

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 8 September 2017

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

→Update of the week

This week, updates are provided for the Czech Republic, Germany, Greece, Ireland, Italy, Romania and Spain.

Chikungunya - France - 2017

Opening date: 11 August 2017

Latest update: 8 September 2017

On 11 August 2017, France gave notification of an autochthonous case of chikungunya virus infection, diagnosed in the Var department (Provence-Alpes-Côte d'Azur region) of south-eastern France through the Early Warning and Alert System (EWRS).

→Update of the week

No update this week.

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

Opening date: 30 May 2017

Latest update: 8 September 2017

During the West Nile virus transmission season, from June to November, ECDC monitors the occurrence of cases of West Nile fever in 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 EU Member States and 267 cases in the neighbouring countries.

→Update of the week

Between 31 August and 7 September 2017, Greece reported three cases in newly affected areas. Hungary has reported four cases, Israel five cases and Serbia seven cases in previously affected areas. Romania has reported six cases, one of which is in a previously unaffected area. In addition, Italy has reported 11 West Nile fever Equidae cases and Hungary has reported one Equidae case through the Animal Disease Notification System (ADNS) of the European Commission.

Non EU Threats

New! Communicable disease risks – Hurricane Irma – 2017

Opening date: 7 September 2017

Latest update: 8 September 2017

On 29 August 2017, the US National Hurricane Center (NHC) reported that Hurricane Irma was forming in the Atlantic Ocean. In the days that followed, Irma gained in intensity and on 4 September it was classified as Category 5, the highest level for hurricanes. Category 5 is defined as wind above 252 km/h and the ensuing damage may include a high percentage of homes destroyed, fallen trees and power outages that could last for weeks or months. Irma is one of the strongest hurricanes ever recorded in the Atlantic. In the past, floods resulting from hurricanes have been associated with outbreaks of infectious diseases (e.g. tetanus, leptospirosis and vector-borne diseases.) ECDC is assessing these risks in the epidemiological context of the Caribbean.

Malaria – Cape Verde- 2017

Opening date: 10 August 2017

Latest update: 8 September 2017

In July 2017, Cape Verde reported a sudden increase in the number of malaria cases. According to WHO, Cape Verde is categorised as a 'very limited risk of malaria transmission area', with limited local transmission from September to November, coinciding with the rainy season.

→Update of the week

There has been an increasing trend in the past few weeks, with over 50 additional cases of malaria reported since 30 August. As of 3 September, 167 cases had been reported. The epicentre of the outbreak is located in the capital city of Praia in Santiago Island. According to WHO, the causative agent is *Plasmodium falciparum*.

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

Opening date: 10 November 2016

Latest update: 8 September 2017

Since October 2016, 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).

→Update of the week

Since the previous CDTR, one new case from the Netherlands with a travel history to Dubai, UAE, has been reported to ELDSNet.

Influenza A(H7N9) – China – Monitoring human cases

Opening date: 31 March 2013

Latest update: 8 September 2017

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, cases continue to be reported from China. No autochthonous cases have been reported outside China. Most cases are isolated, and sporadic zoonotic transmission from poultry to humans is the most likely explanation for the outbreak.

→Update of the week

According to the [Hong Kong avian influenza report](#), since the last update on 2 August 2017, China has reported five cases from Fujian(1), Hunan(1), Xinjiang(2), and Jiangsu(1). According to [WHO WPRO](#), 27 human cases with highly pathogenic avian influenza (HPAI) A(H7N9) virus have been reported during the fifth wave.

Poliomyelitis – Multistate (World) – Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 8 September 2017

Global public health efforts are ongoing to eradicate polio 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, WHO agreed that the spread of poliovirus remains a public health event of international concern and extended the temporary recommendations for an additional three months.

The last locally-acquired wild polio cases within the current EU borders were reported from Bulgaria in 2001. In June 2002, the WHO European Region was officially declared polio-free.

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

→Update of the week

Since the last CDTR on 25 August 2017 and as of 5 September 2017, Pakistan has reported one new wild poliovirus type 1 (WPV1). Syria has reported six and the Democratic Republic of the Congo (DRC) one type 2 circulating vaccine-derived poliovirus (cVDPV2).

In 2017, as of 5 September, 10 wild poliovirus cases have been reported, six cases from Afghanistan and four cases from Pakistan. In addition, 47 circulating cVDPV2 cases have been reported in 2017, eight from the Democratic Republic of Congo and 39 from Syria.

II. Detailed reports

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 8 September 2017

Epidemiological summary

This week, updates are provided for Czech Republic, Germany, Greece, Ireland, Italy and Romania. According to national public health authorities, measles caused 42 deaths in EU countries in 2016 and 2017. In 2016, 12 deaths occurred in Romania and one in the UK. In 2017, deaths were reported from Romania (21), Italy (3), Bulgaria (1), Germany (1), Portugal (1), Spain (1) and France (1).

All EU/EEA countries have reported measles cases this year, except for Latvia, Liechtenstein, Malta and Norway.

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

The **Czech Republic** has reported three cases since the previous report on 5 August 2017. In 2017, as of 3 September, the Czech Republic has reported 136 measles cases. During the same period in 2016, the Czech Republic reported five cases.

Germany has reported six cases since the previous report on 1 September 2017. In 2017, as of 6 September, Germany reported 866 measles cases. During the same time period in 2016, Germany reported 233 cases.

Since May 2017 and as of 3 September, **Greece** reported 100 measles cases. During the last three years, Greece reported around one case per year.

Ireland has reported one case since the previous report on 1 September 2017. In 2017, as of 2 September, Ireland has reported nine measles cases. During the same period in 2016, Ireland reported 43 cases.

Italy has reported 116 cases since the previous report on 1 September 2017. In 2017, as of 5 September, Italy reported 4 444 cases, including three deaths. Of these cases, 294 are healthcare workers. The median age is 27 years; 88% of the cases were not vaccinated, and 7% received only one dose of vaccine. In 2016, Italy reported 861 cases.

Romania has reported 45 cases since the previous report on 1 September 2017. Since 1 January 2016 and as of 1 September 2017, Romania reported 8 982 cases, including 33 deaths. Of these, 1 969 cases were reported in 2016, and 7 013 cases were reported in 2017.

Spain notified through TESSy one death due to measles that occurred in June 2017 in a 76-year-old unvaccinated man.

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

From this week, ECDC will report the measles outbreaks in Europe on a monthly basis.

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 at least two doses remains the most effective measure. ECDC published a [rapid risk assessment](#) on 6 March 2017.

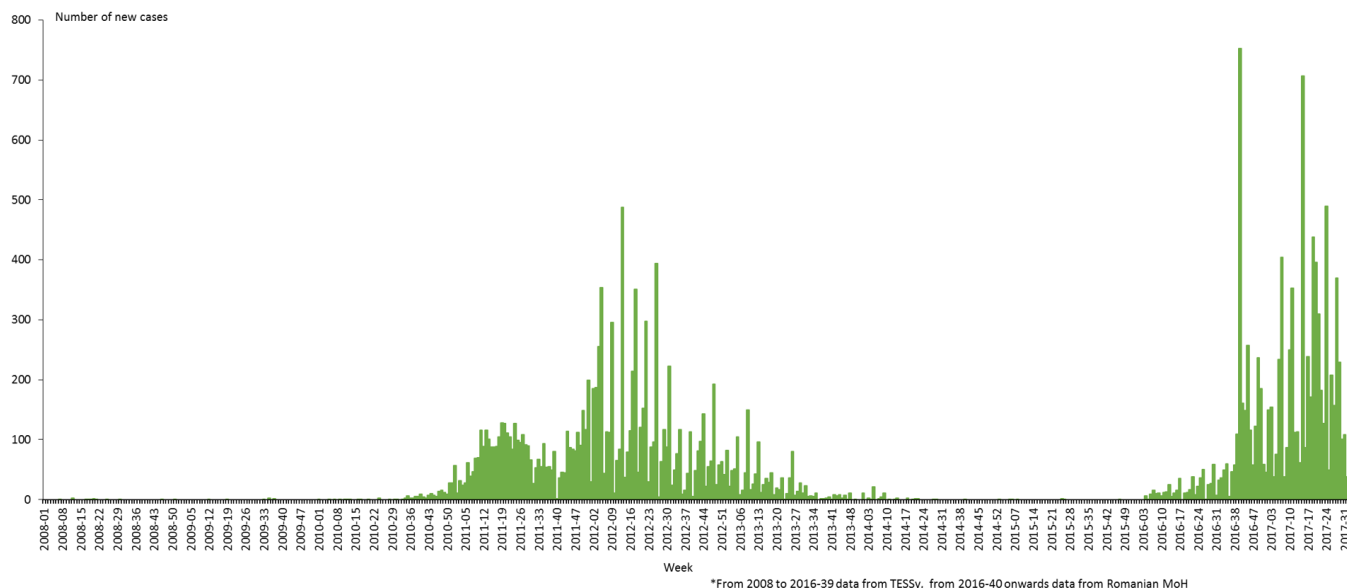
ECDC link: [Measles web page](#)

Actions

EU/EEA countries report measles cases on a monthly basis to ECDC who publishes them monthly. ECDC also monitors worldwide outbreaks on a monthly basis through epidemic intelligence activities.

New measles cases per week of reporting, week 2008-1 to 2017-35, Romania

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



Chikungunya - France - 2017

Opening date: 11 August 2017

Latest update: 8 September 2017

Epidemiological summary

On 11 August 2017, France gave a notification of an autochthonous case of chikungunya virus infection detected in the Var department in southern France through the Early Warning and Alert System (EWRS). As of 6 September 2017, France has reported six confirmed cases and one probable autochthonous cases of chikungunya, all living in the same neighbourhood in Cannet-des-Maures (Var). The dates of onset of the cases range from 28 July to 19 August 2017. There are no reports of imported chikungunya cases in the Var or Alpes-Maritimes Departments that could account for the introduction of the virus into the area.

French authorities have implemented successive vector control campaigns, case finding, blood safety measures, community measures for personal protection and vector control, and widely sensitised the public and physicians to this cluster of chikungunya cases.

ECDC links: [Chikungunya factsheet](#) | [VectorNet map](#) | [rapid risk assessment "Cluster of autochthonous chikungunya cases in France"](#) | [epidemiological update 1 September 2017](#)

Sources: EWRS | [France](#)

ECDC reports on this threat when new information becomes available.

ECDC assessment

Aedes albopictus is established in the southern part of France and in regions of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Greece, Italy, the former Yugoslav Republic of Macedonia, Malta, Montenegro, Romania, Slovenia, Spain and Switzerland (see [VectorNet map](#)).

The report of a cluster of autochthonous chikungunya cases in areas of Europe where *Aedes albopictus* is established is not unexpected during the summer months, when environmental conditions are favourable for mosquitoes. In previous years, France detected several autochthonous clusters of chikungunya and dengue and has acquired experience in managing such clusters. This cluster is currently limited to cases infected within a 200-metre radius during a period of three weeks. The identification of

additional cases associated with this cluster through active surveillance is possible. However, further transmission in the area is unlikely as a result of the vector control measures implemented in the affected area. The risk for a large expansion of the transmission area is very low.

The conclusion of the latest ECDC rapid risk assessment published on 24 August 2017 on the "[Cluster of autochthonous chikungunya cases in France](#)" remains valid.

Actions

ECDC published the rapid risk assessment on the "[Cluster of autochthonous chikungunya cases in France](#)" on 24 August 2017 and an [epidemiological update on 1 September 2017](#).

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

Opening date: 30 May 2017

Latest update: 8 September 2017

Epidemiological summary

Between 31 August and 7 September 2017, Greece reported three cases in newly affected areas. Hungary has reported four cases, Israel five cases and Serbia seven cases in previously affected areas. Romania has reported six cases, one of which is in a previously unaffected area.

In addition, Italy reported 11 West Nile fever Equidae cases and Hungary reported one Equidae case through the Animal Disease Notification System (ADNS) of the European Commission.

Since the beginning of the 2017 transmission season and as of 7 September 2017, Greece has reported 40 human cases, Italy has reported 27 cases, Romania 22 cases, Hungary nine cases and Austria two cases. In addition, Serbia has reported 19 cases and Israel has reported nine cases.

In Equidae, Member States reported 58 West Nile fever cases through ADNS: 47 in Italy, ten in Greece and one in Hungary.

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

Sources: [ADNS](#)

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

ECDC assessment

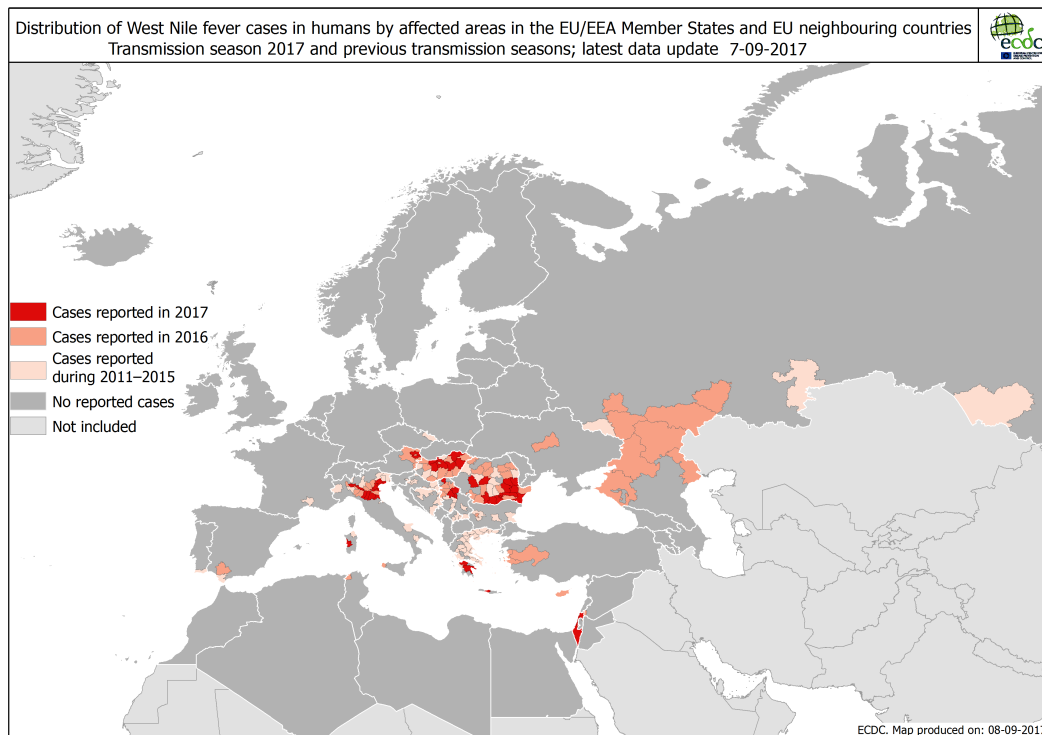
The current West Nile fever epidemiological situation is consistent with observations of seasonal virus transmission from previous years. According to the [Commission Directive 2014/110/EU](#), prospective donors should be deferred for 28 days after leaving a risk area of locally-acquired West Nile virus 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.

Distribution of human WNF cases by affected areas as of 7 September.

ECDC



New! Communicable disease risks – Hurricane Irma – 2017

Opening date: 7 September 2017

Latest update: 8 September 2017

Epidemiological summary

On 29 August 2017, the US National Hurricane Center (NHC) reported that Hurricane Irma was forming in the Atlantic Ocean. In the days that followed, the hurricane gained in intensity and was classified as Category 3 on 31 August and Category 5 on 4 September, on a scale from 1 to 5 according to the Saffir-Simpson hurricane wind scale. Category 5 is defined as wind above 252 km/h and the ensuing damage may include a high percentage of homes destroyed, fallen trees and power outages that could last for weeks or months. Irma is one of the strongest hurricanes ever recorded in the Atlantic.

On 6 September, Irma hit several islands in the Caribbean, in particular Antigua, Barbuda, Saint Barthelemy and Saint Martin. According to the media, some of the affected islands have been severely affected by the winds and flooding, leaving these territories barely habitable. Several fatalities have already been reported from the islands.

As of 7 September, Irma is predicted to hit Dominican Republic, Haiti, Cuba, the Turks and Caicos, the south-eastern area of the Bahamas and the US State of Florida.

As of 7 September, the National Hurricane Centre has identified another hurricane named Jose, currently Category 3 on the Saffir-Simpson scale, which could potentially affect the same territories in the coming days.

Sources: ECHO | [National Hurricane Center](#)

ECDC assessment

As a result of the hurricane, there is an increased risk of multiple disease outbreaks, including acute watery diarrhoea, vaccine-preventable diseases, leptospirosis, vector-borne disease and food-related outbreaks, in particular owing to the low vaccination coverage and basic living conditions of displaced populations, the flooding and heavy rains. In addition, access to basic healthcare will be disrupted.

Actions

ECDC has opened a threat and is preparing a rapid risk assessment to be circulated to Member States and the European

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Commission on 8 September 2017.

Malaria – Cape Verde- 2017

Opening date: 10 August 2017

Latest update: 8 September 2017

Epidemiological summary

There has been an increasing trend in the past weeks with over 50 additional cases of malaria reported since 30 August. As of 3 September, 167 cases had been reported. The epicentre of the outbreak is located in the capital city of Praia in Santiago Island. According to WHO, the causative agent is *Plasmodium falciparum*.

Following the increase in malaria cases in Cape Verde, the Portuguese health authorities issued a statement on 31 August, recommending chemoprophylaxis for travellers to the capital city of Praia on the Island of Santiago. They also recommend that pregnant women postpone their travel to Praia.

The National Travel Health Network and Centre (NaTHNaC) located in the UK, updated the travel recommendation on 5 September, stating that there is a 'very low' risk of malaria on the Island of Santiago (Sao Tiago) except in the city of Praia where the risk level has increased and is now considered to be 'low'. For all travellers awareness of risk and bite avoidance is recommended. Travellers to the city of Praia who are at higher risk of malaria, such as long term travellers, and those at risk of severe complications from malaria (e.g. pregnant women, infants and young children, the elderly and travellers who do not have a functioning spleen), should consider taking chemoprophylaxis with atovaquone-proguanil, doxycycline or mefloquine.

Background: The risk of malaria for Cape Verde is considered as type A, a very limited risk of malaria transmission, according to WHO. The most recent major outbreak was reported in 1999 with 140 cases and 2001 with 95 cases. In the last 10 years, the autochthonous cases in Praia have not exceeded 30.

ECDC link: [ECDC malaria web page](#)

Sources: [Cape Verde Ministry of Health](#) | [WHO](#) | [NaTHNaC](#) | [Portugal](#)

ECDC reports on this threat when new information becomes available.

ECDC assessment

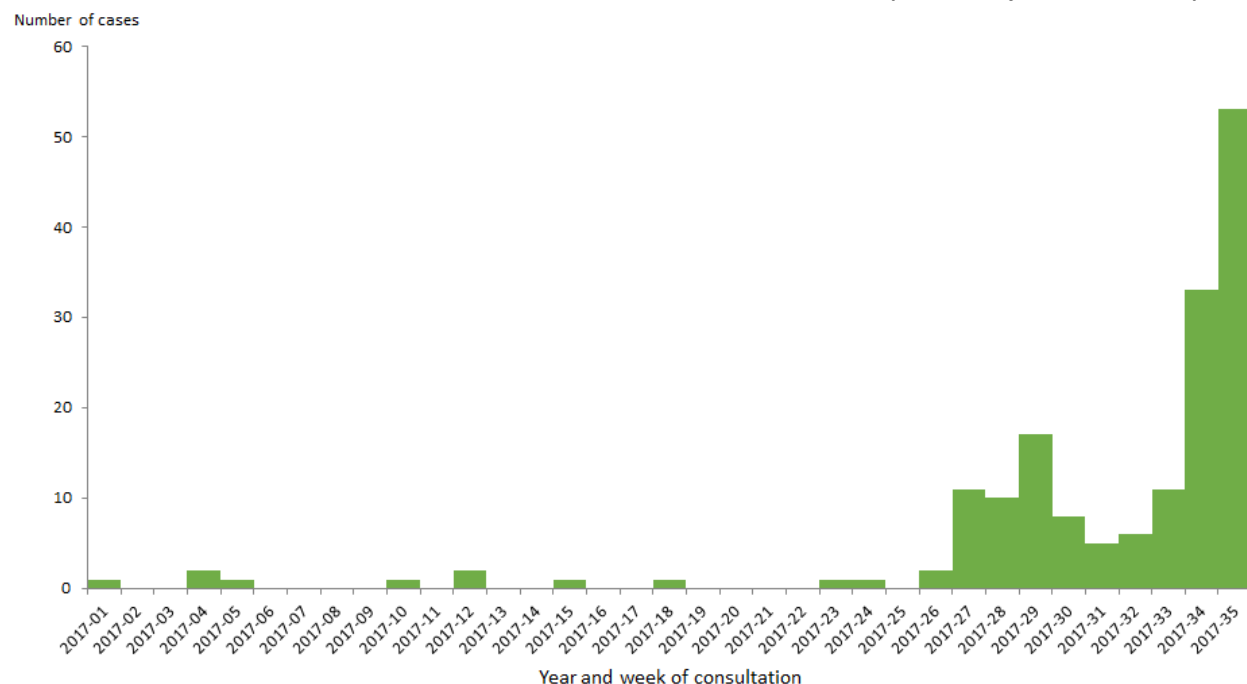
Cape Verde has been a low malaria transmission country, where there was even a possibility that the disease could be eliminated. The increase of autochthonous malaria cases in Cape Verde at the beginning of the rainy season (August to November) is of concern. More cases are likely to be reported in the coming weeks. Malaria due to *Plasmodium falciparum* may cause severe diseases, with fatal outcome in travellers not employing preventive measures against malaria or taking prophylaxis. Therefore, European travellers should consult their travel clinic prior to their journey to Cape Verde to assess their risk and obtain the latest travel recommendations related to malaria chemoprophylaxis. Member States should consider reinforcing malaria prevention measures for travellers.

Actions

ECDC is monitoring this event through epidemic intelligence.

New malaria cases per week of consultation, week 2017-1 to 2017-35, Cape Verde

MoH Cape Verde (data as of 3 September 2017)



Data source: MoH Cape Verde (data as of 3 September 2017)

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

Opening date: 10 November 2016

Latest update: 8 September 2017

Epidemiological summary

Since the previous CDTR, one new case with a travel history to Dubai, UAE, has been reported to ELDSNet.

As of 6 September 2017, 13 EU/EFTA Member States have reported 74 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 (7), Germany (7), Denmark (4), France (6), Austria (1), Belgium (1), the Czech Republic (1), Hungary (1), Ireland (1), Spain (1) and Switzerland (1). Sixty-six 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 fatal.

All cases are laboratory confirmed. Nine cases had their infection further characterised through sequence base typing: five strains were identified as *Legionella pneumophila* serogroup 1, sequence type 616, and one as *Legionella pneumophila* serogroup 1, sequence 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 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 type 1327, and two strains have been characterised as *Legionella pneumophila* serogroup 13, sequence type 1327.

ECDC links: [Legionnaires' disease web page](#) | [rapid risk assessment Increase of cases of Legionnaires' disease in EU travellers returning from Dubai, October December 2016](#)

ECDC reports this threat when a new case is reported.

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 necessarily associated with the reported 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 July 2017 is above the number of cases observed in the same period in previous years. The assessment outlined in the [rapid risk assessment](#) published on 23 December 2016 has not changed.

Actions

ECDC is monitoring this event through ELDSNet. ECDC is in contact with EU Member States, the ELDSNet network, 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 is preparing an update of the rapid risk assessment.

Influenza A(H7N9) – China – Monitoring human cases

Opening date: 31 March 2013

Latest update: 8 September 2017

Epidemiological summary

According to Hong Kong avian influenza report, since the last update on 2 August 2017, China has reported five cases from Fujian (1), Hunan(1), Xinjiang(2), and Jiangsu(1).

According to WHO WPRO, 27 human cases with highly pathogenic avian influenza (HPAI) A(H7N9) virus have been reported during the fifth wave.

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then and up to 7 September 2017, 1 562 cases have been reported, including 568 deaths. The outbreak shows a seasonal pattern. The first wave in spring 2013 (weeks 2013-7 to 2013-40) resulted in 135 cases, the second wave (weeks 2013-41 to 2014-40) led to 320 cases, the third wave (weeks 2014-41 to 2015-40) caused 223 cases, and 120 cases were reported as a result of the fourth wave (weeks 2015-41 to 2016-40). A fifth wave started in October 2016 (week 2016-41), with 763 cases as of 7 September 2017.

The 1 562 cases were reported from Zhejiang (310), Guangdong (258), Jiangsu (252), Fujian (108), Anhui (99), Hunan (94), Shanghai (57), Jiangxi (52), Sichuan (38), Beijing (35), Guangxi (31), Hubei (31), Hebei (29), Henan (28), Shandong (28), Hong Kong (21), Guizhou (20), Xinjiang (13), Chongqing (9), Gansu (5), Shaanxi (7), Taiwan (5), Tianjin (5), Liaoning (4), Jilin (3), Tibet (3), Inner Mongolia (2), Macau (2), Shanxi (3), Yunnan (7). Three imported cases were reported in Canada (2) and Malaysia (1).

ECDC links: [Zoonotic influenza web page](#) | [ECDC rapid risk assessment Influenza A\(H7N9\) virus in China - implications for public health - 7th update, 3 July 2017](#)

Sources: [Chinese CDC](#) | [Hong Kong CHP](#) | [WHO](#) | [WHO FAQ page](#) | [ECDC](#)

ECDC assessment

This is the fifth winter season in the northern hemisphere with human cases caused by influenza A(H7N9) infections. During this wave, the number of human cases has been higher than in previous waves. This is most likely due to greater environmental contamination in live bird markets and increased circulation of the virus among poultry. In contrast to the situations observed during the summer months in previous years, influenza A(H7N9) viruses are continuously circulating in the poultry population, with transmission to humans causing a substantial number of cases.

During the current wave, a new influenza A(H7N9) virus with mutations in the haemagglutinin gene indicating high pathogenicity in poultry was detected. This has resulted in 27 human cases from Guangdong, Guangxi, Hebei, Hunan, Shaanxi and Taiwan (the case had travel history to Guangdong) with illness onset date before July 2017. It is unclear at the moment whether the newly emerged, highly-pathogenic avian influenza virus A(H7N9) will replace the low-pathogenic virus or if both will co-circulate in the bird population. Although the genetic changes in influenza A(H7N9) may have implications for poultry in terms of pathogenicity, there is no evidence to date of increased transmissibility to humans or sustainable human-to-human transmission.

The possibility of humans infected with influenza A(H7N9) returning to the EU/EEA cannot be excluded. However, the risk of the disease spreading in Europe through humans is still considered low, as there is no evidence of sustained human-to-human transmission.

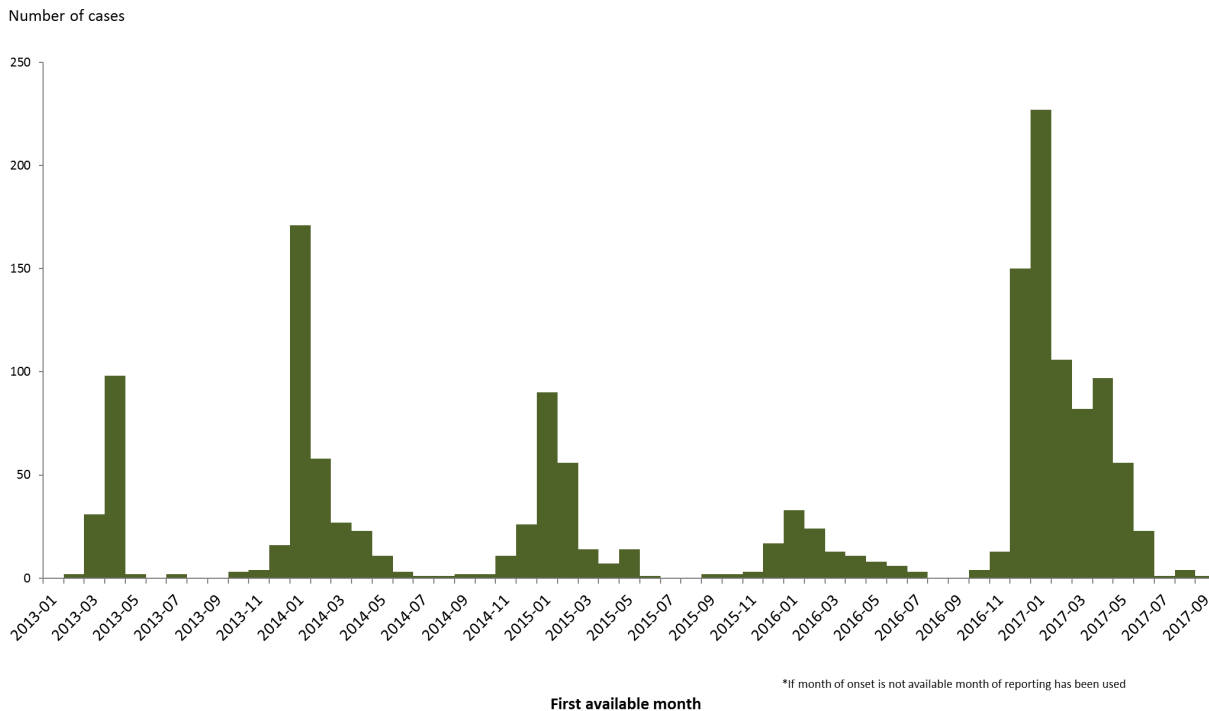
Sources: [WHO](#)

Actions

ECDC published the seventh update of its [rapid risk assessment](#) on 3 July 2017, addressing the genetic evolution of influenza A (H7N9) virus in China and the implications for public health. ECDC monitors this event through epidemic intelligence and will report monthly.

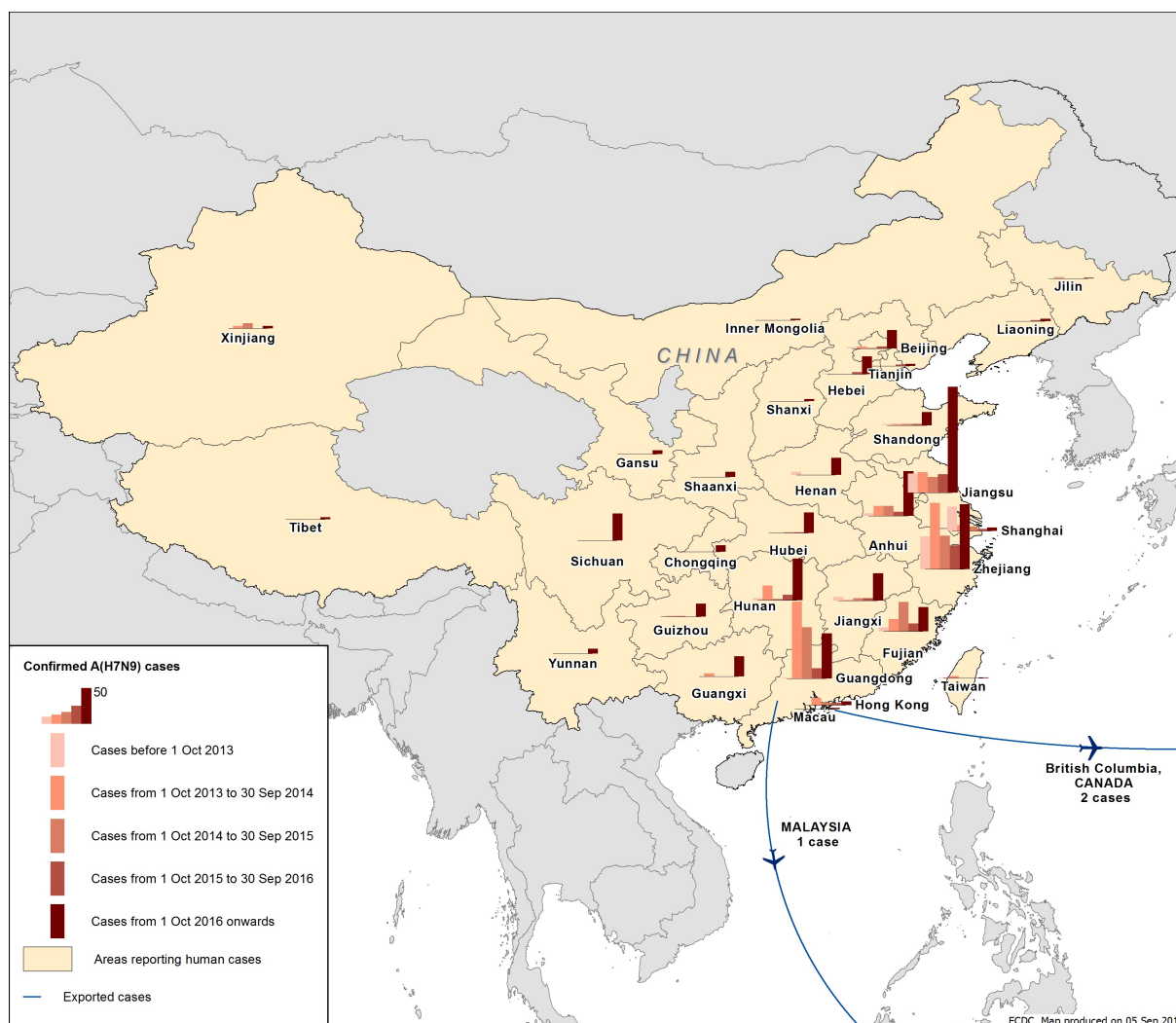
Distribution of confirmed cases of A(H7N9) by first available month, February 2013 to 7 September 2017

ECDC, WHO, Hong Kong MoH



Distribution of confirmed cases of A(H7N9) by five seasons, February 2013 to 9 September 2017

ECDC



Poliomyelitis – Multistate (World) – Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 8 September 2017

Epidemiological summary

Since the last CDTR on 25 August 2017 and as of 5 September 2017, Pakistan has reported one new wild poliovirus type 1 (WPV1). Syria has reported six and the Democratic Republic of the Congo (DRC) one type 2 circulating vaccine-derived poliovirus (cVDPV2).

As of 5 September 2017, 10 wild poliovirus cases have been reported for 2017, six cases from Afghanistan and four cases from Pakistan. In 2016, 37 cases were reported during the same period.

In 2017, 47 circulating cVDPV2 cases have been reported so far, eight from the Democratic Republic of Congo and 39 from Syria. Onset of paralysis in the Syrian cases was between 3 March and 10 July. Thirty-seven of the cases are from Deir-Ez-Zour governorate (with the bulk of the cases from Mayadeen district), one case is from Raqqa governorate (Talabyad district) and one is from Homs governorate (Tadmour district). In 2016, only five cVDPV2 cases were reported during the same period.

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The first mOPV2 round in Deir-Ez-Zour was successfully carried out between 22 and 26 July. Independent post-campaign monitoring reflected a coverage rate of 88.4%. The second round for Deir-Ez-Zour governorate was completed last week. Monovalent OPV2 was provided for children between 0-59 months of age, and inactivated polio vaccine (IPV) for children 2-23 months. In addition to polio vaccines, Aqua Tabs are being provided to families for water purification - 2.5 tons of water purification tablets for 400 000 people have been disseminated at health centres. Raqqa governorate conducted mOPV2 campaigns on 12 August 2017.

Plans are being finalised to mitigate the risk of a further spread from the outbreak zone to neighbouring areas and countries, including immunisation of at-risk populations in northwest Syria, Turkey and Lebanon.

ECDC links: [ECDC poliomyelitis web page](#) | [Information to travellers to polio-infected countries](#)

Sources: [WHO IHR Emergency Committee](#) | [Polio eradication: weekly update](#)

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. Importation of the infection as well as of polio cases in to the EU remains possible.

ECDC links: [Rapid Risk Assessment on suspected polio cases in Syria and the risk to the EU/EEA](#) | [ECDC poliomyelitis web page](#)

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. Following the declaration of polio as a PHEIC, ECDC updated its [risk assessment](#). ECDC has also prepared a background document with travel recommendations for the EU.

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