

**Polio  
program  
transition in  
South Sudan:  
an assessment  
of risks and  
opportunities**

---

Leveraging civil  
society resources  
to scale up  
immunization

**January  
2020**



## Acknowledgements

This assessment was funded by a grant from the United Nations Foundation (UNF) to the International Federation of Red Cross and Red Crescent Societies (IFRC). The cooperation extended by the Government of South Sudan and the in-country offices of the World Health Organization (WHO), United Nation's Children's Fund (UNICEF), CORE Group, South Sudan Red Cross (SSRC), Access for Humanity (AFH), and the Health Pooled Fund) is deeply appreciated. We thank Gavi, The Vaccine Alliance for facilitating our participation in the 2019 Gavi Joint Appraisal in Juba, providing access to key stakeholders and partners, and our colleagues at WHO, UNICEF, and Gavi for their comments on a previous draft of this report.

## Foreword

---

The collective goal of eradicating polio has faced many challenges, and the current landscape of the COVID-19 pandemic is no exception. As the Global Polio Eradication Initiative comes closer to achieving its eradication goal over the next few years, it will be imperative to ensure smooth integration of its experiences, lessons and health assets in high risk and endemic countries, especially in a post-pandemic world.

The assessment outlined in this report was carried out in 2019, prior to COVID-19. It focuses on the role of civil society organizations (CSOs) in the fight to end wild poliovirus and potential challenges and future opportunities. The conclusions and recommendations have become even more important considering the large-scale disruption of immunization services, both routine and campaigns, during the pandemic. COVID-19 has forced a diversion of resources towards the pandemic, and many immunization efforts have been paused. The pandemic has resulted in increases in vaccine preventable diseases and deaths; large scale vaccine stockouts; migration of health workers for pandemic work; and, enhanced community fears.

The pandemic has made it clear that the need to strengthen health systems has never been more urgent to prevent further increases in suffering from vaccine preventable diseases. The roles of all partners, including CSOs, to revamp, restore and sustain immunization delivery cannot wait for COVID-19 pandemic to end or significantly decline. GPEI's experience showed that in fragile countries and conflict settings, partnership with CSOs is crucial for immunization delivery and primary health care.

The COVID-19 pandemic provides many risks to the polio program, but also an opportunity to enhance GPEI's integration efforts, as strong health systems and close collaboration with related health initiatives will be vital to ensuring that polio eradication efforts can catch-up quickly post COVID-19. CSOs, in particular, will find the conclusions and recommendations relevant as they consider their future interventions in the countries.

# Contents

Acronyms	II
Executive summary	IV
<b>1. Introduction</b>	<b>1</b>
<b>2. Country context</b>	<b>3</b>
2.1 Health system	4
2.2 National immunization program	7
<b>3. Methodology</b>	<b>10</b>
<b>4. Results</b>	<b>12</b>
4.1 Polio and immunization funding	13
4.2 Polio transition progress	13
4.3 Polio transition risks	14
4.4 Polio transition opportunities	17
<b>5. Recommendations for stakeholders</b>	<b>23</b>
5.1 South Sudan Government	26
5.2 Donors	27
5.3 UN agencies (UNICEF, WHO)	28
5.4 Civil society	28
<b>6. Conclusions</b>	<b>30</b>

# Acronyms

<b>AFENET</b>	African Field Epidemiology Network
<b>AFH</b>	Access for Humanity
<b>AFP</b>	Acute flaccid paralysis
<b>AFRO</b>	WHO Regional Office for Africa
<b>ARCC</b>	African Regional Certification Commission
<b>BCG</b>	Bacille Calmette–Guérin (vaccine)
<b>BHI</b>	Boma Health Initiative
<b>BMGF</b>	Bill & Melinda Gates Foundation
<b>BPHS</b>	Basic Package of Health Services
<b>CBHFA</b>	Community-Based Health and First Aid (SSRC manual)
<b>CDC</b>	U.S. Centers for Disease Control and Prevention
<b>CHW</b>	Community health worker
<b>CMR</b>	Child mortality rate per 1000 live births
<b>CSO</b>	Civil society organization
<b>cVDPV</b>	Circulating vaccine-derived poliovirus
<b>DPT</b>	Diphtheria-pertussis-tetanus (vaccine)
<b>DPT3</b>	Diphtheria-pertussis-tetanus (vaccine), third dose
<b>Penta 1</b>	Pentavalent vaccine, first dose
<b>Penta 3</b>	Pentavalent vaccine, third dose
<b>EMRO</b>	WHO Regional Office for the Eastern Mediterranean
<b>EPI</b>	Expanded Programme on Immunization
<b>GDP</b>	Gross domestic product
<b>Global Fund</b>	Global Fund to Fight AIDS, Tuberculosis, and Malaria
<b>GNI</b>	Gross national income
<b>GPEI</b>	Global Polio Eradication Initiative
<b>HPF</b>	Health Pooled Fund
<b>HR</b>	Human resources
<b>HSS</b>	Health systems strengthening
<b>ICC</b>	Interagency Coordinating Committee
<b>ICRC</b>	International Committee of the Red Cross
<b>IDP</b>	Internally displaced person
<b>IDSR</b>	Integrated disease surveillance and response
<b>IFRC</b>	International Federation of Red Cross and Red Crescent Societies

<b>IGAD</b>	Intergovernmental Authority on Development
<b>IMR</b>	Infant mortality rate
<b>INGDO</b>	International nongovernmental development organization
<b>IOM</b>	International Organization for Migration
<b>IPV</b>	Inactivated polio vaccine (administered via injection)
<b>JSI</b>	John Snow, Inc.
<b>LMC</b>	Leadership, Management and Coordination (initiative)
<b>MCH</b>	Maternal and child health
<b>MCV1</b>	Measles-containing vaccine, first dose
<b>MMR</b>	Maternal mortality rate per 100,000 live births
<b>MSF</b>	Médecins Sans Frontiers
<b>MRI</b>	Measles & Rubella Initiative
<b>NGO</b>	Nongovernmental organization
<b>NHA</b>	National Health Accounts
<b>NID</b>	National immunization day
<b>OPV</b>	Oral polio vaccine
<b>OPV3</b>	Oral polio vaccine, third dose
<b>PTP</b>	Polio Transition Plan
<b>SIA</b>	Supplementary immunization activity
<b>SNID</b>	Subnational immunization day
<b>SSRC</b>	South Sudan Red Cross
<b>SWOT</b>	Strengths, weaknesses, opportunities, and threats
<b>Td</b>	Tetanus-diphtheria (vaccine)
<b>UNF</b>	United Nations Foundation
<b>UNICEF</b>	United Nations Children’s Fund
<b>USAID</b>	United States Agency for International Development
<b>VPD</b>	Vaccine-preventable disease
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization
<b>WPV</b>	Wild poliovirus

**Notes** Unless indicated otherwise, currency in this report is U.S. dollars (US\$). Civil society organizations (CSOs) are non-State, not-for-profit, voluntary entities formed by people in the social sphere that are separate from the State and the market. CSOs represent a wide range of interests and ties and can include national and international community-based organizations as well as nongovernmental organizations (NGOs).

# Executive summary

## Introduction

The Global Polio Eradication Initiative (GPEI) will sunset following certification of the eradication of wild poliovirus. While finishing the job on polio and ensuring that the world remains free of polio remain top priority, the wind down of this extensive program has already started to affect health systems. To ensure a smooth transition away from GPEI funding (“polio transition”), South Sudan needs to prepare to sustain their national polio and immunization programs through other resources. The impact of GPEI wind down in South Sudan is particularly concerning due to well-documented risks to the country’s broader immunization system and ability to remain polio-free.<sup>1</sup> As in other countries, successful polio transition in South Sudan will require stakeholder engagement. Polio program partners have expressed the view that an expanded range of stakeholders, including civil society organizations (CSOs) at the country level, should be included in this process.

This report describes the results of an assessment carried out by the International Federation of Red Cross and Red Crescent Societies (IFRC) in 2019 to document the realities of integration and transition efforts in South Sudan.

## Objectives

1. Analyze current funding for South Sudan’s immunization and polio programs.
2. Document progress in transition planning and implementation.
3. Determine risks the country faces with the wind down of GPEI funding.
4. Identify opportunities for civil society engagement to support integration of polio program-funded activities and help sustain essential polio programming as well as other immunization activities.

## Methods

### Desk review

A desk review of key documents including South Sudan’s Polio Transition Plan (PTP), country health plans, the Basic Package of Health Services (BPHS), the Boma Health Initiative (BHI), and reports from World Health Organization (WHO) and other health sector organizations.

### Key informant interviews

Country visits were done to conduct key informant interviews with representatives from the Ministry of Health, United Nations (UN) agencies, CSOs, and other stakeholders. Updated data and geographic maps were obtained from the Joint Appraisal draft report for 2019 from Gavi, the Vaccine Alliance, and reports from other humanitarian organizations.

### Workshops

Information was also collected during two visits to South Sudan (August and October 2019). The purpose of the field visits was to meet important stakeholders in the health sector and participate in the Gavi Joint Appraisal in Juba.

<sup>1</sup>GPEI Transition Plan for South Sudan. May 2018. Available at: [http://polioeradication.org/wp-content/uploads/2018/07/South\\_Sudan\\_Polio\\_Transition\\_Plan.pdf](http://polioeradication.org/wp-content/uploads/2018/07/South_Sudan_Polio_Transition_Plan.pdf).



Key limitations of the assessment included the lack of a platform or coordinated mechanism for CSOs, which may have generated more comprehensive and balanced information; the lack of a dedicated CSO focal point in government and other major partner organizations (except UNICEF); and the limited ability to meet with front-line health workers at the state or county level.

### **Funding**

- About 70% of health sector funding in South Sudan comes from external donors.
- The immunization program is entirely dependent on external donors, mainly Gavi, GPEI, and BMGF (the source of most funding from WHO and UNICEF).
- UNICEF is the primary recipient of a large World Bank grant to implement delivery of South Sudan's Basic Package of Health Services (BPHS) in the western region, the most inaccessible part of the country.
- For 2019, the total immunization budget was about \$27 million, with 25% from GPEI.
- GPEI's support has dropped by about one-third as of 2020.
- There is almost no government allocation for immunization in the Ministry of Health budget.

### **Risks**

- The GPEI wind down will affect programming as well as financial support. The financial risk could be mitigated by mainstreaming critical functions of routine immunization and other disease control programs.
- There is a risk of loss of staff for training, monitoring, and supervision of activities—all funded largely by GPEI and the backbone of immunization delivery and polio-specific activities.
- Programmatic risk will depend on the role of CSOs. Many active CSOs, international and national, are already managing the humanitarian crisis in South Sudan by providing human resource support and essential medicines and vaccines and conducting large vaccine campaigns.

### **Opportunities**

- Some polio program-supported assets in South Sudan (staff, infrastructure and systems) are not transferrable to other health areas. Therefore, the GPEI wind down provides an opportunity for civil society, including national and international CSOs, and nongovernmental organizations (NGOs), to help fill these gaps.
- The PTP highlights three priority areas where polio program assets could be integrated with broader health efforts while also ensuring the country remains polio-free: 1) the Expanded Programme on Immunization (EPI), 2) integrated disease surveillance and response, and 3) health systems strengthening, through the Boma Health Initiative (BHI).
- CSOs, which play a critical role in health care service delivery and advocacy in South Sudan, could support the South Sudanese government in health sector development activities as the country's polio program is integrated with the broader system and moves away from GPEI resources. However, CSOs will need extensive capacity building to fill these gaps.

**Government**

- Harness the full potential of civil society by increasing their involvement in planning processes and better CSO–government coordination through existing mechanisms.
- Promote the strategy and vision of the BHI by ensuring all donor resources are mapped geographically across states and counties.
- Continue to direct and monitor the activities of the implementing partners countrywide, including CSOs.
- Establish an immunization budget line in the domestic budget for non-salary expenditures.

**Donors**

- Make long-term funding commitments for the delivery of a uniform BPHS.
- Ensure that immunization becomes a central platform for assessing programmatic progress of the country's BPHS strategy.
- BMG, Gavi, and GPEI should continue efforts to improve coordination of immunization financing.
- Explore the possibility of creating a funding platform that would allow CSOs to adopt and use innovative approaches to immunization service delivery across different geographic areas.

**UN System (UNICEF, WHO)**

- Prioritize government and CSO capacity building.

**Civil society**

- Establish CSO coordination platforms at the country, state, and county level to leverage CSO capacity more effectively.
- Provide advocacy support for immunization and domestic financing, particularly in the context of the GPEI wind down.
- Support service delivery gaps in the context of the GPEI wind down.

<sup>1</sup> GPEI Transition Plan for South Sudan, May 2018. Available at: [http://polioeradication.org/wp-content/uploads/2018/07/South\\_Sudan\\_Polio\\_Transition\\_Plan.pdf](http://polioeradication.org/wp-content/uploads/2018/07/South_Sudan_Polio_Transition_Plan.pdf).

<sup>2</sup> <https://www.unicef.org/southsudan/reports/boma-health-initiative>



# Introduction

1



# 1

## Introduction

For over three decades, the Global Polio Eradication Initiative (GPEI) has funded the global polio eradication program. South Sudan and other countries have relied on this global program for all financial support of their polio programs and some financial support for many other important public health activities outside the scope of polio eradication, including routine immunization, disease surveillance, social mobilization, and vaccine delivery. However, as the world approaches global polio eradication, GPEI resources are progressively declining and will eventually be phased out. Therefore, South Sudan and other countries need to identify and develop alternate sources of funding to prepare for their transition away from the global polio program support (“polio transition”). GPEI has identified 16 countries<sup>3</sup> as high priority for active polio transition planning to ensure a smooth shift away from this support. The original requirement was for all 16 countries to complete their polio transition by 2019, but due to delays in global polio eradication the timeframe has been extended through 2023. Even with this extension, it is urgent that the high-priority countries, including South Sudan, continue to proactively plan how they will manage the effects of the GPEI wind down, which has already begun. To leverage all relevant human resources, global polio program partners have recommended that additional stakeholders,

including civil society, be engaged in each country’s polio transition to speed progress toward identified goals, including integrating national polio programs with the broader health systems and moving them toward other sources of funding and leadership at the country level. Prior to this study, limited progress had been made in determining how these efforts are playing out at the country level and how a broader group of health stakeholders working at the country level could provide support.

To help fill these gaps, an assessment was carried out by the International Federation of Red Cross and Red Crescent Societies (IFRC) in 2019 to document the realities of integration and transition efforts in South Sudan and determine how civil society stakeholders working on relevant health issues at the country level could best support the country as it transitions from GPEI resources. The objectives were to 1) analyze current funding for South Sudan’s immunization and polio programs, 2) document progress in transition planning, 3) determine risks the country faces with the wind down of GPEI funding, and 4) identify opportunities for civil society engagement to support integration of polio program-funded activities and help sustain essential polio programming as well as other immunization activities.

<sup>3</sup>Afghanistan, Angola, Bangladesh, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Myanmar, Nepal, Nigeria, Pakistan, Somalia, South Sudan, and Sudan, which collectively receive more than 90% of GPEI resources.



# Country context

2



## 2

# Country context

South Sudan has a long history of conflict that has contributed to challenges for the country's health system, including many beyond the influence of the health sector, such as a fragile peace agreement, the destruction and resulting dysfunction of many health facilities, and geographic inaccessibility, coupled with very high transportation costs. In addition, the economy is unstable, due to the reduction in oil production, which has limited government's access to foreign currency. High devaluation of the local South Sudanese pound against the U.S. dollar has continued since the country's independence, which has reduced the purchasing power of the local community and demoralized business communities looking for trading opportunities in order to bring essential goods to the country and support economic growth. Regular supply channels for goods and services, including those for health care supplies and services, are often disrupted.

## 2.1 Health system

Challenges within the remit of the health sector include human resource (HR) shortages and lack

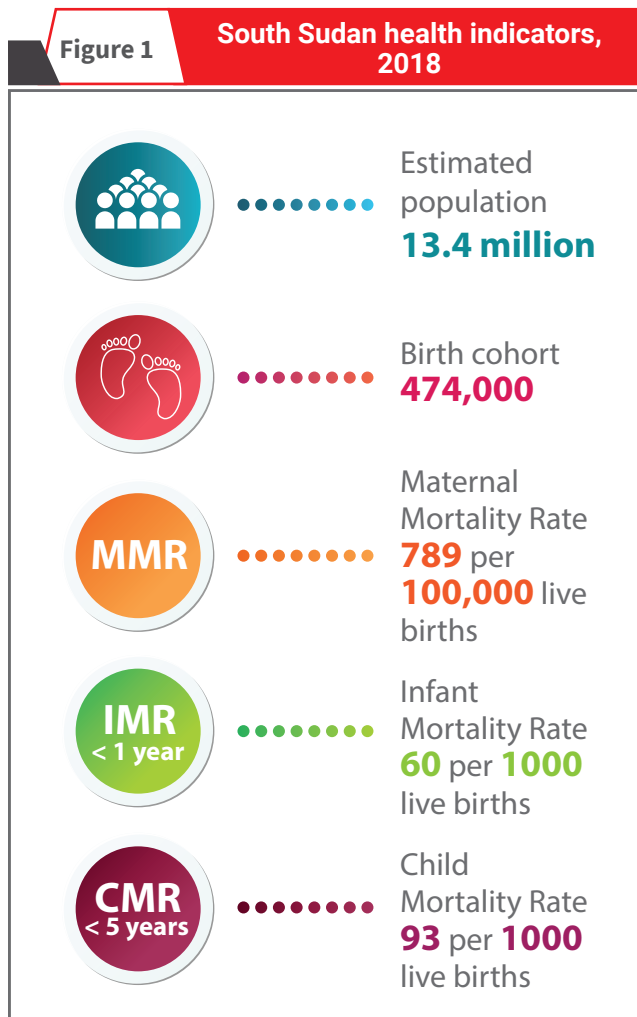
of capacity of both health workers and managers; lack of awareness of and demand for immunization; large numbers of internally displaced persons (IDPs) (almost 4 million); and lack of an effective coordination mechanism for a large number of stakeholders, including CSOs, which operate in a fragmented manner. Over 7.6 million people (more than half the population) do not have essential health services, 1.9 million remain internally displaced, and 2 million have migrated to neighboring countries. Access to displaced and trapped communities remains a challenge and has limited efforts to improve coverage of health care services to alleviate morbidity and mortality.

### 2.1.1 Health Indicators

South Sudan has some of the worst health indicators found worldwide, with an infant mortality rate (IMR) of 60 per 1,000 live births (among the top 20 highest globally), under-5 mortality rate of 93 deaths per 1,000 live births, 75% of child deaths due to preventable diseases, and a maternal mortality rate (MMR) of 789 per 100,000 live births. In addition, less than 8%

of deliveries are attended by skilled birth attendants, mostly due to limited access to health services, with 83% of the population living in rural areas and 56% living more than one-hour walking distance from a health facility.

of subnational polio surveillance, and immunization gaps, as well as the lack of security and population displacement and migration. It is essential to maintain momentum in the country's polio program in order to reach every child with polio vaccines and strengthen disease surveillance.



Source: UNDP Population division, UNICEF, World Bank

The country's polio indicators are encouraging, however, as South Sudan has not reported a single case of WPV since 2009, no cases of circulating vaccine-derived poliovirus (cVDPV) have been reported since 2014, and the country expects polio-free certification from the African Regional Certification Commission (ARCC) in 2020. However, concerns remain about the quality

### 2.1.2 Health System Funding

In 2018, WHO assisted the South Sudanese government in preparing its first National Health Accounts (NHA) report. The report notes that government allocation to public health is about 1.6% of the gross domestic product (GDP) in South Sudan. For 2016–2017, the total health expenditure was \$411 million, of which \$34 million came from the government. An estimated \$68 million was private/out-of-pocket. The remaining \$288 million was provided through external assistance. All-inclusive health expenditure is estimated as \$34 per capita (versus WHO's recommended level of \$84 per capita). The government, private sector, and donor contributions are 8.5%, 21.3%, and 70.2% respectively, underscoring the heavy reliance on external assistance. Hospital expenditures accounted for 47% of the government contribution, whereas preventive care was only 17%. An estimated 88% of government expenditures in the health sector goes to compensation of government employees.

### 2.1.3 Health system governance and leadership

Health system governance and leadership at the subnational level (state and county) remains weak and is characterized by lack of accountability from the implementing partners. Health worker absenteeism is another major challenge that has led to closure of health facilities for days or weeks. The new states<sup>4</sup> formed in December 2016 still lack mid-level health

<sup>4</sup> When South Sudan gained independence from Sudan in 2011, South Sudan had 10 states, as set out in its constitution. In 2015, it was increased to 28 and then later to 32. The president on February 15, 2020 said the country would now be divided among the original 10 states, plus three "administrative areas" of Pibor, Ruweng and Abyei. Available at: <https://www.aljazeera.com/news/2020/02/south-sudan-president-offers-compromise-gov-deadline-looms-200215102003372.html>.

management staff. Coordination between government and implementing NGOs at subnational levels is also weak. Given that government employees do not always receive their salaries on time, and the salaries are often much lower than those of other sectors, another major risk is attrition of trained officials. Supported by Gavi's Leadership, Management and Coordination (LMC) initiative, training in EPI capacity-building for 56 national- and state-level officials, to improve key management functions at the national and state level, is under way. However, South Sudan has a long way to go to catch up to the performance indicators of health services in neighboring countries.

#### 2.1.4 Health Workforce

The health service administrative hierarchy is described in detail in the BHI plan.<sup>5</sup> In brief, there are five levels—federal, state (32), county (75), *payam*<sup>6</sup> (419), and *boma*<sup>7</sup> (1,421). Shortages of skilled workers are acute and coupled with high attrition as health professionals seek better work conditions and environments in other countries. This often leaves service delivery in the hands of underqualified volunteers. The BHI plan calls for the employment of 7,500 staff at the *boma* level to create awareness of the importance of immunization and to conduct social mobilization activities, including default tracking; school health is another responsibility of this level of the workforce. Currently, most health service positions are funded by external donors, but the government plans to fund these positions in future.

#### 2.1.5 Health Partners

The partners providing support for different aspects of the health system can be divided into four groups:

- the five-level government health service structure
- funding partners (HPF and World Bank, which fund eight and two states respectively, and disease-specific funders Gavi, the Global Fund, and GPEI)
- the UN/multilateral system (led by WHO and UNICEF, which support primary health care and immunization)
- international NGOs (IFRC, the International Committee of the Red Cross (ICRC), SSRC, CORE group, the African Field Epidemiology Network (AFENET), Médecins Sans Frontiers (MSF), and various implementing partners contracted by UNICEF and HPF). NGOs usually work in collaboration with local health societies/associations, or other entities, but with varying concentrations across different states and counties.

South Sudan's EPI provided a list of 30 national organizations that also provide support to the polio program, but due to the varied funding cycles and geographic distribution it has been difficult to track the contributions of these organizations. However, in future, it will be crucial to continuously map national CSOs countrywide and build their capacities for service delivery and monitoring. National organizations like AFH (which will be taking some surveillance work from CORE group) operate their own projects and activities, usually on limited scale. The U.S. Centers for Disease Control and Prevention (CDC) also plays a major role. As the country moves forward with its polio program transition, geographic mapping of all relevant organizations will be crucial, given the variable mandates and significant needs countrywide. SSRC holds a unique position in this regard, with formal

<sup>5</sup> The Boma Health Initiative (BHI) was launched in South Sudan in March 2017 as a nationwide strategy to improve access to essential health services. The BHI is also designed to standardize the package of community health services, strengthen linkages between communities and primary health facilities, and improve community ownership and governance of health services. However, while an important step, the BHI is currently unfunded and will not be ready in the immediate term. Described in detail in the GPEI Transition Plan for South Sudan, May 2018. Available at: [http://polioeradication.org/wp-content/uploads/2018/07/South\\_Sudan\\_Polio\\_Transition\\_Plan.pdf](http://polioeradication.org/wp-content/uploads/2018/07/South_Sudan_Polio_Transition_Plan.pdf)

<sup>6</sup> *Payams* have a minimum population of 2,500 and contain about four *Bomas* each.

<sup>7</sup> *Bomas* vary in size and contain multiple (three or four) villages.



“National DPT3 administrative coverage in 2018 was 49%, and there is a wide disparity in immunization coverage across the states.”



recognition (parliamentary approval) of its 17 state branches and a roster of more than 12,000 active volunteers. Each organization/project should design its activities to support the establishment of the structures and functionalities prescribed by the BHI as the ultimate vision of the country.

Partners provide support for different aspects of health care in South Sudan. Immunization and primary health care services can be organized into three streams (governance / disease control and monitoring; funding; and service delivery), as outlined in Table 1.

Administrative level	Governance / disease control and monitoring	Funding	Service delivery
Federal	Federal EPI team	Government and multiple donors	National functions by different organizations
State	State EPI/Maternal and child health (MCH) team	HPF and World Bank (through UNICEF and ICRC)	Implementing partners (UNICEF, international NGOs/CSOs)
County	County health team	Donors and NGOs/CSOs, including the Red Crescent Societies	National and local NGOs/CSOs
Payam and boma			National and local NGOs/CSOs

**Source:** Prepared by author based on analysis

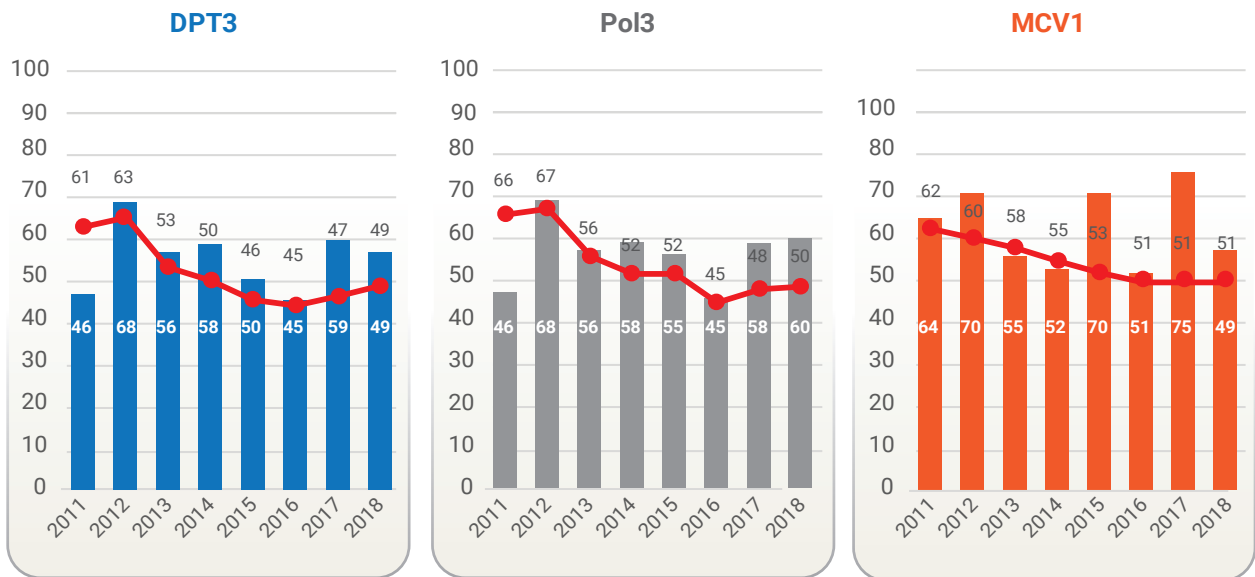
## 2.2 National immunization program

Immunization coverage is low in South Sudan. National DPT3 administrative coverage in 2018 was 49%, as shown in Graph 1, and there is a wide disparity in immunization coverage across the states, as shown in Graph 2. Furthermore, the accuracy of the administrative rates is not definite as the country's

reported administrative coverage (represented with the bars in Graph 1) varies considerably from the WHO and UNICEF estimates of national immunization coverage (represented with the red lines in Graph 1). DTP3 coverage was highest in 2012 according to both administrative coverage (68%) and WHO and UNICEF estimated coverage (63%). The decline afterward has been attributed to post-independence conflict and violence.

Graph 1

South Sudan Immunization Trends for DTP3, Pol3, and MCV1, 2011-2018



Country Administrative Coverage

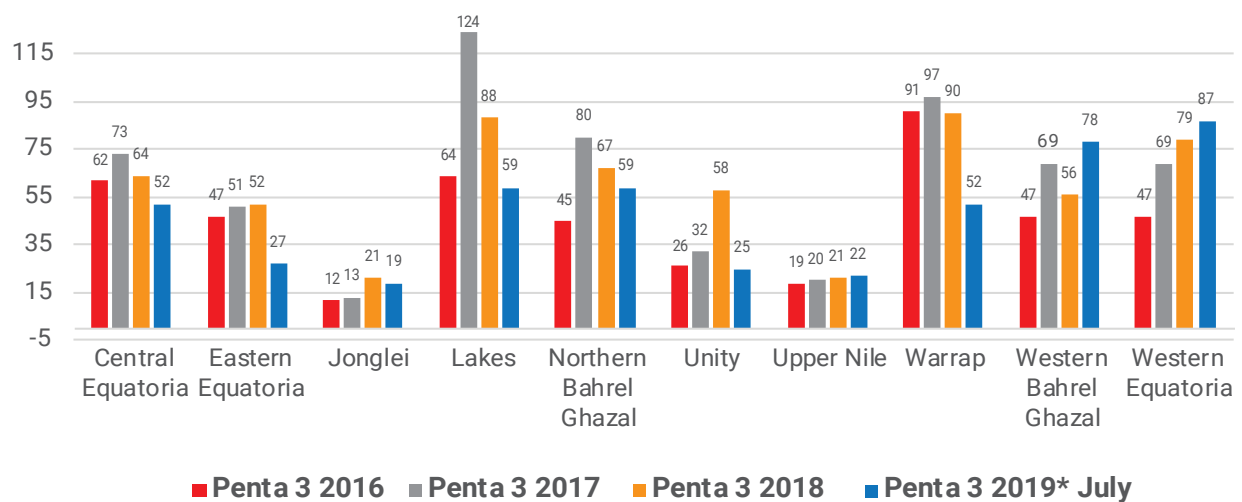
- DTP3**  
Third dose of diphtheria toxoid, tetanus toxoid and pertussis vaccine
- Pol3**  
Third dose of polio vaccine
- MCV1**  
First dose of measles-containing vaccine

**WHO/UNICEF**  
Estimates of National Immunization Coverage

Source: Immunization, Vaccines and Biologicals Data, statistics and graphics; Available at: [https://www.who.int/immunization/monitoring\\_surveillance/data/en/](https://www.who.int/immunization/monitoring_surveillance/data/en/)

Graph 2

South Sudan Penta 3 coverage by state, 2016-2019



Source: <https://www.unicef.org/southsudan/reports/national-immunization-coverage-survey>

The Gavi Joint Appraisal for 2019 captured subnational data on immunization coverage as well as number of missed children. While most of the country has low coverage and is given an equal focus under the BPHS, intervention-specific prioritization for states may be necessary, taking into account vulnerability to importation of the poliovirus from neighboring countries, population density, estimated number of unimmunized and partially immunized children. Service delivery microplans must also consider the cold chain equipment available and functioning properly.

A nationwide immunization coverage survey<sup>8</sup> was conducted in 2017 to validate the quality and coverage of South Sudan's EPI across the country's 10 former states.<sup>9</sup> Various community-based surveillance pilot projects (led by CSOs) have also been conducted and could be gradually scaled up.

The pilot described below was carried out in three western states.

### Pilot for capacity building and transfer model for community-based surveillance

- Issue** ▶ Community-based surveillance for acute flaccid paralysis (AFP) in three western states (Jonglei, Upper Nile, and Unity)
- Funding** ▶ U.S. Agency for International Development (USAID), through CORE group
- Former implementer** ▶ CORE group, an international NGO (<https://coregroup.org>)
- Current implementer** ▶ Access for Humanity (AFH), a national NGO (<http://accessforhumanity.org>)
- Future vision** ▶ Integrate with South Sudan's BMI through village health workers and payam assistants

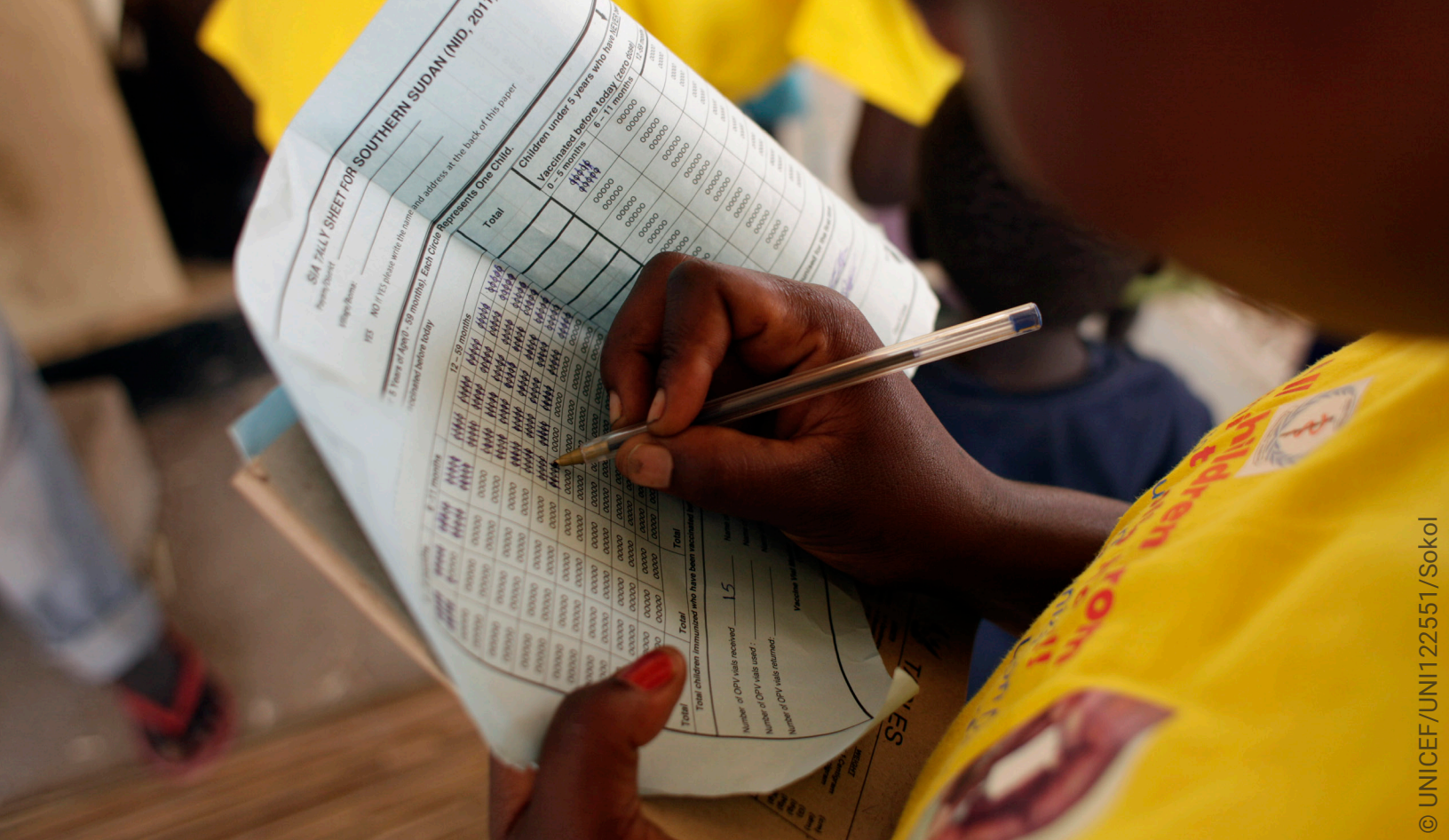
<sup>8</sup> <https://www.unicef.org/southsudan/reports/national-immunization-coverage-survey>

<sup>9</sup> Upper Nile, Jonglei, Unity, Warrap, Northern Bahr El Ghazel, Western Bahr El Ghazel, Lakes, Western Equatoria, Central Equatoria, and Eastern Equatoria



# Methodology

3



### 3

## Methodology

The assessment of polio transition risk and opportunities included a desk review of key documents:

- South Sudan’s Polio Transition Plan (PTP)
- Country health plans
- The Basic Package of Health Services (BPHS)
- The Boma Health Initiative (BHI)
- Reports from WHO and other health sector organizations

Interviews were held with key stakeholders, including representatives from the Ministry of Health, UN agencies, and development partners. Updated data and geographic maps were obtained

from the Gavi Joint Appraisal draft report for 2019 and reports from other humanitarian organizations. Information was also collected during two visits to South Sudan (August and October 2019). The purpose of the field visits was to meet important stakeholders in the health sector and participate in the Gavi Joint Appraisal in Juba. Key limitations of the assessment included the lack of a platform or coordinated mechanism for CSOs, which may have generated more comprehensive and balanced information; the lack of a dedicated CSO focal point in government and other major partner organizations (except UNICEF); and the limited ability to meet with front-line health workers at the state or county level.



# Results

4



# 4

## Results

### 4.1 Polio and immunization funding

Overall, 70% of health sector funding in South Sudan comes from external donors. All funding for immunization from those funds, in descending order, comes from Gavi, GPEI, and BMGF. For 2019, total immunization funding comes to about \$27 million, with about 25% coming from GPEI. GPEI's support has been reduced by about one-third as of 2020. The other ad-hoc external funding to the health sector is expected to continue at the same pace as in the past.

### 4.2 Polio transition progress

In 2019, GPEI launched a new strategy for 2019–2023. In November 2019, partners mobilized an additional \$2.6 billion in pledges for the overall global budget needed to implement the strategy. GPEI and

Gavi have also ramped up collaboration, and Gavi has committed to providing IPV through at least through 2020 and potentially beyond for all countries eligible for Gavi support and for catch-up campaigns for birth cohorts since 2015 that missed receiving one dose of IPV<sup>10</sup>. The consequence of this development is a complete transformation for polio transition planning from ramp down of assets to a more gradual yet already occurring ramp-down process focused on integration of polio and routine immunization activities. WHO plans to update country transition plans for both the African and Eastern Mediterranean regions (AFRO and EMRO). The current transition plan for South Sudan is likely to be extended through to 2023.

The new GPEI strategy, if fully funded, will mitigate any immediate negative consequence on polio assets; however, wind down continues in countries like South Sudan that have not had any reports

<sup>10</sup> Subject to upcoming Gavi replenishment in June 2020, Gavi will commit to IPV support till end of 2025.

## World Health Assembly Report 2019 - A72/10

*“Whereas previously polio transition planning focused primarily on decreasing the risks faced by the Organization owing to the large numbers of polio-funded staff, the country planning process has revealed the need to sustain and/or selectively re-purpose experienced health workforce currently employed with polio funds, particularly in fragile and conflict-affected countries, in order to sustain eradication and to avoid backsliding on vaccine-preventable disease control efforts.”*

of WPV cases for several years. There has been negative impact already, leading to a reduction in the number of national immunization days (NIDs) and subnational immunization days (SNIDs) as well as UNICEF-contracted community mobilizers (from 2,500 to about 850 at present). However, South Sudan has planned measles and tetanus diphtheria (Td) vaccine campaigns that could be combined with polio campaigns. The vulnerability remains from two challenges:

- low immunization coverage.
- sharing of porous borders with countries still reporting cVDPV cases.

Therefore, the focus of the transition will be on strengthening health system bottlenecks in order to improve coverage as well as preparedness for an outbreak response. Not all stakeholders believe that polio elimination certification, expected by mid-2020, would result in a ramp down of the GPEI budget. The country is not fully sensitized about this potential consequence. Recent successful GPEI pledge campaigns may be one reason for this thinking. In addition, as described in the World Health Assembly (WHA) report excerpt below, the need to sustain experienced polio staff to avoid any backsliding in polio eradication efforts in South Sudan is another factor that must be considered.

## 4.3 Polio transition risks

The GPEI wind down in South Sudan has both financial and programmatic risks.

### 4.3.1 Financial

There is almost no government allocation for immunization in the Ministry of Health budget other than for compensation of various officials. The immunization program is entirely dependent on external donors, with the major ones being Gavi, GPEI, and BMGF. WHO and UNICEF are often cited as major funders, but these organizations receive most of their funding from Gavi, GPEI, or BMGF. UNICEF is the primary recipient of a large World Bank grant to implement the BPHS delivery in the western region, the most inaccessible part of the country, with 10 states carved out of the original three. Given the fragmented nature of external support in South Sudan, existing challenges in gathering comprehensive financing data become more complex due to three factors:

- risk of double-counting funds from the primary donor and implementing organizations.
- the nature of time-restricted funding (e.g., annual funding, which may differ from year to year).
- high volatility from currency conversion. Table 2 provides a summary of funding sources for immunization in South Sudan, both direct and indirect. The dollar amounts listed were based on the available data and are subject to change.



Table 2

Summary of direct and indirect funding sources for immunization, South Sudan<sup>a,b</sup>

Funding source	Amount
Government	\$34 million annual for health sector, mostly meant for staff compensation
HPF	45.5 million British pounds (\$59 million) for 15 months (until June 2020) for eight states for delivery of essential health services, managed through 12 implementing partners
World Bank	\$105.4 million for 2.5 years (until December 2021) for two states for delivery of essential health services operated by UNICEF and ICRC. The UNICEF grant is managed through 12 implementing partners.
Gavi	<p>Gavi's commitment for 2019 is \$6.9 million: \$1.5 million for the Penta vaccine, IPV, and injection devices; \$1.4 million for cold chain equipment; and \$4.0 million for HSS support, implemented by WHO and UNICEF.</p> <p>\$17.5 million is being given for 18 months from October 2019 to March 2021 under the Gavi fragility policy.</p> <p>Another \$3.2 million is allocated to CDC, John Snow, Inc. (JSI), UNICEF, and WHO for technical assistance for 2019.</p>
GPEI	<p>GPEI spent \$4.3 million in 2018, through WHO, allocated as follows:</p> <ul style="list-style-type: none"> <li>• Supplementary immunization activities (SIAs)—\$2.38 million</li> <li>• Core functions and infrastructure—\$0.43 million</li> <li>• Surveillance, including technical assistance—\$1.5 million</li> </ul> <p>For 2019, estimated expenditure was \$6.1 million; for 2020 and 2021, it is projected to be \$4.0 million per year. The GPEI expenditures for 2018 are only 42% of the original PTP projections. Activities already affected by the reduced budgets include SIAs and community mobilization. HR is supported through all three streams of GPEI funding. All SIAs for OPV are funded by GPEI resources. Other SIAs are supported by Gavi and the Measles &amp; Rubella Initiative (MRI).</p>
BMGF	BMGF funds community-based surveillance for AFP in three eastern states, now implemented by national NGO Access for Humanity. The \$2.6 million grant is for one year. Previously, CORE Group and World Vision were implementing this activity. The BMGF is also supporting surveillance monitoring activities, through McKing Consulting Corporation (Fairfax, VA, USA).

<sup>a</sup> Organizations such as CDC, International Organization for Migration (IOM), JSI, and Save the Children are primarily supported by Gavi.

<sup>b</sup> The BMGF contribution listed here does not include BMGF contributions to GPEI and Gavi.

**Source:** Compiled by author based on available data collected during assessment.

Despite the highly fragmented nature of financing for immunization and the health sector, based on the data found in this assessment, three conclusions can be made:

- Donor interest in the country is unlikely to decrease. Long-term sustainability is not an urgent requirement or a risk. Service delivery to all communities should remain a prime consideration;
- The financial risk primarily involves GPEI funding and could be mitigated by mainstreaming critical functions of routine immunization and other disease control programs. For example, polio SIAs are an expensive short-term activity. These activities could be integrated with (and funded by) other, similar campaigns (measles, yellow fever and Td). Outbreak response is required less frequently in the absence of any polio case reports for more than five years, and given that the country is headed toward elimination status by mid-2020, and if it were required more frequently, should be transferred to health emergencies. IPV has already become part of routine immunization. There is a potential risk related to retention of staff for training, monitoring, and supervision of activities, which is currently funded largely by GPEI. This staff is currently the backbone of immunization delivery as well as polio-specific activities. This type of bold transition will require significant change in how the GPEI currently operates as well as sustained advocacy and transfer of functions to the respective programs and entities. The current GPEI strategy does not promote integration with other initiatives except for routine immunization for IPV and OPV, and adding OPV to other SIAs.
- Polio surveillance functions need to be integrated with those addressed in the BHI plan to cover multiple diseases (e.g., Ebola and

pandemic influenza, for which several activities are being implemented at present related to the adoption of protocols, training programs, etc.). Once a platform is established, more common diseases such as cholera, measles, and yellow fever could be added. This is one area in which CSOs could participate in the initial stages of rollout. One experience from South Sudan in community-based surveillance has been recently published.<sup>11</sup>

The country has adopted an integrated disease surveillance platform for which protocols and training materials are already available. The strategy calls for focal points in the community to identify suspected disease and inform technical staff for follow-up and investigation. This is exactly what is envisaged with regard to the BHI plan.

#### **4.3.2 Programmatic**

Programmatic risk will depend on the role of the CSOs. Many active CSOs, both international and national, are managing the recurrent humanitarian crisis in South Sudan by providing HR support, and essential medicines and vaccines (in crisis situations), and conducting large national/subnational vaccine campaigns. Thanks to the Comprehensive Peace Agreement of 2005, South Sudan started receiving direct attention and assistance from organizations like Gavi much before it became independent. Since then, there has been priority attention and large investments into the immunization program, including from the GPEI. These investments led to large-scale hiring of technical personnel, who in due course, performed tasks beyond polio, notably routine immunization and surveillance for other VPDs. This did not happen by design but was the result of the need to fill the vacuum in the absence of other programs. The decline in GPEI funding will require CSOs to pick up a greater share of implementation responsibility.

<sup>11</sup> <https://www.ajtmh.org/content/journals/10.4269/ajtmh.19-0120>

It is therefore assumed that the transition of the polio program, which calls for a massive scale-down of technical personnel employed with polio program resources, poses a threat to the sustenance of not just polio-related activities but the entire immunization program. GPEI funding ramp down has already begun and is slated for completion by 2024 (the timeline for the 2018–2022 PTP has been extended by two years).

An attempt was made during polio program transition planning to map all organizations. The CSOs were engaged only during SIAs for mobilization of communities and identifying volunteers and have little capacity for all the essential tasks for achieving and maintaining polio eradication in South Sudan. The CSOs will need extensive capacity building to take on the above needs.

## 4.4 Polio transition opportunities

South Sudan's polio program transition presents opportunities to scale up and consolidate immunization service delivery, supported by the development partners and CSOs, largely due to four main factors: 1) the country's history of conflict, 2) technical and financial dependence, 3) weak health/immunization systems, and 4) the current rebuilding of the country's health/immunization infrastructure and systems.

- **History of in-country conflict.** Ongoing conflict in South Sudan has led to extremely fragile government structures and broken systems. Consequently, the current infrastructure is grossly inadequate, in terms of both health facilities and HR. The country's independence was achieved in July 2011 but was quickly followed by internal ethnic clashes. Given this context, it cannot be expected that the government and its systems will have adequate national resources and capacity for many years to come.

- **Technical and financial dependence.** World Bank data shows that GNI per capita in South Sudan fell sharply from 2015 to 2016 (from \$820 to \$390). Current estimates are that external assistance provides 70% of the country's health expenditure. The bulk of the health expenditures are private / out-of-pocket, with the government contributing 1.6% of GDP (see financing details elsewhere in this report). The protracted fragility and poverty prevents the establishment of strong and sustainable health systems, triggering a bigger role for the CSOs.
- **Weak immunization/health systems.** Weak health system and immunization programs have led to the frequent occurrence of outbreaks of VPDs. The WHO-UNICEF immunization coverage estimate for South Sudan in 2017 was 26%, the second lowest worldwide (for 2018, coverage reached 49%), underscoring the urgent need to fast-track immunization service delivery.
- **Rebuilding of the country's health/immunization infrastructure and systems.** Significant large-scale initiatives have given impetus to rebuilding the country's health/immunization infrastructure and systems. These include the adoption of the BHI, which outlines a vision for establishing a comprehensive primary health care system at all levels; substantial support through the HPF 3 (in eight states) and the World Bank (in two states); substantial support through the Global Fund to Fight AIDS, Tuberculosis, and Malaria and Gavi (Global Fund), with the latter in the form of vaccines and immunization supplies, and substantial cash support through Gavi's HSS funding stream.

In addressing the gaps above, there is a potential role for CSO engagement in three main areas: organization and representation, advocacy support, and service delivery. All CSO activities would be carried out according to the country's BHI and BPHS strategies.

#### 4.4.1 Organization & representation

Given the fragile context in South Sudan, CSOs play a major role in health care—from advocacy activities to service delivery. However, two main challenges limit the effect of current CSO engagement:

- a lack of coordination among them, and with the government and WHO/UNICEF, the main stakeholders for the immunization program.
- the fragmentation of CSO activities, which are often time-limited, and may comprise projects across multiple organizations, leading to overlap and wasted resource.

The CSOs' contribution is not explicitly visible to the national government or major multilateral organizations. This reduces their ability for a strategic influence that would be crucial for immunization outcomes. There is a need to create a platform for the CSOs to increase visibility, coordinate the activities, share lessons and synergize resources.

The BHI calls for the establishment of two coordination forums at the state level—a technical working group, and a stakeholders' forum. Active CSOs in the respective state/county would be part of both forums. The technical working group would harness the technical capabilities of the various entities (individuals and organizations). The stakeholders' forum would be coordinated through a lead representative. Representation activities would be carried out by the organization with largest presence and coverage in the respective state/county. All active CSOs would simultaneously form their own coordination group for periodic information sharing and discussion of challenges and opportunities. Pushing for mapping at the outset of these activities could be a non-starter, given that these organizations differ widely in terms of their mandate, strengths, and influence in the country. Therefore, it is recommended that CSO engagement begin in the form of informal groups.

#### 4.4.2 Advocacy support

Historically, CSOs have played a key role in South Sudan in advocacy for several public health programs, starting with HIV in the 1990s. For immunization activities, the following activities would benefit from support from CSOs within the context of the GPEI wind down:

- strengthening of immunization financing,
- addressing low coverage,
- integrating services and linkages among stakeholders,
- improving vaccination records.

##### a) Strengthening immunization financing

South Sudan does not allocate any funds for its immunization program and is exempt from the cofinancing requirement for Gavi support. CSOs could use a coordination platform to advocate collectively for government allocation of domestic funding for immunization.

In addition, CSOs are well positioned to advocate with UN partners and donors for increased investment in immunization, including its positioning as a core indicator of progress on the BPHS. This could help fill another gap, as UNICEF/HPF funded projects do not explicitly focus on immunization. Currently, the BPHS has multiple monitoring indicators, whereas immunization performance could be a measure of overall progress of the BPHS. Indirectly, this will drive the immunization agenda in the country and help promote the effective integration of relevant polio assets to ensure that these resources are not lost with the wind down of GPEI support.

##### b) Addressing low coverage

South Sudan has locked itself into low coverage for many years. CSOs could advocate with government, partners, and donors to implement large-scale use of mobile health clinics and other tailored outreach strategies for hard-to-reach communities, which could

help break this coverage barrier and (as outlined in the service delivery section below) support the government in implementing these activities.

### **c) Improving vaccination records**

At present, maintaining immunization records for South Sudanese children is a challenge. Introducing home-based records for all children would help address it. CSOs could advocate with the government, UN partners, and donors, for the introduction of home-based records, backed up with a strong education campaign (this recommendation is described in more detail below as a potential area for service delivery support).

### **d) Integrating services and linkages among stakeholders**

There is a lack of integration of services and linkages among CSOs, partners, and government in South Sudan and a need to coordinate activities, share lessons learned, and synergize resources. CSOs could advocate for the integration of services and linkages among these stakeholders.

## **4.4.3 Service delivery**

There are four areas for potential CSO participation in South Sudan's immunization service delivery:

- tailoring immunization activities in crisis-related situations
- building and scaling up HR capacities for service delivery
- building awareness of and demand for immunization in communities
- using name-based data for monitoring progress and tracking defaulters at the community level.

### **a) Tailoring immunization activities in crisis-related situations**

The GPEI wind down will result in a loss of resources for accessing the hardest-to-reach children and vulnerable communities, for both routine immunization and SIAs.

In South Sudan, there are three types of populations: stable, IDP, and returnees (from IDP camps outside and inside the country). There are an estimated 2 million IDPs, and another 1.9 million people migrating to neighboring countries. The service delivery strategies for these groups should be different. For example, the stable population should continue to be reached by routine health facilities or outreach sessions, while children in IDP camps should be accessed through one-time or periodic immunization campaigns. Returnees from IDP camps and migration require catch-up vaccination for missed antigens first and are then reenrolled in the routine systems of their respective communities. In each of three populations, CSOs could work with implementing partners/government to reach more children and increase coverage.

### **b) Building and scaling up HR capacities for service delivery**

HR availability and capacity are dual challenges for field vaccinators and managers of planning and supervision. Any intervention to increase HR capacity—expanding the number of staff with outreach to bomas, for example, and their competencies—will help the country address this bottleneck.

*The South Sudan Red Cross (SSRC) has a roster of well-respected volunteers (about 12,000), including many with a professional background. SSRC is also recognized for its contribution to the BHI, including its*

*volunteer manual (Community-Based Health and First Aid, CBHFA), which influenced the design of social mobilizer and CHW work responsibilities. SSRC volunteers are good potential candidates for training on the provision of immunization services, especially in the payams/bomas, which may lack trained vaccinators. These areas could be mapped to determine gaps and interested volunteers could be recruited for an intense, competency-based training program for CHWs/vaccinators. This could be initiated as a pilot project by SSRC for three years, covering two to four states with five to 10 counties. The project area could be determined based on the overlap of strong state branches of SSRC with underperforming counties. The potential states could be Eastern Equatoria, Western Bahar el Gazal, Western Lakes, and Wau. The objective should be to train 500 volunteers in the delivery of immunization services. In contrast to the South Sudan government and UN organizations, the Red Cross is perceived as neutral and thus more acceptable in areas of conflict. The major weakness of the SSRC is the lack of regular funding and thus longtime sustainability.*

CSOs could train community health workers (CHWs) to develop competencies consistent with GPEI-funded CHWs as well as CHWs implementing the BHI plan. The training should include competencies in the following skills: listing of all families/beneficiaries; maintaining real-time immunization data by name and habitation; defaulter tracing; social mobilization for demand creation; vaccination delivery (oral and injectable); and community-based surveillance. If funded by a donor, the intervention will pave a way

for resolving a critical HR issue in the country. South Sudan has a major challenge from HR shortages and this type of initiative will create a pool of competent health workers as will be required when the government evolves to a more stable situation.

The CSOs could take on projects in which they could train existing volunteers and supplement the health workforce across all states. This mandate already exists as part of the BPHS, funded by the HPF and UNICEF.

### **c) Building awareness and demand for immunization in communities**

The most peripheral unit of administration in South Sudan is the boma, which consists of three to four villages. For approximately 7,500 villages in South Sudan, there is a need to create a nucleus of knowledge for childhood immunization—why it is required and where to seek services. A social movement could be created in the country and one recommendation would be to train roughly 15,000 volunteers/workers countrywide. This would become an asset that would stay through irrespective of crisis situations. Physical facilities, equipment, and drugs can be destroyed in violence, but not knowledge or experience.

Good training strategies, programs, and materials are already available. Accelerating this will require a program approach. A dedicated training program may be developed by one or more CSOs and implemented in two phases: the first one, for its own workers/volunteers, the second one for others. This would complement the Government of South Sudan's vision and not be seen as competition to development partners.

The functions of the community-based workforce, including what is expected from social mobilizers and CHWs, are described in the MCH section of the BHI plan.

► **Boma Health Initiative**

**Social mobilizers**

- Health education: awareness for immunization uptake
- Mobilization of communities for outreach services

**Community health workers**

- Community mobilization for routine and mass vaccination, VPD surveillance, surveillance for adverse effects following vaccination, and immunization defaulter tracking
- Vaccination: carry out vaccination and create awareness on VPDs, effectiveness of vaccination, side effects, and the community vaccination program
- Passive and active community-based integrated disease surveillance and response (IDSR), including campaigns against VPDs

CSOs could take on projects to provide a full range of services, with priority given to creating awareness and demand for immunization. These projects could begin as pilots and then be scaled up across states. Once again, HPF and UNICEF-funded CSOs have the opportunity to move in this direction.

**d) Community-level monitoring**

Innovative ways for monitoring of individual children by CHWs/volunteers are needed. This would require two interventions: the introduction of home-based records and the use of name-based data for monitoring real-time progress and tracking defaulters. Monitoring could be enhanced with the use of tools such as a color-coding system to flag the immunization status of children 6 to 24 months (“red child,” no vaccinations; “orange child,” partially immunized; “green child,” fully immunized), described below.

Figure 3

Example of a color-coding system for child immunization status

**“Zero-dose”**

No vaccinations prior to color-coding



**“Partially-immunized”**

Received one or more doses of any vaccine from any source—SIA, health facility, hospital, mobile team, outreach session



**“Protected”**

Received all doses of routine vaccines applicable for age



The goal of the community health worker/volunteer would be to move individual children from the red and orange categories to the green (“protected”) category. At the aggregate level, the progressive percentages could be used to measure program performance in the village or community.

*“Historically, CSOs have played a key role in South Sudan in advocacy for several public health programs, starting with HIV in the 1990s.”*



© UNICEF/UN0230337/Elfrington

CSOs could help advocate for the introduction of home-based records. However, the mere printing and distribution of immunization cards is insufficient and must be accompanied by a strong education program. CSOs would be well suited to support the government in educating communities and families on the importance of retaining home-based

records. CSOs can leverage innovation more easily than government. Donors may be more interested in sponsoring a CSO activity, as a pilot or in some other form, because impact could be assessed through data quality improvements and higher-quality population surveys. Linking these records with school entry could enhance the demand for immunization.

**Figure 4**

**SWOT analysis of CSO engagement in South Sudan**

<p style="text-align: center;"><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Access to “last mile” communities and unreached populations and IPDs in conflict settings</li> <li>• Large workforce of volunteers and workers</li> <li>• Acceptance by the government</li> </ul>	<p style="text-align: center;"><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Current lack of any mechanism for coordination among CSOs and between CSOs and UN/government stakeholders</li> <li>• Technical capabilities generally weak and not uniform</li> <li>• Geographic outreach limited</li> </ul>
<p style="text-align: center;"><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Future vision adopted through BHI</li> <li>• Educating communities about immunization to increase confidence in vaccination and mitigate the spread of misinformation</li> <li>• Harmonizing efforts among CSOs and other health stakeholders to scale up the impact of relevant interventions</li> <li>• Increased emphasis on immunization due to the polio program transition and low immunization coverage</li> </ul>	<p style="text-align: center;"><b>Threats</b></p> <ul style="list-style-type: none"> <li>• Limited funding opportunities</li> <li>• Donor expectations for showing results in short timeframe</li> <li>• Lack of solutions for contextual barriers, including the fact that half the population is inaccessible for six months each year, making it difficult for the government to monitor the performance of the health system etc.</li> <li>• Risk of continued conflict disrupting health services</li> </ul>

**Source:** Prepared by author, based on assessment





# Recommendations for stakeholders

5



## 5

# Recommendations for stakeholders

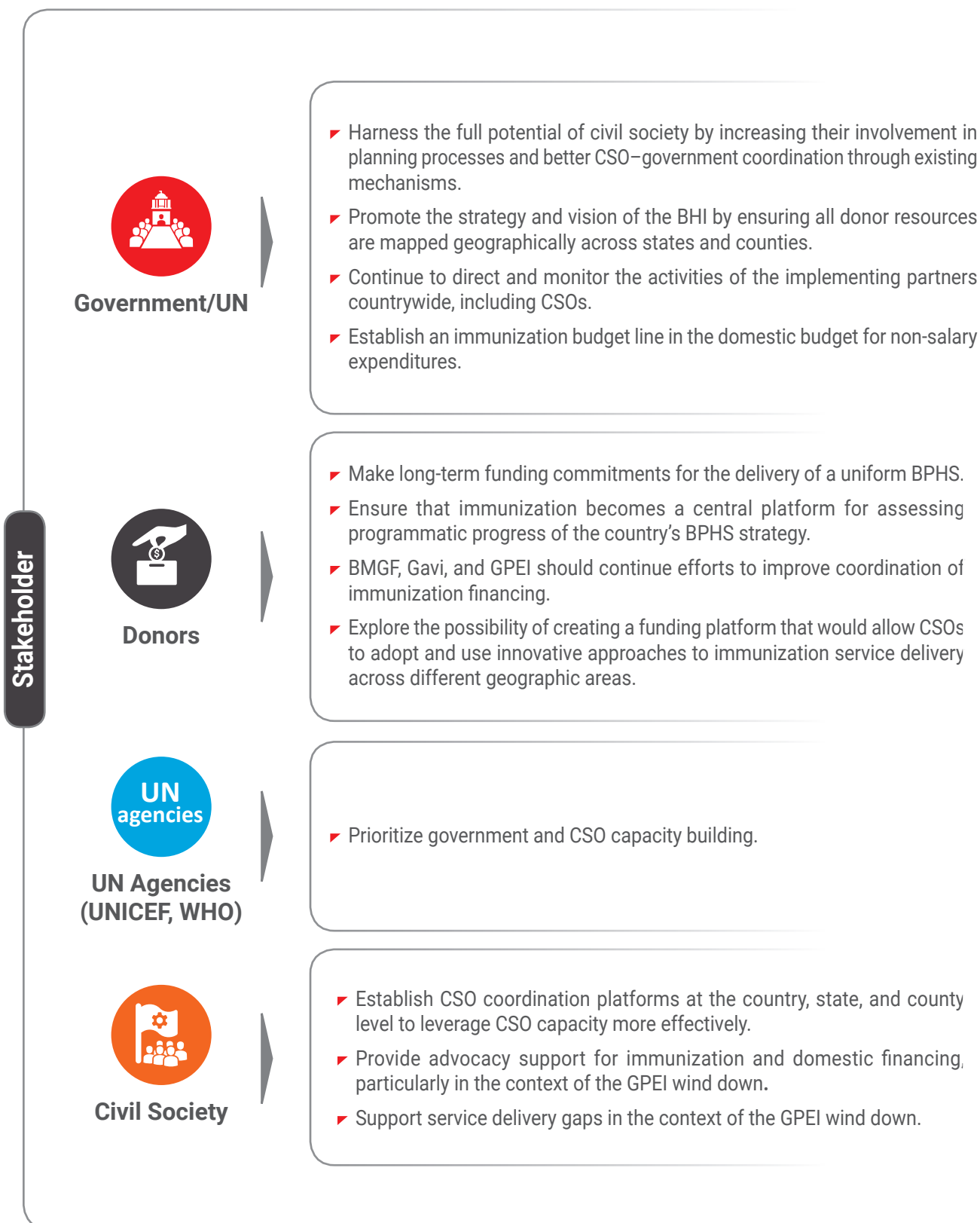
This review has summarized the many challenges and possibilities of the polio program transition and provided several recommendations for addressing them. GPEI resources fund staff and activities for development partners (WHO, UNICEF) and critical government positions, as well as incentives for vaccinators and managers. These positions will be affected by the GPEI wind down. GPEI resources are also providing crucial support for South Sudan's broader surveillance systems, including the ability to collect granular data on missed children and social mobilization for routine immunization and campaigns. As GPEI funding continues to wind down, ideally the government should fill these gaps. However, given the state of the country's challenges, it is likely that CSOs will have to meet these needs in many of the abovementioned areas. There are, however, opportunities for some critical functions to be passed over and integrated with other broader efforts. For example, IPV campaigns could be carried as part of routine immunization; community surveillance could be integrated with the BHI plan (although the laboratory network would need to be involved for certain communicable diseases); polio SIAs could be integrated with SIAs for other vaccines; and outbreak response for cVDPV could be managed by health emergency operations. However, further analysis is needed

to estimate the financial impact of the GPEI wind down accurately and plan effectively. For example, it would be helpful to understand how Gavi resources (primarily provided through HSS grants, additional grants under the Gavi fragility policy, and technical assistance to UNICEF, WHO, and other partners) interact with GPEI financing. Gavi conducts a good analysis of immunization financing in many countries completing their polio program transition, but information on the same process in low-income countries like South Sudan is limited. This gap could be addressed by advocacy for domestic financing for more analysis.

Four stakeholder groups could contribute to a smooth polio transition process in South Sudan: government (at different levels); donors (including BMGF, Gavi HPF, and World Bank); the UN system implementing partners (with WHO and UNICEF as the lead agencies); and CSOs. The recommendations listed below are designed to harness the potential of the civil society constituency in South Sudan. All stakeholders are expected to direct their resources to create an enabling environment for success. The summary of recommendations for each stakeholder group are outlined below - and the details for each respective subset of recommendations can be found on the following pages.

<sup>12</sup> <https://www.gavi.org/programmes-impact/programmatic-policies/fragility-emergencies-and-refugees-policy>

## Summary of recommendations for each stakeholder



## 5.1 Government of South Sudan



1

**Harness civil society's full potential by increasing their involvement in planning processes and improving CSO and government coordination through existing mechanisms.**

CSOs bring an important perspective and should be invited to contribute to joint planning exercises with government and partners. Government could leverage CSOs' unique skill sets to enhance social mobilization efforts, access hard-to-reach communities, and expand the trained workforce.

2

**Promote the strategy and vision of the BHI by ensuring that all donor resources are mapped geographically across states and counties.**

Donor resources should be mapped geographically across states and counties, as is being done through the HPF and World Bank projects.

3

**Continue to direct and monitor the activities of implementing partners countrywide.**

Due to government capacity issues, partner activities should be well coordinated, with clear articulation of the contributions of all BHI implementing partners. Mapping the activities (and budget) of the implementing partners based on their programmatic capacity, geographic presence, and resources will help ensure that all of them, including CSOs, are being fully and efficiently leveraged.

4

**Establish an immunization budget line in the domestic budget for non-salary expenditures.**

There should be domestic resources dedicated to non-salary expenditures for immunization (e.g., procurement of basic EPI vaccines, monitoring performance of different partners).

## 5.2 Donors



1

**Make long-term funding commitments for delivery of a uniform BPHS for the duration of the country's health strategy.**

Current funding commitments by Gavi (under the fragility policy), HPF, and World Bank only extend for a period of two years. Long-term funding commitments would support a uniform BPHS for the duration of the country's health strategy.

2

**Ensure that immunization becomes a central platform for assessing programmatic progress of the country's BPHS strategy.**

Immunization should be perceived as a BPHS delivery platform and not just the delivery of vaccine shots to children. Immunization could be positioned as the strongest pull factor to communities. In later years, the provision of nutrition supplements, hygiene kits, and insecticide-treated nets for malaria prevention could be effective pull factors for communities to primary health services. A good start could be made with the current funding support from the HPF 3 and World Bank. The polio program transition provides a unique opportunity that should be recognized and utilized by immunization partners.

3

**BMGF, Gavi, and GPEI should continue to improve coordination of immunization financing.**

Improved coordination among donors on immunization financing would lead to administrative efficiencies and reduce both the monitoring load and the potential for duplication of financing.

4

**Explore the creation of a funding platform that would allow CSOs to practice innovative approaches to immunization service delivery and/or joint advocacy across different geographic areas.**

At present, direct funding opportunities for CSOs are primarily led by BMGF and USAID. Some CSOs have been involved as implementing partners contracted by HPF or UNICEF. There is a gap in dedicated funding for a coordination platform that would allow CSOs to adopt and apply innovative approaches to service delivery and/or joint advocacy across geographic areas or thematic interventions. Government, both national and state, and the UN system, led by WHO and UNICEF, operate in unison, while CSOs often end up as contractors for service delivery in a fragile country. A partnership model could be more productive, provided there are funding opportunities that allow for creative and innovative CSO efforts. Major funders like BMGF, Gavi, HPF, and World Bank could explore the creation of such a mechanism in South Sudan.

## 5.3 UN agencies (UNICEF, WHO)

### UN agencies

1

#### **Prioritize building capacities of the government and CSOs.**

The UN system has a central role to play in building the capacity of the government and implementing partners. At present, the UN system has a “de-facto” implementation role in polio and broader immunization activities. As government capacity is built, the implementation role should be gradually taken over by government staff. The experiences of the polio program and best practices could be used to build these capacities, including skills in microplanning, supportive supervision, supply management, demand generation, and use of data for decision-making. Both UN and civil society stakeholders will provide critical support to the government within the context of the GPEI wind down.

## 5.4 Civil Society



Recommendations for civil society engagement in polio program transition activities are divided into three categories:



**Organization & Representation**



**Advocacy Support**



**Service Delivery**

## Recommendations for civil society

Category	Gap	Recommendation
 <b>Organization &amp; representation</b>	Lack of coordination among CSOs, resulting in overlap, wasted resources, competition for funding, and low visibility	<ul style="list-style-type: none"> <li>Establish a CSO platform (nongovernment, non-UN) for all international nongovernmental development organizations (INGDOs) and national CSOs, and map CSO activities across all states.</li> </ul>
	Lack of CSO coordination between CSOs and partners (government and WHO/UNICEF)	<ul style="list-style-type: none"> <li>Participate at the national and state level (e.g., Inter-agency Coordination Committee, ICC) in an engaged and systematic manner versus ad hoc/ token participation.</li> </ul>
 <b>Advocacy support</b>	Lack of immunization funding	<ul style="list-style-type: none"> <li>Advocate through a CSO platform for the government to allocate domestic funding for immunization.</li> <li>Advocate with main funders (specifically those for UNICEF-/HPF-funded projects) and implementing organizations for the use of immunization performance as a core indicator for BPHS progress.</li> </ul>
	Low immunization coverage	<ul style="list-style-type: none"> <li>Advocate with government, partners, and donors for the implementation and large-scale use of mobile health clinics and other outreach strategies tailored for hard-to-reach communities.</li> </ul>
	Issues with maintaining immunization records	<ul style="list-style-type: none"> <li>Advocate with the government for home-based immunization records, supported with education campaigns.</li> </ul>
	Lack of integration of services and linkages among CSOs, partners, and government	<ul style="list-style-type: none"> <li>Advocate for integration of services and linkages among CSOs, partners, and the government.</li> </ul>
 <b>Service delivery</b>	Lack of access to children in IDP camps and returnees from IDP camps (inside and outside the country)	<ul style="list-style-type: none"> <li>Work with government and implementing partners to help develop effective, tailor-made approaches for reaching IDP camps and returning refugees with immunization services.</li> <li>Work with government and implementing partners to help implement these tailored strategies.</li> </ul>
	HR gaps at the community level	<ul style="list-style-type: none"> <li>Train CHWs to develop competencies<sup>13</sup> like those of GPEI-funded CHWs and CHWs implementing the BHI.</li> <li>Train existing volunteers and supplement the health workforce across states. (This mandate is already in place as part of the BPHS, funded by the HPF and UNICEF.)</li> </ul>
	Lack of awareness about immunization and where the services can be accessed	<ul style="list-style-type: none"> <li>Take up projects to create awareness of and demand for immunization.</li> <li>Strengthen/create a cadre of village-based social mobilizers to educate communities on immunization services.</li> </ul>
	Absence of data monitoring tools at the community level	<ul style="list-style-type: none"> <li>Dovetail / harmonize existing tools and create a CHW-friendly tool for use at the community level to allow for real-time information on coverage, progress, and defaulter tracking.</li> <li>Support introduction of home-based records for all children and educate families on the importance of retaining home-based records.</li> </ul>

<sup>13</sup>Maintaining home-based immunization; maintaining real-time immunization data by name and household location; defaulter tracking; social mobilization for immunization demand generation; delivery; and community-based surveillance.



# Conclusions

6





## 6

# Conclusions

The massive scale-down of personnel employed with GPEI financing in South Sudan poses a threat to the sustenance of not just polio-related activities but the entire immunization program. CSOs can add value by advocating for integration of polio program assets with the broader health system and pushing (domestically and externally) for adequate, long-term funding of key personnel.

The GPEI wind down, combined with the fragile context of South Sudan, provides an important opportunity for CSOs to continue to play an active role in:

- ensuring access to immunization services in areas where government services are nonexistent or weak,
- integrating immunization with humanitarian work for special population groups, such as IDPs and returning refugees,
- supplementing HR shortages and competencies,
- contributing to strategy discussions through the development of a CSO coordination platform and/or by participating in government forums, and
- creating practical data collection and monitoring tools for use at the community level.

All CSO activities should be in line with the government's BHI.

Given that the health needs of the population are extensive and government systems are unlikely to be established in the near future, South Sudan will continue to attract large humanitarian and development assistance. CSOs currently implement many immunization services, and the wind down of GPEI provides an opportunity for these organizations to step up their contributions and support the country's efforts to integrate these vital functions going forward.



© UNICEF/UNI317152/Ryeng

**+CIFRC**

[www.ifrc.org](http://www.ifrc.org)

#### Disclaimer

Disclaimer: The findings, interpretations, recommendations, and conclusions in this publication do not necessarily represent the views or imply the expression of any opinion whatsoever on the part of the stakeholders and agencies mentioned in report. All reasonable precautions have been taken to verify the information contained in this publication. However, IFRC does not guarantee the accuracy of the data included in this publication. The responsibility for the interpretation and use of the material lies with the reader.