



# Strategic Preparedness, Readiness and Response Plan COVID-19

South Sudan

1 June 2022-31 May 2023

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## Executive summary

An intra-action review (IAR) was conducted on 23-24 May 2022 to share lessons learned and best practices of South Sudan's COVID-19 response between 1 June 2021 and 31 May 2022 as outlined in the second National COVID-19 Strategic Preparedness and Response Plan (SPRP). The outcomes of the IAR will be incorporated in this updated, third SPRP, which will run from 1 June 2022 to 31 May 2023.

The second year of the COVID-19 pandemic in South Sudan was negatively affected by lack of funding for most COVID-19 response interventions. Activities like sample collection, community surveillance, mortality surveillance, and contact tracing were discontinued, impacting the country's ability to test and trace cases.

The impediment to test and trace cases hampered the ability to swiftly mobilize national and State-level Rapid Response Teams (RRT) to investigate (clusters of) COVID-19 cases.

The low number of cases and deaths reported as a result, has significantly impacted the overall population's risk perception of COVID-19. With a very low perceived risk, people have been reluctant to wear face masks, maintain physical distancing and to get vaccinated. This is further aggravated by the lack of enforcement to adherence to these public health measures. It is crucial that Law Enforcement Agencies become involved to reinforce adherence to recommended preventive measures at all levels, for COVID-19 or any other infectious disease.

Furthermore, lack of contact tracing has also resulted in 74% of positive cases being lost to follow up, with the remainder of cases treated through Home-based Care. While many health facilities in the country established isolation facilities for suspected and confirmed COVID-19 cases, there was limited funding for dedicated health workers. Health partners had to prioritize their health workers for more pressing health matters.

Because of stigma, people preferred to be isolated at home, instead of in an isolation facility. Home-based care has also been hindered by lack of incentives for dedicated community health workers. Only in some locations where NGO partners decided to integrate contact tracing and home-based care in community-based health programs, has the system been operationalised. At the same time, there is no possibility to enforce suspected and confirmed COVID-19 cases to isolate in line with existing quarantine and isolation guidance.

Since the start of the pandemic, South Sudan has had just one dedicated treatment centre for severe and critical COVID-19 cases, based in the capital Juba. The Infectious Disease Unit (IDU) is fully equipped in line with WHO international standards and run by an international NGO with specialised staff who are regularly trained on the latest developments. The limited capacity within the health system to early detect COVID-19 among high risk groups, has resulted in late referrals and a relatively high mortality at the IDU. No further funding is available to maintain the IDU until end June 2022, after which it will be handed over to the MOH.

The roll out of COVID-19 vaccination was delayed by unavailability of vaccines and insufficient funding until the late 2021-early 2022. Difficult access to large parts of the country, due to lack of infrastructure, insecurity, and flooding has slowed down the implementation of regular and intensified COVID-19 vaccination activities.

In spite of these challenges, South Sudan managed to vaccinate 7% of its population by 23 May 2022. Thanks to these efforts by implementing partners with support from the United Nations Humanitarian Air Service (UNHAS) for transport of vaccines, the country managed to mobilize sufficient vaccines as well as funding earmarked for operational expenses for COVID-19 vaccination.

Similarly, coordinated by the Logistics Cluster, South Sudan benefited from sufficient supplies of PPE (face masks, coveralls and hand sanitizers) and an efficient system to distribute and deliver these supplies to NGO partners. Still many health facilities report stock out of PPE, mostly due to lack of knowledge how to replenish supplies, or low risk perception.

There has also been a sufficient supply of laboratory reagents for RT-PCR testing, however testing was challenged by lack of incentives for health workers to collect samples, as well as the actual testing itself. Many laboratory staff were therefore recruited by private laboratories, seriously affecting the functioning of the National Public Health Laboratory (NPHL) in Juba, as well as the Molecular Laboratory established for this specific purpose at the Wau Teaching Hospital.

The roll out of antigen rapid diagnostics tests (Ag RDT) for COVID-19 throughout South Sudan was slow, causing several Ag RDTs to expire before being used. While many NGO partners are currently using Ag RDTs, reporting remains a challenge, with many partners not bothering to send reports back to the NPHL if all results are negative. An increase in Ag RDT positivity rate during the first 5 months of 2022 confirms COVID-19 is still circulating in South Sudan. Where testing is done, cases are found.

South Sudan has received 39M USD from the Global Fund COVID-19 Response Mechanism (C19-RM) through UNDP and various sub-recipients for surveillance, laboratory, and case management until end 2023. Most of the funding is for construction, procurement of supplies, and training activities, while only a small amount can be used for incentives for health staff.

South Sudan has also received approximately 48.3M USD from different donors for COVID-19 vaccination, the majority of which (29M USD) from the World Bank through UNICEF until end 2023. An additional 35M USD is allocated by the World Bank for the procurement of vaccines.

While the country's COVID-19 response seems well-funded, many core interventions cannot be implemented as the available funding does not allow for payment of incentives of health workers, unless it is for COVID-19 vaccination. As long as the government is unable to pay adequate salaries to its health workers, the country's response to COVID-19 will remain dependent on donor funding through the payment of incentives to health staff.

Unfortunately, dedicated COVID-19 incentives have led to a much lower coverage for child-hood immunization, as vaccinators prefer to be engaged in COVID-19 vaccination, neglecting other Vaccine Preventable Diseases.

The integration of COVID-19 response interventions into routine health programs aims to address many of the above challenges.

With below 10% of the population fully vaccinated against COVID-19, porous borders and limited control measures, South Sudan remains at elevated risk of further surges in COVID-19 cases, especially in view of the potential emergence of new variants.

# Overview and objectives

## Situation overview

Since the first COVID-19 case was confirmed in South Sudan on 5 April 2020, South Sudan experienced three waves: the first wave from May to July 2020, the second wave from January to April 2021, and the third wave from December 2021 to January 2022. (See Figure 1).

Because of limited testing and weak surveillance, as of 9 May 2022, only 17,513 confirmed COVID-19 cases including 138 deaths have been reported in South Sudan since the start of the pandemic.

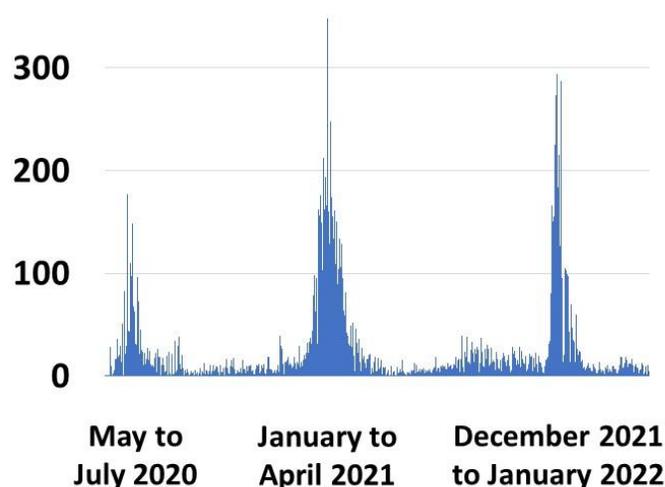
A household sero-prevalence survey conducted in Juba during August and September 2020 estimated that 38.5% of participants had antibodies for SARS-CoV-2, confirming COVID-19 had spread extensively within Juba. A health facility prevalence survey conducted in 7 locations throughout the country during December 2021 and February 2022 shows an overall positivity of 18.7% among participants.

Both surveys confirm significant underreporting of COVID-19 cases and deaths in South Sudan.

Regular genomic sequencing has identified that the BA.1 and BA.2 sub-lineages of the Omicron variant are currently dominant in South Sudan. Earlier, the Alpha [B.1.1.7], Beta [B.1.351], and Delta [B.1.617.2] variants of concern were detected in the country.

With only 7.6% of the population fully vaccinated against COVID-19 by 31 May 2022, South Sudan remains at elevated risk of further surges in cases, especially in view of the potential emergence of new variants.

**Figure 1: COVID-19 cases in South Sudan**  
5 April 2020- 31 May 2022



## Response Plans and Intra Action Reviews

South Sudan's COVID-19 response has been outlined in two National COVID-19 Strategic Preparedness and Response Plans (SRPP):

1. from April 2020 to March 2021, and
2. from June 2021 to May 2022.

The Plans and their implementation have been subjected to three Intra-Action Reviews (IAR):

1. on 26-27 October 2020,
2. on 5-6 August 2021, and
3. on 23-24 May 2022

This newly updated SRPP which runs from 1 June 2022 to 31 May 2023 aims to guide the country's response for the third year of the pandemic, incorporating lessons learned and best practices from the latest IAR.

## Scenarios

### Best Case Scenario

- Situation continues as is, with low average cases and low positivity rate
- No new variants emerge
- Current vaccine continues to be effective, increase in COVID-19 vaccination coverage to 45% (entire population over the age of 18).

### Worst Case Scenario

- New variant emerges which is more transmissible with more severe outcome
- Health system overwhelmed due to more severe illness
- Current vaccine is not protecting against this variant, a new vaccine needs to be developed, need to restart vaccination from scratch.

### Most Realistic Scenario

- New surge in cases, but because of low testing, no significant change in response
- New variant emerges, but because of low testing, no significant change in response
- Current vaccine continues to be effective, increase in COVID-19 vaccination coverage to 20%

## Strategic objectives

South Sudan follows the global strategic objectives set by WHO in the ***Strategic Preparedness, Readiness and Response Plan to End the Global COVID-19 Emergency in 2022*** issued in March 2022 (Figure 2).

**Figure 2: Strategic objectives to end the global COVID-19 health emergency<sup>i</sup>**



**Overall objective:** Reduce morbidity and mortality from COVID-19 by protecting individuals (especially the vulnerable) from exposure and reducing risk of future variants.

**Specific Objectives:**

1. Enable MOH Public Health Emergency Operations Centre (PHEOC) to effectively coordinate preparedness and response to public health threats and emergencies, including COVID-19 **(Pillar 1: Coordination)**
2. Reduce the negative impacts of COVID-19 through sharing of accurate, consistent, easy-to-understand, and empathic messaging in local languages through trusted channels of communication **(Pillar 2: Risk communication and community engagement)**
3. Enable informed decision-making for appropriate and proportionate public health measures through comprehensive epidemiological data collection and analysis **(Pillar 3: Surveillance)**
4. Reduce the risk of transmission of COVID-19 through rapid detection of imported cases at points of entry **(Pillar 4: Points of Entry, Mass Gatherings)**
5. Enable informed decision-making for COVID-19 response through large-scale testing for COVID-19 and regular genomic sequencing for monitoring of variants **(Pillar 5: Laboratory and Diagnostics)**
6. Reduce COVID-19 transmission in health facilities through consistent and appropriate infection prevention and control (IPC) practices **(Pillar 6: Infection Prevention and Control and Protecting, Supporting and Enabling the Health Workforce)**
7. Prevent severe and critical disease through early detection of COVID-19 infection among high-risk groups and adequate treatment and follow up at household level **(Pillar 7: Case Management)**
8. Enable COVID-19 response in the country through rapid distribution of continuously available essential supplies **(Pillar 8: Operational support and logistics)**
9. Minimize the negative impact that COVID-19 has had on other essential health services by allocating COVID-19 funding to strengthening the health system **(Pillar 9: Maintaining essential health services)**
10. Reduce morbidity and mortality from COVID-19 by protecting individuals (especially the vulnerable) through vaccination, by fully vaccinating 70% of the target population **(Pillar 10: Vaccination)**

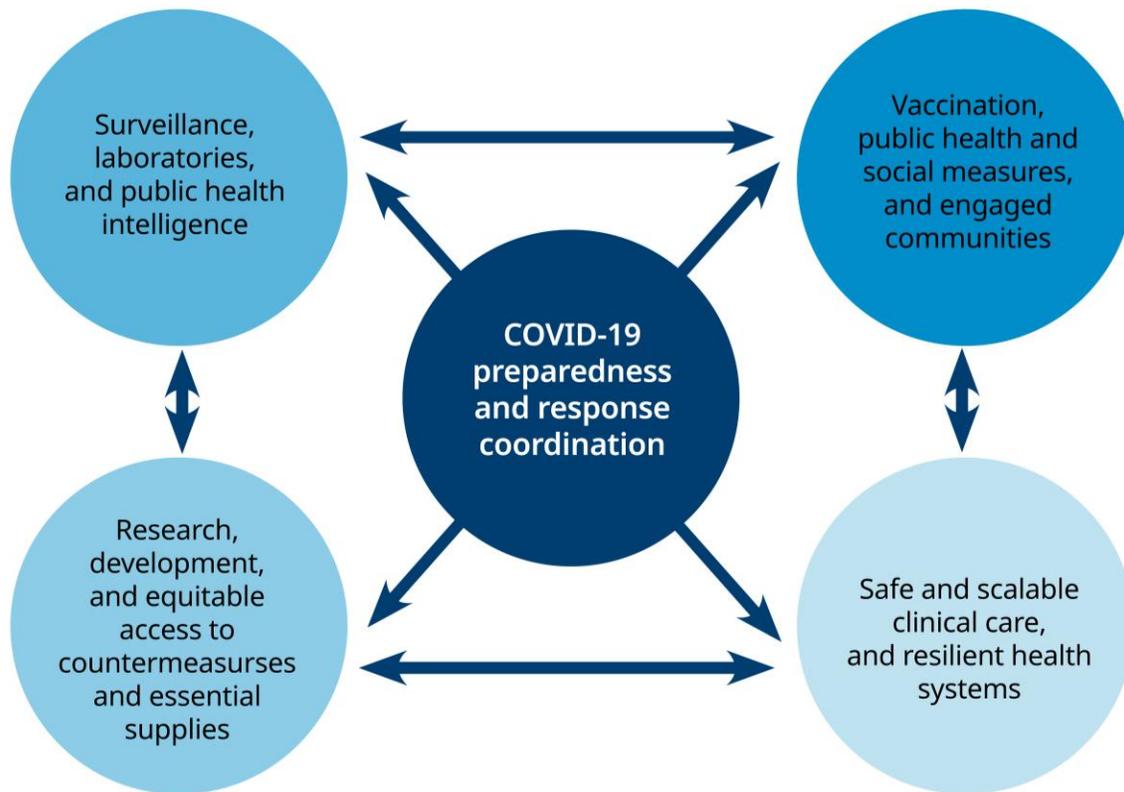
## COVID-19 Response

Similar to the strategic objectives, South Sudan follows WHO's latest **Strategic Preparedness, Readiness and Response Plan to End the Global COVID-19 Emergency in 2022** ensuring the five core components of COVID-19 preparedness, readiness and response are incorporated in its national response plan.

Participants attending the IAR on 23-24 May 2022 unanimously agreed for all pillars to strongly focus on the need for enhanced:

- integration of COVID-19 response interventions in routine health programs,
- decentralization of preparedness and response mechanisms,
- effective advocacy with senior government officials.

**Figure 3: Five core components of COVID-19 preparedness, readiness and response<sup>i</sup>**



As per South Sudan's COVID-19 incident management structure, the current response will continue to be aligned by the different response pillars.

The below costed strategic priorities per pillar focuses on those potentially life-saving interventions for which no financial commitment exists, while including those that are well covered by available funding.

## Pillar 1: Coordination

South Sudan's COVID-19 response is being coordinated according to the Incident Management System (IMS), under the auspices of the Ministry of Health (MOH). Weekly National Steering Committee (NSC) meetings chaired by the MOH COVID-19 Incident Manager bring together the active Technical Working Groups (TWG) representing the various response pillars for consultation on COVID-19 policies. The NSC is furthermore charged with providing guidance to the National Task Force (NTF) as the ultimate decision-making body in the country on COVID-19 measures.

Thanks to efforts from CDC, ICAP and WHO, the IMS system is in the process of being decentralized to the State level. All State Ministry of Health (SMOH) Director Generals were trained on IMS for preparedness and response to public health emergencies during a workshop conducted in May 2022. Additional activities are planned to support the SMOH with the actual implementation of the IMS.

A crucial part of SPRP 2022-23 is joint supportive supervision, enabling MOH and partners to monitor the progress of all COVID-19 response interventions on the ground, allowing for corrective measures where need be.

In 2021, the second floor of the MOH's public health emergency operation centre (PHEOC) was opened with support from WHO, further facilitating the coordination of public health emergencies in the country. The PHEOC is the central place where all stakeholders come together for COVID-19 response, as well as any other disease outbreaks in the country. It is strategically located next to the National Public Health Laboratory (NPHL), on the same compound which hosts key functions like the Data Management unit, the call centre, and the Rapid Response Team (RRT) coordination unit.

However, the functioning of the PHEOC has been challenged with funding cuts for incentive payment of key staff, limiting its ability to operate 24/7. As many donors prioritize funding for infrastructural investments, less money is available for staffing costs.

This SPRP 2022-23 seeks the longer-term commitment for continued operations of the PHEOC particularly in the form of incentives, (emergency) fuel for power generation, internet connectivity, and other.

An intra-action review is planned at any stage of the implementation period of the SPRP 2022-23, where relevant feedback is required from key stakeholders based on ongoing developments in the pandemic.

**Specific Objective:** Enable MOH Public Health Emergency Operations Centre (PHEOC) to effectively coordinate preparedness and response to public health threats and emergencies, including COVID-19

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 1: Coordination</b>	<b>600,000</b>	<b>350,000</b>	<b>250,000</b>
Operational expenses for PHEOC for 1 year period	250,000	125,000	125,000
Training on IMS and PHEOC for State and County level MOH	250,000	125,000	125,000
Joint supportive supervision	50,000	50,000	-
Intra-action review 2023	50,000	50,000	-

## Pillar 2: Risk communication and community engagement

The RCCE TWG has undergone several reviews during the second half of 2021 and the first half of 2022. A large number of partners are involved in the RCCE TWG, which is chaired by the MOH Health Promotion department, and co-chaired by UNICEF. Recent efforts are mostly focused on vaccination, with the majority of rumours circulating in the community related to vaccines, rooted in the low risk perception of COVID-19 among the population, due to the continuous low number of cases and deaths reported.

While the COVID-19 response aims to increase testing through the expansion of antigen rapid diagnostics tests (Ag RDTs) in the country, it is not expected this will have a major impact on people's willingness to adhere to public health measures. The RCCE TWG is therefore trying to convince people to get vaccinated, by debunking false information on the perceived risk of vaccines, as well as by promoting the effectiveness of vaccines.

Close coordination between the RCCE TWG and the COVID-19 vaccination TWG is crucial to ensure messaging is aligned with ongoing vaccination activities, with messages needing to be accurate and up-to-date. Due to the many unknowns of COVID-19 as a new disease, it has not always been feasible to be consistent with messaging to the broader population during the first 2 years of the pandemic. While a new emerging variant may once again be the cause of confusion, RCCE partners are now well skilled in addressing the pitfalls of potentially contradictory messaging around COVID-19.

Fortunately, demand generation and social mobilization of vaccines are areas most partners are well familiar with. Challenges are with the target population of the COVID-19 vaccine, which is the overall population over 18, as compared to more specific populations, such as children, for other types of vaccines. However, effective engagement with community leaders, religious leaders, women leaders, and others remains key to building trust among the population, for promotion of the vaccine. The use of local channels of communication, like community radios, are furthermore contributing to broad dissemination of key messages to large parts of the population.

Another challenge has been the lack of high-level political involvement in COVID-19 response, and vaccination more specifically. Reluctance to wear facemasks by national political leaders worked counterproductive in the promotion of protective measures for COVID-19 among the broader population. Also, very few politicians were willing to get vaccinated on TV, which did not help to convince people of the importance of the vaccine.

Therefore, high-level advocacy at national level, as well as State and County level are seen as important means to involve political leaders in COVID-19 response, further encouraging the broader population about the effectiveness of imposed measures.

The budget for demand generation for vaccination was prepared by the RCCE TWG.

**Specific Objective:** *Reduce the negative impacts of COVID-19 through sharing of accurate, consistent, easy-to-understand, and empathic messaging in local languages through trusted channels of communication*

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 2: RCCE</b>	<b>12,668,638</b>	<b>4,734,265</b>	<b>7,934,373</b>
Demand generation for vaccination at all levels	7,918,638	4,734,265	3,184,373
Training for community health workers	4,000,000	-	4,000,000
Advocacy with media	250,000	-	250,000
High-level advocacy events at all levels	500,000	-	500,000

## Pillar 3: Surveillance

With donor funding prioritizing mostly COVID-19 vaccination, no additional funding is expected to revive discontinued interventions like community surveillance, sample collection, mortality surveillance, and contact tracing. The strategic direction is to integrate these key COVID-19 response interventions in existing community-based platforms, such as the Boma Health Initiative (BHI), to ensure sustainability.

Integration of SARS-CoV2 surveillance with influenza-like illness (ILI), acute respiratory infection (ARI), severe acute respiratory infection (SARI) surveillance at sentinel sites is ongoing, while State-level RRTs are being trained COVID-19 on Ag RDTs.

State Ministries of Health (SMOH) can provide clear directions on the importance to use existing structures like the BHI for COVID-19 surveillance and testing in their areas of concern, using Ag RDTs, as well as to analyse State and County-level data for informed decision-making and sharing with the national level.

At the same time, efforts are underway to integrate COVID-19 epidemiological surveillance systems in the broader Health Management Information System (HMIS) using DHIS2. The strengthening of HMIS is costed under Pillar 9: Maintaining essential health services.

***Specific Objective:*** Enable informed decision-making for appropriate and proportionate public health measures through comprehensive epidemiological data collection and analysis

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 3: Surveillance</b>	<b>2,000,000</b>	<b>725,000</b>	<b>1,275,000</b>
Training of Surveillance Officers	225,000	225,000	-
Training for community health workers	1,000,000	-	1,000,000
Sentinel surveillance system at selected sites	250,000	250,000	-
Coordination meetings at State and County level	75,000	-	75,000

## Pillar 4: Points of Entry

South Sudan borders 5 countries (CAR, DRC, Kenya, Sudan, and Uganda), but only has 23 border crossings. Only 2 crossings currently have screening in place for COVID-19: Juba International Airport (JIA), and Nimule, bordering Uganda, where an estimated 600 trucks enter and exit the country on a daily basis. Surveillance at JIA and Nimule aims to minimise the number of imported COVID-19 cases, and to provide a snapshot of the COVID-19 situation among in-bound travellers. Positive cases at border screening points are currently lost to follow up. SMOH jointly with County Health Directors (CHDs) in border areas can advocate for enhanced coordination with nearby health facilities, and for better awareness among border personnel.

***Specific Objective:*** Reduce the risk of transmission of COVID-19 through rapid detection of imported cases at points of entry

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 4: Points of Entry</b>	<b>975,000</b>	<b>200,000</b>	<b>775,000</b>
Support to Port Health Facility at Juba International Airport	400,000	200,000	200,000
Support to Port Health facility at Nimule Ground Crossing	400,000	-	400,000
Operational expenses for Ag RDT and RT-PCR testing at Nimule	125,000	-	125,000
Refresher training for border and migration personnel	50,000	-	50,000

## Pillar 5: Laboratories and diagnostics

SMOH can play a pivotal role in forcing health facilities in their areas of concern to use Ag RDTs for COVID-19 and to submit daily reports on Ag RDT testing to the adequate channels. The more health facilities use Ag RDT and report their results back on a daily basis, the more complete a picture South Sudan has about its COVID-19 cases in the country, particularly in more remote areas.

While the National Public Health Laboratory (NPHL) is eager to establish its own genomic surveillance capacity, the Global Fund has twice declined this proposal. It is therefore recommended to further improve NPHL's capacity to prepare samples for shipment to reference laboratories, taking advantage of available resources from ICAP and WHO.

Another key priority is for NPHL to implement a quality assurance system for the molecular, GeneXpert, and Ag-RDT platforms in line with existing SOPs, targeting all partners currently supporting diagnostics, including private laboratories.

Thanks to the Global Fund, there is a sufficient supply of laboratory reagents for RT-PCR testing, GeneXpert cartridges and Ag RDT kits available for the country until end 2023. The main challenge has been the lack of incentives for health workers to collect samples, as well as the actual testing itself. Many laboratory staff were recruited by private laboratories, seriously affecting the functioning of the NPHL in Juba, as well as the Molecular Laboratory established for this specific purpose at the Wau Teaching Hospital.

The budget is based on available Global Fund money for the procurement of essential laboratory supplies. The SPRP 2022-23 aims to mobilize funding for NPHL staff incentives, as the only under-funded but essential budget line required for continuous laboratory operations.

**Specific Objective:** *Enable informed decision-making for COVID-19 response through large-scale testing for COVID-19 and regular genomic sequencing for monitoring of variants*

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 5: Laboratories and diagnostics</b>	<b>2,212,511</b>	<b>1,953,852</b>	<b>200,000</b>
Test supplies (Ag RDT, PCR reagents, GeneXpert cartridges)	491,341	491,341	-
Sample collection kits	310,887	310,887	-
PPE, disinfectants, sanitizers, soaps, etc	671,893	671,893	-
Training for Ag RDT roll-out	129,776	129,776	-
Training for NPHL and Wau lab	62,124	62,124	-
NPHL and Wau laboratory staffing cost	250,000	50,000	200,000
Genomic sequencing	100,000	100,000	-
Strengthening EQA	137,831	137,831	-

## Pillar 6: Infection Prevention and Control and Protecting the Health Workforce

The focus of the IPC pillar is to establish a proper IPC program at national level, aimed at institutionalizing IPC in all health facilities. The budget is based on the IPC Multi-Year Strategic Plan (2022-2027), which was endorsed by MOH, including the minimum IPC requirement score card.

**Specific Objective:** Reduce COVID-19 transmission in health facilities through consistent and appropriate infection prevention and control (IPC) practices

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 6: IPC</b>	<b>498,287</b>	<b>211,964</b>	<b>286,323</b>
Institutionalization of IPC program, TWG, national strategy	286,323		286,323
Develop IPC Guidelines, TOT, simulation, cascaded training	211,964	211,964	-

## Pillar 7: Case Management (Integrated clinical care pathways)

Many training activities have been conducted on COVID-19 Case Management, however mostly at national level. There is an urgent need to organize (refresher) trainings for all States and Administrative Areas, to ensure ownership and support for roll-out at health facility level. Basic Emergency Care (BEC), IPC and oxygen therapy TOT is to be conducted in July 2022, focusing on a broad spectrum of diseases, including COVID-19.

To avoid the Infectious Disease Unit (IDU) from closing because of lack of funding, high-level advocacy is required to secure (government) funding to maintain this specialized treatment unit operational, not only for critical and severe COVID-19 cases, but for other infectious diseases as well.

As with other community-based interventions, COVID-19 home-based care should be integrated with the BHI, taking advantage of existent infrastructure and MOH strategic priorities. Early detection of COVID-19 infection among high-risk groups like the elderly, people with underlying health conditions, including the immunocompromised, is best done at the community or health facility level, where health workers are familiar with their clients. Properly trained (community) health workers can make life-saving diagnosis, confirmed COVID-19 infection using Ag RDTs, and isolate cases where need be.

Referral of suspected and confirmed COVID-19 cases among high-risk groups for close follow up and early treatment is key to prevent the disease from deteriorating. SMOH and CHD can play a crucial part in ensuring a minimum number of health facilities in each County are equipped for treatment of COVID-19 cases, including isolation facilities.

**Specific Objective:** Prevent severe and critical disease through early detection of COVID-19 infection among high-risk groups and adequate treatment and follow up at household level

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 7: Case Management</b>	<b>1,650,000</b>		
Coordination meetings at State and County level	100,000	-	100,000
Training for HCW in selected health facilities	400,000	200,000	200,000
Training of community health workers on home-based care	1,000,000	-	1,000,000
Supportive supervision jointly with health partners	50,000	-	50,000
Operational expenses for the oxygen plant	200,000	200,000	-
Operational expenses for the IDU	300,000	-	300,000

## Pillar 8: Operational support and logistics

While sufficient WASH and IPC supplies are available, most are stored in Juba. Prepositioning of supplies in strategic locations can be properly coordinated with partners and health authorities at State and County level, but operational expenses need to be made available for storage and last-mile delivery.

**Specific Objective:** Enable COVID-19 response in the country through rapid distribution of continuously available essential supplies

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 8: Operational support and logistics</b>			
PPE procurement	3,000,000	3,000,000	-
Distribution of PPE (e.g., UNHAS)	500,000	500,000	-
Prepositioning of PPE at State and County level	250,000	-	250,000

## Pillar 9: Maintaining essential health services

Through the humanitarian-development nexus, COVID-19 funding is being proportionally allocated to mitigate the harmful impact of the pandemic on sometimes decades of progress made in areas like routine immunization, neglected tropical diseases, mother and child health care, and HIV, TB, and malaria.

The SPRP 2022-23 focuses on several priorities that could potentially benefit a broad spectrum of programs, based on ongoing efforts by different partners, in particular the HMIS through DHIS2, the operations of a high-temperature incinerator for hazardous waste management at Juba Teaching hospital, the Intensive Care Unit at Juba Teaching hospital, as well as the operations of a virtual training centre at the college of physicians and surgeons for national wide capacity building of health care workers on infectious disease and non-communicable diseases including COVID-19.

The HMIS budget is based on the first year of a 5-year roadmap prepared by multiple stakeholders for endorsement by MOH.

**Specific Objective:** Minimize the negative impact that COVID-19 has had on other essential health services by allocating COVID-19 funding to strengthening the health system (Pillar 9: Maintaining essential health services)

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 9: Maintaining essential health services</b>	<b>13,665,328</b>	<b>125,000</b>	<b>13,540,328</b>
Strengthening of ICU	125,000	125,000	-
Strengthening of HMIS improved through DHIS 2	13,340,328	-	13,340,328
Operational expenses for the virtual training center	100,000	-	100,000
Operational expenses for the incinerator	100,000	-	100,000

## Pillar 10: Vaccination

In line with best practices identified for COVID-19 vaccination, partners should focus on outreach, combined with adequate engagement with community leaders thanks to well-trained, well-equipped social mobilizers at the community level, to ensure high-risk groups are prioritized for COVID-19 vaccination.

Recent data seems to indicate that intensified one-week COVID-19 vaccination activities are more cost-effective than 'regular' COVID-19 vaccination using fixed vaccination posts at health facilities, particularly when reaching remote populations and priority groups.

While sufficient funding is available for COVID-19 vaccination, it is unequally distributed. Some partners with pools of trained vaccinators, are unable to continue vaccination because of funding gaps. Strong leadership from MOH, WHO and UNICEF is needed to oblige donors to more transparently allocate funding to implementing partners, avoiding unnecessary duplication of efforts.

Rapid response to AEFIs at community level is essential in preventing possible misinformation to harm vaccine acceptance. Adequate training on accurately diagnosing AEFIs, correct use of AEFI kits for effective treatment and care, investigations into AEFI, reporting on AEFIs, and communicating on AEFIs with the community, all require an integrated approach with RCCE, case management, and data management components.

MOH leadership at national, State and County level can also be an important bridge in engaging with other key socio-political entities for promotion of the vaccine: parliamentarians, ministers, governors, religious leaders, and so on. These 'social influencers' can also be used to dispel persistent rumours. The importance of having champions at the community level for the spreading of accurate messaging and the debunking of untruths is equally important.

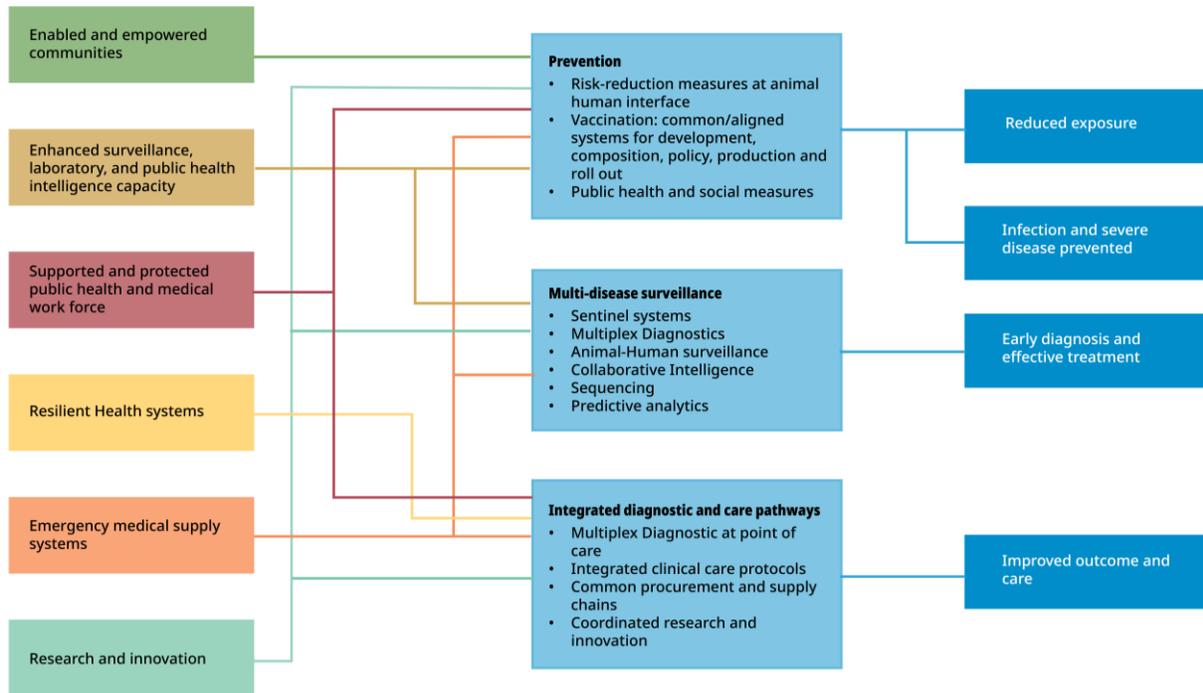
The Johnson & Johnson and Astra Zeneca have so far been the only two vaccines authorized to be used in South Sudan. Delays in the approval mechanisms for incoming shipments can be avoided through a blanket tax exemption from the Ministry of Finance. National-level MOH can possibly support in negotiating for this time-saving arrangement.

Furthermore, SMOH and CHD can play a decisive role in facilitating efforts to integrate COVID-19 vaccination in routine immunization at County level. Possibly, clearer directions from national-level MOH would be helpful to advocate for this.

***Specific Objective:*** Reduce morbidity and mortality from COVID-19 by protecting individuals (especially the vulnerable) through vaccination, by fully vaccinating 70% of the target population

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 10: Vaccination</b>	<b>37,000,000</b>	<b>26,500,000</b>	<b>10,500,000</b>
ICVOPT (7 USD per dose administered for 5M population)	35,000,000	25,000,000	10,000,000
Climate friendly cold chain	1,500,000	1,500,000	-
Integration of COVID-19 in routine immunization	500,000	-	500,000

**Figure 4: A new model for integrated respiratory pathogen prevention, detection and care <sup>i</sup>**



## Budget

	Budget	Funded	Gap
	In USD	In USD	In USD
<b>Pillar 1: Coordination</b>	600,000	350,000	250,000
<b>Pillar 2: RCCE</b>	12,668,638	4,734,265	7,934,373
<b>Pillar 3: Surveillance</b>	2,000,000	725,000	1,275,000
<b>Pillar 4: Points of Entry</b>	975,000	200,000	775,000
<b>Pillar 5: Laboratories and diagnostics</b>	2,212,511	1,953,852	200,000
<b>Pillar 6: IPC</b>	498,287	211,964	286,323
<b>Pillar 7: Case Management</b>			
<b>Pillar 8: OSL</b>			
<b>Pillar 9: Essential health services</b>	13,665,328	125,000	13,540,328
<b>Pillar 10: Vaccination</b>	37,000,000	27,000,000	10,000,000
	<b>75,419,764</b>	<b>39,200,081</b>	<b>36,161,024</b>

	Budget	Funded	Donor	Partner	Gap
	In USD	In USD			In USD
<b>Pillar 1: Coordination</b>	<b>600,000</b>	<b>350,000</b>			<b>250,000</b>
Operations of PHEOC	250,000	125,000	USG	WHO	125,000
Training on IMS for State and County level	250,000	125,000	GF	ICAP	125,000
Joint supportive supervision	50,000	50,000			-
Intra-action review 2023	50,000	50,000		UNDP	-
<b>Pillar 2: RCCE</b>	<b>12,668,638</b>	<b>4,734,265</b>			<b>7,934,373</b>
Demand generation for vaccination	7,918,638	4,734,265	Various		3,184,373
Training for community health workers	4,000,000	-			4,000,000
Advocacy with media	250,000	-			250,000
High-level advocacy events at all levels	500,000	-			500,000
<b>Pillar 3: Surveillance</b>	<b>2,000,000</b>	<b>725,000</b>			<b>1,275,000</b>
Integration of data systems into DHIS2	450,000	250,000	GF	ICAP	200,000
Training of Surveillance Officers	225,000	225,000	GF	ICAP	-
Training for community health workers	1,000,000	-	-	-	1,000,000
Sentinel surveillance system	250,000	250,000	USAID	WHO	-
Coordination meetings with SMOH and CHD	75,000	-	-	-	75,000
<b>Pillar 4: Points of Entry</b>	<b>975,000</b>	<b>200,000</b>			<b>775,000</b>
Support to Port Health Facility at JIA	400,000	200,000	USAID	IOM	200,000
Support to Port Health facility at Nimule	400,000	-	-	-	400,000
Operational expenses for Nimule testing	125,000	-	-	-	125,000
Training for border and migration personnel	50,000	-	-	-	50,000
<b>Pillar 5: Laboratories and diagnostics</b>	<b>2,212,511</b>	<b>1,953,852</b>			<b>200,000</b>
Supplies (Ag RDT, PCR reagents, cartridges)	491,341	491,341	GF	UNDP	-
Sample collection kits	310,887	310,887			-
PPE, disinfectants, sanitizers, soaps, etc	671,893	671,893			-
Training for Ag RDT roll-out	129,776	129,776			-
Training for NPHL and Wau lab	62,124	62,124			-
NPHL and Wau laboratory staffing cost	250,000	50,000	Various		200,000
Genomic sequencing	100,000	100,000	GF	UNDP	-
Strengthening EQA	137,831	137,831			-

**South Sudan COVID-19 Strategic Preparedness, Readiness and Response Plan**  
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	<b>Budget</b>	<b>Funded</b>	<b>Donor</b>	<b>Partner</b>	<b>Gap</b>
	In USD	In USD			In USD
<b>Pillar 6: IPC</b>	<b>498,287</b>	<b>211,964</b>			<b>286,323</b>
Institutionalization of IPC program, TWG	286,323	-	-	-	286,323
Develop IPC Guidelines, simulation, training	211,964	211,964	France	WHO	-
<b>Pillar 7: Case Management</b>	<b>2,050,000</b>	<b>400,000</b>			<b>1,650,000</b>
Coordination at State and County level	100,000	-	-	-	100,000
Training for HCW in selected health facilities	400,000	200,000	France	WHO	200,000
Training of CHW on home-based care	1,000,000	-	-	-	1,000,000
Joint supportive supervision	50,000	-	-	-	50,000
Operations of oxygen plant	200,000	200,000	GF	UNDP	-
Operations of IDU	300,000	-	-	-	300,000
<b>Pillar 8: Operational support and logistics</b>	<b>3,750,000</b>	<b>3,500,000</b>			<b>250,000</b>
PPE procurement	3,000,000	3,000,000	GF	UNDP	-
Distribution of PPE (e.g., UNHAS)	500,000	500,000			-
Prepositioning of PPE at State and County	250,000	-			250,000
<b>Pillar 9: Maintaining essential health services</b>	<b>13,665,328</b>	<b>125,000</b>			<b>13,540,328</b>
Strengthening of ICU	125,000	125,000	USG	WHO	-
Strengthening of HMIS through DHIS 2	13,340,328	-	-	-	13,340,328
Operations of virtual training center	100,000	-	-	-	100,000
Operations of incinerator	100,000	-	-	-	100,000
<b>Pillar 10: Vaccination</b>	<b>37,000,000</b>	<b>27,000,000</b>			<b>10,000,000</b>
ICVOPT (7 USD per dose for 5M population)	35,000,000	25,000,000	WB	UNICEF	10,000,000
Climate friendly cold chain	1,500,000	1,500,000			-
Integration of COVID-19 in RI	500,000	500,000	GAVI	WHO	-

<sup>i</sup> Strategic Preparedness, Readiness and Response Plan to End the Global COVID-19 Emergency in 2022, WHO, March 2022