

## WEEKLY BULLETIN

# Communicable Disease Threats Report

Week 11, 10 – 16 March 2024

## This week's topics

1. Overview of respiratory virus epidemiology in the EU/EEA - weekly monitoring
2. SARS-CoV-2 variant classification
3. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases
4. Measles – Multi-country (World) – Monitoring European outbreaks - monthly monitoring
5. Cholera – Comoros – 2024 - Weekly monitoring

## Executive summary

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

- Syndromic surveillance in primary and secondary care indicate that respiratory activity is decreasing but remains above baseline levels in some countries. The activity is driven largely by influenza.
- **All indicators pointed to elevated, but decreasing influenza activity in the EU/EEA.**
  - At the EU/EEA level, a decreasing trend in pooled primary care positivity for influenza has been observed over the past four weeks, with a mixture of stable and decreasing trends observed at the country level, although most reporting countries continue to be above the 10% sentinel primary care positivity threshold for influenza.
  - Most reporting countries are now reporting medium or low levels of influenza intensity, widespread geographical spread, and baseline rates of influenza-like illness.
  - Decreasing trends in SARI syndromic indicator positivity and in non-sentinel hospital/ICU indicators are being observed in all countries reporting these data.
  - A(H1)pdm09 continues to be dominant in most countries. While the proportion of influenza B detections has increased relative to type A, influenza B detections remain low overall.
  - Interim influenza vaccine effectiveness (VE) estimates for the 2023–2024 season indicate that up to 53% and 44% of vaccinated individuals in primary care or hospital settings, respectively, were protected against mild and severe influenza.
- **RSV activity decreased overall at the EU/EEA level**, although the country-level picture remains mixed and some countries continue to report increasing hospital and/or ICU admissions.
- **SARS-CoV-2 activity was low in all EU/EEA countries.**

### SARS-CoV-2 variant classification

Since the last update on 1 March 2024, and as of 15 March 2024, the variants of interest (VOIs) **XBB.1.5-like** and **XBB.1.5-like+F456L** have been **re-merged** into a **single VOI designated XBB.1.5-like** in ECDC's variant classifications since the levels of circulation of both VOIs are very low and because this simplifies the view in [ERVISS](#).

The variant landscape in the EU/EEA is clearly dominated by **BA.2.86**. As of 11 March 2024, the median proportion for BA.2.86 in the EU/EEA for week 8 (19 February 2024 to 25 February 2024) is 92.7% (range: 75.0–100.0%).

**BA.2.87.1** lineage was classified as a VUM on 2 February 2024. A small number of sequences of this lineage (9) were detected in South Africa, with collection dates ranging from 20 September to 12 December 2023. As of 7 March 2024, BA.2.87.1 has not been detected outside South Africa. This lineage has been circulating in South Africa at low levels since September 2023, without any clear signs of an increase in proportion or an impact on epidemiological indicators. BA.2.87.1 is genetically distinct from currently circulating variants, carrying around 100 mutations compared to the parental lineage BA.2. It also has a distinct N-terminal domain in the spike protein, including several large deletions, and could potentially be associated with a significant shift in antigenic properties. However, to date no virus neutralisation data are available for BA.2.87.1, and further studies are needed to elucidate the properties of this variant. BA.2.87.1 is unlikely to have an impact on the epidemiological situation in the EU/EEA in the near future.

**XBB.1.5-like+F456L** lineages are circulating with a median proportion of 0.0% in EU/EEA countries (range: 0.0–1.8%). The overall proportion of XBB.1.5-like+F456L variants is very low in the EU/EEA.

**XBB.1.5-like+L455F+F456L** variant proportions are very low in the EU/EEA, with a median proportion of 0.0% (range: 0.0–1.8%).

Other **XBB.1.5-like** lineages are circulating in very low proportions in the EU/EEA, with a median proportion of 0.0% (range: 0.0–2.5%).

#### **Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases**

- Four new cases of human infection with avian influenza A(H9N2) infection have been reported in China.
- The Hong Kong authorities have reported a new human infection with avian influenza A(H9N2) in a six-year-old boy from Anhui province, China.
- In addition, three more cases, all children who had exposure to live poultry, were reported in Guangxi, Jiangxi and Guangdong provinces.
- Since 1998, 135 human cases of A(H9N2) have been confirmed globally, including two deaths.
- Most of the cases reported to date have been in China (122 cases). No human cases have been reported in the EU/EEA.

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

- In December 2023, 124 cases of measles were reported by nine countries in The European Surveillance System (TESSy). Between January and December 2023, 2 361 cases of measles were reported in TESSy by 23 countries.
- Through epidemic intelligence, ECDC has identified 3 507 new measles cases in 18 EU/EEA countries since the last monthly update, including reports on the ongoing outbreaks among other in Austria, Cyprus, France, Netherlands, Portugal, and Romania.
- Nine measles-related deaths have been reported in Romania (8) and Ireland (1); in Romania four deaths were in children below one year of age, and two in adults with underlying medical conditions. One adult died in Ireland.
- Overall, measles transmission currently remains low in the EU/EEA.
- Relevant updates for outside the EU/EEA are available for Switzerland, Ukraine, and all WHO Regions.

#### **Cholera – Comoros – 2024 - Weekly monitoring**

- Since the last available update on 4 March and as of 13 March 2024, 87 new cholera cases and six deaths have been reported in Comoros.
- Since the start of the outbreak and as of 13 March 2024, 227 confirmed cholera cases and 12 deaths have been reported. Cases were reported in Grande Comore, Moheli, and Anjouan.
- Given the intense movement of people between Comoros islands and Mayotte and the favourable local conditions in the island, ECDC assess the risk of cholera for the population living in Mayotte as moderate.

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

## Overview

### Respiratory virus activity

- Consultation rates of patients presenting to general practitioners with respiratory illness (influenza-like illness (ILI) and/or acute respiratory infection (ARI)) were reported by 22 EU/EEA countries in week 10, with rates showing a decreasing trend in several countries. The Moving Epidemic Method (MEM) thresholds were available for 20 countries (eight for ARI, 19 for ILI), with nine reporting consultation rates above baseline levels in at least one indicator. ARI rates were low in one country and medium in one; the remaining countries reported baseline activity. ILI rates were low in six countries and medium in three. The remaining countries reported baseline activity in both indicators. Short-term forecasts of ILI and ARI rates in EU/EEA countries are published on ECDC's [RespiCast](#).
- In primary care sentinel settings, the median test positivity at the EU/EEA level was highest for influenza, at 13% (pooled country data: 12%; interquartile range (IQR) of country values: 8–22%), with mostly decreasing trends observed at the country level. Of 17 countries reporting at least 10 tests, 11 observed seasonal influenza activity above the 10% positivity threshold in sentinel primary care. Of 23 countries reporting qualitative assessments of seasonal influenza activity, four reported baseline activity, nine reported low activity and 10 reported medium activity. Fourteen of 23 countries reported widespread geographical spread of seasonal influenza. Influenza detections from non-sentinel sources mirrored the decreasing trend observed in sentinel reporting.
- Among the 273 sentinel primary care detections of seasonal influenza, 192 (70%) were typed as influenza virus type A and 81 (30%) were typed as influenza virus type B. Although the proportion of B detections increased from 20% in week 9 to 30% in week 10, the overall number of detections in the EU/EEA remains low, with the increase driven by reduced detections of influenza A. Of the influenza type A detections that were further subtyped, 107 (70%) were A(H1N1)pdm09 and 45 (30%) were A(H3). The remaining 40 influenza type A detections were of unknown subtype. Of the influenza type B detections, 39 were further defined as B/Victoria lineage, while the remaining 42 were of unknown lineage.
- The median sentinel primary care RSV positivity was 3% (pooled: 4%; IQR: 1–8%). Country-level variation was present, with both increasing and decreasing trends in sentinel positivity.
- The median sentinel primary care positivity for SARS-CoV-2 was 1% (pooled: 2%; IQR: 0–3%). This indicator has been decreasing since week 49, 2023. Both primary care sentinel and non-sentinel data at the country level show decreasing trends in all countries reporting data to week 10.

### Severe disease

- Rates of severe acute respiratory infection (SARI) from sentinel secondary sites were comparable to the same time last year in all eight countries reporting data up to week 10. Five out of six countries reported testing data for all three pathogens.
- The median SARI test positivity for seasonal influenza decreased to 3% (pooled: 14%; IQR: 0–7%), with a decrease observed in all countries reporting this indicator. The pooled test positivity for seasonal influenza has been decreasing since week 5 and was below 10% across all age groups in week 10. All countries reporting non-sentinel hospital or ICU data observed decreasing trends.
- The median SARI test positivity for RSV was 6% (pooled: 7%; IQR: 5–7%). The highest pooled test positivity was observed in children aged 0–4 years and overall this has been decreasing since week 52, 2023. One country continues to report increasing hospital admissions and another country increasing ICU admissions.
- The median SARI test positivity for SARS-CoV-2 was 8% (pooled: 4%; IQR: 5–8%). Overall, rates for non-sentinel hospital admissions, ICU admissions and deaths have gradually decreased since week 50, with decreasing or stable low trends observed in all reporting countries.
- [EuroMOMO](#) pooled estimates of weekly excess all-cause mortality showed 'mortality for participating European countries was decreasing after experiencing substantially elevated levels, since December 2023'.

### Virus characterisation

#### Influenza

- 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).
- From week 40, 2023 to week 10, 2024, 2 006 A(H1N1)pdm09, 751 A(H3) and 93 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the A(H1N1)pdm09 viruses that have been assigned to a clade, 1 197 were reported as clade 5a.2a and 809 were subclade 5a.2a.1. Of the A(H3) viruses that

have been assigned to a clade, 10 were reported as clade 2a.3a, 709 were subclade 2a.3a.1, one was subclade 2a.3b, and 29 were subclade 2a. All B/Victoria viruses were reported as subclade V1A.3a.2.

- Antigenic characterisation data presented in the WHO [2024-2025 northern hemisphere vaccine composition report](#) indicate current northern hemisphere vaccine components are well matched to circulating 5a.2a and 5a.2a.1 A(H1N1)pdm09 subclades and V1A.3a.2 B/Victoria subclades. While components also appear well matched for 2a.3a A(H3) clade viruses, 2a.3a.1 clade viruses are less well matched. Based on human post-vaccination serology studies, haemagglutination inhibition and virus neutralisation against some recent 2a.3a.1 viruses were significantly reduced for some serum panels.
- ECDC has [published](#) interim influenza vaccine effectiveness (VE) estimates for the 2023–2024 season. Analysis of data submitted from multi-country primary care and hospital study sites between September 2023 and January 2024 indicated that up to 53% and 44% of vaccinated individuals in primary care or hospital settings, respectively, were protected against mild and severe influenza.
- Updated WHO [recommendations](#) for the composition of trivalent vaccines for use during the 2024–2025 influenza season in the northern hemisphere are as follows (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 (subclade 2a.3a.1); and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus (subclade V1A.3a.2).

#### **SARS-CoV-2 variants for weeks 8-9 (19 February to 3 March 2024)**

- The estimated distribution (median and IQR of proportions from eight countries) of variants of concern (VOCs) or variants of interest (VOIs) was 91% (86–96%) for BA.2.86 (which includes JN.1 isolates), 1% (0–2%) for XBB.1.5+F456L and 0% (0–0%) for XBB.1.5-like. The proportion of BA.2.86, XBB.1.5-like+F456L and XBB.1.5 have been stable since week 5.

#### **Period overview (week 25, 2023 to week 10, 2024)**

Following relatively low respiratory illness transmission over the summer period, consultation rates increased in primary care settings from September. Transmission of SARS-CoV-2 began increasing in late summer, with clear increases observed at the EU/EEA level up to week 49 and decreases in activity thereafter. Activity is currently low in most EU/EEA countries. Similarly, a steady decrease in severe disease has been observed since week 51. COVID-19 has predominantly affected individuals aged 65 years and above. Week 50 marked the start of the seasonal influenza epidemic. As of week 10, activity remains elevated in some countries, however a decreasing overall trend has been observed since week 5. Severe disease due to influenza has had an impact on all age groups, but the most severe outcomes were observed in older adults. Since week 6, a decrease in the severe disease indicators for seasonal influenza has been observed in most EU/EEA countries. Both influenza type A and type B viruses have been detected, with a dominance of A(H1)pdm09 viruses in most countries. RSV activity began increasing around week 41, reaching a peak in week 50 followed by a decreasing trend. In recent weeks, a mixed epidemiological picture has been observed, with increasing and decreasing trends at country level. RSV continues to have the greatest impact among children aged 0–4 years.

#### **ECDC assessment**

After marking the start of the seasonal influenza epidemic in the EU/EEA in week 50, 2023, seasonal influenza continued to circulate at higher levels than SARS-CoV-2 and RSV in primary care sentinel systems during week 10, 2024, although influenza activity has been decreasing over the past four weeks. Even if the respiratory virus circulation is decreasing, it remains essential to closely monitor the impact of influenza and other respiratory viruses on hospital and ICU admissions.

#### **Actions**

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](#)'.

ECDC published an [epidemiological update](#) that describes the epidemiological situation for acute respiratory infections in EU/EEA countries and provides updated ECDC recommendations to mitigate their impact.

ECDC published guidance on [vaccination rollout for autumn/winter 2023](#) which stresses the importance of influenza and COVID-19 vaccination to protect individuals at increased risk of severe disease – e.g. people aged 60 years and above, and other vulnerable individuals (such as those with underlying comorbidities), irrespective of age.

**Sources:** [ERVISS](#)

**Last time this event was included in the Weekly CDTR:** 8 March 2024.

## 2. SARS-CoV-2 variant classification

### Overview

#### Weekly update on SARS-CoV-2 variants:

Since the last update on 1 March 2024, and as of 15 March 2024, the variants of interest (VOIs) **XBB.1.5-like** and **XBB.1.5-like+F456L** have been **re-merged** into a **single VOI designated XBB.1.5-like** in ECDC's variant classifications since the levels of circulation of both VOIs are very low and because this simplifies the view in [ERVISS](#).

The variant landscape in the EU/EEA is clearly dominated by **BA.2.86**. As of 11 March 2024, the median proportion for BA.2.86 in the EU/EEA for week 8 (19 February 2024 to 25 February 2024) is 92.7% (range: 75.0–100.0%). Among the five EU/EEA countries reporting at least 20 sequences to GISAID EpiCoV for week 8, the proportions of BA.2.86 lineages were as follows: France (92.7%), Germany (100.0%), Ireland (75.0%), Spain (92.3%) and Sweden (96.0%).

A large proportion of the BA.2.86 sequences belong to the sub-lineage **JN.1**. As of 19 December 2023, due to its rapid increase in proportion, [WHO classified](#) JN.1 as a separate VOI from the parent lineage BA.2.86. The most probable driver of the success of BA.2.86-descendant lineages is immune escape in a population where immunity is increasingly derived from XBB-variants.

**BA.2.87.1** lineage was classified as a VUM on 2 February 2024. A small number of sequences of this lineage (9) were identified in South Africa, with collection dates ranging from 20 September to 12 December 2023. As of 4 March 2024, BA.2.87.1 has not been detected outside South Africa. This lineage has been circulating in South Africa at low levels since September 2023, without any clear signs of an increase in proportion or an impact on epidemiological indicators. BA.2.87.1 is genetically distinct from currently circulating variants, carrying around 100 mutations compared with the parental lineage BA.2. It also has a distinct N-terminal domain in the spike protein, including several large deletions, and could therefore potentially be associated with a significant shift in antigenic properties. However, to date no virus neutralisation data are available for BA.2.87.1, and further studies are needed to elucidate the properties of this variant. BA.2.87.1 is unlikely to have an impact on the epidemiological situation in the EU/EEA in the near future.

As of 11 March 2024, and for week 8 2024, **XBB.1.5-like+F456L** lineages are circulating with a median proportion of 0.0% in EU/EEA countries (range: 0.0–1.8%). The overall proportion of XBB.1.5-like+F456L variants is very low in the EU/EEA.

**XBB.1.5-like+L455F+F456L** variant proportions are very low in the EU/EEA, with a median proportion of 0.0% (range: 0.0–1.8%).

Other **XBB.1.5-like** lineages are circulating in very low proportions and in the EU/EEA, with a median proportion of 0.0% (range: 0.0–2.5%).

For the latest information on variants, please see ECDC's [webpage on variants](#).

### Actions

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 \(ERVISS\)](#).

**Last time this event was included in the Weekly CDTR:** 8 March 2024.

### 3. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

#### Overview

**Update:** on 12 March 2024, the Hong Kong authorities reported a new case of human infection in a child under 10 years from Anhui province, China. The child developed symptoms on 3 January 2024. No further information on exposure and disease severity were provided in the report.

Three additional cases in have been reported in China, all with reported exposure to live poultry:

- A three-year-old boy attending a daycare centre in Guangxi province, with onset date 2 February 2024.
- An 11-year-old boy attending school in Jiangxi province with date of onset 11 February 2024.
- A three-year-old boy attending a daycare centre in Guangdong province with date of onset 17 February 2024.

To date, no new cases have been detected among close contacts of the cases.

**Summary:** As of 14 March 2024, and since 1998, a total of 135 laboratory-confirmed cases of human infection with avian influenza A(H9N2) viruses, including two deaths, have been reported in eight countries: China (122), Egypt (4), Bangladesh (3), Cambodia (2), Oman (1), Pakistan (1), India (1), and Senegal (1). Most of the cases were children with mild disease.

**Source:** [Press release of the Government of the Hong Kong Special Administrative Region, 12 March 2024, media report](#)

#### ECDC assessment

Sporadic human cases of avian influenza A (H9N2) have been observed outside the EU/EEA, mainly in young children. The source of infection of the current case is unknown. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses. The risk to human health in the EU/EEA is currently considered very low.

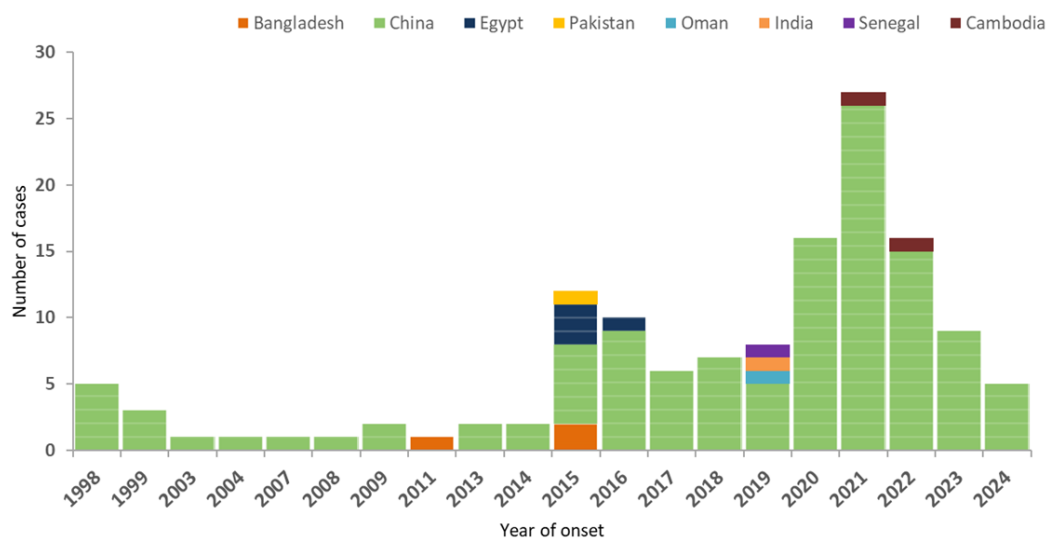
#### Actions

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities and collaborates with the European Food Safety Authority (EFSA) and the EU reference laboratory for avian influenza to identify significant changes in the epidemiology of the virus. ECDC works with EFSA and the EU reference laboratory to produce a quarterly [report on the avian influenza situation](#). The [most recent report](#) was published in December 2023.

**Last time this event was included in the Weekly CDTR:** 1 March 2024.

## Maps and graphs

**Figure 1. Distribution of confirmed human cases of avian influenza A(H9N2) virus infection by year of onset and country, 1998-2024 (updated on 213 March, n=135)**



Source: ECDC

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

### Overview

From 1 January to 31 December 2023, a total of 2 361 measles cases were reported by 23 countries to The European Surveillance System (TESSy), with the majority of cases being reported by Romania (1 755), Austria (186), France (118), Germany (82), Belgium (69), Italy (44), Poland (37), Spain (13) and Sweden (11). The remaining countries with reported cases (Croatia, Czechia, Denmark, Estonia, Finland, Hungary, Ireland, Latvia, Liechtenstein, Lithuania, the Netherlands, Norway, Portugal, and Slovakia) reported fewer than 10 cases in 2023. Detailed data are available in [ECDC's Surveillance Atlas of Infectious Diseases](#).

Complementary epidemic intelligence surveillance data collected between 11 and 14 March 2024 from official public and media sources detected 3 507 new suspected and/or confirmed cases of measles, including two new deaths, since the last monthly update. New cases were reported in 18 EU/EEA countries in recent months: Austria (249), Cyprus (9), Czechia (11), Denmark (5), Finland (1), France (44), Germany (63), Greece (18), Hungary (1), Ireland (2, including one death), Lithuania (10), Netherlands (18), Poland (6), Portugal (8), Romania (3 038 cases, including two new deaths), Spain (16), Slovenia (3), and Sweden (5).

Overall, nine measles-related deaths have been reported in the EU/EEA in 2024 in Romania (8) and in Ireland (1).

Relevant updates for outside the EU/EEA are available for Switzerland, Ukraine, and all WHO Regions.

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

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

[Austria](#) reported 249 confirmed measles cases between 1 January 2024 and 8 March 2024, an increase of 219 cases since 2 February. Of the 243 cases for which information was available, 51 were hospitalised, including three people being treated in intensive care units. All regions, except Carinthia, reported at least one case of measles in 2024. Most of the cases have been reported in Tyrol (69), Lower Austria (61), Vienna (44) and Styria (31).

In 2023, Austria reported 189 cases, including 49 hospitalisations, marking the beginning of a measles outbreak in Styria that has been the region most affected (n=106 in 2023). Cases have been reported in almost all regions, except for the region of Salzburg.

[Cyprus](#) is experiencing an outbreak of measles since the end of February 2024, with nine confirmed cases in two adults and seven children – the first cases of measles reported in the last two years in Cyprus. Eight cases are unvaccinated or insufficiently vaccinated, and one individual with underlying conditions was fully vaccinated. One unvaccinated adult had a travel history one week prior to the occurrence of symptoms. An outbreak investigation is ongoing. Public health authorities have identified contacts who are being monitored for symptoms; vaccination guidance have been provided to paediatricians and adult physicians. Awareness has been raised among laboratories and physicians to include measles in differential diagnostics. According to a [media](#) report on 6 March 2024, a second child has been confirmed with measles. Between 2019 and 2022, vaccination coverage with a measles-containing vaccine was around 86% for the first dose and in 2022 it was 75% for the second dose ([WHO](#)).

[Czechia](#) reported 11 cases in January - February 2024. One case of measles was reported in Czechia in [2023](#).

[Denmark](#) has reported five cases of measles so far in 2024 and as of 11 March 2024. Of the five cases, three were children below 15 years and two were adults aged 25 to 45 years. One of the five cases acquired the infection abroad. In 2023, Denmark reported nine cases.

[Finland](#) has reported one case of measles in 2024, as of 11 March 2024.

[France](#) reported at least 44 cases in 2024 and as of 14 March 2024 by the Auvergne-Rhône-Alpes Regional Health Agency. Outbreaks in 2024 have been reported in Rhône (34 cases) and Drôme (10 cases, another cluster of 11 cases is being monitored). The most recent update is provided for an ongoing outbreak in east [Lyon](#) with 25 cases, 22 of which are children; of 25 identified individuals, 13 are unvaccinated, including six children 12 months of age or younger. Seven people were hospitalised, five of which are children under one year of age; three individuals developed complications (pneumonitis).



[Germany](#) has reported 85 suspected and confirmed measles cases in 2024 for weeks 1 to 10 (data as of 11 March 2024). This represents an increase of 63 cases since 2024 week 5 (data available on 5 February 2024).

[Greece](#): has reported 19 cases in 2024, as of 7 March. According to the report from the national public health authority, quoted by the [media](#), the majority of the cases are adults aged 44–50 years, not immune to measles, including unvaccinated or insufficiently vaccinated health professionals, and the most affected areas are Attica and Crete.

[Hungary](#) has reported seven cases in 2024, as of 25 February, which is an increase of one case since the previous report.

[Ireland](#) has reported two confirmed cases (in week 6 and week 10) and seven possible cases of measles in 2024, as of week 10 (ending 13 March 2024), according to the Health Protection Surveillance Centre. According to a [media report](#), quoting health authorities, four cases of measles have been confirmed in Ireland following a contact tracing related to an infected passenger on a long flight.

[Lithuania](#) has reported ten cases of measles in 2024, as of 20 February, in Kaunas and Klaipėda regions. Of these, three were children (under 14 years) and seven were adults. Three people were unvaccinated and for four people vaccination status was unknown. In [2023](#), three cases were reported, all in unvaccinated children aged 5 to 14 years.

[Netherlands](#) reported 18 cases in 2024 and as of 12 March. An outbreak with 15 cases (14 children and one adult) has been reported by [media](#) on 14 March 2024 in Eindhoven in the province of North Brabant.

[Poland](#) reported 15 cases of measles from January to 29 February 2024, an increase of six cases since 31 January 2024.

[Portugal](#) has reported 14 confirmed cases of measles (of 94 suspected and investigated cases) in 2024 and as of 8 March 2024. Of the confirmed cases, four have been hospitalised and three more are under investigation. Between one and three confirmed cases have been reported per week, mainly among people aged 10 to 29-years, in the regions of Lisbon and Vale do Tejo, Norte and Madeira. Most of the cases are unvaccinated or have no evidence of vaccination.

[Romania](#) had reported 7 243 cases of measles, including eight deaths as of 5 March 2024, an increase of 3 038 cases and two deaths since the national update on 30 January 2024. Of the eight deaths, all were unvaccinated, six were children, four of whom were not eligible for vaccination; at least five of all the reported deaths had underlying conditions. The cases have been reported in 40 counties and the Municipality of Bucharest. Highest incidences are reported in Braşov (229.60 cases per 100 000 population) and Mureş counties (192.21 cases per 100 000 population). Children from 0 to 9 years of age account for 69.9% of all reported cases, including 1 021 children under one year of age (14.1%). The vast majority of the cases are unvaccinated individuals across all age groups (83.4%). Overall, 484 (6.7%) cases had received one dose, and two-dose vaccination was reported in 198 cases (2.7%). Vaccination status was unknown for 522 (7.2%) cases. The highest number of cases was reported in week 7, 2024 – with 500 cases that week.

The [Ministry of Health](#) of Romania declared a national measles epidemic on 5 December 2023 to facilitate vaccination of children from 9 to 11 months of age and individuals with incomplete vaccination. The Ministry of Health will carry out an information campaign for parents, working with family doctors, to achieve better adherence to the vaccination programme.

According to the [Ministry of Health](#), vaccination coverage for the first dose of MMR is 78% at national level, and 62% for the second dose. Vaccination coverage has been decreasing for the past ten years in Romania.

[Slovakia](#) reported six cases in 2023. No new cases have been detected in the country in 2024.

[Slovenia](#) has reported three cases of measles, all three in unvaccinated children, according to media report.

[Spain](#) reported 18 cases of measles from 1 January to 3 March 2024 (weekly bulletin No 10), representing an increase of 16 cases since 28 January 2024. Of the reported cases, six were imported, five related to imported cases and for two cases the importation status was unknown. In 2023, Spain reported 11 cases of measles.

[Sweden](#) has reported five cases in 2024, as of 11 March 2024. Of the reported cases, 63% are in children below 15 years of age. Sixty percent of the five cases acquired infection abroad, 20% were infected in Sweden and for 20% the importation status was unknown. In 2023, Sweden reported 11 cases of measles.

### **Relevant epidemiological summary for countries outside the EU/EEA:**

[Switzerland](#) has reported 54 cases since the beginning of the year and as of 4 March 2024, representing an increase of 52 cases since the previous report on 29 January 2024.

[Ukraine](#) reported nine cases in [January 2024](#), according to the national public health centre. In 2023, Ukraine reported 65 cases based on the most [recent report](#).

According to the WHO Regional Office for Europe ([WHO/EUROPE](#)) data for January–December\* 2023 (data access 12 March 2024) overall 58 115 cases were reported in the region. Of these 55 773 were in the following non-EU/EEA countries: Kazakhstan (15 111), Azerbaijan (13 735), Russia (12 723), Kyrgyzstan (7 044), Türkiye (4 559), Uzbekistan (1 107), Armenia (554), Tajikistan (294), United Kingdom (231), Belarus (188), Ukraine (65), Serbia (52), Switzerland (38)\*\*, Georgia (37), Israel (18), Bosnia and Herzegovina (10), Albania (3), Republic of Moldova (3), and North Macedonia (1).

\*data are incomplete

\*\*see the national report.

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

According to a report by the WHO Regional Office for Africa ([WHO AFRO](#)) as of 18 February 2024 (week 7, 12–18 February 2024), cases and outbreaks of measles in 2023 were reported in the following countries: Burundi, Burkina Faso, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo (DRC), Ethiopia, Kenya, Liberia, Malawi, Mali, Mauritania, Niger, Senegal, South Africa, South Sudan, Uganda (declared an outbreak at the beginning of 2024), and Zambia. As reporting periods vary by country, please check the latest available weekly bulletin.

According to WHO Pan American Health Organization ([WHO PAHO](#)) report in 1–8 week 2024 (ending 24 February 2024), 59 confirmed cases were reported by three countries: Argentina (3), Brazil (1), Canada (7), and [the United States of America](#) (45). On 29 January 2024, WHO PAHO published an Epidemiological Alert – Measles in the Region of the Americas.

In the WHO Regional Office for the Eastern Mediterranean (WHO EMRO) countries, overall 7 077 cases of measles have been reported in January–February 2024\*. Cases have been reported in Iraq (5 551), Afghanistan (3 380), United Arab Emirates (74), Iran (28), Syria (26), Bahrain(5), Qatar (4), Jordan (3), Kuwait (2), Lebanon (2), Oman (2), Djibouti (1).

\*data are incomplete. Source: WHO provisional monthly measles and rubella data.

In the WHO World Health Organization South-East Asia (WHO SEARO) countries, overall 5 004 cases of measles have been reported in January–February 2024\*. Cases have been reported in India (4 353), Indonesia (476), Nepal (91), Thailand (51), Timor-Leste (12), Bhutan (11), Myanmar (7), Sri Lanka (3).

\*data are incomplete. Source: WHO provisional monthly measles and rubella data.

According to a WHO Western Pacific Region ([WHO WPRO](#)) report for January-December 2023 ([Vol 18, Issue 1](#)), overall, 5 044 confirmed and clinically compatible cases (including 2 562 laboratory confirmed cases), and no deaths have been reported by: Australia (26), Hong Kong SAR (4), Japan (28), New Zealand (14), Republic of Korea (7), Singapore (11), Cambodia (11), China (585), Laos (2), Malaysia (1 799), Papua New Guinea (12), Philippines (2 442), and Vietnam (103).

## ECDC assessment

The overall number of measles cases in the EU/EEA has been steadily increasing since June 2023. **Measles cases are expected to continue increasing in the EU/EEA in the coming months** due to reported sub-optimal vaccination coverage for measles-containing vaccines (MCV) in a number of EU/EEA countries (<95% in a many of these countries), the high probability of importation from areas experiencing high circulation and the fact that the coming months represent the seasonal peak of the virus. In addition, the recent report of a majority of cases having acquired the disease within the reported country through community/local transmission, indicates a higher probability of being exposed to the virus within the EU/EEA than in previous months.

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

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

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

## **Actions**

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

**Last time this event was included in the Weekly CDTR:** 9 February 2024.

## 5. Cholera – Comoros – 2024 - Weekly monitoring

### Overview

#### Update

Since the last available update [provided by media](#) on 4 March and as of 13 March\*, 87 new cholera cases and six new deaths [have been reported](#) in Comoros.

Since the outbreak was declared on 2 February, a total of 227 cases and 12 deaths have been reported in Grande Comore, Moheli, and Anjouan. A total of 189 cases have recovered and 26 patients remain at treatment sites.

At Moheli, Comoros health authorities continue to conduct general awareness activities in public settings ([Ouallah II and Ndrondroni](#)) where cholera cases have recently been detected. [Households have been decontaminated](#) on the island of Anjouan.

*\*Note that the report from different sources is irregular and data on date of onset of symptoms is not available.*

#### Summary

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

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

#### Background

There is frequent undocumented population movement between the Comoros archipelago and the French territory of Mayotte. No cholera cases have been recorded in Mayotte since 2000. The Regional Health Agency of Mayotte closely monitors the situation and has set up a response plan to prevent and contain the importation of cholera.

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

#### ECDC assessment

Due to the frequent migration, and possibly undocumented movement of people between the Comoros archipelago and the French territory of Mayotte, ECDC assess the likelihood of cholera being introduced in Mayotte as moderate. In this context, given the reported use of water from at-risk sources (rivers, wells) on the island, the risk of cholera for the Mayotte population is assessed as moderate.

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

#### Actions

ECDC is monitoring the situation through epidemic intelligence activities.

**Last time this event was included in the Weekly CDTR: 8 March 2024.**