WEEKLY BULLETIN

Communicable disease threats report

Week 27, 28 June to 4 July 2025

This week's topics

Executive Summary

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

- On 3 July 2025, the Cambodian Ministry of Health reported one human case of avian influenza A(H5N1) virus infection in a five-year-old boy from Kampot Province. The patient is currently receiving intensive medical care.
- The case had known exposure to sick or dead poultry prior to the onset of symptoms.
- Outbreak investigation, contact tracing, and preventive measures are ongoing.
- The ECDC risk assessment for A(H5N1) remains unchanged.
- Since 2003, and as of 3 July 2025, there have been 985 confirmed human cases of A(H5N1) worldwide, including 473 deaths.

Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update

- Since the previous update on 3 June 2025, and as of 2 July 2025, no new MERS cases have been reported by the World Health Organization (WHO) or national health authorities.
- Since the beginning of 2025, and as of 2 July 2025, 10 MERS cases, including two fatalities, have been reported with date of onset in 2025 in Saudi Arabia.
- The risk of sustained human-to-human transmission in Europe remains very low, and the current MERS-CoV situation poses a low risk to the EU/EEA.

SARS-CoV-2 variant classification

- Since the last update on 28 May 2025, and as of 27 June 2025, **XFG** was added as a **variant under monitoring (VUM)**, and KP.3 (formerly VOI) and XEC (formerly VUM) were de-escalated.
- Note that for this update, sufficient data for estimating variant proportions during the reporting weeks is only available from three EU/EEA countries. The statistics below therefore only represent a limited part of the EU/EEA.
- The VOI and VUM median proportions in the EU/EEA for weeks 23–24, based on three reporting countries, are currently:

  - BA.2.86 (VOI): 22.6% (range: range: 14.0–26.7%)
  - LP.8.1 (VUM): 32.4% (range: 26.7–35.5%)
  - NB.1.8.1 (VUM): 9.7% (range: 8.9–13.3%)
  - XFG (VUM): 33.3% (range: 25.8–39.7%)

Overview of respiratory virus epidemiology in the EU/EEA

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

Circulating vaccine-derived poliovirus type 2 (cVDPV2) – multi-country – 2024–25

- A genetic cluster of vaccine-derived polioviruses type 2 (cVDPV2) has been detected from wastewater samples collected in Europe (the United Kingdom (UK), Finland, Germany, Spain and Poland) during 2024 and the beginning of 2025.
- Germany has reported new detections of cVDPV2 in multiple environmental samples in 2025.
- The cluster shows a degree of genomic diversity that better supports the hypothesis of multiple introductions than a single introduction with local transmission within the EU. However, the large geographical spread in the EU/EEA, the fact that detections occurred over several months, and the identification of specific genetic sub-clusters suggest at least some degree of local transmission.
- No cases of poliomyelitis have been reported.
- Public health authorities in these countries have intensified surveillance and efforts to provide recommended vaccinations against poliovirus in accordance with national schedules.
- Given the presence of non-vaccinated or under-vaccinated population groups in European countries, and the fact that poliomyelitis has not been eradicated globally, the risk of the virus being reintroduced into Europe remains.

Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025

- Since the beginning of 2025 and as of 2 July 2025, two countries in Europe reported cases of Crimean-Congo haemorrhagic fever (CCHF): Greece (2) and Spain (1).
- Greece reported a secondary case in a healthcare professional who provided care to the patient that the primary case occured in.

Weekly seasonal surveillance of West Nile virus infection – 2025

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

Seasonal surveillance of chikungunya virus disease – 2025

- Since the beginning of 2025, and as of 2 July 2025, France is the only country in Europe that has reported cases of chikungunya virus disease (14 cases in seven clusters).

Publication of public health guidance for assessing and mitigating the risk of locally-acquired Aedes-borne viral diseases in the EU/EEA and update of Aedes albopictus and Aedes aegypti distributions

- ECDC has published public health guidance for assessing and mitigating the risk of locally-acquired *Aedes*-borne viral diseases in the EU/EEA and updated the distribution maps of *Aedes albopictus* and *Aedes aegypti*.

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

Overview:

On 3 July 2025, the Cambodian Ministry of Health reported one human case of avian influenza A(H5N1) virus infection in a five-year-old boy from Kampot Province. (https://www.facebook.com/MinistryofHealthofCambodia). This is the first case in Kampot Province in 2025 and the fourth since 2023.

The patient developed symptoms including fever, cough, 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 at 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.

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

As of 3 July 2025, there have been 12 human cases of avian influenza A(H5N1) infection reported in Cambodia in 2025, including six deaths. Since 2003, Cambodia has reported 84 human cases, including 49 deaths (CFR: 58%). 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-nfluenza.PDF).

Summary:
Since 2003, and as of 3 July 2025, there have been 985 human cases of avian influenza A(H5N1) infection worldwide*, including 473 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 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: 27 June 2025

2. Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update

Overview:

Update: Since the previous update on 3 June 2025, and as of 2 July 2025, no new MERS cases have been reported by the World Health Organization (WHO) or national health authorities.

WHO has developed a global comprehensive dashboard displaying key variables and summary statistics of MERS human cases reported by Member States through International Health Regulations (IHR).

Summary: Since the beginning of 2025, and as of 2 July 2025, 10 MERS cases, including two fatalities, have been reported with date of onset in 2025 in Saudi Arabia.

Since April 2012, and as of 2 July 2025, a total of 2 638 cases of MERS, including 957 deaths, have been reported by health authorities worldwide.

Sources: ECDC MERS-CoV page | WHO MERS-CoV | ECDC factsheet for professionals | Qatar MoPH Case #1 | Qatar MoPH Case #2 | FAO MERS-CoV situation update | WHO DON Oman | WHO DON Saudi Arabia | WHO DON UAE | WHO DON Saudi Arabia 1 | WHO IHR | WHO EMRO MERS Situation report | WHO DON Saudi Arabia 2 | WHO DON Saudi Arabia 3 | WHO DON Saudi Arabia 4 | WHO DON Saudi Arabia 5

ECDC assessment:

Human cases of MERS continue to be reported in the Arabian Peninsula. However, the number of new cases detected and reported through surveillance has dropped to the lowest levels since 2014. The risk of sustained human-to-human transmission in Europe remains very low. The current MERS-CoV situation poses a low risk to the EU/EEA, as stated in the Rapid Risk Assessment published by ECDC on 29 August 2018, which also provides details on the last person reported with the disease in Europe.

ECDC published a technical report, 'Health emergency preparedness for imported cases of high-consequence infectious diseases', in October 2019 that is still useful for EU Member States wanting to assess their level of preparedness for a disease such as MERS. ECDC also published 'Risk assessment guidelines for infectious diseases transmitted on aircraft (RAGIDA) – Middle East respiratory syndrome coronavirus (MERS-CoV)' on 22 January 2020.

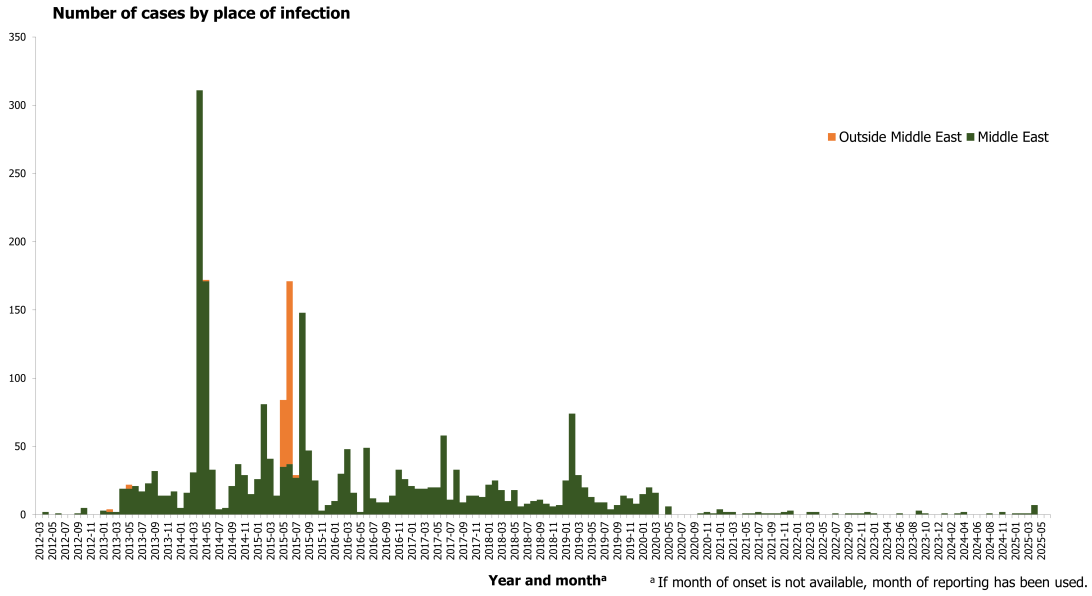
Actions:

ECDC is monitoring this situation through its epidemic intelligence activities, and reports on a monthly basis or when new epidemiological information is available.

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

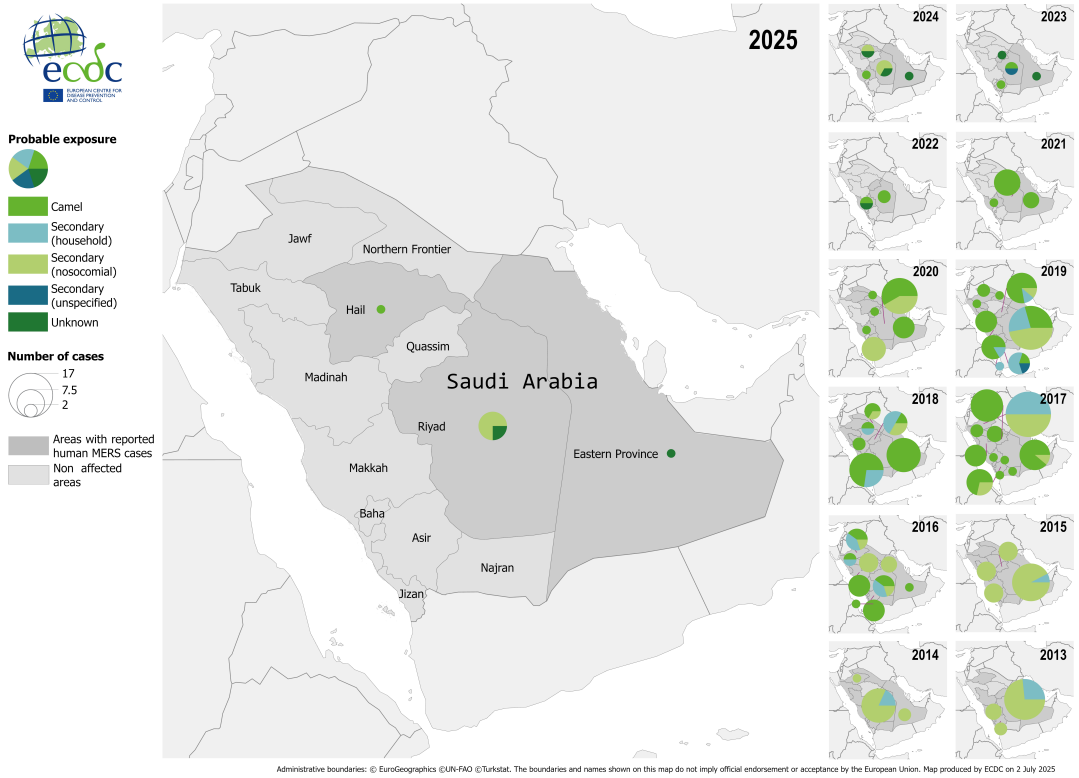
Maps and graphs

Figure 1. Distribution of confirmed cases of MERS by place of infection and month of onset, April 2012 to June 2025



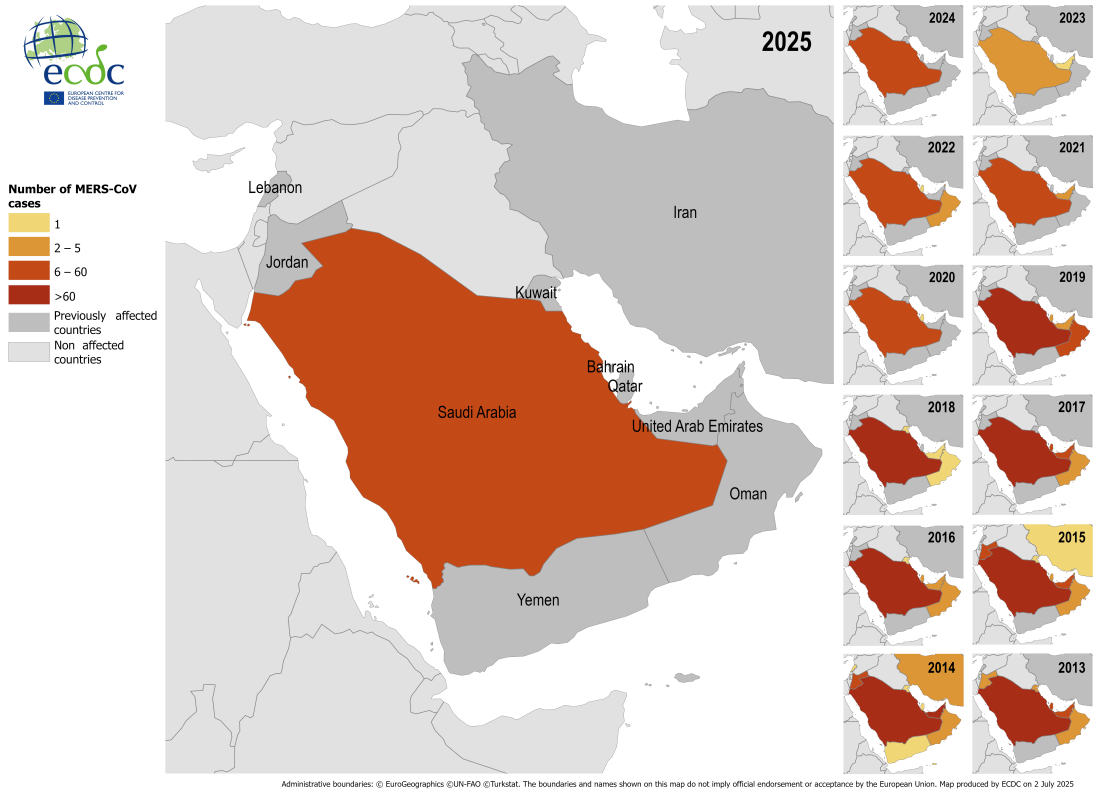
Source: ECDC

Figure 2. Geographical distribution of confirmed cases of MERS in Saudi Arabia by probable region of infection and exposure, with dates of onset from January 2013 to June 2025



Source: ECDC

Figure 3. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2013 to June 2025



Source: ECDC

3. SARS-CoV-2 variant classification

Overview:

Since the last update on 28 May 2025, and as of 27 June 2025, **the following changes** have been made to ECDC variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs) and de-escalated variants:

- **XFG** was added as a **variant under monitoring (VUM)**
- KP.3 (formerly VOI) was de-escalated
- XEC (formerly VUM) was de-escalated

XFG is a descendent of LF.7, which in turn descended from BA.2.86 sub-lineage JN.1. VUM classification is based on evidence of an increased growth rate, relative to other circulating variants, globally, and in the EU/EEA. While this VUM classification serves to highlight the evolution of a SARS-CoV-2 variant that is outcompeting other strains, it is too early to assess if XFG will have any substantial epidemiological impact in the EU/EEA, with current SARS-CoV-2 circulation at low levels. There is currently no evidence of increased severity for XFG and no significant impact on vaccine effectiveness against severe disease is anticipated for currently available vaccines, although further laboratory and clinical studies are awaited [1].

The VOI median proportions in the EU/EEA for weeks 23–24, based on three reporting countries, are currently:

BA.2.86: 22.6% (three reporting countries; range: 14.0–26.7%; IQR:18.3–24.6%)

The VUM median proportions in the EU/EEA for weeks 23–24, based on three reporting countries, are currently:

LP.8.1: 32.4% (range: 26.7–35.5%, IQR: 29.5–33.9%)
NB.1.8.1: 9.7% (range: 8.9–13.3%, IQR: 9.3–11.5%)
XFG: 33.3% (range: 25.8–39.7%, IQR: 29.6–36.5%)

The calculations are based on data reported to GISAID, as of **22 June 2025**. Note that for this update, sufficient data for estimating variant proportions during the reporting weeks is only available from **three** EU/EEA countries. The statistics therefore only represent a limited part of the EU/EEA.

ECDC assessment:

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation.

The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. The variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and individuals who have previously not been infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (e.g. older adults) remains important.

Actions:

In order to assess the impact of emerging SARS-CoV-2 sub-lineages and their possible correlation with increases in COVID-19 epidemiological indicators, it is important that countries sequence positive clinical specimens and report to GISAID and/or TESSy.

For the latest update on SARS-CoV-2 variant classifications, please see ECDC's webpage on variants. Variant surveillance data, including the distribution of VOC and VOI proportions in the EU/EEA and detailed country-specific COVID-19 updates are available as part of the European Respiratory Virus Surveillance Summary (ERVISS).

Routine updates on the SARS-CoV-2 variant classification through the Communicable Diseases Threats Report (CDTR) will be provided on a monthly basis at a minimum.

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

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

Overview:

Based on data reported in week 26, 2025, primary care consultation rates for influenza-like illness (ILI), acute respiratory infection (ARI) and severe acute respiratory infection (SARI) remained at baseline levels in all reporting EU/EEA countries.

Pooled EU/EEA test positivity for SARS-CoV-2 has been slowly increasing in primary care virological specimens since week 9, 2025, mainly in individuals 15 years old and above, with trends aligning very closely with what was observed at the same time last year. Similar trends have been observed from non-sentinel, laboratory-based surveillance systems.

Two countries reported small increases in laboratory-confirmed hospitalised cases for at least three consecutive weeks and one country showed an increasing trend only in laboratory-confirmed deaths in recent weeks.

EuroMOMO has not reported signals of excess reports of all-cause mortality.

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 infections have been observed in many countries, although the overall number of infections 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 difficult.

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

Actions:

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

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

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.

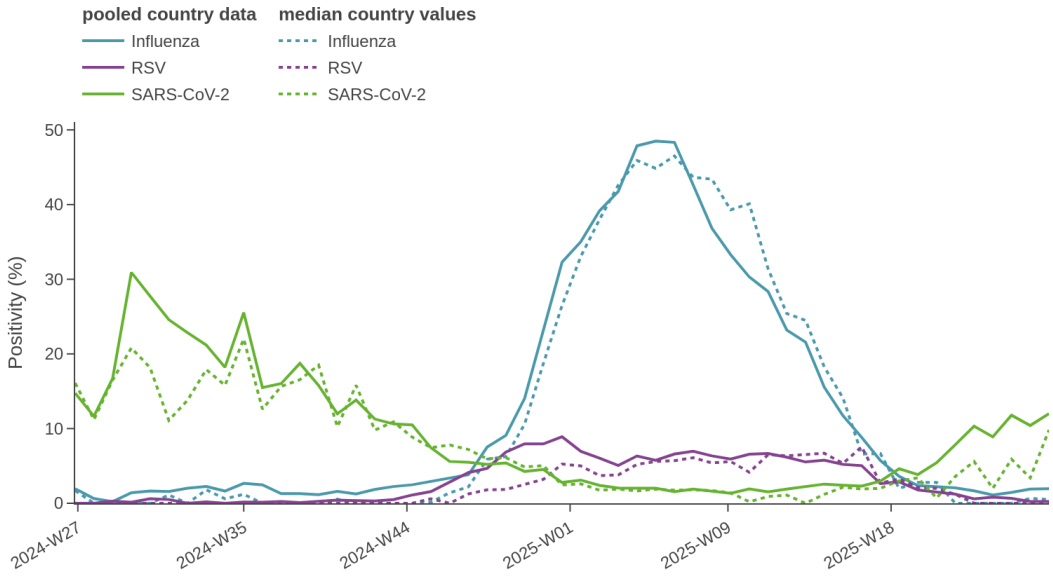
Countries should ensure that infection prevention and control practices in healthcare settings are implemented. Wearing masks in settings such as high-risk wards and long-term care facilities can help protect populations at high risk of severe disease.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 27 June 2025

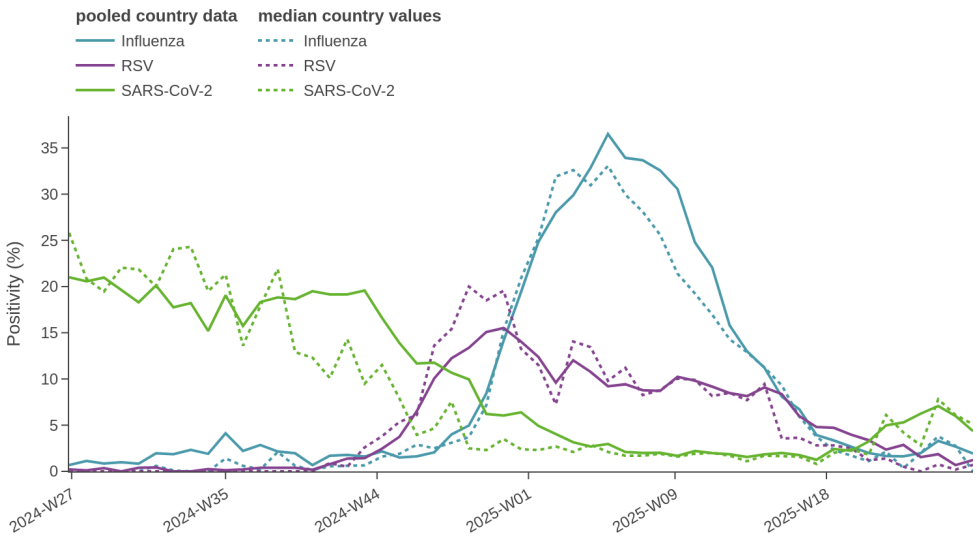
Maps and graphs

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 26, 2025

		Reporting countries		EU/EEA summary		
Indicator	**Syndrome or pathogen**	**Week 26**	**Week 25**	**Description**	**Value**	**Comment**
ILI/ARI consultation rates in primary care	ARI	10 rates (7 MEM)	13 rates (9 MEM)	Distribution of country MEM categories	7 Baseline	
	ILI	13 rates (12 MEM)	16 rates (14 MEM)		12 Baseline	
ILI/ARI test positivity in primary care	Influenza	12	14	Pooled (median; IQR)	1.9% (0.5; 0–4.8%)	
	RSV	9	11		0.2% (0; 0–0%)	
	SARS-CoV-2	10	13		12% (9.8; 6.2–13%)	At the EU/EEA level, the overall pooled SARS-CoV-2 positivity has been slowly increasing since week 9, mainly in those 15 years old and above. While the pooled ILI/ARI test positivity rate remained stable in week 26 (12%) when compared to week 25 (10%), several countries report increasing trends in SARS-CoV-2 test positivity in non-sentinel, laboratory-based data (from a mix of primary care and other sources, including hospital laboratories).
SARI rates in hospitals	SARI	9	10	–	–	
SARI test positivity in hospitals	Influenza	7	8	Pooled (median; IQR)	1.9% (0; 0–3.7%)	
	RSV	7	7		1.2% (0.7; 0–1.8%)	
	SARS-CoV-2	6	7		4.4% (5.1; 0.6–9.7%)	The pooled SARI test positivity rate decreased in week 26 (4%) when compared with week 25 (7%), driven primarily by patients 65 years old and above. Two countries have reported small increases from low levels in weekly, non-sentinel, laboratory-confirmed hospitalised cases and one country has reported small increases in non-sentinel, laboratory-confirmed deaths in recent weeks.
Intensity (country-defined)	Influenza	15	19	Distribution of country qualitative categories	13 Baseline 2 Low	
Geographic spread (country-defined)	Influenza	14	18	Distribution of country qualitative categories	8 No activity 6 Sporadic	

Source: ECDC

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

		Week 26, 2025	Week 40, 2024 - week 26, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**10**	**-**	**25284**	**-**
Influenza A	8	89	14982	60
A(H1)pdm09	8	100	7208	57
A(H3)	0	0.0	5485	43
A (unknown)	0	–	2289	–
Influenza B	1	11	10040	40
B/Vic	0	–	4490	100
B/Yam	0	–	1	0.0
B (unknown)	1	–	5549	–
Influenza untyped	1	–	262	–
RSV	**1**	**-**	**4764**	**-**
RSV-A	0	–	858	44
RSV-B	0	–	1109	56
RSV untyped	1	–	2797	–
SARS-CoV-2	**53**	**-**	**3702**	**-**

Source: ECDC

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

Figure Table

		Week 26, 2025	Week 40, 2024 - week 26, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**13**	**-**	**13668**	**-**
Influenza A	12	100	5728	82
A(H1)pdm09	2	100	1718	60
A(H3)	0	0.0	1127	40
A (unknown)	10	-	2883	-
Influenza B	0	0.0	1263	18
B/Vic	0	-	168	100
B (unknown)	0	-	1095	-
Influenza untyped	1	-	6677	-
RSV	**8**	**-**	**5654**	**-**
RSV-A	1	50	744	48
RSV-B	1	50	806	52
RSV untyped	6	-	4104	-
SARS-CoV-2	**29**	**-**	**4245**	**-**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 26, 2025

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	5315	40	5a.2a(C.1.9)	3609	68
			5a.2a(C.1.9.3)	691	13
			5a.2a.1(D)	658	12
			5a.2a.1(D.3)	162	3
			5a.2a(C.1)	157	3
			Not assigned	38	-
A(H3)	3979	30	2a.3a.1(J.2)	3135	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	4146	31	V1A.3a.2(C.5.1)	2368	57
			V1A.3a.2(C.5.7)	906	22
			V1A.3a.2(C.5.6)	764	19
			V1A.3a.2(C)	72	2
			V1A.3a.2(C.5)	17	0.4
			Not assigned	19	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 24–25, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	4	32	16% (10–21%)
XFG	VUM	4	84	30% (25–36%)
LP.8.1	VUM	4	84	28% (20–35%)
NB.1.8.1	VUM	4	34	16% (11–21%)

Source: ECDC

5. Circulating vaccine-derived poliovirus type 2 (cVDPV2) – multi-country – 2024–25

Overview:

Update: On 3 July 2025, public health authorities in Germany published an epidemiological report that mentions several recent detections of poliovirus type 2 in wastewater samples across several federal states.

According to the report, circulating vaccine-derived polioviruses type 2 (cVDPV2), have been detected in samples collected in 2025 from:

- Dresden during weeks 17, 19, 21 and 23
- Mainz during weeks 15 and 19
- Munich during weeks 21, 22 and 23
- Stuttgart during week 21

All the sequenced viruses closely match the cluster identified in several European countries (Spain, Poland, Germany, Finland and the UK) at the beginning of 2025.

As of 3 July 2025, no clinical cases of poliomyelitis have been reported in the EU/EEA, and sustained human-to-human transmission within Germany has not been confirmed. However, given the prolonged duration of the outbreak and the repeated detection of circulating vaccine-derived poliovirus type 2 (cVDPV2) in multiple environmental samples, there is increasing probability of localised transmission of cVDPV2.

Background:
Finland, Germany, Poland, Spain and the UK reported detections of cVDPV2 in wastewater samples in 2024.

Spain reported the detection of cVDPV2 in Catalonia in wastewater samples collected in mid-September 2024 from the Barcelona Metropolitan area.

Polish public health authorities published a press release on 18 November 2024 reporting the presence of cVDPV2 in a municipal wastewater sample taken in Warsaw.

On 28 November 2024, the public health authorities in Germany reported detections of cVDPV2 in wastewater samples from four different cities (Munich, Bonn, Cologne and Hamburg). In the epidemiological bulletin of 5 December 2024, published by the Robert Koch Institute, it was reported that cVDPV2 was detected in three more sites (Dresden, Dusseldorf and Mainz).

On 9 December 2024, Finnish public health authorities reported that cVDPV2 was detected in wastewater samples in Tampere.

On 10 December 2024, the UK reported that cVDPV2 was detected in Leeds, London and West Essex.

ECDC assessment:

This cluster highlights the importance of continued surveillance and efforts to close existing immunisation gaps.

No cases of paralysis have been reported in any of the countries with environmental cVDPV2 detections.

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

Recommendations
To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake in pockets of under-immunised populations.

Specific focus should be given to ensure protection of children, including the timely administration of polio-containing vaccine in the primary vaccination, which is given in EU/EEA countries as part of routine vaccination programmes.

In addition, as part of immunisation efforts and in order to protect the most vulnerable, children and individuals of all ages that enter the EU/EEA should be evaluated on their vaccination status, and vaccination should be offered if they are assessed as under-immunised.

EU/EEA countries should review their polio vaccination coverage data, including at subnational levels, 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.

Acute flaccid paralysis (AFP) surveillance is the gold standard for detecting polio cases and is essential for global polio eradication. This includes case finding, sample collection, laboratory analysis and mapping of the virus to determine the origin of the virus strain. The examination of composite human faecal samples through environmental surveillance links poliovirus isolates from unknown individuals to populations served by the wastewater system. Testing for wild polio virus (WPV) and vaccine-derived poliovirus (VDPV) in sewage water can provide valuable supplementary information, particularly in urban populations where AFP surveillance is absent or questionable, persistent virus circulation is suspected, or frequent virus re-introduction has been identified (see WHO guidelines).

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 schedules.

ECDC links: ECDC comment on risk of polio in Europe | ECDC risk assessment

Actions:

ECDC is in contact with the affected Member States and WHO. ECDC has posted a news item and a rapid risk assessment regarding the recent wastewater detections.

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

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

Overview:

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

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

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

ECDC assessment:

From 2016 to 2024, a total of 16 autochthonous CCHF cases have been reported in Spain with dates of disease onset between April and August. The province of Salamanca is a hotspot for CCHF, with 50% of the cases being exposed to ticks. In the same locality as the current case, two cases have been detected in 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.

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. WHO published an operational guideline in 2024 on the infection prevention and control of CCHF in healthcare settings.

Additional information on CCHF can be found in the 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: 27 June 2025

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

Overview:

Since the beginning of the 2025 transmission season, and as of 2 July 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: 27 June 2025

8. Seasonal surveillance of chikungunya virus disease – 2025

Overview:

Since the beginning of 2025 and as of 2 July 2025, one country in Europe has reported cases of chikungunya virus disease: **France** (14).

To date in 2025, public health authorities in France have reported 14 cases of locally acquired chikungunya virus disease in seven different local administrative units. All clusters are currently classified as active. This week authorities reported the first locally acquired chikungunya virus disease case from the Bas-Rhin department. The other departments have reported locally acquired chikungunya virus disease or dengue cases in previous years.

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

ECDC assessment:

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

Last time this event was included in the Weekly CDTR: 27 June 2025

9. Publication of public health guidance for assessing and mitigating the risk of locally-acquired Aedes-borne viral diseases in the EU/EEA and update of Aedes albopictus and Aedes aegypti distributions

Overview:

On 1 July 2025, ECDC published public health guidance for assessing and mitigating the risk of locally-acquired *Aedes*-borne viral diseases in the EU/EEA and updated the distribution maps of *Aedes albopictus* and *Aedes aegypti.*

The guidance has been developed on the basis of previous experience and currently applied practices in countries affected by locally-acquired transmissions of *Aedes*-borne viral diseases in the EU/EEA. The measures applied are based on international and national guidelines against *Aedes*-borne viral diseases and general public health measures against mosquito-borne diseases. However, scientific evidence is often missing for the specificity, effectiveness and efficiency of the measures in the European context.

Since the previous update (July 2024) for *Aedes albopictus*, the main changes are that the updated map shows the species' establishment in Cyprus and Slovakia, and spread in Austria, Belgium, France, Germany, Greece, Hungary, Lebanon, Portugal, Serbia, Slovenia, Spain, Switzerland, Tunisia and Türkiye.

For *Aedes aegypti*, since the previous update (May 2024), the main changes are that the updated map shows two more regions affected in Egypt.

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

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 27 June 2025
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 27 June 2025
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 27 June 2025
- Human cases with avian influenza A(H10N3) – Multi-country (World) - last reported on 27 June 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 27 June 2025
- Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025 - last reported on 27 June 2025
- Mass gathering monitoring – EuroPride 2025 Lisbon - Portugal – 2025 - last reported on 27 June 2025
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025 - last reported on 27 June 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 27 June 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 27 June 2025
- Outbreak of Hepatitis A, mostly associated with sexual transmission among MSM, in Portugal - last reported on 19 June 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 19 June 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 19 June 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 13 June 2025
- Outbreak of measles associated with international mass gathering - Germany - 2025 - last reported on 13 June 2025
- Seasonal surveillance of West Nile virus infections started in week 23 - last reported on 13 June 2025
- Mass gathering monitoring – Jubilee of 2025 in Italy - last reported on 13 June 2025
- Risk Assessment under production - last reported on 13 June 2025
- Invasive pneumococcal disease among shipyard workers in Turku, Finland - last reported on 13 June 2025
- Circulating vaccine-derived poliovirus type 2 (cVDPV2) – multi-country – 2024–25 - last reported on 04 July 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 04 July 2025
- SARS-CoV-2 variant classification - last reported on 04 July 2025
- Publication of public health guidance for assessing and mitigating the risk of locally-acquired Aedes-borne viral diseases in the EU/EEA and update of Aedes albopictus and Aedes aegypti distributions - last reported on 04 July 2025