

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 9, 25 February – 2 March 2024

This week's topics

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

Executive Summary

Overview of respiratory virus epidemiology in the EU/EEA

- Syndromic surveillance in primary and secondary care indicate that **respiratory activity remains elevated and above baseline levels**, driven largely by influenza. However, stable or decreasing trends in consultation rates are observed at the country level.
- **All indicators pointed to high influenza activity in the EU/EEA**, which seems to have been decreasing slightly over the past three weeks.
- At the EU/EEA level, a decreasing trend in pooled primary care positivity for influenza has been observed over the past three weeks, with a mixture of stable and decreasing trends observed at the country level.
- Most reporting countries continue to be above the 10% sentinel primary care positivity threshold for influenza. Notably, three countries have dropped below the 10% sentinel primary care positivity threshold.
- At the EU/EEA level, SARI positivity for influenza remains high, with a decreasing trend observed in the majority of countries reporting this indicator.
- The majority of reporting countries continue to report medium or high levels of influenza intensity, widespread geographical spread, and above-baseline rates of influenza-like illness.
- A(H1)pdm09 continues to be dominant in most countries, although a small increase in influenza type B detections was observed in the past week.
- 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 was decreasing overall at the EU/EEA level**, although the country-level picture remains mixed.
- **SARS-CoV-2 activity was low in EU/EEA countries.**

SARS-CoV-2 variant classification

Since the last update on 16 February 2024, and as of 1 March 2024, **no changes** have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs) and de-escalated variants.

The variant landscape in the EU/EEA is clearly dominated by **BA.2.86**. As of 26 February 2024, the median proportion for BA.2.86 in the EU/EEA for week 6 (5 February 2024 to 11 February 2024) is 90.4% (range: 72.4–95.1%).

BA.2.87.1 lineage was classified as a VUM on 2 February 2024. Currently, 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 1 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 proportions 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.

XBB.1.5-like+F456L lineages are circulating with a median proportion of 1.9% in EU/EEA countries (range: 0–9.3%). The overall proportion of XBB.1.5-like+F456L variants is declining in the EU/EEA.

XBB.1.5-like+L455F+F456L variants show a declining trend in the EU/EEA, with a median proportion of 1.9% (range: 0–9.3%).

Other **XBB.1.5-like** lineages are circulating in very low proportions and are declining in the EU/EEA, with a median proportion of 0% (range: 0–6.9%).

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

- According to Hong Kong's authorities, the new A(H9) case reported last week in a child under five years old has a confirmed subtype of avian influenza A(H9N2).
- The household contact who had symptoms of respiratory disease tested negative for influenza A.
- Since 1998, 131 human cases of A(H9N2) have been confirmed globally, including two deaths.
- Most of the cases reported to date have been in China (119 cases). No human cases have been reported in the EU/EEA.

Cholera – Comoros – 2024

- On 2 February 2024, Comoros declared an outbreak of cholera.
- Since the declaration of the outbreak, and as of 24 February 2024, 117 confirmed cholera cases and six deaths have been reported by the Comorian Ministry of Health.
- Due to the frequent movement of population between the Comoros archipelago and the French territory of Mayotte there is a low to moderate possibility of introduction of cholera in Mayotte. In this context, the risk of cholera infection for EU/EEA population living in Mayotte is still assessed as low.

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

- In January 2024, 39 346 new cholera cases, including 698 new deaths, have been reported worldwide.
- New cases have been reported from Afghanistan, Burundi, Cameroon, Comoros, the Democratic Republic of the Congo, Ethiopia, Haiti, Kenya, Malawi, Mozambique, Pakistan, Somalia, South Africa, Uganda, the United Republic of Tanzania, Zambia, and Zimbabwe.
- In recent months, cholera cases have continued to be reported in western, eastern and southern Africa, some parts of the Middle East, Asia, and the Americas. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA remains possible.

1. Overview of respiratory virus epidemiology in the EU/EEA

Overview:

Respiratory virus activity

- Consultation rates of patients presenting to general practitioners with respiratory illness (ILI and/or ARI) were reported by 23 EU/EEA countries in week 8, with rates showing a decreasing trend in several countries. MEM thresholds were available for 20 countries (nine for ARI, 19 for ILI), with 13 reporting consultation rates above baseline levels in at least one indicator. ARI rates were low in two countries and medium in two; none reported high or very high. ILI rates were low in six countries and medium in six; none reported high or very high. 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 28% (pooled country data: 24%; interquartile range (IQR) of country values: 23–33%), with a mixture of stable and decreasing trends observed at the country level. Of 18 countries reporting at least 10 tests, 15 observed seasonal influenza activity above the 10% positivity threshold in sentinel primary care. Of 24 countries reporting qualitative assessments of seasonal influenza activity, all but one reported levels above baseline, including 15 with medium and two with high activity. Eighteen of 24 countries reported widespread geographical spread of seasonal influenza. Influenza detections from non-sentinel sources mirrored the trend observed in sentinel reporting.
- Among the 685 sentinel primary care detections of seasonal influenza, 588 (86%) were typed as influenza virus type A and 97 (14%) were typed as influenza virus type B, with B detections increasing by 7% compared to last week. Of the influenza type A detections that were further successfully subtyped, 347 (85%) were A(H1)pdm09 and 63 (15%) were A(H3). The remaining 178 influenza type A detections were of unknown subtype. Forty-seven of the influenza type B detections were further defined as B/Victoria lineage, while the remaining 50 were of unknown lineage. The influenza type B detections were predominantly reported by five countries, although detections at the EU/EEA level remained low compared to influenza A detections.
- The median sentinel primary care positivity for SARS-CoV-2 was 0% (pooled: 3%; IQR: 0–2%). This indicator has been decreasing since week 49, 2023. Both primary care sentinel and non-sentinel data at the country level show decreasing or stable trends in all countries reporting data to week 8.
- The median sentinel primary care RSV positivity was 5% (pooled: 5%; IQR: 2–8%). Country-level variation was present, with seven countries continuing to report elevated sentinel positivity and/or increasing or elevated counts of non-sentinel detections.

Severe disease

- Rates of severe acute respiratory infection (SARI) from sentinel secondary sites were comparable to the same time last year in all seven countries reporting data up to week 8. Five of seven countries reported testing data for all three pathogens.
- The median SARI test positivity for seasonal influenza was 18% (pooled: 18%; IQR: 2–24%), with a decrease observed in most countries reporting this indicator. The pooled test positivity for seasonal influenza was decreasing, but remained elevated across all age groups.
- The median SARI test positivity for RSV decreased to 8% (pooled: 9%; IQR: 1–14%). The highest pooled test positivity was observed in children aged 0–4 years and has been decreasing since week 52, 2023.
- The median SARI test positivity for SARS-CoV-2 was 4% (pooled: 3%; IQR: 2–6%). Overall, rates for non-sentinel hospital admissions, ICU admissions and deaths have gradually decreased since week 50, with decreasing or stable trends observed in all reporting countries.
- [EuroMOMO](#) pooled estimates of weekly excess all-cause mortality showed a 'substantial elevated level of mortality, overall and in the age groups of 45 years and above'. However, over the latest weeks mortality has been declining.

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 8, 2024, 1 718 A(H1)pdm09, 630 A(H3) and 76 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the A(H1)pdm09 viruses that have been assigned to a clade, 1008 were reported as clade 5a.2a and 703 were subclade 5a.2a.1. Of the A(H3) viruses that have

been assigned to a clade, 10 were reported as clade 2a.3a, 587 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 6–7 (5 February to 18 February 2024)

- The estimated distribution (median and IQR of proportions from eight countries) of variants of concern (VOCs) or variants of interest (VOIs) was 90% (87–93%) for BA.2.86 (which includes JN.1 isolates), 4% (1–7%) for XBB.1.5+F456L and 1% (0–3%) for XBB.1.5-like. The proportion of BA.2.86 continues to grow, with XBB.1.5-like+F456L and XBB.1.5 showing decreasing trends.

Period overview (week 25, 2023 to week 8, 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 impacted individuals aged 65 years and above. Week 50 marked the start of the seasonal influenza epidemic. As of week 8, activity remains high, although a decreasing trend was observed starting from 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 and A(H3) dominant or co-dominant in a few 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 the 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 week 8, 2024, although influenza activity has been decreasing over the past three weeks. Notably, primary care sentinel detections of influenza type B increased by 7% between week 7 and week 8. While influenza type B transmission may increase in the coming weeks, detections remain low compared to influenza A and antigenic characterisation data indicate current northern hemisphere vaccine components are well matched to circulating influenza B virus subclades. It remains essential to closely monitor the impact of influenza and other respiratory viruses on hospital and ICU admissions. The combined effect of co-circulating acute respiratory pathogens is likely to convey an increased burden of severe respiratory disease in the EU/EEA, which may result in further significant pressure on healthcare systems in the coming weeks.

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: 23 February 2024

2. SARS-CoV-2 variant classification

Overview:

Weekly update on SARS-CoV-2 variants:

Since the last update on 16 February 2024, and as of 1 March 2024, **no changes** have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs) and de-escalated variants.

The variant landscape in the EU/EEA is clearly dominated by **BA.2.86**, which was classified as a VOI on 24 November 2023. As of 26 February 2024, the median proportion for BA.2.86 in the EU/EEA for week 6 (15 February 2024 to 11 February 2024) is 90.4% (range: 72.4–95.1%). Among the six EU/EEA countries reporting at least 20 sequences to GISAID EpiCoV for week 6, the proportions of BA.2.86 lineages were as follows: Finland (72.4%), France (84.9%), Ireland (95.1%), Italy (90.7%), Spain (91.8%), Sweden (90.2%)

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. Currently, 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 1 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 proportions 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 26 February 2024, and for week 5 2024, **XBB.1.5-like+F456L** lineages are circulating with a median proportion of 1.9% in EU/EEA countries (range: 0–9.3%). The overall proportion of XBB.1.5-like+F456L variants is declining in the EU/EEA.

XBB.1.5-like+L455F+F456L variants show a declining trend in the EU/EEA, with a median proportion of 1.9% (range: 0–9.3%).

Other **XBB.1.5-like** lineages are circulating in very low proportions and are declining in the EU/EEA, with a median proportion of 0% (range: 0–6.9%).

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: 23 February 2024

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

Overview:

Update: On 23 February 2024, [Hong Kong authorities](#) reported that the new A(H9) case reported last week in a child under five years old has a confirmed subtype of avian influenza A(H9N2). Her symptoms subsided, although she still remains in the isolation in a hospital. One of the close contacts who had symptoms of respiratory disease tested negative for influenza A.

In addition, according to the report, the relevant avian influenza virus showed no re-assortment with genes of human influenza origin and the virus is sensitive to antiviral medicine Tamiflu.

Background: On 21 February 2024, one new human infection with avian influenza A(H9) (neuraminidase subtype unknown) was reported by the Government of the Hong Kong Special Administrative Region. A child under five years old developed symptoms (fever and cough with sputum) on 15 February 2024 and was brought to hospital for consultation the next day (not hospitalised at the time). After testing positive for avian influenza A(H9) on 21 February, the child was admitted to an isolation ward and in stable condition. The patient recently visited Zhongshan (Guangdong province, China) and had no history of recent direct contact with poultry, consumption of undercooked poultry meat, or contact with patients. One of the contacts developed a sore throat on 17 February, which was successfully treated with medications. Other household contacts are asymptomatic so far. Investigations are ongoing.

In 2024, two cases of avian influenza A(H9N2) were reported previously (in January) with onset of symptoms in December 2023 in Sichuan province, China.

Summary: As of 26 February 2024, and since 1998, a total of 131 laboratory-confirmed cases of human infection with avian influenza A(H9N2) viruses, including two deaths, have been reported in eight countries: China (118), 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, 23 February 2024](#), [Press release of the Government of the Hong Kong Special Administrative Region, 21 February 2024](#), [Press release of the Government of the Hong Kong Special Administrative Region, 23 December 2023](#)

ECDC assessment:

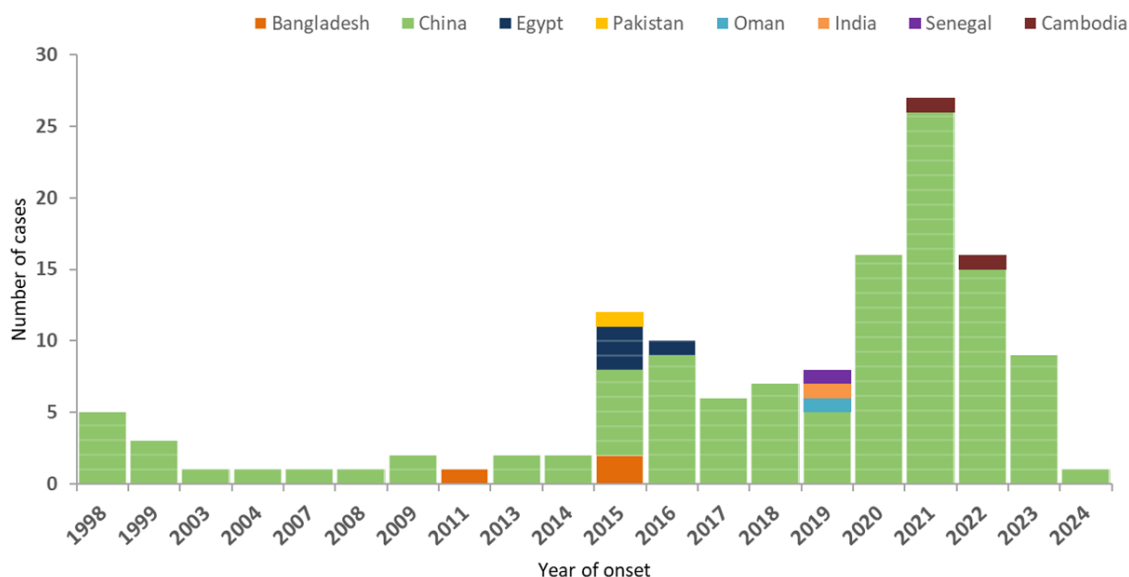
Sporadic human cases of avian influenza A (H9N2) have been observed outside the EU/EEA, mainly in young children. The source of infection of the current case is unknown. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses. 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: 23 February 2024

Figure 1. Distribution of confirmed human cases of avian influenza A(H9N2) virus infection by year of onset and country, 1998 - 2024 (updated on 26 February 2024, n=131)



Source: ECDC

4. Cholera – Comoros – 2024

Overview:

Summary

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

Background

Cholera is a bacterial disease caused by the bacterium *Vibrio cholerae*. The main risk factors are associated with poor water and 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.

On 31 January 2024, a boat from Tanzania carrying 25 persons arrived in Moroni, the capital of the Comoros archipelago. One person on board died of suspected cholera and several people were symptomatic. The first locally transmitted cases in Comoros were reported on 5 February. Since the declaration of the outbreak, and as of 24 February 2024, the Comorian Ministry of Health has reported 117 confirmed cholera cases and six deaths.

Sources: [Comoros Ministry of Health reports \(requires Facebook account\)](#) ; [Comoros Cholera Response DREF Operation](#) ; [Response plan to the risk of cholera introduction in Mayotte](#)

ECDC assessment:

Due to the frequent movement of population between the Comoros archipelago and the French territory of Mayotte, there is a low to moderate possibility of introduction of cholera in Mayotte. In this context, risk of cholera infection for EU/EEA population living in Mayotte is still assessed as low. Sporadic cases cannot be ruled out.

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

Actions:

ECDC is monitoring the cholera situation through its epidemic intelligence activities.

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

5. Cholera – Multi-country (World) – Monitoring global outbreaks

Overview:

Data presented in this report originate from several sources, both official public health authorities and non-official sources, such as the media. Case definitions, testing strategies, and surveillance systems vary between countries. In addition, data completeness and levels of under-reporting vary between countries. All data should therefore be interpreted with caution. Refer to the original sources for more information regarding the case definitions in use and for details on the epidemiological situation.

Summary

As of 24 February, 39 346 new cholera cases, including 698 new deaths, had been reported worldwide in January 2024. The five countries reporting most cases are Zambia (13 015), Afghanistan (8 402), Zimbabwe (7 219), Mozambique (2 563), and Pakistan (2 405). In addition, 57 575 new cases were reported or collected retrospectively from before 31 December 2023.

New cases have been reported from Afghanistan, Burundi, Cameroon, Comoros, Democratic Republic of the Congo, Ethiopia, Haiti, Kenya, Malawi, Mozambique, Pakistan, Somalia, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

Since 1 January 2024, and as of 24 February 2024, 39 346 cholera cases, including 698 deaths, have been reported worldwide. In comparison, since 1 January 2023, and as of 24 February 2023, 124 627 cholera cases, including 1 151 deaths, were reported worldwide.

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

Asia:

Afghanistan: Since 1 January 2024, and as of 27 January 2024, 8 402 cases, including eight deaths, have been reported. In comparison, in 2023 and as of 18 February 2023, 16 489 cases, including six deaths were reported.

Pakistan: Since 20 August 2023, and as of 30 January 2024, 2 405 new cases have been reported. Since 1 January 2024, and as of 30 January 2024, 2 405 cases have been reported. In comparison, in 2023, and as of 24 February 2023, no cases were reported.

Africa:

Burundi: Since 9 December 2023, and as of 31 January 2024, 33 new cases have been reported. Since 1 January 2024, and as of 31 January 2024, 33 cases have been reported. In comparison, in 2023 and as of 1 February 2023, 118 cases, including one death, were reported.

Cameroon: Since 1 January 2024, and as of 31 January 2024, 138 cases, including 27 deaths, have been reported. In comparison, in 2023, and as of 26 January 2023, 56 cases, including one death, were reported.

Comoros: Since 1 January 2024, and as of 31 January 2024, six cases, including one death, have been reported. In comparison, in 2023, and as of 24 February 2023, no cases were reported.

Democratic Republic of the Congo: Since 1 January 2024, and as of 29 January 2024, 783 cases, including 13 deaths, have been reported. In comparison, in 2023, and as of 19 February 2023, 3 677 cases, including 18 deaths, were reported.

Ethiopia: Since 01 January 2024, and as of 31 January 2024, 779 cases, including 12 deaths, have been reported. In comparison, in 2023, and as of 2 February 2023, 258 cases, including one death, were reported.

Kenya: Since 19 December 2023, and as of 31 January 2024, 128 new cases have been reported. Since 1 January 2024, and as of 31 January 2024, 128 cases have been reported. In comparison, in 2023, and as of 12 February 2023, 1 886 cases, including 30 deaths, were reported.

Malawi: Since 01 January 2024, and as of 31 January 2024, 11 cases have been reported. In comparison, in 2023, and as of 24 February 2023, 30 544 cases, including 937 deaths, were reported.

Mozambique: Since 1 January 2024, and as of 31 January 2024, 2 563 cases, including six deaths, have been reported. In comparison, in 2023, and as of 19 February 2023, 4 876 cases, including 33 deaths, were reported.

Somalia: Since 1 January 2024, and as of 31 January 2024, 1 406 cases, including 18 deaths have been reported. In comparison, in 2023 and as of 12 February 2023, 1 307 cases, including one death, were reported.

South Africa: Since 30 July 2023, and as of 20 January 2024, 2 new cases have been reported. Since 01 January 2024 and as of 20 January 2024, 2 cases have been reported. In comparison, in 2023 and as of 23 February 2023, three cases, including one death, were reported.

Uganda: Since 27 August 2023, and as of 29 January 2024, 13 new cases have been reported. Since 01 January 2024 and as of 29 January 2024, 13 cases have been reported. In comparison, in 2023, and as of 24 February 2023, no cases were reported.

United Republic of Tanzania: Since 26 November 2023, and as of 20 January 2024, 164 new cases, including 1 new death has been reported. Since 1 January 2024 and as of 20 January 2024, 164 cases, including one death, has been reported. In comparison, in 2023 and as of 23 February 2023, 29 cases, including three deaths, were reported.

Zambia: Since 1 January 2024, and as of 31 January 2024, 13 015 cases, including 488 deaths have been reported. In comparison, in 2023, and as of 13 February 2023, 122 cases, including two deaths, were reported.

Zimbabwe: Since 1 January 2024, and as of 31 January 2024, 7 219 cases, including 124 deaths, have been reported. In comparison, in 2023, and as of 21 February 2023, 25 cases were reported.

America:

Haiti: Since 1 January 2024, and as of 31 January 2024, 2 279 cases have been reported. In comparison, in 2023, and as of 12 February 2023, 10 439 cases, including 136 deaths, were reported.

ECDC assessment:

Cholera cases have continued to be reported on the African continent and in Asia in recent months. Cholera outbreaks have also been reported in parts of the Middle East and in the Americas. Despite the number of cholera outbreaks reported worldwide, few cases are reported each year among travellers returning to the EU/EEA.

In this context, the risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA remains possible.

In 2022, 29 cases were [reported by nine EU/EEA countries](#), while two were reported in 2021 and none in 2020. In 2019, 25 cases were reported in EU/EEA countries. All cases had a travel history to cholera-affected areas.

According to the World Health Organization (WHO), vaccination should be considered for travellers at higher risk, such as emergency and relief workers who are likely to be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek advice from travel health clinics to assess their personal risk and apply precautionary sanitary and hygiene measures to prevent infection. Such measures can include drinking bottled water or water treated with chlorine, carefully washing fruit and vegetables with bottled or chlorinated water before consumption, regularly washing hands with soap, eating thoroughly cooked food, and avoiding consumption of raw seafood products.

Actions:

ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities. Reports are published on a monthly basis. The worldwide overview of cholera outbreaks is available on [ECDC's website](#).

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

Figure 2. Geographical distribution of cholera cases reported worldwide from February 2023 to January 2024

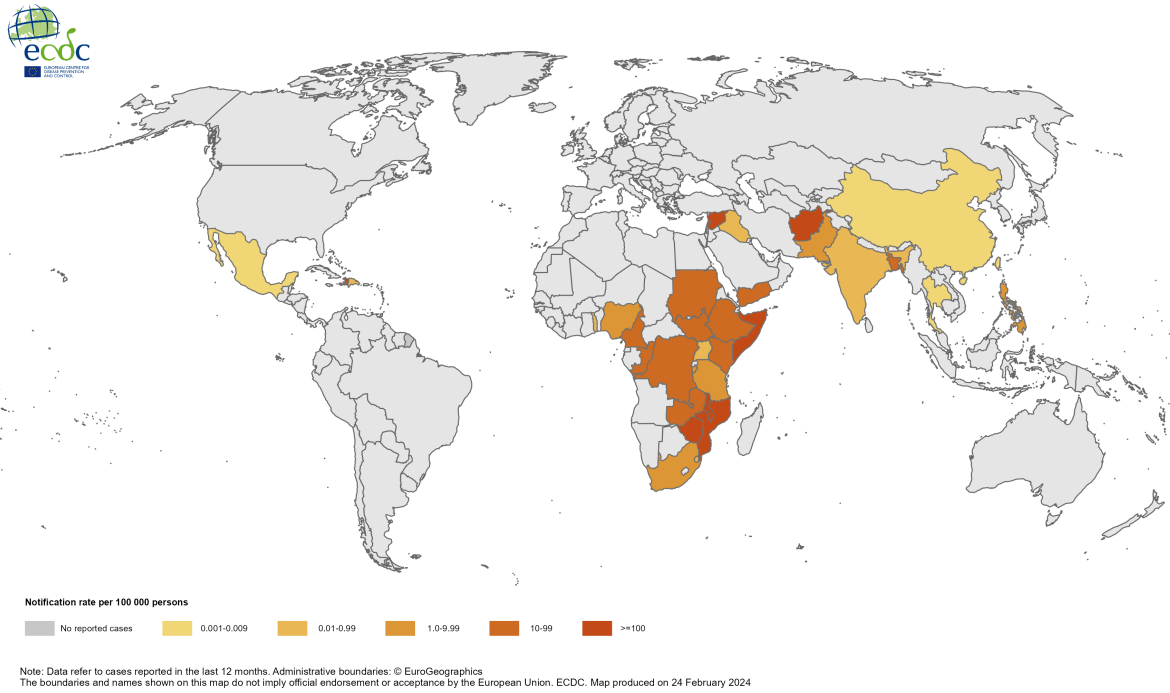


Figure 3. Geographical distribution of cholera cases reported worldwide from November 2023 to January 2024

