

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

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

Opening date: 16 February 2016

Latest update: 30 March 2016

As of 31 March 2016, the Ministry of Health in Romania has reported 24 confirmed cases in an outbreak of Shiga-toxin-producing *Escherichia coli* (STEC) O26. Of these 24 cases, 18 have been hospitalised for haemolytic uraemic syndrome (HUS). Three of the cases have died. On 15 March, the Ministry of Health in Italy reported one case of HUS in a 14-month-old child of Romanian origin. The epidemiological investigation suggests a single source which has not yet been identified.

→Update of the week

No new update during the past week.

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

Opening date: 2 October 2015

Latest update: 1 April 2016

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

→Update of the week

In week 12/2016, despite decreasing trends being reported by 27 countries influenza was reported as widespread, largely in the south-western part of the Region. The proportion of sentinel specimens testing positive for influenza virus remained high at 46% and 21 countries still reported positivity rates of more than 30%. Two thirds of detections in primary care were influenza virus type B. The proportions of influenza virus type A detections in hospitalised cases were 70% in ICUs and 61% in regular wards. The number of cases of severe disease was lower than in previous weeks but varied between countries. Most severe cases were associated with A(H1N1)pdm09 infection and were in people aged 15–64 years.

Fatal case of diphtheria in unvaccinated child - Belgium -2016

Opening date: 17 March 2016

Latest update: 23 March 2016

On 15 March 2016, a fatal case of toxigenic diphtheria caused by *Corynebacterium diphtheriae* was reported in Belgium in an unvaccinated child. Universal immunisation with diphtheria-toxoid-containing vaccine is the only effective preventive control measure for diphtheria. Vaccination against diphtheria in children, adolescents and adults should follow the national immunisation schedules in the EU/EEA Member States.

→Update of the week

Throat swabs collected from parents and siblings of the case tested negative for diphtheria. Preliminary results from the screening of the healthcare personnel (N=15) and school children who came into contact with the case (N=26) indicate they were all negative for diphtheria.

Non EU Threats

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 31 March 2016

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 31 March 2016, 47 countries and territories have reported autochthonous cases of Zika virus infection during the past nine months. 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 an outbreak of Zika virus in 2014–2015. Since 1 February 2016, Zika virus infection and the clusters of microcephaly cases and other neurological disorders constitute a PHEIC. 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, [Kosrae](#) in the Federated States of Micronesia and Papua New Guinea have reported autochthonous transmission of Zika virus.

Chile: On 26 March, the [Ministry of Health](#) reported the first case of Zika virus infection through sexual transmission.

As of 31 March 2016, seven countries have reported non-vector-borne transmission of Zika virus, probably through sexual transmission: Argentina, Chile, France, Italy, New Zealand, Portugal (the Autonomous Region of Madeira) and the United States of America.

Publication

On 30 March, an article published in the [New England Journal of Medicine](#) describes an investigation into brain abnormalities detected in the foetus of a 33-year-old Finnish woman who was infected with Zika virus while on a trip to Mexico, Guatemala and Belize in November 2015, while she was 11 weeks pregnant.

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

In the context of Zika virus circulation, 13 countries or territories have reported an increased incidence of Guillain-Barré syndrome (GBS) and/or laboratory confirmation of a Zika virus infection among GBS cases, according to [WHO](#).

So far only French Polynesia and Brazil have reported an increase in Zika congenital syndrome.

Brazil: According to the [Ministry of Health](#), since October 2015 and as of 29 March 2016, 6 776 suspected cases of microcephaly were reported from 1 285 municipalities in Brazil. This is an increase of 105 suspected cases since the last weekly update on 19 March. As of 29 March 2016, 944 of the cases have been confirmed to have microcephaly and/or other central nervous system findings suggestive of congenital infection. Of these cases, 130 have been confirmed positive for Zika virus by PCR.

There have been 208 intrauterine or neonatal deaths reported among children notified to have microcephaly and/or central nervous system malformations and 47 of these were confirmed. One hundred and thirty-nine cases are still under investigation and 22 cases have been discarded.

Martinique: As of 31 March, two cases of microcephaly and one additional malformation case in a Zika-positive patient have been reported in Martinique, according to [ARS](#).

Outbreak of yellow fever - Angola - 2016

Opening date: 17 March 2016

Latest update: 31 March 2016

There is an ongoing outbreak of yellow fever in Angola that started in December 2015 in the municipality of Viana, Luanda province, and then spread to other provinces of Angola. As of 30 March 2016, the Ministry of Health in Angola has reported 1 794 cases, including 198 deaths. Of these cases, 483 are laboratory-confirmed. According to WHO, 17 laboratory-confirmed locally-acquired cases have been detected in 10 districts of six provinces outside Luanda.

→Update of the week

Since the initial cases were detected in Luanda province, there has been a rapid increase in the number of suspected cases recorded since mid-January 2016. Local transmission is no longer restricted to Luanda. As of 30 March, 16 of 18 provinces across the country have reported suspected cases.

As of 30 March 2016, the Ministry of Health in Angola has reported 1 794 cases, including 198 deaths. Of these cases, 483 are laboratory-confirmed. According to WHO, 17 laboratory-confirmed locally-acquired cases have been detected in 10 districts of six provinces outside Luanda. As of 30 March, 16 of 18 provinces across the country have reported suspected cases. Transmission continues in Luanda, which remains the most affected province with 906 cases, of which 344 are confirmed, including 141 deaths. The number of cases from provinces other than Luanda is reported to be increasing.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 31 March 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, WHO reported two new wild poliovirus type 1 (WPV1) cases, one in Afghanistan and one in Pakistan. No circulating vaccine-derived poliovirus (cVDPV) were reported to WHO.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 31 March 2016

The largest ever epidemic of Ebola virus disease (EVD) affected West Africa from December 2013 to January 2016, mainly affecting Guinea, Liberia and Sierra Leone. On 8 August 2014, WHO declared the Ebola epidemic in West Africa a Public Health Emergency of International Concern (PHEIC). As of 30 March 2016, WHO has reported 28 610 cases of Ebola virus disease related to the outbreak in West Africa, including 11 308 deaths. Sierra Leone was declared Ebola-free by WHO on 7 November 2015, Guinea on 29 December 2015 and Liberia on 14 January 2016. On 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. On 17 March 2016, WHO declared the end of the recent sporadic transmission of Ebola virus disease in Sierra Leone, 42 days after the last person confirmed to have Ebola virus disease in the country tested negative for the second time.

On 29 March 2016, WHO declared the end of the PHEIC and advised that all temporary recommendations previously adopted should now be terminated. However, since the end of February and as of 30 March 2016, five new confirmed and three probable cases of EVD have been reported in the prefectures of N'Zérékoré and Macenta in Guinea. According to WHO, initial tests suggest the newly reported cases are all part of a known transmission chain and not a new introduction from the animal population. On 1 April, WHO confirmed a new sporadic case of EVD in Liberia.

→Update of the week

Following the ninth meeting of the Emergency Committee convened by the WHO Director-General under the IHR 2005 regarding the EVD outbreak in West Africa, the Committee declared that the situation no longer constitutes a Public Health Emergency of International Concern (PHEIC) and the temporary recommendations adopted should now be terminated.

As of 30 March, five confirmed and three probable cases have been recorded in the prefectures of N'Zérékoré and Macenta. All five confirmed cases of EVD in Guinea are epidemiologically linked to a chain of three probable cases in the sub-prefecture of Koropara. According to WHO, initial tests suggest the recently reported cases are part of a known transmission chain and not a new introduction from the animal population.

On 1 April, WHO confirmed a new case of EVD in Liberia, a 30-year-old woman who died on 31 March while being transferred to a hospital in the capital Monrovia.

II. Detailed reports

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

Opening date: 16 February 2016

Latest update: 30 March 2016

Epidemiological summary

The Romanian Ministry of Health reported an outbreak of HUS associated with STEC infection involving 24 individuals, of whom 22 are children aged 5 to 38 months and two are adults. Eighteen cases have been hospitalised for HUS, of whom three died. Following initial environmental investigations, *E. coli* O26 was identified in soft cheese samples produced by a local company that sells traditional dairy items in Arges district. The factory has been closed and the product is no longer available on the market. The cheese is reported to also have been distributed to Germany while cheese products from the same company have been exported to Belgium and Spain. An additional case was reported in Italy.

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

ECDC assessment

This is an outbreak of STEC O26 confirmed through serology. The epidemiological investigation suggests a single source. The microbiological information confirmed that 11 of 20 cases in Romania and Italy were positive for O26; however, it was inconclusive in identifying one single outbreak strain. The molecular information available from the human and food isolates does not provide sufficient evidence towards a single strain outbreak. Romanian and Italian authorities continue collecting information from epidemiological, microbiological and environmental investigations in order to identify the source and to control this outbreak.

Actions

A joint rapid outbreak assessment (ROA) with EFSA is being prepared.

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

Opening date: 2 October 2015

Latest update: 1 April 2016

Epidemiological summary

Influenza A(H1N1)pdm09 viruses predominated at the beginning of the season but this was followed by increased proportions of B virus in the community. Overall, influenza activity, based on laboratory-confirmed mild and severe cases in sentinel and non-sentinel sources, peaked at weeks 5-7/2016. The number of severe cases, mainly due to A(H1N1)pdm09, has decreased or become stable in all reporting countries.

Data from the 16 countries or regions reporting to the European monitoring of excess mortality for public health action project (EuroMOMO) suggest a pattern of excess all-cause mortality among those aged 15–64 years since the end of 2015. However, mortality among elderly people is within expected levels this season.

ECDC assessment

Most of the viruses antigenically and/or genetically characterised so far have been similar to those recommended for inclusion in the trivalent or quadrivalent vaccines for this season in the northern hemisphere. There are no indications among the majority of currently circulating seasonal influenza viruses of reduced susceptibility to neuraminidase inhibitors oseltamivir or zanamivir.

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](#).

Fatal case of diphtheria in unvaccinated child - Belgium -2016

Opening date: 17 March 2016

Latest update: 23 March 2016

Epidemiological summary

A case of diphtheria was confirmed on 15 March in Antwerp, Belgium, in a 3-year-old unvaccinated child. The National Reference Centre in Belgium has confirmed the case. The symptoms started on 6 March and she was admitted to an intensive care unit on 11 March. As there is no stockpile of diphtheria antitoxin (DAT) in Belgium, ECDC mediated the procurement of DAT when contacted by the Scientific Institute of Public Health on 16 March 2016. RIVM in the Netherlands supplied the antitoxin the same day; however, despite administration of DAT, the child died on 17 March.

Web source: [Belgian Care and health website \(Zorg en Gezondheid\)](#) |Media

ECDC assessment

Exposure of unvaccinated individuals to carriers of the pathogen is not unexpected, as vaccination does not prevent carriage of the pathogen. Diphtheria is effectively prevented by vaccination. The diphtheria case in Belgium is a matter of concern in light of the limited availability of DAT across the EU/EEA Member States. Early administration of the antitoxin may prevent unfavourable clinical outcomes.

A range of options needs to be considered for resolving the acute shortage of DAT. Member States should assess the level of access to DAT in their country and, if required, consider transnational options for securing rapid access to it for all patients that have suspected or confirmed diphtheria-toxin-induced disease. Sharing of information collected through such an assessment would also enable an initial assessment of the current stockpiles within the EU. Testing of existing stockpiles for potency and quality, through transnational testing arrangements if necessary, would also help in the assessment of the scope and timescale of future procurement of stock. In light of such assessments, EU/EEA Member States might wish to consider expressing interest in the European joint procurement of medical countermeasures as a mechanism for procuring an emergency stockpile of DAT.

The identification and management of close contacts of a single suspected or confirmed case caused by toxigenic *C. diphtheriae* is a public health emergency and calls for immediate action. Outbreak management guidelines are usually available at national and regional level in the EU/EEA Member States and they should be consulted and followed in light of a suspected case of diphtheria.

Actions

ECDC has published a [risk assessment](#).

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 31 March 2016

Epidemiological summary

As of 31 March, 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 31 March 2016, ECDC has recorded 323 cases imported into 17 EU/EEA countries. In addition, one confirmed case has been published following diagnosis in a Slovenian hospital. Twenty cases are among pregnant women.

Several of the EU's Outermost Regions and Territories continue to report autochthonous transmission:

Martinique: As of 31 March 2016, 15 440 suspected cases have been reported, an increase of 1 020 during the past week.

French Guiana: As of 31 March 2016, 3 190 suspected and 299 laboratory-confirmed cases have been reported, an increase of 410 suspected and 15 laboratory-confirmed cases during the past week.

Guadeloupe: As of 31 March 2016, 900 suspected and 139 laboratory-confirmed cases have been reported, an increase of 106 suspected and 5 laboratory-confirmed cases during the past week.

Saint Martin: As of 31 March, 157 suspected and 36 laboratory-confirmed cases have been reported, this is an increase of 3 suspected and 6 laboratory-confirmed cases during the past week.

As of 31 March 2016, seven countries have reported non-vector-borne transmission of Zika virus, probably through sexual transmission: Argentina, Chile, France, Italy, New Zealand, Portugal (the Autonomous Region of Madeira) and the United States

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of America.

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 intrauterine Zika virus infection and adverse pregnancy outcomes has not yet been absolutely 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 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 the Zika virus epidemic in the Americas is likely to continue as the vectors (*Aedes aegypti* and *Aedes albopictus* mosquitoes) are widely distributed there.

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

Actions

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

ECDC published an update of the [rapid risk assessment](#) on 9 March 2016 and has updated the [ECDC Zika page](#) with [Frequently Asked Questions](#).

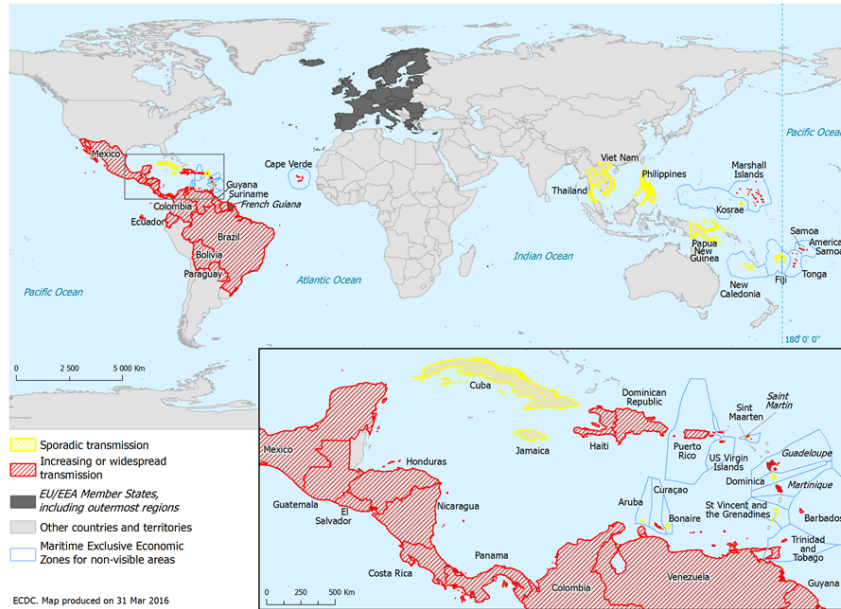
Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past nine months and past two months, as of 31 March 2016

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	Affected in the past 2 months	Affected in the past 9 months
American Samoa	Increasing or widespread	Yes
Aruba	Sporadic transmission	Yes
Barbados	Increasing or widespread	Yes
Bolivia	Increasing or widespread	Yes
Brazil	Increasing or widespread	Yes
Bonaire	Sporadic transmission	Yes
Cape Verde	Increasing or widespread	Yes
Colombia	Increasing or widespread	Yes
Cuba	Sporadic transmission	Yes
Costa Rica	Increasing or widespread	Yes
Curaçao	Increasing or widespread	Yes
Dominica	Sporadic transmission	Yes
Dominican Republic	Increasing or widespread	Yes
Ecuador	Increasing or widespread	Yes
El Salvador	Increasing or widespread	Yes
Fiji	Sporadic transmission	Yes
French Guiana	Increasing or widespread	Yes
Guadeloupe	Increasing or widespread	Yes
Guatemala	Increasing or widespread	Yes
Guyana	Increasing or widespread	Yes
Haiti	Increasing or widespread	Yes
Honduras	Increasing or widespread	Yes
Jamaica	Sporadic transmission	Yes
Kosrae	Sporadic transmission	Yes
Marshall Islands	Increasing or widespread	Yes
Martinique	Increasing or widespread	Yes
Mexico	Increasing or widespread	Yes
New Caledonia	Sporadic transmission	Yes
Nicaragua	Increasing or widespread	Yes
Panama	Increasing or widespread	Yes
Papua New Guinea	Sporadic transmission	Yes
Paraguay	Increasing or widespread	Yes
Philippines	Sporadic transmission	Yes
Puerto Rico	Increasing or widespread	Yes
Saint Martin	Increasing or widespread	Yes
Saint Vincent and the Grenadines	Sporadic transmission	Yes
Samoa	Increasing or widespread	Yes
Sint Maarten	Sporadic transmission	Yes
Solomon Islands	No	Yes
Suriname	Increasing or widespread	Yes
Thailand	Sporadic transmission	Yes
Tonga	Increasing or widespread	Yes
Trinidad and Tobago	Increasing or widespread	Yes
Vanuatu	No	Yes
Venezuela	Increasing or widespread	Yes
Viet Nam	Sporadic transmission	Yes
US Virgin Islands	Increasing or widespread	Yes

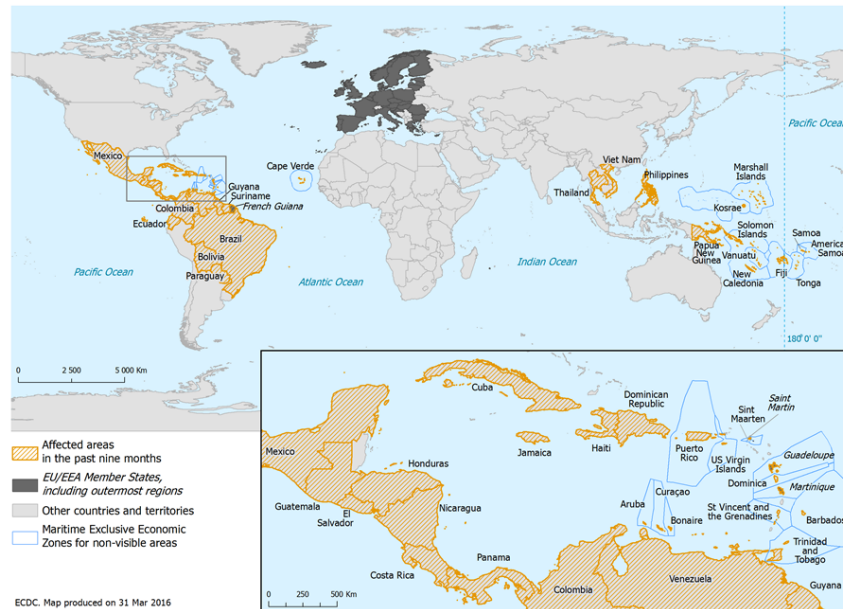
Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past two months, as of 31 March 2016

ECDC



Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past nine months, as of 31 March 2016

ECDC



Outbreak of yellow fever - Angola - 2016

Opening date: 17 March 2016

Latest update: 31 March 2016

Epidemiological summary

As of 29 March, imported cases of yellow fever have been reported in China (6), Kenya (2), the Democratic Republic of Congo (10) and Mauritania (1). In addition, yellow fever cases have been reported among expatriates residing in Angola, including nationals of Eritrea, Democratic Republic of Congo, Cape Verde, Lebanon and India. According to Chinese media, the Chinese Embassy in Angola has issued an alert regarding the need for vaccination against yellow fever, stating that at least six Chinese citizens have died of yellow fever in Angola in 2016.

A mass vaccination campaign has been ongoing since February aiming to immunise 6.7 million people in Luanda province. According to a WHO situation report, as of 14 March 2016 administrative data indicate a vaccination coverage of 80% for the whole province of Luanda.

Web sources: [ECDC factsheet](#) / [WHO yellow fever page](#) | [WHO DON](#) | [Media 1](#) | [MoH](#)

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ECDC assessment

WHO estimates that 508 million people are living in 31 African countries at risk for transmission of yellow fever. Therefore, the large outbreak of yellow fever in Angola is of concern with regards to the risk of introduction of the virus through viraemic travellers to countries at risk of transmission, especially in neighbouring countries.

Yellow fever in an urban setting is considered as a public health emergency that may result in a large number of cases. Vaccination is the single most important measure for preventing yellow fever. Therefore, additional cases in unvaccinated populations related to this urban outbreak should be expected, until a sufficient proportion of the susceptible population is immunised. The outbreak in Angola is not yet controlled and is currently expanding to additional provinces challenging the ongoing mass vaccination campaign. The control of the outbreak in Angola is needed in order to prevent further spread in the region and beyond.

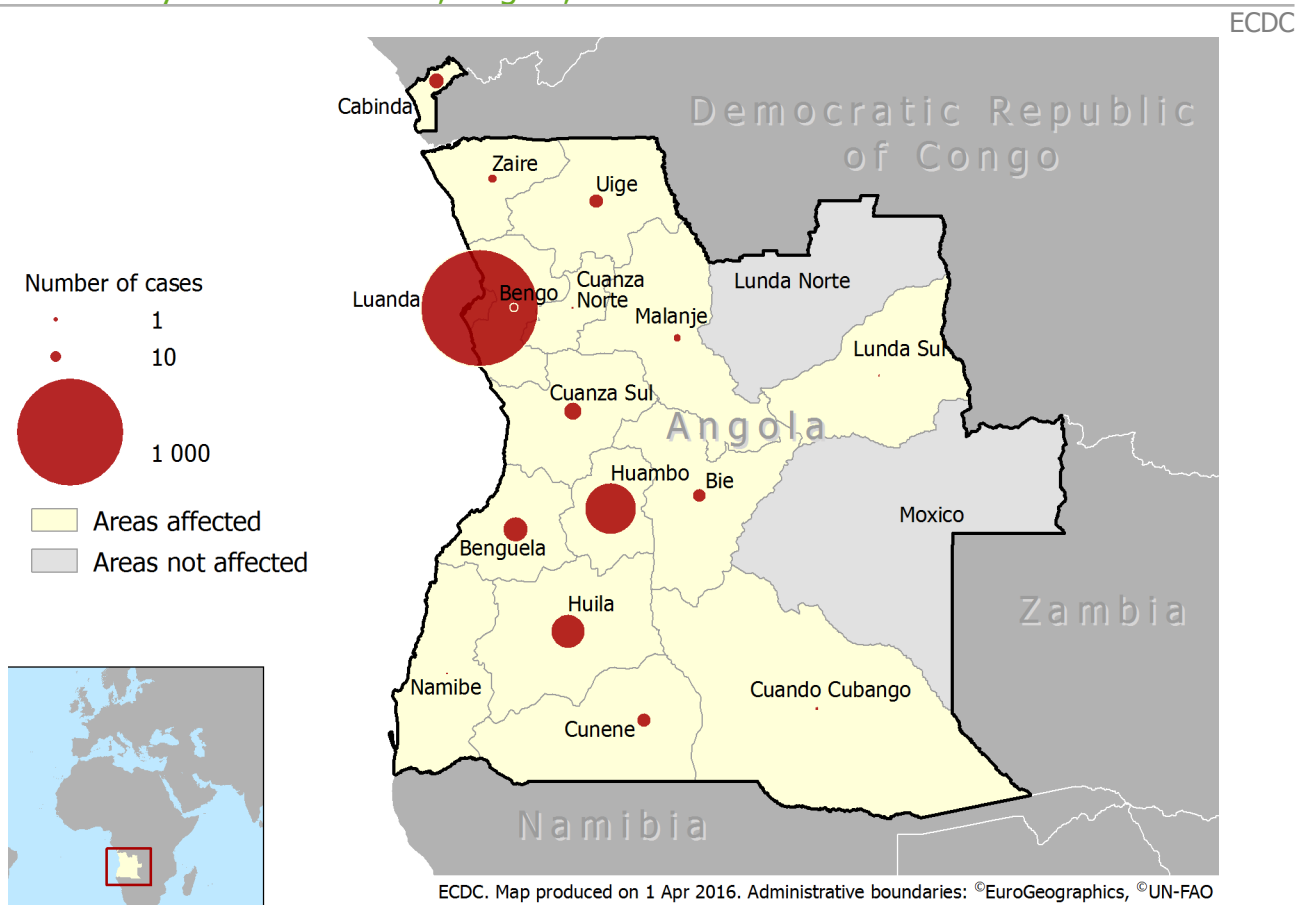
Proof of vaccination is required for all travellers aged 1 year and above entering Angola. WHO recommends vaccination for all travellers older than 9 months of age in areas where there is evidence of persistent or periodic yellow fever virus transmission. European citizens travelling to or residing in Angola should be vaccinated against yellow fever as per their national health authorities' recommendations. Vaccine should be administered at least 10 days before travelling.

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

Actions

ECDC published a [rapid risk assessment](#) on 25 March 2016.

Distribution of yellow fever cases, Angola, 5 December to 27 March 2016



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 31 March 2016

Epidemiological summary

In 2016, nine cases of wild poliovirus type 1 (WPV1) have been reported, compared with 21 cases for the same period in 2015. The cases were detected in Pakistan (seven cases) and in Afghanistan (two cases).

As of 31 March 2016, three cases of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO in 2016, all from Laos. There was one cVDPV case during the same period in 2015.

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

ECDC assessment

The last locally acquired wild polio cases within the current EU borders were reported from Bulgaria in 2001. The most recent wild

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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](#).

Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 31 March 2016

Epidemiological summary

Official WHO figures from 30 March:

- **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. On 1 April 2016, one new case of EVD was reported by WHO (not included in the overall figures as of 30 March).
- **Sierra Leone:** 14 124 cases, including 3 956 deaths. The country was declared EVD-free on 7 November 2015. However, two epidemiologically linked sporadic cases were reported on 14 and 20 January 2016.
- **Guinea:** 3 804 cases including 2 536 deaths. The country was declared EVD-free on 29 December 2015. However, since the end of February and as of 30 March 2016, five confirmed and three probable sporadic cases have been reported by WHO.

Guinea

According to the latest situation report published by [WHO](#) on 30 March, all five confirmed cases of EVD in Guinea are epidemiologically linked to a chain of three probable cases in the sub-prefecture of Koropara. All three probable cases died between 27 February and 15 March and were not buried safely. Viral sequencing data indicate that virus present in the blood of one of the confirmed cases is closely related to virus that circulated in south-eastern Guinea in November 2014.

In total, 1 033 contacts linked to the cluster have been identified so far, 171 of whom are considered to be high risk. All but 10 contacts have been traced. Additional cases are likely because of the large number of contacts. Vaccination teams began vaccination of contacts and contacts of contacts on 22 March. One suspected case reported on 30 March is currently under observation in an Ebola treatment centre.

Liberia

On 1 April, [WHO](#) confirmed a new case of EVD in Liberia in a 30-year-old woman who died on 31 March while being transferred to a hospital in the capital Monrovia.

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 new sporadic cases in Guinea and Liberia is not unexpected and highlights 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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