HEALTH CLUSTER BULLETIN # 9

30 September 2017

South Sudan
Emergency type: Complex Emergency
Reporting period: 1-30 September 2017

<table>
<thead>
<tr>
<th>7.5 MILLION</th>
<th>2.7 MILLION</th>
<th>2 MILLION</th>
<th>1.9 MILLION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFFECTED</td>
<td>TARGETED</td>
<td>DISPLACED</td>
<td>REFUGEES</td>
</tr>
</tbody>
</table>

**HIGHLIGHTS**

So far, the **Health Cluster funding** for HRP 2017 remains at **18%**. With the continued armed conflict and resultant displacement and diseases, the **needs are increasing** while the health response is limited. Impaired access to populations in need continue to increase the cost of operations. As the **heavy rains continue** and **security remains unpredictable**, the humanitarian health situation can only get worse during the remaining part of the year.

The Health cluster hosted 4 **emergency responders meetings** where partners discussed emerging contextual and disease trends, gaps and response. Through the **ICWG prioritization**, the Health Cluster responded with essential life-saving health services in Mvolo, Pading, and Weinchoł.

To **reduce malaria** as well as other vector borne diseases such as lymphatic filariasis and diarrhoeal diseases, the **MENTOR Initiative** conducted **vector control** activities including spraying of mosquito breeding sites, indoor residual spraying of shelters and fly control of open defecation sites, latrines and garbage sites in Bentiu and Malakal PoC as well as in Maban. Besides, the organization in partnership with WHO and the MoH conducted mass drug administration (MDA) to prevent onchocerciasis in nine counties of former Western Equatoria State.

| 35 | HEALTH CLUSTER PARTNERS EARMARKED IN HRP TO IMPLEMENT HEALTH RESPONSE |
| 113 | ASSORTED MEDICAL KITS |
| 5 558 205 | OPD CONSULTATIONS* |
| 1 089 942 | DOSES OF ORAL CHOLERA VACCINE |
| 47 | EWARS SENTINEL SITES |
| 123 M | REQUESTED |
| 21.6 M | FUNDED (17.6%) |
| 101.4 M | GAP |

* Since January 2017
Situation update

- The overall security situation in the country remains volatile and unpredictable. While it was generally calm in some parts of the country, armed conflict was reported in central and northern Unity and northern Jonglei.

- The protracted political and socioeconomic crises resulted in a severe deterioration of living conditions which has also significantly impacted the health system negatively.

- Compromised delivery of services due to security and access challenges along with funding uncertainty hindered health project implementation and continuity.

Public health risks, priorities, needs and gaps

Health risks

- **Population movements and epidemic prone diseases:** Health service delivery to areas where there are increased numbers of internally displaced persons remains a challenge with increased risks to epidemic prone diseases as IDP continuously move to locations with access difficulties. Operational costs have doubled as very expensive air assets are often required to facilitate response. Ongoing cholera outbreak and upsurge of malaria during this rainy season remain some of the main risks.

- **Water, sanitation and hygiene remain a challenge nationwide:** Open defecation is common practice and a high-risk factor for cholera transmission especially with the current ongoing cholera outbreak. Partners continued to support the MoH to address the WASH needs through the provision of basic WASH services and IPC in health facilities. WHO conducted a detailed baseline WASH assessment in health facilities, CTC, CTU and ORP to guide the strategic plan.

- **Malnutrition related morbidities:** Many locations are still reported in catastrophic and emergency IPC phases. In the former famine declared areas, it is estimated that 2100 children with SAM with medical complications will need admission to SC. WHO is currently supporting about 90% of SC across the country. WHO staff participated in a regional workshop for emergency nutrition response to further strengthen response in emergencies.

- **Morbidities in IDP sites:** Malaria, ARI, TB, HIV/AIDS, and measles continue to be major causes of morbidity and mortality in IDP locations and surrounding host communities. In the general population, medical complications from malnutrition, severe pneumonia, severe malaria and perinatal complications remain the most common causes of death in children under 5 years. The MoH in collaboration with the Health Cluster partners continue to keep the CMR for under-fives within the emergency thresholds.

- **Reduced herd immunity:** Routine EPI coverage is generally poor in conflict-affected locations and is further complicated by looting of cold chain equipment and displacement of health workers. Only 38% of children have received measles vaccine, 45% received polio vaccine and 29% received Pentavalent 3 before the age of one in 2017. This low routine immunization coverage will affect herd immunity against vaccine preventable diseases.

- **Measles follows up campaign in conflict affected states:** A total of 1 634 190 children have been immunized with coverage of 87% in 48 counties with plans to cover another 29 counties in November. The Health Cluster continues to collaborate with the MoH and development partners to reach the displaced and those living in remote locations with the support of rapid response teams.

- **Severe shortages of essential medicines:** There is a break in the current health core pipeline due to limited funding and long delays in procurement processes. This has affected service delivery at the health facilities.

- **Mental health, sexual and gender-based violence (SGBV) related services:** Despite a significant proportion of the population being affected by mental health conditions, services are grossly inadequate especially at the PHCC level. WHO, IOM and MoH embarked on scaling up the use of the simple mental health guidelines - mhGAP-HIG at the PHCC level by training 14 health workers from the high volume PHCC of Kator, Munuki, Nyokuron and Gurei.

- **Surveillance reporting:** It remains a challenge to achieve the 80% surveillance reporting target. The average weekly IDSR reporting for August was 62% timeliness and 68% completeness. Some of the reasons for this include the low phone network coverage across the country and lack of handsets for mobile data reporting.
Health Cluster Priorities

- The Health Cluster continues to deploy key expertise in coordination and information management at national and sub-national levels to ensure a well-coordinated response across the country and specifically in locations most affected by conflict, displacement and famine.
- The Health Cluster is committed to its capacity building agenda through trainings on topics identified by a training needs assessment earlier, aimed at increasing knowledge and skills of partners in health project management and service delivery.
- AAP remains top on the list of the cross-cutting issues that should be mainstreamed in all health projects. The Health Cluster has taken every opportunity to refresh partners of the five AAP commitments.
- Work towards increased availability of essential medicines and medical commodities for PHC services, trauma and severe malnutrition with complications.
- Strengthen and sustain ongoing inter-cluster collaboration and response with WASH/Nutrition/Food Security and Livelihoods and with development partners in responding holistically to outbreaks.

Needs and Gaps

- Out of the 7 sub-national health cluster coordinators required, only four were deployed. These are vital positions for a country with complex emergency across vast geographical locations, with multiple partners responding to provide essential health services to vulnerable populations. It is only at this level that the Health Cluster can be able to identify and verify needs and gaps, coordinate response and ensure verify accountability to affected populations.
- There is an increasing need for MHPSS for both the beneficiary populations and aid workers, including health workers. This has resulted from the difficult work environment, armed conflict, displacement, diseases, food insecurity, and deaths, all compounded by unpredictable security situation. MHPSS was identified as an objective of the Health Cluster for 2017, however, low funding of the HRP has affected overall performance on this objective.
- So far the Health Cluster funding for HRP 2017 remains at 18%. With the continued armed conflict and resultant displacement and diseases, the needs are increasing while the health response is limited. Impaired access to populations in need continue to increase the cost of operations. As the heavy rains continue and security remains unpredictable, the humanitarian health situation can only get worse during the remaining part of the year.

Health Cluster Activities

Coordination

- The Health Cluster hosted two national coordination meetings and 8 sub-national coordination meetings in Bentiu and Malakal. During these meetings partners were updated on the general operational context in the country, IDSR and EWARS performance. At the national level, WHO malaria program officer clarified the current malaria situation in the country with a trend similar to previous years, and availability of anti-malaria drugs and RDT through MoH. Also the MoH Logistics Department clarified the process of importation of medicines and tax exemption for partners who have MoU with MoH.
- The Health cluster hosted 4 emergency responders meetings where partners discussed emerging contextual and disease trends, gaps and response. Through the ICWG prioritization, the Health Cluster responded with essential life-saving health services in Mvolo, Pading, and Weinchol.
- The MoH in collaboration with WHO and partners, reviewed the current capacities of the immunization and surveillance system to identify and respond to gaps and challenges to improve the contribution of immunization to child survival and determine strategic directions for the new country Multi Year Plan (2017 – 2021).
- The MoH in collaboration with WHO, other government ministries/agencies and partners including FAO, UNICEF and IOM completed the self-assessment of the implementation of International Health Regulations (2005) and Global Health Security Agenda (GHSA). The Self-assessment is in preparation for the Joint External Evaluation (JEE) of the International Health Regulations (2005) a key component of the IHR monitoring framework.
- The MoH with support from WHO and partners launched the Expanded Special Project for Elimination of Neglected tropical diseases (ESPEN) and Mass Drugs Administration (MDA) to effectively tackle the Neglected Tropical Diseases (NTD) targeted for elimination. NTD have affected over 6 million people living in South Sudan.
Support to Service Delivery

- The cluster continues to provide emergency health kits to partners on a continued basis, using different means of transport where applicable. The cluster has also been supporting in the organization of measles vaccination campaigns in different parts of the country.

Communicable diseases and outbreak response

- The submission of weekly surveillance reports continues to improve steadily though the optimal target of 80% has not been attained. Completeness for submission of weekly surveillance reports in week 39 was 65% and 79% for IDSR and EWARN respectively.

- The cumulative total of cholera cases since June 2016, is 20689 including 378 deaths (CFR 1.8%) reported from 26 counties in South Sudan.

- Cholera transmission is on the decline countrywide. In the last four weeks (weeks 37-40), cholera cases have dropped from at least 40 cases in week 37 to at least 15 cases in week 40. During the same period, at least three counties (Juba, Budi and Fangak) reported cholera transmission.

Health Cluster coverage with oral cholera vaccines by site in 2017

- As part of the ongoing cholera response, oral cholera vaccines have been deployed to complement cholera response in several high-risk populations and locations. In 2017, out of the 1.1 million people targeted, 845,718 (76%) have been vaccinated in the first round while 224,224 (22%) vaccinated in the second round. However, the second round is still ongoing.

Mapping and Triangulation of Health Facility Functionality for Planning

- Many counties are still faced with the challenges of unpredictable health service interruptions. These are mainly due to insecurity, active hostility, bureaucratic impediments and logistical constraints. This map provides more details on access and utilization on health services. 137,908 curative consultations were provided in September, increasing the cumulative number for 2017 to 5,729,356.
During the period under review, there are 41 frontline and 3 pipeline partners operating in 71 counties across the country. Majority of the frontline partners (61%) are operating in the 3 main conflict affected states of former Jonglei, Unity and Upper Nile States. The frontline partners provided essential package of health services. The pipeline partners supported in providing inter-agency emergency health kits to frontline partners especially those in deep-front areas.

Inter cluster Representation and Strategic Decision Making

The Health Cluster participated in four ICWG meetings, which is a good platform for collaboration and working with other clusters including Nutrition, FSL, WaSH and Protection. This is an opportunity to identify priority issues and areas that need attention. The clusters worked together to push for common humanitarian agenda, to ensure essential services are delivered to those most in need. The Humanitarian Program Cycle (HPC) 2018 started in September, with the Humanitarian Needs Overview (HNO) already completed and moving into the next step of Humanitarian Response Plan (HRP).
Update on implementation of the Health Cluster Strategy/ Monitoring and Evaluation

- 187% of targeted children with Severe Malnutrition (SAM) and medical complications were treated in stabilization centres against only 8% of targeted number of HIV positive pregnant women receiving antiretroviral (ARV) treatment. Also 79% of targeted number of survivors of Gender Based Violence (GBV) received Mental Health and Psychosocial Support (MHPSS) against 83% of targeted health facilities providing MHPSS services.

Health Partner updates

Support to health service delivery

- GOAL continued to partner with the MoH to implement health and nutrition (TSFP) services including treatment of Kalaazar in Ulang and Melut counties, routine disease surveillance as well as delivery of health services and referral of obstetric cases to secondary level of health care.

- To reduce malaria as well as other vector borne diseases such as lymphatic filariasis and diarrhoeal diseases, the MENTOR Initiative conducted vector control activities including spraying of mosquito breeding sites, indoor residual spraying of shelters and fly control of open defecation sites, latrines and garbage sites in Bentiu and Malakal PoC as well as in Maban. Besides, the organization in partnership with WHO and the MoH conducted mass drug administration (MDA) to prevent onchocerciasis in nine counties of former Western Equatoria State.

- To support Expanded Programme on Immunization, Health Link South Sudan (HLSS) with support from UNICEF distributed 15 Bicycles to the vaccinators in Ikwoto County. In addition, through a network of 132 CBD, 2 372 children under five were treated for malaria in the former Ikwoto County.

- Christian Mission Aid (CMA) successfully conducted various mobile and rapid responses – integrated health and nutrition outreaches. The outreaches contributed to increased demand for health services and access especially in remote locations. The mobile outreaches proved crucial especially in Fangak County that previously experienced suspected cholera outbreak.

- CMA health facilities received a very high number of patients in OPD. In Fangak county, 12 health facilities (5 PHCC, 7 PHCU) submitted the monthly HMIS report which captured 5013(1867 U5, 3146 over 5) outpatient consultation and 207 ANC first visits. The commonest diagnoses at OPD were malaria, respiratory tract infections and watery diarrhea. In addition, nutrition services were provided in Keew and Juaibor PHCCs through management of SAM, MAM and PLW cases.

- As part of its support in Greater Tonj, Comitato Collaborazione Medica (CCM) through the Health Pooled Fund’s (HPF) primary health care program, in conjunction with the State Ministry of Health (SMoH) supported at least 450 school girls with sanitary pads to give the girl child an equal chance to compete and lead a fulfilled life.

- WHO’s emergency mobile medical teams are providing lifesaving health services to alleviate the myriad of public health challenges faced in famine-affected and hard-to-reach areas of South Sudan. The MMT (one doctor, nurse, nutritionist and community health worker) supports partners in remote locations with case management, vaccinations, setting up of cholera treatment centres and units in areas reporting outbreaks, and help partners to set up mobile clinics. During the reporting period the team visited Aweil North and West to assess availability/accessibility of health services following reported flooding, establish mobile clinics and provide basic supplies for the mobile clinic.

- Over 80 percent of the counties (64 out of 78) are currently in IPC crisis and emergency phases. WHO has been supporting about 90% of Stabilization centres (SC) across the country through provision of SAM kits.
• Medair have recently began working with Nile Hope to support the PHCU in Wiechjol, Akobo County, in light of displacement earlier this year, suspected cholera since June, limited availability and accessibility of essential lifesaving supplies in the wider area. Supported by the Health Cluster in facilitating air access, Medair was able to take in medical supplies three times during September, and a small team from Medair twice went into Wiechjol to provide targeted training to 15 Nile Hope staff; training involved cholera preparedness, appropriate case management and infection control, under five treatment (IEHC guidelines), and trauma management training. Medair also assisted Nile Hope staff to identify and implement improved infection control measures when dealing with kala-azar patients and built a separate clinic shelter for kala-azar treatment.

• TRI-SS through the SSHF has reached a total of 2798 beneficiaries in Kajo Keji and Yei Counties since the project started in August 2017. The key achievements include, procurement and supply of drugs, training of 40 health workers on cholera case management and IDSR, conducted 1073 clinical consultations and reached 1511 community members with health education and health promotion, and conducted 18 skilled deliveries. TRI-SS has also equipped the delivery room in Sokare PHCC with delivery sets.

• TRI-SS conducted three outreach visits to the IDP camps of Logo, Ajio and Keriwa in Kajo Keji county during which 565 IDP received various health interventions including clinical consultations, health education and immunization. Malaria is the leading cause of morbidity with 218 cases managed, followed by ARI with 122 cases, AWD 75, skin diseases 86 and UTI 64. In one of the visits, out of 110 RDT conducted, 85 were malaria positive.

Provision of essential drugs and supplies
• To fill critical gaps in essential medical supplies and services delivery, WHO distributed three IEHK, anti-malaria basic module, 46 IEHK, basic unit kit, seven IEHK, supplementary malaria module, 800 boxes of malaria RDT, two CATT accessories kits, one CATT reagents kit, one cholera investigation kit, one step malaria antigen, 52 kits of pneumonia A and B, 1 NECT KIT, 600 IV giving sets, and 10 000 ciprofloxacin, 500mg. These have been delivered to the implementing partners and health facilities in the areas of Aweil, Terekeka and Mvolo.

• With support from Health Pooled Fund (HPF), HLSS distributed 7 MT of assorted essential medicines and other medical supplies to Juba Teaching Hospital, Al Sabbah Children Hospital and Juba Central Store for all health facilities in Juba County. Besides 6 MT of essential medicines and other supplies are prepositioned in the former Lop/Lafon and Ikwoto Counties of Torit. The supplies are adequate to treat common illnesses for three months.

Training of health staff
• HLSS provided training on community based health care services to 90 HHP and 32 BHC from 7 PHCU; PMIS training to 34 participants in Lopa County. A total of 62 509 people were reached with health education on the prevention of cholera in Torit municipality and Imurok.

• CMA completed a 3-months intensive disease surveillance training for 13 (9 male, 4 female) health and nutrition workers in Keew PHCC, Fangak. The topics covered included active and passive surveillance, surveillance tools, sample collection and transportation, record keeping and reporting, maternal and child health care, malaria and drug management.

• WHO conducted a training to strengthen the organizational capacity in Nutrition in Emergency in order to support field operations and to orient MoH counterparts, partners, PHC staff and CHW at the subnational level on key WHO nutrition interventions. The training focused on the WHO emergency nutrition strategy for South Sudan and elaborated on the inpatient management of SAM, nutrition surveillance, and field monitoring of nutrition services.
• TRI-SS successfully completed a refresher training of 40 health workers drawn from the three facilities of Tire, Sokare and Bori on cholera management and IDSR as part of the TRI-SS six months humanitarian funded project. This training means 50% (2) of the 4 trainings planned are completed.

• To equip health workers with knowledge on diagnosis and treatment of malaria, WHO’s emergency MMT provided training on malaria case management in Aweil Centre, East and South. The course focused on key competencies, including using RDT appropriately, calculating the correct dose of treatment and recognizing danger signs of complications.

• As part of its emergency nutrition programme, WHO and UNICEF provided technical guidance, coordinated partners on establishment of nutrition stabilization centre in Mvolo County. 19 participants from Catholic Medical Mission Board (CMMB), Action Against Hunger (ACF), Medair, Hold the Child and CARE were trained on management of SAM with medical complications.

• Health service functionality monitoring The Health Information Team trained WHO state focal points on the new digital data collection system for assessing whether health facilities are open and providing services, or health service functionality monitoring. The system will track changes in health service availability and barriers to service provision to provide WHO, donors, and partners with essential information prioritize immediate interventions and guide long-term planning.

Child health: Vaccination

• Cluster partners supported the implementation of a measles follow up campaign including Vitamin A and deworming in Malakal from 28 August to 6 September. The MoH-led campaign managed to vaccinate 5,757 children aged 6-59 months against measles in Malakal town and PoC, 83.2% of the planned target with support from IMC, IOM, UNICEF and WHO.

Reproductive health

• As part of its efforts to ensure the delivery and utilization of quality comprehensive emergency obstetrics and newborn care services in hospitals in South Sudan, the WHO with support from the Government of Canada has inaugurated the newly constructed fully-equipped maternity complexes in Aweil, former Northern Bahr el Ghazal State and Kuajok, former Warrap State.

Contacts

<table>
<thead>
<tr>
<th>Ms Magda Armah</th>
<th>Dr Wilbert Shihaji</th>
<th>Ms Jemila M. Ebrahim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Cluster coordinator</td>
<td>Health Cluster Co-Lead,</td>
<td>Communication Officer</td>
</tr>
<tr>
<td>Mobile: +211955036448</td>
<td>Mobile : +211922300184</td>
<td>Mobile: +211950450007</td>
</tr>
<tr>
<td>Email: <a href="mailto:armahm@who.int">armahm@who.int</a></td>
<td>Email: <a href="mailto:southsudan.healthcluster@savethechildren.org">southsudan.healthcluster@savethechildren.org</a></td>
<td>Email: <a href="mailto:ebrahimj@who.int">ebrahimj@who.int</a></td>
</tr>
</tbody>
</table>