



HEALTH CLUSTER

HEALTH CLUSTER BULLETIN # 6

30 June 2017



IOM-RRF monitoring team during the cholera field visit in June sharing with the members of community and standing the Poktap CTC. Photo: SMC.

South Sudan

Emergency type: Complex Emergency

Reporting period: 1 – 30 June 2017

 **7.5 MILLION**
AFFECTED

 **2.7 MILLION**
TARGETED

 **2 MILLION**
DISPLACED



1.9 MILLION
REFUGEES

HIGHLIGHTS

- ❖ The cholera cases have reached unprecedented levels in South Sudan. Currently there are with active transmission in 11 Counties. Both health partners and core pipeline are overstretched requiring different approaches to ensure continuity of the response.
- ❖ The measles follow up campaign in conflict affected states is still outstanding. The Health Cluster continues to collaborate with the Ministry of Health and development partners to reach the displaced and those living in remote locations with the support of rapid response teams.
- ❖ 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.
- ❖ To respond to the urgent health and nutrition humanitarian needs in South Sudan, WHO focuses on life-saving integrated health/nutrition interventions revolving around the Inpatient management of SAM with medical complications. In June 2017, WHO has distributed 50 WHO SAM kits to support 18 partners implementing inpatient nutrition programs across country and working in collaboration with MOH.

HEALTH SECTOR



35 HEALTH CLUSTER PARTNERS
EARMARKED IN HRP TO IMPLEMENT
HEALTH RESPONSE

MEDICINES DELIVERED TO HEALTH FACILITIES/PARTNERS



510 ASSORTED MEDICAL/RH/SAM/TRAUMA
KITS

HEALTH CLUSTER ACTIVITIES



3 822 690 OPD CONSULTATIONS*



VACCINATION

422 860 CHOLERA

EARLY WARNING ALERT AND RESPONSE NETWORK



31 EWARN SENTINEL SITES



FUNDING \$US

123 M REQUESTED

16 M FUNDED (13%)

107 M GAP

*Since Jan 2017

Situation update

- Security situation in all states vary from relative calm to active hostility. Ongoing fighting in the Equatoria continue to hamper inter-cluster response.
- The insecurity in some parts of the country continues to limit access to communities in need of health and other essential services. Nationwide health care attacks continue to compromise access to health facilities and access to health workforce.
- With the onset of the rainy seasons, incidence of water-borne diseases including AWD, Cholera and vector borne diseases like malaria is expected to increase and access to some parts of the country will be difficult to reach due to poor road networks and unlandable airstrips. Since January 2017, 1.1 million malaria cases have been reported. Due to the current crises, routine surveillance reporting is inconsistent, with declining completeness and timeliness rates in both IDSR and EWARN reporting sites.
- The cholera cases have reached unprecedented levels in South Sudan. Currently there are with active transmission in 11 Counties. Both health partners and core pipeline are overstretched requiring different approaches to ensure continuity of the response. The health cluster has worked with health pooled fund (HPF) to reprogramme development funds to support cholera response. In some locations (like Abrouch) partner's response have achieved zero new cases and no new admissions.

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 remain a challenge with increased risks to epidemic prone diseases as IDP's continuously move to locations with access difficulties where there are limited or no health services. Operational resources are doubled as very expensive air assets are often required to facilitate response. Outbreaks of cholera, malaria upsurges, measles and other water-borne and infectious diseases are erupting in several locations.
- Water, sanitation and hygiene remain a challenge nationwide: Open defecation is common practice and with the current rainy season cholera is likely to escalate.
- Malnutrition related morbidities: although there is no more famine many locations are still reported in catastrophic and emergency integrated phase classification (IPC). In the former famine declared areas, it is estimated that 2 100 children with SAM with medical complications will need admission to medical stabilization centres. The expected 10% increase in admissions will continue to require additional support on the already limited health facilities.
- Morbidities in IDP sites: Malaria, Acute Respiratory Tract Infections, TB/HIV/AIDS, and measles continue to be major public health morbidities and mortalities 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. Health Cluster partners have combined efforts with the MOH to keep crude mortality rates 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's and displacement of health workers. Only 52% of children received measles vaccine, 45% received polio vaccine and 45% of children received Pentavalent3 before the age of one in 2016 (HMIS 2016). Herd immunity against vaccine preventable diseases is only ensured with routine immunization coverage of at least 85%.
- The measles follow up campaign in conflict affected states is still outstanding. The Health Cluster continues to collaborate with the Ministry of Health 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. This affects implementation at the health facilities and creates concerning gaps in providing adequate lifesaving health services. The current core pipeline pharmaceuticals

(primary healthcare kits/ reproductive health kits and vaccines) have been earmarked solely for the Equatoria. These are having to be used also in high risk locations to cover existing gaps including supporting development partners in locations of severe shortages. There is also an urgent need to increase essential stocks of SAM kits to support stabilization of malnourished children with medical complications.

- Mental health, sexual and gender-based violence (SGBV) related services are still in its programming infancy and limited in access and provision. There is an urgent need to reinforce this challenge towards improving mental health, sexual and gender based survivors. Health Cluster is better positioned to coordinate the provision of mental health, sexual and gender based violence services in IDP sites.
- Surveillance blind spots: challenges remain with reporting on timeliness and completeness of Integrated Disease Surveillance and Response (IDSR) and Early Warning, Alert and Response System (EWARS) activities at response sites. On-going displacement of health workers, non-functionality of health facilities due to insecurity, inaccessibility widespread looting and vandalization continues to increase the risk of multiple outbreaks to the fleeing population with limited access to healthcare services including surveillance and health alerts.

Health Cluster Priorities

- The cluster prioritises dedicated coordinators and information management officers at both national and subnational levels to translate the implementation of the existing health humanitarian response strategy in famine affected locations and areas of population displacement and to track and analyse data for strengthening support to emergency responders to escalate and provide lifesaving primary health care services, through static and mobile clinics in order to increase and expand access to the affected populations.
- Advocate with multi stakeholders for increased availability of essential pharmaceutical commodities for primary health care response including strategic prepositioning of medical severe acute malnutrition (SAM) kits in facilities for inpatient management of medically complicated severe acute malnutrition.
- Coordinate capacity building of partners to respond to primary health care responsibilities and disease surveillance including the alignment of health capacities to implement SGBV, Clinical Management of Rape (CMR) and Mental Health and Psychosocial Support (MHPSS) response; including emergency preparedness and response.
- 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.
- Support partner establishment of feedback mechanisms and accountability in healthcare programs to the affected population.

Needs and Gaps

- Increased need of seasoned presence of emergency health partners, dedicated cluster coordinators and information management skills especially at the sub national level and displacement sites to assess and manage the health responses and track data for improved planning in health service provision.
- Increase in the number of surveillance staff in locations of displacement to articulate public health risks associated with health coverage, poor access to health services, poor water quality and sanitation hygiene in facilities and to provide effective oversight to lifesaving health intervention.
- Increased funding to partners to enable them to sustain services, build capacity and provide the necessary resources including essential medical supplies to respond to primary health care needs.

Health Cluster Activities

Coordination

- The 2017 health Humanitarian Response Plan (HRP) has earmarked 35 partners to implement the health cluster strategy. The Health Cluster has since admitted new partners' including several national NGO's whose partnership is key to sustainable and resilient health systems.
- The Health Cluster chair weekly and bi-weekly meetings catering for emergency responders and development partners at both National and State level where there is a presence of a Sub-National Health Cluster Coordinator. The meetings bring together a number of National and International NGOs and other cluster representation (i.e. WASH and Nutrition Clusters) to provide key health updates, report on disease outbreaks, health presentations such as 'Attacks on Health Care' and the 'Strategic Advisory Group' (SAG) as well as coordinate health response and participation in Inter cluster rapid response mission (ICRM).
- The Health Cluster liaison to reprogramme 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 primary health services. The Health Cluster continues negotiations to ensure that all partners working in PoCs also to scale up using the reprogramming. In Upper Nile, Cordaid is starting TB testing and treatment services within existing Ministry of Health (MoH) structures in 6 locations, out of which 4 are in Upper Nile (Melut, Paloch, Kodok, and Malakal). Cordaid's strategy includes recruiting skilled health workforce with a focus with community outreach services to scale up the comprehensive responses.

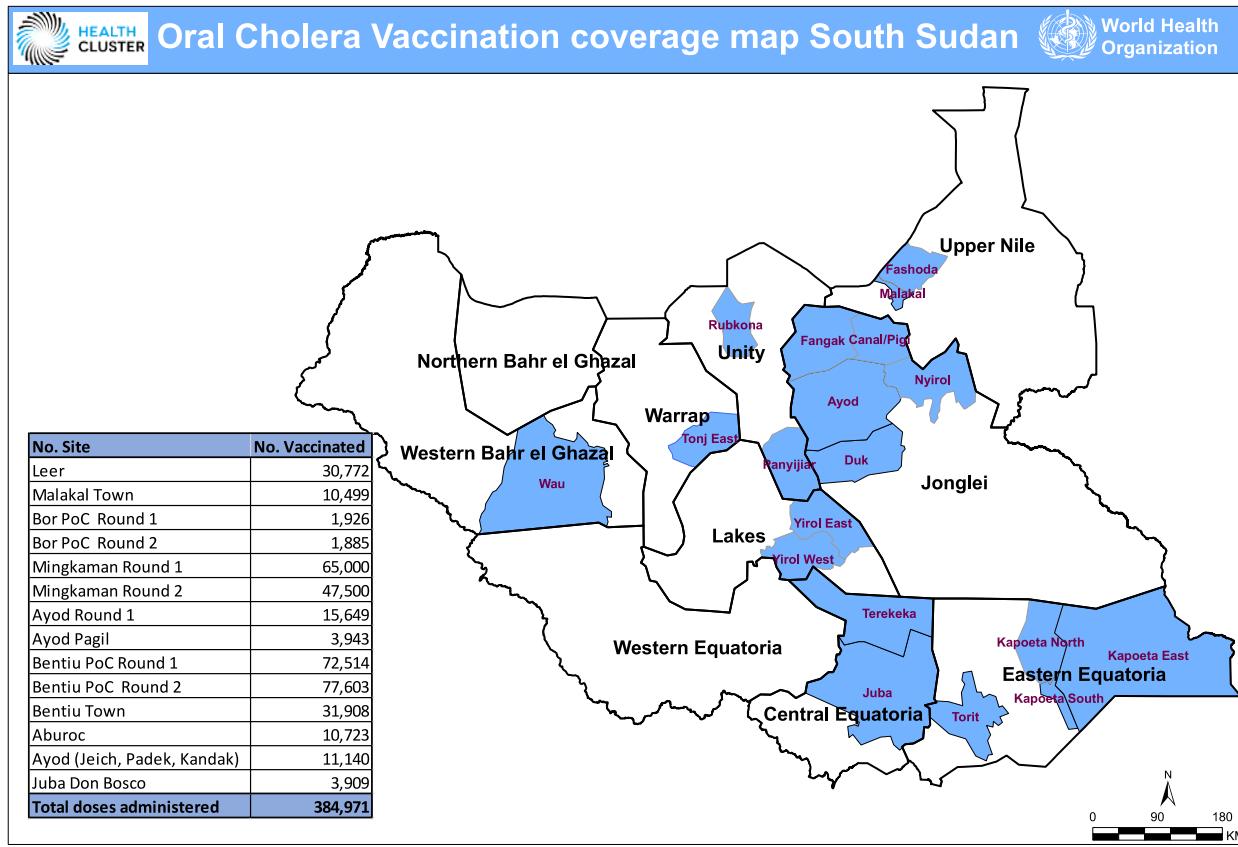
Support to Service Delivery

- 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 capacitated 20 nutrition partners on treating and testing malaria cases in the stabilization centres.

Communicable Diseases and outbreak response

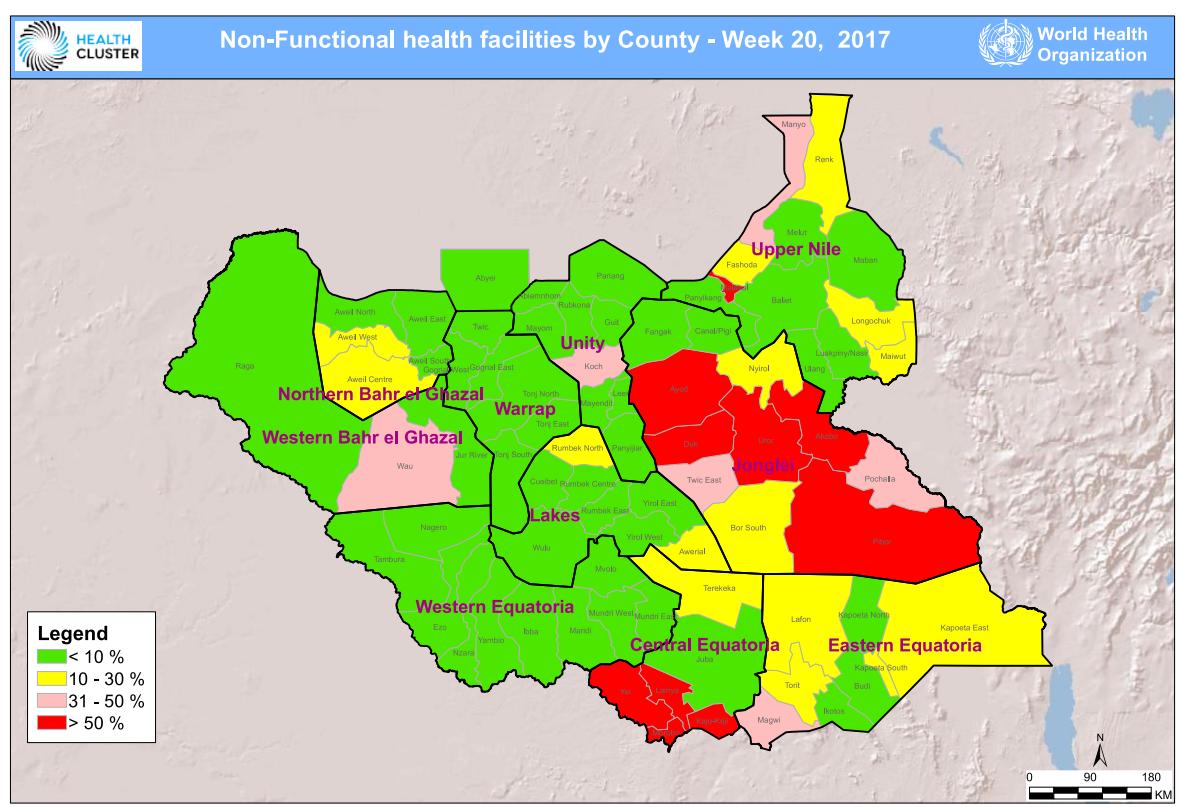
- Surveillance reporting rates for the week under review (week 26) recorded a significant increase in completeness for the IDSR and EWARN reporting sites. Completeness of reporting rates in non-conflict and conflict areas were 74% and 74% respectively.
- Since June 2016, cholera outbreaks remain the major public health concern to population and humanitarian's agencies with 17 815 cholera cases including 323 deaths (CFR 1.8%) reported from 24 Counties in South Sudan.

Health Cluster coverage with oral cholera vaccines by site in 2017



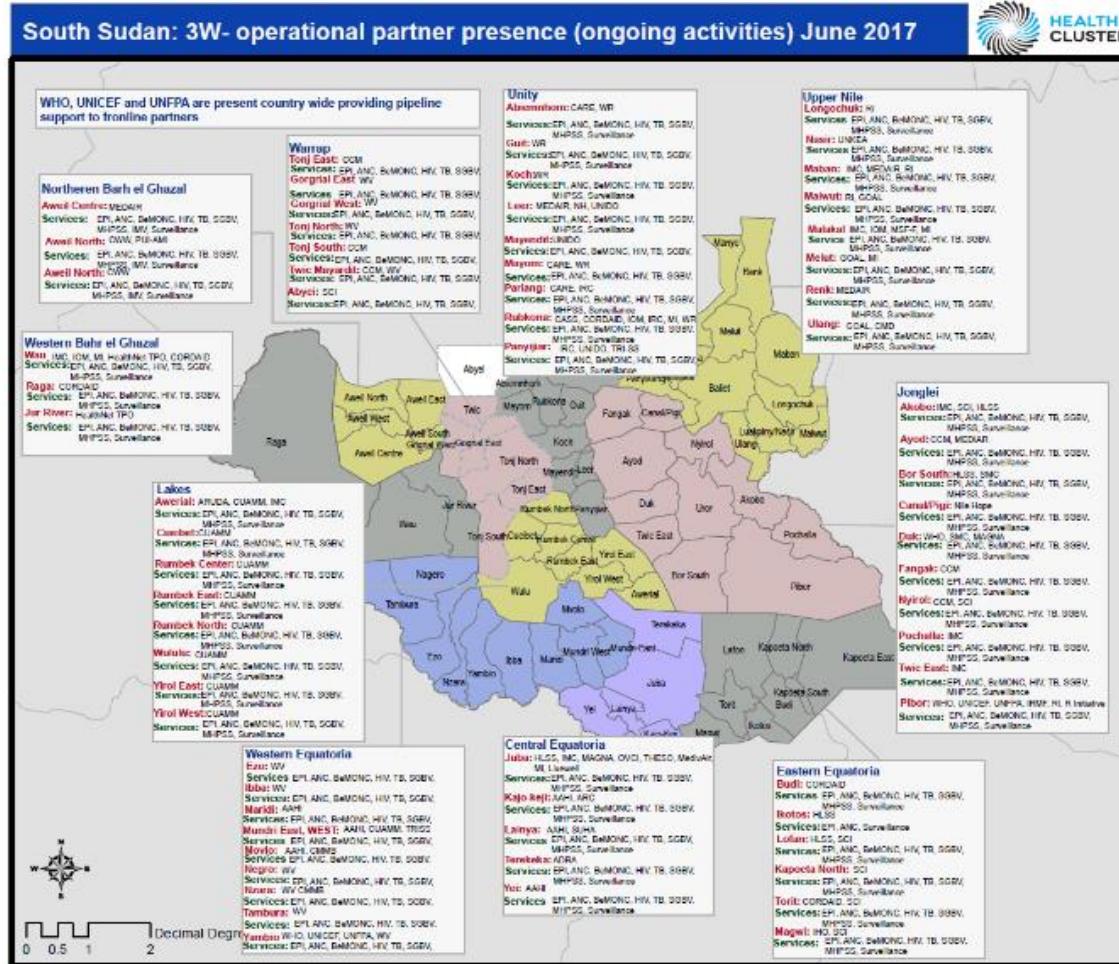
Mapping and Triangulation of Health Facility Functionality for Planning

More than 50% of health services are non-functional or provide only partial primary health care services. This is due to a number of combined effects from the conflict such as direct or indirect attacks on health care including destruction, obstruction, looting and/or lack of funds and availability of health staff. There are recent reports of active recruitment of health personnel into the armed services thereby further depleting trained health staff



Mapping of the concentration of partners and health response in the different states

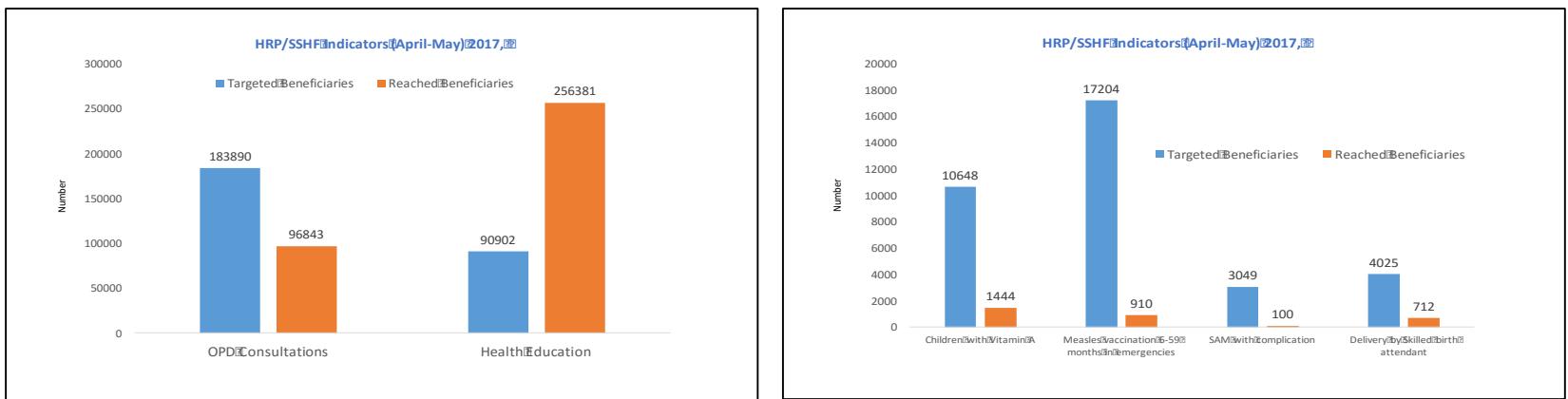
- Recent data from the Health Cluster indicates that only 35 health partners are reporting to the IDSR and EWARNs. Major reasons of under-reporting are related to funding constraints and insecurity in some locations. The maps below show the concentration of partners in the different states.



Inter cluster Representation and Strategic Decision Making

- Health cluster continues to advocate on resource mobilization, access and utilization of health services in emergencies. The health cluster prioritizes coordination with partners on instituting on reporting attacks on health care and protecting health care in danger. The cluster continues to advocate at strategic level on the practical implementation of the humanitarian development nexus.

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



Capacity Building, Preparedness and Contingencies

- Capacity building of health cluster partners (national and international) has commenced and will continue for the rest of 2017.
- Health cluster and WHO have rolled out the web-based reporting of IDSR for emergency responders.
- The health cluster contingency plan for cholera and Ebola Virus Disease (EVD) is completed and is available in the website.

Advocacy and resource mobilization

- The Health Cluster in collaboration with the cluster lead agency continue to engage in donor discussions in support of emergency response and priorities for 2017.

Accountability to Affected Population

- Commencing end of June 2017, the cluster instituting reporting on practical implementation of accountability to affected population.

Attacks on health care

- The Health Cluster with the help of partners has commenced documentation on attacks on health care. In June 2017, reports indicate that attacks in three health care services in the conflict affected locations and health workforce evacuations as a result looting and vandalization has been reported.

Health Partner updates

Support to health service delivery

- GOAL continued to maintain presence in Ulang, and Melut counties conducting routine disease surveillance and providing primary health care services including kala-azar screening, and treatment of Targeted Supplementary Feeding Programme (TSFP) in Ulang and Melut Counties and in the Greater Upper Nile region. Kalaazar management and TSFP services were also supported by IMA and WFP respectively. GOAL resumed health service delivery in Maiwut county and continue to provide technical support and supplies to 2 MOH facilities in Mija and Rumamer.
- Sudan Medical Care (SMC) with support from the health cluster together with WHO and UNICEF continued to deliver curative and preventive health services to control the cholera outbreak in Duk County of Jonglei State. Much improvement has been made with the deployment of the required human resources and the establishment of the 4 cholera treatment centres/cholera treatment units (CTCs/CTUs) and 6 oral rehydration points (ORPs) in the existing Padiet PHCC, Poktap PHCC, Amiel, Pajut and the market centers within the region including Ayueldit and Dorok PHCUs.

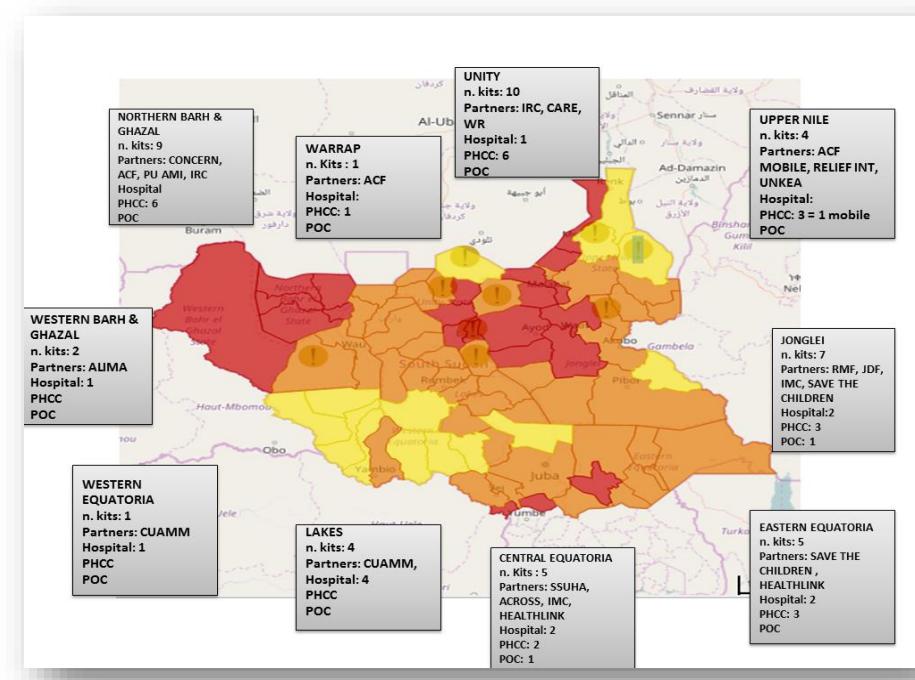
- As part of its ongoing response to the cholera outbreak in Mingkaman, Medair carried out oral cholera vaccine (OCV) campaign where a total of 110 808 vaccines were administered to 68 512 people. A coverage survey was carried out in conjunction with the house-to-house vaccination during the third round. The coverage rate according to this exhaustive household survey was 99% of people vaccinated with one dose and 87% vaccinated with two doses. There is a reduction in the number of cholera cases being reported from Awerial County attributed to the OCV campaign.

Provision of essential drugs and supplies

- To fill critical gaps in essential medical supplies and services delivery, WHO delivered over 500 kits including medical, reproductive, SAM, cholera investigation, trauma and other essential drugs. The supplies have been delivered to the implementing partners and health facilities in the areas of Juba, Wau, Yirol, Kuajok, Rumbek, Bentiu, Malakal, Awiel, Bor, Nirol and Torit.
- To respond to the urgent health and nutrition humanitarian needs in South Sudan, WHO focuses on life-saving integrated health/nutrition interventions revolving around the Inpatient management of SAM with medical complications. In June 2017, WHO has distributed 50 SAM kits to 13 hospitals, 25 primary health care centres and 2 health facilities in the Protection of Civilians (PoCs) supporting Inpatient Therapeutic Programs (ITP) in the Greater Equatoria Regions, Northern Bahr el Ghazal, Unity, Upper Nile and Jonglei and Counties with high prevalence of Global Acute Malnutrition (GAM) to provide sustainable lifesaving interventions.



SAM kits distribution map



Training of health staff

- On 21 June 2017, the American Refugee Council (ARC) with technical support and guidance from WHO trained 15 health workers (3 females and 12 male) from Kapoeta Civil Hospital on cholera case management.
- Through the Health Pooled Fund project for South Sudan (HPF), ARC supported four Primary Health Care Centres (PHCCs) (Aroyo, Gabat, Bar Mayen and Awoda) in Aweil Centre to reduce barriers to antenatal services and improve skills of health workers to provide skilled birth attendance. This included recruitment of four midwives for four PHCCs in Aweil centre, and training of home health promoters and provide integrated on-job training of health service providers.

Child health: Vaccination

- As part of the ICWG mission in Jonglei, The Health Support Organisation (THESO), vaccinated 3 487 children against polio and measles as well as 1 402 women of child bearing age against Tetanus in Pading, Jonglei State.
- In sector 4 Bentiu PoC health facilities, IRC vaccinated 291 children against measles and 190 with Penta 3. IRC provided reproductive health services to 778 pregnant women in sector 4 Bentiu PoC health facilities.
- As part of its efforts to protect the displaced children in the UN House PoC site, from vaccine preventable diseases, Magna vaccinated a total of 4 970 persons (4 196 children and 774 women of child bearing age). In addition, a total of 3 746 people (2 541 Female and 1 205 Male) were reached through health education to create awareness about the importance of immunization and to improve uptake of immunization services. Since January 2017, 64% of the total number of people targeted for social mobilization activities had been effectively achieved.



Mothers with their children waiting for immunization in Pading in South Sudan Photo: THESO©

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