



HEALTH CLUSTER BULLETIN # 2
28 February 2017



Cholera Case Management Sensitization workshop in Mingkaman. Photo: WHO©

South Sudan

Emergency type: Complex Emergency
Reporting period: 1 – 28 February 2017



5.1 MILLION
AFFECTED



2.7 MILLION
TARGETED



1.8 MILLION
DISPLACED



1.5 MILLION
REFUGEES

HIGHLIGHTS

- ❖ Health cluster partners derive a response strategy to support the IPC classified famine locations in 2017. The January Integrated Food Security Phase Classification (IPC) analysis, has reported that famine has left 100 000 people on the verge of starvation, in parts of Unity State in the Northern-Central part of South Sudan, and almost 5 million people, more than 40% of the country's population, in need of urgent help. A further 1 million people were classified as being on the brink of famine.
- ❖ WHO and health cluster partners secured the initial batch of 68 967 doses of oral cholera vaccine to support strategies to interrupt transmission and slow the ongoing cholera outbreaks nationwide.
- ❖ Emergency health cluster partners (MEDAIIR and UNIDO) align with WFP general food distribution to implement cholera vaccination campaign in Leer, Padeah, and Thonyor in Leer county.
- ❖ The Health cluster elects a new 12 member strategic advisory group (SAG) for 2017-2019.
- ❖ IOM Rapid Response Teams have successfully completed a five week primary health care (PHC) response mission in Kajo-Keji in three IDP camps of Kerwa, Logo and Ajjo. Over the last 5 weeks, the team conducted 7 730 consultations in the former Central Equatoria state.

HEALTH SECTOR



37 HEALTH CLUSTER PARTNERS SUPPORTING RESPONSE

MEDICINES DELIVERED TO HEALTH FACILITIES/PARTNERS



30 KITS (IEHK , BASIC UNIT HEALTH KITS AND DDK)

HEALTH ACTION



490 373 CONSULTATIONS*

EWARN



48 EWARN SENTINEL SITES (14 PARTNERS REPORTING)

FUNDING \$US



0.7 % FUNDED

\$123 M REQUESTED

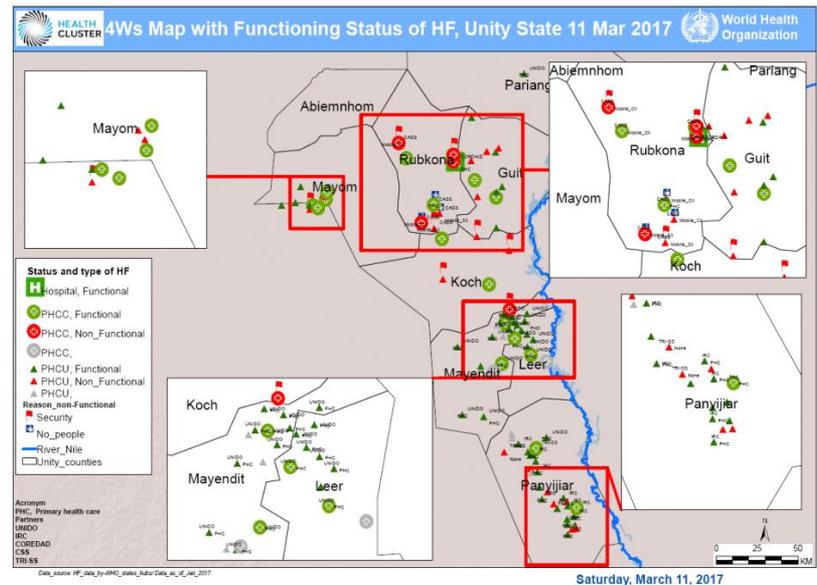
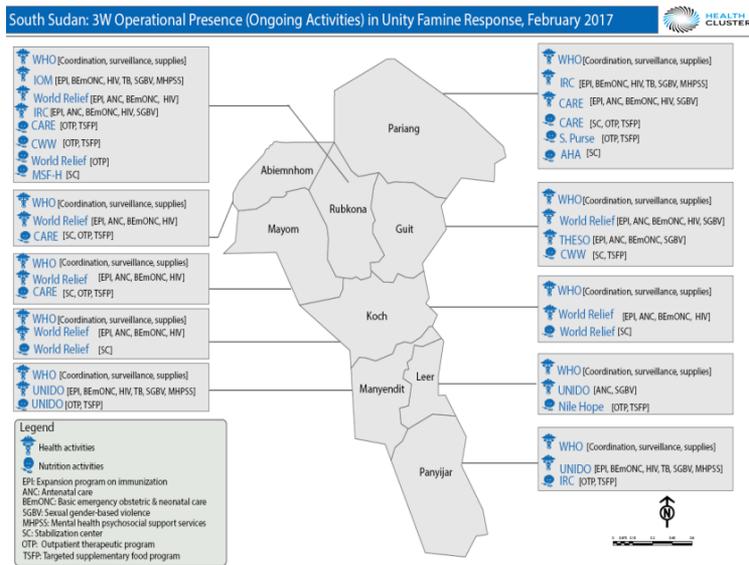
*Since Jan 2017

Situation update

- The security situation in South Sudan is fluid, particularly in the regions of Greater Equatoria, Unity, and Upper Nile.
- Conflict and displacement analysis in the month of February reports a continued and widespread movement of internally displaced. Tensions and anxiety have persisted in Yei and Kajo keji and in areas of South East of Wau. In Unity where the IPC reports famine, health facility functionality is under 40%. One secondary health care facility is accessible to a very small percentage of the population while the majority of primary healthcare centres are non-functional. Referrals and treatment for severe acute malnutrition needing medical stabilization will require investments in structures coupled with innovative health service delivery to mitigate morbidities and mortalities related to famine. Insecurity and access have dictated a more low profile including rapid response emergency bag pack approach to health service delivery.
- The January Integrated Food Security Phase Classification (IPC) analysis has implications for the already displaced and vulnerable population. From the 100 000 population in famine, the 10 000 who became malnourished will require inpatient medical stabilization. Cases which are already immune compromised by TB/HIV/AIDs will need extra support and strong surveillance on health compliance to treatments including the pregnant and lactating women as well as the disabled.
- The IPC report also estimates that 14 of the 23 assessed counties have levels of global acute malnutrition (GAM) at or above the emergency threshold of 15%, and in some cases, higher than 30%. This level of acute malnutrition reflects an extreme critical situation and is associated with a significantly increased risk of child mortality if they didn't receive treatment. The health cluster continues to advocate for urgent core pipeline supplies of severe acute malnutrition (SAM) supplies with medical modules and minimal creative ways to ensure appropriate level of partner and primary health care presence to provide both preventive and clinical support for an efficient health service delivery to the vulnerable population. The health cluster strategy has earmarked 22Million in the 2017 HRP for the response in Leer/Koch/Mayendit and Panijar, this is yet to be realized to support the current emergency. The current response to famine will focus on scale up on existing response including minimum repair to structures that can serve as referral units for SAM with medical complications.

Health Cluster Famine Response snapshot

Working together to avoid excess mortality & morbidity due to famine and related food insecurity	
<p>1) A consistent and sustained delivery of humanitarian support to health services in the IPC dictated time frame to avoid excess mortality as a result of the famine.</p> <p>2) Advocacy for the established and scaled up services to continue through 2017 for a sustained reversal of morbidities associated with food insecurity.</p>	<p>Response Activities focus :</p> <ul style="list-style-type: none"> • Scaling up support to health service delivery: partner presence active case search and referral of malnourished and emaciated cases. • Scale up prevention and increase capacities for case management of referred cases • Core pipeline support with SAM kits for inpatient stabilization of medical complications • Support to a select existing non-functioning health facility Structures for resumption of functionality (Minimal repair if applicable and feasible) to at least 1 secondary health care facility) and a select few static PHCC's • Dissemination of technical guidelines at the facility level to support quality interventions • Deployment of a dedicated health cluster coordinator at the response site to translate the strategy into local deliverables and to offer technical guidance and coordination of the implementation. • Institute accountability to the affected communities at the service delivery sites. <p>Modality of Response - Mobile and Static: A combination of back pack community responders and rapid response actors with temporary structures</p> <ul style="list-style-type: none"> • Rapid Response Mechanism (RRM): Within 48 hours to seven days, the RRM partners will be deployed for up to three months to support the existing response that is unable to scale up immediately • Scale up of existing back pack responders • Scale up of static responders to engage and scale up community outreach



Public health risks, priorities, needs and gaps

Risks

- Health conditions in South Sudan remain precarious with over 1.8 million people displaced with more displacement occurring in the Equatoria regions, greater Upper Nile, Northern Bahr el Ghazal and other conflict affected locations. After the July 2016 crisis, many health facilities have been unable to provide the basic health care package or have closed due to limited funding, insecurity, or widespread looting and vandalization, while those that remain open struggle to meet the health needs of the displaced. In the greater Equatorias, over 277 610 IDPs have been reported with limited access to health services. With minimal access, health partners have managed to offer lifesaving primary health care services through Rapid Response missions (RRM).
- Alarming measles alerts/outbreak is reported nationwide in and outside of displaced populations. There is a plan to conduct a nationwide mass campaign in the month of April 2017. Health cluster is also in coordination with MoH-EPI to use rapid response team to reach displaced population and population in logistically difficult to access locations.
- Medical complications of malnutrition, severe pneumonia, severe malaria and perinatal complications remain the most common causes of death in under 5, although the crude and under five mortality rates remain within the emergency threshold.
- On-going reports of country-wide essential medicines and pharmaceutical stock outs at the facility level. Health cluster continues advocacy for mobilizing medical supplies and supporting partners with cluster stocks managed by the 3 health core pipeline agencies (WHO, UNFPA and UNICEF). Current stocks are earmarked for the Equatorias with a concerning gap for the response in the remaining location. In addition to this there is no essential stock status of medicines to support stabilization of malnourished children with medical complications.
- Limited availability and access to Mental Health and SGBV related services remain a challenge to the holistic health care response across the country. Through the newly established mental health and psychosocial support (MHPSS) cluster, the health cluster has positioned to provide mental health leadership on existing and challenging MHPSS issues for strategic coordination and response.
- Challenges with the timeliness and completeness of reporting on IDSR and EWARN at response sites-Health cluster partners have reached an important milestone in week 9 of 82% reporting in the IDP sites. The IDSR sites still linger at 48% in week 9. With the ongoing displacement of health workers, non-functionality of health facilities due to widespread looting and vandalization, and inaccessibility due to insecurity continues to be surveillance blind spots with an increased danger of multiple outbreaks to the fleeing population with no access to healthcare services.
- Cholera remains a challenge even in dry season along the River Nile, Malaria, Acute Respiratory Tract Infections, TB/HIV/AIDS, and Measles are the major public health morbidities/ mortality in IDP locations and surrounding host communities. Communities fleeing

from the conflict have settled in swamps where WASH facilities are non-existent.

- Acute malnutrition and now the declaration of famine in some locations remain a huge public health concern. Inflation on food security and livelihood in the country remains a big challenge to the household, with the increase in food prices and much less affordability, the population is prone to malnutrition related complications.

Priorities

- Strengthen the existing health humanitarian response strategy to support emergency responders to scale up and provide lifesaving primary Health care services using a combination of mobile and static modalities to increase access to the affected populations.
- Procure and strategically preposition medical SAM kits for inpatient management of medically complicated severe acute malnutrition (SAM) in facilities in facilities where food insecurity and malnutrition rates are high and build capacity of partners to respond in those locations.
- Align health capacities to implement sexual and gender based violence (SGBV), Clinical Management of Rape (CMR) and MHPSS response.
- Improve partner capacity to scale up surveillance on disease with outbreak potential including HIV/AIDS.
- Advocate with multi stakeholder support to availability of essential pharmaceutical stocks for health service delivery. Advocacy for increased funding for essential medicines for strategic prepositioning to support the response.
- Improve partner's capacity on emergency preparedness and response and contingencies.
- Promote the establishment of feedback mechanism and accountability in healthcare programs to the affected population.

Needs and Gaps

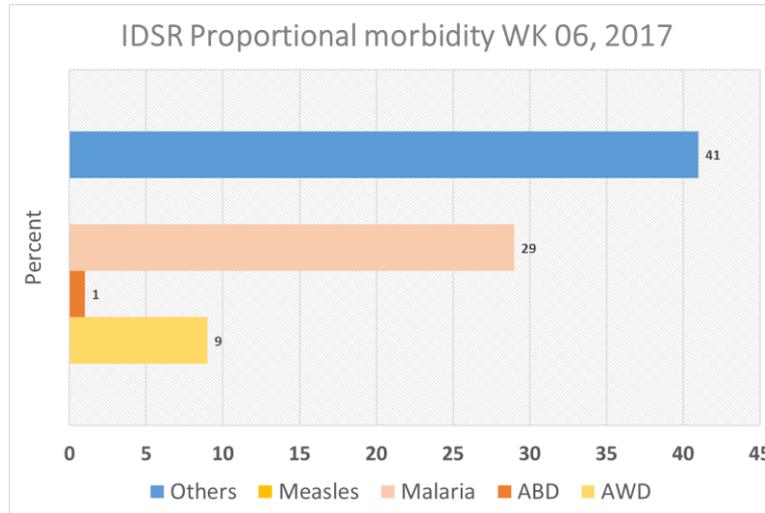
- Inadequate numbers of emergency responders including dedicated cluster coordinators and information management person in new displacement sites.
- Lack of core human resource team required for effective delivery of cluster functions especially dedicated sub-national health cluster coordinators.
- Inadequate surveillance staff in new displacement sites.
- Inadequate funding to partners to respond to acute and chronic emergencies.

Communicable diseases

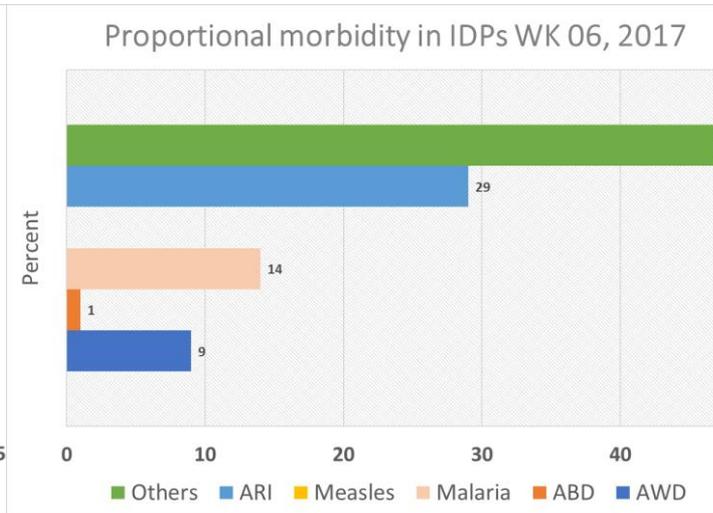
- Completeness of reporting rates in non-conflict and conflict areas were 34% and 68% respectively. Malaria is the top cause of morbidity and accounts for 29% consultations while ARI is the leading cause of morbidity in the IDPs where it accounts for 29% of consultations.

Morbidity statistics as of week 6 of 2017

Non-conflict areas



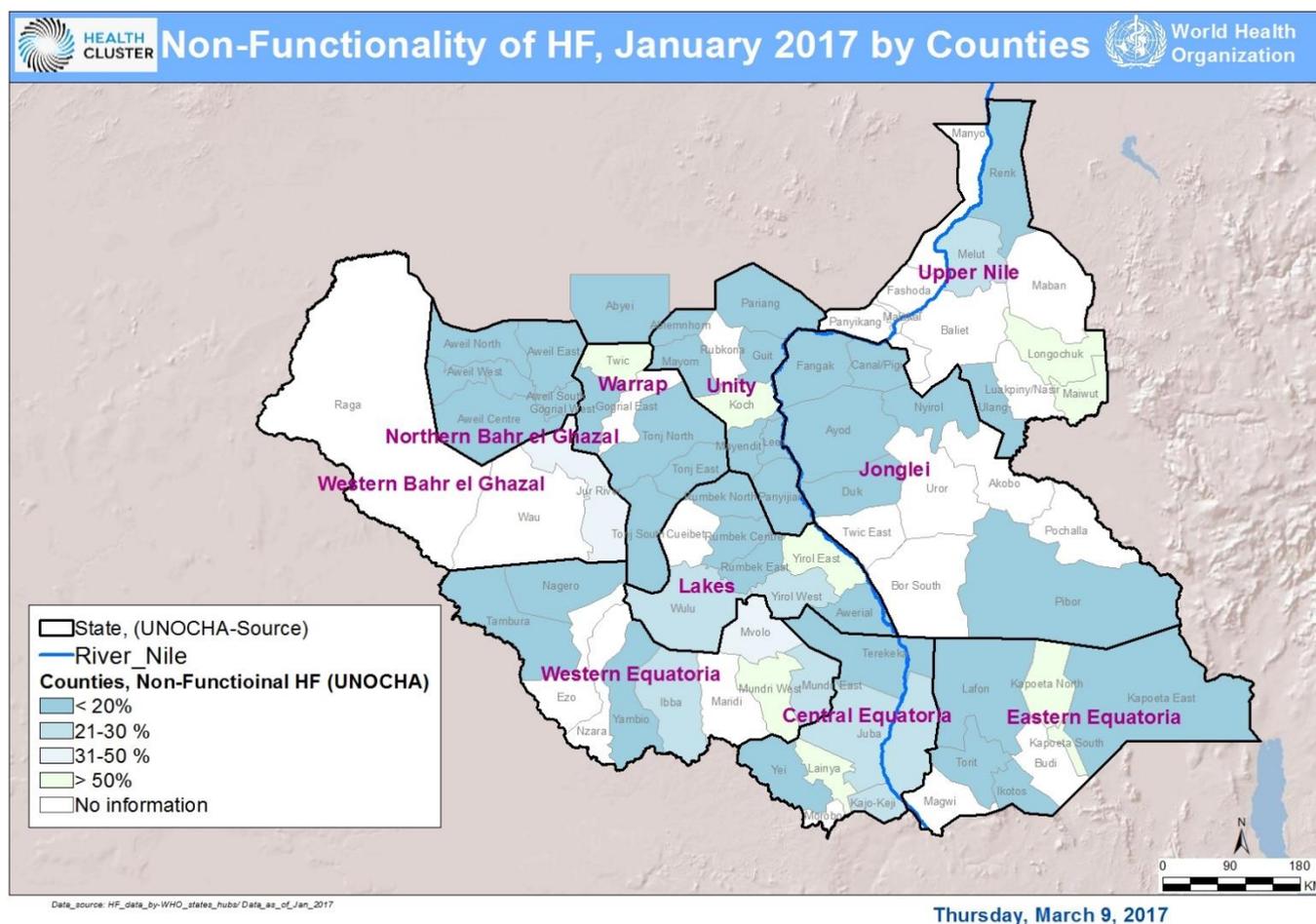
Conflict areas



- While malaria remains the top cause of morbidity in the non-conflict areas, the current trends are within the expected levels. In Within the IDPs, ARI surpassed malaria as the top cause of morbidity.
- Sporadic suspect measles outbreaks continue to be reported countrywide with most of the transmission being reported from Wau PoC where a confirmed outbreak has been raging since December 2016. During the week ending 28 February 2017, 61 measles cases were reported from Wau PoC and Cathedral IDPs in Wau. A cumulative of 702 measles cases including 9 deaths (7 children and 2 adults) with case fatality rate [CFR 1.28%] have been reported since the week 44 of 2016. A countrywide measles follow up vaccination campaign targeting children 9 to 59 months is slated for mid-March 2017.
- Since the beginning of 2017, a total of 236 cases of kala azar including at least 7 deaths (CFR 3.0%) were reported from 21 treatment centers. During the corresponding period in 2016, a total of 212 cases including 4 deaths (CFR 1.9) were reported from 21 treatment centres.
- A total of 13 counties in 32 states have confirmed cholera cases since 18 June 2016. Active but declining transmission is currently limited to four counties – Southern Liech (Leer and Panyijiar); Northern Liech (Rubkona – Bentiu PoC); and Jubek – UN House PoC. The most recent cases were confirmed in Yirol East, Eastern Lakes state on 22 February 2017. Suspect cholera cases have been reported in Malakal Town; Pajatriei Islands, Bor county; Panyagor, Twic East county; and Moldova Islands, Duk county (Cumulatively, 5 321 cholera cases including 122 deaths (55 facilities and 67 community) (CFR 2.29%) have been reported in South Sudan since 18 June 2016. The current outbreak has lasted eight months compared to four months for the 2015 outbreak and seven months for the 2014 outbreak. Nonetheless, the case fatality for the 2016/17 outbreak is lower than 2014 and 2015.
- The high mortality due to TB/HIV/AIDS in the IDPs remains a major concern and a priority for the health cluster. Partners have been supported to provide comprehensive TB/HIV/AIDS services in 2017.

Functionality of health facilities

- Access, utilization of health services, funding and reporting of health facility data continue to remain a challenge due to a combination of conflict related destruction, damage and closure. Out of 80 counties 10 counties have more than 50% non-functional health facilities. In Jonglei, 33.3% (Hospitals), 81.80% (Primary Healthcare Centre's), 98.30% (Primary Healthcare Units) averaging 96.30% of the total health facilities are non-functional representing a total funding gap in excess of 1.1M. Similarly, in Upper Nile, 50% (Hospitals), 95.75% (Primary Healthcare Centre's), 86.60% (Primary Healthcare Units) averaging 84.80% of the total of all health facilities in the locations are non-functional closed.



Availability of essential drugs, vaccines and supplies

- Development supported essential medicines stocks remain fragmented and piecemeal, combined with supply chain challenges often result in reports of nationwide medicines stock out. There continues to be a heavy reliance on health cluster core pipeline medical supplies which are limited in the provision and type and not sustainably packaged for regular development response. Current core pipeline stocks are earmarked for the Equatoria response. The 7 former states still have a huge gap in core pipeline stocks.

Health Cluster Action

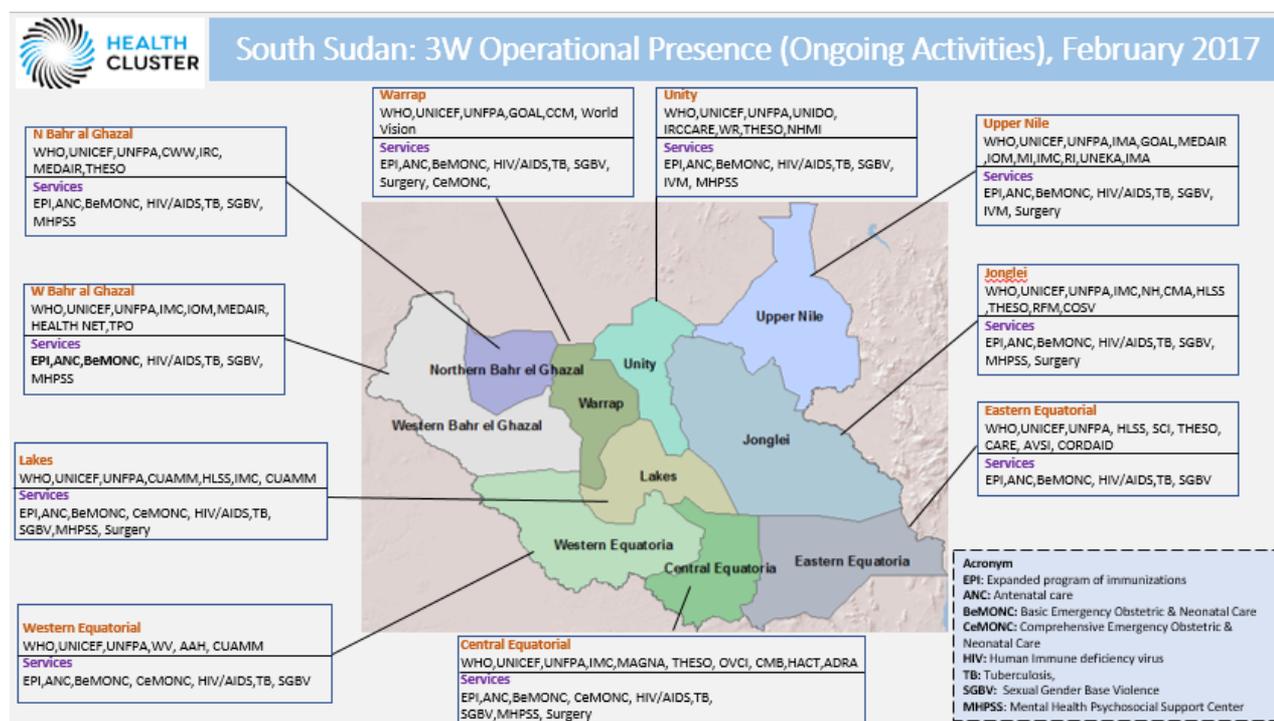
Health cluster coordination

- The 2017 health humanitarian response plan has earmarked 35 partners to implement the health cluster strategy. The cluster has since admitted new partners especially national NGO's whose partnership is key to sustainable and resilient health systems. An average of 60 to 70 stakeholders engages regularly on a weekly basis at the national level. Regular meetings have continued to hold at the main emergency response sites and also at new displacement sites.

- South Sudan continues to battle health systems challenges. Health cluster members are heavily involved in the planning of the upcoming health summit which will create a platform for multi stakeholder engagement in harnessing strong partnerships for the attainment of universal health coverage and building a resilient health system.
- The health cluster has elected a 12 member SAG for the Next two years (2017-2019). The strategic advisory board supports the technical and strategic positioning of the health cluster to effectively deliver on humanitarian health response. The new board has equal representation from INGO's and NNGO's including development fund managers and ICRC and MSF observer role. Inter-cluster coordination and planning is active and has promoted collaboration with other clusters particularly WASH, Nutrition and Protection culminating in an integrated package of response to the counties reporting high malnutrition rates, malaria upsurges and ongoing cholera outbreak.
- Recent data from the Health Cluster indicates that, only 37 health partners are reporting to the IDSR and EWARNs. Major reasons of under-reporting are related to funding constraints and insecurity in some locations. The maps below show the concentration of partners in the different states.



Partners presentation on their comparative advantage for the SAG seats. Photo: WHO©



Support to health service delivery

- The IOM Rapid Response Team have successfully completed a five week primary health care (PHC) response mission in Kajo-Keji targeting populations in three IDP camps of Kerwa, Logo and Ajio and conducted 7 730 consultations. The populations in the three camps had been displaced since September 2016, following fighting and insecurity in Yei, Kaya, Lainya, Morobo, Nyepo, and southern Bari, all in Central Equatoria.
- Medair worked with UNIDO to provide oral cholera vaccines alongside a WFP food distribution. This is a creative methodology towards accessing communities that are moving targets or difficult to access.



Weekly Rapid Response meeting. Photo: WHO©

Health facilities

- As part of fostering a Development and emergency response action for outbreak response, CUAMM the leading health partner in Yirrol East, worked with the IOM rapid response teams to set up three cholera treatment units in Shambe, Adior and Langmatot along the Nile. The organization also identified three areas to setup oral rehydration points (ORPs) especially in Shambe area, the Islands along the Nile and hard to reach areas. CUAMM is also supporting the CHD and co-lead the cholera task force, coordinate efforts of health and WASH partners to contain the outbreak.

Provision of essential drugs and supplies

- In response to the urgent health care needs, WHO provided nine full diarrhoeal disease kits (DDKs) sufficient to treat 6 300 cases, 22 cholera test kits, 300 DDK IV fluid, five ORS Module, 10 Cary Blair, 5 IEHK (supplementary malaria module), five IEHK (Anti-Malaria Basic Module), 25 boxes of anti-malarials, 78 malaria rapid test kit, one Reproductive Health kit, 100 gloves and 16 gumboots. These have been delivered to the implementing partners and health facilities in the areas of former Unity, in Jonglei, Greater Lakes and Jubek states.
- To slow the current surge in cholera cases, WHO working with health cluster partners secured the initial batch of 68 967 doses of oral cholera vaccine that were used for complementary vaccination in Leer, Padeah, and Thonyor in Leer county. MedAir, and emergency operational health cluster partner coordinated the deployment of the vaccine alongside WFP's food distribution headcount from 25 February 2017.

Training of health staff

- To provide overview of the current cholera outbreak in Mingkaman and the country in general, acquaint the participant with the pathogenesis, clinical signs and symptoms and diagnosis of cholera and the principles of case management of cholera based on fluid replacement, WHO and the health cluster supported the SMOH to conduct a one day workshop to the front line health workers in Mingkaman on 23 February 2017.
- To provide comprehensive HIV prevention, care and treatment services to populations of humanitarian concern in the Greater Upper Nile region, WHO in partnership with the MoH trained medical doctors/ clinical officers, nurses, counsellors, pharmacist and data clerk on HIV treatment and prevention.

Child health: Vaccination

- IOM's response to the displaced populations in Kajo keji also focused on immunization services and health education within in Kerwa, Logo and Ajio camps. Over the past five weeks, a total of 2 212 children under five vaccinated against vaccine preventable diseases, 1 534 children were screened for malnutrition (18 identified with SAM and 65 with MAM), administered tetanus vaccination to 286 pregnant and 801 non-pregnant women, and provided antenatal care to 333 women. In addition, a total of 26 972 people were reached through health and hygiene promotion key messages.

Child health: Nutrition

- As part its efforts to respond to the increasing malnutrition rates in the country, WHO supported the MoH to develop Stabilization Centres/Inpatient Therapeutic Programme (SC/ITP) national guidelines for South Sudan. The guidelines will address the integrated management of severe acute malnutrition (IM- SAM) in children under-five for inpatient care.

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