less than 102/ 100,000 by 2024).

The Global Fund Grant Agreement signed for the ongoing NFM3 TBHIV Grant between AAA and the Principal Recipient (PR) United Nations Development Programme (UNDP) was signed by both parties on 27/01/2021, with a 3-year budget (2021-2023) of USD 2,239,426 for the purpose of utilization towards running the existing 52TB units and then expand TB DOTs by integrating TB services in 14 new health facilities. The target for ART sites was 69 but AAA managed to get data from 25sites, HTS target was 69 sites but only 27 sites reported data and PMTCT had a target of 65 sites but data was generated from 40 health facilities. Further, on 13th of September 2021, AAA further signed the Amendment No.1 to the SR agreement with the PR UNDP increasing the 3 -year budget (2021-2023) from USD 2,239,426 to USD 3,218,673. These changes were effected in order to include activities related to the HIV interventions to ensure TB/HIV integration at health facility and community outreach level as from 1st October 2021 (Q4).

1.3: STRATEGIES AND IMPLEMENTATION DURING THE REPORTING PERIOD

The goals of the TBHIV NFM3 Grant are:

2 Reduction of new HIV infections by 50% by 2023 (from 2010 levels)

4. Reduction of deaths among men, women and children living with HV by 50% by 2023 (from 2010 levels)
5. Reduce TB incidence by at least 30% (relative to the 146/100,000 population in 2019) to less than 102/ 100,000 by 2024)

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 during the reporting period so as to achieve the desired results include:

- Engaging the HIV networks, e.g. NEPWU in series of meetings to forge a common understanding regarding their activities e.g. tracing lost to follow up, HIV awareness creation etc.
- Involving the members of the SSNeP+ and NEPWU in communities as champions and Expert patients for HIV awareness and for positive, health, dignity and prevention.
- Intensify HIV awareness so as HIV- related stigma and discrimination is reduced.
- Ensuring that all PLHIV are monitored through viral load for viral suppression
- Engage the networks of PLHIV in communities to promote HTS and to assist with counselling and referral.
- Strengthen linkage and referral processes to ensure that pregnant women who test HIV-positive are not lost-to-follow-up.
- Capacity building of the health care workers on TB care and treatment
- Training of the prison health personnel on TB management.
- Training the laboratory staff on LED microscopy
- Training of laboratory staff on EQA and GeneXpert
- Train/retrain county and State level hospital Health care workers on HTS
- Behaviour 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.
- Continuing with the distribution of IEC materials to Health workers and HHPs together with imperatives like umbrellas, caps, mud boots, motorbikes and bicycles to ease reaching the communities during rainy seasons.
- 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.
- GeneXpert machine was installed by NTP/UNDP in Kuajok State Hospital for molecular diagnosis of TB and detection of RR TB. This boosted the identification of DR-TB cases as 54 DR-TB cases were diagnosed and had 52 initiated on 2nd line treatment.

1.4: RESULTS

5.1 Programmatic TB NFM3 Year 1(January-December 2021)… 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	Jan- December	7846	5746	73%
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	Jan-December	85%	4608/4980(93%)	109%
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	Jan-December	95%	51/57(89%)	94%
TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register	Jan-December	93%	5454/5746(95%)	102%
TB/HIV-6(M) Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	Jan-December	90%	638/652(98%)	109%
MDR TB-9 Treatment success rate of RR TB and/or MDR-TB: Percentage of cases with RR and/or MDR-TB successfully treated	Jan- December	75%	34/37(92%)	123%
MDR-TB 2 (M): Number of TB cases with Rifampicin-resistant (RR-TB) and/or MDR-TB notified	Jan-December	56	54	96%
MDR TB-3: Number of cases with drug resistant TB (RR-TB and/or MDR-TB) that began second-line treatment	Jan-December	56	52	93%

HIV Indicators Versus Targets

Indicator	Reporting Period	Target	Result	% Achievement
PMTCT-2.1 Percentage of HIV-positive women who received ART during pregnancy and/or labour and delivery	January to December	9%	89/233(38%)	422%
PMTCT-3.1 Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth	January to December	5%	12/12(100%)	2000%
TCS-1.1(M) Percentage of people on ART among all people living with HIV at the end of the reporting period	January to December	10%	3577/4185(85%)	850%
M&E-2a Completeness of facility reporting: Percentage of expected facility monthly reports (for the reporting period) that are actually received	January to December	95%	TB (59)+ART (25)=84/135(62%)	65%
Number of health facilities sending EID samples for testing during the reporting period	January to December	65	4	6%

6.2 Status of Implementation of Approved work plan

Activity	Year Planned	Status of Implementation	Concise description of the status/results/achievements and challenges
Train/retrain HCWs in State and County level Hospitals on HIV testing	Year 2021	Conducted	Achievements: 100% attendance of 81 participants: - 41 males - 40 females The training was appreciated by the participants, as it will be used in improving the quality of programme implementation.
Capacity building of health facility health workers on TB care and treatment	Year 2021	Conducted	**Achievements:** 100% attendance of 81 participants: - 70 males - 11 females
Training of lab staff on LED	Year 2021	Conducted	**Achievements:** 100% attendance of 78 participants:

microscopy			-68 males -10 females
Training of lab staff on EQA(Microscopy and GeneXpert)	Year 2021	Conducted	**Achievements**: 100% attendance of 72 participants: -64 males -8 females
Training of prison health personnel on TB and HIV diagnosis and treatment.	Year 2021	Conducted	Achievements: 100% attendance of 103 participants: -84 males -19 females
Conduct quarterly EQA support supervisory visits from the State to the peripheral laboratories	Year 2021	Activity carried out	**Strengths/Achievements** - 42 joint EQA support supervisory visits from the State level to the health facilities in the periphery were conducted. - All reported data for was verified during EQA support supervisory visits and was found corresponding with what had been submitted to NTP and UNDP. -Programme staff were mentored and errors identified were corrected on the spot.
TB contact screening with focus on bacteriologically confirmed TB cases	Year 2021	BHWs were involved in Contact investigations.	**Strengths/Achievements:** Number of bacteriologically confirmed TB cases on whom Contact Investigations were carried out:1583 ♦ Number of people found at home: 5271 ♦ Number of TB contacts screened:4495 ♦ Number of contacts identified with TB symptoms:365 ♦ Number of sputum samples from

			symptomatic contacts tested in the lab:252 ♦ Number of TB contacts confirmed with TB: 23
Intensify TB case detection	Year 2021	Both Intensified and passive case finding approaches were employed during the quarter	**Strengths/Achievements** - Total of 5820 TB cases (caseload) were diagnosed and initiated on TB treatment. **Recommendations** - All index cases should always have their contacts screened for TB for 3 months. - Presumptive TB cases should all be screened using GeneXpert machines, to boost TB case detection.
EQA slide sampling	Year 2021	Done	**Strengths/achievements** - 570 slides were sampled and sent to the NTRL for double-checking. 60 slides had discrepant results which resulted to an EQA result concordance of 89% .
Transporting DST samples from peripheral labs for Gene-Xpert processing at the hub laboratories	Year 2021	Done	**Strengths/Achievements** - 86% (=N186 out of 211) samples were transported from retreatment patients to the nearby hub laboratories for Gene-Xpert processing. Out of these 54 DR-TB patients

			were diagnosed and 52 patients initiated on SLD.

6.3 Financial (Income and Expenditure)

Module	Budget Line	Activity Description	Year 1 (2021) Budget	Total Year 1 (2021): Expenditure	Total Year 1 (2021) Variance
Differentiated HIV Testing Services	10	Train/retrain HCWs in state and county-level hospitals - SR2	18,600.00	18,600.00	-
MDR-TB	160	Conduct quarterly cohort review /performance review meeting at the state level.	-	-	-
PMTCT	31	Conduct annual state level review meetings with mentor mothers	-	-	-
RSSH: Laboratory systems	260	Provision of service contracts to courier companies for facilitation of sample transportation	15,590.00	6,845.00	8,745.00
TB care and prevention	138	Scale up LED microscopy services from 62 facilities to 122 facilities by 2024 - Train 1 lab personnel per facility with LED microscopy services	19,458.00	19,458.00	-

TB care and prevention	139	Train at least two lab staff per health facility on EQA (microscopy and GeneXpert)	11,160.00	11,160.00	-
TB care and prevention	140	Conduct quarterly EQA support supervisory visits from State to peripheral laboratories with TB services	7,279.20	7,280.00	(0.80)
TB care and prevention	148	Build capacity of health facility health workers on TB care and treatment - Train 3 per PHCC and 1 per PHCU health workers per facility on TB treatment and care	19,560.00	19,560.00	-
TB care and prevention	298	AAA Field support - Travel cost	19,075.00	19,052.00	23.00
TB care and prevention	339	Provide enablers (transport) to all DR-TB patients during care	12,525.00	8,885.00	3,640.00
TB care and prevention	340	Provide enablers (nutrition) to all DR-TB patients during care	17,535.00	12,364.00	5,171.00
TB care and prevention	341	Establish monthly follow-up clinics of DR-TB patients and track adverse events	3,267.00	3,247.00	20.00
TB care and prevention	354	AAA Programme Management HR cost	141,920.00	141,920.00	-
TB care and prevention	355	AAA Field support HR cost	394,007.76	362,670.00	31,337.76

TB care and prevention	356	AAA Programme Management - Operating cost	20,552.00	20,552.00	-
TB/HIV	342	Train at least four prisons per state prison health personnel on TB and HIV diagnosis and treatment	19,723.00	19,723.00	-
Treatment, care and support	109	Provide operational support to 130 facilities providing ART/PMTCT	12,455.00	11,828.00	627.00
Treatment, care and support	110	Incentives for HCWs at ART, PMTCT and TB sites - SR1	55,200.00	42,900.00	12,300.00
Program management	357	AAA Programme Management Service ICR	55,153.49	50,823.17	4,330.32
Total			**843,060.45**	**776,867.17**	**66,193.28**

Appendix on the Income & Expenditure.

Notes to the Financial (Income and Expenditure) illustration.

1) Our variance as of 31/12/2021 is $66,193.28 which is Year 1 Budget of USD 843,060.45 Less Year 1 Expenditure of USD 776,867.17.
2) The Grant balance as of 31/12/2021 is USD 66,192.57, which is Year 1 Disbursed funds (income) of USD 843,059.74 Less Year 1 Expenditure of USD 776,867.17
3) Between No.1 and No.2 there is a Variance of USD 0.71, which was not disbursed to AAA in the Q1-Q3 disbursements of Year 1 since it was rounded off.
4) Our bank balance reflected in the bank statement as of 31/12/2021 is $66,193.26 which is Year 1 Disbursement of USD 843,059.74 Less Year 1 Expenditure of USD 776,867.17 (+ $0.69 from closed NFM2 retained for account maintenance as of 31/12/2020 before NFM3 in January 2021).

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

- ***Budget Line 260; Provision of service contracts to courier companies for facilitation of sample transportation:***

Positive variance of USD 8,745 remained.

Since this is a new activity for us, we utilized most of the time in the reporting quarter to carry out ground and fact-finding assessments as well as conduct mobilization in our areas of coverage to create awareness and leeway to the communities and patients for voluntary sample provisions. Consecutively, only few samples were collected upto mid December putting into consideration cases of flooding and insecurities, which hindered the collection and transportation of samples; thus, relatively low expenditure incurred. This means there are projected costs related to December 2021 transportation of samples, which will be paid in January 2022.

As the implementation of this activity progresses, we envisage to employ continuous strategies and lessons learnt from the support and supervision mentorship by NPHL to increase in the collection of TB, EID & VL samples in the quarters to come, thus improved progress of expending the funds allocated for this activity.

- ***Budget Line 140; Conduct quarterly EQA support supervisory visits from State to peripheral laboratories with TB services.***

Negative variance of USD (0.80) due to budget rounding.

- ***Budget Line 298: AAA Field support - Travel cost***

Positive variance of USD 23 remained because of 3rd participation support by AAA towards field travel costs to the programme but it will continue to be utilized during the next quarters of the grant implementation.

- ***Budget Line 339: Provide enablers (transport) to all DR-TB patients during care.***

Positive variance of USD 3,640 remained because within the year, AAA has continued to register less number of MDR patients within our sites due to low disease burden unlike in the assumption that was budgeted for. Following these developments, AAA has engaged the relevant persons in the PR level within the quarter on the issue; thus, we have proposed for reprogramming of the part of funds not absorbed by end of this quarter to be utilized for the MDR TB health facility related activities – majorly, to strengthen power system to maximize the genexpert utilization in Gordhim PHCC, Tonj County Hospital and Yambio State Hospital. Further engagements on this will continue to follow in Year 2 as we envisage occurrences of such positive balances under this budget line due to the same reason highlighted herein.

There is also a small part of funds from the balance for some MDR patients in Tambura, Wau, Aweil and Rumbek sites who were not paid in Q4 due to insecurity issues and late registration but have been projected to be paid in Q5.

- ***Budget Line 340: Provide enablers (nutrition) to all DR-TB patients during care.***

Positive variance of USD 5,171 remained because within the year, AAA has continued to register less number of MDR patients within our sites due to low disease burden unlike in the assumption that was budgeted for. Following these developments, AAA has engaged the relevant persons in the PR level within the quarter on the issue; thus, we have proposed for reprogramming of the part of funds not absorbed by end of this quarter to be utilized for the MDR TB health facility

related activities – majorly, to strengthen power system to maximize the genexpert utilization in Gordhim PHCC, Tonj County Hospital and Yambio State Hospital. Further engagements on this will continue to follow in Year 2 as we envisage occurrences of such positive balances under this budget line due to the same reason highlighted herein.

There is also a small part of funds from the balance for some MDR patients in Tambura, Wau, Aweil and Rumbek sites who were not paid in Q4 due to insecurity issues and late registration but have been projected to be paid in Q5.

- ***Budget Line 341: Establish monthly follow-up clinics of DR-TB patients and track adverse events.***

Positive variance of USD 20 remained for one MDR patient in Tambura site whose costs were paid in Q4 due to insecurity issues but is projected to be paid out in Q5.

- ***Budget Line 355: AAA Field support HR cost.***

Positive variance of USD 31,337.76 remained because:

a) Some is cumulative from Q1-Q4 as was awaiting approval by PR for use in additional HR to aid in extended work related to HIV. The PR approved this usage in end of Q3 thus we utilized part in Q4 and we have projected to continue utilizing the rest for these manpower gaps it the next quarters of the grant implementation

b) Some is for continued expansion of new sites in the current grant for 2021-2023 by engaging staff under top-up in the new sites that will be functional. Expansion is done gradually as it involves ground assessments and fact-finding missions before proceeding; thus some cumulative balances from Q1 to Q4. It is worth nothing that more sites have been added to AAA in the updated PF dispatched in mid December 2021. The balance is therefore expected to continue being utilized in Q5 and continuation.

c) Some is cumulative balance from various positions under medical staff because of internal remuneration reviews but will continue to be utilized during the next quarters of the grant implementation.

- ***Budget Line 109: Provide operational support to 130 facilities providing ART/PMTCT.***

Positive variance of USD 627 remained because of 3rd participation support by AAA towards these costs to the programme but it will continue to be utilized during the next quarters of the grant implementation.

- ***Budget Line 110: Incentives for HCWs at ART, PMTCT and TB sites - SR1***

Positive variance of USD 12,300 remained because:

The verification of the actual number of HCWs at each allocated ART, PMTCT and TB sites was finalized and those verified were enrolled for incentives payment in October to December. In some sites though, the number of the HCWs presented in the initial list shared was contradicting

the actual situation on ground as some sites had more HCWs who were working. In these cases, we requested the sites administration (CHD/SMoH) to raise the issue with the HIV department in central level and the PR for way forward; thus, some of these incentives are still with us until clarification is made on who to be enrolled for payment. This attributes to the fact that some HCWs were not considered for incentives while they were providing HIV services in supported sites. Upon clarifications, we envisage to pay the Q4 incentives in Q5. On the same note, in some sites where the HCWs presented were less than what had been budgeted for, we envisage to enroll and mentor those already working. We also envisage enrolling the HCWs in some of the new sites that have been assigned to us for expansion in the preliminary Performance Framework dispatched to us by the PR in mid December 2021. These action points will ensure that the allocated funds are fully absorbed each quarter in the rest of the grant implementation period.

- ***Budget Line 357: AAA Programme Management Service ICR.***

Positive variance of USD 4,330.32 remained as 7% unutilized ICR for Year 1.

Third Participation:

As highlighted in the acknowledgement, to supplement the financial gaps realized during the implementation of the grant in the course of the year in areas that were not funded by the Global but deemed crucial for TBHIV service delivery, AAA sought financial aid from other well-wishers who stretched their hands with the aim of supporting the programme. These additional funds were mobilized by AAA through fundraising thus regarded as third participation towards the programme implementation.

Below are the summarized tables highlighting AA's 3rd participation to the GF TBHIV programme in the course of the year 2021.

1. 3rd Participation towards: AAA Field support for HR for servicing the GF TBHIV Programme		
No.	**Area of Intervention**	**Amount in USD**
1	**Costs associated with 3 TB Officers** (1 for Agangrial TBMU; 1 for AAA TBMU in Rumbek State Hospital and overseeing surrounding AAA DTCs in Matangai, Cuie-cok, Wulu & Aduel PHCCs; and 1 for Yirol TBMU but also overseeing attached AAA Mapuordit DTC; Adior and Bunagok TBMUs and attached AAA Mingkaman DTC). Costs supported include feeding & Visa renewals (GF budget only covered their salaries but not these costs associated).	2,620
2	**Payment of Support Staff (Cooks/Cleaners** for intensive care patients to aid in treatment adherence and lab sterilization; **night Guards** for safeguarding assets and other programme valuables) for **All** AAA sites. These support staff are crucial for supporting service delivery of GF TBHIV Programme but were	35,188

	not provided for in the GF budget.	
	Total	**37,808**
2. 3rd Participation towards: Operational costs for servicing the GF TBHIV Program		
No.	**Area of Intervention**	**Amount in USD**
1	**Emergency Maintenance of Motorvehicles:** Finalization of repairs for the AAA TB car and 2 bicycles in Agangrial TBMU; Repair of 3 GF motorbikes: for Nyamlell TBMU and 2 AAA DTCs attached namely Marial Baai and Gok Machar; Refund of battery for AAA TBHIV programme car for Nyamlell; and labour cost for repairing 3 GF motorbikes for AAA DTCs in Wulu, Cueicok and Matangai PHCCs; Purchase of spare parts for repairing Wau AAA car and labour; Servicing of Kuajok car; Purchase of spare parts and repair of 3 GF motorbikes for Kuajok AAA TBMU and 2 attached AAA DTCs in 2 different PHCCs; Purchase of spare parts and repair of 1 GF motorbike for Wau AAA TBMU Repair and service for the AAA TB car and 1 GF motorbike in Aweil TBMU; Spareparts for repair of 3 GF motorbikes: for Luanyaker and Wau TBMUs and Udici DTC; Battery for 1 GF UNDP car for Nyamlell TBMU and spareparts for 1 motorbike in Tambura TBMU. (All these motorvehicles are used for supporting AAA TBHIV programme through monitoring & evaluations, patients' follow-ups, outreaches and running other related programmatic errands.	4,792
2	**Provision of Emergency Diesel for vehicles and Petrol for motorbikes**: For Warrap State (AAA TBMUs, DCs and DTCs in Luanyaker, Kuajok, Tonj and Marial Lou); For WBeG State (AAA TBMU and DTCs in Wau); For NBeG State (AAA TBMUs and DTCs in Aweil, Nyamlell and Gordhim) For Lakes State (AAA TBMU in Rumbek State Hospital and surrounding AAA DTCs in Matangai, Cuie-cok, Wulu & Aduel PHCCs; and for AAA Mapuordit DTC in St. Mary Immaculate hospital attached to AAA Yirol TBMU. (All used for supporting AAA TBHIV programme through monitoring & evaluations, patients' follow-ups, outreaches and running other programme errands.	650
3	**Costs associated with Renovations/rehabilitation in existing premises:** Renovation of the TB patients pit latrine using local materials and labour – in AAA Yirol TBMU; Renovation of AAA TBHIV office for AAA Mapuordit DTC in St. Mary Immaculate hospital attached to AAA Yirol TBMU and repairs in Udici.	3,300
4	**Costs related to Laboratories:** New battery for microscope used in laboratory in AluakAluak PHCC AAA DTC; Installation of 3 LED Microscopes donated by NTP for Gok Machar, Mayen Ulem and Marial Baai PHCCs AAA DTCs attached to AAA Nyamlell TBMU.	631

3	**General Running Costs:** Like hygiene materials, internet for reporting, minor emergency repairs like bulbs, photocopies, little petrol, DSA for drivers during outreaches etc for **All** AAA TBMUs/Sites and attached DTCs - including cost of rent for Aweil TBMU where AAA stores TBHIV program items.	8,025
	Total	**17,398**

Total 3rd Participation by AAA towards GF/UNDP TBHIV NFM 3 in 2021 was USD 55,206

Procurement and supply management

The management of items supplies/purchased is well tended and is 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 and during SR Reviews.

There is 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.

The major assets and equipment are purchased directly by the PR. AAA as an SR only purchases minor purchases to aid in the program implementation depending on budget availability. Examples of these are diesel, petrol and spare parts for the motor vehicles and motorbikes used in the different sites.

Within the year, AAA was able to purchase diesel, petrol and spare parts for the motor vehicles used in serving the TBHIV programme. The SR also paid for flights for the M&E officer, programme staff and NPHL consultants during back and forth movements for supervisions, mentorships and other related programme tasks and/or activities.

Further, from the additional budget linked with HIV modules implementation, AAA was able to purchase stationery and hygiene materials as part of providing operational support to 130 facilities providing ART/PMTCT (budget line 109) from Q4. Additionally, from the same period, AAA was involved in the provision of service contracts to courier companies for facilitation of sample transportation (budget line 260).

All other costs linked to minor procurement like infrastructure maintenance /rehabilitation of various structures related to TBHIV programme and some general running costs for the TBMUs were supported through AAA's 3rd participation. There were also some costs associated with 3 TB Officers (like visas, feeding, internal transport, registration etc); some additional diesel, petrol among others which were also supported through AAA's 3rd participation as shown in the table above.

Further, through own resources, AAA was able to purchase some items related to laboratories. These include a new battery for microscope used in laboratory in AluakAluak PHCC AAA DTC,

installation of 3 LED Microscopes donated by NTP for Gok Machar, Mayen Ulem and Marial Baai PHCCs AAA DTCs attached to AAA Nyamlell TBMU.

Despite the facilitation of these purchases through AAA 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 what happens:

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 TB Officers from different TBMUs/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 a AAA's specialized Consultant Mechanic who signs besides the Activity Report.

In cases where transport is involved, selection of the transport 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.

In regards to the stationery and hygiene materials purchases for the ART/PMTCT 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 because of 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 various TBHIV Programs:

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

- Supportive supervision visits
- Monitoring
- Tracing of patients Lost to follow-up
- Running any other authorized/approved programmatic errands

Prior to the approval of any new fuel procurement to the TBHIV Programs, the Project Manager (TB Expert) must have both copies of the Work plan and Logbook from the various TB officers.

- ♦ Work Plan: The document is a reflection of the TB 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 TB 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 Program/ TB Manager.

With both the Work Plan & 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 Work Plan.
- 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 Work Plan but were sanctioned by the Project Manager (TB Expert) e.g. pick up of drugs donated by NTP.
- Armed with the outcome of the above determinants plus the New Work plan, 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 Logistic / Procurement officer for Quotation from various suppliers.
- On 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.

ASSETS

In the year 2021, AAA received an in-kind donation of one Toyota Land Cruiser Hardtop 13 seater for use in supporting the TBHIV Programme. The vehicle was assigned to Gordhim TBHIV programme by the management following the site's busy status yet the vehicle that was operational there had been grounded because it was very old and beyond repair having been donated in 2005.

It is worth noting that AAA has maintained the records of all the assets provided in 2017 and formally transferred to the NFM2 and now current NFM3 grant for continuity of project implementation. Focal persons are also in place as custodians of these assets. All assets are evenly distributed in the implementing locations as reflected in the Statement of Assets and Equipment as of 30/06/21 and 31/12/21 which also reflects their recent estimated value. This Statement is affirmed by signatures of both PR UNDP and SR AAA. The assets are: 3 Vehicles, 26 Motorbikes and 110 Bicycles.

Methods in place for safeguarding assets:

- AAA has no GF/UNDP asset in Nairobi and Juba offices. All assets are in the field TBHIV Programme locations in South Sudan.
- The three vehicles provided have their fitted tracking devices on. As noted in the assets preamble, appointment of focal persons responsible for safeguarding the assets is in place.
- Through regular physical verification of the assets in the field whereby the HQ always receives, updates on the asset list every 5 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 H/Q 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.

CHAPTER 2: CURRENT PROJECT MANAGEMENT ARRANGEMENT

Project Management:

The Global Fund TBHIV NFM3 grant is managed by the Project Manager (TB Expert). He is the overall overseer of all Program activities. This is made possible through the support of the field staff under the leadership of the TB Officers.

The Project Manager (TB Expert) is responsible for monitoring the programme activities and to ensure that they are in line with the approved work plan in order to achieve the set targets. This is with the support of the M&E Officer.

The Project Manager (TB Expert) is also involved in the decisions pertains the recruitment, retention and capacity building of staff.

He also ensures that the Program needs are met which may include; timely supply of drugs, availing the right equipment and offering technical assistance whenever a need arises.

He also oversees the procurement of items as required and is also responsible for forging alliances with other agencies involved in health care delivery in the areas of integration of TB services in the PHCC system. The Project Manager (TB Expert) is the focal contact person for the Program and is the link between the donor agency, the Ministry of Health, NTP and the Program.

The Project Manager (TB Expert) ensures proper management of drug supplied as all the field TB Officers prepares the drug orders using a standardized format which is submitted to the Project Manager (TB Expert) for verification and review. The Project Manager (TB Expert) then submits the orders to the NTP, makes follow-up to ensure the drugs are delivered and contacts the field officers regarding delivery and quantities.

The inventories from the field, consumption records etc are also submitted to the Project Manager (TB Expert) for reviews.

To ensure smooth operation, there is a National Program Officer based at the Country office in Juba, the Program Officer is responsible for all the follow up of Program issues in Juba through the Ministry of Health, NTP, UNDP and other partners.

AAA has a Finance Director who is responsible in managing all the Program funds. The Finance Director in collaboration with the Project Manager (TB Expert) ensures that the funds are utilized as per the work plan to meet the expected end-deliverables. Approval of the expenditures is done in consultation with the Project Manager (TB Expert) and the Project Administrator/Director.

The TB Officers 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 TB Officer or Program Officer.

The AAA M&E officer in conjunction with the Project Manager (TB Expert) are responsible for all the data collection and reporting activities, monitoring of the Program activities to ensure that it is in accordance with the set work plan, prioritizing the activities as required, capacity building, verification and analysis of data and submission of the quarterly reports.

The TB officers 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 trainings and sensitizations on data collection and verification to lower cadres.

Follow - up of the program matters (technically and financially is on a continuous daily basis). Reports submission is on a Monthly basis for evaluations and feedback before the Quarterly compilation for reporting to the PR within the set deadlines.

Finance Management:

The Finance Director is under the leadership 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. Cash withdrawals are made through 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) of the prepared and projected withdrawals after analysis and approval of the programme needs by the Finance Director and the Project Manager/TB Expert. Cheques are signed by two people; the Project Manager/TB Expert and an external person in Verona Fathers' who is a Volunteer for us but the Administrator there. In the reporting year, there was continued liquidity scarcity in the banks of South Sudan for all currencies resulting in an increased use of cash.

The TB Officers 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 TB Officers and/or Program officer.

During the implementation, the Finance staff (under grant management) as are mobile to the field locations, are in charge of monitoring that funds are used in line with what they were approved for during their field visits to the sites where they verify the expenditures before submission of the original copies to H/Q for analysis and filing to await PR review and audits as only photocopies are retained in the field locations.

The Project Manager (TB Expert) together with the M&E officer also assists in verifying that approved activities were actually implemented through the approved funds.

The Project Accountant with the Finance Director keeps all the financial records. Usually, expenditure entry is on a daily basis. Bank balances follow up is done on a daily basis following occurrence of transactions where a daily statement is sent by the bank. Accompanied by these are the monthly statements. Additionally, bank reconciliations are prepared on monthly basis by the Project Accountant, reviewed by the Project Manager (TB Expert) and approved by the Project Administrator/Director.

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.

Regular back-ups are done in the information systems and the back-up disk stored safely.

AAA operates a bank account specifically for the TBHIV grant as a way of increasing transparency in the utilization of the funds.

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

Human Resources:

AAA had an average of 425 (GF/AAA supported) staff and HCWs involved in the TBHIV implementation in year 2021 as illustrated in the "organizational organogram" These staff and HCWs services various AAA TBHIV sites situated in across (26) counties and located in five (5) established States in the Republic of South Sudan as stipulated under subtitle "Project areas".

In HR Management, the Program Manager (TB Expert) with the help of the TB Officers are responsible for recruitment and retention of the Staff. Jobs vacancies are advertised locally and the TB 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 has either:

1. **Contracts:** These are directly employed by the SR to implement the program after thoroughly capacitating them in order to retain them and make them in charge of the program. These are not under GoSS payroll. Originals of these are kept both in H/O and in the field under custody of TB Officers.
2. **Agreements**: These are under Top-up/motivation by SR as they are under GoSS payroll. The SR maintains them by topping them up in order to offer their services to the TBHIV program. Originals of these are kept both in H/O and in the field under custody of TB Officers.
3. **Internal Arrangements with Internal Agreements:** These are for the HHPs who only get incentives. All these are kept in the field under custody of TB Officers as HHPs report directly to them.

Job descriptions are attached to the employment document.

Under normal circumstances, TB officers 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; the Home Health Promoters sign the attendance sheet on monthly basis when they are submitting their monthly reports. The documents are shared with the Project Manager (TB Expert) and Finance Director for approval of the payment.

Approval of salaries is bound on the TB Officers submission of salary 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.

It is worth noting that from Q4, AAA was tasked with the payment of incentives for HCWs at ART, PMTCT and TB sites. 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 the 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 - Presented by the incharge under SMoH and Confirmed by the incharge officers under AAA.

Ongoing traits to improve on quality of work delivered by HR (former) and (newly recruits in new sites):

Capacity Building: AAA TB Officers and the M&E Officer continued/continues to carry out on site mentorship of the programme staff in the course of the year. The focus is on bench training of TBHIV Management and referral of presumptive TB cases to the nearby TB units.

As noted under "**3rd participation**"; in 2021, AAA realized that it was of paramount importance to seek funds from 3rd participants to fill in some gaps essential to aid in the achievement of expected grant results. This meant maintaining some crucial human resource that was not considered in the approved budget for NFM3. These are 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, microscopes etc are stored). Through 3rd participation, AAA was also able retain some TB Officers through provision of their visas, feeding, registration costs etc. Because of these resources from well wishers, AAA was able to maintain all these staff in service of the TBHIV programme and the same recruitment, management and reporting procedures applied for the staff funded under Global fund grant were also applied in these staff supported under 3rd participation.

Other forms of management applied in the reporting year.

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 ensures 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 DR is provided by the referral health facility, which is also attached to the payment sheet as a supporting document.

Trainings Management:

In 2021, AAA embarked on the implementation of the TB and TB/HIV trainings that were approved in the signed agreement in January and those related to HIV modules, which were part of the amendment No.1 signed in September.

All the Trainings were/are managed as follows:

- All Trainings conducted are in line with the approved budget and topics sent by the PR in relation to the RoSS MoH policy and guidelines.
- The Project Manager (TB Expert) shares with the facilitators the trainings scheduled to be conducted within the quarter. He receives suggestions from them on the No. of attendants that may benefit in each training (depending on ground needs and why) in order to factor in these while working on the trainings schedules.
- After this engagement with the facilitators on ground 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 in each site. This includes the no. of days earmarked for each training, no. of participants and the per diem rates of the participants.
- In major trainings, the Project Manager (TB Expert) may develop 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 2021 trainings, at the inception phase of the trainings, an external ToT may be hired to capacitate the TB Officers and other senior HCWs in the TBMUs in order to empower them train low cadres.
- In addition, 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 TBMUs that will conduct the trainings, the period of training (not fixed as change in dates may occur during the preparation), the No. of participants to attend the trainings and the per diem (DSA) each attendant will get.
  - 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 facilitators.
- After dispatching the training schedules, The Project Manager (TB Expert) with the support of the selected technical/finance team prepares the requisitions for the location's 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 No. 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.
- 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 verify.
- The reports are also sent upon completion of each training. They are sent to the Project Manager (TB Expert) and M&E Officer for review.
- The Original copies of the documents are retained in the H/Q.
- The replicas of all the trainings support documents are presented to the PR (UNDP) Office for LFA.

CHAPTER 3: SUCCESSES AND ACHIEVEMENTS

The TBHIV project has managed to carry out the planned activities within the time frame and budget limits provided. The project's 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 and continuous mentoring of the national staff on programme management. The project hierarchy is also well established as per the organogram shown on page 12 and interlinked with other departments such as procurement and logistics.

During the just ended year, AAA signed an amended SR agreement in September where HIV modules and interventions were allocated. The 4 HIV Modules were as indicated below:

- Differentiated HIV testing services with an intervention focusing on facility based testing where AAA carried out health care worker training where participants were drawn from State and County level hospitals. The HTS trainings were carried out in 4 state hubs. The HCWs from various health facilities were selected by the SMoH authorities, as they were the ones who took the lead in the facilitation of these HTS trainings. They were carried out for 5 days each. 81 HCWs (41 males and 40 females) benefitted from the conducted HTS trainings. HTS being an entry point to the HIV service as it is meant for diagnosing HIV early and correctly in order to scale up impact HIV interventions. This is the reason the donor allocated some specific financial support for this activity, so that after the training all staff involved in the HIV programme will end up delivering quality services.

- Out of the 4 elements of comprehensive PMTCT, AAA was allocated funds by the PR for Prong 3 only, which focuses on preventing HIV transmission from women living with HIV to their infants. In the process, AAA held several meetings with HIV networks e.g. NEWPU and SSNeP+. The HIV networks are involved in tracing of PLHIV who interrupt treatment, awareness creation and drug refills for those patients who are unable to go to the facility for the same. The activities that the networks were involved in were outlined during these meetings. Consensus was reached on how to work together and generate reports for the activities conducted in AAA operation areas. The upcoming Annual State level review meetings with mentor mothers was also discussed and the best way of planning for the same was agreed upon by all members. The AAA programme staff took time to encourage the pregnant women and mothers with infants who attended the PMTCT and the Postnatal visits were also explained on the importance of early infant diagnosis and benefits of early ART for infants. This approach resulted in having 12 EID samples taken for screening either at the PHL, Juba or at the hub laboratories. 7 infants were positive for HIV and 5 were negative.

- On monitoring the treatment of the PLHIV, HIV viral load monitoring remains the golden standard for monitoring the virologic response to ART. With this AAA moved with speed to ensure that samples from PLHIV were collected and sent out in the course of the quarter, hence thus 33 PLHIV had their samples sent out for Viral load testing. The overall results that were received from the PHL were as outlined:19 patients had less than 1000 copies /ml and 14 patients had more than 1000copies /ml.

- During the year, the main focus was on the integration of TBHIV services in 12 health facilities that the PR had allocated to AAA especially those in high burden areas like

Warrap State, 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 gave good outcomes as all TB patients (drug susceptible) registered (5746 cases) in the 2020 had their treatment outcomes evaluated as either cured or treatment completed (4608 cases) that showed a treatment success rate of 93% which is above the WHO End TB Strategy Standard.

- 186 out of 211 re-treatment DR-TB cases that had been registered in the course of the year had their sputum samples processed by Gene-Xpert machines in various sites. 54 DR-TB patients were identified out of these samples and had 52 cases initiated on 2nd line treatment. 37 DR-TB patients that had been registered in the cohort of 2020 had their treatment outcomes evaluated and it showed that 34 patients had completed treatment giving 92% 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 TBHIV NFM3 year1 Grant, the following key successes in addition to the above cited, were also noted:

Deliverables	**Achievements**
Number of ANC visits, that were more than 4 visits in the year	6689
Number of HIV positive mothers at the ANC	89
Number of HIV positive mothers linked to care	65
Number of clients who were tested for HIV in the year	2906
Number of clients who were diagnosed HIV positive	240
Number of HIV positive clients	199
Number of people who received TBHIV messages in the year	114,139
Number of Patients with presumptive TB examined in the laboratories	16,943

Number of Patients with presumptive TB cases examined with positive bacteriological examination results	3587
Number of TB patients tested for HIV	5454
Number of co-infected TB patients	652
Number of co-infected TB patients initiated on ART	638
Number of Co-infected TB patients provided with CPT	619
Percentage of new smear positive patients whose smears converted at either 2 or 3 months	2717/3127(87%)
Number of supportive supervisions and mentorships conducted to the TBMU staff	4
Number of Quality Assurance visits conducted from the main TB units to the peripheral health facilities	45

- 25 HHPs (BHWs) monthly feedback meetings were carried out.
- 17 Integrated feedback meetings conducted where all the HHPs (BHWs) and health workers met and discussed challenges they faced and also get lists of names of TB patients from the TBMU registers who might have required immediate follow-ups.
- 60 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.
- 30 assorted IEC materials with basic facts on TB distributed in the community.
- Although there was no direct budget line for commemorating the annual WORLD TB DAY that is always 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 "THE CLOCK IS TICKING!"

In the course of the 2st semester of 2021, AAA was invited by the UNDP and NTP so as to participate in the following:

- SR Review Meeting that was carried out in August by the PR whereby each TBHIV implementer was called upon to highlight the activities carried out, the achievements and the bottlenecks encountered and how they managed to over the same.
- There was another One-on -One Review meeting with the PR. AAA presented the programmatic and financial performance and it was satisfactory to the PR as everything was on track. The indicators lagging behind was discussed in details and then agreed on the strategies to be employed so that the target may be met.
- AAA attended the PMDT training that was conducted by WHO rGLC in Juba which was virtually conducted for 5 days.
- There was another MDR TB management training in Juba where most of the AAA staff were invited and attended the same.
- 2 PR staff conducted support supervision visit in 2 health facilities of Northern Barh Ghazal state. The findings and recommendations from the visit were shared with AAA so as to work on them. One of the recommendations was for the key staff to be trained on MDR TB management. This was achieved within the quarter, as 4 key staff from NBeG State

health facilities were invited and trained on MDT TB management in Juba. The HIV R&R tools had already been ordered and awaiting the supplies from the Warehouse, Juba. Still negotiating with the Aweil Hospital administration as regards the reinforcement of the lab room where the GeneXpert machine is installed.

In order to strengthen TB and HIV activities and improve on the quality of the services rendered; capacity building of the programme staff, engaging the NPHL staff so as to mentor the staff on EQA , IED and Viral load ,the key programme staff were invited to Juba to attend the MDR TB management training, supportive supervision activities for mentorship and on-site training 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.

All the HIV staff were verified to ensure that committed staff remain on the management of the HIV programme. All allocated HIV sites were assessed for suitability of TBHIV integration and the findings submitted to the NTP/HIV and PR for considerations, as the gaps identified were to hamper the implementations unless addressed. The 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 using an approved checklist. During the visits, on job 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 centers that ensure all the programmatic and financial reports are 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 HHPs (BHWs) were assigned patients in their catchment areas to ensure that none got lost to follow up, Door to Door screening of the contacts of the index cases for both drug susceptible and drug resistant TB was carried out.

Success Story:

Mr. Ezekiel Door kuek a 49yrs old male was brought to Aweil state hospital by his wife when his relatives and neighbors have already lost hope that he was never to survive again after he had been taken to many witchdoctors and tried a lot of local herbs and he could not get relief.

He presented with difficulty in breathing, blood cough stains and smelly greenish sputum, weight loss and high temperature. With all the above-mentioned presentations, he was first suspected to have contacted covid 19, and he was forced into isolation, there after went to the covid 19 state level taskforce for intervention. He was tested and the result was negative.
The parents again lost hope saying they don't know what else could be the problem with the old man until the clinical officer from the outpatient department accompanied them to our TBMU for TB investigations and narrated the patient medical history to us.
The unit managed to do the TB microscopic test that turned out negative, however we decided to initiate treatment basing on the clinical presentation and we continued monitoring the patient closely for two weeks.
After close monitoring, and anti TB medication for two weeks, the man reported a steady improvement following the drug intake, and it was also noticed that he was later in position to walk alone without any support from the family members.
Two months later the patient walked to our facility from a distance of 15 km away from the hospital all by himself.
The wife together with the patient were happy and gained so much confidence in the treatment extended to her husband and they continued to appreciate the health team for work well done. They pledged that the patient shall continue taking his medication until he was discharged from the treatment and they promised to be our ambassadors within their community.

Before and after photo of MR. Ezekiel on two months anti TB treatment course

Lessons Learned:

1. Community engagement and buy-in of the community leadership are essential when addressing TB, HIV and emergence crisis like COVID 19.
2. Concerted efforts by the HIV response to close service gaps and eliminate TB and HIV

disparities offer a way forward for optimally inclusive COVID-19 responses. The HIV response should invest focused efforts to ensure that no one is left behind, including joint planning.

3. For quality programme implementation, joint supportive supervision visits should be embraced at all levels. This helps as during these field visits , mentorship and couching of the field programme staff always takes place to correct some minor data errors identified in the R&R tools.
4. Shifting from standardized to differentiated HIV service delivery is the way forward as options for HIV include scaling up the testing approaches like community-led testing (through community outreach, hotspot testing or mobile services), provider-initiated counselling and testing in diverse health service settings and HIV self-testing kits that allow people to learn their HIV status in the privacy of their own home.

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 are 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 included:

1. It takes time to put things in place as regards reviving HIV services in HIV health facilities that had been running HIV services using HIV R&R tools that are outdated.
2. Delay in receiving supplies e.g. HIV R&R tools and HIV test kits on ground
3. Verification of HIV staff offering services. Some of the staff had already relocated to other programmes but their names were still on the HIV payroll.
4. Widespread flooding in areas of operations that hampered the planned outreach activities in remote villages.
5. Insecurity in some of the catchment areas e.g. in Tambura and Tonj North counties where the affected communities relocated.
6. The performance on the number of samples taken from HIV Exposed Infants for EID was low and this was due mainly to multi-months dispensing (MMD) of ARVs to pregnant mothers up to 6 months. Mothers don’t timely bring their babies for sample collection for EID as they see the point.

Way Forward

- HIV staff to be assigned to pregnant mothers so that samples are taken within 2 months for EID
- TB and COVID Health Education integrated messaging should be made as a Policy by the National MOH, as this will make it easier for the health care workers to plan accordingly.

- Integration of TBHIV services in some health facilities that are managed by other partners (whose TB is not their mandate) is and has remained a challenge therefore, the MOH Health Policy guidelines that recommend for the TB integration in all PHCCs is well understood and practiced at the lower levels(County and State), as this will help when it comes to new partners integrating TB in the existing health facilities.
- More mentorship/field supervisory visits should always be embraced at all levels as during these visits health care workers are bench –trained about TB care and management.
- AAA will continue working hand in hand with all levels of Government and the donor community including other stakeholders.

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

- HIV R&R tools and HIV test kits ordered should be supplied timely to all the HIV sites, to ensure that comprehensive services are offered.

- The findings of the Health facility assessments that were carried out by joint team of AAA and SMoH and then shared with the HIV department /NTP and PR should be considered, as mostly the HR gaps in those health facilities were identified as being challenges.

- All the clinical/zonal mentors in AAA operation areas should be encouraged to work hand in hand with the AAA programme staff, for efficiency in the TBHIV programme activity implementation.

Annex 2: Some photos that were taken in 2021 when TBHIV activities were being carried out:

AAA staff and the area HHP visiting the TB patient at his home for TB drug refill

One of the children that was brought to the TB unit with Extra-pulmonary TB

Brand New Landcuriser that was donated to AAA by the PR to support programme implementation in NBeG state

The DG MoH Western Equatoria State,posing for a group photo with the Prison health personnel after TBHIV training in Yambio

Warrap STBHIV coordinator facilitating one of the Trainings in Kuajok