WEEKLY BULLETIN

Communicable Disease Threats Report

Week 42, 16 - 22 October 2022

Today's disease topics

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1. COVID-19 associated with SARS-CoV-2 - Multi-country (EU/EEA) - 2019 - 2022

Overview:

Summary:
At the end of week 41, 2022 (week ending 16 October), increases continued to be observed across all epidemiological indicators although they appear to be slowing down. The number of countries reporting increases in case rates and deaths has decreased compared to the previous week, and in many countries the rate of increase in reported case rates has decreased or appears to have reached a peak. However, hospital and ICU indicators continue to increase in almost half of EU/EEA countries, and increased COVID-19 transmission and mortality continues to be reported among residents of long-term care facilities. In many EU/EEA countries the vaccination uptake for the second booster dose remains low in target groups.

The pooled EU/EEA notification rate of COVID-19 cases among people aged 65 years and older increased by 10% compared with the previous week, as part of a four-week increasing trend, reaching 57% of the maximum value

reported during the pandemic. Increases of three-to-six weeks' duration were observed in nine of the 26 countries reporting data on this indicator. Increases in overall (all-age) notification rates were reported by seven countries.
Pooled EU/EEA rates of ICU occupancy have been increasing for the last three weeks, while trends in ICU admissions, hospital admissions and occupancy were stable or decreasing compared to the previous week. This masks country-level variation, as 14 of 26 countries reporting data observed increasing trends of one-to-four weeks' duration in at least one hospital or ICU indicator. The pooled EU/EEA COVID-19 death rate remained low, similar to the previous week, although increasing trends of one-to-five weeks' duration were observed in eight countries.
Pooled EU/EEA rates of hospital occupancy, ICU occupancy and ICU admissions for COVID-19 have been increasing for the last 2–3 weeks. Of 26 countries reporting data, 14 observed increasing trends of 1–5 weeks' duration in at least one hospital or ICU indicator. The pooled EU/EEA COVID-19 death rate remained at a low level, similar to the previous week, but increasing trends of 1–4 weeks' duration were observed in 11 countries.
The cumulative uptake of a first booster was 65.0% (country range: 11.2–86.7%) among adults aged 18 years and older, 84.4% (country range: 13.3–100.0%) among individuals aged 60 years and older and 53.9% (country range: 9.2–72.0%) in the total population. The cumulative uptake of a second booster was 9.2% (country range: 0.1–33.1%) among adults aged 18 years and older, 19.2% (country range: 0.3–70.0%) among individuals aged 60 years and older and 7.5% (country range: 0.1–26.5%) in the total population.
Among the 11 countries with an adequate volume of sequencing or genotyping for weeks 39–40 (26 September to 9 October 2022), the estimated distribution of variants of concern (VOC) or VOI was 98.5% (96.0–100.0% from 11 countries) for BA.4/BA.5, 1.1% (0.2–1.9% from eight countries) for BA.2.75 and 0.4% (0.1–1.8%, 521 detections from nine countries) for BA.2.
ECDC has reclassified the Omicron variant sub-lineage BQ.1 as a variant of interest (VOI). Although this variant is not included in the data for this week's report, it represents a rapidly increasing proportion of variant detections across the EU/EEA.

As of 20 June 2022, ECDC discontinued the data collection and publication of the number of COVID-19 cases and deaths worldwide. Please refer to World Health Organization (WHO) data on COVID-19 and WHO's Weekly Epidemiological and Weekly Operational Updates page for non-EU/EEA countries.
For the latest COVID-19 country overviews, please see the dedicated web page**.**

Other news:
On 19 October 2022, the European Medicines Agency (EMA) published a press release informing that its Committee for Medicinal Products for Human Use (CHMP) has recommended the use of the Comirnaty and Spikevax COVID-19 vaccines for children from six months of age. The agency recommended the Comirnaty vaccine (developed by Pfizer) for children aged six months to four years, and the Spikevax vaccine (developed by Moderna) for children aged six months to five years. Both the Comirnaty and Spikevax vaccines have already been approved for both adults and children aged from five and six years, respectively. In a separate press release published on the same day, EMA stated that it also recommended the Spikevax bivalent Original/Omicron BA.4-5 COVID-19 vaccine targeting the Omicron subvariants BA.4 and BA.5 for authorisation. This adapted vaccine, Spikevax bivalent Original/Omicron BA.4-5, is recommended for adults and children from 12 years of age who have already had a primary vaccination course against COVID-19.

On 18 October 2022 the World Health Organization (WHO) published the thirteenth meeting report of the International Health Regulations (IHR) Emergency Committee regarding the COVID-19 pandemic which took place on 13 October 2022. According to the report, the committee determined that the COVID-19 pandemic continues to constitute a Public Health Emergency of International Concern (PHEIC). The committee acknowledged progresses made in controlling COVID-19 outbreaks in many countries, as the number of severe cases and deaths have substantially decreased, and high level of immunity has been achieved in many countries through vaccination and/or infections. However, the committee expressed its concerns regarding the uncertainties about the future trajectory of the SARS-CoV-2 virus, the increasing challenges in quantifying the broader COVID-19 burden on health systems including burden of post-COVID-19 condition, and the remaining challenges in epidemiological and laboratory surveillance for SARS-CoV-2. The committee recommended enhanced focus on three key priorities: strengthening integrated surveillance and achieving vaccination targets for at risk-groups; continuing to develop strategies to increase access to affordable therapeutics; strengthening pandemic preparedness planning, while continuing to protect the most at-risk populations.

On 17 October 2022, Gavi, the vaccine alliance announced that it had signed a new agreement with the pharmaceutical company Moderna to supply variant-specific COVID-19 vaccine to lower-income countries supported by the Gavi COVAX Advanced Market Commitment (AMC). Under this new agreement, both parties have agreed to cancel remaining pending orders under the existing COVAX supply agreement and establish a framework that would enable Gavi to purchase up to 100 million doses of variant-specific COVID-19 vaccines for low- and middle-income countries at the beginning of 2023. All doses will be purchased at Moderna's lowest tiered price, on behalf of AMC participants.

Weekly update on SARS-CoV-2 variants:
Since the last update on 13 October 2022 and as of 20 October 2022, the following changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring and De-escalated variants:

As of 20 October 2022, ECDC has categorised SARS-CoV-2 variant BQ.1 including its sub-lineages as a variant of interest. This variant is also part of the broader variant under monitoring Omicron+K444X+N460X.
BQ.1 and BQ.1.1 are present at significant levels in the EU/EEA according to data from GISAID EpiCoV. The EU/EEA countries with the highest proportions reported for samples collected in week 40 are France (19%), Belgium (9%), Ireland (7%), The Netherlands (6%), and Italy (5%). These proportions are not high enough for the variant to already have had a large impact on the epidemiological situation in the affected countries. Any major effect on the number of cases by BQ.1 will come in the coming weeks to months depending on the current proportion of BQ.1 in each country.

Estimates of BQ.1 growth advantage indicate that the doubling time for the proportion of COVID-19 cases caused by this variant is around or just below 1 week, though this may be variable between settings. It is likely that this observed growth rate is mainly driven by immune escape, caused by the presence of mutations in the RBD. It is possible but not likely that the variant is also associated with an increase in intrinsic transmissibility compared to BA.5. There is currently no indication that BQ.1 is associated with any increase in infection severity compared to BA.5, and it is unlikely that this will be the case due to the overall high genetic similarity to BA.5.
Due to the observed increase in growth rate, most likely mainly driven by immune escape, it is likely that the presence of BQ.1 will contribute to a further increase in cases of COVID-19 in the EU/EEA in the coming weeks and months.
For the latest information about variants, please see ECDC's webpage on variants.

Public Health Emergency of International Concern (PHEIC):
On 30 January 2020, the World Health Organization (WHO) 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, sixth, seventh, eighth, ninth, tenth, eleventh, twelfth, and thirteenth International Health Regulations (IHR) Emergency Committee meetings for COVID-19 were held in Geneva on 30 April 2020, 31 July 2020, 29 October 2020, 14 January 2021, 15 April 2021, 14 July 2021, 22 October 2021, 13 January 2022, 11 April 2022, 8 July 2022, and 13 October 2022 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:

On 27 January 2022, ECDC published its Rapid Risk Assessment 'Assessment of the further emergence and potential impact of the SARS-CoV-2 Omicron variant of concern in the EU/EEA, 19th update'.
A dashboard with the latest updates is available on ECDC's website. For the latest update on SARS-CoV-2 variants of concern, please see ECDC's webpage on variants.

2. Monkeypox - Multi-country - 2022

Update:
Since the last update on 11 October 2022, and as of 18 October 2022, 47 monkeypox cases have been reported from eight EU/EEA countries: Italy (17), France (14), Poland (4), Austria (3), Belgium (3), Sweden (3), Ireland (2) and Denmark (1).
Since 11 October 2022, and as of 18 October 2022, three monkeypox cases have been reported by Bosnia and Herzegovina in Western Balkan countries.
Since week 29-2022, the number of reported cases has constantly declined in the EU/EEA, probably due to a combination of factors described in the assessment below.
Since early May 2022, cases of monkeypox have been reported from countries where the disease is not endemic. MPX continues to affect primarily young men who have sex with men (MSM), between 18 and 50 years of age. The clinical presentation is generally described as mild, with most cases presenting with lesions on the genitalia or peri-genital area, indicating that transmission probably occurs through close physical contact during sexual activities.

Summary:

EU/EEA
Since the start of the monkeypox outbreak and as of 18 October 2022, 20 544 confirmed cases of monkeypox (MPX) have been reported from 29 EU/EEA countries: Spain (7 239), France (4 084), Germany (3 651), Netherlands (1 226), Portugal (920), Italy (888), Belgium (785), Austria (322), Sweden (207), Poland (201), Ireland (200), Denmark (191), Norway (92), Greece (82), Hungary (78), Czechia (70), Luxembourg (55), Slovenia (47), Romania (41), Finland (40), Malta (33), Croatia (29), Iceland (16), Slovakia (14), Estonia (11), Bulgaria (6), Latvia (6), Cyprus (5) and Lithuania (5).

Deaths have been reported from: Spain (2), Belgium (1) and Czechia (1).

Western Balkans and Turkey:
Since the start of the monkeypox outbreak and as of 18 October 2022, the following Western Balkan countries have reported confirmed cases of monkeypox: Serbia (40), Bosnia and Herzegovina (9) and Montenegro (2). In addition, 12 cases have been reported from Turkey.
Disclaimer: Data presented in this update are compiled from TESSy and official public sources.
A detailed summary and analysis of data reported to TESSy can be found in the Joint ECDC-WHO Regional Office for Europe Surveillance Bulletin published weekly.

Public Health Emergency of International Concern (PHEIC): On 23 July 2022, the Director-General of World Health Organization declared the global monkeypox outbreak a Public Health Emergency of International Concern (PHEIC).

ECDC assessment:

The weekly number of MPX cases reported in the EU/EEA peaked in July 2022 and a steady declining trend has been observed since then. Multiple factors have probably contributed to the decline of this outbreak, including efforts in risk communication and community engagement resulting in behaviour changes, increasing immunity in the most affected population due to natural immunity and vaccination, and a decrease after the summer in large cultural and social events frequented by the main risk groups for this outbreak.
MPX continues to affect primarily young men who have sex with men (MSM), between 18 and 50 years of age (87%). Summer mass gatherings and specific sexual practices have facilitated the transmission of MPX among MSM groups until now. Sporadic cases in women and children have also been reported.
Cases in the current outbreak continue to present with a spectrum of symptoms and signs that differs from what has been described in past outbreaks of MPX in endemic countries, with mainly mild symptoms. Only a few severe cases (including encephalitis) leading to hospitalisations and four deaths have been reported by Spain (2), Belgium (1), and Czechia (1).
Based on evidence in the current outbreak and the declining number of new infections, the overall risk of MPX infection is assessed as moderate for MSM and low for the broader population.
Options for response for the EU/EEA countries include awareness of health professionals and support to sexual health services to continue case detection, contact tracing, and management of cases; continuing to offer testing for orthopoxvirus; vaccination strategy; and continuing risk communication and community engagement, despite the decreasing number of cases.
Given the limitations in vaccine supplies, primary preventive vaccination (PPV) and post exposure preventive vaccination (PEPV), strategies may be combined to focus on individuals at substantially higher risk of exposure and close contacts of cases, respectively. PPV strategies should prioritise gay, bisexual, or other men or transgender people who have sex with men who are at higher risk of exposure and individuals at risk of occupational exposure, based on epidemiological or behavioural criteria. Health promotion interventions and community engagement are also critical to ensure effective outreach and high vaccine acceptance and uptake among those most at risk of exposure.

Actions:

ECDC continues to monitor this event through its epidemic intelligence activities and reports relevant news on an ad-hoc basis. Multilateral meetings between affected countries, WHO's Regional Office for Europe, and ECDC have taken place to share information and coordinate response. A process in EpiPulse has been created to allow countries to share information with one another, WHO, and ECDC.
A rapid risk assessment, 'Monkeypox Multi-country outbreak', was published on 23 May 2022, first update was published on 8 July 2022 and a second update was published on 18 October 2022. For the latest updates, visit ECDC's monkeypox page.
ECDC is also offering laboratory support to Member States and collaborating with stakeholders on risk communication activities, such as targeted messaging for the general public and MSM communities. It has also provided guidance to countries hosting events during the summer. ECDC is also providing guidance on clinical

sample storage and transport, case and contact management and contact tracing, IPC guidance, cleaning and disinfection in healthcare settings and households, and vaccination approaches.

3. *C. diphtheriae* among migrants – Europe – 2022

Overview:

Summary: As of 19 October 2022, and since the last update on 7 October 2022 one new confirmed case of diphtheria in a migrant has been reported by Norway.
On 17 October 2022, Spanish health authorities reported that the previously suspected case of cutaneous diphtheria in Spain was confirmed using an ELEK test.
On 11 October 2022, the Austrian regional government released a statement reporting 10 additional cases of diphtheria among migrants residing in a refugee centre in Salzburg. According to the statement, of these cases, four are cutaneous type diphtheria. Investigations are ongoing to determine toxigenicity via ELEK test.

Background: Since the beginning of 2022, and as of 19 October 2022, there have been 67 cases of diphtheria among migrants reported by six EU/EEA countries: Austria (19), Belgium (3), France (6), Germany (31), Norway (7) and Spain (1). Cases have also been reported in Switzerland (25) and the United Kingdom (5), bringing the overall number for Europe to 97.

Among these cases, the majority presented with the cutaneous form of the disease (n=71), 16 cases had respiratory diphtheria, and for 10 reported cases this information was missing. All cases were caused by toxigenic *C. diphtheriae* and were detected in male migrants aged 8 to 38 years.

ECDC assessment:

Diphtheria is a rare disease in the EU/EEA countries. According to **WHO/UNICEF**, the immunisation coverage estimates for DTP3 in 2021 in the EU/EEA varied across the Member States, ranging from 85% (Austria) to 99% (Greece, Hungary, Luxembourg, Malta and Portugal). Universal immunisation is the only effective method of preventing the toxin-mediated disease and the occurrence of disease in fully-vaccinated individuals is very rare. This includes the administration of a booster dose of diphtheria toxoid if more than 10 years has passed since the last dose.
Reports of diphtheria cases among migrants are not unexpected and **similar events** have been seen in Europe in recent years. However, the increase in cases reported among this group and the occurrence of similar outbreaks in several EU/EEA countries recently is unusual and needs to be carefully monitored alongside the implementation of necessary public health measures to avoid further spread.
In this context, the probability for individuals residing in the community of developing the disease is very low, provided they have completed a full diphtheria vaccination series and have an up-to-date immunisation status. The impact of this outbreak is therefore expected to be very low for the broader EU/EEA population. Nevertheless, the possibility of secondary infections in the community cannot be excluded and severe clinical diphtheria is possible in unvaccinated or immunosuppressed individuals.
In exposed unvaccinated or immunosuppressed individuals in migrant centres, a severe outcome following a diphtheria infection is possible. The impact of an outbreak in this setting would therefore be higher than in the broader population, especially if vaccination uptake is incomplete among those residing or working within settings where there is an increased risk of exposure. Nevertheless, the impact of the disease for individuals with a complete course of diphtheria vaccination is considered to be low. Given the moderate probability of exposure and the potential individual impact as described above, the risk is considered to be moderate for unvaccinated or immunosuppressed individuals in reception centres or other similar crowded settings in the EU/EEA, but low for fully vaccinated individuals in those settings.

On 6 October 2022, ECDC published a Rapid Risk Assessment (RRA) on the increase of reported diphtheria cases among migrants in Europe due to *Corynebacterium diphtheriae*, stressing the importance of universal immunisation with diphtheria toxoid-containing vaccine. Options for response recommended in this RRA, included the following:

- Identification and vaccination of individuals residing in migrant centres who have incomplete vaccination status.
- Provision of information to migrant centres' health service providers for the rapid identification and isolation of possible cases pending diagnostic confirmation.
- Respiratory droplet isolation of all confirmed or suspected cases with respiratory diphtheria.
- Contact precautions, such as avoiding contact with wounds and the dressing of wounds, for confirmed and suspected cases of cutaneous diphtheria.

- Isolation of all confirmed cases (respiratory and cutaneous presentation) until the elimination of the organism is demonstrated by two negative cultures obtained at least 24 hours apart after completion of antimicrobial treatment.
- Identification of close contacts, including the personnel giving assistance, especially if they performed procedures without appropriate personal protective equipment (PPE).
- Antimicrobial post-exposure prophylaxis and vaccination of incompletely vaccinated or unvaccinated close contacts.
- Alerting clinicians to the possibility of cutaneous and/or respiratory diphtheria among migrants and travellers returning from endemic areas.
- Collection of data on the country of origin and migratory route from all suspected diphtheria cases.
- Up-to-date vaccination status for all personnel working in reception centres for migrants.
- Limiting situations of overcrowding in migrant centres, verification of the availability of laboratory diagnostics in each country.
- Timely reporting to authorities of cases confirmed according to the EU case definition.
- Enhanced surveillance, including molecular typing and whole genome sequencing of patient isolates to improve the understanding and monitoring of transmission patterns.

Additional ECDC tools, such as the **Expert Opinion on the public health needs of irregular migrants, refugees or asylum seekers across the EU's southern and south-eastern borders**, the **Handbook on implementing syndromic surveillance in migrant reception/detention centres and other refugee settings** and the **Handbook on using the ECDC preparedness checklist tool to strengthen preparedness against communicable disease outbreaks at migrant reception/detention centres** may be of relevance during outbreak investigation activities.

Actions:

ECDC continues to monitor this event through Epidemic Intelligence activities and will report weekly updates. The latest information can be found on EpiPulse.

4. West Nile virus - Multi-country (World) - Monitoring season 2022

Overview:

Since last week's update, and as of 19 October 2022, European Union (EU) and European Economic Area (EEA) countries have reported 14 human cases of West Nile virus (WNV) infection and 2 deaths related to WNV infections. Cases were reported by Italy (9), Greece (4) and France (1). Deaths were reported by Italy (2). EU-neighbouring countries reported 16 human cases of WNV infection and three deaths related to WNV infections. Cases were reported by Serbia (16) and deaths were reported by Serbia (3).
This week, among the reporting countries, the following NUTS 3 or GAUL1 regions have reported human cases of WNV infection for the first time since the start of this season: Lefkada in Greece, Zapadno-backi in Serbia, and Catania in Italy.
Since the beginning of the 2022 transmission season and as of 19 October 2022, EU/EEA countries have reported 939 human cases of WNV infection in Italy (573), Greece (274), Romania (47), Hungary (14), Germany (9), Croatia (8), Austria (6), Spain (4), France (3) and Slovakia (1). EU/EEA countries have reported 68 deaths in Italy (37), Greece (26) and Romania (5). EU-neighbouring countries have reported 218 human cases of WNV infection in Serbia (218) and 11 deaths in Serbia (11).
During the current transmission season, within the reporting countries, human cases of WNV infection were reported from 106 different NUTS 3 or GAUL 1 regions, of which the following regions reported human cases of WNV infection for the first time ever: Bouches-du-Rhône in France, Harz, Vogtlandkreis and Salzlandkreis in Germany, Pistoia, Lucca, Monza e della Brianza, Biella, Cagliari and Catania in Italy, Brasov in Romania, Moravicki in Serbia and Tarragona in Spain.
Since the beginning of the 2022 transmission season, 79 outbreaks among equids and 263 outbreaks among birds have been reported by EU/EEA countries. Outbreaks among equids have been reported by Italy (38), Germany (13), Croatia (8), Spain (6), Greece (5), France (4), Hungary (3), Austria (1) and Portugal (1). Outbreaks among birds have been reported by Italy (208), Germany (47), Spain (4), Croatia (2), Austria (1) and Hungary (1).
Please note that due to technical reasons no static maps will be published this week. Please refer to the WNV dashboard instead.

ECDC links: West Nile virus infection webpage
Sources: TESSy | Animal Disease Information System

ECDC assessment:

During the current transmission season, human cases of WNV infection have been reported from countries that had reported WNV infections in previous years.
Two EU countries and one EU-neighbouring country have reported relatively high numbers of human WNV infection cases so far this year. At this stage in the season, the number of cases in Italy and Greece is comparable with those observed in the peak epidemic year, 2018. The number of cases in Serbia is lower at this stage in the 2018 season, but higher than in other years during the past decade at this stage in the season.
In accordance with Commission Directive 2014/110/EU, prospective blood donors should be deferred for 28 days after leaving a risk area for locally-acquired WNV infection, unless the result of an individual nucleic acid test is negative.

Actions:

During transmission seasons, ECDC publishes a dashboard and an epidemiological summary every Friday.

Further information:

Data on human cases are collected via The European Surveillance System (TESSy) managed by ECDC. Only locally-acquired cases with known place of infection are included in this report. The following EU-neighbouring countries report human cases of WNV infection to ECDC: Albania, Kosovo*, Montenegro, North Macedonia, Serbia, and Turkey.
Animal data (i.e. outbreaks among equids and birds) are collected through the Animal Disease Information System (ADIS) of the European Commission. Reporting of WNV in equids and birds is mandatory at the EU/EEA level.
The distribution of human infections covers EU/EEA and EU-neighbouring countries, whereas the distribution of outbreaks among equids and birds only relates to EU/EEA countries.
** This designation is without prejudice to positions on status, and is in line with UNSCR 1244/1999 and the ICJ Opinion on the Kosovo declaration of independence.*

5. Measles - Multi-country (World) - Monitoring European outbreaks

Overview:

Since the previous monthly measles update in ECDC's Communicable Disease Threats Report (CDTR) on 13 September 2022 and as of 18 October, 12 new cases have been reported by three countries in the EU/EEA: Finland (1), Germany (9) and Poland (2). Other countries did not report new cases of measles in the publicly available sources.
No measles-related deaths have been reported in the EU/EEA in 2022 to date.
Relevant updates outside the EU/EEA are available for Ukraine, WHO Regional Office for Europe (WHO/EUROPE), WHO Regional Office for Africa (WHO AFRO), WHO Regional Office for Eastern Mediterranean (EMRO), WHO Pan American Health Organization (PAHO) and WHO Regional Office for South-East Asia (SEARO). No updates were available for WHO Western Pacific Regional Office (WPRO).

***Disclaimer:** the monthly measles report published in the CDTR provides the most recent data on cases and outbreaks from information made publicly available by national public health authorities or the media. This report is a supplement to ECDC's monthly measles and rubella monitoring report, based on data routinely submitted by 29 EU/EEA countries to The European Surveillance System (TESSy). Data presented in the two monthly reports may differ.*

Epidemiological summary for EU/EEA countries with updates since last month
Finland reported one case in September 2022.
Germany reported 67 confirmed and suspected cases in weeks 1 to 41 (ending 16 October 2022) an increase of nine cases since week 36 (ending 11 September 2022).
Poland reported 22 cases in the period from January to 15 October 2022, an increase of two cases since the previous update for January- August 2022.

Relevant epidemiological summary for countries outside the EU/EEA
A global provisional monthly measles and rubella overview by month and country is available from WHO's website.
Ukraine reported six cases of measles from January to August 2022 (according to data available on 17 October 2022), an increase of one case since the last update.

According to the WHO Regional Office for Europe (WHO/EUROPE) (data access 17 October 2022) overall 555 cases of measles were reported in the region, of these 469 in the following non-EU/EEA countries: Azerbaijan(1), Bosnia and Herzegovina (3), Georgia (9), Kazakhstan (3), Kyrgyzstan (9), Russia (26)*, Tajikistan (304), Turkey (58), Ukraine (6), United Kingdom (41), and Uzbekistan (8). According to the same report in the EU/EEA, 86 confirmed cases were reported in Austria (1), Belgium (12), Bulgaria (1), France (15), Germany (13), Greece (1), Ireland (6), Italy (6), the Netherlands (1), Norway (1), Poland (20), Romania (5) and Sweden (4). *Please note that numbers provided to WHO for EU/EEA countries are from TESSy data.*
**one case was reported in September 2022.*

According to WHO Regional Office for Africa (AFRO) report as of 9 October 2022 (week 41), cases and outbreaks of measles in 2022 were reported in the following countries: Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo (DRC), Ethiopia, Guinea, Kenya, Liberia, Mali, Niger, Senegal, Sierra Leone, South Sudan, Tanzania, Zambia, Zimbabwe. Due to varying reporting periods by the countries please visit the latest weekly bulletin available here.

The most recent and ongoing outbreaks reported are in Democratic Republic of the Congo (DRC) (102 877 suspected cases, including 1 317 deaths (CFR:1.3%), Zimbabwe (7 468 cases, including 744 deaths), Ethiopia (9 850 suspected cases, 5 806 confirmed, including 56 deaths (CFR: 0.6%) in January – September 2022), Tanzania (223 suspected cases in June-Auguste 2022). In addition, outbreak of measles has been declared in Limpopo, South Africa following diagnosis of measles in three unvaccinated children. South Sudan is affected by floods between July and September 2022 affecting one third of the counties in addition to an ongoing food insecurity leading to a deterioration of the situation with infectious diseases, including measles.
According to WHO Pan American Health Organization (PAHO) report (Vol. 28, No. 39-40) in 2022 week 40 (ending 9 October 2022) 72 cases were reported in four countries: Brazil (43), the United States of America (24), Canada (3), and Argentina (2).

In the WHO Regional Office for Eastern Mediterranean (EMRO) from January to September 2022, 14 206 cases of measles were reported in all 21 countries of the region: Afghanistan (4 063), Bahrain (115), Djibouti (67), Egypt (368), Iran (296), Iraq (15), Jordan (23), Kuwait (7), Lebanon (65), Libya (22), Morocco (6), Oman (98), Pakistan (5 817), Qatar (6), Saudi Arabia (67), Somalia (421), Sudan (2 098), Syria (101), Tunisia (2), the United Arab Emirates (108) and Yemen (441). Most of the cases were reported in Pakistan (5 817) and Afghanistan (4 063). The update is provided from the WHO Provisional monthly measles and rubella data available on 18 October 2022. Pakistan has been affected by severe flooding that has aggravated disease outbreaks and reduced access to healthcare, increasing the overall risk of measles in the country to high.
In WHO Regional Office for South-East Asia (SEARO) from January to September 2022 there were 13 282 cases of measles reported by eight countries: India (11 156), Indonesia (1 787), Bangladesh (180), Thailand (74), Nepal (56), Timor-Leste (15), Myanmar (10), Bhutan (4). The update is provided from WHO's Provisional monthly measles and rubella data available on 18 October 2022.

ECDC assessment:

The substantial decline in measles cases reported by EU/EEA countries after March 2020, and continuing through 2022, contrasts with the usual annual and seasonal pattern for measles, which peaks during the spring in temperate climates. A similar decrease has been observed in other countries worldwide during the same period. Under-reporting, under-diagnosis, or a real decrease due to the direct or indirect effects of COVID-19 pandemic measures could explain the observed decline in cases. The lifting of non-pharmaceutical interventions related to the COVID-19 pandemic could lead to measles outbreaks in the EU/EEA. Active measles surveillance and public health measures, including high vaccination uptake, provide the foundation for a proper response to possible increases in the number of cases/outbreaks.

Actions:

ECDC monitors the measles situation through its epidemic intelligence activities, which supplement monthly outputs with measles surveillance data from The European Surveillance System (TESSy) routinely submitted by 29 EU/EEA countries. ECDC published a risk assessment entitled 'Who is at risk of measles in the EU/EEA?' on 28 May 2019.

6. Ebola virus disease due to Sudan ebolavirus – Uganda – 2022

Overview: According to World Health Organisation (WHO), as of 19 October 2022, there have been 64 confirmed cases of Ebola virus disease (EVD), including 25 deaths (CFR: 39%, including probable deaths: 54%). Among these, at least 11 healthcare workers have been infected and five have died. There have been 20 probable deaths among individuals who died before a sample was taken. All cases reported out of Mubende as of 12 October 2022 have an epidemiological link to the cases initially reported in Mubende. There have been 25 recoveries from EVD, including six healthcare workers.

Cases have mainly been reported from Mubende. However, the districts of Bunyangabu, Kyegegwa, Kassanda, and Kagadi are also affected. No transmission of EVD has occurred in Kampala district to date.
As of 20 October 2022, according to the media, one case has been detected in Manyi sub-county in Mityana District. The patient is a severely-ill female who is a contact of her deceased mother from Mubende District. Reportedly, the patient's child also died due to EVD. The woman was transferred from Mityana to Mubende hospital and all staff who were in contact with her and the deceased child have been isolated.
As of 19 October 2022, according to WHO, health officials have identified at least 2 007 contacts of cases, 931 of which (46%) have completed 21 days of follow up.

Other news:
As of 19 October 2022, and according to the media, there are at least eight Ebola cases reported recently that have no known links with current cases.
According to a media article from 18 October 2022, the United States sent a supply of the antiviral drug Remdesivir, as well as the experimental monoclonal Ebola antibody drug MBP134.
On 16 October 2022, **media** reported a case of EVD in a school child, whose mother died due to EVD. Schools currently remain open with measures such as temperature checks and close monitoring of absences implemented.
On 14 October 2022, **media** reported that an Israeli man had fallen ill after returning from Uganda. He tested negative for EVD but remains in isolation until the 21-day incubation period has passed.

Background: On 20 September 2022, the Ministry of Health in Uganda, together with WHO AFRO, confirmed an outbreak of EVD due to *Sudan ebolavirus* in Mubende District, Uganda, after one fatal case was confirmed.
The index case was a 24-year-old man, a resident of Ngabano village of Madudu sub-county in Mubende District. The patient experienced high fever, diarrhoea, abdominal pain, and had been vomiting blood since 11 September 2022. Samples were collected on 18 September 2022 and EVD was laboratory-confirmed on 19 September. The patient died on the same day, five days after hospitalisation.
On 15 October 2022, the **president of Uganda** imposed a 21-day lockdown on Mubende and Kassanda districts to contain the outbreak of EVD. Measures include an overnight curfew, closing places of worship and entertainment and restricting movement in and out of the two districts.
There has been one death **reported** in Kampala in a man who travelled from Mubende to the capital city to seek help. The wife of the deceased man has tested positive for EVD and remains in an isolation centre in Kampala. The couple became infected in Mubende.
The Ugandan government is carrying out community-based surveillance and active case finding. An on-site mobile laboratory has been established in Mubende and risk communication activities are ongoing in all affected districts. Africa CDC, WHO, GOARN, and other partners have teams in Uganda to support the coordination of the response.

Previously, EVD was reported in Uganda in 2019 due to *Zaire ebolavirus*, which was imported from the Democratic Republic of the Congo. EVD outbreaks caused by *Sudan ebolavirus* have previously occurred in Uganda (four outbreaks) and Sudan (three outbreaks). The last outbreak of EVD due to *Sudan ebolavirus* in Uganda was reported in 2012.

ECDC assessment:

Risk to EU/EEA citizens living in or travelling to affected areas in Uganda
Considering the limited size of the outbreak and the absence of chains of transmission in densely populated areas (e.g. the capital city of Kampala), the current probability that EU/EEA citizens living in or travelling to EVD-affected areas of Uganda will be exposed to the virus is very low, provided that they adhere to the recommended precautionary measures (see further information below). Transmission requires direct contact with blood, secretions, organs or other bodily fluids of dead or living infected people or animals; all unlikely exposures for the general EU/EEA tourists or expatriates in Uganda.

An increase in cases and, most importantly, the occurrence of chains of transmissions in populated areas and cities such as Kampala would increase the likelihood of exposure of EU/EEA citizens to Ebola virus. Considering that

infection with *Sudan ebolavirus* leads to severe disease but that the probability of exposure of EU/EEA citizens is very low, the impact for the EU/EEA citizens living and travelling in affected areas in Uganda is considered low. Overall, the current risk for EU/EEA citizens living or travelling to affected areas in Uganda is considered low. Staff members of humanitarian, religious and other organisations, particularly healthcare workers who are in direct contact with patients and/or local communities in the affected areas, are more likely to be exposed to the virus. The likelihood of infection for this group is currently low, provided that they adhere to the appropriate infection prevention and control measures. As in the previous scenario, the impact is considered low. Therefore, the overall risk for EU/EEA citizens deployed in response to the outbreak is considered low.

Risk of introduction and spread within the EU/EEA

The most likely route by which the Ebola virus could be introduced to the EU/EEA is through infected people from affected areas travelling to the EU/EEA or medical evacuation of cases to the EU/EEA. According to the International Air Travel Association, in 2019, there were about 126,000 travellers arriving in the EU/EEA from Uganda. The likelihood of secondary transmission of Ebola virus within the EU/EEA and the implementation of sustained chains of transmission within the EU/EEA is very low as cases are likely to be promptly identified and isolated and follow up control measures are likely to be implemented. During the large EVD outbreak in West Africa in 2013–2016, there was only one local transmission in the EU/EEA (in Spain) in a healthcare worker who had attended to an evacuated EVD patient. The impact for the EU/EEA citizens living in the EU/EEA is considered low and overall, the current risk for the citizens in the EU/EEA is considered very low.

Vaccines

The licenced vaccines protect against EVD resulting from *Zaire ebolavirus*. There are no licenced vaccines protecting against EVD resulting from *Sudan ebolavirus* and there are no data available on the level of cross-protection. The availability of a vaccine proved to be very helpful in the control of recent outbreaks in the Democratic Republic of the Congo and the unavailability of vaccine will be an additional challenge in the control of this outbreak.

Actions:

ECDC is monitoring this situation through its epidemic intelligence activities and will report relevant updates twice a week. On 12 October 2022, ECDC published a news item on the Ebola outbreak in Uganda. An ECDC webpage and an epidemiological update on Ebola outbreak in Uganda will be available on 21 October 2022.

Further information:

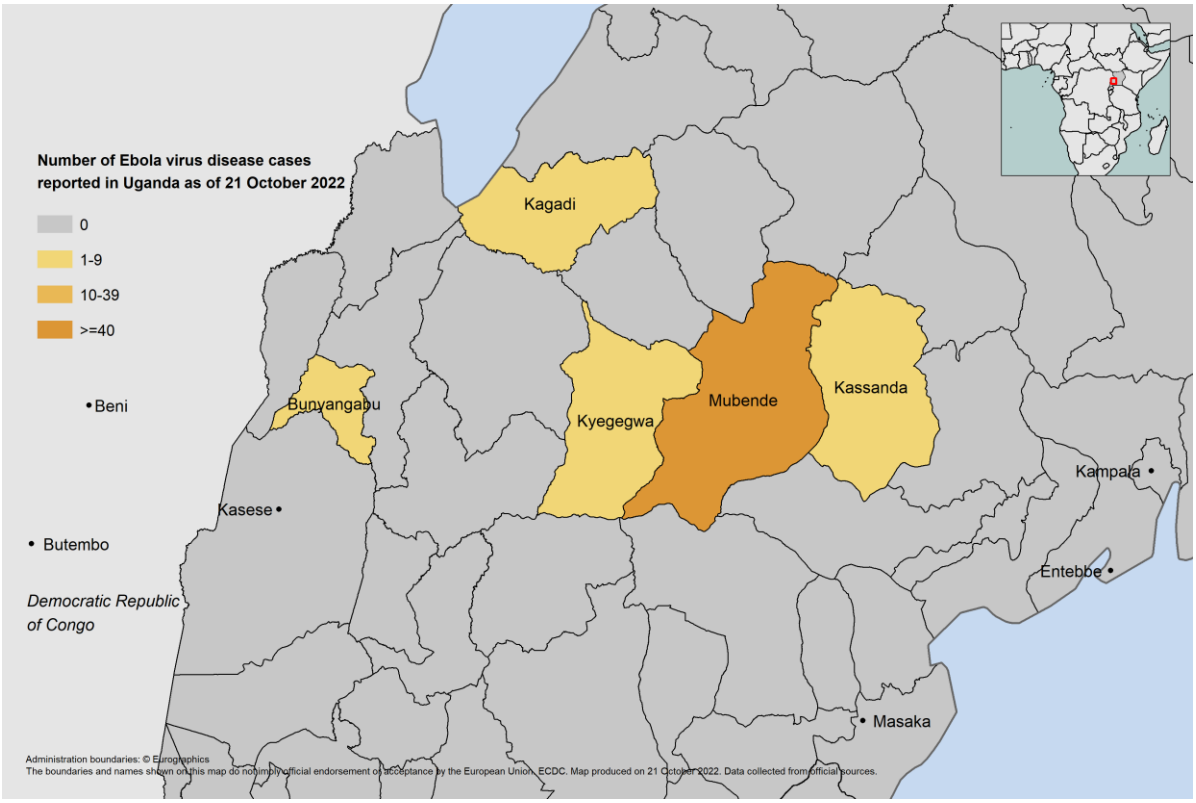
EU/EEA visitors and residents in affected areas in Uganda should apply the following precautionary measures:
- Avoid contact with symptomatic patients/their bodily fluids, bodies and/or bodily fluids from deceased patients.
- Avoid consumption of bush meat and contact with wild animals, both alive and dead.
- Wash and peel fruit and vegetables before consumption.
- Wash hands regularly using soap or antiseptics.
- Ensure safe sexual practices.

WHO advises against any restrictions on travel and/or trade to Uganda based on available information for the current outbreak. Considering the lessons/results of the large EVD outbreak in West Africa (2013-2016), where thousands of cases were reported, transmission was ongoing in large urban centres, and in addition hundreds of EU/EEA humanitarian and military personnel were deployed to the affected areas, ECDC considers that screening of travellers returning from Uganda would not be an effective measure to prevent introduction in Europe. Screening incoming travellers is time and resource consuming and will not identify effectively infected cases. Both experience and evidence show that exit screening can be an effective measure to support the containment of the disease spread.

Additional Sources: **Ministry of Health Uganda** , **OCHA**, **Africa CDC**, **Ministry of Health Kenya**, NCDC, WHO, media (**1**, **2**, **3**, **4**)

Maps and graphs

Figure 1. Geographical distribution of EVD cases in Uganda, 2022.



7. Cholera - Multi-country (World) - Monitoring global outbreaks

Summary

Since the last update on 16 September 2022, approximately 86 154 suspected cholera cases including 293 deaths have been reported worldwide.
Countries reporting new cases since the previous update are Afghanistan, Bangladesh, Cameroon, The Democratic Republic of the Congo, Haiti, Lebanon, Malawi, Mozambique, Niger, Nigeria, Philippines, South Sudan, and Syria.

A list of all countries reporting new cases since our previous update can be found below.

Americas

Haiti: On 2 October 2022, Haitian public health authorities reported two cholera cases in the greater Port-au-Prince area. Additionally, as of 13 October 2022, they have reported a total of 425 suspected cases, 60 confirmed cases and 22 fatalities. Additionally, in the Prison of Port-au-Prince, 217 suspected cases, 12 confirmed cases and 14 fatalities have been reported.

No additional cholera cases have been reported in other regions of the Americas in 2022.

Africa

Burkina Faso: Since the last update no new cases have been reported in Burkina Faso. In 2022 and as of 5 July, one suspected cholera case had been reported in the country.
Cameroon: Since the last update, 1 787 suspected cholera cases including 45 deaths have been reported in Cameroon. In 2022 and as of 22 September, a total of 11 608 suspected cases including 227 deaths have been reported in the country.
The Democratic Republic of the Congo (DRC): Since the last update, 1 038 suspected cholera cases including 33 deaths have been reported in DRC. In 2022, and as of 18 September, a total of 9 705 suspected cholera cases

including 183 deaths (CFR: 1.9%) have been reported in 71 health zones across 14 provinces of the Democratic Republic of Congo. According to WHO Regional Office for Africa, most affected provinces are South Kivu, Haut-Lomami, Tanganyika, and North Kivu.
Kenya: Since the last update, no new cases have been reported in Kenya. In 2022, and as of 31 May, a total of 319 cases including two deaths (CFR 0.6%) have been reported from the country.
Malawi: Since the last update, Malawi has reported 1 691 confirmed cholera cases, including 30 deaths. In 2022, and as of 7 October, a total of 4 170 cholera cases including 85 deaths have been reported in 19 districts.
Mozambique: Since the last update, 215 suspected cholera cases including four deaths have been reported in Mozambique. In 2022 and as of 28 September, a total of 3 685 suspected cholera cases including 19 fatalities have been reported in the country.
Niger: Since the last update, 12 cholera cases have been reported in Niger. In 2022 and as of 24 September, a total of 26 suspected cases have been reported, 14 of them having tested positive for cholera.
Nigeria: Since the last update, 1 841 suspected cases including 58 deaths have been reported in Nigeria. In 2022 and as of 4 September, a total of 5 451 cases including 149 deaths (CFR 2.7%) have been reported from 31 states. According to Nigeria Centre for Disease Control, thirteen states – Yobe (918 cases), Borno (679 cases), Taraba (676 cases), Cross River (650), Katsina (378 cases), kano (333 cases), Jigawa (317 cases), Ondo (283 cases), Zamfara (178 cases) Adamawa (161 cases), Gombe (159 cases), Bayelsa (145 cases) and Bauchi (122 cases), account for 92% of all cumulative cases.
Somalia: Since the last update, no new cholera cases have been reported in Somalia. In 2022 and as of 18 September, a total of 11 300 suspected cholera cases, including 44 deaths have been reported in the country.
South Sudan: Since the last update, five suspected Cholera cases have been reported from South Sudan. In 2022 and as of 18 September, a total of 337 suspected cholera cases, including one death have been reported in the country.
Tanzania: Since the last update, no new cholera cases have been reported in Tanzania. In 2022 and as of 7 August, a total of 341 cases and six deaths (CFR: 1.8%) have been reported in the country.
Zambia: Since the last update no new cholera case has been reported in Zambia. In 2022, and as of 31 July, a total of 160 cholera cases have been reported in the country.

Asia

Afghanistan: Since the last update, 27 734 suspected cholera cases, including eight deaths have been reported in Afghanistan. In 2022 and as of 24 September, a total of 178 012 suspected cholera cases including 63 deaths have been reported. According to WHO, the most affected provinces are Kabul (38,400, 21.5%), Helmand (31,077, 17.4%), Baghlan (11,001, 6.1%), Kandahar (10,405, 5.8%), Nangarhar (9,769, 5.4%), Jawzjan (7,686, 4.3%) and Khost (6,386, 3.6%).
Bangladesh: Since the last update, 35 281 suspected cholera cases have been reported in Rohingya Refugee Camp in Bangladesh. In 2022 and as of 27 August, a total of 554 498 suspected cholera cases including 29 deaths have been reported from the country. Among these cases, 461 611 cases including 29 deaths have been reported from different parts of the country and 92 887 cases have been reported in Rohingya Refugee Camp in Cox's Bazar.
India: Since the last update, no new suspected cholera cases have been reported in India. In 2022 and as of 29 July, a total of 549 suspected cholera cases and nine deaths have been reported in the country.
Iraq: Since the last update, no new cholera cases have been reported in Iraq. In 2022, and as of 23 August, a total of 1 008 confirmed cholera cases and five associated fatalities have been reported in the country.
Lebanon: On 6 October 2022, Lebanon reported a cholera case in the country. As of 17 October 2022, a total of 89 confirmed cases and three fatalities have been reported in Akkar, Minieh Dannieh, Baalbeck and Kerwan. This is the first cholera outbreak in Lebanon since 1993.
Nepal: Since the last update, no cholera cases have been reported in Nepal. In 2022, and as of 5 September, 76 cholera cases have been reported in the Kathmandu valley.
Pakistan: Since the last update, no new cholera cases have been reported in Pakistan. In 2022, and as of 18 August, a total of 258 139 cholera cases including 30 deaths have been reported in the country.
Philippines: Since the last update, 860 suspected cholera cases including 17 deaths have been reported in the Philippines. In 2022 and as of 1 October, 3 890 cholera cases and 37 associate fatalities have been reported in the country.
Syria: Since the last update, 14 887 suspected cholera cases including 60 deaths have been reported in Syria. Between 25 August and 8 October 2022, a total of 15 823 suspected cholera cases including 807 confirmed cases and 68 fatalities have been reported in the country. According to World Health Organization (WHO), the most affected governorates are Deir-ez-Zor (8,940 cases, 56.5 %), Ar-Raqqa (3,325 cases, 21%), Aleppo (2,411 cases, 15.2%) and Al-Hasakeh (841 cases, 5.3%).
No updates were available on previous outbreaks reported in Benin, Ethiopia, Togo, Uganda, and Zimbabwe.

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:

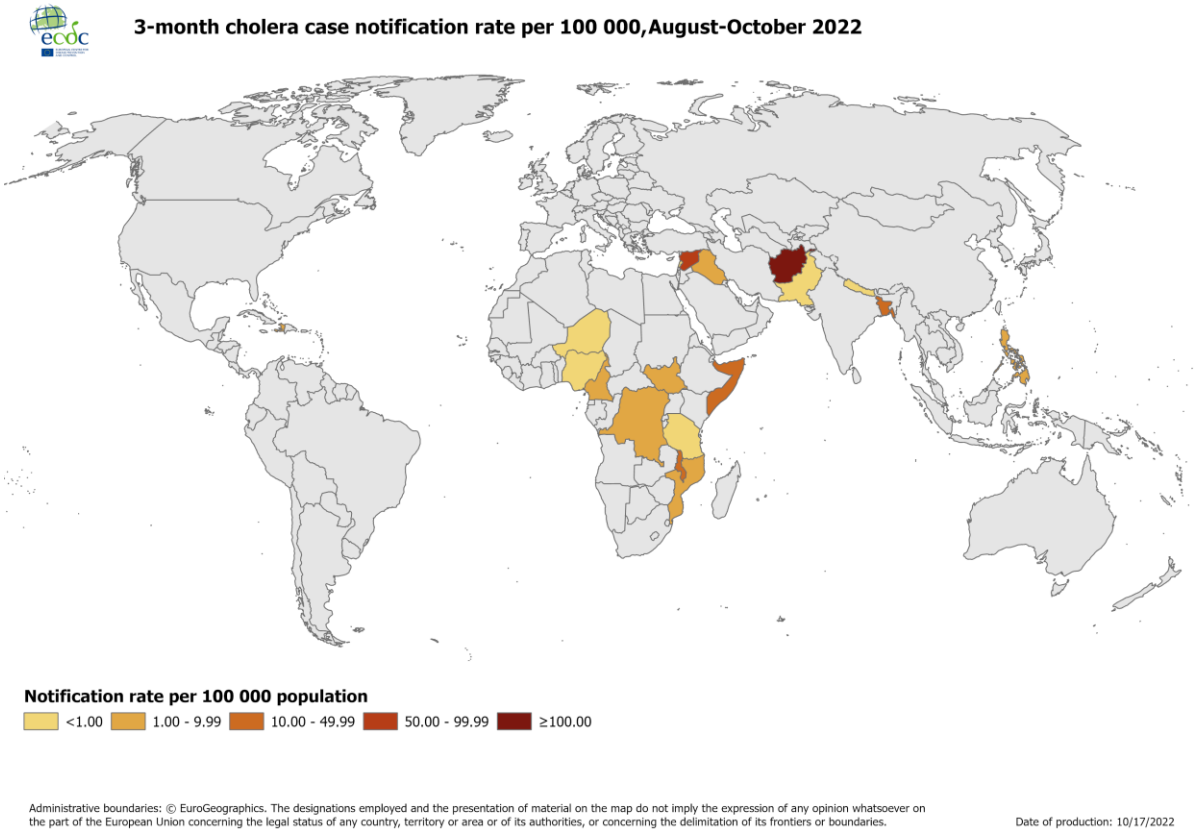
Cholera cases have continued to be reported in western Africa and south-east Asia during the past few months. Cholera outbreaks have also been notified in the eastern and southern parts of Africa, as well as in some areas of Asia. Despite the number of cholera outbreaks reported worldwide, few cases are reported each year among returning EU/EEA travellers. In this context, the risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases in the EU/EEA remains possible. In 2021, two cases were reported in the EU/EEA Member States, while three and 26 cases were reported in 2020 and 2019 respectively. All cases had travel history to cholera-affected areas. 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 precautionary sanitary and hygiene measures to prevent infection. These can 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 continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and to facilitate updates to public health authorities. Reports are published on a monthly basis. The worldwide overview of cholera outbreaks is available on ECDC's website.

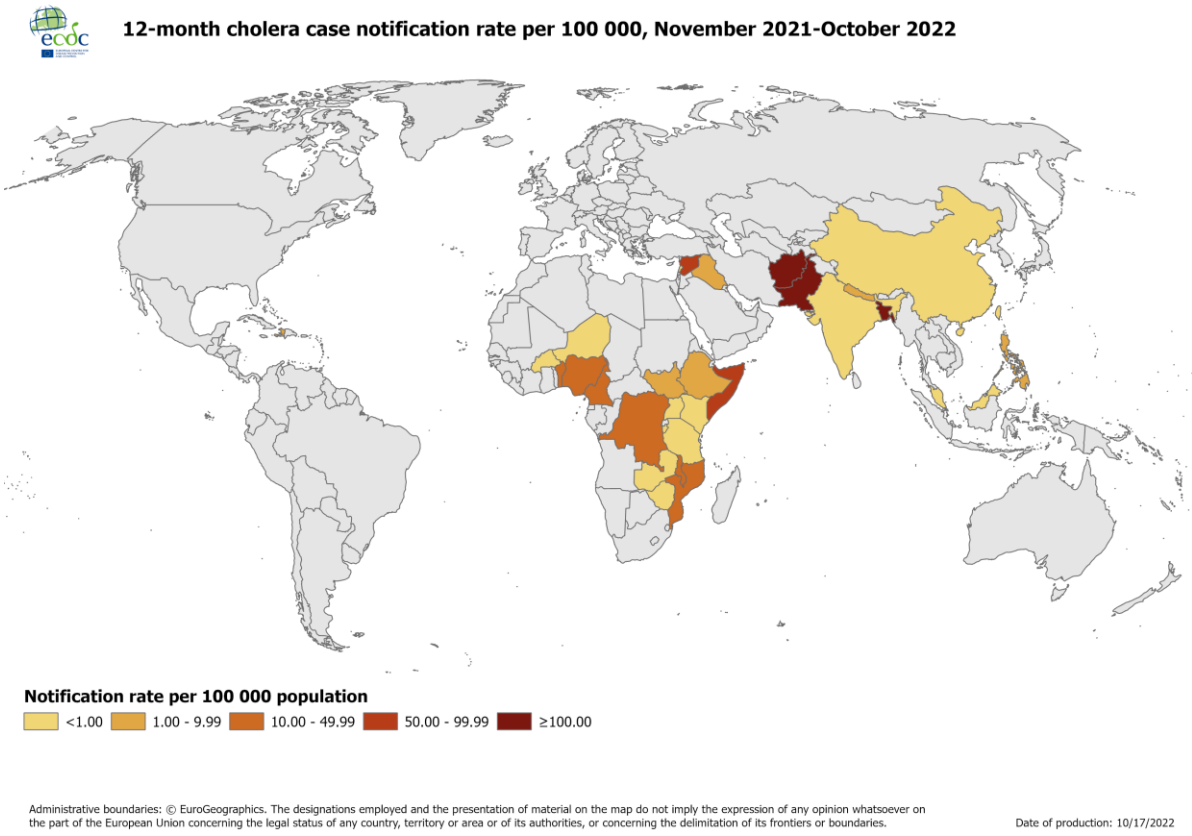
Maps and graphs

Figure 1. Geographical distribution of 3-month cholera case notification rate per 100 000 population reported worldwide



Source: ECDC

Figure 2. Geographical distribution of 12-month cholera case notification rate per 100 000 population reported worldwide



Source: ECDC

8. Influenza A(H5N6) - Multi country - Monitoring human cases

Update: As of 19 October 2022, and since the last case reported in a monthly update on 26 September 2022, one new human case with avian influenza A(H5N6) virus infection was reported in China. The patient was a 3-year-old boy from Guangxi province in China. He developed symptoms on 1 September 2022 and was hospitalized in critical condition with severe pneumonia on 11 September. The case had exposure to a backyard poultry prior to the onset of symptoms. No additional cases were detected among family members of this boy. No influenza was detected in the environmental samples collected by local authorities.

Summary: To date, 82 laboratory confirmed cases, including 33 deaths (CFR: 40%) of human infection with influenza A(H5N6) virus, have been reported since 2014. Most of these cases were reported from China (81) and one from Laos.

ECDC assessment:

Sporadic human cases of avian influenza A(H5N6) have been previously observed. No human-to-human transmission has been reported so far. Sporadic zoonotic transmission cannot be excluded; the use of personal protective measures for people directly exposed to potentially infected poultry and birds with avian influenza viruses will minimise the remaining risk. The risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered to be very low.

Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities and collaborates with EFSA and the EU reference laboratory 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 recent report was published on 3 October 2022.

9. Poliomyelitis - Multi-country (World) - Monitoring global outbreaks

Overview:

Global public health efforts to eradicate polio are continuing through the immunisation of 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 15 June 2022, the 32nd meeting of the Emergency Committee was held under the International Health Regulations (2005) (IHR) on the international spread of poliovirus. The most recent meeting (33rd) was held on 12 October 2022.
In June 2002, WHO's European Region was officially declared polio-free.

Update:
Since the 23 September 2022 and as of 18 October 2022, the following cases have been reported:

Wild poliovirus (WPV1):
- One new case of AFP caused by WPV1 has been reported from Pakistan.
- One new case of AFP caused by WPV1 has been reported from Mozambique.

Circulating vaccine-derived poliovirus (cVDPV):
- Twenty-nine new cases of AFP caused by cVDPV1 have been reported from Democratic Republic of the Congo (24), Malawi (1), and Mozambique (4).

- Seventy-four new cases of AFP caused by cVDPV2 have been reported in 2022 from six countries: DRC (43), Yemen (23), Central African Republic (3), Nigeria (3), Benin (1), and Somalia (1).
- No new cases of AFP caused by cVDPV3 have been reported.

Summary:

Wild poliovirus:
In 2022, and as of 18 October 2022, 29 cases of AFP caused by WPV1 have been reported. These have been reported from the two endemic countries, Pakistan (20) and Afghanistan (2), and one non-endemic country, Mozambique (7). One associated death has been reported in Pakistan.

Circulating vaccine-derived poliovirus (cVDPV):
In 2022, and as of 18 October 2022, 47 cases of AFP caused by cVDPV1 have been reported from DRC (28), Madagascar (8), Mozambique (8), and Malawi (3).

Overall, 392 cases of AFP caused by cVDPV2 have been reported from 14 countries: DRC (154), Yemen (150), Nigeria (36), Chad (18), Niger (10), Benin (7), Mozambique (4), Somalia (4), Central African Republic (3), Ghana (2), Algeria (1), Eritrea (1), USA (1), and Togo (1).
One case of AFP caused by cVDPV3 has been reported from Israel.

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

ECDC assessment:

The WHO European Region, including the EU/EEA, has remained polio-free since 2002. Inactivated polio vaccines are used in all EU/EEA countries.
As long as there are non-vaccinated or under-vaccinated population groups in European countries and poliomyelitis is not eradicated globally, the risk of the virus being reintroduced in Europe remains. Two EU/EEA countries (Poland and Romania) and one neighbouring country (Ukraine) remain at high risk of a sustained polio outbreak following wild poliovirus importation or the emergence of cVDPV, due to sub-optimal programme performance and low population immunity, according to the European Regional Certification Commission for Poliomyelitis Eradication (RCC) report from September 2021 assessment, referring to data from 2020. According to the same report, 11 EU/EEA countries are at an intermediate risk of sustained polio outbreaks. The continuing circulation of wild

poliovirus type 1 (WPV1) in Pakistan and Afghanistan and detection of four WPV1 cases in Mozambique in 2022 genetically linked to a strain from Pakistan show that there is still a risk of the disease being imported into the EU/EEA. Furthermore, the worrying occurrence of outbreaks of circulating vaccine-derived poliovirus (cVDPV), which emerges and circulates 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 pockets of under-immunised populations. EU/EEA countries should review their polio vaccination coverage data and ensure there are no immunity gaps in the population and that there is capacity to identify virus circulation through well-performing surveillance systems.
ECDC endorses WHO's temporary recommendations for EU/EEA citizens who are residents or long-term visitors (>4 weeks) in countries categorised by WHO as having the potential risk of the international spread of polio: an additional dose of poliovirus vaccine should be administered between four weeks and 12 months prior to international travel.
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.

10. Influenza – Multi-country – Monitoring 2022/2023 season

Overview:

Week 41/2022 (10-16 October 2022)
Germany and United Kingdom (Scotland) reported regional influenza spread and Kazakhstan reported widespread influenza activity.
The percentage of all sentinel primary care specimens from patients presenting with ILI or ARI symptoms that tested positive for an influenza virus increased to 4% from 3% in the previous week, which is below the epidemic threshold set at 10%.
Germany, with a rate of 13%, was the only country to report seasonal influenza activity above 10% positivity in sentinel primary care.
Both influenza type A and type B viruses were detected among all monitoring systems.
Both type A and type B viruses were detected among hospitalized patients with laboratory confirmed influenza.

Source: Flu News Europe

ECDC assessment:

For the Region as a whole, influenza activity was at inter-seasonal levels.

Actions:

ECDC and WHO monitor influenza activity in the WHO European Region. Data are available on the **Flu News Europe** website.

11. Avian influenza A(H5N1) in mink - Spain - 2022

Overview:

On 18 October 2022, the regional health authorities of Galicia in Spain reported an outbreak of avian influenza A(H5N1) in a mink farm in the province of A Coruña.
Mink in the farm were tested following regular surveillance procedures after the occurrence of sick mink in the farm with respiratory symptoms and an unusual increase in deaths of the animals. Mink were tested for several diseases, including SARS-CoV-2 and influenza. Two samples tested positive for avian influenza A(H5N1). Avian influenza A(H5N1) has recently been detected in Spain in domestic and wild birds.
Strict measures were immediately implemented in the farm by the official veterinary services. Entry and exit of animals and other materials that can carry the virus is prohibited, entry and exit of external vehicles and people to/from the farm is restricted; biosecurity and cleaning and disinfection measures are implemented. Contact of farm staff with mink are minimised.
Following a public health risk assessment by Spanish authorities, mink were culled in the farm that kept 8 369 breeding females and 43 617 weaned offspring, and the farm premises cleaned and disinfected.
As a precautionary measure, the Ministry of Rural Affairs initiated surveillance in poultry and mink farms located around the affected farm. Among other measures, it will be prohibited to keep concentrations of birds and the release of hunting birds for repopulation.

ECDC assessment:

Transmission of avian influenza to different mammal species has been observed over the past few years globally and in many EU/EEA countries (last joint ECDC/EFSA report). It is important to monitor such events, sequence viruses to support risk assessment to identify mutations associated with mammalian adaptation and increased resistance to antiviral drugs.
The risk of transmission to occupationally or otherwise directly exposed people to avian influenza infected animals and birds is considered to be low to medium with a high level of uncertainty.
It is therefore important that people in close contact to sick animals wear protective equipment to prevent transmission events. They should be monitored or self-monitor for 10-14 days for any respiratory but also unspecific symptoms as previous infected mammals have showed neurological affection. Testing should be initiated immediately upon onset of a suspected infection.

Actions:

ECDC is monitoring this event through epidemic intelligence activities and influenza network.

Further information:

ECDC published the latest avian influenza situation overview on 3 October 2022, as well as a guidance document on **Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work**.