

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: 26 February 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

During week 7/2016, 29 of the 47 countries that reported epidemiological data, indicated medium-intensity influenza activity, while 11 reported low intensity.

Albania, Finland, Greece, Ireland, Poland, Switzerland and the former Yugoslav Republic of Macedonia indicated high-intensity activity. Out of 37 countries that reported on trend, 14 countries reported increasing rates of consultations for influenza-like illness (ILI) and/or acute respiratory infection (ARI) and 21 countries reported declining activity.

Of the 45 Member States that reported on geographical spread, 28 reported widespread activity, four regional activity, 12 reported local/sporadic activity, and one reported no activity.

On 25 February, [WHO](#) announced the recommended composition of influenza virus vaccines for use in the 2016-2017 northern hemisphere influenza season and update on "[Antigenic and genetic characteristics of zoonotic influenza viruses and development of candidate vaccine viruses for pandemic preparedness](#)"

Haemolytic uraemic syndrome (HUS) cases in young children –Romania

Opening date: 16 February 2016

Latest update: 26 February 2016

The Ministry of Health in Romania reports that 13 children aged 5 to 38 months have been hospitalised in Bucharest and Pitesti between 29 January and 24 February while presenting with symptoms of vomiting and diarrhoea, with or without dehydration, and suspected haemolytic uraemic syndrome (HUS). The dates of onset were between 25 January and 14 February. Three of the cases have died. *E. coli* O26 has been identified in several cases.

→Update of the week

A new suspected HUS case in a 16-month-old child from Arges district was admitted to MS Curie hospital on 24 February 2014, with onset on 14 February. As of 25 February five children remain hospitalised and one child is in intensive care.

Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 26 February 2016

Measles, a highly transmissible vaccine-preventable disease, is still endemic in some EU countries where vaccination uptake remains below the level required to interrupt the transmission cycle. Elimination of measles requires consistent vaccination uptake above 95% with two doses of measles vaccine in all population groups, strong surveillance and effective outbreak control measures. In 2014, 16 EU/EEA countries were above the measles vaccination coverage target of 95% for the first dose, and six countries for the second dose. Fourteen countries have coverage rates of <95% for the first dose and 20 countries for the second dose.

→Update of the week

No new outbreaks detected since the last monthly update in the EU/EEA.

In the rest of the world, outbreaks were reported in Senegal, Nigeria, Sudan, Cambodia, Australia and New Zealand.

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012

Latest update: 26 February 2016

Rubella, caused by the rubella virus and commonly known as German measles, is usually a mild and self-limiting disease which often passes unnoticed. The main reason for immunising against rubella is the high risk of congenital malformations associated with rubella infection during pregnancy. All EU Member States recommend vaccination against rubella with at least two doses of vaccine for both boys and girls. The vaccine is given at the same intervals as the measles vaccine as part of the MMR vaccine. No new outbreaks have been detected in the EU since June 2015.

→Update of the week

No new outbreaks have been detected in EU Member States since the last monthly update.

In the rest of the world, there are on-going outbreaks in Togo and Indonesia.

Non EU Threats

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 25 February 2016

Zika virus infections are spreading in previously unaffected areas of the world. Since the beginning of 2014, autochthonous Zika cases have been reported in the Pacific region. In addition, autochthonous transmission of Zika virus has been reported in Brazil since April 2015. As of 25 February 2016, 42 countries and territories have reported autochthonous cases of Zika virus infection in the past nine months. Possible links between Zika virus infection in pregnancy and microcephaly of the foetus have been under investigation since October 2015, when the Brazilian Ministry of Health reported an unusual increase in cases of microcephaly following the Zika virus outbreak in the north-eastern states. French Polynesia reported an increase in cases of central nervous system malformations during 2014–2015 following the Zika virus infection outbreak from September 2013 to March 2014. Investigations of a link between Zika virus infection and Guillain-Barré syndrome (GBS) are ongoing. On 1 February 2016, WHO declared Zika a Public Health Emergency of International Concern (PHEIC), following the first meeting of the Emergency Committee convened by the Director-General under the International Health Regulations 2005, regarding clusters of microcephaly cases and other neurologic disorders in some areas affected by Zika virus.

Considering the growing body of 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, two new territories, [Saint Vincent and the Grenadines](#) and [Sint Maarten](#) reported confirmed cases of Zika virus infection. As of 25 February 2016, 42 countries and territories have reported autochthonous cases of Zika virus infection in the past nine months.

USA

On 23 February, the [US CDC](#) reported that they are investigating 14 new reports of sexual transmission of Zika virus. Some of the women under investigation are pregnant. So far, only two of the infections have been confirmed in women and their only known risk factor was sexual contact with an ill male partner who had recently travelled to an area with local Zika virus transmission. In all events for which information is available, travellers reported symptom onset within 2 weeks prior to their non-travelling female partner's symptom onset.

Publication

On 26 February, a rapid communication published in [Eurosurveillance](#) reported a case of Zika virus infection imported in Florence, Italy, from Thailand, which led to a secondary autochthonous case, probably through sexual transmission. The two cases occurred in May 2014 but were retrospectively diagnosed in 2016 on the basis of serological tests (plaque reduction neutralisation) performed on stored serum samples.

Update on the observed increase of congenital malformations and other central nervous system complications

Brazil

According to the [Ministry of Health](#), there have been 5 640 cases of microcephaly notified to date in Brazil compared with 5 280 a week earlier. As of 20 February 2016, 583 of these cases were confirmed to have microcephaly and/or other central nervous system findings suggestive of congenital infection. Of the total confirmed cases, 67 fulfilled specific laboratory criteria for Zika virus. Across the country, 4 107 suspected cases of microcephaly remain under investigation. The cases have been reported from 1 101 municipalities in 25 Brazilian states. Amapá and Amazonas are the only states with no recorded cases.

There have been 120 intrauterine or neonatal deaths reported among children notified to have microcephaly and/or central nervous system malformations. Of these, 30 cases were investigated and confirmed to have microcephaly and/or central nervous system malformations. Eighty cases are still under investigation and 10 cases have been discarded.

Colombia

According to the [local health authorities](#), there has been a case of microcephaly in a foetus possibly linked to Zika virus infection in Colombia. The mother had a suspected Zika virus infection and had an abortion. However, due to the disposal of the foetal remains, no tissues were available to confirm the diagnosis of Zika virus infection.

Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 26 February 2016

Europe is experiencing its largest influx of refugees since the Second World War. According to the UN Refugee Agency (UNHCR), more than 944 000 refugees arrived in Europe in 2015. 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. The health conditions of the refugees may worsen with the wintery weather due to low temperatures and overcrowding in shelters.

→Update of the week

No new events relating to migrants have been detected during the past week.

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 26 February 2016

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then and up to 26 February 2016, 722 cases have been reported to WHO, including 283 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.

→Update of the week

During the past week, one new confirmed case was reported by Hong Kong. The 60-year-old male patient lives and works in Suzhou, Jiangsu, China and had exposure to poultry prior to falling ill. He came to Hong Kong on 5 February and reported onset of symptoms on 8 February. He consulted a private doctor on 10 February 2016 and was admitted to a hospital the day after and discharged on 15 February. Further testing of his sample confirmed avian influenza A(H7N9) virus.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 25 February 2016

The largest ever epidemic of Ebola virus disease (EVD) has affected West Africa from December 2013 - 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 26 February 2016 (with data as of 24 February 2016), WHO has reported 28 603 cases of Ebola virus disease related to the outbreak in West Africa, including 11 301 deaths. The number of cases in the most affected countries peaked in autumn 2014 and has been slowly decreasing since then. Sierra Leone was declared Ebola-free by WHO on 7 November 2015, Guinea on 29 December 2015 and Liberia on 14 January 2016. On 15 January 2016, WHO reported a new sporadic case in Sierra Leone, and on 20 January, a second case, epidemiologically linked to the previous one.

→Update of the week

No new confirmed cases have been reported since 20 January 2016.

According to a [hospital press release](#), on 23 February 2016, the Scottish nurse who was initially diagnosed with Ebola virus disease in December 2014, and then re-admitted to the hospital with a late complication from the previous EVD infection on 6 November 2015, was admitted for the third time to the Royal Free Hospital in London due to a late complication from her previous infection by the Ebola virus. She will now be treated by the hospital's infectious diseases team under nationally agreed guidelines. During her second admission in November 2015, the patient tested PCR positive for the virus in both cerebral spinal fluid (CSF) and blood. On 12 November 2015, the public health authorities in the United Kingdom reported that the patient had fully recovered.

Initial results from a randomized, controlled trial of the experimental Ebola treatment ZMapp shows that it was well-tolerated and showed promise. Due to decreasing incidence in Ebola, the study could not enrol enough volunteers to determine definitively whether it is a better treatment for Ebola virus disease (EVD) than supportive care only.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 26 February 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 25 November 2015, the Temporary Recommendations in relation to the PHEIC were extended for another three months. WHO recently declared wild poliovirus type 2 eradicated worldwide. The type 2 component of the oral polio vaccine is no longer needed and there are plans for a globally synchronised switch in April 2016 from the trivalent to bivalent oral polio vaccine which no longer contains type 2.

→Update of the week

During the past week, one new wild poliovirus type 1 (WPV1) case was reported to WHO from Pakistan.

Three new circulating vaccine-derived poliovirus type 2 (cVDPV2) cases were reported from Guinea in the past week, all with onset of paralysis in 2015.

In addition, on 25 February 2016, WHO posted an update on the [Disease outbreak news website](#) regarding three new cases of cVDPV1 in the Lao People's Democratic Republic (PDR) with onset of paralysis in 2016. During 7 September 2015-23 February 2016, Lao PDR have reported 10 cases of circulating vaccine-derived poliovirus 1 (cVDPV1). The three new cVDPV1 isolates are genetically linked with the previous Laos cVDPV1 isolates, but have considerable genetic differences compared with the previously identified cases. The new findings suggest that more than one strain of cVDPV1 may have emerged separately and co-circulated in Laos without being detected. In addition, cVDPV1 has also been isolated from the stools of 23 healthy contacts since the beginning of the outbreak.

II. Detailed reports

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

Opening date: 2 October 2015

Latest update: 26 February 2016

Epidemiological summary

So far, a predominance of influenza A(H1N1)pdm09 viruses has characterised the 2015–2016 influenza season in most countries in the region. This virus subtype may cause more severe disease and deaths in individuals aged 15–64 years than A(H3N2) viruses.

Since week 52/2015, several European countries with sentinel surveillance systems for severe acute respiratory infection (SARI) have reported increasing numbers of cases associated with A(H1N1)pdm09 infection. Similarly, countries reporting laboratory-confirmed influenza cases in hospitals and intensive care units (ICUs) have detected influenza A virus in the majority of cases since the start of the season, with A(H1N1)pdm09 being the dominant subtype.

ECDC assessment

Most of the viruses characterised so far have been similar to those recommended for inclusion in this winter's trivalent or quadrivalent vaccines for the northern hemisphere.

Actions

ECDC monitors influenza activity in Europe during the winter season and publishes its report weekly on the [Flu News Europe website](#). Season risk assessments are available from [ECDC](#) and [WHO](#).

Haemolytic uraemic syndrome (HUS) cases in young children –Romania

Opening date: 16 February 2016

Latest update: 26 February 2016

Epidemiological summary

According to the Ministry of Health of Romania, 13 children, aged between 5 and 38 months have been identified with diarrhoea, vomiting and suspected HUS during 29 January-9 February. The dates of onset are between 25 January and 14 February. Three of the cases have died.

Six of the previously reported 13 cases tested positive for *E. coli* O26 by serology. None of the stool samples recently collected from family members of the still hospitalised children tested positive for *E. coli*.

Web sources: [Ministry of Health Romania](#)

ECDC assessment

This is a national outbreak of VTEC O26. Romanian authorities are undertaking environmental investigations to identify the vehicle.

Actions

ECDC is monitoring this event. Two ECDC experts and one EPIET fellow have been deployed to support the outbreak investigation upon request from the Romanian Ministry of Health.

Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 26 February 2016

Epidemiological summary

EU Member States

No new outbreaks detected since the last monthly update.

Rest of the world

Africa

Senegal

[Media](#) report on 22 February 2016 an ongoing outbreak with an unknown number of cases that started in Bantako, a traditional gold mining site in the town of Tombrankoto before it spread in the city of Kedougou. One child died.

Nigeria

[Media](#) report an outbreak of epidemic of febrile rash illness affecting children in a slum area in Lagos State that started at the beginning of January 2016. The children developed rash and fever, and died two or three days after disease onset. There have been 25 fatalities. On 22 February, the government announced that laboratory investigations confirmed that the outbreak is caused by measles.

Sudan

According to [media](#) a new outbreak is reported in Sudan in Abyei in the contested territory between Sudan and South Sudan. The number of suspected measles cases has reached at least 40 at Abyei Hospital as of 15 February 2016. A measles vaccination campaign started in Abyei targeting 35 000 children under 15 years old. Routine vaccination against six childhood diseases has stopped in Abyei since 2011.

Asia

Cambodia

The [Ministry of Health](#) announced that a 7-month-old baby from Kampong Speu province has been diagnosed with the disease and is receiving treatment in the capital. Cambodia was declared measles-free by the World Health Organization almost a year ago. Investigations are ongoing to trace other exposed children.

Oceania

Australia

[Media](#) report a measles outbreak that started in early February 2016 in a Melbourne suburb with 14 cases as of 22 February. Two of the cases are pupils in a primary school. The school announced that those who cannot prove they are fully immunised against measles will have to stay at home until 1 March.

New Zealand

A person contracted measles on an international flight to Auckland in late January 2016. So far, three additional people have been confirmed with measles in Auckland and 51 are in home quarantine. One confirmed case is unrelated to the flight. One of the cases ignored instructions to go into isolation and has potentially put hundreds of people at risk of catching the virus. The health service has been focusing on tracking over 300 individuals who may have been exposed to the disease, establishing their immunity, isolating those infected and managing the quarantine.

Web sources: [ECDC measles and rubella monitoring](#) | [ECDC/Euronews documentary](#) | [MedISys Measles page](#) | [EUVAC-net ECDC](#) | [ECDC measles factsheet](#)

ECDC assessment

During the 12-month period from December 2014 to November 2015, 4 111 cases were reported by 30 EU/EEA countries. Twenty-nine countries reported consistently throughout this period. Germany, France, Austria, Croatia and Italy accounted for the majority of cases. In 14 of the countries reporting consistently, the measles notification rate was less than the elimination target of one case per million population, including eight countries which reported zero cases during the 12-month period.

Measles is targeted for elimination in Europe. Elimination is defined as the absence of endemic cases in a defined geographical area for a period of at least 12 months, in the presence of a well-performing surveillance system. Regional elimination can be declared after 36 or more months of the absence of endemic measles or rubella in all Member States.

Although progress has been made towards elimination, this goal has not yet been achieved. At the third [meeting](#) of the Regional

Verification Commission for measles and rubella in November 2014, based on country reports on 2013 data, 14 EU/EEA countries were declared to have interrupted measles transmission, five of which were classified as at risk of the re-establishment of endemic transmission. Eight countries were classified as still having endemic transmission and seven countries were classified as inconclusive.

Actions

ECDC monitors measles transmission and outbreaks in EU and neighbouring countries in Europe on a monthly basis through enhanced surveillance and epidemic intelligence activities.

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012

Latest update: 26 February 2016

Epidemiological summary

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

Web sources: [ECDC measles and rubella monitoring](#) | [ECDC rubella factsheet](#) | [WHO epidemiological brief summary tables](#) | [WHO epidemiological briefs](#) | [Progress report on measles and rubella elimination](#) | [Towards rubella elimination in Poland](#)

ECDC assessment

The WHO has targeted the elimination of measles and rubella in the 53 Member States of the WHO European region. Elimination is defined as the absence of endemic cases in a defined geographical area for a period of at least 12 months, in the presence of a well-performing surveillance system. Regional elimination can be declared after 36 or more months of the absence of endemic measles or rubella in all Member States. Although progress has been made towards elimination, this goal has not yet been achieved. At the third [meeting](#) of the Regional Verification Commission for measles and rubella in November 2014, based on country reports on 2013 data for rubella, 16 EU/EEA countries were declared to have interrupted endemic transmission, six of which were classified as at risk of re-establishment. Eight countries were classified as still having endemic transmission and five countries were classified as inconclusive.

Actions

ECDC closely monitors rubella transmission in Europe by analysing the cases reported to the European Surveillance System and through its epidemic intelligence activities on a monthly basis. Twenty-four EU and two EEA countries contribute to the enhanced rubella surveillance. The purpose of the enhanced rubella monitoring is to provide regular and timely updates on the rubella situation in Europe in support of effective disease control, increased public awareness and the achievement of the 2015 rubella and congenital rubella elimination target.

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 25 February 2016

Epidemiological summary

As of 25 February, no autochthonous Zika virus transmission has been reported in the continental EU. ECDC is collecting data regarding imported cases through the media and official government communication lines. As of 25 February 2016, ECDC has recorded 177 imported cases in 15 EU/EEA countries: Austria (1), Czech Republic (2), Denmark (1), Finland (2), France (66), Germany (20), Ireland (3), Italy (6), Malta (1), Netherlands (30), Portugal (7), Spain (27), Sweden (2), Slovenia (1) and the UK (8). Ten of the imported cases are pregnant women. This list may not be exhaustive.

Several countries in the Americas, Caribbean and the Pacific continue to report an increase in autochthonous cases of Zika virus infection including outermost EU regions.

Martinique: From December 2015 to 25 February 2016, 7 600 suspected cases have been reported, this is an increase of 1 550

7/17

suspected cases since the last update on 18 February 2016.

French Guiana: From December 2015 to 25 February 2016, 1 030 suspected and 102 laboratory confirmed cases have been reported, this is an increase of 235 suspected and 3 laboratory cases since the last update on 18 February 2016.

Guadeloupe: As of 25 February 2016, 389 suspected and 35 laboratory confirmed cases have been reported, this is an increase of 177 suspected and 10 laboratory confirmed cases since the last update on 18 February 2016.

Saint Martin: As of 25 February 58 suspected and 11 laboratory confirmed cases have been reported, this is an increase of 14 suspected and 4 laboratory confirmed cases since the last update on 18 February 2016.

As of 25 February 2016, several countries or territories have reported confirmed autochthonous cases of Zika virus infection in the past nine months: American Samoa, Aruba, Barbados, Bolivia, Brazil, Bonaire, Cape Verde, Colombia, Costa Rica, Curaçao, Dominican Republic, Ecuador, El Salvador, Fiji, French Guiana, Guadeloupe, Guatemala, Guyana, Haiti, Honduras, Jamaica, Maldives, Marshall Islands, Martinique, Mexico, New Caledonia, Nicaragua, Panama, Paraguay, Puerto Rico, Saint Martin, Saint Vincent and the Grenadines, Samoa, Sint Maarten, Solomon Islands, Suriname, Thailand, Tonga, Trinidad and Tobago, Vanuatu, Venezuela and the US Virgin Islands.

Thirty EU/EEA countries have issued travel advice for people travelling to Zika-affected areas. Of these, 28 have advised pregnant women to consider postponing travel to countries affected by the Zika epidemic.

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

ECDC assessment

There is growing evidence that transplacental infections with Zika virus can cause severe central nervous system damage and microcephaly. 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. However, a causal link between intra-uterine Zika virus infection and adverse pregnancy outcomes has not yet been firmly confirmed.

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

Considering the growing body of evidence of adverse pregnancy outcomes associated with Zika virus infection, ECDC recommends that pregnant women 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 female partner until the end of pregnancy, or for six months with partners at risk of getting pregnant. This precautionary advice is based on limited evidence and will be revised as more information becomes available.

The spread of Zika virus epidemic in the Americas is likely to continue as the vectors *Aedes aegypti* and *Aedes albopictus* mosquitoes are widely distributed there. There is a significant increase in the number of babies born with microcephaly in the north-eastern states of Brazil. However, the magnitude and geographical spread of the increase have not yet been well characterised.

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 daily [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 23 February 2016 and has updated the [ECDC Zika page](#) with [Frequently Asked Questions](#).

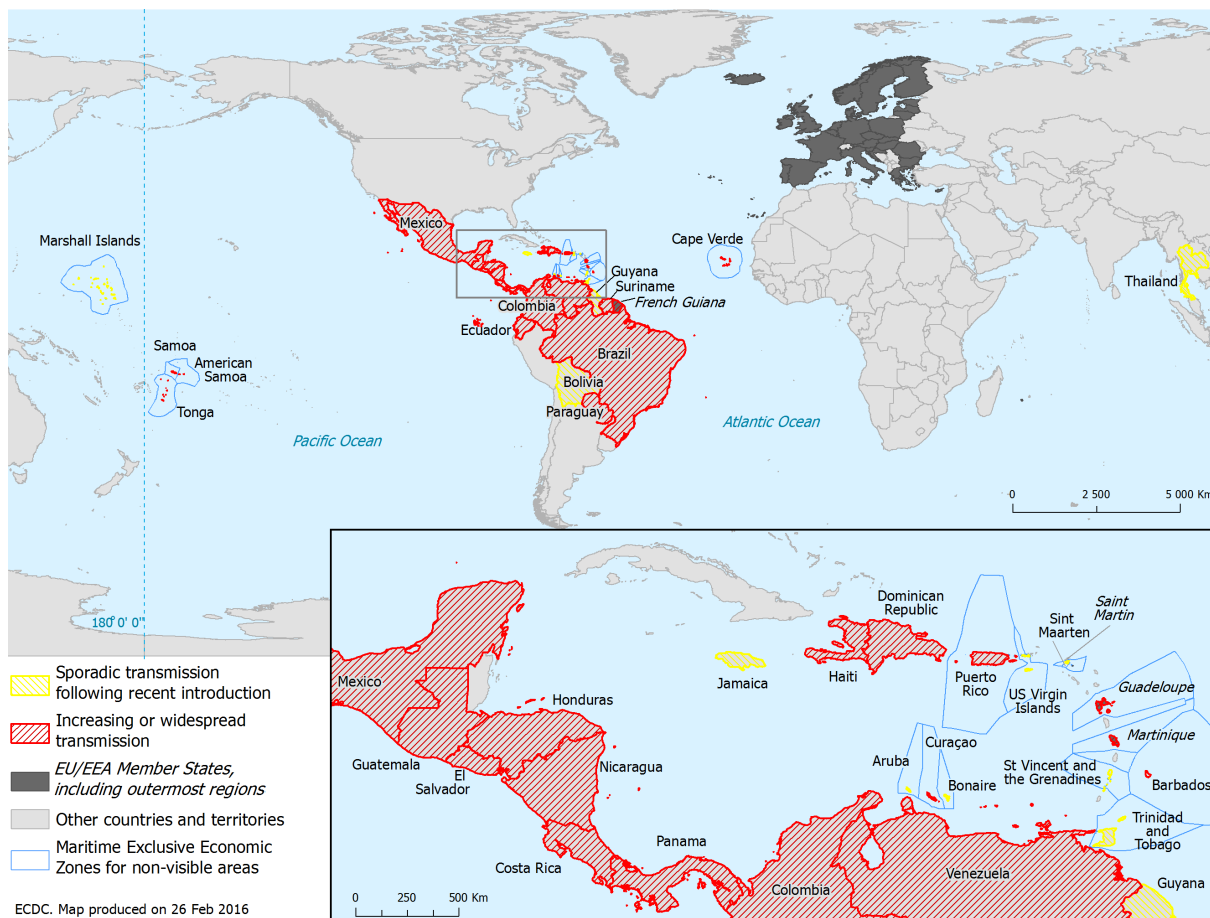
Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past nine months and past two months, as of 25 February 2016

ECDC

	Affected in the past 2 months	Affected in the past 9 months
American Samoa	Increasing or widespread transmission	Yes
Aruba	Sporadic transmission following recent introduction	Yes
Barbados	Increasing or widespread transmission	Yes
Bolivia	Sporadic transmission following recent introduction	Yes
Brazil	Increasing or widespread transmission	Yes
Bonaire	Sporadic transmission following recent introduction	Yes
Cape Verde	Increasing or widespread transmission	Yes
Colombia	Increasing or widespread transmission	Yes
Costa Rica	Sporadic transmission following recent introduction	Yes
Curaçao	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	No	Yes
French Guiana	Increasing or widespread transmission	Yes
Guadeloupe	Increasing or widespread transmission	Yes
Guatemala	Increasing or widespread transmission	Yes
Guyana	Sporadic transmission following recent introduction	Yes
Haiti	Increasing or widespread transmission	Yes
Honduras	Increasing or widespread transmission	Yes
Jamaica	Sporadic transmission following recent introduction	Yes
Maldives	No	Yes
Marshall Islands	Sporadic transmission following recent introduction	Yes
Martinique	Increasing or widespread transmission	Yes
Mexico	Increasing or widespread transmission	Yes
New Caledonia	No	Yes
Nicaragua	Increasing or widespread transmission	Yes
Panama	Increasing or widespread transmission	Yes
Paraguay	Increasing or widespread transmission	Yes
Puerto Rico	Increasing or widespread transmission	Yes
Saint Martin	Sporadic transmission following recent introduction	Yes
Saint Vincent and the Grenadines	Sporadic transmission following recent introduction	Yes
Samoa	Increasing or widespread transmission	Yes
Sint Maarten	Sporadic transmission following recent introduction	Yes
Solomon Islands	No	Yes
Suriname	Increasing or widespread transmission	Yes
Thailand	Sporadic transmission following recent introduction	Yes
Tonga	Increasing or widespread transmission	Yes
Trinidad and Tobago	Sporadic transmission following recent introduction	Yes
Vanuatu	No	Yes
Venezuela	Increasing or widespread transmission	Yes
US Virgin Islands	Sporadic transmission following recent introduction	Yes

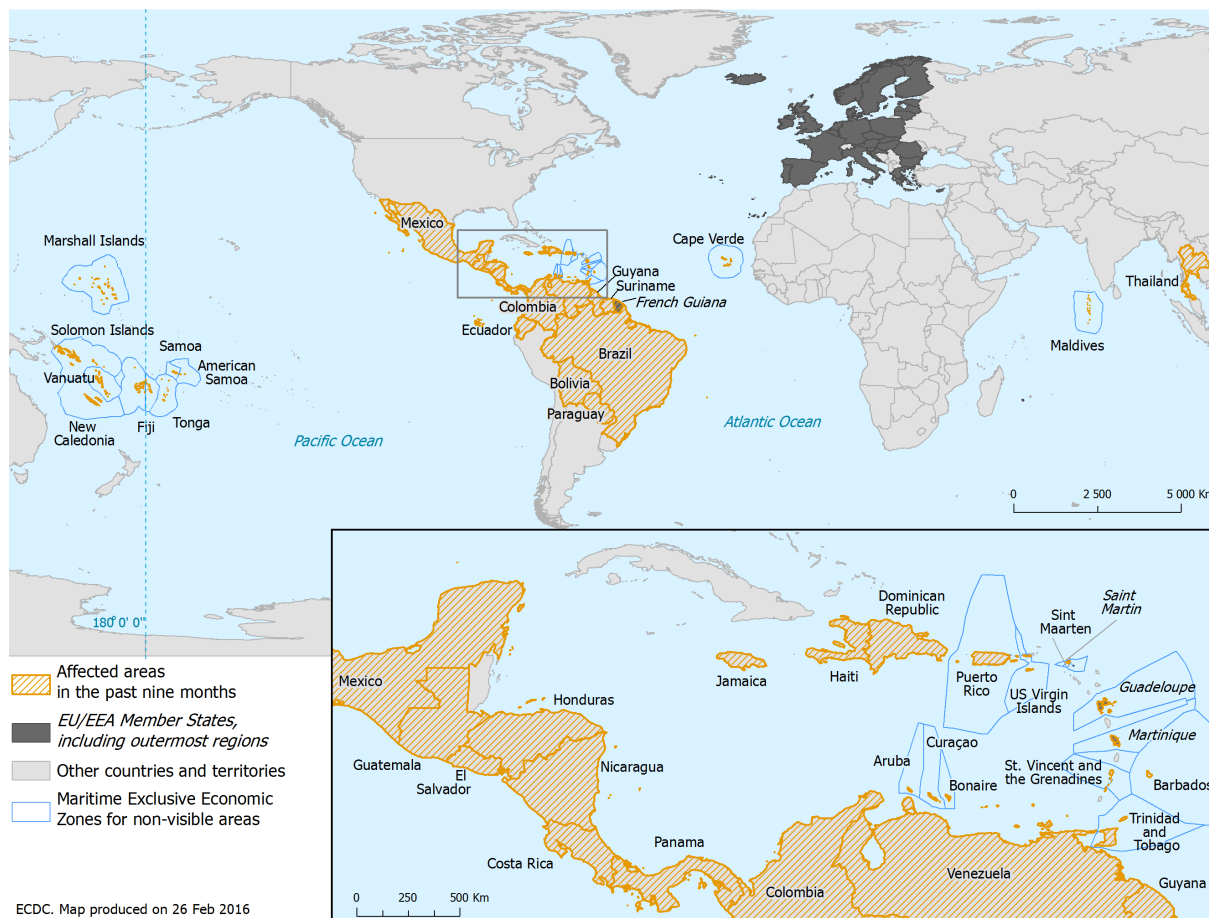
Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past two months, as of 26 February 2016

ECDC



Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past nine months, as of 26 February 2016

ECDC



Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 26 February 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.

While the risk of mosquito-borne diseases has been reduced as a result of the winter, the risk of infection from diseases whose spread is facilitated by overcrowding and lower temperatures has increased. It is therefore expected that the incidence of

11/17

respiratory and gastrointestinal conditions will increase in the coming months.

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 only encountered in certain reception facilities for refugees.

Actions

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 posted 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.

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 26 February 2016

Epidemiological summary

Cases reported by China since March 2013 have the following geographical distribution: Zhejiang (208), Guangdong (187), Jiangsu (85), Fujian (66), Shanghai (50), Hunan (27), Anhui (33), Hong Kong (14), Xinjiang Uygur Zizhiqu (10), Jiangxi (12), Beijing (6), Shandong (6), Guangxi (4), Henan (4), Taiwan (4), Jilin (2), Guizhou (2), Hubei (1) and Hebei (1). Three imported cases have also been reported: one in Malaysia and two in Canada.

Web sources: [Chinese CDC](#) | [WHO](#) | [WHO FAQ page](#) | [ECDC](#) | [WHO avian influence updates](#)

ECDC assessment

This outbreak is caused by a novel reassortant avian influenza virus capable of causing severe disease in humans. This is a zoonotic outbreak, in which the virus is transmitted sporadically to humans in close contact with the animal reservoir, similar to the influenza A(H5N1) situation.

In the past 12 months, there have been continued avian influenza A(H7N9) virus detections in the animal population in several provinces of China, indicating that the virus persists in the poultry population. If the pattern of human cases follows the trends seen in previous years, the number of human cases may rise over the coming months. Further sporadic cases of human infection with avian influenza A(H7N9) virus are therefore expected in areas that are already affected and in neighbouring areas.

Imported cases of influenza A(H7N9) may be detected in Europe. However, the risk of the disease spreading among humans following an importation to Europe is considered to be very low. People in the EU presenting with severe respiratory infection and a history of potential exposure in the outbreak area will require careful investigation.

Actions

The Chinese health authorities continue to respond to this public health event with enhanced surveillance, epidemiological and laboratory investigation, and scientific research.

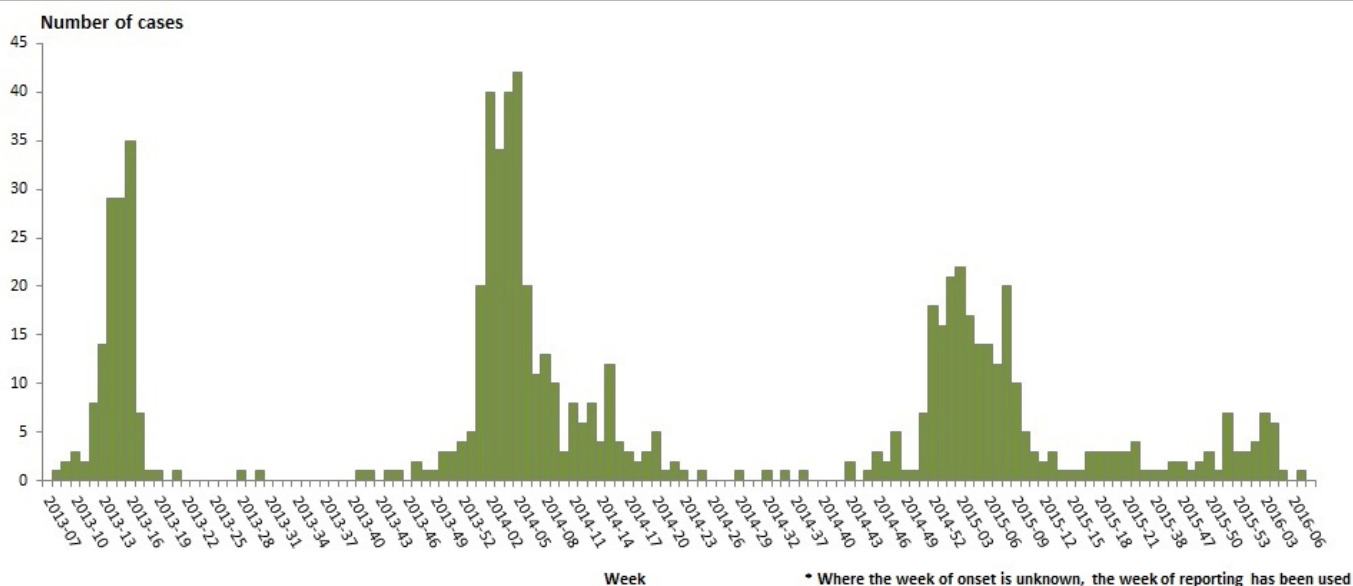
ECDC published an updated [Rapid Risk Assessment](#) on 3 February 2015.

ECDC published a guidance document [Supporting diagnostic preparedness for detection of avian influenza A\(H7N9\) viruses in Europe](#) for laboratories on 24 April 2013.

Distribution of confirmed cases of A(H7N9) by four periods of reporting (weeks 07/2013 to 08/2016)



Distribution of confirmed cases of A(H7N9) by first available date (weeks 07/2013 to 08/2016)



Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 25 February 2016

Epidemiological summary

Distribution of cases on 26 February 2016 (with data as of 24 February 2016):

- **Liberia:** 10 675 cases, including 4 809 deaths. Liberia was declared EVD-free on 3 September 2015. However, a family cluster occurred in the week leading up to 22 November 2015.
- **Sierra Leone:** 14 124 cases, including 3 956 deaths. The country was declared Ebola-free on 7 November 2015. However, two epidemiologically linked sporadic case were reported on 14 and 20 January 2016.
- **Guinea:** 3 804 cases including 2 536 deaths. Guinea was declared EVD-free on 29 December 2015.

If no new cases are reported, transmission linked to the latest cluster of cases will be declared to have ended on 17 March in Sierra Leone.

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](#)

ECDC assessment

The detection of a new case in Sierra Leone in January 2016 was not an unexpected event and highlighted the importance of maintaining heightened surveillance in 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.

Actions

In 2015, ECDC deployed 95 experts (on a rotating basis) from within and outside the EU in response to the Ebola outbreak. This included an ECDC-mobilised contingent of experts to Guinea.

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](#).

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 26 February 2016

Epidemiological summary

In 2016, two cases of wild polio virus type 1 (WPV1) has been reported, compared with 10 cases for the same period in 2015.

As of 25 February 2016, five cases of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO this year. There were no cases reported for 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.