Position Statement

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Zika virus

Background

Zika virus (ZIKV) is a member of the *flaviviridae* family and is transmitted to humans through the bite of an infected mosquito. It is related to other pathogenic vector-borne flaviviruses including dengue, West Nile and Japanese Encephalitis viruses. *Aedes aegypti* is the predominant vector for ZIKV transmission; however, other *Aedes* species, including *Aedes albopictus*, can also transmit ZIKV.

The UK risk is primarily through imported infections in returning travellers.

Epidemiology, pathogenesis, infection dynamics and clinical characteristics relevant to SoHO safety

Zika virus is found primarily in tropical and subtropical regions where *Aedes* mosquitoes (especially *Aedes aegypti*) are present. Historically, the virus circulated in Africa and Asia, but since 2007 it has spread widely through the Pacific Islands and the Americas, with case numbers peaking during the widespread epidemic across Central and South America in 2015–2016. Following this epidemic, the global incidence of Zika virus disease declined markedly from 2017 onwards and has remained at relatively low levels. Globally, the World Health Organization (WHO) Americas region reports the highest number of cases annually, followed by Southeast Asia.

The main route of ZIKV infection is through the bite of an infected mosquito. However, there is evidence that Zika virus can also be transmitted to humans through blood transfusion, sexual contact and perinatally; virus has been found in blood, urine and saliva during the acute phase and in seminal fluid after the acute phase. Most cases of sexual transmission have been from male to female.

ZIKV disease is a self-limiting febrile illness. There is a short incubation period (3 to 14 days) and symptoms are usually mild, lasting for 2 to 7 days. Infection may go unrecognised or be misdiagnosed as dengue, chikungunya or other viral infections giving rise to fever and rash. Asymptomatic infections are common and only 20–25% of infected individuals develop symptoms, commonly low-grade fever, transient arthritis or arthralgia with possible joint swelling (mainly in the smaller joints of the hands and feet), maculopapular rash (often spreading from the face to the body), conjunctivitis and several non-specific symptoms such as myalgia, asthenia and headaches.

In 2016, a WHO statement noted the scientific consensus that ZIKV infection caused microcephaly and Guillain-Barré syndrome. Foetal infection can occur following infection during pregnancy, leading to miscarriage, stillbirth or congenital Zika syndrome (severe microcephaly, brain and eye damage).

Transfusion transmissibility

Transfusion-transmission of ZIKV has been documented during outbreaks, with 3 cases reported in Brazil and evidence of asymptomatic viraemic blood donors in affected regions. No further cases have been published since the 2015–2016 epidemic. Declining global incidence, a short viraemia, and travel-related donor deferral policies reduce the likelihood of asymptomatic viraemic donations entering the blood supply. In addition, a competent vector is not established in the UK.

Local transmission in Europe

In the EU/EEA, travel-associated ZIKV infections peaked in 2016 and have since fallen markedly. The only confirmed cluster of mosquito-borne autochthonous transmission in Europe occurred in southern France in 2019, with no further locally acquired cases reported. Between 2020 and 2024, 174 travel-associated cases were recorded, with around 50% linked to travel in Thailand.

UK epidemiology (travellers)

In the UK, ZIKV risk is largely limited to travel-associated infections, with no evidence of local mosquito-borne transmission. Reported cases peaked at 283 in 2016, including one probable sexually transmitted infection, before declining substantially. Since 2018, annual case numbers have remained below 10, with the exception of 16 cases reported in 2024. Southern Asia is the most reported region of infection among affected UK travellers.

Risk mitigation

Current UK donor measures

Visitors to affected areas are excluded from donation for 4 weeks under the current mosquito-borne viruses Donor Selection Guidelines. Visitors to these areas who have been infected with ZIKV, or who have had symptoms suggestive of ZIKV infection, should not donate blood or tissues for 4 months from their return to the UK.

Surveillance by the Standing Advisory Committee on Transfusion Transmitted Infection (SACTTI) identifies new affected areas which may require revisions to the Geographical Disease Risk Index (GDRI). Countries affected by ZIKV are shown in the GDRI and any associated Change Notifications.

Testing and inactivation

NAT assays for ZIKV exist and have been used for donor screening in outbreak settings elsewhere, but routine UK implementation would require clear incremental benefit over travel deferral.

Commonly used virus inactivation processes used during the production of plasma-derived products are effective for the inactivation of ZIKV. Various pathogen reduction technologies have demonstrated ZIKV inactivation.

Vaccination

There are currently no licensed vaccines available for ZIKV.

Immunity following natural infection is seen and appears to be long-lasting.

Other relevant information

Tissues and organs

ZIKV infection is relevant to tissues and organs as transmission is possible but not yet documented. Tissue donation follows the same principles as for blood donation. Existing UK transplantation guidance for haematopoietic cells and organs supports deferral, testing for viral RNA in blood and individual risk assessment.

Conclusion and recommendations

With current donor selection measures, the residual risk to UK blood safety is considered very low and the available evidence supports no change to UK SoHO measures, beyond maintaining the existing travel-associated donor deferral (28 days if well; longer deferral with illness/diagnosis suggestive of ZIKV disease).

SACTTI surveillance will continue to monitor for transfusion-transmission in comparable settings, substantive changes in UK traveller epidemiology, or sustained local transmission in Europe and the UK with demonstrated impact on donor risk, which may require a review of this position prior to the routine planned review in 2029.

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