Background to the current Humanitarian Crisis

Since its independence in 2011, South Sudan has suffered several internal conflicts some of which predate the war of independence which was fought from 1955 to 2005 (with a ceasefire from 1972 to 1983). On 15 December 2013, disagreements between the President, General Salva Kiir and the former Vice President, Dr Riek Machar resulted in an armed conflict which initially started in Juba, the capital town and took an ethnic dimension which pitched the Dinka tribe of the President against Nuer tribe of the former Vice President.

Thereafter, the violence spread to the neighbouring states of Jonglei, Unity, Upper Nile and Lakes. There are reports that thousands of people have been killed in the civil unrest and 817,711** people internally displaced along ethnic lines. More than 270,000 people have fled to neighbouring countries. More than 4.9 million people are estimated to be in need of emergency assistance in this humanitarian crisis with 1.9 million people targeted with health services. WHO graded this humanitarian crisis as a level 3 on 12 February 2014. The humanitarian community developed a Strategic Response Plan with activities to cover up to June 2014. WHO, as leader of the Health Cluster, has contributed to this plan and is providing technical support to partners in its implementation.
The Current Situation

Currently, the crisis directly affects three States namely: Jonglei, Upper Nile and Unity. Four other States namely Central Equatoria, Lakes, Warrap and Eastern Equatoria are indirectly affected by virtue of population displacement into them. According to the latest situation report issued by UNOCHA on 10 April 2014, an estimated 817,711 have been displaced internally and an estimated 270,000 refugees into neighbouring countries of Uganda, DRC, Kenya, Sudan and Ethiopia. Although most of the conflict affected areas remained calm during the last few weeks, the security situation remains precarious and this has resulted in the restriction of humanitarian response mainly to the United Nations Mission to South Sudan (UNMISS) camps in Juba, Bor, Malakal and Bentiu) and Mingkaman, Awerial County of Lakes States. An estimated 6% of the overall IDP caseload are currently being hosted in Protection of Civilian (PoC) areas in these camps (OCHA, 10 April 2014).

Public Health Impact of the Crisis

This crisis is characterised by targeted damage to critical health system functions, serious violations of the protection of medical missions, human rights and equitable access to health; there has been evidence of deliberate killing of patients within hospitals. An estimated 30 health facilities in the country remained non-functional due to widespread looting and destruction leaving communities unable to access health services. The non-functional facilities include those in the most affected areas such as Bor, Malakal and Bentiu hospitals. Several hundreds of government health workers have fled their duty posts because their safety is not guaranteed, and several of them have become IDPs themselves.

The prevailing insecurity has led to major disruptions in the supply chain management system for essential medicines and medical supplies. The crisis has disrupted implementation of key health programmes such as disease surveillance, immunization (especially polio), HIV/AIDS & Tuberculosis and reproductive health. Prior to the crisis, the measles vaccination coverage was estimated at 60%; this low coverage and the overcrowding in the IDP camps led to measles outbreaks especially in the Tongpiny and Bor camps with initial CFR of up to 25%.

The South Sudan EWARN and Disease Surveillance Update of 16 April 2014 (epidemiological week 15) showed that acute malaria (16.7% of all consultations), acute watery diarrhoea (9% of consultations) and ARIs (8.2%) are currently the highest causes of morbidity while measles (88) and diarrhoea and related complications (98) are the top causes of mortality among the IDPs. The measles morbidity and mortality generally declined after week 6 when there were mass integrated campaigns in Tongpiny and Bor. Recent outbreaks in Yuai (week 8) declined during week 12 after a measles mass campaign. There has been a progressive increase in incidence of malaria in the IDP camps from weeks 10-15, climbing from 8.3% to 16.7%, due in part to the onset of the rain. See figure 1. Although the data shows a declining trend in the in the under-five and crude mortality rates, the living conditions in the camps remain precarious.
Heavy rains in Juba have resulted in flooding and destruction of a few shelters in the Tongping IDP camp; the situation is likely to worsen with continuing rains. About 3000 IDPs are currently being moved from Tongping to Juba III camp to try and decongest the camp. The situation of shelter, water and sanitation is poor in most camps. According to the report of the WASH technical assessments which were conducted by a WHO surge expert in the Juba camps, the shelters cannot effectively protect the IDPs from violence and weather-related hazards such as rain. Many of the latrines in the camps are in poor condition and overflowing thereby heightening the risk of epidemics, in addition, due to the risk of flooding in Mingkaman, Awerial (a flood plain), and latrines will be decommissioned.

Furthermore, the offices and facilities of several health cluster partners (including WHO) in the conflict affected area were looted thereby hampering the capacity of humanitarian health partners to effectively support health services delivery.

**Health priorities**

Health partners identified the following priorities within the first six months of the response:

- Restoration of emergency and essential primary and secondary health services for trauma, infectious diseases, reproductive health (especially safe deliveries/ obstetric care and acute newborn care), care for victims of sexual and gender-based violence, and continuity of treatment for chronic conditions.
- Procurement, storage and distribution of life-saving and essential medicines and supplies.
- Provision of safe drinking water, adequate sanitation and hygiene facilities.
- Referral and care of children with medical complications of severe acute malnutrition.
- Provision of life saving surgery to the critically injured and supporting medical evacuation of the patients caught in cross fire.
- Protection of health care workers and health facilities.
- Strengthen the early warning surveillance and response system for outbreak-prone diseases.
- Vaccination against measles and polio with vitamin A supplementation.
- Infection control in health care facilities including safe transfusion and medical waste management.
- Vector control, especially the provision of Long Lasting Insecticidal nets (LLINs) against malaria.
- Emergency mental health and psychosocial care.
- Risk communication to the public.
Further health needs assessments and monitoring visits are envisaged to keep up with rapid developments, e.g. Ministry of Health, World Health Organization and United Nations Population Fund will assess reproductive health services in the largest camp at Mingkaman, Awerial County where over 80 000 IDPs are present but scattered under trees in the open air.

**WHO response**

I). Technical expertise

Following the grading of the emergency on 26 December 2013 and re-grading to level 3 on 12 February 2014, the health cluster and WCO with support of HQ and AFRO has implemented several emergency health response activities to strengthen its operations and continue to provide technical guidance to the Ministry of Health and emergency response partners in the crisis.

Emergency Support Teams (EST) were established at the regional and WCO levels while the WCO was repurposed to ensure that all four WHO’s critical function in emergency were effectively covered. Following upgrading of the crisis to a WHO level 3 emergency on 12 February 2014, an initial surge team comprising of 4 people namely the health emergency team leader, disease surveillance officer, measles expert and logistician arrived in the country on 14 February.

As at 14 April 2014, 35 (74%) out of the 47 planned emergency response positions in the country had been filled; while 24 (77%) out of the 31 planned external surge had already arrived in the country; these include among others immunization experts, epidemiologists, disease surveillance officers, health cluster coordinators, public health specialists, WASH/environmental health, communication and data management experts and mental health specialist.
In addition, 18 STOP team members are currently supporting the emergency response effort in Upper Nile (2), Unity (2), Jonglei (1), Lakes (2), Juba (2) and non-conflict affected states (Northern Bahr El Ghazal -2, Western Bahr El Ghazal-1, Warrap-1, eastern Equatoria-1), and thus ensuring an integrated approach to polio eradication and emergency response. The health cluster leadership was also strengthened and technical support and guidance is being provided to health cluster partners. As part of the surge deployment plan the dedicated health cluster staff capacity was increased from 1 to 4 and an additional staff (information management officer) is currently being sourced.

Technical support

The teams worked closely with the Ministry of Health and other UN agencies, donors, health cluster partners and local stakeholders to support the planning, coordination, and implementation and monitoring of key strategies to improve the lives of the displaced and conflicted affected persons and communities. The teams conducted field assessments, documented critical finding, recommendations and developed strategies, tools and guidelines to improve the quality of response and capacity of all the key stakeholders in the country.

WHO and health cluster partners had carried out 965,099 medical interventions by 10 April 2014. Ongoing technical support was provided to the MOH to establish and run early warning and disease surveillance system in all displacement camps and the data generated is regularly disseminated through the weekly epidemiological bulletin and is used to guide health cluster partners. The organization also continue to support basic health services delivery to the displaced populations through provision of technical guidance, essential medicines, medical supplies, emergency health kits and support supervision, monitoring and evaluation to the displacement areas. So far, 8 complete Interagency Emergency Health Kits (IEHK) and supplementary units, 151 basic IEHKs, 15 Trauma kits A and B, 20 cylinders of oxygen, 77 ORS modules and 12 basic Diarrhoea Diseases Kits (DDK) modules capable of treating 263,300 persons have been provided to the government and NGOs among other supplies. Furthermore, emergency supplies were pre-positioned in strategic locations in the country in preparedness for the rainy season; so far 70% of the 10 states are either fully covered.

Support was also provided to conduct measles immunization in the displacement camps of Juba, Bentiu, Malakal, Bor, Aerial and Nimule while cholera risk assessments and Oral Cholera Vaccine (OCV) mass vaccination campaign were supported in Aerial and Juba reaching 62,239 people. Currently an OCV campaign is being conducted in Malakal. Health cluster partners (including WHO) had vaccinated 240,365 and 151,146 children for measles and polio respectively, made a cumulative consultation of 214,944 and conducted 2,564 antenatal visits, 1,906 assisted deliveries and 269 caesarean sections.

The health cluster and WHO also continue to coordinate medical evacuations and surgical management of the war related gunshot injuries with other partners. Since the beginning of the crisis in December 2013 to
date, 317 patients have been medically evacuated and an estimated 6,127 cases treated for gunshot wounds with the support of the health cluster and WHO. WHO supported the deployment of one anaesthetic and one theatre nurse to Bentiu Hospital and supported another 24 health workers to Bor state hospital to strengthen secondary health care. The health cluster is currently mapping technical expertise and capacities of partners to scale-up services delivery in the unreached areas and geographical priority locations for scale up to be able to respond to the current operational needs.

As health cluster lead, WHO is working in collaboration with the Ministry of Health to provide the necessary technical support in coordinating partners response activities in the crisis. The Organization is facilitating health cluster meetings at national and subnational levels to discuss the critical issues such as the current mapping of the existing capacities for health response, contingency planning for the rainy season and strengthening health information and data collection to enable a more focused response. In addition, WHO is supporting health coordination mechanisms at central and state levels including deploying additional staff to enhance the health cluster coordination at central and sub-national levels, and using Outbreak and Disaster Management focal points to support coordination in non-conflict affected states. In mapping cluster response, the health cluster, with WHO, has advocated for the involvement of more Health Cluster partners in high risk states and has developed linkages with WASH and nutrition clusters to further enhance its work in areas of common interest.

During the quarter, the Emergency Response Teams conducted different categories of trainings for various cadres of health workers and community health volunteers to strengthen basic service delivery and increase disease surveillance activities and health promotion.

The trainings included community health workers in IDPs camps on surveillance activities as part of the Organization’s community surveillance programme geared towards integration and strengthening of community based disease surveillance. Basic principles of community diagnosis, detection and reporting of guinea worm disease were underscored. A total of 19 community health workers in Tongping (19), Juba (8) III/UN house, Minkaman (13) and Bor (21) were trained through this programme.

Trauma management training has been conducted in three places benefitting 80 health workers involved in emergency major and minor surgery at three locations.
In response to address the gap in mental health services identified in various assessments, WHO recruited a mental health expert to support development of a comprehensive mental health and psychosocial emergency response plan. Among the activities conducted were: assessment of the psychiatric ward at the Juba Teaching (national referral) Hospital to identify key gaps of potential support, interviews with key MoH focal points and coordination with partners. Among the challenges identified was the lack of technical expertise in mental health, lack of essential drugs to support management of mental health and limited infrastructure for managing mental health cases at national and state levels. A number of interventions have been proposed to address these challenges in the short, medium and long term.

In response to suspected cholera, and the threat of outbreaks of diarrhoea due to poor sanitation conditions in the camps, WHO supported the development of response plans including the cholera response framework, cholera communication strategy and water quality surveillance guidelines.

Information management
A communication strategy was developed for handling the information and communication needs during the crisis. Under this, a number of products have been delivered and activities conducted including:

- Health cluster bulletins, WHO situation reports and the Early Warning and Disease Surveillance Bulletin focusing on IDP camps and PoCs,
- 4Ws mapping & mapping products including dashboards and maps
- In collaboration with other agencies through the Information & Communication Working group and UN Communications Group agreed on common working tools and approaches for the current crisis.
- Visibility:
  - The WHO SS website and face book are updated regularly.
  - In addition, WHO is supporting the health cluster to update information on Humanitarian Info including reports, meeting documents and reference documents.
  - Drafting and dissemination of press releases and radio talk shows

Core services
In delivering these interventions and supporting the Ministry of Health, WHO is supported by its finance, administration and logistics unit. The following gains have been registered:

- Swiftly procured life saving supplies to support the emergency operations for the crisis
- Rapidly establishing and deploying emergency response human resources to the areas of need
- Delivering medical and surgical supplies to hospitals, Primary Health Care Units/Centres and mobile clinics.
- Providing emergency drugs and other medical supplies to 26 health partners operating in five crises affected states. WHO is supporting the provision of diagnostic kit and drugs for Visceral Leishmaniasis (Kala Azar) to cushion the stock out in Bentiu state hospital which is a treatment centre for Kala Azar.

Funding requirements and resource mobilization
The Strategic Health Cluster Response Plan (27 January) called for US$61.3 million to cover the most urgent health needs. WHO requires US$ 10.95 million to cover its health response activities through July 2014.

Funding remains one of the most critical gaps in the response effort. As at the review period, about 59% of the funding required by the health cluster has been received even though the crisis continues to displace more people and communities. In an effort to fill the funding gap to facilitate delivery of life saving health care interventions WHO worked closely with the health cluster members to mobilise additional resources.

To date, WHO has received financial contributions to support its health humanitarian work from, the United States of America, the Central Emergency Response Fund and the United Nations Development Program Common Humanitarian Fund and the FINNISH government. In addition as part of the resource mobilisation
efforts, bilateral meetings have been held with the embassy of Netherlands, SIDA, CIDA, Germany, ECHO and the Norway.

**Funding Situation (as at 14 April 2014)**

<table>
<thead>
<tr>
<th>Health cluster**</th>
<th>Total funds required for 6 months (Jan to July 2013)</th>
<th>Amount received</th>
<th>Concrete pledges</th>
<th>Funding gap</th>
<th>Sources of received funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health cluster**</td>
<td>US$61.3 million</td>
<td>US$18,918,662</td>
<td>US$1.2 million</td>
<td>US$42,405,358 million</td>
<td>Common Humanitarian Fund (CHF)</td>
</tr>
<tr>
<td>WHO</td>
<td>US$10.95 million</td>
<td>US$6,490,000</td>
<td>USAID/OFDA:US$1 million</td>
<td>US$ 4,460,000 million</td>
<td>CHF, FINNISH, CERF, USAID/OFDA, FINISH Government,</td>
</tr>
</tbody>
</table>

*Health cluster not included in the second CHF funding
**The health cluster funding does not include funds to ICRC and MSF

**Challenges and Gaps**

**Technical**

1. Rampant violation of health systems functions, public health assets and human rights of patients continue to challenge service delivery. For example looting of the major hospitals have resulted in inadequate secondary health care delivery in the affected areas.

2. While Primary Health Care (PHC) services are well covered in the PoC areas, there is inadequate coverage outside these areas. Secondary health care services such as surgical care, reproductive health, HIV/AIDS, mental and psychosocial are in short supply in both PoC and non-PoC areas due to non-functionality of the State Hospitals.

3. The lack of secondary health care services in the affected areas is further compounded by the inadequate dedicated assets (air and road) for effective referral and medical evacuation of wounded patients. Where these assets are available, the ethnic dimension of the crisis prevents medical evacuation of patients to the appropriate medical facilities.

4. Although there are 56 health cluster partners, less than 40% of them have the technical and logistic capacity for effective field operations and for scaling up services to areas outside the PoCs.

5. Inaccurate displacement figures which challenges accurate planning; for instance in the Mingkaman Camp in Awerial County, despite massive community mobilization and mop-up campaigns only 52,398 (64%) out of the official camp population of 82,000 people could be vaccinated with OCV. Furthermore, the balance of the displaced populations outside the PoC areas are not well documented in terms of their exact location, numbers and status thus making targeted health planning difficult.

6. The diffuse nature of the displacements continues to constrain effective coverage of the displaced populations; many of the displaced populations seem to be in small groups scattered all over the country with many of them being very mobile.

7. Due to the ethnic nature of the crisis, deployment of national staff to the affected areas is difficult thus reducing the available human resources capacity for the emergency response. There is also a general shortage of specialist cadres such as surgeons, obstetricians etc. needed for the response hence partners resort to expatriate staffing which is more expensive.
8. The usual pre-positioning of medical supplies for the rainy season is delayed; insecurity (with high risk of looting), limited storage capacity in State capitals and UNMISS compounds limit the scale of pre-positioning currently available.

Operational

9. Lack of humanitarian access and space for effective emergency health response due to the fluid security situation (and security rules and regulations), delays and sometimes outright denial of clearance of humanitarian missions and the ethnic nature of the crisis continue to restrict service delivery to the PoC areas. Recent developments and the increasing tension between the host government and the UN will further compound this problem.

10. Lack of an enabling environment required for scaling up of services delivery due to inadequate office and residential accommodation for humanitarian staff, harsh living conditions on the field (heat, approaching rainy season, lack of food and supplies), poor Minimum Operational Security Standards (MOSS) compliance of field offices and accommodation vis-à-vis high level of insecurity and difficult terrain (which hampers road travel) continue to constrain field deployments. At the best, staff can only be deployed for 2 to 3 weeks at a time which is expensive and does not facilitate continuity.

11. The current resources level is still inadequate for L3 response; the health cluster is 31% funded and WHO is 41% funded. Although 34 out of the 46 (74%) emergency positions are currently filled; most of these are at Juba level with major gaps in the field.

12. Weak logistics system which makes field operations challenging and expensive.

Important Conclusions

1. This is a very complex humanitarian crisis which based on recent developments, is likely to be protracted; we may therefore be responding to the acute phase of a chronic emergency hence the need to strategize and plan accordingly.

2. Service provision is still largely restricted to the UNMISS PoC due to the technical and operational challenges highlighted above; however the very fluid and unpredictable security situation and lack of an enabling environment remain the most critical challenges to scaling up health services delivery.

3. Despite the L3 declaration and concerted efforts to scale up services delivery, huge gaps persist in the humanitarian response. The clamour for upgrading the emergency to level 3 and scaling up services delivery is not being matched with concrete efforts to provide adequate resources and an enabling environment for level 3 response.

4. Based on recent epidemiological reports, the general and health situation in the camps seems to be stabilizing however, the imminent rainy season is expected to further compound an already bad humanitarian situation; flooding may result in increased incidence of water-borne diseases, cause more population displacement, hamper access to affected populations and complicate emergency health response logistics. There is also the likelihood of the clashes escalating during the rainy season.

Way Forward

1. Creation of an enabling environment for humanitarian response through joint negotiation of access and humanitarian space by the Humanitarian Country Team (HCT) especially in currently unserved and SPLA-IO held areas and creation of adequate, conducive and MOSS compliant working and living conditions on
the field. Specifically; there is need for strong advocacy for security for critical health services in referral hospitals and county hospitals, otherwise scaling up of health service delivery will remain difficult.

2. In-depth analysis of the humanitarian and public health situation, gaps, status and location of the unreached populations to inform development of appropriate context specific emergency health response strategies. In this regard, innovative approaches to services delivery will be required.

3. Stronger advocacy is required to ensure mobilization of resources to cover the funding gaps; furthermore internal WHO resources mobilization efforts is required to at least support establishment of a strong operational platform for the response.

4. Promotion of higher synergies in programming between health cluster partners is required to improve scaling up of health service delivery. Specifically WHO should;
   a. Explore further operational areas to partner with UNICEF and other health cluster partners who have strong field presence.
   b. Identify trusted implementing partners among NGOs for the upcoming CERF and envisage scale up through partners.

5. Advocacy to the HCT to provide dedicated air assets for medical evacuation of wounded patients.

6. Given the likelihood of prolongation of this crisis, medium to long-term planning is required for the health cluster and WHO’s response. In this regard, more predictable and longer term resources (staffing, supplies, logistic and funding) will be required.

7. Advocacy to UNOCHA and IOM to provide the numbers and exact location of the populations displaced outside the PoCs; within the PoCs, regular review of the population will be required to ensure accuracy in the planning figures.

8. Establishment of a monitoring system to document violations of health systems and public health assets and use of the findings to advocate to the warring parties to preserve public health assets and functions. This should be done in tandem with advocacy for respect for principles of human rights and right to health.

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