General Overview

- Completeness for weekly reporting in week 40 of 2015 was 78%, which is lower when compared to 92% in week 39 of 2015 and 92% in week 40 of 2014.
- In week 40 of 2015, malaria was the top cause of morbidity among IDPs and registered a proportionate morbidity of 39.7%, which represents a slight increase when compared to 38.9% in week 39 of 2015. The malaria incidence in week 40 of 2015 was the highest in Bentiu PoC followed by Malakal PoC and Renk. The malaria incidence in Bentiu PoC in week 40 of 2015 is consistent with a malaria upsurge that has reached epidemic proportions. The malaria incidence in Malakal, Renk, and UN House PoC shows decline trend.
- A measles outbreak was confirmed in UN House PoC on 1st October 2015 after three measles cases were laboratory confirmed IgM positive. An integrated Polio, measles, and vitamin A campaign started on 7 October 2015 targeting 7350 children (6 – 59mths).
- Cholera cases have risen to 1,814 including 47 deaths [CFR 2.59%] from three counties namely Juba, Kajo-keji and Bor. The cholera 2015 evaluation meeting took place on 6-7 October 2015 in Juba. Findings are expected to guide better preparedness and response in the future and update the Cholera Preparedness and Response Guidelines.
- In week 40 of 2015, Bentiu PoC reported 55 new HEV cases. The cumulative for HEV is 1,571cases including 14 deaths (CFR 0.89%) in Bentiu; 153 cases including seven deaths (CFR 4.6%) in Mingkaman; and 37 HEV cases including one death (CFR 2.7%) in Lankien.
- The nutrition situation in Bentiu PoC remains critical, results of the SMART Survey conducted in August 2015 revealed a GAM of 34.4% and SAM of 10.5%.
- In week 40 of 2015, the under-5 mortality rate for Bentiu PoC was 0.60 deaths per 10,000 per day, which is below the USMR emergency threshold of 2 deaths per 10,000 per day. The notable causes of death in children <5 years in Bentiu included malaria, and pneumonia.

Editorial Note

This bulletin presents disease trends from data submitted through the Early Warning Alert and Disease Network (EWARN) by health partners providing health services to internally displaced persons in South Sudan. Additional integrated disease surveillance and response (IDSR) data is also presented for select diseases like cholera, Kala-azar and AFP. All other IDSR weekly reports are published through IDSR weekly bulletin of the EPR department in the MoH-RSS.

Completeness and Timeliness of Reporting

- During week 40 of 2015, a total of 59 health facilities were expected to submit weekly disease surveillance reports. However 13 of them did not submit their reports.
- Completeness for weekly reporting was 46 (78%) in week 40 of 2015, which is lower when compared to 51 (91%) in week 39 of 2015 and 34 (92%) in week 40 of 2014.
- Timeliness for the weekly reporting was 38 (64%) in week 40 of 2015, as compared to 38 (64%) in week 39 of 2015.
- Figure 1 shows the completeness for weekly reporting from week 01 of 2014 to week 39 of 2015.
In week 40 of 2015, the total consultations were 32,330 which were higher when compared to 31,940 in week 39 of 2015 and 14,514 consultations in week 40 of 2014 (Figure 2). The cumulative consultations since week 01 of 2015 have risen to 805,159 (Figure 2.1).

The annualised outpatients department (OPD) utilization for 2015 is 1.3 consultations per person per year (Figure 2.2). The IDP site-specific annualised OPD utilization rates are shown in Figure 2.2.
Overall Trends of Priority Epidemic-prone Diseases

Table 1 shows the top five causes of morbidity among IDPs with malaria being at the top, followed by Acute Watery Diarrhoea (AWD), Acute Respiratory tract Infections (ARI), Acute Bloody Diarrhoea (ABD) and measles.

Figures 3 and 4 show the proportionate morbidity trends for Malaria, AWD, ARI, ABD and suspected measles.

### Table 1

<table>
<thead>
<tr>
<th>No.</th>
<th>Disease</th>
<th>New cases for weeks</th>
<th>Cumulative cases since week 01 of 2015</th>
</tr>
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<tr>
<td></td>
<td></td>
<td>40 of 2014</td>
<td>40 of 2015</td>
</tr>
<tr>
<td>1</td>
<td>Malaria</td>
<td>3,511</td>
<td>12,837</td>
</tr>
<tr>
<td>2</td>
<td>AWD</td>
<td>811</td>
<td>2,049</td>
</tr>
<tr>
<td>3</td>
<td>ARI</td>
<td>1,761</td>
<td>6,956</td>
</tr>
<tr>
<td>4</td>
<td>ABD</td>
<td>169</td>
<td>194</td>
</tr>
<tr>
<td>5</td>
<td>Measles</td>
<td>7</td>
<td>17</td>
</tr>
</tbody>
</table>

During week 40 of 2015, malaria was the top cause of morbidity followed by ARI, AWD, ABD and suspect measles. During the corresponding week of 2014, malaria was the top cause of morbidity followed by ARI, AWD, ABD and suspect measles. The proportionate morbidity for malaria, ARI, AWD, and suspect measles increased while ABD decreased during this reporting when compared to week 39 of 2015 (Figures 3 and 4).

### Specific Priority Epidemic-Prone Diseases

#### Acute Respiratory Infection (ARI)

During week 40 of 2015, ARI registered the 2nd highest proportionate morbidity of 21.5% (Figures 4 and 5) which is higher when compared to 12.1% in week 40 of 2014 and 19.8% in week 39 of 2015 (Figure 5).

During week 40 of 2015, Malakal PoC registered the highest ARI incidence (cases per 10,000) of 476 followed by Bentiu PoC (237), and UN House PoC (223). During the corresponding week of 2014, the ARI incidence (cases per 10,000) was 329 in Malakal, 96 in Bentiu, and 131 in UN House. (Figure 5.1).
During week 40 of 2015, AWD registered the 3rd highest proportionate morbidity of 6.3%, which is higher when compared to 5.6% in week 39 of 2014 but lower as compared to 7.3% in week 39 of 2015. Despite the cholera outbreaks in Juba, Kajo-keji and Bor, the overall, the AWD trend among IDPs has remained stable since the beginning of 2015. (Figures 4 and 6)

During week 40 of 2015, Renk registered the highest AWD incidence (cases per 10,000) of 92, followed by Malakal (91), and Bentiu (50). In the corresponding week of 2014, the AWD incidence (cases per 10,000) was 85 in Renk, 67 in Malakal and 40 in Bentiu. (Figure 7)
Dysentery / Acute Bloody Diarrhoea (ABD)

During week 40 of 2015, ABD registered the 4th highest proportionate morbidity of 0.6%, which is lower when compared to 1.2% in week 40 of 2014 and 0.79% in week 39 of 2015. Overall, the ABD trend has remained stable since the beginning of 2015 (Figure 4 and 8).

Figure 8

During week 40 of 2015, Renk and Kodok registered the highest ABD incidence (cases per 10,000) of 11, followed by Malakal (8), and Kodok (16). During the corresponding week of 2014, the ABD incidence (cases per 10,000) was 34 in Akoka, 19 in Renk, and 16 in Bentiu (Figure 9).

Figure 9

Measles

During week 40 of 2015, measles registered the 5th highest proportionate morbidity of 0.053% which is higher when compared to 0.048% in week 39 of 2015 and 0.007% week 40 of 2014 (Figure 4 and 10).

After laboratory confirmation of a measles outbreak in UN House PoC on 1st October 2015, an integrated Polio, measles, and vitamin A campaign started on 7 October 2015 targeting 7350 children (6 - 59mths) as part of the response strategy adopted. The campaign will end on 13 October 2015.

Since the beginning of 2015, 499 suspect measles cases have been registered countrywide as part of the measles case based and laboratory backed surveillance system, of which 31 (6.9%) have been laboratory confirmed as measles. The 31 confirmed measles cases were reported from the following counties: Duk (3), Wulu (2), Rubkona (14), Maridi (1), Tambura (1), Wau (1), Kajo Keji (2), Yei (2), Morobo (1), Renk (1), and Juba (3).

Since the beginning of 2015, a total of 41 Rubella cases have been confirmed from Central Equatoria (15), Eastern Equatoria (12), Lakes (3), Unity (1), Upper Nile (6), Western Bahr el Ghazal (2), and Western Equatoria (2).
Figure 10

Suspected measles Proportionate Morbidity from week 51 of 2013 to week 40 of 2015

Malaria

During week 40 of 2015, malaria registered the highest proportionate morbidity of 39.7%, which represents an increase when compared to 38.9% in week 39 of 2015 and 24.2% in week 40 of 2014 (Figures 4 and 11).

During week 40 of 2015, Bentiu PoC registered the highest malaria incidence (cases per 10,000) of 620, followed by Malakal (470), Renk (272) and Kodok (223) as seen in Figures 12 and 12.1.

As seen from Figures 12.2, 12.3, 12.4, and 12.5 showing the malaria incidence by IDP site for 2014 and 2015; the malaria incidence in week 40 of 2015 shows that Bentiu PoC is experiencing a malaria upsurge that is consistent with a malaria epidemic. The malaria incidence in Malakal PoC, Renk, and UN House PoC has declined significantly.

Figure 11

The malaria trend was stable from the beginning of 2015 up to week 19 of 2015 when it started rising steadily. The rising malaria trend is largely driven by transmission in Bentiu PoC, Malakal PoC, UN House PoC, Renk, and Mingkaman (Figures 11.1, 11.2, 11.3, 11.4, and 11.5).

Figure 11.1

Early Warning and Disease Surveillance System

Figure 11.2

Malaria Proportionate Morbidity, Malakal PoC, 2014-2015

Week of reporting

Figure 11.3

Malaria Proportionate Morbidity, UN House PoC, 2014-2015

Week of reporting

Figure 11.4

Malaria Proportionate Morbidity, Renk, 2014-2015

Week of reporting

Figure 11.5

Malaria Proportionate Morbidity, Mingkaman, 2014-2015

Week of reporting

Figure 12

Malaria Incidence, by IDP Site, for week 40 of 2014 and 2015

Cases per 10,000
Figure 12.1

Malaria incidence by IDP site for weeks 1-39 of 2015

Week of reporting in 2015

Figure 12.2

Malaria incidence trends, Bentiu PoC 2014 to 2015

Week of reporting

Figure 12.3

Malaria incidence trends, Malakal PoC 2014 to 2015

Week of reporting

Figure 12.4

Malaria incidence trends, UN House PoC 2014 to 2015

Week of reporting

Figure 12.5

Malaria Incidence Trends, Renk, 2014 to 2015

Week of reporting
In response to the current malaria trends in Bentiu PoC, health-implementing partners have increased from three to five to improve access to primary health care services. Hence, MSF, IOM and World Relief have opened additional clinics in response to the increased caseload. Malaria diagnostics and medicines have been enhanced and integrated community case management of malaria is ongoing. In addition, the malaria mass presumptive treatment campaign of all fever cases at household level was conducted from 10-16 September 2015. The preliminary results revealed that 16,000 out of the targeted 30,000 children under five years were reached.

To interrupt transmission at community level, the first round of vector control interventions (distribution of Long Lasting Insecticide Treated Nets (LLINs), larviciding, and indoor residual spraying (IRS) was conducted in Bentiu PoC. The second round is planned for a week after the first and the third round will be implemented two weeks after the second round. Advocacy is on-going to extend to other IDP sites where malaria upsurges have been reported. In addition, behavioural change communication for prompt care seeking and malaria prevention is ongoing.

Hepatitis E Virus (HEV)

Hepatitis E Virus remains a major public health problem among IDPs and has been confirmed in three out of eight IDP sites where Acute Jaundice Syndrome (AJS) cases have been reported (Figures 13 and 14).

The first AJS cases were reported in Juba 3 PoC in week 04 of 2014. Since then, HEV cases were confirmed in three IDP sites including Mingkaman [8 by ELISA/PCR]; Bentiu [2 by ELISA; 27 by PCR]; and Lankien [3 by PCR]. Figure 14.

In week 40 of 2015, Bentiu PoC reported 55 new HEV cases. Hence the cumulative for HEV is 1,571 cases including 14 deaths (CFR 0.89%) in Bentiu; 153 cases including seven deaths (CFR 4.6%) in Mingkaman; and 37 HEV cases including one death (CFR 2.7%) in Lankien.

Response to HEV is underway guided by the comprehensive HEV response strategy with priority interventions being 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.
Nutrition in Bentiu PoC

Source: Nutrition Cluster in Bentiu

The SMART Survey conducted in August 2015 in Bentiu PoC by Concern Worldwide, is now validated. According to survey results, the prevalence of global acute malnutrition (WH< -2 z-score and/or oedema) is 34.1%, with associated Severe Acute malnutrition 10.5%. WHO standards define the emergency threshold at 15% for GAM and at 2% for SAM, therefore nutrition indicators are alarmingly above the emergency limit. The GAM rate by MUAC is 11.7% with associated SAM rate at 1.7%. The nutrition situation in Bentiu PoC continues to deteriorate and remains critical.

Cholera

As of 04 October 2015, a total of 1,814 cholera cases including 47 deaths (CFR 2.59%) have been reported in Juba and Kajo-keji (Central Equatoria State) and in Bor (Jonglei State). In Juba County, 1,618 cases including 45 deaths (CFR 2.78%) have been reported from seven Payams; 57 cases including one death (CFR 1.75%) reported from four payams in Kajo Keji County and 139 cases including one death (CFR 0.72%) were reported from Malou and other areas in Bor county.

National and state level cholera taskforce committees are coordinating the ongoing cholera preparedness and response activities. As a result, a drastic decline in cases has been registered in the affected counties. Figure 15

An evaluation of the 2015 cholera preparedness and response activities was conducted on 6-7 October 2015. The findings are expected to guide better preparedness and response in the future and update the South Sudan Cholera Preparedness and Response Guidelines.

Acute Flaccid Paralysis (AFP)

Since the beginning of 2015, a cumulative of 240 AFP cases have been reported countrywide (Table 3).

The annualized non-Polio AFP (NPAFP) rate (cases per 100,000 population children 0-14 years) is 3.99 per 100,000 population of children 0-14 years (target ≥2 per 100,000 children 0-14 years) (Table 3).
All but three states (Jonglei, Unity, and Upper Nile) 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 15.0% (target ≥10%) (Table 3).

Stool adequacy stands at 96%, a rate that is higher than the target of ≥80% (Table 2).

The cumulative for circulating Vaccine Derived Poliovirus type 2 (cVDPV2) cases now stands at three cases with only one case reported in 2015.

### Table 2

<table>
<thead>
<tr>
<th></th>
<th>Population &lt;45 Years</th>
<th>Cumulative AFP Cases</th>
<th>Polio cases</th>
<th>Pending Lab/CFT</th>
<th>Pending Lab/HT</th>
<th>Pending EIR</th>
<th>NPAFP Rate</th>
<th>Stool Adequacy</th>
<th>Lab Indicators</th>
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<td></td>
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<td></td>
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<td>1</td>
<td>7</td>
<td>16</td>
<td>15</td>
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<td>1</td>
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<td>3.6</td>
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<td>10</td>
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<td>6</td>
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<td>0</td>
<td>1.7</td>
<td>11</td>
<td>9</td>
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<td>WARAB</td>
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<td>220</td>
<td>7</td>
<td>1</td>
<td>16</td>
<td>3.99</td>
<td>240</td>
<td>230</td>
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</table>

**Other Diseases of Public Health Importance**

**Guinea worm (Dracunculiasis)**

- There was no new suspect Guinea worm disease case reported during week 40 of 2015.

**Viral Haemorrhagic Fever**

- The Republic of South Sudan continues to enhance its readiness capacities for Ebola/Marburg virus disease.
- The national Ebola/Marburg taskforce is coordinating the implementation of interventions guided by a national Ebola/Marburg contingency plan.
- No Ebola/Marburg cases have been confirmed in South Sudan but six alerts have been investigated in Ezo, Nzara, Terekeka (Tali) and Juba (Hai Jalaba and Gudele) since 2014.

**Visceral Leishmaniasis (Kala-azar)**

- As of week 40 of 2015, a total of 2,767 cases (2,213 [80%] new cases; 554 [20%] relapses/PKDL; 99 [3.6%] defaulters; and 91 [3.3%] deaths) have been reported from 23 treatment centres.
- During the same period of 2014, a total of 5,035 cases (4,675 new cases; 360 relapses/PKDL; 203 defaulters and; 155 deaths (CFR 3.1%) were reported from 21 treatment centres.
- Of the 2,767 cases reported to date, the majority is female [1,545 (55.8%)], those aged ≥15 years [1242 cases (44.97%)] followed by those aged 5-14 years [1115 cases (40.6%)].
- During 2015, Lankien has reported the highest number of cases (1,274); followed by Walgak (306); Pagil (176), Ulang (163); Akobo (133), Chui (126); Melut IDP (116); Narus [(MOH/ARC)] (106); KCH 67 and Rom (64).
- Generally the number of cases reported in 2015 is lower when compared to 2014, which is attributed to the low reporting sites, withdrawal of some partners from health facilities and inaccessibility to health facilities due to insecurity. However, there is need to start preparedness activities for the peak season.
- WHO and partners continue to support enhanced surveillance, case management and interventions to interrupt transmission through the following: supporting implementing partners with case management supplies; training frontline healthcare workers on Kala-azar case management; support supervision of treatment facilities; supporting community sensitisation on Kala-azar; and distribution of LLITNs in affected and high-risk areas.
Meningitis

There was no new suspect meningitis case reported in week 40 of 2015.

Animal bites (suspect rabies)

There was no new suspect rabies case reported in week 40 of 2015.

All-Causes Mortality Data

During week 40 of 2015, mortality lists were received from Akobo, Bentiu PoC and Juba 3 PoC. A total of 33 deaths were reported, of which 23 (69.7%) deaths occurred in Bentiu PoC and 14 (42.4%) occurred in children under five years. During the corresponding week of 2014, 10 deaths were reported. (Table 3).

During week 40 of 2015, malaria registered the highest proportionate mortality of 21% (30% in week 39 of 2015), followed by pneumonia (18%) (Table 4.1).

In week 40 of 2015, the 7 malaria related deaths occurred in Bentiu PoC with the majority (57%) in children under five years of age (Table 3.1).

Table 3: Number of deaths by IDP camp in week 40 of 2015 and week 40 of 2014

<table>
<thead>
<tr>
<th>IDP site</th>
<th>2014</th>
<th>2015</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>&lt;5yrs</td>
<td>≥5yrs</td>
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<tr>
<td>Akobo</td>
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</tr>
<tr>
<td>Bentiu</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Juba 3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Malakal</td>
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<td>1</td>
</tr>
<tr>
<td>Melut</td>
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<td>Tomping</td>
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<tr>
<td>Grand Total</td>
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</table>

Table 3.1: Proportionate mortality by cause of death and by IDP site in week 40 of 2015

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Akobo</th>
<th>Bentiu</th>
<th>Juba 3</th>
<th>Grand Total</th>
<th>Proportionate mortality %</th>
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Under-five Mortality Rate (USMR)

In week 40 of 2015, with a total population of 119,038 and 10 new deaths among under-fives in Bentiu PoC, the under-5 mortality rate was 0.60 deaths per 10,000 per day, which is below the USMR emergency threshold of 2 deaths per 10,000 per day (Figures 16 and 16.1).
The notable causes of death in children under five years in Bentiu during week 40 of 2015 included malaria, pneumonia and SAM.

**Figure 16**

Under-5 Mortality Rate per 10,000 per day by Site - week 51 of 2013 to week 40 of 2015

**Figure 16.1**

Under-5 Mortality Rate per 10,000 per day in Bentiu PoC - week 51 of 2013 to week 40 of 2015

**Crude Mortality Rate**

The crude mortality rates (CMR) from week 51 of 2013 to week 40 of 2015 are shown in Figure 17.

During week 40 of 2015, the CMRs were below the emergency threshold for the three IDP sites that submitted mortality data. The CMR for Bentiu PoC in week 40 of 2015 was 0.3 deaths per 10,000 per day.

**Disease specific Mortality**

**Mortality due to Acute Watery Diarrhoea**

Since the beginning of 2015, a total of 63 AWD deaths have been reported of which 39 (61.9%) occurred in Bentiu, 11 (17.5%) in UN House, 4 (6.4%) in Wau Shiluk, 3 (6.4%) in Akobo, 3 (4.8%) in Mingkaman, and 3 (4.8%) in Malakal PoC. Overall, 215 AWD deaths have been reported since the onset of the crisis with Bentiu PoC having the highest number of AWD deaths (Figure 18).
During week 40 of 2015, a total of 7 malaria deaths were reported from Bentiu PoC. Overall, Bentiu PoC has reported the highest number of deaths (681 deaths) since the beginning of the year with 1452 (22.3%) of the deaths attributed to malaria (Figure 18.1 and Table 7).

**Overall Mortality**

Since the beginning of 2015, a total of 1,126 deaths have been reported from the IDP sites of which 546 (48.5%) were children under-5 years. Most of the deaths occurred in Bentiu, Malakal, Juba 3 PoC and, Wau Shiluk (Table 5).

Since the beginning of 2015, malaria has registered the highest proportionate mortality of 16.7% followed by TB/HIV/AIDS (7.7%), and malnutrition (7.5%), and (Table 5).

**Table 5: Mortality trend by IDP site, week 1 of 2015 to week 40 of 2015**

<table>
<thead>
<tr>
<th>IDP site</th>
<th>Acute Jaundice</th>
<th>Acute watery diarrhoea</th>
<th>Cancer</th>
<th>Diarrhoea</th>
<th>Epilepsy</th>
<th>Hepatitis E</th>
<th>Malaria</th>
<th>Meningitis</th>
<th>Measles</th>
<th>Maternal death</th>
<th>Malaria pneumonia</th>
<th>Dysentery</th>
<th>Gastroenteritis</th>
<th>Septicemia</th>
<th>TB/HIV/AIDS</th>
<th>Typhus</th>
<th>Hepatitis E</th>
<th>Others</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bentiu</td>
<td>6</td>
<td>39</td>
<td>10</td>
<td>12</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>152</td>
<td>0</td>
<td>10</td>
<td>26</td>
<td>39</td>
<td>57</td>
<td>27</td>
<td>32</td>
<td>1</td>
<td>14</td>
<td>244</td>
<td>681</td>
</tr>
<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>9</td>
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<td>10</td>
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<td>15</td>
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<td>154</td>
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<td>0</td>
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<td>61</td>
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<tr>
<td>Grand Total</td>
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<td>63</td>
<td>15</td>
<td>17</td>
<td>20</td>
<td>9</td>
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<td>413</td>
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</tbody>
</table>

**Proportionate mortality [%]**

|                | 0.06 | 0.56 | 1.3 | 1.5 | 1.8 | 0.8 | 1.7 | 16.7 | 0.2 | 1.0 | 6.5 | 6.1 | 7.5 | 2.9 | 7.7 | 0.1 | 1.3 | 36.7 | 100 |

**General recommendations**

In response to the current malaria trends in Bentiu PoC, Malakal PoC, UN House PoC, and Renk a coordinated response has been initiated to improve access to treatment, interrupt transmission, and engage communities. This includes mass presumptive treatment of fever cases for malaria, distribution of LLINs, larviciding, indoor residual spraying, and behavioral change communication.
Early Warning and Disease Surveillance System

- Consistent and sustained implementation of a comprehensive HEV response is already underway and includes supportive case management for symptomatic cases, targeted preventive interventions during antenatal visits; improving access to safe drinking water and improved sanitation facilities; instituting interventions for a safe water chain; preventive vaccination using HEV vaccine for groups with a high risk for adverse clinical outcomes including mortality; and house-to-house hygiene and sanitation promotion including distribution of NFIs like soap and jerry cans.
- The vaccination on arrival approach should be implemented at UN House PoC after the current integrated measles and polio vaccination campaign (7-13 October 2015). In addition the routine vaccination activities should be strengthened.
- Enhanced nutrition screening at designated clinics, mobile clinics, and during the house-to-house visits are underway to identify and initiate early treatment for malnourished cases.
- The national and state level cholera taskforce committees should continue implementing cholera response interventions to control the outbreaks in Juba, Kajo-keji and Bor.
- Integrate TB/HIV/AIDS prevention and control into the routine healthcare services in all the IDP sites.
- Biological samples should be obtained and shipped to Juba to allow laboratory confirmation of emerging outbreaks of measles, AJS, bloody diarrhea, and cholera.
- The ongoing integrated response to Kala-azar that entails enhanced surveillance, improved access to diagnosis and treatment facilities, refresher training of healthcare workers on Kala-azar case management, replenishing of drug stocks in endemic areas, as well as communication on Kala-azar prevention and control should be sustained.
- Support the implementation of the Ebola preparedness and response so as to enhance capacities for case detection, investigation, response and community awareness on Ebola prevention and control.
- Please send all disease surveillance information and any outbreak rumours to outbreak_ss_2010@yahoo.com.
- IDSR reports should be submitted by COB Monday after the close of each epidemiologic week.

For comments or questions, please contact
Department of Epidemics, Preparedness and Response, MoH-RSS
E-mail: outbreak_ss_2010@yahoo.com,
HF radio frequency: 8015 USP; Selcall: 7002