Llywodraeth Cymru
Welsh Government

Yr Is-adran Gwyddoniaeth, Ymchwil a Thystiolaeth
Science Research Evidence Division
Y Grŵp Iechyd, Gofal ac Atal
Health, Care and Prevention Group

Weekly Surveillance Report

13 November 2026



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This report was produced by the Science Research Evidence Division (SRE) (previously Science Evidence Advice Division (SEA)).

Science Research Evidence: Weekly Surveillance Report

A. Top Line Summary (as at week 45 2025, up to 08 November 2026)

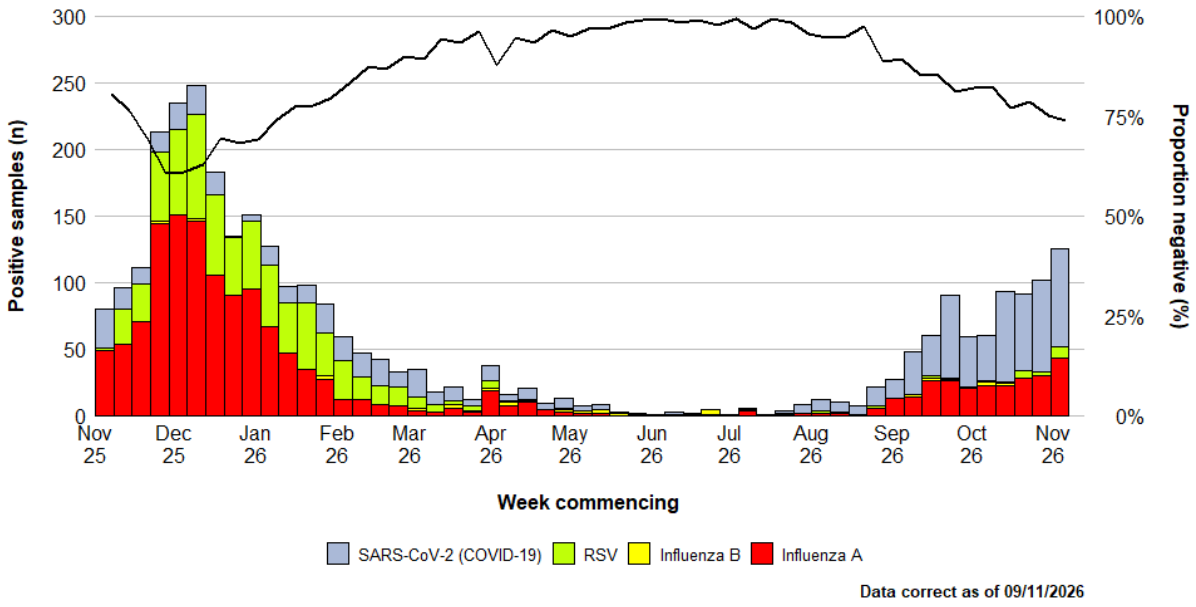
- COVID-19 confirmed case admissions to hospital have **increased** and in-patient cases have **increased** in the most recent week.
- Influenza (flu) confirmed case admissions to hospital have **increased** and in-patient cases have **increased** in the most recent week.
- Respiratory Syncytial Virus (RSV) admissions to hospital have **increased** and in-patient cases have **increased** in the most recent week.
- Respiratory Syncytial Virus (RSV) incidence in children under 5 years has **increased** in the most recent week.
- Scarlet Fever notifications have **decreased** in the most recent week.
- Norovirus confirmed cases have **decreased** in the most recent week.

B. Acute Respiratory Infections Situation Update

B.1. COVID-19 Update

- At a national level, the weekly number of confirmed cases of community-acquired admissions to hospital **increased** and the number of cases who were inpatients **increased** in week 45 2025 (to 08 November 2026).
- As of 08 November 2026 (week 45), the number of confirmed cases of community acquired COVID-19 admitted to hospital **increased** to **49** (**43** in the previous week) and there were **305** in-patient cases of confirmed COVID-19, **2** of whom were in critical care compared to **279** and **1** in the previous week.
- Confirmed cases of positive tests decreased to **9.6%** in hospital and non-sentinel GP practices in the most recent week (week 45).
- In the last six weeks, **Omicron TK.1*** is the most frequently detected Pango lineage group in Wales currently, accounting for **24.2%** of sequenced cases in the previous six weeks (reporting weeks 2026 W35 to 2026 W41) (Data as at 13/10/26).

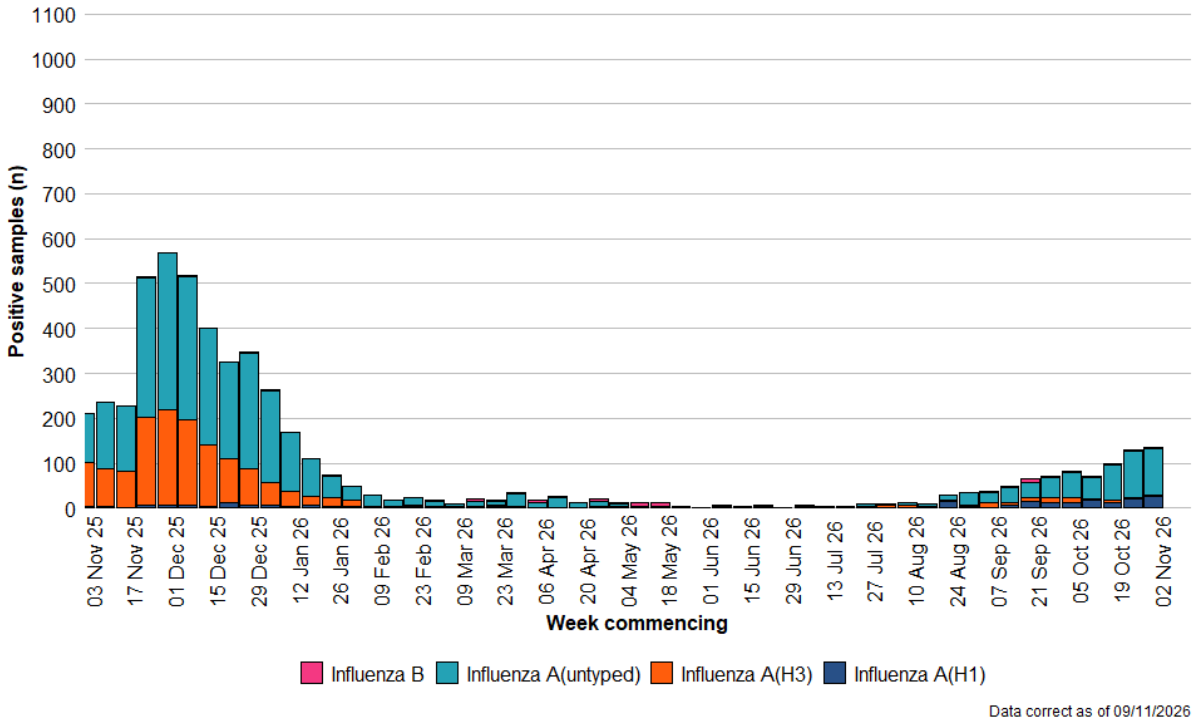
Figure 1: Samples from hospital patients submitted for COVID-19, influenza and Respiratory Syncytial Virus (RSV) testing only, by week of sample collection, week 45 2025 to week 45 2026 (source: PHW).



B.2 Influenza (flu) Update

- The influenza-like-illness GP consultation rate has been variable in the most recent week, however confirmed cases of influenza in sentinel GPs have increased across Wales. This suggests that influenza is now circulating.
- The overall proportion of samples testing positive in hospital and non-sentinel patients **remained stable** in the most recent week to **7.3%.**
- Consultations for influenza-like illness (ILI) with sentinel GPs are at **baseline** intensity levels and increased compared to the previous week. 16 cases of influenza were confirmed from symptomatic sentinel GP network patients across Wales last week.
- The number of confirmed cases of community acquired influenza admitted to hospital increased to **54** in the most recent week (**46** in the previous week) and there were **86** in-patient cases of confirmed influenza, **5** of whom were in critical care compared to **79** and **4** in the previous week.
- In the most recent week (week 45) there were 3 influenza A(H3), 27 influenza A(H1N1), 102 influenza A untyped and 3 influenza B subtypes detected in Wales (Figure 2).

Figure 2: Influenza subtypes based on samples submitted for virological testing by Sentinel GPs and community pharmacies, hospital patients, and non-Sentinel GPs, by week of sample collection, week 45week 45 2025 to week 45week 45 2026 (source: PHW).

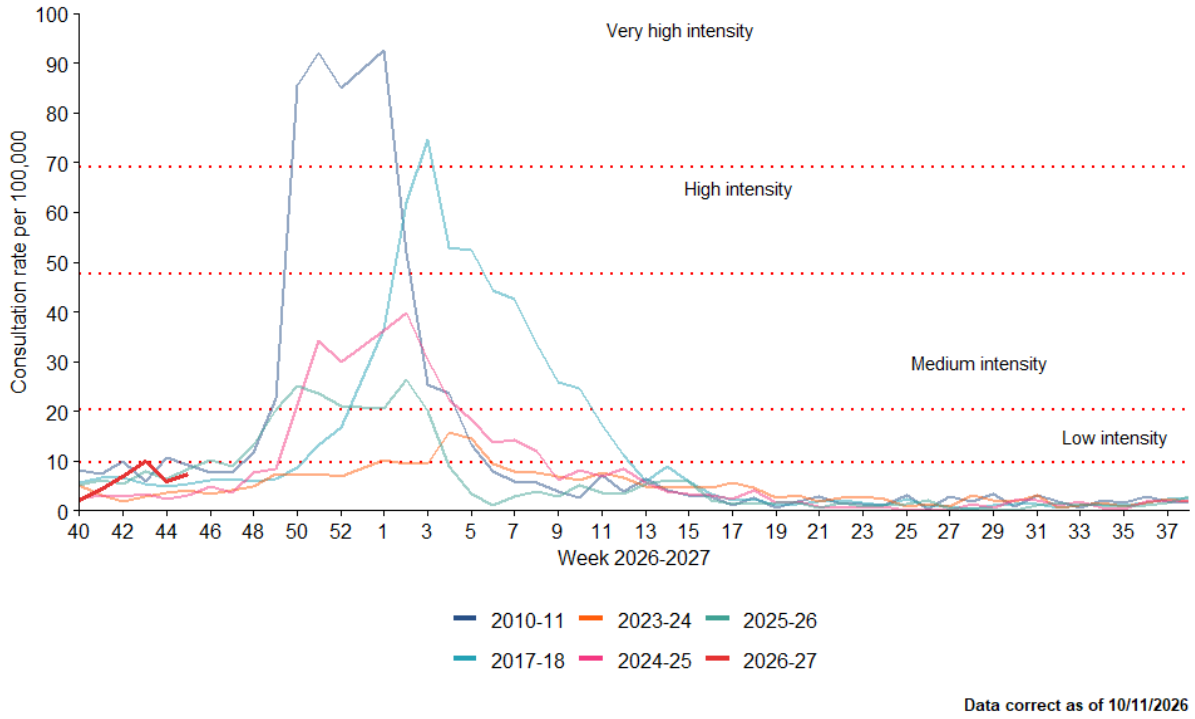


The sentinel GP consultation rate for influenza like illness (ILI) is at baseline and the three-week trend is variable.

There were **7.4** ILI consultations per 100,000 practice population in the most recent week, a **increase** compared to the previous week (6 consultations per 100,000), see Figure 3.

Surveillance indicators for acute respiratory infections in GP consultation data in Wales are **decreasing** in people aged under 5 years.

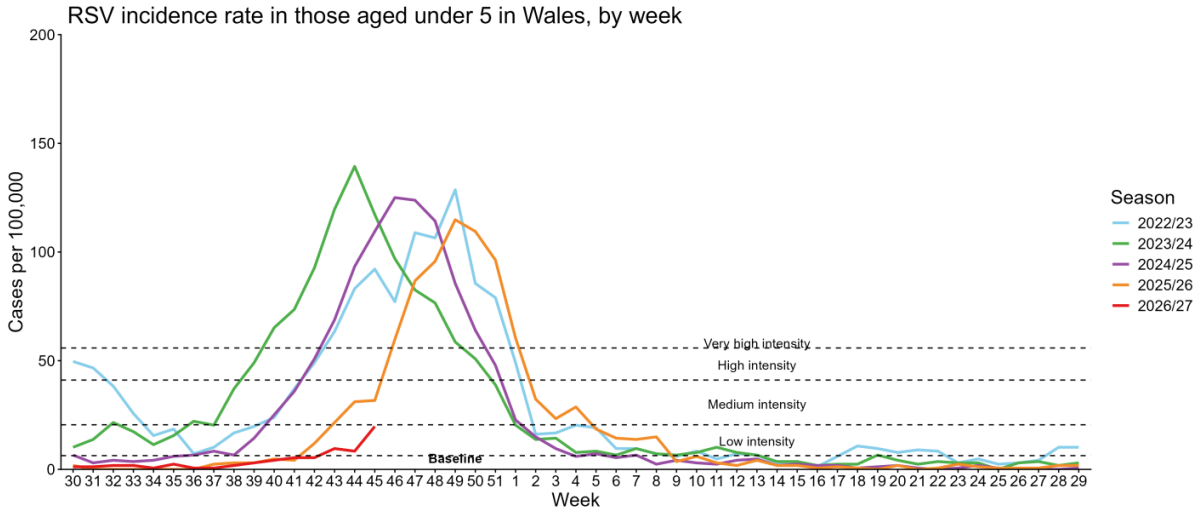
Figure 3: Sentinel GP network clinical consultation rate for ILI per 100,00 practice population (source: PHW).



B.3. Respiratory Syncytial Virus (RSV) Update

- The number of confirmed cases of community acquired RSV admitted to hospital increased to **20** (4 in previous week). There were **13** in-patient cases of confirmed RSV, 1 of whom were in critical care, compared to 5 and 0 in the previous week.
- RSV incidence per 100,000 in children aged up to 5 years is now at **low intensity** levels (19.7 per 100,000), see Figure 4.

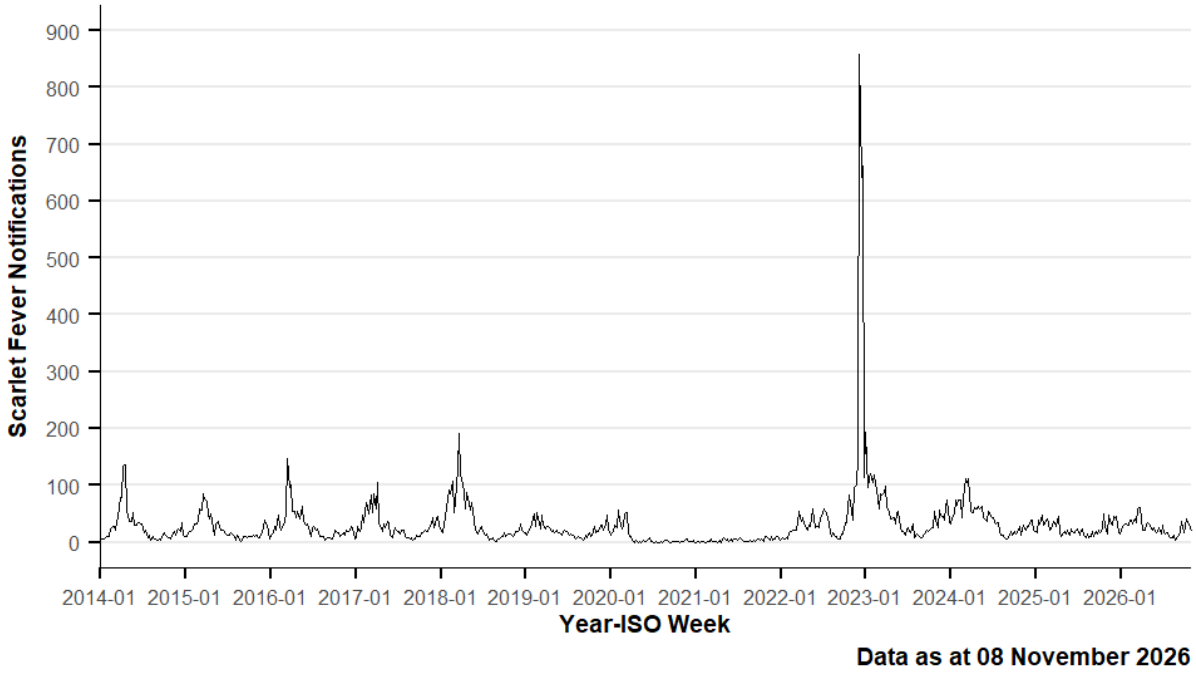
Figure 4: Respiratory Syncytial Virus (RSV) incidence rate per 100,000 population under 5 years, week 30 2022 to week 45 2026 (source: PHW).



B.4 iGAS and Scarlet Fever Update

The number of iGAS notifications are currently low, remaining at seasonally expected levels. Scarlet Fever notifications have **decreased** in the most recent week (week 45, up to 08 November 2026), Figure 5.

Figure 5: Rolling 3-Week average Scarlet Fever notifications, 2014-2026, Wales (source: PHW).



B.5. Additional indicators

- The number of ambulance calls recorded referring to respiratory syndromic indicators **decreased** from 1,495 in the previous week to 1,472 in the latest reporting week (week 45).

- During Week 45, **2** ARI outbreak was reported to the Public Health Wales Health Protection Team. Of these all incidents were COVID-19 and all incidents were in a residential home.

  Thus far this season, According to European Mortality Monitoring (EuroMoMo) methods, no excess has been reported in the weekly number of deaths from all causes in Wales.

C. Science Research Evidence Winter Modelling

C.1 Short Term Projections

The Science Research Evidence (SRE) team at Welsh Government have produced short term projections (STPs) for COVID-19, influenza (flu) and Respiratory Syncytial Virus (RSV) at national and at Local Health Board level. STPs project 2 weeks forward using the most recent data covering the previous 8 weeks, and do not explicitly factor in properties of the infectious disease, policy changes, changes in testing, changes in behaviour, emergence of new variants or rapid changes in vaccinations.

The STPs report the difference between the most recent observed data (7 day rolling sum) and the projected central estimate 2 weeks later. STP computations use admission data from PHW until **08 November 2026** to make short term projections two weeks forward **(to 22 November 2026)**. The dots in the charts represent the most recent observed data points (7 day rolling sum) while the white line is the central estimate from the most recent projection. The colour shadings represent the 95% confidence interval of the projections.

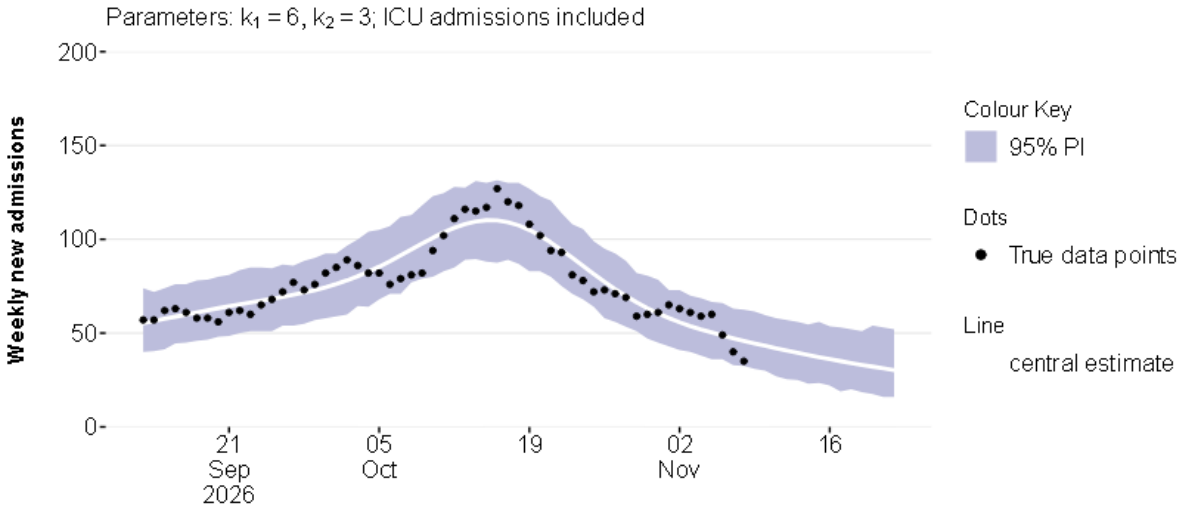
The STPs are produced nationally and at the provider health board level, not at resident health board level. Powys health board is not included in the analysis due to low numbers.

Note: Due to low levels of RSV circulating currently, only modelling for COVID-19 and influenza are presented this week.

C.1.1 COVID-19

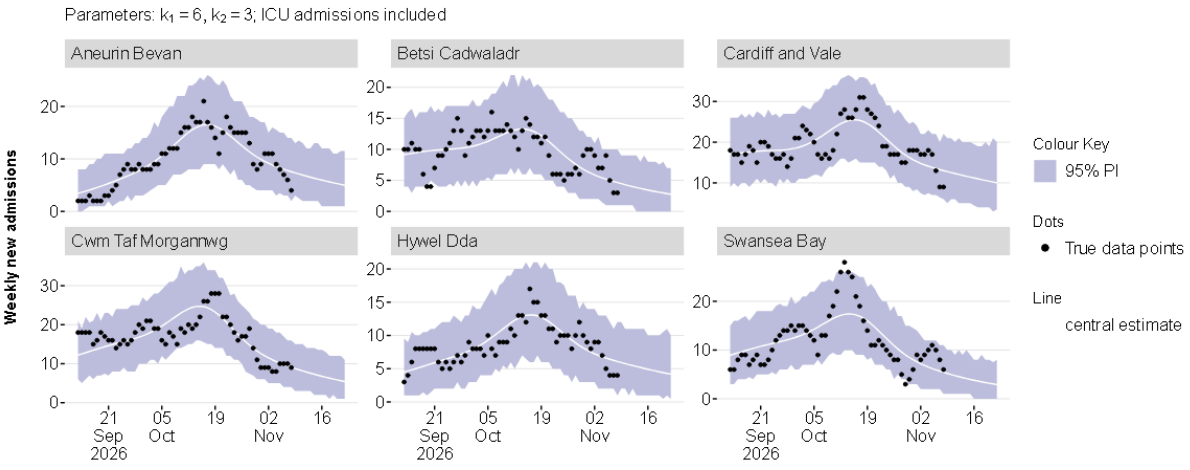
STPs for Wales show that COVID-19 admissions are projected to **remain stable** over the next two-week period (to 22 November 2026), Figure 6.

Figure 6: Short term projections for COVID-19 hospital admissions in Wales (data to 08 November 2026, projection to 22 November 2026).



COVID-19 admissions are projected to **increase** in Aneurin Bevan and Cardiff and Vale, **decrease** in Cwm Taf Morgannwg and Swansea Bay, whereas Betsi Cadwaladr and Hywel Dda show **no clear change** in COVID-19 admission projections over the next two weeks (to 22 November 2026), Figure 7.

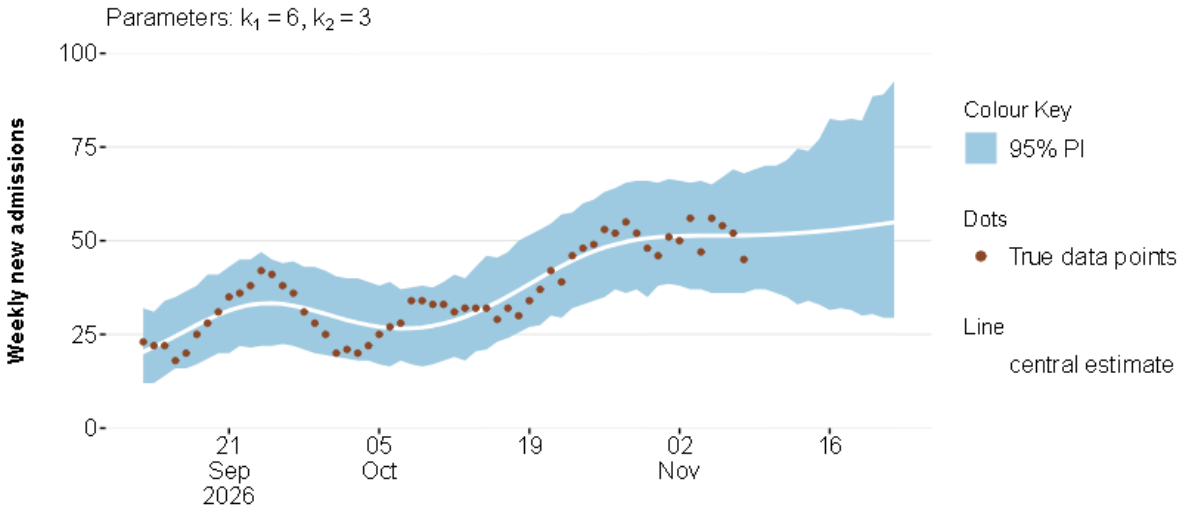
Figure 7: Short term projections for COVID-19 hospital admissions in Wales Health Boards (data to 08 November 2026, projection to 22 November 2026).



C.1.2 Influenza (flu)

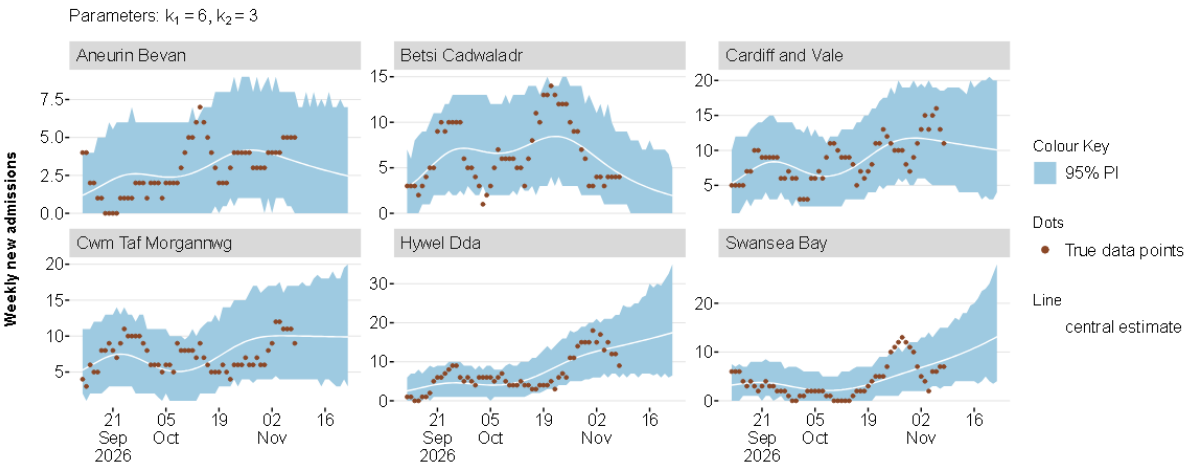
STPs for Wales show that influenza admissions are projected to **remain stable** over the next two-week period (to 22 November 2026), Figure 8.

Figure 8: Short term projections for influenza (flu) hospital admissions in Wales (data to 08 November 2026, projection to 22 November 2026).



Influenza admissions are projected to **increase** in Cwm Taf Morgannwg, Hywel Dda and Swansea Bay and **decrease** in Aneurin Bevan, Betsi Cadwaladr and Cardiff and Vale over the next two-week period (to 22 November 2026), Figure 9.

Figure 9: Short term projections for influenza (flu) hospital admissions in Wales Local Health Boards (data to **08 November 2026**, projection to **22 November 2026)**.



C.2 Winter Modelling 2026/27

The Science, Research and Evidence (SRE) team in Welsh Government have published modelled scenarios for COVID-19, influenza and Respiratory Syncytial Virus (RSV) for Winter 2026/27.

This uses analysis of historical data to estimate what we may see in winter 2026/2027 in terms of hospital admissions and hospital bed occupancy in Wales, contributing to winter planning for NHS Wales.

The figures that follow (Figures 10-11) show an estimate of hospital admissions occurring so far in winter 2026/2027 using actual data and are compared to our 2026/2027 winter modelling scenarios (see the technical notes at this section for details on how the 'actuals' were estimated).

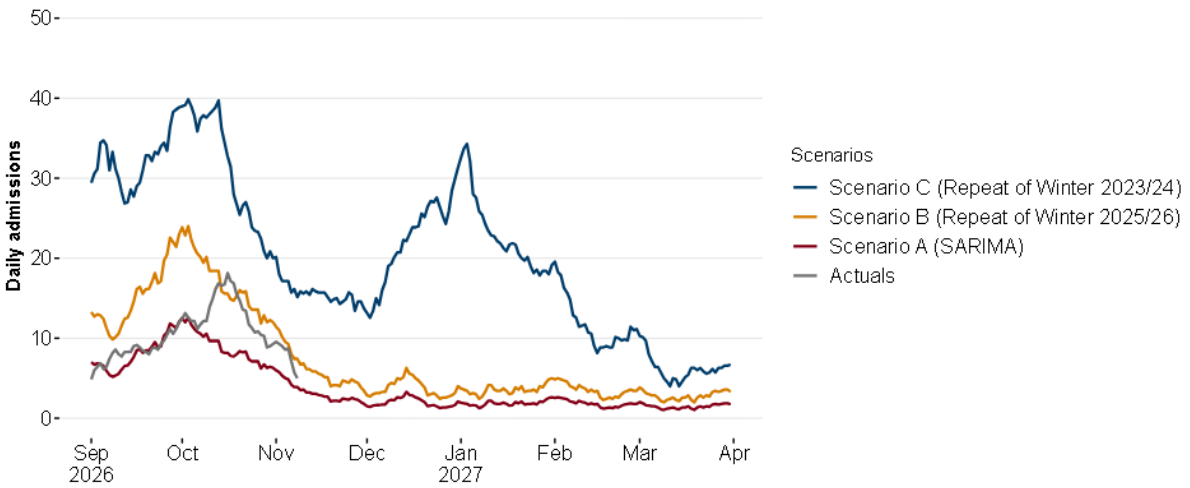
Modelling is an estimate of what may happen, not a prediction of what will happen.

Note: Due to low levels of RSV circulating currently, only modelling for COVID-19 and influenza are presented this week.

C.2.1 COVID-19

COVID-19 actuals are currently decreasing and track between Scenario A and Scenario B, Figure 10.

Figure 10: Daily COVID-19 Winter 2026/2027 admissions scenarios, modelling to 31 March 2027 (actuals data until 08 November 2026).

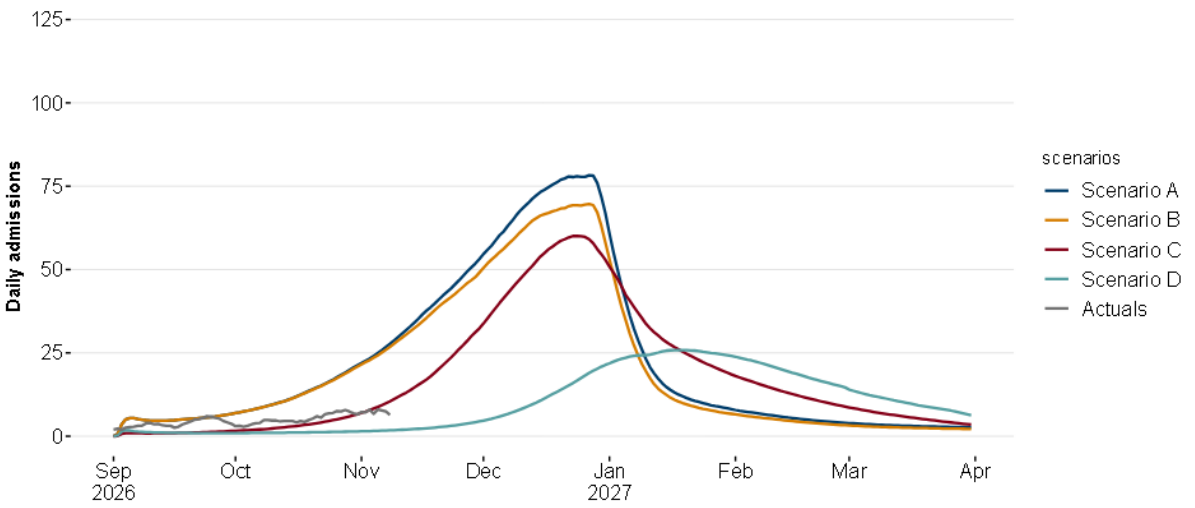


Source: Raw data to 31 March 2026 provided by DHCW, projected scenarios from 01 September 2026 to 31 March 2027 from SRE, actuals data until 08 November 2026 from PHW.

C.2.2 Influenza (flu)

Influenza actuals are tracking closely with Scenario C, Figure 11.

Figure 11: Daily influenza Winter 2026/2027 admissions scenarios, modelling to 31 March 2026 (actuals data until 08 November 2026).



Source: Raw data to 31 March 2026 provided by DHCW, projected scenarios from 01 September 2026 to 31 March 2027 from SRE, actuals data until 08 November 2026 from PHW.

C.2.2 Technical Notes

The winter modelling used hospital admissions data from the Patient Episode Data for Wales (PEDW) dataset provided by Digital Health and Care Wales (DHCW). However, due to a lag in clinical coding and receiving PEDW data from DHCW, the ICNET admissions data provided by Public Health Wales (PHW) were used for the actuals. The data sources differ for a few reasons: the influenza and RSV data from PHW includes lab-confirmed results only and includes inpatients only. The PEDW data from DHCW is based on International Classification of Diseases version 10 (ICD-10) codes.

Modelling Scenario Details:

COVID-19

- Data includes ICD-10 codes U07.1, U07.2, U09.9 and U10.9. Two scenarios repeat recent year's data from Digital Health and Care Wales, and one is calculated by applying a statistical technique.

Table 1: Descriptions for COVID-19 admission scenarios.

Scenario name	Scenario	Description
Scenario A (SARIMA)	SARIMA	Model fit to SARIMA modelling.
Scenario B (Repeat of Winter 2025/26)	Repeat of Winter 2025 to 2026	Model fit to 2025 to 2026 winter season.
Scenario C (Repeat of Winter 2023/24)	Repeat of Winter 2023 to 2024	Model fit to 2023 to 2024 winter season.

Influenza (flu)

- Data includes ICD-10 codes: J09.X, J10.0-J10.2, J10.0, J11.8, J11.1 and J11.2.

Table 2: Descriptions for influenza admission scenarios.

Scenario name	Scenario	Description
Scenario A	Repeat of 2022 to 2023 data, low vaccine coverage	2022 to 2023 winter season (when both H1N1 and H3N2 were dominant) with low vaccine uptake assumptions (20% lower than observed uptake).
Scenario B	Repeat of 2022 to 2023 data, baseline vaccine coverage	2022 to 2023 winter season (when both H1N1 and H3N2 were dominant) with baseline vaccine uptake assumptions (observed vaccine uptake).
Scenario C	Repeat of 2024 to 2025 data, baseline vaccine coverage	2024 to 2025 winter season (when H1N1 was dominant) with baseline vaccine uptake assumptions (observed vaccine uptake).
Scenario D	Repeat of 2023 to 2024 data, high vaccine coverage	2023 to 2024 winter season (when H1N1 was dominant) with high vaccine uptake assumptions (20% higher than observed vaccine uptake).

Respiratory Syncytial Virus (RSV)

- Data includes ICD-10 codes: J12.1, J20.5, J21.0 and B97.4.

Table 3: Descriptions for Respiratory Syncytial Virus (RSV) admission scenarios.

Scenario name	Scenario	Description
Scenario A (Low coverage)	Low vaccine coverage	Model fit to data between 1 April 2023 and 31 March 2026. Vaccine uptake rate assumed to be 20% lower than baseline vaccine coverage.
Scenario B (Baseline coverage)	Baseline vaccine coverage	Model fit to data between 1 April 2023 and 31 March 2026. Baseline vaccine coverage assumes a repeat of from the uptake rates during 2025/26.
Scenario C (High coverage)	High vaccine coverage	Model fit to data between 1 April 2023 and 31 March 2026. Vaccine uptake rate assumed to be 20% higher than baseline vaccine coverage.

D. Communicable Disease Situation Update (non-respiratory)

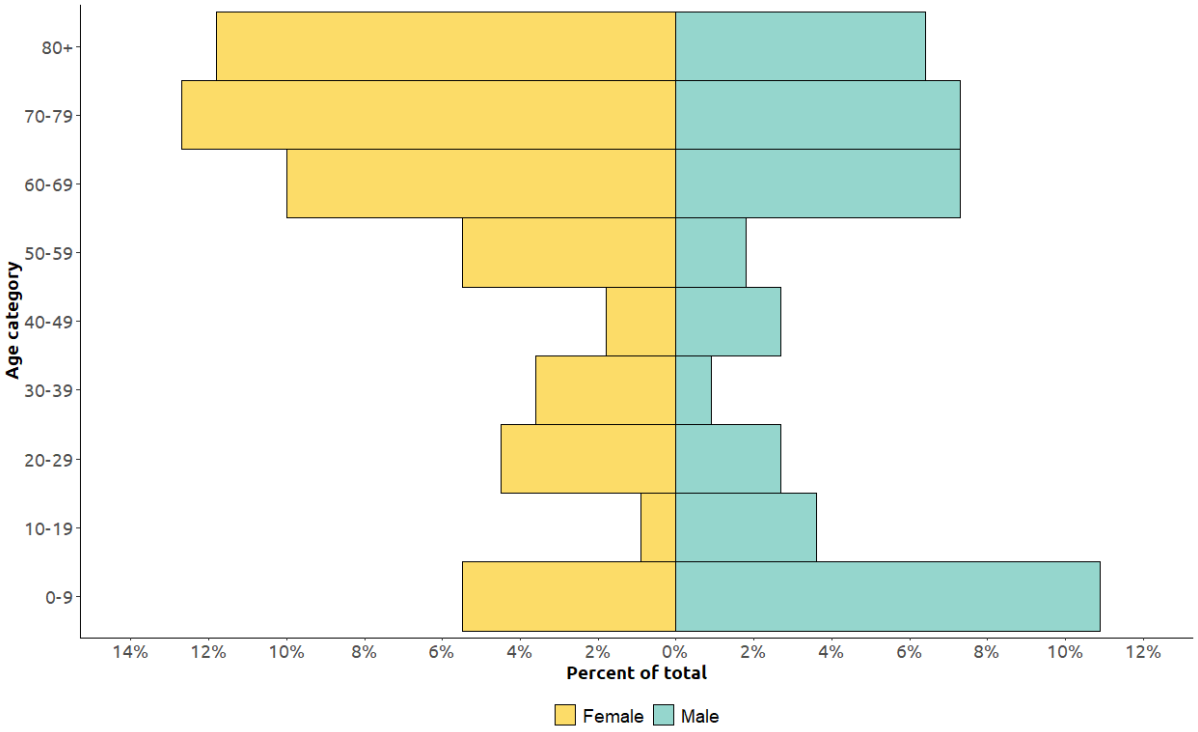
D.1. Norovirus Update

In the current reporting week (week 45 2026), a total of **9** Norovirus cases were reported in Welsh residents. This is a decrease (-25.0%) in reported cases compared to the previous reporting week (week 44 2026), when **12** Norovirus cases were reported.

In the last 12-week period (17/08/2026 to 08/11/2026) a total of **110** Norovirus cases were reported in Welsh residents. This is a decrease (-37.1%) in reported cases compared to the same 12-week period in the previous year (17/08/2025 to 08/11/2025) when **175** Norovirus cases were reported.

In the last 12 weeks (17/08/2026 to 08/11/2026) **62 (56.4%)** Norovirus cases were female and **48** (**43.6%**) cases were male. The age groups with the most cases were the **70-79 (22** cases) and **80+ (20 cases)** age groups (Figure 12).

Figure 12: Age and sex distribution of confirmed Norovirus cases in the last 12 weeks (17 August 2026 to 08 November 2026).



Notes: This data from PHW only includes locally-confirmed PCR positive cases of Norovirus in Wales within the 12-week period up until the end of the current reporting week (week 45, up to 08/11/2026). Under-ascertainment is a recognized challenge in norovirus surveillance with sampling, testing and reporting known to vary by health board. In addition, only a small proportion of community cases are confirmed microbiologically.

E. UK and International Surveillance Update

E.1. UKHSA Influenza update (8 October)

UKHSA report that early signs suggest that the flu season may be starting earlier this year. Flu activity throughout September has been higher than in the same period over the past 4 winters. While levels remain at baseline, the upward trend - if it continues in the coming weeks - suggests an early flu season. The rise so far has been driven largely by cases in the 18- to 24-year-old age group.

So far this season, there's a mix of 2 flu A subtypes, H1N1 and H3N2, circulating in England. The flu vaccine is designed to protect against all 3 main types of flu: influenza A(H1N1), A(H3N2) and influenza B.

Flu viruses are constantly changing through a natural process called antigenic drift. Each year, the World Health Organization monitors circulating strains globally and selects which ones should be targeted by that season's vaccine, but this decision has to be made months in advance, to give manufacturers time to produce enough doses. Sometimes the virus continues to change after that point, resulting in it no longer matching the vaccine strain as closely as originally predicted.

This year, it's the A(H1N1) subtype that has drifted from the strain used in the vaccine. It's still too early in the season to know for certain whether this drifted H1N1 will circulate widely in the UK, or how it will affect vaccine effectiveness. Last winter, a drifted strain of H3N2, known as subclade K, emerged after the vaccine composition for the Northern Hemisphere had already been finalised. Despite this, the vaccine was effective and even with an earlier start to the flu season, overall levels of activity and mortality were lower than the previous year.

E.2. UKHSA COVID-19 Variant update (8 October)

XFG - sometimes referred to in the media as the Stratus variant - remains the most common current COVID-19 variant. XFG has also been referred to as ‘American Covid’ in some media coverage, though it is not new and has been circulating in the UK and other countries for around a year. The name reflects where the strain was first sequenced and detected, rather than necessarily where it originated.

UK Health Security Agency (UKHSA) data shows that COVID-19 positive test rates rose to around 7% in September, with hospital admission rates increasing by approximately 50% over the same period. These increases have been observed consistently across England, Scotland, Wales and Northern Ireland, as well as across Europe and the United States, indicating this is not a localised trend.

Current data does not indicate that these variants lead to more severe illness than other variants in circulation. UKHSA monitors a range of surveillance systems, including GP appointments, A&E attendances and hospitalisations, alongside genomic sequencing, to track how variants are behaving. As increases in hospitalisations are rising in line with

overall increases in COVID-19 circulation - rather than rising sharply on their own - this suggests a general increase in COVID-19 activity rather than a variant causing more severe disease.

There are likely to be several factors behind the current rise. As we move into winter, colder and wetter weather means people spend more time indoors, which enables the spread of respiratory viruses. It has also been roughly a year since the last significant COVID-19 wave, so immunity from vaccination and previous infection may be waning in parts of the population, making people more susceptible.

There have been previous detections of BA.3.2, a highly divergent descendant of the Omicron BA.3 lineage that re-emerged in South Africa in late 2024. It has since been sporadically detected across multiple continents. BA.3.2 is sometimes called the 'Cicada' variant. The World Health Organization (WHO) has designated BA.3.2 a Variant Under Monitoring (VUM). WHO currently assesses the public health risk as low, as there is no evidence of increased severity, hospitalisation, or mortality, although available evidence remains limited.

E.3. Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 (11 November)

- As of 11 November 2026, the Democratic Republic of the Congo (DRC), where community transmission is ongoing, has reported a total of 11 114 confirmed cases, including 5 433 related deaths (from data up until 10 November). Since the beginning of the outbreak, eight provinces have been affected: Ituri, Nord-Kivu, Sud-Kivu, Tshopo, Haut-Uélé, Bas-Uélé, Sud Ubangi and Nord Ubangi.
- In Nigeria, one Ebola case was reported on 20 October 2026. The person has since been medically evacuated to Switzerland. The individual, who had travel history to Uganda, developed symptoms on 7 October, sought medical care on 11 October, and tested positive on 20 October. A total of 62 contacts of the case have been identified.
- In Kenya, a total of nine confirmed cases, including two deaths, have been reported, all linked to the first case. The last case was reported on 20 October 2026 and the second death was reported on 23 October 2026. As of 11 November, seven cases had recovered and all identified contacts under monitoring completed 21 days of quarantine.
- ECDC is monitoring the outbreak through its epidemic intelligence activities and actively liaising with partners to support the response.
- Since 26 October, three ECDC experts have been deployed to Nigeria to provide advice and technical support to the EU Delegation in Abuja. Support has also been offered to the Nigerian authorities in surveillance, contact tracing, IPC and preparedness and response.

E.4. Seasonal surveillance of West Nile Virus infections – 2026 (12 November)

In 2026, and as at 4 November, 15 countries in the EU/EEA have reported 1 883 locally acquired [1] human cases of West Nile virus (WNV) infection. The earliest and latest dates of symptom onset among human cases were 22 May in Italy and 18 October in Spain, respectively. Locally acquired cases have been reported by Italy (783 cases), Greece (469 cases, of which 4 had an unknown place of infection), France (191 cases), Spain (149 cases), Romania (125 cases), the Netherlands (76 cases, of which 3 had an unknown place of infection), Croatia (22 cases), Cyprus (21 cases), Belgium (15 cases), Austria (8 cases), Bulgaria (8 cases), Germany (7 cases), Hungary (5 cases), Slovenia (3 cases) and Slovakia (1 case). A total of 148 deaths have been reported by Italy (60 deaths), Greece (53 deaths), the Netherlands (10 deaths), Romania (9 deaths), Spain (7 deaths), France (4 deaths), Belgium (2 deaths), Bulgaria (1 death), Croatia (1 death) and Hungary (1 death).

The number of human cases reported in the EU/EEA so far this year (1 883 cases) is higher than the average number reported during the same period over the past decade (698 cases), and is the highest number of WNV infections in humans ever reported in the EU/EEA.

As at 4 November 2026, locally acquired human cases have been reported in 211 NUTS 3 regions across 15 EU/EEA countries, making this the most geographically widespread WNV season on record.

As in previous years, most cases were reported among males 65 years old and above. Overall, 76% of cases were hospitalised and 56% presented with neurological symptoms, compared with 10-year averages of 84% and 62%, respectively. The case fatality ratio was approximately 8%, below the 10-year average of 10%. These findings are within expected levels and do not indicate increased disease severity compared with previous years. Country-specific case fatality ratios are affected by the sensitivity of the surveillance system, including blood donor screening practices; therefore, direct comparisons between countries should be made with caution.

E.5. Avian influenza A(H5N1) human cases – United States (9 November

On 6 November 2026, the United States' Centers for Disease Control and Prevention (US CDC) reported that the two most recent cases of avian influenza A(H5) (second and third cases) in Yakima County, Washington State, US, reported on 1 November 2026 were workers in commercial diary cattle farms.

The second case, who died, had onset of symptoms in week 42 and had confirmed A(H5N1) infection. The third case experienced conjunctivitis, was tested in week 43 with positive A(H5) infection and mild symptoms. Further laboratory investigation is ongoing.

The second case developed respiratory symptoms during week 42 (ending 24 October 2026) and presented to an emergency department the following week. The patient was hospitalised and subsequently died. A respiratory specimen tested positive for influenza A and presumptively positive for A(H5) at the University of Washington. A(H5) infection was subsequently confirmed by the Washington State Public Health Laboratory using the CDC influenza A(H5) assay. Further testing by the University of Washington identified the virus as avian influenza A(H5N1).

The third case developed conjunctivitis and sought medical care. Specimens collected from the case were tested during week 43 (ending 31 October 2026) at the state public health laboratory using the CDC influenza A(H5) assay and were confirmed positive for influenza A(H5). The specimen was sent to CDC for further testing.

Sequencing analysis

The sequences of strains from the first and second case, A/Washington/198/2026 and A/Washington/UW-110701/2026, with collection dates 12 and 29 of October 2026 respectively, has become available on GISAID EpiFlu. Phylogenetically, the viruses fell within clade 2.3.4.4b in the sub-branch of genotype B3.13 viruses from United States and included isolates from humans, birds and cows. The two strains resembled closely but with a distinct genetic distance from their closest related strain. Commonly for B3.13, the 631L mutation in PB2 was present which is associated with increased activity of the viral polymerases in mammalian hosts. Of note, A/Washington/UW-110701/2026 has acquired 115I in M1 of unclear phenotype for A(H5) viruses that has previously only been observed in strains of clade 2.3.2.1e from Asia. There are no indications of reassortments between the different clades.

E.6. Seasonal surveillance of chikungunya virus disease (6 November)

Since last week's update, France has reported three new locally acquired chikungunya virus disease cases, bringing the total to 207 cases. These cases are distributed across 30 clusters, with one new cluster identified in the Drôme department. Sixteen clusters are currently active, including the largest clusters in Prayssac (36 cases), Lot department, and Cavalaire-Sur-Mer (32 cases), in Var department, and four clusters have been closed since last week.

No new locally acquired chikungunya virus disease cases have been reported by Italy since last week's update. To date, Italy has reported one locally acquired chikungunya virus disease case in Rome. The associated cluster is closed.

In addition, on 4 November, Swiss authorities and the media reported that four locally acquired cases of chikungunya in the Piana di Magadino area of Ticino, Switzerland had been confirmed. These are the first locally acquired chikungunya cases ever reported in the country.

Chikungunya is a mosquito-borne viral disease that is emerging in Europe, with locally acquired cases reported in several EU/EEA countries. In the light of this development, ECDC has implemented seasonal enhanced surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures. Chikungunya virus disease is a notifiable disease at the EU level and cases are reported in accordance with the EU case definition. Chikungunya virus disease cases – and their corresponding case numbers – have been reported to the European surveillance portal for infectious diseases (EpiPulse Cases). Please note that cases acquired in Portuguese and Spanish Outermost Regions are included. However, due to the distinct epidemiological situation and differences in surveillance systems, cases acquired in the French Outermost Regions are not included.

E.7. Seasonal surveillance of dengue in the EU/EEA (6 November)

Since the beginning of 2026 and as at 4 November 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (76 cases) and France (8 cases).

Since last week's update, Italy has reported three new locally acquired dengue cases. The cumulative number of locally acquired cases in Italy is 76, distributed across seven clusters. No new clusters have been identified this week. Six of the clusters are currently active, and the cluster 'Garbagnate Milanese' in Milano region is now closed.

One new locally acquired case has been reported by France since last week's update. The cumulative number of locally acquired cases in France is eight, distributed across five clusters, one of which is active, in the municipality of La Farlède, Var department.

Dengue is a mosquito-borne viral disease that is increasingly emerging in Europe, with locally acquired cases reported in several EU/EEA countries. In light of this development, ECDC has implemented seasonal enhanced weekly surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures. This includes assessing the risk of dengue transmission through substances of human origin (SoHO).

Dengue is a notifiable disease at the EU level and cases are reported in accordance with the EU case definition. Dengue cases – and their corresponding case numbers – are reported to the European surveillance portal for infectious diseases (EpiPulse Cases).