



This weekly bulletin provides updates on threats monitored by ECDC.

NEWS

ESCAIDE conference: online registration closes 27 October 2017

ESCAIDE, the European Scientific Conference on Applied Infectious Disease Epidemiology, is a three-day annual scientific conference, open to the wider communicable disease community. This year's conference takes place 6-8 November 2017, Stockholm, Sweden. It gathers more than 500 professionals across all fields related to applied epidemiology, to share their knowledge and experience of communicable disease surveillance, prevention and control.

Registered attendees to ESCAIDE are also eligible to attend the one-day training course on an *Introduction to evidence-based methods and tools training course*, 9 November 2017.

For the full programme and to register to attend, go to: <http://www.escaide.eu>

I. Executive summary

EU Threats

New! Travel-associated Legionnaires' disease - Palmanova area, Spain - 2017

Opening date: 11 October 2017

Latest update: 13 October 2017

Since 3 October 2017, 13 cases of travel-associated Legionnaires' disease (TALD) with a travel history of visiting the Palmanova area in Majorca, Spain, have been reported to the European Legionnaires' Disease Surveillance Network (ELDSNet).

New! Influenza – Multistate (Europe) – Monitoring 2017/2018 season

Opening date: 11 October 2017

Latest update: 13 October 2017

Influenza transmission in Europe shows a seasonal pattern, with peak activity during winter months.

→Update of the week

Update Week 2017-40 (2 to 9 October 2017)

This is the first weekly report for the 2017/2018 influenza season. Low influenza activity was reported by all 36 reporting countries. Influenza viruses were detected sporadically both in sentinel and non-sentinel specimens, including hospitalised patients, with both influenza A and B type viruses detected.

For week 2017-40, data from the 20 countries or regions indicated all-cause mortality at expected levels for the time of the year.

Rubella – Multistate (EU) – Monitoring European outbreaks

Opening date: 7 March 2012

Rubella, caused by the rubella virus and commonly known as German measles, is usually a mild and self-limiting disease which often passes unnoticed. The main reason for immunising against rubella is the high risk of congenital malformations associated with rubella infection during pregnancy. All EU Member States recommend vaccination against rubella with at least two doses of vaccine for both boys and girls. The vaccine is given at the same intervals as the measles vaccine as part of the MMR vaccine. No new outbreaks have been detected in the EU since March 2017.

ECDC reports global outbreaks of rubella in the CDTR on a monthly basis or if there is a critical event.

→Update of the week

No new outbreaks have been detected since March 2017.

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

Opening date: 30 May 2017

Latest update: 13 October 2017

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 neighbouring countries in order to inform the blood safety authorities about areas with ongoing virus transmission. In 2016, 225 human cases of West Nile fever were reported in the EU Member States and 267 cases were reported in the neighbouring countries.

→Update of the week

Between 5 and 12 October 2017, Romania reported six cases, Croatia reported five cases, Bulgaria and Serbia both reported one case. One of the cases reported in Croatia is in a newly affected area. All other cases were notified in areas already considered to be affected.

Three deaths were reported due to West Nile fever, two by Romania and one by Croatia.

In addition, 17 equine West Nile fever cases were reported through the Animal Disease Notification System (ADNS) of the European Commission. Italy reported 15 equine cases, Greece and Portugal both reported one equine case.

Sources: [TESSy](#) and [ADNS](#)

Chikungunya - Europe - 2017

Opening date: 15 September 2017

Latest update: 13 October 2017

Since August 2017, both France and Italy have reported autochthonous transmission of chikungunya virus, in the Var department, France and the Lazio and Calabria regions, Italy respectively. The two events involve strains of different origin and are therefore not related.

→Update of the week

Since the previous CDTR and as of 11 October 2017, Italy reports 13 additional chikungunya cases in [Lazio region](#), bringing the number of cases in the region to 252. Of these cases, 197 have been reported in Anzio, 50 in Rome and five in Latina. As of 6 October 2017, according to the Ministry of Health in Italy, the Calabria region has reported 33 cases (probable and confirmed) of chikungunya in Guardavalle marina.

Since the previous CDTR, France has not reported any additional chikungunya cases.

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 13 October 2017

Measles outbreaks continue to occur in a number of EU/EEA countries, with a risk of spread and sustained transmission in areas with susceptible populations.

Since 15 September 2017, ECDC has been reporting EU and global outbreaks of measles in the CDTR on a monthly basis. If there are critical events, additional reports are published.

→Update of the week

Updates are provided for Austria, Germany, Greece, Italy and Romania. Updates outside EU/EEA countries are provided for the former Yugoslav Republic of Macedonia, Ukraine, Liberia, Nigeria, Somalia, Pakistan, Syria, Thailand, Australia, Canada and the US.

Non EU Threats

Cholera – Multistate (World) – Monitoring global outbreaks

Opening date: 20 April 2006

Latest update: 13 October 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 a large-scale humanitarian crisis.

→Update of the week

Since the beginning of 2017, the Gulf of Aden and the Horn of Africa region have been the mainly affected areas, with Yemen, Somalia, Ethiopia, South Sudan and the Democratic Republic of the Congo reporting the majority of the cases.

Plague - Madagascar - 2017

Opening date: 15 September 2017

Latest update: 13 October 2017

On 14 September, media has reported five pulmonary plague deaths in Madagascar. These deaths occurred between 28 August and 11 September. Among these deaths, one occurred in the capital. The index case took a taxi from Ankazobe to Toamasina. He died on the way and he contaminated two persons in the taxi who died in Toamasina within 24 hours of infection. Two women from the same family of the two cases who died in Toamasina were contaminated. One of these women died in Antananarivo, the capital and the second died in another taxi in the south of the capital. On 11 October, WHO reported 561 cases including 415 pneumonic plague cases.

A returning traveller from Madagascar to the Seychelles was confirmed for plague on 10 October in the Seychelles.

→Update of the week

Since the last CDTR update, with data as of 3 October, WHO reports 366 new plague cases including 326 new pulmonary cases in Madagascar. As of 11 October, WHO had reported 561 plague cases in Madagascar. Among these cases, 415 are pneumonic, 145 are bubonic and one is septicaemic. Among the 560 cases, 57 deaths are reported (CFR=10.1%).

On 11 October, the Ministry of Health of the Seychelles reported one case in a returning traveller from Madagascar. The case, a 34-year-old man, returned to the Seychelles on 6 October and had onset of symptoms on 9 October. In addition, on 12 October, the authorities in the Seychelles reported a case with a positive rapid test for which the laboratory confirmation is pending. This case, in a person who is not a citizen of the Seychelles, is not linked to the first one.

II. Detailed reports

New! Travel-associated Legionnaires' disease - Palmanova area, Spain - 2017

Opening date: 11 October 2017

Latest update: 13 October 2017

Epidemiological summary

Since 3 October 2017, 13 cases of travel-associated Legionnaires' disease (TALD) with a travel history of visiting the Palmanova area in Majorca, Spain, have been reported to the European Legionnaires' Disease Surveillance Network (ELDSNet). Seven of the cases had been staying in the same hotel and three cases in a second hotel nearby. The remaining three cases had been staying in separate hotels.

Dates of onset are from 11 to 30 September 2017. The cases, eight men and five women, are aged between 46 and 87 years old and visited Palmanova (12 cases) or the nearby town of Santa Ponca (one case) in the 2-10 days before falling ill. The majority of cases are reported from the United Kingdom but cases are also reported from the Czech Republic, Denmark, the Netherlands and Scotland.

According to ELDSNet definitions, the cluster of seven cases in the one hotel and three cases in another hotel are regarded as rapidly evolving clusters and therefore the network members in the EU and tour operators are being informed of the situation in relation to these hotels.

Authorities in Spain have been informed about the clustering of cases in Palmanova area and more information will be collected in the coming days.

According to ELDSNet data, the number of reported TALD cases with an association to an accommodation site in Palmanova is about one to four cases per year. This shows that the number of cases currently being observed is a very unusual situation.

ELDSNet are informed that more TALD cases are under investigation that probably have a travel history to Palmanova and are in their incubation period.

ECDC assessment

ECDC's on-going monitoring of the situation will be based on the continued timely reporting of TALD cases by the EU Member States through the ELDSNet surveillance scheme. There are also options that EU Member States may consider to assess and mitigate the risks in relation to TALD cases having travelled to areas that have experienced increased numbers of cases in the past:

- Inform travellers − particularly those over 50 years, smokers and immunocompromised persons − to seek medical advice if they experience severe respiratory infection symptoms up to two weeks after travelling in order to ensure early and appropriate diagnosis and treatment.
- Remind clinicians to consider Legionnaires' disease in patients presenting with community-acquired atypical pneumonia and a history of travel in the two weeks prior to disease onset.

Actions

Network members and tour operators subscribing to ELDSNet updates have been informed.

New! Influenza – Multistate (Europe) – Monitoring 2017/2018 season

Opening date: 11 October 2017

Latest update: 13 October 2017

Epidemiological summary

Update Week 2017-40 (2 to 9 October 2017)

This is the first weekly report for the 2017/2018 influenza season. Low influenza activity was reported by all 36 reporting countries. Influenza viruses were detected sporadically both in sentinel and non-sentinel specimens, including hospitalised patients, with both influenza A and B type viruses detected.

For week 2017-40, data from the 20 countries or regions indicated all-cause mortality at expected levels for the time of the year.

Season 2016/2017 overview

After an earlier start than usual (2016-46), influenza activity peaked between weeks 2016-52 and 2017-4. Between weeks 2017-12 and 2017-20, most countries reported decreasing influenza activity with the proportion of sentinel detections returning to the epidemic threshold value (10%) in week 2017-17. Influenza A(H3N2) viruses predominated by a large margin during the season. Significant mortality from all causes was observed in people aged 15 to 64 years, and markedly so in people aged 65 years or older, in the majority of the 20 reporting countries or regions. This is commonly seen when the predominant viruses circulating are A(H3N2).

Two-thirds of the A(H3N2) viruses genetically characterised belonged to subclade 3C.2a1, but remained antigenically similar to cell-culture propagated clade 3C.2a reference virus similar to the vaccine virus but increasingly antigenically less similar to the egg-propagated vaccine virus. This is the reason why WHO recently updated the vaccine strain for A(H3N2) virus in the recommend composition of the seasonal influenza vaccine for use in the 2018 Southern hemisphere influenza season, so it better matches the current circulating viruses. In addition, the influenza B lineage in trivalent vaccines was changed, compared to the virus components recommended for the 2017/2018 northern hemisphere influenza season. See also the [ECDC summary report](#) for June.

A [WHO report](#) on the antigenic and genetic characteristics of zoonotic influenza viruses and development of candidate vaccine viruses for pandemic preparedness is available.

ECDC assessment

The monitoring of the season 2017/2018 has started.

Actions

ECDC monitors influenza activity in Europe during the winter season and publishes its weekly report on the [Flu News Europe website](#). Risk assessments for the season are available on [ECDC](#) website and on [WHO Regional Office for Europe](#) website.

Rubella – Multistate (EU) – Monitoring European outbreaks

Opening date: 7 March 2012

Epidemiological summary

No new outbreaks have been detected in the EU since March 2017.

Web sources: [ECDC measles and rubella monitoring](#) | [ECDC rubella factsheet](#) | [WHO epidemiological brief summary tables](#) | [WHO epidemiological briefs](#) | [Progress report on measles and rubella elimination](#)

ECDC assessment

The World Health Organization (WHO) has targeted the elimination of measles and rubella in the 53 Member States of the WHO European Region. The progress towards elimination of rubella in the WHO European Region is assessed by the European Regional Verification Commission for Measles and Rubella Elimination (RVC). Member States of the WHO European Region are making steady progress towards the elimination of rubella. At the sixth meeting of the RVC for Measles and Rubella in June 2017, of 53 countries in the WHO European Region, 33 (21 of which are in the EU/EEA) were declared to have reached the elimination goal for rubella, and four countries (two in the EU/EEA) were deemed to have interrupted endemic transmission for between 12 and 36 months, meaning they are on their way to achieving the elimination goal. However, seven EU/EEA countries were judged to still have endemic transmission: Belgium, Denmark, France, Germany, Italy, Poland and Romania.

Web source: [European Regional Verification Commission for Measles and Rubella Elimination \(RVC\) \(2017\)](#)

Actions

ECDC closely monitors rubella transmission in Europe by analysing the cases reported to The European Surveillance System and through its epidemic intelligence activities. Twenty-eight EU/EEA countries contribute to the enhanced rubella surveillance. The purpose of the enhanced rubella surveillance is to provide regular and timely updates on the rubella situation in Europe in support of effective disease control, increased public awareness, and achieving the target of rubella and congenital rubella elimination.

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

5/15

Opening date: 30 May 2017

Latest update: 13 October 2017

Epidemiological summary

Since the beginning of the 2017 transmission season and as of 12 October 2017, the EU Member States reported 189 cases: Romania (60 cases), Italy (53), Greece (47), Hungary (19), Croatia (5), Austria (4) and Bulgaria (1). Sixty-three cases were reported in neighbouring countries: Serbia (46) and Israel (17). Nineteen deaths due to West Nile fever have been reported since the start of the transmission season: Romania (10 deaths), Greece (5), Hungary (1), Italy (1), Croatia (1) and Serbia (1).

In equids, EU Member States reported 108 West Nile fever cases through ADNS: 88 in Italy, 13 in Greece, three in Hungary, two in Austria, one in Spain and one in Portugal.

ECDC link: [ECDC West Nile fever web page](#) | [ECDC: equine West Nile fever web page](#) | [ECDC atlas](#)

Sources: [TESSy](#) and [ADNS](#).

ECDC reports on this threat on a weekly basis during the West Nile season.

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 for locally-acquired West Nile virus, unless an individual nucleic acid test (NAT) is negative.

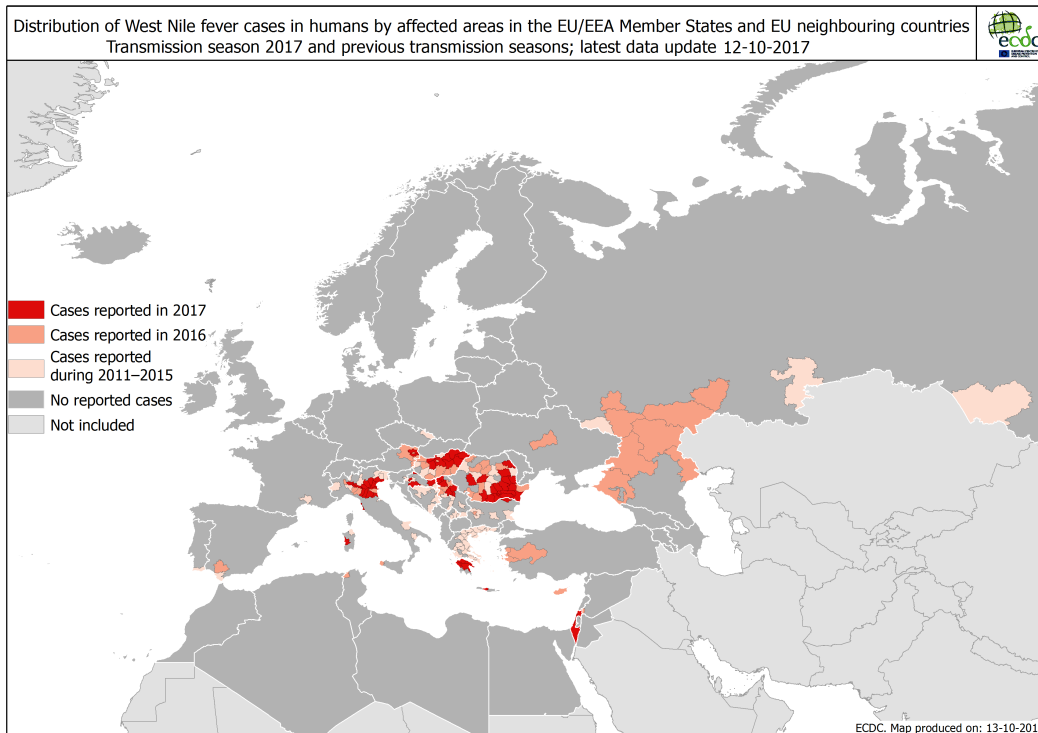
Actions

From 6 October 2017, ECDC publishes three types of West Nile fever maps: 1) human West Nile fever cases; 2) equine West Nile fever cases; 3) combined human and equine West Nile fever cases. Human cases are collected through The European Surveillance System ([TESSy](#)) and equine cases are collected through the Animal Disease Notification System ([ADNS](#)) of the European Commission. While the distribution of human cases covers EU/EEA countries and neighbouring countries, equine cases cover only EU/EEA countries.

Following a One Health approach, the new maps aims to highlight areas, at NUTS3 level, where West Nile virus is circulating in incidental hosts. Currently, deferral or testing of prospective donors applies to blood donors leaving areas with one or more autochthonous human West Nile virus cases. This set of maps aims to provide better information for European Union Member States so that they can implement preventive measures.

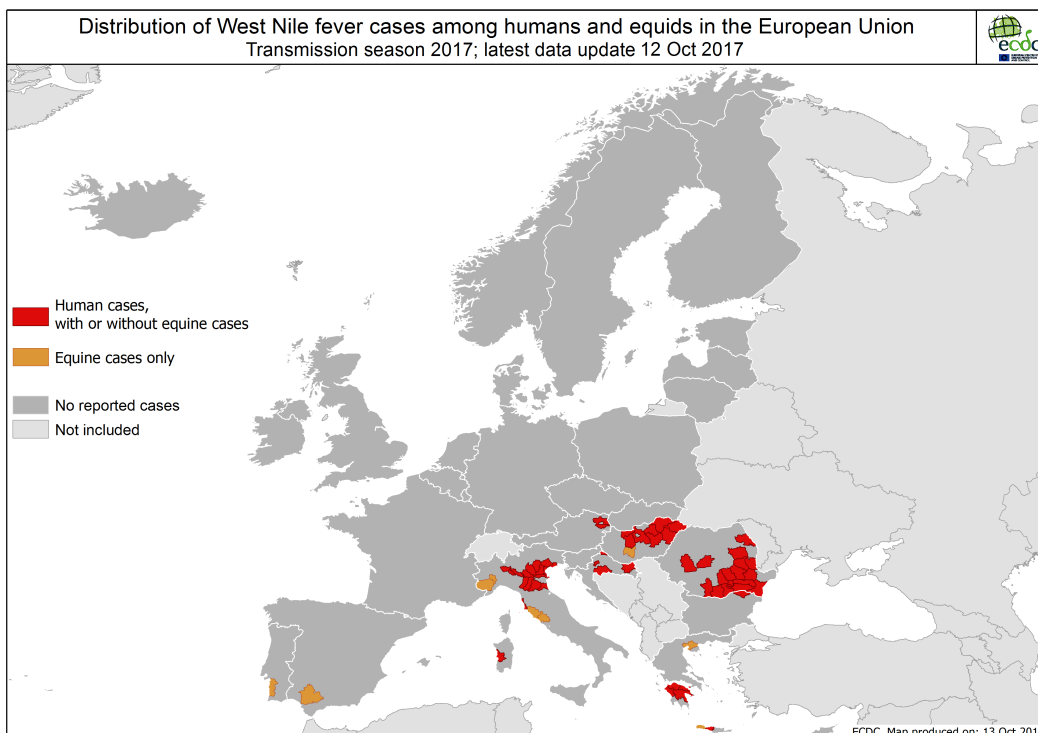
Distribution of human West Nile fever cases by affected areas as of 12 October 2017

ECDC



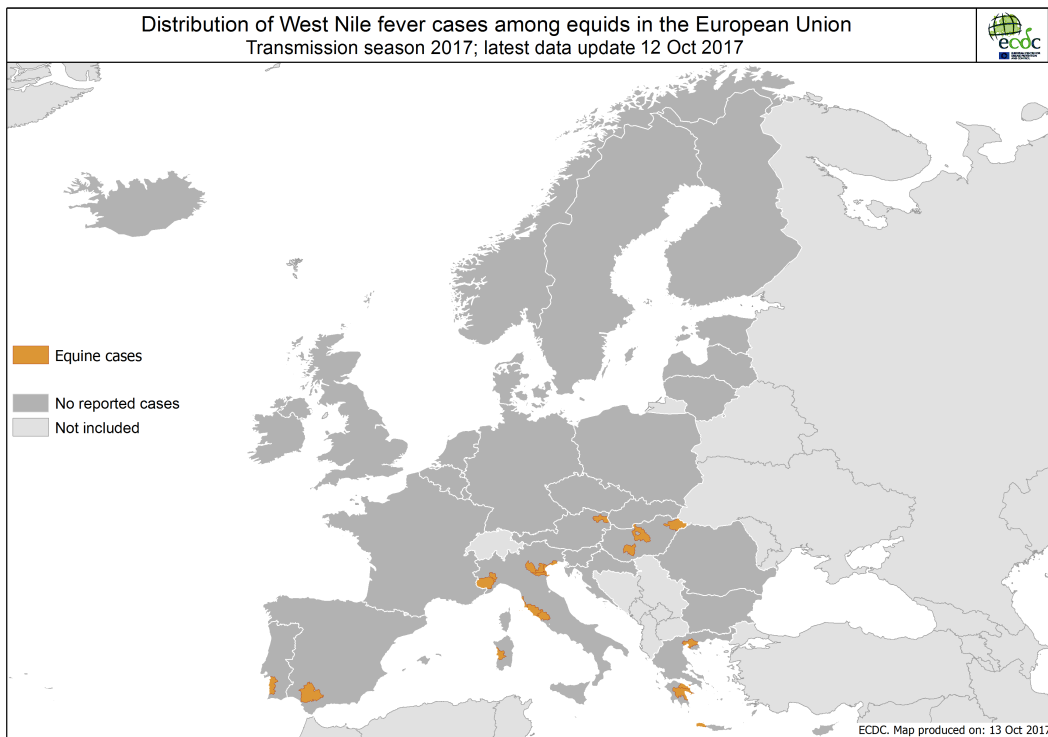
Distribution of West Nile fever cases among humans and equids in the EU as of 12 October 2017

TESSy and ADNS



Distribution of West Nile fever cases among equids in the EU as of 12 October 2017

ADNS



Chikungunya - Europe - 2017

Opening date: 15 September 2017

Latest update: 13 October 2017

Epidemiological summary

The two events described below in France and in Italy are two distinct events. There is epidemiological and microbiological evidence highlighting the fact that the clusters in France and in Italy are not related.

On 11 August 2017, France reported through the EWRs an outbreak of autochthonous chikungunya cases in the Var department, southern France. As of 8 October, France has reported two clusters including 17 cases. The first cluster, in Cannet-des-Maures, includes eleven cases (eight confirmed, two probable and one suspected). The second cluster, in Taradeau includes five confirmed cases and one probable case. Taradeau commune is 13 kilometres away from Cannet-des-Maures. There is an epidemiological link between the cases in Taradeau and Cannet-des-Maures, indicating that the two clusters are related. As stated in the Eurosurveillance article '[Preliminary report of an autochthonous chikungunya outbreak in France, July to September 2017](#)' published 28 September 2017, the virus circulating in France belongs to an East Central South African (ECSA) sub-lineage that includes isolates from the Central African region (e.g. Gabon, Republic of Congo). The virus isolated from the index patient is carrying the E1-A226V mutation. Full genome analysis is ongoing and the sequence will be submitted to GenBank.

As of 11 October 2017, Italy reported 293 cases of chikungunya. Italy notified 252 chikungunya cases in the [Lazio region](#) and six confirmed autochthonous cases among 33 notified cases in the city of Guardavalle Marina, Calabria region. Furthermore, three confirmed cases were reported in Emilia-Romagna (1), Marche (1) and France (1) and one probable case was reported in Germany. Three confirmed cases had an epidemiological link to the Anzio region, and one probable case in Rome. Furthermore, four confirmed cases with a history of travel to Guardavalle marina were notified from Lazio (1) and Emilia-Romagna region (3). As stated in the Eurosurveillance article '[Detection of a chikungunya outbreak in Central Italy, August to September 2017](#)' published 28 September, the virus circulating in Italy belongs to the East Central South African (ECSA) lineage and does not carry the E1-A226V mutation. The outbreak sequence is available in GenBank.

Sources: [Lazio Region](#) | [MoH Italy](#) | [ISS](#) | [France ARS PACA](#) | [France ARS PACA](#)

ECDC links: Rapid risk assessment on [cluster of autochthonous chikungunya cases in France](#) | Rapid risk assessment on [clusters of autochthonous chikungunya cases in Italy](#)

ECDC assessment

The two outbreaks in France and Italy are unrelated and result from separate introductions of the virus, probably from Africa and Asia, respectively. Having concurrent, distinct outbreaks of chikungunya in France and Italy highlights that the environmental conditions in 2017 are favourable for the local transmission of introduced chikungunya virus strains.

In France, response measures, including vector control, have been implemented. The fact that the strain harbours the E1-A226V mutation may explain the relatively larger number of autochthonous cases observed this year compared to the 2010 outbreak in the same region (i.e. two cases reported in 2010). The conclusions of the latest ECDC rapid risk assessment published on 24 August 2017 ('Cluster of autochthonous chikungunya cases in France') remain valid.

In Italy, this is the first known transmission of chikungunya in central and southern Italy and therefore, in the absence of herd immunity, most of the inhabitants should be considered as susceptible to chikungunya virus disease. The likelihood of further spread within Italy is still moderate, with suitable but less favourable conditions for vector activity in the coming weeks. In the areas already affected more cases can be expected to be identified in the near future. There is a low likelihood of the virus being introduced and subsequent local transmission in other EU countries where *Aedes albopictus* is present and active.

Actions

ECDC has published a [rapid risk assessment on the cluster of autochthonous chikungunya cases in France](#) on 24 August 2017 and a [rapid risk assessment on the clusters of autochthonous chikungunya cases in Italy](#) on 14 September 2017. ECDC published the first update of the [risk assessment on the clusters of autochthonous chikungunya cases in Italy](#) on 9 October 2017.

Distribution of chikungunya autochthonous cases in Italy, July to 3 October 2017

ECDC



Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 13 October 2017

Epidemiological summary

Updates are provided for Austria, Germany, Greece, Italy and Romania. According to national public health authorities, measles has caused 44 deaths in EU countries in 2016 and 2017. In 2016, 12 deaths occurred in Romania and one in the UK. In 2017, 31 deaths were reported from Romania (22), Italy (4), Bulgaria (1), Germany (1), Portugal (1), France (1) and Spain (1). All EU/EEA countries have reported measles cases this year, except for Latvia, Liechtenstein, Malta and Norway.

Updates outside EU/EEA countries are provided for the former Yugoslav Republic of Macedonia, Ukraine, Liberia, Nigeria, Somalia, Pakistan, Syria, Thailand, Australia, Canada and the US.

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

9/15

Austria has reported one case since the previous update on 25 August. In 2017, as of 22 September, Austria reported 84 cases. This exceeds the number of measles cases in 2016.

Germany has reported 25 cases since the previous report on 8 September 2017. In 2017, as of 4 October, Germany reported 891 measles cases. During the same time period in 2016, Germany reported 258 cases.

Greece has reported 115 cases since the previous report on 8 September 2017. Between 17 May 2017 and 1 October, Greece reported 215 cases, with a higher incidence in southern Greece. Among the cases were health professionals who were vaccinated or incompletely vaccinated. During the last three years, Greece has reported around one case per year.

Italy has reported 130 cases and one additional death since the previous report on 15 September 2017. In 2017, as of 3 October, Italy has reported 4 617 cases, including four deaths. Of these cases, 302 are healthcare workers. The median age is 27 years; 88% of the cases were not vaccinated, and 6% received only one dose of vaccine. In 2016, Italy reported 862 cases during the whole year (source: [TESSy](#)).

Romania has reported 435 cases since the previous report on 15 September 2017. Since 1 January 2016 and as of 6 October 2017, Romania has reported 9 539 cases, including 34 deaths. Of these, 1 969 cases were reported in 2016, and 7 570 cases were reported in 2017.

Epidemiological summary for countries outside EU/EEA since last month

The former Yugoslav Republic of Macedonia: In September 2017, according to [media](#), the former Yugoslav Republic of Macedonia reported 11 cases in Skopje. Six cases were hospitalised. In 2016, the former Yugoslav Republic of Macedonia reported no measles cases.

Ukraine has reported 241 cases since the previous report on 15 September. In 2017, as of 29 September, Ukraine has reported 1 627 cases of measles. Most cases of measles were reported in Ivano-Frankivsk (747 cases), Odessa (589 cases, including two deaths) and Ternopil (70 cases).

Liberia has reported 72 cases since the previous report on 15 September. In 2017, as of 24 September, Liberia has reported 1 120 suspected measles cases. Of the suspected cases, 942 were tested: 161 positive, 730 negative and 51 equivocal. Of the suspected cases 178 were compatible with measles and had an epidemiological link. Of the 781 equivocal and negative cases, 746 samples have been tested for rubella, 318 of which were positive.

Nigeria has reported 939 cases since the previous report on 15 September. In 2017, as of 17 September, Nigeria has reported 17 772 suspected measles cases, including 105 deaths. During the same time period in 2016, 22 478 suspected cases and 99 deaths were reported.

Somalia has reported almost 1 000 cases since the previous report on 15 September. In 2017, as of 24 September, Somalia has reported more than 17 000 suspected cases. This is about three times the number of cases reported in 2016.

Pakistan: In September 2017, according to [media](#), Pakistan reported 20 deaths in Sindh Province due to measles, nine children in Kunri Taluka and 11 children in other parts of the district.

Syria: Between 6 August and 3 September 2017, Syria has reported 142 measles cases with most cases reported from Lattakia (21), Damascus (19), Ar-Raqqa (19) and Deir-ez-Zor(14). In 2017, as of end of July, Syria had reported 395 confirmed measles cases. Most of the cases were reported in April (92 cases).

Thailand has reported 156 cases since the previous report on 15 September. In 2017, as of 28 September, Thailand had reported 2 387 cases from 72 provinces. No deaths were reported.

Australia has reported 12 cases since the previous report on 15 September. In 2017, as of end of September, Australia had reported 71 cases. During the same time period in 2016, 70 cases were reported. An [outbreak](#) was reported in Melbourne recording 11 cases between mid-September and 2 October 2017.

Canada has reported one additional case since the previous report on 24 June 2017. In 2017, as of end of 23 September, Canada had reported 45 cases. In 2016, [Canada](#) reported 11 cases during the whole year.

The US has reported one case since the previous report on 15 September. In 2017, as of 9 September, 119 cases had been reported from 15 states (California, Florida, Kansas, Maine, Maryland, Michigan, Minnesota, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Texas, Utah, and Washington). In 2016, 70 measles cases were reported from 16 states.

ECDC links: [Measles web page](#) | [ECDC Communicable Disease Threats Reports \(CDTR\)](#) | [ECDC rapid risk assessment ongoing outbreak of measles in Romania, risk of spread and epidemiological situation in EU/EEA countries, 3 March 2017](#)

Sources: National Public Health Institutes | Ministries of Health | media

ECDC assessment

Measles outbreaks continue to occur in a number of EU/EEA countries. There is a risk of spread and sustained transmission in areas with susceptible populations. Vaccination with at least two doses remains the most effective measure. The progress towards elimination of measles in the WHO European Region is assessed by the European Regional Verification Commission for Measles and Rubella Elimination (RVC). Member States of the WHO European Region are making steady progress towards the elimination of measles. At the [sixth meeting of the RVC](#) for Measles and Rubella in June 2017, of 53 countries in the WHO European Region, 33 (22 of which are in the EU/EEA) were declared to have reached the elimination goal for measles, and nine countries (four in the EU/EEA) were deemed to have interrupted endemic transmission for between 12 and 36 months, meaning they are on their way to achieving the elimination goal. However, four EU/EEA countries were judged to still have endemic transmission: Belgium, France, Italy and Romania.

ECDC link: [Measles page](#)

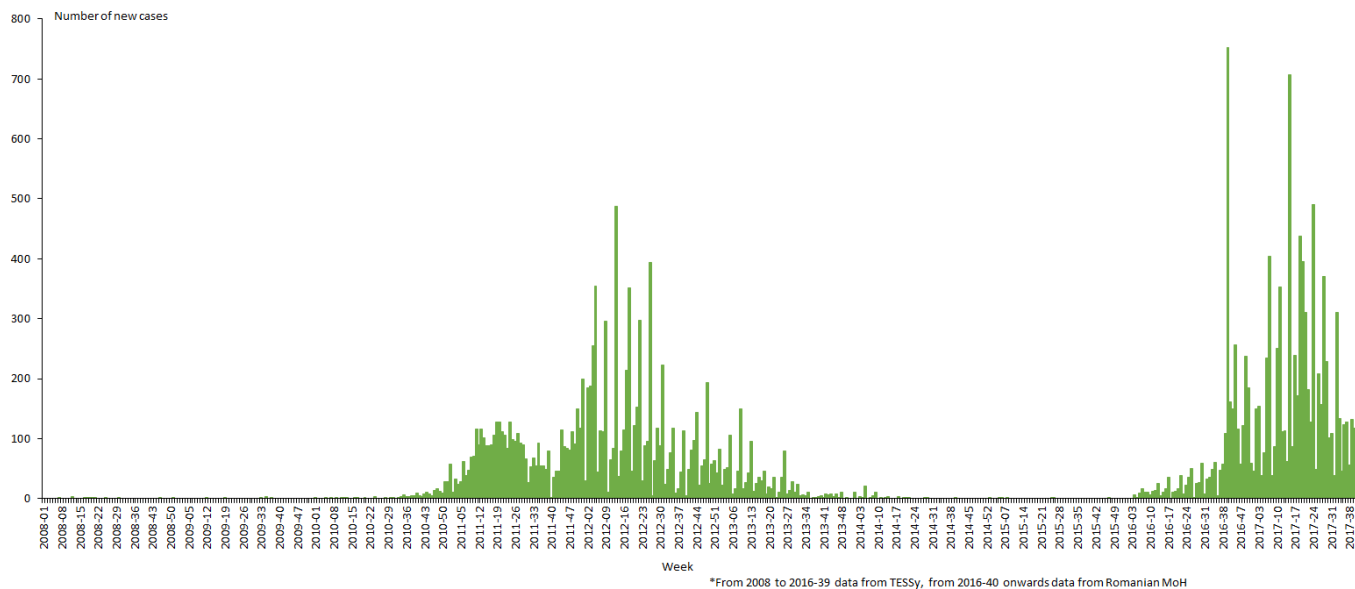
ECDC published a [rapid risk assessment](#) on measles on 6 March 2017.

Actions

All EU/EEA countries report measles cases through TESSy on a monthly basis to ECDC; data are published every month. ECDC also monitors EU/EEA and worldwide outbreaks on a monthly basis through epidemic intelligence activities.

New measles cases per week of reporting, week 2008-1 to 2017-40, Romania

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



Cholera – Multistate (World) – Monitoring global outbreaks

Opening date: 20 April 2006

Latest update: 13 October 2017

Epidemiological summary

Europe

Ukraine: Although there are no reports of new cases since the last update on 19 August 2017, authorities published a [cholera communication](#) on 5 September 2017 to inform the population. On 19 August 2017, [media](#) in Ukraine reported four confirmed cases of cholera. The region affected is Zaporozhye.

Americas

Haiti: In 2017, as of 30 September, Haiti has reported 10 868 cholera cases, including 122 deaths (CFR: 1.1%) in all ten departments. This represents an increase by 2 257 cases since our previous update on 13 September 2017. In the recent weeks, the number of reported cases per week has increased. However, the same trend has been observed at this time of the year for the last 3 years.

Africa

Nigeria: In 2017, as of 22 September 2017, Nigeria has reported 7 052 suspected cases, including 145 confirmed cases and 149 deaths (CFR: 2.1%). This outbreak is affecting the Kwara, Kebbi, Kano, Kaduna, Oyo, Zamfara, Lagos and Borno states.

DR Congo: In 2017, as of 29 September 2017, DR Congo has reported 31 646 suspected cholera cases, including 629 deaths (CFR: 1.9%). This represents an increase by 10 718 cases and 223 deaths since our previous report on 13 September 2017.

Burundi: As of 26 September 2017, Burundi has reported 38 cholera cases in Nyanza-Lac Health District (27), Cibitoke (1), Bubanza (1) and Mpanda (9).

Kenya: In 2017, as of 28 September 2017, Kenya has reported 2 996 cases, including 55 deaths (CFR 1.8%). Of these, 572 were confirmed. Six counties are reporting active outbreaks: Garrissa, Nairobi, Nakuru, Machakos, Vihiga and Kajiado. This represents an increase by 556 cases since our previous report on 13 September 2017.

South Sudan: Since the beginning of the outbreak in June 2016, as of 24 September 2017, South Sudan has reported 20 568 suspected cases, including 378 deaths (CFR: 1.8%). This represents an increase by 753 cases and 23 deaths since our previous report on 13 September 2017.

Ethiopia: In 2017, as of 26 September, Ethiopia has reported 45 268 acute watery diarrhoea (AWD) cases, including 856 deaths (CFR: 1.9%). This represents an increase by 2 253 cases and 18 deaths since our previous update on 13 September 2017. The number of new cases has increased compared to the previous month.

Chad: Since the beginning of the outbreak on 14 August 2017 and as of 28 September 2017, Chad reported 445 cholera suspected cholera cases, including 56 deaths (CFR: 12.6%). This represents an increase by 293 cases and 33 deaths since our previous update on 13 September 2017.

Uganda: On 10 October 2017, an IHR message was posted reporting an outbreak of cholera in Uganda. As of 7 October, 140 cases, including three deaths (CFR:2.1%) were reported in Kasese district. The cases are confined to five sub-counties: Bwera, Isango, Munkunyu, MLTC and Nyakiyumbu. Case finding and contact tracing is being implemented in affected communities.

Malawi: On 17 September 2017, MSF reported 36 cases in Chikwawa since the outbreak on 13 August 2017. No deaths have been reported. In 2017, as of 31 August Malawi has reported 103 cases including one death (CFR: 0.97%).

Zambia: Since 4 September 2017, [media](#) quoting the Ministry of Health from Zambia have been reporting an outbreak of 11 cholera cases in Lusaka. No deaths are associated with this outbreak to date.

Asia

Yemen: Since the beginning of the outbreak in April 2017 and as of 1 October 2017, Yemen has reported to WHO 780 886 suspected cholera cases and 2 137 deaths (CFR: 0.3%) to WHO. This represents an increase by 128 797 cases and 71 deaths since our previous update on 13 September 2017. The outbreak has spread across 22 of the 23 governorates and 305 of 333 districts. The five most affected governorates are Amanat Al Asima, Al Hudaydah, Hajjah, Amran and Dhamar.

Nepal: According to [media](#) reports, in 2017 and as of 9 October 2017, 100 possible cholera cases have been reported in Saptari region in Nepal.

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 who visit countries in the Horn of Africa and the Gulf of Aden every year, particularly Ethiopia, Kenya and Tanzania, only very few cases are reported among returning EU/EEA travellers. 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 fruit and vegetables with bottled or chlorinated water before consumption, regularly washing their hands 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.

Plague - Madagascar - 2017

Opening date: 15 September 2017

Latest update: 13 October 2017

Epidemiological summary

Since the last CDTR update, with data as of 3 October, WHO has reported 366 new plague cases including 326 new pulmonary cases in Madagascar. As of 11 October, WHO had reported 561 plague cases in Madagascar. Among these cases, 415 are pneumonic, 145 are bubonic and one is septicemic. Among the 561 cases, 57 deaths are reported (CFR=10.1%). On 29 September 2017, the Malagasy health authorities confirmed a fatal case of pneumonic plague in a basketball coach from the Seychelles. The case died in a hospital in Madagascar on Wednesday 27 September while participating in the Indian Ocean Club basketball championship (Coupe des clubs Champions de l'Océan Indien de Basketball - 23 September to 1 October- Madagascar). The source of transmission for this case remains unknown.

On 11 October, the Ministry of Health of the Seychelles reported one case in a returning traveller from Madagascar. The case, a 34-year-old man, returned to the Seychelles on 6 October and had onset of symptoms on 9 October. The case was confirmed on 10 October. On 12 October, the Ministry of Health acknowledged a new case without epi-link to the first case. This second case, in a person who is not a citizen of the Seychelles, had onset of symptoms on 10 October. The rapid test for plague is positive and the laboratory confirmation is pending.

To date, 320 people are being monitored and have been given chemoprophylaxis treatment.

ECDC links: [Plague factsheet](#)

Sources: [WHO](#), [MoH Madagascar](#), [MoH Seychelles](#), [media](#)

ECDC assessment

While plague outbreaks in Madagascar are not unexpected, the high proportion of pneumonic plague is of concern. The current outbreak is the largest in the last decade in Madagascar. The risk of further transmission in this country is considered very high until public health prevention and control measures are fully implemented with the support of the World Health Organization (WHO) and international partners working in the country. The risk of regional spread in the Indian Ocean region is considered moderate.

The risk to travellers from the EU or for importation to the EU is considered low. WHO considers the risk for international spread of plague to be very low and advises against any restrictions to travel and trade with Madagascar based on the information to date. There is no restriction of movement in and out of Antananarivo, where cases have occurred, in accordance with the recommendations of the Malagasy authorities.

According to WHO, prophylactic treatment is only recommended for persons who have been in close contact with plague cases, or who have experienced other high-risk exposure such as bites from fleas or direct contact with bodily fluids or tissues of infected animals.

Actions

ECDC is updating the rapid risk assessment to be published on [ECDC website](#) on 16 October 2017.

The Communicable Disease Threat Report may include unconfirmed information which may later prove to be unsubstantiated.