South Sudan COVID-19 Weekly Epidemiologic Bulletin

Issue #: 35

30 August – 05 September 2021

Epidemiologic Week 35

Summary Statistics for Epidemiologic Week 35

99	11526	0	120	513	216772
New Confirmed Cases	Total Confirmed Cases	New Deaths	Total Deaths	Contacts Under Follow-up	Cumulative Samples Tested

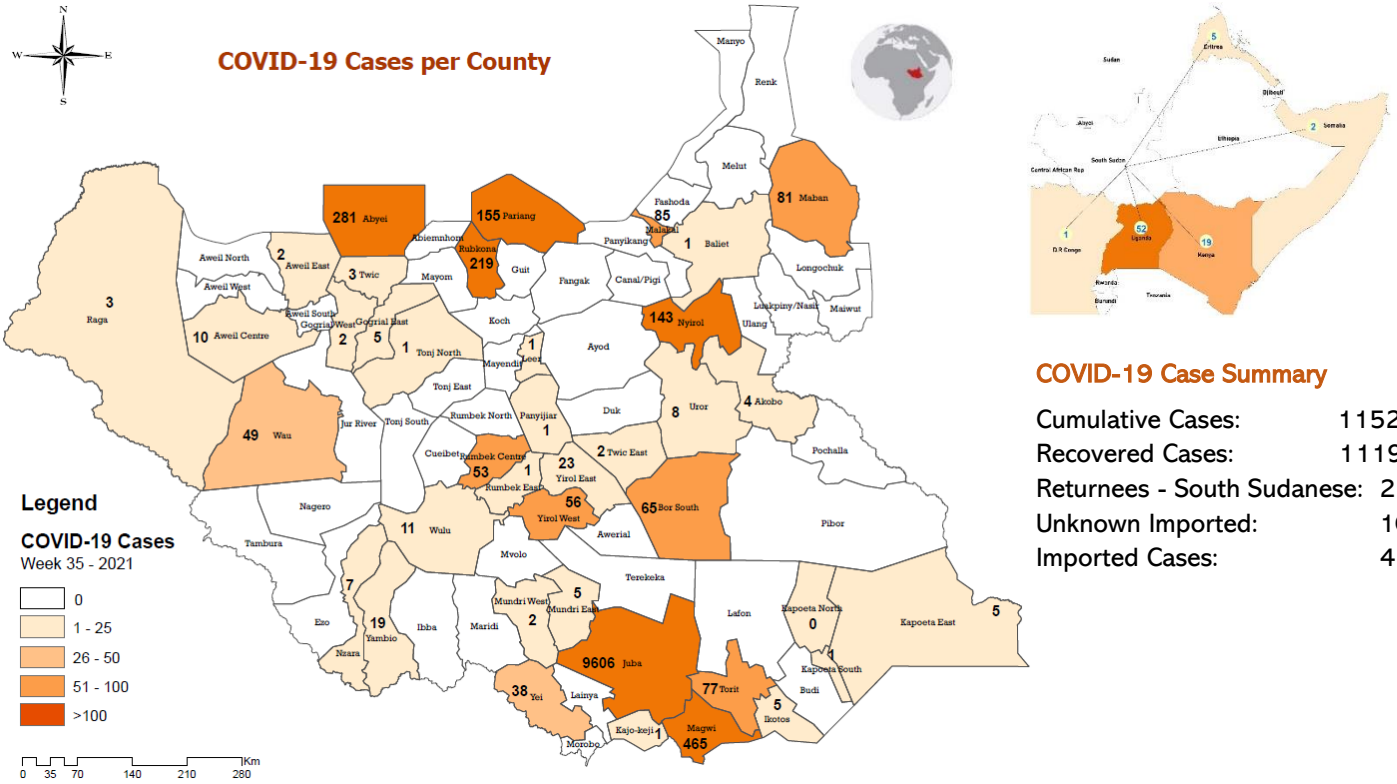

Figure 1. Map of cumulative reported COVID-19 cases, by county

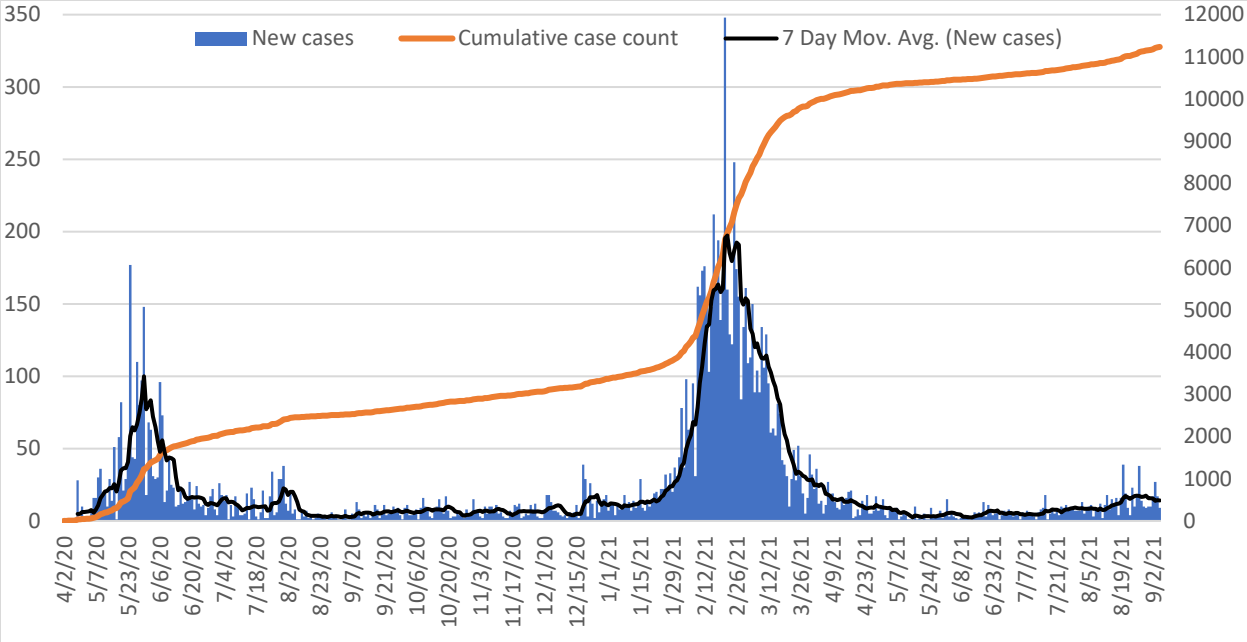

Figure 2. Epidemiological curve of reported cases through Week 35, showing new cases (blue bars), rolling 7-day average of reported cases (black line), and total cumulative reported cases (yellow line)

Epidemiology and Surveillance Update

Ninety-nine new cases were identified in Week 35, bringing the cumulative number of confirmed cases to 11526[1], including 410 imported cases mainly from South Sudanese returnees (238), Uganda (53), and Kenya (19). There were no new imported cases in Week 35. Moving averages for yield, case count, and proportional daily case change are trending upwards, with recorded increase in new cases in the last five epi weeks. There were no reported deaths in Week 35, so the cumulative deaths remained at 120. However, mortality surveillance and reporting in the community needs to be more active (i.e., the mortality surveillance team needs to respond to all community death alerts and visit mortuaries every day to look for suspect deaths and swab them). The case tally for Week 35 represents only 0.9% of the cumulative case total, compared to a high of 19.8% in Week 07 during the peak of the second wave [Figure 2].

At the end of Week 35, 35 (43.8%) of the 80 counties in the country have a confirmed case [Figure 1]. There was no county with a first confirmed case this week. Cumulatively, the age distribution of cases reported is skewed towards people under 50 years old, with most cases occurring in the 20-49 age group and skewed heavily towards males [Figure 3]. Fifty-six percent of cases reported their nationality as South Sudanese, with a significant proportion (22.4%) with unknown nationality [Figure 4]. Despite expanded testing and increases in cases, the demographic breakdown profiles of the cases have not changed since the beginning of the outbreak. However, certainty about the case profiles is affected by increased lack of individual-level data and line lists especially from private testing facilities and GeneXpert (GXP) testing sites. This affects our ability to properly detect any changes in profiles.

[1] 37 cases from Queens Medical Complex in Week 35 will be reported as backlogged cases in Week 36

About 85.9% of the cases in Week 35 were reported through traveler screening, with the remaining cases coming through alerts (14.1%) especially at the GXP sites. Cumulatively, pre-travel screening account for the greatest proportion of cases (62.6%), followed by contact tracing (10.7%), alerts (8.1%), and sentinel surveillance (7.5%) [Figure 5B]. Four testing sites (Med Blue [41], Crawford [18], NPHL [10], and PIC Diagnostic Center [8]) contributed most (77.8%) of the reported cases in Week 35. The cases reported in Week 35 came from Central Equatoria (86.9%), Ruweng Administrative Area (6.1%), Jonglei and Western Equatoria (3.0%), and Eastern Equatoria (1.0%). Upper Nile, Abyei Administrative Area, Western Bahr el Ghazal, Lakes, Northern Bahr el Ghazal, Unity, and Warrap did not report any cases in Week 35 [Figure 6]. In Week 35, seven healthcare workers were confirmed as cases, bringing the cumulative case tally among healthcare workers to 283. Most of the cases among healthcare workers came from Central Equatoria (237), followed by Eastern Equatoria (17), Abyei (13), and Jonglei (10). Three states (Upper Nile, Western Bahr el Ghazal, and Northern Bahr el Ghazal) have not reported any cases among healthcare workers [Figure 7].

Although we have been seeing more testing reported from the states, mostly driven by further decentralization of GXP machines throughout the country (at least 30 sites), it is still difficult to know if there is community transmission in the states because there is still not enough testing being done. Overall, COVID-19 surveillance and testing at sub-national levels continue to be weak and need scaling up.

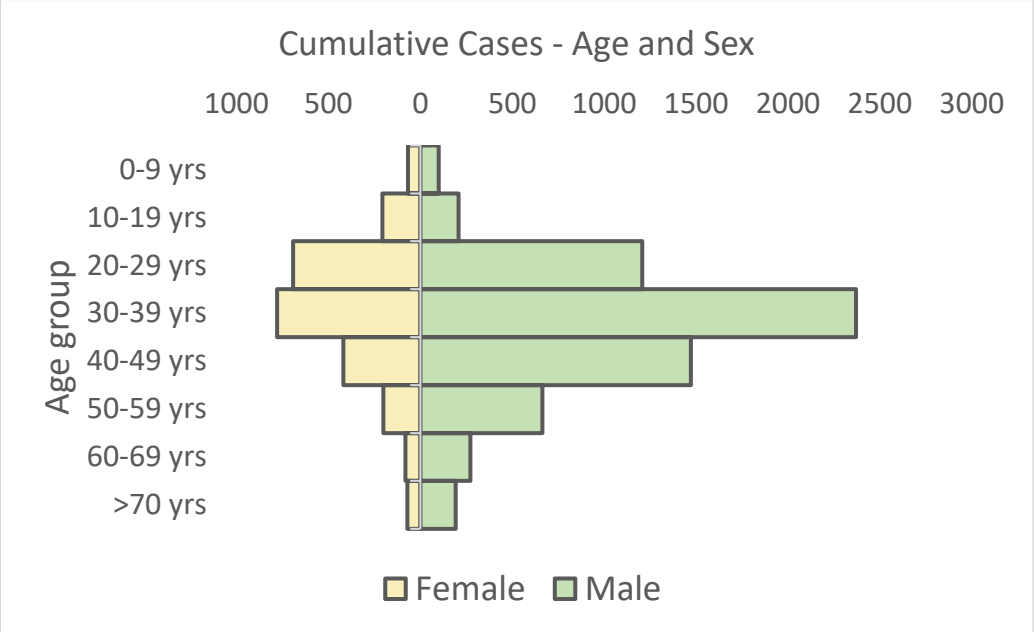

Figure 3. Distribution of cumulative reported cases by age and sex

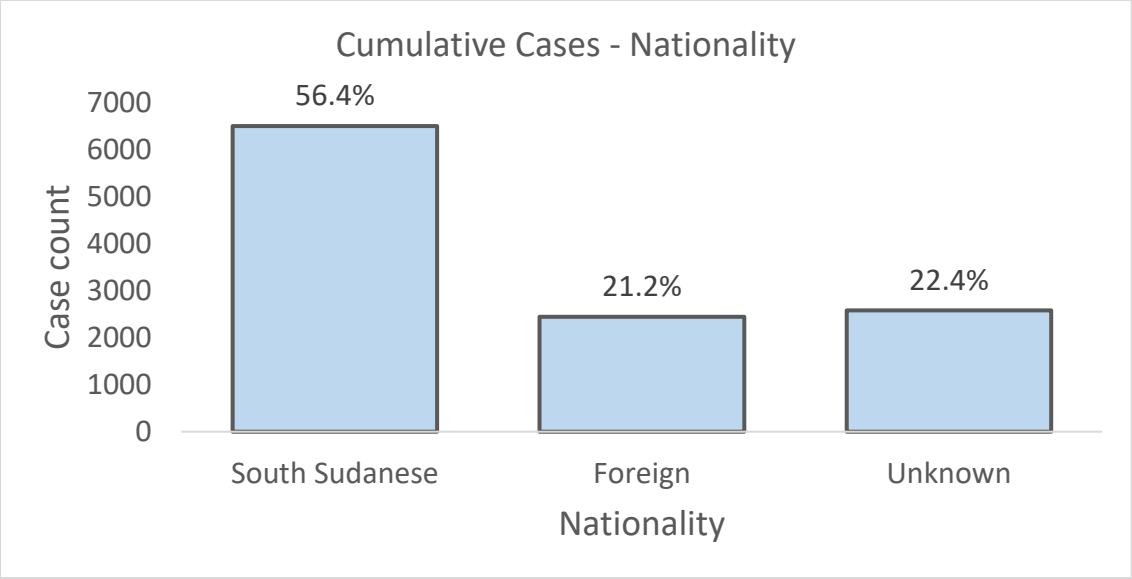

Figure 4. Distribution of cumulative reported cases by nationality

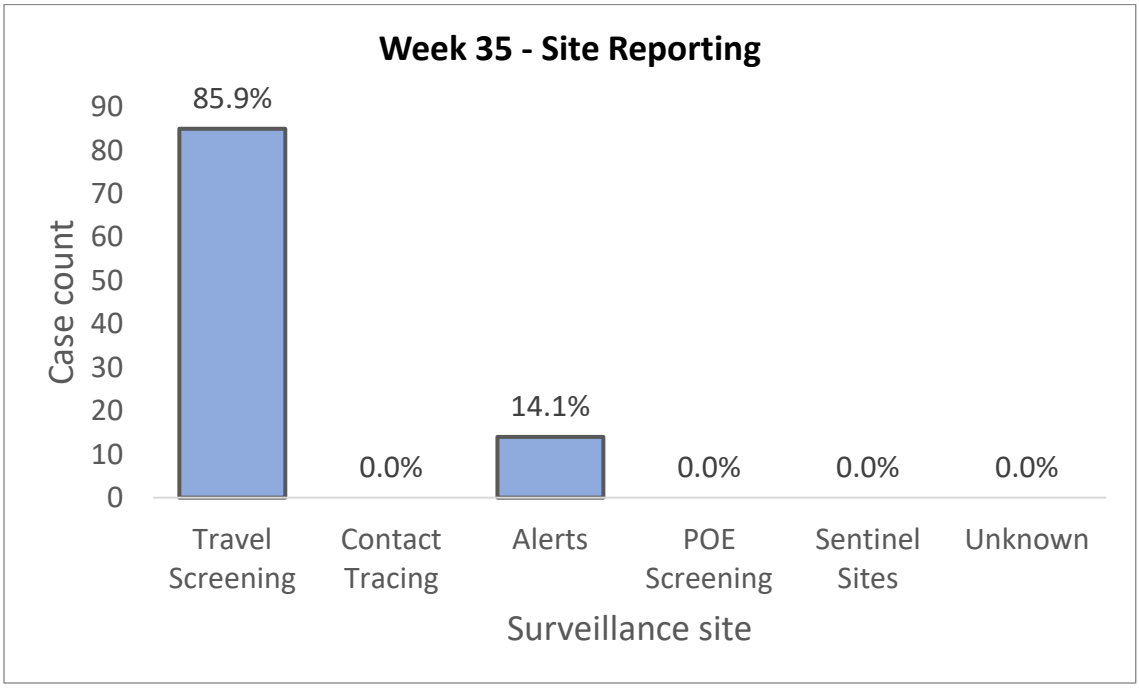

Figure 5A. Case by surveillance site (Week 35)

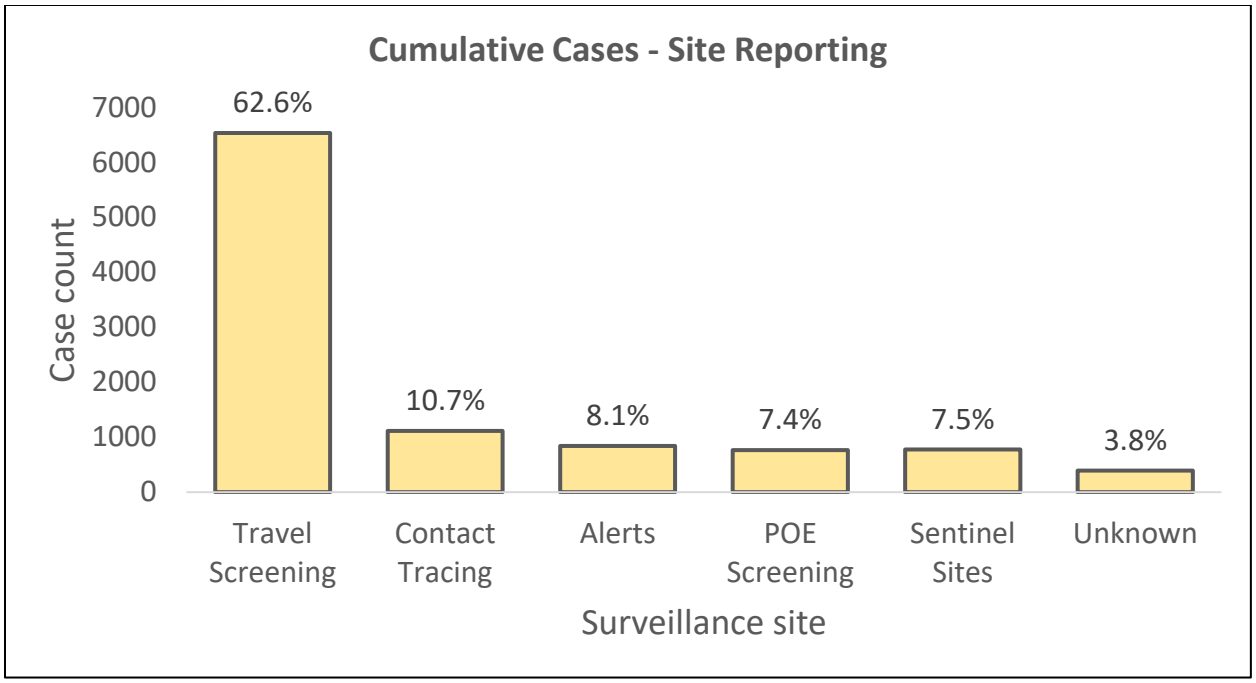

Figure 5B. Cases by surveillance site (cumulative)

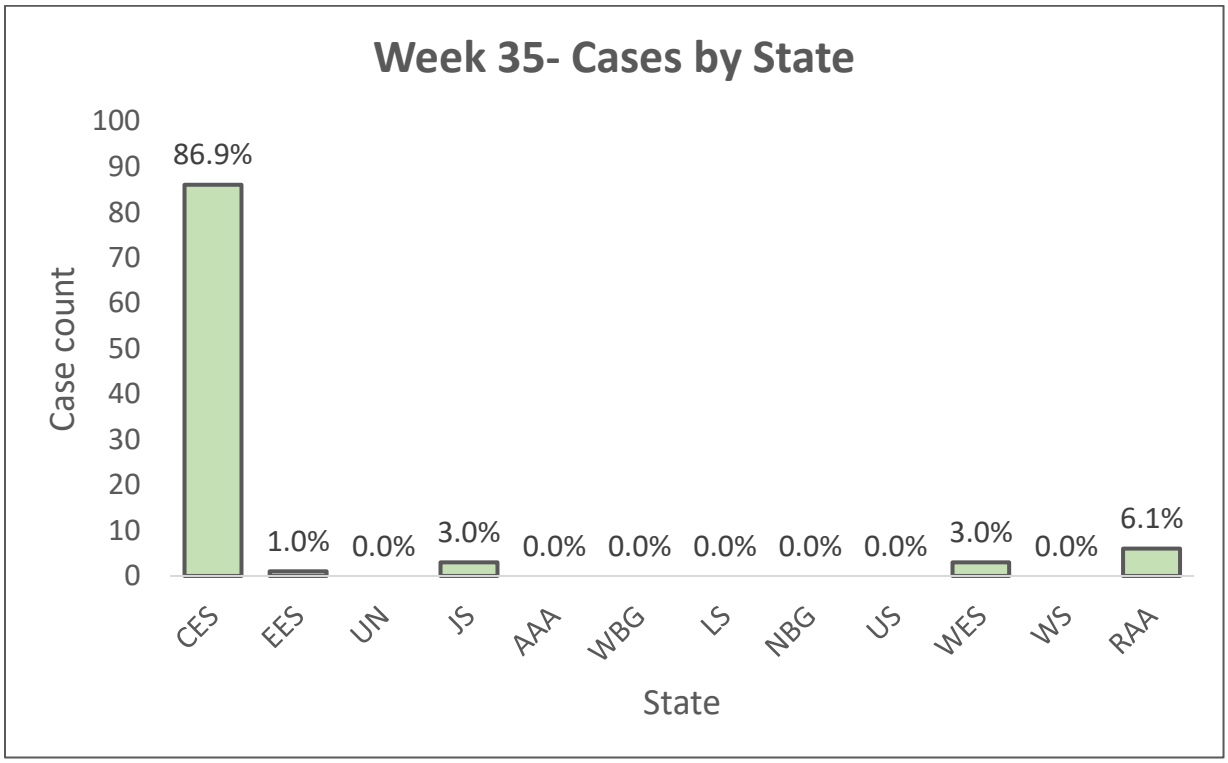

Figure 6. Case distribution by state (Week 35)

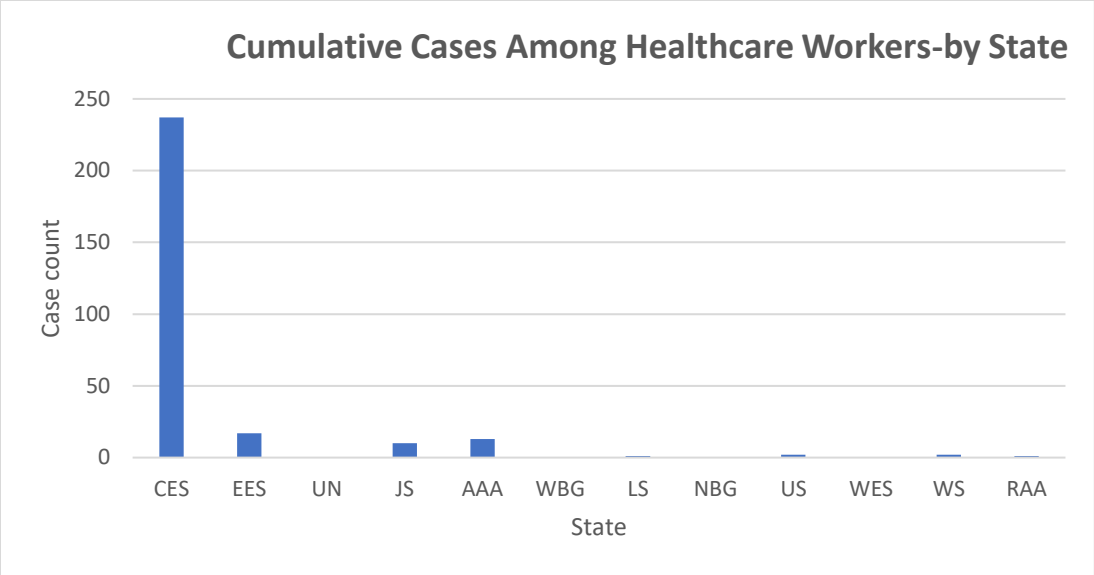

Figure 7. Cases among healthcare workers by state (cumulative)

Interpretation and recommendations

- **This week showed a 16.2% increase in the number of reported cases compared to Week 34. This is fifth consecutive week of recorded increase in new cases. As the country monitors COVID-19 trends for a potential third wave, it is important to conduct regular genomic sequencing to know which variants of SARS-CoV-2 are in circulation since they might change the transmissibility, clinical presentation, and severity of the disease among the population. So far three variants of concern (Alpha [B.1.1.7], Beta [B.1.351], and Delta [B.1.617.2]) have been identified in the country, with the Delta variant predominating (93% of the latest sequencing results)**
- Improved quality of data collection on individuals tested with key variables including surveillance site, nationality, age, sex, previous test history, clinical profile/symptomology remains critical to understand and characterize cases. The lack of complete individual-level data from some private testing sites as well as from most facilities using GXP testing continues to affect our ability to fully describe the outbreak in South Sudan. **Private laboratories and partners supporting the GXP testing sites need to provide to the EOC Data Management Unit individual-level data for both positive and negative results to better characterize the outbreak in the country**
- **Contact tracing and alerts accounted for 0.0% and 14.1% of this week's case tally respectively, with most cases still coming from pre-travel screening (85.9%).** Cumulatively, cases originating from contact tracing (10.7%) and alerts (8.1%) remain important to improve case surveillance in these populations with timely screening/testing of suspects and all listed contacts
- Despite recent improvement in reporting of results from GXP testing sites at sub-national level, only 10.8% of all confirmed cases have been detected in states other than Central Equatoria and Eastern Equatoria. **In addition, about 83.3% of all cases have been detected in Juba compared to 16.7% outside of Juba, indicating that surveillance, testing, and reporting need to be improved and expanded in locations outside Central Equatoria**

Laboratory Update

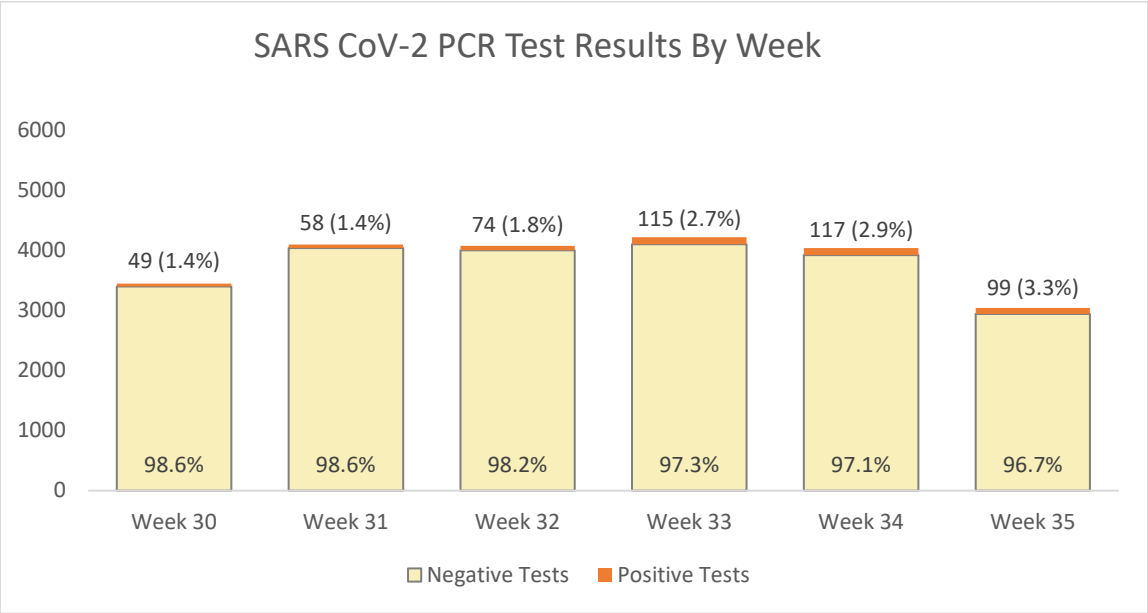

Figure 8. SARS-COV-2 PCR test results by week

Interpretation and recommendations

- **Average positivity yields have been increasing in the last five epi weeks, reaching 3.3% in Week 35 [Figure 8]**
- Positivity yields were as follows in Week 35: Crawford (5.0%), Med Blue (3.2%), NPHL (2.3%), Nojum (2.1%), Nimule (0.0%), PIC Diagnostics (4.4%), Biolab (1.4%) [Figure 9A], Rumbek (0.0%), UN Clinic (10.0%), Gordhim (0.0%), Torit (25.0%), Makpandu (8.3%), Abyei (0.0%), Bor (20.0%), Tambura (0.0%), Lui (0.0%), Agok (0.0%), Mapourdit (0.0%), Pariang (1.5%), Yei (20.0%), and Pamir (5.6%) [Figure 9B]. Approximately 216772 SARS-COV-2 PCR tests have been performed throughout the outbreak with 5.3% crude positivity
- **Currently, there is limited QA oversight of private testing facilities by the NPHL. The NPHL must implement a QA system for all COVID-19 testing laboratories in South Sudan. This can be adapted from the quality assurance (QA) system already in use for HIV and tuberculosis in the country**
- Reluctance to use MOH data capture tools, late and aggregate reporting (i.e., no individual-level data), and refusal to facilitate the work of the contact tracing and case management teams, have been major challenges from working with the private testing facilities. **It is important that the private testing laboratories fully cooperate with the country COVID-19 SOPs including on testing protocols and data collection and reporting requirements**
- Lastly, the EOC needs to produce a comprehensive testing dataset (combining positive and negative results with the CIF variables). This is important to calculate yields of sub-groups presenting for testing to see whether the epidemiology is changing for any of them (e.g., age groups, sex, clinical profile, testing category, etc.). For example, despite expanded testing and increases in cases, the demographic breakdown profiles of the cases have remained unchanged.

A comprehensive testing dataset could tell us if the profile of those presenting for testing is the same as it was during the first six months of the outbreak

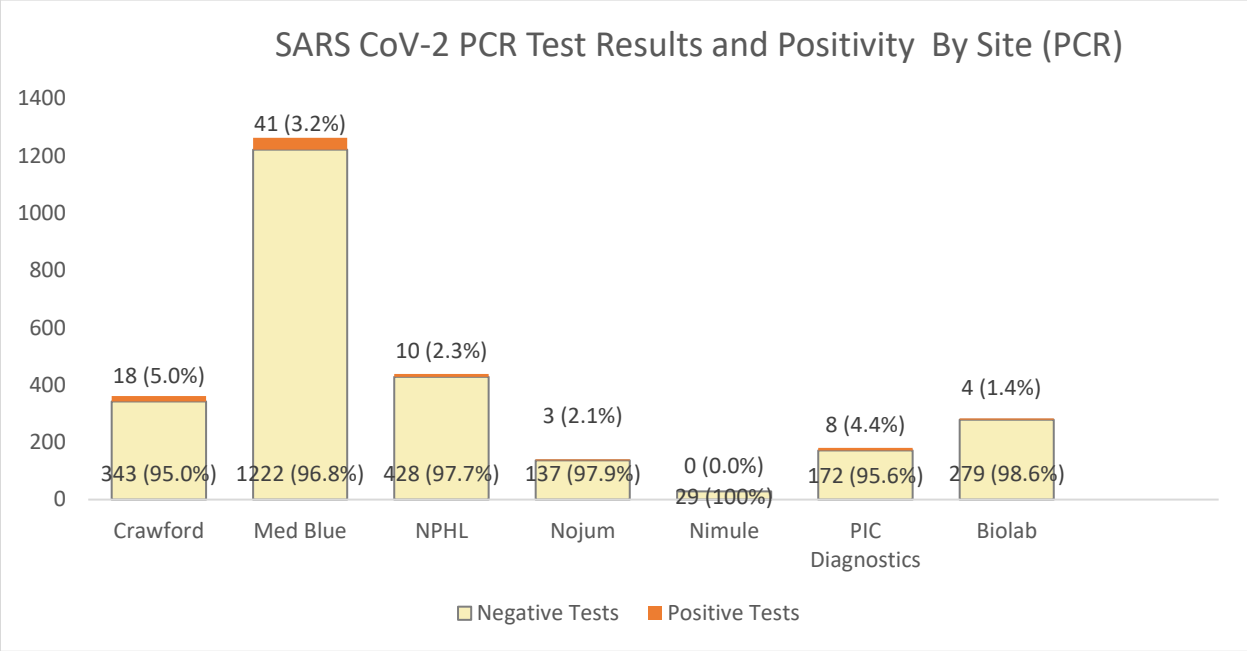

Figure 9A. SARS-COV-2 PCR test results and positivity by testing site [PCR] (Week 35)

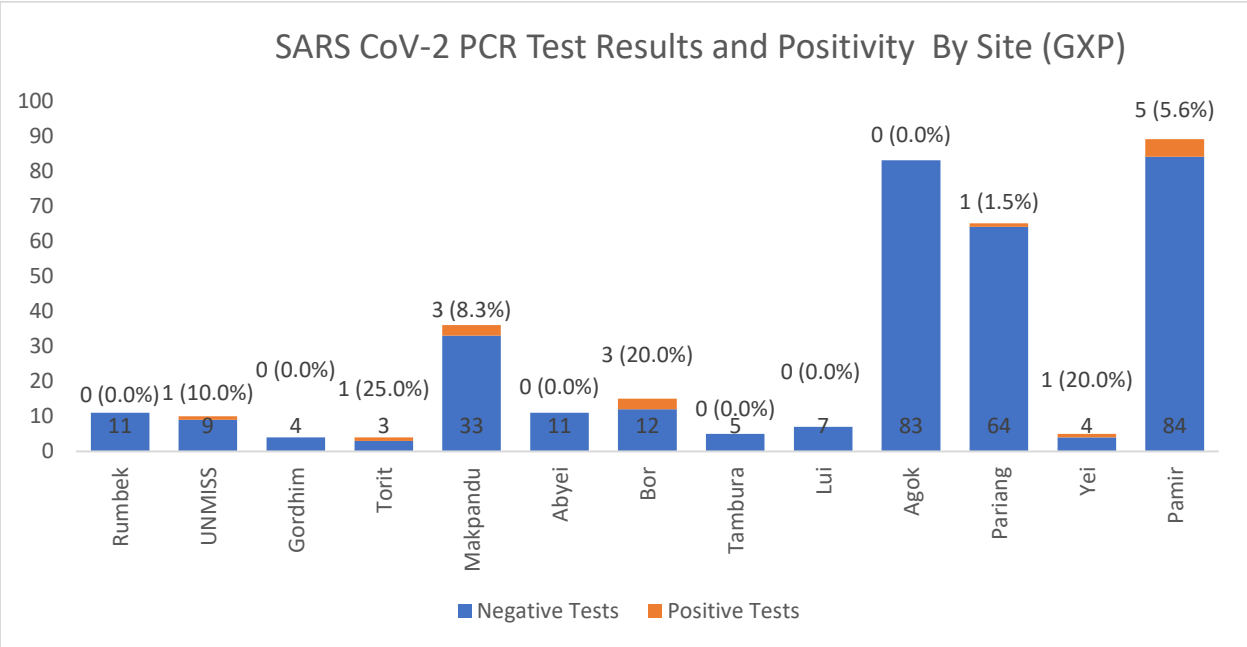

Figure 9B. SARS-COV-2 PCR test results and positivity by testing site [GXP] (Week 35)

Hotline/Alert System Update

There were 21 potential COVID-19 alerts (all through the call center/hotline) in Week 35, an increase of 16.7% from the alerts reported in Week 34. All 21 alerts were verified and investigated by the rapid response team (RRT). Samples were collected from 15 (71.4%) of investigated alerts [Figure 10]. About 71.4% of the potential alerts were from Central Equatoria followed by Warrap (14.3%), Western Equatoria (9.4%), and Upper Nile (4.8%). The other six states did not report any alerts in Week 35 [Figure 11]. Fourteen alerts tested positive for COVID-19 this week. Cumulatively, 3082[2] alerts have been reported, of which 2954 (95.8%) have been verified, and 2872 (97.2%) of the verified alerts were sampled.

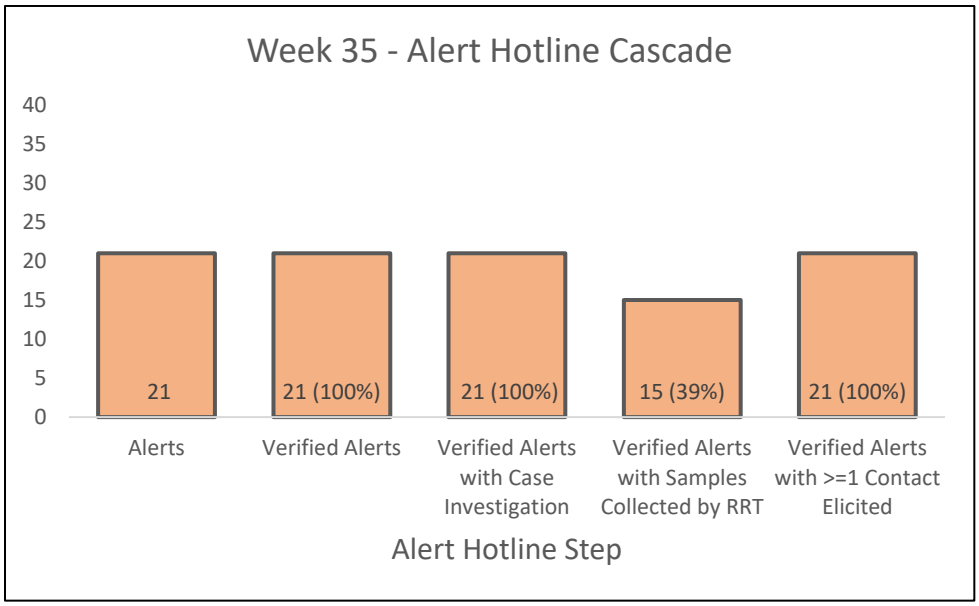

Figure 10: COVID-19 related alerts cascade (Week 35)

[2] Excludes any alerts not reported by the Watch Desk

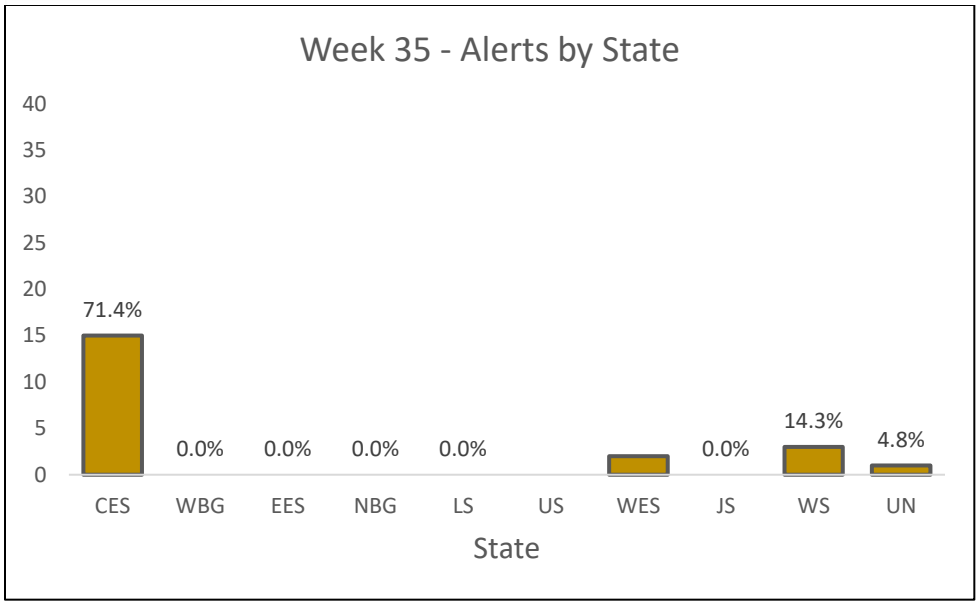

Figure 11: COVID-19 related alerts by state (Week 35)

Recommendations

- Alerts represent a small number of total tests run in South Sudan (1.3%). Understanding the reasons behind the low number of alerts via the call center/hotline should be investigated to identify root causes and potential drivers to remediate. Moreover, alerts outside of Central Equatoria are generally limited. Ongoing discussions to strengthen the hotline system and RRT, case investigation, contact tracing, sentinel sites, and mortality surveillance teams continue to be needed

Contact Tracing System Update

During Week 35, there were 122[3] cases in Juba County, 113 (92.6%) of which were distributed to ICAP by the EOC for contact listing and tracing. One hundred and one (89.4%) of the 113 cases were eligible for contact listing (i.e., had valid phone numbers), of whom 28 (27.7%) provided contacts (down from 29.2% in Week 34). Most of the cases who listed contacts came from Queens Medical Complex (71.4%). From the 28 cases that provided contacts, a total of 61 contacts were listed, providing a case to contact ratio of 1:2.2 (down from 1:4.5 in Week 34). Since community-based contact tracing started in early October 2020, a total of 7086 contacts have been elicited from 838 cases (a ratio of 1:8.5), of which 513 (7.2%) are still under active follow-up. Fifty-seven contacts have completed their follow-up period this week, with a cumulative total of 5005 (70.6%) thus far. None of the 513 contacts followed up in Week 35 reported COVID-19 related symptoms. Samples were collected from 76 contacts this week. None of the 76 contacts sampled this week tested positive for COVID-19. Cumulatively, 17460 contacts have been listed and followed up since the first confirmed case was reported in April 2020, of which 15816 (90.6%) have completed follow-up.

[3] Cases include the 37 from Queens Medical Complex which were not sent to the EOC DMU

Recommendations

- Solicitation of contacts from cases continues to be a challenge for the contact tracing team. Seventy-three 46 (72.3%) of the 101 cases with valid phone numbers this week did not list any contacts. Reasons for non-listing of contacts include denial by the case of the positive COVID-19 result (3), non-pick up of phone (34), and phone number listed did not go through (23). Embedment of contact tracers in five of the six private testing laboratories to facilitate contact listing and checking of listed phone numbers for active status, has had limited impact on improving the case to contact ratio.

Case Management Update

Most cases with documented type of case management are managed at home (39.9%), with very few admitted to a health facility or hospital (0.2%). In Week 35, there were no cases in facility-based case management. However, a significant proportion of cases continues to have “unknown” (59.7%) case management type at first contact. Ninety-seven percent (11195) of all cases were discharged as of Week 35, with 211 cases (1.8%) under active follow-up. One hundred and twenty cases have died, yielding a case fatality rate of 1.04% [Fig 12].

Case management at first detection	Count	Percent of total cases
Home management	4558	39.9%
Hospital	20	0.2%
Isolation center	4	<0.1%
UN health facility	2	<0.1%
UN home management	3	<0.1%
Died	10	0.1%
Unknown	6826	59.7%

Table 1. Distribution of case management type for cumulative cases, showing total count and as a percent of total cases. Data obtained for date of first contact with the patient

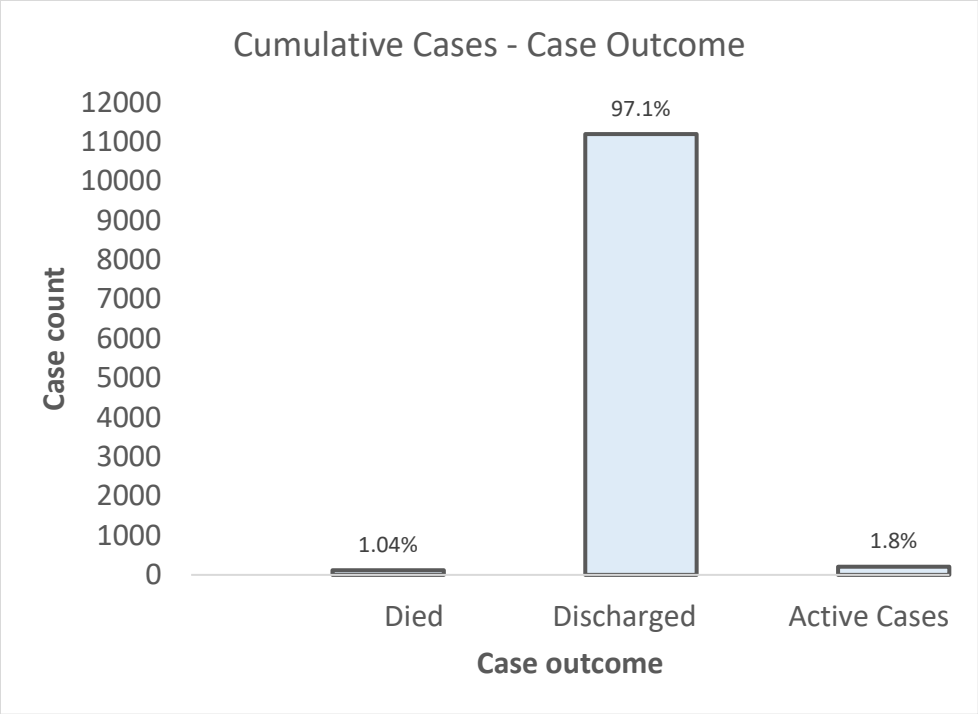

Figure 12. Distribution of case outcome for cumulative cases

Recommendations

- About 60.0% of all cases do not have case management type reported. The coordination of case management data needs to be improved between all reporting and receiving parties

Risk Communication and Community Engagement Update

The following achievements were registered during Week 35 under the risk communication and community engagement (RCCE) pillar:

- Community-based contact tracers supported by ICAP, provided information about COVID-19 to 1757 persons
- Main challenges for the RCCE pillar include:
    1) Community non-compliance with COVID-19 preventive measures
    2) Stigmatization of COVID-19 prevents people from reporting suspected cases to the hotline

Points of Entry Update

During the epidemiological week, IOM screened 1668 (1080 males, 588 females) travelers from Nimule land crossing. Nimule PoE screens only arriving travelers. No traveler underwent secondary screening. The cumulative number of travelers screened for COVID-19 from Feb 15, 2020 to September 05, 2021 is

666760. The number of travelers screened at Nimule PoE was affected in Weeks 34 and 35 by a strike by truck drivers demanding better security along the Nimule-Juba highway.

Most of the travelers screened at Nimule PoE this week were returnees. Of the 1668 inbound travelers, 999 were returnees, 511 were other nationals other than truck drivers, and 158 were truck drivers. The returnees from the camps are allowed to proceed to their destination without undergoing quarantine or presenting COVID-19 certificates but random samples are taken from at least one traveler per household. Other nationals and truck drivers are required to present valid COVID-19 free certificate to enter South Sudan.

IOM continues to support surveillance at Nimule PoE and actively participate in all the established coordination mechanisms for COVID-19 including technical working groups, state task force and national taskforce meetings in Nimule.

Vaccination Update

South Sudan received its second batch of AstraZeneca vaccines in Week 34. Doses were rapidly deployed to various vaccination centers in the same week. So far, South Sudan has vaccinated 70196 people, of whom 13955 are fully vaccinated and 56241 have received one dose. Detailed information about the vaccination program can be found in the link below (https://app.powerbi.com/view?r=eyJrIjoiYzZkMGRmYjQtZTQzYS00MTVjLWEzNzItMDI0YzU4NGQ5NjJlIiwidCI6ImY2MTBjMGI3LWJkMjQtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIsImMiOjh9)

For more information, please contact the South Sudan Public Health Emergency Operation Centre [PHEOC]

Email: sspheoc@gmail.com
Tel #: +211922202028
For additional information follow these links:
http://moh.gov.ss/daily_updates.php
http://moh.gov.ss/covid-19.php

Note: COVID-19 testing in South Sudan is free of charge for alerts, contacts of cases, and suspected cases