

This weekly bulletin provides updates on threats monitored by ECDC.

News

Updated vector maps published ahead of peak activity season

Updated maps showing the distribution of invasive mosquitoes, such as *Aedes albopictus*, ticks and [sandflies](#) in Europe have been published on the ECDC website. The data, presented at NUTS 3 level, are compiled through the joint [VectorNet project](#) of the European Food Safety Authority (EFSA) and ECDC. No major changes are noted in the distribution of vectors covered by the project. VectorNet supports the collection of data on vectors and pathogens in vectors related to both animal and human health. Vector maps are available on [ECDC website](#).

Seasonal West Nile fever 2017 surveillance

ECDC starts its [seasonal West Nile fever monitoring](#) this week. Every Friday, ECDC will provide an update on West Nile fever cases in Europe and the Mediterranean region including:

- an epidemiological situation summary,
- maps showing the geographical distribution of the reported autochthonous human cases from the start of the season,
- the number of cases by country and NUTS 3 administrative levels.

The West Nile fever maps are available through the [Surveillance Atlas of Infectious Diseases](#).



Mosquito maps

Maps on the geographical distribution of the invasive mosquitoes species: *Aedes aegypti*, *Aedes albopictus*, *Aedes japonicus*, *Aedes koreicus*, *Aedes atropalpus* and a surveillance map on invasive mosquitoes



Tick maps

Maps on the geographical distribution of the tick species: *Dermacentor reticulatus*, *Hyalomma marginatum*, *Ixodes persulcatus*, *Ixodes ricinus*



Plebotomine maps

Maps on the geographical distribution of the plebotomine species: *Phlebotomus ariasi*, *Phlebotomus neglectus*, *Phlebotomus papatasi*, *Phlebotomus perfiliewi*, *Phlebotomus perniciosus*, *Phlebotomus sergenti*, *Phlebotomus similis*, *Phlebotomus tobbi*

I. Executive summary

EU Threats

New! West Nile virus - Multistate (Europe) - Monitoring season 2017

Opening date: 30 May 2017

Latest update: 2 June 2017

During the June-to-November transmission season, ECDC monitors the West Nile activity in EU Member States and neighbouring countries in order to inform the blood safety authorities of areas affected by West Nile fever. In 2016, 214 human cases of West Nile fever virus were reported in EU Member States and 267 cases in the neighbouring countries.

→Update of the week

ECDC starts the monitoring of West Nile infections this week. No cases were reported so far in the 2017 season.

Hepatitis A outbreaks in the EU/EEA mostly affecting MSM – 2016/2017

Opening date: 12 December 2016

Latest update: 2 June 2017

European Union Member States are reporting an increase of hepatitis A virus infection cases in 2017. Among the cases, adult men who have sex with men (MSM) are indicated as an affected population. Since June 2016 and as of 17 May 2017, 1 173 confirmed hepatitis A cases infected with three distinct strains of sub-genotype IA virus have been reported by 15 EU countries. Most cases are reported among MSM. Of the 1 173 cases 80 are women.

→Update of the week

Since the beginning of the year and as of 30 April, Spain has reported 1 584 hepatitis A cases. In the light of the upcoming WorldPride mass gathering event to be held in Madrid on 23 June to 2 July, the health authorities in Madrid are encouraging participants to seek advice from health personnel on the vaccination recommendations provided by the [health authorities](#) in Madrid and on the recommended routine vaccination and reinforcement guidelines in their respective countries of origin. [ECDC](#) has published a risk assessment related to this event.

In Portugal since the beginning of the year and as of 23 May, 285 cases have been reported, where the majority of the cases are men.

Hepatitis A vaccine availability in the EU is currently limited with Austria, Italy, Portugal and Spain facing hepatitis A vaccine shortages. The Czech Republic, Denmark, Estonia, Finland, Ireland, Luxembourg, Slovenia and Sweden have reported no shortages.

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 2 June 2017

A measles outbreak in Romania has been ongoing since February 2016. Cases continue to be reported despite ongoing response measures that have been implemented at national level through reinforced vaccination activities. Between 1 January 2016 and 26 May 2017, Romania reported 6 434 cases including 27 deaths (including one under investigation). In 2016, a number of additional EU/EEA countries reported measles outbreaks, and an increase in the number of cases continues to be observed in 2017. Some previous and ongoing measles outbreaks in other EU/EEA countries have been epidemiologically linked to the current outbreak in Romania.

→Update of the week

In addition to Romania, the following EU/EEA countries have reported measles cases in 2017: Austria, Belgium, Bulgaria, Czech Republic, Denmark, France, Germany, Hungary, Iceland, Italy, Portugal, Slovakia, Spain, Sweden and the United Kingdom.

Rubella – Multistate (EU) – Monitoring European outbreaks

Opening date: 7 March 2012

Latest update: 1 June 2017

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 June 2015.

→Update of the week

No new outbreaks have been detected since June 2015.

Poliomyelitis – Facility-related infection with WPV 2 – the Netherlands

Opening date: 12 April 2017

Latest update: 2 June 2017

In early April 2017, the Netherlands reported a spill of poliovirus in a vaccine production plant. According to protocol, immediate measures were taken to prevent further spread. Two employees were exposed and poliovirus was isolated in the faeces of one of them. Strict hygiene measures have been implemented to minimise the risk of further spread.

→Update of the week

On 24 May, the Netherlands provided the final results of the monitoring. The samples taken of the sewage system on 16 May tested negative for wild poliovirus by culture and by PCR and the results of the enhanced environmental surveillance were negative. Therefore, the monitoring and enhanced surveillance has ended. The regular environmental surveillance in the Bible belt area will be continued.

Non EU Threats

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

Opening date: 10 November 2016

Latest update: 2 June 2017

The ECDC ELDSNet 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

On 25 May 2017, the UK reported an additional case of Legionnaires' disease with travel to Dubai. The case is a 59-year-old female who fell ill on 17 May 2017 having stayed three days of his incubation period in Dubai. She stayed at an accommodation site previously not reported to ELDSNet, but in a geographical community area having other hotels associated with cases.

Influenza A(H7N9) – China – Monitoring human cases

Opening date: 31 March 2013

Latest update: 2 June 2017

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then and up to 31 May 2017, 1 512 cases have been reported to WHO, including at least 561 deaths. 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. From week 2016-41, 714 cases have been reported, representing a significant increase compared to previous seasons.

→Update of the week

Since the last update, nine additional cases have been detected in [China](#) according to the health authorities in Hong Kong.

Ebola - Republic Democratic of Congo - 2017

Opening date: 15 May 2017

Latest update: 2 June 2017

According to World Health Organization (WHO) situation report as of 30 May 2017, 17 cases of Ebola virus disease (EVD) have been reported in Bas Uele Province. Among these cases, two are confirmed, three are probable and 12 are suspected. Four deaths are reported among the cases. Investigations and laboratory results confirmed an Ebola outbreak of subtype Zaire on 11 May.

→Update of the week

Since last week, no new confirmed cases have been reported. As of 30 May 2017, authorities in the Democratic Republic of Congo (DRC) have reported two confirmed, three probable and 12 suspected EVD cases.

II. Detailed reports

New! West Nile virus - Multistate (Europe) - Monitoring season 2017

Opening date: 30 May 2017

Latest update: 2 June 2017

Epidemiological summary

Since the beginning of the 2017 transmission season and as of 2 June 2017, no cases of West Nile fever in humans have been reported in EU Member States. No cases were reported from neighbouring countries.

Source: [ECDC WNF page](#)

ECDC assessment

As expected at this time of the year, no cases in the EU Member States have been detected.

Actions

Since the beginning of June 2017, ECDC produces weekly WNF maps during the transmission season to inform blood safety authorities of WNF-affected areas.

Hepatitis A outbreaks in the EU/EEA mostly affecting MSM – 2016/2017

Opening date: 12 December 2016

Latest update: 2 June 2017

Epidemiological summary

Between 1 June 2016 and 17 May 2017, 15 EU countries, Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden and the United Kingdom have reported 1 173 HAV genotype IA confirmed cases. The investigations of these events have identified three separate clusters based on genetic sequencing of the hepatitis A virus (HAV).

Event 1, cluster VRD_521_2016.

As of May 2017, 15 EU Member States have reported 676 cases associated with this cluster initially reported by the UK on 6 December 2016 through an EPIS FWD urgent inquiry. Most cases have been reported by Spain (223), Portugal (144), Italy (114), France (70) and the United Kingdom (56). Of the 588 cases with documented gender, 541 (92%) are male and 189 of 221 documented cases (86%) identify themselves as MSM. Twenty-two of the 51 cases with a travel history, travelled to Spain.

Event 2, cluster RIVM-HAV16-090.

As of 16 May 2017, 12 EU Member States have reported 388 cases through the Early Warning and Response System (EWRS) on 14 October 2016 by the Netherlands and through EPIS-FWD on 31 January 2017. The first two Dutch cases reported visiting the EuroPride festival in Amsterdam between 23 July and 7 August 2016. Most cases have been reported by the United Kingdom (168), France (51) and Italy (35). Of the 375 cases with documented gender, 347 (93%) are in males and 198 of 239 documented cases identify themselves as MSM. Of the 76 cases with a travel history during the incubation period, 28 travelled to Spain and nine to Germany.

Event 3, cluster V16-25801.

As of 17 May 2017, ten EU Member States have reported 109 cases associated with this cluster, which was first reported through EPIS-FWD on 11 January 2017 by Germany. Cases were reported by Germany (40), the United Kingdom (39), Spain (12), Italy (5), the Netherlands (5), France (4), Austria (1), Belgium (1), Denmark (1) and Finland (1). Of the 109 documented cases, 104 are in males and 38 of 42 documented cases identify themselves as MSM. Six of 20 cases with information on travel visited Spain during the incubation period.

Additional outbreaks of hepatitis A in EU Member States affecting MSM

In addition to the previous clusters described, the Netherlands reported one case of HAV of another strain (RIVM-HAV- 16-069) in an MSM. This strain was only identified in the UK (one case, MSM) and Italy (one case, MSM unknown status).

Between July 2016 and 2 April 2017, the UK reported 266 cases belonging to the three above-mentioned circulating strains. Most cases (74%) were among MSM and geographically clustered (63%) in London.

Between 1 January and 8 May 2017, Portugal reported 242 HAV cases of which 93% are men and 79% are from Lisbon and Vale

do Tejo region. Infection through sexual transmission was indicated by 57% of the cases. Hepatitis A vaccine is recommended to people at risk.

Other EU Member States reporting cases

Between January and May 2017, six EU member states have notified an increase in the number of HAV infection cases compared with the same period in 2016; Belgium has reported 203 cases in 2017 compared with 37 cases in the same period for 2016, Estonia has reported ten cases in 2017 compared with two in 2016, Finland has reported 14 in 2017 compared with two in 2016, Italy has reported 20 cases in 2017 compared with 11 in 2016, Spain has reported 1 539 cases in 2017 compared with 236 in 2016, and Sweden has reported 45 cases in 2017 compared with 33 in 2016.

Furthermore, between August 2016 and April 2017, Italy reported, 1 247 cases of hepatitis A, which is a five-fold increase compared with 2015.

ECDC assessment

The highly interconnected sexual networks among MSM in Europe may contribute to the multinational dimension of these clusters. In at least two EU Member States, the United Kingdom and Germany, secondary cases have been linked to travel-associated index cases. The circulation of three different HAV genotype IA strains in the MSM population is likely to be the result of several introductions into these networks.

Further transmission resulting from these clusters may be prevented by vaccination of MSM and post-exposure prophylaxis in the contacts of cases. However, limited vaccine availability in some countries may have an impact on the implementation of control measures. In addition, since many of the risk group contacts are anonymous, their timely vaccination is challenging. National authorities should consider interacting directly with marketing authorisation holders (MAH) to enquire about supply at a national level as early as possible to plan for vaccination arrangements. Countries with limited vaccine availability are encouraged to bring that topic to the Health Security Committee in order to identify possible solutions.

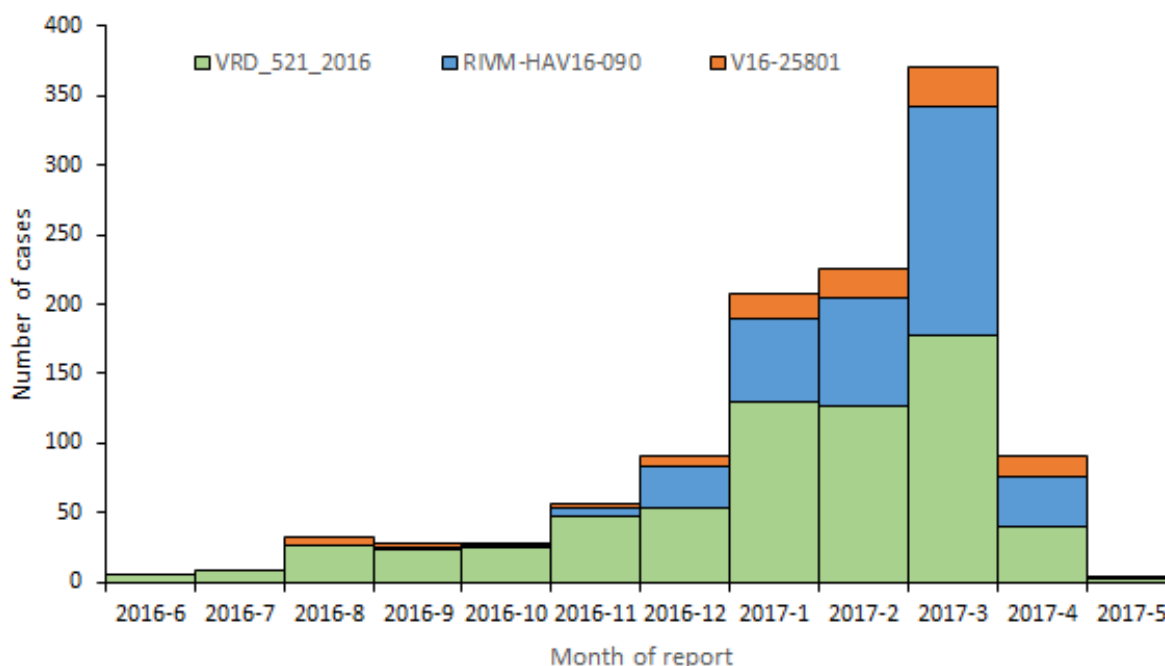
Actions

The main prevention measure in the context of the current outbreaks is hepatitis A vaccination of MSM. The ECDC guidance for '[HIV and STI prevention among men who have sex with men](#)' encourages Member States to offer and promote vaccination of MSM against hepatitis A. Information on vaccine availability should be included in health promotion programmes targeting MSM, particularly at sex venues.

ECDC is supporting a European study to describe the extent of the outbreak and identify possible risk factors and characteristics independently associated with the three currently ongoing clusters. ECDC published the second update of the [RRA](#) on 19 May 2017.

Distribution of hepatitis A cases, by month of report and genetic sequence, June 2016, as of 15 May 2017, EU/EEA (n=1 148)

ECDC



Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 2 June 2017

Epidemiological summary

EU/EEA countries with updates since last week:

Austria: Since the beginning of 2017 and as of 19 May, Austria has reported 78 cases. This exceeds the cumulative number of cases reported in 2016.

Belgium: Since 20 December 2016 and as of 8 May 2017, Wallonia has reported 293 cases, of which 115 were hospitalised. The outbreak affects all provinces of Wallonia, with the exception of the province of Luxembourg. No deaths are reported. The index case of the outbreak in Wallonia travelled to Romania during the incubation period. After a peak of 40 cases per week in the beginning of March, the epidemic is gradually decreasing.

In Flanders, one isolated imported case was reported in January and another in March, with possible links to a cluster in Wallonia. In the Brussels Capital Region, one isolated imported case was reported in February and two cases were notified in March without known links to the outbreak in Wallonia. Both imported cases had a travel history to Romania during the incubation period, and the national reference centre for measles, mumps and rubella (WIV-ISP) identified genotype B3, which is the same strain found in Romania, Italy and Austria, at the end of 2016.

Bulgaria: Since mid-March 2017 and as of 27 May, Bulgaria reported 116 cases of measles in [Plovdiv](#), an increase of 45 cases since the previous monthly update. Bulgaria also reported also cases in [Pazardzhik](#) (5) and in [Montana](#) (2).

Czech Republic: As of 29 May 2017, the Moravian-Silesian region reported 121 measles cases, an increase of 17 cases since the previous monthly update

France: Since 1 January 2017 and as of 30 April, France reported 189 cases, an increase of 55 cases since the previous monthly update and nearly four times the number of reported cases in 2016 over the same period (47). The cases are mainly linked with an outbreak in Lorraine (60 cases between February and April 2017). Two cases of encephalitis and 18 of severe pneumonia have been recorded since the beginning of the year. On 31 May, [media](#) reported 22 additional cases in Perpignan since the beginning of May.

6/16

Germany: Since the beginning of 2017 and as of 7 May, Germany has reported 634 cases. This is an increase of 51 cases since the previous update. In the same period in 2016, Germany reported 62 cases. On 22 May, a 37-year-old woman from Essen died from measles.

Italy: Since the beginning of 2017 and as of 30 May, Italy has reported 2 719 cases in 18 of the 21 regions. Among these, 220 are healthcare workers. Most of the cases (73%) are above the age of 15 years, 89% of the cases were not vaccinated and 6% received only one dose of vaccine. The weekly number of cases is decreasing.

Romania: Between 1 January 2016 and 26 May 2017, Romania has reported 6 434 cases, including 26 deaths. A possible additional death is under investigation. Cases are either laboratory-confirmed or have an epidemiological link to a laboratory-confirmed case. Infants and young children are the most affected group. Forty of the 42 districts have reported cases, Timis (West part of the country, at the border with Serbia) is the most affected district with 1 065 cases. Vaccination activities are ongoing in order to cover communities with suboptimal vaccination coverage. On 31 May, [media](#) reported an additional death, if confirmed bringing the number of deaths to 28.

Sweden: Since mid April and as of 31 May, Sweden reported four cases of measles in the south-western part of the country. Earlier in 2017, Sweden reported 15 cases in the Stockholm area, including three imported cases.

United Kingdom

During the first three months of 2017, England reported 17 confirmed measles cases compared with 37 in the period between October and December 2016. Northern Ireland reported one case and Scotland and Wales have reported no cases so far this year.

EU/EEA countries with no updates since last week:

Denmark: On 15 March 2017, Denmark reported an imported case in an unvaccinated adult who was infected during a holiday in Asia.

Hungary: Between 21 February and 22 March 2017, Hungary has reported 54 cases. Health authorities have lifted the quarantine from the hospital in Mako, Southeast Hungary, as no new cases were detected in two weeks.

Iceland: On 31 March 2017, Iceland reported two cases in two 10-month-old unvaccinated twin siblings. The first case was diagnosed 10 days before the second case. This is the first time in a quarter of a century that measles infection has occurred in Iceland.

Portugal: Since the beginning of 2017 and as of 29 May, Portugal has reported 29 confirmed cases, of which 19 (66%) are older than 18 years of age, 17 (59%) were unvaccinated, 13 (45%) are health professionals and 13 (45%) were hospitalised. Twenty-one cases have been confirmed in the regions of Lisbon and Vale do Tejo, followed by seven cases in the Algarve and one in the North. One death has been reported.

Slovakia: On 24 April 2017, Slovakia reported an imported case in a 25-year-old, unvaccinated Italian who studies in Kosice. In Slovakia, the last endemic cases were reported in 1998 and the last imported cases in 2011 and 2012.

Spain: An outbreak started in the first week of January in Barcelona metropolitan area, due to an imported case from China. As of 7 April, 46 cases have been confirmed. Most of the cases are unvaccinated or incompletely-vaccinated adults. Four of the cases are children, and ten cases were hospitalised.

Outside EU

Canada

As of 13 May, Canada reports 40 cases of measles. There is active transmission in Nova Scotia.

DR Congo

As of March 2017, DR Congo recorded 14 485 suspected measles cases, including 174 deaths in Maniema and South Kivu provinces.

Ethiopia

As of 31 March 2017, Ethiopia confirmed 348 cases and 40 outbreaks in Addis Ababa, Afar, Amhara, Oromia, Southern Nations Nationalities and Peoples, Somali and Tigray regions. The majority of the cases (39%) are children under five years.

Guinea

Since the beginning of this year and as of 23 May, Guinea confirmed 3 468 cases of measles, including 14 deaths throughout the country. Conakry and Nzérékoré are the most affected prefectures. Since 7 April, Médecins Sans Frontières (MSF) has launched a

large measles vaccination campaign in Conakry, in collaboration with the Ministry of Health of Guinea.

Kenya

Since the outbreak in end February, Kenya reported 14 confirmed measles cases.

Nigeria

Between 22 August 2016 and 3 April 2017, Nigeria reported 2 890 suspected cases of measles in 13 of the 27 local government areas (LGAs) of Borno state, located at the north east of the country.

Oman

As of the end of April 2017, Oman reported 44 cases of measles. A National Measles Immunisation Campaign started on 14 May.

Reunion

Between 20 April and 3 May 2017, five cases of measles were diagnosed in young adults residing in Réunion.

Somalia

Since the beginning of 2017 and as of 17 May, Somalia reported 8 390 suspected cases of measles. During the entire 2016 5 657 cases were detected. Children under the age of five are most affected. Most affected regions are Banadir, Toghddeer, Lower Shabelle, Sool and Sahil.

South Africa

As of 6 May 2017, South Africa reported 17 cases of measles in Gauteng area in Johannesburg. Ten of these cases are linked to one family, who chose not to be vaccinated due to religious reasons. Almost all cases were not vaccinated. Five of the patients are under the age of five, one is 45 years old, and the rest are between ages five and 15.

Switzerland

Since the beginning of the year, Switzerland has registered 69 cases. Throughout 2016, there were 71 cases.

Syria

As of 29 May, Syria reported 40 laboratory-confirmed cases. Most of the cases are concentrated in the western region of Dara'a, in addition to Al-Harak area in the eastern countryside of Dara'a. The last outbreak of the disease was reported in 2006.

Tajikistan

Since April 2017 and as of 1 May, Tajikistan notified 345 cases of measles, with 246 (71%) patients hospitalised. No deaths have been reported. The measles epidemic is gradually spreading out of Rudaki district to the capital Dushanbe and the surrounding districts.

Thailand

As of 27 May 2017, Thailand reported 1 638 measles cases from 67 provinces, no deaths. Most affected age groups are the 15-24 year old (21%). The highest morbidity rate was in the south of Thailand (6.40 / 100 000 population).

Ukraine

As of 23 May, during four months Ukraine reported 172 measles cases in ten regions. Most affected regions are Ivano-Frankivsk and Odessa area. In 2016 during the same time period eight cases were reported.

USA

As of 31 May, Minnesota Department of Health reported 70 confirmed cases, most of them are unvaccinated pre-school children. Of these, 59 cases were notified in Hennepin County. A significant number have been hospitalised. Minnesota's measles outbreak is about to exceed the cumulative number of 70 cases reported in the entire United States in 2016.

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. The national vaccination coverage remains less than 95% for the second dose of MMR in the majority of EU/EEA countries. 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 fifth meeting of the RVC for Measles and Rubella in October 2016, of 53 countries in the WHO European Region, 24 (15 of which are in the EU/EEA) were declared to have reached the elimination goal for measles, and 13 countries (nine in the EU/EEA) were concluded to have interrupted endemic transmission for between 12 and 36 months, meaning they are on their way to achieving the elimination goal. However, six EU/EEA countries were judged to still have endemic transmission: Belgium, France, Germany, Italy, Poland and Romania.

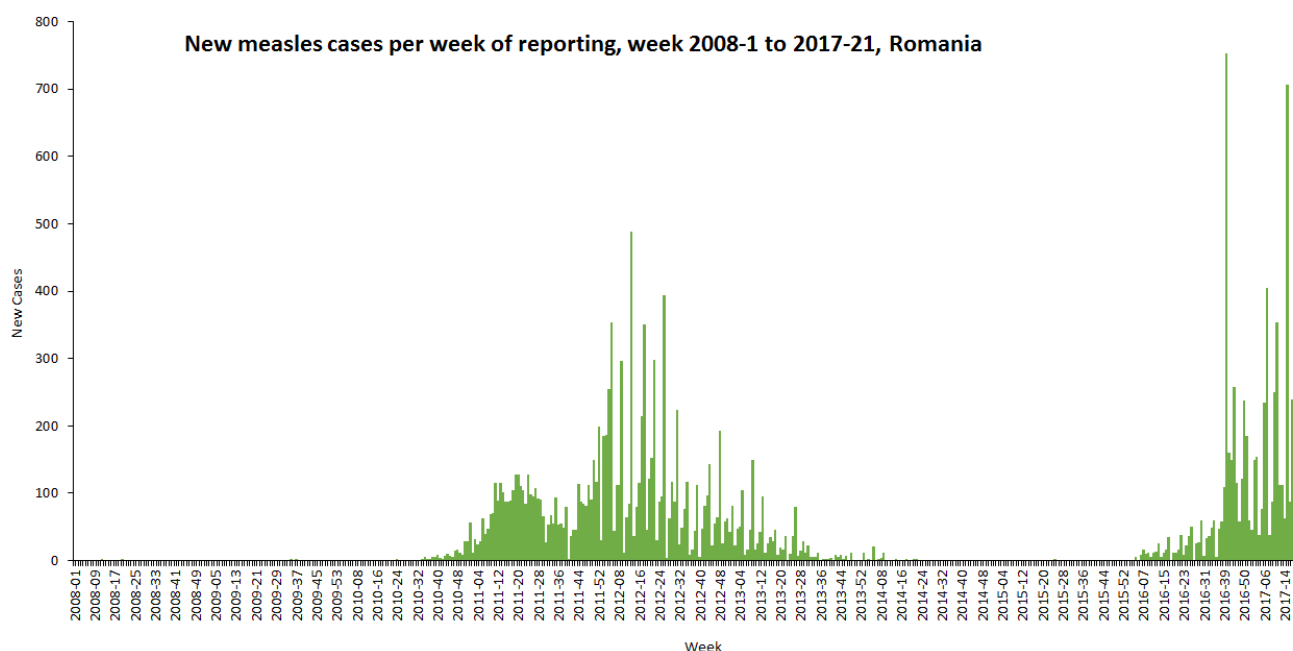
More information on strain sequences would allow further insight into the epidemiological investigation. All EU/EEA countries report measles cases on a monthly basis to ECDC and these data are published every month. Since 10 March 2017, ECDC has been reporting on measles outbreaks in Europe on a weekly basis through epidemic intelligence activities.

Actions

ECDC published a [rapid risk assessment](#) on 6 March. ECDC monitors measles transmission and outbreaks in the EU/EEA on weekly basis through enhanced surveillance and epidemic intelligence activities.

New measles cases per week of reporting, week 2008-1 to 2017-21, Romania

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



*From 2008 to 2016-39 data from TESSy, from 2016-40 onwards data from Romanian MoH

Rubella – Multistate (EU) – Monitoring European outbreaks

Opening date: 7 March 2012

Latest update: 1 June 2017

Epidemiological summary

No new outbreaks have been detected in the EU since June 2015.

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](#) | [European Regional Verification Commission for Measles and Rubella Elimination \(RVC\) \(2016\)](#)

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. Elimination is defined as the absence of endemic cases in a defined geographical area for a period of at least 12 months, in the presence of a well-performing surveillance system. Regional elimination can be declared after 36 or more months of the absence of endemic measles or rubella in all Member States of the WHO European Region. Although progress has been made towards elimination, this goal has not yet been achieved. The fifth Regional Verification Commission meeting was held 24-26 October 2016. According to the results, 24 countries in the WHO EURO region have been judged to have eliminated rubella.

Web source: [WHO-EU](#)

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-four EU and two 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.

Poliomyelitis – Facility-related infection with WPV 2 – the Netherlands

Opening date: 12 April 2017

Latest update: 2 June 2017

Epidemiological summary

In early April 2017, the Netherlands reported a spill of poliovirus in a vaccine production plant. According to protocol, immediate measures were taken to prevent further spread. Two employees were exposed and poliovirus was isolated in the faeces of one of them. Spill of the virus was limited to a confined area of the production plant. Strict hygiene measures were implemented to minimise the risk of further spread. On 15 May the exposed employee was no longer shedding the virus and the isolation was lifted. On 24 May, the Netherlands ended the enhanced surveillance, as environmental and sewage samples taken related to this event tested negative for wild poliovirus.

Source: [RIVM](#) | [Bilthoven Biologicals](#) | [media](#) | [Eurosurveillance](#)

ECDC assessment

The release of WPV and detection of WPV in an exposed person constitutes a polio event in light of wild polio eradication worldwide in April 2017. This polio event and the resulting 'infection' of an employee constitute a biosafety hazard in a production facility containing WPV for IPV vaccine manufacturing. Updated assessment on the outcome of the investigations being performed by Dutch authorities is provided on a regular basis. In the Netherlands, polio vaccination is administered to children from two months of age and the majority of the population is protected from the disease. Control and hygiene measures around the infected employee are necessary until the virus disappears from his stool.

Actions

Due to the final results of the monitoring and the end of the enhanced monitoring in the Netherlands, ECDC will close this threat.

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

Opening date: 10 November 2016

Latest update: 2 June 2017

Epidemiological summary

As of 25 May 2017, 12 EU Member States as well as Switzerland have reported 61 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 United Kingdom (30), Sweden (8), the Netherlands (6), Denmark (4), France (3), Germany (3), Austria (1), Belgium (1), the Czech Republic (1), Hungary (1), Ireland (1), Spain (1) and Switzerland (1). Fifty-five cases are associated with commercial accommodation sites and six with private accommodation sites. Twelve cases spent time in another location in the UAE or in a country other than their home country during their incubation period. One case was reported as fatal.

All cases are laboratory confirmed. Three cases had their infection further characterised 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 the first such identification worldwide and appears to be closely-related to type 616. One case has been characterised with *Legionella pneumophila* serogroup 13, sequence base type 1327. UAE authorities have informed ECDC that no increase in cases of statutory notifiable pneumonia was observed in Dubai between October and December 2016.

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 travel history to Dubai. However, it cannot be ruled-out that some travellers may have

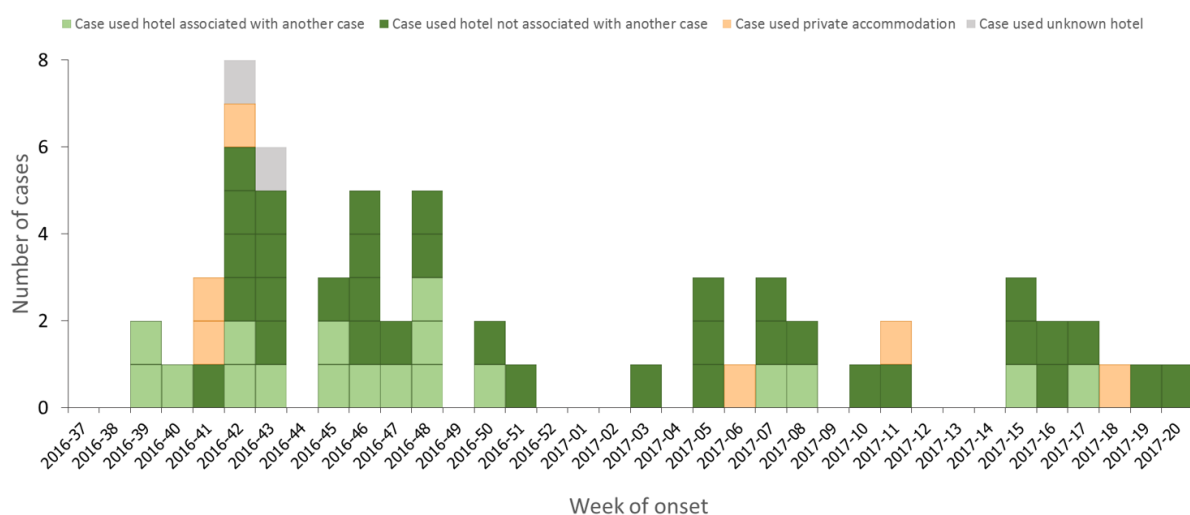
acquired their infection elsewhere if their travel stay in Dubai was shorter than the range of the incubation period. The increase in cases observed between October 2016 and May 2017 is above that observed in previous years.

Actions

ECDC monitors this event through ELDSNet. ECDC is in contact with EU Member States, the ELDSNet network, the World Health Organization and UAE for information sharing. ECDC published a [rapid risk assessment](#) on its website on 23 December 2016 and shared an updated rapid risk assessment with the European Commission and EU Member States on 13 January 2017. The conclusions of the rapid risk assessment remain valid. ECDC also posted an [epidemiological update](#) on 24 May.

Distribution of travel-associated Legionnaires' disease cases with history of stay in Dubai, United Arab Emirates, by week of onset from 37-2016 and 20-2017, as reported to ELDSNet by 26 May 2017 (n=61 cases)

ECDC



Influenza A(H7N9) – China – Monitoring human cases

Opening date: 31 March 2013

Latest update: 2 June 2017

11/16

Epidemiological summary

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then and up to 23 May 2017, 1 512 cases have been reported to WHO, including 561 deaths. The A(H7N9) outbreak shows a seasonal pattern. The first wave in spring 2013 (weeks 2013-7 to 2013-40) included 135 cases, the second wave (weeks 2013-41 to 2014-40) 320 cases, the third wave (weeks 2014-41 to 2015-40) 223 cases, and the fourth wave (weeks 2015-41 to 2016-40) 120 cases. A fifth wave started in October 2016 (week 2016-41), with 714 cases as of 31 May 2017.

The 1 512 cases were reported from Zhejiang (309), Guangdong (258), Jiangsu (249), Fujian (107), Anhui (97), Hunan (92), Shanghai (56), Jiangxi (50), Sichuan (35), Guangxi (30), Hubei (30), Beijing (29), Hebei (27), Henan (26), Shandong (24), Hong Kong (21), Guizhou (17), Xinjiang (10), Chongqing (7), Gansu (5), Shaanxi (5), Taiwan (5), Liaoning (4), Tianjin (4), Jilin (3), Tibet (3), Macau (2), Yunnan (2), Shanxi (2), and three imported cases were reported in Canada (2) and Malaysia (1).

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

ECDC assessment

This is the fifth winter season in the northern hemisphere with human cases caused by 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 February 2017, a new A(H7N9) virus with mutations in the haemagglutinin gene – indicating high pathogenicity in poultry – was detected in three cases related to Guangdong, as well as in environmental and poultry samples. It is unclear at the moment if the newly emerged, highly pathogenic avian influenza (HPAI) virus A(H7N9) will replace the low-pathogenic virus or if both will co-circulate in the bird population. Although the genetic changes in A(H7N9) may have implications for poultry in terms of pathogenicity, surveillance and control strategies, there is no evidence to date of increased transmissibility to humans or sustainable human-to-human transmission.

The continued transmission of A(H7N9) to humans in China poses the risk that sporadic imported cases may be detected in Europe. The following options for prevention and control of the infection should be considered:

- people travelling to China should avoid direct exposure to poultry and refrain from visiting live poultry markets or backyard farms
- travellers who have visited affected areas and develop respiratory symptoms and fever upon their return should consult a physician and mention their recent travel history to enable early diagnosis and treatment
- travellers who have visited affected areas should avoid entering farms for the entire duration of the 10-day incubation period (and during the symptomatic period in the event that they develop symptoms) in order to prevent a possible virus introduction to poultry in the EU.

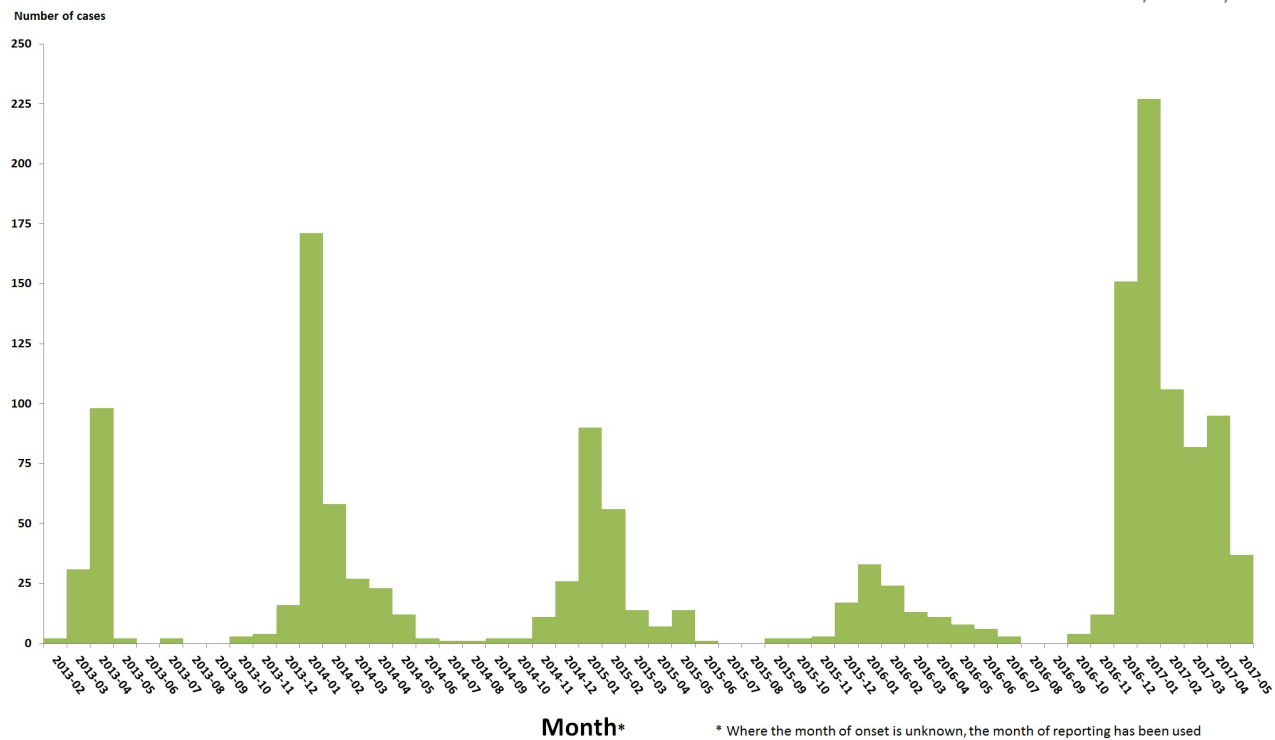
The possibility of humans infected with A(H7N9) returning to the EU/EEA cannot be excluded. However, the risk of the disease spreading within Europe via humans is still considered low, as there is no evidence of sustained human-to-human transmission.

Actions

ECDC published a sixth update of the [rapid risk assessment](#) on 9 March, addressing the genetic evolution of influenza A(H7N9) virus in China and the implications for public health.

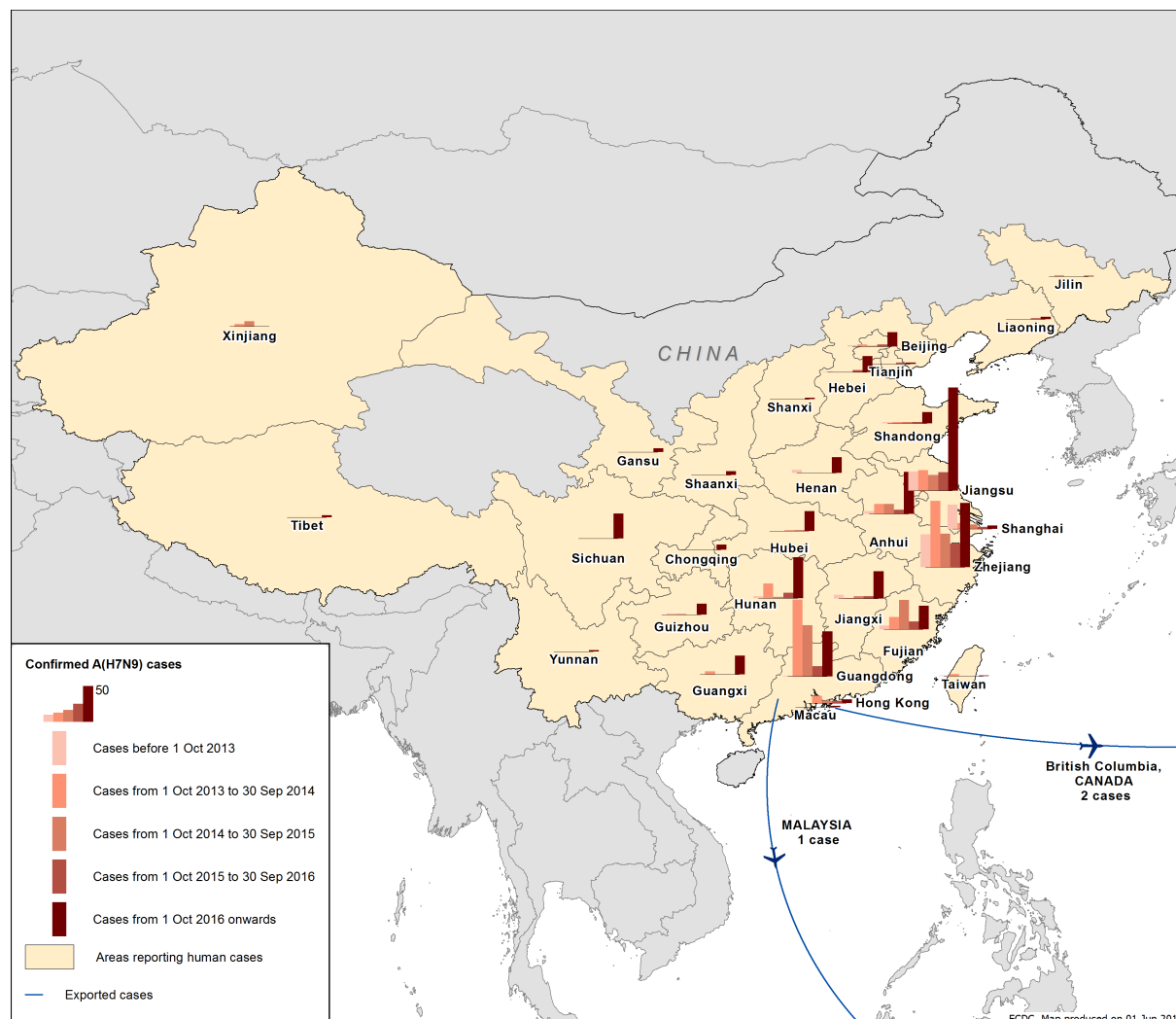
Distribution of confirmed cases of A(H7N9) by first available month, February 2013 to 31 May 2017

WHO, ECDC, Hong Kong



Distribution of confirmed cases of A(H7N9) by five periods (weeks 2013-7 to 2017-22)

ECDC



Ebola - Republic Democratic of Congo - 2017

Opening date: 15 May 2017

Latest update: 2 June 2017

Epidemiological summary

Since 22 April 2017 and as of 30 May, according to the latest WHO situation report, DRC authorities have reported two confirmed cases, three probable and 12 suspected cases in Bas Uele Province. Investigations and laboratory results confirmed an Ebola outbreak of subtype Zaire on 11 May. The cases are from four areas: Nambwa, Muma, Azande and Ngayi. As of 30 May, WHO acknowledged that 101 contacts remain under follow up for signs and symptoms of Ebola.

Response:

- A mobile lab was deployed on 20 May in Likati.
- An Ebola Treatment Centre has been implemented in Likati and a second one is under preparation in Muma.
- Active case finding and surveillance are ongoing.
- DRC, MSF, WHO and other partners are preparing to offer access to the rVSV EBOV experimental/investigational vaccine. The vaccine will be offered to contacts and contacts of contacts of a confirmed EVD case, including Healthcare Workers and Field laboratory workers.

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Source: [WHO](#) | [media](#)

ECDC assessment

This is the eighth outbreak of Ebola Virus Disease (EVD) in the Democratic Republic of the Congo (DRC) since the discovery of the virus in 1976. DRC national authorities have experience in responding to such outbreaks. However, this is the first time the Likati Health zone is affected and the local authorities have no or limited experience in managing such an outbreak. Investigations in DRC are ongoing to assess the extent of the outbreak. WHO and the Global Outbreak Alert and Response Network (GOARN) partners are supporting the national health authorities in the response. Although the outbreak is in an extremely remote area, Likati is situated on the migration route of refugees from the Central African Republic, which may pose a risk of spread of the disease in DRC.

For EU/EEA citizens living or travelling through DRC, the risk of exposure is negligible. For people who are entering the affected area such as healthcare workers supporting the response to the outbreak, the risk of infection remains very low assuming they follow the recommended precautions.

The risk of introduction in the EU is most likely to be related to an infected traveller coming from the affected area. This is most unlikely given the remote location of the outbreak, but cannot be excluded. The overall risk of the introduction and further spread of Ebola virus within the EU/EEA is therefore currently considered to be extremely low.

Actions

ECDC produced a [Rapid Risk Assessment](#) on Outbreak of Ebola virus disease in Bas Uele province, Democratic Republic of the Congo.

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