COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 16, 12-18 April 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

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

Opening date: 9 October 2014 Latest update: 9 April 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 its report weekly on the Flu News Europe website.

➔Update of the week

During week 16/2015, influenza activity continued to decrease in most reporting countries, the proportion of influenza-virus-positive specimens from sentinel sources decreased from 36% in week 14 to 28% in week 15. Since week 51/2014 the positivity rate has been over the threshold of 10%, indicating seasonal influenza activity.

Non EU Threats

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

Opening date: 15 June 2005 Latest update: 9 April 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

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There have been no reports by WHO of human cases of influenza A(H5N1) since last week, but FAO, OIE and national authorities are reporting increasing numbers of outbreaks in poultry in April 2015.
In the same period, outbreaks of Highly Pathogenic Asian-origin Avian Influenza (HPAI) influenza A(H5N1) in birds have been reported in Asia (Bhutan, China, India and Viet Nam) and in Africa (Burkina Faso, Egypt, Ivory Coast, Mali, Niger and Nigeria). In the Middle East an outbreak of the same subtype has been reported from the Gaza strip in Palestine* (*This designation shall not be construed as recognition of a State of Palestine and is without prejudice to the individual positions of the Member States on this issue).

Additionally, in the same period, numerous outbreaks of HPAI influenza A(H5N2) in 27 poultry farms in Iowa, Minnesota, Montana, North Dakota, South Dakota and Wisconsin were reported to FAO in the USA. Canada also reported an outbreak in a farm in Ontario. Most of the outbreaks involve turkey farms. In Asia, Taiwan is reporting three outbreaks of the same serotype in domestic geese and one in a turkey farm.

According to FAO, HPAI Influenza A(H5) was also identified in wild birds in April in the USA (Kansas, Missouri and New Mexico) and in China (Hong Kong - confirmed to be H5N6). In Europe, the Netherlands reported an outbreak of Low Pathogenic Avian influenza (LPAI) influenza A(H5N2) in domestic chickens. Other HPAI A(H5) strains were reported in April from China and Vietnam in geese and chickens.

None of these outbreaks are known to have generated any human case. The risk to people from these HPAI H5 infections in wild birds, backyard flocks and commercial poultry is considered to be low.

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 16 April 2015

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, 651 cases have been reported, including 225 deaths. No autochthonous cases have been reported from outside of China. Most cases have been unlinked, and sporadic zoonotic transmission from poultry to humans is the most likely explanation for the outbreak.

➔Update of the week
Since the last update on 11 March 2015, WHO has reported 20 additional laboratory-confirmed cases of human infection with avian influenza A (H7N9) virus, including 4 deaths, in China. Cases were reported from five provinces: Anhui (3), Fujian (2), Guangdong (4), Shandong (1), and Zhejiang (10).
According to WHO, onset dates ranged from 14 February to 21 March 2015. Cases ranged in age from 32 to 80 years with a mean age of 55 years. Of these 20 cases, 15 (75%) were male. The majority (18 cases, 90%) reported exposure to live poultry. One case is a healthcare worker, who was also exposed to poultry.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 16 April 2015

An epidemic of Ebola virus disease (EVD) has been ongoing in West Africa since December 2013, mainly affecting Guinea, Liberia and Sierra Leone. On 8 August 2014, WHO declared the Ebola epidemic in West Africa a Public Health Emergency of International Concern (PHEIC).

➔Update of the week
As of 14 April 2015, WHO reported 25 831 cases of Ebola virus disease related to the outbreak in West Africa, including 10 699 deaths.

Thirty-seven new confirmed cases of EVD were reported from WHO in the week from 6 April to 12 April (28 in Guinea and 9 in Sierra Leone). Liberia reported no new confirmed cases. In the week up to 12 April, eight prefectures/districts in Guinea and Sierra Leone reported confirmed cases, compared with 10 of the previous week. This is the lowest number of districts to report a confirmed case since the end of May 2014. Of 55 districts in Guinea, Liberia and Sierra Leone that have reported at least one confirmed case of Ebola since the start of the outbreak, 39 have not reported a case for over six weeks.

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

Opening date: 24 September 2012 Latest update: 16 April 2015

Since April 2012 and as of 16 April 2015, 1 123 cases of MERS-CoV have been reported by local health authorities worldwide, including 463 deaths. To date, all cases have either occurred in the Middle East, have direct links to a primary case infected in the Middle East, or have returned from this area. The source of the virus remains unknown but the pattern of transmission and virological studies point towards dromedary camels in the Middle East being a reservoir from which humans sporadically become infected through zoonotic transmission. Human-to-human transmission is amplified among household contacts and in healthcare settings.

➔Update of the week

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Since the last update in 9 April 2015, Saudi Arabia has reported one additional cases of MERS-CoV infection. The case is a 93 year old man from Makkah city with no contact to a confirmed case. Two deaths were recorded among previously reported cases.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 16 April 2015

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission stops and the world is polio-free.
Polio was declared a Public Health Emergency of International Concern (PHEIC) on 5 May 2014 due to concerns regarding the increased circulation and the international spread of wild poliovirus during 2014. On 27 February 2015, the Temporary Recommendations in relation to PHEIC have been extended for another three months.

➔Update of the week
In the past week, no new cases of poliovirus type 1 (WPV1) were reported.

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II. Detailed reports

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

Opening date: 9 October 2014 Latest update: 9 April 2015

Epidemiological summary

Influenza A(H1N1)pdm09, A(H3N2) and type B viruses continued to circulate in the WHO European Region, but type B viruses accounted for 69% of sentinel detections for week 15/2015.
The number of hospitalised influenza cases is returning to low levels.
Excess all-cause mortality among people aged 65 years and above, concomitant with increased influenza activity and the predominance of A(H3N2) viruses, was observed in most countries participating in the European project for monitoring excess mortality for public health action (EuroMOMO), but has now abated (see the EuroMOMO website).
About two thirds of the A(H3N2) viruses characterised to date show evidence of antigenic differences from the virus included in the 2014–2015 northern hemisphere influenza vaccine. These differences may have contributed to the observed reduction in effectiveness of the A(H3N2) component of the vaccine and to the excess mortality reported among older age groups. The A (H1N1)pdm09 and B components of the vaccine are likely to be effective.
Very few influenza viruses have shown reduced susceptibility to neuraminidase inhibitors this season.

Web sources: Flu News Europe | ECDC Influenza |

ECDC assessment

Influenza activity is decreasing in most of the reporting 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: 9 April 2015

Epidemiological summary

Egypt
In Egypt, as of 6 April 2015, the Ministry of Health and Population has reported 134 human cases of influenza A(H5N1), including 38 deaths. Since 2006, Egypt has reported 336 human cases, according to WHO/FAO.
The number of laboratory-confirmed human cases of avian influenza A(H5N1) virus infection in Egypt with onsets of illness from January to March 2015 is the highest reported for a three-month period since the start of the epidemic in 2006. New cases have been reported every month since the surge that started in November 2014. No similar surge in cases has been reported in other affected countries. As communicated by WHO, during the recent surge (November 2014 to March 2015), cases have been reported from 21 of the 29 Egyptian governorates. Females represented 60% of cases. The number of fatal cases in Egypt in 2015 is the highest ever reported. The case-fatality rate for 2015 so far is 28%, although, for recent cases, the final outcomes may not yet be known. There appears to have been no discernible trend in the case-fatality rate between 2006 and 2015.
According to WHO EMRO, despite the recent surge in human cases, the demographic and epidemiological characteristics of the recently reported cases do not significantly differ from previous periods.
The increase in human cases in Egypt may be attributed to several factors including increased circulation of influenza A(H5N1) viruses in poultry, lower public health awareness of risks in middle and upper Egypt, seasonal factors such as closer proximity to poultry because of cold weather and possibly longer survival of the viruses in the environment. A high-level joint WHO/FAO/OIE mission to Egypt to assess the risks associated with the influenza A(H5N1) viruses and to recommend control measures was conducted in March 2015. On 10 April 2015 ECDC published an epidemiological update on the subject.

China
Since the last monthly update on 4 March 2015, WHO Western Pacific Region (WPRO) has reported four new human cases of influenza A(H5N1) virus in China. Three of the cases were from Yunnan province. So far in 2015, five human cases of influenza A (H5N1) have been reported in the WPRO, all from China.
From 2003 to 3 April 2015, WPRO reported 788 cases of human infection with avian influenza A(H5N1) virus from 16 countries

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worldwide. Of these cases, 430 were fatal, resulting in a case-fatality rate of 55%.

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

ECDC assessment

Most human infections of A(H5N1) are the result of direct contact with infected birds, and countries with large poultry populations in close contact with humans are considered to be most at risk of bird flu outbreaks. The ongoing outbreak of influenza A(H5N1) among poultry and humans in Egypt has now caused more cases during one season than has been reported from any other country globally. The virus belongs to a clade, which appears to be restricted to transmission in Egypt and neighbouring countries only for several years. An emergence of a novel cluster within this clade was recently reported in Eurosurveillance, which might explain the increase in poultry infections and/or human cases.
The sharp increase in human cases of A(H5N1) infection in Egypt during the winter months 2014–2015 may be due to an increase in the circulation of A(H5N1) among backyard poultry and exposure to infected poultry across the country. Identification of such sporadic cases or small clusters is not unexpected as avian influenza A(H5N1) viruses are known to be circulating among poultry within the country. Strict implementation of control measures to reduce and eliminate infection in poultry is essential for reducing the risk of zoonotic transmission and human cases. Enhanced human infectivity of the circulating virus and the protection conferred by the poultry vaccines currently in use should be further investigated. Surveillance in poultry as well as in humans needs to be strengthened and coordinated. Intervention programmes to reduce virus circulation in the country should be reinforced. Travellers visiting Egypt should avoid direct contact with poultry and birds or uncooked/untreated poultry products.

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 13 March 2015.
ECDC published an epidemiological update about A(H5N1) in Egypt on 10 April 2015.

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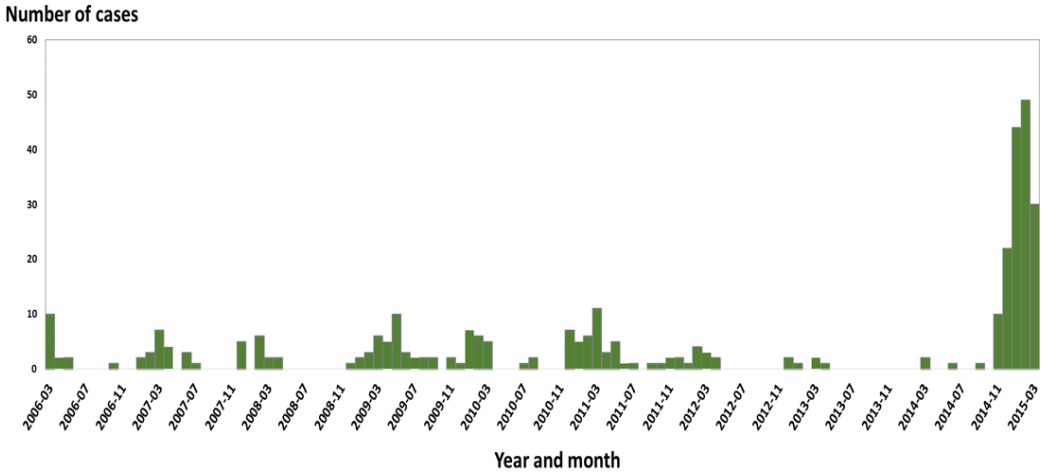
Distribution of human influenza A(H5N1) cases in Egypt by month and year– March 2006 to March 2015

Source: FAO EMPRES



Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 16 April 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 15 April 2015, there were 651 laboratory-confirmed cases: Zhejiang (177), Guangdong (181), Jiangsu (73), Fujian (61), Shanghai (46), Hunan (26), Anhui (25), Hong Kong (13), Xinjiang Uygur Zizhiqu (10), Jiangxi (8), Beijing (5), Shandong (6), Guangxi (4), Henan (4), Taiwan (4), Jilin (2), Guizhou (2) and Hebei (1), one imported case in Malaysia and two imported cases in Canada.
Most cases have developed severe respiratory disease.
Web sources: Chinese CDC | WHO | WHO FAQ page | ECDC |

ECDC assessment

This outbreak is caused by a novel reassortant avian influenza virus capable of causing severe disease in humans. This is a zoonotic outbreak, in which the virus is transmitted sporadically to humans in close contact with the animal reservoir, similar to

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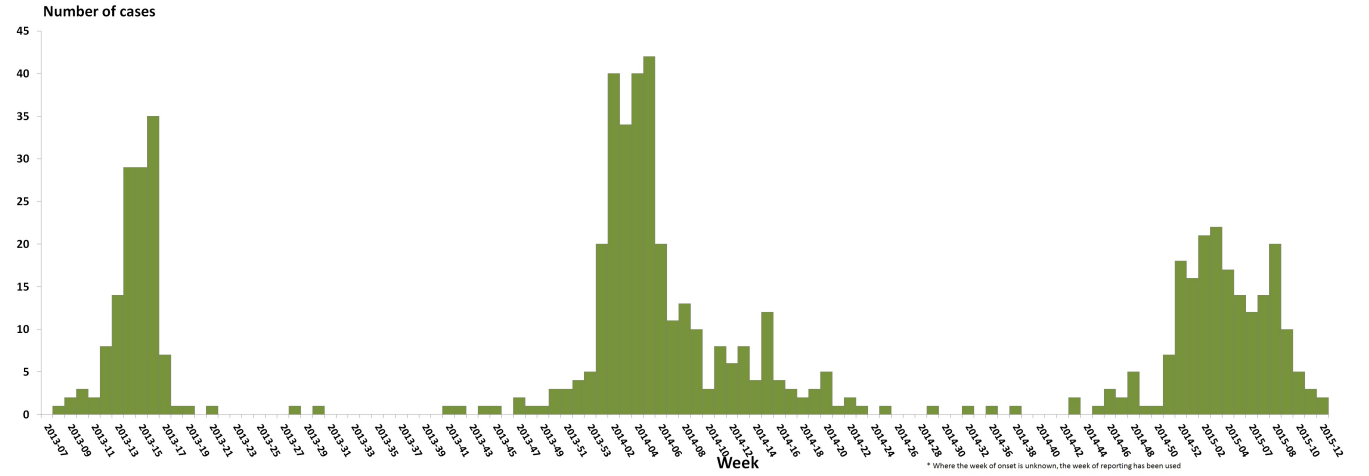
the influenza A(H5N1) situation. It is expected that there may be further sporadic cases of human infection with the virus in affected and possibly neighbouring areas in China. Affected provinces and municipalities continue to maintain surveillance and response activities.
Imported cases of influenza 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.
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 15 April 2015 (n=651)

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 12/2015 (n=651)

Source: ECDC

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 16 April 2015

Epidemiological summary

Distribution of cases as of 14 April 2015:

Countries with intense transmission

- Guinea: 3 566 cases, of which 3 124 are confirmed, and 2 348 deaths as of 14 April.
- Liberia: 10 042 cases, of which 3 151 are confirmed, and 4 486 deaths as of 11 April.
- Sierra Leone: 12 223 cases, of which 8 566 are confirmed, and 3 865 deaths as of 14 April.

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

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

Situation in specific West African countries
In **Guinea**, according to WHO, five prefectures reported at least one confirmed case in the week to 12 April, compared with six in the previous week. Transmission remains confined to the western area, and is primarily focused on the prefecture of Forecariah.

Response indicators for Guinea continue to present a mixed picture. In the week up to 12 April, eight confirmed deaths from EVD were identified post-mortem in the community. In addition, 44% of confirmed cases arose among registered contacts, a figure below 50% for the second consecutive week. WHO reported that a case-finding and community sensitisation operation took place in the Guinean prefecture of Forecariah from 12 to 15 April. In the first three days, over 29 000 households were visited, with 23 suspected cases identified and tested. Similar operations will take place in the prefectures of Boffa, Conakry, Coyah, Dubreka and Kindia.

In **Sierra Leone**, WHO reported cases from three western districts: Kambia, Port Loko, and Western Area Urban, which includes the capital, Freetown.

Response indicators from Sierra Leone continue to be encouraging. The number of EVD-positive deaths that were identified in the community after post-mortem testing was three in the week up to 12 April. The low proportion of laboratory samples that tested EVD-positive (9 of 1 338: <1%) and the increasing proportion of cases that arise among registered contacts (67%) strengthen confidence that the downward trend in case incidence over the past five weeks will continue.

In **Liberia**, the last confirmed case died on 27 March. Investigations are ongoing to establish the origin of infection. Heightened vigilance is being maintained throughout the country. In the six days up to 11 April, 332 laboratory samples were tested for EVD, with no confirmed cases. If no new cases occur the country will be declared Ebola free on 8 May.

In the context of falling case incidence and a receding zone of transmission, treatment capacity exceeds demand in Liberia and Sierra Leone. Accordingly, and with technical guidance from WHO, national authorities have begun to implement plans for the phased safe decommissioning of surplus facilities. Each country will retain a core capacity of high-quality Ebola treatment centres, strategically located to ensure complete geographic coverage, with additional rapid-response capacity held in reserve.

Situation among healthcare workers
Up to 12 April 2015, WHO reported a new infection in Guinea among healthcare workers. Two additional reclassified cases were also reported from Liberia with the cumulative total increasing to 864 healthcare workers (HCWs) infected with EVD in Guinea (187), Liberia (374) and Sierra Leone (303). WHO reports that 503 of them have died of the disease.

Outside of the three most affected countries, two Ebola-infected HCWs were reported in Mali, 11 in Nigeria, one in Spain (infected while caring for an evacuated EVD patient), two in the UK (both infected in Sierra Leone), and six in the USA (two infected in Sierra Leone, two in Liberia and two infected while caring for confirmed case in Texas).

Medical evacuations and repatriations from EVD-affected countries
Since the beginning of the epidemic and as of 9 April 2015, 65 individuals have been evacuated or repatriated worldwide from the EVD-affected countries. Of these, 38 individuals have been evacuated or repatriated to Europe. Thirteen were medical evacuations of confirmed EVD-infected patients to: Germany (3), Spain (2), France (2), UK (2), Norway (1), Italy (1), Netherlands (1) and Switzerland (1). Twenty-five asymptomatic persons have been repatriated to Europe as a result of exposure to Ebola in West Africa: UK (13), Denmark (4), Sweden (3), Netherlands (2), Germany (1), Spain (1) and Switzerland (1).

Twenty-seven persons have been evacuated to the United States.

No new medical evacuations have taken place since 18 March 2015.

Images
- *Epicurve 1 and 2:* the epicurves show the confirmed cases in the three most affected countries.
- *Map*: this map is based on the country situation reports and shows only confirmed cases of EVD in the past six weeks. The scale of the bar graphs is reduced to 50 cases.

Web sources: ECDC Ebola page | ECDC Ebola and Marburg fact sheet | WHO situation summary | WHO Roadmap | WHO Ebola Factsheet | CDC | Latest 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 remain 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 the latest weekly situation report from WHO, the number of reported cases in the week leading up to 12 April increased slightly in Guinea while the number of confirmed cases were the same as the week before in Sierra Leone. Liberia has not reported new confirmed cases. Although surveillance is improving in Guinea, unknown chains of transmission remain a source of new infections. The downward trend in Sierra Leone continues although challenges remain.

Actions

As of 17 April 2015, ECDC has deployed 61 experts coming 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 three months while additional deployments are envisaged but still pending confirmation. ECDC is looking for additional French-speaking experts with field epidemiology experience from EU Member States to join the ECDC-coordinated contingent in response to the Ebola outbreak in Guinea. For further information, please contact Niklas Danielsson, Response group leader at: niklas.danielsson@ecdc.europa.eu with cc to support@ecdc.europa.eu

An epidemiological update is published weekly on the EVD ECDC page
On 15 April 2015, ECDC published an updated rapid risk assessment
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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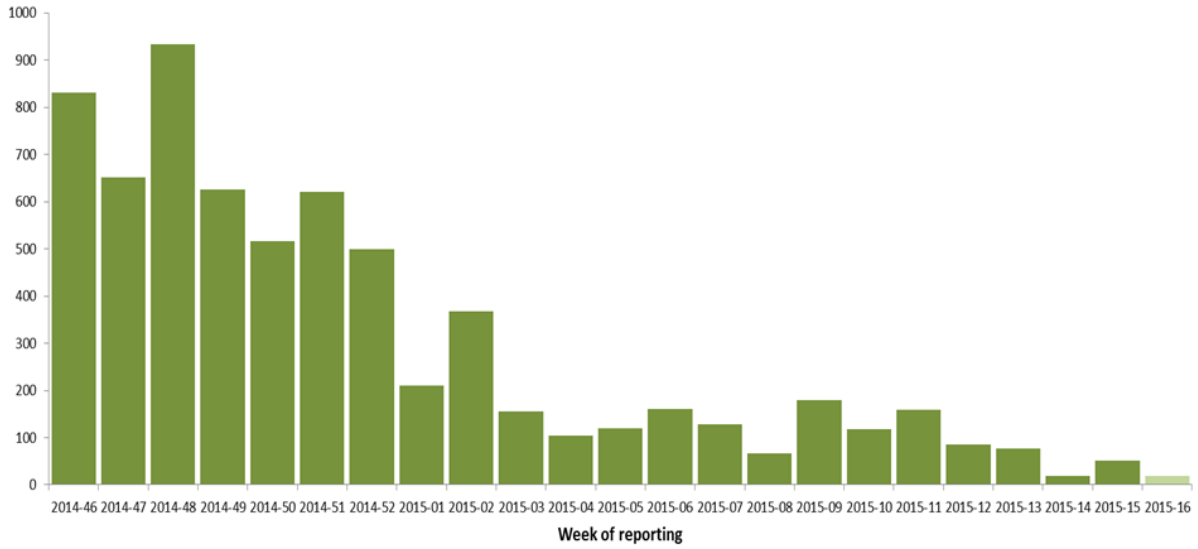
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 16/2015)

Adapted from WHO figures; *data for week 16/2015 are incomplete



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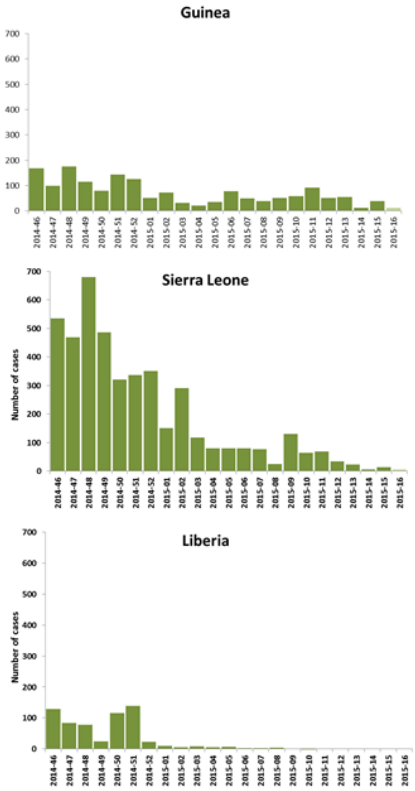

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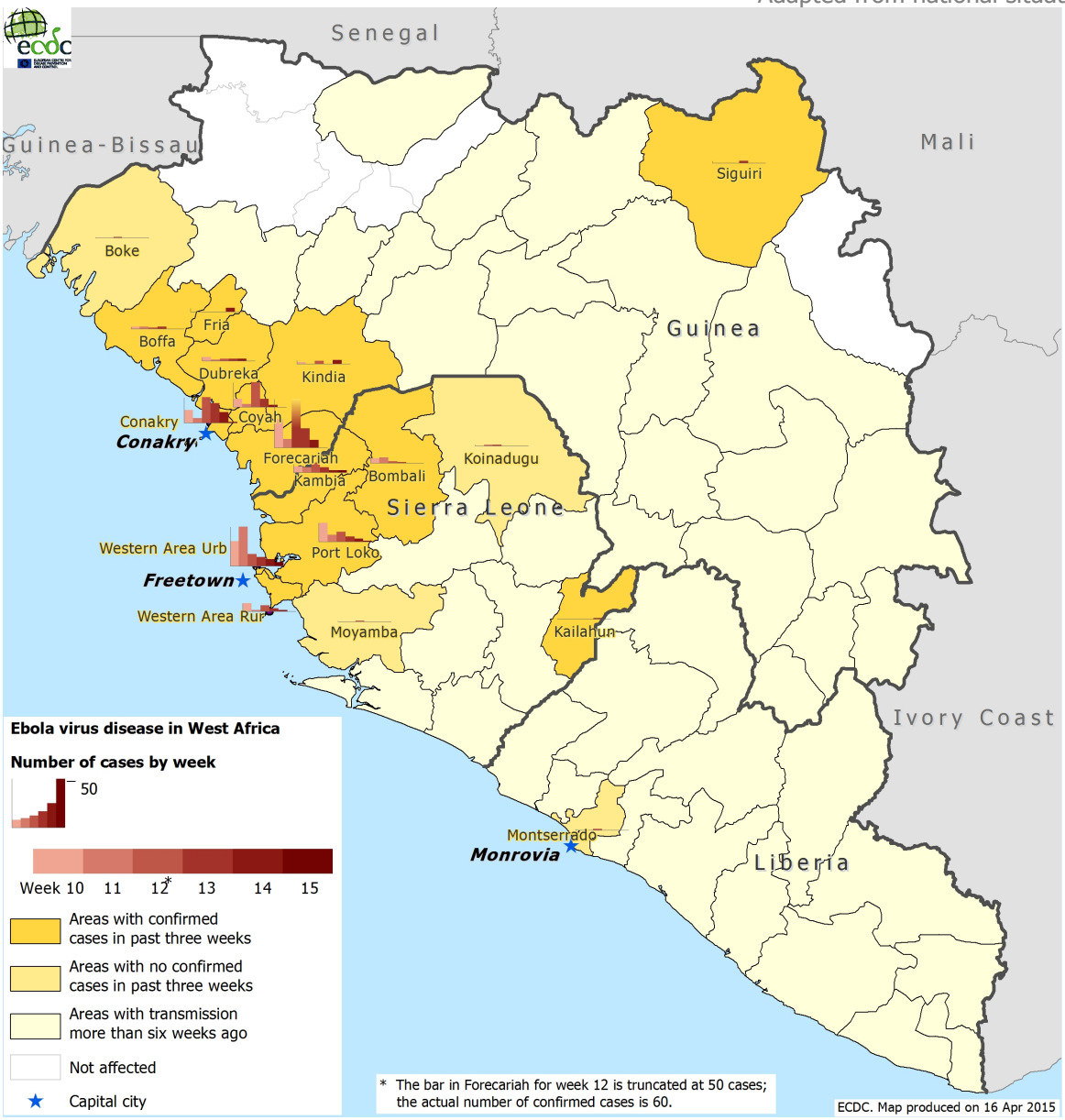
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (as of week 15/2015)

Adapted from national situation reports



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

Opening date: 24 September 2012 Latest update: 16 April 2015

Epidemiological summary

Since April 2012 and as of 16 April 2015, 1 123 cases of MERS-CoV have been reported by local health authorities worldwide, including 463 deaths.

The distribution is as follows:

Confirmed cases and deaths by region:

Middle East
Saudi Arabia: 978 cases/427 deaths
United Arab Emirates: 74 cases/10 deaths
Qatar: 11 cases/4 deaths

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Jordan: 19 cases/6 deaths
Oman: 5 cases/3 deaths
Kuwait: 3 cases/1 death
Egypt: 1 case/0 deaths
Yemen: 1 case/1 death
Lebanon: 1 case/0 deaths
Iran: 5 cases/2 deaths

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

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

Asia
Malaysia: 1 case/1 death
Philippines: 2 cases/0 deaths

Americas
United States of America: 2 cases/0 deaths

Web sources: ECDC's latest rapid risk assessment | ECDC novel coronavirus webpage | WHO | WHO MERS updates | WHO travel health update | WHO Euro MERS updates | CDC MERS | Saudi Arabia MoH | ECDC factsheet for professionals

ECDC assessment

The source of MERS-CoV infection and the mode of transmission to primary cases have not been identified. The majority of MERS-CoV cases are secondary cases and many result from nosocomial transmission. Dromedary camels are a host species for the virus. There is 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 reduced further by screening for exposure among patients presenting with respiratory symptoms (and their contacts), and strict implementation of infection prevention and control measures for patients under investigation.

Actions

The last rapid risk assessment was updated on 9 March 2015.
ECDC is closely monitoring the situation in collaboration with WHO and EU Member States.
ECDC published a factsheet for health professionals regarding MERS-CoV on 20 August 2014.

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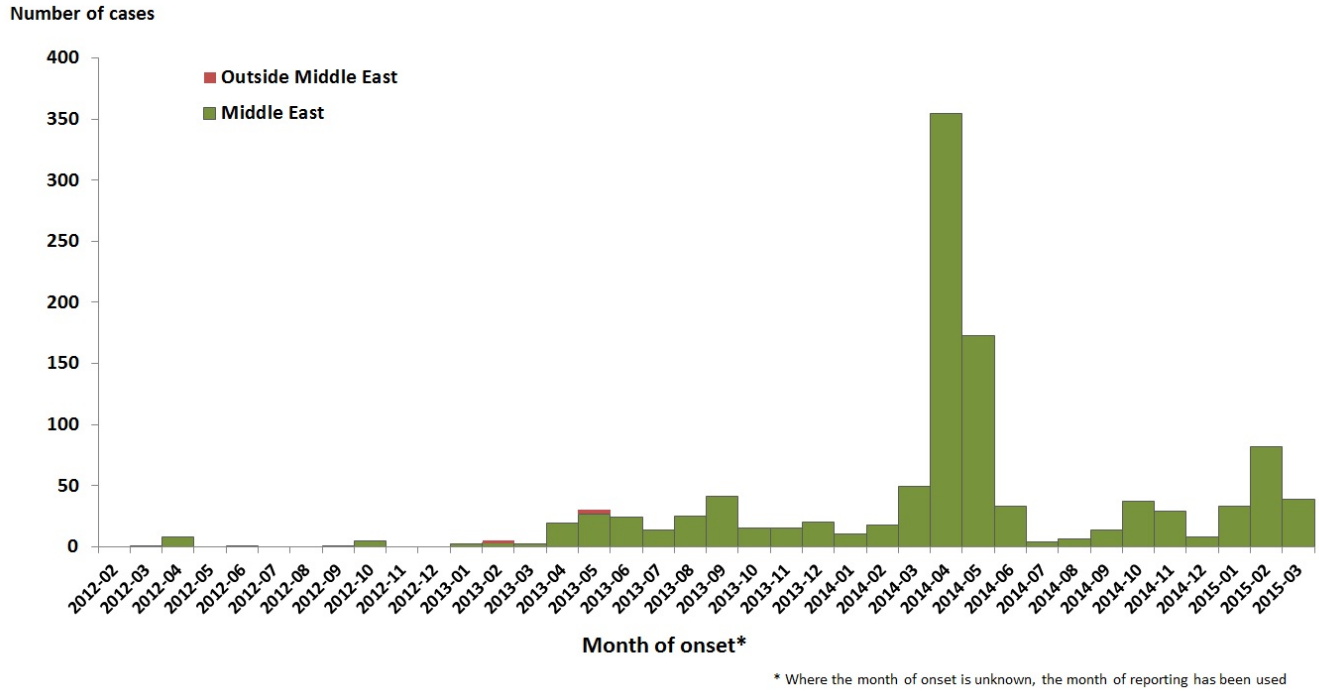
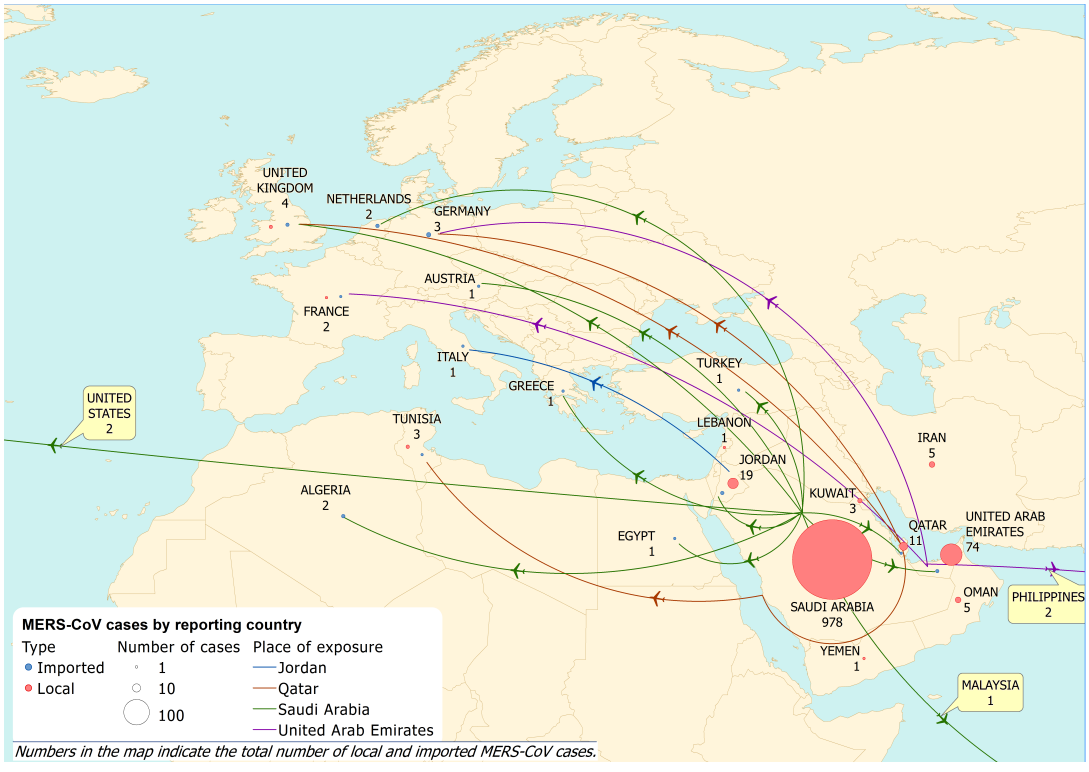
Distribution of confirmed cases of MERS-CoV by first available date, and probable place of infection, March 2012 – 31 March 2015

Source: ECDC



Geographical distribution of confirmed MERS-CoV cases and place of probable infection, worldwide, as of 16 April 2015 (n=1 123)

Source: ECDC



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

European Centre for Disease Prevention and Control (ECDC)
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Opening date: 8 September 2005 Latest update: 16 April 2015

Epidemiological summary

Worldwide in 2015, 22 wild poliovirus type 1 (WPV1) cases have been reported to WHO, compared with 56 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (21 cases) and Afghanistan (one case).
No circulating vaccine-derived poliovirus (cVDPV) cases were reported so far in 2015.

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 for wild poliovirus being re-introduced to the EU/EEA. The highest risk of large poliomyelitis outbreaks occurs in areas with clusters of unvaccinated populations and in people living in poor sanitary conditions, or a combination of both.

References: ECDC latest RRA | Rapid Risk Assessment on suspected polio cases in Syria and the risk to the EU/EEA | Wild-type poliovirus 1 transmission in Israel - what is the risk to the EU/EEA? |

Actions

ECDC monitors reports of polio cases worldwide through epidemic intelligence in order to highlight polio eradication efforts and identify events that increase the risk of wild poliovirus being re-introduced into the EU.
Following the declaration of polio as a PHEIC, ECDC updated its risk assessment. ECDC has also prepared a background document with travel recommendations for the EU.

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

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