The Federal Democratic Republic of Ethiopia

Polio Program Transition Plan 2018-2022

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World Health Organization

unicef

Rotary

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coregroup

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Acronyms and Abbreviations

ADC	Accelerated Disease Control	MCV	Measles Containing Vaccine
AEFI	Adverse Events Following Immunization	MNT	Maternal & Neonatal Tetanus
AFP	Acute Flaccid Paralysis	MOFD	Ministry of Finance & Development
AFRO	WHO Regional Office for Africa	MoU	Memorandum of Understanding
ARCC	African Regional Certification Committee	MR	Measles & Rubella
AWD	Acute Watery Diarrhea	MRI	Measles Rubella Initiative
AWD	Acute Watery Diarrhea	MRI	Measles Rubella Initiative
BMGF	Bill and Melinda Gates Foundation	NIDs	National Immunization Days
CDC	Center for Disease Control and prevention	NORAD	Norwegian Agency For Development
CHAI	Clinton Health Access Initiative	NPT	National Philanthropic Trust
cMYP	Comprehensive Multi-Year Plan	NTC	National Taskforce Committee
DFID	Department for International Development	OPV	Oral Polio Vaccine
DTP	Diphtheria Tetanus Pertussis	PCV	Pneumococcal conjugate vaccine
ECA	Economic Commission for Africa	PCV	Pneumococcal conjugate vaccine
EDHS	Ethiopian Demographic Health Survey	PDA	Personal Digital Assistance
EPHI	Ethiopian Public Health Institute	PDA	Personal Digital Assistance
EPI	Expanded Program on Immunization	PFSA	Pharmaceutical Funds Supply Agency
FMoH	Federal Ministry of Health	PFSA	Pharmaceutical Funds Supply Agency
GAVI	Global Alliance for Vaccines& Immunization	PHCU	Primary Health Care Unit
GPEI	Global Polio Eradication Initiative	PHEM	Public Health Emergency Management
GVAP	Global Vaccine Action Plan	PLPC	Polio Legacy Planning Committee
HAD	Health Development Army	RCS	Rapid Convenience Survey
HEP	Health Extension Program	RED	Reaching Every District
HEW	Health Extension Workers	RI	Routine Immunization
HF	Health Facility	RM	Resource Mobilization
HMIS	Health Management Information System	SIA	Supplementary Immunization Activity
HR	Human Resource	SNID	Sub National Immunization Day
HSS	Health System Strengthening	SOS	Sustainable Outreach Service
HSS	Health System Strengthening	SOS	Sustainable Outreach Service
HSTP	Health Sector Transformation Plan	SSA	Special Service Agreement
ICC	Inter-agency Coordination Committee	TA	Technical Assistance
ICC	Inter-agency Coordination Committee	TBA	Traditional Birth Attendant
IDSR	Integrated Disease Surveillance &Response	TT	Tetanus Toxoid
IEC	Information Education Communication	UNICEF	United Nations International Children's Emergency Fund
IIP	Immunization In Practice	USAID	United States Agency for International Development
IM	Independent Monitoring	USD	United States Dollar
IMD	Independent Monitoring Data	VDPV	Vaccine Drive Polio Virus
IPC	Iner-personal communication	WB	World Bank
IPV	Inactivated Polio Vaccine	WHE	World Health Emergency Program
M & E	Monitoring and Evaluation	WHO	World Health Organization
MCH	Maternal & Child Health	WPV	Wild Polio Virus
MCV	Measles Containing Vaccine		

EXECUTIVE SUMMARY

The Federal Democratic Republic of Ethiopia consists of nine regional states and two city administrative councils. The regional states and city administrations are subdivided into 840 Woredas (districts), which are further divided into about 17,486 Kebeles, the smallest administrative unit. According to projections of the 2007 census, the total population in 2017 is estimated to be 94.3 million and the estimated number of under 1 year surviving infants and under five year children is 3.03 million and 13.15 million respectively.

The Ethiopian health care structure is comprised of administrative and health care delivery systems**.** The health administrative structure is designed from FMoH to kebele levels in line with the country administrative structure. Under health administrative structure, there is EPI unit established within the MCH at all levels. The country has a three-tier health care delivery system. The level one is a Primary Health Care Unit (PHCU) comprised of a primary hospital, health centers and their satellite Health Posts connected to each other by a referral system. The level two is a General Hospital covering a population of 1-1.5 million people and the level three is a Specialized Hospital covering a population of 3.5-5 million people. The EPI program (immunization service) is implemented in all three tiers mainly through fixed sessions and additionally through outreach at health posts.

The current national immunization schedule delivers ten antigens to more than 3 million births annually. The administrative reported OPV3 coverage showed increment over the years from 65% in 2004 to 94% and 89% in 2015 and 2016 respectively. The country has conducted 24 polio NIDs and 37 SNIDs from 1996 to 2017.

Ethiopia established AFP surveillance under Epidemiology Department in 1997. The unit later moved to Public Health Emergency Management (PHEM) in 2009. The PHEM unit is responsible for coordinating surveillance activities in the country. At national level PHEM is under Ethiopian Public Health Institute (EPHI) agency of FMoH and one of the departments at Regional health bureaus. There are PHEM teams within zonal health departments and woreda health offices. At health facility level (hospitals & HCs) there are PHEM focal persons, who are in-charge of surveillance activities including AFP surveillance for case notification and investigation. At community level Health Extension Workers (HCWs) and Health Development Armies (HDAs) are doing community based surveillance and case notification to their respective HC focal persons.

The National Polio Laboratory was established in 1997 and was accredited in 2001, then the country moved from clinical to virological case classification. Since February 2017, environmental surveillance has been started in 3 sites (two in Somali region and one in Addis Ababa).

Ethiopia has been polio-free for four year since January 2014 and the country received polio free certification in June 2017 after submission of completed national documentation to the Africa Regional Certification Committee (ARCC) in Malabo, Equatorial Guinea.

Despite progress in overall child health and advances in the immunization program, there are still disparities among regions where some regions have achieved lower immunization coverage than others. As different coverage surveys and UNICEF/WHO joint estimation showed, the routine immunization coverage is far below the targets set by GVAP. The country is still at high risk of polio virus importation due to low routine OPV3 coverage in border woredas, unavoidable population movements from/to the country and shares borders with countries in conflict like Somali and South Sudan.

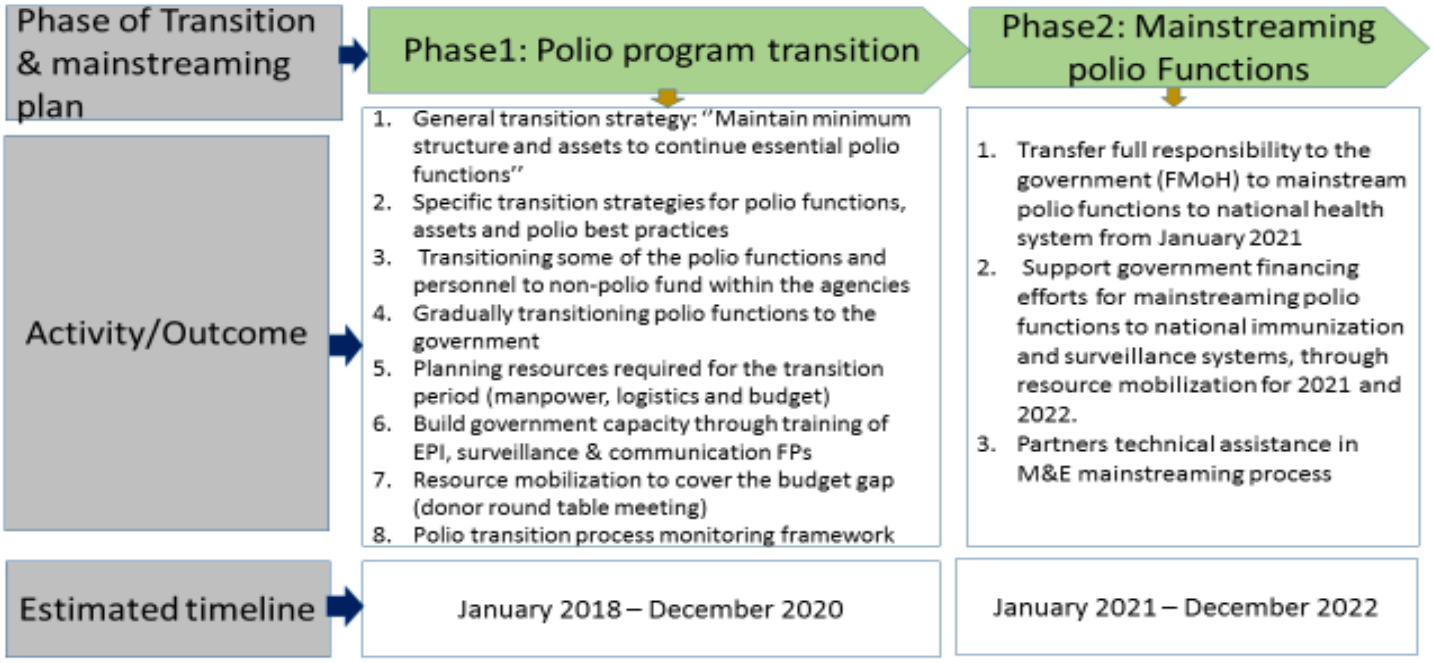
The national polio transition planning process is fully part of the 2013-2018 Polio Eradication and Endgame Strategic Plan as the 4th objective. It aims at both maintaining a polio-free status in Ethiopia and ensuring that the investments made to get this status contribute to future health goals after the completion of global polio eradication.

This polio program transition plan is set to cover the period 2018-2022 and prepare the country to move progressively to the post-eradication era through mainstreaming polio functions to national health system.

The plan has two phases. The first phase from 2018-2020 will be a period on preparation for the transition. It will focus on capacity building and system strengthening. The second phase begins from 2021 at which point, the functions will be

mainstreamed to the national health systems and the government takes full responsibility implementing polio functions and maintain the polio free status.

Polio program transition plan Phases and timing



This polio transition plan 2018-2022 successively captures and describes: i) The background: country, Immunization and AFP surveillance ii) The in-depth situation analysis: National health priorities and how national Polio eradication program works in Ethiopia iii) Polio transition planning process with key steps iv) Epidemiological and Managerial risks to maintaining polio free status; v) Objectives of polio transition and mainstreaming plan; vi) Polio program transition and mainstreaming strategies; vii) Human resource and capacity building plans and detailed budget for the implementation polio activities foreseen in this transition plan; viii) Monitoring and Evaluation framework of the Ethiopian polio transition plan; ix) detailed execution plan; x) Conclusion; and xi) Recommendations.

The cost for implementing the transition plan in the five years (2018-2022) is estimated at $64,732,766 with a gap of $11,930,101. The plan envisages a fund-raising endeavor to raise the funding gap

This polio transition and mainstreaming plan 2018-2022 is in line with the HSTP guiding principle of equity and quality as it aims to ensure equal immunization service and disease surveillance in-all eligible population through acceptable strategies linked to community needs.

1 INTRODUCTION

1.1 Country background

Ethiopia is a country located in the north eastern part of Africa known as Horn of Africa. It shares borders with Eritrea on the North and North-East, Djibouti and Somalia on the East, Kenya on the South, Sudan on the West and South Sudan on the South-West. (Figure1)

Figure 1*: Map of Ethiopia by region and neighboring countries, 2016*

According to projections of the 2007 census, the total population in 2017 is estimated to be 94,351,001 with majority (80%) of them living in rural areas. The estimated number of under 1 year surviving infants and under five year children are 3.03 million and 13.15 million respectively.

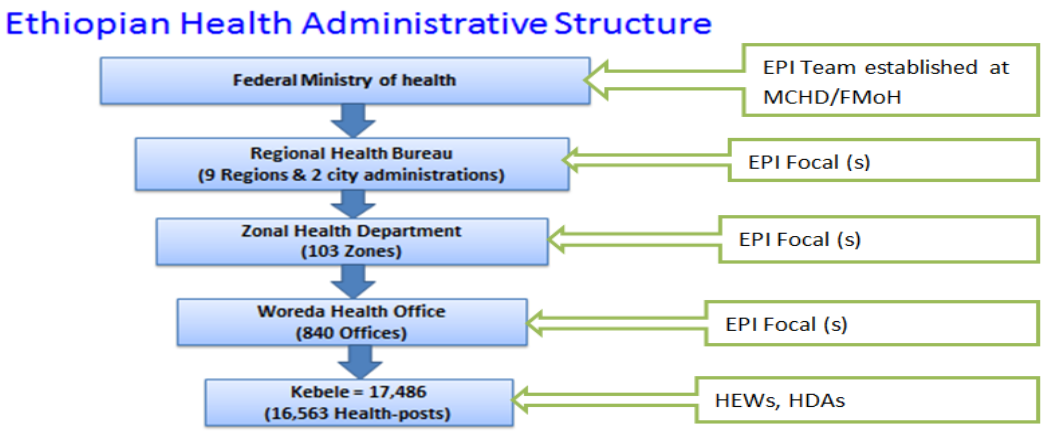
Ethiopia has nine Regional States: Tigray, Afar, Amhara, Benishangul-Gumuz, Gambella, Harari, Oromia, Somali, and Southern Nation Nationalities and Peoples Region (SNNPR); and the City Administration Councils of two cities: Dire Dawa and Addis Ababa. The regional states and city administrations are subdivided into 840 Woredas (districts), which are further divided into about 17,486 Kebeles, the smallest administrative unit.

1.2 Health background

1.2.1 Immunization background

The Ethiopian health care structure is comprised of administrative and health care delivery systems**.** The health administrative structure is designed from FMoH to kebele levels in line with the country administrative structure. Under health administrative structure, there is EPI unit established within the MCH at all levels. The following Organogram shows the EPI structures at different health administrative levels.

Figure 2: Organogram of Ethiopian health administrative and EPI unit



Source: FMoH/EPI case team

Ethiopia has a three-tier health care delivery system. The level one is a Primary Health Care Unit (PHCU) comprised of a primary hospital (to cover 60,000-100,000 people), health centers (1:15,000-25,000 population) and their satellite Health Posts (1:3,000-5,000 population) connected to each other by a referral system. The level two is a General Hospital covering a population of 1-1.5 million people and the level three is a Specialized Hospital covering a population of 3.5-5 million people. The EPI program (immunization service) is implemented in all three tiers mainly through fixed sessions and additionally through outreach at health posts.

The Routine Immunization (RI) program is funded primarily by partners and government. The partners largely channel their funds through WHO, UNICEF and CORE Group. Whilst the bulk of vaccine costs for the new vaccines are financed by GAVI, government covers the cost of traditional vaccines and injection materials since 2009.

In addition to the government efforts, funding for a number of other components such as technical support, cold chain equipment, transport, social mobilization and some operational costs have been made available by WHO, UNICEF, USAID, CDC, CHAI and other development partners.

The current national immunization schedule (Table 1) aims at delivering ten antigens to birth cohort of more than 3 million infants

Table 1: National immunization schedule for infants and women of child bearing age, Ethiopia

VACCINATION FOR INFANTS			WOMEN OF CHILD BEARING AGE (15-49 YEARS)		
AGE	**VISIT**	**ANTIGEN**	**VISIT**	**INTERVAL**	**ANTIGEN**
Birth	1	BCG, OPV0	1	0 (as early as possible)	TT1
6 weeks	2	DTP-HepB1-Hib(Penta)1,OPV1,PCV1, Rota1	2	At least 4 weeks after TT1	TT2
10 weeks	3	DTP-HepB2-Hib2,OPV2,PCV2, Rota2	3	At least 6 months after TT2	TT3
14 weeks	4	DTP-HepB3-Hb3,OPV3, PCV3, IPV	4	At least 1 year after TT3 if not, in subsequent pregnancy	TT4
9 months	5	Measles	5	At least 1 year after TT4 if not, in subsequent pregnancy	TT5
6-59 months		Vitamin A Supplement		All post-natal mothers	Vitamin A Supplement

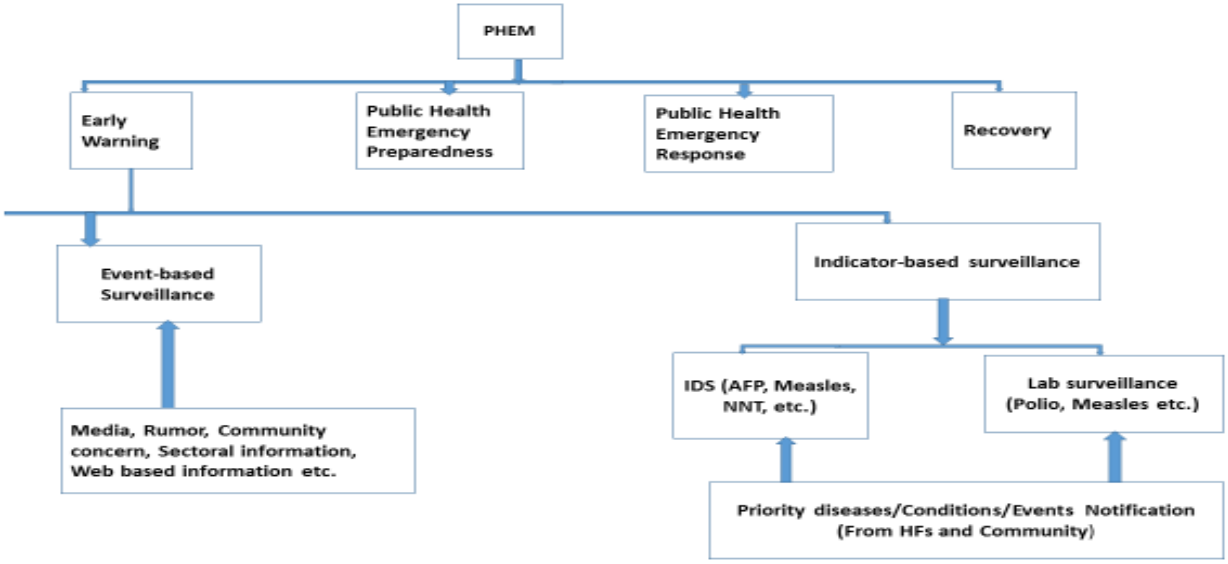
Source: 2016 -2020 national comprehensive Multi Year Plan (cMYP)

The first polio National Immunization days (NIDs) was conducted in 1996 targeting children under the age five years' old. A total of 24 rounds of NIDs and 37 rounds of SINDs were conducted from 1996 to 2017.

1.2.2 AFP surveillance Background

Ethiopia joined the polio eradication initiative in 1996 following the Declaration on Polio Eradication in Africa. In 1997, the country established AFP surveillance under Epidemiology Department. The unit later moved to Public Health Emergency Management (PHEM) in 2009. PHEM is the process of anticipating, preventing, preparing for, detecting, responding to, controlling and recovering from consequences of public health threats to minimize health and economic impacts. The PHEM process is comprised of four sub processes which are: Early Warning, Public Health Emergency Preparedness, Response, and Recovery. The PHEM unit is responsible for coordinating surveillance activities in the country. At national level PHEM is under EPHI agency of FMoH and at regional level it is one of the departments of Regional health bureaus. There are PHEM teams under zonal health departments and woreda health offices. At health facility level (hospitals & HCs) there are PHEM focal persons, who are in-charge of surveillance activities including AFP surveillance for case notification and investigation. At community level HEWs and HDAs are doing community based surveillance for case notification to their respective HC focal persons. The following organogram shows the PHEM process in Ethiopia.

Figure 3: Organogram showing the PHEM process



Source: May, 2012 national PHEM guideline and FMoH/PHEM

Active surveillance (active case search) for AFP and other VPDs surveillance is done at all reporting sites (health institutions) by surveillance focal points. Supportive supervision is provided regularly by higher level officers including WHO field surveillance officers where data are generated and feedback shared to lower levels.

The National Polio Laboratory was established in 1997 and was accredited by WHO in 2001, at which point the country moved from clinical to virological case classification.

The country has been polio-free for four years since January 2014 and the country achieved polio free status certification in June 2017 after submission complete national documentation to Africa Regional Certification Committee (ARCC) in Malabo, Equatorial Guinea.

Efforts to eradicate polio have not operated in isolation from larger immunization or public health programs, enabling tremendous strides in routine immunization. The health workforce, supply chains, surveillance systems, laboratories, social mobilization, and other functions essential to deliver polio vaccines to children nationwide have been leveraged to deliver other vaccines and health services.

Furthermore, AFP surveillance network have provided a foundation upon which vital infrastructure to prevent, detect, and respond to other emerging health threats—including meningitis and acute water diarrhea has been built in Ethiopia.

2 SITUATION ANALYSIS

2.1 National Health Priorities

The national health priorities in general focus on: universal health coverage, maternal and child health, disease control, public health emergencies, integrated community approach and health financing.

In the area of EPI and surveillance, key priorities as indicated in the national comprehensive Multi Year plan (cMYP) 2016 – 2020 for immunization and Health Sector Transformation Plan (HSTP) 2016 - 2020 are:

- Increasing immunization coverage in all populations with all vaccines particularly among those in hard to reach areas by 2020. Routine Immunization is here aligned to GVAP targets.
- Introduction of new vaccines such as MR, MCV2, Men-A, HPV and Yellow fever by 2020.
- Achieving measles elimination by 2020 (Resolutions AFR/RC52/R2).
- Maintaining/sustain the MNT elimination certification.
- Strengthening IDSR and sustaining polio free status.
- Improving Health Emergency Risk Management
- Strengthening communication and the demand for immunization
- Improving the information health system and data management at all levels.
- Improving health management, in particular: planning, training, supervision, monitoring, evaluation, coordination and health financing.

2.2 How polio eradication works in Ethiopia

The following table shows the nine polio functions and their respective activities that have been conducted in Ethiopia since the establishment of the polio eradication program in 1997.

Table 2: Polio Functions and their key activities in Ethiopia

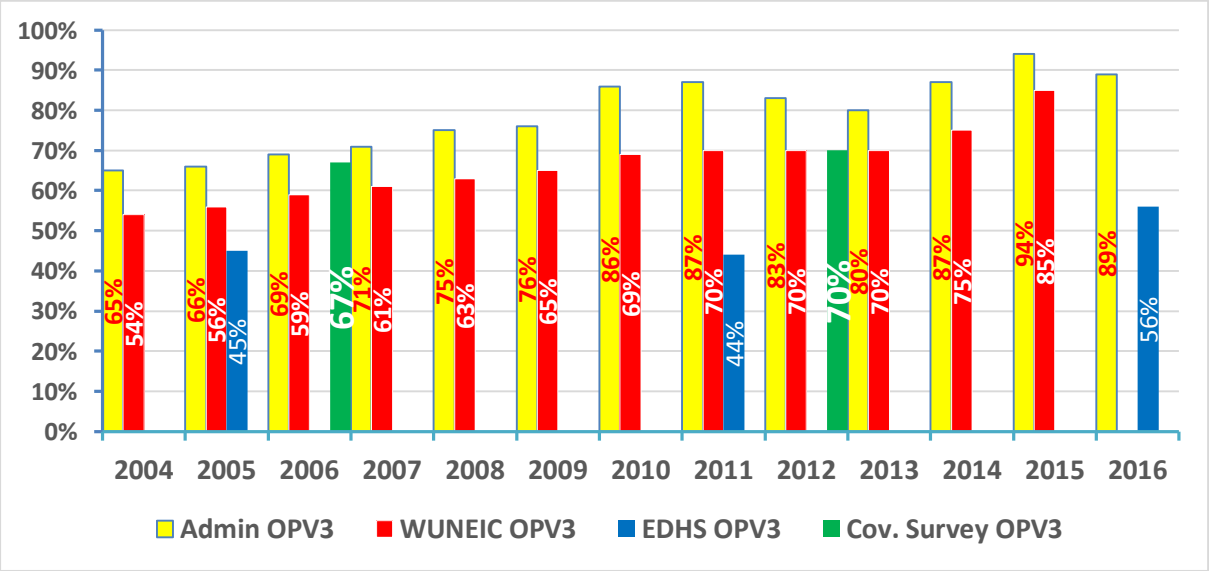
	Polio Functions	Activities
1	Implementation, planning and Service delivery	-Routine Polio vaccination with OPV and IPV -SIA planning, coordination & monitoring -Mapping settlements and high-risk and reaching unreached community, -Developing comprehensive bottom-up micro-plan
2	Monitoring & Data management	-Pre-campaign and in-process activity monitoring using standard forms -In-process & End-process Independent monitoring, -Data analysis and sharing for decision making -Program review
3	Polio Surveillance and outbreak response	-Active case search and community based surveillance, -Outbreak investigation and response - Specimen collection and transportation -Specimen testing and diagnosis -Bio-containment of polio virus and environmental surveillance
4	Communication & Community Engagement	Advocacy for sustained commitment, partnership and resources at all levels -Implement evidence-based communication strategies and preparation and dissemination of messages and using mix of channels (interpersonal communication, TV, Radio and print messages) -Social mobilization and demand generation - Engagement with community structures (HEWs, HDA, influential people) -Social and behavioral change communication

	Polio Functions	Activities
5	Capacity building	-Building technical capacity of personnel on disease surveillance, immunization, lab facility, communication, monitoring and data management
6	Resource mobilization and donor coordination	-Donor engagement and coordination -Financial planning and operation -Financial tracking and reporting
7	Partnership and coordination	- Inter-agency Coordination Committee (ICC) -Task force and Technical working groups -Establishment of cross border coordination committee
8	Management & accountability	-Accountability frame-work -Performance indicators -Motivation of high performing staff
9	Policy development, strategic planning	Multi-year strategic plan and planning process Task-forces at national and sub-national levels to guide implementation process.

2.2.1 Immunization

In Ethiopia routine OPV and recently IPV are administered to under 1 year children with other antigens through fixed and outreach sessions. The OPV3 administrative coverage has improved over the years from 65% in 2004 to 94% and 89% in 2015 and 2016 respectively (figure-4). However, the performance in Gambella and Somali regions remained less than 80%.

Figure 4: Routine OPV3 coverage in Ethiopia, 2004-2016



Source: May, 2017 national polio free status documentation in Ethiopia

The above graph of OPV3 coverage of 2004 – 2016 shows, that the administrative coverage was always greater than the WHO/UNICEF estimations and EDHS. Even though there was steady progress in coverage, all the surveys showed that OPV3 coverage did not achieved the expected ≥90% at national level in those years

The 2016 routine EPI administrative reports of 840 Woredas showed that only about 76% of them achieved the expected ≥80% Penta3 coverage (figure 5a) and only 67% of them achieved OPV3 ≥80% (figure 5b). Among the regions, Somali had the worst performance, as only 21% of the Somali woredas achieved the expected ≥80% of Penta3 & OPV3 coverage.

Figure 5a: 2016 Penta3 coverage by Woreda

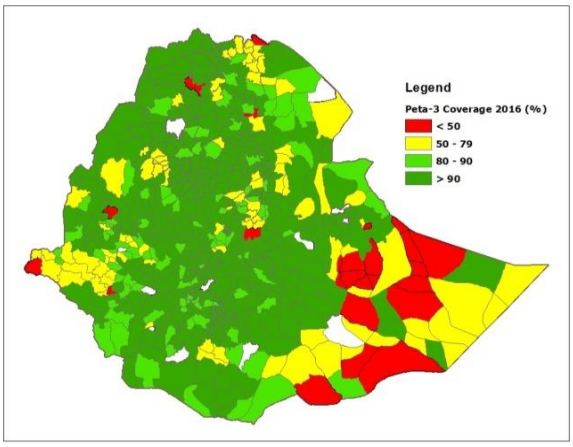
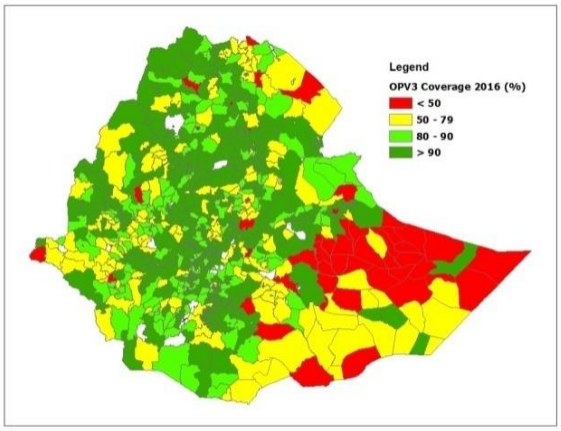


Figure5b: 2016 OPV3 coverage by Woreda



Source: 2016 national HMIS of routine EPI report

The 2016 administrative data clearly shows that one third of all Woredas did not achieve the expected ≥80% OPV3 coverage.
Only 49% of the pastoralists woredas achieved the expected ≥80% Penta3 coverage and about 45% of them ≥80% OPV3 coverage.

2016 administrative data shows that only about 61% of the border Woredas achieved the expected ≥80% Penta3 coverage and about 51% of them achieved >80% OPV3 coverage.

Out of 279 Woredas that did not achieve the expected ≥80% OPV3 administrative coverage, 90 (32%) of them were from pastoralist community and border Woredas.

All the 5 Polio NIDs and 17 SNIDs conducted from 2013 – 2017 in response to June 2013 WPV importation showed campaign administrative coverage of >95% at national level.

2.2.2 AFP Surveillance

The two main targets/indicators of AFP surveillance performance (NP-AFP detection rate and stool adequacy rate) have been achieved at national level since 2001. In the last three years (2014-2016) Ethiopia maintained both targets at certification level at national and sub-national levels

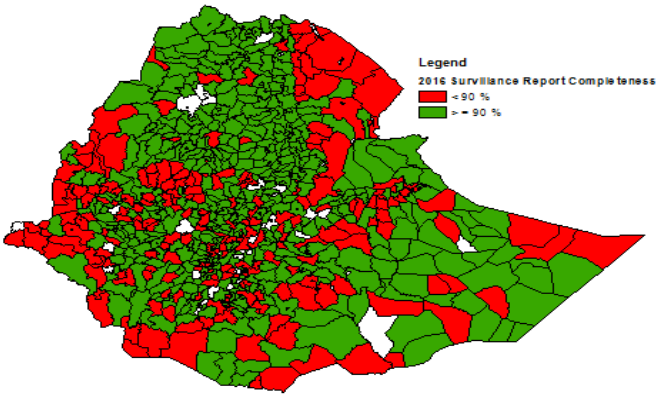
Table 3: Trend of National Main AFP surveillance performance indicators 2008 – 2016

Indicators	Target	2008	2009	2010	2011	2012	2013	2014	2015	2016
NP-AFP rate	2.0	2.9	2.2	2.8	2.7	2.9	2.9	3.1	3.1	2.5
Stool adequacy	80%	82%	82%	85%	88%	89%	87%	87%	92%	91%

Source: 2016, WHO Ethiopia surveillance report

One of the IDSR performance monitoring indicators at Woreda level is weekly surveillance report completeness. The following graph (Figure 6) shows the 2016 weekly surveillance report completeness by Woreda.

Figure 6: Surveillance report Completeness in 2016



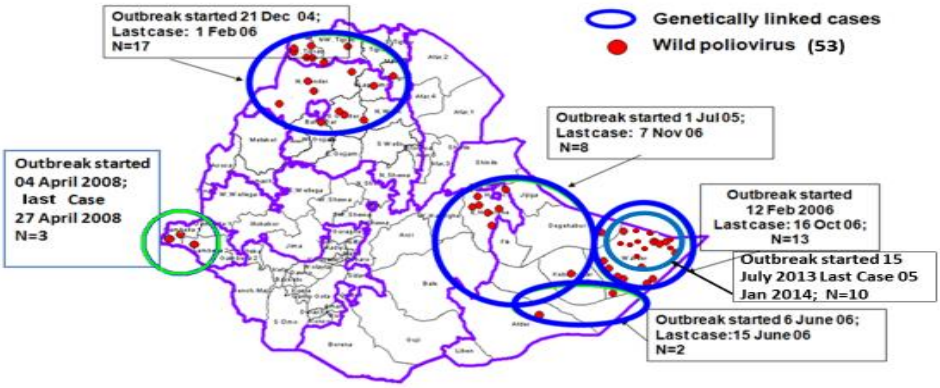
Source: 2016 national PHEM report

The 2016 average weekly surveillance report completeness showed that only 66% of the Woredas achieved the expected ≥90%. As to pastoralist and border woredas only 53% and 47% of them achieved the expected 90% of weekly surveillance report completeness respectively. Out of the 291 Woredas that did not achieve the expected ≥90% report completeness, 77 (26%) of them were pastoralist & border Woredas.

After almost 4 years Polio-free (Jan 2001 until Dec 2004), Ethiopia experienced six importations of wild polio virus (figure 7). All the importations were through bordering woredas from neighboring countries. The low routine immunization coverage, week surveillance and fragile countries like Somalia and South Sudan in war put the country in high-risk for possible polio virus (WPV & VDPV) importation.

Figure 7: wild poliovirus importation 2004-2014

Figure 7: wild polio virus importation to Ethiopia 2004 – 2014



Source: May, 2017 national polio free status documentation in Ethiopia (WCO)

The sixth and last imported outbreak of wild polio virus type 1 was detected on August 14, 2013 with date of onset of paralysis in July 2013 in Somali Region/Warder (Dolo) zone of Ethiopia. Total of 10 cases were reported and the last case was detected on January 05/2014.

2.2.3 Laboratory testing & bio-containment

The National Polio Laboratory was established in 1997 and was accredited by WHO in 2001, then the country moved from clinical to virological case classification. Over the years the lab has processed an average 2500 polio samples annually. The laboratory is used for other VPD sample testing.

With the support from WHO/AFRO, environmental surveillance to supplement the existing routine AFP surveillance was started in February 2017. Five sewage sites were identified for the environmental surveillance and bi-weekly collection of samples started in two sites of Somali region and one in Addis Ababa. There is a plan to start bi-weekly sample collection in the remaining two sites in 2018.

After the global type-specific interruption of WPV2 transmission and sequential cessation, Ethiopia conducted Phase 1a, Polio virus bio-containment successfully. All the type 2 (VDPV infectious stocks and Sabin isolates) were destroyed and Phase 1b, the switch from tOPV to bOPV was successfully completed.

2.2.4 Communication and community engagement

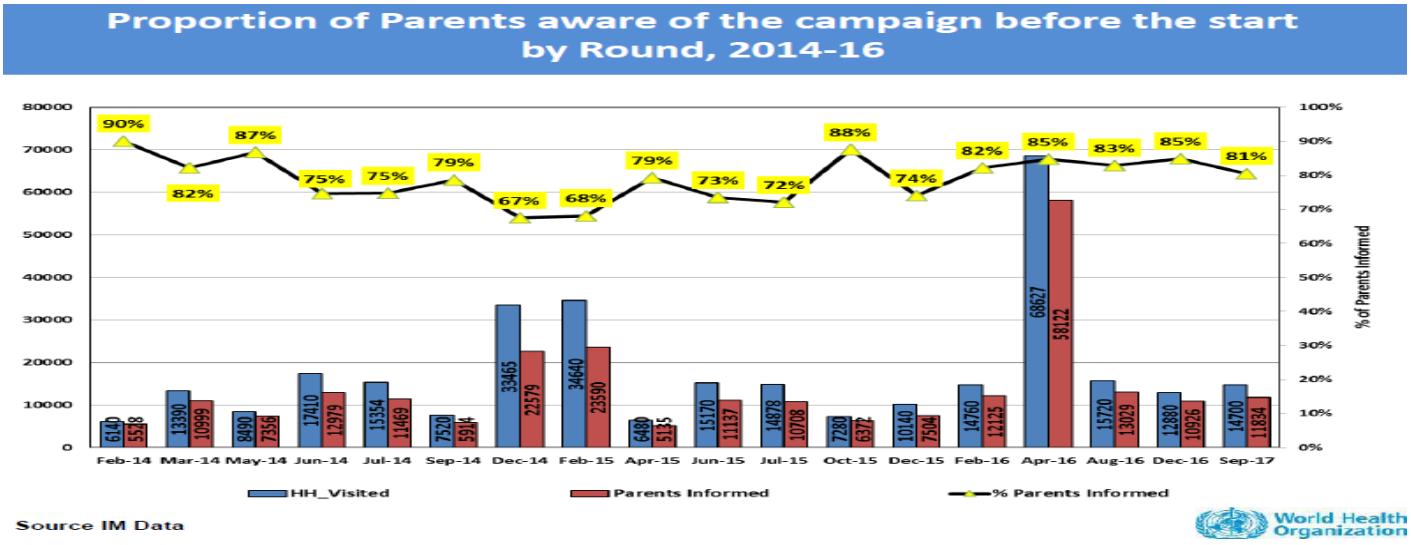
EPI Working Group (CWG) led by EPI case team coordinates polio and EPI communication efforts with supporting partners. FMOH structures historically leading polio communication include leadership at national level through the CWG in collaboration with the FMOH Communication and Public Relations Directorate, and with public relations and health promotion focal points at sub-national level, primarily at regional level in the Regional Health Bureaus.

Communication efforts have aimed to positively increase stakeholder knowledge and immunization behavioral outcomes related to polio and immunization. Five general strategies have been employed for polio communication: 1) strategic planning; 2) building communication capacity; 3) advocacy for sustained commitment; 4) social mobilization (including engagement with local, influential leaders and community groups and use of effective communication channels) and 5) use of data for action.

The use of data (including SIA data, regular communication reports, and special research and assessments) has been critical to guide and improve polio communication strategies, particularly for community level interventions. The WHO independent monitoring (IM) process and the Rapid Convenience Survey (RCS) reports on the source of information about the SIA; community levels of awareness; and reasons for noncompliance (refusals). The IMD reports that throughout the 2013 polio outbreak response, levels noncompliance (out of total missed children) were maintained below the national indicator of less than one percent[1] and awareness levels were maintained above 72 percent (with a high of 90 percent), with the exception of SIAs when dates were postponed (for example, see December 2014 and February 2015 rounds in figure 8, when awareness was at 67 and 68 percent respectively).

A national study of the behavioral determinants for immunization service utilization in Ethiopia in 2012 revealed that caretakers were most familiar (78 percent) with the polio vaccine than any other vaccine and the percentage of respondents who believe vaccine prevents the 'vaccine targeted diseases,' ranked polio first as preventing polio (90 percent),. As related to routine immunization, the study found that communities often lack knowledge about the time, place, and importance of completing routine immunization. Other barriers include weak health worker interpersonal communication during immunization sessions, far distances to the immunization site, fear of vaccine side effects and reactions, inconvenient timing of sessions, and caregiver competing priorities.

Figure 8: Proportion of parents aware of the campaign before the start by round, 2014-2016, IMD



[1] Indicator: "Maintain less than 1% of children not vaccinated during polio rounds due to refusal (noncompliance)."

3 POLIO PROGRAM TRANSITION PLANNING PROCESS:

3.1 Polio Program transition planning background

The GPEI is committed to ensure that the investments made in polio eradication over the last three decades contribute to future health goals after the completion of polio eradication while maintaining world polio free status. As outlined in the 2013-2018 Polio Eradication and Endgame Strategic Plan, the polio transition and mainstreaming planning process has the following three key elements:

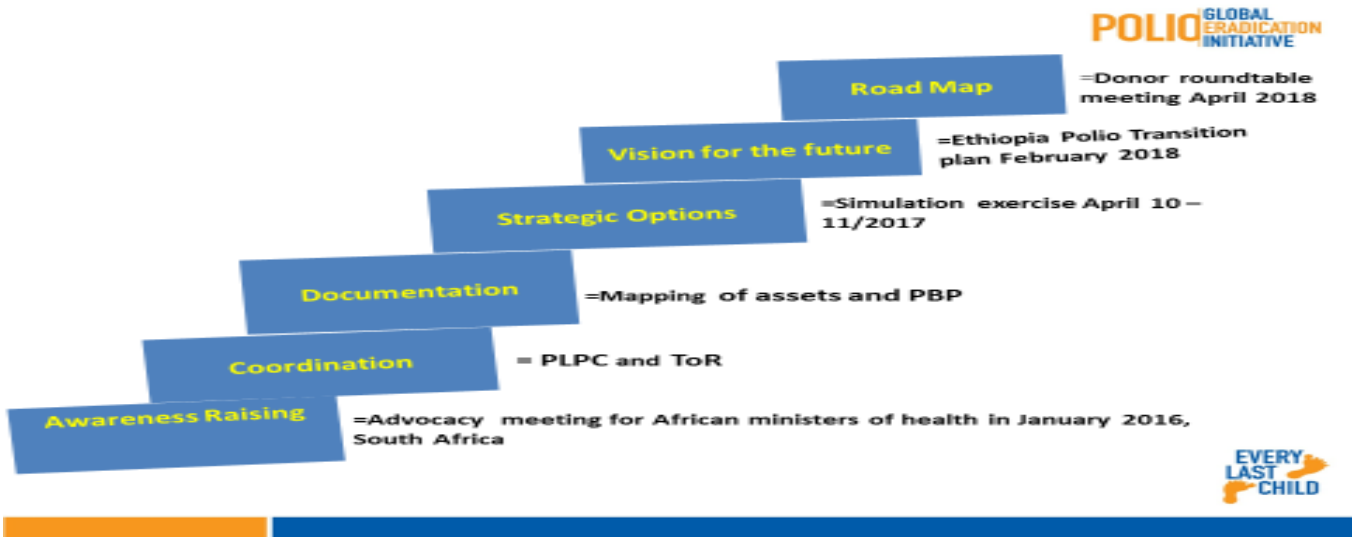
1. To ensure that the functions needed to maintain a polio-free world after eradication are mainstreamed into national immunization systems and other public health programs;
2. To ensure that the knowledge generated and lessons learned from polio eradication activities are documented and shared for the benefit of other health initiatives; and
3. Where feasible and appropriate, transition capabilities and processes are in place to support other health priorities and ensure sustainability of the experience of the GPEI.

3.2 Steps in Ethiopian Polio Program Transition Planning

Eradicating polio in Ethiopia in the coming years will mean that funds that have been devoted to the assets established by the GPEI over the last two decades (people, resources and systems/processes) will reduce and eventually stop.

On the basis of this, the preparation of the polio program transition planning took place from June 2016 to March 2018 in Ethiopia. This process was led by the Ministry of Health, through the Polio Legacy Planning Committee (PLPC) and the existing technical task forces with the support of GPEI and its polio partners.

Figure 9: Polio program transition planning steps in Ethiopia



1. The polio program transition planning process was started in Ethiopia in June 2016 by establishing Polio Transition Legacy Committee (PLPC) by FMoH from key immunization and surveillance partners (WHO, UNICEF, CORE Group, CDC, Rotary international and USAID) and lead by FMoH/MCH directorate. The term of reference (ToR) was developed for PLPC with following key components:

- To develop polio transition planning work-plan with activities, budget, funding source, responsible person/persons and review and update it during every meetings.
- To comment and endorse developed documents based on shared copies, power point presentation and discussions.
- To decide on the recruitment of consultants.
- To establish sub-committees (task-forces), as required: As a result; Communication and resource mobilization task-forces (committees) have been stablished.
- To organize and decide on the date and agenda of transition simulation exercise work-shop (conducted on 10 & 11 of April 2017) and donor round table meeting.

2. For the technical support 7 national and one international consultants were recruited by WHO and UNICEF at the different steps in the process. Some important documents were developed by national consultants under the guidance of international consultant and PLPC:
   - Polio asset mapping exercise: Survey, Forms, Data Analysis and interpretation
   - Polio best practice documentation : Desk review, survey questionnaire, meeting interviews and field survey
   - Resource mobilization strategy document
   - Polio transition human resource and capacity building plans
   - Polio transition communication strategy
   - Linking polio transition objective with the national health priorities.
   - Finally, this draft polio program transition plan 2018 – 2022 is developed based on the above and other available documents and will be presented to ICC for endorsement.

3.3 Polio funded staff and Physical Assets

3.3.1 Polio Funded Personnel

According to the Polio asset mapping exercise of October 2016, there were 257 polio funded personnel from CORE group, WHO and UNICEF. WHO polio funded personnel made up 64% with 165 employees while CORE group made up 31% with 79 and UNICEF 5% with 13 employees.

The majority of polio funded staffs in Ethiopia were categorized under service delivery making up to 48% followed by 22% Management and operation and 16% Surveillance (table 4)

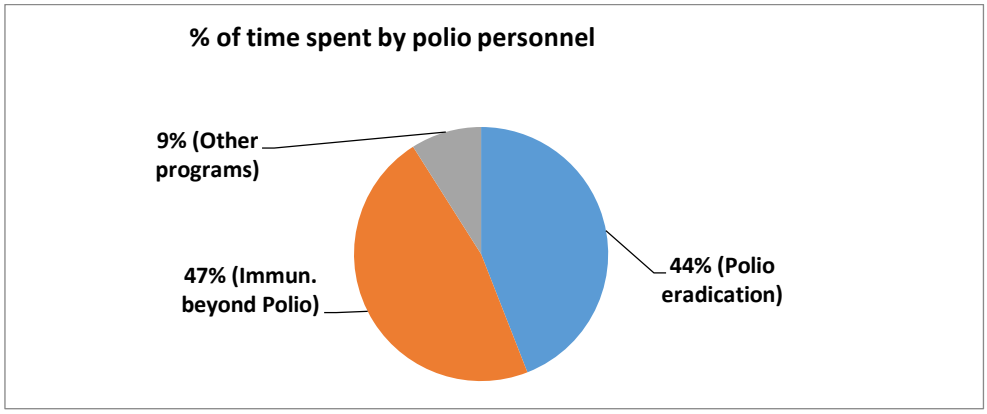
Table 4: Polio funded personnel by function & activity

Function	WHO	CORE Group	UNICF	Total	%
Implementing & service delivery	54	67	2	123	48%
Monitoring	6	1	0	7	3%
Surveillance	42	0	0	42	16%
Communication & Community engagement	2	1	11	14	5%
Resource mobilization	0	10	0	10	4%
Management & Operation	56	0	0	56	22%
Vacant	5	0	0	5	2%
TOTAL Personnel Number	**165**	**79**	**13**	**257**	**100%**

Source: October 2016, Polio asset mapping exercise

According to the study conducted by Van den Ent et al in Ethiopia in 2012, polio funded personnel spent 47% of their time on immunization related activities beyond polio (Figure 10). This was primarily on routine immunization and measles and rubella activities. 43% of polio personnel had routine immunization activities included in their terms of reference.

Figure 10: Summary of time allotments of GPEI funded personnel (Van den Ent et al 2012)

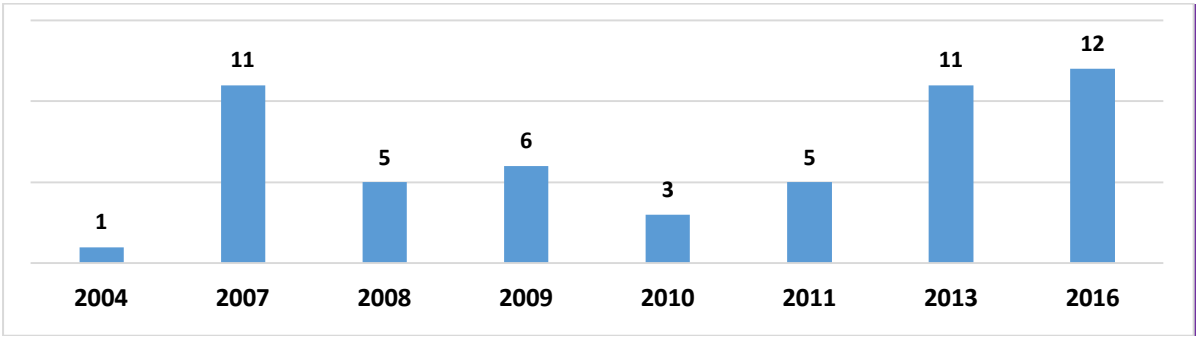


Source: 2017 draft polio asset business case of Ethiopia

3.3.2 Polio Physical assets

As of October 2016, WHO and CORE group owned 54 and 3 vehicles respectively, purchased with polio funds and were used for polio related activities. UNICEF did not have polio funded cars. Out of the 54 WHO cars 31 of them were purchased on or before 2011 (figure 11); this made the percentage of cars aged 5 years and older to be 57%.

Figure 11: WHO polio funded cars by Year of Acquisition



Source: October 2016, Ethiopian polio asset mapping exercise

3.3.3 Polio Fund

In Ethiopia, the polio eradication efforts are mainly supported by GPEI partners. The 2016 annual polio program GPEI funds in Ethiopia was $38,657,000. This cost included campaigns (Polio SIAs), Core functions & infrastructure (Communication and technical assistance) and surveillance

Table 5: GPEI funding for Ethiopia

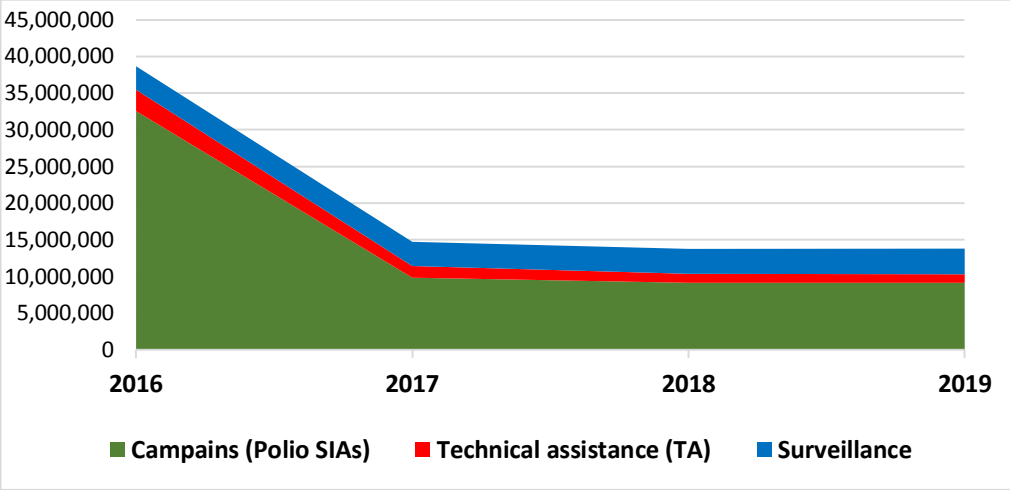
Cost Item/Activity	2016	2017	2018	2019
Campaigns (SIAs)	32,546,000	9,842,000	9,142,000	9,142,000
Technical assistance (TA)	2,911,000	1,588,000	1,226,000	1,160,000
Surveillance	3,200,000	3,296,000	3,395,000	3,497,000
TOTAL	**38,657,000**	**14,726,000**	**13,763,000**	**13,799,000**

Source: Annual GPEI budget allocation to countries

The above table shows that about 84% of the 2016 GPEI fund was allocated for polio SIAs. In 2017, 2018 and 2019 about 66.8%, 66.4% and 66.2% respectively, of GPEI budgets were for polio SIAs.

The Polio eradication effort in Ethiopia, shows GPEI budget ramp-down from $38,657,000 in 2016 to $14,726,000, $13,763,000 and $ 13,799,000 in 2017, 2018 and 2019 respectively with 62% decrease in 2017 and 64% decrease in 2018 and 2019 (figure 12).

Figure 12: GPEI fund ramp-down in Ethiopia



Source: Revised GPEI budget for 2017 with 2018 and 2019

4 EPIDEMOLOGICAL AND MANAGEMENT RISKS TO MAINTAIN POLIO FREE STATUS:

Although Ethiopia has managed to remain polio free for four years, the country still faces challenges to maintain the status. Some of these factors include:

1. Ethiopia is at high risk for Polio virus (WPV or VDPV) importation due to Population movement & refugees in countries in the HOA and neighboring countries with internal conflicts like Somalia and South Sudan.
2. Low OPV3 Administrative coverage in 2016 in 279 Woredas of which 32% were in pastoralist & border Woredas.
3. Weak surveillance performance in 2016 in 291 Woredas 26% of which were pastoralist & border Woredas.
4. Addis Ababa international airport as one of the biggest hub in Sub-Saharan Africa with high number of people transiting through the city every day is also high-risk for polio virus importation.
5. GPEI fund ramp-down with about 62% decrease in 2017 and 64% in 2018 and 2019 comparing to 2016 and totally stop in 2020, which will affect priority health programs supported by Polio fund.
6. Ethiopia is encountering a high health staff turn-over every year.
7. Inequities in service provision and challenges in implementation of specific strategies for hard to reach areas
8. Inadequate immunization and surveillance monitoring and poor data quality
9. Limited operational researches being conducted

5 OBJECTIVES OF THE POLIO PROGRAM TRANSITION PLAN

5.1 General objective

To maintain the country polio free status certification and ensure that the investments made in polio eradication contribute to future health goals after the completion of polio eradication

5.2 Specific Objectives:

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

a. Maintain annual high routing polio vaccination coverage
b. Timely detection and response to any polio outbreak
c. Establish environmental surveillance sites in all regions and strengthen national polio laboratory for sample testing and bio-containment

5.2.2. To ensure that the knowledge generated and lessons learned from polio eradication activities are documented and shared for the benefit of other health initiatives

5.2.3. Where feasible and appropriate, transition capabilities and processes are in place to support other health priorities and ensure sustainability of the experience of the GPEI

a. The AFP case based surveillance system, which is well-established for detection, notification, investigation and response is used for Measles and other priority disease surveillance in integrated manner at all health structure levels
b. The Polio communication network is used for demand creation for routine immunization

6 POLIO PROGRAM TRANSITION AND MAINSTREAMING STRATEGIES for 2018 – 2022

The 2018 – 2022 polio program transition plan comprises of two phases. Phase1 covers the period 2018-2020 that focuses on the implementation of activities to build the capacity of the national immunization and surveillance system at all levels while minimizing the structures in partner agencies. Phase2 includes the period from the beginning of 2021, at which time the ministry of health will have the full capacity to carry out the polio functions through its mainstream functions and maintain polio free status.

Polio program transition plan Phases and timing

Phase of Transition & mainstreaming plan	Phase1: Polio program transition	Phase2: Mainstreaming polio Functions
Activity/Outcome	1. General transition strategy: ''Maintain minimum structure and assets to continue essential polio functions'' 2. Specific transition strategies for polio functions, assets and polio best practices 3. Transitioning some of the polio functions and personnel to non-polio fund within the agencies 4. Gradually transitioning polio functions to the government 5. Planning resources required for the transition period (manpower, logistics and budget) 6. Build government capacity through training of EPI, surveillance & communication FPs 7. Resource mobilization to cover the budget gap (donor round table meeting) 8. Polio transition process monitoring framework	1. Transfer full responsibility to the government (FMoH) to mainstream polio functions to national health system from January 2021 2. Support government financing efforts for mainstreaming polio functions to national immunization and surveillance systems, through resource mobilization for 2021 and 2022. 3. Partners technical assistance in M&E mainstreaming process
Estimated timeline	January 2018 – December 2020	January 2021 – December 2022

6.1 Polio Program Transition strategies for 2018 – 2020.

6.1.1 General Transition strategy

The polio program transition process in Ethiopia has been designed as an intermediate process between current (2018) on –going polio eradication efforts by polio partners and fully taking over responsibility by the government (FMoH) from January 2021 on-ward for financing and mainstreaming polio functions to national immunization and surveillance systems.

The polio program transition simulation exercise work-shop conducted on April, 10 & 11/2017 in Addis Ababa proposed the following transition strategy for Ethiopia: "Maintaining minimum structure and assets to continue essential polio functions (OPV and IPV immunization, AFP surveillance and polio outbreak response and bio-containment) until 2020 and then transfer full responsibility to the government (FMoH) to mainstream them to national immunization and surveillance systems starting from January 2021". This transition strategy was selected, due to the fact that:

a. Some time is needed to develop government capacity (qualified health personnel, material and finance) to fully integrate (mainstream) polio functions to national immunization and surveillance systems.
b. No other alternative implementing partners, which can fully take-over and implement the polio functions.
c. There is possibility to mobilize financial resource from national and international donors to cover the budget gap, due to GPEI fund ramp-down

Until 2020 the polio functions will be implemented by the government/FMoH and implementing partners (WHO, UNICEF and CORE Group) and then the government (FMoH) will take full responsibility to mainstream them to immunization and surveillance systems from January 2021.

6.1.2 Aligning Polio Program Transition functions/ objectives with National Health Priorities

Functions /Sub-functions of the polio program	Top priority global, regional, national or local health and development goals/targets (From cMYP& HSTP)	Outcome indicators, with timeframe	Existing functional needs for achieving these goals/targets	Current polio program assets relevant to this priority (Human resources, infrastructure, financing, etc.)	Activities carried out by polio assets in this functional area (quantifiable, with impacts)	Implications of applying polio program assets/functions to this target/goal (operational, financial, etc.)	Trade-offs versus alternative strategy for achieving objective/goal
Service delivery (Strengthen RI through utilizing OPV & IPV)	Increase and sustain high vaccination coverage	Reach 90% national coverage and 80% in every district with all vaccines by 2020	- RED approach implementation in every district and kebeles - Regular supportive supervision and program monitoring -Capacity building for EPI managers and health workers -Design local strategy and implement for pastoralist areas -Intensify defaulter tracing mechanism using community based structures. -Communication/community mobilization	-Polio and Logistics officers -Polio vehicles -Polio SIA micro-planning guideline	-Micro-planning and field supervision of immunization activities and campaigns -Conducting periodic DQS -Capacity building on immunization -Reaching unreached and high-risk community -Timely feedback	-Some of WHO polio officers and CORE group polio technical staff need to be retained until 2020. -Plan on the number of polio staff of WHO and CORE group to be retained	-To use the existing EPI focal persons working on immunization through short term training -Recruit and train new government staff to fill the gap -Transition all CORE Group polio staff to immunization and other health interventions.
	New vaccine introduction	-Introduction of Men A by 2018 -Introduction of HPV by 2018 -Introduction of Yellow Fever by 2019	-Strengthen new vaccine introduction taskforce to include advocacy and consensus building - Conduct cascade training from EPI managers & FPs -Evaluate vaccine management practices - Communication/community mobilization	-Polio officers & vehicles -Polio planning guidelines	- Cascading trainings -Planning & field monitoring	Some of WHO polio officers and CORE group polio technical staff need to be retained until 2020.	-To use the existing EPI focal persons working on immunization through short term training -Transition all CORE Group polio staff to immunization and other health priority.
Disease surveillance, outbreak response and Polio virus containment	Strengthen IDSR (AFP, Measles, NNT, Rota, meningitis etc. surveillance)	-Maintain polio free status certification -Attain and maintain main measles surveillance indicators -Maintain MNT elimination certification -Attain control of other vaccine preventable diseases, including, Rubella, Yellow fever, Meningitis.	-Conduct regular active surveillance (Active case search) - Capacity building -Regular risk-assessment for priority disease - Strengthen Surveillance deploying international and local STOP -Build the capacity to conduct AEFI surveillance -Strengthen community based surveillance -Establish cross-border surveillance	-AFP Surveillance system & Guidelines -Polio officers & logistics (Cars, posters etc).	-Integrated active surveillance (ACS) -Risk-assessment -Case validation	- Some of WHO polio officers and CORE group polio technical staff need to be retained until 2020. -Plan on the number of polio staff of to be retained	-To use the existing IDSR/PHEM focal persons working on AFP/IDSR through short term orientation -Require and train new government staff to fill the gap -Transition all CORE Group polio surveillance staff to IDSR and other health priority
	Improve Health Emergency Risk Management/outbreak response	- Meet and sustain IHR core capacities -95% TC of weekly priority diseases reporting -85% epidemics	-Emergency risk management for health as a national and local priority -Health risk assessment and early warning - Education and information to build a culture of health, safety and resilience at	-Polio outbreak response guideline -Polio officers & logistics -Outbreak investigation and response capacity	- Early detection & investigation of VPDs outbreak - Capacity building - Outbreak responses (vaccination response)	-Retain some of WHO polio officers until 2020. - Use CORE group polio staff until 2020	-Transfer some of WHO surveillance officers to PHEM/Emergency program within WHO -Build capacity of government EPHI/PHEM

		controlled within the standard mortality rate -85 % of Woredas and HFs annually assessed for preparedness and response	all levels, -Emergency preparedness for effective health response and recovery at all levels, -Meeting international health regulation core capacities -Communication/community mobilization		-Enhanced AFP (Polio) surveillance -Contact tracing		staff.
	Improve laboratory facilities for IDSR and outbreak responses	.Attain standard polio virus containment -Attain environmental surveillance indicators -Attain and maintain quality laboratory indicators	-Provide adequate supply of specimen collection tools and reversal cold chain support at country level -Provide support for shipment of specimens form reporting sites to national labs and to WHO accredited-referral labs	- Financial support for specimen collection & transportation -Top-up payment for lab technician -Lab reagents cost	- Isolation of the cause (polio, Measles, Rubella, Rota viruses). -polio virus containment -Environmental surveillance	- Continue WHO financial support until 2020 -Continue reagent supply by WHO/AFRO until 2020	- Government will take over all the costs through resource mobilization with the support of partners from January 2021. - Government to recruit and train new staff according to the need
Communications & Community engagement,	Strengthen communication, advocacy, and demand for immunization at all levels including community by 2020	-To increase awareness of the community on immunization to 95% by 2020 - To improve the skills of trained health workers per health facility on IPC 2018	- communication strategies, including relevant IEC and other social mobilization materials; print and disseminate - Utilize relevant media and means to reach target audiences - Partnerships with local influential groups and stakeholders to address behavioral barriers to immunization (i.e., collaborations with religious leaders on vaccination objectors) - Train health workers on inter personal communication/IPC/ - Advocacy/promote partnership on Immunization for increased commitment and resources -Monitor impacts of communication - Strengthen regional ICC through advocacy visits/ supportive supervision	-Communication officers	-Communication guidelines & IEC materials - Capacity building -Communication strategies & core messages(using mix channels)	- Retain some of WHO and UNICEF communication staff until 2020	- Government will take the responsibility from January 2021. -Training for existing government communication officers. -Government to recruit and train new staff according to the need

6.1.3 Specific Polio program transition strategies Ethiopia

The specific transition strategies and activities are focused on four main areas: a) Transition strategies and activities for polio functions; b) Transition strategies for polio best practices; c) Transition strategies for polio funded physical assets (polio vehicles); and d) Transition strategies for polio funded personnel

6.1.3.1 Specific transition strategy and activities for polio functions by program implementing agency are indicated in table below:

Polio functions	Polio sub-functions/activities	Current polio program assets supporting these functions	Transition strategy (Alternate funding sources, transition of expertise, etc.)	Funding Source
WHO				
1. Service delivery (immunization utilizing OPV and IPV)	Central support and planning of immunization activities and campaigns	4 Polio immunization officers	Transfer to non-polio fund (GAVI), from January 2018 and maintain support to polio immunization as it is	GAVI
	Field supervisors of immunization activities & campaigns	15 Polio Zonal Immunization assistance	Transfer field supervision of immunization activities to WHO field surveillance officers as of Jan 2018, since ToR is revised to include technical support to immunization. When there is a polio SIA, temporary officers will be hired using polio SIA fund	None
	Cold-chain management/logistics	One Polio funded logistician	Transfer responsibility to government/PFSA and will happen from January 2018	Government
2. AFP surveillance and polio outbreak response	-Active case search and outbreak investigation --Integrated surveillance and immunization supportive supervision to woredas and HFs - Sample collection, handling & transportation -Management & Operation	12 Polio officers 12 drivers 5 Admin staff -Vehicles	- Maintain minimum number of surveillance officers & drivers using the allocated GPEI surveillance fund until 2019. -Then reduce the number to 12 polio officers, 12 drivers and 5 supportive staff for 2020 through RM and then transitioning them to other non-polo programs within WHO. -Focus on government staff capacity building -Maintain top-up payment and per-diem for sample transportation until 2020 and then transfer responsibility to EPHI from Jan 2021	-GPEI -RM GPEI + RM
	-Lab technicians & testing -Environmental surveillance -Bio-containment of polio virus	-Reagents -Top-up payment	-Use the allocated GPEI fund until 2019 and fund mobilization from donors for 2020. Then transfer responsibility to EPHI from Jan 2021.	GPEI and RM
3. Monitoring & Data management	-Data analysis and reporting -Monitoring and Evaluation of surveillance & immunization	-5 Data managers -One Monitoring officer	- Transition the 2 national data management to GAVI fund from Jan 2018. -Use available GPEI technical assistance for 3 data managers and a monitoring officer until 2019 and RM to cover budget gap for 2020.Then transition to non-	-GAVI -GPEI

Polio functions	Polio sub-functions/activities	Current polio program assets supporting these functions	Transition strategy (Alternate funding sources, transition of expertise, etc.)	Funding Source
	activities		polio fund within WHO	-RM for 2020
4. Community engagement & communications	-Social mobilization -Media, communications and advocacy -Develop communication tools	-1 Social Mobilizer -1 Advocacy & communication officer	- Transfer responsibility of social mobilization to government from January 2018 and recruit communication officers on short contract for Polio Campaigns using polio campaign funds - Use available GPEI technical assistant fund for advocacy & communication until 2019 and RM for 2020. Then transfer to non-polio fund within WHO.	GPEI + RM
5. Capacity building	-Government staff capacity building on EPI (IIP, MLM etc.) - Government staff capacity on surveillance (IDSR/PHEM, outbreak response etc.)	-Technical expertise (WHO + Government) -Training Manuals	-Use WHO central & field officers to support government to develop/update training manuals and conduct training, from January 2018 -RM for training cost for 2018 – 2022 (transition and mainstreaming period) - Transfer full responsibility to government from January 2021.	RM
6. Resource mobilization & Advocacy	- Resource mobilization -To support Government's efforts for Resource Mobilization for Polio Transition planning and Post transition era.	- National consultant on short term contract	-Government is already leading the resource mobilization process. -Use the budget allocated for polio transition planning by GPEI and partners for national RM consultant	GPEI/WHO
UNICEF				
1. Service delivery (immunization utilizing OPV and IPV)	Health Emergency & outbreak response planning, implementation & monitoring	-One emergency & outbreak response officer	- Use the allocated GPEI Technical assistant fund until 2019 and fund mobilization for 2020 -Transition to non-polio fund within UNICEF from January 2021.	RM
	Regional Polio SIA and routine EPI support (Somali Region)	One regional immunization officer (Somali region)	Use GPEI Technical assistant fund until 2019 and fund mobilization for 2020 - Transition to non-polio fund within UNICEF from January 2021.	RM
2. Community engagement & communications	Support to regional & zonal EPI communication	11 Health Communication Network officers (Regional and Zonal)	- Maintain polio communication officers on non-polio program funding from Jan 2017 – Dec 2018 and then mobilize resource for them for 2019 - 2020	UNICEF +RM
3. Capacity building	-Government staff capacity building on health promotion and social mobilization focused on EPI and VPD surveillance	-Technical expertise (UNICEF+ Government) -Training Manuals	-Use UNICEF communication officers to support government to develop/update training manuals and conduct training, from January 2018 -RM for training cost for 2018 – 2022 (transition and mainstreaming period)	RM

Polio functions	Polio sub-functions/activities	Current polio program assets supporting these functions	Transition strategy (Alternate funding sources, transition of expertise, etc.)	Funding Source
CORE Group				
1. Service delivery (immunization utilizing OPV and IPV)	support and planning, monitoring and evaluation of immunization activities and campaigns of border & pastoralist in project areas	-Central/National CORE Group polio officers - Management and operations -Vehicles	-Fund is secured until 2022 for immunization including OPV and IPV - Integrate polio activities to other health interventions after 2022	USAID
	Field supervisors of immunization activities & campaigns at high-risk woredas	-CORE group field officers --Logistics & transport support	-Fund is secured for until 2022. -Integrate polio activities to other health interventions after 2022.	USAID
2.AFP Surveillance and outbreak response	-Active case search - Community based surveillance -Cross-border notification -Cross-border collaboration (Planning, review meeting etc.) -support to Polio (WPV & VDPV) outbreak response	- Central CORE Group polio program staff -CORE Group field polio technical staff -Polio fund for ruining cost -Trained Community volunteers	-Fund is secured until 2022 for the implementation of AFP surveillance/IDSR - Integrate polio activities to other health interventions after 2022	USAID
3. Capacity building	Capacity building on EPI/IIP and community based surveillance for HEWs & HDAs in project areas	-CORE Group field officers -Training manuals (IIP and CBS)	- Use the available training manuals prepared for HEWs on IIP and community based surveillance by FMoH -Use CORE Group field program officers and trained woreda EPI & PHEM focal persons. -Fund is secured until 2022	USAID

NB: ***1. Revised GPEI budget for 2017 with 2018 and 2019 received from AFRO is used for 2018 and 2019***

2. At community level the same people are working on both immunization and community based surveillance in CORE Group project areas.

6.1.3.2 Polio best practices potential for transitioning/linking to other health programs

Ethiopia has prepared strategic document to capture and disseminate Polio Best Practices which can potentially benefit other national health priorities of the country.

A total of 27 potential best practices (generalized ones=9, specific nationwide =11 and specific to pastoralist and cross border areas=7) were identified and documented. However, based on the opinion of polio experts at different levels of health structure and the replicability of the best practices, the following ten polio best practices were selected for linking (adapting) to other national health priorities.

1. **Bottom up comprehensive Polio SIA Micro-planning:** at Woreda level by kebele through community and social mapping for the improvement of quality and vaccination coverage for <5 children, using standard micro-planning tools.
2. Using technology assisted devise (**PDA device**): for providing and monitoring effective supportive supervision (SS) at HU and health offices, using standardized integrated supervision check-list.
3. **Polio SIA Independent monitoring (IM) and using data for action**: to measure quality of SIA using quality indicators that can guide improvements to reach more children, through house-to-house & outside house monitoring using standard monitoring tools by trained independent monitors
4. **Polio Social mobilization & coordination committee at different levels**: for developing communication & social mobilization strategies and core messages for use at National, Regional, Zonal, Woreda and community levels.
5. **Effective use of existing community structure (Health Development Armey (HAD), Traditional Birth Attendant (TBA), etc)** for community based AFP (Polio) surveillance, for early detection and notification of case using standard community case definition, house-to-house polio SIAs through community awareness creation activities.
6. **Polio SIAs has integrated Measles SIA, Fistula detection & notification and <5 year children documentation:** using standardized integrated tools for planning, implementation and monitoring (pre-campaign, intra-campaign & post-campaign checklists)
7. **AFP surveillance system has contributed to IDSR and outbreak response**: through well-established system of detection, notification, investigation and response, which integrated other national priority diseases like: Measles, NNT, Yellow fever, Meningitis, Cholera etc.
8. **Inter-sectoral/cross-agency coordination and collaboration:** Non-health sectors (Emergency preparedness & response, Water development, Education, Veterinary, Administration and Security offices) and knowledge, experience and resources of different agencies facilitated the planning & implementation of Polio SIA and AFP surveillance.
9. **Cross border coordination and collaboration**: for Polio SIA implementation, AFP case notification and outbreak response at entry points through regular joint planning and coordination meeting.
10. **Working with religious and community leaders**: for Polio SIA and community based surveillance for awareness creation and involving community.

The transition link for the selected ten polio best practices is displayed in the table below:

Aligning selected Polio best practices with national health priorities						
	Polio Best practices (PBP)	**Description of Polio Best practices (PBP)**	**Comparative advantage**	**Priority programs has been benefiting from PBP**	**Other Health programs can be benefited from PBP**	**How it can be done?**
1	Bottom up comprehensive **Polio SIA** Micro-planning at woreda level by kebele through community and social mapping for the improvement of quality and vaccination coverage for <5 children, using standard micro-planning tools.	-Polio SIA micro-planning done at woreda level by kebele or settlements (bottom-up) and covers manpower, vaccines, transportation means, logistics, space for storage, freezing capacity, social mobilization materials, fund, estimation of <5 children & Mapping of settlements with identifying high-risk areas -The woreda micro-plans aggregated at zonal level, then regional and finally national level	-Cold chain inventory findings are used for the strengthen of Routine immunization & other vaccination campaigns -Mapped settlements and estimated <5 children used for the other child survival health interventions (Measles SIA. Vitamin-A supplementation, de-worming etc) and woreda based plan	Measles SIAs Routine EPI, New vaccine introduction, , Vitamin-A supplementation , nutritional screening and de-worming	Malaria, TB screening, ANC,FP, Delivery and post-natal services	Introducing Polio SIA micro-planning tools , capacity building, and other supports through training
2	Using technology assisted devise (**PDA device**) for providing and monitoring effective supportive supervision (SS) at HU and health offices, using standardized integrated supervision check-list.	-The PDA device is user friendly, Providing real time data, timely feedback and taking corrective actions on spot during monitoring and supportive supervision activities. -PDA assisted integrated checklist currently used by EPI team of WHO/Ethiopia includes different health programs like; AFP, Measles & NNT surveillance, immunization etc and designed for ISS to HFs and health offices.	-Can Integrated different health programs during supportive supervision -Time saving by avoiding writing on hard copy check-list - Easy for carrying as it is just mobile phone apparatus -Data can be transported to any computer for analysis (No need for data entry)	VPD surveillance, Routine EPI, Measles SIAs,	PHEM/IDSR Malaria, TB, MCH, MDSR, NTD etc.	- Introduce PDA apparatus currently used by WHO field officers through Training/work-shop

Aligning selected Polio best practices with national health priorities						
	Polio Best practices (PBP)	**Description of Polio Best practices (PBP)**	**Comparative advantage**	**Priority programs has been benefiting from PBP**	**Other Health programs can be benefited from PBP**	**How it can be done?**
3	Polio SIA Independent monitoring **(IM**) to measure quality of SIA using standard monitoring tools by trained independent monitors and using data for action	-All the Polio SIAs monitored by independent people who are not involved in Polio SIA, to identify missed areas & missed children in high-risk areas and get them vaccinated. -As they are independent monitors reliable data (coverage) is produced, which contributed to improving quality of Polio SIA.	-The data produced by IMs help to validate administrative coverage of the area for action. -Improves Polio SIA data quality (reduce false reports)	Polio and Measles SIAs	Measles SIA & other vaccination campaigns, Malaria (ITN distribution & utilization monitoring), New vaccine introduction. RI, TB and MDSR	Orientation on National Polio IM guideline through work-shop/training
4	Polio Social mobilization & coordination committee at different levels for developing communication & social mobilization strategies and core messages for use at National, Regional, Zonal, Woreda and community levels.	- Prepared evidence based communication & social mobilization strategic plan at national level and cascaded to all levels. -Link communication strategies with community structure for demand creation & community mobilization for Polio SIA. -Advocacy visits & Meeting to political leaders, other sector offices & stakeholders to ensure ownership, political will and resource mobilization & also involved them in launching ceremonies.	-The available committee at different levels can be utilized for other VPD immunization campaigns, new vaccine introduction & for community based disease surveillance. -Advocacy gives an opportunity to discuss & capture issues on the routine immunization	Routine immunization, Measles SIAs, family health (ANC,FP, PNC services), de-worming and vitamin A supplementation	TB screening, Nutrition program, emergencies like; (AWD, malaria), MDSR and HIV/AIDS.	Sensitization /Capacity building through work-shop
5	Effective use of existing community structure (HDA, TBA, etc) for community based AFP surveillance, Polio SIA and community awareness	-Mapping of existing community structure in the area (HDA, TBA/TTBA, kebele leader etc) -Orientation on AFP surveillance (Community case definition) , polio SIA and community engagement -Establish networking with nearby health structure	-Using the existing community health agents for other VPD surveillance - Can be used for identification of unreached areas & unvaccinated	RI, Measles campaign, de-worming and Vitamin A	Family health (ANC, Delivery, PNC), outbreak detection (malaria, AWD, Measles etc.), TB	Introduce community based AFP surveillance, Polio SIA and communication tools through work-shop.

Aligning selected Polio best practices with national health priorities						
	Polio Best practices (PBP)	**Description of Polio Best practices (PBP)**	**Comparative advantage**	**Priority programs has been benefiting from PBP**	**Other Health programs can be benefited from PBP**	**How it can be done?**
	creation activities	(HPs)	children by RI -Can be used for demand creating for RI & other VPD immunization	supplementation	HIV/AIDS, Nutrition screening, NTD and other community based health interventions	
6	Polio SIAs has integrated Measles SIA, Fistula detection & notification and <5 years children documentation, using standardized integrated tools for planning, implementation and monitoring.	-Integration is one of the most important operational strategies of PHC in Ethiopia. -Measles SIA integration to Polio SIA contributed to achievement of Measles Mortality & Morbidity reduction strategy in the country. -Through house-to-house Polio SIAs in the recent years many Fistula cases detected and treated. - In some places RI was also integrated into Polio SIA and improved immunization coverage.	-Integration of Measles SIA & RI to Polio SIA was cost effectiveness, as they are provided at a time -The number of target children documented by their age categories used as target for other health interventions.	Measles SIA & Men-A vaccination, RI, Nutrition screening, de-worming and Fistula case detection.	TB case search, Trachoma, model house hold visit audit, ANC, RI defaulters tracing, FP	Introducing integrated Polio SIA tools/guideline through work-shop/ training.

Aligning selected Polio best practices with national health priorities						
	Polio Best practices (PBP)	**Description of Polio Best practices (PBP)**	**Comparative advantage**	**Priority programs has been benefiting from PBP**	**Other Health programs can be benefited from PBP**	**How it can be done?**
7	AFP surveillance system has contributed to IDSR and outbreak response through well-established system of detection, notification, investigation and response, which integrated other national priority diseases like: Measles, NNT, Yellow fever, Meningitis, Cholera etc.	-Active AFP surveillance has integrated other VDP surveillance like Measles & MNT & outbreak detection. - Stool collection & transportation system has contributed to Measles & Rubella serum samples collection & transportation to National laboratory. -Capacity building on AFP surveillance integrated other VPD/PHEM. - Polio manpower & logistics supported investigation and response of different outbreaks, including Measles, Yellow fever, Meningitis, Cholera etc.	- AFP surveillance system contributed to early detection of Measles, NNT & other VPDs - As other IDS (Measles, MNT etc) are integrated to AFP surveillance, it is cost-effective. -The highly qualified Polio experts are used for investigation and responses to different outbreaks helped to overcome shortage of trained manpower	IDSR, other VPDs surveillance (Measles, NNT, Meningitis, etc), emergencies (AWD H1N1), Nutrition screening, MDSR and RI	IDSR, TB, Malaria, Emergency response (AWD etc). Measles & NNT surveillance, TB case search.	Introduce Active AFP surveillance system tools through work-shop/training
8	Inter-sectoral/cross-agency collaboration and coordination with non-health sectors (Emergency preparedness & response, Water development, Education, Veterinary), Administration and knowledge and resources of different agencies for Polio SIA and AFP (Polio) surveillance.	-Mapping of running water points, food distribution sites, animal vaccination sites for Polio SIAs - Mapping of movement pattern of pastoralist communities to know:-the time/season when the population is moving, the place where the population is moving and for how long the population can stay in a certain place for AFP surveillance & Polio SIAs. Resource (logistics & manpower) support by different agencies for Polio SIAs	-The identified sites can be used for other VPD immunization campaign (Measles, Men-A SIAs etc) and RI -Mapping of community movement pattern can be used beyond AFP (Polio) surveillance for other VPD surveillance and routine immunization	VPD vaccination campaigns, VPD surveillance (Measles etc.), Routine EPI, new vaccine	Nutrition screening, AWD, HIV/AIDS, RI, measles SIAs, malaria, de-worming, TB leprosy, ANC, FP, PHEM, cervical cancer & hygiene	Introduce the available tools through work-shop/Training.

Aligning selected Polio best practices with national health priorities						
	Polio Best practices (PBP)	**Description of Polio Best practices (PBP)**	**Comparative advantage**	**Priority programs has been benefiting from PBP**	**Other Health programs can be benefited from PBP**	**How it can be done?**
9	Cross border coordination and collaboration for Polio SIA implementation, AFP case notification and outbreak response at entry points through regular joint planning and coordination meeting.	-Cross-border collaborative meetings were conducted between Ethiopia and Kenya polio partners in Moyale town. -Horn Africa countries coordination & collaborative meeting was conducted in Jijiga. - Mapping of entry points in cross border areas -Cross-border area collaboration committees were established -Cross border AFP case notification system established across some border areas. - Borrowing logistics (Vaccine carriers, cold boxes, vaccines etc) during Polio SIA campaign among cross-border districts and/or HFs	-Created an opportunity to work together during AWD outbreak. -Created an agreement that all the children with infant immunization card to be given the next serious of vaccination at where they are (regardless of their nationality). -Created an opportunity to establish cross-border notification of other VPDs	IDSR, other VPD surveillance ,Measles SIAs, routine EPI case notification and outbreak response	-IDSR, Environmental sanitation, health promotion, RI, case notification and outbreak response	Introduce the strategies & available tools through work-shop
10	Working with religious and community leaders	-The religious institutions have strong networks from national to grass root level. - People visit to church or mosques at least once a week. -Widely used for dissemination of polio messages (polio SIA, AFP surveillance & RI) to the community -Contributed to reduce noncompliant parents due to religious reasons.	-Using religious leaders, influential individuals for other priority health programs (RI, AWD, ODF, etc.) -Can be used for demand creating for RI & other VPD immunization through social mobilization.	Measles SIA & Men-A vaccination campaign, New vaccine introduction, RI etc.	Family health programs, HIV/AIDS, Malaria, , Emergency response like: AWD	orientation on experience with religious leaders through work-shop/training

6.1.3.3 Specific transition strategies for polio physical assets (vehicles)

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

In principle for the implementation of polio transition plan, WHO and CORE Group will retain polio funded vehicles until 2020. However, they can transition some of the cars during transition period based on the scale-down of the polio officers using those cars and request from FMoH. In-line with this WHO had transitioned three cars to FMoH in December 2017. There is a need to do regular inventory to know the functionality of the existing polio funded cars and update the WHO and CORE Group polio asset records.

B. Strategic options for transitioning polio vehicles, after 2020

Strategic options for the polio funded vehicles after 2020 are different for WHO and CORE Group.

- As the government will fully take-over the responsibility of implementing and mainstreaming polio functions to national health priorities from January 2021, in principle transition option for WHO polio funded cars could be transitioning them to the government (FMoH). However, in addition to polio program, WHO is also using these cars for other diseases surveillance and emergency response activities, which will continue even after polio eradication is achieved. Therefore, WHO and government (FMoH) should design detail transitioning strategies/activities with time-frame during transition period 2018 – 2020, to initiate transition process and the cars to be fully operational in new roles starting from January 2021, if any.
- Even after global polio eradication and certification is declared the NGOs working with CORE Group will continue supporting RI and surveillance activities with other health interventions at border woredas, by mobilizing resources from donors. Therefore, the transitioning of polio funded vehicles will be done according to the agreement between those NGOs and government.

6.1.3.4 Specific transitioning strategies for Polio funded personnel.

- Transfer 4 WHO central immunization officers and 2 data managers to non-polio fund (GAVI) and maintain their support to polio immunization, from January 2018.
- Update ToR of WHO field surveillance officers by incorporating field immunization monitoring and supervision and avoid hiring 15 zonal technical assistants (ZTAs). Already done in 2017.
- Shift 15 WHO polio surveillance officers and 17 drivers to SSA (short-term contract), for 2018 and 2019.
- Transfer responsibility of a WHO cold chain logistician to government PFSA and avoid hiring logistician from January 2018.
- Recruit a WHO polio social mobilization officer on short term contract, when there is only polio SIA using campaign fund.
- Gradually reduce number of regular WHO polio surveillance officers to 12 and shift them to SSA contract for 2020 and then transition them to non-polio fund within WHO from January 2021 [2]
- Gradually reduce number of WHO polio funded drivers to 12 and shift them to SSA contract for 2020, then transitioning them to non-polio fund within WHO from January 2021.

[2] **Reforming for effectiveness of WHO Country Office, Ethiopia:** A functional review of the WHO country office was held in October 2017, to ensure that WHO country office has the right workforce in place in order to support the National health priorities. From these consultations, WHO Ethiopia is planning for programmatic reforms with a strategic refocusing of the work of WHO in Ethiopia; and transformation of the management support capacity and operations in support of more effective delivery on the expectations of stakeholders. The specific areas of programmatic reform target enhancing WHO capacities for public health emergencies preparedness and response; finishing the unfinished business of polio eradication; and shifting WHO investments in health development towards outcome/impact levels.

It is expected that the WHO country presence will be reinforced with key technical staff at subnational level. This would be an opportunity, in polio transition era, for polio funded staff to apply for new created positions within the new structure with strengthened presence of WHO at subnational level

- Gradually reduce number of WHO polio funded general administration to 5 for 2020 and transition them to non-polio fund within WHO from January 2021
- Transfer 7 zonal and 4 regional UNICEF communication coordinators to immunization and other programs with non-polio fund for 2017 until 2018 and then mobilization resources to continue immunization and surveillance communication for 2019 to 2020 (Even though they are transitioned to other non-polio funded programs form 2017 and 2018, their support is required to maintain key polio function(Community engagement & communications) in 2019 & 2020
- Transfer the remaining two polio funded UNICEF staff to other programs within the organization from January, 2021.
- Keep the CORE Group polio funded personnel until 2022, as the fund is secured and transitioned them to non-polio fund within the organization to continue implementation of immunization and community based surveillance with other health interventions at border woredas through resource mobilization.

6.2 Mainstreaming and financing polio functions by the government (FMOH) from January 2021 onward.

AFP surveillance polio immunization and communication are the main polio functions that will be fully taken-over and mainstreamed to national health system by FMoH starting from January 2021. The purpose of this section is to show the AFP surveillance and polio immunization activities, that will be fully taken-over by FMoH from January 2021 and support government financing effort through fund mobilization for two years (2021 and 2022), so that FMoH can fully integrate essential polio functions into national surveillance and immunization systems. During the transition period from 2018 – 2020, further building of the government's capacity at all levels will be done through training of EPI, surveillance and communication focal persons and monitoring their performances, so that the government (FMoH) will be capable of taking full responsibility from January 2021 onward.

6.2.1 Major AFP surveillance activities will be taken-over by FMoH from January 2021.

a. Active case search (active surveillance)

Active case search is a regular visits to health care facilities (Health posts, Health centers, hospitals, rehabilitation centers, privet health facilities, traditional healers etc.) to search for and investigate unreported AFP cases through a review of health facility records, interviews with health workers and/or visit to wards to review cases. Active case search is done mainly by polio funded WHO field officers. However, from January 2021, this activity will be fully taken-over by the government surveillance/PHEM focal persons at all levels.

b. Case validation and 60-days follow-up examination

The purpose of case validation is to re-exam the reported AFP cases, as quality measure to ensure that what is reported as AFP is truly AFP and to provide feedback to reported site and to higher levels. 60-days follow-up exam is usually done for all late detected and inadequate stool cases to facilitate case classification. These two activities have been conducted by Polio funded WHO field surveillance officers and they will be fully taken-over by FMoH/PHEM structure from national to woreda level starting from January 2021.

c. Stool collection and transportation:

The per-diems of all stool transporters has been covered by WHO/Ethiopia. However, the FMoH/EPHI will take full responsibility to cover the sample transporters cost starting from January 2021.

d. Laboratory testing and biocontainment.

WHO/AFRO is supplying reagents to national polio laboratory for virological testing of all reported AFP cases. In-case WHO/AFRO stops supplying reagents for after 2020, the EPHI will take-over the responsibility of supplying polio reagents to the national laboratory from January 2021

e. AFP surveillance training

WHO country office has been conducting AFP surveillance training for untrained surveillance focal persons of zonal & woreda health offices and HFs (HC & Hospital) every year. The AFP surveillance training has always been integrating Measles, NNT, Meningitis, AWD and introduction to PHEM. Starting from January 2021, this responsibility will be fully transferred to government (FMoH/PHEM).

6.2.2 Major Routine Polio Immunization activities will be taken-over by FMoH from January 2021.

As polio immunization activities including community engagement and demand creations are already integrated into national immunization system, it is much easier for the government to continue implementing them after 2020. However, government will need budget to cover activity and logistics costs and costs for capacity building for EPI focal persons at all levels (from national to HF levels) from January 2021 onward.

6.2.3 Resources required to support government efforts of mainstreaming & financing polio functions in 2021 and 2022

To Support the financing and full mainstreaming polio functions to national health system efforts of the government from January 2021, there is need to mobilize financial resource for 2021 and 2022 from national and international donors. This will help the government for smooth taking-over and mainstreaming AFP surveillance and polio immunization activities to national health system from national to community levels. Therefore, there is need to mobilize resources for 2021 and 2022 through resource mobilization task-force. The same-time the government is expected to gradually increase fund allocation for surveillance and immunization activities with the support of partners.

a. Activity cost

For fully taking-over and mainstreaming AFP surveillance including, stool transportation, laboratory testing and biocontainment and polio immunization activities have been implementing by WHO and UNICEF to national health system, government will need **$4,351,856** for the activity costs of 2021 and 2022 (Table-11 & 12 under budget section)

b. Capacity building (training)

To train untrained EPI, surveillance and communication focal persons of newly constructed health facilities (HC and hospitals) and also to fill the gap due to high turn-over of trained staff at different levels there is need to mobilize fund for 2021 and 2022. For this purpose total of **$1,239,266** is required (Table-11 & 12)

c. Transport

For the active case search to reporting sites, regular supportive supervision to health facilities for RI, surveillance and immunization materials distribution et., zonal health departments and woreda health offices has been supported by WHO field surveillance officers' cars. Therefore, for the implementation of the above activities during 2021 – 2022 and beyond FMoH will need some cars. As most of the polio funded WHO cars will reach discarding stage in the coming three years, there is need to purchase at least 11 cars (one each for 9 regions and 2 for FMoH) for the implementation of immunization and surveillance activities. The cost of the 11 cars is estimated to be **$1,000,000**. (Table-11 & 12).

d. Technical Assistance

WHO presence during mainstreaming polio functions to national immunization and surveillance systems by the government (FMoH) from Jan 2021 is crucial to provide technical support and monitoring mainstreaming activities on regular basis. The technical assistance will be in the form of assigning three WHO officers to FMoH in 2021 and 2022. The budget required will be under WHO and will be mobilized from international donors through resource mobilization task-force and the cost is estimated to be **$144,000**. (Table-11& 12)

7 RESOURCES & BUDGET PLANNING

7.1 Polio program transition human resource plan:

For the implementation of Polio functions during first phase of the transition period 2018 – 2020, appropriate HR plan is required to identify adequate number of polio personnel needed for the same period by function and agency.

7.1.1 WHO Polio funded personnel required for the implementation of polio functions during transition period 2018 – 2020

According to HR plan received from WHO/MCH the number of Polio funded personnel available in 2017 and required for 2018, 2019, and 2020 for the implementation of polio functions is indicated in table 6 below. As the government will take full responsibility of mainstreaming polio functions to national immunization and surveillance system from January 2021 and the polio funded staff are not part of the transitioning to the government, the table below shows the WHO/EPI HR plan for 2018 – 2020.

Table 6: WHO Polio funded personnel required for the next 3 years (2018 – 2020)

Function	Primary sub-function	No of personnel available in 2017	No o staff for 2018	No of staff for 2019	No of staff for 2020	Remark
Implementation and service delivery	Cold chain management/ logisticians	1	0			Post was abolished from Jan 2018
	Central support and planning of immunization activities and campaigns	4	0			Transferred to GAVI (already done)
	Field supervisors of immunization activities (ZIAs)	15	0			Abolish posts (already done)
Monitoring	Data analysis and reporting	5	3	3	0	2 central staff to GAVI fund from Feb 2018
	Monitoring and evaluation	1	1	1	0	Abolish posts from Jan 2020
Surveillance	Surveillance officers (Regular)	36	26	24	0	Abolish posts from Jan 2020
	Surveillance officers (SSA)	15	15	15	12	To other program within WHO from Jan 2021
	Lab technicians and testing	1	1	1	0	Abolish posts from Jan 2020
Communication & community engagement	Social mobilizer	1	0			Abolish post from Jan 2018
	Media, communications, and advocacy	1	1	1	0	Abolish posts from Jan 2020
Management and operations	General administration	10	6	6	5	To other program within WHO from Jan 2021
	General operations (Regular)	18	18	18	0	Abolish posts from Jan 2020
	General operations(SSA)	17	17	17	12	To other program within WHO from Jan 2021
	Total	**125**	**88**	**86**	**29**	

7.1.2 UNICEF Polio funded personnel required for the implementation of Polio activities during transition period 2018 - 2020

UNICEF had 13 polio funded technical personnel as of October 2016. However, except two the other polio funded personnel had already been transitioned in 2017 to other health programs with non-polio fund.

Table 7: UNICEF Polio funded personnel required for the next 3 years (2018 – 2020)

Function	Primary sub-function	No of polio staff in 2016	No of polio staff in 2017	No of polio staff for 2018	No of polio staff for 2019	No of polio staff for 2020	Remark
Implementation and service delivery (OPV & IPV)	Health Emergency & outbreak response planning	1	1	1	1	1	To other non-polio fund within UNICEF from Jan 2021
	Regional Polio and routine EPI consultant (Somali Region)	1	1	1	1	1	To other non-polio fund within UNICEF from Jan 2021
Community engagement & communication	Zonal communication Coordinator	7	0	0	7	4	Transferred to non-Polio fund in 2017 & 2018
	Regional Communication Coordinator	4	0	0	4	4	Transferred to non-Polio fund in 2017 & 2018
	Total	**13**	**2**	**2**	**13***	**13***	

**Non polio fund grant expires end of 2018 and there is a need to mobilize additional resources to maintain minimum polio communication function in 2019 and 2020.*

7.1.3. CORE Group Polio funded personnel required for the implementation of polio activities during transition & mainstreaming period 2018 – 2022.

The table below shows the number of polio personnel required to implement RI and surveillance activities in the existing project areas of CORE Group for 2018 – 2022.

Table 8: CORE GROUP Polio funded personnel required for the existing projects (2018 – 2022)

Function	Primary sub-function	No of polio staff in 2017	No for 2018 - 2022
Implementation and service delivery (OPV & IPV)	Central support and planning of immunization activities and SIAs	10	10
	Field supervisors of immunization activities and campaigns	57	57
Monitoring	Monitoring and evaluation	1	1
Communication	Media, communications & advocacy	1	1
Resource mobilization	Financial planning	10	10
	Total	**79**	**79**

For the existing polio project CORE Group secured budget for the next five years (Oct 2017 – Sept 2022) and the plan is to keep the existing staff until 2022 for the implementation of polio activities during transition and mainstreaming period and then transitioning them to other health interventions within CORE Group. For the available budget of the existing polio project of CORE Group, see table-13 & 14 under available budget and annex-6.

7.2 Capacity assessment and capacity building plan

One of the most important steps for implementation of polio transition and mainstreaming plan is to determine if additional capacity building is needed during the transition and execution plan. This can be achieved by using outline strategies to assess the capacity of any personnel being transitioned to carry out their new role, as well as the capacity of any organization taking on new management of polio program people or activities.

Training need-assessment for the Government technical staff implementing Immunization, surveillance and communication activities

According to national polio transition and mainstreaming strategy the government will fully take-over the responsibility to implement and mainstream polio immunization, AFP surveillance and communication activities from January 2021. Therefore for smooth take-over and mainstreaming these activities, government capacity building through trainings is essential. For this purpose all the EPI and IDSR/PHEM focal persons in the government structure and communication focal persons at Regional and Zonal levels will need training (table: 9) due to high-turnover of the trained staff by assuming that in the next three years all the trained focal persons either will be assigned to other programs or will leave the position due to promotion to higher posts or will leave the government structure.

Table 9: Training need-assessment for the Government technical staff implementing PEI activities

Health care UNIT	EPI focal persons			IDSR focal persons			Health communication/promotion		
	Number	Number needed training	Type of training needed	Number	Number needed training	Type of training needed	Number	Number needed training	Type of training needed
Woreda HOs	904	904	MLM	904	904	IDSR/PHEM			
Hospitals	181	181	IIP	181	181	IDSR/PHEM			
Health centers	3476	3476	IIP	3476	3476	IDSR/PHEM			
RHBs & ZHDs							115	115	Health promotion.
Total	**4561**	**4561**		**4561**	**4561**		**115**	**115**	

Table 10: Training schedule for the government immunization, surveillance and communication focal persons.

S/N	Type of training	No of trainees	Time		
			2018	2019	2020
1	IDSR/PHEM training for 30% of HFs & 30% of woreda	2465	X		
2	IDSR/PHEM training for 30% of HFs & 30% of woreda	1368		X	
3	IDSR/PHEM training for 10% of HFs & 40% of woreda	728			X
	Sub-total (IDSR/PHEM training)	**4561**			
1	IIP for 60% HF and MLM for 30% woreda FPs	2465	X		
2	IIP for 30% HF and MLM for 30% woreda FPs	1368		X	
3	IIP for 10% HF and MLM for 40% Woreda FPs	728			X
	Sub-total (EPI training)	**4561**			
1.	Health promotion and social mobilization training for All Regional and 50% of Zonal health communication FPs	63		X	
2.	Health promotion training for 50% of zonal communication FPs	52			X
	Sub-total Communication training)	**115**			
	Total for PHEM, EPI & Communication training	**9237**			

7.3 Budget and financial resource mobilization plan

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

This estimated budget is hereafter described under, as needed budget, available budget, and budget gap to be mobilized for the period 2018-2022.

7.3.1 Budget need (estimation) for 2018 – 2022

The bellow tables show cost estimation for the implementation of polio activities during transition and mainstreaming period 2018 – 2022 required by WHO, CORE Group, UNICEF and the government (FMoH).

Table 11: Budget need for the implementation of polio functions by agency and activity for 2018 – 2022

Function/Activity	WHO (2018 - 2022)	UNICEF (2018 - 2020)	CORE Group (2018 – 2022)	Gov. staff training (2018 - 2020)	Mainstreaming polio functions by the government (2021 – 2022)	Total cost in USD
Vaccine delivery (RI))	2,836,494	2,888,703	1,906,590	0	1,890,996	**9,522,783**
Polio SIA	14,324,000	3,960,000	443,099	0	0	**18,727,099**
Polio Surveillance (AFP surveillance)	8,450,367	0	1,813,098	0	2,246,860	**12,510,325**
Laboratory operations	321,000	0	0	0	214,000	**535,000**
Surveillance activities focusing on high risk areas	6,400,000	0	0	0	0	**6,400,000**
TA (Staff salary)	2,719,716	2,140,544	7,746,633	0	0	**12,606,893**
Capacity building for woreda & HF EPI and IDSR focal persons	0	0	0	1,824,400	1,216,266	**3,040,666**
Capacity building for Regional & Zonal Communication FPs	0	0	0	23,000	23,000	**46,000**
For 11 Vehicle purchase	0	0	0	0	1,000,000	**1,000,000**
Work-shop for PBPs introduction	50,000	0	0	0	0	**50,000**
Bi-annually Monitoring & Evaluation of transition plan activity performance	150,000	0	0	0	0	**150,000**
3-DTAs for support & monitoring of mainstreaming polio functions to health system by FMoH	144,000	0	0	0	0	**144,000**
TOTAL in USD	**35,395,577**	**8,998,247**	**11,909,420**	**1,847,400**	**6,591,122**	**64,732,766**

Table 12: Budget need for the implementation of polio functions by year for 2018 – 2022

Priority function/Program	Annual budget forecast USD					TOTAL Budget (USD)
	2018	2019	2020	2021	2022	
Vaccine delivery (Target country assistance)	2,431,246	2,363,919	2,345,074	1,212,207	1,170,337	9,522,783
Polio SIA	9,257,938	9,252,468	147,832	65,217	3,644	18,727,099
Surveillance (AFP surveillance)	4,078,052	4,064,422	1,536,981	1,475,079	1,355,791	12,510,325
Laboratory operations	107,000	107,000	107,000	107,000	107,000	535,000
Surveillance activities focusing on high risk areas	1,000,000	2,700,000	2,700,000	0	0	6,400,000
Cross cutting (Salary & TA)	3,283,250	3,247,730	3,000,554	1,541,694	1,533,665	12,606,893
Capacity building for woreda & HF EPI and IDSR focal persons	986000	547200	291200	608,133	608,133	3,040,666
Capacity building for RHB & Zonal Communication FPs	0	12,600	10,400	12,600	10,400	46,000
For 11 Vehicles purchase	0	0	0	1,000,000	0	1,000,000
Work-shop for Polio best practice introduction	0	0	50,000	0	0	50,000
Biannual M&E of transition plan	50,000	50,000	50,000	0	0	150,000
For technical support to mainstreaming of polio functions to national health system by WHO	0	0	0	72,000	72,000	144,000
TOTAL	**21,193,486**	**22,345,339**	**10,239,041**	**6,093,930**	**4,860,970**	**64,732,766**

NB: - for the detail budget need breakdown for each agency, see annexes: 4, 5, 6, and 7.

7.3.2 Available budget for the period 2018-2022

The bellow tables show the available budget for the implementation of polio functions and sub-functions for the next three years (2018 – 2020) for WHO & UNICEF and the budget available for CORE Group for 2018 – 2022.

Table 13: Available budget for the three agencies for the implementation of polio functions by agency for 2018 – 2022

Priority function/Program	Available budget						TOTAL Available Budget In USD
	WHO (2018 - 2020)		UNICEF (2018 - 2020)		CORE Group (2018 - 2022)		
	Funding source	Amount (USD)	Funding source	Amount (USD)	Funding source	Amount (USD)	
Vaccine delivery	GAVI	2,836,494	GAVI	2,888,703	USAID	1,906,590	7,631,787
Polio SIAs	GPEI	14,324,000	GPEI	3,960,000	USAID	443,099	18,727,099
Surveillance (AFP surveillance)	GPEI	7,219,336	N/A	0	USAID	1,813,098	9,032,434
Laboratory operations	GPEI	321,000	NA	0	N/A	0	321,000
Surveillance activities focusing on high risk areas	USAID	6,400,000	N/A	0	N/A	0	6,400,000
Cross-cutting (Salaries & TA)	GPEI	2,043,864	GPEI & Non-polio fund	899,848	USAID	7,746,633	10,690,345
TOTAL		**33,144,694**		**7,748,551**		**11,909,420**	**52,802,665**

NB: Only CORE Group secured budget for 2020, 2021 and 2022

Table 14: Available budget for the three agencies for the implementation of polio functions by year for 2018 – 2022

Priority function/Program	Available budget in USD					TOTAL Budget In USD
	2018	2019	2020	2021	2022	
Vaccine delivery	2,431,246	2,363,919	2,345,074	266,709	224,839	7,631,787
Polio SIAs	9,257,938	9,252,468	147,832	65,217	3,644	18,727,099
Surveillance (AFP surveillance)	4,078,052	4,064,422	305,950	351,649	232,361	9,032,434
Laboratory operations	107,000	107,000	107,000	0	0	321,000
Surveillance activities focusing on high risk areas	1,000,000	2,700,000	2,700,000	0	0	6,400,000
Cross-cutting (Salaries & TA)	3,283,250	2,714,882	1,616,854	1,541,694	1,533,665	10,690,345
TOTAL	**20,157,486**	**21,202,691**	**7,222,710**	**2,225,269**	**1,994,509**	**52,802,665**

NB: - for the detail available budget breakdown for each agency, see annexes: 4, 5, 6, and 7.

7.3.3 Budget gap to be mobilized for 2018-2022

Budget gap to be mobilized from donors for the implementation of polio functions have been supported by polio fund, due to GPEI fund ramp-down is indicated in the tables 15, 16, 17, 18 and 19.

Table 15: Budget gap for the implementation of polio functions/activities for 2018 – 2022

Function/Activity	Total budget need (USD)	Total available budget for WHO, UNICEF & CORE	Total budget Gap (USD)
Vaccine delivery (Routine Polio)	9,522,783	7,631,787	1,890,996
Polio SIA	18,727,099	18,727,099	0
Surveillance (AFP surveillance)	12,510,325	9,032,434	3,477,891
Laboratory operations	535,000	321,000	214,000
Surveillance activities focusing on high risk areas	6,400,000	6,400,000	0
TA (Salary)	12,606,893	10,690,345	1,916,548
Training for Gov. EPI, IDSR and communication FPs	3,086,666	0	3,086,666
Work-shop for Polio best practice introduction	50,000	0	50,000
By-annual M&E of transition plan activity performances	150,000	0	150,000
For 11 Vehicle purchase	1,000,000	0	1,000,000
3-WHO TAs for monitoring of mainstreaming polio functions to health system by FMoH	144,000	0	144,000
Total	**64,732,766**	**52,802,665**	**11,930,101**

Table 16: Budget gap for the implementation of polio functions by agency for 2018 – 2022

Function/Activity	WHO (2018 - 2022)	UNICEF (2018 - 2020)	Gov. staff training (2018 - 2020)	Mainstreaming polio functions by the government 2021 – 2022	Total (USD)
Vaccine delivery (Routine Polio)	0	0	N/A	1,890,996	**1,890,996**
Surveillance (AFP surveillance)	1,124,031	N/A	N/A	2,246,860	**3,370,891**
Laboratory operations	107,000	N/A	N/A	214,000	**321,000**
TA (Salary)	675,852	1,240,696	N/A	0	**1,916,548**
Training for Gov. EPI, IDSR & Communication FPs	0	0	1,847,400	1,239,266	**3,086,666**
For 11 Vehicle purchase	N/A	N/A	N/A	1,000,000	**1,000,000**
Work-shop for PBPs introduction	50,000	**0**	**0**	**0**	**50,000**
Bi-annual M&E of transition plan activity performances	150,000	0	0	0	**150,000**
3-DTAs for support & monitoring of mainstreaming polio functions to health system by FMoH	144,000	0	0	0	**144,000**
TOTAL	**2,250,883**	**1,240,696**	**1,847,400**	**6,591,122**	**11,930,101**

N/A = Not applicable

Table 17: Budget gap for the implementation of polio functions by agency and by year for 2018 – 2022

Agency	Budget gap for 2018 (USD)	Budget gap for 2019 (USD)	Budget gap for 2020 (USD)	Budget gap for 2021 (USD)	Budget gap for 2022 (USD)	Total Budget Gap for 2018 – 2022 (in USD)
WHO	50,000	50,000	2,006,883	72,000	72,000	**2,250,883**
UNICEF	0	532,848	707,848	0	0	**1,240,696**
Training for Gov. staff	986,000	559,800	301,600	0	0	**1,847,400**
FMoH for mainstreaming of polio functions to national health system	0	0	0	3,796,661	2,794,461	**6,591,122**
Total	**1,036,000**	**1,142,648**	**3,016,331**	**3,868,661**	**2,866,461**	**11,930,101**

NB: - 1. For the detail budget gap breakdown for each agency, see annexes: 4, 5, 6, and 7.

2. No budget gap to be mobilized for CORE Group, as it is already secured for 2018 – 2022.

Table 18: Proportion of budget gap for the implementation of polio functions by agency 2018 – 2022

Agency	Budget gap	Proportion
WHO	2,250,883	19%
UNICEF	1,240,696	10%
CORE Group	0	0.0%
For training Gov. staff by FMoH	1,847,400	16%
For mainstreaming of polio functions to national health system by FMoH	6,591,122	55%
Total	**11,930,101**	**100%**

8 FINANCIAL RESOURCE MOBILIZATION PLAN

To mobilize the above budget gap, different strategies are proposed, which will help to map and advocate potential local and international donors. The proposed strategies are: 1) Maintain RM from GPEI partners agencies (committed to implementation of Polio program transition strategies and activities); 2) Identify and advocate local traditional & new donors (private sectors, civil society organizations and individuals who are wealthy and well-connected people who are very useful to have as supporters); and 3). Map & advocate additional and new international donors.

The following activities are proposed for the mobilizing of the budget gap for 2018 – 2022. i) Establish resource mobilizing committee in collaboration with the resource mobilization directorate of FMOH; ii). Organize donor round table to obtain their funding commitments within agreed upon time; iii) Finalize their funding commitment in a Memorandum of Understanding (MoU) and; iv) Develop and submit ad hoc proposal to committed donors.

As expected main output, identified traditional and new international/national donors will be financially contributing to developed polio transition and mainstreaming plan. The budget gap to be mobilized for the period is summarized in the table (19) below.

Table 19: Possible Funding Source of budget gap for the implementation of polio functions for 2018 – 2022

Priority function/Program	Possible Funding Source	Annual budget forecast USD					TOTAL Budget (USD)
		2018	2019	2020	2021	2022	
Vaccine delivery (Target country assistance)	GAVI, CDC, JICA, WB, Local Donors (MEDROC, Sunshine, Lion Club, Ethiopian Diaspora, private banks & insurances).	0	0	0	945,498	945,498	**1,890,996**
Surveillance (AFP surveillance)	BMGF, Rotary, NORDA, USAID, CDC, China Government, DANGOTE, ADB, local donors (private banks & insurances).	0	0	1,124,031	1,123,430	1,123,430	**3,370,891**
Laboratory operations	CDC, BMGF, USAID , Local donors	0	0	107,000	107,000	107,000	**321,000**
TA (Salaries)	GAVI, USAID, BMGF	0	532,848	1,383,700	0	0	**1,916,548**
Capacity building for woreda & HF EPI and IDSR focal persons	GAVI, USAID, CDC, local donors	986,000	547,200	291,200	608,133	608,133	**3,040,666**
Capacity building for Regional & zonal health communication FPs	GAVI, CDC, USAID and local donors	0	12,600	10,400	12,600	10,400	**46,000**
For 11 Vehicles purchase	GAVI, USAID, CDC, local donors	0	0	0	1,000,000	0	**1,000,000**
Work-shop for Polio best practice introduction	GPEI,GAVI, USAID, CDC, local donors	0	0	50,000	0	0	**50,000**
Bi-annually M&E of transition plan activity performances	GPEI, GAVI, USAID, CDC	50,000	50,000	50,000	0	0	**150,000**
For technical support to mainstreaming of polio functions to national health system by WHO	GAVI, USAID, CDC, local privet donors, GPEI	0	0	0	72,000	72,000	**144,000**
TOTAL		**1,036,000**	**1,142,648**	**3,016,331**	**3,868,661**	**2,866,461**	**11,930,101**

NB: In 2021 and 2022, except $144,000 for technical assistance by WHO, the remaining $6,591,122 will be mobilized for the government (FMoH). The government is expected to allocate some fund in 2021 and 2022 and will cover all the costs from January 2023 with the support of partners.

For the implementation of activities foreseen in this transition plan 2018 – 2022 a resource mobilization strategy has been developed and, in order to satisfy the urgent budgetary needs as from 2018, the resource mobilization task-force was established on 29th of September 2017.

9 POLIO TRANSITION PLAN MONITORING & EVALUATION FRAMEWORK

This polio program transition plan 2018-2022 will be fully coordinated by MOH/MCH-PHEM at all levels.

The daily management will be assured in collaboration with respective agencies as agreed within the joint annual plan of action as usual.

The monitoring and evaluation processes for the transition phase have to be regulated as follows:

- Initial annual monitoring of available resources at all levels in the beginning of the year
- Biannual monitoring and evaluation of transition activities through review meetings
- Mid-term evaluation of the transition plan in the mid of 2019
- Final evaluation of the transition plan in the beginning of 2020

All these steps are detailed within the execution plan under “Monitoring and Evaluation”. The estimated cost for biannual monitoring and evaluation of activities of transition phase 2018 – 2020 is estimated at $150, 000

10 EXECUTION PLAN

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing		
						2018	2019	2020
1	**Service delivery (Routine immunization)**							
	Expected results: the level of immunity of Ethiopian population for polio and other VPDs is increased and maintained at 90 % FIC nationally and 80 % Penta3 in all Woredas.							
1.1	Continue WHO Central support to polio immunization planning and monitoring using GAVI funded staff	WHO/MCH cluster	% of immunization planning and monitoring supported by WHO		WHO/GAVI fund	X	X	X
1.2	Include technical immunization activity support to ToR of WHO field surveillance officers	WHO/MCH cluster	% of WHO field officers with revised ToR		WHO/GPEI fund	X		
1.3	Transfer WHO cold chain management support to government/PFSA	WHO, FMoH/PFSA	% responsibilities transferred to PFSA		Government, partners	X		
1.4	Transition WHO central data management activities to non-polio fund and continue support to polio data	WHO/MCH	% data managers transitioned to non-polio fund		WHO/GAVI fund	X		
1.5	Organize specific micro-planning to Implement RI in border woredas & hard to reach areas	FMoH/MCH/EPI, CORE Group, UNICEF & WHO	% of Border woredas for which micro-plans developed.		Government WHO, UNICEF, CDC, Core Group	X	X	X
1.6	Conduct regular DQS at Woreda & HFs	FMoH /MCH/EPI and WHO & UNICEF	% DQS conducted/planned		Government, WHO, GAVI	X	X	X
1.7	Support introduction of new vaccines (MR, Men-A, HPV and YF) according to the plan	MCH/EPI/WHO/UNICEF	Proportion of woredas introduced new vaccines		Government GAVI, UNICEF & WHO	X	X	
1.8	Support national catch-up Measles SIAs in 2019	FMoH/MCH/EPI + Regions WHO & UNICEF	Proportion of children vaccinated ≥95%		GAVI, UNICEF,WHO, CDC/Core Group		X	
2.	**Surveillance+ Laboratory+ Containment + Outbreak Response**							
	Expected outcomes: Certification indicators for polio eradication are maintained and expand the approach of AFP surveillance to other priority epidemic prone diseases. Any polio outbreak is appropriately interrupted within the timeframe as recommended by WHO.							
2.1	Implement quality active surveillance of AFP cases (case detection, sample transport) and integrate it with other VPD/PHEM	PHEM/WHO/CORE GROUP	AFP, measles and MNT indicators achieved and polio free status certification maintained		Government, WHO CDC, Core Group	X	X	X
2.2	Implement integrated community-based surveillance in all Woredas (including	PHEM/CORE GROUP	% of Woredas with functional integrated		Government Government, WHO,	X	X	X

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing		
						2018	2019	2020
	border woredas)		community-based surveillance		CDC and Core Group			
2.3	Support technically and financially the activities of the National Polio and Measles Laboratory (NPML)	FMoH/EPHI	Level of technical support as well as proportion of NPML funding needs		Government WHO CDC	X	X	X
2.4	Support establishment of Polio environmental surveillance in 9 Regions and 2 cities Administration.	FMoH/EPHI	Proportion of regions enrolled in environmental surveillance		Government, WHO, CDC	X	X	X
2.5	Support polio outbreak confirmation and Implementation of polio containment activities	PHEM/EPHI/WHO	Level of the implementation the Polio Containment Plan		Government, WHO, CDC	X	X	X
2.6	Strengthen AEFI surveillance system	EPI/PHEM/FMHACA	Proportion of AEFI detected and investigated per year		Government, WHO, UNICEF, CDC, GAVI	X	X	X
2.7	Strengthen Cross border collaboration and cross border notification	PHEM/CORE Group	% of meetings conducted out of planned		Government, WHO, CDC, Other partners	X	X	X
3	**Human Resources and Training**							
	Expected outcomes: Polio competencies are integrated into priority health programs, including EPI							
3.1	Repurpose some of the WHO surveillance officers to PHEM or other programs within WHO (non-polio fund)	WHO/MCH	% of WHO polio officers repurposed to other program		WHO , CDC	X	X	X
3.2	Transition WHO central immunization officers and data managers to non-polio fund (GAVI fund)	WHO/MCH cluster	% of immunization officers transitioned to other fund		WHO/GAVI fund	X		
3.3	Organize training for Woreda and HF EPI and PHEM focal persons and Regional & zonal communication FPs	FMoH/MCH & PHEM, WHO and UNICEF	% of woredas and HF focal persons trained		Fund mobilization from donors (CDC, GAVI etc)	X	X	X
3.4	Conduct training work-shop on selected polio best practices	FMoH, WHO, UNICEF and CORE Group	% of identified priority program staff trained		Fund mobilization from donors (CDC, GAVI etc.)			X
3.5	Adapt training materials and tools to country reality	Government/FMoH	% of adapted modules and training tools		WHO, UNICEF, CDC + Core Group	X		
3.6	Transfer developed polio management tools to other programs	FMoH/ MCH /PHEM + Regions	% of programs using the tools		WHO, UNICEF, CDC and CORE group	X	X	X
3.7	Provide capacity building assistance to Regions as needed	FMoH/ MCH /PHEM, WHO & UNICEF	% of technical assistants provided per year		WHO, UNICEF, CDC and Core Group	X	X	X
3.8	Continue technical support to EPI /PHEM through international consultant such as	Government FMoH/PHEM, WHO	Proportion of consultants and STOP team mobilized		WHO. UNICEF, CDC Core Group	X	X	X

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing		
						2018	2019	2020
	STOP TEAM polio	& UNICEF						
4	**Financing and Resource Mobilization (RM)**							
	Expected outcomes: Funding for the EPI and PHEM for Ethiopia high level population immunity, polio free status and effective outbreak response is ensured.							
4.1	Establish resource mobilization task-force led by FMoH	Gov./FMoH/RM directorate	% of resource mobilized comparing to the plan		Government & partners	X		
4.2	Conduct advocacy at the highest level of the State and national partners for financing polio transition plan	Government/FMoH	Level of Government and partners commitments to fund EPI and PHEM needs		WHO, Rotary International +Development Partners	X	X	X
4.3	Build human capacity to mobilize resources for EPI & surveillance at all levels	Government/FMoH/ Regions	-Level of RM capacity - % of skilled staff in RM		WHO, Rotary, Development Partners	X	X	X
4.4	Map and list potential national and international funding (donors)	FMoH & RM task-force	proportion of potential donors mapped		WHO, UNICEF and other Partners	X	X	X
4.5	Donor round table meeting to discuss business proposal for transition	Government/FMoH and partners	-proportion of partners & stakeholders attended		GPEI and other polio partners	X		
4.6	Develop new partnerships at the local, national and international levels to support polio transition plan	Government/FMoH and partners	Proportion of partnerships for polio transition plan		WHO, Rotary International+ Development Partners	X	X	X
4.7	Develop memorandum of understanding (MoU) to be signed by potential funding	FMoH and RM task-force	Proportion of partnerships signed MoU		WHO, UNICEF and other partners	X	X	X
4.8	Extend the innovative health financing mechanisms (special taxes: telephones, alcoholic beverages, tobacco, sport exhibitions, etc.).	Government/MOFD/ FMoH/ Regions	% of EPI/ PHEM funding from innovative financing mechanisms at all levels		WHO, Rotary International+ Development Partners	X	X	X
5	**Monitoring and Evaluation of transition plan**							
	Expected results: timely decision-making and planning on the basis of evidence							
5.1	Develop a monitoring and evaluation strategy for the polio transition plan	Government /MCH/PHEM	Monitoring & Evaluation strategy for the polio transition plan is available		WHO, UNICEF, CDC, Core Group	X		
5.2	Organize annually a follow-up meeting of the commitments of the agreement between stakeholders as indicated in the ad hoc MoU	Government /MCH/PHEM	Proportion of achieved commitments		WHO, UNICEF, CDC, Core Group	X	X	X
5.3	Organize an initial resource monitoring meeting at the beginning of every year for the polio transition plan	Government /MCH/PHEM	%of available funding in January of each year for the implementation of the		WHO, UNICEF, CDC, Core Group	X	X	X

S/N	Activities	Responsible	Indicator	Cost in USD	Funding sources / program	Timing		
						2018	2019	2020
			polio transition plan					
5.4	Organize biannually monitoring meetings on polio transition activities	Government /MCH/PHEM	% of implemented activities		WHO, UNICEF, CDC, Core Group	X	X	X
5.5	Organize regular Ethiopian PLPC meetings to review monitoring and evaluation data of the polio transition plan in order to take appropriate action	Government /MCH/PHEM	Proportion of annual PLPC meetings to review M& E data		WHO, UNICEF, CDC, Core Group + key immunization partners	X	X	X
5.6	Organize a mid-term evaluation of the polio program transition activities of phase1 (2018-2020)	Government/GPEI	Performance level of the implementation of the polio transition plan		GPEI /AFRO/ESARO WHO, UNICEF, CDC, Core Group		X	
5.7	Conduct final evaluation of the Ethiopia polio program transition activities phase1 (2018-2020)	Government/ GPEI	Outputs and outcomes from the implementation of the Ethiopia polio transition plan		GPEI /AFRO/ESARO WHO, UNICEF, CDC, Core Group			X

11 CONCLUSION

Despite progresses in overall child health and advances in immunization, Ethiopia still has gaps in Polio eradication activities including low routine immunization coverage in some regions, especially pastoralist population and border woredas as well as hard to reach areas.

A harmonious implementation of this polio transition plan through mainly proposed activities for routine immunization, polio surveillance and communication, outbreak response and containment will for sure lead to a smooth transition towards a promising post –polio eradication era.

This polio program transition plan 2018-2022 is in particular in line with the HSTP guiding principle of equity and quality as it aims to ensure equal immunization service and disease surveillance to all eligible population through acceptable strategies linked to community needs.

During the transition phase, which covers 2018 – 2020 the polio program activities (Polio immunization and AFP/Polio surveillance) will be maintained as they are implemented by support of partners (WHO, UNICEF and CORE group) using existing structure and assets through financial gap mobilization from traditional and new donors.

From January 2021, the government will take full responsibility to fully mainstream polio functions to national immunization and surveillance systems through resource mobilization from national and international donors. For smooth take-over and mainstreaming polio activities to national health systems by the government, some of the WHO polio funded vehicles will be transferred to the government (FMoH). Detail transitioning activities with time-frame to be designed by WHO and government (FMoH) during transition period 2018 – 2020, to initiate transition process and the assets to be fully operational in new roles starting from 2021.

Even after global polio eradication achieved, NGOs under CORE Group will continue supporting RI and surveillance activities with other health interventions at border woredas, by mobilizing resources from donors. Therefore, the transitioning of polio funded vehicles to government (FMoH) will be done according to the agreement between the NGOs under Core group and government.

To support government financing efforts in mainstreaming polio functions to national EPI and surveillance systems during phase2 of the plan, $6,591,122 will be mobilized for the government by resource mobilization task-force for 2021 and 2022.

12 RECOMMENDATIONS

Here below few selected key recommendations.

1. Implementing the activities fore-seen in this polio program transition plan 2018 – 2022 focusing on maintaining polio free status and ensure that the investments devoted to polio eradication are contributed to future health goals.
2. Actively mobilize resources for implementation of activities fore-seen in this transition plan 2018 – 2022.
3. Develop a specific health plan targeting pastoralist community, border and low performing woredas aligned with FMOH revitalized health extension program strategy
4. Promote inter-sectoral collaboration, especially for pastoralist and border woredas.
5. Expand environmental surveillance by opening new sites to all regions bordering other countries
6. Conduct operational research to assess the quality of routine EPI, surveillance and communication
7. Monitor & evaluate transition activities biannually by FMoH/EPHI supported by all partners.
8. Disseminate the identified polio best practices for the benefit of other national health priorities
9. With support of partners, FMoH to develop national strategic plans for after 2020 and for post-polio certification to mainstream polio functions to national health system and maintain polio free status.

REFERENCES

1. GPEI. Polio Eradication & Endgame Strategic Plan 2013–2018. Geneva: GPEI; 2016.

2. GPEI. Polio Legacy: Planning for a Polio-Free World. Geneva: GPEI; 2014

4. Putting Immunization at the Heart of Health Systems. London: RESULTS; 2016.

5. GPEI. Polio Legacy Planning: Guidelines for Preparing a Transition Plan. Geneva: GPEI; 2015.

6. Pakistan, National Emergency Action Plan for Polio Eradication 2015-2016

7. GPEI, Contributions to the Global Polio Eradication Initiative, 1985 -2018

8. GPEI, Independent Monitoring Board of the Global Polio Eradication Initiative, Every Missed Child, Geneva, 2012

9. WHO, Ministerial Brief: Polio Legacy Transition Planning, December 2015

10. Ethiopia, FMoH, Health Sector Transformation Plan 2016 -2020, FMoH, August 2015

11. Ethiopia, FMoH, Comprehensive Multi-year Plan 2016.-2020

12. GPEI, WHO-UNICEF, Joint Strategic Acton Plan for Polio Outbreak Response in the Horn of Africa, November 2013

13. GPEI, Sustaining Progress against Polio in Ethiopia, July 2015

14. WHO, UNICEF & CORE Group/Ethiopia, Budget Contribution to Resource Mobilization Strategy, August 2017

15. WCO/ Ethiopia, Resource Mobilization Strategy, August 2017

16. FMoH/ Ethiopia, Polio Program Transition Simulation Exercise Workshop, report, April 2017

17. FMoH/Ethiopia, Polio funded personnel and physical asset mapping as of October 2016

18. FMoH/Ethiopia, Polio Best Practices Documentation, March 2017

19. UNICE/Ethiopia, Polio transition human resource plan, August 2017

20. UNICEF/Ethiopia, Polio transition capacity assessment and capacity building plan, September 2017

21. FMoH/Ethiopia, Ethiopia Pastoralist population, bordering and lower performing Woredas, April 2017

22. WHO/Ethiopia, draft Polio asset case business, October 2017.

23. FMoH/Ethiopia, Measles Strategic Plan 2012-2020, 2012

24. FMoH/Ethiopia, HRH Plan 2016 –2025

25. FMoH/Ethiopia, Documentation for polio free status, June 2017

26. WHA, Polio as Public Health Emergency, 2012 + WCO/Ethiopia Documentation on PHEM program 2017

27. PHEM/ WHO- Public Health Emergency Program, June 2017

28. GPEI, Polio Transition Planning FAQ, March 2015.

ANNEXES

Annex 1: Plan of action 2016/2017 for Ethiopia polio transition planning exercise

Polio Legacy Action Plan 2016-2017 , Ethiopia

Steps to transition	Actions required	Evidence of achievement	Year / Months / weeks	2016 (August Wk1–Wk4, September Wk1–Wk4, October Wk1–Wk4, November Wk1–Wk4, December Wk1–Wk4)	2017 (January Wk1–Wk4, February Wk1–Wk4)	PROPOSED BUDGET in USD	ACHIEVEMENT STATUS
			Suggested timeframe				
Organizing the transition planning process	*1. To involve Governing body*	*Ethiopian ICC clearing the Polio Legacy plan*	*Month 1 to Month 6*				
	1.1 To inform ICC members about the polio legacy planning exercise going on	An ad hoc official letter sent to all ICC members	Month 2				
	1.2 ICC endorses the developed polio transition plan 2017-2019	Ethiopia Polio Transition Plan 2017-2019 endorsed by ICC	Month 6			0	
	2. Donor and civil society engagement and participation in the polio legacy planning process	Commitment of the Polio Legacy Plan Partners Group to participate in all planning activities	*Months 1 to 7*				
	3. Coordination, oversight and action teams established	*TOR and membership for coordination, oversight and action teams available*	Month 1				
	3.1 Put in place a Polio Legacy Planning Committee(PLPC) with clear ToRs	TOR and membership for coordination and oversight team available	Month 1				
	3.2 Organize monthly PLPC meetings	Meeting minutes available	Months 2 to 7			2500	
	3.3 Put in place a Polio Legacy Planning Technical Task Force (PLPTTF)	TOR and membership for technical actions are available	Month 1				
	3.4 Organize weekly PLTTF meetings	Meeting minutes available	Months 1 to 7				
	4. Scope and timeline for transition planning defined	*Decisions on scope and timeline documented in governing body meeting minutes or communications*	*Month 1 and 2*				
	4.1 Define scope and timeline for transition planning	Plan of action for transition planning is available	Month 1				
	4.2 Get the scope and timeline for transition planning endorsed by MOH and by key partners	Briefing visits and communications documented	Month 2			0	
	5. Communication and advocacy strategy in place	*Written communication and advocacy strategy document available*	*Month 2*			*1200*	
Developing transition plans	*6. Mapping of polio program resources (all assets, functions, etc.) completed*	*Resource mapping data available and disseminated*	*Mont1 to 3*				
	6.1 To initiate a mapping exercise of polio program resources	Resource mapping data available	Month 1				
	6.2 To finalize mapping of polio program functions and resources	Function and resource mapping data available	Month 2				
	6.3 To disseminate the finalized mapping of polio program functions and resources	Mapping data of polio program functions and resources disseminated	Months 2 and 3			1200	
	7. Strategy for capturing and operationalizing lessons learned established, documentation efforts begin	*Written strategy document for capturing and disseminating lessons learned available*	*Month 2*				
	7.1 To get an official list of polio best practices and lessons learnt documented or not	A list of polio best practices and lessons learnt endorsed by MoH is available	Month 2				
	7.2 To develop a strategy to capture and disseminate polio best practices and lessons learnt	Written strategy document for capturing and disseminating lessons learned available	Month 2			1200	
	8.Transition simulation exercise conducted	*Written simulation exercise report available*	*Month 3*				
	8.1 Write various transition scenarios	Various transition scenarios are available (see Appendix C)	Month 3				
	8.2 Organize a PLPC meeting to adopt each scenario	Minutes of The PLPC meeting	Month 3			0	
	9. Coordination strategies established for integration with other national, regional/sub-regional health priorities and related planning processes (eMYP, 2015 Health Sector Transformation Plan etc.)	*Governing body reviews and endorses coordination strategies*	*Month 3*				
	9.1 Identify interrelation and gaps between GVAP and the future Polio Legacy Plan	Opportunities and possible contributions to GVAP identified and incorporated in the mapping of potential transitionopportunities (see Appendix D)	Month 3				
	9.2 Identify interrelation and gaps between the actual 2015 Health Sector Transformation Plan and the future polio legacy plan	Opportunities and possible contributions to National Health Strategy identified and incorporated in the mapping of potential transitionopportunities (see Appendix D)	Month 3				
	9.3 Identify interrelations and gaps between the polio related strategies or plans (e.g. CMYP,interministerial committees,etc...)	Opportunities and possible contributions to these concerned strategies, and plans identified and incorporated in the mapping of potential transitionopportunities (see Appendix D)	Month 3			0	
	10. Mainstreaming strategies for essential polio functions developed	*Written list of mainstreaming strategy concepts available*	*Month 3*				
	10.1 Meanstream polio immunization using IPV into routine immunization program in accordance with GVAP requirements (principles, targets and indicators)	A strategy to meanstream polio immunization using IPV is available	Month 3				
	10.2 Meanstream polio surveillance and outbreak response within the national IDSR system and in accordance with GVAP requirements (principles, targets and indicators)	A strategy to meanstream polio surveillance and outbreak response is available	Month 3				
	10. 3 Meanstream appropriate biocontainment of polioviruses and appropriate biosecurity in accordance with national legislation, standardize regulations, and protocols.	A strategy to meanstream containment of poliovirruses is available	Month 3			0	
	11. Transition strategies for non-essential polio program functions developed	*Written list of transition strategy concepts available for non-essential polio functions*	*Month 4*				
	11.1 Meanstream polio functions and assets that contribute to other health or development priorities	A strategy to meanstream non-essential polio program functions is available	Month 4				
	11.2 Develop a specific plan to build local capacity to take over management and implementation of polio program while phasing out polio program assets.	A specific local capacity building plan is available	Month 4			1200	
	12. Transition opportunities prioritized	*Minutes of governing body meeting identifying top priority transition strategies to be pursued*	*Month 4*			0	
	13. Business case for top priority transitions strategies available	*Costed business case available for each set of transition and mainstreaming strategies*	*Month 4*				
	13.1 Build a business case for meanstreaming of polio immunization using IPV	Business case for meanstreaming of polio immunization using IPV is available	Month 4				
	13.1 Build a business case for meanstreaming of polio surveillance and outbreak response	Business case for meanstreaming of polio surveillance and outbreak response is available	Month 4				
	13.1 Build a business case for meanstreaming of polioviruses containment	Business case for meanstreaming of polioviruses containment is available	Month 4				
	13.1 Build a business case for meanstreaming of non essential polio program functions	Business case for meanstreaming of non-essential polio program functions is available	Month 4			0	
	14. Resource mobilization strategy established	*Meetings scheduled with donor consortium/bilateral donors to discuss transition business cases*	*Months 4 & 5*				
	14.1 To write a resource mobilisation strategy	A resource mobilization strategy is available	Month5			1200	
	14.2 To organise a national roundtable to mobilize resources need for the adequate implementation of the Ethiopia Polio Transition Plan 2017-2019	Minutes of the national roundtable are available	Month 5				
	15. Financing strategy in place	*Donor commitments received*	*Month 5*			3000	
	16. Transition strategies for all public resources (including mainstreaming of essential functions) finalized	*Formal endorsement of final transition strategies documented in minutes of governing body meeting, official correspondence to stakeholders from the government, or other formal means*	*Month 6*				
	16.1 Torganize the endorsement of final polio transition strategies	Formal endorsement of final transition strategies documented in minutes of governing body meeting, official correspondence to stakeholders from the government, or other formal means	Month 6			0	
	Human resource plan in place						
	Capacity-building strategy in place						
	Communication plan in place	*Written transition execution document available, including all indicated sections*	*Month 1 to Month 5*				
	M&E framework established						
	Detailed execution budget created					0	
	18. MOU drafted and signed	*Signed MOU document*	*Month 6*				
	18.1 Draft MOU and make it signed	Draft MOU available, accepted and signed	Months 6 & 7			1200	
	19. Activity Chronogram for the international Consultant	Provide technical guidance for the entire Polio Transition Planning process	Months 1 to 7			0	
						Total:	13200

Annex 2 Revised work-plans 2017 for Ethiopia Polio Transition Planning Exercise

Item (Activity/Consultant/Investment)	Expected outcomes	Start Date	End Date	Length (months)	Location	Estimated Cost (USD)	Leading Government/agency	Source of Funds (if known)	Notes/Comments
Compile simulation exercise results	Workshop report	28-Apr-17	26-Apr-17	1 week	Addis	0	Ministry of Health - Getnet	NA	
share report with stakeholders and encorporate comments	Final report	14-Aug-17	30-Aug-17	2 week	Addis	0	Ministry of Health - Getnet	NA	
Develop resource mobilization strategy, advocate for increased domestic investment and identify donors	strategic document	30-Aug-17	15-Sep-17	1 months	Addis	$9,000	WHO (RM Consultant)	WHO	
Finalize asset mapping	final asset map	20-Apr-17	30-Apr-17	1 week	Addis	Funded	Tseday, Ulla	NA	
Align functions with country priorities	aligned fuctions with health priority	20-Apr-17	30-Apr-17	2 weeks	Addis	$9,000	National Consultatn /Ibrahim/	WHO/UNICEF	
Finalize polio communication best practice documentations	Final best practice document	14-Aug-17	30-Aug-17	2 weeks		Funded	Communication Consultant /Metchal/	UNICEF	
Meeting with PLPC to endorse workshop report, asset mapping	Endorsed report	15-Aug-17	15-Oct-17	1 week	Addis	0	MoH -Getnet	NA	
Detail documentation of polio functions (challenges, invotations and best practices ….) To be outsourced for consultants	Documented polio functions	09-Oct- 17	08-Jan-18	3 months	Addis	$20,000	FMoH & UNICEF	UNICEF	
Select and decide transition strategic options	selected Transition strategic option	1-Sep-17	20-Oct-17	3 weeks	Addis	0	FMoH & Partners	NA	
Finalize Resource Mobilization strategy document	Submit final version to FMoH	15-Oct-17	30-Oct-17	2 weeks	Addis	0	WHO/Yilfashewa	WHO	
Develop and submit Human resource plan to FMoH	Finalize draft HR plan	8-Aug-17	30-Aug-17	3 weeks	Addis	0	National Consultatn / Dr.Ibrahim/	UNICEF	
Develop Capacity assessment & Capacity building plan	Develop capacity building plan	15-Aug-17	30-Sep-17	1 1/2 months	Addis		National Consultatn /Dr.Ibrahim	UNICEF	
Costing analysis for business case (working with international consultant)	Cost analysis document	5-May-17	5-Oct-17	1 weeks	Addis, NY	0	Ulla	NA	
Develop business case model	draft document	14-Aug-17	12-Oct-17	2 weeks	Addis, NY		Ulla	NA	
Review and finalize business case	final document	14-Aug-17	30-Aug-17	2 weeks	Addis, NY	0	Ulla	NA	
Disseminate the business case for stakeholders	final document	25-Aug-17	30-Sep-17	1 months	Addis	0	UNICEF	NA	
Organize donor roundtable discussion	Discussion reports	10-Dec-17	15-Dec-17	1 week	Addis	$2,000	FMoH & UNICEF	GPEI	
draft Memorandum of understanding of the donor	signed document	1-Oct-17	15-Oct-17	2 weeks	Addis	0	FMoH (Liya & Getnet)	NA	
Draft transition plan with road map	draft document	15-Oct-17	20-Oct-17	1 week	Addis	0	National Consultatn /Dr.Ibrahim	NA	
Share draft transition plan with stakeholders	document	20-Oct-17	25-Oct-17	1 week	Addis	0	PLPC	NA	
PLPC meeting to review final transition plan	Reviewed transition plan	25-Oct-17	30-Oct-17	1 week	Addis	0	PLPC	NA	
ICC endorses transition plan and roadmap	endorsed transition plan	1-Nov-17	10-Nov-17	2 weeks	Addis	0	Liya & Getnet	NA	
Finalize transition plan, share with GPEI	final transtion plan	15-Nov-17	30-Nov-17	2weeks	Addis	0	Getnet Bayih	NA	
Conduct advocacy & sentisization activities based on the transtion plan	Activity report	20-Nov-17	As needed				MoH, Partners (Rotary, UNICEF, WHO & Core Group)		

Annex 3: Revised Work-plan of 2018 for Ethiopia Polio Transition and mainstreaming Planning Exercise

Item (Activity/Consultant/Investment)	Expected outcomes	Start Date	End Date	Length (months)	Location	Estimated Cost (USD)	Leading Government/agency	Source of Funds (if known)	Notes/Comments
Detail documentation of polio functions through field survey (challenges, invitations and best practices ….)	Documented polio functions	15-Oct-17	1/15/2018	three months	Addis Ababa	$20,000	FMoH & UNICEF	UNICEF	Done and shared with PLPC
Submit final Resource Mobilization strategy document to FMoH	Submit final version to FMoH	15-Jan-18	2/30/18	1 1/2 months	Addis	0	WHO/Yilfashewa	WHO	
Submit final Human resource plan to FMoH	Finalize draft HR plan	15-Jan-18	2/30/18	1 1/2 months	Addis	0	National consultant / Dr.Ibrahim/	UNICEF	
Submit final Capacity assessment & Capacity building plan	Develop capacity building plan	15-Jan-18	2/30/18	1 1/2 months	Addis		National consultant /Dr.Ibrahim	UNICEF	
Costing analysis for business case (working with international consultant)	Cost analysis document	15-Jan-18	2/30/18	1 1/2 months	Addis, NY	0	Ulla	NA	
Develop business case model	draft document	15-Jan-18	2/30/18	1 1/2 months	Addis, NY		Ulla	NA	
Submit final draft polio program transition plan with road map to FMoH	final document	15-Jan-18	2/20/18	1 months	Addis	0	National Consultant / Dr.Ibrahim/	UNICEF	
PLPC meeting to review final transition plan	Reviewed transition plan	10-Mar-18	22-Mar-18	1 week	Addis	0	PLPC	NA	
ICC endorses transition plan and roadmap	endorsed transition plan	24-Mar-18	8-Apr-18	2 weeks	Addis	0	Liya & Getnet	NA	
Finalize transition plan, share with GPEI	final transition plan	15-Apr-18	20-Apr-18	1weeks	Addis	0	Getnet Bayih	NA	
Conduct advocacy & sensitization activities based on the transition plan	Activity report	15-Apr-18	As needed				MoH, Partners (Rotary, UNICEF, WHO & Core Group)		
Organize donor roundtable discussion	Discussion reports	22-Apr-18	30-Apr-18	1 week	Addis	$2,000	FMoH & UNICEF	GPEI	
draft Memorandum of understanding of the donor	signed document	1-May-18	15-May-18	2 weeks	Addis	0	FMoH (Liya & Getnet)	NA	

Annex 4: WHO budget detail for 2018 -2022

1. WHO estimated cost for the implementation of polio activities during transition period 2018 – 2020 & for the technical support to FMoH during mainstreaming in 2021 and 2022

Priority function/Program	Annual budget forecast USD					TOTAL Budget In USD
	2018	2019	2020	2021	2022	
Vaccine delivery (Target country assistance)	945,498	945,498	945,498	0	0	2,836,494
Polio SIAs operations	7,162,000	7,162,000	0	0	0	14,324,000
Surveillance (AFP surveillance)	3,663,168	3,663,168	1,124,031	0	0	8,450,367
Laboratory operations	107,000	107,000	107,000	0	0	321,000
Surveillance activities focusing on high risk areas	1,000,000	2,700,000	2,700,000	0	0	6,400,000
TA (Salaries)	1,051,932	991,932	675,852	0	0	2,719,716
Work-shop for Polio best practice introduction	0	0	50,000	0	0	50,000
Bi-annually M&E of Transition plan activity performances	50,000	50,000	50,000	0	0	150,000
3-TAs to support & monitor mainstreaming polio functions to health system by FMoH	0	0	0	72,000	72,000	144,000
TOTAL	**13,979,598**	**15,619,598**	**5,652,381**	**72,000**	**72,000**	**35,395,577**

2. WHO budget available for the implementation of polio functions for the next three years (2018 – 2020)

Priority function/Program	Funding source	Annual budget forecast USD			TOTAL Budget In USD
		2018	2019	2020	
Vaccine delivery (Target country assistance)	GAVI	945,498	945,498	945,498	2,836,494
Polio SIAs operations	GPEI	7,162,000	7,162,000	0	14,324,000
Surveillance (AFP surveillance)	GPEI	3,663,168	3,663,168	0	7,326,336
Laboratory operations	GPEI	107,000	107,000	0	214,000
Surveillance activities focusing on high risk areas	USAID	1,000,000	2,700,000	2,700,000	6,400,000
Salaries (TA)	GPEI	1,051,932	991,932	0	2,043,864
TOTAL		**13,929,598**	**15,569,598**	**3,645,498**	**33,144,694.00**

3. WHO budget gap for the implementation of polio activities during transition period 2018 – 2020 & for the technical support to FMoH during mainstreaming in 2021 and 2022

Priority function/Program (GAP)	Annual budget forecast USD					TOTAL Budget In USD
	2018	2019	2020	2021	2022	
Vaccine delivery (Target country assistance)	0	0	0	0	0	0.00
Polio SIAs operations	0	0	0	0	0	0.00
Surveillance (AFP/Polio surveillance and lab operations)	0	0	1,231,031	0	0	1,231,031
Surviellance activities focusing high risk areas	0	0	0	0	0	0.00
TA (Salaries)	0	0	675,852	0	0	675,852
Work-shop for Polio best practice introduction	0	0	50,000	0	0	50,000
Monitoring & Evaluation of transition plan	50,000	50,000	50,000	0	0	150,000
For technical support to mainstreaming of polio functions to national health system by WHO	0	0	0	72,000	72,000	144,000
TOTAL	**50,000**	**50,000**	**2,006,883**	**72,000**	**72,000**	**2,250,883**

Annex 5: UNICEF budget detail for 2018 – 2020

1. UNICEF estimated cost for the implementation of polio activities during transition period 2018-2020

Priority function/Program	Annual budget forecast USD			TOTAL
	2018	2019	2020	Budget (USD)
Vaccine delivery (Target country assistance)	962,901	962,901	962,901	**2,888,703**
Polio SIAs	1,980,000	1,980,000	0	**3,960,000**
TA (Salary)	724,848	707,848	707,848	**2,140,544**
Total	**3,667,749**	**3,650,749**	**1,670,749**	**8,989,247**

2. UNICEF budget available for the implementation of polio functions for the next three years (2018-2020)

Priority function/Program	Funding source	Annual budget forecast USD			TOTAL
		2018	2019	2020	Budget (USD)
Vaccine delivery (country assistance)	GAVI	962,901	962,901	962,901	**2,888,703**
Polio SIAs	GPEI	1,980,000	1,980,000	0	**3,960,000**
TA (Salary)	GPEI + Non-polio funding	724,848	175,000	0	**899,848**
TOTAL		**3,667,749**	**3,117,901**	**962,901**	**7,748,551**

3. UNICEF budget gap for the implementation of polio functions for the next three years (2018-2020)

Priority function/Program	Annual budget forecast USD			TOTAL
	2018	2019	2020	Budget (USD)
Vaccine delivery (Target country assistance)		0	0	0
Polio SIAs	0	0	0	**0**
Technical Assistance	0	532,848	707,848	**1,240,696**
TOTAL	**0**	**532,848**	**707,848**	**1,240,696**

Annex 6: Available budget for existing Core Group polio project for Oct 2017 – Sep 2022

SN	Budget Category	FY2018	FY2019	FY2020	FY2021	FY2022	Total
1	**Vaccine Delivery (RI including OPV & IPV)**	**522,847**	**455,520**	**436,675**	**266,709**	**224,839**	**1,906,590**
1.1	Capacity building (IIP/MLM/CC Maintenance)	154,345	118,855	87,719	41,564	8,187	410,669
1.2	Print and distribute recording, reporting and IEC materials Supplies	21,631	22,140	22,631	16,139	11,605	94,146
1.3	Monitoring, supervision & review meetings	155,122	135,099	144,180	66,814	123,070	624,284
1.4	Fuel, maintenance, DSA for outreach - RI	191,750	179,426	182,144	142,192	81,977	777,490
2	**Supplementary Immunization Activities**	**115,938**	**110,468**	**147,832**	**65,217**	**3,644**	**443,099**
2.1	Community sensitization	28,985	27,617	36,958	16,304	911	110,775
2.2	Transportation and logistic support	86,954	82,851	110,874	48,913	2,733	332,324
3	**Surveillance**	**414,884**	**401,254**	**412,950**	**351,649**	**232,361**	**1,813,098**
3.1	Establish and strengthen Community Based Surveillance /CBS/	109,713	108,936	110,652	77,031	22,514	428,847
3.2	Effective engagement of CSOs and stakeholders Partnership	73,848	75,990	77,232	70,657	14,783	312,509
3.3	Certification and Cross border PEI activities	26,901	29,197	29,433	28,914	11,327	125,772
3.4	monitoring, Supervision and stool transport - Travel	204,422	187,131	195,632	175,048	183,737	945,970
4	**Cross Cutting**	**1,506,470**	**1,547,950**	**1,616,854**	**1,541,694**	**1,533,665**	**7,746,633**
4.1	Personnel (Staff Salary &Benefits)	1,005,847	1,063,218	1,135,896	1,152,847	1,185,973	5,543,782
4.2	Operational Cost - Other Direct Cost	284,390	281,327	287,450	236,916	214,005	1,304,086
4.3	Equipment	27,851	11,034	5,272	4,917	-	49,075
4.4	Documentation and use of information	26,078	26,762	28,175	19,480	22,266	122,761
4.5	Indirect Cost - NICRA	162,305	165,609	160,061	127,533	111,421	726,929
	Grand Total	**2,560,139**	**2,515,192**	**2,614,311**	**2,225,269**	**1,994,509**	**11,909,420**

Annex 7: Budget need for the government (for capacity building and mainstreaming) for 2018 – 2022

1. **Budget need for the training of government IDSR, EPI and communication focal persons (2018 – 2020)**

Function/Activity	Year 2018 (USD)	Year 2019 (USD)	Year 2020 (USD)	Total (USD)
IDSR/PHEM training	493,000	273,600	145,600	912,200
IIP	438,800	219,400	73,200	731,400
MLM	54,200	54,200	72,400	180,800
Health Communication	0	12,600	10,400	23,000
Total	**986,000**	**559,800**	**301,600**	**1,847,400**

2. **Budget need for the mainstreaming of polio functions to national health system by FMoH for 2021– 2022**

Function/Activities	2021 (USD)	2022 (USD)	Total in USD
Vaccine delivery (monitoring and supervision)	945,498	945,498	1,890,996
Surveillance (Active case search, stool transportation, outbreak investigation)	1,123,430	1,123,430	2,246,860
Laboratory (sample testing, bio-containment, environment surveillance)	107,000	107,000	214,000
Capacity building (EPI and Surveillance FPs)	608,133	608,133	1,216,266
Capacity building for communication FPS	12,600	10,400	23,000
For 11 Vehicle purchase	1,000,000	0	1,000,000
TOTAL in USD	**3,796,661**	**2,794,461**	**6,591,122**