WEEKLY BULLETIN

Communicable Disease Threats Report

Week 43, 19 - 25 October 2024

This week's topics

Executive summary

Avian influenza A(H5N1) human cases – United States – 2024

- On 24 October 2024, two cases of zoonotic avian influenza A(H5) in Washington state were reported by US CDC.
- US CDC is performing confirmatory testing on other samples from the state.
- Both cases are individuals working with infected poultry at a commercial egg farm.
- According to the US CDC, the risk to the general population remains low, while people with exposure to infected poultry, cattle or other potentially infected domestic or wild animals have a higher risk of infection.

Marburg virus disease (MVD) – Rwanda – 2024

- On 24 October 2024, the Ministry of Health of Rwanda reported a new case of Marburg virus disease (MVD), who is a contact under follow up linked to the presumed index case.
- Since 27 September 2024 and as of 24 October 2024, 64 MVD cases (46 recovered), including 15 deaths, have been reported. Based on the available information, all cases belong to one big cluster with different branches linked to healthcare facilities and the presumed index case.

- In the event of MVD cases being imported into the EU/EEA, ECDC assesses the likelihood of further transmission to be very low, and the associated impact low. Therefore, the overall risk for the EU/EEA is assessed as low. The overall risk for EU/EEA citizens visiting or living in Rwanda is assessed as low. ECDC published a threat assessment brief on the implication of the outbreak for the EU/EEA.

Mpox clade Ib, Germany

- On 22 October 2024, Germany made public the information about an individual confirmed with mpox clade Ib associated with travel abroad.
- The individual reported travelling to Rwanda between September to early October, where he had heterosexual contact.
- All contact persons were classified as low-risk.
- ECDC is closely monitoring the event.

Locally acquired dengue in 2024 in mainland France

- In 2024, and as of 23 October, 82 locally-acquired dengue cases have been reported in mainland France.
- Cases have been reported in the following departments: Alpes-Maritimes (19 cases), Drôme (2 cases), Hérault (3 cases), Pyrénées-Orientales or Lozère (2 cases), Vaucluse (18 cases) and Var (38 cases).
- Investigations are ongoing and vector control measures are being carried out.
- Every Wednesday, the French National Public Health Agency updates its website with any new cases of dengue.

Locally-acquired dengue infection in Italy – 2024

- In 2024, as of 24 October, 200 locally-acquired dengue cases have been reported in the Marche (139 cases), Emilia Romagna (36 cases), Lombardy (12 cases), Abruzzo (9 cases), Tuscany (2 cases) and Veneto (1 case) regions in Italy. One place of infection is currently under investigation.
- Investigations are ongoing and vector control measures have been triggered by the Italian health authorities in accordance with their national response plan.

Seasonal surveillance of West Nile virus infections – 2024

- Since the beginning of 2024, and as of 23 October 2024, cases of West Nile virus (WNV) infection have been reported to the European Surveillance System (TESSy) by 14 EU/EEA countries (Austria, Bulgaria, Croatia, Cyprus, Czechia, Hungary, Romania, France, Germany, Italy, Greece, Slovakia, Slovenia and Spain) and five EU-neighbouring countries (Albania, Kosovo*, North Macedonia, Serbia and Türkiye).
- The latest monthly epidemiological update on WNV infections covers data up to 2 October 2024, with a total of 1 202 locally-acquired WNV infection cases and 88 deaths reported by European countries to TESSy.
- More information, including maps and a dashboard, are available in ECDC's weekly surveillance report on West Nile virus infections: Weekly updates: 2024 West Nile virus transmission season (europa.eu) and West Nile virus Dashboard (europa.eu). Monthly epidemiological updates are available at: Monthly updates: 2024 West Nile virus transmission season (europa.eu).

** This designation is without prejudice to positions on status, and is in line with UNSCR 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.*

Mpox due to monkeypox virus clade I and II – Global outbreak – 2024

- There have been no significant changes in the epidemiological situation related to the global circulation of monkeypox virus (MPXV) clade I and clade II during the past week.
- On 22 October 2024, Germany reported its first confirmed MPXV clade Ib case with travel history to Rwanda.
- Among the countries that had previously reported clade Ib cases, the Democratic Republic of Congo (DRC), Burundi and Uganda have reported new cases in the past week.

- No secondary transmission of MPXV clade Ib has been reported in Germany, Sweden, Thailand or India (countries outside of Africa where MPXV clade I has been detected).
- ECDC is closely monitoring and assessing the epidemiological situation and additional related information can be found in ECDC's rapid risk assessment published on 16 August (Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries), and its Rapid scientific advice on public health measures.

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

- Since 31 August 2024 and as of 23 October 2024, 83 982 new cholera cases, including 900 new deaths, have been reported worldwide. Since 1 January 2024 and as of 23 October 2024, 457 341 cholera cases, including 3 433 deaths, have been reported worldwide.
- New cases have been reported from Afghanistan, Bangladesh, Burundi, Cameroon, China, Comoros, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Iraq, Lebanon, Myanmar, Nepal, Niger, Nigeria, Pakistan, Somalia, Sudan, Togo, United Republic of Tanzania and Yemen.
- Cholera cases continue to be reported in Africa, Asia, the Americas, and the Middle East. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

Overview of respiratory virus epidemiology in the EU/EEA - weekly monitoring

- The number of patients presenting to primary care and hospitals for respiratory illness remains at expected levels for this time of year.
- There has been a downward trend of COVID-19 activity in the EU/EEA since the peak in July, including in most of the countries that experienced a later epidemic during the summer. People aged 65 years and above continue to represent the main age group at risk of hospitalisation and severe outcomes due to COVID-19.
- Influenza and respiratory syncytial virus (RSV) continue to circulate at very low levels. Based on data from past seasons, countries should however prepare to see an increase in RSV activity in the coming weeks.
- Vaccination is the most effective measure to protect against more severe forms of respiratory viral diseases. Vaccination campaigns have started in many EU/EEA countries. People who are eligible for vaccination, particularly those at higher risk of severe outcomes, are encouraged to get vaccinated when it is offered to them.

1. Avian influenza A(H5N1) human cases – United States – 2024

Overview:

Update: On 24 October 2024, US CDC reported two human cases of avian influenza A(H5) in Franklin County, Washington, US (CDC, Bird Flu Response Update). Both people had contact with infected birds or their environments at a commercial egg farm, where highly pathogenic avian influenza (HPAI) was detected in birds on 15 October (News Releases | Washington State Department of Agriculture). Neither individual reported severe illness or required hospitalisation. According to US CDC, there is no evidence of human-to-human transmission at the moment.

US CDC is performing genetic analysis of viruses isolated from other confirmed cases. Genetic sequencing confirmed that six of the cases reported previously in California were infected with avian influenza virus A(H5N1) from clade 2.3.4.4b. All six sequences are closely related genetically to the virus causing infections in domestic dairy cattle. Whole genome sequencing was performed on viruses isolated from two people in California and both viruses were confirmed to be a B3.13 genotype. In addition, partial sequences were obtained from samples collected from four other California individuals (CDC A(H5N1) Bird Flu Response Update October 18, 2024). Sequencing analysis did not identify any changes associated with increased ability to infect or transmit between humans. Similarly, no changes associated with mammalian adaptation in other gene segments were identified in the analysed samples. In addition, no mutations associated with reduced susceptibility to antivirals (e.g. neuraminidase inhibitors or polymerase acidic inhibitors) were identified.

US CDC is performing additional testing, including antigenic characterisation of the isolated viruses. This will reveal if existing candidate vaccine viruses (CVVs) are well-matched to the new reported cases of avian influenza A(H5).

CDC has posted in GISAID and submitted to GenBank the haemagglutinin (HA), neuraminidase (NA), and non-structural (NS) gene segments for A/California/134/2024 (GISAID EPI_ISL_19463619; NCBI_PQ435213- PQ435215) and the whole genome sequences for A/California/135/2024 and A/California/147/2024.

On 24 October US CDC also published results of a retrospective investigation of individuals who had close contact with an H5N1 patient reported in Missouri in September 2024 (CDC Report on Missouri H5N1 Serology Testing). Seven people, including five healthcare workers, the reported patient and one family member of the patient have been identified for further serological testing. The CDC supported this investigation by testing blood samples from six of these contacts and the original patient to detect possible prior exposure to H5N1. None of the healthcare workers showed signs of past H5N1 infection, ruling out human-to-human transmission between the individual and healthcare workers. The Missouri patient and a household contact had some inconsistent signs suggesting possible exposure to, or a previous infection with, H5N1. According to US CDC, "immunologic results coupled with the epidemiologic data that these two individuals had identical symptom onset dates support a single common exposure to bird flu rather than person-to-person spread within the household."

As of 24 October 2024, a total of 31 human cases of avian influenza A(H5) have been reported in the US during 2024. Of these, 19 were individuals exposed to dairy cattle that were infected, or presumed to be infected, with A(H5N1) and 11 were workers exposed to outbreaks of HPAI A(H5) at commercial egg farms. One person had no known animal exposure.

The US CDC's current assessment of the human health risk of A(H5N1) to the general public in the US has not changed and continues to be considered low.

ECDC assessment:

To date, there have been no confirmed human cases of A(H5N1) infection and no reports of A(H5N1) infection in cattle in the EU/EEA. The genotype B3.13 identified in cattle and several of the human cases in the US has not been detected in Europe.

ECDC has assessed the risk of infection from the circulating HPAI A(H5N1) clade 2.3.4.4b viruses as low for the general population and low-to-moderate for those with activities that expose them to infected or dead animals or a contaminated environment (e.g. occupational exposure to infected animals). ECDC will revisit the risk assessment once more information becomes available from the ongoing sequencing and investigations of the most recent human cases in the US.

ECDC is monitoring the situation together with partner organisations in Europe and will continue to update its assessment of the risk for humans in the EU/EEA as new information becomes available.

In addition to enhanced surveillance, active monitoring and testing of exposed individuals is recommended for early detection of human cases and to assess the possibility of human-to-human transmission, according to the relevant ECDC guidance documents (Testing and detection of zoonotic influenza virus infections in humans; Investigation protocol of human cases of avian influenza virus; Enhanced surveillance of severe avian influenza virus infections in hospital settings; Enhanced influenza surveillance to detect avian influenza virus infections in the EU/EEA during the inter-seasonal period). Raising awareness – including about the need to enquire about animal exposure and symptoms compatible with avian influenza infections and testing of symptomatic people with a history of exposure following a risk-based approach – among all primary care workers and communicating on the epidemiological situation is important in order to not miss or delay diagnosis of potential human cases. Given the uncertainties related to mammal-to-mammal transmission and depending on the epidemiological situation, a low threshold can be considered for testing individuals exposed to potentially infected mammals (e.g. symptomatic individuals with conjunctivitis or respiratory symptoms). Due to the higher risk of infection for individuals exposed to infected animals and contaminated environments, appropriate personal protective measures and other precautionary measures should always be taken to mitigate the risk.

ECDC relevant publications:

- 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
- Enhanced influenza surveillance to detect avian influenza virus infections in the EU/EEA during the inter-seasonal period
- Investigation protocol of human cases of avian influenza virus infections in the EU/EEA
- Joint ECDC-EFSA Drivers for a pandemic due to avian influenza and options for One Health mitigation measures

Actions:

ECDC is in contact with the US CDC for further information and is closely following any updates on the event. ECDC monitors avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly updated report on the avian influenza situation.

Sources: FAO | 2024-e000168

Last time this event was included in the Weekly CDTR: 18 October 2024

2. Marburg virus disease (MVD) – Rwanda – 2024

Overview:

On 24 October 2024, the Ministry of Health of of Rwanda reported a new case of Marburg virus disease (MVD), who is a contact under follow up linked to the presumed index case. This brings a total of 64 MVD cases reported since the outbreak of MVD was declared in Rwanda on 27 September 2024. Among these, 46 have recovered and 15 have passed away. Based on the available information, all cases belong to one big cluster with different branches linked to healthcare facilities and the presumed index case.

Rwanda continues to implement communicable disease control measures, including: exit screening at the airport, measures in education settings and conferences, ban on hospitals' visitors, strengthening infection prevention and control protocols in hospitals, and measures to limit contact with dead bodies.

On 27 September 2024, the Ministry of Health of Rwanda reported the first outbreak of Marburg virus disease (MVD) in the country. Most of cases are males (70%), and aged 30-39 years old (48%). All cases have been epidemiologically linked and belong to the same cluster which has three major branches: two linked to healthcare facilities and one around the index case. Over 1 000 contacts have been listed and followed up during the investigation.

The government of Rwanda has applied communicable disease control measures, such as epidemiological investigations, contact tracing, strengthening of infection prevention and control protocols, to control the outbreak. Among the contacts investigated in Rwanda, one travelled to Belgium but has completed the monitoring period (21 days) and is no longer considered at risk of developing the infection.

Further epidemiological investigations led to the reclassification of the the previously presumed index case suggesting there is high probability that the ("new") index case is linked to zoonotic transmission. Based on genomic analysis, there are indications that the sequences from the current outbreak are related to the strain of detected in 2014 (note: in 2014 Marburg had been detected in Kampala, Uganda).

In the context of the MVD outbreak in Rwanda, vaccinations for healthcare workers started as part of a Phase 2 rapid response open-label study. The Sabin Vaccine Institute provided the first 700 doses of the investigational Marburg virus vaccine on 5 October 2024 and 1 000 doses on 14 October 2024.

Background
Marburg virus is present in certain animal species (e.g. bats) in several sub-Saharan African countries. Transmission from animals to humans is rare. However, such events may initiate outbreaks due to subsequent human-to-human transmission.

MVD is not an airborne disease and is not considered contagious before symptoms appear. Direct contact with the blood and other body fluids of an infected person or animal is the most frequent route of transmission. Indirect contact with surfaces and materials, such as clothing, bedding and medical equipment contaminated with infected blood or body fluids may also result in transmission of the virus. Therefore, if proper infection prevention and control measures are strictly adhered to, the likelihood of infection is considered very low.

The incubation period of MVD is usually five to ten days (range: 3–21 days). The onset of MVD is usually abrupt, with non-specific, flu-like symptoms, such as a high fever (usually 39–40°C), severe headache, chills, muscle pain and malaise. In 50–75% of patients, rapid worsening occurs within two to five days, marked by gastrointestinal symptoms such as anorexia, abdominal discomfort, severe nausea, vomiting and diarrhoea. A maculopapular rash and symptoms of haemorrhagic fever, such as petechiae, mucosal and gastrointestinal bleeding, and bleeding from venipuncture sites may follow in severe cases. Neurological symptoms (disorientation, agitation, seizures and coma) can occur in later stages of the disease. The case fatality of MVD can range from 24–88%, depending on the virus strain, mode and intensity of infection, and the timeliness and level of medical care.

There is no specific antiviral treatment for MVD. Supportive therapy such as intravenous fluids, electrolyte replacement, supplemental oxygen, as well as blood and blood product replacement, may improve the clinical outcome significantly. There is no approved vaccine for MVD to date.

More information can be found in the ECDC Factsheet about Marburg virus disease.

ECDC assessment:

On 10 October 2024, ECDC published a threat assessment brief of the implication of the Marburg virus disease outbreak in Rwanda for the EU/EEA (Implications of the Marburg virus disease outbreak in Rwanda for the EU/EEA, 2024).

EU/EEA citizens visiting or living in Rwanda are considered at a **low likelihood of exposure and infection**, since person-to-person transmission of Marburg virus requires contact with body secretions from a symptomatic person and case numbers remain low. There are still unknowns around the epidemiological links of those with the disease and ongoing transmission of the virus. Control measures announced by Rwanda's government in various settings (educational, places of worship, meetings, funerals) will further mitigate the likelihood of exposure and infection.

Transmission of the virus is documented, and most likely ongoing, in healthcare facilities in Kigali, with many healthcare workers affected. Small numbers of EU/EEA citizens may be working in healthcare settings in Rwanda and for them the risk is estimated as higher, particularly if not using proper personal protective equipment (PPE). Healthcare workers, along with caregivers, are at the highest risk of contracting the disease in these outbreaks, due to having close contact with body fluids and performance of invasive procedures.

The impact of an MVD case for an EU/EEA citizen in Rwanda is assessed as low. Although MVD is a potentially life-threatening disease, at the population level case numbers are low and in the context of this outbreak adequate supportive care is available locally. Therefore, the overall risk for EU/EEA citizens visiting or living in Rwanda is estimated as **low**.

In the event that MVD cases are imported into the EU/EEA, we consider the likelihood of further transmission to be very low if appropriate measures are taken (e.g. early detection, isolation of suspected cases (i.e. any person with MVD-compatible symptoms and an epidemiological link to the ongoing outbreak in Rwanda) and contact tracing). In addition, in Rwanda identified contacts of people with MVD in the ongoing outbreak cannot leave the country and, in addition, exit screening is being implemented. The impact associated with imported MVD cases in the EU/EEA is estimated as low. Hence, the overall risk for EU/EEA citizens from a potential imported MVD case is assessed as **low**.

Information about the health risks related to the ongoing MVD outbreak should be provided to EU/EEA travellers going to Rwanda as well as EU/EEA citizens working or living in Rwanda. They should be made aware of the ongoing outbreak in the country and the affected areas and advised to follow the recommendations of the local health authorities, as regards hospital visitation, attending educational settings, places of worship, meetings and funerals. They should be advised to:

- Avoid contact with people exhibiting MVD symptoms (fever, vomiting, diarrhoea or bleeding) or contact with fomites contaminated by body fluids of infected persons. This includes avoiding participating in funerary rituals and the burial process of deceased persons.
- Avoid visiting healthcare facilities in the MVD-affected areas for non-urgent medical care or for non-medical reasons.
- Avoid habitats that may be populated by bats, such as caves or mines, as well as any form of close contact with wild animals, including monkeys, forest antelopes, rodents and bats, both alive and dead, and manipulation or consumption of any type of bushmeat.

Travellers returning from Rwanda to the EU/EEA should be advised to seek prompt medical care if they develop MVD-compatible symptoms and mention their travel history, as well as possible exposure history and close contacts.

Actions:

ECDC is in contact with international partners to acquire more information on the measures being implemented and will continue monitoring the event through epidemic intelligence activities.

Last time this event was included in the Weekly CDTR: 18 October 2024

3. Mpox clade Ib, Germany

Overview:

On 22 October 2024, Germany made public the information about an individual confirmed with mpox clade Ib associated with travel abroad. The case was confirmed to be mpox clade Ib on 18 October. This person represents the first report of importation of MPXV clade Ib in Germany.

The case was detected in North Rhine-Westphalia. The individual is a male aged 30 to 40, who travelled to Rwanda from September to early October and had heterosexual contact in the country. A few days after his return to Germany, he developed symptoms typical of Mpox and consulted a doctor. The patient is receiving medical care in the hospital in compliance with the recommended isolation measures and is recovering.

All contact persons were classified as low-risk. Further investigations are ongoing.

Background

On 13 August 2024, Africa CDC declared mpox a Public Health Emergency of Continental Security. On 14 August 2024, WHO convened a meeting of the IHR Emergency Committee to discuss the mpox upsurge and declared the current outbreak of mpox due to MPXV clade I a public health emergency of international concern. On 15 August 2024, Sweden reported the first imported case of mpox due to MPXV clade Ib in the EU/EEA.

As of 25 October, no secondary transmission of MPXV clade Ib has been reported in Sweden, Thailand or India (countries outside of Africa where MPXV clade I has been detected).

ECDC assessment:

Considering the measures implemented by Germany, including isolation of the case and contact tracing, the risk for the general population in the EU/EEA related to this importation is considered very low, given a very low likelihood of further spread and a low impact. The ECDC Rapid Risk Assessment published on 16 August 2024 remains valid.

Actions:

ECDC is closely monitoring and assessing the evolving epidemiological situation of mpox. The Centre's recommendations are available here.

Last time this event was included in the Weekly CDTR: -

4. Locally-acquired dengue in 2024 in mainland France

Overview:

Update
Overall, France has reported 82 locally-acquired dengue cases in 2024. Two new cases in Vallauris were reported since the last update (16 October).

As of 23 October, France has reported cases in the following departments:

- Alpes-Maritimes: one case in Menton (or Monaco), two cases in La Colle sur Loup and 16 cases in Vallauris;
- Drôme: two cases in one cluster;
- Hérault: two cases in Vendargues and one case in Montpellier or Pérols;
- Pyrénées-Orientales or Lozère: two cases in one cluster;
- Vaucluse: 18 cases in one cluster;
- Var: 25 cases in La Crau and 13 cases in Fréjus.

The following clusters are considered closed:

- Hérault: one case connected to Montpellier or Pérols;
- Pyrénées-Orientales or Lozère: two cases;
- Alpes-Maritimes: two cases connected to La Colle sur Loup and one case connected to Menton (or Monaco);
- Drôme: two cases;
- Vaucluse: 18 cases.

Background
On 8 July, the French Regional Health Agency of Occitania reported the first autochthonous case of dengue in France in 2024 (Montpellier-Pérols, Hérault department, Occitania). The person had onset of symptoms on 17 June, no travel history, and the place of infection was in the region of Occitania.

ECDC assessment:

In 2023, France reported nine outbreaks of dengue involving a total of 45 cases of autochthonous human dengue virus infections. In 2022, France also reported nine outbreaks, with a total of 65 locally- acquired cases of dengue, which – at that time – was the highest number of autochthonous cases and outbreaks in the EU/EEA.

In Europe, the dengue virus is transmitted by the mosquito vector *Aedes albopictus*, which is established in a large part of Europe. These outbreaks are therefore not unexpected. During autumn, environmental conditions will become less favourable for vector activity and virus replication in vectors. However, it is possible that additional locally-acquired cases will occur in the coming weeks.

In addition to France, Italy and Spain have also reported autochthonous dengue cases in Europe in 2024.

In the past, local outbreaks of dengue have been reported by France, Italy, Spain and Croatia. More information is available on ECDC's dedicated webpage on autochthonous transmission of dengue virus in the EU/EEA, and in ECDC's dengue factsheet.

Every Wednesday, the French National Public Health Agency updates its website with any new cases of dengue.

Actions:

Investigations are ongoing and vector control measures have been carried out. Relevant measures have been taken by France's public health authorities to prevent transmission through substances of human origin.

ECDC continues monitoring locally acquired dengue cases in the EU/EEA. Countries are asked to report autochthonous cases through EpiPulse.

Last time this event was included in the Weekly CDTR: 18 October 2024

5. Locally-acquired dengue infection in Italy – 2024

Overview:

As of 24 October, 200 locally acquired-dengue cases have been reported by the Italian National Public Health Authority. These are six more than reported in the previous week's update. The newly reported cases were from Marche (3 cases), Lombardy (2 cases) and Abruzzo (1 case).

For 199 cases, NUTS2 regions were reported:

- Marche: 139 cases;
- Emilia Romagna: 36 cases;
- Lombardy: 12 cases;
- Abruzzo: 9 cases;
- Tuscany: 2 cases;
- Veneto: 1 case.

An additional case (onset of symptoms 18 August, DENV 2) was reported by the Abruzzo region. However, the place of infection is currently under investigation as the infection may have occurred in another region.

ECDC assessment:

Non-travel-associated dengue cases have been reported in Italy since 2020 (10 cases). None were reported in 2021 and 2022. In 2023, 82 locally acquired dengue cases were reported, which was the highest number of locally-acquired cases in the EU/EEA until 2024. The current outbreak in the Marches is the largest dengue outbreak reported in the EU/EEA to date.

In Europe, the dengue virus is transmitted by the mosquito vector *Aedes albopictus*, which is established in a large part of Europe. These outbreaks are therefore not unexpected. During autumn, environmental conditions will become less favourable for vector activity and virus replication in vectors. However, it is possible that additional locally -cquired cases will occur in the coming weeks.

In addition to Italy, France and Spain have also reported autochthonous dengue cases in Europe in 2024.

In the past, local outbreaks of dengue have been reported by France, Italy, Spain and Croatia. More information is available on ECDC's dedicated webpage on autochthonous transmission of dengue virus in the EU/EEA and in ECDC's dengue factsheet.

Actions:

Investigations are ongoing and vector control measures have been triggered in accordance with the national arbovirus prevention and control plan.

ECDC continues to monitor locally acquired dengue cases in the EU/EEA. Countries are asked to report autochthonous cases through EpiPulse.

Last time this event was included in the Weekly CDTR: 18 October 2024

6. Seasonal surveillance of West Nile virus infections – 2024

Overview:

Epidemiological summary

Since the start of 2024, and as of 23 October 2024, human cases of WNV infection have been reported to TESSy by 14 EU/EEA countries and five EU-neighbouring countries. In the EU/EEA, Austria, Bulgaria, Croatia, Cyprus, Czechia, Hungary, Romania, France, Germany, Italy, Greece, Slovakia, Slovenia and Spain reported WNV infections. From EU-neighbouring countries, Albania, Kosovo*, North Macedonia, Serbia and Türkiye have reported WNV infections. In total, 196 NUTS3/GAUL1 regions across 19 countries have reported locally-acquired WNV cases. National investigations concluded that the person with confirmed WNV infection reported with place of infection as Rome (NUTS3 = ITI43) acquired the infection elsewhere. As this is not reflected in the data reported to ECDC, this person is still displayed with place of infection as Rome in ECDC's outputs. For detailed information on places of infection, please refer to ECDC's weekly update and dashboard.

The latest monthly epidemiological update on WNV infections, covering data up to 2 October 2024, was published on 9 October 2024. In 2024, 18 countries in Europe reported 1 202 locally-acquired human cases of WNV infection with known place of infection. The earliest and latest dates of onset were on 1 March and 26 September 2024, respectively. Locally-acquired cases were reported by Italy (422), Greece (202), Spain (114), Albania (102), Hungary (101), Romania (71), Serbia (53), Austria (34), Türkiye (30), France (27), Croatia (20), Germany (8), Slovenia (5), Kosovo* (4), Slovakia (4), Bulgaria (2), North Macedonia (2) and Czechia (1). In Europe, 88 deaths were reported by Greece (31), Italy (16), Albania (13), Romania (10), Spain (10), Bulgaria (2), Serbia (2), Türkiye (2), France (1) and North Macedonia (1).

Case numbers reported this year are above the mean monthly case count for the past 10 years. During the same period in 2023, 681 cases had been reported. However, numbers are lower than in 2018, when 1 728 cases had been reported by this time of year.

All 18 countries had reported human cases of WNV infections in the past. However, Albania, Czechia, Kosovo*, Slovenia and Türkiye have not reported any human cases in the past four to five years. In Albania, the current outbreak is the largest outbreak of WNV infections among humans that has been detected in the country.

So far, 180 regions across 18 countries have reported locally-acquired human cases of WNV infection this year, compared to 120 regions in 2023 and 159 regions in 2018 during the same period. This is the largest geographical distribution of WNV ever reported in a year. The following regions have reported locally-acquired human cases of WNV infection for the first time ever: Berat, Elbasan, Kavaje, Kucove, Kurbin, Lushnje, Vlore, Mallakaster and Kruje in Albania; Bjelovarsko-bilogorska županija in Croatia; Hérault, Guadeloupe and Gard in France; Bautzen, Diepholz, Oder-Spree and Jena Kreisfreie Stadt in Germany; Thesprotia in Greece; Barletta-Andria-Trani, Benevento, Chieti, Roma, Firenze and Napoli in Italy; Prishtinë, Prizren and Mitrovicë in Kosovo*; Položki in North Macedonia; Trnavský kraj and Nitriansky kraj in Slovakia; Podravska in Slovenia; Jaén in Spain; and Bursa and Osmaniye in Türkiye.

As observed in previous years, most cases are men aged over 65 years. Severity indicators are comparable to those observed in previous years, with 92% of cases hospitalised, a case fatality rate of 8% and neurological manifestations in 70% of cases. The dominance of neurological cases is expected, as people with more severe symptoms are more likely to be diagnosed.

In addition, travel-associated cases from outside of the EU/EEA have been reported in travellers arriving from Bosnia and Herzegovina, India, Kenya, Morocco, Oman, Tunisia, Uganda, the United Arab Emirates and the United States.

From the veterinary perspective, 337 WNV outbreaks among equids and 344 outbreaks among birds have been reported in Europe in 2024. Outbreaks among equids have been reported by Germany (122), Austria (47), Spain (46), France (39), Hungary (35), Italy (28), Portugal (16), Greece (3) and Poland (1). Outbreaks among birds have been reported by Italy (248), Germany (57), Austria (18), Spain (8), Slovenia (4), Hungary (3), Bulgaria (2), France (2) and Poland (2). The earliest and latest start dates of outbreaks among birds and/or equids were 2 April 2024 and 27 September 2024, respectively.

More background information on the Commission Directives on blood safety and EU/EEA notifications of WNV infections can be found in ECDC's weekly surveillance report on WNV infections, which is available online (Weekly updates: 2024 West Nile virus transmission season (europa.eu) and West Nile virus Dashboard (europa.eu)). Monthly epidemiological updates are available at: Monthly updates: 2024 West Nile virus transmission season (europa.eu).

** This designation is without prejudice to positions on status, and is in line with UNSCR 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.*

ECDC assessment:

As in previous years, the peak of transmission was observed in August and September. As environmental conditions are becoming less favourable for vector activity and virus replication in vectors, we expect reported case numbers to decrease in the coming weeks.

Due to the delay in diagnosis and reporting of cases of WNV infection, and also that a majority of the WNV infections remain asymptomatic or pauci-symptomatic, the case numbers provided in this report are not a true representation of the actual number of cases.

Actions:

ECDC is monitoring WNV through indicator- and event-based surveillance activities.

Last time this event was included in the Weekly CDTR: 18 October 2024

7. Mpox due to monkeypox virus clade I and II – Global outbreak – 2024

Overview:

Global update

There have been no major changes to the global epidemiological trends in mpox during the past week.

Globally, MPXV clade I and clade II are circulating in different countries. Global epidemiological data are updated weekly by the World Health Organization (WHO), with the most recent updates from Africa highlighting the recent expansion of clade I cases (2022–24 Mpox (Monkeypox) Outbreak: Global Trends). No secondary cases of mpox due to MPXV clade I have been reported by Sweden, Thailand or India. On 22 October 2024. Germany also reported its first MPXV clade Ib case. The case was confirmed on 18 October and reported travel history to Rwanda.

Overall, since monitoring began in 2022, 109 699 confirmed mpox cases (MPXV clade I and clade II), including 236 deaths, have been reported from 123 countries (2022–24 Mpox (Monkeypox) Outbreak: Global Trends and WHO Mpox Multi-country external situation report n. 40, published 13 October 2024).

Epidemiological situation in Africa

In 2024, over 43 700 confirmed and suspected mpox cases due to MPXV clade I and clade II, including over 1 000 deaths, have been reported from Africa. This includes over 9 300 confirmed cases, according to the WHO (WHO Global report on mpox (data as of 20 October)). The countries reporting cases are Burundi, Cameroon, the Central African Republic, the Republic of the Congo (Congo), Cote d'Ivoire, the Democratic Republic of the Congo (DRC), Gabon, Ghana, Guinea, Kenya, Liberia, Morocco, Nigeria, Rwanda, South Africa, Uganda, Zambia and Zimbabwe.

The epidemiological situation regarding mpox due to MPXV clade Ib remains similar to the previous week.

The two countries reporting the largest numbers of cases in recent weeks are still the DRC and Burundi. In addition, cases have been reported by Uganda. Updates on these countries are summarised below:

- In the past six weeks, the DRC has reported 1 743 confirmed cases and Burundi 902, according to the WHO Global report on mpox (data as of 20 October). Deaths have been reported in DRC (235 among all cases according to WHO in the past six weeks). Clade Ib has been detected in both countries, while clade Ia is co-circulating in the DRC.
- The DRC continues to report the highest number of mpox cases in Africa. The cumulative number of cases in 2024 is over 34 000 (over 6 900 confirmed), including over 980 deaths (Africa CDC Epidemic Intelligence Report issued on 20 October 2024 and WHO Global report on mpox (data as of 20 October)).
- In Burundi, as of 20 October 2024, 1 287 confirmed cases have been reported according to the WHO Global report on mpox (data as of 20 October) from several areas of the country. No deaths have been reported in the country. According to the WHO AFRO weekly report of 11 October, cases were reported from 38 of 49 districts and the positivity rate among suspected cases is 40.7%.
- In Uganda where clade Ib has been detected, 56 cases and one death have been reported since the previous report and as of 21 October 2024. A total of 164 cases and one death have been reported in the country from 19 districts since July 2024. 66 cases have been reported in Kampala and 35 in Nakasongola (Mpox Outbreak in Uganda - 21 October 2024). In week 40, Uganda reported mpox outbreak in two prisons (Special Briefing on Mpox & Other Health Emergencies, Africa CDC, 17 October 2024).

Based on an analysis of the patterns of MPXV transmission observed at the national level, and given the limitations and uncertainties, ECDC has used official epidemiological information to classify countries according to whether MPXV clade I is endemic or has been reported for the first time in 2024. The categories are as follows:

- Countries reporting only travel-associated cases or cases with a clear link to travel-associated cases: Germany, India, Sweden, Thailand;
- Countries reporting clusters of cases: Congo, Kenya;
- Community transmission: Burundi, Central African Republic, DRC, Rwanda (cases reported outside Rwanda with travel history to the country and limited epi data on chains of transmission in the country), Uganda.

The classification was last updated on 24 October 2024.

On 13 August 2024, Africa CDC declared mpox a Public Health Emergency of Continental Security. On 14 August 2024, WHO convened a meeting of the IHR Emergency Committee to discuss the mpox upsurge and declared the current outbreak of mpox due to MPXV clade I a public health emergency of international concern.

Epidemiological situation in the EU/EEA for MPXV clade I

Two MPXV clade Ib cases have been reported in EU/EEA. One case was reported by Sweden in August 2024 and one from Germany in October 2024. Both cases reported having travel history to affected countries. No secondary transmission of clade Ib has been reported in EU/EEA.

ECDC assessment:

The number of people with MPXV clade I infection has increased and there has been geographical expansion to newly affected African countries in recent weeks. Germany, India, Sweden, and Thailand have detected cases of mpox due to MPXV clade Ib in people with history of travel to areas where the virus is circulating. More imported mpox cases due to MPXV clade I are likely to be reported by the EU/EEA and other countries. Please see the latest ECDC Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries.

Actions:

ECDC is closely monitoring and assessing the evolving epidemiological situation of mpox on a global basis. The Centre's recommendations are available here. ECDC has been supporting the mpox outbreak response in DRC through the deployment of experts since 29 July 2024.

Sources: ECDC rapid risk assessment

Last time this event was included in the Weekly CDTR: 18 October 2024

8. Cholera – Multi-country (World) – Monitoring global outbreaks - Monthly update

Overview:

Please note that ECDC has changed reporting period. Next updates will include data reported since the previous update until the new one.

Data presented in this report originate from several sources, both official public health authorities and non-official sources, such as the media. Case definitions, testing strategies, and surveillance systems vary between countries. In addition, data completeness and levels of under-reporting vary between countries. All data should therefore be interpreted with caution. For details on the epidemiological situation and more information regarding the case definitions in use, refer to the original sources.

Summary

Since 31 August 2024 and as of 23 October 2024, 83 982 new cholera cases, including 900 new deaths, have been reported worldwide.

The five countries reporting most cases are Afghanistan (24 151), Sudan (23 590), Pakistan (12 954), Nigeria (4 886) and Myanmar (4 756).

The five countries reporting most new deaths are Sudan (598), Nigeria (183), United Republic of Tanzania (34), Ethiopia (33) and Afghanistan (12).

New cases have been reported from Afghanistan, Bangladesh, Burundi, Cameroon, Chile, China, Comoros, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Iraq, Lebanon, Myanmar, Nepal, Niger, Nigeria, Pakistan, Somalia, Sudan, Togo, United Republic of Tanzania and Yemen.

New deaths have been reported from Afghanistan, Burundi, Cameroon, Comoros, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Niger, Nigeria, Somalia, Sudan, Togo, United Republic of Tanzania and Yemen.

Since 1 January 2024 and as of 23 October 2024, 457 341 cholera cases, including 3 433 deaths, have been reported worldwide. In comparison, since 01 January 2023 and as of 23 October 2023, 723 171 cholera cases, including 4 319 deaths, were reported worldwide.

Since the last update, new cases and new deaths have been reported from:

Africa

Burundi: Since 31 August 2024 and as of 18 October 2024, 75 new cases have been reported. Since 1 January 2024 and as of 18 October 2024, 762 cases, including three deaths have been reported. In comparison, in 2023 and as of 10 September 2023, 725 cases, including nine deaths were reported.

Cameroon: Since 28 July 2024 and as of 6 October 2024, 86 new cases, including eight new deaths have been reported. Since 1 January 2024 and as of 6 October 2024, 525 cases, including eight deaths have been reported. In comparison, in 2023 and as of 10 September 2023, 20 025 cases, including 481 deaths were reported.

Comoros: Since 2 August 2024 and as of 18 October 2024, 172 new cases, including three new deaths have been reported. Since 1 January 2024 and as of 18 October 2024, 10 514 cases, including 152 deaths have been reported. In comparison, in 2023 and as of 23 October 2023, no cases were reported.

Democratic Republic of the Congo: Since 31 August 2024 and as of 6 October 2024, 1 909 new cases, including seven new deaths have been reported. Since 1 January 2024 and as of 6 October 2024, 25 200 cases, including 344 deaths have been reported. In comparison, in 2023 and as of 10 September 2023, 31 342 cases, including 230 deaths were reported.

Ethiopia: Since 31 August 2024 and as of 12 October 2024, 2 210 new cases, including 33 new deaths have been reported. Since 1 January 2024 and as of 12 October 2024, 25 240 cases, including 240 deaths have been reported. In comparison, in 2023 and as of 10 September 2023, 21 646 cases, including 275 deaths were reported.

Ghana: Since 31 August 2024 and as of 18 October 2024, 78 new cases, including one new death has been reported. Since 1 January 2024 and as of 18 October 2024, 102 cases, including one death has been reported. In comparison, in 2023 and as of 23 October 2023, no cases were reported.

Niger: Since 7 October 2022 and as of 29 September 2024, 273 new cases, including 10 new deaths have been reported. Since 1 January 2024 and as of 29 September 2024, 273 cases, including 10 deaths have been reported. In comparison, in 2023 and as of 23 October 2023, no cases were reported.

Nigeria: Since 23 August 2024 and as of 06 October 2024, 4 886 new cases, including 183 new deaths have been reported. Since 1 January 2024 and as of 06 October 2024, 10 837 cases, including 359 deaths have been reported. In comparison, in 2023 and as of 30 July 2023, 2 309 cases, including 57 deaths were reported.

Somalia: Since 31 August 2024 and as of 18 October 2024, 1 422 new cases have been reported. Since 1 January 2024 and as of 18 October 2024, 19 640 cases, including 138 deaths have been reported. In comparison, in 2023 and as of 13 August 2023, 12 142 cases, including 30 deaths were reported.

Sudan: Since 31 August 2024 and as of 18 October 2024, 23 590 new cases, including 598 new deaths have been reported. Since 1 January 2024 and as of 18 October 2024, 26 393 cases, including 635 deaths have been reported. In comparison, in 2023 and as of 30 September 2023, 265 cases, including 18 deaths were reported.

Togo: Since 31 August 2024 and as of 18 October 2024, 19 new cases, including two new deaths have been reported. Since 1 January 2024 and as of 18 October 2024, 29 cases, including three deaths have been reported. In comparison, in 2023 and as of 23 October 2023, no cases were reported.

United Republic of Tanzania: Since 28 July 2024 and as of 30 September 2024, 2 079 new cases, including 34 new deaths have been reported. Since 01 January 2024 and as of 30 September 2024, 5 798 cases, including 97 deaths have been reported. In comparison, in 2023 and as of 30 July 2023, 87 cases, including three deaths were reported.

Americas
Haiti: Since 17 August 2024 and as of 5 October 2024, 591 new cases, including three new deaths have been reported. Since 01 January 2024 and as of 5 October 2024, 10 250 cases, including 145 deaths have been reported. In comparison, in 2023 and as of 19 September 2023, 42 470 cases, including 497 deaths were reported.

Asia
Afghanistan: Since 31 August 2024 and as of 12 October 2024, 24 151 new cases, including 12 new deaths have been reported. Since 1 January 2024 and as of 12 October 2024, 149 622 cases, including 72 deaths have been reported. In comparison, in 2023 and as of 16 September 2023, 165 384 cases, including 76 deaths were reported.

Bangladesh: Since 26 August 2024 and as of 7 October 2024, 87 new cases have been reported. Since 1 January 2024 and as of 07 October 2024, 255 cases have been reported. In comparison, in 2023 and as of 13 August 2023, 76 353 cases were reported.

China: Since 31 August 2024 and as of 30 September 2024, one new case has been reported. Since 01 January 2024 and as of 30 September 2024, 10 cases have been reported. In comparison, in 2023 and as of 30 September 2023, 27 cases were reported.

India: Since 24 June 2024 and as of 22 July 2024, 1 970 new cases, including 17 new deaths have been reported. Since 1 January 2024 and as of 22 July 2024, 7 703 cases, including 40 deaths have been reported. In comparison, in 2023 and as of 30 September 2023, 1 113 cases were reported.

Iraq: Since 31 August 2023 and as of 19 August 2024, eight new cases have been reported. Since 1 January 2024 and as of 19 August 2024, eight cases have been reported. In comparison, in 2023 and as of 31 August 2023, 92 cases, including one death was reported.

Lebanon: Since 2 June 2023 and as of 16 October 2024, one new case has been reported. Since 1 January 2024 and as of 16 October 2024, one case have been reported. In comparison, in 2023 and as of 2 June 2023, 8 007 cases were reported.

Myanmar: Since 15 July 2024 and as of 7 October 2024, 4 756 new cases have been reported. Since 1 January 2024 and as of 07 October 2024, 5 897 cases have been reported. In comparison, in 2023 and as of 23 October 2023, no cases were reported.

Nepal: Since 25 August 2024 and as of 23 September 2024, 37 new cases have been reported. Since 1 January 2024 and as of 23 September 2024, 95 cases have been reported. In comparison, in 2023 and as of 23 October 2023, no cases were reported.

Pakistan: Since 12 August 2024 and as of 23 September 2024, 12 954 new cases have been reported. Since 1 January 2024 and as of 23 September 2024, 62 573 cases have been reported. In comparison, in 2023 and as of 20 August 2023, 12 460 cases were reported.

Yemen: Since 19 August 2024 and as of 9 September 2024, 4 595 new cases, including six new deaths have been reported. Since 1 January 2024 and as of 09 September 2024, 36 404 cases, including 159 deaths have been reported. In comparison, in 2023 and as of 13 August 2023, 5 157 cases, including seven deaths were reported.

ECDC assessment:

Cholera cases have continued to be reported in Africa and Asia in recent months. Cholera outbreaks have also been reported in parts of the Middle East and the Americas.

In this context, although the risk of cholera infection for travellers visiting these countries remains low, sporadic importation of cases to the EU/EEA is possible.

In 2022, 29 cases were reported by nine EU/EEA countries, while two were reported in 2021 and none in 2020. In 2019, 25 cases were reported in EU/EEA countries. All cases had a travel history to cholera-affected areas.

According to the World Health Organization (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. Such measures 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.

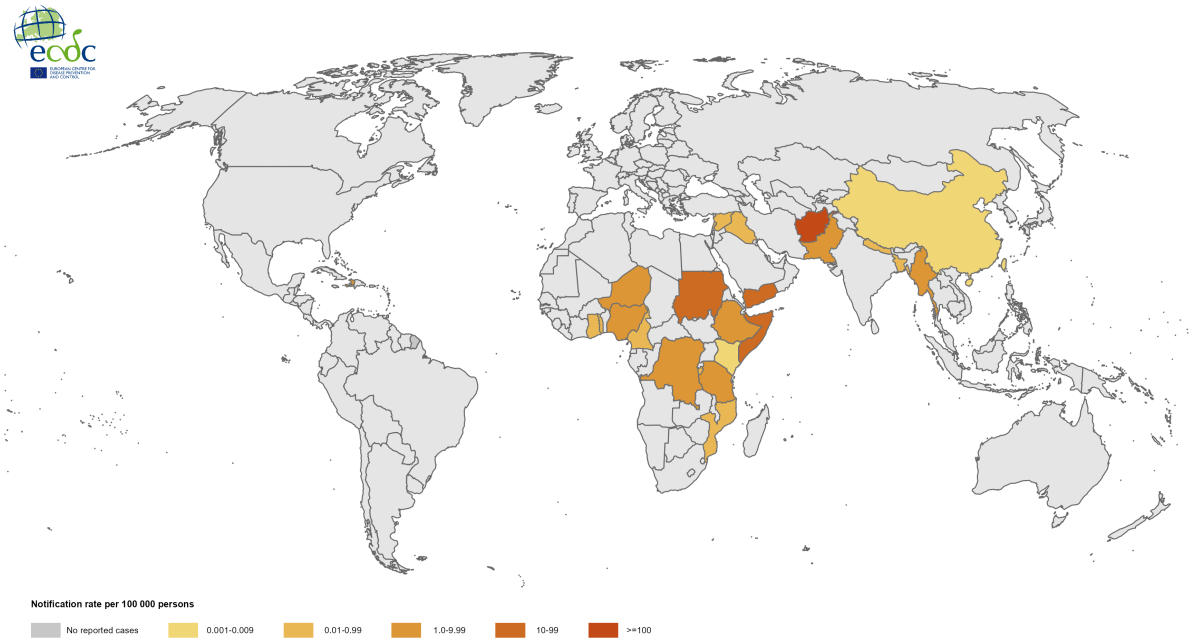
Actions:

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

Last time this event was included in the Weekly CDTR: 27 September 2024

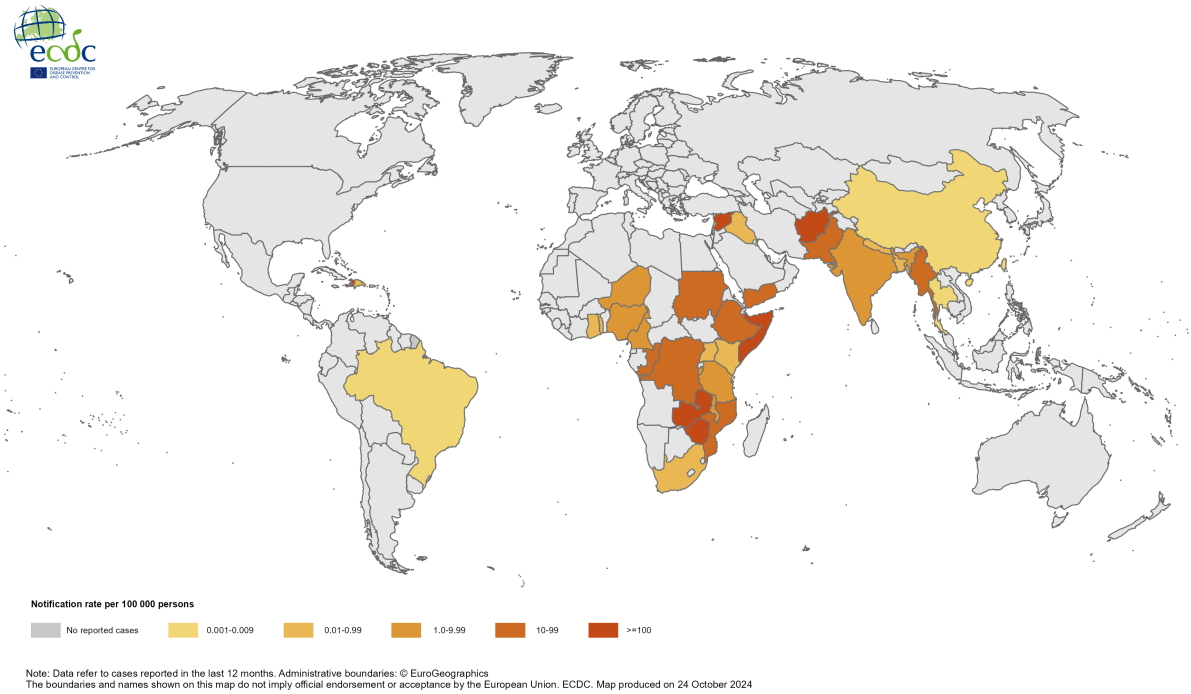
Maps and graphs

Figure 1. Geographical distribution of cholera cases reported worldwide from August to October 2024



Source: ECDC

Figure 2. Geographical distribution of cholera cases reported worldwide from November 2023 to October 2024



Source: ECDC

9. Overview of respiratory virus epidemiology in the EU/EEA - weekly monitoring

Overview:

Key indicators

All data presented in this summary are provisional. Interpretation of trends, particularly for the most recent weeks, should consider the impact of possible reporting delays, non-reporting by individual countries or overall low testing volumes at primary care sentinel sites. 'Country notes' in the footer explain known issues with reported data.

- Syndromic surveillance in primary care and hospitals indicates that respiratory activity remains at baseline levels in most EU/EEA countries, similar to the levels observed during previous seasons at this time of year.
- SARS-CoV-2 activity in primary care and hospitals continues to decrease at the EU/EEA level, with positivity rates below those observed in 2023 at this time of year. At country level the picture remains mixed with most countries reporting a decreasing trend. People aged 65 years and above continue to be most affected by severe COVID-19 disease.
- Seasonal influenza activity remained stable at low levels in the reporting EU/EEA countries. The Netherlands reported a B/Yamagata detection in week 42. Further investigations are ongoing.
- RSV activity remained low in the reporting EU/EEA countries and at lower levels than observed compared to the past three seasons. Countries should be prepared to see a potential increase in RSV activity in the coming weeks.

ECDC assessment:

Influenza and RSV activity in the EU/EEA remain at low levels. While influenza and RSV activity in the EU/EEA remain at low levels, increased activity is anticipated in the coming weeks, as is typical for this time of year. SARS-CoV-2 activity continues to decrease but remains elevated in some reporting countries, with those aged 65 years and above at greatest risk of severe disease.

Actions:

It remains important to continue monitoring the impact of SARS-CoV-2 at national and regional levels despite the observed decreased activity. To continue assessing the impact of emerging SARS-CoV-2 sub-lineages, countries should continue to sequence SARS-CoV-2-positive clinical specimens and report to GISAID and/or TESSy.
While influenza and RSV activity in the EU/EEA remain at low levels, countries should prepare to see an increase in activity in the coming weeks.
Vaccination is the most effective measure to protect against more severe forms of respiratory viral diseases. Vaccination campaigns have started in many EU/EEA countries and vaccinations efforts should continue. While COVID-19 vaccination continues to protect against severe disease, its effect wanes over time and individuals at higher risk should stay up to date with COVID-19 vaccination, following national recommendations.
ECDC monitors rates of respiratory illness presentation and respiratory virus activity in the EU/EEA, presenting findings in the European Respiratory Virus Surveillance Summary (ERVISS.org). Updated weekly, ERVISS describes the epidemiological and virological situation for respiratory virus infections across the EU/EEA and follows the principles of integrated respiratory virus surveillance outlined in ''Operational considerations for respiratory virus surveillance in Europe'.

Further information:

- Short-term forecasts of ILI and ARI rates in EU/EEA countries are published on ECDC's RespiCast.
- EuroMOMO is a weekly European mortality monitoring activity, aiming to detect and measure excess deaths related to seasonal influenza, pandemics and other public health threats.
- WHO recommends that trivalent vaccines for use during the 2024–2025 influenza season in the northern hemisphere contain the following (egg-based and cell culture or recombinant-based vaccines respectively): an A/Victoria/4897/2022 or A/Wisconsin/67/2022 (H1N1)pdm09-like virus (subclade 5a.2a.1); an A/Thailand/8/2022 or A/Massachusetts/18/2022 (H3N2)-like virus (clade 2a.3a.1 (J)); and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus (subclade V1A.3a.2).
- Antigenic characterisation data presented in the WHO 2025 southern hemisphere vaccine composition report indicate current northern hemisphere vaccine components are well matched to circulating 5a.2a and 5a.2a.1 A(H1N1)pdm09 subclades and V1A.3a.2 B/Victoria subclades. The components also appear well matched for the 2a.3a.1 (J) clade viruses, but less well matched for the more recent subclade 2a.3a.1 (J2) viruses characterised by S145N, N158K or K189R HA substitutions (alone or in combination). The majority of the A(H3N2) viruses identified worldwide since February 2024 belonged to the subclade 2a.3a.1 (J2), raising concerns about vaccine effectiveness if they were to dominate the 2024–25 influenza season in the EU/EEA.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 18 October 2024

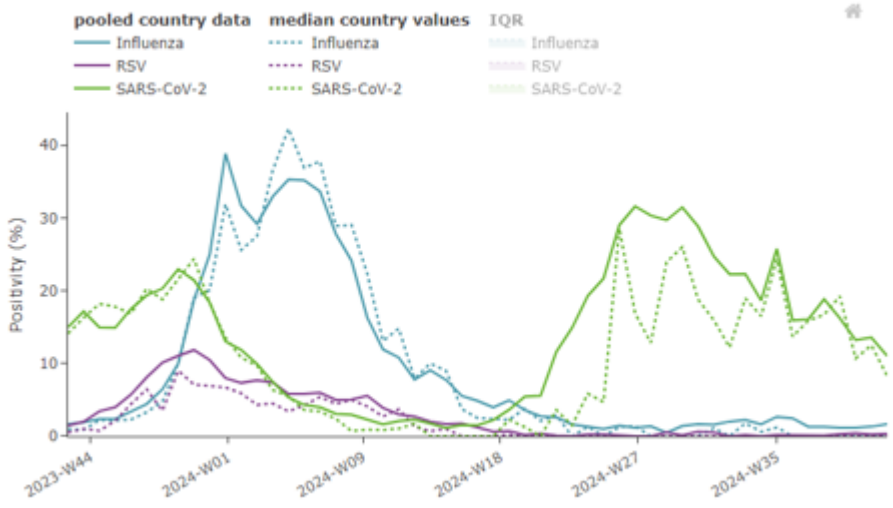
Maps and graphs

Figure 1. Overview of key indicators of activity and severity in week 42

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 42	Week 41	Description	Value	
Primary care consultation rates	ARI	10 rates (9 MEM)	13 rates (11 MEM)	Distribution of country MEM categories	7 Baseline 1 Low 1 Medium	ARI activity remains at similar levels to past seasons at this time of year. Two countries reported above baseline ARI activity: one reported low activity (Estonia) and one reported medium activity (Germany).
	ILI	18 rates (17 MEM)	17 rates (17 MEM)		13 Baseline	ILI activity remains at similar levels to past seasons at this time of year, no countries reported ILI activity above baseline.
Primary care sentinel positivity	SARS-CoV-2	14	17	Pooled (median; IQR)	11% (8.3; 7.5–11%)	The pooled EU/EEA test positivity rate continues to decrease slowly, as observed since the peak in July 2024. At the country level, the situation is more varied. The decreasing trend is also observed in some countries that experienced an epidemic during the summer (e.g. Ireland, Spain), but the levels remain more stable in others (e.g. Denmark, Germany, Slovakia). The highest test positivity rate this week was observed in Poland (24.2%).
	Influenza	13	16		1.6% (0; 0–3%)	Stable trend of very low circulation, similar to past seasons at this time of year. The Netherlands reported a B/Yamagata detection in week 42. Further investigations are ongoing.
	RSV	14	18		0.3% (0; 0–0%)	Stable trend of very low circulation. Based on data from previous seasons, week 41 usually marks the beginning of RSV circulation. The situation will be closely monitored in the coming weeks.
SARI consultation rates	SARI	3	7			Rates continued to be reported at levels comparable to past seasons at the same time of year.
SARI positivity	SARS-CoV-2	4	6	Pooled (median; IQR)	15% (12; 7.5–16%)	As observed in primary care, the pooled positivity rate continues to decrease. The positivity rates in SARI surveillance are below those observed in 2023 at the same time of year for most countries. Non-sentinel indicators of severe disease remain elevated in Czechia, Greece, Hungary, Ireland, and Lithuania.
	Influenza	4	6		1.6% (0.4; 0–1.5%)	Stable trend with very low circulation, similar to past seasons at this time of year.
	RSV	4	6		0.8% (0.6; 0–3.8%)	Stable trend of very low circulation.
Intensity (country-defined)	Influenza	15	22	Distribution of country qualitative categories	13 Baseline 2 Low	
Geographic spread (country-defined)	Influenza	14	21	Distribution of country qualitative categories	6 No activity 8 Sporadic	

Source: ECDC

Figure 2. ILI/ARI virological surveillance in primary care – weekly test positivity



Source: ECDC

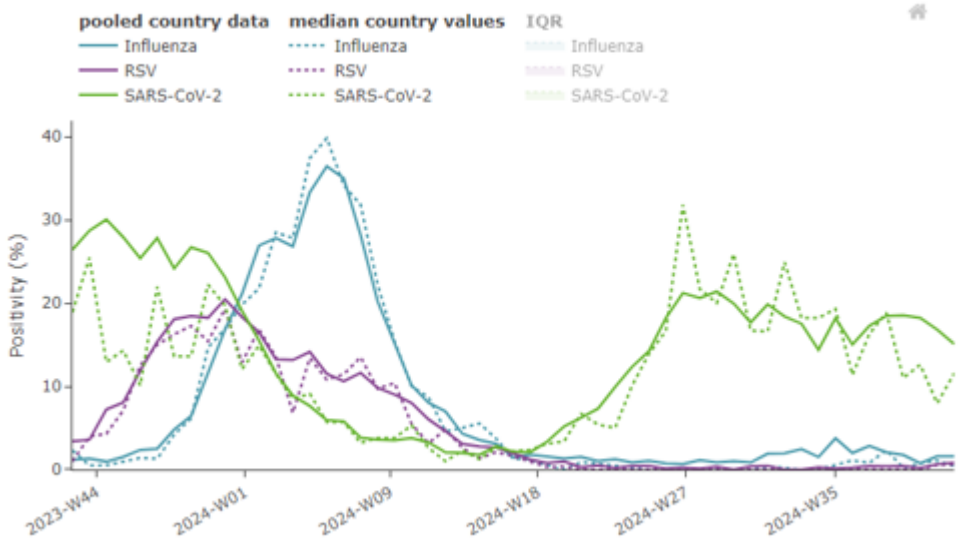
Figure 3. ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution

	Week 42, 2024		Week 40, 2024 – week 42, 2024	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**25**	**–**	**68**	**–**
Influenza A	13	54	42	66
A(H1)pdm09	5	56	13	42
A(H3)	4	44	18	58
A (unknown)	4	–	11	–
Influenza B	11	46	22	34
B/Vic	0	0.0	1	50
B/Yam	1	100	1	50
B (unknown)	10	–	20	–
Influenza untyped	1	–	4	–
RSV	**5**	**–**	**15**	**–**
RSV-B			1	100
RSV untyped	5	–	14	–
SARS-CoV-2	**163**	**–**	**570**	**–**

[a] Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.

Source: ECDC

Figure 4. SARI virological surveillance in hospitals – weekly test positivity



Source: ECDC

Figure 5. SARI virological surveillance in hospitals – pathogen type and subtype distribution

	Week 42, 2024		Week 40, 2024 – week 42, 2024	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**14**	**–**	**40**	**–**
Influenza A	5	83	19	86
A(H1)pdm09	1	100	5	62
A(H3)	0	0.0	3	38
A (unknown)	4	–	11	–
Influenza B	1	17	3	14
B/Vic	0	–	0	–
B (unknown)	1	–	3	–
Influenza untyped	8	–	18	–
RSV	**7**	**–**	**16**	**–**
RSV-A			2	67
RSV-B			1	33
RSV untyped	7	–	13	–
SARS-CoV-2	**134**	**–**	**522**	**–**

[a] Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.

Source: ECDC

Figure 6. SARS-CoV-2 variant distribution, weeks 40–41, 2024

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
KP.3	VOI	7	716	62% (56–62%)
BA.2.86	VOI	7	184	17% (13–20%)

[a] For information on SARS-CoV-2 variants classification, including information on variants under monitoring (VUMs), visit ECDC's variant page.

Source: ECDC

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 25 October 2024
- Overview of respiratory virus epidemiology in the EU/EEA - weekly monitoring - last reported on 25 October 2024
- Avian influenza A(H5N1) human cases – United States – 2024 - last reported on 25 October 2024
- Seasonal surveillance of West Nile virus infections – 2024 - last reported on 25 October 2024
- Locally acquired dengue in 2024 in mainland France - last reported on 25 October 2024
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024 - last reported on 25 October 2024

- Locally-acquired dengue infection in Italy – 2024 - last reported on 25 October 2024
- Marburg virus disease (MVD) – Rwanda – 2024 - last reported on 25 October 2024
- Mpox clade Ib, Germany - last reported on 25 October 2024
- Circulation of VDPV3 in French Guiana - last reported on 18 October 2024
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 18 October 2024
- Detection of cVDPV2 in a wastewater sample, Barcelona, Spain - last reported on 18 October 2024
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2024 - last reported on 11 October 2024
- New strain ofmultidrug-resistant Shigella sonneiST152 - Multi-country - 2024 - last reported on 11 October 2024
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 11 October 2024
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 04 October 2024
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 04 October 2024
- SARS-CoV-2 variant classification - last reported on 04 October 2024