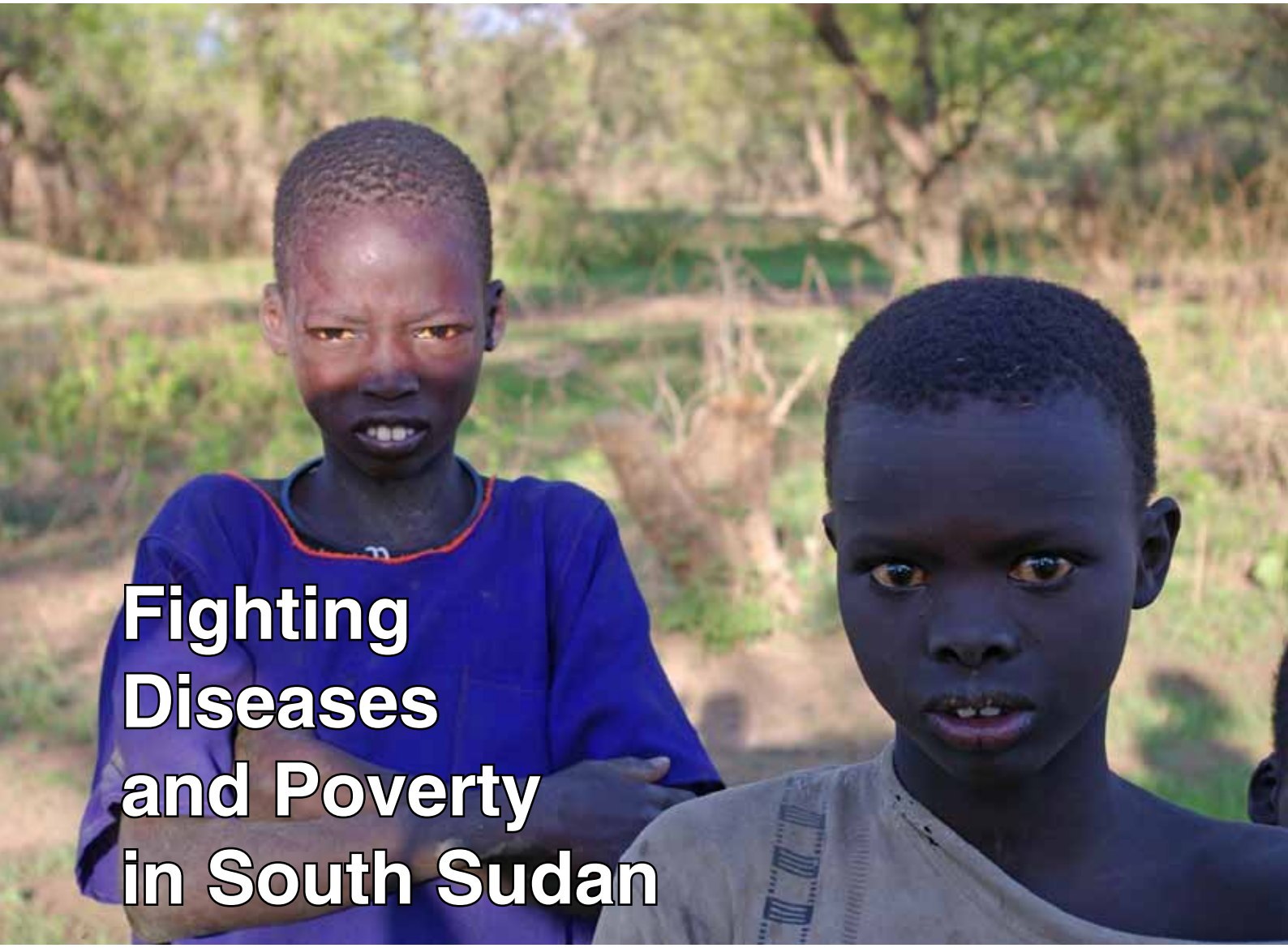
ARKANGELO ALI ASSOCIATION



Fighting Diseases and Poverty in South Sudan

AAA ANNUAL REPORT 2016

We Cannot Deny It Anymore. TB is the New Global Health Emergency.

Dr. Lucica Ditiu's reaction to WHO's Global TB Report 2016

What is happening with TB?

How did we end up in this situation? Many people think we defeated TB long ago, but this epidemic is much worse than we thought last year -- worse than we thought five years ago, than ten years ago. We all are denying a reality which has been slowly unfolding in front of us – **TB is the new global emergency** and since it is airborne, a TB emergency in one country makes it an emergency for every country.

Let me present you with a few numbers:

In the Global TB Report 2011, WHO estimated that the number of people who developed TB dropped below 9 million for the first time ever – reporting an estimated 8.8 million new TB cases (confidence range: 8.5 to 9.2 million). Every year, WHO revises the Global TB Report and the data it contains, and every year since 2012, the estimated number of people who develop TB each year gets higher and higher. In 2015, we believe 10.4 million people fell ill with TB. These consistent upward revisions mean the number of people who are thought to have died from TB each year has also grown – from 1.5 million in 2011 to 1.8 million in 2015, a 20% increase. With a person dying of TB every 18 seconds, TB is and remains the largest cause of death from an infectious disease.

The number of people treated for TB as notified by countries, remained almost constant around 6 million for the last eight years, despite the large upward revisions in estimated TB burden to 10.4 million people in 2015. We used to speak about the missing three million (remember that campaign?) – now, we miss 4.3 million people. We cannot end the TB epidemic unless we close this gap because people with TB who are untreated can infect up to 15 others every year. The SDGs speak about Universal Health Coverage (UHC) and I believe the number of people with TB missed by health services is the best UHC indicator.

The gap between multidrug-resistant TB (MDR-TB) estimates and people diagnosed and treated is highly worrying. There are an estimated 580,000 people who developed MDR-TB in 2015. However, only 132,000 were diagnosed (only 9,000 more than in last year's report) and 126,000 were started on treatment (only 15, 000 more people).

I will tell you what is going on. We are denying the fact that we are losing the battle with TB. A bacteria is outsmarting us. We are denying the fact that TB is the new global health emergency. We do not seem to understand that in order to end TB, we need to fight a full-fledged war.

And to win this, there are four things we must do:

1. Know our enemy

   The (multiple) upward revisions of TB burden are based on the fact that we have better and better data every year. However, every year the picture of the epidemic appears bigger and bigger. The yearly revised TB burden estimates, makes it very difficult for the TB community to run after this moving target in a meaningful way. It is time to seriously look over the data we have and maybe more importantly, data we do not have. We should look over other sources of data: prevalence

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Dear Friends of AAA,

We are honored to present to you the AAA annual report, which is intended to highlight the main activities carried out by the organization in 2016

South Sudan is still struggling with humanitarian challenges which deteriorated in July 2016 after the conflict resumed. A big number of humanitarian workers were evacuated or re-located to other safer locations. Most of humanitarian interventions were stopped or slowed down. Such action exposed mostly the vulnerable people who were already on their knees due to ongoing conflict from Dec 2013.

The July clashes made greater numbers displaced; multiple displacements and thousands of homes destroyed. More than **2.5 million** have been forced to flee their homes: 1 million refugees; 1.6 million IDPs; 200,000 IDPs in PoC sites; **>261,000 refugees** in South Sudan, primarily from Sudan

In spite of the grave humanitarian situation in South Sudan, AAA continued to provide health services in order to alleviate the suffering of people.

Our main credit goes to the committed field staffs that remain calm during July turmoil in order to save the most vulnerable people in the community.

We are appealing to the international community's to continue supporting the people of South Sudan in this trial moments.

Thanking you for walking with us in this journey and for sharing our vision

With kind regards
AAA management

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PROGRAMS

TUBERCULOSIS

Bottlenecks/challenges people with TB face in South Sudan

TB continues to be a major cause of morbidity and mortality worldwide, with an estimated 10.4 million new cases in 2015, and 1.8 million deaths, including 0.4 million among people with HIV. TB is now the leading infectious killer and among the top 10 biggest causes of deaths worldwide, responsible for more deaths than HIV and malaria.

Bottlenecks/challenges people with TB face in South Sudan

Limited integration of TB into the PHC system which is the overall pillar for health service delivery in South Sudan. 35% of the counties in South Sudan lack TB services, only 31% TBMUs coverage. DOT expansion slowed by withdrawal of other organizations from GFATM implementation due to low GMS 2) inadequate implementation of TB prevention, treatment and care services in high risk/hard to reach populations: Recurrent conflicts lead to displacements and IDP situations that lead to limited access. Prisoners and military services' protocol to access services is prohibitive. Dysfunctional data collection/reporting with non-prioritization by many organizations 3) Poverty/ malnutrition: 4.8 million people (about 100,000 children, have severe acute malnutrition) face severe food shortage worsening TB spread, delayed diagnosis and poor adherence. 4) Inadequate implementation of TB and HIV services: Weak TB and HIV referral linkages, screening and reporting of presumptive TB is sub-optimal. 5) Weak community health systems: The HHPs is envisaged in the country's NSP and Boma Health initiative but insufficiently utilized for referral and door-to-door TB screening/tracing. 6) Poor Infrastructure, stigma and cultural practices leading to delayed diagnosis – Patients trek long distances or seek traditional treatment due to infrastructure destruction by floods, poor roads access, of inter-ethnic/clan conflicts. 7) Human Resource and diagnostic capacity challenge of staff and/or services.

In spite of the challenges above, AAA was able to provide so needed TB services to the affected communities in South Sudan.

ACHIEVEMENT 2016

- 3693 of all TB cases detected and put on treatment
- 2211 of new smear positive detected
- 271 of national staff benefitted from capacity building
- 87232 of people benefitted from health education on TB

NUTRITION

By July 2016, **8.9 million people** were estimated to be food insecure, of which about **4.8 million people** - more than one in every three people in South Sudan - were estimated to be severely food insecure

High malnutrition levels – **7/10 former states** classified as critical - GAM above 15%

Some **686,200 children** under age 5 are estimated to be acutely malnourished, including more than **231,300** who are severely malnourished

ACHIEVEMENT 2016

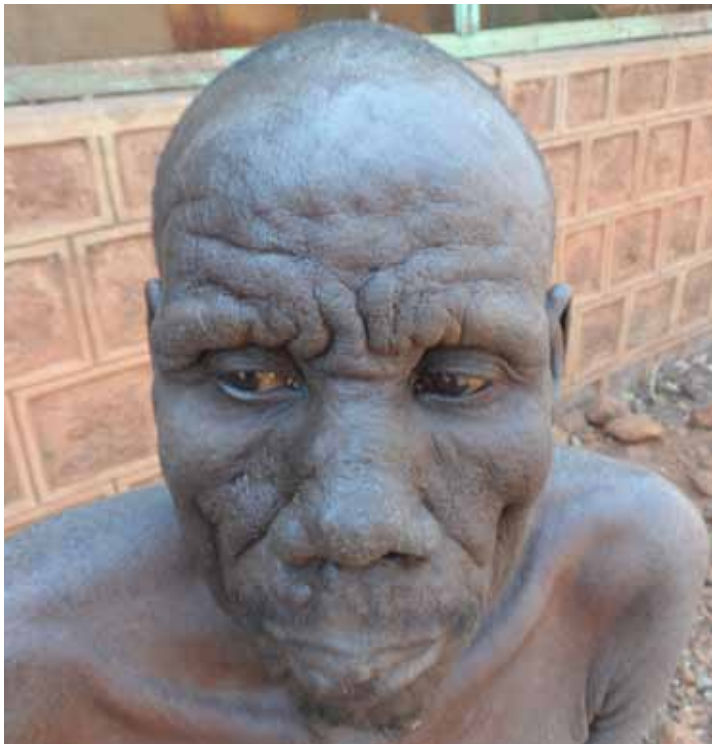
- 504 of children under 5 years benefitted from nutrition support
- 7224 of mothers benefitted from health education related to nutrition
- 2465 of children dewormed

LEPROSY

The ultimate vision and mission of the program is to achieve a leprosy –free South Sudan one day, which can be achieved by continuous emphasis on early case detection and treatment. There is also a need to pool all available resources from national as well as international partners. If we want to achieve success, we have to work hard until we achieve our vision. There is no room for complacency in the program.

ACHIEVEMENT 2016

- 370 of new leprosy cases detected and put on MDT
- 70 of MCR shoes distributed
- 6 of PALs benefitted from surgery



PRIMARY HEALTH CARE

Numerous health challenges in South Sudan

- People in need of emergency health assistance: >4.5 million
- 56% population already had no access to primary health care
- Severe shortage of health work force – displaced, insecurity fears, economic crisis or evacuated
- Health facilities – destroyed, damaged, looted, closed
- Critical shortages of essential medicines and supplies
- Limited range of PHC services currently provided.

ACHIEVEMENT 2016

- 46355 of patients received treatment in OPD
- 2724 of patients received treatment in IPD
- 3456 of pregnant mothers attended ANC
- 6232 of children vaccinated

AID and RELIEF

Through the support of partners, AAA continued to provide food and non food items to the needy people in South Sudan.

ACHIEVEMENT 2016

- WFP provided 105 metric tons of food stuff to the TB and HIV patients

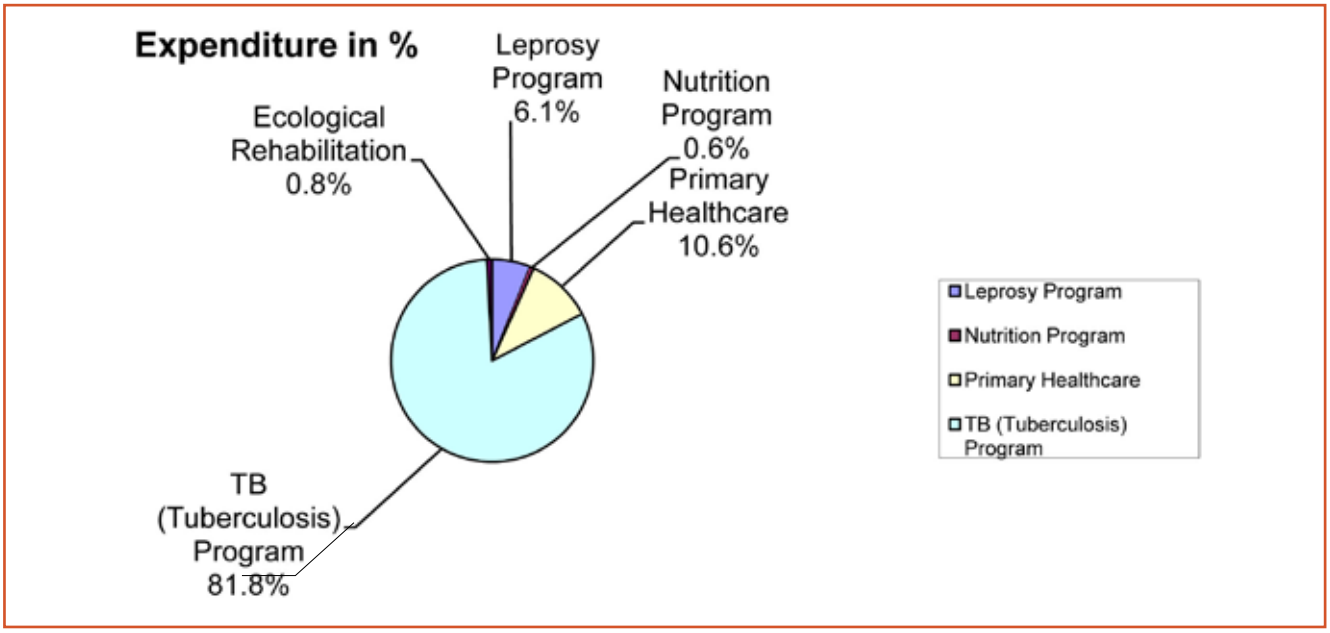
CHALLENGES

- Repetitive insecurity which affected mainly the outreach activities
- Impassable roads during rainy season
- Lack of skilled health workers
- Shortage of fuel for program implementation
- Delay of funds
- Over the first six months of 2016, the South Sudanese Pound (SSP) rapidly depreciated, reaching an all-time high of 80 SSP to 1 US Dollar in August 2016.
- The cost of living raised exponentially, with the South Sudan annual Consumer Price Index (CPI) increasing by 730 per cent from August 2015 to August 2016, the highest year-on-year inflation rate in the world.
- The price of staple foods, such as sorghum, maize and beans, are at record highs.

FINANCIAL REPORT (PROGRAMMES) 2016

AAA Income according to Programmes			
INCOME	Description	Total Euro	% of all programmes
	Excess income over expenditure 2015 b/f	126,948.55	10.24
	Leprosy Program	83,563.56	6.74
	Nutrition Program	3,826.03	0.31
	Primary Healthcare	105,710.35	8.53
	TB (Tuberculosis) Program	896,557.38	72.32
	Ecological Rehabilitation	23,173.56	1.87
	Total Income	**1,239,779.43**	**100.00**

AAA Expenditure according to Programmes			
EXPENDITURE	Description	Total Euro	% of all programmes
	Leprosy Program	67,546.23	6.13
	Nutrition Program	6,639.00	0.60
	Primary Healthcare	116,914.79	10.61
	TB (Tuberculosis) Program	901,340.36	81.81
	Ecological Rehabilitation	9,351.53	0.85
	Total Income	**1,101,791.91**	**100.00**



INCOME RECEIVED FROM DONORS 2016

	INCOME Donors as at 31/12/2016	Total USD	%
1	Excess income over expenditure 2015 b/f	126,948.55	10.24
2	Amici Di Antonio	15,000.00	1.21
3	Associazone Arcali Africa Onlus	21,057.18	1.70
4	Bondeko Onlus	3,197.00	0.26
5	CESAR (funds from Genova Con Africa)	3,826.03	0.31
6	ERKO	23,173.56	1.87
7	GLRA (Germany Leprosy & Relief Agency)	49,309.38	3.98
8	Misereor Healthcare Projects	105,710.35	8.53
9	Global Fund/UNDP TB programs	891,557.38	71.91
	TOTAL	**1,239,779.43**	**100.00**

in kind support

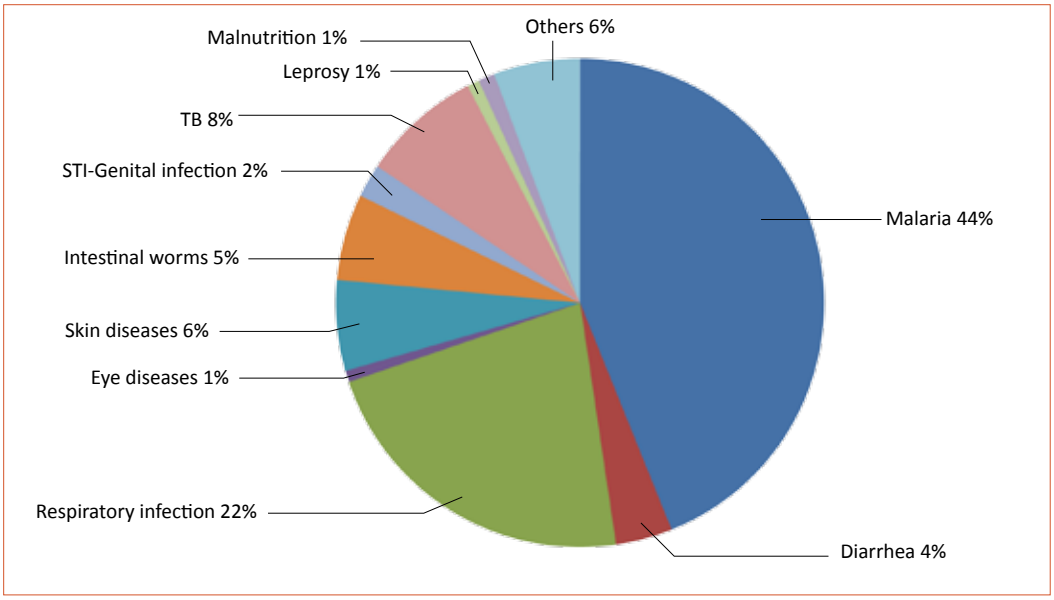
1. NTLP for donation of TB/LEPROSY drugs and HIV testing kits
2. MOH for donation of medicines
3. World Food Programme for the donation of food for patients
4. UNICEF for donation of food and Non-food items for nutrition program

Exchange rate used for non-euro currencies are as follows Euro/US$ 1.08694; USD/Kshs 100.00

OUR FRIENDS, PARTNERS AND SUPPORTERS

Comboni Missionaries	AAA - Arkangelo Ali Association
Verona Fathers	AMREF - Africa Medical Research Foundation
CESAR (Coordinamento Enti Solidali a Rumbek)	ANC - Ante-Natal Clinic
Associazione La Goccia Onlus	CBR - Community Based Rehabilitation
Associazone Arcali Africa Onlus	CHW - Community Health Worker
German Leprosy and Relief Association (GLRA)	IDPs - Internally Displaced Persons
ERKO	IEC - Information, Education and Communication
DKA	IPD - In-Patient Department
BBM-Beschaffungsbetrieb der MIVA	MCR - Micro Cellar Rubber
Diocese of Rumbek (DoR)	MOH - Ministry Of Health
Bondeko Onlus	NGO- Non-Governamental Organization
MISEREOR	NTLP - National Tuberculosis and Leprosy Program
Global Fund/UNDP (TB Programs)	OPD -Out-Patient Department
World Food Programme	PHCC - Primary Health Care Clinic
Genova Con Africa	PHCU - Primary Health Care Unit
Amici Di Antonio	PTB - Pulmonary Tuberculosis
Amici Di Padre Mattia	TB - Tuberculosis
Amici Di Lucia	TBMUs - Tuberculosis Management Units
Associazione Per La Lotta Contro La Fame Nel MONDO Onlus	UNICEF - United Nations Children's Fund
UNICEF (United Nations Children Education Fund)	UN-WFP - United Nations- World Food Programme
NTLP (National Tuberculosis and Leprosy Program)	WHO - World Health Organization
MOH (Ministry of Health)	

AAA EPIDEMIOLOGICAL REPORT 2016



Malaria	Diarrhea	Respiratory infection	Eye diseases	Skin diseases	Intestinal worms	STI-Genital infection	TB	Leprosy	Malnutrition	Others
20345	1742	10250	348	2785	2642	1022	3693	370	504	2654

ACRONYMS	
AAA - Arkangelo Ali Association	NTLP - National Tuberculosis and Leprosy Program
AMREF - Africa Medical Research Foundation	OPD -Out-Patient Department
ANC - Ante-Natal Clinic	PHCC - Primary Health Care Clinic
CHW - Community Health Worker	PHCU - Primary Health Care Unit
IDPs - Internally Displaced Persons	PTB - Pulmonary Tuberculosis
IEC - Information, Education and Communication	TB - Tuberculosis
IPD - In-Patient Department	TBMUs - Tuberculosis Management Units
MCR - Micro Cellar Rubber	UNICEF - United Nations Children's Fund
MOH - Ministry Of Health	UN-WFP - United Nations- World Food Programme
NGO- Non-Governamental Organization	WHO - World Health Organization

We Cannot Deny It Anymore.
TB is the New Global Health Emergency.

From page 15

surveys, IHME data, Global Fund data, other open source data and better understand TB. And this cannot be a global-level exercise: data must be collected, analyzed and **used** at country, regional, district and site level. The TB programmes and the partners should collect data, not "to report" to global-level institutions, but to **use** the data for planning and monitoring their own interventions and work using real time data and new technology.

2. Prepare our weapons and strategies

Microscopy test for TB was developed over 130 years ago, yet it remains (mostly unchanged) our main test to diagnose TB. Would we fight a war today with 19th century cannons? Six years ago, we entered the era of rapid, accurate and affordable molecular testing for TB and drug-resistance. The Global Plan to End TB 2016-2020, which acts as the investment plan for the first five years of the End TB Strategy, calls for every person suspected of having TB to be tested for drug resistance. Despite this, only 20% of the newly diagnosed TB patients get rapid molecular testing. This means most people start TB treatment without knowing if it is appropriate for their form of the disease. Why do we still accept microscopy as our weapon of choice when there are better alternatives? We have new medicines – bedaquiline and delamanid, new child friendly medicines formulations, new short regimens to make MDR-TB treatment cheaper, shorter and more effective, but their uptake is worryingly slow.

The TB programmes must have the strength and vision to start using at scale all these new tools. The TB community and people affected by TB must demand the best available tests and standard of care FOR ALL! I know South Africa makes incredible progress, isn't it time for other countries to step up as well?

Even the best tools in the world will not work if the policies are restricting their use. All countries and programmes should update their TB policies in line with the latest science. The 2015 Out Of Step report released by Stop TB Partnership and MSF found that many countries have yet to do so. Additionally, our arsenal is far from where it should be to end TB. We need a point of care test, a shorter non-toxic treatment for all forms of TB and an effective vaccine. R&D funding for TB is terribly insufficient and decreasing. Why are the investments in R&D for TB so low? With other diseases like Ebola and Zika we have seen what is possible in a short timespan; why not with TB?

3. Create a strong and united army

To win a war, we must align and shoot in the same direction. It is time for all stakeholders from governments to grass roots organizations and people affected by TB to come together and be united to end TB. Our messages are too often different, divergent and confusing and nobody will win. Irrespective of our own agendas, institutions and personalities, let's align and ensure that the message that we send to the world is clear and strong and supporting those most in need, rather than institutional interests.

4. Have the commander lead the battle

The real battle is happening in countries – in governments, communities, and households. Therefore, we must have heads of state or governments leading the battle to end TB. But for too long, TB was not on the agenda of any commander. For many reasons, TB never reached the attention of heads of state. It remained to be battled by small groups of soldiers and captains, without the real leaders even knowing about their fight. We cannot accept anymore this status.

If we are serious about ending TB by 2030 – this battle must be led at a different level.

We must all push to have a United Nations High Level Meeting on TB in September 2017. Let's all align ourselves to make this happen and win this battle!


Upper Nile
Unity
Northern Bahr el Ghazal
Warrap
Western Bahr el Ghazal
Jonglei
Lakes
Western Equatoria
Central Equatoria
Eastern Equatoria
ARKANGELO ALI ASSOCIATION