

practices in health care facilities, especially antenatal clinics need to be further strengthened. Stringent hand hygiene is essential. Contact tracing activities continue in 10 affected health zones with over 24 000 contacts registered to date. The daily follow-up rates among listed contacts ranged from 90–95% over the past week. As of 2 December 2018, over 18 million travellers have been screened, 127 alerts notified, and 40 alerts validated of which two have been confirmed. As of 3 December 2018, the cumulative number of people vaccinated is 39 845.

WHO risk assessment

This outbreak of EVD is affecting north-eastern provinces of the Democratic Republic of the Congo, which border Uganda, Rwanda and South Sudan. Potential risk factors for transmission of EVD at the national and regional levels include the transportation links between the affected areas, the rest of the country, and neighbouring countries including the displacement of Congolese refugees

to neighbouring countries. Additionally, the security situation in North Kivu and Ituri may hinder the implementation of response activities. Based on this context, on 28 September 2018, the public health risk assessment was revised from high to be very high at the national and regional levels, and low globally. WHO continues to advise against any restriction of travel to, and trade with, the Democratic Republic of the Congo based on currently available information.

Situation in South Africa

As at 18 December 2018, there have been no EVD cases in South Africa associated with the current outbreak in the DRC. In addition, there are no suspected cases of EVD in South Africa at present.

Source: Division of Public Health Surveillance and Response, NICD-NHLS (outbreak@nicd.ac.za); WHO: www.who.int

4 SEASONAL DISEASES

a Malaria prevention guidelines updated—2018

Last month's NICD Communicable Diseases Communiqué (November 2018, Vol. 17 (11): 10–11) carried an alert about the expected seasonal increase in malaria and the new malaria risk map for South Africa ([Risk map](#)). The 2017 South African Guidelines for the Prevention of Malaria have been updated and are also available on the NICD website, www.nicd.ac.za.

Addendum to the South African Guidelines for the Prevention of Malaria, updated 2018

Although mefloquine is given as an option for chemoprophylaxis, there are currently no mefloquine-containing products available in South Africa – Lariam® has been discontinued in this country and Cipla have manufacturing issues regarding Mefliam® that will take a while to be resolved. This means that there is currently no product that can be used for pregnant travellers or children weighing less than 11 kg. As these are also the travellers at highest risk of complicated malaria, they should be strongly advised not to go to malaria risk areas. If

they have no option but to go, they should use all methods available to prevent getting bitten by mosquitoes, and should seek immediate medical attention should they have any signs of illness.

There have been some important changes to the guidelines, namely:

- Both doxycycline and atovaquone-proguanil are now Schedule 2 and are available from pharmacies without a prescription.
- The South African Malaria Risk Map has been updated, and some areas that were previously low risk areas are now classified as moderate risk. The changes have been made based on notifications of confirmed cases of locally-acquired malaria infections over the past five malaria seasons (2014–2018). See page 40 of the guidelines.

Source: Centre for Emerging Zoonotic and Parasitic Diseases, NICD-NHLS; johnf@nicd.ac.za

b Enterovirus meningitis outbreak in Khayelitsha Sub-district, Western

On 27 November 2018, clinicians at a hospital in Cape Town, Khayelitsha Sub-district, Western Cape Province, alerted the Western Cape Department of Health (WCDoH) to an increase in cases of confirmed enteroviral meningitis. From 1 September to 5 December 2018, a total of 38 (13 females) children <12 years was diagnosed with PCR-confirmed enteroviral meningitis (Figure 2).

The median age at presentation was 5.5 years (IQR (2.59 – 8.03 years). Twelve (32%) children were <5 years, and of these, six were <1 year of age. The majority of children presented with fever and

vomiting, while older children complained of headache. Clinical features of meningitis were present in the majority of children, including irritability, neck stiffness or photophobia. One child had a seizure and one had a rash.

Examination of the cerebrospinal fluid (CSF) revealed a median total white cell count of 51 cells/ml (IQR 27–104 cells/ml). The median percentage of polymorphonuclear neutrophils (PMN) were 71% and the majority of children had fewer lymphocytes than PMN.

Only three children had a CSF protein more than 0.5g/l and no children had CSF glucose <2.2g/l. The C-reactive protein was <20 g/dl in 53% (20/38) of the cases and >50 g/dl in only two children. To date, all children have recovered without sequelae.

CSF samples from suspected cases of enterovirus aseptic meningitis were tested using an in-house real time PCR targeting the 5'UTR gene. During the period 1 September to 5 December 2018, there were approximately 88 CSF samples tested; 38 (43%) of these cases were enterovirus positive. The increase in enterovirus cases may reflect the seasonal peak that occurs in autumn and summer.

Ongoing epidemiological investigation by the WCDoH has revealed no epidemiological linkages amongst cases. Sequencing of the viral genome is awaited to investigate whether this increase in cases is attributable to a single strain.

Treatment of enteroviral meningitis is supportive with complete recovery in 7-10 days. There are no registered antiviral drugs for the treatment of enterovirus infections. Hand hygiene after using the toilet or changing nappies, before food preparation and after sneezing or coughing is encouraged.

Heightened clinical awareness and laboratory confirmation is useful to characterise the epidemiology and clinical burden of enterovirus infections in South Africa. Viral PCR is not standard of care in local public health institutions. Facilities were requested to record cases of viral meningitis and to complete case report forms. Currently the investigation is ongoing.

Source: Clinicians at a hospital in Cape Town, Western Cape Department of Health (Charlene.Jacobs@westerncape.gov.za)

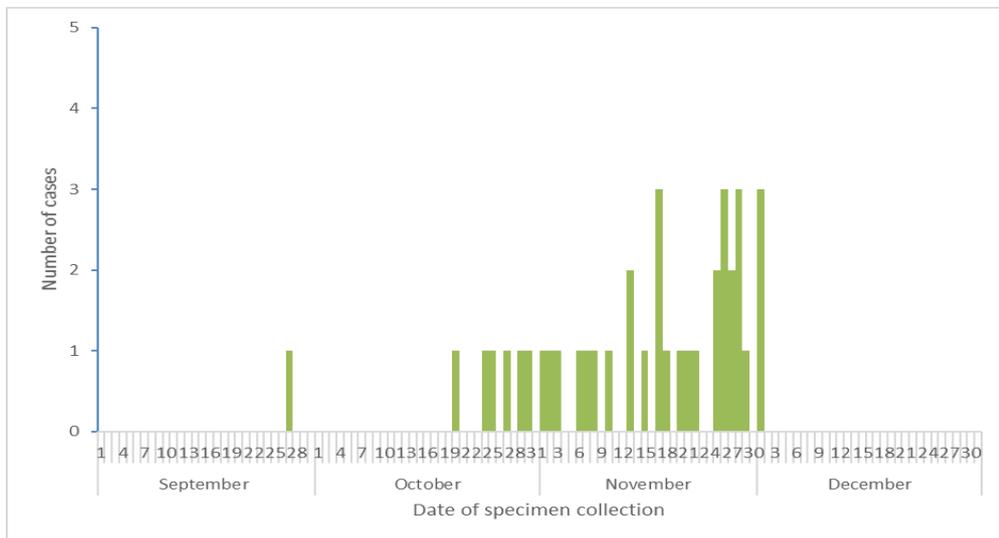


Figure 2. Epidemic curve showing number of laboratory-confirmed enteroviral meningitis cases at Khayelitsha Sub-district, Cape Town, Western Cape Province, 1 September to 5 December 2018

5 INFORMATION FOR TRAVELLERS TO SUB-SAHARAN AFRICA

There have been cholera outbreaks reported in the following countries: Somalia (Banadir region), Zimbabwe (Mashonaland Central Province) and Nigeria (Yobe State, Borno State, Adamawa State and Zamfara State). All people visiting areas where there are known cholera cases, should be aware of the basic cholera facts that can be found on the NICD website at this link, <http://www.nicd.ac.za/index.php/cholera/>. Importantly travelers should follow these basic prevention steps to protect themselves and their families: drink and use safe water, wash hands often with soap and safe water, eat well-cooked food (especially seafood), keep food covered, eat it whilst hot, and wash or peel fruits and vegetables.

There is an ongoing Ebola virus disease outbreak in the Democratic Republic of the Congo, with Rwanda, Uganda, Sudan and South Sudan being at-risk countries for possible spread of the disease. Travellers to high-risk areas in these countries bordering the DRC are urged to take necessary

precautions to protect themselves. Visit the NICD website, www.nicd.ac.za, for more information.

Those travelling to yellow fever-endemic countries are urged to make sure that their yellow fever vaccination is up-to-date, and to refrain from buying fake certificates. Yellow fever outbreaks have been recently reported in South Sudan and Nigeria. In addition to yellow fever, there is an ongoing outbreak of Lassa fever in Nigeria.

For those planning to go on a safari, there have been multiple reports of anthrax in Zimbabwe, Namibia and Malawi in national parks. So far, most cases seen are in animals. However, where there has been contact with livestock, human cases have been identified.

Source: Division of Public Health Surveillance and Response, NICD-NHLS; outbreak@nicd.ac.za