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

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<th>Affected</th>
<th>Targeted</th>
<th>Displaced</th>
<th>Refugees</th>
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**HIGHLIGHTS**

- Access to health care services still remains a challenge due the ongoing insecurity in the country; this has been extended to attack on health care services which continues to increase in different part of the country. In December 4 health facilities were looted and damaged.

- In November 2017, South Sudan celebrated its first full year with no indigenous cases of Guinea Worm disease.

- To reverse the current cholera trend in South Sudan, the after-action review (AAR) of the cholera response endorsed the global roadmap of attaining a 90% reduction of cholera deaths by 2030.

- To understand the needs and gaps of the partner’s health cluster coordinated three health cluster coordination meetings at National level and six sub-national coordination meetings at Sub-national level. Key gaps identified were access to health care services in some hard to reach locations, lack of medical supplies and insufficient health personnel.

- The Humanitarian Response Plan (HRP) 2018 which was largely coordinated by all the cluster groups under the umbrella of UNOCHA was launched in December 2017. Health cluster through Strategic Advisory Group (SAG) approved 43 partners into 2018 HRP.

- To complement cholera response in high risks populations, 250 000 doses of second round were administered in Kapoeta East and South, Tonj East and Malakal

**HEALTH SECTOR**

- 35 HEALTH CLUSTER PARTNERS EARMARKED IN HRP TO IMPLEMENT HEALTH RESPONSE
- 79 ASSORTED MEDICAL KITS
- 6 750 053 OPD CONSULTATIONS*
- 1 381 836 DOSES OF ORAL CHOLERA VACCINE
- 39 EWARN SENTINEL SITES
- 123 M REQUESTED
- 63.4 M FUNDED (52%)
- 59.6 M GAP

* Since January 2017
Situation update

- As part of the ongoing cholera response, the Ministry of Health of South Sudan with support from WHO and partners has deployed cholera vaccines to complement traditional cholera response strategies in several high-risk populations and locations. From the 2,178,177 doses secured by WHO in 2017, a total of 1,133,579 doses have already been deployed with 879,239 doses used during the first round and 254,340 doses utilized in second round campaigns in 16 cholera-affected and high-risk populations countrywide.

- The Ministry of Health, WHO, Health Cluster, United Nations Children Fund (UNICEF), International Organization for Migration (IOM), American Refugee Committee (ARC), Comitato Collaborazione Medica (CCM), Médecins Sans Frontières (MSF) and other partners conducted the second round of the Oral Cholera Vaccine in Kapoeta South, Kapoeta East, and Tonj East.

- To reverse the current cholera trend in South Sudan, the after-action review (AAR) of the cholera response endorsed the global roadmap of attaining a 90% reduction of cholera deaths by 2030. Consequently, the National cholera response strategy has been updated to achieve these ambitious targets. The strategy entails three core axes of implementation: enhanced coordination and leadership through the establishment of a multisectoral National Control Program that reports to the office of the President; enhancing capacities for early detection and rapid initiation of a multi-sectoral, multi-disciplinary response to rapidly contain and prevent widespread outbreaks as well as implementing long-term and sustainable interventions to prevent the recurrence of cholera outbreaks in cholera transmission hotspots.

- Access to health care services still remains a challenge due to the ongoing insecurity in the country; this has been extended to attack on health care services which continues to increase in different part of the country. In December 4 health facilities were looted and damaged. Health cluster continues to advocate for easy access to health care services furthermore health cluster in consultation with other partners are putting in place a unified tool to capture all attack on health care services. The tool will then be rolled out to all health facilities by health cluster partners.

- The South Sudan Guinea Worm Eradication Programme (SSGWEP) with support from the Carter Center, WHO, UNICEF and partners conducted the 12th annual review meeting from 11 to 12 December 2017 to review the progress and performance of the programme in 2017 and scale up the fight against the disease to maintain the free status. In November 2017, the country celebrated its first full year with no indigenous cases of the disease.

- The Ministry of Health (MoH) with support from the World Health organization (WHO) and partners has commenced the implementation of a road map to introduce and institutionalize National Health Accounts (NHA) in South Sudan. The NHA is a framework for measuring total national health expenditures including public, private, and donors. It provides key indicators that are used to diagnose the ‘financial health’ of the health system. NHAs are the main source of data on money flows in healthcare and are used both for national and international purposes.

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 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 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:** Measles outbreak in Panyijar continues despite the mass vaccination campaign conducted in the month of November, the reports indicate that new cases are coming from neighbouring counties (Leer and Mayendit) and Island which were not vaccinated due to insecurity. Since the outbreak started in September a total of 303 cases has been reported. A vaccination campaign and mop up has been completed in the county with 87% coverage. Plans are under way to cover other location where new cases are coming from.

- On the 28 December 2017, the Ministry of Health Eastern Lakes reported suspect cases of Viral Haemorrhagic Fever (VHF) alert to the national Ministry of Health and World Health Organization (WHO). The initial cluster involving three deaths from Thonabutkok village, Yirol East on 7 December 2017. Verification to obtain detailed epidemiological information and more sample collection is underway however, the cases are more declined to zoonotic diseases furthermore, deaths has been reported in animals and/or with history of animal abortions. Ministry of Health, Ministry of livestock, WHO, FAO and health cluster partners have formed taskforce to investigate and manage cases.

- **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.

- **Malaria** continue to be one of the leading cause of morbidity. During the period under review, some 23 counties were reported to exceed the third quartile of the malaria threshold. Out of the 23 counties that exceeded the third quartile, 16 counties (70%) are with within the Crises phase of the IPC classification, whilst 5 (22%) and 2 (9%) are within the Stress and Emergency IPC classification respectively. Malaria surveillance is not available in the former Jonglei State where many counties are in Crises and Emergency state of the IPC Classification.

### 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.

- Accountable to affected population (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.

- Health cluster continues to advocate for more funding to health partners. This will help to reduce excess mortality and morbidity by providing timely lifesaving health care services to vulnerable groups in different parts of the country.
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 52%. 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

• To understand the needs and gaps of the partner’s health cluster coordinated three health cluster coordination meetings at National level and six sub-national coordination meetings at Sub- National level. Key gaps identified were access to health care services in some hard to reach locations, lack of medical supplies and insufficient health personnel.

• The Humanitarian Response Plan (HRP) 2018, largely coordinated by all cluster groups under the umbrella of UNOCHA, was launched in December 2017. Health cluster through Strategic Advisory Group (SAG) approved 43 partners into 2018 HRP.

• Health cluster continues to participate in inter cluster working group meeting at national and state level where cluster member’s concerns/ gaps and response are discussed/ coordinated.

Support to Service Delivery

• Through the coordination of Inter Cluster Response Mission (ICRM) and Rapid Response Mission (RRM), Health cluster has managed to responds to humanitarian needs in Kajo keji, Terekeka, Wau, Northern Ayod, and Kapoeta regions. Partners provided lifesaving primary health care services to displaced population on short emergency missions.

• Health cluster continues to support partners to provide regular live saving primary health care services in hard to reach areas of Jonglei, Upper Nile, Unity and Equatorial state hubs.

Communicable diseases and outbreak response

• Completeness for IDSR reporting at county level was 41%. Completeness for EWARS reporting from IDP sites was 59%. EWARS / IDSR review workshop is planned for first week of December where achievement, challenges, gaps and way forward will be discussed. Low reporting in the month of December could be attributed to staff at county level travelling for holidays as most of the surveillance officers were not reachable.

• No cases of cholera reported since 8 December 2017. The cumulative total of cholera cases since June 2016, is 20 438 cholera cases including 436 deaths (CFR 2.13%) reported from 27 Counties in South Sudan. Ministry of Health, WHO and Health cluster partners continues to collect and testing sample to confirm end of outbreak.

Health Cluster coverage with oral cholera vaccines (OCV) by site in 2017

• Oral Cholera Vaccination (OCV) campaign were conducted in Kapoeta East and South, Tonj East and Malakal where over 250 000 doses of second round were administered to complement cholera response in high risks populations.

Inter cluster Representation and Strategic Decision Making

• Health cluster continues to attend inter cluster working group meeting at national and state level where cluster member’s concerns/ gaps and response are discussed/ coordinated.
Advocacy and resource mobilization

- In 2017 health cluster partners managed to get financial support from South Sudan Humanitarian Funds (SSHF) Round 1 – (SA1) and Round 2 – (SA2). The chart below gives summary of donation received from common funds and other bilateral donations. Apart from the common pool funds, health partners get funding direct from donors.

- As part of its efforts to improve health emergency and humanitarian interventions and to promote co-ordination between the cluster and donor partners, Health cluster hosted donor roundtable meeting on 7 December 2017 to foster an interactive discussion to improve health cluster responsibilities to service delivery.

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

- To strengthen sub-national coordination in Wau, National health cluster visited Wau to address the following:
  - To strengthen communication and coordination between partners and other humanitarian actors.
  - To provide update on Humanitarian Response Plan (HRP) 2017 looking at key achievements, challenges and how the challenges will be taken care of in 2018.
  - Support supervision to partners who are providing health care service to vulnerable population in Wau and its surrounding.
  - To strengthen referral link of patients from PoC AA and PoC 1 to Level 2 hospital and Wau teaching Hospital.

Health Partner updates

Support to health service delivery

- In December 2017, IOM in collaboration with State Ministry of Health, WHO and other partners conducted the second round Oral Cholera Vaccine campaign from 11-16 December 2017. A total of 112,942 people above the age of 1 year (representing 65% coverage of the target population) received the second dose Oral cholera vaccine.

- IOM continued providing routine essential primary health care services in Bentiu, Malakal and Wau POCs and outside PoC through seven (7) static clinics. IOM has also started supporting Farajallah PHCC in Baggari County that has been left without any health services since Nov/Dec 2015 through outreach services from the Wau town base.
With support from UNHCR and Health Pooled Fund, CARE International is managing the recently upgraded Pariang Hospital. Since its inception, a total of 1000 surgical operations has been successfully conducted. Pariang Hospital serves as the main referral point for 3 refugee camps – Yida, Pamir and Ajuang Thok and as well serves the Host Communities of Ruweng State. Over the past 2 years, significant improvements have been made to the service delivery, with installation of X-ray machine, ultrasound, additional maternity and in-patient wards, laboratory supplies and blood bank to provide world-class service delivery. This has led to reduction in referrals of patients to Juba and Khartoum from the State and refugee camps.

During the month of December, Christian Mission Aid (CMA) supported health facilities attended to many patients through the OPD consultation. In the reporting period, 15 health facilities (4 PHCCs, 11 PHCUs) conducted 6,580 (2,813 under 5 and 3,767 over 5) outpatient consultation and 196 ANC first visits in Fangak county and 1,934 (725 under 5 1,209 over 5) and 46 ANC first visit from 6 health facilities (1 PHCC, 5 PHCUs) in Nyirol County. Besides a total of 42 deliveries have been conducted at the health facilities.

To provide Health and Nutrition services, CMA deployed a team of health and nutrition staff to Chuil PHCC, Nyirol. During the reporting period, the team screened 345 children (176 male, 169 female) for malnutrition in Chuil and Pultruk Payams. The team also reached 154 pregnant and lactating women and identified and referred the SAM and MAM cases to Pultruk and Chuil PHCCs for nutritional management.

WHO in collaboration with partners supported the Ministry of Health to enhance capacities for emergency and outbreak preparedness and response through a series of activities undertaken from 27 November to 7 December 2017. The activities included: a refresher training for a multi-sectoral rapid response team followed by a review of the national program for integrated disease surveillance and response (IDSR) and an after-action review (AAR) of the cholera response.

To promote the safety and accessibility of blood and reduce the risks associated with transfusion WHO collaborated with the Ministry of Health (MoH) to review National Blood Policy and Strategic Plan, adapt normative guidelines and standards and forms for the National Blood Transfusion Services.

**Provision of essential drugs and supplies**

- In response to the urgent health care needs in high risk areas, WHO provided 37 (Severe acute malnutrition) SAM kits, 26 Interagency Emergency Health Kit (IEHK), Basic Malaria Module, two IEHK, Supplementary Malaria Module, five Pneumonia kits, five Lumber Puncture kits, and four Cholera investigation kits. These have been delivered to the implementing partners and health facilities.

**Training of health staff**

- Following the training on clinical management of rape survivors (CMR), The Rescue Initiative South Sudan (TRI-SS) conducted training on 18 December 2017 targeting clinical officers and midwives in Pure (Kajo-Keji County). A total of 10 participants (3 clinical officers, 7 midwives) were trained on CMR. Besides, 8 traditional birth attendants were trained on safe delivery to encourage health facility Delivery and strengthen referral.

- To foster compliance to oral cholera vaccine protocols, WHO trained vaccinators and supervised the second round of the oral cholera vaccine in Kapoeta South, Kapoeta East, and Tonj East.

- In December, CMA facilitated various trainings meant to improve health/nutrition care provision:
  - A three day training was conducted on hygiene promotion, in Keew PHCC. A total of 16 women attended the training. The objective of the training was to prevent malnutrition among the community hence promoting health of the mother and the child, promote hygiene and sanitations within the community hence promoting
health, prevent infection and improve child and maternal health, encourage the mothers to deliver in the hospital hence reducing infant mortality rate.

- Community management of acute malnutrition (CMAM) refresher training was conducted for Keew and Nyadin nutrition staff. A total of 5 nutrition workers from Nyadin PHCC and 6 nutrition workers from Keew PHCC attended. The training covered nutritional screening, admission criteria, management of acute malnutrition, discharge criteria and follow up.

- One day refresher training on waste management, infection control, HIV infection and nutritional screening was carried out in Keew targeting the local health and nutrition workers. A total of 9 health workers from Keew, Thokchak, Kueraphone, Kuerdeang, Nyadin and Paguir health facilities were trained.

- On 6 December 2017, CMA trained nine medical staff on Integrated Management of Childhood Illness (IMCI) training in Juaibor PHCC.

- A one day training was provided to six health workers on waste management in Pultruk PHCC. Besides, a one day awareness campaign to sensitize 254 women on hygiene, hand washing and face washing to prevent communicable diseases such as trachoma and diarrhoea was held in Keew PHCC (Fangak).

**Child health: Vaccination**

- In December 2017, CMA’s vaccinators carried out outreaches in Pultruk and Chuil Payam. A total of 211 children under 2 years received BCG, OPV, Pentavalent and Measles vaccine.

- To address critical barriers in reaching vulnerable persons including women and children with life-saving interventions in besieged and hard-to-reach areas, where access and restrictions on movement severely hinder the ability of populations to get health services, WHO partnered with UNKEA to provide accelerated routine immunization services through outreach services in remote areas, implement the measles follow-up, National Immunization Days (NIDs) or supplementary immunization activities (SIAs) and MenAfriVac campaigns in those counties.

**Contacts**

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