

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Influenza - Multistate (Europe) - Monitoring 2015-2016 season

Opening date: 2 October 2015

Latest update: 22 January 2016

Influenza transmission in Europe shows a clear seasonal pattern, with peak activity during winter months. ECDC monitors influenza activity in Europe during the winter season and publishes its report weekly on the [Flu News Europe website](#).

→Update of the week

In week 1 in 2016, 32 of 41 reporting countries indicated low activity, seven medium activity and two high influenza activity. Of the sentinel specimens, 38% were influenza virus-positive and, while not all were subtyped or ascribed to a lineage, the majority of detections (59%) were A(H1N1)pdm09 viruses. Detection of A(H1N1)pdm09, A(H3N2) and type B influenza viruses was reported in sentinel surveillance specimens by an increasing number of countries: 31 compared to 22 in the previous week.

Non EU Threats

New! Lassa fever - Nigeria - 2016

Opening date: 18 January 2016

From December 2015 to 19 January 2016, Nigerian authorities have reported 218 suspected and 42 confirmed cases of Lassa fever, including 79 deaths (CFR=36.2%) in 17 states and the Federal Capital Territory.

Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 21 January 2016

Europe is experiencing its largest influx of refugees since the Second World War. According to the UN Refugee Agency (UNHCR), more than 944 000 refugees have arrived in Europe in 2015. To date, there have been reports of cases of louse-borne relapsing fever, cutaneous diphtheria, scabies, measles, meningococcal meningitis, shigellosis, typhoid fever, hepatitis A, tuberculosis and malaria among refugees. While these cases do not represent a significant disease burden for the host countries, the diseases pose a potential threat, particularly to the health of the refugees themselves. The health conditions of the refugees may worsen with the wintery weather due to low temperatures and overcrowding in shelters.

→Update of the week

No significant outbreaks involving refugees were reported during the past week.

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 22 January 2016

Zika virus infections are spreading in previously unaffected areas of the world. Since the beginning of 2015, autochthonous Zika cases have been reported in the Pacific region. Autochthonous transmission of Zika virus has been reported in Brazil since April 2015. Since then, Zika virus infections have spread to 20 countries in the Americas. In the past nine months, autochthonous transmission has also been reported from Cape Verde, Thailand, Maldives, Fiji, New Caledonia, Samoa and Solomon Island. Possible links between Zika virus infection in pregnancy and microcephaly of the foetus have been under investigation since October 2015, when the Brazilian Ministry of Health reported an unusual increase in cases of microcephaly after the Zika virus outbreak in the north-eastern states. French Polynesia reported an increase in cases of central nervous system malformations during 2014–2015 following the Zika virus infection outbreak from September 2013 to March 2014. Investigations of a link between Zika virus infection and *Guillain-Barré syndrome* (GBS) are ongoing in Brazil and French Polynesia.

→Update of the week

No autochthonous cases of Zika virus infection have been reported in EU/EEA Member States this week, with the exception of two EU Outermost Regions (French overseas departments), Saint Martin and Guadeloupe, each having reported one autochthonous case. As of 15 January, Martinique reported 47 confirmed autochthonous cases and French Guiana reported 15 confirmed autochthonous cases and 12 confirmed imported cases. This week, autochthonous transmission of Zika virus was confirmed in Barbados, Ecuador, Guyana, Bolivia and Thailand.

[Media](#) report the first microcephaly case related to Zika virus infection in Colombia.

On 15 January 2016, the US CDC issued a [travel alert](#) related to Zika virus for regions and certain countries in Central and South America and the Caribbean where Zika virus transmission is ongoing.

Carlos Shagas Institute publish a [study](#) confirming the trans-placenta transmission of Zika virus.

The Pan-American Health Organization published an [epidemiological update](#) with recommendation for surveillance and response measures.

On 19 January 2016 the [US CDC MMWR](#) published Interim Guidelines for Pregnant Women During a Zika Virus Outbreak.

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

Opening date: 24 September 2012

Latest update: 21 January 2016

Since April 2012 and as of 21 January 2016, 1 649 cases of MERS, including 638 deaths, have been reported by health authorities worldwide. The source of the virus remains unknown, but the pattern of transmission and virological studies point 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 past week no new cases of MERS-CoV have been detected.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 21 January 2016

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). As of 20 January 2016, WHO has reported 28 602 cases of Ebola virus disease related to the outbreak in West Africa, including 11 301 deaths. The number of cases in the most affected countries peaked in autumn 2014 and has been slowly decreasing since then. Sierra Leone was declared Ebola-free by WHO on 7 November 2015, Guinea on 29 December 2015 and Liberia on 14 January 2016. On 15 January 2016, WHO reported a new sporadic case in Sierra Leone, which underlines the need to maintain effective surveillance even after EVD-free status is declared. On 20 January, the Ministry of Health reported a second case, epidemiologically linked to the first one. This case is not yet acknowledged by WHO.

→Update of the week

According to the latest [WHO situation report](#), one new confirmed case of Ebola virus disease (EVD) was reported in Sierra Leone on the 14 January. The case was a 22-year-old woman who died on 12 January and was identified after collection of a post-mortem swab. Sierra Leone was previously declared Ebola-free on 7 November 2015.

According to the [Sierra Leone Ministry of Health](#) on 20 January, a second EVD case was identified in the district of Tonkolili in Sierra Leone. The case is a 38-year-old aunt and caregiver of the 22-year-old woman who died on 12 January. She was transferred to a voluntary quarantine facility with four other high-risk contacts on 17 January, where she was placed in isolation and tested positive for EVD on 20 January. She is currently receiving treatment in a military hospital in Freetown. This case has not yet been acknowledged by WHO.

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 22 January 2016

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then and up to 21 January 2016, 700 cases have been reported to WHO, including 278 deaths. No autochthonous cases have been reported outside China. Most cases are isolated and sporadic zoonotic transmission from poultry to humans is the most likely explanation for the outbreak. This week, two new cases were reported in China.

→Update of the week

During the past week, according to the Centre for Health Protection in Hong Kong, two new human cases of avian influenza A (H7N9) were reported in Guangdong. These cases have not yet been acknowledged by WHO, however they have been included in the figures for this report.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 21 January 2016

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, 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) on 5 May 2014 due to concerns regarding the increased circulation and international spread of wild poliovirus during 2014. On 25 November 2015, the Temporary Recommendations in relation to PHEIC were extended for another three months. WHO recently declared wild poliovirus type 2 eradicated worldwide. The type 2 component of the oral polio vaccine is no longer needed and there are plans for a globally synchronised switch in April 2016 from the trivalent to bivalent oral polio vaccine which no longer contains type 2.

→Update of the week

During the past week, one new wild poliovirus type 1 (WPV1) case was reported to WHO from Pakistan and one new case of circulating vaccine-derived poliovirus type 1 (cVDPV1) from Lao People's Democratic Republic. Both cases had onset of disease in December 2015.

According to [WHO](#), there are three months to go until the globally synchronised switch from the trivalent to bivalent oral polio vaccine, an important milestone in achieving a polio-free world. A sample from environmental surveillance in Kabul, Afghanistan, has tested positive for WPV1. A vaccination response is being planned for the immediate vicinity.

II. Detailed reports

Influenza - Multistate (Europe) - Monitoring 2015-2016 season

Opening date: 2 October 2015

Latest update: 22 January 2016

Epidemiological summary

The proportion of influenza virus-positive sentinel surveillance specimens has been over 10% since week 51/2015, indicating that the influenza season in the European Region started in that week.

Three quarters (77%) of the detected viruses were type A and 23% were type B. The vast majority of the subtyped A viruses and B viruses ascribed a lineage were A(H1N1)pdm09 and B/Victoria, respectively.

ECDC assessment

The majority of the viruses characterised so far are genetically similar to the strains recommended for inclusion in this winter's trivalent or quadrivalent vaccines for the northern hemisphere. However, a small number of A(H3N2) viruses showed dissimilarities to the vaccine strain. Furthermore, the most prevalent B virus lineage (Victoria) is not included in the trivalent vaccine, which is the more widely used in Europe.

Actions

ECDC monitors influenza activity in Europe during the winter season and publishes its report weekly on the [Flu News Europe website](#).

New! Lassa fever - Nigeria - 2016

Opening date: 18 January 2016

Epidemiological summary

From December 2015 to 19 January 2016, Nigerian authorities have reported 218 suspected and 42 confirmed cases of Lassa fever, including 79 deaths (CFR=36.24%). The outbreak is affecting 17 states: Bauchi, Niger, Taraba, Kano, Rivers, Oyo, Edo, Plateau, Nassarawa, FCT, Ondo, Delta, Ekiti, Ebonyi, Lagos, Kogi and Zamfara states.

According to WHO, Lassa fever outbreak is a yearly occurrence during the dry season in Nigeria. It was first detected in Nigeria in 1969. The number of recorded cases peaked in 2012 when 1 723 cases and 112 fatalities were recorded. About 80% of people who become infected with Lassa virus have no symptoms. One in five infections result in severe disease, where the virus affects several organs such as the liver, spleen and kidneys. The incubation period of Lassa fever ranges from 6 to 21 days. The onset of symptoms, when present, is usually gradual, starting with fever, weakness and malaise. After a few days, headache, sore throat, muscle pain, chest pain, nausea, vomiting, diarrhoea, cough and abdominal pain may follow. The animal reservoir or host of Lassa virus is a rodent of the genus *Mastomys*, commonly known as the "multimammate rat." *Mastomys* rats infected with Lassa virus do not become ill, but they can shed the virus in their urine and faeces. Person-to-person and laboratory transmission can also occur, particularly in hospitals lacking adequate infection prevention and control measures. Because the clinical course of the disease is so variable, detection of the disease in affected patients has been difficult. However, when presence of the disease is confirmed in a community, prompt isolation of affected patients, good infection prevention and control practices and rigorous contact tracing can stop outbreaks.

Source: [MoH](#) | [media](#) | [WHO](#)

ECDC assessment

Lassa fever is endemic in Nigeria and outbreaks occur yearly during the dry season in Nigeria. The authorities have implemented control measures and are monitoring the situation. The risk of importation in EU/EEA is very low.

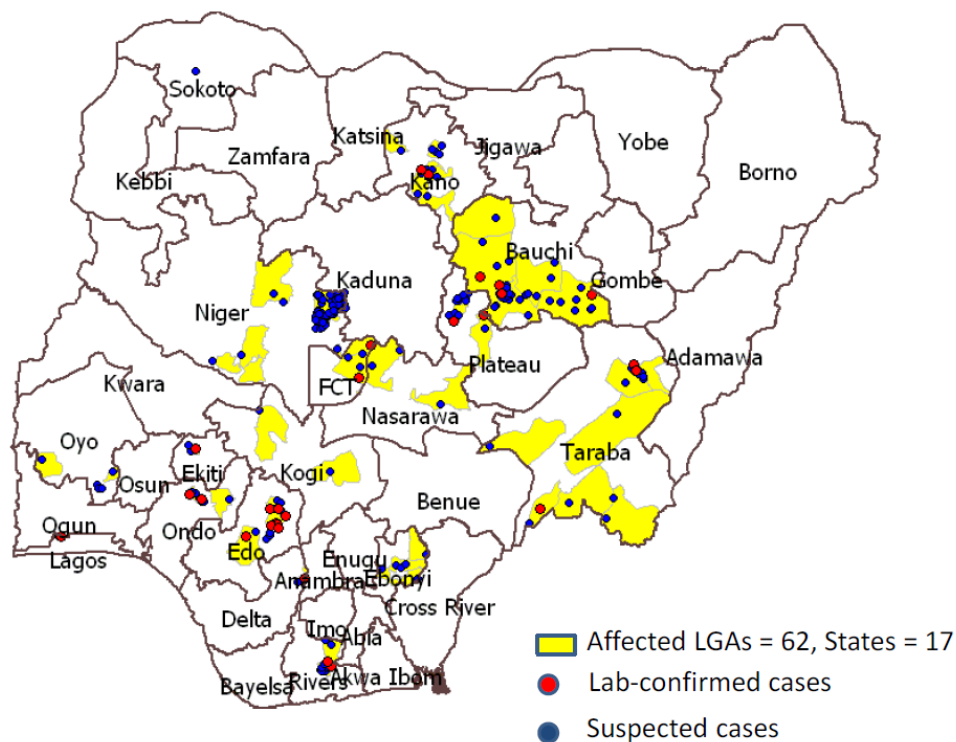
Actions

ECDC is following this event through epidemic intelligence activities.

Lassa fever cases, Nigeria, week 35-2015 to week 2-2016

Nigerian MoH

Cases/Lab-confirmed by State/LGAs as at Wk35 2015 - Wk02 2016



Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 21 January 2016

Epidemiological summary

Reports of emerging episodes of communicable diseases affecting the refugee population including louse-borne relapsing fever, cutaneous diphtheria, scabies, measles, meningococcal meningitis, shigellosis, typhoid fever, hepatitis A, tuberculosis and malaria have been seen.

ECDC assessment

Refugees are not currently a threat to Europe with respect to communicable diseases, but they are a priority group for communicable disease prevention and control efforts because they are more vulnerable. The risk that refugees arriving in Europe will contract communicable diseases has increased because of the current overcrowding at reception facilities.

While the risk of mosquito-borne diseases has been reduced as a result of the winter, the risk of infection from diseases whose spread is facilitated by overcrowding and lower temperatures has increased. It is therefore expected that the incidence of

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respiratory and gastrointestinal conditions will increase in the coming months.

Low vaccination coverage for some diseases, along with low immunity for some diseases, may result in susceptible refugees developing diseases such as measles and chicken pox, given their high incidence in some regions of the EU.

[WHO, UNHCR and UNICEF](#) jointly recommend that refugees, asylum seekers and migrants should have non-discriminatory, equitable access to healthcare services, including vaccines, irrespective of their legal status. They should be provided with timely immunisation against vaccine-preventable diseases, particularly measles and polio. All countries should have effective disease surveillance and reporting systems, outbreak investigation ability and case management and response capacity.

The risk to European residents of being affected by outbreaks occurring among refugee populations remains extremely low because overcrowding, limited access to clean water and poor hygiene levels are only encountered in certain reception facilities for refugees.

Actions

An [ECDC expert opinion](#) on the public health needs of irregular migrants, refugees or asylum seekers across the EU's southern and south-eastern borders was posted on the ECDC website in September 2015.

ECDC prepared:

- an [RRA](#) on the risk of communicable disease outbreaks in refugee populations in the EU/EEA
- an updated [RRA](#) on louse-borne relapsing fever amongst migrants in the EU/EEA
- an [RRA](#) on cutaneous diphtheria among recently arrived refugees and asylum seekers in the EU
- an [RRA](#) on the risk of importation and spread of malaria and other vector-borne diseases associated with the arrival of migrants in the EU
- an [RRA](#) on shigellosis among refugees in the EU.

ECDC, in collaboration with Member States, the European Commission and WHO, continues to closely monitor the situation to rapidly identify and assess potential communicable disease threats.

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 22 January 2016

Epidemiological summary

As of 21 January 2016, several countries or territories have reported confirmed autochthonous cases of Zika virus infection in the past nine months: Barbados, Bolivia, Brazil, Cape Verde, Colombia, Ecuador, El Salvador, Fiji, French Guiana, Guadeloupe, Guatemala, Guyana, Haiti, Honduras, Maldives, Martinique, Mexico, New Caledonia, Panama, Paraguay, Puerto Rico, Saint Martin, Samoa, Solomon Islands, Suriname, Thailand and Venezuela.

Web sources: [ECDC Zika Factsheet](#) | [WHO DON](#) | [PAHO](#) | [Colombian MoH](#) | [Brazilian MoH](#) | [Brazilian microcephaly case definition](#)

ECDC assessment

The spread of Zika virus epidemic in the Americas is likely to continue as the competent vectors *Aedes aegypti* and *Aedes albopictus* mosquitoes are widely distributed there. There is a significant increase in the number of babies born with

microcephaly in the north-eastern states of Brazil. However, the magnitude and geographical spread of the increase have not yet been well characterised. Despite growing evidence of a link between intra-uterine Zika virus infection and adverse pregnancy outcomes, a causal link between these events has not yet been firmly confirmed.

As neither treatment nor vaccines are available, prevention is based on personal protection measures similar to the measures that are applied against dengue and chikungunya infections.

Actions

On 24 November 2015, ECDC published a [rapid risk assessment](#) on microcephaly in Brazil linked to the Zika virus epidemic.

ECDC published an update of the [rapid risk assessment](#) on microcephaly in Brazil on 22 January 2016.

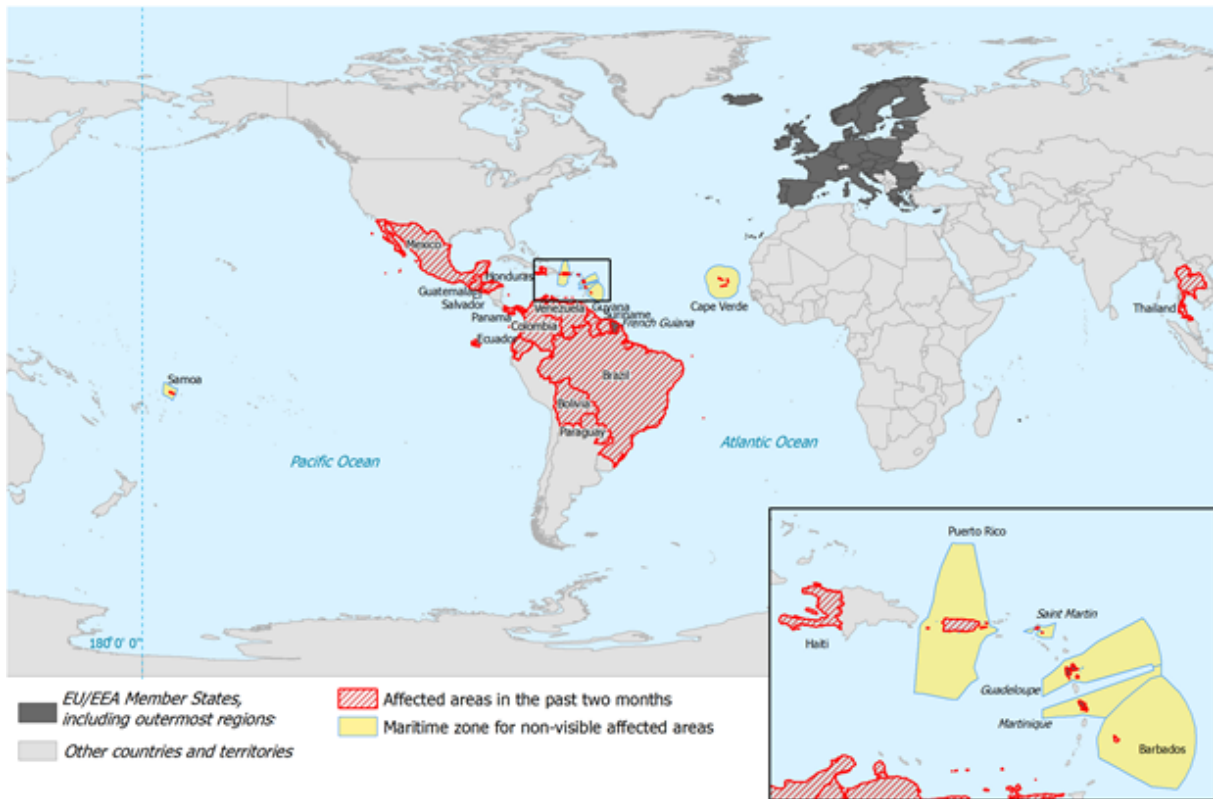
Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past nine months and past two months, as of 21 January 2016

ECDC

	Affected in the past 9 months	Affected in the past 2 months
Barbados	Yes	Yes
Bolivia	Yes	Yes
Brazil	Yes	Yes
Cape verde	Yes	Yes
Colombia	Yes	Yes
Ecuador	Yes	Yes
El salvador	Yes	Yes
Fiji	Yes	No
French Guiana	Yes	Yes
Guadeloupe	Yes	Yes
Guatemala	Yes	Yes
Guyana	Yes	Yes
Haiti	Yes	Yes
Honduras	Yes	Yes
Maldives	Yes	No
Martinique	Yes	Yes
Mexico	Yes	Yes
New Caledonia	Yes	No
Panama	Yes	Yes
Paraguay	Yes	Yes
Puerto Rico	Yes	Yes
Saint Martin	Yes	Yes
Samoa	Yes	Yes
Solomon Islands	Yes	No
Suriname	Yes	Yes
Thailand	Yes	Yes
Venezuela	Yes	Yes

Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past two months, as of 21 January 2016

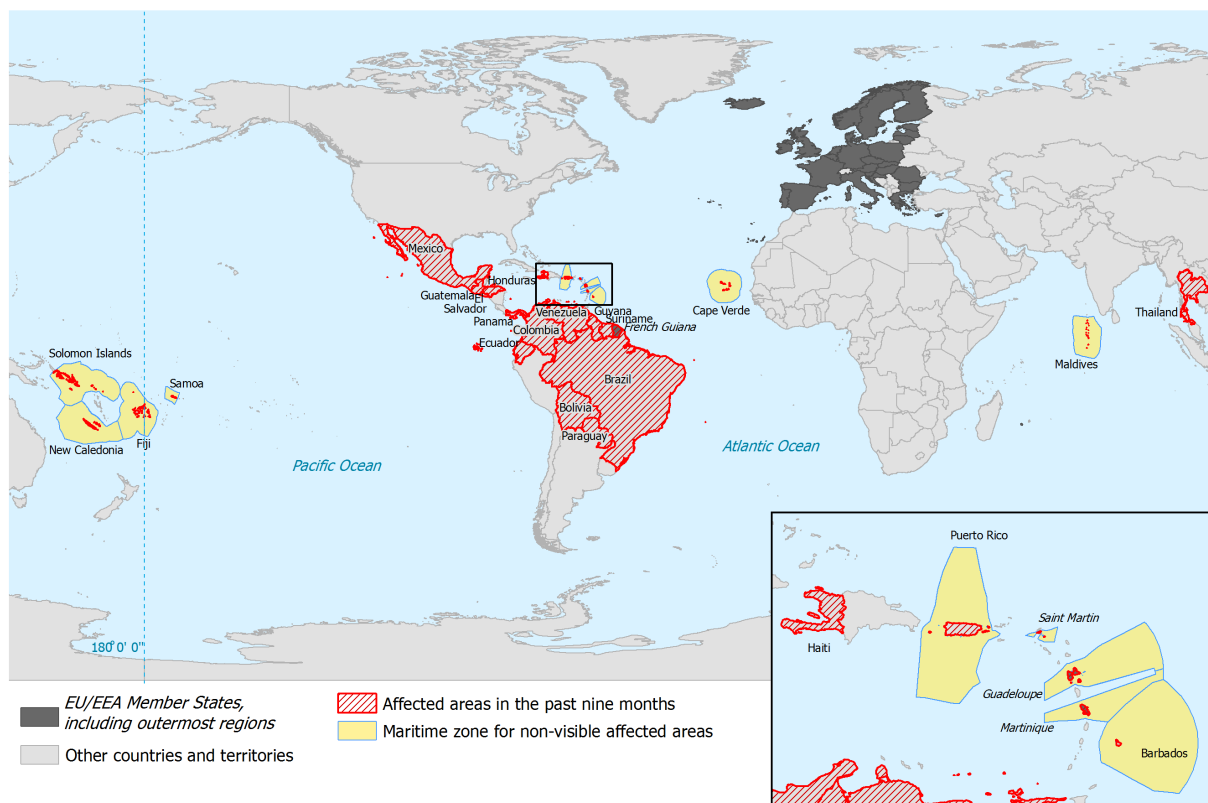
ECDC



ECDC. Map produced on 19 Jan 2016

Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past nine months, as of 21 January 2016

ECDC



ECDC. Map produced on 19 Jan 2016

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

Opening date: 24 September 2012

Latest update: 21 January 2016

Epidemiological summary

As of 21 January 2016, 1 649 cases of MERS, including 638 deaths, had been reported by local health authorities worldwide.

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](#) | [Saudi Arabia statement](#) | [ECDC factsheet for professionals](#)

ECDC assessment

The MERS outbreak in the Middle East 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, the residential cluster of cases reported from Saudi Arabia is a reminder that transmission to unprotected close contacts, not only in healthcare settings, remains possible, as also documented in outbreaks in South Korea and the United Arab Emirates.

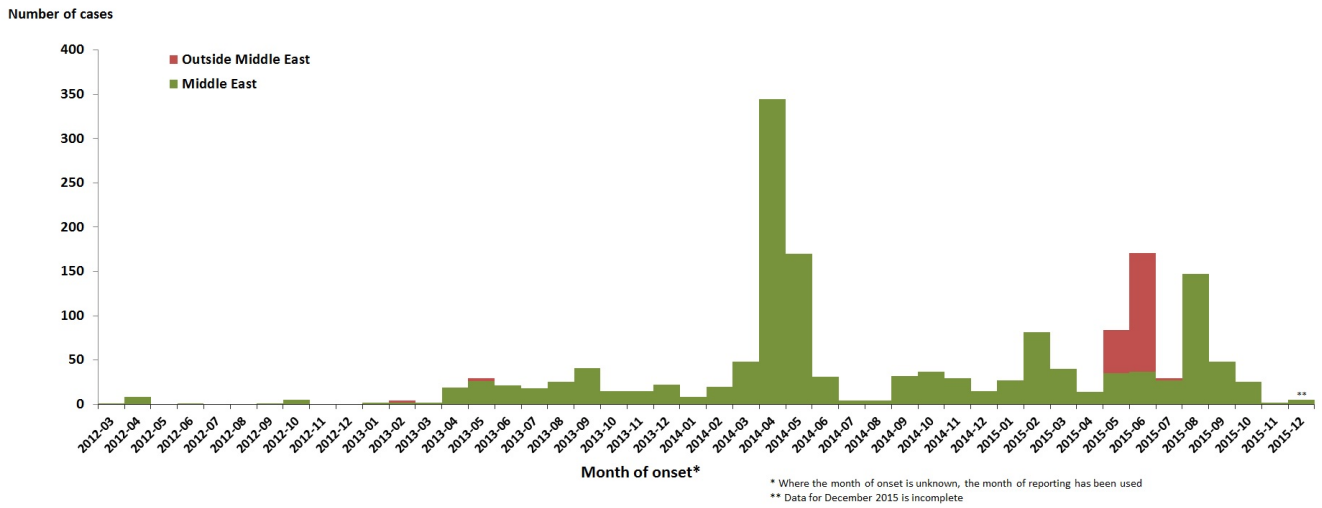
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Actions

ECDC published the 21st update of its MERS CoV [rapid risk assessment](#) on 21 October 2015.

Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 31 December 2015 (n=1 644)

ECDC



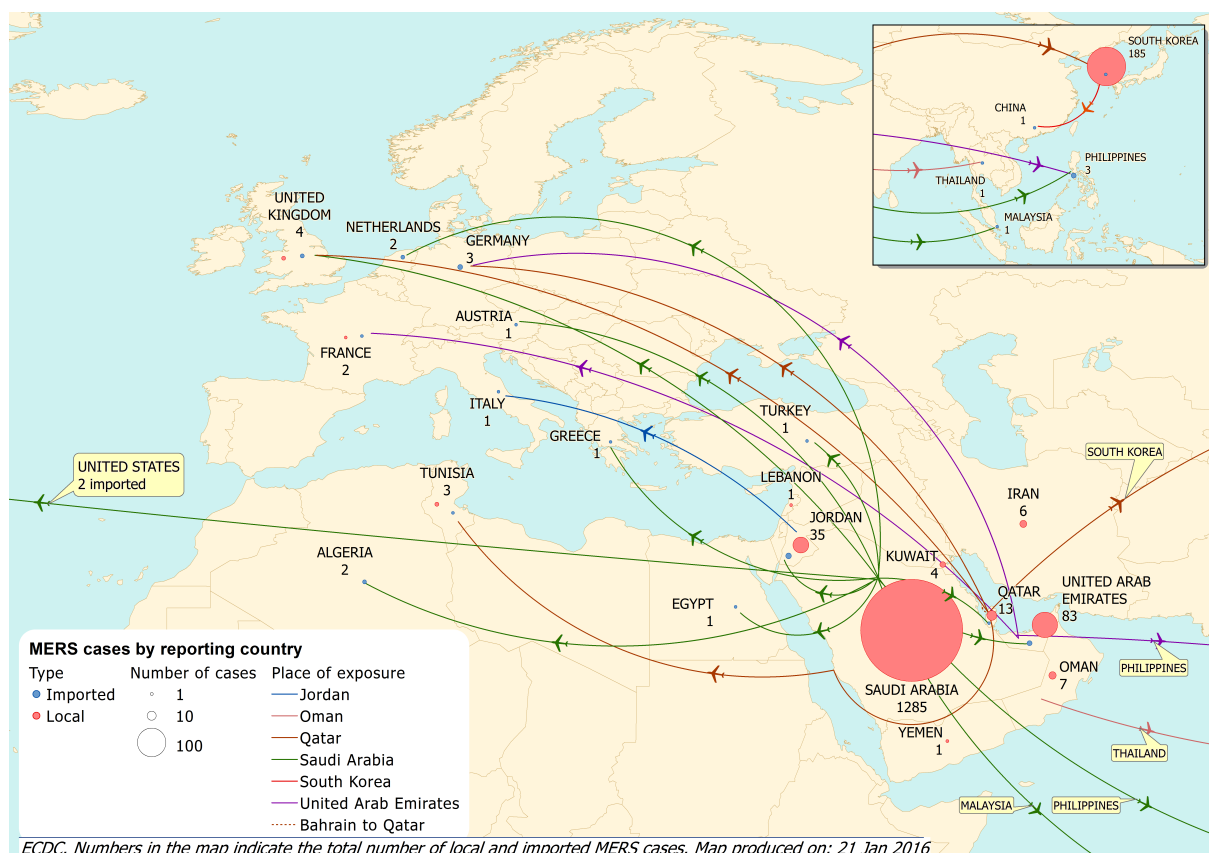
Cases of MERS-CoV by country of reporting, March 2012 – 21 January 2016 (n=1 649)

ECDC

Region	Country	Number of cases	Number of deaths
Middle East	Saudi Arabia	1285	551
	United Arab Emirates	83	11
	Qatar	13	5
	Jordan	35	14
	Oman	7	3
	Kuwait	4	2
	Egypt	1	0
	Yemen	1	1
	Lebanon	1	0
	Iran	6	2
Europe	Turkey	1	1
	UK	4	3
	Germany	3	2
	France	2	1
	Italy	1	0
	Greece	1	1
	Netherlands	2	0
	Austria	1	0
Africa	Tunisia	3	1
	Algeria	2	1
Asia	Malaysia	1	1
	Philippines	3	0
	South Korea	185	38
	China	1	0
	Thailand	1	0
Americas	United States of America	2	0
	Global	1649	638

Distribution of confirmed cases of MERS-CoV by place of probable infection, March 2012 – 21 January 2016 (n=1 649)

ECDC



Ebola Virus Disease Epidemic - West Africa - 2014 - 2016

Opening date: 22 March 2014

Latest update: 21 January 2016

Epidemiological summary

Distribution of cases as of 20 January 2016:

- **Liberia:** 10 675 cases, including 4 809 deaths. Liberia was declared EVD-free on 3 September 2015. However, a family cluster occurred in the week leading up to 22 November 2015.
- **Sierra Leone:** 14 123 cases, including 3 956 deaths. The country was declared Ebola-free on 7 November 2015. However, a sporadic case was confirmed on 14 January 2016.
- **Guinea:** 3 804 cases including 2 536 deaths. Guinea was declared EVD-free on 29 December 2015.

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Sierra Leone

According to [WHO](#), one new confirmed case of Ebola virus disease (EVD) was reported in Sierra Leone on the 14 January. The case was a deceased 22-year-old woman, identified after collection of a post-mortem swab. She died on 12 January at her family home in the district of Tonkolili and received an unsafe burial. In the two weeks preceding her death she travelled from Port Loko, where she was a student, via the districts of Kambia and Bombali. During her travel she experienced symptoms including vomiting and diarrhoea. She arrived in Magburaka, Tonkolili on 7 January. Approximately 150 contacts including approximately 50 high-risk contacts have been identified, with one contact in Tonkolili remaining to be traced. Vaccination of contacts, and contacts of contacts is underway, and the origin of infection is under investigation. Her extensive travel history during the two weeks prior to her death, her presentation to and subsequent discharge from a healthcare facility at which health workers did not use personal protective equipment (PPE), her period of close contact with family whilst ill, and her unsafe burial indicate a significant risk of further transmission.

Seven countries have reported an initial case or localised transmission: Nigeria, Senegal, the USA, Spain, Mali, the UK and Italy.

Situation among healthcare workers

Outside of the three most affected countries, with repatriated cases included, there have been eight cases in Mali, 20 in Nigeria, three in Spain (including two repatriated cases), three in the UK (including two repatriated cases), one in Senegal (infected in Guinea), one in Norway (repatriated), two in France (repatriated), one in the Netherlands (repatriated), one in Switzerland (repatriated), 11 in the USA (seven repatriated) and one in Italy (infected in Sierra Leone).

Epicurve: The epicurve shows the distribution of confirmed cases of Ebola virus disease by week of reporting in Sierra Leone, weeks 01/2015 to 03/2016.

Map: The map shows the distribution of confirmed cases in Sierra Leone during the past six weeks.

Web sources: [ECDC Ebola page](#) | [ECDC Ebola and Marburg fact sheet](#) | [WHO situation summary](#) | [WHO Roadmap](#) | [WHO Ebola Factsheet](#) | [CDC](#) | [Ebola response phase 3: Framework for achieving and sustaining a resilient zero](#) | [ReEBOV Antigen Rapid Test Kit](#) | [Institut Pasteur will open a lab in Conakry](#) | [Emergency Operation Centres in the three affected countries](#) | [Entry screening in US](#)

ECDC assessment

The detection of a new case in Sierra Leone is not an unexpected event and highlights the importance of maintaining heightened surveillance in the coming months as the risk of additional small outbreaks remains. Sporadic cases have been identified previously and are likely to be the result of the virus persisting in survivors even after recovery.

Actions

As of 21 January, ECDC has deployed 95 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.

On 23 November 2015, ECDC published an [epidemiological update](#).

On 16 October 2015, ECDC published the latest (13th) update of the [rapid risk assessment](#).

On 16 October 2015, ECDC published [Recent development on sexual transmission of Ebola virus](#).

On 31 July 2015, ECDC published [Positive preliminary results of an Ebola vaccine efficacy trial in Guinea](#).

On 22 January 2015, 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.

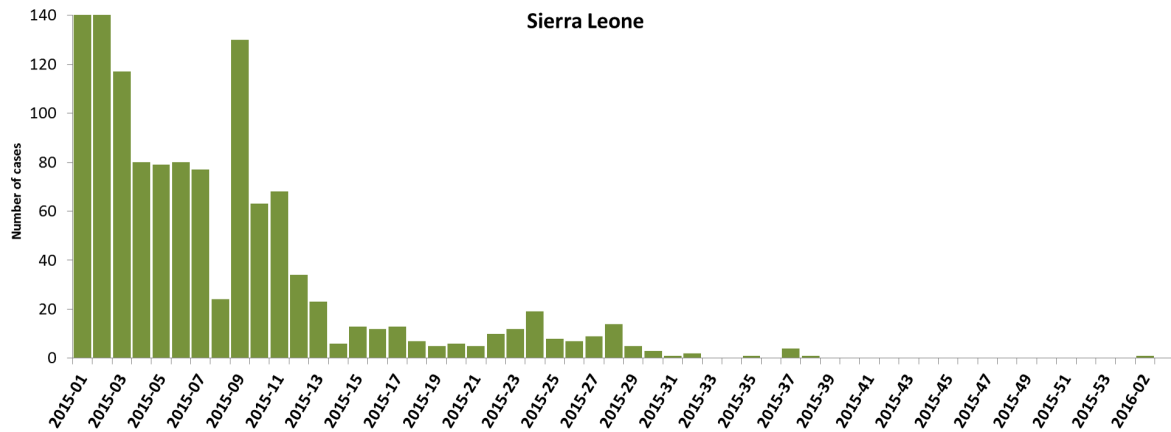
On 6 October 2014, ECDC published risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU.

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.

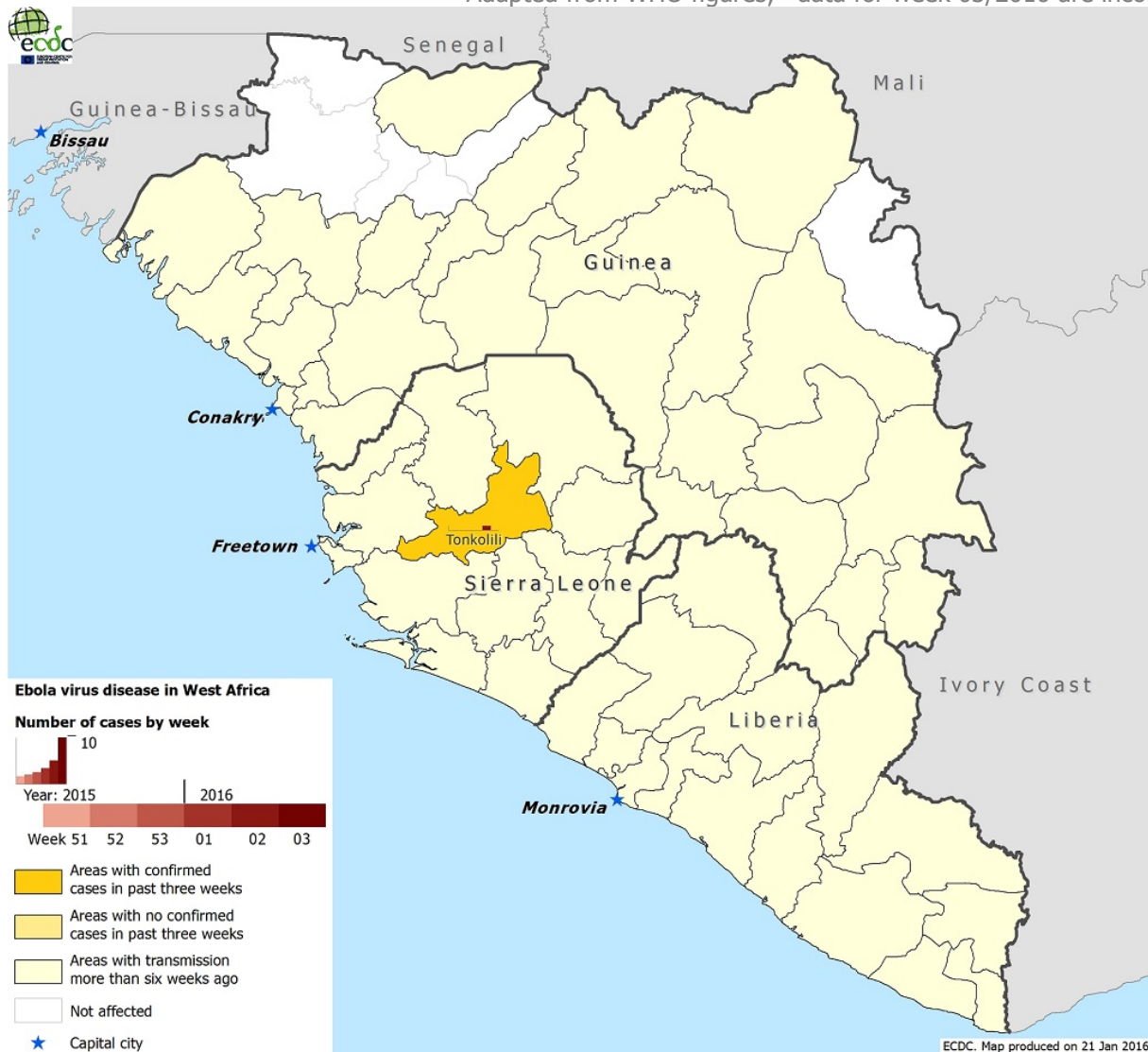
Distribution of confirmed cases of Ebola virus disease by week of reporting in Sierra Leone (weeks 01/2015 to 03/2016)

Adapted from WHO figures; *data for week 03/2016 are incomplete



Distribution of confirmed cases of EVD by week of reporting in Sierra Leone (as of week 03/2016)

Adapted from WHO figures; *data for week 03/2016 are incomplete



Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 22 January 2016

Epidemiological summary

Cases reported by China since March 2013 have the following geographical distribution: Zhejiang (197), Guangdong (186), Jiangsu (80), Fujian (63), Shanghai (50), Hunan (26), Anhui (30), Hong Kong (13), Xinjiang Uygur Zizhiqu (10), Jiangxi (12), Beijing (6), Shandong (7), Guangxi (3), Henan (4), Taiwan (4), Jilin (2), Guizhou (2), Hubei (1) and Hebei (1). Three imported cases have also been reported: one in Malaysia and two in Canada.

Web sources: [Chinese CDC](#) | [WHO](#) | [WHO FAQ page](#) | [ECDC](#) | [WHO avian influenza updates](#)

ECDC assessment

This outbreak is caused by a novel reassortant avian influenza virus capable of causing severe disease in humans. This is a zoonotic outbreak, in which the virus is transmitted sporadically to humans in close contact with the animal reservoir, similar to the influenza A(H5N1) situation.

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During 2015, there have been continued avian influenza A(H7N9) virus detections in the animal population in several provinces of China, indicating that the virus persists in the poultry population. If the pattern of human cases follows the trends seen in previous years, the number of human cases may rise over the coming months. Further sporadic cases of human infection with avian influenza A(H7N9) virus are therefore expected in areas that are already affected and in neighbouring areas.

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.

Actions

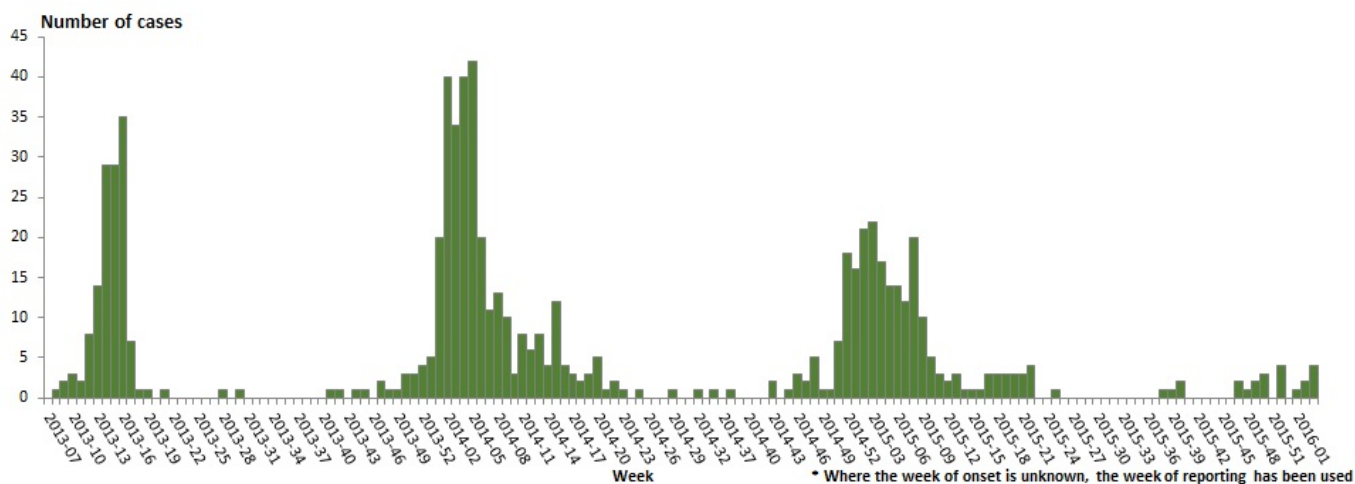
The Chinese health authorities continue to respond to this public health event with enhanced surveillance, epidemiological and laboratory investigation, and scientific research.

ECDC published an updated [Rapid Risk Assessment](#) on 3 February 2015.

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

Distribution of confirmed cases of A(H7N9) by four periods of reporting (weeks 07/2013 to 03/2016)

ECDC



Distribution of confirmed cases of A(H7N9) by week of reporting (weeks 07/2013 to 03/2016)

ECDC



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 21 January 2016

Epidemiological summary

In 2016, no cases of wild polio virus type 1 (WPV1) have been reported, compared with one case for the same period in 2015.

As of 19 January, no cases of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO so far this year, zero cases were also reported for the same period in 2015.

Web sources: [Polio Eradication: weekly update](#) | [MedISys Poliomyelitis](#) | [ECDC Poliomyelitis factsheet](#) | [Temporary Recommendations to Reduce International Spread of Poliovirus](#) | [WHO Statement on the Seventh Meeting of the International Health Regulations Emergency Committee on Polio](#)

ECDC assessment

The last locally-acquired wild polio cases within the current EU borders were reported from Bulgaria in 2001. The most recent wild

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polio outbreak in the WHO European Region was in Tajikistan in 2010, when importation of WPV1 from Pakistan resulted in 460 cases.

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?](#) | [RRA Outbreak of circulating vaccine-derived poliovirus type 1 \(cVDPV1\) in Ukraine](#)

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.

Following the detection of the cases of circulating vaccine-derived poliovirus type 1 in Ukraine, ECDC published a rapid risk assessment on its [website](#).

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