

SEASONAL DISEASES

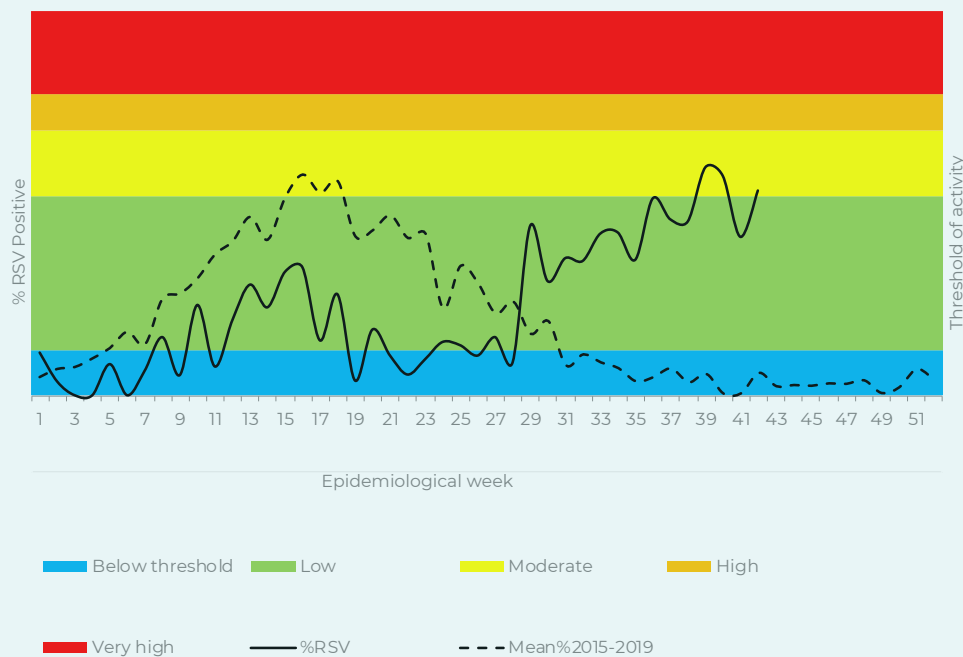


Figure 4. Respiratory syncytial virus detections (percentage positive) and threshold of activity among patients aged <5 years by epidemiological week, pneumonia surveillance, South Africa, 01-January-2020-18 October 2020

Meningococcal disease

Invasive meningococcal disease surveillance update – January to September 2020

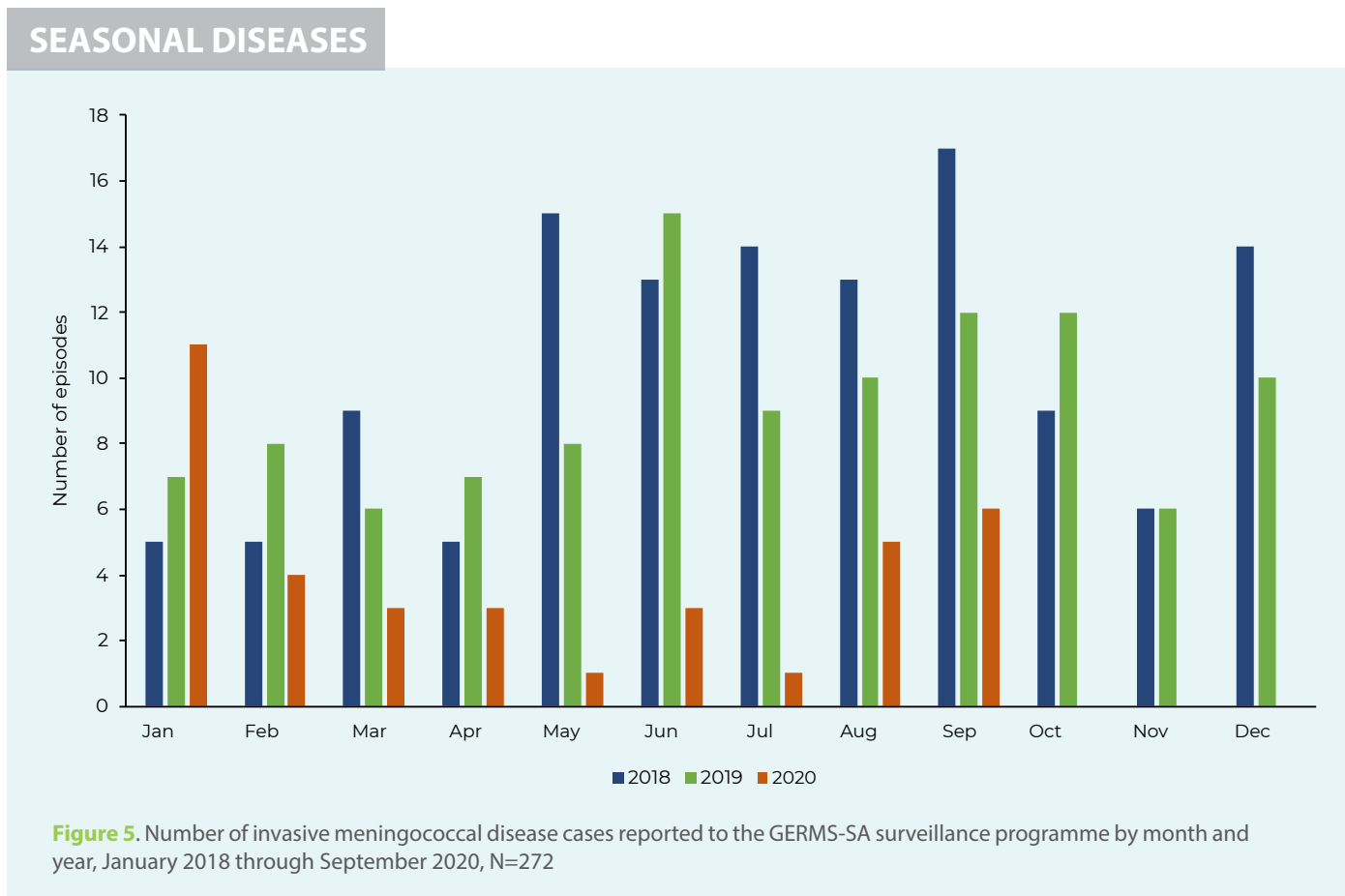
In 2020, invasive meningococcal disease (IMD) cases have been occurring infrequently with only 37 laboratory-confirmed cases being reported until end of September 2020 (compared to 82 episodes over the same period in 2019). Marked reductions in cases were seen since March, following implementation of social distancing and other containment measures aimed at reducing SARS-CoV-2 transmission (Figure 5).

Neisseria meningitidis, the causative organism in meningococcal disease, is spread from person-to-person via respiratory droplets of asymptomatic carriers. New acquisition of a virulent strain of meningococcus, followed by invasion of the organism into the bloodstream may lead to sudden onset of severe illness – including septicaemia or meningitis. Therefore, as lockdown measures are relaxed and more contact is made with other individuals, there is potential for an increase in respiratory transmitted infections, including invasive meningococcal disease.

A small increase in sporadic cases of IMD was detected in the Western Cape Province in September 2020. Five of these six cases occurred in children <5 years, and 4 of the 5 available isolates were serogroup B, one was

serogroup W. The Western Cape Province has seen the majority of IMD in 2020 (20/37 cases, 54%), followed by Gauteng (7/37, 19%), Eastern Cape (6/37, 16%), KwaZulu-Natal and Mpumalanga provinces (2 cases each, 5%). Of the isolates available for serogrouping, serogroup B was predominant (16/28, 57%) followed by serogroups W (7/28, 25%), Y (3/28, 11%) and C (2/28, 7%). IMD was most prevalent in young children, with 43% (16/37) of cases occurring in children <5 years.

Clinicians should remain vigilant in suspecting meningococcal disease in persons presenting with sudden onset of fever, neck stiffness or petechial rash, to ensure rapid access to appropriate care and treatment. Meningococcal disease has the potential to cause clusters and outbreaks and thus is a category 1 notifiable medical condition (NMC). Any clinically suspected or laboratory confirmed case of meningococcal disease should be reported immediately to the provincial communicable disease control coordinators (CDCC) to ensure appropriate contact tracing, responsible prescribing of chemoprophylaxis and case counting.



Malaria

Malaria cases in South Africa are expected to increase as we enter summer, due to higher temperatures and increased rainfall in the malaria transmission areas. For January to October 2020, a total of 5 701 cases and 14 deaths have been reported by the National Department of Health. This is significantly fewer than for the same period in 2019 (around 12 000 cases with 63 deaths) and may be a consequence of COVID-19 related movement restrictions.

During the upcoming holiday season, many people will be exposed because of their travel to higher transmission areas, both internally and outside the country borders, particularly in Mozambique ([see updated malaria risk map](#)). In the last few years, there has been some expansion of low or very low malaria transmission to some districts previously regarded as non-malaria areas in South Africa, such as the Waterberg District in Limpopo Province. People who are planning to travel are urged to take adequate measures to protect themselves from malaria. All people in malaria risk areas should reduce contact with mosquitoes by limiting outdoor activity after dark, covering up bare skin (not forgetting

feet and ankles), using mosquito repellents containing at least 10% DEET, ensuring mosquito screens on windows are closed, and using bednets, fans or airconditioning, if available. Consider antimalarial prophylaxis in higher risk areas – doxycycline and atovaquone-proguanil are available without prescription from pharmacies. Public sector travel clinics will also supply prophylaxis to travellers. It is important to understand that while these precautions will substantially reduce the chance of acquiring malaria, the risk is never completely abolished.

All travellers returning from malaria transmission areas, including very low risk ones, should report 'flu-like illness (headache, fever, chills, fatigue, muscle and joint pain) that occurs up to three weeks after first potential exposure, in case it is malaria. Children with malaria may have very non-specific signs (fever, loss of appetite, vomiting). Healthcare workers seeing febrile patients must remember to ask about travel to malaria transmission areas. Malaria risk map, FAQs and further information on prevention are available on the NICD website: www.nicd.ac.za.

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