

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

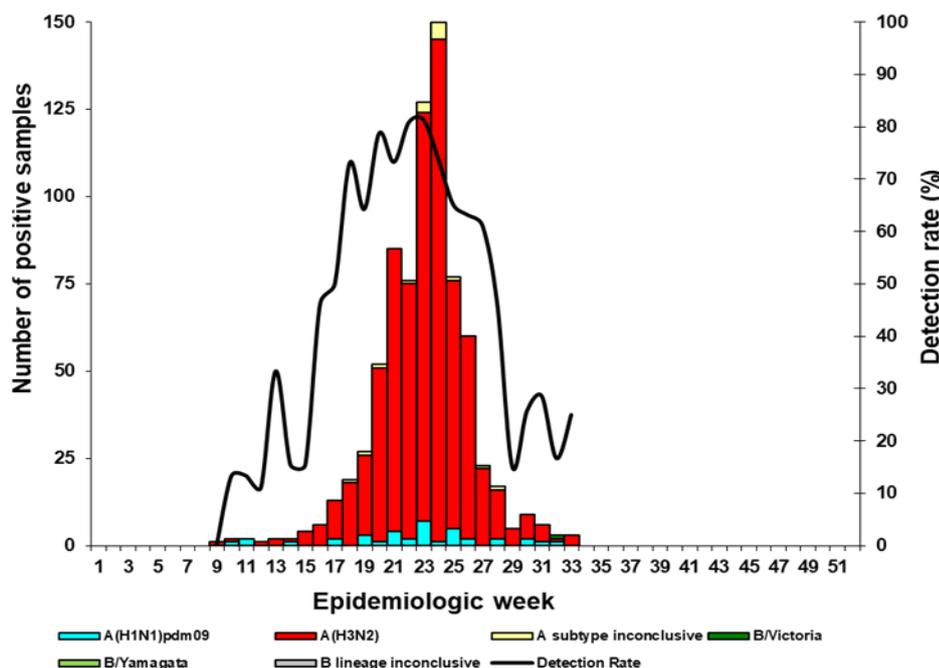
## 4 SEASONAL DISEASES

### 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](mailto: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.