

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

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

Opening date: 2 June 2015

Latest update: 16 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.

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

This week, the environmental conditions in the southern part of the Baltic Sea are considered suitable for *Vibrio* growth but at low level. The areas of concern are around Kiel, Riga, Kaliningrad, Gdansk and Szczecin.

Non EU Threats

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 16 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

As of 12 July 2015, [WHO](#) reported 27 678 cases of Ebola virus disease related to the outbreak in West Africa, including 11 276 deaths.

According to the latest [WHO situation report](#) published on 15 July 2015, 30 confirmed cases of EVD were reported in the week up to 12 July: 13 in Guinea, three in Liberia, and 14 in Sierra Leone. Although the total number of confirmed cases is the same as the previous week, there has been a shift in the foci of transmission. For the first time in several months, most cases were reported from Conakry and Freetown, the capitals of Guinea and Sierra Leone, respectively. All the cases reported by WHO from Conakry and Freetown were either registered contacts of a previous case or have an established epidemiological link to a known chain of transmission. Only one of the 30 cases reported in the week up to 12 July arose from an as-yet unknown source of infection. However, a substantial proportion of cases (7 of 30: 23%) continue to be identified as EVD-positive only after post-mortem testing. This suggests that although case investigation is improving, contact tracing and the early detection of symptoms is still a challenge in several areas.

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

Opening date: 24 September 2012

Latest update: 9 July 2015

Since April 2012 and as of 16 July 2015, 1 392 cases of MERS-CoV have been reported by local health authorities worldwide, including 536 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.

→Update of the week

Since 9 July 2015, Saudi Arabia has reported three new cases.

South Korea has not reported new cases since 4 July, therefore the number of cases remains at 186 including one case who travelled to China. There has been one additional death in a previously reported case, which brings the number of deaths to 36.

Influenza A(H5N1) and other strains of avian flu - Multistate (world) - Monitoring globally

Opening date: 15 June 2005

Latest update: 17 July 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). On 11 July 2015 a human case of A (H5N6) in Yunnan Province was reported by China to [WHO](#).

Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013

Latest update: 16 July 2015

An outbreak of chikungunya virus infection has been ongoing in the Caribbean since December 2013 and has spread to North, Central and South America. In Europe, France reported autochthonous cases of chikungunya virus infection in 2014. This was the first time that locally-acquired transmission of chikungunya had been detected in France since 2010.

→Update of the week

Since the beginning of the year and as of 10 July 2015, the [WHO Pan American Health Organization \(WHO PAHO\)](#) has reported 427 144 suspected and confirmed cases of chikungunya virus infection and 60 deaths in the WHO region of the Americas.

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006

Latest update: 16 July 2015

Dengue fever is one of the most prevalent vector-borne diseases in the world. It affects an estimated 50 to 100 million people each year, mainly in the tropical regions of the world. The identification of sporadic autochthonous cases in non-endemic areas in recent years has already highlighted the risk of locally-acquired cases occurring in EU countries where the competent vectors are present. The dengue outbreak in the autonomous province of Madeira, Portugal, in October 2012 and the autochthonous dengue cases in the south of France in 2014 further underline the importance of surveillance and vector control in other European countries.

→Update of the week

There are several ongoing outbreaks of dengue fever across the globe.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 17 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, three new cases of wild poliovirus type 1 (WPV1) was reported to WHO; one from Afghanistan and two from Pakistan.

II. Detailed reports

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

Opening date: 2 June 2015

Latest update: 16 July 2015

Epidemiological summary

As of 16 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](#) |

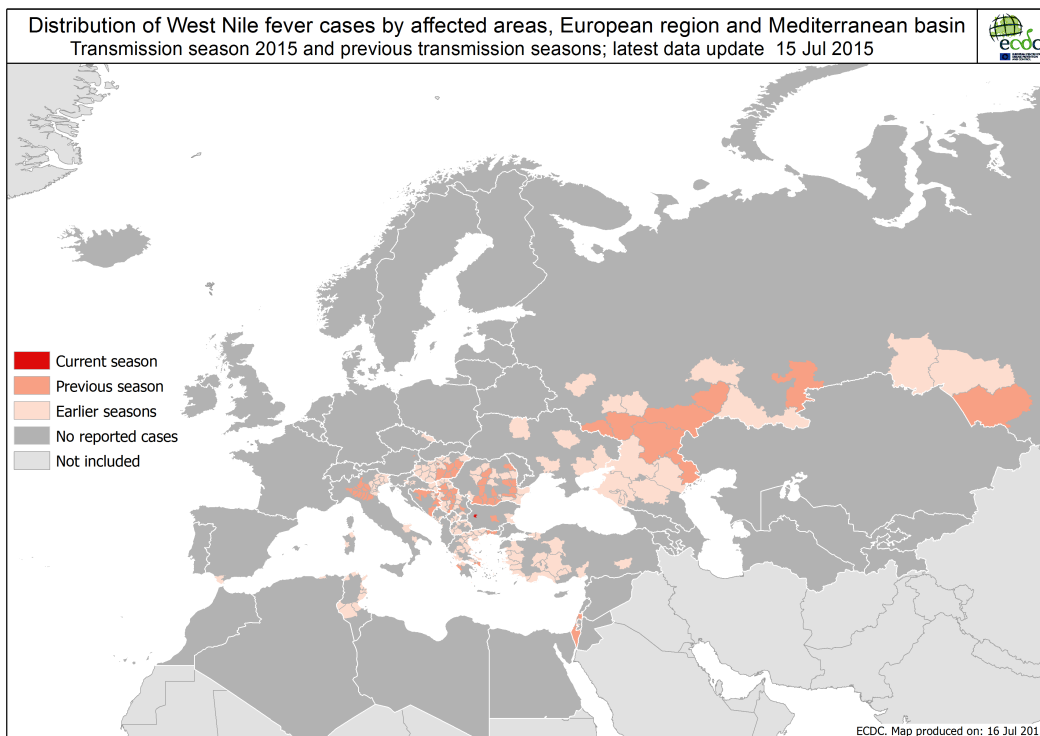
ECDC assessment

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 during the current transmission season.

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.



Monitoring environmental suitability of Vibrio growth in the Baltic Sea – Summer 2015

Opening date: 6 July 2015

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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.

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).

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 the 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 of 2015 and report on increased environmental suitability for growth of *Vibrio* bacteria.

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.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 16 July 2015

Epidemiological summary

Distribution of cases as of 12 July 2015:

Countries with intense transmission:

- **Guinea:** 3 760 cases of which 3 300 are confirmed and 2 506 deaths.
- **Sierra Leone:** 13 209 cases of which 8 688 are confirmed and 3 947 deaths.
- **Liberia:** 10 666 cases as of 9 May 2015. Seven cases, of which six are confirmed, and two deaths as 12 July.

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 13 new confirmed cases in the week up to 12 July, compared to 18 during the previous week. Transmission was centred in three prefectures: Conakry (n=9), Forecariah (n=3) and Fria (n=1). The northern prefecture of Boke, which has been a focus of transmission for over a month, has not reported a case for 11 days. The case in Fria is a contact from Boke who had been lost to follow-up. The prefecture of Fria had not reported a case for over 40 days.

Overall, according to WHO, nine (69%) of the 13 cases reported from Guinea in the week up to 12 July were registered contacts, compared with 12 (67%) of 18 cases reported the previous week. All remaining cases had an epidemiological link to a previous case, with no cases arising from an unknown source of infection. However, according to WHO, three cases (two in Conakry and one in Forecariah) were only identified after post-mortem testing of community deaths.

In **Sierra Leone**, WHO reported 14 newly confirmed cases in the week up to 12 July, compared with nine during the previous

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week. Transmission was centred in three districts: Western Area Urban, which includes the capital Freetown (n=10), Port Loko (n=3) and Kambia (n=1).

According to WHO, eight of the 10 cases reported from the capital were registered contacts residing in quarantined homes. The remaining two cases have an epidemiological link to an existing chain of transmission, but were identified after post-mortem testing of community deaths.

All but one of the cases reported by WHO in Sierra Leone were registered contacts or had a direct link with known chains of transmission. However, four of the cases were only identified as a result of post-mortem testing of community deaths.

In **Liberia**, WHO reported three newly confirmed cases in the week up to 12 July. According to WHO all the confirmed cases were registered contacts associated with the same chain of transmission originated in Margibi county. One of the cases reported in the week to 12 July had symptom onset in a quarantined home in Montserrado County, near to the capital, Monrovia, before being transferred to an Ebola Treatment Centre. The origin of the cluster of cases remains under investigation. Preliminary evidence from genomic sequencing strongly suggests that the most likely origin of transmission is a re-emergence of the virus from a survivor within Liberia, rather than an importation from Guinea or Sierra Leone or new introduction from an animal source.

Situation among healthcare workers

One new healthcare worker infection was reported by WHO from Forecariah, Guinea, during the week up to 12 July.

There have been 876 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 17 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.

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](#)

ECDC assessment

This is the largest ever documented epidemic of EVD, both 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 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.

Although most of the newly detected cases are part of known transmission chains, a substantial proportion of cases continue to be confirmed post mortem. This suggests that effective case investigation is increasing the understanding of chains of transmission, however the early detection of symptoms among identified contacts remains a challenge in several areas.

The recent cases in Liberia highlight the importance of maintaining the capacity of early case detection and enhanced vigilance regarding deaths with unknown causes even in countries that have been declared Ebola free or regions without cases for a number of weeks. At present, these cases are considered by WHO to constitute a separate outbreak from that which was declared over on 9 May.

Actions

As of 17 July 2015, ECDC has deployed 89 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 1 July 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](#).

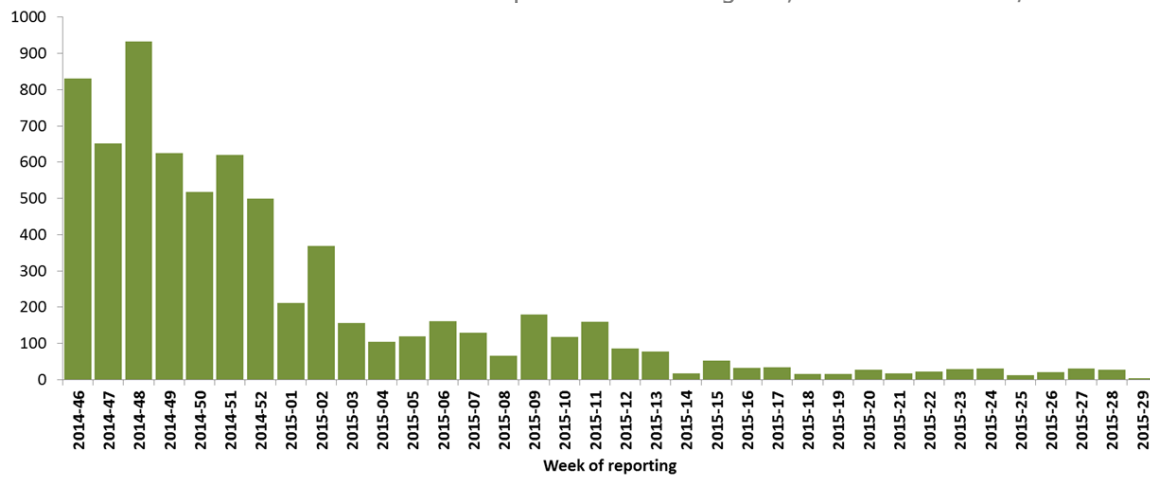
On 6 October 2014, ECDC published [risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU](#).

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](#).

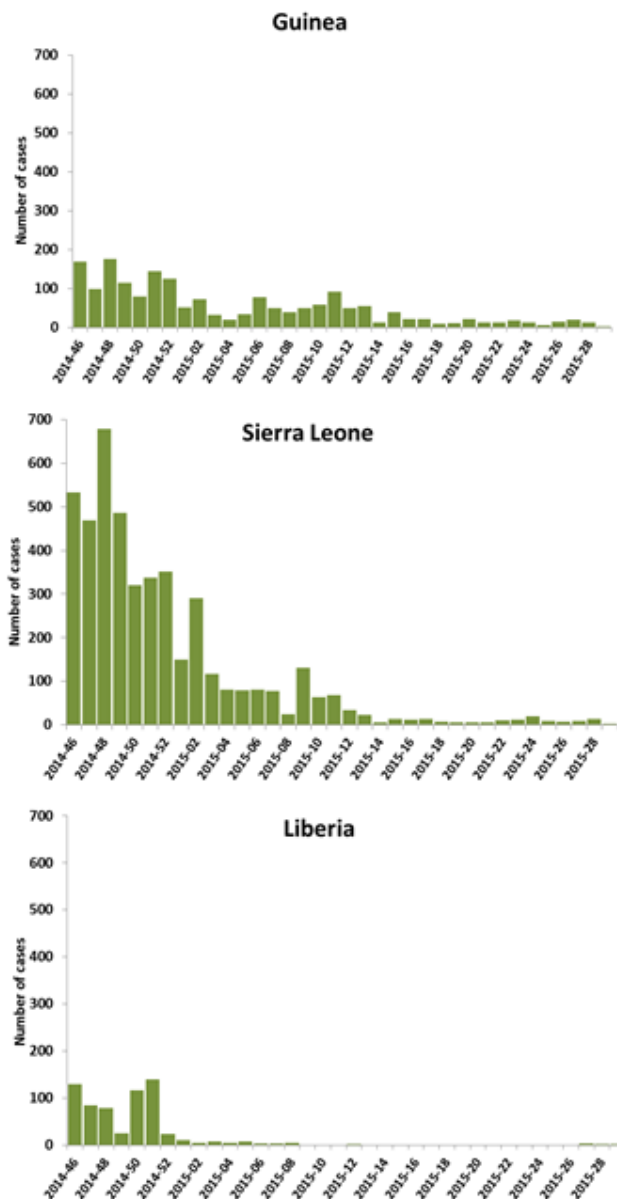
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 29/2015)

Adapted from WHO figures; *data for week 29/2015 are incomplete



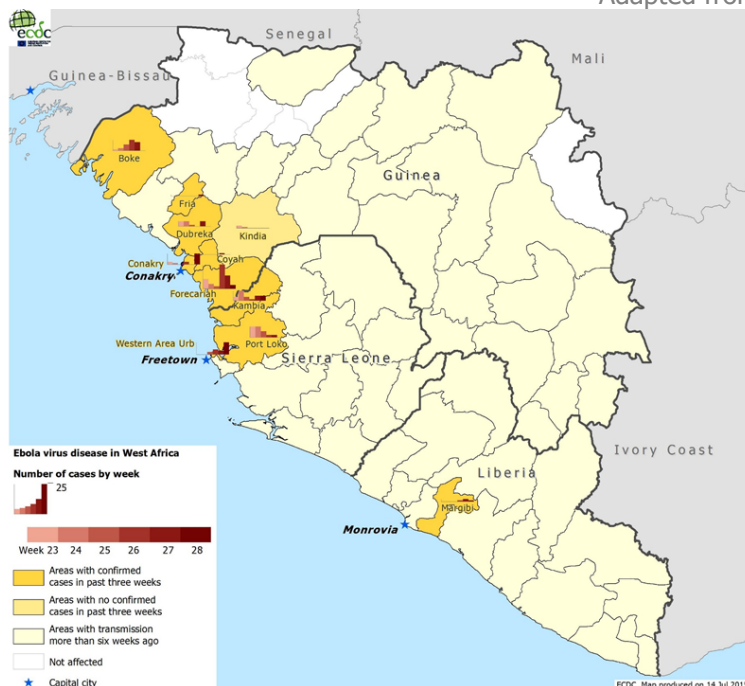
Distribution of confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (weeks 46/2014 to 29/2015)

Adapted from WHO figures; *data for week 29/2015 are incomplete



Distribution of confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (as of week 28/2015)

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.

Between April 2012 and 16 July 2015, 1 392 cases of MERS-CoV have been reported by local health authorities worldwide, including 536 deaths.

The distribution is as follows:

Confirmed cases and deaths by region:

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Middle East

Saudi Arabia: 1 048 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/36 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 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 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 including visits to camel farms, abstain from consuming unpasteurised camel milk, avoid contact with camel urine, and avoid improperly cooked meat.

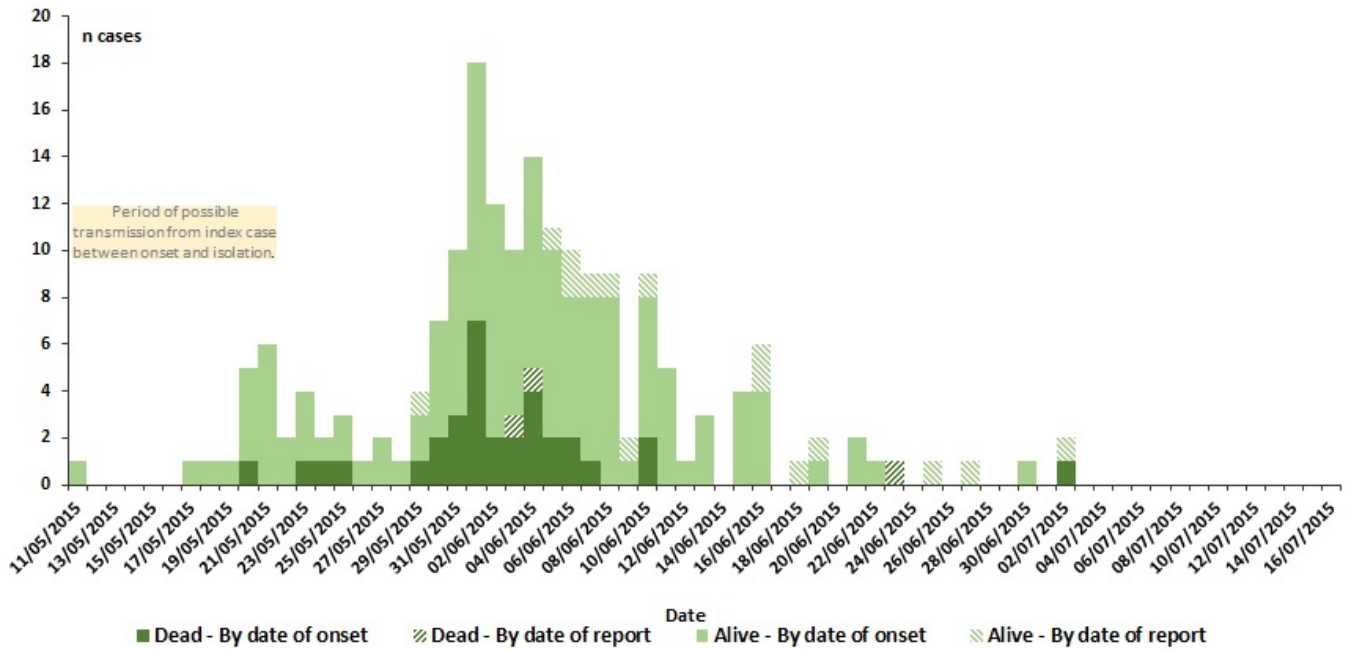
Because of the continued risk of case importation to Europe after exposure in the Middle East and South Korea, international surveillance for MERS-CoV cases among travellers remains essential. Countries should advise returning travellers from all countries affected by MERS to seek medical attention if 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.

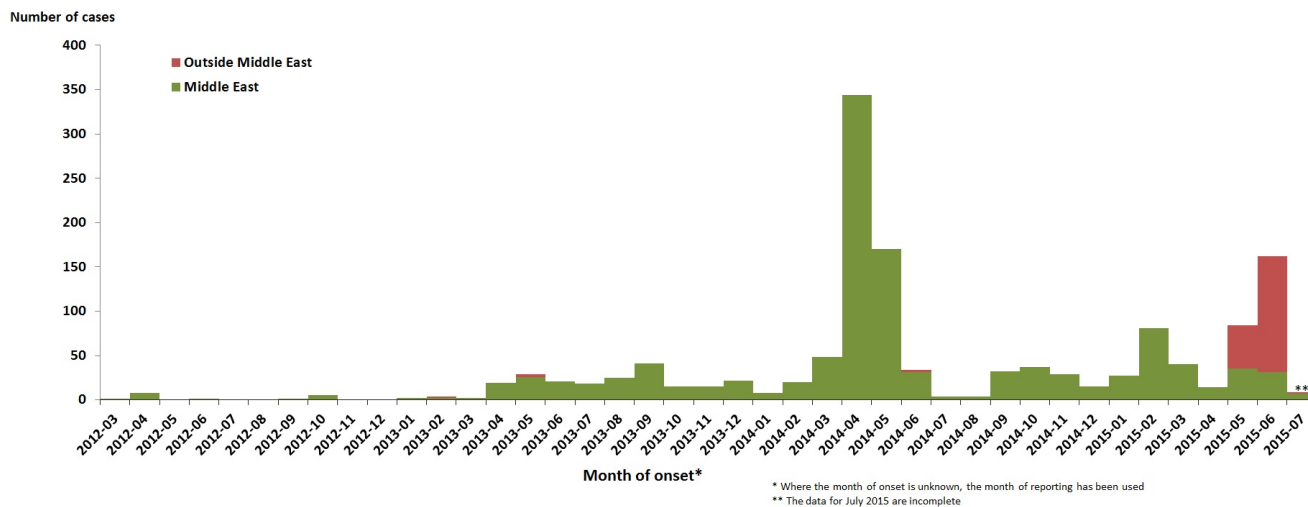
Distribution of confirmed cases of MERS-CoV by first available date and by status in South Korea and China, 11 May - 16 July 2015 (n=186)

Source: ECDC



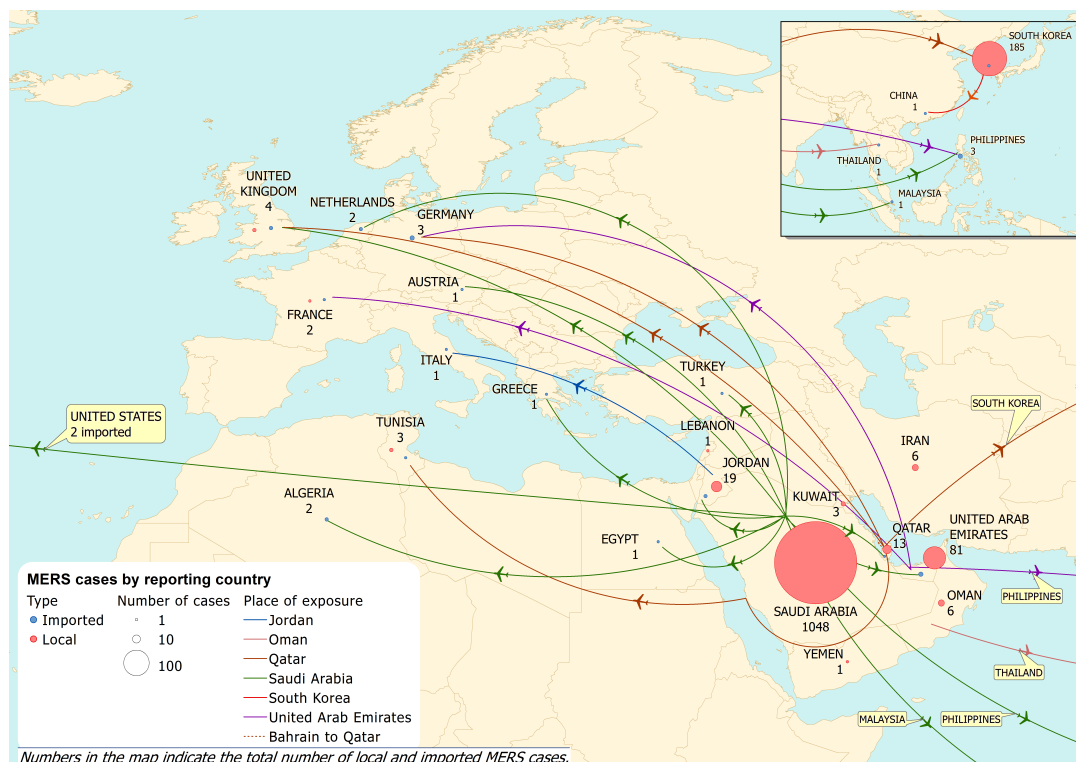
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 16 July 2015 (n=1 392)

Source: ECDC



Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 16 July 2015 (n=1 392)

Source: ECDC



Influenza A(H5N1) and other strains of avian flu - Multistate (world) - Monitoring globally

Opening date: 15 June 2005

Latest update: 17 July 2015

Epidemiological summary

Human cases of avian flu

Since 23 June 2015, there has been no new update from WHO regarding A(H5N1).

On 11 July 2015 a case of A(H5N6) was reported in Yunnan Province by China to [WHO](#). The patient presented with fever and cough on 6 July and was admitted to a local hospital on 9 July. She died one day later. This is the fourth known human case of A(H5N6).

Non-human cases of avian flu

In the past week, Taiwan reported additional cases of influenza A(H5N2) in poultry farms, Ghana reported cases of A(H5N1) in backyard poultry and Nigeria reported cases in poultry farms, according to the World Organization for Animal Health (OIE). In Kazakhstan, the A(H5N1) strain of avian flu was confirmed in a dead cormorant found off the Atyrau region's coast by the Caspian sea. South Africa is reporting four new outbreaks of low pathogenic A(H5N2) in commercial ostriches. A case of A(H7N7) has been confirmed on a poultry farm in Lancashire in [the UK](#).

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 are not 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 to be very low.

Actions

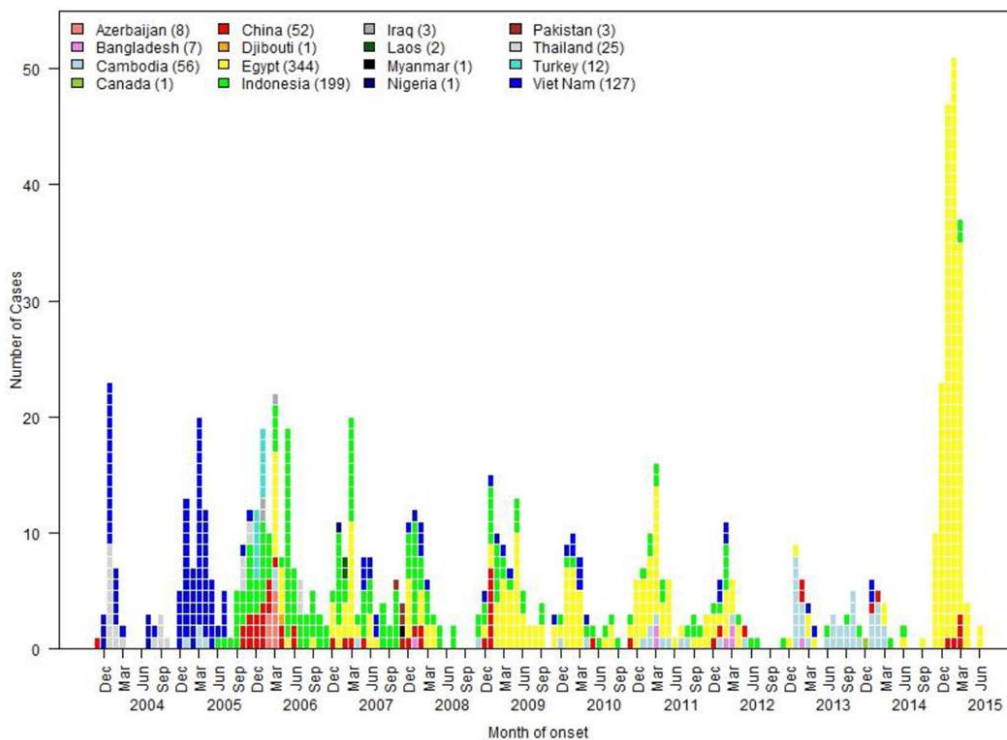
ECDC monitors the worldwide A(H5N1) situation through epidemic intelligence activities on a weekly basis in order to identify significant changes in the epidemiology of the virus. ECDC re-assesses the potential of a changing risk for A(H5N1) to humans on a regular basis.

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.

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

WHO



Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013

Latest update: 16 July 2015

Epidemiological summary

Europe

In **France**, between the 1 May and 10 July, 11 imported cases of chikungunya virus infection were reported. No autochthonous cases of chikungunya were notified, according to [InVS](#).

In **Spain**, between 1 May and 30 June 2015, 16 confirmed cases and six suspected cases of chikungunya virus infection were reported in Catalonia. All cases have been imported and have a travel history to Central America, according to the [public health agency of Catalonia](#).

Americas

Since the beginning of the outbreak in December 2013, more than 1.5 million suspected and confirmed cases of chikungunya virus infection have been reported in the Americas up to the end of June 2015, according to [PAHO](#). Since the start of the year and as of 26 June, the highest incidence rates are reported in **Martinique, Guadeloupe, St. Barthelemy, St. Martin, the Dominican Republic and Dominica**.

In Central America, **Mexico** is reporting a large increase in locally-acquired chikungunya cases so far this year with 2 044 confirmed cases (as of 10 July), according to [PAHO](#). However, this number may be much higher due to underreporting. In addition, [local media](#) report nearly 10 000 suspected cases of chikungunya in Chiapas alone.

In South America, **Colombia** experienced a large increase in suspected cases in June with nearly 10 000 cases reported. In total, around 290 000 suspected cases have been recorded across the country since the start of the year.

In the **United States**, 224 cases of chikungunya virus infection have been reported from 34 states in 2015 (as of 14 July). All reported cases have occurred in travellers returning from affected areas. No locally-transmitted cases have been reported, according to the [US CDC](#). On 6 July, the US CDC updated their [travel notice](#) for the Pacific Islands due to the ongoing chikungunya outbreaks.

Pacific region

There are ongoing chikungunya outbreaks in the **Cook Islands** and **Marshall Islands**. Cook Islands have reported 765 cases

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since October 2014, including 11 new cases in the week ending 12 July 2015, according to the Pacific Public Health Surveillance Network (PACNET).

Web sources: [PAHO update](#) | [ECDC Chikungunya](#) | [WHO Factsheet](#) | [Medisys page](#) |

ECDC assessment

Epidemiological data indicate that the outbreaks are still expanding in the Caribbean, the Americas and the Pacific. The vector is endemic in all three regions, where it also transmits dengue virus. Continued vigilance is needed to detect imported cases of chikungunya in tourists returning to the EU from these regions.

Actions

ECDC published a [Rapid Risk Assessment](#) on 27 June 2014.

ECDC monitors the global chikungunya situation on a bi-weekly basis.

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006

Latest update: 16 July 2015

Epidemiological summary

Europe

No new autochthonous dengue cases have been detected so far in 2015.

Twenty-six imported cases of dengue fever were reported in metropolitan **France** between 1 May and 10 July. No autochthonous dengue cases have been notified, according to [InVS](#).

In **Spain**, Catalonia reports that between 1 May and 30 June 2015 five confirmed and two suspected cases of dengue fever were reported. All are imported cases, with travel history to equatorial Africa and Southeast Asia.

Asia

In **Singapore**, 273 dengue cases were reported in the week ending 11 July, this is 31 cases more than the previous week and the highest number of weekly cases reported so far this year, according to the [National Environmental Agency](#). Certain areas have been reporting a spike in cases in recent weeks, especially the Bishan North area, which has recorded nearly 100 cases and prompted a red alert. Overall, during the first six months of the year, Singapore has experienced a relatively mild dengue fever season compared to last year. There have been 4 292 cases reported as of 3 July, a 45% decrease compared to the same time period in 2014.

The number of dengue fever cases in **Malaysia** continues to rise with 2 832 cases recorded between 28 June and 4 July 2015. This is a 4% increase in cases compared to the previous week according to [media](#) quoting the Ministry of Health. Since the start of the year and as of 4 July, 59 365 cases have been recorded nationally compared with 44 051 cases for the same period last year.

Caribbean

In **Puerto Rico**, 27 suspected cases of dengue fever were reported in week 24, a level of reporting which remains below the epidemic threshold. Between the beginning of the year and 8 July, 876 cases have been reported. DENV-4 has been the predominant circulating serotype during the past eight weeks according to the [US CDC](#).

Americas

In the Americas, nearly 1.5 million suspected and confirmed cases have been reported so far this year, according to the [Pan American Health Organization \(PAHO\)](#). **Mexico**, **Colombia** and **Paraguay** have all reported around 40 000 cases each. In **Brazil**, the number of dengue fever cases has increased by approximately 200 000 in the past month.

Pacific Islands and Australia

There are ongoing dengue outbreaks in **American Samoa** (DENV-3), in the Macuata sub-division of **Fiji** (DENV-2) and **Samoa** (DENV-3) as of 12 July 2015. **French Polynesia** reported nine new confirmed cases of DENV-1 in the week ending 21 June 2015, according to the Pacific Public Health Surveillance Network (PACNET).

In **Australia**, there are currently two ongoing DENV-1 outbreaks in Cairns (31 confirmed cases since 11 December 2014) and Townsville (1 confirmed case since 2 July 2015), according to [Queensland Health](#).

Web sources: [ECDC Dengue](#) | [Healthmap Dengue](#) | [MedISys](#) | [ProMed Americas, Asia, Pacific](#) |

ECDC assessment

The autochthonous transmission of dengue fever in the south of France during 2014 highlights the risk of locally-acquired cases occurring in countries where competent vectors are present. This underlines the importance of surveillance and vector control in European countries with competent vectors.

Actions

ECDC has published a technical [report](#) on the climatic suitability for dengue transmission in continental Europe and [guidance for the surveillance of invasive mosquitoes](#).

ECDC monitors the dengue situation worldwide on a bi-weekly basis.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 17 July 2015

Epidemiological summary

Worldwide in 2015, 33 wild poliovirus type 1 (WPV1) cases have been reported to WHO so far, compared with 122 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (28 cases) and Afghanistan (5 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?](#) |

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.

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