Republic of South Sudan

Transition Plan

for

The Polio Eradication Initiative

Acknowledgments

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Dr. Makur M. Kariom

Undersecretary, Ministry of Health

Acronyms

1. **AFRO:** WHO Regional Office for Africa
2. **AFP:** Acute Flaccid Paralysis
3. **AFENET**: African Field Epidemiology Network
4. **AusAID:** Australian Agency for International Development
5. **APW:** Agreement for performance of Work
6. **ARCC:** African Regional Commission for the Certification of the Eradication of Poliomyelitis
7. **BHI:** Boma Health Initiative
8. **BHT:** Boma Health Team
9. **BMGF:** Bill and Melinda Gates Foundation
10. **CAR:** Central African Republic
11. **CBOs:** Community Based Organizations
12. **CDC:** Center for Disease Control
13. **C4D:** Communication for Development
14. **CGPP:** CORE Group Polio Project
15. **DFID:** Department for International Development
16. **DHIS:** District Health Information System
17. **DRC:** Democratic Republic of Congo
18. **EPI-TWG:** Expanded Programme on Immunization- Technical Working Group
19. **EPI:** Expanded Programme on Immunization
20. **EWARN:** Early Warning Alert and Response Network
21. **GPEI:** Global Polio Eradication Initiative
22. **HIV/AIDS:** Human Immunodeficiency Virus/ Acquired immunodeficiency syndrome
23. **ICC:** Inter-Agency Coordination Committee
24. **ICMN:** Integrated Community Mobilization Network
25. **IDSR:** Integrated Disease Surveillance and Response
26. **IPV:** Inactivated Polio Vaccine
27. **M&E:** Monitoring and Evaluation
28. **MOH:** Ministry of Health
29. **NGO:** Non-Governmental Organization
30. **NIDs:** National Immunization Days

31. **NSVC:** National Switch Validation Committee
32. **ECB/AFENET:** EPI-CAPACITY BUILDING PROGRAMME replaces National-STOP/AFENET
33. **ODK:** Open Data Kit
34. **OPV:** Oral Polio Vaccine
35. **PCA:** Project Corporation Agreement
36. **PEI:** Polio Eradication Initiative
37. **PHCC:** Primary Health Care Centre
38. **PHC:** Primary Health Care
39. **PIRI:** Periodic Intensification of Routine Immunization
40. **PSE:** Polio Simulation Exercise
41. **RI:** Routine Immunization
42. **SIA:** Supplementary Immunization Activities
43. **SSFA:** Small Scale Funding Agreement
44. **STOP:** Stop Transmission of Polio
45. **SIADs:** Supplementary Immunization Activities Days
46. **SOPS:** Standard Operational Procedures
47. **SOC MOB:** Social Mobilization
48. **TB:** Tuberculosis
49. **UNICEF:** United Nations Children's Fund
50. **UNDP:** United Nations Development Programme
51. **USAID:** United States Agency for International Development
52. **UNFIP:** United Nations Fund for International Partnerships
53. **VHWs:** Village Health Workers
54. **WASH:** Water, Sanitation and Hygiene
55. **WHO:** World Health Organization
56. **WUENIC:** WHO UNICEF Estimate of National immunization Coverage

Executive Summary

The Polio transition plan of South Sudan is in line with the 4th objective of the Polio Eradication Endgame Strategic plan (2013-2018) which clearly identifies the need for the assets and knowledge gathered from the Polio eradication program to be documented, transferred and mainstreamed to other health programmes in order to build a resilient health system. The country is among the sixteen priority countries within the Global Polio Elimination Initiative's (GPEI) were major investments has been made.

The polio transition plan commenced in June 2016 with guidance from the Transition Management Group and task force, at the country level, a Polio Transition Management Committee under the Expanded Program on Immunization-Technical Working Group (technical lead) and Inter-Agency Coordination Committee (coordination) was created, led by the Ministry of Health EPI Manager as focal person to ensure the process was properly conducted with the involvement of all stakeholder.

This document summarizes the processes used to generate the polio transition plan which include the following; an initial asset mapping of all Polio assets including human resource in the country and their locations, documentation of best practices and lessons learnt, a simulation exercise to identify health priorities and consequences of the Polio ramp down and development of a business case model, along with a costed transition plan.

It is noted that while the country has remained polio-free for more than 9 years, however a lot of different activities are done using the Polio network that includes routine immunization, outbreak response for different diseases including Polio, mass campaigns (Polio, Measles Meningitis, etc) to boost immunity and strengthening disease surveillance. In planning the Polio transition some objectives were considered that included ensuring that, the functions needed to maintain a polio-free status are mainstreamed into existing national immunization and surveillance systems, improve and attain a high polio vaccination coverage (bOPV, IPV), retain the ability to promptly detect and respond to any polio outbreak, use lessons learnt to benefit other programs and create demand for health programs.

The transition plan will be conducted in 2 phases, currently, about 700 personnel from different organizations work in the Polio program and the costed plan makes a case that about 70% of the staff to be transferred to the Government via the BOMA Health initiative. The staff absorbed will be that at the payam and county levels but Polio staff at the state and National level will need to be maintained and funded by different partnership rather than transfer to Government. In order for the transition to occur a total of estimated USD 105, 870,288 is needed USD 42,885,857 has been pledged to cover 40.51% of the needs, and a shortfall of USD 62,984,431 for the next 5 years.

As GPEI funding will ramp down completely by 2019, the country will continue to engage with development partners to sustain the successful implementation of South Sudan's transition plan, especially in sustaining the critical functions of immunization and surveillance in the medium and long term, in order to keep the country's polio-free status, the country is in the process of having a resource mobilization among donors with plans for the creation of a fund drive for immunization and surveillance activities in the country.

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1. Introduction to Polio Transition Planning for South Sudan

1.1. Background

The end of the highly infectious, crippling disease -polio- is on the horizon. This would make polio the second human disease to be eradicated, following smallpox. This achievement can be attributed to the Global Polio Eradication Initiative (GPEI) partnership led by national governments with its partners: the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), Rotary International, the US Centers for Disease Control and Prevention (CDC), and the Bill & Melinda Gates Foundation (BMGF), the Coregroup and with the untiring efforts the vast network of people, functions and infrastructure working on polio eradication in countries. The GPEI was created in 1988 with the goal of eradicating polio worldwide. Since then substantial progress has been achieved with the number of cases dropping from 350,000 in 1988 to 22 in 2017 while localizing the disease to only three endemic countries (Afghanistan, Pakistan, and Nigeria). In South Sudan, the last wild poliovirus case was in June 2009 from Northern Bahr El-Ghazal state, while the last vaccine-derived polio outbreak case, was in April 2015 in Unity State.

Over the past three decades, the GPEI has built significant infrastructure in immunization campaigns disease surveillance, and programme monitoring, social mobilization, and vaccine delivery; developed in-depth knowledge and expertise; and learned valuable lessons about reaching the most vulnerable and hard-to-reach populations on earth. This has helped strengthen health services and systems for polio and well beyond (from promoting full immunization to preventing outbreaks). The GPEI is now substantially reducing its funding and support and encouraging countries and agencies to prepare for the transition. It is anticipated that the GPEI will stop giving its financial support to countries by end of 2019. South Sudan is one of sixteen priority countries which are required to produce polio transition plan, within the Polio Eradication Endgame Strategic plan's (2013-2018) the fourth objective of the Polio Transition Legacy. The primary goals of transition planning for the GPEI are both to protect a polio-free world and to ensure that the investments, made to eradicate polio, contribute to future health goals after the completion of polio eradication. In addition, for South Sudan, the key is for the transition of GPEI assets to support broader health initiatives.

The key transition planning activities include (a) mapping of human resources, physical assets, and intangible assets; (b) Documentation of best practices and lessons learned; (c) identifying the national health priorities; (d) conducting a simulation exercise to match assets with National health priorities; (e)

outlining the strategies for transition and development of plan for transition; (f) developing a business case and costing for the transition plan; (g) developing a communication plan for the transition and (h) outlining a resource mobilization strategy to seek support for the transition plan. This report is a consolidated plan for the transition of the polio programme in South Sudan and it provides strategies and resources needed for a successful transition.

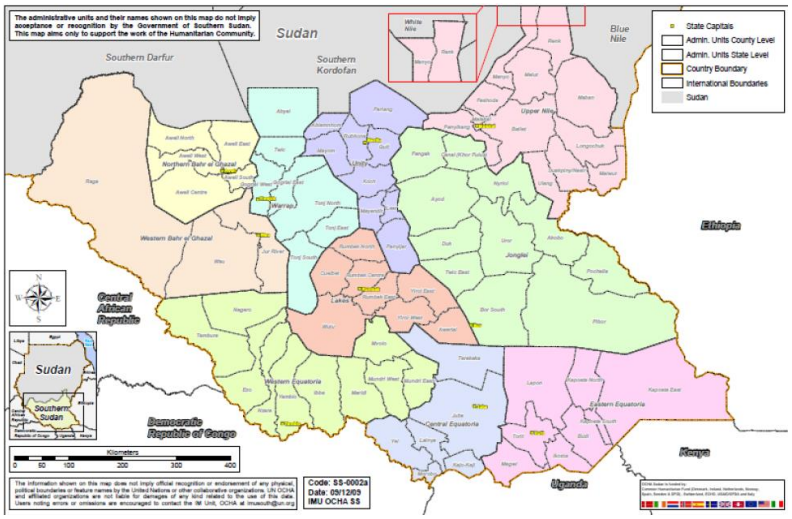
2. Situational Analysis

2.1. Country profile

South Sudan is a country in Eastern Africa and has borders with Ethiopia and Kenya in the East, Uganda in the South, the Central African Republic (CAR) and Democratic Republic of Congo (DRC) to the West and Sudan to the North. It obtained independence in 2011. It has a vast territory of approximately 640,000 square kilometers with a population density of about 21 persons per square kilometer. The total population in 2017 is estimated to be 12,601,591 (population projection from 2008 census), 52% are females, and 51% of the population lives below the poverty line. South Sudan has also suffered famine in the past years and there is the deteriorating economic situation of the country with high inflation rate (>800%) and depreciation of the local currency and an estimated 5.1 million people are at risk of hunger.

In 2015, South Sudan was administratively divided into 10 states, 80 counties, 605 Payams, 2,532 Bomas and 26,544 major villages. This administrative structure has been adjusted in January 2017 to 3 regions (**Greater Equatoria, Greater Upper Nile, Greater Bahr el Ghazal),** 32 states and more than 300 counties as well as sub-administrative system (**Figure 1**) The majority (88%) of the population lives in rural areas and dispersed settlements.

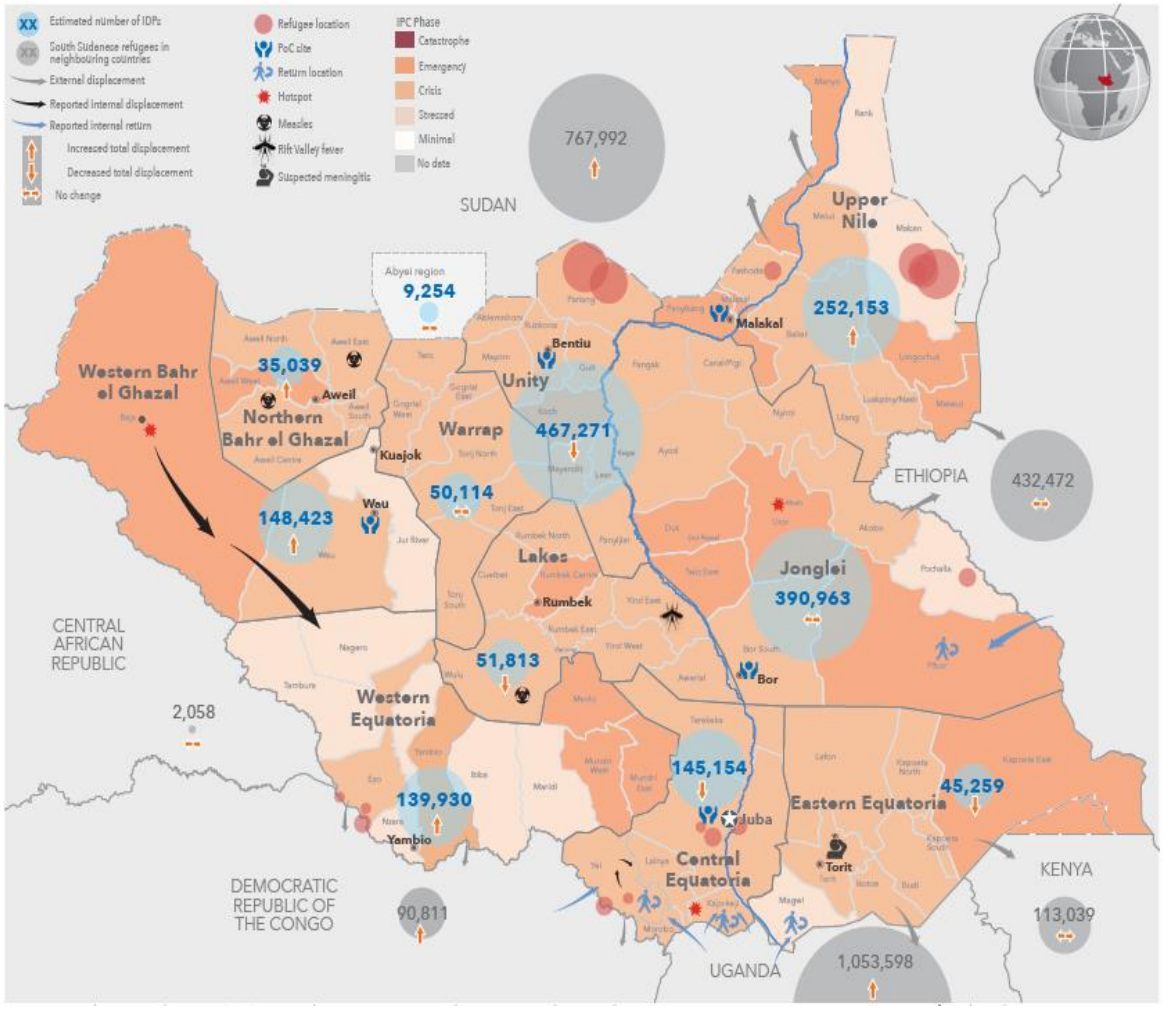
Figure 1. Geopolitical Map of South Sudan, 2017



Shortly after independence, the country experienced many conflict crises which led to the migration of the population inside and outside the country. The on-going conflict and insecurity have resulted in 1.76

million Internally Displaced Persons (IDPs) and more than 2.45 million refugees in neighboring countries (March 2018). (**Figure 2).**

Figure 2. Humanitarian snapshot of South Sudan from OCHA, March 2018.



2.2. Health System and infrastructure

South Sudan's health system is a pyramid of three layers: The Central National Ministry of Health and its reference supporting structures at the top; after which is the States Ministries of Health at the intermediary level coordinating the activities of the counties under them; The last level is the counties where there is the County Health Department which coordinates public health activities. With the conflict situation, there has been disruption of the development of the health system. Many of the health facilities were looted during the period of civil unrest, with staffs abandoning their posts. In addition, currently, not all functioning health facilities are offering immunization. Furthermore, access to

the health facilities is limited due to insecurity, poor road infrastructure, harsh climate (prolonged period of rain with flooding, leaving many counties inaccessible for 6 months of the year). As of end 2017, 80% of health facilities in the country are managed by NGOs. Primary Health Care activities are mostly being delivered by NGOs contracted by 2 fund managers: The Health Pool Funds and IMA World Health and more than 56% of the population do not have access to these facilities, 45% without safe water, 93% have no access to latrines and the child mortality rate is still at 103/1000 live births. The doctor and nurses to population ratios are 0.15/1000 and 0.2/10000 respectively and health financing in the Government budget dropped from 4% in 2012 to <2% in 2017, with an inflation rate put at 800% in 2017 and insufficient liquidity of local currency at times in banks.

Recently, new administrative structures have been created (32 states in 2017 from the initial 10 states in 2011). The creation of new states has however not been accompanied by an increase in health manpower. About 6 months each year, 60% of roads are inaccessible, airstrips non-functional due to flooding. The country has been experiencing multiple disease outbreaks including cholera, measles and the risks for meningitis, hepatitis E and TB outbreaks in displaced populations.

2.3. Health priorities for South Sudan in the context of polio Transition planning

There are three broad areas that are identified as national health priorities in the context of transition planning for South Sudan. These are the key areas where Polio assets make significant contributions as well as areas where the existing polio assets can be expected to make a contribution in the future following the eradication of polio from South Sudan. These areas are (1) The Expanded Programme on Immunization, (2) Integrated Disease surveillance and response and, (3) Health systems strengthening (The Boma Health Initiative).

2.4. Routine EPI

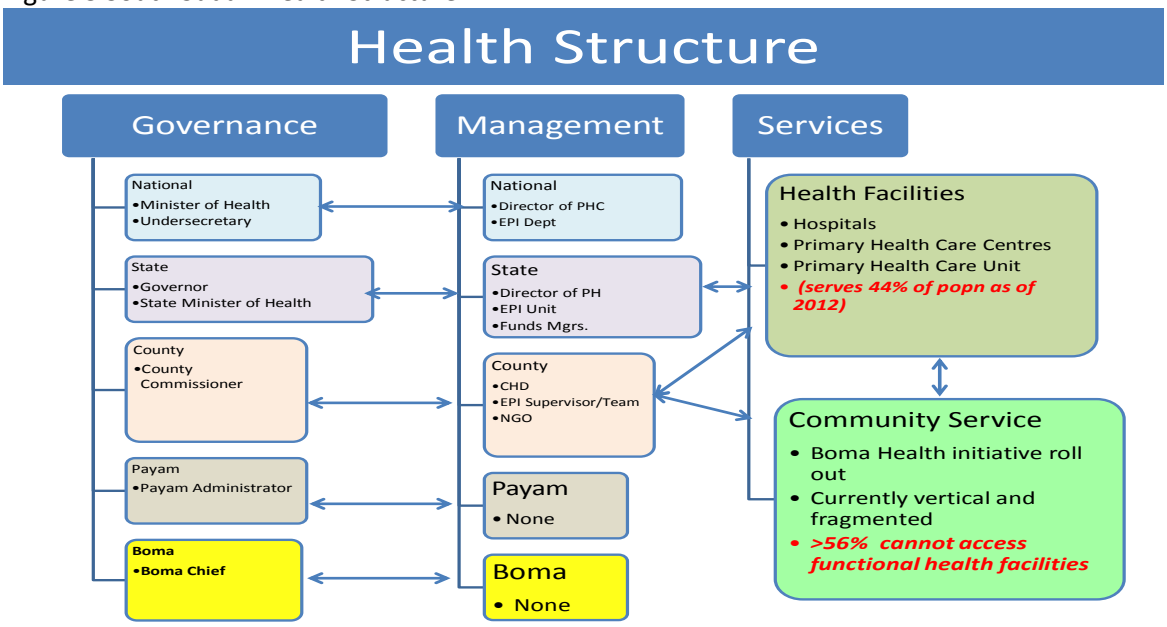
2.4.1. Structure of routine EPI Programme

The current structure for EPI is presented in Table 1. Government supported staffs operate at national, state and county level. There is no EPI staff at payam and Boma or village level.

Table 1. National Structure of the Expanded Programme on Immunization (EPI)

Administrative Level	Available Human Resources Counterpart in MoH
National	- 1 Director EPI, -1 Deputy EPI Director, 1 M & E Officer - 8 NSTOP mentees at post and 5 additional posts remain vacant
State Level: as EPI hubs (10 states)	10 State EPI managers, 2 Qualified Cold Chain Technicians, 8 Cold Chain Assistants, 40 National STOP Mentees. No staff for 23 additional new states
County Level: 80 counties	80 County EPI Officers
Payam: 605 payams	No representation – proposed in Boma Health Initiative
Boma: 2532 Bomas	No representation (proposed in Boma Health Initiative of 3 persons)
Villages (26,544)	No VHWs/Community Informant networks

Figure 3 South Sudan Health Structure



For management of EPI and the eradication of poliomyelitis, the Ministry of Health, South Sudan, and its partners have established 10 state hubs and 80 county hubs based on the ten state status at independence (as of January 2017 the country has thirty-two states). To support field activities UNICEF has 12 sub-offices. Five of these are Zonal (Malakal, Bentiu, Wau, Bor, Juba) and seven are Field Offices (Kuajok, Pibor, Yambio, Yei, Torit, Aweil, and Rumbek). WHO has 10 hubs (Juba, Bor, Yambio, Rumbek, Wau, Aweil, Kuwajok, Torit, Malakal, and Bentiu). Each of the hubs has an EPI National Officer for WHO, , a National C4D Officer and a National Health Officer for UNICEF.

Further strengthening of the routine EPI programme has been through the CDC funded National STOP Programme (EPI-CAPACITY BUILDING PROGRAMME (ECB/AFENET)). This programme is grooming core staff of the EPI for the national and state level responsibility. As of end May 2017, 9 states were provided with a set of national officer mentees for surveillance, data, SIAs, and communication. These mentees will end up being the mainstay of the EPI in South Sudan as they gradually fill existing vacancies. The first set is expected to graduate by the end of 2018.

2.4.2. Status of EPI

The national administrative coverage for DPT3 dropped from 75% in 2012 to 45% in 2016 and only 4 out of 80 counties had 80% or above coverage for DPT3. To increase the EPI coverage the country has adopted several strategies that include of the Periodic Intensification of Routine Immunization (PIRI) as 56% of the population is not reached by health facilities and only 24.1% of 813 health facilities have a functional cold chain to be able to conduct outreach. Planning and implementation and supervision of the PIRI is supported by Polio Eradication Initiative (PEI) staff at all levels. According to the report from EPI bottleneck analysis conducted in 2013, an estimated 44% of the population has access to health facilities. Hospital and PHCC level where all are supposed to be providing routine EPI, only 64% are providing static immunization services (DHIS). The UNICEF/WHO Joint Reporting Form reported a decline in routine immunization (DTP3) from 75% in 2012 to 43% in 2016, with 9 of the 80 counties achieving coverage of 80% and above (Figure 4).

Figure 4 . Trend of DTP3/Penta3 Coverage 2005-2017

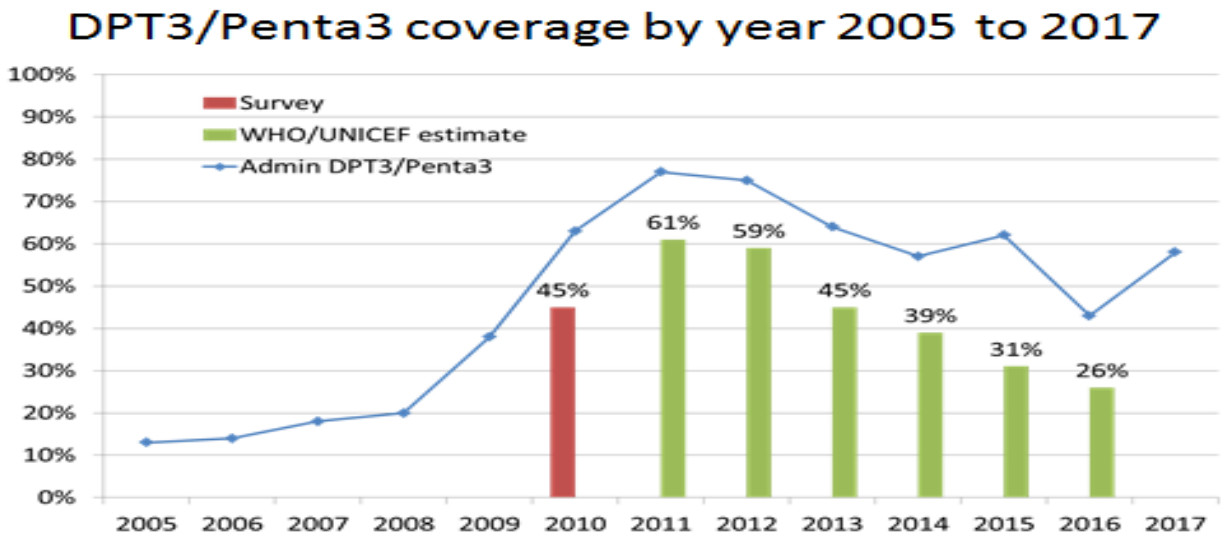


Figure 5: Number of counties with DTP3/Penta$_3$; 2012 to 2017

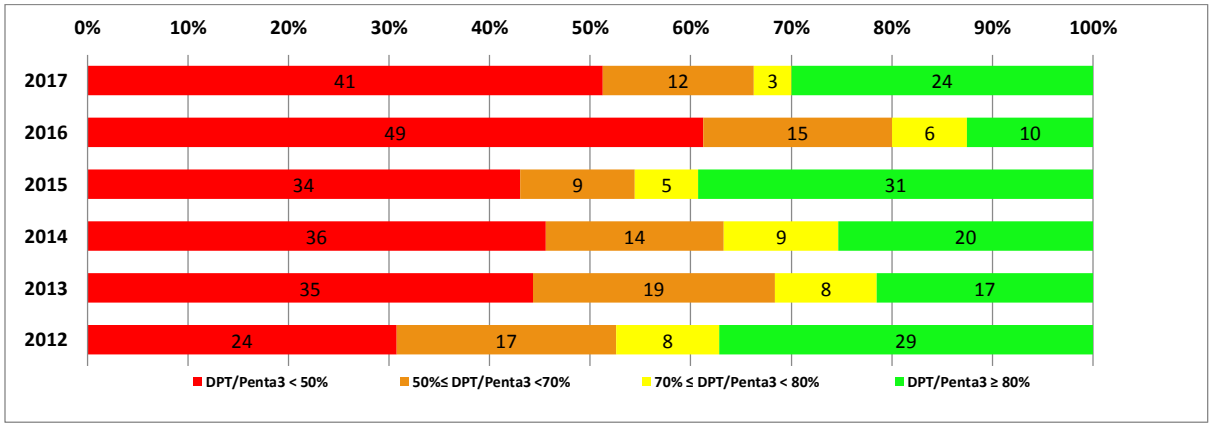
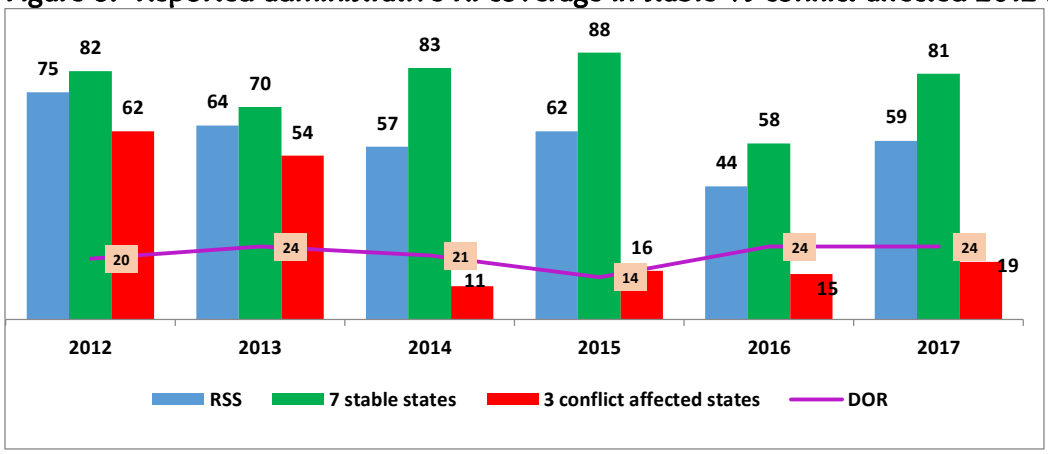


Figure 6. Reported administrative RI coverage in stable Vs conflict-affected 2012-2017



The major reason for the decrease in coverage can be linked to the increasing number of counties in crisis which affects immunization coverage. Also in 2016, the renewal of the managers funding mechanism had some changes with a lot of partners pulling out support for immunization activities. Polio Eradication in South Sudan

2.4.3. Structure of Polio Programme

The structure of the Polio Eradication programme is based on three key strategies (1) providing immunity to the population through routine immunization (as described in the previous section), (2) Supplementary immunization (SIA) activities with OPV to provide immunity, and (3) Identification and investigation of cases of acute flaccid paralysis (AFP surveillance) to detect wild virus or vaccine-derived viruses) and responding to outbreaks in case one is identified.

2.4.4. Support for SIAs

To support supplementary Immunization activities for polio eradication, a total of 17,280 to 20,000 vaccinators, 5,000 community mobilizers, 2,207 team supervisors/Payam supervisors, 154 County Supervisors, 80 State Supervisors (including International and national STOPers), 24 National Supervisors (including staff from WHO, UNICEF and McKing consultancy/BMGF consultants) are engaged in each round of campaign in South Sudan. Health facilities, rapid response missions, and some vaccination posts are the established mechanisms to ensure the vaccination of children below 15 years of age in South Sudan against poliomyelitis.

2.4.5. Support for AFP Surveillance

The South Sudan AFP surveillance has a network of 1,882 surveillance sites (308 high priority, 403 medium priority, 630 low priority and 541 community sites). The human resources include 72 field supervisors at the county level, 236 field assistants at the payam level, and at the community level, 3,086 key community informants (KCI). The community-based structure for surveillance has been strengthened in the three conflict-affected States with 35 county supervisors and 230 payam assistants working closely with 3,129 volunteer key informants in the communities. These staffs collaborate with WHO and Ministry of Health for the investigation, collection of samples from suspected AFP cases and shipment from the point of collection to the reference laboratory (currently specimens are sent to the URVI Reference Laboratory in Uganda). In addition, other cadres (international and national specialists, STOP Team members, consultants) from WHO, UNICEF, CORE group and McKing Consultancy/BMGF support the MoH with the technical expertise, capacity building, coordination and quality control of the activities.

Overall, the non-Polio AFP rate from 2011-2017 has been between 4.31 and 4.72 cases per 100 000 under 15 years children with stool adequacy for the same period of 94-87%. However, the country remains vigilant knowing the vulnerability due to the security situation and with the recent detection of cVDPV2 in DRC in the first quarter of 2017. History of Wild Polio Virus and VDPV in South Sudan, 2008 - 2017

The last indigenous case of wild poliovirus in South Sudan was reported in 2001. Since then South Sudan has witnessed several importations of wild virus. The country has experienced 2 wild polio outbreaks as a result of importations, 12 cases were reported during the 2004-05 outbreak and a total of 64 cases reported during the outbreak of 2008-2009 (refer to Fig 7). In 2014 and 2015, the cVPDV2 and aVDPV2

case were identified respectively, and with intensified efforts of quality NIDs, there have been no cases identified since then.

Figure 7: Incidence of WPV, VDPV cases, 1998 – 2017, Republic of South Sudan

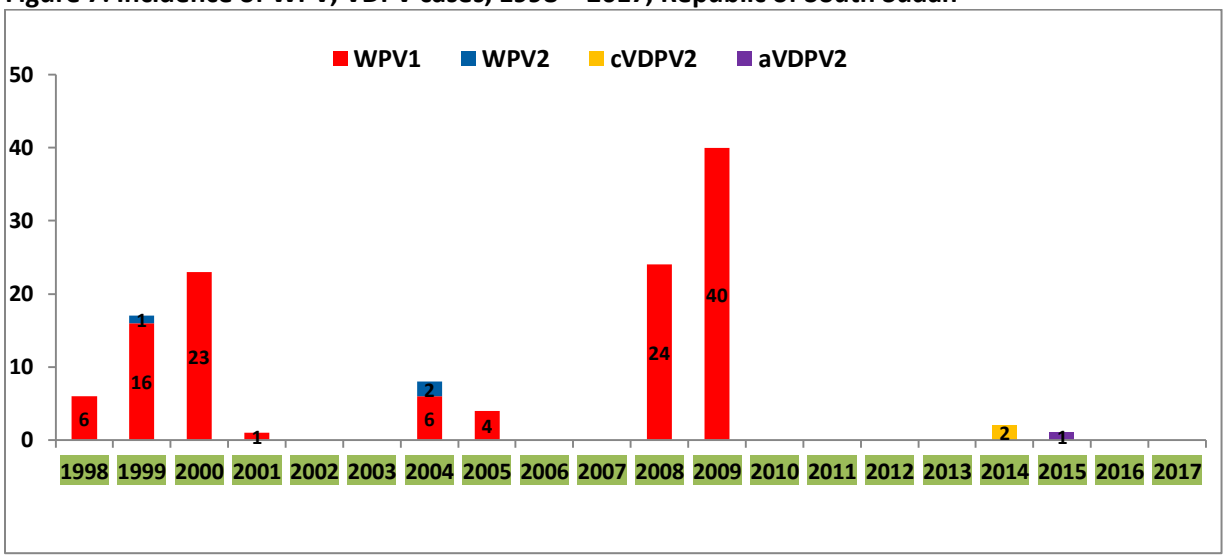
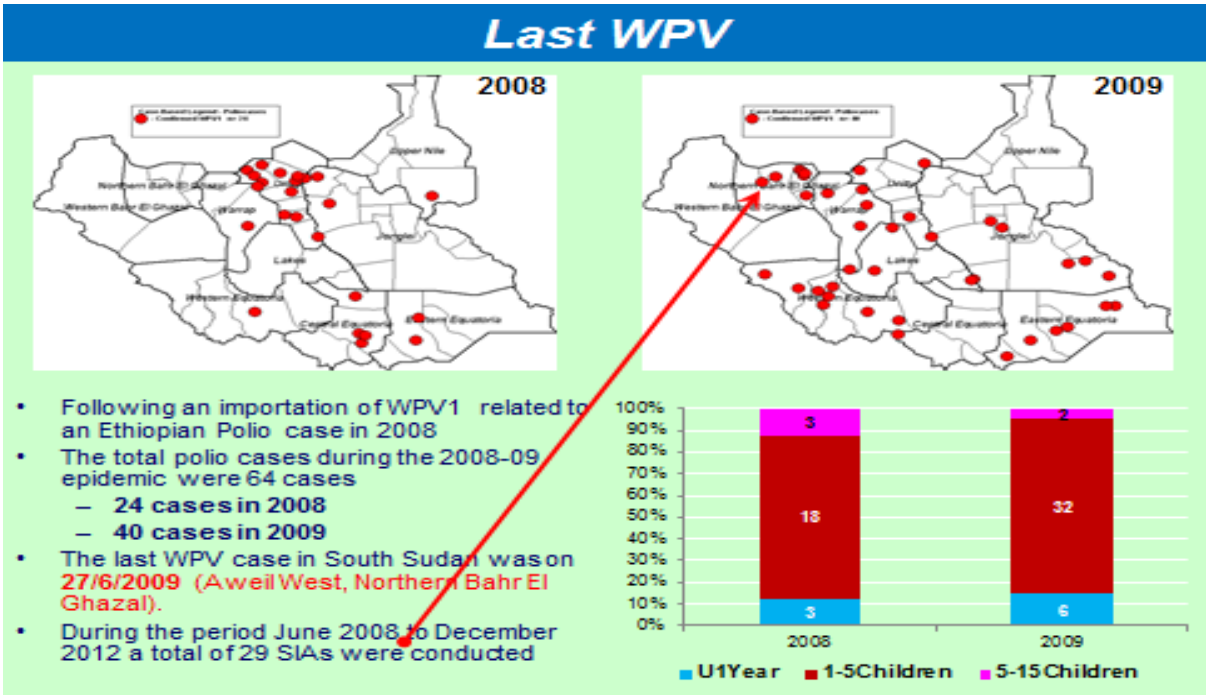


Fig 8: History of WPV in Republic of South Sudan 2008-2009 outbreak

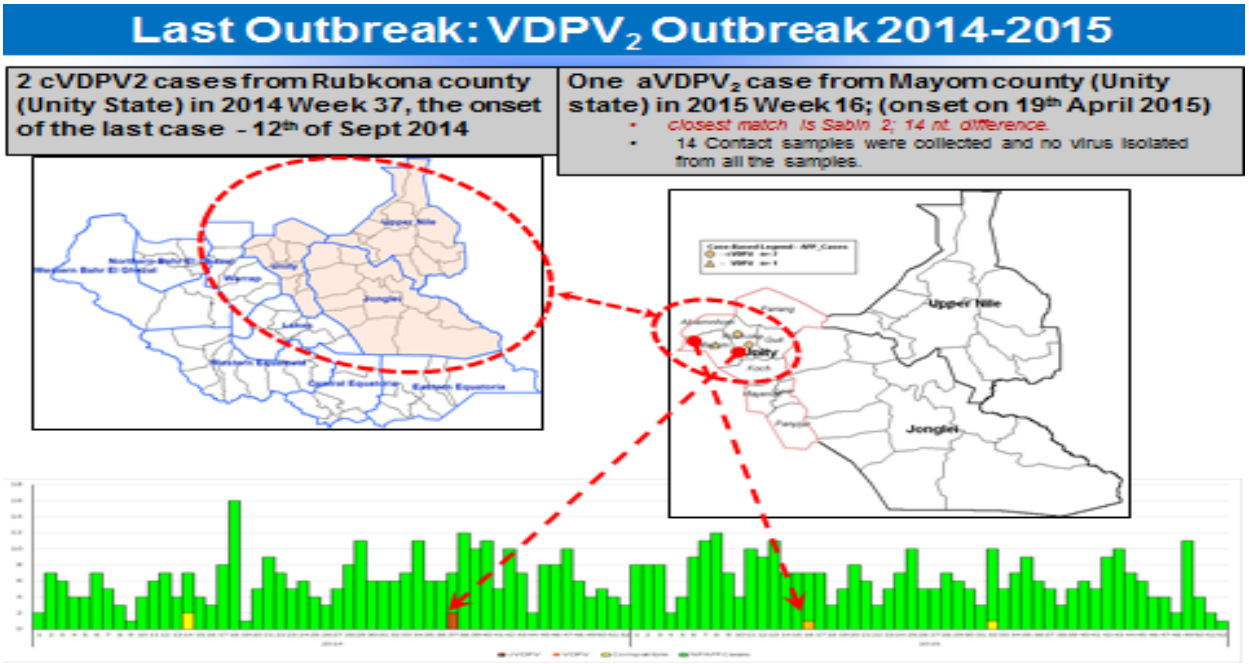


For 2 years (2006-2007), the country had remained Polio free, but between June 2008 and June 2009 a large outbreak of Wild polio (P1) started and spread to nine of the ten states of Southern Sudan (only Western Bahr Ghazal; was spared). The first case of this outbreak was reported from Ayod county of Jonglei State following an index case reported from Akobo County that crossed the border from Ethiopia seeking treatment. The transmission was again re-established in Sudan (Southern parts) between 2008 and 2009, where a total of 64 cases of wild poliovirus infection were confirmed in Southern Sudan. The age group affected was mostly children aged 1-5 years of age (50 cases) followed by the under 1 year of age (9 cases) then the 5-15 years of age (5 cases). The last case was reported from Aweil west county of North Bahr Ghazal State.

Owing to the large spread and delayed interruption of wild poliovirus transmission during the last outbreak (2008-2009); South Sudan was classified among countries with re-established poliovirus transmission. As a response to this outbreak between June 2008 and December 2012, a total 29 SIAs were conducted in South Sudan.

From September 2014 and 2015, South Sudan detected 2 circulating VDPV type 2 in Rubkona and one ambiguous VDPV type 2 in Mayom County respectively. This is easily attributed to low population immunity as a result of low routine immunization associated with mobile population, inaccessible service delivery and numerous hard to reach areas.

Fig 9: History of VDPV Type 2 in Republic of South Sudan 2014



2.4.6. Supplementary Immunization Activities, South Sudan 2008-2017

Between 2008-2017, at least 40 National Immunization Day campaigns, as well as 16 Sub NIDs and Mop-ups, have been conducted all in an effort to boost herd immunity and serve as a barrier to poliovirus importation. The campaigns are resource intensive and engage over 18,000 vaccinators, volunteers, and supervisors in each round, with an extensive and costly transport mechanism of which over 50% are done by chartered flights. The bulk of the overhead cost is in SIAs vaccine transportation and fuel to maintain the cold chain.

Type of Antigen used	2008		2009		2010		2011		2012		2013			2014			2015		2016		2017	Total (SIAs)				
	NIDs	SNIDs	NIDs	SNIDs	Mop up	NIDs	NIDs	Mop up	NIDs	Mop up	NIDs	SNIDs	Mop Up	NIDs	SIADs	SIADs	NIDs	sNID	NIDs	sNIDs	NIDs	NIDs	SNIDs	Mop up	SIADs	All SIAs
m-OPV	4	2	4	1	1	1	0	0	0	0	0	1	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**4**	**1**	**0**	**14**
b-OPV	0	0	0	0	0	2	1	0	2	0	2	0	**0**	**2**	**0**	**0**	**2**	**0**	**1**	**1**	**4**	**16**	**1**	**0**	**0**	**17**
t-OPV	1	1	3	0	0	1	3	1	2	1	2	0	**1**	**2**	**1**	**2**	**2**	**2**	**1**	**1**	**0**	**17**	**4**	**3**	**3**	**27**
Total	**5**	**3**	**7**	**1**	**1**	**4**	**4**	1	**4**	1	**4**	**1**	**1**	**4**	**1**	**2**	**4**	**2**	**2**	**2**	**4**	**42**	**9**	**4**	**3**	**58**

Table 2: Polio SIAs conducted and vaccines used in South Sudan (2008-2017)

2.4.7. Inactivated Polio Vaccine introduction in South Sudan

Inactivated Polio Vaccine (IPV) was introduced in December 2015 and switch occurred on 1st May 2016 in South Sudan. On 20th May, the validation report was signed by the chairperson of the NSVC and the Director General of Primary Health Care of the MOH and submitted to AFRO. Destruction of vials was done by incineration from the 17th of August to the 1st of September 2016. For containment and Global Certification, the ARCC formulated the following recommendations for South Sudan in their June 2017 meeting in Malabo: (a) The ARCC recognizes and commends the work being done under the most challenging and difficult circumstances; (b) The ARCC notes the current security and access issues resulting in sub-optimal performance indicators; (c) The ARCC urges the country to use all opportunities and local innovations to the greatest extent possible; (d) ARCC recommends WHO to continue supporting the national government to explore mechanisms with partners to maintain essential technical support.

2.4.8. Communication for development

Communication for development (C4D) for polio eradication is conducted in an integrated manner with other priority health programmes. Currently, C4D has networked partnerships with community linkages in all states to implement community and social mobilization activities across all thematic areas. By the end of 2017, there were 11 PCA, 3 SSFA partners with around 4500 community mobilizers covering 10

states and 77 counties. This Integrated Community Mobilization Network (ICMN) mobilizes communities towards key healthy behaviours around health, education, water, and sanitation health (WASH), child protection, and nutrition. This community mobilization network operates all year round. Some of the salient features of this network are (a) Boma level mobilization committees and monthly meetings, (b) Quarterly training of all the stakeholders (covering all the thematic areas of UNICEF) including religious and community leaders, (c) Formation and operationalization of mothers' clubs, youth clubs and student clubs, (d) School orientation and other activities. The programme has also developed social mapping for 4 states (Unity, Jonglei, Upper Nile and Western Bahr El Ghazel) and 32 counties. This will be extended to all the other states. With the imminent eradication of Polio from South Sudan and the ramping down of resources for polio communication for development activities, the programme in South Sudan has begun to diversify its intervention and better utilize available resources from all sectors to intervene in an integrated manner, without compromising on-going effort for polio eradication. The principles of this approach are; (a) One partner specializing in C4D will intervene in all thematic areas where he is assigned; (b) Partnership as well as interventions will take place all year round; (c) Resources for different C4D interventions will be pooled from at least 5 sectors (health, nutrition, WASH, protection, education) so as to reduce various reliance on any single source of funds; (d) All activities should achieve higher benefits against costs; and, (e) Ensure maximum utilization of resources with much efficiency and effectiveness.

2.5. Integrated Disease Surveillance and Response

In 2007, South Sudan adopted the IDSR strategy to create a functional national disease surveillance system that is able to (a) predict and detect epidemics early, (b) generate data to identify priority needs, and, (c) to guide public health planning, resource mobilization and allocation, monitoring and evaluation of public health interventions. IDSR is currently being used to strengthen surveillance of priority disease conditions. For disease surveillance in displaced populations, the Early Warning Alert and Response Network (EWARN) is used. Surveillance and response activities take place at Central level (Ministry of Health) with 5 staff: 3 public health officers and 2 data managers), State level (State Ministry of Health in with 10 state surveillance officers), county level (County Health Department), one county surveillance officer. There are no staffs for IDSR at the community level (payam, Boma, village). Event detection takes place at the local level most often involving staff at a health facility. A team from the county and/or the state level does the confirmation, assessment and response planning. This structure is short of staff and its performance is not yet optimal. The World Health Organization supports the Ministry of

Health with event alert, verification, assessment and international response. Currently, the PEI supports IDSR core functions by complementing case detection, reporting and verification of IDSR priority diseases/outbreaks at community level through field assistants and community informants, investigation of community alerts, support sample collection, packaging, and shipment, implementing recommended public health surveillance interventions in response to confirmed outbreaks, linking the health facilities to the communities. In addition, the establishment of community-based surveillance especially in the 3 conflict-affected states via the CORE Group which uses a network of informants in the community has strengthened IDSR in security-compromised counties and states. The IDSR structure for the MoH is based at the State and County level with incentives given by partners. These county surveillance officers collect data from health facility focal persons who report on a weekly basis.

2.6. The Boma Health Initiative: The Community Health Program of South Sudan

The Boma Health Initiative (BHI) is a formal structure of the local governments and primary health system for responding to determinants of health, strengthening and using established systems for reaching communities. It will be dedicated to delivering an integrated package of health promotion and disease prevention and selected treatment services to individuals, families, and communities, using trained, equipped and salaried Community Resource Persons except for the health promoters. It will contribute to the reduction of morbidity and mortality, due to preventable health conditions. The Boma Health Initiative package will include community information system (community health information, community based surveillance, vital statistics), communicable diseases (malaria, HIV/AIDS, Tuberculosis, Epidemics, mass drug administration for Neglected Tropical Diseases), Safe Motherhood (Antenatal Care, Childbirth, Post-Natal Care, Breastfeeding, Child Spacing) Child health (immunization, nutrition screening, diarrhoea disease, pneumonia). In South Sudan, it is known that access to facility-based services is about 44% leaving 56% without access. Three trained community health workers will form the Boma Health Team (BHT) and will provide the priority services package with the aim of increasing access to communities. All interventions at the Boma will support delivery of an integrated package of services. To avoid overloading facility-based health workers with the management of BHI work, the BHT will be managed on daily basis by the Payam Health Office. The Payam Health office will plan for, and manage the Boma Health Teams. They will supervise, mentor and collect reports from the Boma Health Teams. The relationship between BHT and health facilities will be a referral, follow up, storage of commodities, and funds transfer to Boma Health Teams. The polio transition is an opportunity for the

assets to support key structures of the BHI through capacity building and integration of some functions at the primary health care level.

Table 3: Human resources planned for the Boma Health Initiative

Levels	Personnel category	Planned number of personnel required
State Ministry of Health	Director PHC	12
County Health Office	Public Health Officer	85
Payam Health Office	Health Promotion/ Education Officer	545
Boma Health Office	Community Health Workers	2500
Total		**3142**

3. Polio Eradication Programme Transition planning for South Sudan

3.1. Overall objectives for transition planning

In May 2013, the 66th World Health Assembly endorsed the Polio Eradication and Endgame Strategic Plan 2013-2018. The plan outlines a comprehensive approach for the completion of the Global Polio Eradication Initiative (GPEI) by eliminating all paralytic polio due to both wild and vaccine-related polioviruses. The fourth objective of the plan is to document and transition GPEI's knowledge, lessons learned, and assets/infrastructure to address other health goals and priorities. Transition planning should ensure that functions needed to maintain a polio-free world after eradication (such as immunization, surveillance, outbreak response, and bio-containment) are mainstreamed into ongoing public health programs.

Since South Sudan began implementing the strategies for polio eradication, the programme has mobilized and trained thousands of volunteers, social mobilizers, and health workers; accessed households untouched by other health initiatives; mapped and brought health interventions to chronically neglected communities; and established a standardized, real-time national disease surveillance and response capacity. As the initiative nears completion, the primary goals of transition planning for the polio eradication initiative in South Sudan are both to protect it's polio-free status and to ensure that these investments, made to eradicate polio, contribute to future health goals after the completion of polio eradication. In order to take local priorities and contexts into account, the polio transition planning process has been developed to result in individual, customized transition plans for the country. It is expected that GPEI partner agencies, donors, and other stakeholders will also develop organizational transition plans taking this into account. With these efforts, South Sudan should have a single, comprehensive strategy for the responsible transition of polio program people, resources and systems/processes between now and the anticipated achievement of global certification of poliovirus eradication.

3.2. Specific Objectives of the country's polio transition plan:

3.2.1. To ensure that the functions needed to maintain a polio-free status are mainstreamed into existing national immunization and surveillance systems;

a. To improve and attain high polio vaccination coverage (bOPV, IPV);
b. To promptly detect and respond to any polio outbreak.

3.2.2. To ensure that the lessons learned and best practices from polio eradication activities are documented, shared and utilized for other health programmes.

3.2.3. To identify structures for Polio network integration with BHI and IDSR in view.

3.2.4. To ensure the Polio communication network is used for demand creation for other health programs due to its size and penetration.

3.3. Guiding principles and goals for transition planning in South Sudan

The following were the guiding principles for development of the transition plan; (a) Polio transition planning will aim to benefit the country, (b) the process should enable long-term transitions to ***country ownership*** of basic public health functions, wherever possible, as a priority, (c) the process should be under the leadership of the South Sudan government with engagement of a broad range of stakeholders including donors and civil society and (d) the planning should not distract from the current focus on interruption of poliovirus transmission and other objectives of the 2013-2018 Strategic Plan.

The ultimate goals of the transition planning process are to (a) Ensure that functions needed to maintain a polio free world after eradication (such as immunization, surveillance, outbreak response, and bio-containment) are mainstreamed into ongoing public health programs, (b) Ensure that the knowledge generated and lessons learned from polio eradication activities are documented and shared with other health initiatives and, (c) Where feasible, desirable, and appropriate, transition capabilities and processes to support other health priorities and ensure sustainability of the experience of the GPEI program.

3.4. Methods and Processes for Transition Planning for South Sudan

The Ministry of Health South Sudan directed that the functions of Polio transition planning be overseen by the Expanded Programme on Immunization Technical Working Group (EPI/TWG). The following were the key activities for transition planning. The outcomes for each of these activities are described in detail in the sections below.

(a) Mapping of the functions and assets of the polio programme (section 4)

(b) Polio Transition Simulation Exercise: Identification of strategies for the transition of assets (section 5)

(c) Summary of communication Strategy for the Polio Transition (Section6, and a separate document)

(d) The Business Case and costing for the Polio transition (Section 7 and as a separate document)

(e) The Risk on Other Health Programmes as Polio Funding Ramps Down (section 8)

(f) Polio Programme Transition and Mainstreaming Strategies for 2018-2022 (section 9)

(g) Implementation Plan, Advocacy and Resource Mobilization Plan (section 10)

(h) Summary and Conclusions (section 11)

4. Polio eradication Programme Functions and Assets mapping

The Polio Asset Mapping process in South Sudan was carried out in three phases. The first phase was at national level with the collation of available data and information from WHO/UNICEF/CORE group and other partner agencies and on a one-to-one basis as well as with Government personnel. The second phase included information validation with field visits to six states; Western Bahr el Ghazal (WBG), Northern Bhar el Ghazal (NBG), Warrap (WAR), Jonglei (JON), Lakes (LAK) and Central Equatoria (CEQ). Information from the remaining four states was provided by WHO State focal point persons. This was supplemented by visits conducted by a two-person team with an agreed protocol and checklist. An online survey was in addition conducted among field personnel and a survey to collect qualitative information on the structure of social mobilization and communications was also done. The initial asset mapping was done in June 2016 and updated subsequently in May 2017. A detailed report of the Asset Mapping is available as a separate document attached at the end of the electronic version of this plan.

4.1. Programme Functions

The following programme functions were identified that are supporting Polio Eradication activities in South Sudan:

a) Programme implementation and service delivery: **P**olio Personnel apart from the Polio and EPI programs are largely also involved in Health System Strengthening Health Security and Emergencies as well as Humanitarian support;
b) Monitoring and data management;
c) Disease surveillance;
d) Planning: Planning for SAIs and EPI activities;
e) Communication and community engagement;
f) Capacity building;
g) Resource mobilization and advocacy;
h) Policy and strategy;
i) Partnership and coordination;

j) Management and operation.

4.2. Human Resources

South Sudan had by the end May 2017, 703 staff distributed among WHO, UNICEF, Core group, McKing Consultancy/BMFG and the EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET) who are funded totally or partially by the GPEI. The annual cost for these staffs was US$8,979,268. 63.7% of them have Agreement for the performance of Work (APW) contracts and 57.18% of the staff are in the 3 conflict-affected states of Jonglei, Unity and Upper Nile.

Table 4. Polio Eradication Supported Staffs by partner Agency as at Dec 2017

Agency	Number of Personnel	Annual Cost
WHO	361	$ 4,796,300
UNICEF	13	$ 716,515
CoreGroup	283	$ 1,221,988
BMGF	7	$ 1,623,645
ECB/AFENET	59	$ 620,820
Total	**703**	**$8,979,268**

Table 5. Polio Eradication Supported Staffs by Contract type

Contract Type	Number	Percentage
Fixed Term	32	4.6%
Special Services Agreement (SSA)	197	28.0%
STOP Consultant	15	2.1%
Agreement for performance of work	448	63.7%
Temporary Professional (TIP)	1	0.1%
Total	703	100%

Figure 10: Distribution of Polio Eradication staff by State and contract type

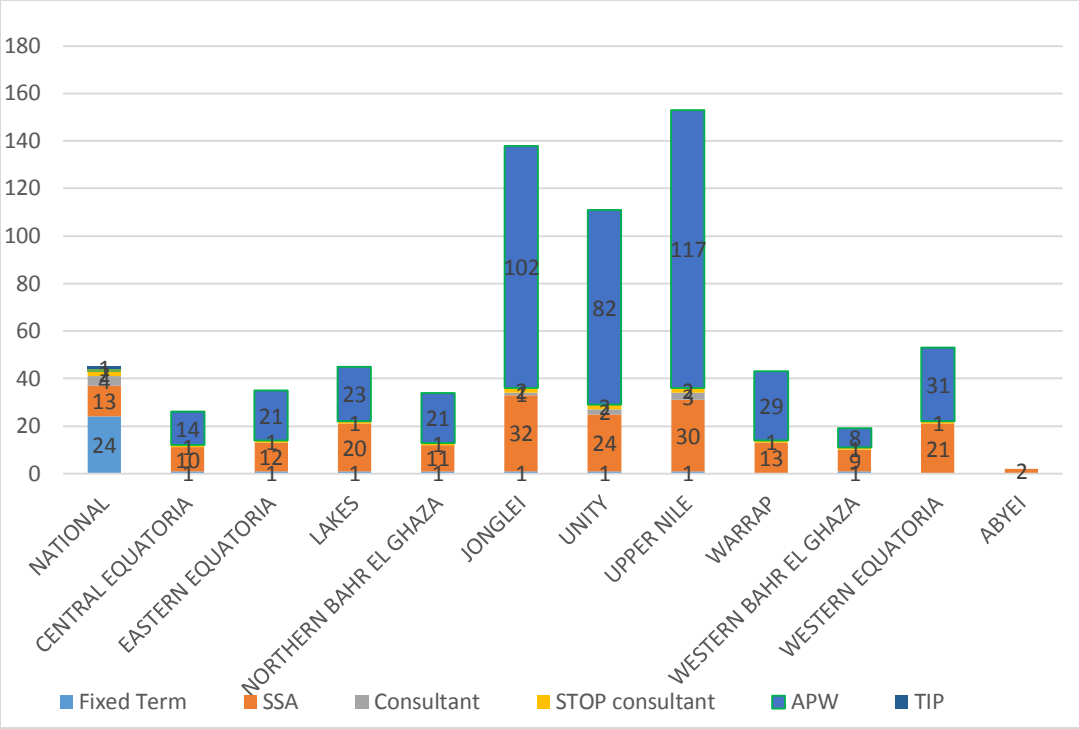
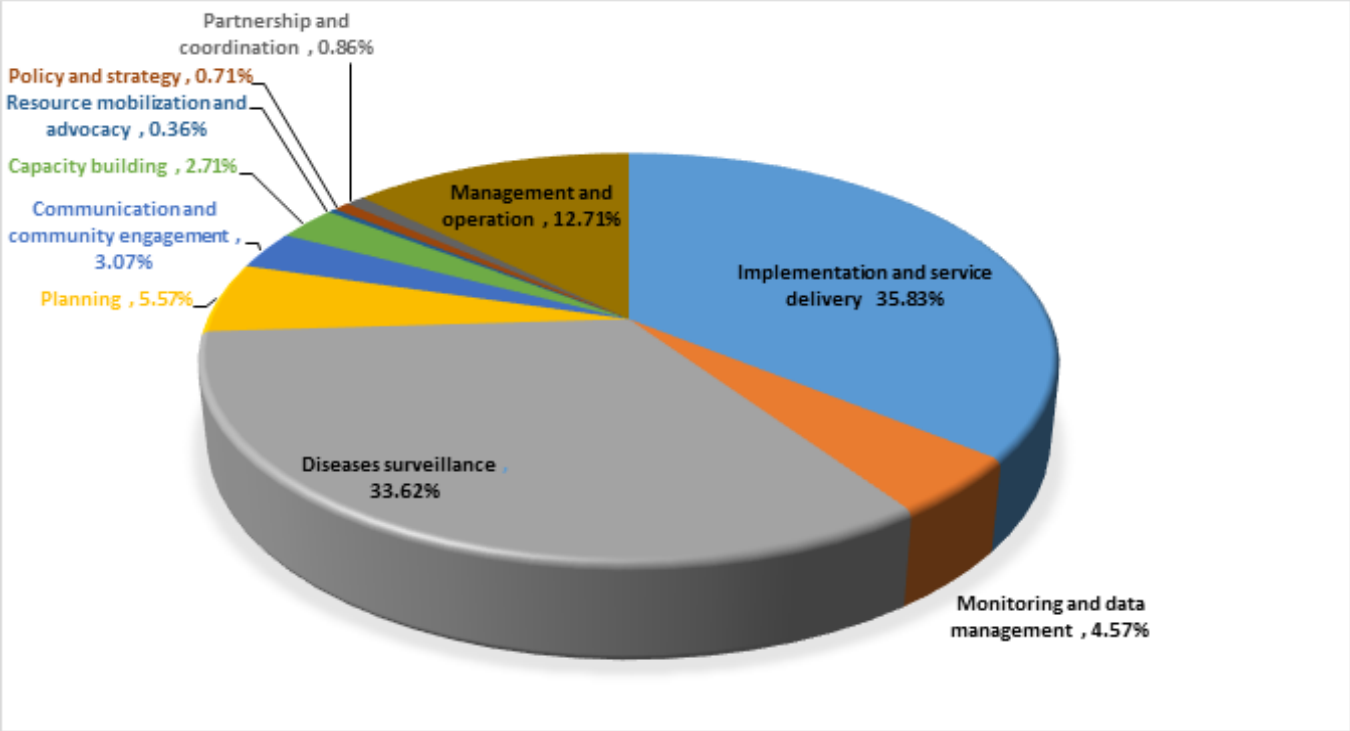


Figure 11: Percentage distribution of the human resources per functions



4.3. Materials and equipment

It is estimated that 18,141 equipment in form of vehicles, motorcycles, generators, computers, smartphones and solar chargers, cold chain equipment worth 2,106,143 $ US has been provided by GPEI to South Sudan between 2009 and 2017.

Table 6: Summary Distribution of the physical assets

Asset	Units	Total Cost
Vehicles	21	$ 770,210
Motorcycles	30	$ 96,000
Generators	17	$ 208,157
Computers, scanner, camera	199	$ 226,925
Satellite phone, Smartphones, solar phones chargers, internet dish, radio handset and others	564	$ 115,515
Cold chain equipment (cold rooms, freezers, refrigerators, cold boxes, ice packs, cold chain spare parts, vaccine carriers, etc..)	17,310	$ 689,335
Total	**18,141**	**$ 2,106,143**

Most of these equipment listed in the table above enable the surveillance team to collect stool samples, do investigations, conduct supportive supervision of surveillance and immunization activities, ensure appropriate vaccine storage and management and transport them where needed. They also enable the prompt collation of data and shipment of stool specimens. For social mobilization, 3,461 megaphones have already been made available to the Ministry of health and communities.

Taking into consideration the year of purchase and integrating a depreciation rate of 25% per year most of the equipment may worth only 1$ by 2020

4.4. Processes and intangible assets

Coordination mechanisms at the central level, as well as other lower levels (States, Counties, Payams and Boma) with some sub technical groups (e.g., cold chain and logistics, communications), have been established. Cross-border cooperation, meetings, and vaccination mechanisms have been established to reduce the importation or exportation of the poliovirus. A network of integrated social mobilization with about 5000 social mobilizers and at least 11 NGOs to coordinate their activities has been established with the assistance of UNICEF. Media, predominantly the community radios have been highly effective in sensitizing the communities in their local language on polio and other vaccine-preventable diseases. A

mixed communication channel (religious, traditional and administrative leaders, schools, health services, theatre groups, church groups, youth groups, mother groups, parliamentarians, social mobilizers, banners, posters, media) is used in the country.

Most states using the social mobilization team have established committees to follow-up defaulters, refusals and missed children during vaccination campaigns or activities and mapping of areas covered by campaign vaccination teams of the country has been done to better implement outreach for routine EPI or EPI periodic vaccination campaigns. Because SIAs are implemented several times a year, microplanning templates are regularly updated for each campaign that is organized or for Periodic Intensified Routine Immunization (PIRI). Tools for data collection, for surveillance performance, communication and social mobilization have been developed and are being used for planning of EPI. In process monitoring, post-campaign evaluation by independent monitoring has become a standard for all SIAs to ensure the quality of the reported results of campaigns. For accountability, tools and procedures for justification of funds used for polio activities have been developed, shared and its utilization is monitored and supervised to improve the accountability framework of financial resources put for polio.

4.5. Lessons learnt and best practices

The following 12 best practices have been identified for some of polio eradication core functions:

a) Communication: Social mapping which is been used in states and counties where they are available for routine and supplementary immunization planning.
b) Data management: Use of Mobile Technology in Data Collection (ODK), has been mainly used for independent monitoring of campaigns.
c) Coordination: Weekly EPI TWG coordination meetings for other disease outbreak monitoring and response as well as discussions on other planning, monitoring, evaluation and strategic matters.
d) Management and operations: Polio hubs which help to manage campaign, routine activities, and surveillance across the states.
e) Surveillance*:* Utilization of the key community information structure to strengthen community surveillance for AFP has enabled to improve the sensitivity of AFP surveillance.
f) Implementation and service delivery: There has been Integration of other activities (deworming, Vitamin A supplementation, AFP and Guinea worm surveillance) in the Polio NIDs in South Sudan; the use of short interval immunization activities (SIADS); Routine Immunization intensification with

PIRI; International/National Vaccination and Transit Vaccination Posts; Rapid Response Missions (RRM) for vaccination and surveillance opportunities; Lone Wolf Strategy.

g) Coordination of field activities: Polio/Measles control rooms are in operation. They compile, analyse data and disseminate information on surveillance and routine immunization. During SIAs, they provide coordination for staff in the field and ensure continuous communication for logistics.

h) Mobilization of political, social and advocacy support: The high government officials at all levels of the state including the head of state are involved with the polio eradication programme, the media, especially the community radios sensitize and inform the population on polio and other immunization activities in English and the local languages and communication plans are regularly developed for the national level and state hubs based on post-campaign evaluation reports, in process monitoring reports, routine data analysis. This is supported by a social mobilization network which has been established in the country and collaborates with other sectors including administration, education, religious.

i) Elaboration of policy and strategic planning documents: These include the Polio outbreak and response plan, guideline on AFP surveillance, guideline on the organization of polio SIAs, Standard Operational Procedures (SOPs) on polio that has been shared with the stakeholders

j) Management of partnership and coordination of donors: An Inter-Agency Coordination Committee (ICC) exists, functions and its capacity is regularly strengthened.

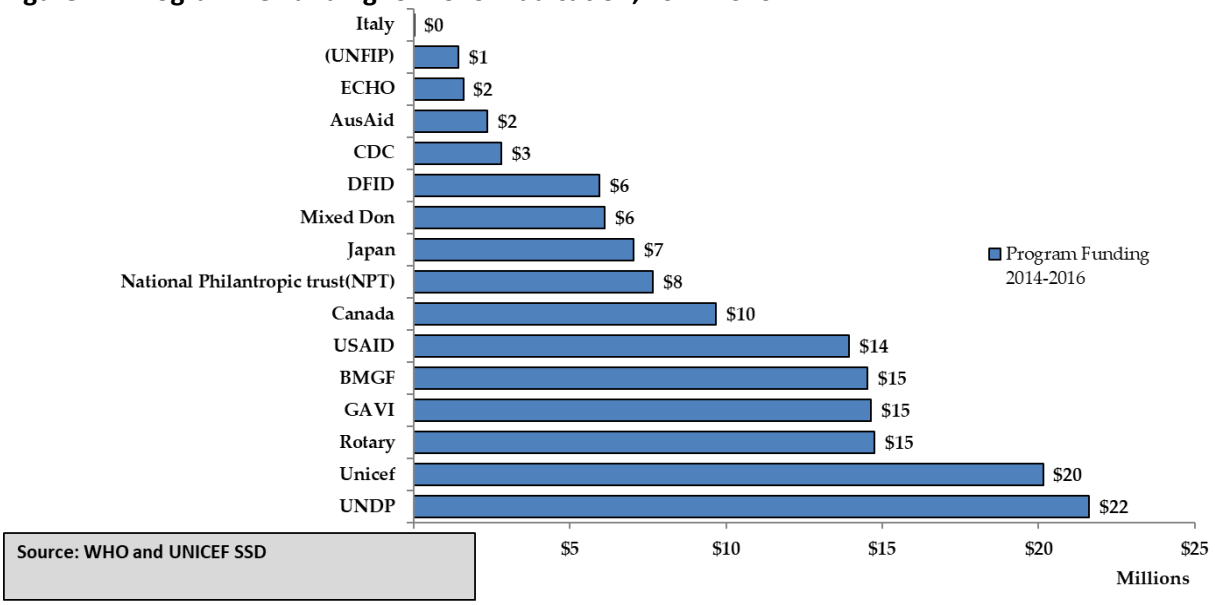
k) Programme implementation: includes micro planning for the campaign and routine immunization combined with mapping, a community-based surveillance system, local special strategies have been developed to vaccinate children in areas with insecurity, and the introduction of an accountability framework.

l) Monitoring and evaluation: A well-established system to collect data, do surveillance on case base for AFP, monitor, report and disseminate findings and the situation. For SIAs, pre-campaign, intra-campaign and post-campaign monitoring (including independent monitoring), has been institutionalized for all SIAs

4.6. Financing

The program is funded almost at 100% by donors and the funding for 2014-2016 has been $144 million, coming from UNDP, AusAid, DFID, Japan, Canada, USAID, BMGF, Rotary, UNFIP, UNDP, GAVI (see fiure12 below).

Figure 12: Programme Funding for Polio Eradication, 2014-2016



For 2016 and 2017 South Sudan got from GPEI through UNICEF and WHO 21,858,000$ and 16,291,000$ respectively. For 2017, 75.15% (12,242,000$) of it was for SIAs, 18.53% (3,019,000$) for core functions and infrastructures and 6.32% (1,030,000$) for surveillance.

5. Polio Transition Simulation Exercise:

5.1. Identification of strategies for transition of assets and functions.

The Simulation exercise was to determine the impact on South Sudan health system due to the withdrawal of Polio assets and human workforce, the chapter summarizes the following:

a) The essential and non-essential functions for Polio Eradication and the matching of assets to the South Sudan Health programme priorities
b) The suggested transition strategies for polio functions/sub-functions
c) The Identification of elements for the development of the Business Case for resource mobilization and Communication strategic plans for the transition process in South Sudan.
d) Proposed phases and the duration of the transition activities.

5.2. Methods

From the 29th -30th June 2017, the MoH organized the polio transition simulation exercise in Juba attended by 57 participants from National and State MoH, CoreGroup, EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET), WHO, UNICEF, USAID, Embassy of Canada, IMA World Health.. Two formats were used, plenary presentations with discussions and working groups. The workshop used information captured in the completed transition planning activities (Asset mapping, documentation of best practices, health priorities for South Sudan). The Polio Simulation Exercise (PSE) required participants to consider a scenario in which polio program funding is no longer available to support public health functions in the country. Within this scenario, stakeholders were tasked to identify critical risks to various public health activities and brainstorm scenarios for addressing these risks. For example, potential solutions could include finding alternate funding sources for existing polio program functions, transitioning polio program expertise to national ownership, or considering alternative technical strategies for achieving public health goals.

5.3. National Health Priorities for South Sudan in the context of Polio transition

There are three broad areas that are identified as national health priorities in the context of transition planning for South Sudan. These are the key areas where Polio assets make significant contributions as well as areas where the existing polio assets can be expected to make a contribution in the future following the eradication of polio from South Sudan.

These areas are (1) The Expanded Programme on Immunization, (2) Integrated Disease surveillance and response and, (3) Health systems strengthening (The Boma Health Initiative). Polio Eradication Functions and transition strategies

The functions for Polio eradication were categorized into three groups: (a) polio essential functions (b) non-polio functions currently supported by polio program and (c) non-polio functions that could benefit from polio asset support. The future for performing these functions was (a) fulfilled using current/modified polio program assets (e.g. continuation of downsized WHO surveillance program with new funding source), (b) Function fulfilled using alternative programs/assets.

5.4. Essential Polio Functions-Mainstreaming

a) Maintain minimal assets and structure within the current system

b) Transfer responsibility for conducting essential polio functions to Government

c) Transfer responsibility for conducting essential polio functions to an alternate implementing partner or to a new organization

5.5. For Non-Essential Polio program functions

a) Maintain polio program functions and assets to contribute to either health/development priorities.

b) Build local capacity to take over management and implementation of the polio program functions while phasing out polio program assets.

c) Transfer polio program functions to Government.

d) Transfer polio program functions to an alternate implementing partner or to a new organizational structure.

e) Discontinue Polio Program functions but retain high performing individuals.

f) Discontinue polio program functions and sunset assets.

g) Discontinue both assets and functions but ensure lessons learned are integrated into other health/development programs.

The participants in the thematic working groups were also tasked to evaluate the options in terms of costs, benefits, feasibility, and risks by function. This was particularly important in that South Sudan is currently in a state of civil strife and insecurity that affects effective implementation of health programmes.

5.6. Matching of functions to national health priorities and proposed transition strategies

Based on the Asset Mapping exercise (see Chapter 3) the following ten functions were identified as being performed or supported by the staff (human resources assets) involved in polio eradication in South Sudan; Under each function, sub-functions can be identified, depending on the priority health area where the polio eradication initiative works or where there is overlap at the operational level. The ten functions are: (1) Implementation and service delivery, (2) Data management and monitoring, (3) Disease surveillance, (4) Planning, (5) Communications and community engagement, (6) Capacity building, (7) Resource mobilization and advocacy, (8) Policy and strategy, (9) Partnership and coordination, and (10) Management and operations. For each of the national health priorities in the context of the polio transition (Health Systems Strengthening (Boma Health Initiative), Integrated Disease Surveillance and Response and Routine EPI), the 10 functions of the programme were analyzed to reflect key sub-functions, risk to function in the absence or reduction of GPEI resources, classification if the function was essential or non-essential, strategy and timeline for transition, possible funding sources to support the function post GPEI. Summary and synthesis transition strategies

Table 7 presents the summary of the transition strategies by function and sub-function. Overall, twenty-six (26) functions were related to surveillance, 29 were for routine EPI and 28 were related to the Boma Health Initiative (or health systems strengthening). Overall, 81%, 90% and 86% in the respective areas of surveillance, routine EPI, and the Boma Health Initiative were considered essential. Of all the PEI supported functions, 50%, 55%, and 36% respectively were at high risk of stopping once polio assets have been removed.

Table 7: Overall Summary of Polio functions and transition strategies

		Health Priority area for Polio Transition		
		Surveillance	**Routine Immunizations**	**Boma Health Initiative**
Functions/ Sub-functions		**26**	**29**	**28**
Risk	High risk	13(50%)	16(55%)	10 (36%)
	Moderate	4 (15%)	8 (28%)	9 (32%)
	Low	3 (12%)	2 (7%)	5 (18%)
	Not applicable	6 (23%)	3 (10%)	4 (14%)
Is the function essential or not	Essential	21 (81%)	26 (90%)	24 (86%)
	Non-essential	1 (4%)	0	4 (14%)
	Not applicable	0	3 (10%)	0
Suggested Transition Strategies	Maintain	7 (27%)	17 (59%)	10 (36%)
	Transfer to Government	3 (12%)	9 (31%)	11 (39%)
	Transfer and integrate into IDSR	9 (35%)	0	0
	Transfer & integrate in (BHI)	1 (4%)	0	0
	Transfer & integrate in M&E unit	2 (8%)	0	0
	Not applicable	4 (15%)	3(10%)	7 (25%)

When the functions were matched with the health priorities, 7 (27%) of the surveillance functions, 17 (59%) of the routine EPI functions and 10 (36%) of the functions in the Boma Health Initiative will need to be maintained. These are functions that are required to maintain a polio-free status until certification of eradication. An example is the collection and transportation and testing of stool specimens collected from AFP cases. For surveillance, 15 (58%) would be transferred to the government and or integrated into IDSR, for routine EPI, 9 (31%) would be transferred to the government, and for the Boma Health Initiative, 11 (39%) of the functions would be transferred to the government.

5.7. Conclusion

The working groups recognized the challenges that will be faced in moving forward with the transitioning of the Polio assets to support the health priorities in South Sudan. Whereas the primary challenges for transferring the functions and assets to the Ministry of Health structure that is already in place, the task may require re-training of many of the staff at the county or payam level to have more responsibilities to support the relevant priority programmes. Secondly, the government will need to find resources from other donors and it's health budget to maintain these staffs when financial support to GPEI will end in 2019. A further challenge for transitioning the human assets to strengthening health systems (the Boma Initiative) is that the Boma Health Initiative is yet to be funded. However, the staffs whose skills match the requirements of the BHI should be integrated at the earliest opportunity. Integration of the assets into routine EPI and IDSR should be less of a challenge as the polio human resources and the functions are already being performed. Training and re-orientation will be required as the terms of reference and activities will be broader. Furthermore, the working groups also noted that for successful transitioning, enabling factors should be in place. These should include recruitment and redeployment policies, strategies and resources to capacity building and ensuring supportive supervision of staff. All this should be accompanied by a clear communication plan addressing issues such as how the polio transition fits into the partner agencies and donors health support plans, how job descriptions will be harmonized during the transition, milestones for monitoring implementation of the transition and resources needed for transition plan implementation.

6. Communication plan for Polio Transition in South Sudan

6.1. Introduction

The communication plan outlines how the polio transition process will help build awareness of its purpose, key messages and success stories to both the local and international audiences. This strategy will be implemented over the period 2017 to 2022. Communication component is crucial from the very start of polio transition planning in order to avoid misconceptions about the whole process. Setting up the right communication strategies and communication channels during the early planning process will help to ensure all stakeholders are supportive of the process. Internally, there will be uncertainty surrounding transition that might have a deep effect on the staff reduction, morale, and effectiveness of the polio assets during transition period and externally, the perception of the transition process by donors and other stakeholders will be critical for securing long-term support for the strategies developed. Thus, a set of key audiences for the advocacy and communication around polio transition planning should be identified. Objectives of the communication plan

The overall objectives of the communication plan for Polio transition in South Sudan are:

a) To advocate for the support of the implementation process of the polio transition to maintain South Sudan polio-free beyond 2019;

b) To advocate for resources to fund the process and maintain South Sudan free of polio;

c) To share polio legacy with other health programmes

d) To engage the key stakeholders in the development and implementation and management of the impact of the polio transition process;

6.2. Target audiences for the communication plan

For this communication plan to be successful, the polio transition team should ensure that the transition messages are adapted and used by the right audience. The following are the target audiences identified:

6.2.1. Primary audience

The primary audience for communicating the transition plan for Polio eradication in South Sudan will include

a) **Political leadership:** This includes the Office of the Presidency (President of Republic of South Sudan and two vice-Presidents), Parliamentarians (Committee for Health-National and State Legislative Assemblies) and State Governors
b) **Technical leadership:** Key line ministries (Health, Finance, Public Service/Labour and Information) and Donor agencies and technical partners
c) **Local administrations:** Local authorities and communities

6.2.2. Secondary Audience

The secondary audience will include

a) Community Based Organizations involved in EPI and health development activities
b) Staff funded by polio
c) Other programmes within the Ministry of health that collaborate in EPI and Polio activities.

6.3. Key activities for communications

a) Programme communication to partners and donors on the progress of the ramp down.
b) Engage with staff who are funded by the polio programme
c) Conducting consultative meetings and detailed discussion with the line ministries who have a direct impact on the polio transition process (Public Service, Labour)

6.4. Communication channels

Multiple channels will be used. Briefing notes will be prepared for all meetings. The meetings will include face-to-face meetings, Donor forums, scheduled Technical meetings and workshops, Parliamentary Sessions, State Governors Forum and Inter-ministerial meeting

6.5. Key messages

The key messages and proposed channels for communicating are listed in Table 8 The programme will take advantage of planned forums and meetings and workshops to deliver the messages to the target audience

Details of key messages and action plan are included in the communication plan referenced as an annex

6.6. Activity plan for communication of Polio Transition Plan

Table 9 gives the timeline for activities for the communication plan for the Polio Transition in South Sudan. As much as possible, opportunities such as planned meetings and workshops with the targeted audiences will be used as for the communication activities.

Attached as an annex (communication plan)

7. The Business Case and Costing for Polio Transition in South Sudan

7.1. Introduction:

South Sudan undertook a transition simulation exercise in 2017 to map the residual Polio program assets and identified health priorities that could assimilate assets.

Economic evaluations of the proposed options are considered vital to supporting countries in the ultimate decisions on the ramping down strategic options to which the balance of polio assets post the eradication certification will be committed. Stating the business or investment case for the options provide the justification of transition strategic options to ensure stakeholder alignment, and will inform and realign the resource mobilization activities, post-certification.

The goal of this business case was to make the compelling investment case for polio eradication and for the strategic health priorities to which polio assets would be transitioned into.

7.2. Objective

The goal of this exploration is to provide the compelling case for the investment of the residual polio assets.

Specifically, the study aimed to:

1. Estimate the aggregate values of these residual assets and functions and match with the resources needed to maintain these assets within the strategic health options within South Sudan health priorities.

2. Estimate the cost consequence and health impacts of the transitioning polio assets to the health priorities in South Sudan.

The outcomes of the study are expected to inform resource planning and resource mobilization targeted at maintaining South Sudan Polio free status, immunization programs and activities in general.

7.3. Methods

7.3.1. Costs

In making the business/investment case, the polio eradication residual physical assets were evaluated by depreciating the assets from the year of purchase or commissioning to 2018. Then the pledges (from GPEI and other development partners that have been funding polio activities) were aggregated to 2022 and matched to the expected expenditure on the residual activities to estimate the funding deficits to 2022. Data from the asset mapping was used to estimate the values of assets.

Two main categories of residual PEI assets that have been acquired over the years include tangible (physical) and functional assets. While tangible assets could be valued in dollar terms based on their purchase or commission dates, years of use and lifespan, the value of functional assets is difficult to similarly estimate

7.3.2.Polio Physical (Tangible) Assets

Since 2012, GPIE has funded the acquisition of a volume of assets which may become idle as the polio activities are ramped down following South Sudan's eradication status. These assets broadly include Human resource (Personnel) Asset; Cold Chain Equipment; Laboratory, Warehouse, Equipment and IT equipment; Logistics: Vehicles, Land Cruisers and motorcycles; Technology (nonphysical, assets); and GPEI donor pledges.

7.3.3.Polio Intangible, nonphysical Assets (Polio Eradication Technology)

As recommended in the polio transition guidelines, in addition to physical assets, polio activities were divide into nine functions: Implementation and service delivery; Monitoring and data management; Disease surveillance; Planning; Community engagement, communications, and political advocacy; Capacity building; Resource Mobilization and Advocacy; Policy and strategy; Partnership and coordination; and Management and operation (Appendixes VI, VII and VIII). These functions were further categorized into sub-functions under each function and risk categorized according to their retention potential in the system.

7.3.4.Donor pledges. Global Polio Eradication Initiative budget for South Sudan

Considering GPEI budget pledges for the years 2017 to 2022 as liquid assets, as shown in Table3 and Figure 2, the total sums pledged including SIA pledges, will decrease from US$ 25.7million in 2017 to US$ 0.7 by 2022, accumulating to a total of US$ 45 million in the years between 2017 and 2022. There are no firm indications as yet, as to the projected contribution from South Sudan towards polio in her budget consideration for the contiguous years.

7.4. Impact, Outcomes and Consequences of the Polio Asset Transition.

The oneHealth tool was used to identify and estimate the cost and the potential additional impact of the options, the consequences transitioned polio eradication assets to health priorities.

Three health priorities were identified as essential programmes that could assimilate polio assets: Boma health initiative, Routine Immunization and Integrated Disease Surveillance and Response (IDSR).

7.4.1. Boma Health Initiative.

The South Sudan Boma Health Initiative (BHI) which was launched in March 2017 operationalizes primary health care to maximize access to care for all.

Some implementation challenges could generally and specifically limit and undermine the Polio asset transition and the health impact of BHI. First, BHI is yet in its nascent stage and the supporting institutions have not been clearly established. Although transitioning Polio asset into the BHI will provide a significant boost to its take off and development. Secondly, the National Ministry of health will require significant managerial and funding support from the international partners that are already funding and delivering healthcare services in the country, to implement the transition process. Although the majority of the PEI personnel for transitioning are already functioning at the county, Payam and community levels, access is limited to some tangible assets like cold-chain related equipment at these levels due to the number of prevailing challenges including insecurity, internal conflicts, and difficult terrains.

7.4.2.Integrated Disease Surveillance and response. IDSR.

South Sudan has an established Integrated Disease Surveillance and Response (IDSR). An alternative strategy that was considered for the transfer of the residual Polio eradication assets is that the polio assets be invested into the IDSR.

7.4.3.Routine Immunization within the Primary health care

Integrating the residual polio asset into the routine immunization (RI) system; potentially strengthening the health system

7.4.4.Mixed distribution of assets within the entire health system

A mixed asset transitioning option was considered a possibility as some or none of the options considered can solely and wholly accommodate all the polio residual assets sufficiently. This option allows for an ordered gradual (staged) uptake of the assets until complete allotment within a given option, and subsequent uptake by the other options until all the transferable assets have been transferred.

7.5. Financial Analysis:

7.5.1.Polio Physical (Tangible) Assets

The physical assets include the following and the asset mapping was used as source data

- Human resources - Polio funded
- Cold Chain equipment acquired between 2012-2016 by UNICEF Laboratories.
- Laboratories.
- ITC Equipment: Computers and communication equipment
- Internet, satellite phones radio handsets and other items
- Logistics: Vehicles and motorcycles.

7.5.2.Polio Intangible, nonphysical Assets (Polio Eradication Technology)

Polio activities were divided into nine functions: Implementation and service delivery; Monitoring and data management; Disease surveillance; Planning; Community engagement,

communications, and political advocacy; Capacity building; Resource Mobilization and Advocacy; Policy and strategy; Partnership and coordination; and Management and operation.

These functions were further divided into sub-functions and categorised by the perceived risk as a result of polio funding ramp down (see simulation exercise report)

7.5.3. Donor pledges. Global Polio Eradication Initiative budget for South Sudan

Considering GPEI budget pledges for the years 2017 to 2022 as liquid assets, will decrease from US$ 25.7million in 2017 to US$ 0.7 by 2022, accumulating to a total of US$ 45 million in the years between 2017 and 2022.

PEI main operational expenditures between 2017 and 2022 that will not be covered by campaigns funds include: personnel, overhead, surveillance, cold chain, logistic transport, OPV & IPV vaccines for RI, social mobilization etc, accumulate to US$ 67.7 million between 2017 to 2022. This ranges from US$ 16.5 million in 2017 to US$ 15.5 million by 2022.

7.6. Asset Transition Cost.

Transferring and relocating polio assets to other health priorities will be at some costs. Personnel training will be necessary to rematch personnel skills to the new sector. Assets like motor vehicles will increase running and maintenance budgets of recipient sectors. All these and similar costs incurred with the transition of assets are regarded as transition related expenses.

Estimates from the base-case, conservative ICCM model showed that taking transitioning polio assets to BHI as the preferred option, it will cost the South Sudanese Health system over US$ 70.1million by 2022, of which US$38 million will be in aggregated salaries (31.5 million) and training cost (US$ 6.7 million). CHW equipment will cost $11.9 million and medicines and supplies for the ICCM community level operations (excluding vaccines) will cost $US 10 million by 2022.

7.7. Conclusiion

South Sudan's Polio Eradication Initiative (PEI) have been mainly funded by external partners which have made pledges targeted at specific aspects of the Polio close out activities till 2022. Matching these pledged yearly inflows with the expected outflows (SIA funds inclusive), results in aggregated deficit balance of US$ 67.7 million to 2022. There are no indications however, that the country plans to assuage these yearly deficits through budgetary provision in the near future. An estimated US$ 18.2 million PEI donor support to directly support Routine Immunization will not be available after the ramp down.

Transitioning polio assets to the BHI option will cost the South Sudanese Health system over US$ 70.1million by 2022,

Polio funding closeout will potentially threaten funding for RI, IDSR and other health sector programs that traditionally share GPEI funding.

So far, there has been no direct South Sudanese government funding to Polio Eradication and Routine Immunization and there are no strong indication of funding in the future. The country anticipates funding support for BHI and for covering the deficits from Polio closeout. While the transitioning of the polio assets to BHI is the obvious option, there is presently no obvious funding for the BHI. Consequently, BHI may fail to adequately take off sufficiently for the desired impact with insufficient funding support. Sustained donor and government collaboration is essential to maintaining the gains of the PEI and sustain its Polio free status.

In conclusion, it is recommended that more value should be placed on the transitioning the polio eradication functions into the preferred strategic option as the physical assets have significantly depreciated in value with likely increase in maintenance costs. The deployment of the functional assets should be according to the health priorities in South Sudan’s health policies for the period between 2018 and 2022. The reliance of GPEI funding poses a great challenge and fiscal risks to the immunizations programs in South Sudan to the future. The

country should be supported to increase efforts for internally generated sources of funding towards self-reliance.

Attached as an annex (Business Case)

8. The Risk on Other Health Programmes as Polio Funding Ramps Down

8.1. Impending risks to non-PEI programs and functions

The polio program in South Sudan has been supporting interventions within the immunization program and to some extent other programs. Some of the support are made directly during intervention and activities and could be estimated in monetary terms. Other activities that include the technical support provided by the polio field staff are difficult to be estimated in monetary terms. Some of the directly supported functions are piggy bagged on polio activities like the SIAs that are deemed to ramp down and eventually discontinue. Hence programs/functions that are currently supported by the polio activities need to take the ramp down effect into consideration and should include the budgetary implications in their future planning. The table below summarizes the annual estimate of the cost that was covered by the polio program during polio activities (SIAs) that may result in as a gap for the routine immunization program.

Table 8: Estimate of the opportunity cost routine immunisation will miss with the polio ramp down

Functions of EPI at funding risk with the polio ramp down	**Annual contribution in USD**
Vaccine management and cold chain	
Transport of vaccines and supplies	1,000,000
Fuel for Cold chain logistic functioning	1,666,436
Contribution to the social mobilization network	1,285,604
Total	3,952,040

8.1.1. Risk of more problems in cold chain logistics and vaccines transportation

Polio has substantially funded the transportation of vaccines from the capital to the states and most counties in South Sudan as well as ensuring fuel to run the generators to keep the cold rooms, refrigerators and deep freezers at states and most counties. Indirectly these generators have been the main source of energy supply for these institutions to enable them work at working ours with their computers at their offices. The reduction of fuel that may come as a consequence of the ramp-down which is not replaced by another source of funding will be a decrease in the efficiency and productivity of staffs at the State and county level as a result of lack of power to work with their computers in their offices.

8.1.2. Risk of demotivation of the social mobilizers in the integrated social mobilization network

A network of about 2,500 integrated social mobilizers of a permanent based and 2,000 on activities based has been established in South Sudan. Polio contributed to fund half of its cost and if there is no replacement source of funding of what polio is already covering, we run the risk of having these social mobilizers demotivated and abandoning their positions which will leave a big gap in the process and constant activity of engaging the communities on health care and others programmes.

8.1.3. Drop in the quality of the AFP/Vaccine Preventable Disease Surveillance

Quality of AFP/Vaccine Preventable Disease Surveillance within IDSR will drop if enough operational funding is not allocated, even if the human resource is moved to the IDSR. Once the human resource is retained to fill some of the structural gap of IDSR, it should be prepared to mobilize about 1 million $ per year to cover its operation cost for AFP/VPD Surveillance.

8.1.4. Difficulties to adequately supervise and coordinates some programmes on the field

The Polio funded staff give technical supervisory and coordination support at the level of states, counties and payams to many programmes as their other duties taking about 70% of their work time.

8.1.5.Difficulties to run some field offices

For the running cost of the field offices of WHO and UNICEF, polio programme makes a considerable contribution which the ramp-down will require the other programmes within these agencies to fill by increasing their contribution so as to keep the physical and technical capacity currently in the field.

9. Polio Programme Transition and Mainstreaming Strategies for 2018-2022

The polio program transition plan comprises of two phases. Phase1 covers the period 2018-2019 that has been partly funded to maintain 50% of WHO staff and 100% of all other partners who will oversee the necessary functions of immunization and surveillance, this focuses on training and repurposing of staff to other programs and streamline the surveillance structure in the country to suit the IDSR.

Phase 2 starts in 2020-2022 will build on improvement and sustenance of the immunization and surveillance of Vaccine-Preventable Diseases as well as ensuring that the functions have fully being moved to the different identified health priorities, while maintaining polio-free status. It is of note that phase 2 has minimal pledged funding.

9.1. Polio Program Transition strategies for 2018 – 2019.

9.1.1.General Transition strategy

In deciding on a strategy South Sudan took into consideration the fragile nature of the country and available resources and have agreed that full transition to the Government could be a challenge rather the country has opted to transit the functions into all identified health priorities. This is mainly for the HR component.

The polio program transition simulation exercise work-shop conducted in June 2017 proposed the following transition strategy: "Maintaining minimum structure and assets to continue essential polio functions (OPV and IPV immunization, AFP surveillance and polio outbreak response, Social mobilization) until 2019 and then transfer full responsibility to other programs including the government, which will in turn mainstream them to national immunization and surveillance systems starting from January 2020". This transition strategy was selected, due to the fact that:

a. Government at present cannot absorb all PEI HR due to the financial constraints;
b. Programs such as EPI and IDSR need the role previously supported by the Polio network to continue to operate optimally;

c. Identified positions especially those currently filled by the EPI-CAPACITY BUILDING PROGRAMME (ECB/AFENET) are needed as these presently are recognized in the Government EPI structure;
d. No other alternative implementing partners, which can fully take-over and implement the polio functions,
e. There is a possibility to mobilize financial resource from national and international donors to cover the budget gap, due to GPEI fund ramp-down but time is needed for this to take place.

Until 2019 the polio functions will be implemented by current GPEI funding while realignment will commence and this will be transferred to identified programs starting 2020

9.1.2. Specific transition strategies for polio physical assets (vehicles)

A. Maintain polio physical assets (vehicles) to continue essential polio functions during transition period

WHO will retain polio funded vehicles in their present locations, as WHO EPI officers are planned to be retained with funding coming from other sources. However, in addition to polio program, WHO uses a shared asset system where the vehicles are pooled and used for other programs.

There is, however, a need to do a regular inventory to know the functionality of existing polio funded assets and update the WHO polio asset records.

CORE group will hand over the assets to the government at the end of the program if its mandate is not repurposed and it does not have enough funding to support routine immunization. Even after global polio eradication and certification is declared the NGOs working with CORE Group will continue supporting RI and surveillance activities along with other health interventions by mobilizing resources from donors. Therefore, the transitioning of polio funded assets will be done based on discussions between the CORE group and government.

At the end of the EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET) programme, the assets will be fully transferred to Government as per the agreement between AFENET/CDC and Government.

B. **Other assets**

Assets such as cold chain equipment have already been transferred to government, while others such as computers and radios will be determined on a case by case basis, as this will depend on its usefulness, state and if this can be used to support other health programs within the different organizations. This will involve ongoing dialogue with government and is agency specific.

9.1.3. Specific transitioning strategies for Polio funded personnel.

WHO

- Transfer 2 WHO officers (SIA and Surveillance), 1 logistician and 1 data managers to non-polio fund (GAVI, IDSR, and others) and maintain their support to immunization and VPD surveillance, from January 2020 and beyond at the National level.
- Transfer 12 National EPI officers that are Polio funded to support 80% routine immunization and 20% surveillance at the state level to GAVI and other identified donors.
- Transfer 80 Field Supervisors at the county level to strengthen IDSR and to be funded by the IDSR, WHE, and other programs.
- Transfer all support staff (27) to other programs within WHO as part of the core staff positions
- Transfer all Field Assistants to support country Boma Health Initiative.
- Update ToR of WHO officers by incorporating field immunization monitoring and supervision already started in 2017.
- All staff on TIP, SSA but 1 on FT (logistician) needs to shift contract in 2019.

UNICEF

- Transfer 13 UNICEF staff that are polio funded into other funding sources to commence from 2019, all positions to be maintained. (Even though they are transitioned to other non-polio funded programs from 2017 and 2018, their support is required to maintain key polio function (Community engagement & communications, Routine immunization service delivery and emergency preparedness and response) in 2019 & 2020

CORE GROUP

- Keep the CORE Group polio funded personnel until 2019, as the fund is secured and transition them to non-polio fund within the organization to continue implementation of immunization and community-based surveillance with other health interventions through resource mobilization. Of its 263 staff, 19 at the country office will be maintained, will transfer its 34 county supervisors into the IDSR and the 210 payam field assistants into the Boma Health Initiative by end 2019.

ECB/AFENET

- EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET) programme has 59 staff of which 56 are national and state mentees. Currently, CDC meets all costs related to the project. Based on the project initiation agreement between CDC/AFENET and the MOH, all the mentees will be transitioned to MOH to continue supporting immunization services after successful completion of the 3 years' mentorship program. However, because of the current economic situation in South Sudan, the Government will not be able to absorb the mentees as was anticipated. Instead, the Government is exploring alternative funding mechanisms (GAVI and other donors) to support the recruitment of the graduating mentees and continuation/expansion of the project to cover the new 22 states. CDC will continue to support the project (mentees and technical team) on a cost share basis with other donors (yet to be identified).

BMGF Consultants

- BMGF 7 staffs in the country are considered as Polio surge and have started support to routine immunization in addition to their polio functions. As soon as the surge is no longer needed the consultants will be allowed to leave.

International STOP and Consultants from HQ

- The country also benefits from support from WHO HQ with 4 consultants and CDC with 15 STOP, and the STOP programme will be needed till certification is achieved.

The Integrated Community Mobilizers Network

- The Integrated Community Mobilization Network (ICMN) which has at least 2,040 community social mobilizers and 357 supervisors will be transferred into the Boma Health Initiative (BHI). As the BHI is not having funding, UNICEF will continue to actively mobilize resources from diverse donors over the next five years to sustain it so as to have a good community engagement and demand creation for immunization, vaccine preventable disease surveillance and other programmes like malaria, nutrition, emergency response and WASH in the eve of polio certification and post-polio certification.

9.1.4. Mainstreaming and financing polio functions by the partners and government from January 2020 onward.

AFP surveillance, routine immunization especially (OPV and IPV) and communication are the main polio functions that need to be considered and financed. The purpose of this section is to show that the AFP surveillance and polio immunization activities, that will be fully taken over by other programs and the MoH from January 2020 and how to mobilize funds to support government financing from 2020. During the transition period from 2018 – 2019, capacity building and realignment of activities and functions will be communicated to all persons involved in the process.

Routine Polio Immunization activities

Routine immunization is done by the implementing partners, however, campaigns, planning, vaccine management, logistics and supportive supervision are done with support from the Polio

network. It is expected that this support will continue beyond 2019, however, a funding gap will exist in terms of HR and logistics as these have heavily been dependent on the Polio GPEI funds. It is expected that the shortfall to be filled by GAVI and other donors from 2018 and more funds needed as from 2020.

AFP surveillance activities will be taken-over by IDSR/MoH from January 2020.

Active case search (active surveillance) and community based surveillance

Active case search are regular visits to health care facilities (Health posts, Health centers, hospitals, rehabilitation centers, private health facilities, traditional healers etc.) to search for and investigate unreported AFP cases through a review of health facility records, interviews with health workers and/or visit to wards to review cases. Active case search is done mainly by polio funded WHO field officers. However, from January 2020, this activity will be fully taken over by the PEI/EPI officers "currently Polio funded" who will be transitioned to the EPI (funded by the Immunization program and other donors), field supervisors to be funded by the IDSR program and will work with their counterparts from the county health department. Field assistants will be transferred to the BHI and liaise with community informants for community surveillance and health informants. Other activities such as case validation, 60 days follow up will be conducted by the EPI officers as currently the case.

Anticipating on government's fragility to be able to retain the staff to play the key polio functions, current partners of the polio programme in the country will assist the government to mobilize and manage resources needed to ensure that South Sudan remains free of polio. Government will pay the salaries of the transitioned staff into the public service and the partners will complement with activities based incentives based on production of results awaited. They will also advocate for the improvement of government's financial accountability so that with time Government manages by itself the resources available. In the Immunisation data quality improvement plan of 2018, it is requested that the National level streamlines and harmonizes parallel reporting systems (IDSR/EWARs and EPI/DHIS) by Dec 2018.

Polio SIA

These are expected to end in 2020, however, there is need to support SIA for all other VPDs with an SIA coordinator within the WHO and Unicef offices to be funded by GAVI or other donors. They will also support other polio functions such as capacity building, planning, monitoring, and evaluation, and work closely with the Routine Immunisation Focal points.

10. RESOURCES & BUDGET PLANNING

10.1. Polio program transition human resource plan:

For the implementation of Polio functions during the first phase of the transition period 2018 – 2019, appropriate HR plan has been identified for an adequate number of polio personnel needed for the same period by function and agency.

10.1.1. WHO Polio funded personnel

WHO need to support functions that are required for the implementation of polio functions during transition period 2018 – 2022

According to HR plan received from WHO the number of Polio funded personnel available in 2017 will be the same for 2018 however in 2019, it is expected that these staff funded by Polio fundings will start to be transitioned while ensuring essential Polio functions are retained. The government is expected to take full responsibility for mainstreaming polio functions to national immunization and surveillance system from January 2019, however for South Sudan exceptions need to be made and the transition handed with great caution. It is planned that not all polio funded staff in WHO will be transitioned to the government, Table 9 below shows the WHO/EPI HR plan for 2018 – 2020.

Table 9: WHO Polio funded personnel required for the next 5 years (2018 – 2022)

Position description	2018	2019	2020	2021-22	Remark
SIA/IVD FP P4 TIP	1	1	1	1	Retain and Move to another funding source not yet identified abolish after certification
Med Off Surveillance P4 TIP	1	1	1	1	Retain and Move to another funding source not yet identified abolish after certification
Logistician G6 Fixed Term	1	1	0	0	Move to WHE
Log /Admin G4 Temp App	10	10	0	0	Move to core functions as role needed for WHO state offices
EPI Off NOA SSA	12	12	0	0	Move to EPI program and find a funding source
FS G4 APW	80	40	0	0	Move to IDSR and identify funding source
FA	236	118	0	0	Move to the BHI initiative
Consultants	4	4			Determined by HQ
Drivers G2 SSA	15	7	0	0	Move to core functions as role needed for WHO state offices
Data Manager NOB SSA	1	1	0	0	Move to EPI program and find a funding source
Support staff	12	12			Individuals and roles performed to be funded by hub running costs
Mechanic	1	1	0	0	Move to core functions as role needed for WHO state offices
STOP	18	18			Determined by HQ

NB: Need to discuss areas of best fit of 2 TIPs in the program.

10.1.2. UNICEF Polio funded personnel

UNICEF also require to support important functions that are required for the implementation of Polio activities during transition period 2017 - 2022

UNICEF had 15 polio funded technical personnel as of May 2018, as from 2019, their number will reduce to 13 and later 0 in 2020 as they will all be transferred under immunization or Communication for Development with non-polio funds which will be mobilize and all 15 staff will be supporting routine immunization, health and other programmes (Table 10 below) till 2022.

Table 10: Evolution of the proportion of polio funding to UNICEF personnel between 2016-2020

Position description	Number	Salary 2016	2017	2018	2019*	2020*	Remark
C4D Specialist P3 FT	01	75%	33.30%	50%	100%	0%	
Immunization Specialist P3 FT	01	100%	33.30%	50%	100%	0%	
Cold Chain Officer P2 TF	01	100%	33.30%	50%	100%	0%	
C4D Officer NoA (10 but were 08 in 2016 & 2017)	10 (08)	100 %	40%	50%	33%	0%	The 2 vacancies are filled by 2018
Immunization Manager P4 FT	01	50%	25%	33%	0%	0%	
Immunization Specialist NoC FT	01	100%	41.70%	50%	0%	0%	
Total	15 (13)						

*The positions are maintained and their funding sources are switched to other donors completely for some staff from 2019.

10.1.3. CORE Group Polio funded personnel

CORE Group as of now for its community based surveillance has pledges from BMGF till December 2019 which can sustain the personnel size of 263 staff (Table11 below).

Table11: CORE GROUP Polio funded personnel required for the existing projects (2018 – 2022*)*

Staff	2018	2019	2020	2021	2022
National and staff level staff	**19**	**19**	**19**	**19**	**19**
County field supervisors	**51**	**51**	**51**	**51**	**51**
Payam field assistants	**265**	**265**	**265**	**265**	**265**
Vaccinators	**57**	**57**	**57**	**57**	**57**
Social mobilizers	**85**	**85**	**85**	**85**	**85**
Total	**477**	**477**	**477**	**477**	**477**

Funding from USAID for polio to strengthen routine immunization in 11 counties is available up to September 2022 for 170 staff.

10.1.4. EPI Capacity Building (ECB) by AFENET/CDC

The personnel required for the implementation of polio activities during transition and mainstreaming period 2018-2022 are shown in table 12.

Table 12: Distribution of the personnel supporting the EPI programme from AFENET mentoring project 2018-2022.

Staff	positions	2017	2018	2019	2020	2021	2022	Remark
National coordination team	Coordinator/Technical advisor	1	1	1	1	1	1	
	Administrative assistant	1	1	1	1	1	1	
	Driver	1	1	1	1	1	1	
The mentees for the EPI at national and	EPI operations officer	12	12	34	22	22	22	
	SIAs officers	10	10	32	22	22	22	
	Data management	11	11	33	22	22	22	

state level	officers							
	Cold chain logistician	1	1	1	1	1	1	
	Cold chain technician	2	2	2	2	2	2	Some 13 will benefit from GAVI HSS2018-19
	C4D officers	8	8	30	22	22	22	
	VPD surveillance officer	12	12	34	22	22	22	
Total		59	59	169	110	110	110	

Currently there are 56 national and state mentees deployed in the former 10 hubs and 2 administrative areas. The national level mentees are expected to graduate in December 2018 while the state mentees will be on-board until end of 2019. Subject to availability of additional funding, the MOH has proposed scaling up of the project to the new 22 states in 2019 through 2021 and it implies and extension of the total staff to 169 by end 2019 (see Table 17 above).

10.1.5. McKing Consultancy/Bill and Melinda Gates Foundation

The foundation has got 7 surge personnel required for the implementation of polio activities during transition and mainstreaming period 2018-2022.

Table 13. Projected McKing Consultancy/BMGF Surge Consultants to support the country 's polio eradication programme

Staff	2017	2018	2019	2020	2021	2022
International consultants	7	7	7	7	7	7

Positively hoping wild polio virus transmission in the world is interrupted in 2018, certification will be in 2022. The BMGF surge team in the country will still be needed to accompany the country through the certification and the post certification of polio.. As of 2018 other than the 7 consultants (Table 18 above)) who were for polio eradication 3 more consultants has been

added into the country to support with routine immunization with data (01 consultant) and the cold chain technicians (02 consultants). This is already showing the gradual shifting to strengthening routine immunization from BMGF. As of now McKing's contract with BMGF is till 2019 for South Sudan. Advocacy is being made for extension of the period.

10.2. Capacity building plan

It is important to note that the polio staff, especially at the lower level, has primarily worked on Polio surveillance and communication and need to use the skills gained, for other health interventions, while building on these skills to be able to perform other functions. These staffs are expected to have their TORs reviewed taking into consideration the need to retain polio essential functions required for post certification, as such, it is expected that series of training will be conducted for staff to be able to carry out these additional roles.

10.2.1. Training need-assessment

There is a need to train the Government technical staff implementing Immunization, surveillance and communication activities to repurpose them into a new and broader role during the transition phase.

According to national polio transition plan and given the fragile nature of the country currently, the government might not be able to take over the full responsibility to implement and mainstream polio immunization, AFP surveillance and communication activities from January 2020 especially given the financial and technical support needed. Therefore, for smooth take-over and mainstreaming these activities, to other programmes. Partners and government capacity building through training is essential. For this purpose, all the EPI and the polio focal persons at all levels along with the EPI and IDSR focal persons in the government structure and communication focal persons will need training to better understand the new structure and return value for money in retaining the HR and also to avoid duplication of roles. All staff involved will be assessed and it is expected that the training will be continous to improve performance and fill the gaps where attrition occurs. Table 19 below gives the list of training planned of which the first two highly needs funding to be carried out while the others will be integrated in routing annual activities for those key functions.

Table14: Training needs during the transition period

Training themes	Target	2018	2019	2020	2021	2022
Repurposing of the polio network on disease surveillance and Routine immunisation	683 from AFP surveillance, IDSR, VPD surveillance of ECB programme-AFENET	x	x			
Training on the BHI for as County and Payam supervisors of BHI	584 from WHO & CoreGroup	x	x			
Continuous training of the staff in the integrated network for social mobilisation	2,500 from UNICEF's supported network	x	x	x	x	X
Continuous training on community based surveillance	532 from WHO, CoreGroup, IDSR, ECB	x	x	x	x	X
Continuous training on surveillance and routine immunisation	683	x	x	x	x	X
EPI Capacity Building Programme training staff/mentees to manage EPI at national and state level	56 in 2018 and 166 from 2019	x	x	x	x	X

10.3. Budget and financial resource mobilization plan

As the GPEI partners fund ramp-down will affect immunization & surveillance activities, there is a need to mobilize financial resources from international and national donors to smoothly implementation of the activities foreseen in this polio program transition plan.

This estimated budget is hereafter condensed in Table 15 below, as needed budget of 105,870,288 US$, pledged budget 42,885,857 US$ covering 40.72 % of the needs, and the budget gap of 59.28 % worth 62,984,431 US$ to be mobilized for the period 2018-2022 if the frequency of SIAs stays at an overall 2 rounds per year that is one full and two 50% NIDs in 2018, one full and two 40% NIDs in 2019 and end NIDs. This last aspect will be directed by the epidemiological data.

Table 15: Budget needs of the polio transition plan

Priority functions/Program	Annual budget forecast USD										TOTAL Budget (USD)		
	2018		2019		2020		2021		2022				
	needs	pledges	needs	pledges	needs	pledges	needs	pledges	needs	pledges	needs	pledges	Gap
Routine immunisation	1,619,605	1,619,605	2,255,125	1,997,690	3,932,411	989,797	3,514,001	558,562	3,548,896	587,372	14,870,038	5,753,026	9,117,012
Polio SIA*	6,760,500	6,760,500	6,100,700	6,100,700	0	0	0	0	0	0	12,861,200	12,861,200	0
Surveillance	3,035,920	3,025,920	3,035,920	3,025,920	3,025,920	0	3,025,920	0	3,025,920	0	15,149,600	6,051,840	9,097,760
Cross border coordination (Core Group)	42,500	42,500	43,800	43,800	45,100		46,500		31,000		208,900	86,300	122,600
Personnel	9,594,345	8,169,333	9,646,345	7,871,333	9,725,095	544,240	9,827,691	44,240	9,894,604	44,240	48,688,080	16,673,387	32,014,693
Over head	300,000	100,000	305,000	0	310,250	0	315,763	0	321,551	0	1,552,563	100,000	1,452,563
Training to capacitate the staff in their new ToRs	1,177,243	0	850,000	0	0	0	0	0	0	0	2,027,243	0	2,027,243
Preservice capacity building for ECB/AFENET	400,000		400,000		400,000		400,000		400,000		2,000,000	0	2,000,000
Total capacity building	1,577,243	0	1,250,000	0	400,000	0	400,000	0	400,000	0	4,027,243	0	4,027,243
Social mobilisation network and communication plan (Contribution to)	835,604	835,604	1,285,000	0	1,285,000	0	1,285,000	0	1,285,000	0	5,975,604	835,604	5,140,000
Field sensitization visits and meetings, needs for the transition structures	100,000	0	50,000	0	50,000	0	27,500	0	25,000	0	252,500	0	252,500
Evaluation of the transition plan	0	0	12,000	0	0	0	0	0	22,000	0	34,000	0	34,000
Preparation in 2022 of the switch from bOPV to 2 doses of IVP in routine	0	0	0	0	0	0	0	0	0	0	0	0	0
Preparation in 2022 of the switch from bOPV to 2 doses of IVP in routine WHO & Unicef	0	0	0	0	0	0	0	0	100,000	0	100,000	0	100,000
Technical assistance for transition and post-certification in Unicef TA 1P3 & 1NOB	325212	0	325212	0	325212	0	325212	0	325212	0	1,626,060	0	1,626,060
Finalization of the polio transitionplan & organisation of the high level advocacy meeting to present the investment case for polio transition	117500	117500									117,500	117,500	0
Other					133,000	133,000	136,000	136,000	138,000	138,000	407,000	407,000	0
TOTAL	24,308,429	20,670,962	24,309,102	19,039,443	19,231,988	1,667,037	18,903,586	738,802	19,117,183	769,612	105,870,288	42,885,857	62,984,431

This budget is driven by the following cost station and functions:

- 46.23% (48,688,080 US$) for the personnel needed to perform core maintained functions;
- 14.12% (14,870,038 US$) for routine immunization and service delivery to cover the gap in funding for some key logistic activities as Polio SIAs fund ramps down and improve routine EPI polio coverage to 85% by 2022 for IVP and OPV3;
- 14.38% (15,149,600 US$) for surveillance to enable mainstreaming of surveillance, make it sensitive enough to promptly detect vaccine preventable disease with emphasis on AFP/polio.
- 12.21% (12,861,200 US$) for SIAs to continue to maintain community herd immunity as the routine immunization for OPV3 is low with admin coverage at 58% while WUENIC is at 26% in 2017.
- 5.64 %(5,975,604) for Social mobilization and the communication so as to sensitize stakeholders on the polio transition plan and maintain community engagement and demand for immunization and other health services.
- 3.82% (4,027,243 US$) for capacity building for the repurposing of the staff during the transition process and preservice capacity building.
- 1.54% (1,626,060 US$) for Technical assistance during the transition, certification and post certification period 2018-2022.
- 0.09%(100,000US$) for the preparation in 2022 of the switch from bOPV to 2 doses of IPV if interruption of Wild Polio Virus occurs in 2018.
- 0.03%(34,000US$) for the evaluation in 2019 and 2022 of the transition plan.

A more detail budget is available in Appendix VII Budget at page 80.

Table 16: Pledged funding per organization

Priority functions/activities	WHO			UNICEF			COREGROUP			ECB/AFENET			Mc King Consultancy/BMGF			GOVERNMENT			Total		
	needs	pledges	gap	needs	pledges	gap	needs	pledges	gap	needs	pledges	gap	needs	pledges	gap	needs	pledges	gap	needs	pledges	gap
Routine immunisation service delivery including purchase of IPV+bOPV	0	0	0	14758038	5641026	9117012	112,000	112,000	0	0	0	0	0		0	0			14,870,038	5,753,026	9,117,012
Polio SIA	4,520,100	4,520,100	0	8086400	8086400	0	254700	254700	0			0							12,861,200	12,861,200	0
Surveillance	7,129,600	2,851,840	4277760	0	0	0	8000000	3200000	4800000			0							15,129,600	6,051,840	9,077,760
Mainstreaming surveillance	20,000	0	20000			0			0			0							20,000	0	20,000
Cross border coordination			0			0	208900	86300	122600			0							208,900	86,300	122,600
Personnel	23,395,504	7,387,400	16008104	3793000	1531000	2262000	8248631	2443976	5804655	5,000,000	1,931,000	3069000	8118225	3247290	4870935	132,721	132,721	0	48,688,081	16,673,387	32,014,694
Over head	0	0	0	500000	0	500000	552563	0	552563	500000	100000	400000	0			0			1,552,563	100,000	1,452,563
Capacity building	1114983.7	0	1114983.7	0	0	0	912259.35	0	912259.35	2,000,000	0	2000000							4,027,243	0	4,027,243
Social mobilisation network and communication plan (Contribution to)	0	0	0	5975604	835604	5140000			0			0							5,975,604	835,604	5,140,000
Field sensitization visits and meetings, needs for the transition structures	101000	0	101000	101000	0	101000	50500	0	50500			0							252,500	0	252,500
Evaluation of the transition plan	34,000	0	34000	0	0	0			0			0							34,000	0	34,000
Preparation in 2022 of the switch from bOPV to 2 doses of IVP in routine	65,000		65000	35,000	0	35000			0			0							100,000	0	100,000
Technical assistance for transition and post-certification in Unicef TA 1P3 & 1NOB	0	0	0	1,626,060	0	1626060			0			0							1,626,060	0	1,626,060
Finalization of the polio transitionplan & organisation of the high level advocacy meeting to present the investment case for polio transition	20000	20000	0	97,500	97,500	0													117,500	117,500	0
Other				0	0	0	407000	407000											407,000	407,000	0
Total	36400188	14779340	21620848	34972602	16191530	18781072	18,746,553	6,503,976	12242577	7500000	2031000	5469000	8118225	3247290	4870935	132721	132721	0	105,870,289	42,885,857	62984432
Proportionof funding gap	59.40%			53.70%			65.31%			72.92%			60.00%			0.00%			59.49%		

The funding gap for WHO is 59.40 % (21, 620,848 $US). Unicef has a gap of 53.70% (18,781,072 US$). EPI Capacity Building Programme by AFENET now ECB/AFENET) has a gap of 72.92% (5,469,000 US$), CoreGroup's gap is 65.31%(12,242,577.4 US$), McKing Consultancy/BMGF has a gap of 60% (4.870.935 US$).

The main donors who have shown interest in funding the polio transition plan and activities for the period 2018-2022 per organization are in Table 17. They include the GPEI till 2019, GAVI, USAID, CDC, UNICEF, WHO, and BMGF. There is need to have more donors stepping in and the other increasing their support so as to mitigate the reduction of funding for surveillance and routine immunization which is with the GPEI ramp down. Government will make the effort to contribute as from 2020.

Table 17: Source of pledged funding per year organisation

Agencies	WHO			UNICEF					COREGROUP		ECB/AFENET		Mc King /BMGF	GOVERNMENT	Total	
Donors	GPEI	CDC	WHO HQ	GPEI	GAVI new vaccines	GAVI HSS	Unicef HQ	Other	BMGF	USAID	CDC	GAVI HSS via Unicef			Pledges	
2018	5209000	1050000	700000	5483000	669613	705000	46400	223992	1221988	1042367	875000	78000	1623645		**18928005**	
2019	5003100	1050000	680000	4584400	825190	1150000		70600	1,778,629	1,041,508	500,000	78000	1623645		**18385072**	
2020					967297					1085535	500,000			44240	**2597072**	
2021					536062					1075974	0			44240	**1656276**	
2022					563872					711319	0			44240	**1319431**	**42885857**

For the resource mobilization strategy, the following steps will be done:

- An investment case for polio transition will be developed and shared with donors;
- An appeal for the establishment of a fund for immunization and surveillance for fragile states during the World Health Assembly of May 2018;
- A high level advocacy meeting with the donors will be held in juba in June 2018;
- Establish a resource mobilisation task force
- Active monitoring and follow-up will be done by the organizations and Government towards the donors and an annual report on the implementation of the transition plan made and share with donors.
- Advocate for the improvement of the health and immunization proportion of the Government budget as per the 2018-2022 cMYP; to the Ministry of Finance and the Parliament
- Advocate for good governance and accountability for health with the MoH

Chapter 10

11. Implementation Plan, Advocacy and Resource Mobilization Plan

11.1. Implementation Plan, Advocacy and Resource Mobilization Plan

Table 18: Table on the Implementation plan, Advocacy and Resource Mobilisation

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing				
						2018	2019	2020	2021	2022
1	**Service delivery (Routine immunisation)**									
	Expected results: Immunisation coverage for VPD is improved from 54%(IPV),58%(OPV3), 59%(Penta3) in 2017 to 85% by 2022 at the national level									
1.1	Continue to ensure Polio vaccines availability for routine in the country	MoH/Unicef	Number of days of polio vaccines stock-out at National Cold Store		UNICEF/GAVI NV	X	X	X	X	X
1.2	Ensure proper functioning of the cold chain with sufficient fuel complementing what SIA provides	MoH/UNICEF	Number of days of fuel stock-out at cold chain stores of National,		UNICEF/GAVI HSS	X	X	X	X	X
1.3	Ensure the delivery of vaccines to the states and counties complementing what SIA provides	MoH/UNICEF	Number of days of vaccines stock-out at state and counties cold stores		UNICEF/GAVI HSS	X	X	X	X	X
1.4	Strengthen routine immunization	MoH/WHO/Unicef/ECB/CoreGroup/BMGF	85% coverage for IPV, OPV3, Penta3, BCG, MCV1		GAVI	X	X	X	X	X

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing				
						2018	2019	2020	2021	2022
1.5	Prepare in 2022 the switch of bOPV to 2 doses of IPV	MoH/WHO/UNICEF	%of preparation for the switch		??					X
2.	Surveillance+ Laboratory+ Containment + Outbreak Response+ quality SIAs									
	Expected outcomes: Certification indicators for polio eradication are maintained and expand the approach of AFP surveillance to other priority epidemic prone diseases. Any polio outbreak is appropriately interrupted within the timeframe as recommended by WHO; Immunise 95% of the target population by PCE for each round of polio SIAs so as to maintain a high herd community protection against polio and a polio free South Sudan									
2.1	Mainstreaming surveillance and harmonize surveillance and EPI data	MoH/WHO/Core Group/BMGF/ECB /UNICEF	Updated Surveillance guidelines available by 2019		??	X	X	X		
2.2	Improve and maintain the quality active surveillance of AFP cases (case detection, sample transport) and integrate it with other VPD in IDSR	MoH/WHO/CORE GROUP/Unicef	AFP, measles and MNT indicators achieved and polio free status certification maintained		GPEI,	X	X	X	X	X
2.3	Improve and expand community-based surveillance in all counties and Bomas	MoH/ WHO/CORE GROUP	% of boma with functional community-based surveillance/year		GPEI, BMGF	X	X	X	X	X
2.4	Expand the environmental surveillance of polio across the country	MoH/WHO	Number of cities with functional environmental surveillance sites/year		GPEI	X	X	X	X	X
2.5	Improve the collection and shipment of samples collected to reference	MoH/WHO/Core	% of samples arriving the laboratory within		GPEI, BMGF				X	X

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing				
						2018	2019	2020	2021	2022
	laboratories safely outside the country	Group	the norms			X	X	X		
2.6	Support polio outbreak preparedness, confirmation and Implementation of polio control activities	MoH/WHO/UNICEF/CoreGroup/BMGF			WHO	X	X	X		
2.7	Strengthen AEFI surveillance system	MoH/WHO	Proportion of AEFI detected and investigated per year		WHO, UNICEF, GAVI	X	X	X		
2.8	Strengthen Cross border Coordination (collaboration and notification)	MoH/CORE Group	% of meetings conducted out of those planned		BMGF, Other partners	X	X	X		
2.9	Conduct quality SIAs as oriented by the HOA's TAG	MoH/WHO/Unicef/ECB/CoreGroup/BMGF	95% polio coverage at PCE		GPEI/USAID/BMGF	X	X			
2.10	Conduct quality PCE	MoH/CoreGroup	Number of polio PCE executed per year		USAID	X	X			
2.11	Conduct quality LQAS after polio campaign	MoH/WHO	Number of polio LQAS executed per year		GPEI/WHO	X	X			
2.12	Conduct vaccination at the borders	MoH/CoreGroup	Number of children vaccinated and number of border vaccination posts		??	X	X			
2.13	Conduct Polio Outbreak Simulation Exercise(POSE) at Sub-national levels	MoH/WHO/Unicef/CoreGroup?BM	50% at least of Hubs which have conducted		????	X	X			

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing				
						2018	2019	2020	2021	2022
	of the 10 Hubs	GF, others	POSE							
2.14	Conduct Polio Outbreak Simulation Exercise(POSE) at national level	MoH/WHO/Unicef/CoreGroup/BMGF, others	1 POSE done by 2020 at the national level		????			X		
2.15	Quarterly review of Polio risk in the country	MoH/WHO/Unicef/CoreGroup/BMGF, others	% quarterly review done		??	X	X	X	X	X
2.16	Produce and distribute tools for surveillance	MoH/WHO/Core Group/BMGF,	% of structures having upto date tools		??	X	X	X	X	X
3	**Human Resources to sustain the country's capacity to immunize children, detect and response to VPD Epidemic Outbreaks**									
	Expected outcomes: Polio competencies are integrated into priority health programs, including EPI									
3.1	Readjust the ToR of AFP surveillance staff to feed their new positions in Routine Immunisation and IDSR	MoH/WHO/Core Group	% of AFP surveillance staff with revised ToR		N/A	X	X			
3.2	Readjust the ToR of County Supervisors and Field assistant so that they support the establishment of the BHI at those levels while strengthening RI and surveillance	MoH/WHO/Core Group	% of county supervisors and field assistants supporting BHI by 2019		N/A	X	X			
3.3	Train and repurpose surveillance staff into their new positions in RI, IDSR/BHI	MoH/WHO/Core Group	% of surveillance WHO polio officers repurposed to other program		GPEI/BMGF/????	X	X	X		
3.4	Continue to build the capacity of the	MoH/AFENET-	% of mentees trained		CDC/GAVI-HSS/???	X	X	X	X	X

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing				
						2018	2019	2020	2021	2022
	EPI while supporting to retain the trained staff with the EPI-Capacity Building PROGRAMme /AFENET-CDC personnel cost	CDC	and retained by the EPI & IDSR after graduation							
3.5	Maintain and transition WHO and Unicef polio funded staff at National and state level into other source of funding by 2020	WHO/UNICEF	% of immunization officers transitioned to other funds		GPEI/GAVI fund/????	X	X	X	X	X
3.6	Transfer County supervisors into IDSR to strengthen it and maintain them	MoH/WHO/Core Group	% of county supervisors transferred by 2020		GPEI/BMGF/??	X	X	X	X	X
3.7	Transfer Payam field assistants into the BHI to strengthen community based surveillance and routine immunisation	MoH/WHO/Core Group	%of payam field assistants transferred by 2020		GPEI/BMGF/??	X	X	X	X	X
3.8	Adapt Post-Polio Certification SOPs and train teams	MoH/WHO/UNICEF/ECB-AFENET/BMGF/CoreGroup	% of adapted modules and training tools		WHO, UNICEF??	X				
3.9	Share polio experience, developed tools and document with other programmes	MoH/WHO/UNICEF/ECB-AFENET/BMGF/CoreGroup	No of tools, documents shared to other programmes		WHO, UNICEF, CDC and CORE group	X	X	X	X	X
3.10	Continue technical support to EPI through international STOP TEAM polio till at least 2 years of polio post-	MoH/ WHO/UNICEF/CDC	Proportion of planned consultants and STOP team mobilized		WHO. UNICEF, CDC	X	X	X	X	X

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing				
						2018	2019	2020	2021	2022
	certification									
3.11	Establish a task force for the transition of HR which meets regularly to manage issues with Polio HR transition	MoH/WHO/Unicef/CoreGroup/ECB-AFENET/BMGF	No of meetings held with action points		??	X	X	X	X	X
3.12	Continue technical assistance for transition through certification and post-certification to the country consultancy or TA at least at UNICEF	MoH/UNICEF/WHO	No of Staff provided for TA		??	X	X	X	X	X
3.13	Ensure that personnel are paid a salary or incentive for work and retained in the health system	MoH and partners	Proportion of staff retained		??	X	X	X	X	X
3.14	Cover the overhead of structures involved in polio transition	WHO/Unicef/ECB-AFENET/CoreGroup	% of overhead cost covered		??	X	X	X	X	X
4	Social Mobilisation, Community engagement and communication plan for polio transition									
	Expected outcomes: The community demands immunization services and the stakeholders of polio transition are sensitized and actively participate in the process									
4.1	Maintain the integrated Social mobilization network and integrate it progressively into the BHI so as to create and maintain community demand for immunization and promptly notify VPD	MoH/UNICEF/partner NGOs	% of boma with a social mobiliser per year		GPEI/GAVI/???	X	X	X	X	X

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing				
						2018	2019	2020	2021	2022
4.2	Incorporate the follow-up of the implementation of the polio transition plan in quarterly coordination meetings at national and state levels of MoH	MoH and partners	% of coordination meetings with PTP follow-up discussed in			X	X	X	X	X
4.3	Produce and share the polio transition plan to the stakeholders	MoH/WHO/UNICEF	% of shareholders with a copy of the transition plan		??	X				
4.5	Produce and share developed communication support materials for the polio transition plan, press file, messages, advocacy kits, banners, …)	MoH/WHO/UNICEF/ECB-AFENET/CoreGroup/BMGF	Number of communication support materials for polio transition produced		??	X				
4.6	Integrate polio transition communication into SIAs and EPI meetings.	MoH/WHO/UNICEF/ECB-AFENET	Number of SIAs and EPI meetings with PTP communication integrated			X	X	X	X	X
4.7	Organize internal meetings with HR managers to adapt the new HR structure and inform the staff accordingly as well as the focal points	MoH/WHO/UNICEF/ECB-AFENET	Number of meeting held			X	X	X	X	X
4.8	Hold advocacy meeting with high level stakeholders and CSOs to have their engagement for the implementation of the transition plan	MoH and partners	Number of meeting held		??	X				
4.9	Carry out field sensitization visits,	MoH/WHO/UNIC	Number of field visits		??	X	X	X	X	X

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing				
						2018	2019	2020	2021	2022
	meetings, needs for polio transition structures	EF/CoreGroup	with report							
5	**Financing and Resource Mobilization (RM)**									
	Expected outcomes: Funding for the EPI and PHEM for Ethiopia high level population immunity, polio free status and effective outbreak response is ensured.									
5.1	Develop the polio transition investment case	MoH/Unicef/WHO	Available business case document		Unicef	X				
5.2	Conduct High level advocacy meeting on polio transition and immunization with donors in Juba June 2018	MoH/Unicef/WHO	Level of Government and partners commitments to fund EPI and PHEM needs		Unicef	X				
5.3	Advocate for the creation of a fund for immunization and surveillance for fragile states	MoH/WHO/Unicef and donors	An intervention of the MoH at the WHA 2018		???	X				
5.4	Establish resource mobilization task-force	MoH/Partners	% of resource mobilized cover the GAP in PT funding			X				
5.5	Advocate for Government to improve its contribution to health and immunization funding during the period	MoH/WHO/Unicef/BMGF/ECB-AFENET	- % of annual Government budget for vaccination			X	X	X		
4.7	Develop memorandum of understanding (MoU) to be signed by potential funding	MoH and RM task-force	Proportion of partnerships signed MoU		WHO, UNICEF and other partners	X	X	X		
6	**Monitoring and Evaluation of transition plan**									

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing				
						2018	2019	2020	2021	2022
	Expected results: The process is regularly monitored and adjusted if need be									
6.1	Ensure Polio transition monitoring is integrated in EPI monitoring and coordination meeting (EPI-TWG, EPI quarterly, semester and annual review, EPI/surveillance external review), ICC, SIAs evaluation meetings)	MoH and partners	% of reports of the monitoring and coordination meetings of EPI & surveillance having monitored polio transition		???	X	X	X	X	X
6.2	Establish an annual detail implementation plan for polio transition	MoH and partners	A yearly detail implementation plan for PT		N/A	X	X	X	X	X
6.3	Produce an annual report on the implementation of the transition plan	MoH and partners	A yearly annual report on SSD PTP		N/A	X	X	X	X	X
6.4	Conduct 2 evaluations of the polio transition (end of GPEI in 2019, final evaluation 2022)	MoH and partners	Number of evaluation conducted		???		X			X

12.Conclusion

South Sudan has remained Polio free since 2009; however routine immunization remains an issue with OPV3 admin coverage put at 58% in 2017 and WUENIC at 26%. Major challenges include security, logistic, seasonality, assess, and economic, etc.

The Polio free status has been achieved through a robust polio network ensuring good AFP surveillance, quality SIAs for the needed herd immunity in the community, a network of integrated social mobilisers that support routine immunization and other health service deliveries in the country. The EPI of the Ministry of Health at all levels do have the required staff numbers.

As part of the polio endgame, South Sudan was in the process of developing a five-year polio transition plan 2018-2022. The transition plan focuses on transferring polio functions into mainly routine immunization and Integrated Disease Surveillance and Response while supporting the establishment of the Boma Health Initiative; repurposing and retaining the human resources needed for these. The transition plan has two phases:

- Phase one from 2018-2019 while there is still some funding from GPEI and SIAs are still being conducted;
- Phase two from 2020-2022 without GPEI funding and for which most of the funding needs to be mobilised actively.

The implementation of this transition plan needs the active participation of the key partners of the Ministry of Health in country for the eradication of polio especially: WHO, UNICEF, CoreGroup, ECB/AFENET, McKing/BMGF.

South Sudan's government will not be able to take over the funding of the transitioned polio function's network and realistically it needs other donors to step in and fill the gap as the GPEI is sun setting. The country is thereby advocating for the creation of a fund for immunization and surveillance to enable it remain polio free.

The plan has an estimated budget need of 105, 870,289 US$, pledged budget of 42,885,857 US$ covering 40.51% of the needs, and the budget gap of 59.49% worth 62,984,431 US$. GAVI has shown interest in supporting the transition plan and has pledged for at least 5.57million US$ for polio vaccines, transportation of vaccines and fuel for the cold chain. Advocacy will be done so that during the transition period Government funding for health and immunization in particular be improved with better financial management and accountability.

APPENDIX

Appendix 1: Cold chain equipment inventory and valuation

Material Description	Delivery Quantity	Unit Cost (indicative)	Total value	Present, 2017 value
Generator set,diesel,water cool,25kVA**	16	12134.8	211269.0	**155425.6**
Cold rooms				
Cold room,walk-in type,10 m³	3	15000	45000	36100
Cold room,walk-in type,40 m³	1	24500	24500	19700
Freezer room,20 m³	1	18125	18125	14600
Total	5		87625	**70400**
Solar fridges				
Solar refrig-freezer,>50L,4.5Kw/24hrs	20	5365.0	10729.98	64379.9
Solar Refrig.,vaccine,photovoltaic,>50 litre	12	5776.0	28879.34	41586.2
Total	32		176610.2	**105966.1**
Icelined refrigerators (+2°C to +8°C)				
Refrig.,Vestfrost MK 304,PQS E3/007	42	968.2	40070.78	24397.6
Total	42		40070.78	**24397.6**
Icelined refrigerators (+2°C to +8°C) with freezer compartment				
Refr/fr.,Electrolux/Dometic TCW 2000 AC	23	2655.0	63341.0	36637.1
Total	23		63341.0	**36637.1**
Freezers				
Freezer,Electrolux TFW 800,PQS E3/004	44	2379.6	113964.7	62,821.2
Freezer,Vestfrost MF 314,PQS E003/023	33	692.3	22846.2	13,707.7
Total	**77**		**136810.8**	**76,528.8**
Cold boxes				
Cold box,B.Kings CB/20/-CF,PQS E004/025	607	108.4	1518.0	39,488.6
VACCINE CARRIER, LARGE	89	13.2	528	704.9
Vaccine cold box,large,long range	544	117	2808	38,188.8
Total	1240		124541.2	**78382.3**
Vaccine carriers				
Vacc.carr.,B.Kings BK-VC1.7,PQS E004/021	**6316**	**6.95**	**44196.2**	**26,337.7**
Total	6316		44196.2	**26,337.7**

Icepacks				
Icepack,0.3 litre capacity	9499	0.28	44196.2	**1,595.8**
Total	9499		44196.2	**1,595.8**
Spare parts				
Air filter, 100kVA	12	70	840	504.0
Oil filter, 100kVA	24	13	312	187.2
Ess. spares for 10 solar systems ordered	1	1067.5	1067.52	640.5
Ess. spares for 10 solar systems ordered	4	1171.2	4684.89	2,810.9
Ess. spares for 10 solar systems ordered	1	1067.5	1067.53	640.5
Tool kit,f.install.solar refrig. Systems	1	684.5	684.54	410.7
Tool kit,f.install.solar refrig. Systems	1	684.5	684.54	410.7
Cylinder head gasket, 100kVA	4	135	540	324.0
Fuel pump, 100kVA	24	128.6	3085.71	1,851.4
Fuel pump, 100kVA	4	128.6	514.3	308.6
Total	76		13481.0	**8,088.6**
Grand total	17326	900604.9		**583,759.73**

Appendix II: Generators and present economic value

Agency	Location	Detail	purchase year	**Quantity**	**Unit cost**	Total cost in USD	Present, 2017 value
CGPP	Juba	FG Wilson	2017	1	14000	14000	14,000.00
UNICEF	Field with MoH	Generator set, diesel, water cool, 25kVA**	2015	2	12,134.81	24,269.60	19,515.70
	Field with MoH	Generator set, diesel, water cool,25kVA**	2014	14	12,134.81	169,887.30	119,071.10
Total				17		208,157.00	**152,586.80**

Appendix III: IT Equipment: Computers

Agency	**Location**	**Item**	**Detail**	**purchase year**	**Quantity**	**Unit cost**	**Total cost in USD**	Present, 2017 value
EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET)	Juba	Computer	Dell Desktops	2016	2	800	1600	1,300.0
CGPP	Juba	Computer	Desktops HP	2011	1	1100	1100	(100.0)
CGPP	Juba	Computer	Desktops HP	2014	2	1100	2200	940.0
WHO	Juba	Computer	Dell Lapto	2015	2	1500	3000	1,840.0
WHO	Juba	Computer	Dell Lapto	2015	22	1120	24640	14,824.0
WHO	Juba	Computer	Dell Lapto	2017	12	1250	15000	15,000.0
WHO	MoH-EPI	Computer	Dell Lapto	2017	2	1250	2500	2,500.0
EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET)	Juba	Computer	Lenovo Laptops	2016	8	1500	12000	9,620.0
CGPP	Juba	Computer	HP laptops	2011	3	1250	3750	(630.0)
CGPP	Juba	Computer	HP laptops	2013	1	1250	1250	330.0
CGPP	Juba	Computer	HP laptops	2016	2	1250	2500	2,020.0
CGPP	MoH-EPI	Computer	HP laptops	2014	1	1250	1250	560.0
	Total Juba				**58**		**70790**	**48,204.0**
WHO	Field	Computer	Dell	2017	6	1250	7500	7,500.0

			Lapto					
WHO	Field	Computer	Dell Lapto	2015	22	1120	24640	14,824.0
UNICEF	Field	Computer	Lenovo Laptops	2015	5	1196	5980	3,628.0
EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET)	Field	Computer	Lenovo Laptops	2016	47	1500	70500	56,420.0
CGPP	Field	Computer	Lenovo Laptops	2017	10	1250	12500	12,500.0
CGPP	Field	Computer	Lenovo Laptops	2017	6	1200	7200	7,200.0
CGPP	Field	Computer	HP laptops	2017	5	1250	6250	6,250.0
CGPP	Field	Computer	Acer laptops	2016	8	1200	9600	7,700.0
	Total field				109		144170	**116,022.0**

Appendix IV: Printers, Scanner , Camera

Agency	Location	Item	Detail	purchase year	Quantity	Unit cost	Total cost in USD	**Present, 2017 value**
WHO	Juba	Muti-function scanner	Ricoh	2015	1	1945	1945	1,187.00
EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET)	Juba	Scanners	HP Scanner/Printer	2016	2	600	1200	970
CGPP	Juba	Scanners	scanner jet	2012	1	300	300	50
CGPP	Juba	Printer	HP PRINTER coloured	2012	1	800	800	50
CGPP	Juba	Printer	HP Printer Black	2011	1	500	500	-40
CGPP	Juba	Printer	HP BLACK Printer	2016	1	500	500	410
CGPP	Juba	Printer	Hp Fax Black Pinter	2017	1	1000	1000	1,000.00
CGPP	Juba	Printer	HP Lesserjet	2017	2	500	1000	1,000.00
EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET)	Field	Scanners	Hp Scanner (only)	2016	15	300	4500	3,610.00
CGPP	Juba	Video projector	Projector	2014	1	1200	1200	510
CGPP	Juba	Camera	Nikon	2014	1	2000	2000	830

CGPP	Field	Camera	Sony	2016	10	300	3000	2,410.00
		Total			37		17945	**11,987.00**

Appendix v: Internet, Satellite Phone, radio handset

Agency	Location	Item	Detail	purchase year	Quantity	Unit cost	Total cost in USD
EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET)	Juba	Internet	Satellite Dish and boosters	2016	1	5000	5000
CGPP	Juba	Internet	Vsat	2017	1	3000	3000
CGPP	MoH Juba	Internet	Vsat	2017	1	3000	3000
CGPP	Juba	Battery	Solar backup	2017	1	6000	6000
CGPP	MoH Juba	Battery	Solar backup	2017	1	6000	6000
EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET)	Field	Internet	Mobile Modems	2016	15	100	1500
WHO	Juba	satellite phone	Thuraya	2015	1	600	600
WHO	Juba	satellite phone	Thuraya	2015	25	600	15000
UNICEF	Field	satellite phone	Thuraya	2015	5	900	4500
CGPP	Field	satellite phone	Thuraya	2017	10	1200	12000
WHO		Radio Hand set	Motorola	2017	100	400	40000
		Total			161		96600

Other Items

Agency	Location	Detail	purchase year	Quantity	Unit cost	Total cost in USD
CGPP	Juba	129 smartphones, 229 solar phone chargers and 51 other items like chairs, tables, house refrigerators etc.		408		23415

Appendix VI: Four and two-wheel vehicles and motorcycles

Agency	Location	Detail	purchase year	Quantity	Unit cost ($)	Total cost
EPI-CAPACITY BUILDING PROGRAM (ECB/AFENET)	Juba	Toyota Land cruiser	2016	1	60,000	60,000
CGPP	Juba	Land cruiser-Hard top	2012	1	60,000	60,000
	Juba	Land cruiser-station wagon	2014	1	55,000	55,000
	Juba	Land cruiser-Hard top	2017	1	60,000	60,000
WHO	Field	Land cruiser-Hard top	2009	5	31,482.9	157,414.6
WHO	Field	Land cruiser-Hard top	2014	12	31,482.9	377,795.08
		Total for vehicles		**21**		**770,209.7**
CGPP	Juba	Honda Motorcycles	2016	29	3,200	92,800
CGPP	Field	Honda Motorcycles	2016	1	3,200	3,200
		Total motorcycles		**30**		**96,000**

South Sudan Annual GPEI Budget 2017-2019				
Row Labels	**2017**	**2018**	**2019**	**Grand Total**
O1 - Detect and Interrupt Poliovirus				
Campaigns - SIAs	**12,242,000**	**6,635,000**	**5971500**	**24,848,500**
Campaign OPS	8,912,000	4,526,000	**4073400**	17,511,400
Campaign SOC MOB	1,440,000	912,000	**820800**	3,172,800
OPV vaccine procurement	1,890,000	1,197,000	**1077300**	4,164,300

Core functions & Infrastructure	**3,019,000**	**2,996,000**	**2,523,000**	**8,538,000**
Communications, engagement, SOC MOB	450,000	450,000		900,000
Technical Assistance	2,569,000	2,546,000	2,523,000	7,638,000
UNICEF	**800,000**	**777,000**	**754,000**	**2,331,000**
WHO	**1,769,000**	**1,769,000**	**1,769,000**	**5,307,000**
Surveillance	**1,030,000**	**1,061,000**	**1,093,000**	**3,184,000**
Laboratory	0	0	0	0
Surveillance & running costs	1,030,000	1,061,000	1,093,000	3,184,000
O2 - Strengthen Immunization Systems and Withdraw OPV				
Technical Assistance	**0**	**0**	**0**	**0**
OPV Withdrawal - SWITCH	0	0	0	0
Grand Total	**16,291,000**	**10,692,000**	**9,587,500**	**36,570,500**

Appendix VII Budget with some details

Priority functions/Program	Annual budget forecast USD										TOTAL Budget (USD)		
	2018		2019		2020		2021		2022				
	needs	pledges	needs	pledges	needs	pledges	needs	pledges	needs	pledges	needs	pledges	Gap
Routine vaccine purchase of IPV+bOPV With Unicef	893,605	893,605	1,082,625	825190	1,243,475	967,297	825,065	536,062	858,960	563,872	4,903,730	3,786,026	1,117,704
Fuel for the cold chain (NB: Total annual need is 1,666,436US$ & SIAs is covering 1,166,436US$ for 2018&2019) with Unicef	500,000	500,000	500,000	500,000	1,666,436	0	1,666,436	0	1,666,436	0	5,999,308	1,000,000	4,999,308
Transportation of vaccines and consumables(NB: Total annual need is 1,000,000US$ and SIAs is covering 795,000US$ in 2018 & 350,000US$ in 2019) With UNICEF	205,000	205,000	650,000	650,000	1,000,000	0	1,000,000	0	1,000,000	0	3,855,000	855,000	3,000,000
Routine vaccine including purchase of IPV+bOPV with Unicef	*1,598,605*	*1,598,605*	*2,232,625*	*1,975,190*	*3,909,911*	*967,297*	*3,491,501*	*536,062*	*3,525,396*	*563,872*	*14,758,038*	*5,641,026*	*9,117,012*
Support to Polio routine immunisation out-reach CoreGroup	21,000	21000	22,500	22500	22,500	22500	22,500	22500	23,500	23500	112,000	112,000	0
Routine immunisation	1,619,605	1,619,605	2,255,125	1,997,690	3,932,411	989,797	3,514,001	558,562	3,548,896	587,372	14,870,038	5,753,026	9,117,012
Polio SIA WHO	2,379,000	2,379,000	2,141,100	2,141,100							4,520,100	4,520,100	0
Polio SIA UNICEF	4256000	4256000	3830400	3830400							8,086,400	8,086,400	0
PCE of Polio SIAs CoreGroup (NB: 133,000US$ for 2020, 136,000US$ for 2021 &138,000US$ for 2022 has been secured by CoreGroup)	125,500	125,500	129,200	129,200	0	0	0	0	0	0	254,700	254,700	0
Polio SIA*	6,760,500	6,760,500	6,100,700	6,100,700	0	0	0	0	0	0	12,861,200	12,861,200	0
Continuous capacity building & review meeting for Surveillance WHO	414,000	414,000	414,000	414,000	414,000	0	414,000	0	414,000	0	2,070,000	828,000	1,242,000
Environmental surveillance WHO	130,000	130,000	130,000	130,000	130,000	0	130,000	0	130,000	0	650,000	260,000	390,000
Surveillance running cost without incentives	881,920	881,920	881,920	881,920	881,920	0	881,920	0	881,920	0	4,409,600	1,763,840	2,645,760
Community based surveillance via CoreGroup	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	0	1,600,000	0	1,600,000	0	8,000,000	3,200,000	4,800,000
Mainstreaming surveillance	10,000	0	10,000	0	0	0	0	0	0	0	20,000	0	20,000
Surveillance	3,035,920	3,025,920	3,035,920	3,025,920	3,025,920	0	3,025,920	0	3,025,920	0	15,149,600	6,051,840	9,097,760
Cross border coordination (Core Group)	42,500	42,500	43,800	43,800	45,100		46,500		31,000		208,900	86,300	122,600
Personnel WHO (13)	868,500	868,500	868,500	868,500	868,500	0	868,500	0	868,500	0	4,342,500	1,737,000	2,605,500
Incentive for staff EPI Officers, Field assistants, Field supervisers via WHO	2,095,200	1,095,200	2,095,200	1,095,200	2,070,868	0	2,070,868	0	2,070,868	0	10,403,004	2,190,400	8,212,604
Cost of consultants WHO (4)	680,000	680,000	680,000	680,000	680,000	0	680,000	0	680,000	0	3,400,000	1,360,000	2,040,000
Cost of International STOP (15)	1,050,000	1,050,000	1,050,000	1,050,000	1,050,000	0	1,050,000	0	1,050,000	0	5,250,000	2,100,000	3,150,000
Personnel UNICEF	777,000	777,000	754,000	754,000	754,000	0	754,000	0	754,000	0	3,793,000	1,531,000	2,262,000
Personnel ECB/AFENET	1,000,000	853,000	1,000,000	578,000	1,000,000	500,000	1,000,000	0	1,000,000		5,000,000	1,931,000	3,069,000
Personnel Coregroup	1,500,000	1,221,988	1,575,000	1,221,988	1,633,842		1,736,438		1,803,351		8,248,631	2,443,976	5,804,655
Personel Mc King Consultancy/BMGF	1,623,645	1,623,645	1,623,645	1,623,645	1,623,645		1,623,645		1,623,645		8,118,225	3,247,290	4,870,935
Government	0		0		44,240	44,240	44,240	44,240	44,240	44,240	132,721	132,721	0
Personnel	9,594,345	8,169,333	9,646,345	7,871,333	9,725,095	544,240	9,827,691	44,240	9,894,604	44,240	48,688,080	16,673,387	32,014,693
Over head WHO	0	0	0	0	0	0	0	0	0	0	0	0	0
Over head Unicef	100,000	0	100,000	0	100,000	0	100,000	0	100,000	0	500,000	0	500,000
Over head Core Group	100,000	0	105,000	0	110,250	0	115,763	0	121,551	0	552,563	0	552,563
Over head ECB/AFENET/CDC	100,000	100,000	100,000	0	100,000	0	100,000	0	100,000	0	500,000	100,000	400,000
Over head	300,000	100,000	305,000	0	310,250	0	315,763	0	321,551	0	1,552,563	100,000	1,452,563
Training to capacitate the staff in their new ToRs	1,177,243	0	850,000	0	0	0	0	0	0	0	2,027,243	0	2,027,243
Preservice capacity building for ECB/AFENET	400,000		400,000		400,000		400,000		400,000		2,000,000	0	2,000,000
Total capacity building	1,577,243	0	1,250,000	0	400,000	0	400,000	0	400,000	0	4,027,243	0	4,027,243
Social mobilisation network and communication plan (Contribution to)	835,604	835,604	1,285,000	0	1,285,000	0	1,285,000	0	1,285,000	0	5,975,604	835,604	5,140,000
Field sensitization visits and meetings, needs for the transition structures	100,000	0	50,000	0	50,000	0	27,500	0	25,000	0	252,500	0	252,500
Evaluation of the transition plan	0	0	12,000	0	0	0	0	0	22,000	0	34,000	0	34,000
Preparation in 2022 of the switch from bOPV to 2 doses of IVP in routine	0	0	0	0	0	0	0	0	0	0	0	0	0
Preparation in 2022 of the switch from bOPV to 2 doses of IVP in routine WHO & Unicef	0	0	0	0	0	0	0	0	100,000	0	100,000	0	100,000
Technical assistance for transition and post-certification in Unicef TA 1P3 & 1NOB	325212	0	325212	0	325212	0	325212	0	325212	0	1,626,060	0	1,626,060
Finalization of the polio transitionplan & organisation of the high level advocacy meeting to present the investment case for polio transition	117500	117500									117,500	117,500	0
Other					133,000	133,000	136,000	136,000	138,000	138,000	407,000	407,000	0
TOTAL	24,308,429	20,670,962	24,309,102	19,039,443	19,231,988	1,667,037	18,903,586	738,802	19,117,183	769,612	105,870,288	42,885,857	62,984,431

Polio transition documents


Polio Assets Mapping for South


SSD Polio best practices F.docx


Polio transition communication plar


South South Business case WHO


SSD tables on funds need and ava