

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Influenza – Multistate (Europe) – Monitoring 2014–2015 season

Opening date: 9 October 2014

Latest update: 23 April 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.

→ Update of the week

Influenza activity continued to decrease in most reporting countries: the proportion of influenza-virus-positive specimens from sentinel sources decreased from 28% for week 15 to 25% for week 16. Since week 51/2014 the positivity rate has been over the threshold of 10%, indicating seasonal influenza activity.

Borna virus - Germany - 2015

Opening date: 20 February 2015

Latest update: 26 February 2015

On 19 February, Germany posted an EWRS message regarding three fatal cases of encephalitis in the German state of Saxony-Anhalt during 2011-2013, involving three breeders of variegated squirrels which can be kept as exotic outside pets. Investigations unveiled the cause of death as an infection from a new type of Borna virus.

→ Update of the week

Investigations to find previously undiagnosed encephalitis cases due to this causative agent have not identified new human cases in Germany since February 2015.

Non EU Threats

Influenza A(H5N1) - Multistate (world) - Monitoring human cases

Opening date: 15 June 2005

Latest update: 23 April 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.

→Update of the week

Since the last update on 17 April, Egypt has reported six additional human cases of influenza A(H5N1).

In birds, new outbreaks of highly pathogenic avian influenza (HPAI) influenza A(H5N1) have been confirmed on poultry farms in [Niger](#) (Maradi) and [Burkina Faso](#) by the World Organisation for Animal Health (OIE). The Food and Agriculture Organization's Emergency Prevention System ([FAO EMPRES](#)) reported a new poultry outbreak of HPAI influenza A(H5N1) in India. In the United States, more outbreaks of HPAI A(H5N2) were detected on poultry farms in Iowa and Ontario. In addition, a new outbreak of HPAI Influenza A(H5) was detected in a turkey flock in Wisconsin.

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

Opening date: 24 September 2012

Latest update: 23 April 2015

Since April 2012 and as of 23 April 2015, 1 126 cases of MERS-CoV have been reported by local health authorities worldwide, including 465 deaths. To date, all cases have either occurred in the Middle East, have direct links to a primary case infected in the Middle East, or have returned from this area. 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 the last update on 14 April, Saudi Arabia has reported three additional cases of MERS-CoV infection and one death in a previously reported case. The new cases were reported in Tabuk (1), Riyadh (1) and Al Sharqia (1). All cases are male and are in a stable condition. None of the cases had contact with suspected or confirmed cases in hospitals or the community.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 23 April 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 21 April 2015, [WHO](#) reported 26 074 cases of Ebola virus disease related to the outbreak in West Africa, including 10 820 deaths.

Thirty-three new confirmed cases of EVD were reported in the week from 13 to 19 April from Guinea (21 cases) and Sierra Leone (12 cases). Liberia reported no new confirmed cases.

According to WHO, community engagement appears to be steadily improving in Guinea and Sierra Leone. A case-finding and community awareness-raising campaign took place in the Guinean prefecture of Forecariah from 12 to 15 April, identifying 12 new confirmed cases seven of which were from post-mortem testing. A similar campaign is planned for the prefectures of Coyah, Dubreka, Conakry, Kindia and Boffa.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 16 April 2015

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission stops and the world is 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 the international spread of wild poliovirus during 2014. On 27 February 2015, the Temporary Recommendations in relation to PHEIC have been extended for another three months.

→Update of the week

In the past week, no new cases of poliovirus type 1 (WPV1) were reported. This year's World Immunisation Week, held from 24 to 30 April, focuses on closing the immunisation gap to ensure that all children have access to life saving vaccines. Vaccinating every child against polio is crucial for eradicating the virus.

II. Detailed reports

Influenza – Multistate (Europe) – Monitoring 2014–2015 season

Opening date: 9 October 2014

Latest update: 23 April 2015

Epidemiological summary

Influenza A(H1N1)pdm09, A(H3N2) and type B viruses continued to circulate in the WHO European Region, but type B viruses accounted for 75% of sentinel detections for week 16/2015. The number of hospitalised influenza cases is returning to low levels.

Low intensity of influenza activity was reported by 31 of 37 reporting countries. Excess all-cause mortality among people aged 65 years and above, concomitant with increased influenza activity and the predominance of A(H3N2) viruses, had been observed in most countries participating in the European project for monitoring excess mortality for public health action (EuroMOMO), but has now abated (see the EuroMOMO website).

Antigenic drift in the A(H3N2) and B/Yamagata viruses was observed in the 2014–2015 influenza season, so the northern hemisphere vaccine did not provide optimal protection against the A(H3N2) viruses. The B/Yamagata component in the vaccine is likely to protect against circulating viruses.

Of all the influenza viruses screened for reduced susceptibility to neuraminidase inhibitors, only four A(H3N2) viruses and one A(H1N1)pdm09 virus have shown genetic evidence for this phenotype: the A(H1N1)pdm09 and three A(H3N2) viruses to oseltamivir only and one A(H3N2) virus to oseltamivir and zanamivir

Web sources: [Flu News Europe](#) | [ECDC Influenza](#) |

ECDC assessment

Influenza activity continued to decrease in most of the reporting countries.

Actions

ECDC and WHO produce the [Flu News Europe](#) bulletin weekly.

Borna virus - Germany - 2015

Opening date: 20 February 2015

Latest update: 26 February 2015

Epidemiological summary

On 19 February 2015, Germany reported three cases of fatal encephalitis in residents of the state of Saxony-Anhalt. The first clinical case was seen in 2011, the second and the third in 2013 in different hospitals. Affected persons were males aged 62 to 72 years and of age-typical health status. Each of them was known to breed variegated squirrels (*Sciurus variegatoides*), a type of tree squirrel common to Central America that can be kept as an exotic outside pet. The three breeders knew each other but did not live in close proximity to one another. It is unclear whether they exchanged animals. During the prodromal phase, which lasted for two weeks or longer, the patients presented with fever and shivering, fatigue, weakness and walking difficulties. Due to increased confusion and psychomotor impairment they were admitted to neurology wards where they developed ocular paresis. They rapidly deteriorated within a few days and died after some time in intensive care, despite mechanical ventilation. Investigations for usual (non-purulent) encephalitis aetiologies performed at the Bernhard Nocht Institute for Tropical Medicine in Hamburg at first did not find evidence of known pathogens in cerebrospinal fluid and samples of brain tissue of the deceased.

Genetic analysis (metagenomics) of the brain tissue of the third patient's squirrel that appeared healthy but died during general anaesthesia produced sequences of a newly identified type of Borna virus. Further molecular and immunohistological analysis of brain tissue from the three deceased patients confirmed presence of this virus in the human cases as well. The newly identified virus is different from currently known Borna viruses. In limited testing of additional variegated squirrels, no other animal was found to be positive for this infection.

Germany has conducted a survey (online and through veterinary departments) among breeders of variegated squirrels that has not produced evidence of additional cases of meningitis, encephalitis or deaths with unclear circumstances among interviewed persons, household contacts or fellow breeders. Response, however, was low (n=10) reflecting the suspected small number of

breeders of such animals in Germany.

The Bernhard-Nocht-Institute for tropical medicine in Hamburg has recently developed a serological test for antibodies against this new Borna virus strain and started offering laboratory testing for breeders of variegated squirrels and persons living in the same household.

ECDC assessment

The reported cluster of acute fatal encephalitis in three squirrel breeders possibly related to an infection with a newly identified bornavirus is an unusual event. The novel nature of this event requires that additional investigations are undertaken into the identification of natural hosts, reservoir and the transmission route. Nevertheless, pending the completion of the cluster investigation, it is advised that feeding or direct contact with living or dead variegated squirrels should be avoided, as a precautionary measure.

Actions

ECDC published a [rapid risk assessment](#) on 26 February 2015 that is currently being updated.

Influenza A(H5N1) - Multistate (world) - Monitoring human cases

Opening date: 15 June 2005

Latest update: 23 April 2015

Epidemiological summary

Human cases

In Egypt, as of 18 April 2015, the Ministry of Health and Population has reported 140 human cases of influenza A(H5N1), including 39 deaths in 2015. Since 2006, Egypt has reported 342 human cases, according to WHO/FAO.

Avian flu in birds

According to the [Pan American Health Organization](#) (PAHO), since December 2014, Canada and the United States of America have detected several outbreaks of HPAI in wild and domestic birds due to new reassortants of H5 influenza viruses.

In Canada, outbreaks of HPAI A(H5N2) and HPAI A(H5N1) were detected in birds in the province of British Columbia and unrelated outbreaks of HPAI A(H5N2) in the province of Ontario.

In the USA to date, ten states, Arkansas, Idaho, Kansas, Minnesota, Missouri, Montana, Oregon, South Dakota, Washington and Wyoming, have notified outbreaks of HPAI A(H5N2) to the OIE. These states are located along the Central, Mississippi and Pacific migratory routes of the birds. Six states, California, Idaho, Nevada, Oregon, Utah, and Washington, located on the Pacific migratory routes of wild birds, reported outbreaks of HPAI A(H5N8). Washington reported birds infected with HPAI A(H5N1) as well.

Web sources: [ECDC Rapid Risk Assessment](#) | [Avian influenza on ECDC website](#) | [WHO PAHO update](#) |

ECDC assessment

Most human infections of A(H5N1) are the result of direct contact with infected birds, and countries with large poultry populations in close contact with humans are considered to be most at risk of bird flu outbreaks. The ongoing outbreak of influenza A(H5N1) among poultry and humans in Egypt has now caused more cases during one season than has been reported from any other country globally. The virus belongs to a clade, which appears to be restricted to transmission in Egypt and neighbouring countries only for several years. An emergence of a novel cluster within this clade was recently reported in [Eurosurveillance](#), which might explain the increase in poultry infections and/or human cases.

The sharp increase in human cases of A(H5N1) infection in Egypt during the winter months 2014–2015 may be due to an increase in the circulation of A(H5N1) among backyard poultry and exposure to infected poultry across the country. Identification of such sporadic cases or small clusters is not unexpected as avian influenza A(H5N1) viruses are known to be circulating among poultry within the country. Strict implementation of control measures to reduce and eliminate infection in poultry is essential for reducing the risk of zoonotic transmission and human cases. Enhanced human infectivity of the circulating virus and the protection conferred by the poultry vaccines currently in use should be further investigated. Surveillance in poultry as well as in humans needs to be strengthened and coordinated. Intervention programmes to reduce virus circulation in the country should be reinforced. Travellers visiting Egypt should avoid direct contact with poultry and birds or uncooked/untreated poultry products. The outbreaks of HPAI in birds in the USA and Canada are the first outbreaks due to HPAI H5 influenza reassortants of Euroasian

origin registered in North America. These viruses are genetically different from the avian influenza A(H5N1) that has caused human infections with high mortality in many countries. To date, there have been no reported human infections with this new reassortant virus.

The risk to people from these HPAI H5 infections in wild birds, backyard flocks and commercial poultry is considered to be low.

Actions

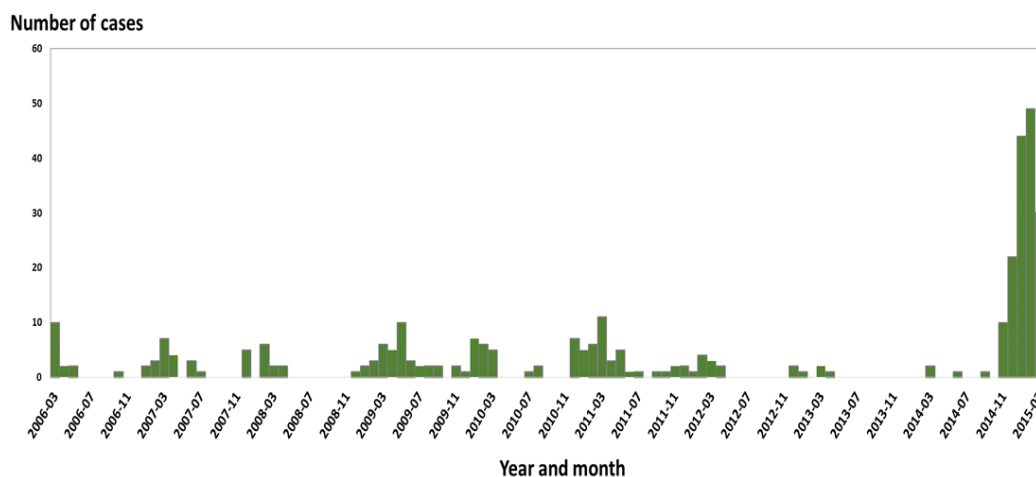
ECDC monitors the worldwide A(H5N1) situation through epidemic intelligence activities on a weekly basis in order to identify significant changes in the epidemiology of the virus. ECDC re-assesses the potential of a changing risk for A(H5N1) to humans on a regular basis.

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.

Distribution of human influenza A(H5N1) cases in Egypt by month and year– March 2006 to March 2015

Source: FAO EMPRES



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

Opening date: 24 September 2012

Latest update: 23 April 2015

Epidemiological summary

Since April 2012 and as of 23 April 2015, 1 126 cases of MERS-CoV have been reported by local health authorities worldwide, including 465 deaths.

The distribution is as follows:

Confirmed cases and deaths by region:

Middle East

Saudi Arabia: 981 cases/428 deaths
United Arab Emirates: 74 cases/10 deaths
Qatar: 11 cases/4 deaths
Jordan: 19 cases/6 deaths
Oman: 5 cases/3 deaths
Kuwait: 3 cases/1 death
Egypt: 1 case/0 deaths
Yemen: 1 case/1 death
Lebanon: 1 case/0 deaths
Iran: 5 cases/2 deaths

Europe

Turkey: 1 case/1 death
UK: 4 cases/3 deaths
Germany: 3 cases/1 death
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: 2 cases/0 deaths

Americas

United States of America: 2 cases/0 deaths

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

The source of MERS-CoV infection and the mode of transmission to primary cases have not been identified. The majority of MERS-CoV cases are secondary cases and many result from nosocomial transmission. Dromedary camels are a host species for the virus. There is a continued risk of cases presenting in Europe following exposure in the Middle East and international surveillance for MERS-CoV cases remains essential.

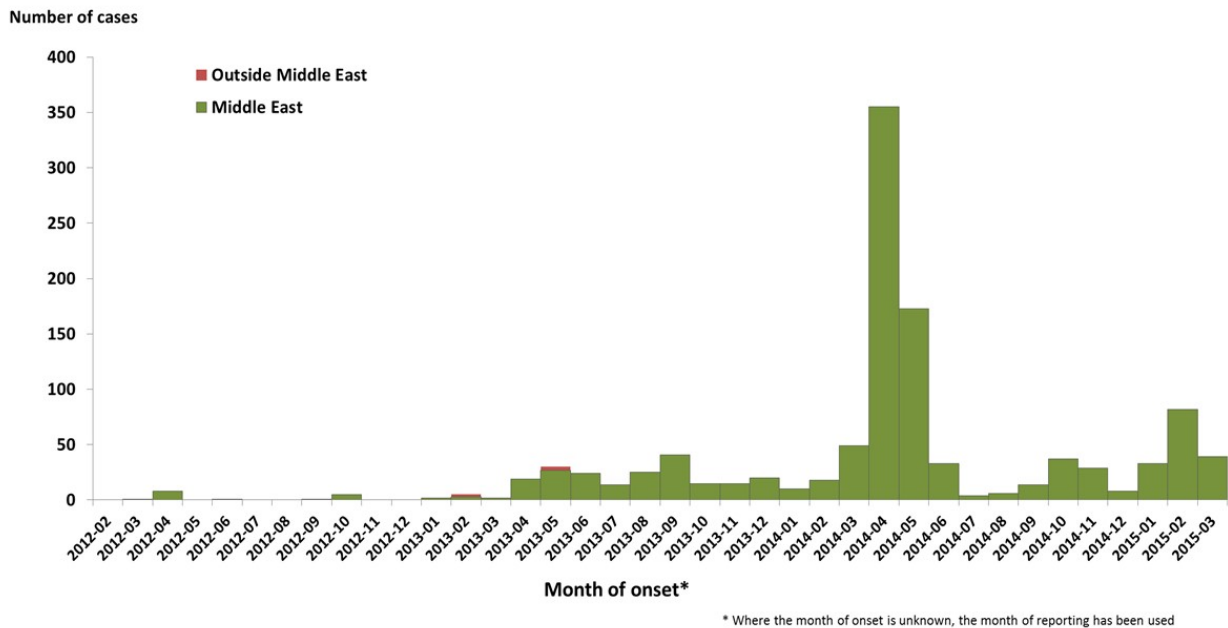
The risk of secondary transmission in the EU remains low and can be reduced further by screening for exposure among patients presenting with respiratory symptoms (and their contacts), and strict implementation of infection prevention and control measures for patients under investigation.

Actions

The last [rapid risk assessment](#) was updated on 9 March 2015.
ECDC published a [factsheet for health professionals regarding MERS-CoV](#) on 20 August 2014.
From week 18 onwards, ECDC will monitor the situation on a monthly basis.

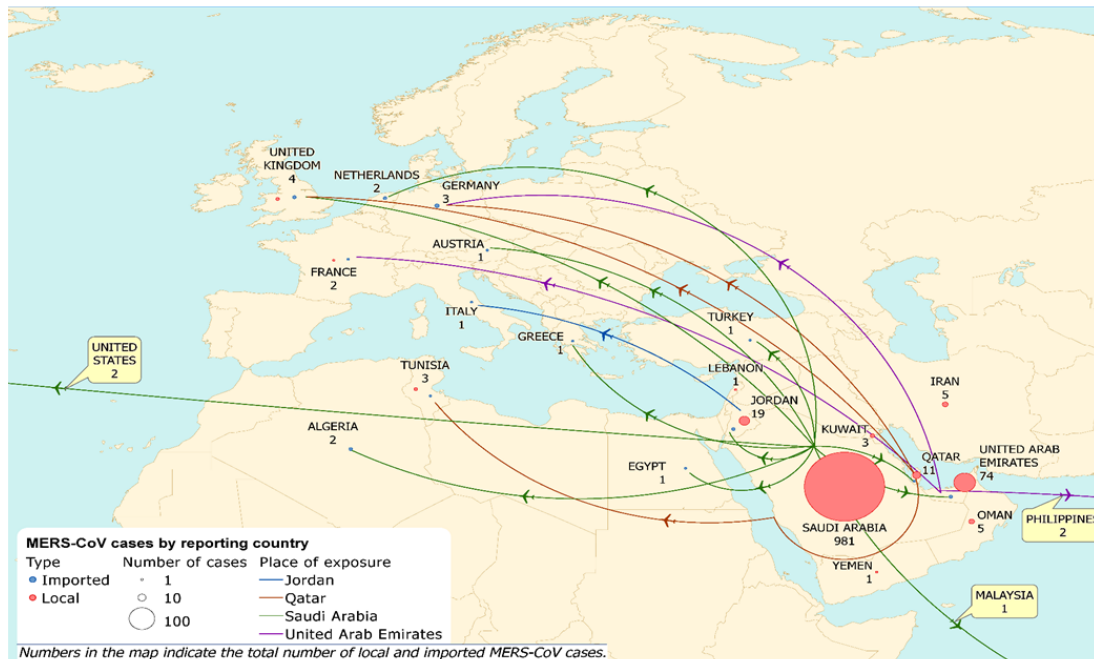
Distribution of confirmed cases of MERS-CoV by first available date, and probable place of infection, March 2012 – 31 March 2015

Source: ECDC



Geographical distribution of confirmed MERS-CoV cases and place of probable infection, worldwide, as of 23 April 2015 (n=1 126)

Source: ECDC



Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 23 April 2015

Epidemiological summary

Distribution of cases as of 21 April 2015:

Countries with intense transmission

- Guinea: 3 568 cases, of which 3 144 are confirmed, and 2 362 deaths (as of 21 April).
- Liberia: 10 212 cases, of which 3 151 are confirmed, and 4 573 deaths (as of 19 April).
- Sierra Leone: 12 294 cases, of which 8 581 are confirmed, and 3 885 deaths (as of 21 April).

Countries with an initial case or cases, or with localised transmission

- Mali, Nigeria, Senegal, Spain, the United States and United Kingdom have been declared free of EVD after having cases related to the current epidemic in West Africa.

Situation in specific West African countries

In **Guinea**, according to WHO, four prefectures reported at least one confirmed case in the week to 19 April, compared with five in the previous week. Transmission remains confined to the west of the country and is primarily focused on the prefecture of Forecariah, bordering Sierra Leone, which reported 86% of all confirmed cases.

Response indicators for Guinea continue to present a mixed picture. In the week up to 19 April, six confirmed deaths from EVD were identified post-mortem in the community. In addition, 46% of confirmed cases arose among registered contacts, a figure below 50% for the third consecutive week.

In **Sierra Leone**, WHO reported cases from four districts: Kambia, Port Loko, Koinadugu and Western Area Urban, which includes the capital, Freetown.

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Response indicators from Sierra Leone also present a mixed picture. The number of EVD-positive deaths that were identified in the community after post-mortem testing was three in the week up to 19 April, but the percentage of new cases arising from known contacts dropped to 44% from 67% in the previous week.

In **Liberia**, the last confirmed case died on 27 March. Investigations are ongoing to establish the origin of infection. Heightened vigilance is being maintained throughout the country. In the six days up to 19 April, 212 laboratory samples were tested for EVD, with no confirmed cases. If no new cases occur the country will be declared Ebola free on 9 May.

Situation among healthcare workers

In the week to 19 April 2015, WHO reported no new infection among healthcare workers (HCWs). The cumulative total of HCWs infected with EVD remains 864: 187 in Guinea, 374 in Liberia and 303 in Sierra Leone. Five hundred and four HCWs have died of the disease.

Outside of the three most affected countries, two Ebola-infected HCWs were reported in Mali, 11 in Nigeria, one in Spain (infected while caring for an evacuated EVD patient), two in the UK (both infected in Sierra Leone), and six in the USA (two infected in Sierra Leone, two in Liberia and two infected while caring for confirmed case in Texas).

Medical evacuations and repatriations from EVD-affected countries

Since the beginning of the epidemic and as of 9 April 2015, 65 individuals have been evacuated or repatriated worldwide from the EVD-affected countries. Of these, 38 individuals have been 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), Netherlands (1) and Switzerland (1). Twenty-five asymptomatic persons have been repatriated to Europe as a result of exposure to Ebola in West Africa: UK (13), Denmark (4), Sweden (3), Netherlands (2), Germany (1), Spain (1) and Switzerland (1).

Twenty-seven persons have been evacuated to the United States.

No new medical evacuations have taken place since 18 March 2015.

Images

- *Epicurve 1 and 2*: the epicurves show the confirmed cases in the three most affected countries.
- *Map*: this map is based on the country situation reports and shows only confirmed cases of EVD in the past six weeks. The scale of the bar graphs is reduced to 50 cases.

Web sources: [ECDC Ebola page](#) | [ECDC Ebola and Marburg fact sheet](#) | [WHO situation summary](#) | [WHO Roadmap](#) | [WHO Ebola Factsheet](#) | [CDC](#) | [WHO latest situation summary](#)

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 remain 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, the decline in confirmed cases of EVD has slowed down as the number of cases has stayed stable during the past three weeks in Guinea and Sierra Leone. In both countries, less than half of all new confirmed cases are identified among known Ebola contacts, and people continue to be diagnosed with Ebola post mortem. These patterns indicate that the disease is circulating in unrecognised chains of transmission. In order to achieve zero cases, there is a need for stronger community engagement, improved contact tracing and earlier case identification.

Actions

As of 24 April 2015, ECDC has deployed 62 experts coming 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 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 Alice Friaux at: alice.friaux@ecdc.europa.eu with copy to support@ecdc.europa.eu

An epidemiological update is published weekly on the [EVD ECDC page](#)

The latest (10th) update of the [rapid risk assessment](#) was published on 15 April 2015.

On 22 January 2014, 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-ECDC published a [Scientific report assessing Risk related to household pets in contact with Ebola cases in humans](#)

On 29 October 2014, ECDC published a training tool on the [safe use of PPE and options for preparing for gatherings in the EU](#)

On 23 October 2014, ECDC published [Public health management of persons having had contact with Ebola virus disease cases in the EU](#)

On 22 October 2014, ECDC published [Assessing and planning medical evacuation flights to Europe for patients with Ebola virus disease and people exposed to Ebola virus](#)

On 13 October 2014, ECDC published [Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures](#)

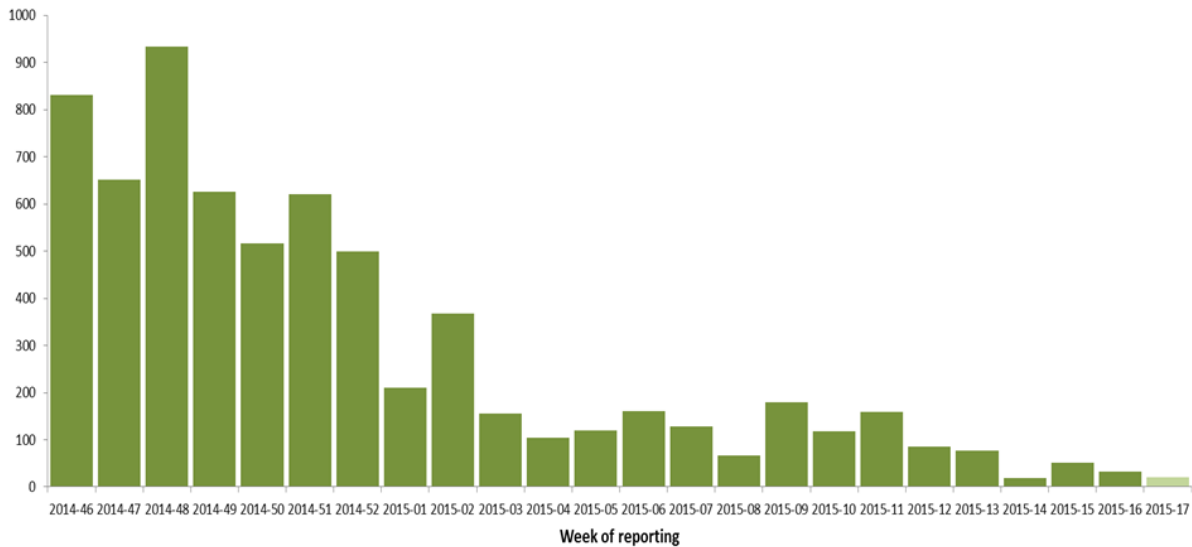
On 6 October 2014, ECDC published [risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU](#)

On 22 September 2014, ECDC published [assessment and planning for medical evacuation by air to the EU of patients with Ebola virus disease and people exposed to Ebola virus](#)

On 10 September 2014, ECDC published an [EU case definition](#)

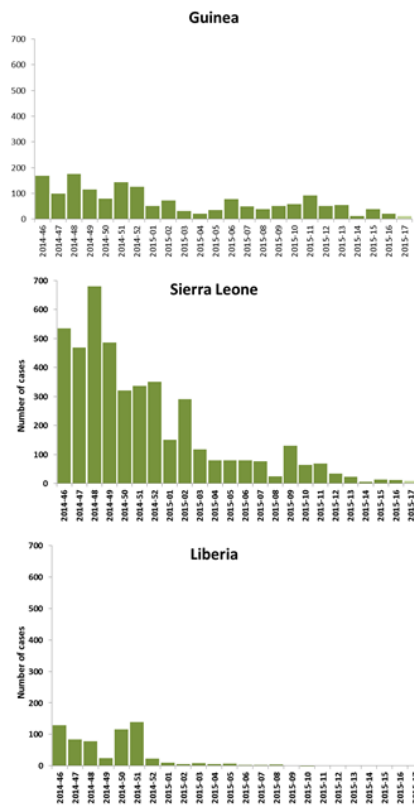
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 17/2015)

Adapted from WHO figures; *data for week 17/2015 are incomplete



Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 17/2015)

Adapted from WHO figures; *data for week 17/2015 are incomplete



Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (as of week 16/2015)

Adapted from national situation reports



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 16 April 2015

Epidemiological summary

Worldwide in 2015, 22 wild poliovirus type 1 (WPV1) cases have been reported to WHO, compared with 62 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (21 cases) and Afghanistan (one case). No circulating vaccine-derived poliovirus (cVDPV) cases were reported so far in 2015.

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

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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 for 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.

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