EU Threats

Romania and Italy have been experiencing large outbreaks of measles in 2017. Cases continue to be reported despite ongoing reinforced vaccination activities at the national level. All EU/EEA countries have reported measles cases this year, except for Latvia, Liechtenstein, Malta and Norway.

I. Executive summary

EU Threats

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011  Latest update: 11 August 2017

Romania and Italy have been experiencing large outbreaks of measles in 2017. Cases continue to be reported despite ongoing reinforced vaccination activities at the national level. All EU/EEA countries have reported measles cases this year, except for Latvia, Liechtenstein, Malta and Norway.

Update of the week

Austria, Finland, France, Germany, Greece, Italy, Romania and the United Kingdom provided updates this week. Several other countries have reported outbreaks. According to national public health authorities, measles have caused 40 deaths in EU countries in 2016 and 2017. In 2016, deaths occurred in Romania (12) and the UK (1). In 2017, deaths were reported from Romania (20), Italy (3), Bulgaria (1), Germany (1), Portugal (1) and France (1).

NEWS

Risk of acquiring infectious diseases during Hajj 2017 is considered low

In 2017, the Hajj begins on Wednesday, 30 August, and lasts until Monday, 4 September. An ECDC rapid risk assessment reports on the risk of outbreaks and spread of communicable diseases during this time period in Saudi Arabia. Vaccination requirements for Saudi Arabia and preparedness plans in the country, addressing the management of health hazards during and after the Hajj, are intended to reduce the overall risk of acquiring infectious diseases.

The risk of communicable disease outbreaks is highest for food- and waterborne diseases and respiratory illnesses, mostly due to occasionally crowded conditions. The risk is not considered higher than can generally be expected for a large international mass gathering. MERS-CoV activity continues to be reported in Saudi Arabia, and cases may be detected in Europe after the Hajj is over. The risk of transmission of vaccine-preventable and vector-borne diseases is considered to be low.

National health authorities should apply appropriate strategies for the prevention and control of communicable diseases before, during and after the completion of the Hajj.
During the West Nile virus transmission season, from June to November, ECDC monitors the occurrence of cases of West Nile fever in the EU Member States and the neighbouring countries in order to inform the blood safety authorities about areas with ongoing virus transmission. In 2016, 214 human cases of West Nile fever were reported in the EU Member States and 267 cases in the neighbouring countries.

### West Nile virus – Multistate (Europe) – Monitoring season 2017

**Opening date:** 30 May 2017  
**Latest update:** 11 August 2017

Between 2 August and 10 August, 15 new cases were reported in Greece, in a previously affected area. So far, Greece reported two deaths in 2017.

Romania and Serbia reported their first cases this year. Romania reported one confirmed case, in the south-east of the country. Two confirmed cases were reported by Serbia.

Eight West Nile fever *Equidae* cases were notified through the Animal Disease Notification System (ADNS) of the European Commission; all case were in Italy, two in Venezia and six in Padova.

**Source:** ADNS | TESSy

### Non EU Threats

**New! Malaria – Cape Verde- 2017**

**Opening date:** 10 August 2017  
**Latest update:** 11 August 2017

In July 2017, Cape Verde reported a sudden increase in the number of malaria cases. The island country is a low malaria risk area, with limited local transmission from September to November, coinciding with the rainy season.

**Update of the week**

Between January and June 2017, eleven sporadic malaria cases were reported in Cape Verde. Many of these cases had recently travelled to Angola or Nigeria. However, between 30 June and 30 July 2017, 45 autochthonous cases and one imported case were notified, compared with an average of one locally acquired case each year over the past five years (2012 to 2016). The 45 autochthonous cases live in the capital city of Praia, Santiago Island. The causative agent has been confirmed as *Plasmodium falciparum*. Preliminary investigations have attributed the recent increase in local transmission to several factors, including suboptimal vector control strategies possibly in combination with the inappropriate application (incorrect dilution) of a new insecticide used in the country since November 2016. Other factors include the unauthorised installation of rice paddy fields in the affected area and an increase in mosquito breeding sites around construction sites. The local authorities are in the process of removing the paddy fields. Further investigations are ongoing.

**Source:** WHO

**Travel-associated Legionnaires’ disease – Dubai, UAE – 2016/2017**

**Opening date:** 10 November 2016  
**Latest update:** 11 August 2017

ELDSNet, the ECDC surveillance scheme on travel-associated Legionnaires’ disease (TALD) has observed an increase in the number of cases of Legionnaires’ disease associated with travel to Dubai, United Arab Emirates (UAE), since October 2016.

**Update of the week**

Since the latest CDTR, one additional case with a travel history to Dubai, UAE, has been reported by the United Kingdom. The case is a 73-year-old female, who spent eight of nine days possible for the incubation period in Dubai and stayed in a private accommodation site.
Seasonal influenza – Asia - 2017
Opening date: 11 July 2017  Latest update: 11 August 2017

In Asia, an increase in seasonal influenza cases, which started in April 2017, has been monitored over the last months.

According to Hong Kong authorities, local influenza activity decreased significantly from its peak in the past two weeks but still remained elevated. It is expected that this summer influenza season will continue for some time. Since the last weekly report, an additional 49 severe influenza cases and 31 deaths were reported in Hong Kong. The number of affected children has remained the same. The main circulating influenza virus type is A(H3N2).

Myanmar has notified 474 cases, 183 cases of whom were influenza A(H1N1)pdm09. There were 19 deaths related to influenza.

Poliomyelitis – Multistate (World) – Monitoring global outbreaks
Opening date: 8 September 2005  Latest update: 11 August 2017

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission of the virus has completely stopped and the world becomes polio-free. Polio was declared a public health emergency of international concern (PHEIC) by the World Health Organization (WHO) on 5 May 2014 due to concerns regarding the increased circulation and international spread of wild poliovirus during 2014. On 3 August 2017, the IHR Emergency Committee agreed that the international spread of poliovirus remains a PHEIC and recommended that the temporary recommendations should be extended for a further three months.

Since the last update on 21 July 2017, no new wild poliovirus type 1 (WPV1) were reported. One new WPV1-positive environmental sample was reported in the past week, collected on 7 July from Lashkargah in Helmand province in Afghanistan. Two new WPV1-positive environmental samples were reported in the past week, the most recent collected on 19 July, from Karachi in Sindh in Pakistan.

In the Democratic Republic of the Congo, three new cases of type 2 circulating vaccine-derived poliovirus (cVDPV2) were reported in the past week. This brings the number of cases this year to seven, in two separate outbreaks of cVDPV2: five cases were reported in Haut Lomami province, with onset of paralysis of the most recent case on 13 June, and two cases in Maniema province, with onset of paralysis on 26 March and 18 April, with an additional isolate detected in a healthy individual (sample collection on 2 May).

In Syria, three new cases of cVDPV2 were officially confirmed in the past week, bringing the number of cases in this outbreak to 30. Onset of paralysis of these cases was between 3 March and 16 June. Twenty-nine of the cases are from Mayadeen district, Deir Ez-Zour governorate, and one case is from Talabat district, Raqqa governorate.

Cholera – Multistate (World) – Monitoring global outbreaks
Opening date: 20 April 2006  Latest update: 11 August 2017

Several countries in Africa, Asia and the Americas are reporting cholera outbreaks. The current situation in Yemen, Somalia, Ethiopia, South Sudan and the Democratic Republic of the Congo is of particular concern as cholera outbreaks are occurring during large scale humanitarian crises.

Since the beginning of 2017, the Gulf of Aden and the Horn of Africa region continue to be the main affected areas with Yemen, Somalia, Ethiopia, South Sudan and the Democratic Republic of the Congo reporting the majority of the cases.
II. Detailed reports

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011
Latest update: 11 August 2017

Epidemiological summary

Epidemiological summary EU/EEA countries, with updates since last week:

**Austria** has reported one case since 7 July 2017. In 2017, as of 4 August, Austria reported 80 measles cases. This exceeds the number of measles cases in 2016.

**Finland** has reported two cases since 4 August 2017. In 2017, as of 9 August 2017, ten cases of measles have been reported in Finland, compared with one case for the same time period in 2016.

**France** has reported 92 cases since the report on 22 June 2017. In 2017, as of 31 July, France reported 387 cases, including one death. In 2016, France reported 79 cases.

**Germany** has reported four cases since the last report on 4 August 2017. In 2017, as of 9 August, Germany reported 818 measles cases. During the same time period in 2016, Germany reported 203 cases.

**Greece** On 6 August 2017, news media quoting the Director of the Department of Epidemiological Surveillance of the Hellenic Centre for Disease Control and Prevention, reported eight measles cases in Greece, mostly among unvaccinated children. Three cases were reported in northern Greece and five cases in Attica.

**Italy** has reported 86 cases since 4 August 2017. In 2017, as of 8 August, Italy reported 4 087 cases, including three deaths. Of these cases, 277 are healthcare workers. The median age is 27 years; 89% of the cases were not vaccinated, and 6% received only one dose of vaccine. In 2016, Italy reported 861 cases.

**Romania** has reported 108 cases since 4 August 2017. Since 1 January 2016 and as of 4 August 2017, Romania reported 8 455 cases, including 32 deaths. Of these, 1 969 cases were reported during 2016, and 6 486 cases were reported in 2017.

United Kingdom: In the CDTR for week 31, ECDC reported the number of suspected cases for measles (n=962), quoting the Statutory Notifications of Infectious Diseases (NOIDs) data for England and Wales. This number refers to suspected measles cases, solely based on clinician assessment. The number of confirmed cases reported by the UK in TESSy is lower, 92 cases for 2017.

ECDC assessment

Measles outbreaks continue to occur in EU/EEA countries. There is a risk of spread and sustained transmission in areas with susceptible populations. Vaccination with two doses remains the most effective measure.

**ECDC link:** [Measles page](#)

Actions

EU/EEA countries report measles cases on a monthly basis to ECDC who publishes them monthly. Since 10 March 2017, ECDC has been reporting on measles outbreaks in Europe on a weekly basis. ECDC also monitors worldwide outbreaks on a monthly basis through epidemic intelligence activities. ECDC published a rapid risk assessment on 6 March 2017.
New measles cases per week of reporting, week 2008-1 to 2017-31, Romania

Data source: National Institute of Public Health Romania and TESSy (ECDC)

West Nile virus – Multistate (Europe) – Monitoring season 2017

Opening date: 30 May 2017
Latest update: 11 August 2017

Epidemiological summary

Since the beginning of the 2017 transmission season and as of 10 August 2017, 20 human cases of West Nile fever (three confirmed and 17 probable) have been reported by Greece; one confirmed case was reported by Italy. Romania reported one case. In the neighbouring countries, six cases were reported; four by Israel, two by Serbia.

In Equidae, 17 West Nile fever cases were notified through ADNS; nine in Veneto, Italy and eight in Argolida, Greece.

Source: ECDC WNF page | ADNS | TESSy

ECDC assessment

The current West Nile fever epidemiological situation is consistent with observations of seasonal virus transmission from previous years. According to the Commission Directive 2014/110/EU, prospective donors should be deferred for 28 days after leaving a risk area of locally acquired West Nile virus unless an individual nucleic acid test (NAT) is negative.

Actions

Since 2011, ECDC has been producing weekly maps displaying the areas (NUTS 3 level) where human West Nile fever cases are detected during the transmission season. The aim of these maps is to inform blood safety authorities of West Nile fever-affected areas to support the implementation of the blood safety directive.
Epidemiological summary

In July 2017, a sudden and unprecedented increase in the incidence of malaria in Cape Verde was reported. The island country is a low malaria risk area, with limited local transmission during the rainy season (September to November). Between January and June 2017, eleven sporadic cases were reported, many of whom had a recent travel history to Angola or Nigeria. However, between 30 June and 30 July 2017, 45 autochthonous cases and one imported case were notified, compared with an average of one locally acquired case reported each year over the last five years (2012 to 2016). All the 45 recent locally acquired cases live in the capital city of Praia, Santiago Island. Fifty-three percent of these cases were adult males aged 20 years and older. The observed high proportion of cases in adult males can possibly be explained by increased transmission around workplaces such as new rice paddy fields and construction sites. The causative agent has been confirmed as *Plasmodium falciparum* using both microscopy and rapid diagnostic tests. Preliminary investigations have attributed the recent increase in local transmission to several factors, including suboptimal vector control strategies possibly coupled with the inappropriate application (incorrect dilution) of a new insecticide used in the country since November 2016, unauthorised rice paddy fields in the affected area, and an increase in mosquito breeding sites around construction sites for a shopping centre and houses. The local authorities are in the process of removing the paddy field. Further investigations are ongoing.

Source: WHO

ECDC assessment

Cape Verde is a low malaria transmission country, eligible for elimination of the disease. So far, local transmission has been restricted to the city of Praia. Nevertheless, there is a high risk of the disease spreading within the archipelago, given the presence of a potential vector (*Anopheles gambiae*) throughout Santiago and neighbouring islands in the context of the upcoming rainy season. The observed high proportion of cases in adult males is also interesting and can be possibly explained by increased transmission around workplaces such as new rice paddy fields and construction sites. Local authorities are facing substantial challenges in responding to this malaria outbreak including gaps in identifying and managing severe cases and limited capacity for vector control interventions.

European travellers should consult their travel clinic prior to their journey to Cape Verde to obtain the latest travel recommendations related to public health issues.
Actions
ECDC is monitoring this event through epidemic intelligence.

Travel-associated Legionnaires' disease – Dubai, UAE – 2016/2017
Opening date: 10 November 2016 Latest update: 11 August 2017

Epidemiological summary
As of 8 August 2017, 13 EU/EFTA Member States have reported 73 TALD cases with onset of symptoms since 1 October 2016 and with travel history to Dubai within two to ten days prior to illness. Cases were reported by the UK (35), Sweden (8), the Netherlands (6), Germany (7), Denmark (4), France (6), Austria (1), Belgium (1), the Czech Republic (1), Hungary (1), Ireland (1), Spain (1) and Switzerland (1). Sixty-five cases are associated with commercial accommodation sites and eight with private accommodation sites. Sixteen cases spent time in another location in the UAE or in a country other than their home country during their incubation period. Two cases were reported as fatal.

All cases are laboratory confirmed. Eight cases had their infection further characterised through sequence base typing: five strains were identified as *Legionella pneumophila* serogroup 1, sequence base type 616, and one as *Legionella pneumophila* serogroup 1, sequence base type 2382. Sequence base type 616 is uncommon in Europe and has been associated with other cases of Legionnaires’ disease returning from Dubai in previous years. Sequence base type 2382 is a new sequence type closely-related to type 616 (personal communication, ELDSNet network). One strain has been characterised as *Legionella pneumophila* serogroup 2-14, sequence base type 1327, and one strain has been characterised as *Legionella pneumophila* serogroup 13, sequence base type 1327.

ECDC assessment
Cases continue to be reported with onset of symptoms in recent weeks, indicating that there is a persistent source of *Legionella* exposure common to travellers with a travel history to Dubai. The majority of reported cases are associated with different accommodation sites dispersed geographically across Dubai, suggesting a common source not associated with accommodation sites. However, it cannot be ruled out that some travellers may have acquired their infection elsewhere if their stay in Dubai was shorter than the range of the incubation period. The increase in cases observed between October 2016 and June 2017 is above the number of cases observed in the same period in previous years.

Actions
ECDC is monitoring this event through ELDSNet. ECDC is in contact with EU Member States, the ELDSNet network, the World Health Organization and the United Arab Emirates to share information. ECDC published a rapid risk assessment on 23 December 2016. The conclusions of the rapid risk assessment remain valid. ECDC also posted an epidemiological update on 3 August 2017. ECDC will prepare an update of the rapid risk assessment.
Distribution of travel-associated Legionnaires' disease cases with history of stay in Dubai, United Arab Emirates, by week of onset and accommodation site clustering, weeks 37/2016–29/2017, as reported to ELDSNet by 8 August 2017 (n=73 cases)

Seasonal influenza – Asia - 2017

Opening date: 11 July 2017
Latest update: 11 August 2017

Epidemiological summary

In Hong Kong, the latest surveillance data show that local influenza activity continues at a high level. Since 5 May and as of 10 August 2017, Hong Kong has reported 489 cases of influenza-associated admissions to intensive care units, including 348 deaths. Most of the cases (438) were due to A(H3N2). In 2017, 27 cases of severe influenza-associated complications and four deaths have been reported in children.

In southern China (week ending 30 July 2017), influenza activity was at a summer peak and continued to increase. The proportion of ILI cases in emergency and outpatient departments reported by sentinel hospitals was 4.0%, lower than that reported in the previous week (4.1%), but higher than in the corresponding periods in 2014, 2015 and 2016 (3.5%, 3.6%, 3.1%). The proportion of influenza detections was 22.5%, slightly lower than the 23.0% recorded in the previous week. The predominant
circulating subtype was influenza A(H3N2).

In Macau (week ending 5 August 2017), the influenza situation has eased. Recently, the number of ILI cases in emergency departments of hospitals has significantly decreased from the peak. The proportion of influenza detections in the last week was 37.3%, and influenza A(H3) constituted 98.2% of the influenza detection.

In Taiwan (week ending 5 August 2017), the numbers and proportions of ILI cases in emergency and outpatient departments showed a decreasing trend. The predominating virus strain was A(H3N2), and influenza B constituted approximately 11% of the influenza detections.

In New Zealand (week ending 30 July 2017), influenza-like illness consultation rates increased slightly compared with the previous week and remained above the seasonal threshold level. The overall influenza positivity rate of tested samples has remained at a high level (about 50%). A(H3N2) is the predominant virus strain in New Zealand this year.

In Australia, during the two-week period ending 21 July 2017, influenza activity continued to increase, indicating that the season is underway in a majority of regions across Australia. Influenza A(H3N2) is currently the predominant circulating A subtype in the majority of regions. Nationally, notifications of laboratory-confirmed influenza B viruses reached a plateau this reporting fortnight.

As of 8 August 2017, the health authorities in Myanmar, have recorded 474 influenza cases and 19 deaths.

Hong Kong | Taiwan | Macau | China | Myanmar

**ECDC assessment**

During the past months, an increase of seasonal influenza activity in Asia was reported, with a significant impact on Hong Kong, Macau and Taiwan, where the main circulating influenza virus type was A(H3N2). In Hong Kong, most indicators suggest that the number of cases and hospitalisations are above the numbers seen since 2013 during this time of year.

Vaccination remains the best documented and most effective preventive measure against influenza. Early treatment and post-exposure prophylaxis with antivirals (neuraminidase inhibitors) can assist in protecting the elderly and people in risk groups from severe influenza illness. The circulating viruses analysed so far show susceptibility to the antiviral drugs oseltamivir and zanamivir. As advised during previous seasons, physicians should always consider early treatment (i.e. within 48 hours of symptom onset for oseltamivir and 36 hours for zanamivir) or post-exposure prophylaxis with neuraminidase inhibitors when treating influenza-infected patients and exposed individuals who belong to risk groups.

Self-isolation, hand-washing and good respiratory hygiene/cough etiquette are effective and simple measures recommended to reduce transmission and to protect individuals against infection. However, strict compliance to these measures is difficult to implement.

**Actions**

ECDC has been in contact with WHO and local health authorities to obtain further information. ECDC monitors this event through epidemic intelligence in order to prepare communication activities and advice for the upcoming European influenza season.

**Poliomyelitis – Multistate (World) – Monitoring global outbreaks**

**Epidemiological summary**

As of 8 August 2017, eight wild poliovirus cases were reported in 2017. In 2016, 19 cases were reported during the same period. In 2017, Afghanistan has reported five cases so far; Pakistan has reported three cases.

In 2017, 37 circulating cVDPV2 cases have been reported, seven from the Democratic Republic of Congo and 30 from Syria. All 30 cases in Syria had onset of paralysis between 3 March and 16 June. Twenty-nine of the cases are from Mayadeen, and one from Raqqa governorate. Confirmation of additional cases would not be unexpected at this time but would not change the operational situation, as outbreak response plans were finalised in line with internationally-agreed outbreak response protocols. Although access to Deir-Al-Zour is currently compromised, the area has been partially covered by several vaccination campaigns against polio and other vaccine-preventable diseases since the beginning of 2016. The first mOPV2 round in Deir Ez-Zour was successfully carried out between 22 and 26 July. Independent post-campaign monitoring reflected a coverage of 88.4% (based on caregiver recall). The second round is planned for 19-23 August and will include mOPV2 and IPV.
Web sources: UNOG | Polio eradication: weekly update | ECDC poliomyelitis factsheet | Temporary Recommendations to Reduce International Spread of Poliovirus | WHO Statement on the Seventh Meeting of the International Health Regulations Emergency Committee on Polio

ECDC assessment

The last locally-acquired wild polio cases within the current EU borders were reported from Bulgaria in 2001. The most recent wild polio outbreak in the WHO European Region was in Tajikistan in 2010, when importation of WPV1 from Pakistan resulted in 460 cases.

References: ECDC latest RRA | Rapid Risk Assessment on suspected polio cases in Syria and the risk to the EU/EEA | Wild-type poliovirus 1 transmission in Israel - what is the risk to the EU/EEA? | RRA Outbreak of circulating vaccine-derived poliovirus type 1 (cVDPV1) in Ukraine

Actions

ECDC monitors reports of polio cases worldwide through epidemic intelligence in order to highlight polio eradication efforts and identify events that increase the risk of wild poliovirus being reintroduced into the EU. ECDC published a risk assessment in June 2014.

Cholera – Multistate (World) – Monitoring global outbreaks

Opening date: 20 April 2006 Latest update: 11 August 2017

Epidemiological summary

**Americas**

**Haiti:** In 2017, as of 29 July, Haiti has reported 8 225 cholera cases, including 91 deaths (CFR: 1.1%) in all ten departments. This represents an increase by 807 cases since the last update on 25 June 2017. The level of transmission is lower than in the past three years.

**Africa**

**Nigeria:** In 2017, as of 27 July 2017, Nigeria reported 1 803 suspected cases, including 18 confirmed cases and 32 deaths (CFR: 1.8%). The ongoing outbreak is affecting the Kwara State with 1 620 cases, including 22 deaths, and a new outbreak was detected in Zamfara State with 183 cases, including 10 deaths.

**DR Congo:** In 2017, as of 2 July 2017, DR Congo has reported 14 689 cholera cases, including 403 deaths (CFR: 2.7%). In June 2017, 2 175 cases have been reported, with around 500 cases notified every week.

Tanzania: During week 30, 24 new cases were reported from Kibiti, Pwani, on the mainland. Between March and July 2017, 5 228 new cases, including 87 deaths, were reported in Tanzania.

**Burundi:** On 15 July 2017, a cluster of six cholera cases, five of which were laboratory-confirmed, was reported in Bujumbura. No further spread has been reported as of 15 July 2017.

**Kenya:** In 2017, as of 30 July, Kenya reported 1 551 cases, including 25 deaths (CFR 1.6%). Of these, 457 were confirmed. Most of the cases were reported in Nairobi County and in the Dadaab refugee camps. During week 30, 108 new suspected cases were reported from eight counties. Three-quarter of the new cases (76%) were from Nairobi (59 cases) and Kisumu (23 cases) counties.

**Somalia:** In 2017, as of 23 July, Somalia reported 59 488 cases, including 816 deaths (CFR: 1.4%). Cases have been recorded in 13 out of 18 regions and show a significant increase when compared to cases reported during the same period in 2016.

**South Sudan:** As of 30 July 2017, South Sudan has reported 19 532 suspected cases, including 1 912 confirmed cases and 352 deaths (CFR: 1.8%) since the beginning of the outbreak June 2016.

**Sudan:** According to media reports, cholera is still spreading in North, West, and South Darfur. In eastern Sudan, hundreds of cholera patients are being treated, however, the number of cases seems to decrease in Kassala and Sennar State.
**Ethiopia:** In 2017, as of 23 July, Ethiopia has reported 39,344 acute watery diarrhoea (AWD) cases, including 801 deaths (CFR: 2.0%). This represents an increase by 1,355 cases since the last update at the end of June. The number of new cases continues to decrease compared to previous months.

**Other countries in Central and West Africa** that have reported cholera cases in June 2017 include Liberia (128), Cameroon (24) and Ivory Coast (20).

**Asia**

**India:** On 7 August 2017, according to media reports, India experienced over 50 cholera cases, including two deaths, due to an outbreak in Nagaland State.

**Yemen:** Since the beginning of the outbreak in April 2017 and as of 6 August, Yemen has reported 473,701 suspected cholera cases and 1,953 deaths (CFR: 0.4%). The outbreak has spread across 22 of the 23 governorates and 297 of 333 districts. The five most affected governorates are Amanat Al Asima, Al Hudaydah, Hajjah, Amran and Dhamar, with 53% of the cases reported since 27 April 2017. At the national level, a decreasing trend has been observed for five consecutive weeks.

**Pakistan:** On 2 August 2017, news media quoting the National Institute of Health, reported two confirmed cholera cases, a four-year-old and a six-year-old child, in Punjab Region (Pakistan). A possible third case, a three-month-old child, is under investigation.

The **Philippines:** Since 4 June 2017 and as of 30 July, the Philippines has reported 259 cholera cases.

**ECDC assessment**

There has been an unusual increase in the number of cases of cholera in the Horn of Africa and the Gulf of Aden in recent years. Despite the large number of travellers from the EU/EEA visiting countries in the Horn of Africa and the Gulf of Aden, particularly Ethiopia, Kenya and Tanzania, very few cases are reported each year among returning EU/EEA travellers. In this context, the risk of cholera infection in travellers visiting these countries remains low, even though the likelihood of sporadic importation of cases may increase in the EU/EEA.

According to the World Health Organization, vaccination should be considered for travellers at higher risk such as emergency/relief workers who are likely to be directly exposed. Vaccination is generally not recommended for other travellers.

Travellers to cholera endemic areas should seek advice from travel health clinics to assess their personal risk and apply precautionary sanitary and hygiene measures to prevent infection. These can include drinking bottled water or water treated with chlorine, carefully washing fruits and vegetables with bottled or chlorinated water before consumption, regularly hand washing with soap, eating thoroughly cooked food and avoiding consumption of raw seafood products.

**Actions**

ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and to facilitate the proper updates to public health authorities. Reports are published on a monthly basis.
The Communicable Disease Threat Report may include unconfirmed information which may later prove to be unsubstantiated.