COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 33, 9-15 August 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

New! Two cases of meningococcal disease in Scouts returning from an international Scout jamboree in Japan - UK

Opening date: 14 August 2015 Latest update: 14 August 2015

On 13 August 2015, Scottish media quoting Health Protection Scotland, reported two confirmed cases of meningococcal disease in Scouts from Scotland who had returned from an international Scout jamboree in Japan. The 12-day event in Kirara-hama was attended by around 33 000 teenagers from across the globe, including around 150 from Scotland.

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

Opening date: 2 June 2015 Latest update: 13 August 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.

➔Update of the week

During the past week, Austria reported its first case of West Nile fever, detected in an asymptomatic blood donor from Vienna. In neighbouring countries, Serbia reported a laboratory-confirmed case of West Nile virus infection in Juzno-Banatski district. This is the first case reported by Serbia in the current transmission season. Israel reported four new cases diagnosed in August in the following areas: Northern District (2), Tel Aviv (1) and Central District (1).

All these areas were also affected in the previous transmission season.

Monitoring environmental suitability of Vibrio growth in the Baltic Sea – Summer 2015

Opening date: 6 July 2015 Latest update: 13 August 2015

ECDC has developed a model to map the environmental suitability for *Vibrio* growth in the Baltic Sea (ECDC E3 Geoportal).

➔Update of the week

As of 11 August, the environmental conditions for *Vibrio* growth for the next five days are considered suitable at a very low to low level in the southern part of the Baltic Sea, particularly around Lübeck, Kiel, Szczecin, Gdansk, Klaipeda, Riga and Parnu.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu

Epidemic Intelligence duty email: support@ecdc.europa.eu

Non EU Threats

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 6 August 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 6 May 2015, the Temporary Recommendations in relation to PHEIC were extended for another three months.

➔Update of the week

During the past week, two new cases of wild poliovirus type 1 (WPV1) have been reported by WHO, one case in Pakistan and one case in Afghanistan. No new cases of circulating vaccine-derived poliovirus (cVDPV) cases were reported in the past week.

WHO reports that for the first time in history, a full year has passed without a single case of wild poliovirus confirmed on the African continent. The most recent case had onset of paralysis on 11 August 2014 in central Somalia. To declare a polio-free year in Africa, six more weeks are required to process all remaining samples in the laboratory and to confirm them negative for poliovirus.

Last week, the emergency committee of the International Health Regulations (IHR) met for the sixth time to assess whether the international spread of polio continues to constitute a Public Health Emergency of International Concern (PHEIC). Their findings and recommendations will be published in the coming week.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 13 August 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).

➔Update of the week

As of 12 August 2015, WHO has reported 27 965 cases of Ebola virus disease related to the outbreak in West Africa, including 11 298 deaths.

According to the latest WHO situation report published on 12 August 2015, three confirmed cases of EVD were reported in the week up to 9 August: two in Guinea and one in Sierra Leone. Liberia has reported no new cases.

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

Opening date: 24 September 2012 Latest update: 13 August 2015

Since April 2012 and as of 13 August 2015, 1 426 cases of MERS have been reported by local health authorities worldwide, including 550 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.

➔Update of the week

Since 7 August, Saudi Arabia has reported 18 additional cases and two deaths in previously reported cases. All these cases have been reported from Riyadh. Ten of the cases are contacts of suspected or confirmed cases, either in the hospital or the community. Two of the cases are healthcare workers.

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Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 13 August 2015

An outbreak of chikungunya virus infection has been ongoing in the Caribbean since December 2013 and has spread to North, Central and South America. There is a concurrent epidemic of chikungunya in the Pacific area. In Europe, France reported autochthonous cases of chikungunya virus infection in 2014. This was the first time since 2015 that locally-acquired transmission of chikungunya was detected in France since 2010.

➔Update of the week

According to the latest update from the WHO Pan American Health Organization (WHO PAHO) on 7 August 2015, nearly 15 000 new chikungunya cases have been reported in the Americas during the past two weeks.

On 3 August 2015, WHO was notified by the National IHR Focal Point for Spain of a case of chikungunya virus infection in the city of Gandia, Valencian Community. This is the first time that an individual with no history of travel to a chikungunya-endemic area has tested positive for the disease in Spain.

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II. Detailed reports

New! Two cases of meningococcal disease in Scouts returning from an international Scout Jamboree in Japan - UK

Opening date: 14 August 2015 Latest update: 14 August 2015

Epidemiological summary

On 13 August 2015, Scottish television quoting Health Protection Scotland, reported two confirmed cases of meningococcal disease in Scouts from Scotland who returned from an international Scout jamboree in Japan. The 12-day event in Kirara-hama was attended by around 33 000 teenagers from across the globe, including around 150 from Scotland. Both cases were treated in hospital and are recovering well. All close contacts were identified and given antibiotics and immunisation as a precautionary measure.

ECDC assessment

This is not an unexpected health event at mass gathering events and the appropriate prevention and control measures were implemented.

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

Opening date: 2 June 2015 Latest update: 13 August 2015

Epidemiological summary

Since the beginning of the 2015 transmission season and as of 13 August, seven human cases of WNF have been reported in EU Member States: Italy (4), Bulgaria (1), Romania (1) and Austria (1). Eight cases were detected in neighbouring countries: Israel (7) and Serbia (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 for ensuring blood safety by the national health authorities 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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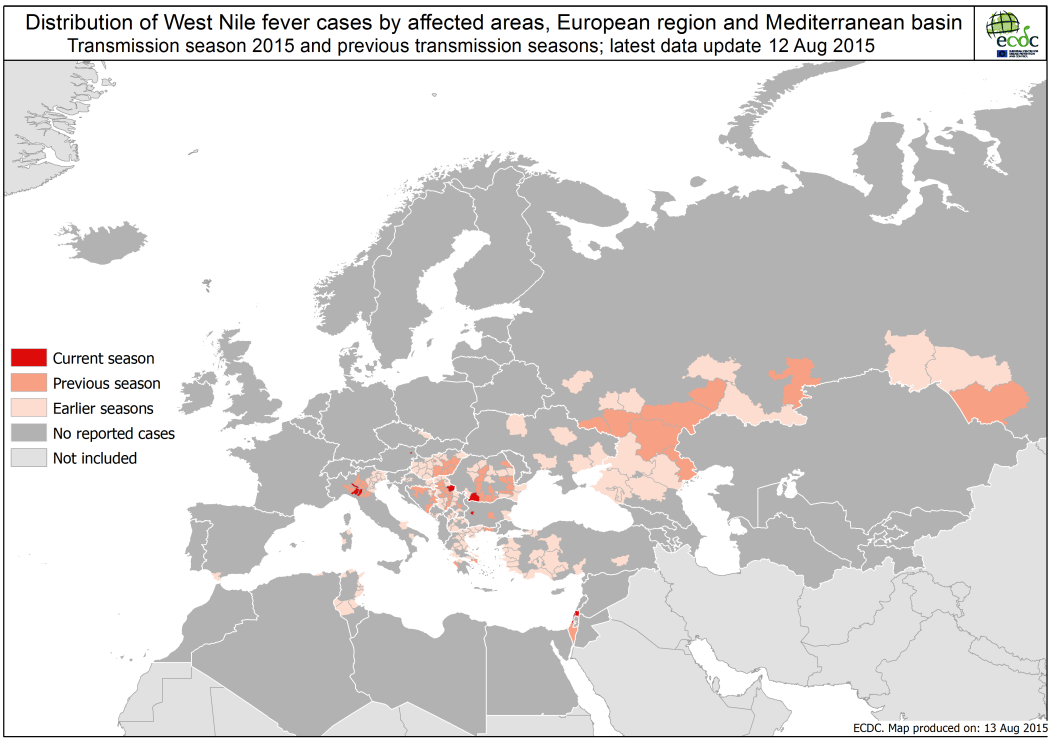
Source: ECDC



Monitoring environmental suitability of Vibrio growth in the Baltic Sea – Summer 2015

Opening date: 6 July 2015 Latest update: 13 August 2015

Epidemiological summary

In late June 2015, the *Vibrio* suitability tool on the ECDC E3 Geoportal helped ECDC to ascertain favourable environmental factors for *Vibrio* growth.
On 3 July 2015, ECDC launched an Urgent Inquiry (UI) in EPIS-FWD after detecting elevated sea surface temperatures (according to the National Oceanic and Atmospheric Administration, NOAA) in the Baltic Sea (as of 2 July 2015).

ECDC assessment

Elevated sea surface temperatures in marine environments with low salt content provide ideal environmental growth conditions for certain *Vibrio* species. These conditions can be found during the summer months in estuaries and enclosed water bodies with moderate salinity. In contrast, open ocean environments do not offer appropriate growth conditions for these bacteria due to the high salt content, low temperatures, and limited nutrient content. These *Vibrio* species, particularly *V. parahaemolyticus, V. vulnificus* and non-toxigenic *V. cholera,* can cause vibriosis infections.
Vibriosis in humans caused by these species in the Baltic region have occurred in the past during hot summer months, particularly when the sea surface temperature has been elevated. The most common clinical manifestations are gastroenteritis (with nausea, vomiting, and diarrhoea), wound infections (exposure of a cut, wound, or abrasion to contaminated seawater), primary septicaemia, and otitis externa (swimmer's ear). Risk factors for illness include consumption of shellfish, particularly raw oysters, and contact with natural bodies of water, especially marine or estuarine waters.

Actions

ECDC launched an UI in EPIS-FWD to inform the FWD network about the elevated surface water temperatures measured in the Baltic Sea, which create a favourable environment for the growth of *Vibrio* bacteria. ECDC will monitor this threat on a weekly basis during the summer of 2015 and report on increased environmental suitability for growth of *Vibrio* bacteria.

The *Vibrio* suitability tool is available on the ECDC E3 Geoportal. Please note that this model has been calibrated to the Baltic region in northern Europe and might not be compatible with other regional settings prior to validation.

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Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 6 August 2015

Epidemiological summary

Worldwide in 2015, 36 wild poliovirus type 1 (WPV1) cases have been reported to WHO so far, compared with 138 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (29 cases) and Afghanistan (7 cases).

In 2015, ten cases (nine in Madagascar and one in Nigeria) of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO so far, compared with 31 for the same period in 2014. The cases in Madagascar are genetically linked to a case reported in September 2014, indicating prolonged and widespread circulation of the virus.

Web sources: Polio Eradication: weekly update | MedISys Poliomyelitis | ECDC Poliomyelitis factsheet | Temporary Recommendations to Reduce International Spread of Poliovirus | Statement on the 4th IHR Emergency Committee meeting regarding the international spread of wild poliovirus

ECDC assessment

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

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.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

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

Epidemiological summary

Distribution of cases as of 9 August 2015:

Countries with intense transmission:

- **Guinea:** 3 787 cases, of which 3 329 were confirmed; 2 524 deaths.
- **Sierra Leone:** 13 470 cases, of which 8 697 were confirmed; 3 951 deaths.
- **Liberia:** 10 672 cases as of 6 August; since the end of June, six cases were confirmed, including two deaths.

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
In **Guinea**, WHO reported two new confirmed cases (one in Conakry and one in Forecariah) in the week up to 9 August, compared with one case reported in the previous week. The case in Conakry was a registered contact, but was lost to follow-up and has generated multiple high-risk contacts in several health facilities. The case in Forecariah was detected by post-mortem testing. The case has a possible link to an unsafe burial in Forecariah, suggesting that transmission may have gone undetected in the community. Many of the high-risk contacts identified by WHO are healthcare workers.

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In **Sierra Leone**, WHO reported one new confirmed case in Freetown in the week up to 9 August, compared with two during the previous week (the number of confirmed cases for the previous week has been revised by WHO up from one to two, after one confirmed case from Tonkolili was added retrospectively). The case was not a registered contact, but has a direct epidemiological link to an existing chain of transmission. Twenty-nine high-risk contacts have been identified by WHO so far.

In **Liberia**, no new cases were reported from Liberia in the week up to 9 August.

Situation among healthcare workers
No new healthcare worker infections were reported during the week up to 9 August. Since the start of the outbreak, 880 confirmed healthcare worker infections have been reported from Guinea, Liberia, and Sierra Leone; 512 deaths were reported.

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).

Medical evacuations and repatriations from EVD-affected countries
Since the beginning of the epidemic and as of 14 August 2015, 65 individuals were evacuated or repatriated worldwide from the EVD-affected countries. Of these, 38 individuals were evacuated or repatriated to Europe. Thirteen were medical evacuations of confirmed EVD-infected patients to: Germany (3), Spain (2), France (2), UK (2), Norway (1), Italy (1), the Netherlands (1) and Switzerland (1). Twenty-five asymptomatic persons were repatriated to Europe as a result of exposure to Ebola in West Africa: UK (13), Denmark (4), Sweden (3), the Netherlands (2), Germany (1), Spain (1) and Switzerland (1).
Twenty-seven persons were evacuated to the United States.
No new medical evacuations have taken place since 18 March 2015.

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, Sierra Leone and Liberia. 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

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.

According to WHO, case incidence has been below 10 confirmed cases per week for three consecutive weeks, but there remains a significant risk of further transmission and an increase in case incidence in the near and medium term. Recent high-risk transmission events in Guinea and Sierra Leone are very likely to result in further cases in the coming weeks. 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.

Actions

As of 14 August 2015, ECDC has deployed 90 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.

ECDC is looking for additional French-speaking experts with field epidemiology experience from EU Member States to join the ECDC-coordinated contingent in response to the Ebola outbreak in Guinea. For further information, please contact Valeria

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

Pelosi at valeria.pelosi@ecdc.europa.eu with copy to support@ecdc.europa.eu.

An epidemiological update is published weekly on the EVD ECDC page.

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 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.

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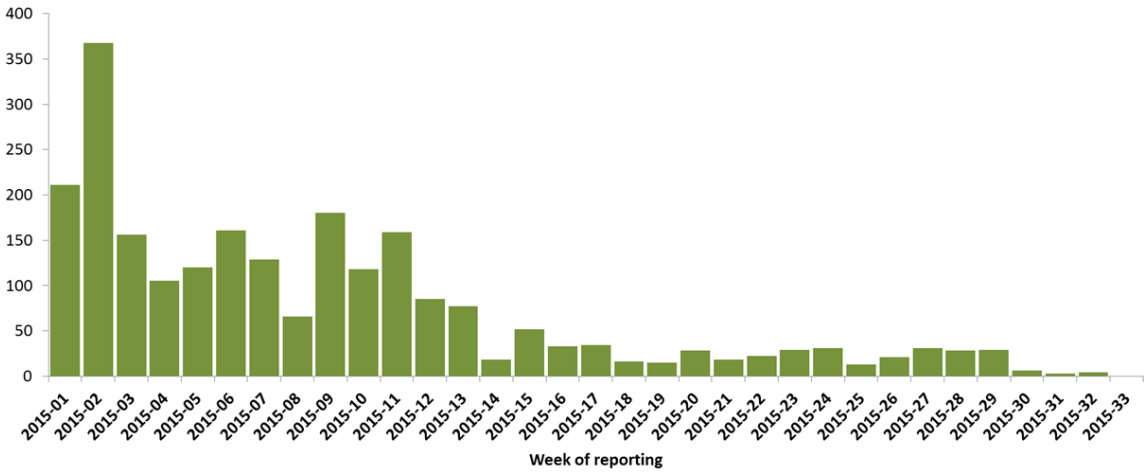
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 01/2015 to 33/2015)

Adapted from WHO figures; *data for week 33/2015 are incomplete



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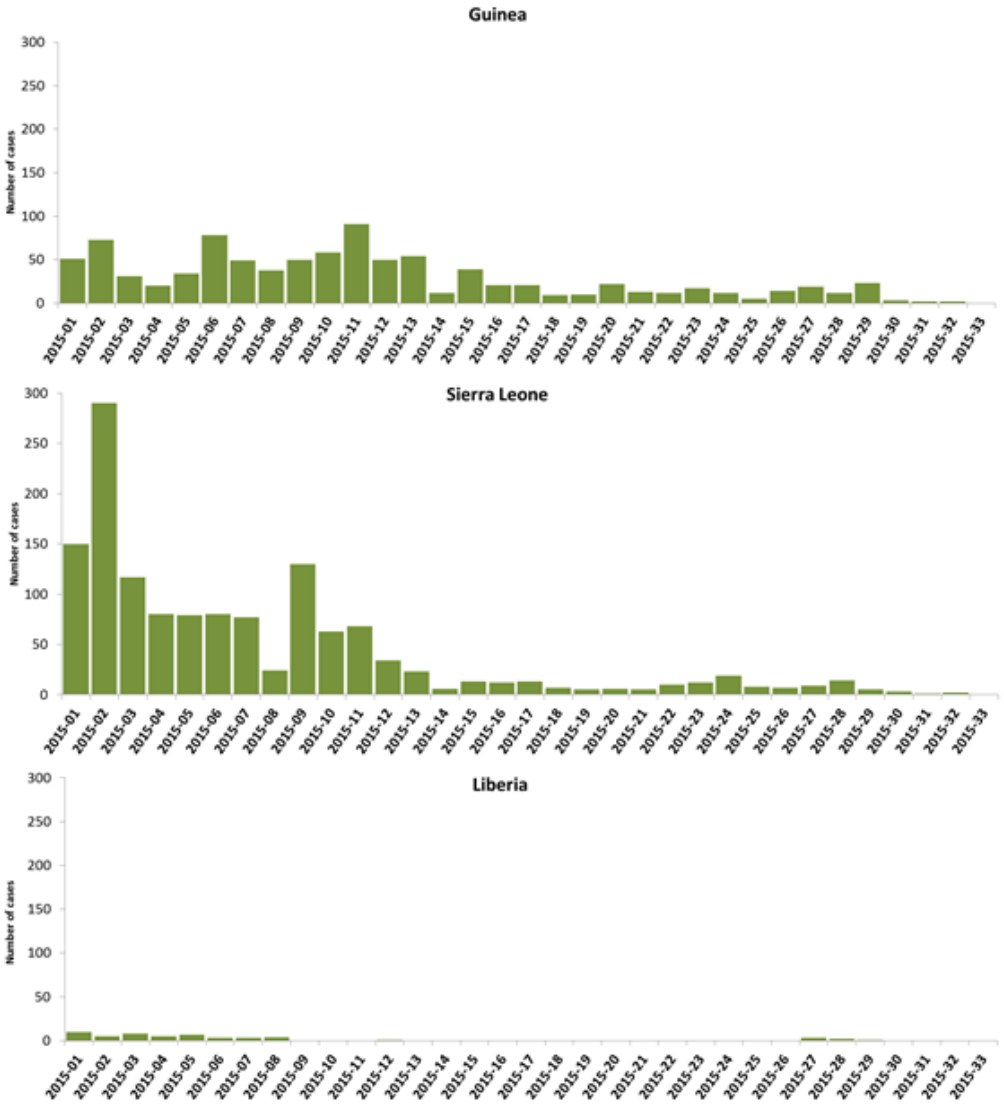
Adapted from WHO figures; *data for week 33/2015 are incomplete



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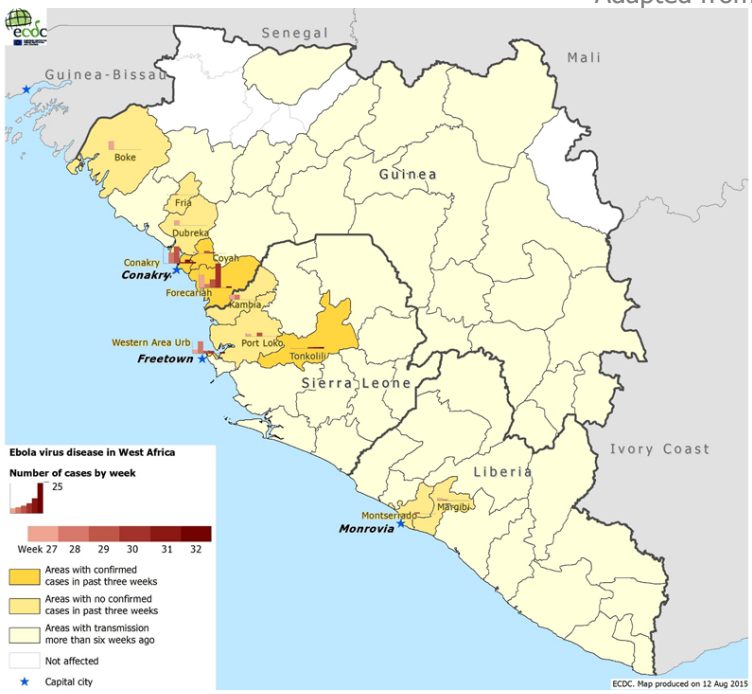
Distribution of confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (as of week 32/2015)

Adapted from national situation reports



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

Opening date: 24 September 2012 Latest update: 13 August 2015

Epidemiological summary

Since April 2012 and as of 13 August, 1 426 cases of MERS-CoV have been reported by local health authorities worldwide, including 550 deaths.

The distribution is as follows:
Confirmed cases and deaths by region:

Middle East
Saudi Arabia: 1 082 cases*/474 deaths
United Arab Emirates: 81 cases/11 deaths
Qatar: 13 cases/5 deaths
Jordan: 19 cases/6 deaths

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Oman: 6 cases/3 deaths
Kuwait: 3 cases/1 death
Egypt: 1 case/0 deaths
Yemen: 1 case/1 death
Lebanon: 1 case/0 deaths
Iran: 6 cases/2 deaths

Europe
Turkey: 1 case/1 death
UK: 4 cases/3 deaths
Germany: 3 cases/2 deaths
France: 2 cases/1 death
Italy: 1 case/0 deaths
Greece: 1 case/1 death
Netherlands: 2 cases/0 deaths
Austria: 1 case/0 deaths

Africa
Tunisia: 3 cases/1 death
Algeria: 2 cases/1 death

Asia
Malaysia: 1 case/1 death
Philippines: 3 cases/0 deaths
South Korea: 185 cases/36 deaths
China: 1 case/0 deaths
Thailand: 1 case/0 deaths

Americas
United States of America: 2 cases/0 deaths

* Saudi Arabia MoH reports a total of 1 087 cases but do not provide details about the five additional cases.

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 | ECDC factsheet for professionals

ECDC assessment

According to ECDC experts, the MERS outbreak 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 South Korea.

Countries should advise travellers returning from all 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. The 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. In addition, 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 31 July 2015.

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Postal address: ECDC 171 83 Stockholm, Sweden
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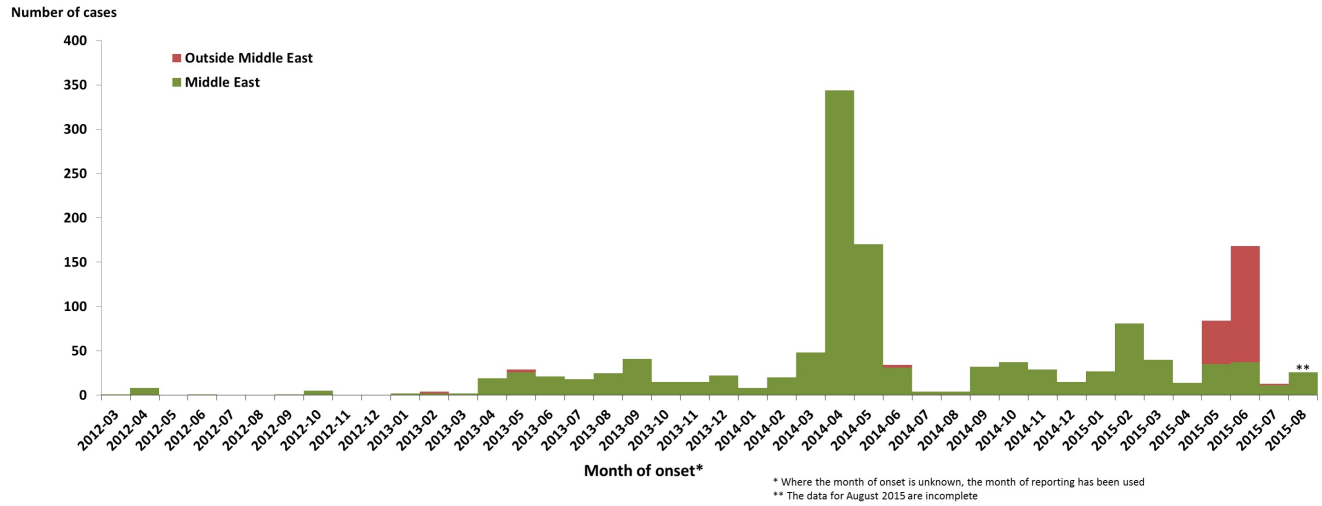
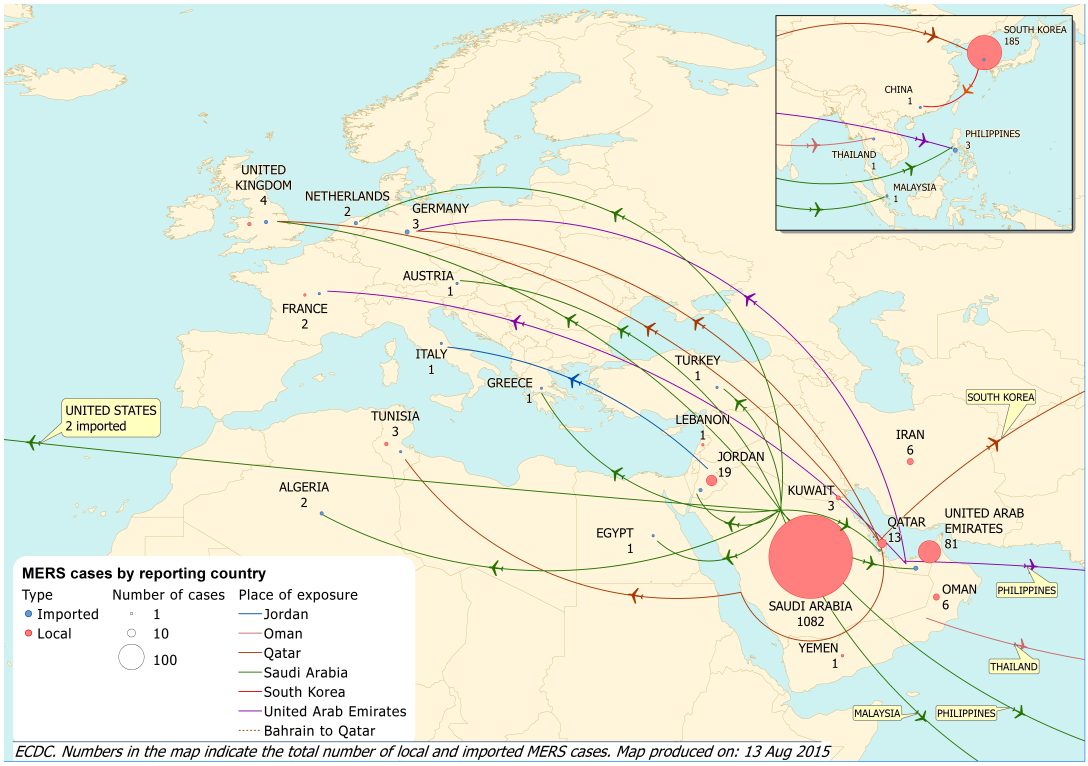
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 13 August 2015 (n=1 426)

Source: ECDC



Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 13 August 2015 (n=1 426)

Source: ECDC



ECDC. Numbers in the map indicate the total number of local and imported MERS cases. Map produced on: 13 Aug 2015

Chikungunya- Multistate (world) - Monitoring global outbreaks

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Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

Opening date: 9 December 2013 Latest update: 13 August 2015

Epidemiological summary

Europe

Spain
On 3 August 2015, WHO was notified by the National IHR Focal Point for Spain of a case of chikungunya virus infection in the city of Gandia, Valencian Community. This is the first time that an individual with no history of travel to a chikungunya endemic area has tested positive for the disease in Spain. This case was previously reported in the RT on 4 August 2015.

As of 12 July 2015, 86 cases of chikungunya virus infection have been reported in Spain since the beginning of 2015. Of these, 18 cases have been reported in the Valencia region. All were travel-associated cases, according to Valencia health authorities.

France
Between 1 May and 7 August, 16 imported cases of chikungunya virus infection were reported in metropolitan France. No autochthonous cases of chikungunya were notified, according to InVS.

Americas
According to the latest update from the WHO Pan American Health Organization (WHO PAHO) on 7 August 2015, nearly 15 000 new chikungunya cases have been reported in the Americas during the past two weeks. Since the beginning of the year and as of 7 August 2015, PAHO has reported 491 117 suspected and confirmed cases of chikungunya virus infection and 61 deaths in the WHO Region of the Americas. The number of cases has reached 1 628 835 since the start of the epidemic in December 2013.

Colombia and Brazil reported the largest increase in cases with 10 703 and 1 675 new suspected and confirmed cases reported respectively. Mexico reported 819 new confirmed cases, bringing its total in 2015 to 3 306 cases, all of these cases are due to autochthonous transmission. Panama reported 123 suspected cases, bringing the total number of cases in 2015 up to 153.

Pacific region
There is an ongoing outbreak on Cook Islands with 780 cases reported since October 2014, including two new cases in the week up to 9 August 2015, according to the Pacific Public Health Surveillance Network (PACNET).

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

ECDC assessment

Epidemiological data indicate that the outbreaks are still expanding in the Caribbean and the Americas. 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.

The recent occurrence of a confirmed case of chikungunya virus infection in an EU citizen who has not travelled to known endemic areas raises the issue of infection having occurred in the EU. As the case travelled to France during the possible exposure period, it is not possible to determine precisely where the infection has taken place. The investigation around this case should identify the areas of possible transmission and trigger appropriate control measures.

The spread of chikungunya virus in the EU is possible following the importation through an infected traveller due to the presence of competent mosquito vectors in many countries, particularly around the Mediterranean coast, and population susceptibility. The presence of the vector and the introduction of the virus are necessary conditions for having local transmission. Chikungunya virus is currently not endemic in continental Europe. Only one large outbreak was reported in northern Italy in 2007, and limited autochthonous cases were reported in France in 2010 and 2014. Otherwise, all reported cases were imported.

Actions

ECDC published a Rapid Risk Assessment on 27 June 2014.

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

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

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

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