WEEKLY BULLETIN

Communicable disease threats report

Week 20, 10–16 May 2025

This week's topics

Executive Summary

Overview of respiratory virus epidemiology in the EU/EEA

Respiratory virus activity is at low levels in the European Union/European Economic Area (EU/EEA). 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. RSV activity has fallen to low levels in almost all reporting countries following a plateau for several weeks. 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.

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

- Since the previous update on 5 May 2025, and as of 12 May 2025, nine new MERS cases, including two fatalities, have been reported by health authorities in Saudi Arabia.
- Cases were reported from Hail (1) and Riyadh (8). Seven cases were part of the same cluster in Riyadh, including one patient with no history of contact with camels and six healthcare workers who acquired a nosocomial infection from the patient.
- Since the beginning of 2025, and as of 12 May 2025, 10 MERS cases, including two fatalities, have been reported with date of onset in 2025 in Saudi Arabia.
- The risk of sustained human-to-human transmission in Europe remains very low, and the current MERS-CoV situation poses a low risk to the EU/EEA.

Human cases with avian influenza A(H10N3) – Multi-country (World)

- One new human case of avian influenza A(H10N3) virus infection was reported in China. The patient is in their sixties and developed the disease in April 2025.
- No human-to-human transmission has been documented.
- The risk to human health in the EU/EEA is considered very low.

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

- On 13 May 2025, eight human cases of avian influenza A(H9N2) virus infection in China were reported by Hong Kong's Centre for Health Protection, with disease onset in April 2025.
- No details about disease severity or exposure are available.
- Seventeen 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 127 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.

Outbreak of *Corynebacterium diphtheriae* ST-574 among migrants, people experiencing homelessness, older adults and unvaccinated people – Germany – 2025

- On 30 April 2025, Germany reported a signal for a diphtheria outbreak caused by Corynebacterium 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 on the 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 ST-574 was available for one death reported in 2022.
- The outbreak reported among migrants and the observation of the same ST-clones in 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.

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 11 May 2025, more than 47 500 confirmed autochthonous cases of chikungunya virus disease have been reported in Réunion.
- Since the beginning of the outbreak, 12 deaths in individuals over 70 years old with comorbidities were classified as chikungunya virus disease related.
- Decrease in surveillance indicators (primary care visits and emergency department visits for chikungunya virus disease) has been observed since week 17.
- 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 people over 65 years old, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remains open for people 18–64 years old with comorbidities.

- On 7 May 2025, the European Medicine Agency (EMA) stated that the agency's safety committee (PRAC) has started a review of the Ixchiq vaccine following the reports of SAEs in older adults. EMA informs that many of the affected people also had other illnesses and the exact cause of these adverse events and their relationship with the vaccine have not yet been determined. The Committee is temporarily recommending restricting the use of the vaccine. As a temporary measure while an in-depth review is ongoing, Ixchiq must not be used in adults 65 years old and above. More information can be found in 2025-EVD-00005.
- On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 9 May 2025, 57 autochthonous cases of the disease have been reported on the island.

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

- In March 2025, 1 097 measles cases were reported by 16 countries. Eleven countries reported zero cases.
- Through its epidemic intelligence activities, ECDC has identified an additional 3 012 new cases from 15 EU/EEA countries.
- Overall, four measles-related deaths have been reported in the EU/EEA in 2025, all of them in Romania.
- There has been high measles activity overall in the EU/EEA over the last 12 months; however, the situation varies by country. Some countries have reported large and/or ongoing outbreaks, while others have reported either no sustained transmission or very low transmission.
- Outbreaks associated with imported measles cases have been reported by EU countries.

Nipah virus disease – India – 2025

- On 8 May 2025, the Health and Family Welfare Department of Kerala reported a case of Nipah virus (NiV) disease in Valanchery Municipality, Malappuram district, Kerala. The case is currently in critical condition.
- As of 15 May 2025, there are two contacts undergoing treatment. A total of 166 contacts have been identified, of which 65 tested negative.
- The likelihood of exposure and infection with NiV for EU/EEA citizens travelling to or residing in India is currently very low given the low number of infections in areas where cases have been identified so far.

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

Overview:

Based on data reported in week 19, 2025, primary care consultation rates suggest a return to 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 activity. There were very few influenza detections in primary care, with all countries reporting test positivity below 10%. Trends in hospital surveillance were decreasing to low levels.

RSV activity in the EU/EEA has fallen to low levels in almost all reporting countries.

SARS-CoV-2 activity remains low overall in all countries. There appears to be a slowly increasing trend in the proportion of positive tests in non-sentinel laboratory-based surveillance in a small number of countries, but it remains too early to assess if this is significant. No increasing trends were visible in secondary care indicators or in COVID-19 deaths.

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, protracted, respiratory syncytial virus (RSV) epidemic. SARS-CoV-2 activity remained at low levels, with no epidemic observed to date.

Overall RSV activity peaked in the EU/EEA in week 52, 2024, then decreased to an elevated plateau that continued until week 15, 2026. It then started decreasing again to the low levels currently observed.

Overall influenza activity peaked in week 6, 2025, and influenza A(H1)pdm09, A(H3) and B/Vic viruses have now all decreased to low levels. 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 was observed.

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 to the expected range.

With virus activity having fallen to low levels in most settings, limited impact on healthcare systems and hospital capacity is expected.

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.

SARS-CoV-2 does not yet have predictable seasonality, but waves of infection in spring and summer months have occurred in the EU/EEA in recent years. Countries should therefore remain vigilant for possible increases in SARS-CoV-2 activity and maintain surveillance year-round, in line with ECDC/WHO guidance.

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.

Countries with ongoing transmission of respiratory viruses should ensure that infection prevention and control practices in healthcare settings are implemented.

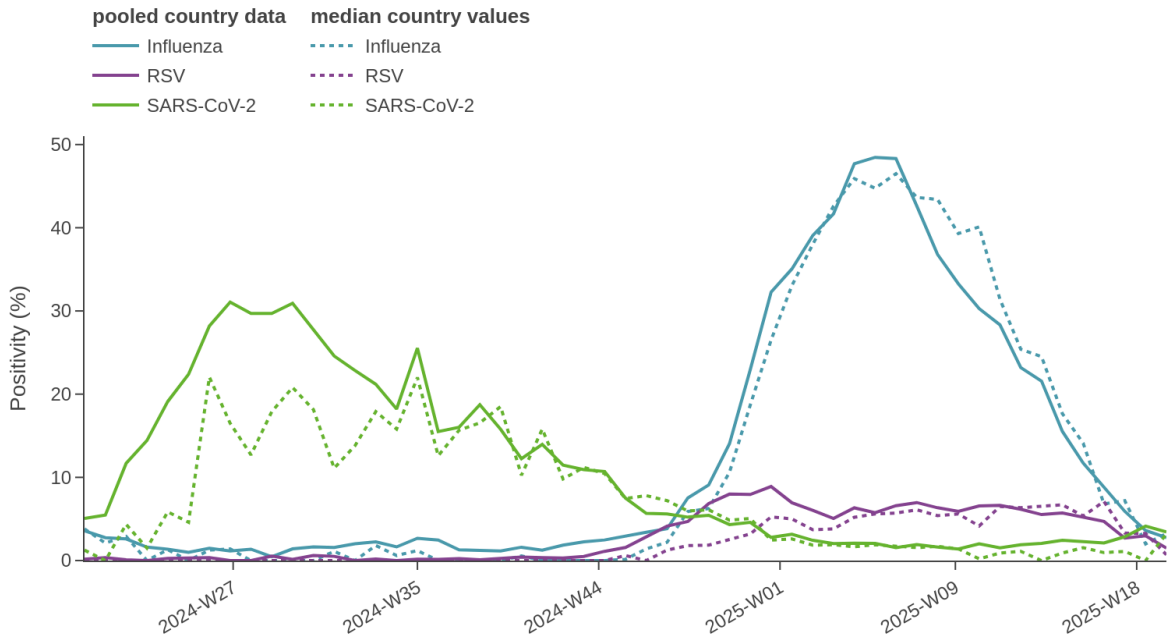
Frequent handwashing, physical distancing, avoiding large gatherings and wearing masks in healthcare settings can all help to reduce transmission of circulating respiratory viruses and protect groups at high risk of severe disease.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 8 May 2025

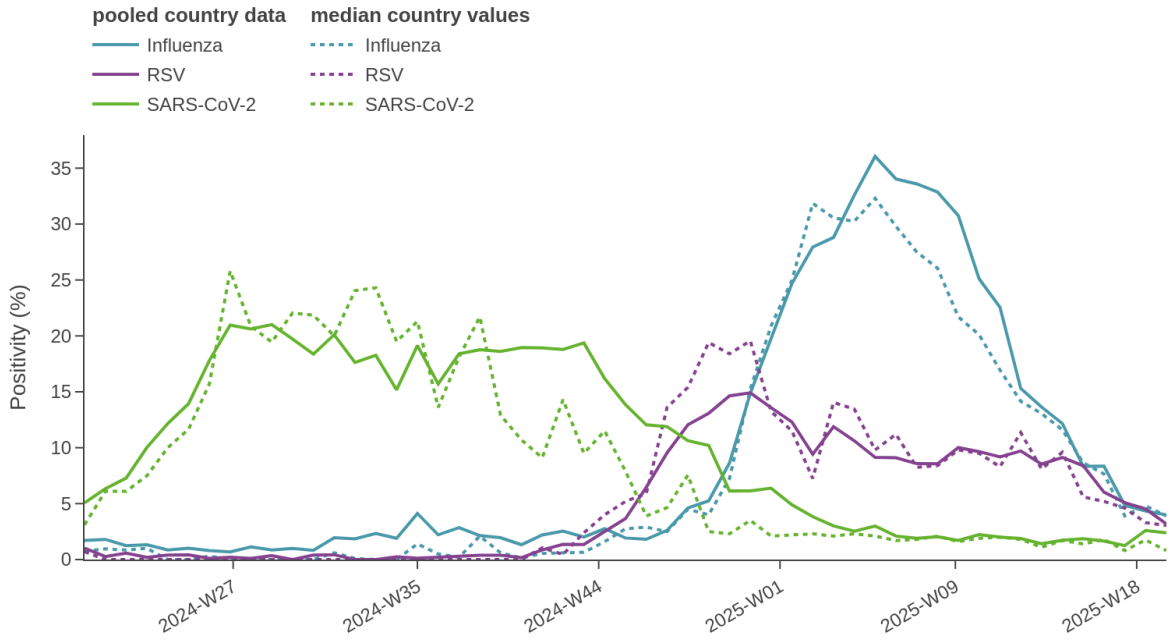
Maps and graphs

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



Source: ECDC

Figure 2. SARI virological surveillance in hospitals – weekly test positivity



Source: ECDC

Figure 3. Overview of key indicators of activity and severity in week 19, 2025

		Reporting countries		EU/EEA summary		
Indicator	**Syndrome or pathogen**	**Week 19**	**Week 18**	**Description**	**Value**	**Comment**
ILI/ARI consultation rates in primary care	ARI	13 rates (10 MEM)	14 rates (11 MEM)	Distribution of country MEM categories	10 Baseline	
	ILI	17 rates (16 MEM)	17 rates (16 MEM)		16 Baseline	
ILI/ARI test positivity in primary care	Influenza	16	17	Pooled (median; IQR)	2.8% (3.2; 2.5–4%)	At the EU/EEA level, the overall pooled influenza positivity continues to decrease in all age groups.
	RSV	14	14		1.5% (0.7; 0–7.7%)	At the EU/EEA level, the overall pooled RSV positivity continues to decrease in all age groups.
	SARS-CoV-2	12	14		3.4% (3.2; 0–4.1%)	At the EU/EEA level, the overall pooled SARS-CoV-2 positivity remains stable and low across all age groups. Non-sentinel laboratory-based data (from a mix of primary care and other sources) reported up to week 19 from five countries suggest slowly increasing trends in test positivity from low levels.
SARI rates in hospitals	SARI	10	11	–	–	
SARI test positivity in hospitals	Influenza	8	9	Pooled (median; IQR)	4% (3.9; 0.3–6.9%)	At the EU/EEA level, the overall pooled influenza positivity remains stable and low across all age groups .
	RSV	8	8		3.2% (3; 1.4–3.9%)	At the EU/EEA level, pooled positivity for RSV continues to decrease, driven mainly by the deceasing trend in positivity in the 0–4 years age group. This age group continues to have the highest positivity (13%).
	SARS-CoV-2	7	8		2.4% (0.8; 0–3.4%)	Activity for SARS-CoV-2 remains low in all countries across all indicators of severity.
Intensity (country-defined)	Influenza	20	20	Distribution of country qualitative categories	12 Baseline 7 Low 1 Medium	
Geographic spread (country-defined)	Influenza	19	19	Distribution of country qualitative categories	4 No activity 7 Sporadic 1 Local 3 Regional 4 Widespread	

Source: ECDC

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

	Week 19, 2025		Week 40, 2024 - week 19, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**22**	**-**	**25155**	**-**
Influenza A	17	77	14883	60
A(H1)pdm09	8	62	7130	57
A(H3)	5	38	5450	43
A (unknown)	4	–	2303	–
Influenza B	5	23	10011	40
B/Vic	0	–	4454	100
B/Yam	0	–	1	0.0
B (unknown)	5	–	5556	–
Influenza untyped	0	–	261	–
RSV	**11**	**-**	**4710**	**-**
RSV-A	0	0.0	849	44
RSV-B	3	100	1095	56
RSV untyped	8	–	2766	–
SARS-CoV-2	**26**	**-**	**3204**	**-**

Source: ECDC

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

Figure Table

		Week 19, 2025	Week 40, 2024 - week 19, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**33**	**-**	**13709**	**-**
Influenza A	18	82	5585	80
A(H1)pdm09	0	0.0	1493	59
A(H3)	4	100	1025	41
A (unknown)	14	-	3067	-
Influenza B	4	18	1381	20
B/Vic	0	-	158	100
B (unknown)	4	-	1223	-
Influenza untyped	11	-	6743	-
RSV	**26**	**-**	**5493**	**-**
RSV-A	1	25	698	47
RSV-B	3	75	786	53
RSV untyped	22	-	4009	-
SARS-CoV-2	**17**	**-**	**3819**	**-**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 19, 2025

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	3993	42	5a.2a(C.1.9)	3284	82
			5a.2a.1(D)	552	14
			5a.2a(C.1)	157	4
A(H3)	2536	27	2a.3a.1(J.2)	1911	76
			2a.3a.1(J.2.2)	360	14
			2a.3a.1(J.2.1)	176	7
			2a.3a.1(J)	43	2
			2a.3a.1(J.1)	27	1
			2a.3a.1(J.4)	2	0.1
			Not assigned	17	-
B/Vic	2931	31	V1A.3a.2(C.5.1)	1824	63
			V1A.3a.2(C.5.6)	546	19
			V1A.3a.2(C.5.7)	466	16
			V1A.3a.2(C)	72	2
			V1A.3a.2(C.5)	8	0.3
			Not assigned	15	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 17–18, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	2	10	16% (14–19%)
KP.3	VOI	2	3	5% (4–5%)
LP.8.1	VUM	2	45	65% (64–65%)
XEC	VUM	1	5	5% (2–8%)

Source: ECDC

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

Overview:

Update: Since the previous update on 5 May 2025, and as of 12 May 2025, nine new MERS cases, including two fatalities, have been reported by health authorities in Saudi Arabia.

Cases were reported from Hail (1) and Riyadh (8). Seven cases were part of the same cluster in Riyadh, including one patient with no history of contact with camels and six healthcare workers who acquired a nosocomial infection from the patient. Of the six healthcare workers, two developed mild symptoms and four were asymptomatic. From the remaining two cases, one had history of indirect contact with camels and one had no history of contact with camels.

The two fatalities had comorbidities.

All contacts (household and healthcare workers) from the cases were followed up and, apart from the six healthcare workers, no secondary cases were identified.

Summary: Since the beginning of 2025, and as of 12 May 2025, 10 MERS cases, including two fatalities, have been reported with date of onset in 2025 in Saudi Arabia.

Since April 2012, and as of 12 May 2025, a total of 2 638 cases of MERS, including 957 deaths, have been reported by health authorities worldwide.

Sources: ECDC MERS-CoV page | WHO MERS-CoV | ECDC factsheet for professionals | WHO updated global summary and assessment of risk (November 2022) | Qatar MoPH Case #1 | Qatar MoPH Case #2 | FAO MERS-CoV situation update | WHO DON Oman | WHO DON Saudi Arabia | WHO DON UAE | WHO DON Saudi Arabia 1 | WHO IHR | WHO EMRO MERS Situation report | WHO DON Saudi Arabia 2 | WHO DON Saudi Arabia 3 | WHO DON Saudi Arabia 4 | WHO DON Saudi Arabia 5

ECDC assessment:

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

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

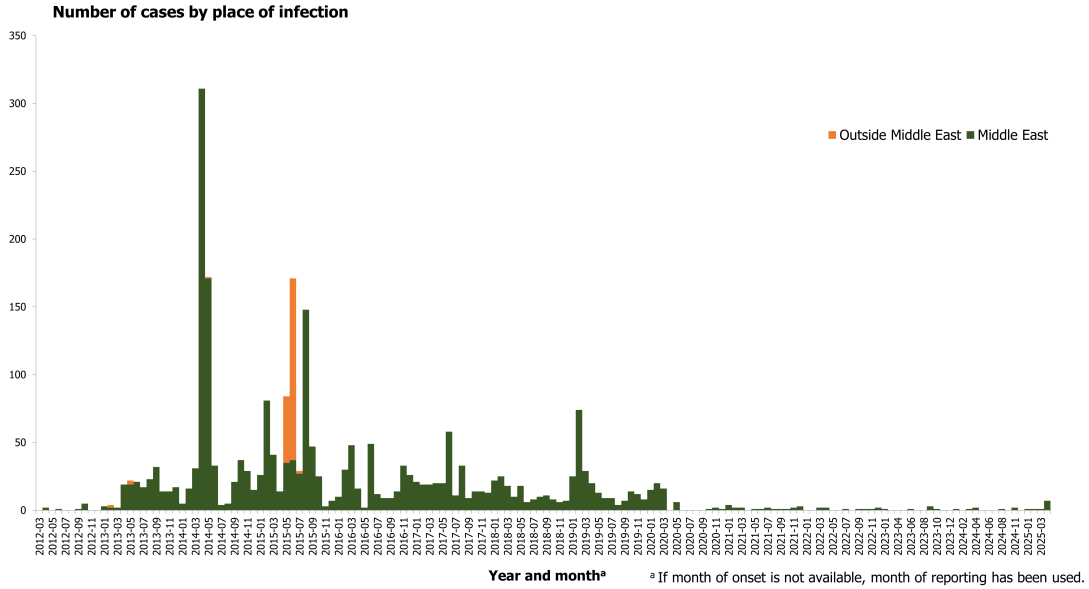
Actions:

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

Last time this event was included in the Weekly CDTR: 8 May 2025

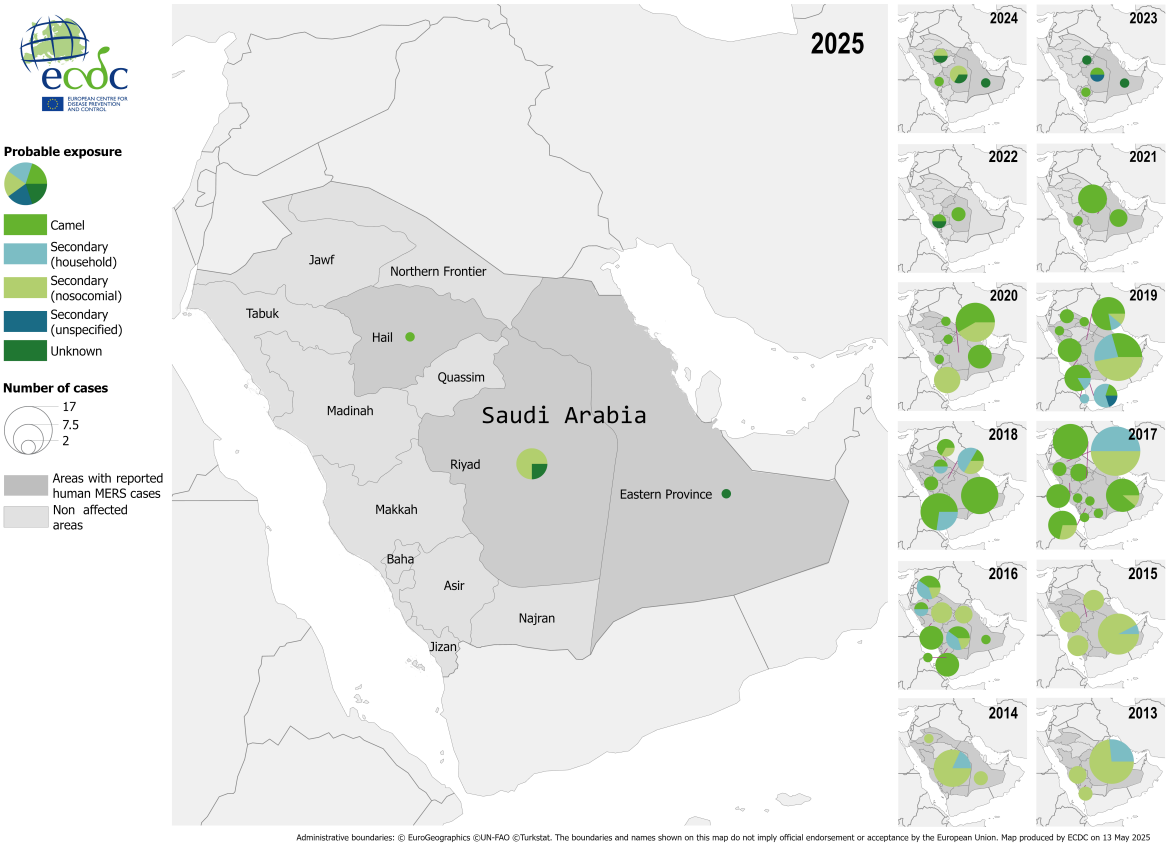
Maps and graphs

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



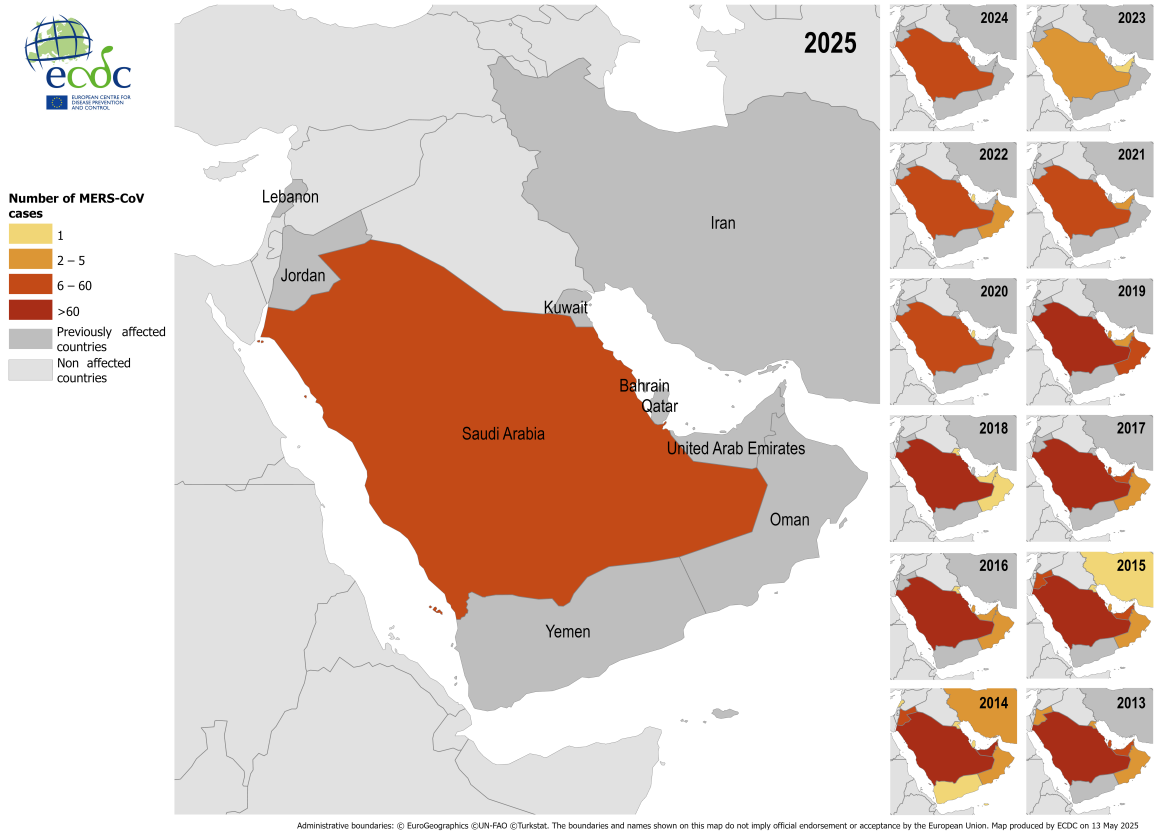
Source: ECDC

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



Source: ECDC

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



Source: ECDC

3. Human cases with avian influenza A(H10N3) – Multi-country (World)

Overview:

Update: One human case of avian influenza A(H10N3) virus infection was reported in China on 13 May 2025 by Hong Kong's Centre for Health Protection. A woman in her sixties from Shaanxi province developed symptoms on 13 April 2025. Information about exposure and symptoms is pending and will be updated as soon it is available.

Summary: To date, five cases of avian influenza A(H10N3) virus have been reported globally, all five in China. The first case was reported in Jiangsu Province, China, in 2021: a man in his forties developed symptoms on 23 April 2021 and eventually recovered. The second case, a man in his thirties from Zhejiang Province, developed severe symptoms on 11 June 2022 and has since recovered. The third case, a man in his fifties from Yunnan Province, developed severe pneumonia on 28 February 2024, following exposure to poultry and a poultry-related environment. The fourth case, an adult woman from Guangxi Zhuang Autonomous Region in China, with disease onset 12 December 2024, had exposure to freshly slaughtered poultry and eventually recovered. All patients had severe illness. However, no new cases were reported among close contacts of these four cases.

ECDC assessment:

Sporadic human cases of avian influenza A(H10N3) have been observed, but no human-to-human transmission has been documented. The risk to human health in the EU/EEA is considered very low.

Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza.

Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and influenza surveillance activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza to identify significant changes in the epidemiology and characteristics of the virus. ECDC works with EFSA and the EU reference laboratory to produce a quarterly report on the avian influenza situation. The most recent report was published in December 2024: Avian influenza overview September - December 2024.

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

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

Overview:

Update: On 13 May 2025, Hong Kong's Centre for Health Protection reported eight new human cases of avian influenza A(H9N2) virus infection in China (Avian Influenza Report). Seven of the cases were children less than 10 years old.

The first case was in an adult in their sixties from Chongqing, with symptom onset on 18 April 2025. The second and third cases were both in one-year-old children from Guizhou province with symptom onset on 7 and 15 April 2025. Four other cases were from Hunan Province, with symptoms onset on 1 April 2025: one in a boy and one in a girl, both under 10 years old; one in a girl that developed symptoms on 3 April 2025; and one in a boy with symptom onset on 19 April 2025. The eighth case was in a one-year-old girl from Yunnan province, with symptom onset on 2 April 2025. No other details regarding symptoms, disease severity, treatment, exposure or outcome are available at the moment.

Background: seventeen 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 127 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: 25 April 2025

5. Outbreak of Corynebacterium diphtheriae ST-574 among migrants, people experiencing homelessness, older adults and unvaccinated people – 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 arrived 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 experiencing 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, 10 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. Cases have been reported in Germany (30), Czechia (8), Belgium (6), Latvia (4) and Norway (4). Of these, 10 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* were reported in the EU/EEA through EpiPulse Cases. Cases were 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* were reported in the EU/EEA through EpiPulse Cases. 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 (358; 67%) presented with an exclusively cutaneous form of the disease. A total of 55 cases had a respiratory presentation; of these, 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 (27%) of these 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 (2%) received 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 ST-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 decline of reported cases has been observed. However, there appears to have been an increase in autochthonous cases reported in at least one Member State, with links to two other countries.

Published genomic data suggests that there have been at least two introductions to vulnerable populations including migrants, people experiencing homelessness, people who inject drugs, unvaccinated individuals, and older adults. The degree of genomic similarity observed suggests a clear link to the diphtheria outbreak reported across several EU/EEA countries in 2022 and onwards but also that there may be an unquantified circulation of the same sequence types (ST-574), which requires enhanced surveillance and implementation of public health measures to identify risk factors for transmission and 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. 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 Member States to report timely, complete diphtheria data to EpiPulse Cases regularly to support assessment of 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: 2 May 2025

6. 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 11 May 2025, more than 47 500 confirmed autochthonous cases of chikungunya virus disease have been reported in Réunion. Since week 17, a decrease in surveillance indicators has been observed. The estimated number of primary care visits and emergency department visits for chikungunya virus disease on week 19 was 8 000 and 161, respectively. This represents a 44% decrease in primary care visits and 37% decrease in emergency department visits, compared with week 18. Cases have been reported in all municipalities.

So far, 386 people with the disease have been hospitalised for more than 24 hours, including 325 for which chikungunya virus disease was the reason for admission. For the other cases, the diagnosis was confirmed incidentally during hospitalisation. To date, 68 severe cases (i.e. those with at least one organ failure) have been reported. These cases were in 37 adults over 65 years old with comorbidities, eight people under 65 years old (including six with co-morbidities) and 23 infants under three months old.

Since the beginning of the year, 12 deaths occurring between weeks 11 and 17 have been classified as chikungunya related (10 directly and two indirectly related). These deaths occurred in people over 70 years old (range: 71–95 years old) with co-morbidities (mainly chronic pathologies). Twenty-eight other deaths (elderly and comorbid) are currently being investigated for chikungunya-related chronic pathologies), 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 old 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 a result, the health authorities suspended the vaccination of individuals 65 years old and above, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remains open for people aged 18–64 years with comorbidities. In this context, travellers 65 years old and above should also not be vaccinated with the Ixchiq vaccine.

On 7 May 2025, the European Medicine Agency (EMA) stated that the agency's safety committee (PRAC) has started a review of the Ixchiq vaccine, following the reports of SAEs in older adults. EMA informs that many of the people affected also had other illnesses and the exact cause of these adverse events and their relationship with the vaccine have not yet been determined. The Committee is temporarily recommending restricting the use of the vaccine. As a temporary measure while an in-depth review is ongoing, Ixchiq must not be used in adults 65 years old and above.

On 26 March 2025, an autochthonous case of chikungunya virus disease was also reported in Mayotte. As of 9 May 2025, 57 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 favourable for the spread of arboviruses. The epidemic is active throughout the island. Nonetheless, the surveillance data indicate decreasing intensity of the outbreak.

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.

The environmental conditions in the areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti* are established are currently becoming favourable for mosquito activity and virus replication in mosquitoes; therefore, locally acquired transmission might occur when conditions become favourable in early summer.

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: 8 May 2025

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

Overview:

In March 2025, 1 097 measles cases were reported by 16 countries. Eleven countries reported zero cases. In the most recent 12-month period, from 1 March 2024 to 28 February 2025, 30 EU/EEA countries reported a total of 28 791 measles cases.

Between 1 April 2024 and 31 March 2025, of the 26 222 cases with known age, 11 654 (44.4%) were in children under five years of age and 7 255 (27.7%) were in individuals aged 15 years or older.

The highest notification rates were observed in infants under one year of age (849.7 cases per million) and children aged 1–4 years (491.7 cases per million). Of 24 337 cases (100.0% of all cases) with a known age and vaccination status, 20 893 (85.8%) were unvaccinated, 2 185 (9.0%) were vaccinated with one dose of a measles-containing vaccine, 1 180 (4.8%) were vaccinated with two or more doses, and 48 (0.2%) were vaccinated with an unknown number of doses.

Fourteen deaths (case fatality rate (CFR): 0.1) attributable to measles were reported to ECDC during the 12-month period by Romania (13) and France (1). Detailed data are available in ECDC's Surveillance Atlas of Infectious Diseases.

Complementary epidemic intelligence surveillance has been conducted, with data collection between 12–15 May 2025. Sporadic cases have been reported in Austria, Czechia, Germany, Hungary, Italy, the Netherlands, Poland, Portugal, Spain and Sweden, and ongoing outbreaks or considerable increases were reported in Belgium (Flanders region), France and Romania. updates outside of the EU/EEA are provided for Morocco and Viet Nam. No updates are provided for WHO regions.

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

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

Austria reported 95 measles cases in 2025 and as of 7 May 2025, an increase of 17 cases since 9 April 2025. The most recent four cases were reported in week 17 in Vienna, Lower Austria and Burgenland. Relevant information was available for 87 cases, of which 25 were hospitalised (28.7%), including one patient being treated in the intensive care unit. No outbreaks have been reported.

Belgium reported a steady increase of measles cases on 3 May 2025. In the region of Flanders, 95 cases were reported in 2025, of which almost a half (48 cases) were reported only in April 2025. Antwerp province has been the most affected, with 60 cases reported since the beginning of the year, of which 47 were not vaccinated. Mainly children 0–9 years of age are affected. Half were hospitalised and some were treated in the intensive care unit, according to a media report. In response to the situation, vaccination strategy has been adapted to reach as many unvaccinated people as possible in Antwerp via general practitioners and hospitals; vaccination is organised in schools, including mobile vaccination teams where cases have been detected, aiming at unvaccinated children up to 12 years of age.

Czechia reported 10 cases in 2025 as of 2 May 2025.

France reported 427 cases of measles, including one death (immunocompromised person) from 1 January to 13 April 2025. Of these, 143 (33.5%) were either hospitalised or visited an emergency room, including nine patients treated in intensive care. Fifty-eight patients had complications. The most affected were children aged 1–4 years (17%) and individuals aged 15–19 years (10%), with the highest incidence rate seen in infants. Of the reported cases, 65 (15%) were imported cases with travel history to Morocco (29 cases), Romania (5), Italy (5), Viet Nam (5), the United Kingdom (4), Switzerland (3), and Guinea (3). The imported cases were associated with at least 12 clusters with 28 cases. Vaccination status was known for 304 cases, of which 68.4% were unvaccinated or had incomplete vaccination. The cases have been reported from 60 departments in mainland France (59.4% of all departments) and no measles cases have been reported in overseas territories. Most of the cases had genotype B3 (62.5%) and D8 (34.7%) (detected from samples of 72 cases). Among the samples from imported cases from Morocco (29), 15 strains were sequenced and are all genotype B3.

Germany reported 148 confirmed and probable measles cases in 2025 and, as of 12 May 2025, an increase of 63 cases since 15 April 2025, of which nearly half (26 cases) were reported in week 19, 2025.

Hungary reported three cases of measles in 2025, as of 4 May 2025.

Italy reported 227 cases from January to March 2025. Of the reported cases, 88.7% were not vaccinated, including eight children not eligible for vaccination; 10.6% were imported cases and about a third had measles-related complications. Transmission mostly occurred in families, though 21 healthcare workers also acquired the infection. Of the 15 regions reporting measles cases, more than half of the cases are reported by four regions.

The Netherlands reported 375 measles cases in 2025 and, as of 7 May 2025, an increase of 124 cases since 9 April 2025. There is no indication of a national outbreak. Clusters of measles cases have been detected among children linked to primary schools, with additional cases reported within households. In 2025, 30 cases were reported to have contracted measles in Morocco, three in Romania, and one in each, Vietnam, Belgium and Iran.

Poland reported 46 measles cases in 2025 and, as of 30 April, an increase of 12 cases since 31 March 2025.

Portugal reported, according to media citing official sources, 19 measles cases in 2025, an increase of eight cases since the previous report on 8 April 2025. Fourteen of the cases are adults, two thirds of whom are unvaccinated; other cases are unvaccinated children. According to another media source citing a health authority, most of the cases are in the Lisbon and Tagus regions, and at least one case is from the Central region. All cases were imported or linked to an imported case.

Romania reported 6 401 measles cases and eight deaths in 2025 and, as of 30 April, an increase of 1 297 cases, including four deaths since 31 March 2025. The recent deaths have been reported in four small children (under two years of age), all unvaccinated, three of whom due to underlying conditions and one due to age.

Spain reported 229 cases of measles as of 11 May 2025, of which 78 were imported and 78 were related to imported cases.

Sweden reported six measles cases in 2025, as of 14 May 2025.

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

Morocco reported a decreasing trend of measles cases for 10 consecutive weeks, following a catch-up vaccination campaign at the national level, according to WHO DON on 13 May 2025. B3 is the circulating genotype. WHO assesses the risk as medium in Morocco and in the region. There are no restrictions on travel or trade in Morocco due to this outbreak.

The United States reported 1 001 confirmed measles cases, including three deaths, in 31 jurisdictions in 2025 and as of 8 May. Of the reported cases, 93% were related to 14 outbreaks.

On 18 March 2025, WHO jointly with UNICEF released a news statement on measles prevention efforts in Viet Nam. An ongoing outbreak of measles continues to affect central and northern Viet Nam, with new outbreaks reported in areas that were not previously affected. The national authorities are putting in place effective efforts to respond to the outbreak. In the latest Measles-Rubella bulletin of the World Health Organization, Regional Office for the Western Pacific (WHO WPRO), Viet Nam reported 144 confirmed measles cases from January to March 2025. However, WHO indicated that according to the official Viet Nam's Government newspaper, as of March 2025, there have been reported 38 807 suspected cases, of which 3 447 cases were positive for measles. So far, five deaths associated with measles have been reported in the country.

Summary of measles cases reported by WHO regional offices:

No updates have been provided from WHO regional offices.

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

ECDC assessment:

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

Actions:

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

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

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

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

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

8. Nipah virus disease – India – 2025

Overview:

On 8 May 2025, the Health and Family Welfare Department of Kerala reported a case of Nipah virus disease in Valanchery Municipality, Malappuram district, Kerala. The case is in a female in her forties who developed fever and sought treatment at a clinic in Valanchery on 25 April 2025. On May 1 2025 she was moved to a hospital in Perinthalmanna, where she is now reported as being in critical condition.

As of 15 May 2025, there have been 166 contacts reported, 65 of which have tested negative. Sixty-five contacts are considered high risk and 101 are considered low risk. All contacts will be monitored for 21 days. In addition to the one confirmed case, two contacts are currently undergoing treatment. The contacts have been reported in 8 districts: Malappuram (108), Palakkad (36), Kozhikode (3), Ernakulam (1), Idukki (1), Thiruvananthapuram (1), Thrissur (1) and Alappuha (1).

As of 11 May, 3 868 houses have been visited, covering 87% of the surveillance target. A containment zone was established within a three-kilometre radius of the confirmed case.

Background:
Nipah virus (*Henipavirus nipahense*) is a highly pathogenic virus of the family *Paramyxoviridae*, genus *Henipavirus*. It was first isolated and identified in 1999 during an outbreak in Malaysia and Singapore. Since then, several outbreaks of NiV disease in Southern and South Eastern Asia were reported, most cases being reported from Bangladesh.

The virus spreads between animals and humans, with most human cases having had direct contact with pigs or bats. NiV can also be transmitted between people through direct contact or indirectly via contaminated food (e.g. date palm sap contaminated by bat saliva), or through aerosols. The incubation period is usually 4–14 days. Symptoms range from mild (fever, headache, muscle pain, and nausea) to more serious conditions including severe respiratory symptoms and encephalitis.

For more information on the disease and its epidemiology, please read the ECDC Factsheet about Nipah virus Disease.

ECDC assessment:

Although the disease is severe with a high fatality rate, the likelihood of exposure to and infection with NiV for EU/EEA citizens travelling to or residing in India is currently very low given the low number of infections in affected areas where cases have been identified so far.

The most likely route of introduction of the virus into the EU/EEA would be via infected travellers. While importation of the virus cannot be excluded, it is currently very unlikely to occur. Should a case be imported, the likelihood of the spread of the virus within the EU/EEA is considered to be very low. It should be highlighted that the natural reservoir hosts of NiV are not native to Europe.

As a general precaution, EU/EEA travellers and residents in Kerala state, India, should not handle domestic or wild animals and avoid contact with their excreta. The virus may be present on food items contaminated by bats. Washing, peeling, and cooking fruit and vegetables before consumption is generally recommended. Raw date palm sap (juice) should not be consumed.

Actions:

ECDC is monitoring this event through its epidemic intelligence activities.

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

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
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 25 April 2025
- Autochthonous chikungunya virus disease – Réunion and Mayotte, France, 2024–2025 – last reported on 25 April 2025
- Outbreak of Corynebacterium diphtheriae ST-574 among migrants, people experiencing homelessness, older adults and unvaccinated people – Germany – 2025 – last reported on 16 May 2025
- Nipah virus disease – India – 2025 - last reported on 16 May 2025
- Human cases with avian influenza A(H10N3) – Multi-country (World) – last reported on 16 May 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring – last reported on 16 May 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update – last reported on 16 May 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
- Serious adverse events to IXCHIQ chikungunya virus disease vaccine – last reported on 8 May 2025
- Yellow fever – South America – 2024–2025 – last reported on 2 May 2025
- SARS-CoV-2 variant classification – last reported on 2 May 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update – last reported on 2 May 2025