COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 28, 5-11 July 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

New! Monitoring environmental suitability of Vibrio growth in the Baltic Sea - Summer 2015

Opening date: 6 July 2015

ECDC has developed a model to map the environmental suitability for *Vibrio* growth in the Baltic Sea (ECDC E3 Geoportal).

➔Update of the week

Some areas of the southern Baltic Sea are starting to show low to very low levels of environmental suitability for *Vibrio* species growth. On 3 July 2015, ECDC launched an Urgent Inquiry (UI) in EPIS-FWD after detecting elevated sea surface temperatures (according to the National Oceanic and Atmospheric Administration, NOAA) in the Baltic Sea (as of 2 July 2015).

Cluster of Schistosoma haematobium - Corsica, France - 2014

Opening date: 8 May 2014 Latest update: 9 July 2015

In 2014, seventeen cases of *Schistosoma haematobium* infection were reported, all linked to a recreational area in southern Corsica (France). Of the 17 cases, 12 were from France and five from Germany. All had been exposed in 2011 and 2013 to freshwater in a natural swimming area called Cavu. Since the first reported cases, 110 cases of *Schistosoma haematobium* infections have been detected by epidemiological investigations, including 33 residents from Corsica.

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

Opening date: 2 June 2015 Latest update: 9 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.

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Non-EU Threats

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 9 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).

➔Update of the week

According to the latest WHO situation report published on 8 July 2015, there were 30 confirmed cases of EVD reported in the week up to 5 July: 18 in Guinea, three in Liberia, and nine in Sierra Leone. This is the highest weekly total since mid-May. However, a decreasing proportion of cases (five of 30) arose from unknown sources of infection, particularly in previously problematic areas such as Boke and Forecariah in Guinea, and Kambia and Port Loko in Sierra Leone.

As of 7 July 2015, WHO reported 27 621 cases of Ebola virus disease related to the outbreak in West Africa, including 11 268 deaths.

The sixth meeting of the Emergency Committee under the International Health Regulations (IHR) (2005) regarding the Ebola virus disease (EVD) outbreak in West Africa, convened on 2 July 2015, advised that the EVD outbreak still constitutes a PHEIC and previously issued temporary recommendations should be extended. Exit screening should be continued in the three affected countries. Detailed statistics on exit screening should be published monthly. The Committee called for international support for these countries to carry out effective exit screening and reaffirmed the need to avoid unnecessary interference with international travel and transport. Only measures commensurate with the current public health risk should be implemented.

There are media reports that the virus strain found in a 17-year-old boy who died of EVD in Liberia last week did not match strains circulating in Guinea and Sierra Leone and that it was unlikely that he caught the virus through cross-border travel. As Liberia has not reported cases for several months, the source of the infection could have been related to a sexual encounter with an Ebola survivor. The genetic sequence in the new case most closely matches the one found in viruses which circulated in Liberia in July and August 2014. A US CDC expert was quoted as saying that the virus degrades quickly in the tropical heat, within hours to days, and that it was implausible that Ebola had been lying dormant in the environment. He said the close similarity with other viruses found in people in Liberia last year argues against the virus having been reintroduced from wildlife.

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

Opening date: 24 September 2012 Latest update: 9 July 2015

Since April 2012 and as of 9 July 2015, 1 389 cases of MERS-CoV have been reported by local health authorities worldwide, including 535 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. The epidemic curve peaked during the first week of June, and the outbreak has been declining since then.

➔Update of the week

Since 2 July 2015, Saudi Arabia has reported three new cases in Makkah, Dammam and Riyadh.

Since the last CDTR on 3 July, South Korea has reported two additional cases and two deaths, bringing the number of cases to 186, including 35 deaths. One of the 186 cases reported by South Korea travelled to China, where he was diagnosed and hospitalised.

On 6 July 2015, the Department of Health in the Philippines reported a laboratory-confirmed case of MERS-CoV in a Finnish citizen who had travelled in the Middle East before arriving in the country. The patient is currently stable.

The Health Security Committee/Early Warning and Response System has published a statement on MERS-CoV infection and advice with regard to travelling.

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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

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.

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 9 July 2015

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, 672 cases have been reported, including 271 deaths. No autochthonous cases have been reported 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 (11 June 2015), WHO has reported 15 new cases of avian influenza A(H7N9) in China.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 9 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 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, one new case of wild poliovirus type 1 (WPV1) was reported to WHO from Pakistan.

Last week, three new cases of circulating vaccine-derived poliovirus type 1 (cVDPV1) were reported in Madagascar. This most recent case (in Boeni region) had onset of paralysis on 29 May.

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II. Detailed reports

New! Monitoring environmental suitability of Vibrio growth in the Baltic Sea - Summer 2015

Opening date: 6 July 2015

Epidemiological summary

In late June 2015, the *Vibrio* suitability tool on the ECDC E3 Geoportal helped ECDC to ascertain favourable environmental factors for *Vibrio* growth.

ECDC assessment

Elevated sea surface temperatures in marine environments with low salt content provide ideal environmental growth conditions for certain *Vibrio* species. These conditions can be found during the summer months in estuaries and enclosed water bodies with moderate salinity. In contrast, open ocean environments do not offer appropriate growth conditions for these bacteria due to the high salt content, low temperatures, and limited nutrient content. These *Vibrio* species can cause vibriosis infections, particularly *V. parahaemolyticus, V. vulnificus* and non-toxigenic *V. cholerae*.
Vibriosis in humans caused by these species in the Baltic region have occurred in the past during hot summer months, particularly when sea surface temperature has been elevated. The most common clinical manifestations are gastroenteritis (with nausea, vomiting, and diarrhoea), wound infections (exposure of a cut, wound, or abrasion to contaminated seawater), primary septicaemia, and otitis externa (swimmer's ear). Risk factors for illness include consumption of shellfish, particularly raw oysters, and contact with natural bodies of waters, especially marine or estuarine waters.

Actions

ECDC launched an UI in EPIS-FWD to inform the FWD network about the elevated surface water temperatures measured in the Baltic Sea which create a favourable environment for the growth of *Vibrio* bacteria. ECDC will monitor this threat on a weekly basis during the summer 2015 and report increased levels.

The *Vibrio* suitability tool is available on the ECDC E3 Geoportal. Please note that this model has been calibrated to the Baltic region in northern Europe and might not be compatible with other regional settings prior to validation.

Cluster of Schistosoma haematobium - Corsica, France - 2014

Opening date: 8 May 2014 Latest update: 9 July 2015

Epidemiological summary

In April 2014, a cluster of *Schistosoma haematobium* infections was detected. It was linked to freshwater exposure in 2013 at Cavu, a natural swimming area in southern Corsica, France.

Following a national screening campaign in France, 110 additional schistosomiasis cases were described (as of 25 March 2015) in residents of Corsica and visitors from other parts of France, over a two-year time span. The majority of these cases were recorded in children and teenagers. Epidemiological investigations are ongoing.

Web sources: ECDC 2014 RRA | French regional authorities statement | WHO factsheet

ECDC assessment

The outbreak marks the first locally-acquired infections of *Schistosoma haematobium* reported in the EU. The disease is known to be very focal in its establishment and as such, the risk of acquiring the infection exists only for residents and travellers who engaged in occupational or recreational activities in the affected swimming area.

In addition, a competent intermediate host snail, *Bulinus truncatus*, was identified in rivers in Corsica. A detailed description of an epidemiological investigation and the findings is available in EID.

The no-swim advisory for the Cavu river area was lifted on 4 June 2015 by the prefecture of Corse-du-Sud. However, based on

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newly identified cases due to autochthonous transmission in 2014 and the presence of a zoonotic reservoir, the French National Agency of Health Security for Food, Environment and Labour issued recommendations that the no-swim notice should be reinstated.

Web Sources: ECDC RRA 2014 | Emerging Infectious Diseases article

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

Opening date: 2 June 2015 Latest update: 9 July 2015

Epidemiological summary

As of 9 July 2015, one human case of West Nile fever in the EU has been reported by Bulgaria. 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 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 (in accordance with the EU case definition) is the first case of the current transmission season reported in the EU.

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 using individual NAT.

Actions

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

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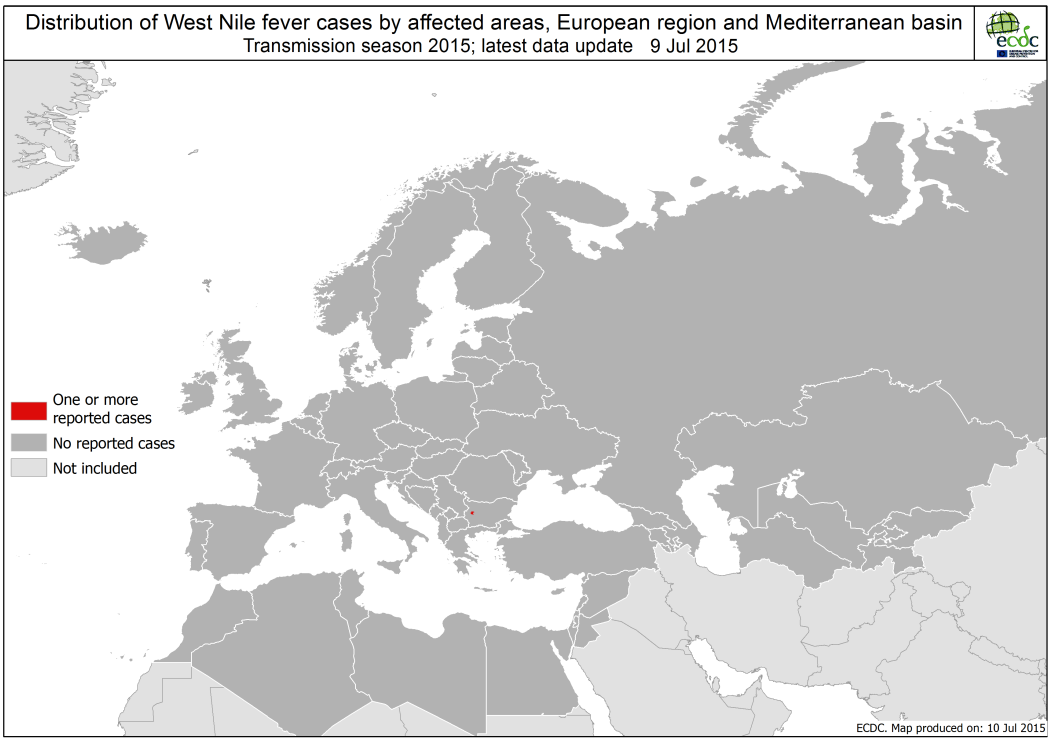
Source: ECDC



Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 9 July 2015

Epidemiological summary

Distribution of cases as of 5 July 2015:

Countries with intense transmission:

- **Guinea:** 3 744 cases of which 3 290 are confirmed and 2 505 deaths.
- **Sierra Leone:** 13 169 cases of which 8 675 are confirmed and 3 941 deaths.
- **Liberia:** 10 666 cases as of 9 May 2015. And, as 7 July, 6 cases, of which 5 are confirmed, and 1 death.

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 18 newly confirmed cases in the week up to 5 July, compared to 12 during the previous week. Transmission was centred in three prefectures: Forecariah (n=11), Boke (n=6) and Conakry (n=1).

All but one of the six cases reported by WHO in Boke were registered contacts. The single case reported from Conakry was a known contact of a previous case from Benty sub-prefecture in Forecariah. Most cases were reported from the prefecture of Forecariah, which reported only one case in the previous week. The sub-prefecture of Benty, which borders Sierra Leone, reported nine cases, of which all but one were either registered contacts of a previous case, or otherwise had an epidemiological link to one. The remaining two cases in Forecariah were reported from the sub-prefectures of Farmoriah and Maferinyah. The case from Farmoriah was a registered contact; the case from Maferinyah arose from an unknown source of infection. Both cases were detected after post-mortem testing of community deaths.

Overall, according to WHO, 12 (67%) of the 18 cases reported from Guinea in the week up to 5 July were registered contacts, compared with 10 (83%) of 12 cases reported the previous week.

In **Sierra Leone**, WHO reported nine newly confirmed cases in the week up to 28 June, compared with eight during the previous week. Transmission was centred in three districts: Kambia (n=4), Western Area Urban, which includes the capital Freetown (n=3) and Port Loko (n=2). All but one of the cases reported by WHO in Sierra Leone were registered contacts or had a direct link with

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known chains of transmission. However, three of the cases were only identified as a result of post-mortem testing of community deaths.

In **Liberia**, which was declared free of Ebola transmission on 9 May 2015, routine surveillance detected a confirmed case of EVD in Margibi County on 29 June. This is the first newly confirmed case reported from the country since 20 March. The case was a 17-year-old male who first became ill on 21 June, died on 28 June, and subsequently tested positive for EVD. According to WHO, two contacts of the case who was detected first have since been confirmed as EVD positive. These additional cases are from the same small community as the case which was detected first and are now being treated in an Ebola Treatment Centre (ETC) in the capital, Monrovia. In addition, a probable case is in isolation at an ETC. The case has a strong epidemiological link to the case detected first and shows some symptoms of EVD, but has indeterminate test results for EVD. The origin of infection of the cluster of cases is currently under investigation. At present, these cases are considered by WHO to constitute a separate outbreak from the one declared over on 9 May.

Situation among healthcare workers
One new healthcare worker infection was reported by WHO from Kambia, Sierra Leone, during the week up to 5 July.
There have been 875 confirmed healthcare worker infections reported from Guinea, Liberia and Sierra Leone since the start of the outbreak, with 509 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).

Medical evacuations and repatriations from EVD-affected countries
Since the beginning of the epidemic and as of 10 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.

Other news:
Since the detection of the new cluster of confirmed EVD cases in Liberia, exit screening procedures at Monrovia airport were enhanced. Airport access measures have been tightened for both visitors and workers. Three thermo-imaging cameras are installed in critical points in order to ensure that passengers can be scanned. Exit screening continues to be in place in Guinea and Sierra Leone.

A report by an independent panel, commissioned by WHO, was published on 7 July, stating that the Ebola crisis proves that WHO lacks in 'capacity and culture' to deal with global health emergencies; the report calls for an urgent overhaul of the organisation. The review praised WHO for playing a critical role in working to find new treatments and a cure for Ebola. According to the report, WHO should continue to lead future health emergency responses. The authors also suggest an immediate contribution from all member countries towards a USD 100 million special outbreak response fund earmarked to, among other activities, establish a Centre for Emergency Preparedness and Response. The report also states that while UN leadership was necessary for a response, the resulting UN Mission for Ebola Emergency Response (UNMEER) was not very successful. During the health crises, more than 40 countries implemented measures that were not recommended by WHO and clearly in breach of the IHR. These measures (for example Ebola tests or compulsory quarantines) interfered with international traffic. As a result, the affected countries faced not only severe political, economic and social consequences but also barriers to receiving the necessary personnel and supplies. The authors propose establishing mechanisms that allow WHO to sanction countries for inappropriate precautions.

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, Sierra Leone and Liberia.
- Map: this map is based on country situation reports and shows only confirmed cases of EVD in the past six weeks.

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 | Ebola Interim Assessment Panel WHO statement on the Sixth Meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa | Latest available situation summary

ECDC assessment

This is the largest ever documented epidemic of EVD, both in terms of numbers and geographical spread. The epidemic of EVD

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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, the decline in case incidence and the contraction of the geographic area affected by Ebola has stalled during the last weeks. However, there have been improvements in contact tracing, additional incentives to improve case reporting, and better compliance with quarantine measures during the recent week. Some affected communities still do not trust responders, which can result in cases evading detection and sparking more unknown transmission chains.

The recent cases in Liberia highlight the importance of maintaining capacities for early case detection and enhanced vigilance with regard to deaths with unknown causes, even in countries that have been declared Ebola free. At present, all newly detected cases are considered by WHO to constitute a separate outbreak from the one declared over on 9 May.

Actions

As of 10 July 2015, ECDC has deployed 88 experts (on a rotating basis) 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 updated the list of affected countries and regions on its website to include the newly affected county of Margibi, Liberia.
ECDC updated the event background on its 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.
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.

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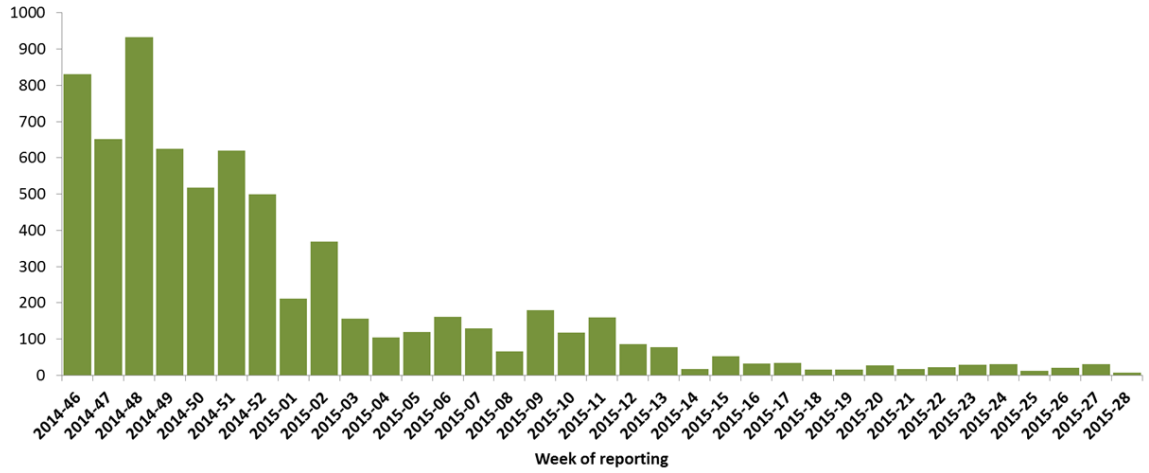
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 28/2015)

Adapted from WHO figures; *data for week 28/2015 are incomplete



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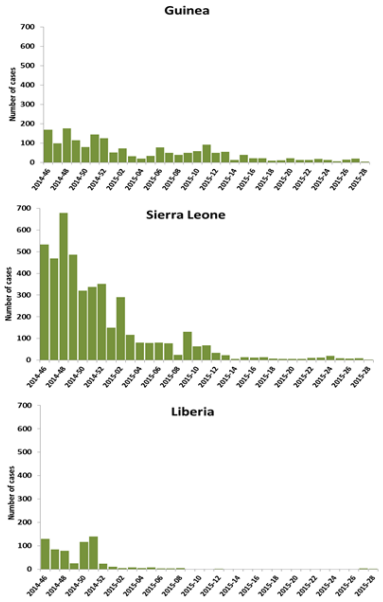

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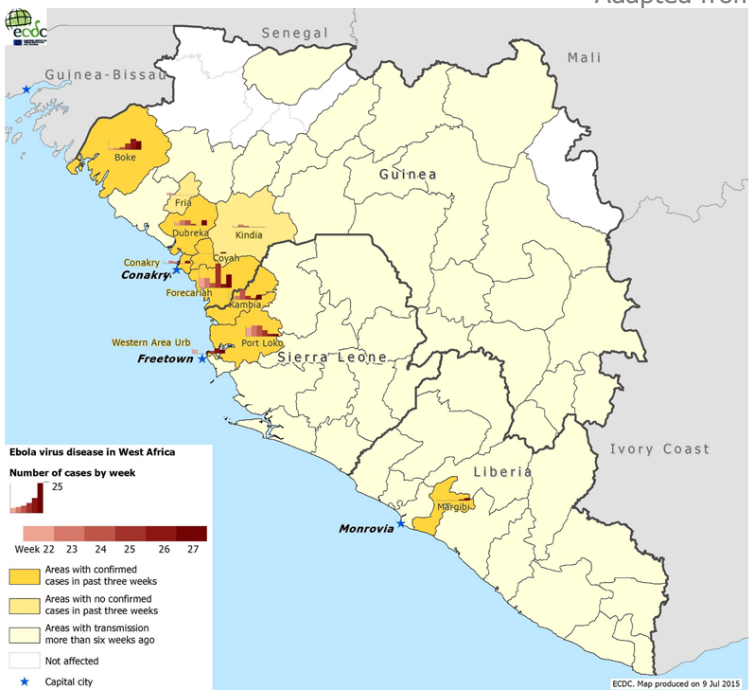
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (as of week 27/2015)

Adapted from national situation reports



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

Opening date: 24 September 2012 Latest update: 9 July 2015

Epidemiological summary

The largest outbreak outside of the Middle East is ongoing in South Korea where a person who returned from travels in the Arabian Peninsula gave rise to several hospital-centred clusters. The outbreak in South Korea has been propagated mainly through nosocomial transmission and transmission to family caregivers. The imported index case was diagnosed on 20 May 2015. The epidemic curve peaked during the first week of June. The outbreak is nearing its end, but the detection of additional cases cannot yet be excluded.

The reported case in the Philippines is the second imported case to the Philippines from the Middle East. The case is a 36-year-old male from Finland who travelled to Saudi Arabia and stayed in Riyadh, Jeddah and Dammam between 10 and 18 June. The patient had cough before travelling to Saudi Arabia; however, while in Saudi Arabia, he did not feel unwell and did not seek medical attention. Investigation of history of exposure to known risk factors in the 14 days prior to the onset of symptoms is ongoing.

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On June 18, the patient left Saudi Arabia, stayed overnight in Dubai, United Arab Emirates, and travelled to Manila, Philippines, on June 19. He was asymptomatic when he left Saudi Arabia. From 20 to 22 June, the patient was in the areas of Taguig and Makati in Manila. Between 23 and 24 June, he travelled from Manila to Penang, Malaysia, via Kuala Lumpur, Malaysia. On 25 June, the patient travelled from Penang, Malaysia, to Singapore and from Singapore to Manila. During his travels from Malaysia to Singapore and back to Manila, he was asymptomatic.

On June 30, the patient developed fever and cough, and on 2 July he visited a hospital where he had specimens taken for laboratory testing. Against medical advice, he decided to leave the hospital. The patient stayed home on 3 July. On 4 July, he returned to the hospital to obtain the results of the tests but the clinic was closed. He then went to another hospital where he was seen by healthcare professionals. He tested positive for MERS-CoV on 4 July and was transferred by ambulance to a third hospital, where he was placed in isolation. Currently, the patient is afebrile and remains in stable condition.

Since April 2012 and as of 9 July 2015, 1 389 cases of MERS-CoV have been reported by local health authorities worldwide, including 535 deaths.

The distribution is as follows:
Confirmed cases and deaths by region:

Middle East
Saudi Arabia: 1 045 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 deaths
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: 3 cases/0 deaths
South Korea: 185 cases/35 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

According to ECDC experts, the MERS-CoV outbreak poses a low risk to the EU. Efforts to contain the nosocomial clusters in the affected countries are vital to prevent wider transmission. Although sustained human-to-human community transmission is

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unlikely, secondary transmission to unprotected close contacts, especially in healthcare settings, remains possible, as documented in South Korea.

The risk for travellers to South Korea is considered extremely low, unless they have contact with healthcare facilities, in particular in the affected districts. The risk for participants in the 2015 Summer Universiade (world student games) fro 3 to 14 July in Gwangju is also considered extremely low because no MERS cases have been reported from the districts where the games take place. The risk for travellers to the Arabian Peninsula, and in particular to Saudi Arabia, is considered low and related to contacts with healthcare facilities or exposure to live camels and camel products.

However, travellers to countries with ongoing MERS-CoV transmission should be made aware that MERS-CoV is circulating in these areas and should be reminded of the importance of good hand and food hygiene. Contact with infected people should be avoided. In addition, travellers to the Arabian Peninsula should avoid close contact with camels, abstain from consuming unpasteurised camel milk, avoid contact with camel urine, and avoid improperly cooked meat. Visits to camel farms should also be avoided.

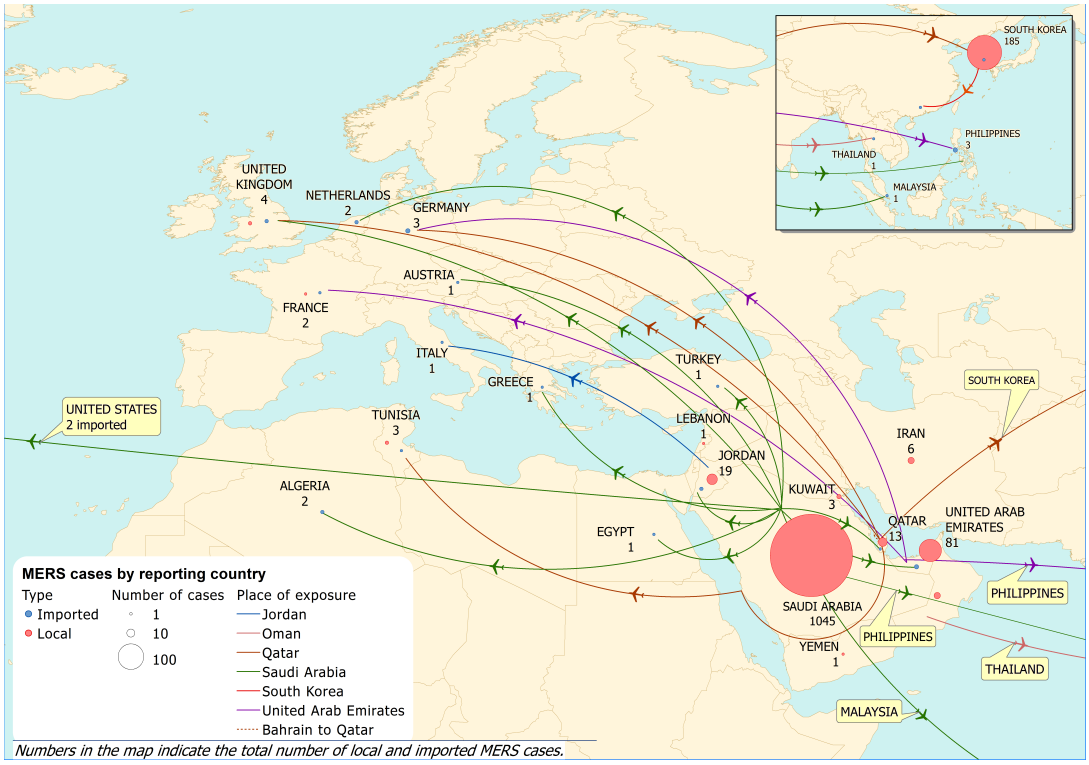
Because of the continued risk of case importation to Europe after exposure in the Middle East and South Korea, international surveillance for MERS-CoV cases among travellers remains essential. Countries should advise returning travellers from all countries affected by MERS to seek medical attention if they develop a respiratory illness with fever and cough during the two weeks after their return. Sick travellers should disclose their recent travel history to their healthcare providers.

Actions

ECDC published a rapid risk assessment on 1 July 2015.

Distribution of confirmed cases of MERS-CoV by place of probable infection, March 2012 – 9 July 2015 (n=1 389)

Source: ECDC



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

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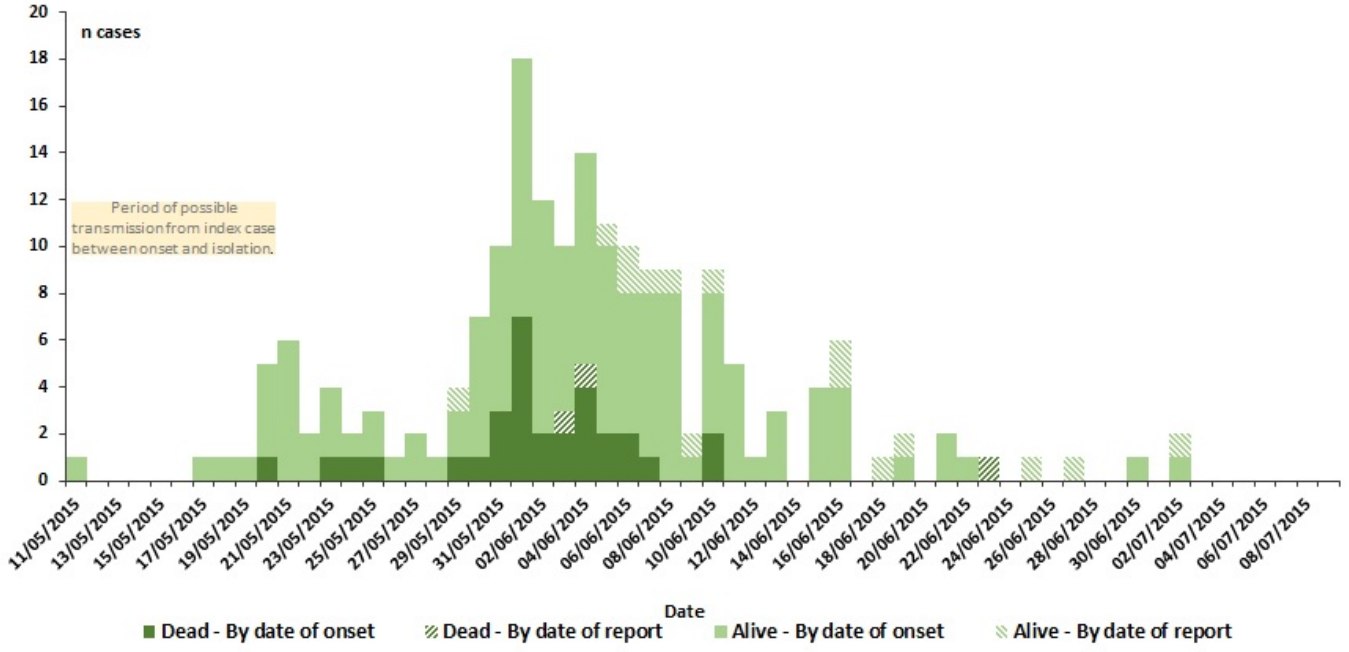
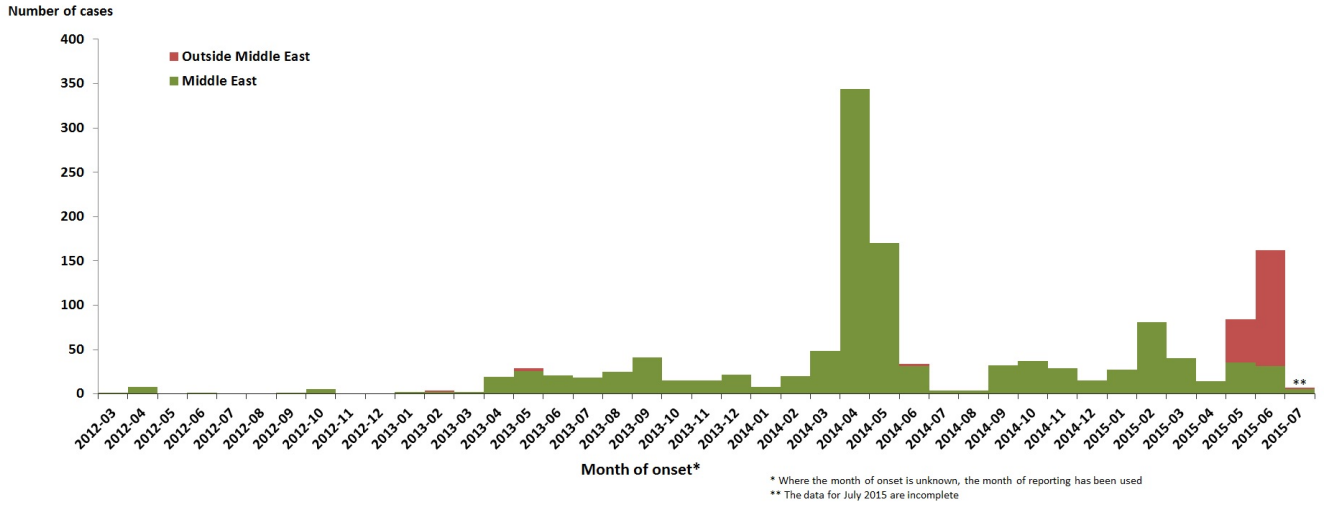
Distribution of confirmed cases of MERS-CoV by first available date and by status in South Korea and China, 11 May - 9 July 2015 (n=186)

Source: ECDC



Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 9 July 2015 (n=1 389)

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
In 2015, 144 human cases of influenza A(H5N1), including 41 deaths, have been reported, all in Egypt.

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, Taiwan reported additional cases of influenza A(H5N2) and A(H5N8) in poultry farms. Nigeria reported cases of A(H5N1) in backyard poultry, according to the World Organization for Animal Health (OIE).

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.

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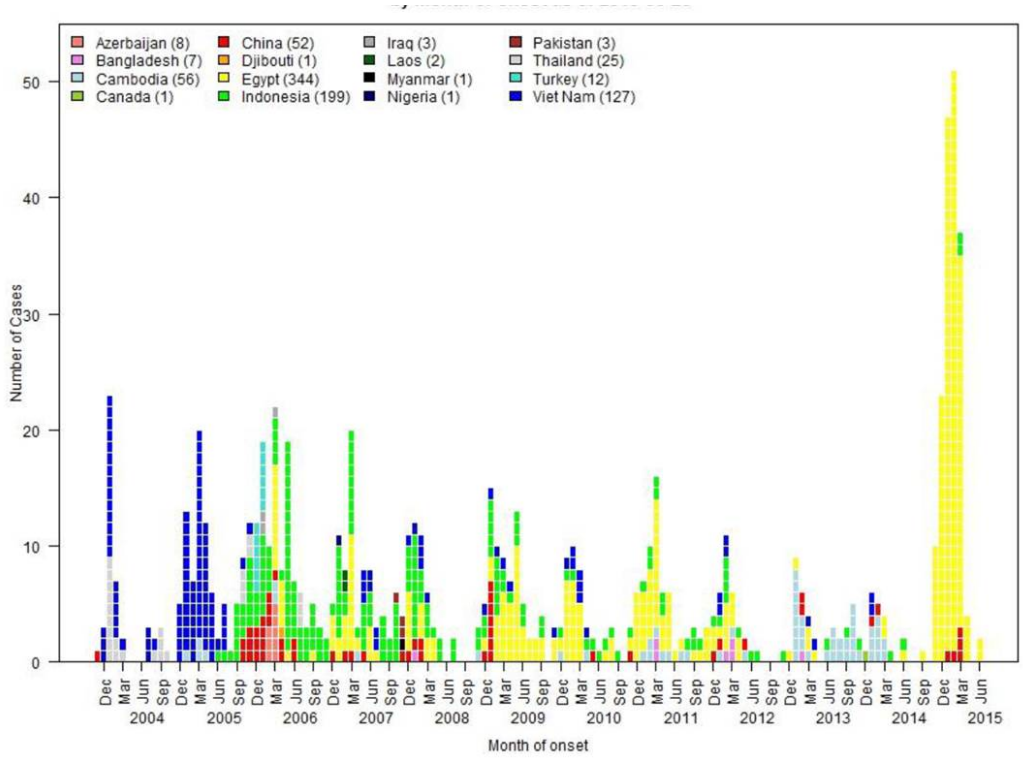
Number of confirmed human H5N1 cases by month of onset as of 23 June 2015

WHO



Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 9 July 2015

Epidemiological summary

On 15 June 2015, WHO reported 15 additional laboratory-confirmed cases of human infection with avian influenza A (H7N9) virus, including three deaths. Onset dates ranged from 19 April to 22 May 2015, and all cases were exposed to a poultry-related environment. No clusters were reported. Cases were reported from seven provinces and municipalities: Anhui (4), Beijing (1), Fujian (1), Hubei (1), Jiangsu (3), Jiangxi (1), and Zhejiang (4).

Cases in China since March 2013 have the following geographic distribution: Zhejiang (183), Guangdong (181), Jiangsu (77), Fujian (63), Shanghai (47), Hunan (26), Anhui (30), Hong Kong (13), Xinjiang Uygur Zizhiqu (10), Jiangxi (9), Beijing (6), Shandong (6), Guangxi (4), Henan (4), Taiwan (4), Jilin (2), Guizhou (2) and Hebei (1).
Three imported cases have also been reported: one in Malaysia and two in Canada.
Most cases 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 areas in China, and possibly in regions neighbouring China. Affected provinces and municipalities continue to maintain surveillance and response activities.
Imported cases of influenza A(H7N9) may be detected in Europe, as demonstrated by the recent importation of two travel-related cases to 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.

ECDC will close the threat this week.

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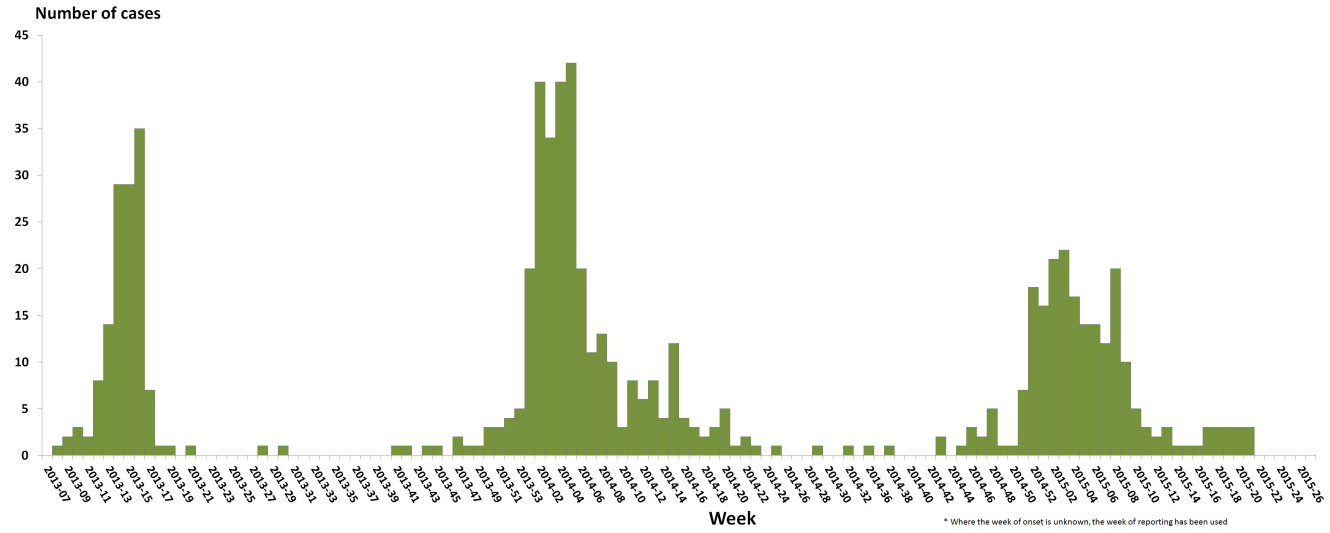
Actions

The Chinese health authorities continue to respond to this public health event with enhanced surveillance, epidemiological and laboratory investigation, including scientific research. ECDC monitors developments and updates reports on a monthly basis.
ECDC published an updated Rapid Risk Assessment on 3 February 2015.
ECDC published a guidance document Supporting diagnostic preparedness for detection of avian influenza A(H7N9) viruses in Europe for laboratories on 24 April 2013.

Distribution of avian influenza A(H7N9) cases by first available week as of 09 July 2015 (n=672)

Source: WHO



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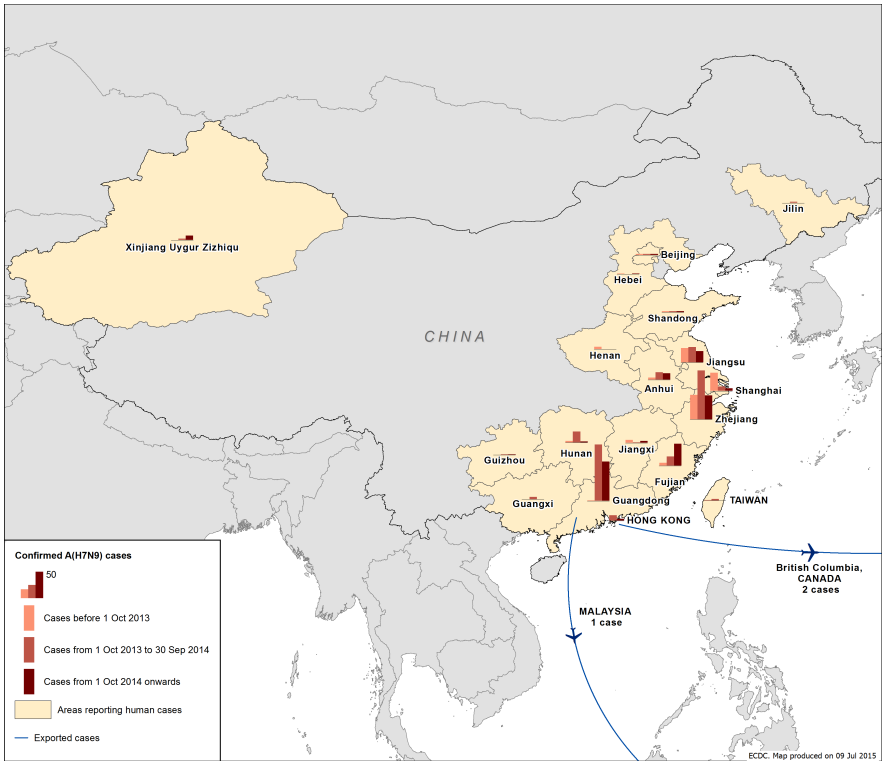
Distribution of cumulative number of human cases of avian influenza A(H7N9), by province and date, China, week 14/2013 to week 27/2015 (n=672)

Source: ECDC



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 9 July 2015

Epidemiological summary

Worldwide in 2015, 30 wild poliovirus type 1 (WPV1) cases have been reported to WHO so far, compared with 114 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (26 cases) and Afghanistan (4 cases).

In 2015, nine cases (eight 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. The cases in Madagascar are genetically linked to a case reported in September 2014, indicating prolonged and widespread circulation of the virus.

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? |

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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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