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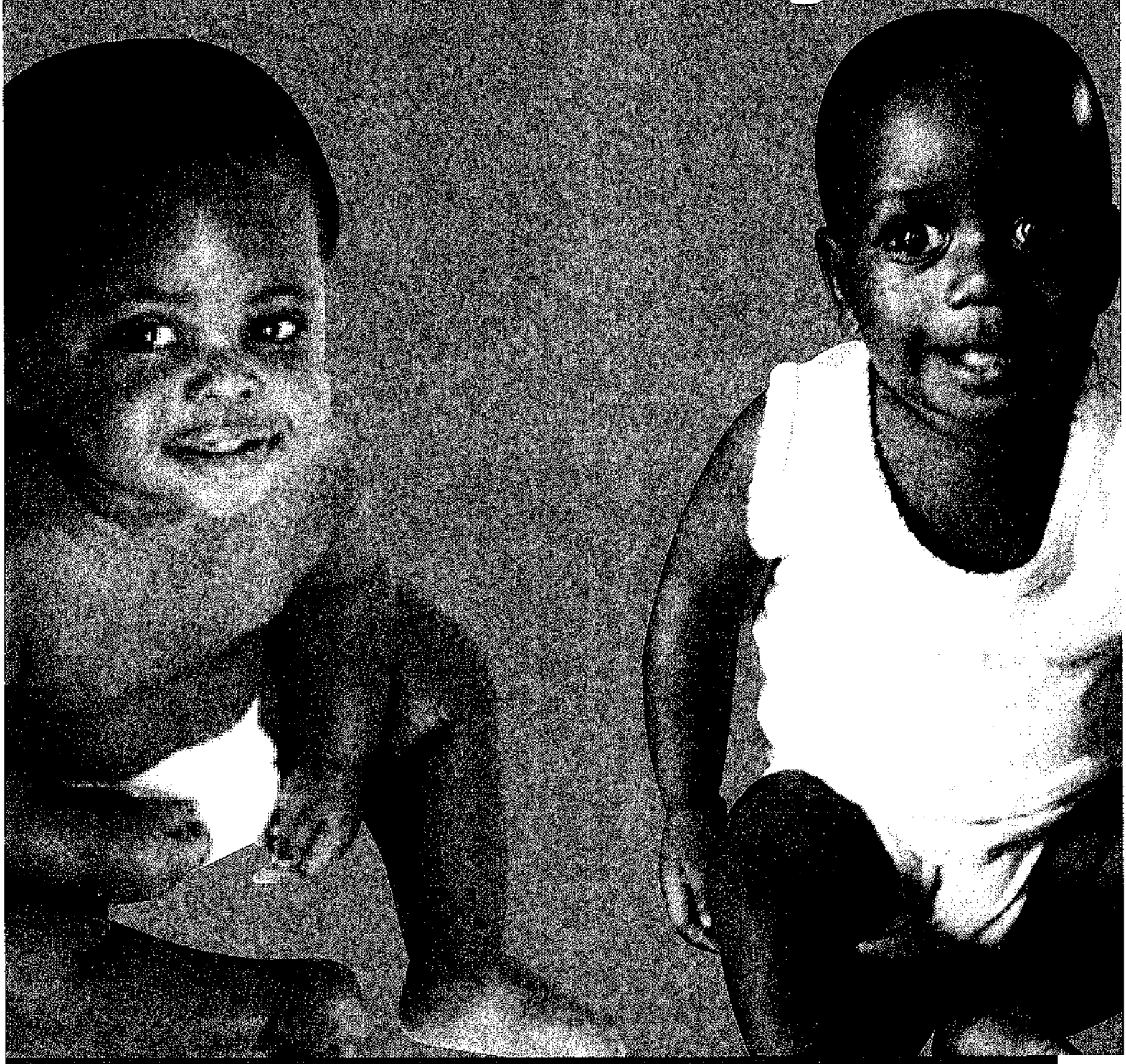

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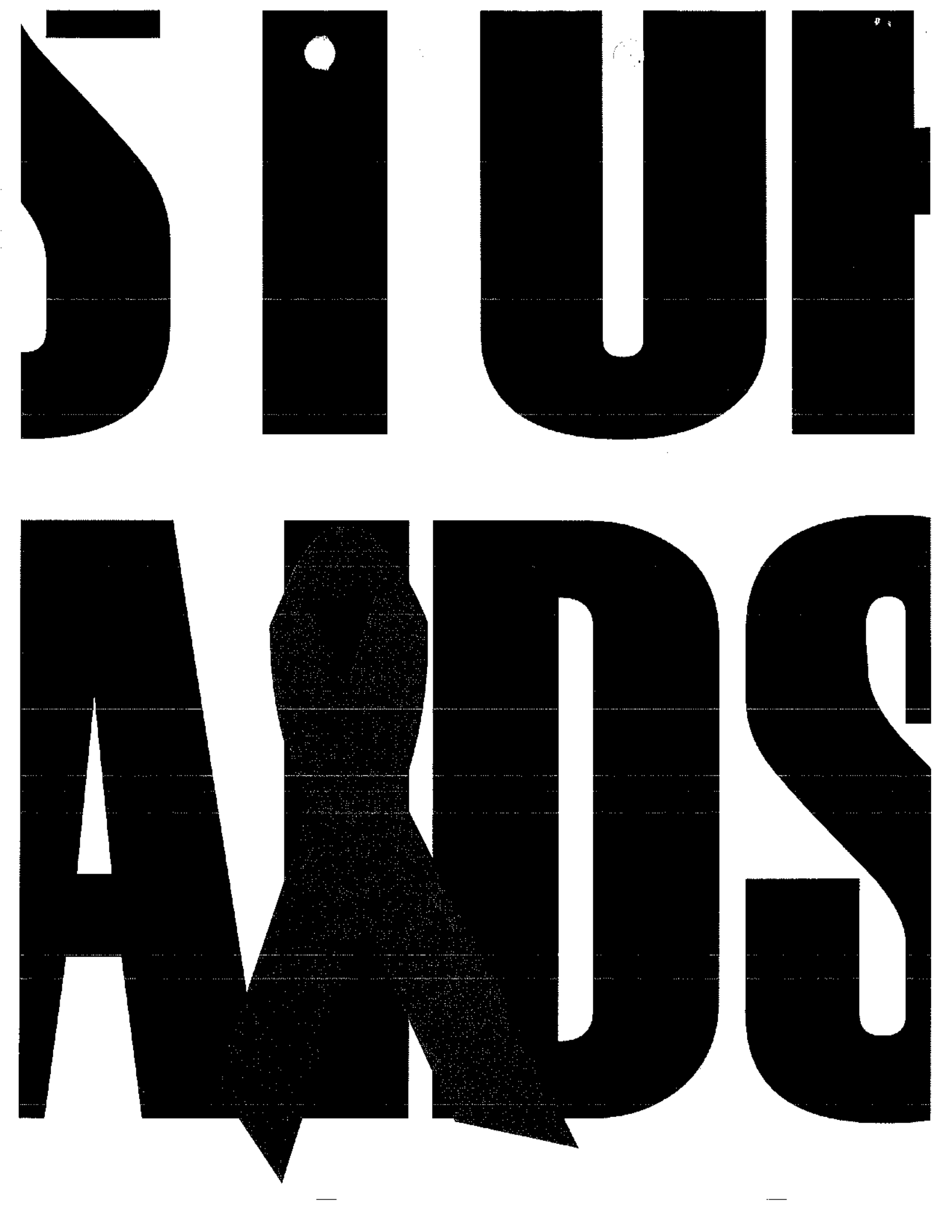
AIDS

Response to CDC Comments on ANISA Year 3 Report

***Note that CMMB is re-submitting its Year 3 APR with revisions based on CDC comments in red text.**

Page 4-"Care and Support-10 service outlets providing HIV-related palliative care" - it is not clear what sites CMMB is referring to or what was accomplished at these sites? Please provide information on the 10 service outlets and more information on the 155 individuals trained to provide palliative care.

The 10 Care and Support services outlets referred to in the report are Social Support group centres. These broken by counties are: Safe Haven, St. Bakhita, Napere refugee camps support group (Ezo county); Rainbow (Nzara county); Bodo, COPE, NACASO, Star group, USAP and ZAIC (Yambio County).

The 155 individuals trained to provide palliative care are community care-givers who are drawn mostly from support groups and trained by Anisa to provide home-based care, support treatment adherence and disclosure, and provide messaging around PwP.

Page 5-Second paragraph states "with Nzara's prevalence the highest at 15%." The executive report, page 2 stated that the highest prevalence was Ezo with 13%. Page 6 states Ezo was the highest also. Please verify which is correct.

This was a mistake in the narrative; the project-level Year 3 prevalence rates are below:

County	*Total tested*	*% positive*
Yambio	*7102*	*8.1%*
Nzara	*4760*	*12.4%*
Ezo	*4111*	*13.1%*
Ibba (Q1 Only)	*240*	*3%*
Total	*16,213*	*10.6%*

**Ibba prevalence rate not included in total project-level prevalence rate calculation. Data from Ibba was only from Q1.*

Page 6-"the report of the exit interviews will be used to inform HTC services for the coming project years." If this CoAg supported these exit interviews, it would be worthwhile to add a paragraph on the findings.

Client exit interviews were done at the beginning of the year to measure clients' satisfaction of HTC services. This survey was conducted in three sentinel sites Western Equatoria State namely Yambio VCT, Ezo VCT and Nzara VCT. 150 clients were randomly interviewed after HTC by a consultant. In each location selected, fifty clients were interviewed. Generally, most of the clients had positive views on the survey and considered that it was better compared to other public services. The majority (>75%) of clients waited less than 30 minutes to see a counselor, and

100% of clients were satisfied on multiple levels with their counselor, including relating to client privacy, thorough discussion of risk reduction behavior, attention to clients, and willingness to discuss concerns and personal issues. To be improved upon is consistent condom demonstrations (78% of clients reported being given a demonstration) and open-mindedness of counselors (88% responded that they felt their counselor was non-judgmental). Overall, 88% of clients were satisfied with their services, and 12% felt the services were excellent. The report of the exit interviews will be used to inform HTC services for the coming project years.

Page 8-"It is estimated that 81% of births in WES are done by TBAs and village midwives, with >15%births having skilled attendance (UNFPA). CMMB was inspired to work with the TBAs based on these findings." Will the final project report assess what change has occurred since the original assessment at the beginning of the ANISA project in 2009?

The final project report will include a best practices document relating to both TBAs and Mentor Mothers and their roles in the program. The document will also include how the TBAs became involved in shaping the outcomes of PMTCT in the project area.

Page 8- In Year 3, Yangiri PHCC started providing PMTCT services (May 2011), but there is no mention of this in the report. The PMTCT summary appears to only have figures from Yambio, Nzara and Ezo. Please provide information on the Yangiri figures and how these affect the overall PMTCT numbers.

From May 2011, Yangiri PHCC served as a fixed outreach point, with PMTCT outreach services provided every 4 weeks. The data for Yangiri in Year 3 appears in Ezo County roll-ups.

Page 9, paragraph 4-"Exposed infant testing for HIV with success rate of 88.2%..." This is a very important figure yet no details were mentioned in the report. Please provide information on how many babies were tested and how many were positive?

Exposed babies in the PMTCT program are tested at 9 months and repeat-tested at 18 months. Year 3 results are below:

	Babies tested	*Babies HIV positive*	*Success rate*
Q1	*98*	*13*	*88%*
Q2	*56*	*8*	*87%*
Q3	*99*	*12*	*88%*
Q4	*69*	*5*	*93%*
Total	*322*	*38*	*88%*

Page 11-"The ANISA project has had discussions with CDC South Sudan and has decided to put more effort on groups that are more likely of having HIV, such as the girls referenced above. This made ANISA in Yr 3 to scale down AB only interventions, and resources were more directed to reaching out to sexually active **adults**." The concern was with young girls starting sexual debut at a very early age, so the reviewer is not sure why the efforts are directed to adults and no mention of efforts directed to these young girls?

The PEPFAR prevention team that visited WES advised the project to focus attention on the population that is most likely to be positive; therefore, CMMB prioritized its attention to at-risk adults. However, through previously trained young lady peer educators, prevention messaging and condom demonstrations continued to reach high risk young girls during Year 3.

Page 12-"ANISA adopted and designed condom promotion leaflets with pictures showing correct use of condoms and benefits." It would be useful to include these as an attachment to the report.

This is attached.

Page 14-This Basic Care Package provided at clinic settings consists of cotrimoxazole prophylaxis, screening for active TB, distribution and education on the use of condoms, linkages to local PLHIV support services and CD4 staging." What about referral for ART and screening for STIs?

This was an error in the narrative with CMMB neglecting to mention these interventions. Referral for ART is one of the priority activities being done, and both the HTC and Care and Support team assist in following up to ensure PLHIV report to the ART clinic. Screening for STIs is also being done.

Page 15-IR 2.4 Stigma and discrimination-80 participants were trained on stigma reduction and discrimination. These numbers should also be reflected in the Excel spreadsheet APR report.

These are included in the spreadsheet and revised report, indicator H2.2.D.

Page 16-SO 3 Build and Strengthen…paragraph 1-"100 uniformed forces were trained." These numbers should also be reflected in the Excel spreadsheet APR report.

These are included in the spreadsheet and revised report, indicator H2.2.D.

Page 18- Please clarify what is meant by empowering PHCCs to perform HIV/Syphilis rapid tests. Is this in response to expanding Provider initiated testing and counseling?

For project sustainability beyond ANISA, PITC has been introduced and as well laboratory staff have been trained and mentored in carrying out STI and opportunistic infection diagnostics.

Page 18-"ANISA also suggests establishing an External Quality Assurance (EQA) programme for malaria and TB slide examination. We will follow up on this in Year 4." Please discuss this with Joel Katoro CCD Laboratory Advisor.

This was discussed with Joel Katoro and found not possible within this CoAg at this time.

ANISA
COMING TOGETHER TO MEET
THE CHALLENGE OF HIV/AIDS

CMMB
CATHOLIC MEDICAL MISSION BOARD

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

ANISA Project

CDC Award No: 5U2GPS001632-03

REVISED Annual End of Year Report: Year 3

September 30th 2011-September 29th 2012

Submitted to: CDC/PEPFAR Sudan

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Executive Summary

Catholic Medical Mission Board is implementing Project ANISA in Western Equatoria State (WES) of The Republic of South Sudan. This report covers the period October 2011 to September 2012, the third year of the project. Achievements, challenges and lessons learned in Year 1 and Year 2 of the project have been very instrumental in the progress made in Year 3. The project currently covers three counties of WEQ State, namely: Yambio, Nzara, and Ezo.
South Sudan gained independence in July 2011 and this has led to improvement in security in some parts of the country, yet the economic situation remains challenging with the close of oil pipes. WES, particularly where ANISA Project is implemented, has had limited threats of LRA rebel activities and more people have left internally displaced camps for their ancestral homes. ANISA has worked towards extending HIV/AIDS services outside the town areas serving the most HIV affected areas like Ezo County among others. The Government of South Sudan continues to revitalize health care services in those areas despite tough austerity measures. ANISA project has continued to prevent new HIV infections as well provide care and support to HIV-infected persons in WES of South Sudan.

ANISA activities have progressed well in FY3, mainly focusing on capacity building and mentorship of the existing government staffs, community based structures and volunteers that CMMB is directly working with. So far, the ANISA program has successfully integrated into the existing primary health care services in health facilities with the aim of identifying more positive people and putting them on treatment.

HIV Counseling and Testing (HTC) reached 16,213 clients, 81% of the annual target. Of this number, 1,740 tested HIV-positive, reflecting a project-level prevalence of 10.7%. Prevalence varied from county-to-county, with Ezo prevalence the highest at 13%. In FY3, ANISA worked towards laying ground for PITC services. CMMB has developed linkages with health facilities to ensure that HIV counseling and testing is adopted within the primary health care systems. Strategies to scale out PITC at all health facilities were challenging at the beginning due to limited health worker at the PHCCs owing to the programmatic settings of the government staffed health facilities.

During FY2, CMMB established a static PMTCT location in Ezo, adding to the two clinics in Nzara and Yambio Town. Outreaches serving more than 16 communities have also been established to follow up pregnant HIV-positive mothers and as well recruit others for testing and counseling. 2,830 pregnant women tested and were given results at the ANC/PMTCT settings, out of which 11% of the mothers were found to be positive. ANISA devised a strategy of using Traditional Birth Attendants, and Mentor Mothers (mothers living positively via ANISA program) to ensure follow up for complete adherence to the PMTCT protocols, which has been successful in its early stages.

The community-based project component is implemented through a sub-partner World Vision with technical support from CMMB. In year 3, ANISA exceeded the target by reaching 43,121 individuals with evidence based prevention message in small groups/individual settings accounting for 144% of the annual target 30,000 set for year. Challenges experienced include a modality of motivation for the peer educators to ensure commitment.

The ANISA Care and Support team provided 6,371 persons with related palliative care at least once by a trained home-based care giver, reaching 64% of the target. A total of 1,965 men, women, and children received cotrimoxazole prophylaxis during FY 3. ANISA works closely with local community support groups of PLHIV (6 in Yambio, 1 in Nzara, and 2 in Ezo). ANISA HTC and PMTCT counselors refer clients to these groups; therefore ANISA clients are direct beneficiaries of the palliative care facilitated via the support groups. Many of the active members have been trained as home based care givers. Through these support groups, 2,771 PLHIV were reached with a minimum package of prevention with the positives achieving 69% of annual target.

A component of ANISA project is focusing on strengthening health Systems to respond to HIV/AIDS in WES. In Year 3, ANISA conducted interactive workshop for community leaders and uniform forces including the headmen, church leaders and Youth leaders. These persons are gatekeepers to ANISA intervention communities. ANISA also trained 100 uniform forces targeting police, prisons, wildlife and military officers. The idea was that Police and prison staffs will become important agents for behavioral change in reversing the spread of HIV if equipped with the right information.

In June, top stakeholders including the Speaker of the State Legislative Assembly, Director for HIV/AIDS at the Ministry of Health, and Chairperson for PLHIV network were facilitated into an experience sharing and learning visit to neighboring Uganda to learn from the success stories of HIV/AIDs programming from HIV/AIDs champion organizations. This visit provided these key decision makers in the state an opportunity to learn from the best practices that those organizations have explored to improved HIV/AIDs activities in the State. ANISA also supported the Department of Health Management Information Systems (HMIS) at the State Ministry of Health (SMoH) by organizing workshops for county data clerks and medical officers.

ANISA continued to support 3 laboratories in the three counties of Yambio, Nzara and Ezo in order to improve clinical management if HIV positive patients. These include: essential supplies, training laboratory personnel, and developing the laboratories to a better standard.

ANISA provided pre-service training programs to 71 peer educators and home based care givers, who are members of the support groups. These have been instrumental in administering these community based interventions as reflected in indicators P8.1.D and C1.1.D. However, a major challenge encountered here is motivating and retaining these cadres for the continuity of services. Meanwhile, 45 health care workers successfully completed an in-service training program, comprising of 12 laboratory personnel, 15 PMTCT counselors and 18 VCT counselors. These health workers were drawn across the counties of ANISA project from both ANISA supported sites and health facilities run by other partners including the PHCCs, and PHCUs.

Summary of Year 3 Annual Progress

Measurable outcomes are determined on an annual basis by the CDC/PEPFAR Sudan team, in consultation with CMMB. The outcomes for Year 3 of ANISA are listed below:

HIV Counselling and Testing

- **4** static service outlets provided counselling and testing according to national and international standards (**16** mobile locations);
- **28** counselors in Western Equatoria State benefited from HCT refresher training that was organised by CMMB in collaboration with other partners. Participants were from different HTC sites across the state.
- **16,213** individuals received counselling and testing for HIV and received their test results.

PMTCT

- **3** static outlets providing the minimum package of PMTCT services;
- **2830** pregnant women who received HIV counselling and testing for PMTCT and received their test results;
- **318** HIV positive pregnant women received antiretroviral prophylaxis for PMTCT; and
- **15** Health workers and counselors attained refresher training in the provision of PMTCT services according to national and international standards.

Primary Prevention

- **43,121** individuals reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards
- **24,155** individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful;
- **24** targeted condom service outlets;
- **23** individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful.

Care and Support

- **10** support groups providing HIV-related palliative care (excluding TB/HIV);
- **6,371** individuals provided with HIV-related palliative care (excluding TB/HIV); and
- **155** community care-givers trained (or received refresher training) to provide HIV palliative care (excluding TB/HIV).

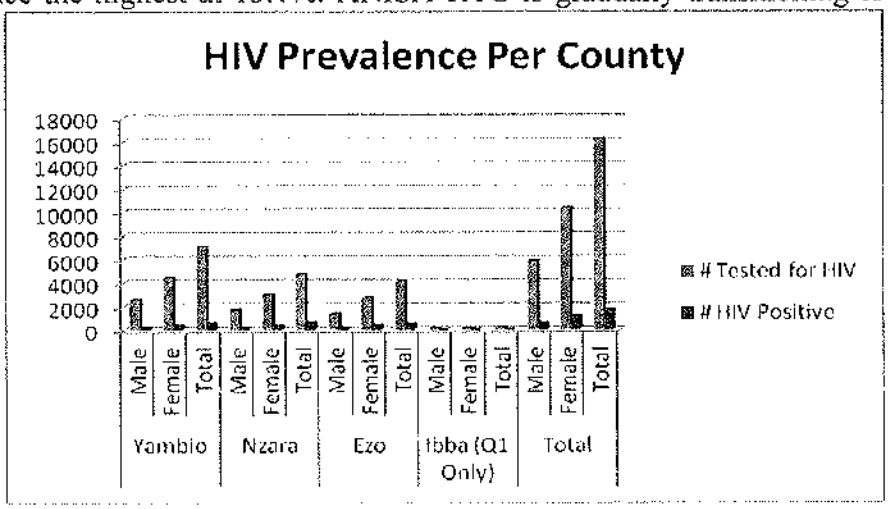
Progress and Challenges by Intermediate Result (IR)

IR 1.1 Expand and improve availability of voluntary, client-initiated and provider-initiated HIV testing.

IR 1.1 Progress

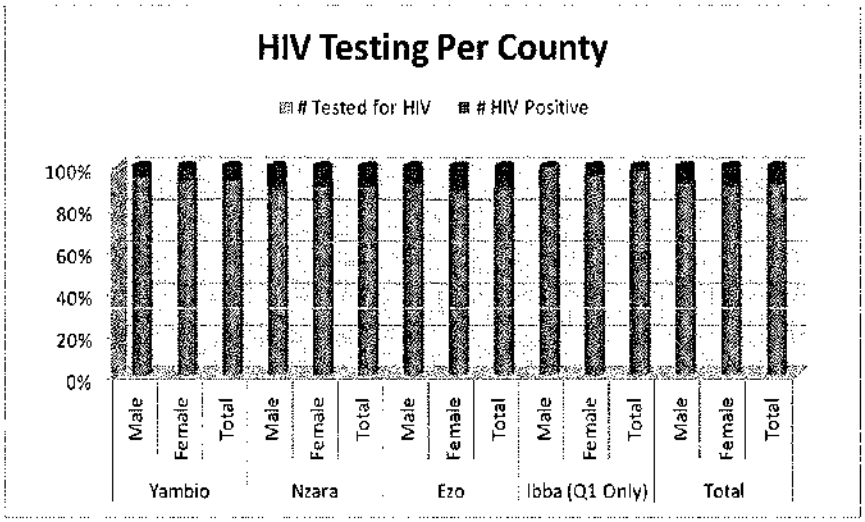
HIV Counseling and Testing (HTC) focus in FY3 was identification of more positive people and linking them to care and treatment services. This was achieved through; a) Promoting linkages between HTC and other care and support services to strengthen referral mechanisms for HTC and b) Promoting strategies aimed at reducing stigma and discrimination to enable the clients and the broader community to cope and make personal decision to come to know ones HIV status.

HTC reached 16,213 clients, 81% of the annual target. Of this number, 1,740 tested HIV-positive, reflecting a project-level prevalence of 10.6%. Prevalence varied from county-to-county, with Ezo's prevalence the highest at 13.1%. ANISA HTC is gradually transitioning to PITC. CMMB has developed linkages with health facilities to ensure that HIV counseling and testing is fully adopted within the primary health care systems. However, scaling up PITC at all health facilities was challenging in FY3 owing to the programmatic settings of the government staffed health facilities and capacity building. The facilities are understaffed and others have staffs who are not yet trained on PITC. CMMB is working closely with CDC (for training) and the State Ministry of Health to ensure PITC kicks off in year 4, beginning from a few facilities and rolling to all PHCCs in the project area by the fourth quarter of FY 4.



Clients that have tested positive are referred for treatment as well as care and support services by use of referral cards. A monthly follow up and counting of the number of referral cards is done in all the ART centres to assess the proportion of those who reach the ART services. In the past two years, nearly 90% of positive clients have registered with the nearest support group.

Quality control programs are ongoing at all the HTC sites to include Dry Blood Spot (DBS) collection that are sent to reference laboratory for QA purposes. Dry Tube Sample (DTS) confirmation was introduced in quarter 4 and performed by on-site counselors, Reports are then sent back to CDC and the reference laboratory in Juba.



Project-level prevalence rates, Year 3:

	Total tested	% positive
Yambio	7,102	8.1%
Nzara	4,760	12.4%
Ezo	4,111	13.1%
Ibba (Q1 Only)	240	3%*
Total	16,213	10.6%

*Ibba prevalence rate not included in total project-level prevalence rate calculation. Data from Ibba was only from Q1.

Client exit interviews were done at the beginning of the year to measure clients' satisfaction of HTC services. This survey was conducted in three sentinel sites Western Equatoria State namely Yambio VCT, Ezo VCT and Nzara VCT. 150 clients were randomly interviewed after HTC by a consultant. In each location selected, fifty clients were interviewed. Generally, most of the clients had positive views on the survey and considered that it was better compared to other public services. The majority (>75%) of clients waited less than 30 minutes to see a counselor, and 100% of clients were satisfied on multiple levels with their counselor, including relating to client privacy, thorough discussion of risk reduction behavior, attention to clients, and willingness to discuss concerns and personal issues. To be improved upon is consistent condom demonstrations (78% of clients reported being given a demonstration) and open-mindedness of counselors (88% responded that they felt their counselor was non-judgmental). Overall, 88% of clients were satisfied with their services, and 12% felt the services were excellent. The report of the exit interviews will be used to inform HTC services for the coming project years.

HTC team leader and supervisors have been at the forefront to support the HTC team. Team leaders conducted regular supervision of counselors to provide technical support. Counselor monthly meetings were conducted as a means of ensuring continual quality of services. Counselors concerns and challenges were addressed during the meetings. The new testing algorithms and DTS collection techniques were also discussed.

ANISA has achieved 81% of the annual target in FY2012.

P11.1.D			Target	Results
	# Individuals who received counseling and testing services for HIV and received their results		20,000	**16,213**
	< 15 yrs	Male		418
		Female		550
	15+ yrs	Male		5478
		Female		9767

IR 1.1 Major findings

Voluntary counseling and testing remains a corner stone for successful implementation of prevention, care and support services among HIV negative and positive individuals. At the project level, ANISA-supported sites have registered between 10-13% prevalence rates in Yambio, Nzara and Ezo counties with the highest prevalence in Ezo at 13%. As the security threat in the State lessens, many IDPs and returnees who had sought refuge in urban areas are now returning home. This urban-rural migration means the disease could increase new infections in rural areas. ANISA prevention and HTC worked hand in hand to increase HIV/AIDs awareness and HTC to these populations. This means that these sites have been visited more frequently, whereas sites reporting lower incidence and with smaller populations have not been visited by the HTC mobile team reducing the outreach sites to 16.

IR 1.1 Barriers

Austerity measures by the Government of South Sudan impacted the country economically as the only resource, the oil pipes, were closed down. This generally affected the programmatic climate in the country as more people focus on livelihood other than health care. A 'farming campaign' was initiated by the government for all employees in the state to work half day on Fridays. This was a barrier to services provision as more people concentrated on agriculture and other businesses leading to low utilization of HTC service delivery.

IR 1.1 Challenges and Resolution

Although the referrals are made for all HIV positive clients and followed up, access to ART still remains a challenge due to inadequate, inaccessible services. VCT has taken initiative to address this by initiating a post test club to offer ongoing support to their clients and continued follow-up and assistance as clients seek ART services.

Change in the testing algorithm that led to Suspension and recall of Bio-Line HIV test kits posed a challenge and barrier to the testing algorithm that we are using in South Sudan. The testing algorithm needed to be changed (i.e. use two kits instead of three). This was a challenge for the new counselors to adjust to due to lack of an additional kit in case of need for a tie-breaker test.

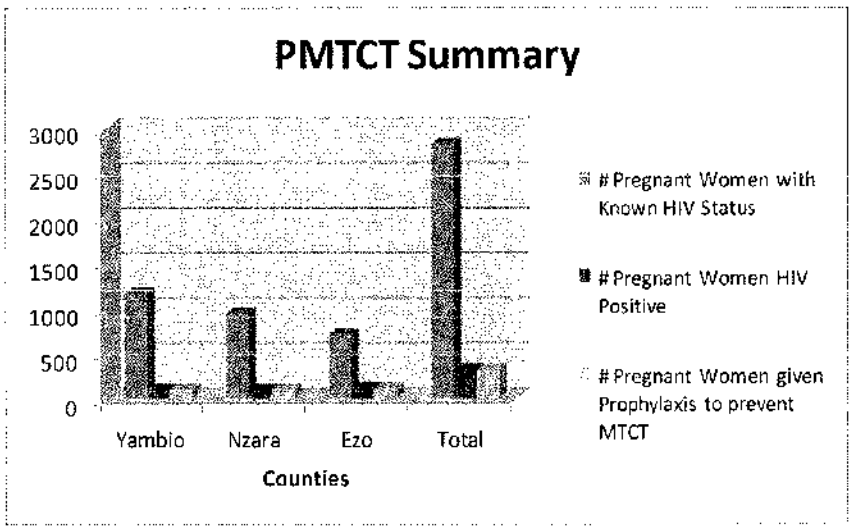
Refresher trainings were conducted for all HTC counselors and group supervision meetings ongoing to address counselors' issues. However, no client sessions were missed and no sites discontinued services.

HTC program still faces challenges delivering results to clients with discrepant results referred to reference laboratory. CMMB is working closely with the CDC laboratory adviser based in Juba to ensure that priority is given to such tests. This has been discussed as well at the Juba PEPFAR meeting and collectively is being addressed for all PEPFAR partners experiencing these issues.

IR 1.2 Expanded and improved mother-to-child prevention services are available in clinics and communities.

IR 1.2 Status

The ANISA project has adopted a comprehensive approach to integrating HCT and PMTCT into ANC services. All HIV positive women receive ARV prophylaxis at the ANC, except those identified to be in stage three and four who are referred to the nearest ART center for ART initiation. All HIV positive mothers are enrolled for ongoing care and support. A "basic care package" of condoms, cotrimoxazole, staging and referral for ART, TB screening, STI screening, and linkages to persons living with HIV community support groups is offered to all HIV positive individuals at the sites. ANISA supports in-service PMTCT refresher training for both ANISA and MOH health care workers (15 midwives and 9 counselors).



To improve adherence of mother-infant pairs as well as strengthen care and support services for HIV positive mothers, ANISA uses a Mentor Mothers program. The goal for Mentor Mothers is to ensure women adhere to taking their ARVs mobilize pregnant women for testing, living positively, and follow up with mothers to ensure exclusive breast feeding. ANISA also trains TBAs to increase the number of pregnant women who attend ANC and to encourage the proper use of prophylactic medicines to ensure babies are born HIV free. Each TBA is assigned positive pregnant women at ANC who reside close to her to monitor. TBAs receive refresher training annually on safe delivery to prevent MTCT.

The CMMB ANISA project will continue to conduct PMTCT activities in three established PMTCT clinics in Yambio, Nzara, and Ezo counties and 16 fixed outreach sites. CMMB has

achieved 94% of the HIV testing target for pregnant women, and 106% of the treatment target for PMTCT.

P1.1.D	# Pregnant women with known HIV status	Target	Results
		3000	**2830**
P1.2.D	# HIV positive pregnant women who received ARVs for PMTCT	Target	Results
		300	**318**

IR 1.2 Major findings

Project-level HIV prevalence has been ranging up to 15.9 percent at PMTCT sites: Yambio 9.0%, Nzara 10.6%, Ezo 15.9%, Overall Average 11.2%. See below for a commentary of scheduling issues due to government testing days.

At the beginning of the ANISA project in 2009, CMMB assessed the uptake of ANC and PMTCT services at health facilities in the state. Reports indicated that there were no PMTCT activities on the ground that time. The Matron at Yambio Hospital was the only person trained in PMTCT. The hospital was referring all HIV Positive women for caesarian section and most PHCCs were not capacitated to conduct deliveries that time. It is estimated that 81% of births in Western Equatoria State are done by TBAs and village midwives, with >15% births having skilled attendance (UNFPA). CMMB was inspired to work with the TBAs based on these findings.

CMMB identified TBAs, trained them and linked them to ANC clinics at the facilities that CMMB was incorporating PMTCT. The "skilled TBAs" started identifying pregnant women in their localities, referring them for ANC and encouraging mothers to deliver in health centers, following up HIV positive mothers until delivery and ensuring that all HIV exposed babies were put on prophylaxis within 72 hours of birth. The TBAs later on presented the need for ANISA to extend these services to the community to reach out to more women in the community, and assisted in the development of an optimized PMTCT outreach schedule.

The turn up of pregnant mothers for ANC shot up by this intervention and the positive mothers who were enrolled into PMTCT later pioneered mobilization and were encouraging other HIV Positive women to come to PMTCT clinics. Learning from the best practices of CMMB's PMTCT Kenya Program, ANISA identified mothers who had gone through PMTCT and had HIV Negative babies share their success stories and mentor other HIV positive mothers. These Mentor Mothers are associated with PMTCT clinics to mobilize HIV positive women, conduct follow up, and facilitate breast feeding education sessions in the community.

A midwife in Ezo County explains the impact of ANISA-trained TBAs and Mentor Mothers: *"In 2010 when CMMB started working here with us in Ezo, our mothers were not comfortable to come for ANC because they feared they would be referred for HIV test. After some time they started appreciating the intervention when they saw HIV positive women deliver HIV negative baby. It is a wish of every mother that their children are safe and healthy. This encouraged women to start accessing health care; ANC, PMTCT and we always have a lot of women here on*

Wednesdays-ANC days. Women are now running like ants to the fire. The TBAs are also mobilizing women to deliver from hospitals and we are now very busy here."

This cadre provides support from the time of identification of the HIV positive pregnant women at first the ANC visit and administration of the prophylaxis, through to delivery time (especially deliveries outside health facilities, a common practice in this community); and infant follow up until 18 months. This strategy has been very effective in follow up of clients. Confirmatory tests at 9 to 18 months for exposed infants passing through ANISA PMTCT intervention put the success rate at 88.2% infants testing negative for HIV. The main challenge encountered is accessing some women and babies who migrate and others in remote areas who are challenging to track down. This challenge related to follow-up presumably decreases adherence to treatment and exclusive breast feeding. For this reason, we are further engaging TBAs and Mentor Mothers to closely follow up of the HIV positive mothers and their babies. In Year 4, different incentive and supervisor follow-up schemes will be attempted to increase rates of client follow-up at clinics.

Exposed babies in the PMTCT program are tested at 9 months and repeat-tested at 18 months. Year 3 results are below:

	Babies tested	Babies HIV positive	Success rate
Q 1	98	13	88%
Q2	56	8	87%
Q3	99	12	88%
Q4	69	5	93%
Total	322	38	88%

IR 1.2 Barriers

A barrier we have encountered is that ANC in the whole state used to occur only on Wednesdays. This made outreach efforts a challenge. We cannot carry out PMTCT at outreach sites only on one day due to scheduling of vehicles, and these forces us to change the days. To try and reach out to pregnant women in remote areas, we established static sites for Wednesdays to try to reach all pregnant women. This is challenge because of staff shortages; however, 2 operational static sites have been established in each county to ensure continual services at those clinics.

Instability in the political and economic situation such as austerity measure, farming campaign by the Government led to no or late payment of Government staffs. It was a challenge for ANISA PMTCT program that works with the Government counter parts to do business normally. In most cases the facilities lacked supplies and consumables and government employees absented from work to take care of thier personal businesses and farming.

IR 1.2 Challenges and Resolution

CMMB leverages TBAs to conduct follow-up with mothers. There is a major complaint that the areas of coverage are too big and the incentives are too small. Each county has at least 2 TBAs for follow ups and they follow up babies and mothers on ARVS. We have tried to engage some of the counselors in follow ups, but they still have to do outreach which is another challenge. In the meantime, CMMB has budgeted for different types of incentives in Year 4, such as bicycles, to try to motivate and better support this important cadre of workers.

Conducting PMTCT outreach in rural communities is important, yet very expensive in terms of staff time and fuel cost. As mentioned, limited resources have scaled down this intervention in terms of numbers of sites visited and frequency. To save additional monies for outreach services, we have resorted to using a motorcycle for areas which are more easily accessible and saving larger vehicles for farther outreaches and reduced the number of sites but continued to raise awareness and encourage women to come to nearby clinics.

IR 1.3 Communities adopt primary prevention techniques based on the *'Abstain and Be Faithful'* approach.

IR 1.3 Status

The Primary Prevention team worked in collaboration with the SMoH, State AIDS Commission, County AIDS Commission and County Health Department as well as Community/Faith Based Organizations in implementing prevention services in the fight against HIV/AIDS. Partnering CBOs, FBOs and community groups also assisted in the provision of peer education, awareness and sensitization activities.

The AB prevention messages are linked to other services through community mobilization/mass media. The target groups are also referred to health facilities to seek help for any health need arising, including access to condoms as part of OP programming should they fail to maintain the A or B option. ANISA project has been able to package messages to address community and cultural social norms and practices. These messages are uniform throughout the program. AB, OP, HTC as well as PMTCT are all linked; a combined team carries out combined sensitization twice a month on the local FM station, key markets and churches. Activities aimed at reducing multiple and concurrent partners to eventually one partner and being faithful to that one partner are also be focused on.

We have met 105% of the goal for AB-based prevention messaging.

		Target	Total
P8.2.D	# Targeted population reached with individual and or/small group level preventive interventions that are primarily focused on abstinence and / or being faithful, and are based on evidence and / or meet the minimum standards required	23,000	24,155

IR 1.3 Major findings

There is a strong cultural practice which encourages young girls to start sexual debut at a very early age, e.g. as soon as a girl shows signs of adolescence. This is done by providing a girl with a separate accommodation hut a few meters away from the main household as a sign of liberty and family/community consensus and permission that she is now free to have male visitors. This cultural practice is probably responsible for rampant teenage pregnancy and increased rates of HIV transmission.

The ANISA project has had discussions with CDC South Sudan and has decided to put more effort on groups that are most likely having HIV, such as the girls referenced above. This made ANISA in Y3 to scale down AB-only interventions, and resources were more directed to reaching out to sexually active adults. The PEPFAR prevention team that visited WES advised the project to focus attention on the population that is most likely to be positive; therefore, CMMB prioritized its attention to at-risk adults. However, through previously trained young lady peer educators, prevention messaging and condom demonstrations continued to reach high risk young girls during Year 3. The focus on evidenced-based prevention methods will continue in Year 4, which will see even more reduced focus on AB messaging.

Sex workers continued to benefit from OP services such as condom distribution, which were accessed in bars, nightclubs, lodges, etc. The population of single women, who are not necessarily sex workers, is so large and all of them accept condoms freely without fear or prejudice.

IR 1.3 Barriers

Low literacy levels rate in the region made it difficult for the community to understand basic idea of HIV/AIDS and talk about it freely, its challenges and impact on the individuals, community and nation.

The ANISA project is addressing the issue by including interactive talk shows on local FM radios in local Zande language. In year 4, radio spots will be shared and rotated with the VCT, PMTCT and ANC messages (paid through VCT and PMTCT activity budget) and practices which expose young girls to HIV will be stressed.

IR 1.3 Challenges and Resolution

Engaging community leaders and the community custodians of culture in interactive discussions and training workshops may be a helpful step towards addressing the cultural practice noted above. ANISA will endeavor to include this work in Year 4 by reducing focus on AB-only messaging and moving towards a more holistic approach.

IR 1.4 Communities adopt prevention practices beyond abstinence and/or being faithful.

IR 1.4 Status

ANISA reached 43,121 with individual and /or small group level prevention interventions that are based on evidence and/or meet the minimum standards required, including condom demonstration and distribution. This is done in small group sessions by ANISA trained peer educators. The ANISA prevention team continued to work with 6 community HIV support groups and CBOs that work in the area of HIV awareness and sensitization. These CBOs and PLWHA support groups have ANISA-trained peer educators that carry out sensitization and small group awareness sessions in their respective group. They also go out for community sensitization arranged and supported by the ANISA primary prevention team. PLWHA includes members from other community partners and government agencies such as the uniform forces from where they carry out sensitization and awareness. There are 23 peer educators and they mostly belong to or are members in CBOs, PLWHA groups and agencies mentioned above.

Promotion of condom use forms a large component of the OP campaign. Peer educators are given special topics on condoms and their role in controlling the spread of HIV. ANISA adopted and designed condom promotion leaflets with pictures showing correct use of condoms and benefits. Condoms are regularly distributed to outlets in lodges, bars, salons and trailer parks in Yambio, Nzara, and Ezo. Through their network, peer educators have identified 24 individual condom distributors (15 male, 9 female) who are regularly supplied with condoms.

Prevention messages are passed in various media including small group/individual sessions presided over by a network of well-trained peer educators; more messages are passed through mass media but however not captured into the M&E data submitted to PEPFAR since this falls outside the small group requirement as per the indicator definition P8.1.D. The Prevention Team also distributed 235 IEC HIV awareness posters to 3 PHCCs and 10 PHCUs around Yambio, Ezo and Nzara Counties.

		Target	**Total**
P8.1.D	# Targeted population reached with individual and /or small group level prevention interventions that are based on evidence and/or meet the minimum standards required	30,000	**43,121**

IR 1.4 Major findings

The high uptake of HTC in the 3 counties can be attributed to the awareness campaign as part of other prevention activities. Activities in the next two years will continue to target locations with a growing HIV risk including the trade corridors and town centres and suburbs. Interest and uptake of condoms in WES, which is assessed by the rate and number of replacements at the condom access points, has substantially increased.

With the massive HIV and AIDS interventions being carried out in Yambio Nzara and Ezo Counties, there is a positive perception about condom in the community; mostly singles are freely coming to ask for condom from the peer educators with out fear.

IR 1.4 Barriers

New myths about condom use are a daily phenomenon, particularly among the community of young women previously mentioned. The primary prevention team and the other team members have to remain alert for new myths and counter each accordingly. High illiteracy level acts as a catalyst for fueling spread of myths and as an impediment for permanently addressing issues of concern such as acceptance of condom use.

IR 1.4 Challenges and Resolution

Inconsistent supply of male condoms for program use remains a challenge in Year 3. Condom supply and availability in the field needs to be streamlined. ANISA will work in Year 4 to ensure condoms are readily accessed via PEPFAR partners, and report any difficulties to the CDC/PEPFAR team for resolution.

IR 2.1 Expanded and improved palliative care services are utilized.

IR 2.1 Status

The ANISA project has met 64% of its target for Year 3 for care service provision and 105% of its target for clinical service provision.

ANISA trained 155 individuals to provide palliative care (as included in indicator H.2.2.D.). These are community care-givers who are drawn mostly from support groups and trained by Anisa to provide home-based care, support treatment adherence and disclosure, and provide messaging around PwP.

C1.1.1	# Eligible adults and children provided with a minimum of one care service	**Target**	**Results**
		10,000	**6,371**
	< 18 yrs	Male	594
		Female	1,265
	18 + yrs	Male	1,716
		Female	2,796

C2.1.D	# HIV-positive adults and children provided with a minimum of one clinical service	**Target**	**Results**

		3,000	**2,212**
	< 15 yrs	Male	187
		Female	264
	15 + yrs	Male	603
		Female	1,158

C.2.2.D	# HIV positive persons receiving cotrimoxazole prophylaxis	**Target**	**Results**
		3,000	1,965

IR 2.1 Major findings

As more and more people turn up for HCT, the limited interventions available to those testing positive do not match the need expressed. There are many OVCs in the support groups, but no interventions geared specifically for them. CMMB has been trying to contact other parters outside PEPFAR to address OVCs, but this has not yet yielded fruit.

IR 2.1 Barriers

The ANISA project has encountered issues with transport of clients, particularly OVC, to the support groups. We have shared this with other INGOs and are looking for ways to provide transport for these individuals who live farther from support groups.

IR 2.2 Linkages/referrals to wrap around services for PLWHA are viable.

IR 2.2 Status

ANISA is focusing on providing the PEPFAR South Sudan Basic Care Package to all persons who test for HIV and to ensure compliance by patients with treatment and follow up to ensure referrals are completed. This Basic Care Package provided at clinic settings consists of cotrimoxazole prophylaxis, screening for STIs and active TB, distribution and education on the use of condoms, linkage to local PLHIV support services, CD4 staging, and referrals for ART. In Year 3, ANISA HTC and PMTCT counselors provided these services on-site to all clients reporting at either static or outreach sites. Clients were then referred for appropriate services based on their status.

IR 2.2 Major findings

Through its intensive community outreach, education, and HTC efforts, CMMB has identified a large number of HIV positive individuals over the course of the project. This has invariably led to an increase in the number of individuals seeking support group and care assistance.

IR 2.2 Barriers

ANISA has observed that there are few well-qualified personnel at the government health facilities who are able to provide specialized care for PLHIV. The ANISA project has tried to make referrals and arrange transport for the clients to reach necessary care.

IR 2.2 Challenges and Resolution

The number of clients receiving OI treatment prophylaxis is overwhelming. This led to the clinic providing OI prophylaxis services to limit the number of clients to be enrolled for OI treatment to avoid possible drug resistance to those who have started in case the supply runs out. In Year 4, ANISA will work to address the supply chain issues which compound this situation.

Additionally, as a response to improving skills of health workers to attend to PLHIV better, ANISA in Y4 plans to train more health workers at health facilities on identifying and management of opportunistic infections.

IR 2.3 PLWA groups are expanded and strengthened.

IR 2.3 Status

To ensure care and support services reach PLHIV, ANISA has continued to support CBOs/support groups that have always been in the communities and played a great role in supporting PLHIV. ANISA's plan for Year 3 was to support five newly formed support groups. We have so far reached 3 newly formed groups, namely Bodo PLHIV Support group, St. Bakhitha support group, and one in Napere IDP/refugee camp in Ezo County.

The project is currently working with 10 support groups, including: Safe Haven, St. Bakhita, Napere refugee camps support group (Ezo county); Rainbow (Nzara county); Bodo, COPE, NACASO, Star group, USAP and ZAIC (Yambio County).

IR 2.3 Major findings

After consultations with CDC South Sudan, ANISA project will scale down support through support groups and focus resource to providing PEPFAR basic package at health facilities. Compared to home based care approach offered through the support group, this is seen to be more cost effective. ANISA in Y4 will concentrate on putting positive clients on treatment early, improve follow up and ensure basic PEPFAR care package is well delivered to reach every PLHIV timely.

IR 2.4 Stigma and discrimination is reduced in communities and among health providers.

IR 2.4 Status

ANISA has conducted three trainings on stigma & discrimination for 80 participants in Yambio, Nzara and Ezo counties. The peer educators and as well PLHIV were targeted so as to include the component of stigma reduction as they reach out to the communities.

IR 2.4 Major findings

HIV & AIDS has been identified as a serious health issue among WES community, and PLHIV have been well supported and comforted within the community structures which ANISA supports. This is one of the reasons that discrimination against PLHIV is becoming more limited and most people are willing to come out openly, based on the experience of the ANISA team. Some of the PLHIV are very active in HIV prevention advocacy with the ANISA project and local CBOs/FBOs.

IR 2.4 Challenges and Resolution

Due to perceived health provider and community acceptance of HIV/AIDS, ANISA will no longer be continuing with this activity. We feel that the community has accepted PLHIV, who are able to seek support at the PLHIV CBO groups that ANISA supports with technical assistance.

SO 3 Build and Strengthen the State, counties, and local partners' capacities in Strategic Information (SI), policy development, and implementation.
Laboratory Strengthening

SO 3 Status

In Year 3, ANISA conducted interactive workshop for community leaders and uniform forces, including the village headmen, church leaders and Youth leaders. This was intended to empower the community leaders join hands in the battle against HIV infections in their respective communities. This strategy was based on analysis of VCT data which indicated that about 60% of the clients got HIV information from community and church gatherings. ANISA also trained 100 uniform forces targeting police, prisons, wildlife and military officers. Police and prison staffs will become important agents for behavioral change in reversing the spread of HIV within the uniform forces and beyond if equipped with the right information.

In June, top stakeholders including the Speaker of the State Legislative Assembly, Director for HIV/AIDS at the Ministry of Health, and Chairperson for PLHIV network were facilitated into an experience sharing and learning visit to neighboring Uganda to learn from the success stories of HIV/AIDs programming from HIV/AIDs champion organizations: The AIDS Support Organization (TASO), MildMay Uganda, Ministry of Health headquarters and Mulago National Referral Hospital of Uganda. This visit provided these key decision makers in the state an opportunity to learn from the best practices that those organizations have explored to improved HIV/AIDS activities in the State.

ANISA also supported the department of HMIS at the state ministry of health (SMoH) by organizing workshops for county data clerks and medical officers and provided basic HMIS items (e.g. stationary, registers) aimed at improving data flow from the health facilities, county, state to the national level.

Laboratory Strengthening

ANISA continued to support 3 laboratories in the three counties of Yambio, Nzara and Ezo, with essential supplies, training lab personnel and devcloping the laboratories to a better standard. ANISA will continue working with these laboratory staff in Year 4, providing refresher training. The trained laboratory staff of Yambio Hospital, Nzara PHCC and Ezo PHCC labs are going to be closely followed with mentoring and a refresher workshop session to ensure by end of Y4 they meet the PEPFAR minimal required standards.

Human Resource for Health

Well over the target of 100 community health and para-social workers successfully completed a pre-service training program, with 406 individuals trained. These comprised of 71 peer educators for primary prevention interventions and 100 uniformed service corps trained in HIV prevention messaging as peer educators. 155 home based care givers received refresher training. These cadres of workers have been instrumental in administering these community based interventions as reflected in indicators P8.1.D and C1.1.D. Additionally, ANISA conducted three trainings on stigma & discrimination for 80 peer educator participants in Yambio, Nzara and Ezo counties. However, a major challenge encountered here is motivating and retaining these cadres for the continuity of services since they are more voluntary workers and not monetarily incentivized or adequately motivated. In Year 4, CMMB will try a different incentive scheme based on monthly airtime allowances to facilitate communication with supervisors and "earnable" incentives, such as bicycles, for top performers.

45 (73%) out of 62 targeted health care workers successfully completed an in-service training program within the reporting period comprising of 12 laboratory personnel, 15 PMTCT counselors and 18 VCT counselors. These health workers were drawn across the counties of ANISA project from both ANISA supported sites and health facilities run by other partners including the PHCCs, and PHCUs.

		Target	Results
H.2.2.D	# Community health and para-social workers who successfully completed a pre-service training program	100	406
H.2.3.D	# Healthcare workers who successfully completed an in-service training program	62	45

SO 3 Challenges and Resolution

Challenges

ANISA project faced challenges in working with the local government and health system. These included limited human resource capacity (e.g. laboratory assistants, data clerks, limited training and skills, low staffing levels). Other challenges include poorly equipped laboratories and lack of

supplies. In relation to M&E, we experience delays on reporting from facilities due to logistical constraints and there is no State M&E technical working group for WES.

Resolutions

In order to address the challenges related to laboratories, ANISA will provide continuous mentorship and an additional refresher training for lab personnel. Mentorship will include follow up to ensure they maintain the standards they have been trained on. Additionally, ANISA will start Lab Quality Management System (LQMS) in ANISA-supported labs. To reduce the burden on laboratories, ANISA suggests empowering PHCCs to perform HIV/syphilis rapid tests to quicken the diagnosis and treatment of patients in a timely manner. ANISA also suggests establishing an External Quality Assurance (EQA) programme for malaria and TB slide examination. We will follow up on this in Year 4.

To address M&E needs, PEPFAR partners could support in supplying report forms to the CHD. ANISA proposes to support the CHD regularly with report forms to ensure effective reporting. ANISA will also support the SMoH to establish an M&E Technical Working Group.

South Sudan USG-PEFAR FY 2012 APR Implementing Partners Reporting Format: CMMB

Indicator	Indicator Definition	FY 2011 Target	FY 2011 Result	FY2012 target	SAPR (Oct 11-Mar 12)	April-Sept (Q3+Q4) 2012 results	APR (Oct 2011-Sept 2012)	% Achievement (APR)	FY12 APR Narrative
P.11.1.D	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results, by age, sex, and test result	11,200	17,312	20,000	7,196	9,017	16,213	81%	Only 81% achieved well above the 75% cutpoint but far from the 100% maximum though. This result includes all testing at different sites including VCT, ANC centres, from static sites, mobile and stand alone. This indicator is well disagregated by sex and age since further disaggregation is allowed by use of the national reporting form and registers which records specific age of all clients testing. There is also a national system to monitor different population and testing types including individual vs couple testing and group counseling and testing at both the VCT and ANC sites. ANISA project has put in place an effective system of referal of all HIV positive cases to the ART centres and a follow up to monitor whether the clients report to the ART centre or not through a well designed referral form which is traced at the ART centres periodically. Clients not reporting at the ART centres are then followed up by designated counselors or mentor mothers (PMTCT setting) where it has been vere effective to ensure they report to the ART centres.
	Women		10,852		4,429	5,888	10,317		
	<15 yrs		432		235	315	550		
	≥15 yrs		10,420		4,194	5,573	9,767		
	Men		6,460		2,767	3,129	5,896		
	<15 yrs		340		160	258	418		
	≥15 yrs		6,120		2,607	2,871	5,478		
P1.1.D	Number of pregnant women with known HIV status (includes women who were tested for HIV and know their status)	3,200	2,296	3,000	1,215	1,615	2,830	94%	The results met only 94% of the COP less than 100% but within the margin of 75%-125%. This figure includes 146 women with known HIV status at initial visit and 2684 newly testing for HIV). The sites supported lack Labour and Delivery Wards but in cases when some positive pregnant women are reached at delivery by trained Traditional Birth Attendants (TBAs) or health midwife, only new cases are counted and women already passing through the PMTCT program not counted again.
P1.1.D	Number of pregnant women testing Positive for HIV		192		127	191	318		This figure includes 172 women newly tested positive at first ANC and 146 already known HIV positive at initial visit. The sites supported lack Labour and Delivery Wards but some positive pregnant women are reached at delivery by trained Traditional Birth Attendants (TBAs) and administered Neverapine. To avoid double counting, only the most recent regimen administered is counted (when NVP is given at delivery to a pregant women who has been on maternal AZT, this women is subtracted from the number on maternal AZT and ocunted only under SDNVP).
P1.2.D	Number of HIV-positive pregnant women who received anti retrovirus to reduce risk of mother to child transmission	160	201	300	148	170	318	106%	The APR result is 106% as total for the different regimens including Maternal AZT, SDNVP, and women already on ART as disagregated. However, further disaggregation on ART newly initiated is not included because, these women are initiated in an independent ART centre not directly under the support of the Project. To check against double counting only the most recent regimen is counted. This avoids double counting women getting SDNVP at deliver after passing through AZT. .
	ART for eligible pregant women		55		39	68	107		
	Martenal Triple ARV prophylaxis (WHO option B)						-		
	Martenal AZT (WHO option A)		18		69	75	144		
	Single dose Nevirapine (SD-NVP)		17		40	27	67		
C.1.1.D	Number of eligible adults and children provided with a minimum of one care service	5,000	5,851	10,000	4,971	1,400	6,371	64%	The APR result is only 64% way below the the 75% margin. The programatic part had challenges hence this low results. This data includes the total count of HIV-affected, HIV-infected in the PLHIV support groups in the project areas reached with a minimum of one care service during the reporting year counted only once to avoid double counting. HIV affected individuals are family members, of persons present at the visit for care service by a care giver. This result reflect clients who have been on care during the reporting year.
	Women		2,981		3,269	792	4,061		
	<18 yrs		45		1,033	232	1,265		
	≥18 yrs		2,936		2,236	560	2,796		
	Men		2,870		1,702	608	2,310		
	<18 yrs		28		388	206	594		
	≥18 yrs		2,842		1,314	402	1,716		

C2.1.D	Number of HIV-positive adults and children receiving a minimum of one clinical service	4,000	1,394	3,000	1,105	1,107	2,212	74%	The APR data is 74% slighiy less than the margin of 75% owing to programatic challenges. This data is extract from the Pre-ART registers at the health centres run by the one support group of PLHIV. ANISA project supports this group directly by provsion of the cotrimoxazole and other medical and non medical supplies. This result is a subset of C1.1.D which constitutes the umbrella indicator.
	Women		968		812	610	1,422		
	<15 yrs		45		77	187	264		
	≥15 yrs		923		735	423	1,158		
	Men		426		293	497	790		
	<15		28		66	121	187		
	≥15		398		227	376	603		
C2.2.D	Number of HIV-positive persons receiving Cotrimoxazole (CTX) prophylaxis	4,000	1,394	3,000	1,105	860	1,965	66%	Only 66% of the COP target resulting from programatic challenges as well as other factors. This indicator constitutes the major subset of the C2.1.D. and includes only clients receiving cotrimoxazole in the ANISA supported sites. More Clients opt to access their medication in other fullyfledged ART centres, and those in a more confidential settings preferably in other counties than their residences perhaps due to stigma and discrimination concerns.
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP)	5	2	10	-	-	-	0%	N/A
	Occupational		2		-	-	-		
	Rape/Sexual Assault Victims				-	-	-		
	Other Non-Occupational				-	-	-		
P7.1.D	Number of people living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions	3,000	3,272	4,000	1,068	1,703	2,771	69%	Only 69% of APR achieved. Challenges concerning data quality include concerns on ability of the service providers to correctly interprete the minimum package as most of these are non salaried semi-literate care givers supporting fellow PLHIV in communities. This component is intergrated into the care package and represents one challenging indicator to accurately measure especially at community based settings.
P8.1.D	Number of the target population (general population) reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards	50000	26,709	30,000	16,031	27,090	43,121	144%	COP target well exceed upto 144% of the APR achieved. This figure completely complies with the PEEPFAR indicator defintion of individual or small groups which are counted in the sessions. big groupd sizes are conducted but not counted under this indicator. However, related M&E challenges with this indicator include the lack of national standard tools whereby the project designed own tools which are not harmonised with other partners. Inoder to ensure evidence based data, the project designed attendance lists for all peer education sessions, but this has not been effective given the resistance by the particiapnts to register attendance only if incentivised. This target was exceeded due to appropriate strategy including conducting visits to market places across the project areas by a network of peer educators in which case, the population is spilt into small groups and given messages as per the small group requirement in the PEPFAR guideline.
	Women				8,151	14,121	22,272		
	<15 yrs				1,980	3,606	5,586		
	≥15 yrs				6,171	10,515	16,686		
	Men				7,883	12,969	20,852		
	<15				1,620	3,024	4,544		
	≥15				6,363	9,945	16,308		

P.8.2.D	Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required.	42000	20,368	23,000	9,184	14,971	24,155	105%	COP target well exceed upto 105% of the APR achieved. This figure completely complies with the PEEPFAR indicator defintion of individual or small groups which are counted in the sessions. big groupd sizes are conducted but not counted under this indicator. However, related M&E challenges with this indicator include the lack of national standard tools whereby the project designed own tools which are not harmonised with other partners.
	Women						-		
	<15 yrs				-		-		
	≥15 yrs				-		-		
	Men				-		-		
	<15				-		-		
	≥15				-		-		
P8.3.D	Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required						-		N/A
	CSW						-		
	Other Vulnerable group 1 (please specify)						-		
	Other Vulnerable group 2 (please specify)						-		
	Other Vulnerable group 3 (please specify)						-		
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests			4	3	3	3	75%	Constitutes the three laboratories supported in the counties of project areas
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program within the reporting period		452	100	71	335	406	406%	This consititues peer educators,homebased care givers, and uniformed officers acting as peer educators.
H2.3.D	Number of health care workers who successfully completed an in-service training program within the reporting period		68	62	-	45	45	73%	Only 73% of the COP reached, but satisfactory for the smooth operation of the project during the reporting year. Perhaps the target was set too high.

ANISA

COMING TOGETHER TO MEET
THE CHALLENGE OF HIV/AIDS

CMMB

CATHOLIC MEDICAL MISSION BOARD

ANISA Project

CDC Award No: 5U2GPS001632-02

Annual Progress Report: Year 2

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Executive Summary

Catholic Medical Mission Board is implementing Project ANISA in Western Equatoria State (WES) of The Republic of South Sudan. This report covers the period October 2010 to September 2011, the second year of the project. Achievements, challenges and lessons learned in Year 1 of the project have been very instrumental in the progress made in Year 2. The project currently covers four counties of WEQ State, namely: Yambio, Nzara, Ezo and Ibba. Insecurity, interrupted flow of commodities (e.g. test kits, condoms) and lack of trained or trainable individuals have been the major limiting factors. Most of the targets set by PEPFAR South Sudan for Year 2 have been met or exceeded with only a few not reached.

Voluntary Counseling and Testing (VCT) reached 17,312 clients, 155% of the annual target. Of this number, approximately 1,904 tested HIV-positive, reflecting a project-level prevalence of 11%. Prevalence varied from county-to-county, with Nzara's prevalence the highest at 13%. Outreach VCT was a success, with 35% of the total number of clients accessing the 37 outreach sites. However, the community expressed additional demand for VCT, as the outreach clinics are open only two days a week, and sometimes experienced test kit shortages.

During FY11, CMMB established a new static PMTCT location in Ezo, adding to the two clinics in Nzara and Yambio Town. Outreaches serving more than 16 communities have also been established to follow up pregnant HIV-positive mothers and as well recruit others for testing and counseling. During Year 2, 30 traditional birth attendants (TBAs) were trained and equipped to follow up pregnant mothers and refer them to the nearby PMTCT clinic. CMMB provided VCT to 4,243 expectant and lactating mothers. Of these, 201 women who tested HIV-positive were provided with ARVs to prevent MTCT (126% of the target). Erratic supply of ARVs from local hospitals and clinics, combined with the schedules of the mobile outreach clinics, resulted in inconsistent follow-up and ARV provision for mothers. CMMB suggests establishing additional static sites which will remain open to the public on a more regular basis.

Evidenced-based HIV primary prevention activities reached a total of 20,368 people with HIV prevention messages focused on abstinence and being faithful, mainly through school-based programs. The prevention program also placed emphasis on other prevention methods which reached 26,709 individuals (e.g. delayed sex, limitation of sex partners, safe sexual practices, condom usage). The small-group prevention targets were reached using a network of 396 ANISA-trained peer educators. Shortages of condoms (provided by World Vision International) meant that demand was not always met. Additionally, it was noted that peer educators expect small cash incentives and/or refreshments as motivators, as many other organizations provide.

The ANISA Care and Support team provided 5,851 persons with related palliative care at least once by a trained home-based care giver, reaching 117% of the target. A total of 1,394 men, women, and children received treatment for opportunistic infection (cotrimoxazole prophylaxis). The technical support team worked to assist People Living with HIV/AIDS (PLWHA) support groups, providing workshops, trainings, and discussion guides. Stigma and discrimination against PLWHA was addressed through a training for 40 religious leaders and distribution of information, education and communication (IEC) materials. Additional resources could allow

the team to reach more individuals with specialized services such as nutritional and agricultural support, economic strengthening, and orphans and vulnerable children (OVC) support.

Lastly, Year 2 saw the ANISA project beginning activities aimed at strengthening the local health system for a better response to community health needs. The ANISA team hosted atraining for 11 laboratory personnel on basic laboratory protocols. As part of the training, three laboratories were assessed for safety, cleanliness, adherence to SOPs, and other factors. A workshop was also held for key government stakeholders in WES regarding knowledge required to address HIV and health issues within their jurisdictions.

Introduction

Based in Hai Naduru Yambio, the ANISA project has continued to prevent new HIV infections as well provide care and support to HIV-infected persons in WES of South Sudan. Serving the most HIV-affected area in South Sudan, and also contending with Lord's Resistance Army (LRA) rebel activity, CMMB mitigates challenges and dangers every day, while bolstering HIV/AIDS and health systems strengthening (HSS) activities in the region. CMMB plans to expand services in Ibba County, in addition to strengthening existing sites/locations, in 2012 (Year 3).

In 2009, CMMB established an office in Yambio, Western Equatoria State to launch the ANISA Project. ANISA, meaning "coming together to fight HIV" in the Zande language, is a five-year project supported by CDC/HHS focused on the HIV/AIDS prevention, treatment, and support.

CMMB prevents HIV transmission by improving the capacity of organizations providing clinical and public health services to prevent and reduce the impact of HIV in South Sudan. This includes support for data collection and systems strengthening required to ensure sustainable programs. CMMB strengthens HIV prevention services using community outreaches for educational messages, PMTCT, and counseling and testing (VCT) sites. In the second year of the project, CMMB added activities that strengthen the systems that provide critical prevention, care and treatment programs for HIV/AIDS, including laboratory systems strengthening and leadership and governance guidance.

CMMB's scope of work conforms to the Sudan CDC/PEPFAR mission as outlined below:

- HIV counseling and testing, including, but not limited to, voluntary counseling and testing (VCT) and provider-initiated counseling and testing (PICT); and client-initiated counseling and testing (CICT);
- Sexual prevention BCC activities focused on abstinence, faithfulness, and risk-reduction techniques such as condom distribution;
- Strengthening the delivery of PMTCT, with a focus on integration with maternal and child health (MCH) services and community-based programs; and
- Care and support for persons living with HIV/AIDS.

CMMB has sub-contracted to World Vision International (WVI) to implement parts of Prevention and Care and Support activities.

Summary of Year 2 Progress

Measurable outcomes are determined on an annual basis by the CDC/PEPFAR Sudan team, in consultation with CMMB. The outcomes for Year 2 of ANISA are listed below:

HIV Counseling and Testing

- **4** static service outlets provided counselling and testing according to national and international standards (**37** mobile locations);
- **13** individuals trained in counseling and testing according to national and international standards; and,
- **17,312** individuals received counseling and testing for HIV and received their test results.

PMTCT

- **3** static outlets providing the minimum package of PMTCT services;
- **2,296** pregnant women who received HIV counselling and testing for PMTCT and received their test results;
- **201** HIV positive pregnant women received antiretroviral prophylaxis for PMTCT; and
- **55** health workers trained in the provision of PMTCT services according to national and international standards.

Primary Prevention

- **20,368** individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful;
- **281** individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful;
- **8** targeted condom service outlets;
- **26,709** individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful; and
- **115** individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful.

Care and Support

- **8** service outlets providing HIV-related palliative care (excluding TB/HIV);
- **5,851** individuals provided with HIV-related palliative care (excluding TB/HIV); and
- **171** individuals trained to provide HIV palliative care (excluding TB/HIV).

Progress and Challenges by Intermediate Result (IR)

IR 1.1 Expand and improve availability of voluntary, client-initiated and provider-initiated HIV testing.

IR 1.1 Progress

In Year 2, the ANISA team continued working closely with MOH and SAC to mitigate HIV transmission by scaling up HIV Counselling and Testing services in Western Equatoria State, aiming at enhancing a comprehensive quality-assurance program in all the VCT static centers and outreach sites. ANISA progressed in year two with expansion of 4 Static VCT sites and 37 outreach sites were active in various Payams in Yambio, Nzara, Ezo and Ibba Counties.

In 2011, ANISA VCT achieved 155% of the annual target for 2011. More than 17,000 individuals (10,852 F and 6,460 M) accessed HIV Counseling and Testing services, including clients in the PMTCT setting. The project prevalence was 11% based upon CMMB's results, with Ezo County registering the highest number of HIV positive clients at 13% prevalence. There is significant increase in the number men who accessed VCT services in Year 2 compared to 2010, where low turnout of men for VCT was noted as a contributing factor to stigma and discrimination among women and increases in new infection in polygamous families. Particularly in the VCT facilities, 47% of those tested (12,377) in 2011 were men compared to 43% in 2010. Out of those tested, 10% of clients tested positive and were referred to ART centers. Thirty-six (36%) percent of those referred reported to ART center for care and treatment. Low client-reporting could be due to many factors including inaccessible clinics and ART stock-outs, as mentioned in *Challenges*. Follow up and counseling is ongoing for those who have not yet reported for treatment.

P11.1.D			Target	Results
	# Individuals who received counseling and testing services for HIV and received their results		11,200	**17,312**
	< 15 yrs	Male		340
		Female		432
	15+ yrs	Male		6,120
		Female		10,420

CMMB developed strategies to expand access to HIV testing and counseling services to increase knowledge of HIV status and spread the benefits of such knowledge by reaching out to more communities with mobile HIV Counseling and Testing services. Thirty-five percent (35%) of the 12,377 clients accessed mobile VCT services during outreach days in the community.

Ezo VCT/PMTCT Center was inaugurated by the Commissioner of Ezo County.

Thirty-seven (37) outreach sites have been established across the counties of operation. VCT Services were offered twice per week in all these sites. However, the VCT mobile services were suspended during the third quarter due to lack of test kits (as discussed in *Challenges*). Renovation of Ezo VCT/PMTCT Center was completed to serve the overwhelming number of clients seeking VCT services at Ezo Primary Health Care Center (PHCC).

Continued community mobilization and sensitization was integrated with mobile Voluntary Counseling and Testing. Market gatherings and events such as World AIDS Day and International Women's Day provided an opportunity to reach more community members with VCT services. Community meetings and sensitization campaigns were organized to introduce ANISA project in Ibba County and also create awareness about voluntary counseling and testing services. In the subsequent months, ANISA also designed culturally-competent services provided in a style and format sensitive to cultural norms, values, and traditions that are understood by the community and accepted by the target population. This intervention has borne fruit and more clients are accessing VCT services.

VCT Counselors during Lab training.

To expand access to high-quality voluntary counseling and testing services in the Western Equatoria State, 13 counselors were recruited and trained on HIV Counseling and Testing in November. These counselors have been integrated into Ibba and Ezo Counties VCT services. Counselors are trained to view all clinical encounters with clients as potential opportunities to provide and reinforce HIV-prevention messages. Client-Centered Counseling is prioritized to fulfill public health functions, tailored to the behaviors, circumstances, and special needs of the person being served.

The VCT Team leader and a counselor were selected to represent Western Equatoria State in Gender-Based Violence (GBV) Master Training in Juba. The trainees were equipped with counseling skills to deal with women and girls who have experienced sexual violence and report to VCT center for counseling and testing for HIV. The VCT center has become an easily accessed point for the community to seek emotional and psychological support, as well as an information pathway for health concerns and other issues.

The VCT Team, together with three counselor supervisors, offer regular support to in addition to the regular field visits conducted by the M&E Officer to monitor the progress of the project and support the staff on using M&E tools. The counselor's learning and continued development was fostered through quarterly group supervision meetings. Supervision in groups provided an

opportunity for counselors to experience mutual support, share common experiences, solve complex tasks, learn new behaviors, participate in skills training, increase interpersonal competencies, and increase insight. These meetings offer in-house trainings and refresher trainings for new and existing counselors. Counselors from the MOH and other organizations are invited to participate in this forum.

The PEPFAR Team visited Yambio in the second quarter and interacted with the staff of Yambio and Nzara VCT and PMTCT centers. The team also had focus group interaction with youths and peer educators from Yabongo Secondary School in which interactive discussion was held on some of the cultural practices among Azande culture, community response of HIV/AIDS.

IR 1.1 Challenges and Way Forward

The VCT centers experienced a shortage of test kits at the end of the second quarter. Timely requests were made, but the kits were not delivered in time to avoid a shortage. Centers networked with other VCT facilities, such as Yambio Hospital, and test kits were borrowed. Additionally, an emergency request was made to UNDP through the MOH to ensure consistency in service delivery to the community.

Inaccessibility to ART Centers in other areas, especially Ezo County, remains a challenge.

High turnout of clients at outreach sites is overwhelming at times. Outreaches are organized once a week at a site and yet there are a number of complaints from the community that they feel service delivery should be expanded, preferably by having static satellite sites which are operational throughout the week.

IR 1.2 Expanded and improved mother-to-child prevention services are available in clinics and communities.

IR 1.2 Progress

ANISA's PMTCT arm's main objective is to put in place all the four pillars of PMTCT. Women who test HIV positive receive anti-retroviral drugs to reduce MTCT. HIV positive women also receive care with ongoing support through the mother-to-mother support group. TBAs play an important role, as their training has made them well-versed in safe delivery practices to prevent MTCT. The last objective was to ensure the existing health personnel are trained in PMTCT.

In this project year, the ANISA team focused on reaching not only pregnant women for PMTCT interventions, but also lactating and post-partum women, to reach the most women in need of services and avert the most pediatric infections. Therefore, while the number of pregnant women who tested for HIV and received their results was 2,296, the ANISA team also tested 1,947 additional post-partum and lactating mothers, bringing the total MTCT intervention to 4,243 mothers reached including 692 who tested as couples. The VCT opt-in rate for mothers was nearly 100%. During the third quarter the team opened the new EZO PMTCT site. Previously,

PMTCT was conducted in a single room, which was very congested. This was a great achievement to have more space with a designated waiting area for PMTCT and ANC.

	Lactating VCT	*Lactating HIV+*	*HIV Prevalence*	*Pregnant VCT*	*Pregnant HIV+*	*HIV Prevalence*	*Total VCT*
Nzara	909	92	10.10%	951	61	6.40%	1,860
Yambio	783	61	7.70%	609	35	5.70%	1,392
Ezo	255	42	16.40%	736	96	13.04%	991
Total	**1,947**	195	10.20%	**2,296**	192	8.36%	**4,243**

PMTCT data October 2010 – September 2011. Table indicates both lactating and pregnant mothers who received VCT.

P1.1.D	# Pregnant women with known HIV status	Target	Results
		3,200	**2,296**
P1.2.D	# HIV positive pregnant women who received ARVs for PMTCT	Target	Results
		160	**201**

PMTCT ARV interventions are varied based on the location of the mother. Single dose nevirapine (SDNVP) is used in the communities who receive only outreach PMTCT where there is no nearby ART center. Outreach clinics were carried out in Payams within each county to reach the very rural areas, including the IDP camp. In most outreach sites, the team also taught mothers on breastfeeding practices because most of them were tested post-partum because of lack of facilities. Contrastingly, Nzara ART Center has started to do CD4 counts on all HIV-positive pregnant women and all those with a CD4 less than 350 are being started on ART at the Center or Yambio State Hospital. The target for maternal prophylaxis was 160 mothers, and 201 received ARVs.

The PMTCT clients are enrolled for monitoring, ongoing care and support to ensure comprehensive care for all HIV positive women. The mother-to-mother peer champions followed up with mothers on ARVs and HIV exposed babies who had received nevirapine to ensure the mothers adherence to treatment. The peer champions counseled lactating mothers on exclusive breastfeeding. Through this system, 529 HIV positive pregnant women were followed up and 55 women were lost-to-follow-up, including many who were internally displaced families due to LRA attacks.

Nutrition demonstration for pregnant women and new mothers.

Mothers also receive breastfeeding and nutrition education and support through community events and radio talk shows. Adequate information was given in the local language and pregnant mothers and their partners were encouraged to visit PMTCT sites. Church leaders and chiefs were encouraged to help in disseminating the exclusive breast feeding message in a culturally accepted manner. Additionally, in Ezo, a nutrition seminar was conducted. Mothers were trained in preparing a balanced diet using safe cooking methods to meet the nutritional needs of themselves and their babies.

Training was conducted in Yambio for nurses and midwives to ensure that health personnel are able to provide HIV testing and counseling to all pregnant women at antenatal settings. Fourteen (14) counselors and Midwives were trained. TBAs continued to have ongoing training on safe delivery. They are also involved in mobilizing mothers to attend ANC and encouraging them to deliver at a health facility where they may access PMTCT services.

The PEPFAR team visited all our partners, the MOH, Yambio Hospital, and county medical offices. The feedback from the donors after their visit was very positive. They concluded that the ANISA program has the best PMTCT services at the national level, particularly in Nzara.

IR 1.2 Challenges and Way Forward

There were financial constraints due to high fuel prizes which affected the outreach mobile clinics. Follow-ups of clients on ARVs was interrupted due to provisional suspensions of outreaches.

The supply of ARVs was very erratic at the ART center. Yambio ART center was getting very limited supplies of ARV and could not cater for all the babies for both the hospital and CMMB's PMTCT sites. The team began receiving pediatric ARVs directly from MOH stores in Juba in September 2011, which has greatly improved services. The MOH HIV/AIDS Directorate should continue to follow up on ARV requests so that they are honored in time to avoid missed opportunities and drop outs on treatment, which leads to resistance.

The institutional framework required to support health activities is significantly lacking in South Sudan. There is a very serious shortage of midwives, most of whom are elderly and have difficulty with drug administration and calculations.

While outreach has made it possible to increase broad coverage, follow up on the HIV-exposed babies is still done with difficulty because of insecurity along some roads are impassable when it rains. There is a particular challenge for mothers in WHO Stage Four (clinical staging) referred for ART. Transport problems still prevail; as a result the mothers referred for ART will not be able to access the ART center, which poses a serious risk on the health of the mother and baby. A permanent mobile clinic for PMTCT should be considered to counteract geographical barriers. The team should consist of a Midwife and two counselors, which could cater for Yambio and Nzara County.

IR 1.3 Communities adopt primary prevention techniques based on the *'Abstain and Be Faithful'* approach.

IR 1.4 Communities adopt prevention practices beyond abstinence and/or being faithful.

IR 1.3 and 1.4 Progress

The ANISA prevention team continued to work with six community HIV support groups of PLWHA and CBOs that work in the area of HIV awareness and sensitization. These CBOs and PLWHA support groups have ANISA-trained peer educators that carry out sensitization and small group awareness sessions in their respective groups, but they may also go out for community sensitization arranged and supported by the ANISA primary prevention team.

Peer educators from various PLWHA support groups and community CBOs delivered HIV prevention and sensitization in small groups in the community. These 281 peer educators are trained by ANISA HIV prevention team and they mostly belong to or are members in the CBOs, PLWHA groups and agencies. In Year 2, the ANISA team trained 115 new peer educators from community partner CBO, FBO, PLWHA, and Government agencies to promote HIV prevention through other behavior change beyond abstinence and/or being faithful.

In small group sessions hosted by ANISA trained peer educators, 26,709 individuals were reached with prevention interventions that are based on evidence and/or meet the minimum standards required. During these sessions and through the condom distribution outlets, the ANISA team distributed 48,000 male and 6,000 female condoms. This however was significantly less than the actual demand and amount needed in the three counties which was estimated at 135,000 pieces per quarter. The TA taskforce monitored 38 partners delivering the OP program. These partners include bars, night clubs, sex workers, mini bus drivers, and lodges, in addition to PLWHA support groups, IDPs, women groups, truck drivers and uniformed forces. Primary prevention is one of the pillars of PMTCT. Peer educators ensured women had access to information by doing condom demonstrations and emphasizing proper use of the condom in promoting safer sex behaviors. Peers also encouraged women to know their status before conceiving, including the status of their partners.

Additionally, 20,368 of the targeted population was reached with individual and or/small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required. Technical assistance

continued to be delivered to 28 partner agencies on 'A' and 'AB' programs. This includes 5 secondary schools and 23 primary schools.

		Target	Q1	Q2	Q3	Q4	Total
P8.1.D	# Targeted population reached with individual and /or small group level prevention interventions that are based on evidence and/or meet the minimum standards required	50,000	1,411	7,715	8,421	9,162	26,709
P8.2.D	# Targeted population reached with individual and or/small group level preventive interventions that are primarily focused on abstinence and / or being faithful, and are based on evidence and / or meet the minimum standards required	42,000	1,166	5,884	6,656	6,662	20,368

Radio talk shows on HIV and community sensitization for one hour on air twice a week in two FM radios in Yambio continued during Year 2. As during Year 1, the prevention team made use of youth leaders, respected local youth figures such as local artists, female youth role models such as university and college female students, in addition to religious leaders and other prominent figures. Testimonies and educative experiences of PLWHA were also aired out directly on air. The prevention team also worked together with the other team leaders of PMTCT and VCT to air out sensitization programs in their respective thematic areas (as discussed in prior sections).

IR 1.3 and 1.4 Challenges and Way Forward

There continued to be a lack or shortage of condoms throughout the prevention implementation activities and areas of operation. This definitely undermined the program's primary prevention efforts. In the future, World Vision, who is providing condoms, will seek to supply condoms through their GIK program.

A number of challenging cultural factors have been identified and mentioned by community partners and members, some of which are: early age of sexual debut, early marriage and multiple partners, and sex outside marriage. There is a need to change the strategy to address and strengthen the policy that could eliminate or reduce the cultural practices of early and forced marriages. ANISA could advocate for policy reform to address these issues.

Trained peer educators are doing good work in the community, raising awareness in regard to HIV prevention and reduction of new HIV infections. However, the issue of motivation for them has remained a challenge throughout this reporting period. Incentives for those already working and refreshments and/or light meals during training meetings could increase motivation.

IR 2.1 Expanded and improved palliative care services are utilized.

IR 2.2 Linkages/referrals to wrap around services for PLWHA are viable.

IR 2.1 and 2.2 Progress

The ANISA care and support team continues to work with the existing 8 service outlets providing HIV-related palliative care. The team also works with the county health departments to strengthen the capacity of community health workers to provide HIV-related palliative care. The eight Community/Faith Based Organizations which are currently involved in implementing care and support activities are handled in such a way that they would be able to work on their own after the end the project. They are as well expected and prepared to be able to provide ongoing support to PLWHA in form of social, psychological and physical support after the project has ended. As part of its training initiatives, 171 community members, including PLWHA, were trained as Community Home-based Caregivers, volunteers/home visitors and primary caregivers for chronically ill persons at homes.

Home-based caregivers reached 5,851 eligible adults with a minimum of one care service. Of these, 2,981 clients were females and 2,870 were males. Similarly, 1,394 eligible adults and children were reached with a minimum of one clinical service (cotrimoxazole prophylaxis). Of these, 968 clients were females and 426 were males. HBC clients also received basic care packages such as Long-lasting Insecticide Treated Nets (LLITNs), plastic basins, bed sheets, mattresses, carpet sheets, and washing soaps. Rice, sugar, beans, and cooking oil were provided to the 8 PLWHA support groups. Additionally, trained community Home Based Caregivers educate their clients, caregivers, and family members in the care process.

C1.1.1	# Eligible adults and children provided with a minimum of one care service	**Target**	**Results**
		5,000	**5,851**
	< 18 yrs	Male	0
		Female	0
	18 + yrs	Male	2,870
		Female	2,981

C2.1.D	# HIV-positive adults and children provided with a minimum of one clinical service	**Target**	**Results**
		4,000	**1,394**
	< 15 yrs	Male	28
		Female	45
	15 + yrs	Male	398
		Female	923

C.2.2.D	# HIV positive persons receiving cotrimoxazole prophylaxis	**Target**	**Results**
		4,000	**1,394**

IR 2.1 and 2.2 Challenges and Way Forward

HBC Givers are key players in care and support activities, but motivation is sometimes lacking. Though they are based in their various support groups, they need some small incentive to motivate them in what they do to improve the lives of PLWHA.

There is a very limited budget to provide the needed support to PLWHA. Essential care needs to be prioritized moving forward. Increased funding would allow additional support activities including: income generating activities, economic strengthening services, care for Orphans and Vulnerable Children (OVC), nutritional support, and patient transport services.

The number of clients receiving OI treatment prophylaxis is overwhelming. This limited the number of clients to be enrolled for OI treatment to avoid possible drug resistance to those who have already started treatment, in case the supply runs out. More cotrimoxazole needs to be procured to ensure constant supply of drugs.

Supporting the peer educators and HBC volunteers and CBOs/FBOs implementing care and support services needs to be continuous.

IR 2.3 PLWA groups are expanded and strengthened.

IR 2.3 Progress

PLWHA participation in the care process, disclosure support, and community participation in the care process of terminal and chronic sickness is strengthened and made sustainable at community levels by collaborating with health facilities and community health workers. The CBOs, mostly formed by groups of PLWHA, are the source for ongoing counseling for their members. Their meetings are an important place where the group members find comfort and interact with others. Each support group is provided with a group discussion guide, and one member or volunteer takes the lead in choosing a topic for discussion whenever the group meets.

Two support groups were visited during the third quarter to determine pregnant women's adherence to ARV prophylaxis or ART and find out if they were receiving proper breastfeeding messages. Exclusive breastfeeding not well understood and most of the pregnant mothers were not on ARV prophylaxis or ART, nor were their babies. A workshop was conducted at the Star Group to reverse misconceptions on exclusive breastfeeding. The pregnant women are also now getting ART at the right time. The Rainbow Support Group babies were severely malnourished and the women lacked knowledge on safety precautions on how to prepare the formula they had been given. The Sisters and staff members were given proper information on breastfeeding practices. This was a major breakthrough at a support group which hosts about 200 to 300 women.

During the year at all PMTCT sites, mothers receive prophylaxis for opportunistic infections and treatment of sexually transmitted infections. Mother to mother support groups are in progress at all PMTCT static sites, mentoring HIV positive women to live positively to adherence to ARV

prophylaxis and treatment. Health education talks on nutrition, hygiene, newborn care, and ARV adherence lectures goes on at each site.

IR 2.3 Challenges and Way Forward

As mentioned in the above section, the budget for PLWHA interventions is limited. Activities must be prioritized and additional funds sought.

Resources for PLWHA nutrition are particularly limited. The ANISA team may need to seek additional support for establishing a sustainable community garden.

PLWHA support groups need additional technical support on quality data collection and reporting.

IR 2.4 Stigma and discrimination is reduced in communities and among health providers.

IR 2.4 Progress

As part of its stigma reduction initiatives, the ANISA team trained 40 religious leaders through Channels of Hope. They participated in HIV/AIDS stigma and discrimination reduction workshops to benefit their communities as well as their church institutions.

Care and Support IEC materials (T-shirts and posters) were distributed in health centers, hospitals, private clinics, pharmacies, State MOH, State AIDS Commission, County AIDS Commission, County Health Department, and support groups. These IEC materials contain messages on positive living, education for PLWHA on nutrition, caring and supporting PLWHA socially, psychologically, and physically at home.

IR 2.4 Challenges and Way Forward

Stigma against PLWHA and those seeking HIV/AIDS-related services continues to be a challenge, despite community sensitization campaigns and training for healthcare workers promoting client-friendly services. Provision of visible care and support programs within the community proves to be effective in reducing stigma and discrimination. Combining counseling and information-based approaches that break the "culture of silence" associated with HIV/AIDS and promote a culture of openness and support are recommended to continue to reduce stigma in the community.

SO 3 Build and Strengthen the State, counties, and local partners' capacities in Strategic Information (SI), policy development, and implementation.
Laboratory Strengthening

Progress

One of the activities taken up in Year 2 was to strengthen laboratory services within the implementation areas so as to improve management of HIV patients. Activities carried out during the year included: assessment of the laboratories in Yambio, Nzara, Naandi, Ezo and Ibba health facilities; procurement of basic laboratory supplies; and initial training of the laboratory personnel from the laboratories mentioned above.

Eleven laboratory personnel participated in the first training. Participants from Yambio hospital and PHCC, Nzara PHCC, Ezo PHCC, Naandi PHCC (Ezo County) and Ibba PHCC attended. The classroom aimed at equipping participants with skill of laboratory safety, laboratory code of conduct, quality assurance and quality control, decontamination, laboratory diagnosis for malaria, urinalysis tests, and maintenance of a microscope, stool examination and ZN staining. Three laboratories were chosen for inspection and practical part of the training, Yambio Hospital, Nzara PHCC, and Naandi PHCC. Inspections revealed unfavorable laboratory environment, limited supply of reagents, poor records keeping, and unskilled lab personnel.

Challenges and Way Forward

Though this first training was successful, there are numerous gaps that were noted that need immediate attention, including: 1) Additional trainings so that the laboratory technicians can become competent, effective, and accurate; 2) All labs need to be renovated to a physical standards including drainage, storage, ventilation; 3) Establish a central laboratory which will be responsible for monitoring the other labs; 4) Need for lab staff leadership; 5) Establish a regional blood bank as transfusions are done directly which risks contamination by HIV; and 6) Equipment replacement including microscopes and reagents.

Leadership and Governance

Progress

Dr. James Eyul facilitating the HSS workshop.

The ANISA team organized a training workshop for senior State decision makers and State heads from the four counties of Ezo, Nzara, Yambio and Ibba. The decision makers not only make or approve policies but as well decide on resource allocation of the State.

The health system strengthening workshop was conducted by CMMB in collaboration with the State MOH. The workshop brought together all the key Government officials together with the objective of enlightening them on HIV/AIDs situation in the state. In the workshop, the government stakeholders were

made to understand the low level uptake of HIV services due to geographical limitation and inaccessibility of services, lack of awareness among community members and lack of political will. The role of the stakeholders in health system strengthening was emphasized. This training emboldened decision makers with key knowledge required to address HIV and health issues within their jurisdictions.

Human Resources for Health (HRH)

As part of the goal to strengthen the health system of Western Equatoria State, the ANISA team trained community health workers and health care personnel in topics related to HIV/AIDS, as mentioned in the sections above. This serves as a summary of those trained. ANISA project trained 281 peer educators, 171 home-based care givers, 30 TBAs, 25 PMTCT personnel, and 13 VCT counselors.

		Target	Results
H.2.2.D	# Community health and para-social workers who successfully completed a pre-service training program	0*	452
II.2.3.D	# Healthcare workers who successfully completed an in-service training program	0*	68

* Did not set targets for these indicators for Year 2. Planning to scale-up implementation of Health Systems Strengthening initiative in Year 3.

CMMB
CATHOLIC MEDICAL MISSION BOARD

ANISA Project

CDC Award No: PS001632

Interim Progress Report: Year 3

October 1st 2011-September 31st 2012

Submitted to: Centers for Disease Control (CDC)

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Summary of Year 3 Progress to Date

Measurable outcomes are determined on an annual basis by the CDC/PEPFAR Sudan team, in consultation with CMMB. The outcomes for Year 3 (Q1 and Q2) of ANISA are listed below:

HIV Counselling and Testing

- **4** static service outlets provided counselling and testing according to national and international standards (**16** mobile locations);
- **15** individuals trained in counselling and testing according to national and international standards; and
- **7,362** individuals received counselling and testing for HIV and received their test results.

PMTCT

- **3** static outlets providing the minimum package of PMTCT services; (5 mobile sites)
- **1,172** pregnant women who received HIV counselling and testing for PMTCT and received their test results;
- **79** HIV positive pregnant women received antiretroviral prophylaxis for PMTCT; and
- **10** health workers trained in the provision of PMTCT services according to national and international standards.

Primary Prevention

- **9,903** individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful;
- **18** targeted condom service outlets;
- **17,163** individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful; and
- **21** individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful.

Care and Support

- **8** service outlets providing HIV-related palliative care (excluding TB/HIV);
- **6,129** individuals provided with HIV-related palliative care (excluding TB/HIV); and
- **51** individuals trained to provide HIV palliative care (excluding TB/HIV).

Progress by Intermediate Result (IR)

IR 1.1 Expand and improve availability of voluntary, client-initiated and provider-initiated HIV testing.

IR 1.1 Status

In the reporting period, VCT managed to target a number of clients in the community at the static centers and outreach centers. With the objectives of a) Promoting linkages between VCT services and other care and support services to strengthen referral mechanisms for VCT and b) Promoting strategies aimed at reducing stigma and discrimination to enable the clients and the broader community to cope and make personal decision to come for counseling and testing.

In year one and two, 37 HTC outreach sites have been active in the counties of Ibba, Yambio, Nzara and Ezo. Increase in cost of fuel made the number of fixed outreach sites to be reduced to 16. ANISA has primarily used client-initiated approaches in the past; the four static sites at the PHCCs have stand-alone VCT sites. ANISA is assessing how to transition to PITC in the next project year. Health workers have been selected to attend training that CMMB will be conducting next quarter. This has already taken shape in Yangiri PHCU and Naandi PHCU and the centers were supported with test kits and other supplies.

Clients that have tested positive as part of the post test counseling are referred for treatment as well as care and support services by use of referral cards. A monthly follow up and counting of the number of referral cards are done in all the ART centres to assess the proportion of those who reach the ART services. In the past two years, nearly 90% of positive clients have registered with the nearest Care and Support organizations. ANISA's HCT team leader conducts regular supervision of counselors. Counselor monthly meetings are conducted as a means of continual quality of services check. Random client exit interviews and dried blood spot (DBS) analysis is also conducted for QA purposes.

CMMB has achieved 37% of the annual target in Q1 and Q2.

P11.1.D			Target	Results
	# Individuals who received counseling and testing services for HIV and received their results		20,000	**7,362**
	< 15 yrs	Male		191
		Female		261
	15+ yrs	Male		2,521
		Female		4,362

IR 1.1 Major findings

Voluntary counseling and testing remains a corner stone for successful implementation of prevention, care and support services among HIV negative and positive individuals. A report from State AIDs Commission, South Sudan indicates that HIV prevalence in South Sudan stands at 3% but the disease burden in Western Equatoria State is higher at prevalence of 7% with the urban population most affected. At the project level, ANISA-supported sites have registered between 10-15% prevalence rates in Yambio, Nzara and Ezo counties. As the security threat in the State lessens, many IDPs and refugees and returnees who had sought refuge in urban areas are now returning home. This urban-rural migration means the disease could the rural population vulnerable to new infections. The VCT program has scaled up HTC mobile services to target the returnees' communities, particularly to rural areas, to curb new infections.

Perceived risk of HIV and benefit of VCT services has influenced the attitude and uptake of VCT among people in Western Equatoria State. Majority of people continue to express their willingness to test for HIV. Client exit interviews were conducted in all the three counties of operation to validate the quality of service provision at the centers. The reports indicate that of those surveyed, the vast majority of clients agreed that they would encourage their friends and families to come for VCT services.

IR 1.1 Barriers

The level of stigma and discrimination is still high especially among males. Many women do turn up for VCT services, but the numbers of males are still lower. Awareness is being created to sensitize the community on the importance of counseling and testing. Couples counseling is being encouraged.

IR 1.1 Challenges and Resolution

Despite the high demand for HIV counseling and testing services by the community, CMMB was not able to deliver services closer to all the people in community (through mobile services) due to limitation in resources, as fuel costs have doubled over the project duration. Strategies are being put in place for the VCT team to rotate to all the sites weekly.

Although the referrals are made for all HIV positive clients, access to ART still remains a challenge due to inadequate, inaccessible services, and LRA insurgency in some areas. VCT has taken initiative to address this by initiating a post test club to offer ongoing support to their clients and continued follow-up and assistance as clients seek ART services. Suspension and recall of Bio-Line HIV test kits posed a challenge and barrier to the testing algorithm that we are using in South Sudan. All trainings were suspended for some time and that caused delays in rolling out additional services to the community.

IR 1.2 Expanded and improved mother-to-child prevention services are available in clinics and communities.

IR 1.2 Status

Implementation of the four PMTCT prongs is delivered directly by the ANISA project or through appropriate referrals. The ANISA project has adopted a comprehensive approach to integrating HCT and PMTCT into ANC services. All HIV positive women receive ARV prophylaxis at the ANC, except those in stage three and four who are referred to the nearest ART center for ART initiation. All HIV positive mothers are enrolled for ongoing care and support. A "basic care package" of condoms, cotrimoxazole, staging and referral for ART, TB screening, and linkages to persons living with HIV community support groups is offered to all HIV positive individuals at the sites. The STI screening and treatment is offered to every woman at ANC

clinics. ANISA supports in-service PMTCT refresher training for project and MOH health care workers (15 midwives and 9 counselors).

To improve adherence of mother-infant pairs as well as strengthen care and support services for HIV positive mothers, ANISA uses a Mentor Mothers program. The goal for Mentor Mothers is to ensure women adhere to taking their ARVs mobilize pregnant women for testing, living positively, and follow up with mothers to ensure exclusive breast feeding. ANISA also trains TBAs to increase the number of pregnant women who attend ANC and to encourage the proper use of prophylactic medicines to ensure babies are born HIV free. Each TBA is assigned positive pregnant women at ANC who reside close to her to monitor. TBAs receive refresher training annually on safe delivery to prevent MTCT.

The CMMB ANISA project will continue to conduct PMTCT activities in four established PMTCT clinics in Yambio, Nzara, Ezo and Ibba counties and 16 fixed outreach sites. CMMB has reached 41% of the HIV testing target for pregnant women, and 46% of the treatment target for PMTCT.

P1.1.D	# Pregnant women with known HIV status	Target	Results
		3000	**1220**
P1.2.D	# HIV positive pregnant women who received ARVs for PMTCT	Target	Results
		300	**137**

IR 1.2 Major findings

Project-level HIV prevalence has been ranging up to 15 percent at PMTCT sites. See below for a commentary of scheduling issues due to government testing days.

IR 1.2 Barriers

A barrier we have encountered is that ANC in the whole state occurs only on Wednesday. This makes outreach efforts a challenge. We cannot carry out PMTCT at outreach sites only on one day due to scheduling of vehicles, and this forces us to change the days. Mothers continue to go

for ANC on Wednesday, and those we meet on the alternative days will only be lactating mothers, who we provides services to but do not count in the PEPFAR Indicator Guidance.

To try and reach out to pregnant women in remote areas, we established static sites for Wednesdays to try to reach all pregnant women. This is challenge because of staff shortages, however, 2 operational static sites have been established in each county.

IR 1.2 Challenges and Resolution

As mentioned above, CMMB frequently reaches only lactating women during outreach days. The target was initially made on a figure which included lactating mothers, and since then it has not been rectified at PEPFAR meetings in Juba.We hope this will be rectfied so that progress can be measured well.

CMMB leverages TBAs to conduct follow-up with mothers. There is a major complaint that the areas of coverage are too big and the incentives are too small. Each county has at least 2 TBAs for follow ups and they follow up babies and mothers on ARVS. We will need to increase the budget in order to increase the stipends or the number of active TBAs. We have tried to engage some of the counselors in follow ups, but they still have to do outreach which is another challenge.

Conducting PMTCT outreach in rural communities is important, yet very expensive in terms of staff time and fuel cost. To attempt to mitigate this and save additional monies for outreach services, we have resorted to using a motorcycle for areas which are more easily accessible and saving larger vehicles for farther outreaches.

IR 1.3 Communities adopt primary prevention techniques based on the *'Abstain and Be Faithful'* approach.

IR 1.3 Status

The AB prevention messages are linked to other services through community mobilization/mass media. The target groups and convinced to know their HIV status to better inform their choice of A or B risk reduction. The target groups are also linked to health facilities to seek help for any health need arising, including access to condoms as part of OP programming should they fail to maintain the A or B option. ANISA project has been able to package messages to address community and cultural social norms and practices. These messages are uniform throughout the program. AB, OP, HTC as well as PMTCT are all linked; a combined team carries out combined sensitization twice a month on the local FM station, key markets and churches. Activities aimed at reducing multiple and concurrent partners to eventually one partner and being faithful to that one partner are also be focused on.

The progress towards achieving this target is ongoing. We have met 43% of the goal for AB-based prevention messaging.

		Target	Q1	Q2	Q3	Q4	Total
P8.2.D	# Targeted population reached with individual and or/small group level preventive interventions that are primarily focused on abstinence and / or being faithful, and are based on evidence and / or meet the minimum standards required	23,000	4,881	5,022			9,903

IR 1.3 Major findings

In the next two years, Sexual prevention activities under AB will target about the relatively more at risk population along the busy trade routes of: Ibba-Yambio, Yambio- Nzara, Nzara- Ezo via Diabio. HTC data from the last two years have shown that there are more positive adults in town areas and along these corridors compared to rural areas. Young adult men and women aged 18-30 who engage in concurrent partnerships will be targeted with designed messages on HIV transmission, faithfulness and benefits of taking an HIV test.

IR 1.3 Barriers

There is a strong cultural practice which encourages young girls to start sexual debut at a very early age, e.g. as soon as a girl shows signs of adolescence. This is done by providing a girl with a separate accommodation hut a few meters away from the main house hold as a sign of liberty and family/community consensus and permission that she is now free to have male visitors. This cultural practice is probably responsible for rampant teenage pregnancy and increased rates of HIV transmission. Addressing this cultural practice will take time.

The ANISA project is has addressed the issue by including interactive talk shows on local FM radios in local Zande language. Engaging community leaders and the community custodians of culture in interactive discussions and training workshops is a tangible step but could not be done in Q1 and Q2 due to its budgetary limits. In year 4, radio spots will be shared and rotate with the VCT, PMTCT and ANC messages (paid through VCT and PMTCT activity budget).

IR 1.3 Challenges and Resolution

Engaging community leaders and the community custodians of culture in interactive discussions and training workshops may be a helpful step towards addressing the cultural practice noted above, but could not be done due to its budgetary implications. ANISA will endeavor to include this work in Year 4 by reducing focus on abstinence education in primary schools, per recommendations by PEPFAR.

IR 1.4 Communities adopt prevention practices beyond abstinence and/or being faithful.

IR 1.4 Status

The high uptake of HTC in the 4 ANISA counties has greatly attributed to the awareness campaign as part of other prevention activities. Activities in the next two years will continue to target locations with a growing HIV risk including the trade corridors and town centres and suburbs. Promotion of condom use forms a large component of the OP campaign. Peer educators

are given special topics on condoms and their role in controlling the spread of HIV. ANISA adopted and designed condom promotion leaflets with pictures showing correct use of condoms and benefits. Condoms are regularly distributed to outlets in lodges, bars, salons and trailer parks in Yambio, Nzara, Ezo and Ibba. Through their network peer educators have identified 14 individual condom distributors (8 male, 6 female) who are regularly supplied with condoms. Use of condoms in WES, which is assessed by the rate and number of replacements at the condom access points, has substantially increased. ANISA has met 57% of the target for Other Prevention (OP) messaging, including condom education.

		Target	Q1	Q2	Q3	Q4	Total
P8.1.D	# Targeted population reached with individual and /or small group level prevention interventions that are based on evidence and/or meet the minimum standards required	30,000	6,969	10,194			**17,163**

IR 1.4 Major findings

Because of the aforementioned cultural practice (of promoting early sexual debut) young ladies who become pregnant at an early teenage period are in a fairly large numbers in the community. These young ladies provide a unique and significant section in the community. They are very young, with many sexual partners. She may practice different forms of transactional sex including prostitution to support herself, her children, and sometimes her relatives or extended family members.

IR 1.4 Barriers

New myths about condom use are a daily phenomenon, particularly among the community of young women previously mentioned. The primary prevention team and the other team members have to remain alert for new myths and counter each accordingly. High illiteracy level acts as a

catalyst for fueling spread of myths and as an impediment for permanently addressing issues of concern such as acceptance of condom use.

IR 1.4 Challenges and Resolution

Inconsistent supply of condoms for program use remains a challenge in Year 3. Condom supply and availability in the field needs to be streamlined. A budget increase would allow the Prevention team to reach the aforementioned adolescent at-risk population with targeted messaging.

IR 2.1 Expanded and improved palliative care services are utilized.

IR 2.1 Status

To ensure care and support services reach PLHIV, ANISA will continue sub-granting CBOs that have always been in the communities and played a great role in supporting PLHIV. The CBOs have a set of experienced care givers and understand the communities and needs of PLHIV well. Currently there are 171 trained and supervised care givers. Training of caregivers is of utmost importance. Care givers take care of bed-ridden individuals living with their families and visit friends and neighbors living with HIV. The need for training of health providers is more than ever before because of the high number of HIV patients in Western Equatoria. ANISA has been holding trainings for home-based caregivers during Q1 and Q2 and providing them with kits containing essntial hygiene and livelihood items to distribute to PLHIV clients.

The ANISA project has met 61% of its target for Year 3 for care service provision and 80% of its target for clinical service provision. As shown below, clinical service provision is exclusively cotrimoxizole prophylaxis.

C1.1.1	# Eligible adults and children provided with a minimum of one care service	**Target**	**Results**
		10,000	**6,129**

	< 18 yrs	Male	388
		Female	1,033
	18 + yrs	Male	2,063
		Female	2,645

C2.1.D	# HIV-positive adults and children provided with a minimum of one clinical service	**Target**	**Results**
		3,000	**2,398**
	< 15 yrs	Male	43
		Female	46
	15 + yrs	Male	868
		Female	1,441

C.2.2.D	# HIV positive persons receiving cotrimoxazole prophylaxis	**Target**	**Results**
			2,398

IR 2.1 Major findings

The number of PLHIV in WES is increasing, but interventions for them are limited, especially with the withdrawal of Global Fund. Additionally, there are many OVCs in the support groups, but no interventions geared specifically for them.

IR 2.1 Barriers

The ANISA project has encountered issues with transport of clients, particularly OVC, to the support groups. We have shared this with other INGOs and are looking for ways to provide transport for these individuals who live farther from support groups.

IR 2.2 Linkages/referrals to wrap around services for PLWHA are viable.

IR 2.2 Status

ANISA is focusing on providing the PEPFAR South Sudan Basic Care Package to all persons who test for HIV and to ensure compliance by patients with treatment and follow up to ensure referrals are completed. This Basic Care Package provided at clinic settings consists of cotrimoxazole prophylaxis, screening for active TB, distribution and education on the use of condoms, linkage to local PLHIV support services and CD4 staging.

IR 2.2 Major findings

ANISA has found that are increasing rates of new infection, which led to increase in the number of PLHIV. This has invariably led to an increase in the number of individuals seeking support group and care assistance.

IR 2.2 Barriers

ANISA has observed that there are few well-qualified personnel at the government health facilities who are able to provide specialized care for PLHIV. The ANISA project has tried to make referrals and arrange transport for the clients to reach necessary care.

IR 2.2 Challenges and Resolution

Transport has become an issue for visiting sites to provide supportive supervision. WVSS has allocated one vehicle for ANISA, but due to increasing fuel costs, taking the vehicle out to the sites remains a challenge.

IR 2.3 PLWA groups are expanded and strengthened.

IR 2.3 Status

ANISA's plan for Year 3 is to expand to five newly formed support groups. We have reached 3 thus far, one in Ibba County and two in Ezo County, including one at Naperere refugee camp.

IR 2.3 Major findings

As the number of PLHIV increases, ANISA endeavors to reach additional support groups and increase the number of caregivers to accessibility to care & support services.

IR 2.4 Stigma and discrimination is reduced in communities and among health providers.

IR 2.4 Status

ANISA has conducted three trainings on stigma & discrimination for 80 participants in Yambio, Nzara and Ezo counties.

IR 2.4 Major findings

HIV & AIDS is not seen as big problem now among WES community, which has limited discrimination against PLHIV. Community members now consider it to be like any normal illness and most people are willing to come out openly. Some of the PLHIV are very active in HIV prevention advocacy.

IR 2.4 Challenges and Resolution (ONLY IF APPLICABLE)

Due to budgetary limits in year 4, ANISA will no longer be continuing with this activity. We feel that the community has accepted PLHIV, who are able to seek support at the PLHIV CBO groups that ANISA supports financially and with technical assistance.

SO 3 Build and Strengthen the State, counties, and local partners' capacities in Strategic Information (SI), policy development, and implementation.

SO 3 Status

CMMB has planned to carry out all the HSS activities during Q3 and Q4 of Year 3. CMMB will be conducting its policy-maker training for education on health-related issues, particularly

HIV/AIDS, during Q3 and Q4 of year 3. This activity has been postponed until after the new state government official are sworn in. CMMB will also train 12 laboratory personnel, procure laboratory equipment and supplies, and train administrators in HMIS during Q3/Q4.

However, CMMB has captured its other HRH activities as below:

		Target	Results
H.2.2.D	# Community health and para-social workers who successfully completed a pre-service training program	500	71
H.2.3.D	# Healthcare workers who successfully completed an in-service training program	62	16

SO 3 Major findings

N/A

SO 3 Barriers

N/A

SO 3 Challenges and Resolution

N/A

Year 4 Proposed Objectives and Activities:

IR 1.1 Expand and improve availability of voluntary, client-initiated and provider-initiated HIV testing.

Year 4 Activities:

- Activity 1: Train additional counsellors to strengthen PITC services and conduct refresher trainings for existing counselors.
- Activity 2: Provide ongoing support and TA to ensure quality HTC in Yambio, Nzara, and Ezo counties.
- Activity 3: Expand HTC services to reach additional remote communities and provide HTC for 00,000 clients.
- Activity 4: Community mobilization to increase uptake of HTC services and reduce stigma against seeking HTC.

Activity 1: Train additional counsellors to strengthen PITC services and conduct refresher trainings for existing counselors.

- Develop and adopt PICT training manuals for local context during Q1. This is a new activity to focus on the directive form PEPFAR for increased PICT
- Recruit and conduct PICT training for 5 health workers at 5 PHCUs (Q1) and provide incentives for each HTC done (throughout year 4). This is a new activity to focus on the directive form PEPFAR for increased PICT.
- Conduct monthly group supervision meetings for HTC counselors across the state to building their capacity and provide an avenue for sharing experiences in handling and responding to client issues.
- Conduct refresher training for 15 HCT counselors and existing PHCC per SSAC guidelines. Including training on post-test counseling (risk reduction techniques).

Activity 2: Provide ongoing support and TA to ensure quality HTC in Yambio, Nzara, and Ezo counties.

- Perform quality Controls for HIV Testing conducted by HTC counselors and health workers through DBS Collection and client exit interviews.
- Develop referral networks for follow-up services (ART, support groups) for clients who visit ANISA-supported HTC sites in the community as part of counselor training. This will reach 3,000 clients during year 4.
- Renovate 3 HTC satellite sites in Yangiri, Li-rangu and Naadianga Payams. Procurement furniture and equipment for newly renovated sites during Q1 and Q2.

Activity 3: Expand HTC services to reach additional remote communities and provide HTC for 20,000 clients.

- Continue to conduct HTC at 3 established static centers and 3 satellite centers (1 existing, 2 newly established as above) to reach 20,000 clients.
- Establish mobile VCT 5 days/week, linked to PHCCs in Yambio, Nzara and Ezo Counties. Mobile sites target returnees, IDPs, refugees, and rural dwellers.

Activity 4: Community mobilization to increase uptake of HTC services and reduce stigma against seeking HTC.

- Using appropriate media to address and promote HTC services to increase demand for VCT e.g talk shows, radio shots, IEC materials among others. Radio talk show organised weekly in collaboration with prevention department.
- Formation of 3 Post test clubs (1 per static site) for people who have known their status who will hold monthly meetings (CMMB provides meeting materials)
- One day workshop in Ezo, Nzara and Yambio for leaders of post test clubs.
- Community campaigns in markets and other social gatherings to include HTC, condom demonstrations and distributions (one event per county per month).

IR 1.2 Expanded and improved mother-to-child prevention services are available in clinics and communities.

Year 4 Activities:

Activity 1: Service outlets outfitted to provide PMTCT services according to national and international standards.
Activity 2: Training for midwives, counselors, and health care workers to provide PMTCT or supportive services.
Activity 3: Provide HTC and appropriate prophylaxis to mother-infant pairs in PMTCT setting.
Activity 4: Provide ongoing support to HIV+ women.
Activity 5: Support TBAs and midwives to provide HIV prevention messages to pregnant women.

Activity 1: Service outlets outfitted to provide PMTCT services according to national and international standards.

- CMMB will introduce 3 static outreach sites (1 per county) to reach women who cannot access permanent services at PHCCs and allow for continuous monitoring of HIV+ women (as opposed to sporadic visits from mobile team) and reduce cost/frequency of outreaches. This is a new activity and CMMB will endeavor to reach 3,000 clients in this way during year 4.
- CMMB will procure delivery beds and install safe, clean flooring in 3 PHCC to ensure safe deliveries by the end of Q1.
- CMMB will provide basic ANC equipment and supplies to 7 (3 new, 4 existing) sites.

Activity 2: Training for midwives, counselors, and health care workers to provide PMTCT or supportive services.

- CMMB will train 19 existing health care workers in HTC for PMTCT to work at the new static sites and refurbished sites as above during the first 2 quarters of Y4.

Activity 3: Provide HTC and appropriate prophylaxis to mother-infant pairs in PMTCT setting.

- CMMB will counsel and test 3,000 women throughout year 4.

- CMMB will provide FP messages and FP methods for 3,000 women who attend ANC throughout year 4.
- CMMB will ensure regular supply for ARVs for PMTCT to ANISA-supported sites through transport from UNDP stores to sites to reach 180 women with ART over the course of year 4.
- CMMB will provide essential medicines (cotrimoxazole, pain killers, iron supplements) to 300 mothers and 300 babies with known positive or unknown HIV status (born to HIV+ mothers) per guidelines. This activity will reach 4 sites throughout the course of year 4.

Activity 4: Provide ongoing support to HIV+ women.

- CMMB will reach 200 PMTCT clients with small-group nutrition demonstration sessions for both mothers and babies.
- CMMB will provide all ANISA-supported PMTCT with IEC materials for safe and exclusive breastfeeding.
- CMMB will enroll 3 existing mentor mothers as PMTCT counselors at ANISA-supported sites.
- CMMB will host radio talk shows on local FM stations for messages on exclusive breastfeeding and the importance of early ANC.

Activity 5: Support TBAs and midwives to provide HIV prevention messages to pregnant women.

- CMMB will support TBAs to make follow-ups with HIV+ pregnant women in the community by providing monthly incentives and purchasing 3 additional bikes to reach 300 PMTCT clients.
- CMMB will train 16 TBAs in exclusive breastfeeding messages and follow-up adherence counseling for HIV+ mothers and safe delivery practices. This is a new activity to ensure all mothers (even in remote communities) receive continuity of care to reduce MTCT.

IR 1.3 Communities adopt primary prevention techniques based on the *'Abstain and Be Faithful'* approach.

Activity 1: Training of community peer educators to promote HIV prevention through abstinence and/or being faithful.
Activity 2: Community outreach for HIV prevention through Abstinence and being Faithful.

Activity 1: Training of community peer educators to promote HIV prevention through abstinence and/or being faithful

- 60 individuals (community leaders and peers) trained to promote HIV prevention through 'A' and 'AB' by the end of Q2, with particular focus on reaching youth and young adults.

Activity 2: Community outreach for HIV prevention through Abstinence and being Faithful.

- 500 individuals reached with individual or small-group AB- based HIV prevention messages throughout year 4.

IR 1.4 Communities adopt prevention practices beyond abstinence and/or being faithful.

Year 4 Activities:

Activity 1: Training of community peer educators to promote HIV prevention through other methods beyond abstinence and or being faithful.

Activity 2: Community outreach to promote HIV prevention through methods beyond abstinence and being faithful, including condom promotion.

Activity 1: Training of community peer educators to promote HIV prevention through other methods beyond abstinence and or being faithful.

- 150 individuals trained to promote HIV prevention through other methods beyond 'AB' by the end of Q2.

Activity 2: Community outreach to promote HIV prevention through methods beyond abstinence and being faithful, including condom promotion.

- 2,000 sexually active at-risk young adults or MARPs reached monthly (24,000 for year 4) with 'OP' messages in small groups.

IR 2.1 Expanded and improved palliative care services are utilized.

Year 4 Activities:

Activity 1: Train home-based care givers to provide palliative care.
Activity 2: Train health providers on treatment of opportunistic infections.

Activity 1: Train home-based care givers to provide palliative care.

- ANISA project will train 100 home-based care-givers to provide palliative care during Q1 and Q2 of year 4.

Activity 2: Train health providers on treatment of opportunistic infections.

- ANISA project will train 10 health providers to provide clinical care of opportunistic infections during Q1 of year 4.

IR 2.2 Linkages/referrals to wrap around services for PLWHA are viable.

Year 4 Activities:

Activity 1: Trained home-based caregivers follow-up regularly with PLHIV clients.

Activity 2: Trained home-based caregivers deliver basic care packages to PLHIV clients.

Activity 1: Trained home-based caregivers follow-up regularly with PLHIV clients.

- ANISA supports 7 local CBOs to provide incentives for caregivers to follow up with PLHIV clients throughout year 4.

Activity 2: Trained home-based caregivers deliver basic care packages to PLHIV clients.

- Each of 7 CBO partners will receive 100 basic care packages to distribute to PLHIV clients. Packages include mosquito nets, soap, water treatment tablets, etc.

IR 2.3 PLHIV groups are expanded and strengthened.

Year 4 Activities:

Activity 1: Support PLHIV groups' ability to conduct regular meetings.

- ANISA supports 7 PLHIV groups through subsidizing the cost of their weekly meetings throughout year 4.

SO 3 Build and Strengthen the State, counties, and local partners' capacities in Strategic Information (SI), policy development, and implementation.

Year 4 Activities:

Activity 1: Procure and deliver laboratory consumables and equipment.

- CMMB will continue providing consumables for 4 laboratories (same target sites and Y3) on quarterly basis throughout Y4. Supplies will include: TB diagnostics, opportunistic infection diagnostics, urinalysis, stool analysis, and common reagents.

Activity 2: Training for 12 laboratory personnel in basic laboratory skills.

- CMMB will follow up with and provide on-site refresher training for the 12 laboratory personnel originally trained during Y3.
- CMMB will fund a specialist to come from Uganda and be with each site for 2 days.

Activity 3: HMIS and M&E strengthening for 4 county medical offices.

- CMMB will conduct refresher HMIS training for the 4 County Medical Officers on-site with the newly procured equipment from Year 3.
- CMMB will follow up the HMIS training from Y3 by providing M&E training to the 4 County Medical Offices.
- Training will be conducted on-site using the computers and software procured during Y3.
- CMMB will procure necessary supplies for the county medical offices to enable them to leverage their new training. This will include ensuring regular supply of stationary and printing materials to allow them to collect, distribute, and share data.

Activity 4: Health policy-makers training for issues affecting health planning and implementation.

- CMMB will conduct a training for 20 health policy-makers, with a particular focus on HIV/AIDS.
- The training will include the following topics: Key WES health indicators, primary prevention of HIV, secondary prevention of HIV, treatment, care and support, health service delivery, role of politicians in health service delivery, advocating for WES healthcare.

Interim Report

ANISA
COMING TOGETHER TO MEET THE CHALLENGE OF HIV/AIDS

CMMB
CATHOLIC MEDICAL MISSION BOARD

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

FY 2010 Activities Against Objectives (Year 2)

Project Summary

The ***ANISA Project ("Together" in Zande, the local language)***, is a 5 year Centers for Disease Control project being implemented by Catholic Medical Mission Board (CMMB) in partnership with its sub-grantee, World Vision. The project has 3 overall goals:

1. Reducing the incidence of new HIV infections through primary and secondary prevention
2. Improving Care and Support to people living with HIV/AIDS by strengthening the local capacity in Western Equatoria State (WES)
3. Increasing access and utilization of VCT and PMTCT among sexually active age groups and pregnant women respectively.

ANISA is being implemented in the counties of Yambio, Ezo and Nzara in Western Equatoria state and although, over half of the general populations are aware of the risks and dangers of HIV, WES is among the states with the highest HIV prevalence, at 8.1%

Administrative Update

In the current year 5 additional VCT counselors were trained. Currently CMMB has on staff 20, 3 counselors were fired for issues with alcohol, etc.

Stephen Tangun is the M&E Officer who has been in place since the start of the program year. He replaced a US volunteer who held the position in Year 1. Stephen is participating actively in PEPFAR national-level SI working groups and has done a great deal to identify data quality issues and address them.

CMMB Southern Sudan
Prevention and Care
Accomplishments

Table of Indicators

	Prevention		FY 11 Targets	Oct.10 - Mar.11 Results	%Total Target Reached
P1.1.D	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)		3,200	2,625	82%
P1.2.D	Number of HIV positive pregnant women who received anti - retrovirals to reduce risk of PMTCT by regimens :		160	109	68%
	Maternal triple ARV Prophylaxis (WHO Option A)			15	
	Maternal AZT (WHO B)			78	
	Single Dose Nevirapine (SDNVP)			16	
P11.1.D	Number of Individuals who received testing & counseling (T&C) services for HIV and received their results		11,200	7,908	71%
	<15 Yrs	Male		119	
		Female		152	
	15+ Yrs	Male		3,524	
		Female		4,113	
	Care				
C1.1.1	Number of eligible adults and children provided with a minimum of one care service		5,000	2,337	47%
	<18 Yrs	Male		-	
		Female		-	
	18+ yrs	Male		825	
		Female		1,512	

C2.1.D	Number of HIV- positive adult and children receiving a minimum of one clinical service	4,000	3,800	95%
C2.5.d	Percent of HIV - Positive patients in HIV care or treatment (Pre - ART or ART) who started TB treatment	N/A	N/A	N/A

SO1 Prevention Primary, Secondary HIV infection through strengthening VCT, Sexual Prevention and PMTCT through an integrated facility and community approaches

IR 1.1 Expanded and improved voluntary, client-initiated and provider-initiated HIV testing is available.

The project is facing challenges with supply chain processes to acquire test kits and other supplies in time. With the exception of Nzara, inaccessibility to ART Centers remains a challenge. For PMTCT, ARV supplies are very erratic at the State Hospital and this has mostly affected HIV exposed babies. Nevirapine syrup is hard to get. Proximity remains a challenge for follow up since other HIV positive women and exposed babies are in outreach areas.

Intervention in pregnancy is affected by late ANC. The number positive in lactating mothers is more significant which a hindrance to preventing MTCT.

IR 1.2 Expanded and improved mother-to-child prevention services are available in clinics and communities.

Health service providers trained including 25 VCT/PMTCT counselors to deliver services in the expanded number of sites/outreaches; coupled with continuous PMTCT in-service training on ARVs. Ezo VCT/PMTCT house renovation completed to national standards. ANISA played a proactive role in enhancing HIV/AIDS awareness and championed the celebration of the World AIDS Day in the State.

IR 1.3 Communities adapt primary prevention techniques based on AB approach
IR 1.4 Community adopts prevention practices beyond abstinence and/or be faithful

Activities:

- 7,910 individuals were reached with HIV prevention messages to promote abstinence and/or being faithful to one partner and 9,980 individuals were reached with HIV prevention messages that promote other prevention methods beyond abstinence and or being faithful. Targets are low because of limited engagement by the CBOs to carry out these planned outreach activities. This is due to ANISA supported CBOs not receiving the necessary training to reach out to these population groups. This also applies for OP programs. These 7,910 individuals were reached through individual peer educators, either within the community or the PE desired location. Sunday outreaches are done as well, visiting different churches each week. Church youth and women groups meet in small HIV awareness sessions.

- 95 individuals were trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or be faithful
- Out of the 165 individuals trained in Q1 to promote HIV prevention through AB, 65 were from the 100 of Q2. In Q2 however to training for the remaining 35 AB promoters was rescheduled for Q3.
- The 10 condom outlets for Q2 were achieved in Q1. The programs would have added the 10 outlets meant for Q3 in the just ended Q2, however continuous shortage of condoms, which remained out of stock almost throughout Q2, became a hindrance.
- 6,500 male condoms were distributed instead of the planned 6,000 target for Q2.
- 2,000 female condoms were distributed throughout the established outlets.

Constraints:

1. Shortage or inconsistent supply of condoms.
2. The delay or inability to train the CBOs for sub-granting as planned.

Lessons learned, best/promising practices, recommendations and successes for this activity.

Though the general belief and practice is that peer educators work as volunteers and are incentivized through non monitory items, field experience shows that this is not always successful in keeping programmatic volunteers motivated and engaged. For the peer educators to do quality and credible work they need to spend a fairly good amount of time in the activity and this, coupled with the relatively high targets, a cash incentive may be necessary for to the peer educators.

SO 2 Improve the care, support and treatment of HIV/AIDS infected and affected individuals/families through integrated facility/community program.

IR 2.1 Expanded and improved palliative care services are utilized.
IR 2.2 Linkages/referral to wrap around services for PLWHAS is viable (500 economic support)
IR 2.3 PLWA groups (500 individual provided with life support) are expanded and strengthened
IR 2.4 Stigma and discrimination is reduced in communities and among health providers

Activities:

- Continue to work with the existing 8 service outlet providing HIV-related palliative care in Yambio, Nzara and Ezo Counties and work with County Health departments to strengthen capacity of community health workers providing HIV-related palliative care. Additionally, continuing to promote HIV awareness creation within the community and with health workers to reduce stigma and discrimination.
- 42 community members (including people living with HIV/AIDS) were trained as Community Home Based Caregivers. Of these, 16 were trained as HBC volunteers or Home visitors and 26 of these were trained as Primary caregivers for chronically ill persons.

- 2337 eligible adults reached with a minimum(1) care services. Of these, 1512 were females and 825 were males and these clients were served by trained community home based caregivers.
- 3800 eligible adults and children were reached a minimum of one clinical service (Cotrimoxazole prophylaxis). The target was exceeded because a partnering health center being supported with Cotrimoxazole prophylaxis has over 2000 clients registered and the center serves a support group.
- 444 HBC clients were provided with basic care packages such as Long Insecticide Treated Mosquito nets, plastic basins, Bed sheets, mattresses, Carpet sheets, washing soaps. Rice, sugar, beans and cooking oil were provided to the 8 support groups in Yambio, Nzara and Ezo counties to facilitate their group meetings. Of the 8 groups being supported by ANISA, each has over 300 PLWHA registered.
- 44 religious leaders were trained through Channels of Hope to participate in HIV/AIDS stigma and discrimination reduction in the community as well as in the church institutions.
- 150 Care and Support posters were distributed in various centers such as VCT, PMTCT, hospitals, PHCCs, PHCUs, private clinics and pharmacies, State ministry of health, State AIDS commission, County AIDS commission, County health department, and support groups in Yambio, Nzara and Ezo Counties. These posters carry message on positive living, educating the PHWHA on good feeding, caring and supporting PLWHA socially, psychologically and physically at home.

Sustainability:

- The 8 Community/Faith Based Organizations currently involved in implementing care and support activities will be sustainable after the project ends as they are able to provide ongoing support to PLWHA in form of social, psychological and physical support.
- The community members who were trained as caregivers are able to contribute to education of others in their community.
- PLWHA participation in the care process and self disclosure to the family members and community participation in the care process of terminal and chronic sickness can be strengthened at community levels by collaborating with health facilities and community health workers.

Partnerships and External Engagements

- Worked in collaboration with state ministry of health, state AIDS commission, county AIDS commission and County health department as well as Community/Faith Based Organizations in implementing Care and Support services in the fight against HIV/AIDS.

The objectives and outcomes or next steps of the engagement

- Building the capacity of the local partners including the local community and faith based organizations to provide care and support service for People living with HIV/AIDS after the end this project.
- Provide support to community home based care clients on regular bases.
- Contact training to caregivers and educate PLWHA on positive living.
- Engage the support groups through ongoing support meetings.

Conclusion

- Community Home Based Caregivers are doing tremendous work in educating the People Living with HIV/AIDS, their caregivers and family members in the care process.

CBOs mostly form by a group of PLWHA are basis for ongoing counseling for their members as it is the only place where the group members find comfort and interact with others. Each support group is provided with a group discussion guide where one member or Home Based Caregiver volunteers take a lead choosing one topic for discussion whenever the group comes to meet.

- There is good coordination with other partners implementing HIV/AIDS in program in the region, this strengthened coordination of activities and movement from one point to another, especially places like Ezo that need escort or convoy due to security problem, this has been possible through coordinating with other partners like UNHCR, UNMIS, and many more.
- More cotrimoxazole drugs need to be procured to ensure constant supply of drugs to avoid resistance

Overall program challenges and potential solutions

- Limited budget to provide the needed support to People Living with HIV/AIDS or Care services which affects WV ability to prioritize demands.
- Low literacy levels rate in the region, make it difficult for the community to understand basic idea of HIV/AIDS and talk about it freely, its challenges and impact on the individuals, community and nation.
- The cultural background that promote early marriage and multiple partners, make it difficult to address the issue of being faithful and use of condoms, as their culture also promote sex outside marriage.

Story of (b)(6)

The Story of (b)(6) with Community Home Based Care Volunteer.

(b)(6) is a resident of (b)(6) (b)(6) Western equatorial State is one of the HBC client of ANISA project getting support from a trained community home based caregiver volunteer with a support from the ANISA project.

(b)(6) year old married to one wife and blessed with 2 children. (b)(6) was in Uganda due to the long civil war in southern Sudan between Sudan People liberation Army (SPLA) with Khartoum based government dominated mostly by Arabs ruling National Congress Party that came to an end in 2005 through Comprehensive Peace Agreement that gave south Sudan semi autonomous government
I have visited VCT in 2007 from Uganda, I was counseled and tested for HIV and the end results was I am HIV positive and from that time I started taking OI prophylaxis (2007).

I decided to come to my home land (Sudan) in February 2010, where currently I am, one time, a Community Home Based Caregiver volunteer met (b)(6) in support group where they (PLWHA) meet every week to discuss issues and challenges affecting their daily living negatively or positively, home hygiene etc. (b)(6) was registered by HBC giver volunteer for follow up and home visit. From that time they keep visiting me at least once a week or a month

Home visiting is very important because I did not know more about CD4 count but when I was visited by Home Based Caregiver volunteer, he advised me to go to Yambio Hospital to get more help and if possible check for CD4 count. I (b)(6) took courage to go to hospital at ART department, I was further send for CD4 count, when I was found with a very low CD4 count, and I was enrolled to start ART. This was in December 2010.

when I am (b)(6) is visited by Home Based Caregiver volunteer, I feel better because most of the time I am alone at home, there is no one that we can share things but when HBC giver come to visit me, they ask about how do I feel, talk about how I take my drugs, use of condom, nutrition, disclosing HIV status to the one you love, etc
I was given washing soap, sugar and some rice by home based caregiver which I could not manage to afford because a bar of washing soap cost 4 Sudanese pounds which is equivalent to US$2 which is expensive to me (b)(6) and it is through this home based caregiver visit that the voice of people living with HIV/AIDS can reach out there to those who like to support such suffering people in the community.

END REPORT