WEEKLY BULLETIN

Communicable Disease Threats Report

Week 42, 12–18 October 2024

This week's topics

Executive Summary

Detection of cVDPV2 in a wastewater sample, Barcelona, Spain

- cVDPV2 has been detected from a single environmental sample collected on 16 September from the Barcelona metropolitan area.
- No cases of acute flaccid paralysis have been detected in the community.
- This is the first detection of an environmental sample positive for cVDPV2 in Spain.
- Continued efforts are necessary in all EU/EEA countries to maintain high vaccination coverage in the population and prevent poliovirus reintroduction and spread.

Detection of cVDPV3 in environmental samples in French Guiana

- cVDPV3 has been detected from three environmental samples collected in May, June and August from three collection sites in French Guiana.
- No cases of paralysis have been detected.
- This is the first detection of an environmental sample positive for cVDPV3 in French Guiana.
- Continued efforts are necessary in all EU/EEA countries to maintain high vaccination coverage in the population and prevent poliovirus reintroduction and spread.

European Centre for Disease Prevention and Control, Solna, Sweden
www.ecdc.europa.eu

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

- Five new cases of avian influenza A(H5N1) have been reported in California, United States, bringing the total number to 11 confirmed cases since 3 October 2024.
- All 11 cases were in individuals with exposure to infected dairy cattle.
- According to the United States Centers for Disease Control and Prevention (US CDC), the risk to the general population remains low, while people with exposure to infected animals have a higher risk of infection.

Marburg virus disease (MVD) – Rwanda – 2024

- On 27 September 2024, Rwanda reported its first Marburg virus disease outbreak.
- As of 17 October 2024, 62 cases, including 15 deaths, have been reported. Forty-three of these individuals have recovered.
- According to the Ministry of Health of Rwanda, the new confirmed cases were linked to healthcare facilities in Kigali and all their contacts were under isolation and treatment.
- On 6 October 2024, vaccinations for healthcare workers started with the investigational Marburg virus vaccine provided by the Sabin Vaccine Institute.
- A number of control measures are being implemented, including: exit screening at the airport, ban on patient visits to hospitals, strengthening infection prevention and control protocols in hospitals, and measures to limit contact with dead bodies.
- ECDC published a threat assessment brief on the implication of the outbreak for the EU/EEA on 10 October 2024.
- The overall risk for EU/EEA citizens visiting or living in Rwanda is assessed as low because the likelihood of exposure to MVD – considering the low number of cases reported and the mode of transmission – and the impact are both assessed as low.
- In the event of MVD cases being imported into the EU/EEA, we consider the likelihood of further transmission to be very low, and the associated impact low. Therefore, the overall risk for the EU/EEA is assessed as low.
- WHO and partners are supporting Rwanda in strengthening their response.

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

- There have been no significant changes in the epidemiological situation related to the global circulation of monkeypox virus (MPXV) clade I and clade II during the past week.
- Among the countries that had previously reported clade Ib cases, the Democratic Republic of Congo (DRC), Burundi, Kenya and Uganda have reported new cases in the past week.
- Mpox cases (clade not defined yet) have been reported this week in Zimbabwe.
- No secondary transmission of MPXV clade Ib has been reported in Sweden, Thailand or India (countries outside of Africa where MPXV clade I has been detected).
- ECDC is closely monitoring and assessing the epidemiological situation and additional related information can be found in ECDC's rapid risk assessment published on 16 August (Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries), and its Rapid scientific advice on public health measures.

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

- The number of patients presenting to primary care and hospitals for respiratory illness remains at expected levels for this time of year. COVID-19 continues to account for approximately one sixth of these presentations in week 41, and influenza and respiratory syncytial virus (RSV) are still circulating at very low levels.
- Although overall SARS-CoV-2 activity in the EU/EEA is at a lower level than at this time of year in 2023, some countries continue to experience relatively high SARS-CoV-2 activity.
- The data reported by EU/EEA countries during the spring/summer COVID-19 epidemic suggest that people aged 65 years and above continue to represent the main age group at risk of hospitalisation and severe outcomes due to COVID-19.
- Vaccination is the most effective measure to protect against more severe forms of respiratory viral diseases. Vaccination campaigns have started or are now starting in many EU/EEA countries. People who are eligible for vaccination, particularly those at higher risk of severe outcomes, are encouraged to get vaccinated when it is offered to them.

Seasonal surveillance of West Nile virus infections – 2024

- Since the beginning of 2024, and as of 16 October 2024, cases of West Nile virus (WNV) infection have been reported to the European Surveillance System (TESSy) by 14 EU/EEA countries (Austria, Bulgaria, Croatia, Cyprus, Czechia, Hungary, Romania, France, Germany, Italy, Greece, Slovakia, Slovenia and Spain) and five EU-neighbouring countries (Albania, Kosovo*, North Macedonia, Serbia and Türkiye).
- The latest monthly epidemiological update on WNV infections covers data up to 2 October 2024, with a total of 1 202 locally acquired WNV infection cases and 88 deaths reported by European countries to TESSy.
- 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.*

Locally acquired dengue in 2024 in mainland France

- In 2024, and as of 16 October, 80 locally acquired dengue cases have been reported in mainland France.
- Cases have been reported in the following departments: Alpes-Maritimes (17 cases), Drôme (2 cases), Hérault (3 cases), Pyrénées-Orientales or Lozère (2 cases), Vaucluse (18 cases) and Var (38 cases).
- Investigations are ongoing and vector control measures are being carried out.
- Every Wednesday, the French National Public Health Agency updates its website with any new cases of dengue.

Locally acquired dengue infection in Italy – 2024

- In 2024, as of 15 October, 194 locally acquired dengue cases have been reported in the Marche (136 cases), Emilia Romagna (36 cases), Lombardy (10 cases), Abruzzo (8 cases), Tuscany (2 cases) and Veneto (1 case) regions in Italy. One place of infection is currently under investigation.
- Investigations are ongoing and vector control measures have been triggered by the Italian health authorities in accordance with their national response plan.

Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

- In 2024, as of 15 October, 54 cases of wild poliovirus infection have been reported in Pakistan (32 cases) and Afghanistan (22 cases).
- In 2024, as of 15 October, overall, eight cases of acute flaccid paralysis (AFP) caused by circulating vaccine-derived poliovirus type 1 (cVDPV1) were reported by the Democratic Republic of Congo (7 cases) and Mozambique (1 case), and 173 cases of AFP caused by cVDPV2 were reported in 16 countries.

1. Detection of cVDPV2 in a wastewater sample, Barcelona, Spain

Overview:

On 3 October 2024, the GPEI published that they received an advance notification by Spain of a cVDPV2 from Barcelona, Spain, from a single positive environmental sample collected from the Barcelona metropolitan area, without evidence of local transmission; initial analysis suggests it is linked to the cVDPV2 emergence originating in Zamfara, northern Nigeria.

On 9 October 2024, the Public Health Agency of Catalonia reported that the virus was detected in a single wastewater sample collected in mid-September from the metropolitan area of Barcelona. The affected wastewater treatment plant receives 36% of the total wastewater from the metropolitan

area of the city and 56% from the city of Barcelona. Usually, wastewater samples are tested every two weeks and, previously, all the samples collected were negative for poliovirus.

Since the detection of VDPV2, all health centres in the areas that drain water to this collector have been informed of the situation in order to alert the Epidemiological Surveillance Network of Catalonia of any patient with symptoms suggestive of poliomyelitis (acute flaccid paralysis or aseptic meningitis). None have been identified with these diseases. The frequency of sampling and collection of new samples from the treatment plant itself has been increased, as well as nine additional collectors that feed it in order to delimit the potentially affected area. Currently, all laboratory results from these additional samples (in total, more than 16) have been negative for VDPV2. The surveillance of possible cases in people and wastewater will be maintained until the end of the alert. A national Technical Support Group, including representatives from the affected region, the National Centres for Epidemiology and for Microbiology, and the Ministry of Health, has been convened to share information and discuss further actions.

ECDC assessment:

These are the first findings of an environmental sample positive for cVDPV2 in Spain. No cases of acute flaccid paralysis have been reported. According to the Spanish authorities, the vaccination coverage of three doses of polio containing vaccine in Catalonia is above 92%.

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

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

To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake in pockets of under-immunised populations. EU/EEA countries should review their polio vaccination coverage data and ensure that there are no immunity gaps in the population and that there is capacity to identify virus circulation through well-performing surveillance systems.

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

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

Sources: EIS:2024-e000414

Last time this event was included in the Weekly CDTR: 11 October 2024

2. Detection of cVDPV3 in environmental samples in French Guiana

Overview:

On 14 October 2024, the Pan American Health Organization (PAHO) / World Health Organization (WHO) reported the detection of circulating vaccine-derived poliovirus type 3 (cVDPV3) in French Guiana. Three environmental samples were found positive for poliovirus.

One environmental wastewater sample collected on 26 June 2024 in Cayenne, French Guiana, as part of a research project was tested positive for poliovirus. Sequencing results confirmed the presence of VDPV3 with 15 mutations in the polio virus protein 1 (VP1) region. Further analysis also showed that this sequence is not genetically related to any previously identified VDPV3 strains, including those that circulated in other countries throughout 2021-2022, suggesting it might not have spread from a known source.

Additional environmental samples were collected at the Leblond (Cayenne) wastewater plants and Saint Laurent du Maroni during July and August, respectively. One of the samples, collected on 6 August at the Morne Coco wastewater plant in Rémire-Montjoly tested positive for poliovirus by molecular methods and cell culture. Genetic sequencing results are pending.

Sequencing results confirmed that the samples collected in May, June and August are genetically linked. On 3 October 2024, the GPEI published that they received an advance notification form French Guiana (France) of cVDPV3 with virus isolated from environmental samples collected in May, June and August.

There is no consolidated data to estimate the third dose of diphtheria-tetanus-pertussis (DTP3) vaccination coverage among infants in French Guiana. situation. At the local level, a state-of-the-art study on available vaccination coverage data is underway. The establishment of routine environmental surveillance for poliovirus is underway. An action plan is being consolidated to respond to this detection of circulating VDPV3 (cVDPV3), in particular to inform clinicians and biologists, strengthen clinical and virological surveillance, launch a catch-up vaccination campaign in the most-at-risk populations and communicate with the general public.

ECDC assessment:

These are the first findings of an environmental sample positive for cVDPV3 in French Guiana. No cases of paralysis have been reported. The WHO European Region, including the EU/EEA, has remained polio-free since 2002. Inactivated polio vaccines are used in all EU/EEA countries.

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

To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake in pockets of under-immunised populations. EU/EEA countries should review their polio vaccination coverage data and ensure that there are no immunity gaps in the population and that there is capacity to identify virus circulation through well-performing surveillance systems.

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

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

Last time this event was included in the Weekly CDTR: 11 October 2024

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

Overview:

Update: On 17 October 2024, the US CDC reported an additional five human cases of avian influenza from Central Valley in individuals with exposure to infected cattle (www.cdc.gov). Six cases reported between 3 and 11 October 2024 were in individuals who experienced only mild symptoms, including eye redness or discharge (conjunctivitis) and did not require hospitalisation. Four of these individuals had contact with infected cattle at different farms in Central Valley, while two were from the same farm. According to the US CDC, the two individuals worked at different parts of the farm and were not close contacts. US CDC considers all cases to be due to sporadic animal-to-human transmission. No additional information is currently available for the last five confirmed cases.

US CDC has previously reported that the virus isolated from the samples collected from the first two cases confirmed on 3 October and one case reported on 9 October belong to clade 2.3.4.4b, closely related to viruses isolated from infected dairy cows (CDC A(H5N1) Bird Flu Response Update). Whole genome sequencing was performed on one of the isolates and the virus was confirmed to be a B3.13 genotype. CDC has posted in GISAID and submitted to GenBank the haemagglutinin (HA), neuraminidase (NA), and non-structural (NS) gene segments for A/California/134/2024 (GISAID EPI_ISL_19463619; NCBI_PQ435213- PQ435215) and the whole genome sequence for A/California/135/2024 (GISAID EPI_ISL_19463618; NCBI_PQ435216-PQ435223).

The HAs of the three analysed viruses contained new amino acid mutations compared with candidate vaccine viruses (CVVs). Two of the changes were in A/California/135/2024, three in A/California/134/2024, and three in A/California/146/2024. However, none of the changes associated with increased ability to infect or transmit between humans have been identified. As for susceptibility to antivirals, there was no reduced susceptibility to neuraminidase inhibitors or polymerase acidic inhibitors. Similarly, no changes associated with mammalian adaptation in other gene segments were identified in the analysed samples.

US CDC is performing additional testing, including antigenic characterisation of the isolated viruses. This will inform if existing CVVs are well-matched to the new reported cases of avian influenza A(H5).

US CDC also performed neutralisation assays with the use of reverse genetic engineered virus containing HA P136S and A156T changes identified in a case reported in Missouri on 6 September 2024. The tests showed that the mutated virus had reduced cross-reactivity to ferret antisera generated to viruses without those changes. The generated virus will now be used for serology testing of serum samples from the confirmed case in Missouri and the individual's close contacts.

As of 18 October 2024, a total of 25 human cases of avian influenza A(H5) have been reported in the US during 2024. Of these, 15 were individuals exposed to dairy cattle that were infected, or presumed to be infected, with A(H5N1) and nine were workers exposed to outbreaks of HPAI A(H5) at commercial egg farms. One case had no known animal exposure.

The US CDC's current assessment of the human health risk of A(H5N1) to the general public in the US has not changed and continues to be considered low.

ECDC assessment:

To date, there have been no confirmed cases of A(H5N1) infection in humans and no reports of A(H5N1) infection in cattle in the EU/EEA. The genotype B3.13 identified in cattle and several of the human cases in the US has not been detected in Europe.

ECDC has assessed the risk of infection from the circulating HPAI A(H5N1) clade 2.3.4.4b viruses as low for the general population and low-to-moderate for those with activities that expose them to infected or dead animals or a contaminated environments (e.g. occupational exposure to infected animals). ECDC will revisit the risk assessment once more information becomes available from the ongoing sequencing and investigations of the most recent human cases in the US.

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

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

ECDC relevant publications:

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

Actions:

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

Sources: FAO | 2024-e000168

Last time this event was included in the Weekly CDTR: 11 October 2024

4. Marburg virus disease (MVD) – Rwanda – 2024

Overview:

On 27 September 2024, the Ministry of Health of Rwanda reported the first outbreak of Marburg virus disease (MVD) in the country. As of 15 October 2024, a total of 62 cases, including 15 deaths, have been reported. Forty-three patients have recovered and four are in isolation and treatment. The last new case was reported on 14 October 2024.

The Ministry of Health of Rwanda has communicated that all new cases reported after the declaration of the outbreak are linked to healthcare facilities.

On 6 October 2024, vaccinations for healthcare workers started as part of a Phase 2 rapid response open-label study. The Sabin Vaccine Institute provided the first 700 doses of the investigational Marburg virus vaccine on 5 October 2024 and 1 000 doses on 14 October 2024.

Rwanda has been implementing a number of control measures, including: exit screening at the airport, measures in education settings and conferences, ban on patient visits to hospitals, strengthening infection prevention and control protocols in hospitals, and measures to limit contact with dead bodies (Travel Advisory, Rwanda (4 October 2024), Ministry of Health, Rwanda: Guidelines for the prevention of Marburg (29 September 2024).

Epidemiological investigations, contact tracing, strengthening of infection prevention and control protocols and other measures are being implemented by the government of Rwanda to control the outbreak. Among the contacts investigated in Rwanda, one travelled to Belgium but has completed the monitoring period (21 days) and is not considered a public health risk.

On 2 October 2024, Germany reported two travellers suspected of having MVD returning from Rwanda. Both were isolated in Hamburg and tested, as one of the two had been working in a medical facility where MVD patients were being treated. Negative test results were reported on 3 October.

Background
Marburg virus is present in certain animal species (e.g. bats) in several sub-Saharan African countries. Transmission from animals to humans is rare. However, such events may initiate outbreaks due to subsequent human-to-human transmission.

MVD is not an airborne disease and is not considered contagious before symptoms appear. Direct contact with the blood and other body fluids of an infected person or animal is the most frequent route of transmission. Indirect contact with surfaces and materials, such as clothing, bedding and medical equipment contaminated with infected blood or body fluids may also result in transmission of the virus. Therefore, if proper infection prevention and control measures are strictly adhered to, the likelihood of infection is considered very low.

The incubation period of MVD is usually five to ten days (range: 3–21 days). The onset of MVD is usually abrupt, with non-specific, flu-like symptoms, such as a high fever (usually 39–40°C), severe headache, chills, muscle pain and malaise. In 50–75% of patients, rapid worsening occurs within two to five days, marked by gastrointestinal symptoms such as anorexia, abdominal discomfort, severe nausea, vomiting and diarrhoea. A maculopapular rash and symptoms of haemorrhagic fever, such as petechiae, mucosal and gastrointestinal bleeding, and bleeding from venipuncture sites may follow in severe cases. Neurological symptoms (disorientation, agitation, seizures and coma) can occur in later stages of the disease. The case fatality of MVD can range from 24–88%, depending on the virus strain, mode and intensity of infection, and the timeliness and level of medical care.

There is no specific antiviral treatment for MVD. Supportive therapy such as intravenous fluids, electrolyte replacement, supplemental oxygen, as well as blood and blood product replacement, may improve the clinical outcome significantly. There is no approved vaccine for MVD to date.

More information can be found in the ECDC Factsheet about Marburg virus disease.

ECDC assessment:

On 10 October 2024, ECDC published a threat assessment brief of the implication of the Marburg virus disease outbreak in Rwanda for the EU/EEA (Implications of the Marburg virus disease outbreak in Rwanda for the EU/EEA, 2024).

EU/EEA citizens visiting or living in Rwanda are considered at a **low likelihood of exposure and infection**, since person-to-person transmission of Marburg virus requires contact with body secretions from a symptomatic person and case numbers remain low. There are still unknowns around the epidemiological links of those with the disease and ongoing transmission of the virus. Control measures announced by Rwanda's government in various settings (educational, places of worship, meetings, funerals) will further mitigate the likelihood of exposure and infection.

Transmission of the virus is documented, and most likely ongoing, in healthcare facilities in Kigali, with many healthcare workers affected. Small numbers of EU/EEA citizens may be working in healthcare settings in Rwanda and for them the risk is estimated as higher, particularly if not using proper personal protective equipment (PPE). Healthcare workers, along with caregivers, are at the highest risk of contracting the disease in these outbreaks, due to having close contact with body fluids and performance of invasive procedures.

The impact of an MVD case for an EU/EEA citizen in Rwanda is assessed as low. Although MVD is a potentially life-threatening disease, at the population level case numbers are low and in the context of this outbreak adequate supportive care is available locally. Therefore, the overall risk for EU/EEA citizens visiting or living in Rwanda is estimated as **low**.

In the event that MVD cases are imported into the EU/EEA, we consider the likelihood of further transmission to be very low if appropriate measures are taken (e.g. early detection, isolation of suspected cases (i.e. any person with MVD-compatible symptoms and an epidemiological link to the ongoing outbreak in Rwanda) and contact tracing). In addition, in Rwanda identified contacts of people with MVD in the ongoing outbreak cannot leave the country and, in addition, exit screening is being implemented. The impact associated with imported MVD cases in the EU/EEA is estimated as low. Hence, the overall risk for EU/EEA citizens from a potential imported MVD case is assessed as **low**.

Information about the health risks related to the ongoing MVD outbreak should be provided to EU/EEA travellers going to Rwanda as well as EU/EEA citizens working or living in Rwanda. They should be made aware of the ongoing outbreak in the country and the affected areas and advised to follow the recommendations of the local health authorities, as regards hospital visitation, attending educational settings, places of worship, meetings and funerals. They should be advised to:

- Avoid contact with people exhibiting MVD symptoms (fever, vomiting, diarrhoea or bleeding) or contact with fomites contaminated by body fluids of infected persons. This includes avoiding participating in funerary rituals and the burial process of deceased persons.
- Avoid visiting healthcare facilities in the MVD-affected areas for non-urgent medical care or for non-medical reasons.
- Avoid habitats that may be populated by bats, such as caves or mines, as well as any form of close contact with wild animals, including monkeys, forest antelopes, rodents and bats, both alive and dead, and manipulation or consumption of any type of bushmeat.

Travellers returning from Rwanda to the EU/EEA should be advised to seek prompt medical care if they develop MVD-compatible symptoms and mention their travel history, as well as possible exposure history and close contacts.

Actions:

ECDC is in contact with international partners to acquire more information on the measures being implemented and will continue monitoring the event through epidemic intelligence activities.

Last time this event was included in the Weekly CDTR: 11 October 2024

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

Overview:

Global update

There have been no major changes to the global epidemiological trends in mpox during the past week.

On a global basis, MPXV clade I and clade II are circulating in different countries. Global epidemiological data are being updated weekly by the World Health Organization (WHO), with the most recent updates from Africa highlighting the recent expansion of clade I cases (2022–24 Mpox (Monkeypox) Outbreak: Global Trends). No secondary cases of mpox due to MPXV clade I have been reported by Sweden, Thailand or India.

Overall, since monitoring began in 2022, 109 699 confirmed mpox cases (MPXV clade I and clade II), including 236 deaths, have been reported from 123 countries (2022–24 Mpox (Monkeypox) Outbreak: Global Trends and WHO Mpox Multi-country external situation report n. 40, published 13 October 2024).

Epidemiological situation in Africa

In 2024, over 42 400 confirmed and suspected mpox cases due to MPXV clade I and clade II, including over 1 100 deaths, have been reported from Africa. This includes over 8 110 confirmed cases, according to the Africa CDC (Special Briefing on Mpox & Other Health Emergencies, Africa CDC, 17 October 2024). The countries reporting cases are Burundi, Cameroon, the Central African Republic, the Republic of the Congo (Congo), Cote d'Ivoire, the Democratic Republic of the Congo (DRC), Gabon, Ghana, Guinea, Kenya, Liberia, Morocco, Nigeria, Rwanda, South Africa, Uganda, Zambia and Zimbabwe.

Since the previous update, Zimbabwe reported two mpox cases for the first time on 13 October 2024. According to the press release from the Ministry of Health, the two individuals had travel history to South Africa and Tanzania. The clade has not yet been defined.

The epidemiological situation regarding mpox due to MPXV clade Ib remains similar to the previous week.

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

- In the past six weeks, the DRC has reported 1 914 confirmed cases and Burundi 841, according to the WHO Global report on mpox (data as of 13 October). Deaths have only been reported in DRC (231 among all cases according to WHO in the past six weeks). Clade Ib has been detected in both countries, while clade Ia is co-circulating in the DRC.
- The DRC continues to report the highest number of mpox cases in Africa. The cumulative number of cases in 2024 is over 34 000 (over 6 160 confirmed), including over 950 deaths (Africa CDC Epidemic Intelligence Report issued on 12 October 2024 and WHO Global report on mpox (data as of 13 October)).
- In Burundi, as of 13 October 2024, 1 169 confirmed cases have been reported according to the WHO Global report on mpox (data as of 13 October) from several areas of the country. No deaths have been reported in the country. According to the WHO AFRO weekly report of 11 October, cases were reported from 38 of 49 districts and the positivity rate among suspected cases is 40.7%.
- Kenya has reported two more cases and one mpox death since the last update. A total of 14 cases and one death have been reported so far in the country. According to the Ministry of Health, the patient died on 11 October 2024, after having recovered from mpox (Ministry of Health, Kenya, 17 October 2024). The cases have been reported from 11 counties. So far only one case has been reported in Nairobi.
- In Uganda where clade Ib has been detected, 39 cases have been reported since the previous report and as of 14 October 2024. A total number of 108 cases have been reported in the country from 16 districts since July 2024. Twenty-nine cases have been reported in Kampala and 29 in Nakasongola (Mpox Outbreak in Uganda - 15 October 2024). In week 40, Uganda reported mpox outbreak in two prisons (Special Briefing on Mpox & Other Health Emergencies, Africa CDC, 17 October 2024).

Based on an analysis of the patterns of MPXV transmission observed at the national level, and given the limitations and uncertainties, ECDC has used official epidemiological information to classify countries according to whether MPXV clade I is endemic or has been reported for the first time in 2024. The categories are as follows:

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

The classification was last updated on 17 October 2024.

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

Epidemiological situation in the EU/EEA for MPXV clade I

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

ECDC assessment:

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

Actions:

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

Sources: ECDC rapid risk assessment

Last time this event was included in the Weekly CDTR: 11 October 2024

6. 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 care and hospitals indicates that respiratory activity remains at baseline levels in most EU/EEA countries, similar to the levels observed during previous seasons at this time of year.
- SARS-CoV-2 activity in primary care and hospitals continues to decrease at the EU/EEA level, with positivity rates below those observed in 2023 at this time of year. However, the situation varies greatly across countries. People aged 65 years and above continue to be most affected by severe COVID-19 disease.
- Seasonal influenza activity remained stable at low levels in the reporting EU/EEA countries.
- RSV activity remained low in the reporting EU/EEA countries. However, based on past seasons, the countries should prepare to see an increase in RSV activity in the coming weeks.

Virus characterisation

Influenza in week 41, 2024

- From week 40, 2024 to week 41, 2024, no genetically characterised viruses were reported to TESSy.

SARS-CoV-2 variants for weeks 39–40 (23 September to 6 October 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:
- 64% (60–64%) for KP.3 (461 detections from nine countries)
- 11% (8–26%) for other BA.2.86 variants (128 detections from eight 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. SARS-CoV-2 activity remains elevated in some reporting countries in both primary and secondary care, with those aged 65 years and above at greatest risk of severe disease. Severity indicators (COVID-19 hospital admissions, ICU admissions and deaths) are still high for some countries and highlight the continued need to monitor the impact of SARS-CoV-2 at national and regional levels.

Actions:

In order to assess the impact of emerging SARS-CoV-2 sub-lineages and their possible correlation with increases in COVID-19 epidemiological indicators, countries should continue to sequence SARS-CoV-2-positive clinical specimens and report to GISAID and/or TESSy. It is important to continue testing symptomatic individuals for SARS-CoV-2 during the autumn.

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

While influenza and RSV activity in the EU/EEA remain at low levels, increased activity is anticipated in the coming weeks, as is typical for this time of year.

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 2024–2025 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/Thailand/8/2022 or A/Massachusetts/18/2022 (H3N2)-like virus (clade 2a.3a.1 (J)); and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus (subclade V1A.3a.2).
- Antigenic characterisation data presented in the WHO 2025 southern 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. The components also appear well matched for the 2a.3a.1 (J) clade viruses, but less well matched for the more recent subclade 2a.3a.1 (J2) viruses characterised by S145N, N158K or K189R HA substitutions (alone or in combination). The majority of the A(H3N2) viruses identified worldwide since February 2024 belonged to the subclade 2a.3a.1 (J2), raising concerns about vaccine effectiveness if they were to dominate the 2024–25 influenza season in the EU/EEA.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 11 October 2024

Maps and graphs

Figure 1. Overview of key indicators of activity and severity in week 41

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 41	Week 40	Description	Value	
Primary care consultation rates	ARI	12 rates (10 MEM)	12 rates (10 MEM)	Distribution of country MEM categories	6 Baseline 2 Low 2 Medium	ARI activity remains at similar levels to past seasons at this time of year, even if four countries reported above-baseline ARI activity: two reported low activity (Belgium and Czechia) and two reported medium activity (Germany and Lithuania).
	ILI	18 rates (17 MEM)	17 rates (17 MEM)		14 Baseline 2 Low 1 Medium	ILI activity remains at similar levels to past seasons at this time of year, even if three countries reported above-baseline ILI activity: two reported low activity (Belgium and France) and one reported medium activity (Denmark).
Primary care sentinel positivity	SARS-CoV-2	16	17	Pooled (median; IQR)	14% (15; 8.6–20%)	The pooled EU/EEA test positivity rate continues to decrease slowly, as observed since the peak in July 2024. At the country level, the situation is more varied. The decreasing trend is also observed in some countries that experienced an epidemic during the summer (e.g. Ireland, Spain), but the levels remain more stable in others (e.g. Denmark, Germany, Greece). The highest test positivity rate this week was observed in Hungary (27.8 %), where primary care surveillance resumed in week 40 after a summer break.
	Influenza	16	17		1.1% (0; 0–1.7%)	Stable trend of very low circulation, similar to past seasons at this time of year.
	RSV	15	15		0.3% (0; 0–0%)	Stable trend of very low circulation. Based on pre-COVID-19 pandemic data, week 41 usually marks the beginning of RSV circulation. The situation will be closely monitored in the coming weeks.
SARI consultation rates	SARI	5	7			Rates continued to be reported at levels comparable to past seasons at the same time of year.
SARI positivity	SARS-CoV-2	4	6	Pooled (median; IQR)	13% (7; 4.8–11%)	As observed in primary care, the pooled positivity rate continues to decrease. The positivity rates in SARI surveillance are below those observed in 2023 at the same time of year for most countries except Belgium. Non-sentinel indicators of severe disease (ICU admissions or deaths due to SARS-CoV-2) remain elevated in Czechia, Greece, Hungary, Ireland, Lithuania, Romania, Slovakia and Sweden.
	Influenza	4	6		1.8% (1.9; 0.9–4%)	Stable trend with very low circulation, similar to past seasons at this time of year. After many weeks of elevated activity, the test positivity rate in Malta is back to the expected level for this time of year.
	RSV	4	6		0.4% (0.4; 0.1–1.1%)	Stable trend of very low circulation.
Intensity (country-defined)	Influenza	21	21	Distribution of country qualitative categories	18 Baseline 3 Low	
Geographic spread (country-defined)	Influenza	20	20	Distribution of country qualitative categories	9 No activity 11 Sporadic	

Source: ECDC

Figure 2. Virological distribution for week 41 and the period week 25, 2024 to week 41, 2024

Pathogen or (sub-)type	Primary care sentinel						SARI sentinel						Non-sentinel			
	Week 41			Period 2024-2025			Week 41			Period 2024-2025			Week 41		Period 2024-2025	
	n	%	positivity	n	%	positivity	n	%	positivity	n	%	positivity	n	%	n	%
Influenza	18	100	1.1%	233	100	1.4%	14	100	1.8%	244	100	1.6%	290	100	4 729	100
Influenza A (total)	11	65	0.7%	160	71	1%	8	100	1%	183	95	1.2%	181	65	3 370	73
A(H1)pdm09	3	43	–	45	34	–	3	60	–	14	54	–	21	60	697	50
A(H3)	4	57	–	89	66	–	2	40	–	12	46	–	14	40	710	50
A (unknown)	4	–	–	26	–	–	3	–	–	157	–	–	146	–	1 963	–
Influenza B (total)	6	35	0.4%	64	29	0.4%	0	0	0%	9	5	0.1%	98	35	1 253	27
B/Vic	1	100	–	16	100	–	0	0	–	0	0	–	0	0	87	100
B/Yam	0	0	–	0	0	–	0	0	–	0	0	–	0	0	0	0
B (unknown)	5	–	–	48	–	–	0	–	–	9	–	–	98	–	1 166	–
Influenza untyped	1	–	0.1%	9	–	0.1%	6	–	0.8%	52	–	0.3%	11	–	106	–
RSV	4	–	0.3%	32	–	0.2%	3	–	0.4%	32	–	0.2%	58	–	804	–
SARS-CoV-2	187	–	13.7%	3 229	–	22.2%	108	–	13.4%	2 841	–	18.1%	29 578	–	537 779	–

Source: ECDC

7. Seasonal surveillance of West Nile virus infections – 2024

Overview:

Epidemiological summary

Since the start of 2024, and as of 16 October 2024, human cases of WNV infection have been reported to TESSy by 14 EU/EEA countries and five EU-neighbouring countries. In the EU/EEA, Austria, Bulgaria, Croatia, Cyprus, Czechia, Hungary, Romania, France, Germany, Italy, Greece, Slovakia, Slovenia and Spain reported WNV infections. From EU-neighbouring countries, Albania, Kosovo*, North Macedonia, Serbia and Türkiye have reported WNV infections. In total, 188 NUTS3/GAUL1 regions across 19 countries have reported locally acquired WNV cases. National investigations concluded that the confirmed WNV infection reported with place of infection as Rome (NUTS3 = ITI43) acquired the infection elsewhere. As this is not reflected in the data reported to ECDC, this case is still displayed with place of infection as Rome in ECDC's outputs. For detailed information on places of infection, please refer to ECDC's weekly update and dashboard.

The latest monthly epidemiological update on WNV infections, covering data up to 2 October 2024, was published on 9 October 2024. In 2024, 18 countries in Europe reported 1 202 locally acquired human cases of WNV infection with known place of infection. The earliest and latest dates of onset were on 1 March and 26 September 2024, respectively. Locally acquired cases were reported by Italy (422), Greece (202), Spain (114), Albania (102), Hungary (101), Romania (71), Serbia (53), Austria (34), Türkiye (30), France (27), Croatia (20), Germany (8), Slovenia (5), Kosovo* (4), Slovakia (4), Bulgaria (2), North Macedonia (2) and Czechia (1). In Europe, 88 deaths were reported by Greece (31), Italy (16), Albania (13), Romania (10), Spain (10), Bulgaria (2), Serbia (2), Türkiye (2), France (1) and North Macedonia (1).

Case numbers reported this year are above the mean monthly case count for the past 10 years. During the same period in 2023, 681 cases had been reported. However, numbers are lower than in 2018, when 1 728 cases had been reported by this time of year.

All 18 countries had reported human cases of WNV infections in the past. However, Albania, Czechia, Kosovo*, Slovenia and Türkiye have not reported any human cases in the past four to five years. In Albania, the current outbreak is the largest outbreak of WNV infections among humans that has been detected in the country.

So far, 180 regions across 18 countries have reported locally acquired human cases of WNV infection this year, compared to 120 regions in 2023 and 159 regions in 2018 during the same period. This is the largest geographical distribution of WNV ever reported in a year. The following regions have reported locally acquired human cases of WNV infection for the first time ever: Berat, Elbasan, Kavaje, Kucove, Kurbin, Lushnje, Vlore, Mallakaster and Kruje in Albania; Bjelovarsko-bilogorska županija in Croatia; Hérault, Guadeloupe and Gard in France; Bautzen, Diepholz, Oder-Spree and Jena Kreisfreie Stadt in Germany; Thesprotia in Greece; Barletta-Andria-Trani, Benevento, Chieti, Roma, Firenze and Napoli in Italy; Prishtinë, Prizren and Mitrovicë in Kosovo*; Pološki in North Macedonia; Trnavský kraj and Nitriansky kraj in Slovakia; Podravska in Slovenia; Jaén in Spain; and Bursa and Osmaniye in Türkiye.

As observed in previous years, most cases are among men aged over 65 years. Severity indicators are comparable to those observed in previous years, with 92% of cases hospitalised, a case fatality rate of 8% and neurological manifestations in 70% of cases. The dominance of neurological cases is expected, as cases with more severe symptoms are more likely to be diagnosed.

In addition, travel-associated cases from outside of the EU/EEA have been reported in travellers arriving from Bosnia and Herzegovina, India, Kenya, Morocco, Oman, Tunisia, Uganda, the United Arab Emirates and the United States.

From the veterinary perspective, 337 WNV outbreaks among equids and 344 outbreaks among birds have been reported in Europe in 2024. Outbreaks among equids have been reported by Germany (122), Austria (47), Spain (46), France (39), Hungary (35), Italy (28), Portugal (16), G reece (3) and Poland (1). Outbreaks among birds have been reported

by Italy (248), Germany (57), Austria (18), Spain (8), Slovenia (4), Hungary (3), Bulgaria (2), France (2) and Poland (2). The earliest and latest start dates of outbreaks among birds and/or equids were 2 April 2024 and 27 September 2024, respectively.

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).

** 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.*

ECDC assessment:

As in previous years, the peak of transmission was observed in August and September. As environmental conditions are becoming less favourable for vector activity and virus replication in vectors, we expect reported case numbers to decrease in the coming weeks.

Due to the delay in diagnosis and reporting of cases of WNV infection, and also that a majority of the WNV infections remain asymptomatic or pauci-symptomatic, the case numbers provided in this report are not a true representation of the actual number of cases.

Actions:

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

Last time this event was included in the Weekly CDTR: 11 October 2024

8. Locally acquired dengue in 2024 in mainland France

Overview:

Update
Overall, France has reported 80 locally acquired dengue cases in 2024. Two new cases were added since the last update (9 October).

As of 16 October, France has reported cases in the following departments:

- Alpes-Maritimes: one case in Menton (or Monaco), two cases in La Colle sur Loup and 14 cases in Vallauris;
- Drôme: two cases in one cluster;
- Hérault: two cases in Vendargues and one case in Montpellier or Pérols;
- Pyrénées-Orientales or Lozère: two cases in one cluster;
- Vaucluse: 18 cases in one cluster;
- Var: 25 cases in La Crau and 13 cases in Fréjus.

The following clusters are considered closed:

- Hérault: one case connected to Montpellier or Pérols;
- Pyrénées-Orientales or Lozère: two cases;
- Alpes-Maritimes: two cases connected to La Colle sur Loup and one case connected to Menton (or Monaco);
- Drôme: two cases;
- Vaucluse: 18 cases.

Background
On 8 July, the French Regional Health Agency of Occitania reported the first autochthonous case of dengue in France in 2024 (Montpellier-Pérols, Hérault department, Occitania). The person had onset of symptoms on 17 June, no travel history, and the place of infection was in the region of Occitania.

ECDC assessment:

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

In Europe, the dengue virus is transmitted by the mosquito vector *Aedes albopictus*, which is established in a large part of Europe. These outbreaks are therefore not unexpected. During autumn, environmental conditions will become less favourable for vector activity and virus replication in vectors. However, it is possible that additional locally acquired cases will occur in the coming weeks.

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

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

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

Actions:

Investigations are ongoing and vector control measures have been carried out. Relevant measures have been 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: 11 October 2024

9. Locally acquired dengue infection in Italy – 2024

Overview:

As of 15 October, 194 locally acquired dengue cases have been reported by the Italian National Public Health Authority. These are 21 more cases than reported in the previous week's update. The newly reported cases were from Marche (22 cases), Emilia Romagna (17 cases), Lombardy (2 cases), Tuscany (1 case) and Abruzzo (1 case).

For 194 cases, NUTS2 regions were reported:

- Marche: 136 cases;
- Emilia Romagna: 36 cases;
- Lombardy: 10 cases;
- Abruzzo: 8 cases;
- Tuscany: 2 cases;
- Veneto: 1 case.

An additional case (onset of symptoms 18 August, DENV 2) was reported by the Abruzzo region. However, the place of infection is currently under investigation as the infection may have occurred in another region.

ECDC assessment:

Non-travel-associated dengue cases have been reported in Italy since 2020 (10 cases). None were reported in 2021 and 2022. In 2023, 82 locally acquired dengue cases were reported, which was the highest number of locally acquired cases in the EU/EEA until 2024. The current outbreak in the Marches is the largest dengue outbreak reported in the EU/EEA to date.

In Europe, the dengue virus is transmitted by the mosquito vector *Aedes albopictus*, which is established in a large part of Europe. These outbreaks are therefore not unexpected. During autumn, environmental conditions will become less favourable for vector activity and virus replication in vectors. However, it is possible that additional locally acquired cases will occur in the coming weeks.

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

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

Actions:

Investigations are ongoing and vector control measures have been triggered in accordance with the national arbovirus prevention and control plan.

ECDC continues to monitor 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: 11 October 2024

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

Overview:

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

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

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

Summary:

Wild poliovirus (WPV):
In 2024, 54 cases of AFP due to wild poliovirus infection have been reported, 32 in Pakistan and 22 in Afghanistan.

Circulating vaccine-derived poliovirus (cVDPV):
With date of symptom onset in 2024 (as of 15 October 2024):
In 2024, eight cases of AFP caused by cVDPV1 have been reported from two countries: the Democratic Republic of Congo (DRC) (7 cases), and Mozambique (1 case).

In 2024, 173 cases of AFP caused by cVDPV2 were reported from 16 countries: Angola (7 cases), Benin (1 cases), Chad (8 cases), DRC (12 cases), Ethiopia (13 cases), Guinea (5 cases), Indonesia (7 cases), Liberia (1 cases), Mali (1 cases), Niger (9 cases), Nigeria (61 cases), Somalia (3 cases), South Sudan (9 cases), Cameroon (2 cases), Palestine* (1 cases), and Yemen (33 cases).

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

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

**This designation shall not be construed as recognition of a State of Palestine and is without prejudice to the individual positions of the Member States on this issue.*

ECDC assessment:

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

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

To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake in pockets of under-immunised populations. EU/EEA countries should review their polio vaccination coverage data and ensure that there are no immunity gaps in the population and that there is capacity to identify virus circulation through well-performing surveillance systems.

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

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

Actions:

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

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

Last time this event was included in the Weekly CDTR: 27 September 2024

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 27 September 2024
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 27 September 2024
- Human cases of swine influenza A(H3N2) variant virus – Multi-country - last reported on 27 September 2024

- Overview of respiratory virus epidemiology in the EU/EEA - weekly monitoring - last reported on 27 September 2024
- Avian influenza A(H5N1) human cases – United States – 2024 - last reported on 27 September 2024
- Seasonal surveillance of West Nile virus infections – 2024 - last reported on 27 September 2024
- Locally acquired dengue in 2024 in mainland France - last reported on 27 September 2024
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024 - last reported on 27 September 2024
- Locally acquired dengue infection in Italy – 2024 - last reported on 27 September 2024
- Severe floods in Central and Eastern Europe - Multi-country - 2024 - last reported on 20 September 2024
- Detection of cVDPV2 in a wastewater sample, Barcelona, Spain - last reported on 18 October 2024
- Marburg virus disease (MVD) – Rwanda – 2024 - last reported on 18 October 2024
- Circulation of VDPV3 in French Guiana - last reported on 18 October 2024
- New strain ofmultidrug-resistant Shigella sonneiST152 - Multi-country - 2024 - last reported on 11 October 2024
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2024 - last reported on 11 October 2024
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 11 October 2024
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 04 October 2024
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 04 October 2024
- SARS-CoV-2 variant classification - last reported on 04 October 2024