



This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

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. Investigations are ongoing to identify the presence of this virus in these type of squirrels and to find previously undiagnosed encephalitis cases due to this causative agent.

→ Update of the week

ECDC published a [rapid risk assessment](#) on 26 February 2015.

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

Opening date: 9 October 2014

Latest update: 26 February 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 the results on its website in the weekly Flu News Europe.

→ Update of the week

For week 8/2015, high and medium intensities of influenza activity were reported by 35 countries and nine countries reported increasing ILI/ARI rates. The number and percentage of influenza virus detections in sentinel specimens showed a slight reduction in what might be described as a 'high plateau' phase of the influenza season. Of 2 535 sentinel specimens, 49% tested positive for influenza virus with positive detections in 34 countries. Influenza A(H1N1)pdm09, A(H3N2) and type B viruses continued to circulate in the region, with A(H3N2) predominating.

Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 26 February 2015

Measles, a highly transmissible vaccine-preventable disease, is still endemic in many EU countries where vaccination uptake remains below the level required to interrupt the transmission cycle. ECDC monitors measles transmission and outbreaks in EU and neighbouring countries in Europe on a monthly basis through enhanced surveillance and epidemic intelligence activities. Elimination of measles requires consistent vaccination uptake above 95% with two doses of measles vaccine in all population groups, strong surveillance and effective outbreak control measures.

→Update of the week

In the EU, since the last monthly update, the outbreak reported in Berlin, Germany is still on-going.

In the rest of the world, outbreaks are ongoing in Serbia, Kyrgyzstan, the US, Mexico, Canada and Guinea.

On 25 February 2015 the [WHO Regional Office for Europe](#) published a press release stating that seven countries in the Region have reported 22 149 cases of measles in 2014 and thus far in 2015. This threatens the Region's goal of eliminating the disease by the end of 2015. Even though measles cases fell by 50% from 2013 to 2014, large outbreaks continue. The WHO Regional Office for Europe calls on policy-makers, healthcare workers and parents immediately to step up vaccination against measles across age groups at risk. This will help to put an end to the outbreaks occurring in countries in the WHO European Region and to prevent similar outbreaks in the future.

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012

Latest update: 26 February 2015

Rubella, caused by the rubella virus and commonly known as German measles, is usually a mild and self-limiting disease and is an infection which often passes unnoticed. The main reason for immunising against rubella is the high risk of congenital malformations associated with rubella infection during pregnancy. All EU Member States recommend vaccination against rubella with at least two doses of vaccine for both boys and girls. The vaccine is given at the same intervals as the measles vaccine as part of the MMR vaccine.

→Update of the week

No new outbreaks have been detected in the EU since the last monthly update.

Non EU Threats

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 27 February 2015

An epidemic of Ebola virus disease (EVD) has been ongoing in West Africa since December 2013, mainly affecting Guinea, Liberia and Sierra Leone. The situation in the affected countries remains serious. 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 24 February, [WHO](#) reported 23 816 cases of Ebola virus disease (EVD) related to the outbreak in West Africa, including 9 652 deaths.

Ninety-nine new confirmed cases of EVD were reported by WHO in the week up to 22 February in Guinea, Liberia and Sierra Leone. Unsafe burials continued in Guinea and Sierra Leone, where part of the cases were detected post mortem in the community rather than among known contacts of Ebola patients. Security incidents related to the Ebola response were also reported, particularly in Guinea. Three new infections among healthcare workers were detected (two from Guinea, one from Sierra Leone), bringing the number of infected workers since the start of the outbreak to 837, with 490 deaths.

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

Opening date: 24 September 2012

Latest update: 26 February 2015

Since April 2012, 1 056 cases of MERS-CoV have been reported by local health authorities worldwide, including 426 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 of 19 February 2015 and as of 26 February, Saudi Arabia has reported 16 additional cases of MERS-CoV.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 26 February 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 14 November, the Temporary Recommendations in relation to PHEIC were extended for a further three months.

→Update of the week

During the past week, three new wild poliovirus type 1 (WPV1) cases were reported by WHO, two in Pakistan and one in Afghanistan.

II. Detailed reports

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. Further tests are ongoing.

ECDC assessment

A recently 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 role of a new bornavirus in the aetiology of these cases, 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.

Further investigations are ongoing to characterise these cases. In addition, testing of cases of human encephalitis for this newly identified bornavirus, especially in areas where the presence of bornavirus is documented in animals, can contribute to a better understanding of the risk of bornavirus infection in humans.

Actions

Germany is investigating tissue and cerebrospinal fluid collections from biobanks for further cases. Previously cryptic cases of encephalitis are re-evaluated in view of the new virus. Breeders/owners of variegated squirrels will be questioned as to their health and anecdotal knowledge of further potentially lethal cases among other breeders/owners. Breeders are asked to send in deceased animals to the Friedrich Loeffler Institute.

ECDC published a [rapid risk assessment](#) on 26 February 2015.

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

Opening date: 9 October 2014

Latest update: 26 February 2015

Epidemiological summary

Excess all-cause mortality among elderly people (aged 65 years and above), concomitant with increased influenza activity and the predominance of A(H3N2) viruses, has been observed since the beginning of the year in six (Belgium, France, Portugal, Spain, Switzerland and the United Kingdom - England, Scotland and Wales) of the 14 reporting countries (see the European project for monitoring excess mortality for public health action, EuroMOMO at <http://www.euromomo.eu/>).

Most of the A(H3N2) viruses characterised so far show antigenic differences from the virus included in the 2014–2015 northern hemisphere influenza vaccine. The observed reduced effectiveness (www.eurosurveillance.org) of the A(H3N2) component of the vaccine might have contributed to the excess mortality reported among elderly people. The A(H1N1)pdm09 and B components of

the vaccine are likely to be effective.

The circulation of respiratory syncytial virus (RSV) has decreased to low levels across the European region.

The vaccine recommendation for the northern hemisphere 2015-2016 season was made on 26 February 2015, indicating that vaccines for use in the 2015-2016 influenza season (northern hemisphere winter) should contain the following:

- an A/California/7/2009 (H1N1)pdm09-like virus;
- an A/Switzerland/9715293/2013 (H3N2)-like virus;
- a B/Phuket/3073/2013-like virus.

It is recommended that quadrivalent vaccines containing two influenza B viruses contain the above three viruses and a B/Brisbane/60/2008-like virus.

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

ECDC assessment

Influenza activity continues, particularly in western and central countries of the WHO European Region.

Actions

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

Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 26 February 2015

Epidemiological summary

EU Member States

Germany- update

A large measles outbreak is ongoing in Berlin. As of 24 February 2015, [media](#) report nearly 600 cases. The outbreak that started in October 2014 initially affected asylum seekers from Bosnia and Herzegovina and Serbia but has now spread to the general population. According to [media](#), at least two cases in Berlin have been linked to the United States. One involved a woman who developed symptoms in the United States before travelling to Berlin. A second involved a child who developed the infection after returning from the United States of America.

There has been one death in an 18 months old unvaccinated [toddler](#). The child fell ill in the Reinickendorf district of Berlin on 12 February with fever and cough and later rash. The child was hospitalised due to worsening condition on 14 February and died in hospital on 18 February. The child was not vaccinated against measles and had no pre-existing conditions.

Denmark

[Media](#) report two epidemiologically linked cases of measles in children in Copenhagen.

Rest of the world

Serbia- update

Since November 2014 and as of 13 February 2015, 228 cases of measles have been reported in [Serbia](#) in several outbreaks affecting numerous areas of the country. This is an increase of 105 cases since 26 January 2015, the last monthly update.

Kyrgyzstan - update

According to WHO, Kyrgyzstan has reported 7 477 cases between May 2014 and February 2015. The first case was identified in Bishkek city on 3 May 2014, but the number increased dramatically in 2015.

US - update

There is a large ongoing measles outbreak in California that began after several people were exposed to measles while visiting

5/17

Disneyland between 17 and 20 December 2014. No source has been identified for this outbreak. The measles genotype was identified as B3, which also caused a large outbreak in the Philippines in 2014.

Since 1 January and as of 24 February, 154 measles cases have been confirmed in [U.S.](#) residents in 17 states. Most of these cases (77 percent) are connected with the outbreak in California. [Linked](#) cases were reported in two neighbouring countries, Mexico and Canada.

During 2014, 644 cases of measles were reported in the US which is the highest number of cases since 2000 when measles was declared eliminated in the US.

Mexico

The [Mexico](#) IHR National Focal Point reported two imported cases of measles with history of travel to the United States. The first case is a 22-month-old female from Baja California Sur, Mexico (rash onset 30 Dec 2014) with history of travel to California from 16 to 18 Dec 2014. The second case is a 37-year-old, unvaccinated female from Nueva Leon state (rash onset 13 Jan 2015), whose only history of recent travel was to San Francisco, California from 26 to 31 Dec 2014. Local and national authorities have implemented appropriate prevention and control measures. So far, no further cases have been registered in Mexico.

Canada - update

As of 10 February 2015, 37 cases of measles have been reported in [Canada](#) for 2015 (19 cases in Quebec with a link to the current outbreak in California and 18 in Ontario). On 10 February, the Manitoba government reported the province's first case of measles of the year in an isolated incident. Different genotypes have been identified: D4 in Ontario, B3 in Quebec, and D8 in Manitoba. The version of the [measles virus](#) circulating in Ontario is a variant that has never before been reported to the World Health Organization database.

Guinea

According to [media](#), 69 measles cases, including two deaths, have been reported since January 2015 in the Gaoual region, north east of the country.

Web sources: [ECDC measles and rubella monitoring](#) | [ECDC/Euronews documentary](#) | [MedISys Measles page](#) | [EU VACC-net ECDC](#) | [ECDC measles factsheet](#)

ECDC assessment

During 2014, eight EU Member States reported measles outbreaks. The target year for measles elimination in Europe is 2015. The current situation suggests that endemic measles transmission continues in many EU Member States and the prospect of achieving the 2015 objective is not feasible.

Actions

On 10 December, ECDC published a [rapid risk assessment](#) on the outbreak of measles linked to an international dog exhibition in Slovenia.

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012

Latest update: 26 February 2015

Epidemiological summary

Twenty-seven EU/EEA countries reported 6 396 cases during the recent 12-month period between November 2013 and October 2014. In 21 countries, the rubella notification rate was less than one case per million population during the last 12 months.

Web sources: [ECDC measles and rubella monitoring](#) | [ECDC rubella factsheet](#) | [WHO epidemiological brief summary tables](#) | [WHO epidemiological briefs](#) | [Progress report on measles and rubella elimination](#) | [Towards rubella elimination in Poland](#)

ECDC assessment

As rubella is typically a mild and self-limiting disease with few complications, the rationale for eliminating rubella would be weak if it were not for the virus' teratogenic effect. When a woman is infected with the rubella virus within the first 20 weeks of pregnancy, the foetus has a 90% risk of being born with congenital rubella syndrome (CRS), which entails a range of serious incurable illnesses. The increase in the number of rubella cases reported in Romania and Poland during the last two years and

the number of babies born with CRS are cause for concern. Rubella occurs predominantly in age and sex cohorts historically not included in vaccination recommendations. To achieve rubella elimination, supplemental immunisation activities in these cohorts are needed.

Actions

ECDC closely monitors rubella transmission in Europe by analysing the cases reported to the European Surveillance System and through its epidemic intelligence activities on a monthly basis. Twenty-four EU and two EEA countries contribute to the enhanced rubella surveillance. The purpose of the enhanced rubella monitoring is to provide regular and timely updates on the rubella situation in Europe in support of effective disease control, increased public awareness and the achievement of the 2015 rubella and congenital rubella elimination target.

An ECDC report is available online: [Survey on rubella, rubella in pregnancy and congenital rubella surveillance systems in EU/EEA countries](#)

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014

Latest update: 27 February 2015

Epidemiological summary

Distribution of cases as of 24 February:

Countries with intense transmission:

Distribution of EVD cases for countries with intense transmission:

- Guinea: 3 175 cases and 2 101 deaths (as of 24 February)
- Liberia: 9 265 cases and 4 057 deaths (as of 23 February)
- Sierra Leone: 11 341 cases and 3 479 deaths (as of 24 February)

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

- United Kingdom: one confirmed case on 29 December 2014.
- Mali, Nigeria, Senegal, Spain and the United States have been declared free of EVD after having cases related to the current epidemic in West Africa.

Situation in specific West African countries

According to WHO, Guinea reported 35 new confirmed cases in the week to 22 February. Cases continue to arise from unknown chains of transmission. Most new cases were reported from Conakry (six new confirmed cases), Coyah (eight new confirmed cases), and Forecariah (16 confirmed cases).

WHO reports that transmission remains widespread in Sierra Leone, with 63 new confirmed cases in the past week. Cases are still arising from unknown chains of transmission. The steep decline in case incidence in Sierra Leone has now ceased. Transmission remains widespread in Sierra Leone, with a total of eight districts reporting new confirmed cases.

Transmission continues at very low levels in Liberia, reported WHO, with one new confirmed case reported in the analysed week. The case was reported from a registered contact associated with a known chain of transmission in the capital, Monrovia.

Situation among healthcare workers

There were 837 confirmed cases as of 22 February, including 490 deaths, among healthcare workers in the three countries with intense and widespread transmission.

Medical evacuations and repatriations from EVD-affected countries

Thirty-eight individuals have been evacuated or repatriated worldwide from the EVD-affected countries. As of 26 February, there have been 12 medical evacuations of confirmed EVD-infected patients to Europe (three to Germany, two to Spain, two to France,

one to the UK, one to Norway, one to Italy, one to the Netherlands and one to Switzerland). Sixteen asymptomatic persons exposed to Ebola have been repatriated to Europe (seven to UK, three to Sweden, two to the Netherlands, one to Denmark, one to Germany, one to Spain and one to Switzerland). Ten persons have been evacuated to the United States.

Since the last update, two medical evacuations have been reported.

On Friday 20 February, [Public Health England](#) reported that an Australian healthcare worker has been repatriated to the UK for assessment, after exposure to the Ebola virus while working in Sierra Leone.

On Wednesday 25 February, [Public Health England](#) confirmed that, as a highly precautionary measure, a UK healthcare worker who had potential contact with the Ebola virus while working in Sierra Leone, has been repatriated to the UK for assessment and monitoring.

Figures

First epi-curve: distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Nigeria, Mali and Senegal, weeks 48/2013 to 09/2015 **

* In week 45/2014, WHO carried out retrospective correction in the data, resulting in 299 fewer cases being reported, which resulted in a negative value for new cases in week 45 which is not plotted.

** According to WHO, the marked increase in the cumulative total number of cases in week 43 is due to a more comprehensive assessment of patient databases, leading to 3 792 additional reported cases. However, these cases have occurred throughout the epidemic period.

Second epi-curve: Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 09* 2015.

* The marked increase in the number of cases reported in Sierra Leone (week 44) and Liberia (week 43) resulted from a more comprehensive assessment of patient databases. The additional 3 792 cases have occurred throughout the epidemic period.

** In week 45/2014, WHO reported -476 cases in Sierra Leone due to retrospective corrections.

§ In week 44/2014, WHO reported zero cases for Liberia.

Web sources: [ECDC Ebola page](#) | [ECDC Ebola and Marburg fact sheet](#) | [WHO Ebola Factsheet](#) | [CDC](#) | [WHO Roadmap](#) | [Australian healthcare worker evacuation](#) | [UK medical evacuation](#) | [Latest available situation summary from WHO](#) |

ECDC assessment

This is the largest ever documented epidemic of EVD 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 EVD being imported into the EU or the risk of transmission occurring within the EU remains low or very low due to the range of risk reduction measures that have been put in place by the Member States and the affected countries. However, continued vigilance is essential in order to ensure that re-entry standards do not lapse.

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.

Engaging effectively with communities is still a challenge in several areas, especially in Guinea where ten prefectures reported at least one security incident in the past week. Guinea and Sierra Leone continue to report unsafe burials and detection of community cases rather than among known contacts of Ebola patients. WHO reported that 16 new confirmed cases were identified in Guinea and Sierra Leone after post-mortem testing of community deaths, indicating that a significant number of individuals are still either unable or reluctant to seek treatment.

Actions

As of 22 February 2015, ECDC has deployed 36 experts within and outside the EU in response to the Ebola outbreak. This includes an ECDC mobilised contingent of experts to Guinea. Furthermore, 12 additional experts are confirmed for deployment to Guinea over the next four months while additional deployments are envisaged but still pending confirmation.

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. ECDC's role is to organise the technical support for contact tracing and epidemiological surveillance in the Guinée Forestière region under the GOARN mechanism. Individual experts are invited to contribute by deploying on 6-week missions with departure from March to June. The ECDC teams in Guinée Forestière are currently based in N'zerekoré town. For further information, please contact Niklas Danielsson, Response group leader at: niklas.danielsson@ecdc.europa.eu with cc to support@ecdc.europa.eu

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

On 4 February 2015, ECDC published an updated [rapid risk assessment](#)

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](#)

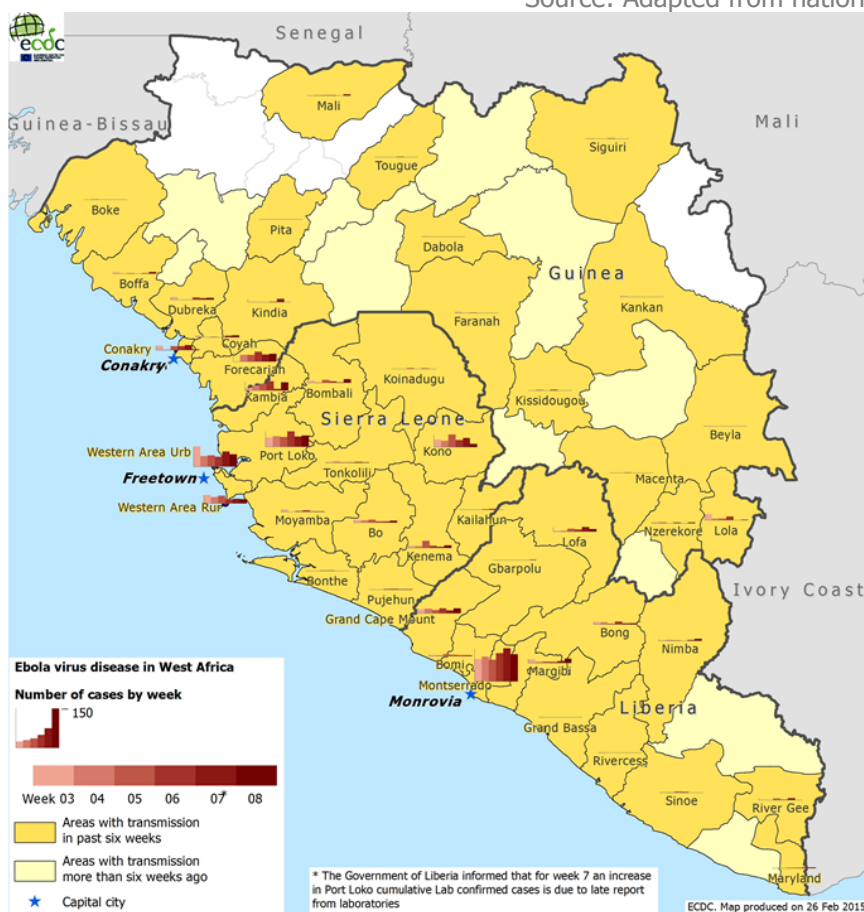
On 6 October 2014, ECDC published [risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU](#)

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 cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (as of week 08/2015)

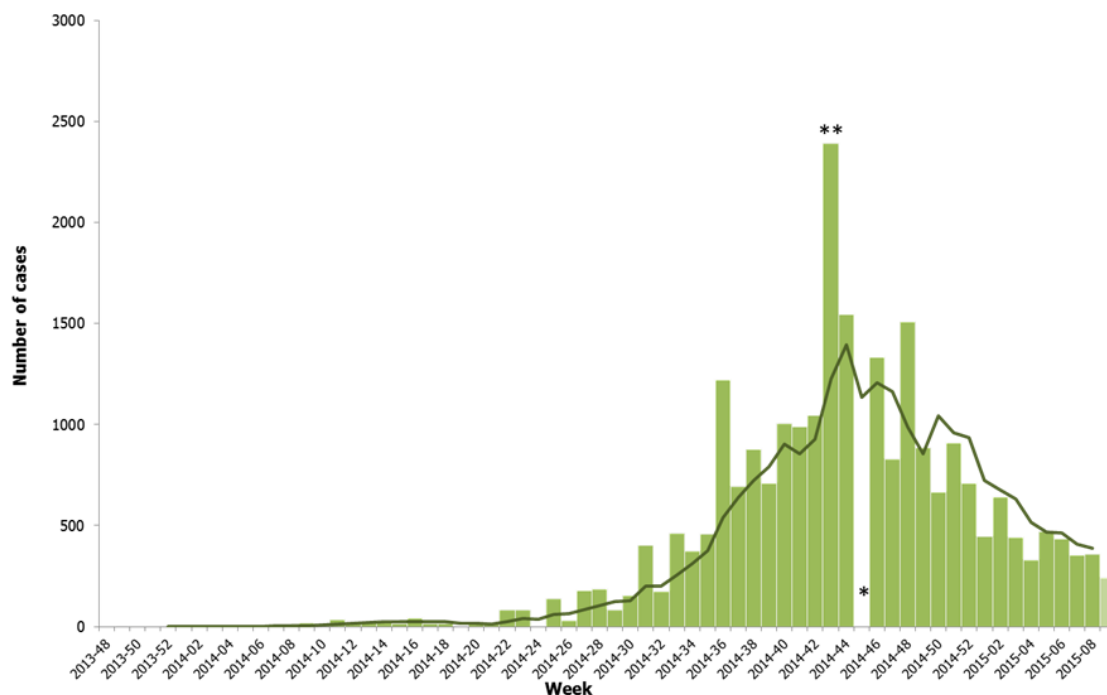
Source: Adapted from national situation reports



Distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Mali, Nigeria and Senegal, weeks 48/2013 to 09*/2015

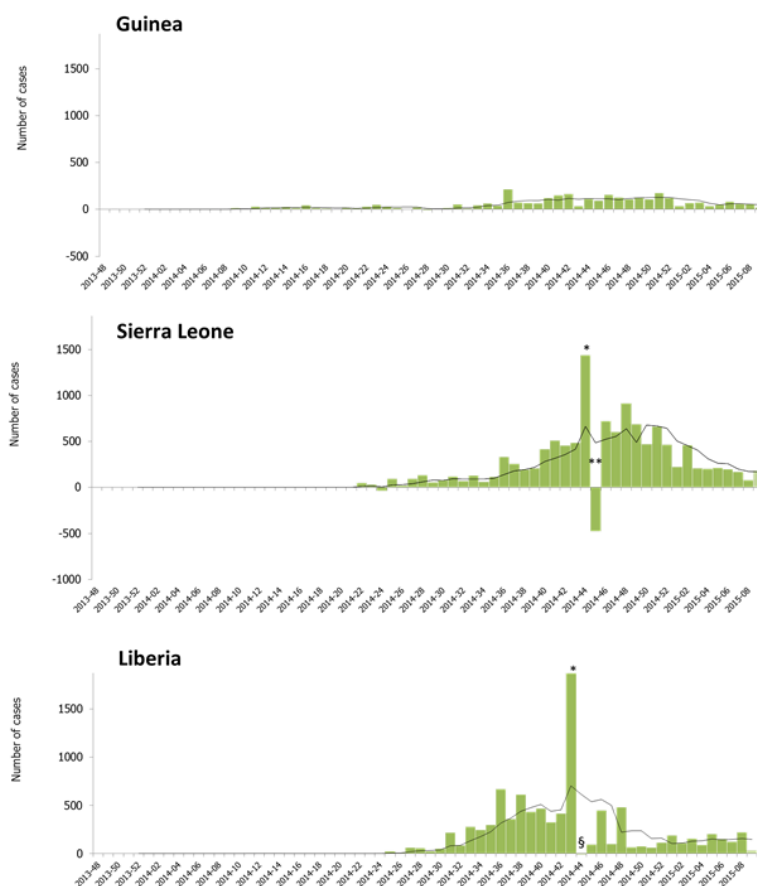
Source: Adapted from WHO figures; *data for week 09/2015 are incomplete

Weekly number of EVD cases published on 26/02/2015



Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 09* 2015

Source: Adapted from WHO figures; *data for week 09/2015 are incomplete



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

Opening date: 24 September 2012

Latest update: 26 February 2015

Epidemiological summary

Since April 2012 and as of 26 February 2015, 1 056 cases of MERS-CoV have been reported by local health authorities worldwide, including 426 deaths.

The distribution is as follows:

Confirmed cases and deaths by region:

Middle East

Saudi Arabia: 913 cases/389 deaths

United Arab Emirates: 74 cases/10 deaths

Qatar: 10 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: 2 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 have not been identified. Dromedary camels are a host species for the virus, and many of the primary cases in MERS-CoV clusters have reported direct or indirect camel exposure. There is therefore 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 further reduced 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

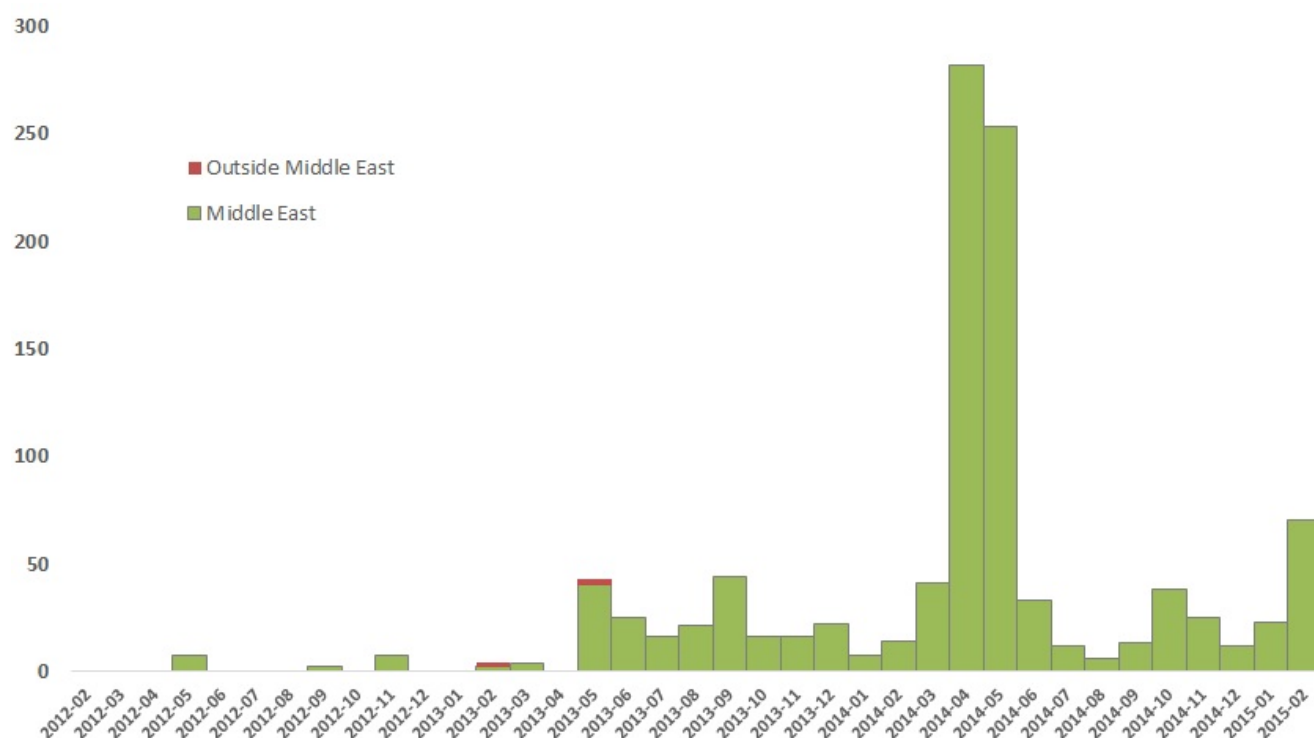
The last [rapid risk assessment](#) was updated on 23 February 2015.

ECDC is closely monitoring the situation in collaboration with WHO and EU Member States.

ECDC published a [factsheet for health professionals regarding MERS-CoV](#) on 20 August 2014.

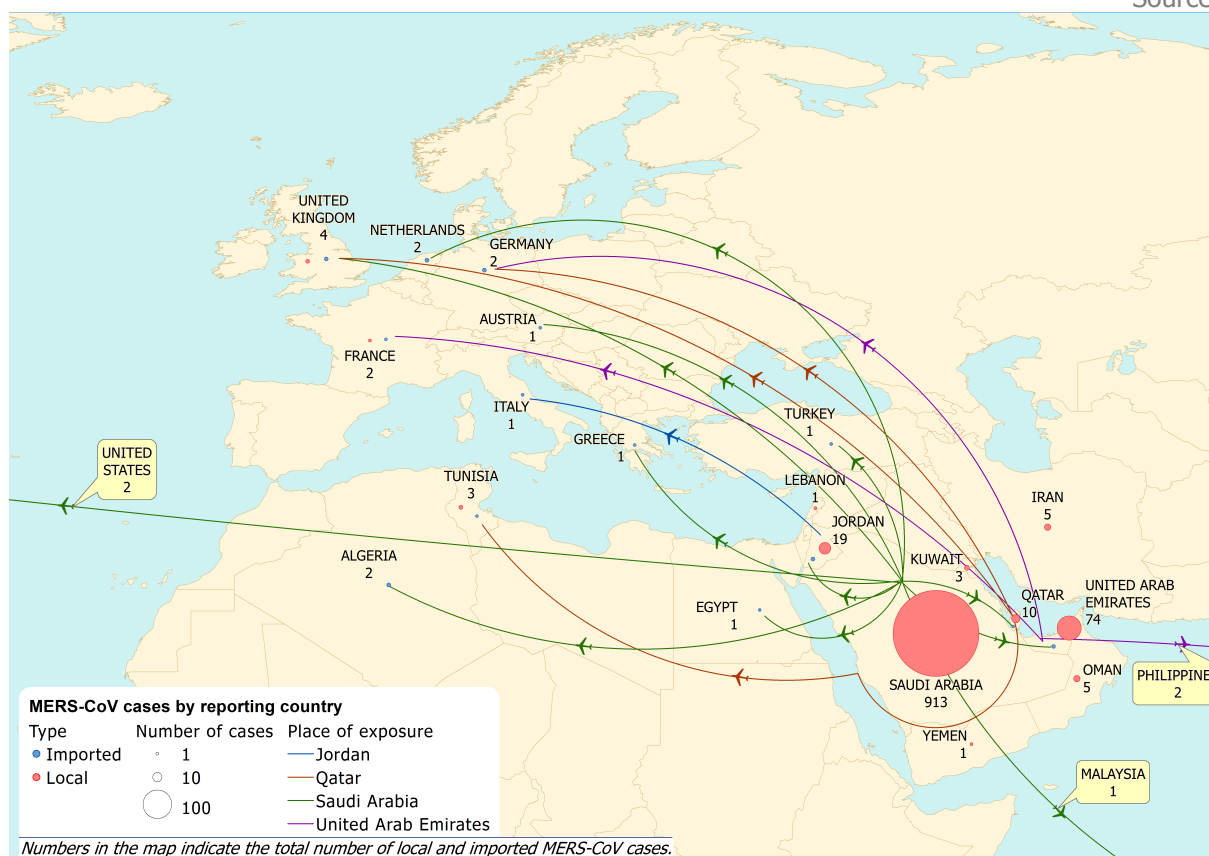
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 26 February 2015 (n=1056)

Source: ECDC



Geographical distribution of confirmed MERS-CoV cases and place of probable infection, worldwide, as of 26 February 2015 (n=1056)

Source: ECDC



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 26 February 2015

Epidemiological summary

Worldwide in 2015, ten WPV1 cases have been reported to WHO, compared with 24 for the same period in 2014. In 2014, nine countries reported cases: Pakistan (306 cases), Afghanistan (28 cases), Nigeria (six cases), Equatorial Guinea (five cases), Somalia (five cases), Cameroon (five cases), Iraq (two cases), Syria (one case), and Ethiopia (one case).

No new circulating vaccine-derived poliovirus (cVDPV) cases were reported in the past week. Worldwide, 54 cVDPV cases were reported in 2014.

The fourth meeting of the IHR Emergency Committee on the international spread of wild poliovirus meeting took place on 17 February via a teleconference. The Emergency Committee (EC) decided to recommend to the Director General of WHO that the international spread of wild poliovirus continues to constitute a Public Health Emergency of International Concern (PHEIC). The EC continues to formulate the temporary recommendations through e-mail exchanges, and if required, during a follow-up

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teleconference.

Web sources: [Polio Eradication: weekly update](#) | [MedISys Poliomyelitis](#) | [ECDC Poliomyelitis factsheet](#) | [Temporary Recommendations to Reduce International Spread of Poliovirus](#)

ECDC assessment

Europe is polio-free. The last 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 WPV in several countries and the documented exportation of WPV to other countries support the fact that there is a potential risk for WPV 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?](#) | [WHO statement on the meeting of the International Health Regulations Emergency Committee concerning the international spread of wild poliovirus, 5 May 2014](#) | [WHO statement on the third meeting of the International Health Regulations Emergency Committee regarding the international spread of wild poliovirus, 14 November 2014](#)

Actions

ECDC follows 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 to 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.