WEEKLY BULLETIN

Communicable disease threats report

Week 17, 19–25 April 2025

This week's topics

Executive Summary

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 continues to decrease. Most of the reporting countries have 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.

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

- Vietnamese authorities have reported a human case of avian influenza A (H5N1) in Ho Chi Minh on 18 April 2025. The patient, a child residing in Ben Cau, Tay Ninh province, tested positive on 18 April and was hospitalised in a serious condition. The child had a history of exposure to dead poultry. Vietnamese authorities implemented infection prevention and control measures.
- Additional information has been provided for the fatal case in Mexico reported earlier. The sample from a child was characterised as avian influenza A(H5N1) clade 2.3.4.4b genotype D1.1. The child from Mexico presented with fever, malaise and vomiting on 7 March 2025. The source of infection is still unknown and remains under investigation; however, there have been detections of A(H5N1) virus infections in birds in Durango. No new human cases have been detected in relation to the Mexican case.
- Since 2003, and as of 22 April 2025, there have been 973 human cases of A(H5N1) worldwide, including 470 deaths.

European Centre for Disease Prevention and Control, Solna, Sweden
www.ecdc.europa.eu

Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

- On 15 April 2025, three human cases of avian influenza A(H9N2) virus infection in China were reported by Hong Kong's Centre for Health Protection, with disease onset between 11 February and 10 March 2025.
- No details about disease severity or exposure are available.
- Nine cases of H9N2 in China have been reported in 2025. Four of the cases had symptom onset in late 2024.
- Since 2015, a total of 119 cases of human avian influenza A(H9N2) infection, including two deaths, have been reported from China to the World Health Organization (WHO).
- The risk to human health in the EU/EEA is currently considered very low.

Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

- In 2025, as of 22 April 2025, eight cases of acute flaccid paralysis (AFP) caused by wild poliovirus type 1 (WPV1) have been reported, six in Pakistan and two in Afghanistan.
- In 2025, as of 22 April 2025, no cases of AFP due to circulating vaccine-derived poliovirus 1 (cVDPV1) or 3 (cVDPV3) have been reported.
- In 2025, as of 22 April 2025, 38 cases of AFP due to circulating vaccine-derived poliovirus 2 (cVPDV2) have been reported from six countries: Ethiopia (16), Nigeria (11), Chad (8), Angola (1), Djibouti (1) and Niger (1).
- On 6 March 2025, the 41st meeting of the Polio Emergency Committee under the International Health Regulations (IHR) (2005) was held to discuss the international spread of poliovirus and it was agreed that it remains a public health emergency of international concern (PHEIC). Temporary recommendations were issued for affected countries, including in EU/EEA countries where the virus was identified in environmental samples.

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 13 April 2025, 39 679 autochthonous cases of chikungunya virus disease have been confirmed in Réunion.
- Since the beginning of the outbreak, nine deaths in individuals over the age of 70 with comorbidities were classified as chikungunya virus disease related.
- 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 initiated a vaccination campaign for prioritised individuals from 7 April.
- On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 18 April 2025, six autochthonous cases of the disease have been reported on the island.

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

Overview:

Based on data reported in week 16, 2025, primary care consultation rates suggest a return to low or baseline levels of respiratory virus activity in all reporting EU/EEA countries and SARI rates have mostly returned to levels observed at this time in previous seasons. Most reporting countries have returned to baseline or low levels of influenza intensity, with the majority of countries now reporting test positivity below 10%. Influenza A(H3) and B viruses were the most commonly reported in week 16. RSV activity in the EU/EEA remains elevated, as around one-third of reporting countries experienced a later season than usual. Some countries are still affected by ongoing RSV epidemics. SARS-CoV-2 activity remains low in the EU/EEA.

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 for influenza A(H1)pdm09, A(H3) and
B/Vic viruses. Most countries experienced an early season dominated by influenza A, followed by A/B co-dominance or B dominance. For a small number of countries, the opposite has applied.

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

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 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.

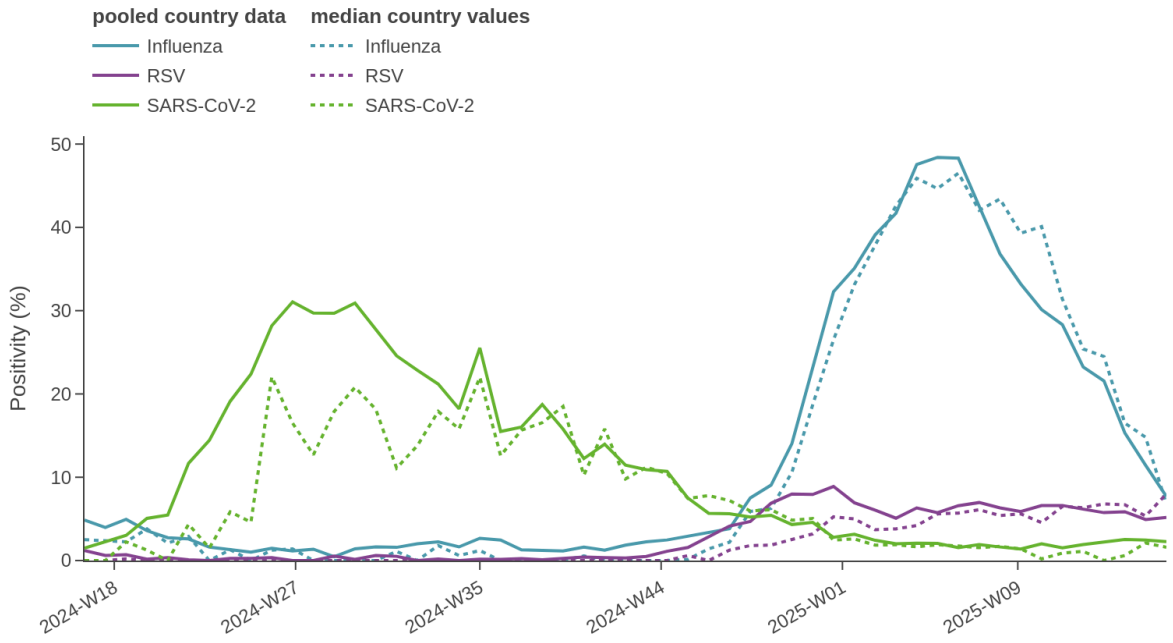
Clinicians should be reminded that, when indicated, the early use of antivirals against influenza may reduce symptom duration and prevent disease progression in groups at high risk of severe outcomes. Frequent handwashing, physical distancing, avoiding large gatherings and wearing masks in healthcare 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: 11 April 2025

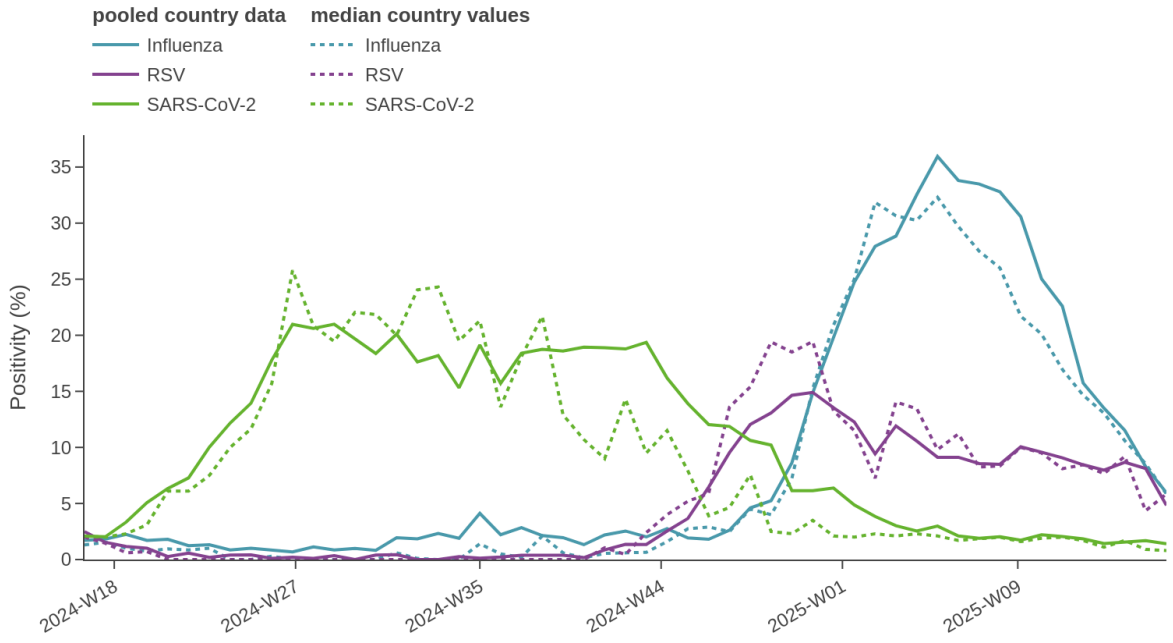
Maps and graphs

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. Overview of key indicators of activity and severity in week 16, 2025

		Reporting countries		EU/EEA summary		
Indicator	**Syndrome or pathogen**	**Week 16**	**Week 15**	**Description**	**Value**	**Comment**
ILI/ARI consultation rates in primary care	ARI	13 rates (10 MEM)	16 rates (12 MEM)	Distribution of country MEM categories	9 Baseline 1 Low	
	ILI	15 rates (15 MEM)	20 rates (20 MEM)		13 Baseline 2 Low	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	16	19	Pooled (median; IQR)	7.7% (6.8; 4.8–12%)	At the EU/EEA level, the overall pooled influenza positivity remains elevated but continues to decrease. Out of 14 reporting countries, 10 reported test positivity below 10%.
	RSV	16	18		5.2% (8; 2.2–10%)	At the EU/EEA level, pooled positivity for RSV continues to plateau.
	SARS-CoV-2	14	16		2.3% (1.6; 0–6%)	Both ILI/ARI virological and non-sentinel laboratory-based data indicate continued low levels of activity. A small number of countries reported recent increases in test positivity, but it is too early to assess the significance of this.
SARI rates in hospitals	SARI	9	11	–	–	
SARI test positivity in hospitals	Influenza	8	11	Pooled (median; IQR)	6% (5.8; 4–8.7%)	At the EU/EEA level, the overall pooled influenza positivity remains elevated but continues to decrease.
	RSV	8	11		4.8% (5.8; 4.7–6.8%)	At the EU/EEA level, a marked decrease was observed in RSV positivity between weeks 14 and 16. There is a decreasing trend in the test positivity among children aged 0-4 years, but the positivity (17%) remains much higher than in the other age groups.
	SARS-CoV-2	7	10		1.4% (0.8; 0–2%)	Activity is low in all countries across all indicators of severity.
Intensity (country-defined)	Influenza	18	24	Distribution of country qualitative categories	6 Baseline 9 Low 2 Medium 1 High	
Geographic spread (country-defined)	Influenza	17	23	Distribution of country qualitative categories	2 No activity 3 Sporadic 1 Local 4 Regional 7 Widespread	

Source: ECDC

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

		Week 16, 2025	Week 40, 2024 – week 16, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**71**	**-**	**24943**	**-**
Influenza A	40	57	14776	60
A(H1)pdm09	9	33	7037	57
A(H3)	18	67	5378	43
A (unknown)	13	–	2361	–
Influenza B	30	43	9903	40
B/Vic	11	100	4299	100
B/Yam	0	0.0	1	0.0
B (unknown)	19	–	5603	–
Influenza untyped	1	–	264	–
RSV	**47**	**-**	**4618**	**-**
RSV-A	10	56	830	44
RSV-B	8	44	1071	56
RSV untyped	29	–	2717	–
SARS-CoV-2	**15**	**-**	**3105**	**-**

Source: ECDC

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

Figure Table

		Week 16, 2025	Week 40, 2024 - week 16, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**84**	**-**	**13282**	**-**
Influenza A	35	65	5383	80
A(H1)pdm09	1	12	1471	60
A(H3)	7	88	977	40
A (unknown)	27	-	2935	-
Influenza B	19	35	1329	20
B/Vic	0	-	142	100
B (unknown)	19	-	1187	-
Influenza untyped	30	-	6570	-
RSV	**54**	**-**	**5139**	**-**
RSV-A			690	48
RSV-B			760	52
RSV untyped	54	-	3689	-
SARS-CoV-2	**23**	**-**	**3723**	**-**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 16, 2025

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	3005	44	5a.2a(C.1.9)	2535	84
			5a.2a.1(D)	312	10
			5a.2a(C.1)	158	5
A(H3)	1701	25	2a.3a.1(J.2)	1230	73
			2a.3a.1(J.2.2)	236	14
			2a.3a.1(J.2.1)	157	9
			2a.3a.1(J)	42	2
			2a.3a.1(J.1)	21	1
			Not assigned	15	-
B/Vic	2077	31	V1A.3a.2(C.5.1)	1305	63
			V1A.3a.2(C.5.6)	362	18
			V1A.3a.2(C.5.7)	324	16
			V1A.3a.2(C)	68	3
			V1A.3a.2(C.5)	3	0.1
			Not assigned	15	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 14–15, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	3	9	12% (5–25%)
KP.3	VOI	2	4	4% (0–14%)
LP.8.1	VUM	3	29	49% (30–59%)
XEC	VUM	4	18	20% (10–41%)

Source: ECDC

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

Overview:

On 18 April 2025, the Ho Chi Minh City Department of Health reported a human case of avian influenza A (H5N1). The case involved a child under 10 years old from Tay Ninh province. The infection was confirmed by the Pasteur Institute of Ho Chi Minh City on 18 April 2025 from cerebroespinal fluid (CSF) samples.

The child developed fever, headache, and gastrointestinal symptoms on 11 April 2025 and was hospitalised the same day. The clinical status of the child deteriorated and they were diagnosed with encephalitis on 13 April 2025. In the same day, nasopharyngeal swab and CSF samples were taken and sent to the Laboratory Department of the Tropical Diseases Hospital. On 17 April, influenza A(H5) virus was identified via PCR in the CSF sample. The PCR of the nasopharyngeal swab samples was negative for influenza virus.

On 18 April 2025, the Pasteur Institute of Ho Chi Minh City confirmed the presence of influenza A(H5N1) in the CSF sample and confirmed the negative result in the respiratory specimens.

Detections of avian influenza A(H5N1) virus in CSF and not in respiratory specimens are rare; cases of encephalitis caused by influenza A(H5N1) have been reported previously from Vietnam.

Additional information has been provided about the fatal case in Mexico that was reported previously in the CDTR. According to WHO DON, on 17 April 2025, the positive A(H5N1) sample from the child under 10 years old from Durango state was characterised as clade 2.3.4.4b genotype D1.1. They presented with symptoms on 7 March 2025, with fever, malaise and vomiting. Overall, 91 close contacts have been identified (21 household contacts, 60 healthcare workers, and 10 people from a childcare center). Nasopharyngeal and pharyngeal swabs were collected from 49 contacts and all tested negative for A(H5N1) virus. The source of infection remains unknown and is under investigation. Several birds have been confirmed with A(H5N1) virus infection in the state of Durango, including a sick vulture at the zoo and a Canada goose at the Peña del Aguila dam in Durango. According to the National Service for Agrifood Health, Safety and Quality, between January 2022 and August 2024, 75 outbreaks of A(H5N1) were reported in poultry from 15 regions across Mexico: Aguascalientes (5), Baja California (4), Chiapas (1), Chihuahua (3), Guanajuato (2), Jalisco (17), México City (7), Michoacán (1), Nuevo León (1), Oaxaca (2), Puebla (2), Sonora (8), Tamaulipas (1), Veracruz (1) and Yucatán (20).

Summary:
Since 2003, and as of 22 April 2025, there have been 973 human cases of avian influenza A(H5N1) infection worldwide*, including 470 deaths (case fatality among reported cases: 48%). These cases were 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: 11 April 2025

3. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

Overview:

Update: On 15 April 2025, Hong Kong's Centre for Health Protection reported three human cases of avian influenza A(H9N2) virus infection in China (Avian Influenza Report).

The first case was in a child from Henan Province, with symptom onset on 11 February 2025. The second case was in another child from Guangxi Autonomous Region, with symptom onset on 3 March 2025. The last case was in a 35-year-old from Guizhou Province, with symptoms onset on 10 March 2025. No other details regarding symptoms, disease severity, treatment, exposure or outcome are available at the moment.

Background: Nine cases of H9N2 have been reported in China in 2025 (of which four had symptom onset in late 2024), none of whom have reported epidemiological links. Since 2015, a total of 119 cases of human avian influenza A(H9N2) infection, including two deaths, have been reported from China to WHO.

ECDC assessment:

Sporadic human cases of avian influenza A (H9N2) have been observed outside the EU/EEA, mainly in young children. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses. Influenza A(H9N2) in most cases leads to mild clinical illness. To date, no clusters of human A(H9N2) infections have been reported. According to WHO, the likelihood of human-to-human transmission of A(H9N2) is low, as there is no evidence that the virus has acquired the ability for sustained transmission among humans.

To date, there have been no human cases of avian influenza A(H9N2) reported in the EU/EEA, and the risk to human health in the region is currently considered very low.

Actions:

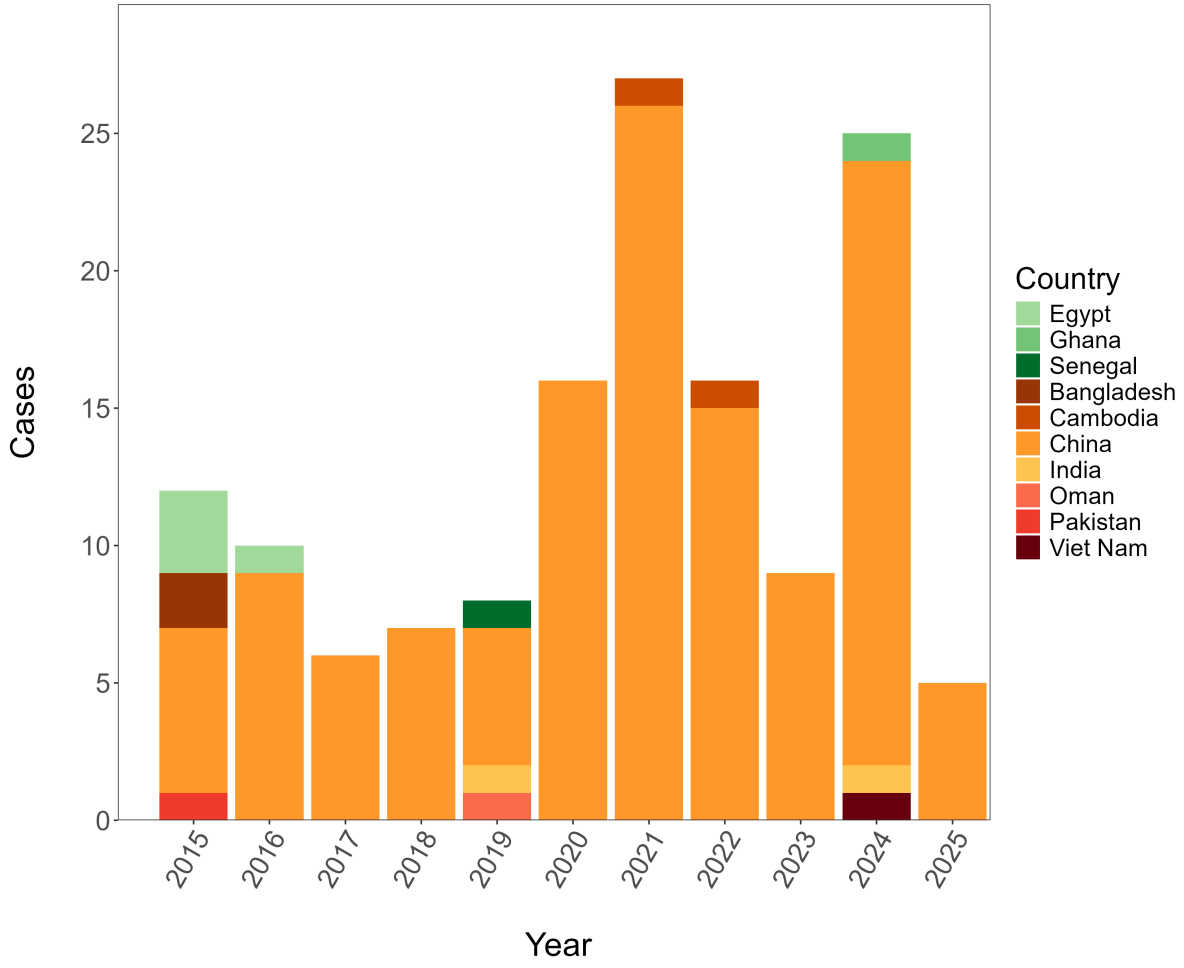
ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities. Together with the European Food Safety Authority and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly report on the avian influenza situation. The most recent report was published in March 2025.

Sources: Event Information Site for IHR National Focal Points

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

Maps and graphs

Figure 1. Distribution of confirmed human cases of avian influenza A(H9N2) virus infection by year of onset and country, 2015–2025 (updated on 22 April, n = 141)



4. Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

Overview:

Global public health efforts to eradicate polio are continuing through the immunisation of every child until transmission of the virus stops and the world becomes polio-free. On 5 May 2014, polio was declared a public health emergency of international concern (PHEIC) by the World Health Organization (WHO) due to concerns over the increased circulation and international spread of wild poliovirus in 2014.

On 6 March 2025, the 41st meeting of the Polio Emergency Committee under the International Health Regulations (IHR) (2005) was held to discuss the international spread of poliovirus and it was agreed that it remains a PHEIC. Temporary recommendations were issued for affected countries, including in EU/EEA countries where the virus was identified in environmental samples.

In June 2002, the WHO European Region was officially declared polio-free.

Summary:

Wild poliovirus type 1 (WPV1):
In 2025, as of 22 April 2025, eight cases of AFP caused by WPV1 have been reported, six in Pakistan and two in Afghanistan.

In 2024, 99 cases of AFP caused by WPV1 have been reported, 74 in Pakistan and 25 in Afghanistan.

Circulating vaccine-derived poliovirus (cVDPV):
In 2025, as of 22 April 2025, no cases of AFP due to cVDPV1 or cVDPV3 have been reported.

In 2025, as of 22 April 2025, 38 cases of AFP due to cVPV2 have been reported from six countries: Ethiopia (16), Nigeria (11), Chad (8), Angola (1), Djibouti (1) and Niger (1).

In 2024, as of 22 April 2025, 11 cases of AFP caused by cVDPV1 have been reported by the Democratic Republic of the Congo (DRC) (10), and Mozambique (1).

In 2024, as of 22 April 2025, 295 cases of AFP caused by cVDPV2 have been reported from 18 countries: Nigeria (98), Ethiopia (43), Chad (39), Yemen (37), Niger (16), DRC (15), South Sudan (10), Angola (9), Indonesia (7), Somalia (7), Guinea (5), Cameroon (3), Algeria (1), Benin (1), Liberia (1), Mali (1), Palestine* (1) and Senegal (1).

In 2024, as of 22 April 2025, four cases of AFP caused by cVDPV3 have been reported by Guinea.

Sources: Global Polio Eradicati on Initiative | ECDC | ECDC dashboard | WPV3 eradication certificate

**This designation shall not be construed as recognition of a State of Palestine and is without prejudice to the individual positions of the Member States on this issue.*

ECDC assessment:

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

As long as there are non-vaccinated or under-vaccinated population groups in European countries and poliomyelitis is not eradicated globally, the risk of the virus being reintroduced in Europe remains. In the EU/EEA, one country (Romania) is considered to be at high risk and five countries (Austria, Estonia, Hungary, Poland and Slovenia) are considered to be at intermediate risk of a sustained polio outbreak following wild poliovirus importation or the emergence of circulating vaccine-derived poliovirus (cVDPV). This is due to suboptimal vaccination programme performance and low population immunity, according to the European Regional Certification Commission for Poliomyelitis Eradication (RCC) report published in December 2024, referring to data from 2023.

The continuing circulation of wild poliovirus type 1 (WPV1) in Pakistan and Afghanistan shows that there is still a risk of the disease being imported into the EU/EEA. The outbreaks of cVDPV that emerge and circulate due to lack of polio immunity in the population also illustrate the potential risk for further international spread.

To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake in pockets of under-immunised populations. EU/EEA countries should review their polio vaccination coverage data and ensure that there are no immunity gaps in the population and that there is capacity to identify virus circulation through well-performing surveillance systems.

ECDC endorses WHO's temporary recommendations for EU/EEA citizens who are residents of or long-term visitors (>4 weeks) to countries categorised by WHO as having the potential risk of causing international spread of polio: an additional dose of poliovirus vaccine should be administered between four weeks and 12 months prior to international travel. Travellers to areas with active transmission of a wild or vaccine-derived poliovirus should be vaccinated according to their national immunisation schedules.

ECDC links: ECDC comment on risk of polio in Europe, ECDC Risk Assessment 2025, ECDC Risk Assessment 2014

Actions:

ECDC provides updates on the polio situation on a monthly basis. ECDC also monitors polio cases worldwide through its epidemic intelligence activities in order to highlight polio eradication efforts and identify events that increase the risk of wild poliovirus being reintroduced into the EU/EEA.

ECDC maintains a dashboard showing countries that are still endemic for polio and have ongoing outbreaks of cVDPV.

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

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

Overview:

Update:
According to the French National Health Authority, as of 13 April 2025, 39 679 autochthonous cases (39 532 in 2025) of chikungunya virus disease have been reported in Réunion. In week 15, 4 304 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, 261 people with the disease have been hospitalised for more than 24 hours, including 231 for which chikungunya virus disease was the reason for admission. (For the other cases, the diagnosis was confirmed during hospitalisation.) Among hospitalised cases, a quarter (26%) were under six months old and nearly half (44%) were over 65 years old. Most of the hospitalised patients (94%) had at least one risk factor for severe disease (e.g. comorbidity, age or pregnancy).

To date, 47 severe cases (i.e. those with at least one organ failure) have been reported. These cases were in 27 adults over 65 years old, three individuals with comorbidities and 17 infants under three months old.

Since the beginning of the year, nine deaths occurring between weeks 11 and 14 in people over 70 years of age with comorbidities have been classified as chikungunya virus disease related (seven directly and two indirectly related). Nine other deaths are currently under investigation for chikungunya virus disease-related causes, including one neonatal death.

The Haute Autorité de Santé (HAS) has advised public decision-makers to vaccinate people over 65 years old, those over 18 years old 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 and extended the group of prioritised individuals on 17 April.

On 26 March 2025, an autochthonous cases of chikungunya virus disease was also reported in Mayotte. As of 18 April 2025, six autochthonous cases of the disease were reported on the island.

Background:
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. 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 high; the current period of austral summer is very favourable for the spread of arboviruses. The epidemic is active throughout the island. Despite a stabilisation observed since week 14, some indicators show a new upward trend in week 15. During week 15, surveillance indicators stabilised in primary care settings, but a new increase in emergency rooms was observed. However, the decrease in laboratory-confirmed cases is partly linked to data that is not yet consolidated and the possible cessation of routine laboratory confirmation for each suspected case.

The impact of hospitalisation is observed among vulnerable individuals, infants, older adults, people with chronic illnesses and pregnant women, in whom the disease can be serious.

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 miscarriage. Newborns 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: 11 April 2025

Events under active monitoring

- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 28 March 2025
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - 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
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 25 April 2025
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 25 April 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 16 April 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 16 April 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 16 April 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 11 April 2025
- SARS-CoV-2 variant classification - last reported on 4 April 2025