

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

New! Legionnaires' disease – Lithuania- 2017

Opening date: 14 March 2017

Latest update: 17 March 2017

From the beginning of 2017 to 16 March, Lithuania has reported three fatal cases of Legionnaires' disease among residents in Vilnius. Legionella has been detected in the hot water supply in two apartment blocks in Vilnius.

Influenza – Multistate (Europe) – Monitoring 2016/2017 season

Opening date: 13 October 2016

Latest update: 17 March 2017

Influenza transmission in Europe shows a seasonal pattern, with peak activity during winter months. ECDC monitors influenza activity in Europe during the winter season and publishes its weekly report on the [Flu News Europe website](#).

→Update of the week

During week 10-2017, influenza activity across the region, while decreasing, remained above levels observed during the out-of-season period.

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 17 March 2017

A measles outbreak in Romania has been ongoing since February 2016 and cases continue to be reported despite ongoing response measures that have been implemented at national level through reinforced vaccination activities. As of 10 March 2017, 3 446 cases had been reported to the National Institute of Public Health in Romania since the end of September 2016.

In 2016, a number of EU/EEA countries have reported measles outbreaks and an increase in the number of cases continues to be observed in 2017. Previous and ongoing measles outbreaks in three other EU countries have been epidemiologically linked to the current outbreak in Romania. However, additional knowledge on genotypic characterisation of the virus is needed to allow further insight into the epidemiological investigations.

→Update of the week

Since the last weekly update, measles cases were reported in Belgium, Denmark, France, Germany, Hungary, Italy, Spain, Sweden and Romania.

Non EU Threats

Yellow fever – South America – 2016/2017

Opening date: 16 January 2017

Latest update: 17 March 2017

Yellow fever is a mosquito-borne viral infection present in some tropical areas of Africa and South America.

In South America, there are two transmission cycles of yellow fever:

- A sylvatic cycle, involving transmission of the virus between *Haemagogus* or *Sabethes* mosquitoes and primates. The virus is transmitted by mosquitoes from primates to humans when humans are visiting or working in the forest.
- An urban cycle, involving transmission of the virus between *Aedes aegypti* mosquitoes and humans. The virus is usually introduced in an urban area by a viraemic human who was infected in the forest.

Brazil has been experiencing an outbreak of yellow fever since December 2016. The outbreak was notified on 6 January 2017. On 16 March, the authorities reported that no urban cases had been reported.

→Update of the week

Between 6 and 16 March 2017, **Brazil** reported 20 additional cases of yellow fever, mostly in Espírito Santo and Minas Gerais. On 15 March 2017, the state of Rio de Janeiro reported its two first confirmed autochthonous cases in the municipality of Casimiro de Abreu, located 135 km from the city of Rio de Janeiro.

On 10 March 2017, the Netherlands reported a confirmed case of yellow fever in a traveller returning from **Suriname**.

During week 10 of 2017, **Ecuador** reported a confirmed case of yellow fever in the province of Sucumbios, which borders Colombia. Prior to this case, the last confirmed yellow fever case in Ecuador was reported in 2012 in the province of Napo.

Increase in travel-associated Legionnaires' disease – Dubai, UAE – 2016/2017

Opening date: 10 November 2016

Latest update: 17 March 2017

The ECDC ELDSNet surveillance scheme on travel-associated Legionnaires' disease (TALD) has observed an increase in the number of legionellosis cases associated with travel to Dubai, United Arab Emirates (UAE) in the past few months. Since October 2016, ten EU Member States as well as Switzerland have reported 47 confirmed cases among travellers coming back from Dubai.

→Update of the week

On 14 March, England and Wales reported an additional case who visited Dubai from 9 to 16 February 2017 and who developed symptoms on 19 February 2017.

Influenza A(H7N9) – China – Monitoring human cases

Opening date: 31 March 2013

Latest update: 17 March 2017

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, and up to 16 March 2017, 1 307 cases have been reported to WHO, including at least 418 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. Five hundred and nine cases were reported since week 40/2016, representing a significant increase compared to previous seasons.

→Update of the week

Since the last update, WHO has posted details regarding 84 additional cases. The onset dates of the cases ranged from 26 January to 4 March 2017. Of the 84 cases, 78.5% (66) had exposure to poultry or visited poultry markets, six had no exposure to poultry, four were possibly due to human-to-human transmission, among the four, two had also exposure to poultry or live poultry markets, and for ten the exposure history is under investigation.

Three small clusters of possible human to human transmission were reported.

[WHO report 16/03/17](#) | [WHO report 15/03/17](#)

Poliomyelitis – Multistate (World) – Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 17 March 2017

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission of the virus has completely stopped and the world becomes polio-free. Polio was declared a public health emergency of international concern (PHEIC) by the World Health Organization (WHO) on 5 May 2014 due to concerns regarding the increased circulation and international spread of wild poliovirus during 2014. On 7 February 2017, the IHR [Emergency Committee](#) agreed that the international spread of poliovirus remains a PHEIC and recommended that the temporary recommendations should be extended for a further three months.

→Update of the week

Since the last report on 13 February 2017 and as of 14 March 2017, three new wild poliovirus type 1 (WPV1) cases have been reported in Afghanistan (1) and Pakistan (2). No circulating vaccine-derived poliovirus (cVDPV) cases have been reported worldwide.

Cholera – Multistate (World) – Monitoring global outbreaks

Opening date: 20 April 2006

Latest update: 17 March 2017

Cholera outbreaks are reported from several countries in Africa, Asia and the Americas. The current situation in Yemen and Somalia are of particular concern as cholera outbreaks are occurring during major humanitarian crises.

→Update of the week

In the Americas, Haiti reports a weekly decreasing number of cases in February 2017. Dominican Republic reported nine confirmed cases in 2017.

In Africa, outbreaks continue in South Sudan, the Democratic Republic of Congo and Mozambique. Since the beginning of 2017, Somalia reported 9 573 cases of cholera.

In Asia, the trend of reported cases in Yemen is declining. As of 1 March 2017, Philippines have reported around 200 cases of cholera on Cebu and Bohol Islands.

II. Detailed reports

New! Legionnaires' disease – Lithuania- 2017

Opening date: 14 March 2017

Latest update: 17 March 2017

Epidemiological summary

From beginning of 2017 to 16 March, Lithuania has reported three fatal case of Legionnaires' disease among residents in Vilnius. Samples have been collected from the hot water supply of each flat where the cases lived. Two buildings tested positive for Legionella and results are pending for the third. Authorities are performing thermal shock of the buildings' water systems.

Background

According to the Centre for Communicable Diseases and AIDS, Lithuania reported 11 cases of Legionnaires' disease in 2016.

Sources: [National Public Health Service \(NVSC\)](#) | [Centre for Communicable Diseases and AIDS](#) |

Actions

ECDC monitors this event through epidemic intelligence and is in contact with Lithuania through ELDSNet.

Influenza – Multistate (Europe) – Monitoring 2016/2017 season

Opening date: 13 October 2016

Latest update: 17 March 2017

Epidemiological summary

Week 10/2017 (6–12 March 2017)

Influenza activity across the region continued to decrease, with the majority of countries reporting low intensity. The proportion of influenza virus detections among sentinel surveillance specimens decreased from 27% to 21% in the previous week.

The majority of detected and subtyped influenza viruses were A(H3N2). While the proportion of type B viruses increased as commonly seen in the second half of an influenza season, their numbers remained low.

The number of reported hospitalised laboratory-confirmed influenza cases from ICU and other wards, primarily in people aged 65 years or older, as well as severe acute respiratory infections continued to decrease.

Season overview

Influenza activity started early this season in week 46-2016, which is the earliest week that the overall influenza-positivity rate in sentinel specimens reached 10% since the emergence of A(H1N1)pdm09 viruses in 2009/10.

Since week 40-2016, influenza A viruses have predominated, accounting for 94% of all sentinel detections; the great majority (99%) of subtyped influenza A viruses from sentinel sites being A(H3N2).

Confirmed cases of influenza virus type A infection reported from hospitals have predominantly been in adults aged over 65 years. Excess all-cause mortality has been observed substantially in people aged 15–64 years and markedly in people aged 65 years or older in the majority of the 19 reporting countries. This is commonly seen when the predominant viruses circulating are A(H3N2). Two-thirds of the A(H3N2) viruses genetically characterized belong to a recently emerged genetic subclade (3C.2a1). However, those that have been antigenically characterized are largely similar to the clade 3C.2a vaccine virus.

Recent vaccine effectiveness estimates for all age groups against A(H3N2) illness from [Canada](#) (42%), the [US](#) (43%) and [Europe](#) (38%) are consistent with estimates from [Stockholm](#) county (28%) and [Finland](#) (32%) earlier in the season.

Given typically suboptimal vaccination coverage and the partial effectiveness of influenza vaccines, rapid use of neuraminidase inhibitors (NAIs) for laboratory-confirmed or probable cases of influenza infection should be considered for vaccinated and non-vaccinated patients at risk of developing complications.

No reduced susceptibility to oseltamivir or zanamivir has been observed for any of the viruses tested so far this season.

The [WHO recommendations](#) for the composition of the 2017/2018 northern hemisphere vaccine, published on 2 March 2017, call for the replacement of the A(H1N1)pdm09 component with an A/Michigan/45/2015 A(H1N1)pdm09-like virus.

ECDC assessment

Influenza activity started early this season in week 46/2016, which is the earliest week that the overall influenza-positivity rate in sentinel specimens reached 10% since the emergence of A(H1N1)pdm09 viruses in 2009/10. The progression of the season confirms the conclusions of ECDC's latest [risk assessment](#) published on 25 January 2017. Severe outcomes are expected in the

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elderly because of the large circulation of A(H3N2), which could result in some healthcare systems experiencing additional pressure.

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](#).

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 17 March 2017

Epidemiological summary

EU/EEA Member States

Austria

Since the beginning of 2017 and as of 8 March, Austria has reported 69 cases of measles which exceeds the number of cases reported throughout 2016. No new cases were reported in the past week.

Belgium

Since 20 December 2016 and as of 8 March, Belgium has recorded 163 cases of measles in Wallonia. Half of the cases are hospitalised. Fifteen cases are among healthcare workers. The number of new cases per week is increasing.

Denmark

On 15 March 2017, Denmark reported an imported case of measles in an unvaccinated adult who got infected during holidays in Asia.

France

Since the beginning of 2017, measles cases are detected in several departments in France. Moselle is currently the most affected area with an outbreak of more than 50 cases as of 14 March 2017. In France 85% of the cases are unvaccinated.

Germany

Since the beginning of 2017 and by mid March, 203 cases have been reported in [Germany](#) compared to 326 throughout 2016. Of the 203 cases, 66 are from Hesse, 54 from Leipzig and 77 from Duisburg. According to [media](#), of the 66 cases in Hesse, 60 were in Wiesbaden city. Of the 77 cases in [Duisburg](#), 61 are children and 22 of them are younger than one year. Since January 2017 and as of 15 March, Berlin [reported](#) 31 cases. As of 3 March 2017, [Baden-Württemberg](#) reported 19 cases.

Hungary

Between 21 February and 8 March 2017, 13 cases of measles have been reported among [healthcare workers](#). According to [media](#), up to 13 March, there are 41 cases compatible with measles.

Italy

From the beginning of the year to mid-March 2017, [media](#), quoting authorities, has reported 700 cases. This represents an increase of 230% compared to the same time period in 2016. The majority of cases were reported in Piedmont, Lazio, Lombardy and Tuscany. Most of the cases are aged between 15 and 39 years. Additionally, since February 2017 in [Pescara](#), authorities report 75 cases in mainly unvaccinated young adults. Of the 75 cases, 25 are hospitalised.

Romania

Between 1 January 2016 and 10 March 2017, Romania reported 3 446 cases of measles, including 17 deaths. Cases are either laboratory-confirmed or have an epidemiological link to a laboratory-confirmed case. Infants and young children are the most affected population. Thirty-seven of the 42 districts report cases, Caras Severin (West part of the country, at the border with Serbia) being the most affected district with 728 cases. Vaccination activities are ongoing in order to cover communities with suboptimal vaccination coverage.

Spain

An outbreak started in the first week of January due to an imported measles case from China. As of 10 March, Barcelona and its

metropolitan area reported 35 confirmed cases of measles. The cases are mostly adults, who are either incompletely vaccinated or not vaccinated at all. Two of the cases are children. Six cases are hospitalised.

Sweden

In [Stockholm](#) three new cases related to each other were reported in the previous week. This brings the number of cases to ten, three adults and seven children.

ECDC assessment

The progress towards elimination of measles in the European Region of WHO 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 EU/EEA) were declared to have reached the elimination goal for measles, and an additional 13 countries (nine in EU/EEA) were concluded to have interrupted endemic transmission for less than 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 of measles: Belgium, France, Germany, Italy, Poland, Romania.

Source: [WHO - Europe](#)

Actions

ECDC has prepared a [Rapid Risk Assessment](#) published on 6 March 2017. ECDC monitors measles transmission and outbreaks in the EU/EEA on weekly basis through enhanced surveillance and epidemic intelligence activities.

Yellow fever – South America – 2016/2017

Opening date: 16 January 2017

Latest update: 17 March 2017

Epidemiological summary

Brazil:

On 6 January 2017, Brazil reported an outbreak of yellow fever. The index case had onset of symptoms on 18 December 2016. The first laboratory confirmation was notified on 19 January 2017.

Between 6 January and 16 March 2017, Brazil has reported 1 357 cases (933 suspected and 424 confirmed), including 249 deaths (112 suspected and 137 confirmed). The case-fatality rate is 18.3% among all cases and 32.3% among confirmed cases.

States reporting suspected and confirmed autochthonous cases:

- Minas Gerais has reported 1 074 cases (749 suspected and 325 confirmed), including 189 deaths (78 suspected and 111 confirmed).
- Espírito Santo has reported 243 cases (150 suspected and 93 confirmed), including 48 deaths (26 suspected and 22 confirmed).
- São Paulo has reported 15 cases (11 suspected and four confirmed), including four deaths (one suspected and three confirmed).
- Rio de Janeiro has reported three cases (one suspected and two confirmed), including one confirmed death.

States reporting suspected autochthonous cases:

- Bahia has reported eight suspected cases, including one fatal.
- Tocantins has reported six suspected cases, including one fatal.
- Rio Grande do Norte has reported one suspected case, fatal.
- Goiás has reported three suspected cases, not fatal.

In addition, investigations are ongoing to determine the probable infection site of four further suspected cases.

On 16 March 2017, authorities in the state of Rio de Janeiro [identified 47 municipalities](#) as a priority for the vaccination campaign, including the municipality of Casimiro de Abreu, where the two confirmed cases are reported.

The Ministry of Health of Brazil has launched mass vaccination campaigns in addition to routine vaccination activities. As of 16 March 2017, 16.15 million extra doses of yellow fever vaccine had been sent to five states: Minas Gerais (7.5 million), São Paulo (3.25 million), Espírito Santo (3.45 million), Rio de Janeiro (1.05 million) and Bahia (900 000).

Other countries in South America:

From week 1 to 10 of 2017, five other countries reported suspected and/or confirmed cases of yellow fever: Bolivia (1), Colombia (1), Ecuador (1), Peru (7) and Suriname (1).

Sources: [Brazil MoH](#) | [Rio de Janeiro MoH](#) | [RIVM](#) | [PAHO](#)

ECDC assessment

Given the geographical extension of the outbreak to municipalities in the state of Rio de Janeiro previously considered low risk, such as Casimiro de Abreu, in addition to considering recommending vaccination in line with the WHO recommendations on yellow fever vaccination, Member States should also consider recommending yellow fever vaccination for travellers aged over nine months going to rural areas in the state of Rio de Janeiro.

The ongoing outbreak should be carefully monitored, as the establishment of an urban cycle of yellow fever would have the potential to quickly affect a large number of people. EU/EEA citizens who travel to, or live in, areas where there is evidence of yellow fever virus transmission should check their vaccination status and obtain medical advice about being vaccinated against yellow fever.

In Europe, *Aedes aegypti*, the primary vector of yellow fever in urban settings, is present in Madeira. Recent studies have shown that *Aedes albopictus* can potentially transmit the yellow fever virus. However, the risk of the virus being introduced into local competent vector populations in the EU through viraemic travellers from Brazil is considered to be very low, as the current weather conditions in Europe are not favourable for vector activity.

Actions

ECDC closely monitors this event in collaboration with the World Health Organization. ECDC published a [rapid risk assessment on the outbreak of yellow fever in Brazil](#) on 26 January 2017 and a [rapid risk assessment on yellow fever among travellers returning from South America](#) on 15 March 2017. ECDC is also producing a [map for travel advice](#).

Increase in travel-associated Legionnaires' disease – Dubai, UAE – 2016/2017

Opening date: 10 November 2016

Latest update: 17 March 2017

Epidemiological summary

As of 17 March 2017, eleven countries have reported 47 TALD cases with illness onset between October 2016 and February 2017: the UK (22), Sweden (6), the Netherlands (5), Denmark (3), France (3), Germany (3), Austria (1), Belgium (1), Hungary (1), Spain (1) and Switzerland (1). One of the 47 cases died. The most recent illness onset was on 25 February 2017. Three cases with complete laboratory investigation are characterised as *Legionella pneumophila* serogroup 1 sequence type 616, which is not common in Europe, but has been identified among returning travellers from Dubai before.

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 returning from Dubai. However, it cannot be ruled out that some of these 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 February 2017 cannot only be explained by the increase in the number of travellers from the EU to Dubai.

Actions

ECDC monitors this event through ELDSNet. ECDC is analysing the investigation questionnaires and is in contact with EU Member States, the ELDSNet network, WHO and UAE for information sharing and assessment. ECDC posted an [epi-update](#) on 9 March 2017.

ECDC published a [rapid risk assessment](#) 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 RRA remain valid.

Influenza A(H7N9) – China – Monitoring human cases

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Opening date: 31 March 2013

Latest update: 17 March 2017

Epidemiological summary

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, and up to 3 March 2017, 1 307 cases have been reported to WHO, including at least 418 deaths. The A(H7N9) outbreak shows a seasonal pattern. Cases reported between weeks 41, and 40 in the subsequent year, are considered to belong to one epidemic wave. The first wave in spring 2013 (weeks 7/2013–40/2013) included 135 cases; 320 cases were reported during the second wave (weeks 41/2013–40/2014), 224 cases were reported during the third wave (weeks 41/2014–40/2015), and 119 were reported in wave four (weeks 41/2015–40/2016). A fifth wave started in October 2016 (week 41/2016), with 509 cases as of 16 March 2017.

The 1 258 cases have been reported from Zhejiang (298), Guangdong (247), Jiangsu (233), Fujian (98), Anhui (88), Hunan (63), Shanghai (55), Jiangxi (41), Hubei (24), Hong Kong (20), Shandong (14), Henan (11), Beijing (11), Xinjiang (10), Sichuan (8), Guizhou (8), Guangxi (6), Taiwan (5), Hebei (4), Liaoning (3), Macau (2), Yunnan (2), Tianjin (2), Jilin (2).

Three imported cases have been reported: one in Malaysia and two in Canada.

Web 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, to date, there is no evidence 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.

In addition, 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 a sustained human-to-human transmission.

Actions

ECDC published a sixth update of the [Rapid Risk Assessment](#) on 9 March 2017, addressing the genetic evolution of influenza A (H7N9) virus in China and the implications for public health.

Poliomyelitis – Multistate (World) – Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 17 March 2017

Epidemiological summary

In 2017, Afghanistan and Pakistan have both reported two cases of WPV1. In addition, Afghanistan and Pakistan reported one and eight positive samples of environmental WPV1, respectively.

Web sources: [Polio eradication: weekly update](#) | [ECDC poliomyelitis factsheet](#) | [Temporary Recommendations to Reduce International Spread of Poliovirus](#) | [WHO Statement on the Seventh Meeting of the International Health Regulations Emergency](#)

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[Committee on Polio](#)

ECDC assessment

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

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

Actions

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

Cholera – Multistate (World) – Monitoring global outbreaks

Opening date: 20 April 2006

Latest update: 17 March 2017

Epidemiological summary

Americas

During the first two weeks of 2017, the [Dominican Republic](#) reported nine cases of cholera, including two deaths (CFR: 22.2%).

During the first six weeks of 2017, [Haiti](#) reported 2 260 cases of cholera, including 35 deaths (CFR: 1.5%), in all ten departments. During the same period in 2016, Haiti reported 6 560 cases.

Africa

Between 1 January and 3 March 2017, the [Democratic Republic of the Congo](#) reported 5 829 cases of cholera, including 203 deaths (CFR: 3.5%), in 15 of the 18 provinces. According to [media](#), cholera incidence has remained very high in the beginning of 2017, notably in the provinces around the Congo River.

According to media quoting the Ministry of Health, since the beginning of 2017 [Mozambique](#) reported 1 222 cases of cholera, including two deaths (CFR: 0.2%), in four of the 13 provinces.

Between 27 February and 4 March 2017, [Somalia](#) reported 1 839 cases of cholera, including 48 deaths (CFR: 2.6%). This brings the number of cases since the beginning of 2017, to 9 573, including 228 deaths (CFR: 2.4%). This is a significant increase compared to the same period in 2016. According to [media](#) quoting the Prime Minister, at least 110 people died of cholera during this week in Bay Region, amid severe drought.

Between 5 and 11 March 2017, [South Sudan](#) reported 15 cases of cholera, compared to 75 during the previous week. The cases occurred in Yirol East (13) and Malakal Town (2). This brings the number of cases since June 2016 to 5 574, including 137 deaths (CFR: 2.5%). According to [media](#), the outbreak, which was already affecting the largest city Juba, has now reached the second-largest city Malakal.

According to media, [Zambia](#) has reported 27 cases of cholera between 14 February and 2 March 2017 in Luopula Province.

Asia

As of 1 March 2017, according to media quoting the Department of Health, the [Philippines](#) have reported nearly 200 cases of cholera, including one death (CFR: 0.5%), on Cebu and Bohol Islands. According to [media](#), a South Korean citizen contracted cholera after travelling to Cebu Island in February.

Between 26 February and 7 March 2017, [Yemen](#) has reported 1 598 cases of cholera, with no deaths. The weekly number of cases is decreasing in most districts and governorates. Since the beginning of the outbreak in October 2016, Yemen has reported 22 181 cases of cholera, including 103 deaths (CFR: 0.5%).

Source: [Cholera platform](#) | [Haitian MoH](#) | [media](#)

ECDC assessment

European travellers should seek information on how to prevent cholera infection prior to visiting affected areas.

Actions

ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology. Reports are published on a monthly basis.

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