WEEKLY BULLETIN

Communicable disease threats report

Week 44, 25–31 October 2025

This week's topics

1. Overview of respiratory virus epidemiology in the EU/EEA
2. Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025
3. Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2025
4. Seasonal surveillance of dengue – 2025
5. Weekly seasonal surveillance of West Nile virus infection – 2025
6. Seasonal surveillance of chikungunya virus disease – 2025
7. Ebola virus disease – Democratic Republic of the Congo – 2025
8. Rift Valley fever in Senegal and Mauritania - 2025
9. Expert deployment

Executive summary

Overview of respiratory virus epidemiology in the EU/EEA

- In the EU/EEA, the number of patients visiting primary care with symptoms of respiratory illness remains low. However, as expected for this time of year, most countries are reporting an increase. To date, similar increases have not been observed in patients admitted to hospital with respiratory illness.
- Circulation of influenza and respiratory syncytial virus (RSV) remains low but is beginning to increase in some countries. SARS-CoV-2 circulation is still widespread but continues to decrease, following a trend similar to this time last season.
- The increase in circulation of RSV is primarily seen in children aged below five years, while influenza circulation is primarily observed in children aged below 15 years.

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

- Since the last update on 16 September 2025, and as of 9 October 2025, 59 mpox cases have been reported from 8 EU/EEA countries to TESSy: Spain (35), Germany (10), France (6), Italy (3), Netherlands (2), Ireland (1), Luxembourg (1) and Portugal (1). Since 16 September 2025, no new countries have reported confirmed cases.
- Thirty mpox clade I cases have been reported in the EU/EEA to TESSy since August 2024 and as of 9 October, from Belgium, France, Germany, Ireland, Italy, and Sweden. All were clade Ib, except for one case in Ireland, which was clade Ia. In addition, since 9 October, six additional

clade I cases were reported to ECDC from Greece, Italy, Netherlands, and Portugal through event-based surveillance.
- Among the cases reported since October 9, four are among men who have sex with men, two of which do not have a travel link to a country with mpox clade Ib transmission. This indicated ongoing transmission in sexual networks of gay, bisexual and other men who have sex with men.
- The risk of mpox clade Ib is assessed as moderate for men who have sex with men and low for the general population in the EU/EEA.
- Identifying clades should be done where individuals have been diagnosed with mpox. Countries are encouraged to report new cases of clade I as soon as possible in EpiPulse Events and to also report the case to TESSy through case-based surveillance.
- Countries should continue efforts to sequence all positive cases and ensure that sequences are deposited in public repositories (ENA, SRA, and/or GISAID EpiPox) or shared with ECDC through the EpiPulse platform or other means.

Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2025

- Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries. While generally the epidemiological trends of mpox cases due to MPXV clade I and II are remaining similar to previous weeks, a limited number of cases of clade I have been reported outside countries with community transmission and among men who have sex with men.
- On the African continent, most mpox clade I cases have been reported by the Democratic Republic of the Congo (DRC), Uganda and Burundi. Trends are decreasing in DRC and Uganda with week-to-week fluctuations.
- Sporadic mpox clade I cases have also been reported outside the African continent during the past month including cases without previous travel history to areas with clade I circulation. This indicates wider community transmission in any country outside Africa and possibly within sexual networks.
- The classification of transmission patterns of mpox clade I has been updated as of 30 October 2025 (details are provided in the overview)

Seasonal surveillance of dengue – 2025

- Since the beginning of 2025, and as of 29 October 2025, three countries in Europe have reported cases of dengue: France (29), Italy (four), and Portugal (two).
- This week, no new cases of dengue have been reported to ECDC.
- One cluster in France is currently active.

Weekly seasonal surveillance of West Nile virus infection – 2025

- Since the beginning of 2025, and as of 29 October 2025, 14 countries in Europe have reported human cases of West Nile virus infection: Albania, Bulgaria, Croatia, France, Germany, Greece, Hungary, Italy, Kosovo*, North Macedonia, Romania, Serbia, Spain, and Türkiye.

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

Seasonal surveillance of chikungunya virus disease – 2025

- Since the beginning of 2025, and as of 29 October 2025, two countries in Europe have reported cases of chikungunya virus disease: France (768) and Italy (370).
- In the past week, France has reported 13 new locally acquired cases of chikungunya virus disease and Italy has reported one. In the week before, 21 and five new cases were reported by France and Italy, respectively.

Ebola virus disease – Democratic Republic of the Congo – 2025

- Since the last update, and as of 29 October 2025, no new Ebola cases have been reported in the Democratic Republic of the Congo (DRC). All patients have been discharged and there are no contacts under active monitoring.
- The 42-day countdown for declaring the outbreak over was initiated on 19 October, following the discharge of the last patient being treated.
- Since the start of the outbreak, and as of 29 October, 64 cases (53 confirmed and 11 probable) of Ebola virus disease (EVD) have been reported in Kasai Province, DRC, including 45 deaths (34 confirmed and 11 probable; case fatality rate (CFR) among all cases: 70.3%).
- All confirmed cases were reported from Bulape health zone.

- The current risk for people from the EU/EEA living in or travelling to Kasai province in DRC is estimated to be low, due to the current low likelihood of exposure. For people living in the EU/EEA, the risk is very low, as the likelihood of introduction and secondary transmission within the EU/EEA is very low.

Rift Valley fever in Senegal and Mauritania - 2025

- Since 21 September 2025, and as of 29 October, 343 human cases (including 28 deaths) of Rift Valley fever have been reported in Senegal.
- Since 2 October 2025, and as of 19 October, 42 human cases (including 14 deaths) of Rift Valley fever have been reported in Mauritania.
- Both countries have reported outbreaks among live animals across multiple districts.

Expert deployment

- The EU Health Task Force deployed one ECDC staff member and an expert from Africa CDC to Kinshasa, the Democratic Republic of the Congo (DRC), to support national authorities in responding to the Ebola outbreak. The ECDC expert's deployment was between 19 and 30 October, while the Africa CDC Expert is expected to stay until 9 November.

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

Overview:

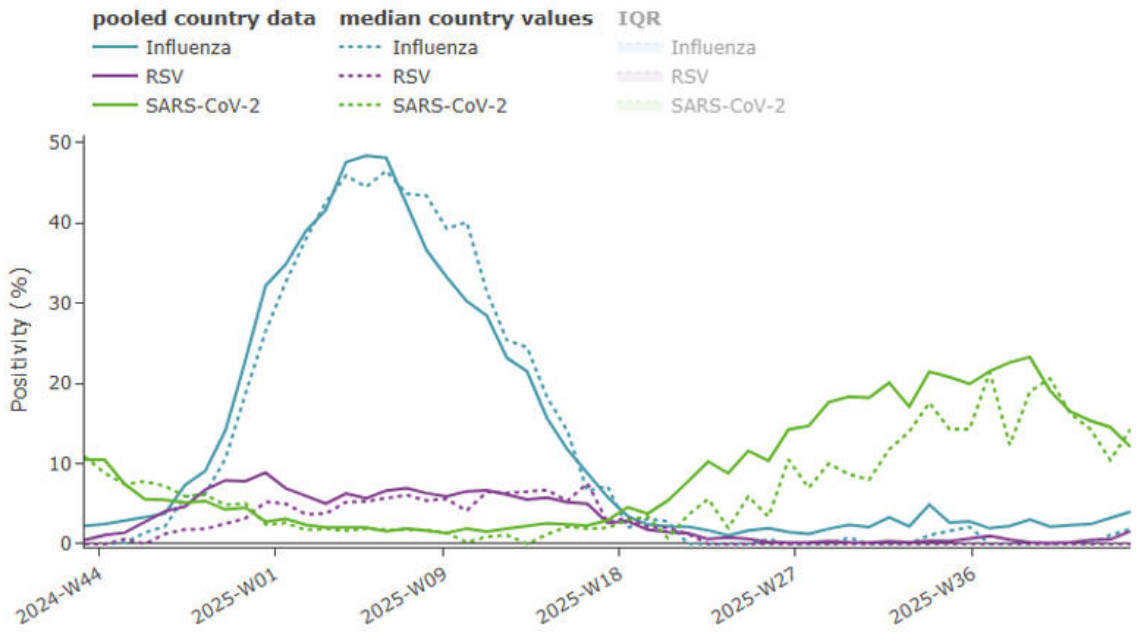
ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary (ERVISS.org), which is updated weekly.

Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

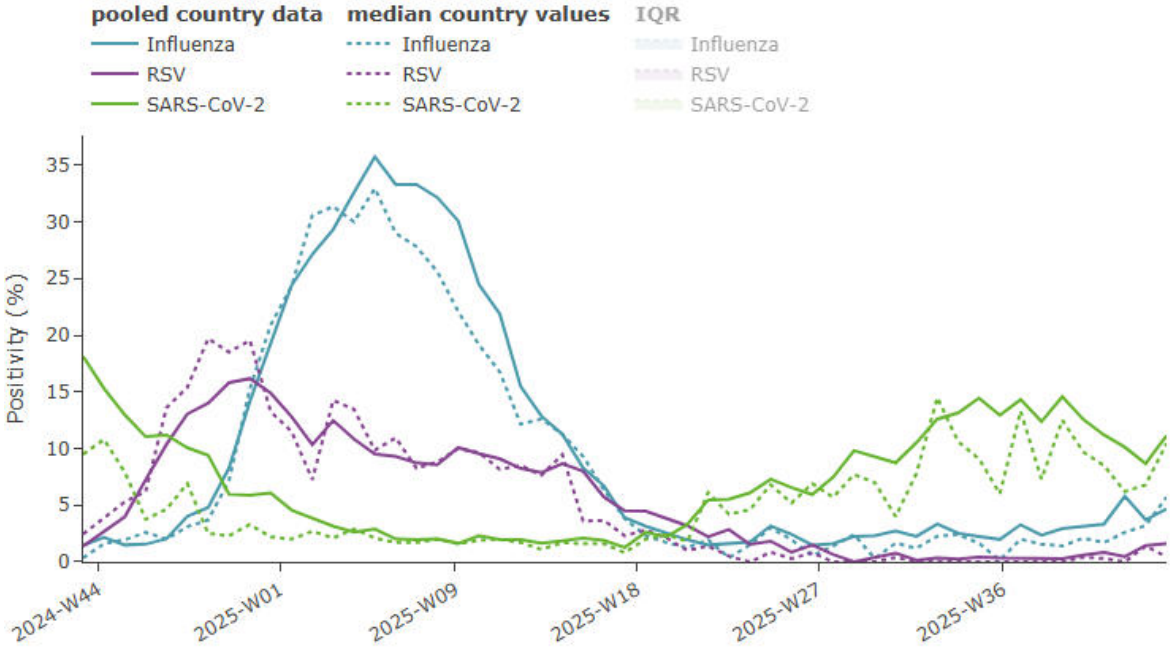
Last time this event was included in the Weekly CDTR: 24 October 2025

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

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 43	Week 42	Description	Value
ILI/ARI consultation rates in primary care	ARI	12 rates (8 MEM)	15 rates (11 MEM)	Distribution of country MEM categories	5 Baseline 3 Low
	ILI	17 rates (17 MEM)	20 rates (20 MEM)		16 Baseline 1 Medium
ILI/ARI test positivity in primary care	Influenza	18	19	Pooled (median; IQR)	4% (1.9; 0.4–3.9%)
	RSV	17	17		1.6% (0; 0–0.8%)
	SARS-CoV-2	16	18		12% (14; 4–24%)
SARI rates in hospitals	SARI	8	10	–	–
SARI test positivity in hospitals	Influenza	6	8	Pooled (median; IQR)	4.7% (5.7; 2.3–14%)
	RSV	6	8		1.6% (0.4; 0–1.9%)
	SARS-CoV-2	6	8		11% (10; 2.5–11%)
Intensity (country-defined)	Influenza	21	24	Distribution of country qualitative categories	16 Baseline 5 Low
Geographic spread (country-defined)	Influenza	20	22	Distribution of country qualitative categories	4 No activity 13 Sporadic 1 Local 1 Regional 1 Widespread

Source: ECDC

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

	Week 43, 2025		Week 40, 2025 – week 43, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**69**	**–**	**268**	**–**
Influenza A	61	95	250	97
A(H1)pdm09	24	50	111	57
A(H3)	24	50	84	43
A (unknown)	13	–	55	–
Influenza B	3	5	7	3
B/Vic	0	–	0	–
B (unknown)	3	–	7	–
Influenza untyped	5	–	11	–
RSV	**23**	**–**	**50**	**–**
RSV-A	2	50	7	41
RSV-B	2	50	10	59
RSV untyped	19	–	33	–
SARS-CoV-2	**173**	**–**	**1143**	**–**

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

Source: ECDC

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

	Week 43, 2025		Week 40, 2025 – week 43, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**42**	**–**	**225**	**–**
Influenza A	29	97	170	98
A(H1)pdm09	5	45	56	69
A(H3)	6	55	25	31
A (unknown)	18	–	89	–
Influenza B	1	3	3	2
B/Vic	0	–	0	–
B (unknown)	1	–	3	–
Influenza untyped	12	–	52	–
RSV	**14**	**–**	**47**	**–**
RSV-A			5	83
RSV-B			1	17
RSV untyped	14	–	41	–
SARS-CoV-2	**101**	**–**	**556**	**–**

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

Source: ECDC

Figure 6. SARS-CoV-2 variant distribution

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	5	16	4% (3–7%)
XFG	VUM	6	252	85% (82–86%)
NB.1.8.1	VUM	6	30	10% (5–13%)

[a] Data are sorted by classification then median distribution. For information on SARS-CoV-2 variant classification visit ECDC's variant page.

Source: ECDC

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

Overview:

Thirty mpox clade I cases have been reported in the EU/EEA to TESSy since August 2024 and as of October 9: Belgium (6), France (4), Germany (12), Ireland (4), Italy (2), Spain (1), and Sweden (1). All were clade Ib except the first case in Ireland, which was clade Ia. Seven cases were hospitalised for treatment. Confirmed secondary transmission events were reported by Germany, Belgium and Ireland among household or other close contacts.

Nine additional clade I cases have been reported to ECDC through event-based surveillance since 9 October: Belgium (1), Germany (2), Greece (1), Italy (2), the Netherlands (1), Portugal (1) and Spain (1). Four of these nine cases were in men who reported sex with other men (Belgium, Greece, Spain, and the Netherlands). The cases in Belgium and Greece were imported whereas the cases in Spain and the Netherlands did not have any travel links. These results indicate transmission of mpox clade I in sexual networks of gay, bisexual and other men who have sex, including local transmission in the EU/EEA.

Since the last update on 16 September 2025, and as of 9 October 2025, a total of 59 mpox cases have been reported from 8 EU/EEA countries: Spain (35), Germany (10), France (6), Italy (3), the Netherlands (2), Ireland (1), Luxembourg (1), and Portugal (1). Since 16 September 2025, no new countries have reported confirmed cases.

Since the start of the mpox outbreak and as of 9 October 2025, 25 420 confirmed cases of mpox (MPX) have been reported from 29 EU/EEA countries: Spain (9 028), France (4 539), Germany (4 493), the Netherlands (1 557), Portugal (1 255), Italy (1 233), Belgium (907), Austria (380), Sweden (373), Ireland (320), Poland (248), Denmark (229), Greece (160), Norway (130), Czechia (109), Hungary (88), Luxembourg (65), Romania (51), Malta (49), Slovenia (48), Finland (43), Croatia (39), Slovakia (19), Iceland (17), Bulgaria (11), Estonia (11), Cyprus (6), Latvia (6), and Lithuania (6). Deaths have been reported from Spain (4), Belgium (2), Portugal (2), Austria (1), and Czechia (1).

Since the start of the mpox outbreak, and as of 9 October 2025, the following Western Balkan countries have reported confirmed cases of mpox: Serbia (40), Bosnia and Herzegovina (9), Montenegro (2), North Macedonia (2), Albania (1) and Kosovo* (1). In addition, 71 cases have been reported from Türkiye.

All other mpox cases with available information on clade reported in the EU/EEA were MPXV clade IIb.Clade II cases reported in 2025 share the same epidemiological profile as those reported since the beginning of the outbreak in the EU/EEA, with the majority of cases occurring in men, and sexual contact among men who have sex with men remaining the primary mode of transmission.

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

For more information on the global update regarding MPXV clade I and II, please refer to the weekly Communicable Diseases Threats Report and the ECDC webpage: Mpox worldwide overview.

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

ECDC assessment

The total number of new infections reported to ECDC is similar to previous months and the overall number remains relatively low in the EU/EEA. However, the recently reported clade Ib cases represent a new pattern of transmission without links to travel and involve men who have sex with men. ECDC published a Threat Assessment Brief on October 24 to assess the

new situation. The risk of clade Ib infection is assessed as moderate for men who have sex with men and low for the general population in the EU/EEA, reflecting current evidence and considerable uncertainties around transmissibility and severity of clade Ib infection relative to clade IIb. The risk for clade IIb infection remains at low for men who have sex with men and very low for the general population in the EU/EEA.

A Threat Assessment Brief on the detection of autochthonous transmission of monkeypox virus (MPXV) clade Ib in the EU/EEA was published on 24 October. It summarises the information on the new cases and outlines actions EU/EEA countries can take, including testing, sequencing and contact tracing; promoting vaccination; risk communication; and community engagement activities. The brief also outlines the knowledge gaps that remain, including on transmissibility and severity of MPXV clade Ib compared with clade IIb.

Response options for EU/EEA countries include raising awareness among healthcare professionals; supporting sexual health services in case detection, contact tracing, and case management; making testing easily accessible; implementing vaccination strategies with a focus on preexposure vaccination and maintaining active risk communication and community engagement.

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

In addition to possible local transmission of clade Ib among MSM, it is likely that mpox cases due to MPXV clade I will continue to be introduced into the EU/EEA through returning travellers.It is important to raise awareness concerning the possible importation of cases, both among returning travellers from affected African countries and among healthcare professionals who may see such patients.

Actions

ECDC is continuously monitoring mpox in the EU/EEA and globally through event- and indicator-based surveillance, and remains in contact with partners.

Countries are encouraged to report new cases of clade I as soon as possible in EpiPulse Events and to also report the case to TESSy through case based surveillance, collecting as much information possible on clade and subclade as well as sequences, vaccination status, prior infection, symptoms, hospitalisation status, transmission category, HIV status, etc. Countries can update the TESSy records as additional information becomes available.

Countries should continue efforts to sequence all positive cases and ensure that sequences are deposited in public repositories (ENA, SRA, and/or GISAID EpiPox) or shared with ECDC through the EpiPulse platform or other means.

ECDC has been assessing the risk of mpox in the multi-country outbreak 2022/23 as well as the emergence of clade I. Previous risk assessments and other information can be found at the bottom of this page: https://www.ecdc.europa.eu/en/mpox together with a rapid scientific advice on public health measures. A resource toolkit for event organisers and social media materials on mpox related to events are also available.

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

3. Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2025

Overview

Monkeypox virus (MPXV) clades I and clade II are circulating in multiple countries across the globe. Since 2022, mpox clade II has been circulating outside the African continent, particularly among men who have sex with men. The epidemiological profile of mpox clade II cases reported outside Africa since 2022 remains similar to previous weeks. With regards to clade I, cases have been reported by several countries outside Africa without travel history to countries with ongoing clade I transmission. For both clade I and II, sexual contacts have been described as drivers of transmission (Multi-country outbreak of mpox, External situation report #59 - 30 October 2025).

A summary of the recently observed global trends of clades I and II is provided below along with the classification of countries based on the clade I transmission.

Mpox clade II summary

Mpox clade II has been circulating globally since 2022. Following the spread and increases outside endemic areas in Africa in 2022, in 2025, increases of clade II have been reported mostly in west African countries (e.g., Ghana, Guinea, Sierra Leone, Liberia) (Multi-country outbreak of mpox, External situation report #59 - 30 October 2025). Outside Africa cases were mostly reported in adults (99%) and males (97%), the majority of whom reported having had sex with men (89%) (Global Mpox Trends published 24 October 2025, data until 19 October 2025). In African countries with recent increases of clade II, cases have been reported among young adults males and females and sexual contact has been described as a driver of spread (Africa CDC Epidemic Intelligence Weekly Report, October 2025 – Africa CDC and Multi-country outbreak of mpox, External situation report #59 - 30 October 2025).

Mpox clade I summary and transmission patterns classification

Overall, in Africa, as of October 2025, most confirmed and suspected clade I cases were reported from the DRC, Uganda and Burundi. However, in recent weeks, increases have been observed in Kenya, CAR and Tanzania compared to the previous six-week period (weeks 37-42 vs weeks 31-36; Special Briefing on Mpox and other Health Emergencies, 30 October 2025).

Summary of recent trends in selected African countries:

- In DRC, clades Ia and Ib are co-circulating. Cases due to clade IIb have also been reported. In recent weeks, and as of week 42 (ending 19 October), the decreasing trend with week-to-week fluctuations in confirmed cases continued according to Africa CDC and WHO (Special Briefing on Mpox and other Health Emergencies, 30 October 2025 and Global Mpox Trends published 24 October 2025, data as of 19 October 2025). However, this trend should be interpreted with caution.
- Uganda continues to be the African country reporting the most mpox clade Ib cases after DRC (Global Mpox Trends published 24 October 2025, data as of 19 October 2025). Over 6 000 cases have been reported in 2025, including 37 deaths. The declining trend in the number of confirmed cases continued but there are fluctuations (Global Mpox Trends published 24 October 2025, data as of 19 October 2025).
- In Burundi, a slight increase in the number of confirmed cases was reported since the end of June and until July. A decrease with fluctuation has been reported since. However the total number of weekly cases remains at low levels (<50 confirmed cases per week) (Global Mpox Trends published 24 October 2025, data as of 19 October 2025).
- The weeks 37-42 (ending 19 October 2025) Kenya 285 confirmed cases, Malawi 38, Zambia 30 cases, Tanzania 26, and CAR 20 confirmed cases (Special Briefing on Mpox and other Health Emergencies, 30 October 2025 and Global Mpox Trends published 24 October 2025, data as of 19 October 2025). No cases were reported in the WHO Dashboard for Angola, Ethiopia, Rwanda, South Africa, South Sudan or Zimbabwe (Global Mpox Trends published 24 October 2025, data as of 19 October 2025).

Between 19-22 October, Namibia reported two mpox cases, the first cases in the country. The first case was liked to a probable case that had travel history to Tanzania and the second was linked to the first. Clade Ib was detected, according to WHO (Multi-country outbreak of mpox, External situation report #59 - 30 October 2025).

In EU/EEA, travel-associated cases or sporadic cases reporting epidemiological links with travel-associated cases of mpox clade I have been reported by Sweden (in 2024), Germany (in 2024 and 2025), Belgium (in 2024 and 2025), France, Ireland, Italy, and Spain (in 2025), as well as by Greece (in October 2025). In addition to Africa and the EU/EEA, since August 2024, clade I cases have been reported by Thailand, India, the United Kingdom, the United States, Canada, Pakistan, Oman, China, the United Arab Emirates, Qatar, Brazil, Switzerland, Australia, Türkiye, and Japan.

Most travel-associated cases reported outside African countries had links to affected countries in Africa. Imported cases with a travel history to Lebanon, Malaysia, Nepal, Thailand and China have also been reported (Global Mpox Trends published 24 October 2025, data as of 19 October 2025). In October 2025, Italy, the Netherlands, Portugal and Spain reported five cases of mpox clade I without travel history and with two of individuals reporting having sexual contact with another male. In addition, the United States reported three unlinked cases of clade I in California without travel history with the investigation indicating that person-to-person transmission among gay, bisexual and other men who have sex with men and their social networks may be ongoing in the state (Community Spread of New Mpox Type (Clade I) in California Has Been Identified; Risk to General Public Remains Low). Confirmed limited secondary transmission of mpox due to MPXV clade I outside of Africa was reported in the EU/EEA since 2024 by Germany, Belgium, and Ireland. Outside the EU/EEA, secondary transmission has been reported in the UK, China, Qatar, and Australia. The number of secondary cases reported in these events outside Africa has been low (range: 1–6 cases per event; Global Mpox Trends published 24 October 2025, data as of 19 October 2025).

Based on the information available, all transmission events were due to close contact and no deaths were reported.

Transmission patterns of mpox due to MPXV clade I – update 30 October 2025

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

- Countries reporting only travel-associated cases or cases with a clear link to travel-associated cases: Angola, Australia, Belgium, Brazil, Canada, France, Germany, Greece, India, Ireland, Japan, Namibia, Oman, Pakistan, Qatar, Senegal, South Africa, South Sudan, Sweden, Switzerland, Thailand, Türkiye, the United Kingdom, the United States, and Zimbabwe;
- Clusters of cases or limited transmission: China, Italy, Malaysia, the Netherlands, Portugal, Spain, the United Arab Emirates, and the United States;
- Community transmission: Burundi, Central African Republic, Congo, DRC, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Tanzania, Uganda, and Zambia.

The extend of ongoing undetected transmission of mpox clade I cannot be quantified with certainty. A number of countries have reported cases with travel history to regions/countries with limited number of clade I cases or no clade I cases and further information on transmission chains is not available (Global Mpox Trends published 24 October 2025, data as of 19 October 2025), For example, Nepal and Lebanon have not reported any mpox clade I detection and they have been reported as places of travel of known cases elsewhere. Imported cases with a travel history to Malaysia, Thailand and China have also been reported but a small number of mostly travel associated cases has been reported by each of these countries (Global Mpox Trends published 24 October 2025, data as of 19 October 2025).

The categorisation was last updated on 30 October 2025. The epidemiological situation is continuously being monitored and the classification is reviewed and adjusted depending on a qualitative assessment of reported trends.

On 13 August 2024, Africa CDC declared mpox a Public Health Emergency of Continental Security, and this decision remains valid (Mpox Still a Continental Emergency, Africa CDC Advisory Group Recommends – Africa CDC). On 14 August 2024, WHO also declared the outbreak of mpox due to

MPXV clade I to be a public health emergency of international concern (PHEIC), which was declared over on 5 September 2025 (WHO Director-General's opening remarks at the media briefing – 5 September 2025).

ECDC assessment

The epidemiological situation regarding mpox due to MPXV clade I remains similar to previous weeks. The sporadic cases of clade I that have been reported outside of Africa, including secondary transmission, are not unexpected. However, a new pattern of transmission is emerging in countries outside Africa, including in the EU/EEA, among men who have sex with men.

The risk for EU/EEA residents travelling to or living in the affected areas is considered moderate if they have close contact with affected individuals, including sexual contact, and low if they do not have contact with affected individuals. The overall risk to the general population in the EU/EEA is currently assessed as low. Imported mpox cases due to MPXV clade I are likely to continue being reported by the EU/EEA and other countries.

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

Please see the latest ECDC 'Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries' and the Threat Assessment Brief Detection of autochthonous transmission of monkeypox virus clade Ib in the EU/EEA

Actions

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

Monthly updates are shared through the Communicable Disease Threats Report. As the global epidemiological situation is monitored continuously, ad hoc epidemiological updates may also be published.

Sources: ECDC rapid risk assessment

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

4. Seasonal surveillance of dengue – 2025

Overview

Since the beginning of 2025, and as of 29 October 2025, three countries in Europe have reported cases of dengue: France (29), Italy (four), and Portugal (two).

This week, no new cases of dengue have been reported to ECDC. Currently, only one cluster in France is active (Aubagne).

For more information on locally acquired dengue virus disease cases, see ECDC's seasonal surveillance report for dengue. This report covers mainland EU/EEA and the outermost regions of Portugal and Spain.

ECDC assessment

The current dengue risk assessment for mainland EU/EEA can be found on ECDC's dedicated dengue webpage.

Last time this event was included in the Weekly CDTR: 24 October 2025

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

Overview

Since the beginning of 2025, and as of 29 October 2025, 14 countries in Europe have reported human cases of West Nile virus infection: Albania, Bulgaria, Croatia, France, Germany, Greece, Hungary, Italy, Kosovo*, North Macedonia, Romania, Serbia, Spain, and Türkiye.

A total of 154 areas are currently known to be affected.

The report is available online.

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

Last time this event was included in the Weekly CDTR: 24 October 2025

6. Seasonal surveillance of chikungunya virus disease – 2025

Overview

Since the beginning of 2025, and as of 29 October 2025, two countries in Europe have reported cases of chikungunya virus disease: France (768) and Italy (370).

In the past week, France has reported 13 new locally acquired cases of chikungunya virus disease. The cumulative number of locally acquired cases in France has reached 768, distributed across 76 clusters. Twenty-six clusters are currently active. The largest cluster is located in Antibes.

Italy reported one new locally acquired case of chikungunya virus disease. The cumulative number of locally acquired cases in Italy is 370, distributed across five clusters. Three clusters are currently active. The largest cluster is located in Carpi, San Prospero, Soliera, Novellara, Cavezzo, Modena, Nonantola, Correggio, Novi di Modena, and Cesenatico.

For more information on locally acquired chikungunya virus disease cases, see ECDC's seasonal surveillance report for chikungunya virus disease. This report covers mainland EU/EEA and the outermost regions of Portugal and Spain.

ECDC assessment

The current chikungunya virus disease risk assessment for mainland EU/EEA can be found on ECDC's dedicated chikungunya webpage.

Last time this event was included in the Weekly CDTR: 24 October 2025

7. Ebola virus disease – Democratic Republic of the Congo – 2025

Overview

On 19 October 2025, WHO announced that the last Ebola patient in DRC was discharged and therefore the 42-day countdown for declaring the outbreak over has been initiated. According to WHO, the outbreak will be declared over in early December 2025, if no new cases are detected.

A total of 19 patients recovered from the disease (29.7%) and no new cases have been reported since 26 September. As of 22 October, of the 1 735/1 787 (97.3%) contacts that were followed up, none are under active monitoring.

Since the outbreak was declared on 4 September 2025, and as of 29 October, there have been 64 cases (53 confirmed and 11 probable) and 45 deaths (34 confirmed and 11 probable) (CFR among all cases: 70.3%). All cases were reported in six health areas in Bulape health zone, Kasai Province.

Summary

On 1 September 2025, WHO received an alert regarding probable cases of Ebola virus disease (EVD) from Bulape health zone, Kasai Province. Following this alert, on 4 September, the DRC Minister of Public Health, Hygiene and Social Security declared an outbreak of EVD in the country.

The first reported case was in a pregnant woman, who was admitted to Bulape General Reference Hospital on 20 August with symptoms of fever, bloody diarrhoea, vomiting, asthenia, and anal, oral, and nasal haemorrhage.

The woman later died due to multiple organ failure. Samples tested on 3 September at the country's National Institute of Biomedical Research in the capital, Kinshasa, confirmed the cause of the outbreak as Ebola Zaire. Based on whole genome sequencing analysis, the causative strain is not linked to previous outbreaks and therefore this is probably a new zoonotic spill-over event. The initial phase of the outbreak was characterised by nosocomial spread and a superspreading event linked to the presumptive index case's funeral.

On 28 September, WHO reported that the majority of cases have occurred in women (n=37; 57.8%), with patients' ages ranging from under one year old to 65 years old. Children aged from under one year old to nine years old and individuals 20–29 years old accounted for 25.0% (n=16) and 23.4% (n=15) of cases, respectively. The most affected populations included children, housekeepers, and farmers. From the beginning of the outbreak in epidemiological week 36 to epidemiological week 39, the median time between symptom onset and isolation shortened from five days to two.

Women represent 60% of the reported deaths. At the beginning of the outbreak, a high proportion of cases and deaths occurred among children under one year old to four years old, and the CFR was very high. As the outbreak progressed, the number of cases among children has decreased and the CFR has gradually declined. Four of the deaths were reported among healthcare workers. In Bulape health zone, the health areas of Dikolo (26 cases, 15 deaths) and Bulape (24 cases, 22 deaths) are considered the epicentres of the outbreak, together accounting for 78.1% of reported cases and 82.2% of all deaths.

Vaccination began in Kasai Province on 13 September. As of 29 October, a total of 37 178 people have been vaccinated. Alongside ring vaccination, geographically targeted vaccination began on 27 September for groups at high risk of infection in hotspots reporting confirmed cases. A total of 31 patients have been treated with monoclonal antibody (mAb114).

The last reported date of symptom onset was 23 September and the last cases were reported on 26 September in Bulape and Dikolo health areas, Bulape health zone.

Background and additional information

Ebola outbreaks in the DRC are recurrent, as the virus is present in animal reservoirs in many parts of the country. This is the sixteenth outbreak recorded since 1976 in DRC and the eighth since 2018.

The last EVD outbreak documented in DRC was in August 2022, in Beni health zone, North Kivu province, but related to only one case. In the same year, another five cases were reported from Mbandaka city, Equateur province. In 2007 and 2008, there were EVD outbreaks affecting Kasai province, including the Bulape and Mweka health zones in 2007. In the country overall, there have been 15 outbreaks since the disease was first identified in 1976.

Earlier in this outbreak, WHO AFRO reported that Bulape health zone is linked to large population centres such as Tshikapa and Kananga, and as there is ongoing cross-provincial and cross-border movement there is a risk of further geographical spread.

The Ministry of Health is leading the outbreak response and is supported technically by WHO and other partners. A regional strategic response plan has been developed to guide coordinated efforts across affected and at-risk areas, focusing on surveillance; diagnostics; vaccination; infection, prevention and control (IPC); and community engagement.

ECDC assessment

Ebola virus causes a severe, often fatal, disease. The current risk for people from the EU/EEA living in or travelling to Kasai province in DRC is estimated to be low, due to the current low likelihood of exposure. For people living in the EU/EEA, the risk is very low, as the likelihood of introduction and secondary transmission within the EU/EEA is very low.

Intense surveillance and contact tracing are essential to rapidly control outbreaks of viral haemorrhagic fevers.

Actions

ECDC is monitoring the situation through its epidemic intelligence activities. In addition, ECDC is in contact with Africa CDC, the Global Outbreak Alert Response Network (GOARN), and the European Commission (DG ECHO, DG SANTE, DG HERA).

Last time this event was included in the Weekly CDTR: 24 October 2025

8. Rift Valley fever in Senegal and Mauritania – 2025

Overview

Update:
Since the last update on 17 October, and as of 29 October, there have been 132 additional cases and seven additional cases reported in Senegal. There have been cases reported in three additional regions (Kaolack, Thiès and Tambacounda).

Since the last update on 17 October and as of 19 October, there have been six additional cases and one additional death reported in Mauritania. No new regions have been reported as affected.

Summary:
Senegal
As of 29 October 2025, there have been a total of 343 confirmed human cases and 28 deaths (case fatality rate (CFR) of 8.6%) of Rift-Valley fever (RVF) reported, since the beginning of the outbreak on September 21. The eight affected regions are Saint-Louis (271), Louga (18), Matam (20), Fatick (11), Dakar (9), Kaolack 10), Thiès (2), and Tambacounda (2). The affected regions are mainly in the north of the country, bordering Mauritania.

According to Africa CDC, most cases are males and the most affected age group is 15-35 years.

On 30 September 2025, WOAH reported cases in terrestrial animals in Senegal and reported that the area is at high-risk of experiencing outbreaks in domestic and wild animals during the winter period, with notable outbreaks in 2013 and 2023. On October 27, Africa CDC reported that there have been

57 cases among animals in Senegal and no deaths. There have also been 452 animal abortions reported and 11 644 animals have been vaccinated.

Mauritania
In Mauritania, the first human cases of RVF in this outbreak were reported on 2 October. As of 19 October, there have been 42 confirmed and 149 suspected human cases reported. According to Africa CDC, there have been 14 deaths among the confirmed cases (case fatality rate (CFR) - 33.3%). The 12 affected regions are mainly concentrated in the south near the Senegal border. The highest proportion of cases are reported in the following areas: Trarza (29%), Brakna (26%), Assaba (19%), Nktt Ouest (7%), and Guidimagha (5.5%).

Among the cases in Mauritania, males account for 79% of confirmed cases and the most affected age group is 20-40 years (58% of all cases).

According to the Ministry of Animal Welfare in Mauritania, as of 29 October there have been 227 confirmed cases among animals in the south of the country since the first outbreak was recorded on 15 September 2025.

The cases in both Senegal and Mauritania are mainly located around the Senegal River delta and valley, and early autumn months are considered as a high-risk period for RVF in the region.

Genomic analysis suggests that the current outbreak in Senegal is linked to previous detections in Senegal (Fatick in 2020 and Matam in 2022) and in Mauritania (2020). The last reported outbreak of RVF in Senegal was in the Fatick region in November 2021. There were three cases reported and no associated deaths. Mauritania has previously reported outbreaks in 1987, 2010, 2012, 2015, 2020 and 2022. The most recent outbreak involved 47 cases and 23 deaths. Animal breeders were most affected, and cases were reported in nine regions.

Disease information:
Rift Valley fever is an acute viral disease that mostly affects domestic animals (such as cattle, buffalo, sheep, goats, and camels). The disease is caused by the RVF virus, generally found in regions of eastern and southern Africa, but also in most countries of sub-Saharan Africa and Madagascar. Outbreaks have also been reported in Saudi Arabia and Yemen in the early 2000s.

Humans may become infected through direct or indirect contact with the blood or organs of infected animals, including virus transmission by mosquito vectors. While most human cases are relatively mild, a small percentage of patients develop a much more severe form of the disease. Uncomplicated cases are characterised by acute influenza-like illness leading to full recovery. In some patients the illness can progress to a severe form with haemorrhagic manifestations and hepatitis; possible complications include retinitis and encephalitis.
In endemic areas, vaccination of the animals at risk is the most important way of preventing infection in humans.

ECDC assessment

Outbreaks of RVF are regularly reported in Senegal and Mauritania and the early autumn is a period of high RVF epidemic potential in northern Senegal (Hélène et al., 2020).

Travellers to and residents of Senegal or Mauritania are at low risk of infection if they apply appropriate preventive measures. Those who are in contact with potentially infected animals (e.g. veterinarians and those involved in livestock farming, butchering and slaughtering of animals in RVF-affected areas) have an increased risk of infection with RVF virus and should ensure safe animal husbandry and slaughtering practices. Visitors to affected areas should apply personal protective measures against mosquito bites.

The likelihood of introduction of RVF virus from the current outbreak in Senegal and Mauritania to EU/EEA countries is very low, as the importation of live ruminants and raw animal products of them are not allowed. Importation of the virus via travellers or vectors is also unlikely.

Should the virus be introduced into continental EU/EEA, further vector-borne transmission among animals or humans cannot be excluded. However, the likelihood is very low during the late autumn and winter season due to the low-level abundance and activity of competent mosquito vector populations in continental EU/EEA countries.

Transmission of RVF virus through substances of human origin (SoHO) has not been reported to date, but the possibility of transmission cannot be excluded. However, as both Senegal and Mauritania are countries endemic for malaria, the deferral period for donors returning from areas affected by malaria would mitigate the risk of RVF virus transmission through SoHO.

Actions

ECDC will continue monitoring this event through its epidemic intelligence activities and report again if there is a relevant epidemiological update.

Last time this event was included in the Weekly CDTR: 17 October 2025

9. Expert deployment

Overview:

- On 19 October, the EU Health Task Force deployed a member of ECDC staff and an expert from Africa CDC to Kinshasa, DRC. The expert from ECDC, an epidemiologist, is supporting the national response to the Ebola outbreak, working with the national Incident Management Support Team.
- The ECDC staff member's deployment was between 19 and 30 October, while the Africa CDC expert will remain in DRC until 9 November.

Last time this event was included in the Weekly CDTR: 24 October 2025

Events under active monitoring

- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 31 October 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 31 October 2025
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2025 - last reported on 31 October 2025
- Seasonal surveillance of dengue – 2025 - last reported on 31 October 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 31 October 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 31 October 2025
- Rift Valley fever in Senegal and Mauritania - 2025 - last reported on 31 October 2025
- Ebola virus disease – Democratic Republic of the Congo – 2025 - last reported on 31 October 2025
- Expert deployment - last reported on 31 October 2025
- Monkeypox virus clade Ib – Multi-country – 2025 - last reported on 24 October 2025
- Human infection with avian influenza A(H5) virus - Mexico - 2025 - last reported on 17 October 2025
- Early start of influenza season - Japan - 2025 - last reported on 17 October 2025
- Medical Product Alert N 5/2025: Substandard (contaminated) oral liquid medicines - last reported on 17 October 2025
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 10 October 2025
- Seasonal surveillance of West Nile virus infections – 2025 - last reported on 10 October 2025
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025 - last reported on 10 October 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 10 October 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 10 October 2025
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 10 October 2025
- SARS-CoV-2 variant classification - last reported on 4 October 2025
- Rabies case – France – 2025 - last reported on 4 October 2025