

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 26, 22–28 June 2024

This week's topics

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2. Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update
3. Overview of respiratory virus epidemiology in the EU/EEA – weekly monitoring
4. Cholera – Comoros and Mayotte – 2024 – Weekly monitoring
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Executive Summary

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

- In May 2024, 48 818 new cholera cases, including 176 new deaths, were reported worldwide. Since 1 January 2024 and as of 31 May 2024, 200 314 cholera cases, including 1 955 deaths, have been reported worldwide.
- New cases were reported from Afghanistan, Bangladesh, Burundi, Comoros, the Democratic Republic of the Congo, Ethiopia, Haiti, India, Kenya, Malawi, Mayotte, Mozambique, Nigeria, Pakistan, Somalia, South Africa, Sudan, Syria, Uganda, the 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.

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

- Since the beginning of 2024, approximately 320 000 chikungunya virus disease (CHIKVD) cases and 120 deaths have been reported worldwide. A total of 19 countries reported CHIKVD cases from the Americas (12), Asia (6), and Africa (1). No autochthonous cases of CHIKVD have been reported in Europe in 2024.
- Since the beginning of 2024, over 10 million dengue cases and over 5 000 dengue-related deaths have been reported globally. No autochthonous dengue cases have yet been reported in Europe in 2024.
- 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.

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

Syndromic surveillance in primary and secondary care indicates that respiratory activity is at baseline levels in EU/EEA countries.

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

- Median SARS-CoV-2 test positivity in primary care sentinel systems has increased to 11%. Pooled test positivity reached 27%, with four countries reporting >20%.
- Median test positivity in SARI sentinel systems has increased over a seven-week period to 21%, with increases primarily among those 65 years of age and above. Test positivity increased to 24% for this age group in the current reporting week.
- Despite the increased activity in primary and secondary care sentinel systems, sentinel syndromic ILI and ARI rates show no increases above baseline levels.
- Non-sentinel primary care data show similar trends to the sentinel system, with increases in test positivity observed in many reporting EU/EEA 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.

Cholera – Comoros and Mayotte – 2024 – Weekly monitoring

- Forty-four new cholera cases have been reported in Mayotte between 11 June and 24 June 2024. Since 18 March, and as of 24 June, there have been 210 cases and two deaths.
- Given the identification of several autochthonous cases and the continued importation of cases from the ongoing outbreak in Comoros, the likelihood of further community transmission and the overall risk of cholera for the population of Mayotte remains high.
- In Comoros, since the last available update on 19 June, and as of 26 June, 465 new cholera cases and three new deaths have been reported. As of 26 June 2024, 10 027 confirmed cholera cases and 146 deaths have been reported in the country.

Mass gathering - Hajj - Kingdom of Saudi Arabia - 2024 - Weekly monitoring

- ECDC concluded monitoring the Hajj pilgrimage through its epidemic intelligence activities on 27 June 2024.
- No infectious disease events of relevance for the EU/EEA were detected during the Hajj between 10 June and 27 June 2024.
- There were media reports of a number of deaths among Hajj pilgrims, mostly related to the severe climate conditions, such as heatwaves, during the event.
- ECDC's epidemic intelligence team acknowledges the excellent collaboration with the Gulf CDC and the World Health Organization's Regional Office for the Eastern Mediterranean (WHO EMRO) in monitoring this event.

Influenza A(H5N2) - Multi-country (World) - Monitoring human cases

- On 23 May 2024, the Mexico IHR National Focal Point reported to PAHO/WHO a confirmed case of human infection with avian influenza A(H5N2). This is the first laboratory-confirmed human infection with avian influenza subtype A(H5N2) reported globally.
- The patient, who was a resident of the State of Mexico, was hospitalised in Mexico City, and died on the day of hospitalisation.
- No human-to-human transmission associated with this event has been reported.
- Genetic analysis performed found that the virus had 99% similarity to low pathogenic avian influenza A(H5N2) strains from birds in Texcoco, State of Mexico.
- The risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered low.

Mass gathering monitoring - UEFA European Football Championship - 2024 - Weekly monitoring

- Since the previous update, and as of 27 June, no relevant public health events related to communicable diseases have been detected in connection with UEFA EURO 2024.
- On 26 June, the media reported there have been 60 cases of tick-borne encephalitis (TBE) in Bavaria since the beginning of the year.
- ECDC is monitoring this mass gathering event through its epidemic intelligence activities between 10 June and 19 July in collaboration with the Robert Koch Institute and the World Health Organization's Regional Office for Europe (WHO/Europe).
- Weekly updates are published in the Communicable Disease Threats Report (CDTR), with daily reporting of relevant events and public health threats.
- The probability of infection by communicable diseases for EU/EEA citizens during UEFA EURO 2024 is considered low if requirements and recommendations by public health authorities in Germany are followed. Together with WHO and Germany's Federal Centre for Health Education, ECDC has produced specific [public health advice for UEFA European Football Championship 2024](#).

Seasonal surveillance of West Nile virus infections – 2024

- Since the beginning of 2024, and as of 26 June 2024, one NUTS 3* region (Seville, Spain) in the EU/EEA has reported a human case of West Nile virus infection.
- On 27 June 2024, Italy confirmed in an [official report](#) the first human case of WNV infection of the 2024 season from the province of Modena.
- 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 \(europa.eu\)](#).

**NUTS - Nomenclature of territorial units for statistics. Classification for the collection, development and harmonisation of European regional statistics. NUTS 3: small regions for specific diagnoses.*

1. 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. Refer to the original sources for more information regarding the case definitions in use and for details on the epidemiological situation.

Summary

Since 30 April 2024, and as of 31 May 2024, 48 818 new cholera cases, including 176 new deaths, have been reported worldwide.

The five countries reporting the most cases are Afghanistan (13 451), Pakistan (13 005), Yemen (4 910), Somalia (3 646), and Comoros (3 385).

The five countries reporting the most new deaths are Comoros (39), Yemen (35), Ethiopia (29), Somalia (27), and Zimbabwe (11).

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

Since 1 January 2024, and as of 31 May 2024, 200 314 cholera cases, including 1 955 deaths, have been reported worldwide. In comparison, since 1 January 2023, and as of 31 May 2023, 324 791 cholera cases, including 2 181 deaths, were reported worldwide.

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

Africa

Burundi: Since 30 April 2024, and as of 31 May 2024, 285 new cases, including one new death, have been reported. Since 1 January 2024, and as of 31 May 2024, 448 cases, including one death, have been reported. In comparison, in 2023, as of 28 May 2023, 450 cases, including seven deaths, were reported.

Comoros: Since 30 April 2024, and as of 31 May 2024, 3 385 new cases, including 39 new deaths, have been reported. Since 1 January 2024, and as of 31 May 2024, 7 335 cases, including 121 deaths, have been reported. In comparison, in 2023, as of 31 May 2023, no cases were reported.

Democratic Republic of the Congo: Since 30 April 2024, and as of 24 May 2024, 2 999 new cases have been reported. Since 1 January 2024 and as of 24 May 2024, 16 554 cases, including 285 deaths, have been reported. In comparison, in 2023, and as of 7 May 2023, 18 794 cases, including 104 deaths, were reported.

Ethiopia: Since 30 April 2024, and as of 31 May 2024, 3 365 new cases, including 29 new deaths have been reported. Since 1 January 2024 and as of 31 May 2024, 16 339 cases, including 126 deaths have been reported. In comparison, in 2023, and as of 13 May 2023, 5 451 cases, including 77 deaths, were reported.

Kenya: Since 29 March 2024, and as of 31 May 2024, 67 new cases have been reported. Since 1 January 2024, and as of 31 May 2024, 253 cases, including one death, have been reported. In comparison, in 2023 and as of 7 May 2023, 7 338 cases, including 109 deaths, were reported.

Malawi: Since 30 April 2024, and as of 31 May 2024, 10 new cases have been reported. Since 1 January 2024, and as of 31 May 2024, 253 cases, including three deaths, have been reported. In comparison, in 2023 and as of 28 May 2023, 41 357 cases, including 1 185 deaths, were reported.

Mozambique: Since 30 April 2024, and as of 31 May 2024, 457 new cases, including 3 new deaths have been reported. Since 1 January 2024 and as of 31 May 2024, 7 828 cases, including 15 deaths have been reported. In comparison, in 2023, and as of 29 May 2023, 30 966 cases, including 134 deaths, were reported.

Nigeria: Since 30 April 2024 and as of 24 May 2024, 256 new cases, including 7 new deaths have been reported. Since 1 January 2024 and as of 24 May 2024, 815 cases, including 14 deaths, have been reported. In comparison, in 2023, and as of 28 May 2023, 1 851 cases, including 52 deaths, were reported.

Somalia: Since 30 April 2024, and as of 31 May 2024, 3 646 new cases, including 27 new deaths have been reported. Since 1 January 2024 and as of 31 May 2024, 12 327 cases, including 114 deaths, have been reported. In comparison, in 2023, and as of 7 May 2023, 7 442 cases, including 24 deaths, were reported.

South Africa: Since 20 January 2024, and as of 30 April 2024, 148 new cases, including 1 new death has been reported. Since 1 January 2024 and as of 30 April 2024, 150 cases, including one death, has been reported. In comparison, in 2023, and as of 22 May 2023, 39 cases, including 15 deaths, were reported.

Sudan: Since 31 December 2023, and as of 30 April 2024, 2 408 new cases have been reported. Since 1 January 2024 and as of 30 April 2024, 2 408 cases have been reported. In comparison, in 2023, and as of 31 May 2023, no cases were reported.

Uganda: Since 29 February 2024, and as of 17 May 2024, 14 new cases, including 2 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 31 May 2023, no cases were reported.

United Republic of Tanzania: Since 30 April 2024 and as of 17 May 2024, 694 new cases, including 10 new deaths, have been reported. Since 1 January 2024 and as of 17 May 2024, 3 197 cases, including 42 deaths, have been reported. In comparison, in 2023, and as of 4 May 2023, 82 cases, including three deaths, were reported.

Zambia: Since 30 April 2024 and as of 31 May 2024, 108 new cases, including 1 new death has been reported. Since 1 January 2024 and as of 31 May 2024, 19 956 cases, including 612 deaths have been reported. In comparison, in 2023 and as of 25 May 2023, 688 cases, including 13 deaths, were reported.

Zimbabwe: Since 30 April 2024 and as of 31 May 2024, 985 new cases, including 11 new deaths have been reported. Since 1 January 2024 and as of 31 May 2024, 19 182 cases, including 382 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 1 January 2024, and as of 18 May 2024, 6 763 cases, including 119 deaths have been reported. In comparison, in 2023, and as of 20 May 2023, 22 727 cases, including 322 deaths, were reported.

Asia

Afghanistan: Since 27 April 2024 and as of 25 May 2024, 13 451 new cases, including 9 new deaths have been reported. Since 1 January 2024, and as of 25 May 2024, 46 758 cases, including 25 deaths, have been reported. In comparison, in 2023, and as of 21 May 2023, 54 908 cases, including 27 deaths, were reported.

Bangladesh: Since 30 April 2024, and as of 20 May 2024, two new cases have been reported. Since 1 January 2024, and as of 20 May 2024, 8 cases have been reported. In comparison, in 2023, and as of 24 May 2023, 34 609 cases were reported.

India: Since 15 April 2024, and as of 30 May 2024, 449 new cases have been reported. Since 1 January 2024 and as of 30 May 2024, 1 769 cases, including four deaths, have been reported. In comparison, in 2023, and as of 19 May 2023, 616 cases were reported.

Pakistan: Since 24 March 2024, and as of 20 May 2024, 13 005 new cases have been reported. Since 1 January 2024 and as of 20 May 2024, 18 318 cases have been reported. In comparison, in 2023, and as of 23 April 2023, 7 314 cases were reported.

Syria: Since 30 April 2024, and as of 20 May 2024, 307 new cases have been reported. Since 1 January 2024, and as of 20 May 2024, 10 127 cases have been reported. In comparison, in 2023 and as of 20 May 2023, 79 903 cases, including seven deaths, were reported.

Yemen: Since 30 April 2024, and as of 31 May 2024, 4 910 new cases, including 35 new deaths have been reported. Since 1 January 2024 and as of 31 May 2024, 9 186 cases, including 58 deaths, have been reported. In comparison, in 2023 and as of 7 May 2023, 3 014 cases, including three deaths, were reported.

Europe

Outermost regions

Mayotte: As of 31 May 2024, 143 new cases, including two new deaths, have been reported. Since 1 January 2024, and as of 31 May 2024, 143 cases, including two deaths, have been reported. In comparison, in 2023, and as of 31 May 2023, no cases 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 in the Americas.

In this context, the risk of cholera infection in travellers visiting these countries remains low, even though 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.

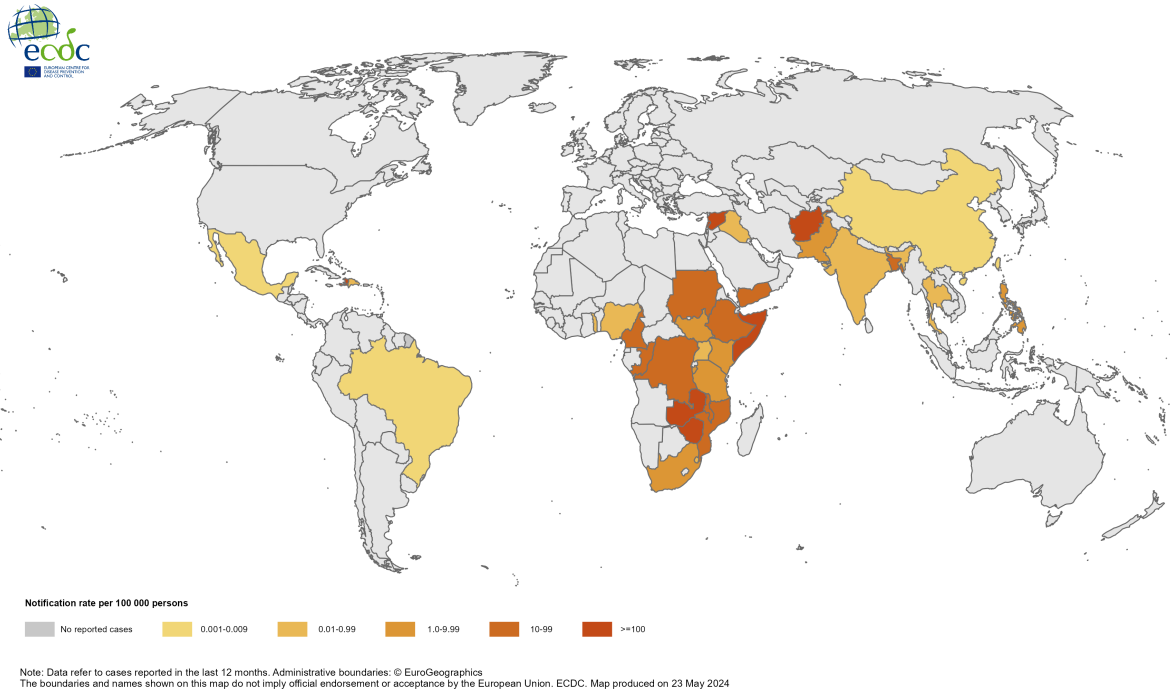
☐ According to the World Health Organization (WHO), vaccination should be considered for travellers at higher risk, such as emergency and relief workers who are likely to be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek 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](#).

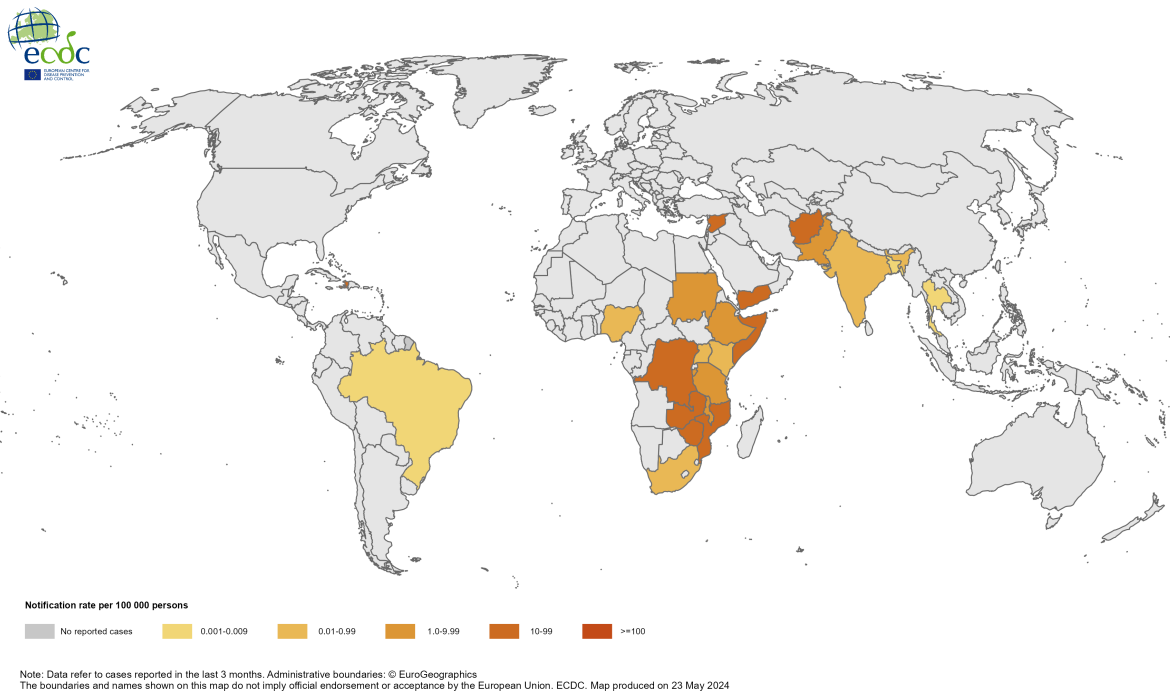
Last time this event was included in the Weekly CDTR: 24 May 2024

Figure 1. Geographical distribution of cholera cases reported worldwide from March 2023 to April 2024



Source: ECDC

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



Source: ECDC

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

Overview:

Chikungunya virus disease (CHIKVD)

In 2024, and as of 31 of May, approximately 320 000 CHIKVD cases and over 120 deaths have been reported worldwide. A total of 19 countries reported CHIKVD cases from the America (12), Asia (6), and Africa (1).

Most countries reporting high CHIKVD burden are from the Americas, in South and Central America. Countries reporting highest number of cases in the Americas are Brazil (317 563), Paraguay (3 034), Argentina (632), and Bolivia (346). Additional countries reporting CHIKVD cases in the Americas can be found at [PAHO's dedicated website](#).

Outside of the Americas, CHIKVD cases were reported in Asia from Pakistan (459), Maldives (389), India (225), Thailand (221), Timor Leste (195), and Malaysia (25). One African countries reported CHIKVD cases in 2024: Senegal (7).

No autochthonous cases of CHIKVD have been reported in Europe in 2024.

CHIKVD associated deaths were reported from Brazil (125).

Updates from selected countries

Maldives

Since the previous update, 149 new CHIKVD cases have been reported in the Maldives. [CHIKVD cases in the Maldives](#) increased constantly since epidemiological week 13 until epidemiological week 18, when the highest number of cases were registered, following with a decreasing trend in epidemiological week 19, the last available epidemiological week with data.

Since the start of the outbreak and as of 11 May, 389 CHIKVD cases have been reported in the Maldives. To date, no CHIKVD-related deaths have been reported during this outbreak. Most cases have been reported from Malé and Hulhumalé, the most populated islands of the archipelago.

Dengue

Since the beginning of 2024, over 10 million dengue cases and over 5 000 dengue-related deaths have been reported from 80 countries/territories. Most cases globally have been reported from the WHO PAHO region. The over nine million cases reported by PAHO in 2024 are twice the number of cases reported throughout 2023. In the region, Brazil has reported most cases in 2024 (over eight million) followed by Argentina, Paraguay, Peru and Colombia (source: [Epidemiological Update - Increase in dengue cases in the Region of the Americas - 18 June 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](#)) but no autochthonous cases have been reported so far.

Guadeloupe, Martinique [continue](#) facing an epidemic classified as in phase 4 and level 1 but a decreasing trend in cases (those presenting with dengue symptoms) continues being reported the past month (mid-May to mid-June). In Saint-Martin dengue circulation continues but at lower levels with sporadic cases reported. ([Bulletin de surveillance de la dengue - point épidémiologique régional du 13 juin 2024.pdf \(guadeloupe.gouv.fr\)](#)) French Guyana, cases have been [decreasing](#) the past weeks after a peak in January 2024.

Overall, 1 180 cases of dengue have been reported in La Reunion until 16 June 2024, according to the [Epidemiological Bulletin published on 16 June 2024](#). Dengue circulation is at higher levels compared to 2023 and cases have been showing a decreasing trend the last four weeks.

Dengue circulation has been reported also in the [South-East Asia](#) and [Western Pacific](#) WHO Regions according to reports from the regional offices (SEARO and WPRO, respectively) as well as in [Africa](#) in June 2024. According to the [SEARO report published on 12 June 2024](#), increases in dengue cases were reported in Maldives (total 1 234 cases reported until May 2024), while dengue cases in Bangladesh, Sri Lanka and Thailand are below levels observed the previous years. According to the [WPRO Dengue Situation update of 13 June 2024](#), increases in cases are observed in Vietnam, but the total number of cases reported as of 26 May was lower compared to the total number of cases reported in the same period in 2023, while in Malaysia, which reported increases in cases the previous months, cases are now decreasing, with a cumulative of 62 107 cases reported until week 21 (an increase of 34% compared to the same period in 2023). In Africa, according to the [Africa CDC Epidemic Intelligence Report of 22 June 2024](#), 44 956 dengue cases have been reported this year from Burkina Faso, Cameroon, Cabo Verde, Chad, Ethiopia, 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 its largest outbreak of dengue ever. As a result, there is a substantial increase in 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 autochthonous outbreaks of [CHIKVD](#) and [dengue](#) in mainland EU/EEA have so far occurred between June and November.

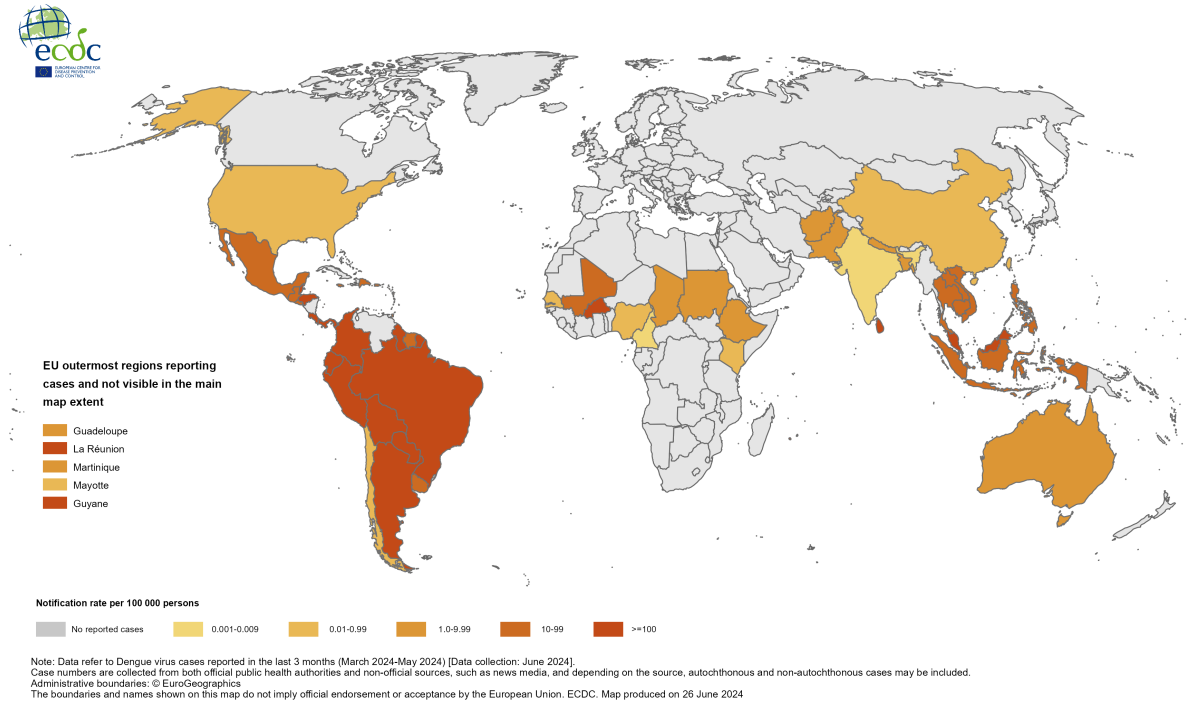
More information on autochthonous transmission of [chikungunya](#) and [dengue](#) virus in the EU/EEA is available on ECDC's webpages, and in ECDC's factsheets on [dengue](#) and [CHIKVD](#).

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.

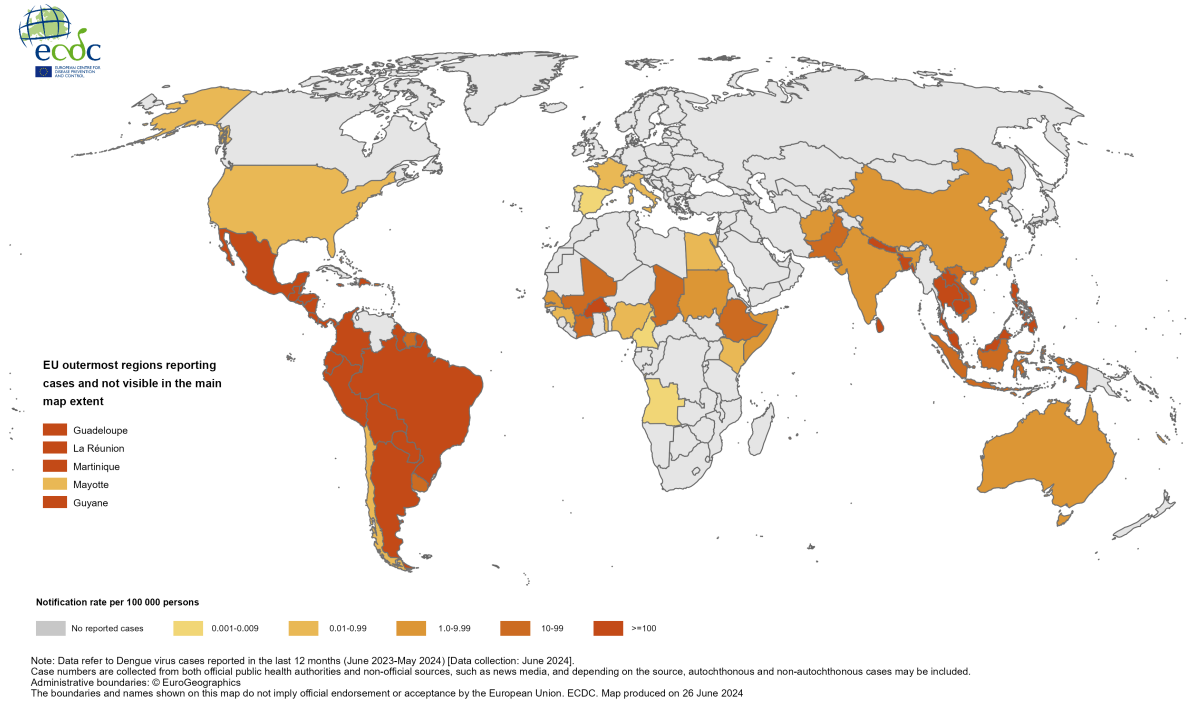
Last time this event was included in the Weekly CDTR: 31 May 2024

Figure 3. Three-month dengue virus disease case notification rate per 100 000 population, March–May 2024



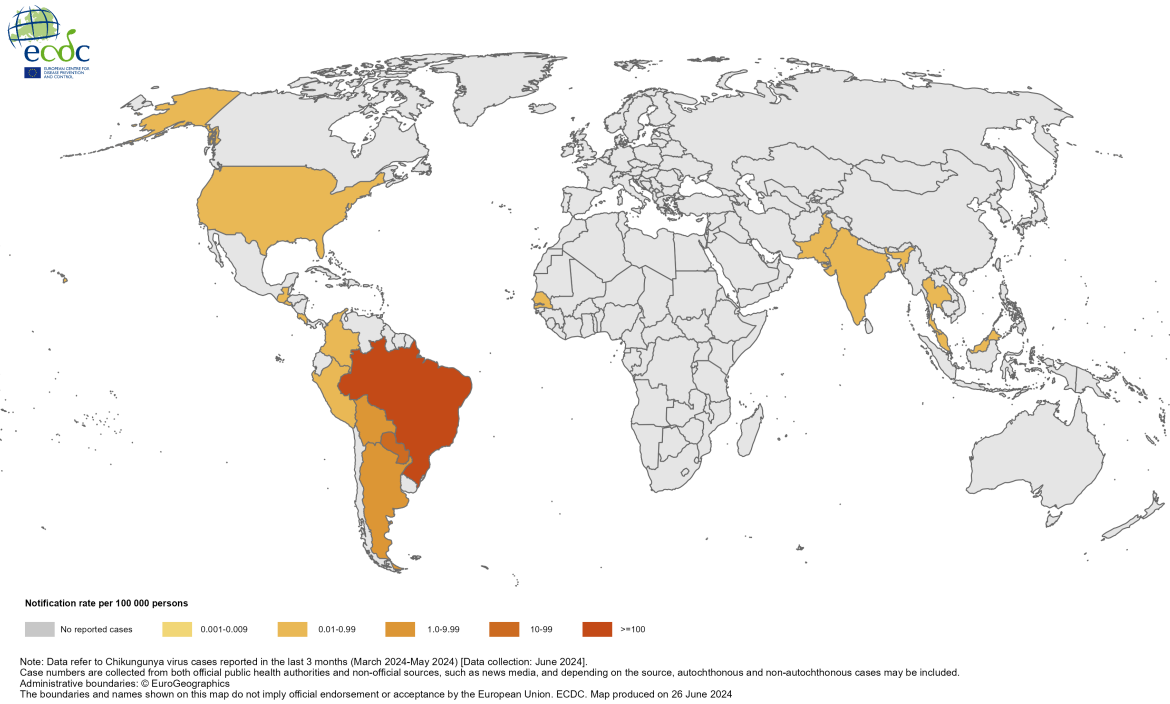
Source: ECDC

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



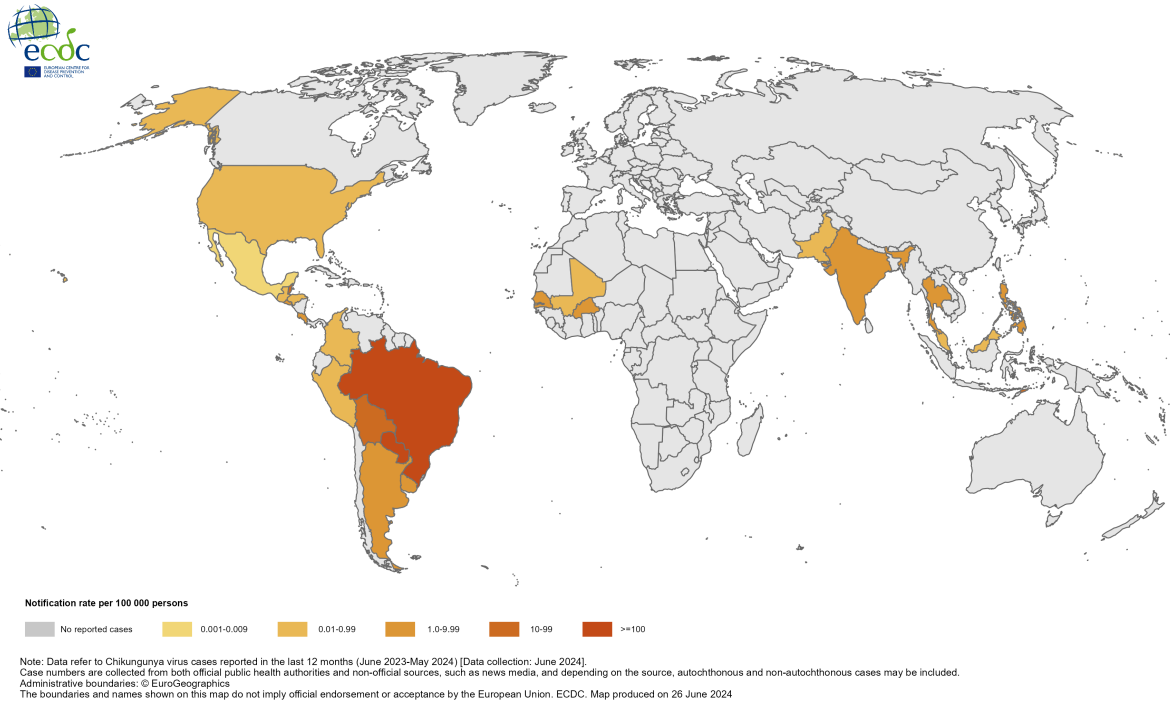
Source: ECDC

Figure 5. Three-month Chikungunya virus disease case notification rate per 100 000 population, March-May 2024



Source: ECDC

Figure 6. 12-month Chikungunya virus disease case notification rate per 100 000 population, June 2023-May 2024



Source: ECDC

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

Overview:

Virus characterisation

Influenza for week 40, 2023 to week 25, 2024

- In the above period 3 868 A(H1)pdm09, 1 538 A(H3) and 504 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the viruses that have been assigned to a clade:
- 3 861 were A(H1)pdm09 – 2 662 (69%) were subclade 5a.2a and 1 199 (31%) were subclade 5a.2a.1.
- 1 535 were A(H3) – 30 (2%) were subclade 2a, 11 (0.7%) were subclade 2a.3a, 1 493 (97%) were subclade 2a.3a.1, and 1 (0.1%) were subclade 2a.3b.
- 504 were B/Vic – all were subclade V1A.3a.2.

SARS-CoV-2 variants for weeks 23–24 (3 June to 16 June 2024)

- The estimated distribution (median and IQR of proportions from seven countries submitting at least 10 sequences) of variants of concern (VOCs) or variants of interest (VOIs) was:
- 96% (94–99%) for BA.2.86 (874 detections from seven countries).
- 0% for XBB.1.5-like (no detections were reported).
- For information on SARS-CoV-2 variants classified as variants under monitoring (VUM), visit [ECDC's variant page](#).

ECDC assessment:

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

Actions:

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

Vaccination remains critically important to protect individuals at high risk for severe outcomes, such as older adults. While COVID-19 vaccination continues to be protective against severe disease, its protective effect wanes over time and individuals at higher risk should continue to remain up to date with COVID-19 vaccination as per national recommendations.

ECDC monitors rates of respiratory illness presentation and respiratory virus activity in the EU/EEA, presenting findings in the European Respiratory Virus Surveillance Summary ([ERVISS.org](#)). Updated weekly, ERVISS describes the epidemiological and virological situation for respiratory virus infections across the EU/EEA and follows the principles of integrated respiratory virus surveillance outlined in '[Operational considerations for respiratory virus surveillance in Europe](#)'.

Further information:

- Short-term forecasts of influenza-like illness (ILI) and acute respiratory infection (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: 14 June 2024

Figure 7. Overview of key indicators of activity and severity in week 25

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary	Comment
		Week 25	Week 24		
Primary care consultation rates	ARI	8 rates (6 MEM)	10 rates (8 MEM)	Distribution of country MEM categories	6 Baseline
	ILI	12 rates (12 MEM)	14 rates (14 MEM)		12 Baseline
Primary care sentinel positivity	SARS-CoV-2	11	11		27% (11; 0–29%) An increasing trend in median test positivity has been observed since week 22, with four countries reporting >20% positivity this week.
	Influenza	9	10	Pooled (median; IQR)	1.1% (1.2; 0–4.1%) Decreasing or stable trends continue to be observed at country level.
	RSV	10	11		0.1% (0; 0–0%) Stable trends continue to be observed at country level.
SARI consultation rates	SARI	7	8		Stable or decreasing rates continue to be reported at levels comparable to the same time last year.
SARI positivity	SARS-CoV-2	5	7		17% (21; 12–36%) An increasing trend in median test positivity has been observed since week 18, with three countries reporting >20% positivity this week. In data from non-sentinel sources, three countries reported an increase in hospitalisations and one country reported an increase in deaths in the 65 years and above age group.
	Influenza	5	7	Pooled (median; IQR)	0.6% (0.5; 0.4–1.8%) Decreasing or stable trends continue to be observed at country level.
	RSV	5	6		0% (0; 0–0%) Stable trends continue to be observed at country level.
Intensity (country-defined)	Influenza	15	18	Distribution of country qualitative categories	13 Baseline 2 Low
Geographic spread (country-defined)	Influenza	14	17	Distribution of country qualitative categories	6 No activity 6 Sporadic 1 Local 1 Regional

Source: ECDC

Figure 8. Virological distribution for week 25 and the period week 25, 2024 to week 25, 2024

Pathogen or (sub-)type	Primary care sentinel						SARI sentinel						Non-sentinel			
	Week 25			Period 2024-2025			Week 25			Period 2024-2025			Week 25		Period 2024-2025	
	n	%	positivity	n	%	positivity	n	%	positivity	n	%	positivity	n	%	n	%
Influenza	10	100	1.1%	10	100	1.1%	5	100	0.6%	5	100	0.6%	142	100	142	100
Influenza A (total)	7	70	0.8%	7	70	0.8%	1	50	0.1%	1	50	0.1%	42	33	42	33
A(H1)pdm09	5	83		5	83								7	88	7	88
A(H3)	1	17		1	17								1	12	1	12
A (unknown)	1			1			1			1			34		34	
Influenza B (total)	3	30	0.3%	3	30	0.3%	1	50	0.1%	1	50	0.1%	85	67	85	67
B/Vic	1	100		1	100											
B (unknown)	2			2			1			1			85		85	
Influenza untyped							3	0.4%		3	0.4%		15		15	
RSV	1		0.1%	1		0.1%	NA			NA			7		7	
SARS-CoV-2	238		26.7%	238		26.7%	137		17.2%	137		17.2%	8 174		8 174	

Source: ECDC

4. Cholera – Comoros and Mayotte – 2024 – Weekly monitoring

Overview:

Update

In Mayotte, since the previous report on 11 June, and as of 24 June, [the Mayotte Regional Health Authority \(ARS Mayotte\)](#) have reported 44 new cholera cases. According to the bulletin, a total of 1 037 contacts have received antibiotic chemoprophylaxis and 7 471 contacts have been vaccinated.

Since 18 March, and as of 24 June, [French health authorities](#) have reported 210 cholera cases and two deaths.

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

Since the last update on 19 June, and as of 26 June, [Comoros Health Authorities](#) have reported 465 new cholera cases and three new deaths. Since the outbreak was declared on 2 February 2024 in the Union of the Comoros, and as of 26 June, a total of 10 027 cases and 146 deaths have been reported on the three islands. In all, 9 801 cases have recovered.

Background

On 31 January 2024, a boat from Tanzania carrying 25 people [arrived in Moroni](#), the capital of the Comoros archipelago. One person on board died of suspected cholera and several others were symptomatic. The Comoros Ministry of Health [declared](#) a cholera outbreak on 2 February. The first locally transmitted cases in Comoros were reported on 5 February in Moroni. Cholera cases were also detected in Moheli and Anjouan by the end of February and 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 detection of several autochthonous cases of cholera in Mayotte, ECDC assesses the likelihood of further community transmission of cholera in Mayotte as high. The impact of the cholera outbreak in Mayotte is considered to be high. The overall risk of cholera for the population in Mayotte is therefore assessed as high.

Early detection and response activities are essential and have been reinforced in the French territory of Mayotte, as well as increasing 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: 20 June 2024

5. Mass gathering - Hajj - Kingdom of Saudi Arabia - 2024 - Weekly monitoring

Overview:

The Hajj ended on 19 June 2024, with an estimated attendance of 1.8 million pilgrims. There have been no reports regarding communicable diseases among pilgrims during the Hajj since 10 June (the start day of the monitoring). However, [media quoting multiple sources](#) reported that 1 301 pilgrims had died while attending the Hajj. These deaths in the context of the Hajj [have been related](#) to the severe climatic conditions, such as heatwaves, during the event.

After the event ended, on 24 June the [Ministry of Health of Senegal](#) reported that 63% (78/124) of the pilgrims returning to the country have tested positive for COVID-19 with rapid diagnostic tests (RDTs). □

Before the start of the event, 14 cases of invasive meningococcal disease (IMD) serogroup W were reported in France (4), the United Kingdom (3), the United States (5), Norway (1), and the Netherlands (1), all among travellers or contacts of travellers returning from Umrah pilgrimage in Saudi Arabia. Travellers eligible for vaccination should be counselled to receive the quadrivalent (ACWY) meningococcal vaccine at least 10 days before departure. Please refer to [ECDC's weekly CDTR w20](#) for further information.

On 29 April 2024, the first MERS-CoV fatality was reported in [Saudi Arabia](#). Since April 2012, 2 610 laboratory-confirmed cases of MERS-CoV have been reported overall, including 940 deaths (CFR: 40%) in 12 countries.

Background

This year, the annual Islamic Hajj pilgrimage took place in Saudi Arabia between 14 and 19 June. Pilgrims aged 12 years and above were allowed to attend the pilgrimage. Over two million pilgrims were expected to attend from all over the world, including from 24 EU/EEA countries.

The [Ministry of Health of Saudi Arabia](#) issued a list of requirements for 2024 Hajj and Umrah pilgrims, which included the requirement to be vaccinated with a quadrivalent meningococcal vaccine (ACYW) polysaccharide vaccine at least 10 days and no more than three years before arrival.

In addition, since it is a densely populated event and there was a heightened risk of respiratory infectious diseases, the Ministry of Health also recommended that pilgrims:

- wear facemasks when in crowded places;

- wash hands frequently, with soap and water or a disinfectant, especially after coughing, sneezing, using toilets, before handling and consuming food, and after touching animals;
- use disposable tissues when coughing or sneezing and dispose of used tissues in wastebaskets;
- avoid contact with those who appear ill and avoid sharing personal belongings;
- avoid contact with camels in farms, markets, or barns;
- avoid drinking unpasteurised milk or eating raw meat or animal products that have not been thoroughly cooked, as well as applying measures to avoid insect bites during the day and night.

Authorities in Saudi Arabia did not permit travellers arriving into the country for Hajj to bring food, unless it was in properly canned or sealed containers. Travellers arriving in areas in the vicinity of Hajj locations for pilgrimage, seasonal work or other purposes were recommended to observe the following:

- wash hands before and after eating and after going to the toilet;
- clean and wash fresh vegetables and fruit;
- cook food thoroughly and store at safe temperatures;
- keep raw and cooked food separated.

Pilgrims were recommended to take necessary measures to avoid mosquito bites during the day and evening, including:

- wearing protective clothing (preferably light-coloured) that covers as much of the body as possible;
- using physical barriers, such as window screens and closed doors;
- applying insect repellent (as per the label instructions on the product) to skin or clothing that contains DEET, IR3535 or Icaridin.

ECDC assessment:

Hajj is now over, but please note that the ECDC assessment for it was as follows:

'ECDC assesses the risk of IMD to the general public in the EU/EEA in connection with these imported cases as very low due to the very low probability of exposure and potential infection. For pilgrims visiting the Hajj and Umrah zones in KSA who are already vaccinated with the quadrivalent meningococcal vaccine, the likelihood of infection is low, as they are protected from the vaccine-induced immunity. For unvaccinated pilgrims, the likelihood of infection is higher, reaching the moderate level of risk.'

The probability of infection to the EU/EEA citizens with communicable diseases during the 2024 Hajj is considered to be low, due to the vaccination requirements for travelling to Mecca and Medina and the preparedness plans by Saudi Arabia that address the management of health hazards before, during, and after Hajj. The risk of infection is considered to be moderate for people with underlying conditions, the elderly, and pregnant women, with a moderate probability of infection and moderate impact. As with other mass gathering events, the risk of communicable disease outbreaks is highest for respiratory, food-, waterborne, and vector-borne diseases.

The risk of vaccine-preventable and vector-borne diseases is considered low if preventive measures are applied. A risk of infection and importation of cases to Europe after Hajj remains.

ECDC published a [rapid risk assessment on Hajj on 2 July 2019](#). The risks and advice to pilgrims attending Hajj remain valid for this year.'

Actions:

ECDC monitored this event through its epidemic intelligence for mass gathering activities between 10 and 27 June 2024 in collaboration with the World Health Organization's Regional Office for the Eastern Mediterranean (WHO/EMRO), and included weekly updates in the Communicable Disease Threats Report (CDTR).

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

6. Influenza A(H5N2) - Multi-country (World) - Monitoring human cases

Overview:

On 23 May 2024, Mexican health authorities reported to PAHO/WHO a deceased case of human infection with avian influenza A(H5N2) virus, detected in Mexico.

The patient was a 59-year-old male, with multiple underlying conditions, who developed respiratory infection on 17 April 2024, sought medical attention on 24 April and was hospitalised, but died from complications related to his comorbidities on the same day. The individual had no known history of exposure to poultry or other animals. The case had no reported travel in the three weeks prior to symptom onset.

A respiratory sample taken on 24 April was analysed on 8 May at the National Institute of Respiratory Diseases and on 20 May at the Institute of Epidemiological Diagnosis and Reference in Mexico using RT-PCR analysis and sequencing. The subtype was confirmed as A(H5N2). Genetic analysis performed found that the virus had 99% similarity to low pathogenic avian influenza A(H5N2) strains from birds in Texcoco, State of Mexico.

No additional cases have been detected among close contacts of the case. These included household contacts (no reported illness, no sampling possible), contacts among healthcare workers (all asymptomatic, only sampled on 27 May), and 12 additional contacts from the vicinity of the case's residence (seven with and five without symptoms, test results also as of 28 May).

Partial genome sequences are available in GISAID. Based on the available sequences the virus is related to H5N2 viruses which have been circulating in poultry in the country for several years. Outbreaks of low pathogenic avian influenza A(H5N2) have been observed in poultry in the State of Mexico in 2024. It has not been possible to establish an epidemiological link between the human case and the outbreak in poultry.

Source: [WHO DON](#), [WAHIS](#), [WHO DON](#)

ECDC assessment:

This is the first laboratory-confirmed human infection with avian influenza A(H5N2). Sporadic human cases of avian influenza A(H5Nx) have previously been reported globally. Transmission to humans remains a rare event and no sustained transmission between humans has been observed to date. However, sporadic zoonotic transmission cannot be excluded. The implementation of personal protective measures for people directly exposed to poultry and birds potentially infected with avian influenza viruses will reduce the associated risk. The risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered to be low.

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: 7 June 2024

7. Mass gathering monitoring - UEFA European Football Championship - 2024 - Weekly monitoring

Overview:

Update

Since the previous update, and as of 27 June, no relevant public health events related to communicable diseases have been detected in connection with UEFA European Football Championship 2024.

On 26 June, [media](#) reported 60 cases of Tick-Borne Encephalitis (TBE) in Bavaria, since the beginning of the year. Bavaria is a state in the southeast of Germany, whose capital is Munich, one of the cities that will host two more football matches by the end of the Championship.

Further information on the high risk areas for TBE infection in Germany are available on the [Robert Koch Institut's website](#).

Background

The UEFA European Football Championship 2024 is taking place in Germany between 14 June and 14 July. Around 2.8 million people are expected to follow the 51 scheduled matches of the 24 qualified national teams, which will take place in 10 stadiums in 10 German cities: Berlin, Dortmund, Düsseldorf, Frankfurt (Main), Gelsenkirchen, Hamburg, Cologne, Leipzig, Munich, and Stuttgart.

The stadiums have registered [different capacities for EURO 2024](#) with Berlin, Munich and Dortmund having the largest stadiums and Leipzig and Cologne having the venues with the smallest capacities.

National teams from the following 24 countries, including host country Germany, have qualified for EURO 2024: Albania, Belgium, Denmark, England, France, Georgia, Italy, Croatia, the Netherlands, Austria, Poland, Portugal, Romania, Scotland, Switzerland, Serbia, Slovakia, Slovenia, Spain, Czech Republic, Turkey, Ukraine and Hungary.

In addition to the matches in the stadiums, a large number of [public viewing events](#) are being planned in Germany, such as the transmission of football matches shown on television outside the home environment. These include the viewing of matches in the official fan zones that UEFA will operate in each of the ten host cities for each EURO 2024 match. Most visitors are expected in [Berlin](#) and in [Frankfurt](#). Non-commercial and commercial public viewing events can be registered in other German cities by arranging a mandatory UEFA public viewing licence.

ECDC assessment:

Mass gathering events involve a large number of visitors in an area at the same time. This may increase the risk of communicable disease outbreaks and non-communicable health risks, including heat stroke, crowd injury and drug- and alcohol-related conditions.

The probability of infection of EU/EEA citizens by communicable diseases during the UEFA European Football Championship 2024 is considered to be low if preventive measures are applied, e.g. being fully vaccinated according to the national immunisation schedule, following hand and food hygiene, respiratory etiquette, refraining from any activities or contact with people should symptoms occur, and seeking prompt testing and medical advice as needed. This is particularly important in relation to vaccine-preventable diseases that may be on the increase in the EU/EEA, such as [measles](#) and [whooping cough](#).

In collaboration with the German Federal Centre for Health Education (BZgA) and ECDC, WHO has published a [public health advice for travellers attending the UEFA EURO 2024](#). In addition, given that Europe will be hosting a range of other high-profile events this summer, including the 2024 Summer Olympics and Paralympics in Paris, ECDC has [published recommendations for public health authorities](#) preparing for mass gathering events.

Actions:

ECDC will monitor this mass gathering event through epidemic intelligence activities between 10 June and 19 July 2024 in collaboration with the Robert Koch Institute and the World Health Organization Regional Office for Europe (WHO/Europe), and including weekly updates in the Communicable Disease Threats Report (CDTR).

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

8. Seasonal surveillance of West Nile virus infections – 2024

Overview:**Epidemiological summary**

Since the beginning of 2024, and as of 26 June 2024, only one country in Europe has reported human cases of West Nile virus infection: Spain.

On 27 June 2024, Italy confirmed in an [official report](#) confirmed the first human case of WNV infection of the 2024 season from the province of Modena. The ECDC weekly update and dashboard has information on places on infection up to 26 June 2024. The data from Italy will be updated in the upcoming weekly update and dashboard.

Background information

According to the Commission Directives 2004/33/EC and 2014/110/EU on blood safety, blood establishments in the EU/EEA, countries should apply temporary deferral criteria for donors of allogeneic blood donation for 28 days having left a risk area for locally-acquired West Nile virus (WNV) unless an individual Nucleic Acid Test (NAT) is negative.

The WNV surveillance activities carried out by ECDC support the competent authorities responsible for blood safety in the implementation of these directives. Therefore, the Emerging and Vector-borne Diseases team at ECDC currently provides weekly and monthly updates with the latest reports on cases of WNV infections in Europe. A map and table are updated every Friday between June and November which is the time of the year when WNV infections are most likely to be reported. In addition, an [interactive dashboard](#) is made available. ECDC provides an enhanced analysis of the current WNV epidemiology on a monthly basis, which includes an assessment of the situation.

EU/EEA notification of West Nile virus infections

West Nile virus infection in humans is a notifiable disease at the EU level and cases should be reported by national public health authorities through The European Surveillance System (TESSy) according to the EU case definition.

Outbreaks of WNV infections in equids and birds should be notified to the Animal Disease Information System (ADIS) of the European Commission. At EU/EEA level, it is mandatory to report equine encephalomyelitis due to WNV infection and West Nile virus infections among birds in accordance with Commission Implementing Regulation (EU) 2018/1882. Data from passive and active surveillance activities, including outbreaks, are collected by the European Food Safety Authority (EFSA). Analyses of animal data are only included in the monthly update.

ECDC's weekly surveillance report on West Nile virus infections is available online ([Weekly updates: 2024 West Nile virus transmission season \(europa.eu\)](#) and [West Nile virus Dashboard \(europa.eu\)](#)).

Actions:

ECDC is monitoring WNV through indicator- and event-based surveillance activities.

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

Events under active monitoring

- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update – last reported on 31 May 2024
- Overview of respiratory virus epidemiology in the EU/EEA – weekly monitoring – last reported on 31 May 2024
- Cholera – Comoros and Mayotte – 2024 – Weekly monitoring – last reported on 31 May 2024
- Highly pathogenic avian influenza A(H5N1) in cattle and related human cases – United States – 2024 – last reported on 31 May 2024
- Imported invasive meningococcal disease in travellers returning from the Kingdom of Saudi Arabia – Multi-country – 2024 – last reported on 31 May 2024
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks – last reported on 31 May 2024
- Mass gathering – Hajj – Kingdom of Saudi Arabia – 2024 – Weekly monitoring – last reported on 31 May 2024
- Influenza A(H5N2) – Multi-country (World) – Monitoring human cases – last reported on 28 June 2024
- Mass gathering monitoring – UEFA European Football Championship – 2024 – Weekly monitoring – last reported on 28 June 2024
- Seasonal surveillance of West Nile virus infections – 2024 – last reported on 28 June 2024
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update – last reported on 28 June 2024
- Avian influenza A(H5N6) – Multi-country – Monitoring human cases – last reported on 20 June 2024
- Risk assessments under production – last reported on 20 June 2024
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases – last reported on 14 June 2024
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring – last reported on 14 June 2024
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update – last reported on 7 June 2024
- Out-of-season increase in norovirus (NoV) activity – last reported on 7 June 2024
- Oropouche virus disease – Cuba – 2024 – last reported on 7 June 2024
- Seasonal surveillance on West Nile virus infections starts in week 23 – last reported on 7 June 2024
- SARS-CoV-2 variant classification – last reported on 7 June 2024