

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 36, 31 August – 6 September 2024

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Executive summary

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

- Since the beginning of mpox monitoring in 2022 and until 31 July 2024, over 100 000 confirmed cases of mpox due to monkeypox virus (MPXV) clade I and clade II, including over 200 confirmed deaths, have been reported globally, according to the World Health Organization (WHO).
- Overall, more than 20 000 mpox cases including over 600 deaths (confirmed and suspected) due to MPXV clade I and clade II have been reported from 13 African Union Member States in 2024, including over 5 000 confirmed cases, according to the [Africa CDC Epidemic Intelligence Report, issued on 31 August 2024](#). Although the epidemiological profile of cases remains similar to the previous week, one new country, Guinea, has reported one mpox case, while cases without an epidemiological link to DRC have been reported in Uganda and one case with travel history to Rwanda has been reported in Kenya.
- Imported Clade I cases outside of the African continent have been reported by Sweden (15 August; one person) and Thailand (22 August; one person). No secondary transmission has been reported.
- Additional information can be found in the ECDC Rapid Risk Assessment published on 16 August ([Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#)) and the Epidemiological Update published on 26 August, including the [latest ECDC recommendations](#).
- ECDC is closely monitoring and assessing the epidemiological situation.

Mass gathering monitoring – Olympic and Paralympic Games – France – 2024 - Weekly Monitoring

- Since the previous update on 30 August, and as of 6 September, no major public health events related to communicable diseases have been detected in the context of the Paris 2024 Paralympic Games.
- The probability of EU/EEA citizens becoming infected with communicable diseases during the Paris 2024 Olympic and Paralympic Games is considered low, if general preventive measures are applied.
- ECDC will monitor this event until 13 September 2024 through epidemic intelligence activities in collaboration with Santé publique France and partners. Weekly updates will be included in the [Communicable Disease Threats Report \(CDTR\)](#).

Seasonal surveillance of West Nile virus infections – 2024

- Since the beginning of 2024, and as of 28 August 2024, West Nile virus (WNV) infection cases have been reported to the European Surveillance System (TESSy) by ten EU/EEA countries (Austria, Bulgaria, Croatia, France, Germany, Greece, Hungary, Italy, Romania, and Spain) and five EU neighbouring countries (Albania, Kosovo*, North Macedonia, Serbia and Türkiye). In addition, Slovenia has reported human cases of West Nile Virus infection through EpiPulse.
- 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.

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 the SARS-CoV-2 epidemic in hospitals and on mortality has been relatively low since May 2024. Individuals aged 65 years and above remain the most affected group in hospital settings, highlighting the fact that vulnerable populations are at higher risk of severe illness.
- The SARS-CoV-2 variant BA.2.86 and its subvariants, including KP.3, continue to dominate.
- 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.

SARS-CoV-2 variant classification

Since the last update on 26 July 2024, and as of 30 August 2024, **no changes** have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants.

KP.3 was classified as a VOI on 26 July 2024 due to potentially enhanced transmissibility, immune evasion, and potential for further antigenic changes compared to other BA.2.86 lineages.

The VOI median proportions in the EU/EEA for weeks 32-33, based on 10 reporting countries are currently:

KP.3: 81.2% (range: 55.0%-100.0%, IQR: 70.5%-88.9%)

BA.2.86: 18.4% (range: 0.0%-45.0%, IQR: 10.9%-28.6%)

The VUM median proportions in the EU/EEA for weeks 32-33, based on 10 reporting countries are:

BA.2.86+F456L: 96.6% (range: 55.0%-100.0%, IQR: 93.6%-99.5%)

BA.2.86+R346T+F456L: 9.2% (range: 0.0%-22.4%, IQR: 5.2%-15.9%)

BA.2.86+R346T: 13.0% (range: 0.0%-24.8%, IQR: 10.3%-17.6%)

The calculations are based on data reported to GISAID from ten reporting countries, as of 26 August 2024.

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

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

Summary

- On 20 August 2024, the Ministry of Health of Cambodia announced one fatal human case of A(H5N1) avian influenza virus infection.
- The case was an adolescent from Prey Veng province in Cambodia.
- This is the 10th human case of A(H5N1) avian influenza virus infection and the second fatality reported from Cambodia in 2024.
- Since 2003, Cambodia has reported 72 human cases of A(H5N1) avian influenza virus infection, including 43 deaths (case-fatality rate (CFR): 60%)
- Since 2003, 908 human cases of avian influenza A(H5N1), including 464 deaths (CFR: 51%), have been reported in 24 countries worldwide.

Human cases of swine influenza A(H1N1) virus variant - Multi-country - 2024

- On 19 August 2024, one person infected with an influenza A(H1N1) variant virus of swine origin was reported to the World Health Organization (WHO) by the Viet Nam IHR National Focal Point.
- The person was an adult resident of Son La province in northern Viet Nam.
- The person, who suffered from comorbidities, developed severe respiratory illness and was hospitalised, but their condition deteriorated and they passed away after several days of treatment.
- There were no further cases identified among contacts.
- This is the first person infected with A(H1N1)v reported in Viet Nam.

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

Overview

Global background

Since the beginning of mpox monitoring in 2022 and until 31 July 2024, over 100 000 confirmed cases of mpox due to MPXV clade I and clade II, including over 200 deaths, have been reported by more than 120 countries globally, according to WHO ([2022-24 Mpox \(Monkeypox\) Outbreak: Global Trends](#)). All the cases of mpox due to MPXV clade I have been reported from the African continent, apart from one case reported by Sweden and one by Thailand.

Epidemiological situation in Africa

In 2024, over 20 000 mpox cases including over 600 deaths (confirmed and suspected) due to MPXV clade I and clade II have been reported from Africa Union Member States, including over 5000 confirmed cases, according to the [Africa CDC Epidemic Intelligence Report issued on 31 August 2024](#) and the [WHO AFRO weekly report of 30 August](#). The reporting countries are Burundi, Cameroon, Central African Republic, Republic of the Congo, Cote d'Ivoire, Democratic Republic of Congo (DRC), Gabon, Liberia, Kenya, Nigeria, Rwanda, South Africa and Uganda.

The epidemiological situation remains similar to the previous week. Since the previous update, one new country, Guinea, has reported one mpox case. The clade has not yet been determined ([WHO Global update reporting data as of 1 September](#) and [media reported on it quoting official authorities](#)).

The two countries reporting the largest numbers of cases in recent weeks are still the DRC and Burundi:

- The DRC continues to report the highest number of mpox cases in Africa, with 1 838 confirmed, 1 095 suspected cases and 35 deaths reported since 23 August and as of 30 August ([Africa CDC report](#)). The cumulative number of cases in 2024 is over 20 000 infections (4 799 confirmed and 17 801 suspected) including 610 deaths ([Africa CDC Epidemic Intelligence Report issued on 31 August 2024](#)). According to the [WHO Global report on mpox](#), 27 confirmed mpox deaths have been reported in DRC overall, 25 in 2024 as of 25 August. Monkeypox virus clades Ia and clade Ib are circulating. The majority of cases and deaths reported are among <15-year-olds (66% of cases and 82% of deaths) while males account for 73% of all people with mpox, according to Africa CDC.
- In Burundi, as of 1 September 2024, 328 confirmed cases have been reported according to the WHO report ([2022-24 Mpox \(Monkeypox\) Outbreak: Global Trends](#)). According to the [WHO AFRO weekly situation report of 30 August](#), cases were reported from 29 of 49 districts. Over a third of cases (37.5%) were reported among children under 10 years (24% among <5-year-olds) and 24.6% among those aged 20-30 years. There is a slight preponderance of males among cases (56%). The test positivity rate is 37.6% (455 tests conducted in total, as of 28 August).

Additional updates

- As of 2 September, [Uganda](#) had reported 10 confirmed mpox cases. Of these, seven were reported outside Kasese, which is the area bordering DRC where three cases have been reported overall (including the first two cases reported in Uganda). At least seven cases have no history of travel in affected areas and two were reported from Kampala.
- Kenya has [reported](#) five mpox cases. The first two cases were males who had been detected at points of entry. The third case, [reported](#) on 30 August, is a female with travel history to Uganda. The case was reported in Nairobi. On 31 August, a fourth case was [reported](#) from Nakuru country (travel history to Rwanda) and a fifth case linked to the fourth was [reported](#) on 6 September. Clade Ib has been detected.
- Liberia [reported one mpox case on 2 September 2024](#), although the clade has not been identified yet. An additional six cases have been [reported](#) to date in 2024, the most recent in August but [before the declaration of the Public Health Emergency of Continental Security by Africa CDC on 13 August 2024](#).

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

Epidemiological situation in the EU/EEA

On 15 August 2024, Sweden [reported](#) the first imported case of mpox due to MPXV clade Ib in EU/EEA countries. As of 5 September, no secondary cases have been detected.

ECDC assessment

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

Actions

ECDC is closely monitoring and assessing the evolving epidemiological situation of mpox on a global basis. ECDC recommendations are available [here](#). ECDC has been supporting the mpox outbreak response in DRC through the deployment of experts since 29 July 2024.

Sources: [ECDC rapid risk assessment](#)

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

2. Mass gathering monitoring – Olympic and Paralympic Games – France – 2024 - Weekly Monitoring

Overview

Update

Since the previous update of 30 August, and as of 6 September, no major public health events related to communicable diseases have been detected in the context of the Paris 2024 Paralympic Games.

The Paris 2024 Paralympic Games started on 28 August and will end on 8 September. ECDC will continue epidemic intelligence activities until 13 September.

Summary

During the Paris 2024 Olympic Games, COVID-19 cases were reported among athletes in the Olympic village from the [Australian Women's Water Polo Team](#), the [United States Swimming Team](#), the [French Foil Fencers](#), the [German Women's Football Team](#) and [Great Britain's Swimming Team](#). In addition, there were multiple [media reports](#) of Olympic athletes with gastrointestinal disease in weeks 32 and 33. 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](#) is taking 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 metropolitan area during the Olympics and 3.8 million are projected during the Paralympics.

The Paris 2024 Olympic and Paralympic Games are being 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, Châteauroux, Nice, Bordeaux, Nantes, and 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 are being organised to celebrate the Games across France. In Paris, the [Club France Paris 2024](#), a special zone with activities for fans, will be located at La Villette; up to 700 000 people are expected to visit to attend activities and celebrations during the Paris 2024 Olympic and Paralympic Games.

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, sale 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 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: 30 August 2024.

3. Seasonal surveillance of West Nile virus infections – 2024

Overview

Epidemiological summary

Since the start of 2024, and as of 28 August 2024, human cases of West Nile virus (WNV) infection have been reported to TESSy by ten EU/EEA countries and five EU-neighbouring countries. In the EU/EEA, Austria, Bulgaria, Croatia, Hungary, Romania, France, Germany, Italy, Greece, and Spain reported WNV infections. From EU neighbouring countries, Albania, Kosovo*, North Macedonia, Serbia and Türkiye reported WNV infections. In total, 126 NUTS3/GAUL1 regions across 15 countries have reported locally-acquired WNV cases. For detailed information on places of infection, please refer to ECDC's [weekly update](#) and [dashboard](#). In addition, Slovenia has reported human cases of West Nile Virus infection in two regions through EpiPulse.

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

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Actions

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

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

4. 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 is at baseline levels in all EU/EEA countries except one (Denmark), similar to what was 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:
 - In 2024, SARS-CoV-2 activity started about six weeks earlier than during the summer of 2023. However, 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 increased slightly to 24% compared to the previous week. At the country level there is a mixed picture of increasing, stable and decreasing trends in primary care positivity. Overall pooled non-sentinel detections showed a slight increase this week and increases were observed in ten countries (out of 20 reporting countries).
 - In SARI sentinel systems (hospitals), the pooled test positivity (13%) is similar to last week, with test positivity ranging from 12–29% in the five reporting countries (Ireland, Germany, Greece, Malta and Spain). The age group 65 years and above remained the most affected (17% positivity).
 - Non-sentinel secondary care notifications are at low levels overall, with most EU/EEA countries that report these indicators reporting stable or decreasing trends in the number of positive test results among hospitalised, ICU-admitted patients, and deaths. Slightly increasing trends in ICU-admitted cases and ICU-inpatients have been observed for Sweden and Romania, respectively.
 - Despite test positivity in primary and secondary care sentinel systems remaining elevated, sentinel syndromic rates (ILI/ARI/SARI) showed no clear elevation above baseline or low levels.
- Seasonal influenza activity remained stable at low levels overall in reporting EU/EEA countries, however, one country (Malta) reported an elevated influenza test positivity (above 10%) in sentinel secondary care over the past eight weeks.
- Respiratory syncytial virus (RSV) activity remained low in the reporting EU/EEA countries.

Virus characterisation

Influenza for week 40, 2023 to week 35, 2024

- In the above period 4 435 A(H1N1)pdm09, 1 878 A(H3) and 703 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the viruses that have been assigned to a clade:
- In total, 4 428 were A(H1N1)pdm09 - 3 139 (71%) were subclade 5a.2a and 1 289 (29%) were subclade 5a.2a.1.
- In total, 1 875 were A(H3) - 30 (2%) were subclade 2a, 11 (0.6%) were subclade 2a.3a, 1 833 (98%) were subclade 2a.3a.1 and 1 (0.1%) were subclade 2a.3b.
- In total, 699 were B/Vic - all were subclade V1A.3a.2.

SARS-CoV-2 variants for weeks 33–34 (12 August to 25 August 2024)

- The estimated distribution (median and IQR of proportions from nine countries submitting at least 10 sequences) of variants of concern (VOCs) or variants of interest (VOIs) was:
- 78% (62–82%) for KP.3 (289 detections from nine countries)
- 22% (18–28%) for BA.2.86 (105 detections from nine 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 sub-lineages, and their possible correlation with increases in COVID-19 epidemiological indicators, it is important that countries continue to sequence SARS-CoV-2-positive clinical specimens and report to GISAID and/or TESSy. It is therefore important that testing of symptomatic individuals for SARS-CoV-2 continues during the summer period.

Vaccination remains critically important to protect individuals at high risk of severe outcomes, such as 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](#)). 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: 30 August 2024.

Maps and graphs

Figure 1. Overview of key indicators of activity and severity in week 35

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 35	Week 34	Description	Value	
Primary care consultation rates	ARI	9 rates (7 MEM)	8 rates (6 MEM)	Distribution of country MEM categories	7 Baseline	Stable rates continue to be reported at levels comparable to the same time last year.
	ILI	12 rates (12 MEM)	11 rates (11 MEM)		11 Baseline 1 Medium	Stable rates continue to be reported at levels comparable to the same time last year.
Primary care sentinel positivity	SARS-CoV-2	12	14	Pooled (median; IQR)	24% (14; 12–19%)	Pooled test positivity showed a slight increase compared to the previous week. One country reported >30% SARS-CoV-2 positivity this week. Of 20 countries reporting non-sentinel detections data, increases in detections were observed in ten.
	Influenza	12	13		2.7% (1.4; 0–2.3%)	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			Stable or decreasing rates continue to be reported at levels comparable to the same time last year.
SARI positivity	SARS-CoV-2	5	6	Pooled (median; IQR)	13% (14; 12–21%)	Stable trend observed this week in both pooled test positivity and median test positivity. In data from non-sentinel sources, overall decreasing trends in the pooled number of positive test results among hospitalised and ICU-admitted patients, and deaths.
	Influenza	5	6		3.5% (0.2; 0–1.4%)	Stable trend with very low circulation. One country continues to report elevated influenza positivity (39% positivity in week 35; Malta).
	RSV	5	5		0% (0; 0–0%)	Stable trend of very low circulation.
Intensity (country-defined)	Influenza	17	16	Distribution of country qualitative categories	15 Baseline 2 Low	
Geographic spread (country-defined)	Influenza	16	15	Distribution of country qualitative categories	8 No activity 5 Sporadic 1 Local 2 Regional	

Source: ECDC

Figure 2. Virological distribution for week 35 and the period week 25, 2024 to week 35, 2024

Pathogen or (sub-)type	Primary care sentinel						SARI sentinel						Non-sentinel			
	Week 35			Period 2024-2025			Week 35			Period 2024-2025			Week 35		Period 2024-2025	
	n	%	positivity	n	%	positivity	n	%	positivity	n	%	positivity	n	%	n	%
Influenza	17	100	2.7%	137	100	1.6%	24	100	3.5%	134	100	1.4%	170	100	2 671	100
Influenza A (total)	14	82	2.2%	94	70	1.1%	23	100	3.3%	105	95	1.1%	130	82	1 596	68
A(H1)pdm09	0	0	–	22	28	–	2	67	–	3	33	–	2	12	316	46
A(H3)	12	100	–	57	72	–	1	33	–	6	67	–	15	88	364	54
A (unknown)	2	–	–	15	–	–	20	–	–	96	–	–	113	–	916	–
Influenza B (total)	3	18	0.5%	40	30	0.5%	0	0	0%	6	5	0.1%	29	18	760	32
B/Vic	1	100	–	10	100	–	0	0	–	0	0	–	0	0	48	100
B (unknown)	2	–	–	30	–	–	0	–	–	6	–	–	29	–	712	–
Influenza untyped	0	–	–	3	–	0%	1	–	0.1%	23	–	0.2%	11	–	315	–
RSV	0	–	0%	14	–	0.2%	0	–	–	16	–	0.2%	10	–	420	–
SARS-CoV-2	134	–	24.2%	2 189	–	27.2%	95	–	13.5%	1 785	–	18.4%	29 919	–	313 002	–

Source: ECDC

5. SARS-CoV-2 variant classification

Overview

Since the last update on 26 July 2024, and as of 30 August 2024, **no changes** have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants.

KP.3 was classified as a VOI 26 July 2024 due to potentially enhanced transmissibility, immune evasion, and potential for further antigenic changes compared to other BA.2.86 lineages.

The VOI median proportions in the EU/EEA for weeks 32-33, based on 10 reporting countries are currently:

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BA.2.86+F456L: 96.6% (range: 55.0%-100.0%, IQR: 93.6%-99.5%)

BA.2.86+R346T+F456L: 9.2% (range: 0.0%-22.4%, IQR: 5.2%-15.9%)

BA.2.86+R346T: 13.0% (range: 0.0%-24.8%, IQR: 10.3%-17.6%).

ECDC assessment

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

Actions

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

For the latest update on SARS-CoV-2 variant classifications, please see [ECDC's webpage on variants](#). Variant surveillance data, including the distribution of VOC and VOI variant proportions in the EU/EEA and detailed country-specific COVID-19 updates are available as part of the [European Respiratory Virus Surveillance Summary \(ERVISS\)](#).

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

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

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

Overview

Update: On 20 August 2024, the Ministry of Health of Cambodia reported a human case of A(H5N1) avian influenza virus infection in an adolescent person (with no comorbidities) from Kanhchriech district, Prey Veng province ([Ministry of Health of Cambodia](#)). On 17 August, the case was admitted to a severe acute respiratory infection (SARI) sentinel hospital in Phnom Penh with symptoms including fever, cough, sore throat, shortness of breath, and fainting. Despite medical care and antiviral treatment with oseltamivir, initiated on the day of hospital admission, the patient passed away on 20 August 2024.

According to the World Health Organization's Disease Outbreak News (WHO DON) published on 2 September 2024, nasopharyngeal and oropharyngeal swab specimens were collected on 17 August and were received by the National Institute of Public Health of Cambodia two days later ([WHO DON - Avian Influenza A\(H5N1\) - Cambodia](#)). The specimens tested positive for influenza A(H5N1) by RT-qPCR on 20 August. On the same day the Pasteur Institute in Cambodia confirmed the laboratory diagnosis. Phylogenetic analysis of the haemagglutinin (HA) gene revealed that the virus belongs to H5 clade 2.3.2.1c, similar to other viruses which have been circulating in Cambodia and South-East Asia since 2013-2014. It is important to note that the internal genes of the sequenced virus belong to H5 clade 2.3.4.4b. This is a novel influenza A(H5N1) reassortant virus, which has been reported in human cases from Cambodia since late 2023.

According to an investigation by health authorities, five days prior to the onset of disease, dead chickens were reported in the village where the case lived. The case touched and held the dead chickens when preparing a meal.

Contact tracing conducted by the Cambodian Communicable Disease and Control Department (CDC) of the Ministry of Health, and a local rapid response team identified six close contacts. All received oseltamivir treatment and have so far shown no respiratory illness. Further environmental, public and animal health response measures and investigations are ongoing. Samples collected from chickens and ducks in the village are being analysed and the results are pending.

Since 2003, Cambodia has reported 72 human H5N1 cases, with 43 fatalities, highlighting the ongoing zoonotic transmission risk in the region. National and local health authorities, together with the Ministry of Agriculture, Forestry and Fisheries and the Ministry of Environment, continue to search for sources of transmission in both animals and humans, and are conducting contact tracing, administering Tamiflu prophylaxis to close contacts, and emphasising the importance of the proper handling and cooking of poultry to prevent further infections.

A joint assessment published by the [UN Food and Agricultural Organization/World Health Organization/World Organization for Animal Health](#) published on 14 August 2024 (and based on data up to 18 July 2024) reports that while the majority of A(H5N1) viruses characterised globally since 2020 belong to the haemagglutinin (HA) H5 clade 2.3.4.4b, regional exceptions exist. These include a novel reassortant influenza A(H5N1) virus detected in poultry and human cases in Cambodia since late 2023 and neighbouring Vietnam in 2024. This reassortant virus has HA and NA genes from clade 2.3.2.1c viruses, while its internal genes belong to clade 2.3.4.4b viruses. Of the 13 human infections reported from Cambodia between February 2023 and July 2024, viruses from 10 of these cases were confirmed to belong to clade 2.3.2.1c. Of these 13 human infections from Cambodia, two of the cases had no symptoms and were detected as part of contact tracing, two were mild, and the others had more severe disease or were fatal. All reported cases from Cambodia had exposure to infected/sick poultry and the case reported from Vietnam had exposure to wild birds and there was no person-to-person transmission.

Virus sequences from the human cases have not shown markers for reduced susceptibility to neuraminidase inhibitors (antiviral medicines such as oseltamivir) or endonuclease inhibitors (such as baloxavir marboxil). Some of the virus sequences, as seen in other mammalian infections detailed above, have had genetic markers associated with mammalian adaptation, with PB2 E627K mutations present in sequences from 2.3.2.1c viruses from four cases reported from Cambodia in October and November 2023. Overall, the A(H5N1) viruses currently detected largely retain the genomic and biological characteristics of avian influenza viruses and remain well-adapted to spread among birds. With the exception of in-host obtained amino acid mutations in polymerase proteins, there is still limited evidence of adaptation to mammals and humans. No changes in receptor binding tropism have been consistently observed that would increase binding to receptors in the human upper respiratory tract, which would intensify transmission to and among people. Therefore, human-to-human transmission of the currently circulating A(H5N1) viruses is considered unlikely without further genetic changes in the virus.

Summary

Since 2003, and as of 21 August 2024, there have been 908 human cases worldwide*, including 464 deaths (CFR: 51%), with avian influenza A(H5N1) infection reported in 24 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, Indonesia, India, Iraq, Laos, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Vietnam, the United Kingdom, and the United States).

To date, no sustained human-to-human transmission has been detected. In 2024, 26 cases, including three deaths, have been reported in four countries: Cambodia (10 cases, two deaths), the United States (13 cases), Vietnam (two cases, one death), and Australia (one case).

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

ECDC assessment

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

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

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

Actions

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

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

7. Human cases of swine influenza A(H1N1) virus variant - Multi-country - 2024

Overview

On 4 September 2024, WHO published information about one person from Viet Nam infected with influenza A(H1N1) variant virus of swine origin ([WHO DON - influenza A\(H1N1\) variant virus – Viet Nam](#)). The case was notified to WHO by the Viet Nam IHR National Focal Point on 19 August 2024. The case was an elderly resident of Son La province in northern Viet Nam, with underlying medical conditions. A week after returning from a month-long visit to their home village in Hung Yen province, the case developed fever, fatigue and loss of appetite. The person was admitted to a district hospital on 1 June 2024, where they were diagnosed with pneumonia. A rapid influenza test conducted on 5 June was positive for influenza A and the patient was transferred to the National Hospital for Tropical Diseases (NHTD). The patient was treated there for six days, but sadly passed away on 11 June 2024.

A sample was collected on 5 June and tested by real-time PCR. On 18 June, a diagnosis of influenza A was confirmed, however the sub-type was not determined. On 1 August, A(H1N1)v was identified in the patient sample by genomic sequencing, which was further confirmed by the WHO Collaborating Centre (WHO CC) for Influenza at the United States Centers for Disease Control and Prevention (US CDC) on 5 August. Further analysis of the virus is ongoing.

Investigation by public health authorities did not identify any further cases of respiratory illness among the patient's contacts, including healthcare workers, in the period between June and 11 August 2024. The person lived on their own and had limited contact with neighbours and caretakers after returning to Son La province. No cases of illness in livestock, including swine, were reported around the person's residence in Son La. No information is available from the person's residence in Hung Yen province. The source of exposure is currently unknown.

This is the first person infected with influenza A(H1N1) variant virus of swine origin reported from Viet Nam.

ECDC assessment

Sporadic transmission of influenza variant viruses of swine origin to humans causing mild to severe infections have been reported from several countries, including in the EU/EEA. Swine influenza viruses circulate widely in the pig population and direct human exposure to pigs represents the most common risk factor for infection. Cases have also occurred among otherwise healthy people and sporadic infections cannot be excluded when people have unprotected direct contact with infected animals.

When a human infection is detected, it is necessary to rapidly perform contact tracing in order to exclude onward transmission to contacts, and to implement control measures to prevent human-to-human spread. Zoonotic influenza viruses isolated from patients should be further sequenced and characterised, as well as shared with the national influenza reference laboratories and WHO Collaborating Centres.

Sporadic cases of swine influenza in humans can occur and usually pose a very low risk for the general population and a low risk for occupationally-exposed individuals due to the high prevalence of swine influenza viruses in the pig population. Although there is no indication of human-to-human transmission following the detection of this case (whose symptoms already started before 1 June 2024), as further characterisation is still ongoing at the WHO CC, ECDC will assess the risk from this specific variant virus when more information becomes available.

ECDC published a [Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work](#) in October 2022 and [Threat Assessment Brief on Eurasian avian-like A\(H1N1\) swine influenza viruses](#) in July 2020.

Actions

ECDC is monitoring zoonotic influenza events through its epidemic intelligence activities in collaboration with disease experts to identify potential significant changes in the epidemiology of the virus. Human cases of zoonotic influenza should be reported immediately to EWRS and IHR.

Sources: [2022-E000398](#)

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

Events under active monitoring

- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 30 August 2024
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 30 August 2024
- Cholera – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 30 August 2024
- Human cases of swine influenza A(H1N1) virus variant - Multi-country - 2024 - last reported on 30 August 2024
- Overview of respiratory virus epidemiology in the EU/EEA - weekly monitoring - last reported on 30 August 2024
- Mass gathering monitoring – Olympic and Paralympic Games – France – 2024 - Weekly Monitoring - last reported on 30 August 2024
- Seasonal surveillance of West Nile virus infections – 2024 - last reported on 30 August 2024
- Legionnaires' disease outbreak - Italy - 2024 - last reported on 30 August 2024
- Mpox due to monkeypox virus clade I – Multi-country – 2024 - last reported on 30 August 2024
- Autochthonous chikungunya virus disease - Department of La Réunion, France, 2024 - last reported on 30 August 2024
- Locally acquired dengue in 2024 in mainland France - last reported on 23 August 2024
- Circulating vaccine-derived poliovirus type 2 (cVDPV2) - Palestine* - 2024 - last reported on 23 August 2024
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 23 August 2024
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 23 August 2024
- Human cases of swine influenza A(H3N2) variant virus – Multi-country - last reported on 16 August 2024
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 16 August 2024
- Chandipura virus disease – India – 2024 - last reported on 16 August 2024
- Risk assessments under production - last reported on 9 August 2024
- SARS-CoV-2 variant classification - last reported on 6 September 2024
- Locally acquired chikungunya virus disease in mainland France - last reported on 2 August 2024
- Imported Oropouche virus disease cases in the EU/EEA, 2024 - last reported on 2 August 2024.