COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 44, 25-31 October 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

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

Opening date: 2 October 2015 Latest update: 30 October 2015

Following the 2009 pandemic, influenza transmission in Europe has returned to its seasonal epidemic pattern, with peak activity during winter months. ECDC monitors influenza activity in Europe during the winter season and publishes its report weekly on the Flu News Europe website. The reporting for the season 2015-2016 has started. As is usual for this time of year, intensity of influenza activity in the European Region is still low in week 43.

➔Update of the week

In week 43, epidemiological data were reported by 42 countries, with all reporting low influenza activity.

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

Opening date: 2 June 2015 Latest update: 29 October 2015

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

➔Update of the week

During the past week, Italy reported one additional case in the already affected province of Modena. Romania reported one new case in the already affected district of Dolj. No new cases were reported in neighbouring countries.

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Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011 Latest update: 29 October 2015

Measles, a highly transmissible vaccine-preventable disease, is still endemic in some EU countries where vaccination uptake remains below the level required to interrupt the transmission cycle. 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. Europe has recently seen a particularly large ongoing measles outbreak in Berlin which started in week 41 of 2014. In 2015, other major outbreaks have occurred in China, Mongolia, USA, Democratic Republic of Congo (DRC) and Sudan while smaller outbreaks have been reported in many other countries in Africa, Asia, Americas and Europe.

➔Update of the week

No new outbreaks were detected in the EU since the last monthly update in September.

In the rest of the world, measles outbreaks are ongoing in Kazakhstan, DRC and Sudan.

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012 Latest update: 29 October 2015

Rubella, caused by the rubella virus and commonly known as German measles, is usually a mild and self-limiting disease 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. Very few outbreaks of rubella have been reported in the EU so far this year.
According to the latest US CDC Morbidity and Mortality Weekly Report (MMWR), reported rubella cases have declined by 95%, from 670 894 cases reported in 2000 in 102 countries to 33 068 cases reported in 2014 in 162 countries.

➔Update of the week

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

Non EU Threats

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

Opening date: 24 September 2012 Latest update: 29 October 2015

Since April 2012 and as of 29 October 2015, 1 635 cases of MERS, including 628 deaths, have been reported by local health authorities worldwide. The source of the virus remains unknown, but the pattern of transmission and virological studies point towards dromedary camels in the Middle East being a reservoir from which humans sporadically become infected through zoonotic transmission. Human-to-human transmission is amplified among household contacts and in healthcare settings, as was clearly shown in the recent outbreak in South Korea and in the current situation in Riyadh, Saudi Arabia.

➔Update of the week

Since 22 October 2015, there have been nine new cases and three deaths reported from Saudi Arabia. The Republic of Korea has reported a case testing positive again for MERS-CoV and a death in another case related to the hospital cluster reported earlier this year.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 29 October 2015

An epidemic of Ebola virus disease (EVD) has been ongoing in West Africa since December 2013, mainly affecting Guinea, Liberia and Sierra Leone. On 8 August 2014, WHO declared the Ebola epidemic in West Africa a Public Health Emergency of International Concern (PHEIC). As of 27 October 2015, WHO has reported 28 546 cases of Ebola virus disease related to the outbreak in West Africa, including 11 299 deaths. The number of cases in the most affected countries peaked in autumn 2014 and has been slowly decreasing since. Liberia was declared Ebola-free by WHO on 3 September 2015. Since the end of July 2015, in Guinea and Sierra Leone, the last two affected countries, case incidence has remained below 10 cases per week and EVD transmission has been geographically confined to small areas in both countries. The risk of spread, regionally and globally, remains until all the countries in West Africa are declared Ebola-free.

➔Update of the week

According to WHO, three confirmed cases were reported from Guinea in the week leading up to 25 October. No new cases have been reported for six consecutive weeks in Sierra Leone. If no new cases are reported, Sierra Leone will be declared Ebola free on 7 November.

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Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 29 October 2015

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, 679 cases have been reported up until 29 October 2015, including 275 deaths. No autochthonous cases have been reported outside of China. Most cases have been unlinked, and sporadic zoonotic transmission from poultry to humans is the most likely explanation for the outbreak.

➔Update of the week

No new cases have been notified since last week.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 29 October 2015

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission of the virus has completely stopped and the world becomes polio-free. Polio was declared a Public Health Emergency of International Concern (PHEIC) on 5 May 2014 due to concerns regarding the increased circulation and international spread of wild poliovirus during 2014. On 17 August 2015, the Temporary Recommendations in relation to PHEIC were extended for another three months. WHO recently declared wild poliovirus type 2 eradicated worldwide. As of 22 October 2015, WHO has reported 51 cases of wild poliovirus compared with 246 during the same time period last year. All cases so far in 2015 have been reported from Afghanistan and Pakistan.

➔Update of the week

According to WHO, no new wild poliovirus cases were reported in the past week.

One new case of circulating vaccine-derived poliovirus type 1 (cVDPV1) with onset of paralysis on 22 August, was reported to WHO from a new district in Madagascar. The case is from the Sud-Ouest province and genetically linked to the case reported in September 2014.

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II. Detailed reports

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

Opening date: 2 October 2015 Latest update: 30 October 2015

Epidemiological summary

Influenza activity in the WHO European Region is at a low level in all 42 countries which reported data for week 43/2015. Influenza virus was detected in 16 sentinel and non-sentinel specimens and in two hospitalised patients.

ECDC assessment

As is usual for this time of year, influenza activity in the European Region continued to be low, with few influenza viruses detected (<1% of sentinel specimens).

Actions

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

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

Opening date: 2 June 2015 Latest update: 29 October 2015

Epidemiological summary

As of 29 October 2015, 106 cases of West Nile fever in humans have been reported in EU Member States and 134 cases in neighbouring countries since the beginning of the 2015 transmission season.

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

ECDC assessment

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

Actions

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

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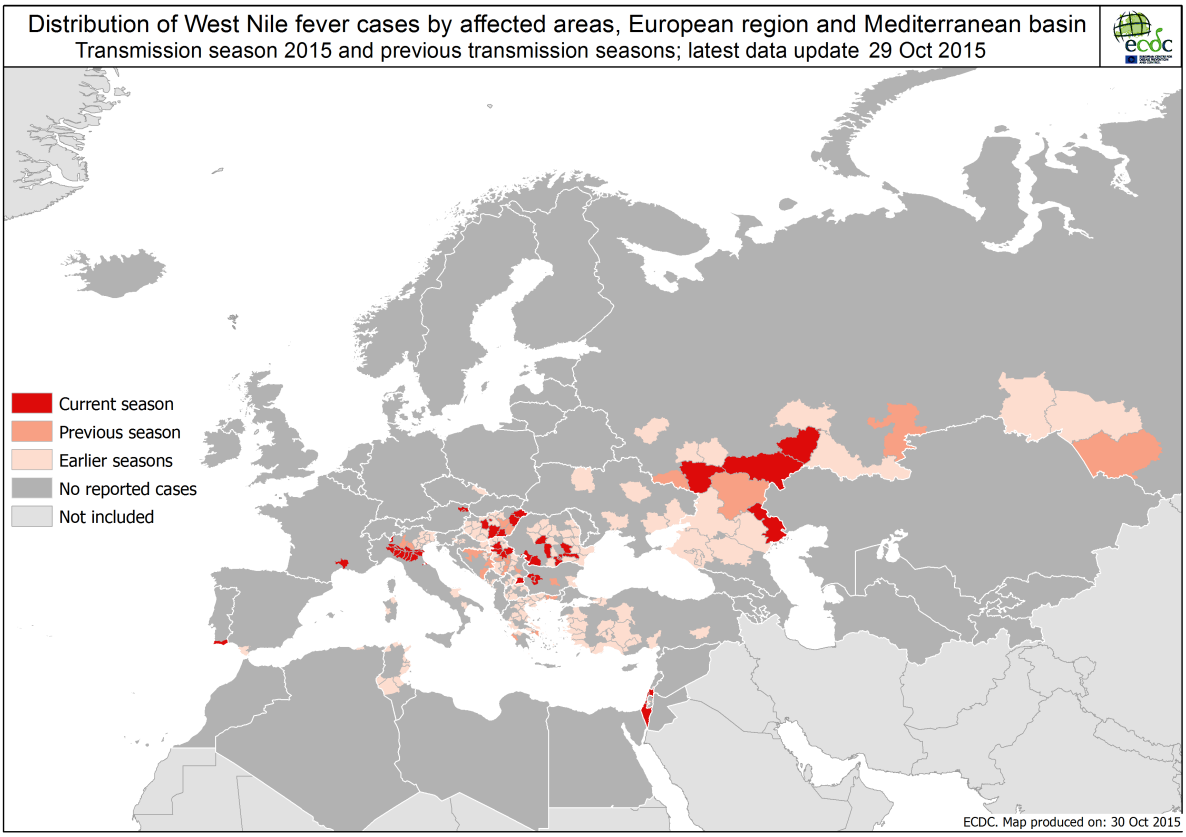
Source: ECDC



Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011 Latest update: 29 October 2015

Epidemiological summary

EU Member States

No new outbreaks or updates identified since the last monthly update in September 2015.

Rest of the world

Cambodia

Cambodia has reported its first confirmed measles case since November 2011. The country was declared to have reached its measles free elimination status by WHO on 27 March 2015.

DRC – update

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As of October 4 2015, Katanga province has recorded nearly 30 000 cases of measles, 80% of all cases in the country, including 428 fatalities. The number of cases has nearly tripled in 2015 compared to last year.

Sudan – update

As of 4 October, the number of confirmed cases reached 3 351, including 71 deaths. The outbreak that started in December last year affected people in 71 localities across all the 18 states. In total, 73 percent of the cases are children under 15 years, of whom 55 percent are children under five years.

Kazakhstan – Update

Measles outbreaks continue in Kazakhstan. Since the beginning of the year and as of 27 October 2015, 2 283 cases have been notified with 17% of the cases aged under one year. A large immunisation campaign is currently ongoing.

Publications
Economic Costs of Measles Outbreak in the Netherlands, 2013–2014

Measures taken by Dutch hospitals to prevent measles in healthcare personnel; a 2014 survey

Web sources: ECDC measles and rubella monitoring | ECDC/Euronews documentary | MedISys Measles page | EUVAC-net ECDC | ECDC measles factsheet

ECDC assessment

During the 12-month period from July 2014 to June 2015, 4 224 cases were reported by 30 EU/EEA countries. The target for measles elimination in Europe has not been reached in 2015 due to continuing endemic measles transmission in many EU Member States.

Actions

ECDC monitors measles transmission and outbreaks in EU and neighbouring countries in Europe on a monthly basis through enhanced surveillance and epidemic intelligence activities.

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012 Latest update: 29 October 2015

Epidemiological summary

EU Member States
No outbreaks have been detected in the EU since June 2015.

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 are needed in these cohorts.

Actions

ECDC closely monitors rubella transmission in Europe by analysing the cases reported to The European Surveillance System and

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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

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

Opening date: 24 September 2012 Latest update: 29 October 2015

Epidemiological summary

As of 29 October, 1 635 cases of MERS, including 628 deaths, have been reported by local health authorities worldwide.

Saudi Arabia
During the past week, Saudi Arabia has reported cases from Riyadh (three), Hufoof (five) and Alkharj (one). Seven of these cases were due to secondary transmission (six nosocomial and one household contact). Three cases were healthcare workers. Two cases were identified as primary cases.

There are several ongoing MERS-CoV clusters in Saudi Arabia.

One of them involves female expatriate non-healthcare workers, also called the 'janitors cluster'. According to CIDRAP, Saudi health officials have acknowledged the cluster among 36 females sharing a villa east of Riyadh. They are foreigners working under contract for Princess Noura bint Abdurrahman University (PNU). The number of cases linked to the janitor roommate cluster is uncertain. As of 29 October, at least eight cases fit this profile.

According to the Ministry of Health, there is an ongoing cluster in Hofuf (Al-Ahsa), where one primary case resulted in eight secondary cases, two of which are healthcare workers.

South Korea
On 12 October 2015, the Republic of Korea provided follow-up information on a previously reported case of MERS-CoV infection. The patient was discharged from hospital on 3 October following two consecutive negative PCR tests for MERS-CoV, was readmitted to hospital with fever on 11 October and tested again positive for MERS-CoV on 12 October.

According to local media quoting health authorities, a South Korean man died of complications from MERS-CoV on 25 October 2015. This is the first death due to MERS-CoV in more than three months. The 66-year-old man was diagnosed in June after contracting the virus at the Samsung Medical Centre in Seoul. He was later said to be cured of the disease but had an acute lung ailment that was a complication resulting from the virus.

Web sources: ECDC's latest rapid risk assessment | ECDC novel coronavirus webpage | WHO | WHO MERS updates | WHO travel health update | WHO Euro MERS updates | CDC MERS | Saudi Arabia MoH | Saudi Arabia statement |ECDC factsheet for professionals

ECDC assessment

The MERS outbreak in the Middle East poses a low risk to the EU. Efforts to contain the nosocomial clusters in the affected countries are vital to prevent wider transmission. Although sustained human-to-human community transmission is unlikely, the residential cluster of cases reported from Saudi Arabia is a reminder that transmission to unprotected close contacts, not only in healthcare settings, remains possible, as also documented in outbreaks in the Republic of Korea and the United Arab Emirates.

Actions

ECDC published a rapid risk assessment on 21 October 2015.

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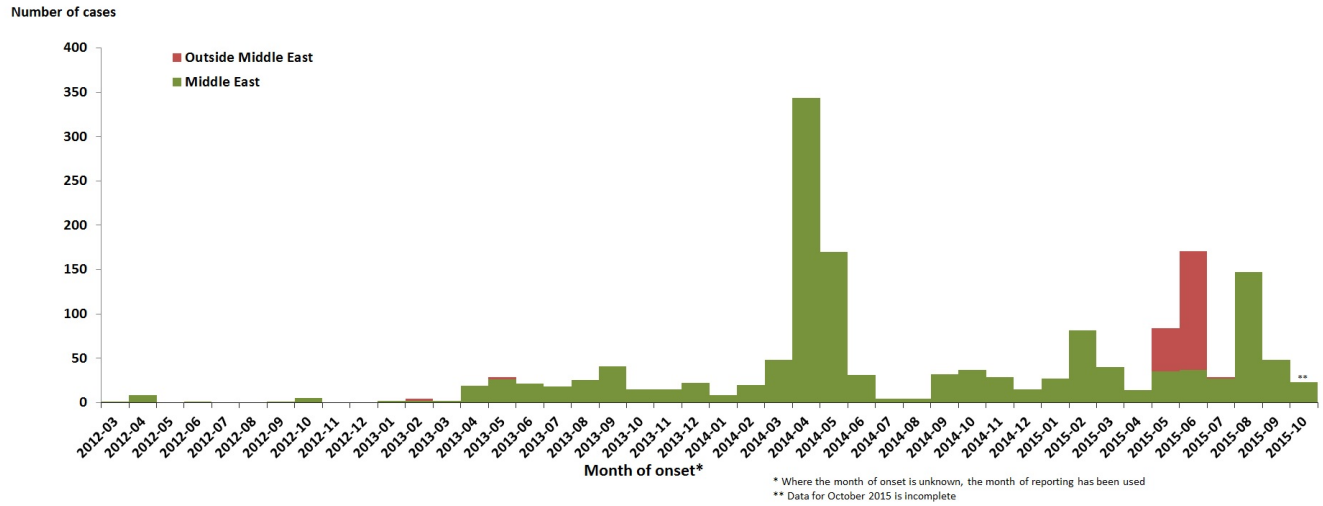
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 29 October 2015 (n=1 635)

Source: ECDC



MERS-CoV by country of reporting, March 2012 – 29 October 2015 (n=1 635)

ECDC

Region	Country	Number of cases	Number of deaths
Middle East	Saudi Arabia	1274	541
	United Arab Emirates	81	11
	Qatar	13	5
	Jordan	35	14
	Oman	6	3
	Kuwait	4	2
	Egypt	1	0
	Yemen	1	1
	Lebanon	1	0
	Iran	6	2
Europe	Turkey	1	1
	UK	4	3
	Germany	3	2
	France	2	1
	Italy	1	0
	Greece	1	1
	Netherlands	2	0
	Austria	1	0
Africa	Tunisia	3	1
	Algeria	2	1
Asia	Malaysia	1	1
	Philippines	3	0
	South Korea	185	37
	China	1	0
	Thailand	1	0
Americas	United States of America	2	0
	Global	**1635**	**627**

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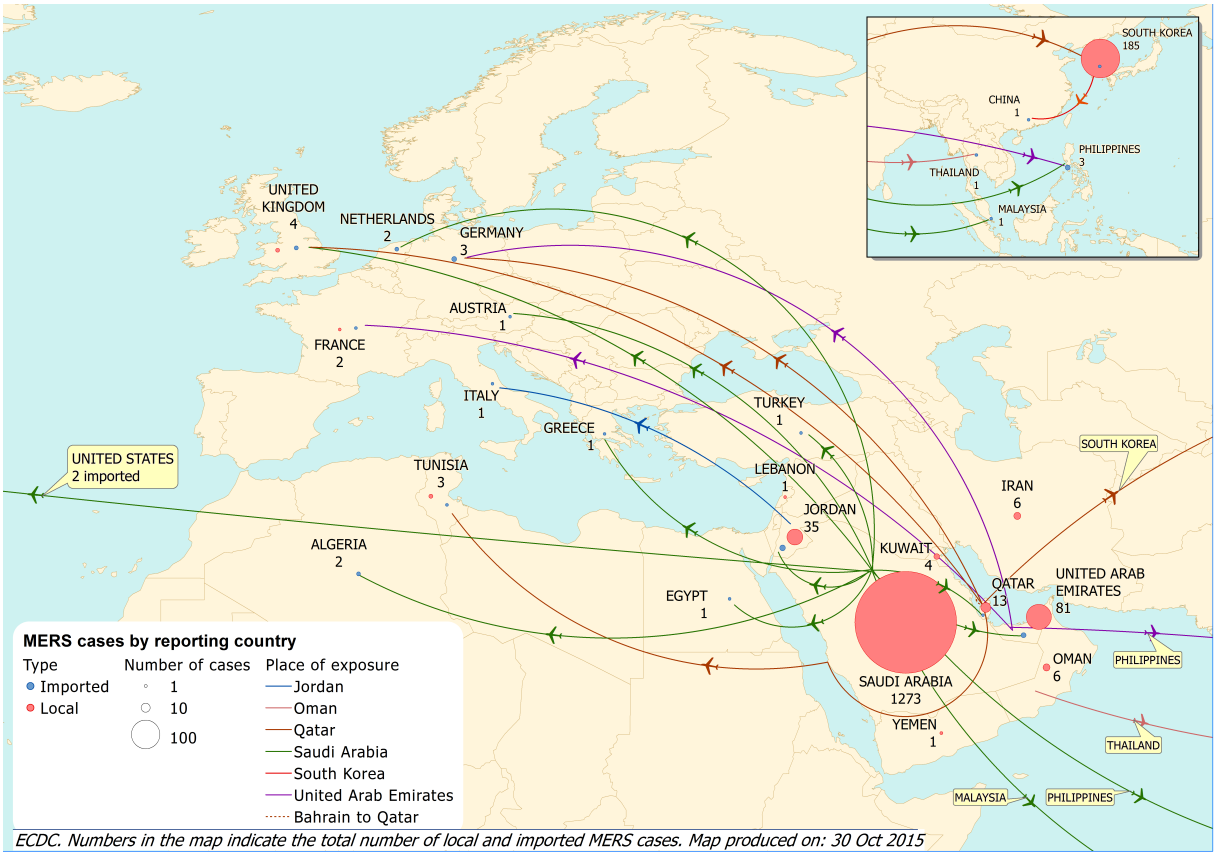

ECDC. Numbers in the map indicate the total number of local and imported MERS cases. Map produced on: 30 Oct 2015

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 29 October 2015

Epidemiological summary

Distribution of cases as of 27 October 2015:

Countries with intense transmission:

- **Guinea:** 3 808 cases, of which 3 350 were confirmed; 2 536 deaths.
- **Sierra Leone:** 14 066 cases, of which 8 704 were confirmed; 3 955 deaths.

Countries with previously widespread and intense transmission:

- **Liberia**: declared Ebola-free on 3 September 2015.

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Countries that have reported an initial case or localised transmission:

- Nigeria, Senegal, the USA, Spain, Mali, the UK and Italy.

Situation in West African countries
Guinea
According to WHO, three confirmed cases were reported from Guinea in the week leading up to 25 October. The cases are members of the same family and household in Forecariah. All are high-risk contacts of one of the three cases reported from the same village in the previous week. The cases are a 25-year-old female who is 7-months pregnant, and her 10-year-old son and 4-year-old daughter. All are linked to the Ratoma chain of transmission. Three hundred and sixty four contacts remained under follow-up in the week leading up to 25 October, of which 43 were located in Conakry with the remainder located in Forecariah. In addition, 233 contacts have been identified but have so far proven untraceable in the past 42 days. The ring vaccination trial is continuing in Guinea. All rings comprised contacts, and contacts of contacts associated with confirmed cases, and are receiving immediate vaccination with the rVSV-ZEBOV Ebola vaccine.

Sierra Leone
No new confirmed cases were reported for the sixth consecutive week. The last case to receive treatment was discharged from an Ebola treatment centre in Kambia on 26 September. All identified contacts have now completed a 21-day follow-up. However, one high-risk contact from Kambia remain untraced. The ring vaccination Phase 3 efficacy trial of the rVSV-ZEBOV vaccine was extended from Guinea to Sierra Leone in September.

Situation among healthcare workers
No new health worker infections were reported by WHO in the week leading up to 25 October.

Outside of the three most affected countries, 2 Ebola-infected healthcare workers were reported in Mali, 11 in Nigeria, 1 in Spain (infected while caring for an evacuated EVD patient), 3 in the UK (all infected in Sierra Leone), 9 in the USA and 1 in Italy (infected in Sierra Leone).

Images
- Epicurve 1: the epicurve shows the confirmed cases in the three most affected countries. In order to better represent the tail of the epidemic, only the data for 2015 are shown.
- Epicurve 2: the epicurve shows the confirmed cases in Guinea and Sierra Leone. In order to better represent the tail of the epidemic, only the data for 2015 are shown.

Web sources: ECDC Ebola page | ECDC Ebola and Marburg fact sheet | WHO situation summary | WHO Roadmap | WHO Ebola Factsheet | CDC | Ebola response phase 3: Framework for achieving and sustaining a resilient zero | ReEBOV Antigen Rapid Test Kit | Institut Pasteur will open a lab in Conakry | Emergency Operation Centres in the three affected countries | Entry screening in US

ECDC assessment

This is the largest-ever documented epidemic of EVD, both in terms of numbers and geographical spread. The epidemic of EVD increases the likelihood that EU residents and travellers to the EVD-affected countries will be exposed to infected or ill persons. The risk of infection for residents and visitors in the affected countries through exposure in the community is considered low if they adhere to the recommended precautions. Residents and visitors to the affected areas run a risk of exposure to EVD in healthcare facilities.

The risk of importing EVD into the EU and the risk of transmission within the EU following an importation remains low or very low as a result of the range of risk reduction measures that have been put in place by the Member States and by the affected countries in West Africa. However, continued vigilance is essential. If a symptomatic case of EVD presents in an EU Member State, secondary transmission to caregivers in the family and in healthcare facilities cannot be excluded.

The number of confirmed cases has remained low since the end of July. The introduction of an EVD case into unaffected countries remains possible as long as cases exist in any country. With adequate preparation, however, such an introduction can be contained through a timely and effective response. Following the recent report about the previously positive EVD UK nurse, unusual late complications should also be taken into account.

Actions

As of 22 October 2015, ECDC has deployed 95 experts (on a rotating basis) from within and outside the EU in response to the Ebola outbreak. This includes an ECDC-mobilised contingent of experts to Guinea. ECDC is reporting this threat on a weekly basis in the CDTR.

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The latest (13th) update of the rapid risk assessment was published on 16 October 2015.
On 16 October 2015, ECDC published Recent development on sexual transmission of Ebola virus.
On 31 July 2015, ECDC published Positive preliminary results of an Ebola vaccine efficacy trial in Guinea.
On 22 January 2015, ECDC published Infection prevention and control measures for Ebola virus disease. Management of healthcare workers returning from Ebola-affected areas.
On 4 December 2014, EFSA and ECDC published a Scientific report assessing Risk related to household pets in contact with Ebola cases in humans.
On 29 October 2014, ECDC published a training tool on the safe use of PPE and options for preparing for gatherings in the EU.
On 23 October 2014, ECDC published Public health management of persons having had contact with Ebola virus disease cases in the EU.
On 22 October 2014, ECDC published Assessing and planning medical evacuation flights to Europe for patients with Ebola virus 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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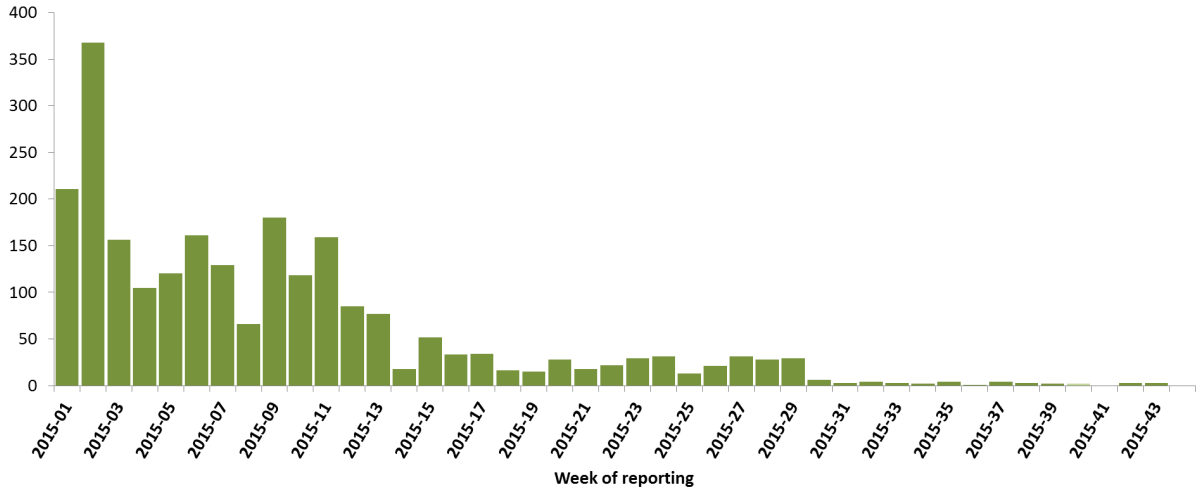
Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 01/2015 to 44/2015)

Adapted from WHO figures; *data for week 44/2015 are incomplete



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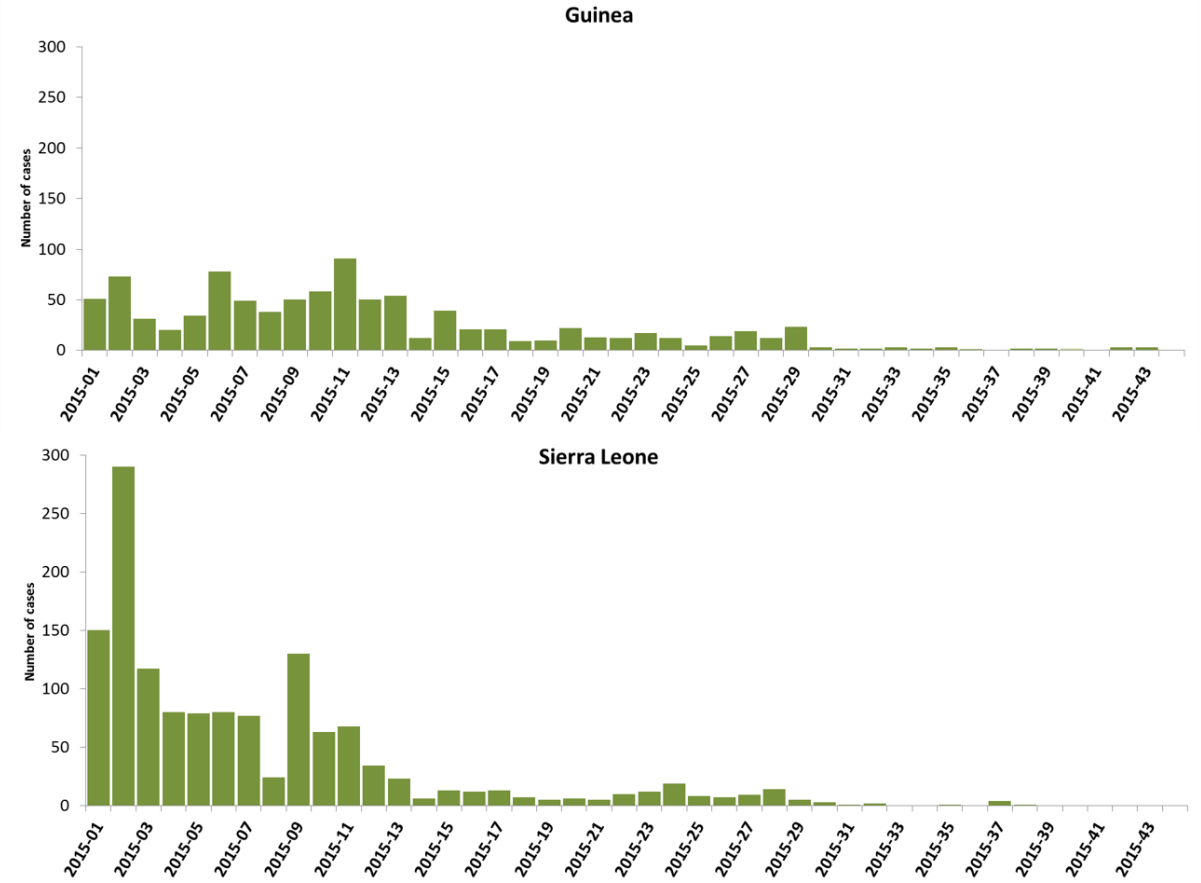
Distribution of confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (weeks 01/2015 to 44/2015)

Adapted from WHO figures; *data for week 44/2015 are incomplete



Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 29 October 2015

Epidemiological summary

On 16 October, WHO acknowledged two new laboratory-confirmed cases of human infection with avian influenza A (H7N9) virus. The cases are from two municipalities, Huzhou city and Jinhua city, both in Zhejiang province. One of the cases is a 55-year-old female and the other case a 53-year-old male, with dates of onset on 18 and 21 September 2015 respectively. Both had exposure to poultry and live poultry markets. No epidemiological link between the cases was reported.

As of 29 October 2015, 679 laboratory-confirmed cases of human infection with avian influenza A(H7N9) viruses, including at least 275 deaths, have been reported to WHO.
Cases in China since March 2013 have the following geographical distribution: Zhejiang (186), Guangdong (181), Jiangsu (78), Fujian (63), Shanghai (48), Hunan (26), Anhui (32), Hong Kong (13), Xinjiang Uygur Zizhiqu (10), Jiangxi (9), Beijing (6), Shandong (6), Guangxi (4), Henan (4), Taiwan (4), Jilin (2), Guizhou (2) and Hebei (2).
Three imported cases have also been reported: one in Malaysia and two in Canada.

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Web sources: Chinese CDC | WHO | WHO FAQ page | ECDC | WHO avian influence updates

ECDC assessment

This outbreak is caused by a novel reassortant avian influenza virus capable of causing severe disease in humans. This is a zoonotic outbreak, in which the virus is transmitted sporadically to humans in close contact with the animal reservoir, similar to the influenza A(H5N1) situation.

During 2015, there have been continued avian influenza A(H7N9) virus detections in the animal population in multiple provinces in China, indicating that the virus persists in the poultry population. If the pattern of human cases follows the trends seen in previous years, the number of human cases may rise over the coming months. Further sporadic cases of human infection with avian influenza A(H7N9) virus are therefore expected in affected and possibly neighbouring areas.

Imported cases of influenza A(H7N9) may be detected in Europe. However, the risk of the disease spreading among humans following an importation to Europe is considered to be very low. People in the EU presenting with severe respiratory infection and a history of potential exposure in the outbreak area will require careful investigation in Europe.

Actions

The Chinese health authorities continue to respond to this public health event with enhanced surveillance, epidemiological and laboratory investigation, including scientific research.

ECDC published an updated Rapid Risk Assessment on 3 February 2015.
ECDC published a guidance document Supporting diagnostic preparedness for detection of avian influenza A(H7N9) viruses in Europe for laboratories on 24 April 2013.

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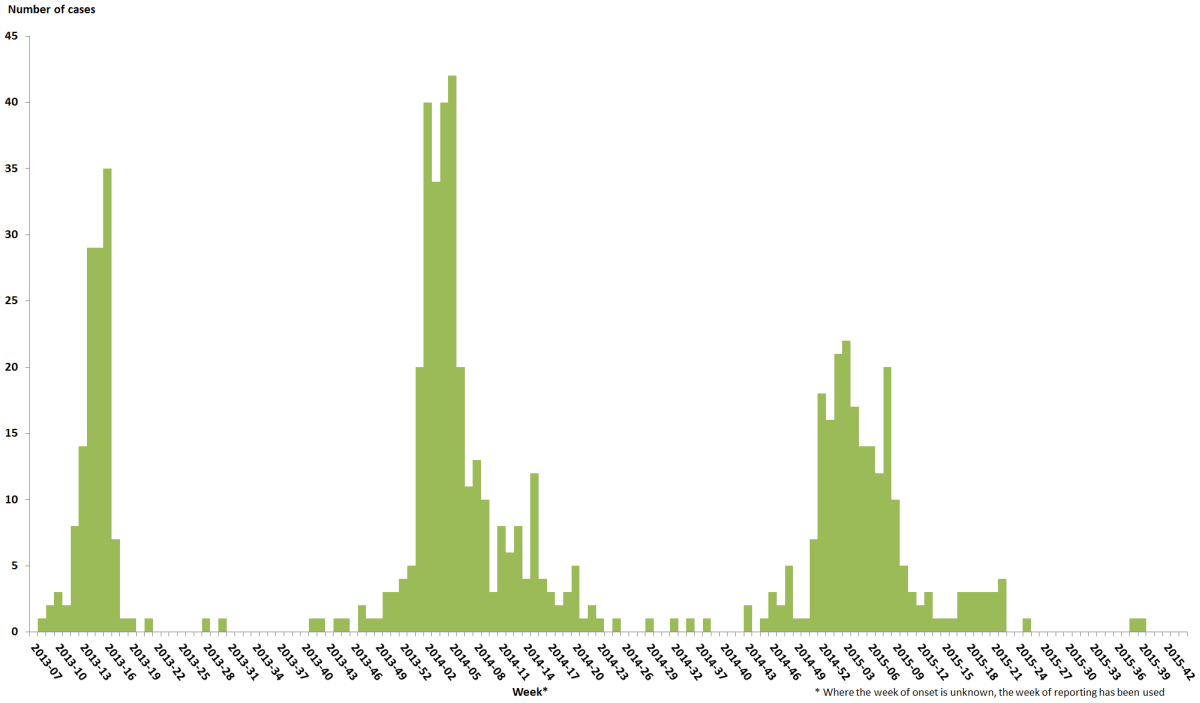
Distribution of avian influenza A(H7N9) cases by first available week as of 29 October 2015 (n=679)

Source: WHO



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 29 October 2015

Epidemiological summary

Worldwide in 2015 so far, 51 wild poliovirus type 1 (WPV1) cases have been reported to WHO, compared with 256 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (38 cases) and Afghanistan (13 cases).

In 2015 so far, 15 cases of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO, compared with 40 for the same period in 2014 from Madagascar (10), Nigeria (1), Ukraine (2), Mali (1) and Laos (1).

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

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ECDC assessment

The last locally acquired wild-polio cases within the current EU borders were reported from Bulgaria in 2001. The most recent wild-polio outbreak in the WHO European Region was in Tajikistan in 2010, when importation of WPV1 from Pakistan resulted in 460 cases.

The confirmed circulation of wild poliovirus in several countries and the documented exportation of wild poliovirus to other countries support the fact that there is a potential risk of wild poliovirus being re-introduced to the EU/EEA. The highest risk of large poliomyelitis outbreaks occurs in areas with clusters of unvaccinated populations and in people living in poor sanitary conditions, or a combination of the two.

References: ECDC latest RRA | Rapid Risk Assessment on suspected polio cases in Syria and the risk to the EU/EEA | Wild-type poliovirus 1 transmission in Israel - what is the risk to the EU/EEA? |RRA Outbreak of circulating vaccine-derived poliovirus type 1 (cVDPV1) in Ukraine

Actions

ECDC monitors reports of polio cases worldwide through epidemic intelligence in order to highlight polio eradication efforts and identify events that increase the risk of wild poliovirus being re-introduced into the EU. Following the declaration of polio as a PHEIC, ECDC updated its risk assessment. ECDC has also prepared a background document with travel recommendations for the EU.
Following the recent detection of the cases of circulating vaccine-derived poliovirus type 1 in Ukraine, ECDC published a rapid risk assessment on its website.

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

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