

## WEEKLY BULLETIN

# Communicable Disease Threats Report

Week 30, 20 - 26 July 2024

## This week's topics

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## Executive summary

### Avian influenza A(H5N6) – Multi-country – Monitoring human cases

- On 25 July 2024, the Centre for Health Protection (CHP) of the Department of Health in Hong Kong SAR reported a new laboratory-confirmed human infection with avian influenza A(H5N6) virus.
- The case is a 70-year-old female from Hefei, Anhui Province.
- Since 2014, 93 cases have been reported globally (92 in China and one in Laos), of which 38 were fatal (CFR: 41%).
- To date, no instances of human-to-human transmission have been documented.
- The risk of zoonotic influenza transmission to the general public in EU/EEA countries remains very low.

### SARS-CoV-2 variant classification

Since the last update on 28 June 2024, and as of 26 July 2024, the **following 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:

- KP.3 lineages has been classified as a VOI, due to potentially enhanced transmissibility, immune evasion, and potential for further antigenic changes compared to other BA.2.86 lineages. This variant is a sub-lineage of BA.2.86, carrying additional spike changes F456L and Q493E. The mutation Q493E has previously been rare in BA.2.86 lineages but in this specific variant it likely provides a significant selective advantage over other circulating lineages. The variant has been increasing in proportion in the EU/EEA during the spring and summer of 2024 and is now the dominant variant. The increase of the variant coincides in time with an increase in test positivity for COVID-19 in the EU/EEA, with the variant being one possible factor contributing to the increase.

Currently, for weeks 27-28, BA.2.86 + F456L is circulating in the EU/EEA at a median of 96.2% (range: 50.0%-100.0%, IQR: 88.2%-98.8%), BA.2.86 + R346T is circulating at a median of 36.8% (range: 15.2%-50.0%, IQR: 19.0%-41.0%) and BA.2.86 + R346T + F456L is circulating at a median of 29.7% (range: 14.4%-50.0%, IQR: 18.1%-40.9%). The calculations are based on data reported to GISAID from ten reporting countries, as of 22 July 2024.

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation. The EU/EEA population overall has a significant level of hybrid immunity (prior infection + vaccination/boosters), conferring protection against severe disease. BA.2.86 + F456L, BA.2.86 + R346T and BA.2.86 + R346T + F456L variants are unlikely to be associated with any increase in infection severity compared to previously circulating BA.2.86 variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and previously uninfected individuals could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (such as older people) remains important.

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

- Following a period of very low SARS-CoV-2 circulation, there has been evidence of increased SARS-CoV-2 activity in primary and secondary care since May in several EU/EEA countries, with positivity stabilising over the past few weeks. Importantly, the elevated SARS-CoV-2 positivity was observed without any concurrent increase in respiratory activity (measured by the number of visits to GPs or hospital admissions with respiratory symptoms).
- SARS-CoV-2 test positivity in secondary care currently remains the highest among those aged 65 years and above, indicating that vulnerable populations remain at risk of experiencing severe disease.
- Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccine protection of individuals at high risk of severe outcomes (such as older people) remains important.
- The currently circulating and largely dominating SARS-CoV-2 variant BA.2.86 (including subvariants carrying R346T and/or F456L mutations, often referred to in the media as FLiRT variants and including lineages KP.2 and KP.3) is not expected to be associated with increased infection severity or to significantly reduce vaccine effectiveness.

### Circulating vaccine-derived poliovirus type 2 (cVDPV2) - Palestine\* - 2024

- On 23 July 2024, the Global Polio Eradication Initiative (GPEI) confirmed the presence of circulating vaccine-derived poliovirus type 2 poliovirus (cVDPV) in the Gaza Strip.
- The virus was isolated from six environmental (sewage) samples, collected from two different collection sites in two sub-regions within Gaza on 23 June 2024.
- Genomic sequencing showed a link with polioviruses detected in samples collected in Egypt in 2023.
- To date, no cases of acute flaccid paralysis (AFP) have been reported.
- The probability of polio spread in the Gaza strip has been assessed as high by WHO.
- The overall polio risk assessment for the EU remains unchanged.

### Cholera – Comoros and Mayotte – 2024 – Weekly monitoring

- In Mayotte, since the previous report on 15 July, and as of 22 July, French health authorities have reported one new cholera case. Since 18 March, and as of 22 July, there have been 220 cases and two deaths.
- In the Union of Comoros, since the previous update on 10 July, and as of 24 July, local authorities reported 50 new cholera cases and no new deaths. As of 24 July 2024, 10 338 confirmed cholera cases and 149 deaths have been reported in the country.
- Given the decline in the number of autochthonous cases of cholera in Mayotte, and in neighbouring Comoros, ECDC has lowered the overall risk from high to moderate.

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

- On 22 July 2024, the US CDC reported six human cases of A(H5N1) avian influenza virus among workers exposed to infected poultry as part of the response to the ongoing outbreak at a commercial egg layer operation in Colorado. The cases showed mild respiratory symptoms and none have required hospitalisation to date.
- The virus was characterised as genotype B3.13 clade 2.3.4.4b HPAI A(H5N1) and it was closely related to the recent poultry outbreaks and infected dairy cattle herds.
- The virus maintains avian genetic characteristics and lacks adaptations for human infection. However, a specific change at PB2 M631L suggests mammalian adaptation.
- No markers of antiviral resistance were found and the HA sequence closely resembles to the two existing HPAI A(H5) candidate vaccine viruses.
- On 25 July 2024, the US CDC confirmed three human cases of highly pathogenic avian influenza (HPAI) A(H5) among workers exposed to infected poultry as part of the response to an outbreak at a second poultry farm in Colorado. The cases had mild symptoms and have been offered antiviral treatment.
- In 2024 and as of 25 July 2024, a total of 13 human cases of HPAI A(H5), including 10 human cases of A(H5N1), have been reported in USA. From these, four cases have been reported in workers exposed to dairy cattle infected with A(H5N1) and nine cases have been reported in workers exposed to commercial egg layer farms with outbreaks of HPAI A(H5).
- To date, there have been no confirmed cases of A(H5N1) infection in humans and no reports of A(H5N1) infection in cattle in the EU/EEA.
- 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-moderate.

**Crimean-Congo haemorrhagic fever - Spain - 2024**

- A second confirmed case of CCHF in an elderly man was notified by the Spanish health authorities on 21 July 2024. The probable place of infection is Toledo province (Castilla-La Mancha).
- Previously, a confirmed case of CCHF in an elderly man was notified by regional Spanish health authorities on 27 April 2024. The probable place of infection was the Arribes del Duero natural park (Salamanca province, Castile-León). The patient passed away on 1 May.
- The risk of contracting CCHF for the general population in the areas where the virus is known to be present in Spain is low, this risk drastically increases for people performing activities that expose them to tick bites.

**Oropouche virus disease - Multicountry (America) - 2024**

- During July 2024, two cases of presumed Oropouche virus (OROV) vertical transmission have been documented in Brazil.
- These concerns two infected pregnant women who experienced miscarriages during gestational weeks 8 and 30.
- As of 16 July 2024, 7 688 confirmed cases of Oropouche have been reported in five countries in the Region of the Americas: the Plurinational State of Bolivia (313), Brazil (6 976), Colombia (38), Cuba (74), and Peru (287). During the last quarter, cases of Oropouche have been reported in areas and countries where no autochthonous cases had been previously reported.
- Although a few Oropouche virus disease cases were reported by Italy and Spain among returning travellers from Cuba and Brazil, the overall risk of importation and of further transmission in the EU/EEA are considered low and very low respectively.

**Seasonal surveillance of West Nile virus infections – 2024**

- Since the beginning of 2024, and as of 24 July 2024, West Nile virus (WNV) cases have been reported to The European Surveillance System (TESSy) by France, Spain, Italy and Greece in the in EU/EEA, and by Serbia.
- ECDC's weekly surveillance report on West Nile virus infections is available online at the dedicated webpage along with a dashboard: [Weekly updates: 2024 West Nile virus transmission season \(europa.eu\)](https://ecdc.europa.eu/en/weekly-updates/2024-west-nile-virus-transmission-season) and [West Nile virus Dashboard \(europa.eu\)](https://ecdc.europa.eu/en/west-nile-virus-dashboard).

**Mass gathering monitoring - Olympic and Paralympic Games - France - 2024**

- Since the previous update on 19 July and as of 25 July, no major public health events related to communicable diseases have been detected in the context of the Paris 2024 Olympic Games. COVID-19 cases have been reported among athletes of the Australian Water Polo Women's Team.
- The probability of EU/EEA citizens becoming infected with communicable diseases during the Paris 2024 Olympic and Paralympic Games is considered to be low, if general preventive measures are applied.

- ECDC is monitoring this mass gathering event through epidemic intelligence activities until 13 September 2024, in collaboration with Santé Publique France and partners. Weekly updates will be included in the [Communicable Disease Threats Report \(CDTR\)](#).

### Nipah virus disease - India - 2024

- On 21 July 2024, media reports quoting Indian health authorities reported a confirmed case of Nipah virus (NiV) disease in Kerala State, India. The case passed away on 22 July. A total of 330 contacts have been identified.
- Cases of NiV disease have been reported previously in India and Bangladesh. This is the fifth outbreak of NiV disease in Kerala state, the previous four being in 2018 (Kozhikode district), 2019 (Ernakulum district), 2021 (Kozhikode district), and 2023 (Kozhikode).
- The likelihood of exposure and infection by NiV for EU/EEA citizens travelling or residing in India is currently very low given the low number of infections and of areas where cases have been identified so far.

## 1. Avian influenza A(H5N6) – Multi-country – Monitoring human cases

### Overview:

**Update:** On 25 July 2024, the [Centre for Health Protection](#) (CHP) of the Department of Health in Hong Kong SAR reported a new laboratory-confirmed human infection with avian influenza A(H5N6) virus.

The case was a 70-year-old female from Hefei, Anhui Province, with onset of symptoms on 17 June 2024. On 19 June 2024, the case was admitted to hospital. The patient's condition did not improve and she passed away on 8 July 2024.

The case had exposure to live poultry in a live poultry market/wet market before the onset of disease.

**Summary:** Since 2014, and as of 19 July 2024, 93 laboratory-confirmed cases of human infection with influenza A(H5N6) virus have been reported globally: 92 from China and one from Laos. 38 deaths have been reported (CFR: 41%).

### ECDC assessment:

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

### Actions:

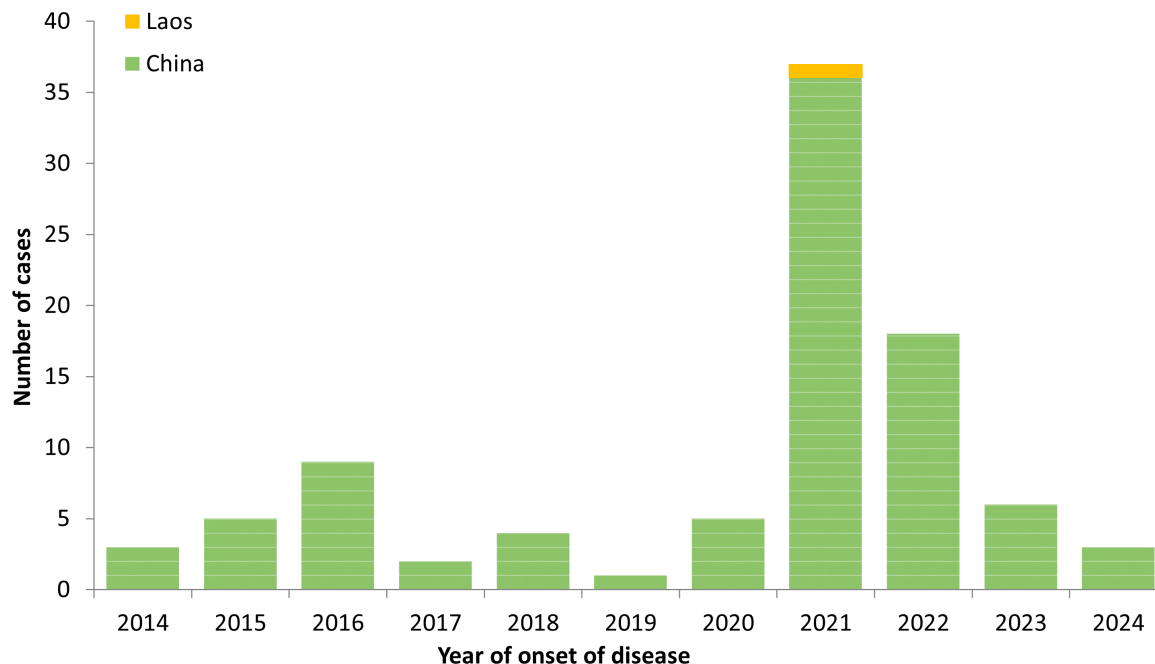
ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities and collaborates with the European Food Safety Authority (EFSA) and the EU reference laboratory for avian influenza to identify significant changes in the epidemiology of the virus. ECDC works with EFSA and the EU reference laboratory to produce a quarterly [report on the avian influenza situation](#). The most recent report was published in July 2024.

**Sources:** [CHP - HK](#)

**Last time this event was included in the Weekly CDTR:** 19 July 2024

## Maps and graphs

**Figure 1. Distribution of confirmed human cases of avian influenza A(H5N6) virus infection by year of onset and country, 2014 - 26 July 2024 (n=93)**



Source: ECDC

## 2. SARS-CoV-2 variant classification

### Overview:

Since the last update on 28 June 2024, and as of 26 July 2024, the **following 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:

- KP.3 lineages has been classified as a VOI, due to potentially enhanced transmissibility, immune evasion, and potential for further antigenic changes compared to other BA.2.86 lineages. This variant is a sub-lineage of BA.2.86, carrying additional spike changes F456L and Q493E. The mutation Q493E has previously been rare in BA.2.86 lineages but in this specific variant it likely provides a significant selective advantage over other circulating lineages. The variant has been increasing in proportion in the EU/EEA during the spring and summer of 2024 and is now the dominant variant. The increase of the variant coincides in time with an increase in test positivity for COVID-19 in the EU/EEA, with the variant being one possible factor contributing to the increase.

Currently, for weeks 27-28, BA.2.86 + F456L is circulating in the EU/EEA at a median of 96.2% (range: 50.0%-100.0%, IQR: 88.2%-98.8%), BA.2.86 + R346T is circulating at a median of 36.8% (range: 15.2%-50.0%, IQR: 19.0%-41.0%) and BA.2.86 + R346T + F456L is circulating at a median of 29.7% (range: 14.4%-50.0%, IQR: 18.1%-40.9%). The calculations are based on data reported to GISAID from ten reporting countries, as of 22 July 2024.

### ECDC assessment:

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation. The EU/EEA population overall has a significant level of hybrid immunity (prior infection + vaccination/boosters), conferring protection against severe disease. BA.2.86 + F456L, BA.2.86 + R346T and BA.2.86 + R346T + F456L variants are unlikely to be associated with any increase in infection severity compared to previously circulating BA.2.86 variants,

or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and previously uninfected individuals could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccine protection of individuals at high risk of severe outcomes (such as older people) remains important.

### Actions:

Following a long period of low SARS-CoV-2 transmission, there are signals of increased SARS-CoV-2 detection in primary and secondary care in the EU/EEA. In order to assess the impact of emerging SARS-CoV-2 sub-lineages and their possible correlation with increases in COVID-19 epidemiological indicators, it is important that countries sequence positive clinical specimens and report to GISAID and/or TESSy.

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 \(ERVISS\)](#).

Routine updates on the SARS-CoV-2 variant classification through the Communicable Diseases Threats Report will be provided on a monthly basis as a minimum.

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

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

### Overview:

#### Key indicators

All data 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 in primary care sentinel sites. 'Country notes' in the footer explain known issues with reported data.

Syndromic surveillance in primary and secondary care indicates that respiratory activity remains at baseline levels in EU/EEA countries, at similar levels to that observed during summer 2023.

#### **SARS-CoV-2 positivity in both primary and secondary care at the EU/EEA level have stabilised following several weeks of increasing positivity.**

- Increase in SARS-CoV-2 activity started about six weeks earlier than during the summer of 2023, but the trends are comparable in terms of the number of tested samples and positivity rates in both primary and secondary sentinel systems.
- In primary care sentinel systems (general practitioners), the pooled test positivity slightly increased to 29.8%, after plateauing over the past two weeks, with a median test positivity of 20%. At a country level we observed a mixed picture, however a decreasing trend in positivity was notable in several countries that had been reporting high positivity over the past weeks. A single country continues to contribute more than 50% of the test results and reports a positivity above 35%, which drives the observed divergence between pooled and median positivity.
- Following six weeks of an increasing trend, the pooled test positivity in the SARI sentinel systems (hospitals) stabilised over the past four weeks to 20%, with a median positivity of 33.3%. Among the five countries reporting, three have shown a decreasing trend in test positivity. The age group 65 years and above remained the most affected (26% positivity).
- While there is an elevated positivity in primary and secondary care sentinel systems, sentinel syndromic ILI and ARI rates show no increases above baseline levels.
- Non-sentinel secondary care data showed similar trends to the sentinel system. A mixed trend at a country level was observed, with 10 countries reporting slight increases in positivity, while three countries showed stable or decreasing trends. One country continued to report an increase in hospitalisations and two countries reported an increase in SARS-CoV-2 deaths.

Seasonal influenza activity at the EU/EEA level remained stable at low levels.

Respiratory syncytial virus (RSV) activity remained low in the reporting EU/EEA countries.

### Virus characterisation

Influenza for week 40, 2023 to week 29, 2024

In the above period 3 892 A(H1N1)pdm09, 1 568 A(H3) and 541 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the viruses that have been assigned to a clade:

- 3 885 were A(H1N1)pdm09 - 2 684 (69%) were subclade 5a.2a and 1 201 (31%) were subclade 5a.2a.1.
- 1 565 were A(H3) - 30 (2%) were subclade 2a, 1 (0.1%) were subclade 2a.1b, 11 (0.7%) were subclade 2a.3a, 1 522 (97%) were subclade 2a.3a.1 and 1 (0.1%) were subclade 2a.3b.
- 541 were B/Vic - all were subclade V1A.3a.2.

SARS-CoV-2 variants for weeks 27–28 (1 July to 14 July 2024)

The estimated distribution (median and IQR of proportions from 10 countries submitting at least 10 sequences) of variants of concern (VOCs) or variants of interest (VOIs) was:

- 100% (98–100%) for BA.2.86 (758 detections from 10 countries)

For information on SARS-CoV-2 variants classified as variants under monitoring (VUM), visit [ECDC's variant page](#).

### ECDC assessment:

Influenza and RSV activity in the EU/EEA remain at low levels. Following a period of very low activity, there is evidence of increased SARS-CoV-2 activity for some reporting countries in both primary and secondary care, with those aged 65 years and above at greatest risk of experiencing severe disease. Although COVID-19 hospital admissions, ICU admissions and deaths remain low at the EU/EEA level, increases in SARS-CoV-2 activity highlight the continued need to monitor the impact of SARS-CoV-2 at national and regional level.

### Actions:

In order to assess the impact of emerging SARS-CoV-2 sub-lineages, and their possible correlation with increases in COVID-19 epidemiological indicators, it is important that countries continue to sequence SARS-CoV-2-positive clinical specimens and report to GISAID and/or TESSy. It is therefore important that testing of symptomatic individuals for SARS-CoV-2 continues during the summer period.

Vaccination remains critically important to protect individuals at high risk of severe outcomes, such as older adults. 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, as per 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 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).
- Antigenic characterisation data presented in the WHO [2024-2025 northern 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, 2a.3a.1 clade viruses are less well matched. Based on human post-vaccination serology studies, haemagglutination inhibition and virus neutralisation against some recent 2a.3a.1 viruses were significantly reduced for some serum panels.
- ECDC has [published](#) interim influenza vaccine effectiveness (VE) estimates for the 2023–2024 season. Analysis of data submitted from multi-country primary care and hospital study sites between September 2023 and January 2024 indicated that up to 53% and 44% of vaccinated individuals in primary care or hospital settings, respectively, were protected against mild and severe influenza.

Sources: [ERVISS](#)

Last time this event was included in the Weekly CDTR: 19 July 2024

## Maps and graphs

**Figure 1. Overview of key indicators of activity and severity in week 29**

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment	
		Week 29	Week 28	Description	Value		
Primary care consultation rates	ARI	9 rates (7 MEM)	10 rates (8 MEM)	Distribution of country MEM categories	7 Baseline	Stable rates continue to be reported at levels comparable to the same time last year.	
	ILI	11 rates (11 MEM)	13 rates (13 MEM)		10 Baseline 1 Low		Stable rates continue to be reported at levels comparable to the same time last year.
Primary care sentinel positivity	SARS-CoV-2	15	15	Pooled (median; IQR)	30% (20; 4.6–28%)	A slight increase in pooled test positivity; three countries reporting >30% positivity this week; four countries reporting 10-20% positivity; and one country reporting 5-10% positivity.	
	Influenza	14	13		1.5% (0; 0–0%)		Stable trend of very low circulation.
	RSV	14	14		0% (0; 0–0%)		Stable trend of very low circulation.
SARI consultation rates	SARI	7	8			Stable or decreasing rates continue to be reported at levels comparable to the same time last year.	
SARI positivity	SARS-CoV-2	5	6	Pooled (median; IQR)	20% (33; 12–35%)	Stable trend in pooled and median test positivity; three countries reporting >30% positivity this week and two countries reporting 10-15% positivity. In data from non-sentinel sources, one country continued to report an increase in hospitalisations while two countries report decreasing or stable trend in hospitalisations. Two countries reported an increase in deaths and one country is showing decreasing trend in deaths.	
	Influenza	5	6		1.2% (0; 0–0.7%)		Stable trend of very low circulation; only one country reporting 16% positivity.
	RSV	5	5		0% (0; 0–0%)		Stable trend of very low circulation.
Intensity (country-defined)	Influenza	15	17	Distribution of country qualitative categories	11 Baseline 4 Low		
Geographic spread (country-defined)	Influenza	14	16	Distribution of country qualitative categories	9 No activity 3 Sporadic 2 Regional		

Source: ECDC

**Figure 2. Virological distribution for week 29 and the period week 25, 2024 to week 29, 2024**

Pathogen or (sub-)type	Primary care sentinel						SARI sentinel						Non-sentinel			
	Week 29			Period 2024-2025			Week 29			Period 2024-2025			Week 29		Period 2024-2025	
	n	%	positivity	n	%	positivity	n	%	positivity	n	%	positivity	n	%	n	%
<b>Influenza</b>	10	100	1.5%	55	100	1.2%	9	100	1.2%	43	100	0.9%	140	100	1 075	100
Influenza A (total)	8	89	1.2%	31	60	0.7%	6	100	0.8%	21	81	0.5%	99	77	515	53
A(H1)pdm09	1	17		14	54					1	100		6	40	136	67
A(H3)	5	83		12	46							9	60	68	33	
A (unknown)	2			5			6						84		311	
Influenza B (total)	1	11	0.2%	21	40	0.5%				5	19	0.1%	29	23	459	47
B/Vic				5	100										16	100
B (unknown)	1			16						5			29		443	
Influenza untyped	1		0.2%	3		0.1%	3		0.4%	17		0.4%	12		101	
<b>RSV</b>	0		0%	4		0.1%	NA			7		0.2%	20		203	
<b>SARS-CoV-2</b>	181		29.8%	1 253		29.5%	149		20.1%	923		19.6%	17 158		66 408	

Source: ECDC



## 4. Circulating vaccine-derived poliovirus type 2 (cVDPV2) - Palestine\* - 2024

### Overview:

On 23 July 2024, the [Global Polio Eradication Initiative \(GPEI\)](#) confirmed the presence of circulating vaccine-derived poliovirus type 2 (cVDPV) in the Gaza Strip. Six wastewater samples collected from two environmental surveillance sites in Khan Younis and Deir al Balah tested positive for poliovirus.

Following genomic sequencing, a link was established between these strains and a poliovirus variant that was circulating in Egypt during the second half of 2023. The last detection of the related variant polioviruses in Egypt was in samples collected in December 2023.

Based on the analysis of genetic changes in the isolates, the variant poliovirus could have been introduced in Gaza as early as September 2023. To date, no cases of acute flaccid paralysis (AFP) have been reported.

According to GPEI, only 16 out of 36 hospitals are partially functional and 45 out of 105 primary healthcare facilities are operational. The impact on the health system, insecurity, inaccessibility, population displacement, and shortages of medical supplies, coupled with poor water quality and weakened sanitation, have contributed to reduced routine immunisation rates and an increased risk of vaccine-preventable diseases, including polio.

### ECDC assessment:

These are the first findings of environmental samples positive for poliovirus in Palestine\* since 2022. GPEI reported that routine immunisation rates in Palestine\* were optimal before the start of the conflict in October 2023. Polio vaccination coverage (POL3), primarily conducted through routine immunisation, was estimated at 99% in 2022. This declined to 89% in 2023, according to the latest WHO-UNICEF routine immunisation estimates ([WUENIC](#)).

Although the situation in the Gaza strip remains critical with severe disruption to health services and increased risk of infectious disease outbreaks, the likelihood of poliovirus infection for EU/EEA citizens (e.g. humanitarian workers) in Gaza strip is very low, assuming that they are up to date with their polio vaccination.

The probability of polio spread in the Gaza strip has been assessed as high by WHO.

The overall polio risk assessment for the EU remains unchanged.

Further information on monitoring global outbreaks of poliomyelitis can be found here **ECDC links:** [ECDC comment on risk of polio in Europe](#) | [ECDC risk assessment](#)

\*This designation shall not be construed as recognition of a State of Palestine and is without prejudice to the individual positions of the Member States on this issue.

### Actions:

ECDC is monitoring the event through its epidemic intelligence activities.

## 5. Cholera – Comoros and Mayotte – 2024 – Weekly monitoring

### Overview:

#### Update

In Mayotte, since the previous update on 15 July, and as of 22 July, [French health authorities](#) have reported one new cholera case and no new deaths.

Since 18 March, and as of 22 July, French health authorities have reported 220 cholera cases, none of which are currently active, and two deaths. According to the bulletin, there are four additional deaths probably related to cholera. A total of 1 112 contacts have received antibiotic chemoprophylaxis and 16 255 contacts have been vaccinated.

Further information on the case definition and close contacts is available on the [Prefecture of Mayotte's](#) website.

In the Union of Comoros, since the previous update on 10 July, and as of 24 July, [local authorities](#) reported 50 new cholera cases and no new deaths. As of 24 July 2024, 10 338 confirmed cholera cases and 149 deaths have been reported in the country. In all, 10 189 cases have recovered.

#### Background

On 31 January 2024, a boat from Tanzania carrying 25 people [arrived in Moroni](#), the capital of the Comoros archipelago. One person on board died of suspected cholera and several others were symptomatic. The Comoros Ministry of Health [declared](#) a cholera outbreak on 2 February. The first locally transmitted cases in Comoros were reported on 5 February in Moroni. Cholera cases were also detected in Moheli and Anjouan by the end of February and during the first week of March.

Following the increase in cholera cases in Comoros during February, the Mayotte Regional Health Agency (ARS Mayotte) [announced](#) that health surveillance capacities would be strengthened on the island, including risk communication for health professionals and passengers. The first [imported cholera](#) case was detected in Mayotte on 18 March.

There is frequent undocumented population movement between the Comoros archipelago and the French territory of Mayotte. No cholera cases had been reported in Mayotte since 2000.

Cholera is a bacterial disease caused by the bacterium *Vibrio cholerae*. The main risk factors are associated with poor water, sanitation and hygiene practices. Several countries in eastern and southern Africa are currently responding to cholera outbreaks. Response efforts are constrained by global shortages of cholera vaccines.

#### ECDC assessment:

Given the decline in the number of autochthonous cases of cholera in Mayotte, and in neighbouring Comoros, ECDC assesses the likelihood of further community transmission of cholera in Mayotte as moderate. The impact of the cholera outbreak in Mayotte is estimated to be low, considering the [measures](#) taken in the last months. The overall risk of cholera for the population in Mayotte is therefore assessed as moderate.

Early detection and response activities are essential and have been reinforced in the French territory of Mayotte, as well as increased awareness among healthcare workers and at points of entry.

#### Actions:

ECDC is in contact with France's authorities and relevant partners and is monitoring the situation through its epidemic intelligence activities.

**Last time this event was included in the Weekly CDTR:** 19 July 2024

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

### Overview:

**Weekly update:** On 22 July 2024, the [US CDC](#) confirmed six human cases of A(H5N1) avian influenza virus among workers exposed to infected poultry as part of the response to the ongoing outbreak at a commercial egg layer operation in Colorado. The cases showed mild respiratory symptoms and none have required hospitalisation to date. Sequencing results available from one case show a close match with the first human case exposed to cattle in Michigan, including the absence of antiviral resistance and close resemblance to the two existing HPAI A(H5) candidate vaccine viruses (IDCDC-RG78A and IDCDC-RG71A), which have only 2 to 4 amino acid changes compared to the Colorado virus. The virus was characterised as genotype B3.13 clade 2.3.4.4b HPAI A(H5N1), closely related to recent poultry outbreaks and infected dairy cattle herds. Notably, the virus maintains avian genetic characteristics and lacks adaptations for human infection. A specific change at PB2 M631L suggests mammalian adaptation, similar to dairy cow sequences. However, unlike the Texas case, this virus lacks the PB2 E627K change associated with human adaptation.

Partial gene segments were obtained from two other confirmed human cases associated with the poultry farm depopulation. Only internal genes (not HA or NA) provided sufficient data for analysis.

On 25 July 2024, the [US CDC](#) confirmed three human cases of highly pathogenic avian influenza (HPAI) A(H5) among workers exposed to infected poultry as part of the response to an outbreak at a second poultry farm in [Colorado](#).

These three cases have mild symptoms and have been offered antiviral treatment.

The US CDC has deployed a multidisciplinary field team to support the response in Colorado to the ongoing poultry outbreak of H5 avian flu in the state.

A seroprevalence study from Michigan analysed blood samples from 35 individuals who worked on dairies with confirmed HPAI A(H5N1) outbreaks. None of these participants showed neutralising or hemagglutination inhibition (HI) antibodies specific to the avian influenza A(H5N1) virus. However, many participants had neutralising antibodies to seasonal flu, indicating prior infection or vaccination. These results suggest that the seroprevalence of HPAI A(H5N1) among workers with known exposures is low.

**Summary:** In 2024 and as of 25 July 2024, a total of 13 human cases of HPAI A(H5), including 10 human cases of A(H5N1), have been reported in the US. From these, four cases have been reported in workers exposed to dairy cattle infected with A(H5N1) and nine cases have been reported in workers exposed to commercial egg layer farms with outbreaks of HPAI A(H5).

The cases among workers exposed to dairy cattle have been reported in the states of Texas (1), Michigan (2) and Colorado (1). All cases among workers exposed to commercial egg layer farms have been reported in Colorado (9).

**Background:** On 1 April 2024, the first human case of HPAI A(H5N1) was reported in Texas, USA. The individual had prior exposure to dairy cattle presumed to be infected with HPAI A(H5N1). Genetic analysis revealed the virus belonged to HA clade 2.3.4.4b, genotype B3.13, and displayed the PB2 E627K mutation, indicating mammalian adaptation. The virus retained avian genetic characteristics and showed no markers for antiviral resistance.

On 22 May 2024, a second human infection with avian influenza A(H5N1) was reported in a farm worker in Michigan, USA, associated with infected dairy cattle. The virus identified belonged to the same clade and genotype as the Texas case but lacked the PB2 E627K mutation. Instead, it had the PB2 M631L change, also associated with mammalian adaptation. The genome of the virus was closely related to viruses found in dairy cattle, suggesting cow-to-human transmission.

On 30 May 2024, a third human case of HPAI A(H5N1) was [reported](#) in Michigan, USA. The dairy farm worker exhibited upper respiratory tract symptoms and eye discomfort. The virus was closely related to those found in US cattle, with a high similarity to the virus sequences from US cattle confirmed.

[Michigan Department of Health and Human Services](#) further mentioned that neither of the two cases reported in Michigan were wearing full personal protective equipment (PPE). The case reported on 22 May 2024 developed eye symptoms after having milk splashed in their eye, highlighting the importance of appropriate PPE. Since the three reported cases had direct contact with infected cattle, the [US CDC's](#) current assessment of the human health risk of A(H5N1) to the general public in the US does not change.

On 3 July 2024, a fourth human case of HPAI A(H5N1) was [reported](#) in Colorado, USA. The dairy farm worker had exposure to infected cows and reported eye symptoms. Genetic sequencing of the virus is pending.

On 19 July 2024, the Colorado Department of Public Health and Environment, in coordination with other agencies, reported six human cases of avian influenza in workers responding to an outbreak at a commercial egg layer operation. The workers exhibited mild symptoms, including conjunctivitis and respiratory infection symptoms. Sequencing results from one case showed a close match with the first human case exposed to cattle in Michigan, including the absence of antiviral resistance and close resemblance to two existing HPAI A(H5) candidate vaccine viruses. On 20 July the [US CDC](#) confirmed these six human cases of and the virus was characterised as genotype B3.13 clade 2.3.4.4b HPAI A(H5N1), closely related to recent poultry outbreaks and infected dairy cattle herds. The virus maintains avian genetic characteristics and lacks adaptations for human infection, with no markers for influenza antiviral resistance found in the patient's specimen.

On 25 July 2024, the [US CDC](#) confirmed three human cases of highly pathogenic avian influenza (HPAI) A(H5) among workers exposed to infected poultry as part of the response to an outbreak at a second poultry farm in [Colorado](#).

The United States' Department of Agriculture (USDA) Food Safety and Inspection Service (FSIS) has detected viral particles of HPAI A(H5N1) in tissue samples, including muscle, from a culled dairy cow that had been condemned (declared unfit for consumption) during a post-mortem inspection due to signs of systemic disease. Dairy cattle slaughtered for beef production undergo routine inspection before and after slaughter by the FSIS. Meat from dairy cattle condemned at slaughter due to systemic disease do not enter the human food supply.

A [study](#) of ground beef inoculated with A(H5N1) suggested cooking burgers medium to well done (to a temperature of 63C to 71C) inactivated the virus, while cooking burgers to 49C (rare) also substantially inactivated the virus.

HPAI A(H5N1) virus has been detected in dairy cattle in several states in the US. As of 3 July 2024, the [USDA](#) reports the detection of HPAI A(H5N1) in 12 states, affecting 138 dairy farms/herds. The most recently reported detection was on 1 July 2024 in Colorado. Markers of influenza A(H5) have also been detected in wastewater in Texas ([Tisza et al., 2024](#); [Wolfe et al., 2024](#)). Furthermore, cats fed unpasteurised milk and colostrum from affected cows developed systemic, fatal infection ([Burrough et al., 2024](#)).

HPAI A(H5N1) has also been reported in some other mammals in the US, including [goats](#) and [alpacos](#) at farms with infected poultry. The virus genotype identified in the infected goats was different to the one identified in cattle (B3.13), while a virus from the same genotype B3.13 had infected the alpacas.

Genetic material of HPAI A(H5N1) has been detected in milk samples. Studies performed by US FDA have shown that pasteurisation inactivates HPAI in milk and dairy products, with no viable virus being detected following pasteurisation. The [USDA](#) and [US FDA](#) highlight that commercially produced, pasteurised milk is safe for consumers and recommend that milk from cattle with clinical signs of infection is removed from the human food chain. For further information, please refer to the [US FDA](#) update. Samples of ground beef from states with affected dairy herds tested negative for HPAI A(H5N1) ([USDA](#)).

### ECDC assessment:

To date, there have been no confirmed cases of A(H5N1) infection in humans and no reports of A(H5N1) infection in cattle in the EU/EEA. The genotype B3.13 identified in cattle and the human case in the US has not currently been detected in Europe. In addition, HPAI A(H5N1) has not been detected in European (waste)water.

ECDC 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. occupationally exposure to infected animals). The implementation of personal protective measures mitigate the risk.

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](#)). 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 (for example 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 Centers for Disease Control and Prevention (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 of the [avian influenza situation](#).

Sources: [FAO](#) | [2024-e000168](#)

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

## 7. Crimean-Congo haemorrhagic fever - Spain - 2024

### Overview:

#### Update

On 21 July 2024 a second CCHF case was reported. The case is an elderly man, with symptoms onset on 18 July 2024 and a history of tick-bite in the previous days. The probable place of infection is in a rural area Toledo province close to Cáceres province (Castilla-La Mancha). The case has been admitted to hospital.

#### Summary

On 27 April 2024, the regional Spanish health authorities notified a confirmed case of CCHF in an elderly man, who went hiking in Arribes del Duero natural park, on the border with Portugal, and who, upon examination, was found have an attached Hyalomma tick. The patient was hospitalised and appropriate infection prevention and control measures to prevent human-to-human transmission were applied. The case was laboratory confirmed (positive real-time PCR specific for CCHFV in blood, serum and urine). The patient passed away on 1 May.

### ECDC assessment:

The case in April is the fifth case of CCHF with likely exposure to ticks in Salamanca province, Castile-León, Spain. Previous cases occurred there in 2018, 2020, and 2021. It is the 13th case in Spain since 2013. Although early in the season, the onset of symptoms in April is not unusual (of the previous cases in Spain, one had onset of symptoms in April, two in May, three in June, two in July and four in August).

The case in July is the first case reported from the autonomous community of Castilla-La Mancha.

Although the risk of contracting CCHF for the general population in the areas where the virus is known to be present in Spain is low, this risk drastically increases for people performing activities that expose them to tick bites (e.g. hunting, forestry work, hiking, animal surveillance). As a general precaution against CCHF, but also against other tick-borne diseases, people who may potentially be exposed to ticks should apply personal protective measures against tick bites ([ECDC Protective Measures against ticks](#)). Ticks from the Hyalomma spp. are considered the principal vectors of the CCHF virus. [Hyalomma marginatum](#) is widely [present in southern and](#)

[eastern Europe](#). A further vector is *Hyalomma lusitanicum*, which is [present in parts of southern Europe](#). Additional information on CCHF can be found in ECDC [factsheet](#) and information on the occurrence of CCHF cases in the EU/EEA can be found on the ECDC [website](#). In December 2023, ECDC published a [report](#) on the spatial distribution of CCHF based on predicted ecological suitability.

### **Actions:**

ECDC is monitoring the CCHF situation in Spain through epidemic intelligence activities.

**Last time this event was included in the Weekly CDTR:** 03 May 2024

## **8. Oropouche virus disease - Multicountry (America) - 2024**

### **Overview:**

#### **Summary**

On 12 July 2024, the Brazil IHR National Focal Point (NFP) informed [PAHO/WHO](#) about a presumptive vertical transmission of Oropouche virus (OROV).

The case was a pregnant woman with no history of travel outside of Brazil. She resided in Northeastern Brazil, where OROV transmission has been reported since May 2024. On 24 May 2024, the patient presented with symptoms compatible with OROV, during the 30th week of gestation. Samples were collected from the pregnant woman and her placenta, with positive results confirmed for OROV by RT-PCR on 3 June 2024. On 6 June 2024, foetal death was confirmed. On 4 July 2024, OROV was detected in the umbilical cord blood and in the organ tissue obtained from the foetus and confirmed by RT-PCR, indicating vertical transmission of the virus. Further laboratory analysis, along with epidemiological, clinical and pathological investigations, are ongoing for the final classification of this case.

In addition, the Brazil IHR NFP reported a second suspected case in a pregnant woman residing in the same Brazilian state as the first case, with no history of travel. On 6 June 2024, the patient presented symptoms compatible with OROV. On 12 June 2024, a serum sample was collected and tested positive for OROV by PCR. On 27 June 2024, the woman had a miscarriage in the eighth week of gestation. No samples from the foetus could be collected.

In June 2024, the Instituto Evandro Chagas (IEC) of Brazil conducted a retrospective analysis of serum and cerebrospinal fluid samples collected and stored for arbovirus research at the institution, which had tested negative for dengue, chikungunya, Zika, and West Nile virus. In this study, four newborns with microcephaly (three newborns at one day of life and one at 27 days of life) were detected with the presence of IgM class antibodies against OROV in serum samples (one newborn at one day of life and the newborn at 27 days of life) and cerebrospinal fluid (two newborns at one day of life and the newborn at 27 days of life). However, the studies cannot confirm a causal relationship between OROV infection and neurological malformations.

As of 16 July 2024, 7 688 confirmed cases of Oropouche have been reported in five countries in the Region of the Americas: the Plurinational State of Bolivia (313), Brazil (6 976), Colombia (38), Cuba (74), and Peru (287). During the last quarter, cases of Oropouche have been reported in areas and countries where no autochthonous cases had been previously reported.

In Brazil, between epidemiological week 1 and 27 of 2024, 6 976 confirmed cases of OROV were detected. Most cases have had a probable place of infection in municipalities in the northern states. The Amazon region, considered endemic, concentrates 78% of the cases registered in the country. Regarding the distribution of cases by sex and age group, 52% (3 611) correspond to male cases and the highest proportion of cases is registered in the 20-29 years age group, accounting for 21% (1 484) of the cases.

#### **Background**

On 27 May 2024, the Cuban Ministry of Public Health (MoPH) reported the detection of an outbreak of Oropouche virus (OROV) for the first time in Cuba. An increase in cases with non-specific febrile illness was detected in the province of Santiago de Cuba which gave rise to an increase in monitoring and surveillance. OROV was identified in samples from patients analysed at the National Reference Laboratory of the Pedro Kourí Institute.

The most frequent symptoms were fever, lower back pain, headache, loss of appetite, vomiting, weakness, arthromyalgia and eye pain. No severe, critical or fatal cases have been reported.

Fatalities associated to OROV have been [reported](#) from Brazil in 2023 and 2024.

Recently, Italy and Spain reported imported case of Oropouche virus disease among returning travellers exposed in Cuba and Brazil ([2024-EVD-00022](#)).

**Sources:** [Cuban MoPH](#), [Cienfuegos regional government](#)

### ECDC assessment:

Oropouche virus disease is a zoonotic disease caused by the Oropouche virus (Orthobunyavirus oropoucheense). Outbreaks of Oropouche virus disease have been reported in humans in several countries in South America (e.g. Brazil, Peru, Argentina, Bolivia, Colombia) and the Caribbean (e.g. Panama, Trinidad and Tobago). The principal vector of the virus is the *Culicoides paraensis* midge, which is widely distributed in the Americas, but absent in Europe. Other known vectors of OROV include *Coquillettidia venezuelensis*, *Mansonia venezuelensis*, and *Aedes serratus*. Wild birds and mammals are considered to be the natural hosts of OROV. In humans, OROV infection may manifest as an acute febrile illness (with headache, nausea, vomiting, muscle and joint pains), occasionally with more severe symptoms (e.g. haemorrhages and meningitis). Although no direct human-to-human transmission of the virus has been documented, vertical transmission has been documented with severe outcomes for the foetus. Evidence on the prevalence and severity of pregnancy complications is currently lacking.

The Pan American Health Organization (PAHO) issued an [Epidemiological Alert on Oropouche in the Region of the Americas](#) on 2 February 2024, emphasising the increasing risk for the expansion of OROV distribution beyond South America.

The risk of infection for EU/EEA citizens travelling to the affected countries is considered low, provided that they follow personal protective measures against midge and mosquito bites. Personal protective measures include the appropriate use of insect repellents following the product label instructions, wearing clothes that cover most of the body, and resting in airconditioned rooms or rooms with fine-meshed window and door screens. An insecticide-treated mosquito net should be used when camping or if screens are not available. However, it should be noted that *Culicoides paraensis* bite during the daytime.

The likelihood of importation of cases into continental Europe is considered to be low, although low number of imported cases from Cuba and Brazil were reported by Italy and Spain in 2024. The likelihood of observing secondary transmission within continental Europe is considered very low as the competent vectors commonly described in the Americas are absent in continental Europe. However, there is no evidence that European midge or mosquito species cannot transmit the virus. So far, the disease is limited to the American continent and no outbreaks of Oropouche virus disease have ever been reported in continental Europe. However, further imported cases can be expected in travellers returning from areas with ongoing outbreaks.

### Actions:

ECDC will monitor this event through epidemic intelligence activities and report if new relevant epidemiological information becomes available.

**Last time this event was included in the Weekly CDTR:** 07 June 2024

## 9. Seasonal surveillance of West Nile virus infections – 2024

### Overview:

#### Epidemiological summary

Since the beginning of 2024, and as of 24 July 2024, human cases of West Nile virus infection cases have been reported to TESSy in both EU/EEA and Western Balkan countries. In the EU/EEA, France reported West Nile virus infection cases in addition to Spain, Italy and Greece that had already reported cases the previous weeks. From the Western Balkans, Serbia also reported West Nile Virus in humans.

The first case reported from EU/EEA countries in 2024 was [reported in April 2024](#) in Seville, Spain with the patient developing symptoms in March 2024. Additional cases were reported with onset of symptoms in June and July 2024. In Italy, the first West Nile virus infection was reported in [June 2024 in Modena, Italy](#). On 5 July 2024, [Greece reported](#) that the first West Nile virus case in the country, and third by an EU/EEA country in 2024 had been detected in the region of Larissa, with symptom onset at the end of June 2024.

The ECDC [weekly update](#) and [dashboard](#) has information on places of infection up to 24 July 2024.

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

### Actions:

ECDC is monitoring West Nile virus through indicator- and event-based surveillance activities.

**Last time this event was included in the Weekly CDTR:** 19 July 2024

## 10. Mass gathering monitoring - Olympic and Paralympic Games - France - 2024

### Overview:

#### Update

Since the previous update on 19 July and as of 25 July, no major public health events related to communicable diseases have been detected in the context of the Paris 2024 Olympic Games.

On 23 July, COVID-19 cases were [reported](#) among athletes of the Australian Water Polo Women's Team. Since then, a total of five cases of COVID-19 have been [reported](#).

#### Summary

No major public health events related to infectious diseases have been reported in the context of the 2024 Paris Olympic Games.

Other events outside of the 2024 Paris Olympic Games included the first autochthonous case of dengue in 2024, which was [reported in week 28 in Occitania](#). There are no Olympic venues in Occitania.

#### Background

The Paris [2024 Olympic and Paralympic Games](#) will take place from 26 July to 11 August 2024 and from 28 August to 8 September 2024, respectively. Around 15 000 athletes are expected, 20 countries will be represented, and the event will involve up to 50 000 volunteers. A total of [11.3 million visitors](#) are projected to attend the Olympics and 3.8 million the Paralympics. During the first phase of the ticket sale, there were buyers from 158 different countries, although most buyers were from France.



The Games will be hosted at [13 sites](#) in Paris, 12 sites outside Paris in the Ile-de-France region, as well as 10 sites across eight other cities (Saint-Etienne, Marseille, Lyon, Chateauroux, Nice, Bordeaux, Nantes, Villeneuve-d'Ascq), and one overseas territory (Tahiti). Up to 90% of the competitions will occur in the Ile-de-France region. Different activities will be organised to celebrate the Games across France, and many gatherings will take place. In Paris, the [Club France Paris 2024](#), a special zone with activities for fans, will be held at La Villette: up to 700 000 people are expected to visit to attend activities and celebrations.

### ECDC assessment:

Mass gathering events involve a large number of visitors in an area at the same time. Multiple factors can lead to the emergence of a public health threat such as; imported diseases, increased number of susceptible persons, risk behaviour, sale of food and beverages by street vendors. At the same time, non-communicable health risks, including heat stroke, crowd injury, and drug- and alcohol-related conditions should be considered by the organisers and the public health authorities of the hosting country.

The probability of EU/EEA citizens becoming infected with communicable diseases during the Paris 2024 Olympic and Paralympic Games is considered to be low if general preventive measures are applied, e.g. being fully vaccinated according to the national immunisation schedules, following hand and food hygiene and respiratory etiquette, self isolate should flu-like symptoms occur until symptoms' resolution, wearing a mask in crowded settings and seeking prompt testing and medical advice as needed, and practice safe sex, as per guidance provided by the French authorities. This is particularly important in relation to vaccine-preventable diseases that may be on the increase in the EU/EEA, such as [measles](#), [whooping cough](#) and COVID-19.

### Actions:

ECDC is monitoring this mass gathering event through epidemic intelligence activities between 15 July and 13 September 2024, in collaboration with Santé Publique France and the World Health Organization, and will include weekly updates in the [Communicable Disease Threats Report \(CDTR\)](#).

ECDC has published '[Mass gatherings and infectious diseases, considerations for public health authorities in the EU/EEA](#)', along with additional [public health advice for travellers](#) attending the Paris 2024 Olympic and Paralympic Games.

Further information on the Paris 2024 Olympic and Paralympic Games is available at [Santé Publique France's website](#) and the [French Ministry of Labour, Health, and Solidarity](#).

**Last time this event was included in the Weekly CDTR:** 19 July 2024

## 11. Nipah virus disease - India - 2024

### Overview:

#### Summary

On 21 July 2024, media quoting Indian health authorities [reported](#) a confirmed case of Nipah virus (NiV) in Kerala State, India. Further [media sources reported](#) that the case passed away on 22 July. Epidemiological investigations are ongoing to identify the source of infection. A total of 330 contacts have been identified, of which 101 are considered of high-risk.

#### Background

Nipah virus (Henipavirus nipahense) is a highly pathogenic virus of the family Paramyxoviridae, genus Henipavirus. It was first isolated and identified in 1999 during an outbreak in Malaysia and Singapore. Since then, several outbreaks of NiV disease in Southern and South-Eastern Asia were reported, most cases being reported from Bangladesh. This is the fifth outbreak of NiV disease in Kerala state, being the previous four in 2018 (Kozhikode district), 2019 (Ernakulum district), 2021 (Kozhikode district), and 2023 (Kozhikode).

The outbreak in 2023 had six confirmed cases with ages ranging from 9 to 45 years old. The first case had an unknown source of infection, and the other cases were family and hospital contacts of [the first case](#).

The virus spreads between animals and humans, with most human cases having had direct [contact with pigs or bats](#). NiV can also be transmitted between people through direct contact or indirectly via contaminated food (date palm sap contaminated by bat saliva), or [through aerosols](#). The incubation period is usually 4–14 days. Symptoms range from mild (fever, headache, muscle pain, and nausea) to more serious conditions including severe respiratory symptoms and encephalitis.

**ECDC assessment:**

Although the disease is severe with a high fatality rate, the likelihood of exposure and infection by NiV for EU/EEA citizens travelling or residing in India is currently very low given the low number of infections and of areas where cases have been identified so far; therefore the risk of infection by NiV for EU/EEA citizens travelling or residing in India is therefore also currently very low.

The most likely route of introduction of the virus into the EU/EEA would be via infected travellers. While importation of the virus cannot be excluded, it is currently very unlikely to occur. Should a case be imported, the likelihood of the spread of the virus within the EU/EEA is considered to be very low. It should be highlighted that the natural reservoir host of NiV is not native to Europe.

As a general precaution, EU/EEA travellers and residents in Kerala state, India, should not handle domestic or wild animals and avoid contact with their excreta. The virus may be present on food items contaminated by bats. Washing, peeling, and cooking fruit and vegetables before consumption is generally recommended. Raw date palm sap (juice) should not be consumed.

The laboratory network EVD-LabNet has mapped the capability of its network members for the diagnosis of NiV infections and the result is available in [EVD-LabNet directory](#). Eleven countries within the EU/EEA can perform laboratory diagnostics for NiV infection.

**Actions:**

ECDC is monitoring this event through epidemic intelligence activities.

**Events under active monitoring**

- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 28 June 2024
- Cholera – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 28 June 2024
- Overview of respiratory virus epidemiology in the EU/EEA - weekly monitoring - last reported on 28 June 2024
- Cholera – Comoros and Mayotte – 2024 – Weekly monitoring - last reported on 28 June 2024
- Influenza A(H5N2) - Multi-country (World) - Monitoring human cases - last reported on 28 June 2024
- Seasonal surveillance of West Nile virus infections – 2024 - last reported on 28 June 2024
- Circulating vaccine-derived poliovirus type 2 (cVDPV2) - Palestine\* - 2024 - last reported on 26 July 2024
- Avian influenza A(H5N6) – Multi-country – Monitoring human cases - last reported on 26 July 2024
- SARS-CoV-2 variant classification - last reported on 26 July 2024
- Avian influenza A(H5N1) human cases – United States – 2024 - last reported on 26 July 2024
- Crimean-Congo haemorrhagic fever - Spain - 2024 - last reported on 26 July 2024
- Oropouche virus disease - Multicountry (America) - 2024 - last reported on 26 July 2024
- Mass gathering monitoring - Olympic and Paralympic Games - France - 2024 - last reported on 26 July 2024
- Nipah virus disease - India - 2024 - last reported on 26 July 2024
- Risk assessments under production - last reported on 20 June 2024
- Measles – Multi-country (World) – Monitoring European outbreaks - monthly monitoring - last reported on 19 July 2024
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 19 July 2024
- Imported Oropouche human infections - Multi-country - 2024 - last reported on 19 July 2024
- Mpox Multi-country 2022 - 2024 - last reported on 12 July 2024
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 12 July 2024
- Locally acquired dengue in 2024 in mainland France - last reported on 12 July 2024
- Multi country outbreak of Yersinia enterocolitica linked to raw goat cheese - last reported on 12 July 2024
- Human cases infected with swine influenza A(H1N2) variant virus – Multi-country – 2024 - last reported on 05 July 2024
- Botulism - Germany - 2024 - last reported on 05 July 2024
- Increase in parvovirus B19 detections – Multi-country – 2024 - last reported on 05 July 2024