WEEKLY BULLETIN

Communicable Disease Threats Report

Week 28, 5–11 July 2025

This week's topics

Executive summary

Seasonal surveillance of chikungunya virus disease – 2025

- In 2025, France has reported 25 locally acquired cases of chikungunya virus disease from seven local administrative units. To date, no other EU/EEA country has reported locally-acquired cases in 2025.

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 29 June 2025, 54 233 confirmed autochthonous cases of chikungunya virus disease have been reported in Réunion. Since the beginning of the outbreak, 27 deaths, mostly in people aged over 65 years, have been 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, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remains open for people aged 18–64 years 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 for adults aged 65 years and above. More information can be found in the Communicable disease threats report, 3 May - 9 May 2025, week 19.

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

- On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 29 June 2025, 1 098 confirmed cases of the disease have been reported on the island. Due to the intensified circulation of locally acquired cases of chikungunya virus disease, the ORSEC plan is in phase 3 to control the outbreak.

Seasonal surveillance of West Nile virus infections – 2025

- In 2025, and as of 2 July 2025, no countries in Europe have reported any locally acquired human cases of WNV infection with known place of infection.
- From the veterinary perspective, two WNV outbreaks among equids and three among birds have been reported in Europe in 2025.

Weekly seasonal surveillance of West Nile virus infection – 2025

- Since the beginning of the 2025 transmission season, and as of 2 July 2025, no countries in Europe have reported human cases of West Nile virus (WNV) infection.

Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025

- Since the beginning of 2025 and as of 9 July 2025, two countries in Europe have reported cases of Crimean-Congo haemorrhagic fever (CCHF): Greece (2) and Spain (1).
- Greece reported a secondary case in a healthcare professional who provided care to the patient in whom the primary case occurred.
- No additional cases have been reported since week 27.

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

- The UEFA Women's EURO 2025 is taking place in Switzerland between 2 and 27 July.
- ECDC is monitoring this mass gathering event through epidemic intelligence activities until 1 August and will report weekly in the CDTR and on an ad hoc basis should a relevant public health event or threat arise.
- Respiratory diseases including COVID-19, food and waterborne diseases, tick-borne and sexually transmitted diseases are among the potential health threats for those attending.
- The probability of exposure to any of these infections for EU/EEA citizens during the UEFA Women's EURO 2025 is considered very low to low, with an estimated low impact. The impact would be higher for people with underlying conditions, older individuals, and pregnant women.

Monitoring of bathing/swimming related-vibriosis - Summer 2025

- With the arrival of the summer and the increases in sea surface temperatures, the European Centre for Disease Prevention and Control (ECDC) is highlighting the seasonal risk posed by Vibrio bacteria.
- Every summer, ECDC monitors environmental conditions that favour Vibrio growth in the Baltic Sea and publishes regular updates through its Communicable Disease Threat Report and the Vibrio Map Viewer.

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

- In May 2025, 686 measles cases were reported by 17 countries in the EU/EEA. Thirteen countries reported zero cases.
- Overall, six measles-related deaths have been reported in the EU/EEA in 2025, two from France, one from the Netherlands and three from Romania.
- Overall, case numbers decreased compared with the previous month; this is consistent with measles seasonality.

Overview of respiratory virus epidemiology in the EU/EEA

- In recent weeks, increases in indicators of SARS-CoV-2 infection have been observed in many countries, although the overall number of infections remains low and the impact on secondary case is still limited. Influenza and RSV activity is low in all reporting countries.
- Due to a reduction in the number of countries reporting data since the end of the respiratory virus season and the low number of tests performed, a complete interpretation of the epidemiological situation across the EU/EEA is difficult.

Nipah virus disease – India – 2025

- Two Nipah cases were reported in Kerala, India on 4 July 2025. This year, another case was also reported in Kerala, in May 2025.
- The likelihood of exposure and infection with NiV for EU/EEA citizens travelling to or residing in India is currently very low, given the low number of infections in areas where cases have been identified so far.

1. Seasonal surveillance of chikungunya virus disease – 2025

Overview

Since the beginning of 2025 and as of 9 July 2025, one country in Europe has reported cases of chikungunya virus disease: **France** (25). To date in 2025, public health authorities in France have reported 25 cases of locally acquired chikungunya virus disease in 11 different local administrative units. All clusters are currently classified as active.

The largest cluster consists of 10 cases and is located in Salon-de-Provence, Bouches-du-Rhône department. This week authorities reported the first locally acquired chikungunya virus disease case from the Gironde department. In the previous week, authorities reported the first locally acquired chikungunya virus disease case from the Bas-Rhin department. The other departments have reported locally acquired chikungunya virus disease or dengue cases in previous years.

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

ECDC assessment

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

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

2. 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 29 June 2025, 54 233 confirmed autochthonous cases of chikungunya virus disease have been reported in Réunion. The decrease in the total number of cases since the last publication is due to a revision of the database. Since week 17, a decrease in surveillance indicators has been observed. In week 25, 119 confirmed cases were reported, compared to 219 in week 24. The estimated number of emergency department visits for chikungunya virus disease in week 26 was seven, compared to 10 visits in week 25. Since the beginning of the year and as of 22 June, 27 deaths occurring between weeks 11 and 22 have been classified as chikungunya virus disease-related (17 directly and 10 indirectly related). These deaths occurred mostly in people aged over 65 years (range: 41–95 years) with co-morbidities (mainly chronic diseases).

On 5 March 2025, the Haute Autorité de Santé (HAS) advised public decision-makers to vaccinate people aged over 65 years, those aged over 18 years 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 aged over 80 years with comorbidities. Two of them experienced symptoms similar to those of a severe form of chikungunya a few days after vaccination and one 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 and above, with or without comorbidities, pending a risk/benefit reassessment.

In addition, 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 aged 65 years and above. Vaccination remains open for people aged 18–64 years with comorbidities. In this context, travellers aged 65 years and above should also not be vaccinated with the Ixchiq vaccine.

On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 29 June 2025, 1 098 confirmed cases of the disease have been reported on the island. The number of cases has been decreasing since week 22. However, the actual number of chikungunya cases is still probably underestimated. Since week 10, 38 chikungunya cases have been hospitalised, including 15 children under one year of age, 19 pregnant women admitted as a precaution due to an elevated risk of complications and two neonatal ICU admissions. No deaths have been reported.

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.

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 decreasing in Réunion, however the epidemic is still active throughout the island and the probability of infection for residents and travellers to Réunion is assessed as moderate. The impact in terms of hospitalisation has mainly been seen in 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 weakened due to several factors, which limit the quality and completeness of the data.

Chikungunya virus disease risk assessment for mainland EU/EEA can be found on the dedicated ECDC website: Chikungunya virus disease risk assessment for mainland EU/EEA.

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. The first locally acquired chikungunya virus disease cases in the EU/EEA (excluding the outermost regions) have been reported, with a date of symptom onset in late May/early June. This was unusually early in the year, with most cases in previous years occurring in July or August, and might be related to the high pressure of imported cases.

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

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).

Travellers who visit areas endemic for Aedes-borne diseases (e.g. chikungunya virus disease, dengue virus disease and Zika virus disease) and reside in areas of mainland EU/EEA where Aedes albopictus and/or Aedes aegypti mosquitos are established should continue to apply personal protective measures after their return for a period of three weeks.

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 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: 27 June 2025.

3. Seasonal surveillance of West Nile virus infections – 2025

Overview

In 2025, and as of 2 July 2025, no countries in Europe have reported any locally acquired human cases of WNV infection with known place of infection.

In the previous five years, the first locally acquired cases of the WNV transmission season usually had symptom onset in June. However, the absence of notifications of locally acquired WNV cases in the EU/EEA and EU-neighbouring countries is not unexpected at this time of the year. This could either be due to the absence of WNV infections in humans, or a delay in diagnosis and reporting of WNV infection cases. Furthermore, a majority of WNV infections in humans remain asymptomatic or pauci-symptomatic.

From the veterinary perspective, two WNV outbreaks have been reported among equids and three among birds in Europe in 2025. The earliest start date of an outbreak among equids and birds was 15 January 2025 in Germany and 16 February 2025 in Italy, while the latest outbreaks among equids and birds began 12 June 2025 in Hungary and 11 June 2025 in Italy, respectively.

The number of outbreaks in birds and equids reported during this first period of 2025 is below the mean monthly outbreak count for the same timeframe in other years (calculated from 2015–2024). During the same period in 2024, 16 outbreaks were reported. In 2025, the figure as of 2 July represents the lowest number of outbreaks in birds and equids reported during the same period since 2022. All three countries (and their associated regions) reported WNV outbreaks in birds and/or equids in 2024 and in prior years, indicating endemic WNV activity in these regions.

More information

More background information on the Commission Directives on blood safety and EU/EEA notifications of WNV infections can be found in ECDC's weekly surveillance report on WNV infections, which is available online (Weekly updates: 2025 West Nile virus transmission season (europa.eu). Monthly epidemiological updates are available at: Monthly updates: 2025 West Nile virus transmission season (europa.eu).

ECDC assessment

In temperate regions like Europe, WNV transmission typically occurs from mid-June to mid-November, when mosquito activity is highest. Off-season reports of WNV outbreaks in birds and equids should be carefully evaluated as they raise questions about the timing of infection. The two early-season WNV outbreak reports (Germany's equid case in January and Italy's bird case in February) require cautious interpretation, as they may reflect residual detection (e.g. lingering antibodies or viral RNA from prior infections) rather than active transmission in 2025.

The absence of reported human WNV infections in Europe as of 2 July 2025, alongside a notably lower number of outbreaks in birds and equids compared to 2024, suggests a reduced level of viral circulation in the environment during the early transmission season in 2025. Natural fluctuations in virus prevalence can occur from year to year, influenced by immunity levels in bird populations and ecological conditions. Human cases are expected to occur in the coming weeks.

Actions

ECDC is monitoring WNV through indicator- and event-based surveillance activities.

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

Overview

Since the beginning of 2025, and as of 9 July 2025, 2 countries in Europe reported human cases of West Nile virus infection: **Greece** and **Romania**.

The report is available online.

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

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

Overview

Since the beginning of 2025 and as of 9 July 2025, two countries in Europe have reported cases of Crimean-Congo haemorrhagic fever (CCHF): Greece (2) and Spain (1).

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

The event in Spain is not unexpected, as CCHF virus is known to be circulating among animals in this region and human CCHF cases have been previously reported in the area.

ECDC assessment

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

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

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

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

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

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

Overview

Summary

Since the start of the monitoring period and as of 10 July, no relevant public health events associated with infectious diseases have been detected in the context of the UEFA Women's EURO 2025.

Background

This year, the UEFA Women's EURO 2025 is taking place in Switzerland between 2 to 27 July. Around 600 000 people are expected to watch the 31 scheduled matches of the16 qualified national teams. The tournament is taking place at eight stadiums in eight Swiss cities across a total of seven cantons: Basel (Canton of Basel-Stadt), Bern (Canton of Bern), Geneva (Canton of Geneva), Zurich (Canton of Zürich), St. Gallen (Canton of St. Gallen), Lucerne (Canton of Lucerne), Sion (Canton of Valais), and Thun (Canton of Bern).

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

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

In addition to the matches in the stadiums, a large number of public viewing events, such as the transmission of football matches shown on screens outside the home environment, are planned in Switzerland. These include the official fan zones that UEFA will operate in each of the eight host cities. Furthermore, other European cities, such as Berlin, will also hold public viewing events.

ECDC assessment

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

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

Actions

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

7. Monitoring of bathing/swimming related-vibriosis - Summer 2025

Overview

With the arrival of the summer and the increases in sea surface temperatures, the European Centre for Disease Prevention and Control (ECDC) is highlighting the seasonal risk posed by Vibrio bacteria. These bacteria live naturally in brackish coastal waters, where saltwater and freshwater mix, especially when temperatures are high and salinity is lower, conditions that are increasingly common in parts of Europe due to climate change.

Vibrio species are most often detected during the summer in the Baltic Sea, as it offers especially favourable conditions for bacterial growth due to its lower salt concentration. The bacteria have also been found in other places, including the North Sea and various enclosed or estuarine bathing sites, and as sea surface temperatures increase across Europe, Vibrio expansion to other coastal areas is anticipated.

Vibriosis is caused by several species of Vibrio bacteria, some of which can cause serious infections. These include foodborne infections after eating raw or undercooked shellfish and severe bloodstream infections when bacteria enter the body through cuts or wounds in the skin. People with weakened immune systems or chronic liver conditions are particularly vulnerable.

Although Vibrio infections remain relatively rare in Europe, several northern countries bordering the Baltic Sea have reported increases in recent years. This has been particularly evident during summers with extended heatwaves and higher water temperatures, such as the summer of 2018 when 445 cases were reported, more than triple the annual median of 126 cases recorded between 2014 and 2017.

Recognising the symptoms and staying safe

The symptoms of vibriosis depend on how the infection is acquired. In cases where vibriosis is contracted through the consumption of raw or undercooked shellfish, symptoms typically include watery diarrhoea, abdominal pain, nausea, vomiting, fever, and chills. The infection can also arise from bathing in waters with large amounts of Vibrio bacteria, causing ear infections or, if the bacteria come into contact with open wounds, skin-related symptoms like redness, swelling, and pain around the affected area. Untreated wound infections may lead to serious complications such as necrotising fasciitis, bloodstream infections, sepsis or even limb amputation, particularly among individuals with underlying conditions, such as chronic liver conditions or weakened immune systems.

To reduce the risk of Vibrio infections there are precautions that can be taken: avoiding eating raw or undercooked shellfish, particularly oysters, and cooking seafood thoroughly to safe internal temperatures. Those who have open wounds, recent piercings, or cuts should avoid swimming in brackish water or saltwater, or cover the affected area with a waterproof bandage. If individuals with scratches, cuts or wounds accidentally come into contact with seawater, it is important to wash the area with clean, fresh water.

Raising awareness among the public, healthcare providers, and travellers is key to preventing severe infections and reducing the public health impact of vibriosis. ECDC encourages individuals to stay informed and to consult a doctor if symptoms appear after contact with the type of water where Vibrio bacteria thrive. ECDC also encourages countries that could be affected to set up surveillance of the disease as it is probably under-reported.

Actions

Every summer, ECDC monitors environmental conditions that favour Vibrio growth in the Baltic Sea and publishes regular updates through its Communicable Disease Threat Report and the Vibrio Map Viewer. The map viewer uses real-time satellite data on sea surface temperature and salinity to assess environmental suitability for Vibrio species, providing a snapshot of potential risk across countries.

The relevant news item has been published in the ECDC Website (Increased risk of Vibrio infections throughout the summer season).

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

Overview

In May 2025, 30 countries reported measles data in the EU/EEA, with 686 measles cases reported by 17 countries. There were 13 countries that reported zero cases.

Overall, case numbers decreased compared with the previous month; which is consistent with the seasonality of the disease. The highest case counts were reported by Romania (162), France (134), Belgium (126), Italy (72) and the Netherlands (54).

Between 1 June 2024 and 31 May 2025, 30 EU/EEA Member States reported a total of 17 940 cases of measles, 12 694 (70.8%) of which were laboratory confirmed. Of the total reported cases with known age, 7 732 (43.1%) were in children under five years; 5 243 (29.2%) cases were aged 15 years or above. The highest notification rates were observed among infants under one year of age (602.4 cases per million) and children aged 1-4 years (333.2 cases per million).

Of 16 360 cases (100.0% of all cases) with a known age and vaccination status, 13 968 (85.4%) were unvaccinated, 1 446 (8.8%) were vaccinated with one dose of a measles-containing vaccine, 883 (5.4%) were vaccinated with two or more doses, and 39 (0.2%) were vaccinated with an unknown number of doses.

During the 12-month period, 11 deaths (case fatality rate (CFR): 0.1) attributable to measles were reported to ECDC by Romania (eight), France (two) and the Netherlands (one). 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 has reported 133 measles cases in 2025 and as of 2 July 2025, an increase of 17 cases since 11 June 2025. In the last four weeks, cases have been reported from Vienna, Lower Austria, Upper Austria and Steiermark. Relevant information was available for 123 cases, 31 of which were hospitalised (25.2%), including one patient who was being treated in intensive care unit.

Czechia had reported 30 cases as of 1 July 2025, an increase of 14 cases since 1 June 2025.

France: an increase in cases and the number of outbreaks has been observed in 2025 and this trend has been continuing since 2023. According to the national public health authorities, the number of cases in the first five months of 2025 (658 cases, including two deaths among immunocompromised patients) is already exceeding the number of cases reported in 2024 by 35% (483 cases; 0.58 cases per 100 000 population). Among the subjects targeted by vaccination (those aged over one year and born since 1980), for whom vaccination status was known (n = 429), 304 (70.8%) cases occurred in individuals who were unvaccinated or incompletely vaccinated. At the national level, the number of reported cases appears to have peaked in March, but remains high. The increase is caused by transmission occurring through imported cases and locally acquired infections.

Germany has reported 207 confirmed and probable measles cases in 2025 and as of 8 July 2025, an increase of 19 cases since 13 June 2025.

Lithuania has reported six cases in 2025 as of 8 July 2025, an increase of one case since 12 June 2025.

The Netherlands has reported 475 cases of measles as of 2 July 2025, an increase of 38 cases since the end of May 2025. The reports mainly consist of individual cases and several small clusters with transmission occurring within families and at day-care centres. There is no indication of a national outbreak. In 2025, 51 cases were reported to have contracted measles abroad, with most of these infections occurring in Morocco (35). Other cases

had travel histories to Greece, Romania, Viet Nam, Türkiye, Belgium, Uganda, Iran and Bosnia and Herzegovina. On 12 June 2025, RIVM reported a death from measles of an adult with a severe immune disorder.

Poland has reported 59 measles cases in 2025 and as of 30 June, an increase of eight cases since 31 May 2025.

Romania has reported 7 836 measles cases and eight deaths in 2025 and as of 30 June, an increase of 420 cases since May 2025. No new deaths have been reported in this reporting period. A decreasing trend is observed in 2025, with fewer cases reported per month compared to the same period in 2024.

Spain has reported 309 cases as of 29 June 2025 (303 cases reported as of 8 June 2025), 94 of which were imported and 87 related to imported cases.

Sweden has reported seven measles cases in 2025 and as of 8 July 2025, an increase of one since 14 May 2025.

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

Based on the WHO Provisional Monthly Measles data, as of 2 July 2025, the non-EU/EEA countries reporting most measles cases in the WHO EURO region in 2025 are Georgia (464), Kyrgyzstan (7 399), Tajikistan (1 676) and Ukraine (914).

In addition, in 2025, as of 9 July 2025, measles cases had been reported from Bosnia and Herzegovina (8), Montenegro (12), the Republic of Moldova (119), Serbia (187), and Switzerland (37).

England reported 529 laboratory confirmed cases from January to 3 July 2025, an increase of 209 cases since the last report on 10 April 2025. The majority of cases involve children under 10 years of age (68%).

Scotland reported 23 laboratory confirmed measles cases between January and March 2025. Of these, four cases had been imported and were related to travel outside of the United Kingdom.

Northern Ireland has reported 27 confirmed measles cases in 2025, as of 30 June, representing an increase of 24 cases since 30 April 2025.

According to the report published by Africa CDC on 28 June 2025, a total of 96 018 measles cases, 8 002 of which were confirmed, and 618 deaths were reported in the 18 countries: Cameroon, Chad, DRC, Ethiopia, Guinea, Kenya, Malawi, Mali, Mauritania, Morocco (40 000 cases and 79 deaths), Nigeria, Rwanda, Senegal, Somalia, South Africa, Sudan and Zambia.

According to the WHO Provisional Monthly Measles data, 37 992 cases of measles have been reported in 2025 and as of 2 July 2025 in the WHO Regional Office for the Eastern Mediterranean (WHO EMRO) countries: Afghanistan (7 037), Pakistan (12 390), Somalia (466) and Yemen (14 748).

According to the WHO Pan American Health Organization (WHO PAHO) report published on 20 June 2025, 7 150 confirmed cases were reported by nine countries, the majority of which were reported by Canada (3 391), Mexico (2 434), and the United States (US).

As of 1 July 2025, the US reported 1 267 confirmed measles cases in 2025, including three deaths in 38 jurisdictions. 92% of the cases were unvaccinated or had an unknown vaccination status.

On 24 June 2025, Bolivia declared a National Health Emergency due to the increase in measles cases in the country. From April 21 to June 24, 60 positive cases had already been reported in the country.

According to the WHO Provisional Monthly Measles data, in WHO South-East Asia (WHO SEARO) countries 13 201 cases have been reported in 2025, and as of 2 July 2025, mainly from India (10 543) and Indonesia (1 841).

According to a WHO Western Pacific Region (WHO WPRO) report for January to May 2025, there were 3 864 confirmed measles reported in the region in 13 countries. Most of the cases were reported in China (1 184) and Cambodia (1 097), followed by Mongolia (377), the Philippines (232) and Viet Nam (144).

For more information on the 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

Since March 2025, an overall decrease in reported cases has been observed. A further decline in case numbers is expected over the summer months, in line with the known seasonality of measles.

However, continued vigilance is essential due to suboptimal vaccination coverage for measles-containing vaccines (MCV) in several EU/EEA countries, the likelihood of importation from areas with ongoing transmission, and increased travel and population movement during the holiday period.

Although most recent cases were acquired through local or community transmission, travel-related cases continue to be 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 EpiPulse Cases, which are routinely submitted by 30 EU/EEA countries.

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

- **Close immunity gaps, achieve and maintain high vaccination coverage for 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.
- In light of the upcoming summer holiday season, **travellers should check their vaccination status** and consult their general practitioner to ensure they are up to date with recommended immunisations prior to departure.

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

Last time this event was included in the Weekly CDTR: 13 June 2025.

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

Overview

Based on data reported in week 27, 2025, primary care consultation rates for influenza-like illness (ILI), acute respiratory infection (ARI) and severe acute respiratory infection (SARI) remained at baseline or low levels in all reporting EU/EEA countries.

Pooled EU/EEA test positivity for SARS-CoV-2 has been slowly increasing in ILI/ARI primary care virological specimens since week 9, 2025, mainly in individuals aged 65 years and older, with trends aligning closely with those observed at the same time last year. However, a decrease in SARS-CoV-2 positivity was observed in week 27, with only ten countries reporting 265 tests. Overall, similar trends for SARS-CoV-2 have been observed in non-sentinel, laboratory-based surveillance systems as in ILI/ARI primary care systems.

In recent weeks, two countries have reported increases in SARS-CoV-2 laboratory-confirmed hospitalised cases and one country showed an increasing trend in SARS-CoV-2 laboratory-confirmed deaths.

EuroMOMO has not reported signals of excess all-cause mortality, with the exception of Spain, where an increase was reported among individuals aged 85 years and older.

ECDC assessment

In recent weeks, increases in indicators of SARS-CoV-2 infection have been observed in many countries, although the overall number of infections remains low and the impact on secondary care is still limited. Influenza and RSV activity is low in all reporting countries.

Due to a reduction in the number of countries reporting data since the end of the respiratory virus season and the low number of tests performed, a complete interpretation of the epidemiological situation across the EU/EEA is difficult.

Following a winter with low SARS-CoV-2 circulation, population immunity against SARS-CoV-2 may have waned to a certain extent. As a result, the increasing trend in activity currently being observed may lead to further increases in COVID-19 hospitalisations in the coming weeks, particularly among older adults and individuals vulnerable to severe outcomes, as described in ECDC's recently published Epidemiological update.

Actions

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

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

ECDC/WHO guidance recommends that surveillance of respiratory viruses is maintained year-round.

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

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

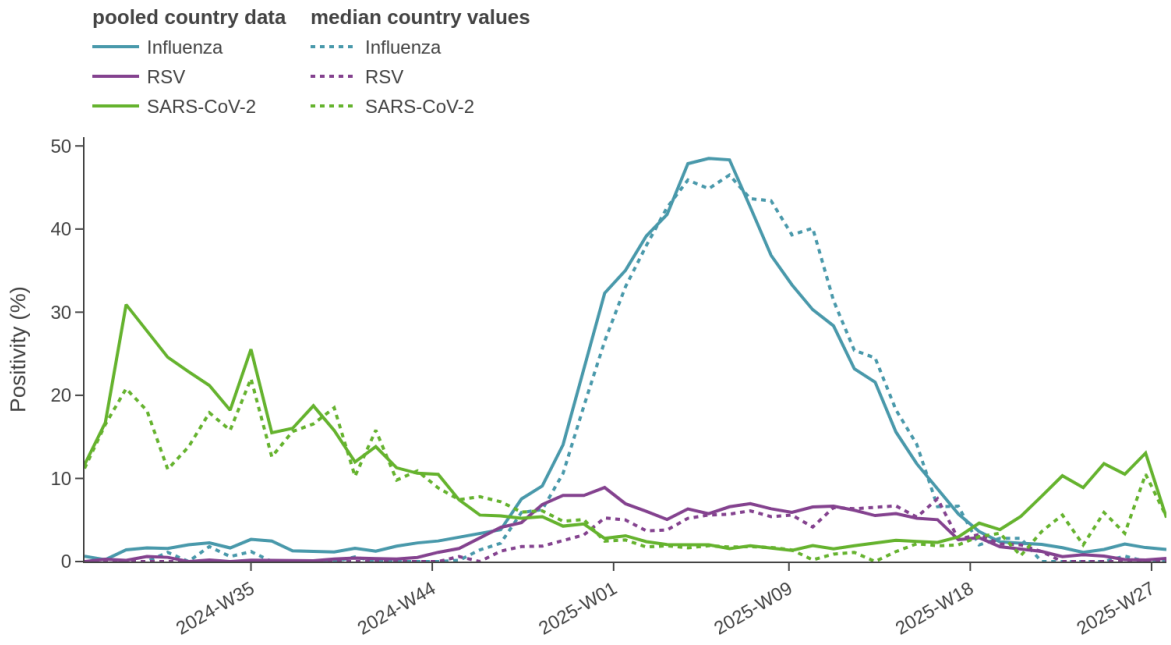
EpiPulse Item: 2023-IRV-00007

Sources: ERVISS

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

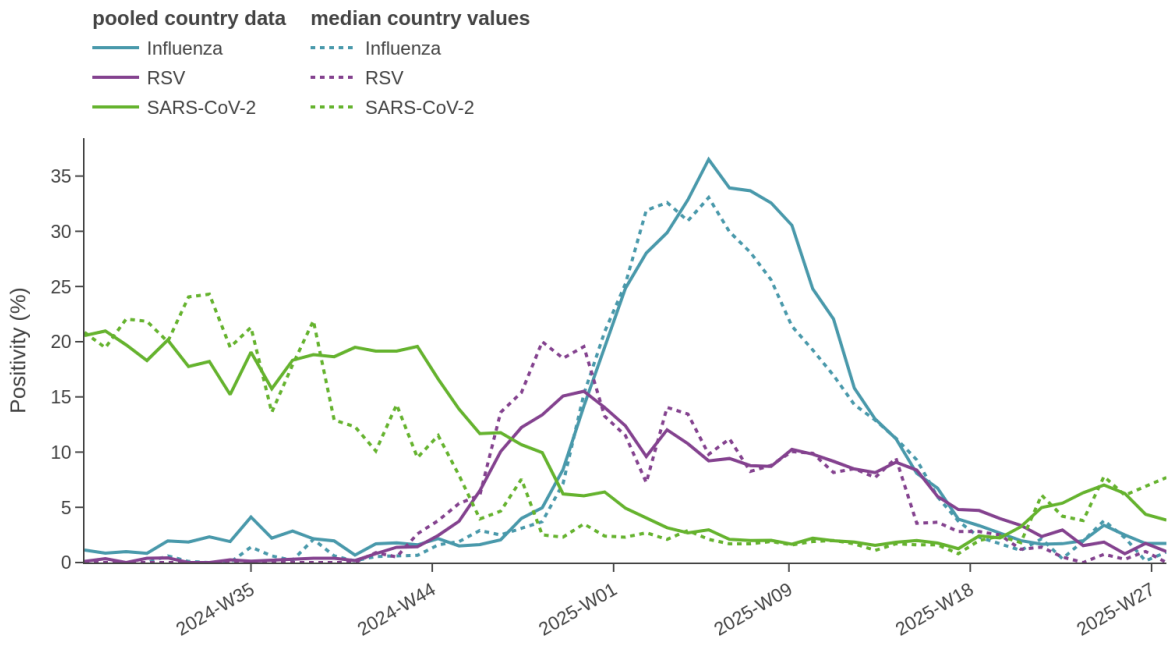
Maps and graphs

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 27, 2025

		Reporting countries		EU/EEA summary		
Indicator	**Syndrome or pathogen**	**Week 27**	**Week 26**	**Description**	**Value**	**Comment**
ILI/ARI consultation rates in primary care	ARI	10 rates (8 MEM)	11 rates (8 MEM)	Distribution of country MEM categories	8 Baseline	
	ILI	12 rates (12 MEM)	15 rates (14 MEM)		12 Baseline	
ILI/ARI test positivity in primary care	Influenza	12	15	Pooled (median; IQR)	1.4% (0; 0–1.2%)	
	RSV	11	12		0.4% (0; 0–0%)	
	SARS-CoV-2	10	14		5.3% (5.4; 2.6–10%)	At the EU/EEA level, the overall pooled SARS-CoV-2 positivity has been slowly increasing since week 9. The pooled ILI/ARI test positivity rate decreased in week 27 (5%) compared to week 26 (11%), however several countries report 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)	1.7% (0.9; 0–2.2%)	
	RSV	6	7		1% (0; 0–3.4%)	
	SARS-CoV-2	5	7		3.8% (7.7; 5.3–7.7%)	Pooled SARI test positivity remained stable in week 27 (4%) when compared with week 26 (4%). In recent weeks, two countries have reported increases from low levels in weekly, non-sentinel, laboratory-confirmed hospitalised cases and one country has reported small increases in non-sentinel, laboratory-confirmed deaths.
Intensity (country-defined)	Influenza	14	17	Distribution of country qualitative categories	12 Baseline 2 Low	
Geographic spread (country-defined)	Influenza	13	16	Distribution of country qualitative categories	9 No activity 4 Sporadic	

Source: ECDC

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

	Week 27, 2025		Week 40, 2024 - week 27, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**5**	**-**	**25293**	**-**
Influenza A	4	80	14990	60
A(H1)pdm09	2	100	7212	57
A(H3)	0	0.0	5487	43
A (unknown)	2	–	2291	–
Influenza B	1	20	10041	40
B/Vic	0	–	4490	100
B/Yam	0	–	1	0.0
B (unknown)	1	–	5550	–
Influenza untyped	0	–	262	–
RSV	**1**	**-**	**4765**	**-**
RSV-A	0	–	858	44
RSV-B	0	–	1109	56
RSV untyped	1	–	2798	–
SARS-CoV-2	**14**	**-**	**3732**	**-**

Source: ECDC

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

		Week 27, 2025	Week 40, 2024 - week 27, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**7**	**-**	**13676**	**-**
Influenza A	2	100	5732	82
A(H1)pdm09	0	–	1718	60
A(H3)	0	–	1127	40
A (unknown)	2	–	2887	–
Influenza B	0	0.0	1263	18
B/Vic	0	–	168	100
B (unknown)	0	–	1095	–
Influenza untyped	5	–	6681	–
RSV	**4**	**-**	**5665**	**-**
RSV-A			744	48
RSV-B			806	52
RSV untyped	4	–	4115	–
SARS-CoV-2	**15**	**-**	**4271**	**-**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 27, 2025

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	5316	40	5a.2a(C.1.9)	3609	68
			5a.2a(C.1.9.3)	691	13
			5a.2a.1(D)	659	12
			5a.2a.1(D.3)	162	3
			5a.2a(C.1)	157	3
			Not assigned	38	–
A(H3)	3987	30	2a.3a.1(J.2)	3143	79
			2a.3a.1(J.2.2)	502	13
			2a.3a.1(J.2.1)	241	6
			2a.3a.1(J)	43	1
			2a.3a.1(J.1)	36	0.9
			2a.3a.1(J.4)	3	0.1
			Not assigned	19	–
B/Vic	4153	31	V1A.3a.2(C.5.1)	2368	57
			V1A.3a.2(C.5.7)	906	22
			V1A.3a.2(C.5.6)	764	18
			V1A.3a.2(C)	79	2
			V1A.3a.2(C.5)	17	0.4
			Not assigned	19	–

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 25–26, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	3	47	21% (18–26%)
XFG	VUM	3	130	29% (17–39%)
LP.8.1	VUM	3	70	24% (23–34%)
NB.1.8.1	VUM	3	23	19% (13–24%)

Source: ECDC

10. Nipah virus disease – India – 2025

Overview

On 4 July 2025, the Health and Family Welfare Department of Kerala reported two cases of Nipah virus disease in Palakkad and Malappuram, Kerala. The patients reported symptoms on 23 and 25 June. One of them passed away. In May 2025, a Nipah case was also reported in Malappuram district.

Nipah prevention measures have been intensified in the areas (Nipah prevention, Press Release 4 July 2025). As of 5 July, 2025, over 400 contacts were being followed up, 12 people were under treatment and five were in intensive care, according to a press release from the Health and Family Welfare Department of Kerala.

Background

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

The virus spreads between animals and humans, with most human cases having had direct contact with pigs or bats. NiV can also be transmitted between people through direct contact or indirectly via contaminated food (e.g. date palm sap contaminated by bat saliva), or through aerosols. The incubation period is usually 4–14 days. Symptoms range from mild (fever, headache, muscle pain, and nausea) to more serious conditions, including severe respiratory symptoms and encephalitis.

For more information on the disease and its epidemiology, please read the ECDC Factsheet about Nipah virus Disease.

ECDC assessment

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

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

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

Actions

ECDC is monitoring this event through its epidemic intelligence activities.

Last time this event was included in the Weekly CDTR: 16 May 2025.

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 27 June 2025
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 27 June 2025
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 27 June 2025
- Human cases with avian influenza A(H10N3) – Multi-country (World) - last reported on 27 June 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 27 June 2025
- Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025 - last reported on 27 June 2025
- Mass gathering monitoring – EuroPride 2025 Lisbon - Portugal – 2025 - last reported on 27 June 2025
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025 - last reported on 27 June 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 27 June 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 27 June 2025
- Outbreak of Hepatitis A, mostly associated with sexual transmission among MSM, in Portugal - last reported on 19 June 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 19 June 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 19 June 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 11 July 2025
- Seasonal surveillance of West Nile virus infections – 2025 - last reported on 11 July 2025
- Mass gathering monitoring - UEFA Women's EURO 2025 - Switzerland - 2025 - last reported on 11 July 2025
- Monitoring of bathing/swimming related-vibriosis - Summer 2025 - last reported on 11 July 2025
- Nipah virus disease – India – 2025 - last reported on 11 July 2025
- Circulating vaccine-derived poliovirus type 2 (cVDPV2) – multi-country – 2024–25 - last reported on 4 July 2025
- Publication of public health guidance for assessing and mitigating the risk of locally-acquired Aedes-borne viral diseases in the EU/EEA and update of Aedes albopictus and Aedes aegypti distributions - last reported on 4 July 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 4 July 2025
- SARS-CoV-2 variant classification - last reported on 4 July 2025.