

WEEKLY BULLETIN

Communicable disease threats report

Week 18, 26 April - 2 May 2025

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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.

SARS-CoV-2 variant classification

- Since the last update on 28 March 2025, and as of 25 April 2025, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) and de-escalated variants.
- Note that for this update, sufficient data for estimating variant proportions during the reporting weeks is only available from four EU/EEA countries. The statistics below therefore only represent a limited part of the EU/EEA.
- The VOI and VUM median proportions in the EU/EEA for weeks 14-15, based on four reporting countries, are currently:
 - -KP.3 4.2% (range: 0.0%-30.0%)
 - -BA.2.86 11.8% (range: 0.0%-50.0%)
 - -XEC 20.5% (range: 8.3%-70.0%)
 - -LP.8.1 49.2% (range: 0.0%-62.1%)

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 the beginning of the year and as of 27 April 2025, more than 44 000 confirmed autochthonous cases of chikungunya virus disease have been reported 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 April 2025, the [French Ministry of Health and Access to Care reported](#) three serious adverse events (SAE) following vaccination against chikungunya with the IXCHIQ vaccine in Reunion, including one death. As result, the health authorities suspended the vaccination of individuals aged 65 and over, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remains open for people aged 18 to 64 with comorbidities.
- On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 24 April 2025, 17 autochthonous cases of the disease have been reported on the island.

Outbreak of *C. diphtheriae* ST-574 among migrants, persons living in homelessness, elderly and unvaccinated persons – Germany – 2025

- On 30 April 2025, Germany reported a signal for a diphtheria outbreak caused by *C. diphtheriae* sequence type ST-574.
- The strain was first detected in 2022 as part of the international outbreak of imported diphtheria among newly arriving migrants in Germany. Sequence analyses suggest the emergence of two sub-clusters primarily affecting non-migrant population groups.
- The first sub-cluster comprises at least 15 cases of cutaneous diphtheria in Frankfurt/Main. The second cluster includes at least 10 diphtheria cases including five cases of cutaneous diphtheria among people experiencing homelessness in Berlin and five cases of respiratory diphtheria including three deaths (one each in Lower Saxony, Brandenburg and Saxony).
- Since the beginning of 2022, and as of 30 April 2025, there have been 536 cases of diphtheria due to *C. diphtheriae* reported in the EU/EEA (2022: 318 cases, 2023: 156 cases, 2024: 52 cases, 2025: 10 cases) to EpiPulse Cases.
- Out of the cases reported to EpiPulse Cases, in 2022, information on sequence type was available for 64 cases. In 2023, information on sequence type was available for two cases. In 2024 and 2025, information on sequence type was not available for any of the reported cases. The sequence type (574) was available for one death reported in 2022.
- The outbreak reported among migrants and the observation of the same ST-clones to other populations is unusual and needs to be carefully monitored alongside the implementation of necessary public health measures to avoid the occurrence of more cases and further spread.
- The probability of developing the disease is very low for individuals residing in the community, provided they have completed a full diphtheria vaccination series and have an up-to-date immunisation status.
- Severe clinical diphtheria is possible in unvaccinated or immunosuppressed individuals; diphtheria should be considered as a differential diagnosis in cases with compatible clinical presentation of the disease.

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

- Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries, with the epidemiological trends remaining largely unchanged.

- Most cases of mpox clade I in Africa are still reported by the Democratic Republic of the Congo (DRC), Burundi, and Uganda. Uganda continues to show an increasing trend in reported cases.
- Sporadic mpox clade I cases have also been reported outside Africa the past month without any indication of wider community transmission outside the continent.
- The classification of transmission patterns has been updated (details are provided in the overview).
- ECDC is closely monitoring and assessing the epidemiological situation, and additional related information can be found in the Centre's rapid risk assessment published on 16 August 2024 ('[Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#)') and its '[Rapid scientific advice on public health measures](#)'.

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

- On 21 April 2025, the sequence isolated from a case previously reported from India was released in GISAID and belongs to Clade 2.3.2.1a.
- The strain is most closely related to a virus in an Australian child with travel history to India and that these two are on a separate branch from other sequences of this Clade which have their origin from ducks in Bangladesh.
- A mutation analysis found no mammalian adaptations of significance.
- Since 2003, and as of 22 April 2025, there have been 973 human cases of A(H5N1) worldwide, including 470 deaths.

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

- Since 1 January 2025 and as of 2 May 2025, 111 359 cholera cases, including 1 562 deaths, have been reported worldwide.
- Since 17 March 2025 and as of 2 May 2025, 16 111 new cholera cases, including 372 new deaths, have been reported worldwide.
- New cases have been reported from Afghanistan, Angola, Bangladesh, Burundi, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Kenya, Malawi, Mozambique, Myanmar, Namibia, Nepal, Nigeria, Pakistan, Rwanda, 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.

Yellow fever – South America – 2024–2025

- From 12 May 2025, travellers entering Ecuador from neighbouring countries will be required to present proof of yellow fever vaccination.
- On 3 February 2025, the Pan American Health Organization (PAHO/WHO) issued an Epidemiological Alert on an increase in human yellow fever cases reported in South American countries.
- South America is a popular tourist destination for travellers from the EU/EEA and it is important that travel medicine clinics and vaccination centres are aware of the yellow fever risk.
- Since 2005, 16 imported yellow fever cases have been reported in the EU/EEA. The likelihood of virus transmission in the EU/EEA is very low.

Ebola disease – Uganda – 2025

- On 26 April 2025, the Ministry of Health in Uganda declared the end of the Ebola outbreak.
- Overall, during the outbreak, 12 confirmed and two probable cases were reported, including four deaths (two confirmed and two probable cases) (case-fatality rate (CFR) 28.6%). The last patient being treated was discharged on 14 March 2025 and the 42 day countdown begun. Cases were reported from Jinja, Kampala, Kyegegwe, Mbale, Ntoroko, and Wakiso regions.

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.

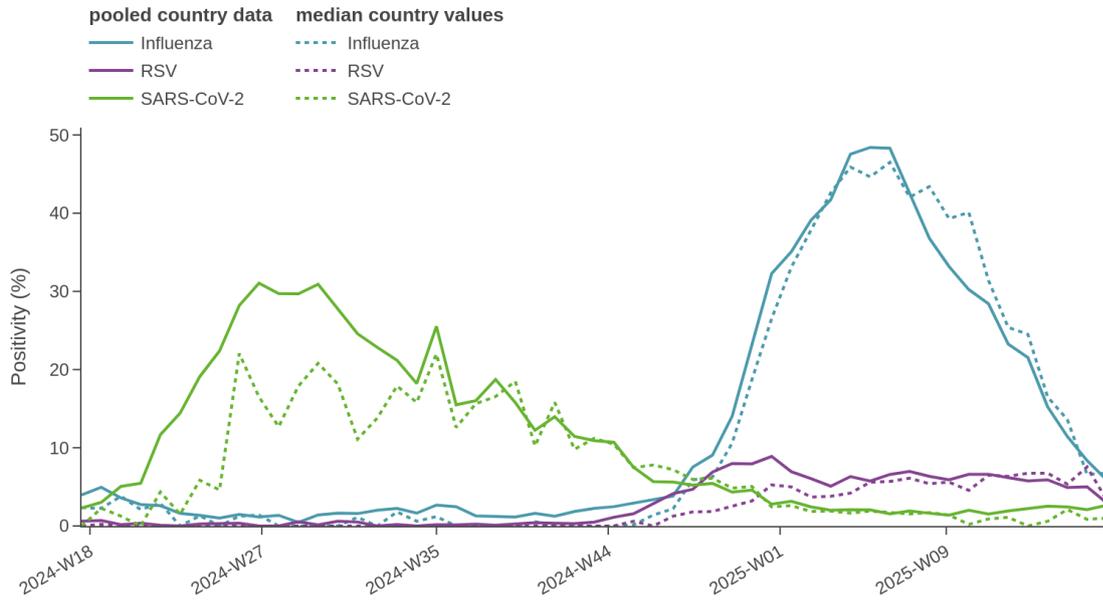
Clinicians should be reminded that, when indicated, the early use of antivirals against influenza may reduce symptom duration and prevent disease progression in groups at high risk of severe outcomes. Frequent handwashing, physical distancing, avoiding large gatherings and wearing masks in healthcare 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: 25 April 2025

Maps and graphs

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



Source: ECDC

Figure 2. Overview of key indicators of activity and severity in week 17, 2025

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 17	Week 16	Description	Value	
ILI/ARI consultation rates in primary care	ARI	14 rates (11 MEM)	15 rates (12 MEM)	Distribution of country MEM categories	11 Baseline	ARI consultation rates in primary care are at baseline level in all reporting countries.
	ILI	16 rates (16 MEM)	18 rates (18 MEM)		15 Baseline 1 Low	
ILI/ARI test positivity in primary care	Influenza	16	18	Pooled (median; IQR)	5.9% (6.8; 3-14%)	At the EU/EEA level, the overall pooled influenza positivity continues to decrease. Out of 16 reporting countries this week, four reported test positivity above 10%. At the EU/EEA level, pooled positivity for RSV has been slowly decreasing since week 14, although four out of the 14 reporting countries this week reported test positivity between 5 and 10%. The remaining countries all reported test positivity below 5%. Both ILI/ARI virological and non-sentinel laboratory-based data indicate continued low levels of activity. Only one country reported a test positivity above 15% in ILI/ARI surveillance but based on a relatively low number of tested samples.
	RSV	14	17		2.9% (3.3; 1.7-6.1%)	
	SARS-CoV-2	14	15		2.6% (1; 0-3.2%)	
SARI rates in hospitals	SARI	10	11	-	-	
SARI test positivity in hospitals	Influenza	9	9	Pooled (median; IQR)	3.4% (3.5; 2.8-4.8%)	At the EU/EEA level, the overall pooled influenza positivity continues to decrease in all age groups in all reporting countries. At the EU/EEA level, pooled positivity for RSV continues to plateau (4.5%), but median positivity this week decreased compared to the previous week (2.1% compared to 5.8%). The decreasing trend in the test positivity among children aged 0-4 years continues, but the positivity (17%) remains much higher than in the other age groups. Activity for SARS-CoV-2 remains low in all countries across all indicators of severity.
	RSV	9	9		4.5% (2.1; 1-5.3%)	
	SARS-CoV-2	8	8		1% (0; 0-0.7%)	
Intensity (country-defined)	Influenza	18	21	Distribution of country qualitative categories	5 Baseline 10 Low 2 Medium 1 High	
Geographic spread (country-defined)	Influenza	18	20	Distribution of country qualitative categories	2 No activity 3 Sporadic 3 Local 5 Regional 5 Widespread	

Source: ECDC

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

Pathogen	N	Week 17, 2025		Week 40, 2024 - week 17, 2025	
		N	% ^a	N	% ^a
Influenza	53		-	25019	-
Influenza A	36		68	14822	60
A(H1)pdm09	6		32	7074	57
A(H3)	13		68	5399	43
A (unknown)	17		-	2349	-
Influenza B	17		32	9935	40
B/Vic	2		100	4405	100
B/Yam	0		0.0	1	0.0
B (unknown)	15		-	5529	-
Influenza untyped	0		-	262	-
RSV	25		-	4650	-
RSV-A	1		50	841	44
RSV-B	1		50	1078	56
RSV untyped	23		-	2731	-
SARS-CoV-2	21		-	3127	-

Source: ECDC

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

Figure Table

Pathogen	Week 17, 2025		Week 40, 2024 - week 17, 2025	
	N	% ^a	N	% ^a
Influenza	42	-	13394	-
Influenza A	18	62	5436	80
A(H1)pdm09	0	0.0	1470	60
A(H3)	2	100	980	40
A (unknown)	16	-	2986	-
Influenza B	11	38	1356	20
B/Vic	0	-	143	100
B (unknown)	11	-	1213	-
Influenza untyped	13	-	6602	-
RSV	43	-	5235	-
RSV-A			693	47
RSV-B	1	100	768	53
RSV untyped	42	-	3774	-
SARS-CoV-2	15	-	3750	-

Source: ECDC

Figure 5. Genetically characterised influenza virus distribution, week 40, 2024 to week 17, 2025

Subtype	Subtype distribution		Subclade	Subclade distribution	
	N	%		N	%
A(H1)pdm09	3318	43	5a.2a(C.1.9)	2811	85
			5a.2a.1(D)	350	11
			5a.2a(C.1)	157	5
A(H3)	1925	25	2a.3a.1(J.2)	1416	74
			2a.3a.1(J.2.2)	263	14
			2a.3a.1(J.2.1)	168	9
			2a.3a.1(J)	42	2
			2a.3a.1(J.1)	21	1
			Not assigned	15	-
B/Vic	2385	31	V1A.3a.2(C.5.1)	1429	60
			V1A.3a.2(C.5.6)	457	19
			V1A.3a.2(C.5.7)	410	17
			V1A.3a.2(C)	71	3
			V1A.3a.2(C.5)	3	0.1
			Not assigned	15	-

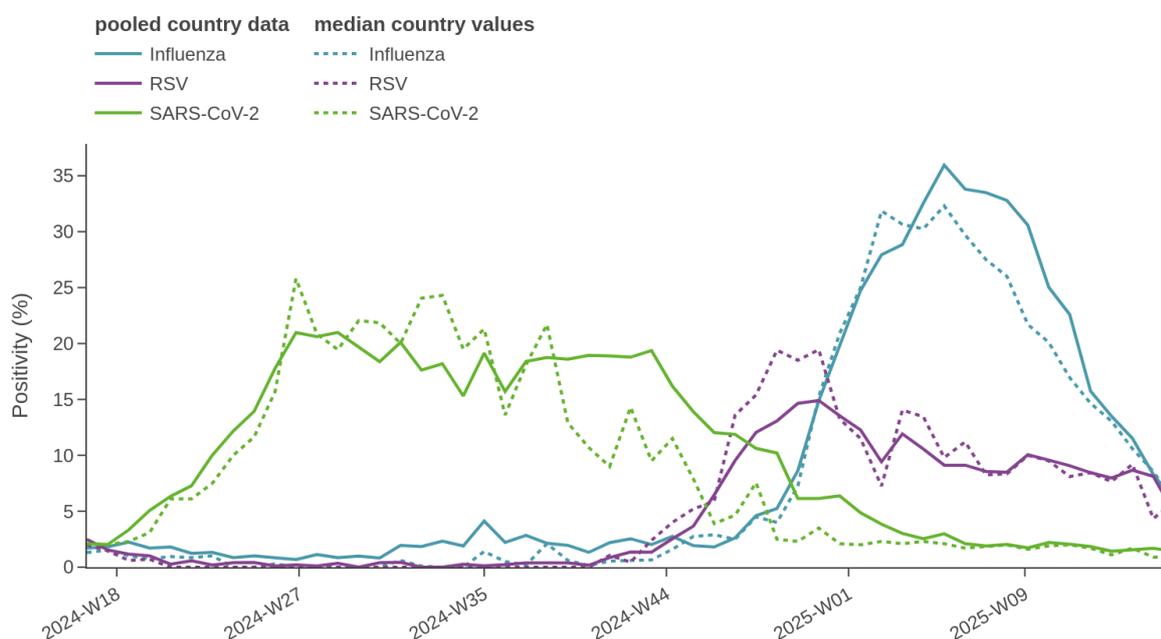
Source: ECDC

Figure 6. SARS-CoV-2 variant distribution, weeks 15–16, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	2	15	33% (17-34%)
KP.3	VOI	3	6	9% (7-19%)
XEC	VUM	3	18	30% (25-50%)
LP8.1	VUM	2	14	26% (13-32%)

Source: ECDC

Figure 7. SARI virological surveillance in hospitals- weekly test positivity



Source: ECDC

2. SARS-CoV-2 variant classification

Overview:

Since the last update on 28 March 2025, and as of 25 April 2025, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) and de-escalated variants.

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

The VOI median proportions in the EU/EEA for weeks 14-15, based on four reporting countries, are currently:

- KP.3: 4.2% (range: 0.0%-30.0%, IQR: 0.0%-13.8%)
- BA.2.86: 11.8% (range: 0.0%-50.0%, IQR: 5.2%-25.0%).

The VUM median proportions in the EU/EEA for weeks 14-15, based on four reporting countries, are currently:

XEC: 20.5% (range: 8.3%-70.0%, IQR: 9.6%-40.8%)
LP.8.1: 49.2% (range: 0.0%-62.1%, IQR: 30.0%-59.3%).

The calculations are based on data reported to GISAID, as of 20 April 2025.

The currently circulating variants that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and individuals who were previously not infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (e.g. older adults) remains important.

ECDC assessment:

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation. The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. The variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and individuals who have previously not been infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (e.g. older adults) remains important.

Actions:

In order to assess the impact of emerging SARS-CoV-2 sub-lineages and their possible correlation with increases in COVID-19 epidemiological indicators, it is important that countries sequence positive clinical specimens and report to GISAID and/or TESSy.

For the latest update on SARS-CoV-2 variant classifications, please see [ECDC's webpage on variants](#). Variant surveillance data, including the distribution of VOC and VOI variant proportions in the EU/EEA and detailed country-specific COVID-19 updates are available as part of the [European Respiratory Virus Surveillance Summary \(ERVISS\)](#).

Routine updates on the SARS-CoV-2 variant classification through the Communicable Diseases Threats Report will be provided on a monthly basis at a minimum.

Last time this event was included in the Weekly CDTR: 04 April 2025

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

Overview:

Update:

According to the [French National Health Authority](#), since the beginning of the year and as of 27 April 2025, more than 44 000 confirmed autochthonous cases of chikungunya virus disease have been reported in Réunion. In week 16, 3 245 new confirmed cases were reported. The decrease in 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, 302 people with the disease have been hospitalised for more than 24 hours, including 270 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 were under six months old and nearly half (42%) were over 65

years old. Most of the hospitalised patients (95%) had at least one risk factor for severe disease (e.g. comorbidity, age or pregnancy).

To date, 57 severe cases (i.e. those with at least one organ failure) have been reported. These cases were in 33 adults over 65 years old with comorbidities, three individuals with comorbidities and 21 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). Twenty 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 April 2025, the **French Ministry of Health and Access to Care reported** that it was informed on 23 April 2025 by the French National Agency for the Safety of Medicines (ANSM) of the occurrence of two serious adverse events (SAE) following vaccination against chikungunya with the IXCHIQ vaccine in Reunion, including one death, and a third serious adverse event on 25 April. The three SAE occurred in people over 80 years of age with comorbidities. Two of them experienced symptoms similar to those of a severe form of chikungunya a few days after vaccination and one of them died. The third person was discharged from hospital. On 25 April, the French [National Authority for Health \(HAS\)](#) advised a revision of the vaccination recommendations. As result, the health authorities suspended the vaccination of individuals aged 65 and over, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remains open for people aged 18 to 64 with comorbidities. In this context, travellers aged 65 and over should also not be vaccinated with the IXCHIQ vaccine.

On 26 March 2025, an autochthonous case of chikungunya virus disease was also reported in [Mayotte](#). As of 24 April 2025, 17 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. 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: 25 April 2025

4. Outbreak of *C. diphtheriae* ST-574 among migrants, persons living in homelessness, elderly and unvaccinated persons – Germany – 2025

Overview:

On 30 April 2025, Germany reported a signal for a diphtheria outbreak caused by *C. diphtheriae* sequence type ST-574. This strain was first detected in 2022 as part of the international outbreak of imported diphtheria among newly arriving migrants in Germany. Recent sequencing analyses conducted by the National Consiliary Laboratory for Diphtheria showed that isolates from cases across different federal states and population groups are closely related.

A total of 126 lab-confirmed cases of *C. diphtheriae* ST-574 have been identified across Germany. There were 55 cases in 2022, 49 cases in 2023, 18 cases in 2024 and at least four cases in 2025. Recent analyses suggest the emergence of two sub-clusters primarily affecting non-migrant population groups.

The first sub-cluster comprises at least 15 cases of cutaneous diphtheria with fewer than nine allelic differences (<9 AD) notified between June 2023 and January 2025. This cluster primarily, though not exclusively, affects people who experience homelessness in Frankfurt on the Main.

The second cluster includes at least 10 diphtheria cases (<8 AD). Five of these were cases of cutaneous diphtheria among people experiencing homelessness in Berlin, with notification dates between January and December 2024. In addition, the cluster comprises five cases of respiratory diphtheria including three deaths (Lower Saxony:1, Brandenburg:1, Saxony:1).

Germany has initiated an outbreak investigation with the aim of gathering further information on the extent of the event and identifying possible epidemiological links to inform appropriate public health measures, especially targeting vulnerable populations.

Diphtheria is a rare disease in EU/EEA countries. According to WHO/UNICEF, immunisation coverage estimates for diphtheria tetanus toxoid and pertussis (DTP3) in 2023 in the EU/EEA varied across Member States, ranging from 78% (Romania) to 99% (Greece, Hungary, Luxembourg, and Portugal). Universal immunisation is the only effective method for preventing the toxin-mediated disease. This includes the administration of a booster dose of diphtheria toxoid if more than 10 years have passed since the last dose. The occurrence of the disease in fully-vaccinated individuals is very rare.

Additional epidemiological information:

Since the beginning of 2022, and as of 30 April 2025, there have been 536 cases of diphtheria due to *C. diphtheriae* reported in the EU/EEA (2022: 318 cases, 2023: 156 cases, 2024: 52 cases, 2025: 10 cases) to EpiPulse Cases.

In 2025, and as of 22 April 2025, ten cases of diphtheria caused by *C. diphtheriae* have been reported in the EU/EEA through EpiPulse Cases. Cases have been reported in Germany (5), Belgium (2), Austria (1), Czechia (1) and Latvia (1). Of these, one case was imported to Austria. One death in an 80-year-old female was reported by Germany with no information on clinical presentation available.

In 2024, 52 cases of diphtheria caused by *C. diphtheriae* were reported in the EU/EEA through EpiPulse. Cases have been reported in Germany (30), Czechia (8), Belgium (6), Latvia (4) and Norway (4). Of these, ten cases were imported. Two deaths were reported by Germany (1) (information on clinical presentation not available) and Latvia (1) (respiratory clinical presentation).

In 2023, 156 cases of diphtheria caused by *C. diphtheriae* have been reported in the EU/EEA through EpiPulse. Cases have been reported in Germany (95), France (18), the Netherlands (13), Belgium (9), Slovenia (4), Austria (3), Czechia (2) Italy (2), Latvia (2), Norway (2), Slovakia (2), Spain (2), Luxembourg (1) and Sweden (1). Of these, 69 cases were imported. Two deaths were reported by Belgium (1) and Latvia (1), both deaths presented with respiratory clinical presentation.

In 2022, 318 cases of diphtheria caused by *C. diphtheriae* have been reported in the EU/EEA through EpiPulse. Cases have been reported in Germany (149), France (52), Austria (61), Belgium (26), Norway (8), Slovakia (8), the Netherlands (5), Czechia (3) Italy (3), Sweden (2) and Spain (1). Of these, 134 cases were imported. Four deaths were reported by France (2) (information on clinical presentation not available), Austria (1) (respiratory clinical presentation) and Slovakia (1) ('other' clinical presentation).

Among the 536 cases, more than two-thirds (67%) presented with an exclusively cutaneous form of the disease (n=358). A total of 55 cases had a respiratory presentation; of those, seven cases had both respiratory and cutaneous presentations. Six cases had 'other' clinical presentation, and three cases had a nasal presentation. Information on clinical presentation was missing for 114 cases.

Vaccination status was available for 209 cases (39%). Fifty-seven of these (27%) were reported to have been vaccinated with a known number of doses: 41 (20%) received one dose, two (1%) received two doses, four (2%) received three doses, four (2%) received four doses, five received (2%) five doses and one (0.5%) received six doses. Sixty-eight cases (33%) were vaccinated with an unknown number of doses and 84 cases (40%) were not vaccinated.

Information on antibiotic susceptibility testing was available for six cases (1%) (four cases in 2022, two cases in 2023).

Information on cluster-relatedness was available for 117 cases. Forty cases (34%) were reported as being related to a cluster while 77 cases (66%) were not related to a cluster.

Information on whole genome sequencing was available for 92 cases. Of these, whole genome sequencing had been processed for 68 cases (74%).

In 2022, information on sequence type was available for 64 cases. The three main sequence types reported were 377 (24 cases, 36%), 384 (21 cases, 33%) and 574 (15 cases, 23%). In 2023, information on sequence type was available for two cases (183 and 377, respectively). In 2024 and 2025, information on sequence type was not available for any of the reported cases. The sequence type (574) was available for one death reported in 2022.

ECDC assessment:

Since the outbreak of cutaneous diphtheria among migrants in EU/EEA countries in 2022 a major decline of reported cases has been observed. However, the outbreak reported among migrants and the observation of the

same ST-clones to other populations requires enhanced surveillance and implementation of public health measures to identify risk factors for transmission and avoid the occurrence of more cases and further spread.

The probability of developing the disease is very low for individuals residing in the community, provided they have completed a full diphtheria vaccination series and have an up-to-date immunisation status. Nevertheless, secondary cases and severe clinical diphtheria is possible in unvaccinated or immunosuppressed individuals. Diphtheria should be considered in the differential diagnosis of cases with compatible clinical presentation of the disease.

Actions:

ECDC continues to monitor this event through its epidemic intelligence activities and routine indicator-based surveillance, which is published on a monthly basis on the ECDC Atlas for Infectious Diseases. ECDC encourages MS to report complete diphtheria data to EpiPulse cases regularly and timely to assess diphtheria epidemiology in the EU/EEA population.

In 2022, ECDC published a [Rapid Risk Assessment \(RRA\)](#) on the increase of reported diphtheria cases among migrants in Europe due to *Corynebacterium diphtheriae*. The conclusions, options for response and considerations for immunisation policy proposed in this RRA remain valid.

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

5. Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025

Overview:

Globally, monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries. Since 2022, MPXV clade II has mainly been circulating outside of the African continent among men who have sex with men. In 2024, an increase in MPXV clade Ia and Ib was reported in the Democratic Republic of the Congo (DRC), while clade Ia cases continued to be reported by the Central African Republic and the Republic of the Congo (Congo), where it is endemic.

In 2025, cases continue to be reported in DRC and other countries in Africa where clade I was first detected the previous year. Additionally, sporadic cases have been reported outside Africa, mostly linked to travel and with limited onward transmission.

The countries in Africa that have reported clade I detection (Ia and/or Ib) in 2025, are: DRC, Uganda, Burundi, Kenya, Zambia, Tanzania, Congo, South Sudan, the Central African Republic, South Africa, and Angola. In 2024, Zimbabwe reported cases of clade Ib and Gabon reported mpox cases for which clade information is not available ([Global Mpox Trends](#)).

Overall, in Africa, until the beginning of April 2025, most confirmed and suspected clade I cases have been reported from the DRC, Uganda and Burundi ([Mpox: multi-country external situation report no. 50, 11 April 2025, WHO Global Report with data until 6 April 2025](#)). However, different trends have been observed recently in each country.

In DRC, clade Ia and Ib co-circulate to different degrees. The number of confirmed cases has plateaued over the last four weeks. Testing coverage remained low during the same period ([Africa CDC Special Briefing on Mpox and other Health Emergencies, 10 April 2025, Mpox: multi-country external situation report no. 50, 11 April 2025](#)). In Kinshasa, both clades Ia and Ib co-circulate. Epidemiological data and sequencing suggest there is human-to-human transmission of clade Ia with high rates of APOBEC3-driven mutations. Similar signals have not been reported in provinces outside Kinshasa, where clade Ia is circulating in DRC. However, the number of samples sequenced and analysed varies across provinces in DRC ([Mpox: multi-country external situation report no. 48, 10 March 2025](#)). APOBEC3 mutations have also been noted in clade Ib. Based on the available information on clade Ia circulation in Kinshasa there is currently no evidence that the strain is inherently more transmissible than other clade Ia strains or clade Ib according to WHO ([Mpox: multi-country external situation report no. 48, 10 March 2025](#)).

Uganda is currently the African country reporting most mpox clade Ib cases after DRC. Over 1 400 cases have been reported in the past six weeks, including 15 deaths ([WHO data as of 6 April 2025](#)). The number of cases has been showing an increasing trend with a total of 5 538 cases and 37 deaths reported overall as of the end of March 2025 ([Africa CDC Special Briefing on Mpox and other Health Emergencies, 10 April 2025](#)). According to WHO, Uganda is the country that has reported the highest number of cases in recent weeks. The age group mainly affected in Uganda is 20-39-year-olds. Transmission is reported in sexual networks, and the highest incidence is reported in and around Kampala ([Africa CDC Special Briefing on Mpox and other Health Emergencies, 10 April 2025](#); [Mpox: multi-country external situation report no. 48, 10 March 2025](#)).

In Burundi, the decreasing trend observed in the last weeks in the number of reported mpox cases continues and only clade Ib has been detected ([Mpox: multi-country external situation report no. 50, 11 April 2025](#)). In the past six weeks, 199 cases have been reported, and no deaths, according to the WHO ([WHO data as of 6 April 2025](#)).

Detailed information on the mpox clade I case numbers can be found in the [WHO Global Report \(as of 14 April the report included data until 6 April 2025\)](#). In general, and as of 14 April 2025, no major changes were noted in the epidemiological trends of mpox clade I in Africa.

Outside Africa, travel-associated cases or sporadic cases reporting epidemiological links with travel-associated cases of MPXV clade I have been reported in the EU/EEA by: Sweden (in 2024), [Germany](#) (in 2024 and 2025), [Belgium](#) (in 2024 and 2025), France and Ireland (in 2025).

[In addition to Africa and the EU/EEA](#), since August 2024, clade I cases have been reported by Thailand, India, the United Kingdom, the United States, Canada, Pakistan, Oman, [China](#), the United Arab Emirates, Qatar, and [Brazil](#). On 4 April 2025, [China](#) reported the first case mpox clade Ia in the country, with travel history to DRC. On 8 April 2025, [Switzerland](#) also reported the first case of mpox clade Ib. The person had recently travelled to Uganda at the beginning of April.

Most travel-associated cases who reported travel to non-African countries had links to affected countries in Africa. However, China, India, Oman, Pakistan and Thailand have reported at least one case each with travel links to the United Arab Emirates ([WHO external situation reports](#)).

Confirmed secondary transmission of mpox due to MPXV clade Ib outside of Africa was reported for the first time in 2024 in the EU/EEA by Germany and Belgium, and outside of the EU/EEA by the UK and China. The number of secondary cases reported in these events outside of Africa has been low. Based on the available information, all transmission events were due to close contact, secondary cases presented with mild symptoms and no deaths have been reported.

On 13 August 2024, Africa CDC [declared](#) mpox a Public Health Emergency of Continental Security. On 14 August 2024, WHO [convened](#) a meeting of the IHR Emergency Committee to discuss the mpox upsurge and [declared](#) the current outbreak of mpox due to MPXV clade I as a public health emergency of international concern.

Transmission patterns of mpox due to monkeypox virus clade I – update 14 April 2025

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

The categories are as follows:

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

The categorisation was last updated on 14 April 2025 to include Switzerland (category of countries with travel-associated cases or cases with links to travel associated cases).

Below you can find some notes on the interpretation of the different trends reported in countries included:

- On 25 March 2025, the UK reported the 11th mpox clade Ib case. This case reported no travel history and no contact with any known mpox case or with anyone who had travelled to any affected country ([Mpox: multi-country external situation report no. 50, 11 April 2024, Latest update on Clade Ib mpox - GOV.UK](#)). No secondary cases had been identified linked to this case, as of 14 April 2025. Given that this is a sporadic case,

the UK is still included in the first category of the classification. In case more information becomes available, the classification may be modified.

- The United Arab Emirates have reported cases with travel history to Uganda, however a number of other countries have reported cases with travel history to the United Arab Emirates. Although there is no evidence of wider community transmission in the United Arab Emirates, it is presumed that undetected transmission is ongoing ([Mpox: multi-country external situation report no. 50, 11 April 2024](#)). The United Arab Emirates are therefore classified as having 'clusters of cases or limited transmission'.
- Congo has reported clade Ib detection (Congo is endemic for clade Ia) ([Africa CDC Press Briefing of 20 February 2025](#)). A total of 26 confirmed cases have been reported in 2025 (until week ending 30 March 2025) according to the National Situation Report published of 10 April 2025 ([Epidémie de Mpox : Rapport de Situation \(SITREP\) N°48 du 10 avril 2025 | OMS | Bureau régional pour l'Afrique](#)). The total number of confirmed cases reported in 2024 was 24. Most cases have been reported close to the border with DRC. Based on the national report, there is a large number of suspected cases in different areas of the country.
- South Sudan and South Africa are currently in the first category given the small number of confirmed cases (five and three cases respectively reported the past six weeks [according to WHO, and as of 6 April](#)). No additional information on suspected cases is available, and there are no indications of wider community transmission.

The epidemiological situation is continuously monitored and the classification is reviewed and adjusted depending on a qualitative assessment of reported trends.

ECDC assessment:

The epidemiological situation regarding mpox due to MPXV clade Ib remains similar to previous weeks. The sporadic cases of mpox clade I that have been reported outside Africa, including secondary transmission, are not unexpected.

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

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

Please see the latest ECDC '[Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#)'.

Actions:

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

Reporting through the Communicable Disease Threats Report is monthly. As the global epidemiological situation is monitored continuously, ad hoc epidemiological updates may be published.

Sources: [ECDC rapid risk assessment](#)

Last time this event was included in the Weekly CDTR: 16 April 2025

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

Overview:

In the [CDTR](#) published on 4 April 2025, a fatal case of A(H5N1) avian influenza was reported in a two-year-old girl from Palnadu district, Andhra Pradesh, India, marking the country's second confirmed human case and death from A(H5N1) since 2003. On 21 April 2025, the sequence from the virus isolated from the sample was released on GISAID EpiFlu under Isolate Id EPI_ISL_19836227 belonging to Clade 2.3.2.1a. Phylogenetic analysis of the HA segment among sequences of 2.3.2.1a revealed that the strain is most closely related to a virus from an Australian child with travel history to India, and that these two are on a separate branch from other sequences of this Clade which mostly originate from ducks in Bangladesh. Sequences from birds or environments close to the region of the case are absent. A mutation analysis found no mammalian adaptations of significance.

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).

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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: 25 April 2025

7. 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 17 March 2025 and as of 02 May 2025, 16 111 new cholera cases, including 372 new deaths, have been reported worldwide.

Since 1 January 2025 and as of 2 May 2025, 111 359 cholera cases, including 1 562 deaths, have been reported worldwide. In comparison, since 1 January 2024 and as of 2 May 2024, 151 497 cholera cases, including 1 752 deaths, were reported worldwide.

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

The five countries reporting most cases are Angola (6 971), Ethiopia (2 951), Mozambique (2 787), Sudan (1 965) and Ghana (514).

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 most new deaths are Angola (247), Sudan (62), Mozambique (29), Ethiopia (15) and Zimbabwe (10).

Since the last update, new cases and new deaths have been reported from:

Asia:

Afghanistan: Since 24 February 2025 and as of 17 March 2025, 5 249 new cases, including two new deaths have been reported. Since 1 January 2025 and as of 17 March 2025, 19 652 cases, including 8 deaths have been reported. In comparison, in 2024 and as of 27 April 2024, 33 307 cases, including 16 deaths were reported.

Bangladesh: Since 31 December 2024 and as of 24 February 2025, 80 new cases have been reported. Since 1 January 2025 and as of 24 February 2025, 80 cases have been reported. In comparison, in 2024 and as of 30 April 2024, 6 cases were reported.

India: Since 11 November 2024 and as of 03 March 2025, 93 new cases have been reported. Since 01 January 2025 and as of 03 March 2025, 93 cases have been reported. In comparison, in 2024 and as of 15 April 2024, 1 320 cases, including four deaths were reported.

Myanmar: Since 20 January 2025 and as of 10 March 2025, 451 new cases have been reported. Since 1 January 2025 and as of 10 March 2025, 1 004 cases have been reported. In comparison, in 2024 and as of 2 May 2024, no cases were reported.

Nepal: Since 23 September 2024 and as of 3 March 2025, 85 new cases have been reported. Since 1 January 2025 and as of 3 March 2025, 85 cases have been reported. In comparison, in 2024 and as of 2 May 2024, no cases were reported.

Pakistan: Since 20 January 2025 and as of 10 February 2025, 1 809 new cases have been reported. Since 1 January 2025 and as of 10 February 2025, 4 038 cases have been reported. In comparison, in 2024 and as of 24 March 2024, 5 313 cases were reported.

Yemen: Since 17 February 2025 and as of 24 February 2025, 296 new cases, including one new death has been reported. Since 1 January 2025 and as of 24 February 2025, 10 080 cases, including 10 deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 4 276 cases, including 23 deaths were reported.

Africa:

Angola: Since 14 March 2025 and as of 30 April 2025, 6 971 new cases, including 247 new deaths have been reported. Since 1 January 2025 and as of 30 April 2025, 14 090 cases, including 505 deaths have been reported. In comparison, in 2024 and as of 2 May 2024, no cases were reported.

Burundi: Since 24 February 2025 and as of 17 March 2025, 34 new cases have been reported. Since 1 January 2025 and as of 17 March 2025, 129 cases have been reported. In comparison, in 2024 and as of 30 April 2024, 163 cases were reported.

Democratic Republic of the Congo: Since 17 February 2025 and as of 10 March 2025, 3 862 new cases, including 69 new deaths have been reported. Since 1 January 2025 and as of 10 March 2025, 11 918 cases, including 240 deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 13 555 cases, including 285 deaths were reported.

Ethiopia: Since 3 March 2025 and as of 30 April 2025, 2 951 new cases, including 15 new deaths have been reported. Since 1 January 2025 and as of 30 April 2025, 3 808 cases, including 40 deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 12 974 cases, including 97 deaths were reported.

Ghana: Since 12 March 2025 and as of 25 April 2025, 514 new cases, including 2 new deaths have been reported. Since 01 January 2025 and as of 25 April 2025, 2 767 cases, including 14 deaths have been reported. In comparison, in 2024 and as of 02 May 2024, no cases were reported.

Kenya: Since 12 March 2025 and as of 30 April 2025, 88 new cases, including five new deaths have been reported. Since 1 January 2025 and as of 30 April 2025, 125 cases, including six deaths have been reported. In comparison, in 2024 and as of 29 March 2024, 186 cases, including one death was reported.

Malawi: Since 3 March 2025 and as of 20 March 2025, one new case has been reported. Since 1 January 2025 and as of 20 March 2025, 91 cases, including three deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 243 cases, including three deaths were reported.

Mozambique: Since 3 February 2025 and as of 30 April 2025, 2 787 new cases, including 29 new deaths have been reported. Since 1 January 2025 and as of 30 April 2025, 2 851 cases, including 29 deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 7 371 cases, including 12 deaths were reported.

Namibia: Since 2 March 2025 and as of 17 March 2025, 21 new cases have been reported. Since 1 January 2025 and as of 17 March 2025, 22 cases have been reported. In comparison, in 2024 and as of 2 May 2024, no cases were reported.

Nigeria: Since 24 February 2025 and as of 17 March 2025, 90 new cases have been reported. Since 01 January 2025 and as of 17 March 2025, 1 214 cases, including 28 deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 559 cases, including seven deaths were reported.

Rwanda: As of 04 April 2025, four new cases have been reported. Since 1 January 2025 and as of 04 April 2025, four cases have been reported. In comparison, in 2024 and as of 2 May 2024, no cases 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 has been reported. In comparison, in 2024 and as of 30 April 2024, 8 681 cases, including 87 deaths were reported.

South Sudan: Since 24 February 2025 and as of 17 March 2025, 6 057 new cases, including 127 new deaths have been reported. Since 1 January 2025 and as of 17 March 2025, 25 179 cases, including 389 deaths have been reported. In comparison, in 2024 and as of 2 May 2024, no cases were reported.

Sudan: Since 03 March 2025 and as of 30 April 2025, 1 965 new cases, including 62 new deaths have been reported. Since 01 January 2025 and as of 30 April 2025, 8 568 cases, including 211 deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 2 408 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 2 May 2024, no cases were reported.

Uganda: Since 3 February 2025 and as of 03 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 was reported.

United Republic of Tanzania: Since 17 February 2025 and as of 17 March 2025, 323 new cases, including three new deaths have been reported. Since 1 January 2025 and as of 17 March 2025, 2 085 cases, including 16 deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 2 503 cases, including 32 deaths were reported.

Zambia: Since 3 March 2025 and as of 15 April 2025, 148 new cases have been reported. Since 1 January 2025 and as of 15 April 2025, 463 cases, including nine deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 19 848 cases, including 611 deaths were reported.

Zimbabwe: Since 12 March 2025 and as of 30 April 2025, 257 new cases, including 10 new deaths have been reported. Since 1 January 2025 and as of 30 April 2025, 505 cases, including 17 deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 18 197 cases, including 371 deaths were reported.

America:

Haiti: Since 5 January 2025 and as of 07 April 2025, 425 new cases, including two new deaths have been reported. Since 1 January 2025 and as of 07 April 2025, 794 cases, including 29 deaths have been reported. In comparison, in 2024 and as of 30 April 2024, 6 483 cases, including 119 deaths were reported.

ECDC assessment:

In 2025, cholera cases have continued to be reported in Africa and Asia, 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.

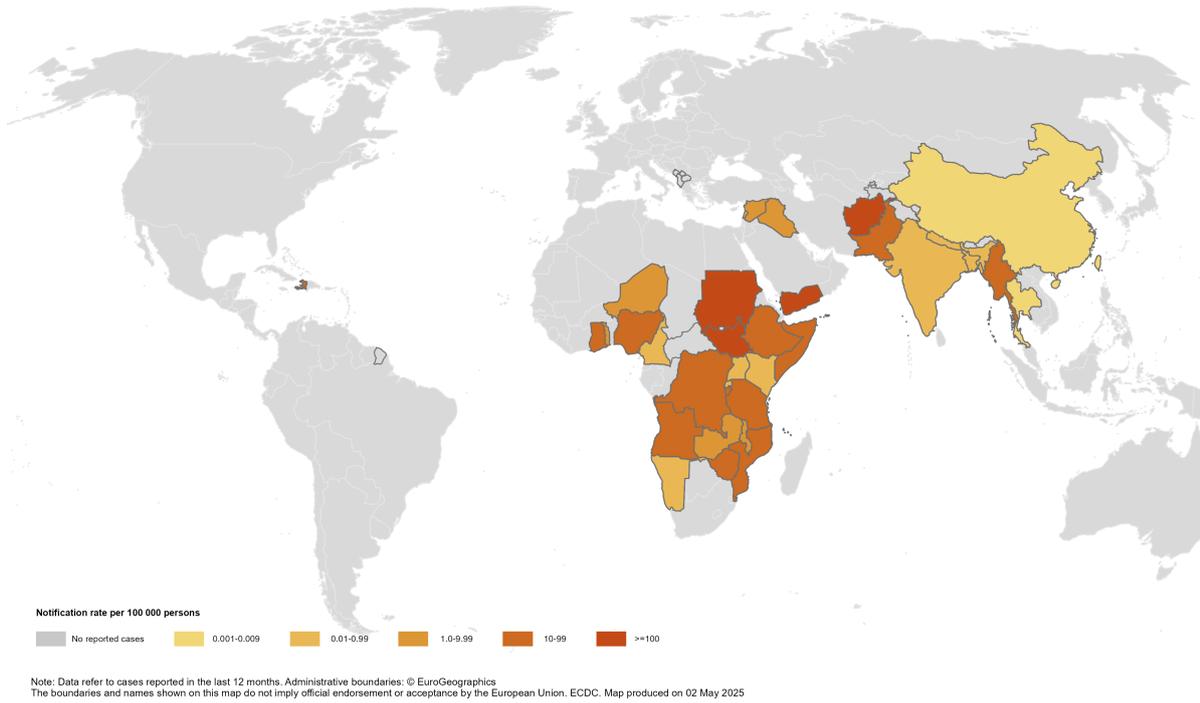
Actions:

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 March 2025

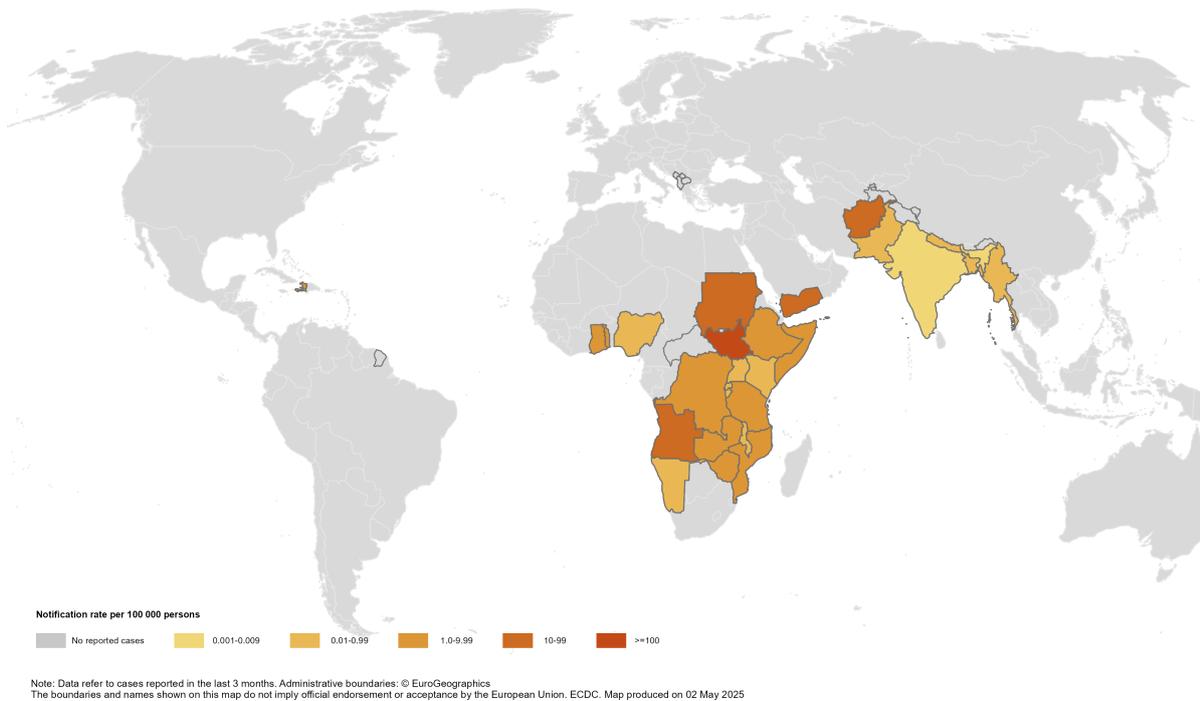
Maps and graphs

Figure 1. Geographical distribution of cholera cases reported worldwide from May 2024 to April 2025



Source: ECDC

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



Source: ECDC

8. Yellow fever – South America – 2024–2025

Overview:

On 3 February 2025, PAHO/WHO issued an [Epidemiological Alert](#) following an increase of human yellow fever cases in South American countries. On 17 April, Colombia declared a [public health emergency due to an increase in yellow fever](#).

[Between 1 January and 13 April 2025](#), 189 confirmed cases and 74 deaths associated with yellow fever were reported from four countries: Bolivia, Brazil, Colombia and Peru. According to media citing official sources, yellow fever [cases](#) have recently also been reported from Ecuador, including two deaths ([1](#), [2](#)). For comparison, [in 2024](#), a total of 61 yellow fever cases, including 30 deaths, were confirmed in five countries: Bolivia, Brazil, Colombia, Guyana and Peru.

All of above mentioned countries are included in the WHO list of '[Countries with risk of yellow fever transmission and countries requiring yellow fever vaccination](#)'. According to the list, these countries do not require travellers arriving from the EU/EEA to show proof of yellow fever vaccination. However, [Ecuador](#) has announced that, from 12 May 2025, travellers entering the country will be required to present a yellow fever vaccination certificate. This requirement applies to:

- Travellers of Peruvian, Colombian, Bolivian, or Brazilian nationality or residency.
- Travellers of any nationality or residency who have stayed more than 10 days in, or transited through, any of these countries before entering Ecuador.

In general, EU/EEA countries do not require proof of yellow fever vaccination for travellers going to or returning from countries at risk for yellow fever transmission. However, there might be some exceptions, such as travel to/from certain territories.

Between 2005 and 2023, 16 imported yellow fever cases have been reported in the EU/EEA (2009: 1; 2017: 2; 2018: 11; 2020: 2). In 2024, none of the EU/EEA countries reported an unusual increase in yellow fever cases.

ECDC assessment:

The recent increase in yellow fever cases in South America is noteworthy, as previously yellow fever activity has been reported mainly from African countries. South America is a popular destination for EU/EEA travellers, and it is important for travel medicine clinics and vaccination centres to be aware of the yellow fever risk in South America. For EU/EEA travellers going to South American countries listed by WHO as with risk of yellow fever transmission, those who take precautions to prevent mosquito bites and are vaccinated have a low likelihood of yellow fever infection.

The likelihood of local yellow fever virus transmission in mainland EU/EEA following introduction of the virus by a viraemic traveller is currently considered very low. The main vector [Aedes aegypti is not established](#) in the EU/EEA, with the exception of Cyprus, and vector competency of [Aedes albopictus, which is established](#) in several EU/EEA countries, is limited.

Actions:

- Healthcare professionals in travel medicine clinics should be aware of the risk of yellow fever in the countries listed by WHO as with risk of yellow fever transmission.
- European citizens travelling to yellow fever risk areas should seek medical advice before departure, receive vaccination if not contraindicated, and take measures to prevent mosquito bites.
- ECDC will keep monitoring the ongoing situation and will report again should relevant epidemiological reports become available.

Last time this event was included in the Weekly CDTR: 07 February 2025

9. Ebola disease – Uganda – 2025

Overview:

On 26 April 2025, [WHO](#) released a news item stating that the Ministry of Health in Uganda declared the end of the Ebola outbreak, after 42 days without any new probable or confirmed Ebola case. The last confirmed case was [reported](#) on 6 March 2025. The last case was discharged on [14 March](#) and the 42 day countdown period began.

Overall, from 30 January to 26 April 2025, 12 confirmed and two probable cases, including four deaths (two confirmed and two probable) (case-fatality rate (CFR) 28.6%), were [reported](#) during this outbreak.

Among the 634 contacts [identified](#), all concluded their monitoring period. The last case was discharged on [14 March](#) and therefore the countdown for declaring the outbreak over was initiated.

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 the newly reported case. 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.

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.

During this outbreak, the importation of a case to the EU/EEA was very unlikely. In the event of a case being imported into the EU/EEA, we considered the likelihood of further transmission to be very low.

Actions:

ECDC monitored the event and was in contact with the EU bodies in Kampala, as well as Africa CDC.

Last time this event was included in the Weekly CDTR: 11 April 2025

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 25 April 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
- Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025 - last reported on 25 April 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 25 April 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 16 April 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 16 April 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 16 April 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 11 April 2025
- Ebola disease – Uganda – 2025 - last reported on 11 April 2025
- Yellow fever – South America – 2024–2025 - last reported on 02 May 2025
- Outbreak of *C. diphtheriae* ST-574 among migrants, persons living in homelessness, elderly and unvaccinated persons – Germany – 2025 - last reported on 02 May 2025
- SARS-CoV-2 variant classification - last reported on 02 May 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 May 2025