

I. Executive summary

EU Threats

Influenza – Multistate (Europe) – Monitoring 2014–2015 season

Opening date: 9 October 2014

Latest update: 13 March 2015

Following the 2009 pandemic, influenza transmission in Europe has returned to its seasonal epidemic pattern, with peak activity during winter months. ECDC monitors influenza activity in Europe during the winter season and publishes the results on its website in the weekly Flu News Europe.

→ Update of the week

In week 10/2015, 23 countries reported widespread activity and/or medium levels of influenza. The proportion of influenza virus detection in sentinel specimens is decreasing this week, after having been over 50% since week 04/2015. Influenza A (H1N1)pdm09, A(H3N2) and type B viruses continued to circulate in the region, with A(H3N2) predominating, despite increasing detections of type B viruses.

Non EU Threats

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 13 March 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).

→ Update of the week

As of 10 March 2015, [WHO](#) reported 24 385 cases of Ebola virus disease (EVD) related to the outbreak in West Africa, including 10 019 deaths.

In the week leading to 8 March 2015, WHO reported 116 new confirmed cases of Ebola virus disease (EVD), compared with 132 of the previous week. Liberia reported no new confirmed cases for the second consecutive week. New cases in Guinea (58) and Sierra Leone (58) occurred in a geographically adjacent area around the capital cities of Conakry and Freetown.

Influenza A(H5N1) - Multistate (world) - Monitoring human cases

Opening date: 15 June 2005

Latest update: 12 March 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 the last [WHO](#) influenza update on 26 January 2015, 66 new laboratory-confirmed human cases of avian influenza A (H5N1) virus infection, including 13 fatal cases have occurred in Egypt (65) and China (one).

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 12 March 2015

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, 631 cases have been reported, including 221 deaths. No autochthonous cases have been reported from outside of China. Most cases have been unlinked, and sporadic zoonotic transmission from poultry to humans is the most likely explanation for the outbreak.

→Update of the week

Since the last update of 12 February 2015, [WHO](#) has reported 60 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus in China. Cases were reported from nine provinces: Anhui (4), Fujian (1), Guangdong (35), Guizhou (1), Hunan (2), Jiangsu (3), Jiangxi (1), Shanghai (1), Zhejiang (11). One case has been reported from [Hong Kong](#).

According to WHO 76% (45) of the 60 cases were male. All but ten cases reported exposure to live poultry or visited live poultry markets. The exposure history of six cases is unknown or unavailable. Among the 60 cases, three family clusters were detected, each comprised of two family members. Four of the six cases had exposure to live poultry or live poultry markets, one case had no exposure to poultry, and one case is still under investigation. Onset dates for the cases ranged from 19 January 2015 until 25 February 2015.

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

Opening date: 24 September 2012

Latest update: 12 March 2015

Since April 2012, 1 093 cases of MERS-CoV have been reported by local health authorities worldwide, including 449 deaths. To date, all cases have either occurred in the Middle East, have direct links to a primary case infected in the Middle East, or have returned from this area. 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.

→Update of the week

Since the last update of 6 March 2015 and as of 12 March 2015, Saudi Arabia has reported 12 additional cases of MERS-CoV in Riyadh (8 cases), Jeddah (2), Buraydah (1) and Hofuf (1). Two of the cases were healthcare workers. Of the 12 cases, one was classified as nosocomial infection, three are currently under investigation for possible nosocomial transmission, and one case had contact with a previously reported case in the community. Three of the 12 cases reported contact to animal of which one was specified as camel contact. Of the 12 cases 58% (n=7) were male. The median age for the cases was 58 years ranging between 37 and 72 years.

On 7 March 2015, Germany reported a confirmed case of MERS-CoV through the Early Warning and Response System. The patient is a 65-year-old German male who returned from a holiday in Abu Dhabi, United Arab Emirates, on 8 February 2015. Onset of symptoms was on 10 February with respiratory symptoms. The patient was hospitalised in an intensive care unit one week later and is now in a severe but stable condition. Contact tracing is ongoing, led by the local public health authorities. Until now, no additional cases have been notified. An investigation into the case and possible exposure is underway. According to [media](#) the case had exposure to camels during his stay in the United Arab Emirates.

The health authorities in Qatar reported a case of MERS-CoV on 9 March 2015, in a 69-year-old male. He had onset of symptoms on 27 February. According to [WHO](#) the case has history of frequent contact with camels and regular consumption of raw camel milk.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 13 March 2015

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission stops and the world is 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 27 February 2015, the Temporary Recommendations in relation to PHEIC were extended for a further three months.

→Update of the week

During the past week, three new wild poliovirus type 1 (WPV1) cases were reported by WHO, all from Pakistan.

II. Detailed reports

Influenza – Multistate (Europe) – Monitoring 2014–2015 season

Opening date: 9 October 2014

Latest update: 13 March 2015

Epidemiological summary

Excess all-cause mortality among people aged 65 years and above, concomitant with increased influenza activity and the predominance of A(H3N2) viruses, has been observed since the beginning of the year in Belgium, Denmark, France, the Netherlands, Portugal, Spain, Switzerland and the United Kingdom (see EuroMOMO at: <http://www.euromomo.eu/>).

Most of the A(H3N2) viruses characterised so far show antigenic differences compared to the virus included in the 2014–2015 northern hemisphere influenza vaccine. The observed reduced effectiveness of the A(H3N2) component of the vaccine might have contributed to the excess mortality reported among elderly people. The A(H1N1)pdm09 and B components of the vaccine are likely to be effective.

The circulation of respiratory syncytial virus (RSV) has decreased to low levels across the European Region

Web sources: [Flu News Europe](#) | [ECDC Influenza](#) |

ECDC assessment

Influenza activity seems to have passed its peak in most of the European countries as decreasing (27) or stable (12) activity is reported by 39 of the 40 countries.

Actions

ECDC and WHO produce the [Flu News Europe](#) bulletin weekly.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 13 March 2015

Epidemiological summary

Distribution of cases as of 10 March 2015:

Countries with intense transmission

Distribution of EVD cases for countries with intense transmission:

- Guinea: 3 330 cases and 2 187 deaths (as of 10 March 2015)
- Liberia: 9 343 cases and 4 162 deaths (as of 5 March 2015)
- Sierra Leone: 11 677 cases and 3 655 deaths (as of 10 March 2015)

Countries with an initial case or cases, or with localised transmission

- Mali, Nigeria, Senegal, Spain, the United States and United Kingdom have been declared free of EVD after having cases related to the current epidemic in West Africa.

Situation in specific West African countries

In Guinea, in the week to 8 March, WHO reported 58 new confirmed cases, compared with 51 cases in the previous week, from six districts: Conakry, Boffa, Coyah, Dubreka, Forecariah, and Kindia. The number of confirmed community EVD deaths reported by WHO has risen for the past three weeks, suggesting that there are still significant challenges in contact tracing and community engagement. Of the 40 EVD-positive deaths reported in the week leading to 8 March, 24 occurred in the community. Thirteen unsafe burials were reported during the same period. In the week to 1 March, 7 of 51 (14%) confirmed cases of EVD arose among known contacts of previous cases, indicating that there are large numbers of untraced contacts associated with

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known chains of transmission, and that unknown chains of transmission persist. The average daily number of contacts traced in the week to 8 March was 1 433. Seven prefectures reported at least one security incident in the week to 8 March including every one of the prefectures that reported a confirmed case over the same period.

In Sierra Leone, in the week leading to 8 March, WHO reported 58 new confirmed cases from five north and western districts: Freetown, Bombali, Kambia, Port Loko and Western Rural Area. With the exception of four districts in the south of the country, all districts in Sierra Leone have reported a confirmed case within the past 21 days. Of 83 EVD-positive deaths, 11 occurred in the community. Two unsafe burials were reported over the week leading up to 8 March. WHO reported that 52 out of 81 (64%) of the confirmed EVD cases arose among known contacts in the week leading to 1 March. The number of confirmed cases identified post-mortem found in the community fell to 11 in the week leading to 8 March, compared with 14 in the previous week. Four districts reported at least one incident of community resistance. The average daily number of contacts traced in the week to 8 March was 7 934.

No new confirmed cases were reported in Liberia, this is the second consecutive week with no new confirmed cases. Montserrado and Margibi are the only counties to have reported a confirmed case within the past 21 days. In the four days leading to 5 March there were 90 suspected cases reported in Liberia, none of whom tested positive for EVD, indicating that vigilance is being maintained. The number of contacts followed-up was 102.

Situation in European countries

On Tuesday 10 March 2015, the United Kingdom has been declared free of Ebola ([WHO](#)).

Situation among healthcare workers

In the week leading to 8 March, one new healthcare worker infection was reported in Guinea, bringing the number of health worker infections reported across the three most-affected countries since the start of the outbreak to 840, including 491 deaths.

Medical evacuations and repatriations from EVD-affected countries

Forty-two individuals have been evacuated or repatriated worldwide from the EVD-affected countries. As of 13 March 2015, there have been 13 medical evacuations of confirmed EVD-infected patients to Europe (three to Germany, two to Spain, two to France, two to the UK, one to Norway, one to Italy, one to the Netherlands and one to Switzerland). Eighteen asymptomatic persons exposed to Ebola have been repatriated to Europe (nine to UK, three to Sweden, two to the Netherlands, one to Denmark, one to Germany, one to Spain and one to Switzerland). Eleven persons have been evacuated to the United States.

On 11 March a UK military healthcare worker in Sierra Leone tested positive for Ebola. On 12 March, [Public Health England](#) informed that the healthcare worker and two contacts have been medically evacuated to England using a specially-equipped RAF airplane. Two other individuals (contacts of the infected healthcare worker) are currently being assessed in Sierra Leone, to inform a clinical decision regarding bringing them to the UK.

Figures

First epi-curve: Distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Nigeria, Mali and Senegal, weeks 48/2013 to 11/2015 **

* In week 45/2014, WHO carried out retrospective correction in the data, resulting in 299 fewer cases being reported, which resulted in a negative value for new cases in week 45 which is not plotted.

** According to WHO, the marked increase in the cumulative total number of cases in week 43 is due to a more comprehensive assessment of patient databases, leading to 3 792 additional reported cases. However, these cases have occurred throughout the epidemic period.

Second and third epi-curves: Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 11/2015).

The prevalence of the EVD outbreak has been low in the first months of 2015 and it appears that we are reaching the tail of the epidemic. For a clearer overview of the epidemic in these late stages we are showing only the confirmed cases (Figures 2 and 3) since the adoption of the WHO situation reports in all the three countries in week 46 2014.

Fourth epi-curve: Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 11* 2015.

* The marked increase in the number of cases reported in Sierra Leone (week 44) and Liberia (week 43) resulted from a more comprehensive assessment of patient databases. The additional 3 792 cases have occurred throughout the epidemic period.

** In week 45/2014, WHO reported -476 cases in Sierra Leone due to retrospective corrections.

Map: To better show the current epidemiological situation, ECDC has produced a map based on the country situation reports showing only confirmed cases of EVD in the past six weeks. Please note that due to the lower number of cases, the scale of the bar graphs is reduced to 50 cases.

Web sources: [ECDC Ebola page](#) | [ECDC Ebola and Marburg fact sheet](#) | [WHO Ebola Factsheet](#) | [CDC](#) | [WHO Roadmap](#) | [Latest available situation summary](#) | [WHO declaration on UK Ebola free](#) | [Statement from Public Health England](#)

ECDC assessment

This is the largest ever documented epidemic of EVD 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 EVD being imported into the EU or the risk of transmission occurring within the EU remains low or very low due to the range of risk reduction measures that have been put in place by the Member States and the affected countries. However, continued vigilance is essential in order to ensure that re-entry standards do not lapse.

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 the latest weekly situation report from WHO on 11 March 2015, there has been no significant decline in the overall case incidence in Guinea and Sierra Leone since late January. The relatively low proportion of cases arising among known contacts, the relatively high proportion of EVD positive deaths that occur in the community and the continued occurrence of unsafe burials in Guinea indicate continued difficulties in engaging effectively with affected communities.

Actions

As of 13 March 2015, ECDC has deployed 43 experts within and outside the EU in response to the Ebola outbreak. This includes an ECDC mobilised contingent of experts to Guinea. Furthermore, 12 additional experts are confirmed for deployment to Guinea over the next four months while additional deployments are envisaged but still pending confirmation.

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 Niklas Danielsson, Response group leader at: niklas.danielsson@ecdc.europa.eu with cc to support@ecdc.europa.eu

An epidemiological update is published weekly on the [EVD ECDC page](#)

On 4 February 2015, ECDC published an updated [rapid risk assessment](#)

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-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](#)

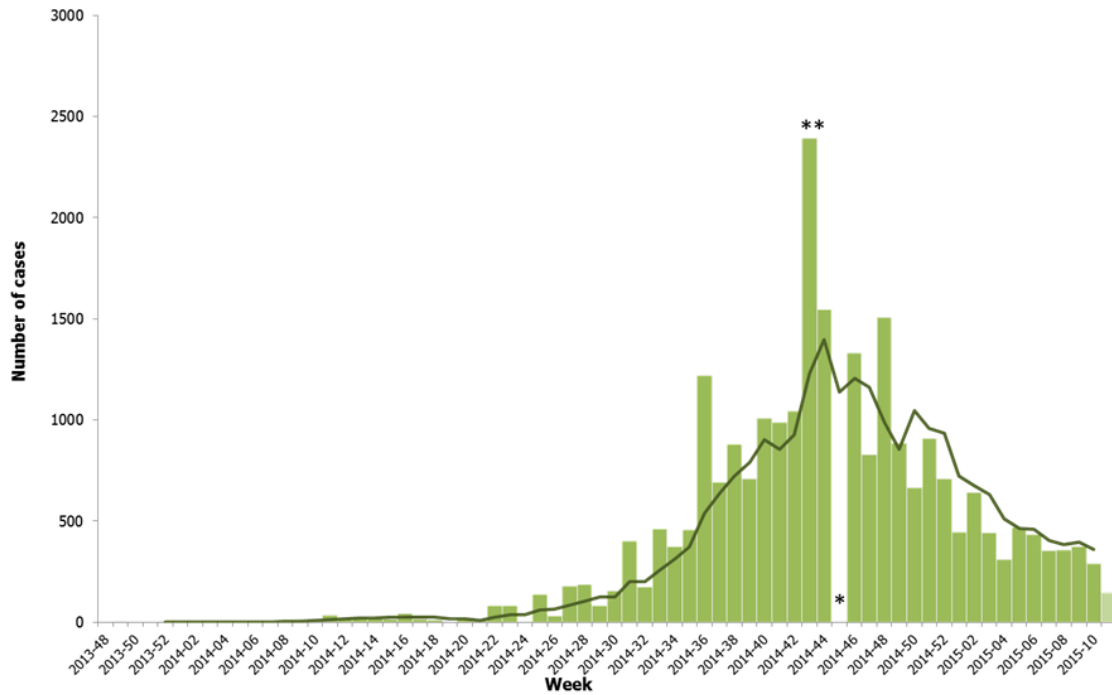
On 22 September 2014, ECDC published [assessment and planning for medical evacuation by air to the EU of patients with Ebola virus disease and people exposed to Ebola virus](#)

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

Distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Mali, Nigeria and Senegal, weeks 48/2013 to 11*/2015

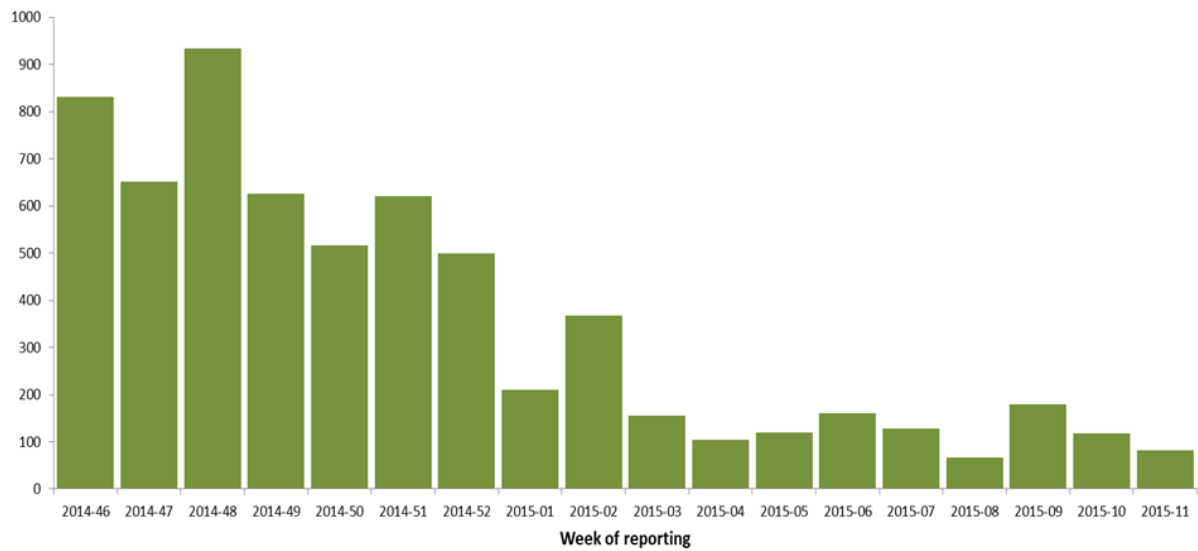
Source: Adapted from WHO figures; *data for week 11/2015 are incomplete

Weekly number of EVD cases published on 12/03/2015



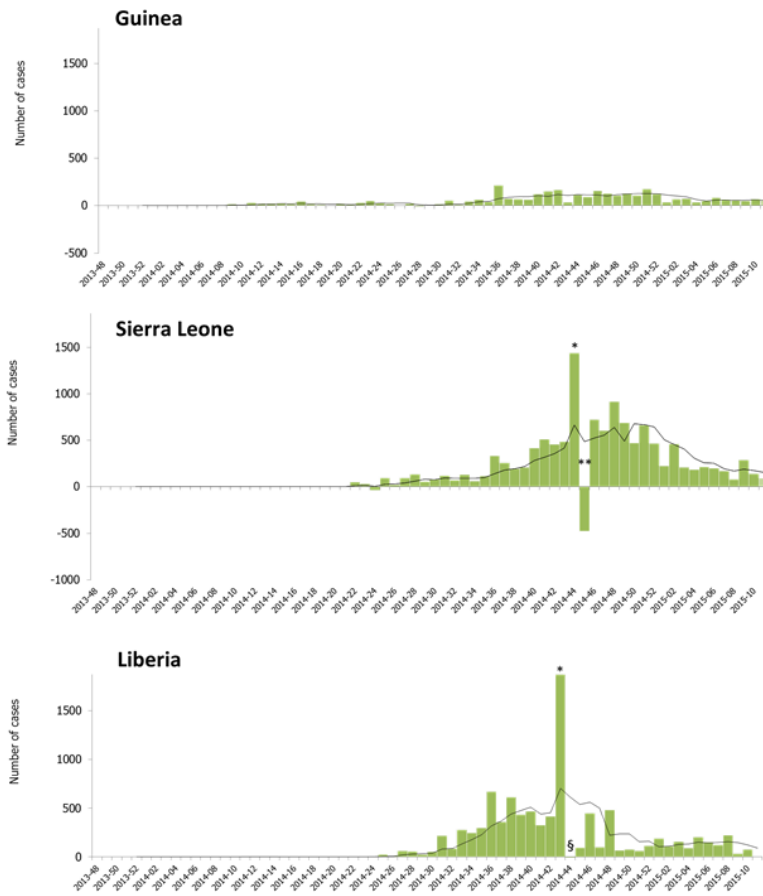
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 11/2015).

Source: Adapted from WHO figures; *data for week 11/2015 are incomplete



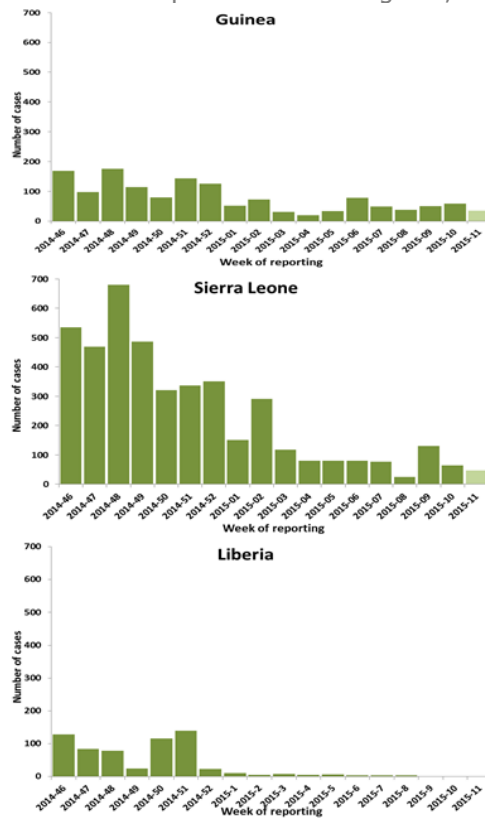
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 11/2015).

Source: Adapted from WHO figures; *data for week 11/2015 are incomplete



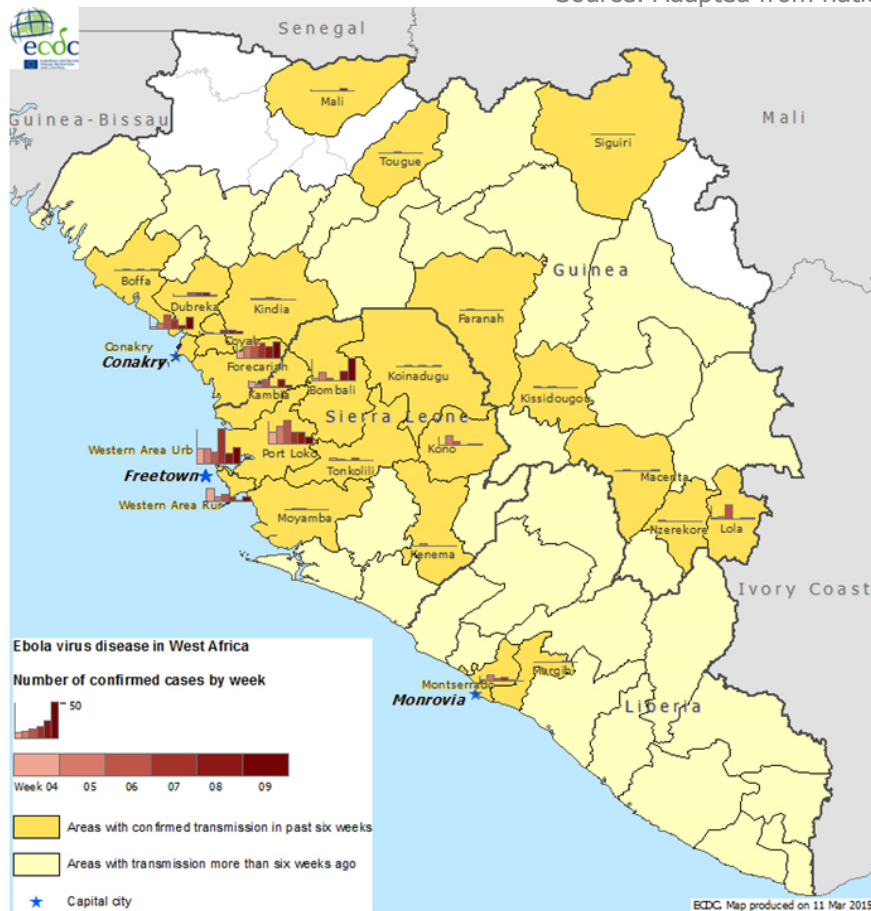
Distribution of confirmed cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 11* 2015

Source: Adapted from WHO figures; *data for week 11/2015 are incomplete



Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (as of week 09/2015)

Source: Adapted from national situation reports



Influenza A(H5N1) - Multistate (world) - Monitoring human cases

Opening date: 15 June 2005

Latest update: 12 March 2015

Epidemiological summary

Between 26 January and 12 March 2015, 65 human cases of influenza A(H5N1) virus infection were reported from Egypt, 29 had onset of disease in January and the rest had onset of disease in February. The cases were reported from 18 different governorates of Egypt. The age range of the cases is from one to 75 years, with a median age of 26 years, and 23% of the cases are under 10 years of age. All cases had exposure to poultry or poultry markets, were hospitalised and all but one reportedly received treatment with antiviral medication. Of the newly-reported cases, there was one cluster which included two confirmed family members (mother and a daughter) from Fayoum governorate. The mother had an onset of illness two days prior to the daughter's onset of illness and both had exposure to backyard poultry.

China reported a human infection with an avian influenza A(H5N1) virus in a 37-year-old woman from Jiangsu province with onset of symptoms on 14 January 2015. The patient had a history of exposure to poultry. No further cases among contacts were

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reported.

From 2003 through 3 March 2015, 784 laboratory-confirmed human cases of avian influenza A(H5N1) virus infection have been officially reported to WHO from 16 countries. Of these cases, 429 have died.

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

ECDC assessment

Most human infections of A(H5N1) are the result of direct contact with infected birds, and countries with large poultry populations in close contact with humans are considered to be most at risk of bird flu outbreaks. 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.

Human cases and fatalities due to influenza A(H5N1) virus continue to increase in Egypt, with cases from Egypt now accounting for the highest number of human cases reported worldwide . Continuous increase of virus circulation in backyard poultry and exposure to infected poultry are most probably contributing to the increase of human cases. Although an increased number of animal-to-human infections have been reported by Egypt over the past few months, these influenza A(H5) viruses do not currently appear to transmit easily among people, and no sustained human-to-human transmission has been observed. As such, the risk of community-level spread of these viruses remains low. The current assessment remains that there is no risk for the general public in the EU. Travellers from the EU should avoid direct contact to poultry or poultry products when travelling to Egypt.

Actions

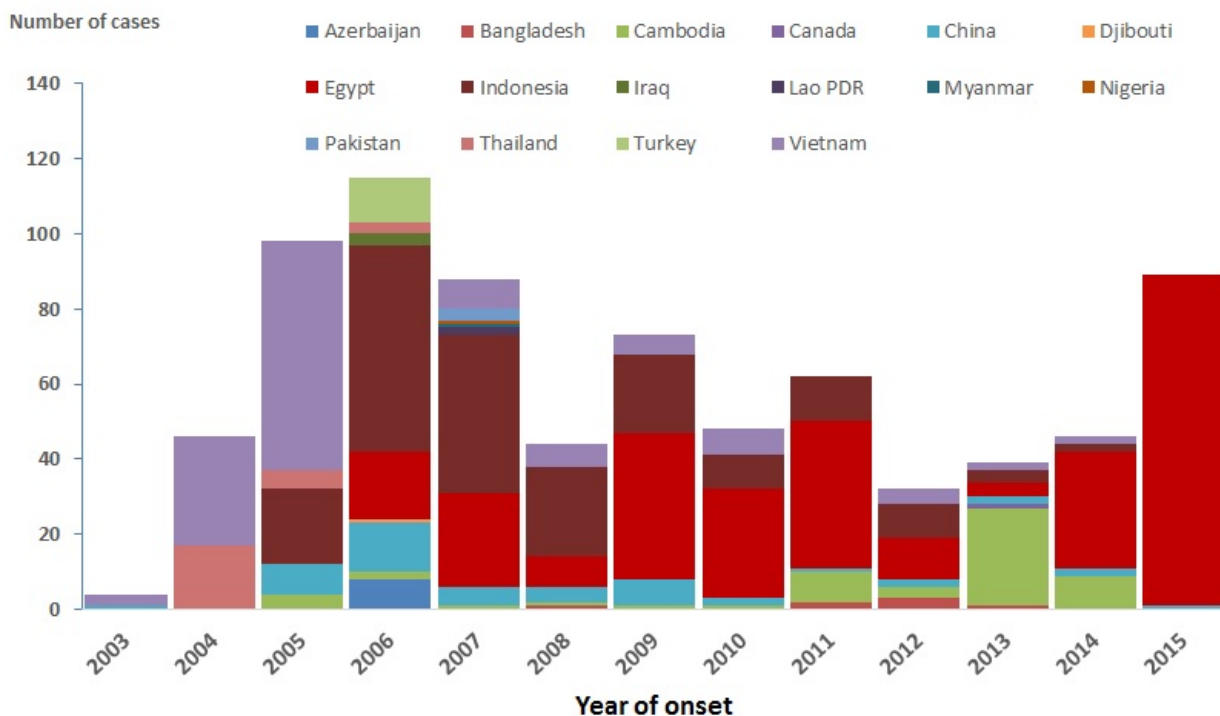
ECDC monitors the worldwide A(H5N1) situation through epidemic intelligence activities in order to identify significant changes in the epidemiology of the virus. ECDC re-assesses the potential of a changing risk for A(H5N1) to humans on a regular basis.

ECDC published a [rapid risk assessment](#) covering A(H5N1) in Egypt on 23 December 2014. ECDC is preparing an updated rapid risk assessment.

WHO is now reporting H5N1 cases on a monthly basis. ECDC will continue monthly reporting in the CDTR to coincide with WHO reporting.

Avian influenza A(H5N1) cases in humans by reporting country and year of onset

Source: ECDC



Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 12 March 2015

Epidemiological summary

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, human cases have continued to be reported, and as of 12 March 2015, there were 631 laboratory-confirmed cases: Zhejiang (167), Guangdong (177), Jiangsu (73), Fujian (59), Shanghai (46), Hunan (26), Anhui (22), Hong Kong (13), Xinjiang Uygur Zizhiqu (10), Jiangxi (8), Beijing (5), Shandong (5), Guangxi (4), Henan (4), Taiwan (4), Jilin (2), Guizhou (2) and Hebei (1), one imported case in Malaysia and two imported cases in Canada.

Most cases have developed severe respiratory disease.

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

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. It is expected that there may be further sporadic cases of human infection with the virus in affected and possibly neighbouring areas in China. Affected provinces and municipalities continue to maintain surveillance and response activities.

Imported cases of influenza A(H7N9) may be detected in Europe, as indicated by the recent importation of two travel-related cases in Canada. 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 in Europe.

Actions

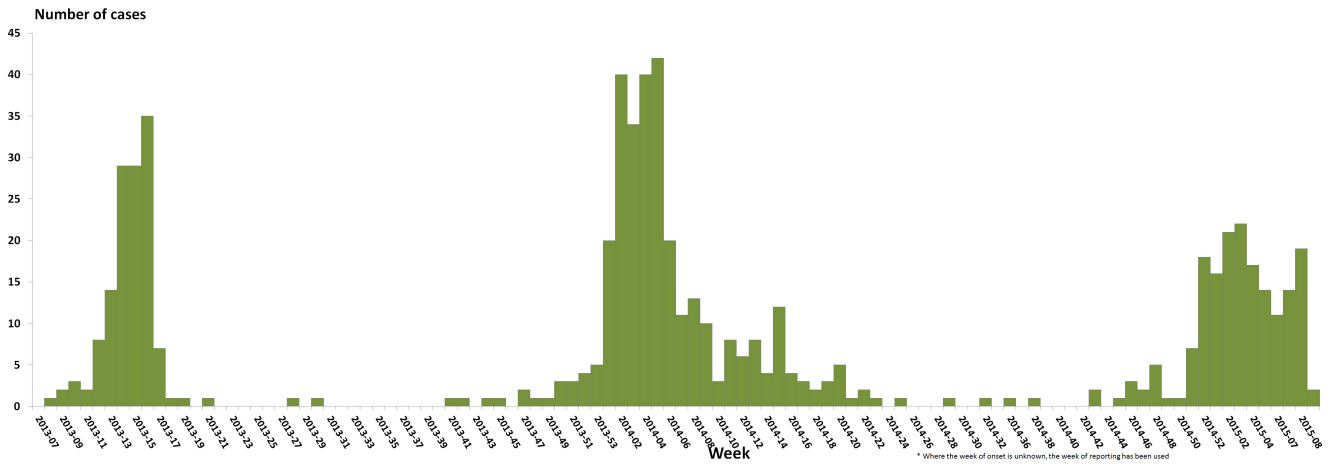
The Chinese health authorities continue to respond to this public health event with enhanced surveillance, epidemiological and laboratory investigation, including scientific research. ECDC is monitoring developments and updates reports on a monthly basis. ECDC published an updated [Rapid Risk Assessment](#) on 3 February 2015 and an [epidemiological update](#) on 12 February 2015.

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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 avian influenza A(H7N9) cases by first available week as of 12 March 2015 (n=631)

Source: ECDC



Distribution of cumulative number of human cases of avian influenza A(H7N9), by province and date, China, week 14/2013 to week 9/2015 (n=631)

Source: ECDC



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

Opening date: 24 September 2012

Latest update: 12 March 2015

Epidemiological summary

Since April 2012 and as of 12 March 2015, 1 093 cases of MERS-CoV have been reported by local health authorities worldwide, including 449 deaths.

The distribution is as follows:

Confirmed cases and deaths by region:

Middle East

Saudi Arabia: 948 cases/412 deaths

United Arab Emirates: 74 cases/10 deaths

Qatar: 11 cases/4 deaths

Jordan: 19 cases/6 deaths

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Oman: 5 cases/3 deaths
Kuwait: 3 cases/1 death
Egypt: 1 case/0 deaths
Yemen: 1 case/1 death
Lebanon: 1 case/0 deaths
Iran: 5 cases/2 deaths

Europe

Turkey: 1 case/1 death
UK: 4 cases/3 deaths
Germany: 3 cases/1 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

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

The source of MERS-CoV infection and the mode of transmission to primary cases have not been identified. The majority of MERS-CoV cases are secondary cases and many result from nosocomial transmission. Dromedary camels are a host species for the virus. There is continued risk of cases presenting in Europe following exposure in the Middle East and international surveillance for MERS-CoV cases remains essential.

The risk of secondary transmission in the EU remains low and can be reduced further by screening for exposure among patients presenting with respiratory symptoms (and their contacts), and strict implementation of infection prevention and control measures for patients under investigation.

Actions

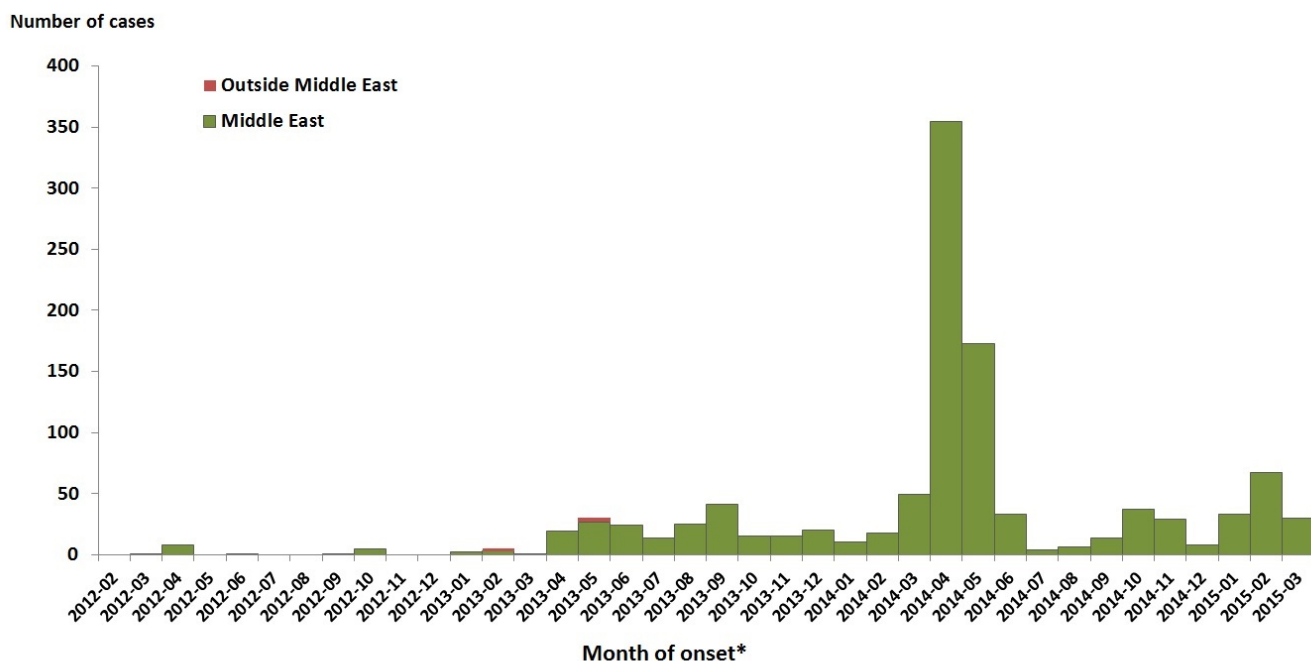
The last [rapid risk assessment](#) was updated on 9 March 2015.

ECDC is closely monitoring the situation in collaboration with WHO and EU Member States.

ECDC published a [factsheet for health professionals regarding MERS-CoV](#) on 20 August 2014.

Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 12 March 2015 (n=1093)

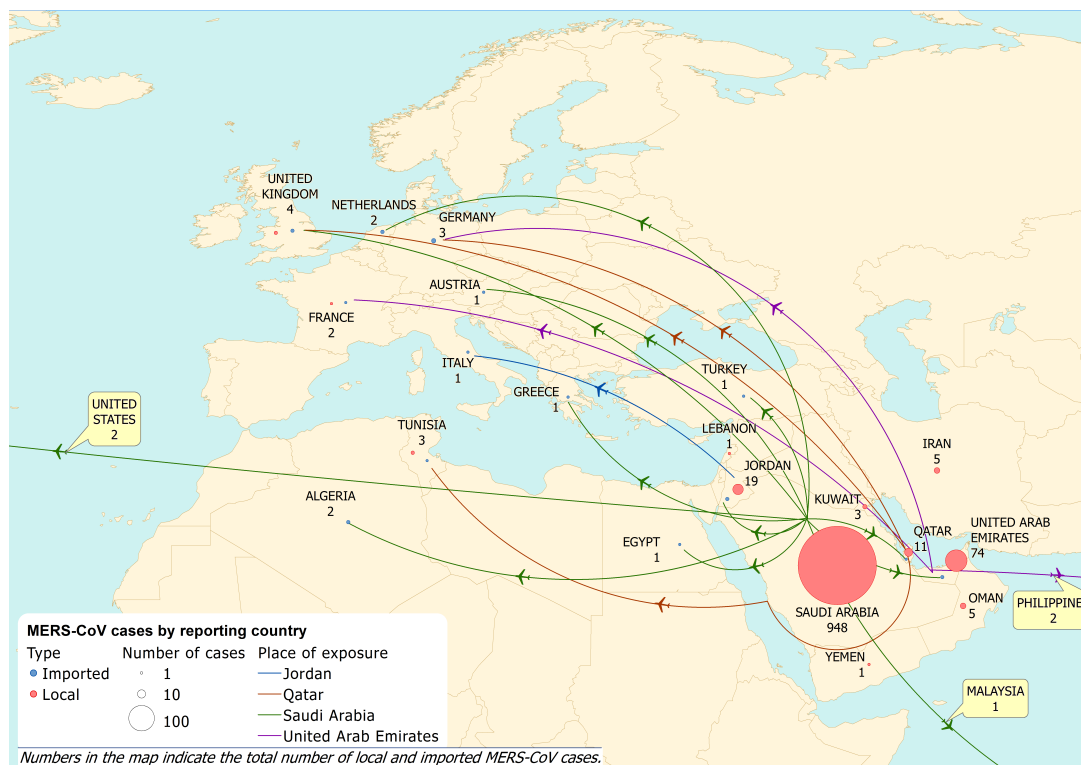
Source: ECDC



* Where the month of onset is unknown, the month of reporting has been used

Geographical distribution of confirmed MERS-CoV cases and place of probable infection, worldwide, as of 12 March 2015 (n=1 093)

Source: ECDC



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 13 March 2015

Epidemiological summary

Worldwide in 2015, 17 WPV1 cases have been reported to WHO, compared with 32 for the same period in 2014. In 2014, nine countries reported cases: Pakistan (306 cases), Afghanistan (28 cases), Nigeria (six cases), Equatorial Guinea (five cases), Somalia (five cases), Cameroon (five cases), Iraq (two cases), Syria (one case), and Ethiopia (one case).

No circulating vaccine-derived poliovirus (cVDPV) cases were reported so far in 2015. In 2014, 54 cVDPV cases were reported worldwide.

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 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 WPV in several countries and the documented exportation of WPV to other countries support the fact that there is a potential risk for WPV 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 the two.

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 follows 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 to 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.

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