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## Editor's Note



Dr Ann Mathews

In the November 2020 edition of the *Communiqué*, we present an update on the ongoing COVID-19 pandemic in South Africa, as well as the ongoing Ebola outbreak in the Democratic Republic of Congo. We also provide an update on rabies in South Africa, including two new cases confirmed last month.

Preliminary results from three COVID-19 vaccine efficacy trials have recently been announced. The mRNA vaccines developed

by Pfizer/BioNTech Pharmaceuticals and Moderna have both been shown to be safe with 95% efficacy in over 80 000 participants. The ChAdOx1 nCoV-19 vaccine showed 70% protection. The high level of vaccine efficacy for all three vaccines has been encouraging as even 60% efficacy could significantly impact public health.

In mid-November, the Department of Agriculture, Land Reform and Rural Development issued a media statement about animal brucellosis in northern KwaZulu-Natal Province. Brucellosis, an important zoonotic condition in South Africa, is subject to state veterinary surveillance and control, and is a notifiable medical condition in humans. Transmission from animals to humans is mainly through the consumption of unpasteurised milk and occupational exposures, which typically occur in farm, abattoir, veterinary and laboratory situations.

Three laboratory-confirmed measles cases have been detected between 30 October to 5 November in two provinces (Eastern Cape and KwaZulu-Natal). Although these cases do not yet comprise a cluster or outbreak, they do require heightened awareness to identify possible clusters or outbreaks.

Interim results of the HIV Prevention Trials Network (HPTN) 084 study showed that the long-acting injectable cabotegravir was 89% more effective than daily oral tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) in preventing infection with HIV. Further details are provided in the article.

Other international outbreaks of significance include yellow fever in Nigeria, leptospirosis in India, plague in the Democratic Republic of Congo and salmonellosis in Canada, all further discussed in our 'Beyond our Borders' article.

**ZOONOTIC AND VECTOR-BORNE DISEASES**

**An update on rabies in South Africa**

Two cases of human rabies have been laboratory confirmed in South Africa in the last month. For 2020 to date, a total of six human cases has been laboratory-confirmed. These confirmed cases were reported from KwaZulu-Natal Province (KZN) (n=5) (including the two cases reported here), and Limpopo Province (n=1). Three probable cases were also reported from KZN (n=1), Limpopo (n=1) and the Eastern Cape (n=1) provinces. Probable cases present with a clinical and epidemiological history compatible with a rabies diagnosis, where no alternative diagnosis could be confirmed and laboratory investigation for rabies was not possible.

In mid-October, a nine-year old boy from Adam’s Mission, located 40 km south of eThekweni, KZN, presented with headache, fever, restlessness, chest pain, shortness of breath and trouble swallowing. The child was reportedly taken to a traditional healer, and subsequently to a hospital in eThekweni District. The patient was admitted and was reportedly confused, aggressive and hypersalivating. The patient died on the day of admission. Rabies was confirmed by a direct fluorescence assay on a post-mortem brain sample. Investigations revealed no clear exposure history, and post-mortem investigation found no bite wounds or scars. There were reportedly many free-roaming dogs in the Adam’s Mission area. There was no history of rabies post-exposure prophylaxis in this case. Exposures may be related to small wounds or scars or mucous membrane contamination with contaminated saliva.

The second case involved a 28-year-old man from KwaNyuswa, near Port Shepstone, KZN, who was bitten in his neck by a stray dog on 1 November in Inanda, eThekweni District. The dog attacked the man without provocation. The same dog reportedly had bitten cattle, and was therefore killed but not tested for rabies. Nine days later, the man became ill with nausea, vomiting and later hypersalivation and was unable to walk. Rabies was confirmed in two ante-mortem collected saliva samples. The patient demised on 22 November.

Human rabies cases are almost exclusively linked to exposures to rabid dogs. Domestic dog rabies remains uncontrolled throughout Africa; however, it is known that that human rabies can be avoided through control of rabies in these animals. Although cases are recorded across South Africa, the largest proportion of human rabies cases in the country has historically occurred in KZN. 160 canines were diagnosed with rabies through laboratory surveillance by KZN this year alone (Figure 1). Vaccination of domestic dogs (and cats), in combination with health education and awareness of rabies in affected communities, can contribute to the prevention of human rabies cases. When possible exposures do occur, timely and effective administration of post-exposure prophylaxis against rabies prevents infection in 100% of human victims. Please visit the NICD website for more information on rabies and its disease prevention: <https://www.nicd.ac.za/diseases-a-z-index/rabies/>.



**Figure 1.** Canine and human rabies detection in KwaZulu-Natal Province.

**Source: Kevin le Roux, Department of Agriculture, Environment and Rural Development, KwaZulu-Natal.**

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

**ZOONOTIC AND VECTOR-BORNE DISEASES****Brucellosis in KwaZulu-Natal Province and its clinical overlap with malaria and COVID-19**

The Department of Agriculture, Land Reform and Rural Development issued a media statement on 18 November about animal brucellosis in northern KwaZulu-Natal Province (KZN) ([https://www.dalrrd.gov.za/docs/media/Media%20statement\\_Brucellosis\\_18112020\\_draft%20AC%20\(1\)%20\(003\)-Dr%20R-clean-FINAL.pdf](https://www.dalrrd.gov.za/docs/media/Media%20statement_Brucellosis_18112020_draft%20AC%20(1)%20(003)-Dr%20R-clean-FINAL.pdf)). While this highlights a long-standing problem with this livestock disease in KZN and other areas of South Africa, it also brings attention to the fact that brucellosis is an important zoonotic condition in this country. In South Africa, brucellosis is subject to state veterinary surveillance and control, and is a notifiable medical condition in humans. The predominant clinical manifestation in animals is abortion. Transmission from animals to humans is mainly through consumption of unpasteurised milk. Occupational exposure typically occurs in farm, abattoir, veterinary and laboratory situations. Bovine brucellosis (caused by *B. abortus*) occurs across all nine provinces, but most infected cattle herds occur in the central and

Highveld regions. Clinically, human brucellosis is highly variable in presentation (see <https://www.nicd.ac.za/diseases-a-z-index/brucellosis/>). In the geographic context of northern KZN, where there is low-level malaria transmission in rural cattle-owning communities, both malaria and brucellosis could present initially as a non-specific febrile illness; but if the diagnosis of malaria is missed, severe and potentially fatal illness can rapidly develop. Likewise, the current national focus on COVID-19 could also lead to malaria infections being overlooked, as symptoms and signs can be similar (especially in early malaria, but also in more advanced cases with lung and other organ involvement). We take this opportunity to remind readers that as the malaria season unfolds, increasing numbers of malaria cases can be expected in both endemic (Limpopo, Mpumalanga, and KZN) and non-endemic provinces, particularly Gauteng (see <https://www.nicd.ac.za/as-the-malaria-season-begins-in-southern-africa-covid-19-complicates-the-picture/>).

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

**VACCINE-PREVENTABLE DISEASES****Measles alert**

Three laboratory-confirmed measles cases have been detected between 30 October to 5 November in two provinces (Eastern Cape and KwaZulu-Natal) by the National Institute for Communicable Diseases (NICD). These cases do not yet comprise a cluster or outbreak (defined as three cases within one health district within one month), but warrant heightened attention. There have been changes in health-seeking behaviour since the start of the COVID-19 pandemic, with declining vaccine coverage rates. Healthcare professionals should remain vigilant when faced with a suspected measles case. Due to complications and mortality associated with measles, it is important for individuals to be aware of symptoms, seek help early and have a blood test to differentiate measles from other rash illnesses such as rubella (German measles).

Measles is a contagious disease caused by the measles virus and is spread by droplets from respiratory secretions of infected persons when coughing or sneezing. People at high risk for severe illness and complications from measles include infants and children aged <5 years, pregnant women and persons with compromised immune systems, such as from certain cancers and HIV infection. Measles starts with respiratory tract symptoms similar to the common cold or 'flu' – fever, tiredness and muscle pain; with 'the three Cs': conjunctivitis (red, watery eyes), cough and coryza (runny nose). The rash of measles usually appears 3–5 days after the start of symptoms, beginning on the face and spreading down the body. It is important for individuals with these signs and symptoms

to visit a clinic/doctor to confirm the diagnosis, and make sure complications of measles do not occur. Measles is a notifiable medical condition (NMC) and any doctor in the public or private sector can send blood specimens to the NICD for testing at no cost to the patient. Throat swabs or urine samples should be sent in addition to blood samples during an outbreak, provided they are collected within 7 days of the date of onset of rash. Any patient with suspected measles should be notified to the NMC Surveillance System and a case investigation form (CIF) should be completed.

Vaccination is the most important way of preventing measles. The National Department of Health provides measles vaccine free of charge at local clinics. After two doses of vaccine, 95% of persons will be protected from measles. The measles vaccine is safe and effective. The MeasBio® (Biovac) vaccine is administered at 6 months of age with a booster at 12 months of age according to the South African Expanded Programme on Immunisation. Public and private providers in South Africa use the MeasBio® (Biovac) vaccine. In the private health sector, there are additional vaccines (Priorix® and Omzzyta®) that each offer protection against measles, mumps and rubella (MMR).

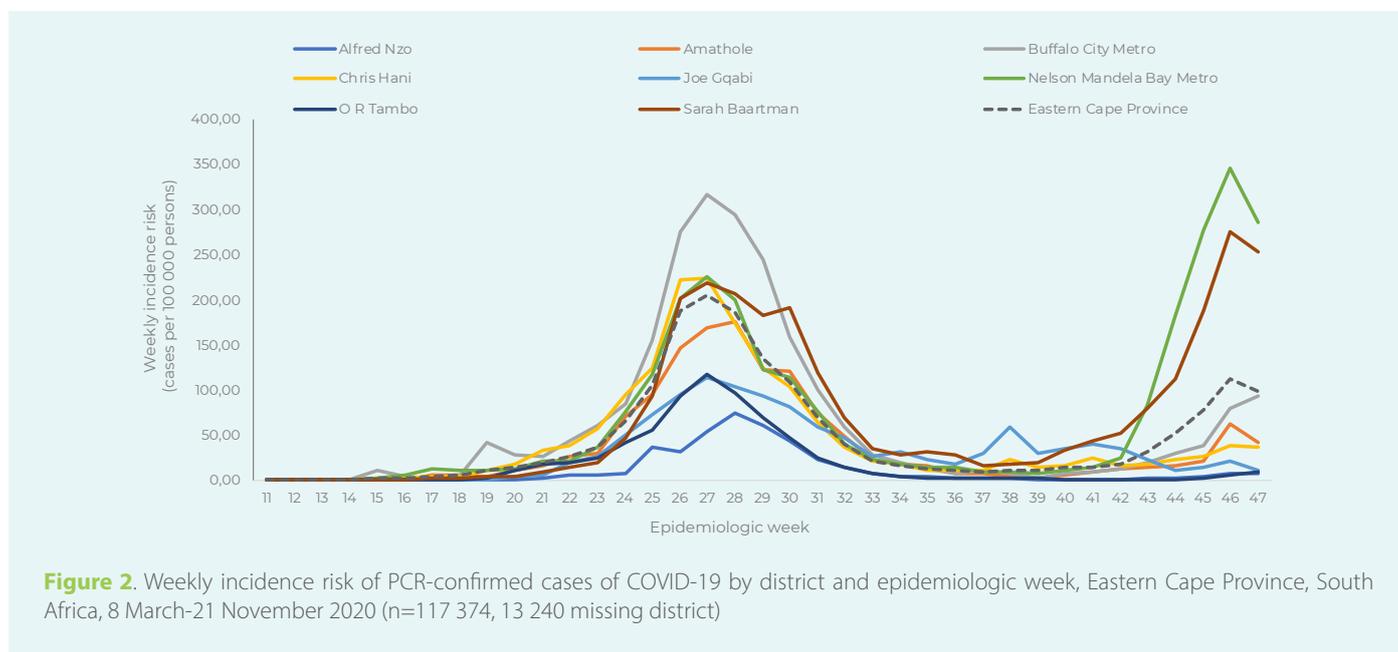
Visit the NICD website at <http://www.nicd.ac.za/diseases-a-z-index/measles/> for further information and for the measles case investigation forms. Vaccine information for mothers and caregivers is available at <https://www.nicd.ac.za/faq/vaccination-information-for-parentscaregivers/>.

**INTERNATIONAL OUTBREAKS OF IMPORTANCE**

## Resurgence of COVID-19 cases in Eastern Cape Province, November 2020

The Eastern Cape Province, in South Africa, with an estimated population of 6 734 001 people in 2020, reported its first case of COVID-19 on 8 March 2020 (epidemiologic week 11). From 8 March through 21 November (week 47), there were 117 374 cases of COVID-19 reported from Eastern Cape Province, of which 104 134 (88.7%) had allocation by district. At the start of the pandemic the weekly incidence risk of cases was 0.01 cases per 100 000 persons and it increased steadily and

peaked in week 27 (week ending on 4 July 2020) (206 cases per 100 000 persons). From week 28 there was a steady decline in weekly incidence risk until week 37 (8.9 cases per 100 000 persons). There has been a resurgence of cases from week 38 to 46 (11.6 to 99.4 cases per 100 000 persons), with a steep increase reported from week 43 to week 46 (Figure 2). The reduction in numbers in week 47 may be as a result of delayed reporting and it is unclear when the resurgence will peak.



Almost half of the new cases detected in South Africa in week 47 (6 695/13 539, 49.4%), were from the Eastern Cape Province. The first wave in Eastern Cape peaked in week 27, incidence risk 205.5 cases per 100 000 persons with highest incidence risk reported in Buffalo City Metro (315.8 cases per 100 000), followed by Nelson Mandela Bay (225.6 cases per 100 000), and Chris Hani (224.6 cases per 100 000). The overall second peak in incidence risk of cases from the Eastern Cape in week 46 was lower (111.9 cases per 100 000) than the peak in week 27. However, the peak incidence risk reported in week 46 from two of the three districts contributing to the resurgence in cases was higher than that reported during the first peak,

Nelson Mandela Bay (345.0 vs 266.0 cases per 100 000) and Sarah Baartman District (274.7 vs 218.1 cases per 100 000 persons). Buffalo City Metro (79.7 cases per 100 000) contributed the third highest incidence risk in week 46. (Table 1).

The majority of cases in the first wave (week 11-37) were in the 20-39- (32 622/87 499, 37.3%) and 40-59-year (33 199/87 499, 37.9%) age groups. Similarly during the resurgence in the past few weeks majority of cases were in the 20-39- (10 309/29 875, 34.5%) and 40-59-year (10 607/29 875, 35.5%) age groups.

## INTERNATIONAL OUTBREAKS OF IMPORTANCE

**Table 1.** Number and incidence risk (cumulative/weekly) of laboratory-confirmed cases of COVID-19, hospitalisations and deaths per 100 000 population during the first wave (week 11-37) and second wave (week 38-47) by district, Eastern Cape, South Africa, 3 March-21 November 2020 (n=117 374, 13 240 missing district)

District	Cumulative number of cases in Eastern Cape Province to date	Number of cases in weeks 11-37	Number of cases in weeks 38-46	Population mid-2020*	First wave peak weekly incidence risk of cases per 100,000 population (week 27)	Second wave peak weekly incidence risk of cases per 100,000 population (week 46)	First wave peak weekly incidence risk of admissions** per 100 000 population (week 28)	Second wave peak weekly incidence risk of admissions per 100 000 population (week 46)	First wave peak weekly incidence risk of deaths** per 100,000 population (week 30)	Second wave peak weekly incidence risk of deaths** per 100 000 population (week 47)
Alfred Nzo	3 411	3 172	239	832 248	56.5	7.6	8.3	1.8	1.3	0.2
Amathole	11 073	9 544	1 529	799 205	169.2	62.6	11.0	3.9	3.4	0.4
Buffalo City Metro	18 415	15 990	2 425	800 874	315.8	79.7	43.3	13.6	12.5	3.5
Chris Hani	12 011	10 292	1 719	727 652	224.6	38.1	15.7	7.0	6.7	1.5
Joe Gqabi	4 112	3 139	973	344 967	114.8	20.9	3.8	0.3	2.0	0.0
Nelson Mandela Bay Metro	31 934	16 877	15 057	1 213 060	225.6	345.0	38.3	50.1	11.2	11.9
O R Tambo	10 565	10 136	249	1 532 174	117.4	5.6	5.2	1.6	1.7	0.5
Sarah Baartman	12 613	7 414	5 199	483 821	218.1	274.7	14.9	8.7	3.5	3.3
Unallocated	13 240	10 935	2 305	-	-	-	-	-	-	-
Grand Total	117 374	87 499	29 875	6 734 001	205.5	111.9	40.9	29.8	5.5	3.1

\*2020 Mid-year population Statistics South Africa;\*\*Data on hospital admissions and deaths sourced from DATCOV report published in week 47, hospitalisations and deaths are expected to be delayed in relation to cases, in addition there may be delays in reporting.

Hospital admissions for COVID-19 cases in Eastern Cape peaked in week 28 (18.5 cases per 100 000 persons) and in week 46 (13.1 cases per 100 000 persons) during the first and second waves respectively. Nelson Mandela Bay and Buffalo City districts contributed the majority of hospital admissions in both waves. However the peak weekly incidence risk of admissions in Nelson Mandela Bay (50.1 cases per 100 000 persons) during the current resurgence was higher than that reported during the 1st peak (38.3 cases per 100 000 persons) in week 28. The peak incidence risk of hospitalisations in Buffalo City (13.6 cases per 100 000 persons) during the current resurgence was lower than that reported during the first peak (43.3 cases per 100 000 persons). The peak weekly incidence risk of deaths reported in Eastern Cape Province was in weeks 30 and 47 for the first and second wave, respectively. Buffalo City and Nelson Mandela Bay districts reported the majority of deaths during both peaks. The peak incidence risk of deaths was lower during the second wave compared to the first wave in Buffalo City District (3.5 vs 12.5 cases per 100 000) and was similar in Nelson Mandala Bay District (11.9 vs 11.2 cases per 100 000). Testing rates peaked to 522.7 tests per 100 000 in week 26 (first wave) and to 253.0 tests per

100 000 in week 46 (second wave)<sup>1</sup>.

This summary highlights an increase in the burden of COVID-19 cases in Eastern Cape Province currently, mainly driven by two districts, Nelson Mandela Bay Metro and Sarah Baartman Districts, with incidence risk of cases exceeding those reported during the first wave in some districts. In addition the incidence risk of hospitalisation in Nelson Mandela Bay was also much higher during the second wave<sup>2</sup>. To date in-hospital deaths reported during the second wave are lower compared to the first wave, however, this could be due to a delay in deaths and a delay in reporting of deaths. With increasing numbers of cases, strengthening the capacity of facilities to cope with increasing demand for admissions is recommended.

### References

- [1.https://www.nicd.ac.za/wp-content/uploads/2020/11/COVID-19-Testing-Summary-Week-46-Nov-2020.pdf](https://www.nicd.ac.za/wp-content/uploads/2020/11/COVID-19-Testing-Summary-Week-46-Nov-2020.pdf)
- [2.https://www.nicd.ac.za/wp-content/uploads/2020/11/NICD-COVID-19-Weekly-Sentinel-Hospital-Surveillance-update-Week-46-2020-updated.pdf](https://www.nicd.ac.za/wp-content/uploads/2020/11/NICD-COVID-19-Weekly-Sentinel-Hospital-Surveillance-update-Week-46-2020-updated.pdf)

## INTERNATIONAL OUTBREAKS OF IMPORTANCE

**Efficacy data emerging from COVID-19 vaccine trials**

Preliminary results from three COVID-19 vaccine efficacy trials have recently been announced in the media. The mRNA vaccines developed by Pfizer/BioNTech Pharmaceuticals and Moderna were both shown to be safe with 95% efficacy in over 80 000 participants. This included people over the age of 65 years who are at higher risk of severe COVID-19 disease. It is envisaged that sufficient vaccine will be available for 35 million individuals in 2020 and up to 1 billion in 2021. While mRNA vaccines are easier to produce, they need to be kept at low temperatures, which makes their distribution difficult especially in developing countries.

The ChAdOx1 nCoV-19 vaccine developed by AstraZeneca and Oxford University is a vector-based vaccine that can be handled under normal cold chain conditions and is much more affordable. This vaccine showed 70% protection; however, comparisons

are complicated as the mRNA trials tested only symptomatic individuals, whereas AstraZeneca set a higher bar, testing for all infections. The high level of vaccine efficacy for all three vaccines is encouraging as even 60% efficacy could significantly impact public health. Details on the immune correlates of protection, and their longevity are eagerly awaited.

Overall, these preliminary results suggest that multiple vaccines will be effective against COVID-19. South Africa is currently testing the AstraZeneca vaccine and a similar vectored vaccine developed by Johnson and Johnson. The protein-based Novavax vaccine is also being tested, but efficacy results are not yet available. Much needs to be done to ensure that vaccines are available to South Africans in the next 9-12 months, including negotiating access, securing funding to purchase vaccines and developing the capacity to manufacture vaccines locally.

Source: Centre for HIV and STIs, NICD-NHLS; nonom@nicd.ac.za and pennym@nicd.ac.za

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

On 18 November 2020, the 11th Ebola Virus Disease (EVD) outbreak in the Democratic Republic of Congo (DRC), 42 days after the last known confirmed case tested negative twice, was declared over.

The outbreak was first declared on 1 June 2020, following the report of seven EVD cases in Mbandaka city and neighbouring Health Zone Bikoro in Équateur Province, in the north-west part of the country.

During this outbreak, a total of 130 cases was reported (119 confirmed and 11 probable) across 13 health zones, 55 of whom demised and 75 recovered. Three healthcare workers were also reported to be among those affected.

This latest outbreak arose in the Équateur Province, on the north-west side of the DRC, as the 10th EVD outbreak was approaching its close towards the eastern parts of the country. These two outbreaks were geographically far apart and were proven, using genetic sequencing, to be unrelated.

The outbreak response carried out by the Ministry of Health in the DRC included more than 100 World Health Organization (WHO) staff, as well as others from a range of different organisations, with help from several partners through donations. The outbreak posed many challenges, amid the paralleled COVID-19 response, with obstacles such as access and logistical difficulties (with communities affected both in overcrowded urban areas, and remote rural areas), on top of resistance from some communities. These challenges were surmounted due to government leadership, community engagement and support from the WHO and partners.

During their efforts, the outbreak response was responsible for the successful vaccination of more than 40 000 people at high risk of disease. With support from partners, challenges such as the vaccination cold chain, requiring temperatures as low as -80 degrees Celsius, were overcome, allowing vaccinations to reach

even the most rural of communities, without dependence on electricity supply. Vaccination strategies were rolled out as early as four days after the start of the outbreak, with up to 90% of the vaccinators from local communities, highlighting the critical role and strength in community engagement.

*WHO Regional Director for Africa, Dr Matshidiso Moeti noted that "Overcoming one of the world's most dangerous pathogens in remote and hard to access communities demonstrates what is possible when science and solidarity come together. The technology used to keep the Ebola vaccine at super-cold temperatures will be helpful when bringing a COVID-19 vaccine to Africa. Tackling Ebola in parallel with COVID-19 hasn't been easy, but much of the expertise we've built in one disease is transferrable to another and underlines the importance of investing in emergency preparedness and building local capacity."*

The risk of resurgence of cases in the DRC remains, as undetected viral transmission cannot be excluded as the virus is known to persist in the bodily fluids of some disease survivors for some time, as well as on medical apparatus used to treat those infected. As a result, for a period of six months following the declaration of the end of an outbreak, a combination of passive and active surveillance must be maintained. In addition, the survivor programme and the biological follow up of those who have recovered must continue for a minimum of 18 months. Ebola virus remains endemic in the region due to its presence in animal reservoirs in many parts of the DRC.

The end of this outbreak serves as a reminder to all governments and partners to continue to focus their attention and efforts on other emergencies, as the fight against COVID-19 continues. There is an ongoing need for increased investment in improving the core capacities of countries in implementation of International Health Regulations. Enhanced preparedness will improve responses to future threats arising from epidemic-prone diseases and result in a lessened social and economic impact.

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))

**PREVENTING HIV INFECTION**

## **Long-acting injectable cabotegravir proving to be highly efficacious in preventing HIV infection**

Interim results of the HIV Prevention Trials Network (HPTN) 084 study were announced on 9 November 2020, wherein the long-acting injectable cabotegravir was shown to be 89% more effective than daily oral tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) in preventing infection with HIV. This followed an early un-blinding recommendation from an independent data safety monitoring board, given that the study showed superiority of cabotegravir relative to current pre-exposure prophylaxis (PrEP) standard-of-care. The study confirms similar outcomes of HPTN 083, announced in May 2020, wherein long-acting injectable cabotegravir proved superior in preventing HIV infection in 4 570 men who have sex with men and transgender women who have sex with men in Argentina, Brazil, Peru, United States, South Africa, Thailand and Vietnam.

HPTN 084 study is a phase III double-blind study designed to evaluate the safety and efficacy of injectable cabotegravir administered as an intramuscular injection once every eight weeks, relative to daily oral TDF/FTC tablets (200 mg/300 mg) for preventing HIV acquisition. The study began in November 2017 and enrolled 3 223 women aged 18–45 years at increased risk of HIV acquisition in Botswana, Kenya, Malawi, South Africa, Eswatini, Uganda and Zimbabwe. Of 38 women who acquired

HIV during the trial, four were from the cabotegravir arm, and 34 were from the daily oral TDF/FTC arm. The HIV incidence rate was 0.21% (95% confidence interval [CI] 0.06%–0.54%) in the cabotegravir group and 1.79% (95% CI 1.24%–2.51%) in the TDF/FTC group. While both methods were highly effective at preventing HIV infection, long-acting cabotegravir was 89% (95% CI 68–96%) more effective than TDF/FTC.

If approved, the use of long-acting injectables provides women with more discrete, empowering and effective options to minimise their risk of HIV infection.

For further information:

<https://viivhealthcare.com/en-gb/media/press-releases/2020/november/viiv-Healthcare-announces-investigational-injectable-cabotegravir-is-superior-to-oral-standard-of-care-for-HIV-prevention-in-women/>

<https://www.who.int/news/item/09-11-2020-trial-results-reveal-that-long-acting-injectable-cabotegravir-as-prep-is-highly-effective-in-preventing-hiv-acquisition-in-women>

<https://www.hptn.org/news-and-events/press-releases/long-acting-injectable-cabotegravir-highly-effective-prevention-hiv>

## BEYOND OUR BORDERS

The 'Beyond our Borders' column focuses on selected and current international diseases that may affect South Africans travelling abroad. Numbers correspond to Figure 3 on page 10.

### Yellow fever: Nigeria

Nigeria is responding to the latest successive yearly outbreak of yellow fever since the return of the disease in September 2017. Since the beginning of 2020, a total of 1 558 suspected cases and 46 confirmed cases has been reported from 481 (62%) local government areas (LGAs) across all 36 states and the Federal Capital Territory (FCT).

On Monday 16 November 2020, three more LGAs in the state of Enugu were suspected to have recorded yellow fever outbreaks. Enugu had already documented an outbreak in two communities where yellow fever had reportedly claimed 52 lives between the first reports of the outbreak in October 2020 and 16 November 2020. Yellow fever has also been confirmed in Nigeria's Benue State, where epidemiologists reported that 26 people had fallen ill. State government alerted that it had received reports of 'strange deaths within communities' in three other local government agencies. In response to this, the ministry of health has initiated a rapid response team which is working in collaboration with international and national

partners to visit these communities and take samples for testing. These specimens will be sent to the national reference laboratory in the country's capital city, Abuja.

Following the initial rise in laboratory confirmed cases, a large scale vaccination campaign was launched with an anticipated 922 463 residents of Enugu State set to be vaccinated. This number represents 85% of the entire population in the affected local councils. Vaccinations will take place in primary health centres, special outreach centres, as well as house-to-house vaccination using fully trained and mobilised vaccinators. This vaccination strategy will target individuals between the ages of 9 months and 44 years of age. Initially, the programme aims to cover affected local councils and then later, extended to ten neighbouring councils and then the state. Officials believe that their robust public health response involving public education, extensive vaccination and rapid testing and management will result in timeous control of the outbreak.

### Leptospirosis: India

Leptospirosis cases have been on the rise with a total of 203 cases reported between January and October this year. In January 2020, 559 people were tested, 24 of whom were symptomatic. Twenty-six people were infected in February, a further 23 in March, five in May, 11 in June and 25 in August. The highest number of cases were reported in September 2020 with a total of 34 cases. It is important to note that fewer cases have been reported in 2020 than in 2019 (344 cases) and in 2018 (330 cases). The infection normally spreads through the urine of rats. Dogs, pigs and cattle can also shed leptospira in their urine.

Usually farmers who visit the fields for harvesting paddy crops get infected. It is thought that the decline in reported cases during 2020 may be, in part, as a result of the prolonged four-month lockdown and consequent decline in people farming or going out. Moreover, the healthcare workers who visited houses to create awareness about coronavirus also used the opportunity to educate about dengue fever and leptospirosis, highlighting some of the precautionary measures that can be taken to prevent these diseases.

### Plague: Democratic Republic of the Congo

A new outbreak of suspected bubonic plague was reported on 29 October 2020 from the Aungba health zone located in the Mahagi territory, Ituri Province, in north-eastern Democratic Republic of the Congo (DRC). The area is located in the most active endemic plague focus in continental Africa and is the 8<sup>th</sup> plague outbreak reported in less than a year from this area in the DRC.

Initial reports came from a nurse on 29 October who alerted the Chief Medical Officer in the region of four community deaths. The following day, the supervision team in the Aungba health zone began their outbreak investigation and recorded a total of seven cases of bubonic plague, including four deaths.

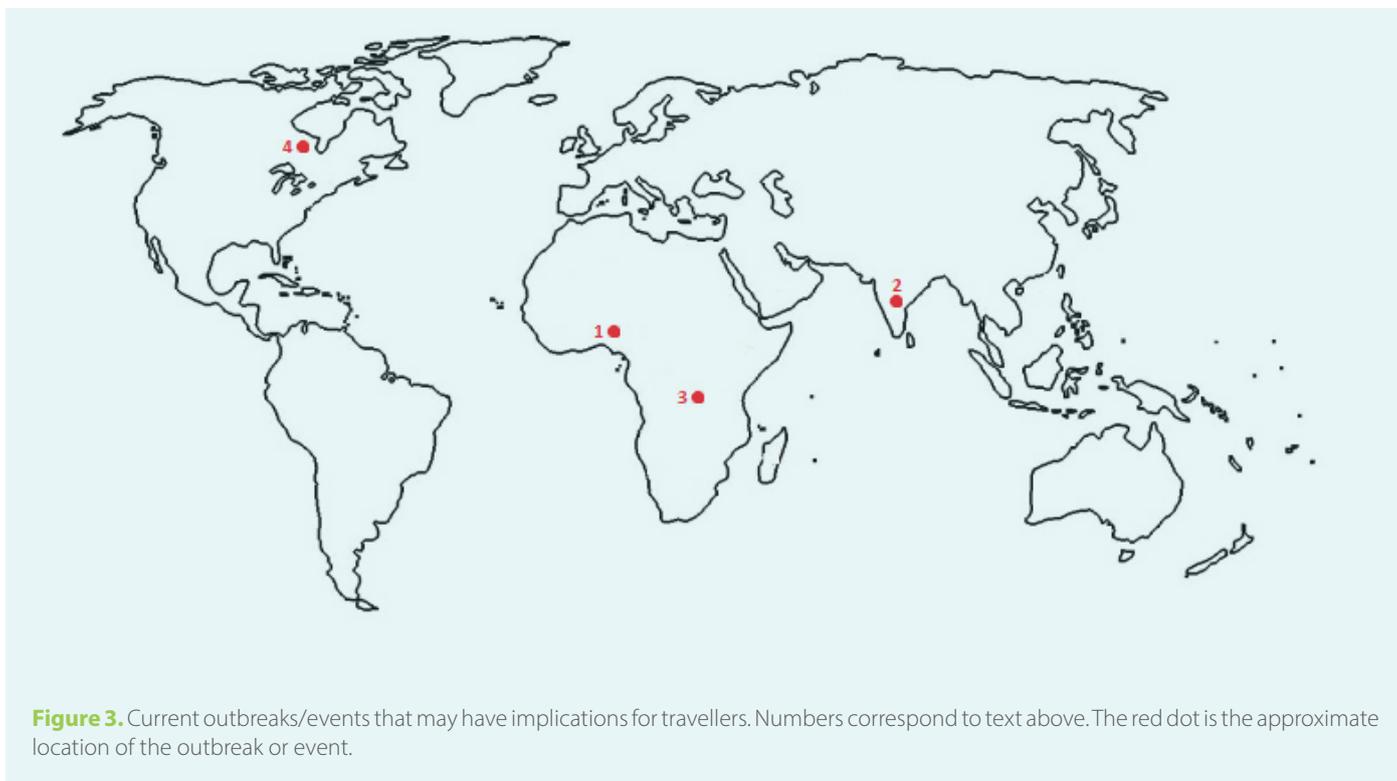
The index cases appear to have been two boys, aged 10 and 13 years, from the same family. They presented with symptoms classic of the disease and consequently both died between 26 and 27 October. The other two recorded deaths are of two girls, aged 13 and 14 years, also belonging to one family and residing in a household close to the index cases. The remaining three active cases were sourced in the area by the outbreak investigation team and are currently being treated at nearby health centres. Public health measures has also extended to trace 26 contacts who were preventatively managed with doxycycline. Furthermore, the houses where the deaths occurred were dusted with deltamethrin to control potentially infected fleas.

**BEYOND OUR BORDERS**

## Salmonellosis: Canada

Lambton Public Health has now reported that dozens of people have contracted salmonella infections after eating at the Barakat restaurant in Sarnia and at the Barakat food truck in Corunna, Ontario, Canada, between 19 and 29 October 2020. On Monday 9 November 2020, the local health unit confirmed that a total of 41 people has been diagnosed with salmonellosis. The first news release was made on 30 October 2020, alerting the public that an investigation was being conducted. By 5 November 2020, 33 cases related to the outbreak had been identified in people aged between 9 months and 73 years. Majority of these exposures occurred between 21 and 25 October 2020.

Awareness of the outbreak is increasing and the public has been encouraged to report illness to the Lambton Public Health as well as to contact healthcare providers if symptomatic. In earlier news releases, public health reported that food and environmental swabs from the location had shown that food samples were negative, although results for some of these samples remain pending. The investigation is still ongoing and restaurant owners continue to remain cooperative, with their facilities remaining closed whilst pending an outcome.



**WHO AFRO UPDATE**

# WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 42: 12 - 18 October 2020  
Data as reported by: 17:00; 18 October 2020



**0** New event

**118** Ongoing events

**106** Outbreaks

**12** Humanitarian crises



<b>49</b> Grade 3 events	<b>19</b> Grade 2 events	<b>2</b> Grade 1 events	<b>40</b> Ungraded events
<b>2</b> Protracted 3 events	<b>2</b> Protracted 2 events	<b>3</b> Protracted 1 events	

Health Emergency Information and Risk Assessment

**Figure 4.** The Weekly WHO Outbreak and Emergencies Bulletin focuses on selected public health emergencies occurring in the WHO African Region. The African Region WHO Health Emergencies Programme is currently monitoring 118 events. For more information see link below:  
<https://apps.who.int/iris/bitstream/handle/10665/336161/OEW42-1218102020.pdf>

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