WEEKLY BULLETIN

Communicable disease threats report

Week 6, 31 January - 6 February 2026

This week's topics

Executive summary

Overview of respiratory virus epidemiology in the EU/EEA

Summary

The number of people with symptoms of respiratory illness remains elevated, and has continued to increase since the start of the year, suggesting widespread respiratory virus circulation across the EU/EEA.

Influenza virus circulation remains widespread: activity has peaked in some countries while others appear to be approaching their peak. Children aged 5-14 years appear to be the main group driving transmission, with increases seen both in milder and more severe illness. Overall, hospitalisations have decreased compared with the beginning of the year, although adults aged 65 years and over continue to account for most hospital admissions, ICU admissions and deaths. Influenza A remains dominant with A(H1N1) and A(H3N2) co-circulating.

Early estimates of seasonal influenza vaccine effectiveness in the EU/EEA for the 2025/26 season were published by ECDC on 19 December 2025, and match those published for A(H3N2) viruses by other countries.

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Respiratory syncytial virus (RSV) circulation is elevated and continues to increase, with this season starting later than the previous two seasons. Children under five years are the most affected and account for most of the hospitalisations.

SARS-CoV-2 circulation remains low in all age groups, and the number of hospitalisations due to SARS-CoV-2 is currently limited compared to influenza and RSV.

EuroMOMO reports substantially elevated levels of all-cause mortality, primarily driven by increased mortality in several countries in age groups above 65 years.

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'.

SARS-CoV-2 variant classification

- Since the last update on 28 November 2025, and as of 30 January 2026, BA.3.2 has been added to the list of variants under monitoring (VUM).
- For this update, sufficient data for estimating variant proportions during the reporting weeks are only available from five EU/EEA countries. Therefore, the statistics below only represent a limited part of the EU/EEA.
- The variants of interest (VOI) and VUM median proportions in the EU/EEA for weeks 2-3 2026 are currently:
  - BA.2.86 (VOI): 0.0% (range: 0.0%-14.3%,IQR: 0.0%-6.7%)
  - NB.1.8.1 (VUM): 23.1% (range: 0.0%-28.6%,IQR: 20.0%-27.3%)
  - XFG (VUM): 47.6% (range: 23.1%-100.0%,IQR: 27.3%-50.0%)
  - BA.3.2 (VUM): 6.7% (range: 0.0%-46.2%, IQR: 0.0%-45.5%)

Bacillus cereus toxin in infant formula

- A multi-country recall of several infant nutrition products (different batches, products, and brands) was initiated following the detection of cereulide, the emetic toxin produced by Bacillus cereus.
- The precautionary recall was initiated in December 2025 and is still ongoing in February 2026. The root cause analysis identified the ingredient being arachidonic acid (ARA) oil leading to the contamination event.
- Belgium has reported five infants with cereulide positive feacal samples.
- ECDC and EFSA are jointly developing a Rapid Outbreak Assessment to support countries in managing the incident.
- Investigations are ongoing in the member states to investigate the link between recalled batches of formula and cases of gastrointestinal disease in children.

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

- The Winter Olympic Games in Milano-Cortina 2026 are taking place between 4 and 22 February 2026, followed by the Paralympic Winter Games from 6 to 15 March 2026. Attendance it is expected to surpass one million cumulative attendees based on previous Winter Games trends. ECDC is monitoring this mass gathering event from 2 February until 20 March through epidemic intelligence activities, through close collaboration with the Italian National Institute of Health (Istituto Superiore di Sanita') and other partners.
- Since the start of the monitoring period on 2 February and as of 5 February, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic Games.
- The probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games 2026 is low, if general preventive measures are applied.

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 cases of clade I 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 cases without previous travel history to areas with clade I circulation. This indicates wider transmission in any country outside Africa and likely within sexual networks.
- The classification of transmission patterns of mpox clade I has been updated as of 3 February 2026 (details are provided in the overview).

Nipah virus disease- India- 2026

- On 26 January 2026, the National International Health Regulation Focal Point of India reported to WHO that there had been two confirmed cases of Nipah Virus (NiV) reported in the state of West Bengal, India.
- Several media outlets, quoting India's health authorities, have reported five NiV disease cases in the district of North 24 Parganas, in the state of West Bengal.
- Both confirmed cases are in healthcare workers at the same hospital.
- As of 27 January 2026, a total of 196 contacts of the confirmed cases were identified and tested negative for NiV and no additional cases have been reported to date, according to the Indian Ministry of Health and Family Welfare.
- Thailand, Nepal, Cambodia, and other neighbouring countries have initiated measures, including information campaigns and screening for passengers arriving from India at airports.
- 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 where cases have been identified to date.

Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update

- Since the previous update on 5 January 2026, and as of 3 February 2026, no new MERS cases have been reported by the World Health Organization (WHO) or national health authorities.
- Since the beginning of 2026, and as of 3 February 2026, no MERS cases have been reported by WHO or national health authorities.
- The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in the general population is also considered to be low. The current MERS-CoV situation poses a low risk to the EU/EEA.

Rapid Outbreak Assessment under production.

ECDC, jointly with EFSA, is developing a Rapid Outbreak Assessment on the multi-country food-borne incident caused by cereulide and linked to infant formula products. The expected publication date is 19 February 2025.

1. 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.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 30 January 2026

2. SARS-CoV-2 variant classification

Overview:

Since the last update on 28 November 2025, and as of 30 January 2026, BA.3.2 has been added to the list of variants under monitoring (VUM). An increase in detections of BA.3.2 has been observed in two EU/EEA countries, with the variant circulating at a proportion > 40% in Germany and the Netherlands in week 1, 2026. However, estimates are subject to considerable uncertainty due to low levels of SARS-CoV-2 circulation and sequence depositions. Notably, BA.3.2 features 44 mutations relative to BA.2.86 sub-lineages LP.8.1/LP.8.1.1 and antigenic cartography suggests it is antigenically distant from other Omicron variants. However, preliminary studies show that JN.1- and LP.8.1-adapted booster vaccines effectively induce broad humoral immunity in humans against currently circulating JN.1 subvariants (including XFG) and BA.3.2. There is no evidence of increased severity for BA.3.2 when compared to previously circulating variants and surveillance indicators thus far indicate that replacement of XFG—which currently dominates in the EU/EEA—by BA.3.2 is unlikely to have a significant epidemiological impact.

The VOI median proportion in the EU/EEA for weeks 2-3 2026, based on five reporting countries, are currently:

BA.2.86: 0.0% (range: 0.0%-14.3%,IQR: 0.0%-6.7%)

The VUM median proportions in the EU/EEA for weeks 2-3, based on five reporting countries, are currently:

NB.1.8.1: 23.1% (range: 0.0%-28.6%,IQR: 20.0%-27.3%)
XFG: 47.6% (range: 23.1%-100.0%,IQR: 27.3%-50.0%)
BA.3.2: 6.7% (range: 0.0%-46.2%, IQR: 0.0%-45.5%)

The calculations are based on data reported to GISAID, as of 27 January 2026. Note that for this update, sufficient data for estimating variant proportions during the reporting weeks are only available from five EU/EEA countries. The statistics therefore only represent a very limited part of the EU/EEA.

ECDC assessment:

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation.

The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. The variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older adults (aged 65 years old and above), those with underlying conditions, and people who have previously not been infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of people at high risk of severe outcomes (e.g. older adults) remains important.

Actions:

In order to assess the impact of emerging SARS-CoV-2 sub-lineages and their possible correlation with increases in COVID-19 epidemiological indicators, it is important that countries sequence positive clinical specimens and report to GISAID and/or TESSy.

For the latest update on SARS-CoV-2 variant classifications, please see ECDC's webpage on variants. Variant surveillance data, including the distribution of VOC and VOI proportions in the EU/EEA and detailed country-specific COVID-19 updates are available as part of the European Respiratory Virus Surveillance Summary (ERVISS).

Routine updates on the SARS-CoV-2 variant classification through the Communicable Diseases Threats Report (CDTR) will be provided on a monthly basis at a minimum.

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

3. Bacillus cereus toxin in infant formula

Overview:

In January 2026, the recall of infant nutrition products was expanded after cereulide, the emetic toxin produced by Bacillus cereus, was detected in the products. Cereulide is a highly thermostable toxin capable of causing sudden onset of nausea and vomiting shortly after ingestion. The root cause analysis carried out so far led to the identification of the contaminated ingredient being the arachidonic acid (ARA) oil, which is an omega 6 supplement.

The recall is global, with recalls both in the EU/EEA market and in countries outside EU/EEA. The preventive recall is a risk-management action, taken following the detection of the toxin. Investigations following the recalls are ongoing in the Member States.

Cereulide toxin analysis in faecal samples is not a method that is available for routine diagnostic purposes in clinical microbiological laboratories. So far, Belgium is the only country that has reported positive faecal samples. Investigations are ongoing in Member States to investigate the possible link between recalled batches of formula and cases of gastrointestinal disease in children.

Belgium reports five infants who have tested positive based on clinical samples. All five had consumed the recalled infant formula and experienced favourable clinical outcomes. Of the infant formula consumed, three out of five case samples tested positive; the remaining two samples may not be tested.

Denmark reports that the food safety authority has received reports of infants who developed diarrhoea following consumption of the recalled product, but it is not known if there is any relation between the development of diarrhoea and consumption of the product. Samples have not been investigated for the presence of toxin, they therefore fall into the category of possible cases, and no probable or confirmed cases have been identified. No new reports have been received since the broadening of the product recall.

France reports that to date, 11 hospitalised infants have been notified and investigated by the Regional health agencies. All infants have recovered and returned home. Of the 11 hospitalised infants, five consumed recalled infant formula and for six it was not possible to confirm consumption. It is important to note that winter related gastro-enteritis is active in France. Five of the 11 hospitalised children received a differential diagnosis for the gastro-enteritis symptoms. Two unexplained infant deaths were notified in France and are currently under medico-legal investigation per routine protocols. Each year approximately 300 unexplained infant deaths are reported. Both infants consumed recalled infant formula. So far, no link has been established between the consumed formula and the reported illnesses or deaths.

Spain reported eight cases with vomiting, all of them with a history of consumption of a potentially affected product, five of whom required hospitalisation. None of the suspected cases have been laboratory-confirmed. Although additional notifications were received, it was not possible to establish a causal relationship between the clinical presentation and the consumption of the affected batches.

the UK reports 36 cases with gastrointestinal symptoms following consumption of implicated batches in England (24), Scotland (7), Wales (3), Northern Ireland (1) and the Crown Dependencies (1). Testing of recalled formula has confirmed presence of cereulide.

ECDC assessment:

The recalled products are widely distributed in EU/EEA and other countries, and the likelihood of exposure to a contaminated formula batch is therefore moderate to high for infants drinking formula. The impact of exposure to the toxin and developing of gastrointestinal symptoms is low to moderate depending on the age of the child. Neonates and young infants less than six months may be more likely to develop symptoms and are more sensitive for dehydration, electrolyte abnormalities etc. Therefore, the overall risk to children less than one year in the EU/EEA would be assessed as moderate in this incident. Many of the contaminated products have been identified and recalled, so the current likelihood of exposure is therefore decreasing, and this will also decrease the risk.

Actions:

An ECDC-EFSA Rapid Outbreak Assessment (ROA) is under preparation and the publication date is planned for 19 February. A survey has been shared with the National Focal Points (NFPs) for Food- and Waterborne Diseases (FWD) in order to collect information on case definition, need for laboratory support, and indication for testing. The information collected in the survey will be used in the ROA.

Member States are encouraged to share information about cases and their investiagtions in the EpiPulse event, and to work closely with food safety authorities on national investigations if suspected cases are identified to investigate the potential link to recalled batches of formula.

ECDC is monitoring the event and is liaising with other stakeholders including affected countries, EFSA and the European Commission. An internal response team (IRT) has been convened within ECDC for this event.

EFSA is monitoring the food incident in close co-operation with the European Commission and ECDC. On 2 February and upon request of the European Commission, EFSA's scientists established an acute reference dose (ARfD) for cereulide in infants and estimated cereulide concentrations in infant formula of potential safety concern. This advice is intended to help EU risk managers determine when products should be withdrawn from the market as a precautionary public health measure. EFSA provides rapid risk assessment on cereulide in infant formula | EFSA

Consumers are recommended to follow the advice and instructions provided by national food safety authorities. Parents, guardians and caregivers who have affected products should not feed them to infants and young children.

Further information:

ECDC news item published 28 January 2026: Precautionary global recall of infant nutrition products following detection of Bacillus cereus toxin

Food safety authorities in the Member States have issued the recalls and are reporting food data under the following RASFF notifications: 2025.9962; 2026.0027; 2026.0173; 2026.0179; 2026.0196; 2026.0509; 2026.0347; 2026.0407; 2026.0663; 2026.0542; 2026.0598; 2026.0177; 2026.0647

Last time this event was included in the Weekly CDTR: 30 January 2026

4. Mass gathering monitoring - Winter Olympic and Paralympic Games in Milan 2026

Overview:

Summary

Since the start of the monitoring period on 2 February and as of 5 February, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic Games.

On 4 February, the Olympic Games organizers reported a norovirus outbreak at the Olympic Village among the Finnish female ice hockey team. The source of infection is not known. According to media quoting Finnish health authorities, disease control measures are in place, including isolation of cases, quarantine of close contacts, and physical distance.

Background

The Winter Olympic Games Milano Cortina 2026 are taking place between 4 and 22 February 2026. The competitions will start on 4 February, and Opening Ceremony on 6 February at San Siro Stadium, Milan with the Closing Ceremony on 22 February at Verona Arena. The Games will be spread across Northern Italy, primarily in Milan and Cortina d'Ampezzo, with additional clusters in Valtellina, Val di Fiemme, and Anterselva/Antholz. More than 2 900 athletes are expected and participants are expected from over 90 countries. Organizers anticipate hundreds of thousands of spectators across venues. Exact numbers are not finalised but expected to surpass one million cumulative attendance based on previous Winter Games trends.

The Paralympic Winter Games will take place from 6 to 15 March 2026 with more than 600 athletes competing. The Opening Ceremony will take place at Verona's Olympic Arena, Milano will host the Para ice hockey tournament. Wheelchair curling, Para Alpine skiing, Para snowboard competitions and the Closing Ceremony will be hosted in Cortina, and Val di Fiemme will host Para cross-country skiing and biathlon.

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 susceptible people, risk behaviour, sale of food and beverages by street vendors, etc. At the same time, non-communicable health risks, including heat stroke, crowd injury, and drug- and alcohol-related conditions, should also be considered by the organisers and the public health authorities of the hosting country.

The Winter Olympic and Paralympic Games 2026 is a mass gathering that comprises multiple events indifferent event locations which take place from February to March. The general assessment provided below refers to the probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and 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 Olympic and 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 practising safe sex. This 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 for vaccination to get vaccinated without delay.

Actions:

ECDC is monitoring this mass gathering event through epidemic intelligence activities through a close collaboration with the Italian National Institute of Health (Istituto Superiore di Sanita') 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: -

5. 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 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, Sierra Leone, Liberia), cases have been reported among young adults, affecting both males and females. Sexual contact has been described as a main driver of spread (Multi-country outbreak of mpox, External situation report #60 - 8 December 2025, Multi-country outbreak of mpox, External situation report #62-23 January 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 3 February 2026).

Mpox clade I summary and transmission patterns classification

In Africa, in 2025, the five countries that reported most confirmed and suspected clade I cases are DRC, Uganda and Burundi, followed by Kenya and Zambia. According to WHO, in the past six weeks, and as of 1 February 2026, most confirmed cases of clade I were reported by DRC and Madagascar (253 and 196 cases, respectively). In DRC, clades Ia and Ib are co-circulating. Cases due to clade IIb have also been reported. Madagascar reported confirmed mpox clade Ib cases for the first time in December 2025. Since the first reports, confirmed cases have been reported from eight regions and suspected cases from 20 of 24 regions (Multi-country outbreak of mpox, External situation report #62 - 23 January 2026). Comoros also reported four clade Ib cases imported from Madagascar in January 2026. All other countries in Africa reported fewer than 50 cases during the last six weeks. Overall, a decreasing trend in clade I mpox cases has been reported in Africa since May 2025 (Global Mpox Trends published 3 February 2026).

In EU/EEA travel-associated cases of mpox clade I, or locally-acquired cases of clade I have been reported by Sweden (in 2024), Germany (in 2024 and 2025), Belgium (in 2024 and 2025), France, Ireland, Italy, and Spain (in 2025), as well as by Greece (in October 2025), Romania (December 2025) and Czechia (January 2026). In addition to Africa and the EU/EEA, since August 2024 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, and Japan (Global Mpox Trends published 3 February 2026). Since December 2025, imported cases were also reported by Israel, Mexico and Nepal. 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 3 February 2026).

Since October 2025, Italy, the Netherlands, Portugal and Spain reported mpox clade I in men without travel history. In the Netherlands and Spain, these were men who reported having sexual contact with another male. Additionally, the United States reported three cases of clade I in California without travel history with the investigation indicating that person-to-person transmission among gay, bisexual and other men who have sex with men and their social networks may be ongoing in the state (Community Spread of New Mpox Type (Clade I) in California Has Been Identified; Risk to General Public Remains Low). These three cases were considered unlinked following interviews. However, phylogenetic analysis showed that the sequences cluster with the sequence of a previously reported travel-associated case (Detection of Community Transmission of Clade Ib Mpox Virus in the United States | NEJM Evidence).

In addition, 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 3 February 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 3 February 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, 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 rates 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 rates 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 3 February 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 3 February 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.

A Threat Assessment Brief on the detection of autochthonous transmission of monkeypox virus (MPXV) clade Ib in the EU/EEA was published on 24 October. It 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: 19 December 2025

6. Nipah virus disease- India- 2026

Overview:

Summary

According to the National IHR Focal Point of India reporting to the World Health Organization (WHO) on 26 January 2026, there have been two confirmed cases of Nipah Virus (NiV) reported in the state of West Bengal, India. A total of 196 contacts of the confirmed cases were identified and tested negative for NiV and no additional cases were reported to date, according to the Indian Ministry of Health and Family Welfare, as of 27 January 2026.

Several media outlets, quoting India's health authorities, have reported five NiV disease cases in the same outbreak in healthcare workers at the same hospital, in the district of North 24 Parganas, in the West Bengal State, India.

Both individuals are between the ages of 20-30-year-old, one male and one female, working as nurses at the same private hospital in Barasat, located in North 24 Parganas district, West Bengal State. Both of them developed symptoms typical of severe NiV infection in late December 2025 and were admitted to hospital in early January 2026. As of 21 January 2026, the second individual showed clinical improvement, while the first person remained under critical care.

They were identified as suspected NiV infections in preliminary testing and were confirmed at the National Institute for Virology in Pune, on 13 January 2026. They were laboratory confirmed using Real-Time Polymerase Chain Reaction (RT-PCR) and Enzyme-Linked Immunosorbent Assay (ELISA) testing.

On 30 January 2025, WHO reported that investgations into the source of exposure are ongoing. According to media reporting, both cases had attended to a patient with NiV-like symptoms at the hospital they work at, although this has not been reported in official sources. Furthermore, one of two nurses recently travelled to a village in Nadia district, close to the Bangladesh border and might have consumed raw date palm sap, according to media reports. This information on possible exposure has not been reported in official sources.

Following confirmation of the two cases, the Government of India, working closely with the Government of West Bengal, implemented comprehensive public health measures in line with established protocols, according to the MoHFW. Enhanced surveillance, laboratory testing, and field investigations were carried out through coordinated action by Central and State health agencies.

In West Bengal, previous outbreaks occurred in 2001 (Siliguri) and 2007 (Nadia district). In 2025, a total of four NiV disease cases have been reported in India from the Palakkad (2) and Malappuram (2) districts. Of these, two have died, both from the Palakkad district.

Thailand, Nepal, Cambodia, and other neighbouring countries have initiated measures including information campaigns and screening for passengers arriving from India at airports.

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 East 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 area 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. Although the virus can be transmitted through direct contact with infected wild or domesticated animals, because the natural hosts are not present in Europe, the likelihood of the virus spreading in the current context within the EU/EEA after importation is considered to be very low.

As a general precaution, EU/EEA travellers and residents in West Bengal 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.

Sources: ECDC press release published 29 January 2026: Nipah virus disease cases reported in West Bengal, India: very low risk for Europeans

Last time this event was included in the Weekly CDTR: 30 January 2026

7. Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update

Overview:

Update: Since the previous update on 5 January 2026, and as of 3 February 2026, no new MERS cases have been reported by the World Health Organization (WHO) or national health authorities.

Summary: Since the beginning of 2026, and as of 3 February 2026, no MERS cases have been reported by the World Health Organization (WHO) or national health authorities.

Since April 2012, and as of 3 February 2026, a total of 2 647 MERS cases, including 959 deaths, have been reported by health authorities worldwide.

Sources: ECDC MERS-CoV page | WHO MERS-CoV | ECDC factsheet for professionals | Qatar MoPH Case #1 | Qatar MoPH Case #2 | FAO MERS-CoV situation update | WHO DON Oman | WHO DON Saudi Arabia | WHO DON UAE | WHO DON Saudi Arabia 1 | WHO IHR | WHO EMRO MERS Situation report | WHO DON Saudi Arabia 2 | WHO DON Saudi Arabia 3 | WHO DON Saudi Arabia 4 | WHO DON Saudi Arabia 5 | MERS-CoV Dashboard | French Ministry of Health | WHO DON France & Saudi Arabia

ECDC assessment:

Human MERS cases continue to be reported in the Arabian Peninsula. However, the number of new cases detected and reported through surveillance has dropped to the lowest level since 2014. The probability of sustained human-to-human transmission among the general population in Europe remains very low and the impact of the disease in the general population is considered low. The current MERS-CoV situation poses a low risk to the EU/EEA, as stated in the Rapid Risk Assessment published by ECDC on 29 August 2018.

ECDC published a technical report, 'Health emergency preparedness for imported cases of high-consequence infectious diseases', in October 2019 that is still useful for EU Member States wishing to assess their level of preparedness for a disease such as MERS. ECDC also published 'Risk assessment guidelines for infectious diseases transmitted on aircraft (RAGIDA) – Middle East respiratory syndrome coronavirus (MERS-CoV)' on 22 January 2020.

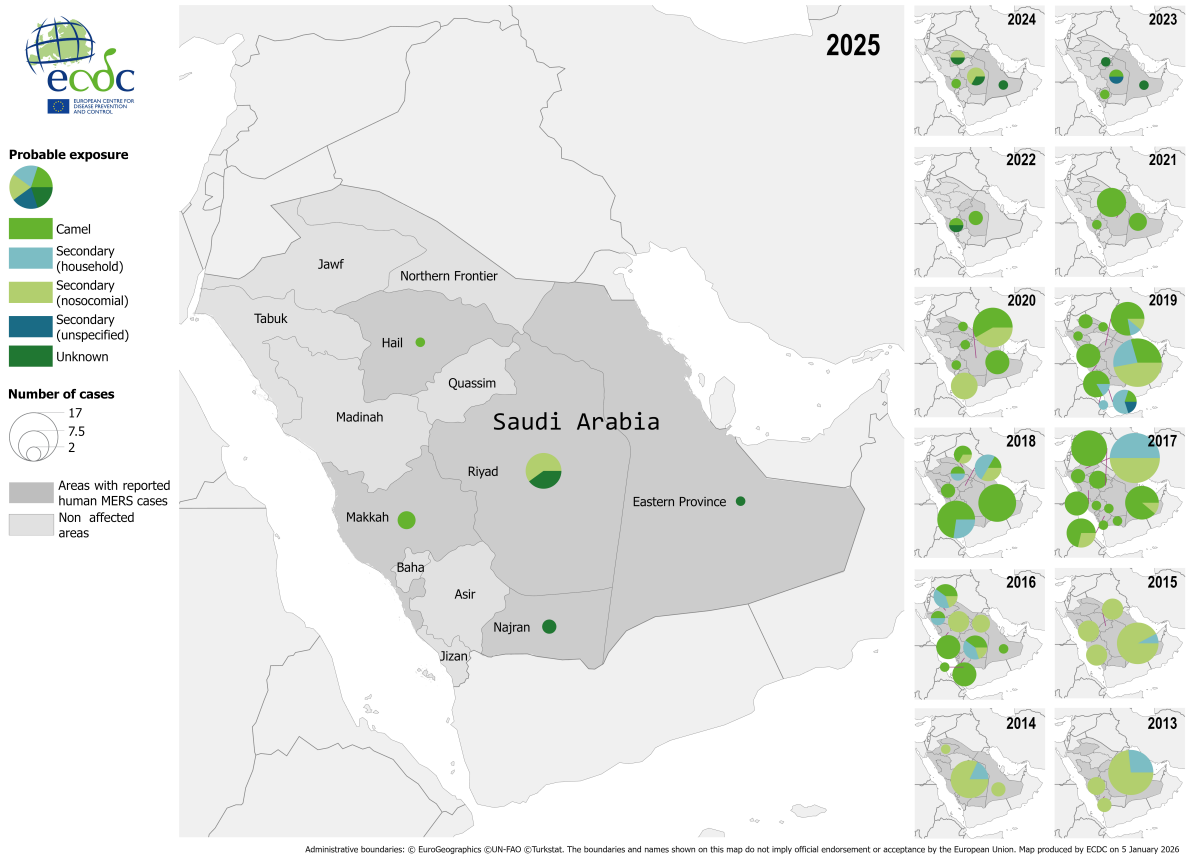
Actions:

ECDC is monitoring this situation through its epidemic intelligence activities, and reports on a monthly basis or when new epidemiological information is available.

Last time this event was included in the Weekly CDTR: 9 January 2026

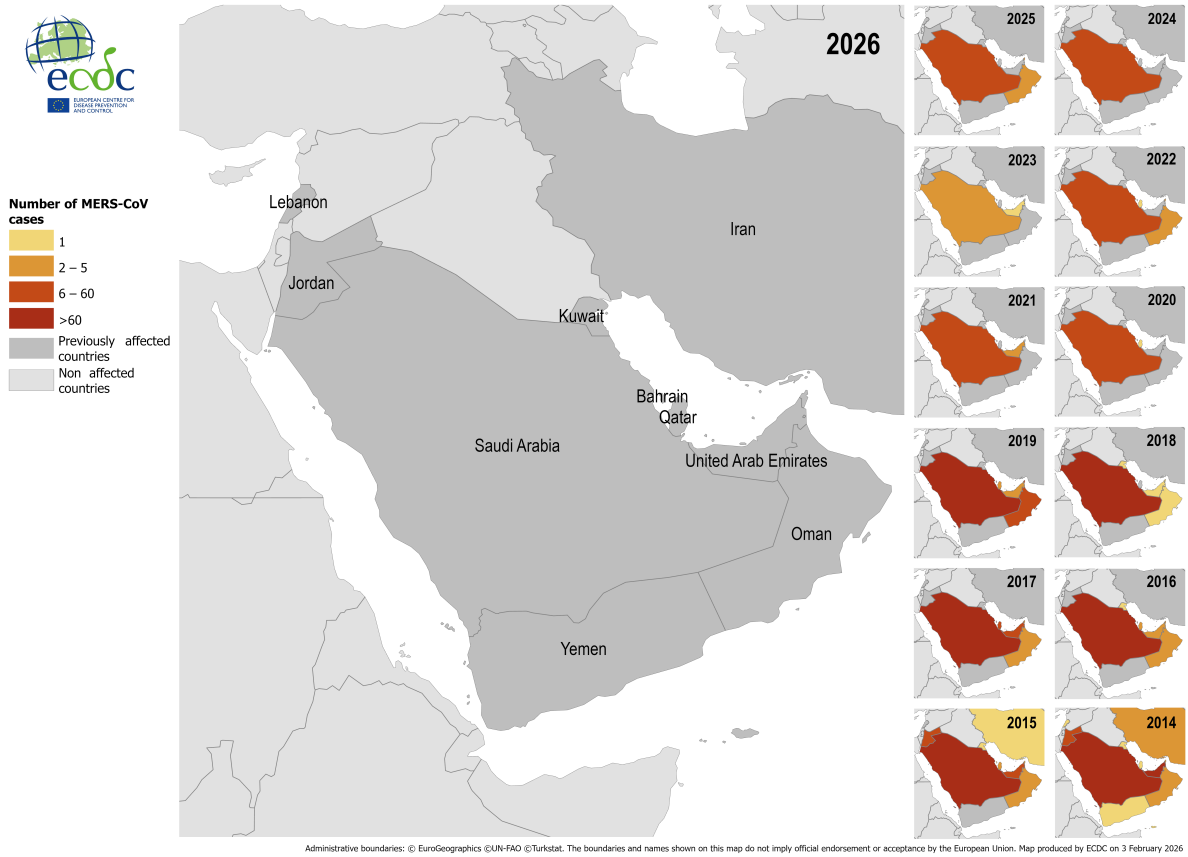
Maps and graphs

Figure 1. Geographical distribution of confirmed cases of MERS in Saudi Arabia by probable region of infection and exposure, with dates of onset from January 2013 to December 2025



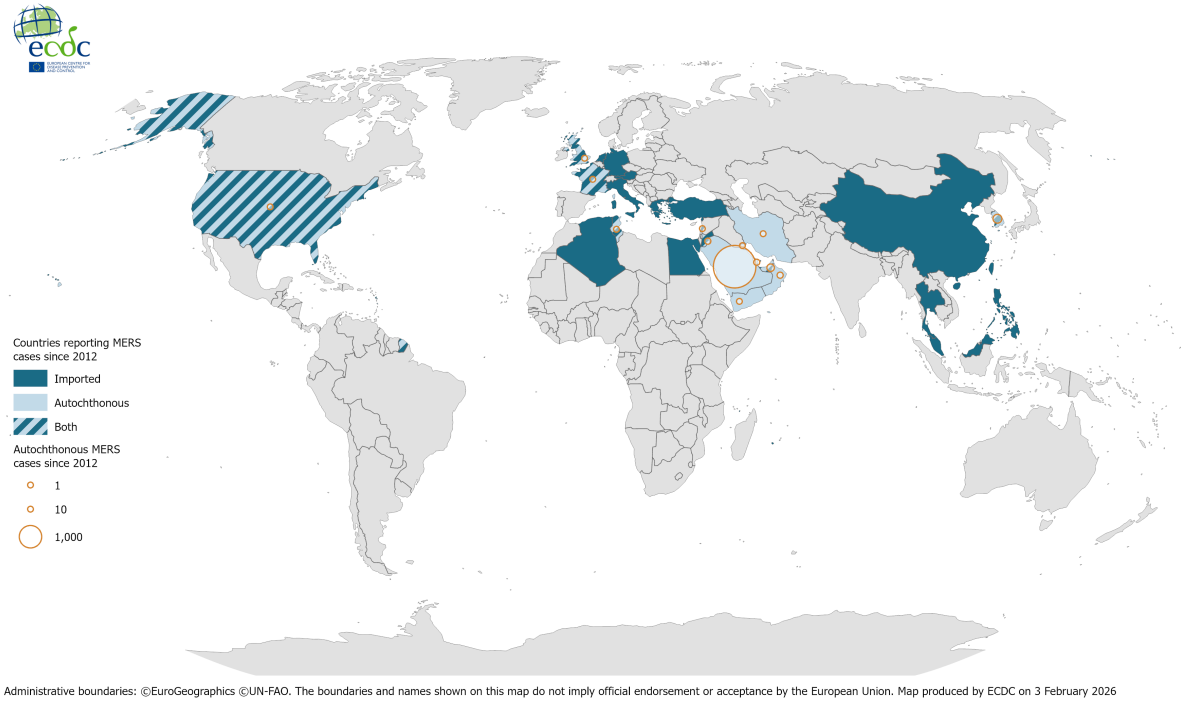
Source: ECDC

Figure 2. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2014 – January 2026



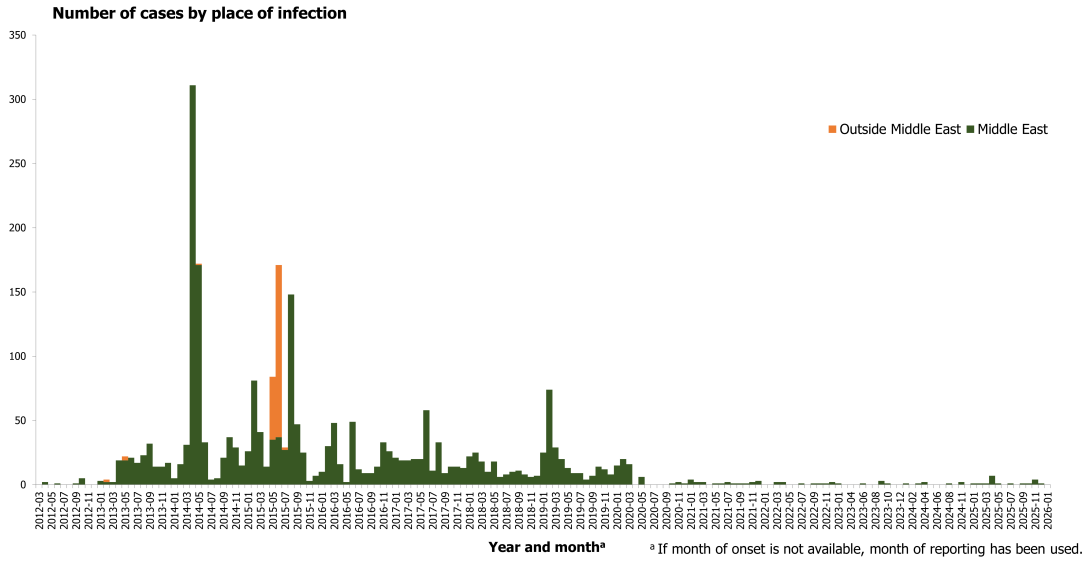
Source: ECDC

Figure 3. Geographical distribution of confirmed cases of MERS-CoV by reporting country, April 2012 - January 2026



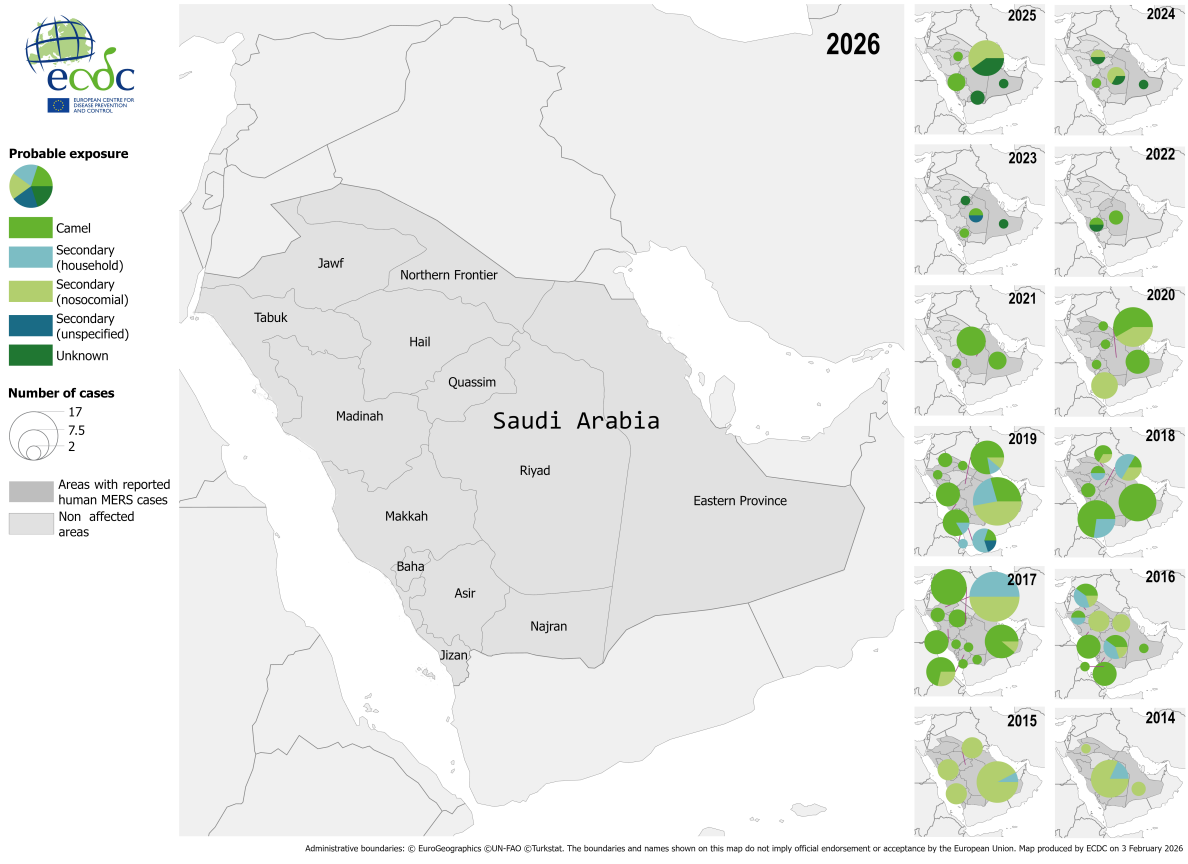
Source: ECDC

Figure 4. Distribution of confirmed cases of MERS by place of infection and month of onset, April 2012 – January 2026



Source: ECDC

Figure 5. Geographical distribution of confirmed cases of MERS in Saudi Arabia by probable region of infection and exposure, with dates of onset from January 2014 to January 2026



Source: ECDC

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 30 January 2026
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 30 January 2026
- Bacillus cereus toxin in infant formula - last reported on 30 January 2026
- Nipah virus disease – India – 2026 - last reported on 30 January 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 23 January 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 16 January 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2025 - last reported on 16 January 2026
- Human cases of swine influenza A(H1N1) virus variant - Multi-country - 2024 - last reported on 09 January 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 09 January 2026
- SARS-CoV-2 variant classification - last reported on 06 February 2026
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - last reported on 06 February 2026
- Rapid Outbreak Assessment under production. - last reported on 06 February 2026
- Mass gathering monitoring - Winter Olympic and Paralympic Games in Milan 2026 - last reported on 06 February 2026