HEALTH CLUSTER

HEALTH SECTOR/ CLUSTER BULLETIN:
1 August - 31 October 2017

WHO and Federal Ministry of Health (FMoH) distributing medical supplies in White Nile state

SUDAN

4.3 Million	4.06 Million	2.3 Million	453,258	2.2 Million
PEOPLE IN NEED	POPULATION TARGETTED	DISPLACED PEOPLE	REFUGEEE POPULATION	ACUTE MALNUTRITION CHILDREN UNDER 5

HIGHLIGHTS

- Major hazards like drought, floods, epidemics and internal conflicts that affect health in Sudan continue unabated.
- Disaster related internal displacements and refugee movements overwhelm capacity of available health services in host communities.
- Unavailability of health care facilities and services where affected people are increases their vulnerability to other hazards.
- Inadequate funding of the health sector reduces their operational capacity to deliver life-saving and other essential health care services to affected population.
- Acute Watery Diarrhoea (AWD) outbreak that began in August 2016 and spread to all 18 states in Sudan by August 2017 is finally giving way.

*** Different Cholera modules & other medicines*
♣ Vaccination coverage by April 2017
♣♣ Annualized by end of September 2017

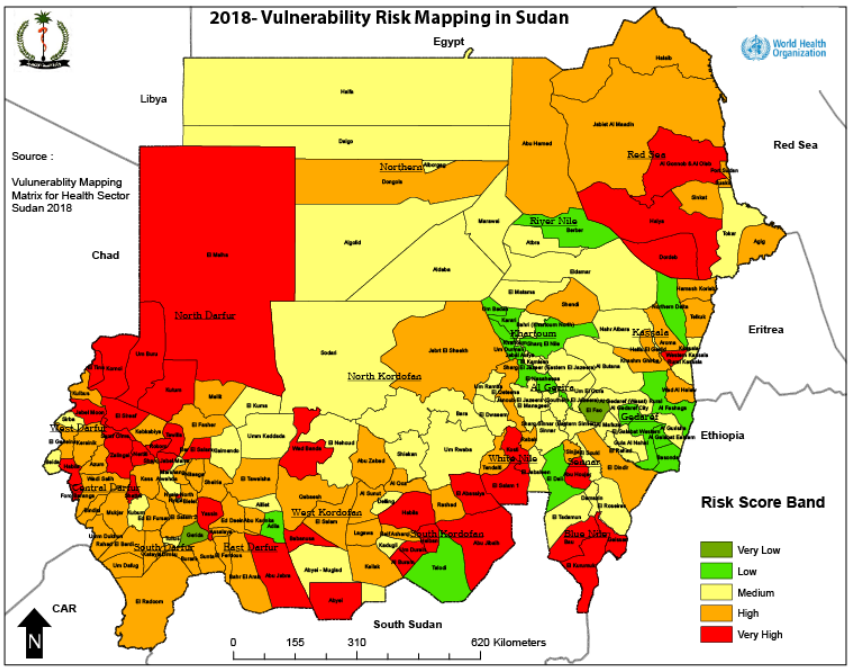
HEALTH SECTOR

53	HEALTH CLUSTER PARTNERS
MEDICINES DELIVERED TO HEALTH FACILITIES	
73%	ESSENTIAL MEDICINES
HEALTH FACILITIES	
6,220	TOTAL NUMBER OF HEALTH FACILITIES
5,115	HEALTH FACILITIIES FUNCTIONING
HEALTH ACTION	
43	ASSORTED DELIVERIES**
VACCINATION AGAINST COVERAGE	
97.9%	POLIO ♣
84%	MEASLES ♣♣
EWARS (Early Warning Alert and Reporting System)	
1,563	SENTINEL SITES
FUNDING US$	
19%	FUNDED
64.2M	REQUESTED

Situation Update

Disaster Causing Hazards: The humanitarian situation in Sudan remains complex, with acute humanitarian needs across the Darfur region (five Darfur States), Blue Nile and South Kordofan states, eastern Sudan and other areas. These humanitarian needs are predominantly caused by conflict and inter-communal tensions, which, in turn, drive displacement and food insecurity. However, humanitarian needs are also driven by poverty, underdevelopment, and climatic factors. Some of the highest rates of malnutrition are found in eastern Sudan – an area free from conflict. From Dec 2013, South Sudanese refugees have been coming in thousands because of conflict and food insecurity. Current conflicts in South Kordofan and Blue Nile states are also causing displacements. Recently, the country also experienced an unusual rainfall patterns and drought that negatively affected harvests and food supply. Food insecurity and malnutrition are a nationwide crisis; 11 states are experiencing Global Acute Malnutrition (GAM), which are at or above the emergency threshold of 15 per cent. The country has been struggling with the problem of AWD, which started in Kassala state in Aug 2016 and spread to all 18 States of Sudan by Aug 2017. Although the AWD cases have reduced and only 4 states are reported cases, the potential for the condition to flare again is possible. All these different hazards continue to exacerbate humanitarian need and crises.

Disaster related displacements & population movements: Currently Sudan is experiencing lots of population movement – asylum seeker, refugees, internally displaced persons, returnees and even the host community. Asylum seekers from the neighbouring country like Chad, Eritrea, Ethiopia, Yemen, and Syria among others are also coming to Sudan. The country is hosting about 420,000 South Sudanese refugees in different places; many of them have settled in camps in White Nile, East, North and South Darfur states. According to the 2017 Humanitarian Needs Overview (NHO), about 3 million people are in need of assistance in Darfur only. The security situation in Darfur has relaxed a bit with ceasefire between Government of Sudan and the armed groups; inter-communal tensions likewise reduced. Previously inaccessible areas are now more accessible although people still fear to return because of lack of basic services, poor infrastructure and fear of insecurity. According to UN and partners, about 8,200 people were newly displaced across Darfur this year; all these displacements and population movements implies some form of humanitarian situation requiring external support or intervention of some form.



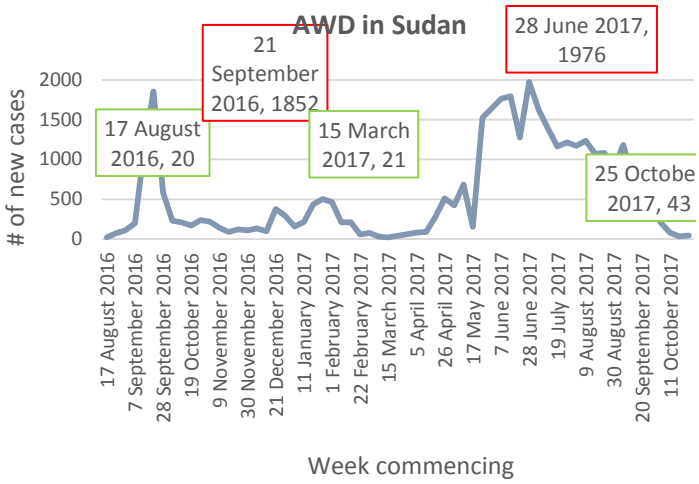
Unavailability of proper health care facilities and services: The 2018 vulnerability risk mapping of localities revealed that most of the locality vulnerabilities ranges from medium to very high. The locality vulnerability levels are on the map of Sudan. The degrees of vulnerability risks vary in the different localities across the country. According to the Health Sector Vulnerability Score for localities, of the 187 localities in Sudan, 109 are in the vulnerability

categories “very high” and “high”. These are localities where there is no or minimum health service delivery due limited or very low level of access. About 36 per cent of the primary health care (PHC) facilities across Sudan are not fully functional due to either under staffing, poor physical infrastructure or lack of drugs and medical supplies. Only 24 per cent of functional health facilities offer all main service components of the PHC package. NGOs are providing 42 per cent of PHC services in Darfur. Actually the increased population, continue to pose a serious challenge to the present capacity of the health sector.

Limited funding to support health service provision: The Federal and State Ministry of Health (MoH) in Sudan exists to deliver health services and improve health status and outcomes, for the population including internally displaced persons (IDPs), refugees, returnees and host communities. Despite the Federal and State MoH and Health Cluster partner support to healthcare provision to the population, persistent, prolonged crises and inadequate resources including funding weakens the operational capacity of these institutions, particularly in the conflict-affected areas especially Darfur region, South Kordofan and Blue Nile. According to Funds Tracking System (FTS), the 2017 Humanitarian Response Plan (HRP) has secured only 19% of the requested funding, leaving a funding gap of up to 81%.

Public health risks, priorities, needs and gaps

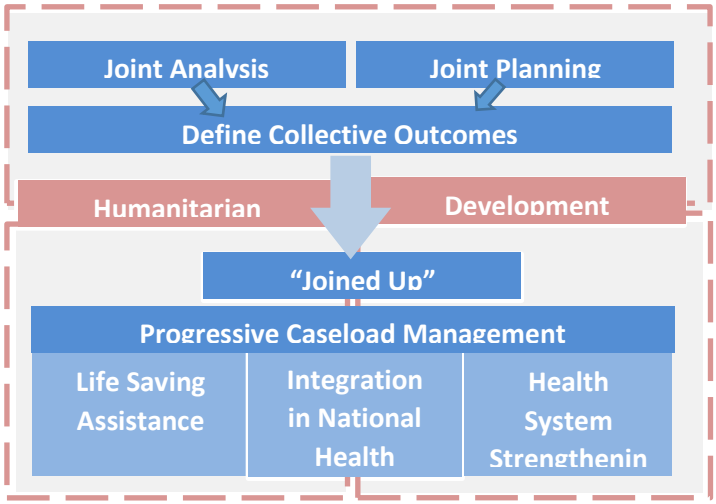
Public Health Risks: The immediate threat to public health is the uncontrolled population movement that remains a potential channel by which communicable diseases like AWD, meningitis, dengue fever, malaria, and other water borne diseases can be imported and spread in the camps or the host communities. Around 109 localities countrywide have health facilities that are underserved, i.e. providing very limited or no health care services - in the event of an outbreak, quick mobilization of the necessary resource to respond to and the capacity to rapidly respond and contain the crises would be a great challenge. The health sector is inadequately equipped to manage outbreaks of certain communicable diseases. In August 2016, some 20 people died of AWD in Kassala state. Small as the problem started, it flared to cover all the 18 states of the country in about a year. Right now, approximately one year and two months, AWD is still spreading in some states. Since start of the outbreak until 26 Oct 2017, up to 36,209 AWD cases were reported and 815 deaths recorded throughout Sudan. Although in the last 3 weeks the number of new cases has dropped down to two-digit figures, the new cases still keep popping up in one state or the other. The weekly epi-curve is showing the entire period from 17 Aug 2016 to 26 Oct 2017.



Another area of critical concern is Water, Sanitation and Hygiene. The health cluster partners have been educating the public and creating awareness on use of clean water, hygiene and sanitation practices, wherever a large number of people leave together several things can happen. As a precaution, there is continuous use of chlorine and other water purification mechanisms to ensure that the people have access to chlorinated or purified water. Other practices like continuous testing of water from various sources for contaminants, clearing of vector breeding sites and cleaning and burning garbage heaps and general cleanliness of the surrounding to ensure clean sanitation are applied. Absence of the appropriate public health or medical workers in the camps or overcrowded places poses a health risk.

Many refugees or displaced people fled from conflicts and/or food insecurity; now while in the camps or hosts communities they can become more vulnerable to food insecurity than the war. Consequently, the responsibility is upon the host government and/or the humanitarian community to provide the correct ration of foods, water and every other requirement based on Sphere to the people depending on the age group. In the event that the government or humanitarian community do not fully comply with those requirements, the people of families suffer chronic hunger or other nutritional problems; this seriously affects growth and development in children. In March 2017, the Sudan Ministry of Health and UNICEF conducted Mid-Upper Arm Circumference (MUAC) screening for acute malnutrition among children under-five in 16 out of 18 states. The localities of North Jebel Marra and Central Jebel Marra in Central Darfur state were localities that presented the highest cases of Oedema - 393 and 368 respectively.

Health Cluster Priorities: An important priority that the health cluster is and will be committed to continue the linking/joining of humanitarian and development perspectives while programming or developing interventions. This programming approach incorporates the short, medium and long-term results of interventions at the different points in time. The programming approach called "Humanitarian, Development and Peace Nexus". Part of this process is the ongoing review/development of the Multi-Year Strategic Plan (MYSP), the framework from which the different humanitarian sectors/clusters including health formulates annual Humanitarian Needs Overview (HNO), and the Humanitarian Response Plan (HRP) respectively. The Sudan health sector/cluster (SHS) is working on the 2018 HNO and the 2018 HRP. A simplified illustration of the programming method of bridging the Humanitarian Development Divide is shown.



With the high population movement with implication of increased risk of disease outbreaks, one of the health cluster's priorities would be to strengthen the prevailing EWARS, the system that detects and communicate about outbreaks in a timely manner. The improvement of EWARS would be by training of surveillance officers from health facilities 6 states and equipping the facilities with the required communication gadgets. The EWARS system allows the early detection of possible outbreaks in camps and overcrowded host communities, where the risk of outbreaks are high.

Needs and Gaps: On the other hand, the Federal and State MoH required prepositioning stocks of vaccines, drugs and medical supplies that for rapid response in the event of outbreaks. As more refugees or displaced persons continue to arrive in camps or host communities, protecting their health and the host communities, requires a coordinated effort by WHO and all health cluster partners. Close collaboration and coordination of interventions of all the different clusters would ensure greater effect, consistency and cost effectiveness in delivery of the service to the refugees, displaced persons and their host communities. Developing, strengthening and sustaining inter-sectoral or inter-cluster coordination with WASH/Nutrition/Food Security, Livelihoods, and development partners would enhance this. The health sector requires continuity and will need to strengthen support to health clinics and their workforce, including ensuring sufficient medical supplies are in place, in order to respond in a timely and effective way to new health emergencies and ongoing health concerns. By the end of October 2017 the health cluster had secured only 19% of the funds for 2017 HRP. One of the important needs is the resource mobilizations.

Health Cluster Actions

Heath Sector/Cluster Coordination: Currently, there are 53 health sector/cluster partners in Sudan. At the national level, monthly, the health sector/cluster coordinator convenes the sector/cluster meeting, chaired by the Federal MoH representative, the meeting is a forum in which the health sector/cluster partners come in to share their achievements, challenges and any other issues. Similarly, at the sub-national level health sector/cluster coordination meeting are regularly in five Darfur states, South Kordofan State and Blue Nile State.

Participants, trainers and WHO Representative to Sudan, Dr Naeema Al Gasseer, hold up the "zero cases" sign after completion of training (Photo: Simon van Woerden/WHO

Heath service delivery: Health Sector/Cluster partners collaborated with the Federal and State supported health sector response.

The Federal MoH has continued to support initiatives that would take primary health care to within five kilometres of the population of Sudan especially to the most vulnerable people. In line with that focus, the ministry through its different partnerships has continued to develop and strengthen primary health care services delivery, through construction of health centres, training of medical staff and particularly mid-wives and provision of drugs and medical supplies at Federal, State and Locality levels. The Federal MoH and WHO organized a training of health staff of the Federal and State MoH and WHO officers on Diarrheal disease management in September 2017 facilitated by the International Centre for Diarrheal Disease Research (ICDDR), Bangladesh. The training aimed to increase the awareness on diarrhoeal diseases among the health staff, as well as enhance their knowledge and skills in the ongoing AWD response effort. The FMoH continued to strengthen health staff capacity through basic and complementary trainings. In this regard, at state level the ministry trained 1,660 mid-wives, 650 health assistants at state level, 507 medical assistants, 191 joint cadres and additionally complementary training provided to serving health/medical staff.

A training of mid-wives on newborn care and breastfeeding (Photo: Federal MoH)

WHO: WHO responded to the increased risk of disease outbreaks, and improved the EWARS, trained 264 surveillance officers from 23 health facilities in six states. The Federal MoH conducted Water Quality Control Mission in White Nile State.

WHO in collaboration with the Federal and State MoH launched a vaccination campaign in two camps hosting South Sudanese refugees in South and West Kordofan states, reached a total number of 51,525 people over the age of one with the Oral Cholera Vaccine (OCV) through two rounds of vaccination; also to protect children against vaccine-preventable diseases, WHO and UNICEF supported a mass immunization campaign by the Federal MoH in

Water Quality Control Mission in White Nile State (Photo: Khalid Sarou/WHO)

White Nile camps in which 1,600 children (6 months–15 years old) were vaccinated against measles, and 1,680 children (under 5 years) were vaccinated against polio.

WHO, scaled up the AWD response plan in all 18 states with deploying 18 epidemiologists and clinicians to strengthen case management and infection control in 27 WHO supported Cholera Treatment Centres (CTCs) countrywide. Through the steady support, to MoH and other health sector partners, the outbreak in Blue Nile, Red Sea, Kassala, West Kordofan, West Darfur and East Darfur was controlled and Case Fatality Rate (CFR) reduced in all areas still reporting AWD cases. The WHO donated 43 different cholera modules to 27 CTCs in the 18 states that can serve 6,000 AWD cases and other assorted medicines and supplies to cover the needs of at least 160,000 beneficiaries for 3 months.

WHO staff providing Oral Cholera Vaccine (OCV), to a refugee in a camp in South Kordofan State

WHO together with Federal MoH conducted AWD Risk Assessment during from 8 to 19 October 2017 covered five States i.e. South Darfur, West Darfur, Kassala, White Nile and South Kordofan, WHO led the assessment with team being deployed from the regional office. The aim of the assessment was to assess the current status of the outbreak and to identify areas that could be prioritized for OCV in the immediate and medium term based on local epidemiology of the outbreak; strengths and gaps in ongoing interventions including case management, risk communication and environmental inventions. WHO recommended the introduction of OCV in high risk areas as pre-emeptive campaigns to supplement the existing AWD prevention and control interventions.

Addition for Disaster Assistance and Development (ADD): ADD collaborated with the State MoH and Qatar Charity Foundation to combat the spread of AWD in White Nile and Blue Nile States. ADD aimed to strengthen surveillance and educate the community on environmental health and vector control, use of safe water, hygiene and sanitation; trained community volunteers, visited homes for inspection, educated the public on use of clean and safe water, hygiene and sanitation, raised awareness about AWD, school sanitation improvements, conducted vector control spraying in the community among other things.

CARE international Switzerland (CIS): CIS supported delivery of health services through eight Primary Health Centres in South Darfur state providing health services to IDPs, host and rural communities in Kass locality and Al Salam IDP camps. CIS provided RH services through seven health facilities and one emergency obstetric care (EmOC) at Kass; basic PHC services including RH services in Abujebaha, and Elabasia localities. Community outreach activities in South Darfur and South Kordofan with community participation; community awareness and sensitization for target population. Some key support included essential drugs provision; training of health staff; trauma and injury care; vaccination; nutrition programme; communicable disease control and surveillance and early warning alert and response; AWD and support to CTCs and referral services.

Concern Worldwide: Concern worldwide handed over three new fully furnished medical staff houses to State Ministry of Health in Jebel Moon locality, West Darfur State, a project funded by Jersey Overseas Aid. The staff houses were in the following PHCs: Josmino, Manjura and Hejlija. Concern also supported construction of perimeter wall around Seleia PHC. Together with the medical staff houses was a donation of hospital furniture (beds and bedside locker). About 64,000 internally displaced persons, returnees and host communities in this area now benefit from the improved health infrastructure and the quality primary health care services.

Talaweit Organization for Development (TOD): TOD collaborated with the State MoH in Kassala State and UNICEF to support delivering various packages of health care kits and services to communities in two localities of Kassala State, North Delta and Rural Kassala. TOD delivered health services through 20 health facilities in the two localities and 12 outreach clinics and some of the key support was provided include essential drugs provision; paediatric care and child health; nutrition; reproductive health (RH); and support to trauma and injury care.

UNFPA: Working in collaboration with the Federal and State MoH, the UNFPA trained 80 medical service providers on obstetrics care and mid-wifery and other RH issues and distributed RH kits in Kore Al-Wral refugee camp that shelters 29,077 refugees in White Nile state. In Kassala State together with Italian Cooperation, UNFPA equipped 60 mid-wives and 40 religious leaders with information on public education on RH matters. In South, North, Central and West Darfur, UNFPA carried out a highly specialized campaign to prevent and repair obstetric fistula and successfully operated 211 women. The specialist fistula surgeon who carried out the operations also proceeded to train 24 Obstetrics Gynecologists from Darfur region to continue the campaign. Additionally, the agency also works closely with Social Welfare Development Ministry to address underlying causes of fistula like child marriage, early child bearing, Female Genital Mutilation (FGM) and gender inequality. In South Kordofan, the agency provided refresher training to 45 health care providers on RH issues and carried out public education on RH matters.

Plans for future response

Health cluster partners are in the process of developing 2018 HNO and 2018 HRP and will guide humanitarian response programming and implementation for next year. For the remaining part of the year, the health cluster partners will focus the remaining part of their contribution to the 2017 HRP while also preparing for next year.

Funding status of action plan

Health Sector/Cluster received almost 19% of the total funding (US$ 64.2 million) request under the 2017 HRP. A funding gap of 81% to support the sector/cluster's interventions remains unfulfilled. In August, a total of 14 million was allocated for Sudan under the Central Emergency Response Fund (CERF) under-funded emergencies (UFE) window and the SHS secured a total of US$1,250,000 for South Kordofan State for Health AWD intervention (US$550,000); Blue Nile State for Health AWD intervention (US$300,000); and East Jabel Mara Health interventions including SRH (US$400,000) and was allocated to WHO. In addition, the SHS secured from Sudan Humanitarian Funds (SHF) a total of US$1,100,000 for South Kordofan State for Health AWD intervention (US$700,000) and for Blue Nile State for Health intervention (US$400,000) and allocated to the Sudan Red Crescent Society (SRCS).

Sudan Health Sector/Cluster (SHS) Partners

There are 53 SHS partners. Federal MoH, State MoH; ADRA, ARC, CIS, CRS, CONCERN, DRC, Emergency, GOAL, IMC, IRW, KPHF, Muslim Aid-UK, NCA, Plan, QRCS, RI, SCI, SRC, WR, WVI; ADD, Al Massar, DPI, DAMO, GAH, GHF, HAICO, HAD, NIDO, PANCARE, RHF, RCDO, SOD, SIMA, SHPDO, SRCS,TOD; IOM, UNAIDS, UNAMID, UNICEF, UNFPA, UNHCR, UNOCHA and WHO; ECHO, Italian Cooperation, UKAID/DFID, USAID/OFDA; ICRC, MSF-Swiss; and MSF-Spain.

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