COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 27, 28 June-4 July 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

West Nile virus - Multistate (Europe) - Monitoring season 2015

Opening date: 2 June 2015 Latest update: 2 July 2015

West Nile fever (WNF) is a mosquito-borne disease which causes severe neurological symptoms in a small proportion of infected people. 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

During the past week, no new cases were reported in EU Member States or neighbouring countries.

Non EU Threats

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 2 July 2015

An epidemic of Ebola virus disease (EVD) has been ongoing in West Africa since December 2013, 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). On 9 May, Liberia was declared free of Ebola virus disease. Transmission is still ongoing in Sierra Leone and Guinea.

➔Update of the week

On 2 July 2015, WHO reported 27 576 cases of Ebola virus disease related to the outbreak in West Africa, including 11 244 deaths.

According to WHO's latest situation report, 20 confirmed cases were reported by WHO from Guinea (12) and Sierra Leone (8) for the week leading up to 28 June, the same number of cases as the previous week. Cases continue to arise from unknown chains of transmission. The area of transmission has slightly expanded and infections among health workers have been registered.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu

Epidemic Intelligence duty email: support@ecdc.europa.eu

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

Opening date: 24 September 2012 Latest update: 2 July 2015

Since April 2012 and as of 1 July 2015, 1 382 cases of MERS-CoV have been reported by local health authorities worldwide, including 533 deaths. The source of the virus remains unknown but the pattern of transmission and virological studies point towards dromedary camels in the Middle East 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.

An outbreak of MERS-CoV has been ongoing in South Korea since May 2015. All cases are linked to the same transmission chain originating from a case imported from the Middle East.

➔Update of the week

During the past week, Saudi Arabia has reported three new cases: one case in Hofuf who is a household contact of a confirmed case, and two additional cases in Riyadh.

On 26 June, the United Arab Emirates reported two new cases in the Eastern region. Both cases were family members of a previously reported confirmed case.

Since 25 June, South Korea has reported three additional cases and four deaths, bringing the number of cases to 183 cases, including 33 deaths. One of the cases reported by South Korea travelled to China where he was diagnosed and hospitalised. All the three reported cases are healthcare workers (two from Samsung hospital in Kangnam-gu district and one from Gangdong Kyuang Hee University Hospital in Gangdong-gu district).

Influenza A(H5N1) and other strains of avian flu - Multistate (world) - Monitoring globally

Opening date: 15 June 2005 Latest update: 25 June 2015

The influenza A(H5N1) virus, commonly known as bird flu, is fatal in about 60% of human infections. Sporadic cases continue to be reported, usually after contact with sick or dead poultry from certain Asian and African countries. No human cases have been reported from Europe.

➔Update of the week

Since 23 June 2015, there has been no new update from WHO regarding A(H5N1) and other strains of avian influenza in humans.

During the past week, Egypt reported one fatal case of influenza A(H5N1) in a five-and-a-half year old child.

Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 2 July 2015

An outbreak of chikungunya virus infection has been ongoing in the Caribbean since December 2013 and has spread to North, Central and South America. In Europe, France reported autochthonous cases of chikungunya virus infection in 2014. This was the first time that locally-acquired transmission of chikungunya had been detected in France since 2010.

➔Update of the week

Since the beginning of the year and as of 26 June 2015, the WHO Pan American Health Organization (WHO PAHO) has reported 398 907 suspected and confirmed cases of chikungunya virus infection and 56 deaths in the WHO region of the Americas.

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 4 June 2015

Dengue fever is one of the most prevalent vector-borne diseases in the world. It affects an estimated 50 to 100 million people each year, mainly in the tropical regions of the world. The identification of sporadic autochthonous cases in non-endemic areas in recent years has already highlighted the risk of locally-acquired cases occurring in EU countries where the competent vectors are present. The dengue outbreak in the autonomous province of Madeira, Portugal, in October 2012 and the autochthonous dengue cases in the south of France in 2014 further underline the importance of surveillance and vector control in other European countries.

➔Update of the week

There are several ongoing outbreaks of dengue fever across the globe.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 3 July 2015

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until all transmission of the virus 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 the international spread of wild poliovirus during 2014. On 6 May 2015, the Temporary Recommendations in relation to PHEIC were extended for another three months.

➔Update of the week

During the past week, no new cases of wild poliovirus type 1 (WPV1) were reported to WHO.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

II. Detailed reports

West Nile virus - Multistate (Europe) - Monitoring season 2015

Opening date: 2 June 2015 Latest update: 2 July 2015

Epidemiological summary

As of 2 July 2015, one human case of West Nile fever has been reported by Bulgaria in the EU. No cases have been recorded in neighbouring countries since the beginning of the 2015 transmission season.

Web sources: ECDC West Nile fever | ECDC West Nile fever risk assessment tool | ECDC West Nile fever maps | WHO fact sheet |

ECDC assessment

The detection of a WNF case in Bulgaria is not unexpected. The country previously reported a case in 2012 in Burgas province and is surrounded by countries that have reported WNF cases in previous years. However, this probable case (as per the EU case definition) is the first case reported in the European region for the current transmission season.

West Nile fever in humans is a notifiable disease in the EU. The implementation of control measures is 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 unless donations are tested by individual NAT.

Actions

From week 23 onwards, ECDC will produce weekly West Nile fever (WNF) risk maps during the transmission season (June-November) to inform blood safety authorities regarding WNF affected areas.

Source: ECDC

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 2 July 2015

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Epidemiological summary

Distribution of cases as of 30 June 2015:

Countries with intense transmission:

- **Guinea:** 3 745 cases of which 3 277 are confirmed and 2 490 deaths.
- **Sierra Leone**: 13 129 cases of which 8 668 are confirmed and 3 933 deaths.

Countries with localised transmission:

- **Liberia**: three cases including one death (as of 2 July WHO has only acknowledged one case). Liberia was declared Ebola-free on 9 May 2015 by WHO.

Countries that have reported an initial case or localised transmission:

- Nigeria, Senegal, the USA, Spain, Mali, the UK and Italy.

Situation in West African countries
In **Guinea**, WHO reported 12 new confirmed cases in the week up to 28 June, the same number as the previous week. Transmission was centred in three prefectures: Boke (n=10), Forecariah (n=1) and Conakry (n=1). Nine cases reported in Boke came from the sub-prefecture of Boke Centre and were all registered contacts. One case has been reported in the Kamsar prefecture. The case in Kamsar and one case in Boke are healthcare workers. WHO reported that the case registered in Conakry arose from an unknown chain of transmission and was tested post-mortem. The case reported from the prefecture of Forecariah was a registered contact. This is the lowest weekly total of cases reported from Forecariah since January this year.

Overall, according to WHO, 10 (83%) of the 12 cases reported from Guinea in the week to 28 June were registered contacts.

In **Sierra Leone**, WHO reported eight new confirmed cases in the week up to 28 June, the same number as the previous week. Transmission was centred in three districts: Western Area Urban which includes the capital Freetown (n=4), Port Loko (n=2) and Kambia (n=2). All the cases reported by WHO in Sierra Leone were registered contacts or had a direct link with known chains of transmission.

According to WHO in the week up to 28 June, 99.8% of 520 credible reports of sick people with possible EVD-like symptoms were responded to within 24 hours.

Liberia: WHO reported that on 29 June, routine surveillance detected a confirmed case of EVD in Margibi County, Liberia. This is the first confirmed case in the country since 20 March. The country was declared Ebola free by WHO on 9 May 2015.
The case was a 17-year-old male who first became ill on 21 June. After presenting at a local health facility the patient was treated for malaria and discharged. He died on 28 June and received a safe burial the same day. An oral swab taken before the burial subsequently tested positive twice for EVD. One hundred and two contacts have been identified, although that number is expected to increase as investigations continue. At this stage, according to WHO, the origin of infection is not known. The case had no recent history of travel, contact with visitors from affected areas, or funeral attendance.

According to the Liberian Ministry of Health, a second case tested positive for Ebola virus. According to media sources quoting the Liberian Ministry of Health, a third case who was living in the same household as the 17-year-old boy was identified. After the teenager's death, authorities have quarantined the area.
Health officials reported that a traditional healer, who had treated the 17-years-old boy, had evaded the authorities and has not yet been found.

Situation among healthcare workers
Two new healthcare worker infections were reported by WHO from Boke, Guinea, during the week up to 28 June. No new healthcare worker infections were reported from Sierra Leone.
There have been 874 confirmed healthcare worker infections reported from Guinea, Liberia and Sierra Leone since the start of the outbreak, with 507 reported deaths.

Outside of the three most affected countries, 2 Ebola-infected healthcare workers were reported in Mali, 11 in Nigeria, 1 in Spain (infected while caring for an evacuated EVD patient), 2 in the UK (both infected in Sierra Leone), 6 in the USA (2 infected in Sierra Leone, 2 in Liberia, and 2 infected while caring for a confirmed case in Texas) and 1 in Italy (infected in Sierra Leone).

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Medical evacuations and repatriations from EVD-affected countries
Since the beginning of the epidemic and as of 2 July 2015, 65 individuals have been evacuated or repatriated worldwide from the EVD-affected countries. Of these, 38 individuals have been evacuated or repatriated to Europe. Thirteen were medical evacuations of confirmed EVD-infected patients to: Germany (3), Spain (2), France (2), UK (2), Norway (1), Italy (1), Netherlands (1) and Switzerland (1). Twenty-five asymptomatic persons have been repatriated to Europe as a result of exposure to Ebola in West Africa: UK (13), Denmark (4), Sweden (3), Netherlands (2), Germany (1), Spain (1) and Switzerland (1).
Twenty-seven persons have been evacuated to the United States.
No new medical evacuations have taken place since 18 March 2015.

Images
- Epicurve 1: the epicurve shows the confirmed cases in the three most affected countries.
- Epicurve 2: the epicurve shows the confirmed cases in Guinea and Sierra Leone.
- Map: this map is based on country situation reports and shows only confirmed cases of EVD in the past six weeks. Please note that in order to better represent the tail of the epidemic the scale of the map has been changed.

Web sources: ECDC Ebola page | ECDC Ebola and Marburg fact sheet | WHO situation summary | WHO Roadmap | WHO Ebola Factsheet | CDC | WHO declaration of the end of epidemic in Liberia | UNMEER | Ministry of Health in Liberia

ECDC assessment

This is the largest ever documented epidemic of EVD, both in terms of numbers and geographical spread. The epidemic of EVD increases the likelihood that EU residents and travellers to the EVD-affected countries will be exposed to infected or ill persons. The risk of infection for residents and visitors in the affected countries through exposure in the community is considered low if they adhere to the recommended precautions. Residents and visitors to the affected areas run a risk of exposure to EVD in healthcare facilities.

The risk of importing EVD into the EU and the risk of transmission within the EU following an importation remains low or very low as a result of the range of risk reduction measures that have been put in place by the Member States and by the affected countries in West Africa. However, continued vigilance is essential. If a symptomatic case of EVD presents in an EU Member State, secondary transmission to caregivers in the family and in healthcare facilities cannot be excluded.

According to WHO, a decline in case incidence and the contraction of the geographic area affected by Ebola has stalled during the last weeks. Both in Guinea and Sierra Leone new confirmed cases are still identified among unregistered contacts and people continue to be diagnosed with Ebola post mortem. These patterns indicate that the disease is circulating in unrecognised chains of transmission. In order to achieve zero cases, there is a need for strong community engagement, improved contact tracing and earlier case identification.

The recent cases in Liberia highlight the importance of maintaining the capacity of early case detection and enhanced vigilance regarding deaths with unknown causes even in countries that have been declared Ebola free.

Actions

As of 2 July 2015, ECDC has deployed 86 experts from within and outside the EU in response to the Ebola outbreak. This includes an ECDC-mobilised contingent of experts to Guinea. Furthermore, additional experts are already confirmed for deployment to Guinea over the next few months.

ECDC is looking for additional French-speaking experts with field epidemiology experience from EU Member States to join the ECDC-coordinated contingent in response to the Ebola outbreak in Guinea. For further information, please contact Alice Friaux at alice.friaux@ecdc.europa.eu with copy to support@ecdc.europa.eu.

An epidemiological update is published weekly on the EVD ECDC page.

ECDC has updated the list of affected countries and regions on his website to include the newly affected county of Margibi in Liberia
ECDC has updated the event background on his website to report the newly reported cases in Liberia.
The latest (12th) update of the rapid risk assessment was published on 30 June 2015.
On 22 January 2014, 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.

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Postal address: ECDC 171 83 Stockholm, Sweden
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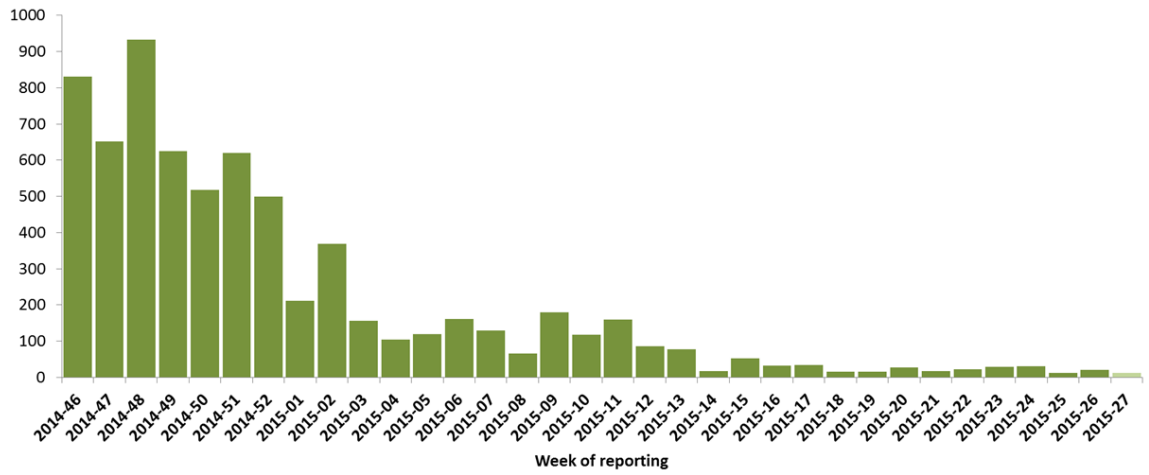
On 23 October 2014, ECDC published Public health management of persons having had contact with Ebola virus disease cases in the EU.
On 22 October 2014, ECDC published Assessing and planning medical evacuation flights to Europe for patients with Ebola virus disease and people exposed to Ebola virus.
On 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.

Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 27/2015)

Adapted from WHO figures; *data for week 27/2015 are incomplete



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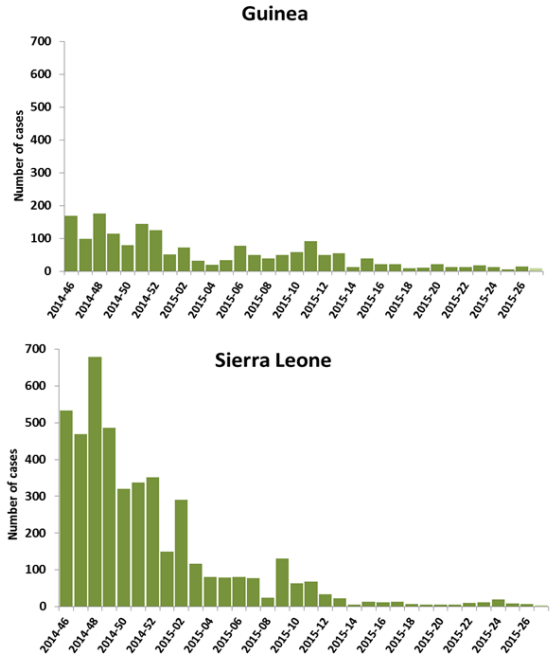
Distribution of confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (weeks 46/2014 to 27/2015)

Adapted from WHO figures; *data for week 27/2015 are incomplete



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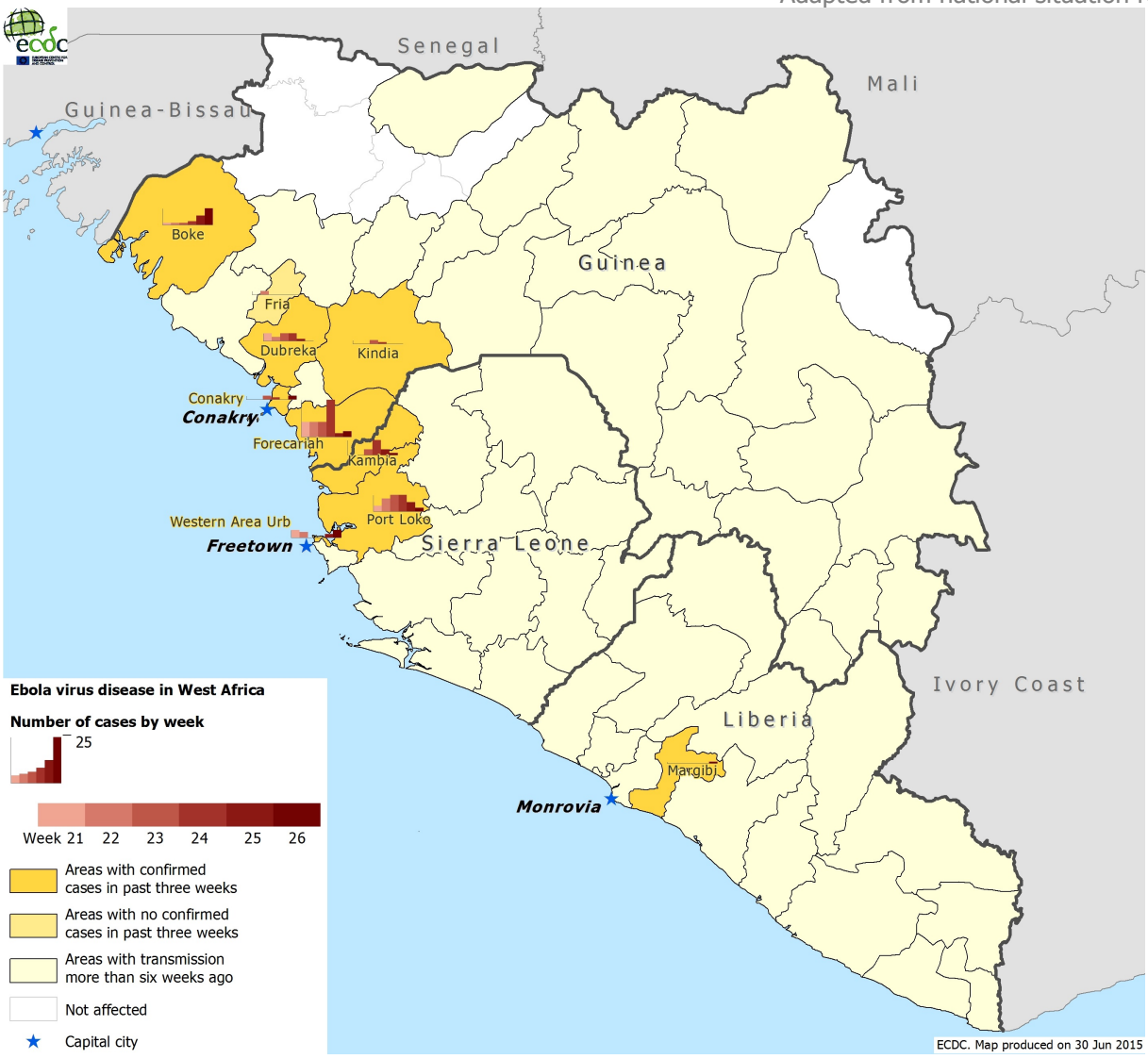
Distribution of confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (as of week 26/2015)

Adapted from national situation reports



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

Opening date: 24 September 2012 Latest update: 2 July 2015

Epidemiological summary

In South Korea, during the last two weeks, the number of new cases reported has decreased. Over the past week, South Korea reported three additional cases and four deaths in previously reported cases.

On 1 July 2015, the South Korean Ministry of Health reported that of the 183 cases, 12 were in a severe condition, 36 in moderate condition, 102 discharged and 33 have died. Overall, 55% of the reported fatal cases had comorbidities (n=18). The median age for the 102 cases discharged is 50-years-old, while the median age for the 33 deaths is 70 years-old. As part of the transmission of MERS-CoV in hospital settings, 37 healthcare workers have been infected during the outbreak: 21 doctors or nurses, eight caregivers and eight medical support staff. These 37 healthcare workers represent 20% of all the cases.

Since April 2012 and as of 1 July 2015, 1 382 cases of MERS-CoV have been reported by local health authorities worldwide, including 533 deaths.

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Postal address: ECDC 171 83 Stockholm, Sweden
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The distribution is as follows:

Confirmed cases and deaths by region:

Middle East
Saudi Arabia: 1 042 cases/460 deaths
United Arab Emirates: 81 cases/11 deaths
Qatar: 13 cases/5 deaths
Jordan: 19 cases/6 deaths
Oman: 6 cases/3 deaths
Kuwait: 3 cases/1 death
Egypt: 1 case/0 deaths
Yemen: 1 case/1 death
Lebanon: 1 case/0 deaths
Iran: 6 cases/2 deaths

Europe
Turkey: 1 case/1 death
UK: 4 cases/3 deaths
Germany: 3 cases/2 death
France: 2 cases/1 death
Italy: 1 case/0 deaths
Greece: 1 case/1 death
Netherlands: 2 cases/0 deaths
Austria: 1 case/0 deaths

Africa
Tunisia: 3 cases/1 death
Algeria: 2 cases/1 death

Asia
Malaysia: 1 case/1 death
Philippines: 2 cases/0 deaths
South Korea: 183 cases/33 deaths
China: 1 case/0 deaths
Thailand:1 case/ 0 deaths

Americas
United States of America: 2 cases/0 deaths

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 | ECDC factsheet for professionals

ECDC assessment

In South Korea, the number of new cases has been falling over the last week, indicating that the public health measures are effective in interrupting the chains of transmission and controlling the outbreak.
ECDC's assessment continues to be that the MERS-CoV outbreak poses a low risk to the EU. The risk for visitors to South Korea is extremely low, unless visitors have had contact with healthcare facilities, in the ones which report MERS confirmed cases. The risk for visitors to Saudi Arabia is low, and related to exposures either to live camels and camel products or to healthcare facilities.

However, because of the continued risk of case importation to Europe after exposure in the Middle East and South Korea, international surveillance for MERS-CoV cases among travellers remains essential. Moreover, rapid efforts to contain the nosocomial clusters in the affected countries are vital to prevent wider transmission. Although sustained human-to-human community transmission is unlikely, secondary transmission to unprotected close contacts, especially in healthcare settings, remains possible, as now documented in South Korea.

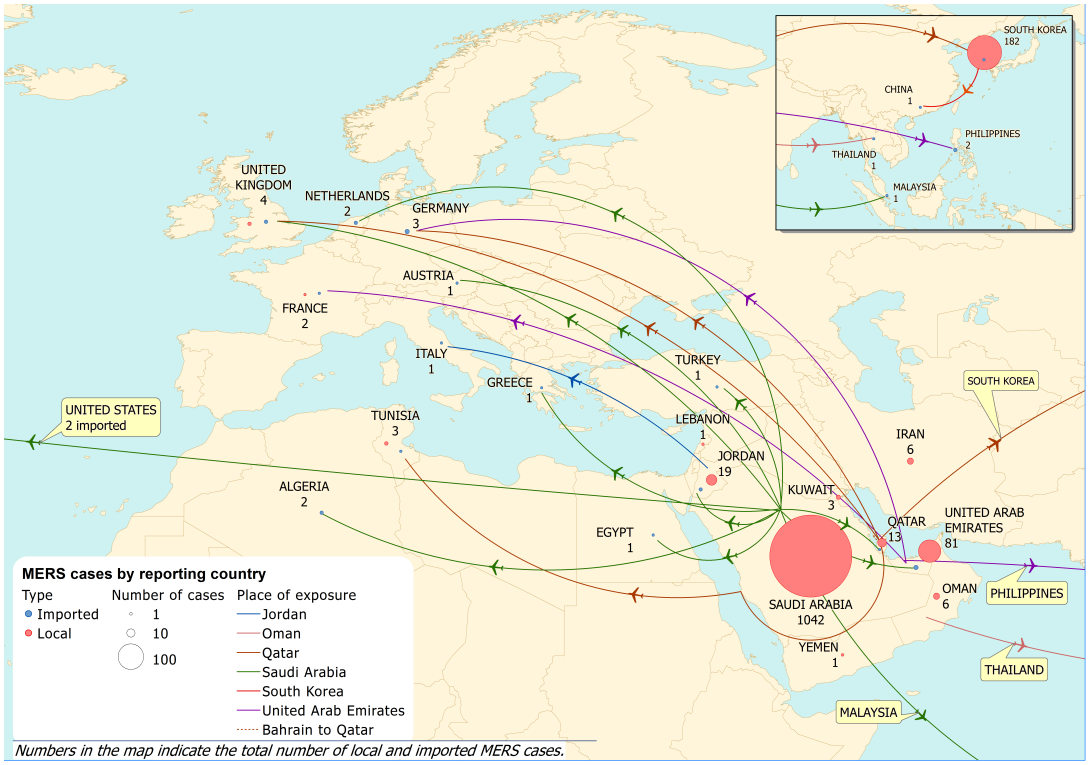
Actions

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

ECDC published a rapid risk assessment on 1 July 2015.

Distribution of confirmed cases of MERS-CoV by place of probable infection, March 2012 – 1 July 2015 (n=1 382)

Source: ECDC

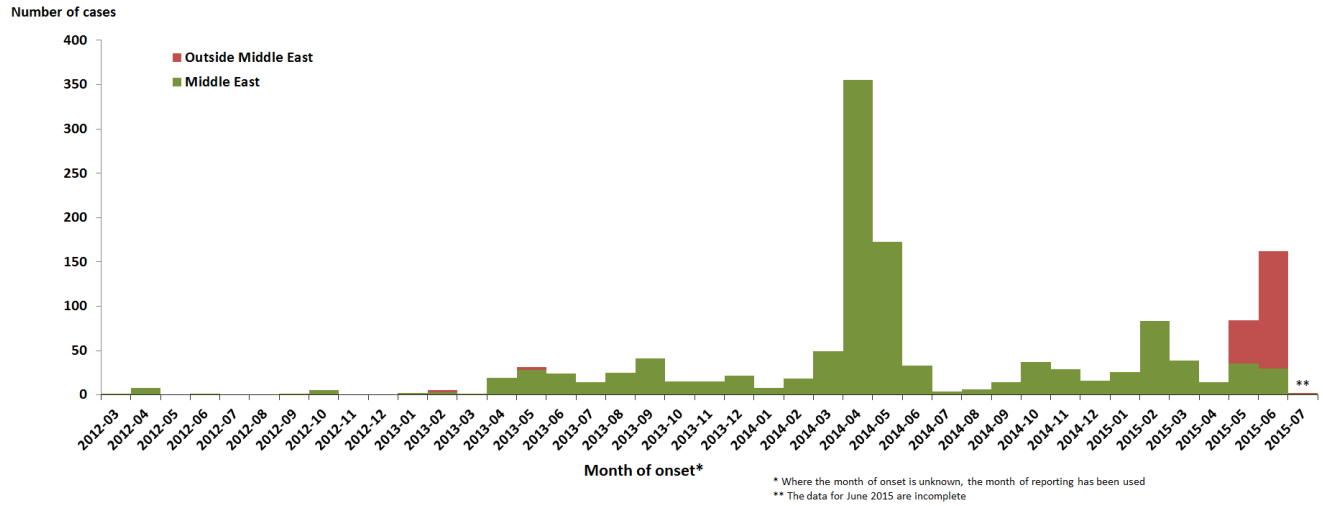


Numbers in the map indicate the total number of local and imported MERS cases.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

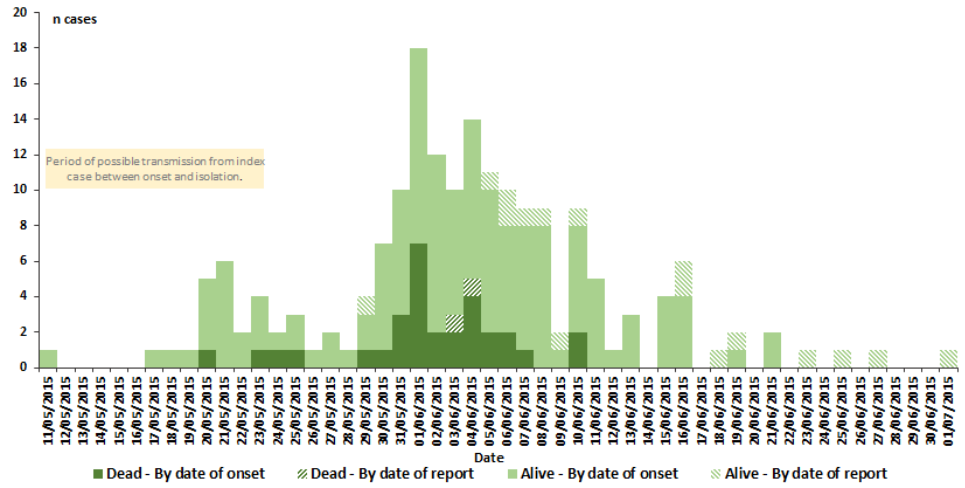
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 1 July 2015 (n=1 382)

Source: ECDC



Distribution of confirmed cases of MERS-CoV by first available date and by status, 11 May - 1 July 2015 (n=183)

Source: ECDC



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Influenza A(H5N1) and other strains of avian flu - Multistate (world) - Monitoring globally

Opening date: 15 June 2005 Latest update: 25 June 2015

Epidemiological summary

Human cases of avian flu
On 1 July 2015, Egypt reported a fatal case of A(H5N1) in a five-and-a-half year old boy from Aswan Governorate, Edfu District with known exposure to poultry who developed symptoms on 16 June. He was admitted to a private hospital with bilateral pneumonia on 24 June and was put on treatment with Tamiflu on 25 June, but passed away on 27 June. Confirmation was done by RT-PCR at Central Public Health Laboratories on 28 June.

In 2015, 144 human cases of influenza A(H5N1), including 41 deaths have been reported in Egypt, according to the Ministry of Health.

Worldwide, from 2003 to 23 June 2015, 842 laboratory-confirmed human cases of avian influenza A(H5N1) virus infection have been officially reported to WHO from 16 countries. Of these cases, 447 have died.

Non-human cases of avian flu
In the past week, Iran and Ghana reported additional cases of influenza A(H5N1) in wild birds and poultry respectively, according to the World Organization for Animal Health (OIE). In the USA, Iowa reported a new outbreak of A(H5N2) in poultry.

Web sources: ECDC Rapid Risk Assessment | Avian influenza on ECDC website |EMPRES | OIE | WHO

ECDC assessment

Most human infections of A(H5N1) are the result of direct contact with infected birds or contaminated environments, and countries with large poultry populations in close contact with humans are considered to be most at risk of bird flu outbreaks. Therefore, additional human cases would not be unexpected. There are currently no indications of a significant change in the epidemiology associated with any clade or strain of the A(H5N1) virus from a human health perspective. However, vigilance for avian influenza in domestic poultry and wild birds in Europe remains important.

Although an increased number of animal-to-human infections have been reported by Egypt during 2015, it is not thought to be related to virus mutations but rather to more people becoming exposed to infected poultry.

Various influenza A(H5) and A(H7) subtypes, such as influenza A(H5N1), A(H5N2), A(H5N3), A(H5N6), A(H5N8) and A(H7N3), have recently been detected in birds in West Africa, Asia, Europe, and North America, according to the World Organisation of Animal Health (OIE). Although these influenza viruses might have the potential to cause disease in humans, to date, there have been no reported human infections with these viruses with the exception of human infections with influenza A(H5N1) and A (H5N6) viruses. The risk to people from these infections in wild birds, backyard flocks and commercial poultry is considered to be low.

A novel highly pathogenic influenza virus A(H5N9) detected in poultry in live-bird markets in China in 2013 is a novel reassortant of avian influenza viruses H5N1, H7N9 and H9N2, all of which have already transmitted to humans and caused moderate to severe disease. So far, no human cases infected with this new avian influenza variant have been detected. The potential of this virus for transmission to humans is considered as very low.

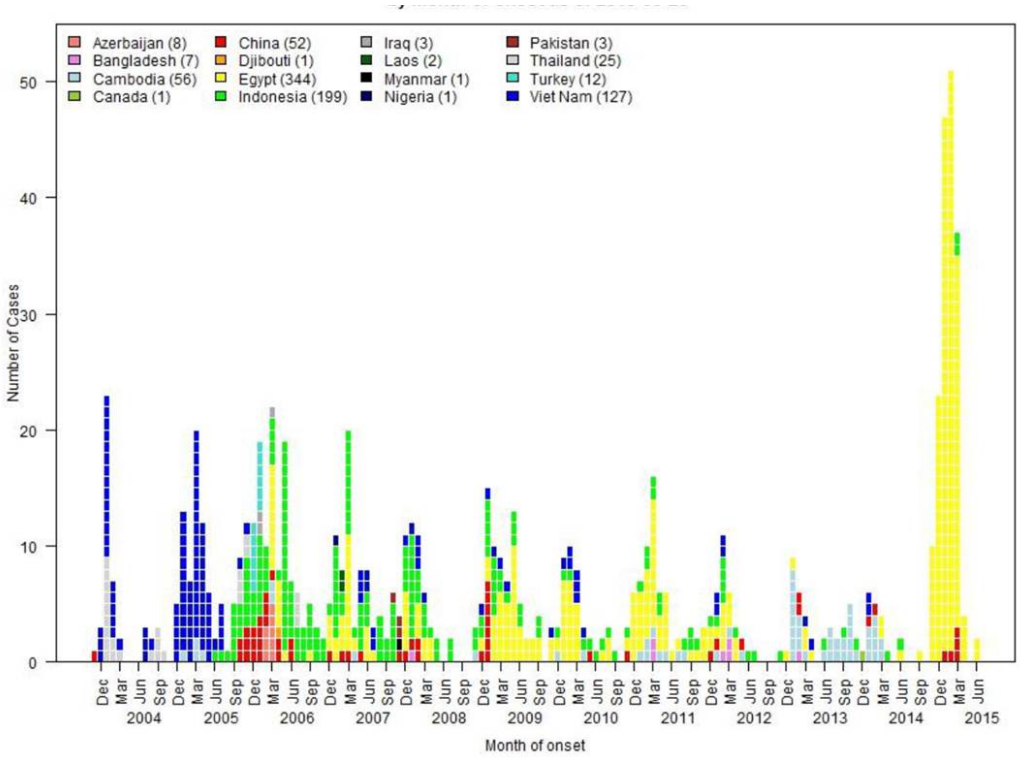
Actions

ECDC monitors the worldwide A(H5N1) situation through epidemic intelligence activities on a weekly basis in order to identify significant changes in the epidemiology of the virus. ECDC re-assesses the potential of a changing risk for A(H5N1) to humans on a regular basis.
ECDC published a Rapid Risk Assessment covering A(H5N1) in Egypt on 13 March 2015.
ECDC published an epidemiological update about A(H5N1) in Egypt on 10 April 2015.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

Number of confirmed human H5N1 cases by month of onset as of 23 June 2015

WHO



Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 2 July 2015

Epidemiological summary

Europe
In France, between the 1 May and 26 June, 7 imported cases of chikungunya virus infection were reported. No autochthonous cases of chikungunya were notified, according to InVS.

Americas
Since the beginning of the year and as of 26 June 2015, the WHO Pan American Health Organization (WHO PAHO) has reported 398 907 suspected and confirmed cases of chikungunya virus infection and 56 deaths in the WHO region of the Americas.

In Central America, several locations are affected in **Mexico** (Isthmus of Tehuantepec region, Oaxaca state and Veracruz state). There is intense transmission in **Honduras** with a recent increase in cases. In June 2015, four countries in South America reported an increasing trend of new cases to WHO PAHO: **Colombia** (week 23), **Peru** (Tumbes region, week 24), **Ecuador** (week 24) and **Paraguay** (week 22).

In the **United States**, 200 cases of chikungunya virus infection have been reported from 32 states in 2015 (as of 30 June). All reported cases have occurred in travellers returning from affected areas. No locally-transmitted cases have been reported, according to the US CDC.

Pacific region
According to the Pacific Public Health Surveillance Network, there are ongoing chikungunya outbreaks in Cook Islands and Marshall Islands (as of 28 June).

Web sources: PAHO update| ECDC Chikungunya | WHO Factsheet | Medisys page |

ECDC assessment

Epidemiological data indicate that the outbreaks are still expanding in the Caribbean, the Americas and the Pacific. The vector is endemic in all three regions, where it also transmits dengue virus. Continued vigilance is needed to detect imported cases of chikungunya in tourists returning to the EU from these regions.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

Actions

ECDC published a Rapid Risk Assessment on 27 June 2014.

ECDC monitors the global chikungunya situation on a monthly basis.

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 4 June 2015

Epidemiological summary

Europe: No new autochthonous dengue cases have been detected so far in 2015. In **France**, 23 imported cases of dengue fever were reported in metropolitan France between 1 May and 26 June, according to InVS. Although no ongoing transmission or autochthonous cases have been reported, the vector *Aedes albopictus*, is present in some of these areas.

Asia: Malaysia is experiencing a very large dengue outbreak with more than 40 000 dengue cases and 157 deaths reported so far in 2015 (as of 24 June 2015). In addition, the number of deaths has almost doubled compared with the same time period last year, according to media quoting the Ministry of Health.

The number of dengue fever cases in **Myanmar** continues to rise with more than 10 000 cases and 45 deaths so far this year (as of 23 June), according to media quoting the Ministry of Health. This year's figures are also significantly higher compared with the same time period in 2014 (between 1 January and 26 May in 2014, 3 667 cases were reported compared to 5 092 cases in 2015).

In **Cambodia**, the number of dengue cases has almost doubled in the past six months compared with the same time period last year, according to media quoting the Ministry of Health. The majority of cases reported so far this year have been between the ages of five and 14 years. Three children have died. In **Thailand**, as of 18 June 2015, cases of dengue fever have been reported in Phuket (160 cases) and Krabi (over 400 cases) since the beginning of 2015, according to media quoting local health authorities.

In **Pakistan**, nearly 600 cases of dengue fever have been reported in Sindh province since the start of the year and the majority of cases have been recorded in Karachi, according to media quoting local health authorities.

Middle East: In **Yemen**, more than 3 000 suspected cases of dengue fever have been reported since March, according to media quoting WHO.

Americas: In Central America, increased dengue activity is reported across two states (Hidalgo and Tamaulipas) in **Mexico**. In South America, **Brazil** reports a rise in dengue cases in Pernambuco state. The most affected municipalities are Recife, Camaragibe, Jaboatao dos Guararapes and Goiana.

Pacific Islands and Australia: According to the Pacific Public Health Surveillance Network (PACNET), 20 newly confirmed cases of dengue fever were reported in **French Polynesia** during the week ending 21 June 2015. There are currently ongoing outbreaks of DENV-3 in **American Samoa** and DENV-2 in the Macuata Sub division of **Fiji**.

In **Australia,** there is an ongoing DENV-1 outbreak in Cairns but the outbreak in Tully/El Arish was declared over on 3 June, according to Queensland Health.

Web sources: ECDC Dengue | Healthmap Dengue | MedISys | ProMed Americas, Asia, Pacific, Middle East, Europe |

ECDC assessment

The autochthonous transmission of dengue fever in the south of France during 2014 highlights the risk of locally-acquired cases occurring in countries where the competent vectors are present. This underlines the importance of surveillance and vector control in European countries with competent vectors.

Actions

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ECDC published a technical report on the climatic suitability for dengue transmission in continental Europe and guidance for the surveillance of invasive mosquitoes.

ECDC monitors the dengue situation worldwide on a monthly basis.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 3 July 2015

Epidemiological summary

Worldwide in 2015, 29 wild poliovirus type 1 (WPV1) cases have been reported to WHO so far, compared with 111 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (25 cases) and Afghanistan (4 cases).

In 2015, six cases (five in Madagascar and one in Nigeria) of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO so far, compared with 26 for the same period in 2014.

Web sources: Polio Eradication: weekly update | MedISys Poliomyelitis | ECDC Poliomyelitis factsheet | Temporary Recommendations to Reduce International Spread of Poliovirus | Statement on the 4th IHR Emergency Committee meeting regarding the international spread of wild poliovirus

ECDC assessment

Europe is polio-free. The last locally acquired wild-polio cases within the current EU borders were reported from Bulgaria in 2001. The most recent outbreak in the WHO European Region was in Tajikistan in 2010, when importation of WPV1 from Pakistan resulted in 460 cases.
The confirmed circulation of wild poliovirus in several countries and the documented exportation of wild poliovirus to other countries support the fact that there is a potential risk of wild poliovirus being re-introduced to the EU/EEA. The highest risk of large poliomyelitis outbreaks occurs in areas with clusters of unvaccinated populations and in people living in poor sanitary conditions, or a combination of both.

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? |

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.

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

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