

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 3, 11–17 January 2025

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Executive summary

Mass gathering monitoring - Jubilee of 2025 in Italy

- The Jubilee 2025 is a special holy year which occurs once every 25 years, involving a major religious mass gathering event in Rome. It is expected that 35 million pilgrims will visit the city.
- In 2000, 26 million pilgrims attended the Jubilee and there were no specific events or increases in the incidence of communicable diseases.
- 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 be 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.

Overview of respiratory virus epidemiology in the EU/EEA

- Primary and secondary care consultation rates have been increasing in several countries during recent weeks and currently indicate that there is significant respiratory virus activity in the EU/EEA. For most countries with historic data, the consultation rates do not exceed the levels observed in previous winter periods.
- Influenza virus activity in primary and secondary care remains high and, over the past 13 weeks, test positivity in primary care has continued to rise. Hospital admissions due to influenza are currently at similar levels to those observed during the epidemic peak of the 2022/23 season, which placed significant pressure on healthcare systems and strained hospital capacity in several countries. People aged 65 years and above have the highest risk of severe outcomes, highlighting the continued need for targeted prevention measures (e.g. vaccination).

- RSV test positivity rate has remained stable over the past three weeks after rising for several weeks, with the aggregate test positivity rate in primary care in the EU/EEA at 10% in week 1. Children under five years of age have the highest risk for hospitalisation and severe outcomes due to RSV.
- Overall, respiratory syncytial virus (RSV) activity is showing a decreasing trend in the EU/EEA, however, the epidemiological situation is mixed at country level, with increasing activity in primary and secondary care reported by several Member States. Children under five years of age have the highest risk for hospitalisation and severe outcomes due to RSV.
- SARS-CoV-2 activity has gradually decreased in most EU/EEA countries. Among those who experience SARS-CoV-2 infection, people aged 65 years and above remain the age group at greatest risk of hospitalisation and severe outcomes due to COVID-19.
- ECDC has published recommended actions for response during the winter season 2024/2025 in an epidemiological update. Vaccination is the most effective measure to protect 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.

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

- On 10 January 2025, a fatal case of human infection with influenza A(H5N1) was reported from Cambodia.
- The case was an adult male from Kampong Cham province in central Cambodia.
- The case had exposure to backyard poultry that was sick prior to symptom onset.
- Since 2003, Cambodia reported 73 human cases of A(H5N1) avian influenza virus infection, including 44 deaths (case fatality among reported cases: 60%).

Avian influenza A(H5N1) human cases – United States – 2024

- The United States Centers for Disease Control and Prevention (US CDC) has confirmed an additional human case of avian influenza A(H5) in California.
- The source of exposure is currently unknown. No other details about the case have been released.
- US CDC has provided additional details of individuals at increased risk of avian influenza A(H5N1) infection and listed factors which could lead to an increase in the risk assessment in the future.
- According to the US CDC, the risk to the general population remains low, while farmers and workers who work with infected animals or their by-products, backyard bird flock owners, animal care workers (e.g. veterinarians, wild animal facility workers), and animal health and public health responders are at increased risk of infection.
- As of 17 January 2025, a total of 67 human cases of avian influenza A(H5) have been reported from 10 states in the United States (US) during 2024. Of these, 40 were individuals exposed to dairy cattle known or presumed to be infected with A(H5N1) and 23 were workers exposed to outbreaks of HPAI A(H5) at poultry farms. Three people had no known animal exposure and one had exposure to other animals, such as backyard flocks, wild birds, or other mammals.

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

- In November 2024, 249 cases were reported by 11 countries. Thirteen countries reported zero cases.
- Through its epidemic intelligence activities, ECDC identified an additional 68 new cases from eight EU countries.
- In 2024, 19 measles-related deaths have been reported in Romania (18) and Ireland (1).
- There has been high measles activity overall in the EU/EEA over the last 12 months; however, the situation varies by country. Some countries have reported large and/or ongoing outbreaks, while others have reported no sustained or very low transmission.
- Outbreaks associated with imported measles cases have been reported by EU countries.
- Updates are available for countries outside of the EU/EEA, for (Morocco) and WHO Regions.

Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

- In 2025, as of 13 January 2025, two cases of AFP caused by WPV1 have been reported in Pakistan.
- In 2024, as of 13 January 2025, 95 cases of AFP caused by WPV1 have been reported in Pakistan (70 cases) and Afghanistan (25 cases).
- In 2024, as of 13 January 2025, ten cases of AFP caused by cVDPV1 have been reported by the Democratic Republic of Congo (nine cases) and Mozambique (one case), 253 cases of AFP caused by cVDPV2 have been reported in 17 countries and three cases of AFP caused by cVDPV3 have been reported by Guinea.

Suspected Marburg virus disease - Tanzania - 2025

- On 14 January 2025, WHO published a Disease Outbreak News (DON) item on a suspected Marburg virus disease (MVD) outbreak in Kagera region, Tanzania.
- According to the DON and Africa CDC, nine suspected cases have been identified, including eight deaths. Samples were collected from five of the cases. Official communication from the Ministry of Health of Tanzania reported that the collected samples have so far tested negative.
- According to Africa CDC, approximately 300 contacts are being followed up, including healthcare workers.
- Kagera Region experienced an [MVD outbreak in March 2023](#).

Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025

- Since the last update on 12 December 2024, and as of 14 January 2025, 123 mpox cases have been reported from 15 EU/EEA countries: Germany (50), Greece (18), Spain (17), France (8), Belgium (6), Netherlands (6), Italy (5), Ireland (4), Czechia (2), Malta (2), Bulgaria (1), Cyprus (1), Poland (1), Portugal (1) and Sweden (1). Since 12 December 2024, no new countries have reported confirmed cases.
- Since the start of the mpox outbreak and as of 14 January 2025, 23 682 confirmed cases of mpox have been reported from 29 EU/EEA countries.
- In December 2024, an 18% decrease in mpox cases was observed compared with November (123 cases reported in December versus 150 cases reported in November).
- Eleven MPXV clade Ib cases have been reported in the EU/EEA since August 2024 from Sweden, Germany, Belgium and France.
- The number of imported cases of MPXV clade Ib cases may increase following holiday travel, but the overall risk of infection remains low for men who have sex with men and low for the broader EU/EEA population.

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

- Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries, with the epidemiological trends remaining largely unchanged.
- In 2024, most clade Ib cases have been reported by the Democratic Republic of the Congo (DRC), Burundi, and Uganda in Africa. According to the World Health Organization global update, Burundi and Uganda reported new cases in January 2025, while for the DRC the most recently available data refer to 2024.
- Outside the affected African countries, no new MPXV clade I cases have been reported this week. Confirmed secondary transmission of mpox due to MPXV clade I outside of Africa has been reported by the UK and Germany, and recently by Belgium and China.
- ECDC is closely monitoring and assessing the epidemiological situation, and additional related information can be found in the Centre's rapid risk assessment published on 16 August 2024 ([Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#)) and its [Rapid scientific advice on public health measures](#).

Autochthonous chikungunya virus disease - Department of La Réunion, France, 2024

- France has reported the first autochthonous case of chikungunya virus disease in Department of La Réunion for 10 years, with onset of symptoms on 12 August 2024.
- As of 13 January 2025, 192 cases of autochthonous chikungunya virus disease have been confirmed in La Réunion. Seven active clusters have been defined.

Community-associated outbreaks of impetigo by fusidic acid-resistant MRSA - multi-country - 2024

- On 13 December 2024, Denmark reported community-onset outbreaks of fusidic-acid-resistant MRSA among children with impetigo, starting in the summer months of 2023 and 2024.
- The strains match an outbreak strain reported by the Netherlands in 2019 and 2023, detailed in a 2022 publication. In recent years, Belgium has reported cases with the outbreak strain, and Luxembourg, Norway and Spain have reported microbiologically-similar strains.
- Cases have commonly been in kindergartens, and most cases are children. To date, only a few cases are reported to have had disease sequelae more severe than impetigo, with one reported hospitalisation, and no deaths.

1. Mass gathering monitoring - Jubilee of 2025 in Italy

Overview

The Jubilee 2025 is a special holy year which occurs once every 25 years, involving major religious mass gathering events in Rome which 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 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 level 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 will be 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.

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

Overview

Key indicators

All data presented in this summary are provisional. Interpretation of trends, particularly for the most recent weeks, should consider the impact of possible reporting delays, non-reporting by individual countries or overall low testing volumes at primary care sentinel sites. In the footer, known issues with reported data can be found under 'Country notes', with supporting information also available under 'Additional resources'.

- Of the 20 countries reporting influenza-like illness (ILI)/acute respiratory infection (ARI) activity with the moving epidemic method (MEM), most (15 countries) reported above-baseline activity.
- Influenza activity remains high, with 19 countries reporting primary care test positivity rates at or above 10% in primary care. Since Week 40, about 50% of severe acute respiratory infection (SARI) cases with influenza are aged 65 years and above. Non-sentinel indicators of severe disease (hospital admissions, ICU admissions, and deaths) have been increasing since week 48.
- RSV test positivity has decreased over the past two weeks in primary care and since Week 51 among SARI cases. Since Week 40, about 70% of SARI cases with RSV are children under five years of age and about 20% are people aged 65 years and above. Hospital admissions and ICU admissions due to RSV remain elevated.
- SARS-CoV-2 activity in primary care and hospitals has continued to decrease or remain stable at the EU/EEA level in recent weeks.
- EuroMOMO pooled estimates of weekly excess all-cause mortality are at expected levels, however, increased mortality has been observed in some countries.

ECDC assessment

There is currently significant respiratory virus activity in the EU/EEA. Influenza activity remains high and continues to increase in some EU/EEA countries. RSV activity is decreasing in primary care at the EU/EEA level, but admissions to hospital and ICU remain elevated. The levels of respiratory virus activity currently observed may place pressure on healthcare systems and strain hospital capacity, particularly where capacity is already limited. The age of those most impacted by severe disease differs, with RSV cases mostly observed in very young children and severe influenza cases in those aged 65 years and above.

Actions

Countries should be prepared for continued strain on healthcare systems during the coming weeks and consider [infection prevention and control practices in healthcare settings](#).

Vaccination against influenza viruses helps to limit severe disease outcomes for people at high risk. People eligible for vaccination against influenza, COVID-19 or RSV, particularly those at higher risk of severe outcomes and healthcare workers, are encouraged to get vaccinated without delay, in line with national recommendations, to have the best chance of being protected. RSV immunoprophylaxis for infants, which has been shown to be safe and effective, can be considered in accordance with national guidelines. In addition, clinicians should be reminded that, if indicated in national guidelines, the early use of antiviral treatments for influenza and COVID-19 may prevent progression to severe disease in vulnerable groups.

Despite currently low SARS-CoV-2 activity, it is important to continue monitoring SARS-CoV-2 at national and regional levels. To assess the impact of emerging SARS-CoV-2 sub-lineages, countries should continue to sequence SARS-CoV-2-positive clinical specimens and report to GISAID and/or the European Surveillance System (TESSy).

ECDC monitors rates of respiratory illness presentation and respiratory virus activity in the EU/EEA, presenting findings in the European Respiratory Virus Surveillance Summary ([ERVISS.org](https://er viss.org)). Updated weekly, ERVISS describes the epidemiological and virological situation for respiratory virus infections across the EU/EEA and follows the principles of integrated respiratory virus surveillance outlined in '[Operational considerations for respiratory virus surveillance in Europe](#)'.

Further information

- Short-term forecasts of ILI and ARI rates in EU/EEA countries are published on ECDC's [RespiCast](#).
- [EuroMOMO](#) is a weekly European all-cause mortality monitoring activity, aiming to detect and measure excess deaths related to seasonal influenza, pandemics and other public health threats, based on weekly national mortality statistics from up to 27 reporting European countries or subnational regions.

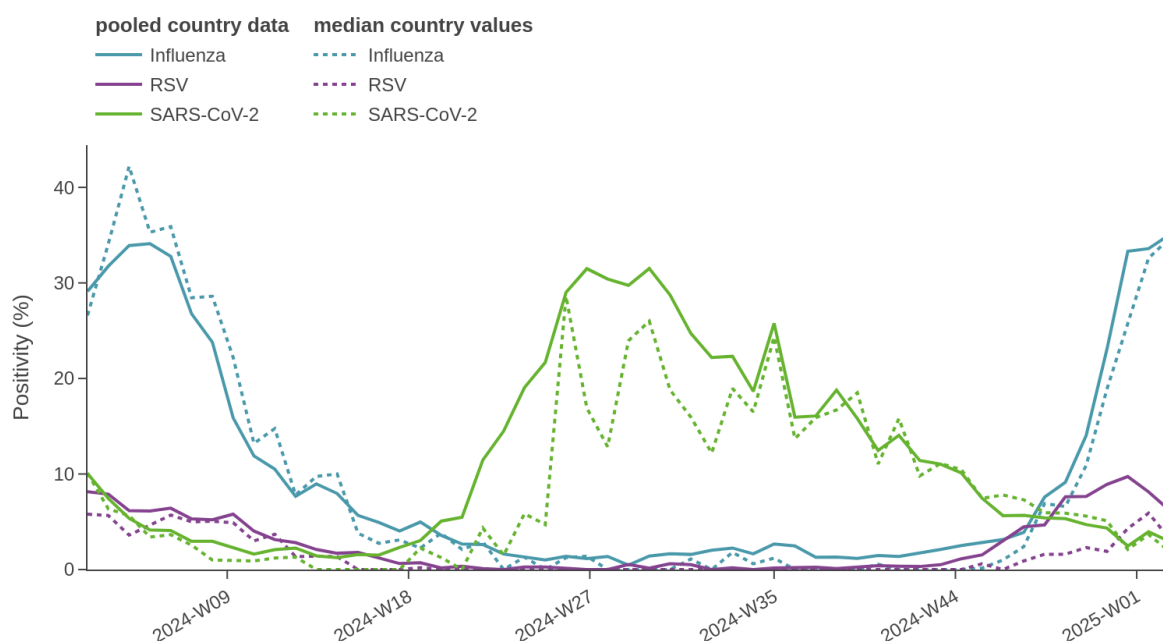
- WHO [recommends](#) that trivalent vaccines for use during the 2024–2025 influenza season in the northern hemisphere contain the following (egg-based and cell culture or recombinant-based vaccines respectively): an A/Victoria/4897/2022 or A/Wisconsin/67/2022 (H1N1)pdm09-like virus (subclade 5a.2a.1); an A/Thailand/8/2022 or A/Massachusetts/18/2022 (H3N2)-like virus (clade 2a.3a.1 (J)); and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus (subclade V1A.3a.2).
- Antigenic characterisation data presented in the WHO [2025 southern hemisphere vaccine composition meeting](#) report indicate that current northern hemisphere vaccine components are well matched to circulating 5a.2a and 5a.2a.1 A(H1N1)pdm09 subclades and V1A.3a.2 B/Victoria subclades. The components also appear well matched for the A(H3N2) 2a.3a.1 (J) clade viruses, but less well matched for some of the more recent subclade 2a.3a.1 (J2) viruses characterised by S145N, N158K or K189R HA substitutions (alone or in combination). The majority of the A(H3N2) viruses identified worldwide since February 2024 belong to the subclade 2a.3a.1 (J2).

Sources: [ERVISS](#)

Last time this event was included in the Weekly CDTR: 10 January 2025

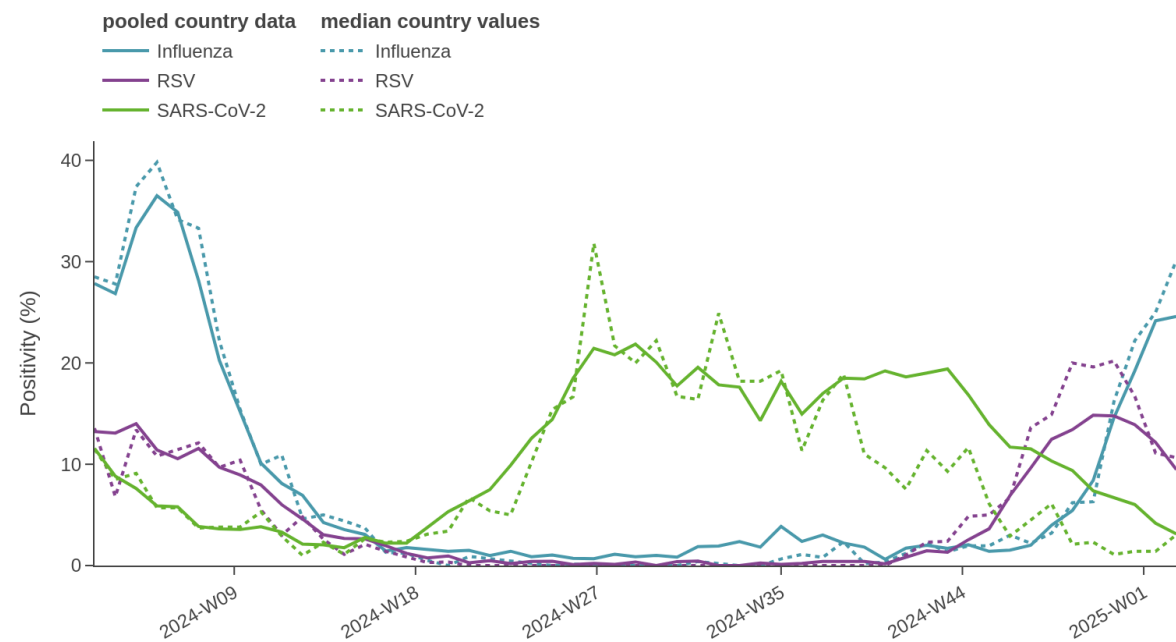
Maps and graphs

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 2, 2025

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 2	Week 1	Description	Value	
ILI/ARI consultation rates in primary care	ARI	13 rates (11 MEM)	16 rates (12 MEM)	Distribution of country MEM categories	6 Baseline 4 Low 1 Medium	
	ILI	20 rates (18 MEM)	22 rates (20 MEM)		7 Baseline 3 Low 8 Medium	
ILI/ARI test positivity in primary care	Influenza	21	20	Pooled (median; IQR)	35% (35; 27-42%)	The pooled EU/EEA test positivity rate increased slightly from 34% last week.
	RSV	17	16		6.2% (3.2; 1.4-6.9%)	The pooled EU/EEA test positivity rate decreased from 8% last week.
	SARS-CoV-2	18	16		3% (1.9; 0-6.7%)	
SARI rates in hospitals	SARI	8	9	-	-	SARI consultation rates continue to be reported at levels comparable to, or lower than, the same period in previous years.
SARI test positivity in hospitals	Influenza	7	8	Pooled (median; IQR)	25% (30; 21-36%)	The pooled EU/EEA test positivity rate for SARI has been stable since last week. Non-sentinel laboratory-based severity indicators are elevated in several countries including France, Hungary, Ireland, Hungary, Lithuania, and Slovakia.
	RSV	7	8		9.5% (11; 4.9-16%)	The pooled EU/EEA test positivity rate for SARI has decreased from 12% last week. Non-sentinel laboratory-based severity indicators are elevated in several countries including France, Ireland, and Malta.
	SARS-CoV-2	7	8		3.1% (3; 0.6-5.9%)	The pooled EU/EEA test positivity rate for SARI decreased from 4% last week.
Intensity (country-defined)	Influenza	23	24	Distribution of country qualitative categories	2 Baseline 7 Low 12 Medium 2 High	
Geographic spread (country-defined)	Influenza	22	24	Distribution of country qualitative categories	2 Sporadic 1 Local 2 Regional 17 Widespread	

Source: ECDC

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

Pathogen	Week 2, 2025		Week 40, 2024 - week 2, 2025	
	N	% ^a	N	% ^a
Influenza	1089	-	4466	-
Influenza A	744	70	2990	68
A(H1)pdm09	421	72	1805	72
A(H3)	166	28	691	28
A (unknown)	157	-	494	-
Influenza B	326	30	1413	32
B/Vic	97	100	421	100
B/Yam	0	0.0	1	0.2
B (unknown)	229	-	991	-
Influenza untyped	19	-	63	-
RSV	145	-	1426	-
RSV-A	19	40	251	44
RSV-B	29	60	324	56
RSV untyped	97	-	851	-
SARS-CoV-2	67	-	2254	-

Source: ECDC

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

Figure 5-Table

Pathogen	Week 2, 2025		Week 40, 2024 - week 2, 2025	
	N	% ^a	N	% ^a
Influenza	429	-	1987	-
Influenza A	220	89	1084	91
A(H1)pdm09	37	67	441	73
A(H3)	18	33	160	27
A (unknown)	165	-	483	-
Influenza B	26	11	109	9
B/Vic	0	-	7	100
B (unknown)	26	-	102	-
Influenza untyped	183	-	794	-
RSV	163	-	1907	-
RSV-A	9	53	387	52
RSV-B	8	47	358	48
RSV untyped	146	-	1162	-
SARS-CoV-2	55	-	2453	-

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 2, 2025

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	327	57	5a.2a(C.1.9)	311	95
			5a.2a.1(D)	12	4
			5a.2a(C.1)	4	1
A(H3)	152	27	2a.3a.1(J.2)	96	64
			2a.3a.1(J.2.1)	26	17
			2a.3a.1(J.2.2)	26	17
			2a.3a.1(J)	3	2
			Not assigned	1	-
B/Vic	92	16	V1A.3a.2(C.5.1)	45	56
			V1A.3a.2(C.5.6)	14	17
			V1A.3a.2(C.5.7)	14	17
			V1A.3a.2(C)	8	10
			Not assigned	11	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, week 52, 2024 to week 1, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
KP.3	VOI	5	39	25% (24–28%)
BA.2.86	VOI	4	12	10% (4–12%)

Source: ECDC

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

Overview

Update: On 10 January 2025, a fatal case of human infection with influenza A(H5N1) was reported by the Cambodia Ministry of Health. The case was in an adult male from Kampong Cham province in central Cambodia. The case was laboratory confirmed by the National Institute of Public Health on 9 January 2025. The patient passed away on 10 January, following severe illness with symptoms including fever, cough, fatigue, and difficulty breathing. According to investigation, the patient raised backyard poultry and had prepared and consumed meat from sick chickens.

The rapid response team of the Ministry of Health in collaboration with the Ministry of Agriculture, Forestry and Fisheries, the Ministry of Environment, and the local authorities have responded to the incident according to technical methods and protocols. This includes continued search for sources of infection in humans and animals, identifying suspected cases and contacts, and distributing Tamiflu to close contacts of the case.

The Cambodia Ministry of Health has published advice regarding the threats to public health associated with avian influenza A(H5N1). It had also urged the public to remain vigilant and provided guidance on symptoms and actions to take if avian influenza exposure is suspected. It has also advised the public on preventive measures to limit the risk of infections.

Summary

Since 2003, and as of 10 January 2025, there have been 963 human cases worldwide*, including 466 deaths (case fatality among reported cases: 48%), with avian influenza A(H5N1) infection reported in 24 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, Indonesia, India, Iraq, Laos, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Vietnam, the United Kingdom, and the United States). To date, no sustained human-to-human transmission has been detected.

***Note:** this includes six detections due to suspected environmental contamination with no evidence of infection that were reported in 2022 by Spain (two detections) and the United States (1), as well as in 2023 by the United Kingdom (3). 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).

ECDC assessment

Sporadic human cases of different avian influenza A(H5Nx) subtypes have previously been reported globally. Current epidemiological and virological evidence suggests that A(H5N1) viruses remain avian-like. Transmission to humans remains a rare event 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-medium.

Direct contact with infected birds or a contaminated environment is the most likely source of infection, and the use of personal protective measures for people exposed to dead birds or their droppings will minimise the remaining risk. The recent severe cases in Asia and South America 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 of the [avian influenza situation](#).

Last time this event was included in the Weekly CDTR: 06 December 2024

4. Avian influenza A(H5N1) human cases – United States – 2024

Overview

Update

The [US CDC](#) has reported an additional case of avian influenza A(H5N1) in California. The case has no known source of exposure. No further details about the case have been released.

The [US CDC](#) has also provided additional details of individuals at increased risk of avian influenza A(H5N1) infection and listed factors which could lead to changes in the risk assessment for the general public in future. The risk to the general population remains low, however farmers and workers who work with infected animals or their by-products, backyard bird flock owners, animal care workers (e.g. veterinarians, wild animal facility workers) and animal health and public health responders are at increased risk of infection. The US CDC listed four areas that are being closely monitored: virus transmission, disease severity, case distribution, and effects of genetic changes in the virus. Any changes to these factors which are of concern may lead to an increase in the risk assessment and implementation of further public health action. Additional action may include updating guidance for A(H5) avian influenza protection, procuring treatments and vaccines, and initiating voluntary vaccination programmes for exposed individuals or broader groups if transmission risk increases.

Background: In 2024, as of 17 January 2025, 67 human cases of avian influenza A(H5N1), including one death, have been confirmed by the US CDC from 10 states. Forty cases reported exposure to dairy cattle in the following states: California (36), Colorado (1), Michigan (2) and Texas (1). Twenty-three cases reported exposure to poultry in the following states: Colorado (9), Iowa (1), Oregon (1), Washington (11), and Wisconsin (1). One case, the patient reported in [Louisiana](#) who died, had exposure to backyard flocks and other wild birds. Three additional cases have been identified with unknown exposure: one in Missouri and two in California.

ECDC assessment

To date, there have been no confirmed human cases of influenza A(H5N1) infection and no reports of A(H5N1) infection in cattle in the EU/EEA. The genotype B3.13, identified in cattle and several of the human cases in the US, has not been detected in Europe.

ECDC has assessed the risk from the circulating HPAI A(H5N1) clade 2.3.4.4b viruses as low for the general population and low-to-moderate for those with activities that expose them to infected animals or contaminated environments (e.g. occupational exposure to infected animals).

Actions

ECDC is monitoring the situation together with partner organisations in Europe and will continue to update its assessment of the risk for humans in the EU/EEA as new information becomes available.

In addition to enhanced surveillance, active monitoring and testing of exposed individuals is recommended for early detection of human cases and to assess the possibility of human-to-human transmission, according to relevant ECDC guidance documents ([Testing and detection of zoonotic influenza virus infections in humans](#); [Investigation protocol of human cases of avian influenza virus](#); [Enhanced surveillance of severe avian influenza virus infections in hospital settings](#)).

It is important to raise awareness, including among all primary care workers, of the need to enquire about animal exposure and symptoms compatible with avian influenza infections and testing of symptomatic individuals with a history of exposure, following a risk-based approach. It is also important to communicate regarding the epidemiological situation so as not to miss or delay diagnosis of potential human cases.

Given the uncertainties related to mammal-to-mammal transmission and depending on the epidemiological situation, a low threshold can be considered for testing individuals exposed to potentially infected mammals (e.g. symptomatic individuals with conjunctivitis or respiratory symptoms). Due to the higher risk of infection for individuals exposed to infected animals and contaminated environments, appropriate personal protective measures and other precautionary measures should always be taken to mitigate the risk.

Relevant ECDC publications:

- [Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work](#)
- [Investigation protocol of human cases of avian influenza virus infections in the EU/EEA](#)
- [Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA](#)
- [Joint ECDC-EFSA Drivers for a pandemic due to avian influenza and options for One Health mitigation measures](#)

ECDC is in contact with the US CDC for further information and is closely following any updates on the event. ECDC monitors zoonotic 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](#).

Sources: [Event Information Site for IHR National Focal Points](#) | [FAO](#) | [2024-e000168](#)

Last time this event was included in the Weekly CDTR: 10 January 2025

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

Overview

In November 2024, 249 measles cases were reported by 11 countries and zero cases by 13 countries. In the most recent 12-month period, from 1 December 2023 to 30 November 2024, 30 EU/EEA countries reported a total of 17 329 cases of measles. Between 1 December 2023 and 30 November 2024, of the 17 329 cases with known age, 7 598 (43.8%) cases were in children under five years old and 5 081 (29.3%) cases were in individuals aged 15 years or above.

The highest notification rates were observed in infants under one year old (550.3 cases per million population) and children aged 1–4 years old (321.6 cases per million population). Of 14 364 cases (100.0% of all cases) with a known age and vaccination status, 12 522 (87.2%) were unvaccinated, 1 200 (8.4%) were vaccinated with one dose of a measles-containing vaccine, 600 (4.2%) were vaccinated with two or more doses, and 25 (0.2%) were vaccinated with an unknown number of doses. Thirteen deaths (case fatality rate (CFR): 0.1) attributable to measles were reported to ECDC during the 12-month period by Romania (12) and Ireland (1). Detailed data are available in [ECDC's Surveillance Atlas of Infectious Diseases](#).

Complementary epidemic intelligence surveillance, with data collection conducted on 9 January 2025 from official public sources, identified 68 new measles cases reported since the last monthly update. New cases were reported in eight EU countries: Austria (new: 20; total: 529), Czechia (new: 1; total: 35), Germany (new: 10; total: 646), Hungary (new: 1; total: 32), Ireland (new: 31; total: 213), the Netherlands (new: 3; total: 190), Norway (new: 1; total: 10) and Sweden (new: 1; total: 38). No measles-related deaths have been reported in recent months. Overall, 19 measles-related deaths have been reported in the EU/EEA in 2024, in Romania (18) and in Ireland (1). On 17 January 2025, we updated the monthly report with information about reported outbreaks associated with imported measles cases.

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:

Since the last monthly update, new measles cases have been reported in the following countries.

[Austria](#) has reported 529 confirmed measles cases since 1 January 2024 and as of 2 January 2025, an increase of 20 cases since 3 December 2024. On 3 January 2025, the Gmunden district administration [reported](#) a measles case in Gosau in Dachstein West ski region and reported that further infections may be associated with this exposure.

[Czechia](#) reported one measles case in December 2024, and as of 1 January 2025, 35 measles cases have been reported in 2024.

[Finland](#) reported no new measles cases since the last monthly update and as of 9 January 2025. On 9 January 2025, the National Institute for Health and Welfare (THL) reported that an individual infected with measles travelled on a ferry from Tallinn to Helsinki on 7 January. The risk of infection for other passengers was assessed as 'very small'.

[Germany](#) reported 646 measles cases, an increase of 10 cases since the last monthly report. Of these, 645 measles cases were reported in 2024 and one in 2025 (data as of 9 January 2025).

[Hungary](#) reported 32 measles cases as of 6 January 2024, an increase of one case since 1 December 2024.

[Ireland](#) reported 29 measles cases between weeks 47–52, 2024 and a total of 213 measles cases in 2024. Two measles cases were reported in week 1, 2025 (data as of 4 January 2025).

[Netherlands](#) reported 190 measles cases in 2024 up to and including 16 December, of which three cases were reported in December 2024.

[Norway](#) reported 10 measles cases in 2024 and one case in 2025 (data as of 9 January 2025).

Spain: on [16 January 2025](#), health authorities in the Basque country reported an outbreak of measles in Bizkaia, with 12 confirmed cases, originating from an imported case.

[Sweden](#) reported 38 cases in 2024 and as of 9 January 2025. Of these, one case was reported in December 2024.

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

Morocco

According to media reports ([1,2](#)), on 30 December 2024 the Moroccan health authorities provided an update on the ongoing nationwide measles epidemic in Morocco. The outbreak began in the Souss-Massa region in October 2023 and has since spread nationwide.

Since October 2023, 19 515 cases have been reported, with an incidence rate of 52.5 cases per 100 000 population. The authorities have reported 107 deaths due to measles (0.55% of the reported cases), of which approximately half were in children under 12 years. In 2024 alone, authorities reported 17 999 measles cases (5 094 confirmed) and 104 deaths.

The increase in measles cases is attributed to declining vaccination rates following the COVID-19 pandemic and vaccine hesitancy. However, according to the [WHO data](#), between 2016 and 2023 Morocco reported 99% coverage of the first and second doses of measles vaccine.

Summary of measles cases reported by WHO regional offices (as of [13 January 2025](#))

WHO Regional Office for Europe (WHO/EUROPE) reported 106 237 measles cases in 2024. The five non-EU/EEA countries reporting the most measles cases were: Kazakhstan (28 066), Russian Federation (21 682), Azerbaijan (16 685), Kyrgyzstan (13 203), and the United Kingdom (2 915).

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.

WHO Regional Office for Africa (WHO AFRO) has reported 59 358 measles cases in 2024. The highest numbers of cases were reported from Ethiopia (28 139), Nigeria (10 237), Burkina Faso (7 147), Cote d'Ivoire (6 464) and the Democratic Republic of the Congo (4 489).

WHO Regional Office for the Americas (WHO PAHO) has reported 455 measles cases in 2024. Most cases were reported from the United States (284) and Canada (141).

WHO Regional Office for the Eastern Mediterranean (WHO EMRO) has reported 90 007 measles cases in 2024. The highest numbers of cases were reported from Iraq (32 179), Pakistan (23 596), Yemen (19 988), Afghanistan (9 596) and Somalia (1 303).

WHO Regional Office for South-East Asia (WHO SEARO) has reported 32 838 measles cases in 2024. The highest numbers of cases were reported from India (19 852), Thailand (7 507), Indonesia (4 718), Sri Lanka (296), and Nepal (222).

WHO Regional Office for the Western Pacific (WHO WPRO) has reported 10 484 measles cases in 2024. The following five countries reported the most cases: the Philippines (3 985), Malaysia (3 904), Viet Nam (1 408), China (1 026), and Australia (48).

ECDC assessment

The overall number of measles cases in the EU/EEA steadily increased between June 2023 and March 2024 and decreased between April 2024 and October 2024. In November 2024, a slight increase in case numbers compared with October 2024 was observed. **Measles cases may continue to increase in the EU/EEA in the coming months.** This is due to reported suboptimal vaccination coverage for measles-containing vaccines (MCV) in a number of EU/EEA countries (<95% in many of these countries), as well as a high probability of importation from areas experiencing high circulation. In addition, the majority of recently reported cases have acquired the disease within the reported country through community/local transmission, indicating a higher probability of being exposed to the virus within the EU/EEA than in previous months.

Actions

ECDC is monitoring the measles situation through its epidemic intelligence activities, which supplement monthly outputs with measles surveillance data from TESSy, routinely submitted by 30 EU/EEA countries. 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 on 15 February 2024.

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.**
- **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 underserved 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: 10 January 2025

6. Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

Overview

Global public health efforts to eradicate polio are continuing through the immunisation of every child until transmission of the virus stops and the world becomes polio-free. On 5 May 2014, polio was declared a public health emergency of international concern (PHEIC) by the World Health Organization (WHO) due to concerns over the increased circulation and international spread of wild poliovirus in 2014.

On 6 November 2024, the [40th meeting](#) of the Polio Emergency Committee under the International Health Regulations (IHR) (2005) was held to discuss the international spread of poliovirus and it was agreed that it remains a PHEIC. It was decided that the temporary recommendations would be extended for a further three months.

In June 2002, the WHO European Region was officially declared polio-free.

Summary

Wild poliovirus type 1 (WPV1):

In 2025, as of 13 January 2025, two cases of AFP caused by WPV1 have been reported in Pakistan.

In 2024, as of 13 January 2025, 95 cases of AFP caused by WPV1 have been [reported](#), 70 in Pakistan and 25 in Afghanistan.

Circulating vaccine-derived poliovirus (cVDPV):

In 2025, as of 13 January 2025, no cases of AFP due to cVDPV1, cVDPV2 or cVDPV3 have been reported.

In 2024, as of 13 January 2025, ten cases of AFP caused by cVDPV1 have been [reported](#) by the Democratic Republic of Congo (DRC) (nine cases), and Mozambique (one case).

In 2024, as of 13 January 2025, 253 cases of AFP caused by cVDPV2 have been reported from 17 countries: Nigeria (94), Yemen (35), Chad (29), Ethiopia (27), Niger (15), Democratic Republic of Congo (14), South Sudan (10), Angola (7), Indonesia (7), Guinea (5), Somalia (3), Cameroon (2), Benin (1), Liberia (1), Mali (1), Palestine* (1) and Senegal (1).

In 2024, as of 13 January 2025, three cases of AFP caused by cVDPV3 have been [reported](#) by Guinea.

Sources: [Global Polio Eradication Initiative](#) | [ECDC](#) | [ECDC dashboard](#) | [WPV3 eradication certificate](#)

*This designation shall not be construed as recognition of a State of Palestine and is without prejudice to the individual positions of the Member States on this issue.

ECDC assessment

The WHO European Region, including the EU/EEA, has remained polio-free since 2002. Inactivated polio vaccines are used in all EU/EEA countries.

As long as there are non-vaccinated or under-vaccinated population groups in European countries and poliomyelitis is not eradicated globally, the risk of the virus being reintroduced in Europe remains. In the EU/EEA, one country (Romania) is considered to be at high risk and five countries (Austria, Estonia, Hungary, Poland and Slovenia) are considered to be at intermediate risk of a sustained polio outbreak following wild poliovirus importation or the emergence of circulating vaccine-derived poliovirus (cVDPV). This is due to suboptimal vaccination programme performance and low population immunity, according to the [European Regional Certification Commission for Poliomyelitis Eradication \(RCC\)](#) report published in December 2024, referring to data from 2023.

The continuing circulation of wild poliovirus type 1 (WPV1) in Pakistan and Afghanistan shows that there is still a risk of the disease being imported into the EU/EEA. The outbreaks of cVDPV that emerge and circulate due to lack of polio immunity in the population also illustrate the potential risk for further international spread.

To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake in pockets of under-immunised populations. EU/EEA countries should review their polio vaccination coverage data and ensure that there are no immunity gaps in the population and that there is capacity to identify virus circulation through well-performing surveillance systems.

ECDC endorses WHO's temporary recommendations for EU/EEA citizens who are residents of or long-term visitors (>4 weeks) to countries categorised by [WHO](#) as having the potential risk of causing international spread of polio: an additional dose of poliovirus vaccine should be administered between four weeks and 12 months prior to international travel. Travellers to areas with active transmission of a wild or vaccine-derived poliovirus should be vaccinated according to their national immunisation schedules.

ECDC links: [ECDC comment on risk of polio in Europe](#) | [ECDC risk assessment](#)

Actions

ECDC provides updates on the polio situation on a monthly basis. ECDC also monitors polio cases worldwide through its epidemic intelligence activities in order to highlight polio eradication efforts and identify events that increase the risk of wild poliovirus being reintroduced into the EU/EEA.

ECDC maintains a [dashboard](#) showing countries that are still endemic for polio and have ongoing outbreaks of cVDPV.

Last time this event was included in the Weekly CDTR: 18 October 2024

7. Suspected Marburg virus disease - Tanzania - 2025

Overview

On 14 January 2025, WHO published a [Disease Outbreak News](#) item reporting on a suspected Marburg virus disease (MVD) outbreak in Kagera Region, Tanzania. Overall, nine suspected cases and eight deaths have been reported since December 2024 and as of 11 January 2025 ([WHO DON News, 14 January 2025](#); [Africa CDC Press Briefing of the 16 January 2025](#)). The suspected index case is a woman, 24-weeks pregnant, who was treated at the district hospital where she died on 16 December 2024. A healthcare worker who attended the suspected index case also fell ill and died on 27 December 2024 ([Africa CDC Press Briefing of the 16 January 2025](#)). The cases [presented](#) with similar symptoms of headache, high fever, back pain, diarrhoea, vomiting blood, body weakness and at a later stage bleeding from orifices. The approximately 300 contacts that are being followed up include 56 health workers. Sixteen of the contacts had direct contact with cases ([Africa CDC Press Briefing of the 16 January 2025](#)).

According to a [press release from the Ministry of Health of Tanzania](#) (15 January 2025), samples tested so far are negative for Marburg virus. Response efforts are reportedly ongoing and the event is being followed up by international partners ([WHO Media briefing on global health issues; 16 January 2025](#), [Africa CDC Press Briefing of the 16 January 2025](#)).

According to [WHO](#), Kagera region serves as a major transit hub with significant cross-border movement to Rwanda, Burundi, and Uganda, thus raising the risk of further spread in the region.

Background

MVD is a severe disease in humans caused by Marburg marburgvirus (MARV) with a case fatality ratio of up to 88%. MVD is not an airborne disease and is not considered contagious before symptoms appear. Direct contact with the blood and other body fluids of an infected person or animal is the most frequent route of transmission. The incubation period of MVD is usually five to ten days (range 3–21 days). If proper infection prevention and control measures are strictly adhered to, the likelihood of infection is considered very low. To date, there is no specific antiviral treatment and no approved vaccine for MVD.

All recorded MVD outbreaks have originated in Africa. Since 1967, when MVD was first detected, approximately [600 MVD cases](#) have been reported as a result of outbreaks in Angola, the Democratic Republic of the Congo, Ghana, Guinea,

Equatorial Guinea, Kenya, South Africa, Tanzania, and Uganda. In 2024, Rwanda reported its first MVD outbreak (66 cases including 15 deaths) which was [declared over on 20 December 2024](#).

Kagera Region experienced an earlier [MVD outbreak in March 2023](#), during which nine cases and six deaths were reported.

More information can be found in the [ECDC Factsheet on Marburg virus disease](#).

ECDC assessment

The overall risk for the EU/EEA related to this event is assessed as low, with a likelihood of importation in the EU/EEA assessed as being very low, and the associated impact as low. The assessment is based on the assumption that this is an outbreak of a viral haemorrhagic fever disease, given the clinical characteristics of the cases, the information available on transmission among suspect cases, and the ongoing response effort from WHO, Africa CDC, and national public health authorities.

Actions

ECDC is following up with relevant stakeholders and the assessment will be updated once more information is available.

8. Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025

Overview

Since the last update on 12 December 2024, and as of 14 January 2025, 123 mpox cases have been reported from 15 EU/EEA countries: Germany (50), Greece (18), Spain (17), France (8), Belgium (6), Netherlands (6), Italy (5), Ireland (4), Czechia (2), Malta (2), Bulgaria (1), Cyprus (1), Poland (1), Portugal (1) and Sweden (1). Since 12 December 2024, no new countries have reported confirmed cases.

Since the start of the mpox outbreak and as of 14 January 2025, 23 682 confirmed cases of mpox have been reported from 29 EU/EEA countries

In December 2024, an 18% decrease in mpox cases was observed compared with November (123 cases reported in December versus 150 cases reported in November).

Since the start of the mpox outbreak in 2022 and as of 14 January 2025, 23 682 confirmed cases of mpox have been reported from 29 EU/EEA countries: Spain (8 480), France (4 383), Germany (4 090), Netherlands (1 428), Portugal (1 206), Italy (1 087), Belgium (852), Austria (365), Sweden (306), Ireland (270), Poland (227), Denmark (211), Greece (129), Norway (119), Czechia (94), Hungary (85), Luxembourg (62), Romania (48), Slovenia (47), Finland (43), Malta (41), Croatia (35), Slovakia (18), Iceland (17), Estonia (11), Bulgaria (10), Cyprus (6), Latvia (6) and Lithuania (6). Deaths have been reported from: Spain (3), Belgium (2), Portugal (2), Austria (1) and Czechia (1).

Since the start of the mpox outbreak in 2022 and as of 14 January 2025, the following Western Balkan countries have reported confirmed cases of mpox: Serbia (40), Bosnia and Herzegovina (9), Montenegro (2) and [Kosovo*\(1\)](#). In addition, 20 cases have been reported from Türkiye.

A total of eleven MPXV clade Ib cases have been reported in the EU/EEA since August 2024. On 15 August 2024, Sweden reported the first imported case of mpox due to MPXV clade Ib in EU/EEA countries. Seven cases have been reported by Germany (one in October, five in December 2024 and one in January 2025), two cases by Belgium in December 2024 and one case by France in January 2025. All individuals had mild disease. Confirmed secondary transmission events were reported by Germany and Belgium. In Germany, three individuals (including two children) were household contacts of an index case with a travel history to an affected country. In Belgium, one child was a household contact of an index case with a travel history to an affected country.

All other mpox cases with available information on clade reported in the EU/EEA were MPXV clade IIb.

Cases reported in 2024 share the same epidemiological profile as those reported since the beginning of the outbreak in the EU/EEA, with the majority of cases being men, and sexual contact among men who have sex with men remaining the primary mode of transmission.

On 13 August 2024, Africa CDC [declared](#) mpox a Public Health Emergency of Continental Security. On 14 August 2024, WHO [convened](#) a meeting of the IHR Emergency Committee to discuss the mpox upsurge and [declared](#) the current outbreak of mpox due to MPXV clade I a Public Health Emergency of International Concern (PHEIC).

For more information on the global update regarding MPXV clade Ib, please refer to [the weekly Communicable Diseases Threats Report](#).

A detailed summary and analysis of data reported to TESSy can be found in the [Joint ECDC-WHO Regional Office for Europe Mpox Surveillance Bulletin](#).

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

ECDC assessment

The number of new infections remains relatively low in the EU/EEA, and a decrease was observed in December compared to November. This decrease comes after a slight upward trend in previous months, albeit with very few reported cases overall. The changes in case numbers reflect normal month-to-month variations in reporting, given the overall small total number of cases reported. There may also be under-reporting or a reporting delay of cases diagnosed in December.

Following holiday travel, it is likely that more mpox cases due to MPXV clade I will be introduced into the EU/EEA and other countries in the coming weeks and it is important to raise awareness concerning the possible importation of cases, both among returning travellers from affected African countries and among healthcare professionals who may see such patients. Furthermore, it is important for public health authorities to be prepared to carry out contact

tracing and infection prevention and control measures if cases are diagnosed. An ECDC [epidemiological update](#) and [news item](#), published on 14 January, highlighted the options for response.

The overall risk of MPXV infection is assessed as low for MSM and low for the broader population in the EU/EEA.

Response options for EU/EEA countries include raising awareness among healthcare professionals; supporting sexual health services in case detection, contact tracing, and case management; continuing to offer orthopoxvirus testing; implementing vaccination strategies and maintaining risk communication and community engagement, despite the decreasing number of cases. EU/EEA countries are also encouraged to sequence and report clades and subclades to identify new cases of mpox, particularly those linked to clade Ib.

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

Actions

ECDC is closely monitoring the mpox epidemiological situation through indicator- and event-based surveillance.

A [rapid risk assessment](#), 'Mpox multi-country outbreak', was published on 23 May 2022. The [first update](#) to the rapid risk assessment was published on 8 July 2022, and a [second update](#) was published on 18 October 2022. ECDC published a [report](#) on public health considerations for mpox in EU/EEA countries on 14 April 2023. ECDC published a [Threat Assessment Brief on MPXV clade I in the Democratic Republic of the Congo \(DRC\) on 5 December 2023](#), an [epidemiological update on 5 April 2024](#) and [another on 14 January 2025](#) together with a [news item](#). A [risk assessment](#) for the EU/EEA on the mpox epidemic caused by mpox virus clade I in affected African countries was published on 16 August 2024, and [rapid scientific advice on public health measures](#) was released on 9 September 2024 and updated on 14 January 2025.

A [resource toolkit for event organisers](#) and [social media materials](#) on mpox related to events are also available. Member States can use these materials to work with event organisers ahead of Pride events to ensure that attendees have access to the right information.

Member States can also consider providing those who travel to Pride events abroad with updated information on how to protect themselves and others from mpox.

For the latest updates, visit [ECDC's mpox page](#).

Last time this event was included in the Weekly CDTR: 13 December 2024

9. Mpox due to monkeypox virus clade I and II – Global outbreak – 2024

Overview

Update

There are no changes in the mpox epidemiological trends this week. No new mpox cases due to monkeypox virus (MPXV) clade I were reported this week outside of Africa.

In Africa, according to the World Health Organization global update, Burundi and Uganda (which are the countries which had most cases in 2024 after the Democratic Republic of the Congo (DRC)) have reported 714 and 955 new cases in the past six weeks and as of 12 January 2025 ([WHO Global report on mpox \(data as of 12 January 2025\)](#)). The mpox epidemic is continuing in the DRC, with the most recent epidemiological data reporting over 9 000 cases in 2024. However, more recent data for December 2024 or early January 2025 have not been published yet. Sierra Leone has [reported](#) two mpox cases (clade not yet defined) neither of which involved travel history outside of the country.

Summary

Globally, MPXV clade I and clade II are circulating in multiple countries. Since 2022, MPXV clade II has mainly been circulating outside of Africa among adult men who have sex with men. In 2024, an increase in MPXV clade Ia and Ib was reported in the DRC, while clade Ia cases continued to be reported by the Central African Republic and the Republic of the Congo (Congo) where it is endemic.

Following the epidemic of MPXV clade I in the DRC in 2024, MPXV clade I was first detected in Burundi, Rwanda, Uganda and Zambia (all neighbouring the DRC), as well as in Kenya and Zimbabwe. Overall, on the African continent in 2024 and as of 5 January 2025, most confirmed clade I cases have been reported from the DRC (over 40 000 cases overall, over 9 000 confirmed and over 40 confirmed deaths), Burundi (over 3 000 confirmed cases and one death), and Uganda (overall 1 830 cases reported, including 10 deaths). Rwanda has reported 74 cases, Kenya 31 cases, Zambia four cases and Zimbabwe two cases ([WHO Global report on mpox \(data as of 12 January 2025\)](#)).

Outside of Africa, in the EU/EEA, travel-associated cases or sporadic cases reporting epidemiological links with travel-associated cases of MPXV clade Ib have been reported in the EU/EEA by:

- Sweden (one case in August 2024);
- Germany (one case in October, five in December 2024 and one in January 2025);
- [Belgium \(two cases in December 2024\)](#); and
- France ([one case in January 2025](#)).

[In addition to Africa and the EU/EEA](#), clade I cases have been reported by Thailand (one case in August 2024), India (one case in September 2024), the UK (five cases in October and November 2024), the United States (US) (one case in November 2024), Canada (one case in November 2024), Pakistan (one case in December 2024), Oman (one case in December 2024), and [China](#) (five cases in January 2025).

Travel-associated cases from all non-African countries besides India, Pakistan and Oman have reported a travel history to Africa. The travel-associated cases reported by India, Pakistan and Oman had a travel history to the United Arab Emirates ([WHO Multi-country outbreak of mpox, External situation report 44, 23 December 2024](#)).

Confirmed secondary transmission of mpox due to MPXV clade Ib outside of Africa was reported for the first time in 2024 in the EU/EEA by Germany and Belgium, and outside of the EU/EEA by the UK and China. The number of secondary cases reported in all secondary transmission events outside of Africa range from one to four cases per event. Based on the available information, all transmission events were due to close contact, the cases presented with mild symptoms and no deaths have been reported.

On 13 August 2024, Africa CDC [declared](#) mpox a Public Health Emergency of Continental Security. On 14 August 2024, WHO [convened](#) a meeting of the IHR Emergency Committee to discuss the mpox upsurge and [declared](#) the current outbreak of mpox due to MPXV clade I as a public health emergency of international concern.

Since September 2024, following an analysis of the patterns of MPXV transmission observed at the national level and given the limitations and uncertainties, ECDC has used official epidemiological information to classify countries according to whether MPXV clade I is endemic or was reported for the first time in 2024. The categories are as follows:

- countries reporting only travel-associated cases or cases with a clear link to travel-associated cases: Belgium, Canada, China, Germany, France, India, Oman, Pakistan, Sweden, Thailand, the UK, the US, Zambia, and Zimbabwe;
- countries reporting clusters of cases: Congo and Kenya;
- countries reporting community transmission: Burundi, Central African Republic, the DRC, Rwanda, and Uganda.

The classification was last updated on 16 January 2025.

ECDC assessment

The epidemiological situation regarding mpox due to MPXV clade Ib remains similar to the previous weeks. The sporadic cases of mpox clade I that have been reported outside Africa, including secondary transmission, are not unexpected.

The risk for EU/EEA citizens travelling to or living in the affected areas is considered to be moderate if they have close contact with affected persons, or low if contact with affected individuals is avoided. The overall risk to the general population in the EU/EEA is currently assessed as low. However, more imported mpox cases due to MPXV clade I are likely to be reported by the EU/EEA and other countries.

EU/EEA countries may consider raising awareness in travellers to/from areas with ongoing MPXV transmission and among primary and other healthcare providers who may be consulted by such patients. If mpox is detected, contact tracing, partner notification and post-exposure preventive vaccination of eligible contacts are the main public health response measures.

Please see the latest ECDC [Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#).

Actions

ECDC is closely monitoring and assessing the evolving epidemiological situation related to mpox on a global basis. The Centre's recommendations are available [here](#).

Sources: [ECDC rapid risk assessment](#)

Last time this event was included in the Weekly CDTR: 10 January 2025

10. Autochthonous chikungunya virus disease - Department of La Réunion, France, 2024

Overview

Update:

- According to the [Regional Health Agency \(ARS\) La Réunion](#), as of 13 January 2025, 192 cases of autochthonous chikungunya virus disease have been confirmed in La Réunion in seven active clusters:
- Étang-Salé: quartier ravine Sheunon (90 cases)
- Saint-Paul: Ermitage (12 cases)
- Tampon:
- Grand-Bassin (seven cases)
- 3 Mares les bas (nine cases)
- Bras Creux (three cases)
- Ligne des 400 (eight cases)
- Saint-Pierre: La Vallée (four cases).

According to the Public Health Agency, in recent days, the circulation of chikungunya has intensified on the island, with a worrying geographical dispersion and increase in the proportion of sporadic cases. Due to the increase in the number of cases and the spread of outbreaks, Level 3 of the ORSEC "Arboviruses" system was activated, which corresponds to the circulation of a low-intensity epidemic.

Background:

France has reported the first autochthonous case of chikungunya virus disease in Department of La Réunion for 10 years, with onset of symptoms on 12 August 2024. In addition, on 30 August, France [announced the confirmation](#) of two more cases from the same neighbourhood. The first case had no link to travellers having visited chikungunya-endemic areas.

ECDC assessment

The last major chikungunya virus disease epidemic in La Réunion was in during 2005–2006. Population immunity is considered to be low for people born on or arriving on the island after 2014. The mosquito *Aedes albopictus*, which is a known vector of Chikungunya virus (CHIKV), is established on La Réunion.

The probability of infection for residents of and travellers to La Réunion is currently moderate, as at present the environmental conditions are favourable for mosquito-borne transmission on La Réunion. The impact is considered to be moderate as a significant number of people are expected to be affected and the overall risk is moderate.

In the event that CHIKV is introduced into the continental EU/EEA by infected travellers, the likelihood for further, autochthonous transmission is very low, because at this time of the year, the environmental conditions in the areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti* are established are unfavourable for vector activity and virus replication in vectors.

Actions

To avoid virus spread, reinforced prevention and control measures were implemented by the local authorities.

The vector control and intervention strategy is based on:

- Elimination of mosquito breeding sites around the homes of patients,
- Carrying out insecticide and/or larvicide treatments during the day,
- Raising awareness among residents of preventive measures,
- Distribution of repellents to priority groups around cases,
- Search for other cases within the perimeter of the initially reported case,
- Encouragement to consult a doctor promptly if symptoms occur and to carry out laboratory tests.

ECDC is monitoring the situation through its epidemic intelligence activities.

Last time this event was included in the Weekly CDTR: 30 August 2024

11. Community-associated outbreaks of impetigo by fusidic acid-resistant MRSA - multi-country - 2024

Overview

On 13 December 2024, **Denmark** (SSI) reported isolation of fusidic acid-resistant MRSA among children with impetigo, and their close contacts. The cases were identified in the summer months of 2023 (36 cases) and 2024 (43 cases). Several cases had documented contact with kindergartens. The outbreak strain was spa type t272, MLST ST121, CC121, SeqSphere cgMLST CT4265, and was positive for exfoliative toxins eta and etb, and virulence factor edinC, but negative for pvl.

WGS analyses in Denmark suggested that there were several introductions of a clone into different geographical areas of Denmark. They also identified a close genetic relatedness to strains published by the Netherlands ([Vendrik K, Eurosurveillance 2022](#)) and to strains shared by the Belgium national reference laboratory (NRL).

Background

The prevalence of fusidic acid-resistant MRSA appears to be increasing globally, from 1.4% (1.1%–1.8%) pre-2000 to 3.2% (2.3%–4.1%) in 2010–2020 ([Hajikhani B, 2021](#)).

The Netherlands reported outbreaks to ECDC involving the same strain as Denmark in October 2019 and February 2023, and in Eurosurveillance in December 2022 ([Vendrik K et al.](#)) and November 2024 ([Landman et al.](#)), including accession numbers for outbreak strains.

Retrospective investigations by national MRSA surveillance in the Netherlands identified the outbreak strain in only three samples from before 2019 (first sample from 2014). During the summer of 2019, several general practitioners in the east of the Netherlands noted rapidly increasing numbers of impetigo cases that were unresponsive to topical fusidic acid treatment. This is the first-line empiric treatment choice for community-onset impetigo in the Netherlands, and flucloxacillin is the second choice. Therefore, this MRSA strain is of special concern for the Netherlands, given the co-resistance to both treatment options. In total, 57 people were subsequently identified in the Netherlands, including 47 children, with infection (n=49 cases) or colonisation (n=8 cases) with the outbreak strain (MLST-type ST121, MLVA-type MT4627). The 57 samples were obtained between June 2018 and January 2020, with 51 samples obtained during the period July–September 2019. The cases were community onset, with no cases admitted to hospital at time of sampling. Only one case was later admitted to hospital, for severe generalised bullous impetigo. No cases are reported to have died.

In 2023, the Netherlands reported identification of 50 cases in 2021–2022. Outbreak investigations rarely identified contacts between the child cases. At least four of the 50 cases had a more severe disease, such as scalded skin syndrome (two neonates) or osteomyelitis (two adults). In 2024, the Netherlands reported identification of 51 cases in 2023 and 106 cases in 2024 (as of 17 December 2024).

In total, the national MRSA surveillance in the Netherlands has received MRSA isolates from 323 persons with MLVA-type MT4627 since 2018. Sixty-nine percent of the isolates were detected in samples from patients visiting general practitioners. Fifty-seven percent of the patients were aged 0–9 years. Information on disease severity was not systematically collected, but at least one neonate had scalded skin syndrome in 2024. Some of these isolates were missing the etb and edinC gene (probably located on a plasmid), but they form a genetic cluster (based on wgMLST) with Dutch isolates of this MRSA type that do have these genes (which cluster with the Danish strains).

To date, four other countries have reported an update to ECDC regarding national investigations into similar cases:

- The NRL in **Belgium** reported that they had only received voluntary submissions from sporadic impetigo cases, with 1–2 MRSA strains sharing the same microbiological characteristics as the RIVM strains, collected each year during the period 2019 to 2024. In Belgium, if MRSA is isolated from an impetigo case, mupirocin is the recommended topical treatment rather than fusidic acid.
- **Spain** reported identification of 15 paediatric cases with community onset of impetigo with fusidic-acid-resistant methicillin-sensitive *S. aureus* (MSSA). Five of these were identified in Asturias in August 2022, with spa type t1994. The remaining 10 cases were reported in Castilla y León in August 2023. The NRL in Spain identified all 10 as CC121, nine strains were MLST ST121, 'most' were resistant to fusidic acid, and four strains were 'genetically related' by cgMLST.
- **Luxembourg** reported identification of one paediatric impetigo case in January 2020, with an MRSA strain sharing the same microbiological characteristics as the RIVM strains. A 'family member' had recently travelled to Amsterdam.

- The NRL in **Norway** identified 12 MRSA cases since March 2020 that were spa type t272/CC121. Of these, nine strains were fusidic-susceptible, and three strains were fusidic-acid-resistant. The three resistant strains were obtained in 2024 from adults in different parts of Norway. WGS (NGS of the core genome) identified two of the three strains as being closely clustered.
- **Ireland** reported that no isolates typed at the NRL matched the outbreak strain.

ECDC assessment

There is an increasing number of reports from EU/EEA countries of community-focussed outbreaks of MRSA-associated impetigo during summer months, with resistance to a topical treatment used in many European countries. To date, only a few cases are reported to have had disease sequelae more severe than impetigo, with one reported hospitalisation, and no deaths. There is a high likelihood of further cases of impetigo caused by this strain among children in the EU, prompting the actions recommended below.

Actions

Health authorities in EU/EEA countries should ensure that healthcare professionals are aware of fusidic-acid-resistant MRSA as a potential diagnosis for impetigo among children, to prevent and control outbreaks.

Health authorities EU/EEA countries should continue to monitor this event, and provide relevant national findings from epidemiological and microbiological analyses, when available. Reference laboratories in EU/EEA countries should consider increased monitoring of fusidic acid resistance among *S. aureus* strains, sharing sequences with NRLs that identify similar strains.

Events under active monitoring

- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 20 December 2024
- Avian influenza A(H5N1) human cases – United States – 2024 - last reported on 20 December 2024
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024 - last reported on 20 December 2024
- SARS-CoV-2 variant classification - last reported on 20 December 2024
- Mpox due to monkeypox virus clade I - Germany - 2024 - last reported on 20 December 2024
- Cyclone Chido, Mayotte - 2024 - last reported on 20 December 2024
- Mpox due to monkeypox virus clade I – Belgium – 2024 - last reported on 20 December 2024
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 17 January 2025
- Autochthonous chikungunya virus disease - Department of La Réunion, France, 2024 - last reported on 17 January 2025
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 17 January 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 17 January 2025
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 17 January 2025
- Mass gathering monitoring - Jubilee of 2025 in Italy - last reported on 17 January 2025
- Suspected Marburg virus disease - Tanzania - 2025 - last reported on 17 January 2025
- Community-associated outbreaks of impetigo by fusidic acid-resistant MRSA - multi-country - 2024 - last reported on 17 January 2025
- Circulating vaccine-derived poliovirus type 2 (cVDPV2) - multi-country - 2024 - last reported on 13 December 2024
- Hepatitis A - multi-country - 2024 - last reported on 13 December 2024
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 13 December 2024
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 10 January 2025
- Increase in respiratory viral infections – China – 2024 - last reported on 10 January 2025
- Mpox due to monkeypox virus clade I – France – 2025 - last reported on 10 January 2025
- Avian influenza A(H5N1) human case – Canada – 2024 - last reported on 3 January 2025.