

Communicable disease threats report

Week 15, 5–11 April 2025

This week's topics

- [1. Influenza A\(H5N1\) – Multi-country \(World\) – Monitoring human cases](#)
- [2. Middle East respiratory syndrome coronavirus \(MERS-CoV\) – Multi-country – Monthly update](#)
- [3. Overview of respiratory virus epidemiology in the EU/EEA](#)
- [4. Autochthonous chikungunya virus disease - Réunion and Mayotte, France, 2024-2025](#)
- [5. Ebola disease – Uganda – 2025](#)
- [6. Expert deployment](#)

Executive summary

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

- The first human case of avian influenza A (H5N1) in Mexico died on 8 April 2025.
- The patient, a three-year-old child from the state of Durango, tested positive on 1 April 2025 and was hospitalised in a serious condition.
- Authorities have begun targeted epidemiological and environmental response actions.
- To date, 38 human contacts of the case have been sampled and all tested negative.
- Since 2003, and as of 9 April 2025, there have been 972 human cases of A(H5N1) worldwide, including 470 deaths.

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

- Since the previous update on 18 March 2025, and as of 7 April 2025, no new MERS-CoV cases have been reported by the World Health Organization (WHO) or national health authorities.
- Since the beginning of 2025, and as of 7 April 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 is decreasing overall in the European Union/European Economic Area (EU/EEA) but remains elevated in some countries affected by ongoing flu and/or RSV epidemics. Overall influenza activity peaked in week 6, 2025 and is now decreasing, with two-thirds of reporting countries having now returned to baseline or low levels of influenza intensity. Co-circulation of influenza A and B viruses continues. RSV activity is lower than at the peak in week 52, 2204 but remains elevated. The greatest impact in secondary care has been in adults aged 45 years and above for influenza (with the impact increasing with age) and in children under five years for RSV. Excess mortality was observed between week 51, 2024 and week 9, 2025, affecting adults aged 45 years and above, with levels now having returned to the expected range. SARS-CoV-2 activity remains at a low level.

Autochthonous chikungunya virus disease - Réunion and Mayotte, France, 2024-2025

- In August 2024, France reported the first autochthonous case of chikungunya virus disease in 10 years in Réunion, with onset of symptoms on 12 August.
- Since then and up to 30 March 2025, 27 668 autochthonous cases of chikungunya virus disease have been confirmed in Réunion.
- On 21 March 2025, two deaths were reported in older individuals with comorbidities.
- The Haute Autorité de Santé (HAS) has advised public decision-makers to vaccinate groups who are at 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.
- On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte.

Ebola disease – Uganda – 2025

- Since the last update, and as of 10 April, no new Ebola cases have been reported. All cases have been discharged and there are no active contacts under follow-up.
- The countdown for declaring the outbreak over was initiated on 15 March, following the discharge of the last patient being treated. As of 10 April, 26 days of the 42-day countdown period had been completed.
- Since the beginning of the outbreak, and as of 10 April, 12 confirmed and two probable cases have been reported, including four deaths (two confirmed and two probable cases). The total number of individuals who have recovered is 10 (83%).
- 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.

Expert deployment

- On 7 April, the EU Health Task Force deployed two ECDC staff members to Riga, Latvia, to support the national team in [investigating enterohemorrhagic E.coli cases](#).

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

Overview:

On 8 April 2025, the Mexican Ministry of Health reported the country's first human death from avian influenza A(H5N1) virus infection (www.gob.mx/salud/prensa/secretaria-de-salud). The case involved a three-year-old child from the state of Durango. The infection was confirmed by Mexico's Institute of Epidemiological Diagnosis and Reference (InDRE) on 1 April 2025.

The child was hospitalised in a serious condition at a tertiary care facility in the city of Torreón, Coahuila, and was treated with the antiviral medication oseltamivir. On 8 April 2025, the patient died from respiratory complications related to the infection.

The Ministry of Health has notified the World Health Organization (WHO) in line with international protocols and emphasised that, according to current assessments, the risk to the general population remains low.

Environmental monitoring is underway around the patient's residence, including sampling of wild and domestic birds. The Ministry of Agriculture and Rural Development has confirmed that no commercial production units have been recently affected by avian influenza A (H5N1) in any region of the country. To date, 38 human contacts of the case have been sampled and all tested negative.

In response to the case, Mexican authorities have implemented a series of health and surveillance measures. Health personnel in Durango and Coahuila have been trained under the National Guidance for zoonotic influenza preparedness and response. Active surveillance has been initiated to detect additional suspected respiratory infections. Public health messaging emphasises preventive hygiene practices, safe food handling, and avoiding contact with wild, sick or dead animals.

This is the first avian influenza A(H5N1) human infection and fatality in Mexico since the virus was first tracked globally in 2003. The case brings the total number of confirmed A(H5N1) human infections in the Americas to 76 since December 2013.

Summary:

Since 2003, and as of 9 April 2025, there have been 972 human cases worldwide*, including 470 deaths (case fatality among reported cases: 48%), of avian influenza A(H5N1) infection reported in 25 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, India, Indonesia, Iraq, Laos, Mexico, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Vietnam, the United Kingdom, and the United States). To date, no sustained human-to-human transmission has been detected.

**Note: this includes detections due to suspected environmental contamination, with no evidence of infection, that were reported in 2022 and 2023 by Spain (two detections), the United States (1), and the United Kingdom (4, 1 inconclusive). Human cases of A(H5) epidemiologically linked to A(H5N1) outbreaks in poultry and dairy cattle in the United States are included in the reported number of cases of A(H5N1).*

ECDC assessment:

Sporadic human cases of different avian influenza A(H5Nx) subtypes have previously been reported globally. Current epidemiological and virological evidence suggests that A(H5N1) viruses remain avian-like. Transmission to humans remains a rare event and no sustained transmission between humans has been observed.

Overall, the risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered low. The risk to occupationally exposed groups, such as farmers and cullers, is considered low-to-medium.

Direct contact with infected birds or a contaminated environment is the most likely source of infection, and the use of personal protective measures for people exposed to dead birds or their droppings will minimise the associated risk. The recent severe cases in Asia and the Americas in children and people exposed to infected, sick or dead backyard poultry underlines the risk of unprotected contact with infected birds in backyard farm settings. This supports the importance of using appropriate personal protective equipment.

Actions:

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

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

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

Overview:

Update: Since the previous update on 18 March 2025, and as of 7 April 2025, no new MERS-CoV cases have been reported by the World Health Organization (WHO) or national health authorities

Summary: Since the beginning of 2025, and as of 7 April 2025, one MERS case has been reported with date of onset in 2025 in Saudi Arabia.

Since April 2012, and as of 7 April 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.

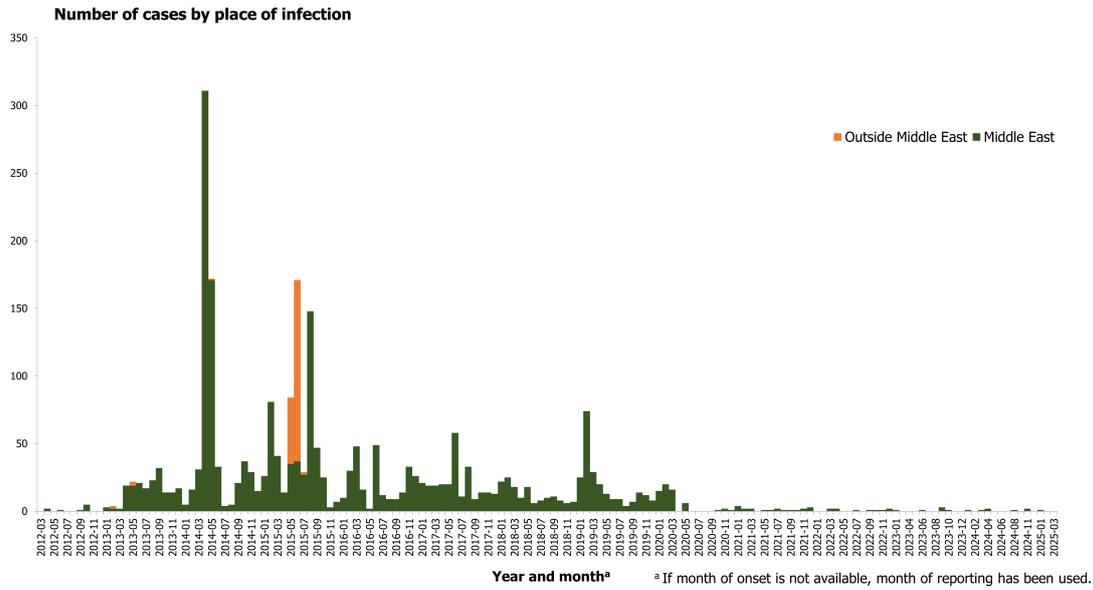
ECDC published a technical report, '[Health emergency preparedness for imported cases of high-consequence infectious diseases](#)', in October 2019 that is still useful for EU Member States wanting to assess their level of preparedness for a disease such as MERS. ECDC also published '[Risk assessment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

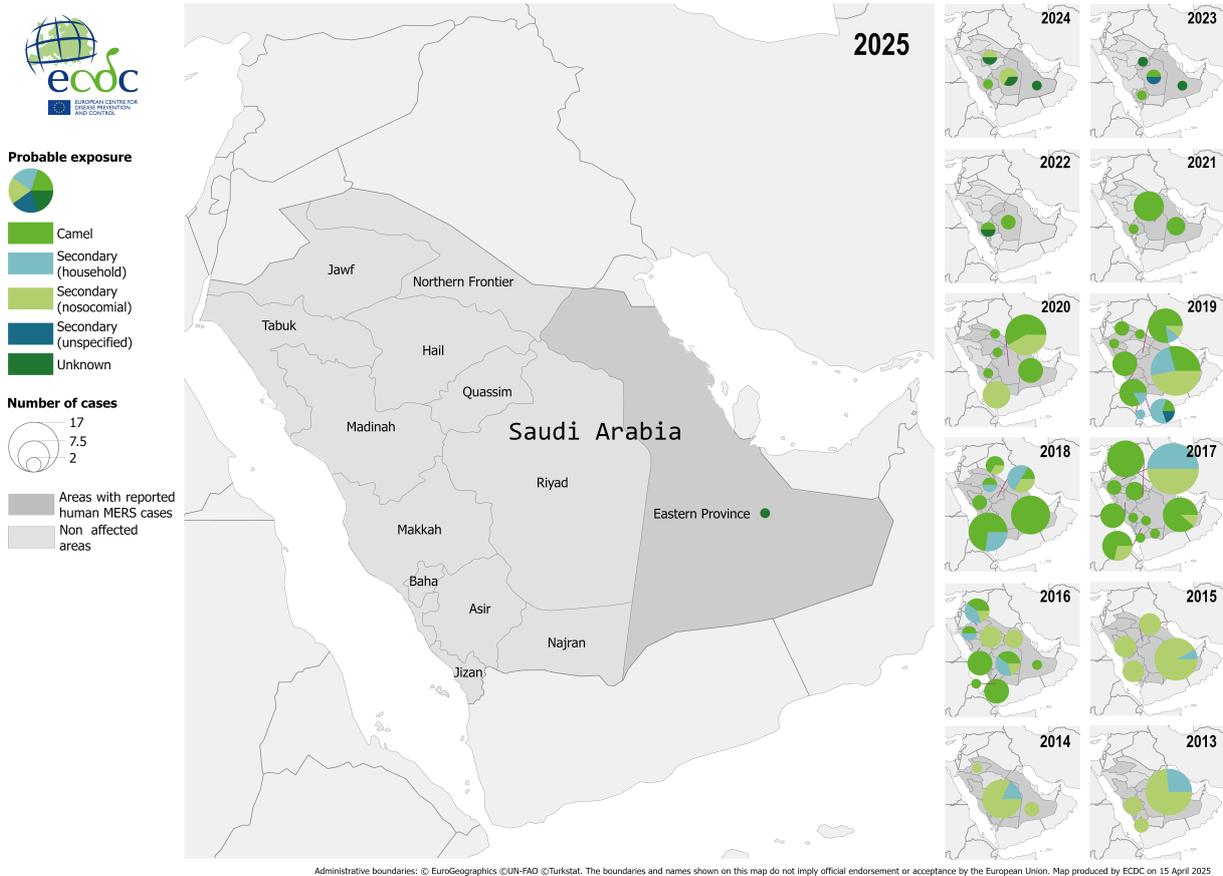
Last time this event was included in the Weekly CDTR: 21 March 2025

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



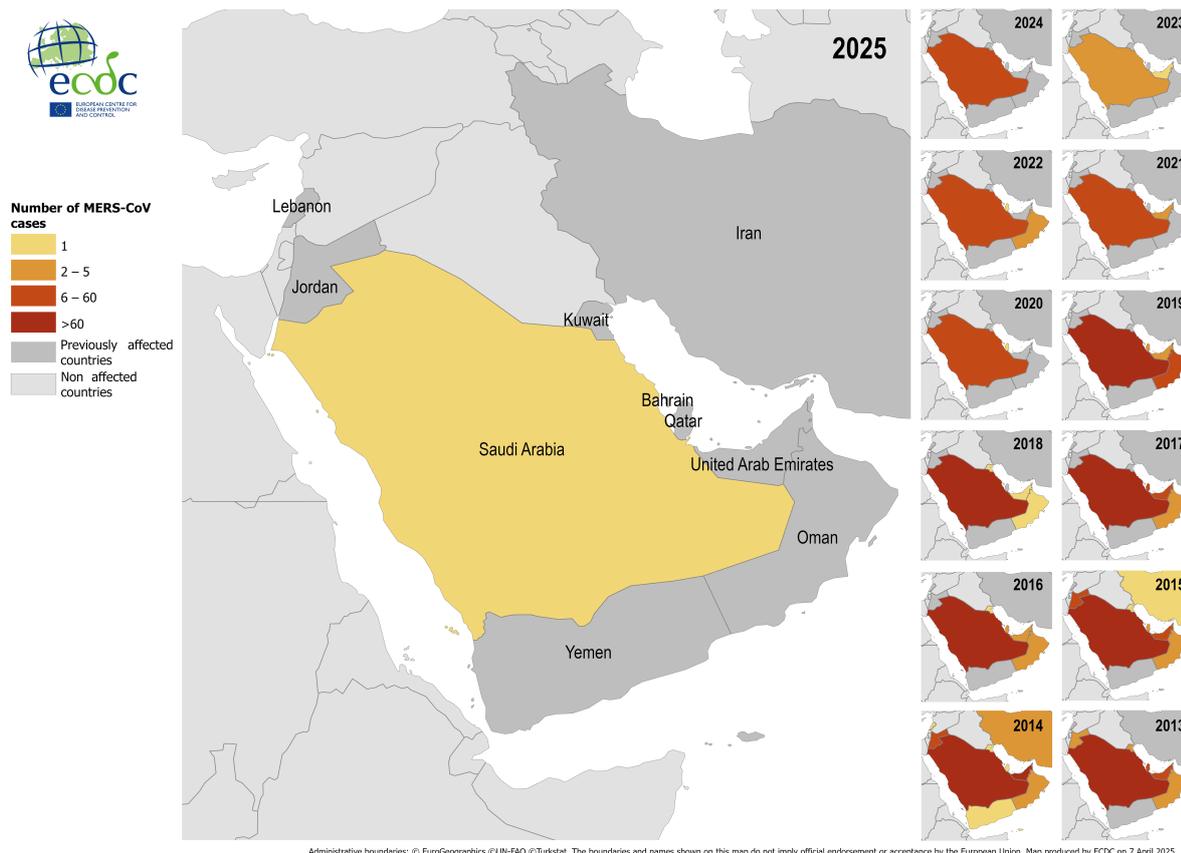
Source: ECDC

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 March 2025



Source: ECDC

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



Source: ECDC

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

Overview:

Based on data reported to week 14, 2025, primary and secondary care consultation rates suggest a return to low or baseline levels of respiratory virus activity in the majority of reporting EU/EEA countries. Decreasing trends in influenza activity are being observed in almost all countries, with two-thirds of reporting countries having returned to baseline or low levels of influenza intensity. Influenza A(H3) and B viruses were most commonly reported in week 14. RSV activity in the EU/EEA remains elevated, driven by around one third of EU/EEA countries that have experienced a later season. Data reported to week 14 suggest that peak activity may now have been reached in many of these countries. SARS-CoV-2 activity remains at low levels in all countries.

ECDC assessment:

The 2024/2025 respiratory virus season (starting week 40, 2024) in the European Union/European Economic Area (EU/EEA) has been characterised by an intense influenza season and a concurrent respiratory syncytial virus (RSV) epidemic. SARS-CoV-2 activity declined to low levels, with no epidemic observed to date. Although overall RSV activity peaked in the EU/EEA in week 52, 2024 and has since decreased, it has remained at an elevated plateau due to considerable variation between countries in the timing of the RSV season. Overall influenza activity peaked in week 6, 2025 and decreasing trends are now being observed in each of the influenza A(H1)pdm09, A(H3) and B/Vic viruses. Most countries have moved from an early season dominated by influenza A to A/B co-dominance or B dominance, while for a small number the opposite has applied. The greatest impact

in secondary care has been in adults aged 45 years and above for influenza (with the impact increasing with age) and in children under five years for RSV. EuroMOMO reported all-cause mortality above expected levels between week 51, 2024 and week 9, 2025, affecting adults aged 45 years and over, with levels of mortality now having returned to the expected range.

Although the level of virus activity is decreasing in many settings, countries with ongoing circulation may experience pressure on healthcare systems and hospital capacity, particularly where this is already limited.

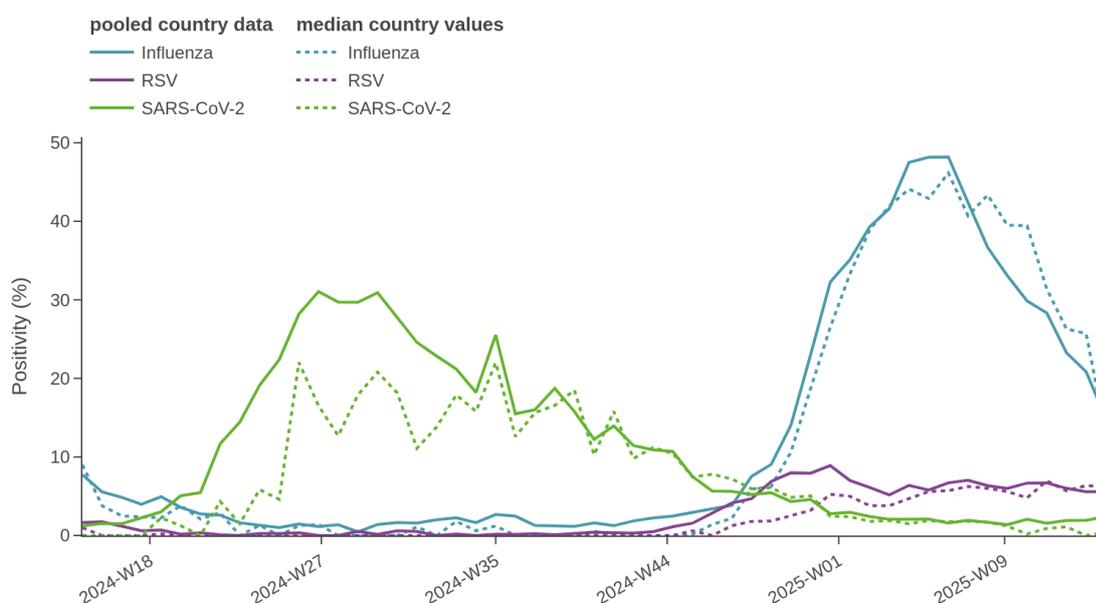
Actions:

- 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 with ongoing transmission should ensure that [infection prevention and control practices in healthcare settings](#) are implemented.
- Vaccination is the most effective measure for protecting against more severe forms of viral respiratory diseases. Those eligible for vaccination, particularly those at higher risk of severe outcomes, are encouraged to get vaccinated in line with national recommendations.
- 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 indicates 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](#)

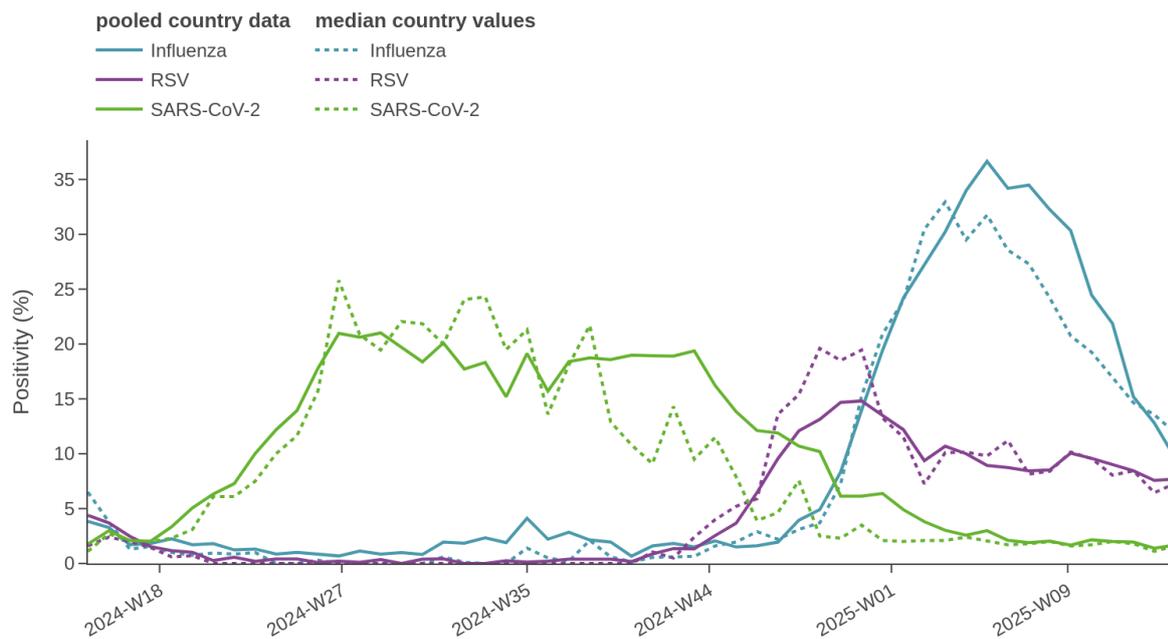
Last time this event was included in the Weekly CDTR: 4 April 2025

Figure 4. ILI/ARI virological surveillance in primary care – weekly test positivity



Source: ECDC

Figure 5. SARI virological surveillance in hospitals – weekly test positivity



Source: ECDC

Figure 6. Overview of key indicators of activity and severity in week 14, 2025

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 14	Week 13	Description	Value	
ILI/ARI consultation rates in primary care	ARI	16 rates (12 MEM)	16 rates (12 MEM)	Distribution of country MEM categories	9 Baseline 2 Low 1 Medium	
	ILI	21 rates (19 MEM)	22 rates (20 MEM)		13 Baseline 5 Low 1 Medium	Norway reported that they assessed overall intensity as medium, even though their ILI rate was baseline according to MEM.
ILI/ARI test positivity in primary care	Influenza	18	19	Pooled (median; IQR)	15% (13; 11–26%)	At the EU/EEA level, the overall pooled influenza positivity remains elevated but continues to decrease in all age groups. Four countries reported test positivity below 10%.
	RSV	17	18		5.6% (6.2; 3.6–7.8%)	At the EU/EEA level, there is a decreasing trend among children aged 0-4 years while a plateau is observed in all other age groups.
	SARS-CoV-2	16	17		2.4% (0.4; 0–3.2%)	Both ILI/ARI virological and non-sentinel laboratory-based data indicate continued low levels of activity.
SARI rates in hospitals	SARI	11	12	-	-	
SARI test positivity in hospitals	Influenza	9	11	Pooled (median; IQR)	9.6% (12; 6.7–12%)	At the EU/EEA level, the overall pooled influenza positivity remains elevated but continues to decrease in all age groups.
	RSV	9	11		7.7% (7.3; 4.3–20%)	At the EU/EEA level, the plateau in test positivity is reflected in all ages. Positivity among children aged 0-4 years (25%) remains much higher than in the other age groups.
	SARS-CoV-2	8	10		1.7% (1.6; 0.8–3.1%)	Activity is low in all countries across all indicators of severity.
Intensity (country-defined)	Influenza	24	25	Distribution of country qualitative categories	5 Baseline 11 Low 5 Medium 2 High 1 Very high	
Geographic spread (country-defined)	Influenza	23	24	Distribution of country qualitative categories	1 No activity 4 Sporadic 1 Local 5 Regional 12 Widespread	

Source: ECDC

Figure 7. ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution

Pathogen	Week 14, 2025		Week 40, 2024 - week 14, 2025	
	N	% ^a	N	% ^a
Influenza	312	-	24137	-
Influenza A	164	54	14367	60
A(H1)pdm09	30	24	6872	57
A(H3)	96	76	5189	43
A (unknown)	38	-	2306	-
Influenza B	141	46	9501	40
B/Vic	40	100	4054	100
B/Yam	0	0.0	1	0.0
B (unknown)	101	-	5446	-
Influenza untyped	7	-	269	-
RSV	106	-	4409	-
RSV-A	18	62	800	44
RSV-B	11	38	1036	56
RSV untyped	77	-	2573	-
SARS-CoV-2	38	-	3021	-

Source: ECDC

Figure 8. SARI virological surveillance in hospitals – pathogen type and subtype distribution

Figure Table

Pathogen	Week 14, 2025		Week 40, 2024 - week 14, 2025	
	N	% ^a	N	% ^a
Influenza	169	-	12622	-
Influenza A	64	79	4981	82
A(H1)pdm09	2	14	1397	61
A(H3)	12	86	901	39
A (unknown)	50	-	2683	-
Influenza B	17	21	1068	18
B/Vic	0	-	132	100
B (unknown)	17	-	936	-
Influenza untyped	88	-	6573	-
RSV	105	-	4748	-
RSV-A			663	50
RSV-B			666	50
RSV untyped	105	-	3419	-
SARS-CoV-2	34	-	3655	-

Source: ECDC

Figure 9. Genetically characterised influenza virus distribution, week 40, 2024 to week 14, 2025

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	2691	45	5a.2a(C.1.9)	2392	89
			5a.2a.1(D)	242	9
			5a.2a(C.1)	57	2
A(H3)	1513	25	2a.3a.1(J.2)	1120	75
			2a.3a.1(J.2.2)	214	14
			2a.3a.1(J.2.1)	140	9
			2a.3a.1(J.1)	14	0.9
			2a.3a.1(J)	10	0.7
			Not assigned	15	-
B/Vic	1764	30	V1A.3a.2(C.5.1)	1161	66
			V1A.3a.2(C.5.6)	292	17
			V1A.3a.2(C.5.7)	271	15
			V1A.3a.2(C)	22	1
			V1A.3a.2(C.5)	3	0.2
			Not assigned	15	-

Source: ECDC

Figure 10. SARS-CoV-2 variant distribution, weeks 12–13, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	3	18	19% (8–33%)
KP.3	VOI	3	12	11% (8–14%)
LP.8.1	VUM	3	29	38% (23–47%)
XEC	VUM	3	26	28% (17–45%)

Source: ECDC

4. Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025

Overview:

Update:

According to the [French National Health Authority](#), up to 30 March 2025, 27 668 autochthonous cases (27 521 in 2025) of chikungunya virus disease have been reported in Réunion. In week 13, 6 289 new confirmed cases were reported. This slowdown in the increase of confirmed cases is potentially linked to the cessation of systematic laboratory confirmation for each suspected case, particularly in areas where the disease is circulating most.

Cases have 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.

So far, 189 people with the disease have been hospitalised for more than 24 hours. Among these cases, a quarter were under six months of age and nearly half (46%) were over 65 years. Most of the hospitalised patients (78%) had at least one comorbidity constituting a risk factor for severe disease.

To date, 36 severe cases (i.e. those with at least one organ failure) have been reported. These cases were in 19 adults over 65 years, one individual with comorbidities and 16 infants under two months (two new cases reported since the previous update).

On 21 March 2025, two deaths were [reported](#) in older individuals with comorbidities. Several deaths are currently under investigation with the possibility of chikungunya virus disease being the cause of death.

The Haute Autorité de Santé (HAS) has [advised](#) public decision-makers to vaccinate people over 65 years of age, those over 18 years with comorbidities, and vector control professionals with Ixchiq® vaccine, as a reactive short-term measure to prevent severe disease. The regional health agency initiated a [vaccination campaign for prioritised individuals](#) from 7 April.

On 26 March 2025, an autochthonous cases of chikungunya virus disease was also reported in [Mayotte](#).

Background:

In August 2024, France reported the first autochthonous case of chikungunya virus disease for 10 years in Réunion, with onset of symptoms on 12 August. 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 Réunion was in 2005–2006. The mosquito *Aedes albopictus*, which is a known vector of chikungunya virus (CHIKV), is established in Réunion.

The probability of infection for residents and travellers to 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 around homes that could contain water and serve as potential mosquito propagation sites, to protect themselves against mosquito bites, and to consult a doctor if symptoms occur.

Pregnant women, especially in the third trimester, are strongly advised to protect themselves from mosquito bites by using effective, pregnancy-safe repellents, and to sleep under a mosquito net. This precautionary measure is useful throughout pregnancy, given that fever during pregnancy can also lead to miscarriages. New-borns and infants should also be protected from mosquito bites by using effective and age-appropriate mosquito repellents (from three months of age) and nets.

ECDC is monitoring the situation through its epidemic intelligence activities.

Further information:

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

Aedes mosquitoes have diurnal biting activities, both in 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 a 28-day temporary deferral period, for travellers who have stayed at least one night in Réunion 28 days prior to donation.

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

5. Ebola disease – Uganda – 2025

Overview:

According to an [Africa CDC press briefing on 10 April](#), and since the last update, no new Ebola cases have been reported. As of 10 April, of the 340 contacts that were being followed-up, none are active. The last case was discharged on [15 March](#) and therefore the countdown for declaring the outbreak over has been initiated. As of 10 April, 26 days of the 42-day countdown period had been completed.

Since the beginning of the outbreak, and as of 10 April, 12 confirmed and two probable cases have been reported, including four deaths (two confirmed and two probable). According to [WHO](#), six regions were 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 having treated the patient who was 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, although 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 to Case 10. The [age range](#) of the individuals involved in the confirmed cases is 1.5 years to 55 years, the mean age is 27 years and males account for 55% of the total cases.

The last case was discharged on [15 March](#) when the countdown period began.

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 has announced](#) that the first ever vaccination trial of a vaccine against SVD is 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 being 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](#) that evaluated the risk to citizens in the EU/EEA as very low. The assessment, including ECDC's options for response, remains valid. 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.

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

6. Expert deployment

Overview:

On 7 April, the EU Health Task Force deployed two ECDC staff members to Riga, Latvia. The two experts, an epidemiologist and a microbiologist, will support the national team in [investigating enterohemorrhagic E.coli cases](#).

Last time this event was included in the Weekly CDTR: 13 September 2024

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 28 March 2025
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 28 March 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 28 March 2025
- Autochthonous chikungunya virus disease - Réunion and Mayotte, France, 2024-2025 - last reported on 28 March 2025
- Ebola disease – Uganda – 2025 - last reported on 28 March 2025
- World Tuberculosis Day - 2025 - last reported on 28 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
- Avian influenza A(H5N1) human cases – United States – 2024 - last reported on 21 March 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 21 March 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 21 March 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 14 March 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 14 March 2025
- Legionnaires' disease outbreak - Vorarlberg, Austria - 2025 - last reported on 14 March 2025
- Expert deployment - last reported on 11 April 2025
- SARS-CoV-2 variant classification - last reported on 04 April 2025