Cholera outbreak in Juba, Central Equatoria State

Situation Report (Sitrep No. 1) as at 17:00 Hours; 16 May 2014

Summary statistics

<table>
<thead>
<tr>
<th>Payam</th>
<th>Week 18</th>
<th>Week 19</th>
<th>Week 20</th>
<th>Total by Payam</th>
</tr>
</thead>
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<tr>
<td>Northern Bari</td>
<td>2</td>
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<td>15</td>
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<tr>
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<td>11</td>
</tr>
<tr>
<td>Gondokoro</td>
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<td>1</td>
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<tr>
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<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Kator</td>
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<td>3</td>
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<tr>
<td>Lirya</td>
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<td>1</td>
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<tr>
<td>Total by epi-week</td>
<td>3</td>
<td>2</td>
<td>38</td>
<td>43</td>
</tr>
</tbody>
</table>

Situation update

On 29 April 2014, the MSF clinic in Juba 3 UN House IDP camp notified WHO of a suspect cholera case involving a 28 year-old male who left his household in Juba 3 IDP camp on 28 April, 2013 at around 11a.m to visit his relatives in Gudelle 2. While there, he ate beans, eggplant, and bread bought from a street vendor in the Suk Zande market in Gudelle 2. Around 4p.m. the same day, he developed severe diarrhoea, abdominal pain, and vomiting and body weakness. He slept in Gudelle with his relatives and was brought to MSF clinic in Juba 3 IDP camp on the 29 April 2014 by his brother in a hired private car. His stool samples were shipped to AMREF, Nairobi where *Vibrio cholerae inaba* was isolated.

Epidemiological investigations showed that the case received one dose of oral cholera vaccine (OCV) on 11 March 2014. Two probable cholera cases not vaccinated using OCV were identified in the household he visited in Gudelle but none were identified among the household members in Juba 3 IDP camp since they were all fully vaccinated using OCV.

As seen from the above summary table; a total of 43 cases including 2 deaths (CFR = 4.7%) have been reported from seven (7) Payams in Juba county. The majority of the cases have been reported from Northern Bari 15 (35%), Muniki 11 (26%), and Juba 8 (19%) (see map below). A total of two (2) cases have now been confirmed to have *Vibrio Cholerae inaba* following tests by AMREF, Nairobi.
Figure one shows the outbreak trends since the initial case was reported on 29th April 2014. These trends show a typical propagated outbreak that is typical of person-to-person transmission. The below map also shows the distribution of cases throughout Juba town.
The main risk factors include; drinking of unboiled or untreated river water supplied by water tankers, poor latrine coverage, and eating petty foods sold on the roadside and makeshift markets. Poor personal and communal hygiene in the communities are a major barrier to public health. Open defecation in the bush and affinity to consume water from unsafe sources (surface water-river & ponds) is high.

**Response Actions**

**Coordination**

- A national emergency task force has been activated and has convened the first meeting.
- Technical working groups within the national task force have also convened separated meetings to discuss the response plan.
- A national Cholera Preparedness and Response plan has formally been activated.
- Cholera emergency meeting was convened at the Mayor’s office to discuss roles and responsibilities of different partners.

**Case management:**

*(MOH, WHO, UNICEF and MSF):*

- Held a meeting with Juba hospital management to identify dedicated staff to manage the isolation ward and to take stock of supplies required to manage cholera cases.
- Tourd the hospital to identify additional space for setting up a tent to accommodate additional cases.
- Zoned out the current isolation ward to designate triage and assessment areas, staff or sterile area, severely ill patients area, and convalescent areas.
- Identified Health car workers to man the isolation ward and their training scheduled, planned for 17 May 2014.
- Ministry of Health Officials from Central Equatorial state moved around Juba to identify suitable areas to set up additional cholera treatment centres. A play field belonging to a local school in Muniki was identified as appropriate for a CTC. The Ministry of Education will be engaged to access the playground. El-Shaba children’s hospital land was also assessed but found not to be appropriate for CTC.
- MSF provided medical supplies and specialized beds for cholera.
- WHO provide one Diarrhea Disease Kit, worth treating 100 severe cases of cholera and 400 mild or moderate cases of cholera; UNICEF also provided one diarrhea kit and one large tent to Juba Teaching Hospital
- WHO also donated with two Personal Protective Equipment (PPE) kits including 20 body bags and 40 PPE for the health personnel to Juba Teaching Hospital (JTH).
Social mobilization:

(Who, UNICEF, MEDAIR, SSRC, CES and ARI):

- A social mobilization plan has been developed and shared with partners involved in social mobilization.
- Key messages have been widely shared with communities, partners and media houses (eye radio, Radio Miraya and Radio Bakhita.). Community leaders in the affected communities have been alerted and message dissemination has commenced.
- A press release has been issued and disseminated widely to all media houses and partners.
- The Minister of Health and the City Mayor of Juba Town Council convened a meeting of community leaders and the media and used it to pass key messages which are running on air.
- A partner has been identified and agreed on (Medair) to commence trainings of community volunteers in areas worse affected.

WASH:

UNICEF did the following:

- Distributed WASH supplies to Juba Teaching Hospital
- Donated chlorine to the Mayors office as protective materials for those working in the isolation ward.
- Improved sanitation at Juba teaching hospital and
- Distributed cholera kits enough to treat 100 people.
- WASH has mobilized mobile teams to conduct door to door hygiene promotion and identified teams to conduct spraying of all houses with suspected cases, and
- Has increased the levels of water chlorination in the protection of civilian sites in Juba.

Surveillance and Laboratory:

(WHO & MOH)

- Conducted epidemiological investigations after the index case that culminated into the identification of the current outbreak.
- Line listing and epidemiological analyses continue to document trends that are being used to direct the response.
- A rumor register has been created to support comprehensive case and death verification in the community and health facilities.
- Prioritized contact listing is currently being undertaken by the team to ensure that all new suspect cases are promptly identified and isolated.
- Sample collection, rapid testing, and shipment of samples for culture and sensitivity testing in Nairobi continues. On May 14 and 16, 2014, a total of 21 stool samples were collected from suspect cases admitted in Juba Teaching
Hospital isolation ward. All the samples tested negative for cholera following tests using monovalent 0139 rapid test. Aliquots of the samples have been shipped for culture and sensitivity testing in AMREF, Nairobi.

Current gaps:

1. Shortage of human resources to manage the CTU.
2. Referrals is suffering major lags due to fuel shortages,
3. Need for tarpaulin for the CTU floor.
4. Blankets for keeping the patients warm are lacking.
5. Funding to support public health response (Social mobilization, WASH and Surveillance) at community level and case management are short.

Planned activities

1. The second national taskforce meeting is scheduled for 17 May 2014 starting 10:00 am in the Ministry of Health Boardroom.
2. Training of health workers, cleaners, guards, and sprayers in Juba Teaching Hospital to manage the isolation ward is scheduled for 17 May 2014.
3. Case line listing, contact tracing, active case search, and epidemiological investigations are ongoing.
4. Provide technical and logistical support to Juba Teaching hospital to ensure that cholera patients receive optimum care.
5. Set up additional CTCs in Juba to decongest Juba Teaching hospital and to prevent cases from travelling long distances to access medical care.
6. Training of media house owners, managers and staff
7. Intensify social mobilization and health promotion activities through door to door campaigns, public service announcements, radio jingle, films, and counseling.

Conclusion:

Given that the outbreak has just been declared, all partners are working hard to ensure that all plans are up and running. Additional partners are coming on board. Most of the huddles in case management could get fixed in the coming days should the horizon keep constant. There is a risk of the outbreak spreading to other surrounding counties and villages if community interventions are delayed. For the moment, there is minimal funding to support community interventions.

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