



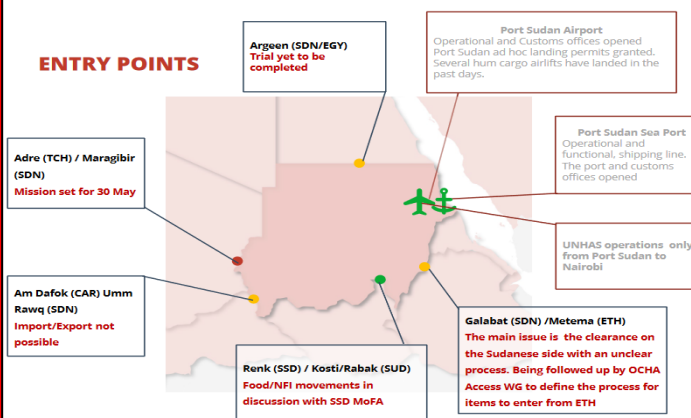
News:

- On 5 May 2023 the [WHO Director-General concurs with the advice offered by the IHR Committee](#) regarding the ongoing COVID-19 pandemic. He determines that COVID-19 is now an established and ongoing health issue which no longer constitutes a public health emergency of international concern (PHEIC).
- WHO: 76th World Health Assembly adopts first ever [resolution on drowning prevention](#). The resolution was sponsored by the Governments of Bangladesh and Ireland and adopted by Member States to address this public health concern.
- WHO: issues urgent call for [global climate action to create resilient and sustainable health systems](#).
- WHO: launched a [global network to help protect people from infectious disease threats](#) through the power of pathogen genomics. The International Pathogen Surveillance Network (IPSN) will provide a platform to connect countries and regions, improving systems for collecting and analyzing samples, using these data to drive public health decision-making, and sharing that information more broadly.
- WHO Technical Advisory Group on COVID-19 Vaccine Composition (TAG-CO-VAC): launched a [statement on the antigen composition of COVID-19 vaccines](#). As previously stated by the TAG-CO-VAC, the objective of an update to COVID-19 vaccine antigen composition is to enhance vaccine-induced immune responses to circulating SARS-CoV-2 variants. This statement and the recommendation for change is intended for all vaccine manufacturers and is intended to inform future formulations of COVID-19 vaccines.
- IHR Emergency Committee on Polio: The [committee agreed that the risk of international spread of poliovirus](#) still remains a Public Health Emergency of International Concern (PHEIC) and recommended the extension of Temporary Recommendations for a further three months.
- IHR Emergency Committee on mpox: The [Committee noted a significant decline in the number](#) of reported cases compared to the previous reporting period and no changes in the severity and clinical manifestation of the disease. The Committee acknowledged remaining uncertainties about the disease, regarding modes of transmission in some countries, poor quality of some reported data, and continued lack of effective countermeasures in the African countries, where mpox occurs regularly.
- ECDC: To decrease the impact of COVID-19, and related hospitalisations and mortality, countries should plan for a continued roll-out of COVID vaccines in 2023. Efforts should focus on protecting older adults and other vulnerable groups, such as those with underlying comorbidities and the immunocompromised, irrespective of age. These considerations are part of [ECDC's latest report on interim public health considerations for COVID-19 vaccination roll-out during 2023](#).

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Logistics Cluster Sudan Snapshot, #4. 29 May 2023

If you have any logistical information you would like to share with partners, please send an email to sdn.response.logcoordination@wfp.org



KEY UPDATES

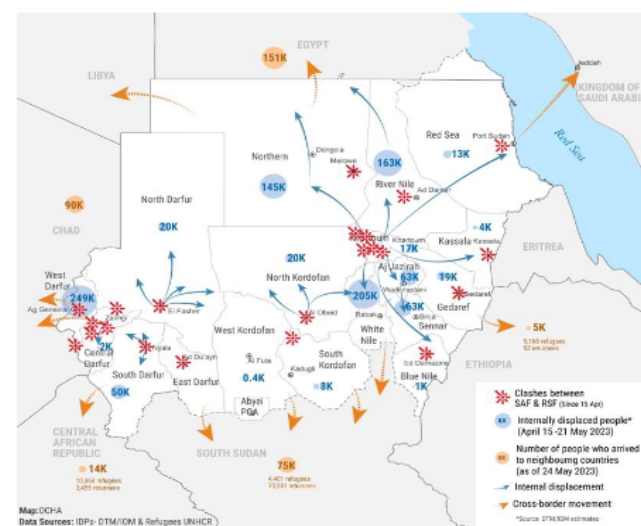
- Chad mission to border set for 30 May
- Customs entry on the Sudan side from Ethiopia (Metema) proving difficult. OCHA Access WG in Sudan has been informed to support a clearance process.
- 2 x Storage units in Port Sudan have been contracted. To access Logistics Cluster storage (and other services), Service Request Forms (SRF) are required. [SOPs](#), [SRF online](#), [SRF-Excel](#)
- The Logistics Cluster is expecting shortly the arrival of four or five 40' refers (2 to 8 °C) in Port Sudan from Maersk. The Logistics Cluster will temporarily manage access to these units for health partners with the eventual aim of handing these over.

Information represented in this document is based on the most accurate data currently available from the Field Logistics Cluster staff supporting the emergency response operation. It may be revised or updated as new, or more complete data becomes available.

WEBSITE https://logcluster.org/ops/sdn20a	CONTACTS Fiona Lithgow Ali Awan	Regional Logistics Coordinator (Nairobi) Sudan Logistics Cluster Coordinator Sudan Logistics Response	fiona.lithgow@wfp.org ali.awan@wfp.org Sdn.response.logcoordination@wfp.org
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HIGHLIGHTS

- The conflict in Sudan has entered its seventh week, with fighting between the Sudanese Armed Forces (SAF) and the Rapid Support Forces (RSF) continuing in multiple locations, despite the ceasefire which went into effect on 22 May.
- Nearly 1.4 million people have been forced to flee their homes since the conflict started on 15 April 2023 and are now displaced inside and outside the country.
- Reports of gender-based violence, including sexual violence, are increasing.
- Humanitarian partners have worked intensively to move relief supplies to the locations where they are most needed but have faced insecurity and transportation challenges.
- Additional funding is urgently needed to respond to the rising needs and increased cost of operating.



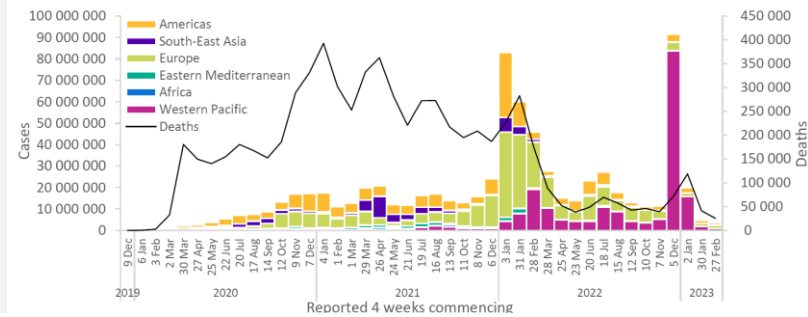
COVID-19 Situation by WHO Region, as of 25 May

Global epidemiological situation overview; WHO as of 25 May 2023

Globally, nearly 2.3 million new cases and nearly 15 000 deaths were reported in the last 28 days (24 April to 21 May 2023), a decrease of 21% and 17%, respectively, compared to the previous 28 days (27 March to 23 April 2023) (Figure 1, Table 1). The situation is mixed at the regional level, with increases in reported cases seen in the WHO African and Western Pacific Regions and increases in deaths in the African, the Americas, South-East Asia, and Western Pacific Regions. As of 21 May 2023, over 766 million confirmed cases and over 6.9 million deaths have been reported globally.

At the country level, the highest numbers of new 28-day cases were reported from the Republic of Korea (462 726 new cases; +52%), the United States of America (256 909 new cases; -47%), Japan (164 367 new cases; -24%), Brazil (146 105 new cases; -28%), and Australia (125 992 new cases; +49%). The highest numbers of new 28-day deaths were reported from the United States of America (4135 new deaths; -31%), Brazil (1206 new deaths; -7%), France (810 new deaths; -1%), Spain (745 new deaths; +92%), and the Russian Federation (663 new deaths; -33%).

Figure 1. COVID-19 cases reported by WHO Region, and global deaths by 28-day intervals, as of 26 March 2023**



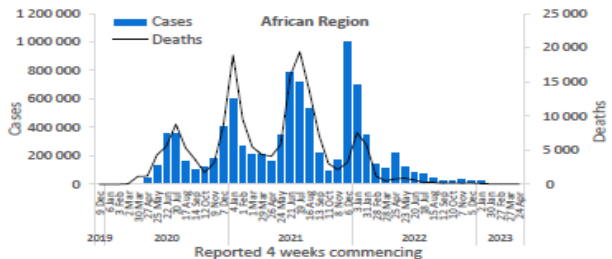
WHO regional overviews

Data for 24 April to 21 May 2023

African Region

The African Region reported 6835 new cases, an 11% increase as compared to the previous 28-day period. Six (12%) of the 50 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Cabo Verde (467 vs 96 new cases; +386%), the Democratic Republic of the Congo (583 vs 174 new cases; +235%), and Uganda (173 vs 92 new cases; +88%). The highest numbers of new cases were reported from Mauritius (4457 new cases; 350.5 new cases per 100 000; +77%), the Democratic Republic of the Congo (583 new cases; <1 new case per 100 000; +235%), and Cabo Verde (467 new cases; 84 new cases per 100 000; +386%).

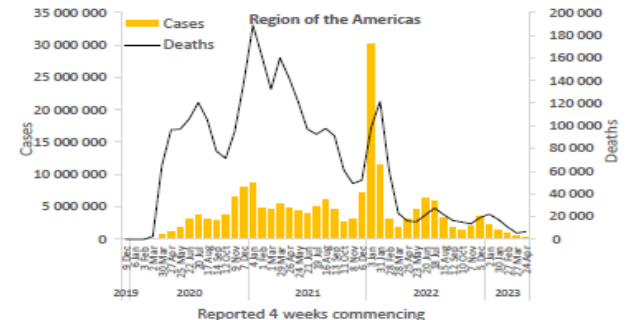
The number of new 28-day deaths in the Region increased by 6% as compared to the previous 28-day period, with 19 new deaths reported. The highest numbers of new deaths were reported from Mauritius (six new deaths; <1 new death per 100 000; no deaths reported the previous 28-day period), Zimbabwe (five new deaths; <1 new death per 100 000; -17%), and the Democratic Republic of the Congo (three new deaths; <1 new death per 100 000; no deaths reported the previous 28-day period).



Region of the Americas

The Region of the Americas reported over 484 000 new cases, a 41% decrease as compared to the previous 28-day period. Twelve (21%) of the 56 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Aruba (66 vs 15 new cases; +340%), Guyana (74 vs 19 new cases; +289%), and Curaçao (14 vs five new cases; +180%). The highest numbers of new cases were reported from the United States of America (256 909 new cases; 77.6 new cases per 100 000; -47%), Brazil (146 105 new cases; 68.7 new cases per 100 000; -28%), and Mexico (30 764 new cases; 23.9 new cases per 100 000; -27%).

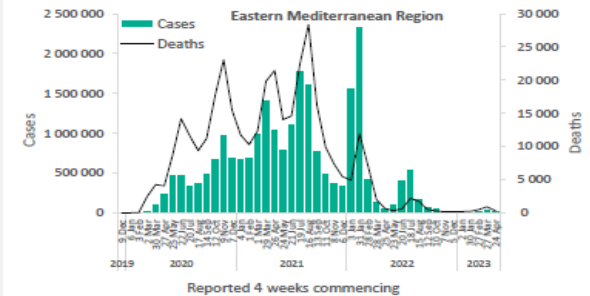
The number of new 28-day deaths in the Region increased by 21% as compared to the previous 28-day period, with 6655 new deaths reported. The highest numbers of new deaths were reported from the United States of America (4135 new deaths; 1.2 new deaths per 100 000; -31%), Brazil (1206 new deaths; <1 new death per 100 000; -7%), and Peru (488 new deaths; 1.5 new deaths per 100 000; +34%).



Eastern Mediterranean Region

The Eastern Mediterranean Region reported over 26 000 new cases, a 48% decrease as compared to the previous 28-day period. Two (9%) of the 22 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Morocco (1050 vs 508 new cases; +107%), and Afghanistan (5904 vs 3 990 new cases; +48%). The highest numbers of new cases were reported from Afghanistan (5904 new cases; 15.2 new cases per 100 000; +48%), Qatar (5609 new cases; 194.7 new cases per 100 000; -33%), and the United Arab Emirates (4984 new cases; 50.4 new cases per 100 000; -4%).

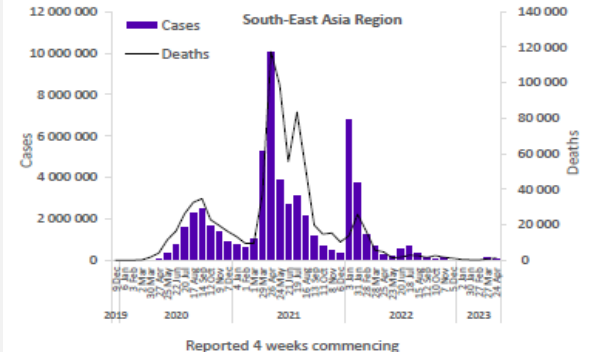
The number of new 28-day deaths in the Region decreased by 63% as compared to the previous 28-day period, with 330 new deaths reported. The highest numbers of new deaths were reported from the Islamic Republic of Iran (244 new deaths; <1 new death per 100 000; -69%), Tunisia (34 new deaths; <1 new death per 100 000; +48%), and Afghanistan (26 new deaths; <1 new death per 100 000; +420%).



South-East Asia Region

The South-East Asia Region reported over 146 000 new cases, a 31% decrease as compared to the previous 28-day period. Six (55%) of the 10 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Myanmar (3685 vs 276 new cases; +1235%), Thailand (8498 vs 1858 new cases; +357%), and Timor-Leste (16 vs four new cases; +300%). The highest numbers of new cases were reported from India (94 472 new cases; 6.8 new cases per 100 000; -50%), Indonesia (38 150 new cases; 13.9 new cases per 100 000; +92%), and Thailand (8498 new cases; 12.2 new cases per 100 000; +357%).

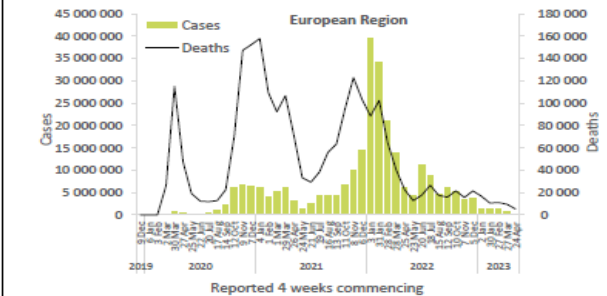
The number of new 28-day deaths in the Region increased by 61% as compared to the previous 28-day period, with 1143 new deaths reported. The highest numbers of new deaths were reported from India (503 new deaths; <1 new death per 100 000; +1%), Indonesia (497 new deaths; <1 new death per 100 000; +172%), and Thailand (106 new deaths; <1 new death per 100 000; +783%).



European Region

The European Region reported nearly 573 000 new cases, a 45% decrease as compared to the previous 28-day period. Three (5%) of the 61 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Andorra (70 vs 28 new cases; +150%), Liechtenstein (six vs four new cases; +50%), and Spain (43 197 vs 34 472 new cases; +25%). The highest numbers of new cases were reported from France (122 239 new cases; 187.9 new cases per 100 000; -43%), the Russian Federation (90 491 new cases; 62.0 new cases per 100 000; -60%), and Italy (70 136 new cases; 117.6 new cases per 100 000; -24%).

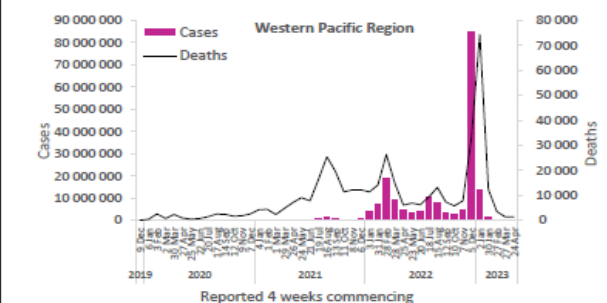
The number of new 28-day deaths in the Region decreased by 44% as compared to the previous 28-day period, with 5373 new deaths reported. The highest numbers of new deaths were reported from France (810 new deaths; 1.2 new deaths per 100 000; -1%), Spain (745 new deaths; 1.6 new deaths per 100 000; +92%), and the Russian Federation (663 new deaths; <1 new death per 100 000; -33%).



Western Pacific Region

The Western Pacific Region reported over one million new cases, a 38% increase as compared to the previous 28-day period. Fourteen (40%) of the 35 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Mongolia (685 vs 56 new cases; +1123%), Papua New Guinea (26 vs three new cases; +767%), and Brunei Darussalam (16 909 vs 3465 new cases; +388%). The highest numbers of new cases were reported from the Republic of Korea (462 726 new cases; 902.5 new cases per 100 000; +52%), Japan (164 367 new cases; 130.0 new cases per 100 000; -24%), and Australia (125 992 new cases; 494.1 new cases per 100 000; +49%).

The number of new 28-day deaths in the Region increased by 9% as compared to the previous 28-day period, with 1465 new deaths reported. The highest numbers of new deaths were reported from Australia (417 new deaths; 1.6 new deaths per 100 000; +30%), Japan (338 new deaths; <1 new death per 100 000; -44%), and the Republic of Korea (262 new deaths; <1 new death per 100 000; +38%).



Marburg virus disease - Equatorial Guinea and the United Republic of Tanzania

Source: [WHO](#)

Situation at a glance

Equatorial Guinea and the United Republic of Tanzania have been responding to separate outbreaks of Marburg virus disease (MVD) since early February and late March 2023, respectively.

In [Equatorial Guinea](#), from 13 February to 1 May 2023, 17 laboratory-confirmed MVD cases and 23 probable cases have been reported. The last confirmed case was reported on 20 April. Among the laboratory-confirmed cases, there are 12 deaths (Case Fatality Ratio (CFR) 75%). For one confirmed case, the outcome is unknown. Among the confirmed cases, four have recovered. All of the probable cases are dead. The most affected district is Bata in Litoral province, with 11 laboratory-confirmed MVD cases reported.

In the [United Republic of Tanzania](#), between 16 March to 30 April 2023, a cumulative total of nine cases including eight laboratory-confirmed cases and one probable case have been reported. The last confirmed case was reported on 11 April 2023. A total of six deaths (CFR 66.7%) have been reported, including one probable case and five among the confirmed cases. Among the confirmed cases, three have recovered. All cases have been reported from Bukoba district, Kagera region.

Health authorities in both countries have shown strong political commitment. In recent weeks they have further strengthened critical response functions, such as disease surveillance, including at points of entry; laboratory activities; clinical case management; infection prevention and control; risk communication and community engagement; and operations support and logistics with support of WHO and partners.

WHO continues to monitor the situation in these two countries closely and to support the responses.

Description of the situation

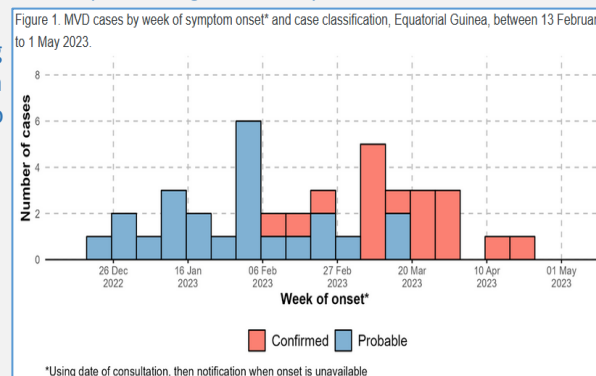
Equatorial Guinea:

Since the declaration of the outbreak on 13 February 2023, a total of 17 laboratory-confirmed cases of MVD and 23 probable cases have been reported as of 1 May (Figure 1). Among laboratory-confirmed cases, 12 deaths were recorded (CFR 75%). For one confirmed case, the outcome of the illness is unknown. All probable cases are dead. Five districts (Bata, Ebebiyin, Evinayong, Nsok Nsomo and Nsork) in four of the country's eight provinces (Centro Sur, Kié-Ntem, Litoral and Wele-Nzas) have reported confirmed or probable cases (Figure 2). The most affected district is Bata in Litoral province, with 11 laboratory-confirmed MVD cases reported.

Among the confirmed cases, four have recovered and five have been reported among healthcare workers, of whom two died. Among the reported cases, many are linked within a social network/gathering or by geographic proximity, however, the earlier presence of cases and/or clusters across multiple districts without clear epidemiologic links may indicate undetected virus transmission.

There are currently no confirmed cases in the Marburg treatment centre following the most recent discharge of a patient on 26 April 2023. This brings the total of survivors to four since the outbreak was declared.

In the last 21 days before the WHO report (from 11 April to 1 May 2023), two confirmed cases were reported from Bata district (Figure 3). These cases had a known epidemiological link to a confirmed case, through a family cluster or through a healthcare setting.



The United Republic of Tanzania:

Since the declaration of the MVD outbreak on 21 March 2023, a total of nine cases (eight laboratory-confirmed and one probable case) have been reported as of 30 April 2023 (Figure 4). Among the total cases, six deaths were recorded (CFR 66.7%). Among the confirmed cases, three have recovered, and two have been reported among healthcare workers, one of whom died.

In the last 21 days, from 10 to 30 April, one confirmed case was reported on 11 April. This case was the mother of a previously reported MVD case, a child of 18 months old, who died on the same day. The mother was quarantined as soon as MVD was detected in the child in March. No further contacts linked to this case have been reported. There are currently no confirmed cases in the treatment centre in Bukoba following the discharge of the confirmed patient on 21 April 2023. This brings the total of survivors to three since the outbreak was declared.

WHO risk assessment

Both countries have reported MVD outbreaks for the first time.

In [Equatorial Guinea](#), while many cases are linked within a social network/gatherings or by geographic proximity, the earlier presence of cases and/or clusters across multiple districts without clear epidemiologic links may indicate undetected virus transmission. The last cases occurred in Bata, the most populated city and economic hub of Equatorial Guinea, with an airport and seaport, posing challenges for the response. The country surveillance system remains suboptimal, with few alerts reported. Additionally, there are population movements between the different districts of the mainland and island regions. Frequent population movements and porous land borders are also reported in the districts bordering Cameroon and Gabon, with suboptimal surveillance at land entry points and countless uncontrolled paths or trails along the border with Cameroon and Gabon.

In the [United Republic of Tanzania](#), the affected region, Kagera, borders three countries (Uganda to the north, and Rwanda and Burundi to the west) and Lake Victoria, and cross-border population movements may increase the risk of disease spread. Following the recent Ebola virus outbreaks in the Democratic Republic of the Congo from 23 April - 3 July 2022 and from 21 August - 27 September 2022, and Sudan ebolavirus outbreak in Uganda from 20 September 2022 to 11 January 2023, neighbouring countries in the subregion, including the United Republic of Tanzania, have been building preparedness capacities against filovirus diseases. However, an epidemiological investigation, which is still being carried out, has not revealed the source of the outbreak which may pose an additional risk to the population in the affected district.

In March 2023, WHO assessed the **public health risk** posed by the MVD outbreaks in Equatorial Guinea and the United Republic of Tanzania as **very high at the national level, high at the sub-regional level, moderate at the regional level, and low at the global level**. WHO continues to monitor the situation in these two countries closely.

WHO advice

MVD outbreak control relies on using a range of interventions, such as early isolation and optimized supportive care; surveillance including active case search, case investigation and contact tracing; an optimal laboratory service; infection prevention and control; safe and dignified burial; and social mobilization. Risk Communication and Community engagement is key to successfully controlling MVD outbreaks.

Statement of the thirty-fifth Polio IHR Emergency Committee

On 3 May 2023 the Emergency Committee reviewed the data on wild poliovirus (WPV1) and circulating vaccine derived polioviruses (cVDPV) in the context of global target of eradication of WPV and cessation of outbreaks of cVDPV2 by the end of 2023. Technical updates were received about the situation in the following countries: Afghanistan, Benin, Burundi, the Central African Republic, Chad, the Democratic Republic of the Congo, Indonesia, Pakistan and Somalia.

Wild poliovirus

In [Pakistan](#), the committee noted that since the last meeting, there has been one new case of WPV1 with onset 20 February 2023, in Khyber Pakhtunkhwa (KP) province, the first case since 15 September 2022. There have been three environmental surveillance positive samples in 2023, two in Punjab and one in KP, the most recent positive sample collected was 21 February 2023. Two of these three ES detections were linked to viruses circulating in Afghanistan.

In [Afghanistan](#) there have been no cases reported in 2023 with the last case occurring on 29 August 2022. However, there have been 18 positive environmental samples to date in 2023, all in the eastern region, three from Kunar and 15 from Nangarhar. Although the number of positive samples in Afghanistan was 18 in 2023 to date compared to 22 for the year 2022, this was in part due to more intensive surveillance in the country, with more sites being sampled and increased frequency of testing. This appears to signal considerable progress in the polio endgame and although all areas of both countries are fully accessible during immunization rounds, there are areas of insecurity and vaccine refusals, with a high number of zero dose children in the southern region. Afghanistan has increased the number of female front line workers to assist in accessing households. The next six months will be a critical opportunity to finally interrupt endemic WPV1 transmission.

There have been no new cases reported in the outbreak of WPV1 in [southern Africa](#), with the most recent case having onset of paralysis on 10 August 2022 in Mozambique. There have been no new cases of WPV1 in Malawi, and it is now more than 16 months since the single case was detected in Malawi. However, the committee noted that GPEI outbreak response assessments which were conducted in October in Malawi and in November in Mozambique to review progress concluded that ongoing transmission could not be ruled out in either country, due to gaps in polio surveillance and suboptimal coverage in immunization campaigns. Based on Lot Quality Assurance Sampling, campaign quality was less than the target 90% in Malawi, Mozambique, Zambia and Zimbabwe in the recent round.

Globally there remain only three genetic clusters of WPV1, a major reduction in the genetic diversity of WPV1 which indicates that **chains of transmission have been reduced to two in the remaining endemic countries Pakistan and Afghanistan, and one in Africa.**

Circulating vaccine derived poliovirus (cVDPV)

Despite the ongoing decline in the number of cVDPV2 cases and the number of lineages circulating, the risk of international spread of cVDPV2 remains high. Evidence of this includes the [high transmission in DR Congo with spread of cVDPV2 to Burundi and Malawi](#). The committee noted that in the African Region, which now uses novel OPV2 exclusively, there have been two new cVDPV2 detected in DR Congo that have emerged from novel OPV2 use. However, novel OPV2 is retaining its enhanced genetic stability compared to Sabin OPV2, with most isolates analyzed through whole genome sequencing indicating no or minimal changes in genetic structure of novel OPV2.

Only 2% of all isolates reported so far have shown evidence of losing key genetic modifications that reduce neurovirulence due to recombination and these have only been detected in Uganda, CAR, DRC and Burundi, versus the expected 75% for Sabin OPV2.

The committee was concerned that in Indonesia, there is evidence of missed transmission of cVDPV2 and that the occurrence of a case of cVDPV2 in Israel indicates ongoing transmission in the country. However, the committee noted that Indonesia had responded very quickly, and this was commendable.

The emergence and ongoing transmission of cVDPV1 in Madagascar, DR Congo and Mozambique is of concern in the context of the WPV1 outbreak in southern Africa, as it highlights gaps in population immunity to type 1 polioviruses including WPV1.

The committee noted that much of the risk for cVDPV outbreaks can be linked to a combination of inaccessibility, insecurity, a high concentration of zero dose children and population displacement. These factors are most evident in northern Yemen, northern Nigeria, south central Somalia and eastern DRC, but also in northern Mozambique.

The committee noted that the roll out of wider use of novel OPV2 continues under EUL, with over 600 million doses administered to date.

The committee noted that a few countries had outbreaks of more than one cVDPV indicating a significant immunity gap in their populations.

Conclusion

Although encouraged by the reported progress, the Committee unanimously agreed that the **risk of international spread of poliovirus still remains a Public Health Emergency of International Concern (PHEIC)** and recommended the extension of Temporary Recommendations for a further three months.

Risk categories

The Committee provided the Director-General with the following advice aimed at reducing the risk of international spread of WPV1 and cVDPVs, based on the risk stratification as follows:

1. States infected with WPV1, cVDPV1 or cVDPV3.
2. States infected with cVDPV2, with or without evidence of local transmission:
3. States no longer infected by WPV1 or cVDPV, but which remain vulnerable to re-infection by WPV or cVDPV.

Criteria to assess States as no longer infected by WPV1 or cVDPV:

- Poliovirus Case: 12 months after the onset date of the most recent case PLUS one month to account for case detection, investigation, laboratory testing and reporting period OR when all reported AFP cases with onset within 12 months of last case have been tested for polio and excluded for WPV1 or cVDPV, and environmental or other samples collected within 12 months of the last case have also tested negative, whichever is the longer.
- Environmental or other isolation of WPV1 or cVDPV (no poliovirus case): 12 months after collection of the most recent positive environmental or other sample (such as from a healthy child) PLUS one month to account for the laboratory testing and reporting period.
- These criteria may be varied for the endemic countries, where more rigorous assessment is needed in reference to surveillance gaps.

Once a country meets these criteria as no longer infected, the country will be considered vulnerable for a further 12 months. After this period, the country will no longer be subject to Temporary Recommendations, unless the Committee has concerns based on the final report.

TEMPORARY RECOMMENDATIONS

States infected with WPV1, cVDPV1 or cVDPV3 with potential risk of international spread

WPV1

Afghanistan	most recent detection 3 April 2023
Malawi	most recent detection 19 November 2021
Mozambique	most recent detection 10 August 2022
Pakistan	most recent detection 21 February 2023

cVDPV1

Madagascar	most recent detection 1 March 2023
Mozambique	most recent detection 27 February 2023
Malawi	most recent detection 1 December 2022
DR of the Congo	most recent detection 6 March 2023
Congo	most recent detection 15 October 2022

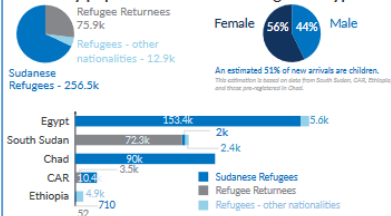
2023 Sudan Conflict

OVERVIEW: There are now close to 1.4 million displaced overall due to the recent outbreak of conflict in Sudan, including 1,042,114 internally and over 330,000 in neighbouring countries. Sudan, impacted by this new emergency is already hosting large refugee populations. Assistance to the majority remains severely underfunded. Hosting countries will need additional support to provide protection and critical life-saving assistance. Initial assessments show that the new asylum-seekers, refugees, refugee returnees and other arrivals' most urgent needs identified to date are water, food, shelter, health, and core relief items. In terms of protection, the current priority activities are the registration of new arrivals and ensuring that mechanisms are in place to try and prevent and respond to gender-based violence and ensure alternative care services for refugee children.

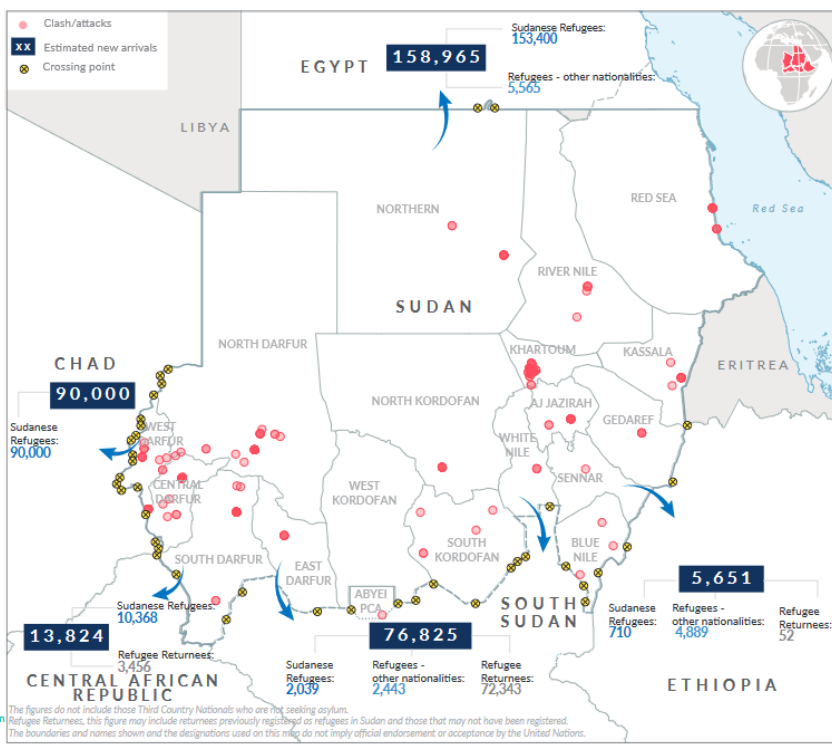
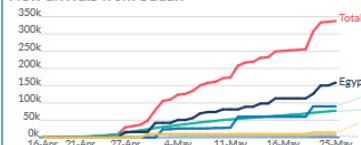
345,265 Estimated newly arrived individuals

269,414 Total newly arrived refugees/asylum-seekers

Arrivals by population and estimated gender type



New arrivals from Sudan



The figures do not include those Third Country Nationals who are not seeking asylum.
Refugee Returnees: this figure may include returnees previously registered as refugees in Sudan and those that may not have been registered.
The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations.

Increasing risk of hunger in hotspot areas as the Sudan crisis spills over into subregion and El Niño looms

The spill-over from the crisis in the Sudan is driving massive population displacement and hunger among people forced from their homes in search of refuge and those hosting them -- the . More than one million people are expected to flee the country while an additional 2.5 million inside the Sudan set to face acute hunger in coming months.

The Sudan was already hosting over one million refugees -- and if the conflict persists hundreds of thousands are likely to return to their countries of origin -- many of which are already in the grips of underfunded and protracted refugee crises, compounded by social, political and economic stressors.

Supply routes for commercial and relief goods in and out of Port Sudan are being disrupted by insecurity, putting in jeopardy humanitarian assistance flows and regional relief efforts, the report notes. Disruptions to trade,



In line with the Global Compact on Refugees, UNHCR is facilitating coordination mechanisms in each country with the aim to support the host government, ensure a multistakeholder approach and lay the groundwork for solutions from the start. The implementation of the Sudan Regional Refugee Response Plan will be done in line with the Refugee Coordination Model (RCM) in close collaboration with inter-agency partners and other stakeholders. Coordination mechanisms in some countries will need to be strengthened with the set-up of specific inter-agency refugee coordination fora to help steer the immediate response and ensure information sharing with all partners.

ETHIOPIA:

The priority needs identified include food, water, sanitation and hygiene promotion, health and nutrition, shelter, core relief items and the delivery of protection services. The provision of protection services to newly arrived refugees is key, including child protection, family reunification, protection risk mitigation, referral pathways and community engagement. Due to the vulnerable situation of the refugees (45% are women and girls), protection risks, including family separation, gender-based violence, exploitation and sexual abuse, are high with the urgent need for the establishment of mitigation and response mechanisms.

SOUTH SUDAN:

Many arrivals are very vulnerable, exhausted and in need of immediate assistance. Most of them also need support to continue their journey to intended destinations in South Sudan. The vast majority of people are arriving through Renk from where onward transportation has to be organized primarily by boat on the river Nile, making the emergency response and onward movement logistically challenging. South Sudan already faces a challenging humanitarian situation in which peace and security remain fragile. Intercommunal violence, food insecurity, and the severe impact of climate change present constant challenges. Protection concerns remain high for people of all genders and ages and South Sudan remains one of the worst food insecurity emergencies in the world.

CENTRAL AFRICAN REPUBLIC:

Emergency teams have been deployed. A rapid assessment among the new arrivals was conducted with a team of local actors to identify arrivals and emergency needs. The major needs at this stage are emergency shelter, food, health, WASH, core relief items and relocation, as moving people away from the border to more secure locations will mitigate some of the protection challenges.

CHAD:

Urgent actions are needed to provide essential protection and humanitarian assistance, maintain vital assistance to vulnerable communities in eastern Chad, and avoid inter-community tension. Authorities have requested assistance in relocating the new arrivals to camps far from the border.

EGYPT:

Based on initial information, access to territory and asylum procedures can be challenging for people forced to flee Sudan, particularly for third-country nationals, those without valid travel documents, and those who are unable to obtain visas. This has resulted in family separation, breakdown of support systems, and a high number of unaccompanied and separated children and female-headed households. Some of the people fleeing Sudan have resorted to try and enter through irregular pathways, which exposes them to risks of exploitation.

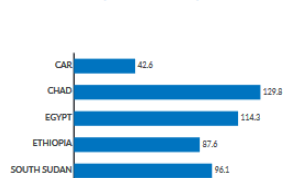


140 INTER-AGENCY PARTNERS



\$470.4 M TOTAL INTER-AGENCY REQUIREMENTS

Regional budget summary per country (million in USD)



cross-border commercial activities, and supply chains risk also driving up prices and inflation and depleting foreign exchange reserves in several countries -- particularly in South Sudan -- a country that relies on Port Sudan for both commercial and humanitarian imports, as well as vital oil exports.

The report warns that displacement into neighbouring countries and disruptions to trade risk also driving tensions among displaced people, those hosting them and new arrivals, as many hard-hit countries are already grappling with significant numbers of displaced people competing for limited livelihood and labour opportunities -- particularly Chad and South Sudan - where fragile sociopolitical environments are at risk of deteriorating.



ECDC lessons learned from the COVID-19 pandemic

Source: ECDC

The ECDC report highlights two strategic areas requiring organisational and political commitment and investment at national level. These areas are closely interconnected.

One area is the investment in the public health workforce. It is of vital importance to recruit, train and retain public health professionals, and attract young professionals, especially as the current public health workforce is ageing, as well as plan for surge capacity when responding to a public health crisis.

The other strategic area relates to improvements and investment in preparedness planning and the need for a formalised decision making and crisis management structure that supports intersectoral work. Moreover, legislation governing the control of communicable diseases should also be updated and take into account ethical considerations and human rights.

At the operational level, lessons learned from the pandemic converge around increasing the capacities of public health professionals in risk communication and community engagement to tailor messages more appropriately. In addition, institutions need to develop robust but agile systems to collect and analyse different types of data in support of policy decisions and to dynamically adjust measures to control infectious disease outbreaks.

Lessons from the COVID-19 pandemic and the way forward

Lesson Area 1: Investment in the public health workforce

Box 1. Main lessons and follow-up actions for investing in the public health workforce

Lessons identified by countries and the ECDC	ECDC follow-up actions
<ul style="list-style-type: none"> Having sufficient numbers of trained public health staff is a critical need in almost all Member States for peace-time work, but particularly when responding to crises. Staff working under significant pressure for prolonged periods of time has resulted in significant burnout, causing staff to leave the workforce or have a decreased capacity to work. Reversal of budgets for public health activities to pre-pandemic levels in the coming years will negatively affect the retention of new staff employed during the pandemic. Lack of resources at all administrative levels was reported by the countries, and this will have an impact on future planning activities. Emergency procedures for surge capacity are required, including basic training of new staff. 	<ul style="list-style-type: none"> Continue mapping the existing workforce through workforce capacity assessments and forecast Member State workforce needs in the EU, as well as developing country overviews. Advocacy for recruitment and retention of an adequately skilled public health workforce at the national and international level, and for underpinning public health training programmes (e.g. through ECDC country visits and technical reports, and as part of the EU Global Health Strategy, in collaboration with WHO). Continue investing in existing workforce capacity development projects and collaborations (i.e. ECDC Fellowship programme (EPIET), MediPIET, ECDC4Africa CDC, Global Field Epidemiology Roadmap and Global Laboratory Leadership Programme) to increase the quality and number of trained specialists for preparedness, surveillance, and response. ECDC will continue to offer EPIET, EUPHEM and MediPIET training programmes. Advocacy and support for inclusion of processes to meet surge capacity needs as part of preparedness plans at all levels, national, local and EU. This should include mechanisms for mobilising young professionals, experts from countries not affected by the event, or retired staff. ECDC will continue to offer short courses as part of Continuous Professional Development (CPD) for the European public health workforce, in accordance with training needs. ECDC will continue to build its Virtual Academy (EVA) and offer free online courses and webinars on various public-health related topics for the European public health workforce. A new training programme in the area of preparedness (2024) will offer a wide range of courses and workshops to strengthen preparedness capacity in the Member States. Professional exchanges will be further supported. Participants will be selected via the National Focal Points (NFPs), depending on the Member State priorities. Encourage Member State representatives taking part in various training activities to further disseminate the knowledge acquired to other colleagues within their organisations.

Lesson areas identified by ECDC



Lesson Area 2: Preparing for the next public health crisis

Box 2. Main lessons and follow-up actions to prepare for the next public health crisis

Lessons identified by countries and the ECDC	ECDC follow-up actions
<ul style="list-style-type: none"> Updated, generic/all-hazard, flexible, scalable preparedness plans are needed. Formalise the role of public health in decision-making and crisis management structures. Intersectoral work in preparedness and response to public health crises is very important. Facilitate intersectoral advice and work with stakeholders and experts outside the public health sector. Organise a feedback mechanism for ECDC outputs. Provide assistance to conduct simulation exercises by offering staff, training or training material. Facilitate sharing of lessons learned from the COVID-19 pandemic among the Member States. Continue work with countries to perform In-action reviews and After-action reviews, as requested. Communicate and share results of systematic literature reviews on NPIs, lessons learned and other scientific questions on COVID-19 response. Facilitate evaluation and monitoring of the implementation of NPIs (e.g. development of guidance and/or training). Define indicators for preparedness planning. Assess Member State prevention, preparedness and response plans every three years. 	<ul style="list-style-type: none"> Develop guidance on generic preparedness planning, based on the lessons identified. Facilitate sharing of national preparedness plans among the Member States. Facilitate intersectoral advice and work with stakeholders and experts outside the public health sector. Organise a feedback mechanism for ECDC outputs. Provide assistance to conduct simulation exercises by offering staff, training or training material. Facilitate sharing of lessons learned from the COVID-19 pandemic among the Member States. Continue work with countries to perform In-action reviews and After-action reviews, as requested. Communicate and share results of systematic literature reviews on NPIs, lessons learned and other scientific questions on COVID-19 response. Facilitate evaluation and monitoring of the implementation of NPIs (e.g. development of guidance and/or training). Define indicators for preparedness planning. Assess Member State prevention, preparedness and response plans every three years.

Lesson Area 3: Risk communication and community engagement

Box 3. Main lessons and follow-up actions for improved risk communication and community engagement

Lessons identified by countries and the ECDC	ECDC follow-up actions
<ul style="list-style-type: none"> Risk communication and community engagement were identified as a significant challenge throughout the COVID-19 pandemic. Communication capacity with the public and the media should be strengthened. Management of media requests, and control of the mis-/disinformation put additional pressure on public health staff. In some cases, little or no skills or capacity existed in public health institutes for the management of misinformation. The Member States and ECDC also identified the need to include behavioural and social science input in their guidance documents. During the pandemic, there was a need for more coordination of messages at EU level. Several needs for training were identified, along with different sets of guidance on risk communication and community engagement. 	<ul style="list-style-type: none"> Organise trainings in risk communication for European public health professionals. Foster social and behavioural research in preparedness planning and during response to outbreaks. Coordinate a community of practice across the EU/EEA for behavioural and social scientists in public health. Increase ECDC communication activities - e.g. production of videos, infographics and material that can be re-used by the Member States - and increase use of social media.

Lesson Area 4: Collection and analysis of data and evidence

Box 4. Main lessons and follow-up actions for improved collection and analysis of data and evidence

Lessons identified by countries and the ECDC	ECDC follow-up actions
<ul style="list-style-type: none"> Digitalised systems for COVID-19 surveillance helped to monitor the epidemiological situation and will continue to be used. Digitalisation of surveillance tailored to public health needs including a built-in interface with other registries (e.g. cause of death registers, immunisation registries). Surveillance systems should be agile and adaptable, robust but also flexible and scalable. Analysis, interpretation and presentation of epidemiological data should be strengthened and tailored to the needs of policymakers and the public. During the pandemic, the scale-up of the capacity for testing and sequencing SARS-CoV-2 was slow. Information systems handling public health data need to be strengthened and redundancy should be built-in ahead of time. Data protection and data governance should be taken into consideration when building new systems and in all transfers of public health data. 	<ul style="list-style-type: none"> ECDC is prioritising diseases under EU/EEA surveillance to ensure that sufficient resources are available for diseases with the highest impact and degree of preventability. This entails developing objective-driven systems and relying more on rapid event reporting to EpiPulse. ECDC is re-engineering and integrating the IT systems supporting EU/EEA surveillance. Digitalisation and automatization in the collection of all surveillance data should be encouraged in the EU/EEA countries <ul style="list-style-type: none"> a joint action on surveillance systems, financed by the EC, is currently underway. EC EU4Health programme allocated increased budget to strengthen Member State surveillance systems in 2023. Support to Member States to increase laboratory capacity for genomic sequencing will be continued. Training in sequence analysis and applied genomic epidemiology will be provided to Member States. Tools to assess Member State laboratory capacity will be improved. Pre-design web outputs for situation awareness in a crisis. Pre-design and pilot operational research protocols (e.g. first-few-hundred cases) and provide training for available tools (e.g. Go.Data, REDCap, etc.)

Other Infectious Disease Outbreaks

[Marburg virus disease - Equatorial Guinea and the United Republic of Tanzania – Follow up](#)

Equatorial Guinea and the United Republic of Tanzania have been responding to separate outbreaks of Marburg virus disease (MVD) since early February and late March 2023, respectively.

In [Equatorial Guinea](#), from 13 February to 1 May 2023, 17 laboratory-confirmed MVD cases and 23 probable cases have been reported. The last confirmed case was reported on 20 April. Among the laboratory-confirmed cases, there are 12 deaths (Case Fatality Ratio (CFR) 75%). For one confirmed case, the outcome is unknown. Among the confirmed cases, four have recovered. All of the probable cases are dead. The most affected district is Bata in Litoral province, with 11 laboratory-confirmed MVD cases reported.

In the [United Republic of Tanzania](#), between 16 March to 30 April 2023, a cumulative total of nine cases including eight laboratory-confirmed cases and one probable case have been reported. The last confirmed case was reported on 11 April 2023. A total of six deaths (CFR 66.7%) have been reported, including one probable case and five among the confirmed cases. Among the confirmed cases, three have recovered. All cases have been reported from Bukoba district, Kagera region.

Health authorities in both countries have shown strong political commitment. In recent weeks they have further strengthened critical response functions, such as disease surveillance, including at points of entry; laboratory activities; clinical case management; infection prevention and control; risk communication and community engagement; and operations support and logistics with support of WHO and partners.

WHO continues to monitor the situation in these two countries closely and to support the responses.

Source: [WHO](#)

[Lassa fever – Nigeria](#)

Nigeria is currently experiencing a large outbreak of Lassa fever, with 4702 suspected cases, five probable cases, and 877 confirmed cases between epidemiological weeks 1 and 15 of 2023 (week ending 16 April). Among confirmed cases, there have been 152 deaths (CFR 17%). Lassa fever is endemic in Nigeria and parts of West Africa where the multimammate rat, the main reservoir of the Lassa virus, is common.

Responding to the current outbreak is challenging due to the need to respond to multiple emergencies simultaneously.

Laboratory-confirmed cases have been reported in states bordering Cameroon (Adamawa, Benue, Cross Rivers, and Taraba) and states bordering Benin (Oyo and Niger).

The overall [regional and global risks](#) are considered **low** because the primary mode of transmission of Lassa fever is through contact with food or household items contaminated with rat excreta.

The [rate of human-to-human transmission](#) is **low**.

Source: [WHO](#)

[Lassa fever – Ghana](#)

In Ghana, the Lassa fever outbreak has been declared over by the Ghana Health Service after an outbreak affected 27 people and killed one person. Swift implementation of public health measures led to the effective control and ultimate break in transmission of the disease. However, lessons can still be learned from this outbreak including the need for rigorous health worker precautions since they were among the cases infected.

Source: [African WHO](#)

[Avian influenza overview March – April 2023 - Europe](#)

Between 2 March and 28 April 2023, highly pathogenic avian influenza (HPAI) A(H5Nx) virus, clade 2.3.4.4b, outbreaks were reported in domestic (106) and wild (610) birds across 24 countries in Europe. Most of these outbreaks were classified as primary outbreaks without secondary spread and some of them associated with atypical disease presentation, in particular low mortality.

Since 13 March 2022 and as of 10 May 2023, two A(H5N1) clade 2.3.4.4b virus detections in humans were reported from China (1), and Chile (1), as well as three A(H9N2) and one A(H3N8) human infections in China. The [risk of infection](#) with currently circulating avian H5 influenza viruses of clade 2.3.4.4b [in Europe](#) popremains **low for the general ulation** in the EU/EEA, and **low to moderate for occupationally** or otherwise exposed people.

Source: [ECDC](#)

[Crimean-Congo Hemorrhagic Fever \(CCHF\) – Iraq](#)

At least 13 people have died in Iraq since the start of the year in Iraq. Nearly 100 other people have been infected, where the disease claimed many more victims last year.

In 2022, at least 212 people were infected while 27 died, according to ministry spokesman Saif al-Badr. Most of those who have been infected are livestock breeders from the rural southern province of Dhi Qar, as well as workers in abattoirs.

[Crimean–Congo hemorrhagic fever \(CCHF\) – Georgia](#)

Georgian health authorities confirmed the first cases of Crimean-Congo hemorrhagic fever in the country this year on Tuesday 23 May, with eight confirmed patients admitted to medical facilities with the condition. All eight patients admitted to the facility had been treated, with six already discharged. The cases had been mainly recorded in the central-eastern Shida Kartli and south-west Samtskhe-Javakheti regions.

Source: [NewsMedia Iraq](#); [NewsMedia Georgia](#)

[Meningitis - Nigeria](#)

From 1 October 2022 to 16 April 2023, a total of 1686 suspected cases, 532 confirmed cases and 124 deaths (CFR: 7%) have been reported from 81 local government areas (LGAs) in 22 out of 36 administrative states, including the Federal Capital Territory (FCT). Jigawa state consists of 27 LGAs, of which 25 have reported at least one suspected case. There have been 66 deaths in Jigawa state. During the current outbreak, Maigatari LGA and Sule-tankarkar LGA have both crossed the epidemic threshold of 10 suspected cases per 100 000 population and account for 60% of the total reported cases, with 505 and 247 cases respectively.

Source: [WHO](#)

[Diphtheria - Nigeria](#)

Since the beginning of 2023, 557 confirmed cases of diphtheria have been detected in Nigeria, affecting 21 of the 36 states and the Federal Capital Territory. In December 2022, the Nigeria Centre for Disease Control and Prevention (NCDC) was notified of suspected diphtheria outbreaks in Kano and Lagos States. From 14 May 2022 to 9 April 2023, 1439 suspected cases have been reported, of which 557 (39%) have been confirmed, including 73 deaths among the confirmed cases (case fatality ratio of 13%). Nigeria had recorded diphtheria outbreaks in the past. The most significant outbreak reported was between February and November 2011 in the rural areas of Borno State, north-eastern Nigeria, where 98 cases were reported.

Source: [WHO](#)

[Measles - Indonesia](#)

Since 2022, Indonesia has recorded an increase in suspected and confirmed measles cases compared to previous years. Between 1 January and 3 April 2023, a total of 2161 suspected measles cases (848 laboratory-confirmed and 1313 clinically compatible [suspected]) have been reported across 18 of 38 provinces in Indonesia, primarily from the provinces of West Java (796 cases), Central Papua (770 cases), and Banten (197 cases). Measles is endemic in Indonesia and is reported every year. However, in 2022 and 2023, there has been a significant increase in the number of confirmed cases, as compared to those reported annually since 2018: there were 920 reported cases in 2018, 639 in 2019, 310 in 2020, and 132 in 2021.

The current outbreak is characterized by suboptimal population immunity, including children without measles vaccination. Supplemental immunization activity (SIA) was conducted in 2022, targeting children.

Source: [WHO](#)

Other Infectious Disease Outbreaks



Measles - Ethiopia

Measles is endemic in Ethiopia, with cases reported every year. Between 12 August 2021 and 1 May 2023, 16 814 laboratory-confirmed measles cases and 182 deaths – with a Case Fatality Ratio (CFR) of 1.1% - have been reported nationally. There are active measles outbreaks reported in 44 woredas/districts from eight regions: Afar, Amhara, Harari, Oromia, Southern Nations, Nationalities and Peoples Region (SNNPR), South West Ethiopia Peoples' Region (SWEPR), Tigray and Somali.

From 2021, the annual number of confirmed measles cases has increased significantly, from 1953 in 2021 to 9291 (>375%) in 2022 and 6933 in 2023 as of 1 May. Thus, there was, an almost five-fold increase in confirmed measles cases between 2021 and 2022.

Low population immunity, combined with concurrent epidemics, conflict, forced displacement, and other humanitarian crises that disrupt childhood vaccinations, are some factors that may explain the increases.

Source: [WHO](#)

Acute hepatitis E – South Sudan

On 14 April 2023, the Ministry of Health (MoH) of South Sudan declared an outbreak of the hepatitis E Virus (HEV) in Wau city, the capital of Western Bahr el-Ghazal state and one of the largest cities in South Sudan. Between 23 March 2023 and 13 April 2023, a total of 91 HEV suspected cases have been reported from Wau, of which 35 are confirmed; there have been five deaths reported (case fatality ratio [CFR] 5.5%). A multidisciplinary national rapid response team has been deployed by the MoH to conduct an epidemiological investigation, determine the extent of the outbreak, identify exposures or risk factors to prevent further spread and implement appropriate preventive measures.

Cases of the hepatitis E virus have been reported in the Bentiu camp for internally displaced persons (IDPs) in South Sudan since 2018, with seasonal upsurges reported yearly, particularly during the rainy season due to floods leading to contamination of drinking water. There is a risk of international spread of the disease as South Sudan shares borders with Sudan and Ethiopia, with substantial traffic between them. The situation is further aggravated by the highly mobile IDP and refugee population, mainly from Rubkona county, Unity State, where the Bentiu IDP camp is located.

Source: [WHO](#)

Flooding – Rwanda

The Northern and Western Provinces of Rwanda were left devastated by rains that occurred on 2 and 3 May 2023 primarily in the districts of Ngororero, Rubavu, Nyabihu, Rutsiro, Karongi, Gakenke, Burera, Musanze, Gicumbi, and Nyamagabe. A complete risk assessment is still pending since some affected districts are unreachable. As of 5 May 2023, 131 people had died while 104 were injured. A total of 7 408 people have been internally displaced. People who have been displaced have sought shelter in overcrowded camps which face challenges to meet the needs of the surge of victims. There have been 14 health facilities that have been damaged and are either inaccessible or operating with limited services. A total of eight national roads, nine district roads, and 26 bridges were damaged. Furthermore, destruction was also reported for agricultural lands, water treatment plants, and sewage systems. More rains were expected through 6 May 2023, and were projected to drop more than 20 mm rainfall per day likely causing even more damage to people and infrastructure.

Source: [African WHO](#)

Yellow Fever– Cameroon

From the beginning of the outbreak in February 2021 to 2 April 2023, 3 483 suspected cases of YF have been reported and investigated, including 84 laboratory-confirmed cases among whom three have died (CFR 3.6%). From weeks 1-13 in 2023, 250 new suspected cases have been reported. Cases have been reported from all ten regions of the country in 2023, but Extreme Nord accounts for the most cases (47, 18.8%).

Source: [African WHO](#)

Myocarditis - United Kingdom of Great Britain and Northern Ireland

On 5 April 2023, the National IHR Focal Point for the United Kingdom informed WHO of an increase in severe myocarditis in neonates associated with enterovirus infection in Wales. Between June 2022 and April 2023, ten hospitalised neonates with a positive enterovirus PCR test were found to have myocarditis. Seven of the ten cases had further subtyping, with either coxsackie B3 or coxsackie B4 identified. As of 5 May 2023, one patient was still hospitalised, and one had died.

Although enterovirus infections are common in neonates and young infants, the reported increase in myocarditis with severe outcomes in neonates and infants associated with enterovirus infection is unusual.

According to the authorities of the United Kingdom, a review of past data from the previous six years from the same tertiary care centre in Wales, United Kingdom, has identified only two similar cases prior to June 2022 (which may or may not be linked to the current incident).

Based on the limited information available at this point, WHO assesses the [public health risk](#) for the general population to be **low**.

Source: [WHO](#)

Extensively drug-resistant Pseudomonas aeruginosa (artificial tears/eye drops) - USA

The United States Centers for Disease Control and Prevention (US CDC) reported an update of an outbreak investigation on an extensively drug-resistant strain of Pseudomonas aeruginosa related to the use of artificial tears/eye drops affecting 81 patients with four deaths. The severe outcomes included 14 patients with lost vision and four others who had an eyeball removed.

The manufacturer has recalled EzriCare Artificial Tears, Delsam Pharma Artificial Tears, and Delsam Pharma Artificial Eye Ointment products following advice from US Food and Drug Administration (FDA) and US CDC. These products have been sold in the US and on internet.

Although the disease is severe, the likelihood of infection of VIM-GES-CRPA via exposure to contaminated artificial tears is low for EU/EEA citizens at this time, given the product recalls and public information campaigns.

Source: [ECDC/CDC](#)

Influenza Europe; Week 20/2023 (14 -21 May 2023)

- The percentage of all sentinel primary care specimens from patients presenting with ILI or ARI symptoms that tested positive for an influenza virus decreased to 2% from 4% in the previous week, which is below the epidemic threshold set at 10%.
- 15 of 39 countries or areas reported low intensity; there were no reports of medium or higher intensity. 2 of 38 countries across the Region reported widespread activity.
- 2 countries with more than ten specimens tested reported sentinel primary care specimen influenza virus positivity above the 10% epidemic threshold.
- Influenza type A and type B viruses were detected in sentinel and non-sentinel surveillance, with type B predominating in both systems.
- Hospitalized patients with confirmed influenza virus infection were reported from ICU (one each of type A and B viruses), other wards (one type A virus detected) and SARI surveillance (with higher proportions of type B viruses). No country reported influenza virus positivity rates above 10% in SARI surveillance..

Source: [Flu News Europe](#)