THE FEDERATION OF INFECTIOUS DISEASES SOCIETIES OF SOUTHERN AFRICA

FIDSSA Quarterly

FIDSSA 4WARD, Durban 8-11 Sept 2011. 1 week to go!

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With just over a week to go to the opening of the 4th FIDSSA conference, the LOC led by the incomparable Prashini Moodley is ready to welcome you to the beautiful city of Durban! The conference has been awarded **12 Ethics points and 18**

CEU points. The international faculty will be giving the following plenaries as well as talks in parallel sessions . We look forward to seeing you there!



Deborah Goff (USA) Antibiotic Stewardship



Philip LaRussa (USA) Paediatric vaccines



Eduardo Gotuzzo (Peru) Typhoid Fever



Patrice Nordmann (France) Antibiotic resistance



Theresa Horan (USA) Nosocomial infections



James Todd (USA) Toxic Shock Syndrome



Francis Ndowa (Switzerland) STIs and HIV



Nicholas White (Thailand) Malaria



We are proud to announce that South Africa has successfully bid to host the 8th Options for the Control of Influenza conference, the largest international conference exclusively devoted to influenza. Congratulations to Prof Wolfgang Preiser who led the bid.

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Making FIDSSA more relevant outside of South Africa **Windssa**



fidssa soci



The Zimbabwe Medical Association Conference at Victoria Falls focused on the theme of 'Sustained & Enhanced Medical Education'. The FIDSSA president was invited to the conference to speak on Infectious Diseases training in southern Africa, and it was an excellent opportunity to discuss with colleagues in Zimbabwe, how FIDSSA can become more relevant to countries within the region other than South Africa where the majority of our activities are focused.

A number of models of support are feasible, including 2-3 day training sessions from a FIDSSA faculty representing our different societies, the setting up of a Zimbabwean branch of FIDSSA with financial and human resource support for meetings and other activities, and application for training fellowships to enable Zimbabwean physicians to train in Infectious Diseases in South Africa. More details will be given at the FIDSSA AGM.

News from the FIDSSA Office - Lea Lourens

Membership information

With the congress just around the corner, we have had a great response from members updating details and renewing their membership. However, we still have a large number of people with out-dated information. The 3 most important information areas we need your help with are:

*Postal address *Cell number *E-mail

This information is **not given to any outside companies** and are only used for FIDSSA communications. Without this information you will not be receiving relevant information, updates, your free copy of the SAJEI and your notice of when to renew your FIDDSA membership.

Please help us in this regards to ensure smooth communication.

FIDSSA Congress

Please note that you will be able to check your membership status and information at the congress. No credit card facility will be available there, but as payment of fees can be done via the internet, it should not be a problem. Cheques are most welcome!!

Have a fabulous time at the congress - I will see you there!!!

"Benign Malaria". Not so "benign"- Dr Salim Parker, SASTM Executive Member



South African Society of Travel Medicine

"Plasmodium falciparum is to P. vivax what algebra is to calculus; it is far more complex and nuanced." This is how Dr Peter Baird introduced his talk on P.vivax at the ISTM (International Society of Travel Medicine) conference held in May in Boston. P. Vivax, often considered to be a benign tertian infection, is increasingly shown to be a large worldwide burden, to lead to a severe and at times fatal course, and to be developing resistance to stalwart drugs like chloroquine and primaquine.

In 2005 it was estimated that 2.5 billion were at risk of *P. falciparum* infection, with 0.27 billion attacks, 60% of which were in Africa. The at risk population for the same period for *P. vivax* was 2.8 billion, with 0.1-0.4 billion attacks, less than 5% occurring in Africa. The relative low rate in Africa is due to the high prevalence of Duffy blood type negativity. The Duffy antigen acts as a receptor for P.*vivax* and its absence precludes infection, though some contrary evidence surfaced in Madagascar recently. The parasite and the vector are present across Africa, as indicated in the map below. Visitors to these areas, often Duffy positive, are not immune to *P. vivax* exposure and infection has been reported from virtually all countries in Africa where the Anopheles species are found. P. vivax has a wider range than P. falciparum as it is able to develop at lower temperatures during sporogony and can hence exist at higher altitudes and further latitudes.



Fig 1: The global spatial limits of *Plasmodium vivax* malaria transmission in 2009. Areas where Duffy negativity prevalence was estimated as >90% are hatched.¹

It is mistakenly held that 90% of the world's malaria burden is in Africa, hence trivialising *P. vivax* infections. *P. viviax* is generally well treated in an otherwise healthy population, in well-resourced settings. The converse is true for the vast highly populated, but under resourced areas of Asia where co-morbidities, poor nutrition and emerging resistance to drugs complicate the clinical course. Recently in Papua, Indonesia, *P. vivax* accounted for 24% of malaria-related hospital admissions compared to 64% due to *P. falciparum*. Severe disease was seen in 20% of *P. falciparum* admissions with an 11% case fatality rate (CFR) compared with 23% severe disease in *P. vivax* disease with n CFR of 7%. Findings in Brazil, India and Papua New Guinea also point to the burden of severe disease, CFR's and clinical spectra being similar for the two species.

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Severe clinical sequelae include anaemia, thrombocytopaenia, renal failure, jaundice, seizures, coma, and ARDS. In adult returning travellers, acute lung injury resulting in respiratory distress has been shown to have been caused by *P. vivax*. The pathophysiology of severe disease is still being elucidated as the high parasite count, sequestration of cytoadherent organisms, and the decreased flexibility of both the infected and uninfected cells seen in *P. falciparum* are not features of *P. vivax* infections.

Managemtne of *P.vivax* involves treating the acute stage using the blood schizontocide chloroquine, and preventing relapse by using the hypnozoitocide primaquine. Resistance to chloroquine is increasingly being reported, with high grade resistance occurring in eastern Indonesia and Papua New Guinea. Low level resistance has been detected in Burma, Somalia, Turkey, South Korea, Vietnam, Madagascar, and South America. Susceptibility to other drugs like mefloquine remains high.² Relapse rates of up to 22% have been documented with primaquine though it remains highly effective and is the only hypnozoitocide available. There is not enough knowledge of primaquine efficacy when used with schizontocides other than chloroquine, and its effectiveness as radical cure in such circumstances needs further evaluation.

Reference:

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GeneExpert MTB/RIF (Xpert) testing for tuberculosis in South Africa - Mark Nicol



Xpert is a new, real-time PCR-based assay for the simultaneous detection of tuberculosis and rifampicin (RIF) resistance. The major advantages of this technology over previous nucleic acid amplification tests for TB are improved sensitivity, particularly in smear-negative patients, and substantially reduced operator dependence, due to use of an integrated sample preparation/amplification/detection cartridge. Sample preparation takes approximately 15 minutes and the test itself less than 2 hours.

The World Health Organization endorsed the use of Xpert late last year, and recommended its use as a firstline test for TB in settings where HIV-associated TB and multidrug resistant (MDR) TB are prevalent. The test has been available in the private sector and in research settings in South Africa for some time and a phased roll out in the State sector is now underway. Since the majority of TB patients in South Africa are coinfected with HIV, Xpert is indicated as the first-line test (in place of smear microscopy) for all TB suspects.

Xpert does, however, have a number of important limitations. Firstly, a single Xpert test, whilst able to detect all smear-positive TB, only detects between 70 and 75% of smear-negative TB. A negative Xpert test cannot be used to rule out TB, particularly in HIV-infected patients. A second test increases the sensitivity by approximately 13%. The test has very high specificity, so a positive test is sufficient evidence to confirm the diagnosis of TB.

A further limitation is the specificity of Xpert for the diagnosis of RIF resistance. Current versions of the assay have specificity for RIF resistance of 98%. Therefore, for every 100 cases of TB detected by Xpert, RIF resistance will be falsely identified in 2. If the prevalence of RIF resistance in the patient population is 4%, then 2 out of every 6 RIF resistant calls by Xpert will be false.

An improved assay version is currently in the final stages of testing and looks promising, however, until this version is released, all RIF resistant calls on Xpert should be confirmed by a second test (e.g. line probe assay or culture-based drug-susceptibility testing).

The national algorithm for implementation of Xpert testing makes allowance for these limitations. For HIVinfected patients with a negative Xpert test, mycobacterial culture is recommended. Since the majority of TB suspects in South Africa are likely to be HIV-infected, and since a proportion of these will have a negative Xpert test, if this algorithm is widely followed then culture will still be required in a large proportion of TB suspects. Since Xpert is substantially more expensive than smear microscopy this is likely to have significant cost implications.

Much has been said about the use of Xpert as a 'point of care' test. Since the technology is simple to use and does not require highly trained staff, it could feasibly be implemented closer to the point of care than current diagnostics. It is far, however, from the ideal point of care test. It uses expensive instrumentation that requires complex annual calibration, a stable uninterrupted power supply, regular basic maintenance and a trained operator. The cartridges are bulky and create substantial medical waste. These considerations should be carefully weighed when making decisions regarding the long-term sustainability of offering testing outside of a laboratory.

In field studies, use of Xpert has been shown to substantially reduce time to diagnosis and treatment for TB. However, diagnosis of TB and identification of drug resistance are only the first steps. Despite more rapid diagnosis, initial default rates remained high in South African studies using Xpert, and increased diagnosis of TB/ MDR-TB will likely place considerable strain on TB treatment services. Whilst Xpert is a major advance in the field of TB diagnostics, it is not a panacea for the TB epidemic in this country.

Accessing Antimicrobial Surveillance data on the FIDSSA website (http://www.fidssa.co.za)



In recent months, SASCM has worked on standardizing surveillance activities between the private and public sectors. We have created an updated set of organisms and antibiotics from specified specimen types on which we will report data. We have also undertaken to publish the surveillance data twice a year in the South African Journal of Epidemiology and Infection. The first such article appeared in June 2011 entitled "National surveillance of private sector respiratory tract pathogens in South Africa, 2010".

Within the public sector considerable effort has gone into developing tools for extracting data from the central data repository administered for the NHLS by Central Data Warehouse (CDW). Accessing data centrally would remove much of the inconsistency that has plagued past surveillance reports. There have however been some complicated hurdles to overcome, but it appears likely that we will be able to access data more consistently in the near future.

To access surveillance data, you need to:

1. Be a member of FIDSSA with a username and password – contact Lea Lourens <u>info@fidssa.co.za</u> if you need help to obtain this.

2. Login to the 'Member Secure Section' on the FIDSSA website.

3. Navigate to the 'Surveillance' tab (look at the top of the screen for tabs), then select 'Antimicrobial Surveillance Data' and choose either Private or Public Sector and select desired report.

If you are a corporate member of SASCM, you should follow the same procedure, but please contact Steve Oliver <u>Stephen.oliver@uct.ac.za</u> first if you need to confirm your membership status.

Solidarity for Survival





Dr Prinitha Pillay is from Johannesburg, graduated from Wits

in 1996 with a BSc (Honours) in Medical Biochemistry and in 2003 with a MBBCh. She has worked for Medecins Sans Frontieres (MSF)/Doctors Without Borders since 2006 and is currently President of the MSF SA Board. She is pursuing her Masters in Infectious Diseases at the London School of Hygiene and Tropical Medicine and writes from South Sudan.

As the overwhelming "yes" for the separation of Southern Sudan passed relatively peacefully on the 9th January 2011, at least 100 people lost their lives in violent clashes in the contested border region of Abyei. Approximately 220 000 people were once again uprooted to return home to the South. Medicins Sans Frontieres/ Doctors Without Borders (MSF) has long sought to draw attention to the medical and humanitarian needs of vulnerable populations in Southern Sudan, which remain largely unmet as our priorities get subordinated to political interests surrounding the birth of the newest nation in Africa. In Southern Sudan, where an alarming 75% of people do not have access to primary health care, this is further compounded by the arrival of almost a quarter of a million returnees.

Thousands of kilometres away, in South Africa where I am from, the MSF office will launch a new campaign to raise public awareness about the massive medical and humanitarian needs we face in places like Southern Sudan. This campaign will not only expose the humanitarian needs of vulnerable populations in these key countries, it will also heighten critical consciousness and promote a sense of solidarity with people fleeing these very contexts to seek refuge in South Africa. It will highlight why people flee or are displaced and illustrate the conditions they endure to survive. It will also aim to inspire positive individual and collective action amongst people and communities in South Africa by taking a stand to improve the lives of those seeking refuge in the country. It will focus on five key contexts where MSF operates in sub-Saharan Africa: Democratic Republic of Congo, Somalia, Southern Sudan, Zimbabwe and South Africa.

In Gogrial Southern Sudan, where I write from, and where MSF runs a new modest primary health care centre which serves a population of 250 000, it has the usual gambit of primary and secondary care including life-saving surgeries. The urban returnees arrive home to already limited resources, limited diagnostics, and no access to effective treatments.

These uprooted urban returnees demonstrate remarkable resilience as they are faced with difficult conditions during their travels. They cannot access treatment along the way if they fall sick, upon arrival they have to endure time in transit sites with little access to water or sanitation, they are further encouraged to return and integrate into a rural lifestyle and start cultivating, or go to school where they don't understand the language. Practically, we have heard that they don't even know where the nearest health centre is if they do fall sick. The odds are constantly against them. Despite these hardships, many residents have shown solidarity as they actively seek out their relatives returning to South Sudan. Witnessing this solidarity in the midst of such extreme deprivation is extremely moving.

As measles makes an unnecessary comeback this last decade, the recent measles outbreaks among the returnees living in transit sites highlighted the low vaccination coverage they have had in the North. And seeing the spread of the disease from returnees in urban transit sites to the resident population in outlying rural areas, in adults *and* children, exposes the underlying reality of low vaccination coverage here in Southern Sudan. It has one of the lowest vaccination coverage rates in the world. In 2008 DPT3 coverage (the percentage of children under one year of age who receive the third dose of DPT [diphtheria, pertussis, tetanus]), which is used by international funders as a critical indicator of functioning of EPI programmes, stood at a dismally low 12% and is reportedly up to 44% in 2010. Southern Sudan is still being held hostage, as it does not qualify for funded pentavalent vaccine or the newer pneumococcal vaccine.

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Making ministry of health programmes vaccinate children under 1 year while withholding the better vaccines from vaccinated children who can benefit is a doubled-edged sword. We should seek to show just how to provide at least routine vaccination in this context of cold chain in hot places! And we should push strongly for newer vaccines.

The returnees' vulnerability in Southern Sudan is further highlighted as to date, in our modest centre, we have had to treat three diabetic returnees who had not been able to access insulin during their travels or in the South. We also have three children with diabetes, picked up through our nutrition programme. MSF hopes to broaden its horizon to chronic diseases for urban and other populations on the move who are geographically marginalised.

In Southern Sudan my experience over the last 6 months has helped me to understand that many complaints of generalised body pain are actually hidden extra-pulmonary TB or Brucellosis. However, the diagnostic capacity is slim even for MSF when the poorly sensitive Rose Bengal test for Brucellosis costs a prohibitive €100/test. In this cow-centred universe that is Sudan, we need to take heed from the *first* ever diagnosed outbreak of Cutaneous Anthrax in Southern Sudan made in our small project last year. Unless we diagnose we cannot treat. For remote settings, with a scarcity of skilled human resources the syndromic approach might becoming quickly outdated as RDTs for malaria taught us. Diagnosing malaria was not just about malaria; it was about not neglecting the fact that our individual patients get other diseases too. There has to be a better alternative to standardised protocols for isolated populations and we should not be shying away from investing in bringing these technologies to assist low level health care workers make more erudite diagnoses.

Kala azar (visceral Leishmaniasis) is a treatable but largely neglected disease. Southern Sudan is currently facing a massive Kala azar epidemic. This is a region where three-quarters of the population has no access to basic medical care, and the health system is unable to deal with an emergency on this scale. In 2010, MSF treated 2355 patients which was eight times more than the previous year. The last big outbreak of the disease was eight years ago. There is a whole new generation that has not built up immunity against the infection since then and the returnees from the North will not be immune either. Apart from other influencing factors such as climatic conditions which favor the sand fly, allowing it to thrive and transmit the disease, high levels of malnutrition in various regions of Southern Sudan because of insecurity and failed harvests compound the problem as it makes people more susceptible to Kala azar. This epidemic sadly further compounds the already dire medical humanitarian situation facing the population. The MSF Access to Essential Medicines Campaign appeals for better treatment and for the reduction of the prohibitively high cost of Ambisome for treatment of Kala-azar. Unfortunately we still have to use toxic, painful and archaic Sodium Stibogluconate, a heavy metal to treat Kala-azar in Sudan. We certainly need a more affordable treatment for Kala azar that is better adapted to the reality of field conditions. This is all the more urgent as we enter the next epidemic wave of Kala azar in Southern Sudan with returnees without immunity to the disease.

Perhaps what is most frustrating for me is that for this rural population or for those in conflict settings where Medecins Sans Frontieres (MSF)/Doctors without Borders work, there is hardly a rapid response to these emergencies or simple diagnostic tests or effective treatment available for most of these diseases. I have to rely on my clinical acumen as there is certainly no culture techniques available in the entire country and no X-ray facility within reach. As a South African trained doctor I have had the luxury of training in a resource-constrained setting with state of the art healthcare, that makes me feel well placed to serve populations in need. With MSF, I realised that working in different places, like Lesotho, India, Darfur, Sierra Leone and Sudan has helped me feel part of the world –the middle of nowhere is somewhere for someone. Clearly, we need newer approaches to deliver routine immunisations when there is a global setback in vaccine preventable disease strategies; we should not fear addressing chronic disease management for isolated populations and those on the move; and we must continue to fight for research and development for better tools and implement technological advances to improve our disease detection and treatment for marginalised isolated populations. And that we must continue to show our solidarity by bearing witness and speaking out for patients who cannot.

Randomised Trials in Child Health in Developing Countries www.ichrc.org



Southern African Society of Paediatric Infectious Diseases

The booklet is produced yearly by WHO, AusAID and partners. Ben Marais has brought the most recent edition to our attention.

4 trials reported significant reductions in child mortality:

- In Kenya, South Africa and Burkina Faso, giving 3 antiretrovirals (ARV) to pregnant women with HIV infection, from the last trimester through to six months of breastfeeding, reduced the risk of transmitting HIV to the baby and improved survival, compared to zidovudine in pregnancy and single dose nevirapine.¹
- In 11 centers in 9 African countries, among more than 5000 children with severe malaria, Artesunate substantially reduced mortality compared to quinine treatment.²
- In rural China, iron and folic acid supplementation to pregnant women from the poorest households reduced neonatal mortality, and reduced low birth weight. Standard iron and folic acid provided more protection against neonatal death than multiple micronutrient supplements.³
- In Pakistan, in a trial involving over 46,000 households, a community-based program involving lady health workers delivering antenatal care and maternal health education, clean delivery kits, promoted facility births, immediate newborn care, identification of danger signs, and care seeking, significantly reduced still-births and neonatal deaths.⁴

Other outcomes from studies in 2010-11 include:

- In Rwanda, paying primary health facilities for performance resulted in a 23% increase in the number of institutional deliveries and a significant increase in the number of preventive care visits by children.
- In Bangladesh, day-case management of severe pneumonia in hospital was successful (as it was in four other countries), as long as children with hypoxia were identified and managed as inpatients.
- A green banana-supplemented diet hastened recovery of acute and prolonged childhood diarrhoea managed at home in rural Bangladesh.
- There were several trials of Zn in India, Bangladesh and Pakistan this year. In a communitybased effectiveness trial in India, educating caregivers to provide zinc supplementation to infants <6 months old reduced diarrhoea and acute lower respiratory infection. The protective effect of Zn for diarrhoea was the identical if given for 5 or 10 days in Bangladesh; and in India there was no added effect of giving multivitamins or micronutrients on the treatment effect of zinc for diarrhoea. Although Zn supplementation in some populations seems to *prevent* acute respiratory infection, two trials this year from India showed no effect in *treatment* of pneumonia.
- In a community-based trial in an urban slum in India, probiotics given daily for 12 weeks showed a 14% reduction in the occurrence of diarrhoea.

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- Co-trimoxazole prophylaxis in HIV exposed children in rural Uganda provided 39% protection against malaria, when continued up to 2 years of age, and in a trial in South Africa, daily cotrimoxazole preventive therapy was associated with significantly lower risk of bacteraemia in HIV-infected children than intermittent prophylaxis given 3 times per week.
- In Zambia the use of rapid diagnostic tests (RDTs) for malaria by community health workers resulted in more rational prescribing of antimalarials, with significant decreases in inappropriate prescribing of artemether-lumefantrine, and a significant increase in giving amoxicillin for pneumonia. Community health workers adhered closely to simple guidelines based on RDTs (in contrast to some earlier studies where health workers treated with antimalarials regardless of the result).
- In phase II trials in Tanzania and Kenya, the lead candidate malaria vaccine RTS,S/AS01E provided sustained protective efficacy of 39% and 45% at 12 and 15 months respectively against the first episode of malaria, when given to young infants with other EPI vaccines.
- While many trials in recent years have shown the protective effect of intermittent preventative treatment for malaria, the effectiveness in communities using insecticide treated bed nets was not established. Two trials from Burkina Faso and Mali showed a strong protective effect (69% and 85% reduction in severe malaria respectively) among children who sleep under insecticide treated bed nets.
- To address treatment failure for visceral leishmaniasis with paromomycin, three studies investigated high doses or for longer duration or combination drug treatment with amphotericin B alone, or amphotericin B and miltefosine, or paramomycin and miltefisine. Combination therapy resulted in cure for more than 95% of patients.
- A 23 year follow-up of a cohort of people in China involved in an early RCT of Hepatitis B vaccine showed sustained protective immunity, meaning that booster doses are unnecessary in fully vaccinated children for over 20 years

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(For other references, see publication)

Mark Cotton

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The new "Superbug" *Neisseria gonorrhoea* makes Gonorrhoea untreatable? - Frans Radebe, NICD



Sexually Transmitted Diseases Society of Southern Africa

Highlights from the 9th ISSTDR Quebec, Canada Meeting 2011

Neisseria gonorrhoeae (*N. gonorrhoeae*) has developed resistance to most available therapeutic antimicrobials. Recently it has been observed that the susceptibility of *N. gonorrhoeae* to extended spectrum cephalosporins, ceftriaxone (injectable) and cefixime (oral), the last remaining first-line treatment options for gonorrhoea, is decreasing. In 2010, the first two cases outside Japan of clinical failures to cefixime were descripted¹. Now, in 2011, the first *N. gonorrhoeae* strain (HO41) worldwide that is highly resistant to the extended-spectrum cephalosporin (ESC) ceftriaxone, which is the last remaining option for empirical treatment of gonorrhoea, has been identified. This is a huge public health problem and the era of untreatable gonorrhoea may now have been initiated.

The strain HO41, was genetically and phenotypically characterized by the Japanese and Swedish team to confirm the findings. Seven species-confirmatory tests were used to examine the antimicrobial resistance mechanisms of the HO41 strain, namely, antibiograms with Etest and agar dilution, porB sequencing, *N. gonorrhoeae* multi-antigen sequence typing (NG-Mast), multilocus sequence typing (MLST) and sequencing of ESC resistance determinants (penA, mtrR, penB, ponA and pilQ). The HO41 strain proved to be highly resistant to ceftriaxone (MIC 2– 4 mg/I, which is 4-8 fold higher than any previously described isolate) and all other cephalosporins. It was assigned serovar Bpyust, MLST ST7363 and the new NG-Mast ST4220. A new penA mosaic allele which caused ceftriaxone resistance was detected in the strain.

This new "superbug" *N. gonorrhoeae* which has now developed means that gonorrhoea may soon become untreatable if the strain spreads to other parts of the world. The public health worry is that because of poor or inadequate antimicrobial resistance (AMR) surveillance there is no information on how prevalent this strain is, even in Japan from where the isolate was identified. Thus, a reduction in global gonorrhoea burden by enhanced disease control activities combined with wider strategies for general control of AMR and enhanced understanding of mechanisms of emergence and spread of AMR, which need to be monitored globally, is crucial. A public health response plan which includes sustainable clinical, microbiological and epidemiological responses is essential, as is the development of newer drugs for the treatment of gonorrhoea.

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- M.Ohnishi, M Unemo, D Golparian, K Shimuta, T Saika, S Hoshina, K Iwasaku, S I Nakayama, J Kitawaki. The new superbug *Neisseria gonorrhoeae* makes gonorrhoea untreatable ? – First high-level ceftriaxone resistance worldwide and public health importance . *Sex Trans Infect* 2011 87: A76

Stop Press: *Plasmodium vivax* malaria re-surfaces in Greece

The CDC has posted a report sent in by the GeoSentinel Surveillance Travel system of a case of Plasmodium vivax malaria in a traveller to Elos and Skala in southern Greece around the last week of July 2011. The traveller had no history of travel to malaria-endemic countries.

Although there have been no reported cases of malaria in Greece since 1974, Greek health authorities report 6 cases of vivax malaria in patients with no history of travel to a malaria-endemic area. The southern districts of Laconia and Evoia are implicated. Heightened surveillance and mosquito control has been implemented.

For more information, visit the CDC website at http://wwwnc.cdc.gov/travel/news-announcements/ malaria-greece.htm

Infection Control Society News

There is increasing recognition within the national Department of Health about the importance of infection prevention & control (IPC) within South Africa, both at public and private sector level. Many of you are probably aware of, or were possibly involved in, the survey of Infection Prevention & Control resources conducted by the DoH within the last year (some of which were discussed in the recently published supplement in the SAMJ). The survey showed that none of the facilities questioned had the required number of Infection Prevention & Control Practitioners (based on a ratio of one IPC practitioner per 200 beds), and of the IPC practitioners that responded, more than half had no formal training in infection control. This probably comes as no surprise to anyone involved in IPC – we have long recognised the lack of adequately trained staff. However, it is gratifying that the DoH is now also formally aware of the extent of the problem.

The Department of Health has been engaging with the Infection Control Society as well as with the three major infection control training centres to review the core essential training requirements, in an effort to standardise training as far as possible. Concurrent with this, there is a renewed emphasis on giving recognition to the post graduate training by the SA Nursing Council. As this process unfolds we will keep you informed of the progress. However, in order to do this, we need up to date contact information. If you are reading this, your contact information is probably correct. However, if you know of anyone who used to belong to, or thinks they belong to, or should belong to the society, please ask them to check their contact details. They can contact Lesley Devenish (Lesley.devenish@netcare.co.za) who has a list of the contact details on the ICSSA / FIDSSA database. Alternatively they can contact Lea Lourens (info@fiddsa.co.za) to check and update details.

Best Care Always... continues to expand within the public sector, and a number of hospitals in the Western Cape are now on board with implementing the CLA-BSI bundles (Red Cross Children's Hospitals, Tygerberg Hospital and Groote Schuur Hospital), SSI bundle (Mowbray Maternity Hospital), VAP bundle (Tygerberg, and soon Red Cross) and CA-UTI bundle(Paarl Hospital).

Finally, a reminder to everyone about both the upcoming FIDSSA congress (at which we will also hold our AGM), as well as the IPCAN congress in Namibia. Both promise to be exciting and productive meetings, and I hope that everyone is able to attend at last one of them, if not both.



