WEEKLY BULLETIN

Communicable disease threats report

Week 24, 7–13 June 2025

This week's topics

Executive Summary

Seasonal surveillance of West Nile virus infections started in week 23

- The seasonal surveillance of West Nile virus (WNV) infections in the EU/EEA and EU-neighbouring countries started in week 23, 2025.
- Updates on risk areas for locally acquired WNV infection will be reported weekly during the transmission season.
- Enhanced analysis of the WNV epidemiological situation will be provided monthly.

Weekly seasonal surveillance of West Nile virus infection – 2025

- This is the first report of the weekly seasonal surveillance of West Nile virus (WNV) infections in 2025.
- Since the beginning of 2025, and as of 11 June 2025, no countries in Europe reported human cases of WNV infection.

European Centre for Disease Prevention and Control, Solna, Sweden
www.ecdc.europa.eu

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

- In April 2025, 975 measles cases were reported by 18 countries. Eleven countries reported zero cases.
- Overall, four measles-related deaths have been reported in the EU/EEA in 2025, all of them in Romania.
- Overall, case numbers decreased compared with the previous month; however, this is subject to change in the event of a future retrospective update.
- Outbreaks associated with imported measles cases have been reported in Belgium and Germany.

Overview of respiratory virus epidemiology in the EU/EEA

Respiratory virus activity is at low levels in the European Union/European Economic Area (EU/EEA). During the 2024/2025 respiratory virus season, SARS-CoV-2 activity remained at low levels with no winter epidemic. In recent weeks, increases in indicators of SARS-CoV-2 activity have been observed in several countries, but the overall activity remains low and the impact in secondary case is very limited.

Following an intense influenza season and a concurrent respiratory syncytial virus (RSV) epidemic, influenza and RSV activity have now returned to low or baseline levels in all countries. Excess mortality levels have also returned to the expected range.

Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025

- In August 2024, France reported the first autochthonous case of chikungunya virus disease in 10 years in Réunion, with onset of symptoms on 12 August. A decrease in surveillance indicators (primary care visits and emergency department visits for chikungunya virus disease) has been observed since week 17.
- Since the beginning of the year, and as of 8 June 2025, close to 53 750 confirmed autochthonous cases of chikungunya virus disease have been reported in Réunion. Since the beginning of the outbreak, 23 deaths, mostly in people aged over 64 years, were classified as chikungunya virus disease-related.
- The Haute Autorité de Santé (HAS) has advised public decision-makers to vaccinate groups who are at higher risk of severe disease and vector control professionals. The regional health agency initiated a vaccination campaign for prioritised individuals on 7 April.
- On 26 April 2025, the French Ministry of Health and Access to Care reported three serious adverse events following vaccination against chikungunya with the Ixchiq vaccine in Reunion, including one death. As a result, the health authorities suspended the vaccination of people over 65 years old, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remains open for people 18–64 years old with comorbidities.
- On 7 May 2025, the European Medicines Agency (EMA) stated that the agency's safety committee (PRAC) had started a review of the Ixchiq vaccine following the reports of serious adverse events in older adults. As a temporary measure while an in-depth review is ongoing, Ixchiq must not be used in adults 65 years old and above. More information can be found in the Communicable disease threats report, 3 May - 9 May 2025, week 19.
- On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 2 June 2025, 560 confirmed cases of the disease have been reported on the island. Due to the intensified circulation of locally acquired cases of chikungunya, the ORSEC plan has transitioned to phase 3 to control the outbreak and better prepare for a possible epidemic phase.

Mass gathering monitoring – Jubilee of 2025 in Italy

- ECDC has conducted enhanced monitoring of the Jubilee through its epidemic intelligence activities between 9 and 13 June 2025, on the occasion of the Jubilee of the Holy See.
- No infectious disease events of relevance for the EU/EEA were detected during the Jubilee between 9 and 13 June 2025.
- The probability of EU/EEA citizens becoming infected with communicable diseases during the Jubilee 2025 is low if general preventive measures are applied.
- ECDC will keep monitoring this mass gathering event through epidemic intelligence and will be reporting when there are relevant updates in collaboration with the Italian National Institute of Health (Istituto Superiore di Sanita'), the Italian Ministry of Health, SERESMI (National Institute for Infectious Diseases 'L.Spallanzani' – Lazio Region), and other partners.

Mass gathering monitoring – Hajj – Kingdom of Saudi Arabia – 2025

- ECDC concluded its monitoring of the Hajj pilgrimage through its epidemic intelligence activities on 13 June 2025.
- No infectious disease events of relevance for the EU/EEA were detected during the Hajj between 26 May and 13 June 2025.
- There were media reports of several deaths among Hajj pilgrims, mainly related to the severe climate conditions during the event.
- ECDC's epidemic intelligence team acknowledges the excellent collaboration with the Gulf Centre for Disease Prevention and Control (CDC) in monitoring this event.

Mass gathering monitoring – EuroPride - Portugal – 2025

- As of 13 June 2025, no relevant public health events related to communicable diseases have been detected in connection with EuroPride.
- ECDC is monitoring this event through its epidemic intelligence for mass gathering activities between 9 and 27 June 2025 in collaboration with the Portuguese health authorities and the World Health Organization Regional Office for Europe (WHO/Europe), and is including weekly updates in the Communicable Disease Threats Report (CDTR).
- Sexually transmitted infections (STIs), HIV and hepatitis, as well as mpox and shigella, are already spreading in networks of men who have sex with men (MSM) in Europe, including an ongoing outbreak of hepatitis A among MSM in Portugal. The probability of infection with STIs and other infections that spread through sex is high for people who attend EuroPride and engage in sex with non-steady and multiple partners, particularly if preventive measures are not consistently applied.

Outbreak of measles associated with international mass gathering - Germany - 2025

- Germany reported an outbreak of measles with 18 cases associated with an international festival.
- Among the reported cases six are from Germany, and 12 from other European countries (Czechia, Italy, Poland and United Kingdom).
- Exchange of information on cross-border cases via established EU and international channels is important to avoid re-establishment of measles in receiving countries. Overall, measles cases in the EU/EEA may continue to rise in the coming months.
- To prevent further transmission and protect public health, it is essential to close immunity gaps and achieve high vaccination coverage—specifically, at least 95% coverage with two doses of MCV.

Invasive pneumococcal disease among shipyard workers in Turku, Finland

- In May 2025, the Southwest Finland Wellbeing Services Country (Varha) reported twelve confirmed or suspected cases of pneumococcal pneumonia among adults employed at the Turku shipyard.
- Several response measures have been put in place including vaccination.
- Although the cases reported in this outbreak are of different nationalities, given the experience of the previous outbreaks, the risk of international spread is considered low, as control measures are being taken by the Finnish authorities.

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

- On 27 May 2025, two new human cases with avian influenza A(H5N1) infection were reported in children in Bangladesh.
- Exposure to backyard poultry has been reported for all the cases.
- No new cases have been detected among contacts of the reported patients.
- The investigations did not reveal instances of human-to-human transmission around this case.
- The ECDC risk assessment for A(H5N1) remains unchanged.
- Since 2003, and as of 9 June 2025, there have been 978 human cases of A(H5N1) worldwide, including 471 deaths.

Risk Assessment under production

ECDC is preparing a Rapid Risk Assessment on Diphtheria caused by *C. diphtheriae* ST-574 in the EU/EEA, 2025, with a planned date for publication on 25 June 2025.

1. Seasonal surveillance of West Nile virus infections started in week 23

Overview:

The seasonal surveillance of WNV infections in the EU/EEA and EU-neighbouring countries for 2025 began in week 23, 2025 (2 June 2025).

Throughout the season, ECDC will publish a weekly report updating on risk areas for locally acquired WNV infection. In addition, a monthly report will be published.

WNV infection in humans is a notifiable disease at the EU level and cases should be reported by national public health authorities through the EpiPulse Cases platform according to the EU case definition.

According to Commission Directives 2004/33/EC and 2014/110/EU on blood safety, blood establishments in EU/EEA countries should apply temporary deferral criteria for donors of allogeneic blood donation for 28 days after they have left a risk area for locally acquired WNV, unless an individual nucleic acid test (NAT) is negative. WNV surveillance activities carried out by ECDC support the competent authorities responsible for blood safety in the implementation of these directives. ECDC will provide weekly and monthly updates with the latest reports on cases of WNV infections in Europe. A map and table will be updated every Friday from June to November, which is the time of year when WNV infections are most likely to be reported.

ECDC will provide an enhanced analysis of the current WNV epidemiology on a monthly basis, which includes the numbers of reported locally acquired human cases, outbreaks of West Nile fever in equids and birds notified to the Animal Disease Information System (ADIS) of the European Commission, and an assessment of the situation.

Last time this event was included in the Weekly CDTR: –

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

Overview:

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

Since the beginning of 2025, and as of 11 June 2025, no countries in Europe reported human cases of WNV infection.

The report is available online.

Last time this event was included in the Weekly CDTR: –

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

Overview:

In April 2025, 29 countries reported measles data, with 975 cases reported by 18 countries. There were 11 countries that reported zero cases.

Overall, case numbers decreased compared with the previous month; however, this is subject to change in the event of a future retrospective update. The highest case counts were reported by Romania (402), France (186), Netherlands (111), Belgium (100) and Spain (52).

Between 1 May 2024 and 30 April 2025, 30 EU/EEA Member States reported a total of 22 481 cases of measles, 15 633 (69.5%) of which were laboratory confirmed. Of the total reported cases with known age, 9 852 (43.8%) were in children under five years old and 6 371 (28.3%) cases were in individuals 15 years old or above. The highest notification rates were observed among infants under one year old (768.3 cases per million) and children one to four years old (424.4 cases per million).

Of 20 669 cases (100.0% of all cases) with a known age and vaccination status, 17 678 (85.5%) were unvaccinated, 1 851 (9.0%) were vaccinated with one dose of a measles-containing vaccine, 1 067 (5.2%) were vaccinated with two or more doses, and 43 (0.2%) were vaccinated with an unknown number of doses.

Fourteen deaths (case fatality rate (CFR): 0.1) attributable to measles were reported to ECDC during the 12-month period by Romania (12) and France (2). Detailed data are available in ECDC's Surveillance Atlas of Infectious Diseases.

Complementary epidemic intelligence surveillance has been conducted, with data collection between 11 and 13 June 2025. Ongoing outbreaks or considerable increases were reported in Belgium (Flanders region), Germany (Bavaria region), and Romania. Sporadic cases have been reported in Austria, Czechia, Denmark, Estonia, Italy, Lithuania, the Netherlands, Poland, Slovakia, and Spain.

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 TESSy and EpiPulse. Data presented in the two monthly reports may differ.*

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

Austria reported 116 measles cases in 2025 and as of 11 June 2025, an increase of 21 cases since 7 May 2025. In the recent four weeks, one to five cases have been reported across Austria with recent cases being reported from Vienna, Upper Austria and Steiermark. Relevant information was available for 106 cases, of which 28 were hospitalised (26.4%), including one patient being treated in an intensive care unit. No outbreaks have been reported.

Belgium: The outbreak continues in Flanders, with 82 cases reported only in May, of which 48 cases were in Antwerp and 31 in Limburg, as of a report on 2 June by the Flemish public health authority. The outbreak was notified in April 2025, mainly affecting Antwerp. Most of the cases are children zero to nine years old. Overall in 2025, 178 cases of measles have been reported in the Flanders region, with 108 cases reported in Antwerp and 33 in Limburg. Of the reported cases, 43% were hospitalised. In Limburg, measles cases have mostly occurred in large families.

Czechia reported 16 cases as of 2 June 2025.

Denmark reported four measles cases in 2025, as of 13 June (an increase of three since January).

Estonia has reported five cases from January to May 2025.

France: An increase in cases and number of outbreaks is observed in 2025 since 2023. According to the national public health authorities, the number of cases in the first quarter of 2025 (427 cases, including one death as of 13 April 2025) has reached the overall annual number of cases reported in 2024 (483 cases; 0.58 cases per 100 000 population). The increase is caused by transmission occurring due to imported cases as well as locally acquired infections. For more details, please read reports of the French authorities.

Germany reported 188 confirmed and probable measles cases in 2025 and as of 13 June 2025, an increase of 40 cases since 12 May 2025.

An outbreak related to an international festival in Jandelsbrunn/Zielberghas, Bavaria, Germany that took place in the beginning of May 2025 was reported on 4 June 2025, comprising at least 18 cases from Germany, Czechia, Italy, Poland and the United Kingdom. Please see a separate item on this with a respective assessment in this issue of the CDTR.

Italy reports a continuous increase of cases in 2025. As of data on 31 May, in 2025 there have been 334 cases reported, of which 65 cases were reported in May 2025. Nineteen regions reported measles, with the majority of cases observed in Sicily, Lombardy, Lazio and Emilia-Romagna. Almost half of the cases (48.8%) are 15 years old or above (median age: 32 years old); however, the highest incidence is seen in children under five years old. The vast majority of cases are unvaccinated (275 cases; 87.9% of those with known vaccination status – 313 cases).

Lithuania reported five cases in 2025 as of 12 June 2025, an increase of two cases since the end of March 2025.

The Netherlands reported 437 cases of measles as of 28 May 2025, indicating a slow decrease. The reports are mainly comprising individual cases and several small clusters with transmission occurring within families and daycare centres. There is no indication of a national outbreak. In 2025, 50 cases were reported to have contracted measles abroad. Most of these contracted infection in Morocco (33), but other cases had travel history to Greece, Romania, Viet Nam, Türkiye, Belgium, Uganda, Iran, and Bosnia and Herzegovina. In addition, the national public health authority (RIVM) reported on 12 June 2025 one death with measles in an adult with underlying conditions.

Poland reported 51 measles cases in 2025 and as of 31 May, an increase of five cases since 30 April 2025.

Romania reported 7 416 measles cases and eight deaths in 2025 and as of 31 May, an increase of 1 015 cases since April 2025. No new deaths were reported in this reporting period. A decreasing trend is observed in 2025, with three to four times less cases reported per month compared with the same period in 2024.

Slovakia reported two unrelated cases in an adult and a child on 27 March 2025.

Spain reported 303 cases as of 8 June 2025 (229 case reported as of 11 May 2025), of which 93 were imported and 89 were related to imported cases.

Epidemiological summary for select countries outside of the EU/EEA with relevant epidemic intelligence updates:

According to the WHO Pan American Health Organization (WHO PAHO) report on 10 June, 4 592 confirmed cases were reported by nine countries, of which the majority of cases are reported by Mexico (1 888), Canada (1 494) and the United States (US) (1 166).

According to a WHO Western Pacific Region (WHO WPRO) report for January to April 2025, there were 3 353 confirmed measles reported in the region in 12 countries. Most of the cases have been reported in Cambodia (1 060) and China (1 002), followed by Mongolia (377), the Philippines (232) and Viet Nam (144).

Apart from ongoing outbreaks reported previously, no new large outbreaks have been detected in this reporting period through ECDC epidemic intelligence activities. For more information on provisional number of cases outside the EU/EEA region, please visit the WHO website.

The numbers provided to WHO for EU/EEA countries are from TESSy 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:

The overall number of measles cases in the EU/EEA increased steadily between June 2023 and March 2024, before decreasing between April 2024 and March 2025.

Measles cases may continue to increase in the EU/EEA in the coming months, in line with measles' observed seasonality. This is due to reported suboptimal vaccination coverage for measles-containing vaccines (MCV) in a number of EU/EEA countries, as well as a high probability of

importation from areas experiencing high circulation. The majority of recently reported cases have acquired the disease within the reported country through community/local transmission; however, cases related to international travel have been reported.

Actions:

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

As the number of cases is expected to rise in the near future, ECDC urges EU/EEA public health authorities to focus on the following areas:

- **Close immunity gaps, achieve and maintain high vaccination coverage for MCV** (>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 under-served populations**. Systemic barriers that impact vaccine uptake in under-served, isolated and difficult-to-reach populations need to be monitored and addressed with targeted strategies in order to reduce inequalities in vaccine uptake.

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: 16 May 2025

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

Overview:

Based on data reported in week 23, 2025, primary care consultation rates remained at baseline levels for respiratory virus activity in all reporting EU/EEA countries; for severe acute respiratory infection (SARI), rates have returned to levels observed at this time in previous seasons.

Increases in SARS-CoV-2 activity from low levels continue to be observed, most notably in non-sentinel, laboratory-based surveillance (which comes from a mix of primary care and other sources, including hospital laboratories), where many countries report increasing trends in the proportion of tests that are positive for SARS-CoV-2.

Pooled EU/EEA test positivity for SARS-CoV-2 has been slowly increasing in influenza-like illness (ILI)/acute respiratory infection (ARI)-based surveillance in primary care and SARI surveillance in secondary care (see figures below); however, these trends are driven mainly by data from one country. The number of detections reported by other countries in week 23 remained very low. These trends align very closely with what was observed at the same time last year.

No significant impact in indicators of severe COVID-19 in secondary care or deaths has been observed to date.

EuroMOMO reports all-cause mortality in the expected range.

ECDC assessment:

The 2024/2025 respiratory virus season (week 40, 2024 to week 20, 2025) in the European Union/European Economic Area (EU/EEA) was characterised by an intense influenza season and a concurrent, protracted, respiratory syncytial virus (RSV) epidemic. Influenza and RSV activity has now returned to low or baseline levels in all countries. SARS-CoV-2 activity remained at low levels with no winter epidemic.

In recent weeks, increases in indicators of SARS-CoV-2 activity have been observed in many countries, although overall activity remains low and the impact in secondary care is very limited. A reduction in the number of countries reporting data since the end of the respiratory virus season makes a complete interpretation of the epidemiological situation across the EU/EEA challenging.

With virus activity at low levels, limited impact on healthcare systems is currently expected. However, if population immunity has fallen following a winter with low circulation of SARS-CoV-2, it is possible that the increasing trends in activity currently observed may lead to increases in severe COVID-19 in the coming weeks.

Actions:

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

Countries should remain vigilant, particularly in settings with populations vulnerable to severe disease. ECDC/WHO guidance recommends that surveillance for respiratory viruses is maintained year-round.

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

Countries should ensure that infection prevention and control practices in healthcare settings are implemented.

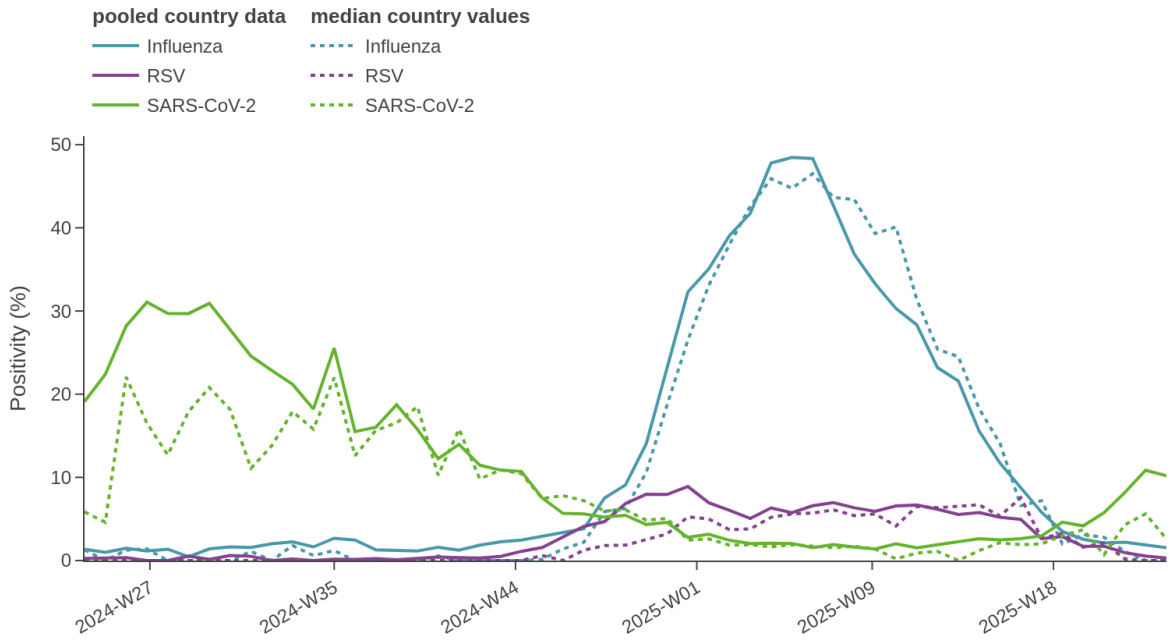
Wearing masks in settings such as high-risk wards and long-term care facilities can help protect groups at high risk of severe disease.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 23 May 2025

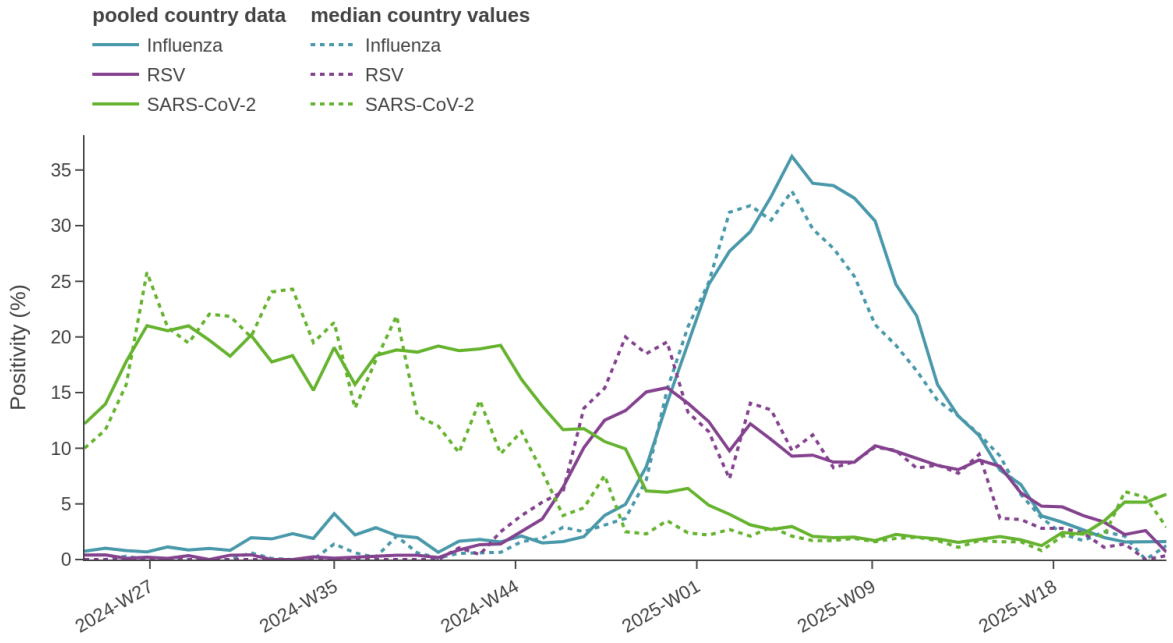
Maps and graphs

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



Source: ECDC

Figure 2. ILI/ARI virological surveillance in hospitals – weekly test positivity



Source: ECDC

Figure 3. Overview of key indicators of activity and severity in week 23, 2025

		Reporting countries		EU/EEA summary		
Indicator	**Syndrome or pathogen**	**Week 23**	**Week 22**	**Description**	**Value**	**Comment**
ILI/ARI consultation rates in primary care	ARI	12 rates (9 MEM)	13 rates (9 MEM)	Distribution of country MEM categories	9 Baseline	
	ILI	14 rates (14 MEM)	15 rates (14 MEM)		14 Baseline	
ILI/ARI test positivity in primary care	Influenza	12	16	Pooled (median; IQR)	1.6% (0; 0–1.5%)	
	RSV	10	13		0.3% (0; 0–0.4%)	
	SARS-CoV-2	11	15		10% (2.6; 0–6.7%)	At the EU/EEA level, the overall pooled SARS-CoV-2 positivity has been slowly increasing since week 9, mainly in those 15 years old and above. This is mainly driven by one country (Spain). Several countries are reporting increasing trends in SARS-CoV-2 test positivity in non-sentinel, laboratory-based data (from a mix of primary care and other sources, including hospital laboratories).
SARI rates in hospitals	SARI	7	10	–	–	
SARI test positivity in hospitals	Influenza	6	8	Pooled (median; IQR)	1.6% (1.2; 0.2–1.8%)	
	RSV	6	7		0.7% (0.3; 0–2.3%)	At the EU/EEA level, a decreasing trend in pooled positivity for RSV continues in all age groups.
	SARS-CoV-2	5	7		5.9% (2.9; 1.5–6.7%)	The observed increasing trend in pooled test positivity, mainly in patients 65 years old and above, is driven by data from one country (Spain).
Intensity (country-defined)	Influenza	17	17	Distribution of country qualitative categories	15 Baseline 2 Low	
Geographic spread (country-defined)	Influenza	16	17	Distribution of country qualitative categories	6 No activity 8 Sporadic 2 Regional	

Source: ECDC

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

	Week 23, 2025		Week 40, 2024 - week 23, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**10**	**-**	**25231**	**-**
Influenza A	9	100	14944	60
A(H1)pdm09	7	88	7181	57
A(H3)	1	12	5474	43
A (unknown)	1	–	2289	–
Influenza B	0	0.0	10025	40
B/Vic	0	–	4479	100
B/Yam	0	–	1	0.0
B (unknown)	0	–	5545	–
Influenza untyped	1	–	262	–
RSV	**2**	**-**	**4746**	**-**
RSV-A	0	–	853	44
RSV-B	0	–	1104	56
RSV untyped	2	–	2789	–
SARS-CoV-2	**65**	**-**	**3508**	**-**

Source: ECDC

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

Figure Table

	Week 23, 2025		Week 40, 2024 - week 23, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**12**	**-**	**13590**	**-**
Influenza A	5	100	5655	82
A(H1)pdm09	0	-	1677	60
A(H3)	0	-	1110	40
A (unknown)	5	-	2868	-
Influenza B	0	0.0	1256	18
B/Vic	0	-	163	100
B (unknown)	0	-	1093	-
Influenza untyped	7	-	6679	-
RSV	**5**	**-**	**5659**	**-**
RSV-A			734	48
RSV-B			802	52
RSV untyped	5	-	4123	-
SARS-CoV-2	**43**	**-**	**4096**	**-**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 23, 2025

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	4377	41	5a.2a(C.1.9)	3403	78
			5a.2a.1(D)	605	14
			5a.2a(C.1)	157	4
			5a.2a(C.1.9.3)	113	3
			5a.2a.1(D.3)	99	2
A(H3)	3146	29	2a.3a.1(J.2)	2414	77
			2a.3a.1(J.2.2)	432	14
			2a.3a.1(J.2.1)	204	7
			2a.3a.1(J)	43	1
			2a.3a.1(J.1)	34	1
			2a.3a.1(J.4)	2	0.1
			Not assigned	17	-
B/Vic	3232	30	V1A.3a.2(C.5.1)	2050	64
			V1A.3a.2(C.5.6)	579	18
			V1A.3a.2(C.5.7)	503	16
			V1A.3a.2(C)	72	2
			V1A.3a.2(C.5)	11	0.3
			Not assigned	17	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 21–22, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	3	49	18% (18–25%)
KP.3	VOI	3	25	10% (7–13%)
LP.8.1	VUM	3	100	41% (32–48%)
NB.1.8.1	VUM	2	20	7% (3–15%)
XEC	VUM	2	5	2% (1–4%)

Source: ECDC

5. Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025

Overview:

Update:
According to the French National Health Authority, since the beginning of the year and as of 8 June 2025, close to 53 750 confirmed autochthonous cases of chikungunya virus disease have been reported in Réunion. Since week 17, a decrease in surveillance indicators has been observed. The estimated number of emergency department visits for chikungunya virus disease in week 23 was 23 visits, compared to 53 visits in week 22.

Since the beginning of the year, 23 deaths occurring between weeks 11 and 22 have been classified as chikungunya virus disease-related (15 directly and eight indirectly related). These deaths occurred in people over 64 years old (range: 41–95 years old) with co-morbidities (mainly chronic pathologies).

The Haute Autorité de Santé (HAS) has advised public decision-makers to vaccinate people over 65 years old, those over 18 years old with comorbidities, and vector control professionals with Ixchiq vaccine, as a reactive short-term measure to prevent severe disease. On 7 April, the regional health agency initiated a vaccination campaign for prioritised individuals and extended the group of prioritised individuals on 17 April. On 26 April 2025, the French Ministry of Health and Access to Care reported that it was informed on 23 April 2025 by the French National Agency for the Safety of Medicines (ANSM) of the occurrence of two serious adverse events following vaccination against chikungunya with the Ixchiq vaccine in Reunion, including one death, and a third serious adverse event on 25 April. The three events occurred in people over 80 years old with comorbidities. Two of them experienced symptoms similar to those of a severe form of chikungunya a few days after vaccination and one died. The third person was discharged from hospital. On 25 April, the French National Authority for Health (HAS) advised a revision of the vaccination recommendations. As a result, the health authorities suspended the vaccination of individuals aged 65 years old and above, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remains open for people 18–64 years old with comorbidities. In this context, travellers 65 years old and above should also not be vaccinated with the Ixchiq vaccine.

On 7 May 2025, the European Medicines Agency (EMA) stated that the agency's safety committee (PRAC) had started a review of the Ixchiq vaccine, following the reports of severe adverse events in older adults. EMA reports that many of the people affected also had other illnesses and the exact cause of these adverse events and their relationship with the vaccine have not yet been determined. The Committee is temporarily recommending restricting the use of the vaccine. As a temporary measure while an in-depth review is ongoing, Ixchiq must not be used in adults 65 years old and above.

On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 1 June 2025, 746 confirmed cases of the disease have been reported on the island. Case numbers have risen steadily since week 15, indicating sustained local transmission. From week 16 onwards, all cases for which the transmission mode is known, have been locally acquired. The number of cases on week 22 decreased by 29% compared to week 21. The disease has now spread among the entire island, particularly in Mamoudzou (272 cases), Dzaoudzi (126 cases) and Pamandzi (114 cases). Since week 10, 19 chikungunya cases have been hospitalised, which included seven children under one year of age and 11 pregnant women admitted as a precaution due to an elevated risk of complications. No deaths have been reported. The actual number of chikungunya cases is likely underestimated. Due to increasing pressure on the emergency departments, case confirmation has been suspended and general practitioners are also requesting fewer tests. Combined with limited healthcare access for parts of the population, this situation contributes to underreporting. Due to the intensified circulation of locally acquired cases of chikungunya, the ORSEC plan has transitioned to phase 3 on 27 May to control the outbreak. Several management and surveillance measures will be implemented to control the outbreak and better prepare for a possible epidemic phase.

Background:
In August 2024, France reported the first autochthonous case of chikungunya virus disease in Réunion for 10 years, with onset of symptoms on 12 August. In recent weeks, the number of cases has increased sharply, as well as the geographical spread.

ECDC assessment:

The last major chikungunya virus disease epidemic in Réunion was in 2005–2006. The mosquito *Aedes albopictus*, which is a known vector of chikungunya virus (CHIKV), is established in Réunion.

The surveillance data indicate that the outbreak is in decreasing phase in Réunion. Nonetheless, the epidemic is still active throughout the island and the probability of infection for residents and travellers to Réunion remains high.

The impact of hospitalisation is observed among vulnerable individuals, infants, older adults, people with chronic illnesses and pregnant women, in whom the disease can be serious.

In Mayotte, both the mosquito *Aedes albopictus*, and the mosquito *Aedes aegypti* (which is also a known vector of CHIKV) are widely established. Although surveillance data indicate a decrease in cases, this must be interpreted with caution, as the surveillance system is weakening due to several factors, which limit the quality and completeness of the data.

The environmental conditions in the areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti* are established are currently favourable for mosquito activity and virus replication in mosquitoes; therefore, locally acquired transmission might occur in summer.

Actions:

To avoid virus spread, reinforced prevention and control measures have been implemented by the local authorities. The population is being encouraged to remove objects around homes that could contain water and serve as potential mosquito propagation sites, to protect themselves against mosquito bites, and to consult a doctor if symptoms occur.

Pregnant women, especially in the third trimester, are strongly advised to protect themselves from mosquito bites by using effective, pregnancy-safe repellents, and to sleep under a mosquito net. This precautionary measure is useful throughout pregnancy, given that fever during pregnancy can also lead to miscarriage. Newborns and infants should also be protected from mosquito bites by using effective and age-appropriate mosquito repellents (from three months of age) and nets.

ECDC is monitoring the situation through its epidemic intelligence activities.

Further information:

Travellers to Réunion are advised to apply personal protective measures to avoid the risk of being bitten by mosquitoes.

Aedes mosquitoes have diurnal biting activities, both in indoor and outdoor environments. Personal protective measures should therefore be applied all day long and especially during the hours of highest mosquito activity (mid-morning and late afternoon to twilight). Personal protective measures to reduce the risk of mosquito bites include wearing long sleeves and trousers impregnated with insect repellent, the use of repellent sprays applied in accordance with the instructions indicated on the product label, and limiting activities that increase mosquito exposure. In addition, it is recommended to sleep or rest in screened or air-conditioned rooms and to use mosquito bed nets (preferably insecticide-treated nets).

In the context of the outbreak, following the recommendations of the French health authorities, the national blood services have put the following measures in place for blood safety:
- CHIKV NAT for all donors in the overseas department of La Réunion;
- CHIKV-NAT, or a 28-day temporary deferral period, for travellers who have stayed at least one night in Réunion 28 days prior to donation.

Last time this event was included in the Weekly CDTR: 5 June 2025

6. Mass gathering monitoring – Jubilee of 2025 in Italy

Overview:

Updates
ECDC has conducted enhanced monitoring of the Jubilee through its epidemic intelligence activities between 9 and 13 June 2025, on the occasion of the Jubilee of the Holy See.

No infectious disease events of relevance for the EU/EEA were detected between 9 and 13 June 2025 in connection with the Jubilee.

Summary
The Jubilee 2025 is a special holy year which occurs once every 25 years, involving major religious mass gathering events in Rome that are attended by millions of pilgrims from all around the world. In 2025, starting from 24 December 2024 until December 2025, it is estimated that more than 35 million pilgrims will visit Rome.

In 2000, 26 million pilgrims attended the Jubilee in Rome. Although there were visitors from all continents, the majority were from Italy. There was no noted increase in the incidence of communicable diseases during the year of the event. Nevertheless, cases of Legionnaires' disease and foodborne outbreaks increased among tourists, with limited impact at the regional level. Outside of Italy, no public health events were reported that were linked to attending the Jubilee.

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 Jubilee is a mass gathering that comprises multiple events taking place throughout the year. Therefore, the context differs slightly from other mass gatherings. The general assessment provided below refers to the probability of EU/EEA citizens becoming infected with communicable diseases during the Jubilee. 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 Jubilee 2025 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 COVID-19.

Actions:

ECDC is monitoring this mass gathering event through epidemic intelligence activities and will report any relevant updates in collaboration with the Italian National Institute of Health (Istituto Superiore di Sanita'), the Italian Ministry of Health, SERESMI (National Institute for Infectious Diseases 'L.Spallanzani' – Lazio Region) and other partners.

Last time this event was included in the Weekly CDTR: 17 January 2025

7. Mass gathering monitoring – Hajj – Kingdom of Saudi Arabia – 2025

Overview:

The Hajj ended on 9 June 2025. There have been no reports regarding communicable diseases among pilgrims during the Hajj since 26 May (the start date of the monitoring). However, media quoting multiple sources reported that several pilgrims had died while attending the Hajj. These deaths have been attributed to the severe climate conditions during the event. Early reports indicate a much lower death toll at this year's Hajj pilgrimage than in previous years.

Summary

In recent months, prior to the event, cases of invasive meningococcal disease (IMD) serogroup W have been reported to ECDC through EpiPulse. France has reported through EpiPulse an outbreak linked to travellers or contacts of travellers returning from the Umrah pilgrimage in Saudi Arabia. Travellers eligible for vaccination should be counselled to receive the quadrivalent (ACWY) meningococcal vaccine at least 10 days before departure.

In 2025, and as of 3 June, 10 MERS-CoV cases have been reported, including two fatalities. All cases were reported in Saudi Arabia. Of these, seven cases were part of the same cluster in Riyadh, including one patient with no history of contact with camels and six healthcare workers who acquired a nosocomial infection from the patient. Of the six healthcare workers, two developed mild symptoms and four were asymptomatic. From the remaining two cases, one had history of indirect contact with camels, and one had no history of contact with camels.

Since April 2012, 2 638 laboratory-confirmed cases of MERS-CoV, including 957 deaths, have been reported worldwide.

Background

This year, the annual Islamic Hajj pilgrimage took place in Saudi Arabia from 4–9 June. Pilgrims aged 12 years and above were allowed to attend the pilgrimage. Over 1.8 million pilgrims attended the Hajj from all over the world, including from EU/EEA countries.

The Ministry of Health of Saudi Arabia issued a list of requirements for the 2025 Hajj and Umrah pilgrims. This includes a requirement for vaccination with quadrivalent (ACYW) meningococcal polysaccharide vaccine at least 10 days and up to three years prior to arrival.

In addition, since it is a densely populated event and there is a heightened risk of respiratory infectious diseases, the Saudi Arabian Ministry of Health recommends:

- regularly wearing face masks when in crowded places;
- washing hands frequently with soap and water or a disinfectant, especially after coughing, sneezing or using toilets; before handling and consuming food; and after touching animals;
- using disposable tissues when coughing or sneezing and disposing of used tissues in wastebaskets;
- avoiding contact with those who appear ill and avoiding sharing personal belongings;
- avoiding visits and contact with camels in farms, markets, or barns;
- avoiding drinking unpasteurised milk or eating raw meat or animal products that have not been thoroughly cooked, as well as applying measures to avoid insect bites during the day and night.

Travellers arriving to Hajj areas for Hajj, seasonal work or other purposes are recommended to observe the following:

- wash hands before and after eating and after going to the toilet;
- clean and wash fresh vegetables and fruit;
- cook food thoroughly and store at safe temperatures;
- keep raw and cooked food separated.

Pilgrims are recommended to take necessary measures to avoid mosquito bites during the day and evening, which include:

- wearing protective clothing (preferably light coloured) that covers as much of the body as possible;
- using physical barriers such as window screens and closed doors;
- applying insect repellent (as per the label instructions on the product) to skin or clothing that contains DEET, IR3535 or Icaridin.

ECDC assessment:

The Hajj is now over, but please note that the ECDC assessment for it was as follows:

The likelihood of infection with communicable diseases for EU/EEA citizens during the 2025 Hajj is considered to be low, due to the vaccination requirements for travelling to Mecca and Medina and the preparedness plans by Saudi Arabia that address the management of health hazards before, during, and after the Hajj. The risk of infection is considered to be moderate for people with underlying conditions, the older adults and pregnant women, with a low probability of infection and moderate impact. As with other mass gathering events, the risk of communicable disease outbreaks is higher for respiratory, food-, waterborne, and vector-borne diseases.

The risk of vaccine-preventable and vector-borne diseases is considered low if preventive measures are applied. A risk of infection and importation of cases to Europe after the Hajj remains. For pilgrims visiting the Hajj and Umrah zones in Saudi Arabia who are already vaccinated with the quadrivalent meningococcal vaccine, the likelihood of infection is low, as they are protected by vaccine-induced immunity. For unvaccinated pilgrims, the likelihood of infection is moderate.

ECDC published a rapid risk assessment on the Hajj on 2 July 2019. The risks and advice to pilgrims attending the Hajj remain valid for this year.

Actions:

ECDC monitored this event through its epidemic intelligence for mass gathering activities between 26 May and 13 June 2025 in collaboration with the Gulf CDC, including weekly updates in the Communicable Disease Threats Report (CDTR).

Last time this event was included in the Weekly CDTR: 5 June 2025

8. Mass gathering monitoring – EuroPride - Portugal – 2025

Overview:

Update
As of 13 June 2025, no relevant public health events related to communicable diseases have been detected in connection with EuroPride.

Summary
EuroPride 2025 is taking place in Lisbon, Portugal, from 14 to 22 June 2025. The event is expected to attract a high number of participants, including international visitors from across the EU/EEA. Activities will include multiple gatherings such as cultural and artistic performances and large-scale social gatherings, culminating in a public parade on 21 June in central Lisbon. The event will be hosted across multiple indoor and outdoor venues, some with expected high-crowd density and extended duration of contact among attendees.

In recent years, rates of STIs such as gonorrhoea and syphilis have continuously increased among MSM. Additionally, clusters and outbreaks of other infections transmitted through intimate contact among sexual partners are currently spreading among MSM, including mpox, viral hepatitis and extensively drug-resistant *Shigella*. In Portugal there is currently an ongoing outbreak of hepatitis A among MSM.

For this year's Pride event in Lisbon, the main recommendations stated in the 2017 ECDC risk assessment, the ECDC guidance on HIV and STI prevention among men who have sex with men, the ECDC public health considerations on mpox, and the ECDC guidance on PrEP remain valid. Additional points on *Shigella* prevention are also important and outlined below. Public health authorities are recommended to work with civil society and other partners to ensure that MSM have access to correct information and services.

It is recommended that participants in Pride events be mindful of the following:

- Ensure that their routine vaccination and boosters are up to date according to the national immunisation recommendations in their country of residence, including those against hepatitis A. It is advised to discuss the need for additional vaccinations, such as for mpox, or booster doses with their healthcare providers.
- Ensure coverage with valid health insurance or obtain a European Health Insurance Card.
- Educate themselves prior to attendance about the prevention of STIs, including recommendations on HIV pre-exposure prophylaxis, and familiarise themselves with additional advice and information on the website of the event.
- Consult a healthcare provider in the home country to discuss other precautions based on a sexual health risk assessment: they may recommend pre-exposure prophylaxis (PrEP) for HIV, but remember that PrEP does not protect against other STIs.
- Practise safer sex using condoms to prevent STIs, including HIV and hepatitis B and C.
- While using a condom is an important protective measure, it does not provide full protection against mpox, as mpox can be transmitted through close skin-to-skin contact, especially if there are rashes, sores, or lesions on the skin.
- Avoid sexual activity and seek healthcare if symptoms of STIs are present, including gastrointestinal symptoms and symptoms suggestive of mpox, in themselves or any sexual partner.
- Avoid faecal-oral exposure during sexual activity in order to prevent other infections such as shigellosis and hepatitis A (i.e. washing hands, genital and anal areas before and after sexual contact, always using a condom, changing condoms between anal and oral sex, using gloves or condoms on sex toys, using dental dams for oral sex and latex gloves for fingering or fisting). If gastrointestinal symptoms appear, tell healthcare providers about sexual activities.
- Follow standard hygiene measures and advice on the prevention of food and waterborne diseases to decrease the risk of gastrointestinal illnesses and consider general hygiene/food safety practices when consuming food and drink.
- If you think you have been exposed to HIV, hepatitis A or B, or mpox infection, contact a healthcare provider as soon as possible for advice, as post-exposure prophylaxis (PEP) is available for some infections as vaccination or tablets and should be started as soon as possible (within 72 hours for HIV).
- Contact a healthcare provider at the event if experiencing symptoms suggestive of an infection. People with STIs might have no symptoms; however, common symptom include unusual discharge from the genitals or rectum, itching, pain during urination, rectal pain, skin changes (including rashes or blister-like lesions), yellowing of the skin, pain during sex or influenza-like symptoms. If you have any of these symptoms, or experience severe diarrhoea (which can be caused by shigella or hepatitis A), avoid sexual activity and seek healthcare promptly.
- In general, if engaged in unprotected sexual activity with a casual partner, consider contacting a healthcare provider for advice on testing for STIs, including mpox, HIV and hepatitis, as STIs can be present without causing any symptoms.
- Alternatively, use the European Test Finder tool to identify the most conveniently located testing centre. Known partners of those diagnosed should be notified as well as offered testing and treatment according to clinical guidelines.

ECDC assessment:

Euro Pride is a mass gathering with a large number of visitors, some of whom may engage in different type of sex with new partners, anonymous partners and multiple partners. Sometimes sexual activity may be in the context of drug use, which has been associated with an increased risk of transmission of infectious disease through sex.
STIs, HIV and hepatitis, as well as mpox and *shigella,* are already spreading in MSM networks in Europe. The probability of infection with STIs and other infections that spread through sex is high for people who attend EuroPride and engage in sex with non-steady and multiple partners, particularly if preventive measures are not consistently applied.

Mass gathering events in general 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 probability of EU/EEA citizens becoming infected with other communicable diseases while attending EuroPride 2025 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).

In 2017, ECDC published a rapid risk assessment on potential public health risks related to communicable diseases at the WorldPride festival in Madrid. The main recommendations stated in the ECDC risk assessment remain valid together with the ECDC guidance on HIV and STI prevention among men who have sex with men, the ECDC public health considerations on mpox, and the ECDC guidance on PrEP.

Actions:

ECDC is monitoring this event through its epidemic intelligence for mass gathering activities between 9 to 27 June 2025 in collaboration with the Portuguese health authorities and WHO/Europe, and is including weekly updates in the Communicable Disease Threats Report (CDTR).

ECDC has published recommendations on STIs in the upcoming holiday season.

Last time this event was included in the Weekly CDTR: –

9. Outbreak of measles associated with international mass gathering - Germany - 2025

Overview:

On 4 June 2025, authorities in the district of Freyung-Grafenau, Bavaria, Germany, reported an outbreak of measles, associated with international festival in Jandelsbrunn/Zielberg, which took place in the beginning of May this year. The authorities reported 18 confirmed cases, of whom six were reported in Germany (Freyung-Grafenau district), and 12 cases were reported from Czechia, Italy, Poland and England, United Kingdom. The festival hosted about 400 participants.

The German authorities are conducting outbreak investigation and implementing measures to sustain the transmission of the infection, including the information of the public and suggesting vaccination within 72 hours from contact with infected person, for the unvaccinated. One school-aged child was detected. All related contacts at school have been checked for vaccination status - all but one were vaccinated.

ECDC assessment:

Measles prodrome starts after a 10–12-day incubation period and is characterised by fever, conjunctivitis, coryza, cough and bronchiolitis. Nearly all infected susceptible individuals develop clinical disease.

Capacity for case investigation, contact tracing, implementation of swift isolation and control measures including vaccination are needed to prevent further transmission upon the detection of new cases. Exchange of information on cross-border cases via established EU and international channels is important to avoid re-establishment of measles in receiving countries.

Overall, measles cases in the EU/EEA may continue to rise in the coming months. This anticipated increase is linked to greater population movement during the summer holiday season, persistently suboptimal vaccination coverage for measles-containing vaccines (MCV) in several countries, and a high likelihood of importation from regions with ongoing widespread transmission.

To prevent further transmission and protect public health, it is essential to close immunity gaps and achieve high vaccination coverage—specifically, at least 95% coverage with two doses of MCV. Timely administration of the first and second doses in infants and children, as per national immunisation schedules, is critical. In addition, immunisation catch-up efforts should focus on identifying and vaccinating susceptible individuals, such as non-immune adolescents and adults, as advised by local and national public health authorities.

The importance of pre-travel health advice is well recognised, particularly in the context of mass gathering events such as concerts/festivals. Travellers attending such events may be exposed to infectious diseases, including measles, and risk carrying the infection back to their home countries, potentially spreading it to others. Conversely, visitors can also introduce infections from their country of origin, posing a risk to fellow attendees and the host population. In light of the upcoming summer holiday season, travellers are strongly encouraged to 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.

Actions:

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

Last time this event was included in the Weekly CDTR: –

10. Invasive pneumococcal disease among shipyard workers in Turku, Finland

Overview:

On 23 May 2025, the Southwest Finland Wellbeing Services Country (Varha) reported ten suspected or confirmed cases of pneumococcal pneumonia among adults employed at the Turku shipyard (Employees have fallen ill with pneumococcal disease at the Turku shipyard, vaccinations are about to start | Varha). The patients belong to different occupational groups, have different nationalities and are employed in different companies. Since then, two further suspected cases have been identified in this outbreak. Several response measures have been put in place including vaccination.

Outbreaks of invasive pneumococcal disease have been reported in the past in Turku shipyards in Finland in 2019 and 2023 (Eurosurveillance | Outbreak of invasive pneumococcal disease among shipyard workers, Turku, Finland, May to November 2019 and Second reported outbreak of pneumococcal pneumonia among shipyard employees in Turku, Finland, August–October 2023: a case–control study | Epidemiology & Infection | Cambridge Core). In the outbreaks of 2019 and 2023, most cases reported being smokers, working mainly indoors, living with roommates/family and not having as a main task welding. In microbiological analysis *Streptococcus pneumoniae* serotype 4 was identified in 30% (11/37) of the 2019 and 36% (5/14) of the 2023 reported cases analysed in two studies. Isolates from 2019 were related to isolates from 2023 with 4-8 allelic differences.

ECDC assessment:

Outbreaks of invasive pneumococcal disease (IPD) have been previously reported among shipyard workers in several EU/EEA countries. Two outbreaks have been reported by Finland in the same area, one in 2019 and on in 2023. Exposure to welding fumes and other factors such as smoking,

exposure to respiratory irritants, working or living in crowded conditions are known risk factor for pneumococcal infection and may be prevalent to different degrees alone or in combination in settings similar to shipyards. Although the cases reported in this outbreak are reported to be of different nationalities, given the experience of the previous outbreaks, the risk of international spread is considered low, as control measures are being taken by the Finnish authorities.

Actions:

ECDC is monitoring the event through epidemic intelligence and is in contact with Finland.

Last time this event was included in the Weekly CDTR: –

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

Overview:

On 27 May 2025, WHO reported in their monthly Influenza at the human-animal interface report, two new cases in Bangladesh, both children from Khulna division. At the time reporting, it is not known if the two children were epidemiologically related apart from living in the same district and detection of the same virus clade 2.3.2.1a.

The first report described an eight-year-old boy from Jessore district, Khulna division, who was treated in hospital on 24 April 2025 due to fever and difficulty breathing. The child recovered. The child could possibly have had exposure to backyard poultry, according to the state news report. The second case was retrospectively detected in a sample collected in February 2025 from a child in Khulna division, who subsequently recovered.

Summary:
Since 2003, and as of 9 June 2025, there have been 978 human cases of avian influenza A(H5N1) infection worldwide*, including 471 deaths (case fatality among reported cases: 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, and the United States). To date, no sustained human-to-human transmission has been detected.

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

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ECDC assessment:

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

Overall, the risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered low. The risk to occupationally-exposed groups, such as farmers and cullers, is considered low-to-moderate.

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

Actions:

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

Last time this event was included in the Weekly CDTR: 5 June 2025

12. Risk Assessment under production

Overview:

ECDC is preparing a Rapid Risk Assessment on Diphtheria caused by *C. diphtheriae* ST-574 in the EU/EEA, 2025, with a planned date for publication on 25 June 2025.

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

Events under active monitoring

- SARS-CoV-2 variant classification - last reported on 28 May 2025
- Risk Assessment under production - last reported on 28 May 2025
- Hepatitis A - Multi-country (EU) - 2024-2025 - last reported on 28 May 2025
- Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025 - last reported on 28 May 2025
- Mass gathering monitoring – Hajj – Kingdom of Saudi Arabia – 2025 - last reported on 28 May 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 23 May 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 23 May 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 23 May 2025
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 23 May 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 16 May 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 16 May 2025
- Human cases with avian influenza A(H10N3) – Multi-country (World) - last reported on 16 May 2025
- Nipah virus disease – India – 2025 - last reported on 16 May 2025

- Outbreak of Corynebacterium diphtheriae ST-574 among migrants, people experiencing homelessness, older adults and unvaccinated people – Germany – 2025 - last reported on 16 May 2025
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 16 May 2025
- Seasonal surveillance of West Nile virus infections started in week 23 - last reported on 13 June 2025
- Outbreak of measles associated with international mass gathering - Germany - 2025 - last reported on 13 June 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 13 June 2025
- Invasive pneumococcal disease among shipyard workers in Turku, Finland - last reported on 13 June 2025
- Mass gathering monitoring – EuroPride - Portugal – 2025 - last reported on 13 June 2025
- Mass gathering monitoring – Jubilee of 2025 in Italy - last reported on 13 June 2025
- Serious adverse events to IXCHIQ chikungunya virus disease vaccine - last reported on 08 May 2025
- Salmonella Infantis outbreak among small children in Germany and Austria - last reported on 05 June 2025
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 05 June 2025
- Crimean-Congo haemorrhagic fever, Spain 2025 - last reported on 05 June 2025