COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 14, 4-10 April 2021

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

COVID-19 associated with SARS-CoV-2 – Multi-country (World) – 2019 - 2021

Opening date: 7 January 2020 Latest update: 9 April 2021

On 31 December 2019, the Wuhan Municipal Health and Health Commission reported a cluster of pneumonia cases of unknown aetiology with a common source of exposure at Wuhan's 'South China Seafood City' market. Further investigations identified a novel coronavirus as the causative agent of the respiratory symptoms for these cases. The outbreak rapidly evolved, affecting other parts of China and other countries worldwide. On 30 January 2020, WHO declared that the outbreak of coronavirus disease (COVID-19) constituted a Public Health Emergency of International Concern (PHEIC), accepting the Committee's advice and issuing temporary recommendations under the International Health Regulations (IHR). On 11 March 2020, the Director-General of WHO declared the COVID-19 outbreak a pandemic.

➔Update of the week

Since week 2021-12 and as of 5 April 2021, 4 042 411 new cases of COVID-19 (in accordance with the applied case definitions and testing strategies in the affected countries) and 66 863 new deaths have been reported.

Globally, since 31 December 2019 and as of 5 April 2021, 131 639 092 cases of COVID-19 (in accordance with the applied case definitions and testing strategies in the affected countries) have been reported, including 2 857 866 deaths.

In the EU/EEA, 27 513 674 cases have been reported, including 627 242 deaths.

More details are available here. The latest daily situation update for EU/EEA is available here.

Non EU Threats

New! Influenza A(H5) – Nigeria – 2021

Opening date: 7 April 2021 Latest update: 9 April 2021

In 2021, Nigerian authorities have reported outbreaks of influenza A(H5N1) in poultry and human cases of influenza A(H5).

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Outbreak of Ebola virus disease in North Kivu – Democratic Republic of the Congo – 2021

Opening date: 9 February 2021 Latest update: 9 April 2021

On 7 February 2021, the Minister of Health of the Democratic Republic of the Congo (DRC) declared an outbreak of Ebola virus disease (EVD) after a laboratory-confirmed case was detected. The outbreak is in the North Kivu province in the eastern region of the DRC, where a large outbreak occurred between 2018 and 2020.

➔Update of the week

Since the last update, and as of 5 April 2021, no new cases or deaths have been reported. The 42-day countdown to declaring the end of the outbreak began on 22 March 2021, a day after the last confirmed case of EVD tested negative for the second time and was released from the Ebola Treatment Centre (ETC) in Katwa. Therefore, as of 5 April 2021, 27 days remain to declaring the end of the outbreak, provided no new confirmed cases are detected.

Ebola virus disease in Nzérékoré – Guinea – 2021

Opening date: 19 February 2021 Latest update: 9 April 2021

On 14 February 2021, an Ebola virus disease (EVD) outbreak was declared in the rural area of Gouéké in the N'Zerekore region, Guinea. Three cases were confirmed by the national laboratory and are the first confirmed cases reported since the 2013-2016 West Africa outbreak, which was the largest EVD outbreak ever recorded.

➔Update of the week

Since the last update, and as of 6 April 2021, two new confirmed cases and three probable cases, including three deaths, have been reported by WHO. All new cases are being reported from the Soulouta sub-prefecture in the prefecture and region of N'Zerekore. The 42-day countdown to declaring the end of the outbreak was therefore cancelled when the first confirmed case, since the countdown began, was reported on 1 April 2021. Ring vaccination around this new case has started and, as of 2 April 2021, 129 contacts have been vaccinated.

In addition, the Agence Nationale de Securite Sanitaire (ANSS) report an additional two suspect cases from the N'Zerekore region, one of whom refuses to be isolated in a healthcare facility, as well as one escaped case who also refused isolation.

Influenza A(H5N6) – Multi country – Monitoring human cases

Opening date: 17 January 2018 Latest update: 9 April 2021

Animal influenza viruses that cross the animal-human divide to infect people are considered novel to humans and have the potential to become pandemic threats. In 2014, a novel avian influenza A(H5N6) reassortant causing a human infection was detected in China.

➔Update of the week

The first human case of avian influenza A(H5N6) virus infection has been reported in Laos. A five-year-old boy developed symptoms on 28 February 2021, was hospitalised and recovered. He had exposure to poultry, which also tested positive to A (H5N6). No further cases were detected.

Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country

Opening date: 24 September 2012 Latest update: 9 April 2021

Since the disease was first identified in Saudi Arabia in April 2012, over 2 500 cases of Middle East respiratory syndrome coronavirus (MERS-CoV) have been detected in 27 countries. In Europe, eight countries have reported confirmed cases, all with direct or indirect connections to the Middle East. The majority of MERS-CoV cases continue to be reported from the Middle East. The source of the virus remains unknown, but the pattern of transmission and virological studies point towards dromedary camels in the Middle East as 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 previous CDTR published on 5 March, and as of 6 April 2021, three MERS-CoV cases, including one death, have been reported by Saudi Arabia (2) and the United Arab Emirates (1).

Influenza – Multi-country – Monitoring 2020/2021 season

Opening date: 14 October 2020 Latest update: 9 April 2021

Reported influenza activity in Europe remained at interseasonal levels.

➔Update of the week

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Week 13/2021 (29 March–4 April 2021)

Influenza activity remained at interseasonal levels.

Of the 1 019 specimens tested for influenza viruses in week 13/2021 from patients presenting with ILI or ARI symptoms to sentinel primary healthcare sites, one was positive for an influenza type B virus.

Influenza viruses were detected sporadically from non-sentinel sources (such as hospitals, schools, primary care facilities not involved in sentinel surveillance, or nursing homes and other institutions). Only influenza type B viruses were detected.

There were no hospitalised laboratory-confirmed influenza cases reported in week 13/2021.

The influenza epidemic in the European Region has usually peaked and started to decline by this point in the year but, despite widespread and regular testing for influenza viruses, reported influenza activity has remained at a very low level throughout the season, likely due to the impact of the various public health and social measures implemented to reduce transmission of SARS-CoV-2.

The COVID-19 pandemic has affected healthcare-seeking behaviours, healthcare provision, and testing practices and capacities in countries and areas of the European Region, which negatively impacted on the collection of influenza epidemiologic and virologic data from March 2020. However, surveillance improved over the course of the 2020-2021 season and although there was a small decrease in the number of samples tested (~20%) compared with previous seasons, there was remarkable decrease (>99%) in the number of influenza infections detected, with numbers detected on a weekly basis being similar to those reported during interseasonal periods.

Cholera – Multi-country (World) – Monitoring global outbreaks

Opening date: 20 April 2006 Latest update: 9 April 2021

Several countries in Africa and Asia have reported cholera outbreaks. Major ongoing outbreaks are being reported from Bangladesh and Yemen. Haiti reported its last laboratory-confirmed case in February 2019.

➔Update of the week

Since the last update on 5 March 2021, new cholera cases have been reported worldwide. The countries reporting the majority of new cases since the previous update are Bangladesh and Yemen. A list of all countries reporting new cases since our previous update can be found below.

Poliomyelitis – Multi-country (World) – Monitoring global outbreaks

Opening date: 9 December 2019 Latest update: 9 April 2021

Global public health efforts to eradicate polio are continuing by immunising every child until transmission of the virus has stopped and the world becomes polio-free. On 5 May 2014, polio was declared a public health emergency of international concern (PHEIC) by the World Health Organization (WHO) due to concerns over the increased circulation and international spread of wild poliovirus in 2014. The Emergency Committee under the International Health Regulations (2005) stated that the risk of the international spread of poliovirus remains a Public Health Emergency of International Concern (PHEIC). On 1 February 2021, the 27th meeting of the Emergency Committee under the International Health Regulations (2005) (IHR) on the international spread of poliovirus was held.

In June 2002, the WHO European Region was officially declared polio-free.

➔Update of the week

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Since the previous CDTR update on 5 March 2021, and as of 30 March 2021, 50 cases of cVDPV2 have been reported. No new cases of WPV1, cVDPV1 and cVDPV3 have been reported.

Wild poliovirus (WPV1):
- No new cases of Acute Flaccid Paralysis (AFP) caused by WPV1 have been reported in Afghanistan.
- No new cases of Acute Flaccid Paralysis (AFP) caused by WPV1 has been reported in Pakistan.
- 15 WPV1 environmental samples have been detected in Pakistan (14) and Afghanistan (1).

Circulating vaccine-derived poliovirus (cVDPV):
- No new cases of AFP caused by cVDPV1 have been reported.
- 50 cases of AFP caused by cVDPV2 have been reported from nine countries: Afghanistan (20), South Sudan (7), Mali (5), Sierra Leone (5), Tajikistan (4), Democratic Republic of the Congo (3), Nigeria (3), Senegal (2), and Sudan (1).
- No new cases of cVDPV3 have been reported.
- 93 cVDPV2 environmental samples have also been detected: Côte D'Ivore (39), Afghanistan (17), Pakistan (13), Niger (6), Liberia (4), Egypt (3), Sierra Leone (3), South Sudan (3), Senegal (2), Tajikistan (2), and Guinea (1).

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II. Detailed reports

COVID-19 associated with SARS-CoV-2 – Multi-country (World) – 2019 - 2021

Opening date: 7 January 2020 Latest update: 9 April 2021

Epidemiological summary

Summary: Since 31 December 2019 and as of 5 April, 131 639 092 cases of COVID-19 (in accordance with the applied case definitions and testing strategies in the affected countries) have been reported, including 2 857 866 deaths.

Cases have been reported from:
Africa: 4 268 688 cases; the five countries reporting most cases are South Africa (1 551 964), Morocco (498 197), Tunisia (261 177), Ethiopia (215 189) and Egypt (204 965).
Asia: 25 106 356 cases; the five countries reporting most cases are India (12 589 067), Iran (1 932 074), Indonesia (1 496 085), Iraq (873 568) and Israel (834 446).
America: 57 314 971 cases; the five countries reporting most cases are United States (30 706 129), Brazil (13 013 601), Colombia (2 456 409), Argentina (2 407 105) and Mexico (2 251 705).
Europe: 44 882 774 cases; the five countries reporting most cases are France (4 822 470), Russia (4 580 894), United Kingdom (4 359 388), Italy (3 668 264) and Turkey (3 487 050).
Oceania: 65 598 cases; the five countries reporting most cases are Australia (29 348), French Polynesia (18 633), Guam (7 816), Papua New Guinea (6 857) and New Zealand (2 151).
Other: 705 cases have been reported from an international conveyance in Japan.

Deaths have been reported from:
Africa: 113 798 deaths; the five countries reporting most deaths are South Africa (52 987), Egypt (12 163), Tunisia (8 993), Morocco (8 850) and Algeria (3 108).
Asia: 390 696 deaths; the five countries reporting most deaths are India (165 101), Iran (63 160), Indonesia (40 449), Pakistan (14 821) and Iraq (14 463).
America: 1 380 490 deaths; the five countries reporting most deaths are United States (555 001), Brazil (332 752), Mexico (204 339), Colombia (64 293) and Argentina (56 471).
Europe: 971 595 deaths; the five countries reporting most deaths are United Kingdom (126 836), Italy (111 030), Russia (100 374), France (96 678) and Germany (77 013).
Oceania: 1 281 deaths; the five countries reporting most deaths are Australia (909), French Polynesia (141), Guam (136), Papua New Guinea (61) and New Zealand (26).
Other: 6 deaths have been reported from an international conveyance in Japan.

EU/EEA:
As of 5 April 2021, 27 513 674 cases have been reported in the EU/EEA: France (4 822 470), Italy (3 668 264), Spain (3 311 325), Germany (2 893 883), Poland (2 448 463), Czechia (1 553 820), Netherlands (1 305 803), Romania (977 986), Belgium (903 890), Sweden (831 882), Portugal (823 494), Hungary (689 853), Austria (555 411), Slovakia (365 400), Bulgaria (352 999), Croatia (280 164), Greece (275 414), Ireland (238 148), Denmark (233 797), Slovenia (220 425), Lithuania (220 212), Estonia (109 781), Latvia (104 105), Norway (98 674), Finland (79 737), Luxembourg (62 360), Cyprus (47 713), Malta (29 279), Iceland (6 225) and Liechtenstein (2 697).

As of 5 April 2021, 627 242 deaths have been reported in the EU/EEA: Italy (111 030), France (96 678), Germany (77 013), Spain (75 783), Poland (55 005), Czechia (27 057), Romania (24 190), Belgium (23 198), Hungary (21 928), Portugal (16 885), Netherlands (16 609), Bulgaria (13 589), Sweden (13 501), Slovakia (10 094), Austria (9 189), Greece (8 380), Croatia (6 083), Ireland (4 718), Slovenia (4 369), Lithuania (3 615), Denmark (2 430), Latvia (1 931), Estonia (950), Finland (846), Luxembourg (750), Norway (676), Malta (399), Cyprus (261), Liechtenstein (56) and Iceland (29).

The latest daily situation update for EU/EEA is available here.

The final report of the joint WHO-China study on the origins of COVID-19 is now available on WHO's website.

Public Health Emergency of International Concern (PHEIC):
On 30 January 2020, the World Health Organization declared that the outbreak of COVID-19 constitutes a PHEIC. On 11 March 2020, the Director-General of WHO declared the COVID-19 outbreak a pandemic. The third, fourth, fifth and sixth International Health Regulations (IHR) Emergency Committee meeting for COVID-19 were held in Geneva on 30 April 2020, 31 July 2020, 29

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October 2020, and 14 January 2021, respectively. The committee concluded during these meetings that the COVID-19 pandemic continues to constitute a PHEIC.

ECDC assessment

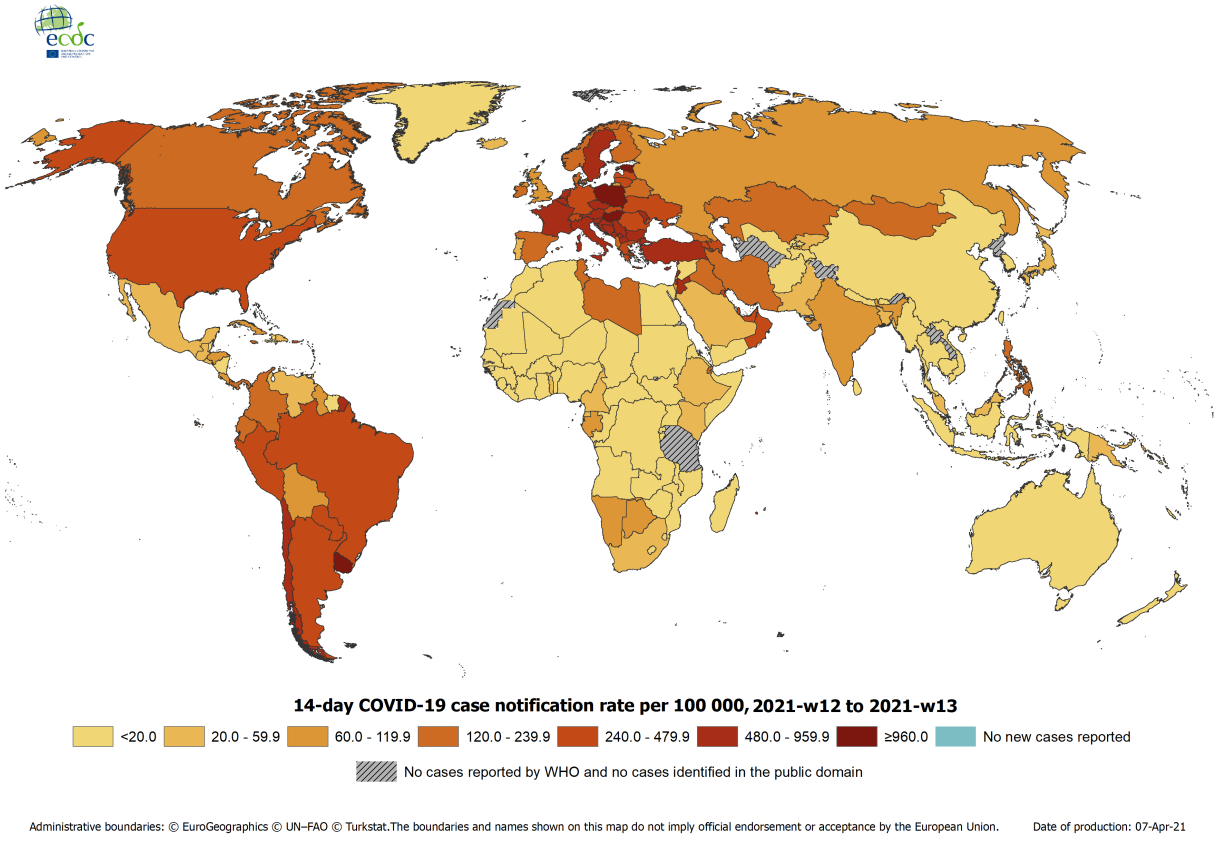
For the most recent risk assessment, please visit ECDC's dedicated webpage.

Actions

Actions: ECDC published the 14th update of its rapid risk assessment on 15 February 2021. A dashboard with the latest updates is available on ECDC's website.

Geographic distribution of 14-day cumulative number of reported COVID-19 cases per 100 000 population, worldwide, 2021-w12 to 5 April 2021

Source:ECDC



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New! Influenza A(H5) – Nigeria – 2021

Opening date: 7 April 2021 Latest update: 9 April 2021

Epidemiological summary

In 2021, and as of 28 March, outbreaks of highly pathogenic avian influenza (HPAI) H5N1 in poultry have been reported in 30 farms from seven states in Nigeria: Kano, Plateau, Bauchi, Gombe, Kaduna, Nasarawa, and the Niger states. The Nigerian authorities initiated an outbreak investigation, and a joint team from Nigeria CDC (NCDC) and the Federal Ministry of Agriculture and Rural Development (FMARD) were deployed to Bauchi, Kano, and Plateau states. Public health measures have been initiated in the affected states, including biosecurity measures in the poultry farms and sensitisation to farm owners, workers, live bird market associations, and communities.

As of 28 March 2021, 83 human nasopharyngeal/oropharyngeal samples have been collected from contacts of confirmed birds in four states: Kano (27), Bauchi (19), Gombe (19), and Plateau (18). All contacts were farmers, farmworkers, bird-handlers, and traders, and all were asymptomatic. Of the 83 collected samples, 64 samples were analysed using real-time RT-PCR (rRT-PCR). From the 64 analysed samples, seven were positive for influenza A virus, including six samples of influenza A(H5) (neuraminidase (NA) remains undetermined) and one sample of unsubtypable influenza A virus. These seven confirmed samples have been reported in Kano (four) and Plateau (three) states and have been shipped to the WHO Collaborating Centre in the US for further characterisation.

In addition, 13 blood samples have been collected from the very-close human contacts of birds in Bauchi (5), Gombe (5), and Plateau (3) states.

Sources: Nigeria CDC | media

ECDC assessment

Different A(H5Nx) viruses are currently circulating in west African countries and confirmation about the respective viral subtype is pending. Available information does not detail symptoms in positive tested people nor any transmission events. More epidemiological and virological details are needed to assess the situation.

The risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered to be very low.

Direct contact with infected birds or a contaminated environment is the most likely source of infection. The use of personal protective measures for people exposed to dead birds or their droppings will minimise the remaining risk.

Actions

ECDC monitors avian influenza strains through its epidemic intelligence activities in order to identify significant changes in the epidemiology of the virus. ECDC, together with EFSA and the EU reference laboratory for avian influenza, produces a quarterly updated report on the avian influenza situation. The most recent report was published on 26 February 2020. ECDC has published an outbreak alert for new avian influenza outbreaks of A(H5) among wild and domestic birds.

Outbreak of Ebola virus disease in North Kivu – Democratic Republic of the Congo – 2021

Opening date: 9 February 2021 Latest update: 9 April 2021

Epidemiological summary

Since the start of the outbreak (on 7 February 2021), and as of 5 April 2021, 12 EVD cases (11 confirmed and one probable), including six deaths, have been reported in the North Kivu province in the eastern region of the DRC. More specifically, the cases were reported from the Biena (6), Butembo (3), Katwa (2), and Musienene (1) health zones. Since the start of the outbreak, two healthcare workers have been infected. Six patients have recovered and will be integrated into the survivor's care programme. The 42-day countdown was initiated on 22 March 2021.

The index case was in a patient who sought treatment for Ebola-like symptoms at two healthcare centres in Butembo city in the Biena Health Zone from 25 January 2021 onwards, and was admitted to a hospital ICU ward in the Katwa health zone on 3 February 2021, where she died one day later. The EVD diagnostic was laboratory-confirmed on 6 February 2021. The source of infection of the index case in this outbreak is currently unknown and investigations are ongoing.

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Results from genome sequencing confirmed that the first cases were infected with the Zaire ebolavirus species and suggest that the ongoing outbreak is genetically linked to the 10th EVD outbreak that occurred between 2018 and 2020 in the North Kivu and Ituri provinces.

North Kivu provincial health authorities are leading the response, supported by the WHO and the DRC Ministry of Health. The Ministry states that of the 80 contacts that were being searched for at the beginning of the 42-day monitoring period, 17 could be found, 45 completed their 42-day period without being seen, and 18 remain to be found. Of the 18 remaining to be found, two are lost to follow-up and 16 have never been seen. These contacts have not completed their 42 day follow-up as of 5 April 2021, and therefore continue to be sought to monitor for potential signs of EVD. A vaccination campaign was launched on 15 February 2021 in Butembo. The ring vaccination strategy is being deployed, and so as of 5 April, 1 898 contacts, including 542healthcare workers have been vaccinated since the start of this outbreak.

According to WHO, there are a number of ongoing challenges for surveillance, including access to affected areas due to ongoing conflicts in the country and community mistrust towards authorities and outbreak responders. In addition, a much lower number of (false) alerts are being received than expected in some previously affected and at-risk health zones, indicating a malfunctioning surveillance system. Further challenges include poor alert management, tracing contacts that are lost to follow-up, limited infrastructure for isolation of cases, and insufficient financial resources to support all pillars of the response.

Background: The 10th EVD outbreak occurred in the eastern regions of the DRC, affecting the Kivu and Ituri provinces, where this ongoing outbreak is occurring. The 10th outbreak resulted in 3 470 cases, including 2 287 deaths. The start of the outbreak was declared in August 2018 and the end was declared on 25 June 2020. The 11th outbreak of EVD in the DRC was declared on 1 June 2020 and occurred on the western side of the country in the Equateur Province. It culminated to 130 cases, including 55 deaths, and was declared over on 18 November 2020.

Sources: WHO Regional Office for Africa | Ministere de la Sante Sitrep | WHO Disease Outbreak News | WHO Country Office DRC Twitter | Weekly Afro Bulletin

ECDC assessment

These EVD cases are the first reported in North Kivu, DRC, since the 10th outbreak was declared over in June 2020 (see the Threat Assessment Brief published on 22 February 2021 for more information). According to the current information, the health authorities in the DRC have been successful in controlling the outbreak as the number of cases has remained low (compared to previous outbreaks in the country) and no new cases have been reported recently. However, due to the above-mentioned difficulties, the possibility of subsequent cases and further spread is still considerable. The COVID-19 pandemic and other ongoing outbreaks (such as cholera and measles) might challenge the response.

Overall, the current risk for European Union/European Economic Area (EU/EEA) citizens living in or travelling to affected areas in the DRC is considered low. While disease in unvaccinated people is severe and most EU/EEA citizens are not vaccinated against the disease, there is a very low likelihood of EU/EEA citizens becoming infected in the DRC. The current risk for citizens in the EU/EEA is considered very low, as the likelihood of introduction and secondary transmission within the EU/EEA is very low.

Actions

ECDC is following the situation through its epidemic intelligence activities. ECDC published a threat assessment brief, EVD Outbreak in North Kivu, DRC, on 22 February 2021, in which options for response measures are described.

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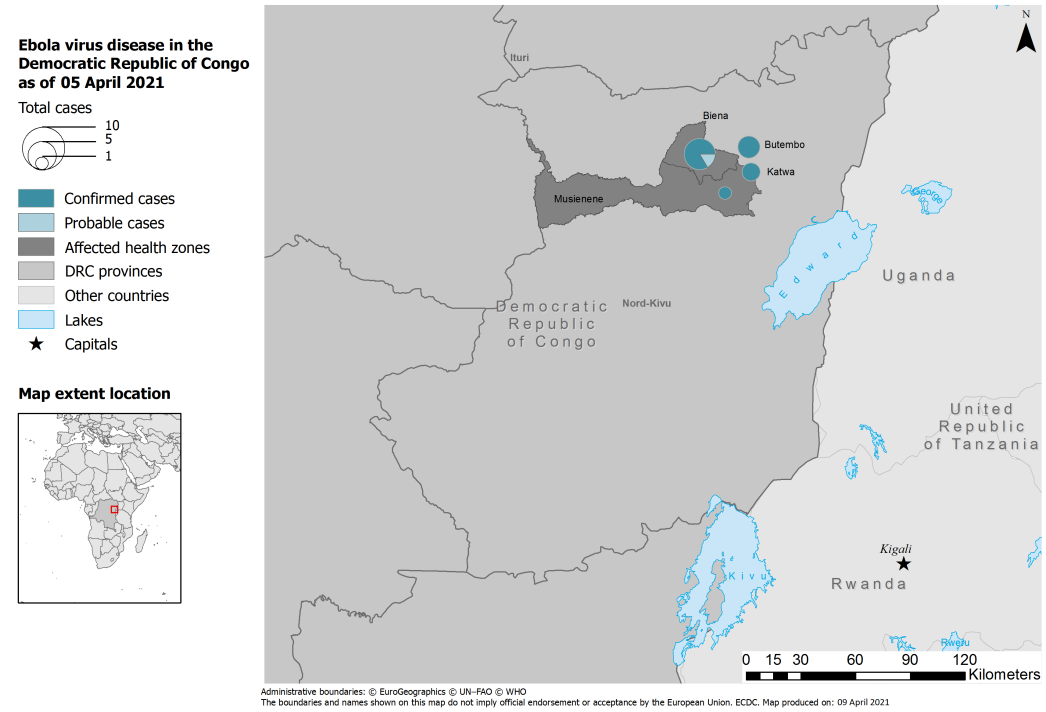
Geographical distribution of confirmed and probable Ebola virus disease cases in the DRC, 2021

Source: ECDC



Ebola virus disease in Nzérékoré – Guinea – 2021

Opening date: 19 February 2021 Latest update: 9 April 2021

Epidemiological summary

Since the start of the outbreak (on 14 February 2021), and as of 6 April 2021, 23 EVD cases (16 confirmed and seven probable), including 12 deaths (from five confirmed and seven probable cases), have been identified. Among these, five healthcare workers have been infected, resulting in two deaths (one confirmed and one probable case). All cases have been reported from the N'Zerekore prefecture, in the region of N'Zerekore. Nine patients with confirmed EVD have recovered.

According to WHO, the initial cluster of seven cases began with the index case in a patient who died on 28 January 2021, after having visited two healthcare facilities and a traditional practitioner. Five family members who attended the funeral on 1 February and the traditional practitioner showed Ebola-like symptoms. Five of the seven cases resulted in death. Two unsafe burials took place for these EVD patients. The source of infection of this case is unknown. However, preliminary results of genomic sequencing indicate that the index case of the 2021 Guinea cluster was probably infected from a persistent source, suggesting that the virus from the 2013-2016 West Africa epidemic has survived and re-emerged. Further investigations will be carried out to understand this occurrence.

The vaccination campaign began on 23 February in Gouecke, N'Zerekore, and vaccines have been further deployed to the Boke and Kankan regions. The ring vaccination strategy is being deployed, whereby healthcare workers, contacts of EVD cases, contacts of contacts and suspected contacts are being vaccinated. As of 5 April, 5 365 people have been vaccinated, in the Conakry, Kindia, and N'Zerekore regions.

Response measures are ongoing and WHO is supporting the country to procure an EVD vaccine, as well as therapeutics, reagents, and personal protective equipment. To date, 32 960 vaccines have been deployed to Guinea. WHO considers the risk of spread in the country as very high, given the unknown size, duration and origin of the outbreak, the potentially large number of contacts, the potential spread to other parts of Guinea and neighbouring countries, and the limited response capacity currently on the ground. The Guinean Ministry of Health, together with Global Outbreak Alert and Response Network (GOARN) partners, are supporting case management and training teams in the practice of safe and dignified burials. Multidisciplinary teams are currently in the field to actively search and provide care for cases, trace and follow-up contacts, and sensitize communities on infection prevention and control.

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As the outbreak is located in a porous border area, WHO is also liaising with health authorities from Liberia and Sierra Leone to enhance surveillance activities in their bordering districts as well as strengthening their testing capacity and conducting surveillance in health facilities. WHO is also in contact with the bordering countries of Côte d'Ivoire, Mali, Senegal, and Guinea-Bissau. These countries have completed their national preparedness and readiness plans, and are on high alert, however their overall estimated state of readiness lies below the required benchmark. Governmental representatives of Guinea and the six bordering countries held a meeting on 2 March 2021, at which it was agreed to unify the response by setting up a coordination mechanism, increasing surveillance and screening at border crossings and in high-risk communities, and facilitating import regulations for vaccines. WHO assesses the risk for the region as high.

According to WHO, challenges remain in the surveillance and response, and include inadequate coordination in N'Zerekore, a lower number of alerts than expected and a therefore too low number of samples being tested, community resistance to response measures, especially in Soulouta where the most recent cases are reported from, and the need for additional staff to strengthen field operations, which is limited by insufficient funds.

Background: Guinea was one of the three most-affected countries in the 2013-2016 West Africa EVD outbreak, which was the largest since the virus was first discovered in 1976, and during which there were over 28 000 cases, including around 11 000 deaths. The outbreak started in Guinea and then moved across land borders to Sierra Leone and Liberia.

Sources: WHO regional office for Africa | Ministry of health of Guinea | Agence Nationale de Sécurité Sanitaire (ANSS) | WHO Disease Outbreak News | WHO Regional Office for Africa Twitter | ANSS report | Weekly Afro Bulletin

ECDC assessment

These EVD cases are the first cases of the disease reported in Guinea since the large outbreak that occurred in West Africa between 2013 and 2016. Based on preliminary molecular studies, re-emergence of the virus from a persistently infected person from the 2013-2016 outbreak is hypothesised. However, importation via travellers from an Ebola virus-endemic country or a spill-over event from animal reservoirs cannot be ruled out as potential sources of the outbreak. Some bat species are reservoir hosts for Ebola virus in Central Africa. However, the evidence for competent animal reservoirs of the virus in West Africa is inconclusive, and the role of other animals, such as non-human primates, as (intermediate) hosts remains unclear (see the Threat Assessment Brief published on 22 February 2021 for more information). The ongoing outbreak may spread to other areas within Guinea and/or to neighbouring countries. During the 2013-2016 outbreak in West Africa, Guinea acquired essential experience, which is an asset to adequately respond to this outbreak. However, the current epidemiological data and situation reports indicate issues with timely identification and isolation of cases to prevent further transmission. The COVID-19 pandemic and other ongoing outbreaks (e.g. Yellow Fever and measles) might challenge the response.

Overall, the current risk for European Union/European Economic Area (EU/EEA) citizens living in or travelling to affected areas in Guinea is considered low. While disease in unvaccinated people is severe and most EU/EEA citizens are not vaccinated against the disease, there is a very low likelihood of EU/EEA citizens becoming infected in Guinea. The current risk for citizens in the EU/EEA is considered very low, as the likelihood of introduction and secondary transmission within the EU/EEA is very low.

Actions

ECDC is following the situation through its epidemic intelligence activities. ECDC published a threat assessment brief, EVD outbreak in Guinea, on 22 February 2021, in which options for response measures are described.

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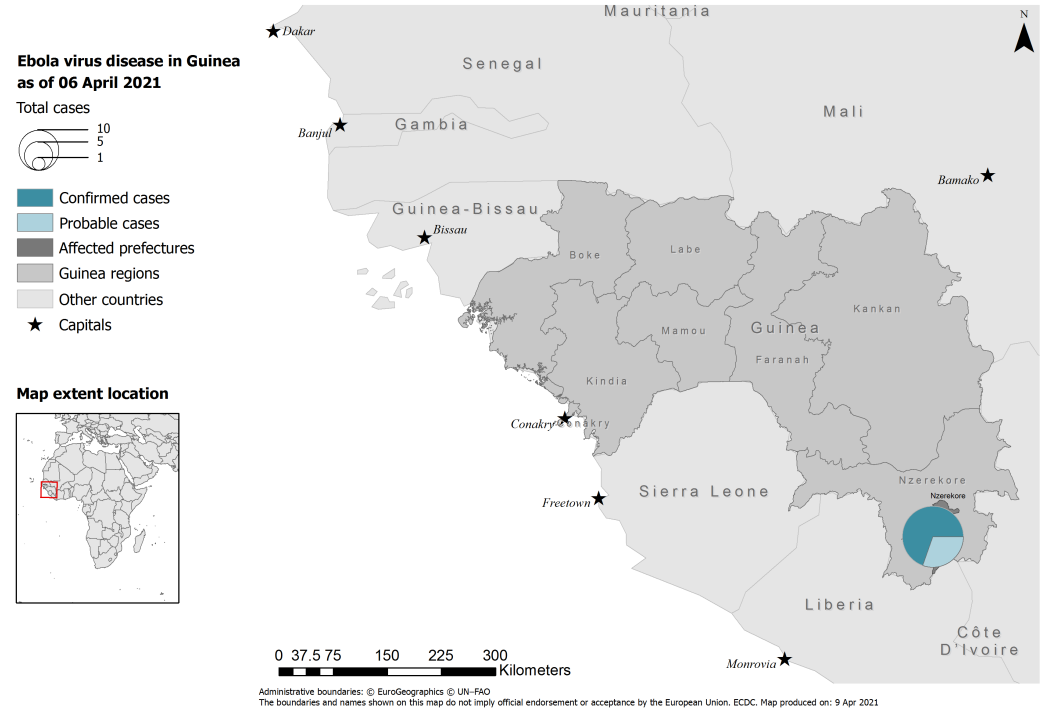
Geographical distribution of confirmed and probable Ebola virus disease cases in Guinea, 2021

Source: ECDC



Influenza A(H5N6) – Multi country – Monitoring human cases

Opening date: 17 January 2018 Latest update: 9 April 2021

Epidemiological summary

The first human case of avian influenza A(H5N6) virus infection has been reported in Laos. A five-year-old boy from Luang Prabang province in northern Laos developed symptoms on 28 February 2021, was hospitalised and tested positive for A(H5N6) on 8 March 2021. The boy recovered. He had exposure to poultry. The poultry tested positive for H5N6. None of the contacts at home or in the hospital had the disease.

Since 2014 and as of 6 April 2020, two countries, Laos and China, reported 32 human cases of influenza A(H5N6), including one case in China with year of onset 2015 reported in literature. The cases have occurred in China: Anhui (2), Chongqing (1), Fujian (1), Guangdong (9), Guizhou (1), Hubei (1), Hunan (5), Sichuan (1), Jiangsu (2) and Yunnan Provinces (2), Guangxi Zhuang Autonomous Region (5) and Beijing (1), and in Laos: Luang Prabang province(1). Of the reported cases, 17 have died. All cases had exposure to live poultry or live poultry markets, except for five cases where the exposure source was not reported. No clustering of cases has been reported.

Sources: ECDC Avian influenza page | Joint ECDC, EFSA, EURLAI report: Avian influenza overview August – December 2020 | WHO Avian Influenza Weekly Update | Government of Hong Kong Special Administrative Region | WHO | media

ECDC assessment

Although avian influenza A(H5N6) has caused severe infection in humans, human infections remain rare and no sustained human-to-human transmission has been reported. However, characterisation of the virus detected recently in the Guangxi Province is ongoing and therefore complete information is lacking on virus evolution to assess its pandemic potential.

Currently detected avian influenza viruses in poultry and wild bird outbreaks in the EU/EEA are not related to viruses that have been involved in human infections. The above-mentioned A(H5N6) viruses have not been detected in EU/EEA countries. The risk of zoonotic influenza transmission to the general public in EU/EEA is considered very low. As the likelihood of zoonotic transmission of newly introduced or emerging reassortant avian influenza viruses is unknown, the use of personal protective measures for people exposed to poultry and birds with avian influenza viruses will minimise the remaining risk.

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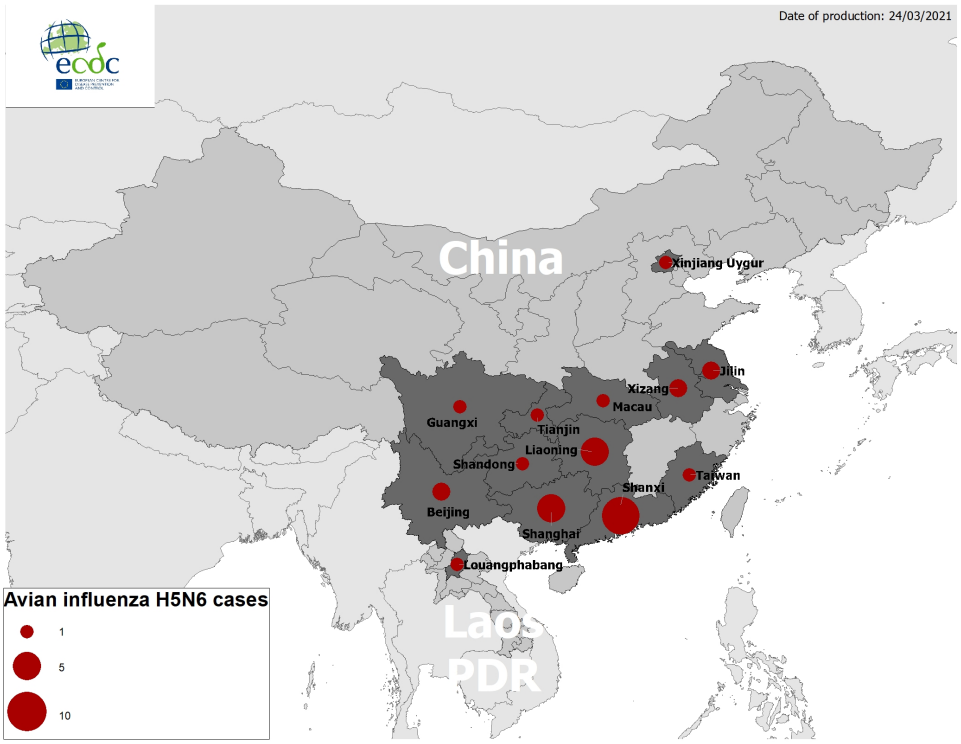
Actions

ECDC monitors avian influenza strains through its epidemic intelligence activities in order to identify significant changes in the epidemiology of the virus. ECDC, together with EFSA and the EU reference laboratory for avian influenza, produces a quarterly updated report of the avian influenza situation. The most recent report was published on 26 February 2021.

Geographical distribution of confirmed human cases with avian influenza A(H5N6) virus infection, 2014–2021

Source: ECDC



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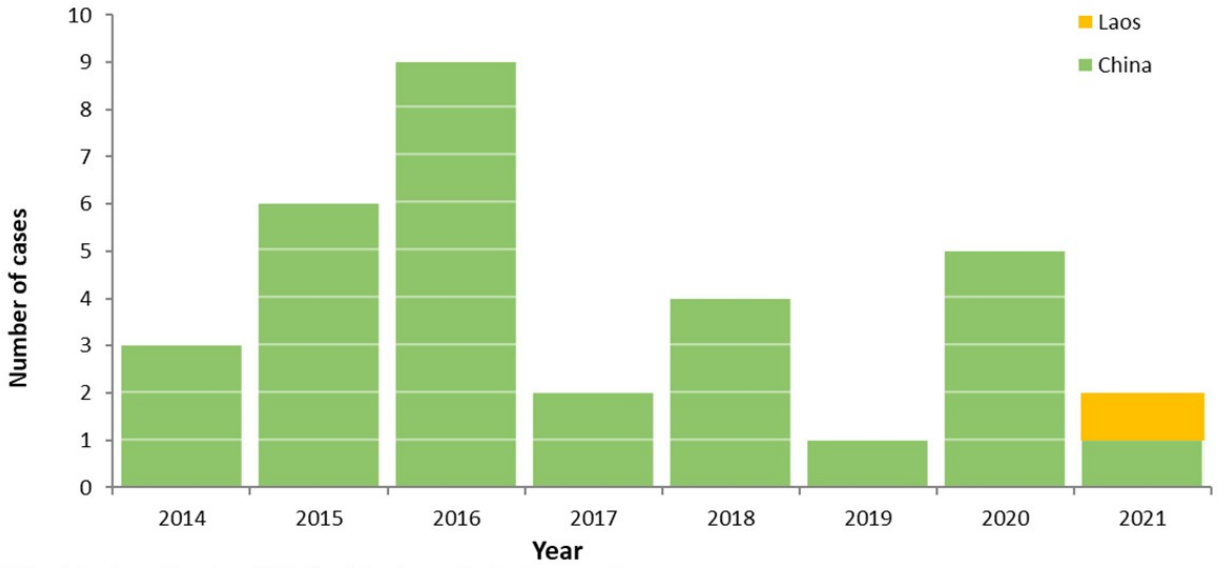
Distribution of confirmed human cases with avian influenza A(H5N6) virus infection, 2014–2021

Source: ECDC



*If the date of onset is not available the date of reporting has been used
** the epicurve includes one case reported in the literature with year of onset in 2015

Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country

Opening date: 24 September 2012 Latest update: 9 April 2021

Epidemiological summary

From 1 January 2021 to 6 April 2021, eight MERS-CoV cases have been reported in Saudi Arabia (7) and the United Arab Emirates (1), including four deaths. In Saudi Arabia, all were primary cases, of whom four reported contact with camels. These seven cases were reported in Riyadh (4), Makkah (2), and Eastern Province (1).

Since April 2012 and as of 6 April 2021, 2 589 cases of MERS-CoV, including 940 deaths, have been reported by health authorities worldwide.

Sources: ECDC MERS-CoV page | WHO MERS-CoV | ECDC factsheet for professionals | Saudi Arabia Ministry of Health | WHO DON

ECDC assessment

Human cases of MERS-CoV continue to be reported in the Arabian Peninsula, particularly in Saudi Arabia. However, the number of new cases detected and reported through surveillance have dropped to the lowest levels since 2014. The risk of sustained human-to-human transmission in Europe remains very low. The current MERS-CoV situation poses a low risk to the EU, as stated in ECDC's rapid risk assessment published on 29 August 2018, which also provides details on the last case reported in Europe.

ECDC published a technical report, Health emergency preparedness for imported cases of high-consequence infectious diseases, in October 2019, which will be useful for EU Member States wanting to assess their level of preparedness for a disease such as MERS. ECDC also published Risk assessment guidelines for infectious diseases transmitted on aircraft (RAGIDA) – Middle East Respiratory Syndrome Coronavirus (MERS-CoV) on 22 January 2020.

Actions

ECDC is monitoring this threat through its epidemic intelligence activities, and reports on a monthly basis.

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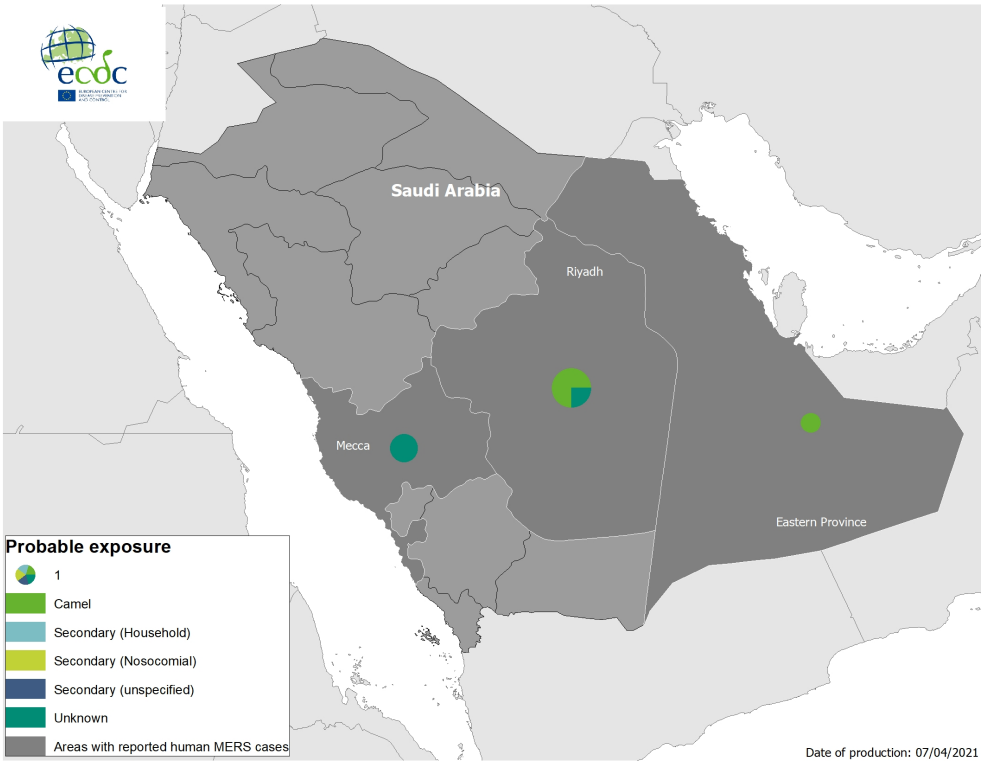
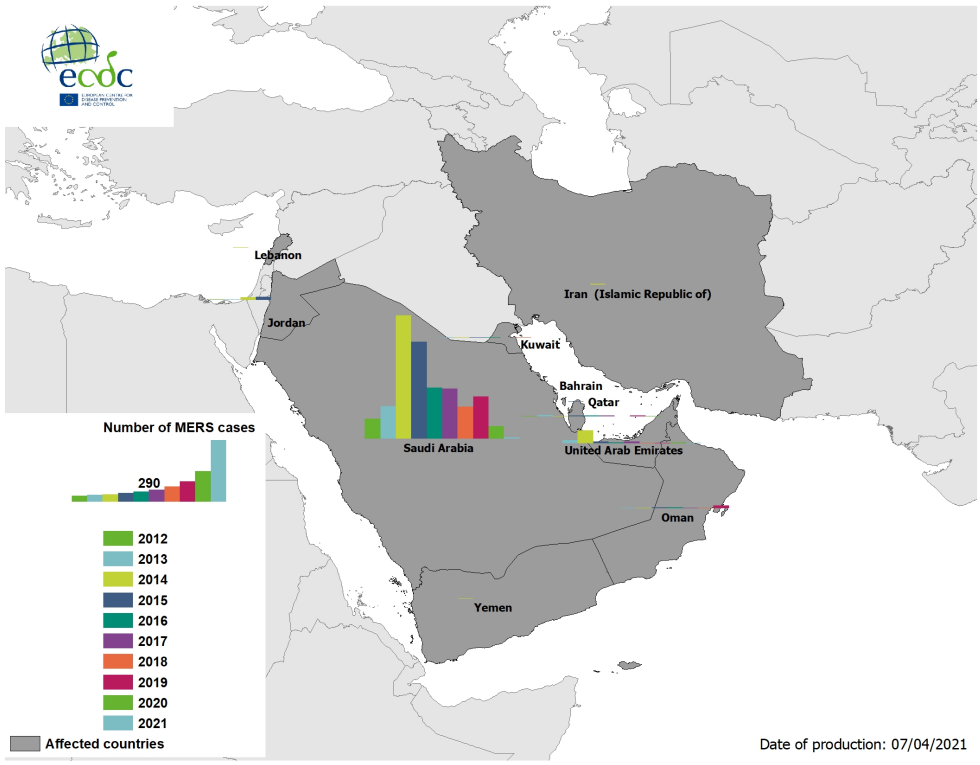
Geographical distribution of confirmed MERS-CoV cases by probable region of infection and exposure, from 1 January 2021 to 6 April 2021

Source: ECDC



Geographical distribution of confirmed MERS-CoV cases by country of infection and year, from April 2012 to 6 April 2021

Source: ECDC



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Influenza – Multi-country – Monitoring 2020/2021 season

Opening date: 14 October 2020 Latest update: 9 April 2021

Epidemiological summary

Week 13/2021 (29 March–4 April 2021)

Influenza activity remained at interseasonal levels.

Of the 1 019 specimens tested for influenza viruses in week 13/2021, from patients presenting with ILI or ARI symptoms to sentinel primary healthcare sites, one was positive for an influenza type B virus.

Influenza viruses were detected sporadically from non-sentinel sources (such as hospitals, schools, primary care facilities not involved in sentinel surveillance, or nursing homes and other institutions). Only influenza type B viruses were detected.

There were no hospitalised laboratory-confirmed influenza cases reported in week 13/2021.

The influenza epidemic in the European Region has usually peaked and started to decline by this point in the year but, despite widespread and regular testing for influenza viruses, reported influenza activity has remained at a very low level throughout the season, likely due to the impact of the various public health and social measures implemented to reduce transmission of SARS-CoV-2.

The COVID-19 pandemic has affected healthcare-seeking behaviours, healthcare provision, and testing practices and capacities in countries and areas of the European Region, which negatively impacted on the collection of influenza epidemiologic and virologic data from March 2020. However, surveillance improved over the course of the 2020-2021 season and although there was a small decrease in the number of samples tested (~20%) as compared with previous seasons, there was remarkable decrease (>99%) in the number of influenza infections detected, with numbers detected on a weekly basis being similar to those reported during interseasonal periods.

2020-2021 season overview

For the Region as a whole, influenza activity has been at baseline level since the start of the season.

In total, 785 specimens have tested positive for influenza viruses, 38 from sentinel sources and 747 from non-sentinel sources, with type A (both subtypes) and type B (both lineages) viruses being detected.

Since the start of the season, few hospitalized laboratory-confirmed influenza cases have been reported: 11 from ICUs (all infected with type A viruses); 10 (all type A viruses) in wards outside ICUs; and 20 from severe acute respiratory infection (SARI)-based surveillance (19 infected with type A viruses and 1 with type B).

Sources: EuroMOMO | Flu News Europe | Influenzanet

ECDC assessment

Despite widespread and regular testing for influenza, reported influenza activity remains at a very low level, which is unusual. This is probably due to the impact of the various public health and social measures implemented to reduce transmission of SARS-CoV-2.

The novel coronavirus disease 2019 (COVID-19) pandemic has also affected healthcare-seeking behaviour, healthcare provision, and testing practices and capacities in countries and areas of the European Region and this has had a negative impact on the reporting of influenza epidemiological and virological data during the 2020–2021 season.

Due to the COVID-19 pandemic, the influenza data presented by ECDC will need to be interpreted with caution, notably in terms of seasonal patterns.

Actions

ECDC and WHO monitor influenza activity in the WHO European Region between week 40–2020 and week 20–2021. They publish their weekly report on the Flu News Europe website.

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Cholera – Multi-country (World) – Monitoring global outbreaks

Opening date: 20 April 2006 Latest update: 9 April 2021

Epidemiological summary

Americas

Haiti: No new cases have been reported since last update. In 2020 and 2021, no confirmed cholera cases were reported in Haiti. According to a UNICEF report, the last confirmed cholera cases in Haiti were reported in February 2019. In 2019, Haiti reported 684 suspected cases, including three deaths (CFR: 0.4%). Since the beginning of the outbreak in 2010, and as of 25 January 2020, Haiti has reported 820 461 suspected cholera cases, including 9 792 deaths (CFR: 1.2%).

Dominican Republic: No new cases have been reported since the last update. In 2021, no cholera cases were reported in the Dominican Republic.

Africa

Cameroon: In 2021, and as of 24 March, media has reported at least 10 cholera cases, including one death, in the city of Douala.

DR Congo: In 2021, and as of 12 February, media reported 80 cases of cholera including three deaths in South Kivu. Between 22 February and 10 March, OCHA reported 56 suspected cholera cases, including six deaths, in the Kambove health zone.

Mozambique: In 2021, and as of 21 March, WHO has reported 3 215 cholera cases in Mozambique. There is currently a decreasing trend in cholera cases in Cabo Delgado, but the cases in 2021 have already surpassed levels from 2020 (2 176 cases).

Nigeria: In 2021, and as of 28 March, Nigeria has reported 1 746 suspected cases, including 50 deaths (CFR: 2.9%). A total of 75 samples were collected, of which 49 were positive.

Somalia: In 2021, and as of 7 March, WHO has reported 780 suspected cholera cases, including two associated deaths (CFR: 0.3%). All cases were reported from the Banadir and Bay regions. Of the 780 reported cases, 284 are aged two years old or younger and one death occurred among children two years old or younger.

Benin, Burundi, Ethiopia, Kenya, Togo and Uganda have no updates available since the last report in the CDTR.

Asia

Bangladesh: In 2021, and as of 28 March, 33 604 acute watery diarrhoea (AWD) cases were reported in Cox's Bazar, Bangladesh. Among these cases, 12 tested positive by means of a cholera rapid diagnostic test or culture.

India: In 2021, as of 14 February, 97 cholera cases were reported in the Hooghly district of West Bengal. The outbreak began on 6 February. Three stool samples and two water samples were sent for investigation, of which one sample showed growth of *Vibrio cholera*.

Yemen: In 2021, and as of 28 February, 9 643 cholera suspected cases have been reported, including two deaths. The outbreak has affected 14 of 23 governorates and 175 of 333 districts in Yemen.

***Disclaimer**: Data presented in this report originate from several sources, both official public health authorities and non-official, such as the media. Data completeness depends on the availability of reports from surveillance systems and their accuracy, which varies between countries. All data should be interpreted with caution as there may be areas of under-reporting and figures may not reflect the actual epidemiological situation.*

ECDC assessment

Cholera cases have continued to be reported in eastern Africa, the Horn of Africa, and the Gulf of Aden over the past few months. Cholera outbreaks have also been reported in the western and southern part of Africa and in some areas of Asia. Despite the high number of cholera outbreaks reported worldwide, few cases are reported each year among returning EU/EEA travellers. The risk of cholera infection in travellers visiting countries with ongoing outbreaks remains low, although sporadic infections among EU/EEA travellers are possible. In 2018, 26 cases were reported in EU/EEA Member States, while 17 and 23 cases were reported in 2017 and 2016, respectively. All cases had travel history to cholera-affected areas. The risk of further transmission of *Vibrio cholerae* within the EU/EEA is very low.

According to WHO, vaccination should be considered for travellers at higher risk, such as emergency and relief workers who are likely to be directly exposed. Vaccination is generally not recommended for other travellers.

Travellers to cholera-endemic areas should seek advice from travel health clinics to assess their personal risk and apply

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precautionary sanitary and hygiene measures to prevent infection. These include drinking bottled water or water treated with chlorine, carefully washing fruit and vegetables with bottled or chlorinated water before consumption, regularly washing hands with soap, eating thoroughly cooked food, and avoiding the consumption of raw seafood products.

Actions

ECDC monitors cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and to inform public health authorities. Reports are published on a monthly basis. The worldwide overview of cholera outbreaks is available on ECDC's website.

Geographical distribution of cholera cases reported worldwide in 2021

ECDC

Poliomyelitis – Multi-country (World) – Monitoring global outbreaks

Opening date: 9 December 2019 Latest update: 9 April 2021

Epidemiological summary

Wild poliovirus:
In 2021 overall, as of 30 March two cases of WPV1 have been reported from two endemic countries: Afghanistan (1) and Pakistan (1). In 2020, a total of 140 cases of WPV1 have been reported from Pakistan (84) and Afghanistan (56).

Circulating vaccine-derived poliovirus (cVDPV): In 2020 overall, and as of 30 March 2021, 30 cases of cVDPV1 have been reported by Yemen (29) and Malaysia (1). In addition, 1 044 cases of cVDPV2 have been reported from 24 countries: Afghanistan (308), Pakistan (135), Chad (99), Democratic Republic of the Congo (81), Burkina Faso (59), Côte D'Ivoire (59), Sudan (58), South Sudan (50), Guinea (45), Mali (43), Ethiopia (26), Somalia (14), Ghana (12), Niger (9), Togo (9), Nigeria (8), Sierra Leone (8), Cameroon (7), Central African Republic (4), Angola (3), Benin (3), Congo (2), Philippines (1), and Tajikistan (1). No cases of cVDPV3 have been reported.

In 2021 overall, as of 30 March 2021, 43 cases of cVDPV2 have been reported from six countries: Afghanistan (23), Pakistan (6), Tajikistan (5), South Sudan (4), Nigeria (3), and Senegal (2). No cases of cVDPV1 and cVDPV3 have been reported to date this year.

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Sources: Global Polio Eradication Initiative | ECDC | ECDC Polio interactive map | WHO DON | WPV3 eradication certificate

ECDC assessment

The WHO European Region has remained polio-free since 2002. Inactivated polio vaccines are used in all EU/EEA countries. However, the risk of the virus being reintroduced into Europe remains as long as there are non- or under-vaccinated population groups in European countries and poliomyelitis is not eradicated. According to the May 2019 report of the European Regional Commission for Certification of Poliomyelitis Eradication, one EU/EEA country (Romania) and two neighbouring countries (Bosnia and Herzegovina, and Ukraine) remain at high risk of a sustained polio outbreak. According to the same report, an additional 15 EU/EEA countries are at intermediate risk of sustained polio outbreaks, following wild poliovirus importation or the emergence of cVDPV due to suboptimal programme performance and low population immunity. The continuing circulation of wild poliovirus type 1 (WPV1) in two countries shows that there is still a risk of the disease being imported into the EU/EEA. Furthermore, the concerning occurrence of outbreaks of circulating vaccine-derived poliovirus (cVDPV), which only emerge and circulate due to lack of polio immunity in the population, shows the potential risk for further international spread.

To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake in the pockets of under-immunised populations.

ECDC endorses WHO's temporary recommendations with regard to EU/EEA citizens who are resident in or long-term visitors (>4 weeks) to countries with the potential risk of international spread.

ECDC links: ECDC comment on risk of polio in Europe | ECDC risk assessment

Actions

ECDC provides updates on the polio situation on a monthly basis. The agency also monitors polio cases worldwide through its epidemic intelligence activities in order to highlight polio eradication efforts and identify events that increase the risk of wild poliovirus being reintroduced into the EU/EEA.

ECDC maintains an interactive map showing countries that are still endemic for polio and that have ongoing outbreaks of cVDPV.

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