

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Influenza - Multistate (Europe) - Monitoring 2015-2016 season

Opening date: 2 October 2015

Latest update: 13 May 2016

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

→ Update of the week

In week 18/2016, influenza activity continued to decrease in the WHO European Region. Most countries (94%) reported low intensity. Although the percentage of influenza-positive specimens increased slightly compared to the previous week, the absolute number of detections further decreased. As is often seen late in the northern hemisphere's influenza season, a shift towards circulation of type B influenza virus has occurred. Type B accounted for 82% of detections in sentinel sources and 84% in non-sentinel sources. Fewer cases of severe disease were reported than in previous weeks, although numbers varied between countries. Most severe cases were associated with A(H1N1)pdm09 infection and were in people aged 15–64 years.

Non EU Threats

Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 13 May 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

No new events of epidemiological relevance have been reported during the past week.

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 13 May 2016

As of 12 May 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. Given this scientific consensus on the evidence of adverse pregnancy outcomes associated with Zika virus infection, ECDC recommends that pregnant women postpone non-essential travel to Zika-affected areas.

→Update of the week

Since last week:

Europe

Spain

On 5 May, the first case of microcephaly case was detected in the foetus of a mother linked to Zika virus infection (ex South America) in [Catalonia](#).

Germany

On 12 May 2016 [Germany](#) reported a case of Zika virus disease due to male to female sexual transmission.

Americas

Argentina

Two autochthonous mosquito-borne cases of Zika virus infection were detected in [Tucuman](#), Argentina.

Update on the observed increase of congenital Zika syndrome and other neurological complications

Microcephaly and other foetal malformations potentially associated with Zika virus infection or suggestive of congenital infection have been reported in Brazil (1 326 cases), Cape Verde (2 cases), Colombia (7 cases), French Polynesia (8 cases), Martinique (3 cases), Marshall Islands (1 case), Panama (5 cases), United States of America (2 cases) and Spain (1). In the context of Zika virus circulation, 13 countries or territories have reported an increased incidence of Guillain-Barré syndrome (GBS) and/or laboratory confirmation of a Zika virus infection among GBS cases.

Outbreak of yellow fever - Multistate (world) - Monitoring global outbreaks

Opening date: 17 March 2016

Latest update: 13 May 2016

An outbreak of yellow fever in Angola started in December 2015 in the municipality of Viana, Luanda province and spread to 16 provinces of Angola. A mass immunisation campaign is taking place. The neighbouring Democratic Republic of Congo (DRC) reports imported cases of yellow fever and on 2 May the first confirmed autochthonous transmission in Kinshasa, the capital. On 5 May, DRC reported an additional autochthonous case in Kongo Central. Media reported one imported case in Namibia. An outbreak of yellow fever not linked to the outbreak in Angola has been reported in several districts in Uganda.

→Update of the week

Angola

Since the initial cases were detected in Luanda province, there has been a rapid increase in the number of suspected cases recorded since mid-January 2016. Local transmission is no longer restricted to Luanda province. As of 8 May, the Angolan Ministry of Health reported 2 267 suspected cases of yellow fever and 293 deaths. Of those, 696 cases are confirmed. Of the confirmed cases, 445 are from Luanda and 251 are from outside of Luanda. Confirmed cases have now been reported in 14 of Angola 18 provinces. This week, Namibe province (south of Angola – bordering Namibia) was reported affected.

Democratic Republic of Congo (DRC)

On 5 May 2016, the Ministry of Health issued an update on the yellow fever outbreak. Between the beginning of January 2016 and 4 May 2016, DRC has reported 5 probable cases and 39 laboratory confirmed cases: 37 imported from Angola, reported in Kongo central province and Kinshasa and two autochthonous cases in Ndjili, Kinshasa and Matadi, Kongo central province. The possibility of locally acquired infections is under investigation for at least 10 non-classified cases in both Kinshasa and Kongo Central provinces.

Uganda

On 5 May 2016, WHO issued an update on the yellow fever outbreak in Uganda. Between 26 March and 18 April 2016, health authorities reported 41 yellow fever cases, including seven deaths. Among them, seven cases and two deaths were laboratory-confirmed. The 41 cases are reported in the districts of Masaka, Rukungiri, Ntungamo, Bukumansimbi, Kalungu, Lyantonde, and Rakai. None of the cases has recent travel history to Angola.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 13 May 2016

The largest ever epidemic of Ebola virus disease (EVD) affected West Africa from December 2013 to January 2016, mainly affecting Guinea, Liberia and Sierra Leone. On 8 August 2014, 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. Sierra Leone was declared Ebola-free by WHO on 7 November 2015, Guinea on 29 December 2015 and Liberia on 14 January 2016. On 29 March 2016, WHO declared the end of the PHEIC and advised that all temporary recommendations previously adopted should now be terminated. However, since the end of February 2016 up to 10 April, there have been ten cases reported in Guinea and three in Liberia.

→Update of the week

<?xml:namespace prefix = "o" />There have been no new cases reported since 10 April. Follow-up of contacts related to the recent cases in Guinea and Liberia has been completed.

Influenza A(H5N1) and other strains of avian flu - Non EU/EEA countries

Opening date: 15 June 2005

Latest update: 13 May 2016

Highly pathogenic avian influenza viruses A(H5) of Asian origin are highly infectious for several bird species, including poultry. The human infections with influenza A(H5) viruses have been caused by influenza A(H5N1) virus in several non EU/EEA countries and by influenza A(H5N6) virus in China. Other avian influenza subtypes, including H7N7 and H9N2, have infected people sporadically. Many of these infections have been mild or even subclinical in humans, but some have been severe and have resulted in deaths.

ECDC is following the development of these viruses and is monitoring infections in humans.

→Update of the week

According to [WHO](#) between 25 February and 4 April 2016, four human cases of A(H5N1) virus infection were reported from Egypt.

In addition between 4 April and 4 May 2016, China notified [WHO](#) of four laboratory-confirmed cases of human infection with avian influenza A(H5N6) virus. All cases were exposed to poultry.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 13 May 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 1 March 2016, the Temporary Recommendations in relation to the PHEIC were extended for another three months. WHO recently declared wild poliovirus type 2 eradicated worldwide.

→Update of the week

During the past week, WHO reported one new wild poliovirus type 1 (WPV1) case in Afghanistan. There were no official circulating vaccine-derived poliovirus (cVDPV) cases reported. However, [media](#) report one case of cVDPV2 in Maiduguri district of Borno province, Nigeria.

Between 17 April and 1 May, the type 2 component of the oral polio vaccine (OPV) was removed from use through a globally synchronised switch from the trivalent to bivalent oral polio vaccine. This was the first stage of objective 2 of the Polio Eradication and Endgame Strategic Plan 2013-2018 to withdraw OPV in a phased manner following the eradication of wild poliovirus type 2 in September 2015. As of 10 May 154 of 155 (99%) countries and territories have stopped using the trivalent oral polio vaccine.

II. Detailed reports

Influenza - Multistate (Europe) - Monitoring 2015-2016 season

Opening date: 2 October 2015

Latest update: 13 May 2016

Epidemiological summary

This season, influenza A(H1N1)pdm09 viruses have predominated in most countries in the Region, although type B has dominated since week 9/2016 in specimens from primary care surveillance. Influenza activity, based on laboratory-confirmed mild and severe cases in sentinel and non-sentinel sources, peaked in weeks 05–07/2016. The countries first affected were in general located in the eastern part of the Region. Data from the 18 countries or regions reporting to the European monitoring of excess mortality for public health action (EuroMOMO) project suggested a pattern of excess all-cause mortality among those aged 15–64 years between the end of 2015 and week 14/2016. This may have been associated with influenza, as well as other factors. The level of excess all-cause mortality was similar to that of the 2012–2013 winter season and slightly lower than that of the 2014–2015 winter season.

ECDC assessment

Most of the viruses antigenically and/or genetically characterised so far have been similar to those recommended for inclusion in the trivalent or quadrivalent vaccines for this season in the northern hemisphere. There are no indications among the majority of currently circulating seasonal influenza viruses of reduced susceptibility to neuraminidase inhibitors oseltamivir or zanamivir. Recommendations on the composition of the seasonal influenza [vaccines](#) for the 2016–2017 season in the northern hemisphere call for replacement of the A(H3N2) component with a more recent virus and inclusion of a B/Victoria-lineage virus in trivalent vaccines.

Actions

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

Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 13 May 2016

Epidemiological summary

There have been reports of emerging episodes of communicable diseases affecting 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. The risk that refugees arriving in Europe will contract communicable diseases has increased because of the current overcrowding at reception facilities. The risk of infectious diseases varies with the seasons, particularly for respiratory, gastrointestinal and mosquito-borne diseases. The risk of infectious diseases in refugees increases with overcrowding and lack of access to water and sanitation. Low vaccination coverage for some diseases, along with low immunity for others, may result in susceptible refugees developing diseases such as measles and chicken pox, given their high incidence in some regions of the EU.

[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 because overcrowding, limited access to clean water and poor hygiene levels are mostly encountered in certain reception facilities

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for refugees.

Actions

Following the request of the Greek authorities an ECDC senior expert has been in the field to review the risk assessment for communicable diseases on the basis of the current situation, supported the revision of the protocol for Point of Care public health surveillance for refugees, and advised on response procedures and priority settings. Two EPIET fellows were deployed to Greece on 13 April 2016 for one month 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: 13 May 2016

Epidemiological summary

Brazil

Between October 2015 and as of 7 May 2016, Brazil reported more than 7 438 suspected cases of microcephaly from all states and in the Federal District. Of these cases, 1 326 are reported as confirmed cases of microcephaly, 205 of which had laboratory confirmed presence of Zika virus infection. Of the remaining cases, 2 679 were investigated and discarded as they did not fit the case definition, while 3 433 cases are under investigation.

Among the 7 438 suspected cases of microcephaly, 262 intrauterine or neonatal deaths were reported. Of these, 56 cases were investigated and confirmed (microcephaly and/or central nervous system malformations).

Colombia

Since the start of the epidemic in Colombia in epidemiological week 40 of 2015, as of week 17 of 2016, 78 085 cases (3 751 lab-confirmed, 74 334 suspected) of Zika virus infection were reported in Colombia. Between weeks 1 and 17, Colombia reported 58 cases of microcephaly. Of these, 5 have been confirmed as associated with Zika virus infection, 21 cases were discarded and 32 cases were under investigation.

Congenital zika syndrome and GBS

As of 12 May 2016, microcephaly and other foetal malformations potentially associated with Zika virus infection or suggestive of congenital infection have been reported in seven countries (Brazil, Cape Verde, Colombia, French Polynesia, Martinique, Marshall Islands and Panama). Two additional cases, each linked to a stay in Brazil, were detected in Slovenia and the United States of

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America. One more case was reported in a returning traveller from the affected countries in the United States of America. One additional case was detected in Spain in a returning traveller. In the context of Zika virus circulation, 13 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.

Imported cases to Europe

As of 12 May 2016, ECDC has recorded 523 imported cases in 18 EU/EEA countries. Twenty-six of the imported cases are pregnant women. In addition, one confirmed case was published following the diagnosis in a Slovenian hospital. The number of imported cases reported is not based on a systematic reporting surveillance systems hence cannot be considered exhaustive.

As of 12 May 2016, twenty-three cases of non-vector-borne transmission of Zika virus, probably through sexual transmission have been reported by nine countries: Argentina (1), Chile (1), France (5), Italy (1), New Zealand (1), Portugal (in the Autonomous Region of Madeira) (1), Peru (1), Canada (1), the United States of America (10) and Germany (1).

EU's Outermost Regions and Territories

Martinique: As of 28 April 2016, 22 690 suspected cases have been reported, an increase of 1 740 since last week. Since the beginning of the outbreak to 28 April 2016, two microcephaly cases and one additional congenital abnormality have been reported with confirmed Zika virus infection. Additionally, 15 cases with neurological complications have been detected, among these 12 have been confirmed with Zika virus infection, three are under investigation.

French Guiana: As of 28 April 2016, 5 360 suspected cases have been reported, an increase of 500 since last week. Three cases with neurological complications have been identified since the beginning of the outbreak.

Guadeloupe: As of 28 April 2016, 3 000 suspected cases have been reported, an increase of 850 suspected cases since last week. One case with neurological complications has been reported since the beginning of the outbreak.

St Martin: As of 28 April 2016, 235 suspected and 82 laboratory-confirmed cases have been reported, an increase of 23 suspected and 21 laboratory-confirmed cases since last week. One case with neurological complications was reported, however this can not directly be attributed to Zika.

St Barthélemy: As of 28 April 2016, ten suspected and one laboratory- confirmed case has been reported.

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

ECDC assessment

Based on a growing body of research, there is scientific consensus that Zika virus is a cause of microcephaly and GBS. Several studies have documented steps in the chain of an intrauterine infection; from symptomatic Zika-like infection in a pregnant mother residing in a Zika-affected area, to detection of microcephaly with brain calcifications in the foetus, and detection of Zika virus either in the amniotic fluid, in the cerebrospinal fluid of the newborn, or in the central nervous system of an aborted foetus or a dead newborn.

The magnitude of the risk that Zika virus infection during pregnancy will result in malformations in the foetus is under investigation, but remains unquantifiable at present.

Given the scientific consensus on the evidence of adverse pregnancy outcomes associated with Zika virus infection, ECDC recommends that pregnant women should consider to postpone non-essential travel to Zika-affected areas. In addition, in order to protect pregnant women, male travellers returning from affected areas should consider using a condom with a pregnant partner until the end of pregnancy. This precautionary advice is based on limited evidence and will be revised as more information becomes available.

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.

With the spread of the Zika virus, the likelihood of travel-related cases in the EU is increasing. As neither treatment nor vaccines are available, prevention is based on personal protection measures similar to those that are applied against dengue and chikungunya infections.

Actions

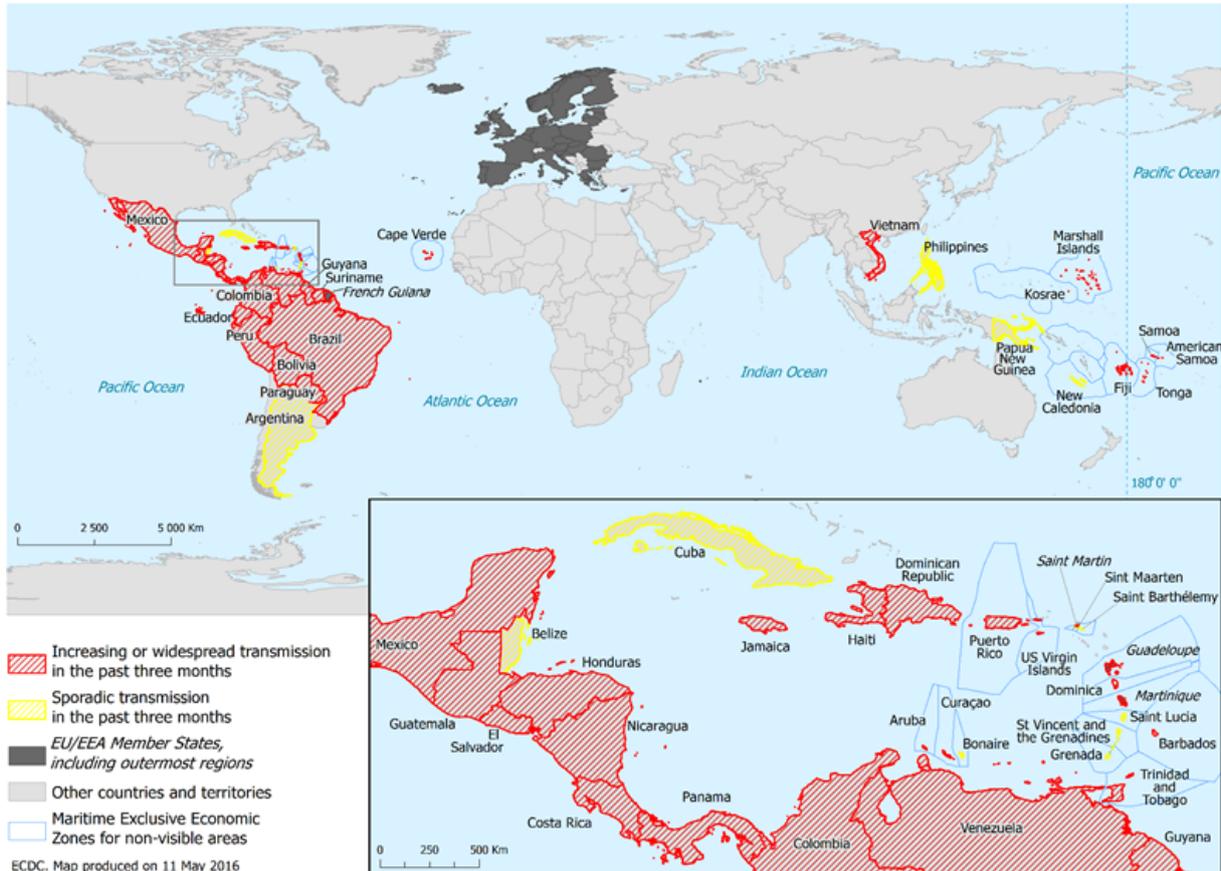
ECDC publishes an [epidemiological update](#) every Friday and [maps](#) with information on countries or territories which have reported

confirmed autochthonous cases of Zika virus infection.

ECDC published an update of the [rapid risk assessment](#) on 11 April 2016 and has updated the [ECDC Zika page](#) with [Frequently Asked Questions](#).

autochthonous cases of Zika virus infection in the past three months, as of 11 May 2016

ECDC



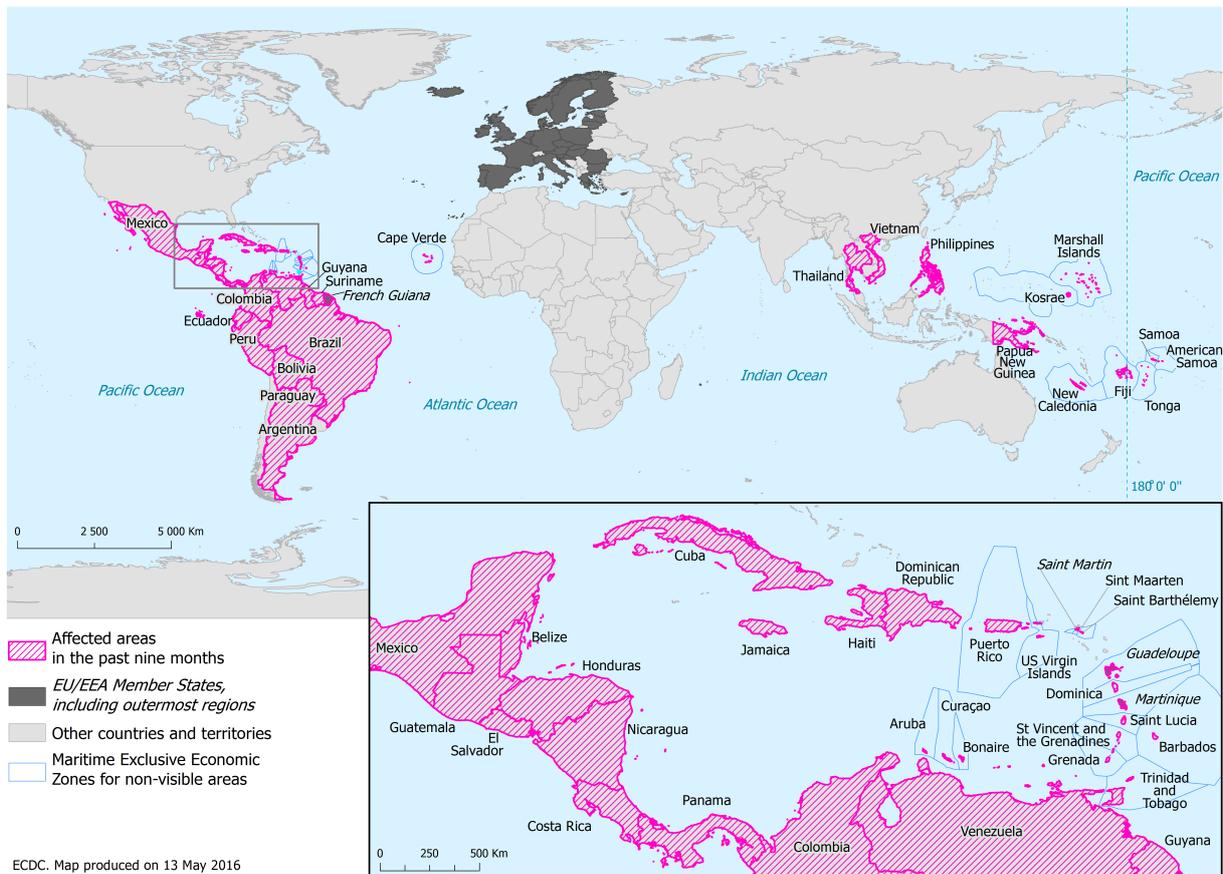
Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past nine months and past two months, as of 11 May 2016

ECDC

| | Current Zika transmission | Zika transmission in the past nine months |
|----------------------------------|---------------------------------------|---|
| American Samoa | Increasing or widespread transmission | Yes |
| Argentina | Sporadic transmission | Yes |
| Aruba | Increasing or widespread transmission | Yes |
| Barbados | Increasing or widespread transmission | Yes |
| Belize | Sporadic transmission | Yes |
| Bolivia | Increasing or widespread transmission | Yes |
| Bonaire | Sporadic transmission | Yes |
| Brazil | Increasing or widespread transmission | Yes |
| Cape Verde | Increasing or widespread transmission | Yes |
| Colombia | Increasing or widespread transmission | Yes |
| Costa Rica | Increasing or widespread transmission | Yes |
| Cuba | Sporadic transmission | Yes |
| Curaçao | Increasing or widespread transmission | Yes |
| Dominica | Increasing or widespread transmission | Yes |
| Dominican Republic | Increasing or widespread transmission | Yes |
| Ecuador | Increasing or widespread transmission | Yes |
| El Salvador | Increasing or widespread transmission | Yes |
| Fiji | Increasing or widespread transmission | Yes |
| French Guiana | Increasing or widespread transmission | Yes |
| Grenada | Sporadic transmission | Yes |
| Guadeloupe | Increasing or widespread transmission | Yes |
| Guatemala | Increasing or widespread transmission | Yes |
| Guyana | Increasing or widespread transmission | Yes |
| Haiti | Increasing or widespread transmission | Yes |
| Honduras | Increasing or widespread transmission | Yes |
| Jamaica | Increasing or widespread transmission | Yes |
| Kosrae | Increasing or widespread transmission | Yes |
| Marshall Islands | Increasing or widespread transmission | Yes |
| Martinique | Increasing or widespread transmission | Yes |
| Mexico | Increasing or widespread transmission | Yes |
| New Caledonia | Sporadic transmission | Yes |
| Nicaragua | Increasing or widespread transmission | Yes |
| Panama | Increasing or widespread transmission | Yes |
| Papua New Guinea | Sporadic transmission | Yes |
| Paraguay | Increasing or widespread transmission | Yes |
| Peru | Increasing or widespread transmission | Yes |
| Philippines | Sporadic transmission | Yes |
| Puerto Rico | Increasing or widespread transmission | Yes |
| Saint Lucia | Sporadic transmission | Yes |
| Saint Martin | Increasing or widespread transmission | Yes |
| Saint Vincent and the Grenadines | Sporadic transmission | Yes |
| Saint-Barthélemy | Sporadic transmission | Yes |
| Samoa | Increasing or widespread transmission | Yes |
| Sint Maarten | Sporadic transmission | Yes |
| Suriname | Increasing or widespread transmission | Yes |
| Thailand | No | Yes |
| Tonga | Increasing or widespread transmission | Yes |
| Trinidad and Tobago | Increasing or widespread transmission | Yes |
| US Virgin Islands | Increasing or widespread transmission | Yes |
| Venezuela | Increasing or widespread transmission | Yes |
| Vietnam | Increasing or widespread transmission | Yes |

Countries and territories with reported confirmed autochthonous cases of Zika virus infection in the past nine months, as of 11 May 2016

ECDC



Outbreak of yellow fever - Multistate (world) - Monitoring global outbreaks

Opening date: 17 March 2016

Latest update: 13 May 2016

Epidemiological summary

Angola

As of 8 May, the Angolan Ministry of Health has reported 2 267 cases and 293 deaths. Of those, 696 cases are confirmed. Of the confirmed cases, 445 are from Luanda and 251 are from outside of Luanda. Confirmed cases have been reported in 14 of Angola 18 provinces. This week, Namibe province (south of Angola – bordering Namibia) was reported affected.

Yellow fever cases in people who travelled from Angola have been reported in China (11 cases), Democratic Republic of Congo (37 confirmed cases), Kenya (two cases) Mauritania (one case) and Namibia (one case).

More than seven million people in Luanda have benefited from a large-scale vaccination campaign since the beginning of February using vaccines made available from the yellow fever vaccine emergency stockpile made available through the International Coordinating Group (ICG) for Vaccine Provision, with support from Gavi, the UN Central Emergency Response Fund

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(CERF) and a vaccine donation from Brazil.

Democratic Republic of Congo (DRC)

The Ministry of Health issued on 5 May 2016 an update on the yellow fever outbreak. Since the beginning of January 2016 and as of 4 May 2016, DRC has reported 5 probable cases and 39 laboratory confirmed cases: 37 imported from Angola, reported in Kongo central province and Kinshasa and two autochthonous cases in Ndjili, Kinshasa and Matadi, Kongo central province. The possibility of locally acquired infections is under investigation for at least 10 non-classified cases in Kinshasa and Kongo Central provinces.

A response plan, involving the Ministry of Health, WHO and Non Governmental organisations has been developed. It includes a vaccination campaign of eight health zones, the six districts of Kongo Central and at least two districts in Kinshasa.

Namibia

Media ,quoting the Ministry of Health in Namibia, reported on 29 April 2016 one confirmed case of yellow fever. In addition, according to media, a suspected case of yellow fever was reported last week at the Engela district hospital in the Ohangwena region. The patient had travelled to Lubango in Angola and was transferred to the Oshakati Hospital and later discharged.

Uganda

On 5 May 2016, WHO issued an update on the yellow fever outbreak in Uganda, which is unrelated to the outbreak in Angola. Between 26 March and 18 April 2016, health authorities reported 41 yellow fever cases, including seven deaths. Among them, seven cases and two deaths were laboratory-confirmed. The 41 cases are reported in the districts of Masaka, Rukungiri, Ntungamo, Bukumansimbi, Kalungu, Lyantonde, and Rakai. None of the cases has recent travel history to Angola.

Web sources: [ECDC factsheet](#) / [WHO yellow fever page](#) | [MoH](#) | [WHO AFRO](#) | [WHO SitRep 28 April 2016](#) | [WHO-Uganda](#) | [MoH Uganda](#) | [media Uganda](#) | [WHO-DRC](#) | [WHO-WER](#) | [MoH-DRC](#) | [media namibia](#)

ECDC assessment

WHO estimates that 508 million people are living in 31 African countries 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 the 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 the continental EU but is present in the island of Madeira, an autonomous region of Portugal where the weather conditions are not currently suitable for mosquito activity.

Actions

ECDC published a [rapid risk assessment](#) on 25 March 2016 and an [epidemiological update](#) on 1 April. Since 10 May, a team of EU medical corps, which includes two ECDC senior staffs has been deployed in Angola.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 13 May 2016

Epidemiological summary

Between the end of February 2016 and 10 April, there have been seven confirmed and three probable cases of EVD in N'Zerekore, Guinea. Of these cases, eight have died. On 10 April, WHO reported three cases in Liberia linked to the Guinean

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cluster. Of these, one was fatal. Investigations suggest that the recent flare up in Guinea is linked to an EVD survivor and not to a new introduction from the animal population.

Official WHO figures as of 11 May 2016:

- **Guinea:** 3 804 cases including 2 536 deaths. The country was declared EVD-free on 29 December 2015. However, between the end of February and 10 April 2016, seven confirmed and three probable sporadic cases have been reported by WHO;
- **Liberia:** 10 666 cases, including 4 806 deaths. Liberia was declared EVD-free on 14 January 2016. However, between the end of March and 10 April 2016, three confirmed cases have been reported by WHO;
- **Sierra Leone:** 14 122 cases, including 3 955 deaths. The country was declared EVD-free on 7 November 2015. However, two epidemiologically linked sporadic cases were reported on 14 and 20 January 2016.

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 detection of new sporadic cases and small clusters of cases in Guinea and Liberia is not unexpected and highlights the importance of maintaining heightened surveillance and early detection of cases during the coming months as the risk of additional small outbreaks remains. Sporadic cases have been identified previously and are likely to be the result of the virus persisting in survivors even after recovery. Following the recent cases in Guinea and Liberia, [WHO](#) acknowledged that the 42-day (two incubation periods) countdown must elapse before the outbreak can be declared over in Guinea and Liberia. In Guinea, this is due to end on 31 May and in Liberia, this is due to end on 9 June.

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](#)

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[virus disease and people exposed to Ebola virus.](#)

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

Influenza A(H5N1) and other strains of avian flu - Non EU/EEA countries

Opening date: 15 June 2005

Latest update: 13 May 2016

Epidemiological summary

From 2003 to 4 May 2016, 850 laboratory-confirmed cases of human infection with avian influenza A(H5N1) virus, including 449 deaths, have been reported from 16 countries. In addition, 14 laboratory-confirmed cases of human infection with avian influenza A(H5N6) virus, including 6 deaths, have been detected in China since 2013.

Web sources: [ECDC Rapid Risk Assessment](#) | [Avian influenza on ECDC website](#) | [EMPRES](#) | [OIE](#) | [WHO](#)

ECDC assessment

The identification of sporadic cases in Egypt is not unexpected as avian influenza A(H5N1) viruses are known to be circulating in poultry in the country.

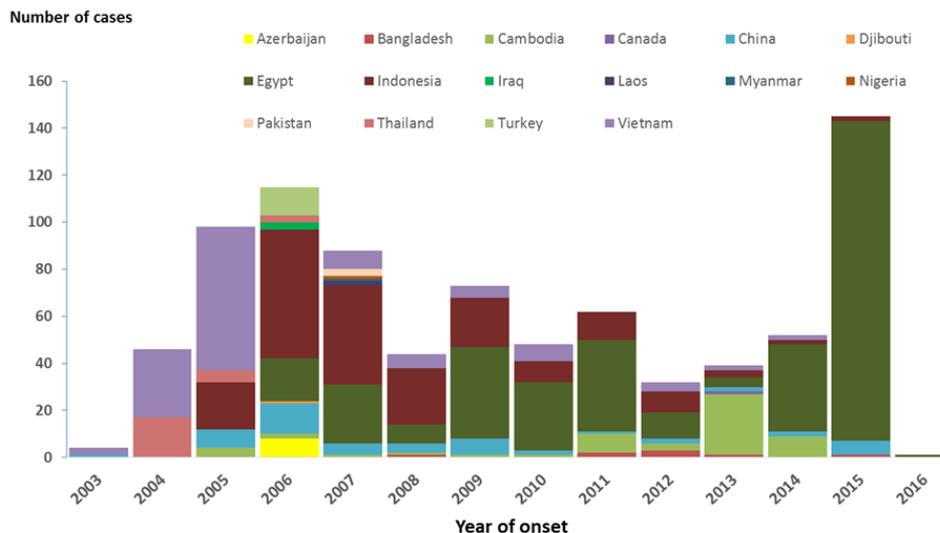
When avian influenza viruses circulate in poultry, sporadic infections or small clusters of human cases are possible in people exposed to infected poultry or contaminated environments, especially in households and at live bird markets. The viruses remain poorly adapted to humans and transmission from birds to humans is infrequent. Only limited clusters of human cases have been reported since the first human epidemics of A(H5N1). No sustained human-to-human transmission has been observed. The risk of foodborne transmission, e.g. through the consumption of eggs or meat, is considered extremely low.

Actions

ECDC monitors avian influenza strains through epidemic intelligence activities in order to identify significant changes in the epidemiology of the virus. ECDC re-assesses the potential of the A(H5N1) risk to humans on a regular basis.

Distribution of confirmed cases of influenza A(H5N1) by country of reporting

Adapted from WHO figures



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 13 May 2016

Epidemiological summary

In 2016, fourteen cases of wild poliovirus type 1 (WPV1) have been reported, compared with 23 cases for the same period in 2015. The cases were detected in Pakistan (nine cases) and in Afghanistan (five cases).

As of 10 May 2016, three cases of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO in 2016, all from Laos. There was one cVDPV case 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

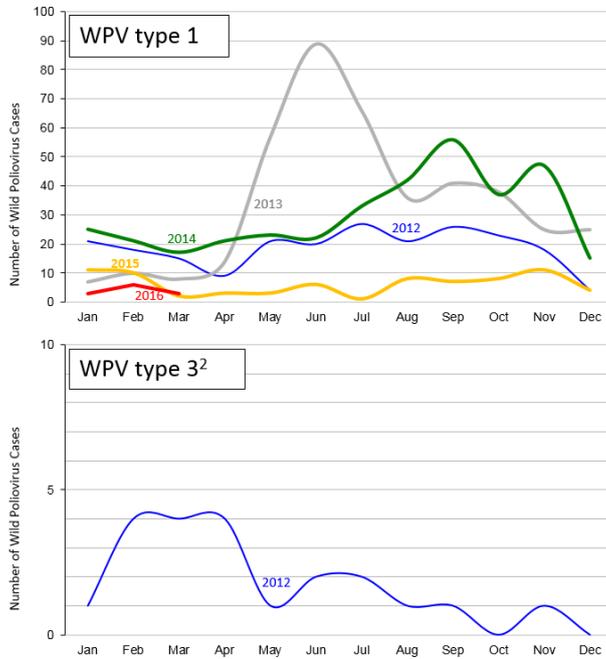
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assessment on its [website](#).

Monthly Distribution of Wild Poliovirus Cases, 2012-2016 by onset of paralysis

Global Polio Eradication Initiative WHO

Monthly Distribution of Wild Poliovirus Cases¹, 2012-2016



Data in WHO/HQ as of 10 May 2016

¹By date of onset of paralysis. WPV type 1 includes 1 case in 2012 with a mixture of W1W3 virus. Cases with onset in February 2016 will be reflected in the next update.
²No WPV3 cases were reported in 2013 - 2016.

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