

WEEKLY BULLETIN

Communicable disease threats report

Week 29, 12–18 July 2025

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Executive summary

Seasonal surveillance of dengue – 2025

- This is the first report of the weekly seasonal surveillance of dengue infections in 2025.
- Three countries in Europe have reported cases of dengue: France, Italy, and Portugal (in the outermost region Madeira).

Seasonal surveillance of chikungunya virus disease – 2025

- In 2025, to date France has reported 30 locally acquired cases of chikungunya virus disease in 12 local administrative units.
- In 2025, to date Italy has reported one locally acquired case of chikungunya virus disease.

Serious adverse events to IXCHIQ chikungunya virus disease vaccine

In a [news item](#) published on 7 May 2025, the European Medicines Agency (EMA) informed of 17 serious adverse events (SAEs) that had been reported worldwide in people aged between 62 and 89 years who had received the live attenuated chikungunya vaccine IxchIQ, including two cases resulting in death. This corresponds to an increase of two cases from the previous information published by EMA as of 30 April 2025.

EMA also reported in a [news item](#) on 7 May 2025 that the agency's Pharmacovigilance Risk Assessment Committee (PRAC) had started a review of the Ixchiq vaccine, following the reports of SAEs in older people. EMA reported that many of the people affected also had other illnesses, and that the exact cause of these adverse events and their relationship with the vaccine have not yet been determined. PRAC is temporarily recommending restricting the use of the vaccine. As a temporary measure while an in-depth review is ongoing, Ixchiq must not be used in adults aged 65 years and above.

On 11 July 2025, EMA's Pharmacovigilance Risk Assessment Committee (PRAC) concluded its [review](#) of the live-attenuated chikungunya vaccine Ixchiq. The temporary age restriction for adults aged 65 and older has been lifted because this is the age group in which chikungunya can be severe. However, PRAC strongly emphasises that **Ixchiq should only be used when there is a significant risk of chikungunya infection and after a careful benefit-risk evaluation** in all age groups.

Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025

- Since the beginning of 2025, and as of 16 July 2025, two countries in Europe have reported cases of Crimean-Congo haemorrhagic fever (CCHF): Greece (2) and Spain (2).
- The second case reported by Greece is a healthcare professional who provided care to the primary case.

Weekly seasonal surveillance of West Nile virus infection – 2025

- Since the beginning of 2025, and as of 16 July 2025, three countries in Europe have reported human cases of West Nile virus infection: **Greece, Italy** and **Romania**.

Overview of respiratory virus epidemiology in the EU/EEA

- Rates of consultations and hospitalisations for respiratory infections are at expected levels for the summer, although in recent weeks increases on indicators of SARS-CoV-2 circulation have been observed in many countries. Influenza and RSV activity is low in all reporting countries.
- Due to the currently limited number of countries reporting data and the low number of tests performed, a complete interpretation of the epidemiological situation across the EU/EEA is difficult.

Influenza A(H5N1) – Multi-country (World) – Monitoring human cases

- On 1 July 2025, one human case with avian influenza A(H5N1) infection was reported in a child in Chittagong district, Bangladesh.
- Exposure to backyard poultry has been reported for the case.
- No new cases have been detected among contacts of the reported patients.
- The investigations did not reveal instances of human-to-human transmission around this case.
- ECDC's risk assessment for A(H5N1) remains unchanged.
- Since 2003, and as of 9 June 2025, there have been 986 human cases of A(H5N1) worldwide, including 471 deaths.

Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025

- Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries, with the epidemiological trends remaining largely unchanged.
- On the African continent, most mpox clade I cases have been reported by the Democratic Republic of the Congo (DRC), Uganda and Burundi. Trends are levelling off or decreasing in DRC and Uganda, although this should be interpreted with caution, and a clear decline continues to be observed in Burundi.
- Sporadic mpox clade I cases have also been reported outside of the African continent during the past month. Investigations on recently reported cases continue however so far, there is no indication of wider community transmission in any country outside Africa.
- The classification of transmission patterns has been updated as of 18 July 2025 (details are provided in the overview).
- Mpox clade IIa and IIb cases continue to be reported in Africa. Increases have been reported the past month in Liberia and Guinea with a stable trend at lower levels compared to the peak in May reported in Sierra Leone.
- ECDC is closely monitoring and assessing the epidemiological situation, and additional related information can be found in the Centre's rapid risk assessment published on 16 August 2024 ('[Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#)') and its '[Rapid scientific advice on public health measures](#)'.

Nipah virus disease – India – 2025

- On 16 July 2025, Indian health authorities reported an additional Nipah virus (NiV) disease case in the district of Palakkad, in the state of Kerala. The case is a close contact of a previously reported case.
- In 2025, Kerala state has reported a total of four NiV disease cases, in Malappuram (2) and Palakkad (3) districts, including two deaths.
- The likelihood of exposure and infection with NiV for EU/EEA citizens travelling to or residing in India is currently very low, given the low number of infections in areas in which cases have been identified to date.

Mass gathering monitoring - UEFA Women's EURO 2025 - Switzerland - 2025

- On 15 July, media reports quoting the Swiss Football Federation (SFV) reported that some players on the Swiss national team had experienced influenza-like symptoms.
- Respiratory diseases including COVID-19, food and waterborne diseases, tick-borne and sexually transmitted diseases are among the potential health threats for those attending.
- The probability of exposure to any of these infections for EU/EEA citizens during the UEFA Women's EURO 2025 is considered very low to low, with an estimated low impact. The impact would be higher for people with underlying conditions, older individuals, and pregnant women.

1. Seasonal surveillance of dengue – 2025

Overview:

This is the first report of the weekly seasonal surveillance of dengue infections in 2025.

Since the beginning of 2025 and as of 16 July 2025, three countries in Europe have reported cases of dengue: **Italy** (1), **Portugal** (2), and **France** (1).

This week, France and Italy reported their first locally-acquired dengue cases of 2025, from the Loire department and the province of Bologna, respectively. This is the first time that locally-acquired dengue cases have been reported from these regions.

The two cases reported in January in Madeira, an outermost region† of Portugal, were likely transmitted in 2024.

† This report covers mainland EU/EEA, as well as outermost regions of Portugal and Spain.

ECDC assessment:

Please find the current [dengue risk assessment](#) for mainland EU/EEA on ECDC's dedicated [dengue webpage](#).

2. Seasonal surveillance of chikungunya virus disease – 2025

Overview:

Since the beginning of 2025 and as of 16 July 2025, two countries in Europe have reported cases of chikungunya virus disease: **Italy** (1) and **France** (30).

To date, in 2025, public health authorities in France have reported 30 cases of locally acquired chikungunya virus disease in 12 different local administrative units. All clusters except one are currently classified as active. The largest cluster consists of 13 cases and is located in Salon-de-Provence, Bouches-du-Rhône department. This year, authorities reported the first locally acquired chikungunya virus disease cases from the Gironde department and the Bas-Rhin department. The other departments have reported locally acquired chikungunya virus disease or dengue cases in previous years.

This week, Italy reported its first locally acquired chikungunya virus disease case since 2017, in the province of Piacenza.

For more information on locally acquired chikungunya virus disease cases, see ECDC's [seasonal surveillance report for chikungunya virus disease](#).

ECDC assessment:

Please find the current [chikungunya virus disease risk assessment](#) for mainland EU/EEA on ECDC's dedicated [chikungunya webpage](#).

Last time this event was included in the Weekly CDTR: 11 July 2025

3. Serious adverse events to IXCHIQ chikungunya virus disease vaccine

Overview:

Updated guidance on the chikungunya vaccine (IxchIQ):

In its July 7–10 meeting, EMA's Pharmacovigilance Risk Assessment Committee (PRAC) concluded its [review](#) of the live-attenuated chikungunya vaccine IxchIQ. The temporary age restriction for adults aged 65 and older has been lifted because this is the age group in which chikungunya can be severe. However, PRAC strongly emphasises that **IxchIQ should only be used when there is a significant risk of chikungunya infection and after a careful benefit-risk evaluation** in all age groups. Healthcare professionals are reminded that IxchIQ must not be given to people whose immune system is weakened because of disease or medical treatment as they are at greater risk of having complications from vaccines containing live attenuated viruses. Updated product information and a Direct Healthcare Professional Communication (DHPC) are forthcoming.

Recap of this event

In a [news item](#) published on 7 May, EMA informed of 17 serious adverse events (SAEs) that had been reported worldwide in people aged between 62 and 89 years who had received IxchIQ (a live attenuated chikungunya vaccine), including two cases resulting in death. This corresponds to an increase of two cases from the previous information published by EMA as of 30 April 2025. Of the fatal cases, one of them concerned an 84-year-old man who developed encephalitis. The second concerned a 77-year-old man with Parkinson's disease whose difficulty with swallowing worsened and may have caused aspiration pneumonia. The two fatal cases occurred in the French overseas department of La Réunion, where a vaccination campaign is underway following a recent chikungunya outbreak.

Further to the information that EMA published on 2 May 2025 on considerations on the use of IxchIQ, the [news item](#) published on 7 May 2025 announced that the EMA's safety committee (PRAC) had started a review of IxchIQ, following the reports of SAEs in older people. EMA reported that many of the people affected also had other illnesses and that the exact cause of these adverse events and their relationship with the vaccine have not yet been determined. Given that studies on IxchIQ mainly involved people aged below 65 years and the vast majority of serious cases concerned people aged 65 years and above, PRAC had temporarily recommended restricting the use of the vaccine in adults aged 65 years and above.

Background

As of 30 April 2025, [according to EMA](#), 15 cases of SAEs were reported following vaccination with IxchIQ, including nine from the European Union (eight from France, including La Réunion) and six from the United States. Of the nine SAEs reported from the EU, four occurred in people older than 80 years with multiple underlying comorbidities and who required hospitalisation. One of the cases died.

On 2 May 2025, the European Medicine Agency's (EMA) safety committee, PRAC, and EMA's Emergency Task Force (ETF) issued '[PRAC-ETF considerations on the use of IxchIQ live attenuated virus vaccine against chikungunya](#)', informing that they were aware of the serious adverse events (SAEs) reported with IxchIQ vaccination. PRAC was reviewing the available data, and

said it would consider regulatory actions during its plenary meeting opening on 5 May 2025. Until PRAC communicated further, caution should be used when considering vaccination with Ixchiq in frail older adults, especially those with comorbidities potentially affecting immune responses to the vaccine.

On 26 April 2025, the **French Ministry of Health and Access to Care reported** that it was informed on 23 April 2025 by the French National Agency for the Safety of Medicines (ANSM) of the occurrence of two SAEs following vaccination against chikungunya with the IXCHIQ vaccine in Reunion, including one death, and a third SAE on 25 April. The three SAEs occurred in people aged over 80 years with comorbidities. Two of them experienced symptoms similar to those of a severe form of chikungunya a few days after vaccination and one of them died. The third person was discharged from hospital.

These cases were detected as part of the reinforced pharmacovigilance system set up for this vaccine by the health authorities. According to the analysis carried out by the Bordeaux Regional Pharmacovigilance Centre (CRPV), in charge of pharmacovigilance in the Overseas Territories in conjunction with the ANSM for these three SAEs, the **causal link** with the vaccine seems very likely considering the symptoms and their onset after vaccination, as well as the detection of the vaccine virus by PCR in the patients' biological samples. Given the seriousness of these events, the Directorate-General for Health (DGS) urgently referred the matter to the HAS on 24 April to reassess the indications for vaccination against chikungunya with the IXCHIQ vaccine. On 25 April, the French **National Authority for Health (HAS)** advised a revision of the vaccination recommendations. As a result, the health authorities suspended the vaccination of individuals aged 65 years and over, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remains open for people aged 18 to 64 years with comorbidities. In this context, travellers aged 65 years and over should also not be vaccinated with the IXCHIQ vaccine.

During its 16 April 2025 session, the United States' CDC Advisory Committee on Immunization Practices (ACIP) had reported six SAEs following administration of the IXCHIQ vaccine in people aged 65 years and older. Five of these cases required hospitalisation for cardiac and/or neurological symptoms. The cases are currently under investigation by US **CDC** and results are expected to be discussed at an upcoming ACIP meeting. In the meantime, the CDC advises healthcare providers to discuss the risks and benefits of vaccination with individual travellers based on age, destination, trip duration, and planned activities.

Actions:

No specific action currently ongoing at ECDC on this event

Last time this event was included in the Weekly CDTR: 8 May 2025

4. Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025

Overview:

Since the beginning of 2025, and as of 16 July 2025, two countries in Europe have reported cases of Crimean-Congo haemorrhagic fever (CCHF): Greece (2) and Spain (2).

The cases in Greece that occurred in Thessaly region are unexpected, as this region and neighbouring regions have not reported CCHF cases or CCHF virus circulation in animals previously. The primary case was probably infected through a tick bite, while the secondary case was a healthcare professional who provided care to the primary case, although the exact transmission route is still under scrutiny. These are the first cases since 2008, when the only other locally acquired case reported by Greece to date was found in the Thrace region (bordering Bulgaria).

The cases in Spain are not unexpected, as CCHF virus is known to be circulating among animals in the province of Salamanca, autonomous community of Castile and León, and human CCHF cases have been previously reported in the area.

ECDC assessment:

From 2016 to 2024, a total of 16 autochthonous CCHF cases have been reported in Spain, with dates of disease onset between April and August. The province of Salamanca is a hotspot for CCHF, with 50% of the cases being exposed to ticks. Two cases have been detected in previous years in the same locality as the current case. In this area, the presence of *Hyalomma marginatum*, the main vector of this disease, is well known, and studies conducted in wild and domestic animals have shown seroprevalence higher than 70% for CCHF virus. The current event is therefore not unexpected.

Although the risk of contracting CCHF for the general population in the areas where the virus is known to be present in Spain is low, this risk drastically increases for people performing activities that expose them to tick bites (e.g. hunting, forestry work, hiking, animal surveillance). As a general precaution against CCHF, but also against other tick-borne diseases, people who may potentially be exposed to ticks should apply personal protective measures against tick bites ([ECDC Protective Measures against ticks](#)). Ticks from the *Hyalomma* spp. are considered the principal vectors of the CCHF virus. *Hyalomma marginatum* is widely [present in southern and eastern Europe](#). A further vector is *Hyalomma lusitanicum*, which is [present in parts of southern Europe](#).

Non-tick-mediated healthcare-associated transmission is also documented and most often follows percutaneous or other cutaneous contact with a patient's blood or bodily fluids, but can also occur after close, unprotected proximity or contact with contaminated surfaces. In 2024, WHO published [operational guidelines](#) on the infection prevention and control of CCHF in healthcare settings.

Additional information on CCHF can be found in ECDC's [factsheet](#) and information on the occurrence of CCHF cases in the EU/EEA can be found on ECDC's [website](#). In December 2023, ECDC published a [report](#) on the spatial distribution of CCHF based on predicted ecological suitability.

Last time this event was included in the Weekly CDTR: 11 July 2025

5. Weekly seasonal surveillance of West Nile virus infection – 2025

Overview:

Since the beginning of 2025, and as of 16 July 2025, three countries in Europe have reported human cases of West Nile virus infection : **Greece, Italy and Romania**.

The report is available [online](#).

Last time this event was included in the Weekly CDTR: 11 July 2025

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

Overview:

Data reported in week 28, 2025, showed that consultation rates for respiratory infections were at baseline or low levels in all reporting EU/EEA countries, both in primary (influenza-like illness (ILI), acute respiratory infection (ARI)) and secondary care (severe acute respiratory infection (SARI)) surveillance systems.

Pooled test positivity for SARS-CoV-2 nonetheless continued to increase in ILI/ARI primary care specimens in several EU/EEA countries, mainly in individuals belonging to the 15–64 and 65 years and older age groups.

EU/EEA test positivity for SARS-CoV-2 in secondary care specimens showed a clear increase in four countries in week 28 (based on data collected from SARI secondary care syndromic surveillance for two countries and from laboratory-confirmed non-sentinel surveillance systems for the other two).

[EuroMOMO](#) has not reported signals of excess all-cause mortality except for Portugal, where a moderate excess mortality was reported among individuals aged 65 years and older.

ECDC assessment:

Rates of consultations and hospitalisations for respiratory infections are at expected levels for the summer, although in recent weeks increases in indicators of SARS-CoV-2 circulation have been observed in many countries. Influenza and RSV activity is low in all reporting countries.

Due to the currently limited number of countries reporting data and the relatively low number of tests performed, a complete interpretation of the epidemiological situation across the EU/EEA remains difficult.

Following a winter with low SARS-CoV-2 circulation, population immunity against SARS-CoV-2 might have waned to a certain extent. As a result, the proportion of tests positive for SARS-CoV-2 is currently higher than that for other viruses. This might lead to some increases in COVID-19 hospitalisations during this period, particularly among older adults and people vulnerable to severe outcomes, as described in ECDC's recently published [Epidemiological update](#). However, such increases have not been observed in the data reported to ECDC to date.

Actions:

ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary ([ERVISS.org](#)), which is updated weekly.

Countries should remain vigilant to increases in epidemiological indicators, particularly in settings with populations vulnerable to severe disease, and to increases in severe disease.

[ECDC/WHO guidance](#) recommends that surveillance of respiratory viruses is maintained year-round.

Vaccination is the most effective measure for protecting against more severe forms of viral respiratory diseases. Those eligible for vaccination, particularly those at higher risk of severe outcomes, are encouraged to get vaccinated in line with national recommendations.

Countries should ensure that [infection prevention and control practices in healthcare settings](#) are implemented.

Wearing masks in settings such as high-risk wards and long-term care facilities can help protect populations at high risk of severe disease.

Sources: [ERVISS](#)

Last time this event was included in the Weekly CDTR: 11 July 2025

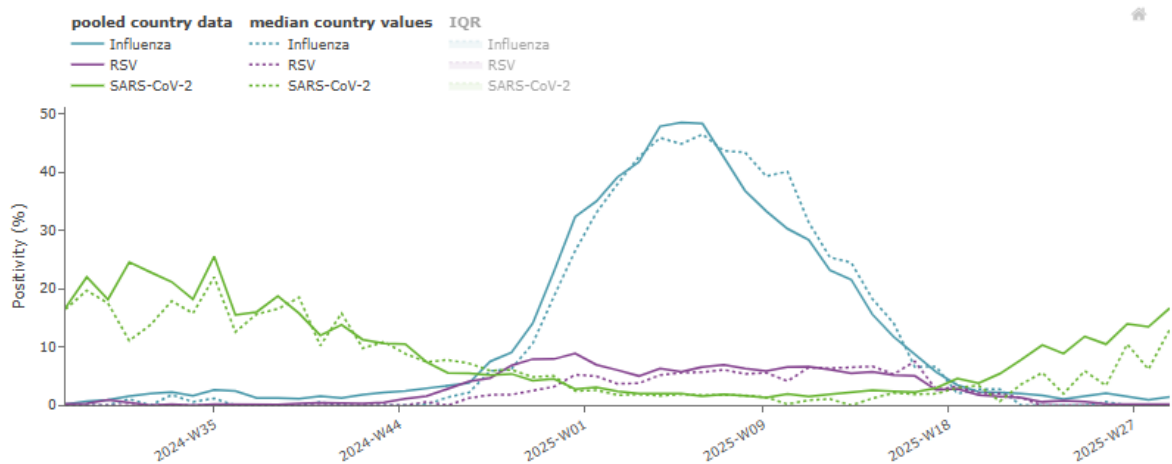
Figure 1. Overview of key indicators of activity and severity in week 28, 2025

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 28	Week 27	Description	Value	
ILI/ARI consultation rates in primary care	ARI	9 rates (8 MEM)	12 rates (9 MEM)	Distribution of country MEM categories	6 Baseline	
	ILI	9 rates (8 MEM)	14 rates (13 MEM)		8 Baseline	
ILI/ARI test positivity in primary care	Influenza	12	14	Pooled (median; IQR)	1.4% (0; 0–2.3%)	At the EU/EEA level, the pooled ILI/ARI test positivity sharply increased in week 28 (17%) compared to week 27 (5.3%). However, two countries contributed to 70% of the total number of tested samples. Clear increasing trends in SARS-CoV-2 test positivity in laboratory-based, non-sentinel data (from a mix of primary care and other sources, including hospital laboratories) were also observed in several other countries.
	RSV	11	12		0.2% (0; 0–0%)	
	SARS-CoV-2	10	12		17% (13; 5.1–21%)	
SARI rates in hospitals	SARI	8	8	--	--	
SARI test positivity in hospitals	Influenza	7	7	Pooled (median; IQR)	2.6% (1.8; 0–8.2%)	At the EU/EEA level, the pooled SARI test positivity increased in week 28 (9%) when compared with week 27 (4%). Two countries contributed to 80 % of the total number of tested samples, although with opposite situations (test positivity: 0.8% versus 17.5%). In recent weeks, two other countries have continuously reported increases in weekly, laboratory-confirmed, non-sentinel hospitalised cases and another country has reported small increases in laboratory-confirmed, non-sentinel deaths.
	RSV	7	7		0.3% (0; 0–0%)	
	SARS-CoV-2	6	6		8.7% (10; 1.8–18%)	
Intensity (country-defined)	Influenza	12	16	Distribution of country qualitative categories	10 Baseline 2 Low	
Geographic spread (country-defined)	Influenza	11	15		5 No activity 6 Sporadic	

Source: ECDC

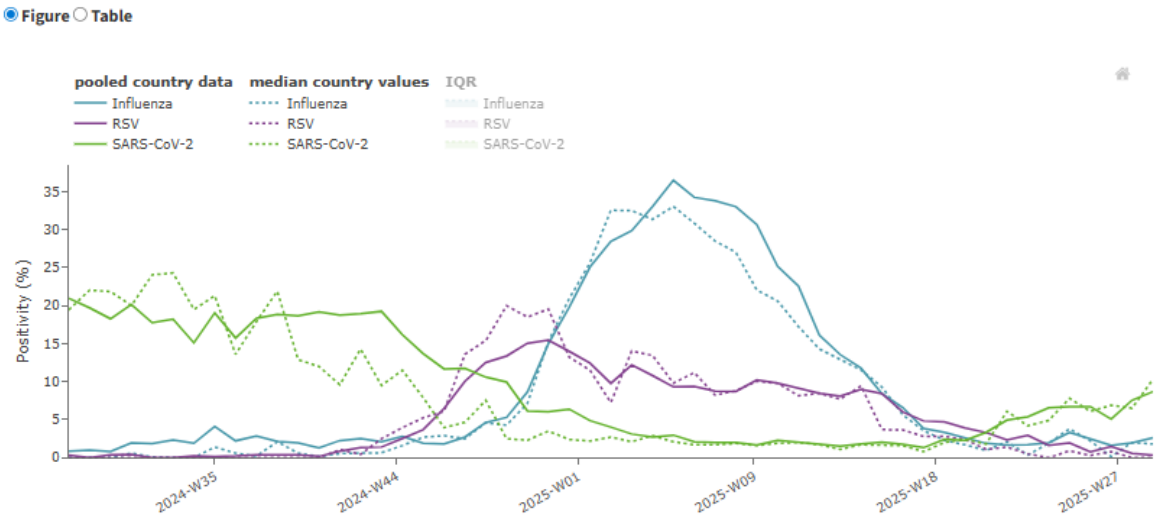
Figure 2. ILI/ARI virological surveillance in primary care - weekly test positivity

Figure Table



Source: ECDC

Figure 3. ILI/ARI virological surveillance in hospitals - weekly test positivity



Source: ECDC

Figure 4. Genetically characterised influenza virus distribution, week 40, 2024 to week 28, 2025

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	5333	39	5a.2a(C.1.9)	3615	68
			5a.2a(C.1.9.3)	691	13
			5a.2a.1(D)	670	13
			5a.2a.1(D.3)	162	3
			5a.2a(C.1)	157	3
			Not assigned	38	–
A(H3)	4000	30	2a.3a.1(J.2)	3156	79
			2a.3a.1(J.2.2)	502	13
			2a.3a.1(J.2.1)	241	6
			2a.3a.1(J)	43	1
			2a.3a.1(J.1)	36	0.9
			2a.3a.1(J.4)	3	0.1
			Not assigned	19	–
B/Vic	4172	31	V1A.3a.2(C.5.1)	2376	57
			V1A.3a.2(C.5.7)	909	22
			V1A.3a.2(C.5.6)	772	19
			V1A.3a.2(C)	79	2
			V1A.3a.2(C.5)	17	0.4
			Not assigned	19	–

Source: ECDC

Figure 5. SARS-CoV-2 variant distribution, weeks 26–27, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	2	25	17% (16–19%)
XFG	VUM	2	84	52% (51–52%)
LP.8.1	VUM	2	31	16% (15–18%)
NB.1.8.1	VUM	2	17	12% (11–12%)

Source: ECDC

Figure 6. ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution
☐ Figure
 ☒ Table

Pathogen	Week 28, 2025		Week 40, 2024 – week 28, 2025	
	N	% ^a	N	% ^a
Influenza	8	–	25303	–
Influenza A	7	88	14995	60
A(H1)pdm09	6	100	7225	57
A(H3)	0	0.0	5493	43
A (unknown)	1	–	2277	–
Influenza B	1	12	10046	40
B/Vic	0	–	4510	100
B/Yam	0	–	1	0.0
B (unknown)	1	–	5535	–
Influenza untyped	0	–	262	–
RSV	1	–	4765	–
RSV-A	0	–	865	44
RSV-B	0	–	1113	56
RSV untyped	1	–	2787	–
SARS-CoV-2	85	–	3894	–

^a Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.

Source: ECDC

Figure 7. SARI virological surveillance in hospitals – pathogen type and subtype distribution

○ Figure ● Table

Pathogen	Week 28, 2025		Week 40, 2024 – week 28, 2025	
	N	% ^a	N	% ^a
Influenza	16	–	14016	–
Influenza A	13	93	5892	80
A(H1)pdm09	0	0.0	1720	60
A(H3)	1	100	1123	40
A (unknown)	12	–	3049	–
Influenza B	1	7	1435	20
B/Vic	0	–	168	100
B (unknown)	1	–	1267	–
Influenza untyped	2	–	6689	–
RSV	2	–	5718	–
RSV-A			750	48
RSV-B			806	52
RSV untyped	2	–	4162	–
SARS-CoV-2	52	–	4403	–

^a Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.

Source: ECDC

7. Influenza A(H5N1) – Multi-country (World) – Monitoring human cases

Overview:

On 1 July 2025, WHO [reported](#) in their monthly Influenza at the human-animal interface report, one confirmed human case of avian influenza A(H5N1) virus infection. The infected person was one year of age and lived in Cumilla district, Chittagong district, Bangladesh. After developing a SARI syndrome, the case was admitted to hospital on 21 May. Additional symptoms included diarrhoea and fever. Samples for laboratory testing were collected the same day.

The patient fully recovered at home, despite being discharged against medical advice. No travel history was reported. Exposure to backyard poultry was reported prior to symptom onset. No further cases were detected among the contacts of the patient.

On 28 May, the Institute of Epidemiology, Disease Control and Research (IEDCR) confirmed infection with avian influenza A(H5) through RT-PCR; the N-type was later confirmed as N1. The information about the clade of this case is pending.

As of 1 July 2025, this is the 11th reported case from Bangladesh since the first case reported in the Dhaka division in 2008. This is the third confirmed case of human infection with influenza A(H5N1) in Bangladesh in 2025. The two other cases in Bangladesh in 2025 were both in children from the Khulna division.

In March 2025, an outbreak of avian influenza A(H5N1) was confirmed on a poultry farm in Jessore district, Khulna division. Following this outbreak, in April, a human infection with avian influenza A(H5N1) was reported in an 8-year-old person in the same district. However, no epidemiological link has been established between this human case and the earlier poultry outbreak. Also in April 2025,

two deceased serval cats in Narayanganj district, Dhaka division, tested positive for A(H5N1). To date, no epidemiological link has been established between feline cases and the currently reported human cases.

Summary:

Since 2003, and as of 16 July 2025, there have been 986 human cases of avian influenza A(H5N1) infection worldwide*, including 473 deaths (case fatality among reported cases: 48%). It needs to be noted, however, that the seroprevalence levels observed in exposed groups for A(H5) in various studies within and outside Asia provide valuable context for interpreting case fatality, as they suggest that reported human cases, which are predominantly severe, may lead to an overestimation of case fatality for A(H5) subtypes (ECDC/EFSA Scientific Opinion on [Preparedness-prevention-and-control-related-to-zoonotic-avian-influenza.PDF](#)).

Cases have been reported in 25 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, India, Indonesia, Iraq, Laos, Mexico, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Viet Nam, the United Kingdom, and the United States). To date, no sustained human-to-human transmission has been detected.

***Note:** this includes detections due to suspected environmental contamination, with no evidence of infection, that were reported in 2022 and 2023 by Spain (two detections), the United States (1), and the United Kingdom (4, 1 inconclusive). Human cases of A(H5) epidemiologically linked to A(H5N1) outbreaks in poultry and dairy cattle in the United States are included in the reported number of cases of A(H5N1).

Acknowledgements: we gratefully acknowledge all data contributors, i.e. the authors and their originating laboratories responsible for obtaining the specimens, and the submitting laboratories for generating the genetic sequence and metadata and sharing via the GISAID Initiative, on which this research is based.

ECDC assessment:

Sporadic human cases of different avian influenza A(H5Nx) subtypes have previously been reported globally. Current virological evidence suggests that circulating A(H5N1) viruses retain genetic characteristics consistent with avian-adapted influenza viruses. Given the widespread transmission of avian influenza viruses in animals, transmission to humans with avian influenza remains infrequent and no sustained transmission between humans has been observed.

Overall, the risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered low.

Direct contact with birds and other infected animals, their secretions or a contaminated environment is the most likely source of infection, and the use of personal protective measures for people exposed to dead animals or their secretions will minimise the associated risk. The recent severe cases in Asia and the Americas in children and people exposed to infected, sick or dead backyard poultry underlines the risk of unprotected contact with infected birds in backyard farm settings. This supports the importance of using appropriate personal protective equipment.

Actions:

ECDC is in contact with WHO counterparts for closer monitoring of the situation. ECDC monitors avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly updated report on the [avian influenza situation](#).

Last time this event was included in the Weekly CDTR: 4 July 2025

8. Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025

Overview:

Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries across the globe. Since 2022, MPXV clade II has mainly been circulating outside of the African continent among men who have sex with men. The epidemiological profile of cases reported outside Africa since 2022 remains largely unchanged.

In 2024, an increase in MPXV clade Ia and Ib was reported in the Democratic Republic of the Congo (DRC), while clade Ia cases continued to be reported by the Central African Republic and the Republic of the Congo (Congo), where it is endemic. Since August 2024, a number of countries outside Africa have also reported mostly travel-related cases of mpox clade I, with limited onward transmission.

The countries in Africa that have reported clade I detection (Ia and/or Ib) in 2025, are: DRC, Uganda, Burundi, Kenya, Zambia, Tanzania, Rwanda, Congo, South Sudan, the Central African Republic, South Africa, Malawi, Angola and Ethiopia ([Global Mpox Trends published 11 July 2025, data as of 6 July 2025](#)). In 2024, Zimbabwe reported cases of clade Ib and Gabon reported mpox cases for which clade information was not available ([Global Mpox Trends published 11 July 2025, data as of 6 July 2025](#)).

In general, and as of 18 July 2025, no major changes have been noted in the epidemiological trends of mpox clade I in Africa.

Mpox clade IIa and IIb cases are also continuously being reported in Africa, with notable increases reported at the end of May in Sierra Leone. Recently, increases have been noted in Guinea, Liberia and Togo where clade IIb circulates.

Besides the countries mentioned above, Mozambique reported three confirmed cases of mpox ([Africa CDC Special Briefing on Mpox and other Health Emergencies, 17 July 2025](#)).

Mpox clade I summary and transmission patterns classification

Overall, in Africa, as of the beginning of July 2025, most confirmed and suspected clade I cases were reported from the DRC, Uganda and Burundi.

- In DRC, clade Ia and Ib are co-circulating. In recent weeks and as of week 26 (end of June), a decreasing trend in confirmed cases has been noted, according to Africa CDC ([Special Briefing on Mpox and other Health Emergencies, 10 July 2025](#)). However, this trend should be interpreted with caution as testing coverage remains low.
- Uganda is still currently the African country reporting most mpox clade Ib cases after DRC ([Global Mpox Trends published 11 July 2025, data as of 6 July 2025](#); [Uganda National Mpox Situation Report, 8 July 2025](#)). Over 7 400 cases have been reported since 2024, including 46 deaths. The last four weeks an increase in confirmed weekly cases has been reported from 104 cases in week 23 to 233 cases in week 26. Most cases overall have been reported in Kampala district and among young adults (aged 25 to 29 years old). A resurgence has been noted in Wakiso and Masaka City ([Africa CDC Special Briefing on Mpox and other Health Emergencies, 17 July 2025](#)).
- In Burundi, a slight increase in the number of confirmed cases has been reported since end of June. However the total number of weekly cases remains at low levels (<50 confirmed cases per week) ([Africa CDC Special Briefing on Mpox and other Health Emergencies, 10 July 2025](#)).

Kenya and Zambia have reported over 50 confirmed cases the past six weeks, as of 6 July, according to WHO. Malawi and Ethiopia also reported 35 and 20 cases, respectively, in the same period, and South Sudan and Rwanda reported two cases each ([Global Mpox Trends published 11 July 2025, data as of 6 July 2025](#)).

At the end of May, Ethiopia reported its first mpox cases and detection of clade Ib. The first cases were reported in Oromia region, near the border with Kenya ([Africa CDC Epidemic Intelligence](#)

[Weekly Report, June 2025](#)) As of week 27 2025, 27 cases have been confirmed (Africa CDC Special Briefing on Mpox and other Health Emergencies, 17 July 2025).

Outside of the African continent, travel-associated cases or sporadic cases reporting epidemiological links with travel-associated cases of MPXV clade I, have been reported in the EU/EEA by Sweden (in 2024), Germany, (in 2024 and 2025), Belgium (in 2024 and 2025), France, Ireland and Italy (in 2025).

Türkiye reported recently a clade Ia case that had been detected in October 2024 ([Global Mpox Trends published 11 July 2025, data as of 6 July 2025](#)). In addition to Africa and the EU/EEA, since August 2024, clade I cases have been reported by Thailand, India, the United Kingdom, the United States, Canada, Pakistan, Oman, China, the United Arab Emirates, Qatar, Brazil, Switzerland and Australia. In the United States, in 2025, positive MPXV clade I wastewater samples have now also been reported from Iowa, North Carolina and California ([ECDC Communicable disease threats report, 17-23 May 2025](#)).

Most travel-associated cases involving travel to non-African countries had links to affected countries in Africa. China, India, Oman, Pakistan and Thailand have reported at least one case each with travel links to the United Arab Emirates. One mpox clade I case reported from India had a travel history to Oman and the case reported by Australia had a travel history to Thailand ([Global Mpox Trends published 11 July 2025, data as of 6 July 2025](#)).

Confirmed secondary transmission of mpox due to MPXV clade Ib outside of Africa was reported for the first time in 2024 in the EU/EEA by Germany and Belgium, and outside of the EU/EEA by the UK and China. The number of secondary cases reported in these events outside of Africa has been low.

Based on the information available, all transmission events were due to close contact, secondary cases presented with mild symptoms and no deaths have been reported.

Transmission patterns of mpox due to monkeypox virus clade I – update 17 July 2025

Since September 2024, following an analysis of the patterns of MPXV transmission observed at the national level and given the limitations and uncertainties, ECDC has used official epidemiological information to classify countries according to whether MPXV clade I is endemic or was reported for the first time since 2024. The categories are as follows:

- Countries reporting only travel-associated cases or cases with a clear link to travel-associated cases: Angola, Australia, Belgium, Brazil, Canada, Germany, France, India, Ireland, Italy, Oman, Pakistan, Qatar, South Africa, South Sudan, Sweden, Switzerland, Thailand, Türkiye, the United Kingdom, the United States, and Zimbabwe;
- Clusters of cases or limited transmission: China, the United Arab Emirates;
- Community transmission: Burundi, Central African Republic, Congo, the DRC, Ethiopia, Kenya, Malawi, Rwanda, Tanzania, Uganda and Zambia.

The categorisation was last updated on 18 June 2025 to include Türkiye in the category of countries with travel-associated cases and to include China in the category of countries with clusters of cases or limited transmission.

Below you can find some notes on the interpretation of the different trends reported in countries included:

- China has been included in the category of countries with clusters of cases or limited transmission. According to WHO, nine cases were recently reported of which four were linked to a cluster, three involve recent travel, one had travel history and one had exposure to a symptomatic individual that had not been previously diagnosed. The total number of clade Ib cases in China is 23 ([Mpox: Multicountry external situation report 55, 11 July 2025](#)). Given the recently reported cases, the unknowns on the exact transmission chains as epidemiological investigations are pending China has included in the category of countries reporting clusters or limited transmission.
- The United Arab Emirates has reported cases with travel history to Uganda, however a number of other countries have reported cases with travel history to the United Arab Emirates. Although there is no evidence of wider community transmission in the United Arab Emirates, it is presumed that undetected transmission is ongoing ([Mpox: multi-country external situation](#)

[report no. 50, 11 April 2025](#)). The United Arab Emirates are therefore classified as having 'clusters of cases or limited transmission'.

The epidemiological situation is continuously being monitored and the classification is reviewed and adjusted depending on a qualitative assessment of reported trends.

Mpox clade II focus in selected countries in Africa reporting recent increases

Sierra Leone: The first cases of mpox in Sierra Leone were reported at the beginning of the year. Clade II was detected. As of week 27, over 4 600 confirmed cases had been reported, including 32 deaths for all 16 districts of the country according to Africa CDC ([Africa CDC Special Briefing on Mpox and other Health Emergencies, 17 July 2025](#)). Of the confirmed cases, 5.4% are aged under 15 years and 51% are males. A sharp increase in cases since May 2025 has been followed by a decline and a stable trend in the last two weeks (and as of week 27). The testing positivity rate has also decreased but it is 81% on week 27 ([Africa CDC Special Briefing on Mpox and other Health Emergencies, 17 July 2025](#)).

Guinea: Guinea has reported 87 confirmed mpox clade II cases in 2025 all of which were reported the last six weeks and as of 6 July 2025. Most cases are from the Conakry and the Kindia regions ([Mpox: Multicountry external situation report 55, 11 July 2025](#), [Africa CDC Special Briefing on Mpox and other Health Emergencies, 17 July 2025](#)).

Liberia: Mpox cases due to clade IIa and IIb have been reported in Liberia since 2024. In recent weeks another increase has been noted with 27 confirmed cases reported on week 26 compared to 11 cases reported on week 25. The majority of the cases continue to be in males (86%) and 31% are under 15 years ([Special Briefing on Mpox and other Health Emergencies, 10 July 2025](#)). Overall, and until 3 July 2025, 271 confirmed cases have been reported ([National Public Health Institute of Liberia, 4 July 2025 \(Facebook\)](#)).

Ghana: A resurgence of mpox cases has been reported in Ghana in recent weeks. Previously the country had reported mostly sporadic cases ([Special Briefing on Mpox and other Health Emergencies, 12 June 2025](#)). Clade IIb has been detected in the country. The first confirmed cases in 2025 were reported on 15 May 2025 in Accra and as of 6 July 2025, the total number of confirmed cases is 170 ([Ghana Health Services, 15 May 2025 \(Facebook\)](#) and [Ghana Health Services, 9 July 2025 \(Facebook\)](#)).

Togo: The first cases of mpox in Togo were reported in May 2025 and clade II has been detected. Until 6 July, 45 confirmed cases have been reported from different districts ([Mpox: Multicountry external situation report 55, 11 July 2025](#)).

On 13 August 2024, Africa CDC [declared](#) mpox a Public Health Emergency of Continental Security. On 14 August 2024, WHO [convened](#) a meeting of the IHR Emergency Committee to discuss the mpox upsurge and [declared](#) the current outbreak of mpox due to MPXV clade I to be a public health emergency of international concern. On 5 June 2025, the WHO IHR Emergency Committee convened for the fourth time, advised that the event continues to meet the criteria for a public health emergency of international concern and revised the set of temporary recommendations which are now valid until 20 August 2025 ([Fourth meeting of the International Health Regulations \(2005\) Emergency Committee regarding the upsurge of mpox 2024 – Temporary recommendations](#)).

ECDC assessment:

The epidemiological situation regarding mpox due to MPXV clade Ib remains similar to previous weeks. The sporadic cases of mpox clade I that have been reported outside Africa, including secondary transmission, are not unexpected.

The risk for EU/EEA citizens travelling to or living in the affected areas is considered to be moderate if they have close contact with affected individuals, and low if they do not have contact with affected individuals. The overall risk to the general population in the EU/EEA is currently assessed as low. However, more imported mpox cases due to MPXV clade I are likely to be reported by the EU/EEA and other countries.

EU/EEA countries may consider raising awareness in travellers to/from areas with ongoing MPXV transmission and among primary and other healthcare providers who may be consulted by such

patients. If mpox is detected, contact tracing, partner notification and post-exposure preventive vaccination of eligible contacts are the main public health response measures.

Please see the latest ECDC '[Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#)'.

Actions:

ECDC is closely monitoring and assessing the evolving epidemiological situation related to mpox on a global basis. The Centre's recommendations are available [here](#).

Reporting through the Communicable Disease Threats Report is monthly. As the global epidemiological situation is monitored continuously, ad hoc epidemiological updates may be published.

Sources: [ECDC rapid risk assessment](#)

Last time this event was included in the Weekly CDTR: 19 June 2025

9. Nipah virus disease – India – 2025

Overview:

Update

On 16 July 2025, Indian health authorities [reported](#) a NiV disease case in the district of Palakkad, in the state of Kerala. The person sought [healthcare assistance](#), where NiV was suspected. The person is a close contact of previously reported NiV case on 13 July.

Following the reporting of this new case, Indian health authorities have expanded contact tracing activities, as well as risk communication.

Summary

Since May 2025, a total of five NiV disease cases have been reported in India from the Palakkad (3) and Malappuram (2) districts. Of these, two have died, both from the Palakkad district.

This year, the first case of NiV disease was [reported](#) in May from the Malappuram district. Following this detection, two additional NiV disease cases were [reported](#) on 4 July 2025 from the Palakkad and Malappuram districts. These two patients [reported](#) symptoms onset on 23 and 25 June, one of them dying soon afterwards. One of the contacts of these patients [tested positive](#) to NiV disease on 16 July.

Background:

Nipah virus (*Henipavirus nipahense*) is a highly pathogenic virus of the family *Paramyxoviridae*, genus *Henipavirus*. It was first isolated and identified in 1999 during an outbreak in Malaysia and Singapore. Since then, several outbreaks of NiV disease in Southern and South-Eastern Asia have been reported, with most cases in Bangladesh.

The virus spreads between animals and humans, with most human cases having had direct [contact with pigs or bats](#). NiV can also be transmitted between people through direct contact or indirectly via contaminated food (e.g. date palm sap contaminated by bat saliva) or [through aerosols](#). The incubation period is usually four to 14 days. Symptoms range from mild (fever, headache, muscle pain, and nausea) to more serious, including severe respiratory symptoms and encephalitis.

For more information on the disease and its epidemiology, please read ECDC's [factsheet about Nipah virus Disease](#).

ECDC assessment:

Although the disease is severe and has a high fatality rate, the likelihood of exposure to and infection with NiV for EU/EEA citizens travelling to or residing in India is currently very low, given the low number of infections in the affected areas in which cases have been identified to date.

The most likely route for the virus to be introduced into the EU/EEA would be via infected travellers. While importation of the virus cannot be excluded, its likelihood is currently very low. Should a case be imported, the likelihood of the virus spreading within the EU/EEA is considered to be very low. It should be highlighted that the natural reservoir hosts of NiV are not native to Europe.

As a general precaution, EU/EEA travellers and residents in Kerala state, India, should not handle domestic or wild animals and avoid contact with their excreta. The virus may be present on food items contaminated by bats. Washing, peeling, and cooking fruit and vegetables before consumption is generally recommended. Raw date palm sap (juice) should not be consumed.

Actions:

ECDC is monitoring this event through its epidemic intelligence activities.

Last time this event was included in the Weekly CDTR: 11 July 2025

10. Mass gathering monitoring – UEFA Women's EURO 2025 – Switzerland – 2025

Overview:**Update**

On 15 July, [media](#) quoting the Swiss Football Federation (SFV) reported that some players on the Swiss national team had experienced influenza-like symptoms. No further cases have been reported among other national teams' players.

Summary

Since the start of the monitoring period, no major public health events associated with infectious diseases have been detected in the context of the UEFA Women's EURO 2025.

Background

This year, the [UEFA Women's EURO 2025](#) is taking place in Switzerland between 2 to 27 July. Around 600 000 people are expected to watch the 31 scheduled matches of the 16 qualified national teams. The tournament is taking place at eight stadiums in eight Swiss cities across a total of seven cantons: Basel (Canton of Basel-Stadt), Bern (Canton of Bern), Geneva (Canton of Geneva), Zurich (Canton of Zürich), St. Gallen (Canton of St. Gallen), Lucerne (Canton of Lucerne), Sion (Canton of Valais), and Thun (Canton of Bern).

The stadiums have [different capacities](#), with Basel, Bern, Geneva, and Zurich being the cities with the largest stadiums, able to host between 20 000 and 35 000 spectators, while Sion and Thun are the venues with the smallest capacity (approximately 8 000 spectators).

National teams from the following 16 countries, including the host country Switzerland, have qualified for UEFA Women's EURO 2025: Belgium, Denmark, England, Finland, France, Germany, Iceland, Italy, Netherlands, Norway, Poland, Portugal, Spain, Sweden, and Wales. Around [700 000 tickets were made available](#) for the final tournament, with more than 600 000 tickets already sold by 27 June 2025. It is expected that spectators from approximately 114 countries will attend the event, with the highest attendance expected from Germany, France, England, the Netherlands, and the United States.

In addition to the matches in the stadiums, a large number of [public viewing events](#), such as the transmission of football matches shown on screens outside the home environment, are planned in

Switzerland. These include the official fan zones that UEFA will operate in each of the eight host cities. Furthermore, other European cities, such as Berlin, will also hold [public viewing events](#).

ECDC assessment:

Mass gathering events involve a large number of visitors collected together in one area at the same time. This may increase the risk of communicable disease outbreaks and non-communicable health risks, including heat stroke, crowd injury, and drug- and alcohol-related conditions. Respiratory infections including COVID-19, food and waterborne diseases, tick-borne and sexually transmitted diseases are among the potential health threats for those attending.

The probability of EU/EEA citizens becoming infected with communicable diseases during the UEFA Women's EURO 2025 is considered very low to low, with an estimated low impact, if requirements and recommendations are followed (e.g. being fully vaccinated according to national immunisation schedules; following hand and food hygiene and respiratory etiquette guidelines; refraining from participating in activities or having contact with people should symptoms occur, and seeking prompt testing and medical advice as necessary). The impact can be higher for people with underlying conditions, older people, and pregnant women.

Actions:

ECDC is monitoring this mass gathering event through epidemic intelligence activities until 1 August.

Last time this event was included in the Weekly CDTR: 11 July 2025

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 27 June 2025
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 27 June 2025
- Human cases with avian influenza A(H10N3) – Multi-country (World) - last reported on 27 June 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 27 June 2025
- Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025 - last reported on 27 June 2025
- Mass gathering monitoring – EuroPride 2025 Lisbon - Portugal – 2025 - last reported on 27 June 2025
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025 - last reported on 27 June 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 27 June 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 27 June 2025
- Seasonal surveillance of dengue – 2025 - last reported on 18 July 2025
- Serious adverse events to IXCHIQ chikungunya virus disease vaccine - last reported on 18 July 2025
- Nipah virus disease – India – 2025 - last reported on 18 July 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 18 July 2025
- Mass gathering monitoring - UEFA Women's EURO 2025 - Switzerland - 2025 - last reported on 18 July 2025
- Monitoring of bathing/swimming related-vibriosis - Summer 2025 - last reported on 11 July 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 11 July 2025
- Seasonal surveillance of West Nile virus infections – 2025 - last reported on 11 July 2025
- Publication of public health guidance for assessing and mitigating the risk of locally-acquired Aedes-borne viral diseases in the EU/EEA and update of Aedes albopictus and Aedes aegypti distributions - last reported on 04 July 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 04 July 2025
- SARS-CoV-2 variant classification - last reported on 04 July 2025
- Circulating vaccine-derived poliovirus type 2 (cVDPV2) – multi-country – 2024–25 - last reported on 4 July 2025