COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 7, 8-14 February 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Botulism in people who inject drugs - Norway and the UK - 2015

Opening date: 5 January 2015 Latest update: 5 February 2015

Since December 2014, 23 cases of botulism have been reported in Norway (8) and Scotland (15) affecting people who inject drugs (PWID). Four additional cases are under investigation in Scotland. These cases raise the possibility that a batch of contaminated heroin is in circulation.

➔Update of the week

Since the last weekly bulletin, Norway reported two, and Scotland eight, new cases of wound botulism in people who inject drugs.

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

Opening date: 9 October 2014 Latest update: 5 February 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

For week 06/2015, 20 countries reported increasing influenza activity. Of 2 625 sentinel specimens, 1 331 (51%) tested positive for influenza virus with positive detections being made in all 33 countries that reported virological data. Influenza A(H1N1) pdm09, A(H3N2) and type B viruses continued to circulate in the Region with A(H3N2) predominating.

Non EU Threats

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

Opening date: 15 June 2005 Latest update: 15 January 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 6 January 2015, there have been 24 additional cases of influenza A(H5N1) reported in Egypt, including 11 deaths.

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Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 12 February 2015

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, 571 cases have been reported, including 204 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. Sustained person-to-person transmission has not been documented and transmission peaked during the winter of 2013-2014.

➔Update of the week

Since the last update of 30 January 2015, WHO has reported 83 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus. Onset dates ranged from 20 December 2014 to 27 January 2015.
According to WHO these most recently reported cases ranged in age from 1 to 88 years with a median age of 56 years. Of the 83 cases, 19 were fatal. The majority of the cases 73 % (n=60) were among men. All but five cases (78 cases, 93%) reported exposure to live poultry or live poultry markets; the exposure history of four cases is unknown. Three family clusters were reported, each comprised two cases; all had exposure to live poultry or live poultry markets.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 5 February 2015

An epidemic of Ebola virus disease (EVD) has been ongoing in West Africa since December 2013, mainly affecting Guinea, Liberia and Sierra Leone. The situation in the affected countries remains serious. 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 9 February, according to WHO, there have been 22 938 cases of Ebola virus disease (EVD) related to the outbreak in West Africa, including 9 209 deaths. WHO reported that the decline in Ebola cases has stalled, despite improvements in case finding and management, burial practices and community engagement. Weekly case incidence increased for the second consecutive week, with 144 new confirmed cases reported in the week to 8 February. The case-fatality rate among hospitalised cases remains high, between 53% and 60%.

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

Opening date: 24 September 2012 Latest update: 12 February 2015

Since April 2012, 1 006 cases of MERS-CoV have been reported by local health authorities worldwide, including 405 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 points 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 last update of 3 February 2015 and as of 12 February, Saudi Arabia has reported 11 additional cases of MERS-CoV.

On 11 February 2015, WHO posted notice of one fatal case of MERS-CoV in the United Arab Emirates and one additional case in Qatar.

On 11 February 2015, health authorities in the Philippines reported an imported MERS-CoV case travelling from Saudi Arabia. The healthcare worker flew with her husband from Riyadh on 1 February to Manila. According to media reports, 11 of the 56 people identified as having had close contact with the healthcare worker showed flu-like symptoms, including her husband.

On 9 February WHO posted a summary of the current situation and a risk assessment.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 5 February 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 14 November, the Temporary Recommendations in relation to PHEIC were extended for a further three months.

➔Update of the week

During the past week, two new wild poliovirus type 1 (WPV1) cases were reported in Pakistan, one with onset of paralysis in 2014 and one with onset in 2015.

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II. Detailed reports

Botulism in people who inject drugs - Norway and the UK - 2015

Opening date: 5 January 2015 Latest update: 5 February 2015

Epidemiological summary

On 29 December 2014, the Norwegian Institute of Public Health (NIPH) was notified of one case of wound botulism in a heroin-injecting drug user residing in the Oslo area. The patient developed symptoms on 26 December. As of 10 February 2015, the NIPH has reported eight cases in the Oslo area since December 2014.

Since 1 January and as of 10 February 2015, Public Health Scotland notified 15 cases of botulism among people who inject drugs. Four patients remain under investigation, with botulism as a possible cause (these are currently not counted as cases).

The hypothesis that these cases are the result of a single batch of heroin contaminated with *C. botulinum* spores remains to be positively confirmed.

Web sources: NHS | Folkhelseinstitutet |Public Health Scotland

ECDC assessment

Botulism in people who inject drugs has been reported in recent years in several European countries and the USA. Cases occurring in two EU Member States during a short time period indicate that a batch of heroin may have been contaminated with spores of the anaerobic bacterium *Clostridium botulinum*.

Given the complex international distribution chain of heroin, the exposure of people who inject drugs in other EU Member States cannot be excluded. Member States should consider increasing awareness in healthcare settings to support prompt diagnosis and treatment as well as reporting to appropriate public health authorities. In addition, heroin users, their social networks, drug treatment and harm reduction services should be alerted to the signs and symptoms of wound botulism infection and the importance of seeking immediate medical treatment.

Actions

ECDC published a rapid risk assessment during the previous outbreak of botulism in Norway in October 2013. It is currently being updated.

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

Opening date: 9 October 2014 Latest update: 5 February 2015

Epidemiological summary

Excess all-cause mortality among the elderly (aged 65 years and above), concomitant with increased influenza activity and the predominance of A(H3N2) viruses, has been observed in recent weeks in Belgium, France, Portugal, Spain, Switzerland and the United Kingdom (England, Scotland and Wales). Across all countries, a pooled analysis shows a higher level of mortality among elderly people than in the four previous seasons (see the European project for monitoring excess mortality for public health action, EuroMOMO at http://www.euromomo.eu/).

The majority of A(H3N2) viruses characterised so far exhibit antigenic differences from the virus included in the 2014–2015 northern hemisphere influenza vaccine. A reduction in the effectiveness of the A(H3N2) component of the vaccine may be expected, which in turn may contribute to the excess mortality reported among elderly people in six European countries. The vaccine is still expected to provide some cross-protection against A(H3N2) viruses which may reduce the likelihood of severe outcomes, such as hospitalisation or death, in some cases. The A(H1N1)pdm09 and B components of the vaccine are likely to be effective.

The circulation of respiratory syncytial virus (RSV) has been decreasing across the Region, following peak activity during the first two weeks of 2015.

Web sources: Flu News Europe | ECDC Influenza |

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ECDC assessment

The influenza season is well under way, particularly in western and central European countries.

Actions

ECDC and WHO produce the Flu News Europe bulletin weekly.

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

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

Epidemiological summary

Between 6 January and 23 January 2015, 24 laboratory-confirmed influenza A(H5N1) cases, including 11 deaths, had been reported in Egypt. Of the 24 new cases, seven had onset of disease in December 2014 and the rest had onset of disease in January 2015. The cases were reported from nine different governorates of Egypt. Of the new cases, there was one cluster which included two confirmed cases in siblings from Assiut governorate. Both of these cases had disease onset on the same day and both had exposure to backyard poultry. All cases had exposure to poultry or poultry markets, except for three cases in which the source of infection is still under investigation.

Worldwide, between 2003 and 23 January 2015, 718 cases, including 413 deaths, were reported to WHO from 16 countries.

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

ECDC assessment

The occurrence of sporadic cases or small clusters in Egypt is not unexpected as avian influenza A(H5N1) viruses are known to be circulating in poultry within the country. According to WHO EMRO (the Regional Office for the Eastern Mediterranean), Egypt has been the most affected country in the region since 2003 where the disease has remained endemic. The increase in the number of human cases reported in Egypt in 2014 does not change the current risk status of this epidemic.

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. This assessment is based on the absence of sustained human-to-human transmission, and on the observation that there is no apparent change in the size of clusters or reports of chains of infection. However, vigilance for avian influenza in domestic poultry and wild birds in Europe remains important.

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.

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

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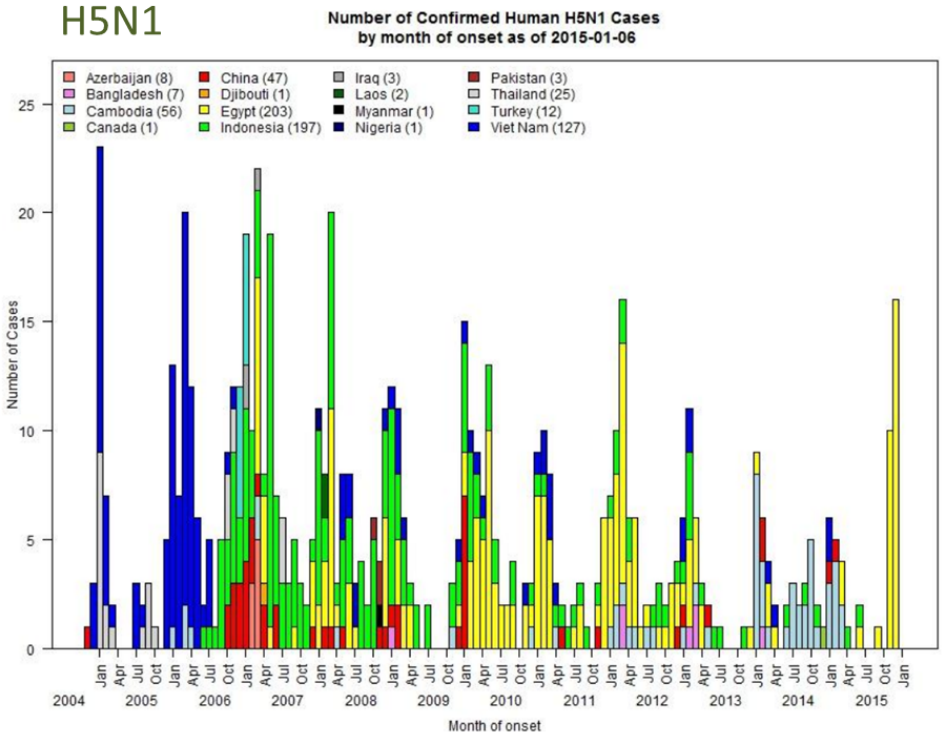
Avian influenza A(H5N1) cases in humans by reporting country and month of onset

Source: WHO



Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 12 February 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 February 2015, there were 571 laboratory-confirmed cases: Zhejiang (156), Guangdong (142), Jiangsu (70), Fujian (58), Shanghai (45), Hunan (24), Anhui (18), Hong Kong (12), Xinjiang Uygur Zizhiqu (10), Jiangxi (7), Beijing (5), Shandong (5), Guangxi (4), Henan (4), Taiwan (4), Jilin (2), Guizhou (1) 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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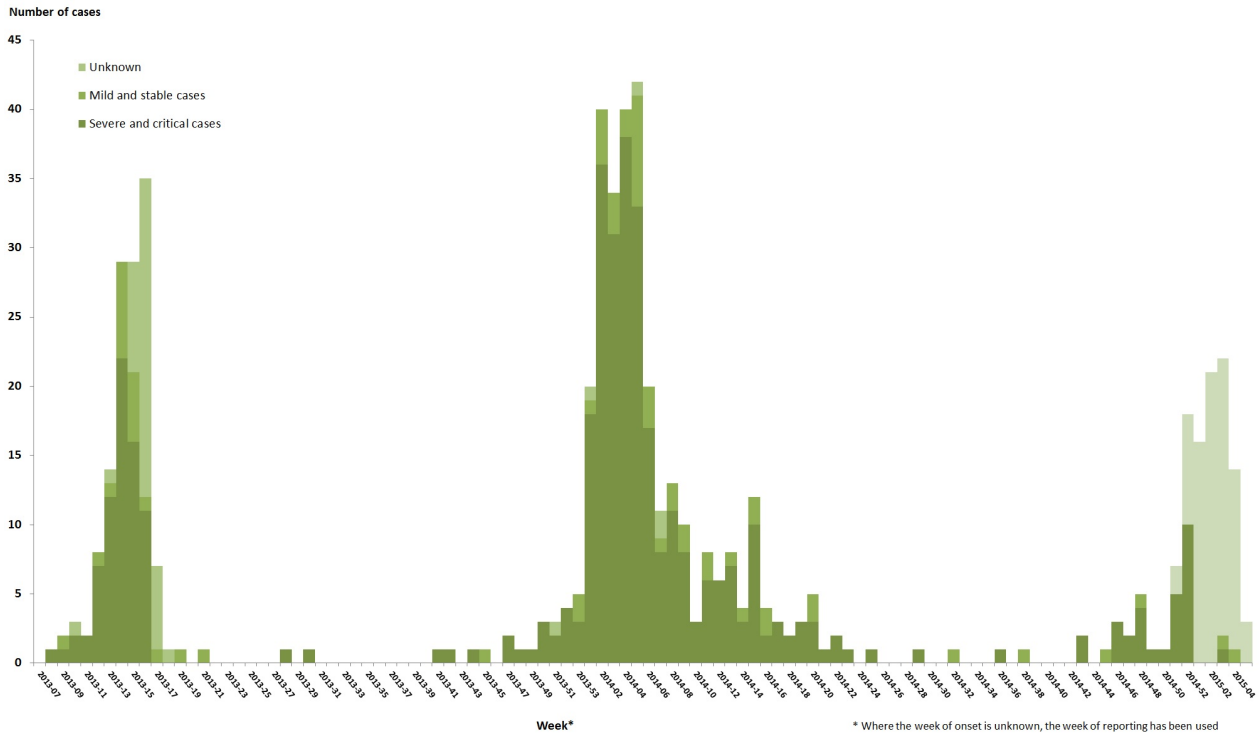
ECDC published a guidance document Supporting diagnostic preparedness for detection of avian influenza A(H7N9) viruses in Europe for laboratories on 24 April 2013.

Distribution of avian influenza A(H7N9) cases by first available week* and severity, as of 12 February 2015 (n=571)

Source: ECDC



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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 6/2015 (n=571)

Source: ECDC

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 5 February 2015

Epidemiological summary

Distribution of cases as of 8 February:

Countries with intense transmission:

- Guinea: 3 068 cases and 2 018 deaths (as of 9 February 2015)
- Liberia: 8 881 cases and 3 826 deaths (as of 7 February 2015)
- Sierra Leone: 10 954 cases and 3 350 deaths (as of 9 February 2015)

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

- United Kingdom: one confirmed case on 29 December 2014.
- Mali, Nigeria, Senegal, Spain and the United States have been declared free of EVD after having cases related to the current epidemic in West Africa.

Situation in specific West African countries
Guinea reported a sharp increase in incidence and transmission continues to be widespread in Sierra Leone. Unsafe burials continue in Guinea and Sierra Leone, and cases continue to be detected in the community rather than among known contacts of Ebola patients. Liberia continues to report a low number of new confirmed cases.

In Guinea most of the new confirmed cases were reported in the capital, Conakry (21 confirmed cases) and the western prefecture of Forecariah (26 confirmed cases). Almost one third of the affected prefectures reported at least one security incident in the week to 8 February. Effective contact tracing, which relies on the cooperation of communities, has also proved challenging. In the week to 1 February, just seven of 42 cases arose among registered contacts. A total of 34 unsafe burials were reported, with 21 EVD-positive deaths reported in the community.

Three confirmed cases were reported from Liberia during the week leading up to 8 February. All of them originated from the same area of Montserrado county and are linked to a single chain of transmission.

Following the intense decline in case incidence in Sierra Leone from December until the end of January, incidence has now stabilised. Transmission remains widespread, with seven districts reporting new confirmed cases and a total of 41 unsafe burials in the week to 8 February.

Situation in Europe
There are Media reports that two UK volunteers who had potential exposure to the Ebola virus while working in Sierra Leone have now completed the 21-day monitoring period, and are no longer considered at risk of developing Ebola. These volunteers were transported to the UK on 16 January 2015 and subsequently monitored for any symptoms for the remainder of their 21-day follow-up period, in line with standard procedures for returning workers.

Situation among healthcare workers
WHO reports 830 confirmed cases including 488 deaths among healthcare workers in the three countries with intense and widespread transmission.

Medical evacuations and repatriations from EVD-affected countries
Thirty-four individuals have been evacuated or repatriated worldwide from the EVD-affected countries. As of 12 February, there have been 12 medical evacuations of confirmed EVD-infected patients to Europe (three to Germany, two to Spain, two to France, one to the UK, one to Norway, one to Italy, one to the Netherlands and one to Switzerland). Thirteen persons exposed to Ebola who then tested negative have been repatriated to Europe (four to UK, three to Sweden, two to the Netherlands, one to Denmark, one to Germany, one to Spain and one to Switzerland).

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 07/2015 **
* 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 epi-curve: Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 07* 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.

§ In week 44/2014, WHO reported zero cases for Liberia.

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Web sources: ECDC Ebola page | ECDC Ebola and Marburg fact sheet | WHO Ebola Factsheet | CDC | WHO Roadmap | UK Media Report | Latest available situation summary |

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 WHO, the decline in Ebola cases observed in recent weeks has stalled. Weekly case incidence increased for the second consecutive week. Guinea reports a sharp increase in incidence and transmission continues to be widespread in Sierra Leone. Unsafe burials continue in Guinea and Sierra Leone, and cases continue to be detected in the community rather than among known contacts of Ebola patients.

All the necessary resources are now in place to control the outbreak. Focus should now move to full implementation of response measures, in order to control and eventually end the epidemic.

Actions

As of 12 February 2015, ECDC has deployed 30 experts within and outside the EU in response to the Ebola outbreak. This includes an ECDC mobilised contingent of experts to Guinea. Furthermore, 14 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. ECDC's role is to organise the technical support for contact tracing and epidemiological surveillance in the Guinèe Forestière region under the GOARN mechanism. Individual experts are invited to contribute by deploying on 6-week missions with departure from March to June. The ECDC teams in Guinèe Forestière are currently based in N'zerekoré town. 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

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Distribution of cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (as of week 06/2015)

Source: Adapted from national situation reports

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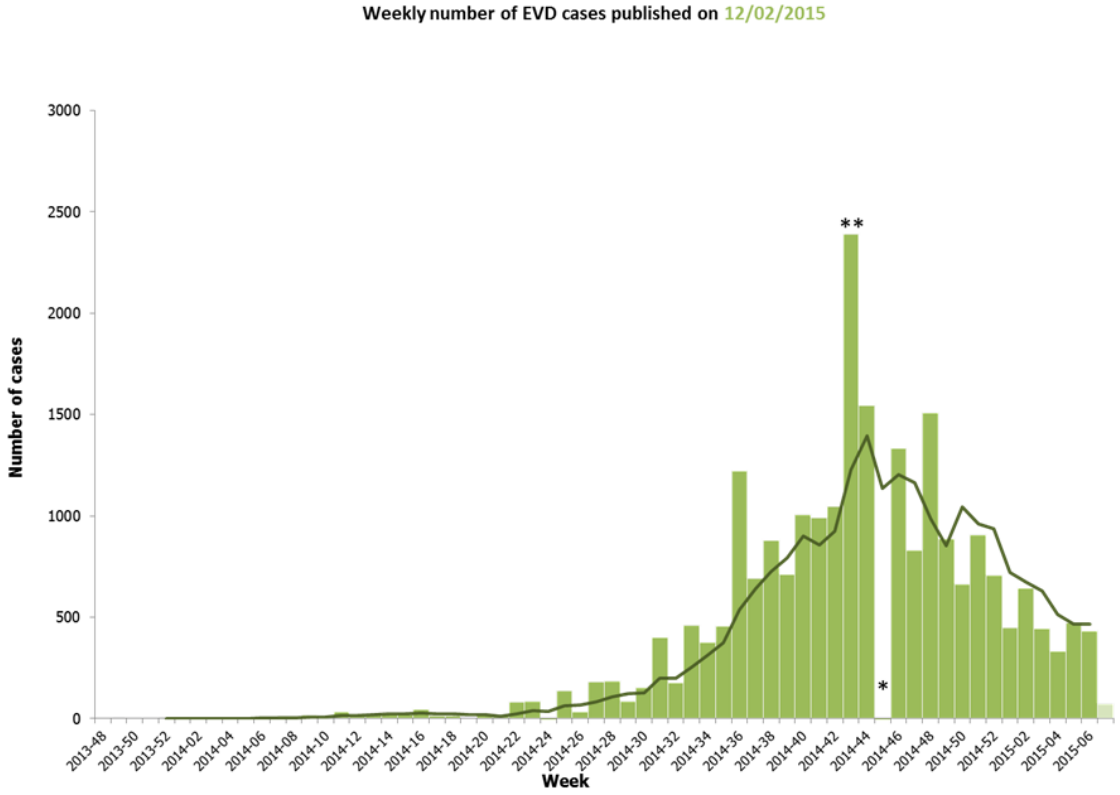
Distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Mali, Nigeria and Senegal, weeks 48/2013 to 07*/2015

Source: Adapted from WHO figures; *data for week 07/2015 are incomplete



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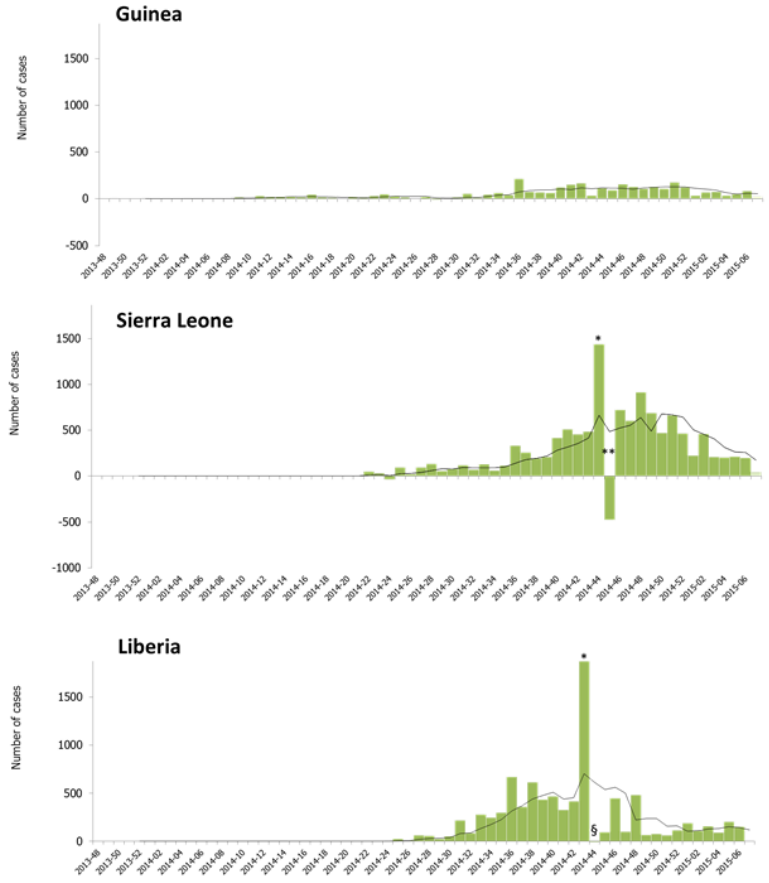
Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 07* 2015

Source: Adapted from WHO figures; *data for week 07/2015 are incomplete



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

Opening date: 24 September 2012 Latest update: 12 February 2015

Epidemiological summary

Since April 2012 and as of 12 February 2015, 1 006 cases of MERS-CoV have been reported by local health authorities worldwide, including 405 deaths.

The distribution is as follows:

Confirmed cases and deaths by region:
Middle East
Saudi Arabia: 862 cases/368 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: 2 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 have not been identified. Dromedary camels are a host species for the virus, and many of the primary cases in MERS-CoV clusters have reported direct or indirect camel exposure. There is therefore a 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 further reduced 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

ECDC published an epidemiological update on 6 November 2014.
The last rapid risk assessment was updated on 21 January 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.

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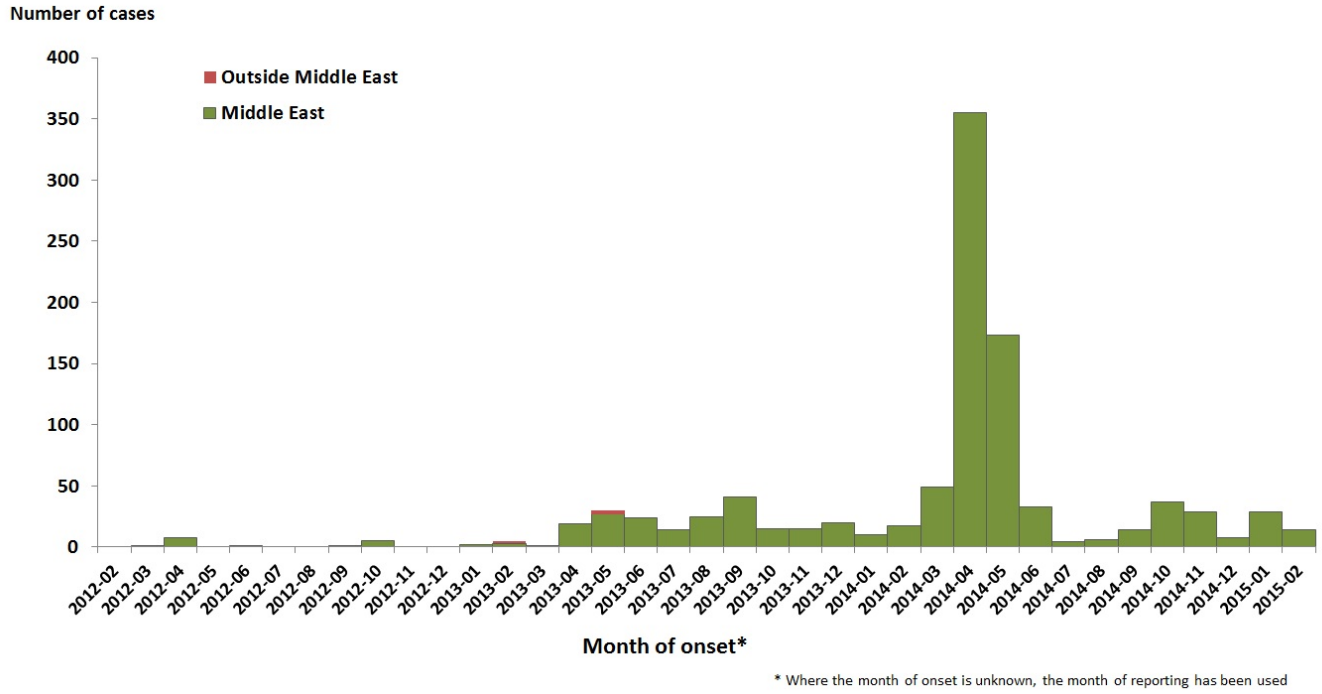
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 12 February 2015 (n=1006)

Source: ECDC



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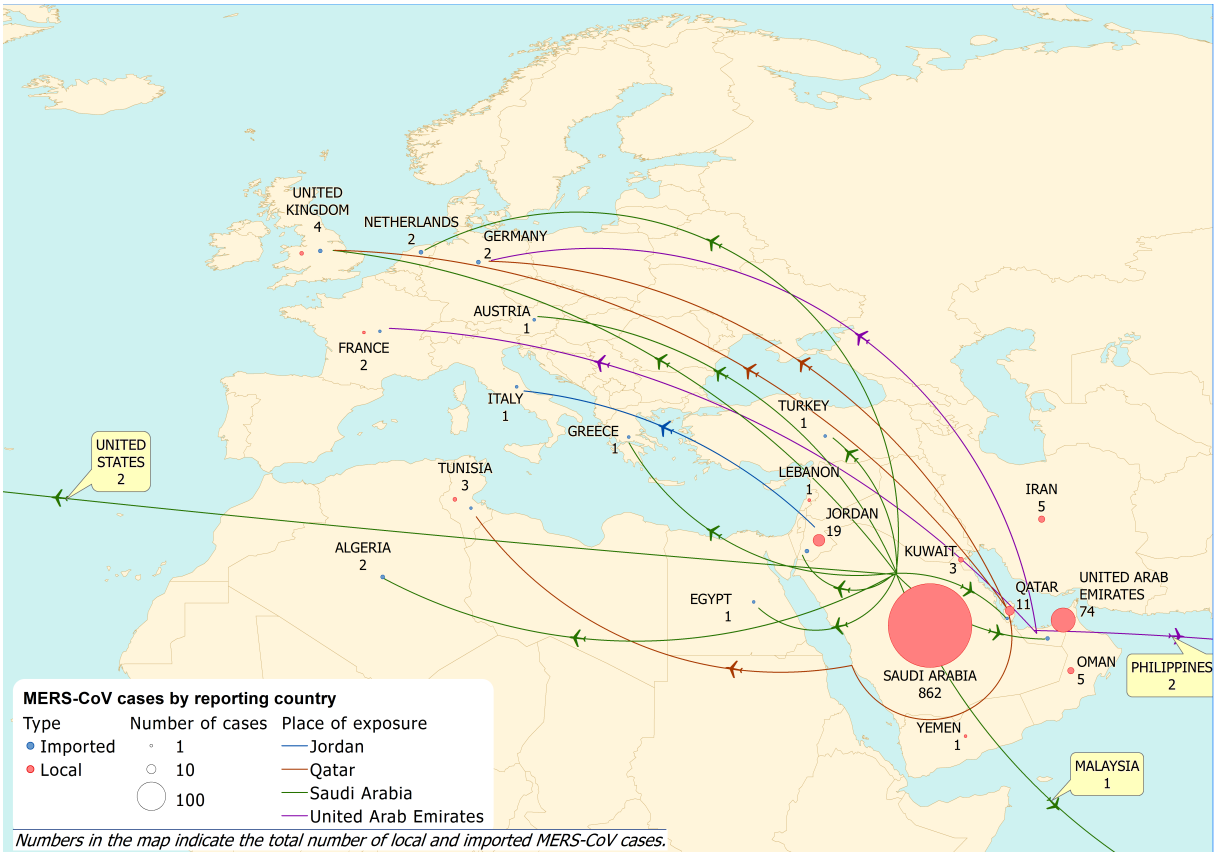
Geographical distribution of confirmed MERS-CoV cases and place of probable infection, worldwide, as of 12 February 2015 (n=1006)

Source: ECDC



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

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 5 February 2015

Epidemiological summary

Worldwide in 2015, seven WPV1 cases have been reported to WHO, compared with 11 for the same period in 2014.
In 2014, nine countries reported cases: Pakistan (304 cases), Afghanistan (28 cases), Nigeria (6 cases), Equatorial Guinea (5 cases), Somalia (5 cases), Cameroon (5 cases), Iraq (2 cases), Syria (1 case), and Ethiopia (1 case).

One new cVDPV2 case was reported in the past week for 2014 in Pakistan bringing the number of cVDPV2 cases for 2014 to 21 in the country. Worldwide, 54 cases of cVDPV were reported in 2014.

After the declaration of a PHEIC, WHO issued a set of Temporary Recommendations that call for the vaccination of all residents in, and long-term visitors to, countries with polio transmission prior to international travel.

Web sources: Polio Eradication: weekly update | MedISys Poliomyelitis | ECDC Poliomyelitis factsheet |Temporary

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Recommendations to Reduce International Spread of 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? | WHO statement on the meeting of the International Health Regulations Emergency Committee concerning the international spread of wild poliovirus, 5 May 2014 | WHO statement on the third meeting of the International Health Regulations Emergency Committee regarding the international spread of wild poliovirus, 14 November 2014

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.

In 4 September 2014, ECDC published a news item regarding the WHO IHR Emergency Committee decision to add Equatorial Guinea as a wild-poliovirus-exporting country and the renewal of the WHO PHEIC recommendations.

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

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