COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 15, 6-12 April 2014

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Influenza - Multistate (Europe) - Monitoring 2013-2014 season

Opening date: 4 October 2013 Latest update: 3 April 2014

Following the 2009 pandemic, influenza transmission in Europe has returned to its seasonal epidemic pattern, with peak activity during winter months. ECDC monitors influenza activity in Europe during the winter season and publishes the results on its website in the Weekly Influenza Surveillance Overview.

➔Update of the week

Influenza activity is declining towards an inter-seasonal pattern with most of the countries reporting low intensity, local or sporadic geographical spread and decreasing trend.

Hepatitis A outbreak -Multistate (Europe)- January 2013- March 2014

Opening date: 10 May 2013 Latest update: 10 April 2014

Since 1 January 2013 and up to date, outbreaks or clusters of confirmed and probable hepatitis A virus infections with no travel history have been reported in Italy, Ireland, the Netherlands and Norway. During the same time period, France, Germany, Sweden and the United Kingdom reported sporadic cases of hepatitis A infection with no travel history. In addition, most of these countries and Denmark reported cases of HAV infection with a travel history to Italy during the relevant exposure period.

➔Update of the week

In recent developments, Norway reported an ongoing outbreak of hepatitis A virus (HAV) infection with most patients having symptom onset in February and March 2014. Confirmed cases were infected with an outbreak strain of genotype IA identical to the European outbreak strain (KF182323) isolated from outbreak patients in Italy, Ireland and the Netherlands. Patients did not have a travel history to Italy or countries with a high HAV endemicity during the relevant exposure period.

Non EU Threats

Zika virus infection outbreak - The Pacific - 2013-2014

Opening date: 9 January 2014 Latest update: 10 April 2014

There is an ongoing outbreak of Zika virus (ZIKAV) infection in the Pacific affecting several countries, including Easter Island, a territory administered by Chile. There is a simultaneous dengue outbreak in the region (DENV 1 and 3). The French Polynesian health authorities reported a concurrent significant increase in neurological syndromes and autoimmune illnesses. The cause and possible links with Zika or dengue virus infections are being investigated.

➔Update of the week

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In **French Polynesia**, no new cases have been recorded since 28 March 2014. To date, 8 723 suspected Zika Virus (ZIKAV) cases have been reported by the Health Surveillance Bureau for French Polynesia.
In **New Caledonia**, as of 8 April 2014, 658 confirmed cases, 33 imported cases and 626 autochthonous cases have been reported.
On the **Cook Islands**, as of 4 April, 905 cases of dengue-like illness and 49 confirmed cases have been reported.
On Easter Island, a territory administered by Chile, there is no new update this week.

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

Opening date: 24 September 2012 Latest update: 9 April 2014

Since April 2012, 229 laboratory-confirmed cases, including 91 deaths, of acute respiratory disease caused by Middle East respiratory syndrome coronavirus (MERS-CoV), have been reported by national health authorities. To date, all cases have either occurred in the Middle East, have had 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 points towards an animal reservoir in the Middle East, from which humans sporadically become infected through zoonotic transmission. Human-to-human transmission to close contacts and in hospital settings has occurred, but there is no evidence of sustained transmission among humans. MERS-CoV is genetically distinct from the coronavirus that caused the SARS outbreak.

➔Update of the week
Since the previous CDTR, 18 new cases have been reported in the Middle East. Sixteen cases were reported from Saudi Arabia, one case from the United Arab Emirates and one case from Jordan, who had travelled to Saudi Arabia.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 10 April 2014

Polio, a crippling and potentially fatal vaccine-preventable disease that mainly affects children, is close to being eradicated as a result of global public health efforts. Polio remains endemic in Afghanistan, Pakistan and Nigeria.

➔Update of the week
During the past week, five new cases of wild poliovirus type 1 (WPV1) were reported to WHO.

Chikungunya outbreak - The Caribbean, 2013-2014

Opening date: 9 December 2013 Latest update: 28 March 2014

On 6 December 2013, France reported two laboratory-confirmed autochthonous cases of chikungunya in the French part of the Caribbean island of Saint Martin. Since then, local transmission has been confirmed in the Dutch part of Saint Martin, on Martinique, Saint Barthélemy, Guadeloupe, British Virgin Islands, Dominica, Anguilla, Saint Kitts and Nevis, Saint Lucia, Dominican Republic and French Guyana. Aruba only reported imported cases. This is the first documented outbreak of chikungunya with autochthonous transmission in the Americas. As of 11 April 2014, there have been more than 20 000 probable and confirmed cases in the region. Six fatalities have been reported.

➔Update of the week
During the past week, new cases have been reported in most of the affected areas. In the French Antilles the number of new cases is relatively stable with a substantial increase only in Guadeloupe, almost all municipalities are now affected.
The Department of Health of the Dominican Republic has confirmed cases of chikungunya on the island. WHO reports at least one confirmed case of chikungunya virus infection in Saint Lucia.
To date, islands with confirmed cases are Saint Martin/Sint Maarten, Martinique, Saint Barthélemy, Guadeloupe, British Virgin Islands, Anguilla, Dominica, Aruba, Saint Kitts and Nevis, Saint Lucia, Dominican Republic and French Guiana in mainland South America. In most of the territories of the French Antilles, given the caseload, the health authorities decided not to seek laboratory confirmation for all suspected cases.

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 10 April 2014

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, 414 cases have been reported from China, including 142 deaths. No autochthonous cases have been reported from outside of China. Most cases have been unlinked and sporadic zoonotic transmission from poultry to humans is the most likely explanation for the outbreak. Sustained person-to-person transmission has not been documented. Transmission has peaked in two distinct waves; during the winter months in 2013 and during the winter of 2013-2014. The reason for this pattern is not obvious. Since October 2013, 279 cases have been reported and the majority of these cases were reported from previously affected provinces or in patients who visited these provinces prior to onset of illness.

➔Update of the week
Between 4 and 10 April 2014, eight cases of influenza A(H7N9) infection were reported in China: Jiangsu (2), Guangdong (2), Anhui (2) and Hong Kong (2).

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Outbreak of Ebola Virus Disease - West Africa - 2014

Opening date: 22 March 2014 Latest update: 8 April 2014

An outbreak of Ebola Virus Disease (EVD) is currently evolving in West Africa, with onset in early February 2014, affecting Guinea and Liberia. The first cases were reported from the Forested Region of south-eastern Guinea in Guéckédou prefecture near the border with Liberia and Sierra Leone. Results from sequencing showed strongest homology of 98% with *Zaire ebolavirus* (ZEBOV), last reported in 2009 in Kasai-Occidental Province of the Democratic Republic of Congo.

This is the first such outbreak in this region. Multidisciplinary teams have been deployed to the field to actively search and manage cases, trace and follow-up contacts, and to sensitise communities on outbreak prevention and control.

➔Update of the week

Guinea: According to the latest available figures from 9 April 2014, 158 people, including 101 people who have died, have been infected with the Ebola virus disease (case fatality ratio 64%). This is an increase of 24 cases and 17 deaths since the last ECDC report on 4 April 2014. Sixty-six cases have been confirmed by laboratory analysis.

Liberia: As of 10 April, the Ministry of Health and Social Welfare (MOHSW) of Liberia has reported 12 deaths, 5 laboratory confirmed cases and 20 suspected cases of EVD.

Sierra Leone: The two earlier reported fatal cases of haemorrhagic fever tested positive for Lassa fever. Sierra Leone has no reported or suspected cases of EVD at present.

There are no cases reported in the other neighbouring countries except in **Mali** where four suspected cases are currently under investigation.

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

Opening date: 15 June 2005 Latest update: 11 April 2014

The influenza A(H5N1) virus, commonly known as bird flu, is fatal in about 60% of human infections. Sporadic cases continue to be reported, usually after contact with sick or dead poultry from certain Asian and African countries. No human cases have been reported from Europe.

➔Update of the week

Since the last monthly update published on 14 March 2014, WHO has acknowledged four new human cases of influenza A (H5N1) infection: two in Cambodia and two in Egypt. These were the first human cases reported from Egypt since April 2013, and both cases had contact with sick and dead poultry.

In addition, media quoting the Ministry of Health in Egypt has reported a third human case of influenza A(H5N1) in Egypt.

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II. Detailed reports

Influenza - Multistate (Europe) - Monitoring 2013-2014 season

Opening date: 4 October 2013 Latest update: 3 April 2014

Epidemiological summary

For week 14/2014:
- Low intensity was reported by all reporting countries except Northern Ireland that reported medium intensity.
- Of the 404 sentinel specimens tested across 23 countries, 31% were positive for influenza virus. Of these, 95% were type A and 5% type B.
- Six countries reported 76 hospitalised laboratory-confirmed influenza cases of which 28 were admitted to intensive care units.

Overall, influenza activity is declining but influenza viruses were still detected in the vast majority of reporting countries.

Web sources: WISO | ECDC Seasonal influenza | US-CDC health advisory | CDC Seasonal influenza | FluWatch, Canada | FluView, USA

ECDC assessment

The influenza season started in EU/EEA countries in week 2/2014.

Actions

ECDC will continue to produce the weekly influenza surveillance overviews during the northern hemisphere influenza season.

Hepatitis A outbreak -Multistate (Europe)- January 2013- March 2014

Opening date: 10 May 2013 Latest update: 10 April 2014

Epidemiological summary

Since 1 January 2013, 1 315 cases of HAV infection have been reported by 11 Member States as potentially linked to the ongoing HAV infection outbreak. Of these, 240 were confirmed outbreak cases, sharing the same sequence KF182323 at the junction VP1-2a of the viral genome. When first declared, the outbreak was associated with travel to Italy. Currently, besides Italy, seven Member States have reported cases with no travel history, namely France, Germany, Ireland, Norway, the Netherlands, Sweden and the United Kingdom.

ECDC together with the affected countries developed a European outbreak case definition, distributed a standard questionnaire developed by the Irish public health institute for interviewing cases, collected epidemiological information from all reported cases and, with the support of HAVNET in the Dutch public health institute, disseminated a standard protocol to guide the sequencing of human samples. The majority of the cases reported consumption of mixed frozen berries. The HAV sequence (region VP1/2A) obtained from one of the berries samples was identical with the 'outbreak sequence' obtained from human cases (KF182323). In addition, 30 lots of frozen berries have been implicated by epidemiological investigations.

The new outbreak reported in Norway involves 23 patients. Of these, 19 cases had onset in February or March 2014. Confirmed cases were infected with an outbreak strain of genotype IA identical to the European outbreak strain (KF182323) isolated from outbreak patients in Italy, Ireland and the Netherlands. Patients did not have a travel history to Italy or countries with a high HAV endemicity during the relevant exposure period. Most patients reported consumptions of berries in trawling interviews; a case-control study is currently underway to test the hypothesis of an association between HAV infection and consumption of berries. A review of credit card information from cases and a trace-back exercise are also being conducted.

ECDC assessment

Epidemiological, microbiological and environmental investigations indicate mixed frozen berries as the vehicle of infection for this outbreak and suggest that this is a single outbreak linked to a common, continuous source in the EU/EEA. However, other hypotheses such as cross contamination in a food production environment or that the outbreak strain is already widespread but previously undetected cannot be excluded.

Due to the characteristics of the pathogen, i.e. low infectivity dose and long incubation period, and of the food vehicle, i.e. long shelf-life and complex processing and distribution chain, it is expected that more cases will be reported and that more Member

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States may be involved. Member States, in accordance with their national guidelines, may consider active or passive immunisation of close contacts of cases in order to prevent secondary transmission.

Despite coordinated efforts from EFSA, ECDC, affected Member States and the European Commission (HAV-Trace working group), the ongoing trace back investigation has not yet identified a likely source of contamination. The working group will continue the trace back exercise and will extend the participation, on a voluntary basis, to newly involved countries, namely France, Norway and Sweden. All relevant information on national trace back investigations shall be gathered and integrated in the HAV-Trace exercise via the utilization of the RASFF platform.

Actions

An updated joint ECDC-EFSA outbreak assessment was published on 11 April 2014.

ECDC, EFSA and the European Commission, in cooperation with the affected Member States, will continue to strengthen efforts to identify the vehicle and source of infection.

Zika virus infection outbreak - The Pacific - 2013-2014

Opening date: 9 January 2014 Latest update: 10 April 2014

Epidemiological summary

There is an ongoing outbreak of ZIKAV infection in the Pacific affecting several countries, including Easter Island. There is a simultaneous dengue outbreak in the region. The French Polynesian health authorities reported at the start of the epidemic a concurrent significant increase in neurological syndromes and autoimmune illnesses. No such neurological complications have been reported since week 9-2014. The cause and possible links with Zika or dengue virus infections are being investigated. No neurological complications have been reported to date in the other affected areas.

ECDC assessment

ZIKAV infection continues to spread to new areas in the Pacific, despite a decreasing trend in French Polynesia. There is a risk for the disease spreading further in the Pacific and to the countries of the Americas where the Aedes mosquito is present, and for sporadic imported cases in Europe from endemic areas. Vigilance must be enhanced towards imported cases of ZIKAV infection in the EU Member States and EU overseas countries and territories and outermost regions, in particular where effective vectors are present.

Actions

ECDC published a risk assessment on 14 February 2014. ECDC is monitoring this event through epidemic intelligence.

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

Opening date: 24 September 2012 Latest update: 9 April 2014

Epidemiological summary

As of 10 April 2014, 229 laboratory-confirmed cases of MERS-CoV have been reported by local health authorities worldwide, including 91 deaths. The following countries have reported MERS-CoV cases:

Saudi Arabia: 182 cases / 67 deaths
United Arab Emirates: 19 cases / 8 deaths
Qatar: 7 cases / 4 deaths
Jordan: 4 cases / 3 deaths
Oman: 2 cases / 2 deaths
Kuwait: 3 cases / 1 death
UK: 4 cases / 3 deaths
Germany: 2 cases / 1 death

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France: 2 cases / 1 death
Italy: 1 case / 0 death
Tunisia: 3 cases / 1 death

Twelve cases have been reported from outside the Middle East: the UK (4), France (2), Tunisia (3), Germany (2) and Italy (1). In France, Tunisia and the UK, there has been local transmission among patients who had not been to the Middle East, but had been in close contact with laboratory-confirmed or probable cases. Person-to-person transmission has occurred both among close contacts and in healthcare facilities. However, with the exception of a possible nosocomial outbreak in Al-Ahsa, Saudi Arabia, secondary transmission has been limited. The Ministry of Health in Saudi Arabia issued a press release dated 8 April 2014 offering information about eleven cases that were recently reported from Jeddah. Thirty-two asymptomatic cases have been reported by Saudi Arabia and three by the United Arab Emirates.

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 | Eurosurveillance article 26 September |Saudi Arabia MoH press release, 8 Apr 2014

ECDC assessment

The source of MERS-CoV infection and the mode of transmission have not been identified, but the continued detection of cases in the Middle East indicates that there is an ongoing source of infection in the region. There is therefore a continued risk of cases presenting in Europe following exposure in the Middle East, and surveillance for MERS-CoV cases is essential.

The risk of secondary transmission in the EU remains low and could be reduced further through screening for exposure among patients presenting with respiratory symptoms and their contacts, and strict implementation of infection prevention and control measures for patients under investigation.

Actions

ECDC's latest epidemiological update was published on 25 November 2013.

The latest update of a rapid risk assessment was published on 7 November 2013.

The first 133 cases are described in Eurosurveillance published on 26 September 2013.

ECDC is closely monitoring the situation, in collaboration with WHO and EU Member States.

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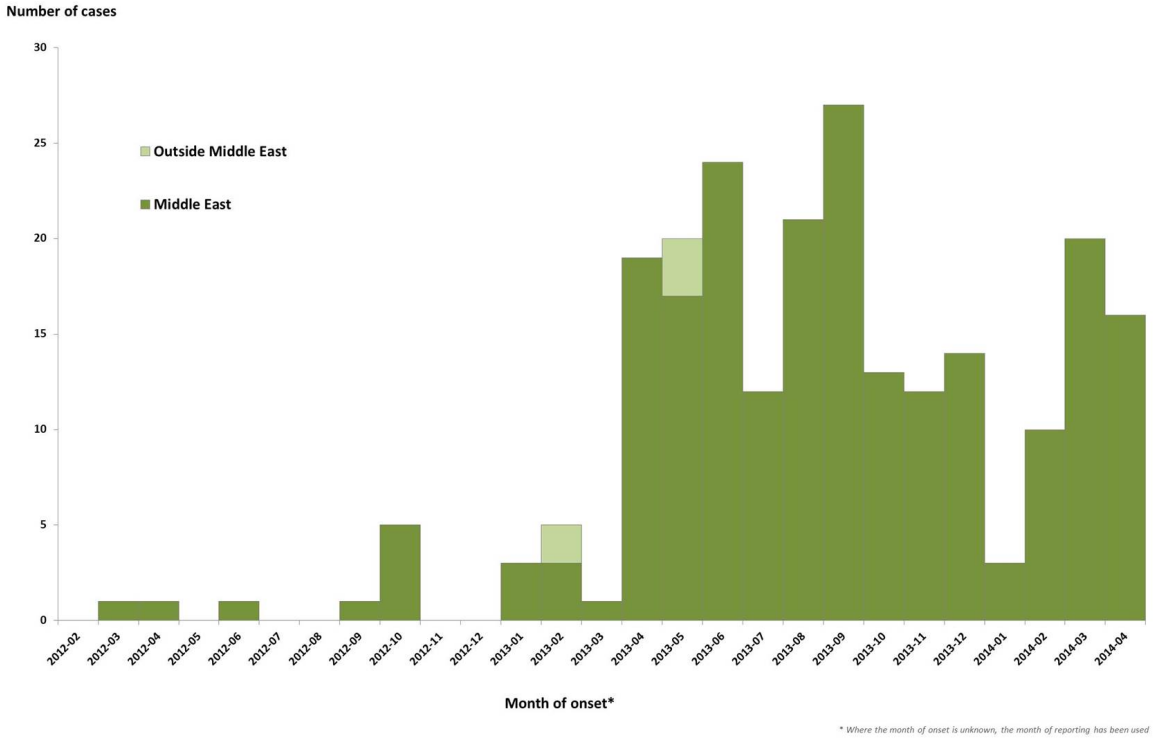
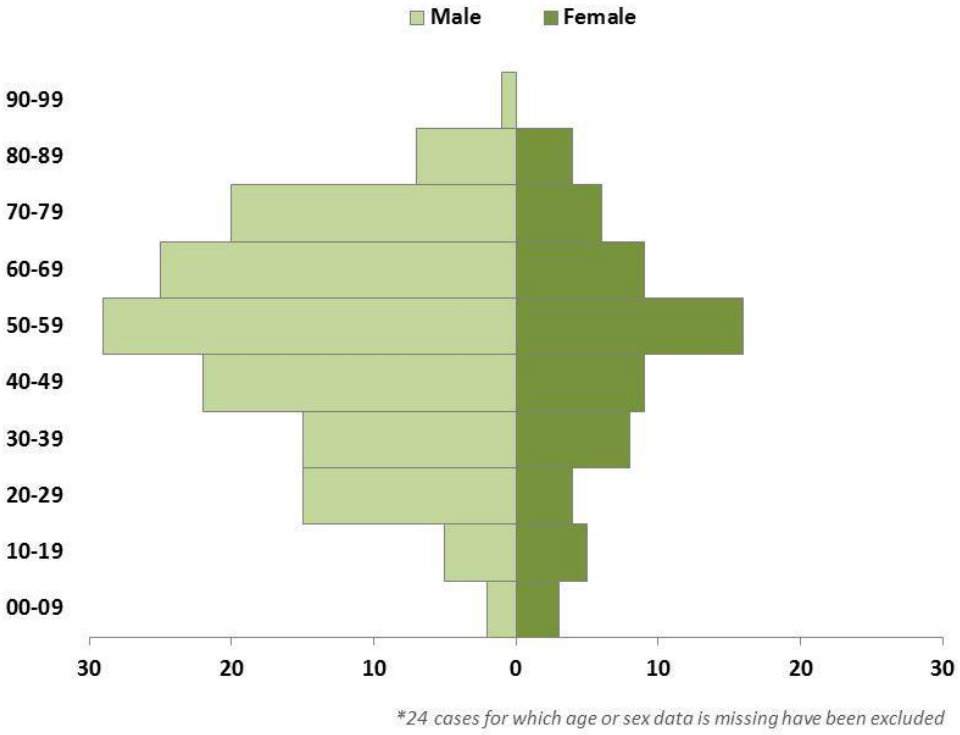
Distribution of confirmed cases of MERS-CoV by month of onset and place of probable infection, March 2012 - 10 April 2014 (n=229*)

ECDC SRS



Distribution of confirmed cases of MERS-CoV by gender and age group, March 2012 - 10 April 2014 (n=205*)

ECDC SRS



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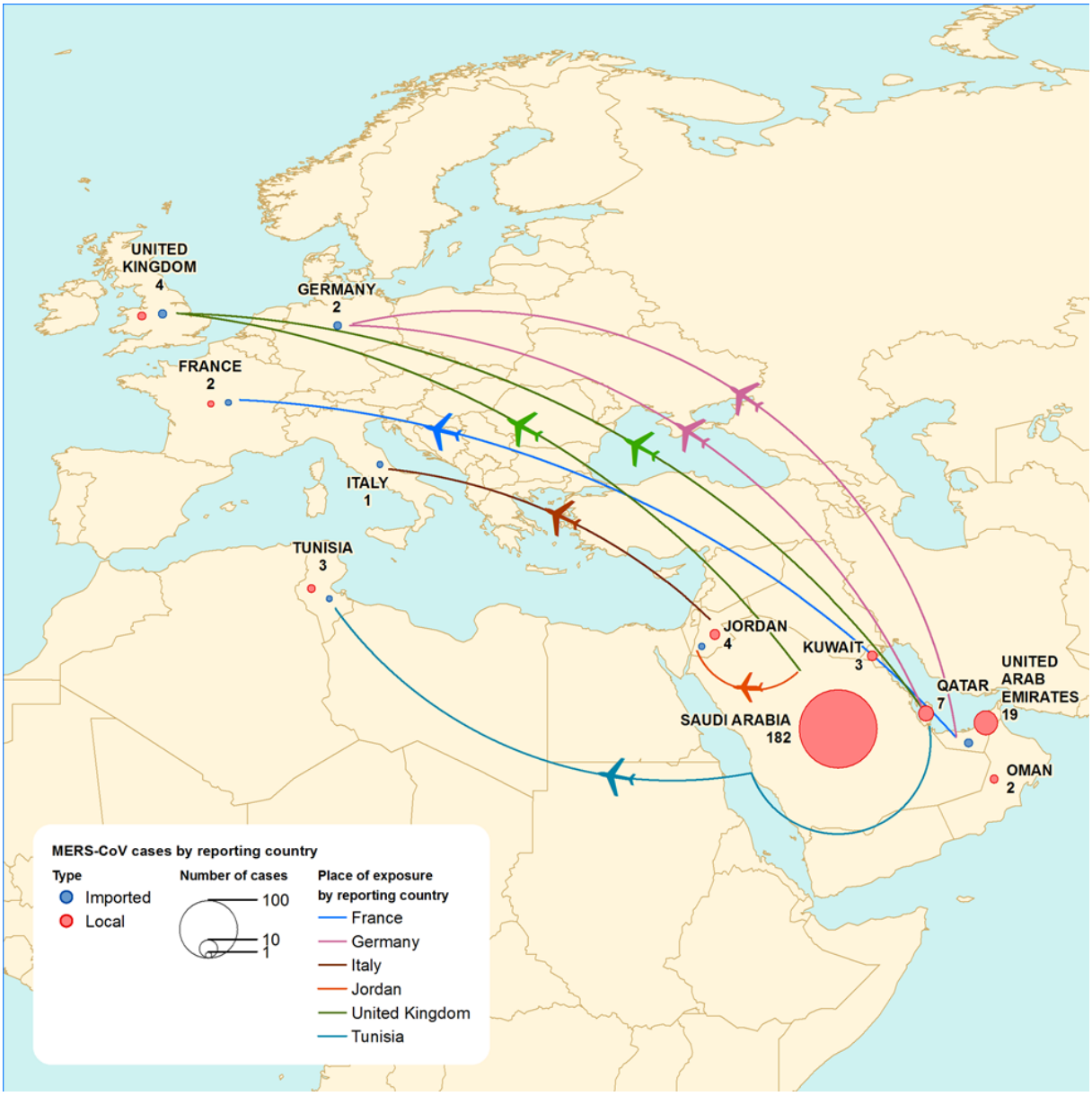
Distribution of confirmed MERS-CoV cases by place of reporting, March 2012 - 10 April 2014 (n=229)

ECDC SRS



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 10 April 2014

Epidemiological summary

During week 15, five new cases of WPV1 were notified to WHO (with onset of disease from 2014). Four cases were from Pakistan and one from Equatorial Guinea.

Worldwide, 56 cases have been reported to WHO in 2014, compared with 18 for the same time period in 2013. The most affected country is Pakistan (43 cases this year).

WPV1 positive samples have been detected by environmental surveillance in Israel since 3 February 2013 and continue to be detected in 2014 (12 positive samples have been collected this year, the most recent of which was collected on 02 March 2014).

The Strategic Advisory Group of Experts on Immunization (SAGE) met in Geneva on 1-3 April to discuss vaccination requirements for travellers from polio-infected countries, and the progress in eliminating wild and vaccine derived poliovirus. Additionally, SAGE

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reviewed progress towards setting a confirmed date for the trivalent to bivalent OPV switch, which requires the absence of persistent circulating vaccine-derived poliovirus type 2 (cVDPV2) for at least six months globally.

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

ECDC assessment

Europe is polio free. The last polio cases within the current EU borders were reported from Bulgaria in 2001. This was an imported outbreak and it was demonstrated that the WPV originated from India. An outbreak in the Netherlands, in a religious community opposed to vaccinations, caused two deaths and 71 cases of paralysis in 1992.

The last indigenous WPV case in the WHO European Region was in Turkey in 1998. The latest outbreak in the WHO European Region was in Tajikistan in 2010, when importation of WPV1 from Pakistan resulted in 460 cases.

The recent detection of WPV in environmental samples in Israel, and the confirmed and ongoing outbreaks in Syria and Somalia, highlight the risk of re-importation into Europe. Recommendations are provided in the recent ECDC risk assessments:
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 follows reports of polio cases worldwide through epidemic intelligence, in order to highlight polio eradication efforts and identify events that increase the risk of re-introduction of wild poliovirus into the EU.

Due to the current situation of polio, the threat is being followed weekly.

Chikungunya outbreak - The Caribbean, 2013-2014

Opening date: 9 December 2013 Latest update: 28 March 2014

Epidemiological summary

Cases reported as of 11 April 2014:

- Virgin Islands (UK), 7 confirmed cases;
- Saint Martin (FR), 2 910 suspected and 791 confirmed or probable cases, 3 deaths;
- Sint Maarten (NL), 224 confirmed autochthonous cases;
- Martinique, 13 500 suspected and 1 284 confirmed or probable cases, 2 deaths;
- Saint Barthélemy, 444 suspected and 135 confirmed or probable cases;
- Guadeloupe, 3 690 suspected and 942 confirmed or probable cases, one death;
- Dominica, 764 suspected cases and 81 confirmed cases;
- French Guiana, 27 confirmed autochthonous cases and 15 imported cases;
- Anguilla, 14 confirmed cases on the island with one case probably originating from Saint Martin;
- Aruba, one imported case originating from Sint Maarten;
- Saint Lucia one confirmed case
- St. Kitts and Nevis, one confirmed case;
- Dominican Republic reports confirmed cases, but has not reported the total numbers yet.

ECDC assessment

Epidemiological data indicate that the outbreak, which started in Saint Martin (FR), is expanding. An increasing number of cases have been observed from most of the affected areas. The vector is endemic in the region, where it also transmits dengue virus. Vigilance is recommended for the occurrence of imported cases of chikungunya in tourists returning to the EU from the Caribbean, including awareness among clinicians, travel clinics and blood safety authorities. The autochthonous cases in French Guyana are the first autochthonous chikungunya cases in mainland South America.

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Actions

ECDC published a rapid risk assessment on 12 December 2013 and an epidemiological update on 10 January and on 7 February 2014.

The Caribbean islands

Wikipedia

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 10 April 2014

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 10 April 2014, there have been 414 laboratory-confirmed cases: Zhejiang (138), Guangdong (98), Jiangsu (47), Shanghai (42), Fujian (22), Hunan (20), Anhui (13), Jiangxi (5), Henan (4), Beijing (4), Guangxi (4), Shandong (2), Hebei (1), Guizhou (1), Jilin (1), Hong Kong (9), Taiwan (2) and one case reported in Malaysia imported from China.

Most cases have developed severe respiratory disease. One hundred and forty-two patients have died (case-fatality ratio=34.3%).

Since October 2013, 279 cases were reported from Guangdong (97), Zhejiang (92), Jiangsu (20), Fujian (17), Hunan (17), Shanghai (8), Anhui (9), Guangxi (4), Beijing (2), Guizhou (1), Jilin (1), Taiwan (1) and Hong Kong (9). One exported case from China was diagnosed in Malaysia.

Web sources: Chinese CDC | WHO | WHO FAQ page | ECDC |

ECDC assessment

The continued transmission in one of the most densely populated areas in the world, of a novel reassortant avian influenza virus capable of causing severe disease in humans, is a cause for concern due to the pandemic potential of the virus. Currently, the most likely scenario is that this remains a local although geographically widespread zoonotic outbreak, in which the virus is transmitted sporadically to humans in close contact with the animal reservoir, similar to the influenza A(H5N1) situation.

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The fatal case of influenza A(H5N1) imported from China to Canada and the recent imported case of influenza A(H7N9) in Malaysia support the scenario that imported cases of influenza A(H7N9) may be detected in Europe. 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.

The risk of increased transmission of H7N9 viruses between humans is not negligible. European countries should continue to prepare for the eventuality of future pandemics, including one caused by A(H7N9). Preparedness activities should include the precautionary development of early human vaccine candidates and increased monitoring of animal influenzas at the animal–human interface.

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 closely monitoring developments.

ECDC published an updated Rapid Risk Assessment on 26 February 2014.

ECDC published an epidemiological update on 7 February 2014.

ECDC published a guidance document for Supporting diagnostic preparedness for detection of avian influenza A(H7N9) viruses in Europe for laboratories on 24 April 2013.

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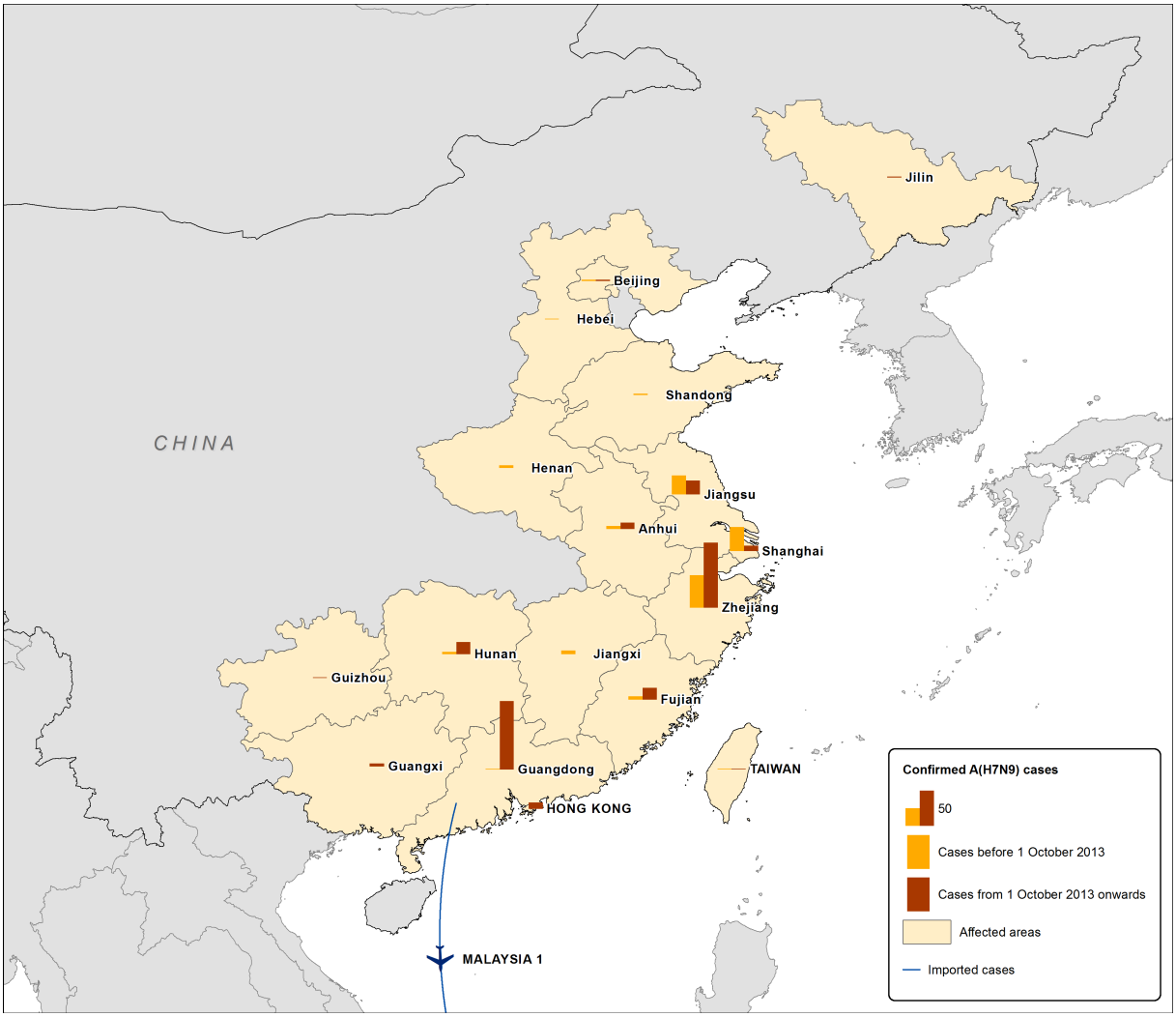
Distribution of confirmed A(H7N9) cases by place of reporting, week 15/2013 to 15/2014 (n=414)

Source: ECDC SRS



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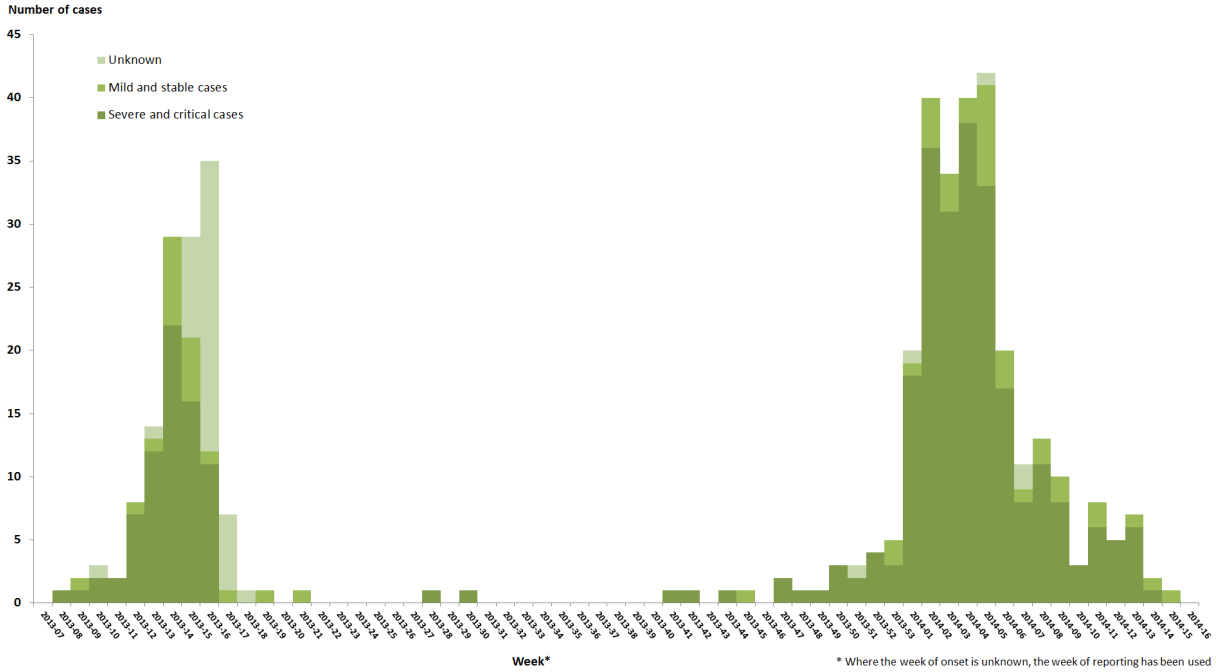
Distribution of confirmed A(H7N9) cases by week of onset and severity, week 14/2013 to week 15/2014, China (n=414)

Source: ECDC SRS



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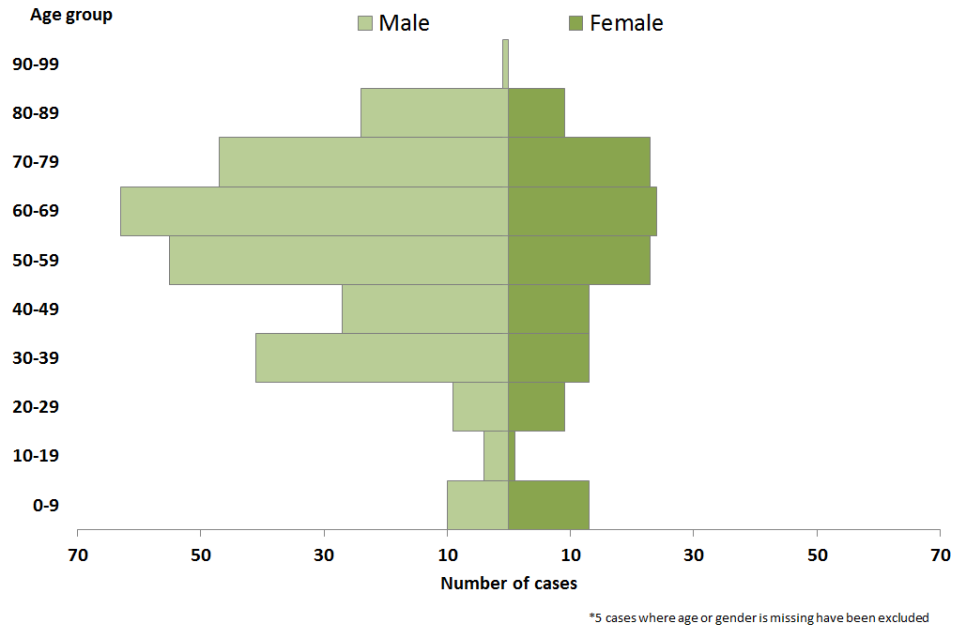
Distribution of confirmed A(H7N9) cases by age and gender, week 14/2013 to week 15/2014, China (n=409*)

Source: ECDC SRS



Outbreak of Ebola Virus Disease - West Africa - 2014

Opening date: 22 March 2014 Latest update: 8 April 2014

Epidemiological summary

In Guinea, cases have been reported from Conakry, Guéckédou, Macenta, Kissidougou, and from Dabola and Djingaraye prefectures. At least 15 cases in Guinea have been in healthcare workers indicating the need to further strengthen health facility-based infection prevention and control. As of 9 April, medical observation is continuing for 488 contacts while 453 have been discharged from follow-up. No new contacts were identified since 8 April.

In Liberia, Foya, Lofa County, remains the epicentre of the Ebola outbreak. Suspected, probable and confirmed Ebola cases have been reported in Lofa (10), Margibi (6), Bong (4), Nimba (3), Montserrado (1) and Grand Cape Mount (1) Counties.

The national authorities of Guinea and Liberia have activated their national emergency committees, prepared response plans and carried out needs assessments.

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Control activities supported by WHO, UNICEF, Médecins Sans Frontières and other stakeholders are being implemented, including contact tracing, enhanced surveillance and strengthening of infection control practices, free-of-charge access to healthcare for suspected cases, case isolation and management, and social mobilisation. Information and education materials have been developed and distributed, intensive multimedia communications are underway and psychosocial support is being provided to patients, their families and the affected communities. There is ongoing training for carers and the community in safe practices and in safe burials. A team of EU scientists have set up a field laboratory to test suspect cases, working alongside Médecins Sans Frontières at an isolation centre near the borders with Sierra Leone and Liberia.

Web sources: WHO/AFRO outbreak news |Interim Infection Control Recommendations for Care of Patients with Suspected or Confirmed Filovirus (Ebola, Marburg) Haemorrhagic Fever WHO |ECDC Ebola health topic page |ECDC Ebola and Marburg fact sheet |Risk assessment guidelines for diseases transmitted on aircraft

ECDC assessment

This is the first time an Ebola virus disease outbreak is reported in Guinea. The origin of this outbreak is currently unknown. The outbreak is still evolving and the number of cases is expected to increase in the coming weeks in Guinea and in bordering countries in the region. However, control measures, such as isolation of cases and active monitoring of contacts, currently implemented with the support of international partners should be able to control this outbreak and prevent further spread of the disease.

The risk of infection for travellers is considered very low since most human infections result from direct contact with the body fluids or secretions of infected patients, particularly in hospitals (nosocomial transmission) and as a result of unsafe procedures, use of contaminated medical devices (including needles and syringes) and unprotected exposure to contaminated body fluids.

Returning visitors from the affected areas who develop infectious disease symptoms such as fever, headache, diarrhoea or general malaise within three weeks after return should always seek rapid medical attention and mention their recent travel to the attending physician. It is unlikely, but not impossible, that travellers infected in affected areas could arrive in the EU while incubating the disease and develop symptoms compatible with EVD while in the EU. These cases should immediately seek and receive medical attention and be isolated to prevent further transmission. Clinicians managing returning travellers from visiting these areas with compatible symptoms are advised to take into consideration the possibility of EVD.
EU citizens travelling or living in the affected countries can eliminate the risk of getting infected if they avoid:

- direct contact with blood or bodily fluids of a person or corpse infected with the Ebola virus
- close contact with or handling of wild animals, alive or dead, such as monkeys, forest antelopes, duikers, porcupines, and bats, or their meat.
- having unprotected sexual intercourse with an infected person or a person recovering from EVD
- having contact with any object, such as needles, that have been contaminated with blood or bodily fluids.

Those who are providing medical care in the outbreak area are advised to wear protective clothing, including masks, gloves, gowns, eye protection and practice proper infection prevention and control measures. The risk related to seeking medical care in affected countries depends on the implementation of precautionary measures in those settings.

WHO advises against the application of travel or trade restrictions on Guinea and neighbouring countries based on the current information available on this Ebola outbreak.

Actions

ECDC has prepared a rapid risk assessment and an epidemiological update and is closely monitoring this event.

An updated rapid risk assessment was posted on 9 April 2014.

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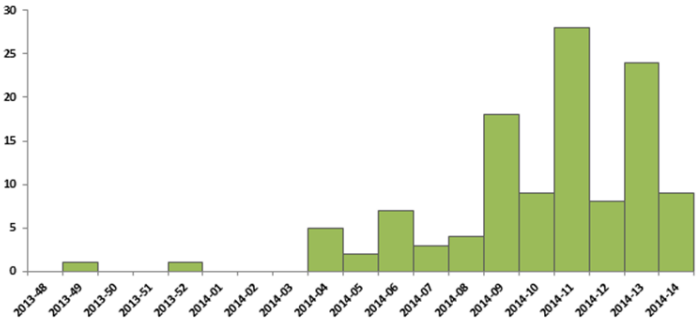
Distribution of suspected and confirmed cases of Ebola Virus Disease by week, Guinea, week 48/2013 to 14/2014

Source: ECDC



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Distribution of EVD cases by affected areas and confirmation status, as of 10 April 2014

Source: ECDC

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

Opening date: 15 June 2005 Latest update: 11 April 2014

Epidemiological summary

From 2003 through to 9 April 2014, 665 laboratory-confirmed human cases of avian influenza A(H5N1) virus infection have been reported worldwide from 16 countries. Of these cases, 391 have died (case fatality rate 58.8%).

Web sources: ECDC Rapid Risk Assessment | Avian influenza on ECDC website | WHO update | United Nations in Cambodia | Media

ECDC assessment

The risk of secondary cases in Europe is considered to be very low. Europeans travelling to China and South-East Asia should avoid live poultry markets and contact with chickens, ducks, wild birds and their droppings. This reduces the risk of exposure not only to A(H5N1) but also to A(H7N9). Poultry meat and eggs should be well cooked.

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Hong Kong reported the world's first outbreak of bird flu among humans in 1997, when six people died. Most human infections are the result of direct contact with infected birds, and countries with large poultry populations in close contact with humans are considered to be most at risk of bird flu outbreaks. There are currently no indications of a significant change in the epidemiology associated with any clade or strain of the A(H5N1) virus from a human health perspective. This assessment is based on the absence of sustained human-to-human transmission, and on the observation that there is no apparent change in the size of clusters or reports of chains of infection. However, vigilance for avian influenza in domestic poultry and wild birds in Europe remains important.

Actions

ECDC follows 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) and other human infections with avian influenza viruses in China on 26 February 2014.

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

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