South Sudan Response
01 May - 23 June 2015

Highlights

1. A cholera outbreak has been declared in Juba. By 23 June 2015, a total of 206 cases and 19 deaths (CFR 10%) had been reported.

2. Humanitarian access remains constrained, particularly in the areas where fighting is concentrated. Large populations remain in hiding, unable to access health services.

3. The safety of humanitarian workers on the ground has become an increasing concern following the shooting of health workers in an ambush in Tonj South, Warrap State.

Notes:
* This number has received assistance.
** 2nd Round National Immunisation Days, March 2015.
*** UNHCR Portal, June 2015.
**** OCHA South Sudan, June 2015.
RH data last updated in June 2015.

Laboratory Scientists from IMC and WHO conduct a rapid test on a specimen as health partners step up surveillance for cholera with the onset of the rainy season. Photo: WHO/M. Moyo.
The security situation in South Sudan has been unstable due to intensified fighting in parts of the country following the resumption of hostilities that began in April 2015.

Fighting is concentrated in sections of Unity and Upper Nile States, with grave humanitarian consequences and a spike in internal displacements as people flee to more secure areas.

The security situation in Rubkona, Unity State, remains volatile as fighting for control of the oil fields continues. It is anticipated that the fighting could spill over to Bentiu hence humanitarian partners on the ground remain on high alert in anticipation of any deteriorating situation. An influx of internally displaced persons (IDP) into the Protection of Civilians (PoC) sites from neighbouring counties has led to facilities and amenities at the camp being overstretched, particularly in Koch which is receiving the majority of IDPs.

In Upper Nile State, the situation in Malakal town, including the PoC site, remains tense as fighting continues. Inter-ethnic tensions are also threatening the security of some locally recruited aid workers. Partners in Wau Shilluk have reported that some 38,500 displaced people are in urgent need of clean water, sanitation and medical supplies. According to the WHO field team, the Malakal team is planning a mission to Wau Shilluk pending security clearance. Reports from Melut town indicate that the town has been partially burned and destroyed, and assets have been looted. The reported looting and destruction of infrastructure, including health institutions, further limits access to services in states with already constrained health services due to destruction when the conflict began in December 2013.

Health partners have reported a sharp increase in casualties due to the clashes and are responding to the increasing needs. Mass casualty plans for Bentiu, Malakal and Melut have been updated, while partners on the ground were supported with provision of trauma kits, in addition to those already prepositioned in the affected areas.

Nearly 800 new arrivals in the Melut PoC are currently sheltered in the Women’s Center and temporary learning centres. Food, health, NFIs, clean water and sanitation are the identified needs. The movement of humanitarian partners in Melut remains restricted.

In May 2015, humanitarian partners relocated staff, with 155 staff of 22 organisations relocated from Leer, Ganyiel, Nyal, Koch in Unity State and 40 staff of four organisations relocated from Melut (Paloich) in Upper Nile State on 18 May 2015.

On 4 June unknown armed men ambushed a health mission to Manyang Ngok Primary Health Care Unit (PHCU) at Tonj South County, Warrap State, resulting in the death of the driver and severe injuries to three passengers, who included a WHO employee and two international non-governmental organisation (INGO) staff. The team was on their way to deliver medical supplies to the health care unit. Subsequently, the INGO has withdrawn 19 health workers from the Tonj area and this will greatly affect the delivery of health services in this area.

Although Eastern Equatoria State is calm with no major security threats, inter-ethnic tensions along Torit Hiyala payam have been reported following the shooting of a girl on 30 May. Western Equatoria State remains tense due to the ongoing clashes and a key road through Mundri to Wau has been cut off hence affecting operations and land deliveries to the greater Bahr El Ghazal states.

According to the April Integrated Food Security Phase Classification (IPC) analysis, an estimated 4.6 million people have been classified as severely food insecure (3.6 million in Crisis and 1 million in Emergency) in May to July 2015 as the lean season progresses. The majority of these populations are located in the three conflict affected states of the Greater Upper Nile region and most parts of the Greater Bahr el Ghazal.

The Minister of Health Dr. Riek Gai Kok on 23 June declared an outbreak of cholera in Juba County, South Sudan. A total of 206 suspected cholera cases including 19 deaths (CFR 10%) have been reported. The declaration automatically triggers the activation of a full-scale response involving all relevant sectors and partners in line with International Health Regulation (IHR 2005) requirements. Health partners are responding to the outbreak.
Public health risks, needs and gaps

- Basic health services have been disrupted. Extensive disruption of essential primary and secondary health care services due to the conflict has aggravated the limited capacity for basic service delivery. April and May have seen the most serious clashes in Upper Nile and Unity States, as well as escalated tensions along the Sudan-South Sudan border. Over 57% of the health facilities in the conflict-affected states have either been looted or destroyed and remain non-functional thereby reducing access to much needed health care services. Consequently, preventative care, vaccination campaigns and cold chain capacity are compromised. Reproductive health services and psychosocial services are inadequate.
More than 4.6 million people face severe food insecurity, especially in greater Upper Nile region. Global Acute Malnutrition (GAM) levels are above the emergency threshold in close to 80% of counties in the three conflict states of Jonglei, Unity and Upper Nile, while GAM levels in Warrap and Western Bahr El Ghazal states remain critical.

With the rainy season approaching, an increase in morbidity and mortality due to waterborne infectious diseases is expected, particularly in the areas that have reported displacements due to the dire living conditions. Flooding in most counties will further aggravate the health situation. Displaced populations continue to live in swamps, with inadequate shelter and poor sanitary conditions that prompt them to drink swamp water, which predisposes them to waterborne diseases and malaria and increases the risk of an outbreak of communicable diseases such as cholera.

Parts of Unity and Upper Nile states where fighting is concentrated remain inaccessible due to insecurity. Humanitarian partners are unable to move back to the counties to provide medical services, while people are reluctant to come out of hiding to seek medical treatment from the limited available facilities.

Access to information about affected populations remains limited.

Enormous gaps remain in the provision of life saving surgery, especially in the deep front areas affected by the crisis and due to limited capacities of the NGOs on the ground.

Costs of delivering humanitarian assistance continue to sky rocket and market forces have negatively impacted on the humanitarian assistance. Operation costs have almost tripled in some key states.

The capacity of the Ministry of Health to deliver basic health services is limited and humanitarian actors continue to cover over 90% of the response even in non-crisis affected states. Human resources in conflict affected states remain a major constraint, with local manpower non-available or unable to be deployed due to their ethnicity. Lack of payment of government health workers is also placing pressure on humanitarian partners.

Drug stock outs across the states and the anticipated country wide stock out of essential medicines in the coming three months remain a huge public health need.

Trauma cases due to fighting continue to be reported.

Due to the protracted crisis, chronic diseases like tuberculosis and HIV/AIDS have now emerged as significant causes of morbidity and mortality among IDPs.

**Health Cluster Action**

**Cholera Preparedness**

- Health partners have begun a series of Oral Cholera Vaccination (OCV) Campaigns in concerted efforts to prevent a potential outbreak of the disease. The campaigns, targeted for Bentiu and Juba 3 PoC sites in June 2015, aim to prevent more cases and will complement measures to improve hygiene and community awareness that are already in place. In Bentiu, Unity State, the first round of the OCV campaign was conducted from 1 to 5 June. Preliminary administrative coverage data shows that 72,265 (98.5%) individuals aged one year and above were vaccinated. The second round began on 22 June.

  - Altogether 35 people, comprised of vaccinators, mobilizers and team supervisors were trained for conducting the campaign in Bentiu. Partners involved in the campaigns are the International Medical Corps (IMC), the International Organization for Migration (IOM), UNICEF and WHO. A similar campan was conducted from 1 to 5 June. Preliminary administrative coverage data shows that 72,265 (98.5%) individuals aged one year and above were vaccinated. The second round began on 22 June.

  - In Central Equatoria State, cholera coordination meetings are underway at the State Ministry of Health (SMOH) and in UN House PoC in response to the confirmed cholera case at this site. Cholera preparedness and response plans and protocols are being updated to enhance readiness capacities at both state and national level WHO supported the Ministry of Health to develop a protocol for enhanced Acute Watery Diarrhoea (AWD) surveillance in Juba County. Subsequently, WHO supported orientation of the state rapid response teams and provided logistical support to facilitate the implementation of the protocol. Interventions by partners include building surveillance and case management capacity, building awareness on cholera prevention, stepping up residual chlorine levels in drinking water, sanitation and hygiene promotion, and garbage collection.

  - The first round of the OCV campaign in Juba began on 22 June 2015 targeting 33,565 individuals aged one year and above. The second round will take place in mid-July targeting the same people.

  - Disease surveillance has been enhanced in the PoC and health facilities in Juba County. Cary Blair media and outbreak kits have been provided to partners that support health services to ensure specimens from suspected cases are collected regularly.

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A Social Mobilisation and Communication Strategy has been developed to ensure the public is adequately informed to prevent the disease. Tools include radio talk shows and jingles, regular media updates, as well as distribution of information, communication and education (IEC) materials. Community leaders and social mobilisers are among the channels being used to reach people.

In Eastern Equatoria State, the Emergency Preparedness Plan has been activated, with regular weekly meetings with the State Ministry of Health (SMOH) and partners. Eastern Equatoria State faced a cholera outbreak in February 2015.

Material Support

- Partners are responding to the needs of people affected by fighting in Malakal and Melut in southern Unity State, despite the challenges. Interventions include delivering survival kits in an innovative approach to reaching the affected people in locations that cannot be accessed through the existing emergency response models and where aid workers have been relocated and relief supplies looted. Over 4,400 kits (for 4,400 Households) have been assembled and WHO provided nine Oral Rehydration Salts (ORS) module kits for this response. In addition, WHO donated one Interagency Emergency Health Kit (IEHK) (for 10,000 people for three months) to World Relief to support the response in Koch. In addition, eight Basic units (for 8,000 people for three months) were donated to IRC for the response in Mayom, targeting Bouth and Wicok payams.
- UNHCR donated medicines and medical supplies to Juba Teaching Hospital and to El-Sabah Children’s Hospital. In addition, the agency procured a mobile X-ray, Ultra Sound and CD-4 device for Panrieng Primary Health Care Center (PHCC). Prepositioning of the equipment is ongoing pending the completion of expansion and renovation at PHCC.
- World Relief was among the last group of NGOs to evacuate Koch on 5 May. Since then, local health staff have fled with the population to various swamp areas in Koch and Leer counties, as well as the Bentiu POC. WHO supplied two interagency emergency health kits (IEHK) to Koch staff to treat IDPs and there has been daily contact with remaining staff on the ground, to look for possible opportunities to deliver health supplies and high energy biscuits to the population these areas. Conditions for the Koch population are reported to be dire, with no access to emergency aid or food supplies.

HIV Services Strengthening

- As part of continued efforts to strengthen HIV services in emergencies, a WHO consultant provided on-the-job training for service providers involved in Prevention of Mother to Child Transmission (PMTCT) of HIV at different health facilities within the PoCs.
- Two specialists have been contracted to support partners in strengthening HIV services across the country. During the reporting period, health partners and the SMOH visited Naandi seminal Site ART site, Western Equatoria State to conduct clinical mentorship. Key observations were that there has been a steady increase in client enrolment over the last five months, reaching a current total of 85 clients, including both transfer in from Ezo and new cases in Naandi. All services are running smoothly and there are enough antiretroviral (ARV) drug stocks to last one month. Other HIV clinics in the county are operating well. WHO also supplied 20 cartons of ARVs to Ezo clinic, which had run out of stock.

Rapid Response Missions (RRM)

- UNICEF and partners conducted a Rapid Response Mission to Keurnyang Boma, Barboi payam, Fangak County in Jonglei State from 29 April to 5 May 2015 during which 2,357 children aged 6 to 59 months were screened for malnutrition using Mid-upper Arm Circumference (MUAC) measurement. Among these 48 children (2%) were found with Severe Acute Malnutrition (SAM) and 324 children (13.7%) with Moderate Acute Malnutrition (MAM). All children identified with SAM were admitted for treatment. The nutrition situation of children is at the emergency threshold level (above 15 per cent), so integrated nutrition interventions are required. All children with SAM were provided with a one week ration of Ready-to-Use Therapeutic Food (RUTF) and were counselled to visit after one week to assess the progress made during the course of treatment. Similarly, children with MAM were provided with a 15 day ration of Ready-to-Use Supplementary Food (RUSF) for regular follow up. A tent was erected to establish outpatient and Targeted Supplementary Feeding Programme (TSFP) services, and provide treatment for children with SAM and MAM, and for pregnant and lactating women with MUAC below 21 cm. Altogether 2,282 children from 6-59 months (1,218 boys and 1,064 girls) received Vitamin A supplementation, while 2,070 children from 12-59 months (1,094 boys and 976 girls) received

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2 Including rapid, mobile and static response mechanisms.
deworming tablets; 5,858 children between 0 to 15 years were vaccinated against polio; 5,630 children between 6 months to 15 years were vaccinated against measles; 494 pregnant women received the first dose/booster of Tetanus Toxoid (TT) vaccination. Advocacy on malaria prevention was done by distributing long lasting insecticide treated nets (LLIN) to 2,000 households.

- UNICEF and partners conducted another RRM to Ngop payam, Rubkona County, Unity State from 9 to 16 April. There are no humanitarian actors based in Ngop. There are no health facilities, essential primary health care (PHC) drugs, medical supplies or equipment. The result is a complete lack of emergency PHC services, including routine immunization, since 2013. The only referral health facility in the area is the Nihaldu primary health care centre (PHCC). Based on the identified critical humanitarian needs, the following interventions were carried out: 4,825 children 6-59 months screened for acute malnutrition; 44 (0.9%) SAM cases detected; 44 children 6-59 months admitted to a SAM management programme; 173 (3.6%) MAM cases detected; 173 MAM cases 6-59 months referred for treatment; 1,841 PLW access IYCF messaging; 4,393 children reached 6-59 months reached with Vitamin A; and 3,821 children 12-59 months reached with deworming medication.

**Feature: Introducing the KalaCORE**

In early 2014, the KalaCORE consortium consisting of Médecins Sans Frontieres (MSF), Drugs for Neglected Diseases initiative (DNDi), London School of Hygiene and Tropical Medicine (LSHTM) and Mott MacDonald Ltd was awarded a 4.5 year programme from the British Department for International Development (DFID) to support activities aiming at diagnosing, treating and monitoring Visceral Leishmaniasis (Kala-Azar) in the six most affected countries of the world. These include South Sudan, Ethiopia, Sudan, India, Bangladesh and Nepal. After the inception period, lasting until October 2014, the program started to take shape.

Kala-Azar in South Sudan mainly affects Upper Nile and Jonglei states, but also parts of Unity and Eastern Equatoria. IMA World Health is the implementing partner in the country, supporting health facilities in endemic areas in order to create access to diagnosis and treatment for Kala-Azar patients, and MSF Holland provides in-kind support with technical expertise, knowledge and training facilitation. The goal of KalaCORE is to reduce the economic and health burden of Kala-Azar. In South Sudan, the aims are to support all partners dealing with Kala-Azar with knowledge transfer and capacity building, to supply Kala-Azar specific drugs and diagnostic tests to treatment facilities, and to strengthen the epidemiological surveillance system.

To achieve the aims, two rapid response teams have been set up by IMA and started activities in January 2015. They visited some of the worst affected areas of Upper Nile and Jonglei states, assessed the situation on the ground, delivered supplies and gave training and support to the local health staff.

Comprehensive training of health professionals has been successfully conducted in Juba in January and May 2015, under the facilitation of MOH, WHO, IMA and MSF. A third training is planned in preparation for the Kala-Azar peak season. Further details will be announced by IMA in due time.

**Health Cluster Coordination**

- Cluster meetings continue to take place bi-monthly at national and weekly at sub-national level.
- Due to the escalation of armed conflicts in Upper Nile and Unity States, there has been a massive displacement of population, among them pregnant women and under five children, to swampy areas and islands considered as safe places and to other neighbouring counties or states. The health cluster coordinated with partners and IOM to ensure the collection of information on the movement of affected people. The health cluster coordinated with partners operating in affected areas and host communities to identify gaps and strategize on a coordinated humanitarian response. WHO, through the health cluster, provided the necessary support namely technical support, medical supplies and drugs. GOAL and IRC are among the organizations that received interagency emergency health kits from WHO.
• At inter-cluster level, the health cluster participated in the constitution of the survival kits which were distributed through OCHA to displaced people in the southern part of Unity state.
• The Health sub-cluster in Upper Nile State held an extraordinary meeting on 17 June to discuss ways to manage growing needs as the population in the Malakal PoC continues to increase. While existing facilities can cater for up to 10,000 people, the total population in new PoC is currently 22,700. Community level services delivered by Community Health Workers (CHW) are critical to prevent some epidemic prone diseases including cholera. Timely identification of outbreaks for quick response, case tracking and quick referral may save many lives. The cluster resolved to negotiate for new space in order to expand the existing clinic, while partners work on procuring tents to house the extension. The weekly Health cluster meeting took place on 18 June. Partners agreed that IOM’s Rapid Response Team (RRT) will be available to respond in the event of cholera cases, IMA will focus on daily AWD surveillance until the risk of cholera in Wau Shilluk is over, while UNICEF and partners will strengthen Social Mobilisation for cholera in Malakal PoC using video clips and other means.

Health service delivery

• By 15 June 2015, a total of 1,723,330 medical interventions had been conducted since the start of the year. These include the following:
  o 1,693,930 consultations and treatment, within and outside the IDP camps countrywide;
  o 2,473,817 children (0-15 years) vaccinated against polio;
  o 53,389 women provided with Antenatal Care (ANC) services;
  o 7,843 women had assisted deliveries;
  o 755 women had caesarean sections;
  o 82,566 people reached with gender-based violence (GBV) prevention messages.

Vaccination

• WHO and partners also conducted the first round of an integrated measles and oral polio vaccination (OPV) emergency vaccination campaign for new arrivals at Malakal PoC site. Activities entailed training vaccinators and immunising children over two days old. Altogether 1,231 children were immunised against measles and 1,967 against polio out of a targeted 3,000 children below 15 years.
• Following the arrival of about new 66 households comprising 344 individuals in Mingkaman, partners facilitated the vaccination of 106 children under 15 from measles. Mosquito nets and water containers were also distributed.
• Training for 58 vaccinators and team supervisors was conducted at county level in Maban, Upper Nile on 2 May with the aim of enhancing the quality of supervision of integrated campaigns.
• As of week 22, altogether 392 suspected measles cases from nine states have been investigated since January 2015 and are classified below.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected measles cases investigated</td>
<td>392</td>
</tr>
<tr>
<td>Laboratory confirmed Measles(IgM+) cases</td>
<td>23</td>
</tr>
<tr>
<td>Confirmed by epidemiological linkage</td>
<td>79</td>
</tr>
<tr>
<td>Clinically compatibles</td>
<td>194</td>
</tr>
<tr>
<td>Discarded</td>
<td>75</td>
</tr>
<tr>
<td>Pending for laboratory results</td>
<td>21</td>
</tr>
</tbody>
</table>

Rubella (IgM –Lab) confirmed cases are 32.
• The annualized measles incidence rate is 60.2/1,000,000 population.
• **Measles Outbreaks:** Ongoing clashes in three conflict affected states continue to fuel an influx of IDPs to PoC camps and other major towns. Consequently, three measles outbreaks have been investigated in Duk, Jonglei State; Rubkona, Unity State; and Maban, Upper Nile State since January 2015. Another potential outbreak has not yet been investigated because of insecurity in Fashoda County.
**Support to health service delivery (capacity building)**

- **Mentoring:** Coaching, mentoring, on-the-job training during field visits and supportive supervision are being continuously done by WHO staff in the field. Areas covered during the reporting period include Katire PHCC in Eastern Equatoria State, as well as Bor PoC clinic and Bor Hospital in Jonglei State. Orientation was conducted on infection prevention and disease control, as well as AFP and measles surveillance.

- **IDSR Training:** WHO conducted Integrated Disease Surveillance and Response (IDSR) Case Management training for 34 participants in Western Equatoria State from 25 to 29 May 2015 for five counties of Ezo, Nagero, Nzara, Tambura and Yambio in Western Equatoria State. Similar training took place in Warrap State for 36 participants. The participants were drawn from Gogrial East, Tonj North and Tonj East counties. The training sought to give health workers, particularly those involved in disease control and surveillance, appropriate knowledge and skills in identifying cases of priority diseases as well as processing and using data for action.

- **CHW Training:** During a Rapid Response Mission to Fangak County, Jonglei State from 29 April to 5 May, the UNICEF health team had a one day training for 28 volunteers/community health workers to carry out integrated immunization campaign against measles for children from 6 months – 15 years and polio for children 0-15 years as well as Tetanus Toxoid for all pregnant mothers. Further, refresher training was provided for the team carrying out health care consultations. Health education was conducted throughout the mission focussing on hygiene and social habits which were noted to contribute to eye infections and diarrhoeal diseases.

- **Obstetric ultrasound investigation Training:** UNHCR in collaboration with MSF-France is conducting on the job training in Yida for selected health staff from CARE and IRC on obstetric ultrasound investigations. This is in preparation for starting the service in Parieng PHCC.

- **HIS Training:** Nine staff from IRC, AHA and CARE have also been trained on UNHCR health information systems.

**Assessments and investigations**

- **Rapid Needs Assessment in Melut:** Partners, comprising UNHCR, UNICEF, GOAL and IMA visited Melut from 30 May to 1 June 2015 to assess the conditions of the IDPs and host communities in the county after the conflict. The mission visited Dinthoma I, Dinthoma II, PoCs, Hai Soma and Paloich sites in Melut to establish the immediate response required for the IDPs. The mission also assessed the feasibility of the return of humanitarian organizations to Melut to resume operations, pending normalization of the security situation. Findings were that all the offices of humanitarian actors located outside UNMISS have been looted. Presently, there are no humanitarian activities going on in Melut following the relocation of humanitarian actors. As reported by the community leaders, currently there are limited drugs to treat patients. Serious cases are being referred to the Indian Battalion. At Dinthoma I health interventions by the MSF facility were interrupted by the conflict and medical supplies have been looted. In case of serious health concerns, IDPs have to travel to Paloich to access medical services. The conflict has also affected access to clean drinking water, forcing IDPs to use untreated water from the Nile River, resulting in increased cases of diarrhoea. Latrines in the area are also full hence people are practicing open defecation, which enhances their risk of contracting diseases.

- In Dinthoma II, where an estimated 3,000 individuals have returned to the settlement, the assessment team found that health services are limited and IDPs have to travel as far as Paloich to access health services. On 1 June, Health and Nutrition (OTP) interventions resumed in the health facility run...
by GOAL. The IDPs are also fetching drinking water from the river, resulting in an increase in diarrhoea cases. Latrines are not in working condition leading to open defecation. Among the recommendations are the urgent need for the provision of safe drinking water; repair or construction of WASH facilities, including latrines, as well as provision of WASH NFIs; and the resumption of interventions at the health facilities.

- **OCV Evaluation in Malakal:** WHO conducted an Oral Cholera Vaccine Coverage Evaluation Survey (OCV CES) and risk assessment in Malakal PoC from 6 to 8 May 2015. Key recommendations are that WHO should conduct an OCV campaign in Malakal PoC and Wau Shilluk IDP camp in light of the frequent interaction among the populations, which would place all the camps at risk in the event of a cholera outbreak in any one camp. In addition, there is a need to improve hygiene promotion activities and provide hand washing soap during the upcoming high risk season. The mission noted that the last immunization campaign in the area was done in September 2013. Urgent needs include essential drugs and a 72 m³ tent to serve as inpatient ward.

- **IRNAs:** In Western Bahr El Ghazal, health partners participated in an Interagency Rapid Needs Assessment (IRNA) from 19 to 24 May, to establish the humanitarian needs of the IDPs in Raja, Diem Jailab, Minamba and Boro Medina. No significant health needs were documented as IDPs are being served by the health facilities in the area.

- Another IRNA was conducted in Nyadin, Fangak County, Jonglei State from 16 to 18 June to assess the needs of over 5,400 IDPs in Keew coming from Koch and Guit counties. A multi-sectoral team comprised of WASH, health and nutrition conducted the assessment.

- **Partner Assessments:** Medair, working with local partner Christian Medical Aid (CMA), conducted a multi-sectoral assessment in Mareang, Fangak County, Jonglei State from 12 to 26 May. Their assessment indicated vulnerabilities in the IDP population of food insecurity, malnutrition (proxy GAM of 30%; 25%MAM; 5%SAM), lack of access to clean water (no functioning boreholes) and limited resources for shelter.

- IRC conducted a health assessment in the Ganyiel area, Unity State from 6 to June, and noted that there is are urgent health needs in Thornoum (30 minutes by canoe from Ganyiel). The IDP population is reported to be approximately 15,000, many of whom fled to the area after recent fighting in Panyijiar, Mayendit and Leer.

### Surveillance and communicable disease control (update on surveillance in IDP/Protection of Civilian sites)

- **Disease burden among IDPs:** The five leading causes of morbidity among IDPs remain the same. Acute Respiratory tract Infections (ARI) is the leading cause followed by malaria, Acute Watery Diarrhoea (AWD), Acute Bloody Diarrhoea (ABD) and suspected measles.

- Since the beginning of 2015, altogether 367,645 consultations have been registered from 45 IDP sites that submitted weekly disease surveillance reports as part of the Early Warning Alert and Response Network (EWARN)⁴.

- **Suspected cholera:** On 26 May 2015, a cluster of four suspect cholera cases was reported following investigations conducted jointly by the Ministry of Health with support from WHO and International Medical Corps (IMC) in UN House PoC. On 1 June one of the four suspect cases was confirmed to have cholera after *Vibrio cholerae inaba* was isolated at the National Public Health Laboratory. AWD surveillance, prevention and control have been enhanced following confirmation of the case.

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⁴ For more details refer to: [http://www.who.int/hac/crises/ssd/epi/en/](http://www.who.int/hac/crises/ssd/epi/en/)
A review of priority disease trends for UN House PoC (Figure 1) shows that acute watery diarrhoea is the third highest cause of morbidity.

Outside UN House PoC, suspected cholera cases are being investigated\(^5\).

**Hepatitis E Virus:** In week 22 of 2015, two HEV new cases were reported from Bentiu PoC while Mingkaman reported one new case. Hence the cumulative total for HEV is 75 cases including one death (CFR 1.33%) in Bentiu and 148 cases including seven deaths (CFR 4.7%) in Mingkaman. Probable HEV cases have been reported from Lankien with a cumulative total of 19 probable HEV cases being reported since week 35 of 2014. Response interventions by partners include supportive case management, targeted preventive interventions during antenatal visits, soap distribution, shock chlorination of boreholes, as well as house-to-house hygiene and sanitation promotion. However, with the recent influx of new IDPs into Bentiu, the barely adequate WASH indices will continue to be stressed and with the onset of the rains, HEV transmission is likely to escalate in the coming weeks.

**Acute Flaccid Paralysis (AFP):** Since the beginning of 2015, a total of 135 AFP cases have been reported, although no new cases were reported in week 22. The annualized non-Polio AFP (NPAFP) rate (cases per 100,000 population children 0-14 years) is 4.49 per 100,000 population of children 0-14 years (target ≥2 per 100,000 children 0-14 years). All states have attained the targeted NPAFP rate of ≥2 per 100,000 children 0-14 years. The non-Polio Enterovirus (NPEV) isolation rate (a measure of the quality of the specimen cold chain) is 9% (target ≥10%). Stool adequacy stands at 96%, a rate that is higher than the target of ≥80%.

**Visceral Leishmaniasis (Kala-azar) Update:** From week 1 to date, a total of 1,862 cases and 61 deaths (CFR 3.3%) have been reported from 21 treatment centres in 2015. These comprise 1,477 (79.3%) new cases; 385 (20.7%) relapses/PKDL; and 53 (2.8%) defaulters. In comparison 1,647 cases and 50 deaths (CFR 2.8%) had been reported from 15 treatment centres by the end of week 22 of 2014. These comprised 1,456 new cases; 191 relapses/PKDL; and 113 defaulters. WHO, in collaboration with the Ministry of Health and partners, continues to support enhanced surveillance, case management and interventions to interrupt transmission. Interventions include supporting implementing partners with case

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management supplies; training frontline healthcare workers on Kala-azar case management; supportive supervision of treatment facilities; supporting community sensitisation on Kala-azar; and distribution of long lasting insecticide treated nets (LLITN) in affected and high-risk areas.

- **Mortality surveillance**: Prospective mortality surveillance and reporting is ongoing in the major IDP sites. At least 466 deaths have been reported among IDPs since the beginning of 2015. During this period, Bentiu PoC registered the highest number of deaths, followed by Malakal PoC and Juba 3 PoC. The most frequent cause of death during the reporting period was TB and HIV/AIDS, followed by AWD, perinatal death and severe acute malnutrition (SAM). However, the under-5 and crude mortality rates by IDP site remained below the emergency threshold during the reporting period.

![Figure 4: Crude Mortality Rate per 10,000 Persons per day, week 51 of 2013 to week 22 of 2015](image)

**Figure 4: Crude Mortality Rate per 10,000 persons per day, week 51 of 2013 to week 22 of 2015**

- **Reproductive Health**

  ![Figure 5: Cumulative Numbers of People Reached with UNFPA Services since December 2013](image)

  **Figure 5: Cumulative Numbers of People Reached with UNFPA Services since December 2013**

  Health partners continue to provide reproductive health services. The graph (left) shows the cumulative number of people reached with UNFPA support since the crisis began in December 2013.

  - In Jonglei State WHO supported the setting up of a maternity operating theatre room at Bor Hospital. The support entailed bringing in the WHO anaesthetist from Aweil, assembling two anaesthetic machines at Bor Hospital; training doctors and midwives on the management of obstructed labour and how to use the partogram; and establishing a neonatal unit in the maternity ward. On-the-job monitoring of the maternity ward still ongoing.

**Resource Mobilization**

- The Health Cluster’s request of $93.2 million in the revised 2015 Strategic Response Plan (SRP) is 68% funded at $63.5 million as of 23 June.
- Advocacy continues with donors, partners and MOH to address the impending stock out of drugs procured through the Emergency Medicines Fund (EMF).
Plans for future response

- Continue responding to conflict affected areas through innovative ways as humanitarian space shrinks and access becomes increasingly constricted.
- Prepare for flooding season.
- Continue to support Short Interval Additional Dose (SIAD) in three conflict-affected states.

Health Cluster Partners

Partners supporting the response in South Sudan include the following:

1. National and State Ministries of Health:
2. International Organisations: ICRC, IOM
3. International NGOs: AAHI, AHA, AMREF, ARC, BRAC, CARE, Catholic Medical Mission Board, Caritas South Sudan, CCM, CMA, Concern, COSV, CUAMM, Dorcas, GOAL, Healthnet TPO, IMA, IMC, IRC, Johanniter, Magna, Malteser, Medair, Mentor Initiative, Merlin, MSF-B, MSF-CH, MSF-F, MSF-H, MSF-Spain, PIN, RI, Save the Children, Sign of Hope, World Relief, World Vision
4. National NGOs: HLSS, MRDA, Nile Hope, NPA, RUDI, SMC, SSRC, SUHA, THESO, UNKEA, UNIDO
5. UN Agencies: UNHCR, UNFPA, UNICEF, UNAIDS, UNMISS and WHO.

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