

I. Executive summary

EU Threats

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

Opening date: 2 October 2015

Latest update: 18 December 2015

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

Influenza activity remained low in most countries in the WHO European Region. While the number of consultations for influenza-like illness (ILI) and/or acute respiratory infections (ARI) were stable, the proportion of sentinel specimens testing positive for influenza virus increased from 6% for week 50/2015 to 11% for week 51/2015. Sporadic detections of A(H1N1) pdm09, A(H3N2) and type B influenza viruses were reported.

Non EU Threats

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

Opening date: 24 September 2012

Latest update: 17 December 2015

Since April 2012 and as of 24 December 2015, 1 642 cases of MERS, including 637 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

No new cases were reported this week.

As of 24 December 2015, 1 642 cases of MERS, including 637 deaths, had been reported by local health authorities worldwide.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 17 December 2015

An epidemic of Ebola virus disease (EVD) has been ongoing in West Africa since December 2013, mainly affecting Guinea, Liberia and Sierra Leone. On 8 August 2014, WHO declared the Ebola epidemic in West Africa a Public Health Emergency of International Concern (PHEIC). As of 20 December 2015, WHO had reported 28 602 cases of Ebola virus disease related to the outbreak in West Africa, including 11 300 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. The risk of spread, regionally and globally, remains until all the countries in West Africa are declared Ebola-free. The need to maintain effective surveillance, even after EVD-free status, is underlined by the recent re-emergence of cases in previously Ebola-free countries.

→Update of the week

According to [WHO](#), no confirmed cases of Ebola virus disease (EVD) were reported in the week to 20 December 2015. All contacts associated with the cluster of three confirmed cases of EVD reported from Liberia in the week to 22 November have now completed 21-day follow-up.

On 21 December 2015, WHO posted an IHR message on the eighth meeting of the IHR Emergency Committee that took place by teleconference on Tuesday, 15 December 2015, and via electronic correspondence during the period 15-21 December 2015. The Committee emphasised that between March and November 2015 as many as 10 new outbreaks had occurred as a result of re-introduction of Ebola virus from the convalescent population, based on epidemiological investigations and genetic sequencing data. The Committee considers these outbreaks as extraordinary events, which continue to require coordinated international action in support of the affected States.

The Committee remains deeply concerned that 34 countries still enact inappropriate travel and transport measures and highlights the need to immediately terminate any such measures due to their negative impact, particularly on recovery efforts.

The Committee advised that in this critical phase of transition, from stopping the original chains of transmission to managing new outbreaks, most likely due to the re-introduction of the virus from survivor populations, often in densely populated areas, the EVD outbreak continues to constitute a Public Health Emergency of International Concern (PHEIC).

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 17 December 2015

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then and up to the present time (24 December 2015), 683 cases have been reported, including 275 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.

→Update of the week

There have been no new cases reported during the past week.

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 18 December 2015

Zika virus (ZIKV) infections are still spreading in previously unaffected areas of the world. In 2014, indigenous circulation of ZIKV was detected in the Americas on Easter Island, Chile for the first time. Since then, ZIKV infections have spread to 12 countries in the Americas.

Autochthonous cases have also been reported from Cape Verde recently.

In the Pacific area, since the beginning of the year, autochthonous transmission has been reported in Samoa, Fiji, New Caledonia, Solomon Islands and Vanuatu.

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 in September 2013 to March 2014.

Investigations of an association with 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 (ZIKV) infection have been reported in EU/EEA Member States so far in 2015.

Two new countries in the Americas reported local transmission of Zika virus during the past week: French Guiana and Martinique.

As of 24 December 2015, 2 782 suspected cases of microcephaly have been notified in Brazil including 40 deaths, affecting 618 municipalities in 20 states. This is an increase by 381 since the last week.

Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 18 December 2015

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, shigellosis, 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 outbreaks involving refugees were reported during the past week.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 10 December 2015

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.

→ Update of the week

In the past week four new cases of wild poliovirus type 1 were reported to WHO. Two from Pakistan and two from Afghanistan. One case of circulating vaccine derived poliovirus type 2 was reported WHO from a district that had already been affected in Guinea.

According to WHO there are four months to go until the globally synchronised switch from the trivalent to bivalent oral polio vaccine. This will be an important milestone in achieving a polio-free world.

II. Detailed reports

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

Opening date: 2 October 2015

Latest update: 18 December 2015

Epidemiological summary

The proportion of influenza virus positive specimens has increased to over 10% for the first week, indicating the start of the season.

The increase in virus detections seen since week 49 in sentinel and non-sentinel cases has been due almost exclusively to influenza A(H1N1)pdm09. These were detected more frequently than A(H3N2), and B/Victoria lineage more frequently than B/Yamagata in both sentinel and non-sentinel specimens.

Viruses characterised so far this season are similar to the strains recommended for inclusion in this winter's trivalent or quadrivalent vaccine.

ECDC assessment

Influenza activity remains low which is usual for this time of the year.

Although few viruses have been subtyped (type A) or ascribed to a lineage (type B), A(H1N1)pdm09 viruses were detected more frequently than A(H3N2), and B/Victoria lineage more frequently than B/Yamagata in both sentinel and non-sentinel specimens. All characterised viruses matched the strains included in vaccines for this season, although B/Victoria vaccine strains are only included in tetravalent vaccines.

Actions

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

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

Opening date: 24 September 2012

Latest update: 17 December 2015

Epidemiological summary

As of 24 December, 1 642 cases of MERS, including 637 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.

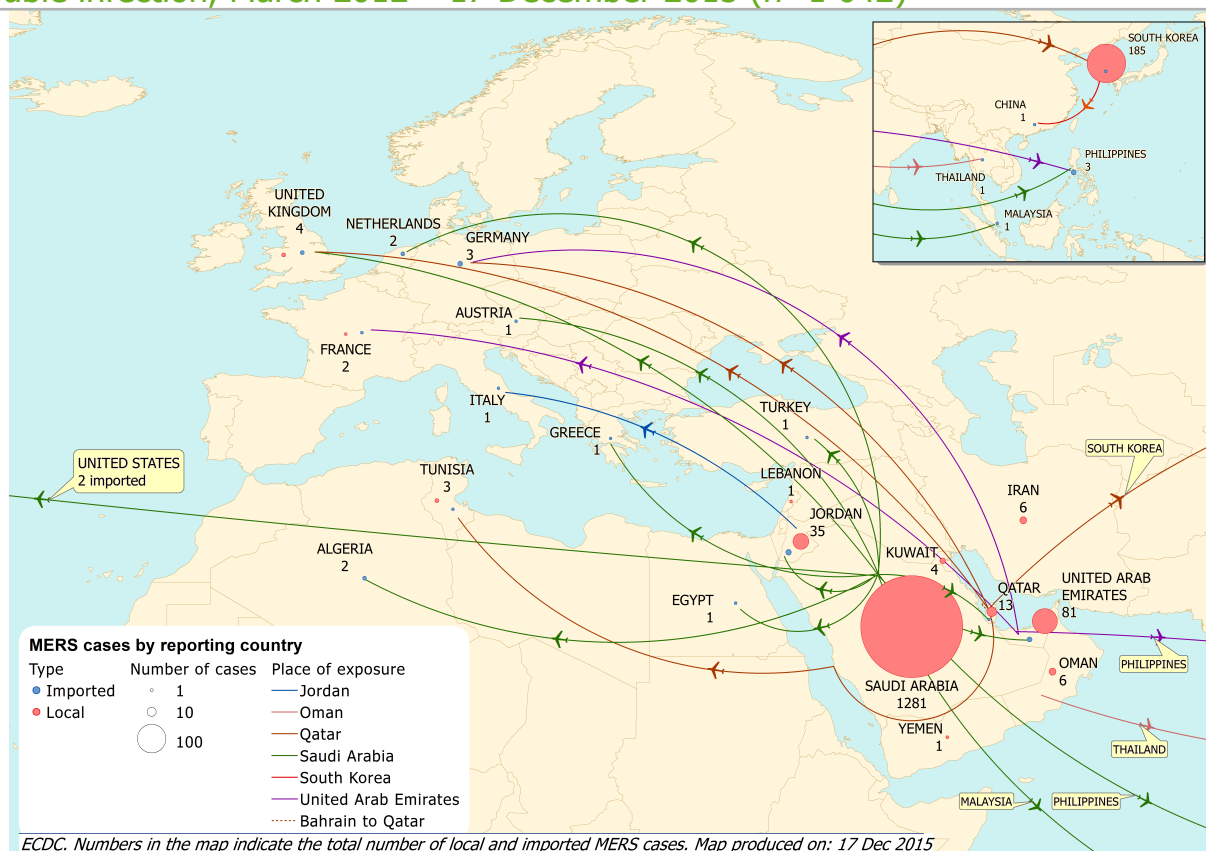
Actions

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

Cases of MERS-CoV by country of reporting, March 2012 – 17 December 2015 (n=1 642)

Region	Country	Number of cases	Number of deaths
Middle East	Saudi Arabia	1281	550
	United Arab Emirates	81	11
	Qatar	13	5
	Jordan	35	14
	Oman	6	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		1642	637

Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 17 December 2015 (n=1 642)



Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 17 December 2015

Epidemiological summary

Distribution of cases as of 24 December 2015:

Countries with ongoing Ebola virus transmission in the human population:

- **Guinea:** 3 805 cases including 3 351 confirmed, and 2 536 deaths
- **Liberia:** 10 675 cases, including 3 160 confirmed, and 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.

Countries with previously widespread and intense transmission:

- **Sierra Leone:** declared Ebola-free on 7 November 2015.

Countries that have reported an initial case or localised transmission:

- Nigeria, Senegal, the USA, Spain, Mali, the UK and Italy.

Situation in West African countries

Guinea

No new cases were confirmed in Guinea during the past week. The most recent case was reported on 29 October 2015, from which a second consecutive blood sample tested negative for Ebola virus on 16 November. If no new cases are reported, Guinea will be declared Ebola free on 28 December 2015.

Liberia

No new confirmed cases were reported during the week leading up to 20 December. All contacts of the family cluster of EVD reported from Liberia in the week to 22 November have completed 21-day follow up and as of 11 December, 210 eligible recipients associated with the cluster had received the rVSV-ZEBOV Ebola vaccine. The last two cases had their second consecutive negative EVD test on 3 December and if no new cases are reported, Liberia will be declared Ebola free on 14 January 2016. Liberia was previously declared free of Ebola transmission on 3 September 2015.

Sierra Leone

On 7 November 2015, WHO declared that Sierra Leone was Ebola free and that the country had entered a 90-day period of enhanced surveillance scheduled to conclude on 5 February 2016.

Situation among healthcare workers

No new infections in healthcare workers were reported by WHO in the week leading up to 20 December.

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 confirmed cases in Guinea and Liberia. In order to better represent the tail of the epidemic, only 2015 data are shown.

Map: The map shows the distribution of confirmed cases in Guinea and Liberia 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

This is the largest-ever documented epidemic of EVD, both in terms of numbers and geographical spread. The epidemic of EVD increases the likelihood that EU residents and travellers to the EVD-affected countries will be exposed to infected or ill persons. The risk of infection for residents and visitors in the affected countries through exposure in the community is considered low if they adhere to the recommended precautions. Residents and visitors to the affected areas run a risk of exposure to EVD in healthcare facilities. The risk of importing EVD into the EU, and the risk of transmission within the EU following an importation, remains low or very low as a result of the range of risk reduction measures that have been put in place by the Member States and by the affected countries in West Africa. However, continued vigilance is essential. If a symptomatic case of EVD presents in an EU Member State, secondary transmission to caregivers in the family and in healthcare facilities cannot be excluded.

The number of confirmed cases has remained low since the end of July. The introduction of an EVD case into unaffected countries remains possible as long as cases exist in any country. With adequate preparation, however, such an introduction can be contained through a timely and effective response. Following the recent report about the previously positive EVD nurse in the UK, unusual late complications should also be taken into account.

The recent cluster of cases in Liberia is understood to have been a result of the re-emergence of Ebola virus that had persisted in a previously infected individual. Although the probability of such re-emergence events is low, the risk of further transmission underscores the importance of implementing a comprehensive package of services for survivors that includes the testing of body

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fluids for the presence of EVD RNA. The governments of Liberia and Sierra Leone are now expanding a network of clinical services for survivors and both countries have implemented voluntary semen screening as well as counselling programmes for male survivors.

Actions

As of 24 December 2015, 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. ECDC is reporting this threat on a weekly basis in the CDTR.

ECDC has updated its website following the WHO declaration on Sierra Leone, which has been Ebola-free since 7 November 2015.

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](#).

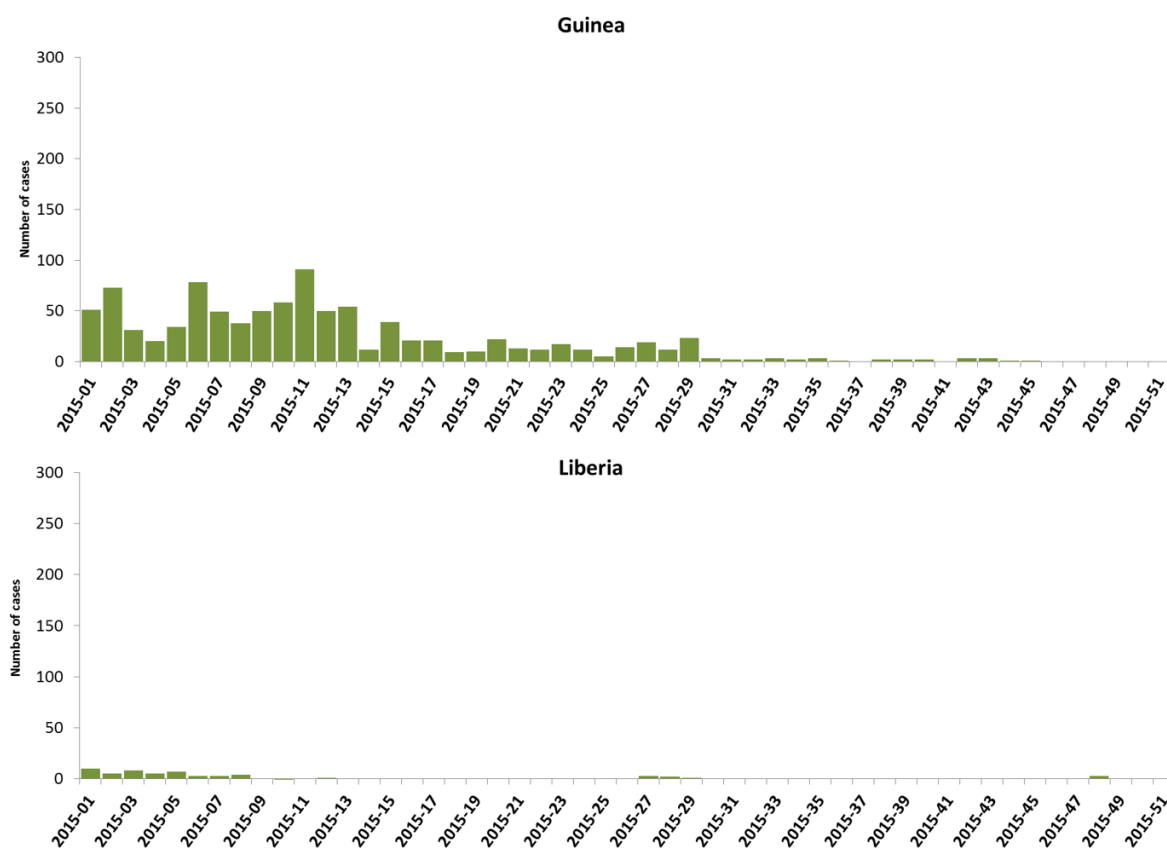
On 6 October 2014, ECDC published [risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU](#).

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](#).

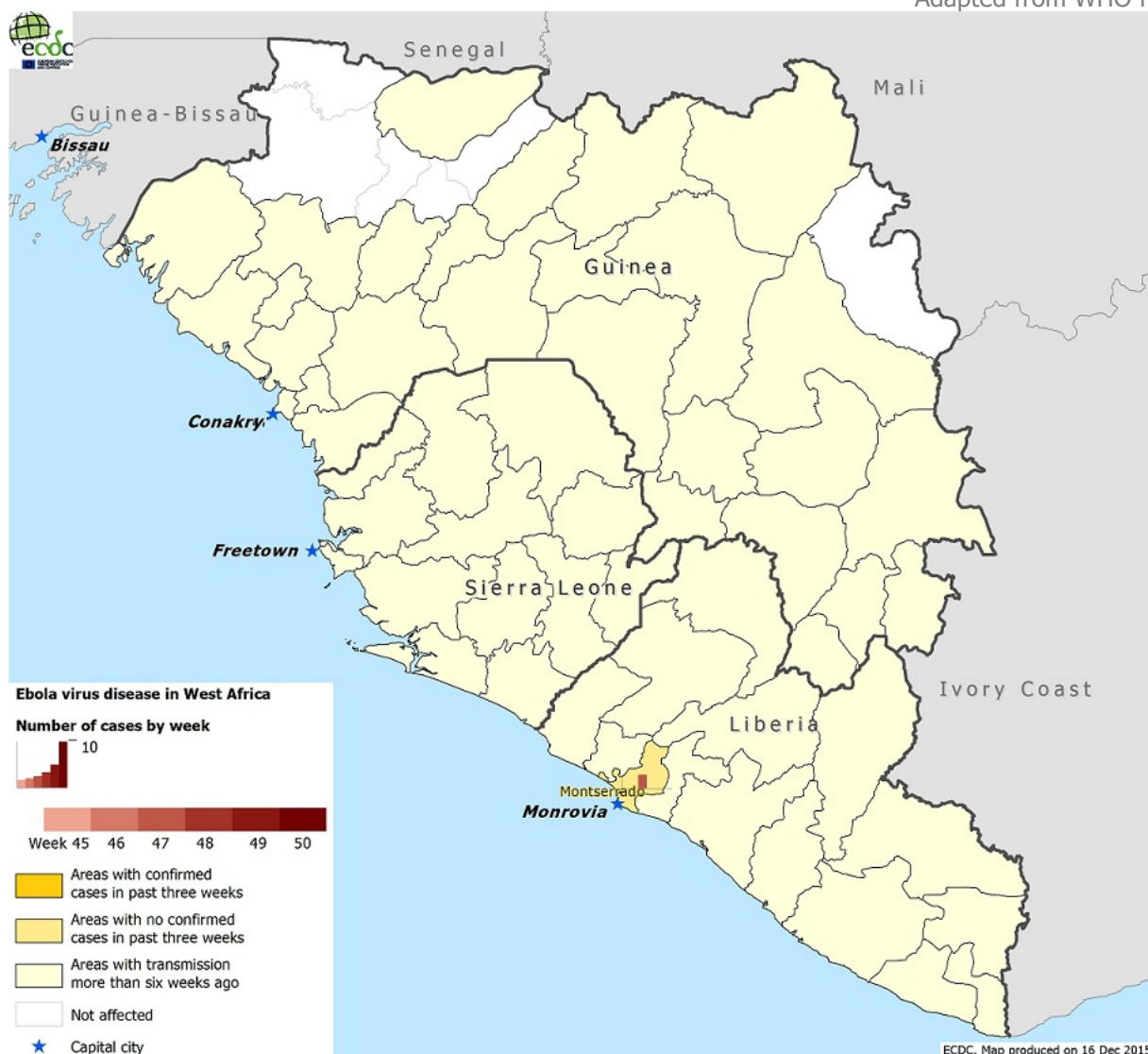
Distribution of confirmed cases of EVD by week of reporting in Guinea and Liberia (weeks 01/2015 to 51/2015)

Adapted from WHO figures; *data for week 51/2015 are incomplete



Distribution of confirmed cases of EVD by week of reporting in Guinea and Liberia (as of week 50/2015)

Adapted from WHO figures



Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 17 December 2015

Epidemiological summary

Cases reported in China since March 2013 have the following geographical distribution: Zhejiang (189), Guangdong (182), Jiangsu (78), Fujian (63), Shanghai (48), Hunan (26), Anhui (32), Hong Kong (13), Xinjiang Uygur Zizhiqu (10), Jiangxi (9), Beijing (6), Shandong (6), Guangxi (4), Henan (4), Taiwan (4), Jilin (2), Guizhou (2) and Hebei (2). 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 in 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 in Europe.

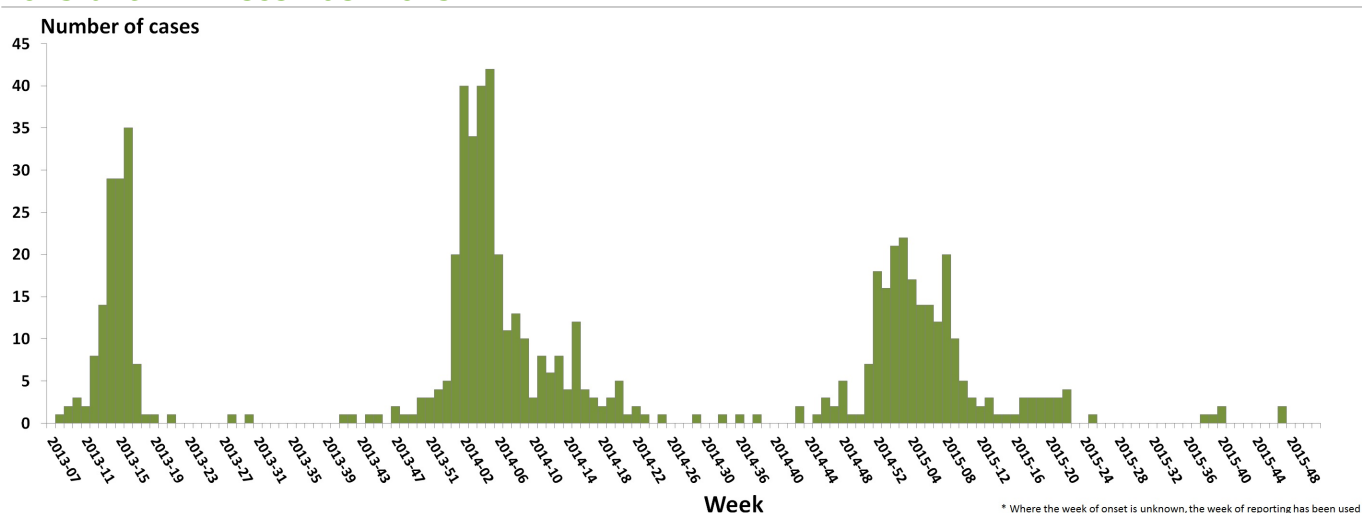
Actions

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 week of onset (n=683) from February 2013 until 17 December 2015



Distribution of confirmed cases of A(H7N9) by week of onset (n=683) from February 2013 until 17 December 2015



Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015

Latest update: 18 December 2015

Epidemiological summary

No autochthonous cases of Zika virus infection have been reported in EU Member States so far in 2015.

As of 24 December 2015, 12 countries in the Americas reported locally acquired cases of Zika virus infection: Brazil, Colombia, El Salvador, Guatemala, Mexico, Paraguay, Suriname, Venezuela, Honduras, Martinique, French Guiana and Panama.

Outside of the Americas, cases have been confirmed in Cape Verde recently.

Possible links between Zika virus infection in pregnancy and microcephaly of the foetus have been under investigation in Brazil since October 2015 when the Brazilian Ministry of Health reported an unusual increase in cases of microcephaly following the Zika virus outbreak in the north-eastern states.

In French Polynesia investigations are also ongoing following the detection of 17 cases of central nervous system malformations in foetuses and infants that had occurred in pregnancies during 2014-2015 after the 2013-2014 ZIKV outbreak. None of the mothers described clinical signs of ZIKV infection during pregnancy, but four of the women tested were found positive for flavivirus using IgG serology assays, suggesting a possible asymptomatic ZIKV infection. Based on the temporal correlation of these cases with the ZIKV epidemic, the health authorities of French Polynesia hypothesise that ZIKV infection may be associated with these abnormalities if mothers are infected during the first or second trimester of pregnancy.

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

ECDC assessment

Further cases of Zika virus are expected to be reported in other countries, particularly in the Americas, where the mosquito vector is present.

So far, only a few travel-associated cases of ZIKV infection have been reported in the EU. With the spread of the ZIKV epidemic in the Americas, the likelihood of travel-related cases of ZIKV infection in the EU is increasing. Imported ZIKV infection cases in the EU Overseas Countries and Territories and the EU Outermost Regions, with onward autochthonous transmission in EU Members States in continental Europe during the summer season in areas where *Aedes albopictus* or *Aedes aegypti* are established, cannot be excluded. Vigilance during the mosquito season is therefore required in areas where a potential vector is present because early detection of cases is essential when it comes to reducing the risk of autochthonous transmission.

Clinicians and travel medicine clinics should be aware of the evolution of ZIKV infections in the affected areas and should include ZIKV infection in their differential diagnosis for travellers from those areas. Fever and/or macular or papular rash not attributable to dengue or chikungunya infection among travellers, especially in pregnant women returning from areas currently experiencing Zika virus infection outbreaks, should prompt a possible investigation for Zika virus infection. In addition, blood safety authorities need to be vigilant regarding the epidemiological situation and might wish to consider the deferral of donors with relevant travel history, in line with measures defined for West Nile virus.

This is the first time that Zika virus infections during pregnancy have been suspected of causing congenital malformations. The information currently available does not allow to confirm a causative link between microcephaly and Zika infection during pregnancy and does not allow quantifying the magnitude of the public health issue.

Further investigations are being conducted to confirm the link between this increase in microcephaly incidence or other neurological malformations and the Zika virus outbreaks in Brazil and French Polynesia.

Actions

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

ECDC published a second [rapid risk assessment](#) on microcephaly in Brazil on 10 December 2015.

States with laboratory-confirmed cases Zika virus disease, Brazil, 2015, as of 5 December 2015

Source: ECDC



Countries with reported confirmed autochthonous cases of Zika virus infection in 2015, as of 24 December

ECDC



Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015

Latest update: 18 December 2015

Epidemiological summary

Recent weeks have seen reports of emerging episodes of communicable diseases affecting the refugee population including shigellosis, scabies, typhoid fever, diphtheria, hepatitis A and tuberculosis. Twenty-seven cases of louse-borne relapsing fever (LBRF) in different locations along the routes followed by refugees arriving in Italy has been a matter of concern.

ECDC assessment

Refugees are not currently a threat for 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

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contract communicable diseases has increased because of the current overcrowding at reception facilities, and the consequent compromising of hygiene and sanitation arrangements.

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 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 low 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.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 10 December 2015

Epidemiological summary

In 2015, wild poliovirus transmission has been at the lowest level ever, with fewer cases reported from fewer countries than ever before. In 2015, 70 wild poliovirus cases were reported from two countries: Pakistan (51 cases) and Afghanistan (19 cases),

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compared with 322 cases from nine countries during the same period in 2014.

In 2015, as of 15 December, 24 cases of circulating vaccine-derived poliovirus (cVDPV) had been reported to WHO, compared with 51 for the same period in 2014. The cases this year are from Madagascar (10), Laos (5), Ukraine (2), Pakistan (2 cases), Nigeria (1), Myanmar/Burma (2) and Guinea* (2).

* Previously reported as cases from Mali.

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

The confirmed circulation of wild poliovirus in several countries and the documented exportation of wild poliovirus to other countries support the fact that there is a potential risk of wild poliovirus being re-introduced to the EU/EEA. The highest risk of large poliomyelitis outbreaks occurs in areas with clusters of unvaccinated populations and in people living in poor sanitary conditions, or a combination of the two.

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.