

# Contingency Planning and Emergency Response in SRH: the case study of South Sudan

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## Background

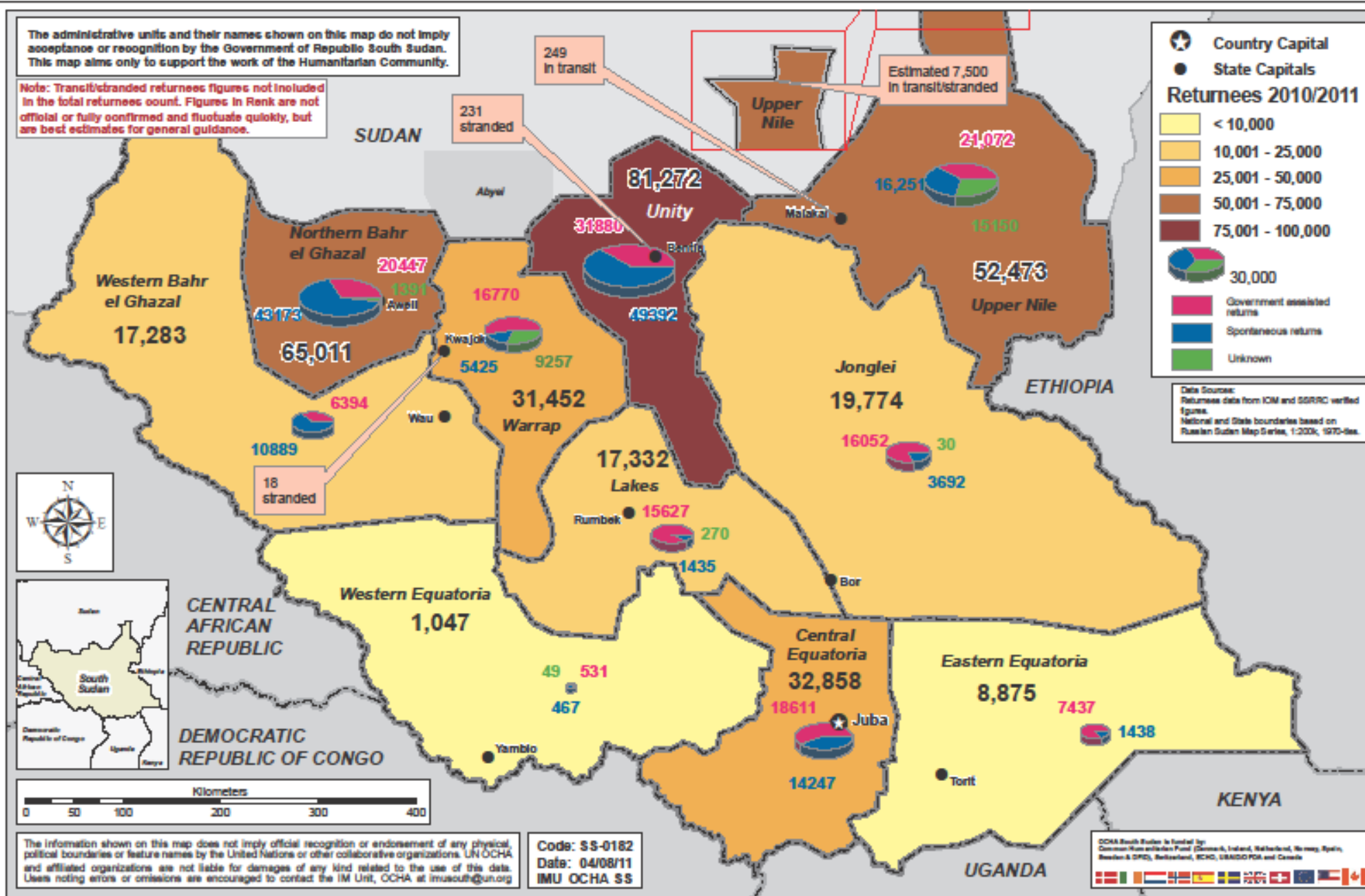
- South Sudan's conflict lasting for more than 30 years
- Great destruction and extreme poverty:
  - ✓ 8 to 1 million people (of which 78% rural) (IDMC)
  - ✓ MMR 2,054 per 100,000 live births (data CARE – South Sudan Country Profile)
  - ✓ Female Literacy Rate 16%; Males Literacy Rate 40%
  - ✓ critical shortage of health personnel, health facilities poorly equipped
- Comprehensive Peace Agreement (CPA) signed in Jan 2005: chronic emergency
- > 100 Humanitarian Actors operating in 2010
- Referendum on South Sudan Independence held on the 9th of January 2011
- Risks: North-South conflict, Internal inter-communal conflicts

## Background *cont.*

- In 2010 **215,000 people** were newly displaced by inter-tribal clashes in South Sudan (source UNOCHA) and political violence in the South.
- The Health Cluster was activated in July 2010
- **January 9 Referendum led to:**  
Massive returns from the North (organized and spontaneous)  
Low-intensity communal fightings and Militia-SPLA clashes  
leading to internal displacement

The administrative units and their names shown on this map do not imply acceptance or recognition by the Government of Republic South Sudan. This map aims only to support the work of the Humanitarian Community.

Note: Transit/stranded returnees figures not included in the total returnees count. Figures in Renk are not official or fully confirmed and fluctuate quickly, but are best estimates for general guidance.



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## **Reproductive Health Interagency efforts in 2010**

### ***Pre-referendum phase***

**October 2010: MISP and Contingency Planning workshop,  
Juba** 3-days MISP Training and 2-days contingency planning

SPRINT Africa Regional training in Naivasha, April 2010: UNHCR,  
Concern Worldwide, Sudanese Red Crescent

SPRINT, UNFPA and WRC: financial and organizational support

SPRINT and WRC: Technical Expertise (3 international experts)

20 participants from States MoH (5 SRH Focal Points /10), NGOs  
(Concern, IMC, IRC), Red Crescent, UNICEF, UNFPA and UNHCR

Workshop endorsed by the National MoH

## Activity(ies)

### Preparedness:

- Pre-position 3 emergency health kits, 2 trauma and 2 diarrhea kits to health service providers. <sup>1</sup>
- Pre-position 30,000 doses of meningitis vaccines, 8,000 vials of tOPV, and 40,000 vials of DPT vaccines, injection materials and cold chain equipment to health service providers.
- Establish Programme Cooperation Agreements with partners for the use of supplies and synchronization of the emergency health supplies.
- Train emergency response and rapid assessment teams.
- Identify standby capacities to be deployed in the event of a crisis (WHO).
- Identify RH Coordinator/focal point at different level
- Order, stockpile and manage RH supply and logistics
- Ensure that medical services including psychosocial support as well reporting and documentation are available for survivors and ensure community is aware of the services.
- Protection system is in place from the outset at top of the agenda
- Ensure functioning EmNOC services in place 24/7
- Identify storage capacities
- Revitalize state crisis committees for coordination purposes

MoH,  
WHC  
MSF-  
MSF-  
NPA,  
UNICEF etc.  
IOM,  
THES

DRAFT SEPTEMBER 2010

Emergency funding available	
Control the spread of communicable diseases (children affected by the crisis).	
Available location (c)	Identified gaps in response capacity
trauma kits, 3 (O), identified 5 mobilised at 5 members nity, and city for a WCEF, O, UNICEF, UNICEF, S (MSF)	- Inadequate emergency and RH kits. - Space at Juba Teaching hospital may be inadequate - Human resource capacity. - Inadequate logistical support including ambulance service. - warehousing

**Health**

## Preparedness and response

### *Few highlights*

#### Pre-referendum phase

UNFPA pre-positioned RH Kits and ordered Kits based on chosen scenario and figures

1 NGO assembled locally Clean Delivery Kits

Etc.

#### Response phase

- In 2 States of high return, IRC implemented PHC services in transit camps by providing mobile clinics (2 mobile teams)
- UNFPA released RH kits to partners at national and State level
- UNHCR and UNFPA together with WHO worked to ensure that health and protection sector partners prioritized RH interventions
- UNFPA and partners conducted trainings on clinical management of rape survivors and elaborated SOPs for GBV response (targeting areas of high return)
- 1.2 M.\$ received by UNFPA .Etc.

## Lessons-learnt and recommendations

### Timing is critical

- Preparedness and contingency planning shall begin earlier to allow a proper MISP training roll-out at States level
- Preparedness activities take time to be implemented
- Prepositioning of RH Kits is essential; BUT supp Kits were ordered after the Referendum with too large quantities (figures not reviewed)
- Not enough time given to build consensus and involve all key partners

### Coordination is critical

- Coordination space/forum must be formalized and permanent  
*“have an RH sub-cluster within the Health Cluster”*
- Coord. has to happen at all relevant levels, including field level, and must include multi-level coordination
- Inter agency at regional level (SPRINT, UNFPA and WRC) was key to achieve the RH Contingency Plan
- Competing Contingency Plans creating confusion and lack of buy-in

## Lessons-learnt and recommendations cont.

### Staffing is critical

- MISRP Roll out did not take place on time; there are not enough service providers trained on the MISRP
- Lack of identified RH Coordinator jeopardized the inter-agency coordination efforts ; UNFPA was lacking a dedicated qualified RH in Emergency Officer ; turnover at Cluster Lead position ; lack of some MoH RH Focal points at State level
- A significant proportion of staff took their leave at the time of the referendum, decreasing response capacity

## Lessons-learnt and recommendations cont.

### Quality of plan is critical

- Logistics coordinators were not involved in the Contingency Planning – decreasing its operationalization
- Integration in the Contingency Plan has to be specific and adapted to each context

### Advocacy/buy-in is critical

- Pre-positioning of Kits helped put RH onto the agenda and to begin mobilizing partners and resources behind a key issue
- Approval of MoH at that time was key



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