



Bulletin # 02 February 2016



HIGHLIGHTS

	CONSULTATIONS	328,705
	NEONATAL CARE	2,086
	ASSISTED DELIVERIES ANC SERVICES	1,742 8,034
	MEASLES VACCINATION	21,114
	% HRP FUNDED	6.0%
	HEALTH CLUSTER PARTNERS <i>(47-INGO, 16- NNGO, 4 - UN)</i>	67



 4.73 M PEOPLE IN NEED	 2.5 M TARGETED FOR HEALTH	 1.6 M DISPLACED	 300,000 REFUGEES
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Dear Partners

Thank you for all the responses in February. We are encouraged by your energies

February 2016 Gallery



Health and Nutrition cluster strategizes



Malakal Response IOM Clinic



National Health Cluster meeting February 2016



Health Facility Ruins in Malakal

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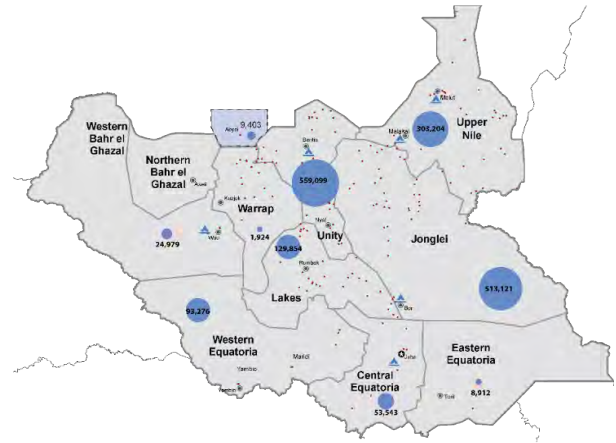
SOUTH SUDAN HEALTH CLUSTER SITUATION UPDATES

SITUATION OVERVIEW

The December 2013 conflict has devastated the lives of millions of South Sudanese and displaced more than 2.3 million people. About 1.69 million of them have been displaced internally in South Sudan and over 648,000 are refugees in neighbouring countries.

Towards the end of 2015, The Health cluster and partners played a key role in engaging with the MOH /other clusters/donors/ in formulating the 2016 Humanitarian Needs Overview and Humanitarian Response that clearly articulated the Health cluster specific response strategy for responding in 2016.

Resources have been advocated for and attracted over USD 4.7 Million from the Common Humanitarian Fund (CHF) to kick start response implementation in 2016. While the CHF funds took a little time to come through, many of the partners have worked tirelessly to sustain the health response.



February has witnessed yet more displacements primarily in Unity, Wau and also in the Equatorias and In Upper Nile, but it has also engaged new strengths. Health cluster partners have continued to rise to the myriad of challenges and have respond to them in a timely manner. All the assessments conducted and participated by the health cluster partners in February have received a health response.

Health cluster partners have assessed, reached and responded in many difficult to access locations and have strategically used the rapid response approach to have quick high impact interventions in various locations including Mundri West, Twic East, Baltet, Duk, Fangak, Wau Shiluk and Agok in Abyei.

The POC's spaces within the UNMISS base have largely remained calm and have continued to receive health intervention with the exception of the intercommunal conflict that occurred in the Malakal POC mid February. This resulted in new displacements and a number of health risk related public health challenges related to overcrowding, lack of WASH facilities and malnutrition. The health cluster foresaw the potential for disease outbreaks and strategically aligned with the wash and nutrition partners to mitigate this.

February saw the emergence of a strong collaboration and a forged strategic Health/Nutrition and Wash cluster intervention. Cluster Partners coordinated and responded within 24hours and by the end of the week assessment and response had been availed to the affected communities within and outside the POC.

The Health cluster has also assumed a new approach to response in relation to emerging disease surveillance data and outbreak alerts. Partners responding in locations that are alerting health risks are followed and guided to interrupt transmission as has been the various responses to the measles alerts in early February.

February also witnessed a strengthening of the Health component of the Humanitarian website. Activities pertinent to health interventions have been regularly shared widely and preserved.

In response to partner requests for understanding individual partner programs the health cluster in February responded by providing opportunities for partners to present on their programmes and to identify and share best practices.

While the economic downturn has reported high operational costs for partners, health partner efforts have continue to provide response to the affected communities.

The cluster recognizes the challenge of data collection and reporting and continues to work with partners through the EWARNs system to forge progress in this area.

The health cluster exists to bring together development and humanitarian partners to scale up response to the L3 conflict. This requires a complex set of interrelated variables including the availability of health facilities, Skilled human resources for health, pharmaceuticals and health commodities, availability of experienced humanitarian actors, logistics and dedicated coordinators and coordinating mechanisms. The presence of all these variables will then need to work together to provide direction for efficiency and to be able to report on aid quality and effectiveness.

Prior to the December 2013 conflict, South Sudan was already recovering from a protracted conflict that has left the health system weak and reporting some of the worst indicators. The recent conflict saw a looting and destruction of health facilities and displacements that moved communities even further away from access to health services and exposed them to overcrowded shelters with inadequate WASH and nutrition services especially for inpatient stabilization of severely acutely malnourished children. In order to be able to adequately and appropriately respond to humanitarian public health risks, the humanitarian health community is faced with a number of Emergency Related Health Needs.

In addition to this multiple insecurities have turned IDP's into a fluid and moving target that is often resource intensive to follow with health interventions.

The health cluster is targeting 2.4M for assistance in the Humanitarian Response Plan and a further 6941 SAM cases for comprehensive medical interventions in stabilization centre's.

There is the need to:

- ✓ Reduce the risk of epidemic prone, endemic diseases, vaccine preventable and other diseases as a result of conflict and displacement.

With overcrowded locations and poor water and sanitation access, two cholera outbreaks have been responded to in 2014-2015. The health cluster has already responded to 2 confirmed measles outbreaks in 2016. Mortality surveillance reported Malaria, TB/HIV, and medical complications of malnutrition, and in the U5, malaria, medical complications of malnutrition, perinatal deaths and pneumonia in 2015. We have also reports of increase in Hepatitis E cases in the Bentiu POC in March 2016.

- ✓ Boost adequate and skilled Health Workforce for frontline response:

There is a severe shortage of health human resources to respond to frontline health needs. Injectable vaccines require a skilled health workforce to respond including assistance for obstetric emergencies in humanitarian settings. This is stemming from an overall nationwide shortage of health human resources. (1 doctor to a population of 65,574 individuals, 1 midwife to 39088 women) and further exacerbated by conflict and displacement.

- ✓ Mitigate drug stock outs and to preposition essential medicines and supplies for outreach emergency response.

Procure and preposition core pipeline health medicines and supplies in the dry season in the States and in key healthcare facilities to ensure that emergency response continues. The sector is experiencing shortages of essential medicines and supplies in key healthcare facilities. Procurement of essential medicines and supplies stalled in the last quarter of 2015. Short-term measures are in place to bridge the gap only till the end of January 2016. The short-term stopgap is not nationwide and the proposed supplies from donors are incomplete. Arrangements for supporting the rest of 2016 are still under discussion and require substantive resources and complex logistics to mitigate pharmaceutical stock outs.

- ✓ Need to increase the number of functional health facilities to sustain emergency health response

Due to destruction, damage and closure, 45% of health facilities are nonfunctional in the conflict affected states, and are unavailable to provide effective surveillance or serve as referral mechanisms, especially for maternal obstetric complications. Need to scale up use of rapid response modality to access and provide health services to fluid and moving populations including resources for reestablishing damaged or closed health facilities.

- ✓ There is an emerging need to integrate emergency response including HIV/AIDS and TB services. In 2015, malaria, TB/HIV/AIDS, malnutrition, pneumonia, & perinatal deaths were the major causes of mortality among IDPs.

- ✓ Deploy dedicated skilled Health Cluster Coordinators to provide strategic guidance to the implementation of the Humanitarian health response plans. Technical assistance on health leadership provided by dedicated cluster coordinators contributes to building capacities on developmental health response and also accounts for 100 % of health cluster performance where all the cluster partners are dependent on the Health cluster vision for strategic health interventions. Currently other than the health cluster coordinator at the national level, all coordination activities are reliant on the double hatting role of state focal points.

With the challenging funding weather, the cluster has prioritized the following service delivery and coordination needs for resource mobilization.

- Primarily- "To Prevent detect and respond to disease outbreaks and immunizations of U5." This will mitigate mortality due to epidemic prone vaccine preventable diseases and complications of severe malnutrition.
- To have dedicated Cluster coordinators in place for an effective response
- Secondly the cluster will seek to mitigate essential medicines and supplies stock out through the core pipeline.
- Thirdly the cluster will address through the rapid response modality increased access to functional health facilities to increase coverage and service delivery
- The strengthening of an integrated essential basic package that will also respond to TB/HIV co-morbidities.
- Provision of supportive Supervision to partners and documenting gains made.

COORDINATION

Cluster meetings continued to take place bi-monthly at national and weekly at sub-national level. At the national level, the cluster worked closely with WHO IDSR unit on surveillance activities. It also worked closely with the Nutrition and WASH cluster in strategizing responses to EWARN Emerging data of concern.

At the national level, Health cluster partners engaged on dialogue and response activities in the following thematic areas:

1. Advocacy for the allocation of humanitarian resources for partner response in (Mingkaman/Western Equatoria/ Upper Nile- Malakal POC)
2. Initiation of Write Up of cluster Note and Work plan for Resource mobilization and operationalization of the Health specific Humanitarian response plan.
3. Review of the health section within the Interagency Rapid Needs Assessment tool
4. Review of Health cluster meeting modality and activities to reflect
 - Strategic Guidance on response to emerging EWARN/IDSR data of concern
5. Dry season preparedness
6. Contingency Planning
7. Creating opportunities for partners to understand peer programmes and to identify and share best practice.
8. Support to the Upper Nile HC coordination and response to the intercommunal conflict and displacement in the Malakal POC. A multisectoral plan was also drawn between health nutrition and WASH partners to sustain the response for the next 3 months.
9. Support to partners implementing integrated TB/HIV services
- 10.

At the States level WHO focal points have continued to double hat the Health cluster coordinator role and have been actively engaged in strategic guidance and discussions and response on the following thematic areas:

JONGLEI STATE:

- Engaged State and HC partners on referral pathways from the POC to the secondary health care facilities
- Disposal of Expired drugs and Local IDSR/EWARS response

LAKES STATE: MINGKAMAN

Health Partners have continued to respond to health needs within Aweriel County and the Minkaman host community on IDSR and public health service delivery.

UPPER NILE STATE:

The conflict that erupted in the Malakal POC, causing displacements out of the POC witnessed the February discussions mainly focus on the Malakal POC preparedness and response.

- Within the first 24 hours, WHO and Health cluster partners in Malakal activated the mass casualty plan and coordinated the responsibilities within the plan.
- Partners have continued to meet fortnightly to monitor the response

UNITY STATE:

Coordination efforts 1 February were focused on mobilizing partners to operationalize Bentiu State Hospital which has been out of operation for the last 2 years

ACHIEVEMENTS AGAINST HRP, MONITORING VISITS AND ACCOUNTABILITY TO THE AFFECTED POPULATION

"HEALTH CLUSTER AND PARTNERS REACH 21,114 CHILDREN AGE 0 – 59 MONTHS MEASLES VACCINES"

With concerted efforts of the humanitarian health partners, the health cluster was able to achieve the following key output indicators during the period under review;

- 328,705 medical interventions of which 316 were curative outpatients consultations
- 8034 were provided with antenatal services
- 1742 assisted deliveries
- 2066 babies provided with neonatal care
- 21,114 children age 0 – 59 months were reached with measles vaccine through the outbreak response campaign in CES, Warrap, Unity and NBS. In addition, health cluster partners are currently participating in the Meningitis campaign currently conducted in some selected states

See below, progress update on the 2016 HRP;

(Results indicated in this table is cumulative annually, beginning January of 2016) **Achievement matrix by February, 2016**

Indicator Description	Baseline	People in Need	Target	# Achieved
Objective 1: Improve access, and scale-up responsiveness to, essential and emergency health care, including emergency addressing the major causes of mortality among U5C (malaria, diarrhoea and Pneumonia), obstetric care and neonate services				
% decrease in Crude Death Rate	0.14	811470	≤1	0.18
% decrease in under 5 Crude Death Rate	0.33	107409	≥2	2.53
% increase in # births attended by skilled birth attendants in conflict affected and other vulnerable states	36%	101432	41%	0.33%
% increase in health facilities providing Basic Emergency Obstetric and New-born Care (BeMONC) services	11%		15%	11%
# of functional health facilities in conflict-affected and other vulnerable states.	400		500	400
Proportion of facilities with functioning cold chain in conflict affected and other vulnerable states	5%		25%	<i>Data not available</i>
# of children under 5 with severe acute malnutrition with medical complications, who are clinically managed in stabilization centres.	231368	231368	6941	78
Objective 2: Prevent, detect and respond to epidemic prone disease outbreaks in conflict affected and vulnerable states				
% of epidemic prone disease alerts verified and responded to within 48 hours	79%		90%	60%
Proportion of children 6 to 59 months receiving measles vaccinations in emergency or returnee situations	47%	481802	80%	6%
Proportion of people reached by health education and promotion before and during outbreaks	56%	1242542	80%	0.49%
Objective 3: Improve access to psychosocial support and mental health services for the vulnerable population, including those services related to the SGBV response.				
# of health facilities providing Clinical Management of Rape (CMR) services, including emergency contraceptive pills, PEP, and STI presumptive treatment	14		20	14
# of health personnel trained on MHPSS in conflict affected states	90		132	11

MONITORING VISIT



other essential supplies in Nasir County.

In February 2016, a supportive field monitoring visit was conducted with Universal Network for Knowledge and Empowerment Agency (UNKEA), a local NGO implementing a Common Humanitarian Funded (CHF) in Nasir County, Upper Nile State. The purpose of the visit was to verify the progress, quality, and challenges of project implementation and help to provide evidence-based decision making.

Following the outcome of the field monitoring visit, some 20 basic units and 1 supplementary health kit were prepositioned through WHO pipeline support as a response to the acute shortage of medicine and

HEALTH CLUSTER AND PARTNERS FOCUS ENERGIES ON PROVIDING ACCOUNTABILITY TO THE AFFECTED POPULATION (AAP)



AAP refers to a set of commitments that ensures that responses in communities recognize the community participation in identifying the responses and build into the response an effective evaluation by the communities and commit to ensure their views are incorporated into further response.

This concept is underpinned by 5 Commitment Pillars- See Snapshot Below

In February, the cluster-focused commitment on the accountability to affected population was based on using the Monitoring and evaluation field mission to engage the communities and to actively

seek out modalities of response that communities expressed. (Pillar5)

THE 5 PILLARS THAT UNDERPIN THE AAP CONCEPT

1. Leadership/Governance Demonstrate their commitment to accountability to affected populations by ensuring feedback and accountability mechanisms are integrated into country strategies, programme proposals, monitoring and evaluations, recruitment, staff inductions, trainings and performance management, partnership agreements, and highlighted in reporting.
2. Transparency
Provide accessible and timely information to affected populations on organizational procedures, structures and processes that affect them to ensure that they can make informed decisions and choices, and facilitate a dialogue between an organization and its affected populations over information provision.
3. Feedback and Complaints Actively seek the views of affected populations to improve policy and practice in programming, ensuring that feedback and complaints mechanisms are streamlined, appropriate and robust enough to deal with (communicate, receive, process, respond to and learn from) complaints about breaches in policy and stakeholder dissatisfaction
4. Participation
Enable affected populations to play an active role in the decision-making processes that affect them through the establishment of clear guidelines and practice to engage them appropriately and ensure that the most marginalized and affected are represented and have influence.
5. Design, Monitoring and Evaluation
Design, monitor and evaluate the goals and objectives of programmes with the involvement of affected populations, feeding learning back into the organization on an ongoing basis and reporting on the results of the process •

IDSR/EWARS

SYSTEM PERFORMANCE AVERAGES

- IDSR Performance: 42% Completeness
- EWARN Performance: 58.5% % Completeness

CONSULTATIONS

- IDSR: Average total consultation per week was 68, 849, and cumulatively was at 507,416.
- EWARN: Average total consultation per week was 23,462, and cumulatively was at 202,417.

MORBIDITY TRENDS

- IDSR: Malaria was the top cause of morbidity in non-conflict affected states with average proportionate morbidity of 35.5%. Registering an average 24,077 cases per week and cumulatively 218,998 cases by the end of February 2016.
- EWARN: Acute respiratory infections (ARI) was the top cause of morbidity in the conflict affected sites with average proportionate morbidity of 25%. Registering an average 5,602 cases per week and cumulatively 46,362 cases by the end of February 2016.

MORTALITY TRENDS:

- IDSR: A total of 118 deaths were reported from the stable areas in February 2016, with 33 (28%) deaths attributed to malaria and 61 (51.7%) occurring in under 5 years
- EWARN: A total of 137 deaths were reported from the conflict affected areas in February 2016, with 10 (7.2%) deaths attributed to TB/HIV/AIDS and 42 (35.6%) occurring in under 5 years CMR and U5MR remain below emergency threshold of 1 and 2 per 10,000 death per day.

Surveillance alert on Measles

State	County	New suspect cases (deaths) W10, 2016	Suspect cases in 2016	Confirmed Cases in 2016	Samples tested in 2016	Outbreak status in 2016
CES	Mangatain IDP		2	2	2	Confirmed
CES	UN House PoC	1	4	3	3	Confirmed
CES	Juba		9			Alert
CES	Yei		7	0	0	Alert
EES	Magwi	1	8		7	Alert
Lakes	Rumbek Center		4	2	4	Alert
Lakes	Yirol East		1		0	Alert
Lakes	Yirol West	1	7			Alert
NBG	Aweil West	7	31	8	5	Confirmed
NBG	Aweil East	1	3	0	0	Alert
NBG	Aweil South	1	4	0	2	Alert
NBG	Aweil North	2	4	0	0	Alert
Unity	Abiemnhom		1	1	0	Alert
Unity	Mayendit	1	27	2	12	Confirmed
Unity	Mayom	30	161	9	12	Confirmed
Unity	Leer (Adok)		7	2	6	Confirmed
Unity	Bentiu PoC	3	22			Alert
UNS	Maban		1	1	1	Alert
Warrap	Agok		52	8	16	Confirmed
Warrap	Gogrial West		3	1	3	Alert
Warrap	Twic		10	11	11	Confirmed
WBG	Wau		8	0	1	Alert
WES	Ibba		2	0	2	Alert
WES	Tambura		4	0	4	Alert
WES	Yambio		7	0	7	
Total		48	389	49	98	

HEALTH PARTNERS RESPONSE TO IDSR/EWARS

“HEALTH CLUSTER PARTNERS RESPOND IN ABYEI

17,753 VACCINATED AGAINST MEASLES OUTBREAK IN AGOK (GOAL) “



Month old child with suspected Measles case in MSF hospital.

Abyei Administrative Area is an area covering 10,460 km². It is bordering South Kordofan to the north, Twic to the south, Unity to the east and Northern Bahr-el Gazal to the west. The population in Abieyi is estimated at 75,270 inhabitants. The national EPI coverage in 2015 was 72% while Unity State, a neighbouring state to Abieyi where outbreak was declared in 2015 had 29% of EPI coverage.

GOAL reported a suspected case of measles in Juljock that paved the way for rapid assessment in collaboration with WHO Kuajok office and SMOH.

Since the beginning of the outbreak, a total of 96 suspected cases were reported and managed in MSF hospital. 3 cases were reported to have died of complication making the CFR 3.1%. On February 26, 2016, Health Cluster's partners concluded six days of measles vaccination campaign in Abyei area and AjakKuac payam in neighbouring Twic

Achievements

- ✓ Over 94% of the targeted 14,301 under five children in Abyei area were vaccinated.
- ✓ 3452 children in adjoining payam of AjakKuac in Twic were vaccinated.

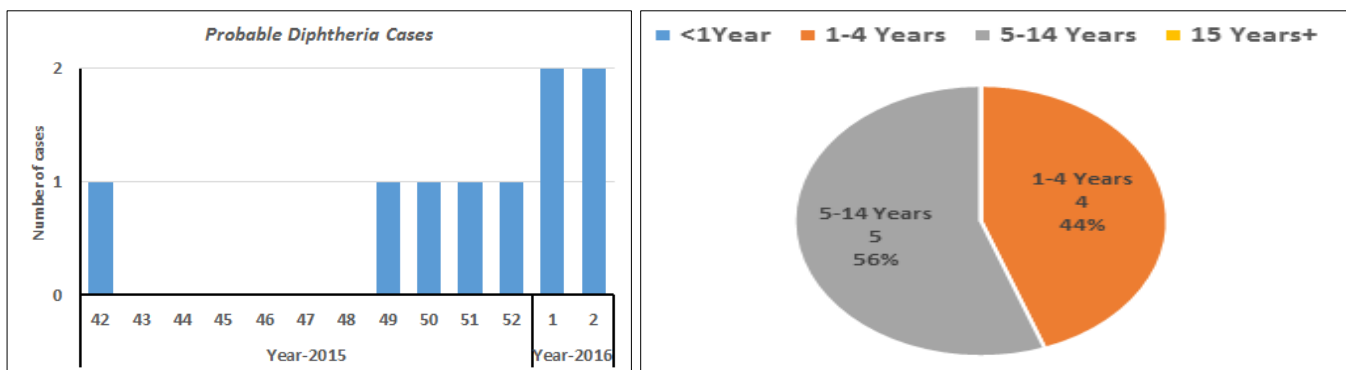
PROBABLE DIPHTHERIA CASES IN OLD FANGAK- SITUATION UPDATE

Diphtheria is a contagious and potentially life-threatening bacterial infection caused by toxins producing strains of *Corynebacterium diphtheriae* and *Corynebacterium ulcerans*. Symptoms usually begin two to five days (range 1 - 10 days) after exposure to the diphtheria bacteria. Symptoms will depend on the site of infection but the most severe form of diphtheria affects the throat and tonsils. The first symptoms are usually a sore throat, loss of appetite and a mild fever. Within 2-3 days, a membrane forms over the throat and tonsils that can make it hard to swallow and breathe. The infection can also cause the lymph glands and tissues on both sides of the neck to swell ("bull neck"). The toxin formed by the diphtheria bacteria can also cause inflammation of the heart muscle and the nerves, which can be fatal. Sometimes diphtheria can cause small skin sores that form larger ulcers, commonly on the legs. This form of diphtheria is more common in the tropics. Illness can also occur with non-toxin-producing strains of the diphtheria bacteria, but the disease is generally milder. The bacteria can live in the mouth, nose, throat or skin on infected individuals. It spreads via airborne droplets with coughing and sneezing and rarely from close contact with discharges from an infected person's mouth, nose, throat or skin. Without antibiotic treatment, people with diphtheria are infectious for up to 4 weeks from the onset of symptoms. Some people become carriers and are infectious for longer. *Corynebacterium ulcerans* infection is occasionally associated with consumption of unpasteurized milk or contact with animals.

Probable Public Health Impact Although most infections with *C. diphtheriae* are asymptomatic or run a relatively mild clinical course, high case-fatality rates (>10%) have been reported even in recent outbreaks.

Recent Surveillance data on Diphtheria in South Sudan: The disease is still endemic in South Sudan due to low DPT3 coverage across all the states. Currently the Greater Upper Nile Region, followed by Bahr el Ghazal are reporting sporadic cases or small clusters of upsurges. Health Partners reported an increasing trend of sporadic probable diphtheria cases in Old Fangak in the last quarter of 2015, which triggered a joint WHO and UNICEF investigation in January 2016. Fangak County is located in one of the world's largest wetlands in the Nile basin, which is considered to be nearly impassable either overland or by watercraft. The logistics of operations in the region is very costly. At the time of the investigation there were 4 probable cases in isolation with clinical symptoms of diphtheria.

Findings: Fig ! : Epi curve (by week of onset) & Pie chart of Distribution by Age Group



1. Epidemiological data: The first case with onset of disease in Week 42 was from Pathiech Village in Toch Payam, spread to Old Fangak Payam and Paguir affecting mainly young children (44% between 1-4 years) and adolescent (56% between 5-14 years of age). No case recorded for under 1 year.

Most cases seem to be residents of Old Fangak Payam (56%), following by Toch (22%).

Of the 9 cases, 2 had been vaccinated, 3 unvaccinated and 4 unknown. Of the 35 contact cases 21 were (11 under 5 years and 10, 5-14 years of age) only 1 had received vaccination.

2. Suboptimal Functioning of the County Health system: The entire unit has been displaced to Old Fangak town and functioning only with the CHD Director, M&E and Surveillance officer and Pharmaceutical officer. Health infrastructure is 1

hospital, 5 PHCC, 13 PHCUs and 1 outreach unit. 39,900 IDP's are resident in New Fangak Town and surrounding Bomas, accessing an MSF-F mobile clinic service twice a week.

- Of the 6 Health facility cold chain systems 4 are functional and 2 non-functional. The CHD cold chain is destroyed.
 - Reports of stock outs of essential medicines for long periods.
 - NGO county lead is operating from elsewhere
3. **EPI Coverage and Immunization Services:** With the exception of 2011, DPT3/Penta3 routine immunization coverage in the County have remained far below the protective index and has worsened during the last 2 years of conflict. Only 2 children out of 35 of 6 to 24 months of age (5.7%) assessed have received at least 3 OPV doses during routine EPI, 29 children under 5 years of age (38.6%) out of a total 76 assessed in the 32 households received OPV during November 2015, 23 children under 5 years of age (30.3%) out of a total 76 assessed in the 32 households received OPV during December 2015. Many children were also missed during the November and December NID's due to proximity or caretaker unawareness. Only 10 children under 5 years of age (13%) out of a total 76 assessed in the 32 households had 4 to 6 OPV doses, in other words fully protected against wild poliovirus.
 4. **Weak HMIS and Surveillance systems:** Outdated versions of MoH registers still in use in some health facilities, no record of zero reporting , inconsistent and incomplete data, lack of IDSR case definition information at the facility level.
 5. **Social Mobilization and Facts from community profiling:** Diphtheria is well known by Fangak local communities, and called in Nuer "Ng'orkoda". There is however Low community awareness for demand for comprehensive health care.
 6. **CONCLUSIONS:** The surge of probable diphtheria cases in Old Fangak community is the result of a cumulated proportion of susceptible persons to Vaccine Preventable Diseases. There is a myriad of health facility access challenges. Mobility is very difficult due to the swamps and 3 rivers that surround the location. Air transport, local canoes and boats are the modes of transport and these are very expensive and a number of Health facilities along with their catchment areas are landlocked by swamps as such they can't be reached neither by boat or by road. There is also the blockage of the main canal of supplies from Malakal leading to food and fuel scarcity and high prices. Due to the tensions emanating from the conflict, there is a marked reduction of skilled health workforce with little supervision and monitoring of health interventions. The ill functioning County Health System compounds this including high staff turnover.

HEALTHCLUSTER PARTNERS CALL TO ACTION

- Partners currently operating in the location to institute and tighten up coordination and surveillance on vaccine preventable diseases (MSF-F, NPA, SSMR, ICRC) and to sustain ongoing active and passive case search.
- Partners with representation at the national level should closely align with and attend the Immunization technical working group discussions- WHO conference room on Fridays from 10am-1pm.
- Availability of Medium for transportation of samples-WHO
- Partners to liaise with the national M&E department to avail and disseminate current OPD registers and IDSR reporting tools to the Health Facilities
- Partners to refer to context protocols for case management of existing cases.
- Partners to step up social mobilization and information to the community on early detection and health care access.
- The NGO county lead/Health Cluster/ and EPI will lead leveraging of available health resources to scale up routine immunization services in the County.
- Partner response plans should cater for logistical bottlenecks in the areas. Plan for A coordinated multi sectoral Assessment in the County

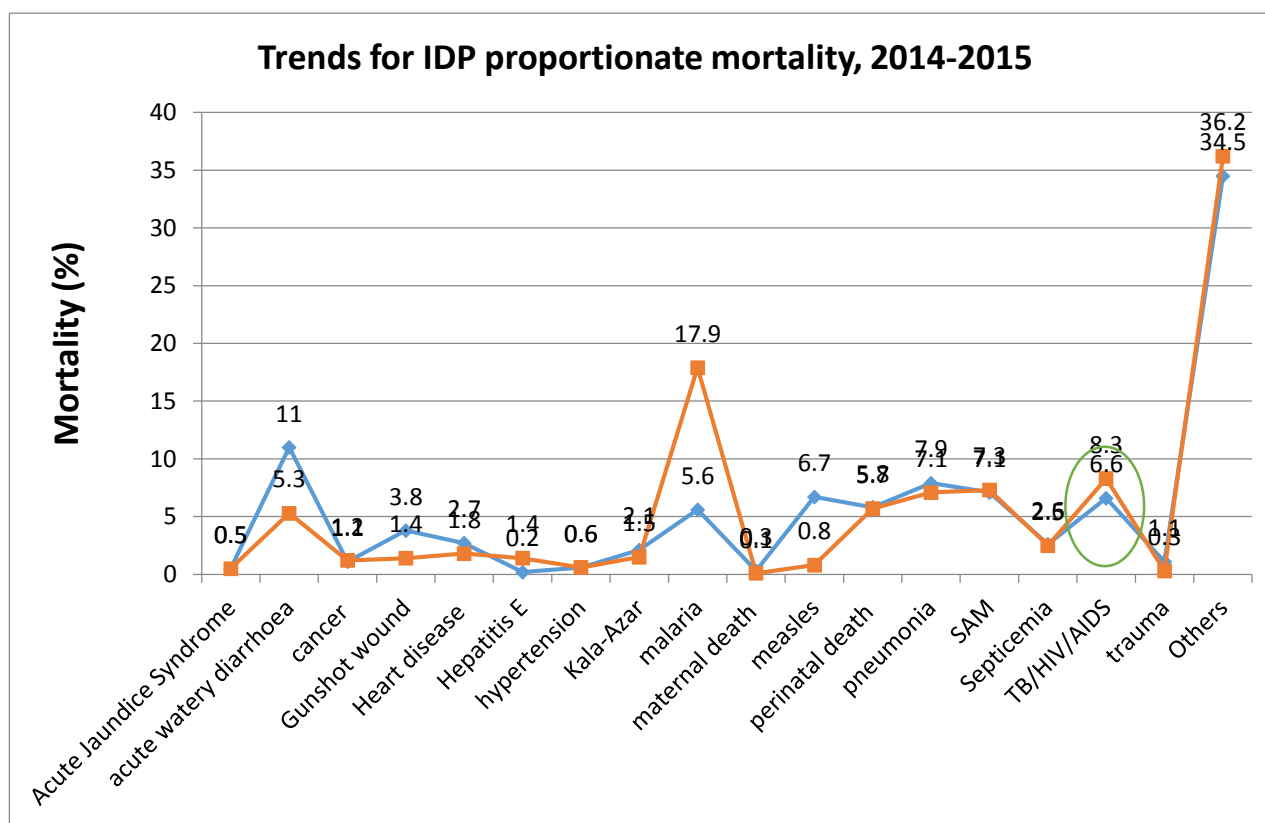
Current Ongoing Response: Case Management is ongoing under the lead of MSF-F with (Antitoxin plus antibiotherapie)

- Contact tracing + preventive antibiotherapie
- Immunization Response: Booster dose of TD to close contacts ongoing (MSF-F)
- Ongoing Dialogue on expanding Routine immunization and acceleration activities (Planning phase-WHO/UNICEF/MOH).

HIV AND TUBERCULOSIS MORTALITY TRENDS AMONG IDPS IN SOUTH SUDAN

ANALYSIS OF MORTALITY TRENDS, CHALLENGES AND THE RESPONSE

Tuberculosis (TB) and Human Immunodeficiency Virus (HIV) are two infectious diseases of chronic nature affecting millions of people worldwide and ranking among the top 10 leading causes of morbidity and mortality in South Sudan. The country has a generalized HIV epidemic with an estimated adult HIV prevalence of 2.6 % and the number of people living with HIV estimated at 190,000. The UNAIDS/WHO Global AIDS Response and Progress Report 2015, estimates annual deaths attributable to AIDS in 2014 at 15,000, whereas WHO also estimates mortality of Tuberculosis at 29 per 100,000 in South Sudan. The proportion of HIV among TB new infections is 15%; co-infection rates could be higher in some settings where HIV prevalence is high. The conflict that began in December 2013 led to a massive displacement of more than 2.2 million people, with about 1.6 million displaced internally in South Sudan and over 600,000 refugees in neighboring countries. Jonglei, Upper Nile and Unity States which were most affected by the conflict led to the destruction of health infrastructure which further compromised access and delivery of HIV and health services. An estimated 40,000 – 50,000 People Living with HIV (PLHIV) were affected at the outset of the crisis with very minimal access to TB and HIV treatment, care and support services. There is a lack of quality data on TB and HIV mortality and survival in these settings. With increased vulnerability, lack of diagnostics, treatment and care services, we are likely to see an increase in the cases.



Reports from the weekly EWARN bulletin, indicate an increasing trend of mortality among IDPs due to TB/HIV/AIDS. TB/HIV&AIDS didn't feature among the top 10 causes mortality in 2013. However, in 2014, TB/HIV&AIDS were fifth (6.6%) top causes of mortality among IDPs and worsening trends recorded in 2015, where TB/HIV&AIDS were second (8.3%) to Malaria as major causes of mortality among IDPs, ahead of malnutrition, pneumonia, & perinatal deaths. In early 2016 (week three), TB/HIV/AIDS has recorded one of the highest proportionate mortality at 16%.

The increment in absolute numbers of deaths for TB/HIV&AIDS is from 88 in 2014 to 121 in 2015 and proportionately with slight increase between the years. However, what is probably more significant is the trend for other diseases within the same period. The leading causes of morbidity and mortality such as diarrhea, pneumonia and malaria have had a decline, probably due to better control and management of acute illnesses as part of primary health care response in IDP settings, or due to

seasonal variation. The gradual increase in TB and HIV infections is attributable to improved surveillance and diagnostic capabilities among partners in IDP camps. This hasn't been complemented by capacity to better manage chronic diseases such as HIV, TB, cancer and Hypertension. The diagnostic capacity, treatment and monitoring of chronic care is lacking and remains a challenge supplies are erratic and due to high stigma many patients get diagnosed late and often when the condition has become terminal..

Gaps/challenges

Numerous obstacles to proper prevention, care and treatment have been identified to hinder access to services in the IDP camps. High mobility of the population makes compliance and follow up difficult. Coordination of HIV supplies and commodities (condoms, HIV test kits, Antiretroviral drugs), poor storage of commodities; inadequate systems especially at community level for providing information, education and follow up/tracking patients on treatment leads to, extremely low ART retention rates for TB, PMTCT and ART. Stigma, lack of knowledge, discrimination, cultural norms, GBV and male dominance; inadequate food support and nutrition programmes for PLHIV are notable obstacles for a sustained comprehensive intervention. Competing health priorities often lead to the neglect of HIV interventions by many partners. Poor funding, insufficient number of staff dedicated for HIV, and inadequate skills to handle chronic care and high staff turnover compromise the sustainability of HIV programs. Furthermore many of the settings lack proper infrastructure for diagnostics, laboratory support and monitoring for long-term therapy. There is also lack of appropriate operating space to uphold client confidentiality and the tools for collection, analysis and reporting data to the national level.

The Response Strategy

Over the last 2 years, as part of the overall humanitarian response, the UN joint team and INGO partners initiated a humanitarian response towards addressing the vast TB and HIV humanitarian needs to ensure displaced people have access to the minimum set of prevention, treatment, care and support services for HIV and TB during the crisis.

Access to diagnostic, prevention (including PMTCT, VCT, condoms), care and treatment services have improved but the scope of technical interventions and geographical coverage is far too narrow for meaningful TB and HIV control in this setting.

The leadership of the National authorities with support from WHO and UNAIDS and with the participation of UN bodies (UNHCR, UNFPA, UNICEF, UNDP), NGO partners (IOM, IMC, South Sudan Health-Link, MSF, CCM, IMC, IRC and HPF), as well as members from PLHIV networks (SSNEP, JHAS) and Key populations have developed action plans to address the gaps.

There is an established task force led by UNHCR and IOM that has initiated the coordination of response for HIV and TB in humanitarian settings to scale up services and reverse the upward mortality trend. .

Health Cluster Partners Call to Action

1. Multisectoral Partners involved in HIV/TB related Activities should closely align with the task force.
2. Activities within the task force should primarily aim to guide active search for cases and direct them to health interventions
3. Health and Nutrition need to link HIV programs to ensure nutritional support for PLHIV
4. Coordination at the lower levels should seek to address the presence of the minimum package of HIV/TB intervention in the displaced and request for commodity and supplies support
5. Health interventions should guide a context specific follow up protocol for identified cases
6. Social mobilization should ensure creativity and constant information support to cases.
7. Client confidentiality is key to the compliance of interventions.
8. Health gains made should be documented reported.

Since January 2016, TB, HIV/AIDS and Malaria have had the highest proportionate mortality of 13.2% and 7.9% among the IDPs; with most deaths reported from Bentiu PoC and UN House PoC. On February of this year, health cluster coordinators touched base with health cluster partners implementing HIV and TB projects within and outside the PoC Sites.

MoH, WHO, John Dau Foundation, Nile Hope (JDF), CADA, IOM, IRC, Charity Foundation took part in the meeting and the following points were discussed:

- Scale up of HIV prevention activities
- PMTCT
- Initiation to ART and care
- HIV commodities
- Funding for HIV response

It came out from the discussion that although partners are responding to HIV and TB in their respective areas, funding for HIV and TB projects implementation remains a big challenge among health cluster partners, especially national NGOs.

WHO TB focal person informed the health cluster partners that UNDP is the main recipient of funding from Global fund for HIV, TB and Malaria. These funds are meant for HIV prevention, treatment and care, strategic information and community system. The MOH and AAA are the sub recipients. Other sources of funding for TB and HIV are USAID, CDC, PEPFAR, and DOD. Health cluster partners who want to get details on funding can get in touch with the WHO TB and HIV focal persons. Regarding HIV and TB commodities, partners were encouraged to collect them from the MoH.

PREPAREDNESS AND RESPONSE

PREPAREDNESS AND RESPONSE TO ZIKA VIRUS DISEASE IN SOUTH SUDAN 02 MARCH 2016

BACKGROUND

On 1 February 2016, the World Health Organization (WHO) declared that the cluster of microcephaly and other neurological disorders linked to Zika virus transmission in the Americas constitutes a public health emergency of international concern (PHEIC). This was upon the advice of the first meeting of the International Health Regulations (IHR, 2005) Emergency Committee on Zika Virus and observed increase in neurological disorders and neonatal malformations. Zika virus transmission has been reported in at least 50 countries with six of them reporting a concomitant increase in microcephaly and other neurological disorders. In Africa, a Zika virus outbreak of over 7,000 cases has been reported in Cape Verde while South Africa has reported one imported case from Columbia.

In South Sudan, a three-pillar strategy has been adopted to enhance capacities for Zika preparedness and response through: 1) conducting epidemiological and laboratory surveillance for Zika virus disease and associated neurological complications; 2) risk communication to enhance public awareness and to address their concerns; and 3) integrated vector surveillance and control. The national epidemic preparedness and response (EPR) committee is coordinating these efforts within the context of integrated disease surveillance and response (IDSR).

PROGRESS TO DATE

1. The national EPR committee has been designated to coordinate national activities for Zika preparedness and response.
2. The National EPR committee has been sensitized on the current Zika virus disease situation and recommended strategies for its prevention and control.
3. The communications, case management, and surveillance working groups of the national EPR committee have embarked on the process of developing surveillance guidelines, factsheets, messages, travel advisory, and an action plan for Zika preparedness and response.
4. The national framework for Zika preparedness and response has been developed and presented to the national EPR committee for review and endorsement.
5. Consultative meetings have been held with radio Miraya to agree on a schedule of radio talk shows to sensitize the public on Zika presentation, prevention, and control.

PLANNED ACTIVITIES

1. Finalize and disseminate the Zika preparedness plan, surveillance guidelines, guidelines for points of entry, travel advisory and messages to enhance national capacities for Zika preparedness and response
2. National and sub-national sensitizations and training of key stakeholders – rapid response teams, healthcare workers, points of entry (immigration, civil aviation, and airlines) and communities on Zika prevention and control
3. Use multimedia channels to reach out to the public and sensitize them on Zika prevention and control.
4. Integrating healthcare workers training on Zika into existing IDSR trainings at state, county, and health facility level.
5. Integrate Zika vector surveillance and control into existing national vector interventions for control of malaria and other vector borne diseases. Establish collaborative arrangements with reference laboratories in the region to facilitate testing of suspect Zika cases
6. Periodic follow up laboratory testing for Zika in fever-rash cases that test negative for measles and rubella.

CHALLENGES

1. Low sensitivity of the surveillance system as measured from the completeness of reporting which currently stands at 54%. This year, the EPR committee has prioritized investment in mHealth applications to enhance speed and accuracy of report submission. However, this will require substantial investment of resources to complete a multiyear phased countrywide rollout of mobile health reporting if the sensitivity of the surveillance system is to improve.
2. Weak incident management that currently depends on a single disease outbreak hotline in Juba. Effective event surveillance and response should be coordinated by a public health emergency operations center (PHEOC), which is not present in South Sudan. The WHO Country office has embarked on a resource mobilization drive that is intended to facilitate the establishment of a functional PHEOC.
3. Weak capacities for laboratory based disease surveillance. South Sudan currently has one National Public Health Laboratory (NPHL) that started functioning in 2014 and can confirm several disease conditions including cholera, meningitis, measles, tuberculosis, and HIV. To enhance the panel and quality of laboratory tests, the NPHL has enrolled in the Strengthening Laboratory Management towards Accreditation (SLMTA) program meant to improve laboratory management process, facilitate the development and adherence to standard operating procedures, and enhance biosafety and biosecurity in the laboratory. This will however require substantial investment of resources over the years if its to attain the minimum laboratory core capacity requirements.
4. Little engagement of communities for timely detection and response to priority disease conditions. The Ministry of Health has developed the Boma Health Initiative (BHI), to facilitate the implementation of public health interventions including disease surveillance and response at community level. The implementation of the BHI is slated to commence in 2016 and calls for all programs extend their services to the communities to improve access to basic healthcare. However, the implementation of the BHI calls for substantial investment of resources which in the long run will result in savings in terms of disease and mortality averted.
5. Overall, substantial efforts are required to improve national capacities for surveillance and response as stipulated in the International Health Regulations. These capacities are critical for effective response to seasonal disease outbreaks of cholera and malaria and are equally vital for effective response to emerging diseases like Zika.

SUPPORT REQUIRED

South Sudan continues to register significant progress in improving national capacities for disease surveillance and response. Nonetheless, a lot more remains to be done to improve the sensitivity of the surveillance system, streamline incident management through the establishment of a PHEOC, and to establish a fully functional laboratory surveillance system. These gaps can only be addressed through substantial investments in support of current efforts to enhance the IHR (2005) core capacity requirements for surveillance and response. The IDSR network offers a platform to realize these targets if the required resources are to be mobilized.

ASSESSMENTS AND RESPONSE

“HEALTH CLUSTER AND PARTNERS ASSESS 4 COUNTIES (DUK, TWIC EAST, BALIET AND MUNDRI WEST) IN” JONGLE, UPPERNILE AND WESTERN EQUATORIA STATE.

The Emergency and Rapid Response Missions deploy at short notice to provide quick health impact interventions. The modality is varied and assistance can be sustained from a week up to three months in a location. Life-saving interventions include rapid health assessments leading to provision of Primary Health Care Services, Medical Supplies, emergency Immunization, and Capacity building and epidemics response for vulnerable IDPs, returnees and affected host communities.”

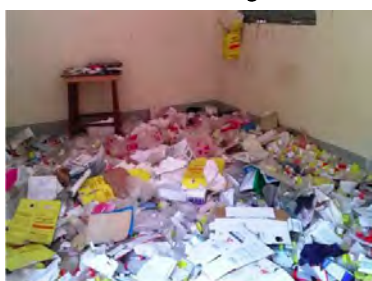
Table 1: RRM Matrix for the Month of February for 4 Assessments

Total number of beneficiaries through mobile response	435,795
Total number of outpatient consultations conducted	12,753
Number of measles vaccination given to children in emergency or returnee	16,985
Number of measles vaccination given to children above 5 up to 15 yrs in emergency or returnee	5,750
Number of children vaccinated with OPV	2,643
Communicable diseases outbreaks detected and responded to within 48 hours	1
Number of PLW diagnosed with MAM	1,523
Number of PLW diagnosed with SAM	934
Number of children screened with MUAC	2,743
Number of training conducted for existing partners on the ground	2
Number of direct beneficiaries from emergency drug supplies	742,567
Number of location of which a mobile response team has been deployed for an intervention	4

“HEALTH CLUSTER PARTNERS RESPOND TO HUMANITARIAN NEEDS IN MUNDRI WEST “

Mundri West has experienced increased insecurity over the last few months with ongoing fighting in the Western Equatoria State. There are estimated 30,000 IDPs in Mundri West County. The Health Cluster participated in the IRNA to Mundri West in February led by Save the Children with participation from local partner AAHI. Of the five health facilities visited during the assessment, Mundri Town PHCC is offering limited outpatient services while the PHCCs and PHCUs in Bangaloo, Bari, and Garia are not functional due to extensive looting. The remaining 14 health facilities are likely to be looted or destroyed during the conflict as well. Malaria, acute respiratory infection, diarrhea, intestinal worm infestation and pregnancy related illnesses are found to be the most common cause of morbidity.

It is also worth noting that the EPI programme has not been functional since September 2015 following the immense destruction of the infrastructures. The previous gain of 75% overall antigen coverage in Mundri West County has been lost therefore necessitating the re-installation of cold chain system and the re-launch of routine EPI services.



After the 5 months stock out of essential medicine in the area, the IRNA team was able to deliver medical supply that would provide support for the next 2 to 3 months.

Although the County Health Department record shows a total of 47 healthcare workers, during the assessment, the team was only able to identify 11 healthcare worker actively providing services in the functional facilities. The gap in human resources is extensive.

The challenges identified by the team are the inconsistency of essential medicine supply chain, logistic constraint due to security and accessibility issues, establishment of cold chain infrastructure, and equippin

There are glaring gap in accessing primary health care services by both IDPs and host population, which could be temporarily addressed by 3-months response. However, since long-term donor funding has previously supported the project, any rapid response plan should have a clear exit strategy and long term funding options to ensure sustainability.

EMERGENCY NUTRITION

WHO EMERGENCY NUTRITION (EN) TEAMS UP WITH MOH, HEALTH CLUSTER AND NUTRITION CLUSTER PARTNERS TO DEVELOP A “GLOBAL FIRST TIME DRUG MODULE FOR INPATIENT CARE OF SEVERELY ACUTE MALNOURISHED CHILDREN”



The WHO Emergency Nutrition operation in South Sudan is focusing on an innovative approach to improve inpatient management of severe acute malnutrition and medical complications. With focused energies on the development of a standard kit of drugs and supplies needed in Stabilization centers, a global drug module for inpatient care of SAM/MC children has been put together for the first time.

The long procurement process is expected to result soon in a pre-packed kit, which will be assembled in the WHO Juba warehouse in South Sudan ready to be dispatched to meet priority health needs in emergency.

This exciting exercise has brought together the MOH ROSS, WHO South Sudan Health Securities and Emergencies unit, South Sudan Health and Nutrition Cluster partners, WHO headquarters Emergency Operations and WHO country office logistics unit in tracking the drug modules into the country.

Preparatory works have been ongoing to ensure that the kits are immediately used to respond to needs. The functionality of Stabilization centers across the country has been assessed with the MOH and State focal points in February. Health and Nutrition Clusters have been heavily involved and have contributed immensely to a strategic comprehensive capacity building package which has been field tested in February 2016.

This key innovation in emergency nutrition has also been discussed and widely broadcasted through an interview of WHO Emergency Nutrition with Radio Miraya in Juba in February 2016. The kits will be available widely: locally in South Sudan and worldwide.

WHO Emergency Nutrition has also advocated for and developed a Minimum package of health services to be provided in Rapid response, which explicitly integrates a nutrition component. The Minimum package has been finalized and finally endorsed in February 2016.

INFORMATION MANAGEMENT

"HEALTH CLUSTER REACTIVATES HEALTH INPUTS TO THE HUMANITARIAN RESPONSE SITE"

February also witnessed a strengthening of the Health component of the Humanitarian website. Activities pertinent to health interventions have been regularly shared widely and preserved. Health cluster acknowledges the use of Humanitarian Response web site for communication and data sharing with partners. Activities and documents pertinent to health interventions have been regularly shared widely and uploaded.

- ✓ All Health Cluster meeting minutes are uploaded 72 hours after meeting.
- ✓ Health Guidelines and SOP are uploaded to the site.
- ✓ Updated Cluster partners contacts details are shared through the site.
- ✓ The new 5W data collection tool (offline and online) is uploaded to the site.

Agencies reporting to the 5W

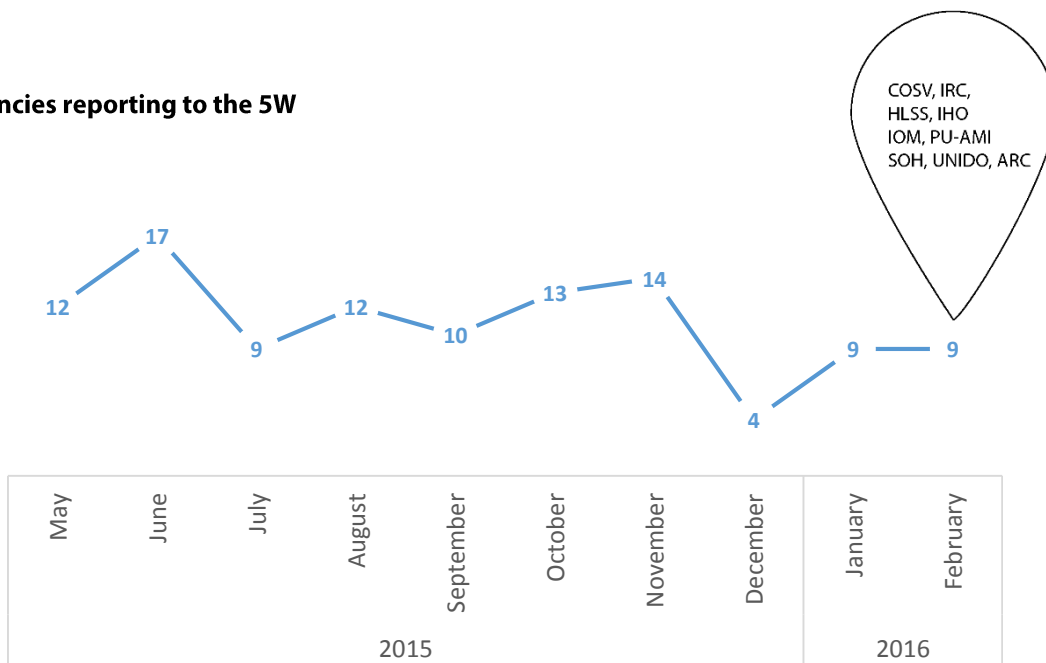


Figure 1: Agencies reporting to the 5W

PROGRESS OF HEALTH CLUSTER RESPONSE PLAN

"NEW CHALLENGES IN SOUTH SUDAN BRING NEW WORK PLAN FOR HEALTH CLUSTER IN 2016"



Health Cluster Response work plan 2016

The Health Cluster is a platform for health partners from all over South Sudan to come together, coordinate and share information and collaboratively ensure a strong and coherent approach to health service delivery in humanitarian emergencies.

As we enter 2016, South Sudan continues to face a myriad of challenges, even more so in the area of healthcare. In recent months, there are humanitarian needs across South Sudan as a result of multiple and interlocking threats, including armed conflict and inter-communal violence, economic decline, disease and climatic shock. Despite the enormity of the challenges, health cluster partners have worked tirelessly to reach the people in need. As we enter 2016, health cluster partners' resolve has remained firm. As we enter 2016, we are committed to stay and deliver health services to those in greatest need, in close coordination with all relevant stakeholders.

The 2016 South Sudan Humanitarian Response Plan launched in early 2016 is robust, strictly prioritized, and focused on responding to the most urgent and life-saving needs in South Sudan.

The Health Cluster Work Plan to complement the South Sudan Humanitarian Response Plan by drafting its own Health Cluster Work Plan to operationalize the specific issues related to healthcare within the humanitarian context. In the upcoming months, Health Cluster will report on the progress of the 2016 Health Cluster Work Plan. The plan is aimed to be ambitious but achievable. When implemented, it will save the lives and wellbeing of millions of South Sudanese. It will set a clear boundaries and is focused strictly on reaching people who have fallen below emergency thresholds.

In order to maximize impact, the cluster will focus on integrated health and nutrition life-saving packages support life-saving referral mechanisms and rapid response modalities. The cluster will support the scale-up of disease surveillance, prevention and response at facilities and community level, including through expanded immunization coverage

BEST PRACTICE

Health Cluster partners have expressed an interest in learning from each other. Beginning in 2016, partners will have an opportunity to present their organizations and their best practices in the bi-monthly Health Cluster Meetings. Some of the lessons learnt will be featured in the monthly Health Cluster Bulletin to be shared.

“HEALTH CLUSTER PARTNER SHARES BEST PRACTICE IN ENGAGING COMMUNITY: ACTION AFRICA HELP INTERNATIONAL (AAHI)”



Training of nurses is part of the program for AAHI

AAH South Sudan programme was started over 20 years ago. It is uniquely known for its community empowerment approach for helping refugees, stayees, returnees, and host communities get over the effects of war and other forms of conflict. The programme runs projects in primary health care services, food and income security, education, water, hygiene and sanitation and capacity building programmes for peace and reintegration. Currently, the programme is operational in eight out of the 10 States of South Sudan.

In its program, AAHI has maintained a close working relationship with partners (community, authorities, NGOs, donors & staff) to ensure maximum security, support and trust. AAHI is training 40 Students (20 Nurses & 20 midwives) as well as overseeing the successful construction of two PHCUs through active community mobilization.

Some of AAHI best practices included quick response to security warnings that ultimately led to staff safety and protection assets. Synergy in the design & implementation of health projects continue to be one of the cornerstones of its success.

AAHI projection for 2016 includes enhancing the performance of the existing health projects particularly in Mundri West and scaling up resource mobilization and venturing into other thematic areas like safe water & sanitation, emergence response.

RESOURCE MOBILIZATION

“HEALTH CLUSTER ENGAGES DONORS FOR EFFECT REALIZATION OF THE ACTIVITIES WITHIN THE HRP”

Health cluster funding requirement for 2016 is estimated at USD 110,000,000 in the Humanitarian Response Plan. The health cluster has, since the beginning of the year, managed to mobilize USD 6,486,402.

Donors' pledges:

CERF: USD 1,850,000 will be allocated to the provision of primary health care services to internally displaced persons (IDP) and vulnerable population in Malakai PoC, Mundri East, Mundri West and Maridi and to the rehabilitation of two health facilities in Malakai PoC.

INGO, NGO AND UN AGENCIES THAT RECEIVED CHF FUNDING IN 2016

CCM	Improve the quality of essential health service delivery (safety nets) and strengthen the emergency response to the humanitarian needs, including obstetric services and supportive care to GBV victims in Mingkamann and underserved area of selected counties of Lakes.
CMA	Strengthening the capacity of primary health care facilities to deliver life saving emergency health services integrated with nutrition services in Fangak county of Jonglei State
CUAMM	Improving host and displaced population and other vulnerable groups' access to and utilization of quality essential and emergency health services in Mundri East County (Western Equatoria State)
GOAL	Provision of integrated and lifesaving Primary Health Care (PHC) services for conflict affected and vulnerable populations and strengthening emergency responses in Baliet, Melut, Maiwut and Ulang Counties, Upper Nile State (UNS), Twic, Warrap State and Agok: Abyei Administrative Area (AAA).
HLSS	Increasing access to quality essential and emergency Primary Health Care services to women, girls, boys and men in conflict affected and vulnerable communities in Upper Nile, Unity, Lakes and Jongolei States in order to reduce, protect and save lives from the excess mortality
IMC UK	Provision of emergency health assistance to IDPs and conflict affected persons in South Sudan
IOM	Sustaining Life- saving Primary Health Care Services and Provision of Rapid Response and Psychosocial Support for Vulnerable IDPs, Returnees and Affected Host Communities in Upper Nile, Unity, and Jonglei States
IRC	Provision of quality life saving primary and reproductive health care services in Unity State, South Sudan.
MEDAIR	Emergency response to acute and chronic complex health emergencies and increased access to health care for vulnerable populations in South Sudan
Nile Hope	Provision of emergency lifesaving and gender sensitive high impact health services for hard to reach, underserved and conflict affected IDPs and vulnerable communities in Leer County of Unity state and Fangak County of Jonglei state.
SMC	Improve Health status of the communities of returnees and internally displaced in Duk County of Jonglei state
UNIDO	Improve the quality and availability of comprehensive basic emergency primary healthcare services including Basic Emergency and Obstetric and Neonatal Care at the facilities and community levels in Mayendit, Leer counties and Great Nyal in Panyigar county of Unity State
UNICEF	Primary health care and vaccine core pipeline supplies provision and management for timely emergency preparedness and response in South Sudan
WHO	Provision of quality lifesaving health services including responding to health related emergencies (core pipeline supplies, enhancing outbreak preparedness and response) affecting the vulnerable population of South Sudan

SUCCESS STORIES

(1) "MATERNAL AND NEONATAL HEALTH CARE RESTORED IN BENTIU HOSPITAL"

IOM has restored maternal health care services in Bentiu town for the first time in nearly two years when the maternity ward opened at Bentiu Hospital on February 29. This is a response to a call to action from Health Cluster in Bentiu, Ministry of Health, IRC and HPF recognizing the gap in basic health services in the region.

Midwives at the maternity ward are now able to provide antenatal and post-natal care, care during deliveries, family planning support and prevention of mother-to-child transmission of HIV in town.



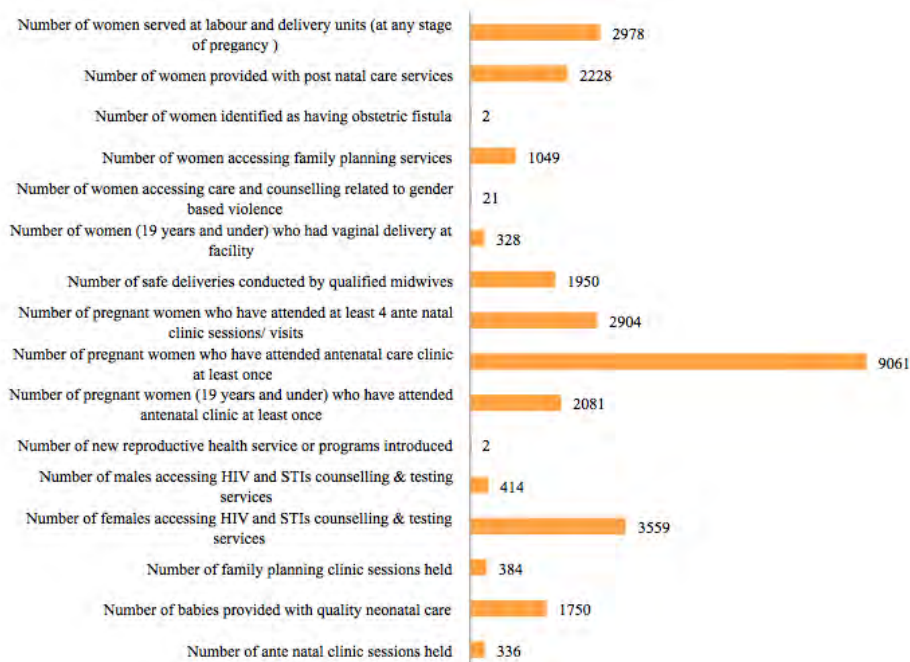
Opening of the Maternity ward in Bentiu Hospital

The hospital was damaged in fighting in 2014. The maternity ward was ransacked and critical infrastructure was damaged, including delivery chairs and incubation units. The maternity ward was not operational until now. IRC is currently running the outpatient department in Bentiu Hospital.

Although most of the population of Bentiu still lives in the UN protection site but the town population has been slowly growing, with nearly 22,700 people registering for assistance in Bentiu town and surrounding areas since July 2015.

With equipment supplied by UNFPA, the restored maternity ward is now equipped with beds, equipment and medical supplies. The maternity ward is now ready to welcome women from the community.

The State Minister of Health has indicated plans to assign additional midwives to enable the ward to run 24-hours a day. The availability of quality maternal services to the community in Unity state means a lot as it helps hundreds of women who were left without facility in the area for so long. Unity State has one of highest maternal morbidity and mortality in the country.



Use and availability of quality midwifery and reproductive health in Bentiu Maternity Ward (UNFPA, 2016)



On the job training at Akobo Hospital

With funding from CHF, OFDA, and IMA, International Medical Corps is providing outpatient, inpatient, stabilization center, mental health and maternity services, Akobo County Hospital offers lifesaving emergency surgery 24/7.

The first quarter of 2016 has seen large scale revenge killings, intercommunal and intertribal fighting throughout Akobo. Patients are often brought to the Hospital from large distances after suffering serious trauma in ambushes, cattle raids or other attacks.

Dr. Jules, an International Medical Corps Trauma Surgeon, and his team are on call throughout the week to serve these emergency cases no matter the hour. Since the beginning on 2016, the surgical team has performed 90 major surgical cases, primarily gunshot victims.

On the job training is a vital component of the International Medical Corps model and Dr. Jules takes the time to develop the skills of Dr. William and Dr. Chol in trauma surgery. In this way he is building up the surgical skills of the cadre of South Sudanese doctors who will be leading the health care system in the years to come.

The ongoing tensions in the Akobo area ensure that Dr. Jules and his team will continue to be a lifesaving asset to the Akobo community.

(3) HEALTH CLUSTER PARTNERS REESTABLISH HEALTH SERVICE DELIVERY POINTS 24 HRS AFTER THE INTER COMMUNAL CONFLICT THAT DEVASTATED THE MALAKAL POC STRUCTURES AND RESIDENTS



Arial photos of before and after the conflict



Damaged and looted IMC clinic. Photo:



Causalities receiving first aid at IMC ward. Photo:

Inter communal conflict within the Malakal Point of Concentration (POC) resulted in mass casualties and burning of the health facilities within the POC. As violence escalated, the IDP residents fled and resettled at the UNMISS base where they were recently evacuated and relocated to other sectors. Health humanitarian responders had to also exit the POC with their National staff and are currently sheltering at the UNMISS Civilian bases. Tensions post the conflict has restricted movements and led to overcrowding of over 42,000 IDPs in an inappropriate space and the flight of over 4000 others into Malakal town. Malakal POC was erected in response to the humanitarian needs during the December 2013 conflict in South Sudan. There are 47, 000 IDPs from the Shiluk, Nuer, Dafuri and Dinka communities. Health planning and response anticipated the potential for fires and public health disasters and the health cluster put together a preparedness and mass casualty plan, which was activated as soon as the conflict evolved.

Assessment: Initial rapid assessment of damages led by the health cluster partners revealed the following:

- A complete burning of 2 Primary Healthcare units and 1 pharmacy that was providing Primary health care, reproductive health- PMTCT, EPI and nutrition screening.
- A complete looting of the only PHCC with surgical capacity
- Severely malnourished inpatient children in the only stabilization centre have fled with their parents
- Mortality in excess of 24 and a further 120 critical cases needing extensive critical care and the evacuation of at least 10 severely injured to other locations.

Health cluster partners initiated and responded in the following ways.

1ST 24HRS

- Health Cluster Partners Mobilized: IMC, MSF, WHO, IOM and ICRC.
- The Health cluster activated their mass casualty plan and coordinated the responsibilities within the plan
- UNMISS (ambulatory response) transported the casualties to the facilities
- MSF (Yellow & Green response) admitted all the wounded and critically ill
- IMC (Red) boosted surgical capacity within UNMISS level II operating theatre
- ICRC evacuated the critically ill.

48-72 HRS

- Health partners were supported to reestablish 2 PHCU's to mitigate the interruption of essential health services to the IDP's and various health and nutrition commodities were prepositioned to support the scale up of the response.
- WHO deployed 150 cartoons of trauma kits and medical supplies to support the response
- IMC deployed up to 1.1 metric tonnes to support the response
- IOM deployed a number of health human resources in addition to 900kg of medical supplies and drugs to support the response.
- UNICEF donated health commodities including 4 tents, IPHCC kit, 10,000 ORS sachets, antimalarials, IEHK and surgical delivery instruments.

Health Cluster partners visited the newly established IOM and IMC clinics and IDP's interviewed to understand their needs.

KEY FINDINGS

- Potential for increased malaria incidence rate due to inadequacy of shelter and mosquito nets -(The health cluster at the national level are negotiating to send antimalarials to support the response)
- Children need blankets; The nights are cold- Health and nutrition engagements at the national level have cleared and prioritized health supplies including blankets to Malakal
- High risk of GBV in POC
- Confirmed that Reestablished clinics are responding to Patients with minor injuries and IMC have reestablished the Operating theatre with donations of surgical delivery instruments and trauma kits from WHO and UNICEF. (25 surgical interventions including 13 major cases were attended to in the first 24hrs)
- With this swift and strategic response 22 deliveries were conducted in the reestablished clinics in the POC during the conflict and none was obstructed/CS.

72 HOURS ONWARDS

A multisectoral plan was drawn between health nutrition and wash partners to sustain the response for the next 3 months. The multisectoral plan was based on the following anticipated health impacts on the vulnerable population

- Large communities living in inappropriate and overcrowded spaces
- Potential for disease outbreak (cholera/diarrheal diseases/Meningitis)
- Risk of vector diseases -Potential for recording high numbers of malaria cases.
- Inadequate water and sanitation availability
- Gender Based Violence due to further breakdown of social networks
- Disruption and non-compliance of TB/HIV cases that had been recorded from end of 2015 and were being carefully managed.
- Maternal and neonatal deaths that will have required skilled workforce to attend to them including Emergency obstetrics and neonatal attention
- Essential drug and medicines stock out for severely wounded cases requiring emergency attention.
- Reduced access to stabilization Centre's and inpatient medical treatment for children and Pregnant and Lactating women.

Health cluster partners both in Malakal and at the national level continue to monitor the situation closely and have prepositioned supplies, trauma kits and cluster partners ready to scale up the emergency response.

Partners have also prepositioned mobile outreach packages in preparation for response into Malakal town. It is also anticipated that the community will need support to build resilience to the psychological impact. This is also being negotiated as part of the health response. A costed estimate went out for donor considerations to support the response. The holistic response from the Health Cluster Partners extended services to the communities that fled out of the POC into Malakal.

MALAKAL TOWN RESPONSE

After conducting needs assessment in the town, health cluster partners continued coordination among the partners to commence basic medical services in the town.

In Baliet: a report of approximately 200 households displaced from the POC to Ballet was responded to by the Health cluster partners. Adequate drugs and supplies were prepositioned in Baliet PHCC including (Minor surgical supplies, DDK, Kala Azar, Basic kits, Anti Malaria). The health cluster also led ongoing multisectoral dialogue and planning for Baliet response.

PRIORITIES FOR MARCH

- Capacity building for state focal points/HCC
- Deployment of dedicated HC coordinators and of sub-sub national coordinators
- Training and capacity building of partners
- Resource mobilization – active in-country donor
- Quarterly progress review of the HRP
- Support early warning and response activities
- Dry season prepositioning

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