COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 46, 8-14 November 2015

All users

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: 13 November 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 has started.

➔Update of the week

In week 45, influenza activity across the WHO European Region was at low levels in most of the 42 countries that reported data.

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

Opening date: 2 June 2015 Latest update: 12 November 2015

The 2015 transmission season started later than in previous years and is still active, but at a lower level than last year. In week 41, France reported its first human case of West Nile virus infection since 2003. During weeks 45 and 46, no cases were reported in the EU, but cases are still being reported in Israel with 32 cases notified week 46.

➔Update of the week

During the past week, no new cases were reported in EU Member States. In neighbouring countries, Israel reported 32 new cases, 22 cases in the already affected areas of Central district (6), Haifa (7) Northern district (1) and Southern district (8); four cases in the newly affected district of Jerusalem and six cases whose probable place of infection is unknown.

Non EU Threats

Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015 Latest update: 13 November 2015

Europe is experiencing its largest influx of refugees since the Second World War. According to the UNHCR, there have been almost 800 000 arrivals in Europe in 2015. To date, there have been reports of cases of louse-borne relapsing fever, cutaneous diphtheria and malaria among the refugees. While at the moment these cases do not represent a significant disease burden, the diseases do pose a potential threat, particularly to the health of the refugees themselves.

➔Update of the week

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This week, eight cases of louse-borne relapsing fever among migrants were reported in *Emerging Infectious Diseases* (EID). The cases occurred in Italy between June and September 2015.

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

Opening date: 24 September 2012 Latest update: 12 November 2015

Since April 2012 and as of 12 November 2015, 1 637 cases of MERS, including 633 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 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

On 12 November, Saudi authorities reported one confirmed case of MERS in a 47-year-old male from Riyadh. The case is considered by authorities as a secondary case, healthcare-acquired.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 13 November 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 3 November 2015, WHO has reported 28 581 cases of Ebola virus disease related to the outbreak in West Africa, including 11 299 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 and Sierra Leone on 7 November. Guinea has not reported any cases in the past week. The risk of spread, regionally and globally, remains until all the countries in West Africa are declared Ebola-free.

➔Update of the week

According to WHO, there have been no confirmed cases in Guinea in the week up to 8 November. Sierra Leone was declared Ebola-free on 7 November.

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 12 November 2015

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, 681 cases have been reported up until 12 November 2015, including 275 deaths. No autochthonous cases have been reported outside of China. Most cases have been unlinked, and sporadic zoonotic transmission from poultry to humans is the most likely explanation for the outbreak.

➔Update of the week

Since October 2015 four cases have been found in Zhejiang, China. Among these four cases, two were reported by the media in week 46 and they have not yet been acknowledged by WHO.

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 12 November 2015

Dengue fever is one of the most prevalent vector-borne diseases in the world. It affects an estimated 50 to 100 million people each year, mainly in the tropical regions of the world. The identification of sporadic autochthonous cases in non-endemic areas in recent years has already highlighted the risk of locally-acquired cases occurring in EU countries where the competent vectors are present. On 12 November 2015, WHO announced an outbreak of dengue fever in Assuit Governorate in Egypt. Between 1 and 31 October 2015, 253 cases were hospitalised due to acute febrile illness. Twenty-eight out of 118 serum samples were positive for DENV-1.

➔Update of the week

There are several ongoing outbreaks of dengue fever across the globe.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 13 November 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 12 November 2015, WHO has reported 52 cases of wild poliovirus compared with 278 during the same time period last year. All cases so far in 2015 have been reported from Afghanistan and Pakistan.

➔Update of the week

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One new wild poliovirus case was reported in the past week in Pakistan and one new case of circulating vaccine-derived poliovirus type 1 (cVDPV1) in Laos.

On 10 November it had been three years without a new wild poliovirus type 3 (WPV3) infection in the world.

The Emergency Committee of the International Health Regulations (IHR) met this week by teleconference to determine whether the current epidemiology continues to represent a public health emergency of international concern, and whether to maintain the temporary recommendations associated with it for a further three months. The Committee's report is expected to be published by early next week.

An outbreak response started in Ukraine in October with supplementary immunisation activities taking place in every oblast. The next few weeks will be critical in terms of continued political support and oversight to ensure all children are reached with the vaccines.

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II. Detailed reports

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

Opening date: 2 October 2015 Latest update: 13 November 2015

Epidemiological summary

In line with the low activity, influenza viruses were detected in 45 patients only: seven from sentinel influenza-like illness (ILI) sources, 36 from non-sentinel sources and two laboratory-confirmed influenza cases in hospitalised patients. Representatives of all seasonal influenza viruses (A(H1N1)pdm09, A(H3N2) and B) were detected.

ECDC assessment

As is usual at this time of year, influenza activity in the European Region is low, with few influenza viruses detected.

Actions

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

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

Opening date: 2 June 2015 Latest update: 12 November 2015

Epidemiological summary

As of 12 November 2015, 106 human cases of West Nile fever have been reported in EU Member States and 174 cases in the neighbouring countries, since the beginning of the 2015 transmission season.

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 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

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. 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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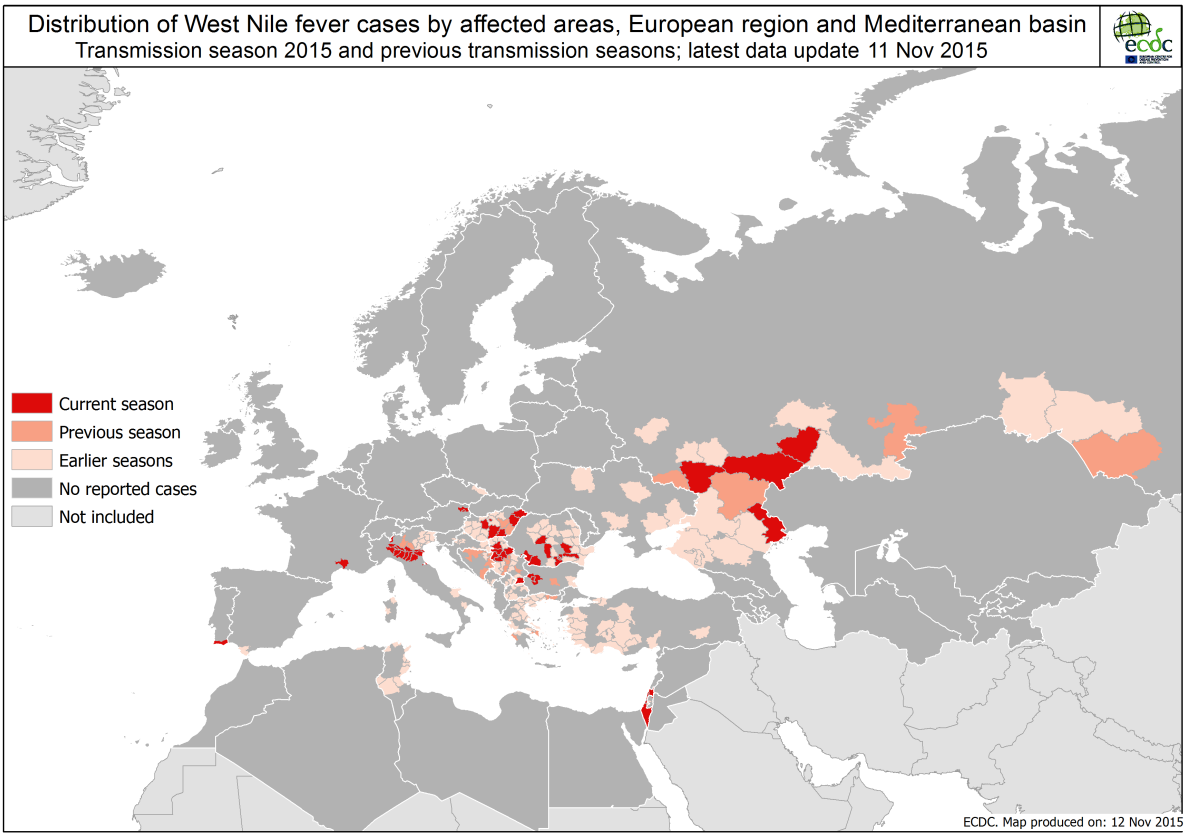
Source: ECDC



Public health risks - Multistate - Refugee movements

Opening date: 4 November 2015 Latest update: 13 November 2015

Epidemiological summary

Louse-borne relapsing fever (LBRF)

Twenty-seven LBRF cases have been identified in the EU in recent months among refugees from the Horn of Africa.

Italy

Five of the eight cases reported in EID this week occurred in Turin among refugees from Somalia, with onset of symptoms between 7 June and 26 September. Two of the cases had been residing in Italy since 2011 without recent travel to LBRF-endemic areas. The three other cases travelled through Kenya, Uganda, Sudan and Libya, where two of them stayed in a crowded environment. Two of the cases developed symptoms suggestive of a Jarisch-Herxheimer reaction (JHR). All five patients were hospitalised.

Three additional cases among Somali migrants were diagnosed in Sicily (Palermo, Lampedusa and Trapani) between 11 July and 4 September. All three, one 13-year-old and two 17-year-olds, had onset of symptoms within two to six days after arrival in Italy from Libya. The patients did not associate with each other during their journey towards Italy. As the incubation period of LBRF is

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usually between four and eight days (range 2–15 days), it is likely that patients were infested with body lice and infected with *B. recurrentis* in countries prior to their arrival in Italy. However, the time and place of exposure are unknown.

Other countries that have reported LBRF cases

Four additional countries have reported LBRF among asylum seekers from the Horn of Africa during the period July-October 2015: Germany (15 cases), the Netherlands (2 cases), Switzerland (1 case) and Finland (1 case). The cases reported in Germany had travelled through Sudan, Libya and Italy.

Cutaneous diphtheria

In July 2015, three EU countries (Denmark, Germany and Sweden) reported seven cases of toxigenic cutaneous diphtheria and two cases of non-toxigenic cutaneous diphtheria among refugees in 2015. For the toxigenic cutaneous diphtheria cases, the countries of origin are Eritrea (4), Libya (1), Ethiopia (1) and Syria (1).

Malaria

On 16 October, Sweden posted an EWRS message aimed at raising awareness about the possibility of *Plasmodium vivax* malaria infection among refugees from Syria. A Syrian child was diagnosed with *Plasmodium vivax* malaria in a Swedish hospital on 8 October. The child arrived in Sweden with its family on 15 September after a journey that started on 31 August. On their way to Sweden, they travelled through Turkey, Greece, the former Yugoslav Republic of Macedonia, Serbia, Hungary and Austria. During the trip, they spent several nights in camps with refugees from different countries. It is not known where the child was infected with malaria. Syria has been declared malaria-free, but this status may have changed in recent years. Turkey and Greece have experienced limited autochthonous transmission in recent years, with the most recent autochthonous cases in Greece in 2015.

Cholera

According to the media, quoting the UNICEF Representative in Iraq, the cholera outbreak in Iraq, which has infected at least 2 200 people with six fatalities, has spread to neighbouring Kuwait, Bahrain and possibly Syria. The Ministry of Health in Bahrain has announced that seven patients have been found to be infected with cholera, including a woman who was diagnosed in Kuwait. One case of cholera was reported by the media in an Omani traveller returning from Iraq. On 10 November, the media reported three confirmed cases in two Syrian cities, Aleppo and Deir ez-Zor in the eastern part of the country. However, WHO at this stage is not confirming that cases of cholera have been confirmed in Syria.

Scabies

Media reports have described outbreaks of scabies in refugee accommodation centres across Europe.

Tuberculosis

In France, according to the French Ministry of Health, four cases of tuberculosis have been diagnosed among refugees in Calais.

Source: EID I | EID II | RKI | Eurosurveillance I| Eurosurveillance II | UNHCR | ScienceDirect | Reuters |Media I | Media II | French MoH

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 to refugees arriving in Europe of contracting 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 diseases whose spread are facilitated by overcrowding and lower temperatures has increased as a result of the likely increased close gathering of refugees seeking shelter from the cold weather. It is therefore expected that the incidence of respiratory and gastrointestinal conditions will increase in the coming months.

Recent weeks have seen reports of emerging episodes of communicable diseases affecting the refugee population. Of concern is the emergence of 27 cases of louse-borne relapsing fever in different locations along the route that the refugees arriving in Italy are following. The probable transmission of LBRF among refugee communities in the EU indicates that more cases may be seen in the near future, unless appropriate hygiene measures are implemented rapidly.

Low coverage for some vaccines, along with low immunity for some diseases, may result in susceptible refugees developing

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diseases such as measles and chicken pox, given the high incidence of these in some areas of the EU.

The risk to European residents of being affected by outbreaks occurring among refugee populations remains extremely low since the hygiene levels, overcrowding and limited access to clean water responsible for their transmission are specific to the reception facilities in which they are occurring.

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

ECDC is preparing a rapid risk assessment on the risk of communicable disease outbreaks in refugee populations in the EU/EEA.
ECDC is updating the RRA on louse-borne relapsing fever in the Netherlands published on 24 July 2015.
ECDC published an RRA on cutaneous diphtheria among recently arrived refugees and asylum seekers in the EU on 30 July 2015.
ECDC published 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 on 22 October 2015.

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

Opening date: 24 September 2012 Latest update: 12 November 2015

Epidemiological summary

As of 12 November, 1 638 cases of MERS, including 633 deaths, have been reported by local health authorities worldwide.

Possible nosocomial cluster in Hofuf, Saudi Arabia
During the month of October 2015 eight cases occurred in Hofuf, Saudi Arabia. Among these cases there were two male primary cases, two female expatriate healthcare workers and four nosocomial cases in patients. Of these eight cases, four have died.

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 a rapid risk assessment on 21 October 2015.

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Cases of MERS-CoV by country of reporting, March 2012 – 12 November 2015 (n=1 638)

Source: ECDC

Region	Country	Number of cases	Number of deaths
Middle East	Saudi Arabia	1277	547
	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	37
	China	1	0
	Thailand	1	0
Americas	United States of America	2	0
	Global	**1638**	**633**

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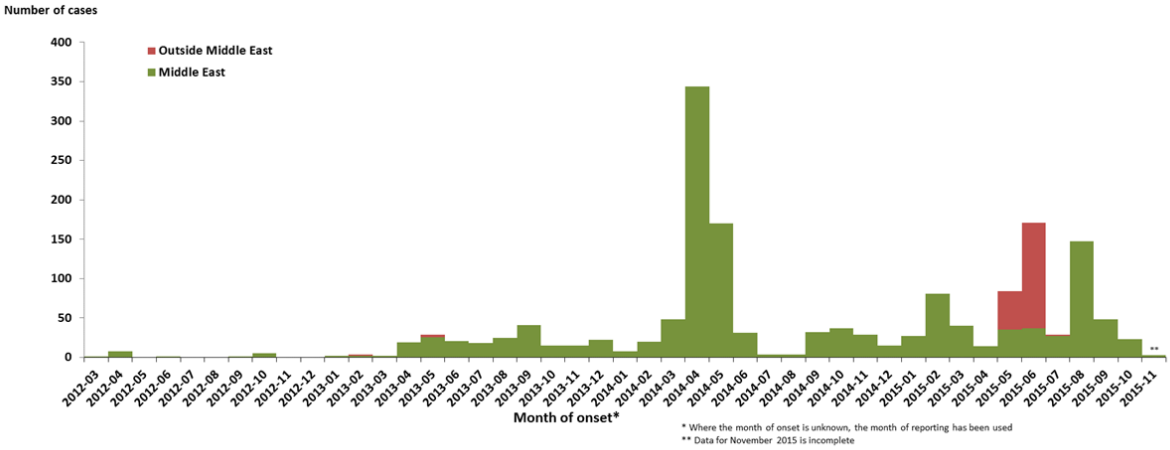
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 12 November 2015 (n=1 638)

Source: ECDC



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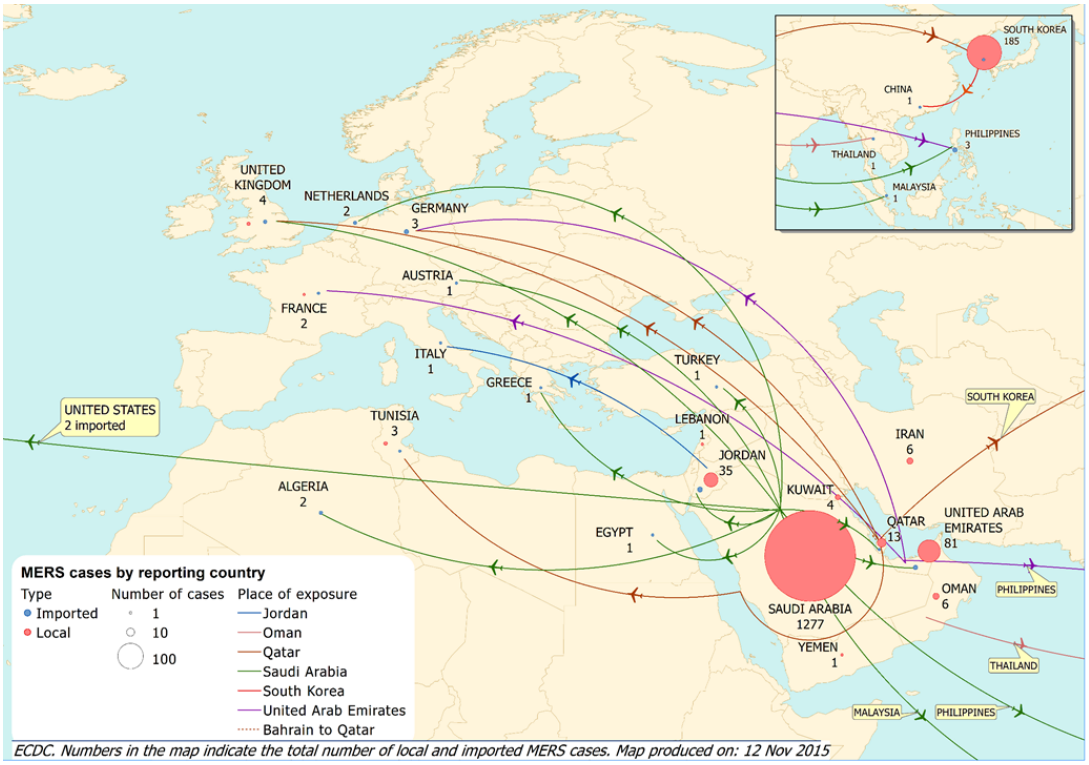
Distribution of confirmed cases of MERS-CoV by place of probable infection, March 2012 – 12 November 2015 (n=1 638)

Source: ECDC



ECDC. Numbers in the map indicate the total number of local and imported MERS cases. Map produced on: 12 Nov 2015

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 13 November 2015

Epidemiological summary

Distribution of cases as of 8 November 2015:

Countries with intense transmission:

- **Guinea**: 3 805 cases including 3 351 confirmed, and 2 536 deaths

Countries with previously widespread and intense transmission:

Sierra Leone: declared Ebola-free on 7 November 2015.
Liberia: declared Ebola-free on 3 September 2015.

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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: A total of 4 cases have been reported from Guinea in the past 21 days, all of whom are members of the same family from the village of Kondeyah, in the sub-prefecture of Kaliah in Forecariah. All 69 contacts currently being followed in Guinea are located in Kaliah and are scheduled to complete their 21-day follow-up period on 14 November. However, 60 of the contacts are considered to be at high risk, and one contact from Forecariah has been lost to follow up within the past 42 days. Therefore there remains a short-term risk of further cases among both registered and untraced contacts.

Situation among healthcare workers
No new infections in healthcare workers were reported by WHO in the week leading up to 8 November.

Outside of the three most affected countries, with repatriated cases included, there have been 8 cases in Mali, 20 in Nigeria, 3 in Spain (including two repatriated cases), 3 in the UK (including two repatriated cases), 1 in Senegal, 1 in Norway (repatriated), 2 in France (repatriated), 1 in the Netherlands (repatriated), 1 in Switzerland (repatriated), 11 in the USA (7 repatriated) and 1 in Italy (infected in Sierra Leone).

Epicurve: the epicurve shows the confirmed cases in Guinea. In order to better represent the tail of the epidemic, only the data for 2015 are shown.

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 UK nurse, unusual late complications should also be taken into account.

Actions

As of 12 November 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.
The latest (13th) update of the rapid risk assessment was published on 16 October 2015.
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

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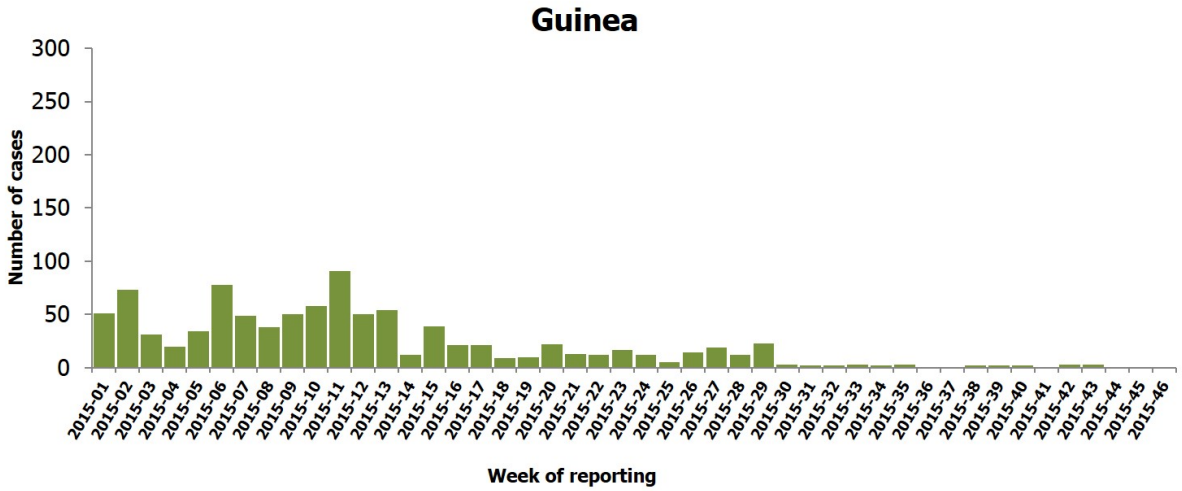
disease and people exposed to Ebola virus.
On 13 October 2014, ECDC published Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures.
On 6 October 2014, ECDC published risk of transmission of Ebola virus via donated blood and other substances of human origin 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 (weeks 01/2015 to 46/2015)

Adapted from WHO figures; data for week 46 are incomplete



Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 12 November 2015

Epidemiological summary

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As of 12 November 2015, 681 laboratory-confirmed cases of human infection with avian influenza A(H7N9) viruses, including at least 275 deaths, have been reported.
Cases in China since March 2013 have the following geographical distribution: Zhejiang (188), Guangdong (181), 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 influence 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.

During 2015, there have been continued avian influenza A(H7N9) virus detections in the animal population in multiple 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 affected and possibly 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, including 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.

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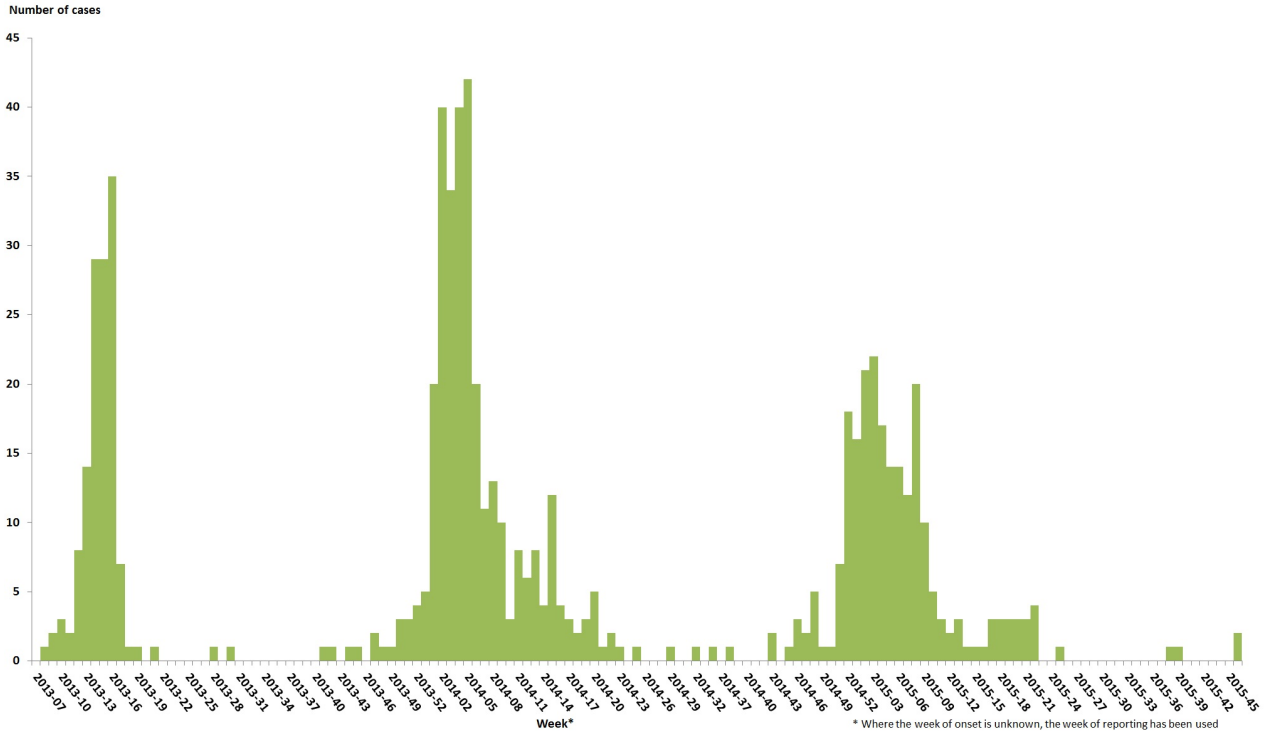
Distribution of confirmed cases of A(H7N9) by week of reporting (weeks 07/2013 to 46/2015**)

** Data for week 46/2015 is incomplete



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Distribution of confirmed cases of A(H7N9) by week of onset (n=681) from February 2013 until 12 November 2015

Source: ECDC

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 12 November 2015

Epidemiological summary

Europe
No new autochthonous cases reported since the last monthly update.

Asia
In **India**, the number of dengue cases in Delhi has risen to nearly 15 000 since the start of the year with more than 7 200 cases reported in October alone, according to the media quoting local health authorities. This is the biggest dengue outbreak reported in the capital since 1996 when 10 252 cases were reported.

In **China**, as of 3 November Hong Kong has reported 97 confirmed cases of dengue fever so far this year, comprising one locally-acquired case, 95 imported and one unclassified case, according to the Centre for Health Protection of the Department of Health. In **Taiwan**, the dengue fever outbreak in Tainan City is subsiding but dengue activity has peaked in Kaohsiung City with

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210 cases reported in the past week. As of 8 November, 31 756 locally-acquired dengue cases and 141 deaths have been reported nationally, according to Taiwan CDC.

Recently published figures from the Ministries of Health in **Thailand**, **Malaysia** and the **Philippines** show that dengue activity continued to grow in the past month. All three countries have now recorded more than 100 000 dengue fever cases each so far this year. As of 23 October, 1 561 dengue cases and no deaths have been reported in **Laos** since the beginning of the year, according to WPRO.

Caribbean
Cayman Islands is reporting a decrease in the number of confirmed dengue cases so far this year compared to the same period last year, according to the media, quoting local health authorities. In the **Dominican Republic**, more than 8 000 cases and 97 deaths have been reported so far in 2015, according to the media, quoting the Ministry of Health. DENV-2 and DENV-4 are the pre-dominant circulating serotypes.
Americas
Egypt: On 12 November 2015, WHO notified an outbreak of dengue fever in Assuit Governorate. Between 1 and 31 October 2015, 253 cases were hospitalised due to acute febrile illness. Twenty-eight out of 118 serum samples were positive for DENV-1 by ELISA and PCR.
According to the latest update from the WHO Pan American Health Organization (WHO PAHO) as of 6 November 2015, more than 2 million cases of dengue virus infection and 1 007 deaths have been reported so far this year in the WHO Region of the Americas. **Brazil** accounts for around 75% of all cases. Other countries reporting a high number of cases so far in 2015 include **Mexico** (166 255 cases) and **Colombia** (76 462 cases).

Pacific region and Australia
According to the Pacific Public Health Surveillance Network (PACNET), as of 1 November there have been 463 cases of DENV-3 and 146 hospital admissions reported in **American Samoa** since May 2015. The number of weekly reported cases has been decreasing. In **French Polynesia**, there were 23 cases of DENV-1 reported in the week ending 25 October 2015.

In **Australia**, as of 31 October, 1 455 laboratory-confirmed dengue cases have been reported so far this year. Compared with the same reporting period last year (n=1 532), the number of reported cases is consistent with previous years and follows a seasonal trend, according to WPRO.

The Hawaii State Department of Health is investigating a cluster of locally-acquired dengue fever cases on **Hawaii Island**. As of 11 November, 33 confirmed cases have been reported. This is the first cluster of locally-acquired dengue fever cases recorded since the 2011 outbreak on Oahu.

Africa
In **Sudan**, between 29 August and 30 October 2015, 200 suspected viral haemorrhagic fever cases, including 104 deaths were reported from South, East, Central, West and North Darfur. Laboratory analysis of 105 samples collected from suspected cases found that 28 samples from West and North Darfur were positive for Dengue virus, according to WHO EMRO. In addition, the media, quoting the Ministry of Health, report more than 200 cases of dengue fever in Darfur states. A team of international experts from WHO is currently in Sudan to assess the situation.

Web sources: ECDC Dengue | Healthmap Dengue | MedISys | ProMed Asia, Americas, Africa | WPRO | WHO DON

ECDC assessment

Introduction and autochthonous transmission of dengue fever in Europe is possible where and when competent vectors are present. This underlines the importance of surveillance and vector control in European countries that have competent vectors.

Actions

ECDC has published a technical report on the climatic suitability for dengue transmission in continental Europe and guidance for the surveillance of invasive mosquitoes.

ECDC monitors the dengue situation worldwide on a monthly basis.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 13 November 2015

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Epidemiological summary

Worldwide in 2015 so far, 52 wild poliovirus type 1 (WPV1) cases have been reported to WHO, compared with 278 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (39 cases) and Afghanistan (13 cases).

In 2015 so far, 17 cases of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO, compared with 42 for the same period in 2014 from Madagascar (10), Nigeria (1), Ukraine (2), Mali (1) and Laos (3).

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

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 recent detection of the cases of circulating vaccine-derived poliovirus type 1 in Ukraine, 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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