WEEKLY BULLETIN

Communicable Disease Threats Report

Week 8, 14–20 February 2026

This week's topics

Executive summary

Overview of respiratory virus epidemiology in the EU/EEA

Summary

The number of primary care consultations for respiratory illness remain high in most reporting countries, indicating that respiratory viruses are still circulating widely across much of the EU/EEA.

Influenza virus circulation remains elevated but has been declining in recent weeks. Hospitalisations have decreased since the beginning of the year, with adults aged 65 years and above accounting for most of the admissions during the season. Influenza A(H3) remains the dominant subtype, followed by A(H1)pdm09.

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 by other countries for A(H3N2) viruses.

Respiratory syncytial virus (RSV) circulation remains elevated and varies from country to country. Children under five years account for most of the admissions cumulatively this season.

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 increased levels of all-cause mortality, both overall and in those aged 65 years and above.

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'.

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

- On 14 February 2026, a new human case of avian influenza A(H5N1) virus infection was reported in an adult man from Kampot province, Cambodia.
- The infection was laboratory-confirmed in an adult man on 14 February 2026.
- The patient had exposure to dead backyard poultry, which was cooked by him three days prior symptoms onset.
- No new case have been reported among contacts of the case.

- Since 2003, a total of 994 confirmed human cases of A(H5N1) have been reported worldwide, including 476 deaths (case fatality rate (CFR): 48%). Of these, 91 cases were reported from Cambodia, including 52 deaths (CFR: 58%).
- ECDC's risk assessment for A(H5N1) remains unchanged. Overall, the risk related to zoonotic influenza for the general population in the EU/EEA is considered low.

Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases

An update has been provided for a human case of avian influenza A(H10N3) virus infection in Guangdong province, China, that was reported on 10 February 2026.

- The case an adult man in his 30s who had onset of symptoms on 29 December 2025.
- The patient had exposure to live poultry prior to disease onset.
- No human-to-human transmission has been documented.
- The risk to human health in the EU/EEA is considered very low.

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

- Since 1 January 2026, and as of 17 February 2026, a total of 255 mpox cases have been reported from 10 EU/EEA countries (Spain, Germany, Italy, Netherlands, Portugal, France, Ireland, Norway, Czechia and Poland). This includes 80 clade Ib cases reported from Spain (36), Italy (19), Germany (10), France (8), the Netherlands (5), Czechia (1) and Ireland (1).
- The number of clade I cases reported by month has steadily increased in recent months with 8 cases in September, 12 cases in October, 20 cases in November and 37 cases in December 2025, reaching 73 cases in January 2026.
- In total, 185 clade I cases have been reported in the EU/EEA since August 2024 and as of 17 February 2026. Information on sexual behaviour was available for 91 cases and of these, 80 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 MSM 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.

Mpox clade Ib and clade IIb recombinant strain

- On 14 February 2026, WHO published a Disease Outbreak News (DON) Item summarising two cases of mpox infected by a clade Ib and clade IIb recombinant strain of monkeypox virus (MPXV).
- The cases were reported by the United Kingdom and India in December 2025 and January 2026, respectively. Both cases had travel history albeit to different areas.
- According to WHO, the case in India is the earliest detection of the recombinant strain that has been reported so far. However, the origin of the recombinant remains unknown and the transmission of the recombinant virus already involves at least four countries in three WHO regions. Conclusions about transmissibility or clinical characterisation of mpox due to recombinant virus cannot be currently made.
- Detections of recombinant MPXV virus strains is not unexpected as both clades are circulating. The events highlight the continued potential for mpox virus to evolve and the importance of continued genomic surveillance.

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

- Since the previous update and as of 19 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.

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.

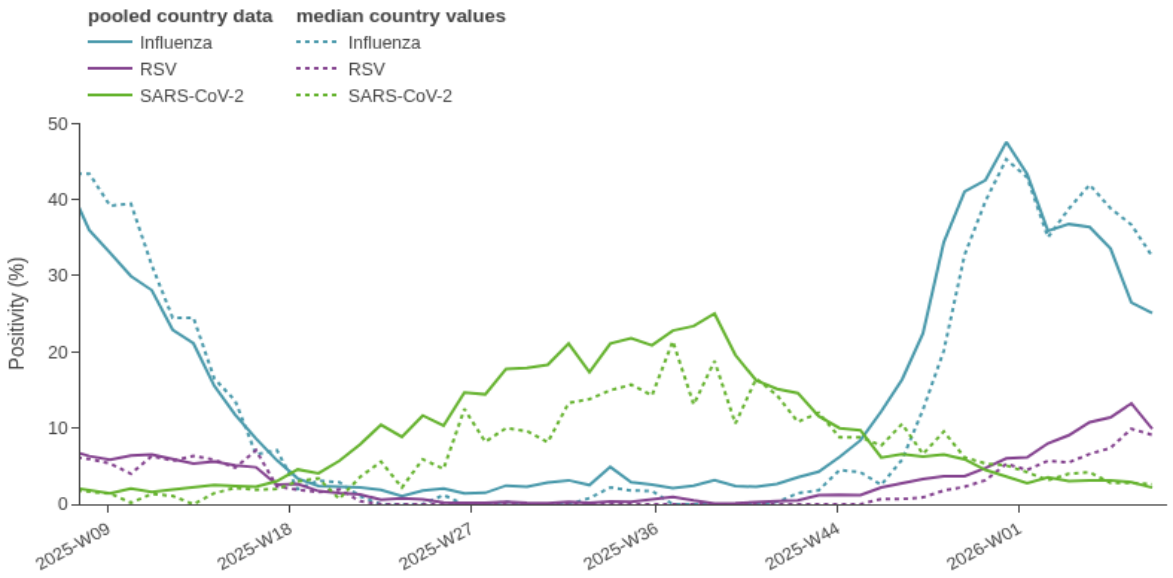
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

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

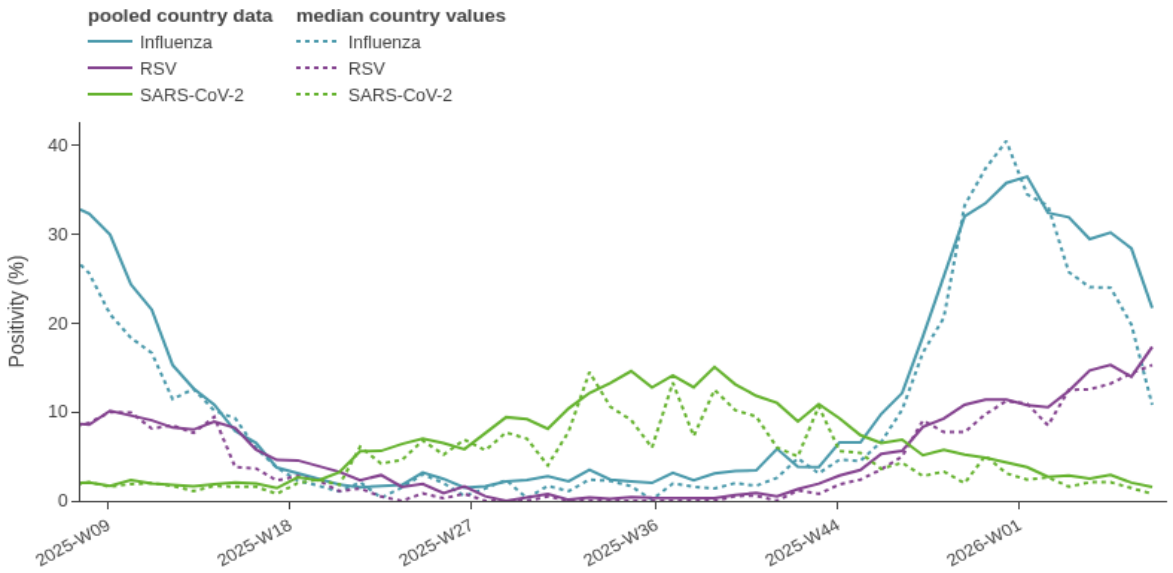
Maps and graphs

Figure 1. ILI/ARI virological surveillance in primary care - weekly test positivity



Source: ECDC

Figure 2. SARI virological surveillance in hospitals - weekly test positivity



Source: ECDC

Figure 3. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	**Syndrome or pathogen**	**Week 7**	**Week 6**	**Description**	**Value**
ILI/ARI consultation rates in primary care	ARI	13 rates (8 MEM)	18 rates (10 MEM)	Distribution of country MEM categories	3 Baseline 4 Low 1 Medium
	ILI	18 rates (16 MEM)	22 rates (20 MEM)		5 Baseline 7 Low 4 Medium
ILI/ARI test positivity in primary care	Influenza	17	21	Pooled (median; IQR)	25% (33; 19–48%)
	RSV	16	20		9.9% (9.1; 5.4–13%)
	SARS-CoV-2	15	18		2.2% (2.6; 1.2–7.5%)
SARI rates in hospitals	SARI	10 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)	22% (11; 3.6–26%)
	RSV	9	12		17% (15; 13–24%)
	SARS-CoV-2	9	11		1.6% (0.8; 0.4–2.3%)
Intensity (country-defined)	Influenza	21	25	Distribution of country qualitative categories	2 Baseline 7 Low 9 Medium 3 High
Geographic spread (country-defined)	Influenza	20	24	Distribution of country qualitative categories	3 Regional 17 Widespread

Source: ECDC

Figure 4. **ILI/ARI virological surveillance in primary care - pathogen type and subtype distribution**

	Week 7, 2026		Week 40, 2025 – week 7, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**503**	**–**	**16304**	**–**
Influenza A	501	100	15767	100
A(H1)pdm09	150	39	3462	27
A(H3)	238	61	9571	73
A (unknown)	113	–	2734	–
Influenza B	2	0.4	70	0.4
B/Vic	1	100	21	100
B (unknown)	1	–	49	–
Influenza untyped	0	–	467	–
RSV	**172**	**–**	**3043**	**–**
RSV-A	18	40	565	50
RSV-B	27	60	561	50
RSV untyped	127	–	1917	–
SARS-CoV-2	**37**	**–**	**3539**	**–**

Source: ECDC

Figure 5. **SARI virological surveillance in hospitals - pathogen type and subtype distribution**

	Week 7, 2026		Week 40, 2025 – week 7, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**512**	**–**	**12098**	**–**
Influenza A	153	99	7340	99
A(H1)pdm09	7	64	1128	36
A(H3)	4	36	1987	64
A (unknown)	142	–	4225	–
Influenza B	1	0.6	45	0.6
B/Vic	0	–	4	100
B (unknown)	1	–	41	–
Influenza untyped	358	–	4713	–
RSV	**318**	**–**	**3973**	**–**
RSV-A	14	40	866	55
RSV-B	21	60	705	45
RSV untyped	283	–	2402	–
SARS-CoV-2	**36**	**–**	**2475**	**–**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 7, 2026

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	2221	41	5a.2a.1(D.3.1)	2189	99
			5a.2a.1(D)	26	1
			5a.2a(C.1.9.3)	6	0.3
A(H3)	3238	59	2a.3a.1(K)	2906	90
			2a.3a.1(J.2)	233	7
			2a.3a.1(J.2.4)	56	2
			2a.3a.1(J.2.2)	26	0.8
			2a.3a.1(J)	17	0.5
B/Vic	19	0.3	V1A.3a.2(C.5.6)	9	47
			V1A.3a.2(C.5.6.1)	4	21
			V1A.3a.2(C.5.1)	3	16
			V1A.3a.2(C.5)	2	11
			V1A.3a.2(C.5.7)	1	5

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, week 5, 2026 - week 6, 2026

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	2	0% (0–0%)
XFG	VUM	5	50	56% (53–75%)
NB.1.8.1	VUM	3	12	25% (0–25%)
BA.3.2	VUM	3	9	13% (0–19%)

Source: ECDC

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

Overview

On 14 February 2026, the Cambodian Ministry of Health reported a new human case of avian influenza A(H5N1) virus infection in an adult man from Teuk Chhou district, Kampot province. The patient developed fever, cough, and abdominal pain, sought medical care, and subsequently made a full recovery by 14 February 2026.

Field investigations identified the likely exposure source: several chickens that had died at the patient's residence. Family members reported that the carcasses were prepared and consumed three days before symptom onset.

National and local authorities are actively investigating the event and implementing response measures. As part of the response, close contacts of the case have received antiviral prophylaxis (Tamiflu), and health education campaigns are ongoing in the affected villages.

This is the first human case reported in Cambodia this year. The previous case in Cambodia was reported in November 2025 in a young man who died on 15 November 2025. Clade 2.3.2.1c has been circulating among birds in Cambodia and has been detected in infected humans in the past.

Summary

Overall, since 2003, Cambodia has reported 91 cases, including 52 deaths (CFR: 48%).

Since 2003, and as of 16 February 2026, there have been 994 human cases of avian influenza A(H5N1) infection worldwide*, including 476 deaths (CFR: 48%). These cases have been reported in 25 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, India, Indonesia, Iraq, Laos, Mexico, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Viet Nam, the United Kingdom (UK), and the United States (US)). To date, no sustained human-to-human transmission has been detected.

* This includes detections due to suspected environmental contamination, with no evidence of infection, that were reported in 2022 and 2023 by Spain (two detections), the US (one), and the UK (four, one of which was inconclusive). Human cases of A(H5) epidemiologically linked to A(H5N1) outbreaks in poultry and dairy cattle in the US are included in the reported number of cases of A(H5N1).

Acknowledgements: we gratefully acknowledge all data contributors – i.e. the authors and their originating laboratories responsible for obtaining the specimens, and the submitting laboratories for generating the genetic sequences and metadata and sharing via the GISAID Initiative.

ECDC assessment

Sporadic human cases of different avian influenza A(H5) subtypes have previously been reported around the world. Current virological evidence suggests that circulating A(H5N1) viruses retain genetic characteristics consistent with avian-adapted influenza viruses. Despite the widespread transmission of avian influenza viruses in animals, transmission to humans remains infrequent and no sustained transmission between humans has been observed.

Based on the information currently available, the overall risk related to zoonotic influenza for the general population in the EU/EEA is considered low.

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

Actions

ECDC monitors avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly updated avian influenza overview. The most recent report was published in December 2025.

Last time this event was included in the Weekly CDTR: 28 November 2025.

3. Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases

Overview

An update has been provided for the human case with avian influenza A(H10N3) infection in a 34-year-old man from Guangdong province, China, that was reported on 10 February 2026 by the Hong Kong Centre for Health in its Avian Influenza Report. According to WHO report on 20 February 2026, the patient, who developed symptoms on 29 December 2025, was hospitalised and is currently in stable condition. Exposure to live poultry has been reported prior to his symptoms onset. This is the third case reported in 2025.

Summary

Since 2021 and as of 20 February 2026, seven human cases of avian influenza A(H10N3) virus infection have been reported globally, all in China (from different provinces), with no associated deaths. All reported cases occurred in adults. All but one of the cases had severe or critical infections and reported history of exposure to live animals or a contaminated environment. The cases were reported from the following provinces in China: Jiangsu, Zhejiang, Yunnan, Guangxi Zhuang Autonomous Region, Shaanxi (1, 2), Guangdong.

ECDC assessment

Based on the limited information about the current case, it is difficult to provide an assessment. It will be revised when more information is available.

Sporadic human cases of avian influenza A(H10N3) have been observed, but no human-to-human transmission has been documented. The risk to human health in the EU/EEA is currently considered very low.

Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza.

Actions

ECDC monitors avian influenza strains through its epidemic intelligence and influenza surveillance activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza to identify significant changes in the epidemiology and characteristics of the virus. Together with EFSA and the EU reference laboratory, ECDC produces a quarterly Avian influenza review. The most recent report was published in December 2025.

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

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

Overview

Summary of clade I mpox

Since 1 January 2026, and as of 18 February 2026, 80 mpox clade I cases were reported to TESSy by Spain (36), Italy (19), Germany (10), France (8), the Netherlands (5), Czechia (1), and Ireland (1).

The number of clade I cases reported by month has steadily increased in recent months with 8 cases in September, 12 cases in October, 20 cases in November and 37 cases in December 2025, reaching 73 cases in the calendar month of January 2026. In Spain the number of cases increased from 14 in November, 29 in December to 35 in January. In Italy, the number of cases increased from 4 in December to 16 in January and in Germany from 2 in December to 9 in January. France had 1 case in December and 6 in January. In the Netherlands on the other hand, 5 cases were reported in each of October and November and January.

Overall, 185 mpox clade I cases have been reported in the EU/EEA to TESSy since August 2024 and as of 17 February 2026: Spain (82), Italy (29), Germany (27), Netherlands (15), France (13), Belgium (8), Ireland (6), Czechia (1), Greece (1), Portugal (1), Romania (1), Sweden (1). All were clade Ib except the first case in Ireland, which was clade Ia. Of all 180 mpox clade I cases with information on hospitalisation available, 17 were hospitalised for treatment, 10 of which were in Italy. The cases reported from Spain are reported from multiple different regions and the cases from Germany are largely from Berlin.

Of the 91 cases with information available on sexual behaviour, 80 were reported in men who have sex with other men (MSM): Spain (62), Netherlands (14), Belgium (2), Czechia (1) and Greece (1). All cases among MSM except the case in Greece and one case in Belgium had symptom onset since October 2025.

Among MSM, 75 cases had travel information available and 59 were due to local transmission. Several countries have reported cases mong MSM directly or indirectly related to travel to Germany.

Six of the 48 cases among MSM were hospitalised (all in Spain), but it is unknown whether the reason for hospitalisation was for treatment or isolation. Of the 72 cases among MSM with vaccination information available, 50 (66%) were unvaccinated, 16 people were vaccinated with two doses and six people 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. 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 January 2026, and as of 18 February 2026, 255 mpox cases have been reported from 10 EU/EEA countries: Spain (84), Germany (45), Italy (30), Netherlands (28), Portugal (28), France (26), Ireland (6), Norway (4), Czechia (2) and Poland (2). Since 1 January 2026, no new countries have reported confirmed cases.

Since the start of the mpox outbreak and as of 18 February 2026, 26 252 confirmed cases of mpox (MPX) have been reported from 29 EU/EEA countries: Spain (9 420), Germany (4 644), France (4 502), Netherlands (1 611), Portugal (1 352), Italy (1 337), Belgium (919), Austria (387), Sweden (374), Ireland (330), Poland (257), Denmark (247), Greece (161), Norway (136), Czechia (112), Hungary (90), Luxembourg (66), Romania (51), Malta (49), Slovenia (48), Finland (43), Croatia (39), 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, 75 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 185 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

The number of mpox clade I cases reported to ECDC has increased in recent months, mostly among MSM. While not unexpected, this development is still 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 for clade IIb infection remains at 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.

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 as soon as possible, 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: 16 January 2026.

5. Mpox clade Ib and clade IIb recombinant strain

Overview

On 14 February 2026, WHO published a Disease Outbreak News (DON) Item summarising two cases of mpox infected by a clade Ib and clade IIb recombinant strain of monkeypox virus (MPXV) (WHO Disease Outbreak News "Mpox: recombinant virus with genomic elements of clades Ib and IIb – Global situation", 14 February 2026). The cases were reported by the United Kingdom and India in December 2025 and January 2026, respectively. Both cases had travel history albeit to different areas. The case reported by the UK had travel history to the Asia Pacific region in October 2025 and was reported by the UKHSA in December 2025 (New mpox strain identified in England - GOV.UK, 8 December 2025). The case reported by India had travel history to the Arabian Peninsula in and presented symptoms in September 2025. The cases had clinical presentation that was consisted with clade I and clade II (non-recombinant infections). The virus from the patient from India was reclassified as the recombinant when comparison with the UK recombinant strain was possible. Phylogenetic analysis showed >99.9% similarity between the recombinant strain from India and the recombinant strain from the UK.

According to WHO, the case in India is the earliest detection of the recombinant strain that has been reported so far. The DON notes that given the current transmission of clade I and clade II across sexual networks in many countries and settings, co-infection can be expected as well as that the origin of the recombinant virus remains unknown and the transmission of the recombinant virus already involves at least four countries in three WHO regions. Other conclusions about transmissibility or clinical characterisation of mpox due to recombinant virus cannot be currently made.

ECDC assessment

Detections of recombinant MPXV virus strains are not unexpected as both clades are circulating. The events highlight the continued potential for mpox virus to evolve and the importance of continued genomic surveillance.

Actions

ECDC is continuously monitoring global and EU/EEA trends of mpox transmission.

EU/EEA 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.

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

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

Overview

Summary
Since the previous update and as of 19 February, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic Games.

Background

The Winter Olympic Games Milano Cortina 2026 are taking place between 4–22 February 2026. The competitions will start 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 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. Organisers anticipate hundreds of thousands of spectators across venues. Exact numbers are not finalised but are expected to surpass one million cumulative attendees based on previous Winter Games trends.

The Paralympic Winter Games will take place from 6–15 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 the 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 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 Olympic and Paralympic Games 2026 is a mass gathering that comprises multiple events in different event locations that 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 adopting safer sexual practice. 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. ECDC has published recommendations for attendees to this mass gathering event.

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 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: 13 February 2026.

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 20 February 2026
- Bacillus cereus toxin in infant formula - last reported on 6 February 2026
- Nipah virus disease – India and Bangladesh – 2026 - last reported on 13 February 2026
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 20 February 2026
- Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026 - last reported on 20 February 2026
- Mpox clade Ib and clade IIb recombinant strain - last reported on 20 February 2026
- Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases - last reported on 20 February 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2026 - last reported on 20 February 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 13 February 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 13 February 2026
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 13 February 2026
- SARS-CoV-2 variant classification - last reported on 6 February 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 6 February 2026.
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - last reported on 6 February 2026.
- Rapid Outbreak Assessment under production - last reported on 13 February 2026