WEEKLY BULLETIN

Communicable Disease Threats Report

Week 39, 21–27 September 2024

This week's topics

Executive summary

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

- Since late spring and during summer 2024, increased SARS-CoV-2 activity in primary and secondary care has been observed in several EU/EEA countries. The timing of the epidemic varies between EU/EEA countries, with most countries now observing a stable or declining trend. However, some countries continue to experience elevated levels of test positivity.
- SARS-CoV-2 test positivity in secondary care remains below levels observed during previous seasons at this time of year. The highest test positivity is among individuals aged 65 years and above, indicating that vulnerable populations remain at risk of severe disease.
- The SARS-CoV-2 variant BA.2.86 and its subvariants, including KP.3, continue to dominate in EU/EEA countries.
- Vaccination is the most effective measure to protect against more severe forms of COVID-19 and seasonal influenza. Since the protective effect wanes over time, promoting vaccination against respiratory viral diseases according to national recommendations before the beginning of the winter season remains important for all EU/EEA countries, particularly to protect individuals at higher risk of severe outcomes.

European Centre for Disease Prevention and Control, Solna, Sweden
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Mpox due to monkeypox virus clade I and II – Global outbreak – 2024

- The epidemiological situation regarding monkeypox virus (MPXV) clade I and clade II circulation globally has not significantly evolved during the past week.
- Among countries which had previously reported clade Ib cases, the Democratic Republic of Congo, Burundi, Kenya, Rwanda, and Uganda reported new cases during the past week.
- In addition, two imported cases have been reported in India, one of which has been identified as MPXV clade Ib.
- ECDC is closely monitoring and assessing the epidemiological situation and additional related information can be found in ECDC's Rapid Risk Assessment published on 16 August (Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries), and its Rapid scientific advice on public health measures.

Locally acquired dengue in 2024 in mainland France

- In 2024, and as of 25 September, 68 locally acquired dengue cases have been reported in mainland France.
- Cases have been reported in the following departments: Alpes-Maritimes (8 cases), Drôme (2 cases), Hérault (2 cases), Pyrénées-Orientales or Lozère (2 cases), Vaucluse (18 cases), and Var (36 cases).
- Investigations are ongoing and vector control measures are being carried out.
- Every Wednesday, the French National Public Health Agency updates its website with new cases of dengue.

Seasonal surveillance of West Nile virus infections – 2024

- Since the beginning of 2024, and as of 25 September 2024, West Nile virus (WNV) infection cases have been reported to The European Surveillance System (TESSy) by 13 EU/EEA countries (Austria, Bulgaria, Croatia, Czechia, France, Germany, Greece, Hungary, Italy, Romania, Slovakia, Slovenia, and Spain) and five EU neighbouring countries (Albania, Kosovo*, North Macedonia, Serbia, and Türkiye).
- More information, including maps and a dashboard, are available in ECDC's weekly surveillance report on West Nile virus infections: Weekly updates: 2024 West Nile virus transmission season (europa.eu) and West Nile virus Dashboard (europa.eu). Monthly epidemiological updates are available at: Monthly updates: 2024 West Nile virus transmission season (europa.eu).

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

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

- On the 20th of September the US CDC provided an update on the recent avian influenza A(H5N1) infection in a person in Missouri including further details on the follow-up investigation. A second healthcare worker who experienced mild respiratory symptoms was identified through contact tracing. They were not tested for influenza as they had already recovered at the time of investigation but will be offered serological testing.
- In 2024, and as of 24 September 2024, a total of 14 people with avian influenza A(H5) have been reported in the United States. From these, four people were workers exposed to dairy cattle infected or presumed to be infected with A(H5N1) and nine people were workers exposed to commercial egg layer farms with outbreaks of HPAI A(H5). The most recent person had no known animal exposure identified.
- 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.

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

- On 26 August 2024, the IHR National Focal Point for Ghana notified the World Health Organization (WHO) of one human case of avian influenza A(H9N2) virus.
- The patient is a child with no known exposure to poultry or any sick person with similar symptoms.
- No onward transmission among close contacts was found, although the investigation was delayed.
- This is the first human case of avian influenza A(H9N2) reported from Ghana.
- Since 1998, 140 human cases of A(H9N2), including two deaths, have been confirmed globally. No human cases have been reported in the EU/EEA.
- The risk to human health in the EU/EEA is currently considered very low.

Human cases of swine influenza A(H3N2) variant virus – Multi-country

- Two human cases of influenza A(H3N2)v virus infection were reported by the Minnesota Department of Health.
- Both persons were under 18 and reported exposure to swine at the same agricultural fair.
- Symptoms started during week 36, did not require hospitalisation, and resolved completely.
- The investigation concluded that no person-to-person transmission occurred.

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

- In August 2024, 60 834 new cholera cases, including 227 new deaths, were reported worldwide. Since 1 January 2024, and as of 31 August 2024, 371 381 cholera cases, including 2 517 deaths, have been reported worldwide.
- New cases have been reported from Afghanistan, Bangladesh, Burundi, China, Comoros, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, Kenya, Mozambique, Nepal, Nigeria, Pakistan, Somalia, Sudan, Syria, Togo, and Yemen.
- Cholera cases continue to be reported in Africa, Asia, the Americas, and the Middle East. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

- In 2024, as of 24 September, 40 cases of wild poliovirus infection have been reported, in Pakistan (21) and Afghanistan (19).
- In 2024, as of 24 September, overall, six cases of acute flaccid paralysis (AFP) caused by circulating vaccine-derived poliovirus type 1 (cVDPV1) were reported by the Democratic Republic of Congo (5) and Mozambique (1), and 165 cases of AFP caused by cVDPV2 were reported in 16 countries.

1. 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, similar to the levels observed during previous seasons at this time of year. However, several reporting countries show increasing trends in ILI and ARI rates.

- **SARS-CoV-2 activity is variable in both primary and secondary care in EU/EEA countries.**
  - In summer 2024, SARS-CoV-2 activity increased about six weeks earlier than in 2023. However, the levels 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 has fluctuated, increasing from last week to 24%. At the country level, most reporting countries observed a stable or decreasing trend in test positivity.
  - In SARI sentinel systems (hospitals), the pooled test positivity remained stable at 15%, with test positivity ranging from 2.5–35% in the four reporting countries (Germany, Greece, Ireland, and Malta). The age group 65 years and above remained the most affected (21% test positivity).
  - Non-sentinel secondary care notifications were at low levels overall, with most EU/EEA countries that report these indicators reporting stable or decreasing trends in the number of positive test results among hospitalised, ICU-admitted patients, and deaths. However, Czechia and Slovakia continued to show an increasing number of SARS-CoV-2 positive hospitalised patients.
  - An increase in the number of deaths related to SARS-CoV-2 has been observed in seven countries (Bulgaria, Czechia, Hungary, Lithuania, Poland, Romania, and Sweden) over the past few weeks, but numbers are relatively low; other countries reported decreasing or stable numbers.
  - Despite test positivity in primary and secondary care sentinel systems remaining elevated, sentinel syndromic rates (ILI/ARI/SARI) showed no clear elevation above baseline or low levels.

- **Seasonal influenza activity at the EU/EEA level remained stable at low levels in almost all reporting EU/EEA countries. One country (Malta) has continued to report elevated SARI sentinel test positivity rates (>15%) since week 31, with type A influenza viruses detected (subtype unknown).**
- **Respiratory syncytial virus (RSV) activity remained low in the reporting EU/EEA countries.**

Virus characterisation

Influenza for week 40, 2023 to week 38, 2024

- In the above period, 6 199 A(H1)pdm09, 2 245 A(H3) and 1 157 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the viruses that have been assigned to a clade:
- 6 192 were A(H1)pdm09 – 4 628 (75%) were subclade 5a.2a and 1 564 (25%) were subclade 5a.2a.1.
- 2 242 were A(H3) – 30 (1%) were subclade 2a, 13 (0.6%) were subclade 2a.3a, 2 198 (98%) were subclade 2a.3a.1, and 1 (0%) was subclade 2a.3b.
- 1 153 were B/Vic – all were subclade V1A.3a.2.

SARS-CoV-2 variants for weeks 36–37 (2 September to 15 September 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:
- 20% (12–25%) for BA.2.86 (198 detections from 10 countries)
- 71% (61–79%) for KP.3 (557 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. 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, elevations in these severity indicators in some countries highlights the continued need to monitor the impact of SARS-CoV-2 at national and regional levels.

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 autumn 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, in accordance with 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: 20 September 2024

Table 1. Overview of key indicators of activity and severity in week 38

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 38	Week 37	Description	Value	
Primary care consultation rates	ARI	7 rates (6 MEM)	9 rates (7 MEM)	Distribution of country MEM categories	5 Baseline 1 Low	ARI rates continued to be reported at levels comparable to past seasons at the same time of year. Though some reporting countries showed increasing rates, the intensity remained at baseline or low levels.
	ILI	12 rates (12 MEM)	13 rates (13 MEM)		11 Baseline 1 Low	ILI rates continued to be reported at levels comparable to past seasons at the same time of year. Though some reporting countries showed increasing rates, the intensity remained at baseline or low levels.
Primary care sentinel positivity	SARS-CoV-2	11	14	Pooled (median; IQR)	24% (17; 9.7–24%)	Pooled test positivity continued to fluctuate, increasing from last week. By country, test positivity ranged between 5% and 94% with variable trends.
	Influenza	11	15		1% (0; 0–1.9%)	Stable trend of very low circulation.
	RSV	11	15		0% (0; 0–0%)	Stable trend of very low circulation.
SARI consultation rates	SARI	6	8			Stable rates continued to be reported at levels comparable to past seasons at the same time of year.
SARI positivity	SARS-CoV-2	4	7	Pooled (median; IQR)	15% (16; 12–21%)	Stable trends observed this week in both pooled test positivity and median test positivity. Most countries show stable or decreasing trends. In data from non-sentinel sources, two countries (Czechia and Slovakia) show increasing trends in hospitalisation, while in other countries the number of reported hospitalised cases are stable or decreasing.
	Influenza	4	7		2.1% (3.6; 1.1–9.8%)	Stable trend with very low circulation. One country continued to report elevated, though decreasing, test positivity (Malta, 21%).
	RSV	4	7		0% (0; 0–0%)	Stable trend of very low circulation.
Intensity (country-defined)	Influenza	16	18	Distribution of country qualitative categories	14 Baseline 2 Low	
Geographic spread (country-defined)	Influenza	15	17	Distribution of country qualitative categories	9 No activity 5 Sporadic 1 Regional	

Source: ECDC

Table 2. Virological distribution for week 38 and the period week 25, 2024 to week 38, 2024

Pathogen or (sub-)type	Primary care sentinel						SARI sentinel						Non-sentinel			
	Week 38			Period 2024-2025			Week 38			Period 2024-2025			Week 38		Period 2024-2025	
	n	%	positivity	n	%	positivity	n	%	positivity	n	%	positivity	n	%	n	%
Influenza	6	100	1%	173	100	1.5%	12	100	2.1%	195	100	1.6%	144	100	3 806	100
Influenza A (total)	5	83	0.8%	118	71	1.1%	11	100	1.9%	155	96	1.3%	110	84	2 755	74
A(H1)pdm09	4	80	–	31	31	–	1	50	–	7	41	–	14	70	612	49
A(H3)	1	20	–	69	69	–	1	50	–	10	59	–	6	30	626	51
A (unknown)	0	–	–	18	–	–	9	–	–	138	–	–	90	–	1 517	–
Influenza B (total)	1	17	0.2%	49	29	0.4%	0	0	0%	7	4	0.1%	21	16	966	26
B/Vic	1	100	–	12	100	–	0	0	–	0	0	–	1	100	75	100
B (unknown)	0	–	–	37	–	–	0	–	–	7	–	–	20	–	891	–
Influenza untyped	0	–	–	6	–	0.1%	1	–	0.2%	33	–	0.3%	13	–	85	–
RSV	0	–	0%	18	–	0.2%	0	–	–	21	–	0.2%	8	–	602	–
SARS-CoV-2	115	–	24.5%	2 590	–	25.5%	84	–	14.7%	2 213	–	18.1%	38 145	–	418 902	–

Source: ECDC

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

Overview:

Global update

One case of mpox due to monkeypox virus (MPXV) clade Ib has been reported in Kerala, India, in the week of 23 September 2024. The case is a male with recent travel history to the United Arab Emirates (UAE) according to reports. A second case of mpox was reported in Kerala on 27 September 2024, according to media quoting health authorities in another person with recent travel history to UAE.

Previously, cases of mpox due to MPXV clade Ib outside Africa had been reported by Sweden and Thailand.

Globally, MPXV clade I and clade II circulate in different countries. Global epidemiological data are updated weekly by the World Health Organization (WHO), with the most recent updates from Africa highlighting the recent expansion of clade I cases (2022-24 Mpox (Monkeypox) Outbreak: Global Trends). No secondary transmission of MPXV clade Ib has been reported outside of the affected African countries.

Overall, since the beginning of monitoring in 2022, 106 310 confirmed mpox cases (MPXV clade I and clade II), including 234 deaths, have been reported from 123 countries (2022-24 Mpox (Monkeypox) Outbreak: Global Trends and WHO Mpox Multi-country external situation report n. 37, published 22 September 2024).

Epidemiological situation in Africa

In 2024, over 30 000 confirmed and suspected mpox cases due to MPXV clade I and clade II, including over 800 deaths, have been reported from Africa. This includes over 6 000 confirmed cases, according to the Africa CDC Epidemic Intelligence Report issued on 23 September 2024 and the WHO AFRO weekly report of 20 September. The countries reporting cases are Burundi, Cameroon, the Central African Republic, the Republic of the Congo (Congo), Cote d'Ivoire, the Democratic Republic of the Congo (DRC), Gabon, Guinea, Kenya, Liberia, Morocco, Nigeria, Rwanda, South Africa, and Uganda.

The epidemiological situation remains similar to the previous week.

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

- The DRC has reported 774 confirmed cases in the past four weeks and Burundi 465, according to the WHO Global report on mpox (data as of 22 September). Deaths have only been reported in DRC (over 152 among all cases according to WHO in the past four weeks). Clade Ib has been detected in both countries, while clade Ia is co-circulating in the DRC.
- The DRC continues to report the highest number of mpox cases in Africa. The cumulative number of cases in 2024 is over 26 000 (over 5 000 confirmed), including over 800 deaths, while the proportion of suspected cases tested has increased to 38.6% (Africa CDC Epidemic Intelligence Report issued on 23 September 2024 and WHO AFRO weekly report of 20 September).
- In Burundi, as of 22 September 2024, 696 confirmed cases have been reported according to the WHO Global report on mpox (data as of 22 September) from several areas of the country. According to the WHO AFRO weekly report of 20 September, cases were reported from 29 of 49 districts and the positivity rate among suspected cases is 38.5%.
- Two new cases have been reported by Kenya and two more from Rwanda. Both countries had reported detections of clade Ib. For both Kenya, (total of seven reported cases), and Rwanda, (total of six reported cases), no details are available on the epidemiological links of the new cases to other mpox cases or travel to affected areas (sources: WHO AFRO Mpox bulletin, 20 September 2024,Ministry of Health, Kenya, X Post, 24 September 2024 and Press Release Ministry of Health, Kenya, 24 September 2024).
- Uganda (clade Ib detected) has reported 24 cases in total, including two additional ones during the last week. Of the 24 reported cases three had links with other cases. Six of the cases have been reported from Kampala.

Based on an analysis of the patterns of MPXV transmission observed at national level, and considering limitations and uncertainties, ECDC has classified countries where MPXV clade I is endemic or has been reported for the first time in 2024 using official epidemiological information in the following categories:

- Countries reporting only travel-associated cases or cases with a clear link to travel-associated cases (India, Sweden, Thailand)
- Countries reporting clusters of cases (Congo, Kenya, Rwanda)
- Community transmission (Burundi, Central African Republic, DRC, Uganda)

This classification takes into consideration several limitations of the available data as well as uncertainties. It has last been updated based on epidemiological information available as of 26 September 2024.

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

Epidemiological situation in the EU/EEA for MPXV clade I

On 15 August 2024, Sweden reported the first imported case of mpox due to MPXV clade Ib in the EU/EEA. As of 26 September, no secondary cases have been detected.

ECDC assessment:

The number of people with MPXV clade I infection has increased and there has been geographical expansion to newly affected African countries in recent weeks. India, Sweden, and Thailand have detected cases of mpox due to MPXV clade Ib in people with history of travel to areas where the virus is circulating in Africa since August 2024. More imported mpox cases due to MPXV clade I are likely to be reported by EU/EEA and other countries. Please see the latest ECDC Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries.

Actions:

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

Sources: ECDC rapid risk assessment

Last time this event was included in the Weekly CDTR: 20 September 2024

3. Locally acquired dengue in 2024 in mainland France

Overview:

Update

Overall, France has reported 68 locally acquired dengue cases in 2024.

As of 25 September, France has reported cases in the following departments:

- Alpes-Maritimes: 1 case in Menton (or Monaco), 2 cases in La Colle sur loupe and 5 cases in Vallauris
- Drôme: 2 cases in one cluster
- Hérault 2 cases in two clusters
- Pyrénées-Orientales or Lozère: 2 cases in one cluster
- Vaucluse: 18 cases in one cluster
- Var: 36 cases in two clusters

The following clusters are considered closed:

- Hérault (1 case)
- Pyrénées-Orientales or Lozère (2 cases)
- Alpes-Maritimes (2 cases connected to La Colle sur Loup and 1 case connected to Menton (or Monaco))
- Drôme (2 cases)

Background

On 8 July, the French Regional Health Agency of Occitania reported the first autochthonous case of dengue in France in 2024 (Montpellier-Pérols, Hérault department, Occitania). The case had onset of symptoms on 17 June, no travel history, and the place of infection was in the region of Occitania. According to the Regional Health Agency, the patient has been treated and the health status does not give cause for concern. Preventive measures were applied in the Port Marianne district of Montpellier and near the Parc des Expositions in Pérols. As no additional cases connected to this local transmission were detected in the subsequent 45 days, the event has been closed.

ECDC assessment:

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

In Europe, the dengue virus is transmitted by the mosquito vector *Aedes albopictus*, which is established in a large part of Europe. Therefore, these outbreaks are not unexpected. With autumn approaching, environmental conditions will become less favourable for vector activity and

virus replication in vectors. However, it is possible that additional locally acquired cases will occur in the coming weeks.

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

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

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

Actions:

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

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

Last time this event was included in the Weekly CDTR: 23 August 2024

4. Seasonal surveillance of West Nile virus infections – 2024

Overview:

Epidemiological summary

Since the start of 2024, and as of 25 September 2024, human cases of WNV infection have been reported to TESSy by 13 EU/EEA countries and five EU-neighbouring countries. In the EU/EEA, Austria, Bulgaria, Croatia, Czechia, Hungary, Romania, France, Germany, Italy, Greece, Slovakia, Slovenia, and Spain reported WNV infections. From EU-neighbouring countries, Albania, Kosovo*, North Macedonia, Serbia and Türkiye reported WNV infections. In total, 163 NUTS3/GAUL1 regions across 18 countries have reported locally acquired WNV cases. For detailed information on places of infection, please refer to ECDC's weekly update and dashboard.

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

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Actions:

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

Last time this event was included in the Weekly CDTR: 20 September 2024

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

Overview:

Update

On 20 September, the US CDC provided an update on the recent avian influenza A(H5N1) infection in a person in Missouri, including further details on the follow-up investigation. Previously, two contacts of the person with symptoms had been reported, one household contact who developed symptoms on the same day as the patient but was not tested at the time, and one healthcare worker with mild respiratory symptoms who tested negative for influenza virus. Blood samples were collected for serological testing from the patient and the household contact to test for the presence of antibodies to avian influenza A(H5) virus as an indication of previous exposure to infection. A second healthcare worker who experienced mild respiratory symptoms was also identified through contact tracing. They were not tested for influenza as they had already recovered at the time of investigation but will be offered serological testing.

Background

On 13 September 2024, the US CDC published additional information on the recent case of avian influenza A(H5) in the state of Missouri. The person was an adult with serious comorbidities, who on 20 August developed symptoms of chest pain, nausea, vomiting, diarrhoea, and weakness. The case was hospitalised on 22 August and received antiviral treatment. The patient was not severely ill and has subsequently recovered. One household contact developed symptoms on the same day as the patient, but was not tested and has since recovered. As the symptoms developed at the same time, the two people were likely exposed to the same source and were not part of a person-to-person transmission chain. A healthcare worker, who was a close contact of the patient developed mild symptoms but tested negative for influenza. No additional cases have been identified within a 10-day follow-up period.

The clinical specimen contained low amounts of genetic material (viral RNA) and only partial sequencing data was generated. Full-length gene sequences were produced for matrix (M) and non-structural (NS) genes only. Because of low amounts of genetic material (viral RNA) in the clinical specimen, sequencing produced limited data for analyses. Analysis of partial sequences of the haemagglutinin (HA) and neuraminidase (NA) genes (GISAID: EPI_ISL_19413343) showed a close match to A(H5N1) viruses from US dairy cattle. Similar HA and NA genes sequences have been found in birds and other animals around dairy farms, as well as in raw milk, and poultry.

Analysis of the HA gene sequence shows that the virus belongs to clade 2.3.4.4b, and the NA sequence was confirmed as N1. Compared to previous human cases, the HA has two amino acid differences not observed before. The two amino acid changes are not known to modify virus ability to infect and spread among people. However, the location of the two amino acid changes may impact the cross-reactivity of clade 2.3.4.4b candidate vaccine viruses (CVVs). Further antigenic testing is planned. Additional antigenic testing is planned. The first amino acid change, HA A156T, has been found in fewer than 1% of viruses identified in dairy cows, while the second mutation, HA P136S, has been observed in one virus sequence from dairy cows.

Outbreaks of avian influenza A(H5) have been reported in both commercial and backyard poultry in Missouri in 2024, but not in cattle. Avian influenza A(H5N1) has also been previously detected in the state in wild birds.

In relation to previously reported cases associated with poultry exposure in Colorado, US CDC stated that all virus specimens were determined to be susceptible to antivirals (oseltamivir, zanamivir, peramivir, and baloxavir) following antiviral susceptibility testing.

In 2024, and as of 24 September 2024, a total of 14 people with avian influenza A(H5) have been reported in the United States. From these, four people were workers exposed to dairy cattle infected or presumed to be infected with A(H5N1) and nine people were workers exposed to commercial egg layer farms with outbreaks of HPAI A(H5). The most recent person infected had no known animal exposure identified.

Where genetic analysis has been available, the virus has been characterised as genotype B3.13 clade 2.3.4.4b of highly pathogenic avian influenza (HPAI) A(H5N1) and been closely related to viruses identified in recent poultry outbreaks and infected dairy cattle herds in the US. The virus maintains avian genetic characteristics. However, mutations associated with mammalian adaptation have been observed in viruses from some cases. No markers of antiviral resistance were found in viruses from human cases and they remain antigenically similar to the two existing HPAI A(H5) candidate vaccine viruses.

The US CDC's current assessment of the human health risk of A(H5N1) to the general public in the US does not change and continues to be considered low. Nevertheless, findings from the ongoing investigation will inform whether the assessment needs to be updated.

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 several of the human cases in the US has not been detected in Europe.

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. occupational exposure to infected animals). ECDC will revisit the risk assessment once more information becomes available from the ongoing sequencing and investigations of the most recent human case in the US.

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

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

Relevant ECDC publications:

- Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work
- Enhanced influenza surveillance to detect avian influenza virus infections in the EU/EEA during the inter-seasonal period
- Investigation protocol of human cases of avian influenza virus infections in the EU/EEA
- Joint ECDC-EFSA Drivers for a pandemic due to avian influenza and options for One Health mitigation measures

Actions:

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

Sources: FAO | 2024-e000168

Last time this event was included in the Weekly CDTR: 20 September 2024

6. Influenza A(H9N2) – Multi-country (World) – Monitoring human cases

Overview:

Update

On 26 August 2024, one human case of avian influenza A(H9N2) was reported to WHO by the IHR National Focal Point for Ghana. The patient is a child from the Upper East region, located on the border with Burkina Faso. On 5 May, the case developed symptoms including sore throat, fever and cough. On 7 May the patient presented at the local hospital, where they were diagnosed with influenza-like illness.

On 7 May, respiratory samples were collected and sent to the Ghana National Influenza Centre (NIC), Noguchi Memorial Institute for Medical Research, where they tested positive by PCR for seasonal influenza A(H3N2) on 15 May. On 9 July, the sample was further analysed at Ghana NIC by sequencing, which indicated avian influenza A(H9) virus. Aliquots of the sample were sent to WHO Collaborating Centres (WHO CC) in London, United Kingdom, and Atlanta, United States (US). On 6 August, WHO CC in the US confirmed the sample as positive for avian influenza A(H9N2) virus.

After A(H9N2) infection confirmation, the Upper East Regional Health Directorate visited the household of the patient and reported that several family members had developed respiratory symptoms. Respiratory and serum samples were collected during the visit and sent to the Ghana NIC, where they tested negative for influenza virus. The child has since completely recovered.

Samples from close contacts were collected and tested negative. There were no other human cases of avian influenza A(H9N2) associated with this patient. The child had no known exposure to poultry or any people with similar symptoms before the onset of illness.

There have been reports of illness in poultry in the Upper East region of Ghana, but the cause has not been established. Low pathogenicity avian influenza A(H9N2) has been circulating in poultry farms in Ghana since November 2017.

The Ghanaian government has taken monitoring, prevention and control measures, including strengthened case surveillance, epidemiological investigation, monitoring close contacts and risk communication activities for the public and for key occupational groups with high risk of exposure.

This is the first case of human infection with avian influenza A(H9N2) virus reported to WHO from Ghana. Since 1998, and as of 24 September 2024, a total of 140 laboratory-confirmed cases of human infection with avian influenza A(H9N2) virus, including two deaths (both in patients with underlying conditions), have been reported in nine countries: China (124), Egypt (4), Bangladesh (3), Cambodia (2), Oman (1), Pakistan (1), India (2), Senegal (1), Vietnam (1) and Ghana (1). Most of the cases were children with mild disease.

ECDC assessment:

Sporadic human cases of avian influenza A (H9N2) have been observed outside the EU/EEA, mainly in young children. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses, including A(H9N2), and in most cases leads to mild clinical illness. To date, no clusters of human A(H9N2) infections have been reported. According to WHO, the likelihood of human-to-human transmission of A(H9N2) is low, as there is no evidence that the virus has acquired the ability for sustained transmission among humans.

To date, there have been no human cases of avian influenza A(H9N2) reported in the EU/EEA, and the risk to human health in the region is currently considered very low.

Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities and collaborates with the European Food Safety Authority (EFSA) and the EU reference laboratory for avian influenza to identify significant changes in the epidemiology of the virus. ECDC also 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.

Last time this event was included in the Weekly CDTR: 13 September 2024

7. Human cases of swine influenza A(H3N2) variant virus – Multi-country

Overview:

Two human cases of influenza A(H3N2)v virus infection were reported by the Minnesota Department of Health (Weekly US Influenza Surveillance Report: Week 37|CDC). Both infections occurred in persons under 18 years of age, who sought medical care in week 36, ending on 7 September 2024. They were not hospitalised and have since fully recovered. Prior to disease onset, both persons, who are not contacts with each other, attended the same agricultural fair, where the first person had indirect, and the second person had direct contact with swine.

Epidemiological investigation revealed that one day after the agricultural fair, all family members in the household of the first person developed symptoms. One family member was tested and was positive for SARS-CoV-2. All have recovered, but the initial patient has subsequently developed new symptoms. The person tested positive for influenza A, which was later further identified as influenza A(H3N2)v. The initial illness in the household is not thought to be linked to influenza A(H3N2)v.

No illness was reported among contacts of the second person.

There was no person-to-person transmission of influenza A(H3N2)v identified in relation with either of the cases.

During 2023-2024 season, four human cases of influenza A(H3N2)v infections were reported in the US.

Background

Swine influenza A viruses continue to circulate in swine populations around the world. This can sporadically lead to infections in humans, most often through contact with infected swine or a contaminated environment.

It is important that these influenza viruses from humans are fully characterised in influenza reference laboratories. If needed, the assessment will be reviewed should further epidemiological or virological information become available.

There is no vaccine against swine influenza A viruses licensed for use in humans. Influenza A viruses circulating in humans differ from the ones circulating in pig populations. Thus, influenza vaccines against seasonal influenza are not expected to protect people from swine influenza viruses. Available antiviral drugs against influenza are expected to be effective for treatment.

Swine influenza virus infection should always be considered in patients with respiratory symptoms who report contact with pigs prior to the onset of disease. This supports early identification of events of transmission to humans and initiation of follow-up investigations. Unsubtypeable influenza viruses should be shared with national influenza centres or reference laboratories, as well as World Health Organization (WHO) Collaborating Centres, for further virus characterisation.

ECDC assessment:

Currently there is no evidence of sustained transmission between humans with swine influenza A viruses, and this is also the case for this specific event.

Therefore, the likelihood of importation and further circulation in the EU/EEA linked to this event is considered negligible, and so is the risk for the EU/EEA.

Actions:

ECDC is monitoring zoonotic influenza events through its epidemic intelligence activities in order to identify significant changes in the epidemiology of the virus. Cases in the EU/EEA should be reported immediately to the Early Warning and Response System (EWRS) and International Health Regulations (IHR).

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

8. 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 31 July 2024, and as of 31 August 2024, 60 834 new cholera cases, including 227 new deaths, have been reported worldwide.

The five countries reporting most cases are Afghanistan (30 170), Pakistan (10 983), Yemen (10 656), Nigeria (3 142), and Ethiopia (1 743).

The five countries reporting most new deaths are Nigeria (94), Sudan (37), Democratic Republic of the Congo (30), Ethiopia (25), and Yemen (21).

New cases have been reported from Afghanistan, Bangladesh, Burundi, China, Comoros, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, Kenya, Mozambique, Nepal, Nigeria, Pakistan, Somalia, Sudan, Syria, Togo, and Yemen.

New deaths have been reported from Afghanistan, Burundi, the Democratic Republic of the Congo, Ethiopia, Haiti, Kenya, Nigeria, Somalia, Sudan, Togo, and Yemen.

Since 1 January 2024 and as of 31 August 2024, 371 381 cholera cases, including 2 517 deaths, have been reported worldwide. In comparison, since 1 January 2023 and as of 31 August 2023, 652 902 cholera cases, including 3 789 deaths, were reported worldwide.

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

Africa
Burundi: Since 28 July 2024,and as of 31 August 2024, 41 new cases, including two new deaths, have been reported. Since 1 January 2024, and as of 31 August 2024, 687 cases, including three deaths, have been reported. In comparison, in 2023 and as of 13 August 2023, 609 cases, including nine deaths, were reported.

Comoros: Since 28 July 2024 and as of 2 August 2024, 13 new cases have been reported. Since 1 January 2024, and as of 2 August 2024, 10 342 cases, including 149 deaths, have been reported. In comparison, in 2023, and as of 31 August 2023, no cases were reported.

Democratic Republic of the Congo: Since 28 July 2024 and as of 31 August 2024, 1 527 new cases, including 30 new deaths have been reported. Since 1 January 2024, and as of 31 August 2024, 23 291 cases, including 337 deaths, have been reported. In comparison, in 2023, and as of 5 August 2023, 24 121 cases, including 222 deaths, were reported.

Ethiopia: Since 28 July 2024 and as of 31 August 2024, 1 743 new cases, including 25 new deaths, have been reported. Since 1 January 2024 and as of 31 August 2024, 23 030 cases, including 207 deaths, have been reported. In comparison, in 2023 and as of 23 August 2023, 17 796 cases, including 220 deaths, were reported.

Ghana: Since 1 August 2017 and as of 31 August 2024, 24 new cases have been reported. Since 1 January 2024 and as of 31 August 2024, 24 cases have been reported. In comparison, in 2023 and as of 31 August 2023, no cases were reported.

Kenya: Since 28 July 2024 and as of 9 August 2024, five new cases have been reported. Since 1 January 2024 and as of 9 August 2024, 300 cases, including three deaths, have been reported. In comparison, in 2023 and as of 29 June 2023, 8 735 cases, including 137 deaths were reported.

Mozambique: Since 28 July 2024 and as of 2 August 2024, 12 new cases have been reported. Since 1 January 2024 and as of 2 August 2024, 8 183 cases, including 17 deaths, have been reported. In comparison, in 2023 and as of 6 August 2023, 33 299 cases, including 137 deaths, were reported.

Nigeria: Since 19 July 2024 and as of 23 August 2024, 3 142 new cases, including 94 new deaths, have been reported. Since 1 January 2024 and as of 23 August 2024, 5 951 cases, including 176 deaths, have been reported. In comparison, in 2023 and as of 30 July 2023, 2 309 cases, including 57 deaths, were reported.

Somalia: Since 28 July 2024 and as of 31 August 2024, 1 649 new cases, including four new deaths, have been reported. Since 1 January 2024 and as of 31 August 2024, 18 218 cases, including 138 deaths, have been reported. In comparison, in 2023 and as of 13 August 2023, 12 142 cases, including 30 deaths, were reported.

Sudan: Since 30 April 2024 and as of 31 August 2024, 395 new cases, including 37 new deaths, have been reported. Since 1 January 2024 and as of 31 August 2024, 2 803 cases, including 37 deaths, have been reported. In comparison, in 2023 and as of 31 August 2023, no cases were reported.

Togo: Since 19 December 2023 and as of 31 August 2024, 10 new cases, including one new death, has been reported. Since 1 January 2024 and as of 31 August 2024, 10 cases, including one death, has been reported. In comparison, in 2023 and as of 31 August 2023, no cases were reported.

Americas

Haiti: Since 27 July 2024 and as of 17 August 2024, 181 new cases, including one new death, has been reported. Since 1 January 2024 and as of 17 August 2024, 9 659 cases, including 142 deaths, have been reported. In comparison, in 2023 and as of 10 August 2023, 38 036 cases, including 421 deaths, were reported.

Asia

Afghanistan: Since 27 July 2024 and as of 31 August 2024, 30 170 new cases, including 12 new deaths, have been reported. Since 1 January 2024 and as of 31 August 2024, 125 471 cases, including 60 deaths, have been reported. In comparison, in 2023 and as of 12 August 2023, 128 880 cases, including 63 deaths, were reported.

Bangladesh: Since 8 July 2024 and as of 26 August 2024, 98 new cases have been reported. Since 1 January 2024 and as of 26 August 2024, 168 cases have been reported. In comparison, in 2023 and as of 13 August 2023, 76 353 cases were reported.

China: Since 31 July 2024 and as of 31 August 2024, four new cases have been reported. Since 1 January 2024 and as of 31 August 2024, nine cases have been reported. In comparison, in 2023 and as of 31 August 2023, 18 cases were reported.

Nepal: Since 28 July 2024 and as of 25 August 2024, 38 new cases have been reported. Since 1 January 2024 and as of 25 August 2024, 58 cases have been reported. In comparison, in 2023 and as of 31 August 2023, no cases were reported.

Pakistan: Since 15 July 2024 and as of 12 August 2024, 10 983 new cases have been reported. Since 1 January 2024 and as of 12 August 2024, 49 619 cases have been reported. In comparison, in 2023 and as of 20 August 2023, 12 460 cases were reported.

Syria: Since 22 July 2024 and as of 26 August 2024, 143 new cases have been reported. Since 1 January 2024 and as of 26 August 2024, 10 563 cases have been reported. In comparison, in 2023 and as of 12 August 2023, 228 032 cases, including 952 deaths, were reported.

Yemen: Since 15 July 2024 and as of 19 August 2024, 10 656 new cases, including 21 new deaths have been reported. Since 1 January 2024 and as of 19 August 2024, 31 809 cases, including 153 deaths, have been reported. In comparison, in 2023 and as of 13 August 2023, 5 157 cases, including seven deaths, were reported.

ECDC assessment:

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

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

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

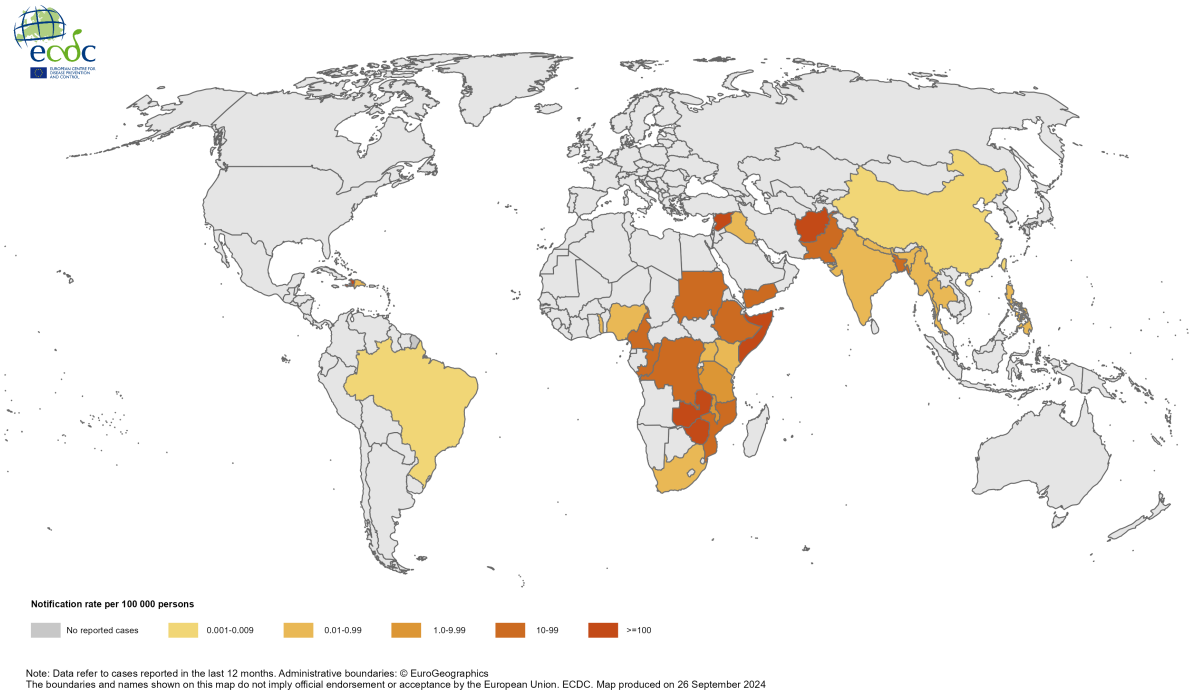
According to the World Health Organization (WHO), vaccination should be considered for travellers at higher risk, such as emergency and relief workers who are likely to be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek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

Actions:

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

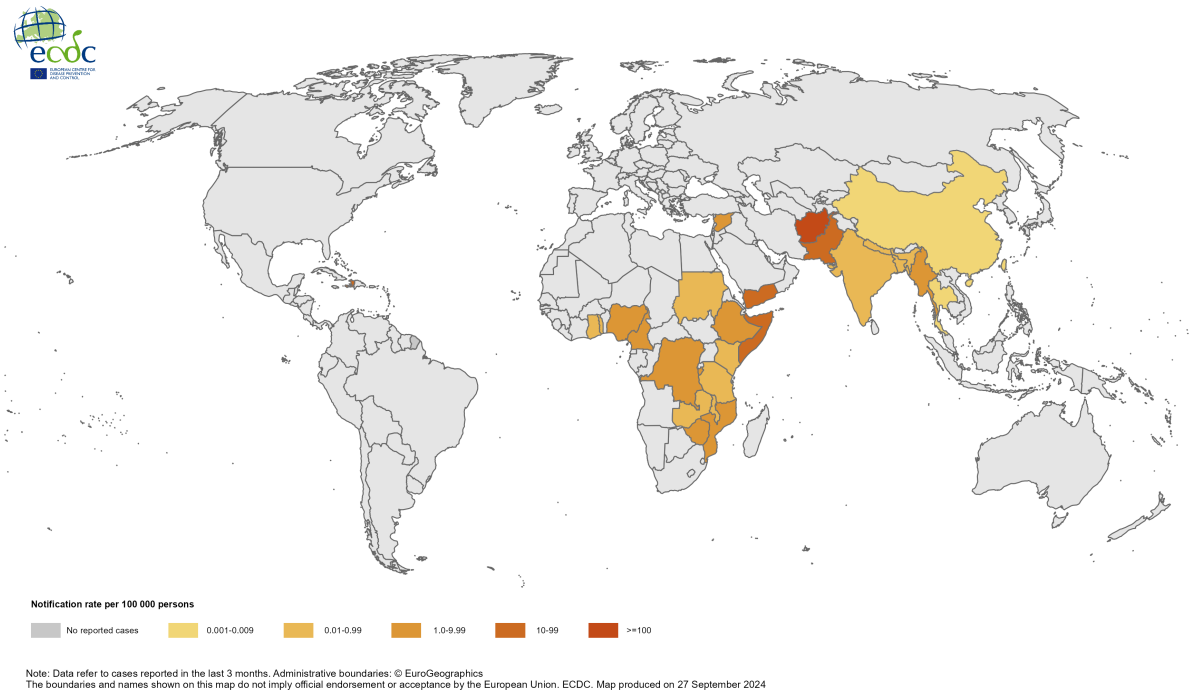
Last time this event was included in the Weekly CDTR: 30 August 2024

Figure 1. Geographical distribution of cholera cases reported worldwide from September 2023 to August 2024



Source: ECDC

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



Source: ECDC

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

Overview:

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

On 8 July 2024, the 39th meeting of the Polio Emergency Committee under the International Health Regulations (IHR) (2005) was held to discuss the international spread of poliovirus and it was agreed that it remains a PHEIC. It was recommended that the temporary recommendations be extended for a further three months.

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

Summary:

Wild poliovirus (WPV):
In 2024, 40 cases of AFP due to wild poliovirus infection have been reported, 21 in Pakistan and 19 in Afghanistan.

Circulating vaccine-derived poliovirus (cVDPV):
With date of symptom onset in 2024 (as of 20 August 2024):
In 2024, six cases of AFP caused by cVDPV1 have been reported from two countries: the Democratic Republic of Congo (DRC) (5), and Mozambique (1).

In 2024, 165 cases of AFP caused by cVDPV2 were reported from 16 countries: Angola (6), Benin (1), Chad (8), DRC (12), Ethiopia (11), Guinea (5), Indonesia (7), Liberia (1), Mali (1), Niger (9), Nigeria (57), Somalia (3), South Sudan (8), Cameroon (2), Palestine* (1), and Yemen (33).

In 2024, no cases of AFP caused by cVDPV3 were reported.

Sources: Global Polio Eradicati on Initiative | ECDC | ECDC dashboard | WPV3 eradication certificate

**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.*

ECDC assessment:

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

As long as there are non-vaccinated or under-vaccinated population groups in European countries and poliomyelitis is not eradicated globally, the risk of the virus being reintroduced in Europe remains. Two EU/EEA neighbouring countries (Bosnia and Herzegovina and Ukraine) remain at high risk of a sustained polio outbreak following wild poliovirus importation or the emergence of circulating vaccine-derived poliovirus (cVDPV). This is due to suboptimal vaccination programme performance and low population immunity, according to the **European Regional Certification Commission for Poliomyelitis Eradication (RCC)** report published in November 2023, referring to data from 2022. According to the same report, six EU/EEA countries are at intermediate risk of sustained polio outbreaks. The continuing circulation of wild poliovirus type 1 (WPV1) in Pakistan and Afghanistan shows that there is still a risk of the disease being imported into the EU/EEA. The outbreaks of cVDPV that emerge and circulate due to lack of polio immunity in the population also illustrate the potential risk for further international spread.

To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake

in pockets of under-immunised populations. EU/EEA countries should review their polio vaccination coverage data and ensure that there are no immunity gaps in the population and that there is capacity to identify virus circulation through well-performing surveillance systems.

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

ECDC links: ECDC comment on risk of polio in Europe | ECDC risk assessment

Actions:

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

ECDC maintains a dashboard showing countries that are still endemic for polio and have ongoing outbreaks of cVDPV.

Last time this event was included in the Weekly CDTR: 23 August 2024

Events under active monitoring

- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update – last reported on 30 August 2024
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks - Monthly update – last reported on 30 August 2024
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update – last reported on 30 August 2024
- Human cases of swine influenza A(H1N1) virus variant – Multi-country - 2024 – last reported on 30 August 2024
- Overview of respiratory virus epidemiology in the EU/EEA – weekly monitoring – last reported on 30 August 2024
- Legionnaires' disease outbreak – Italy – 2024 – last reported on 30 August 2024
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024 – last reported on 30 August 2024
- Autochthonous chikungunya virus disease – Department of La Réunion, France, 2024 – last reported on 30 August 2024
- Seasonal surveillance of West Nile virus infections – 2024 – last reported on 30 August 2024
- Locally acquired dengue in 2024 in mainland France – last reported on 27 September 2024
- Avian influenza A(H5N1) human cases – United States – 2024 – last reported on 27 September 2024
- Human cases of swine influenza A(H3N2) variant virus – Multi-country – last reported on 27 September 2024
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases – last reported on 27 September 2024
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks – last reported on 27 September 2024
- Circulating vaccine-derived poliovirus type 2 (cVDPV2) – Palestine* - 2024 – last reported on 23 August 2024
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases – last reported on 23 August 2024
- Severe floods in Central and Eastern Europe – Multi-country – 2024 – last reported on 20 September 2024
- Oropouche virus disease – Multi-country (Americas) – 2024 – last reported on 13 September 2024
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2024 – last reported on 13 September 2024
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring – last reported on 13 September 2024

- SARS-CoV-2 variant classification – last reported on 06 September 2024