

Communicable disease threats report

Week 26, 21 - 27 June 2025

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Executive summary

Overview of respiratory virus epidemiology in the EU/EEA

- Respiratory virus activity is at low levels in the European Union/European Economic Area (EU/EEA). During the 2024/2025 respiratory virus season, SARS-CoV-2 activity remained at low levels with no winter epidemic. In recent weeks, increases in indicators of SARS-CoV-2 activity have been observed in several countries, but the overall activity remains low and the impact in secondary care is very limited.
- Following an intense influenza season and a concurrent respiratory syncytial virus (RSV) epidemic, influenza and RSV activity have now returned to low or baseline levels in all countries. Excess mortality levels have also returned to the expected range.

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

- One new human case of avian influenza A(H5N1) infection was reported in a 41-year-old adult in Cambodia in a press release from the Cambodian Ministry of Health on 24 June 2025.
- The patient is currently hospitalised in critical condition.

- The patient had exposure to sick and dead poultry prior to the onset of symptoms.
- Contact tracing and investigations are ongoing, along with outbreak prevention measures.
- As of the time of this report, no instances of human-to-human transmission have been detected or reported in connection with this case.
- The ECDC risk assessment for A(H5N1) remains unchanged.
- Since 2003, and as of 24 June 2025, there have been 981 confirmed human cases of A(H5N1) worldwide, including 472 deaths.

Human cases with avian influenza A(H10N3) – Multi-country (World)

- A new human case of avian influenza A(H10N3) virus infection was reported in Shaanxi province, China with onset date in April 2025.
- The patient is a 70-year-old female farmer with travel history to Inner Mongolia.
- Exposure to backyard poultry and live poultry markets has been reported both, in Shaanxi province where the patient resides and during their visit to Inner Mongolia.
- No human-to-human transmission has been documented.
- The risk to human health in the EU/EEA is considered very low.

Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

- On 20 June 2025, WHO reported three new human cases with avian influenza A(H9N2) in China.
- All three cases were epidemiologically unrelated, had onset of symptoms in May 2025 and had exposure to backyard poultry or live poultry markets.
- No new cases have been detected among contacts of these patients.
- Since 2015, a total of 130 cases of human avian influenza A(H9N2) infection, including two deaths, have been reported from China to the World Health Organization (WHO).
- The risk to human health in the EU/EEA is currently considered very low.

Mass gathering monitoring – EuroPride 2025 Lisbon - Portugal – 2025

- ECDC concluded its monitoring on 27 June of EuroPride 2025 (9-22 June 2025) in Lisbon through its epidemic intelligence activities.
- No infectious disease events of relevance for the EU/EEA were detected during the event.
- ECDC's epidemic intelligence team acknowledges the excellent collaboration with the Portuguese health authorities and the World Health Organization Regional Office for Europe (WHO/Europe) in monitoring this event.

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 22 June 2025, 54 242 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 old, 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](#).
- On 7 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 15 June 2025, 969 confirmed cases of the disease have been [reported](#) on the island. Due to the intensified circulation of locally acquired cases of chikungunya, the ORSEC plan has transitioned to phase 3 to control the outbreak.

Seasonal surveillance of chikungunya virus disease – 2025

- Since the beginning of 2025, and as of 25 June 2025, France is the only country in Europe that has reported cases of chikungunya virus disease (eight cases).

Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2025

- Since the beginning of 2025, and as of 25 June 2025, Spain is the only country in Europe that has reported cases of Crimean-Congo haemorrhagic fever (one case).

Weekly seasonal surveillance of West Nile virus infection – 2025

- Since the beginning of the 2025 transmission season, and as of 25 June 2025, no countries in Europe have reported human cases of West Nile virus (WNV) infection.

Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

- In 2025, as of 24 June 2025, fourteen cases of acute flaccid paralysis (AFP) caused by WPV1 have been reported, twelve in Pakistan and two in Afghanistan.
- In 2025, as of 24 June 2025, no cases of AFP due to circulating vaccine-derived poliovirus 1 (cVDPV1) have been reported.
- In 2025, as of 24 June 2025, 75 cases of AFP due to cVPV2 have been reported from ten countries: Ethiopia (33), Nigeria (15), Chad (11), Angola (3), Benin (3), Yemen (3), Niger (3), Sudan (2), Djibouti (1) and Burkina Faso (1).
- In 2025, as of 24 June 2025, two cases of AFP due to cVDPV3 have been reported by Guinea.
- On 6 March 2025, the [41st 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 public health emergency of international concern (PHEIC). Temporary recommendations were issued for affected countries, including in EU/EEA countries where the virus was identified in environmental samples.

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

Overview:

Based on data reported in week 25, 2025, primary care consultation rates remained at baseline levels for respiratory virus activity in all reporting EU/EEA countries; for severe acute respiratory infection (SARI), rates have returned to levels observed at this time in previous seasons.

Pooled EU/EEA test positivity for SARS-CoV-2 has been slowly increasing in influenza-like illness (ILI)/acute respiratory infection (ARI)-based surveillance in primary care and SARI surveillance in secondary care for several weeks in a number of countries, with trends aligning very closely with what was observed at the same time last year.

While pooled test positivity remained stable in both ILI/ARI and SARI surveillance from week 24 to week 25, increases in SARS-CoV-2 activity from low levels continue to be observed in non-sentinel, laboratory-based surveillance (which comes from a mix of primary care and other sources, including hospital laboratories), where many countries report increasing trends in the proportion of tests that are positive for SARS-CoV-2.

Although syndromic SARI rates remained at low levels, two countries have reported small increases in weekly, non-sentinel, laboratory-confirmed hospitalised cases and one country has reported small increases in non-sentinel, laboratory-confirmed deaths in recent weeks, from low levels.

[EuroMOMO](#) reports all-cause mortality in the expected range.

ECDC assessment:

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

In recent weeks, increases in indicators of SARS-CoV-2 activity have been observed in many countries, although overall activity remains low and the impact in secondary care is still limited.

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

Following a winter with low SARS-CoV-2 circulation, population immunity against SARS-CoV-2 may have partly waned. As a result, the increasing trends in activity currently being observed may lead to further increases in COVID-19 hospitalisations in the coming weeks, particularly among older adults and vulnerable individuals, 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, particularly in settings with populations vulnerable to severe disease. [ECDC/WHO guidance](#) recommends that surveillance for respiratory viruses is maintained year-round.

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

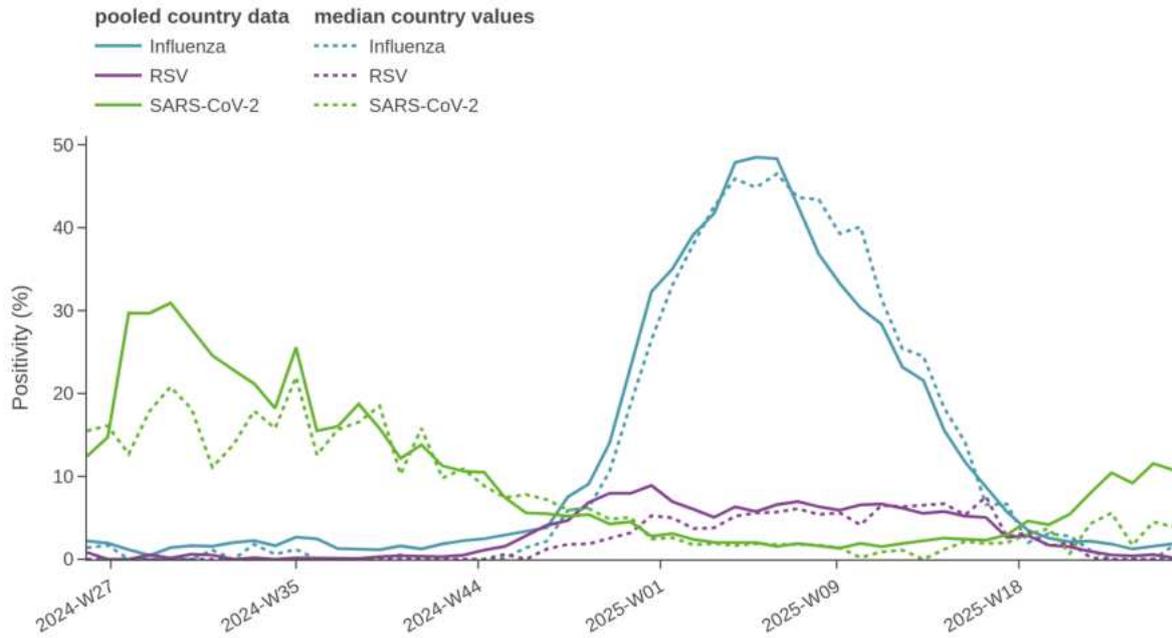
Countries should ensure that [infection prevention and control practices in healthcare settings](#) are implemented. Wearing masks in settings such as high-risk wards and long-term care facilities can help protect groups at high risk of severe disease.

Sources: [ERVISS](#)

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

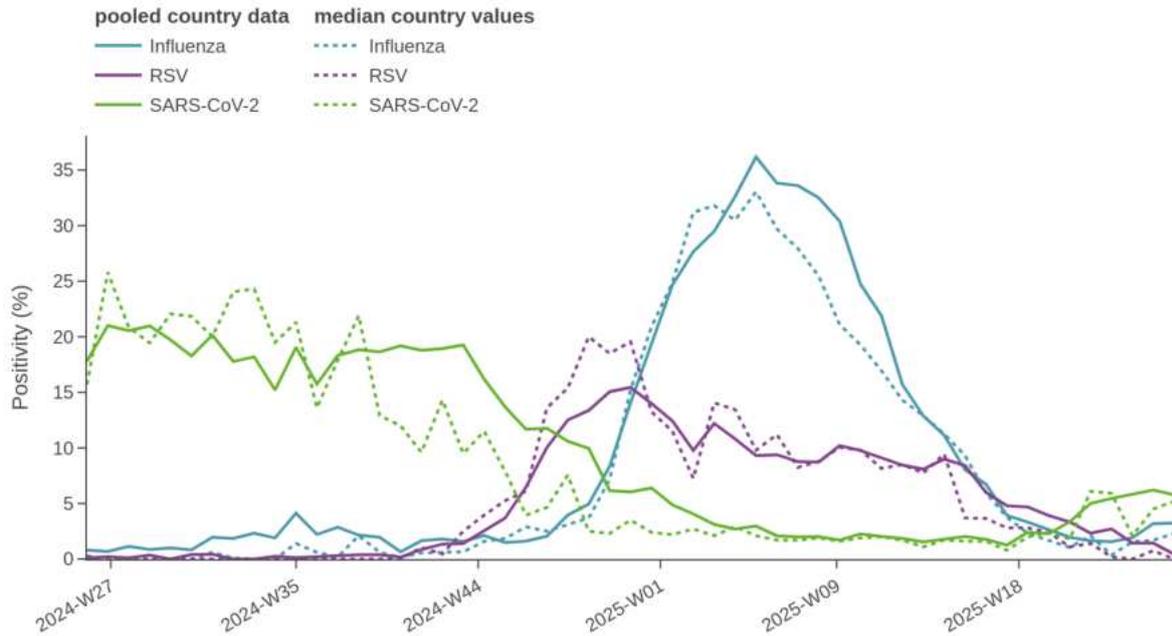
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 3. Overview of key indicators of activity and severity in week 25, 2025

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 25	Week 24	Description	Value	
ILI/ARI consultation rates in primary care	ARI	11 rates (8 MEM)	14 rates (10 MEM)	Distribution of country MEM categories	8 Baseline	
	ILI	14 rates (13 MEM)	17 rates (15 MEM)		13 Baseline	
ILI/ARI test positivity in primary care	Influenza	12	15	Pooled (median; IQR)	1.9% (1.7; 0-3%)	At the EU/EEA level, the overall pooled SARS-CoV-2 positivity has been slowly increasing since week 9, mainly in those aged 15 years and above. While the pooled ILI/ARI test positivity rate remained stable in week 25 (11%) when compared to week 24 (12%), 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).
	RSV	9	12		0.2% (0; 0-0%)	
	SARS-CoV-2	10	13		11% (3.9; 3-7.9%)	
SARI rates in hospitals	SARI	9	10	-	-	
SARI test positivity in hospitals	Influenza	7	8	Pooled (median; IQR)	3.2% (2.3; 0.8-11%)	The pooled SARI test positivity rate remained stable in week 25 (6%) when compared to week 24 (6%), driven primarily by patients aged 65 years and above. Two countries have reported small increases in weekly, non-sentinel, laboratory-confirmed hospitalised cases and one country has reported small increases in non-sentinel, laboratory-confirmed deaths, in recent weeks, from low levels.
	RSV	7	7		0.4% (0; 0-1.2%)	
	SARS-CoV-2	6	7		5.8% (5.2; 0-15%)	
Intensity (country-defined)	Influenza	17	19	Distribution of country qualitative categories	15 Baseline 2 Low	
Geographic spread (country-defined)	Influenza	16	19	Distribution of country qualitative categories	8 No activity 8 Sporadic	

Source: ECDC

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

Pathogen	N	Week 25, 2025		Week 40, 2024 - week 23, 2025	
		N	% ^a	N	% ^a
Influenza	14		-	25269	-
Influenza A	14		100	14970	60
A(H1)pdm09	5		71	7196	57
A(H3)	2		29	5483	43
A (unknown)	7		-	2291	-
Influenza B	0		0.0	10037	40
B/Vic	0		-	4490	100
B/Yam	0		-	1	0.0
B (unknown)	0		-	5546	-
Influenza untyped	0		-	262	-
RSV	1		-	4751	-
RSV-A	0		-	854	44
RSV-B	0		-	1103	56
RSV untyped	1		-	2794	-
SARS-CoV-2	72		-	3617	-

Source: ECDC

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

Figure Table

Pathogen	Week 25, 2025		Week 40, 2024 - week 25, 2025	
	N	% ^a	N	% ^a
Influenza	23	-	13649	-
Influenza A	12	92	5707	82
A(H1)pdm09	1	100	1696	60
A(H3)	0	0.0	1117	40
A (unknown)	11	-	2894	-
Influenza B	1	8	1263	18
B/Vic	0	-	168	100
B (unknown)	1	-	1095	-
Influenza untyped	10	-	6679	-
RSV	3	-	5685	-
RSV-A			750	48
RSV-B			810	52
RSV untyped	3	-	4125	-
SARS-CoV-2	39	-	4209	-

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 25, 2025

Subtype	Subtype distribution		Subclade distribution		
	N	%	Subclade	N	%
A(H1)pdm09	4405	41	5a.2a(C.1.9)	3408	77
			5a.2a.1(D)	628	14
			5a.2a(C.1)	157	4
			5a.2a(C.1.9.3)	113	3
			5a.2a.1(D.3)	99	2
A(H3)	3182	29	2a.3a.1(J.2)	2443	77
			2a.3a.1(J.2.2)	436	14
			2a.3a.1(J.2.1)	207	7
			2a.3a.1(J)	43	1
			2a.3a.1(J.1)	34	1
			2a.3a.1(J.4)	2	0.1
			Not assigned	17	-
B/Vic	3275	30	V1A.3a.2(C.5.1)	2069	64
			V1A.3a.2(C.5.6)	589	18
			V1A.3a.2(C.5.7)	515	16
			V1A.3a.2(C)	72	2
			V1A.3a.2(C.5)	13	0.4
			Not assigned	17	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 23–24, 2025

Variant	Classification*	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	4	39	20% (17-21%)
KP.3	VOI	2	6	1% (0-4%)
LP.8.1	VUM	4	78	30% (28-32%)
NB.1.B.1	VUM	4	23	10% (9-12%)
XEC	VUM	2	3	0.3% (0-2%)

Source: ECDC

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

Overview:

On 24 June 2025, the [Cambodian Ministry of Health](#) reported a new case of avian influenza A(H5N1) virus infection in Puok District, Siem Reap Province, Cambodia. The case involves a 41-year-old woman who is currently hospitalised in critical condition. She presented with symptoms including fever, cough, shortness of breath, and difficulty breathing. The presence of the avian influenza A(H5N1) virus was confirmed on 23 June 2025 by the National Institute of Public Health.

Five days before the onset of symptoms, the patient had contact with sick and dead poultry both at her home and at a neighbours' home. She reportedly handled and prepared the poultry for consumption.

The authorities are performing active outbreak investigation and contact tracing along with outbreak prevention measures, including distribution of Tamiflu to close contacts, following established protocols.

The information about the clade of this case is pending. Clade 2.3.2.1e (previously classified 2.3.2.1c) has been detected in the previously reported cases from Cambodia in 2025 (four of six cases).

There have been seven human cases, including five deaths, reported in 2025 in Cambodia. Overall, Cambodia reported 79 human cases with avian influenza A(H5N1) infection, including 48 deaths (CFR 61%) since 2003 and as of 24 June 2025. It needs however to be noted that the seroprevalence levels observed in exposed groups for A(H5) in various studies within and outside Asia provide valuable context for interpreting case fatality, as they suggest that reported human cases, which are predominantly severe, may lead to an overestimation of case fatality for A(H5) subtypes (ECDC/EFSA Scientific Opinion on [Preparedness-prevention-and-control-related-to-zoonotic-avian-influenza.PDF](#)).

Summary:

Since 2003, and as of 24 June 2025, there have been 981 human cases of avian influenza A(H5N1) infection worldwide*, including 472 deaths (case fatality among reported cases: 48%). These cases have been reported in 25 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, India, Indonesia, Iraq, Laos, Mexico, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Viet Nam, the United Kingdom, and the United States). To date, no sustained human-to-human transmission has been detected.

***Note:** this includes detections due to suspected environmental contamination, with no evidence of infection, that were reported in 2022 and 2023 by Spain (two detections), the United States (1), and the United Kingdom (4, 1

inconclusive). Human cases of A(H5) epidemiologically linked to A(H5N1) outbreaks in poultry and dairy cattle in the United States are included in the reported number of cases of A(H5N1).

Acknowledgements: we gratefully acknowledge all data contributors i.e. the authors and their originating laboratories responsible for obtaining the specimens, and the submitting laboratories for generating the genetic sequence and metadata and sharing via the GISAID Initiative, on which this research is based.

ECDC assessment:

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

Clade 2.3.2.1e A(H5) viruses that are circulating in Cambodia have not been reported in animals in the EU/EEA so far. The risk of A(H5N1) clade 2.3.2.1e zoonotic influenza transmission to the general public in EU/EEA countries is considered very low.

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

Actions:

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

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

3. Human cases with avian influenza A(H10N3) – Multi-country (World)

Overview:

On 20 June 2025, [WHO WPRO](#) reported about a new human case with avian influenza A(H10N3) virus infection in a 70-year-old female farmer from Shaanxi province, China. This was the second case reported in the same province with date of onset in April 2025. The patient developed symptoms (fever and chest tightness) on 21 April 2025 while travelling in Ordos City, Inner Mongolia. She was hospitalised on 25 April in Inner Mongolia with severe pneumonia. Later she was transferred to a hospital in Shaanxi province. The patient is still under treatment and improving.

All close contacts of the patient tested negative for influenza A and all remained asymptomatic during the monitoring period.

Summary: Since 2021 and as of 25 June 2025, six human cases of avian influenza A(H10N3) virus infection have been reported globally, all in China. All of the cases had severe or critical infections and reported history of exposure to live animals or animal environments.

The [first case](#) was reported in Jiangsu Province, China, with symptoms onset in April 2021. The [second case](#) from Zhejiang Province, developed severe symptoms in June 2022. The [third case](#) from Yunnan Province, developed severe pneumonia in February 2024. The [fourth case](#), was from Guangxi Zhuang Autonomous Region in China with

disease onset in December 2024. The [fifth case](#) and the [sixth case](#) from Shaanxi province, both developed symptoms in April 2025.

ECDC assessment:

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

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

Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and influenza surveillance activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza to identify significant changes in the epidemiology and characteristics of the virus. ECDC with EFSA and the EU reference laboratory produces a quarterly Avian influenza review, the most recent report covers the period from [March to June 2025](#).

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

4. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

Overview:

On 20 June 2025, [WHO office for Western Pacific Region](#) (WPRO) reported three new human cases of avian influenza A(H9N2) infection involving two adults and one child in China. All three patients had symptom onset in May 2025. Two adults were hospitalised, one of them with severe pneumonia. All three cases recovered and all three had exposure to poultry. There was no epidemiological link between the cases. No new cases have been detected among the close contacts of these patients after a 10-day health monitoring period.

The first case was a 52-year-old woman from Henan province, Zhoukou city. She was hospitalised with severe pneumonia on 12 May 2025 where treatment with antivirals was initiated. The patient was discharged on 23 May following her recovery.

The second case is a 6-year-old boy from Sichuan province, Deyang city, with onset of mild symptoms 14 May 2025.

The third case is a 72-year-old woman from Hunan province, Hengyang city, who was hospitalised on 17 May 2025 due to age and pre-existing health conditions. The patient received treatment with antivirals, recovered and was discharged on 24 May 2025. The patient is listed as having mild symptoms.

Background: twenty human cases of influenza A(H9N2) virus infection have been reported in China in 2025 (of which four had symptom onset in late 2024), none of whom have reported epidemiological links to each other. Since 2015, a total of 130 cases of human avian influenza A(H9N2) infection, including two deaths (CFR 1.5%), have been reported from China to WHO.

ECDC assessment:

Sporadic human cases of avian influenza A (H9N2) have been observed outside the EU/EEA, mainly in young children. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses. Influenza A(H9N2) in most cases leads to mild clinical illness. To date, no clusters of human A(H9N2) infections have been reported. According to WHO, the likelihood of human-to-human

transmission of A(H9N2) is low, as there is no evidence that the virus has acquired the ability for sustained transmission among humans.

To date, there have been no human cases of avian influenza A(H9N2) reported in the EU/EEA, and the risk to human health in the region is currently considered very low.

Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities. ECDC jointly with EFSA and the EU reference laboratory produces a quarterly Avian influenza review. The most recent review covers the period from [March to June 2025](#).

Sources: [Event Information Site for IHR National Focal Points](#)

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

5. Mass gathering monitoring – EuroPride 2025 Lisbon - Portugal – 2025

Overview:

The EuroPride 2025 Lisbon ended on 22 June 2025. There have been no reports regarding communicable diseases among attendants during the EuroPride since 9 June 2025 (the start date of the monitoring).

Summary

[EuroPride 2025 Lisbon](#) attracted a high number of participants, including international visitors from across the EU/EEA. Activities included multiple gatherings such as cultural and artistic performances and large-scale social gatherings, culminating in a public parade on 21 June in central Lisbon. The event was hosted across multiple indoor and outdoor venues, some for which high-crowd density was anticipated, along with extended duration of contact among attendees.

In recent years, rates of STIs such as gonorrhoea and syphilis have [continuously increased](#) among men who have sex with men. In addition, clusters and outbreaks of other infections transmitted through intimate contact among sexual partners are currently spreading among this group, including mpox, viral hepatitis and extensively [drug-resistant Shigella](#).

In Portugal there is an ongoing outbreak of hepatitis A among men who have sex with men and an increasing number of cases have been detected since November 2024. The local and regional public health teams in Portugal have reinforced early detection, epidemiological surveillance, diagnostics, sampling and sequencing and preventive community measures for populations at risk of acquiring the disease, and in spaces where exposure may occur. In the context of preparedness and response to the EuroPride 2025 Lisbon event, national guidance has been reinforced and stockpiles of hepatitis A vaccine replenished at healthcare service facilities in the areas near the events.

It is recommended that participants at Pride events be mindful of the following recommendations stated in the [2017 ECDC risk assessment](#), ECDC's guidance on [HIV and STI prevention among men who have sex with men](#), ECDC's [public health considerations on mpox](#), and [ECDC's guidance on PrEP](#). Additional points on Shigella prevention are also important, as outlined below.

Public health authorities are recommended to work with civil society and other partners to ensure that men who have sex with men have access to correct information and services. It is recommended that participants at Pride events be mindful of the following:

- Ensure that their routine vaccination and boosters are up-to-date according to the national immunisation recommendations in their country of residence, including those against hepatitis A. It is advised to discuss the need for additional vaccinations, such as mpox, or booster doses, with healthcare providers.
- Ensure coverage with valid health insurance or obtain a European Health Insurance Card.
- Educate themselves prior to attendance about the prevention of STIs, including recommendations on HIV pre-exposure prophylaxis, and familiarise themselves with additional advice and information on the website for the event.

- Consult a healthcare provider in the home country to discuss other precautions based on a sexual health risk assessment: they may recommend pre-exposure prophylaxis (PrEP) for HIV, but remember that PrEP does not protect against other STIs.
- Practise safer sex using condoms to prevent STIs, including HIV and hepatitis B and C.
- Although use of a condom is an important protective measure, it does not provide full protection against mpox, as this can be transmitted through close skin-to-skin contact, especially if there are rashes, sores, or lesions on the skin.
- Avoid sexual activity and seek healthcare if symptoms of STIs are present, including gastrointestinal symptoms and symptoms suggestive of mpox (this applies to the individuals themselves and any of their sexual partners).
- Avoid faecal-oral exposure during sexual activity in order to prevent other infections such as shigellosis and hepatitis A (i.e. washing hands, genital and anal areas before and after sexual contact, always using a condom, changing condoms between anal and oral sex, using gloves or condoms on sex toys, using dental dams for oral sex and latex gloves for fingering or fisting). If gastrointestinal symptoms appear, tell healthcare providers about sexual activities.
- Follow standard hygiene measures and advice on the prevention of food and waterborne diseases to decrease the risk of gastrointestinal illnesses and consider general hygiene/food safety practices when consuming food and drink.
- If you think you have been exposed to HIV, hepatitis A or B, or mpox infection, contact a healthcare provider as soon as possible for advice, as post-exposure prophylaxis (PEP) is available for some infections in the form of a vaccination or tablets and should be started as soon as possible (within 72 hours for HIV).
- Contact a healthcare provider at the event if experiencing symptoms suggestive of an infection. Although people with STIs may not experience symptoms, some of the most common can include unusual discharge from the genitals or rectum, itching, pain during urination, rectal pain, skin changes (including rashes or blister-like lesions), yellowing of the skin, pain during sex or influenza-like symptoms. If you have any of these symptoms, or experience severe diarrhoea (which can be caused by shigella or hepatitis A), avoid sexual activity and seek healthcare promptly.
- In general, if engaged in unprotected sexual activity with a casual partner, consider contacting a healthcare provider for advice on testing for STIs, including mpox, HIV and hepatitis, as STIs can be present without causing any symptoms.
- Alternatively, use the European Test Finder tool to identify the most conveniently located testing centre. Known partners of those diagnosed should be notified, and offered testing and treatment in accordance with clinical guidelines.

Men who have sex with men who attended Euro Pride and acquired an infection could then transmit these further through sexual networks in their home countries and Member States should therefore consider raising awareness among clinicians and laboratory professionals accordingly, while also preparing to provide post-exposure prophylaxis and carry out partner management of identified cases.

ECDC assessment:

The EuroPride 2025 Lisbon is now over, but please note that the ECDC assessment for it was as follows:

"Euro Pride is a mass gathering with a large number of visitors, some of whom may engage in different type of sex with new partners, anonymous partners and multiple partners. Sometimes sexual activity may be in the context of drug use, which has been associated with an increased risk of infectious disease transmission through sex.

STIs, HIV and hepatitis, as well as mpox and shigella, are already spreading in MSM networks in Europe. The probability of infection with STIs and other infections that spread through sex is high for people who attend EuroPride and engage in sex with non-steady and multiple partners, particularly if preventive measures are not consistently applied.

Mass gathering events in general involve a large number of visitors in one area at the same time. Multiple factors can lead to the emergence of a public health threat, such as an imported disease, increased numbers of susceptible people, risk behaviour, sale of food and beverages by street vendors, etc. At the same time, non-communicable health risks, including heat stroke, crowd injury, and drug- and alcohol-related conditions, should also be considered by the organisers and the public health authorities of the hosting country.

The probability of EU/EEA citizens becoming infected with other communicable diseases while attending EuroPride 2025 is low if general preventive measures are applied (e.g. being fully vaccinated according to national

immunisation schedules, following advice regarding hand and food hygiene and respiratory etiquette, self-isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, seeking prompt testing and medical advice as needed, and practising safe sex).

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

Actions:

ECDC monitored this event through its epidemic intelligence for mass gathering activities between 9 to 27 June 2025 in collaboration with the Portuguese health authorities and WHO's Regional Office for Europe, and included weekly updates in the Communicable Disease Threats Report (CDTR).

ECDC has [published recommendations](#) on STIs in the upcoming holiday season.

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

6. 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 22 June 2025, 54 242 confirmed autochthonous cases of chikungunya virus disease have been reported in Réunion. Since week 17, a decrease in surveillance indicators has been observed. The estimated number of emergency department visits for chikungunya virus disease in week 25 was nine visits, compared to 12 visits in week 24.

Since the beginning of the year, 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).

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

On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 15 June 2025, 969 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 probably underestimated. Due to increasing pressure on the emergency departments, case confirmation has been suspended and general practitioners are also requesting fewer tests. Combined with limited healthcare access for parts of the population, this situation contributes to underreporting. Due to the increase in the number of cases, individual investigations for each case have also not been conducted which impacts the quality of the data. The disease has spread across the entire island and initial hotspots were identified in Mamoudzou, Dzaoudzi and Pamandzi. Since week 10, 36 chikungunya cases have been hospitalised, including 14 children under one year of age, 18 pregnant women admitted as a precaution due to an elevated risk of complications and two neonatal ICU admissions. No deaths have been reported. Due to the intensified circulation of locally acquired cases of chikungunya, the ORSEC plan has transitioned to phase 3 on 27 May to control the outbreak.

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 remains high.

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 weakening 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 EDC 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 already 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 mosquitoes 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 La Réunion;
- CHIKV-NAT, or a 28-day temporary deferral period, for travellers who have stayed at least one night in Réunion 28 days prior to donation.

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

7. Seasonal surveillance of chikungunya virus disease – 2025

Overview:

Since the beginning of 2025, and as of 25 June 2025, France is the only country in Europe that has reported cases of chikungunya virus disease (eight cases).

France has reported **eight** cases of locally acquired chikungunya virus disease in six regions of the country: in Prades le Lez in the Hérault department (**one case**), in La Crau in the Var department (**one case**), in Bernis in the Gard department (**one case**), in Montoisson in the Drôme department (**one case**), in Salon-de-Provence in the Bouches-du-Rhône department (**two cases**) and in Grosseto-Prugna in the Corse-du-Sud department (Corsica, **two cases**). All clusters are currently classified as active.

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: 19 June 2025

8. Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2025

Overview:

Since the beginning of 2025, and as of 25 June 2025, Spain is the only country in Europe that has reported cases of Crimean-Congo haemorrhagic fever (one case). No additional cases have been reported since week 23.

This event was 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. In the same locality as the current case, two cases have been detected in the previous years. 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 showed 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](#). Additional information on CCHF can be found in ECDC [factsheet](#) and information on the occurrence of CCHF cases in the EU/EEA can be found on the ECDC [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: -

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

Overview:

Since the beginning of the 2025 transmission season, and as of 25 June 2025, no countries in Europe have reported human cases of WNV infection.

The report is available [online](#).

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

10. 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 March 2025, the [41st 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. Temporary recommendations were issued for affected countries, including in EU/EEA countries where the virus was identified in environmental samples.

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

Summary:

Wild poliovirus type 1 (WPV1):

In 2025, as of 24 June 2025, fourteen cases of AFP caused by WPV1 have been reported, twelve in Pakistan and two in Afghanistan.

In 2024, 99 cases of AFP caused by WPV1 have been [reported](#), 74 in Pakistan and 25 in Afghanistan.

Circulating vaccine-derived poliovirus (cVDPV):

In 2025, as of 24 June 2025, no cases of AFP due to cVDPV1 have been reported.

In 2025, as of 24 June 2025, 75 cases of AFP due to cVPV2 have been reported from ten countries: Ethiopia (33), Nigeria (15), Chad (11), Angola (3), Benin (3), Yemen (3), Niger (3), Sudan (2), Djibouti (1) and Burkina Faso (1).

In 2025, as of 24 June 2025, two cases of AFP due to cVDPV3 have been reported by Guinea

In 2024, as of 24 June 2025, 11 cases of AFP caused by cVDPV1 have been [reported](#) by the Democratic Republic of the Congo (DRC) (10), and Mozambique (1).

In 2024, as of 24 June 2025, 305 cases of AFP caused by cVDPV2 have been reported from 20 countries: Nigeria (98), Ethiopia (44), Chad (39), Yemen (44), Niger (16), DRC (15), South Sudan (10), Angola (9), Indonesia (7), Somalia (7), Guinea (5), Cameroon (3), Algeria (1), Benin (1), Liberia (1), Mali (1), Sudan (1), Côte d'Ivoire (1), Palestine* (1), Mali (1) and Senegal (1).

In 2024, as of 24 June 2025, four 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 populations groups who are not vaccinated or under-vaccinated 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 populations who are under-immunised. 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 2025](#), [ECDC Risk Assessment 2014](#)

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: 25 April 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
- Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025 - last reported on 27 June 2025
- Overview of respiratory virus epidemiology in the EU/EEA - 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 13 June 2025
- Risk Assessment under production - last reported on 13 June 2025
- Outbreak of measles associated with international mass gathering - Germany - 2025 - last reported on 13 June 2025
- Invasive pneumococcal disease among shipyard workers in Turku, Finland - last reported on 13 June 2025
- Seasonal surveillance of West Nile virus infections started in week 23 - last reported on 13 June 2025
- Salmonella Infantis outbreak among small children in Germany and Austria - last reported on 05 June 2025
- Crimean-Congo haemorrhagic fever, Spain 2025 - last reported on 05 June 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 05 June 2025
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 05 June 2025