

this infection. Prior systemic antifungal use, and invasive medical devices increased the risk of a *C. auris* infection compared with an infection with other *Candida* species. NICD collected information on in-hospital outcome for 102 patients – 46 died (45% crude mortality). However, it is important to note that most cases occurred in critically ill patients, and we are not certain that *C. auris* infection was directly related to these deaths. NICD has led development of a national consensus guideline for diagnosis, prevention and management of *C. auris* infections (available at www.nicd.ac.za) and has continued laboratory surveillance in 2019 to monitor the emergence of antifungal resistance in this fungus.

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Source: Centre for Healthcare-Associated Infections, Antimicrobial Resistance and Mycoses, NICD-NHLS; neleshg@nicd.ac.za

3 INTERNATIONAL OUTBREAKS OF IMPORTANCE

a An update on Ebola virus disease outbreak, Democratic Republic of Congo

On 19 August 2019, a 'ville morte' (civil strike) protest took place in Beni, Butembo and Oicha in response to recent attacks by armed groups on civilians in the Democratic Republic of the Congo (DRC). The protest resulted in temporary suspension of Ebola response activities, but operations continued the next day with extra caution. Further demonstrations are anticipated amidst persistent insecurity and unrest, which hampers response in areas like Beni. Suspension of response activities has a negative impact on the outbreak as the number of cases can increase and spread to new areas in the following weeks. The overall Ebola response activities in the DRC remain challenged by continued insecurity, unrest, funding shortfalls, and pockets of community resistance.

Although there is a slight declining trend in the overall number of new confirmed cases being reported, the disease continues to spread to new health zones. Cases were detected in two new health zones this past week: Mwenga Health Zone in South Kivu, and Pinga Health Zone in North Kivu. As of 18 August 2019, in Mwenga, four confirmed cases were reported after two individuals (mother and child) had contact with a confirmed case in Beni before travelling south. The father of the child was subsequently confirmed positive, as was a co-patient in a community health facility where the first case initially sought care. In Pinga, one confirmed case has been reported with no apparent epidemiological link to other cases, and no recent travel or visitors from outbreak affected areas. Surveillance and response teams have been scaled up rapidly in these two areas.

As of 24 August 2019, 2 968 EVD cases (2 863 confirmed and 105 probable) were reported. A total of 1 986 deaths was reported with an overall case fatality ratio of 67%. Of the confirmed and probable cases with reported sex and age, females accounted for 58% (1 721), and children aged less than 18 years accounted for 29% (863). Health worker cases continue to be reported, with a cumulative number of infected rising to 153. This accounts for 5% of all confirmed and probable cases.

During the week ending 18 August 2019, 2 280 358 screenings were performed at official points-of-entry, bringing the cumulative number of screenings to close to 77 million. As of 17 August 2019, 197 172 people at risk have consented to and received the rVSV-ZEBOVGP Ebola vaccine. Of those, 49 451 are primary contacts, and 134 934 secondary contacts (contacts-of-contacts). The total number of people who have received vaccines includes 40 256 healthcare and fieldworkers, and 62 004 children 1-17 years of age.

There are currently no confirmed EVD cases in Uganda. The focus on preparedness activities continues across the 30 high-risk districts and other districts. There is active surveillance in all communities, health facilities and all formal and informal border crossings. Since August 2018, Uganda has reported and investigated over 6 000 alerts. A total of 4 915 health workers in 150 health facilities were vaccinated as a preventative measure in Uganda. This was followed by a second round of vaccination that commenced on 15 June 2019 for contacts of the two confirmed cases in Uganda's Kasese district.

The World Health Organization (WHO) conducted a 2-day meeting on 14 and 15 August 2019 to enhance preparedness, and step up measures against EVD in DRC, and Priority 1 neighbouring countries (South Sudan, Uganda, Rwanda and Burundi). The meeting was attended by government and WHO staff from the DRC, Burundi, Rwanda, South Sudan and Uganda, as well as WHO staff from the Regional Office for Africa. Overview of the International Health Regulations (2005), and improving cross-border collaboration in the context of the EVD outbreak in the DRC, were among a number of issues discussed. WHO advises against any restriction of travel to, and trade with, the DRC based on the currently available information.

The implications for South Africa are that the risk of spread of Ebola to South Africa remains low according to risk assessments conducted by the Department of Health, National Institute for Communicable Diseases (NICD) and WHO. Currently, there are no EVD cases in South Africa.

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

4 SEASONAL DISEASES

a Influenza

The 2019 influenza season that started in week 16 (week ending 21 April) when influenza detections in the Viral Watch programme rose above the seasonal threshold, continues to decline. The number of specimens received per week from Viral Watch sites dropped from an average of 135 during June, 35 during July, to 17 during August to date. Influenza transmission (measured using Viral Watch programme data) has been at low levels, or below threshold, since the middle of July, whereas impact (measured using pneumonia surveillance programme data), is currently at moderate levels. Thresholds are determined by the Moving Epidemic Method (a sequential analysis using the R Language, available from: <http://CRAN.R-project.org/web/package=mem>) by comparing observed levels of influenza to those seen in previous years.

Since April, influenza A has been detected in 757/1 175 (64%) specimens received from Viral Watch sites. The majority (707; 93%) has been further identified as influenza A(H3N2). In addition, 32 (4%) have been identified as A(H1N1)pdm09, and in 14, subtyping was inconclusive due to low viral load. Two specimens were dual positive for both influenza A(H1N1)pdm09 and A(H3N2), and one for A(H3N2) and influenza B/Yamagata (Figure 3). In previous years, there has often been a second wave of influenza B virus after the peak of the dominant circulating strain, prolonging the season into September/early October.

Source: Centre for Respiratory Diseases and Meningitis, NICD-NHLS; cherylc@nicd.ac.za

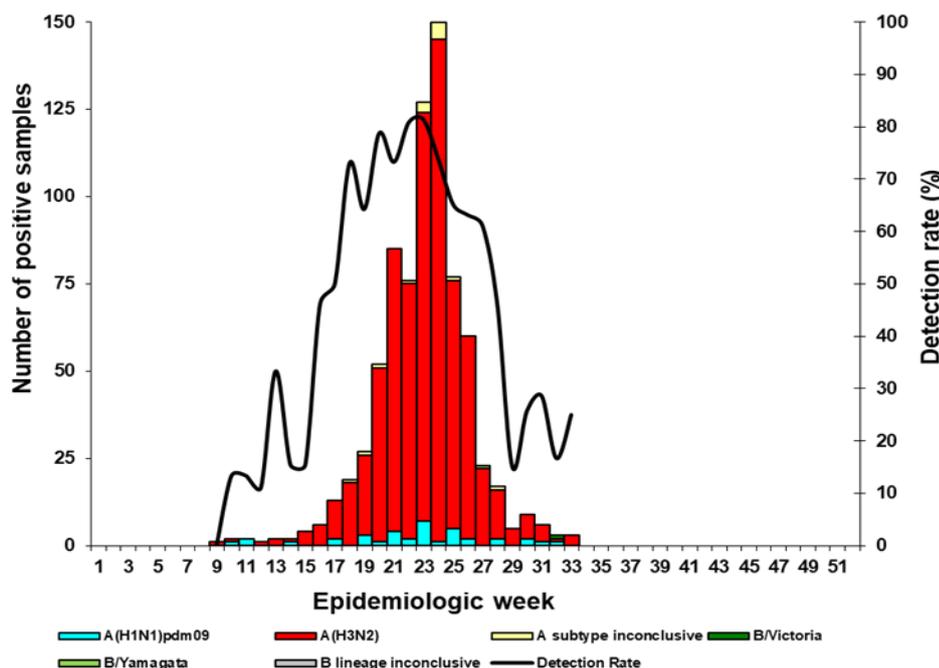


Figure 3. Viral watch 2019: Number of positive samples by influenza types and subtypes and detection rate*

* Only reported for weeks with >10 specimens submitted.

Inconclusive: insufficient viral load in sample and unable to characterise further.

Patients known to have acquired influenza abroad or from contact with travellers are not included in the epidemiological curve.