WEEKLY BULLETIN

Communicable Disease Threats Report

Week 43, 23 - 29 October 2022

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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 42, 2022 (week ending 23 October), small decreasing trends in the EU/EEA case rate, the case rate among people aged 65 years and older, and death rates were observed. At the EU/EEA level, hospital and ICU indicators have remained stable in comparison to the previous week. 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 decreased by 2% compared to the previous week, as part of a one-week decreasing trend, reaching 55% of the maximum value reported during the pandemic. Increases of one to five weeks duration were observed in five of the 30 countries reporting data on this indicator. Increases in overall (all-age) notification rates were reported by four countries.

Pooled EU/EEA rates of hospital occupancy, ICU admission, and ICU occupancy have been stable, while trends in hospital admissions decreased in comparison to the previous week. Country-level variation of these indicators remains, as six of 26 countries reported an increasing trend in at least one of these indicators compared to the

previous week. The pooled EU/EEA COVID-19 death rate remained low, with a 13% decrease compared to the previous week, although increasing trends of one to three weeks duration were observed in five countries.

The cumulative uptake of a first booster was 65.0% (country range: 11.2–86.7%) among people aged 18 years and older; 84.4% (country range: 13.3–100.0%) among people 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 people aged 18 years and older; 19.3% (country range: 0.3–70.0%) among people aged 60 years and older; and 7.6% (country range: 0.1–26.5%) in the total population.

Among the 13 countries with an adequate volume of sequencing or genotyping for weeks 40–41 (3 October to 16 October 2022), the estimated distribution of variants of concern (VOC) or variants of interest (VOI) was 97.6% (64.4–100.0% from 13 countries) for BA.4/BA.5; 1.3% (0.1–11.4% from 10 countries) for BA.2.75; and 0.3% (0.1–2.0%, 243 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 20 October 2022, the Spanish Ministry of Health published a resolution lifting all remaining COVID-19 travel measures. The resolution annuls the need for any sanitary control measures for people coming from countries outside the European Union and Schengen-associated countries. The resolution came into effect on 21 October 2022.

On 26 October 2022, CanSino Biologics Inc. published a news item reporting the rollout of a new inhaled booster COVID-19 vaccine, Convidecia Air. According to the news item, the Recombinant COVID-19 inhaled vaccine was approved by the Joint Prevention and Control Mechanism of the State Council of China. This is the world's first inhaled COVID-19 vaccine.

Weekly update on SARS-CoV-2 variants:
Since the last update on 20 October 2022 and as of 27 October 2022, **no changes** have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring and de-escalated variants.

For the latest information on 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.

ECDC invites countries to use the EpiPulse event (**2022-IRV-00008**) on BQ.1 and sub-lineages to discuss and share information on this variant as they become available. Of particular interest are information on virus characterisation and evidence on changes in disease severity, virus transmissibility, immune evasion and effects on diagnostics and therapeutics. Case reporting should continue through TESSy.

Source: EpiPulse: 2020-EIP-00001

2. Monkeypox - Multi-country - 2022

Overview:

Update:
Since the last update on 18 October 2022, and as of 25 October 2022, 26 monkeypox (MPX) cases have been reported from 10 EU/EEA countries: Spain (7), Ireland (5), Germany (4), Greece (2), the Netherlands (2), Sweden (2), Austria (1), Italy (1), Poland (1) and Romania (1).

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 primarily affect 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 25 October 2022, 20 675 confirmed cases of monkeypox (MPX) have been reported from 29 EU/EEA countries: Spain (7 317), France (4 084), Germany (3 662), the Netherlands (1 235), Portugal (932), Italy (890), Belgium (785), Austria (323), Sweden (209), Ireland (206), Poland (206), Denmark (191), Norway (92), Greece (84), Hungary (80), Czechia (70), Luxembourg (55), Slovenia (47), Romania (42), 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 Türkiye:
Since the start of the monkeypox outbreak and as of 25 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 Türkiye.

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 in the number of large cultural and social events after the summer, frequented by the main risk groups for this outbreak.

MPX continues to primarily affect 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.

Response options for the EU/EEA countries include creating awareness among health professionals and supporting 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, the WHO Regional Office for Europe, and ECDC have taken place to share information and coordinate responses. 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, the 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.

Source: EpiPulse: 2611, 2611, 2022-STI-00005 2611, 2611

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

Overview:

Since last week's update, and as of 26 October 2022, European Union (EU) and European Economic Area (EEA) countries reported five human cases of West Nile virus (WNV) infection and no deaths related to WNV infections. Cases were reported by Greece (2), Spain (1), France (1) and Romania (1). EU-neighbouring countries reported eight human cases of WNV infection and one death related to WNV infections. Cases were reported by Serbia (8). One death was also reported by Serbia.

This week, among the reporting countries, the following NUTS 3 or GAUL 1 regions have reported human cases of WNV infection for the first time: Córdoba in Spain.

Since the beginning of the 2022 transmission season and as of 26 October 2022, EU/EEA countries have reported 949 human cases of WNV infection in Italy (573), Greece (283), Romania (46), Hungary (14), Germany (9), Croatia (8), Austria (6), Spain (5), France (4) and Slovakia (1). EU/EEA countries have reported 72 deaths in Italy (37), Greece (30) and Romania (5). EU-neighbouring countries have reported 226 human cases of WNV infection in Serbia (226) and 12 deaths in Serbia (12).

During the current transmission season, within the reporting countries, human cases of WNV infection were reported from 107 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, Brașov in Romania, Moravički in Serbia and Tarragona and Córdoba in Spain.
Since the beginning of the 2022 transmission season, 84 outbreaks among equids and 283 outbreaks among birds have been reported by EU/EEA countries. Outbreaks among equids have been reported by Italy (41), Germany (14), Croatia (8), Spain (6), Greece (5), France (5), Hungary (3), Austria (1) and Portugal (1). Outbreaks among birds have been reported by Italy (228), 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 are 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 places 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 Türkiye.
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

Source: EpiPulse: 2022-EVD-00004

4. C. diphtheriae among migrants – Europe – 2022

Overview:

Summary: As of 26 October 2022, and since the last update on 19 October 2022, two confirmed cases of diphtheria in migrants have been reported by the Netherlands, and three cases by Italy. New cases were also reported by Austria (5), Belgium (5), France (8) and the United Kingdom (9).

On 20 October 2022, Dutch health authorities reported that the first case of cutaneous diphtheria was detected on 12 October 2022. The disease was caused by *Corynebacterium diphtheriae* (*C. diphtheriae*) as confirmed by PCR. However, the ELEK test was negative. The case did not show any respiratory symptoms and throat swabs were negative for *C. diphtheriae.* The case's vaccination status is unknown. A second case of toxigenic *C. diphtheriae* was detected on 21 October 2022, however, the laboratory method of confirmation is not known at this stage. The case did not show any respiratory symptoms, but results of the throat swab are pending. The case was not vaccinated. Both cases concern individuals who arrived in the Netherlands from Syria at the end of September 2022 and resided in refugee centres. Both cases developed symptoms prior to their arrival in the Netherlands and while travelling through Greece or North Macedonia.

On 20 October 2022, Italian authorities reported three cases of toxigenic *C. diphtheriae.* Of these, two are of cutaneous form and one presented with both cutaneous and respiratory disease. All cases were admitted to hospital with skin lesions and/or wounds, and one case additionally presented with fever and acute pharyngitis without pseudomembrane formation. The cases are among male refugees aged 35–44 years, arriving in Italy between August and October from Bangladesh, Pakistan and Turkey. The cases' vaccination status is unknown. PCR tests were positive for all cases, ELEK tests were positive for two cases and one result is still pending.

Background: Since the beginning of 2022, and as of 26 October 2022, there have been 90 cases of diphtheria among migrants reported by eight EU/EEA countries: Austria (24), Belgium (8), France (14), Germany (31), Italy (3), the Netherlands (2), Norway (7) and Spain (1). Cases have also been reported in Switzerland (25) and the United Kingdom (14), bringing the overall number for Europe to 129.

Among these cases, the majority presented with the cutaneous form of the disease (n=100), 19 cases had respiratory diphtheria, and for 10 cases this information was missing. All cases were caused by toxigenic *C. diphtheriae* and were detected in male migrants aged 8 to 44 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 have 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 completed 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 responses 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 the completion of antimicrobial treatment.
- Identification of close contacts, including the personnel providing 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.

Source: EpiPulse: 3672, 2022-VPD-00003

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

Overview:

Overview: According to World Health Organization (WHO), as of 26 October 2022, there have been 115 confirmed cases of Ebola virus disease (EVD), including 32 deaths (CFR: 28%). In addition, 20 deaths among probable cases have been **reported** prior to 28 September 2022.

According to the Ugandan Minister of Health, transmission is now occurring in Kampala, where 17 cases have been detected to date. Of these cases, 13 are linked to a man from Kassanda district who previously died in Kampala. These cases concern his family members including his wife and **6 children** who attend three different schools in Kampala, as well as two healthcare workers who tended to the deceased man. To date, there has been one death in Kampala, in the Entebbe isolation centre.

Health officials have identified 2 430 contacts of cases, of which 1 032 have completed the 21-days follow up. There have been 34 recoveries.

Other news:
On **24 October 2022**, the pharmaceutical company Merck announced a planned donation of 1 000 000 doses of an experimental vaccine against the Sudan ebolavirus to Uganda. According to the Ugandan health minister, Merck's vaccine will be incorporated in vaccine trials for which plans are underway. Other candidates include vaccines from Oxford (UK) and Sabin Vaccine Institute (US). The aim is to evaluate the vaccine efficacy in primary contacts of EVD cases within 29 days of contact. Contacts of 150 cases (approx. 3 000 people) will be vaccinated initially.

As of 25 October 2022, first cases have been reported in Wakiso (2). There are currently seven Ugandan districts affected by this outbreak: Bunyangabu, Kagadi, Kampala, Kassanda, Kyegegwa, Mubende and Wakiso. The majority of new cases are epidemiologically linked to known cases.

On 26 October 2022, the Minister of Health announced that the second round of mass polio vaccination campaign will start in the country but will not take place in the districts of Kampala, Kassanda, Mubende, Mukono and Wakiso due to the ongoing EVD outbreak.

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 the Madudu sub-county in Mubende District. The patient experienced high fever, diarrhoea, abdominal pain, and started 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.

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

Despite the increase in the number of cases and the transmissions reported in the densely populated 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 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.

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.

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. Based on experience from the largest EVD outbreak in West Africa to date (2013 -2016), where thousands of cases were reported, with transmission in large urban centres, and hundreds of EU/EEA humanitarian and military personnel deployed to the affected areas, importation of cases by travellers is considered unlikely.

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.

Healthcare providers in the EU/EEA should be informed of and sensitised to:

- the possibility of EVD among travellers returning from affected areas;
- the clinical presentation of the disease and the need to enquire about travel history and contacts in people returning from EVD-affected countries;
- the availability of protocols for the ascertainment of possible cases and procedures for referral to healthcare facilities;
- the imperative need for strict implementation of barrier management, use of personal protective measures and equipment and disinfection procedures in accordance with specific guidelines and WHO infection control recommendations when providing care to EVD cases.

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. On 21 October 2022, ECDC published a webpage and an epidemiological update on the Ebola outbreak in Uganda.

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 fruits and vegetables before consumption.
- Wash hands regularly using soap or antiseptics.
- Ensure safe sexual practices.

ECDC considers that screening of travellers returning from Uganda would not be an effective measure to prevent introduction of the disease 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 from affected regions/countries can be an effective measure to support the containment of disease spread.

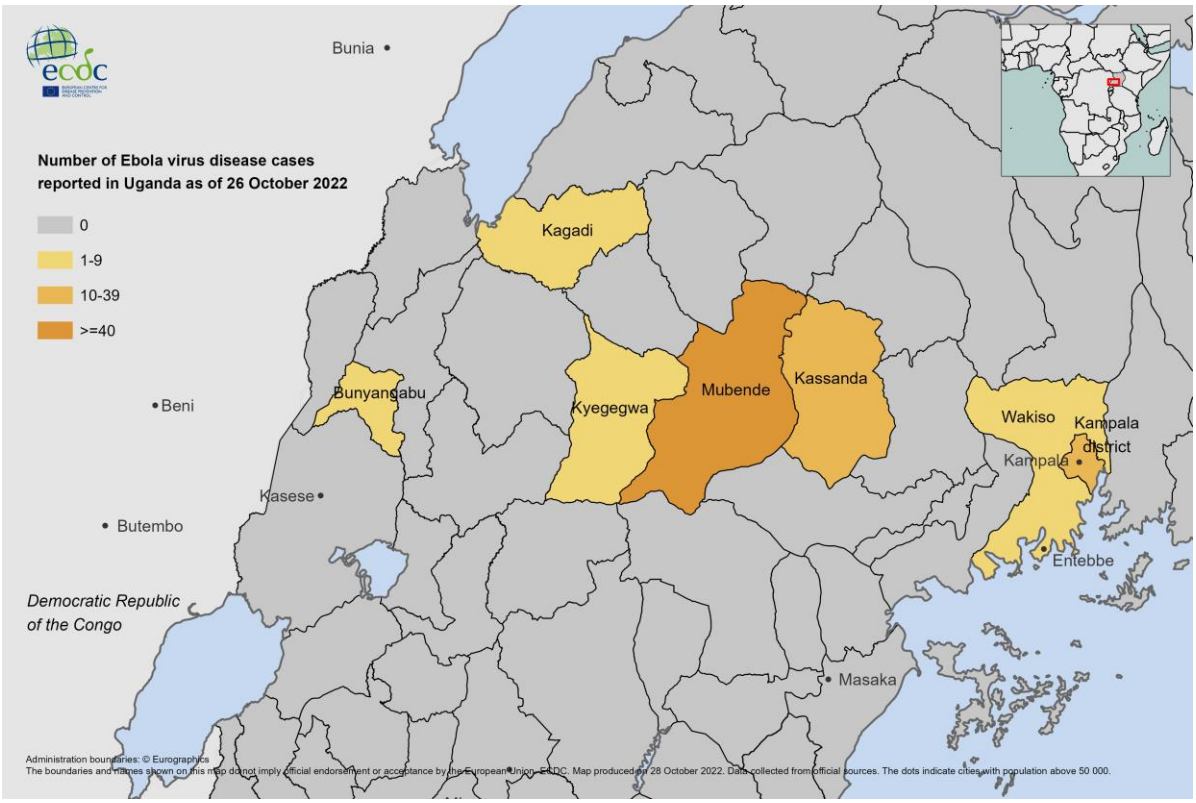
WHO advises against any restrictions on travel and/or trade to Uganda based on available information for the current outbreak.

The licensed vaccines protect against EVD resulting from Zaire ebolavirus. There are no licensed 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.

Sources: EpiPulse: 2022-EIP-00068, **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.



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

Overview:

Week 42, 2022 (17 October – 23 October 2022)
Two countries in the WHO European Region reported widespread influenza activity – Kazakhstan and United Kingdom (Scotland).

The percentage of all sentinel primary care specimens from patients presenting with ILI or ARI symptoms that tested positive for an influenza virus decreased to 6% from 7% in the previous week, which is below the epidemic threshold set at 10%.

Germany, Kazakhstan, Portugal and Spain reported seasonal influenza activity above 10% positivity in sentinel primary care.

Of 339 SARI cases tested for influenza, 64 were positive, 59 (92%) of which were infected with influenza type B viruses.

For the season, among the SARI influenza B positive cases ascribed to a lineage, 93% were B/Victoria.
Both influenza type A and type B viruses were detected among all monitoring systems, with influenza A(H3) viruses dominant in sentinel and non-sentinel surveillance.
Both type A and type B viruses were detected among hospitalised patients with laboratory-confirmed influenza, with A(H3) viruses dominating in both ICU and non-ICU wards while type B viruses dominated in data from SARI surveillance.

Source: **Flu News Europe**

ECDC assessment:

For the WHO European Region as a whole, influenza activity remained at inter-seasonal levels with signs of slowly increasing activity.

Overall, influenza A(H3) viruses have dominated across the surveillance systems with the majority of SARI cases tested being type B viruses.

Currently three European countries, Germany, Spain and Portugal are experiencing seasonal influenza activity above 10% positivity with A(H3) being the dominant virus.

Actions:

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

Source: EpiPulse: 2022-EIP-00078

7. Cholera - Lebanon/Syria - 2022

Overview:

Lebanon

On 6 October 2022, the **Lebanese Ministry of Public Health** reported a cholera case in the country. By 27 October 2022, a total of 1 095 confirmed cases and 15 fatalities were reported in Akkar, Minieh-Dannieh, Tripoli, Baalbeck, Keserwan, Zahlé, Zghorta, Baabda, Metn, Nabatieh, Saida, and Jbeil. This is the first cholera outbreak in Lebanon since 1993.

On 24 October 2022, the Lebanese Ministry of Public Health issued a **Decision** to regulate cholera-related hospital costs. All charges for cholera treatment will be fully covered by the Lebanese Ministry of Public Health.

On 25 October 2022, the Lebanese Ministry of Public Health reported that a field hospital was deployed in the Al-Iman Medical Center in Bebnîne, Akkar. The hospital is equipped with 20 beds and resource capacities to treat 500 affected persons.

Syria

On 10 September 2022, the Syrian Ministry of Health declared an outbreak of cholera in the Aleppo Governorate. As of 15 October 2022, UNICEF reported 20 014 suspected cholera cases, 989 confirmed cases and 75 cholera-related fatalities (CFR: 0.37%) in all 14 governorates of Syria. Most affected governorates are Deir-ez-Zor (10 960), Ar-Raqqa (4 519), Aleppo (3 091), and Al-Hasakah (1 017). Suspected cases have been reported from different displaced peoples' camps.

ECDC assessment:

Cholera cases continue to be reported in western Africa, and southeast Asia over the past months. Cholera outbreaks have also been notified in the eastern and southern parts of Africa as well as in some parts of the Middle East. 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, three cholera cases were reported in the EU/EEA Member States, while zero 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 fruits and vegetables with bottled or chlorinated water before consumption, regularly washing hands with soap, eating thoroughly cooked food and avoiding 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 the proper updates to public health authorities. Reports are published on monthly basis.

Source: EpiPulse: 2022-EIP-00084

8. Increasing trend of infection with Respiratory Syncytial Virus (RSV) – Muti-country – 2022

Overview:

In October 2022, high levels of hospitalisations of children with Respiratory Syncytial Virus (RSV) infection have been reported in the United States of America (US). According to multiple media reports on 27 October 2022, children's hospitals in the Washington, DC, area, including Children's National Hospital, Inova Fairfax, and Johns Hopkins in Baltimore, have reached their capacity. Similarly, a hospital in Fort Worth, Texas, says that they are seeing more than 300 cases per day.

Data presented at the US CDC RSV-NET Interactive Dashboard on 27 October 2022, demonstrates higher hospitalisation rates for RSV in children in October, at the start of 2022–2023 season, compared to the previous seasons. In seasons before the COVID-19 pandemic, the peak was seen in January, however currently higher rates than usual are seen in October 2022 exceeding the unusually high rates in the same month a year ago (2021–2022 season). According to the US CDC, RSV annually causes 2.1 million outpatient hospital visits and 58 000 hospitalisations for children under five years of age.

In Canada, the reported cases of RSV are within the expected levels as per data on 15 October 2022.
Some countries in EU are reporting an increasing RSV activity:

France is reporting an increasing proportion of children hospitalised with bronchiolitis and higher proportions of positive RSV samples, according to the weekly national report on 26 October 2022.

Spain, in the epidemiological week 43 (24–30 October), reported an increase in the number of cases of RSV in primary care and hospitals, mainly in children between 0–4 years of age, according to the sentinel system of respiratory acute infections in primary care and sentinel surveillance system.

Sweden has reported a slight increase in week 41, 2022 (45 cases) from week 40, 2022 (16 cases). The majority of the cases are among children and 39% of the cases in weeks 40–41 were children under one year of age. Over a 1 000 confirmed RSV cases were reported in the 2021–2022 season peaking between weeks 42 and 52, compared to around 700 cases in season 2018–2019 and around 200 in 2019–2020 season.

According to data in the ECDC Atlas, an increase in reported cases (sentinel data) in the EU/EEA compared to previous years was observed in week 45, 2021 followed by a decrease, but higher than usual numbers of cases in the following weeks up to week 41 in 2022.

ECDC assessment:

RSV is a common respiratory virus that generally leads to mild respiratory symptoms. It can, however, lead to severe illness among infants and the elderly and is a main cause of bronchiolitis and pneumonia in infants.
A number of countries have reported an increase in RSV detections very early during the season, with reports of increasing paediatric hospital admissions in the United States and France. The RSV season also started earlier than previous years in 2021, likely due to increase in contact among children as schools and nurseries re-opened following relaxation of pandemic-related non-pharmaceutical interventions. This early increase in cases is therefore not unexpected although requires further monitoring and raised awareness among clinicians.
While RSV is not a mandatory reportable infection at the EU/EEA level, many EU/EEA Member States have strong laboratory and sentinel surveillance systems in place.

Actions:

ECDC monitors and collects available data on RSV through FluNewsEurope and in the Atlas. ECDC will monitor the situation through epidemic intelligence.

Source: EpiPulse: 2022-EIP-00086