HEALTH CLUSTER BULLETIN # 8
31 August 2017

South Sudan
Emergency type: Complex Emergency
Reporting period: 1-31 August 2017

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<th><strong>HIGHLIGHTS</strong></th>
<th><strong>HEALTH SECTOR</strong></th>
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<td><img src="image1" alt="Health Cluster Partners Earmarked in HRP to Implement Health Response" /></td>
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<td><img src="image2" alt="Assorted Medical/RH/SAM/Trauma KITs" /></td>
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<tr>
<td>❖ So far the Health Cluster funding for HRP 2017 remains at 16%. With the continued armed conflict and resultant displacement and diseases, the needs are increasing while the health response is limited</td>
<td><img src="image3" alt="Health Cluster Activities" /></td>
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<td><img src="image4" alt="Early Warning Alert and Response Network" /></td>
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<tr>
<th><strong>7.5 MILLION</strong></th>
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<tr>
<td>AFFECTED</td>
<td>TARGETED</td>
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*Since January 2017*
**Situation update**

- **The general security situation remains unpredictable.** Active fighting continued in pockets of Jonglei and Upper Nile, with multiple security incidents reported in the Equatorias. Movement of healthcare workers and medical supplies was restricted in locations where these had to cross form an area controlled by one armed faction to the other, hence severely affected the delivery of PHC services.

- **Cholera transmission is on the decline countrywide.** Cholera cases dropped from 145 cases in week 31 to 39 cases in week 34. During August, five counties (Budi, Juba, Kapoeta East, Kapoeta South, and Nyirol) reported cholera transmission. The interruption of transmission is attributed to coordinated interventions in WaSH, case management and OCV. The spread across new counties could be due to high population mobility.

**Public health risks, priorities, needs and gaps**

- **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. In the former famine declared areas, it is estimated that 2,100 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 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 follow up campaign in conflict affected states:** A total coverage of 109.2% has been achieved in 45 counties out of the 47 targeted. 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 the 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 that were identified by a training needs assessment earlier in the year. The aim is to increase the 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 on-going intercluster 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 seven 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 16%. 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 ten 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. Also the two grant managers, HPF and IMA provided presentations on the distribution of essential medicines in their areas of coverage.

❖ The Health cluster hosted five emergency responders meetings during which partners discussed in detail emerging contextual and disease trends, gaps and ongoing response. During this month, the ICWG harmonized the prioritization process to enable usage of air assets by UNHAS and Logistics Cluster to support assessments and response through RRM, ICRM and other mechanisms. Therefore, prioritization was made a standing agenda at the ERM so that the Health Cluster can identify and agree on locations before proposing to ICWG the following week.

❖ The Health Cluster convened meetings to reprogram Global Fund resources to scale up comprehensive response of TB, HIV/AIDS. IOM is currently managing these resources in the PoCs where they are providing PHC services. The Health Cluster continued negotiations to ensure that all partners working in POC can scale up. Cordaid is on track with plans to start TB testing and treatment services within existing MoH structures in 6 locations, out of which 4 are in Upper Nile (Melut, Paloch, Kodok, and Malakal).
Support to Service Delivery

❖ The Health Cluster in collaboration with WHO has conducted a number of trainings to improve partner’s capacity to respond to the cholera upsurge. Besides, the cluster mobilised medical supplies, deployed surveillance and investigation teams to improve the overall response.

❖ The health cluster conducted training for 20 nutrition partners on testing and treatment of malaria cases in the stabilization centres.

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 34 was 60% and 73% for IDSR and EWARN respectively.

❖ The cumulative total of cholera cases since June 2016, is 19862 cholera cases including 355 deaths (CFR 1.8%) reported from 24 Counties in South Sudan.

❖ Cholera transmission is on the decline countrywide. In the last four weeks (weeks 31-34), cholera cases have dropped from at least 145 cases in week 31 of 2017 to at least 39 cases in week 34 of 2017. During the last four weeks (week 31-34, 2017), at least five counties (Budi, Juba, Kapoeta East, Kapoeta South, and Nyirol) have registered 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 907860 people targeted, 662844 (73%) have been vaccinated in the first round while 172812 (19%) vaccinated in the second round. However, the second round is still ongoing.

Mapping and Triangulation of Health Facility Functionality for Planning

❖ Humanitarian partners providing health services in some counties especially in the greater Unity and Upper Nile States are faced with the challenges of providing uninterrupted health services. These are mainly due to Insecurity, active hostility, bureaucratic impediments and logistical constraints continue to pose challenges in accessing health care services in South Sudan. This map provides more details on access and utilization on health services.
Mapping of the concentration of partners and health response in the different states

❖ Recent data from the Health Cluster indicates that only 35 health partners are reporting to the IDSR and EWARNs. Major reasons of under-reporting are related to funding constraints and insecurity in some locations. This map shows the concentration of partners in the different states.

Inter cluster Representation and Strategic Decision Making

❖ The Health Cluster participated in five 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.

Update on implementation of the Health Cluster Strategy/ Monitoring and Evaluation

❖ The graphs depict the trend of SAM children admitted in SC and the rate of defaulter and mortality which is below the threshold in both cases. Also there’s comparison of the rate of SAM children in 2016 and 2017 with the highest number of SAM children for 2016 in the months of April and July. The decline in the number of SAM children with medical complication in July 2017 is attributed to the improvement of the food security situation and the impact of the concerted humanitarian interventions.

Capacity Building, Preparedness and Contingencies

❖ On 11/8/2017 the Health Cluster conducted training on proposal writing intended to improve the quality of project proposals from partners, for different funding mechanisms. 50 participants were drawn from 23 organizations. The one day training provided feedback on the SSHF second allocation proposals that were reviewed in July, and the scoring criteria that partners should be aware of. Also, there were sessions on the HPC, HNO, HRP, logical frame work, project M&E and reporting.
Advocacy and resource mobilization
❖ The Health Cluster’s Strategic Advisory Group (SAG) held the monthly meeting on 24/8/2017. During the meeting there was discussion on the low funding status which is not sufficient to realize the Health Cluster’s HRP 2017 objectives, and it was agreed that more advocacy and resource mobilization is required. Therefore the Health Cluster will be holding a donors’ briefing meeting in the first half of October to outline the needs and gaps and necessity for more resources.

Accountability to Affected Population
❖ During the partners’ training on proposal writing, conducted by the Health Cluster on 11/8/2017, inclusion of AAP in project proposals and implementation was emphasized. Partners have been periodically reminded of the 5 commitments to AAP during the Health Cluster coordination meetings.

Attacks on health care
❖ During August, all humanitarian partners and aid workers including healthcare workers evacuated from Longechuk due to heavy fighting. It was reported that supplies and equipment were vandalized and looted. Up to date the level of destruction is not known since the location is still unsafe for any assessment.

Health Partner updates
Support to health service delivery
❖ To improve access to quality health services, the American Refugee Committee (ARC) in collaboration with the CHD increased coverage of health services through integrated outreach to locations with limited access to health facilities. In August 2017, a total of 1 013 beneficiaries were reached with various health services including curative, immunization, Nutrition, anti-natal care/post-natal care.
❖ With support from HPF, WHO and UNICEF, ARC in partnership with Kapoeta South and East CHD organized OCV campaigns to boost the cholera control efforts.
❖ IOM continued to provide PHC services in 7 health facilities (3 in Bentiu PoC, 1 in Malakal Poc, 1 in Wau Poc, 2 in Wau collective centers). There were a total of 57,845 medical consultations conducted, 270 births attended by skilled birth attendants, 371 children under 5 years who received measles vaccinations, and 136,556 people reached with health promotion messages.
❖ The IOM rapid response team conducted one round of oral cholera vaccination campaign in Tonj East from 6 – 10th August, reaching a total of 160,862 people above the age of 1 year, representing 85% coverage of the target population.
❖ With funding from RRF, ARC and the SMOH activated case management response plan including training of health workers on cholera case management and establishment of CTC at the state level with an average capacity of 30-50 patients; three CTU and 4 ORP at the lowest level to handle patients with non-life-threatening symptoms.
❖ As part of its support to the IDP in Ayod County, IMA’s emergency health services reached over 23 700 IDPs in Losca Payam of Ayod County.
❖ John Dau Foundation (JDF) with funding from UNICEF completed the rehabilitation and expansion of maternity ward as well as installation of solar system at Panyagor Hospital.
❖ JDF continues to provide immunization and health education services to children, pregnant women and women of child bearing age. As part of primary health care services JDF in partnership with the CHD and with support from UNICEF and SSHF SA1, is providing emergency curative and preventive health services in one Hospital, 3 PHCC and 5 PHCU. In the reporting period, over 1 400 consultations with 220 inpatient admissions was conducted. In addition, 577 children were immunized against vaccine preventable diseases, 77 children dewormed and 69 received Vitamin A supplementation. Over 170 LLIN were also distributed to children under one-year-old.
UNICEF continued to provide most of the supplies required for medical management of cholera cases at both community and facility levels in the affected areas including the scaling up of the response in Juba. 46 ORP, 15 CTU and two CTC in key cholera hotspots in nine counties across five states were supported, and 4 DDK and 100 cholera beds distributed. UNICEF engaged 11 national partners and MOH field staff to respond to the current outbreak through community engagement activities, including house-to-house mobilization, community theatre and meetings with community and religious leaders.

During this reporting period, UNICEF supported cholera awareness campaigns through 21 radio stations in Juba, Yei, Kapoeta, Torit, Bentiu, Tonj, Bor and Mingkaman, where active transmission is ongoing. This includes, broadcasting of five to ten radio jingles with cholera messages per day, with a total of 27 talk shows and 24 interviews, reaching approximately 1.8 million people (listenership data of 21 radio stations) with cholera prevention messages during the reporting period.

**Provision of essential drugs and supplies**

Besides the ongoing clinical consultations, training of health staff and health education, The Rescue Initiative-South Sudan (TRI-SS) successfully delivered its first consignment of essential drugs procured through funding from SSHF SA2 to IDP camps in Logo and Keriwa in Kajo-Keji County. This consignment represents 60% supply of essential drugs meant to meet the health needs of 9225 IDPs and host community in Kajo-Keji county.

**Training of health staff**

In August 2017, HealthLink South Sudan (HLSS) trained 22 HCW in Bor South County, 40 HHP in Bor South county on community hygiene promotion towards the prevention of cholera. Besides orientation session on ICCM and Boma Health Initiative (BHI) concept was provided to participants on community leaders including Boma chiefs in Malakal, former Upper Nile state.

To improve community case management, JDF with support from UNICEF trained 260 CBD to provide home treatment on simple cases of malaria, diarrhoea and ARI for children under age 5. The trained CBD along with 20 trained mother to mother groups, conducted community health education, community engagement activities, including house-to-house mobilization. During the community engagement activities 4200 people were reached with health seeking as well as uptake of immunization messages.

**Child health: Vaccination**

TRI-SS with support from UNICEF is scaling up routine immunization in Mundri West County. In August 2017, EPI outreaches were conducted in 9 sites including; Bari, Garia, Bangolo, Diko, Kotobi, Madi, Amadi, Biti and Gullu villages. During these outreaches a total of 3289 children under age five and women of child bearing age were vaccinated with different antigens such as BCG, OPV, IPV, Pentavalent, Measles and TT.

In August 2017, UNICEF conducted 6 RRM in 2 states of Jonglei (Buong, Kaikuiny and Wechijol communities in Akobo county) and Unity (Padeah, Dindin and Thornyoor in Leer county). During the mission a total of 12057 children 6 months-15 years (6 60 male and 5797 female) were vaccinated against measles, 8281 children under 15 years (3950 male and 4331 female) vaccinated against polio while 1159 pregnant women received TT and clean delivery kits given to 200 pregnant women. A total of 2300 individuals predominantly children benefitted from primary health care consultations.

**Reproductive health**

JDK with support from UNICEF and SSHF SA1, conducted reproductive health activities ANC, PNC, FP and facility based deliveries. A total of 43 deliveries were conducted, 169 mothers have received anti-natal care, 28 mothers received HIV/AIDS counseling and testing, 73 received TT vaccine, 126 pregnant women as well as women of reproductive age received vitamin A supplementation. In addition, 43 mothers received LLIN.

**Contacts**

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