

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 8, 18–24 February 2024

This week's topics

1. Influenza A(H5N1) – Multi-country (World) – Monitoring human cases
2. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases
3. Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks
4. SARS-CoV-2 variant classification
5. Overview of respiratory virus epidemiology in the EU/EEA

Executive Summary

Influenza A(H5N1) – Multi-country (World) – Monitoring human cases

Summary:

- On 20 February 2024, the Cambodian Ministry of Health reported one new human case of avian influenza A(H5N1) infection in Kampot province. Overall, five cases have been reported in 2024 in Cambodia, including one death.
- No human-to-human transmission associated with these events has been reported.
- A(H5N1) clade 2.3.2.1c viruses have been circulating in Cambodia and caused human cases in 2023. Genotypic characterisation of the virus isolated from one of the cases reported in 2024 was confirmed as the same clade 2.3.2.1c.
- Worldwide, 887 human cases of avian influenza A(H5N1), including 462 deaths (case-fatality rate (CFR): 52%), have been reported in 23 countries since 2004.
- The risk of zoonotic influenza transmission to the general public in the EU/EEA countries is considered low. The risk to occupationally exposed groups, such as farmers and cullers, is considered low-to-medium.

Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

- One new human infection with avian influenza A(H9) has been reported in China in a child under 5 years old, with onset of symptoms on 15 February 2024.
- Since 1998, 130 human cases of A(H9N2) and one of A(H9) have been confirmed globally, including two deaths.
- Most of the cases reported to date have been in China (118 cases). No human cases have been reported in the EU/EEA.

Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

- There have been no reports of acute flaccid paralysis (AFP) cases due to poliomyelitis with onset of symptoms in 2024.
- In 2023, and as of 20 February 2024, 133 cases of AFP caused by cVDPV1 were reported from three countries: the DRC (105), Madagascar (24) and Mozambique (4).
- In 2023, 372 cases of AFP caused by cVDPV2 were reported from 22 countries: Benin (3), Burkina Faso (2), Burundi (1), Central African Republic (14), Chad (54), Côte d'Ivoire (6), the DRC (118), Guinea (46), Indonesia (6), Israel (1), Kenya (8), Mali (12), Mauritania (1), Mozambique (1), Niger (2), Nigeria (81), Somalia (5), South Sudan (2), Tanzania (3), Yemen (4), Zambia (1) and Zimbabwe (1).

SARS-CoV-2 variant classification

Since the last update on 16 February 2024, and as of 23 February 2024, **no changes** have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs) and de-escalated variants.

The variant landscape in the EU/EEA is clearly dominated by **BA.2.86**. As of 19 February 2024, the median proportion for BA.2.86 in the EU/EEA for week 5 (29 January 2024 to 4 February 2024) is 93.4% (range: 73.1–100%).

BA.2.87.1 lineage was classified as a VUM on 2 February 2024. Currently, a small number of sequences of this lineage (9) were detected in South Africa, with collection dates ranging from 20 September to 12 December 2023. As of 19 February 2024, BA.2.87.1 has not been detected outside South Africa. This lineage has been circulating in South Africa at low levels since September 2023, without any clear signs of an increase in proportions or an impact on epidemiological indicators. BA.2.87.1 is genetically distinct from currently circulating variants, carrying around 100 mutations compared with the parental lineage BA.2. It also has a distinct N-terminal domain in the spike protein, including several large deletions, and could therefore potentially be associated with a significant shift in antigenic properties. However, so far there are no virus neutralisation data available for BA.2.87.1 and further studies are needed to elucidate the properties of this variant. BA.2.87.1 is unlikely to have an impact on the epidemiological situation in the EU/EEA in the near future.

XBB.1.5-like+F456L lineages are circulating with a median proportion of 1.7% in EU/EEA countries (range: 0–19.2%). The overall proportion of XBB.1.5-like+F456L variants is declining in the EU/EEA.

XBB.1.5-like+L455F+F456L variants show a declining trend in the EU/EEA, with a median proportion of 1.7% (range: 0–19.2%).

Other **XBB.1.5-like** lineages are circulating in very low proportions and are declining in the EU/EEA, with a median proportion of 0% (range: 0–3.8%).

Overview of respiratory virus epidemiology in the EU/EEA

- Syndromic surveillance in primary and secondary care indicate that **respiratory activity remains elevated and above baseline levels**, driven largely by influenza.
- **All indicators pointed to high influenza activity in the EU/EEA**, which seems to have been decreasing slightly over the past two weeks.
- At the EU/EEA level, a decreasing trend in pooled primary care positivity for influenza has been observed over the past two weeks, with a mixture of stable and decreasing trends observed at the country level.
- Most reporting countries continue to be above the 10% sentinel primary care positivity threshold for influenza. Notably, two countries have dropped below the 10% sentinel primary care positivity threshold.
- At the EU/EEA level, SARI positivity for influenza remains high, with a decreasing trend observed in the majority of countries reporting this indicator.
- The majority of reporting countries continue to report medium or high levels of influenza intensity, widespread geographical spread, and above-baseline rates of influenza-like illness.
- A(H1)pdm09 continues to be dominant in most countries.
- **RSV activity was decreasing overall at the EU/EEA level**, although the country-level picture remains mixed.
- **SARS-CoV-2 activity was low in EU/EEA countries.**

1. Influenza A(H5N1) – Multi-country (World) – Monitoring human cases

Overview:

Update:

On 20 February 2024, the Cambodian Ministry of Health reported one new human case of avian influenza A(H5N1) infection in a person under 18 years old from Chhuk district, Kampot province, Cambodia. The patient had fever, cough, tiredness and difficulty breathing. They have received treatment and their condition is improving. Several dead chickens were reported in the case's household five days prior to the onset of symptoms. The most recent previous case in Kampot province was reported in November 2023.

This is the fifth human case with avian influenza reported in Cambodia in 2024. Two of the previous cases in Cambodia in 2024 involved two siblings from Kratié Province, one of whom died. Clade 2.3.2.1.c was detected in samples from the deceased case.

The authorities have implemented a range of measures, including urging people experiencing symptoms such as fever, cough, runny nose or shortness of breath and who have a history of contact with sick or dead chickens during the 14 days prior to the onset of symptoms to not visit crowded places and to seek consultation and examination. They should get treatment at the nearest health facility as soon as possible.

Summary:

In January and February 2024, the Cambodian Ministry of Health reported five human cases of avian influenza A(H5N1) infection, including one death. The infection was detected in an adult and four children under 18 years of age from Kampong Trabek district (Prey Veng province), Puok district (Siem Reap province), Kratié province and Kampot province. All cases in 2024 have had exposure to infected or dead backyard poultry. Three cases were not epidemiologically related, while two cases were siblings. Out of the cases reported in 2024, one is still undergoing treatment, two cases recovered, one died and one was asymptomatic. The closest contacts received prophylactic treatment with antivirals (Oseltamivir) and clade 2.3.2.1c. was identified in samples from three of the five cases.

Overall, six cases, including three deaths, due to A(H5N1) were reported in Cambodia in 2023: two cases reported in February, two in October and two in November. Since 2005, Cambodia has reported 65 cases of avian influenza A(H5N1) infection, including 40 deaths (CFR: 64%). In the cases detected in 2023 and at least three cases in 2024, virus clade 2.3.2.1c was identified (GISAID EPI_ISL_18540514, ID EPI_ISL_18823967, ID EPI_ISL_18879683).

Since 2004 and as of 22 February 2024, there have been 887 human cases* worldwide, including 462 deaths (CFR: 52%), from infection with avian influenza A(H5N1) reported in 23 countries. To date, no sustained human-to-human transmission has been detected.

**Note: this includes six detections due to suspected environmental contamination and no evidence of infection that were reported in 2022 by Spain (2 detections) and the United States (1), as well as in 2023 by the United Kingdom (3).*

Sources: [MoH report on Facebook \(5th case\)](#), [MoH report on Facebook account \(4th case\)](#), [MoH report on Facebook \(3rd case\)](#), [WHO DON \(8 February 2024\)](#), [report on Facebook account of the MoH of Cambodia \(second case\)](#), [media report \(second case\)](#), [media report \(first case\)](#), [report on Facebook account of the MoH of Cambodia \(first case\)](#), [ECDC Avian influenza](#), [ECDC Avian influenza overview: Latest situation update of the avian influenza in the EU/EEA](#)

ECDC assessment:

Sporadic human cases of different avian influenza A(H5Nx) subtypes have previously been reported globally. Current epidemiological and virological evidence suggests that A(H5N1) viruses remain avian-like. Transmission to humans remains a rare event and no sustained transmission between humans has been observed.

Overall, the risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered low. The risk to occupationally exposed groups, such as farmers and cullers, is considered low-to-medium.

Direct contact with infected birds or a contaminated environment is the most likely source of infection, and the use of personal protective measures for people exposed to dead birds or their droppings will minimise the remaining risk. The recent severe cases in Asia and South America in children and people exposed to infected, sick or dead backyard poultry underlines the risk of unprotected contact with infected birds in backyard farm settings. This supports the importance of using appropriate personal protective equipment.

Actions:

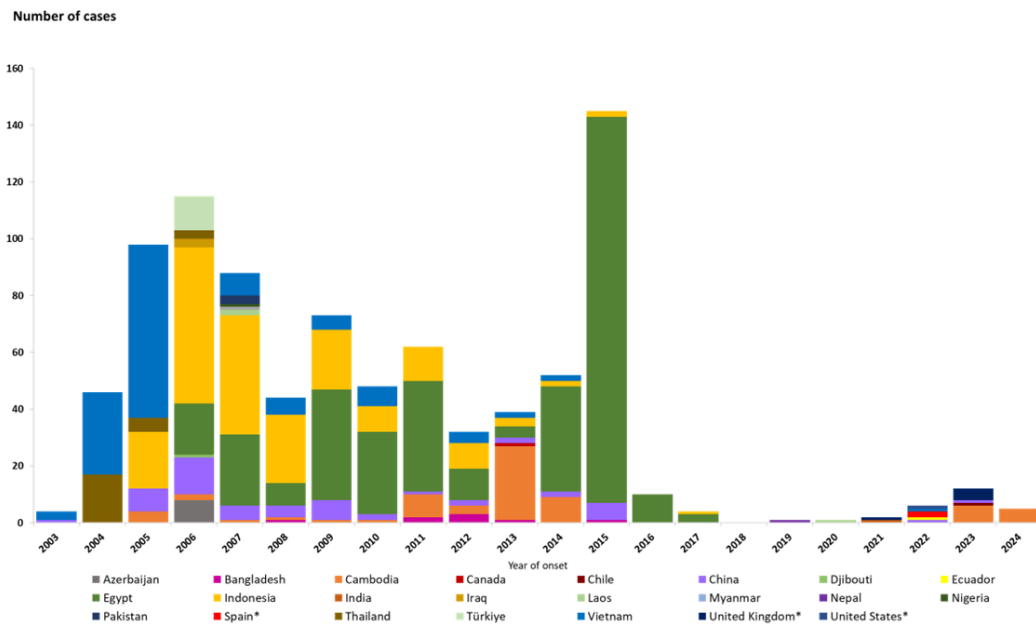
ECDC monitors avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly updated report of the [avian influenza situation](#).

Sources: [42877](#) | [2023-E000065](#) | [2023-E000065](#)

Last time this event was included in the Weekly CDTR: 16 February 2024

Maps and graphs

Figure 1. Distribution of confirmed human cases of avian influenza A(H5N1) virus infection by year of onset and country, 2003 to 22 Feb 2024 (n = 887)



Source: ECDC

* This includes six detections due to suspected environmental contamination and no evidence of infection that were reported in 2022 by Spain (2 detections) and the United States (1), as well as in 2023 by the United Kingdom (3).

2. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

Overview:

One new human infection with avian influenza A(H9) (neuraminidase subtype unknown) has been reported by the Government of the Hong Kong Special Administrative Region. A child under 5 years old developed symptoms (fever and cough with sputum) on 15 February 2024 and was brought to hospital for consultation the next day (not hospitalised at the time). After testing positive for avian influenza A(H9) on 21 February, the child was admitted to an isolation ward and was in stable condition. The patient recently visited Zhongshan (Guangdong province, China) and had no history of recent direct contact with poultry, consumption of undercooked poultry meat or contact with patients. One of the contacts developed a sore throat on 17 February, which was successfully treated with medications. Other home contacts are asymptomatic so far. Investigations are ongoing.

In 2024, two cases of avian influenza A(H9N2) were reported previously (in January) with onset of symptoms in December 2023 in Sichuan province, China.

Summary: As of 22 February 2024, and since 1998, a total of 130 laboratory-confirmed cases of human infection with avian influenza A(H9N2) viruses and one additional case with A(H9) in China, including two deaths, have been reported in eight countries: China (117), Egypt (4), Bangladesh (3), Cambodia (2), Oman (1), Pakistan (1), India (1) and Senegal (1). Most of the cases were children with mild disease.

Source: [Press release of the Government of the Hong Kong Special Administrative Region, 21 February 2024](#), [Press release of the Government of the Hong Kong Special Administrative Region, 23 December 2023](#)

ECDC assessment:

Sporadic human cases of avian influenza A (H9N2) have been observed outside the EU/EEA, mainly in young children. The source of infection of the current case is unknown. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses. The risk to human health in the EU/EEA is currently considered very low.

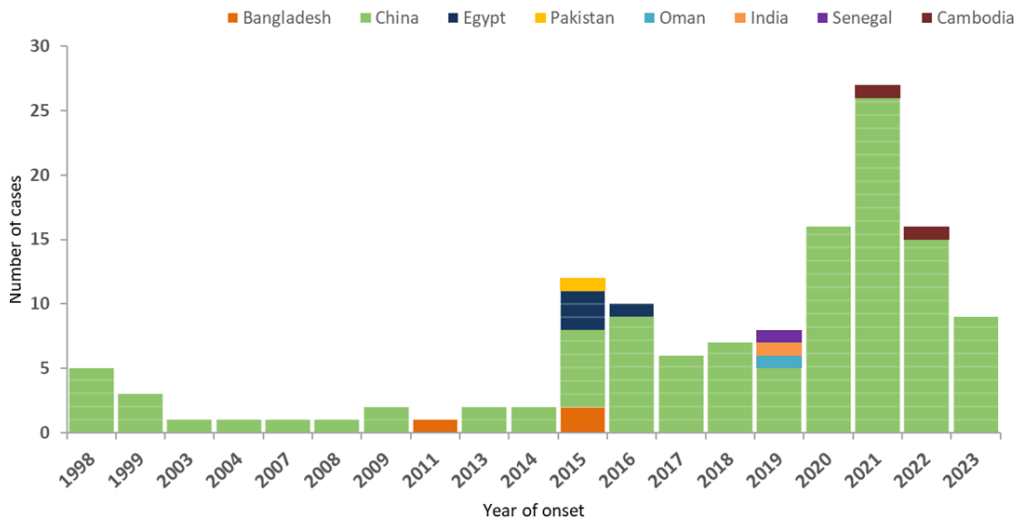
Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities and collaborates with the European Food Safety Authority (EFSA) and the EU reference laboratory for avian influenza to identify significant changes in the epidemiology of the virus. ECDC works with EFSA and the EU reference laboratory to produce a quarterly [report on the avian influenza situation](#). The [most recent report](#) was published in December 2023.

Last time this event was included in the Weekly CDTR: 5 January 2024

Maps and graphs

Figure 2. Distribution of confirmed human cases of avian influenza A(H9N2) virus infection by year of onset and country, 1998–2023 (updated on 3 January 2024, n = 130)



Source: ECDC

3. Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

Overview:

Global public health efforts to eradicate polio are continuing through the immunisation of every child until transmission of the virus stops and the world becomes polio free. On 5 May 2014, polio was declared a public health emergency of international concern (PHEIC) by the World Health Organization (WHO) due to concerns over the increased circulation and international spread of wild poliovirus in 2014.

On 12 December 2023, the [37th meeting](#) of the Polio Emergency Committee under the International Health Regulations (IHR) (2005) was held to discuss the international spread of poliovirus and it was agreed that it remains a PHEIC. It was recommended that the Temporary Recommendations be extended for a further three months.

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

Update:

Wild poliovirus type 1 (WPV1):

Since 24 October 2023 and as of 20 February 2024, no new cases of AFP caused by WPV1 were reported.

Circulating vaccine-derived poliovirus (cVDPV):

Since the previous update on 10 January 2024, the following new cases of polio due to cVDPV were reported with the date of onset of symptoms in 2023:

- There were nine new cases of AFP caused by cVDPV1, reported from the DRC (8) and Madagascar (1).
- There were 61 new cases of AFP caused by cVDPV2 reported from 10 countries, including Zimbabwe, which reported a case for the first time. The geographical distribution of the new cases is: Chad (4), Côte d'Ivoire (1), the DRC (1), Guinea (12), Indonesia (1), Niger (1), Nigeria (38), South Sudan (1), Yemen (1) and Zimbabwe (1).
- No cases of AFP due to cVDPV3 were reported.

Summary:

Wild poliovirus (WPV):

In 2024, no cases of AFP due to wild poliovirus infections have been reported.

Circulating vaccine-derived poliovirus (cVDPV):

With the date of onset of symptoms in 2023:

In 2023, and as of 20 February 2024, 133 cases of AFP caused by cVDPV1 were reported from three countries: the DRC (105), Madagascar (24) and Mozambique (4).

In 2023, 372 cases of AFP caused by cVDPV2 were reported from 22 countries: Benin (3), Burkina Faso (2), Burundi (1), Central African Republic (14), Chad (54), Côte d'Ivoire (6), the DRC (118), Guinea (46), Indonesia (6), Israel (1), Kenya (8), Mali (12), Mauritania (1), Mozambique (1), Niger (2), Nigeria (81), Somalia (5), South Sudan (2), Tanzania (3), Yemen (4), Zambia (1) and Zimbabwe (1).

In 2023, no cases of AFP caused by cVDPV3 were reported.

Sources: [Global Polio Eradication Initiative](#) | [ECDC](#) | [ECDC dashboard](#) | [WPV3 eradication certificate](#)

ECDC assessment:

The WHO European Region, including the EU/EEA, has remained polio free since 2002. Inactivated polio vaccines are used in all EU/EEA countries.

As long as there are non-vaccinated or under-vaccinated population groups in European countries and poliomyelitis is not eradicated globally, the risk of the virus being reintroduced in Europe remains. One EU/EEA country (Romania) and three neighbouring countries (Bosnia and Herzegovina, Montenegro, and Ukraine) remain at high risk of a sustained polio outbreak following wild poliovirus importation or the emergence of circulating vaccine-derived poliovirus (cVDPV). This is due to suboptimal programme performance and low population immunity,

according to the [European Regional Certification Commission for Poliomyelitis Eradication \(RCC\)](#) report published in February 2023, referring to data from 2021. According to the same report, eight EU/EEA countries are at intermediate risk of sustained polio outbreaks. The continuing circulation of wild poliovirus type 1 (WPV1) in Pakistan and Afghanistan, and the detection of WPV1 cases in Mozambique in 2022 (which are genetically linked to a strain from Pakistan), show that there is still a risk of the disease being imported into the EU/EEA. The outbreaks of cVDPV that emerge and circulate due to lack of polio immunity in the population also illustrate the potential risk for further international spread.

To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake in pockets of under-immunised populations. EU/EEA countries should review their polio vaccination coverage data and ensure that there are no immunity gaps in the population and that there is capacity to identify virus circulation through well-performing surveillance systems.

ECDC endorses WHO's temporary recommendations for EU/EEA citizens who are residents of or long-term visitors (>4 weeks) to countries categorised by [WHO](#) as having the potential risk of causing international spread of polio: an additional dose of poliovirus vaccine should be administered between 4 weeks and 12 months prior to international travel. Travellers to areas with active transmission of a wild or vaccine-derived poliovirus should be vaccinated according to their national schedules.

ECDC links: [ECDC comment on risk of polio in Europe](#) | [ECDC risk assessment](#)

Actions:

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

ECDC maintains a [dashboard](#) showing countries that are still endemic for polio and have ongoing outbreaks of cVDPV.

Last time this event was included in the Weekly CDTR: 12 January 2024

4. SARS-CoV-2 variant classification

Overview:

Weekly update on SARS-CoV-2 variants:

Since the last update on 16 February 2024, and as of 23 February 2024, **no changes** have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs) and de-escalated variants.

The variant landscape in the EU/EEA is clearly dominated by **BA.2.86**, which was classified as a VOI on 24 November 2023. As of 19 February 2024, the median proportion for BA.2.86 in the EU/EEA for week 5 (29 January 2024 to 4 February 2024) is 93.4% (range: 73.1–100%). Among the seven EU/EEA countries reporting at least 20 sequences to GISAID EpiCoV for week 5, the proportions of BA.2.86 lineages were as follows: France (80.7%), Germany (95.2%), Ireland (100.0%), Italy (73.1%), Netherlands (94.9%), Spain (93.4%) and Sweden (91.5%)

A large proportion of the BA.2.86 sequences belong to the sub-lineage **JN.1**. As of 19 December 2023, due to its rapid increase in proportion, [WHO classified](#) JN.1 as a separate VOI from the parent lineage BA.2.86. The most probable driver of the success of BA.2.86-descendant lineages is immune escape in a population where immunity is increasingly derived from XBB-variants.

BA.2.87.1 lineage was classified as a VUM on 2 February 2024. Currently, a small number of sequences of this lineage (9) were identified in South Africa, with collection dates ranging from 20 September to 12 December 2023. As of 19 February 2024, BA.2.87.1 has not been detected outside South Africa. This lineage has been circulating in South Africa at low levels since September 2023, without any clear signs of an increase in proportions or an impact on epidemiological indicators. BA.2.87.1 is genetically distinct from currently circulating variants, carrying around 100 mutations compared with the parental lineage BA.2. It also has a distinct N-terminal domain in the spike protein, including several large deletions, and could therefore potentially be associated with a significant shift in antigenic properties. However, to date no virus neutralisation data are available for BA.2.87.1, and further studies are needed to elucidate the properties of this variant. BA.2.87.1 is unlikely to have an impact on the epidemiological situation in the EU/EEA in the near future.

As of 19 February 2024, and for week 5 2024, **XBB.1.5-like+F456L** lineages are circulating with a median proportion of 1.7% in EU/EEA countries (range: 0–19.2%). The overall proportion of XBB.1.5-like+F456L variants is declining in the EU/EEA.

XBB.1.5-like+L455F+F456L variants show a declining trend in the EU/EEA, with a median proportion of 1.7% (range: 0–19.2%).

Other **XBB.1.5-like** lineages are circulating in very low proportions and are declining in the EU/EEA, with a median proportion of 0% (range: 0–3.8%).

For the latest information on variants, please see ECDC's [webpage on variants](#).

Actions:

For the latest update on SARS-CoV-2 variant classifications, please see [ECDC's webpage on variants](#). Variant surveillance data, including the distribution of VOC and VOI variant proportions in the EU/EEA and detailed country-specific COVID-19 updates, are available as part of the [European Respiratory Virus Surveillance Summary \(ERVISS\)](#).

Last time this event was included in the Weekly CDTR: 16 February 2024

5. Overview of respiratory virus epidemiology in the EU/EEA

Overview:

Respiratory virus activity

- Consultation rates of patients presenting to general practitioners with respiratory illness (ILI and/or ARI) were reported by 22 EU/EEA countries in week 7. MEM thresholds were available for 20 of these countries (eight for ARI, 19 for ILI), with 15 countries reporting consultation rates above baseline levels in at least one indicator. ARI rates were low in one country, medium in three, and very high in one. ILI rates were low in three countries, medium in eight, and high in three. Short-term forecasts of ILI and ARI rates in EU/EEA countries are published on ECDC's [RespiCast](#).
- In primary care sentinel settings, the median test positivity at the EU/EEA level was highest for influenza at 29% (pooled country data: 28%; interquartile range (IQR) of country values: 15–48%), with a mixture of stable and decreasing trends observed at the country level. Of 20 countries reporting at least 10 tests, 18 observed seasonal influenza activity above the 10% positivity threshold in sentinel primary care. Of 23 countries reporting qualitative assessments of seasonal influenza activity, all but one reported levels above baseline, including two with high and one with very high activity. Eighteen of 23 countries reported widespread geographical spread of seasonal influenza. Influenza detections from non-sentinel sources mirrored the trend observed in sentinel reporting.
- Among the 841 sentinel primary care detections of seasonal influenza, 782 (93%) were typed as influenza virus type A and 58 (7%) were typed as influenza virus type B. Of the influenza type A detections that were further successfully subtyped, 438 (76%) were A(H1)pdm09 and 142 (24%) were A(H3). The remaining 202 influenza type A detections were of unknown subtype. Twenty-eight of the influenza type B detections were further defined as B/Victoria lineage, while the remaining 30 were of unknown lineage. The B detections were predominantly reported by four countries, but their frequency remained low compared to influenza A detections.
- The median sentinel primary care positivity for SARS-CoV-2 was 2% (pooled: 3%; IQR: 2–4%). This indicator has been decreasing since week 49, 2023. Both primary care sentinel and non-sentinel data at the country level show decreasing or stable trends in all countries reporting data to week 7.
- The median sentinel primary care RSV positivity was 5% (pooled: 5%; IQR: 1–11). Country-level variation was present, with some countries continuing to report elevated sentinel positivity and/or increasing or elevated counts of non-sentinel detections.

Severe disease

- Rates of severe acute respiratory infection (SARI) from sentinel secondary sites were higher than at the same time last year in one of the seven countries reporting data up to week 7. Five of seven countries reported testing data for all three pathogens.
- The median SARI test positivity for seasonal influenza was 29% (pooled: 23%; IQR: 10–28%), with a decrease in most countries reporting this indicator. The pooled test positivity for seasonal influenza is decreasing, but remains high in all age groups.
- The median SARI test positivity for RSV decreased to 7% (pooled: 11%; IQR: 5–11%). The highest pooled test positivity is observed in children aged 0–4 years and has been decreasing since week 52, 2023. However, a slight increase in positivity was noted for this week.
- The median SARI test positivity for SARS-CoV-2 was 9% (pooled: 4%; IQR: 4–10%). Overall, rates for non-sentinel hospital admissions, ICU admissions and deaths have gradually decreased since week 50, with decreasing or stable trends in all reporting countries.
- [EuroMOMO](#) pooled estimates of weekly excess all-cause mortality showed a 'substantial elevated level of mortality, overall and in the age groups above 45 years of age'.

Virus characterisation

Influenza

WHO recommends that trivalent vaccines for use during the 2023–2024 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/Darwin/9/2021 or A/Darwin/6/2021 (H3N2)-like virus (clade 2a); and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus (subclade V1A.3a.2).

From week 40, 2023 to week 7, 2024, 1 496 A(H1)pdm09, 557 A(H3) and 75 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the A(H1)pdm09 viruses that have been assigned to a clade, 903 were reported as clade 5a.2a and 586 were subclade 5a.2a.1. Of the A(H3) viruses that have been assigned to a clade, eight were reported as clade 2a.3a, 516 were subclade 2a.3a.1, one was subclade 2a.3b, and 29 were subclade 2a. All B/Victoria viruses were reported as subclade V1A.3a.2.

Antigenic characterisation data presented in the WHO 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. While components also appear well matched for 2a.3a A(H3) clade viruses, those expressing 2a.3a.1 or 2b HA genes may be less well matched. Clade-specific influenza vaccine effectiveness data from human studies are awaited.

SARS-CoV-2 variants for weeks 5–6 (29 January–11 February 2024)

The estimated distribution (median and IQR of proportions from 12 countries) of variants of concern (VOCs) or variants of interest (VOIs) was 92% (83–95%) for BA.2.86 (which includes JN.1 isolates), 2% (0–7%) for XBB.1.5+F456L and 0% (0–1%) for XBB.1.5-like. The proportion of BA.2.86 continues to grow, with XBB.1.5-like+F456L and XBB.1.5 showing decreasing trends.

Period overview (week 25, 2023 to week 7, 2024)

Following relatively low respiratory illness transmission over the summer period, consultation rates increased in primary care settings from September. Transmission of SARS-CoV-2 began increasing in late summer, with clear increases observed at the EU/EEA level up to week 49 and decreases in activity thereafter. Currently, activity is low in most EU/EEA countries. Similarly, a steady decrease in severe disease has been observed since week 51. COVID-19 has predominantly impacted individuals aged 65 years and above. Week 50 marked the start of the seasonal influenza epidemic. Activity remains high, although a decreasing trend was observed starting from week 5. Severe disease due to influenza has had an impact on all age groups, but the most severe outcomes were observed in older adults. Since week 6, a decrease in the severe disease indicators for seasonal influenza has been observed in most EU/EEA countries. Both influenza type A and type B viruses have been detected, with a dominance of A(H1)pdm09 viruses in most countries and A(H3) dominant or co-dominant in a few countries. RSV activity began increasing around week 41, reaching a peak in week 50 followed by a decreasing trend. In recent weeks, a mixed epidemiological picture has been observed, with increasing and decreasing trends at the country level. RSV continues to have the greatest impact among children aged 0–4 years.

ECDC assessment:

After marking the start of the seasonal influenza epidemic in the EU/EEA in week 50, 2023, seasonal influenza continued to circulate at higher levels than SARS-CoV-2 and RSV in week 7, 2024. It remains essential to closely monitor the impact on hospital and ICU admissions. The combined effect of co-circulating acute respiratory pathogens is likely to convey an increased burden of severe respiratory disease in the EU/EEA, which may result in further significant pressure on healthcare systems in the coming weeks.

Actions:

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](https://erwiss.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](#)'.

ECDC published an [epidemiological update](#) that describes the epidemiological situation for acute respiratory infections in EU/EEA countries and provides updated ECDC recommendations to mitigate their impact.

ECDC published guidance on [vaccination rollout for autumn/winter 2023](#), which stresses the importance of influenza and COVID-19 vaccination to protect individuals at increased risk of severe disease – e.g. people aged 60 years and above, and other vulnerable individuals (such as those with underlying comorbidities), irrespective of age.

Sources: [ERVISS](#)

Last time this event was included in the Weekly CDTR: 16 February 2024