

## WEEKLY BULLETIN

# Communicable Disease Threats Report

**Week 31, 27 July - 2 August 2024**

## Executive summary

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

- Since the previous update on 26 July and as of 1 August, no major public health events related to communicable diseases have been detected in the context of the Paris 2024 Olympic Games.
- 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 \(CDTR\)](#).

### **Imported Oropouche virus disease cases - Multi-country - 2024**

- Italy has reported five confirmed cases of Oropouche virus (OROV) disease in travellers returning from Cuba (4) and Brazil (1).
- Spain has reported three confirmed OROV disease cases imported from Cuba.
- Germany has reported two confirmed cases of OROV disease in Germany in travellers returning from Cuba.
- The risk of infection for EU/EEA citizens travelling to Cuba or the Americas is low, provided that they follow the instructions of public health authorities on the use of personal protective measures against midge and mosquito bites.
- The likelihood of secondary transmission of OROV within continental Europe is considered to be very low, due to the absence of the known competent vectors commonly found in the Americas.

### **Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks - Monthly update**

- Since the beginning of 2024, approximately 350 000 chikungunya virus disease (CHIKVD) cases and over 140 deaths have been reported worldwide. A total of 21 countries reported CHIKVD cases from the Americas (13), Asia (6), Africa (1) and Europe (1). In mainland Europe, one autochthonous case of CHIKVD has been reported by France in 2024.
- Since the beginning of 2024, over 11 million dengue cases and over 7 000 dengue-related deaths have been reported globally. In mainland Europe, one autochthonous dengue case has been reported by France.
- The current likelihood of local transmission events of chikungunya and dengue viruses occurring in areas where the vector is present in mainland EU/EEA is high, as the environmental conditions are favourable for vector activity and virus replication in vectors.

**Locally acquired chikungunya virus disease in mainland France**

- On 31 July 2024, France reported an autochthonous case of chikungunya virus (CHIKV) disease to ECDC. The case had onset of symptoms on 18 July. The suspected place of infection was Paris or Gennevilliers in the region of Ile-de-France.
- The risk of chikungunya virus disease in residents of and visitors to the suspected places of infection is currently low; however this assessment is made with low confidence.

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

- Since the beginning of 2024, and as of 31 July 2024, West Nile virus (WNV) infection cases have been reported to The European Surveillance System (TESSy) by seven EU/EEA countries (Austria, France, Greece, Hungary, Italy, Romania, and Spain), 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 \(europa.eu\)](#) and [West Nile virus Dashboard \(europa.eu\)](#).

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

- The Cambodia MoH has announced one human case of A(H5N1) avian influenza virus infection.
- The case is a child from Svay Rieng province in Cambodia.
- The patient has been admitted to intensive care unit but their condition has improved.
- This is the 8th human case of A(H5N1) avian influenza virus infection reported from Cambodia this year. The country has also reported one fatality in 2024.
- Since 2003, 906 human cases of avian influenza A(H5N1), including 463 deaths (case-fatality rate (CFR): 51%), have been reported in 24 countries worldwide.

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

Since May, there has been evidence of increased SARS-CoV-2 activity in primary and secondary care in several EU/EEA countries. However, the increase in SARS-CoV-2 positivity was observed without any concurrent increase in number of visits to GPs or hospital admissions due to respiratory symptoms.

- This week, stable or decreasing trends in SARS-CoV-2 activity have been observed.
- SARS-CoV-2 test positivity in secondary care currently remains the highest among persons aged 65 years and above, indicating that vulnerable populations remain at risk of severe disease.
- Vaccination continues to be protective, with stronger protection against more severe disease, although the protective effect wanes over time. Vaccine protection of individuals at high risk of severe outcomes (such as older people) remains important.
- The 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) continues to dominate. The KP.3 subvariant was recently designated as a Variant of Interest by ECDC and is now shown in the weekly report. Its proportion is rapidly increasing among the BA.2.86. However, it is not expected to be associated with increased infection severity or to significantly reduce vaccine effectiveness.

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

- According to French authorities, no further cholera cases have been reported in Mayotte since 12 July. Since 18 March, there have been 221 confirmed cases, five probable and two possible deaths.
- In the Union of Comoros, since the previous update on 24 July, and as of 31 July, local authorities have reported four new cholera cases, but no new deaths. As of 31 July 2024, 10 342 confirmed cholera cases and 149 deaths have been reported in the country.
- Given the decline in the number of autochthonous cholera cases in Mayotte, and in neighbouring Comoros, ECDC has lowered the overall risk from high to moderate.

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

- In June 2024, 45 787 new cholera cases, including 164 new deaths, were reported worldwide. Since 1 January 2024 and as of 30 June 2024, 247 071 cholera cases, including 2 121 deaths, have been reported worldwide.
- New cases have been reported from Afghanistan, Bangladesh, Burundi, Cameroon, Comoros, Democratic Republic of the Congo, Ethiopia, Haiti, India, Kenya, Malawi, Mayotte, Mozambique, Nigeria, Pakistan, Somalia, Syria, Uganda, United Republic of Tanzania, Yemen, Zambia, and Zimbabwe.
- Cholera cases have continued to be reported in western, eastern and southern Africa and the Americas. Cases have also been reported from the outermost regions of the EU. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

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

## Overview

### Update

Since the previous update on 26 July and as of 1 August, no major public health events related to communicable diseases have been detected in the context of the Paris 2024 Olympic Games.

On 31 July, French authorities [reported](#) an autochthonous case of chikungunya in France. The case was reported in Ile-de-France region, with symptom onset 18 July. So far, no further cases have been reported.

### Summary

Since week 30, COVID-19 cases have been reported among athletes at the Olympic villa from the [Australian Polo Women's Team](#), the [United States Swimming Team](#), and the [Great Britain Swimming Team](#).

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 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 sales, 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, and 10 sites in 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 one area at the same time. Multiple factors can lead to the emergence of a public health threat such as an imported disease, increased numbers of susceptible persons, risk behaviour, sales of food and beverages by street vendors, etc. 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 isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, seeking prompt testing and medical advice as needed, and practising 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:** 26 July 2024.

## 2. Imported Oropouche virus disease cases - Multi-country - 2024

### Overview

Italy has reported five confirmed cases of OROV virus disease in travellers returning from Cuba (4) and Brazil (1).

On 7 June 2024, Italy reported that a confirmed case of OROV disease was identified in a traveller who returned from Cuba to the Veneto Region on 26 May. The traveller experienced symptom onset, including fever, arthralgia, arthritis, headache, and retro-orbital pain, on the day of arrival. The case was hospitalised from 28 to 31 May 2024. Blood tests were performed following hospital admission, and molecular testing confirmed OROV disease on 6 June 2024.

Subsequently, two additional cases of OROV disease were confirmed in June and one in July 2024 in travellers returning from Cuba to Italy. In addition, one case was retrospectively identified in a traveller who returned from Brazil, with onset of symptoms in late March 2024.

In July 2024, Spain reported three confirmed cases of OROV infection in travellers returning from Cuba. The cases reside in (and have been notified by) three different autonomous regions in Spain. The symptom onset was from 30 May 2024 to 17 June 2024. The clinical symptoms were mild in all three (fever, myalgia, rash, etc), and all recovered. There is no association among the cases except for a travel history involving Cuba.

On 29 July, Germany reported two confirmed cases of OROV disease in travellers returning from Cuba. Symptoms onset was on 16 June 2024 and 2 July 2024, during their stay in Cuba. One case reported fever, myalgia and headaches and the other reported headaches, feeling very unwell and arthralgia. The patients tested positive for OROV-specific IgG and IgM antibodies after they returned to Germany. There is no known epidemiological link between the two cases.

The first outbreak of OROV disease in Cuba was recently [reported](#).

Italy reports that no additional public health measures were taken, as the primary and secondary vectors of the virus are not currently known to be present in the country. There are no known alternative transmission routes for this virus, and no locally acquired cases have been reported in Europe to date.

### ECDC assessment

Oropouche virus disease is a zoonotic disease caused by the Oropouche virus (OROV) (Orthobunyavirus oropoucheense). Outbreaks of OROV 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 from Europe. Other possible vectors of OROV include the mosquito species *Coquillettidia venezuelensis*, *Mansonia venezuelensis*, *Culex quinquefasciatus* and *Aedes serratus*. However, the evidence for their vector competence is limited. Wild birds and mammals are considered to be the natural hosts of OROV. In humans, OROV disease can manifest as an acute febrile illness (with headache, nausea, vomiting, muscle and joint pains), occasionally with more severe symptoms (e.g. haemorrhages and meningitis). No direct human-to-human transmission of the virus has been documented. However, recently, Brazil [reported](#) two possible vertical transmission cases that are under investigation, which were also reported in an [Epidemiological Alert](#) by PAHO. Furthermore, Brazil [reported](#) a potential foetopathic effect of OROV infection, which is under further investigation.

The risk of infection for EU/EEA citizens travelling to OROV-endemic countries in the Americas is low, provided that they follow the instructions of public health authorities on the use of personal protective measures against midge and mosquito bites. Should a case be imported, the likelihood of observing secondary transmission within continental Europe is considered very low, as the competent vectors commonly described in the Americas are absent from continental Europe. However, there is lack of evidence as to whether European midge or mosquito species could transmit the virus. To date, the disease is limited to the American continent and no outbreaks of OROV disease have ever been reported in continental Europe. However, imported cases can be expected in travellers visiting areas with ongoing outbreaks.

Based on International Air Travel Association (IATA) data, the average number of flight passengers arriving from Cuba to the EU/EEA was about 39 000 per month during the first four months of 2024. During the past two years, the month with the highest number of passengers arriving from Cuba was August, with approximately 49 000 passengers. From January to April 2024, the approximate number of travellers from Cuba to various EU/EEA countries was as follows:

- Spain: 50 000–60 000
- Germany, France: 20 000–30 000
- Italy: 10 000–20 000
- Czechia, Poland: 5 000–10 000
- Portugal, Belgium, Austria, Hungary, Netherlands, Greece: 1 000–5 000
- Sweden, Denmark, Ireland, Romania, Slovakia, Norway, Bulgaria, Finland, Cyprus, Latvia, Croatia, Iceland, Slovenia, Lithuania, Luxembourg, Estonia, Malta: less than 1 000.

Source: International Air Transport Association. MarketIS: IATA; 2024 [Cited 2024 Jun 28]. Requires subscription. Data are the property of IATA and are licenced to ECDC for research purposes.

## Actions

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

## Further information

The Pan American Health Organization (PAHO) issued an [Epidemiological Alert on Oropouche in the Region of the Americas](#) on 2 February 2024.

Castilletti et al. have published a description of Oropouche virus disease cases in Italy, involving two travelers from Cuba, which is available [here](#).

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

## 3. Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks - Monthly update

### Overview

#### Chikungunya virus disease (CHIKVD)

In 2024, approximately 350 000 CHIKVD cases and over 140 deaths have been reported worldwide. A total of 21 countries have reported CHIKVD cases from the Americas (13), Asia (6), Africa (1) and Europe (1).

The majority of countries reporting large numbers of CHIKVD cases are from the Americas, in South and Central America. Countries reporting the highest numbers are Brazil (353 495), Paraguay (2 771), Argentina (680), and Bolivia (372). Other countries in the Americas reporting CHIKVD cases can be found at [PAHO's dedicated website](#).

Outside of the Americas, CHIKVD cases have been reported in Asia from [Pakistan](#) (1 141), the [Maldives](#) (389), [Thailand](#) (256), [India](#) (243), [Timor Leste](#) (195), and [Malaysia](#) (34). One African country has reported CHIKVD cases in 2024: [Senegal](#) (7).

In mainland Europe, one autochthonous case of CHIKVD has been [reported](#) by France (Île-de-France Region), with symptom onset 18 July 2024.

CHIKVD associated deaths have been reported from Brazil (144).

#### Dengue

Since the beginning of 2024, over 11 million dengue cases and over 7 000 dengue-related deaths have been reported from 84 countries/territories. Most cases have been reported from the WHO PAHO region. Over 10 million cases have been reported by PAHO in 2024, with the total number of cases being twice the number reported for 2023. Brazil has reported the most cases in 2024 (over nine million) followed by Argentina, Paraguay, Peru and Colombia (source: [Situation Report No 27 - Dengue Epidemiological Situation in the Region of the Americas - Epidemiological Week 27, 2024 - PAHO/WHO | Pan American Health Organization](#)).

In mainland Europe, imported cases from endemic areas have been reported in 2024 (e.g. in [Germany](#), [Italy](#) and [France](#)) and an autochthonous case has been [reported](#) in France, with symptom onset on 17 July 2024.

Guadeloupe [continues](#) to face an epidemic classified as phase 4, level 1. Although the numbers are decreasing (those presenting with dengue symptoms) cases were continuing to be reported in June/beginning of July. [Since June](#), Martinique has passed to phase 5, based on the decrease in cases to expected/normal levels. In Saint-Martin dengue circulation continues, but at lower levels, with only sporadic cases [reported](#).

In French Guyana, over 8 000 confirmed dengue cases have been reported since the beginning of 2024. However, case numbers are decreasing and have stabilised at lower levels in recent weeks after a peak in January 2024 ([Bimonthly Epidemiological Bulletin published on 25 July 2024](#) and [Dengue Epidemiological Bulletin of 18 July 2024](#)).

Overall, 1 209 cases of dengue had been reported in La Reunion until week 25 (ending on 23 June) 2024, according to the [Epidemiological Bulletin published on 4 July 2024](#). Dengue circulation in 2024 overall has been at higher levels than in 2023. However, cases have been showing a decreasing trend recently, with four cases reported on week 26 (ending 30 June 2024). The current levels of dengue circulation in La Reunion are comparable to those observed in 2023 and 2022 for the same months ([Epidemiological Bulletin of 11 July 2024](#)).

Dengue circulation has also been reported in the [Eastern Mediterranean](#), [South-East Asia](#) and [Western Pacific](#) WHO Regions according to reports from the regional offices (EMRO, SEARO and WPRO, respectively) as well as in [Africa](#) in July 2024.

In the EMRO region, autochthonous cases were reported by Iran in June 2024. Until 17 July 2024, a total of 12 cases had been reported according to the [WHO Disease Outbreak News Item published on 22 July 2024](#). These are the first autochthonous cases reported in the country.

According to the [SEARO report published on 24 July 2024](#), increases in dengue cases were reported in Bangladesh, in Karnataka, India. In Bangladesh overall, the total number of dengue cases for the period January to July 2024 remains lower than that reported for the same period in 2023 (4577 in 2024 as of 14 July compared to 20 837 in 2023). In Karnataka, India, the total number of cases reported until week 28 (ending 13 July) was 2 362. In the Maldives, the total number of cases reported on June 2024 was lower than that reported in May, but overall 1 944 cases were reported between January and June 2024, which is higher than the number reported during the same period in 2023 (total 1 788).

According to the [WPRO Dengue Situation update of 27 July 2024](#), increases in cases are being observed in Cambodia, Laos and Vietnam. In all three countries, while increases are observed, the total number of dengue cases reported up until mid-July was lower than the total number of cases reported during the same period in 2023.

In Africa, according to the [Africa CDC Epidemic Intelligence Report of 28 July 2024](#), 50 370 dengue cases have been reported this year from Burkina Faso, Cameroon, Cabo Verde, Chad, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Mali, Mauritius, Sao Tome and Principe, Senegal and Sudan.

Note: the data presented in this report originate from both official public health authorities and non-official sources, such as news media, and depending on the source, autochthonous and non-autochthonous cases may be included. Data completeness depends on the availability of reports from surveillance systems and their accuracy, which varies between countries. All data should be interpreted with caution and comparisons, particularly across countries, should be avoided due to under-reporting, variations in surveillance system structure, different case definitions from country to country and over time, and use of syndromic definitions.

## ECDC assessment

The Americas is currently facing the largest ever outbreak of dengue. As a result, there has been a substantial increase in the number of imported cases of dengue to the EU/EEA since the beginning of the year.

The likelihood of onward transmission of dengue and chikungunya virus in mainland EU/EEA is linked to importation of the virus by viraemic travellers into receptive areas with established and active competent vectors (e.g. [Aedes albopictus](#) and [Aedes aegypti](#)). [Aedes albopictus](#) is [established](#) in a large part of Europe. In Europe and neighbouring areas, [Aedes aegypti](#) is [established](#) in Cyprus, on the eastern shores of the Black Sea, and in the outermost region of Madeira.

The current likelihood of the occurrence of local transmission events of chikungunya and dengue viruses in areas where the vectors are present in mainland EU/EEA is high, as the environmental conditions are favourable for vector activity and virus replication in vectors. All past autochthonous outbreaks of [CHIKVD](#) and [dengue](#) in mainland EU/EEA have so far occurred between June and November.

More information on autochthonous transmission of [chikungunya](#) and [dengue](#) virus in the EU/EEA is available on ECDC's webpages, and in ECDC's factsheets on [dengue](#) and [CHIKVD](#).

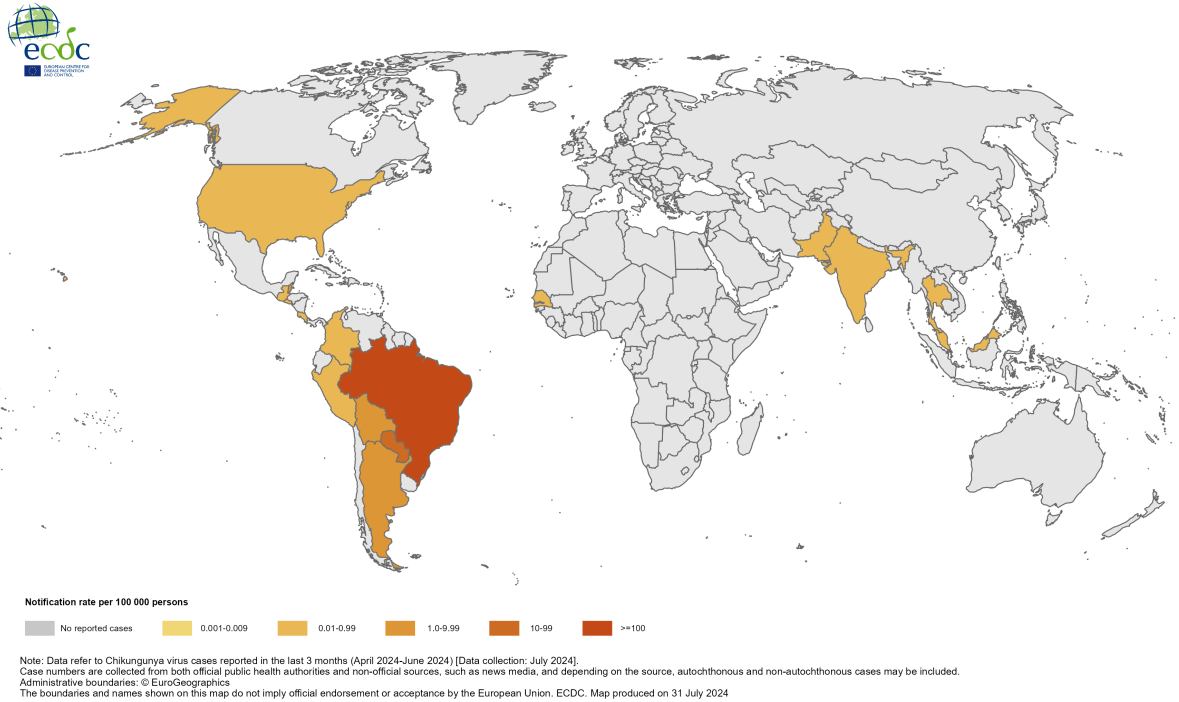
## Actions

ECDC monitors these threats through its epidemic intelligence activities, and reports on a monthly basis. A summary of the worldwide overview of [dengue](#) and [CHIKVD](#) is available on ECDC's website.

**Last time this event was included in the Weekly CDTR:** 28 June 2024.

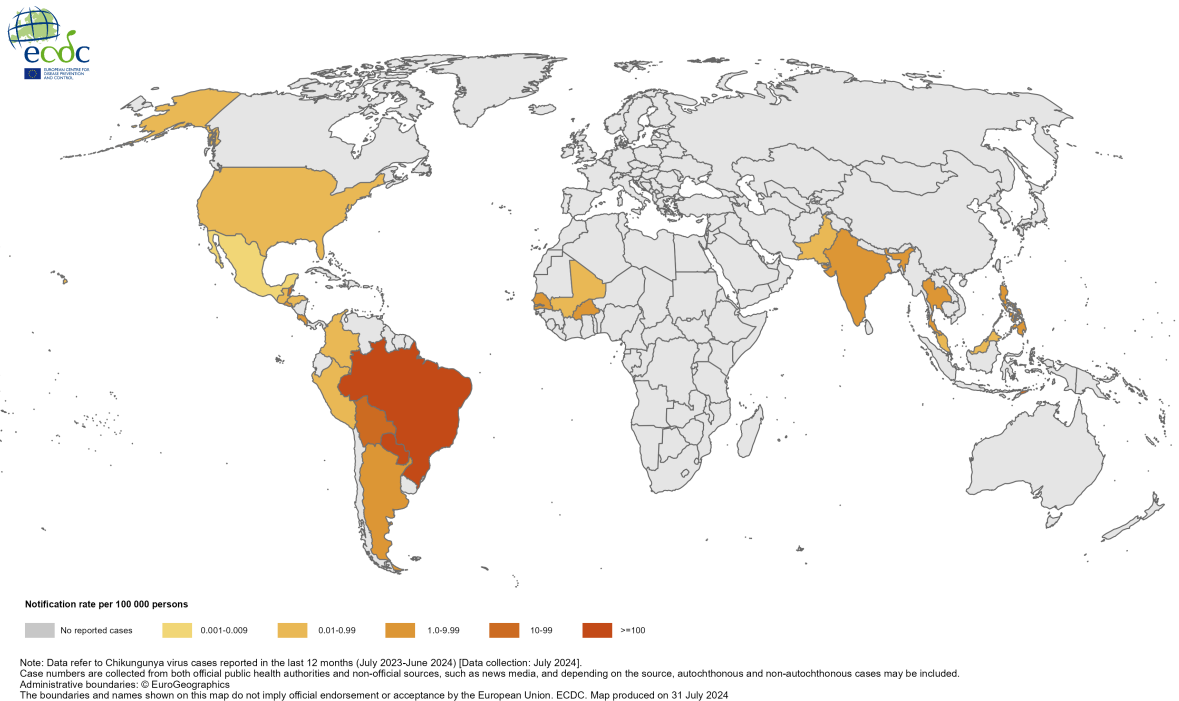
## Maps and graphs

**Figure 1. Three-month Chikungunya virus disease case notification rate per 100 000 population, April-June 2024**



Source: ECDC

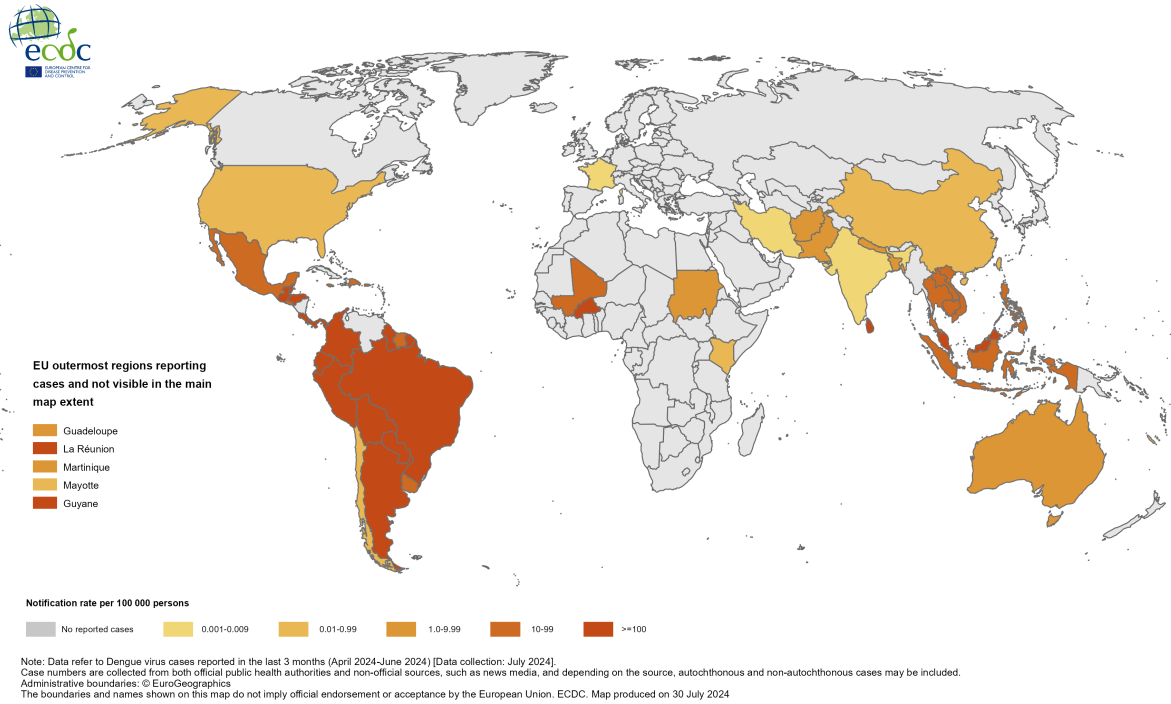
**Figure 2. 12-month Chikungunya virus disease case notification rate per 100 000 population, July 2023-June 2024**



Source: ECDC

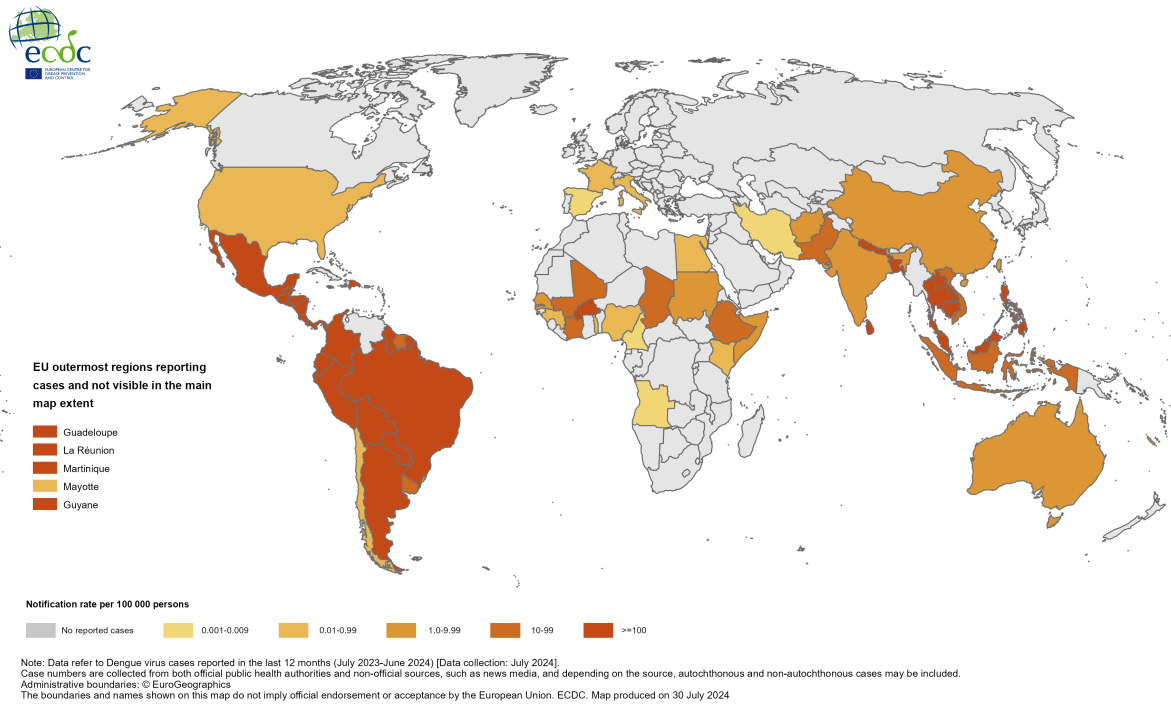


**Figure 3. Three-month dengue virus disease case notification rate per 100 000 population, April-June 2024**



Source: ECDC

**Figure 4. 12-month dengue virus disease case notification rate per 100 000 population, July 2023–June 2024**



Source: ECDC

## 4. Locally acquired chikungunya virus disease in mainland France

### Overview

On 31 July 2024, France [reported](#) a confirmed, autochthonous case of chikungunya virus (CHIKV) disease in Île-de-France with suspected exposure in Paris (Paris Department) and Gennevilliers (Hauts-de-Seine Department). The case had onset of symptoms on 18 July 2024. Since 1 May and as of 30 July 2024, [nine imported chikungunya cases have been reported in France](#).

Globally, since the beginning of 2024, approximately 350 000 CHIKV disease cases and over 140 deaths have been reported worldwide. A total of 21 countries reported CHIKV disease cases in the Americas (13), Asia (6), Africa (1) and Europe (1). Further information on the CHIKV cases worldwide are published on the dedicated page: [Chikungunya worldwide overview \(europa.eu\)](#). Since 1 May 2024, [nine imported cases of chikungunya have been reported in France](#).

### ECDC assessment

This is the first autochthonous chikungunya virus disease case reported in Europe since 2017. In France, autochthonous CHIKV disease cases were reported in 2010 (two cases in Var department), in 2014 (12 cases in Hérault department) and in 2017 (17 cases in Var department). In the past, local outbreaks of CHIKV disease in Europe have been reported by Italy and France. More information is available on ECDC's dedicated webpage on autochthonous transmission of [chikungunya virus in the EU/EEA](#), and in ECDC's [chikungunya virus disease factsheet](#).

The yellow fever mosquito (*Aedes aegypti*) and the Asian tiger mosquito (*Aedes albopictus*) are the principal vectors of CHIKV. Certain genetic markers of CHIKV are associated with vectorial competence by *Ae. albopictus*. Previous autochthonous transmission of CHIKV in Europe has been attributed to *Ae. albopictus*, which is established on a large part of the continent.

The early detection of this case is the result of enhanced surveillance for mosquito-borne diseases in France.

According to the information currently available, the probability of further transmission of CHIKV at the suspected places of infection in France is very low, as no competent vectors were identified at the places visited by the case. Although CHIKV can cause severe disease, it is unlikely that a significant number of people would be affected (in the absence of vectors). Therefore the impact of the outbreak is low. Consequently, the risk for chikungunya virus disease in residents of and visitors to the suspected places of infection (Paris and Gennevilliers) is low. However, the confidence of this assessment is low, as epidemiological and entomological investigations are still ongoing. *Ae. albopictus* is established in Paris and Hauts-de-Seine departments, and the current environmental conditions are favourable for *Ae. albopictus* propagation and vectorial transmission of CHIKV. Therefore, further autochthonous transmissions cannot be excluded.

### Actions

Epidemiological and entomological investigations (e.g. monitoring of laboratory platform data and health professional reporting, genetic characterisation of the virus, mosquito monitoring) are ongoing. Relevant measures are being taken by France's public health authorities, including awareness-raising among health professionals. Blood donations collected in Paris and surrounding departments are already being screened for CHIKV since 23 July as a preventive measure. Throughout France, donors who travelled in the vicinity of the places visited by the case for at least a day will also be screened for CHIKV to prevent transmission through substances of human origin.

ECDC continues to monitor this event and will provide timely updates.

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

### Overview

#### Epidemiological summary

Since the beginning of 2024, and as of 31 July 2024, human cases of West Nile virus (WNV) infection cases have been reported to TESSy from both EU/EEA and Western Balkan countries. In the EU/EEA, Austria, Hungary, and Romania have recently reported WNV infection cases, in addition to France, Italy, Greece and Spain that had already reported cases in previous weeks. From the Western Balkans, Serbia has also reported WNV infections in humans.

The first case reported from EU/EEA countries in 2024 occurred [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 WNV was reported in [June 2024 in Modena, Italy](#). On 5 July 2024, [Greece reported](#) its first WNV case for 2024. In July, cases were also reported in Austria, France, Hungary and Romania.

The ECDC [weekly update](#) and [dashboard](#) has information on places of infection up to 31 July 2024.

More background information on the Commission Directives on blood safety and EU/EEA notifications of WNV infections can be found in ECDC's weekly surveillance report on WNV infections which is available online ([Weekly updates: 2024 West Nile virus transmission season \(europa.eu\)](#)) and 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:** 26 July 2024.

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

### Overview

#### Update

On 1 August 2024, Cambodia MoH has reported a human case of A(H5N1) avian influenza virus infection in a child from Romeas Hek

district, Svay Rieng province ([Ministry of Health in Cambodia](#)). The case developed fever, cough, tiredness, difficulty in breathing and drowsiness and was admitted to an intensive care unit. The patient's condition has since improved.

The case has been laboratory confirmed by National Institute of Public Health and the Pasteur Institute in Cambodia on 30 July 2024. Virus clade has not yet been announced.

According to investigation by local authorities, 12 days prior the onset of disease the case had exposure to a large number of dead chickens and other poultry and brought dead poultry home for consumption.

Since 2003, Cambodia has reported 70 human H5N1 cases with 42 fatalities, highlighting the ongoing zoonotic transmission risk in the region. National and local health authorities together with the Ministry of Agriculture, Forestry and Fisheries and the Ministry of Environment continue to search for sources of transmission in both animals and humans, and are conducting contact tracing, administering Tamiflu prophylaxis to close contacts, and emphasizing the importance of proper handling and cooking of poultry to prevent further infections.

#### Summary

Globally, since 2003, and as of 22 May 2024, there have been 906 human cases\*, including 463 deaths (CFR: 51%), with avian influenza A(H5N1) infection reported in 24 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, Indonesia, India, Iraq, Laos, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Vietnam, United Kingdom and the United States). To date, no sustained human-to-human transmission has been detected. In 2024, 24 cases, including two deaths, have been reported in four countries: Cambodia (eight cases, one death), the United States (thirteen cases), Vietnam (two cases, one death), and Australia (one case).

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

## ECDC assessment

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

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

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

## Actions

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

**Last time this event was included in the Weekly CDTR:** 26 July 2024.

## 7. 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 at 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 most EU/EEA countries, at similar levels to those observed during summer 2023.

#### Evidence of continuing SARS-CoV-2 activity in both primary and secondary care was observed for some reporting EU/EEA countries.

- SARS-CoV-2 activity started about six weeks earlier than during summer 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), pooled test positivity remained at 29%, with the median test positivity also stable at 20%. One country (Spain) continues to contribute to >60% of all tested samples and reported 35% positivity, driving the divergence between pooled and median estimates.
- In SARI sentinel systems (hospitals), the pooled test positivity decreased to 16%, with test positivity ranging from 10 to 25% in the five reporting countries (Germany, Greece, Ireland, Malta and Spain). The age group 65 years and above remained the most affected (20% positivity).
- Despite test positivity in primary and secondary care sentinel systems remaining above 10%, sentinel syndromic ILI and ARI rates showed no increase above baseline levels in most countries.
- Non-sentinel secondary care data showed similar trends to the sentinel system, with three EU/EEA countries reporting a decrease in the number of positive test results among hospitalised patients, and only one country continuing to report increasing numbers. In addition, a stable or decreasing number of deaths related to SARS-CoV-2 was observed in two countries.

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

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

#### Virus characterisation

##### Influenza for week 40, 2023 to week 30, 2024

During the above period, 3 896 A(H1)pdm09, 1 570 A(H3) and 553 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the viruses that have been assigned to a clade:

- 3 889 were A(H1)pdm09 – 2 687 (69%) were subclade 5a.2a and 1 202 (31%) were subclade 5a.2a.1.
- 1 567 were A(H3) – 30 (2%) were subclade 2a, one (0.1%) was subclade 2a.1b, 11 (0.7%) were subclade 2a.3a, 1 524 (97%) were subclade 2a.3a.1, and one (0.1%) was subclade 2a.3b.
- 553 were B/Vic – all were subclade V1A.3a.2.

##### SARS-CoV-2 variants for weeks 28–29 (8 July to 21 July 2024)

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

- 56% (48–69%) for KP.3 (396 detections from seven countries).
- 44% (30–52%) for other variants included in BA.2.86 (222 detections from seven 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 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](https://eriss.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: 26 July 2024.

## Maps and graphs

**Figure 1. Overview of key indicators of activity and severity in week 30**

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 30	Week 29	Description	Value	
Primary care consultation rates	ARI	8 rates (6 MEM)	9 rates (7 MEM)	Distribution of country MEM categories	6 Baseline	Stable rates continue to be reported at levels comparable to the same time last year.
	ILI	12 rates (12 MEM)	13 rates (13 MEM)		11 Baseline 1 Medium	Stable rates continue to be reported at levels comparable to the same time last year, except for one country reporting an increase over the past two weeks.
Primary care sentinel positivity	SARS-CoV-2	10	15	Pooled (median; IQR)	29% (21; 18–25%)	Stable trend in pooled test positivity compared to last week. Only one country reporting >35% positivity this week; one country reporting 29% positivity; and the remaining countries reporting between 14 and 23% positivity.
	Influenza	9	15		1.1% (0; 0–1.2%)	Stable trend of very low circulation.
	RSV	9	14		0.2% (0; 0–0%)	Stable trend of very low circulation.
SARI consultation rates	SARI	7	7			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)	16% (15; 13–20%)	Decreasing trend observed this week in both pooled test positivity and median test positivity; two countries reporting 20-25% positivity this week and three countries reporting 10-15% positivity. In data from non-sentinel sources, three countries reported a decrease in hospitalisation, but one country continued to report an increase in hospitalisation; the number of deaths associated with SARS-CoV-2 was stable in one country, and another showed a decrease in the number of deaths.
	Influenza	5	6		1.1% (0.5; 0–0.6%)	Stable trend with very low circulation; but one country reported 15% positivity with >20 samples being tested.
	RSV	5	5		0.5% (0; 0–0%)	Stable trend with very low circulation.
Intensity (country-defined)	Influenza	17	18	Distribution of country qualitative categories	13 Baseline 4 Low	
Geographic spread (country-defined)	Influenza	16	17	Distribution of country qualitative categories	11 No activity 3 Sporadic 2 Regional	

Source: ECDC

**Figure 2. Virological distribution for week 30 and the period week 25, 2024 to week 30, 2024**

Pathogen or (sub-)type	Primary care sentinel						SARI sentinel						Non-sentinel			
	Week 30			Period 2024-2025			Week 30			Period 2024-2025			Week 30		Period 2024-2025	
	n	%	positivity	n	%	positivity	n	%	positivity	n	%	positivity	n	%	n	%
<b>Influenza</b>	7	100	1.1%	64	100	1.2%	7	100	1.1%	50	100	0.9%	146	100	1 439	100
Influenza A (total)	6	86	1%	39	64	0.7%	5	100	0.8%	26	84	0.5%	116	83	783	59
A(H1)pdm09	1	25		17	53								9	45	171	54
A(H3)	3	75		15	47		1	100		1	100		11	55	144	46
A (unknown)	2			7			4			25			96		468	
Influenza B (total)	1	14	0.2%	22	36	0.4%				5	16	0.1%	23	17	536	41
B/Vic	1	100		6	100										20	100
B (unknown)				16						5			23		516	
Influenza untyped				3		0.1%	2		0.3%	19		0.4%	7		120	
<b>RSV</b>	1		0.2%	7		0.1%	3		0.5%	9		0.2%	15		232	
<b>SARS-CoV-2</b>	156		29.4%	1 451		29.5%	102		15.6%	1 065		19.2%	18 219		84 796	

Source: ECDC

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

### Overview

#### Update

According to [French authorities](#), no further cholera cases have been reported in Mayotte since 12 July 2024.

Since 18 March, [French health authorities](#) have reported 221 confirmed cases, five probable and two possible deaths. Of the 221 confirmed cases, 199 cases were acquired locally and 22 were imported. A total of 1 243 contacts have received antibiotic chemoprophylaxis and 18 766 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 24 July, and as of 31 July, [local authorities](#) have reported four new cholera cases and no new deaths. As of 31 July 2024, 10 342 confirmed cholera cases and 149 deaths have been reported in the country. In all, 10 193 cases have recovered since the start of the outbreak.

#### 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 absence of autochthonous cases of cholera in Mayotte since mid-July, and the decline in the number of new cases in neighbouring Comoros, ECDC assesses the likelihood of further community transmission of cholera in Mayotte as very low to low. Importation of cases to Mayotte remains possible. The impact of the cholera outbreak in Mayotte is estimated to be very low, considering the [measures](#) taken in recent months. The overall risk of cholera for the population in Mayotte is therefore assessed as very low to low.

Early detection and response activities are essential and have been reinforced in the French territory of Mayotte, along with 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:** 26 July 2024.



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

### Overview

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

### Summary

Since 1 June 2024 and as of 30 June 2024, 45 787 new cholera cases, including 164 new deaths, have been reported worldwide.

The five countries reporting most cases are Afghanistan (23 592), Pakistan (7 815), Democratic Republic of the Congo (3 589), Somalia (2 582), and Comoros (2 536).

The five countries reporting most new deaths are Nigeria (40), Yemen (35), Comoros (25), Afghanistan (13), and the Democratic Republic of the Congo (13).

In addition, 50 535 new cases were reported or collected retrospectively from before 1 June 2024.

New cases have been reported from Afghanistan, Bangladesh, Burundi, Cameroon, Comoros, Democratic Republic of the Congo, Ethiopia, Haiti, India, Kenya, Malawi, Mayotte, Mozambique, Nigeria, Pakistan, Somalia, Syria, Uganda, United Republic of Tanzania, Yemen, Zambia, and Zimbabwe.

Since 1 January 2024 and as of 30 June 2024, 247 071 cholera cases, including 2 121 deaths, have been reported worldwide.

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

#### Africa

**Burundi:** Since 31 May 2024 and as of 30 June 2024, 80 new cases have been reported. Since 1 January 2024 and as of 30 June 2024, 528 cases, including one death, have been reported. In comparison, in 2023 and as of 28 May 2023, 450 cases, including seven deaths were reported.

**Cameroon:** Since 31 January 2024 and as of 30 June 2024, 273 new cases have been reported. Since 1 January 2024 and as of 30 June 2024, 411 cases, including 27 deaths have been reported. In comparison, in 2023 and as of 7 May 2023, 720 cases, including 43 deaths were reported.

**Comoros:** Since 31 May 2024 and as of 30 June 2024, 2 536 new cases, including 25 new deaths have been reported. Since 1 January 2024 and as of 30 June 2024, 9 871 cases, including 146 deaths have been reported. In comparison, in 2023 and as of 30 June 2023, no cases had been reported.

**Democratic Republic of the Congo:** Since 24 May 2024 and as of 30 June 2024, 3 589 new cases, including 13 new deaths have been reported. Since 1 January 2024 and as of 30 June 2024, 20 143 cases, including 298 deaths have been reported. In comparison, in 2023 and as of 7 May 2023, 18 794 cases, including 104 deaths, were reported.

**Ethiopia:** Since 31 May 2024 and as of 16 June 2024, 1 457 new cases, including 10 new deaths have been reported. Since 1 January 2024 and as of 16 June 2024, 17 796 cases, including 136 deaths have been reported. In comparison, in 2023 and as of 13 May 2023, 5 451 cases, including 77 deaths, were reported.

**Kenya:** Since 31 May 2024 and as of 16 June 2024, 12 new cases have been reported. Since 1 January 2024 and as of 16 June 2024, 265 cases, including one death, have been reported. In comparison, in 2023 and as of 29 June 2023, 8 735 cases, including 137 deaths, were reported.

**Malawi:** Since 31 May 2024 and as of 16 June 2024, eight new cases have been reported. Since 1 January 2024 and as of 16 June 2024, 261 cases, including three deaths have been reported. In comparison, in 2023 and as of 20 June 2023, 41 429 cases, including 1 185 deaths, were reported.

**Mozambique:** Since 31 May 2024 and as of 30 June 2024, 281 new cases, including two new deaths have been reported. Since 1 January 2024 and as of 30 June 2024, 8 109 cases, including 17 deaths have been reported. In comparison, in 2023 and as of 29 May 2023, 30 966 cases, including 134 deaths, were reported.

**Nigeria:** Since 24 May 2024 and as of 30 June 2024, 764 new cases, including 40 new deaths have been reported. Since 1 January 2024 and as of 30 June 2024, 1 579 cases, including 54 deaths have been reported. In comparison, in 2023 and as of 28 May 2023, 1 851 cases, including 52 deaths were reported.

**Somalia:** Since 31 May 2024 and as of 30 June 2024, 2 582 new cases, including 13 new deaths have been reported. Since 1 January 2024 and as of 30 June 2024, 14 909 cases, including 127 deaths have been reported. In comparison, in 2023 and as of 4 June 2023, 9 391 cases, including 28 deaths, were reported.

**Uganda:** Since 29 February 2024 and as of 17 May 2024, 14 new cases, including two new deaths have been reported. Since 1 January 2024 and as of 17 May 2024, 52 cases, including three deaths, have been reported. In comparison, in 2023 and as of 30 June 2023, no cases were reported.

**United Republic of Tanzania:** Since 17 May 2024 and as of 30 June 2024, 104 new cases, including 10 new deaths, have been reported. Since 1 January 2024 and as of 30 June 2024, 3 301 cases, including 52 deaths have been reported. In comparison, in 2023 and as of 4 May 2023, 82 cases, including three deaths, were reported.

**Zambia:** Since 31 May 2024 and as of 22 June 2024, 103 new cases have been reported. Since 1 January 2024 and as of 22 June 2024, 20 059 cases, including 612 deaths, have been reported. In comparison, in 2023 and as of 22 June 2023, 757 cases, including 14 deaths, were reported.

**Zimbabwe:** Since 31 May 2024 and as of 30 June 2024, 227 new cases, including three new deaths, have been reported. Since 1 January 2024 and as of 30 June 2024, 19 409 cases, including 385 deaths, have been reported. In comparison, in 2023 and as of 28 May 2023, 1 649 cases, including 44 deaths, were reported.

## Americas

**Haiti:** Since 30 April 2024 and as of 18 May 2024, 280 new cases have been reported. Since 01 January 2024 and as of 18 May 2024, 6 763 cases, including 119 deaths have been reported. In comparison, in 2023 and as of 11 June 2023, 26 357 cases, including 363 deaths were reported.

## Asia

**Afghanistan:** Since 25 May 2024 and as of 29 June 2024, 23 592 new cases, including 13 new deaths have been reported. Since 01 January 2024 and as of 29 June 2024, 70 350 cases, including 38 deaths have been reported. In comparison, in 2023 and as of 10 June 2023, 67 754 cases, including 27 deaths, were reported.

**Bangladesh:** Since 20 May 2024 and as of 27 May 2024, one new case has been reported. Since 1 January 2024 and as of 27 May 2024, nine cases have been reported. In comparison, in 2023 and as of 24 May 2023, 34 609 cases were reported.

**India:** Since 6 May 2024 and as of 12 May 2024, 225 new cases have been reported. Since 1 January 2024 and as of 12 May 2024, 2 226 cases, including six deaths, have been reported. In comparison, in 2023 and as of 18 June 2023, 616 cases were reported.

**Pakistan:** Since 20 May 2024 and as of 10 June 2024, 7 815 new cases have been reported. Since 1 January 2024 and as of 10 June 2024, 26 133 cases have been reported. In comparison, in 2023 and as of 15 June 2023, 9 343 cases were reported.

**Syria:** Since 20 May 2024 and as of 27 May 2024, 513 new cases have been reported. Since 1 January 2024 and as of 27 May 2024, 10 640 cases have been reported. In comparison, in 2023 and as of 15 June 2023, 114 064 cases, including 621 deaths, were reported.

**Yemen:** Since 31 May 2024 and as of 17 June 2024, 2 297 new cases, including 35 new deaths have been reported. Since 1 January 2024 and as of 17 June 2024, 11 483 cases, including 93 deaths have been reported. In comparison, in 2023 and as of 11 June 2023, 3 878 cases, including four deaths were reported.

## Europe

### Outermost regions

**Mayotte:** Since 31 May 2024 and as of 26 June 2024, 67 new cases have been reported. Since 1 January 2024 and as of 26 June 2024, 210 cases, including two deaths, have been reported. In comparison, in 2023 and as of 30 June 2023, no cases had been reported.

## ECDC assessment

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

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

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

According to the World Health Organization (WHO), vaccination should be considered for travellers at higher risk, such as emergency and relief workers who are likely to be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek advice from travel health clinics to assess their personal risk and apply precautionary sanitary and hygiene measures to prevent infection. Such measures can include drinking bottled water or water treated with chlorine, carefully washing fruit and vegetables

with bottled or chlorinated water before consumption, regularly washing hands with soap, eating thoroughly cooked food, and avoiding the consumption of raw seafood products.

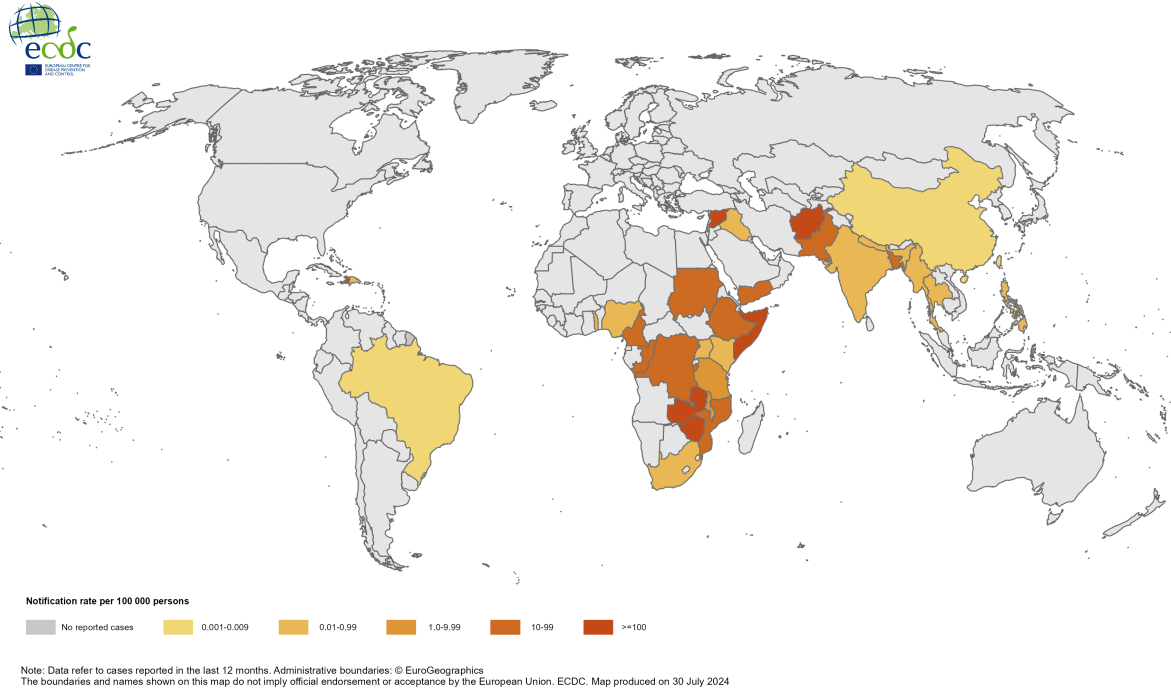
**Actions**

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

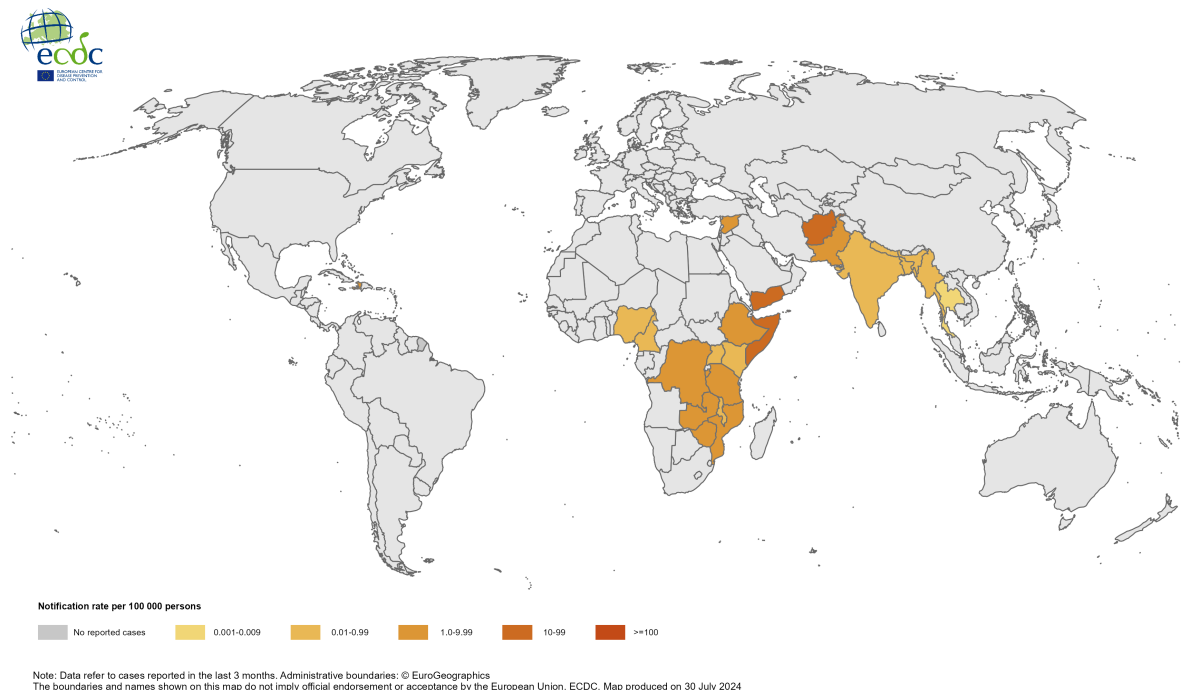
**Last time this event was included in the Weekly CDTR:** 28 June 2024

**Maps and graphs**

**Figure 1. Geographical distribution of cholera cases reported worldwide from May 2023 to June 2024**



Source: ECDC

**Figure 2. Geographical distribution of cholera cases reported worldwide from April to June 2024**

Source: ECDC

## 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
- Measles – Multi-country (World) – Monitoring European outbreaks - monthly monitoring - last reported 19 July 2024
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 19 July 2024
- Imported Oropouche virus disease cases - 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 5 July 2024
- Botulism - Germany - 2024 - last reported on 5 July 2024
- Increase in parvovirus B19 detections – Multi-country – 2024 - last reported on 5 July 2024
- Locally acquired chikungunya virus disease in mainland France - last reported on 2 August 2024.