



HEALTH CLUSTER BULLETIN # 9
31 December 2016

South Sudan

Emergency type: Complex Emergency
 Reporting period: 27 November – 31 December 2016



HIGHLIGHTS

- ❖ As of 22 December 2016, a total of 3 708 cholera cases including 64 deaths (29 facilities and 35 community) (CFR 1.73%) were reported in South Sudan. With the concerted response efforts of health cluster partners, the on-going cholera outbreak remain confined to 9 states with active transmission in Bentiu PoC.
- ❖ Humanitarian needs increased significantly in the whole country over 2016 as the crisis spread to previously peaceful areas, including the Greater Equatoria region. The number of internally displaced persons (IDPs) across the country has now reached 1.87 million.
- ❖ WHO, key humanitarian and development donors and health partners held a meeting in Juba on 29 November 2016, to share an overview of the current situation and discussed solutions on how to improve coordination and enhance a coherent and harmonised support from national and international partners.
- ❖ According to UNAIDS, nearly 3 out of 100 adults in South Sudan are living with HIV. Displacement, insecurity and destitution created environments of high risk to HIV infection, especially among vulnerable groups such as women, girls and children. Sexual violence, increase in casual sex in displacement sites and non-availability of prevention services, including prevention of mother to child transmission of HIV services are putting affected people (including children) at high risk of HIV infection.

HEALTH SECTOR

	37	HEALTH CLUSTER PARTNERS CURRENTLY OPERATING IN SOUTH SUDAN
	67	PARTNERS AFFILIATED WITH THE HEALTH CLUSTER IN SOUTH SUDAN
MEDICINES DELIVERED TO HEALTH FACILITIES/PARTNERS		
	160	IEHK BASIC UNITS
HEALTH FACILITIES		
	1 392	TOTAL NUMBER OF HEALTH FACILITIES
	6%	DAMAGED/LOOTED/ NOT FUNCTIONAL **
HEALTH ACTION		
	5 754 856	CONSULTATIONS*
VACCINATION AGAINST		
	69 039	ORAL CHOLERA VACCINE
	181 694	MEASLES
EWARN		
	51	EWARN SENTINEL SITES
FUNDING \$US		
	34	% FUNDED
	\$110M	REQUESTED

*Since Jan 2016 . ** This information is based on report received from 29 out of the 67 health partners responded to the health cluster partner capacity request.

Compliments of the Season to all our Partners- Happy Holidays and Thank you for the Relentless Efforts Put into the 2016 Response to the affected Communities- We look forward to Collaborating on the Same in 2017.

Situation update

- The ongoing conflict in South Sudan is aggravating an already fragile socio- economic context, affecting the overall health and livelihood situation further increasing the risk for communicable disease outbreaks and malnutrition.
- Humanitarian needs increased significantly in the whole country over 2016 as the crisis spread to previously peaceful areas, including the Greater Equatoria region. A number of population displacements have occurred in the emergency health response in 2016 which is markedly reflected in high population numbers both at the major concentrated response sites and in new locations. Malakal has witnessed two major fighting within the Protection of Civilian sites (POC) and in the West Bank. Four major conflicts with one currently ongoing intermittently in Mayendit and Leer counties have witnessed a major back and forth shift in population numbers in the Bentiu POC from 120 000 reduced to 99 000 in June and currently at a steady increase to 103 494. In Bor, the population exiting the POC stalled as four major conflicts have retained 2 001 IDPs in the POC. In former Western Bahr Ghazal, fighting in June recorded the highest population displacement of 24 580 individuals into Wau POC site. The Equatorias have continued to remain as major response locations for essential emergency health where active assessments and rapid response modalities have been used to reach affected communities. This has necessitated the health cluster and partners to step up coordination, resource mobilization, information management and communication, technical advice, disease trends monitoring and emergency preparedness and response beyond what was strategically planned for in the 2016 humanitarian response. This is also in a phase where reduced partner presence is affecting capacities to respond.
- Although the full impact of the on-going crisis on the HIV/TB epidemic and response cannot yet be quantified, it is known that thousands of people living with HIV are now cut off from accessing health care services, are food insecure and some have been displaced from their homes. This has devastating impact on the health of individuals and on the progress made in the national response. Furthermore those who were on treatment of chronic non communicable diseases (hypertension, diabetics, cancer epilepsy etc are also in the same dilemma thus posing more health risks to individuals.

Public health risks, priorities, needs and gaps

Risks

- Health conditions in South Sudan remain precarious with over 1.6 million people displaced with more displacement occurring in the Equatoria regions, greater Upper Nile 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 or insecurity, 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 life saving primary health care services through Rapid Response missions (RRM)
- Reported Measles alert nationwide within and without displacement sites. Health partners provided mass vaccination to the confirmed outbreak areas and thereafter intensified routine EPI to reduce further risks.
- 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 is on its toes on mobilizing medical supplies and supporting the partners through core pipeline received from WHO, UNFPA and UNICEF however the need are huger than what is available.
- Malnutrition rates are on the increase with over 4.8 million people who are food insecure with a predisposed burden of Severe Acute Malnutrition (SAM) 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. However the health partner in collaboration with Protection and GBV cluster has been coordinating the activities within the PoCs and the host communities.

- Challenges with the timeliness and completeness of reporting on IDSR and EWARN at response sites.
- Cholera 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.
- Devaluation of South Sudan currency which had led to increase in food prices and less affordability of basic needs by the general population.

Priorities

- Strengthen and support emergency responders to scale up and provide lifesaving emergency health services to displaced population in conflict affected locations through mobile response.
- Strategically preposition nutrition 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.
- Support SGBV sub-cluster to continue to map facility capacity to implement SGBV, CMR and MHPSS response.
- Improve partner capacity to scale up surveillance on disease with outbreak potential.
- Advocacy with health stakeholders to support the on-going response to scale up emergency TB/HIV/AIDS interventions.
- Advocacy for increased funding for essential medicines for strategic preposition to support the response.
- Improve partner's capacity on Emergency Preparedness and Response.

Needs and Gaps

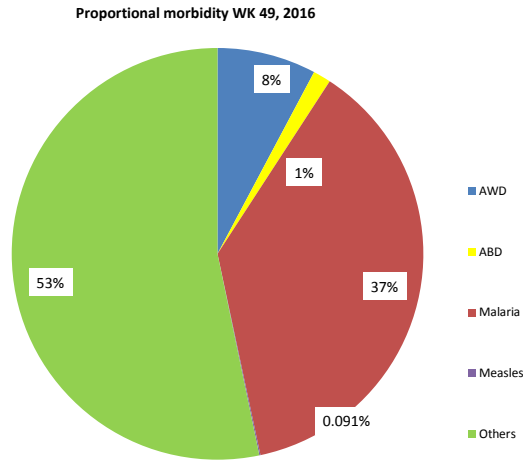
- Inadequate numbers of emergency responders to support response in new displacement sites.
- Lack of dedicated sub-national health cluster coordinators and information management personnel for an improved coordinated response.
- Human resource gaps in Mental Health and Clinical Management of Rape (CMR) for SGBV response.
- Inadequate surveillance staff in new displacement sites.
- Inadequate funding to partners to respond to acute and chronic emergencies.

Communicable diseases

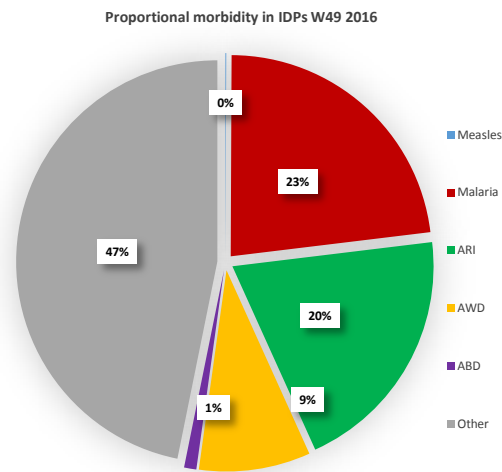
- Completeness of reporting rates in non-conflict and conflict areas were 39% and 92% respectively. Malaria is the top cause of morbidity and accounts for 37% consultations in non-conflict areas and 23% in IDP sites.

Morbidity statistics as of week 49 of 2016

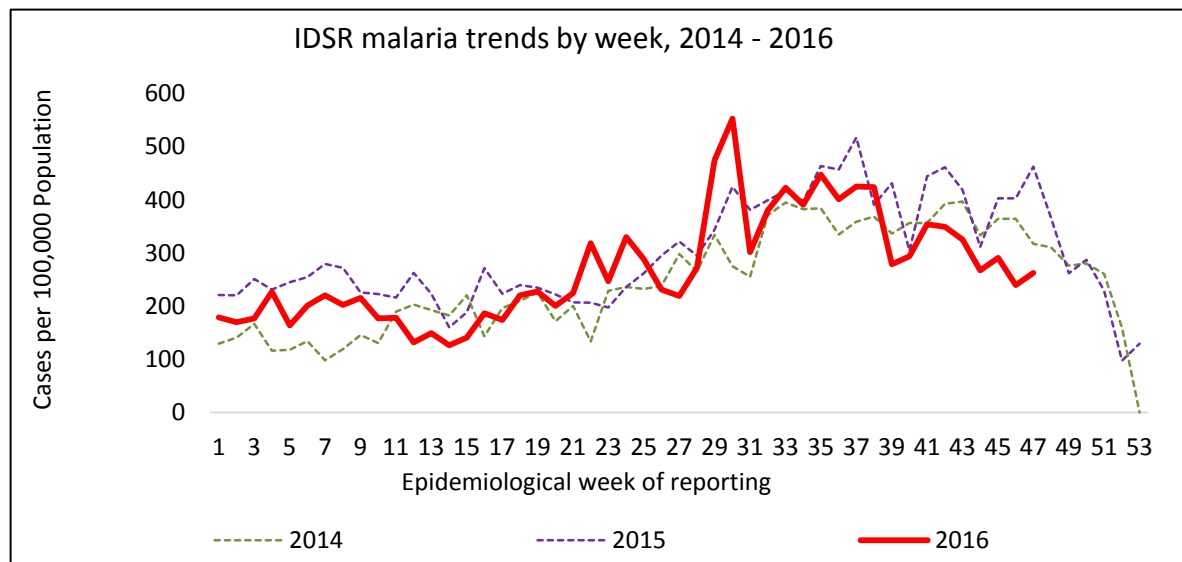
Non conflict areas



Conflict areas

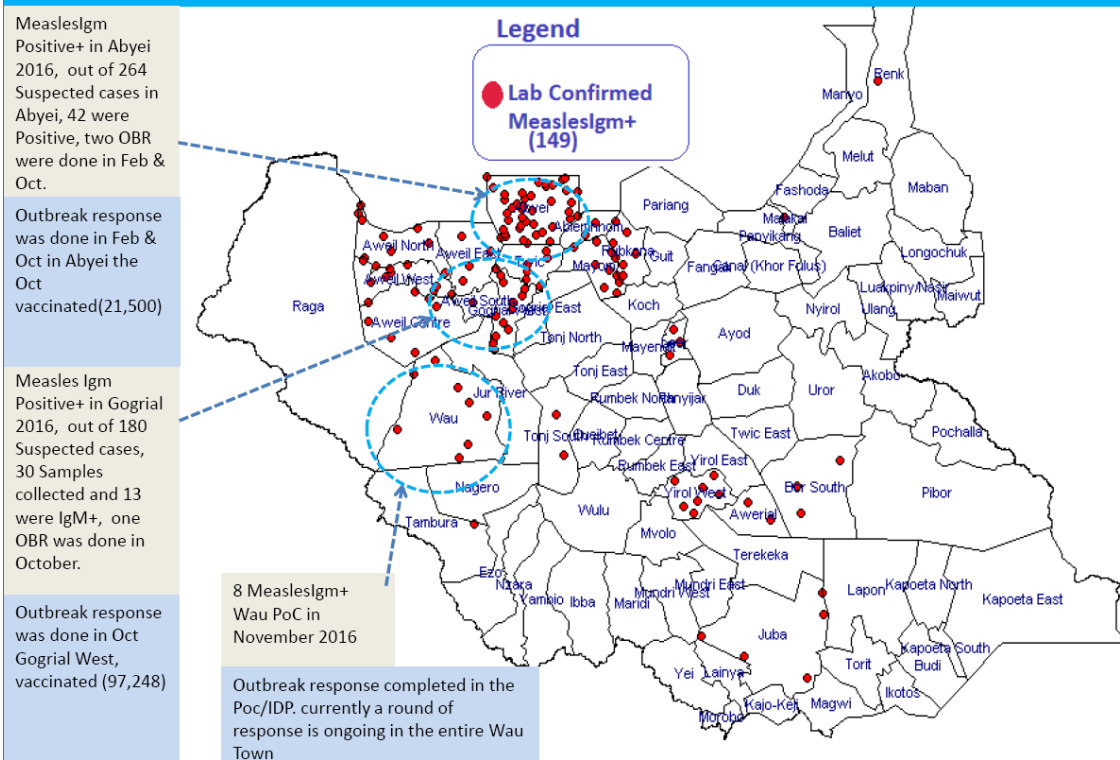


- The malaria trend in the IDP and non-conflict areas has continued to decline to the expected endemic transmission levels. These trends have also been registered in the 26 counties where during the peak transmission period had trends consistent with epidemic transmission.



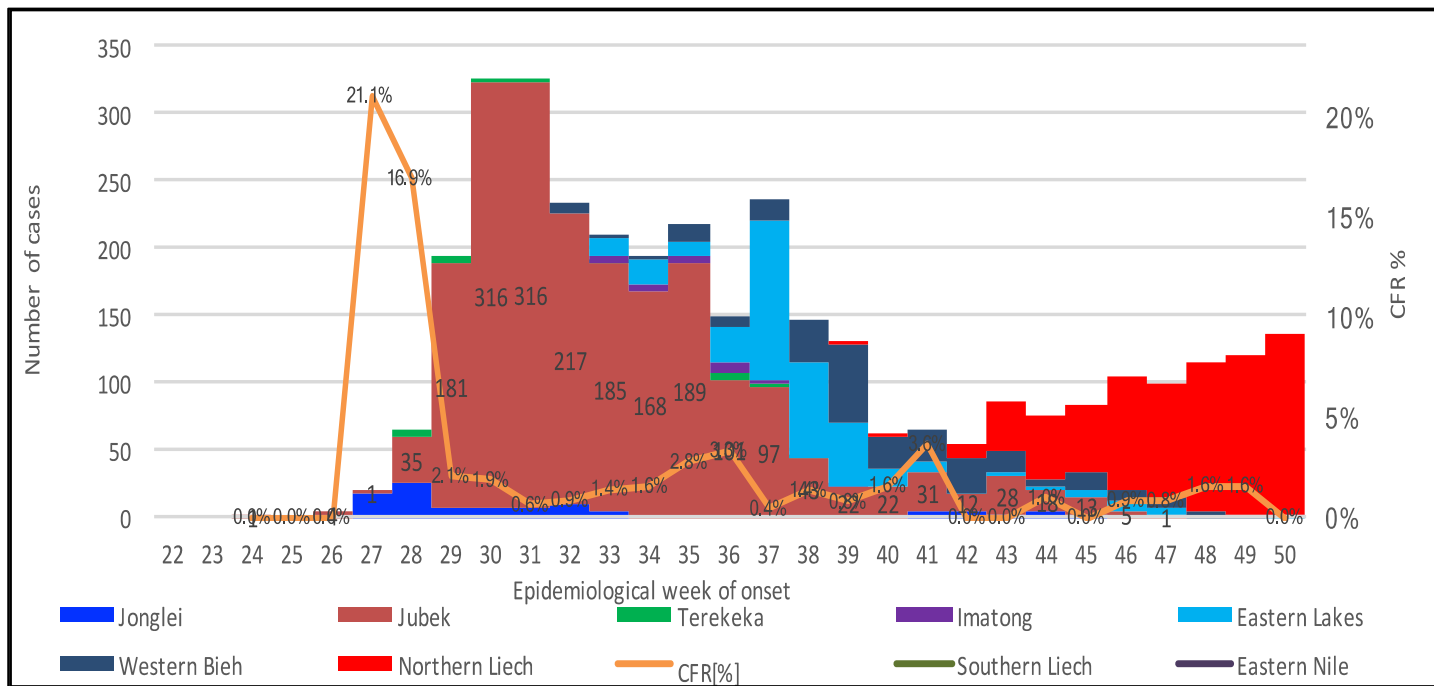
- Since the beginning of 2016, a total of 1 909 cases of suspected measles cases including at least 20 deaths (CFR 1.05%) were reported (IDSR). In week 49, a total of 40 new suspected cases of measles were reported from Wau POC, Aweil South and Gogrial West.

Dot Map of confirmed Measles Cases (Period of Jan-Oct 2016) and the most resent out break responses

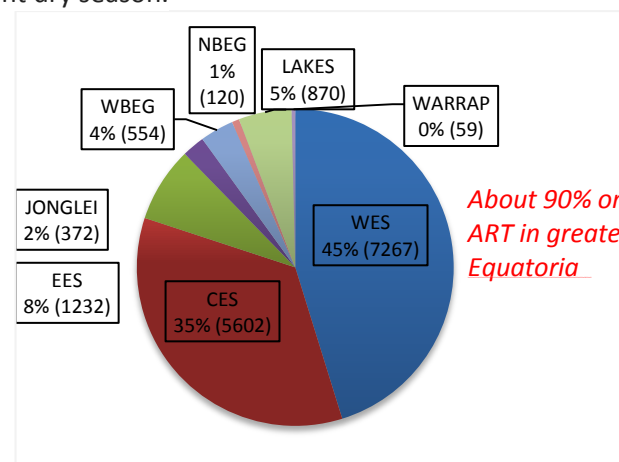


- The cholera outbreaks remain confined to 9 states including; Imatong, Eastern Lakes, Jubek, Terekeka, Jonglei, Western Bieh, Southern Liech Northern Liech and Eastern Nile. As of 22 December 2016, a total of 3 708 cholera cases including 64 deaths (29 facilities and 35 community) (CFR 1.73%) were reported in South Sudan. Most of the cholera cases were reported in Juba County where a total 2 006 cases including 27 deaths (CFR 1.35%) were registered. Active transmission has persisted in Bentiu PoC where transmission is attributed to exposure to water from an oxidation pond.

Epidemic curve for cholera cases in South Sudan, from 18 June - 22 December 2016

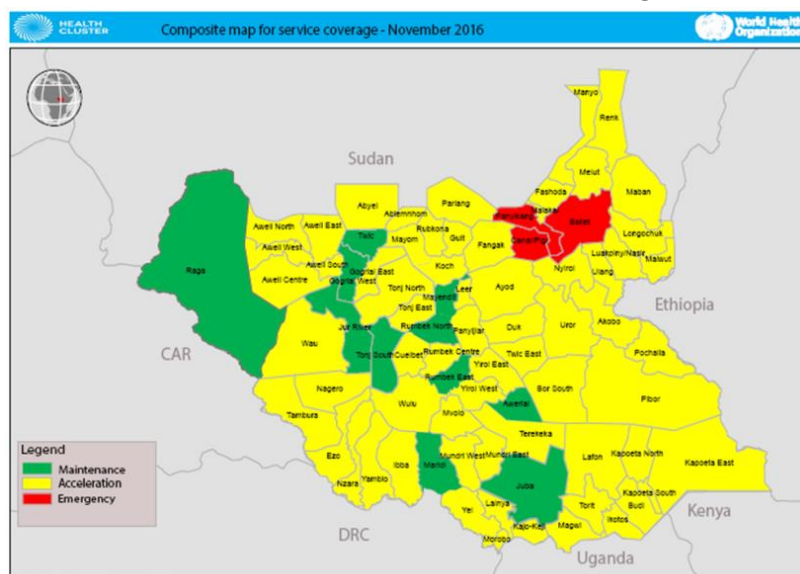


- The on-going conflict has exacerbated the pre-existing epidemiological risks for meningitis in many parts of the country. Since the beginning of the year a total of 26 suspected cases have been reported. Increased displacement across the country, massive destruction of health facilities, huge cohort of persons from the conflict affected states (Upper Nile, Unity, Jonglei and Western Equatorial) did not benefit from the MenA phase one vaccination campaign as well as previous trend of Meningococcal meningitis outbreaks in the country points to high likelihood of an outbreak during the current dry season.
- The on-going crisis is having adverse impacts on the HIV epidemic and response in South Sudan. Over 179,000+ people living with HIV in South Sudan were more preoccupied with where they will get their next prescription or meal, and/or whether they are safe or not. Although much progress has been seen in the last couple of years in scaling up HIV treatment from about 3 500 in 2011 to over 19 500 in 2015, this progress has been halted by the current crisis. Most of the people on HIV treatment are now directly affected by the crisis, especially in the Equatoria region which hosts about 90% of the people on HIV treatment.
- In week 49 of 2016, three deaths were reported from the non-conflict affected areas, two of which were attributed to malaria and one to meningitis. In the conflict affected areas, three IDP sites (Akobo, Juba 3 and Bentiu PoC) reported a total of 24 deaths.
- Increased morbidity and mortality due to TB/HIV/AIDS in the IDPs has become a rising concern country wide. Overall, Bentiu PoC, registered the highest number of deaths followed by Malakal PoC and Juba PoC.
- During 2016, the most common causes of death in under-five were medical complications of malnutrition, severe pneumonia, severe malaria and perinatal complications. The crude and under five mortality rates remain within the emergency threshold.

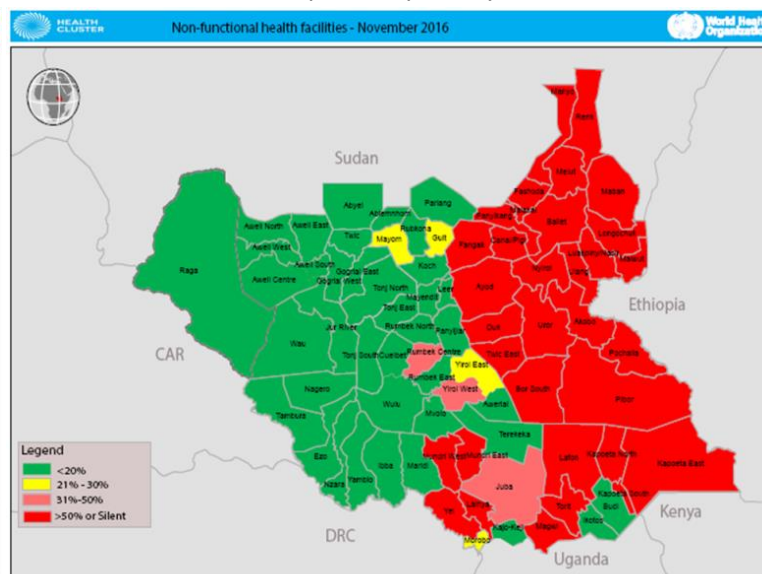


Functionality of health facilities

- In order to strategically initiate or scale-up healthcare services and allocate financial and human resources efficiently, WHO and partners undertook assessments on the health needs and health service utilization among IDPs and affected communities. As shown in the composite map, out of the 79 Counties, 11 have adequate health care services, 65 have inadequate health care services and the remaining three have limited or no services at all.
- Many facilities are currently either not functioning or partially functioning, leaving most of the population without adequate healthcare. According to the data collected from partners 50 % of the health facilities in the Greater Equatoria region are non-functional, due to conflict related destruction, damage and closure and are unavailable to provide primary health care services.



Creation date: 7th November, 2016
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.



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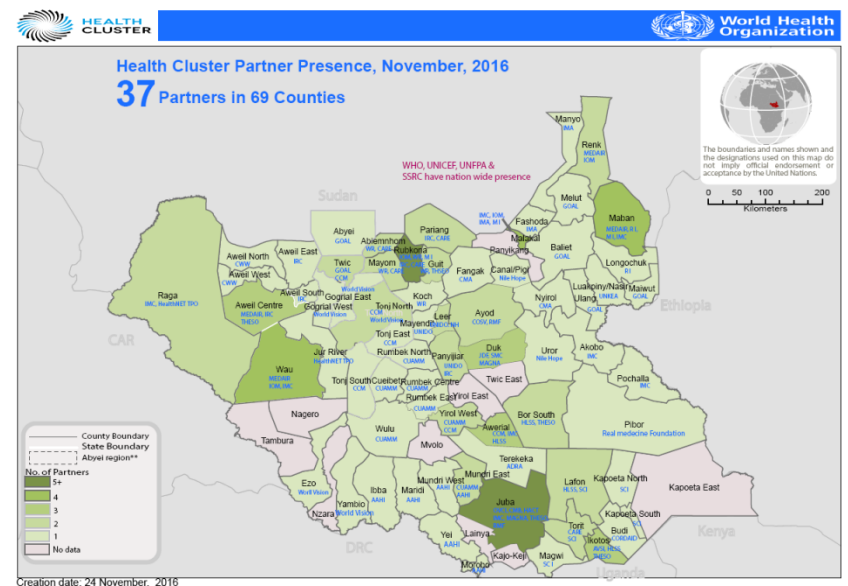
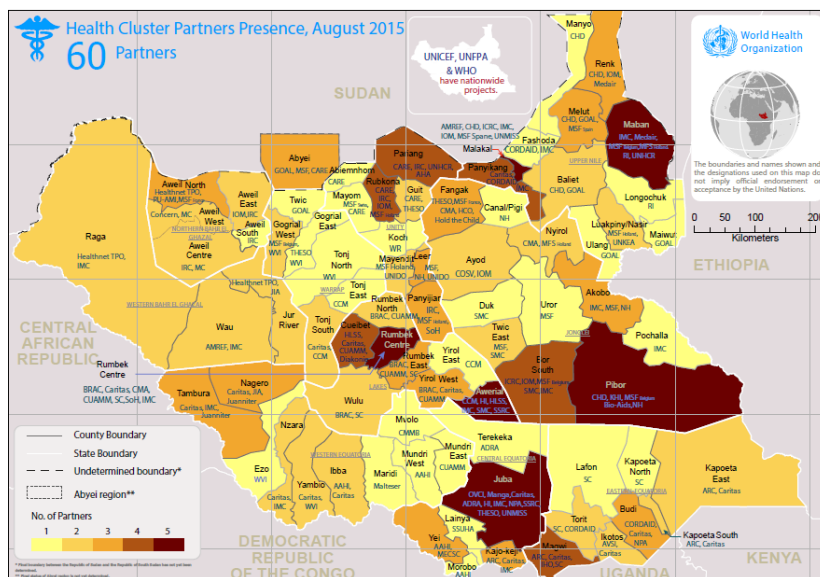
Availability of essential drugs, vaccines and supplies

- With the insecurities some development supported health facilities lack drugs, the pattern is widespread across the country and coupled with limited funding and access challenges, 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.

Health Cluster Action

Health cluster coordination

- Currently, the health cluster coordinates the humanitarian health response of over 35 partners in South Sudan. Regular meetings have continued to hold at the main emergency response sites and also at new displacement sites. Strategic and continued updates on health status, needs assessments and response, accountability to the affected population remain a key focus to the activities of the cluster.
- WHO, key humanitarian and development donors and health partners held a meeting in Juba on 29 November 2016, to share an overview of the current situation and discuss solutions for improved coordination and to enhance a coherent and harmonised support from national and international partners.
- 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 and malaria upsurges.
- Recent data from the Health Cluster indicates that, only 37 out of the 60 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 after the current crises in comparison with their presence in August 2015.



Support to health service delivery

Health facilities

- To provide emergency primary health care, IOM in collaboration with Africa Action Help International and MoH through the support of health cluster, the health team set up a temporary clinic in Yei town, former Central Equatorial State to provide emergency primary health care services to displaced population. Health care providers were recruited locally to support the mission. To date, over 350 health consultations have been conducted. The mission will end on 5th January 2017. The team is also building the capacity of the staff to continue with the response thereafter.

- GOAL continues to provide integrated health and nutrition services in Maiwut, Melut and Ulang counties, former Upper Nile state. Efforts had also led to a reduction in of kala-azar cases in the three counties.

Provision of essential drugs and supplies

- In response to the urgent health care needs in conflict affected areas, WHO provided 10 IEHK Basic Unit Kits, two Diarrheal Disease Kits complete, Seven Supplementary Malaria Module, 16Anti-Malaria Basic Module, one 2011, Supplementary Unit, 200 boxes of Malaria rapid test (adequate to test 5 000 patients), 500 DDK, IV fluids, 15 Triple Package Cat. These have been delivered to the implementing partners and health facilities in the areas of Northern Liech, Eastern, Bieh, Imatong and Jubec states.

Training of health staff

- WHO supported the SMOH to conduct a five day training for 31 health care workers from the two states of Gok and Western Lakes from 13 to 17 December 2016 in Rumbek Town. The training aimed to orient the Health workers on the IDSR strategy and thus enhance their capacity for early detection, prompt investigations and rapid response to suspected outbreaks. Given the drastic decline in the timeliness and completeness of IDSR reporting nationally the training also aimed to improve their skills in generating the reports as well as underscoring the public health importance of accurate, timely and complete reports. Participants comprised County medical officer, County Surveillance officers, Nurses, Community Health Workers and data clerks drawn from Rumbek Central, Wulu, Cuebet and Rumbek East.

Child health: Vaccination

- MAGNA's response focused on immunization services and health education within UN House PoC site in Juba. Over the past two weeks, a total of 1 735 persons (1 533 children, 59 pregnant and 143 women of child bearing age) were immunized against vaccine preventable diseases. A total of 1 417 people (807 Female and 610 Male) were reached with health education services to create awareness about the importance of immunization and to improve uptake of immunization services. In collaboration with partners, MAGNA a total of 11 662 (7,955 children aged 12-59 months and 3,707 children aged 0-11 months) were reached during the last round of national immunization campaign.

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