South Sudan Response
11 April – 17 April 2014

4.2 M
IN NEED OF HEALTH
ASSISTANCE

817,700
INTERNALLY
DISPLACED

1.9 M
TARGETED
FOR
HEALTH

278,600
REFUGEES

6,136
INJURED*

Highlights

- A total of 16,055 people received the Oral Cholera Vaccine (OCV) in round one of the vaccination campaign at Malakal PoC.
- The health cluster has delivered 999,004 medical interventions to internally displaced persons and host populations across the country.
- New displacements are being reported in conflict affected areas.

** Since 15 December 2013
*** Updated Health Cluster 3Ws, 31 March 2014
Population data: OCHA-10 April 2014
Situation Update

- The security situation remained relatively calm in most parts of the country except on going fighting between SPLA in opposition and SPLA in Mayom County, Bentiu and Bor. Unity oil fields and other locations including Bentiu were reported to have been captured by the SPLA In Opposition. Bor PoC was attacked on 17 April 2014, resulting in the death of at least 15 people and injury of about 50 others according to UNMISS sources. There have been reports of fighting in Renk. The situation in the other conflict affected areas also remained volatile with high tension and rumours of attacks by the opposition forces.

- Over 100,000 people displaced in and around Kodok, Lul and Wau Shiluk in Upper Nile State are in urgent need of assistance. Following assessments, partners are expected to start response in Kodok, focusing on health, WASH, food and shelter interventions.

- Among aid agencies, the fear of famine is growing because of the displacement and insecurity which has prevented communities from conducting agricultural activities while at the same time, eroding their normal coping mechanisms. About 7 million South Sudanese are thought to be at risk of some form of food insecurity, 1 million of whom are severely food insecure¹.

Public health risks, needs and gaps

- The numbers of civilians hosted in Bentiu PoC is reported to have tripled, reaching about 14,000 by 17 April 2014². The new displacements put an increasing strain on existing health services, as well as water and sanitation structures and could easily result into an outbreak.

- In response to the threat of cholera, particularly in IDP settings, a cholera response framework was developed and cholera case projections were calculated for 10 high-risk IDP camps and nine (9) host communities to support preparedness planning.

- The malaria burden is increasing due to the onset of the rains. In addition, the two recently confirmed cases of Hepatitis E (Awerial and Yirrol West counties) are cause for concern, particularly the case reported in Awerial county which hosts the largest IDP population in South Sudan. Given the poor sanitation in IDP settings, the disease could easily spread.

- Aid agencies are concerned that the humanitarian situation may deteriorate with the onset of the rains. During previous years, the rainy season resulted in serious floods, displacement of people and destruction of property, including health facilities. Heavy rains are therefore expected to lead to flooding with a negative impact on internally displaced persons, whose makeshift shelters and tents make them particularly vulnerable to the effects of flooding. In addition, health infrastructure may be damaged cutting off already limited access to services and leading to increased health risk and high disease burden; strain on existing safe water sources, damage to crops and other livelihood in vulnerable communities. The health cluster partners both at national and sub-national levels are preparing to respond including prepositioning of the required medical supplies to high risk counties.

¹ OCHA, 10 April 2014
² UNMISS, April 2015
Gaps

Critical health response gaps include:

- Inadequate facilities for emergency obstetric care in Bor.
- Lack of secondary health care in Bor, Malakal and Bentiu due to shortage of qualified staff, infrastructure and funding shortage.
- Limited availability of mental health and psychological services across the country especially among the displaced population.
- Limited primary health care services in some of the affected states for people living outside PoC areas.
- Shortage of emergency blood services and supplies.
- Lack of space for expansion of the clinic at the PoC in Bor.
- Lack of laboratory capacity to detect epidemic prone diseases including cholera and dysentery.
- In accessibility of counties due to insecurity limited our activities within IDPs and Bentiu hospital only.
- Lack of incubators for new born babies at health facilities in the IDP camps and communities.

Health Cluster Action

Health cluster coordination

This week, the Health cluster has commenced consultations with partners on the review of the Crisis Response Plan (CRP). Some of the needs identified include: Vaccination of displaced and other vulnerable groups; reproductive health services for pregnant mothers; medical evacuations for injured patients and primary healthcare for all conflict-affected people.

In response to fighting in Bentiu and Bor, the health cluster is supporting the evacuation of critically injured civilians to various destinations including Juba for secondary care.

Health cluster meetings were convened at the sub-national levels, in Awerial (Mingkaman) and Malakal. The key highlights included the following:

- In Malakal, the health cluster meeting discussions were focused on contingency planning for the rainy season and lesson learned from the OCV campaign.
- In Mingkaman, Awerial, the health cluster coordination meeting focused on addressing the identified gaps in the upcoming measles and Polio immunization and Vitamin A Supplementation campaign and contingency planning for cholera.

  - The sub-national health cluster coordinator is conducting an assessment of capacities for outbreak response and will share the results next week. In the event of a cholera outbreak, MSF is able to set up and run a cholera treatment centre, while IMC can manage a cholera treatment unit. CCM and HLSS will stabilize patients and transport them to the MSF CTU as needed.
  - WHO/UNICEF and SMOH presented the immunization micro plan for Mingkaman and identified gaps in storage capacity for vaccines, ice packs, vaccine carriers and vaccinators. MSF will provide storage capacity, vaccine carriers and ice packs needed to fill the gap identified in the micro plan.

- A WASH/Environmental health expert from WHO provided support to the health cluster and made a number of recommendations for improving environmental health in Juba III and Tongping camps. The following is a summary of the key recommendations:

  - Water quality monitoring is being conducted at Tongping; this should also be done at Juba III. The inclusion of regular bacteriological analysis in the water quality monitoring is crucial.
Agencies contracted to conduct water quality monitoring in the camps should share data with the camp management, the Health, Nutrition and WASH Clusters to inform public health action. In view of the increasing number of malaria cases in the camps, efforts should be made to increase coverage of mosquito nets among the IDPs. Camp management should discourage erection of shelters close to the drainage running through Juba III camp. A buffer zone of at least four metres of clear area should be maintained on both sides of the ditch. This will help to prevent injuries and deaths that could occur as a result of flooding after heavy rains. As part of routine duties, community hygiene promoters should monitor availability of water and soap for washing hands at the stands/units next to the toilets. Hygiene messages that were finalized in March 2014 should be disseminated in the camps and host community to complement on-going health and hygiene promotion efforts. Community education and follow up on safe household water collection, storage and use needs to be strengthened. Use of participatory methodologies could be explored to promote community involvement in the learning process. The ditches in the camps should be regularly cleaned in order to minimize flooding during the rainy season. Communities in the two camps should be mobilized to play an active role in the cleaning campaigns.

Health service delivery

- As of 16 April 2014, a total of 13,069 consultations were reported from areas with IDP concentrations including IDP camps and PoC areas and 33,893 consultations were recorded country wide for week 15.

- The following activities were reported this week in Mingkaman:
  - Handicap International conducted an assessment in which they identified 205 people with disabilities. The organization conducted 49 rehabilitation sessions and delivered 18 assistive devices to people living with disabilities.
  - South Sudan Red Cross (SSRC) reached 1000 people (300 women and 700 men) with health promotion messages focused on diarrhoeal diseases and malaria. SSRC and other partners conducting health promotion will meet to harmonise messaging and approach.
  - UNICEF provided a delivery bed, maternity kits to the maternity unit at SMoH facility and will provide WASH support on confirmation that MOH will continue to use the mobile primary health centre/maternity unit in the future.

- People in Need (PIN) this week continued to deliver primary health services to IDP populations in Central Equatoria state at Mahad primary school and through Lologo mobile clinic in Juba. They reported a total of 2493 consultations.

- Goal continued to support the delivery of primary health care services, specifically consultations, patient referrals, routine and emergency vaccination, ANC and nutrition screening through PHCCs and mobile clinics at the following locations: Twic county (Manawan, Man Angwi, Aweng, Turalei) in Warrap state; Melut County (Rom and Melut); Ulang county (Kuich, Ulang, Yomding, Roupbard, Bimbim, Ying and Doma) in Upper Nile state. This week, a total of 3634 consultations, 4144 nutrition screening and 393 referrals were reported from those locations.
**Vaccination**

- From December 2013 to date, a total of 240,365 measles and 151,146 polio vaccinations have been conducted by health cluster partners among IDP populations. In addition, 33,250 Vitamin A and 25,675 deworming treatments were provided to children.
- An overall total of 16,055 (89.6% of the target) people received the first round of OCV in a vaccination campaign conducted by MSF in Malakal PoC. A Rapid Convenient Assessment (RCA) for OCV campaign was conducted by WHO, below is a summary of the findings:
  - House to house assessment (178) coverage was 90.4%.
  - Street level assessment (56 business men and women), coverage was 86%.
  - Average coverage of 89%. If same coverage is achieved in the 2nd round then at least 53% of total population will be protected (the best case scenario) against Cholera.
- In Malakal, training on routine EPI was conducted covering injection safety, vaccine handling and surveillance at IOM and IMC clinics.
- In preparation for the Integrating Measles, Polio and Vitamin A campaign, training of supervisors and training of vaccinators at County, Payam and Boma levels is being conducted from 11 to 19 April 2014 in all targeted 7 states (Central Equatoria, Eastern Equatoria, Western Equatoria, Lakes, Warrap, Northern Bahr El Ghazal, and Western Bahr El Ghazal). The training includes cold chain management, social mobilization, injection safety and waste disposal, Adverse Events Following Immunization among other topics. Funds have been pre-positioned to cover the three remaining states depending on the level of security and the capacities (human resources, cold chain and transport) on the ground.
- In addition, health messages and radio talk shows in various states/counties will focus on the upcoming campaign, raising awareness about its importance as well as informing the public about the dates and antigens to be given. Health cluster partners have been requested to use their community health networks to disseminate information about the campaign.

**Surveillance and communicable disease control**

- As of 16 April 2014, 90% (9/10) camps and 79% (23/29) sites had reported as part of the national requirements for epidemiological monitoring. The highest consultations were from Malakal, Awerial and Bentiu. See figure one for more.

![Figure 1: Total Consultations by Camp, week 13-15, 2014](image-url)

*Source: South Sudan IDP Surveillance-Epidemiological Update, 17 April 2014*
Malaria (14.2%), acute respiratory infections (10.7%) and acute watery diarrhoea (7.7%) continue to account for the highest proportionate morbidity. The increase in malaria incidence continued to be observed, this warrants intensified malaria prevention interventions especially in Bentiu, Mingkaman and Malakal IDP camps/PoCs. See figure two for more.

In Mingkaman, in response to increasing malaria morbidity, Mentor Initiative has conducted Indoor Residual Spraying, covering about 90% of the target households. See table below for details:

<table>
<thead>
<tr>
<th>Indoor Residual Spraying</th>
<th>Achieved</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houses sprayed</td>
<td>10,331</td>
<td>10,560</td>
</tr>
<tr>
<td>Sleeping rooms</td>
<td>14,226</td>
<td>14,300</td>
</tr>
<tr>
<td>Animal shelters</td>
<td>470</td>
<td>471</td>
</tr>
</tbody>
</table>

Two cases of Hepatitis E (HEV) from Yirrol West (1) and Awerial County (1) both in Lakes state were confirmed by the AMREF Nairobi laboratory during the period under review.

In Northern Bahr El Ghazal, Rapid Response Teams (RRT) refresher training was conducted by WHO for 20 participants with a focus on epidemic response covering such topics as epidemiology, outbreak investigation and infectious disease prevention and control.

Health facility and community based mortality surveillance among the IDPs is ongoing and despite the exponential increases in morbidity due to malaria, respiratory tract infections, and acute watery diarrhea in the recent weeks, the crude mortality rates have remained below the emergency threshold of 1 death per 10,000 per day during the past five weeks. This is attributed to the enhanced access to public health services including routine primary health care, better access to safe water and sanitation facilities, and vaccinations against measles, poliomyelitis, and cholera. See figure 2 for more.

Source: South Sudan IDP Surveillance-Epidemiological Update, 17 April 2014
Resource mobilization

- About 31% (USD 18,918,662) of the cluster’s requirements have been funded to date as shown in the financial tracking system. USD 1,200,000 is still uncommitted.

- About $1.95 million is urgently required by the health cluster to continue to support medical evacuation of patients for further emergency management at appropriate levels of care.

Plans for future response

- Conduct the National Integrated Measles, Polio and Vitamin A vaccination campaign from 23-30 April 2014
- Conduct the 3rd round of OCV campaign in Mingkaman (starting on 21 April 2014) and UN House Juba III.
- Continue prepositioning of drugs and medical supplies
- Finalise plans for mental health training to key providers
- Assessments as the need arises

Announcement

Two new Sub-National Health Cluster Coordinators have arrived and will be posted to Bentiu and Bor in the coming weeks. Their details are as follows:

- Bentiu: Dr. Tesfaye email address: t_beyene@yahoo.com
- Bor: Magdalene Armah email address: magda.armah@gmail.com

The Global Gender Capacity Advisor (GenCAP), Ms April Pham, has arrived in South Sudan to support clusters with gender related matters.

Health Cluster Partners

Partners working supporting the response include the following:


The following donors are supporting the response:

CIDA, DFID, ECHO, EU, OFDA, USAID, CHF

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