

Communicable disease threats report

Week 10, 1–7 March 2025

This week's topics

- [1. Cholera associated with holy well water from Ethiopia](#)
- [2. Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025](#)
- [3. Avian flu detected in cats – Belgium – 2025](#)
- [4. SARS-CoV-2 variant classification](#)
- [5. Overview of respiratory virus epidemiology in the EU/EEA](#)
- [6. Measles – Multi-country \(World\) – Monitoring European outbreaks – monthly monitoring](#)
- [7. Ebola disease – Uganda – 2025](#)
- [8. Middle East respiratory syndrome coronavirus \(MERS-CoV\) – Multi-country – Monthly update](#)

Executive summary

Cholera associated with holy well water from Ethiopia

Between January and February 2025, seven cases of toxigenic O1 *Vibrio cholerae* have been reported by two European countries (Germany: 3 and United Kingdom: 4) in connection with travel to Ethiopia and/or exposure to holy water from the Amhara region of Ethiopia.

- Six individuals had exposure to holy water from Ethiopia, of which five reported consuming the water outside Ethiopia from plastic bottles in the UK or Germany; toxigenic O1 *Vibrio cholerae* was also isolated from leftover water in one of the bottles.
- Three individuals specified that the water came from the Bermel Giorgis well, which was also visited by a fourth individual and is located in a region (West Gondar zone of Amhara) currently affected by a cholera outbreak.
- Travellers to Ethiopia intending to visit the well, as well as friends and family who may be gifted bottles of water from the well, remain at risk until the source of contamination has been addressed.

Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025

France reported the first autochthonous case of chikungunya virus disease in 10 years in the Department of La Réunion, with onset of symptoms on 12 August 2024.

- Since then, and as of 2 March 2025, 3 390 cases of autochthonous chikungunya virus disease have been confirmed in La Réunion.
- The Haute Autorité de santé (HAS) has advised public decision makers to vaccinate certain risk groups and vector control professionals.

Avian flu detected in cats – Belgium – 2025

- Belgium reported of two outdoor cats infected with influenza A(H5) in a farm with recent avian influenza A(H5) infections in poultry.

SARS-CoV-2 variant classification

Since the last update on 31 January 2025, and as of 28 February 2025, the following changes have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants:

- LP.8.1 has been added as a variant under monitoring (VUM) due to its fast growth globally as well as within the EU/EEA.

Note that for this update, sufficient data for estimating variant proportions during the reporting weeks is only available from three EU/EEA countries (France, Germany and Spain). The statistics below therefore only represent a limited part of the EU/EEA.

The VOI median proportions in the EU/EEA for weeks 6–7, based on three reporting countries, are currently:

KP.3: 26.1% (range: 19.0%-38.9%; IQR: 22.6%-32.5%)
BA.2.86: 26.1% (range: 22.2%-35.7%, IQR: 24.2%-30.9%)

The VUM median proportions in the EU/EEA for weeks 6–7, based on three reporting countries, are currently:

XEC: 45.2% (range: 38.9%-47.8%, IQR: 42.1%-46.5%)
LP.8.1: 5.6% (range: 4.3%-21.4%, IQR: 5.0%-13.5%)

The calculations are based on data reported to GISAID, as of 23 February 2025.

The currently circulating variants 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 were previously not 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.

Overview of respiratory virus epidemiology in the EU/EEA

- There is currently significant respiratory virus activity in the European Union/European Economic Area (EU/EEA). Intense seasonal influenza activity is being reported, together with a respiratory syncytial virus (RSV) epidemic, while SARS-CoV-2 activity is at a very low level. The biggest impact in secondary care has been in adults aged 65 years and above for influenza and in children under five years for RSV.
- For influenza, most countries have reached, or have passed peak activity, however increasing trends in activity continue to be observed in around a quarter of the EU/EEA countries. Influenza hospital admissions have now started to decrease from very high levels in most reporting countries.

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

- In January 2025, 1 033 measles cases were reported by 17 countries. Eleven countries reported zero cases.
- Through its epidemic intelligence activities, ECDC has identified an additional 1 868 new cases from eight EU countries.
- Overall, four measles-related deaths have been reported in the EU/EEA in 2025, all of them in Romania.
- There has been high measles activity overall in the EU/EEA over the last 12 months; however, the situation varies by country. Some countries have reported large and/or ongoing outbreaks, while others have reported either no sustained transmission or very low transmission.

- Outbreaks associated with imported measles cases have been reported by EU countries.
- Relevant epidemiological updates are available for WHO regions.

Ebola disease – Uganda – 2025

- On 6 March 2025, Africa CDC [reported](#) two new confirmed cases of Ebola disease. The total number of confirmed cases is now 12, including two deaths. A new cluster has been identified around the previously reported four-year-old male (the tenth overall case). There are 69 new contacts connected with this cluster, who are under follow-up.
- The index case of this outbreak was a healthcare worker in a hospital.
- EU/EEA citizens working in healthcare settings in Uganda should be aware of the ongoing outbreak and take appropriate personal protective measures.
- In light of evidence from previous larger outbreaks, the importation of the disease to the EU/EEA through someone with the infection is very unlikely and, should that happen, the likelihood of further transmission is considered very low.

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

- Since the previous update on 5 February 2025, and as of 5 March 2025, no new MERS cases have been reported by the World Health Organization (WHO) or by national health authorities.
- Since the beginning of 2025, and as of 5 March 2025, no MERS cases have been reported with date of onset in 2025.
- 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.

1. Cholera associated with holy well water from Ethiopia

Overview:

Seven cases of toxigenic O1 *Vibrio cholerae* have been reported by two countries; Germany (3) and UK (4). Four individuals had exposure to water from a holy well at Bermel Giorgis in the Amhara region of Ethiopia. Another two individuals had exposure to holy water from an unknown source in the Amhara region. The seventh individual had recently travelled to Ethiopia, but the region visited and exposures they had during their visit were not reported.

Germany reported three cases of toxigenic O1 *Vibrio cholerae* following exposure to water from a holy well at Bermel giorgis in Ethiopia. The water was brought to Germany in a plastic bottle by two of the individuals, but exposure occurred in Germany together with a third person, who had not travelled. Onset of the disease was in early February, four days after the exposure. Toxigenic O1 *V. cholerae* has been isolated from the stools of the three individuals and from the water that was left over in the bottle.

United Kingdom reports four adult cases of toxigenic O1 *Vibrio cholerae* diagnosed in mid February 2025. Three individuals reported recent travel to Ethiopia, two specifically to the Amhara region and of these, one had visited the holy well at Bermel Giorgis during their trip. One individual had not travelled outside the UK prior to onset but reported consuming holy water from an unknown source that had been brought back from Ethiopia by one of the other individuals, who also became ill after consuming the holy water in the UK.

ECDC assessment:

In January, an outbreak of cholera was noted to be associated with consumption of water from the [Bermel Giorgis well](#) in the West Gondar zone of Amhara, Ethiopia. The well is situated in a region where an armed conflict is occurring, rendering interventions to address the source of contamination currently challenging. More broadly, contamination of holy water sites in Ethiopia with *Vibrio cholerae* is a recognised issue and the Ethiopian Public Health Institute (EPHI) has included improvements to facilities at holy water sites as a preventive measure in their national cholera response plan (see references below).

The use of holy water in the Ethiopian orthodox Tewahedo church is a deeply-rooted practice and often used for curative purposes. It is poured onto people or consumed by drinking. The primary group at risk for infection outside Ethiopia are members of the Ethiopian diaspora who may travel to Ethiopia and visit the holy well during their trip, or drink water from the well that has been gifted to them by a returning traveller. New cases may continue to occur until the source of contamination at the well has been addressed and protection of water sources is improved.

Actions:

ECDC continues to monitor the situation through epidemic intelligence activities.

Further information:

Further information on the current outbreak linked to the Bermel Giorgis well in Amhara and links to Ethiopian national cholera response plans are provided below.

1. [Cholera response in Quara: Ethiopia Situation Report #1, February 28, 2025 \(International Medical Corps\)](#)
2. [Ethiopia – Cholera outbreak \(DG ECHO, UN OCHA, WHO\) \(ECHO Daily Flash of 06 February 2025\)](#)
3. ['Stop cholera together' 8-week response plan \(Ethiopian Public Health Institute\)](#)
4. [National Guideline for cholera surveillance and outbreak response – 3rd edition, 2022 \(Ethiopian Public Health Institute\)](#)
5. [Multi-sectoral cholera elimination plan – Ethiopia 2021 – 2028 \(Global Task Force on Cholera Control\)](#)

2. Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025

Overview:

Update:

According to the [French National Health Authority](#), as of 2 March 2025, 3 390 cases (3 245 in 2025) of autochthonous chikungunya virus disease have been reported in La Réunion. In week 8, 1 300 new confirmed cases were reported, representing a strong increase compared to week 7, when 695 cases were reported.

Cases have now been reported in 23 of 24 municipalities.

The municipalities reporting the most cases since the start of the epidemic are:

- Le Tampon
- L' Étang-Salé

Virus circulation is also increasing considerably in Les Aviron, Petite-Île, Saint-Philippe, Saint-Louis (south), Saint-Paul, Saint-Leu La Possession and Trois-Bassins (west).

At present, the health impact on the individuals with the disease is relatively low, with only 13 of them hospitalised for more than 24 hours. However, this information has not been updated since last week due to cyclone Garance.

The Haute Autorité de santé (HAS) has [advised](#) public decision makers to vaccinate people over 65 years of age, people over 18 years of age with comorbidities and vector control professionals with the IXCHIQ vaccine, as a reactive short-term measure to prevent severe disease.

Background:

France reported the first autochthonous case of chikungunya virus disease for 10 years in the Department of La Réunion, with onset of symptoms on 12 August 2024. Since then, France has [confirmed](#) two more cases from the same neighbourhood. In recent weeks, the number of cases has increased sharply, as well as the geographical spread.

ECDC assessment:

The last major chikungunya virus disease epidemic in La Réunion was in 2005–2006. The mosquito *Aedes albopictus*, which is a known vector of chikungunya virus (CHIKV), is established on La Réunion.

The probability of infection for residents and travellers to La Réunion is currently moderate; the current period of austral summer is very favourable for the spread of arboviruses. Given the current dynamics of the epidemic, the likelihood of further dissemination of CHIKV across the entire island is high for the coming weeks. The impact is anticipated to be moderate, as a significant number of people are expected to be affected.

At present, environmental conditions in the areas of mainland Europe where *Ae. albopictus* or *Ae. aegypti* are established are unfavourable for vector activity and virus replication in vectors.

Actions:

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

The vector control and intervention strategy is based on:

- the elimination of mosquito breeding sites around the homes of patients;
- carrying out insecticide and/or larvicide treatments during the day;
- raising awareness of preventive measures among residents;
- distributing repellents to priority groups in the area around cases;
- searching for other cases in the area around the location of the initial case;
- encouraging people to consult a doctor promptly if symptoms occur;
- encouraging clinicians to carry out laboratory tests.

ECDC is monitoring the situation through its epidemic intelligence activities.

Further information:

Travellers to La Réunion are advised to apply personal protective measures to avoid the risk of being bitten by mosquitoes.

Aedes mosquitoes have diurnal biting activities in both indoor and outdoor environments. Personal protective measures should therefore be applied all day long and especially during the hours of highest mosquito activity (mid-morning and late afternoon to twilight). Personal protective measures to reduce the risk of mosquito bites include wearing long sleeves and trousers impregnated with insect repellent, the use of repellent sprays applied in accordance with the instructions indicated on the product label and limiting activities that increase mosquito exposure. In addition, it is recommended to sleep or rest in screened or air-conditioned rooms and to use mosquito bed nets (preferably insecticide-treated nets).

In the context of the outbreak, following the recommendations of the French health authorities, the national blood services have put the following measures in place for blood safety:

- CHIKV NAT for all donors in the overseas department of La Réunion;
- CHIKV-NAT, or 28-day temporary deferral period, for travellers who have stayed at least one night in La Réunion 28 days prior to their donations.

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

3. Avian flu detected in cats – Belgium – 2025

Overview:

On 4 March 2025, the Federal Agency for the Safety of the Food Chain of Belgium published a press release notifying that two outdoor cats were infected with avian influenza. The cats had severe symptoms and have been euthanised. They belonged to a poultry keeper at a farm where avian influenza A(H5) was detected in birds in February ([Joint press release by the FASFC, Sciensano and the FPS Public Health, Food Chain Safety and Environment | Federal Agency for the Safety of the Food Chain](#)). According to the press release, other cats in the same farm are healthy.

ECDC assessment:

ECDC assesses the current risk to the general public as low and the risk of infection for those occupationally or otherwise exposed to avian influenza infected animals or contaminated environments (wild or domesticated) as low-to-moderate. Sporadic infections in outdoor cats are not uncommon when circulation is high in nearby poultry/wild birds, such as farms experiencing outbreaks. There is no reported evidence of feline-to-feline or feline-to-human transmission.

Actions:

ECDC advises avoiding contact with dead or sick cats and practising proper hand hygiene when handling or feeding cats. The World Organisation for Animal Health (WOAH) advises isolation of suspected cases in animals and use of appropriate personal protective equipment for their handlers.

Those exposed to sick/dead cats with confirmed A(H5N1) infection are advised to monitor their symptoms for 10–14 days after the last exposure, self-isolate if they develop symptoms and report to public health authorities immediately. Any person exposed to sick/dead cats confirmed with A(H5N1) infection should be tested as soon as possible for A(H5N1) as a precautionary measure.

Further information:

[Avian influenza overview September-December 2024](#)

[Investigation protocol of human cases of avian influenza virus infections in EU/EEA](#)

[Coordinated One Health investigation and management of outbreaks in humans and animals caused by zoonotic avian influenza viruses](#)

4. SARS-CoV-2 variant classification

Overview:

Since the last update on 31 January 2025, and as of 28 February 2025, the following changes have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants:

- LP.8.1 has been added as a variant under monitoring (VUM) due to its fast growth globally as well as within the EU/EEA.

Note that for this update, sufficient data for estimating variant proportions during the reporting weeks is only available from three EU/EEA countries (France, Germany and Spain). The statistics below therefore only represent a limited part of the EU/EEA.

The VOI median proportions in the EU/EEA for weeks 6–7, based on three reporting countries, are currently:

KP.3: 26.1% (range: 19.0%-38.9%; IQR: 22.6%-32.5%)

BA.2.86: 26.1% (range: 22.2%-35.7%, IQR: 24.2%-30.9%)

The VUM median proportions in the EU/EEA for weeks 6–7, based on three reporting countries, are currently:

XEC: 45.2% (range: 38.9%-47.8%, IQR: 42.1%-46.5%)

LP.8.1: 5.6% (range: 4.3%-21.4%, IQR: 5.0%-13.5%)

The calculations are based on data reported to GISAID, as of 23 February 2025.

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 variant 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 will be provided on a monthly basis as a minimum.

Last time this event was included in the Weekly CDTR: 7 February 2025

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

Overview:

Based on data reported to week 8, 2025, primary and secondary care consultation rates reported by countries indicate that there are still significant levels of respiratory virus activity in the EU/EEA. Intense seasonal influenza activity is reported together with a respiratory syncytial virus epidemic, while SARS-CoV-2 activity is at a very low level.

All indicators point to continued, widespread, intense influenza activity in the EU/EEA, driven by co-circulating A(H1)pdm09, A(H3) and B/Vic viruses, with patterns of dominance varying greatly across countries. Most countries have reached, or passed peak activity, however increasing trends in activity continue to be observed in around a quarter of the EU/EEA countries. Influenza hospital admissions have now started to decrease from very high levels in most reporting countries.

Since peaking in week 52, 2024, RSV activity in the EU/EEA has decreased. However, at country level the picture is mixed, with approximately half of the reporting countries showing decreases and the remainder reporting stable or increasing levels of activity.

ECDC assessment:

Since week 40, 2024, the winter respiratory virus season in the EU/EEA has been characterised by an intense influenza season, a concurrent RSV epidemic and steadily declining SARS-CoV-2 activity. The biggest impact in secondary care has been in adults aged 65 years and above for influenza and SARS-CoV-2 and in children aged under five years for RSV. Since week 51, 2024, [EuroMOMO](#) has reported all-cause mortality above expected levels, mostly in adults aged 65 years and over.

The levels of respiratory virus activity currently observed in the EU/EEA, with intense influenza activity and co-circulation of RSV, are expected to continue to place pressure on healthcare systems and hospital capacity, particularly where this is already limited.

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.
- ECDC has published recommended public health actions to mitigate against the impact of respiratory virus circulation during winter 2024/2025 in an [epidemiological update](#). Countries should be prepared for continued pressure on healthcare systems, ensuring that [infection prevention and control practices in healthcare settings](#) are implemented.
- Vaccination is the most effective measure to protect against more severe forms of viral respiratory diseases. Those eligible for vaccination, particularly those at higher risk of severe outcomes, are encouraged to get vaccinated in line with national recommendations.
- Interim [influenza vaccine effectiveness](#) estimates are available for the 2024/2025 season. Analysis of data submitted from multi-country primary care and hospital study sites indicate that influenza vaccination prevented between one third and more than three-quarters of the influenza infections medically attended in primary care or hospital settings, although protection varied by age group and study site.
- Clinicians should be reminded that, when indicated, the early use of antivirals against influenza may reduce symptom duration and prevent disease progression in groups at high risk of severe outcomes. Frequent handwashing, physical distancing, avoiding large gatherings and wearing masks in healthcare settings can all help to reduce transmission and protect groups at high risk of severe disease.

Sources: [ERVISS](#)

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

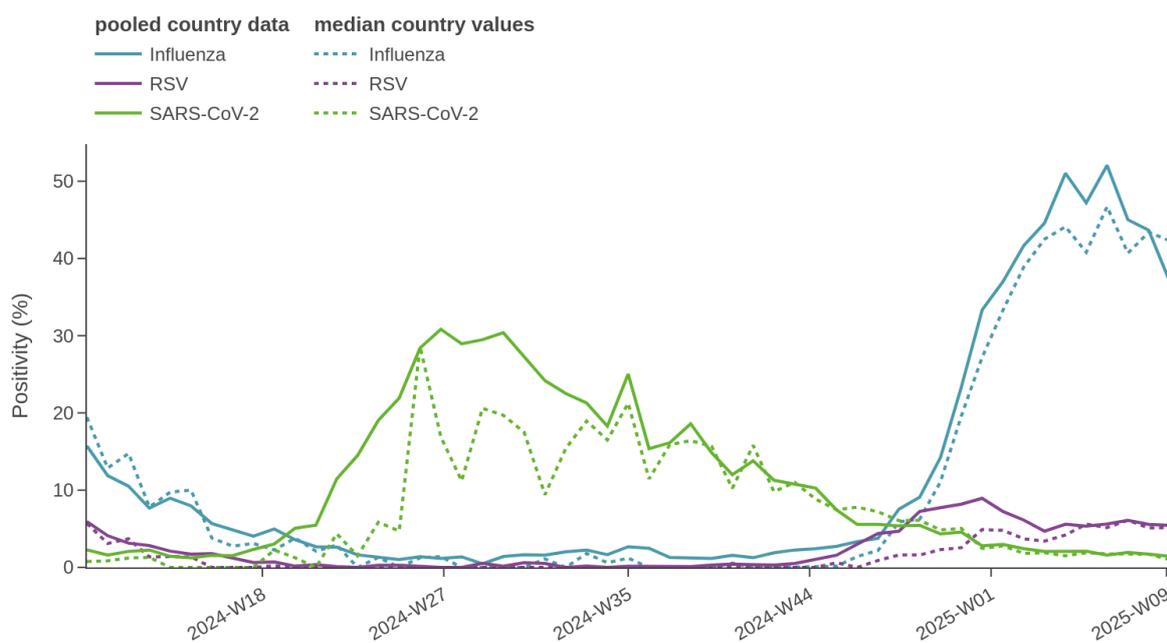
Figure 1. Overview of key indicators of activity and severity in week 9, 2025

Key indicators in week 9, 2025

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 9	Week 8	Description	Value	
ILI/ARI consultation rates in primary care	ARI	13 rates (10 MEM)	15 rates (11 MEM)	Distribution of country MEM categories	3 Baseline 1 Low 5 Medium 1 Very High	Medium to very high levels based on the Moving Epidemic Method (MEM) in the majority of countries reflect the intensity of influenza activity.
	ILI	18 rates (16 MEM)	20 rates (18 MEM)		2 Baseline 3 Low 8 Medium 2 High 1 Very High	
ILI/ARI test positivity in primary care	Influenza	19	20	Pooled (median; IQR)	37% (42; 30–50%)	Behind the slowly decreasing trend in pooled influenza positivity at the EU/EEA level, observed in all age groups, is a mix of decreasing in influenza A activity together with influenza B activity that has been increasing but may be nearing a peak. The EU/EEA level pooled data mask considerable heterogeneity between countries.
	RSV	18	18		5.4% (5.2; 5.8–9.5%)	
	SARS-CoV-2	18	18		1.4% (1; 0.8–2%)	
SARI rates in hospitals	SARI	9	10			
SARI test positivity in hospitals	Influenza	8	9	Pooled (median; IQR)	29% (14; 12–23%)	The pooled positivity has stabilised since week 5 and is now decreasing in all reporting countries. The overall age distribution in the season to date does not differ substantially from that observed in the 2023–2024 season. Positivity is increasing in the 5–14 years age group, but this seems to be driven largely by data from one country, with SARI consultation rates among the lowest in this age group in all reporting countries.
	RSV	7	8		8.5% (11; 7.3–13%)	
	SARS-CoV-2	7	8		1.3% (1; 0–1.5%)	
Intensity (country-defined)	Influenza	21	23	Distribution of country qualitative categories	1 Baseline 4 Low 9 Medium 5 High 2 very High	
Geographic spread (country-defined)	Influenza	20	22	Distribution of country qualitative categories	1 Local 2 Regional 17 Widespread	

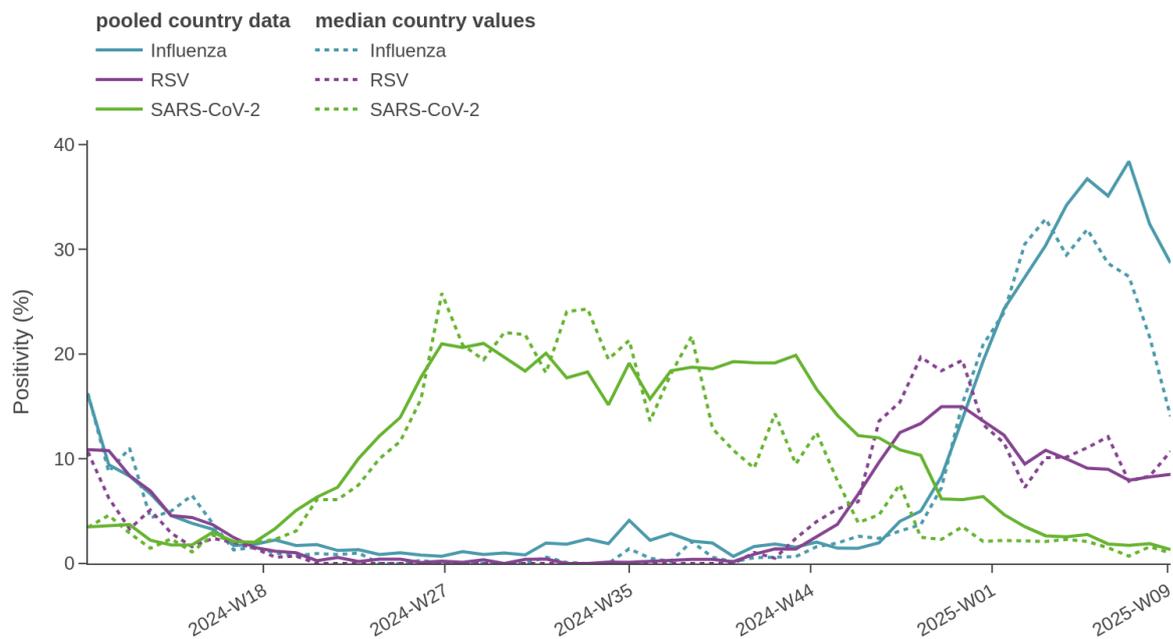
Source: ECDC

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



Source: ECDC

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



Source: ECDC

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

Pathogen	N	Week 9, 2025		Week 40, 2024 - week 9, 2025	
		N	% ^a	N	% ^a
Influenza	1306		-	19561	-
Influenza A	650		50	12092	63
A(H1)pdm09	197		37	6122	61
A(H3)	339		63	3915	39
A (unknown)	114		-	2055	-
Influenza B	651		50	7248	37
B/Vic	305		100	2815	100
B/Yam	0		0.0	1	0.0
B (unknown)	346		-	4432	-
Influenza untyped	5		-	221	-
RSV	133		-	2867	-
RSV-A	22		51	461	40
RSV-B	21		49	687	60
RSV untyped	90		-	1719	-
SARS-CoV-2	35		-	2775	-

Source: ECDC

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

Figure Table

Pathogen	Week 9, 2025		Week 40, 2024 - week 9, 2025	
	N	% ^a	N	% ^a
Influenza	526	-	9237	-
Influenza A	71	75	3617	87
A(H1)pdm09	11	48	1277	64
A(H3)	12	52	707	36
A (unknown)	48	-	1633	-
Influenza B	24	25	527	13
B/Vic	0	-	59	100
B (unknown)	24	-	468	-
Influenza untyped	431	-	5093	-
RSV	151	-	3686	-
RSV-A	4	67	601	50
RSV-B	2	33	599	50
RSV untyped	145	-	2486	-
SARS-CoV-2	24	-	3240	-

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 9, 2025

Subtype	Subtype distribution		Subclade	Subclade distribution	
	N	%		N	%
A(H1)pdm09	1991	48	5a.2a(C.1.9)	1764	89
			5a.2a.1(D)	170	9
			5a.2a(C.1)	57	3
A(H3)	1010	24	2a.3a.1(J.2)	727	73
			2a.3a.1(J.2.2)	131	13
			2a.3a.1(J.2.1)	116	12
			2a.3a.1(J)	10	1
			2a.3a.1(J.1)	10	1
			2a.3a.1(J.4)	2	0.2
			Not assigned	14	-
B/Vic	1151	28	V1A.3a.2(C.5.1)	790	69
			V1A.3a.2(C.5.7)	169	15
			V1A.3a.2(C.5.6)	156	14
			V1A.3a.2(C)	22	2
			V1A.3a.2(C.5)	2	0.2
			Not assigned	12	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 7–8, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	2	13	23% (11–23%)
KP.3	VOI	2	12	14% (7–20%)
XEC	VUM	3	35	48% (44–70%)
LP8.1	VUM	3	7	10% (9–10%)

Source: ECDC

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

Overview:

In January 2025, 1 033 measles cases were reported by 17 countries. Eleven countries reported zero cases. In the most recent 12-month period, from 1 February 2024 to 31 January 2025, 30 EU/EEA countries reported a total of 32 265 cases of measles. Between 1 February 2024 and 31 January 2025, of the 29 481 patients with known age, 14 556 (45.1%) were children under five years old and 8 721 (27%) were individuals aged 15 years or above.

The highest notification rates were observed in infants under one year of age (1 052.2 cases per million) and children aged 1–4 years (617.1 cases per million). Of 29 481 cases (100.0% of all cases) with a known age and vaccination status, 25 503 (86.5%) were unvaccinated, 2 583 (8.8%) were vaccinated with one dose of a measles-containing vaccine, 1 304 (4.4%) were vaccinated with two or more doses, and 52 (0.2%) were vaccinated with an unknown number of doses.

Nineteen deaths (case fatality rate (CFR): 0.1) attributable to measles were reported to ECDC during the 12-month period, by Romania (18) and Ireland (one). Detailed data are available in [ECDC's Surveillance Atlas of Infectious Diseases](#).

Complementary epidemic intelligence surveillance, with data collection conducted on 6 March 2025 from official public sources, identified 1 868 new measles cases since the last monthly report on 10 February 2025.

Since the last monthly report, new cases were reported in eight EU countries: Austria (7), Denmark (1), Germany (15), Ireland (7), the Netherlands (37), Poland (15), Romania (1727) and Spain (59).

Disclaimer: *The [monthly measles report published in the CDTR](#) provides the most recent data on cases and outbreaks based on information made publicly available by the national public health authorities or the media. Sometimes this information is made available retrospectively. This report is a supplement to [ECDC's monthly measles and rubella monitoring report](#), based on data routinely submitted by 30 EU/EEA countries to TESSy and EpiPulse. Data presented in the two monthly reports may differ.*

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

[Austria](#) reported 54 confirmed measles cases in 2025 and as of 5 March 2025, an increase of seven cases since 5 February 2025.

[Denmark](#) reported one measles case in 2025 and as of 1 March 2025.

[France](#) has reported measles circulation in several regions, including in [Hauts-de-France](#) and [Auvergne-Rhône-Alpes](#). Furthermore, a significant increase in imported measles cases has been observed. As of 14 February 2025, 13 measles cases linked to travel to Morocco have been reported. The [authorities issued a press statement](#) to raise awareness among travellers to Morocco and to enhance vigilance among healthcare professionals caring for travellers returning from areas where measles is circulating.

[Germany](#) reported 41 measles cases in 2025 and as of 5 March 2025, an increase of 15 cases since 10 February 2025.

[Ireland](#) reported 36 measles cases in 2025 and as of 1 March 2025, an increase of seven cases since 10 February 2025.

[Netherlands](#) reported 63 measles cases in 2025 and as of 5 March 2025, an increase by 37 cases since 6 February 2025. There is no indication of a national outbreak. However, a cluster of measles cases has been detected among children linked to a school, with additional cases reported within

households. In 2025, 16 cases were reported to have contracted measles in Morocco and three in Romania. Healthcare professionals in the Netherlands have been advised to be alert to measles in patients who have recently returned from an area where measles is prevalent.

[Poland](#) reported 15 measles cases in 2025 and as of 28 February 2025.

[Romania](#) reported 2 645 measles cases and four deaths in 2025 and as of 28 February 2025, an increase of 1 727 cases and two deaths since 31 January 2025. The first new death occurred in a two-year-old unvaccinated female, and the second death was in a one-year-old unvaccinated female.

[Spain](#) reported 123 measles cases in 2025 and as of 2 March 2025, an increase by 59 cases since 9 February 2025. Of the reported cases, 40 (33%) were imported and 50 (41%) were linked to an imported case. Outbreaks have been reported in several parts of Spain.

On 16 January, [the Department of Health of the Basque Government](#) reported a measles outbreak associated with an imported case in Bizkaia, with 12 confirmed measles cases. According to [media reports](#), the number of cases associated with this outbreak has increased to 50. A large proportion of those affected are [healthcare workers](#).

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

Morocco

Morocco is experiencing a significant measles outbreak that began in October 2023 and has spread nationwide. According to [media reports](#) citing official sources, 20 086 measles cases, including 3 391 confirmed cases and 37 deaths have been reported in 2025. In total, over 40 000 cases and nearly 150 deaths have been reported since the beginning of the outbreak and as of 5 March 2025. Most deaths occurred in children under five years of age and adults over 37 years of age.

The reasons for the increase in measles cases are not known. The rise in cases might be attributed to declining vaccination rates following the COVID-19 pandemic. However, according to [WHO data](#), the estimated vaccination coverage rate in the country for the first and second doses of measles vaccine was 99% between 2019 and 2023.

Summary of measles cases reported by WHO regional offices

Increased measles activity has been reported globally. The latest report on measles cases from the WHO regional offices, dated [11 February 2025](#), was already included in the previous monthly measles report. A total of 3 106 measles cases have been reported to the WHO Regional Offices in 2025 and as of 11 February 2025.

Below, we provide a summary by WHO region, complemented by additional data collected through epidemic intelligence activities:

The WHO Regional Office for Europe (WHO/EUROPE) reported 15 measles cases in 2025 as of 11 February 2025, all from the United Kingdom.

The numbers provided to WHO for EU/EEA countries are from TESSy data, which are updated monthly and available on the [ECDC Surveillance Atlas of Infectious Diseases](#). Due to differences in reporting times, the numbers may not correspond to the data from epidemic intelligence screening.

The WHO Regional Office for Africa (WHO AFRO) reported 1 469 measles cases in 2025 as of 11 February 2025. The highest numbers of cases were reported from Ethiopia (314), Rwanda (250), Nigeria (219), Uganda (135) and Burkina Faso (108). Between 24 February and 2 March 2025, [WHO AFRO](#) reported measles cases from Cameroon, Ethiopia, Guinea, Kenya, and Senegal.

The [WHO Regional Office for the Americas \(WHO PAHO\)](#) reported 268 measles cases, including one death in 2025 as of 28 February 2025. Measles cases were reported from the United States of America (164, including one death), Canada (96, of which 95% were import related), Argentina (4), and Mexico (4). On 28 February 2025, WHO PAHO issued an [Epidemiological Alert for measles](#), calling on Member States to strengthen vaccination, epidemiological surveillance, and rapid response activities.

The WHO Regional Office for South-East Asia (WHO SEARO) reported 1 558 measles cases in 2025 as of 11 February 2025. The highest numbers of cases were reported by India (1 419), Thailand (103) and Nepal (34).

The WHO Regional Office for the Eastern Mediterranean (WHO EMRO) and the WHO Regional Office for the Western Pacific (WHO WPRO) have reported no measles cases in 2025 as of 11 February 2025. However, in the EMRO region, a large measles outbreak has been reported in Morocco, and in the WPRO region, in Vietnam. According to [media reports](#), WHO has assessed the risk of a measles outbreak in Viet Nam as very high.

ECDC assessment:

The overall number of measles cases in the EU/EEA increased steadily between June 2023 and March 2024 before decreasing between April 2024 and January 2025. **Measles cases may continue to increase in the EU/EEA in the coming months, in line with measles observed seasonality.** This is due to reported suboptimal vaccination coverage for measles-containing vaccines (MCV) in a number of EU/EEA countries, as well as a high probability of importation from areas experiencing high circulation. The majority of recently reported cases have acquired the disease within the reported country through community/local transmission, however cases related to international travel have been reported.

Actions:

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

As the number of cases is expected to rise in the near future, ECDC urges EU/EEA public health authorities to focus on the following areas:

- **Close immunity gaps, achieve and maintain high vaccination coverage for MCV** (>95% with the second dose). It is vital to ensure first and second dose vaccinations are administered on time as per national schedules among infants and children. It is also important to identify and vaccinate eligible individuals (for example, non-immune adolescents and adults) in immunisation catch-up programmes (as recommended by local and national authorities).
- **Strive towards high-quality surveillance** and adequate public health capacity, especially for early detection, diagnosis, response and control of outbreaks.
- **Increase the clinical awareness of health professionals, including reminding them of the importance of checking individuals' vaccination status ahead of travel.**
- **Healthcare professionals should be fully vaccinated.**
- **Promote vaccine acceptance and uptake** by employing specific risk communication strategies and identifying drivers of suboptimal MMR vaccine acceptance and uptake to ensure that tailored interventions are implemented in response.
- **Address barriers and engage with under-served populations.** Systemic barriers that impact vaccine uptake in under-served, isolated and difficult-to-reach populations need to be monitored and addressed with targeted strategies in order to reduce inequalities in vaccine uptake.

ECDC's latest advice on measles is available in the Threat Assessment Brief '[Measles on the rise in the EU/EEA: Considerations for a public health response](#)', published in February 2024 and the conclusions remain valid. Additional information on the risk classification and ECDC recommendations can be found in this report.

Last time this event was included in the Weekly CDTR: 14 February 2025

7. Ebola disease – Uganda – 2025

Overview:

Update

On 6 March 2025, Africa CDC [reported](#) two new confirmed cases of Ebola disease. The total number of confirmed cases is now 12, including two deaths. A new cluster has been identified around the previously reported four-year-old male (the tenth overall case). This cluster is not epidemiologically linked to the previous one but the clusters are genetically linked. There are 69 new contacts connected with this cluster, who are under follow up.

The total number of affected districts is now five. The Africa CDC briefing mentioned that community transmission is highly likely and that there are concerns since cases have been reported in Kampala.

Summary

On 30 January 2025, public health authorities in Uganda [declared](#) an outbreak of Sudan virus disease (SVD) in Kampala, Uganda. This follows laboratory confirmation from three national reference laboratories: the Central Public Health Laboratory in Kampala, the Uganda Virus Research Institute in Entebbe, and Makerere University. According to the Ministry of Health's press release, the index case was a 32-year-old male nurse at the Mulago National Referral Hospital. As of 1 March 2025, 10 cases had been reported in total, including two deaths. Two deaths are also investigated as being probable cases.

Event background and additional information

The patient identified as the index case [presented](#) with symptoms on 19 January 2025 and passed away on 29 January 2025. The patient sought treatment at multiple health facilities in the Central district, as well Mbale City, and also from a traditional healer.

As of 20 February 2025, nine confirmed cases had been reported. Of these, one patient had passed away and eight had recovered. All these cases were [reported](#) from five districts in the country: Wakiso (4), Kampala (2), Mbale (1), Jinja (1), and Mukono (1). The age range was from 1.5 to 49 years, with a mean age of 27 years, and males accounting for 56% of the total cases.

All initial cases [belonged](#) to the same transmission chain and were divided into two sub-clusters. One included five family members of the index case and the other involved three healthcare workers who had treated the index case. The secondary cases had symptom onset between 29 January and 6 February. On 18 February, WHO [reported](#) that at the time the remaining confirmed cases under hospitalisation had recovered and been discharged after two consecutive negative tests taken 72 hours apart. A new case was then [reported](#) on 1 March 2025 in Mulago Hospital (Kampala) in a child (4.5 years old) who died on 25 February 2025. Two other deaths are being investigated due to their links with the tenth case. These two individuals were classified as probable cases by [WHO](#).

On 6 March 2025, Africa CDC [reported](#) two new confirmed cases and that the total number of affected districts is now five. A new cluster has been identified around the previously reported four-year-old male (the tenth overall case). This cluster is not epidemiologically linked to the previous one, but the clusters are genetically linked.

The total number of cases reported in the outbreak as of 6 of March is 12 confirmed and two probable cases including four deaths (two confirmed cases and the two probable cases). A total of 489 contacts have been identified.

The [phylogenetic analysis](#) of samples taken from the index case showed them to be genetically close to sequences from the 2012 Sudan Ebola outbreak in Luwero District (Uganda).

In the context of the current outbreak, [WHO announced](#) the first ever vaccination trial of a vaccine against SVD, taking place in Uganda. This is the first time that a clinical trial has been conducted to measure the efficacy of a vaccine against SVD.

The response in Uganda is lead by the Ministry of Health with support from partners ([WHO AFRO Weekly Bulletin, Week 9: 24 February–2 March 2025](#)).

This is the eighth Ebola outbreak in the country, with the [most recent](#) having occurred in 2022. For more information on the disease and its epidemiology, please read the ECDC [Factsheet about Ebola disease](#).

ECDC assessment:

During the previous SVD outbreak in Uganda, ECDC produced a [Rapid risk assessment](#) assessing the risk to citizens in the EU/EEA as very low. The assessment, including ECDC's options for response, remains valid.

The current outbreak started in Kampala, the densely populated capital of Uganda, so there is a greater probability of local transmission, despite the low number of cases currently being reported.

Since the index case occurred among healthcare workers in hospital, EU/EEA citizens working in healthcare settings in Uganda should be aware of the ongoing outbreak and take appropriate personal protective measures.

Given the above, and in light of evidence from previous larger outbreaks, the importation of a case to the EU/EEA is very unlikely and, should that happen, the likelihood of further transmission is considered very low.

Actions:

ECDC is monitoring the event and is in contact with the EU bodies in Kampala as well as Africa CDC.

Sources: [WCO-Uganda](#)

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

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

Overview:

Update: Since the previous update on 5 February 2025, and as of 5 March 2025, no new MERS cases have been reported by WHO or national health authorities.

Summary: Since the beginning of 2025, and as of 5 March 2025, no MERS cases have been reported with date of onset in 2025.

Since April 2012, and as of 5 March 2025, a total of 2 626 cases of MERS, including 953 deaths, have been reported by health authorities worldwide.

Sources: [ECDC MERS-CoV page](#) | [WHO MERS-CoV](#) | [ECDC factsheet for professionals](#) | [WHO updated global summary and assessment of risk \(November 2022\)](#) | [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](#)

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.

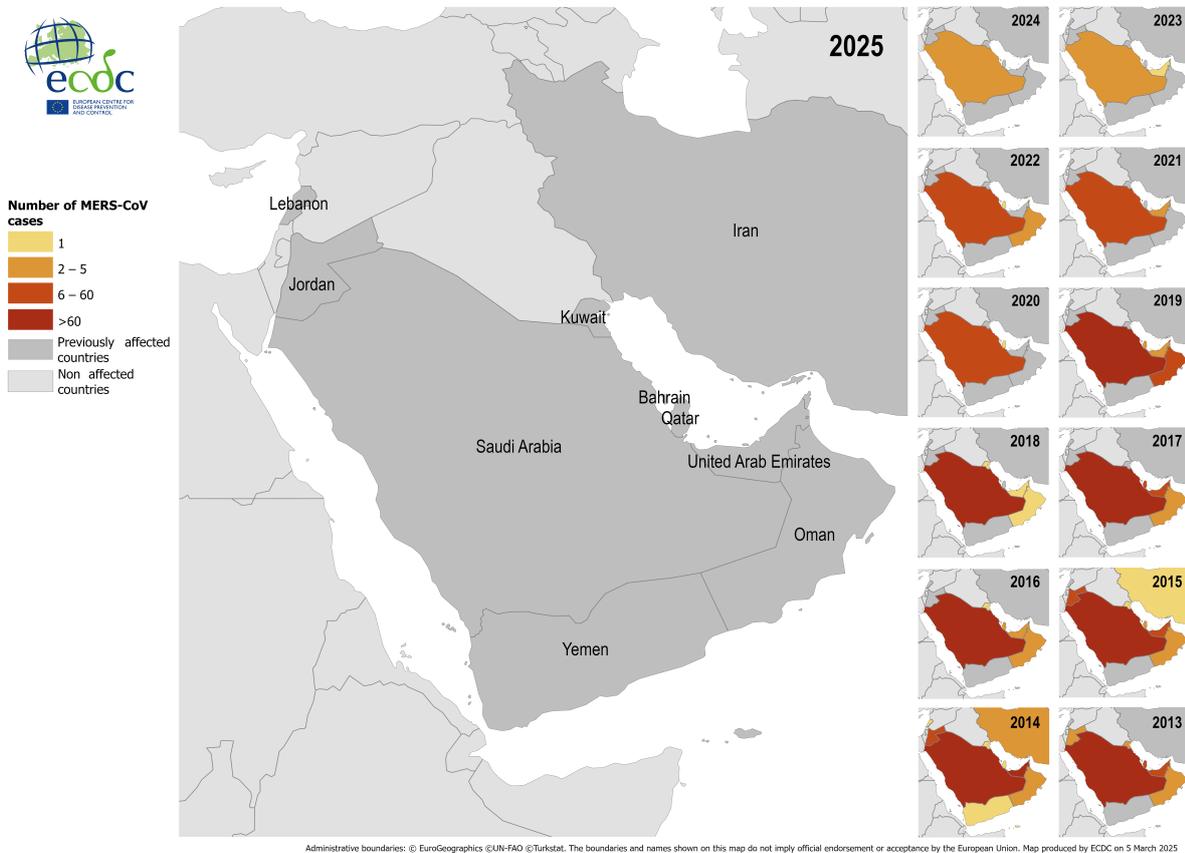
ECDC published a technical report, '[Health emergency preparedness for imported cases of high-consequence infectious diseases](#)', in October 2019 which is still useful for EU Member States wanting to assess their level of preparedness for a disease such as MERS. ECDC also published '[Risk assessment 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.

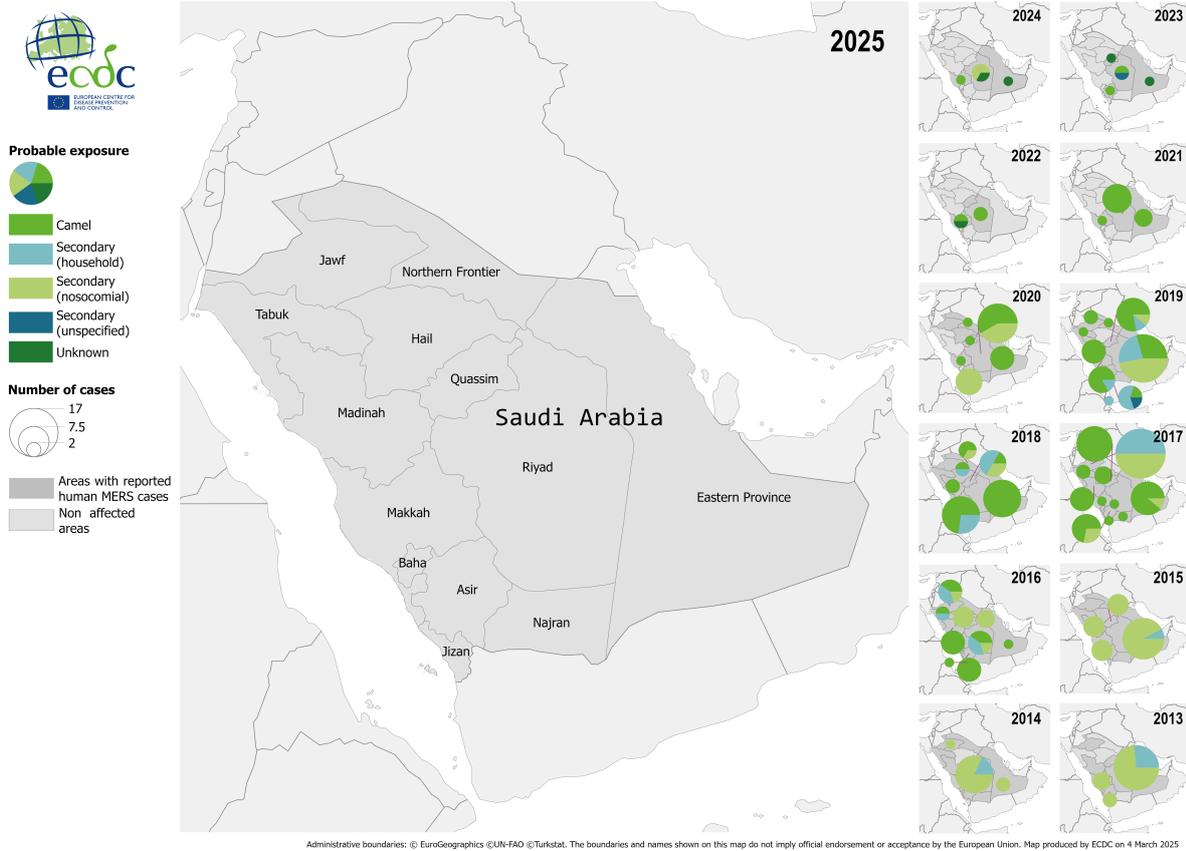
Last time this event was included in the Weekly CDTR: 7 February 2025

Figure 8. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2013 – February 2025



Source: ECDC

Figure 9. 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 February 2025



Source: ECDC

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases – last reported on 28 February 2025
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update – last reported on 28 February 2025
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks – last reported on 28 February 2025
- Overview of respiratory virus epidemiology in the EU/EEA – last reported on 28 February 2025
- Avian influenza A(H5N1) human cases – United States – 2024 – last reported on 28 February 2025
- Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025 – last reported on 28 February 2025
- Ebola disease – Uganda – 2025 – last reported on 28 February 2025
- Legionnaires' disease outbreak – Vorarlberg, Austria – 2025 – last reported on 28 February 2025
- Unknown disease – DRC – 2025 – last reported on 28 February 2025
- Locally acquired dengue cases in Madeira – Portugal – 2025 – last reported on 21 February 2025
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases – last reported on 21 February 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update – last reported on 21 February 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring – last reported on 14 February 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 – last reported on 14 February 2025
- Human cases with avian influenza A(H10N3) – Multi-country (World) – last reported on 14 February 2025
- Human cases infected with swine influenza A(H1N2) variant virus – Multi-country – 2024 – last reported on 14 February 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 – last reported on 14 February 2025
- STI cases continue to rise across Europe – last reported on 14 February 2025
- Cholera associated with holy well water from Ethiopia – last reported on 07 March 2025
- Avian flu detected in cats – Belgium – 2025 – last reported on 07 March 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update – last reported on 07 March 2025
- SARS-CoV-2 variant classification – last reported on 07 March 2025
- Yellow fever – South America – 2024–2025 – last reported on 07 February 2025
- Shigella sonnei ST152 outbreak associated with international travel on long-haul flights – last reported on 07 February 2025
- Mpox due to monkeypox virus clade I – Ireland – 2025 – last reported on 07 February 2025