

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

West Nile virus - Multistate (Europe) - Monitoring season 2016

Opening date: 30 May 2016

Latest update: 10 June 2016

During the June to November transmission season, ECDC monitors the situation in EU Member States and neighbouring countries in order to inform blood safety authorities of WNF-affected areas and identify significant changes in the epidemiology of the disease.

→Update of the week

ECDC started the seasonal monitoring of West Nile fever last week. As of 9 June, no human cases of West Nile fever have been reported in the EU and neighbouring countries.

Outbreak of Enterovirus A71 - Catalonia, Spain - 2016

Opening date: 30 May 2016

Latest update: 10 June 2016

An outbreak of enterovirus with neurological complications has been ongoing in Catalonia since mid-April 2016 mostly affecting children. The causative agent has been identified as enterovirus A71. As of 7 June, 87 probable (encephalitis, in particular rhomboencephalitis, or acute flaccid paralysis and altered NMR) cases have been detected, most of which have developed favourably. Eleven of these 87 cases required Intensive Care Unit admission. No fatalities were reported. A confirmed case is defined as a probable case with positive enterovirus detection. The cases are widespread in Catalonia and no epidemiological link between cases has been identified. No cases have been reported from other regions in Spain.

→Update of the week

As of 6 June, 87 probable cases have been detected, most of which have developed favourably. Eleven of these 87 cases required ICU admission. No fatalities were reported.

UEFA EURO 2016 - mass gathering - France

Opening date: 23 May 2016

Latest update: 10 June 2016

The UEFA football cup takes place from 10 June to 10 July 2016 in ten venues in France. Twenty-four European teams participate. The majority of the participating teams are from EU countries with the exception of Ukraine, Turkey, Switzerland, Albania and Russia. ECDC has enhanced epidemic intelligence activities to target communicable disease-related events that may occur during the games. The enhanced monitoring starts one week prior to the event and will continue until one week after its end.

→Update of the week

The UEFA football cup starts this Friday 10 June. No relevant communicable disease-related events have been reported so far.

Non EU Threats

Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 10 June 2016

Europe is experiencing its largest influx of refugees since the Second World War. According to the UN Refugee Agency (UNHCR), more than one million refugees arrived in Europe in 2015 and around 150 000 in 2016. To date, there have been reports of cases of acute respiratory tract infections, louse-borne relapsing fever, cutaneous diphtheria, scabies, measles, meningococcal meningitis, shigellosis, typhoid fever, hepatitis A, tuberculosis and malaria among refugees. While these cases do not represent a significant disease burden for the host countries, the diseases pose a potential threat, particularly to the health of the refugees themselves.

→Update of the week

According to the media in France, in one camp in Paris, 1 200 migrants, mainly originating from sub-Saharan Africa, have been relocated due to flooding. Three tuberculosis cases have been identified among migrants.

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 10 June 2016

As of 10 June 2016, 51 countries and territories have reported autochthonous cases of Zika virus infection during the past nine months. On 1 February 2016, WHO declared that Zika virus infection and the related clusters of microcephaly cases and other neurological disorders constitute a public health emergency of international concern (PHEIC). There is now a scientific consensus that Zika virus is a cause of microcephaly and Guillain-Barré syndrome.

→Update of the week

In the week to 8 June 2016, Indonesia reported an autochthonous Zika virus infection.

Yellow fever outbreak- Multistate (world) - Monitoring global outbreaks

Opening date: 17 March 2016

Latest update: 10 June 2016

An outbreak of yellow fever in Angola started in December 2015 in the municipality of Viana, Luanda province and spread to all 18 provinces of Angola. The neighbouring Democratic Republic of Congo (DRC) reports both imported and autochthonous cases of yellow fever. An outbreak of yellow fever, not linked to the outbreak in Angola, has been reported in several districts in Uganda. Another unrelated outbreak of yellow fever is reported in Peru.

→Update of the week

In Africa, outbreaks of yellow fever are ongoing in Angola (2 954 suspected cases), DRC (819 suspected cases) and Uganda (68 suspected cases). Further three countries have reported suspected cases of yellow fever in Africa since the beginning of June: Republic of Congo (one case), Ethiopia (22 cases) and Ghana (4 cases). The two suspect cases previously reported in Sao Tome and Principe have been discarded. For both cases, a previous yellow fever vaccination was fully documented.

Yellow fever cases in people who travelled from Angola have been reported in China (11 cases), Democratic Republic of the Congo (51 confirmed cases) and Kenya (two cases).

Peru is experiencing an outbreak of yellow fever since the beginning of the year. As of 8 June 2016, there were 52 suspected yellow fever cases with four deaths.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 10 June 2016

The largest-ever epidemic of Ebola virus disease (EVD) mainly affected Guinea, Liberia and Sierra Leone between 2014 and 2015. On 8 August 2014, the World Health Organization (WHO) declared the Ebola epidemic in West Africa a Public Health Emergency of International Concern (PHEIC). As of 11 May 2016, WHO has reported 28 616 cases of Ebola virus disease related to the outbreak in West Africa, including 11 310 deaths. On 29 March 2016, WHO declared the end of the PHEIC and advised that all temporary recommendations previously adopted should now be terminated. Sierra Leone declared the end of Ebola human-to-human transmission on 17 March 2016 and Guinea on 1 June 2016 following the last flare ups.

→Update of the week

There have been no new cases reported since 10 April 2016. On 9 June, [WHO](#) declared the end of the most recent outbreak of Ebola virus disease in Liberia.

Middle East respiratory syndrome – coronavirus (MERS CoV) – Multistate

Opening date: 24 September 2012

Latest update: 10 June 2016

Since April 2012 and as of 9 June 2016, 2016, 1 753 cases of MERS, including 680 deaths, have been reported by health authorities worldwide. The source of the virus remains unknown, but the pattern of transmission and virological studies point towards dromedary camels in the Middle East as being a reservoir from which humans sporadically become infected through zoonotic transmission. Human-to-human transmission is amplified among household contacts and in healthcare settings.

→Update of the week

Since the last update on 18 May 2016, two additional cases of MER-CoV were reported by Saudi Arabia. Both cases were classified as primary cases. The cases came from Riyadh and Tabuk.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 10 June 2016

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) on 5 May 2014 due to concerns regarding the increased circulation and international spread of wild poliovirus during 2014. On 20 May 2016, in the 9th meeting of the emergency committee, the temporary recommendations in relation to the PHEIC were extended for another three months. The World Health Organization recently declared wild poliovirus type 2 eradicated worldwide.

→Update of the week

During the past week, no wild poliovirus cases or circulating vaccine-derived poliovirus cases were reported.

II. Detailed reports

West Nile virus - Multistate (Europe) - Monitoring season 2016

Opening date: 30 May 2016

Latest update: 10 June 2016

Epidemiological summary

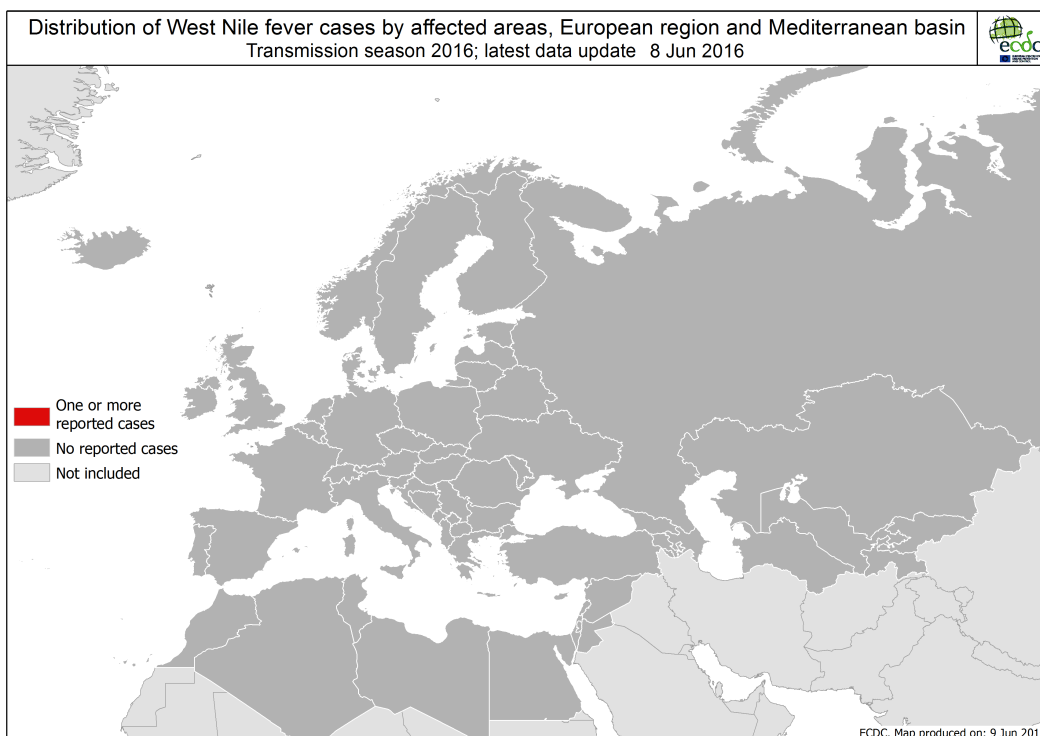
In week 22, 2016 ECDC started the seasonal monitoring of West Nile fever and will publish updated [West Nile maps](#) for the 2016 transmission season. As of 9 June, no human cases of West Nile fever have been reported in the EU and neighbouring countries.

ECDC assessment

West Nile fever in humans is a notifiable disease in the EU. The implementation of control measures are considered important for ensuring blood safety by the national health authorities when human cases of West Nile fever occur. According to the [EU blood directive](#), efforts should be made to defer blood donations from affected areas with ongoing virus transmission.

Actions

From week 22 onwards, ECDC is producing weekly West Nile fever (WNF) risk maps during the transmission season (June-November) to inform blood safety authorities regarding WNF affected areas.



Outbreak of Enterovirus A71 - Catalonia, Spain - 2016

Opening date: 30 May 2016

Latest update: 10 June 2016

Epidemiological summary

An outbreak of enterovirus with neurological complications caused by enterovirus has been ongoing in Catalonia since mid-April 2016 affecting children. As of 7 June, 87 cases of enterovirus infection with neurological complications have been reported, most of which have evolved favourably. As of 6 June, 11 of these cases have been admitted in ICUs. No fatalities have been reported. The cases are widespread in Catalonia. No cases have been identified from other areas in Spain.

For 82 of 87 cases who were documented as of 3 June, the onset of symptoms ranges from 10 April to 28 May, with a peak

detected between 11 and 15 May. The age of the cases varies between three months and eight years (with 57% of cases between 1 and 2 years of age and 22% between 3 and 4 years). 58% of cases are male and 42% are female. 28% of cases are classified as probable (encephalitis, in particular rhomboencephalitis, or acute flaccid paralysis and altered NMR) and 72% are confirmed (probable case with positive sample for enterovirus). The main clinical symptoms associated with the cases are seizures, drowsiness and myoclonia. Eleven patients (13%) have been hospitalised in ICUs, out of which only six were still admitted as of 6 June. According to the information received from regional authorities, there are no deaths related to this outbreak. Follow-up of cases will be carried out according to local clinical protocols.

In the current outbreak, both stool and respiratory specimens have been collected and found positive for EV-A71. The proportion of positive specimens is as follows: 1/3 tested CSF samples, 9/12 tested stool samples and 15/16 tested nasopharyngeal swab specimens were positive for EV-A71. Two specimens (one CSF and one stool specimen) have EV-A71 results still pending further analysis. This finding is consistent with the predominant circulation of EV-A71 this year in Spain according to the information obtained from the EV surveillance system in Spain.

Web sources: [Department of Health, Catalonia](#) | [Media](#)

ECDC assessment

Enterovirus A71 (EV-A71) is a major cause of hand, foot and mouth disease (HFMD) and is particularly prevalent in parts of Southeast Asia, affecting thousands of children and infants each year. There are only four larger outbreaks of EV-A71 in Europe documented in the published literature. The last epidemics of EV-A71 infection in Europe occurred in Bulgaria in 1975 with over 705 cases, of which 149 cases developed paralysis and 44 died. Hungary experienced an outbreak of EV-A71 in 1978 involving 323 cases (13 poliomyelitis-like paralysis, 145 encephalitis, 161 aseptic meningitis, 4 HFMD).

EV-A71 infection is transmitted from person to person by direct contact with nose and throat discharges, saliva, fluid from blisters, or the stool of infected persons and therefore outbreaks are difficult to control. The virus can also be shed up to 11 weeks after recovery in stool, which makes the transmission within close contacts possible even when no symptoms in the primary case are visible. EV-A71 is the most neuropathogenic non-polio enterovirus in humans causing a variety of neurological diseases including aseptic meningitis, encephalitis, brainstem encephalitis and poliomyelitis-like paralysis and any outbreak of it needs therefore careful assessment. As many of the patients in Catalonia have presented with severe illness requiring admission to intensive care, the epidemic causes considerable burden on paediatric intensive care units.

Actions

ECDC is preparing a RRA to be released shortly.

UEFA EURO 2016 - mass gathering - France

Opening date: 23 May 2016

Latest update: 10 June 2016

Epidemiological summary

The UEFA football cup takes place from 10 June until 10 July 2016 in ten venues in France. Twenty-four European teams participate. The majority of the participating teams are from EU countries with the exception of Ukraine, Turkey, Switzerland, Albania and Russia. ECDC has enhanced epidemic intelligence activities to target communicable disease-related events that may occur during the games. The enhanced monitoring starts one week prior to the event and continues until one week after its end. No relevant communicable disease-related events have been reported so far.

ECDC assessment

Mass gathering events involve a large number of visitors present in an area at the same time. This may increase the risk of communicable disease outbreaks and non-communicable health risks, including heat stroke, crowd injury and drug- and alcohol-related conditions.

Actions

During June 2016, ECDC will undertake enhanced event-based daily surveillance as part of its routine epidemic intelligence activities. The epidemic intelligence team will adapt the media screening tools and its daily procedures to assist detecting infectious disease threats in hosting and participating countries which are relevant for the event. Detected events requiring further attention will be reported through the weekly CDTR.

Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 10 June 2016

Epidemiological summary

Emerging episodes of communicable diseases have been reported to affect the refugee population, including acute respiratory tract infections, louse-borne relapsing fever, cutaneous diphtheria, scabies, measles, meningococcal meningitis, shigellosis, typhoid fever, hepatitis A, tuberculosis and malaria.

ECDC assessment

Refugees are currently not a threat to Europe with respect to communicable diseases, but they are a priority group for communicable disease prevention and control efforts as they are more vulnerable.

[WHO, UNHCR and UNICEF](#) jointly recommend that refugees, asylum seekers and migrants should have non-discriminatory, equitable access to healthcare services, including vaccines, irrespective of their legal status. They should be provided with timely immunisation against vaccine-preventable diseases, particularly measles and polio. All countries should have effective disease surveillance and reporting systems, outbreak investigation ability and case management and response capacity.

The risk to European residents of being affected by outbreaks occurring among refugee populations remains extremely low.

Actions

Two EPIET fellows are currently deployed to Greece to support communicable disease surveillance and response operations.

An [ECDC expert opinion](#) on the public health needs of irregular migrants, refugees or asylum seekers across the EU's southern and south-eastern borders was published on the ECDC website in September 2015.

ECDC prepared:

- an [RRA](#) on the risk of communicable disease outbreaks in refugee populations in the EU/EEA
- an updated [RRA](#) on louse-borne relapsing fever amongst migrants in the EU/EEA
- an [RRA](#) on cutaneous diphtheria among recently arrived refugees and asylum seekers in the EU
- an [RRA](#) on the risk of importation and spread of malaria and other vector-borne diseases associated with the arrival of migrants in the EU
- an [RRA](#) on shigellosis among refugees in the EU.

ECDC, in collaboration with Member States, the European Commission and WHO, continues to closely monitor the situation to rapidly identify and assess potential communicable disease threats.

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 10 June 2016

Epidemiological summary

EU/EEA imported cases:

As of 10 June 2016, ECDC has recorded 780 imported cases in 20 EU/EEA countries. Fourty of the imported cases are pregnant women. The number of imported cases reported is not based on a systematic reporting surveillance system hence cannot be considered exhaustive.

EU's Outermost Regions and Territories:

Martinique: As of 9 June 2016, 28 910 suspected cases have been reported, an increase of 1 120 since last week. Two microcephaly cases and two additional congenital malformations have been reported with confirmed Zika virus infection. In addition, 21 cases with GBS have been detected. Among these, 19 have been confirmed with Zika virus infection.

French Guiana: As of 9 June 2016, 7 540 suspected cases have been reported, an increase of 365 since last week. Three cases with GBS have been identified since the beginning of the outbreak.

Guadeloupe: As of 9 June 2016, 10 180 suspected cases have been reported, an increase of 2 355 suspected cases since last week. Three cases with severe neurological complications have been reported and confirmed with ZVD.

St Martin: As of 9 June 2016, 690 suspected cases have been reported, an increase of 155 suspected cases since last week. One case with neurological complications has been reported.

St Barthélemy: As of 9 June 2016, 50 suspected cases have been reported, an increase of 12 suspected cases since last week.

Update on microcephaly and /or central nervous system (CNS) malformations potentially associated with Zika virus infection:

Congenital malformations associated with Zika virus infection have been reported by eleven countries or territories. In the EU, Spain and Slovenia report some congenital malformations cases associated with travel in the affected area.

Thirteen countries and territories worldwide have reported an increased incidence of Guillain-Barré syndrome (GBS) and/or laboratory confirmation of a Zika virus infection among GBS cases.

Brazil: Since October 2015 and as of 4 June 2016, Brazil has reported 7 830 suspected cases of microcephaly and other nervous system disorders suggestive of congenital infection from 27 states. Of these cases, 1 551 are microcephaly confirmed cases, 224 of which are laboratory-confirmed for Zika virus infection. This is an increase of 62 suspected cases since the last update on 28 May.

Web sources: [ECDC Zika Factsheet](#) | [PAHO](#) | [Colombian MoH](#) | [Brazilian MoH](#) | [Brazilian microcephaly case definition](#)

ECDC assessment

The spread of the Zika virus epidemic in the Americas is likely to continue as the vectors (*Aedes aegypti* and *Aedes albopictus* mosquitoes) are widely distributed there. The likelihood of travel-related cases in the EU is increasing. A detailed risk assessment is available [here](#).

As neither treatment nor vaccines are available, prevention is based on personal protection measures. Pregnant women should consider to postpone non-essential travel to Zika-affected areas.

ECDC assessment is however limited by the absence of regular notification at state level of the cases of Zika virus disease in Brazil. A close monitoring of surveillance data would be needed, especially as the Olympic Games are approaching.

Actions

ECDC publishes an [epidemiological update](#) every Friday and [maps](#) with information on countries or territories which have reported confirmed autochthonous cases of Zika virus infection.

Yellow fever outbreak- Multistate (world) - Monitoring global outbreaks

Opening date: 17 March 2016

Latest update: 10 June 2016

Epidemiological summary

7/14

In Angola, as of 8 June 2016, 2 954 cases and 328 deaths have been reported since the beginning of the outbreak in December 2015. Of these, 819 cases are confirmed.

The Democratic Republic of Congo has reported 819 suspected cases and 57 laboratory-confirmed cases as of 8 June: 51 imported from Angola, 35 cases reported in Kongo central province, 10 reported in Kinshasa province, and 5 reported in Kwango province. The place of reporting is not identified for one of the cases. Two sylvatic autochthonous cases have also been reported: one in Bas-Uele province and one in Tshuapa province since the beginning of the year.

In Uganda, health authorities reported 68 yellow fever cases of which seven have been laboratory confirmed, including seven deaths between 26 March and 4 June 2016.

As of 8 June 2016, Peruvian authorities report 52 yellow fever cases in the country since the beginning of the year. Most of these cases are reported from Junin department (35). However, one case is reported in the capital, Lima and three cases are from Cusco which is a tourist area. This outbreak is not related to the current African outbreaks.

Web sources: [ECDC factsheet](#) / [WHO yellow fever page](#) | [WHO AFRO](#) | [WHO SitRep 2 June2016](#) | [WHO-DRC](#) | [PAHO](#) | [MoH Peru](#) | [ECDC updated risk assessment](#)

ECDC assessment

WHO estimates that 508 million people living in 31 African countries are at risk for transmission of yellow fever. Therefore, the large outbreak of yellow fever in Angola is of concern with regards to the risk of introduction of the virus through viraemic travellers to countries at risk of transmission, especially in neighbouring countries. Yellow fever in an urban setting is considered as a public health emergency that may result in a large number of cases. Vaccination is the single most important measure for preventing yellow fever. The outbreak in Angola is not yet controlled and is currently expanding to additional provinces challenging the ongoing mass vaccination campaign. The control of the outbreak in Angola is needed in order to prevent further spread in the region and beyond. Concerns exist that if yellow fever should spread to other countries in Africa and Asia there would be a need to further prioritise vaccine supplies, which would interrupt routine immunisation programmes in some countries.

In DRC, the confirmation of autochthonous circulation in the capital is a major concern as Kinshasa is highly populated, representing a risk of extension to Brazzaville, the capital of Republic of the Congo, that is located across the Congo river.

Proof of vaccination is required for all travellers aged 9 months and above entering Angola and DRC. WHO recommends vaccination for all travellers older than 9 months of age in areas where there is evidence of persistent or periodic yellow fever virus transmission. European citizens travelling to or residing in Angola should be vaccinated against yellow fever as per their national health authorities' recommendations. Vaccine should be administered at least 10 days before travelling.

The competent vector for yellow fever, the *Aedes aegypti* mosquito, is not present in continental EU but is present in the island of Madeira, an autonomous region of Portugal where the weather conditions will be suitable soon for mosquito activity.

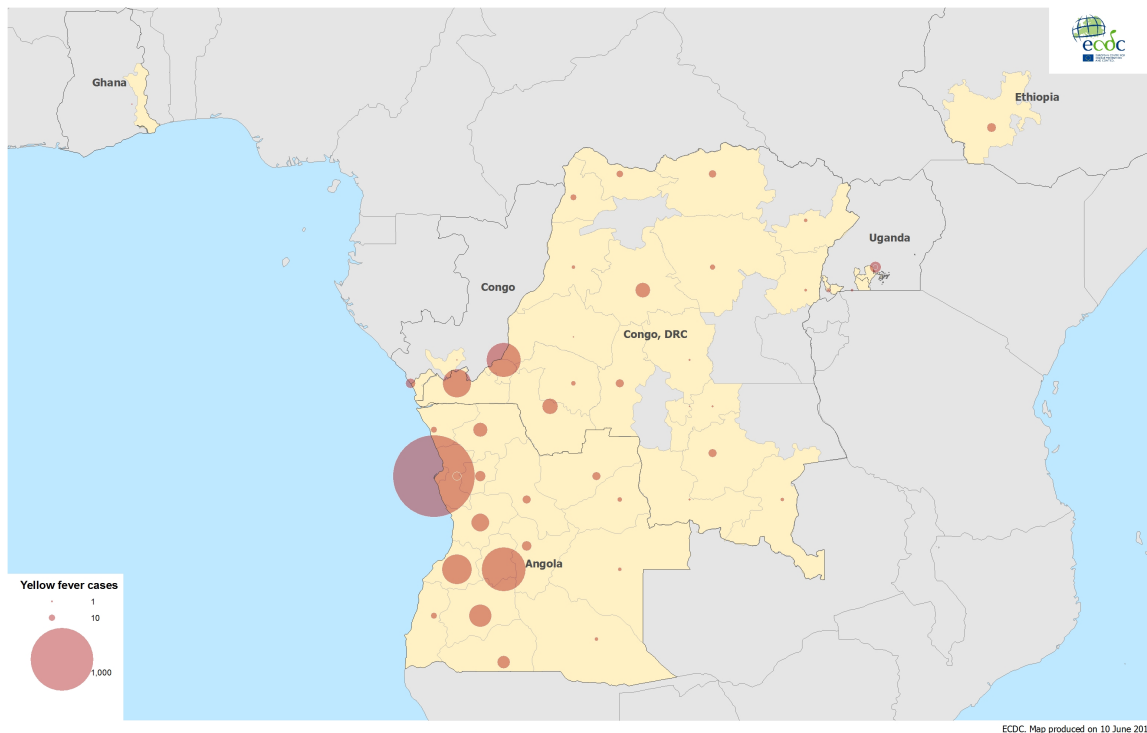
Actions

More than ten million people in Angola have been vaccinated through a large-scale vaccination campaign since the beginning of February, using vaccines mobilised through the yellow fever vaccine emergency stockpile made available through the International Coordinating Group for Vaccine Provision, with support from Gavi, the UN Central Emergency Response Fund, and a vaccine donation from Brazil.

ECDC published a [rapid risk assessment](#) on 25 March 2016 and an updated [risk assessment](#) on 30 May 2016.

Yellow fever cases distribution in Africa, week 1 to 24, 2016

ECDC



Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 10 June 2016

Epidemiological summary

On 9 June 2016, WHO declared the end of the most recent outbreak of Ebola virus disease in Liberia. This date marks the fourth time since the start of the epidemic two years ago that Liberia has reported zero cases for at least 42 days.

Official WHO figures published on 11 May 2016:

- **Guinea:** 3 804 cases including 2 536 deaths.
- **Liberia:** 10 666 cases, including 4 806 deaths.
- **Sierra Leone:** 14 122 cases, including 3 955 deaths.

Sierra Leone declared the end of Ebola human-to-human transmission on 17 March 2016, Guinea on 1 June 2016 and Liberia on 9 June 2016.

9/14

Seven countries have reported an initial case or localised transmission: Nigeria, Senegal, the USA, Spain, Mali, the UK and Italy.

Web sources: [ECDC Ebola page](#) | [ECDC Ebola and Marburg fact sheet](#) | [WHO situation summary](#) | [WHO Roadmap](#) | [WHO Ebola Factsheet](#) | [CDC](#) | [Ebola response phase 3: Framework for achieving and sustaining a resilient zero](#) | [ReEBOV Antigen Rapid Test Kit](#) | [Institut Pasteur will open a lab in Conakry](#) | [Emergency Operation Centres in the three affected countries](#) | [Entry screening in US](#) | [media Liberia](#) | [WHO](#) | [media](#)

ECDC assessment

The risk of additional outbreaks from exposure to infected body fluids of survivors remains. This highlights the importance of maintaining heightened surveillance and early detection of cases during the coming months.

Actions

An [epi-update](#) was published on 23 March 2016.

On 16 October 2015, ECDC published the latest (13th) update of the [rapid risk assessment](#).

On 16 October 2015, ECDC published [Recent development on sexual transmission of Ebola virus](#).

On 31 July 2015, ECDC published [Positive preliminary results of an Ebola vaccine efficacy trial in Guinea](#).

On 22 January 2015, ECDC published [Infection prevention and control measures for Ebola virus disease. Management of healthcare workers returning from Ebola-affected areas](#).

On 4 December 2014, EFSA and ECDC published a [Scientific report assessing risk related to household pets in contact with Ebola cases in humans](#).

On 29 October 2014, ECDC published a training tool on the [safe use of PPE and options for preparing for gatherings in the EU](#).

On 23 October 2014, ECDC published [Public health management of persons having had contact with Ebola virus disease cases in the EU](#).

On 22 October 2014, ECDC published [Assessing and planning medical evacuation flights to Europe for patients with Ebola virus disease and people exposed to Ebola virus](#).

On 13 October 2014, ECDC published [Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures](#).

On 6 October 2014, ECDC published [risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU](#).

On 22 September 2014, ECDC published [assessment and planning for medical evacuation by air to the EU of patients with Ebola virus disease and people exposed to Ebola virus](#).

On 10 September 2014, ECDC published an [EU case definition](#).

Middle East respiratory syndrome – coronavirus (MERS CoV) – Multistate

Opening date: 24 September 2012

Latest update: 10 June 2016

Epidemiological summary

As of 9 June 2016, 1 753 cases of MERS, including 680 deaths, have been reported by health authorities worldwide.

Web sources: [ECDC's latest rapid risk assessment](#) | [ECDC novel coronavirus webpage](#) | [WHO](#) | [WHO MERS updates](#) | [WHO travel health update](#) | [WHO Euro MERS updates](#) | [CDC MERS](#) | [Saudi Arabia MoH](#) | [Saudi Arabia statement](#) | [ECDC factsheet for professionals](#)

ECDC assessment

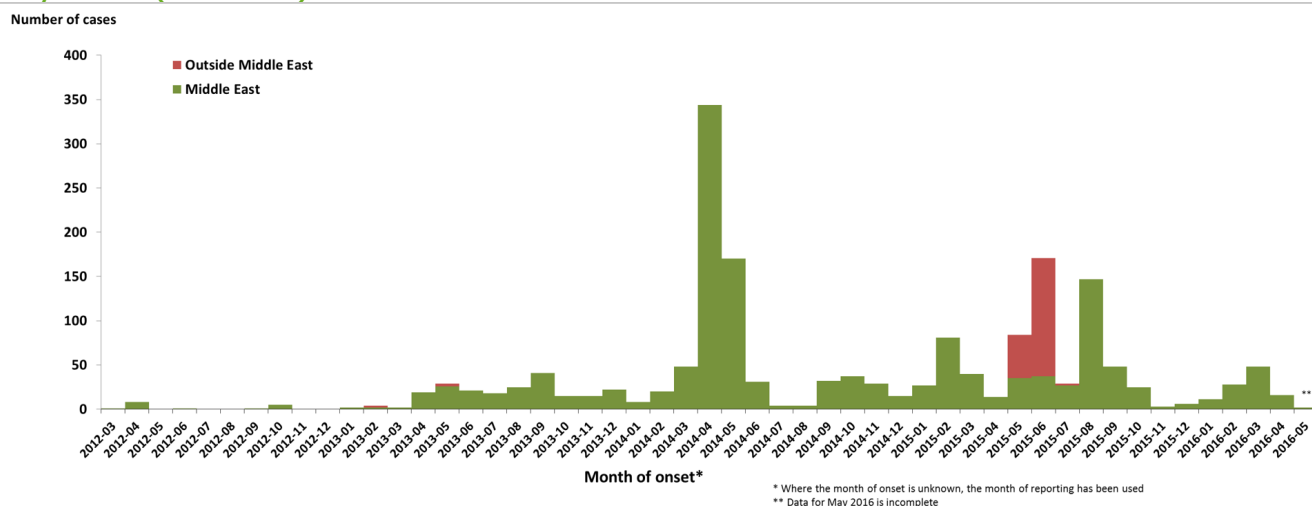
The MERS outbreak in the Middle East poses a low risk to the EU. Efforts to contain the nosocomial clusters in the affected countries are vital to prevent wider transmission. Although it is likely that zoonotic transmission is the starting point of most clusters, human-to-human transmission is the most common mode of transmission for MERS-CoV. Human-to-human transmission occurs mostly in healthcare settings and, to a much more limited extent, within communities, mainly within households. So far, the majority of cases have been reported from hospital outbreaks in Saudi Arabia, the United Arab Emirates and South Korea.

Most nosocomial transmissions occur when infection prevention and control precautions are suboptimally applied and before a specific case is suspected or confirmed. The successful prevention of amplification of MERS-CoV infections associated with healthcare facilities depends on the effective implementation of infection prevention and control programmes.

Actions

ECDC published the 21st update of its MERS CoV [rapid risk assessment](#) on 21 October 2015.

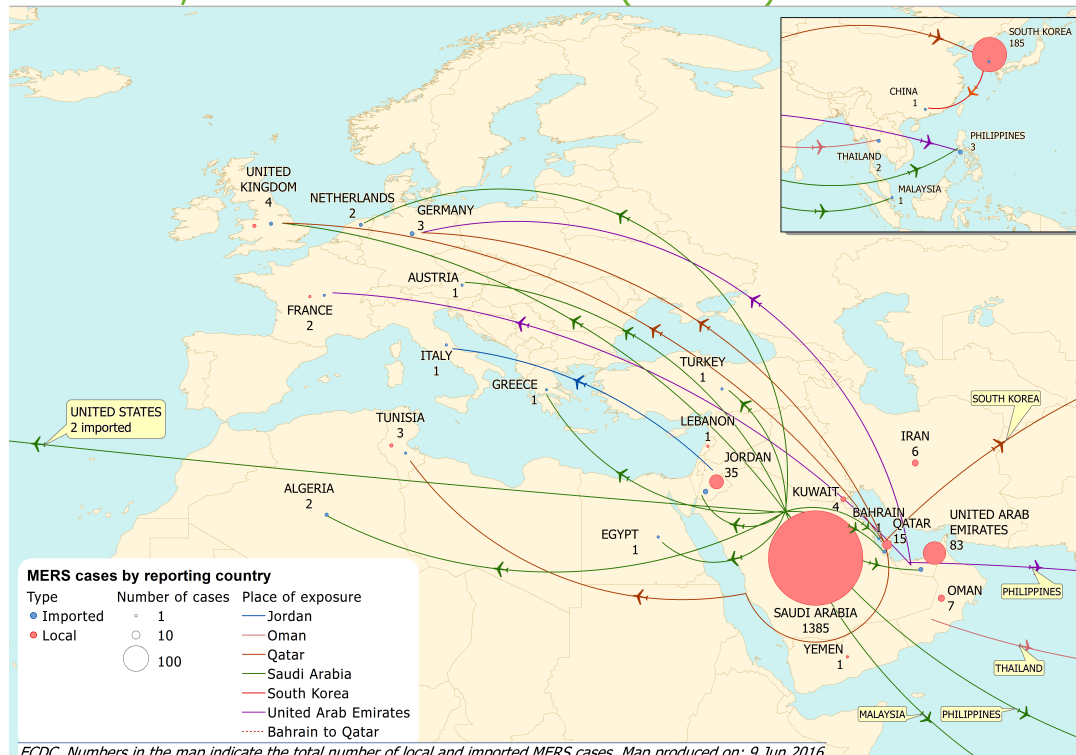
Distribution of confirmed cases of MERS-CoV by region of reporting, March 2012 – 31 May 2016 (n=1 751)



Distribution of confirmed cases of MERS-CoV by country of reporting, March 2012 – 9 June 2016 (n=1 753)

Region	Country	Number of cases	Number of deaths
Middle East	Saudi Arabia	1385	592
	United Arab Emirates	83	12
	Qatar	15	5
	Jordan	35	14
	Oman	7	3
	Kuwait	4	2
	Egypt	1	0
	Yemen	1	1
	Lebanon	1	0
	Bahrain	1	0
Europe	Turkey	1	1
	UK	4	3
	Germany	3	2
	France	2	1
	Italy	1	0
	Greece	1	1
	Netherlands	2	0
Africa	Tunisia	3	1
	Algeria	2	1
Asia	Malaysia	1	1
	Philippines	3	0
	South Korea	185	38
	China	1	0
	Thailand	2	0
Americas	United States of America	2	0
Global		1753	680

Distribution of confirmed cases of MERS-CoV by first available date, and probable place of infection, March 2012 – 9 June 2016 (n=1 753)



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 10 June 2016

Epidemiological summary

In 2016, sixteen cases of wild poliovirus type 1 (WPV1) have been reported, compared with 27 cases for the same period in 2015. The cases were detected in Pakistan (11 cases) and in Afghanistan (five cases).

As of 3 June 2016, three cases of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO in 2016, all from Laos. There were 2 cVDPV cases during the same period in 2015.

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

ECDC assessment

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

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

Actions

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

Following the detection of the cases of circulating vaccine-derived poliovirus type 1 in Ukraine, ECDC published a rapid risk assessment on its [website](#).

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