

b Invasive meningococcal disease surveillance: January to August 2018

Meningococcal disease in South Africa occurs most frequently in the winter and spring months (Figure 7); therefore, doctors should consider meningococcosis in any patient presenting with symptoms suggestive of meningitis/bacteraemia and not delay in providing appropriate antibiotic treatment targeting meningococcal disease. Meningococcal disease is a Category 1 notifiable medical condition (NMC) and any clinically-suspected case should be reported immediately to the provincial Communicable Disease Control Coordinators to ensure appropriate contact tracing, responsible prescribing of chemoprophylaxis and case counting.

In total for 2018, 61 cases have been reported to the GERMS-SA network, 69% (42/61) of which had isolates available for serogrouping. Serogroup B caused 43% (18/42) of disease, followed by W (26%, 11), Y (19%, 8) and C (12%, 5). The majority of cases occurred in Gauteng Province (33%, 20/61), followed by Eastern Cape (26%, 16/61) and Western Cape (23%, 14/61) provinces. Most people presented with meningitis (67% (41/61) had

a positive culture from cerebrospinal fluid), whilst the remainder had positive blood cultures. One fifth (13/61) of disease occurred in children <1 year of age.

Although numbers of cases reported through GERMS-SA surveillance network only indicate one additional case in August 2018, there have been at least nine laboratory-confirmed cases reported through the NMC network for August and we await those clinical isolates. Microbiology laboratories (both NHLS and private laboratories) are encouraged to submit ALL meningococcal isolates as soon as possible to the NICD for confirmation and serogrouping of the isolates; or to submit the actual CSF, blood and/or blood culture (for culture negative, but latex antigen positive and Gram-negative cocci seen on Gram stain) for PCR confirmation.

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

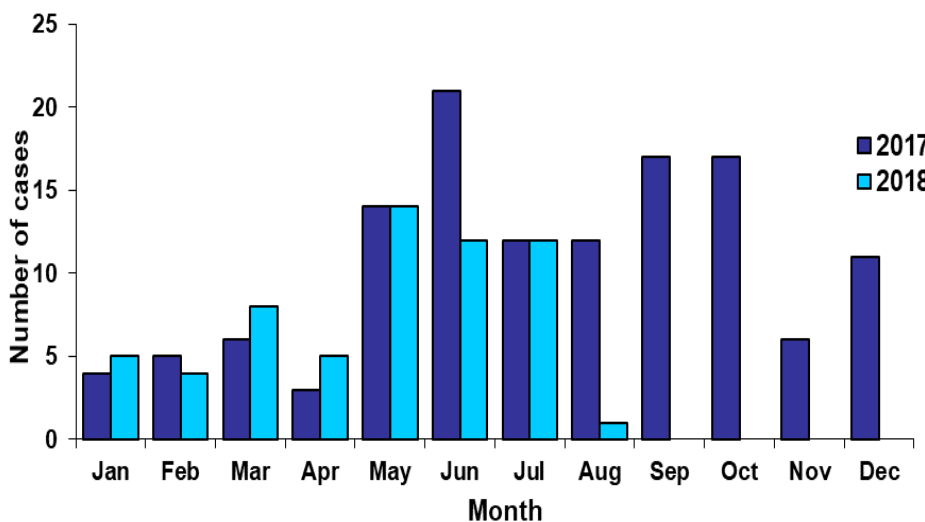


Figure 7. Number of *Neisseria meningitidis* cases reported to GERMS-SA by month, South Africa, 2017 and 2018 (until end week 34).

c Revised malaria risk map for South Africa

South Africa’s malaria risk profile has changed since the last edition of the map was released in 2013. The draft revised map is made available here (Figure 8, below), as the local malaria season (September – May) has started. Please note that this draft map is awaiting final approval, and is subject to amendment. Major changes to the malaria risk areas, based on recent malaria transmission data from various sources, are as follows:

- The moderate risk areas (pink colour) in Vhembe and Mopani districts, Limpopo Province, have extended westwards, towards Tzaneen, and now include Musina, Thohoyandou and surrounds.

- The low risk areas (yellow colour) have likewise extended westwards to include the rest of Vhembe District, and the northern parts of Capricorn and Waterberg districts, including Makhado, Alldays, Swartwater and Lephalale.

The malaria situation in the Kruger National Park, Mpumalanga and KwaZulu-Natal provinces, and neighbouring countries, remains largely unchanged. The borders of risk areas should be regarded as approximate, and map users should understand that sporadic transmission may occur outside designated areas. Infected malaria mosquitoes are sometimes transported outside usual risk areas,

and may transmit the infection (so-called 'taxi malaria'). Visitors and residents should be aware of the 'flu-like' common symptoms of early malaria, and promptly seek healthcare advice if they think they may have malaria.

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

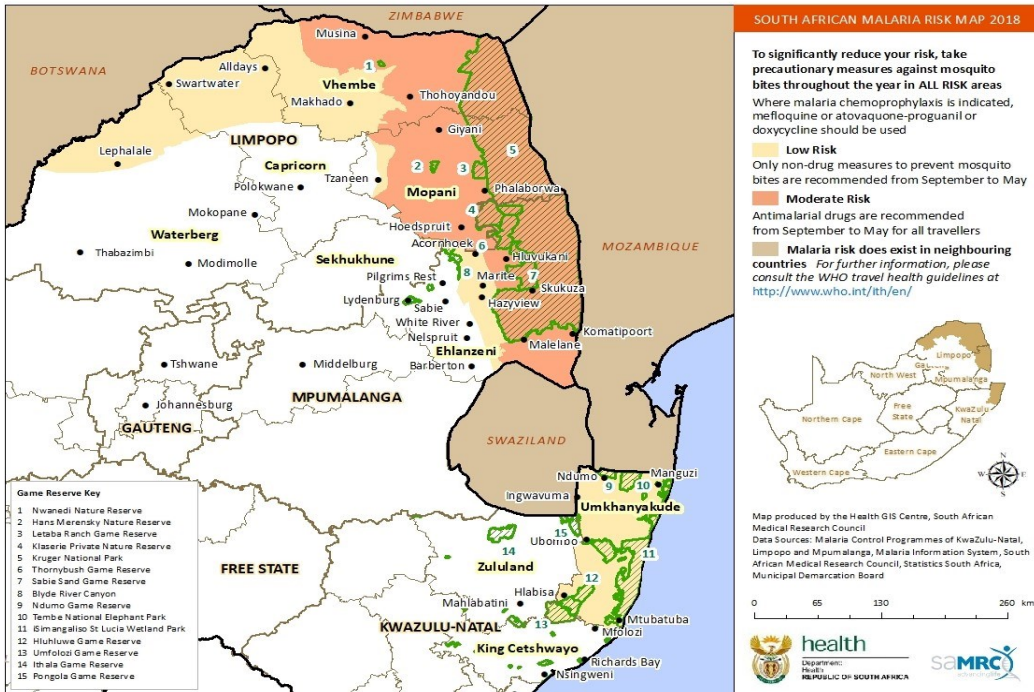


Figure 8. Revised malaria risk map for South Africa—Final technical draft September 2018 (subject to approval by Director General: National Department of Health).

6 JOINT EXTERNAL EVALUATION (JEE)

a World Health Organization’s Joint External Evaluation, South Africa

A joint external evaluation (JEE) is a voluntary, collaborative, multisectoral process to assess country capacities to prevent, detect and rapidly respond to public health risks, whether occurring naturally or due to deliberate or accidental events. The JEE helps countries identify the most critical gaps within their human and animal health systems in order to prioritise opportunities for enhanced preparedness and response, by gauging how well the International Health Regulations (IHR) are being implemented in the country across nineteen core-competencies.

In November 2017, South Africa welcomed a WHO-convened multisectoral team to conduct the South African JEE following the country’s self-assessment earlier in 2017. The WHO team found that South Africa achieved fairly high scores for the majority of technical areas. Communication and advocacy, IHR coordination, zoonotic diseases, national laboratory system, linking public health and security authorities and points of entry were singled out for particular praise. The achievements in these technical areas were largely attributed to a high level of political will and technical commitment. However, the WHO team stated that it is imperative to continue investing in IHR capacity building to maintain and strengthen the level of capacity observed in South Africa. Technical areas identified as requiring

strengthening included national legislation, policy and financing, preparedness, emergency response operations, food safety, biosafety and biosecurity, and antimicrobial resistance. The evaluation also found that South Africa demonstrated a very high level of collaboration across the technical areas, with clear willingness among multisectoral partners (human, animal, port health and security sectors) to work together. It was recommended that this collaborative approach should be facilitated by a clear chain of command and decision-making structures to allow for scaling-up in times of emergency.

The next step in the JEE process will be unfolding in September 2018, where small working groups constituted by the relevant stakeholders for each technical area, will convene at a workshop to develop costed plans to sustainably address the gaps identified through the evaluation process.

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