

**1 ZOO NOTIC AND VECTOR-BORNE DISEASES**

**a An update on rabies in South Africa**

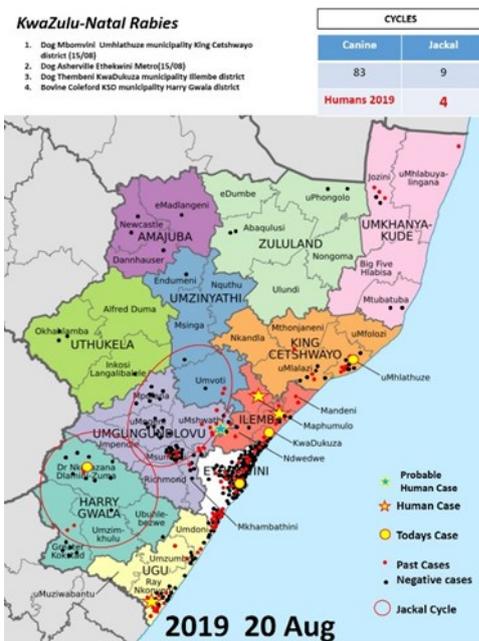
Eight cases of human rabies were confirmed for South Africa for 2019 to date. These cases were from three different provinces: KwaZulu-Natal (n=3), Eastern Cape (n=3) and Limpopo (n=2). In addition, two deaths were classified as probable rabies cases, one case from KwaZulu-Natal Province and another from the Eastern Cape Province.

As dog bites cause almost all human rabies cases in South Africa and globally, dog vaccination programmes are the most effective way to reduce the risk of this disease. The Department of Agriculture and Rural Development holds regular vaccination clinics in hotspot areas gripped by rabies outbreaks, predominantly in the eastern part of South Africa (Figures 1 and 2). It however remains the responsi-

bility of the pet owner to have domestic dogs (and cats) vaccinated against the disease.

Even after exposure to a rabid dog, the development of clinical rabies disease can be prevented through timely administration of prophylactic vaccine and rabies immunoglobulin. The guidelines for prophylaxis and further information on rabies are accessible at [www.nicd.ac.za](http://www.nicd.ac.za)

**Source:** Centre for Emerging Zoonotic and Parasitic Diseases, NICD-NHLS; [januszp@nicd.ac.za](mailto:januszp@nicd.ac.za)



**Figure 1 & 2.** Canine and human rabies detection in KwaZulu-Natal and Eastern Cape provinces  
 Source: Kevin le Roux, Department of Agriculture, Environment and Rural Development, KwaZulu-Natal

**2 HOSPITAL ASSOCIATED INFECTIONS**

**a Candida auris update**

Globally, *Candida auris*, the multidrug-resistant fungus, causes invasive disease and healthcare-associated outbreaks (1). NICD conducted active national laboratory-based surveillance for candidaemia (a type of fungal bloodstream infection) at 269 hospitals in 2016 and 2017. This was supplemented by enhanced surveillance at 27 acute-care hospitals in the public and private sectors (2). Compared to a national survey conducted in 2009 and 2010 (3),

there was a major shift in the fungal species causing bloodstream infection over five years. In 2016-2017, *C. auris* accounted for 14% (794/5 876) of cases of candidaemia (versus only two cases in the prior survey) (4). The number of new *C. auris* cases, adjusted for hospital admissions, was almost twice as high in the private than the public sector. Patients with *C. auris* candidaemia spent an average of four weeks in hospital before they developed

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](http://www.nicd.ac.za)) and has continued laboratory surveillance in 2019 to monitor the emergence of antifungal resistance in this fungus.

#### REFERENCES:

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4. Magobo RE, Corcoran C, Seetharam S, Govender NP. *Candida auris*-associated candidemia, South Africa. *Emerg Infect Dis*. 2014;20(7):1250-1.

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