WEEKLY BULLETIN

Communicable Disease Threats Report

Week 30, 19 – 25 July 2025

This week's topics

Executive summary

Overview of respiratory virus epidemiology in the EU/EEA

- Rates of consultations and hospitalisations for respiratory infections are at expected levels for the summer. In recent weeks increases in indicators of SARS-CoV-2 circulation have been observed in many countries. Influenza and RSV activity is low in most reporting countries.
- Due to the currently limited number of countries reporting data and the relatively low number of tests performed, a complete interpretation of the epidemiological situation across the EU/EEA remains difficult.

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

- On 22 July 2025, WHO office for Western Pacific Region (WPRO) reported two new human cases with avian influenza A(H9N2) in China.
- Both cases had known exposure to poultry and recovered without hospitalisation.
- Since 2015, a total of 132 cases of human avian influenza A(H9N2) infection, including two deaths, have been reported from China.
- The risk to human health in the EU/EEA is currently considered very low.

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

- Two additional cases of human case of avian influenza A(H5N1) virus infection have been reported, one in Cambodia and one in India.
- On 21 July 2025, the Cambodian Ministry of Health reported one human case of avian influenza A(H5N1) virus infection in a child aged <10 years from Tbong Khmum Province, Cambodia. The case had known exposure to sick or dead poultry prior to the onset of symptoms. The patient is currently receiving intensive medical care and outbreak investigation is ongoing.
- On 1 July 2025, WHO reported one human case of avian influenza A(H5N1) virus infection in Karnataka State, India.
- The ECDC risk assessment for A(H5N1) remains unchanged.

Suspected cholera - Poland - 2025

- The Polish National Public Health Authority has reported a suspected case of cholera in the West Pomeranian Voivodeship. The patient is an elderly woman who exhibited gastrointestinal symptoms and is reported as being in a stable condition.
- The patient is being treated at the provincial hospital in Szczecin.
- Laboratory tests confirmed the presence of Vibrio cholerae bacteria. Tests are ongoing to assess if the bacteria are toxin-producing.

Imported Oropouche virus disease cases - EU/EEA and UK - 2024/2025

- In 2025, Germany reported one imported case of Oropouche virus disease in a person who visited Dominica in the period 24 January 2025 to 7 February 2025, France reported one imported case in a person who visited Brazil until 1 March 2025, the United Kingdom reported three imported cases in travellers returning from Brazil in March and April 2025.
- In 2024, 44 imported cases of Oropouche virus disease were reported in EU countries: Spain (23), Italy (8), France (7), Germany (3), Austria (1), Sweden (1) and the Netherlands (1). Forty-three cases had a travel history to Cuba and one to Brazil.
- The risk of infection for EU/EEA citizens travelling to Oropouche virus (OROV)-epidemic countries in the Americas is assessed as moderate.
- The risk of locally-acquired OROV disease in the EU/EEA is low.

Mass gathering monitoring – Jubilee of 2025 in Italy

- On the occasion of the Jubilee of the Youth between 21 July and 8 August 2025, ECDC is conducting enhanced monitoring through its epidemic intelligence activities.
- On 24 July 2025, the Lazio region reported 21 confirmed cases of West Nile virus infection, including one death, since the beginning of the year, all in the province of Latina.
- The probability of EU/EEA citizens becoming infected with communicable diseases during the Jubilee 2025 is low if general preventive measures are applied.
- ECDC will keep monitoring this mass gathering event through epidemic intelligence and will be reporting relevant updates in collaboration with the Italian National Institute of Health (Istituto Superiore di Sanita' - ISS), the Italian Ministry of Health, SERESMI (National Institute for Infectious Diseases 'L.Spallanzani' – Lazio Region), and other partners.

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

- Since the previous update and as of 24 July, no relevant public health events associated with infectious diseases have been detected in the context of the UEFA Women's Football EURO 2025.
- Respiratory diseases including COVID-19, food and waterborne diseases, tick-borne and sexually-transmitted diseases are among the potential health threats for those attending.
- The probability of exposure to any of these infections for EU/EEA citizens during the UEFA Women's Football EURO 2025 is considered very low to low, with an estimated low impact. The impact would be higher for people with underlying conditions, older individuals, and pregnant women.

Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025

- Since the beginning of 2025, and as of 23 July 2025, two countries in Europe have reported cases of Crimean-Congo haemorrhagic fever (CCHF): Greece (2) and Spain (2)
- The second case reported by Greece is a healthcare professional who provided care to the primary case

Weekly seasonal surveillance of West Nile virus infection – 2025

- Since the beginning of 2025, and as of 23 July 2025, three countries in Europe have reported human cases of West Nile virus infection: **Greece**, **Italy** and **Romania**

Seasonal surveillance of dengue – 2025

- Three countries in Europe have reported locally acquired cases of dengue in 2025 so far: France (4), Italy (3), and Portugal (2 in the outermost region of Madeira).
- Italy has reported two new cases and France three new cases since last week.

Seasonal surveillance of chikungunya virus disease – 2025

- In 2025, to date France has reported 38 locally acquired cases of chikungunya virus disease in 12 local administrative units.
- In 2025, to date Italy has reported one locally acquired case of chikungunya virus disease.

Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update

- Since the beginning of 2025, and as of July, approximately 240 000 CHIKVD cases and 90 CHIKVD-related deaths have been reported in 16 countries/territories. Cases have been reported in the Americas, Africa, Asia, and Europe (France - mainland and outermost regions, i.e. Réunion and Mayotte - and Italy).
- Since the beginning of 2025, 3.6 million dengue cases and over 1 900 dengue-related deaths have been reported globally. In mainland Europe, autochthonous cases have been reported in 2025 in the EU/EEA (excluding outermost regions) by France and Italy as well as from the EU outermost regions.

- The environmental conditions in the areas of the European Union/European Economic Area (EU/EEA) where Ae. albopictus or Ae. aegypti are established are currently favourable for mosquito activity and virus replication in mosquitoes. There is therefore a risk of local chikungunya and dengue virus transmission.

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

Overview

Data reported in week 29, 2025, showed that consultation rates for respiratory infections were at baseline or low levels in all reporting EU/EEA countries, both in primary (influenza-like illness (ILI), acute respiratory infection (ARI)) and secondary care (severe acute respiratory infection (SARI)) surveillance systems.

Following multiple weeks of increases, the pooled EU/EEA test positivity for SARS-CoV-2 in ILI/ARI primary care specimens has stabilised over the past week, with one country reporting a week-on-week increase.

EU/EEA test positivity for SARS-CoV-2 in secondary care specimens showed an increase in three countries in week 29 (based on data collected from SARI surveillance for two countries and from laboratory-confirmed non-sentinel surveillance systems for another country).

In six countries, detections of SARS-CoV-2 from laboratory-based, non-sentinel specimens (from a mix of primary care and other sources, including hospital laboratories) continuing to increase.

While the number of SARS-CoV-2 deaths remained low across the EU/EEA, three countries reported increased SARS-CoV-2 deaths compared to the previous week.

ECDC assessment

Rates of consultations and hospitalisations for respiratory infections are at expected levels for the summer, although in recent weeks increases in indicators of SARS-CoV-2 circulation have been observed in many countries. Influenza and RSV activity is low in most reporting countries.

Due to the currently limited number of countries reporting data and the relatively low number of tests performed, a complete interpretation of the epidemiological situation across the EU/EEA remains difficult.

Following a winter with low SARS-CoV-2 circulation, population immunity against SARS-CoV-2 might have waned to a certain extent. Test positivity for SARS-CoV-2 is currently higher than that for other respiratory viruses. This might lead to some increases in COVID-19 hospitalisations, particularly among older adults and people vulnerable to severe outcomes, as described in ECDC's recently published Epidemiological update.

Actions

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

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

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

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

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

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

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 21 July 2025

Maps and graphs

Figure 1. Overview of key indicators of activity and severity in week 29, 2025

		Reporting countries		EU/EEA summary		
Indicator	Syndrome or pathogen	Week 29	Week 28	Description	Value	Comment
ILI/ARI consultation rates in primary care	ARI	10 rates (8 MEM)	12 rates (9 MEM)	Distribution of country MEM categories	8 Baseline	
	ILI	12 rates (12 MEM)	16 rates (15 MEM)		12 Baseline	
ILI/ARI test positivity in primary care	Influenza	11	14	Pooled (median; IQR)	2.2% (1.8; 0–4.5%)	
	RSV	10	12		0.1% (0; 0–0%)	
	SARS-CoV-2	9	13		16% (8.3; 3.6–9.8%)	At the EU/EEA level, the pooled ILI/ARI test positivity remained similar in week 29 (18%) to that in week 28 (16%). However, two countries contributed to 70% of the total number of tested samples. Clear increasing trends in SARS-CoV-2 test positivity in laboratory-based, non-sentinel data (from a mix of primary care and other sources, including hospital laboratories) were also observed in several other countries.
SARI rates in hospitals	SARI	9	10	–	–	
SARI test positivity in hospitals	Influenza	7	8	Pooled (median; IQR)	3.1% (0.7; 0–2.5%)	One country (Malta) reported a positivity of 26%, with similar increases also reflected in laboratory-confirmed, non-sentinel hospitalised cases. ECDC has contacted Malta to follow up on the unusually high inter-season positivity.
	RSV	7	7		0.3% (0; 0–0.2%)	
	SARS-CoV-2	6	7		9.4% (8.5; 3.5–18%)	At the EU/EEA level, the pooled SARI test positivity remained at the same level in week 29 as in week 28 (9%). Two countries contributed to 80% of the total number of tested samples, although in contrasting situations (test positivity: 1% versus 20%). In recent weeks, one other country has continuously reported increases in weekly, laboratory-confirmed, non-sentinel hospitalised cases. Three countries have reported small increases in laboratory-confirmed, non-sentinel deaths.
Intensity (country-defined)	Influenza	14	18	Distribution of country qualitative categories	13 Baseline 1 Low	
Geographic spread (country-defined)	Influenza	13	17	Distribution of country qualitative categories	8 No activity 5 Sporadic	

Figure 2. ILI/ARI virological surveillance in primary care - weekly test positivity

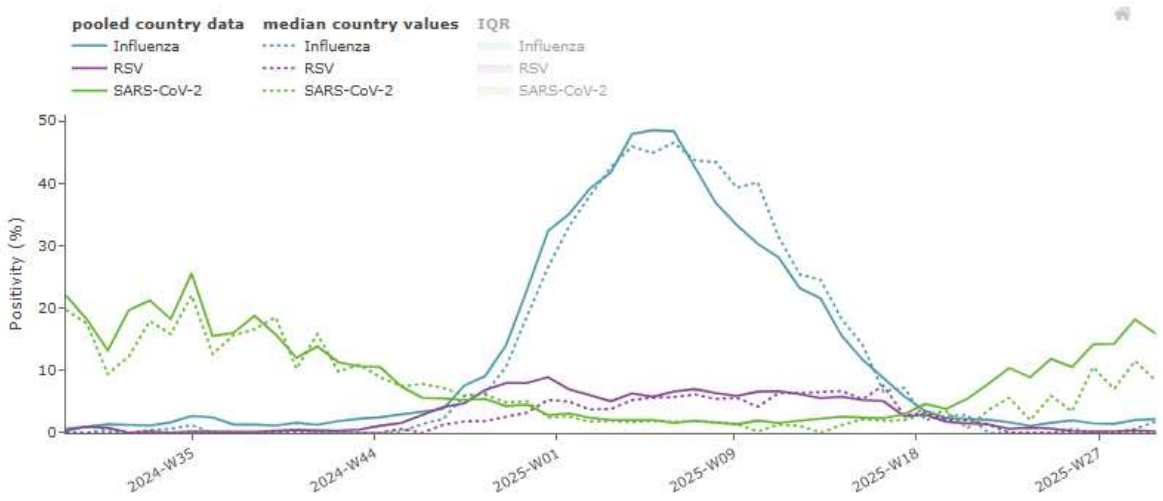


Figure 3. ILI/ARI virological surveillance in hospitals - weekly test positivity

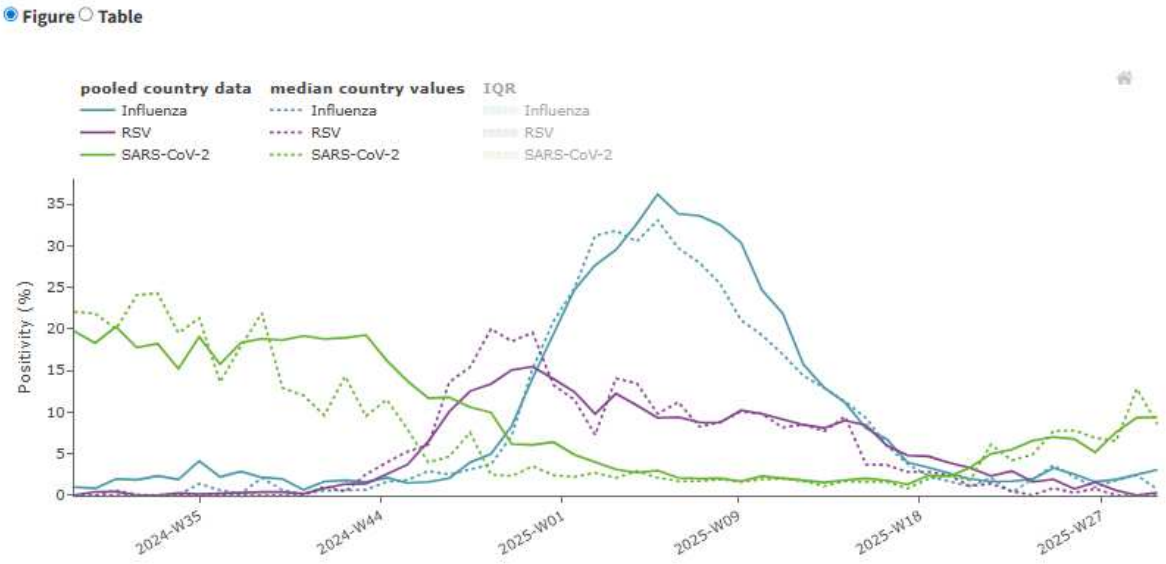


Figure 4. Genetically characterised influenza virus distribution, week 40, 2024 to week 29, 2025

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	5333	39	5a.2a(C.1.9)	3615	68
			5a.2a(C.1.9.3)	691	13
			5a.2a.1(D)	670	13
			5a.2a.1(D.3)	162	3
			5a.2a(C.1)	157	3
			Not assigned	38	–
A(H3)	4000	30	2a.3a.1(J.2)	3156	79
			2a.3a.1(J.2.2)	502	13
			2a.3a.1(J.2.1)	241	6
			2a.3a.1(J)	43	1
			2a.3a.1(J.1)	36	0.9
			2a.3a.1(J.4)	3	0.1
			Not assigned	19	–
B/Vic	4172	31	V1A.3a.2(C.5.1)	2376	57
			V1A.3a.2(C.5.7)	909	22
			V1A.3a.2(C.5.6)	772	19
			V1A.3a.2(C)	79	2
			V1A.3a.2(C.5)	17	0.4
			Not assigned	19	–

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

○ Figure ◉ Table

	Week 29, 2025		Week 40, 2024 – week 29, 2025	
Pathogen	N	%[a]	N	%[a]
Influenza	**20**	–	**13725**	–
Influenza A	17	100	5765	82
A(H1)pdm09	0	0.0	1720	60
A(H3)	1	100	1133	40
A (unknown)	16	–	2912	–
Influenza B	0	0.0	1266	18
B/Vic	0	–	168	100
B (unknown)	0	–	1098	–
Influenza untyped	3	–	6694	–
RSV	**2**	–	**5719**	–
RSV-A			751	48
RSV-B			805	52
RSV untyped	2	–	4163	–
SARS-CoV-2	**60**	–	**4496**	–

[a] *Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.*

Figure 6. ILI/ARI virological surveillance in primary care - pathogen type and subtype distribution

○ Figure ◉ Table

	Week 29, 2025		Week 40, 2024 – week 29, 2025	
Pathogen	N	%[a]	N	%[a]
Influenza	**13**	–	**25295**	–
Influenza A	12	92	15000	60
A(H1)pdm09	5	62	7228	57
A(H3)	3	38	5494	43
A (unknown)	4	–	2278	–
Influenza B	1	8	10033	40
B/Vic	0	–	4507	100
B/Yam	0	–	1	0.0
B (unknown)	1	–	5525	–
Influenza untyped	0	–	262	–
RSV	**1**	–	**4761**	–
RSV-A	0	–	863	44
RSV-B	0	–	1112	56
RSV untyped	1	–	2786	–
SARS-CoV-2	**85**	–	**3999**	–

[a] *Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.*

Figure 7. SARS-CoV-2 variant distribution, weeks 27–28, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	2	13	9% (9–10%)
XFG	VUM	2	96	64% (64–65%)
LP.8.1	VUM	2	24	13% (12–15%)
NB.1.8.1	VUM	2	15	10% (10–10%)

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

Overview

On 18 July 2025, WHO office for Western Pacific Region (WPRO) reported two new human cases of avian influenza A(H9N2) in China.

The first case was from Guangdong Province, with onset of symptoms on 28 May 2025. This is the third case reported in the province in 2025.

The second case was from Hubei Province, with onset of symptoms on 21 June 2025. This is the second case reported in the province in 2025.

Both cases have recovered without hospitalisation. They were known to have exposure to

poultry. The ages of the cases were not reported.

Background: Twenty-two human cases of influenza A(H9N2) virus infection have been reported in China in 2025 (four with symptom onset in late 2024), none of whom have reported epidemiological links to each other. Since 2015, a total of 132 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. In most cases, influenza A(H9N2) 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: 18 July 2025

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

Overview

On 21 July 2025, the Cambodian Ministry of Health reported one human case of avian influenza A(H5N1) virus infection in a child aged <10 years from Tbong Khmum Province. This is the first case in Tbong Khmum Province in 2025.

The patient developed symptoms including fever, cough, diarrhoea, vomiting, shortness of breath and difficulty breathing. He is currently receiving intensive medical care. According to the Ministry of Health, there were sick and dead chickens 100 metres from the patient's house, and frequent close contact was reported between the child and the birds.

The authorities are performing active outbreak investigation and contact tracing along with outbreak prevention measures following established protocols. Information on the clade of these cases is pending. Seven of the thirteen reported cases in Cambodia in 2025 have belonged to the 2.3.2.1e clade, the clade for the remaining cases is unknown.

As of 22 July 2025, there have been 13 human cases of avian influenza A(H5N1) infection reported in Cambodia in 2025, including six deaths. Since 2003, Cambodia has reported 85 human cases, including 49 deaths (CFR: 58%). However, it should be noted that the seroprevalence levels observed in exposed groups for A(H5) in 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_Preparedness_Prevention_and_control_related_to_zoonotic_avian_influenza. Preparedness, prevention and control related to zoonotic avian influenza).

In addition, on 1 July, WHO reported one human case of avian influenza A(H5N1) virus infection in a male from Karnataka State, India. Samples were collected from the patient in May 2025, and the patient later died. No details are available concerning the patient's exposure. The clade was reported as being 2.3.2.1a, known to circulate in birds in India.

This is the second human case of avian influenza A(H5N1) virus infection reported in India in 2025, and the third since 2003. The last case, reported in April 2025, was a child aged <5 years from Andhra Pradesh state who died from the infection. All three cases in India since 2003 have resulted in fatalities.

Summary

Since 2003, and as of 22 July 2025, there have been 988 human cases of avian influenza A(H5N1) infection worldwide*, including 474 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 (one), and the United Kingdom (four, one of which was 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.

Overall, the risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered low.

Direct contact with birds and other infected animals, their secretions or a contaminated environment is the most likely source of infection, and the use of personal protective measures for people exposed to dead animals or their secretions will minimise the associated risk. The recent severe cases in Asia and the Americas in children and people exposed to infected, sick or dead backyard poultry 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 is in contact with WHO counterparts for closer monitoring of the situation. 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: 18 July 2025

4. Suspected cholera - Poland - 2025

Overview

Summary

On 21 July 2025, the Polish National Public Health Authority reported a suspected case of cholera in the West Pomeranian Voivodeship. This statement came after several media reports describing a suspected case of cholera in an elderly woman in this region. The patient exhibited gastrointestinal symptoms and was treated at the district hospital in Stargard. She was later transferred to the provincial hospital in Szczecin and is reported as being in a stable condition. Laboratory tests confirmed the presence of Vibrio cholerae bacteria. To confirm that this is a case of cholera, laboratory tests are ongoing to assess if the bacteria are toxin-producing. The patient does not have any recent travel history outside of Poland.

Background

According to the Surveillance Atlas of Infectious Diseases (ATLAS), between 2007 and 2023, there was one case of cholera reported in Poland. The case (in 2019) had a travel history to a cholera-endemic country, India. Cholera is not endemic in the EU/EEA and the majority of the reported cases had acquired the infection abroad.

ECDC assessment

In the EU/EEA, cholera is a very rare and mainly travel-related disease. Further microbiological information is needed to determine whether this is a toxin-producing Vibrio cholerae.

Please see attached the ECDC cholera factsheet for more information on case definitions.

Actions

ECDC is in contact with the Polish authorities and continues to monitor the cholera epidemiological situation in the EU/EEA and worldwide. Further updates on the global cholera epidemiology are provided in the regular **monthly reports**.

5. Imported Oropouche virus disease cases - EU/EEA and UK - 2024/2025

Update

In 2025, Germany reported one imported case of Oropouche virus disease in a person who visited Dominica in the period 24 January 2025 to 7 February 2025, France reported one imported case in a person who visited Brazil until 1 March 2025 and the United Kingdom (UK) reported three imported cases in citizens who travelled from the UK to Brazil from February to April and returned to the UK in March-April 2025.

In 2024, 44 imported cases of Oropouche virus disease were reported in EU countries: Spain (23), Italy (8), Germany (3), France (7), Austria (1), Sweden (1) and the Netherlands (1). Forty-three cases had a travel history to Cuba and one to Brazil.

Oropouche virus disease is a zoonotic disease caused by the Oropouche virus (OROV). To date, outbreaks of OROV disease have been reported in several countries across South America, Central America and the Caribbean. During 2024, outbreaks have been reported in Brazil, Bolivia, Colombia, Peru, and more recently in Cuba. Oropouche virus is mainly transmitted to humans as a result of being bitten by infected midges, however some mosquitoes species can also spread the virus. The principal vector (Culicoides paraensis midge) is widely distributed across the Americas, but absent in Europe. To date, there has been a lack of evidence as to whether European midges or mosquitoes could transmit the virus. Oropouche virus disease can manifest as an acute febrile illness with headache, nausea, vomiting, muscle and joint pains, and occasionally more severe symptoms. The prognosis for recovery is good and fatal outcomes are extremely rare. There are no vaccines to prevent or specific medication to treat OROV disease. Direct, horizontal, human-to-human transmission of the virus has not been documented so far. The Brazilian Ministry of Health reported possible cases of OROV disease being passed from mother-to-child during pregnancy. The potential risk during pregnancy and foetopathic effects of OROV infection are still under investigation and have not been confirmed.

ECDC assessment

The likelihood of infection for EU/EEA citizens travelling to, or residing in epidemic areas of South and Central America is currently assessed as moderate. The likelihood of infection increases if travellers visit the more-affected municipalities of the northern states of Brazil and/or the Amazon region, and/or if personal protection measures are not taken. Given the good prognosis for recovery, the impact is assessed as low. The risk of infection for EU/EEA citizens travelling to OROV-epidemic countries in the Americas is therefore assessed as moderate.

Recent data indicate that OROV infection in pregnant women may lead to miscarriage, abortion and/or developmental problems, and deformities of the foetus. The impact of OROV infection for pregnant women, foetuses and new-borns could therefore be higher than for the general population, although this is still under investigation.

The likelihood of human exposure to OROV in the EU/EEA is considered very low, despite the possible importation of further OROV disease cases, as the competent vectors commonly described in the Americas are absent from continental Europe, and to date, no secondary transmission has ever been reported. Therefore, the risk of locally-acquired OROV disease in the EU/EEA is low.

Personal protective measures to reduce the risk of bites in epidemic areas include the use of repellent in accordance with the instructions indicated on the product label, wearing long-sleeved shirts and long trousers and using insecticide-treated fine mesh mosquito bed nets when resting. These measures are essential to provide protection against bites in rooms that are not adequately screened (with fine-mesh screens on doors and windows) or air-conditioned, and during outdoor activities.

Symptoms of OROV disease can be similar to other arboviral infections such as dengue, chikungunya virus disease, Zika virus disease, or malaria. The early detection of travel-associated cases can be enhanced by an increasing awareness among health professionals of travellers returning from areas with active OROV transmission, and adequate laboratory diagnostic capability. Laboratory testing for OROV should be performed when other tests for diseases of common aetiology return negative. In addition, travel medicine clinics should inform travellers to epidemic areas of the risks related to the disease and protective measures that can reduce the likelihood of infection. In addition, public health authorities should report new cases of OROV infection through Epipulse to enable a continuous assessment of the situation.

Due to the potentially high impact of congenital OROV infection, pregnant women planning to travel to epidemic countries where transmission is ongoing or has been reported should be provided with comprehensive information on the potential risk associated with OROV infection and prevention strategies. Areas affected by OROV are also classified as countries and territories with current or previous Zika virus (ZIKV) transmission, and travel advice for pregnant women related to ZIKV can also adequately address the potential risk associated with Oropouche virus disease. A link to the US-CDC recommendation, including information for pregnant women, can be found here.

Actions

ECDC issued a Threat Assessment Brief on 9 August 2024.

Last time this event was included in the Weekly CDTR: 18 July 2025.

6. Mass gathering monitoring – Jubilee of 2025 in Italy

Updates

On the occasion of the Jubilee of the Youth between 21 July and 8 August 2025, ECDC is conducting enhanced monitoring through its epidemic intelligence activities.

Since the beginning of the year, and as of 24 July 2025, the Lazio region has reported 21 confirmed cases of West Nile virus infection, including one death, all in the province of Latina. Of the other 20 cases, 12 patients are currently hospitalised, two of whom are in intensive care, two have been discharged and six are being treated at home.

For further information on West Nile Virus infection in Italy and other EU/EEA countries, please refer to our weekly report and ISS webpage. Please note that our weekly report includes notifications received up to Wednesday of the same week, so the numbers may differ.

Summary

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

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

ECDC assessment

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

The Jubilee is a mass gathering that comprises multiple events taking place throughout the year. Therefore, the context differs slightly from other mass gatherings. The general assessment provided below refers to the probability of EU/EEA citizens becoming infected with communicable diseases during the Jubilee. However, if specific public health events with potential impact at local, national and EU/EEA levels are identified, they will be assessed separately.

The probability of EU/EEA citizens becoming infected with communicable diseases during the Jubilee 2025 is low if general preventive measures are applied (e.g. being fully vaccinated according to national immunisation schedules, following advice regarding hand and food hygiene and respiratory etiquette, self-isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, seeking prompt testing and medical advice as needed, and practising safe sex). This is particularly important in relation to vaccine-preventable diseases that may be on the rise in the EU/EEA, such as measles, whooping cough, and COVID-19.

Actions

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

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

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

Update

Since the previous update and as of 24 July, no relevant public health events associated with infectious diseases have been detected in the context of the UEFA Women's Football EURO 2025.

Summary

Since the start of the monitoring period, no major public health events associated with infectious diseases have been detected in the context of the UEFA Women's Football EURO 2025.

On 15 July, media quoting the Swiss Football Federation (SFV) reported that some players on the Swiss national team had experienced influenza-like symptoms. No further cases have been reported among the players of other national teams.

Background

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

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

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

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

ECDC assessment

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

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

Actions

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

Last time this event was included in the Weekly CDTR: 18 July 2025

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

Overview

Since the beginning of 2025, and as of 23 July 2025, two countries in Europe have reported cases of Crimean-Congo haemorrhagic fever (CCHF): Greece (2) and Spain (2).

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

The cases in Spain are not unexpected, as CCHF virus is known to be circulating among animals in the province of Salamanca, in the autonomous community of Castile and León, and human CCHF cases have previously been reported in the area.

ECDC assessment

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

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

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

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

Last time this event was included in the Weekly CDTR: 18 July 2025

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

Overview

Since the beginning of 2025, and as of 23 July 2025, three countries in Europe have reported human cases of West Nile virus infection: **Greece**, **Italy** and **Romania**.

The report is available online.

Last time this event was included in the Weekly CDTR: 18 July 2025

10. Seasonal surveillance of dengue – 2025

Overview

Since the beginning of 2025 and as of 23 July 2025, three countries in Europe have reported cases of dengue: **Italy** (3), **Portugal** (2), and **France** (4).

This week, Italy reported two locally-acquired dengue cases in the province of Bologna in addition to the first case reported in week 29. In France, one case was reported from the Loire department in addition to the first case reported in week 29, and two further cases were reported in the Bouches-du-Rhône and Var departments, respectively. Locally-acquired dengue cases have been reported from Bouches-du-Rhône and Var departments in previous years. The two cases reported in January in Madeira, an outermost region† of Portugal, were probably transmitted in 2024.

† This report covers mainland EU/EEA, as well as outermost regions of Portugal and Spain.

ECDC assessment

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

Last time this event was included in the Weekly CDTR: 18 July 2025

11. Seasonal surveillance of chikungunya virus disease – 2025

Overview

Since the beginning of 2025 and as of 23 July 2025, two countries in Europe have reported cases of chikungunya virus disease: **Italy** (1) and **France** (38).

To date, in 2025, public health authorities in France have reported 38 cases of locally acquired chikungunya virus disease in 12 different local administrative units. Compared to the previous week, the number of clusters did not change. Two new cases were reported in the Corse-du-Sud cluster, one new case in Isère, one new case in Var and four new cases in Hérault departments, respectively. Ten clusters are currently classified as active. The largest cluster consists of 13 cases and is located in Salon-de-Provence, Bouches-du-Rhône department. This year, authorities reported the first locally acquired chikungunya virus disease cases from the Gironde department and the Bas-Rhin department. The other departments have reported locally acquired chikungunya virus disease or dengue cases in previous years.

Last week, Italy reported its first locally acquired chikungunya virus disease case since 2017, in the province of Piacenza. No new, locally acquired chikungunya virus disease cases were reported in Italy in week 30.

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: 18 July 2025.

12. Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update

Chikungunya virus disease (CHIKVD)

Since the beginning of 2025, and as of July, approximately 240 000 CHIKVD cases and 90 CHIKVD-related deaths have been reported in 16 countries/territories. Cases have been reported in the Americas, Africa, Asia, and Europe.

In EU (excluding the outermost regions), there have been 31 autochthonous cases of CHIKVD reported in 2025 from France (30) and Italy (1). In addition, over 54 000 CHIKVD cases have been reported from the French outermost region of Réunion as of 18 July 2025. Cases have been reported in all of the island's municipalities. The Level of the ORSEC 'Arboviruses' system has been downgraded to 2, which corresponds to the circulation of a moderate-intensity epidemic. In Mayotte, 1 098 autochthonous cases of CHIKVD have also been reported. Mayotte continues to be in the epidemic phase (phase 3 since 27 May 2025), which indicates intense and widespread transmission of the virus throughout the territory.

In 2025 to date, the Americas account for the highest number of CHIKVD cases reported worldwide. As of mid-July 2025 (data collected on 14-15 July 2025), the countries reporting the highest number of CHIKVD cases are Brazil (185 553), Bolivia (4 721), Argentina (2 836), and Peru (55). A complete list of the countries of the Americas reporting CHIKVD cases can be found on PAHO's dedicated website.

As of beginning of July 2025, over 34 000 CHIKVD cases were reported in Asia from India, Sri Lanka, Mauritius, Pakistan, and China. In Africa, CHIKVD cases in 2025 have been reported by Senegal and Kenya. EU/EEA countries have reported imported cases from other African countries, e.g. Madagascar and the Seychelles, possibly indicating more widespread circulation of chikungunya in the Indian Ocean region (Arbovirosi • bollettini periodici arbovirosi, Arboviruses Report 16 July 2025 Sante Publique France).

Dengue

Since the beginning of 2025, 3.6 million dengue cases and over 1 900 dengue-related deaths have been reported from 94 countries/territories in the WHO Region of Europe (EURO), the Regions of the Americas (PAHO), South-East Asia and West Pacific (SEARO and WPRO, respectively), in the Eastern Mediterranean WHO Region (EMRO) and in Africa.

In the EU/EEA (excluding the outermost regions), four autochthonous cases have been reported in France and three in Italy in 2025. Cases have also been reported from the EU outermost regions.

In Madeira, two locally acquired cases were reported on 18 February, with symptom onset early January 2025. In the third week of January, entomological investigations confirmed the presence of dengue in mosquitoes captured on Madeira.

In Guadeloupe, the current situation is classified as an epidemic of phase 2 level 1 (isolated outbreaks) (Epidemiological Bulletin of French Antilles, 26 June 2025). The decreasing trend observed since earlier in the year continued into June. The most prevalent serotype continues to be DENV-3 (Epidemiological Bulletin of French Antilles, 26 June 2025). In Martinique, the epidemiological situation is characterised as phase 1 (sporadic cases reported; Epidemiological Bulletin of French Antilles, 26 June 2025). The classification was modified in April, following a decrease in reported cases since March (Epidemiological Bulletin of French Antilles, 3 April 2025)). In Saint Martin and Saint Barthélemy, dengue circulation continues, but at lower levels (epidemic phase 1), with no confirmed cases reported for either of the islands (Epidemiological Bulletin of French Antilles, 26 June 2025). In French Guiana, case numbers have decreased in recent months and are displaying a stable trend at lower levels with an average of four cases per week (Health surveillance in French Guiana. Bulletin of 10 July 2025). The serotype identified in the last two weeks was exclusively DENV-2. In Mayotte, 28 dengue cases have been reported this year as of the beginning of July (Chikungunya et dengue à Mayotte Bulletin du 4 July 2025.). This trend indicates a sporadic viral circulation, stable for the moment. In Reunion, 44 dengue cases, 17 of them confirmed, have been reported since the beginning of the year and as of 11 July 2025 (Health surveillance in Reunion Island. Bulletin of 11 July 2025). The most recent autochthonous case was identified in week 17 of 2025 (end of April).

A summary of recent epidemiological trends in dengue outside the EU/EEA for the first half of 2025 is presented below. The summary is based on available information from official sources and reports from different countries/territories.

In the WHO PAHO Region, as of week 25 of 2025, over 3.3 million cases have been reported, 40% of which have been laboratory confirmed. Since the peak, the decreasing trend observed since weeks 12-14 has continued. The number of cases currently reported is 70% less compared to the number of cases reported during the same period in 2024 and is 11% above the average for the last five years, according to the WHO PAHO report published on 10

July 2025. While all serotypes have been reported as of week 25 of 2025, their distribution varies in the different countries of PAHO (Report on the epidemiological situation of dengue in the Americas).

According to the SEARO report published on 16 July 2025, there has been an increasing trend in dengue cases in Bangladesh (2 609 new cases reported for the week 7-13 July) compared to 2 404 cases reported during the week of 30 June - 6 July. The total of cases reported so far in 2025 in Bangladesh is lower than the total reported during the same period in 2024.

India continues to report cases of dengue. A recent increase has been noted in Kerala (566 cases reported during the week 30 June - 6 July, with lower levels reported in Karnataka (183 cases for the same week). In both areas the cases are lower than for the same period last year. In the SEARO region, based on the same report, cases of dengue have also been reported by Thailand, Sri Lanka, Nepal and the Maldives. However, in all countries the circulation is at levels similar to or lower than those observed during the same period last year.

In Laos, Viet Nam and Singapore, so far in 2025 dengue cases have been lower than those reported in 2024 (Laos: 2 614 cases as of 28 June 2025; Vietnam: 28 787 cases and five deaths as of 22 June 2025; Singapore: 2 585 cases as of 28 June 2025 WPRO Dengue Situation update of 10 July 2025). In China, 563 cases were reported in the first half of 2025, which is higher than the total number of cases in June 2024 (130).

In Afghanistan (WHO EMRO region), in 2025 the number of suspected dengue fever cases has increased since week 15 of 2025 (mid-April), with 595 cases reported as of 21 June 2025.

Since the beginning of 2025, in Africa, over 8 700 cases and seven deaths have been reported from Burkina Faso, Cabo Verde, Comoros, Guinea, Kenya, Mali, Mauritius, Nigeria, Senegal and Sudan (Africa CDC Epidemic Intelligence Report of 15 July 2025).

Note: the data presented in this report originate from both official public health authorities and non-official sources, such as news media, and depending on the source, autochthonous and non-autochthonous cases may be included. Data completeness depends on the availability of reports from surveillance systems and their accuracy, which varies between countries. All data should be interpreted with caution and comparisons, particularly across countries, should be avoided due to under-reporting, variations in surveillance system structure, different case definitions from country to country and over time, and use of syndromic definitions.

ECDC assessment

The likelihood of onward transmission of dengue and chikungunya virus in mainland Europe is linked to importation of the virus by viraemic travellers into receptive areas with established and active competent vectors (e.g. Aedes albopictus and Aedes aegypti). Aedes albopictus is established in a large part of Europe. In Europe and neighbouring areas, Aedes aegypti is established in Cyprus, on the eastern shores of the Black Sea, and in the outermost region of Madeira.

The environmental conditions in the areas of mainland Europe where Ae. albopictus or Ae. aegypti are established are currently favourable for mosquito activity and virus replication in mosquitoes. For the risk related to chikungunya and dengue in mainland EU/EEA, please see the dedicated webpages: Chikungunya virus disease risk assessment for mainland EU/EEA and Dengue risk assessment for mainland EU/EEA.

More information on autochthonous transmission of chikungunya and dengue virus in 2025 in the EU/EEA is available on ECDC's webpages, and in ECDC's factsheets on dengue and CHIKVD.

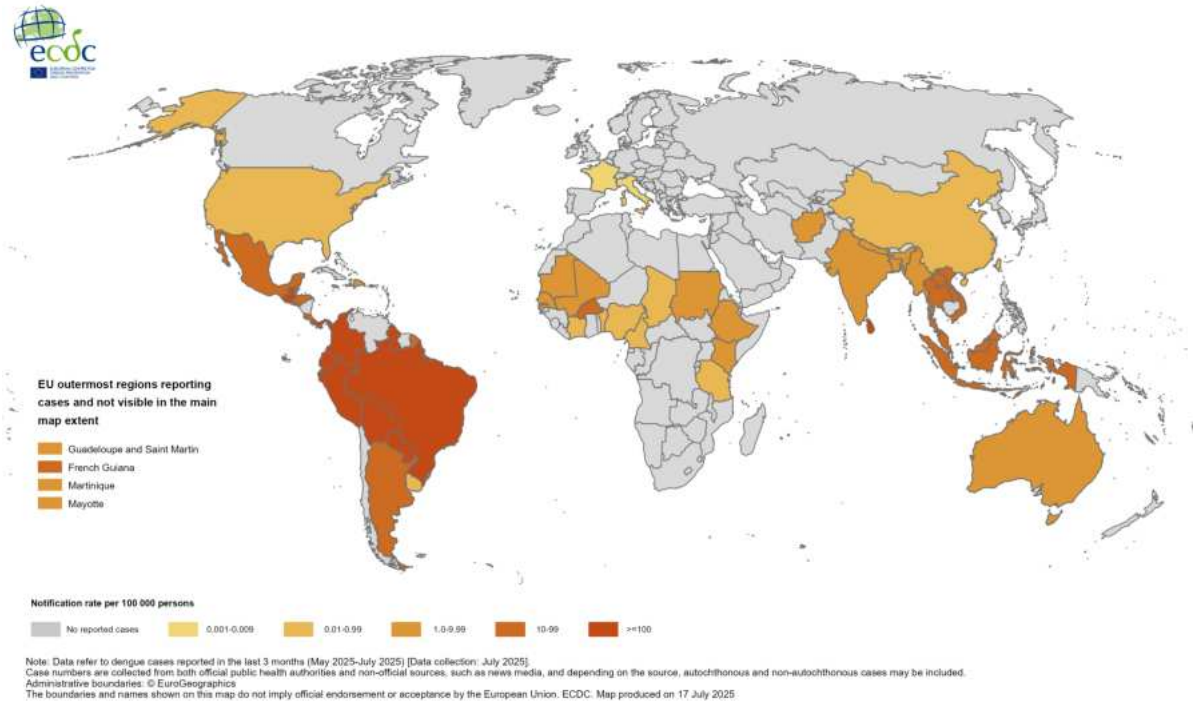
Actions

ECDC monitors these threats through its epidemic intelligence activities, and reports on a monthly basis. A summary of the worldwide overview of **dengue** and **CHIKVD** is available on ECDC's website.

Last time this event was included in the Weekly CDTR: 21 July 2025

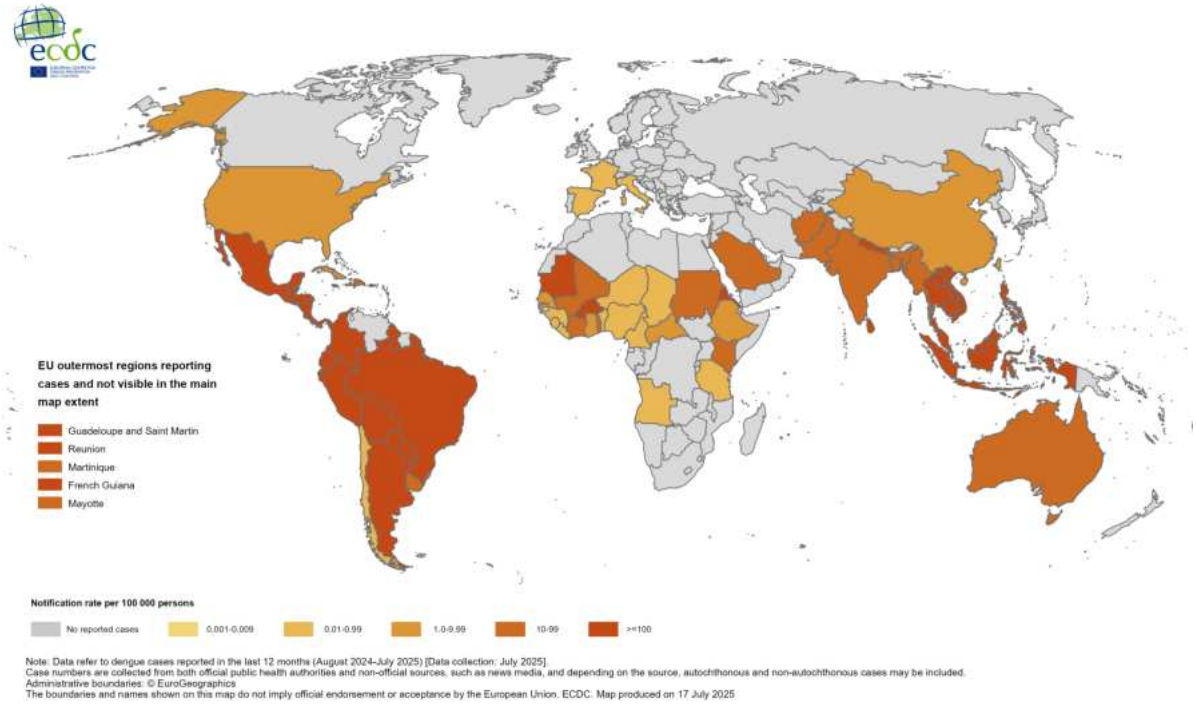
Maps and graphs

Figure 1. Three-month dengue virus disease case notification rate per 100 000 population, May-July 2025



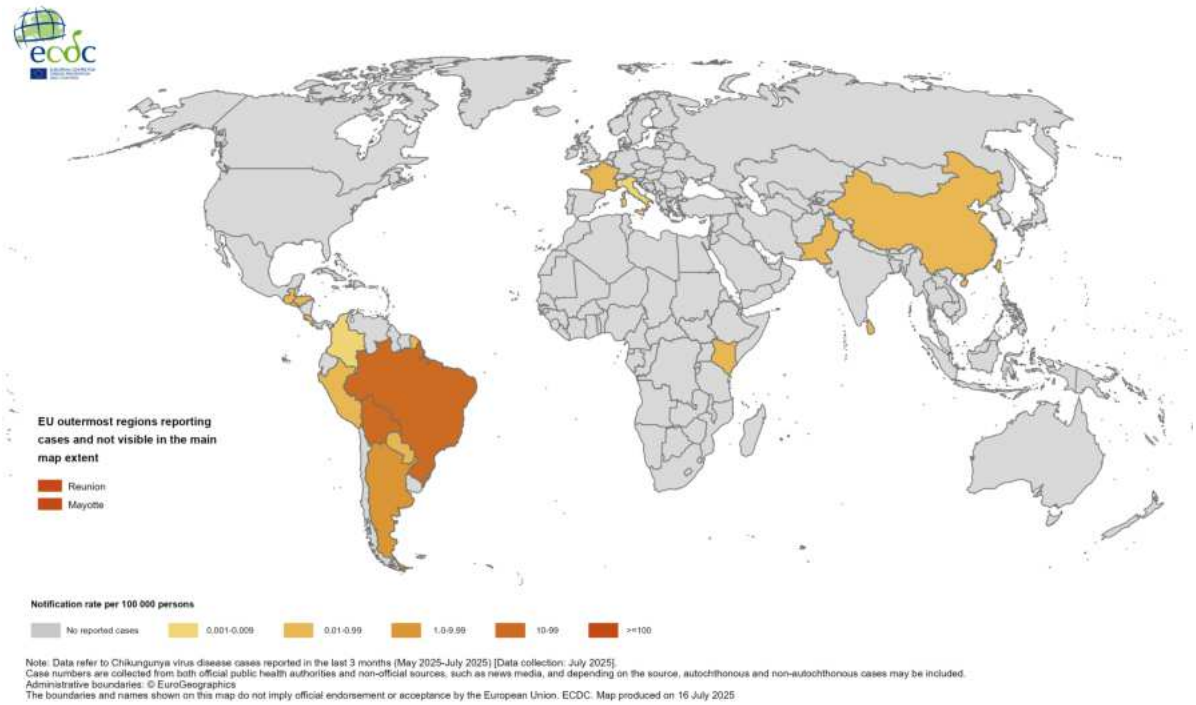
Source: ECDC

Figure 2. 12-month dengue virus disease case notification rate per 100 000 population, August 2024-July 2025



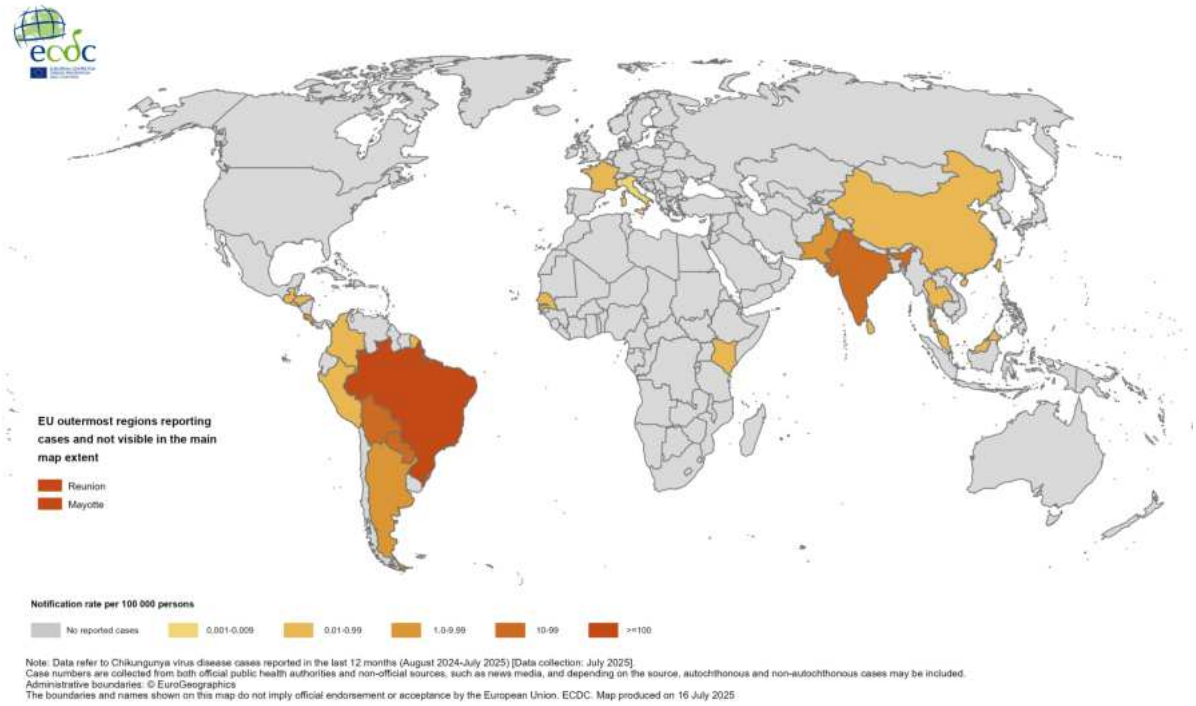
Source: ECDC

Figure 3. Three-month Chikungunya virus disease case notification rate per 100 000 population, May-July 2025



Source: ECDC

Figure 4. 12-month Chikungunya virus disease case notification rate per 100 000 population, August 2024-July 2025



Source: ECDC

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 25 July 2025
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 25 July 2025
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 25 July 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 25 July 2025
- Imported Oropouche virus disease cases - EU/EEA and UK - 2024/2025 - last reported on 25 July 2025
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025 - last reported on 25 July 2025
- Seasonal surveillance of dengue – 2025 - last reported on 25 July 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 25 July 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 25 July 2025
- Mass gathering monitoring - UEFA Women's EURO 2025 - Switzerland - 2025 - last reported on 25 July 2025
- Suspected cholera - Poland - 2025 - last reported on 25 July 2025
- Mass gathering monitoring – Jubilee of 2025 in Italy - last reported on 25 July 2025
- Serious adverse events to IXCHIQ chikungunya virus disease vaccine - last reported on 18 July 2025
- Nipah virus disease – India – 2025 - last reported on 18 July 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 18 July 2025.