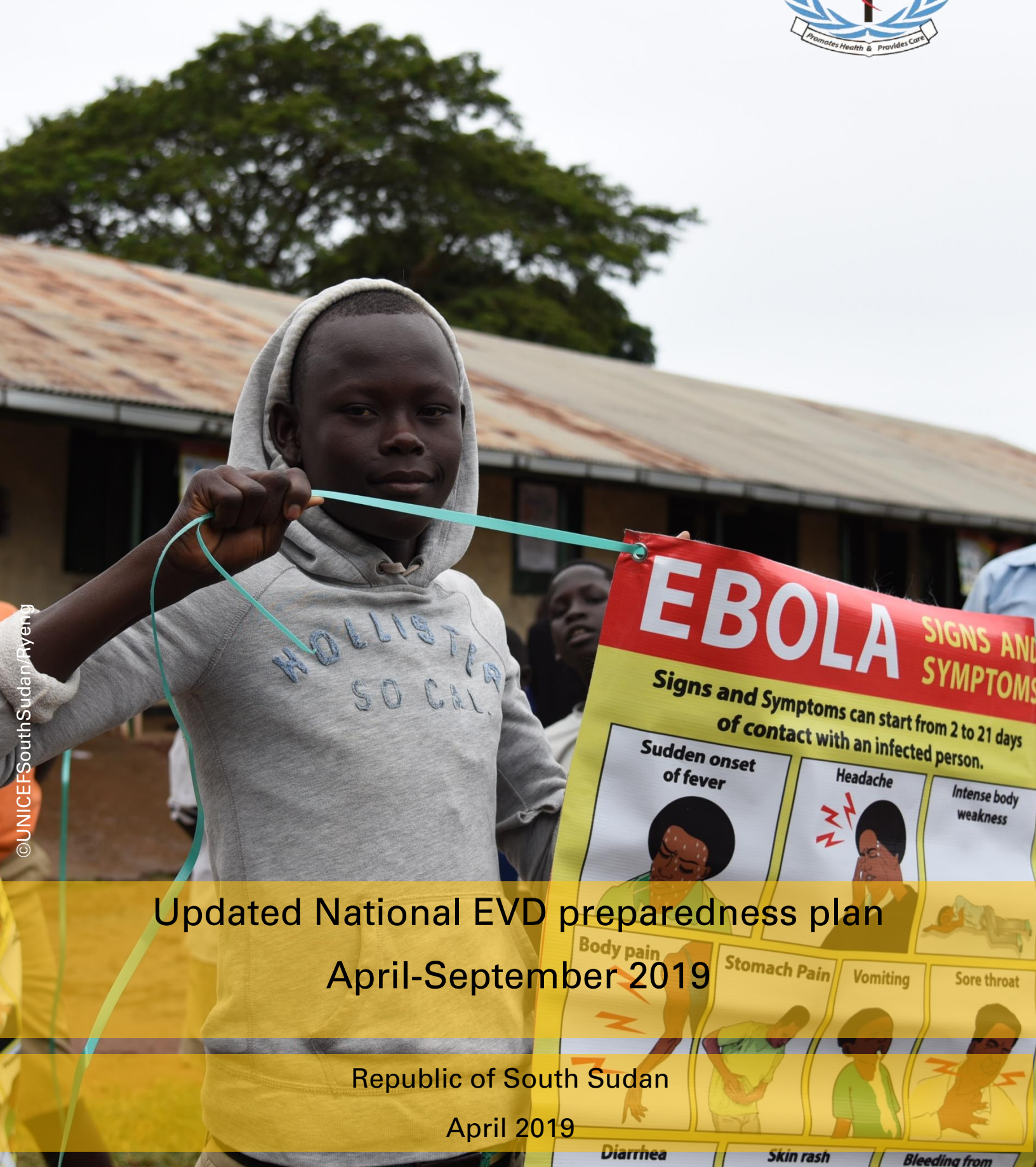




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EBOLA SIGNS AND SYMPTOMS

Signs and Symptoms can start from 2 to 21 days of contact with an infected person.

Sudden onset of fever 	Headache 	Intense body weakness
Body pain 	Stomach Pain 	Vomiting
Diarrhea 	Skin rash 	Bleeding from

Updated National EVD preparedness plan April-September 2019

Republic of South Sudan

April 2019

Acknowledgements

This document reflects the dedicated work of a wide array of stakeholders working on Ebola virus disease (EVD) preparedness and response in South Sudan. The updated EVD Preparedness Plan covers the period from April to September 2019, building on achievements under the previous plan from August 2018 to March 2019. It identifies prioritized activities and commensurate financial requirements under different pillars, to strengthen a coordinated and effective preparedness effort.

The plan has been developed under the auspices of the EVD National Task Force, with analysis and inputs from the Leads, Co-leads and members of Technical Working Groups concerned with different components of the work. The process has brought together the Ministry of Health, donors, non-governmental organizations and UN Agencies, including Health and WASH cluster partners. I would like to express my sincere appreciation to AAH, ACROSS, AMLIMA, AMREF, ARC, Canada, CDC, CERF, CMMB, CONCERN, COPE, CORDAID, CUAMM, DFCA, ECHO, ECSS, GAVI, Germany, GOAL, HELP, HLSS, HPF, IFRC, IMC-UK, Internews, IOM, IRC, JICA, MEDAIR, MSF, OXFAM, REACH, SAC, Samaritan's Purse, Save the Children, Solidarity International, SPLA, Ministry of Interior, SSDO, SSHF, SSRC, SSUHA, TRISS, UK/DFID, UMCOR, UNHCR, UNDP, UNICEF, UNMISS, UNOCHA, USAID/OFDA, WFP, WHO, World Bank, WVSS, and all other entities and individuals that have contributed to the development of the plan and the ongoing preparedness work.

I would also like to extend my thanks to the ad-hoc team that spearheaded and coordinated the planning process, including CDC, DFID, UNICEF, UNOCHA, WFP and WHO; and to UNICEF for its support with the final design and layout of the document.

Finally, I would like to take this opportunity to extend my gratitude to the Honourable Dr Riek Gai Kok, Minister of Health, Republic of South Sudan, for his guidance and oversight of the national EVD preparedness endeavour.

Dr Makur Matur Kariom

Undersecretary of Health

April 2019

Juba, Republic of South Sudan

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Summary

The ongoing and escalating Ebola Virus Disease (EVD) outbreak in the Democratic Republic of Congo (DRC) remains a serious public health threat to South Sudan. Since the outbreak in DRC was announced in August 2018, the Government of South Sudan and its partners have been working collectively to carry out activities in high-risk locations¹ to prevent the spread of EVD to the country, and to enhance readiness to respond in the event of an outbreak.

Between August 2018 and March 2019, under the first iteration of the EVD Preparedness Plan, South Sudan's preparedness has improved significantly, as recognized by the findings of successive Joint Monitoring Missions (JMMs). Generous and timely donor contributions have enabled, amongst others, the setting up of 24 functioning screening sites at border points of entry; the establishment of four isolation units with dedicated ambulances; the training of 900 frontline health care workers and community volunteers on signs, symptoms and protective measures, including infection prevention and control; the training and equipping of 28 Rapid Response Teams (RRTs) to respond to alerts; and the pre-positioning of personal protective equipment (PPE) in high-risk locations including screening and surveillance points.

This second iteration of the EVD Preparedness Plan, covering the period from April to September 2019, consolidates and sustains achievements to date, while prioritizing other critical activities to prevent and control a possible Ebola outbreak in South Sudan.

An additional **\$12 million** is required to reach the required preparedness thresholds. Priorities include:

1. Maintaining improvements made in **surveillance and screening**; enhancing **supervision of isolation units**; and continuing the **training cadres of health professionals** through on the job mentoring and regular supportive supervision;
2. Strengthening and expanding **risk communications and community mobilization**; increasing targeted **training of health and community workers**; upgrading three holding units to **establish three additional phase two isolation unit status**; enhancing **coordination structures**; and consolidating **information management and reporting**; and
3. Improving **community surveillance**; and putting in place a **72-hour response plan**.

The plan has been developed by the EVD National Task Force (NTF), based on inputs from respective Technical Working Groups (TWGs). It is intended to inform all stakeholders about the focus and prioritization of prevention and preparedness activities to be conducted over the coming six months, guiding the deployment of technical and financial resources.

¹ Gbudwe, Jubek, Maridi, Tambura, Torit, Wau and Yei River states under current administrative structures; located within former states of Central, Eastern and Western Equatoria, and Western Bahr al Ghazal.

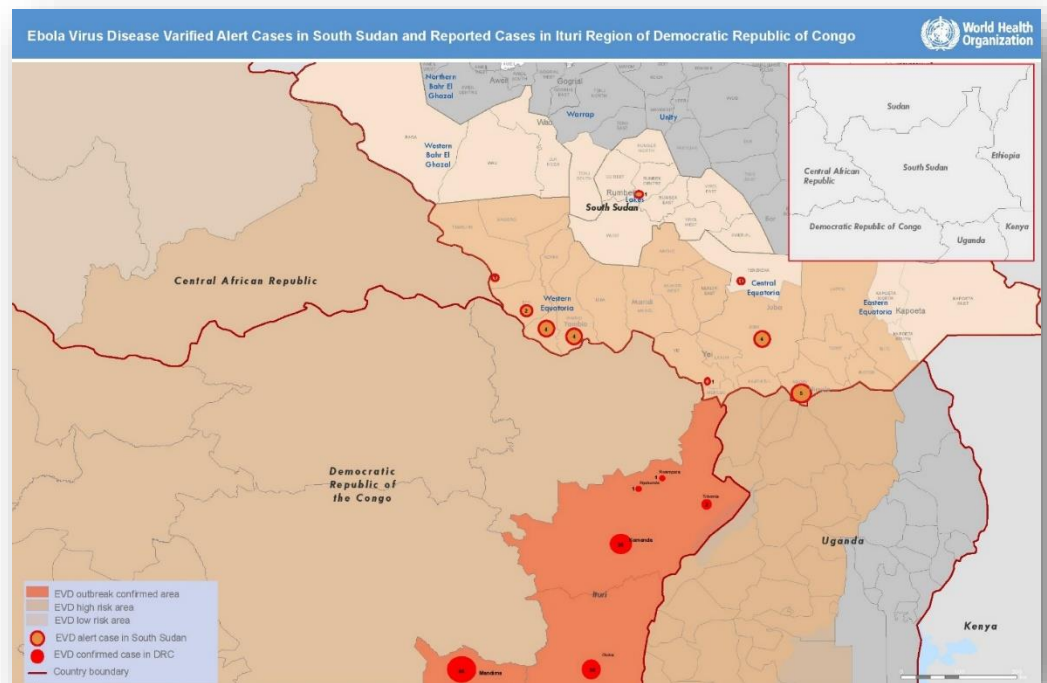
Introduction

The ongoing EVD outbreak in DRC, which started in August 2018, remains a serious public health threat to South Sudan. As of 10 April, 1,206 cases had been reported in North Kivu and Ituri provinces, resulting in 764 deaths, with a risk of spread to neighbouring countries². With the upward trend in reported cases, ongoing insecurity including attacks on EVD response teams, and public mistrust in response measures, the outbreak in DRC is unlikely to be contained soon. It is, therefore, vital that South Sudan continues to strengthen its prevention and preparedness measures.

South Sudan has experienced three outbreaks of EVD, in 1976, 1979 and 2004, in Nzara, Maridi, and Yambio respectively³. The geographic scope of these outbreaks was limited, primarily due to poor road transport, the absence of air connections and the low volume and slow rate of population movement.

Increasing travel and trade, conflict and displacement, and the deterioration of health systems have changed the context, however, increasing the potential for importation and rapid spread of EVD.

There are two likely routes of EVD importation to South Sudan, directly from DRC or via Uganda. In addition, the possibility of an indigenous outbreak of EVD in South Sudan cannot be discounted. Based on geographic proximity to the provinces in DRC experiencing the current outbreak, the volume of travel and trade, and the previous history of EVD in the country, seven states have been assessed to be at highest risk of transmission, namely Gbudwe, Jubek, Maridi, Tambura, Torit, Wau, and Yei River⁴.



² <https://www.who.int/ebola/situation-reports/drc-2018/en/>

³ https://www.who.int/Ebola_fact_sheet_formatted_23Dec2014.pdf

⁴ South Sudan follows a five-tier administrative structure: Federal, State, County, Payam and Boma administrations. The designation of states used in this document follows current administrative arrangements following decrees promulgated in 2015 and 2017.

First iteration of the EVD preparedness plan, August 2018- March 2019

The Government of South Sudan and partners designed and implemented the first preparedness plan with a financial requirement of S\$16.2 million, of which was 78 per cent was secured. The primary focus was on screening and surveillance in high-risk locations. Using a generic checklist developed by WHO at global level, independent Joint Monitoring Missions (JMMs) assessed the overall level of readiness as 17 per cent in November 2018, increasing to 62 per cent in March 2019.

Improvements were most notable in terms of coordination, epidemiology/surveillance, laboratory, case management, risk communication, border health and safe and dignified burial⁵. Progress, albeit at a slower pace, was identified regarding vaccination of frontline health workers, with nearly half the target reached by mid-March and the absence of serious adverse effects⁶.

Some 900 health care workers, frontline workers, community volunteers and military personnel were trained on EVD surveillance (detection, alert and investigation), management of suspected and confirmed cases, laboratory safety procedures, safe and dignified burial, risk communication and social mobilization, and infection prevention and control (IPC) in the high-risk states. An Emergency Operations Center (EOC)⁷ supports a free hotline to report EVD alerts. 28 Rapid Response Teams (RRTs) are in place. Local capacity for GeneXpert testing is established, with referral arrangements in place for PCR testing at a WHO collaborating center at Uganda Virology Research Institute (UVRI) to enable early detection of infections before the body produces antibodies.



The toll-free
Ebola number
is 6666

Key results from the first national EVD plan:



24
screening
points



4
isolation
units



900
frontliners
trained



28 rapid
response
teams

⁵ Briefings and summary presentations, and final report of the JMM, March 2019.

⁶ Start-up was delayed until February 2019 owing to the need for specialized training, importation of cold-chain equipment and vaccines, mapping of functional health facilities, and establishment of counselling and follow-up services.

⁷ The EOC is a multipurpose hub for all public health emergencies, with state-of-the-art conferencing facilities.

Second iteration of the EVD preparedness plan, April - September 2019

Purpose

To optimize national EVD preparedness and response by implementing proven, prioritized activities.

Critical Assumptions

Timely and comprehensive implementation of the plan is contingent upon:

- i) conditions that allow for timely and unhindered access by implementing partners to all appropriate locations. This entails high-level political commitment from all parties to the conflict and all parties engaged in the ongoing peace process;
- ii) adequate resources being available from donors, implementing partners and the public sector, including financial, material and human resources, as well as technical and logistical support;
- iii) capacity to prevent, and where required to effectively address, potential community mistrust and resistance vis a vis planned activities. This entails transparency and demonstrated commitment by the government, partners and other parties to mobilize and engage community actors; and
- iv) the situation remaining at 'phase 1', i.e. with no outbreak. In the event of case confirmation (index case, or cluster of cases), the plan identifies the need to transition to a containment phase as an interim measure to full scale response.

“
For timely and comprehensive implementation of the plan, adequate resources are necessary”

These assumptions are drawn from experiences and lessons from previous and current EVD preparedness and response initiatives. The plan will remain flexible and adapt to any newly emerging barriers and threats as a result or evolving circumstances.

Process and Prioritization

This document outlines the updated plan for the coming period, building on achievements during the preceding period while introducing additional activities to meet preparedness thresholds. Preventing and controlling a possible EVD outbreak requires establishing a critical set of activities and services.

The full, minimum package includes desired knowledge, set of skills, equipped and well-supplied healthcare facilities⁸, and rapid response teams. Missing or fragmented elements of the minimum package will impact on the safety of healthcare and frontline workers, responders and the general public, and fall short of the aim of containing a possible outbreak within a short time.

Using the agreed checklist, TWGs initially conducted a self-assessment of readiness as of March 2019 within their respective areas of responsibility, before determining activities to be carried out in the next period and commensurate financial requirements, in order to continue to increase readiness.



“ Preventing and controlling a possible EVD outbreak requires establishing a critical set of activities and services

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⁸ The lessons from ongoing outbreak in DR Congo, demonstrate averting nosocomial infection in nascent and fragile healthcare facilities is a daunting challenge. <https://www.who.int/csr/don/11-april-2019-ebola-drc/en/>

The analysis was reinforced by the recommendations of the JMM in March 2019⁹. In addition to specific observations related to each TWG, general recommendations included:

- i) establish a Secretariat under the leadership of a dedicated EVD Coordinator to strengthen the national and state level EVD preparedness coordination system;
- ii) develop a scenario-based EVD preparedness plan (builds on and is linked to six-month plan);
- iii) enhance Safety, Security and Access TWG with participation from all security organs to support EVD preparedness activities: including National Security Service, Immigration, Military Intelligence, Customs and CID.
- iv) negotiate safety of staff and access to all areas of the high-risk states especially in Yei River and Gbudwe States;
- v) strengthen Ebola health information management through additional staffing support to the National Taskforce;
- vi) engage all humanitarian and development partners to promote health systems approach; and
- vii) re-structure the Technical Working Groups.



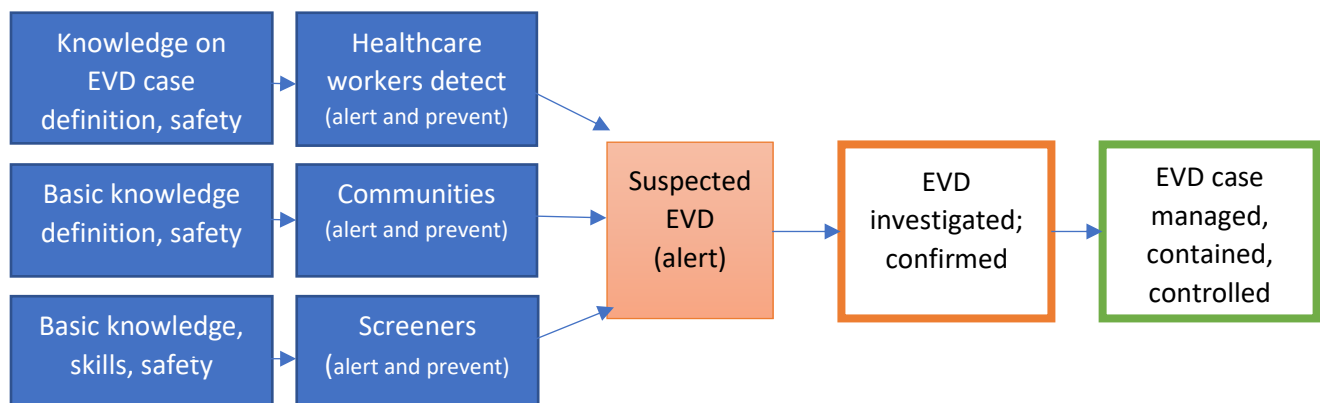
Activities and corresponding financial requirements were prioritized by considering:

- Which activities are most **critical** (if this is not done, it will hold up all other activities)?;
- What is the **minimum threshold needed** to be adequately prepared (targets are “ideal”: minimum number to start, achieve, and build up)?;
- Which activities are likely to be **feasible** (given the timeframe, resources and logistics)?

⁹ Report of the Second Joint Monitoring Mission (JMM) to South Sudan for Ebola Virus Disease Preparedness and readiness, 4-8 March 2019, draft.

Figure 1 below illustrates the pathway to prevent, manage, mitigate, and contain an EVD outbreak. As depicted, a set of knowledge and skills have to be acquired to achieve the intermediate result of detecting a suspected EVD case; which then triggers the system and a series of additional activities to confirm and manage the case, and contain to prevent further transmission. Certain activities have the potential to hold up the whole preparedness process if not implemented, and are therefore considered as high priority. Several of these are reinforcing and to be implemented simultaneously rather than sequentially.

Figure 1: Pathways to prevent, manage and control an outbreak:



The updated EVD preparedness plan also takes into account the following, when prioritizing activities and estimating associated cost requirements:

- i) activities already being implemented and where reasonable progress has been made. In such cases scaling up may not be a first-order priority, but rather to maintain existing scope while improving functionality. Examples include training on case management, IPC/WASH, and the operation of isolation facilities.
- ii) locations where scaling up existing activities, or initiating new activities, is critical. Examples include the establishment of isolation units, or an additional hub and rapid response team.
- iii) the funding landscape and likely level of resources that may become available, learning from the previous iteration of the preparedness plan.
- iv) the changing number and role of implementing partners, with increasing interest of NGOs to engage in EVD preparedness activities. In some cases the NGO may be initiating its engagement, in other cases the NGO may be diversifying and expanding its activities.

Based on the above, activities were prioritized with emphasis on consolidating gains made in the previous period; improving functionality, and where necessary expanding scope and reach of activities, while considering the six-month planning timeframe and feasibility of implementation.

Guidance for Implementation

The following serves as a guidance for implementation;

- i) **Invest in bundled activities** by function, in order to implement the whole package of standard operating procedures (SOPs) to safeguard healthcare and frontline workers, including members of rapid response teams; and prevent a possible outbreak in healthcare and community settings;
- ii) **Prioritize areas and facilities** that are strategic and with maximum returns in terms of prevention and control of a possible outbreak, even among high-risk states. These **include border counties and those with high population movement**, including high numbers of crossing points and facilities near cross-border points;
- iii) **Assign one EVD partner as responsible for each frontline health facility**, to ensure the delivery of a minimum package of preparedness activities and services, while improving accountability when sites are assessed or in the event of an outbreak;
- iv) **Fund all activities of rapid response teams before moving forward with additional teams**, investing in a limited number of fully operational teams rather than training a larger number that may not have the resources and operational support to mobilize. The NTF will need to consider when a rapid response team should be disbanded due to poor performance;
- v) **Invest in one community level package of EVD preparedness**, including community engagement, rumor and feedback monitoring, and community-based surveillance, rationalizing the geographical coverage of implementing partners.
- vi) **Solidify national level laboratory readiness** (Gene Xpert + ABI PCR platform) before expanding and decentralizing to state level, assessing functionality including skilled personnel, cartridge/reagent supplies and finance. This will avoid overstressing which could affect continuity of services at the national laboratory.
- vii) **Support a coherent package of activities for the operation of isolation facilities**, including basic maintenance, ability to scale up the number of staff and supplies if needed, singular local control and management in the event of patient care being launched, and links to transport dispatch. If an outbreak is declared, establish Ebola Treatment Center (ETC) but maintain isolation units to serve as triage of suspected cases until lab confirmation and transfer to ETC.
- viii) **Integrate monitoring**, internal and external where applicable, for each component above, rather than a separate activity of monitoring and supervision. Broader monitoring, sub-national preparedness assessments and simulation exercises will be conducted.



The NTF and TWGs will develop operational plans with emphasis on implementation of a package of EVD preparedness and response activities which are synergistic and ensure essential sets of services to protect, contain and control a possible outbreak. These operational plans will include clear roles and responsibilities, timelines and targets. Some elements of the packages such as risk communication will have broader reach than specific target geographic areas.

Partnerships

The effort of the Government of South Sudan to strengthen national EVD preparedness is supported by a range of humanitarian and development partners. These include international donors, UN agencies, non-governmental organizations (NGOs) and civil society groups. Partners are also engaged in improving access to, and quality of, humanitarian response; and in development programming including health and other social services. The implementation of the EVD preparedness plan is directed through the NTF state task forces (STFs) and the TWGs, of which these partners are members.

Building on experience from the previous period, and consistent with findings from both JMMs of November 2018 and March 2019, there is a need to define implementation arrangements more clearly. As part of this, the NTF has developed a partner matrix which will be periodically updated and includes mapping of implementing partners, including focal points and contact details; implemented activities or areas of potential engagement; geographic location; resources available; and intended duration of engagement.

The Federal Ministry of Health and State Ministries of Health are the leads for all preparedness activities, while co-leads and implementing partners may change periodically. Based on current information, Table 1 below indicates co-leads and member implementing partners under different pillars. However, it is important to recognize that the number, interest and level of engagement of partners continues to evolve.

Table 1: Mapping of partners by revised pillar, South Sudan April 2019¹⁰

Thematic/Pillar ¹¹	Co-leads (IPs)	Implementing Partners	Technical
Coordination (Secretariat/ Technical)	UNOCHA, WHO	NTF and STF members	
EVD Vaccine	WHO		CDC
Surveillance			CDC
Rapid response teams	CDC,	UNHCR, AAH, CORDAID,	
Point of Entry	WHO	IMC, WVSS, ALIMA,	
Contact tracing	IOM	CONCERN, GOAL	
Laboratory			
Case management; Infection prevention and control/WASH Safe and dignified burials	UNICEF, WHO, IFRC/SSRC	MSF (Case Management), ALIMA, AAH, CORDAID, IMC, WVSS, CONCERN, GOAL, UNHCR, MEDAIR, Health Link SS, Samaritan's Purse. Save the Children (SC), Oxfam, SSDO, Solidarity	
Risk communication, social mobilization and community engagement Psychosocial support	UNICEF	IMC, Solidarity (SI), SSDO, WVI, CONCERN, GOAL, OXFAM, UNHCR, UMCOR, SSUHA, ACROSS	
Operations and Logistics	WFP	WFP, UNICEF, WHO	
Security, Safety and Access	UNDSS/ WHO/UNMISS	IOM, OCHA, UNICEF, NGO Forum	

To ensure well-coordinated, timely and quality implementation of the plan, the NTF, STFs and TWGs will be supported with a dedicated secretariat and technical team. These are critical for the functionality of the overall coordination and implementation structures, the implementation of preparedness activities and providing guidance to different partners in the field.

Monitoring

The NTF and STFs will monitor implementation of the preparedness plan on a continuous basis using a set of key performance indicators and targets, and which provide the basis for coordination. Furthermore, periodic performance monitoring will be done through field supervision and other reviews.

¹⁰ Both geographic locations and activity areas will continue to be defined based on comparative advantages of agencies.

¹¹ Revised pillars based on the recommendations of the JMM in March 2019.

Prioritized Financial Requirements

Table 2 below sets out financial requirements to undertake prioritized activities during the six-month period of the updated preparedness plan. Costs are estimated based on targets, geographic coverage, and required activities and their corresponding scale that is feasible within the six-month period.

Table 2: Budget Summary by thematic pillar, South Sudan 2019

S/n	Pillar	Financial requirement in US\$
1	Coordination	2,777,000
2	EVD Vaccination	350,000
3.1	Surveillance (Detection and Alert)	565,000
3.2	Border Health (POE Screening)	1,161,000
3.3	Surveillance (Rapid Response)	415,000
3.4	Surveillance (Contact Tracing)	107,000
3.5	Laboratory	166,000
4.1	Case Management	420,000
4.2	IPC/WASH	2,000,000
4.3	SDB	170,000
5	Risk Communication and Social Mobilization	3,826,000
6	Operations and Logistics	205,000
Total		12,162,000

The plan assumes that funding will be secured in tranches, and that funds will be allocated accordingly recognizing the critical pathways outlined above. Table 3 below sets out the indicative, desired allocation of funding across the pillars for successive tranches of secured funding. Recognizing that donors have different priorities and areas of focus, this document serves as a guide for the optimal allocation of resources. Implementing partners may align funding proposals accordingly. The secretariat will continue to monitor funding, track alignment with priorities, and facilitate discussions between donors and implementing partners as required.

Table 3: Prioritized allocation of funding tranche

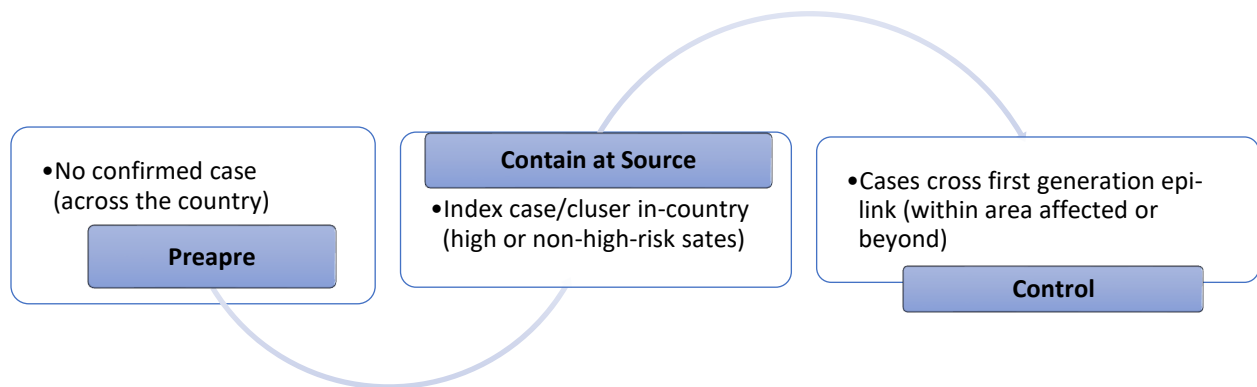
	Cumulative	Distribution between pillars
US\$ 1 million	\$1 million	35% Surveillance (Point of entry, health care facilities, communication, rapid response teams, laboratory, contact tracing) 28% Coordination (National and state taskforces, technical working groups and human relations) 12% Risk Communication and Psychosocial Support, 10% Case Management, IPC/WASH and SDB 5% Operations and logistics 10% Vaccines
US\$ 2 million	\$3 million	35% Surveillance (Point of entry, health care facilities, communication, rapid response teams, laboratory, contact tracing) 15% Coordination (National and state taskforces, technical working groups and human relations) 15% Case Management, IPC/WASH and SDB 20% Risk Communication and Psychosocial Support, 5% Operations and logistics; 10% Vaccines
US\$ 5 million	\$8 million	25% Surveillance (Point of entry, health care facilities, communication, rapid response teams, laboratory, contact tracing) 25% Coordination (National and state taskforces, technical working groups and human relations) 22.5% Case Management, IPC/WASH and SDB 25% Risk Communication and Psychosocial Support, 1.5% Operations and logistics; 1% Vaccines
US\$ 4million	\$12 million	5% Surveillance (Point of entry, health care facilities, communication, rapid response teams, laboratory, contact tracing) 20% Coordination ((National and state taskforces, technical working groups and human relations) 25% Case Management, IPC/WASH and SDB 50% Risk Communication and Psychosocial Support,

From preparedness to response

This second iteration of the national EVD preparedness plan is based on the current situation where there have been no confirmed EVD cases in South Sudan. In the event of a confirmed case, all partners will have to rapidly transition to containment mode. **The trigger to shift from preparedness to response is a single confirmed case and the focus will be on containment of the event where it occurs.**

Priority activities at this stage will include notification of, and transparency about, the event; public messaging on prevention of further spread; rapid deployment of multidisciplinary rapid response teams (RRTs); and rolling-out targeted containment measures. Figure 2 below sets out a schematic for the transition triggers and phases.

Figure 2: Schematic presentation of transition triggers and phases



To guide the transition a **scenario-based contingency response plan for the first 72-hour period has been prepared.**¹² While most of the activities included in this updated preparedness plan will also underpin the response phase, the geographic focus, scope of activities and intensity of response will shift to the affected area with the ultimate goal of effectively containing the outbreak at its source.

In the event where the index case, or cluster of cases from the same index case, are not swiftly contained at source and the outbreak spreads to other geographic areas, and/or affects more people in the same location crossing one-generation contacts, full scale response must be activated. At this stage, case management, contract tracing, and IPC/WASH activities will take priority and be intensified.

¹² The contingency plan considers two scenarios: a case in high-risk and non-high-risk areas with and without access issues.

For more information, contact:

Dr. Richard Lako Lino
Incident Manager
Email: richardlako@yahoo.com
Tel.: +211 926 592 520

Dr Ayana Yeneabat
Incident Manager
Email: ayanay@who.int
Tel.: +211 917 158 172

David Throp
EVD Coordination Secretariat
Email: throp@un.org
Tel.: +211 922 406 061

