

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 33, 10–16 August 2024

This week's topics

- [1. Mpox due to monkeypox virus clade I – Multi-country – 2024](#)
- [2. Overview of respiratory virus epidemiology in the EU/EEA – weekly monitoring](#)
- [3. Seasonal surveillance of West Nile virus infections – 2024](#)
- [4. Mass gathering monitoring – Olympic and Paralympic Games – France – 2024](#)
- [5. Cholera – Comoros and Mayotte – 2024 – Weekly monitoring](#)
- [6. Locally acquired dengue in 2024 in mainland France](#)
- [7. Measles – Multi-country \(World\) – Monitoring European outbreaks – monthly monitoring](#)
- [8. Human cases of swine influenza A\(H3N2\) variant virus – Multi-country](#)
- [9. Chandipura virus disease – India – 2024](#)

Executive Summary

Mpox due to monkeypox virus clade I – Multi-country – 2024

- Sweden reported one imported mpox case due to Monkeypox virus (MPXV) clade Ib on 15 August 2024. The case had previously visited a country where confirmed monkeypox virus clade Ib cases have been reported.
- In 2024, and as of 8 August, 685 mpox cases have been reported by 20 EU/EEA countries through The European Surveillance System (TESSy). All cases were part of the ongoing epidemic of MPXV clade II.
- Overall in 2024, 17 541 mpox cases have been reported in Africa, including 2 822 confirmed cases and 517 deaths (case fatality (CF): 3%) from 13 Africa Union Member States, according to the [Africa CDC Epidemic Intelligence Report issued on 9 August 2024](#).
- Since the beginning of the monitoring in 2022 and until the end of July 2024, 99 176 confirmed cases of mpox, including 208 deaths, were reported by 116 countries globally, according to the World Health Organization (WHO).
- 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 mpox outbreak a public health emergency of international concern.

- Additional information can be found in the ECDC Rapid Risk Assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries ([Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#)).
- ECDC is closely monitoring and assessing the epidemiological situation.

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

- Indicators of increased SARS-CoV-2 activity in primary and secondary care settings have been observed since late spring 2024. The timing of the epidemic has varied between EU/EEA countries, with many now reporting declining trends, but some continuing to observe increases.
- The overall impact of this SARS-CoV-2 epidemic on hospitals and mortality has been relatively low since May. The most affected group in hospital settings has been individuals aged 65 years and above, highlighting the fact that vulnerable populations remain at higher risk of severe illness.
- The SARS-CoV-2 variant BA.2.86 and its subvariants, including KP.3, continue to dominate. KP.3 is not expected to be associated with increased infection severity or to significantly reduce vaccine effectiveness.
- Vaccination is the most effective measure for preventing COVID-19 and seasonal influenza infection from progressing to severe disease. It is essential that all Member States actively promote vaccination against respiratory viral diseases, in line with national recommendations.

Seasonal surveillance of West Nile virus infections – 2024

- Since the beginning of 2024, and as of 14 August 2024, West Nile virus (WNV) infection cases have been reported to The European Surveillance System (TESSy) by eight EU/EEA countries (Austria, Croatia, France, Greece, Hungary, Italy, Romania and Spain) and two EU-neighbouring countries (Serbia and Kosovo*).
- 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.

Mass gathering monitoring – Olympic and Paralympic Games – France – 2024

- Since the previous update on 9 August and as of 15 August, no major public health events related to communicable diseases have been detected in the context of the Paris 2024 Olympic and Paralympic Games.
- The probability of EU/EEA citizens becoming infected with communicable diseases during the Paris 2024 Olympic and Paralympic Games is considered to be low if general preventive measures are applied.
- ECDC is monitoring this mass gathering event through epidemic intelligence activities until 13 September 2024, in collaboration with Santé Publique France and partners. Weekly updates will be included in the [Communicable Disease Threats Report \(CDTR\)](#).

Cholera – Comoros and Mayotte – 2024 – Weekly monitoring

- As of 12 August, no further cholera cases have been reported in Mayotte since the last update provided by French authorities on 12 July. Since 18 March, there have been 221 confirmed cases, five probable cases and two possible deaths.
- In the Union of Comoros, since the previous update on 4 August and as of 12 August, local authorities have reported no new cholera cases or new deaths. As of 12 August, 10 342 confirmed cholera cases and 149 deaths have been reported in the country.
- Given the decline in the number of autochthonous cholera cases in Mayotte, and in neighbouring Comoros, ECDC now considers the overall risk to be very low to low.

Locally acquired dengue in 2024 in mainland France

- In 2024, as of 13 August, six locally acquired dengue cases have been reported in mainland France.
- On 8 August, three autochthonous cases of dengue were [reported in the region of Occitania](#), with probable places of infections in the Pyrénées-Orientales, Lozère and Gard departments.

- In the beginning of August 2024, the [Regional Health Agency of Provence-Alpes-Côte d'Azur](#) reported two autochthonous cases of dengue in the Alpes-Maritimes department, in the region of Provence-Alpes-Côte d'Azur.
- On 8 July, France reported an autochthonous case of dengue in Hérault department in [Occitania](#). The case had onset of symptoms on 17 June and this event has now been closed.

Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring

- In June 2024, 27 countries reported measles data to The European Surveillance System (TESSy), with 1 891 cases reported by 16 countries. Eleven countries reported zero cases.
- Through its epidemic intelligence activities, ECDC has identified 2 950 new measles cases in 17 EU/EEA countries that were not reported before the last monthly update.
- In 2024, 19 measles-related deaths have been reported in Romania (18) and Ireland (1).
- Overall in the EU/EEA, over the last 12 months, there has been high measles activity; however, the situation varies by country. Some countries have reported large and/or ongoing outbreaks and others have sustained no or very low transmission.
- Relevant updates outside the EU/EEA are available for Switzerland, the United Kingdom (UK), and countries in the Western Balkan and WHO Regions.

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

- On 9 August 2024, two cases of human infection with swine influenza A(H3N2) variant (A(H3N2)v) virus were reported in the United States (US), one in Colorado and one in Michigan.
- The case from Colorado was aged under 18 years and reported onset of illness during the week ending 13 July 2024 (week 28). The case was not hospitalised.
- The case from Michigan tested positive in late July 2024. The case did not report any exposure to swine or other animals.
- Although investigations are still ongoing, no infections have been detected among close contacts of the two cases.

Chandipura virus disease – India – 2024

- Since June 2024, cases of acute encephalitis syndrome have been reported in Gujarat, India.
- As of 31 July 2024, 148 cases have been reported from the districts of Gujarat (140), Rajasthan (3), Madhya Pradesh (4) and Maharashtra (1), including 59 deaths (case fatality rate (CFR): 40%). From these, Chandipura virus (CHPV) has been confirmed in 51 cases.

1. Mpox due to monkeypox virus clade I – Multi-country – 2024

Overview:

One mpox case due to monkeypox virus (MPXV) clade Ib was reported by Sweden on 15 August 2024. The case is an adult who returned from an African country where MPXV clade Ib transmission has been reported. The mode of transmission is under investigation. Contacts of the case have been informed and are being monitored. The Swedish Public Health Agency's press release can be found at: [One case of mpox clade I reported in Sweden - The Public Health Agency of Sweden \(folkhalsomyndigheten.se\)](#).

Epidemiological situation in the EU/EEA

As of 8 August 2024, 22 662 confirmed mpox cases have been reported by 29 countries in the EU/EEA via The European Surveillance System (TESSy). Most cases (93%) were reported during an intense period of circulation in 2022. In 2024, 685 cases have been reported by 20 EU/EEA countries. Information on the virus clade was reported for 2.1% of all mpox cases reported to TESSy since 2022 and as of 8 August 2024, and all cases were from clade II. On 15 August 2024, Sweden reported the first imported case of mpox due to MPXV clade I. This is the first confirmed case of clade I reported outside the African continent.

Between 2022 and 2024, the profile and severity of mpox cases diagnosed in the EU/EEA has remained stable, with >95% of cases in males and 39% in 31–40 years-olds. Cases reported to date in the EU/EEA have been mostly mild (proportion of hospitalised cases: 7%) and 10 deaths have been reported.

Epidemiological situation in Africa

Overall in 2024, over 17 000 mpox cases have been reported in Africa, including over 2 500 confirmed cases and over 500 deaths (CF: 3%) from 13 Africa Union Member States, according to the [Africa CDC Epidemic Intelligence Report issued on 9 August 2024](#). These Member States are Burundi, Cameroon, Central African Republic (CAR), Republic of the Congo (hereafter referred to as Congo), Cote d'Ivoire, Democratic Republic of Congo (DRC), Ghana, Liberia, Kenya, Nigeria, Rwanda, South Africa and Uganda. Both MPXV monkeypox virus clade I and clade II are circulating in different countries in the continent.

DRC has been the most affected country, with a large increase of mpox cases due to MPXV clade I being reported since November 2023. There have been over 16 000 suspected and confirmed cases [reported](#), including over 500 deaths (CF: 3%).

In recent weeks, confirmed mpox cases have been [reported](#) in countries neighbouring DRC that had not reported mpox cases in 2024, such as Burundi, Rwanda, Uganda and Kenya.

Both MPXV clade Ia and clade Ib have been circulating in DRC. MPXV clade Ia has been [detected](#) in Congo and CAR and clade Ib in Burundi, Rwanda, Uganda and Kenya. The type of exposure [reported](#) by cases in DRC includes sexual contact, non-sexual direct contact, household contact and healthcare facility contact. For clade Ib (reported in Eastern DRC, Burundi, Rwanda, Uganda and Kenya), sexual transmission has been documented as the predominant mode of transmission, while for clade Ia (in endemic areas of DRC, Congo and CAR) multiple modes of transmission have been [documented](#).

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 clade I monkeypox virus outbreak a public health emergency of international concern.

Global background and EU/EEA

Since the beginning of the monitoring in 2022 and until the end of July 2024, 99 176 confirmed cases of mpox, including 208 deaths, were reported by 116 countries globally, according to WHO ([2022-24 Mpox \(Monkeypox\) Outbreak: Global Trends](#)).

ECDC assessment:

The number of mpox cases due to MPXV clade I is increasing and a geographical expansion in newly affected African countries has occurred in recent weeks. On 15 August 2024, Sweden reported the first case of MPXV clade Ib identified in the EU/EEA and the first detected outside the African continent. More imported mpox clade I cases are likely to be reported.

Overall risk due to MPXV clade I in the EU/EEA

In the event of more sporadic importations of the MPXV clade I in the EU/EEA, the likelihood of infection for close contacts of possible or confirmed cases is assessed as high. The likelihood of infection is much lower for contacts that have been vaccinated or have a history of previous infection with MPXV clade I Ib.

The likelihood of infection in the general population in the EU/EEA is assessed as very low, provided that imported cases are diagnosed promptly and control measures are implemented.

Severe disease is more likely for people with underlying immunocompromising conditions and those with an untreated HIV infection (as was the case for clade I Ib). Based on these factors, the impact of the disease is assessed as moderate for this group and low for the general population.

Therefore, the level of risk is assessed as high for close contacts with underlying immunocompromising conditions and those with an untreated HIV infection, moderate for healthy close contacts, and low for the remaining general EU/EEA population.

Overall risk due to MPXV clade I circulation for EU/EEA citizens who are travelling to or living in the affected African countries

Given the uncertainties around the extent of community transmission in the affected areas and the lack of conclusive evidence on the relative efficiency of different routes of transmission, likelihood of infection for EU/EEA citizens visiting affected countries and engaging in activities that involve close contact with affected local communities is considered as high.

Based on current preliminary data from Africa, which doesn't show higher clinical severity in confirmed cases, and considering the relatively low number of EU/EEA citizens potentially affected, the impact of mpox on EU/EEA citizens visiting or living in the areas affected by the current epidemic is considered low.

Overall, the risk for EU/EEA citizens travelling to the affected countries and having close contact with affected communities or living in the affected countries is assessed as moderate.

Regarding EU/EEA citizens travelling to the affected countries who do not have close contact with the local community, the likelihood of infection is assessed as low and the impact of mpox is also considered as low; therefore, the risk for this population group is assessed as low.

This assessment is based on historical data on MPXV clade I, the ongoing epidemic in DRC, and the recent MPXV clade IIb outbreak. However, many aspects of transmission and clinical outcomes, in particular the severity of the clinical presentation of MPXV clade Ib infection and the role of sexual transmission for this sub-clade remain uncertain.

Further information can be found in the ECDC Rapid Risk Assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries ([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 globally.

Last time this event was included in the Weekly CDTR: 9 August 2024

2. 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 all but one EU/EEA country (Denmark), at similar levels to those observed during summer 2023.

SARS-CoV-2 activity is stable or decreasing in both primary and secondary care in the EU/EEA, although the country-level picture remains mixed:

- SARS-CoV-2 activity started about six weeks earlier than during summer 2023, but the trends are comparable in terms of the number of tested samples and positivity rates in both primary and secondary sentinel systems.
- In primary care sentinel systems (general practitioners), pooled test positivity was similar to the previous week at 24%, with the median test positivity increasing to 17%. One country (Spain) continues to contribute >50% of all tested samples and reported 27% positivity, driving the divergence between pooled and median estimates. One country (Greece) showed 39% positivity and an increasing trend. The other reporting countries reported stable or decreasing trends in positivity. Non-sentinel detections showed a stable trend; however, increases were observed in five countries (16 reporting countries).
- In SARI sentinel systems (hospitals), the pooled test positivity decreased to 14%, with test positivity ranging from 5–36% in the five reporting countries (Germany, Greece, Ireland, Malta and Spain). The age group 65 years and above remained the most affected (20% positivity).
- Non-sentinel secondary care notifications are at low levels in general. However, country data showed a mixed picture. Three EU/EEA countries (Czechia, Ireland and Slovakia) reported a decreasing or stable trend in the number of positive test results among hospitalised patients, and one country (Ireland) reported an increase in ICU inpatients. One country (Romania) reported increases in SARS-CoV-2 deaths, while the other seven reporting countries observed stable or decreasing trends.
- Despite test positivity in primary and secondary care sentinel systems remaining elevated above 10%, sentinel syndromic rates (ILI/ARI/SARI) showed no increase above baseline levels, apart from in one EU/EEA country (ILI rates in Denmark).

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

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

Virus characterisation

Influenza for week 40, 2023 to week 32, 2024

During this period, 3 918 A(H1)pdm09, 1 576 A(H3) and 590 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the viruses that have been assigned to a clade:

- 3 911 were A(H1)pdm09, 2 707 (69%) were subclade 5a.2a, and 1 204 (31%) were subclade 5a.2a.1.
- 1 573 were A(H3), 30 (2%) were subclade 2a, 1 (0.1%) was subclade 2a.1b, 11 (0.7%) were subclade 2a.3a, 1 530 (97%) were subclade 2a.3a.1, and 1 (0.1%) was subclade 2a.3b.
- 590 were B/Vic and all were subclade V1A.3a.2.

SARS-CoV-2 variants for weeks 30–31 (22 July to 4 August 2024)

The estimated distribution (median and IQR of proportions from 12 countries submitting at least 10 sequences) of variants of concern (VOCs) or variants of interest (VOIs) was:

- 28% (18–39%) for BA.2.86 (288 detections from 12 countries)
- 69% (60–81%) for KP.3 (678 detections from 12 countries)

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

ECDC assessment:

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

Actions:

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

Vaccination remains critically important to protect individuals at high risk of severe outcomes, such as adults aged 65 years and above. While COVID-19 vaccination protects 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](https://er viss.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 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: 9 August 2024

Maps and graphs

Figure 1. Overview of key indicators of activity and severity in week 32

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comments
		Week 32	Week 31	Description	Value	
Primary care consultation rates	ARI	7 rates (5 MEM)	8 rates (6 MEM)	Distribution of country MEM categories	5 Baseline	Stable rates continue to be reported at levels comparable to the same time last year.
	ILI	10 rates (10 MEM)	12 rates (12 MEM)		9 Baseline 1 Medium	Stable rates continue to be reported at levels comparable to the same time last year, except for one country (Denmark) reporting an increase over the past four weeks.
Primary care sentinel positivity	SARS-CoV-2	13	12	Pooled (median; IQR)	24% (17; 13–27%)	Pooled test positivity stayed at the same level compared to last week. Only one country reported >30% SARS-CoV-2 positivity this week. Of 16 countries reporting non-sentinel detections data, increases in detections were observed in five countries.
	Influenza	11	13		2.2% (0; 0–2.7%)	Stable trend of very low circulation.
	RSV	11	12		0% (0; 0–0%)	Stable trend of very low circulation.
SARI consultation rates	SARI	7	8	Pooled (median; IQR)	14% (14; 9.5–24%)	Stable or decreasing rates continue to be reported at levels comparable to the same time last year.
	SARS-CoV-2	5	6		1.9% (1.4; 0–2.8%)	Decreasing trend observed this week in both pooled test positivity and median test positivity. In data from non-sentinel sources, three countries reported a decrease in laboratory-confirmed SARS-CoV-2 hospitalisations, but Ireland reported an increase in ICU inpatients; Romania reported an increase in SARS-CoV-2 deaths.
SARI positivity	Influenza	5	6	Pooled (median; IQR)	0% (0; 0–0%)	Stable trend with very low circulation, but one country has been reporting an increased influenza activity trend over the past weeks (21% positivity in week 32; Malta)
	RSV	5	5		0% (0; 0–0%)	Stable trend with very low circulation.
Intensity (country defined)	Influenza	15	17	Distribution of country qualitative categories	13 Baseline 2 Low	
Geographical spread (country defined)	Influenza	14	16	Distribution of country qualitative categories	8 No activity 3 Sporadic 1 Local 2 Regional	

Source: ECDC

Figure 2. Virological distribution for week 31 and weeks 25–31, 2024

Pathogen or (sub)type	Primary care sentinel						SARI sentinel						Non-sentinel			
	Week 32			2024–2025			Week 32			2024–2025			Week 32		2024–2025	
	n	%	positivity	n	%	positivity	n	%	positivity	n	%	positivity	n	%	n	%
Influenza	13	100	2.2%	94	100	1.4%	12	100	1.9%	76	100	1.1%	154	100	1 838	100
Influenza A (total)	11	85	1.9%	62	68	0.9%	12	100	1.9%	50	91	0.7%	126	85	1 068	64
A(H1)pdm09	2	29		20	39					1	14		4	25	222	52
A(H3)	5	71		31	61		2	100		6	86		12	75	208	48
A (unknown)	4			11			10			43			110		638	
Influenza B (total)	2	15	0.3%	29	32	0.4%				5	9	0.1%	22	15	609	36
B/Vic				8	100								1	100	28	100
B (unknown)	2			21						5			21		581	
Influenza untyped				3		0%				21		0.3%	6		161	
RSV	0		0%	12		0.2%	NA			13		0.2%	15		267	
SARS-CoV-2	118		23.6%	1 748		28.3%	90		13.8%	1 370		19%	19 761		176 786	

Source: ECDC

3. Seasonal surveillance of West Nile virus infections – 2024

Epidemiological summary

Since the start of 2024, and as of 14 August 2024, human cases of West Nile virus (WNV) infection have been reported to TESSy by eight EU/EEA countries and two EU-neighbouring countries. In the EU/EEA, Austria, Croatia, Hungary, Romania, France, Italy, Greece and Spain reported WNV infections. From EU-neighbouring countries, Serbia and Kosovo reported WNV infections. Fifty-five NUTS3/GAUL1 regions across nine countries reported locally acquired WNV cases. Kosovo did not specify the place of infection at the NUTS3/GAUL1 level. For detailed information on places of infection, please refer to the ECDC [weekly update](#) and [dashboard](#).

The EU candidate country Albania also reported WNV infection cases in the regions of Lezhe (AL014), Berat (AL031) and Fier (AL032) counties.

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 \(europa.eu\)](#).

Actions:

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

Last time this event was included in the Weekly CDTR: 9 August 2024

4. Mass gathering monitoring – Olympic and Paralympic Games – France – 2024

Overview:

Update

Since the previous update on 9 August and as of 15 August, no major public health events related to communicable diseases have been detected in the context of the Paris 2024 Olympic Games.

The Paris 2024 Olympic Games officially closed on 11 August. ECDC will continue monitoring the Paris 2024 Paralympic Games until 13 September.

Summary

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

There have been multiple [media reports](#) of athletes with gastrointestinal diseases. No single common source of transmission is suspected.

Other events outside of the 2024 Paris Olympic and Paralympic Games included autochthonous cases of [West Nile fever](#), [dengue](#) and [chikungunya](#) in France in 2024.

Background

The Paris [2024 Olympic Games](#) took place from 26 July to 11 August and the Paris [2024 Paralympic Games](#) will take place from 28 August to 8 September. Around 15 000 athletes are expected and the event will involve up to 50 000 volunteers. It was estimated that [11.2 million people](#) visited the Greater Paris Metropolis during the Olympics and 3.8 million are projected during the Paralympics. During the first phase of ticket sales, there were buyers from 158 different countries, although most buyers were from France.

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

ECDC assessment:

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

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

Actions:

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

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

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

Last time this event was included in the Weekly CDTR: 9 August 2024

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

Overview:

Update

According to the last bulletin published on 12 August by the [French authorities](#), no further cholera cases have been reported in Mayotte since 12 July 2024.

Since 18 March, and as of 30 July, [French health authorities](#) have reported 221 confirmed cases, five probable cases and two possible deaths. Of the 221 confirmed cases, 199 were acquired locally and 22 were imported. A total of 1 243 contacts have received antibiotic chemoprophylaxis and 23 721 contacts have been vaccinated.

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

In the Union of Comoros, since the last update on 4 August and as of 12 August, [local authorities](#) have reported no new cholera cases or new deaths. No further cholera cases or deaths have been reported in the country since 27 July.

As of 12 August, 10 342 confirmed cholera cases and 149 deaths have been reported in the Union of Comoros. In total, 10 193 cases have recovered since the start of the outbreak.

Background

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

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

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

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

ECDC assessment:

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

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

Actions:

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

Last time this event was included in the Weekly CDTR: 9 August 2024

6. Locally acquired dengue in 2024 in mainland France

Overview:

Update

On 8 August, three additional autochthonous cases of dengue have been reported in the Pyrénées-Orientales, Lozère and Gard departments.

On 2 August the French [Regional Health Agency reported](#) an autochthonous case of dengue in a person living in La Colle-sur-Loup, Alpes-Maritimes department, Provence-Alpes-Côte d'Azur region. This is the first locally acquired dengue case in the region in 2024. Recently, a second case was reported from the same region.

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

Background

On 8 July, France [reported](#) an autochthonous case of dengue. The case had onset of symptoms on 17 June, no travel history, and the place of infection was in Hérault department in the region of Occitania. The case was reported as confirmed by the French National Reference laboratory for arboviruses. As no additional cases connected to this local transmission were detected in the subsequent 45 days, the event has been closed.

ECDC assessment:

These are the first autochthonous dengue cases reported in Europe in 2024. The first case presented with symptoms in June, which is early in the season but not unusual (in 2022, a case was reported with onset of symptoms on 12 June).

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 was the highest number of autochthonous cases and outbreaks in the EU/EEA in this century to date.

In Europe, the dengue virus is transmitted by the mosquito vector *Aedes albopictus*, which is [established](#) in a large part of Europe.

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.

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: 12 July 2024

7. Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring

Overview:

In June 2024, 27 countries reported measles data to The European Surveillance System (TESSy), with 1 891 cases reported by 16 countries. Eleven countries reported zero cases.

In the most recent 12-month period, from 1 July 2023 to 30 June 2024, 30 EU/EEA countries reported 17 273 measles cases, 13 308 (77.0%) of which were laboratory confirmed. During this 12-month period, three countries (Latvia, Luxembourg and Liechtenstein) reported zero cases. The highest number of cases were reported by Romania (13 879), Italy (753), Austria (514), Belgium (493) and France (436). The highest notification rates were observed in infants under one year of age (559.3 cases per million population) and children aged one to four years (333.8 cases per million population). Thirteen deaths attributable to measles were reported to ECDC during the 12-month period by Romania (12) and Ireland (1). Detailed data are available in [ECDC's Surveillance Atlas of Infectious Diseases](#) and the [Measles and Rubella monthly report](#).

Complementary epidemic intelligence surveillance, with data collection conducted between 6 and 12 August 2024 from official public and media sources, detected 2 950 new suspected and/or confirmed measles cases that were not reported before the last monthly update. New cases were reported in 17 EU/EEA countries in recent months: Austria (new: 26; total: 490), Belgium (new: 10; total: 275), Bulgaria (new: 7; total: 24), Croatia (new: 10; total: 18), Czechia (new: 1; total: 30), Denmark (new: 1; total: 20), France (new: 135; total: 300), Germany (new: 9; total: 399), Ireland (new: 13; total: 82, including 1 death), Italy (new: 251; total: 807), Netherlands (new: 42; total: 147), Norway (new: 3; total: 9), Poland (new: 24; total: 246), Portugal (new: 4; total: 34), Romania (new: 2 392; total: 19 785, including 18 deaths), Spain (new: 20; total: 181), Sweden (new: 2; total: 23).

Overall, 19 measles-related deaths have been reported in the EU/EEA in 2024, in Romania (18) and Ireland (1).

Relevant updates for outside the EU/EEA are available for Switzerland, the UK, and countries in the Western Balkan and WHO Regions.

Disclaimer: *The [monthly measles report published in the CDTR](#) provides the most recent data on cases and outbreaks based on information made publicly available by the national public health authorities or the media. Sometimes this information is made available retrospectively. This report is a supplement to [ECDC's monthly measles and rubella monitoring report](#), based on data routinely submitted by 30 EU/EEA countries to TESSy. Data presented in the two monthly reports may differ.*

Epidemiological summary for EU/EEA countries with epidemic intelligence updates since last month:

[Austria](#) reported 490 confirmed measles cases in 2024, as of 9 August 2024, an increase of 26 cases since 9 July 2024. Of the 479 cases for which hospitalisation information was available, 102 individuals (21%) were hospitalised, including four in the intensive care unit. All regions reported at least one case of measles in 2024, with most of the cases reported in Lower Austria (116; 24%) and Tyrol (88; 18%).

[Belgium](#) reported 275 confirmed measles cases in TESSy between January and June 2024 and as of 12 August 2024, an increase of 10 cases since 10 July 2024.

[Bulgaria](#) reported 24 measles cases in 2024 and as of 12 August 2024, an increase of seven cases since 8 July 2024. No cases were reported for the same period of the previous year.

[Croatia](#) reported 18 measles cases in 2024 and as of 6 June 2024, an increase of 10 cases since 13 May 2024.

[Czechia](#) reported 30 measles cases in January to July 2024, an increase of one case since June.

[Denmark](#) reported 20 measles cases in 2024 and as of 8 August 2024, an increase of one case since the monthly update in July.

[France](#) reported 300 measles cases in TESSy between January and June 2024, an increase of 135 cases since the monthly report in June. Of these, 35 cases were reported in June.

[Germany](#) reported 399 confirmed and suspected measles cases in 2024 (data as of 8 August 2024), an increase of nine cases since 10 July 2024.

[Ireland](#) has reported 82 confirmed measles cases as of 9 August 2024, an increase of 13 cases since the last monthly update on 9 July 2024. In addition, 11 cases are currently under investigation. Outbreaks have been reported across all six Health Service Executive (HSE) regions.

[Italy](#) reported 807 measles cases between 1 January and 31 July 2024 and as of 8 August 2024. This is an increase of 251 cases since the 11 June 2024 report. Cases have been reported from 17/21 regions, mostly in unvaccinated individuals (90%). At the national level, the incidence in this period was 23.5 cases per million population.

[Netherlands](#) reported 147 measles cases in 2024 and as of 24 July 2024, an increase of 42 cases since 26 June 2024.

[Norway](#) reported nine measles cases as of 12 August 2024, an increase of three cases since 9 July 2024.

[Poland](#) reported 246 measles cases from January to 31 July 2024 and as of 8 August 2024, an increase of 24 cases since 30 June 2024.

[Portugal](#) has reported 34 confirmed measles cases from January to 23 July 2024, an increase of four cases since 2 June 2024. Of these, 21 (62%) cases were unvaccinated.

[Romania](#) has reported 19 785 measles cases, including 18 deaths, from January to 4 August 2024, an increase of 2 052 cases since 7 July 2024. This nationwide outbreak started in 2023, and 22 590 confirmed measles cases, including 21 deaths, have been reported from 1 January 2023 to 4 August 2024. The cases have been reported in all 41 counties and the Municipality of Bucharest. Among cases with known vaccination status (20 117), unvaccinated individuals across all age groups accounted for 90%.

[Spain](#) reported 181 measles cases from 1 January to 28 July 2024, an increase of 20 cases since 7 July 2024. Of these, 30 cases were imported.

[Sweden](#) has reported 23 measles cases in 2024 as of 8 August, an increase of two cases since 9 June 2024. Of these, 15 (65%) were imported.

Relevant epidemiological summary for countries outside the EU/EEA:

[Switzerland](#) has reported 93 measles cases in 2024 and as of 5 August 2024, an increase of three cases since 9 July 2024.

The [UK](#) has reported several outbreaks of measles in 2024. As of 22 July, 2 149 measles cases have been confirmed in [England](#) in 2024. In [Northern Ireland](#), 14 cases were confirmed in 2024 and as of 1 August 2024. In [Scotland](#), there have been 16 laboratory-confirmed measles cases in 2024, as of 7 August 2024.

Western Balkans: Several countries continue to report increases in measles cases this year.

[Bosnia and Herzegovina](#)

The [Republic of Srpska](#) has reported 296 measles cases as of 2 August 2024, an increase of 45 cases since 5 July 2024. Most cases were in the age group one to four years (156 cases; 53%). The city of Bijeljina contributed 75% of the confirmed cases. In 2024, as of 12 August 2024, the [Federation of Bosnia and Herzegovina](#) notified [7 060 measles cases](#), including [one death](#) in an 18-year old unvaccinated male, an increase of 828 cases and one death since 7 July 2024. Most notified cases are in the age group one to four years (2 858; 40%). Of all notified cases, 6 053 (86%) were unvaccinated. As of 8 August 2024, [Brcko district](#) reported 188 measles cases in 2024. This is an increase of 74 cases since May.

[Serbia](#) reported 255 measles cases as of 7 August 2024, an increase of 74 cases since 7 July.

[Montenegro](#) reported 12 measles cases as of 2 August 2024, an increase of five cases since 5 July, of which 10 (83%) were unvaccinated.

Summary for WHO regional offices

WHO Regional Office for Europe (WHO/EUROPE) reported [84 932 measles cases](#) in 2024, as of 5 August 2024. The five non-EU/EEA countries reporting the most measles cases were: [Kazakhstan \(27 330\)](#), [Azerbaijan \(16 633\)](#), [Russia \(13 018\)](#), [Kyrgyzstan \(11 759\)](#), and the [United Kingdom \(2 123\)](#).

The numbers provided to WHO for EU/EEA countries are from TESSy data, which are updated monthly and available on the [ECDC Surveillance Atlas of Infectious Diseases](#). Due to differences in reporting times, the numbers may not correspond to the data from epidemic intelligence screening.

WHO Regional Office for Africa (WHO AFRO) has reported [58 551 measles cases](#) in 2024, as of 5 August 2024. The highest numbers of cases were reported from [Ethiopia \(25 109\)](#), [Nigeria \(7 073\)](#), [Burkina Faso \(6 312\)](#), [Cote d'Ivoire \(5 624\)](#) and [Democratic Republic of the Congo \(2 402\)](#).

WHO Regional Office for the Americas (WHO PAHO) has reported [301 confirmed measles cases](#) in 2024, as of 2 August 2024. Over [50% of cases were imported and 70% in unvaccinated individuals](#). Most cases (203) were confirmed in the United States.

WHO Regional Office for the Eastern Mediterranean (WHO EMRO) has reported [63 252 measles cases](#) in 2024, as of 5 August 2024. The highest numbers of cases were reported from [Iraq \(29 769\)](#), [Pakistan \(17 985\)](#), [Yemen \(7 307\)](#), [Afghanistan \(5 532\)](#) and [Somalia \(907\)](#).

WHO Regional Office for South-East Asia (WHO SEARO) has reported [22 522 measles cases](#) in 2024, as of 5 August 2024. The highest numbers of cases were reported from [India \(16 851\)](#), [Indonesia \(3 325\)](#), [Thailand \(1 746\)](#), [Sri Lanka \(221\)](#), and [Nepal \(176\)](#).

WHO Regional Office for the Western Pacific (WHO WPRO) has reported [8 033 measles cases](#) in 2024, as of 5 August 2024. Nine countries reported cases: [Malaysia \(3 364\)](#), [the Philippines \(3 039\)](#), [Viet Nam \(829\)](#), [China \(536\)](#), and [Cambodia \(83\)](#).

ECDC assessment:

The overall number of measles cases in the EU/EEA has been steadily increasing since June 2023. **Measles cases may continue increasing in the EU/EEA in the coming months.** This is due to reported sub-optimal vaccination coverage for measles-containing vaccines (MCV) in a number of EU/EEA countries (<95% in many of these countries), as well as a high probability of importation

from areas experiencing high circulation. In addition, the majority of recently reported cases have acquired the disease within the reported country through community/local transmission, indicating a higher probability of being exposed to the virus within the EU/EEA than in previous months.

As the number of cases is expected to rise in the near future, ECDC urges EU/EEA public health authorities to focus on the following areas:

- **Close immunity gaps, achieve and maintain high vaccination coverage for MCV** (>95% with the second dose). It is vital to ensure first and second dose vaccinations are administered on time as per national schedules among infants and children. It is also important to identify and vaccinate eligible individuals (for example, non-immune adolescents and adults) in immunisation catch-up programmes (as recommended by local and national authorities).
- **Strive towards high-quality surveillance**, and adequate public health capacity, especially for early detection, diagnosis, response and control of outbreaks.
- **Increase the clinical awareness of health professionals.**
- **Promote vaccine acceptance and uptake** by employing specific risk communication strategies and identifying drivers of sub-optimal MMR vaccine acceptance and uptake to ensure that tailored interventions are implemented in response.
- **Address barriers and engage with underserved populations.** Systemic barriers that impact vaccine uptake in under-served, isolated and difficult-to-reach populations need to be monitored and addressed with targeted strategies, to reduce inequalities in vaccine uptake.

ECDC's latest advice on measles is available in the Threat Assessment Brief '[Measles on the rise in the EU/EEA: Considerations for a public health response](#)' published in February 2024 and the conclusions of that remain valid. Additional information on the risk classification and ECDC recommendations can be found in this report.

Actions:

ECDC is monitoring the measles situation through its epidemic intelligence activities, which supplement monthly outputs with measles surveillance data from TESSy, routinely submitted by 30 EU/EEA countries. ECDC's latest advice on measles is available in the Threat Assessment Brief, '[Measles on the rise in the EU/EEA: Considerations for a public health response](#)', published on 15 February 2024.

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

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

Overview:

On 9 August 2024, two cases of human infection with swine influenza A(H3N2) variant (A(H3N2)v) virus were reported in the US.

The first case was reported by Colorado Department of Public Health and Environment and in the CDC Weekly U.S. Influenza Surveillance Report ([Weekly U.S. Influenza Surveillance Report | CDC](#)). The case, who is under 18 years old, sought healthcare in the week ending 13 July 2024 (week 28) and was not hospitalised. The case attended an agricultural event prior to the onset of illness. Investigation by public health authorities did not identify any additional cases among close contacts. The investigation is ongoing.

The second case was reported by The Michigan Department of Health and Human Services (MDHHS) and Ingham County Health Department ([MDHHS confirms detection of influenza A H3N2 variant](#)). The case, a resident of Ingham County, tested positive for influenza A(H3N2)v in late July. The case did not report any exposure to swine or other animals. The source of infection is still under investigation. Public health investigators believe the infection is an isolated event.

ECDC assessment:

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.

Currently there is no evidence of sustained transmission between humans with swine influenza A viruses. However, there is some limited evidence for non-sustained human-to-human transmission.

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.

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.

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: 19 July 2024

9. Chandipura virus disease – India – 2024

Overview:

Summary: Since June 2024, cases of acute encephalitis syndrome have been reported in Gujarat, India. Cases are less than 15 years old.

As of 31 July 2024, 148 cases have been reported from the districts of Gujarat (140), Rajasthan (3), Madhya Pradesh (4) and Maharashtra (1), including 59 deaths (CFR: 40%). From these, CHPV has been confirmed in 51 cases.

Prevention and control measures have been taken by the state government, including vector control, communication campaigns targeting the public and medical personnel, and deployment of a response team to support and conduct an epidemiological outbreak investigation.

Source: [Indian Ministry of Health and Family Welfare](#)

ECDC assessment:

The Chandipura virus (*Vesiculovirus chandipura*, CHPV) is a zoonotic arbovirus in the family *Rhabdoviridae*. The virus is endemic in several regions of India and has been detected in other countries in the Indian subcontinent. Sporadic cases and limited outbreaks have been reported in India since 1965. The virus has also been detected in animals in some African countries (e.g. Nigeria, Senegal, Tanzania) without reported human cases.

The principal vector of CHPV in India is the sand fly *Phlebotomus papatasi*, which is also [present in several regions of Europe](#). Other sand fly, mosquito and tick species are also potential vectors of the virus. A broad range of animals are suspected as vertebrate hosts of CHPV; however, little information is available on the natural ecological cycle of the virus.

CHPV infection may manifest in rapid course as a general febrile disease with meningitis and/or encephalitis (Acute Encephalitis Syndrome). Predominantly children below the age of 15 years are affected. The case fatality rate can reach 50–75%. Serological data indicate asymptomatic human infections.

No human-to-human transmission of CHPV has been reported. Humans are understood to be incidental, dead-end hosts of the virus. Therefore, it is unlikely that vectors can get infected with the virus through biting infected humans. However, there is no sufficient scientific evidence supporting this assumption.

EU/EEA citizens travelling to or residing in areas in India affected by the CHPV disease outbreaks should apply personal protective measures to prevent sand fly, mosquito and tick bites to reduce the likelihood of infection. They should also follow the instructions of the local health authorities.

The likelihood of importation of CHPV to the EU/EEA by travellers is very low, considering the acute course of severe disease, which would limit capacity for long-distance travel. Although competent vectors of CHPV are present in Europe, in case of importation of the virus into the EU/EEA by an infected traveller, further transmission is unlikely, as human-to-human and human-to-vector transmission have not been described so far. The likelihood of importation of the virus into the EU/EEA by infected vectors is very low.

Actions:

ECDC is following this event through its epidemic intelligence activities.

Last time this event was included in the Weekly CDTR: -

Events under active monitoring

- Avian influenza A(H5N6) – Multi-country – Monitoring human cases – last reported on 26 July 2024
- SARS-CoV-2 variant classification – last reported on 26 July 2024
- Overview of respiratory virus epidemiology in the EU/EEA – weekly monitoring – last reported on 26 July 2024
- Circulating vaccine-derived poliovirus type 2 (cVDPV2) – Palestine* – 2024 – last reported on 26 July 2024
- Cholera – Comoros and Mayotte – 2024 – Weekly monitoring – last reported on 26 July 2024
- Avian influenza A(H5N1) human cases – United States – 2024 – last reported on 26 July 2024
- Crimean-Congo haemorrhagic fever – Spain – 2024 – last reported on 26 July 2024
- Oropouche virus disease – Multi-country (America) – 2024 – last reported on 26 July 2024
- Seasonal surveillance of West Nile virus infections – 2024 – last reported on 26 July 2024
- Mass gathering monitoring – Olympic and Paralympic Games – France – 2024 – last reported on 26 July 2024
- Nipah virus disease – India – 2024 – last reported on 26 July 2024
- Imported Oropouche virus disease cases in the EU/EEA, 2024 – last reported on 19 July 2024
- Human cases of swine influenza A(H3N2) variant virus – Multi-country – last reported on 19 July 2024
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases – last reported on 19 July 2024
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring – last reported on 19 July 2024
- Chandipura virus disease – India – 2024 – last reported on 16 August 2024
- Locally acquired dengue in 2024 in mainland France - last reported on 16 August 2024
- Mpox due to monkeypox virus clade I – Multi-country – 2024 – last reported on 16 August 2024
- Legionnaires' disease outbreak – Italy - 2024 – last reported on 9 August 2024
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update – last reported on 9 August 2024
- Risk assessments under production – last reported on 9 August 2024
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update – last reported on 2 August 2024
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update – last reported on 2 August 2024
- Locally acquired chikungunya virus disease in mainland France – last reported on 2 August 2024

* 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.