



COMMUNICABLE DISEASE THREATS REPORT

CDTR

Week 36, 2-8 September 2018

All users

This weekly bulletin provides updates on threats monitored by ECDC.

NEWS

Crimean-Congo haemorrhagic fever: case imported from Bulgaria to Greece

A recent [Eurosurveillance article](#) reported an imported case of Crimean-Congo haemorrhagic fever (CCHF) into Greece from Bulgaria.

On 30 May 2018, a Greek male in his late 40s returned to Greece after spending 23 days in a forested area in Blagoevgrad Province, southwestern Bulgaria, where he was working in bridge construction. The man was bitten by a tick while he was working in an area where CCHF cases have been reported previously. He presented with a severe form of Crimean-Congo haemorrhagic fever confirmed by serology and molecular diagnostic in June 2018.

[CCHF virus](#) is transmitted mainly by bites from infected ixodid ticks, especially of the genus *Hyalomma*. Crimean-Congo haemorrhagic fever is a tick-borne zoonotic disease reported in Bulgaria since the 1952 with around 1600 reported cases since then. A recent [serosurvey](#) among livestock (n=1 061 animals) assessed the virus circulation in the 28 administrative regions of Bulgaria. Overall, the seroprevalence was 18.4% (95% CI: 16.2–20.8) with a regional variation across Bulgaria (ranging from to 2.2% to 85.7%). The estimated seroprevalence of CCHF in the human population in Blagoevgrad Province is low (1%), however a seroprevalence estimate of 41.9% (95% CI: 15.3–47.1) among the 43 livestock animals tested was reported recently.

The [Bulgarian National Centre of Infectious and Parasitic Diseases](#) has reported 5 cases of CCHF in Bulgaria since the beginning of 2018 and one case in the same period in 2017. According to ECDC's [Surveillance Atlas of Infectious Diseases](#), in the past decade, EU/EEA countries reported 4 to 14 cases of CCHF annually. The majority of these cases were reported by Bulgaria, ranging between 4 and 13 cases annually, while sporadic cases were reported by Spain, the UK (imported cases only), Germany and Greece.

Due to the high pathogenicity of the CCHF virus, the absence of a specific drug treatment or vaccine and the risk of person-to-person transmission, rapid diagnosis is critical to ensure that appropriate infection control measures (e.g. isolation of patient and barrier precautions) can be implemented in a timely manner. A case of nosocomial CCHF infection in 2016 in Spain highlights the challenges of early detection of CCHF cases ([ECDC rapid risk assessment, Crimean-Congo haemorrhagic fever in Spain, published 9 September 2016](#)), therefore a detailed medical history of the patient, including travel history and possible risk factors, is instrumental for the timely diagnosis of the disease.

Overall, the risk for visitors to rural areas in southwestern Bulgaria is low and visitors and people living in endemic areas should use personal protective measures that include the avoidance of areas where tick vectors are abundant, particularly when they are active regular examination of clothing and skin for ticks and their removal, and the use of repellents. For more information about personal protective measures against tick bites is available [here](#).

The risk for further spread in EU is very low. ECDC monitors this event through epidemic intelligence.

I. Executive summary

West Nile virus - Multistate (Europe) - Monitoring season 2018

Opening date: 30 May 2018

Latest update: 7 September 2018

During the West Nile virus transmission season (expected to be between June and November), ECDC monitors the occurrence of West Nile fever cases in EU/EEA Member States and EU neighbouring countries and publishes weekly epidemiological updates to inform blood safety authorities of areas where there is ongoing virus transmission.

→Update of the week

Between 31 August and 6 September 2018, EU Member States reported 86 human cases of West Nile fever: Hungary (38), Croatia (22), Greece (19), France (5) and Austria (2). EU neighbouring countries reported 49 cases, all by Serbia.

In five areas, human cases were reported for the first time: Croatia (4) and France (1). All other human cases were reported from areas that have been affected during previous transmission seasons.

This week, 8 deaths were reported by Serbia (5), Greece (2) and Hungary (1).

In the same week, 40 outbreaks among equids were reported by Italy (25), Hungary (11), Greece (3) and Romania (1).

Ebola virus disease - tenth outbreak - Democratic Republic of the Congo - 2018

Opening date: 1 August 2018

Latest update: 7 September 2018

On 1 August 2018, the Ministry of Health of the Democratic Republic of the Congo (DRC) declared the 10th outbreak of Ebola virus disease in the country. The outbreak affects North Kivu and Ituri Provinces in the northeast of the country, close to the border with Uganda.

→Update of the week

Over the past week, the Ministry of Health of the Democratic Republic of the Congo has reported 13 additional cases and 12 deaths.

As of 5 September 2018, there have been 129 Ebola virus disease cases (98 confirmed, 31 probable), including 89 deaths (58 confirmed, 31 probable).

Since the last CDTR update, two new health zones have reported confirmed Ebola virus disease cases in North Kivu Province: Masereka (one fatal case) and Kalunguta (one case).

Additionally, over the past week, the first confirmed case in a large urban area has been reported. This fatal case was recorded in the city of Butembo and had an epidemiological link with another confirmed case in Beni. According to [media](#), a healthcare worker who took care of the case in Butembo has also been confirmed on 6 September. If this is proved, it would represent the second Ebola virus disease case in the city of Butembo.

Cholera - Algeria - 2018

Opening date: 27 August 2018

Latest update: 7 September 2018

On 23 August 2018, the Algerian Ministry of Health reported a cholera outbreak in the northern part of the country, including the capital city of Algiers. According to the health authorities, the first cases identified had onset of symptoms on 7 August 2018.

→Update of the week

As of 5 September 2018 and since the beginning of the outbreak, 217 suspected cholera cases including two deaths (CFR: 0.9%) have been reported in Algeria. Among these cases, 83 have been confirmed. This represents an increase of 27 confirmed cases since the previous CDTR. Additionally, one new area is reporting confirmed cases since the previous update: Ain Defla (1).

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

Opening date: 24 September 2012

Latest update: 7 September 2018

Since the disease was first identified in Saudi Arabia in September 2012, more than 2 000 Middle East respiratory syndrome coronavirus (MERS-CoV) cases have been detected in over 20 countries. In Europe, eight countries have reported confirmed cases, all with direct or indirect connections to the Middle East. The majority of MERS-CoV cases continue to be reported from the Middle East. The source of the virus remains unknown, but the pattern of transmission and virological studies points towards dromedary camels in the Middle East as 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

During the month of August, six MERS-CoV cases, including one death, were reported by [Saudi Arabia](#). All cases but one were male. Of these cases, two reported camel contact and four were community-acquired.

During the [Hajj](#), a religious Muslim pilgrimage that took place between 19 and 24 August 2018 in Saudi Arabia, no MERS-CoV cases were detected.

The UK reported a case of MERS-CoV that had recent travel history to Saudi Arabia.

Influenza A(H5N6) – China – Monitoring human cases

Opening date: 17 January 2018

Latest update: 7 September 2018

Animal influenza viruses that cross the animal–human divide to infect people are considered novel to humans and therefore have the potential to become pandemic threats. In 2014, a novel avian influenza A(H5N6) reassortant causing a human infection was detected in China.

→Update of the week

One new human case of avian influenza A(H5N6) was reported in August 2018 from China. The case is a 42-year-old man from Guangxi.

Listeriosis - South Africa - 2017 - 2018

Opening date: 25 January 2018

Latest update: 7 September 2018

The South African National Department of Health, with the support of WHO, has investigated a large listeriosis outbreak in the country. The outbreak was detected in October 2017, when an increasing number of neonatal cases of listeriosis was observed. Retrospective epidemiological investigations established that the increase in the number of listeriosis cases has occurred since May 2017.

Between January 2017 and 17 July 2018, 1 060 laboratory-confirmed listeriosis cases were detected in the country.

→Update of the week

On 3 September 2018, the Ministry of Health of South Africa declared the outbreak of listeriosis over.

Poliomyelitis – Multistate (World) – Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 7 September 2018

Global public health efforts are ongoing to eradicate polio by immunising every child until transmission of the virus has completely stopped and the world becomes polio-free. Polio was declared a Public Health Emergency of International Concern (PHEIC) by WHO on 5 May 2014 due to concerns regarding the increased circulation and international spread of wild poliovirus in 2014. On 15 August 2018, WHO agreed that the spread of poliovirus remains a PHEIC and extended the temporary recommendations an additional three months. In June 2002, the WHO European Region was officially declared polio-free.

→Update of the week

Since the CDTR published on 3 August 2018, Afghanistan has reported two new cases of wild poliovirus type 1 and four other countries have detected cases of circulating vaccine-derived polio viruses type 2 (cVDPV2): Papua New Guinea (7), Nigeria (6), the Democratic Republic of the Congo (6) and Somalia (1).

II. Detailed reports

West Nile virus - Multistate (Europe) - Monitoring season 2018

Opening date: 30 May 2018

Latest update: 7 September 2018

Epidemiological summary

Between 31 August and 6 September 2018, EU Member States reported 86 human cases of West Nile fever: Hungary (38), Croatia (22), Greece (19), France (5) and Austria (2). EU neighbouring countries reported 49 cases, all by Serbia. In five areas, human cases were reported for the first time: Croatia (4) and France (1). All other human cases were reported from areas that have been affected during previous transmission seasons. This week, 8 deaths were reported by Serbia (5), Greece (2) and Hungary (1).

In the same week, 40 outbreaks among equids were reported by Italy (25), Hungary (11), Greece (3) and Romania (1).

In 2018, as of 6 September 2018, EU Member States have reported 798 human cases: Italy (327), Greece (168), Romania (117), Hungary (134), Croatia (25), France (16), Austria (10) and Slovenia (1). EU neighbouring countries reported 314 human cases: Serbia (262), Israel (49) and Kosovo* (3). To date, a total of 71 deaths due to West Nile fever have been reported by Serbia (26), Greece (18), Italy (13), Romania (12), Hungary (1) and Kosovo* (1).

During the current transmission season, 117 outbreaks among equids have been reported by Italy (66), Hungary (42), Greece (8) and Romania (1).

In accordance with [European Commission Directive 2014/110/EU](#), prospective blood donors should defer for 28 days after leaving an area with evidence of West Nile virus circulation among humans unless the results of an individual nucleic acid test are negative.

*This designation is without prejudice to positions on status, and is in line with UNSCR 1244 and the International Court of Justice Opinion on the Kosovo Declaration of Independence.

Publications: [An early start of West Nile virus seasonal transmission: the added value of One Health surveillance in detecting early circulation and triggering timely response in Italy, June to July 2018](#)

[Early start of the West Nile fever transmission season 2018 in Europe](#)

ECDC links: [West Nile fever](#) | [Atlas](#)

Sources: [TESSy](#) | [ADNS](#)

ECDC assessment

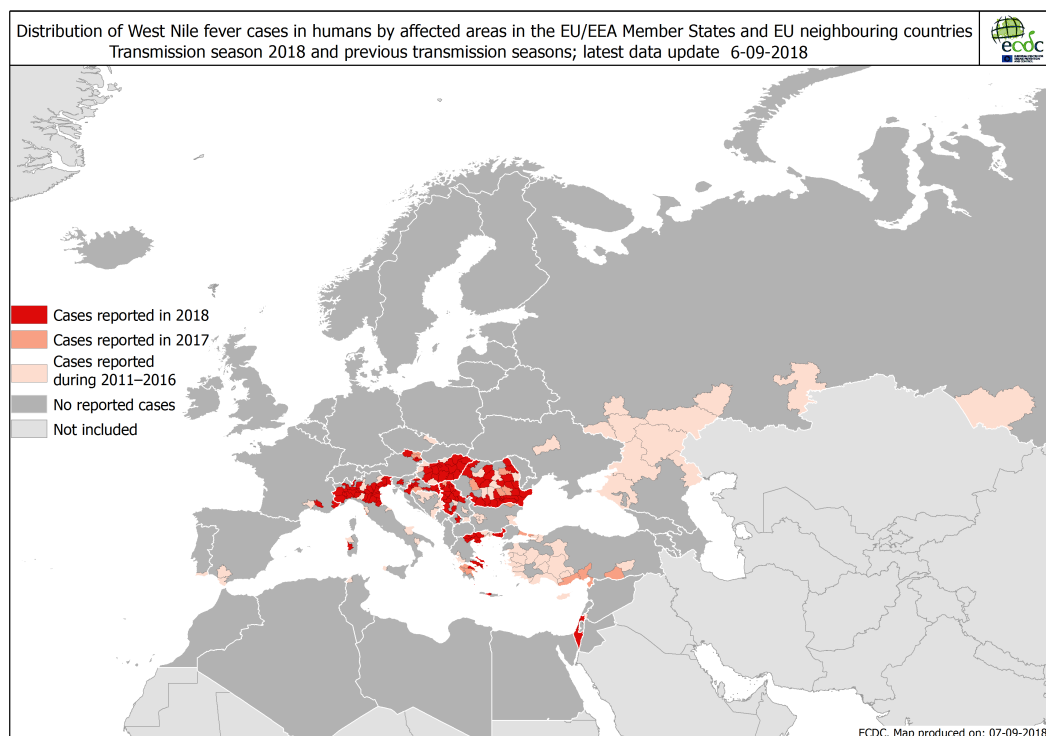
The 2018 transmission season started earlier than usual and higher case numbers have been reported than in the same period in previous years. All human cases reported during the current transmission season were reported in previously affected countries. Since it is currently a particularly intense transmission season for West Nile fever, precautionary measures for travellers and residents, mainly elderly and immunocompromised individuals, to affected areas must be highlighted.

Actions

During the transmission season, ECDC publishes [West Nile fever maps](#) together with an epidemiological summary every Friday. ECDC published a rapid risk assessment on the ['Early large increase in West Nile virus infections in the EU/EEA and EU neighbouring countries'](#) on 13 August 2018.

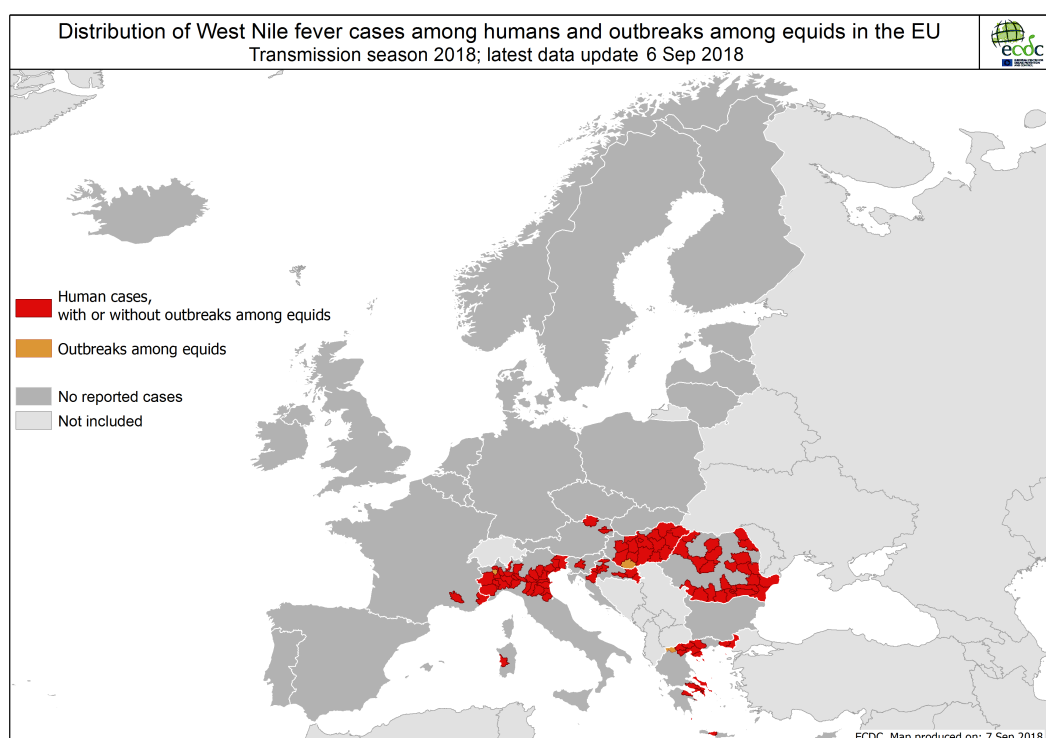
Distribution of human West Nile fever cases by affected areas as of 6 September

ECDC



Distribution of West Nile fever cases among humans and outbreaks among equids in the EU as of 6 September

TESSy and ADNS



Ebola virus disease - tenth outbreak - Democratic Republic of the Congo - 2018

Opening date: 1 August 2018

Latest update: 7 September 2018

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Epidemiological summary

As of 5 September 2018, the Ministry of Health of the Democratic Republic of the Congo has reported 129 Ebola virus disease cases (98 confirmed, 31 probable), including 89 deaths (58 confirmed, 31 probable).

Eight health zones in two provinces have reported confirmed and probable Ebola virus disease cases, including Mabalako, Beni, Butembo, Oicha, Masereka, Kalungata and Musienene health zones in North Kivu Province and Mangina health zone in Ituri Province.

As of 6 September 2018 and according to a European Civil Protection and Humanitarian Aid Operations (ECHO) report, 2 265 contacts have been identified in Mabalako (1 331), Beni (517), Mandima (207), Oicha (123) and Butembo (87). Of these, 93% are being followed up.

Response activities: As of 6 September 2018 and according to ECHO, 6 486 people have been vaccinated in Mabalako (3 279), Beni (1 930), Mandima (1 067), Oicha (121), Katwa (70) and Kinshasa (19). According to the same sources, 4 830 Ebola vaccines are still available in Beni.

Travel: According to the WHO disease outbreak news (DON) released on 14 August 2018, Burundi, Central African Republic, Rwanda, South Sudan, Uganda and Zambia are implementing [entry screening](#).

In EU/EEA countries, [Belgium](#), [Germany](#), [Italy](#) and [Spain](#) have issued advice against traveling to the North Kivu region due to the Ebola outbreak. Additionally, the [US CDC](#) and [WHO](#) have issued travel recommendations.

Sources: [Ministry of Health of the Democratic Republic of the Congo](#) | [WHO](#)

ECDC assessment

If the second case in Butembo city is confirmed, it would be of concern as this city of more than 1 million inhabitants is a commercial and travel hub between the DRC and Uganda. The situation has the potential for new chains of transmission if not rapidly controlled.

Due to the security situation and humanitarian crisis in North Kivu Province, implementation of outbreak control measures may be challenging. The risk of introduction of the virus via an infected traveller to the EU/EEA is considered very low at this stage.

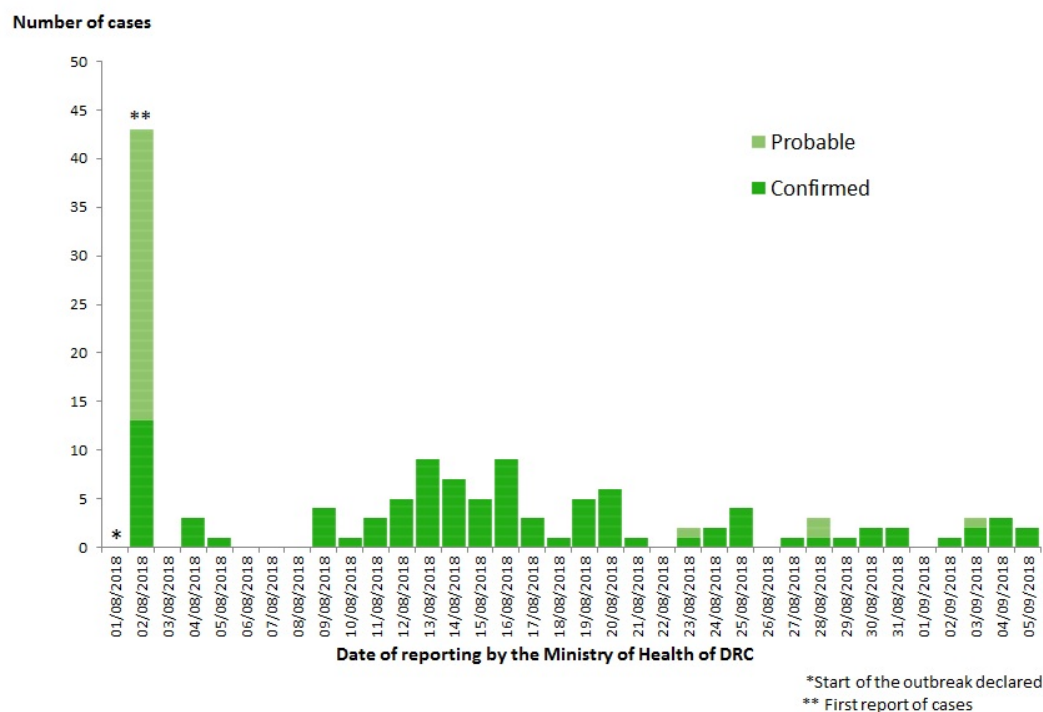
Transport routes linking the affected areas to other regions in the DRC and several neighbouring countries (mainly Rwanda and Uganda) may facilitate the spread of the virus. The situation is aggravated by the displacement of people due to conflict and crisis. According to [WHO](#), the public health risk is considered high at the national and regional levels.

Actions

ECDC is monitoring this threat on a daily basis through epidemic intelligence. ECDC published a [rapid risk assessment](#) on 9 August 2018.

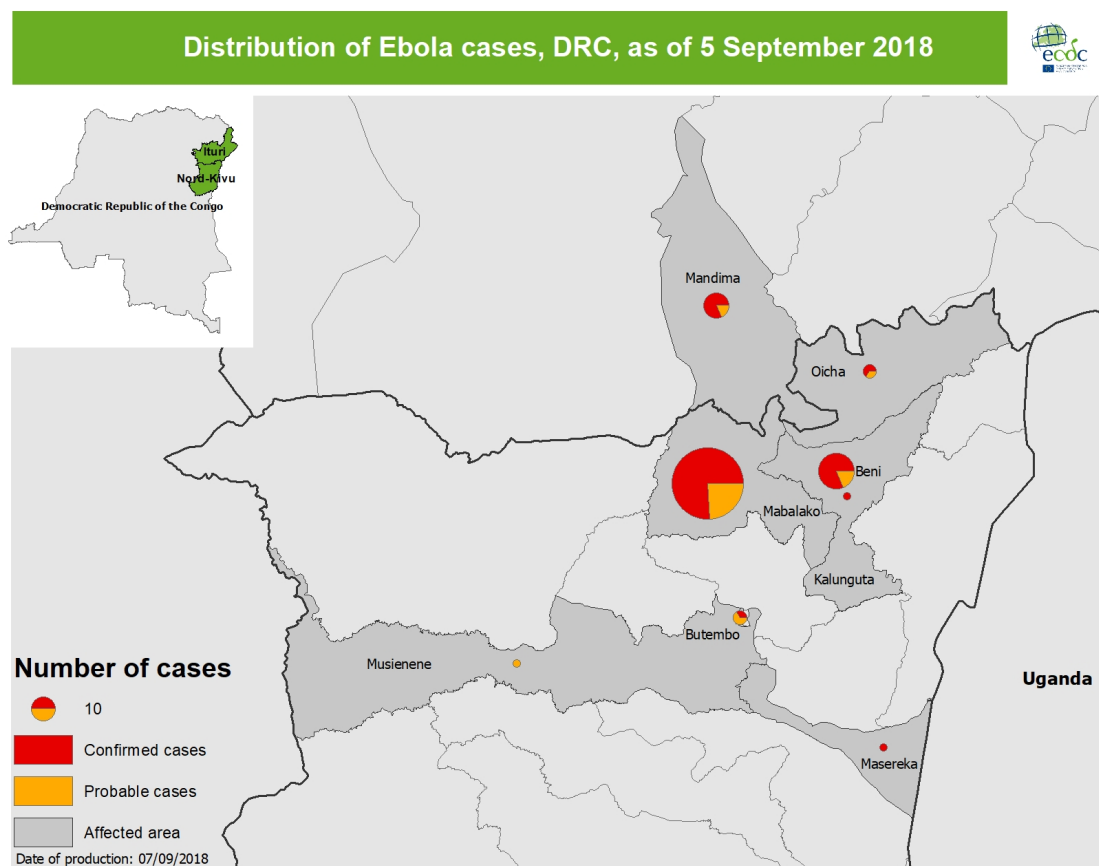
Distribution of confirmed and probable cases of Ebola virus disease, North Kivu and Ituri Provinces, Democratic Republic of the Congo, as of 5 September 2018

Epicurve adapted from DRC MoH data



Geographical distribution of confirmed and probable cases of Ebola virus disease, North Kivu and Ituri Provinces, Democratic Republic of the Congo, as of 5 September 2018

ECDC



Cholera - Algeria - 2018

Opening date: 27 August 2018

Latest update: 7 September 2018

Epidemiological summary

According to the Institut Pasteur in Algiers, as of 5 September 2018 and since the beginning of the outbreak, 217 suspected cholera cases including two deaths (CFR: 0.9%) have been reported in Algeria. Among these cases, 83 have been confirmed. However, as these cases are pending confirmation by the Algerian Ministry of Health (MoH), they are not displayed on the figures attached to this document.

The Algerian MoH published a breakdown of cases on 30 August 2018, when 74 cases were confirmed. At that time, six areas were affected and reported confirmed cases: Blida (39 cases, including two deaths), Tipaza (15), Algiers (15), Bouira (3), Médéa (1) and Aïn Defla (1).

The Institut Pasteur in Algiers confirmed the identification of *Vibrio cholerae* O1 serotype Ogawa in human samples. It also confirmed the presence of *Vibrio cholerae* in samples from a natural water source in Sidi el Kebir, located in the village of Hamr Al

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Ain in the wilayah of Tipaza. According to the Ministry of Health, health authorities have taken corrective measures and have closed down this source.

Source: [Algerian Ministry of Health](#), [Institut Pasteur Algeria](#)

ECDC assessment

Due to the number of cases and the geographical extension of the outbreak, additional cases are expected to be reported.

The risk of infection is very low for EU/EEA travellers to and residents in Algeria that follow correct preventive hygiene measures. The risk of importation into the EU/EEA is very low and the risk of spread within the EU is negligible because of the high sanitation and hygiene standards in the EU/EEA and availability of appropriate healthcare. Travellers should seek advice from travel medicine clinics in order to assess their personal risk. According to WHO, vaccination should be considered for travellers at higher risk such as emergency and relief workers who are likely to be directly exposed. Vaccination is generally not recommended for other travellers.

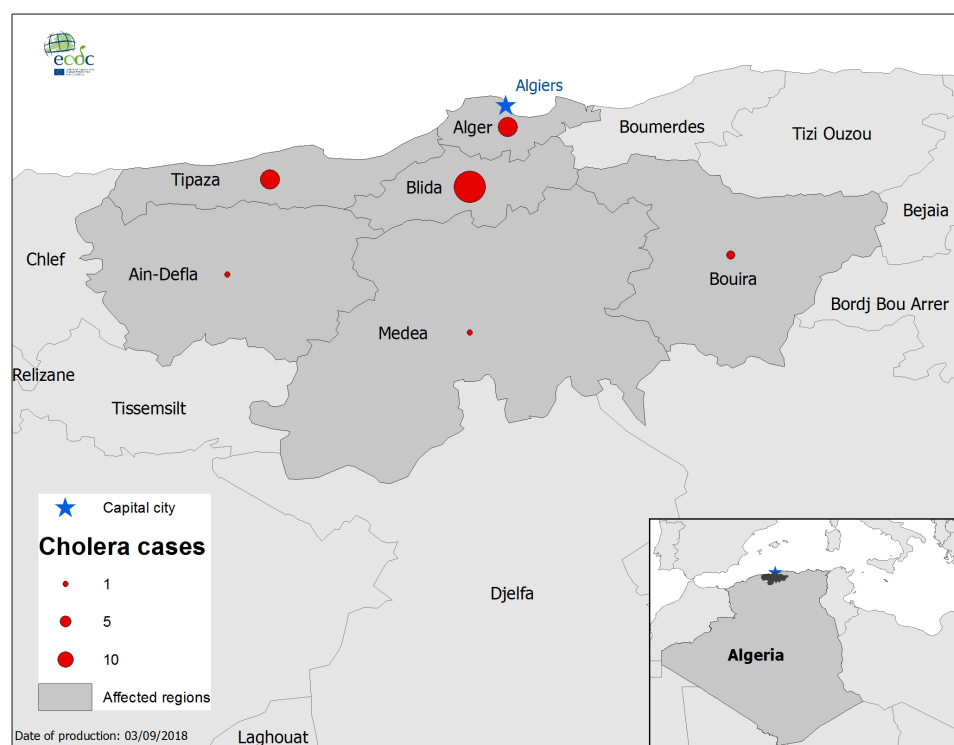
Adhering to suitable preventive hygiene measures plays a key role in the prevention of the infection. Visitors of cholera-affected areas should only drink bottled, boiled or chlorinated water, regularly wash their hands (especially before eating), carefully wash all fruits and vegetables with bottled, boiled or chlorinated water before consumption, eat well-cooked food and avoid consuming ice cubes, ice cream and raw or undercooked seafood products.

Actions

ECDC is monitoring this event through epidemic intelligence and will publish a rapid risk assessment on 7 September 2018. Additionally, ECDC has published a [news item](#) about this event.

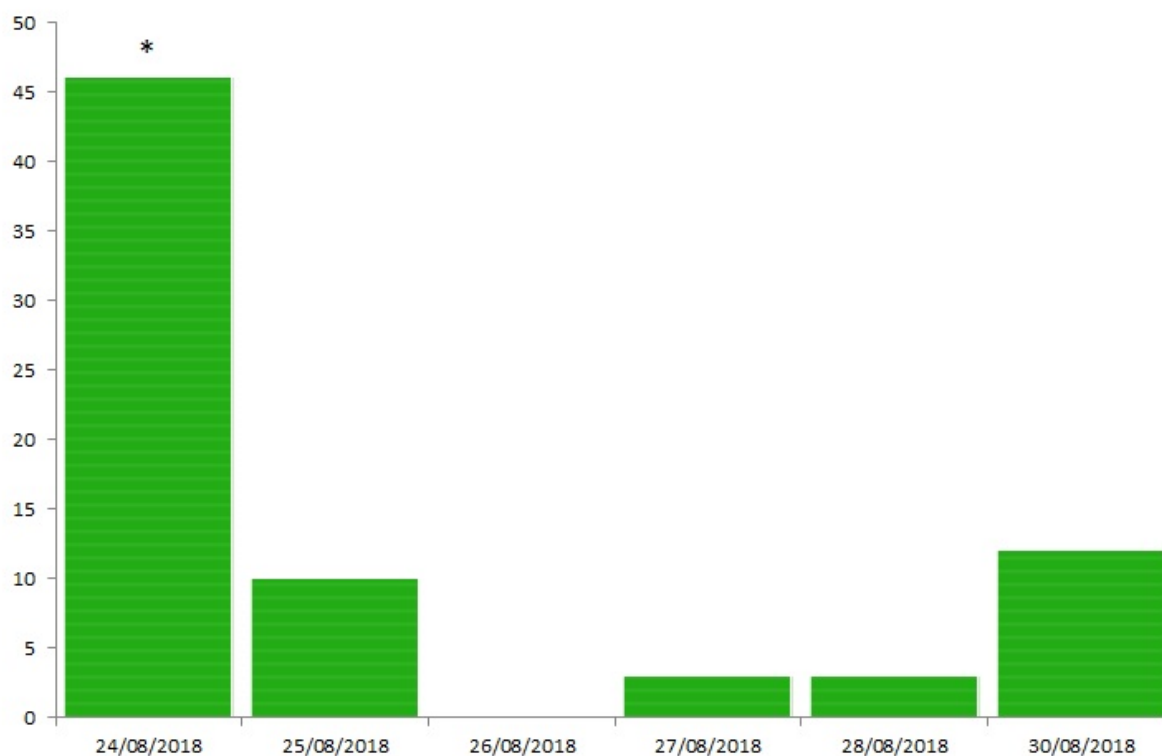
Geographical distribution of confirmed cholera cases, Algeria, as of 30 August 2018

ECDC



Distribution of confirmed cholera cases, Algeria, as of 30 August 2018

Epicurve adapted from Algeria MoH data



Number of cases by date of report

*Cases since the beginning of August

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

Opening date: 24 September 2012

Latest update: 7 September 2018

Epidemiological summary

Since April 2012 and as of 31 August 2018, 2 256 cases of MERS-CoV, including 841 deaths, have been reported by health authorities worldwide.

Sources: [ECDC MERS-CoV page](#) | [WHO MERS-CoV](#) | [WHO MERS updates](#) | [ECDC fact sheet for professionals](#)

ECDC assessment

The risk of sustained human-to-human transmission in Europe remains very low. ECDC's conclusion continues to be that the MERS-CoV outbreak poses a low risk to the EU, as stated in the [rapid risk assessment](#) published on 29 August 2018, which also provides details on the last case reported in Europe.

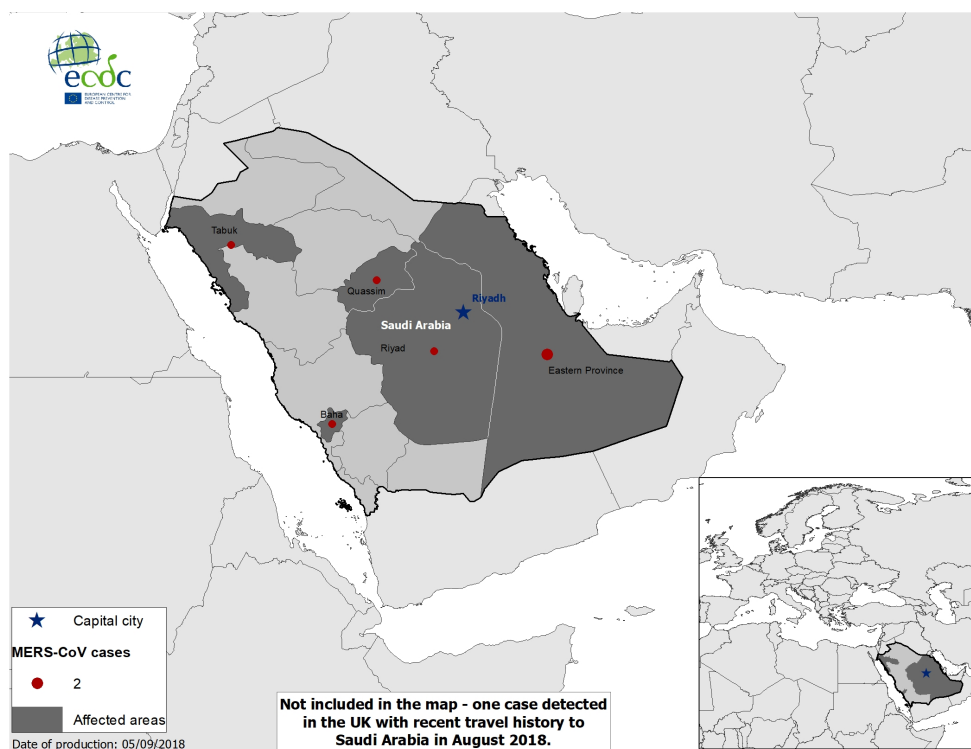
On 2 August 2018, ECDC published a [risk assessment regarding public health risks related to communicable diseases during the 2018 Hajj, Saudi Arabia, 19–24 August 2018](#) where MERS-CoV is discussed.

Actions

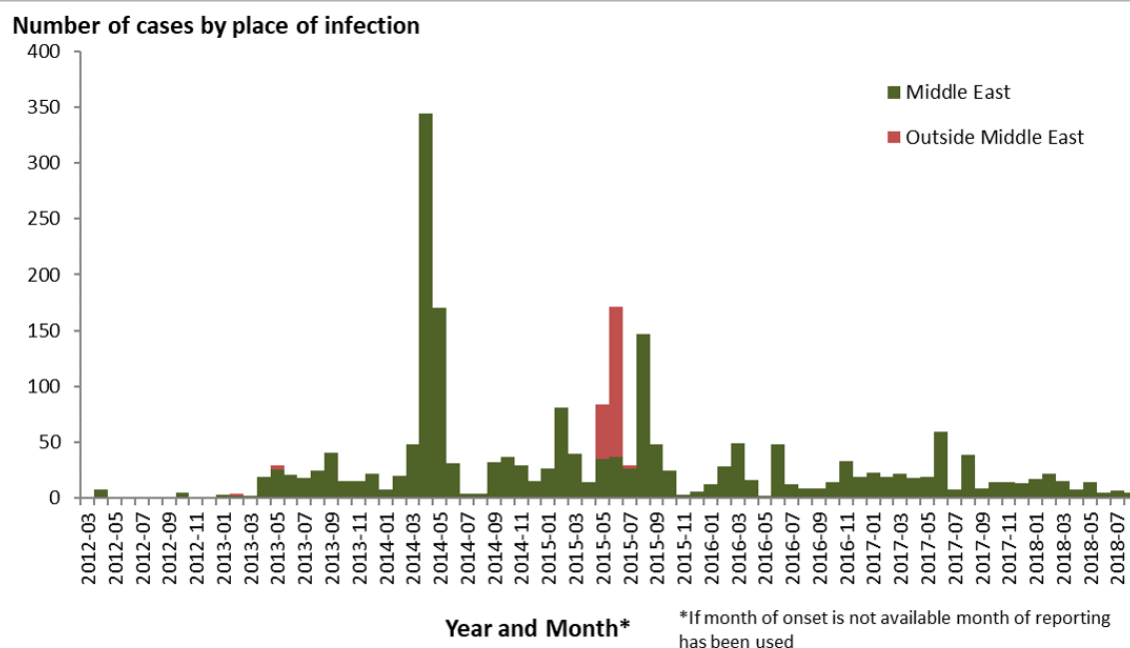
ECDC is monitoring this threat through epidemic intelligence and monthly reports.

Geographical distribution of confirmed cases of MERS-CoV by probable region of infection in August 2018

ECDC



Distribution of confirmed cases of MERS-CoV by first available month and region, from March 2012 and as of 31 August 2018



Influenza A(H5N6) – China – Monitoring human cases

Opening date: 17 January 2018

Latest update: 7 September 2018

Epidemiological summary

Since 2014 and as of 5 September 2018, 20 human cases of influenza A(H5N6) have been reported from China. The cases occurred in Anhui (1), Fujian (1), Guangdong (7), Guangxi (3), Hubei (1), Jinan (4), Sichuan (1) and Yunnan Provinces (2). Of the 20 cases, at least 13 have died. All cases had exposure to live poultry or live poultry markets, except for three cases where the exposure source was not reported. No clustering of cases was reported. The latest case had onset of symptoms in August 2018.

Sources: [ECDC avian influenza page](#) | [WHO avian influenza page](#) | [ECDC/EFSA joint report: Avian influenza overview February - May 2018](#)

ECDC assessment

Although avian influenza A(H5N6) has caused severe infection in humans, human infections remain rare and no sustained human-to-human transmission has been reported. However, the characterisation of this virus is ongoing and its implication to the

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evolution and potential emergence of a pandemic strain is unknown. According to [WHO](#), the risk of international disease spread is considered to be low.

The risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered to remain very low. As the likelihood of zoonotic transmission of newly introduced or emerging reassortant AI viruses is unknown, the use of personal protective measures for people being exposed to avian influenza viruses will minimise the remaining risk.

Assessment related to the ongoing outbreaks in poultry in Europe:

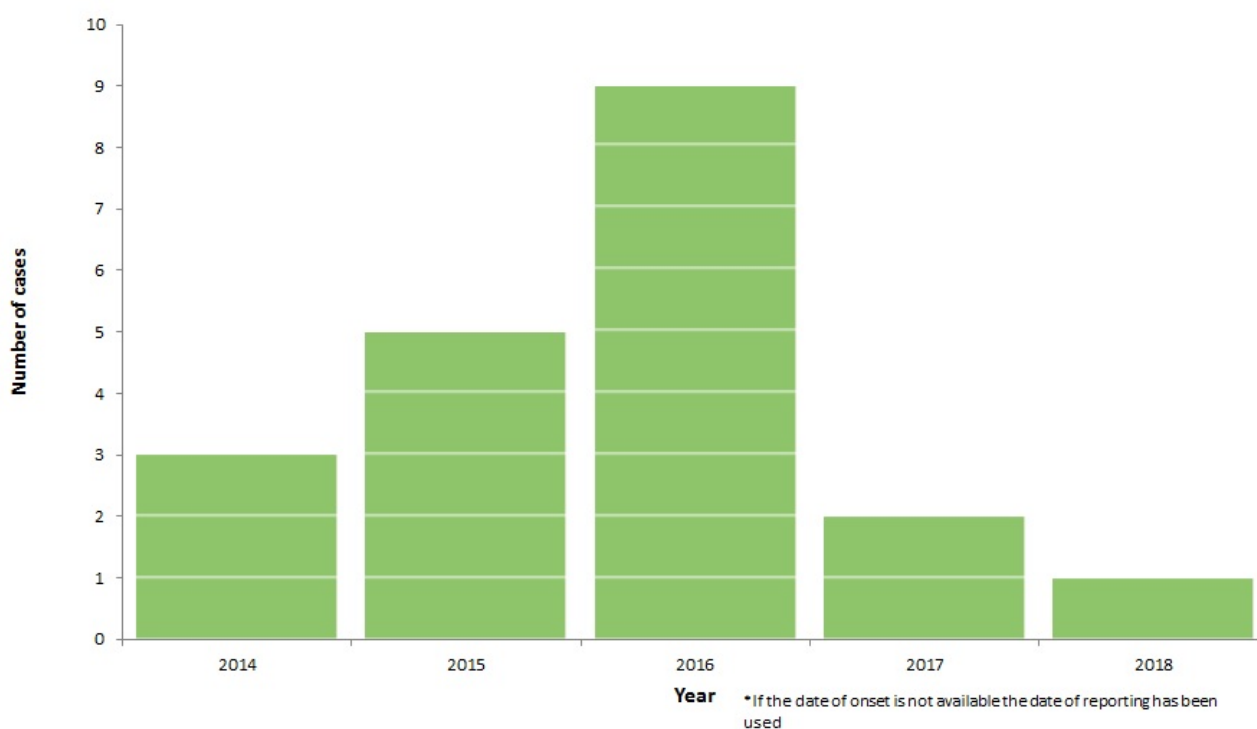
The World Organisation for Animal Health (OIE)/Food and Agriculture Organization (FAO)/EU reference laboratory for avian influenza at the Animal and Plant Health Agency (APHA) Weybridge has conducted a detailed genetic analysis of a small number of H5N6 highly pathogenic avian influenza (HPAI) viruses recently detected in both Europe and Asia. The European strains can be differentiated from those strains associated with zoonotic infection in Asia. Furthermore, they do not carry any virulence markers strongly associated with human infection risk. In addition, there have been no reported human infections with this particular genetic sublineage of H5N6 HPAI to date.

Actions

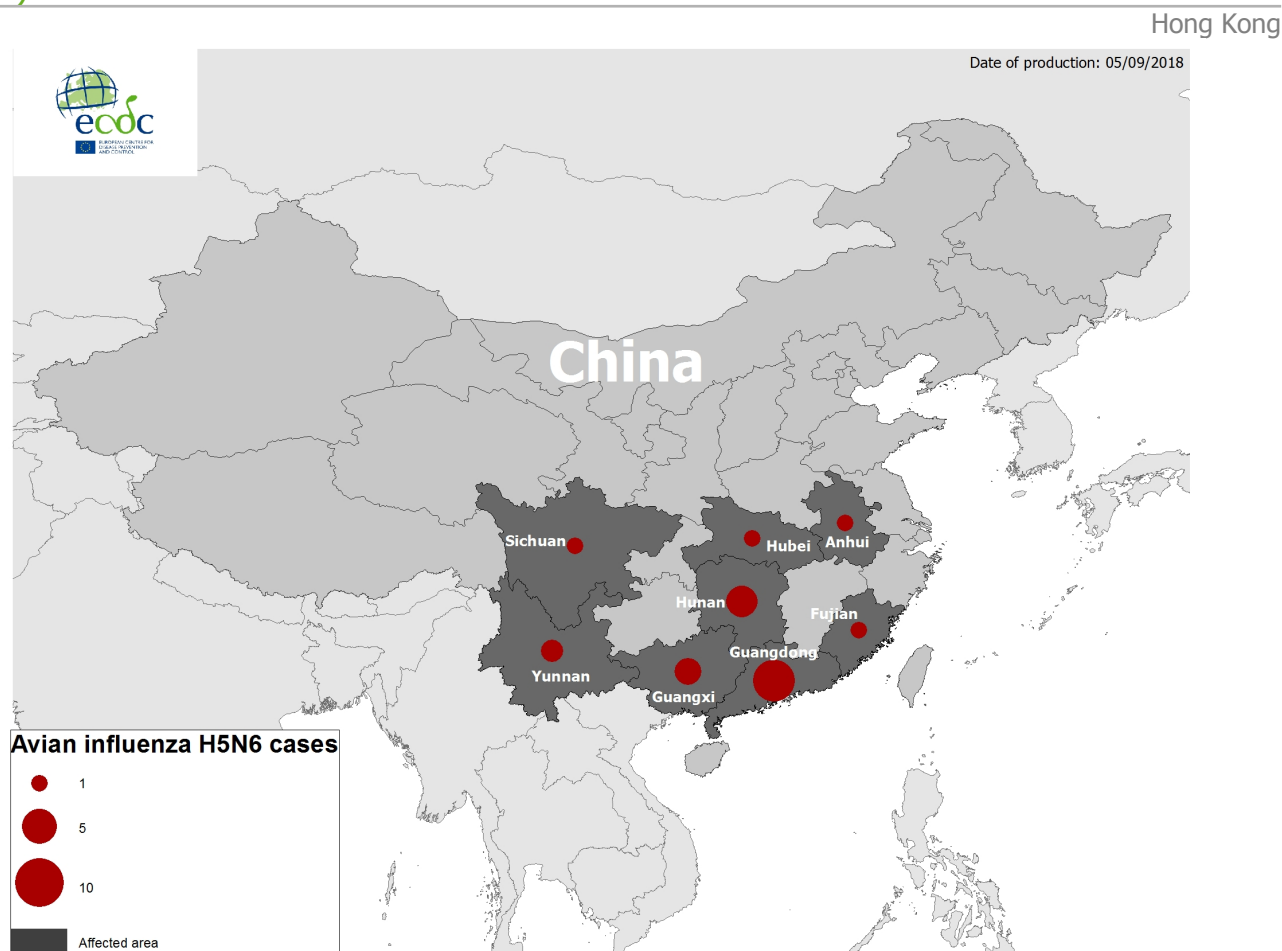
ECDC monitors outbreaks of avian influenza in humans through epidemic intelligence.

Distribution of confirmed cases of A(H5N6) by year of onset 2014 – 2018 (n=20)

Hong Kong



Geographical distribution of avian influenza A(H5N6) cases in China 2014 - August 2018 (n=20)



Listeriosis - South Africa - 2017 - 2018

Opening date: 25 January 2018

Latest update: 7 September 2018

Epidemiological summary

Between January 2017 and 17 July 2018, 1 060 laboratory-confirmed cases of listeriosis were detected. Since the implicated products were recalled on 4 March 2018, the number of new cases reported decreased weekly. Most cases occurred in Gauteng Province, followed by Western Cape and KwaZulu-Natal Provinces. The most recent case was reported during the first week of June 2018.

On 4 March 2018, the South African National Department of Health declared that the vehicle of infection and point of contamination had been identified. A recall of the possibly contaminated products was put in place for the entire distribution networks, both domestic and international. The South African Department of Health also advised the public to avoid all processed meat products that are sold as ready-to-eat.

Prior to 2017, an average of 60 to 80 laboratory-confirmed listeriosis cases per year were reported in South Africa. In July 2017,

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an increase in laboratory-confirmed cases of listeriosis was reported to the National Institute for Communicable Diseases, which was followed by investigations into the reported increase. The current outbreak of listeriosis was declared by the South African National Department of Health on 5 December 2017. The source of the outbreak was identified as ready-to-eat processed meat products manufactured at Enterprise Foods' Polokwane production facility.

Additionally, on 24 March 2018, WHO published an IHR informing that the food production facilities and three of the retailers related to this outbreak exported their products to 15 other African countries: Angola, Botswana, DRC, Ghana, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Swaziland, Uganda, Zambia and Zimbabwe. All these countries have issued recalls of the implicated products.

Sources: [South Africa NICD](#) | [WHO AFRO outbreaks and emergencies](#) | WHO IHR | [Ministry of Health of South Africa](#) | [Ministry of Health of South Africa](#)

ECDC assessment

Listeriosis can be a serious bacterial infection acquired via ingestion of contaminated food. Pregnant women, neonates, elderly and immunocompromised patients are at increased risk of severe disease and death. In pregnant women, the infection can cause premature labour, stillbirth and neonatal meningitis in a newborn. Milder forms of the disease result in gastroenteritis, which can lead to a severe infection in those with a weakened immune system.

Prior to the current outbreak in South Africa, the first documented outbreaks occurred in 1977 (14 cases) and 2015 (7). Since then, only sporadic cases have been detected throughout the country. Since October 2017, an increase in the number of neonatal cases was observed. This increase and the associated deaths are of concern, as South Africa also has a high prevalence of HIV infection.

Based on whole genome sequencing analysis, no associated cases were reported in EU/EEA countries. The risk of spread to Europe is very low.

Even though the outbreak is declared over, sporadic cases can still be reported as people may have food items stored or older cases can be detected. In addition, because of certain reporting delays, cases with onset in the past may be belatedly reported.

Travellers experiencing symptoms compatible to [listeriosis](#) upon return should consider consulting their healthcare provider.

Actions

ECDC is monitoring this event through EPIS-FWD and epidemic intelligence.

Poliomyelitis – Multistate (World) – Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 7 September 2018

Epidemiological summary

Since the beginning of 2018 and as of 4 September, two countries have recorded cases of wild poliovirus type 1 (WPV1): Afghanistan (12) and Pakistan (3), an increase of five cases compared with the same period in 2017.

Since the beginning of 2018 and as of 4 September, four countries have detected 35 cases of circulating vaccine-derived poliovirus type 2 (cVDPV2): the Democratic Republic of the Congo (13), Nigeria (8), Papua New Guinea (8) and Somalia (6), compared with 47 cases reported in the same period in 2017.

ECDC link: [ECDC poliomyelitis page](#)

Sources: [WHO IHR Emergency Committee](#) | [Polio eradication: weekly update](#)

ECDC assessment

Europe has remained polio-free since 2002. Inactivated polio vaccines (IPV) are used in all EU/EEA countries. Vaccination coverage levels in the EU/EEA can be considered satisfactory as a whole (>90% for three doses). The risk of reintroduction of the virus in Europe exists as long as there are non-vaccinated or under-vaccinated groups in European countries and poliomyelitis is not eradicated.

ECDC link: [ECDC risk assessment](#)

Actions

ECDC provides updates on the polio situation on a monthly basis. ECDC monitors reports of polio cases worldwide through epidemic intelligence in order to highlight polio eradication efforts and to identify events that increase the risk of wild poliovirus being reintroduced in the EU.

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