WEEKLY BULLETIN

Communicable disease threats report

Week 11, 7 - 13 March 2026

This week's topics

Executive summary

Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles

- A high number of travel-related cases of chikungunya virus disease has been reported among travellers returning to Europe from the Seychelles since late 2025, indicating intense ongoing transmission in the country.
- The current likelihood of chikungunya virus infection for travellers to the Seychelles is high. Travellers should be advised to take enhanced mosquito bite prevention measures. Vaccination of travellers may be considered, based on national recommendations.
- A news item has been published in the ECDC website: High number of chikungunya cases reported among travellers returning from Seychelles: local transmission in mainland Europe currently unlikely.

Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

- Since the previous update and as of 12 March, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic and Paralympic Games.
- The Winter Paralympic Games Milano Cortina 2026 started on 6 March 2026 and runs until 15 March. ECDC will continue to monitor this event until 20 March.
- The probability of EU/EEA residents becoming acquiring communicable diseases during the Winter Olympic and Paralympic Games 2026 is low, if general preventive measures are applied.

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Overview of respiratory virus epidemiology in the EU/EEA

Summary

Primary care consultations for respiratory illness have returned to baseline levels in more than half of reporting countries, indicating that respiratory virus circulation has declined across much of the EU/EEA in recent weeks.

Influenza virus circulation continues to decrease. Hospitalisations are also decreasing, with adults 65 years old and above accounting for most admissions. Influenza A(H3) remains the dominant subtype, followed by A(H1)pdm09.

Respiratory syncytial virus (RSV) circulation remains high. RSV hospitalisations remain elevated, with children under five years old accounting for most admissions.

SARS-CoV-2 circulation remains low in all age groups, with few hospitalisations.

EuroMOMO reported all-cause mortality at expected levels across all age groups.

All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026

- Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries. While generally the epidemiological trends of mpox cases due to MPXV clades I and II remain similar to previous weeks, a number of mpox clade I cases have been reported outside countries with community transmission and among men who have sex with men.
- On the African continent, most mpox clade I cases since 2024 have been reported by the Democratic Republic of the Congo (DRC), Uganda and Burundi. Trends are decreasing with week-to-week fluctuations.
- Sporadic mpox clade I cases have also been reported outside the African continent, including in people without previous travel history to areas with clade I circulation. This indicates wider transmission outside Africa and likely within sexual networks.
- The classification of transmission patterns of mpox clade I has been updated as of 12 March 2026 (details are provided in the overview).
- Replacement of the general cell culture protocol (2.1). Updated version now also includes cultivation advice for VeroE6 TMPRSS cells.

Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2026

- Since 1 February 2026, and as of 12 March 2026, 189 mpox cases have been reported from 14 EU/EEA countries: Spain (57), France (31), Italy (27), Ireland (12), Netherlands (12), Germany (10), Portugal (10), Sweden (9), Belgium (8), Austria (7), Czechia (3), Greece (1), Norway (1) and Poland (1). Since 1 February 2026, no new countries have reported confirmed cases.
- Following a gradual increase in the number of mpox clade I cases reported by month between September (7 cases) to January (84 cases), fewer cases (38) were reported in February 2026.
- In total, 239 mpox clade I cases have been reported in the EU/EEA since August 2024 and as of 12 March 2026.
- •Information on sexual behaviour was available for 114 cases and of these, 102 cases were reported among men who have sex with men and all except two cases had symptom onset since October 2025. The majority of cases among men who have sex with men, with available information, do not have a travel link to a country with mpox clade Ib transmission. This indicates ongoing local transmission in sexual networks of gay, bisexual and other men who have sex with men in the EU/EEA.
- The risk of mpox clade Ib is assessed as moderate for men who have sex with men and low for the general population in the EU/EEA.
- Implementing vaccination strategies is key with a focus on preexposure vaccination and maintaining active risk communication and community engagement.
- Identifying clades should be done where individuals have been diagnosed with mpox. Countries are encouraged to report new cases of clade I as soon as possible in EpiPulse Events and to also report the case to TESSy through case-based surveillance.

- Countries should continue efforts to sequence all positive cases and ensure that sequences are deposited in public repositories (ENA, SRA, and/or GISAID EpiPox) or shared with ECDC through the EpiPulse platform or other means.

Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring

- In January 2026, 12 EU/EEA countries reported 173 measles cases. Sixteen countries reported zero cases.
- During the last 12-month period, six deaths attributable to measles were reported to ECDC by France (4), Romania (1) and the Netherlands (1).
- Overall, case numbers increased compared with previous months.
- Complementary epidemic intelligence surveillance was performed on 10 and 11 March 2026. An increase of cases has been detected in Madrid, Spain. Sporadic cases and clusters were reported in several EU/EEA countries. Updates are provided for several countries and regions outside the EU/EEA.

1. Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles

Overview:

Since November 2025, more than 110 travel-related cases of chikungunya virus disease have been reported by 13 EU/EEA countries among travellers returning from Seychelles. This represents a marked increase compared with the earlier months of 2025, and no cases have been reported in preceding years.

The emergence of chikungunya virus disease in the Seychelles aligns with a broader regional spread throughout the Indian Ocean. Notably, Réunion (France) experienced a major outbreak in 2025.

According to local health authorities, chikungunya virus has become more prevalent in the Seychelles compared with other circulating arboviruses. For global epidemiological updates, see ECDC's dedicated chikungunya webpage.

ECDC assessment:

The current likelihood of chikungunya virus infection for travellers to the Seychelles is high.

Given that the peak travel period to the Seychelles occurs between February and April, it is important to strengthen communication to travellers and travel medicine clinics regarding the ongoing outbreak and the need for reinforced preventive measures. Vaccination of travellers may be considered, based on national recommendations.

The likelihood of onward transmission of chikungunya virus in mainland Europe following introduction by a viraemic traveller is currently considered low, as environmental conditions are not favourable for Aedes mosquito activity at this time of year.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities. A news item has been published in the ECDC website: High number of chikungunya cases reported among travellers returning from Seychelles: local transmission in mainland Europe currently unlikely. Monthly updates are provided at: ECDC's dedicated chikungunya webpage.

Last time this event was included in the Weekly CDTR: 27 February 2026

2. Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

Overview:

Update
Since the previous update and as of 12 March 2026, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic and Paralympic Games.

Summary
Since the start of the Winter Paralympic Games Milano Cortina 2026, no major public health events related to communicable diseases have been detected among participants. ECDC is monitoring this mass gathering event until 20 March.

The Winter Olympic Games Milano Cortina 2026 finished on 22 February. During the mass gathering event, no major public health events related to communicable diseases were detected. There were limited outbreaks reported among athletes in the Olympic Village. These outbreaks were related to gastrointestinal and influenza-like illnesses. Outside of the Olympic Village, there was no indication of communicable disease transmission among attendees linked to their attendance at Olympic venues.

Background
The Paralympic Winter Games takes place from 6–15 March 2026 with more than 600 athletes competing. The event is taking place at Verona's Olympic Arena, Milan, Cortina, and Val di Fiemme.

The Winter Olympic Games Milano Cortina 2026 took place 4–22 February 2026. The competitions started on 4 February, with the Opening Ceremony on 6 February at San Siro Stadium, Milan and the Closing Ceremony on 22 February at Verona Arena. The Game spread across northern Italy, primarily in Milan and Cortina d'Ampezzo, with additional events in Valtellina, Val di Fiemme, and Anterselva/Antholz. More than 2 900 athletes and participants participated from over 90 countries.

ECDC assessment:

Mass gathering events involve a large number of visitors in one area at the same time. Multiple factors can lead to the emergence of a public health threat, such as an imported disease, increased numbers of people susceptible to disease, behaviour which means you may be at higher risk of contracting a disease, sale of food and beverages by street vendors, etc. At the same time, non-communicable health risks, including crowd or extreme weather-related injuries and drug- and alcohol-related conditions, should also be considered by the organisers and the public health authorities of the hosting country.

The Winter Paralympic Games 2026 is a mass gathering involving multiple events in different event locations, taking place in March. The general assessment provided below refers to the probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Paralympic Games. However, if specific public health events with potential impact at local, national and EU/EEA levels are identified, they will be assessed separately.

The probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Paralympic Games 2026 is low, if general preventive measures are applied - e.g. being fully vaccinated according to national immunisation schedules, following advice regarding hand and food hygiene and respiratory etiquette, self-isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, seeking prompt testing and medical advice as needed, and adopting safer sexual practices. Adopting general preventive measures is particularly important in relation to vaccine-preventable diseases that may be on the rise in the EU/EEA, such as measles, whooping cough, and respiratory infections including influenza and COVID-19. In view of the earlier start of the influenza season 2025/26 in November 2025, ECDC urges those eligible to get vaccinated without delay. ECDC has published recommendations for those attending this mass gathering event.

Actions:

ECDC is monitoring this mass gathering event through epidemic intelligence activities and close collaboration with the Italian National Institute of Health (Istituto Superiore di Sanità) and other partners. Updates with relevant signals and events are being provided on a weekly basis.

Last time this event was included in the Weekly CDTR: 6 March 2026

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

Overview:

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.

Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 6 March 2026

Maps and graphs

Figure 1. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 10	Week 9	Description	Value
ILI/ARI consultation rates in primary care	ARI	16 rates (10 MEM)	18 rates (10 MEM)	Distribution of country MEM categories	8 Baseline 2 Low
	ILI	20 rates (18 MEM)	22 rates (20 MEM)		13 Baseline 3 Low 2 Medium
ILI/ARI test positivity in primary care	Influenza	18	21	Pooled (median; IQR)	11% (15; 3.6–25%)
	RSV	17	20		10% (10; 7.9–16%)
	SARS-CoV-2	17	19		2.7% (1.9; 0–7%)
SARI rates in hospitals	SARI	11 rates (5 MEM)	12 rates (6 MEM)	Distribution of country MEM categories	5 Baseline
SARI test positivity in hospitals	Influenza	9	11	Pooled (median; IQR)	9.2% (5.3; 3.4–12%)
	RSV	9	11		17% (13; 13–27%)
	SARS-CoV-2	9	10		2.6% (0.9; 0.4–5%)
Intensity (country-defined)	Influenza	22	25	Distribution of country qualitative categories	6 Baseline 11 Low 4 Medium 1 Very high
Geographic spread (country-defined)	Influenza	20	23	Distribution of country qualitative categories	5 Sporadic 2 Local 2 Regional 11 Widespread

Source: ECDC

Figure 2. ILI/ARI virological surveillance in primary care - pathogen type and subtype distribution

	Week 10, 2026		Week 40, 2025 – week 10, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**209**	–	**17903**	–
Influenza A	204	99	17360	99
A(H1)pdm09	65	46	3922	27
A(H3)	75	54	10374	73
A (unknown)	64	–	3064	–
Influenza B	3	1	93	0.5
B/Vic	0	–	31	100
B (unknown)	3	–	62	–
Influenza untyped	2	–	450	–
RSV	**168**	–	**4025**	–
RSV-A	21	40	732	48
RSV-B	31	60	780	52
RSV untyped	116	–	2513	–
SARS-CoV-2	**45**	–	**3773**	–

[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 3. SARI virological surveillance in hospitals - pathogen type and subtype distribution

	Week 10, 2026		Week 40, 2025 – week 10, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**188**	–	**14338**	–
Influenza A	98	98	8511	99
A(H1)pdm09	12	86	1284	35
A(H3)	2	14	2340	65
A (unknown)	84	–	4887	–
Influenza B	2	2	49	0.6
B/Vic	0	–	4	100
B (unknown)	2	–	45	–
Influenza untyped	88	–	5778	–
RSV	**276**	–	**5454**	–
RSV-A	9	43	1027	56
RSV-B	12	57	822	44
RSV untyped	255	–	3605	–
SARS-CoV-2	**51**	–	**2744**	–

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

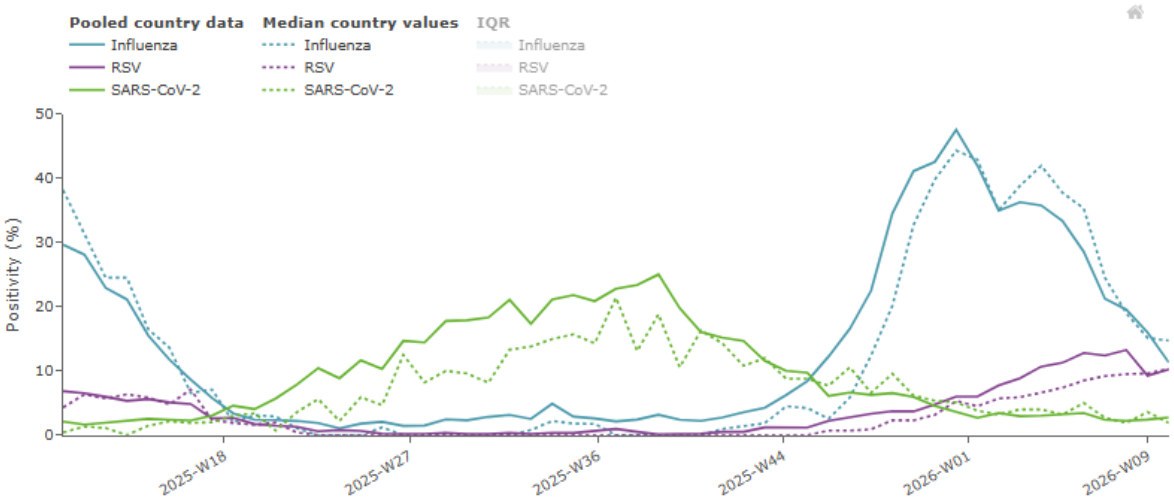
Source: ECDC

Figure 4. Genetically characterised influenza virus distribution, week 40, 2025 – week 10, 2026

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	2703	41	5a.2a.1(D.3.1)	2600	96
			5a.2a.1(D)	97	4
			5a.2a(C.1.9.3)	6	0.2
A(H3)	3938	59	2a.3a.1(K)	3518	89
			2a.3a.1(J.2)	283	7
			2a.3a.1(J.2.4)	83	2
			2a.3a.1(J.2.2)	29	0.7
			2a.3a.1(J)	25	0.6
B/Vic	29	0.4	V1A.3a.2(C.5.6)	10	34
			V1A.3a.2(C.5.6.1)	8	28
			V1A.3a.2(C.5.1)	7	24
			V1A.3a.2(C.5)	2	7
			V1A.3a.2(C.5.7)	2	7

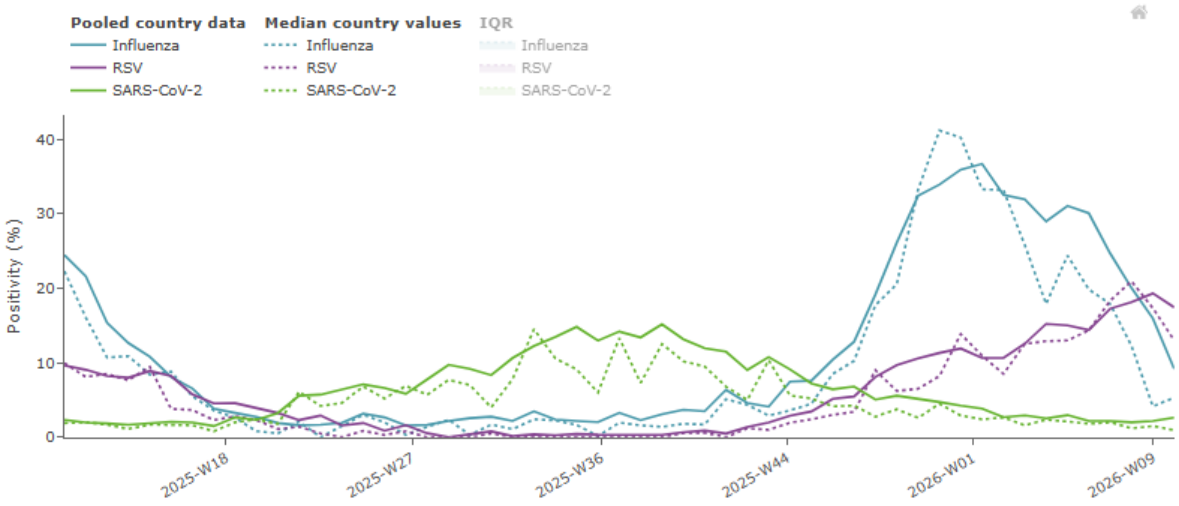
Source: ECDC

Figure 5. ILI/ARI virological surveillance in primary care - weekly test positivity



Source: ECDC

Figure 6. SARI virological surveillance in hospitals - weekly test positivity



Source: ECDC

4. Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026

Overview:

Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries globally. The epidemiological profile of mpox cases due to MPXV clade II cases reported outside Africa since 2022 remains similar to previous weeks. With regards to mpox clade I, cases have been reported by several countries outside Africa with and without travel history to countries with ongoing clade I transmission. For both clade I and II, sexual contacts have been described as drivers of transmission.

A summary of the recently observed global trends of clades I and II is provided below along with the classification of countries based on the clade I transmission.

Mpox clade II summary

Mpox clade II has been circulating globally since 2022. In African countries with recent mpox clade II outbreaks (e.g. Ghana, Guinea, Liberia), cases have been reported among young adults, affecting both males and females. Sexual contact has been
described as a main driver of transmission (Multi-country outbreak of mpox, External situation report #60 - 8 December 2025, Multi-country outbreak of mpox, External situation report #62-23 January 2026, Multi-country external situation report #63 – 24 February 2026). Outside Africa, cases were mostly reported in adults (99%) and males (97%), the majority of whom reported having had sex with men (89%) (Global Mpox Trends published 6 March 2026).

Mpox clade I summary and transmission patterns classification

In Africa, since 2025, the five countries that reported most confirmed and suspected mpox clade I cases are DRC, Uganda and Burundi, followed by Kenya and Madagascar. According to WHO, in the past six weeks, and as of 1 March 2026, most confirmed cases of clade I were reported by Madagascar and DRC (357 and 216 cases, respectively). All other countries in Africa with clade I detections have reported fewer than 100 cases during the last six weeks. Overall, a decreasing trend in mpox clade I cases that has been reported in Africa since May 2025 continues in March 2026 (Global Mpox Trends published 6 March 2026).

Since August 2024, in EU/EEA travel-associated mpox clade I cases, or locally-acquired mpox clade I cases have been reported by Sweden, Germany, Belgium, France, Ireland, Italy, Spain, Greece, Romania, Czechia and Austria. In addition to Africa and the EU/EEA, since August 2024, mpox clade I cases have been reported by Thailand, India, Türkiye, the United Kingdom, the United States, Canada, Pakistan, Oman, China, the United Arab Emirates,

Qatar, Brazil, Switzerland, Australia, Japan, Israel, Mexico and Nepal (Global Mpox Trends published 6 March 2026). Most travel-associated cases reported outside African countries had links to affected countries in Africa. Imported cases with a travel history to China, Germany, Lebanon, Malaysia, Nepal, Netherlands, Oman, Pakistan, Russia, Thailand, United Arab Emirates, and VietNam have also been reported (Global Mpox Trends published 6 March 2026).

Since October 2025, several EU/EEA countries have reported mpox clade I in men who have sex with men, most of whom have no travel history. In addition to the cases reported among men who have sex with men, confirmed limited secondary transmission of clade I within households has been reported in the EU/EEA, mainly among household contacts since 2024, by Germany, Belgium, and Ireland. Outside the EU/EEA and Africa, secondary transmission has also been reported in the UK, China, Qatar, and Australia. The number of secondary cases reported in these events has been low (range: 1–6 cases per event; Global Mpox Trends published 6 March 2026). Based on the information available, all transmission events were due to close contact and no deaths were reported.

Transmission patterns of mpox due to MPXV clade I - update 12 March 2026

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 that have reported MPXV clade I cases since 2024.

The definitions of the categories have been revised to account for context and availability of epidemiological data (see note below). The classification is as follows:

- Community transmission: Burundi, Central African Republic, Congo, DRC, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Rwanda, the United Arab Emirates, Tanzania, Uganda, and Zambia.
- Countries with travel-associated cases or limited transmission: Angola, Austria, Australia, Belgium, Brazil, Canada, China, Comoros, Czechia, France, Germany, Greece, India, Ireland, Israel, Italy, Japan, Malaysia, Mexico, Namibia, Nepal, the Netherlands, Oman, Pakistan, Portugal, Romania, Qatar, Senegal, Spain, South Africa, South Sudan, Sweden, Switzerland, Thailand, Türkiye, the United Kingdom, the United States, and Zimbabwe;

Note:
Community transmission is defined as follows:
When there are adequate epidemiological data and the following apply:

- cases without links to travel-associated cases are reported,
- multiple age groups are affected,
- cases are reported outside specific risk groups/settings,
- there is wide geographical spread.

If epidemiological data and/or testing are known to be limited and at least one of the following apply:

- there is a large number of suspected cases,
- there are multiple (suspected or confirmed) cases with limited data on transmission chains,
- multiple cases likely infected in the country are reported from other areas/countries.

Countries are classified as with travel-associated cases or limited transmission when the following apply:

- only travel-associated cases have been reported
- sporadic cases have been reported having epidemiological links with travel-associated cases
- there is only a small number of cases for which epidemiological links to travel-associated cases have not been reported or are unclear.
- transmission chains are mostly contained within specific groups or settings (e.g., groups with high numbers of sexual partners, camps with internally displaced populations, prisons)
- there is limited spillover to other groups (e.g., children)
- zoonotic spillover and small clusters of cases reported in endemic countries
- there is no evidence of wider community transmission (e.g., clade I following patterns similar to clade II in countries where clade II has been reported since 2022 and has been circulating continuously at low levels and in groups with high numbers of sexual contacts)

There are several limitations and caveats in the classification of community transmission of mpox clade I as the extend of ongoing undetected transmission cannot be quantified with certainty. Moreover, a number of countries have reported cases with travel history to regions/countries with limited number of clade I cases or no clade I cases and further information on transmission chains is not available (Global Mpox Trends published 6 March 2026), For example, VietNam, Mali, Russia and Lebanon have not reported any mpox clade I detection and they have been reported as places of travel of known cases elsewhere. Imported cases with a travel history to countries

that have reported a small number of mostly travel associated cases have also been reported e.g., Malaysia, Nepal, Thailand, Oman and China (Global Mpox Trends published 6 March 2026). Countries that have been categorised as having community transmission for fulfilling the definitions may be reporting currently smaller number of cases (e.g., Kenya) or decreasing case trends. All the above, should be taken into account when interpreting the classification.

ECDC assessment:

The epidemiological situation regarding mpox due to MPXV clade I remains similar to previous weeks. The cases of clade I that have been reported outside of Africa, including secondary transmission, are not unexpected. A new pattern of transmission is emerging in countries outside Africa, including in the EU/EEA, among men who have sex with men.

ECDC published a Threat Assessment Brief on 24 October 2025 to assess the new situation. The risk of clade Ib infection is assessed as moderate for men who have sex with men and low for the general population in the EU/EEA, reflecting current evidence and considerable uncertainties around transmissibility and severity of clade Ib infection relative to clade IIb. The risk for clade IIb infection remains low for men who have sex with men and very low for the general population in the EU/EEA.

The Threat Assessment Brief on the detection of autochthonous transmission of monkeypox virus (MPXV) clade Ib in the EU/EEA summarises the information on new cases and outlines actions EU/EEA countries can take, including testing, sequencing and contact tracing; promoting vaccination; risk communication; and community engagement activities. The brief also outlines the knowledge gaps that remain, including on transmissibility and severity of MPXV clade Ib compared with clade IIb.

Recommendations for EU/EEA countries include raising awareness among healthcare professionals; supporting sexual health services in case detection, contact tracing, and case management; making testing easily accessible; implementing vaccination strategies with a focus on pre-exposure vaccination and maintaining active risk communication and community engagement.

Primary preventive vaccination (PPV) and post-exposure preventive vaccination (PEPV) strategies may be combined to focus on individuals at substantially higher risk of exposure and close contacts of cases, respectively, particularly in the event of limited vaccine supply. PPV strategies should prioritise gay, bisexual, and transgender people, and men who have sex with men, who are at higher risk of exposure, as well as individuals at risk of occupational exposure, based on epidemiological or behavioural criteria. Health promotion interventions and community engagement are also critical to ensure effective outreach and high vaccine acceptance and uptake among those most at risk of exposure.

In addition to increased risk of local transmission of MPXV clade Ib among men who have sex with men, it is likely that mpox cases caused by MPXV clade I will continue to be introduced into the EU/EEA through returning travellers. This is the case particularly after holiday travel. It is important to raise awareness concerning the possible importation of cases, both among returning travellers from affected African countries and among healthcare professionals who may see such patients.

EU/EEA countries should 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. Clade identification and virus sequencing should also be prioritised.

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' and the Threat Assessment Brief Detection of autochthonous transmission of monkeypox virus clade Ib in the EU/EEA.

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.

Monthly updates are shared through the Communicable Disease Threats Report. As the global epidemiological situation is monitored continuously, ad hoc epidemiological updates may also be published.

Sources: ECDC rapid risk assessment

Last time this event was included in the Weekly CDTR: 6 February 2026

5. Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2026

Overview:

Summary of clade I mpox

Since 1 February 2026, and as of 12 March 2026, 50 mpox clade I cases were reported to TESSy by Spain (16), France (8), Sweden (7), Austria (6), Italy (5), Czechia (3), Belgium (1), Germany (1), Greece (1), Ireland (1) and Portugal (1).

The number of clade I cases reported by calendar month has decreased in February following an increase in recent months, with seven cases in September, 12 cases in October, 20 cases in November, 38 cases in December 2025, 84 cases in January 2026 and 38 cases in February 2026.

In Spain, the number of cases increased from 14 in November, 29 in December to 41 in January, but decreased to 16 in February. In Italy, the number of cases increased from four in December to 19 in January, but only five cases were reported in February. Germany had two cases in December to nine in January and one in February. France had one case in December, six in January and seven in February.

Overall, 239 mpox clade I cases have been reported in the EU/EEA to TESSy since August 2024 and as of 12 March 2026: Spain (103), Italy (34), Germany (27), France (18), Netherlands (17), Belgium (9), Sweden (8), Ireland (7), Austria (6), Czechia (4), Portugal (3), Greece (2), Romania (1). All were clade Ib except the first case in Ireland, which was clade Ia. Of all 228 mpox clade I cases with information on hospitalisation available, 20 were hospitalised for treatment (12 of which were in Italy) and 14 for unknown reason (10 of which were in Spain).

Of the 114 cases with information available on sexual behaviour, 102 were reported in men who have sex with other men: Spain (74), Netherlands (15), Austria (6), Belgium (2), Greece (2), Portugal (2) and Czechia (1). All cases among men who have sex with men except one case in Greece and one case in Belgium had symptom onset since October 2025.

Among men who have sex with men, 96 cases had travel information available and 77 were due to local transmission. Several countries have reported cases among men who have sex with men directly or indirectly related to travel to Germany.

Ten of the 101 cases among men who have sex with men were hospitalised, nine of whom were in Spain with unknown reason for hospitalisation (treatment or isolation).

Of the 86 cases among men who have sex with men with vaccination information available, 59 (69%) were unvaccinated, 20 were vaccinated with two doses and seven with one dose.

These results indicate ongoing transmission of mpox clade I in sexual networks of gay, bisexual and other men who have sex, including local transmission in the EU/EEA. No wider community transmission has been reported outside the sexual networks. Prior to October 2025 all cases were imported, or directly related to imported cases, and were related to heterosexual and household transmission.

Overall situation

Since 1 February 2026, and as of 12 March 2026, 189 mpox cases have been reported from 14 EU/EEA countries: Spain (57), France (31), Italy (27), Ireland (12), Netherlands (12), Germany (10), Portugal (10), Sweden (9), Belgium (8), Austria (7), Czechia (3), Greece (1), Norway (1) and Poland (1). Since 1 February 2026, no new countries have reported confirmed cases.

Since the start of the mpox outbreak and as of 12 March 2026, 26 349 confirmed cases of mpox (MPX) have been reported from 29 EU/EEA countries: Spain (9 482), Germany (4 644), France (4 476), Netherlands (1 619), Portugal (1 364), Italy (1 358), Belgium (927), Austria (394), Sweden (383), Ireland (342), Poland (258), Denmark (247), Greece (162), Norway (137), Czechia (115), Hungary (90), Luxembourg (66), Romania (51), Malta (49), Slovenia (48), Croatia (39), Finland (21), Slovakia (19), Iceland (18), Bulgaria (11), Estonia (11), Cyprus (6), Latvia (6) and Lithuania (6). Deaths have been reported from: Spain (4), Belgium (2), Portugal (2), Austria (1) and Czechia (1).

Within the same period (since the beginning of the outbreak), the following Western Balkan countries have reported confirmed cases of mpox: Serbia (40), Bosnia and Herzegovina (9), Montenegro (2), North Macedonia (2), Albania (1) and Kosovo* (1). In addition, 76 cases have been reported from Türkiye, one of which was clade Ia and five clade Ib, the most recent being reported in December 2025.

Other than the 239 clade I cases, all other mpox cases with available information on clade reported to Tessy in the EU/EEA were MPXV clade IIb. Clade II cases reported in 2025 share the same epidemiological profile as those reported since the beginning of the outbreak in the EU/EEA, with the majority of cases occurring in men, and sexual contact among men who have sex with men remaining the primary mode of transmission.

For more information on the global update regarding MPXV clades I and II, please refer to the Weekly Communicable Diseases Threats Report and the ECDC webpage: Mpox worldwide overview.

*This designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the Internati onal Court of Justice (ICJ) Opinion on the Kosovo declaration of independence.

ECDC assessment:

Following an increase in the number of mpox clade I cases reported to ECDC in recent months fewer cases were reported in February. Still, the overall development is of concern and highlights the need for Member States to increase efforts to vaccinate and raise awareness among men who have sex with men in particular.

ECDC published a Threat Assessment Brief on October 24 to assess the new situation and this risk assessment remains valid. The risk of clade Ib infection is assessed as moderate for men who have sex with men and low for the general population in the EU/EEA, reflecting current evidence and considerable uncertainties around transmissibility and severity of clade Ib infection relative to clade IIb. The risk of clade IIb infection remains low for men who have sex with men and very low for the general population in the EU/EEA.

The Threat Assessment Brief on the detection of autochthonous transmission of monkeypox virus (MPXV) clade Ib in the EU/EEA summarises the information on new cases and outlines actions that EU/EEA countries can take, including testing, sequencing and contact tracing; promoting vaccination; risk communication; and community engagement activities. The brief also outlines the knowledge gaps that remain - e.g. on transmissibility and severity of MPXV clade Ib compared with clade IIb.

Recommendations for EU/EEA countries include raising awareness among healthcare professionals; supporting sexual health services in case detection, contact tracing, and case management; making testing easily accessible; implementing vaccination strategies with a focus on pre-exposure vaccination and maintaining active risk communication and community engagement.

Primary preventive vaccination (PPV) and post-exposure preventive vaccination (PEPV) strategies may be combined to focus on individuals at substantially higher risk of exposure and close contacts of cases, particularly where vaccine supply is limited. PPV strategies should prioritise gay, bisexual, and transgender people, and men who have sex with men, who are at higher risk of exposure, as well as individuals at risk of occupational exposure, based on epidemiological or behavioural criteria. Health promotion interventions and community engagement are also critical to ensure effective outreach and high vaccine acceptance and uptake among those most at risk of exposure.

In addition to increased risk of local transmission of MPXV clade Ib among men who have sex with men, it is likely that mpox cases caused by MPXV clade I will continue to be introduced into the EU/EEA through returning travellers. This is particularly relevant after holiday travel. It is important to raise awareness concerning the possible importation of cases, both among returning travellers from affected African countries and among healthcare professionals who may see such patients.

Actions:

ECDC is continuously monitoring mpox in the EU/EEA and globally through event- and indicator-based surveillance, and remains in contact with partners. ECDC is in contact with affected countries to gather further information.

Countries are encouraged to report new mpox cases caused by MPXV clade I as soon as possible in EpiPulse Events and to also report these cases to TESSy through case-based surveillance, with information on clade and subclade, vaccination status, prior infection, symptoms, hospitalisation status, transmission category, HIV status, etc. Countries can update TESSy records as additional information becomes available, but it is important to submit clade I mpox cases as soon as possible to TESSy even though the overall reporting deadline is the first Wednesday of the month.

Countries should continue efforts to sequence all positive cases and ensure that sequences are deposited in public repositories (ENA, SRA, and/or GISAID EpiPox) or shared with ECDC through the EpiPulse platform or other means.

Countries are also asked to submit as much detailed information as possible on clade II mpox cases, as this will allow us to do a direct comparison of severity between clade I and clade II mpox cases from the same time period.

ECDC has been assessing the risk of mpox in the multi-country outbreak 2022/23 as well as the emergence of clade I. Previous risk assessments and other information can be found at the foot of this page: https://www.ecdc.europa.eu/en/mpox together with a rapid scientific advice on public health measures. A resource toolkit for event organisers and social media materials on mpox related to events are also available.

Last time this event was included in the Weekly CDTR: 20 February 2026

6. Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring

Overview:

In January 2026, 28 EU/EEA countries reported measles data. Twelve countries reported 173 cases and 16 countries reported zero cases.

Overall, case numbers increased compared with the previous month, however this may be subject to change in the event of a future retrospective update. The highest case counts were reported by Italy (84), Spain (48), France (12), Romania (nine) and Belgium (seven).

Between 1 February 2025 and 31 January 2026, 30 EU/EEA countries reported a total of 6 037 cases of measles, 4 866 (80.6%) of which were laboratory confirmed.

Of the 6 037 cases with known age, 2 250 (37.3%) were in children aged under five years; and 2 282 (37.8%) cases were in those aged 15 years or above. The highest notification rates were observed in infants under one year of age (185.5 cases per million) and children aged 1-4 years (94.6 cases per million).

Of 5 736 individuals (95.0% of all cases) with a known age and vaccination status, 4 455 (77.7%) were unvaccinated, 638 (11.1%) were vaccinated with one dose of a measles-containing vaccine, 516 (9.0%) were vaccinated with two or more doses, and 117 (2.0%) were vaccinated with an unknown number of doses.

During the 12-month period, six deaths (case fatality rate (CFR): 0.099 %) attributable to measles were reported to ECDC by France (four), Netherlands (one) and Romania (one). Detailed data are available in ECDC's Surveillance Atlas of Infectious Diseases.

Complementary epidemic intelligence surveillance was performed on 10 and 11 March 2026. An increase of cases has been detected in Madrid, Spain. Sporadic cases and clusters were reported in several EU/EEA countries. Outside the EU/EEA, updates have been provided for Serbia, England, Northern Ireland, Israel, Ukraine, Australia, Africa CDC, Canada, US and the World Health Organization Pan American Health Organization (WHO PAHO) region.

Disclaimer: The monthly measles report published in the CDTR provides the most recent data on cases and outbreaks based on information made publicly available by the national public health authorities or the media. Sometimes this information is made available retrospectively. This report is a supplement to ECDC's monthly measles and rubella monitoring report, based on data routinely submitted by 30 EU/EEA countries to EpiPulse Cases. Data presented in the two monthly reports may differ.

Epidemiological summary for EU/EEA countries with relevant epidemic intelligence updates:

Austria reported three cases in 2026 and as of 26 February, an increase by one case.

Estonia reported two new cases in January 2026 and as of 10 March 2026 and 11 cases in 2025.

Germany reported 38 confirmed and probable measles cases in 2026 (week 1 to 10), an increase of four cases from week 7. No outbreaks have been detected by ECDC EI group.

Hungary reported one case in 2026 and as of 10 March.

Ireland reported four cases in 2026 in weeks 1 to 8. Data from Ireland (National Notifiable Disease Hub) includes confirmed, probable, and possible measles cases.

Italy reported 84 new cases in January 2026 (73 laboratory confirmed, five probable and six possible cases) in January 2026 as of 19 February 2026. Of the reported cases, five were healthcare workers. Genotype D8 and B3 were detected in 15 and 6 samples, respectively.

Poland reported eight cases of measles from 1 January to 28 February 2026, an increase of 6 cases since end of January 2026.

Spain reported 81 cases of measles from 1 January to 1 March 2026, including three imported and six cases related to imported cases. This represents an increase of 49 cases since 8 February 2026.

According to media report on 11 March 2026, an increase of measles cases has been reported in Madrid. Between weeks 1 and 7 in 2026, Madrid reported 24 cases of measles involving several family clusters. The number of cases in Madrid is now exceeding the total number reported in the city in 2025.

Sweden reported three cases in 2026 and as of 10 March.

Epidemiological summary for EU/EEA outermost territories with relevant epidemic intelligence updates:

No new outbreaks or cases have been detected in the reporting period.

Western Balkan countries and Türkiye
Serbia reported 204 measles cases in 2025 and as of report in February 2026.

Epidemiological summary for selected countries outside of the EU/EEA with relevant epidemic intelligence updates:
England reported 195 laboratory confirmed cases between 1 January and 2 March 2026. Cases have increased in January 2026, mostly driven by the ongoing outbreak in North London. The majority of cases involve children under aged 10 years of age and under (73%).

Northern Ireland reported six suspected measles cases during January and February 2026, of those none were confirmed.

Ukraine reported 1 461 measles cases from January to December 2025.

Israel reported 372 measles cases in 2026 and as of 25 February 2026.

Australia reported 64 cases in 2026 and as of 11 March 2026.

Africa CDC reported on 9 March 2026, overall, in 2026, there have been reported 23 843 cases of measles (692 confirmed) and 238
deaths in eight countries: DRC (20 231 cases, 238 deaths), Guinea (71; 0), Liberia (46; 0), Mali (123;0) Mozambique (85; 0), Senegal (11; 0), Somalia (2 920; 0) and South Africa (356; 0). Mali is listed as a high risk to population and a moderate risk is indicated in Mozambique.

The US continues to face multiple concurrent outbreaks, including several that began in 2025 and continue into 2026. High transmission is concentrated in select states, with 89% of cases outbreak-associated, indicating persistent chains of community transmission and pressure on elimination status. Overall US CDC reported 1 281 cases and no deaths as of national report on 6 March 2026.

Canada reported 339 measles cases (314 confirmed) and no deaths across seven jurisdictions in 2026 and as of 2 March 2026. The country remains in active transmission across multiple provinces.

Mexico reported on 10 March 2026, overall since the beginning of the outbreak in 2025, 12 963 confirmed cases were reported, including 34 deaths. In 2026, Mexico reported 6 511 confirmed cases and seven deaths. Mostly affected state is Jalisco (3 823 cases; two deaths).

According to WHO PAHO, in 2026 (week 1–6), 2 740 measles cases and no deaths were reported in the Americas Region. Cases were notified by Mexico (1 104), the United States (US) (970), Guatemala (374), Canada (254), Bolivia (34), Chile (1), Costa Rica (1), Peru (1), and Uruguay (2).

For more information on the provisional number of cases outside the EU/EEA region, please visit the World Health Organization (WHO) website.

The numbers provided to WHO for EU/EEA countries are from EpiPulse Cases data, which are updated monthly and available on the ECDC Surveillance Atlas of Infectious Diseases. Due to differences in reporting times, the numbers may not correspond to the data from epidemic intelligence screening.

ECDC assessment:

Although most recent cases were acquired through local or community transmission, travel-related cases continue to be reported.

Continued vigilance is essential due to sub-optimal vaccination coverage for measles-containing vaccines (MCV) in several EU/EEA countries, possible introduction from areas with ongoing transmission, and increased travel and population movement during holiday periods.

Actions:

ECDC is monitoring the measles situation through its epidemic intelligence activities. Data collected via epidemic intelligence supplement the monthly outputs of measles surveillance data from EpiPulse Cases, which are routinely submitted by 30 EU/EEA countries.

ECDC urges EU/EEA public health authorities to focus on the following areas:

- **Close immunity gaps, achieve and maintain high vaccination coverage for measles-containing vaccines** (>95% with the second dose). It is vital to ensure first and second dose vaccinations are administered on time, as per national schedules among infants and children. It is also important to identify and vaccinate eligible individuals (for example, non-immune adolescents and adults) in immunisation catch-up programmes (as recommended by local and national authorities).
- **Strive towards high-quality surveillance** and adequate public health capacity, especially for early detection, diagnosis, response and control of outbreaks.
- **Increase the clinical awareness of health professionals**, including reminding them of the importance of checking individuals' vaccination status ahead of travel.
- **Healthcare professionals should be fully vaccinated.**
- **Promote vaccine acceptance and uptake** by employing specific risk communication strategies and identifying drivers of suboptimal MMR vaccine acceptance and uptake to ensure that tailored interventions are implemented in response.
- **Address barriers and engage with populations underserved by healthcare services.** Systemic barriers that affect vaccine uptake in populations that are isolated and underserved by healthcare services need to be monitored and addressed with targeted strategies in order to reduce inequalities in vaccine uptake.
- In light of the upcoming summer holiday season, **travellers should check their vaccination status** and consult their general practitioner to ensure they are up-to-date with recommended immunisations prior to departure.

ECDC's latest advice on measles is available in the Threat Assessment Brief '**Measles on the rise in the EU/EEA: Considerations for a public health response**', published in February 2024 and the conclusions remain valid. Additional information on the risk classification and ECDC recommendations can be found in this report.

Last time this event was included in the Weekly CDTR: 13 February 2026

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Human cases of influenza virus A(H1N1) variant of swine origin - Multi-country
- Overview of respiratory virus epidemiology in the EU/EEA
- Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026
- Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles
- Mpox clade Ib and clade IIb recombinant strain
- Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2026
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Rapid Outbreak Assessment under production
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Nipah virus disease – India and Bangladesh – 2026
- Chikungunya virus disease – Mayotte, France – 2026
- SARS-CoV-2 variant classification
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update