South Sudan
Country brief and funding request
February 2015

Highlights
Conflict continues as the main actors have not yet reached a political resolution.
Violence intensified in the dry season with more displaced people and worsening humanitarian needs.
The country’s economy is in a precarious position. Access contraints are impeding delivery of humanitarian assistance to high risk areas due to insecurity and poor infrastructure.
Severe food insecurity and high risk of famine will worsen the situation.
An increase in the malnutrition rate among children places thousands at risk of SAM.
Recurrent communicable disease outbreaks due to poor living conditions, low immunization coverage, etc.
Weak health system and service delivery at all levels, with over 80% of services being provided by international organizations.
Secondary health care in the crisis affected states remains poor with limited surgical capacity.
Humanitarian actors are making efforts to provide humanitarian assistance and deploying rapid response teams in high risk areas.

Contact:
Country Office:
Dr Manzila Tarande Constant,
WHO Representative a.i.
Email: manzilat@who.int
Telephone: +211 955036411

Regional Office:
Lucien Manga, PA Coordinator
Email: mangal@who.int
Telephone: +41 797515492

Headquarters
Cintia Diaz-Herrera, Coordinator
External Relations
diazherrerac@who.int
+41 22 79 11629

Crisis affected states and displaced populations

PEOPLE AFFECTED
6 400 000 affected population
3 358 100 of those in affected, targeted for health cluster support
1 500 000 internally displaced
504 539 refugees

HEALTH SECTOR
7% of health facilities damaged
57% of health facilities functioning in the crisis affected states with external support
1 531 cases of measles
6 421 cases of cholera
7 204 cases of Kala azar
130 cases of Hepatitis E Virus
235 000 children at risk of SAM

BENEFICIARIES REACHED (2014)

About 945,619 reached

<table>
<thead>
<tr>
<th>People reached</th>
<th>Consultations</th>
<th>Antenatal Care</th>
<th>Vacc Measles</th>
<th>Vacc Polio</th>
<th>Vacc OCV</th>
<th>Assisted Deliveries</th>
<th>Surgical Cases</th>
<th>Ceasarian Sections</th>
<th>Drugs/Supplies</th>
</tr>
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<tbody>
<tr>
<td>2.4M</td>
<td></td>
<td>92,975</td>
<td>945,619</td>
<td>927,584</td>
<td>257,000</td>
<td>14,849</td>
<td>7,177</td>
<td>1,593</td>
<td>202000 T</td>
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FUNDING REQUIREMENTS

Health Cluster (FTS OCHA)
US$ 90 million requested
US$ 7 million received
92% funding gap

WHO
US$ 16.7 million requested
US$ 1.4 million received
92% funding gap

The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations. **Final boundary between the Republic of South Sudan and Republic of Sudan has not yet been determined. Final status of the Abyei area is not yet determined. New arrivals from South Sudan (NOT REFUGEES).** "Unspecified of the GOP & returned figures is a work in progress (21 December 2016)." Data Sources: OCHA, UNICEF, UNHCR, PFLG and partners. Reproductive figures as of 29 January 2015. OCHA South Sudan, 29 January 2015.
Key public health concerns

- 30 damaged and 184 non-functional facilities.
- Main referral hospitals not operational.
- Damage to cold chain and EPI infrastructure.
- Respiratory infections, malaria and diarrhoeal diseases are top cause of morbidity.
- Cholera, measles, hepatitis E, kala azar and malaria outbreaks confirmed.
- Supply chain disrupted and limited EPI services.
- Access constraints due to insecurity.
- HIV/AIDS and TB services disruption.
- Mental health services remain limited.
- Increased sexual and GBV prevalence
- Limited human resource capacity.

Situation update

The political crisis which evolved into an armed conflict on 15 December 2013 between the government and opposition forces started in Juba, then quickly spread to other locations within Jonglei, Upper Nile and Unity states. Although an agreement for the cessation of hostilities was signed on many occasions, the fighting continued unabated until today. This resulted in a major humanitarian crisis with unprecedented displacement among civilians, and tens of thousands of deaths. The ongoing conflict and political stalemate have also led to further deterioration of the already weak economy. Despite the recent peace and power-sharing pact between the President and Chief of the Opposition on February 2, 2015 in Addis Ababa, fighting between the conflicting parties has intensified and the security situation remains extremely unpredictable.

Humanitarian needs, among displaced people and other vulnerable groups continue to grow, while the humanitarian operations in South Sudan remain precarious, complex and uncertain. Moreover, the cost of implementing humanitarian programmes is particularly high due to insecurity, poor infrastructure and limited capacity. Emergency health needs are on the rise, and many health partners are thin on ground (logistic and technical capacities) or have minimum staffing. The on-going clashes in Jonglei, Upper Nile and Unity have hindered the access and delivery of humanitarian assistance, although both government and opposition groups have committed to facilitating humanitarian response activities.

Since December 2013, over 1.5 million civilians have been displaced inside the country by the conflict and 500,000 civilians sought refuge in neighbouring countries. Of these displaced people, over 100,000 have sought protection from attacks in Protection of Civilians (PoC) sites inside UN camps. Over 6.4 million people are in need of humanitarian assistance and 2.5 million people are expected to face an alarming level of food insecurity, while the risk of famine is very high.

Public health concerns

The crisis in South Sudan has caused a major public health emergency with extensive disruption of essential primary and secondary health care services. At the end of 2014, access to life-saving health services was very limited in conflict affected areas, with only 41% of health facilities in Unity, 57% in Upper Nile and 68% in Jonglei functioning. On the other hand, a third (184 of 425) of all health facilities in conflict-affected states are not functioning due to looting and destruction. Insecurity, poor infrastructure, shortage of drugs and lack of health personnel contribute to limited accessibility and availability of basic health services. Several hundreds of health workers have fled their duty posts for fear of ethnically motivated attacks and their safety, while some have also become IDPs. The provision of secondary health care services, such as general surgery and emergency obstetric care, is very limited due to the destruction and
looting of main referral hospitals in Bor, Bentiu and Malakal. HIV/AIDS, TB, mental health and psychosocial services are quite limited in the IDP camps and other areas.

The latest epidemiological data shows that respiratory infections, malaria and watery diarrhoea are currently the highest causes of morbidity and mortality among displaced population within the PoCs and outside the camps. In 2014, cholera, measles, hepatitis E, kala azar and malaria outbreaks were confirmed in South Sudan due to poor living conditions, a shortage of safe drinking water, malnutrition, low vaccination coverage and congested camps. The risk of more communicable disease outbreaks remains high and outbreaks are likely to continue in 2015 given the prevalence of predisposing factors.

Access to reproductive health services is very limited in conflict affected areas, and most women and girls cannot get appropriate reproductive services including safe delivery, and emergency obstetrical and neonatal care. According to the 2013 EMoNC assessment, only 24 EMoNC facilities are functional out of the targeted 109 in the country. Only 15% of deliveries are attended by a skilled birth attendant. During the crisis, sexual and gender-based violence and exploitation have increased significantly. However, the lack of appropriate health services for survivors is a significant gap, especially outside major displacement sites.

The main health needs among vulnerable groups include: improving access to primary health care services to high risk areas; strengthening surgical and trauma management capacity; prepositioning adequate life-saving drugs and medical supplies; improving vaccination coverage among children; establishing reproductive health services in IDP camps and other high risk areas; and strengthening the early warning and disease surveillance system.

**Health Cluster objectives:**

- Improve access to, and responsiveness of, essential and emergency health care, including emergency obstetric care services;
- Enhance existing systems to prevent, detect and respond to disease outbreaks; and
- Improve availability, access and demand for Gender Based Violence (GBV) and Mental Health and Psycho-Social Support (MHPSS) services targeting highly vulnerable people.

**Health Cluster priorities and targets**

Across the country, 6.4 million people need humanitarian assistance in 2015. The health cluster is targeting 3.4 million of these, including 706,000 children under five years and 840,000 women of child-bearing age. Priority health needs identified by health cluster partners and health authorities in 2015 include:

**Priority 1:** Expansion of primary health care services beyond the Protection of Civilian (PoC) areas to reach at least 80% of IDPs and host populations including case management of common illnesses, routine and emergency vaccination, hygiene promotion, awareness raising and distribution of mosquito nets, etc.

**Priority 2:** Strengthen secondary health care services, especially surgical, reproductive health and mental health care in the conflict affected areas;

**Priority 3:** Enhance the early warning and disease surveillance network through the existing integrated disease surveillance for epidemic prone diseases;

**Priority 4:** Procurement and prepositioning of life-saving emergency drugs in the conflict affected states including health emergency kits, trauma kits, etc.; and

**Priority 5:** Monitoring and supervising health services delivery.
WHO and Health Cluster action

The devastating conflict and political predicament in South Sudan have resulted in the displacement of millions of people, of whom more than half are children. Over 7,000 people were wounded, while about 10,000 were killed. This has resulted in the country’s worst humanitarian crisis, leading to the designation of the South Sudan crisis as a “Level 3” global emergency on 11 February 2014.

Massive disruption of basic social service delivery, the strained ability of partners and the Ministry of Health to respond and grave health consequences, with mortality rates at some IDP camps shooting above the emergency threshold, were among the key elements in considering the declaration of a level 3 emergency. During the crisis, WHO played a critical role in providing health cluster leadership and life-saving interventions including:

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<th>Surge capacity</th>
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<tr>
<td>• Level 3 emergency declared in February 2014.</td>
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<tr>
<td>• 125 staff supported the emergency response including 55 repurposed staff; 65 surge members and 18 CDC STOP members. (Refer to the map for number of WHO staff deployed and geographic distribution of deployed staff).</td>
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<td>• 36 health partners operating on the ground in the crisis affected states.</td>
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<td>• Established operational hubs in conflict affected states.</td>
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<td>• Trained all staff on WHO' Emergency Response Framework.</td>
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Developing a health strategic response plan in collaboration with partners to address the urgent health needs;

Supporting emergency primary health care services in the IDP camps;

Providing life-saving drugs to 36 partners and health authorities;

Participating in Initial Rapid Needs Assessments in various locations to identify health needs;

Establishing an early warning and disease surveillance system in the IDP camps;

Supporting the outbreak investigation and response activities;

Supporting emergency vaccination campaigns including for measles, polio, oral cholera vaccination, etc.;

Establishing referral mechanisms to facilitate medical evacuations to various secondary health care facilities;

Participating in the implementation of an integrated Rapid Response Mechanism to reach inaccessible areas;

Supporting the establishment of the reference laboratory to confirm disease outbreaks; and

Deploying surgical teams to manage trauma cases in Juba, Bor, Malakal and Bentiu.

The growing demand to scale up the humanitarian health emergency response has necessitated the establishment of Emergency Support Teams (EST) at the Regional and WCO levels, while 52 repurposed office staff ensured that all four WHO critical functions in emergency were effectively covered. So far over 40 surge team members were deployed in South Sudan, and 12 CDC STOP team members also supported the emergency response.
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Donors
- Africa Public Health Emergency Fund, CERF, CHF, Finland, and USAID.

<table>
<thead>
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<th>Amount (USD)</th>
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<td>USAID</td>
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<td>APHEF</td>
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<td><strong>TOTAL</strong></td>
<td><strong>13 542 605</strong></td>
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Funding requirements for 2015

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Required amount (USD)</th>
<th>Received amount (USD)</th>
<th>Carry-over funds</th>
<th>Gap (%)</th>
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<tbody>
<tr>
<td>Health Cluster</td>
<td>$90 million</td>
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