

# Summary

## Week 11/2022 (14 – 20 March 2022)

- Belgium, Bulgaria, Denmark, Estonia, France, Georgia, Hungary, Ireland, Kazakhstan, Luxembourg, Netherlands, Norway, Portugal, Slovenia and United Kingdom (Scotland) reported widespread influenza activity and/or medium influenza intensity.
- The percentage of all sentinel primary care specimens from patients presenting with ILI or ARI symptoms that tested positive for an influenza virus had been rising from week 4/2022 until week 10/2022 (when it reached 27%) but declined slightly, to 20%, in week 11/2022.
- Countries, mostly in the western-central part of the Region, reported seasonal influenza activity above 30% positivity in sentinel primary care: Hungary (79%), France (71%), Belgium (63%), Netherlands (62%), Slovenia (52%), Italy (44%), Serbia (38%) and Spain (35%).
- Both influenza type A and type B viruses were detected with A(H3) viruses being dominant across all monitoring systems.
- A(H3) viruses were most frequently detected in patients hospitalized with confirmed influenza virus infection.

## 2021-2022 season overview

- For the Region as a whole influenza activity has increased compared to 2020-2021 but remains at lower levels compared to seasons prior to the COVID-19 pandemic.
- Influenza activity, based on sentinel primary care specimens from patients presenting with ILI or ARI symptoms, first peaked in week 52/2021 (when it reached 20% positivity), declining thereafter until week 4/2022 and reaching a second peak in week 10/2022 (27%).
- Different levels of activity have been observed between the countries and areas of the Region, with a dominance of A(H3) viruses in most countries.

- During the influenza Vaccine Composition Meeting for the northern hemisphere 2022/23 season, held in February 2022, WHO recommended updating of the A(H3N2) and the B/Victoria-lineage components. The full report can be found [here](#).
- [Preliminary results](#) of 2021-2022 seasonal influenza vaccine effectiveness (VE) estimates from the United States showed that VE against medically attended outpatient acute respiratory infection associated with A(H3N2), the dominant influenza virus in circulation, was 16% (95% CI = -16% to 39%).
- The European I-MOVE network estimated influenza VE using a multicenter test-negative design among symptomatic patients presenting at primary care level between October 2021 and March 2022. Preliminary influenza VE against influenza A among seven study sites and among all ages was 36% (95%CI: 13–53) and 41% (95%CI: 15–59) among those aged 18–64 years. All-age VE against influenza A(H3N2) was 35% (95%CI: 6–54) and 37% (95%CI: 3–59) among those aged 18–64 years. There were too few influenza positive cases among other age groups to allow VE estimations.
- In [Sweden](#), the vaccine effectiveness against laboratory-confirmed influenza was estimated to be 47% for individuals over 65 years of age.
- According to preliminary data in mainland [France](#), the VE was estimated to be 50% (95% CI: 14-71) against all circulating influenza viruses, 77% (95% CI: 36-92) for A(H1N1)pdm09 and 31% (95% CI: -29-64) for A(H3N2).
- With increased circulation of influenza virus clinicians should consider early antiviral treatment of patients in at-risk groups with influenza virus infection, according to local guidance, to prevent severe outcomes. Viruses analyzed so far have remained susceptible to neuraminidase inhibitors and baloxavir marboxil.

## Other news

For information about the SARS-CoV-2 situation in the WHO European Region visit:

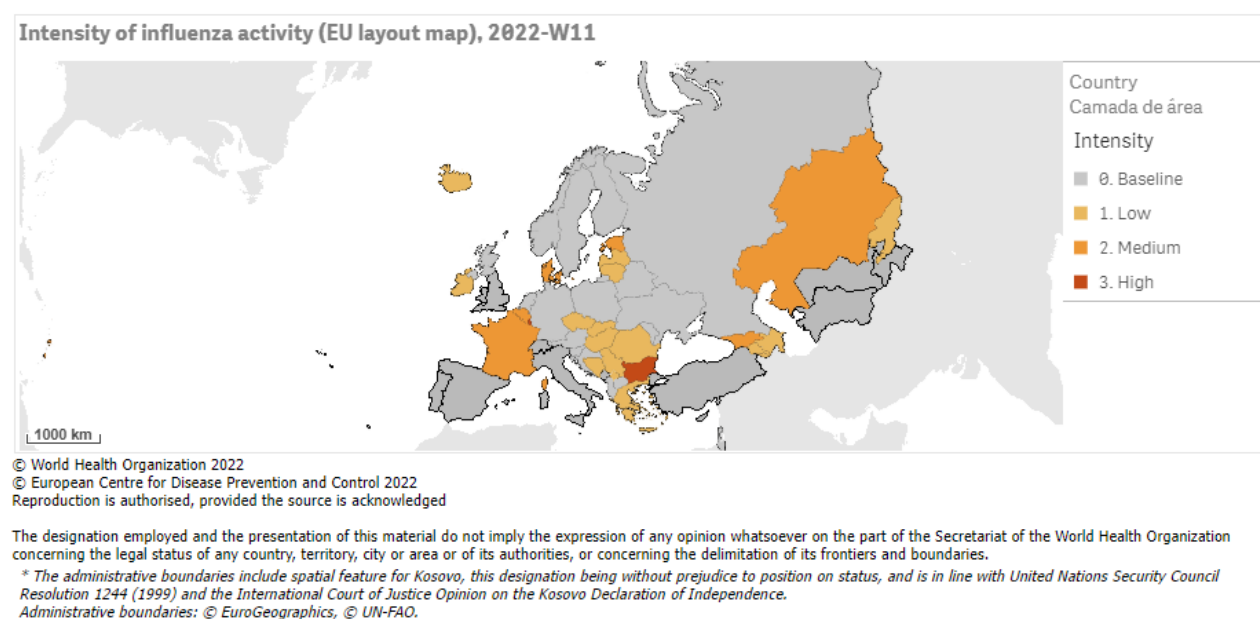
- WHO website: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>
- ECDC website: <https://www.ecdc.europa.eu/en/novel-coronavirus-china>

## Qualitative indicators

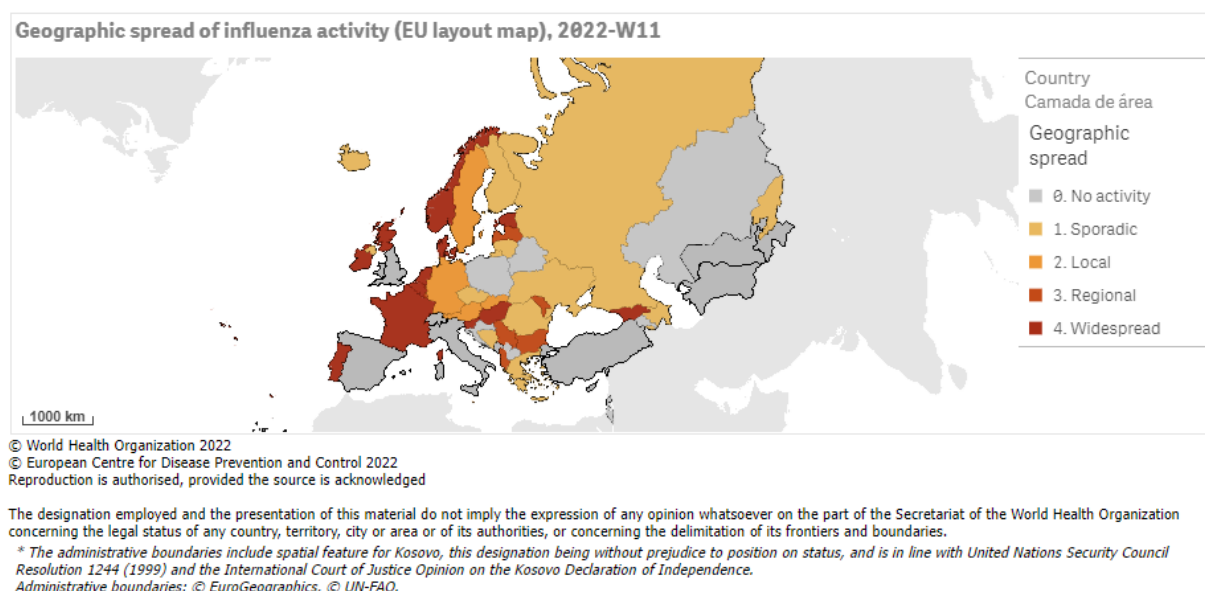
For week 11/2022, of 42 countries and areas reporting on intensity of influenza activity, 19 reported baseline-intensity (across the Region), 15 reported low-intensity (across the Region), 6 reported medium-intensity (Belgium, Denmark, Estonia, France, Georgia and Kazakhstan) and 2 reported high-intensity (Bulgaria and Luxembourg) (Fig. 1).

Of 43 countries and areas reporting on geographic spread of influenza viruses, 8 reported no activity (Armenia, Belarus, Croatia, Israel, Kazakhstan, Kosovo (in accordance with UN Security Council Resolution 1244 (1999)), North Macedonia and Poland), 12 reported sporadic spread (across the Region), 5 reported local spread (Austria, Germany, Malta, Slovakia and Sweden), 6 reported regional spread (Albania, Bulgaria, Latvia, Luxembourg, Republic of Moldova and Serbia) and 12 reported widespread activity (across the Region) (Fig. 2).

**Figure 1. Intensity of influenza activity in the European Region, week 11/2022**



**Figure 2. Geographic spread of influenza viruses in the European Region, week 11/2022**



For interactive maps of influenza intensity and geographic spread, see the [Flu News Europe website](#).

### Please note:

- Assessment of the intensity of activity indicator includes consideration of ILI or ARI rates. These ILI or ARI rates might be driven by respiratory infections other than influenza virus, including SARS-CoV-2, leading to observed increases in the absence of influenza virus detections.
- Assessment of intensity and geographic spread indicators includes consideration of sentinel and non-sentinel influenza virus detection data. Non-sentinel influenza virus detections, often higher, might translate into reporting of elevated geographic spread even in the absence of sentinel detections.

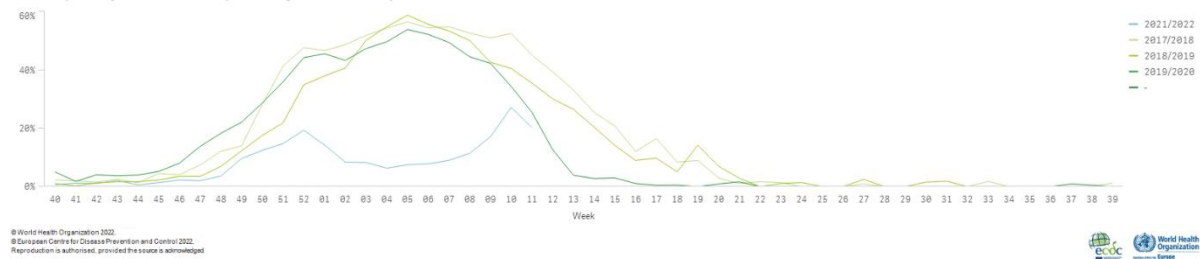
## Influenza positivity

For the European Region, influenza virus positivity in sentinel primary care specimens was 20%, well above the epidemic threshold which is set at 10% (Fig. 3).

**Figure 3. Influenza virus positivity in sentinel-source specimens by week, WHO European Region, seasons 2017/2018-2019/2020 and**

## 2021/2022

Influenza positivity in sentinel-source specimens by week - WHO Europe



## External data sources

**Mortality monitoring:** Week 11/2022 overall pooled EuroMOMO estimates of all-cause mortality for the participating European countries showed signs of decreasing excess mortality among the elderly (65 years or older) and among older adults (45 to 64 years of age). Data from 24 European countries or subnational regions were included in this pooled analysis of all-cause mortality. The full EuroMOMO report can be found here: <https://www.euromomo.eu/>.

## Primary care data

### Syndromic surveillance data

Of the countries and areas in which thresholds for ILI activity are defined, countries in eastern (n=2; Azerbaijan and Georgia), northern (n=4; Denmark, Estonia, Iceland and Latvia), southern (n=4; Croatia, Greece, Romania and Serbia) and western (n=5; Austria, Belgium, Hungary, Luxembourg and Switzerland) areas of the European Region reported activity above baseline levels.

Of the countries and areas in which thresholds for ARI activity are defined, countries in northern (n=2; Estonia and Latvia) and southern (n=2; Bulgaria and Romania) areas of the European Region reported activity above baseline levels.

### Please note:

- Assessment of the syndromic surveillance data of ILI or ARI rates might be driven by respiratory infections other than influenza virus, including SARS-CoV-2, leading to observed increases in the absence of influenza virus detections. The thresholds mentioned are related to the Moving Epidemic Method (MEM) and based on historic ILI/ARI data.

## Viruses detected in sentinel-source specimens (ILI and ARI)

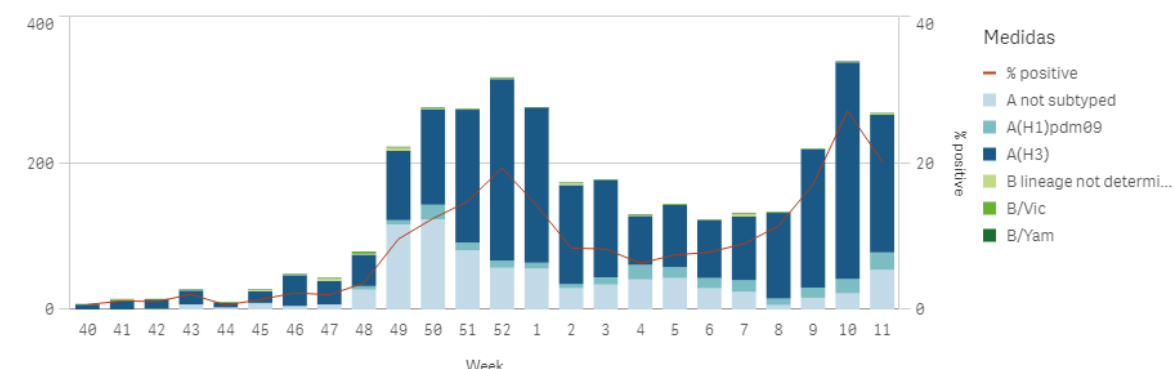
For week 11/2022, 268 (20%) of 1 326 sentinel specimens tested positive for an influenza virus; 266 (99%) were type A and 2 were type B. Of 212 subtyped A viruses, 89% were A(H3) and 11% A(H1)pdm09 (Fig. 4 and Table 1). Of 26 countries or areas across the Region that each tested at least 10 sentinel specimens in week 11/2022, 13 reported a rate of influenza virus detections at or above 10% (median 38%; range 11% - 79%): Hungary (79%), France (71%), Belgium (63%), Netherlands (62%), Slovenia (52%), Italy (44%), Serbia (38%), Spain (35%), Greece (29%), Switzerland (27%), Republic of Moldova (18%), Poland (15%) and Bulgaria (11%).

For the season to date, 3 471 (8%) of 41 204 sentinel specimens tested positive for an influenza virus. More influenza type A (n=3 431, 99%) than type B (n=40, 1%) viruses have been detected. Of 2 643 subtyped A viruses, 2 434 (92%) were A(H3) and 209 (8%) were A(H1)pdm09. Of 6 influenza type B viruses ascribed to a lineage, all were B/Victoria (85% of type B viruses were reported without a lineage) (Fig. 4 and Table 1).

Details of the distribution of viruses detected in non-sentinel-source specimens are presented in the [Virus characteristics](#) section.

**Figure 4. Influenza virus positivity and detections by type, subtype/lineage – sentinel sources, WHO European Region, season 2021/22**

Influenza virus positivity and detections by type, subtype/lineage and week - WHO Europe, season 2021/2022



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**Table 1. Influenza virus detections in sentinel source specimens by type and subtype for week 11/2022 and cumulatively for the season**

Sentinel	Current Week (11)		Season 2021-2022	
Virus type and subtype	Number	% <sup>a</sup>	Number	% <sup>a</sup>
<b>Influenza A</b>	<b>266</b>	<b>99.3</b>	<b>3 431</b>	<b>98.8</b>
A(H1)pdm09	24	11.3	209	7.9
A(H3)	188	88.7	2 434	92.1
A not subtyped	54	-	788	-
<b>Influenza B</b>	<b>2</b>	<b>0.7</b>	<b>40</b>	<b>1.2</b>
B/Victoria lineage	0	-	6	100
B/Yamagata lineage	0	-	0	0
Unknown lineage	2	-	34	-
<b>Total detections (total tested)</b>	<b>268 (1 326)</b>	<b>20.2</b>	<b>3 471 (41 204)</b>	<b>8.4</b>

<sup>a</sup>For influenza type percentage calculations, the denominator is total detections; for subtype and lineage, it is total influenza A subtyped and total influenza B lineage determined, respectively; for total detections, it is total tested.

## External data sources

[Influenzanet](#) collects weekly data on symptoms in the general community from different participating countries across the EU/EEA. Please refer to the website for additional information for week 11/2022.

## Hospital surveillance

A subset of countries and areas monitor severe disease related to influenza virus infection by surveillance of 1) hospitalized laboratory-confirmed influenza cases in ICUs (Czechia, France, Ireland, Sweden and the UK(England)) or other wards (Czechia, Ireland and Ukraine), or 2) severe acute respiratory infection (SARI; mainly in the eastern part of the Region).

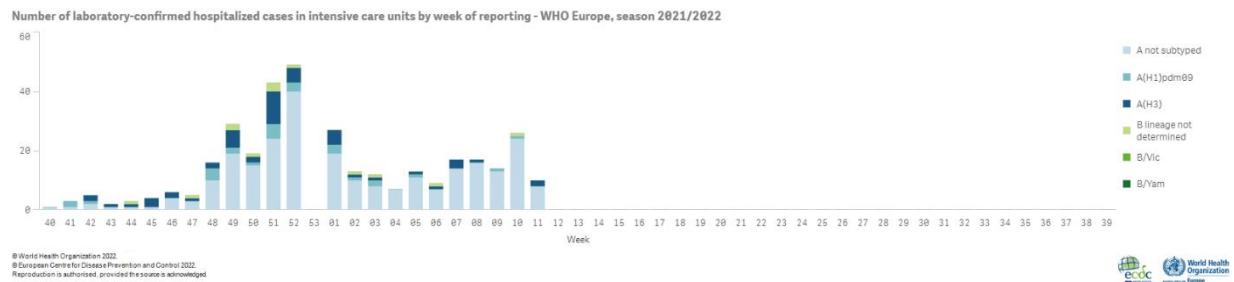
## Laboratory-confirmed hospitalized cases

### 1.1) Hospitalized laboratory-confirmed influenza cases – ICUs

For week 11/2022, 10 laboratory-confirmed influenza cases were reported from ICU wards (in Sweden and United Kingdom (England)). Only influenza A viruses (n=10) were detected (Fig. 5 and 6).

Since week 40/2021, more influenza type A (n=337, 96.3%) than type B (n=13, 3.7%) viruses were detected. Of 78 subtyped influenza A viruses, 35% were A(H1)pdm09 and 65% were A(H3). No influenza B viruses were ascribed to a lineage. Of 251 cases with known age, 115 were 15-64 years old, 73 were 65 years and older, 38 were 0-4 years old and 25 were 5-14 years old.

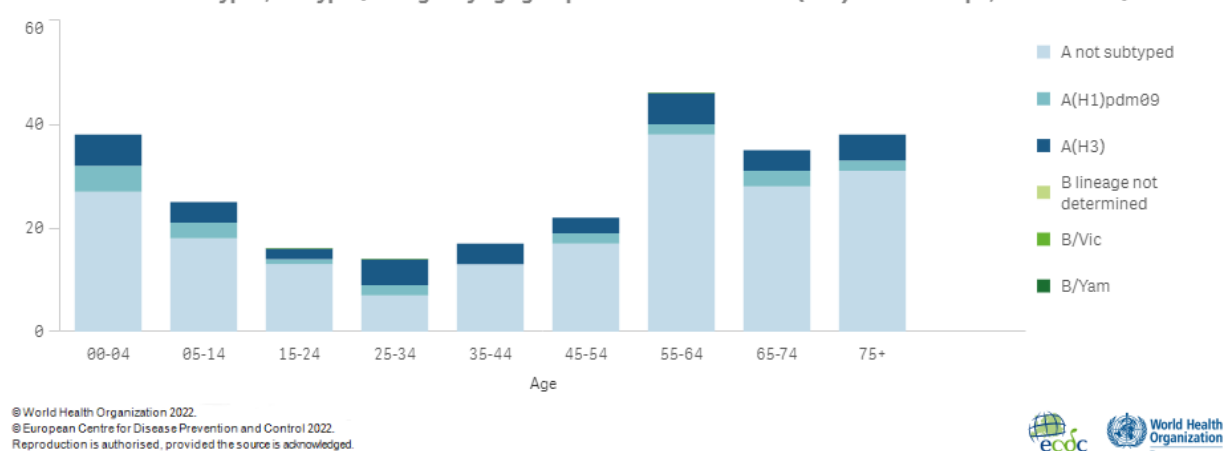
**Figure 5. Number of laboratory-confirmed hospitalized influenza cases in intensive care units (ICU) by week of reporting, WHO European Region, season 2021/2022**





**Figure 6. Distribution of influenza virus types, subtypes/lineages by age group in intensive care units (ICU), WHO European Region, season 2021/2022**

Distribution of virus types, subtypes/lineages by age group in intensive care units (ICU) - WHO Europe, season 2021/2022



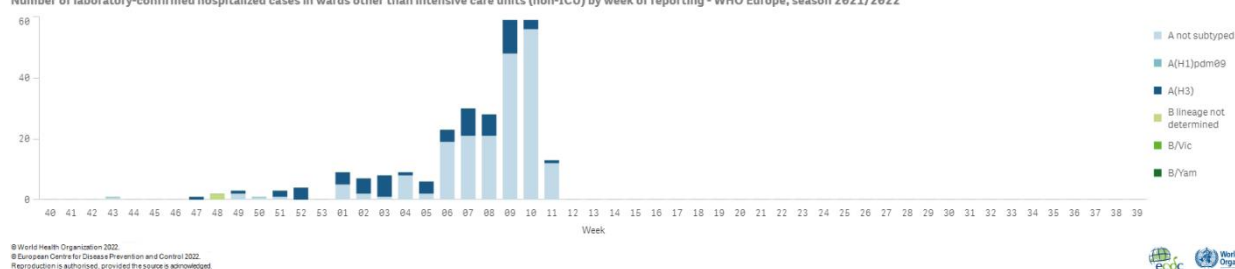
## 1.2) Hospitalized laboratory-confirmed influenza cases – other wards

Among laboratory-confirmed influenza cases reported in wards other than ICUs in week 11/2022 ( $n = 13$ ), 12 were reported from Ireland and one from Czechia. All were typed as influenza A viruses, one of which was subtyped as A(H3) (Fig. 7 and 8).

Since week 40/2021, 264 influenza type A viruses and 2 influenza type B viruses were detected. All 64 subtyped influenza A viruses were A(H3). The 266 cases with known age fell in four age groups: 110 were 15-64 years old, 108 were 65 years and older, 32 were 0-4 years old and 16 were 5-14 years old.

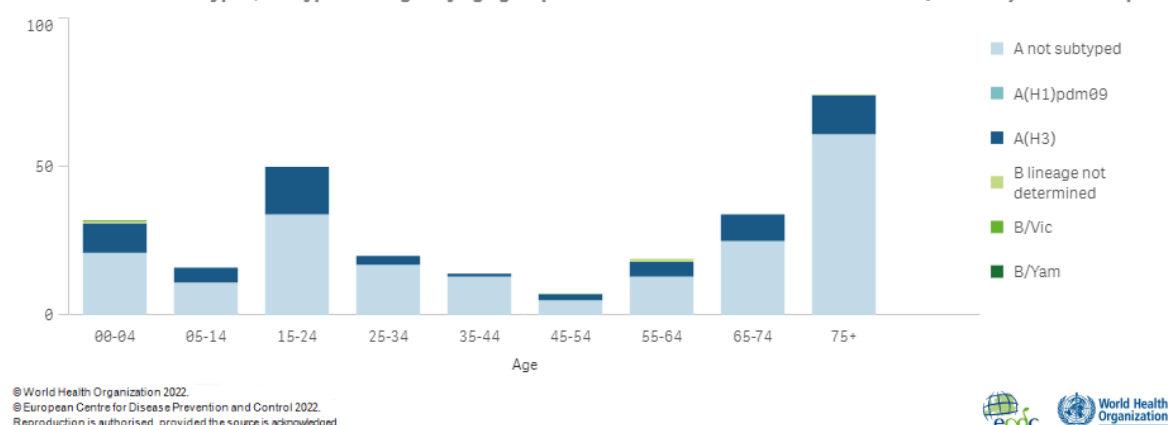
**Figure 7. Number of laboratory-confirmed hospitalized influenza cases in wards other than intensive care units (non-ICU) by week of reporting, WHO European Region, season 2021/2022**

Number of laboratory-confirmed hospitalized cases in wards other than intensive care units (non-ICU) by week of reporting - WHO Europe, season 2021/2022



**Figure 8. Distribution of influenza virus types, subtypes/lineages by age group in wards other than intensive care units (non-ICU), WHO European Region, season 2021/2022**

Distribution of virus types, subtypes/lineages by age group in wards other than intensive care units (non-ICU) - WHO Europe...



## Severe acute respiratory infection (SARI)-based hospital surveillance

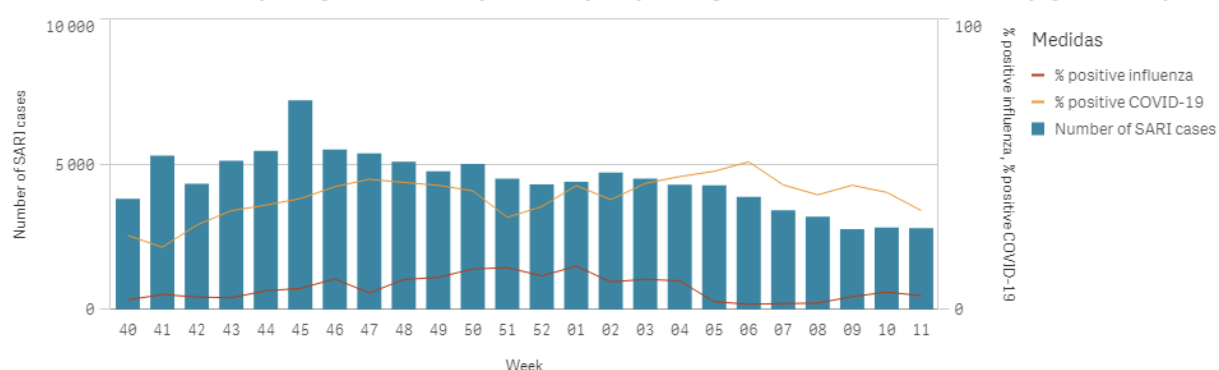
For week 11/2022, 2 805 SARI cases were reported by 13 countries or areas (Albania, Armenia, Belarus, Georgia, Germany, Kazakhstan, Kyrgyzstan, Malta, Republic of Moldova, Russian Federation, Serbia, Spain and Ukraine). Of 269 specimens tested for influenza viruses, 5% (n=13) were positive. Of these, influenza type A viruses (n=9, 69%) were detected more frequently than influenza type B viruses (n=4, 31%) (Fig. 9 and Fig. 10). The highest positivity rates for influenza virus detections were reported by Republic of Moldova (40%), Serbia (30%) and Malta (15%).

For the season, 107 073 SARI cases were reported by 19 countries or areas (Albania, Armenia, Belarus, Georgia, Germany, Kazakhstan, Kyrgyzstan, Lithuania, Malta, Montenegro, North Macedonia, Republic of Moldova, Russian Federation, Serbia, Spain, Turkey, Ukraine, Uzbekistan and Kosovo (in accordance with Security Council resolution 1244 (1999))).

For SARI cases testing positive for influenza virus since week 40/2021, type A viruses have been the most common (n=949, 98%). For 832 cases where influenza virus subtyping was performed, 830 (99.8%) were infected by A(H3) viruses and 2 (0.2%) were infected by A(H1)pdm09 viruses. Of the 2 influenza B viruses detected, none were ascribed to a lineage (Fig. 10).

**Figure 9. Number of severe acute respiratory infection (SARI) cases (bar) and positivity for influenza and COVID-19 (line) by week, WHO European Region, season 2021/2022**

Number of severe acute respiratory infection (SARI) cases (bar) and positivity for influenza and COVID-19 (line) by week of report...

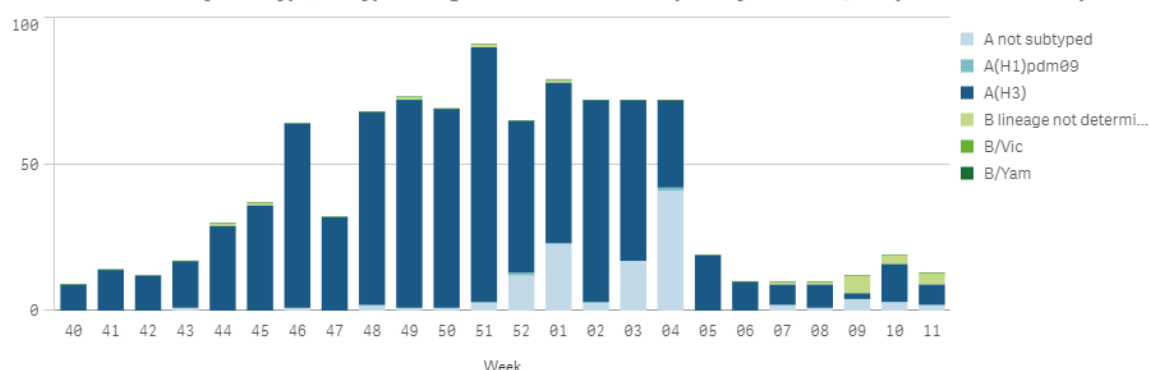


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**Figure 10. Influenza virus detections by type, subtype/lineage from severe acute respiratory infection (SARI), WHO European Region, season 2021/2022**

Influenza detections by virus type, subtype/lineage from severe acute respiratory infection (SARI) surveillance in hospitals - ...



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## Virus characteristics

Details of the distribution of viruses detected in sentinel-source specimens can be found in the [Primary care data](#) section.

## Non-sentinel virologic data

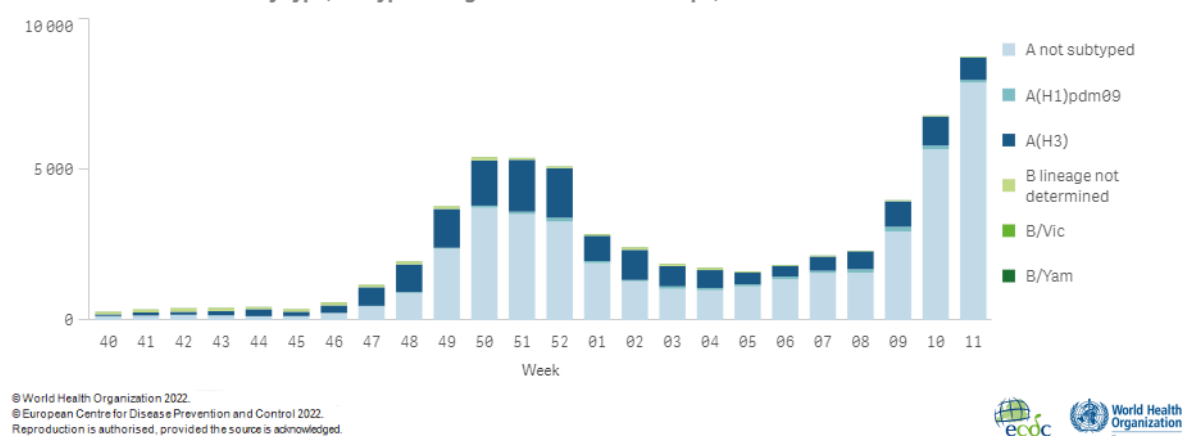
For week 11/2022, 8 757 of 80 936 specimens from non-sentinel sources (such as hospitals, schools, primary care facilities not involved in sentinel surveillance, or nursing homes and other institutions) tested positive for an influenza virus; 8 729 (99.7%) were type A and 28 (0.3%) were type B. Of 840 subtyped A viruses, 748

(89%) were A(H3) and 92 (11%) were A(H1)pdm09. No B viruses were ascribed to a lineage (Fig. 11 and Table 2).

For the season to date, more influenza type A (n=60 359, 97%) than type B (n=1 599, 3%) viruses have been detected. Of 17 629 subtyped A viruses, 16 222 (92%) were A(H3) and 1 407 (8%) were A(H1)pdm09. Of 17 influenza type B viruses ascribed to a lineage, all were B/Victoria (99% of type B viruses were reported without a lineage) (Fig. 11 and Table 2).

**Figure 11. Influenza virus detections by type, subtype/lineage and week, non-sentinel sources, WHO European Region, season 2021/2022**

Influenza virus detections by type, subtype/lineage and week - WHO Europe, season 2021/2022



**Table 2. Influenza virus detections in non-sentinel source specimens by type and subtype, week 11/2022 and cumulative for the season**

Virus type and subtype	Current Week (11)		Season 2021-2022	
	Number	% <sup>a</sup>	Number	% <sup>a</sup>
<b>Influenza A</b>	<b>8 729</b>	<b>99.7</b>	<b>60 359</b>	<b>97.4</b>
A(H1)pdm09	92	11	1 407	8
A(H3)	748	89	16 222	92
A not subtyped	7 889	-	42 730	-
<b>Influenza B</b>	<b>28</b>	<b>0.3</b>	<b>1 599</b>	<b>2.6</b>
B/Victoria lineage	0	-	17	100
B/Yamagata lineage	0	-	0	0
Unknown lineage	28	-	1582	-
<b>Total detections (total tested)</b>	<b>8 757 (80 936)</b>		<b>61 958 (1 941 994)</b>	

<sup>a</sup> For type percentage calculations, the denominator is total detections; for subtype and lineage, it is total influenza A subtyped and total influenza B lineage determined,

respectively; as not all countries have a true non-sentinel testing denominator, no percentage calculations for total tested are shown.

## Genetic characterization

Up to week 11/2022, 1 315 A(H3) viruses had been characterized genetically, of which 1 306 were attributed to clade 3C.2a1b.2a.2, one virus was attributed to clade 3C.2a1b.2a.1 and 8 to clade 3C.2a1b.1a. 109 A(H1)pdm09 viruses were characterized genetically, of which 91 were attributed to clade 6B.1A.5a.1 and 11 to clade 6B.1A.5a.2. One virus was genetically characterized, but not attributed to a clade, and six viruses were attributed to a recognized group but not listed.

Up to week 11/2022 10 B/Victoria viruses were characterized genetically, 2 belonging to clade V1A.3 and 7 to clade V1A.3a.2. One virus was not attributed to a clade. Seven viruses were characterized as B/Yamagata, however, the possibility that they were derived from live attenuated influenza vaccine (LAIV) could not be excluded.

**Table 3. Number of influenza viruses attributed to genetic groups, cumulative for the season- WHO Europe\***

# Number of influenza viruses attributed to genetic groups, cumulative for the season - WHO Europe

<div> <div>Virus Type</div> <div>Virus Subtype</div> <div>Genetic charact...</div> </div>	Number of influenza viruses attributed to genetic groups 2021/2022
<b>Influenza A</b>	<b>1 424</b>
<b>A(H1)pdm09</b>	<b>109</b>
A(H1)pdm09_NOClade *	1
A(H1)pdm09_SubgroupNotListed *	6
A/Guangdong-Maonan/SWL1536/2019(H1N1)pdm09_6B.1A.5a.1	91
A/India/Pun-NIV312851/2021(H1N1)pdm09_6B.1A.5a.2	7
A/Victoria/2570/2019(H1N1)pdm09_6B.1A.5a.2	4
<b>A(H3)</b>	<b>1 315</b>
A/Bangladesh/4005/2020(H3)_3C.2a1b.2a.2	1 306
A/Cambodia/e0826360/2020(H3)_3C.2a1b.2a.1	1
A/Denmark/3264/2019(H3N2)_3C.2a1b.1a	8
<b>Influenza B</b>	<b>17</b>
<b>B/Vic</b>	<b>10</b>
B/Austria/1359417/2021(Victoria lineage_1A.3a.2)	7
B/Victoria_NOClade *	1
B/Washington/02/2019(Victoria lineage_1A.3)	2
<b>B/Yam</b>	<b>7</b>
B/Phuket/3073/2013(Yamagata lineage_3)	4
B/Yamagata_NOClade *	3

\* No Clade: not attributed to a pre-defined clade and SubgroupNotListed: attributed to recognised group in current guidance but not listed here

ECDC published the [February](#) virus characterization report that describes the available data from circulating viruses this influenza season: currently type A influenza virus circulation is dominating over type B, due mainly to A(H3) viruses. Vaccination remains the best protective measure for prevention of influenza. However, based on post-infection ferret antisera data, the predominant A(H3N2) viruses in circulation are not well recognized by antisera raised against viruses genetically and antigenically similar to the vaccine virus, indicating antigenic diversity. Therefore, it is possible that the A(H3) vaccine component may induce less good recognition of the prevalent A(H3) viruses. Clinicians should therefore consider early antiviral treatment of at-risk groups with influenza infection, according to local guidance, to prevent severe outcomes.

This and previously published influenza virus characterization reports are available on the [ECDC website](#).

## **Antiviral susceptibility of seasonal influenza viruses**

Up to week 11/2022, 1 220 viruses were assessed for susceptibility to neuraminidase inhibitors (797 A(H3), 82 A(H1)pdm09 and 2 B virus genotypically and 317 A(H3), 10 A(H1) and 12 B viruses phenotypically), and 674 viruses were assessed for susceptibility to baloxavir marboxil (600 A(H3), 72 A(H1)pdm09 and 2 B virus genotypically). Phenotypically no viruses with reduced susceptibility were identified and genotypically no markers associated with reduced susceptibility were identified.

## Vaccine effectiveness

[Preliminary results](#) of 2021-2022 seasonal influenza vaccine effectiveness (VE) estimates from the United States showed that VE against medically attended outpatient acute respiratory infection associated with influenza A(H3N2) virus was 16% (95% CI = -16% to 39%), this was interpreted to show that “influenza vaccination did not reduce the risk for outpatient medically attended illness with influenza A(H3N2) viruses that predominated so far this season.”

The European I-MOVE network estimated influenza VE using a multicentre test-negative design among symptomatic patients presenting at primary care level between October 2021 and March 2022. Preliminary influenza VE against influenza A among seven study sites and among all ages was 36% (95%CI: 13–53) and 41% (95%CI: 15–59) among those aged 18–64 years. All-age VE against influenza A(H3N2) was 35% (95%CI: 6–54) and 37% (95%CI: 3–59) among those aged 18–64 years. There were too few influenza positive cases among other age groups to allow VE estimations.

In [Sweden](#), the VE against laboratory-confirmed influenza was estimated to be 47% for individuals over 65 years of age.

According to [preliminary data in mainland France](#), the VE was estimated to be 50% (95% CI: 14-71) against all circulating influenza viruses, 77% (95% CI: 36-92) for A(H1N1)pdm09 and 31% (95% CI: -29-64) for A(H3N2).

### Available vaccines in Europe

<https://www.ecdc.europa.eu/en/seasonal-influenza/prevention-and-control/vaccines/types-of-seasonal-influenza-vaccine>

## Vaccine composition

**On 24 September 2021, WHO published [recommendations](#) for the components of influenza vaccines for use in the 2022 southern hemisphere influenza season:**

### Egg-based Vaccines

- an A/Victoria/2570/2019 (H1N1)pdm09-like virus;
- an A/Darwin/9/2021 (H3N2)-like virus;
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.



## **Cell- or recombinant-based Vaccines**

- an A/Wisconsin/588/2019 (H1N1)pdm09-like virus;
- an A/Darwin/6/2021 (H3N2)-like virus;
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

It is recommended that **trivalent influenza vaccines** for use in the 2022 southern hemisphere influenza season contain the following:

## **Egg-based vaccines**

- an A/Victoria/2570/2019 (H1N1)pdm09-like virus;
- an A/Darwin/9/2021 (H3N2)-like virus; and
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus.

## **Cell- or Recombinant-based vaccines**

- an A/Wisconsin/588/2019 (H1N1)pdm09-like virus;
- an A/Darwin/6/2021 (H3N2)-like virus; and
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus

The full report is published [here](#).

**On 25 February 2022, WHO published [recommendations](#) for the components of influenza vaccines for use in the 2022-2023 northern hemisphere influenza season:**

The WHO recommends that quadrivalent vaccines for use in the 2022-2023 influenza season in the northern hemisphere contain the following:

## **Egg-based Vaccines**

- an A/Victoria/2570/2019 (H1N1)pdm09-like virus;
- an A/Darwin/9/2021 (H3N2)-like virus;
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

## **Cell culture- or recombinant-based Vaccines**

- an A/Wisconsin/588/2019 (H1N1)pdm09-like virus;
- an A/Darwin/6/2021 (H3N2)-like virus;
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus; and

- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

The WHO recommends that trivalent vaccines for use in the 2022-2023 influenza season in the northern hemisphere contain the following:

### **Egg-based vaccines**

- an A/Victoria/2570/2019 (H1N1)pdm09-like virus;
- an A/Darwin/9/2021 (H3N2)-like virus; and
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- an A/Wisconsin/588/2019 (H1N1)pdm09-like virus;
- an A/Darwin/6/2021 (H3N2)-like virus; and
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus

**Disclaimer:**

*\* The administrative boundaries include spatial feature for Kosovo, this designation being without prejudice to position on status, and is in line with United Nations Security Council Resolution 1244 (1999) and the International Court of Justice Opinion on the Kosovo Declaration of Independence.*

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