# Bulletin # 03 *March 2016*

## HIGHLIGHTS

| | |
|---|---|
| CONSULTATIONS | 141,590 |
| INDIVIDUALS REACHED THROUGH HEALTH EDUCATION | 9,228 |
| ASSISTED DELIVERIES | 2,085 |
| ANC SERVICES | 9,061 |
| MEASLES VACCINATION | 21,114 |
| % HRP FUNDED | 11% |
| HEALTH CLUSTER PARTNERS *(47-INGO, 16- NNGO,4 - UN)* | 67 |

4.73 M PEOPLE IN NEED

2.5 M TARGETED FOR HEALTH

1.6 M DISPLACED

300,000 REFUGEES

*Dear Partners,*

*Thank you for the continuing support and for the good work that you do,*
*We are encouraged by your energies.*

## March 2016 Gallery

*Presentation of Health/ Wash/ Nutrition strategy to state focal point*

*Group discussion on leadership*

*Dr Allan Mpawire presenting on Emergency Response*

*Dr David Lai presenting on RRMse*

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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 neighboring countries.

The Health cluster and partners are now fully engaged with the MOH /other clusters/donors/ in implementing the health responses articulated in the 2016 Humanitarian Needs Overview and 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. In March the health Strategic Advisory group with the coordination leadership have worked on a strategic response health work plan that will support the operationalization of the 2016 health humanitarian response plan. This is necessary as advocacy for resources to deploy dedicated coordinators in the various locations especially in the 3 conflict affected states including the Equatoria's is imminent. With a focused work plan the WHO focal points who are double hatting the health cluster role have been trained by the health cluster team to ascertain a smart technical focus in guiding the response at the various levels.

March has witnessed yet more displacements primarily in the Equatorias and In Pibor, but it has also engaged new strengths. Health cluster partners have continued to rise to the myriad of challenges and have respond to them in a timely manner. All the assessments conducted and participated by the health cluster partners in March 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 Pibor, Weichdeng and Mayom. Health cluster partners have reopened the maternity wing in Bentiu hospital and recorded impressive levels of maternal access to skilled birth attendance and improvements in reproductive health delivery.

The POC's spaces within the UNMISS base have largely remained calm and have continued to receive health intervention with the exception of the intercommunal conflict that occurred in the Juba POC mid-March. This resulted in a number of injured residents requiring critical health response. The health cluster foresaw the potential for strengthening key partners within the POC to respond and took advantage of this. Effective collaboration between partners led to the prepositioning of Health commodities including trauma kits and surgical capacity for immediate response.

The Health cluster in March 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 in early February, morbidity due to HIV/TB co infections and high reports of suspected HEP E cases.

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.

March 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 is working 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.

## *HUMANITARIAN NEEDS AND GAPS - HRP*

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

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

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

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

There is the need to:

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

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

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

There is a severe shortage of health human resources to respond to frontline health needs. Injectable vaccines require a skilled health workforce to respond including assistance for obstetric emergencies in humanitarian settings. This is stemming from an overall nationwide shortage of health human resources. (1 doctor to a population of 65,574 individuals, I 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 heath facilities to sustain emergency health response

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

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

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

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

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

## COORDINATION

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

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

1. Advocacy for the allocation of humanitarian resources for partner response in (Minkaman/Western Equatoria/ Upper Nile- Malakal POC)
2. Write Up of Draft cluster Note and Work plan for Resource mobilization
3. Operationalization of the Draft Health specific Humanitarian response work plan.
4. Training of State Focal points
5. Strategic Guidance on response to emerging ewarn/IDSR data of concern
6. Dry season preparedness
7. Health Core pipeline Commodities and prepositioning ahead of the rainy season
8. Creating opportunities for partners to understand peer programmes and to identify and share best practice.
9. Support to the Upper Nile HC coordination and response to the intercommunal conflict and displacement in the Malakal POC. Follow up on the update of the multisectoral plan between health nutrition and WASH partners to sustain the response for the next 3 months.
10. Support to partners implementing integrated TB/HIV services
11. Liaison with Wash Partners on response to rise in Hep E cases in the Bentiu POCs

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

### JONGLEI STATE:

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

### LAKES STATE: MINKAMAN

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

### UPPER NILE STATE:

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

- Partners have continued to meet fortnightly to monitor the 3-month Wash/ Nutrition/ Health activated response Plan
- Ongoing monitoring of health outreach and mobile response to the IDP's in Malakal town
- Continuous advocacy for resources for a more permanent reestablishment of the destroyed health facility structures.

### UNITY

In March, health cluster partners focused on moving services to areas accessible from Bentiu to Guit and Koch counties.

## ACHIEVEMENTS AGAINST HRP, MONITORING VISITES AND ACCOUNTABILITY TO THE AFFECTED POPULATION

### *60% OF EPIDEMICPRONE DISEASE ALERTS VERIFIED AND RESPONDED TO BY HEALTH PARTNERS WITHIN 48HR*

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;

- 21,114 of children age 0 – 59 months reached with measles vaccine through outbreak response campaign in CES, Warrap, Unity and NBS
- 141,590 consultations were provided in conflict-affected and other vulnerable states through the humanitarian health partners
- 2085 assisted deliveries conducted by skilled birth attendants in conflict-affected and other vulnerable states. In addition, 11 health workers received training on safe delivery
- 9061 representing 53% (17,095) of the cumulative women provided ANC services since January
- 9228 individuals were reached with health education and promotion messages

See below, progress update on the 2016 HRP;

**(Results** *indicated in this table is cumulative annually, beginning January of 2016*) **Implementation Updates - March, 2016**

| Indicator Description | Baseline | People in Need | Target | # Achieved |
|---|---|---|---|---|
| **Objective 1*: Improve access, and scale-up responsiveness to, essential and emergency health care, including emergency addressing the major causes of mortality among U5C (malaria, diarrhoea and Pneumonia), obstetric care and neonate services*** | | | | |
| % decrease in Crude Death Rate | 0.14 | 811470 | ≤1 | 0.42 |
| % decrease in under 5 Crude Death Rate | 0.33 | 107409 | ≥2 | 5.32 |
| % increase in # births attended by skilled birth attendants in conflict affected and other vulnerable states | 36% | 101432 | 41% | 2.1% |
| % 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. | 231368 | 231368 | 6941 | 710 |
| **Objective 2: *Prevent, detect and respond to epidemic prone disease outbreaks in conflict affected and vulnerable states*** | | | | |
| % of epidemic prone disease alerts verified and responded to within 48 hours | 79% | | 90% | 60% |
| Proportion of children 6 to 59 months receiving measles vaccinations in emergency or returnee situations | 47% | 481802 | 80% | 6% |
| Proportion of people reached by health education and promotion before and during outbreaks | 56% | 1242542 | 80% | 0.7% |
| **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 March 2016, a supportive field monitoring and supervisory visit was conducted with Rural Twic East County, Jonglei State. The purpose of the visit was to verifying the progress, quality, and challenges of project implementation and help to provide evidence-based decision making.

During the visit, some vaccination teams were facilitated to travel to Diam-Diam; a hard to reach community in swampy area that houses fishermen and cattle camps. These vaccination teams vaccinated some children against vaccine preventable diseases including oral polio and pentavalent.

*"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- See Snapshot Below

In March, the cluster-focused commitment on the accountability to affected population was based on using the Monitoring and evaluation field mission to engage the communities to actively seek out community satisfaction of health response. (Pillar 3) .Quick assessments were conducted through discussions with community leaders and other social structures (county health department, community health volunteers) and humanitarian actors present at the location. Community members expressed satisfaction on the lifesaving interventions provided by humanitarian partners. The requested additional funding support to sustain the gains registered in cold chain to strengthen immunization against vaccine preventable diseases.

### 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 •

## SYSTEM PERFORMANCE AVERAGES

- IDSR Performance: 41.5% Completeness
- EWARN Performance:  78.8% % Completeness

## CONSULTATIONS

- IDSR: Average total consultation per week was 68,432, and cumulatively was at 781,142.
- EWARN: Average total consultation per week was 21,777, and cumulatively was at 326,778.

## MORBIDITY TRENDS

- IDSR: Malaria was the top cause of morbidity in non-conflict affected states with average proportionate morbidity of 31.3%. Registering an average 21,477 cases per week and cumulatively 218,998 cases by the end of March, 2016.
- EWARN: Acute respiratory infections (ARI) was the top cause of morbidity in the conflict affected sites with average proportionate morbidity of 27%. Registering an average 5,635 cases per week and cumulatively 72,243 cases by the end of March, 2016.

## MORTALITY TRENDS:

- IDSR: A total of 77 deaths were reported from the stable areas in March 2016, with 17 (22%) deaths attributed to malaria and  46 (60%) occurring in under 5 years
- EWARN: A total of 134 deaths were reported from the conflict affected areas in March 2016, with 18 (23.4%) deaths attributed to TB/HIV/AIDS and 47 (61%) occurring in under 5 years CMR and U5MR remain below emergency threshold of 1 and 2 per 10,000 death per day.

**2016 Measles alert**

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

## *VACCINATION IN HARD TO REACH PLACES. TEAM GOES OVER RIVERS AND INTO BUSHES SAVE THE CHILDREN LAUNCHES MEASLES CAMPAIGN IN MAYOM.*

During the recent measles outbreak, Health Cluster partners have responded quickly and efficiently in launching campaigns in many Counties. One of most challenging location that our Health Cluster responded to is in Mayom County. There have been 60 suspected measles cases reported in 5 Payams in Kuerbona, Mayom Town, Pub, Mankien and Riak.

There are a total 169 villages in Mayom County. Many of these villages are only accessible through rivers and thicket bushes. As a result, the team has to travel on foot for many hours in order to get to the communities; many of these communities have not received healthcare services for years. There are many logistic issues involved need of a boat and inaccessibility from a vehicle. There are villages that the mission team is unable to reach due to security issues. The pastoralist lifestyle of the population also makes it more difficult for the vaccination team. Despite all the challenges, Save the Children was able to cover 85% of the County.

Initially, the approach was to vaccinate the entire county in 7 days. However, after assessment of available resources, specifically cold chain capacity, a staggered approach was implemented over 14 days. The vaccination include fixed sites located in existing health facilities, fixed advanced in the location without existing health facilities and most challenging of all, mobile sites in hard to reach places. The campaign consisted of combined measles vaccination and vitamin A supplementation as well as rapid nutrition screening (MUAC)

Save the Children issued 51, 580 doses of vaccine. Covering 165% of the community health department target. Like many counties in South Sudan, lack of sufficient cold chain capacity is an ongoing issue. Particularly in Mayom, the logistics in moving cold chain materials to inaccessible areas prove to be very difficult.

The health cluster partner recommends that cold chain capacity should be thoroughly check to manage concurrent campaign in the whole county. Building partnerships, working with health cluster and collaboration with local partners/INGOs can facilitate and accelerate deployment. Finally, the need of authentic population data is very important for precise micro planning and avoidance of stock outs in the course of the campaign.

## PREPAREDNESS AND RESPONSE

### PREPAREDNESS FOR CHOLERA

The Cholera season is fast approaching and concerted preparedness efforts have been put in place to strengthen the response

Oral Rehydration Salts and Diarrheal Diseases Kits have been prepositioned in strategic locations in high risk states. In addition to this trainings have been scheduled for the following states (CES, EES.JONGLE,WBG, NBG and other affected states). The health and Wash cluster will be coordinating, implementing and evaluating the response jointly with an inter cluster joint strategy.

Below are key information for partners and health workers.

### *RECOMMENDATIONS FOR ENHANCED ACUTE WATERY DIARRHEA SURVEILLANCE IN SOUTH SUDAN*

**Suspect cholera case definition:**

Any person 2 years and above that presents with diarrhoea (three or more loose stools in 24 hours) should be regarded as a suspect cholera case and should undergo the following:

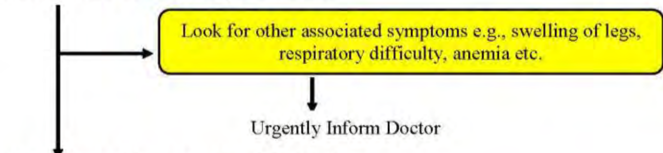
**Recommended actions for suspect cholera cases:**

1. All suspect cholera cases should undergo onsite rapid diagnostic testing for cholera.
2. All suspect cholera cases with that test positive using the cholera rapid diagnostic tests should have their stool samples preserved in Carry Blair and shipped to the national reference laboratory for microbiological culturing.
3. At least three stool samples should be collected daily from suspect cholera cases, preserved in Cary Blair and shipped in a cold box with frozen icepacks to the national reference laboratory for microbiological culturing. This recommendation will be reviewed in 1-2 weeks' time depending on the laboratory isolation findings.
4. Please note that rehydration of suspect cases should not be delayed by preparations to obtain and conduct stool testing.
5. However, endeavor to collect the stool samples before antibiotics are initiated.
6. Community health workers should therefore conduct active case search in the villages by moving from house-to-house seeking for any one with lots of watery stools and referring them to the designated treatment centers for assessment and treatment.
7. All health workers working in Health facilities should be alerted about the updated case suspect cholera case definition and should use the case definition to identify suspect cholera cases and refer them to the laboratory for testing.

Any patient ≥ 2 years presenting with acute watery or rice watery diarrhoea with or without vomiting and with signs of dehydration should be suspected as a case of cholera during an outbreak (*children <2 years can also be affected during an outbreak).* Acute watery diarrhea – passage of watery or liquid stools ≥ 3 times in last 24 hours

**Management of patients presenting with acute watery diarrhoea**

Patient with acute watery diarrhoea




**Assessment of the patient for dehydration**

| | | | | |
|---|---|---|---|---|
| **Assess** | Condition | Normal | Irritable/Less active* | Lethargic / Comatose* |
| | Eyes | Normal | Sunken | |
| | Tongue | Normal | Dry | |
| | Thirst | Normal | Thirsty (drinks eagerly)* | Unable to drink* |
| | Skin pinch | Normal | Goes back slowly* | Goes back very slowly* |
| | Radial pulse | Normal | Reduced | Uncountable or absent* |
| **Diagnosis** | | **No sign of dehydration** | If at least 2 signs including 1 (*) sign is present, diagnose **Moderate Dehydration** | If moderate dehydration plus 1 of the (*) signs are present, diagnose **Severe Dehydration** |
| **Management** | | A | **B** | **C** |

**A. No sign of dehydration – ORS**

- 50 ml ORS per kg body weight over 6 hours *plus* ongoing losses
- Send patient to home with 4 packets of ORS
- Feeding should be continued
- Return if condition does not improve or deteriorates
- Maintain hydration, replace continuing fluid losses until diarrhoea stops

**B. Moderate dehydration – ORS**

- 80 ml ORS per kg body weight over 4 – 6 hours *plus* ongoing losses
- Patient should be kept under observation for 6 - 12 hours
- Feeding should be continued
- Reassess the dehydration status frequently - hourly.
- In case of frequent vomiting (>3 times in 1 hour): Treat with IV fluid
- Maintain hydration, replace continuing fluid losses until diarrhoea stops

**C. Severe dehydration – IV Sodium, potassium, bicarbonate solution (Ringer's lactate)**

- Start IV fluid immediately (100 ml/kg)

**Children < 1 year:** give 100ml/kg IV in 6 hours, as follows

30 ml / kg in the first 1 hour then
70 ml / kg in the next 5 hours

**Adults and Children ≥ 1 year:** give 100 ml/kg IV in 3 hours, as follows

30 ml / kg as rapidly as possible within 30mn and then
70 ml / kg in the next $2^1/_2$ hours

- Monitor regularly and reassess rehydration status
- Encourage the patient to take ORS solution (5ml/kg per hour) as soon as he/she is able to drink
- Start antibiotic after initial rehydration (4-6 hours)
- Maintain hydration, replace continuing fluid losses until diarrhoea stops

**Antibiotics in cholera outbreak for South Sudan**

- Antibiotics should be given **ONLY** to cases with **SEVERE DEHYDRATION**. This should be done under supervision of a **MEDICAL DOCTOR** in a **HEALTH FACILITY**
- Choice of antibiotics depends on local sensitivity pattern

***First line drug (except in pregnancy)***

- **For adults:** Ciprofloxacin, 1g (500 mg x 2) – single dose after correction of severe dehydration
- **For children:** Ciprofloxacin susp. 20 mg /kg – single dose after cessation of vomiting (if any)

***Second line drug***

- **For adults:** Azithromycin, 1g (500 mg x 2) – single dose after correction of severe dehydration
- **For children:** Azithromycin susp. 20 mg /kg – single dose after cessation of vomiting (if any)

***Alternative drugs***

- Doxycycline, 300 mg (100 mg x 3) – single dose after food (*Adults only, except in pregnancy*)

## *HEALTH CLUSTER PARTICIPATES IN THE TAKE OFF MILESTONE TOWARDS THE ELIMINATION OF CEREBRO SPINAL MENINGITIS IN SOUTH SUDAN*

South Sudanese Youths turned out en-mass to be vaccinated against meningitis.

Cerebrospinal meningitis (CSM) refers to the inflammation of the meninges (the covering of the brain and the spinal cord), and is usually due to infection with the bacterium Neisseria meningitides A (Nm A). The disease is commonly spread by contact with an affected individual's respiratory secretions, such as coughing or kissing and is highly contagious. CSM has an equally high fatality rate if not recognized and treated properly. CSM is prevalent in South Sudan and The Republic of South Sudan falls in the 26 countries in Africa that lies in the Africa Meningitis Belt, which records the largest burden of cerebrospinal meningitis (CSM) in the sub-Saharan Africa.

The Government of the Republic of South Sudan is committed to the protection of the population and the elimination of this disease in its health profile and has focused energies in 2016 to ensure massive coverage. The vaccine has an expansive positive knock on effect. It will protect the (1-29) age group against the Nm A for ten years. It will protect children as young as one; and it is expected to both protect children from the disease for significantly longer periods as the vaccine will reduce infection and transmission and in turn protect the larger community, including family members and others who have not been immunized.

The mass vaccination campaign against the CSM disease which started 15th March through 5th April, 2016 will protect over 5 million South Sudanese youth in the age group of 1 to 29years. 70% of the entire population of the country in the stipulated age group will be covered during the 1st phase of the campaign in the Greater Equatoria and Greater Bahr el Ghazal. The 2nd phase is expected to cover the Greater Upper Nile. This phase is also expected to take off soon.

## ASSESSMENTS AND RESPONSE

### *HEALTH CLUSTER PARTNERS ASSESS 3 COUNTIES (WEICHDENG, MAYOM, PIBOR) IN JONGLEI AND UNITY STATES*

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 March for 3 Counties**

| Total number of beneficiaries through mobile response | 265,993 |
|---|---|
| Total number of outpatient consultations conducted | 23,345 |
| Number of measles vaccination given to children in emergency or returnee | 2,394 |
| Number of measles vaccination given to children above 5 up to 15 yrs in emergency or returnee | 4,432 |
| Number of children vaccinated with OPV | 1,334 |
| Communicable diseases outbreaks detected and responded to within 48 hours | 0 |
| Number of PLW diagnosed with MAM | 924 |
| Number of PLW diagnosed with SAM | 642 |
| Number of children screened with MUAC | 1,935 |
| Number of training conducted for existing partners on the ground | 1 |
| Number of direct beneficiaries from emergency drug supplies | 534,593 |
| Number of location of which a mobile response team has been deployed for an intervention | 3 |

### *"HEALTH CLUSTER BRINGS RESPONSE TO INACCESSIBLE AYOD COUNTY "*

Ayod County in Jonglei State is currently flagged as one of the priority areas for emergency intervention with 4,100 newly internally displaced persons in Weichdeng. The general population of Weichdeng is estimated at 38,000. The population is in dire need of life saving health and nutrition services.

**IOM and COSV in Weichdeng**

Since UNHAS currently does not have regular scheduled flight to Weichdeng, this presented a particular challenge to the Health Cluster partners planning an assessment and response in the area. Health Cluster had worked closely with IOM, COSV, Logistic Cluster and UNHAS to secure flight going and returning from Juba to Weichdeng for this assessement. This has been a unique learning experience but the knowledge gained will be valuable fro further mission.

**Conducting assessment in the community**

In March, COSV and IOM deployed a joint assessment and response mission to Weichdeng. The objective was to assess reports of humanitarian need resulting from conflict-related displacement that occurred from April 2014. The team was stationed in Weichdeng for 13 days and visited Lorbek, Weibuok and Panbich villages. The team conducted a simultaneous IRNA and response for health and nutrition. The Weichdeng centre was reportedly almost completely deserted as some of the host population has moved to the Toch swamps, as pasture and water is dried up in Weichdeng. The team met multiple families residing with the host community, at an estimated ratio of about four IDP families to one host family for the IDPs encountered.

Suspected measles cases were reported, and therefore investigation into the need for a vaccination campaign is recommended. As the last EPI vaccination is unknown, establishment of emergency immunization with at least polio, measles for children under 15 years and tetanus for pregnant women is highly recommended.

The main challenges are access constraints as a result of distance from Weichdeng to Pagil and Old Fangak respectively. There have been no immunization services and no reproductive health services which are urgently needed.

Pibor Town: destroyed MOH / IMA / Kissito PHCC with scattered papers

Pibor: MSF PHCC busy on 14/03/16

Pibor was ransacked shortly after the designation of the town as capital of the new "Boma State". Compounds belonging to a number of international aid and development organizations were looted, including Doctors without Borders, INTERSOS, Vétérinaires Sans Frontières and AECOM, Polish Humanitarian Action, Finnish Church Aid and UNOPS. Relief workers and about two thousand civilians in Pibor took shelter at the UN base in the town during the outbreak of fighting from 23 to 25. The situation in Pibor and the surrounding area remains tense with significant presence of armed groups. As part of UNOCHA multi-sectoral Initial Rapid Needs Assessment, Health Cluster partner Medair sent a team from ERT Health to identify health needs, assess gaps and make recommendations for a health emergency response in Pibor.

Working in one of the most challenging location in the country, the Medair team identified the lack of access to primary health care services in Vertet Payam for IDPs and vulnerable host community as the most urgent priority. As a result of this assessment, Medair plans to respond by bringing in primary health care services in Vertet with focus on maternal and child health provision. In addition, there will be provision of drugs, supplies for curative consultations and distribution of Clean Delivery Kits, prioritizing under-5s and women, for the commonest causes of morbidity. Capacity building and training of CHW in reproductive health will be one of the main focuses of the response.

Medair along with many Health Cluster partners are active participants of the Health Cluster Rapid Response Mechanism Working Group. This group works hard to identify priority areas and aim to response quickly in an integrated manner.

### *"WHO EMERGENCY NUTRITION CONSOLIDATES NUTRITION INFORMATION FROM MULTIPLE SOURCES INTO THE EWARN BULLETIN AND PROVIDES ANALYSIS FOR IDENTIFYING NUTRITION CONCERNS AND ALERTS"*

WHO Emergency Nutrition (EN) is supporting the development and maintenance of a comprehensive mechanism for information sharing and dissemination of nutrition data, in close coordination with WHO EWARN team. In March 2016 WHO EN has consolidated nutrition information from multiple sources into the EWARN bulletin and has provided analysis to identifying nutrition concerns and alerts. Locations were covered in Unity (Mayendit North), where MUAC screening of children under 5 confirmed suspected emergency levels of acute malnutrition and Lankien in Jonglei where the GAM prevalence was found below the emergency threshold of 15%, but SAM rate indicated acute levels. IPC updates and map were also translated in the bulletin. A factsheet on Nutrition in EWARN has been prepared to support information exchange and it can be found on the HC website.

### *"PROCUREMENT OF DRUGS FOR THE WHO KIT FOR INPATIENT MALNUTRITION COMPLETED"*

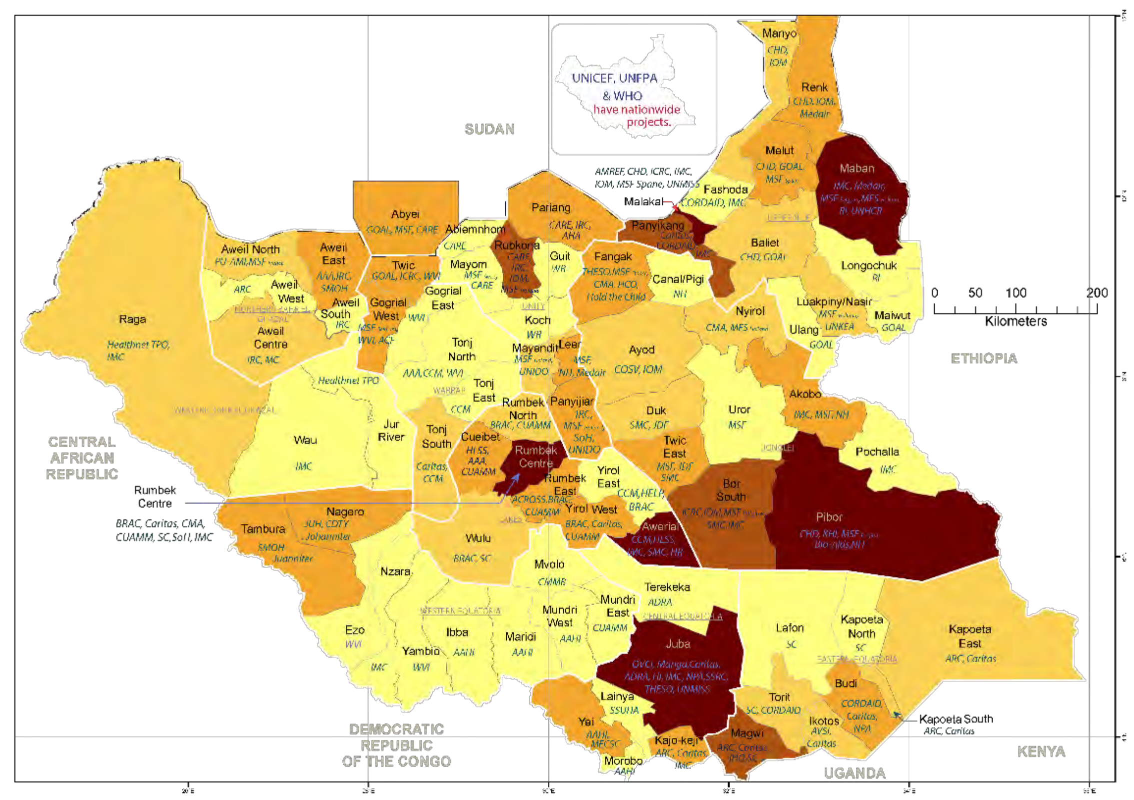
With all supplies finally in WHO warehouse in Juba South Sudan, WHO EN is taking final steps and getting ready to launch the intervention and coordinate the overall distribution plan of medical kits to ensure provision of supplies to PHCC and hospitals, prioritizing expressed needs in conflict-affected and high burden states, in collaboration with implementing partners, MoH, Health and Nutrition Clusters.

### *"WHO EN PROVIDES TECHNICAL GUIDANCE TO MOH AND PARTNERS"*

- CMAM guidelines: WHO EN has conducted technical review of the first and second drafts to ensure quality and appropriateness of the protocol.
- Maternal and Infant and Young child Nutrition strategy development process: provided guidance on IYCF in the context of HIV, based on national standards, IDP and non IDP settings adapted strategy, the producing user-friendly materials, filing information gaps on micronutrient deficiencies, and going beyond coverage assessment.

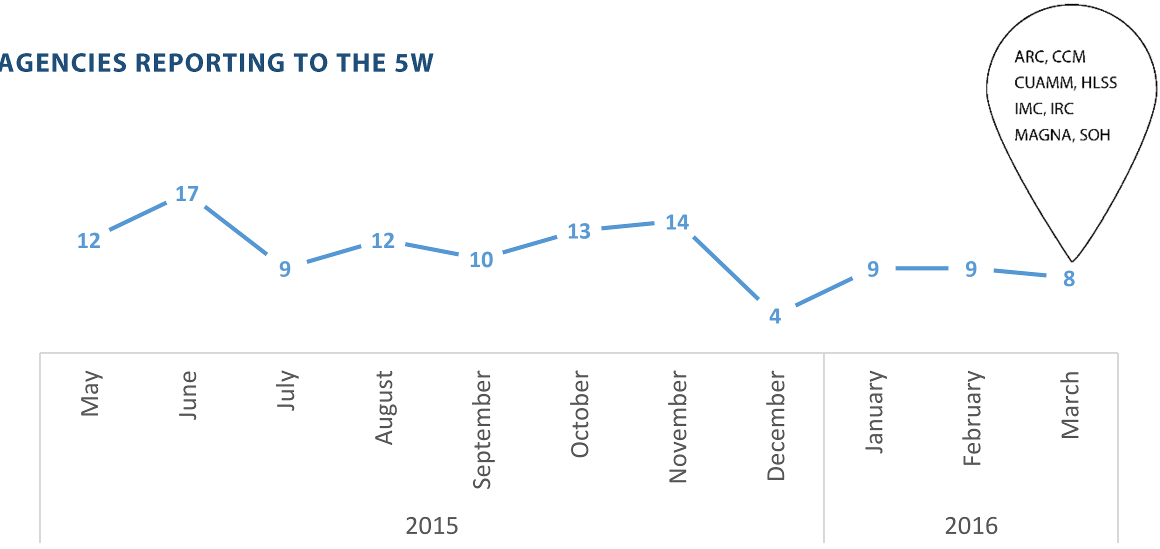
## INFORMATION MANAGEMENT

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




Health Cluster Partners presence map

## AGENCIES REPORTING TO THE 5W




Agencies reporting to the 5W

## PROGRESS OF HEALTH CLUSTER RESPONSE PLAN

### *"WHO AND HEALTH CLUSTER SOUTH SUDAN CONDUCTS ITS FIRST EVER TRAINING WORKSHOP FOR STATE FOCAL POINTS"*

**Juba, 19 March 2016 -** WHO country office held a three-day workshop for state focal points from 17 to 19 March 2016 at Juba Regency Hotel.

The objective of the workshop was to strengthen the capacity of WHO state focal points and Health Cluster Coordinators to develop substantive knowledge in the overall WHO technical outputs as well as Coordination related skills that will improve the performance of WHO and Health Cluster operations in South Sudan in line with the smart technical focus of the WHO/AFRO Transformation Agenda.

WHO Country Representative, Dr Usman during workshop

The workshop was launched by WHO Country Representative, Dr Abdulmumini Usman, who urged the participants to stay focused in order to realize the objectives of the workshop. Dr Abdulmumini also thanked the health cluster coordination team who facilitated the workshop under the leadership of Ms Magda Armah.

The 23 participants focused on intensive discussion and learning around five themes: building capacities on coordination for effective results from developmental and humanitarian response; contextual policy and WCO technical and health cluster operations; WHO visibility including effective reporting on outputs in programme implementation at all levels; strengthening programmes linkages and health sector development; and documenting and sharing best practice on health response. Technical assistance on health leadership provided by the WCO in South Sudan contributes to building capacities on developmental health response and health cluster performance. The cluster partners are dependent on health cluster vision for strategic health interventions and therefore WHO must ensure that the vision is sound.

WCO South Sudan State Focal Points and Health Cluster Team in a group photograph at the workshop

Dr Abdulmumini delivered a presentation on leadership and challenged the participants to uphold excellence, a focused vision and visibility in health leadership in order to generate significant inter-cluster multiplier effects in contributing to an enhanced and strengthened health system in South Sudan.

WCO national level programmes and Outbreaks and Disaster Management Unit were heavily involved and shared the direction of their programmes with the state focal points for technical collaboration and strengthened implementation at the states level. In addition, the state focal points reflected on a number of issues including inputs from WHO emergency nutrition focal point, OCHA, WASH and Nutrition clusters towards an effective and efficient integrated response. All focal points were guided to complete their State specific contingency plans for 2016.

At the closing ceremony, Dr Abdulmumini reminded the team to stay focused on health security and to forge ahead with taking health service delivery closer to the communities through the Boma Health Initiative to realize health gains in South

## *CONSORTIUM OF NATIONAL ORGANIZATIONS BRINGS FAMILY PLANNING TO COMMUNITY*

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

Children's Aid South Sudan (CASS) is a national non-governmental, not for profit organization founded by a group of South Sudanese with expertise in health, education, gender equality, livelihood and agriculture. CASS aims to address the problems of South Sudan's humanitarian situation based on the practical experience seen in the community by the founding members. Children's Aid South Sudan's contribution is towards improving the quality of health in the communities with emphasis on children and women. We strive to reduce and eventually eliminate absolute poverty, illiteracy and social inequalities in the South Sudan society. CASS partners with the community in identifying their own problems and solving them by using local initiative.

"*Scaling up Family Planning Services*" project is a project funded by HPF to support the scaling up of family planning services in the six states of South Sudan. The six states selected for this project are: Eastern Equatoria state, Lakes state, Warrap state, Unity state, Western Bahr-el-Ghazal state and Northern Bahr-el-Ghazal state. The project will be implemented by a consortium of the National NGOs which are composed of: Reproductive Health Association of South Sudan **(RHASS),** Children's Aid South Sudan **(CASS),** The Rescue Initiative South Sudan **(TRISS),** Universal Network for Knowledge and Empowerment Association (**UNKEA),** Peace Child South Sudan **(PCSS),** and Initiative for Rural Empowerment **(IRE).**

Aligned with the strategic priorities of the Government of South Sudan, Ministry of Health- Health Sector Development Plan 2012-16 (HSDP) and the Family planning Policy of 2013. The project is aimed at improving and strengthening the reproductive health services specifically Family Planning Services in the selected states from the state hospitals to the County hospitals, PHCCs and PHCUs.

**Discussing family planning in the community**

## 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. The health cluster has, since the beginning of the year, managed to mobilize USD 12.2 M.

Donors' pledges:
CERF: USD 1.850,000 will be allocated to the provision of primary health care services to internally displaced persons (IDP) and vulnerable population in Malakai PoC, Mundri East, Mundri West and Maridi and to the rehabilitation of two health facilities in Malakai PoC.

*CORE PIPE LINE COMMODITY SUMMARY*

### WHO: HEALTH COMMODITIES

3 types of IEHK

- Full IEHK-10,000 people for three months
- Basic Unit(1000people) and Supplementary unit(10,000)
- Diarrhea Disease Kits (700 people)
- Trauma Kits-A and B and surgical support module(100 surgical cases)

Kit is intended for use only in the early phases of the emergency and is neither designed nor RECCOMENDED for re-supplying the existing health care facilities.

### UNICEF: VACCINES AND COLD CHAIN

| N° | Antigens | Doses available | Doses in Pipeline | Doses in fund-raising proposal |
|---|---|---|---|---|
| 1 | Measles | 1,127,400 | | 910,072 |
| 2 | Penta | 875,500 | | |
| 3 | TT | 2,230,010 | | 0 |
| 4 | tOPV | 2,434,000 | | 0 |
| 5 | bOPV | 1,240,000 | | 32500 |
| 6 | IPV | 3,910 | 114,200 | |
| 7 | Men A | 349,340 | | 0 |
| 8 | BCG | 147,600 | 890,400 | 18,600 |

| N° | Description | Available | Pipeline | Doses in fund-raising proposal |
|---|---|---|---|---|
| 1 | Solar Fridges | 0 | 18 | 24 |
| 2 | Electric Fridge | 19 | 0 | 0 |
| 3 | Electric Freezers | 1 | 0 | 0 |
| 4 | Cold Boxes | 272 | 100 | 60 |
| 5 | Vaccines carriers | 748 | 2500 | 517 |
| 6 | Ice Pack | 3000 | 20000 | 30000 |

### UNFPA: REPRODUCTIVE HEALTH COMMODITIES

| Block 1 (Each kit is designed to provide for 10,000 people for 3 months ) | Block 2 (Each kit is designed to provide for 30,000 people over a 3-month period) | Block 3 (Each kit is designed to provide for 150,000 persons for 3 months) |
|---|---|---|
| Kit 1: Condoms (A and B) | Kit 6: Clinical delivery assistance (A and B) | Kit 11: Referral level kit for reproductive health (A and B) |
| Kit 2: Clean delivery, individual (A and B) | Kit 7: Intrauterine devices (IUDs) | Kit 12: Blood transfusion kit |
| Kit 3: Post rape treatment | Kit 8: Management of miscarriage and complications of abortion | |
| Kit 4: Oral & injectable contraception | Kit 9: Suture of tears (cervical and vaginal) and vaginal examination | |
| Kit 5: Treatment of STIs | Kit 10: Vacuum extraction delivery | |

## SUCCESS STORIES

### (1)WALKING THE DISTANCE – BEST PRACTICE FROM GUIT COUNTY

**Healthcare worker walked up to 30 km to the community daily**

Before the total breakdown of primary care services in Guit County, there were four PHCCs in Nimni, Kadet, Guit and Kuac. Violence erupted on April 2015 resulting in most healthcare workers fleeing into the Bentiu PoC. Health facilities were destroyed and health personnel had fled during the conflict. Incidentally, the head of the County Health Department was among the internally displaced population.

World Relief has approached the head of the County Health Department to explore the possibility of reaching the population outside the PoC that is now in dire need of medical care. Two healthcare workers were recruited in Bentiu PoC. They were trained and equipped with tools for data collection. In addition, they were given a supply of essential medications to be distributed to the field. The team would repeat this mission *on foot* every two weeks to different areas in the region from November 2015 to February 2016. The involvements of community members who have now settled in Bentiu PoC were a tremendous asset to guide the mission team.

This small mission team has carried out consultations and reported malaria, acute watery diarrhea and acute respiratory infection as main morbidities in the region. Cases of kalaazar were also reported.

The main challenge was to keep in touch with the healthcare workers once they left the field. Thuraya, a regional mobile satellite phone, provides a partial solution. However, since there is no electric power in the field, charging the device proves to be a significant bottleneck in terms of the length of the mission. In addition, medications were packed in such a way they are too heavy for one person to carry. This limits the amount that can be delivered to the community at any given time.

When the only means of reaching a population is by walking long distance, the colleagues in Guit County with a strengthen coordination and determination have shown that no distance is too far.

## *(2) HEALTH CLUSTER MALAKAL RESPONSE – ONE MONTH LATER*

One month after the fighting that destroyed and damaged 35% of the UN Protection of Civilians (PoC) site in Malakal, South Sudan, on February 18th, over 40,000 people are now living in makeshift shelters with an average of only 2.5 sq m of living space per person. Congestion is leading to poor sanitation and increasing the risk for the spread of disease within the PoC. The Health Cluster and its partners are continuing to work tirelessly to ensure the internally displaced people are looked after within the PoC and in the town where many people have fled.

WHO and the Health Cluster activated their mass casualty plan and coordinated the responsibilities within the plan immediately at the onset of the conflict. Within 24 hours, the Health Cluster coordinated IOM, IMC, WHO, MSF and ICRC to provide and sustain emergency services to the Malakal PoC. Our partners adapted quickly and opened two temporary clinics, offering primary health care services, nutritional commodities, maternal and neonatal care and surgical services.

*Health Cluster Coordinator Ms. Magda Armah visited the Malakal PoC Health Facility site and shared her concerns with the visiting OCHA Assistant Secretary General February 26, 2016. Behind the photo lies a ruined health facility burnt to the ground.*

The Health Cluster facilitated the transport of 150 cartons of trauma kits and medical supplies. Our partners have deployed a number of health human resources in addition to 2 metric tonnes of medical supplies.

Figure 1 shows the achievement of the humanitarian standards within the health sector in the first two weeks after the crisis.

*Crisis Response in Malakal Snapshot. CCCM 2016*

Within 72 hours, the Health Cluster joined forces with the Nutrition Cluster to look at how the two clusters can respond in a collaborative and strategic manner. The two clusters drafted the Health and Nutrition matrix that addressed the immediate as well as the long-term health and nutrition needs facing the Malakal PoC residents and Malakal town IDP's nearby by looking at human resources, supplies, facility, and funding ensuring immediate and ongoing collaboration in the future.

Following through with this response plan, the Health Cluster facilitated the procurement of essential medications to the Malakal PoC through the Emergency Medicine Fund. Shipment of drug was sent to Malakal on March 15 to provide the much-needed support to the medical facilities.

*Health and Nutrition Cluster discussing the joint integrated response plan. Feb 22, 2016*

Given that more than 4000 people fled into Malakal town from the PoC last month, the Health Cluster partners mobilized resources in a timely manner to respond to the health needs in the town using mobile clinics and nutrition teams.

*The Health cluster advocated for and received EMF drugs for IOM and IMC to sustain the Malakal Response, March 15, 2016*

WHO and Health cluster partners both in Malakal and at the national level continue to monitor the situation closely. The Health cluster has sustained advocacy including advocacy for CERF funds to rebuild the ruined facilities and EMF health commodities to ensure that services to the affected is not disrupted, and that the partners who are responding have prepositioned health commodities and supplies in readiness to sustain the scaled up emergency response. In addition, ongoing discussions with WASH are focusing on issues of a strengthened integrated health and wash strategy against potential disease outbreak as well as vector borne diseases.

## *(3) IRC INTERVENTION IN RUBKONA COUNTY*

**Offering outpatient service in Rubkona County**

IRC has been running primary healthcare and reproductive health services in Rubkona County in Unity State for the last two years.

The CHF supported programmes include PHCC in Bentiu PoC and Rubkona, Bentiu Hospital as well as two mobile Medical Units that operates in Thong and Ding Ding twice a week.

IRC runs clinics and trains local health workers to provide basic and reproductive healthcare. Some of the services provided include outpatient services, antenatal and postnatal care, routine immunization, nutrition services, health education, family planning services and maternity services. In addition, within the medical setting, the IRC empowers survivors of sexual violence through support and existing referral pathway.

The top morbidities in Rubkona are upper respiratory infection at 26%, malaria at 16% and acute watery diarrhea at 12%. Service utilization rate at the facilities is 2.8 consultations per person per year. Of the 400 expected deliveries per month, IRC has reached 32.6% since inception of the project.

IRC plans to continue to service the health needs of the region. Planned activities include re-activation of Nyaldiu PHCC as well as incorporating iCCM approach with volunteer community health workers in Waak, Tuochloka and Ngop.

## *(4) "HEALTH CLUSTER PARTICIPATES IN ASSESSMENT FOR EXPANSION OF ACTIVITIES BEYOND THE POC'S."*

From 21 to 23 March 2015 the health cluster participated in the Inter-Cluster Working Group (ICWG) mission visited Bentiu in order to develop, together with the partners in Bentiu, the 'Beyond Bentiu' Response Strategy.

The overall aim of the mission was to see how humanitarian services can be provided to people in needs outside Bentiu PoC and get insight in the challenges faced partners operating in Bentiu PoC and surrounding.

Lead by OCHA, the mission visited Bentiu State hospital, a government run health facility partially supported by IOM and IRC and Rubkona health facility supported by IRC. Because of security concern, Niemni payam was not visited.

After the mission, the health cluster developed and submitted the health cluster strategy for health service provision in the three selected locations (Kuach, Nyaldu and Niemni). The financial requirement for health cluster for frontline and core pipeline activities is estimated at USD 2,860,000.

## *(5)NATIONAL NGO REACHES BENEFICIARIES IN NEW FANGAK*

### NILE HOPE SET UP MOBILE HEALTH CLINIC

A Health Worker conducting Health Education at Puom locality

New Fangak is among the locations which had been faced with repeated armed conflicts. Following signing of peace agreement, community that fled the area for fear of attacks are coming back.

Nile Hope with funding from CHF is supporting two mobile units in leer and Fangak Counties. In New Fangak, specifically in Puom area a mobile clinic is setup and is equipped to providing both community outreach and facility based Primary health care consultations. So far a total 3,480 people have been reached with health education, 120 mothers were reached with ANC and 28 mothers were assisted with skilled birth attendant whilst 6 mothers were referred to a nearest health facility for further assistance.

A total of 1,240 Adults and 940 Under-five beneficiaries had been reached through consultation for for different health problems. Gastro enteritis, Pneumonia and malaria are among the top causes of morbidity. 248 LLINs were distributed to beneficiary's especially pregnant mothers and under five children who visited the mobile clinic for medical and other services,

## PRIORITIES FOR APRIL

- Dry season prepositioning – exercise with core pipeline managers
- ME and supportive supervision
- Develop IEC materials
- Launch the cluster web site (www.southsudanhealthcluster.info)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