









Bulletin #04 April 2016



HIGHLIGHTS

	CONSULTATIONS	100,824
	NEONATAL CARE	2,066
	ASSISTED DELIVERIES	1,745
	ANC SERVICES	8,848
	MENINGITIS VACCINATIONS	2,644,164
	MEASLES VACCINATION (6-15 YEARS)	66,886
	<i>(children 6-59 months - 35,789)</i>	
	% HRP FUNDED	14%
	HEALTH CLUSTER PARTNERS	67
	<i>(47-INGO, 16-NNGO, 4-UN)</i>	



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

April has been a very busy and productive month for us. Thank you for all your support.

April 2016 Gallery



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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.

The Health Cluster and partners continue to engage with the MOH/other clusters/donors/ in implementing the health responses articulated in the 2016 Health Humanitarian Response plan. 2016 has witnessed a slow and reduced funding for humanitarian response. This has also been the case for development partners. While the resources have been reduced, the needs have not changed.

The Health Strategic Advisory group with the coordination leadership continues to implement and monitor the progress of the response package outlined in the health HRP and the outputs within the Health cluster note. Gains in the investment in the training of the state focal persons in March are gradually being realized in the strengthened regular reporting from all the states. Advocacy for resources to deploy dedicated coordinators in the various locations especially in the three conflict affected states including the Equatoria's continue.



April has witnessed yet more displacements and heavy losses of humanitarian assets and partner presence, but it has also engaged new strengths. On 26th April, Riek Machar returned to Juba to take up his post as first Vice President of South Sudan. On 27th April, the USA announced more than \$86 million in additional humanitarian assistance to help conflict-affected people in South Sudan, as well as South Sudanese refugees in the region. Prior to the above announcements, the HRP was only 20% funded (\$254 million) of the HRP 2016 requirements with the health cluster being funded at 11% of its 110M USD requirements.

Health cluster partners have continued to RISE to the myriad of challenges and have responded to them in a timely manner. In the Equatoria's the displaced have congregated in Mundri with a smaller scale presence in Juba centre - and in Wau where 38,845 individuals have been verified in Wau town. Emergency Health Kits and WASH NFIs were distributed to over 1,000 HHs in Lakamadi, Kediba and Lozoh in Mundri East. There is ongoing multi-cluster response to IDPs/ host communities in Wau town, surrounding areas and Mboro. In Ulang Over 20,000 IDPs are reported to be in Kuich

All the assessments conducted and participated by the health cluster partners in April 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 East, Wau, Ayod, and Pibor.

Ongoing insecurities have also resulted in the looting of humanitarian operational basis including health facilities and health commodities. 17 humanitarian staffs from Wathjak (Ulang) were relocated on 17 April, necessitating response from Health and Nutrition RRM teams. Documented assets losses to humanitarians from Dec 2015 to date incurred by UN agencies and partners in Malakal, Pibor, Yambio, Mundri and Ezo is currently totaling approximately USD 5M of which health cluster partners have reported an accumulated loss of over USD 3M.

The POC's spaces within the UNMISS base and IDP settlements have largely remained calm and have continued to receive health intervention. Health partners observed adhoc and in small numbers **voluntary exits from the POC's** and with the peace promise that the return of the Vice president brings, health cluster partners are seeing more and more regular IDP **movements outside of the POC's and reported heading to their places of origin.** On 26 April, 1,400-1,700 IDPs from Juba area

arrived in Mingkaman on 11 trucks with the intention to proceed through Yirol and Rumbek directly to Bentiu Town. From Bentiu Town they would then depart to areas including Mayom, Parieng, Adok, Leer, Guit, Koch, and Panyijar. This has engaged health partners on strengthening of early recovery discussions on the health preparedness to receive the returning individuals into the communities.

The Health cluster in April has continued to engage energies on strategically supporting partners to respond 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.

The risk of measles outbreaks in South Sudan in 2016, has been predicted especially for the three conflict affected states where measles mortality could be as high as 15 - 20%. The low coverage of Routine Immunization in South Sudan show at national level the Penta 3 and measles coverage are respectively 41% and 48%. In the 3 states affected by the conflict the situation is worse, in Unity state (penta3: 11%, measles13%), Upper Nile (penta3: 5%, Measles: 10%), Jonglei (Penta3: 8%, measles: 12%). Even though the risk of measles outbreak is country wide, the effect will be massive in the three conflict affected states, requiring high mobilization of resources to reach the population and avert avoidable debilitating effects that could arise from preventable complications and deaths from the disease

In April, Health cluster Partners have detected and responded to measles outbreaks in Warrap (Ajak Kuak), Unity (Rubkwai catchment), and in Malakal POC. The health cluster is drafting a strategy soon to be shared on clustering the locations and leveraging resources to target responses in wider geographic boundaries including working with partners/stakeholders to resource mobilize for the planned 2016 campaign country wide.

With the seasonal rains that heavily affect logistics, partners have been briefed on available core pipeline supplies/how to access them and where they have been prepositioned ahead of the rainy season. With the dry season deteriorating in April, the health cluster has been heavily engaging partners in capacity building and prepositioning for a majority of epidemic prone diseases response.

April has also witnessed a further strengthening of the Health component of the Humanitarian website. In addition to activities pertinent to health interventions being regularly shared widely and preserved, the cluster activity on creating a link to its own directory that will allow partners to blog, post needs and spiral live interactive learning and health related discussions has made progress. The site will be launched at the end of May.

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 centres.

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 to include 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 comorbidities.
- Provision of supportive Supervision to partners and documenting gains made.

Updates/Needs and Gaps

There is evidence that with the emerging peace process IDP’s have commenced voluntary returns to their places of origin. This will require close monitoring by the health cluster and partners and will engage discussions and investments in

1. Analysis on the public health risks and preparedness to receive the communities
2. Early recovery health discussions with all stakeholders
3. Health cluster support to the government on sustaining the gains made on the pharmaceutical efforts in the country
4. Investments in Surveillance that will track sensitive IDSR /EWARN /Pharmaceutical data for planning effective response
5. Effective HERAMS to update the functionality of the health infrastructure/programme efficiency as it relates to the government basic package of healthcare
6. Strengthening of and strategic inter-cluster linkages especially HEALTH/WASH/Nutrition
7. Strengthening of Coordination through placing dedicated human resource to strategically guide to leverage resources and document the gains made.
8. Intensify advocacy for resource mobilization to support early recovery initiatives in emergency response.

These developments will also attract a different set of strategy and resource considerations for the upcoming mid-year review of the health Humanitarian response plan.

The Ministry of Health Government of South Sudan has set up a Pharmaceutical Technical working group (PTWG) to oversee the projection, procurement, distribution, the logistics and managements of pharmaceuticals and health commodities including surveillance for pharmaceutical stock outs in the country. This technical arm of the MOH sits regularly every 2 weeks and has membership from all stakeholders in the country. They encourage participation by all interested actors in activities concerning pharmaceuticals in South Sudan. The pharmaceuticals logistics management (LMU) unit of the MOH is supported by Management sciences for health (MSH) and has commenced reporting on a monthly basis to the PTWG on drug surveillance based on an agreed absence of 15 tracer drugs from the facilities to constitute drug stock out. The LMU is in the final stages of developing an online surveillance on the pharmaceutical situation in the country and is currently piloting the drug status in selected facilities based on the agreed 15 tracer drugs.

1. A projection for country wide pharmaceutical requirements commenced in 2012 and was supported by the Emergency Medicines Fund (EMF) using the earlier MDTF approach. The EMF was tasked to procure and distribute pharmaceuticals that covered all the 130 essential medicines required for health service delivery.
2. EMF ended in June 2015 and the buffer stocks were distributed to cover the facilities through March 2016.
3. Based on the recommendations from the Pharmaceutical Working Group (PTWG) in 2015, the projection for pharmaceuticals needs for the country in 2016 was USD32 million. These were to be procured by the Government.
4. With the anticipated delay of the government proposed procurements, DFID contracted CAIPA to procure 55 out of the 130 EMF commodities to supply the entire Health facilities for 6 months in 2016.
5. The choice of the 55 out of the 130 essential medicines was based on drug and health commodities consumption data. The Government with donors and all stakeholders agreed on these as the highly prioritized list of pharmaceuticals required for the treatment of potentially fatal common morbidities.
6. With the support of donors and stakeholders the country has also recently received a buffer distribution of anti-malaria to the tune of 1.6million doses. Global fund covered the logistics from the national level directly to the health facilities.
7. With the EMF buffer stocks covering the first quarter of 2016 and the DFID procurement through CAIPA, it is anticipated that there should be sufficient medicines until end of September 2016.
8. Humanitarians with support from WHO core pipeline have supported 12 health partners with basic drug kits in the 3 conflict affected states of (Jonglei/Upper Nile and Unity) that have necessitated the creation of mobile responses in newly displaced locations. WHO has also donated various antibiotic and antimalarial kits to the Central Medical Stores .
9. The initial results arising from the consumption data collection, analysis & dissemination currently being piloted by the MOH, Logistics Management Unit (LMU) based on the agreed 15 tracer drugs whose absence in a facility constitutes drug stock out, have reported no drug stock out due to the absence of all the 15 tracer drugs that constitute a stock out.

Update

Crown Agents and International Procurement Agency (CAIPA) is implementing on behalf of the UK Department for **International Development (DFID) the “Emergency Procurement and Distribution Priority Essential Drugs and Medical Commodities” project for the Ministry of Health South Sudan for 2016 and 2017.**

The CAIPA procured consignment of 55 essential medicines is packaged in 10 lots. Currently 84% of the lots are in the country and Ministry of Health has approved the distribution of the stock currently in the warehouse in Juba to cover a **quarter/3 month’s supply.**

Drug distribution from the centre (National level) targets the end point delivery to the referral hospitals, State hospitals and County Health Department (CHD).

The health cluster in November 2015 facilitated CAIPA to collect data from stakeholders and implementing partners on states with potential drug stock outs. Partners and stakeholders have been mapped to support the last mile distribution from the CHD to the facilities, as was the case for the distribution of the anti-malaria in 2015.

Distribution has commenced on the 29th of April by truck for the prioritized States of Jonglei - Bor South, Warrap – Tonj East, Tonj North and Tonj South and Wau – Referral Hospital. Lakes and Upper Nile distribution by air is also planned for Wednesday, 4th May 2016. Detailed distribution plan for the rest of the country is shared during the PTWG platform.

Challenges:

1. The overall national investment in health is at \$146 million. This represents only 4% of the national budget. Of this, \$50 million was allocated for transfers from the national government to pay salaries of health workers and cover operational costs for the state Ministries of Health, County Health Departments and state and county hospitals. There is evidence that transfers are being sent to state ministries of finance and reaching the intended targets, but budgeting processes at the State and County levels are often not strong and delays are experienced. Health systems strengthening activities are **working towards improving the County's ability to plan and budget in an effort to increase stewardship of health programs** at the local level.
2. Pharmaceutical supply chain is currently heavy on the push system with a weakness in the reporting that is necessary for introducing the pull system
3. The overall health Humanitarian Response Plan (HRP) is funded at 14% to date, the three-core pipeline managers have prepositioned PHC IEHK, Vaccines and Reproductive health Commodities. High-level advocacy continues to engage to ensure that the HRP requests are realized.

Way forward:

The Government and stakeholders continue dialogue on a more robust system of continuous supply to the facilities. Long-term pharmaceutical procurement of medicines by Government is being addressed through two routes:

- a. Ongoing discussions with H4+ and Government.
- b. The upcoming health summit slated for early May 2016

In the meantime:

1. Both DFID and Rapid Results Health Project have extended their current support for distributing the agreed pharmaceuticals through the end of 2017(CAIPA for DFID) and (RRH for WB) now in discussion with two UN agencies to identify a procurement route.
2. These commodities will cover the facilities from September 2016 to September 2017 and is planned as follows
 - a. HPF II (through DFID) will fund procurement and distribution of essential medicines to the 8 States of (WES, CES, EES, NBG, WBG, LS, US, WS,)
 - b. RRHP II of the World Bank (WB) will fund procurement and distribution of essential medicines in the 2 States of (UNS, JS)

COORDINATION

Coordination activities have taken place both at the national and subnational levels.

At the national level, the HC has engaged partners on biweekly coordination. The themes in focus have been on response to the emerging IDSR/EWARM data of interest and response based on active engagements with partners providing response in those areas. Partners have also continued to update the cluster on their programmes and shared best practice. Partners have been engaged in discussions on mapping hot spots for cholera response, policy and guidelines on measles outbreak response and the suspected VHF cases.

The rapid response arm of the health cluster has engaged in weekly coordination with partners and has coordinated the response to Mundri East, Pibor and Wau.

At the State level, a combination of monthly and biweekly coordination modalities have been used to focus partner engagements in response. State focal points with cluster partners are finalizing state level health contingency plans:

Jonglei: Reactivation of the cholera task force with sustained discussions on preparedness for response including capacity building

Unity: IOM, WHO, UNICEF and partners conducted measles campaign targeting under fifteen children in Bentiu PoC and reached 95% (45,897) Measles campaign in Bentiu PoC has been conducted 22-27th April 2016 and have reached 95% of the targeted under fifteen children. Partners are reaching Nhialdu, Nimni, Boaw and Kuach with lifesaving mobile outreaches. Active discussion continued on water issues in the Bentiu POC and the beyond Bentiu response.

Upper Nile: active discussions on measles response, disposal of expiry drugs and cholera preparedness. Partners have sustained health outreach within the POC and in Malakal town.

CES: The inactivated polio vaccine was introduced into the routine EPI services in the state. The trivalent (tOPV) to bivalent (bOPV) switch activities are well on course in the state. 40 health facilities staff identified to be trained from the 23 sentinel sites for surveillance of Acute Watery Diarrhea in Juba City. Health staff within the Juba POC has received refresher training for cholera management and for rational use of drugs.

EES: focused on the job training for reproductive health activities

Western Bahr el Ghazal: Health Cluster (WHO, UNICEF, EPI/sMOH and Wau county health department) coordinated the humanitarian response to Mboro IDPs and delivered emergency kits twice. There have also been focused vaccination **activities to the vulnerable groups targeting 8000 IDP's covering the following:**

1- Oral Polio Vaccine: 0-5 years (25% of total population approximately 2000 children)

2- Measles vaccine: 6 months - 5 years (1800 children).

3- Vit-A supplementation: (1800 children)

4- Meningitis vaccine: (1 year - 29 years), 70% of total population (5000 individuals)

5- Tetanus vaccine: (15 year - 49 years) women of child bearing age, planned to cover 45% of total population, approximately 4000 women.

Lakes: Focused on withdrawal/collection of the tOPV vaccines from the health facilities in the counties and the distribution of the bOPV replacement vaccines to the counties. Plans for active measles search and response is ongoing. Verification conducted of IDPs in Denghial, Malakal, Cumchok and Makurieric of Rumbek Centre County. Emergency assessment conducted in Rumbek North in order to verify the number of the reported 180 individuals IDPs in Meen Payam of Rumbek North.

Mingkaman: Orientation of nurses/midwives to IPV introduction & OPV/IPV switch. PMTCT training is completed at HLSS Hospital. There is ongoing monitoring of the special vaccination post at the Mingkaman port as well as ongoing supportive supervision and monitoring of EPI services including the cold chain at the clinics and hospitals.

Northern Bahr el Ghazal: With Measles outbreak confirmed in all the five counties, there was integrated measles and polio campaign in whole of Aweil South and four Payams of Aweil East for age 6-59 months. 42,988 targeted for Aweil East - coverage was 39,918, target for Aweil South was 18,934, coverage was 15,860. With insecurity in Western Bahr El Ghazal, the commissioner of Aweil Centre County reported to have received 500 IPDs.

Western Equatoria: Preparations and conduction of 1st round NIDs was done on 22nd - 26th April in 8 out of the 10 counties. (Mundri W & E excluded because of insecurity) - results still awaited. LOAS exercise for 5/8 counties is in process. Preparations and implementation of tOPV-bOPV Switch on 28th Apr - monitoring & validation visits going on. Reproductive H. Coordination Forum was launched on 28th Apr - Co-chaired by two State Ministers; Health & Education, with the presence of Nat. MOH and UNFPA Country Office Mission. WHO has handed over the Maternity Ward of Yambio State Hospital to AMREF.

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

61% OF CHILDREN AGED 1 TO 29 YEARS RECEIVED MENAFRIVAC DURING THE RECENT MENINGITIS CAMPAIGN

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;

- 2,644,164 aged 1 to 29 years received MenAfriVac during the recent meningitis campaign. This represents 61% of the total population targeted.
- 100,824 consultations were provided given a cumulative curative consultations of 810,567 in conflict-affected and other vulnerable states through the humanitarian health partners
- 1,745 assisted deliveries conducted by skilled birth attendants in conflict-affected and other vulnerable states. In addition, 11 health workers received training on safe delivery
- 8,848 representing 34% (25,943) of the cumulative women provided ANC services since January
- 9228 individuals were reached with health education and promotion messages
- 29,644 and 31,207 children received 3 doses of OPV and Pentavalent through routine immunization against vaccine preventable diseases

See below, progress update on the 2016 HRP.

(Results indicated in this table is cumulative annually, beginning January of 2016) Implementation Updates – April 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	811,470	≤1	0.17
% decrease in under 5 Crude Death Rate	0.33	107,409	≥2	0.45
% increase in # births attended by skilled birth attendants in conflict affected and other vulnerable states	36%	101,432	41%	5.4%
% 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 sates	5%		25%	7%
# of children under 5 with severe acute malnutrition with medical complications, who are clinically managed in stabilization centres.	231,368	231,368	6941	814
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%	481,802	80%	7%
Proportion of people reached by health education and promotion before and during outbreaks	56%	1,242,542	80%	0.7%
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



In April 2016, the Health Cluster team in Juba PoC 3 conducted a supportive field monitoring and supervisory visit. The purpose of the visit was to conduct quality spot checks and to verify the progress made, including challenges on project implementation and help to provide evidence-based decision making.

Service data were reviewed and a comprehensive facility tours were conducted. In one of the clinics,, the importance on data quality and record keeping were emphasized. The visiting team encouraged the staff especially those providing immunization against vaccine preventable diseases to ensure that, continuous weighing of children is integrated into the process as this is a very important component of the primary health care program.

“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 recognizes the community participation in identifying the responses and builds into the response an effective evaluation by the communities and commits to ensure their views are incorporated into further response. This concept is underpinned by 5 Commitment Pillars.

In April, the cluster-focused commitment on the accountability to affected population was based on Pillar 1 and 5 as described in the 5-pillar concept, using the onsite supportive field mission conducted in Juba 3 PoC that housed over 30,000 IDPs. Quality spot checks were conducted to key facilities providing health care services for the affected population in the PoC. Discussions with service providers were held during the facility tours and key programmatic performance documented for evidence based-decision making.

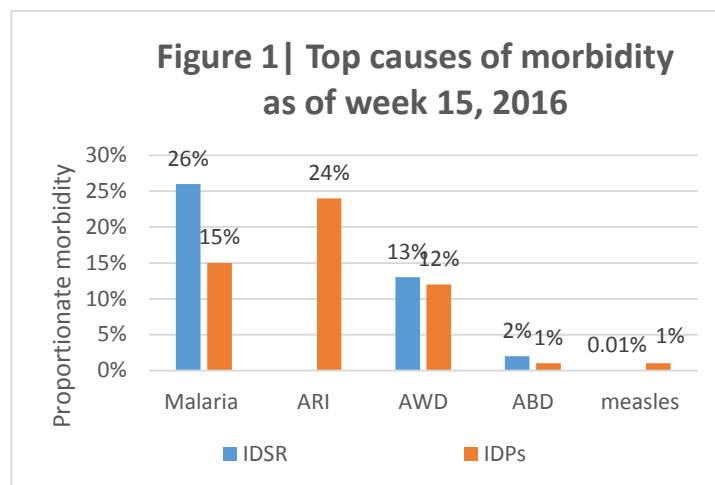
THE 5 PILLARS THAT UNDERPIN THE AAP CONCEPT

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** •

SURVEILLANCE AND COMMUNICABLE DISEASE CONTROL

HIGHLIGHTS - IDSR/EWARS

- Completeness: 42% for IDSR and 68% for EWARS.
- # of Consultations: 1,316,252 consultations in 2016 (938,628 under IDSR and 377,624 under EWARN).
- Measles cases are on the increase countrywide with outbreaks now confirmed in 11 counties.
- Under IDSR Malaria is the top cause of morbidity; while under EWARN, ARI stands as the top cause of morbidity among the IDPs (Figure 1).



- Acute watery diarrhea trends in the IDPs are currently higher when compared to 2014 and 2015.
- The under-five and crude mortality rates in the IDPs remain below the emergency threshold in all the IDP sites with TB/HIV/AIDS being the leading cause of death.
-

Measles:

- Measles cases are on the increase countrywide with outbreaks confirmed in 11 counties since the beginning of 2016.
- During April 2016, new measles outbreaks have been confirmed in Malakal PoC, Yirol West, and Aweil North counties.
- While vaccination campaigns have been completed in eight counties, plans are under way to conduct mop up vaccination in two of the counties (Agok and Mayom) and reactive vaccination in three counties (Malakal, Yirol West, and Aweil North).
- Since the beginning of 2016, at least 832 suspect measles cases have from 10 states (Table 1). A total of 76 measles IgM cases have been confirmed in 2016 with outbreaks confirmed in Mangatain IDP, UN House PoC, Aweil West, Mayendit, Mayom, Leer, Rubkona, Twic, and Abyei. Mop up vaccination underway in UN House, Mangatain, Agok, Leer, Mayendit, Malakal PoC, Aweil North, and Yirol West.

Cholera:

- Two suspected cholera cases have been investigated from Bentiu PoC and Bor State Hospital. Both cases tested negative for cholera on RDT testing and culture.
- In light of the rain season; the following activities have been instituted to prop up readiness capacities for cholera response at all levels:
 - The National Epidemic Preparedness and Response Committee at the national level and the State Health and Nutrition committees at state level currently coordinate preparedness and response activities for cholera.
 - The national cholera preparedness plan has been updated and disseminated at national and sub-national levels.
 - Stockpiling of cholera case management and WASH supplies is ongoing at state level guided by the projected cholera caseloads for 2016.
 - The national cholera preparedness and response guidelines have been disseminated with all stake holders to guide preparedness and response activities.
 - The Juba Teaching Hospital Cholera Treatment Center, the main isolation facility in Juba has been assessed to ensure that all gaps are identified and addressed.
 - Supervision visits are underway to assess all the designated oral rehydration points to ensure they are supported to effectively detect and manage suspect cholera cases.

- Three sentinel surveillance sites (Juba Teaching Hospital; Al Sabah Children’s Hospital; and Juba 3 IMC clinic) have been identified and supported to detect, conduct rapid diagnostic testing and management for suspect cholera cases.

2016 Measles alert

State	County	New suspect cases W15, 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		4	3	3	Confirmed
CES	Juba		9			Alert
CES	Yei		7	0	0	Alert
EES	Magwi	1	9		7	Alert
Lakes	Rumbek Center		4	2	4	Alert
Lakes	Yirol East		1		0	Alert
Lakes	Yirol West	3	20	3	3	Confirmed
NBG	Aweil West		77	13	13	Confirmed
NBG	Aweil Center		1	0	0	Alert
NBG	Aweil East		6	0	0	Alert
NBG	Aweil South		18	1	3	Alert
NBG	Aweil North	4	21	2	2	Confirmed
Unity	Abiemnhom		3	1	0	Alert
Unity	Mayendit		27	2	12	Confirmed
Unity	Mayom		166	11	14	Confirmed
Unity	Leer (Adok)		7	2	6	Confirmed
Unity	Rubkona	1	91	7	8	Confirmed
UNS	Maban		1	1	1	Alert
Warrap	Abyei	4	252	15	23	Confirmed
Warrap	Gogrial East		1			Alert
Warrap	Gogrial West		13	2	4	Alert
Warrap	Twic	3	63	12	12	Confirmed
WBG	Wau		10	0	1	Alert
WES	lbba		2	0	2	Alert
WES	Tambura		4	0	4	Alert
WES	Yambio		9	0	7	Alert
UNS	Malakal PoC		3	1	1	Confirmed
JNG	Bor South	1	1	0	0	Alert
Total		17	832	76	129	

- Plans are underway to conduct refresher trainings for health care workers in high risk counties like Juba, Kajo-keji, Yei, Torit, Kapoeta, and Bor on cholera surveillance, case management, rapid diagnosis for cholera, and outbreak investigation and response.
- At least 76, 000 doses of oral cholera vaccines have been secured by WHO to support preventive oral cholera vaccination in Wau Shiluk and Melut.
- The cholera hotline (1144) has been activated to facilitate notification of suspect cholera alerts and information sharing on cholera prevention and control.
- Messages on cholera prevention and control have been updated to facilitate social mobilization and health education of the public.

Mortality surveillance: Since the beginning of 2016, a total of 466 deaths have been reported from all IDP sites of which TB/HIV/AIDS accounted for 57 (12.2%) deaths. Bentiu PoC registered the highest number of deaths, followed by Malakal and Juba 3 PoC (Table 1). During this period, the under-5 and crude mortality rates by IDP site remained below the emergency threshold.

Mortality trend by IDP site, week 1 of 2016 to week 15 of 2016

IDP site	acute watery diarrhoea	cancer	Heart disease	Heart Failure	hypertension	Kala-Azar	malaria	measles	perinatal death	pneumonia	SAM	Septicemia	TB/HIV/AIDS	GSW	Meningitis	Maternal death	Others	Grand Total
Bentiu	8	1	1	4			19	2	5	16	15		29	2	1	1	140	244
Juba 3	1	2					1	1	5	5	2	3	17				26	63
Malakal	3			1	2	1	1	1	4	5	5	1	3	4			52	83
Melut	1	1		3		1	1			2	2		2			2	5	20
Akobo	3			1			10		1	3				1			16	35
Wau Shiluk							1			2			6				12	21
Grand Total	16	4	1	9	2	2	33	4	15	33	24	4	57	7	1	3	251	466
Proportionate mortality [%]	3.4	0.9	0.2	1.9	0.4	0.4	7.1	0.9	3.2	7.1	5.2	0.9	12.2	1.5	0.2	0.6	53.9	100

Suspected Haemorrhagic Fever

- The number of cases presenting with Hemorrhagic HF symptoms in Aweil North and West is declining.
- One (1) new suspected Hemorrhagic Fever (HF) case has been reported since last update on 13 April.
- The cumulative cases stands at 48 suspect cases including 10 deaths (CFR 21%).
- Results (PCR, PRNT, ELISA) performed by WHO CC laboratories in Uganda (UVRI), South Africa (NICD) and Senegal (IPD) were negative for Ebola, Marburg, CCHF, Rift Valley Fever, Yellow Fever, Zika, and West Nile; 4 of samples tested positive for Onyong-nyong virus, 3 positive for Chikungunya and 1 positive for Dengue at NICD. Preliminary results on the second batch of 5-samples shipped to NICD showed 2 samples positive for malaria by rapid test.
- Further virological testing is currently on going.
- Laboratory testing for possible bacterial pathogens is also underway.

(1) MEASLES CAMPAIGNS IN AWEIL WEST AND AWEIL SOUTH BY IOM

Following outbreak of measles in Aweil Town where more than 13 cases were line listed, 9 confirmed by blood test, IOM through RRT was requested by WHO, MoH to support the outbreak response which included financial, logistic, HR and supervision of the campaign. The campaign targeted children from 6 months to 5 years, which was estimated to be 42,000 (19% of the total population) across the 9 Payams. The campaign took place from 5th to 11th April. Despite some logistic and accessibility challenges the campaign had administrative coverage of about 90% (37,089 children vaccinated) within 5 days across all the 9 payams.

The high coverage was attributed to good coordination and support between IOM and other stakeholders who actively supported in logistics and implementation of the campaign. The stakeholders were: State/County Ministry of Health, Concern Worldwide, WHO and UNICEF.

After IOM had finished measles vaccination campaign in Aweil West, IOM- RRT supported County Health Department in Aweil South in supervising integrated measles and Polio campaign. The campaign targeted children between 6 to 59 months which translate to 17,764 (19%) of the total population.



Measles vaccination at Nyamlel PHCC in Aweil West by IOM Staff

The integration of measles vaccines into polio campaign was agreed upon following some suspected cases of measles in the county. The Integration also helped in reducing logistics expenses. The exercise was supervised and coordinated by 6 CHD staff, 4 IOM and 2 SMOH representatives. The campaign was largely supported by WHO and UNICEF in logistics and supplies.

(2) MASS INTEGRATED MEASLES VACCINATION AND MUAC SCREENING CAMPAIGN IN MABAN COUNTY

Measles outbreaks continued to be an issue in Maban County in April. To abate the impending outbreak amongst hard to reach communities, Relief International (RI) conducted an integrated EPI/Measles campaign in response to the outbreak.

During the campaign, RI carried out health education to promote safe health practices and positive health seeking behavior as well as improved immunization coverage. In addition to the health education RI carried out immunization, nutrition screening and antenatal care in Maban County.



Health Education in Nilla

Achievements

- ✓ Over 2 150 (936 immunized for the first time) children were vaccinated (9.74% received BCG, 8.58% received Penta3 and 79% vaccinated against measles).
- ✓ 2188 CU5 screened
- ✓ 1047 PLW screened
- ✓ Mebendazole and Vitamin A supplementation was given to children and lactating mothers



RI EPI vaccinator administering OPV

	Red MUAC %		Yellow MUAC %		Green MUAC %	
	M	F	M	F	M	F
CU5	1.5	2.0	4.0	6.0	44.5	42
	3.5		10		88.5	
PLW	MUAC <21 cm		MUAC 21-23 cm		MUAC >23 cm	
	1.0		21.4		77.6	

Percentages of CU5 (6-59 months) and PLW with Severe and Moderate levels of Malnutrition

PREPAREDNESS FOR CHOLERA

1) INTERNATIONAL MEDICAL CORPS (IMC) PREPARES FOR CHOLERA OUTBREAK

Entering the rainy season, the International Medical Corps (IMC) is playing a leading role in cholera preparedness in Juba POCs. Much has been learnt from the cholera outbreak last year where 76 cholera cases were treated in IMC health facility in the POCs.

Cholera beds have been prepositioned in the 10 beds capacity isolation room of the Inpatient Department, which will be the functioning Cholera Treatment Unit (CTU) in the event a cholera case is diagnosed in the POCs.

A joint cholera preparedness plan was drafted and shared among partners to identify the roles of each partner in the fight against cholera. Under coordination of ACTED, UN House health and WASH partners meet every week to assess progress made in this regard.

Key cholera messages were prepared and are currently being played by the community radio through a Boda Boda talk show run by Internews.

Various trainings have been conducted as part of the preparedness plan. Refresher training on cholera mainly focusing on case management was conducted for IMC staff by WHO last week. The training also included hands on demonstration of how to do a cholera test. In this training, the prevention aspect was also presented by UNICEF. More cholera testing kits and Carry Blaire transport media were also provided by WHO.

IMC also provided training on cholera prevention for about 70 community health mobilizers from IMC and THESO to strengthen community sensitization activities.

Trends of acute watery diarrhea are well monitored through a system of active surveillance, which has long been put in place even before the rainy season started. Community health mobilizers are continuing to provide health education on cholera in IMC health facilities and also within the community.

IEC materials on cholera prevention have also been posted in IMC health facilities and also in key areas in the POCs.

The IMC emergency unit in POC 1 functions 24/7 providing services for IDPs in both POC 1 and POC 3. This is the unit that receives any suspected cholera cases that may be referred to IMC health facilities. Hence IMC clinical staffs are now well versed on how to do a rapid cholera test at any given time and are also capable of managing cholera cases based on standard treatment protocols.



2) MEDAIR PREPARES FOR CHOLERA OUTBREAK

Over the past two years, the Ministry of Health declared an outbreak of cholera in Juba County. Following the declaration, the national cholera taskforce was mandated to initiate concrete interventions for cholera prevention and control. The initial cases in Juba were traced back to 18 May 2015 in UN House PoC where the first cholera case was confirmed on 1 June 2015.

The measures adopted by the Ministry of Health and non-governmental organizations have led to interrupting the transmission of the disease. . In 2015, a total of 1,601 Cholera cases including 45 deaths have been recorded, where as in 2014, cholera killed 46 people out of 2,260 registered cases before the disease was contained following the interventions of WHO and other aid agencies.

Though intensive efforts have been made in hygiene education and cholera awareness over the last two years, cholera is still an important public health problem in South Sudan.

MEDAIR has been working with national authorities and partners on the ground to prepare for any outbreak of cholera. In **line with this, MEDAIR's Health** and WASH Emergency Response Team is planning to conduct a survey in Kator payam and Rejaf payam **to determine the communities' relative vulnerability** that had been at high risk. The survey intended to stamp out the disease by improving WASH practices and engaging the community in implementation of control measures, and sustaining control efforts to prevent its re-emergence.

(3) HEALTH CLUSTER PARTICIPATES IN THE INTRODUCTION OF IPV AND THE SWITCH OF TOPV TO BOPV IN SOUTH SUDAN

Following the recommendation of WHO's Strategic Advisory Group of Experts (SAGE), in September 2014, South Sudan submitted applications to introduce at least one dose of IPV into the routine immunization schedule by the end of 2015. MoH together with partners adopted Objective 2 that urges countries currently using OPV in routine immunization to introduce at least one IPV before the end of 2015 in preparation for removal of OPV type 2.

The EPI TWG developed a proposal and submitted to GAVI to introduce IPV in South Sudan. The MoH with support from WHO and UNICEF introduced one dose of IPV in the routine immunization schedule in all health facilities.

Preparation and implementation status:

- National and State level TOT on IPV /REC approach was conducted between July and October 2015.
- Vaccine and injection material stock management books distributed to all levels prior to the introduction date.
- Field guide on vaccine management including SOPs that in cooperate IPV were developed and disseminated to counties and health facilities.
- Vaccine management training was provided to state and county cold chain assistants.
- About 126,000 doses of IPV received in 2015 and additional 140,000 doses are expected to arrive by the end of April 2016.
- Vaccinators drawn from each health facility were trained using the revised training materials.
- Supportive supervision was provided for overall performance of the immunization program and in particular on data collection practices and vaccine safety (AEFIs).
- IPV has been introduced in the seven stable states.

Status of IPV Implementation by State as of 1st April 2016

State	Total functional Health Facilities	Implementing Health Facilities	% of implementation	Remarks
Central Equatoria	185	139	75%	
Eastern Equatoria	201	84	42%	Breakage of Cold chain in some counties
Lakes	117	93	79%	
Northern Bahir El Ghazal	121	103	85%	
Warrap	109	80	73%	
Western Bahir El Ghazal	94	73	78%	
Western Equatoria	189	29	15%	Insecurity to access the facilities
Total -7 states	1016	601	59%	
Jonglei	42	3	7%	Based on accessible counties
Unity	17	6	35%	Based on accessible Counties
Upper Nile	91	NA	NA	
National	1166	610	52%	

Update on TOPV to bOPV Switch

The Ministry of Health of the Republic of South Sudan with due recognition of the WHA recommendations on Polio, and further advice from Global agencies including GPEI, WHO and UNICEF intended to implement the Switch from tOPV to bOPV plan as contained in the Global Endgame Strategy. Since June 2009, the country has no recorded case of Wild Polio Virus; but in September 2014, the country responded to an outbreak of circulating Vaccine-derived Polio Virus type 2. The Switch Plan is intended to ensure effective withdrawal of trivalent Oral Polio Vaccine (tOPV) and use of bivalent Oral Polio Vaccine (bOPV) to effectively eliminate the risk of cVDPV2 in the country. The switch day for South Sudan was 28 April 2016. The implementation and monitoring plan have been developed and approved by the Inter-agency Coordination Committee (ICC). The plan provides details of the structures and activities that would ensure a successful withdrawal of tOPV in all cold chain facilities in the country. The ICC provides oversight responsibility for the Switch, relying on the technical and administrative advices of the EPI Technical Working Group.

Implementation status:

- ✓ State Switch Coordinating teams comprising the EPI Team (SMoH, WHO, UNICEF and partners) as well as two additional support teams, 1 county support team, and 2 health facilities teams have been recruited. The entire staffing is dependent on the available polio staff (Field Supervisors and Assistants) at the lowest level.
- ✓ Training of State Supervisors/Coordinators as well as Support teams was accomplished.
- ✓ 5000 field training manuals and handouts have been prepared and distributed to all states. In addition, tOPV withdrawal bag and accompanying tags and forms have also been distributed to all states.
- ✓ Two SIAs (1 SNID covering Lakes, Warrap, Eastern Equatoria and Terekeka County and Juba PoC and one NID held on 15 February and 15 April 2016 respectively) were conducted as last doses for herd immunity for type 2 polioviruses as well as recommended doses to further interrupt the circulating Vaccine Derived Polio Virus type 2 outbreak.
- ✓ tOPV inventory are ongoing following the just ended NID.
- ✓ bOPV stocks have been repositioned in the stable areas

ASSESSMENTS AND RESPONSE

HEALTH CLUSTER PARTNERS ASSESS FOUR COUNTIES (MUNDRI EAST, WAU, AYOD AND PIBOR)

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

RRM Matrix for the Month of April.

Total number of beneficiaries through mobile response	36,083
Total number of outpatient consultations conducted	3,954
Number of measles vaccination given to children in emergency or returnee	28,045
Number of measles vaccination given to children above 5 up to 15 yrs in emergency or returnee	14,094
Number of births attended by skilled birth attendants	567
Communicable diseases outbreaks detected and responded to within 48 hours	2
Number of pregnant mothers who attended ANC	2,304
Number of facility based delivery	689
Number of pregnant women who received clean delivery kits	896
Number of mothers attended PNC	3,395
Number of pregnant/lactating women PLW screened with MUAC	1,094
Number of children (6-59 months) screened with MUAC	3,607
Number of children (6-59 months) diagnosed for SAM (MUAC<11.5 cm)	204
Number of children (6-59 months) diagnosed for MAM (MUAC ≥11.5cm -<12.5cm)	694
Number of location of which a mobile response team has been deployed for an intervention	5
Number of RRM responses leading to permanent NGO presence in the area	

(1) HEALTH PARTNERS ALERT URGENT RESPONSE NEEDS IN WAU

Fighting in and around Wau Town over the past three months has generated displacement and urgent humanitarian needs. Among the needs identified by the community were food, water, shelter and non-food items (NFIs). The malnutrition situation was also reported to be concerning, with an increase of acute malnutrition rates among children and pregnant and lactating mothers. Further, displaced community noted the need to enroll displaced children into existing schools before the commencement of final exams.

In regard to the ongoing tensions and security situation in Wau Town and surrounding payams, there are reports of lack of humanitarian access to r displaced populations outside of Wau Town with missions to the southwest area being denied on three separate occasions.

Currently there are two types of displaced populations in Wau Town. The first are former inhabitants of the south and western parts of Wau Town who were displaced as a result of insecurity in mid-February 2016. The second are those who were initially displaced from Kpaile, Bagari and Bessilia payams into Wau Town in November and December 2015 as a result of insecurity in the exterior payams. These people were then displaced a second time in mid-February, when they fled to Wau Town centre during the fighting.

Both groups of displaced populations were invited to the Isaac stadium in Wau Town for the assessment. Relief and Rehabilitation Commission estimated the number of displaced to be 96,000 individuals. At the time of the assessment, it was also reported that there were 12,000 IDPs who remained in hiding in the south of Wau County, and that the main villages were largely deserted. On 6 April, DTM partners commenced the verification of displaced people in Wau town.



There are 4 functional healthcare facilities in Wau Teaching Hospital, Locoloco, Bazia Jedid, and Jabel Kheir with one functional cold chain. There are 4 months supply of essential medications but no anti-retrovirals and PEP-kits. The highest disease burden is diarrhea, acute respiratory disease and malaria with pregnancy-related illness and injuries also significant as cause of morbidity. Malnutrition is a serious problem with GAM up to 50% of the population.

In nearby Gette Boma in Udici Payam, given the high number of cases reported with diarrhoea and poor sanitation

in the camp, urgent provision of additional drugs including hygiene promotion is needed to prevent an outbreak of diarrhoea. Many women delivered in the camp in the past week, more reproductive health interventions need to be delivered to encourage women to deliver in a health facility. The Mboro Boma is highly insecure with frequent attacks, the health facility has been vandalized, drugs and equipment looted, data tools shredded. The solar fridge in the facility was damaged and all things thrown about. There are no EPI services at the facility. The health workers are now providing services under a tree, which is also a storage area. This may not continue when the rains start and storing the few remaining drugs will be very challenging.

(2) RAPID ASSESSMENT TO MUNDRI EAST BY CUAMM

After weeks of insecurity in the Mundri East, the RRM team was finally able to undertake an assessment in the County as part of the Initial Rapid Needs Assessment (IRNA). CUAMM is the medical partner operating in Mundri East so the Health Cluster coordinated with CUAMM to carry out the assessment.

Three health facilities were visited – Lakamadi, Lozoh, and Kediba. The health facilities in Lui Payams have suffered substantial damage with situation particularly poor in Lozoh. Malaria, acute watery diarrhea, acute respiratory infection and pneumonia being the leading cause of morbidity in the communities. Records in Lozoh have been looted during insecurity. Health facilities in all three health facilities, reports stock out of drugs, lack of clean water source, lack of functional cold chain, and general poor infrastructure. In Lozoh, there have been 22 reported deaths from October due to lack of healthcare and medicines that has not been able to get into the facilities due to ongoing insecurities.

In Lamazadi, health care workers are bringing vaccines from nearby PHCU in Kasiko on a monthly basis. Last routine EPI in Lozoh was from October 2015. There are a severe shortage of midwives and antenatal attendant in the Payam. The closest health facility could be 4 hours away.

It is clear from the assessment that healthcare service in Mundri East is extremely poor. CUAMM was able to bring with them core pipeline commodities as part of the response. But the community requires far more that.

After the IRNA, CUAMM has commenced the process of starting a sustainable response in the area.

(3) COSV RESPONSE IN AYOD COUNTY

Since 2006, COSV has been implementing programs in Ayod County/ Jonglei State. Ayod County is made up of five payams including Pagil, Wau, Pajiek, Gorwai and Mogok. In 2013, COSV was appointed by the South Sudanese Ministry of Health as the Health lead agency in Ayod County to support the County Health Department in the provision of primary health care and rehabilitating the existing non-functional 12 facilities located in the different payams.

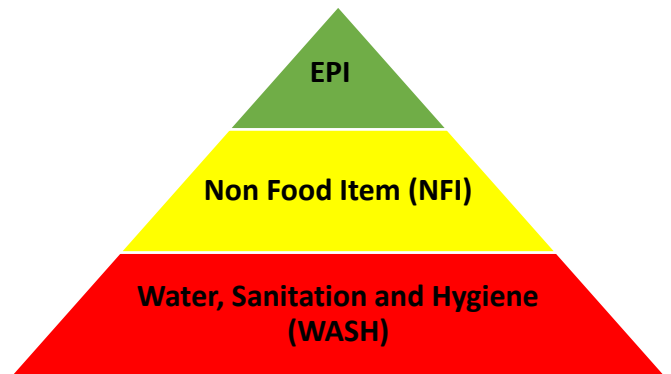
COSV uses a multi-sectoral approach, which ensures the integration of health and nutrition services in delivering its programs. The organization works closely with the health cluster partners not only in strategizing on health responses but also in responding to emergencies in a coordinated manner.



Post December 2013 conflict, Ayod County was identified as one of the priority areas for emergency interventions, as it is considered the safe destination for internally displaced persons fleeing the conflict in the Upper Nile and Unity states.

Following the arrival of the new IDPs, the COSV and IOM RRM team conducted an Inter-agency Rapid Needs Assessment (IRNA) to assess the humanitarian situation in Wiechdeng and respond to the needs the IDPs as well as host community. Hence COSV and IOM, with support of the Health Cluster, responded to the arrival of 4,100 new IDPs in Wiechdeng/Pagil Payam.

According to the results of the assessment the humanitarian needs in Wiechdeng is alarming. WASH is the most urgent need followed by NFI and EPI. The communities have not received health and nutrition services, including SIAs or SNID campaign. Recently measles outbreak was reported in Lowir and Got islands.



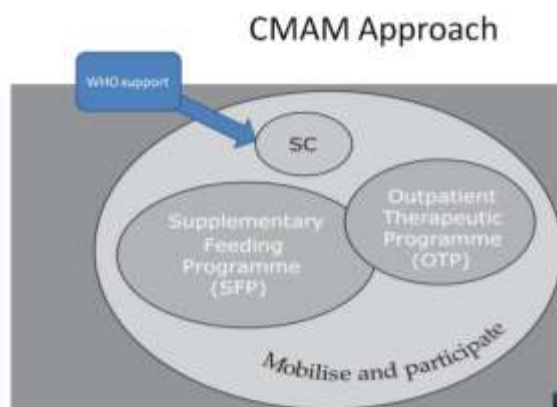
The RRM team recommendation was shared with the health cluster partners and resources are being mobilized to address the needs of the community in Wiechdeng. To cover the needs of the community, COSV, the lead health agency in Ayod County responded by strengthening the capacity of the Pagil PHCU (3 hours walking distance from Wiechdeng) and expanding the outreach activities to Wiechdeng and surrounding areas to reach more women and children. The COSV team will continue responding to the different humanitarian needs of Aayod County.



EMERGENCY NUTRITION

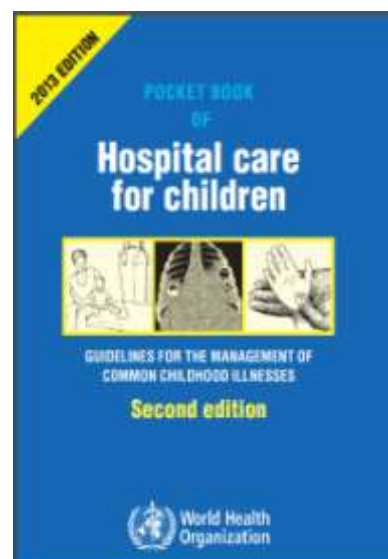
WHO EMERGENCY NUTRITION (EN) ASSEMBLES MEDICAL KITS FOR MALNUTRITION

WHO Emergency Nutrition (WHO EN) in collaboration with MOH ROSS and WHO Logistics, is moving forward with assembling the malnutrition medical kits to support Inpatient therapeutic program in South Sudan. The provision of supplies is part of a comprehensive strategy implemented by WHO EN and MOH RoSS in South Sudan, which retains primary focus on the Inpatient care component of the Community-Based Management of Acute Malnutrition (CMAM) approach.



The strategy includes capacity building, supplies management and monitoring. WHO EN has developed a capacity building package to support medical staff working frontline in hospitals and PHCC treating complicated malnutrition. The package includes training material, handouts, photos depicting medical complications associated with SAM for immediate identification, WHO has produced a video on Emergency Treatment in Nutrition wards. The package also includes the WHO Hospital Care for Children Pocketbook 2013. These guidelines focus on

the management of the major causes of childhood mortality and related conditions, including severe acute malnutrition, a valued and useful references for inpatient management of SAM children with medical complications.



Partners can use the link below to access the "The Pocket Book"

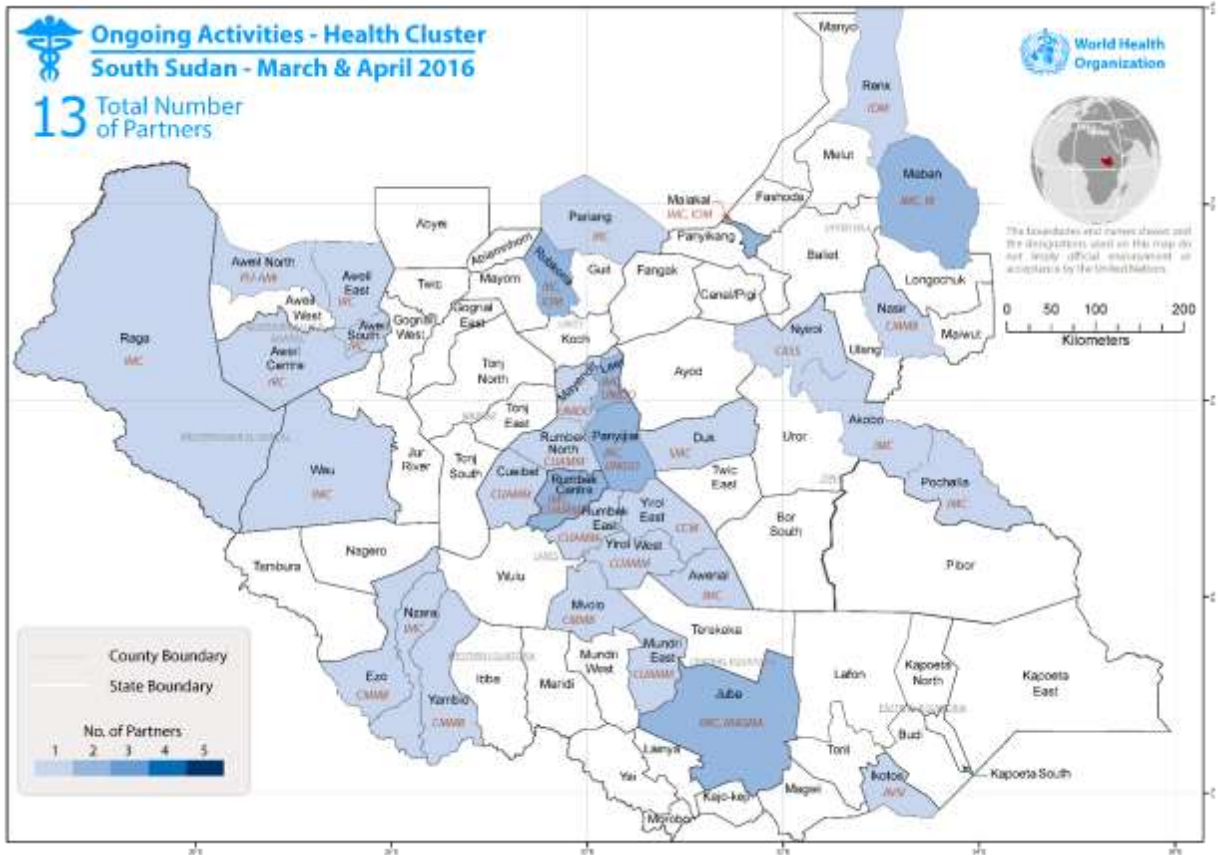
http://www.who.int/maternal_child_adolescent/documents/child_hospital_care/en/

"WHO EN PROVIDES TECHNICAL SUPPORT TO MOH AND PARTNERS"

WHO EN continues to provide strong technical support for integrated health and nutrition rapid response in various locations in South Sudan. These currently include response in Ulang, Upper Nile, and Isoko, Eastern Equatoria. Technical and strategic guidance is also ongoing on the nutrition section of the concept Note for Joint Health, Nutrition, WASH Clusters Response Work Plan.

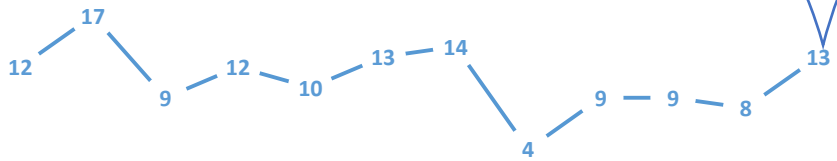
"HEALTH CLUSTER HAS 67 PARTNERS INCLUDING DONORS, UN, AND INGO AND NGO"

APRIL HEALTH CLUSTER INTERVENTIONS AS PER 5W DATA



Agencies reporting to the 5W

IRC, PU-AMI, IMC, MAGNA, UNIDO, AVSI, SMC, CCM, CASS, RI, IOM, CMMB, CUAMM



May	June	July	August	September	October	November	December	January	February	March	April
2015						2016					

DEDICATED HEALTH CLUSTER WEB SITE

The health cluster is pleased to announce A SNEAK preview of the website under development which can be found on **www.southsudanhealthcluster.info**. The new website is being designed to help improve navigation and make access to information easier. .



PROGRESS ON HEALTH CLUSTER NOTE AND WORK PLAN

HEALTH CLUSTER VISIBILITY AND COMMUNICATION UPDATE

The communication and visibility strategy of the Health Cluster is intended to foster visibility and raise the public profile of the cluster response. It is also intended to communicate **“positive results of partnership”** with the cluster partners and donors who make it possible for the responses to be effective. In so doing beneficiaries are also made aware of the partnerships that work together to support the health response.

To heighten the visibility of the health cluster the donors and partner involvement in response at all levels, The health cluster has committed to a onetime procurement and distribution of a limited number of visibility and IEC items earmarked for capacity building and fielded based response. They include multiple use banners during capacity building workshops, T-shirts and notepads and a set of health cluster guide documents for field use and for building the capacity of cluster partners.



ACHIEVEMENTS ON THE HEALTH CLUSTER NOTE RESPONSE PLAN

Activity	Milestone/Strategy	Progress
Dry season repositioning – exercise with core pipeline managers	Coordination meeting with Pipeline partners per quarter: 1 meeting	Core pipeline managers were facilitated to present progress on the commodities in the country and where they have been repositioned.
Monitoring and evaluation and Supportive Supervision (every 2 months)	DSA and air-ticket for 6 for every 2 months	2 monitoring / support visits were conducted. The third one, which was to be conducted in Ulang, did not take place because of security reasons.
Health Cluster Coordination Meeting (national 2x;state, weekly; sub-sub 2x)	Meeting with health cluster partners: 52 meetings at 11 sites	Two meetings were conducted for the month of April 2012
Health Cluster Coordination Meeting (weekly; sub 2x)	Meeting with health cluster Partners: 52 meetings at 10 sites	Cluster meetings in the states were conducted as per schedule
Mapping of health cluster deliverables and compilation of data analysis	Data analysis /IMO support	5 Ws for the months of April and data analysis were done Progress has advanced on the Health cluster specific website under development
Scale up rapid response modality	Support the deployment of RRM teams	HC Partners have engaged in RRM response to the measles outbreak in 4 counties
Develop, print and distribute IEC materials	T-shirts, fliers and banners	A request has gone out for banners/Tshirts/notepads
Support the recovery of looted facilities in conflict affected states	2 facilities per month	Funding not yet secured, but advocacy and application has been sent to CERF for consideration. The health cluster is working on this activity in conjunction with WHO country, office and WHO regional and the GHC
Facilitate logistical support for Pharmaceuticals and referrals.	Support for pharmaceuticals and Referrals.	Funds not yet secured/ mobilized. The health cluster is working on this activity in conjunction with WHO country, regional and the GHC. The cluster is providing support to the Pharmaceutical technical working group on mapping of partners to support the last mile distribution and drug consumption data

GLOBAL HEALTH CLUSTER (GHC) AND HEALTH SECURITIES AND EMERGENCIES MISSION TO SOUTH SUDAN

The Global health Cluster (GHC) provides a platform for organizations to work in partnership to ensure collective actions result in a timely, effective, predictable and accountable response to health emergencies

Persistent insecurities in the more stable states, coupled with the current economic challenges, have led to continuous widespread displacements, fluid populations and significantly increased humanitarian needs. With the removal of the L3 emergency status, South Sudan has become a protracted crisis, while the needs have increased, donor interest has continued to decrease, and key international NGOs are reducing operational capacities, due to high operational costs and insecurities. WHO Country Office (WHO CO) and the health cluster partners raised the impact of the reduced funding against the increased demand for response for both emergency and developmental health service delivery. At the request of the WHO CO as the cluster lead agency, 2 levels of WHO strata comprising of representation from the Global Health cluster - Dr. Gabriel Novelo Sierra, the Regional AFRO Health Securities and Emergencies Cluster - Dr. Nsenga Ngoy conducted a mission to South Sudan from the 14-22nd of April.

The objectives of the mission were to review the cluster mechanism and assess coordination performance at national and subnational levels. This included identification and mapping of coordination capacity and structure, health interventions, and health information management in relation to the 6 functions of the cluster deliverables including accountability to the affected population. To make recommendations and identify core advocacy concerns related to health cluster interventions and inter-cluster collaboration in South Sudan.

The team met with the WR, key UN agencies, Ministry of Health (MoH), health cluster partners, donors, and selected other cluster coordinators. In addition, the team visited Bentiu and Juba PoCs to assess sub-national coordination and response.

Findings:

- ✓ Regular coordination forum exists at the national and state levels (Malakal /Bentiu /Bor)
- ✓ A strong collaboration and partnership exists with the MOH
- ✓ A health HRP exists articulating response priorities and strategic guidance
- ✓ A cluster note exists to operationalize the HRP and to focus resource mobilization efforts
- ✓ Strong Evidence of health leadership on inter cluster collaboration and strategic response between the Health/Nutrition/WASH Clusters
- ✓ Active Health Cluster resource mobilization so far solicited over 4.7 USD for partner response in 2016
- ✓ Established early Warning and Response Network (EWARN) providing valuable information at state level intervention sites to detect and respond to outbreaks.
- ✓ Capacity building exists for partners and MOH and also for focal points that double hat as Cluster coordinators
- ✓ Cluster bulletin exists to report on cluster activities



The Global health cluster team in a discussion with the Health Strategic advisory group on the 7 functions of the health cluster in Juba.



- Dr. Kediende and Dr Nsenga in discussion with HC partners



The Global and South Sudan health cluster team at the IMC clinic in Juba PoC.



The Global and South Sudan health cluster team visiting the IRC clinic in Bentiu PoC.

Recommendation:

- ✓ Human Resource for in country coordination is thin and surge oriented: Need for dedicated Health Cluster Coordinators/IMO/M&E/Public Health officers/logisticians including a dedicated cluster envelope to strengthen cluster efforts.
- ✓ Partners were also encouraged to continue the response efforts and to own the cluster partnership. Country level gains made in inter cluster programming will be developed further at the international level. The health cluster to publish widely all the activities they engage in.

Experience from the field has highlighted some overlaps and gaps in emergency interventions in South Sudan where there already exists an interface between Health, Nutrition and WASH Clusters. In November 2015 Nutrition and Health Clusters, technically supported by WHO Emergency Nutrition (WHO EN), developed a set of Nutrition Sensitive interventions to be implemented by the health sector. The strategy has been presented during Health Cluster Meeting in late 2015 and it is currently reflected in the Health Cluster Response strategy for 2016 and integrated in the Rapid Response matrix for **“Minimum Package of Health Intervention, integrating nutrition.”** In recent months, the three clusters have collaborated during the violence in Malakal Protection of Civilians (PoC) sites and the hepatitis E outbreak in Bentiu PoC. These efforts clearly demonstrated a recognized need to better-defined roles and responsibilities of the different clusters outside of the emergency context in order to avoid duplication of effort whilst ensuring that all areas of need are covered within the humanitarian response.

The rationale for better integrating Health, Nutrition and WASH programs is both to enhance the coordination of all three sectors and to build more comprehensive and integrated programming leading to common objectives and goals that will improve the lives of population in South Sudan in a more predictable and sustainable manner. This combined work plan outlined in this concept note will outline this synergistic approach.

Key areas for integration of Health, Nutrition and WASH programmes would include:

1. Identify overlapping geographic work areas: Health, Nutrition and WASH programmes typically focus on the most vulnerable populations including geographic areas with high poverty rates, households without sanitation facilities, regions with high percentages of wasting (acute malnutrition) and areas with poor or no access to health facilities. In the context of South Sudan, the Protection of Civilians (PoC) sites are potential locations for joint interventions between the three clusters, but this does not exclude other locations of identified needs.
2. Identify and agree on a set of criteria for selecting locations for joint interventions
3. Recognize interventions that affect Health, Nutrition, and WASH. Programmes in all three sectors require social mobilization that includes preventive measures, harmonized and improved referral system and rapid response mechanism.
4. Develop a monitoring framework to document the impact of joint interventions versus separate activities, taking advantage of the current Clusters reporting systems.
5. Map out the capacity of partners implementing cross-sectoral activities, to identify gaps and strengthen capacity accordingly
6. Joint activities will have common objectives and goals as well as inter-accountability among all clusters involved and not assigned only to a single cluster/ lead organization.
7. This combined approach will develop activities to be integrated by other clusters/sectors that will look into the specific nature of the work of each one individually rather than a generic list of the same interventions.

NATIONAL UNV MIDWIVES TRAINED ON GENDER EQUALITY AND GBV IN SOUTH SUDAN

In 2015, UNFPA in collaboration with the national Ministry of Health and with funding from the Government of Canada deployed 15 national UN Volunteer Midwives across the country to work alongside the 30 international midwives initially posted to provide midwifery and reproductive health services. These national midwives are among the graduate midwives from the initial 4 Health Science Institutes in South Sudan likewise supported by UNFPA with funding from Canada.

The volunteer midwives provide a wide range of direct services including conduct of safe deliveries and basic emergency obstetric and new born care (EmONC) as well as provide health education, counseling and support to women and families.

To strengthen their skills and build their capacity to provide gender sensitive midwifery services, UNFPA organized a three-day workshop for the national midwives on gender equality and gender-based violence (GBV). The training was facilitated by a team of Gender and GBV Specialists from UNFPA South Sudan Country office supported by Ms. Dorothy Nyasulu, Gender Specialist from the UNFPA Malawi Country Office.

The training aims at equipping the midwives with knowledge and skills on gender and gender based violence so that they are able to provide culturally sensitive, gender responsive and human rights compliant midwifery information and services to women, girls, individuals and families in South Sudan.

The workshop opening was graced by H. E. Mr. Nicholas Coghlan, the Canadian Ambassador in South Sudan who reiterated the commitment of the Government and People of Canada to continue supporting the efforts towards reducing maternal and neonatal morbidity and mortality in South Sudan. He recalled on how when he first came to South Sudan there were only 11 midwives in the country. He praised the young midwives for having chosen the noble career of midwifery and assured them that whatever challenges they are likely to encounter in the course of their work, they should put in their best efforts knowing that they are among the heroines and heroes of contributing to saving mothers and new born lives. He urged the national midwives to work closely with their international colleagues with whom they are serving in various health facilities across the country to further enhance their **skills from the latter's experience.**

On his side the UNFPA Representative a.i in South Sudan Mr. Ibrahim Sambuli thanked the Canadian Ambassador for having spared some time from his busy schedules to officiate at the opening session of the Workshop. He assured the Ambassador of **UNFPA's commitment as has been echoed by none other than the UNFPA Executive Director to ensure prudent utilization of the resources provided by the Government and People of Canada and demonstrate desired results from the supported Projects.**

UNFPA with funding from Canada has been implementing the Strengthening of Midwifery Services Project and the Deploying Midwives project since 2012 and 2013 respectively with the aim of increasing the number of trained Midwives and deploying UN volunteer Midwives across the country to provide midwifery service and for clinical mentoring of nursing and midwifery students. The second phase of the Strengthening of Midwifery Services Project up to 2020 is now being co-funded by the Governments of Canada and Sweden.



H.E. Mr. Nicholas Coghlan, Canadian Ambassador in South Sudan and Mr. Ibrahim Sambuli UNFPA South Sudan Representative a.i. during the workshop opening ceremony.



Mrs. Erica Talentino, UNFPA South Sudan GBV Specialist facilitating GBV training for national UNV midwives in Juba.

“Equipping such health workers with Gender and GBV knowledge will have a multiplier effect on the ground” said Mrs Dorothy Nyasulu, GBV Specialist and facilitator at the training. “They will be able to start the dialogue with clients they will meet, mobilise communities and address the structural challenges and barriers that affect uptake of services such as family planning¹” she added.

“As a male midwife this training is timely for me in the sense that I learned how to receive clients regardless of their ages and gender and also how to provide counseling and care to GBV survivors” said Archangelo Utum, UN volunteer midwife serving at Aweil State Hospital.

Midwives are critical front line staff, who play vital role in ensuring women and girls together with their families access quality sexual reproductive health and rights services.

According to the State of the World Midwifery 2014 Report, investing in educated and well-trained midwives can save millions of lives each year and will contribute to healthier families and communities and will also help end preventable child and maternal deaths. It also adds that 87% of the essential care for women and newborns can be performed by an educated midwife.



National UNV Midwives posing in group during a training on Gender equality and GBV in Juba

South Sudan has some of the world’s poorest health indicators, with a maternal mortality ratio estimated at between 2,054 and 1989 per 100,000 live births (SHHS, 2005; 2010). The number of health professionals is quite low generally estimated at 10% of the staffing norms filled by trained health workers and only 0.15 doctors and 0.2 Nurse/midwife per 10,000 populations.

¹ The contraceptive prevalence rate (CPR) in South Sudan is at 4.7% and 52% girls are married by the age of 18 years. [SSHHS 2010]

BEST PRACTICE

(1) NEONATAL CARE IN YIROL HOSPITAL

Yirol hospital is a referral hospital located in the Eastern part of Lakes State. It provides Comprehensive Emergency Obstetrical and Neonatal Care for a population estimated at 270 000 inhabitants. Since the inception of the CUAMM CEmONC project in the county, **women's access to essential services**, including antenatal and postnatal care, has tremendously improved. Admissions increased from 474 in 2010 to 1438 in 2015, with an average of 120 deliveries per month in 2015 and 124 deliveries per month in the first quarter of 2016.

In the last quarter of 2015, CUAMM established a new neonatal unit which offers 24/7 neonatal resuscitation as well as neonatal care. Since October 2015 to date, this unit offered services to over 50 newborns, of which 14 were referred cases from other health facilities and babies born in the communities .

The hospital has made significant progress in performing life-saving interventions. The main causes of admissions are sepsis (33.3%) followed by prematurity (27%) and asphyxia (21%). Prematurity accounts for 47% of neonatal death among the admissions.

	2010	2011	2012	2013	2014	2015
Total deliveries	474	738	1089	1226	1461	1438
Maternal Deaths	8	3	6	3	4	2
% maternal deaths among hospital deliveries	1,7%	0,4%	0,55%	0,24%	0,27%	0,14%



A mother from Anuol, who had forced by her relatives to escape the hospital with her premature baby girl walked back to the hospital after two days to seek for a newborn care.

(2) HEALTH AND NUTRITION SERVICES IN FANGAK AND NYIROL COUNTIES

In November 2015, Christian Mission Aid (CMA) signed a small scale funding agreement (SSFA) with UNICEF to implement health and nutrition services in Fangak and Nyirol Counties of Jonglei State.

The response aimed at reducing acute malnutrition affecting the children in Fangak and Nyirol Counties through Outpatient Therapeutic Program (OTP) and training of nutrition workers to effectively and efficiently manages cases of moderate acute malnutrition in the communities.

Achievements of the response:

- To enhance service delivery, two new OTPs were established in Chuil and Pultruk PHCCs.
- From 14 to 17 March 2016, a total of 13 nutrition workers (7 male & 6 females) were trained in Community Management of Acute Malnutrition (CMAM) at Chuil and Pultruk PHCCs.
- In January 2016, ACF conducted a three days training to 33 staff (11 males, 22 females), in nutritional screening, admission criteria, mobilization and nutrition referral. Additionally, ACF conducted two IYCF trainings to 57 staff in Keew, of which 43 trainees belong to mother-to-mother groups. The group were trained on importance of exclusive breastfeeding, complementary feeding, good positioning and attachment.
- In Juaibor, MEDAIR provided trainings to 6 community nutrition workers and 21 community outreach workers.
- Management was provided to a total of 314 (boys & girls) MAM cases and 1,328 (boys & girls) SAM cases in Keew. Currently, 374 are still admitted in the hospital, 227 of them were discharged.



CMAM Training in Pultruk PHCC



These two girls being enrolled into OTP in Chuil PHCC

(3) INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI)

The Ministry of Health (MOH) of the Republic of South Sudan is committed to accelerating child survival interventions to reduce child morbidity and mortality in the country. In April 2016, UNICEF supported the MOH in updating the protocol of the Integrated Management of Childhood Illnesses (IMCI) to include aspects of newborn care (IMNCI). Subsequently, UNICEF supported the MOH to conduct a three-week training of trainers to 25 medical personnel from across the country. The IMNCI training also targeted community health workers in the IMNCI practices, using the human rights approach in working with children and communities.

The core group of trainers will support the scale up of the programmes with plans for rolling out IMCI training in the country. It is also expected that the IMCI programme will help improve childcare practices by involving communities at all level to reduce childhood diseases, especially in children less than five years of age.

UNICEF in collaboration with the MoH, WHO and health partners launched the National Immunization Days (NIDs) in all counties except Pibor, Pochalla and Ulang. During the campaign 2,400,000 children under 5 were vaccinated against polio. In addition 300,600 doses of bOPV were provided to children under 5 in the seven stable states. In response to the measles outbreaks in Bentiu PoC, Twic, and Aweil west, UNICEF provided 678,000 doses of Measles vaccine.



Trainees undergoing a practicum on IMNCI

(4) REINFORCING RATIONAL DRUG USE IN JUBA UN HOUSE

International Medical Corps (IMC) is constantly striving to provide high quality care to patients while maintaining an efficient and resource-conscious work model. In the UN House, IMC is able to provide these services primarily through the support of OFDA, CHF, UNFPA and UNICEF.

In the UN House, most of the community members have preconceived notions of which and what type of medications they should receive regardless of their actual diagnosis and needs. This has led to significant pressure on staff members to dispense medications that may not be the optimal course of treatment. This led to irrational use of essential medicines.

To combat this tendency, during the first quarter of this year, the IMC Site Manager and the Medical Coordinator analyzed the use of essential medicines in the health facilities and trained health workers on the rational use of essential medicines in April. A significant progress has been made following the refresher training as well as the presentation on the findings of the use of drugs.



As a result, prescriptions are aligned to the **IMC Pharmacist presenting findings on Q1 Drug Use in UN House.** **needs of patient's diagnosis.** This shows that staff and the community renewed their commitment to a rational drug use and understanding of its importance that best meets the needs of the patients.



IMC Clinical Officer discussing how to successfully communicate with patients regarding prescriptions.

5) BRINGING HEALTH EDUCATION TO THE COMMUNITY IN DUK

In order to minimize the rate of outbreak in Duk, Sudan Medical Care developed a new strategy on how to reach people with health knowledge within the community. This is important because SMC acknowledges that members of the community that are educated and sensitized through health education program will be able help take precaution and prevention diseases.

The SMC strategy on health education was rolled out in April 2016 in all of the facilities supported by Sudan Medical Care.

150 beneficiaries in average are registered per day with health education. The majority of beneficiaries are reached mostly Sundays after church services.

From the 14th to 20th of April, the number of beneficiaries reached with health education was 2,387 beneficiaries. For the whole month of April, SMC is expecting to reach more than 5000 beneficiaries.



Health education session carried two times daily in the facility: Duk County.

It is worth mentioning that of the four health facilities are participating in the health education strategy, Poktap has been completely renovated The Padaiet facilities are partially completed.



The picture seen above is the school room which is used as a health facility. The facility structure was destroyed during the war and this circumstance forced SMC to operate in it. We had no option because of the high returning number of IDPs/hosts in the area in Duk padiet.

6) REACHING THE INVISIBLE CHILDREN AND WOMEN

Ikwotos County is one of the seven counties in Eastern Equatoria state. It is located on the southwestern part of the state. The community resides through the eight Payams, which are on the valleys of the greater Lomohidang and the Imotong ranges.

There are 27 functional health facilities spread within the Payams and Bomas of the county; 21 PHCUs, 5 PHCC and one missionary hospital. Access to health services provision remains a huge challenge, particularly for pregnant women and children. People are required to walk long distances to reach health facilities as most of the community settlements are on the mountainsides. This has negatively impacted the EPI coverage, ANC and skilled birth deliveries with as a result death from vaccine preventable disease and complications and death related to pregnancy.

To address limited access to health services in the county, AVSI international in partnership with the county health department with funding from health pool fund (HPF) is keeping hope alive for many invisible children and women residing on the mountains and valleys of county through its outreach program. Two teams comprising of trained health personnel operate the integrated outreach program: these are mobile teams operating in hard to reach areas and health facility teams in the villages of their catchment areas. Mobile teams technically are comprised of midwives, vaccinators and community health workers (CHW) while the health facility teams are constituted of midwives, clinical officers and vaccinators. All the teams are linked to the community by a network of community volunteers engaged in mobilization and disease surveillance.



RESOURCE MOBILIZATION

"HEALTH CLUSTER ENGAGES DONORS FOR EFFECTIVE 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. In April, the Financial tracking system for health reports 23% funded with a deficit of over USD 85M. The cluster continues to invest in donor time for the effective realization of the requirements in the HRP.

An appeal has also been launched with the Cluster lead agency to advocate a resource envelope for operationalizing the health HRP.

~~In the event of a return to the PoC, it is important that cross support the availability of the funds to ensure response is sustained and to also prepare to interrupt transmissions resulting from population movements.~~

Donor ~~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 Melakal PoC, Mundri East, Mundri West and Maridi

SUCCESS STORIES

(1) DELIVERING ESSENTIAL SURGICAL SUPPLY TO INACCESSIBLE GANYIEL

(2)

In December 2015, International Rescue Corps, with funding from the Health Pooled Fund (HPF), opened the Ganyiel Reproductive Health Centre, the first operating theatre in the history of Panyijiar County. Before the facility opened, when there was a medical emergency, the people of greater Ganyiel might walk 12 hours to reach Nyal where there were several health facilities but no operating theatre.



The WHO team loading trauma kits and essential medications.

In the first seven weeks after it opened, the IRC run operating theatre in Ganyiel carried out 33 operations including five emergency Caesareans and five major surgeries. However, the facility reported shortage of surgical supply and anesthetic kits. .

Some 500 kilograms of medical supplies including trauma, anesthetic and inter-agency kits were transported through a UNMISS helicopter on humanitarian mission to Ganyiel. These supplies were loaded into the helicopter by the health cluster coordinating staffs including the visiting from Juba.

(2) WHEN THE HEALTH CLUSTER TOOK ON AN ARMY – RUBKONA PHCC

When we look at health partners' activities in Unity State, much of the attention has been on Bentiu PoC. Recently, members of the Health Cluster together with Global Health Cluster visited Bentiu PoC and Rubkhona.



Health negotiated the military to leave, the Health Cluster promised to work with its partner's to operate the PHCC. Intense discussion between the County Health Department (CHD) and the military carried on for one month but finally the military vacated the Rubkhona PHCC in 2015.

Rubkhona PHCC has been non-operational since the conflict in 2013. The facility was looted and occupied by the military as their base.

When the Ministry of Health approached the Health Cluster focal point about starting mobile clinics in Rubkhona to address the gap in healthcare services in town, Dr. Guracha presented a much more sustainable proposal.

Mobile clinics by their very nature are not sustainable and do not offer long-term solution to the chronic needs of the population so Dr. Guracha asked the Unity State Ministry of Health to work with the military to vacate the PHC so the already existing infrastructure can be used to support health service delivery. When the Ministry of



Beneficiaries at the Rubkhona PHCC.

The Health Cluster was able to coordinate with partners working in Bentiu, initially with CARE and then IRC to begin service delivery in PHCC. The PHCC now is a comprehensive health facility that serves the growing population of Rubkhona with an integrated service delivery package comprising of nutrition centre, EPI, maternity and outpatient department.

Health Cluster partners worked in excellent collaboration with the Ministry of health to strengthen the health facility capacity to function at its ultimate response, here evidenced to have provided real time support on capacity, commodities and service.

Working together with the Ministry of Health to fulfilling that responsibility ensures a sustainable health system for the community.

(3) THE HEALING OF A BROKEN HOSPITAL



Around 50 percent of South Sudan's medical facilities have been destroyed or looted, according to estimates by Health Cluster Health Resources Availability Mapping System (HeRAMS) and those that are operating are running at a reduced capacity. This is a challenge that many Health Cluster partners are now facing.

During the spring of 2014, the Bentiu Hospital, the largest in Unity State, became the scene of one of the most horrific massacres in the region. The town had flipped back and forth between government and opposition control in the weeks before April 15. But on that day, opposition fighters launched an attack on the facility. The hospital lost much of its equipment and all doctors fled to less dangerous areas. The hospital no longer has the resources they need to do their jobs.



Some two years after the Bentiu Hospital was attacked, much of the carnage remains. It has been looted many times over. Glass and syringes litter the floor. Only a small outpatient clinic run by the International Rescue Committee and a UNICEF child nutrition site were running and a 24-hour maternity ward run by the IOM has just opened. They serve about a tenth of the number of patients the hospital used to.

The Health Cluster partners in Bentiu and the County Health Department (CHD) have a three-step plan to restore access to medical care in Bentiu Hospital. The first is to rebuild and provide infrastructure - buildings, electricity and equipment. Number two, supplies and drugs. The third point is to make sure that the county has enough doctors and support staff. Many medical personnel have fled, leaving the country with a critical shortage. The health cluster partners have worked tirelessly to provide health services. The Health Cluster and its partners regularly engage the CHD despite many challenges.



More ore positive stories coming out from Bentiu Hospital during our visit include Health and WASH Clusters working together to bring clean and safe water to the hospital. A new water tank has been installed and workers are now digging new drainage.

There is much more to be done to rehabilitate Bentiu Hospital. With increasing population moving back to Bentiu town, a functional Bentiu Hospital is a necessity when the Health cluster strategies are engaged to implement the Beyond Bentiu, response plan.

(4) IOM SUPPORTS OUTPATIENT SERVICES AT BENTIU STATE HOSPITAL



IOM Reproductive Health Assistant conducts a health education session for Breastfeeding Mothers at Bentiu State Hospital

On Monday 4th April 2016, IOM's Health Rapid Response Team began providing outpatient services at the Bentiu State Hospital. The hospital, which is the largest in Unity State, was the scene of a horrific attack in April 2014 that led to loss of lives and damage to the expensive equipment and infrastructure present at the hospital. All the medical personnel working in the facility fled, including 17 doctors, and this rendered the hospital non-functional. IOM took over the outpatient services from IRC, which had been running a mobile clinic at the facility from the last quarter of 2015.

With Coordination among MOH/WHO/The Health cluster/ and medical supplies from the UNFPA and UNICEF core pipeline, the hospital is now offering consultations for adult and pediatric cases, EPI, Health Education and Reproductive Health Services in addition to the TB testing and treatment program that has been in place in the hospital from February 2016.

The Director General of the State Ministry of Health, Dr. Wigoah Pieny, acknowledged and appreciated the support that IOM is providing to the needy population of Unity State, who had nowhere to go since the conflict broke out two years ago.

(5) THE IRC IMPROVES MATERNAL-CHILD HEALTH AND SURGICAL CARE IN RURAL PANYIJAR COUNTY



*The Operating Theatre at Ganyiel PHCC ready to receive patients.
Photo Dr Omoke.*

On 17 December 2015, the International Rescue Committee (IRC) in conjunction with the Panyijiar County Health Department officially launched Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services at the Ganyiel PHCC. This was after the completion of an operating theater at the PHCC with support from the Health Pooled Fund (HPF) grant. WHO, UNFPA and UNICEF provided essential in-kind donations to facilitate lifesaving surgical activities in the operating theater. The facility is run by one Medical Doctor with support from the County Health Coordinator who is also a medical doctor supported by the IRC through the HPF. The CEmONC facility offers services to the whole of Panyijiar county which has an estimated population of 74,734 as per the mid -year 2015 WFP census. Previously patients had to be referred to Leer which has since become impossible due to the ongoing conflict.

When the CEmONC Centre started operating, the first operation conducted was a cesarean section successfully done on 24 December 2015. As of 31 March 2016, 40 surgical operations had been successfully conducted at the facility among them 10 caesarean sections, 8 laparatomies and 23 minor surgeries. One of the patients who have benefitted from the services is an 18 year old Nyaboar from Pator Boma in Ganyiel Payam, who presented to the facility on the 8th of April 2016 at night with a case of extended breech with arm presentation. The patient and her relatives were counseled and they finally consented to the operation. A cesarean section was conducted with a successful outcome of a 2.8kg live female infant. The mother was very happy and said, ***“I am very happy because the operation was done successfully and the life of my baby was saved. I will advocate to other mothers on the importance of hospital delivery because had I not come to the hospital, I might have got complications and even lost my baby”.***

Though a lot still needs to be done to improve the facility in terms of infrastructure and personnel, the IRC/CHD, Ganyiel health staff continues to strive to offer lifesaving services to the people of Panyijiar County.

There has been a 98% success rate with only 1 mortality reported during post-operative care after laparotomy.



*Nyaboar with her newborn baby girl born through caesarean at Ganyiel PHCC.
Photo Dr Omoke. Photo taken and used with written consent from the client*

FACES OF HUMANITARIANS

Dr. Argata Guracha is a Medical Officer/Communicable Disease Surveillance and Response working for World Health Organization Based in Bentiu.

He is a field Epidemiologist who has been involved in strengthening communicable disease surveillance, outbreak investigations, strengthening coordination among partners who work in emergencies as well as strengthening information systems.

Where is your home?

My Home is in Nairobi, Kenya

How did you end up working in humanitarian work?

After completing medical school, I was posted to one of the most remote districts in Kenya. I was the only medical officer on call all the time. I felt that even the most remote, unreached communities also deserve my skills. That is how I got more and more attached to working in the Humanitarian world.

What do you find rewarding about working in your duty station?

It is most rewarding when my intended intervention brings medical services and hence save the lives of the most vulnerable population inside and outside of the Bentiu PoC, I feel more energized when my efforts contribute to reaching especially children with lifesaving vaccines.

What do you find frustrating?

I feel frustrated when I see the population suffers, being displaced from their villages. It really feels bad if you think that these persons were forced to move into IDPs due to situations out of their control.

What is the one thing you miss the most from home?

The greatest thing I miss is being with my family.



Dr Argata Guracha, IFP, WHO, Bentiu Field Office



**Ms Khawater Makki,
Country Director, COSV**

Khawater Makki is the current COSV (Co-ordination of Organization of Voluntary Services Country) Director in South Sudan. She is a bachelor holder in English language and literature and a Masters degree in Peace and conflict studies with over ten years of experience in the nonprofit sector and extensive skills in management, analytical insight, monitoring and evaluation and cultural sensitivity. Prior to taking on COSV leadership, she worked with UNICEF, WFP, Oxfam GB, Samaritans Purse and Atlas Corps in programs related to health and nutrition, food security, and peace building. In her spare time, Khawater enjoys reading and listening to music from different parts of the world.

Where is your home?

Originally I am from Sudan.

How did you end up working in humanitarian work?

When I was young, my school bus always drove past the WFP office in Khartoum, around the time the staff was getting onto the shuttle to go home. The mass combination of people who looked different, and came from different places, but worked together in one place and were all speaking one language and laughing with each other fascinated me. I made a promise to myself to join that group when I finished school and was older.

What do you find rewarding about working in your duty station?

The appreciation and gratitude from the women in the remote communities who give birth in a safe environment, and the smiles on the faces of children, when they are nursed to health by the health responders.

What do you find frustrating?

People who take decisions about situations, and places they have never been too.

What is the one thing you miss the most from home?

Being cared for by my Family

PRIORITIES FOR MAY

- Dry season prepositioning - exercise with core pipeline managers
- Mapping of health cluster deliverables and data analysis
- Scale up rapid response modalities
- HC strategy for responding to the multiple measles outbreak
- Support the recovery of looted facilities in conflict affected states engaging development partners
- Facilitate logistical support for pharmaceuticals and referrals.

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