

WEEKLY BULLETIN

Communicable disease threats report

Week 12, 15–21 March 2025

This week's topics

- [1. Cholera – Multi-country \(World\) – Monitoring global outbreaks – Monthly update](#)
- [2. Middle East respiratory syndrome coronavirus \(MERS-CoV\) – Multi-country – Monthly update](#)
- [3. Overview of respiratory virus epidemiology in the EU/EEA](#)
- [4. Avian influenza A\(H5N1\) human cases – United States – 2024](#)
- [5. Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025](#)
- [6. Risk of severe infections, carriage and cross-border transfer of carbapenem-resistant bacteria in victims of the fire at Pulse nightclub \(Kocani\) – North Macedonia](#)
- [7. Ebola disease – Uganda – 2025](#)

Executive Summary

Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update

- Since 1 January 2025 and as of 17 March 2025, 76 919 cholera cases, including 969 deaths, have been reported worldwide.
- Since 20 February 2025, and as of 17 March 2025, 20 851 new cholera cases, including 374 new deaths, have been reported worldwide.
- New cases have been reported from Afghanistan, Angola, Burundi, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Namibia, Nigeria, Pakistan, Somalia, South Sudan, Sudan, Togo, Uganda, United Republic of Tanzania, Yemen, Zambia and Zimbabwe.
- In 2025, cholera cases continue to be reported in Africa, Asia, and the Middle East. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

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

- Since the previous update on 5 March 2025, and as of 18 March 2025, four new MERS cases, including two fatalities, have been reported in Saudi Arabia.
- Dates of onset ranged from November 2024 to January 2025. One person had exposure to camels, one person was a nosocomial contact and the other two people had an unknown exposure. All cases occurred in males 27–78 years old with comorbidities.

- Since the beginning of 2025, and as of 18 March 2025, one MERS case has been reported with date of onset in 2025 in Saudi Arabia.
- The risk of sustained human-to-human transmission in Europe remains very low and the current MERS-CoV situation poses a low risk to the EU/EEA.

Overview of respiratory virus epidemiology in the EU/EEA

Respiratory virus activity remains elevated in the European Union/European Economic Area (EU/EEA). High but decreasing seasonal influenza activity continues, together with ongoing elevated respiratory syncytial virus (RSV) activity. Pooled data suggest that the peak in influenza activity has passed while co-circulation of influenza A and B viruses continues. The greatest impact in secondary care has been seen in adults 65 years old and above for influenza and in children under five years old for RSV. Excess mortality has been observed since week 51, 2024, primarily affecting adults aged 45 years and above, with levels now beginning to decrease. SARS-CoV-2 activity has been steadily declining since summer 2024, with no winter epidemic observed to date, and remains at a very low level.

Avian influenza A(H5N1) human cases – United States – 2024

- The United States Centers for Disease Control and Prevention (US CDC) conducted two separate investigations into previously reported human cases of avian influenza A(H5N1): a serology study related to a child in San Francisco and a sequencing analysis related to a case in Ohio.
- The serology study confirmed recent infection with avian influenza A(H5N1) virus in the child, but found no evidence of transmission to close contacts, indicating no person-to-person spread in that case.
- Sequencing of the virus isolated from the Ohio case identified the virus as clade 2.3.4.4b of genotype D1.3, with no markers present that would suggest antiviral resistance or enhanced transmission to mammals; this is the first detection of genotype D1.3 in a human case in the current A(H5N1) outbreak.
- The US CDC has also published analyses of three recent studies on pre-existing immunity, immune response following mild illness, and antiviral susceptibility related to avian influenza A(H5N1).
- Since 1 April 2024, and as of 21 March 2025, a total of 70 human cases of avian influenza A(H5) have been reported from 13 states in the United States (US). Of these, 41 were individuals exposed to dairy cattle known or presumed to be infected with A(H5N1) and 24 were workers exposed to outbreaks of HPAI A(H5) at poultry farms. Three people had no known animal exposure and two had exposure to other animals, such as backyard flocks, wild birds, or other mammals.
- According to the US CDC, the risk from A(H5N1) viruses to the general population remains low, while the risk to individuals in contact with potentially infected animals, contaminated surfaces or fluids is considered moderate to high.

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 up to 9 March 2025, 8 749 cases of autochthonous chikungunya virus disease have been confirmed in La Réunion.
- On 21 March 2025, two deaths were reported in older adults, one of whom presented with comorbidities.
- The Haute Autorité de santé (HAS) has advised public decision-makers to vaccinate groups who are at a higher risk of severe disease and vector control professionals. The regional health agency is preparing to provide vaccine access to prioritised individuals from the beginning of April.

Risk of severe infections, carriage and cross-border transfer of carbapenem-resistant bacteria in victims of the fire at Pulse nightclub (Kocani) – North Macedonia

- North Macedonia reported 59 deaths and 155 injuries due to a fire at a nightclub in Kočani during the night of Saturday 15 to Sunday 16 March 2025.
- Several of the injured people have burn injuries and many have already been or are going to be [transferred](#) to EU Member States or neighbouring EU enlargement countries.

Ebola disease – Uganda – 2025

- Since the last update and as of 20 March, no new cases have been reported. Of the 12 confirmed cases identified so far, two more were discharged, bringing the total number of recovered individuals up to 10 (83%).
- Since the beginning of the outbreak and as of 20 March, 12 confirmed and two probable cases have been reported, including four deaths (two confirmed and two probable cases).
- 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.

1. Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update

Overview:

Data presented in this report originate from several sources, both official public health authorities and non-official sources, such as the media. Case definitions, testing strategies, and surveillance systems vary between countries. In addition, data completeness and levels of under-reporting vary between countries. All data should therefore be interpreted with caution. For details on the epidemiological situation and more information regarding the case definitions in use, refer to the original sources.

Summary

Since 1 January 2025 and as of 17 March 2025, 76 919 cholera cases, including 969 deaths, have been reported worldwide.

Since 20 February 2025 and as of 17 March 2025, 20 851 new cholera cases, including 374 new deaths, have been reported worldwide. In comparison, since 1 January 2024 and as of 17 March 2024, 66 532 cholera cases, including 930 deaths, were reported worldwide.

New cases have been reported from Afghanistan, Angola, Burundi, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Namibia, Nigeria, Pakistan, Somalia, South Sudan, Sudan, Togo, Uganda, United Republic of Tanzania, Yemen, Zambia and Zimbabwe.

The five countries reporting the most new cases are South Sudan (5 240), Afghanistan (4 947), Sudan (4 166), Angola (3 972) and Yemen (3 674).

New deaths have been reported from Afghanistan, Angola, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, Somalia, South Sudan, Sudan, Togo, Uganda, United Republic of Tanzania, Yemen and Zimbabwe.

The five countries reporting the most new deaths are Angola (150), Sudan (96), Democratic Republic of Congo (86), South Sudan (69) and Ethiopia (22).

In 2025, new cholera cases and new deaths have been reported from:

Africa

Angola: Since 18 February 2025 and as of 14 March 2025, 3 972 new cases, including 150 new deaths, have been reported. Since 1 January 2025 and as of 14 March 2025, 7 119 cases, including 258 deaths, have been reported. In comparison, in 2024 and as of 17 March 2024, no cases were reported.

Burundi: Since 3 February 2025 and as of 24 February 2025, 21 new cases have been reported. Since 1 January 2025 and as of 24 February 2025, 95 cases have been reported. In comparison, in 2024 and as of 29 February 2024, 58 cases were reported.

Democratic Republic of the Congo: Since 27 January 2025 and as of 17 February 2025, 3 285 new cases, including 86 new deaths, have been reported. Since 1 January 2025 and as of 17 February 2025, 8 056 cases, including 171 deaths, have been reported. In comparison, in 2024 and as of 29 February 2024, 5 613 cases, including 129 deaths, were reported.

Ethiopia: Since 3 February 2025 and as of 3 March 2025, 680 new cases, including 22 new deaths, have been reported. Since 1 January 2025 and as of 3 March 2025, 857 cases, including 25 deaths, have been reported. In comparison, in 2024 and as of 29 February 2024, 2 288 cases, including 18 deaths, were reported.

Ghana: Since 18 February 2025 and as of 12 March 2025, 774 new cases, including three new deaths, have been reported. Since 1 January 2025 and as of 12 March 2025, 2 253 cases, including 12 deaths, have been reported. In comparison, in 2024 and as of 17 March 2024, no cases were reported.

Kenya: Since 9 August 2024 and as of 12 March 2025, 37 new cases, including one new death, have been reported. Since 1 January 2025 and as of 12 March 2025, 37 cases, including one death, have been reported. In comparison, in 2024 and as of 29 February 2024, 165 cases were reported.

Malawi: Since 18 February 2025 and as of 3 March 2025, seven new cases, including one new death, have been reported. Since 1 January 2025 and as of 3 March 2025, 90 cases, including three deaths, have been reported. In comparison, in 2024 and as of 29 February 2024, 187 cases, including three deaths, were reported.

Mozambique: Since 3 February 2025 and as of 12 March 2025, 410 new cases, including eight new deaths, have been reported. Since 1 January 2025 and as of 12 March 2025, 474 cases, including eight deaths, have been reported. In comparison, in 2024 and as of 29 February 2024, 4 035 cases, including seven deaths, were reported.

Namibia: Since 31 January 2018 and as of 2 March 2025, one new case has been reported. Since 1 January 2025 and as of 2 March 2025, one case has been reported. In comparison, in 2024 and as of 17 March 2024, no cases were reported.

Nigeria: Since 10 February 2025 and as of 24 February 2025, 235 new cases, including 14 new deaths, have been reported. Since 1 January 2025 and as of 24 February 2025, 1 124 cases, including 28 deaths, have been reported. In comparison, in 2024 and as of 29 February 2024, 169 cases, including two deaths, were reported.

Somalia: Since 20 January 2025 and as of 17 February 2025, 632 new cases have been reported. Since 1 January 2025 and as of 17 February 2025, 1 409 cases, including one death, have been reported. In comparison, in 2024 and as of 29 February 2024, 2 943 cases, including 26 deaths, were reported.

South Sudan: Since 10 February 2025 and as of 24 February 2025, 5 240 new cases, including 69 new deaths, have been reported. Since 1 January 2025 and as of 24 February 2025, 19 122 cases, including 262 deaths, have been reported. In comparison, in 2024 and as of 17 March 2024, no cases were reported.

Sudan: Since 18 February 2025 and as of 3 March 2025, 4 166 new cases, including 96 new deaths, have been reported. Since 1 January 2025 and as of 3 March 2025, 6 603 cases, including 149 deaths, have been reported. In comparison, in 2024 and as of 17 March 2024, no cases were reported.

Togo: Since 3 February 2025 and as of 24 February 2025, 23 new cases have been reported. Since 1 January 2025 and as of 24 February 2025, 161 cases, including four deaths, have been reported. In comparison, in 2024 and as of 17 March 2024, no cases were reported.

Uganda: Since 3 February 2025 and as of 3 March 2025, 52 new cases, including two new deaths, have been reported. Since 1 January 2025 and as of 3 March 2025, 139 cases, including three deaths, have been reported. In comparison, in 2024 and as of 29 February 2024, 38 cases, including one death, were reported.

United Republic of Tanzania: Since 31 December 2024 and as of 17 February 2025, 1 762 new cases, including 13 new deaths, have been reported. Since 1 January 2025 and as of 17 February 2025, 1 762 cases, including 13 deaths, have been reported. In comparison, in 2024 and as of 29 February 2024, 1 274 cases, including six deaths were reported.

Zambia: Since 18 February 2025 and as of 3 March 2025, 91 new cases have been reported. Since 1 January 2025 and as of 3 March 2025, 315 cases, including nine deaths, have been reported. In comparison, in 2024 and as of 29 February 2024, 16 857 cases, including 554 deaths were reported.

Zimbabwe: Since 18 February 2025 and as of 12 March 2025, 115 new cases, including five new deaths, have been reported. Since 1 January 2025 and as of 12 March 2025, 248 cases, including seven deaths, have been reported. In comparison, in 2024 and as of 29 February 2024, 11 211 cases, including 157 deaths, were reported.

Asia

Afghanistan: Since 3 February 2025 and as of 24 February 2025, 4 947 new cases, including three new deaths, have been reported. Since 1 January 2025 and as of 24 February 2025, 14 403 cases, including six deaths, have been reported. In comparison, in 2024 and as of 24 February 2024, 15 566 cases, including 10 deaths, were reported.

Pakistan: Since 6 January 2025 and as of 20 January 2025, 1 067 new cases have been reported. Since 1 January 2025 and as of 20 January 2025, 2 229 cases have been reported. In comparison, in 2024 and as of 17 March 2024, 4 876 cases were reported.

Yemen: Since 20 January 2025 and as of 17 February 2025, 3 674 new cases, including five new deaths, have been reported. Since 1 January 2025 and as of 17 February 2025, 9 784 cases, including nine deaths, have been reported. In comparison, in 2024 and as of 17 March 2024, no cases were reported.

ECDC assessment:

In 2025, cholera cases have continued to be reported in Africa and Asia. Within the last six months, cholera outbreaks have also been reported in parts of the Middle East and the Americas.

In this context, although the risk of cholera infection for travellers visiting these countries remains low, sporadic importation of cases to the EU/EEA is possible.

In the EU/EEA, cholera is rare and primarily associated with travel to endemic countries. Cholera reporting at the EU level is done on an annual basis, at the end of May for the year prior. In 2023, 12 confirmed cases were [reported by five EU/EEA countries](#), while 29 were reported in 2022, two in 2021, and none in 2020. In 2019, 25 cases were reported in EU/EEA countries (including the United Kingdom). All cases had a travel history to cholera-affected areas.

According to the World Health Organization (WHO), vaccination should be considered for travellers at higher risk, such as emergency and relief workers who may be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek advice from travel health clinics to assess their personal risk and apply precautionary sanitary and hygiene measures to prevent infection. Such measures can include drinking bottled water or water treated with chlorine, carefully washing fruit and vegetables with bottled or chlorinated water before consumption, regularly washing hands with soap, eating thoroughly cooked food, and avoiding the consumption of raw seafood products.

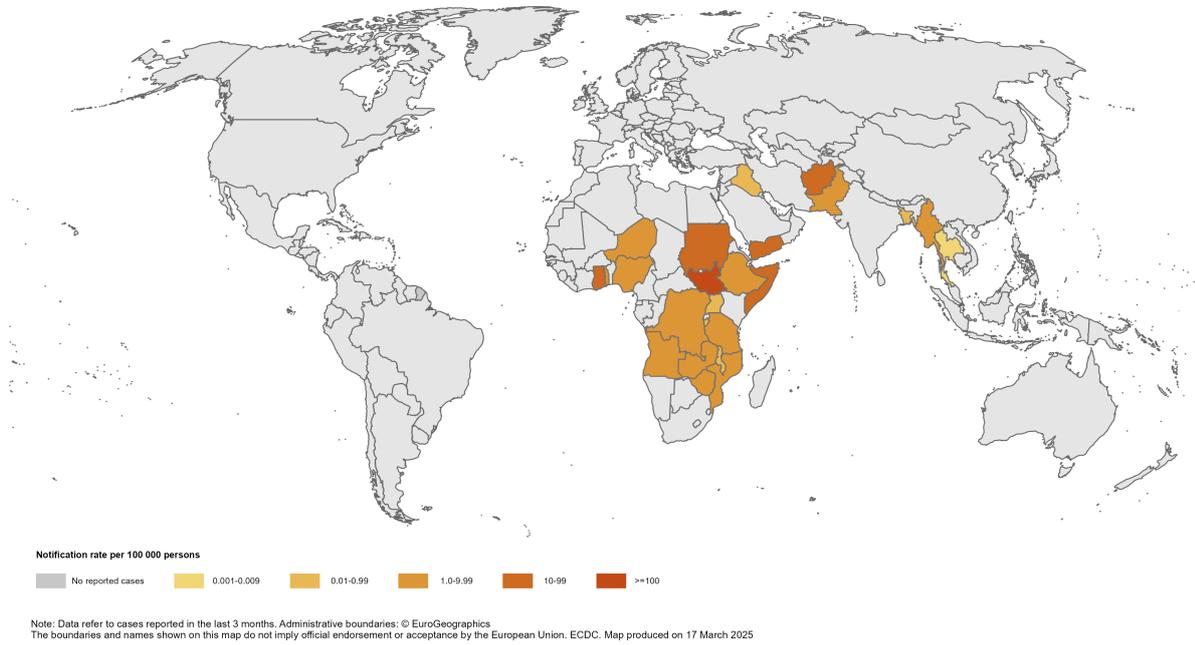
Actions:

ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities. Reports are published on a monthly basis. The worldwide overview of cholera outbreaks is available on [ECDC's website](#).

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

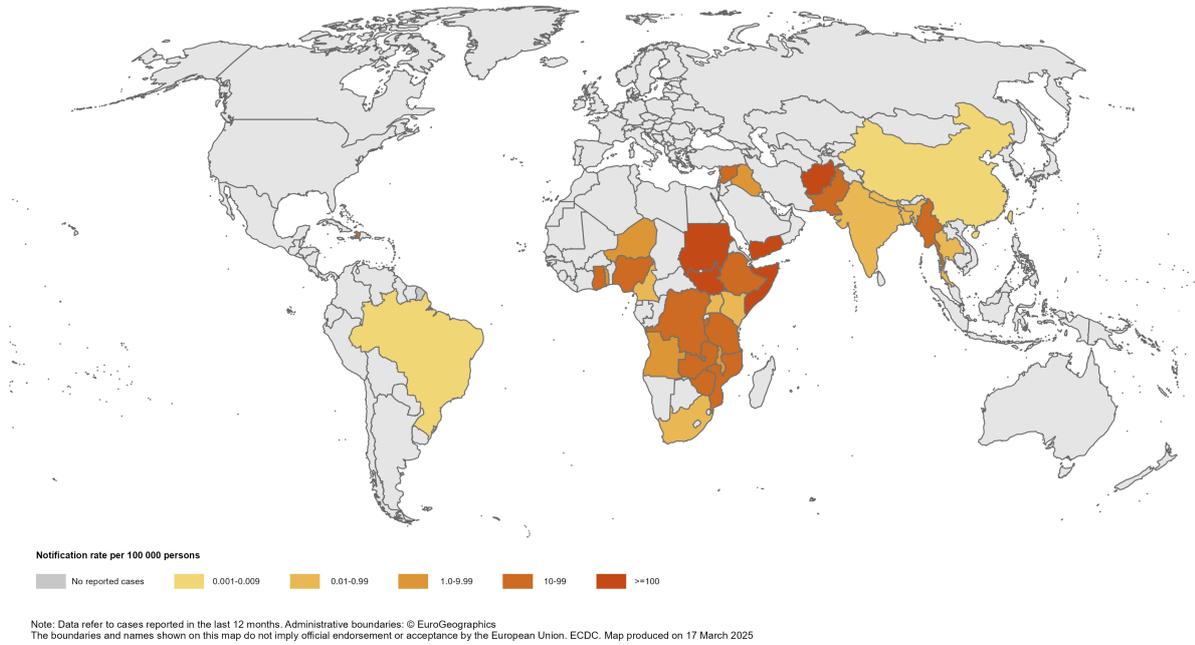
Maps and graphs

Figure 1. Geographical distribution of cholera cases reported worldwide from January 2025 to March 2025



Source: ECDC

Figure 2. Geographical distribution of cholera cases reported worldwide from April 2024 to March 2025



Source: ECDC

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

Overview:

Update: Since the previous update on 5 March 2025, and as of 18 March 2025, four new MERS cases, including two fatalities, have been reported in Saudi Arabia.

Dates of onset ranged from November 2024 to January 2025. One person had exposure to camels, one person was a nosocomial contact and the other two people had an unknown exposure. All cases occurred in males 27–78 years old with comorbidities.

All contacts were followed-up and, apart from the person who was a nosocomial contact of one of the other three cases, no secondary cases were identified by the national health authorities.

Summary: Since the beginning of 2025, and as of 18 March 2025, one MERS case has been reported with date of onset in 2025 in Saudi Arabia.

Since April 2012, and as of 18 March 2025, a total of 2 629 cases of MERS, including 955 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](#) | [WHO DON Saudi Arabia 4](#)

ECDC assessment:

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

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

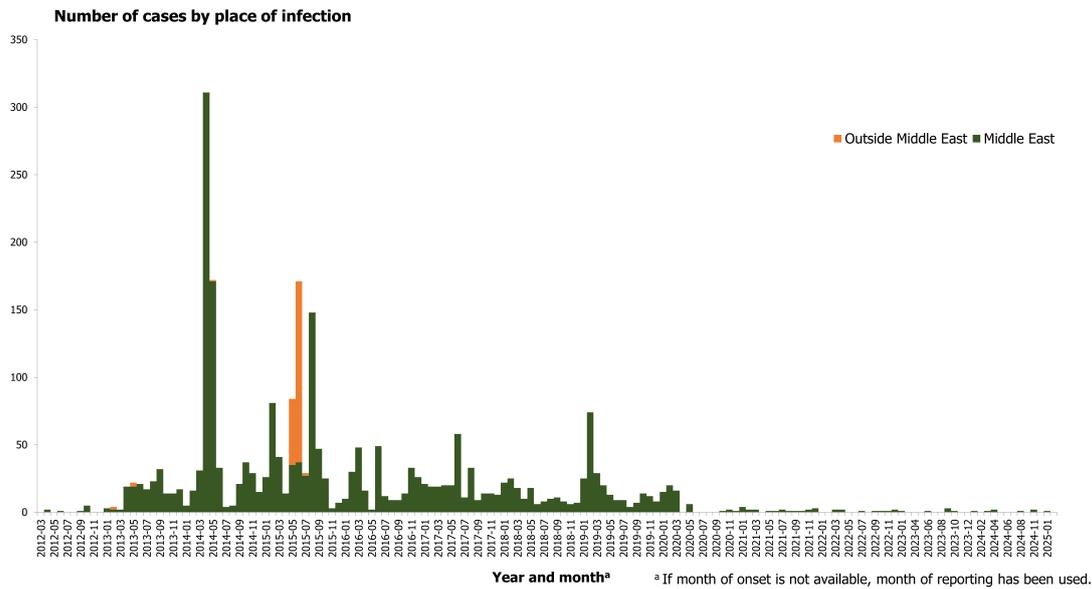
Actions:

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

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

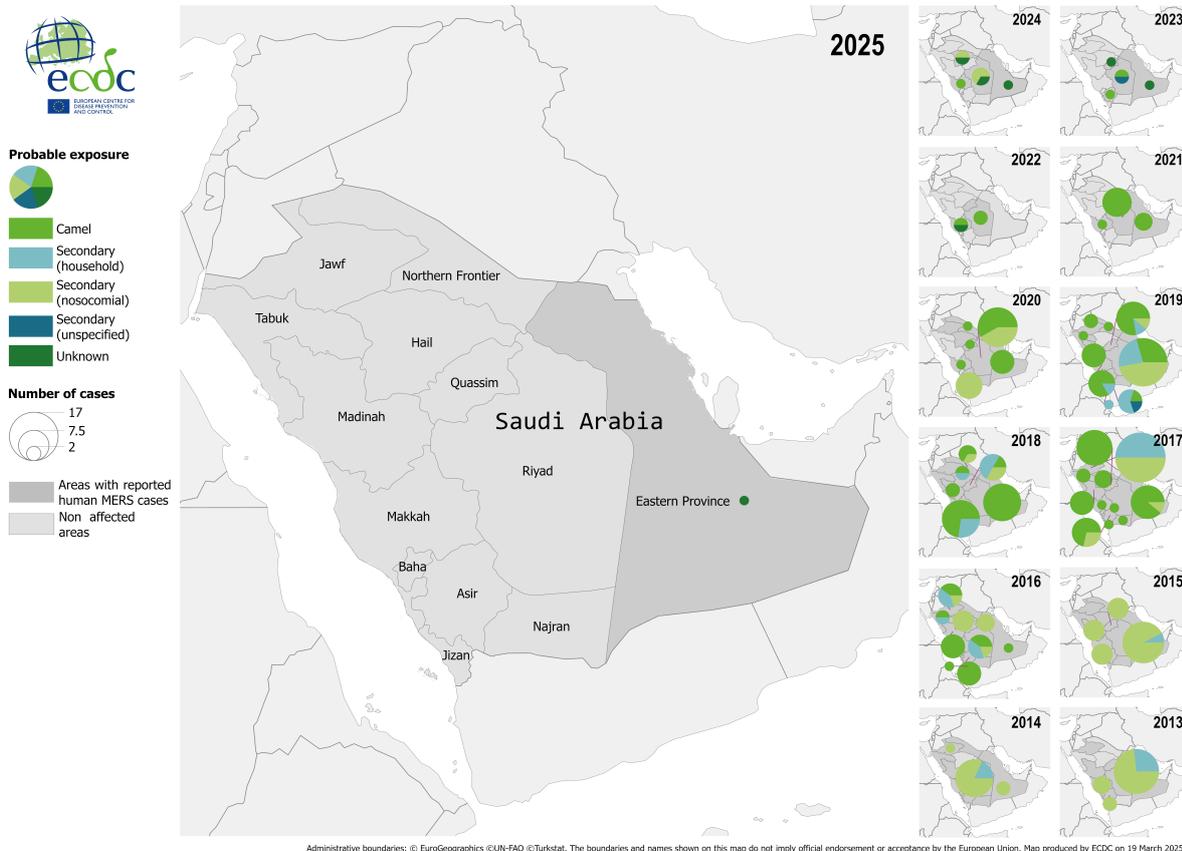
Maps and graphs

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



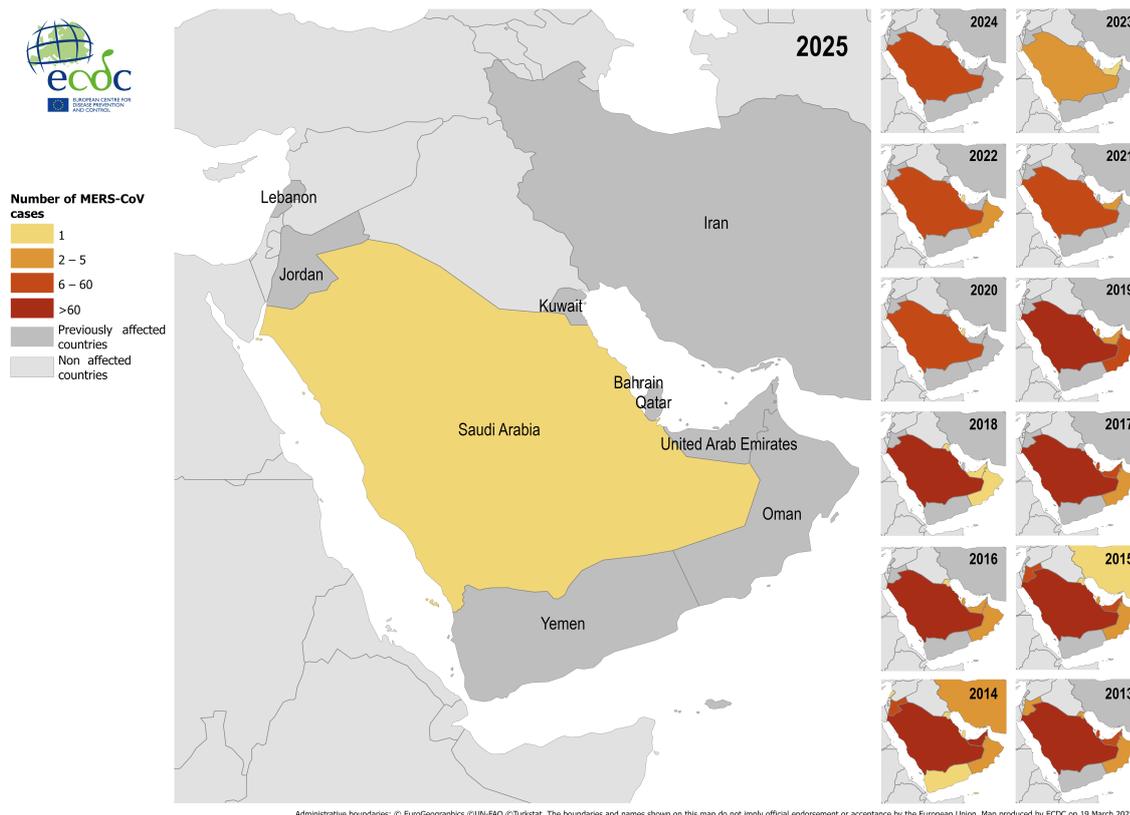
Source: ECDC

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



Source: ECDC

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



Source: ECDC

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

Overview:

Based on data reported up to week 11, 2025, primary and secondary care consultation rates reported by countries indicate elevated levels of respiratory virus activity in the EU/EEA. High but decreasing seasonal influenza activity continues, together with ongoing elevated RSV activity, while SARS-CoV-2 activity remains at low levels in all countries.

Pooled data from the EU/EEA suggest that the peak in influenza activity has passed, with decreases observed in most countries. Co-circulation of influenza A(H1)pdm09, A(H3) and B/Vic viruses continues to be observed in the EU/EEA, with influenza A and B viruses reported in nearly equal proportions in week 11.

RSV activity in the EU/EEA remains elevated, with little change in recent weeks. There is nonetheless considerable variation between countries in the timing of the RSV season, with some countries still observing an elevated and increasing circulation of RSV.

ECDC assessment:

Since week 40, 2024, the winter season in the EU/EEA has been characterised by an intense influenza season and a concurrent RSV epidemic. Influenza activity peaked in week 6, 2025 and most countries moved from an influenza A-dominated early season to A/B co-dominance or B dominance. However, some countries observed the opposite, with an early season marked by influenza B dominance. In week 52, 2024, RSV activity peaked and has since decreased but remained elevated, with a mixture of increasing and decreasing trends at the country level.

The greatest impact in secondary care has been seen in adults 65 years old and above for influenza and in children under five years old for RSV. [EuroMOMO](#) reported all-cause mortality above expected levels since week 51, 2024, primarily affecting adults aged 45 years and above, with levels now beginning to decrease. SARS-CoV-2 activity has been steadily declining since summer 2024, with no winter epidemic observed to date.

The levels of respiratory virus activity currently observed in the EU/EEA are expected to continue to place pressure on healthcare systems and hospital capacity, particularly where these are already limited.

Actions:

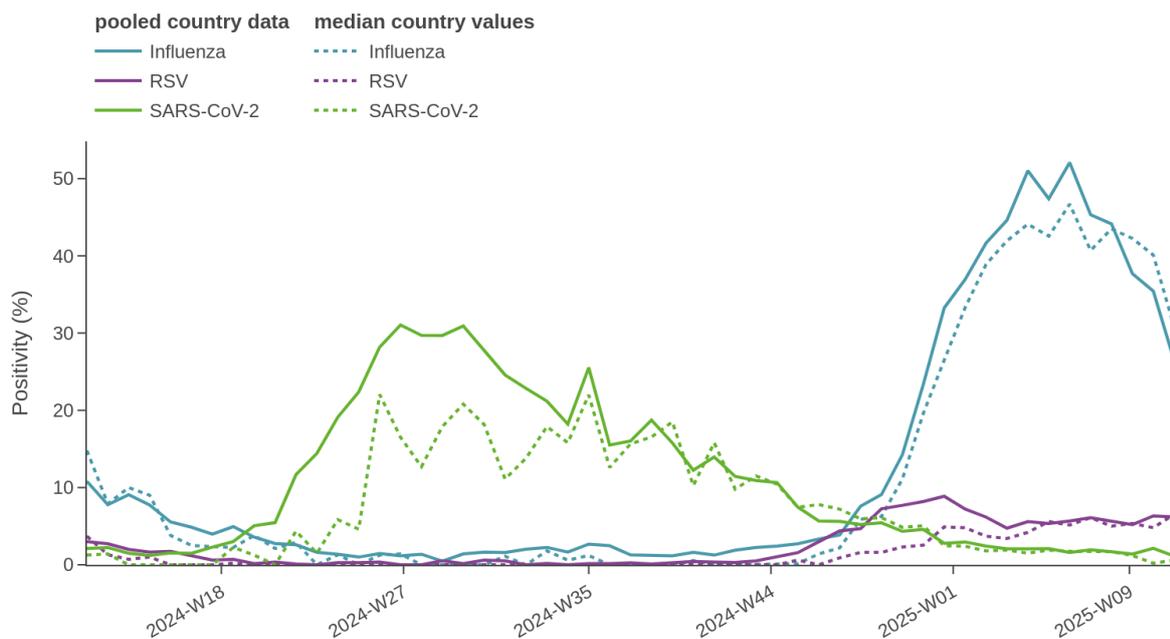
- ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary ([ERVISS.org](#)), which is updated weekly.
- ECDC has published recommended public health actions to mitigate against the impact of respiratory 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.
- Based on interim [influenza vaccine effectiveness](#) estimates available for the 2024/2025 season, analysis of data submitted from multi-country primary care and hospital study sites 'indicated that influenza vaccination prevented from one-third to more than three-quarters of [the expected number of] influenza infections medically attended in the primary care or hospital settings among the vaccinated, although protection varied by age group and study'.
- 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: 14 March 2025

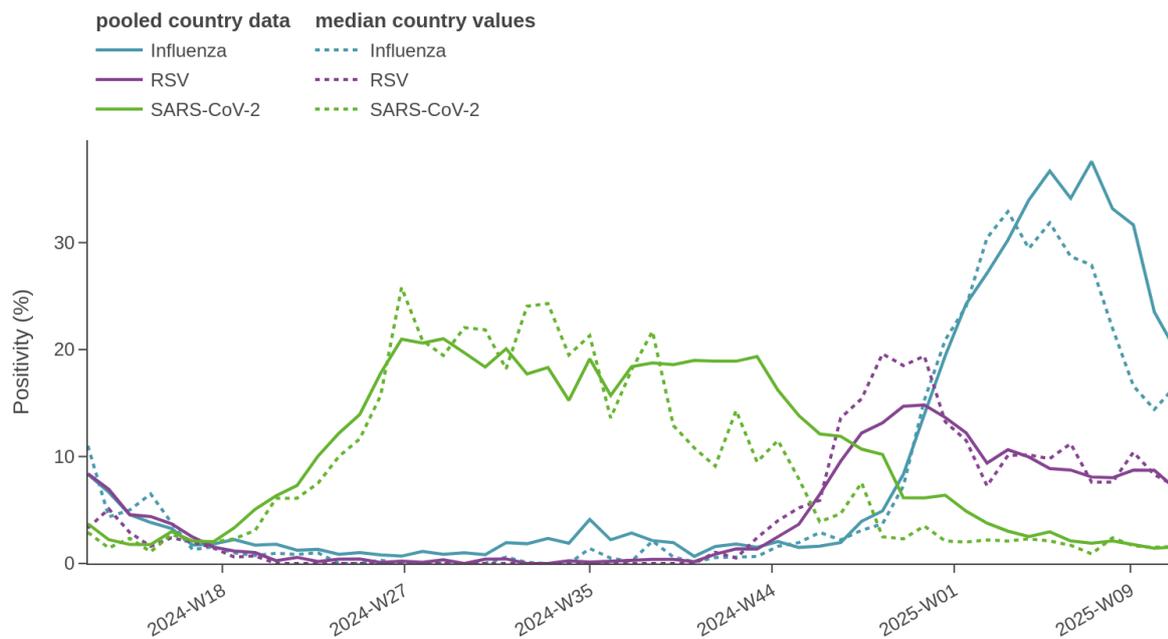
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 3. ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution

Pathogen	Week 11, 2025		Week 40, 2024 - week 11, 2025	
	N	% ^a	N	% ^a
Influenza	571	-	21399	-
Influenza A	266	47	13007	61
A(H1)pdm09	76	37	6430	59
A(H3)	129	63	4394	41
A (unknown)	61	-	2183	-
Influenza B	297	53	8146	39
B/Vic	72	100	3160	100
B/Yam	0	0.0	1	0.0
B (unknown)	225	-	4985	-
Influenza untyped	8	-	246	-
RSV	102	-	3141	-
RSV-A	6	25	499	40
RSV-B	18	75	759	60
RSV untyped	78	-	1883	-
SARS-CoV-2	18	-	2870	-

Source: ECDC

Figure 4. SARI virological surveillance in hospitals – pathogen type and subtype distribution

Figure Table

Pathogen	Week 11, 2025		Week 40, 2024 - week 11, 2025	
	N	% ^a	N	% ^a
Influenza	319	-	10577	-
Influenza A	87	78	4104	86
A(H1)pdm09	13	50	1361	63
A(H3)	13	50	811	37
A (unknown)	61	-	1932	-
Influenza B	24	22	662	14
B/Vic	0	-	95	100
B (unknown)	24	-	567	-
Influenza untyped	208	-	5811	-
RSV	110	-	4097	-
RSV-A	1	33	618	49
RSV-B	2	67	645	51
RSV untyped	107	-	2834	-
SARS-CoV-2	23	-	3400	-

Source: ECDC

Figure 5. Genetically characterised influenza virus distribution, week 40, 2024 to week 11, 2025

Subtype	Subtype distribution		Subclade	Subclade distribution	
	N	%		N	%
A(H1)pdm09	2374	47	5a.2a(C.1.9)	2113	89
			5a.2a.1(D)	204	9
			5a.2a(C.1)	57	2
A(H3)	1291	25	2a.3a.1(J.2)	945	74
			2a.3a.1(J.2.2)	175	14
			2a.3a.1(J.2.1)	133	10
			2a.3a.1(J.1)	11	0.9
			2a.3a.1(J)	10	0.8
			2a.3a.1(J.4)	2	0.2
			Not assigned	15	-
B/Vic	1430	28	V1A.3a.2(C.5.1)	965	68
			V1A.3a.2(C.5.6)	214	15
			V1A.3a.2(C.5.7)	212	15
			V1A.3a.2(C)	22	2
			V1A.3a.2(C.5)	2	0.1
			Not assigned	15	-

Source: ECDC

Figure 6. SARS-CoV-2 variant distribution, weeks 9–10, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
KP.3	VOI	4	14	21% (10–21%)
BA.2.86	VOI	3	16	21% (0–36%)
XEC	VUM	5	41	39% (36–90%)
LP.8.1	VUM	3	9	7% (0–18%)

Source: ECDC

Figure 7. Overview of key indicators

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment	
		Week 11	Week 10	Description	Value		
ILI/ARI consultation rates in primary care	ARI	11 rates (7 MEM)	15 rates (11 MEM)	Distribution of country MEM categories	3 Baseline 2 Low 2 Medium	Based on the Moving Epidemic Method (MEM), baseline to low levels of influenza activity were observed in most reporting countries.	
	ILI	16 rates (14 MEM)	20 rates (18 MEM)		4 Baseline 5 Low 4 Medium 1 High		
ILI/ARI test positivity in primary care	Influenza	18	20	Pooled (median; IQR)	26% (31; 21–38%)	At the EU/EEA level, the overall pooled influenza positivity remains elevated but continues to decrease, with both influenza A and B activity decreasing. Heterogeneity between countries remains.	
	RSV	17	19		6.2% (6.6; 3.3–9.4%)		At EU/EEA level, RSV positivity continues to plateau after reaching a peak of 9% in week 52, 2024. The country-level picture remains mixed due to considerable variation in the timing of the epidemic between countries.
	SARS-CoV-2	16	19		1.1% (0.6; 0–1.5%)		Activity is low in all countries.
SARI rates in hospitals	SARI	10	11	-	-		
SARI test positivity in hospitals	Influenza	9	10	Pooled (median; IQR)	20% (17; 13–24%)	Pooled influenza positivity at the EU/EEA level continues to decrease in all age groups but remains elevated, with heterogeneity between countries.	
	RSV	9	10		7% (7.2; 3.2–17%)		At the EU/EEA level, RSV positivity continues to plateau.
	SARS-CoV-2	8	9		1.5% (1.6; 0.3–3.3%)		Activity is low in all countries and across all indicators of severity.
Intensity (country-defined)	Influenza	19	23	Distribution of country qualitative categories	2 Baseline 6 Low 8 Medium 3 High		
Geographic spread (country-defined)	Influenza	18	22	Distribution of country qualitative categories	1 Local 2 Regional 15 Widespread		

Source: ECDC

4. Avian influenza A(H5N1) human cases – United States – 2024

Overview:

Update:

On 19 March 2025, US CDC published [findings](#) from two laboratory investigations related to previously reported human cases of avian influenza A(H5N1) virus infections.

The first study involved serological testing of blood samples from a previously reported case in a child in San Francisco, who had mild illness and no known animal exposure, as well as close contacts of the child. The child tested positive for antibodies to avian influenza A(H5N1) virus, consistent with a recent infection. However, none of the close contacts tested positive for antibodies, supporting the conclusion that they were not infected and that no person-to-person transmission occurred in this case. To date, human-to-human transmission of influenza A(H5) virus has not been detected in the US.

In the second study, US CDC sequenced the virus from a recent human case reported in February 2025 in Ohio. The genetic data were submitted to GenBank and posted on GISAID (Epi ID 19785793). The sequencing revealed that the virus belonged to clade 2.3.4.4b, genotype D1.3, according to the genotyping criteria of the United States Department of Agriculture (USDA). This is the first detection of genotype D1.3 in a human case in the current A(H5N1) outbreak. Similarly to viruses of genotype D1.1, viruses of D1.3 derive from genotype A3, which was introduced to North America in 2022, and have since reassorted with influenza viruses present in North American wild birds. D1.3 has a different NA sequence compared to D1.1. No genetic markers were found that would affect the efficacy of antiviral treatments or existing candidate vaccine viruses. Additionally, the US CDC did not identify any mutations that would make the virus more capable of infecting or transmitting among mammals. Virus isolation efforts in eggs are ongoing.

Mutation analysis performed by ECDC – of the sequenced strain A/Ohio/06-1/2025 – displayed a HA profile (T108I, S123P, S133A, K218Q, S223R, 328del) common for genotype D1.1 strains isolated from human cases in Washington state, US, related to exposure to poultry (e.g. A/Washington/240/2024). Interestingly, the PB2 amino acid substitution I292V was also present, which has not been observed in strains from human cases of genotype D1.1. The mutation is associated with increased polymerase activity in mammalian cells and increased virulence in mice.

The US CDC has also published analyses of four recent studies on pre-existing immunity, immune response following mild illness, and antiviral susceptibility related to avian influenza A(H5N1).

Pre-existing antibodies

Recent studies in animal models suggest that prior infection with seasonal influenza A(H1N1)pdm09 may reduce the severity of A(H5N1) illness. A US CDC study published on 21 February 2025 in [Emerging Infectious Diseases](#) found that ferrets with prior A(H1N1)pdm09 infection developed cross-reactive antibodies and showed reduced viral replication and transmission after A(H5N1) exposure. A second study, published on 17 March 2025 in [The Lancet Microbe](#), also reported that ferrets previously infected with A(H1N1)pdm09 virus and subsequently infected with A(H5N1) virus developed milder illness and were less likely to spread the virus. The [authors](#) hypothesise that the findings may explain the lower fatality rate observed among A(H5N1) cases reported in the US and support further research into cross-protective immunity. However, the reasons for the variation in outcome of infection with influenza A(H5N1) virus is likely to be multi-factorial and may be attributed to the virus genotype, duration of exposure, viral load, transmission route, individual health status, personal protective measures taken, and medical treatment provided ([EFSA, ECDC, EURL et al., 2024](#)). The Lancet study also showed that ocular exposure to A(H5N1) [A/Texas/37/2024] resulted in severe, transmissible disease, highlighting the importance of eye protection.

Immune response from mild illness

A report published on 7 March 2025 in [Emerging Infectious Diseases](#) evaluated immune responses in two Michigan dairy workers exposed to cows infected with A(H5N1) virus. One worker that A(H5N1) clade 2.3.4.4b virus was isolated from experienced mild symptoms such as conjunctivitis and developed neutralising antibodies. The second worker was positive for influenza A(H5), but no virus was isolated from the individual and they did not develop antibodies. This marks the first study showing that mild illness from A(H5N1) infection in humans can generate an immune response. Prior to this, data on immunity following mild cases were limited.

Antiviral susceptibility

A study published on 7 March 2025 in [Emerging Infectious Diseases](#) suggested that HPAI H5N1 clade 2.3.2.1c and clade 2.3.4.4b viruses isolated from sporadic human cases in Cambodia, Chile and the US in 2023 and 2024 are susceptible to approved NA inhibitors and the PA inhibitor baloxavir. The viruses were also susceptible to M2 blockers, except for two non-reassortant viruses isolated in Cambodia in 2023. The [US CDC](#) continues to recommend initiating treatment with oseltamivir promptly – ideally within two days of symptom onset – for confirmed or suspected A(H5N1) infections.

Background:

Since 1 April 2024, and as of 21 March 2025, 70 human cases of avian influenza A(H5N1), including one death, have been confirmed by the US CDC from 13 states. In total, 41 cases reported exposure to dairy cattle in the following states: California (36), Colorado (1), Michigan (2), Nevada (1) and Texas (1) and 24 cases reported exposure to poultry farms and culling operations in the following states: Colorado (9), Iowa (1), Ohio (1), Oregon (1), Washington (11), and Wisconsin (1). Two cases reported exposure to other animals, such as backyard flocks, wild birds, or other mammals: one case in Louisiana, who later died, and one in Wyoming. Three additional cases with unknown exposure have also been identified: two in California and one in Missouri.

ECDC assessment:

To date, there have been no confirmed human cases of influenza A(H5N1) infection and no reports of A(H5N1) infection in cattle in the EU/EEA. The genotype B3.13, identified in cattle and several of the human cases in the US, has not been detected in Europe. The genotype D1.1 has been found in wild birds, poultry, a limited number of cattle herds in the US, and a small number of human cases in the US and Canada. The genotype D1.3 has been identified in one human case in Ohio.

ECDC has assessed the risk from the circulating HPAI A(H5N1) clade 2.3.4.4b viruses as low for the general population and low-to-moderate for those whose activities expose them to infected animals or contaminated environments (e.g. occupational exposure to infected animals).

Actions:

ECDC is monitoring the situation together with partner organisations in Europe and will continue to update its assessment of the risk for humans in the EU/EEA as new information becomes available.

In addition to enhanced surveillance, active monitoring and testing of exposed individuals is recommended for early detection of human cases and to assess the possibility of human-to-human transmission, according to relevant ECDC guidance documents ('[Testing and detection of zoonotic influenza virus infections in humans](#)'; '[Investigation protocol of human cases of avian influenza virus](#)'; '[Enhanced surveillance of severe avian influenza virus infections in hospital settings](#)').

It is important to raise awareness, including among all primary care workers, of the need to enquire about animal exposure and symptoms compatible with avian influenza infections and to test symptomatic individuals with a history of exposure, following a risk-based approach. It is also important to communicate the epidemiological situation so as not to miss or delay diagnosis of potential human cases.

Given the uncertainties related to mammal-to-mammal transmission and depending on the epidemiological situation, a low threshold can be considered for testing individuals exposed to potentially infected mammals (e.g. symptomatic individuals with conjunctivitis or respiratory symptoms). Due to the higher risk of infection for individuals exposed to infected animals and contaminated environments, appropriate personal protective measures and other precautionary measures should always be taken to mitigate the risk.

Relevant ECDC publications:

- [Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work](#)
- [Investigation protocol of human cases of avian influenza virus infections in the EU/EEA](#)
- [Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA](#)
- [Joint ECDC-EFSA Drivers for a pandemic due to avian influenza and options for One Health mitigation measures](#)
- [Coordinated One Health investigation and management of outbreaks in humans and animals caused by zoonotic avian influenza viruses](#)
- [Preparedness, prevention and control related to zoonotic avian influenza](#)

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

Sources: [FAO](#)

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

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

Overview:

Update:

According to the [French National Health Authority](#), up to 9 March 2025, 8 749 cases (8 600 in 2025) of autochthonous chikungunya virus disease have been reported in La Réunion. In week 10, 2 888 new confirmed cases were reported, representing a 29% increase compared with the previous week.

Cases have now been reported in all municipalities.

The municipalities reporting the most cases since the start of the epidemic are those in the south, particularly Le Tampon.

At present, the health impact on the individuals with the disease is relatively low, with 24 of them hospitalised for more than 24 hours (an increase of four since the previous week).

However, on 21 March 2025, two deaths were [reported](#) in older adults, one of whom presented with comorbidities.

The Haute Autorité de santé (HAS) has [advised](#) public decision-makers to vaccinate people over 65 years old, people over 18 years old with comorbidities and vector control professionals with the IXCHIQ vaccine, as a reactive short-term measure to prevent severe disease. The regional health agency is preparing to provide vaccine access to prioritised individuals from the beginning of April.

Background:

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. 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 population is being encouraged to remove objects that could contain water and serve as potential mosquito propagation sites around homes, to protect themselves against mosquito bites, and to consult a doctor if symptoms occur.

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: 14 March 2025

6. Risk of severe infections, carriage and cross-border transfer of carbapenem-resistant bacteria in victims of the fire at Pulse nightclub (Kocani) – North Macedonia

Overview:

North Macedonia reported 59 deaths and 155 injuries due to a fire at the Pulse nightclub in Kočani during the night of Saturday 15 to Sunday 16 March 2025. Several of the injured people have burn injuries and many have already been or are going to be [transferred](#) to EU Member States or neighbouring EU enlargement countries.

On 17 March, the Ministry of Foreign affairs in North Macedonia [reported](#) that 51 patients had already been transferred for treatment to Türkiye, Bulgaria, Greece, Serbia and Lithuania, and that additional patients were expected to be transported to Austria, Slovenia, Croatia and Norway. According to ECHO, as of 17 March 2025, nine European countries [had offered](#) assistance (Croatia, Greece, Romania, Slovenia, Sweden, Lithuania, Hungary, Luxembourg and Norway). Spain also [received](#) patients on 20 March 2025.

ECDC assessment:

There is a precedent for such an event. After the fire at the Colectiv nightclub in Bucharest on 30 October 2015, 38 of the injured people died while hospitalised, in many cases from burn wound infection due to carbapenem-resistant (CR) bacteria. Several of the patients were transferred from hospitals in Romania to hospitals in EU Member States, with [reports](#) of carriage and infections by CR bacteria. This similar event highlights the risk of carriage and difficult-to-treat infections by CR bacteria among the victims of the fire in North Macedonia, as well as the risk of cross-border transfer of such CR bacteria.

Burn wounds are often colonised by gram-negative bacteria, such as *Pseudomonas aeruginosa*, *Acinetobacter* spp. and Enterobacterales, including *Klebsiella pneumoniae*. There is a high risk of colonisation with CR strains in burn victims hospitalised in countries with high prevalence of such bacteria, especially after longer hospital stays and administration of antibiotics.

In the latest published [data](#) from North Macedonia (2023), the prevalence of carbapenem resistance among invasive infections (mostly bloodstream infections) was 97% in *Acinetobacter* spp., 52% in *Pseudomonas aeruginosa* and 26% in *Klebsiella pneumoniae*. In 2024, ECDC, EFSA and the Directorate-General for Health and Food Safety conducted a country visit to North Macedonia on AMR. The [report](#) concluded that “alarmingly high rates of multidrug resistance among various bacterial species indicate that transmission within healthcare settings remains the main driver”.

Actions:

Infections by CR bacteria, especially [CR Enterobacterales](#), have been increasing and constitute a serious threat to patient safety in the EU/EEA and globally. Healthcare providers should be aware of these risks among burn victims transferred from North Macedonia to support timely identification and successful treatment of infections with multidrug-resistant organisms, in order to prevent onward transmission of such organisms in hospitals and other healthcare settings. Healthcare facilities that admit patients who were hospitalised in North Macedonia should pre-emptively apply isolation precautions (single room isolation or cohorting) and screen for carriage of multidrug-resistant organisms, in particular CR gram-negative bacteria, in accordance with local guidance for infection prevention and control (IPC). Hospitals should ensure the implementation of multimodal IPC strategies, including hand hygiene, screening, contact precautions, patient isolation and environmental cleaning, to prevent the spread of such microorganisms.

Antimicrobial stewardship is key for the prevention of colonisation by CR bacteria. Specifically, for burn victims of a mass-casualty event, unless specifically clinically indicated, systemic antibiotics [should not routinely be given prophylactically](#).

Countries are encouraged to share information on carriage and infections by CR bacteria among patients related to this mass-casualty event.

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

7. Ebola disease – Uganda – 2025

Overview:

According to the [Africa CDC Press Briefing on 20 March](#), and since the last update, no new cases have been reported. Of the 12 confirmed cases identified so far, two more were discharged, bringing the total number of recovered individuals up to 10 (83%).

Since the beginning of the outbreak and [as of 20 March](#), 12 confirmed and two probable cases have been reported, including four deaths (two confirmed and two probable). Out of a total of 340 contacts, 12 are still under quarantine. According to [WHO](#), there are six regions affected (Jinja, Kampala, Kyegegwe, Mbale, Ntoroko and Wakiso).

Summary

On 30 January 2025, public health authorities in Uganda [declared](#) an outbreak of Ebola 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. The patient [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 as in Mbale City and from a traditional healer.

All eight of the initial secondary 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. They had symptom onset between 29 January and 6 February. On 18 February, WHO [reported](#) that they were all discharged.

On 1 March, [WHO](#) reported a new case (case 10) with no epidemiological links to the previous cluster, but they are genetically linked. The case was a child who died on 25 February 2025 in Mulago Hospital (Kampala). On 6 March 2025, Africa CDC [reported](#) two new confirmed cases and two probable deaths linked with case 10.

The [age range](#) of confirmed cases is 1.5 years to 55 years, the mean age is 27 years and males account for 55% of the total cases.

Event background and additional information

The [phylogenetic analysis](#) of samples taken from the index case showed them to be genetically close to sequences from the 2012 SVD 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 led by the Ministry of Health with support from partners.

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 and several subsequent cases involved 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: 14 March 2025

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
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update – last reported on 21 March 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update – last reported on 21 March 2025

- Risk of severe infections, carriage and cross-border transfer of carbapenem-resistant bacteria in victims of the fire at Pulse nightclub (Kocani) – North Macedonia – last reported on 21 March 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
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 – last reported on 14 March 2025
- Marburg virus disease – Tanzania – 2025 – last reported on 14 March 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 – last reported on 14 March 2025
- Avian flu detected in cats – Belgium – 2025 – last reported on 7 March 2025
- Cholera associated with holy well water from Ethiopia – last reported on 7 March 2025
- SARS-CoV-2 variant classification – last reported on 7 March 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring – last reported on 7 March 2025