COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 41, 4-10 October 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Salmonella Stanley - Multistate (EU) - 2012-2015

Opening date: 19 July 2012 Latest update: 11 April 2014

In July 2012, ECDC initiated a Europe-wide investigation of a *Salmonella* Stanley outbreak, affecting more than 400 patients in seven Member States, together with the affected Member States, the European Food Safety Authority (EFSA) and the European Reference Laboratory for *Salmonella* (EURL *Salmonella*). Cases were associated with strains showing an indistinguishable pulsed field gel electrophoresis (PFGE) pattern not previously reported in Europe. Investigations implicated the turkey food production chain as the primary source of the outbreak. Clusters of cases were reported in the following years and are still being reported this year in at least six Member States.

➔Update of the week

As of 8 October 2015, Austria is investigating an increase in the number of *S.* Stanley cases reported since the beginning of the year. About 60% of the cases were part of three clusters, of which two are occurring in Upper Austria and one in Tirol. Molecular typing of isolates showed a PFGE pattern indistinguishable from the strain having caused the multi-country outbreak of *S.* Stanley infections in the European Union from August 2011 to January 2013, and clusters of cases in 2013 and 2014.

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

Opening date: 2 June 2015 Latest update: 8 October 2015

West Nile fever (WNF) is a mosquito-borne disease which causes severe neurological symptoms in a small proportion of infected people. During the June-to-November transmission season, ECDC monitors the situation in EU Member States and neighbouring countries in order to inform blood safety authorities of WNF-affected areas and identify significant changes in the epidemiology of the disease. The 2015 transmission season started later than in previous years and it is still active, but at a lower level than last year. In 2015 in week 41 France reported its first human case of WNV infection since 2003.

➔Update of the week

During the past week, Bulgaria reported a case from the newly affected area of Sofia, a district surrounding the already affected area of Sofia-stolitsa. France reported its first human case of the current transmission season, a confirmed case detected in the department of Gard. Italy reported seven new cases from already affected provinces: Cremona (2), Mantova (2), Modena (1), Pavia (2).

In neighbouring countries, Serbia reported eight new cases, five from two already affected areas: City of Belgrade (4), South Banat (1), and three cases from the newly affected districts of Pcinjski (1), South Backi (1) and Sremski (1).

In addition, new infections in horses have been detected in the autonomous communities of Andalusia and Extremadura in Spain.

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Non EU Threats

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

Opening date: 2 October 2015 Latest update: 8 October 2015

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 its report weekly on the Flu News Europe website. The reporting for the season 2015-2016 starts with week 41.

➔Update of the week

- This is the first weekly influenza report for the season 2015-2016.
- Epidemiological data were reported by 38 countries, all of which reported low intensity.
- Two sentinel specimens tested positive for influenza A virus.

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

Opening date: 24 September 2012 Latest update: 8 October 2015

Since April 2012 and as of 8 October 2015, 1 612 cases of MERS have been reported by local health authorities worldwide, including 620 deaths. The source of the virus remains unknown but the pattern of transmission and virological studies point towards dromedary camels in the Middle East being a reservoir from which humans sporadically become infected through zoonotic transmission. Human-to-human transmission is amplified among household contacts and in healthcare settings, as was clearly shown in the recent outbreak in South Korea. The very recent hospital clusters in Riyadh in Saudi Arabia, and Amman in Jordan, are of concern because of the risk of spread linked to the recent Hajj pilgrimage in Saudi Arabia and to the re-emergence of the disease in Jordan after a couple of years without cases.

➔Update of the week

Since 30 September 2015, there have been two new cases reported. One from Saudi Arabia and one from Jordan.

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

Opening date: 15 June 2005 Latest update: 8 October 2015

The influenza A(H5N1) virus, commonly known as bird flu, is fatal in about 60% of human infections. Sporadic cases continue to be reported, usually after contact with sick or dead poultry from certain Asian and African countries. No human cases have been reported from Europe. From 2003 through 8 October 2015, 844 laboratory-confirmed human cases of avian influenza A (H5N1) virus infection have been officially reported to WHO from 16 countries. Of these cases, 449 have died.

➔Update of the week

No new human cases of A(H5N1) reported since 17 July 2015.

On 2 October, one new A(H7N9) influenza infection was reported from Shaoxing City, Jiangsu Province in China. The case is a 62-year-old female who had exposure to poultry prior to disease onset. She is currently hospitalised in critical condition. This is the first H7N9 influenza infection reported in China since June 2015. Since 31 March 2013, 678 A(H7N9) cases have been reported including 275 deaths. According to WHO, cases have been reported from China (658), Hong Kong (13), Taiwan (4), Canada (2) and Malaysia (1).

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 8 October 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 4 October 2015, WHO has reported 28 421 cases of Ebola virus disease related to the outbreak in West Africa, including 11 297 deaths. The number of cases in the most affected countries peaked in autumn 2014 and has been slowly decreasing since. Liberia was declared Ebola-free by WHO on 3 September 2015. Since the end of July 2015, in Guinea and Sierra Leone, the last two affected countries, case incidence has remained below 10 cases per week and EVD transmission has been geographically confined to small areas in both countries. This week, for the first time since March 2014, no EVD cases have been reported worldwide in a week. The risk of spread, regionally and globally, remains until all the countries in West Africa are declared Ebola-free.

➔Update of the week

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According to the latest WHO situation report published on 7 September 2015, no confirmed cases of EVD were reported in the week up to 4 October in Guinea and Sierra Leone. However, in Guinea 509 contacts remain under follow-up in three prefectures: Conakry, Coyah, and Forecariah and approximately 290 contacts have been identified but have so far proven untraceable in the past 42 days. In Sierra Leone, all identified contacts have now completed follow-up. However, two high-risk contacts remain untraced.

Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 8 October 2015

An outbreak of chikungunya virus infection started in the Caribbean in December 2013 later spreading to the Americas and Pacific region. In 2015, there remained ongoing outbreaks in these regions but at a lower level compared with the same period last year, especially in the Pacific region. So far this year, no autochthonous cases of chikungunya virus infection have been detected in Europe .

➔Update of the week
Ongoing outbreaks are reported in the Caribbean, Americas, Pacific and Africa.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 1 October 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 17 August 2015, the Temporary Recommendations in relation to PHEIC were extended for another three months. WHO recently declared wild poliovirus type 2 eradicated worldwide. As of 7 October 2015, WHO has reported 48 cases of wild poliovirus compared with 221 during the same time period last year. All cases so far in 2015 are reported from Afghanistan and Pakistan.

➔Update of the week
During the past week, WHO reported four new wild poliovirus type 1 (WPV1) cases in Pakistan. No new circulating vaccine-derived poliovirus (cVDPV) cases were reported.

On 30 September 2015, Afghanistan became the final polio-endemic country to introduce the inactivated polio vaccine as part of the biggest globally synchronised vaccine introduction in history.

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II. Detailed reports

Salmonella Stanley - Multistate (EU) - 2012-2015

Opening date: 19 July 2012 Latest update: 11 April 2014

Epidemiological summary

As of 8 October 2015, The Austrian Ministry of Health and the Austrian Agency for Health and Food Safety (AGES) are investigating an increase in the number of cases of *S*. Stanley with antibiotic resistance to nalidixic acid and low-level resistance to ciprofloxacin. Between 1 January and 8 October 2015, 141 cases of non-travel related infection with nalidixic acid/ciprofloxacin resistant *S*. Stanley were identified in eight of the nine Austrian provinces, with the highest number of cases reported in Upper Austria (n=55) and Tyrol (n=46). The age of the cases range from 4 months to 81 years (median age of 19 years) and 95 (67%) are in males; hospitalisation was reported for 45 cases (32%). Eighty cases were part of three clusters defined by time and place (one in January, one from April to June in Upper Austria, and one in July and August in the province Tirol). Descriptive epidemiology and microbiological investigation strongly suggested turkey kebab as the source of at least 36 of these cases. Trace-back analyses by national authorities identified that the implicated turkey meat distributed in the two outlets in Upper Austria and one in Tirol had been supplied by a single food retailer located in Slovakia. The turkey meat of the Slovakian retailer was suspected to originate from a turkey fattening and slaughtering facility in Hungary already involved in an Austrian *S*. Stanley cluster in 2014. PFGE analysis of the isolates from outbreak cases showed indistinguishable PFGE profiles from the strain having caused the multi-country outbreak of *S*. Stanley infections in the European Union from August 2011 to January 2013, and clusters of cases in 2013 and 2014.

In 2015, six countries (Austria, Germany, Hungary, Luxembourg, the Netherlands and Slovenia) uploaded isolates to The European Surveillance System (TESSy) with indistinguishable profile from the outbreak strain (XbaI.0261). PFGE results for two additional EU/EEA countries are pending. TESSy holds information on 5 167 *S*. Stanley cases reported from 2007 to 2014. The median number of cases reported per year is 646, ranging from 418 in 2010 to 979 in 2012. The number of *S*. Stanley cases reported to TESSy more than doubled from 2010 to 2012. The number of non-travel related cases sharply increased in this period, while the number of travel-related cases declined (Figure 1 and Figure 2). When compared with cases reported from 2009 to 2011, cases reported from 2012 to 2014 are strongly associated with a lack of travel history (p-value <0.001) and with foodborne transmission (p-value <0.001).

TESSy holds molecular typing information on isolates submitted from 1990 to 2015. The *S*. Stanley PFGE profile associated with the outbreak in 2011-2013 (UI-166) and with clusters in 2013 and 2014 was reported for the first time in August 2012. Seventy-two isolates submitted from nine Member States showed this PFGE profile from 2012 to 2015. Three multi-country clusters with this PFGE profile have been detected in TESSy, in the third quarter of 2012, in the first and second quarters of 2014 and in the first three quarters of 2015. The discriminatory power of PFGE is high for *S*. Stanley (D=0.95).

From 2007 to 2014, the proportion of isolates resistant to nalidixic acid among *S*. Stanley cases increased markedly from 10% in 2010 to 68% in 2011, and continued to increase in the following four years up to 90% in 2014. The resistance to nalidixic acid in *S*. Stanley became more common within the EU/EEA since 2011, whereas the proportion of nalidixic resistant isolates among cases acquired outside of the EU/EEA remained constant from 2007 to 2014. The proportion of isolates resistant to both nalidixic acid and ciprofloxacin was low (range 1-17%) until 2014 when it reached 77.9%. Variation in ciprofloxacin resistance should be interpreted with caution due to change in EUCAST recommendations on antimicrobial testing and clinical break-points. The 2015 strains are resistant to nalidixic acid and exhibit low-level resistance to ciprofloxacin. The 2011-2012 outbreak strain was resistant to nalidixic acid only, however considering the revision of the EUCAST recommendations, the resistance pattern can be considered identical.

ECDC assessment

The increase in the number of *S*. Stanley cases reported in Austria in 2015 is suspected to be associated with the same turkey fattening and slaughtering facility in Hungary, previously implicated with *S*. Stanley cases reported in Austria in 2014. The PFGE pattern of cases reported in 2015 in Austria and in five other EU Member States is indistinguishable from the strains associated with outbreaks and clusters reported from 2012 to 2014. A descriptive analysis of TESSy case-based and isolate-based data shows a large increase in the number of non-travel related cases and in isolates indistinguishable from the outbreak strains from 2012 to 2014. These different pieces of information suggest that the strain causing outbreaks and clusters in previous years is still circulating and that additional sporadic or cluster cases are to be expected. As per the last ECDC and EFSA rapid outbreak assessment, ECDC and EFSA recommend that further actions should be taken by risk managers in countries to detect and contain *S*. Stanley infections in the turkey production chain, thus avoiding the subsequent contamination of turkey meat.

Actions

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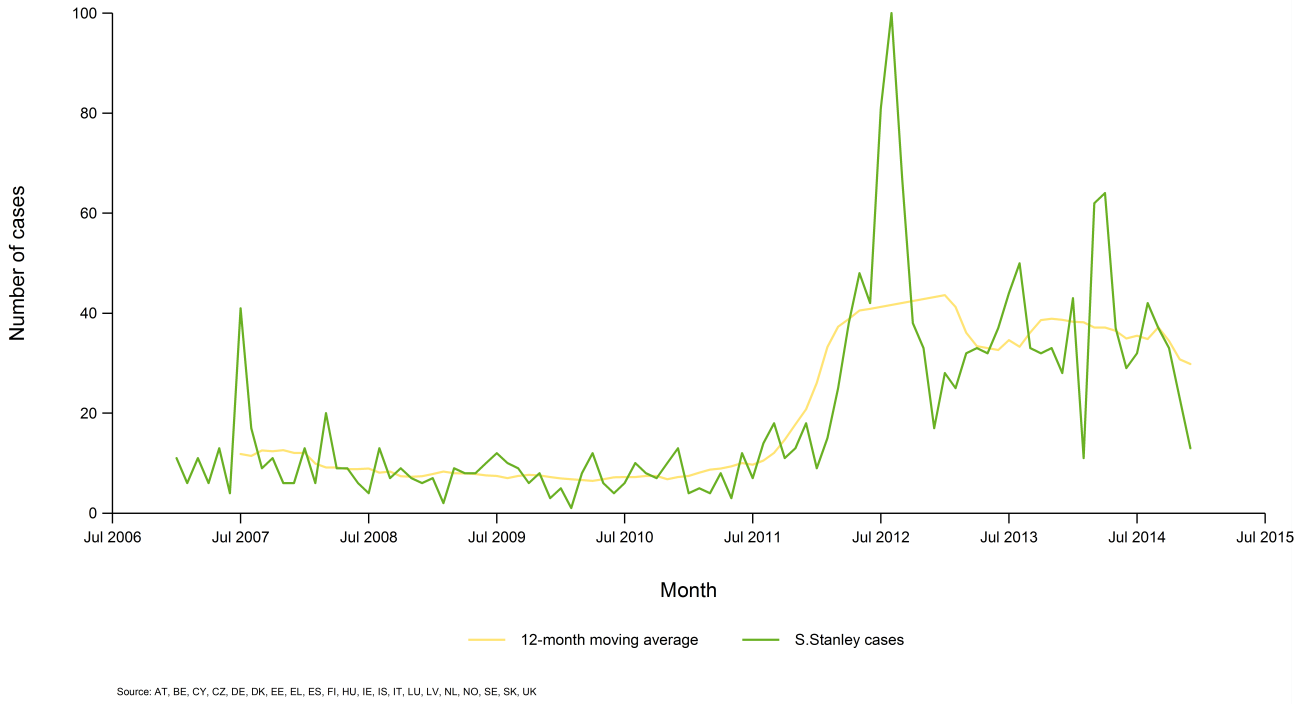
ECDC will continue monitoring the situation through the Epidemic Intelligence Information System - Food- and Waterborne Diseases (EPIS-FWD). ECDC encourages EU Member States to report any increase in the number of non-travel-related *S.* Stanley cases through EPIS-FWD, and to upload to TESSy isolates for PFGE and anti-microbial resistance comparison.

Salmonella Stanley non-travel related cases, EU/EEA 2007-2014 (n=1 895)

Source: ECDC



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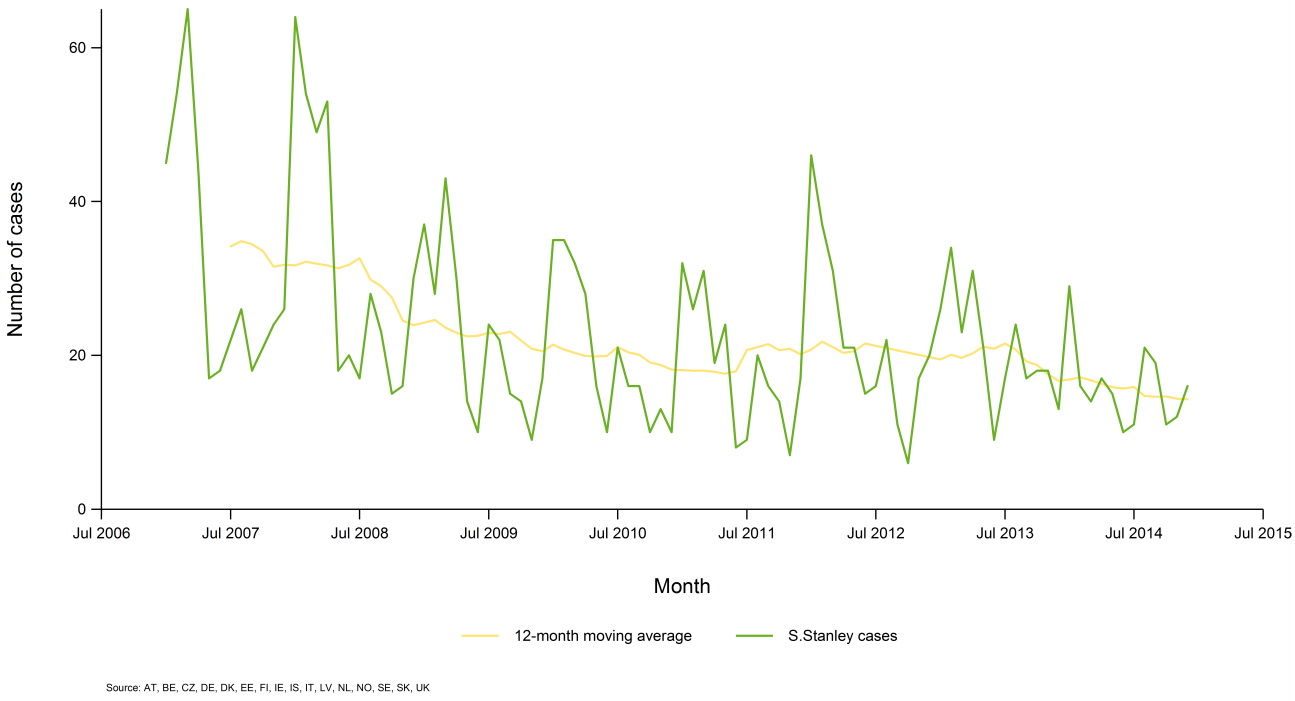
Salmonella Stanley travel related cases, EU/EEA 2007-2014 (n=2 201)

Source: ECDC



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

Opening date: 2 June 2015 Latest update: 8 October 2015

Epidemiological summary

As of 8 October 2015, 96 cases of West Nile fever in humans have been reported in the EU Member States this season: Italy (58), Romania (16), Austria (6), Hungary (12), Bulgaria (2), France (1) and Portugal (1). Since the beginning of the 2015 transmission season, 105 cases have been detected in neighbouring countries: Israel (64), Russia (16), Serbia (24) and Palestine (1) .

Web sources: ECDC West Nile fever | ECDC West Nile fever risk assessment tool | ECDC West Nile fever maps | WHO fact sheet

ECDC assessment

WNF in humans is a notifiable disease in the EU. The implementation of control measures is considered important by the national health authorities for ensuring blood safety when human cases of WNF fever occur. According to the EU Blood Directive, efforts should be made to defer blood donations from affected areas with ongoing virus transmission, unless donations are tested using individual nucleic acid amplification testing (NAAT).

Actions

ECDC produces weekly WNF maps during the transmission season (June to November) to inform blood safety authorities of WNF affected areas.

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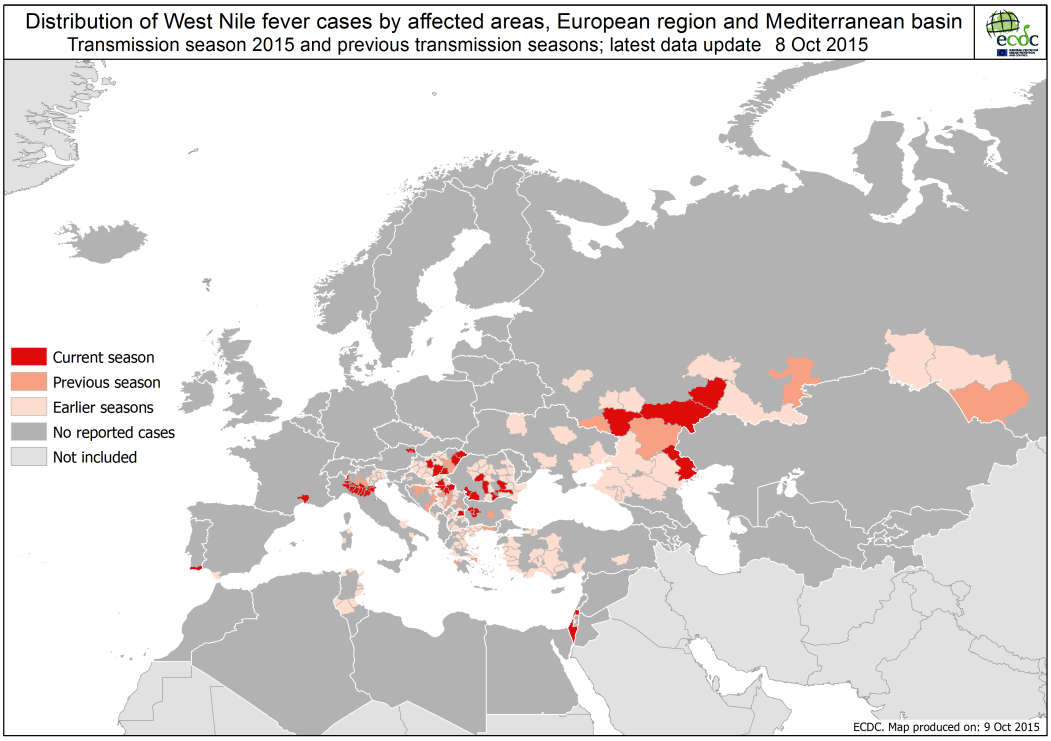
Source: ECDC



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

Opening date: 2 October 2015 Latest update: 8 October 2015

Epidemiological summary

This is the first weekly influenza report for the season 2015-2016.
Epidemiological data were reported by 38 countries, all of which reported low intensity.
Two sentinel specimens tested positive for influenza A virus.

ECDC assessment

As is usual for this time of year, influenza activity in the European Region is very low even though there are some indications of influenza activity from sentinel and non-sentinel sources.

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: 8 October 2015

Epidemiological summary

As of 8 October, 1 612 cases of MERS-CoV have been reported by local health authorities worldwide, including 620 deaths.

Saudi Arabia
The newly reported case this week is a 38-year-old male from Riyadh, Saudi Arabia with no contact to a previously reported case.

Jordan
One additional case of MERS-CoV has been reported from Amman, Jordan in a 53-year-old male, who is the contact of a previous

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case.

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, secondary transmission to unprotected close contacts, especially in healthcare settings, remains possible, as documented in a recent outbreak in South Korea or Saudi Arabia.

Countries should advise travellers returning from countries affected by MERS to seek medical attention if they develop a respiratory illness with fever and cough during the two weeks after their return and to disclose their recent travel history to the healthcare provider. Travellers, especially those with pre-existing medical conditions, should be reminded of the importance of good hand and food hygiene, and to avoid contact with sick people. Travellers to the Arabian Peninsula should avoid close contact with camels, visiting farms and consuming unpasteurised camel milk, urine or improperly cooked meat.

Actions

ECDC published a rapid risk assessment on 27 August 2015 and an epi update on 2 September 2015.

MERS-CoV by country of reporting, March 2012 – 8 October 2015 (n=1 612)

Source: ECDC

Region	Country	Number of cases	Number of deaths
Middle East	Saudi Arabia	1251	536
	United Arab Emirates	81	11
	Qatar	13	5
	Jordan	35	13
	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	36
	China	1	0
	Thailand	1	0
Americas	United States of America	2	0
	Global	**1612**	**620**

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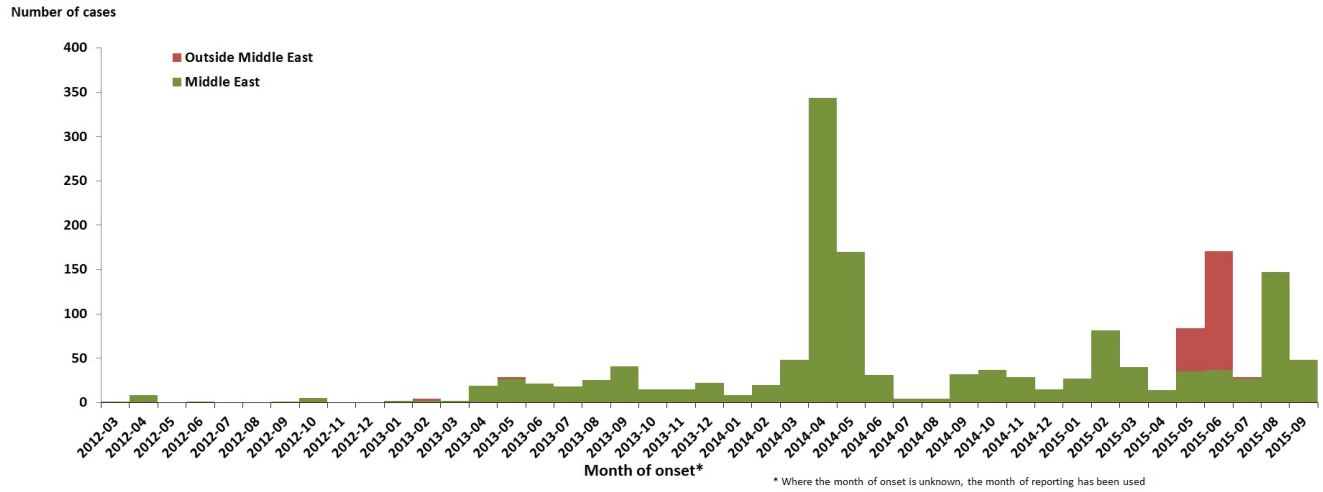
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 8 October 2015 (n=1 612)

Source: ECDC



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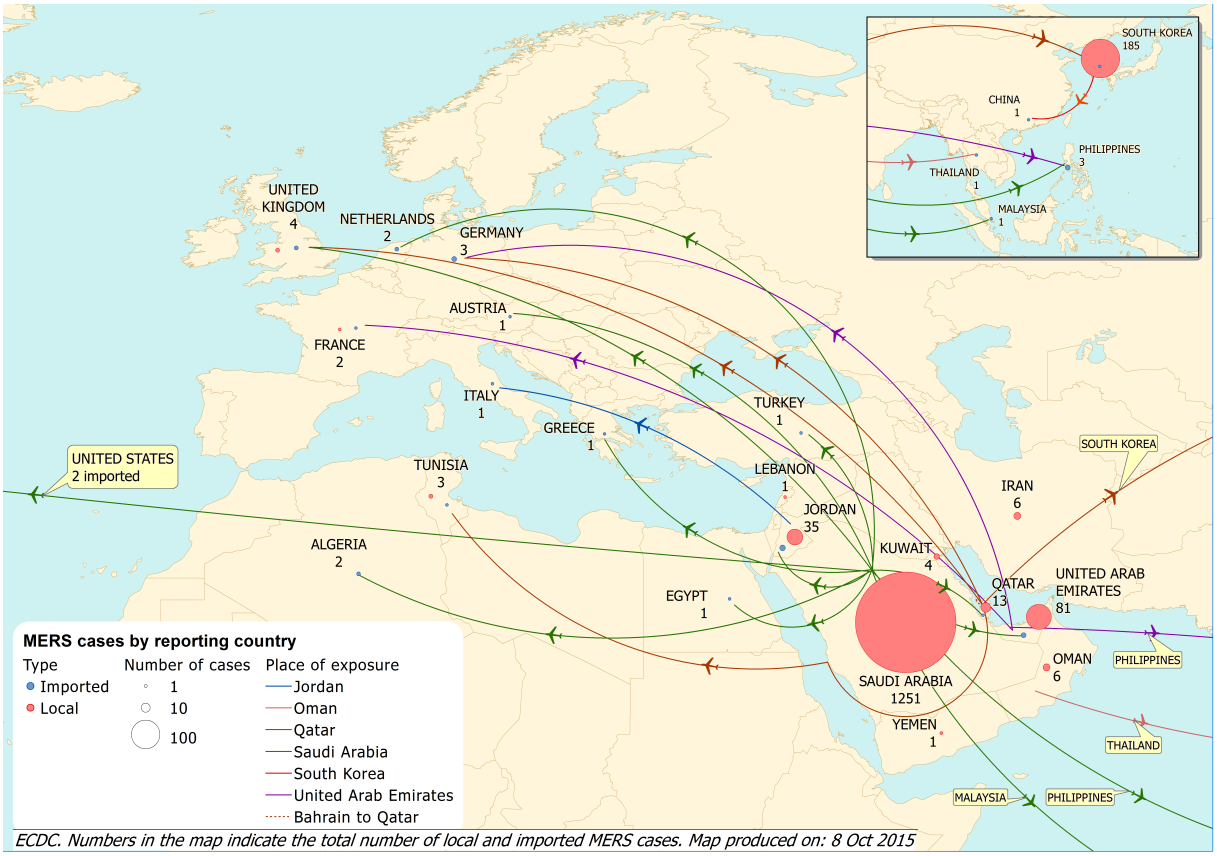
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 8 October 2015 (n=1 612)

Source: ECDC



ECDC. Numbers in the map indicate the total number of local and imported MERS cases. Map produced on: 8 Oct 2015

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

Opening date: 15 June 2005 Latest update: 8 October 2015

Epidemiological summary

Update: No new update from WHO on human cases of influenza A(H5N1) virus since 17 July 2015.

On 2 October, one new A(H7N9) influenza infection was reported from Shaoxing City, Jiangsu Province in China. The case is a 62-year-old female who had exposure to poultry prior to disease onset. She is currently hospitalised in critical condition. This is the first H7N9 influenza infection reported in China since June 2015. Since 31 March 2013, 678 A(H7N9) cases have been reported including 275 deaths. According to WHO, cases have been reported from China (658), Hong Kong (13), Taiwan (4), Canada (2) and Malaysia (1).

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Summary: From 2003 through to 8 October 2015, 844 laboratory-confirmed human cases of avian influenza A(H5N1) virus infection have been officially reported to WHO from 16 countries. Of these cases, 449 have died.

Outbreaks in birds
Various influenza A(H5) subtypes, such as influenza A(H5N1), A(H5N2), A(H5N6) and A(H5N8), continue to be detected in birds in Africa and Asia, according to reports received by World Organisation for Animal Health (OIE).

Web sources: ECDC Rapid Risk Assessment | Avian influenza on ECDC website |EMPRES | OIE | WHO

ECDC assessment

Most human infections of A(H5N1) and A(H7N9) are the result of direct contact with infected birds or contaminated environments, and countries with large poultry populations in close contact with humans are considered to be most at risk of bird flu outbreaks. Therefore, additional human cases are not unexpected. There are currently no indications of a significant change in the epidemiology associated with any clade or strain of the A(H5N1) and A(H7N9) virus from a human health perspective. However, vigilance for avian influenza in domestic poultry and wild birds in Europe remains important.

Although an increased number of animal-to-human infections was reported by Egypt during the first half of 2015, this increase is not thought to be related to virus mutations but rather to more people becoming exposed to infected poultry.

Various influenza A(H5) and A(H7) subtypes, such as influenza A(H5N1), A(H5N2), A(H5N3), A(H5N6), A(H5N8), A(H5N9) and A (H7N3), have recently been detected in birds in West Africa, Asia, Europe, and North America, according to OIE. Although these influenza viruses might have the potential to cause disease in humans, to date, there have been no reported human infections with these viruses with the exception of human infections with influenza A(H5N1) and A(H5N6) viruses. The risk to people from these infections in wild birds, backyard flocks and commercial poultry is considered to be low.

Actions

ECDC monitors the worldwide A(H5N1) situation through epidemic intelligence activities on a monthly basis in order to identify significant changes in the epidemiology of the virus. ECDC re-assesses the potential of a changing risk for A(H5N1) to humans on a regular basis.
ECDC published a Rapid Risk Assessment covering A(H5N1) in Egypt on 13 March 2015.
ECDC published an epidemiological update about A(H5N1) in Egypt on 10 April 2015.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 8 October 2015

Epidemiological summary

Distribution of cases as of 4 October 2015:

Countries with intense transmission:

- **Guinea:** 3 804 cases, of which 3 344 were confirmed; 2 534 deaths.
- **Sierra Leone:** 13 945 cases, of which 8 704 were confirmed; 3 955 deaths.

Countries with previously widespread and intense transmission:

- **Liberia**: declared Ebola-free on 3 September 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
509 contacts remain under follow-up in three prefectures: Conakry, Coyah, and Forecariah. All these contacts are associated with one chain of transmission centred on Ratoma area in Conakry. In addition, approximately 290 contacts have been identified but

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have so far proven untraceable in the past 42 days. The four most recent cases in Guinea, from two villages in Forecariah, were infected by an unregistered contact of a probable case linked to the Ratoma chain of transmission.
The ring vaccination trial is continuing in Guinea. All rings comprised contacts, and contacts of contacts associated with confirmed cases now receive immediate vaccination with the rVSV-ZEBOV Ebola vaccine.

Sierra Leone
Sierra Leone reported no confirmed cases for the third consecutive week. All identified contacts have now completed follow-up. However, two high-risk contacts, one from Bombali and one from Kambia, remain untraced.
The ring vaccination Phase 3 efficacy trial of the rVSV-ZEBOV vaccine has been extended from Guinea to Sierra Leone.

Situation among healthcare workers
No new health worker infections were reported by WHO in the week up to 4 October.

Outside of the three most affected countries, 2 Ebola-infected healthcare workers were reported in Mali, 11 in Nigeria, 1 in Spain (infected while caring for an evacuated EVD patient), 2 in the UK (both infected in Sierra Leone), 6 in the USA (2 infected in Sierra Leone, 2 in Liberia, and 2 infected while caring for a confirmed case in Texas) and 1 in Italy (infected in Sierra Leone).

Images
- Epicurve 1: the epicurve shows the confirmed cases in the three most affected countries. In order to better represent the tail of the epidemic, only the data for 2015 are shown.
- Epicurve 2: the epicurve shows the confirmed cases in Guinea and Sierra Leone. In order to better represent the tail of the epidemic, only the data for 2015 are shown.
- Map: this map is based on country situation reports and shows only confirmed cases of EVD in the past six weeks.

Web sources: ECDC Ebola page | ECDC Ebola and Marburg fact sheet | WHO situation summary | WHO Roadmap | WHO Ebola Factsheet | CDC | 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 and for the first time since March 2014, no EVD cases have been reported during the week. The introduction of an EVD case into unaffected countries remains a risk as long as cases exist in any country. With adequate preparation, however, such an introduction can be contained through a timely and effective response. This week, WHO IHR Emergency Committee on Ebola was concerned that 34 countries continue to enact measures that are disproportionate to the risks posed.

Actions

As of 2 October 2015, ECDC has deployed 96 experts (on a rotating basis) from within and outside the EU in response to the Ebola outbreak. This includes an ECDC-mobilised contingent of experts to Guinea. Furthermore, additional experts are already confirmed for deployment to Guinea over the next few months.

The latest (12th) update of the rapid risk assessment was published on 1 July 2015.
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

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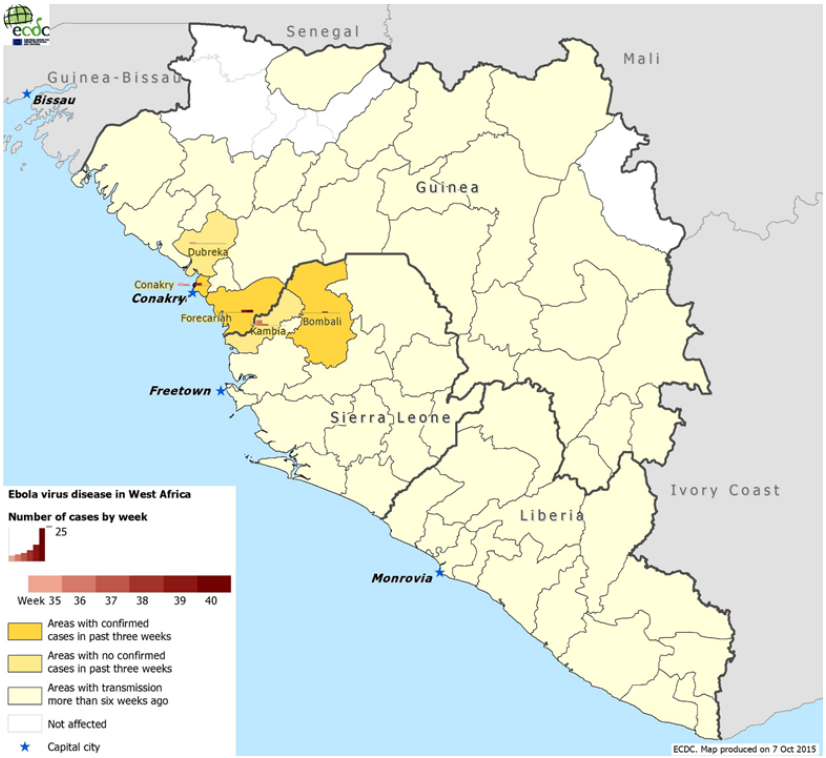
the EU.
On 22 October 2014, ECDC published Assessing and planning medical evacuation flights to Europe for patients with Ebola virus disease and people exposed to Ebola virus.
On 13 October 2014, ECDC published Infection prevention and control measures for Ebola virus disease: Entry and exit screening 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 Sierra Leone (as of week 40/2015)

Adapted from national situation reports



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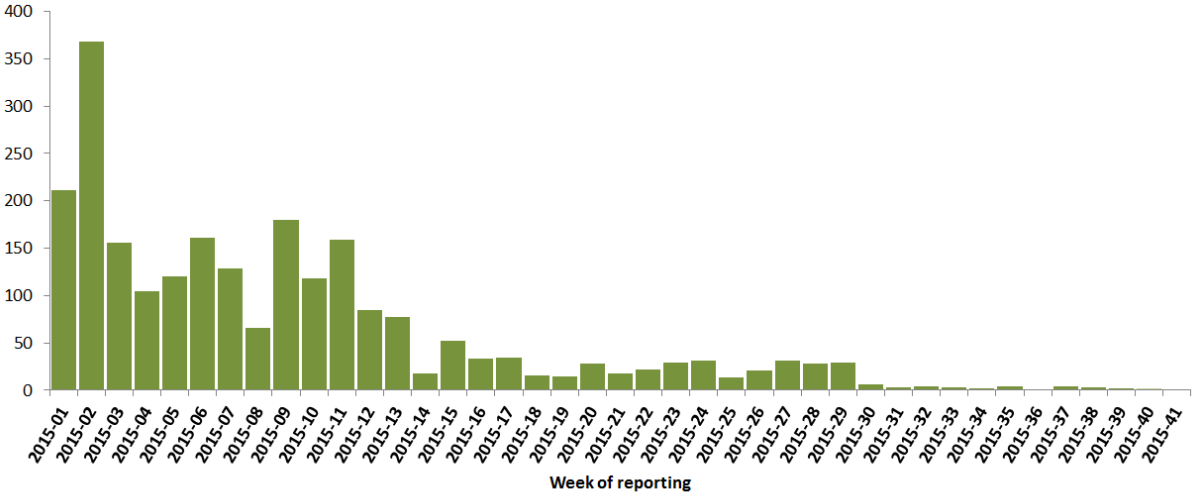
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 01/2015 to 41/2015)

Adapted from WHO figures; *data for week 41/2015 are incomplete



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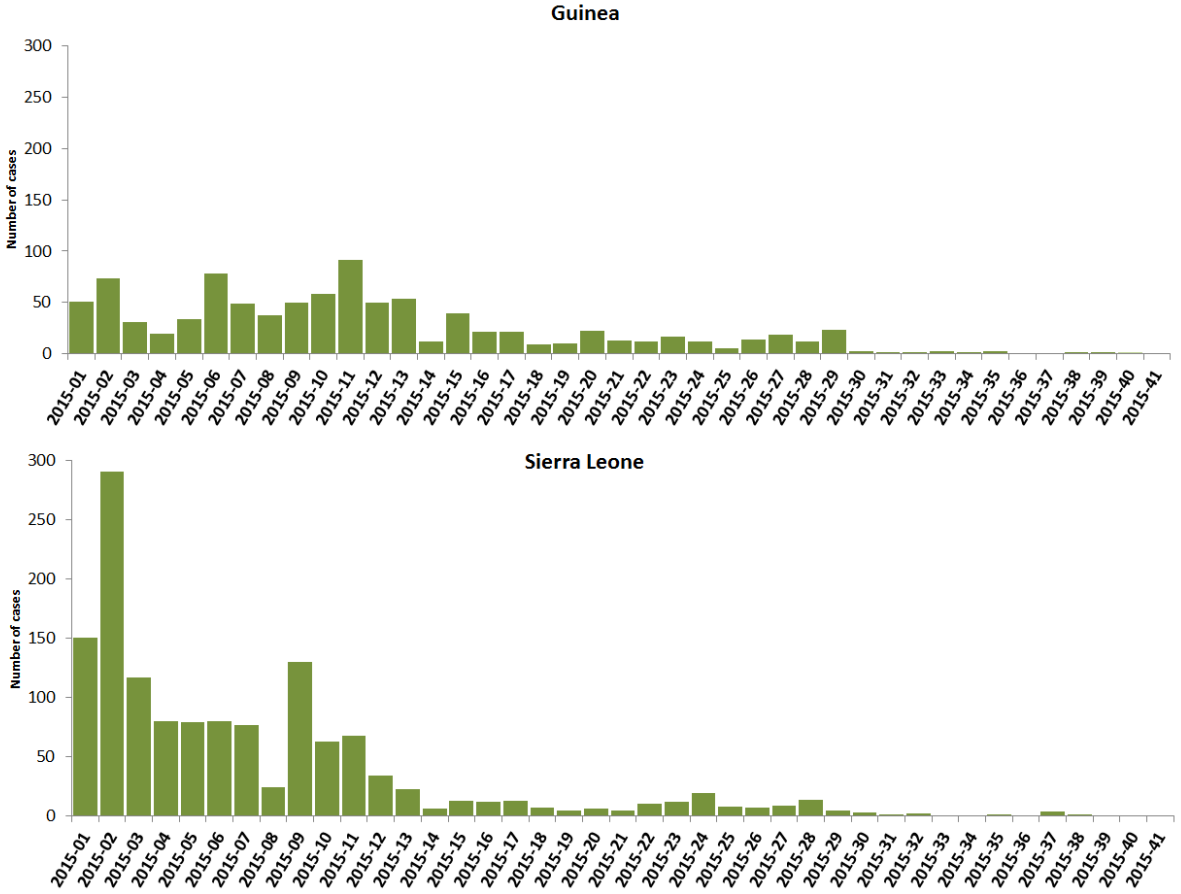
Distribution of confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (weeks 01/2015 to 41/2015)

Adapted from WHO figures; *data for week 41/2015 are incomplete



Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 8 October 2015

Epidemiological summary

Europe

France

Between 1 May and 2 October 2015, 25 imported cases of chikungunya virus infection were reported in France in the areas where the vector is present. No autochthonous cases of chikungunya were notified, according to InVS.

Americas

Chikungunya cases in the Caribbean and the Americas continued to increase during the past couple of weeks. According to the latest update from the WHO Pan American Health Organization (WHO PAHO) on 2 October 2015, 17 114 new cases (suspected and confirmed) have been reported since 18 September. Since the beginning of the year and as of 2 October 2015, PAHO has reported 591 534 suspected and confirmed cases of chikungunya virus infection and 62 deaths in the WHO Region of the Americas. The cumulative number of cases has reached 1 739 354 since the start of the epidemic in December 2013.

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The highest number of cases were reported in **Brazil** and **Colombia** in the past two weeks with 3 037 and 2 902 new suspected and confirmed cases recorded respectively.

USA
As of 6 October 2015, 501 chikungunya virus disease cases have been reported from 39 US states so far this year, according to the US CDC. All reported cases occurred in travellers returning from affected areas. No locally-transmitted cases have been reported. In addition, 116 chikungunya cases have been reported from US territories. All reported cases were locally-transmitted cases reported from **Puerto Rico** and the **US Virgin Islands**.

Pacific region
As of 2 October 2015, the **Marshall Islands** are experiencing ongoing but decreasing outbreaks according to the Pacific Public Health Surveillance Network.

Africa
In **Senegal**, as of 30 September 2015, 31 cases of chikungunya virus infection have been reported in the Kédougou region (Southeast) since active circulation started on 27 August, according to media quoting the Ministry of Health and Social Action (MSAS). The last active circulation in this area was reported in 2009 and 2010, according to WHO.

Web sources: PAHO update| ECDC Chikungunya | WHO Factsheet | Medisys page |

ECDC assessment

Outbreaks are still ongoing in the Caribbean and Americas. Cases continued to moderately increase in the past two weeks but at a lower level compared with the same period last year. The vector is endemic in these regions, where it also transmits dengue virus. Continued vigilance is needed to detect imported cases of chikungunya in tourists returning to the EU from these regions.

Europe is vulnerable to the autochthonous transmission of chikungunya virus. The risk for onward transmission in Europe is linked to importation of the virus by viraemic patients in areas with competent vectors (*Aedes albopictus* in mainland Europe, primarily around the Mediterranean, and *Aedes aegypti* on Madeira). Autochthonous transmission from an imported viraemic chikungunya case is possible during the summer season in the EU .

Actions

ECDC published an epidemiological update on 16 September regarding the false positive case of chikungunya in Valencia province, Spain. Despite the fact that autochthonous transmission has not been confirmed in Spain, the conclusions of ECDC's rapid risk assessment published on 24 August remain valid.

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

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 1 October 2015

Epidemiological summary

Worldwide in 2015 so far, 48 wild poliovirus type 1 (WPV1) cases have been reported to WHO, compared with 221 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (36 cases) and Afghanistan (12 cases).

In 2015 so far, 13 cases of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO, compared with 36 for the same period in 2014 from Madagascar (9), Nigeria (1), Ukraine (2) and Mali (1).

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

ECDC assessment

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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 both.

References: ECDC latest RRA | Rapid Risk Assessment on suspected polio cases in Syria and the risk to the EU/EEA | Wild-type poliovirus 1 transmission in Israel - what is the risk to the EU/EEA? |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 in Ukraine of circulating vaccine-derived poliovirus type 1, ECDC published a rapid risk assessment on its website.

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

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