WEEKLY BULLETIN

Communicable Disease Threats Report

Week 21, 17–23 May 2025

This week's topics

Executive summary

Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025

- Since the last update on 14 April 2025, and as of 19 May 2025, 117 mpox cases have been reported from 14 EU/EEA countries: Germany (33), Netherlands (21), Spain (14), France (13), Sweden (8), Ireland (7), Italy (6), Portugal (4), Belgium (3), Czechia (2), Greece (2), Norway (2), Austria (1) and Croatia (1). Since 14 April 2025, no new countries have reported confirmed cases.
- Since the start of the mpox outbreak and as of 19 May 2025, 24 548 confirmed cases of mpox (MPX) have been reported from 29 EU/EEA countries
- Twenty-one MPXV clade I cases have been reported in the EU/EEA since August 2024, from Sweden, Germany, Belgium, Ireland, and France. All were clade Ib except for the case in Ireland, which was clade Ia.
- The overall risk remains low for men who have sex with men and low for the broader EU/EEA population. However, as summer travel and Pride season starts, transmission could increase and it is important to raise awareness among men who have sex with men in the context of general messaging on sexually transmitted infections.

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.
- On the African continent, most mpox clade I cases have been reported by the Democratic Republic of the Congo (DRC), Uganda and Burundi. There are signals that trends are levelling off or decreasing in DRC and Uganda, although these should be interpreted with caution, and a clear decline has been noted in Burundi (less than 50 cases per week reported recently).
- Sporadic mpox clade I cases have also been reported outside of the African continent during the past month, without any indication of wider community transmission. Australia is the latest country to report a clade Ib case in a person who had travelled overseas.
- The classification of transmission patterns has been updated as of 19 May 2025 (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'.

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

- In August 2024, France reported the first autochthonous case of chikungunya virus disease for 10 years in Réunion, with onset of symptoms on 12 August.
- Since the beginning of the year, and as of 18 May 2025, close to 51 000 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 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 on 7 April.
- On 26 April 2025, the **French Ministry of Health and Access to Care** reported three serious adverse events 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, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remains open for people 18–64 years 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 aged 65 years and above. More information can be found in Communicable disease threats report, 3 May - 9 May 2025, week 19.
- On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte. As of 16 May 2025, 101 autochthonous cases of the disease have been reported on the island, which is 77% increase compared to the previous week. Due to the intensification of the circulation of locally acquired cases of chikungunya, the ORSEC plan has transitioned to phase 2B to control the outbreak and better prepare for a possible epidemic phase.

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 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.

1. Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025

Overview

Since the last update on 14 April 2025, and as of 19 May 2025, 117 mpox cases have been reported from 14 EU/EEA countries: Germany (33), Netherlands (21), Spain (14), France (13), Sweden (8), Ireland (7), Italy (6), Portugal (4), Belgium (3), Czechia (2), Greece (2), Norway (2), Austria (1) and Croatia (1). Since 14 April 2025, no new countries have reported confirmed cases.

Since the start of the mpox outbreak and as of 19 May 2025, 24 548 confirmed cases of mpox (MPX) have been reported from 29 EU/EEA countries: Spain (8 725), France (4 453), Germany (4 288), Netherlands (1 487), Portugal (1 225), Italy (1 160), Belgium (878), Austria (372), Sweden (364), Ireland (301), Poland (242), Denmark (222), Greece (157), Norway (123), Czechia (103), Hungary (88), Luxembourg (62), Romania (49), Slovenia (47), Malta (45), Finland (43), Croatia (38), Slovakia (19), Iceland (17), Bulgaria (11), Estonia (11), Cyprus (6), Latvia (6) and Lithuania (6). Deaths have been reported from: Spain (3), Belgium (2), Portugal (2), Austria (1) and Czechia (1).

Since the start of the mpox outbreak, and as of 12 February 2025, the following Western Balkan countries have reported confirmed cases of mpox: Serbia (40), Bosnia and Herzegovina (9), Kosovo* (1), and Montenegro (2). In addition, 38 cases have been reported from Türkiye.

A total of 21 MPXV clade I cases have been reported in the EU/EEA since August 2024. On 15 August 2024, Sweden reported the first imported case of mpox due to MPXV clade Ib in the EU/EEA. Ten cases have been reported by Germany (one in October, five in December 2024, one in January 2025, one in February 2025 and two

in April 2025), six cases by Belgium (two in December 2024, one in January 2025, two in February 2025 and one in April 2025), three cases by France (one in December 2024, one in February 2025 and one in April 2025), and one case by Ireland in February 2025. All were clade Ib except the case in Ireland, which was clade Ia. All individuals had mild disease. Confirmed secondary transmission events were reported by Germany and Belgium among household contacts.

All other mpox cases with available information on clade reported in the EU/EEA were MPXV clade IIb.

The 117 cases reported represents a decrease compared to the previous report when 142 cases were reported between 13 March and as of 14 April, largely driven by substantial decreases in Germany (33 cases versus 57 in the last report) and Spain (14 cases versus 22). However, the Netherlands has reported an increase compared to the last report (21 cases in this report versus 10 in the previous report).

Cases reported in 2025 share the same epidemiological profile as those reported since the beginning of the outbreak in the EU/EEA, with the majority of cases being men, and sexual contact among men who have sex with men remaining the primary mode of transmission.

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 a Public Health Emergency of International Concern (PHEIC).

For more information on the global update regarding MPXV clade Ib, please refer to the weekly Communicable Diseases Threats Report.

A detailed summary and analysis of data reported to TESSy can be found in the Joint ECDC-WHO Regional Office for Europe Mpox Surveillance Bulletin.

*This designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the International Court of Justice (ICJ) Opinion on the Kosovo Declaration of Independence.

ECDC assessment

The number of new infections reported to the to The European Surveillance System (TESSy) has decreased compared to the last reporting period and the overall number remains relatively low in the EU/EEA.

It is likely that mpox cases due to MPXV clade I will continue to be introduced into the EU/EEA and it is important to raise awareness concerning the possible importation of cases, both among returning travellers from affected African countries and among healthcare professionals who may see such patients. Furthermore, it is important for public health authorities to be prepared to carry out contact tracing and infection prevention and control measures if cases are diagnosed. An ECDC epidemiological update and news item, published on 14 January, highlighted the options for response.

The overall risk of mpox is assessed as low for men who have sex with men and low for the broader population in the EU/EEA. As the spring season arrives and events such as Pride take place where MSM gather, it is important to raise awareness of mpox - please see resources under Actions.

Actions

ECDC is closely monitoring the mpox epidemiological situation through indicator- and event-based surveillance.

Response options for EU/EEA countries include raising awareness among healthcare professionals; supporting sexual health services in case detection, contact tracing, and case management; continuing to offer orthopox virus testing; implementing vaccination strategies and maintaining risk communication and community engagement, despite the decreasing number of cases. EU/EEA countries are also encouraged to sequence and report clades and subclades to identify new cases of mpox, particularly those linked to clade Ib or Ia.

Primary preventive vaccination (PPV) and post-exposure preventive vaccination (PEPV) strategies may be combined to focus on individuals at substantially higher risk of exposure and close contacts of cases, respectively, particularly in the event of limited vaccine supply. PPV strategies should prioritise gay, bisexual, and transgender people, and men who have sex with men, who are at higher risk of exposure, as well as individuals at risk of occupational exposure, based on epidemiological or behavioural criteria. Health promotion interventions and community engagement are also critical to ensure effective outreach, high vaccine acceptance and uptake among those most at risk of exposure.

A rapid risk assessment, 'Mpox multi-country outbreak', was published on 23 May 2022. The first update to the rapid risk assessment was published on 8 July 2022, and a second update was published on 18 October 2022. ECDC published a report on public health considerations for mpox in EU/EEA countries on 14 April 2023. ECDC published a Threat Assessment Brief on MPXV clade I in the Democratic Republic of the Congo (DRC) on 5 December 2023, an epidemiological update on 5 April 2024 and another on 14 January 2025 together with a news item. A risk assessment for the EU/EEA on the mpox epidemic caused by mpox virus clade I in affected African countries was published on 16 August 2024, and rapid scientific advice on public health measures was released on 9 September 2024 and updated on 14 January 2025.

A resource toolkit for event organisers and social media materials on mpox related to events are also available. Member States can use these materials to work with event organisers ahead of Pride events to ensure that attendees have access to the right information.

Member States can also consider providing those who travel to Pride events abroad with updated information on how to protect themselves and others from mpox.

For the latest updates, visit ECDC's mpox page.

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

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

Overview

Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries across the globe. 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. Since August 2024, a number of countries outside of Africa have also reported mostly travel-related cases of mpox clade I, 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, Rwanda, Congo, South Sudan, the Central African Republic, South Africa, Malawi and Angola (Global Mpox Trends published 14 May 2025, data as of 11 May 2025). In 2024, Zimbabwe reported cases of clade Ib and Gabon reported mpox cases for which clade information was not available (Global Mpox Trends published 14 May 2025, data as of 11 May 2025). Mpox clade IIa and IIb cases have also been reported in Africa and in recent weeks Sierra Leone has reported a notable increase in clade II cases (Mpox : multi-country outbreak of mpox, External situation report no. 52, 14 May 2025).

Overall, in Africa, until the beginning of May 2025, most confirmed and suspected clade I cases were reported from the DRC, Uganda and Burundi (Mpox: multi-country outbreak of mpox, External situation report no. 52, 14 May 2025). However, different trends have recently been observed in each country.

In DRC, clade Ia and Ib are co-circulating to different degrees. The epidemiological trends remain similar to that reported in the previous update. The number of confirmed cases has levelled off over the last two months. However, epidemiological trends should be interpreted with caution. 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, Mpox: multi-country external situation report no. 51, 29 April 2025, Mpox: multi-country outbreak of mpox, External situation report no. 52, 14 May 2025). In Kinshasa, both clades Ia and Ib are co-circulating. 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 of Kinshasa, where clade Ia is circulating in DRC. However, the number of samples sequenced and analysed varies if different provinces of DRC (Mpox: multi-country external situation report no. 51, 29 April 2025). APOBEC3 mutations have also been noted in clade Ib. According to WHO, 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 (Mpox: multi-country external situation report no. 51, 29 April 2025).

Uganda is currently the African country reporting most mpox clade Ib cases after DRC (Global Mpox Trends published 14 May 2025, data as of 11 May 2025). The total number of mpox cases reported in the country since 2024 is over 6 000. Following an increase earlier this year, there has been a decline since mid-April. Widespread transmission is ongoing in the country however testing rates have decreased, according to the National Mpox Situation Report of 15 May 2025 (Uganda National Mpox Situation Report, 14 May 2025).

In Burundi, the decreasing trend observed in the number of reported mpox cases in recent weeks has continued for the first two weeks of May and only clade Ib has been detected (Mpox: multi-country outbreak of mpox, External situation report no. 52, 14 May 2025). In the past few weeks, the average number of confirmed cases reported by Burundi has been below 50 Mpox: multi-country outbreak of mpox, External situation report no. 52, 14 May 2025).

Detailed information on the mpox clade I case numbers can be found in the WHO Global Report (including data until 11 May 2025). In general, and as of 19 May 2025, no major changes have been noted in the epidemiological trends of mpox clade I in Africa.

Outside of the African continent, 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, Brazil and Switzerland. On 16 May 2025, Australia reported its first mpox clade Ib case which was travel-associated (First mpox clade Ib confirmed in Australia | Australian Centre for Disease Control).

In the United States, in 2025, positive MPXV clade I wastewater samples have now also been reported from Iowa (U.S. Mpox Wastewater Data | National Wastewater Surveillance System | CDC). Previously, MPXV clade I had been detected in wastewater samples in North Carolina in March and April 2025 during routine testing (Mpox Found in Wastewater in North Carolina, NCDHHS Urges Public and Providers to Be on Alert | NCDHHS) and in California (Detection of mpox clade Ib nucleic-acids in wastewater solids at 147 wastewater treatment plants across the United States | medRxiv).

Most travel-associated cases involving 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 information available, 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 to be a public health emergency of international concern.

Transmission patterns of mpox due to monkeypox virus clade I – update 19 May 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, Australia, 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: the United Arab Emirates;
- Community transmission: Burundi, Central African Republic, Congo, the DRC, Kenya, Malawi, Rwanda, Tanzania, Uganda and Zambia.

The categorisation was last updated on 19 May 2025 to include Australia (category of countries reporting only travel-associated cases or cases with a clear link to travel-associated cases) and Malawi (category of countries with community transmission).

Below are some notes on the interpretation of the different trends reported in the included countries:

- Malawi reported its first mpox clade Ib cases in April. In total, ten cases have been reported, most of which do not have any travel history, according to WHO and the Public Health Institute of Malawi (Mpox: multi-country external situation report no. 51, 29 April 2025, Mpox: multi-country outbreak of mpox, External situation report no. 52, 14 May 2025 and Africa CDC Epidemic Intelligence Weekly Report, April 2025 – Africa CDC, Malawi NPHI Mpox Situation Report 18 May 2025). Given the number of cases reported without travel links, Malawi has been included in the category of countries with community transmission.
- Tanzania has reported a total of 43 cases in 2025, with 12 of these having occurred in the past six weeks and as of 11 May 2025 in Tanzania (2022-25 Mpox (Monkeypox) Outbreak: Global Trends (data as of 11 May 2025)). Previously, Tanzania was included in the classification as it was presumed that undetected transmission may be ongoing, given that mpox clade Ib cases with travel links to Tanzania have been reported elsewhere.
- South Sudan and South Africa are currently in the first (travel-associated) category, given the small number of confirmed cases. South Sudan has reported six cases in the past six weeks and a total of 14 cases, according to WHO, and as of 11 May 2025. In South Africa, no new cases have been reported the past six weeks and as of 11 May 2025. No additional information on suspected cases is available and there are no indications of wider community transmission in either country.
- The United Arab Emirates has 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'.

The epidemiological situation is continuously being 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 individuals, or 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: 2 May 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 18 May 2025, close to 51 000 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 20 was 4 730 and 116, respectively. This represents a 42% decrease in primary care visits and 30% decrease in emergency department visits, compared with week 19, but data are still being consolidated. Cases have been reported in all municipalities.

So far, 391 people with the disease have been hospitalised for more than 24 hours, including 342 for which chikungunya virus disease was the reason for admission. For the other cases, the diagnosis was confirmed incidentally during hospitalisation. To date, 71 severe cases (i.e. those with at least one organ failure) have been reported. These cases were in 39 adults aged over 65 years with comorbidities, nine people aged under 65 years (including six with co-morbidities) and 23 infants under three months.

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 aged over 70 years (range: 71–95 years) with co-morbidities (mainly chronic pathologies). Thirty-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 aged over 65 years, those over 18 years with comorbidities, and vector control professionals with Ixchiq vaccine, as a reactive short-term measure to prevent severe disease. The regional health agency initiated a vaccination campaign for prioritised individuals on 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 following vaccination against chikungunya with the Ixchiq vaccine in Reunion, including one death, and a third serious adverse event on 25 April. The three events occurred in people aged over 80 years 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 aged 65 years 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 aged 65 years 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 severe adverse events in older adults. EMA reports 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 aged 65 years and above.

On 26 March 2025, an autochthonous case of chikungunya virus disease was also reported in Mayotte. As of 9 May 2025, 101 autochthonous cases of the disease were reported on the island. A sharp increase in locally acquired infections has been observed since week 15. The number of cases in week 19 increased by 77%, compared to week 18. Cases of chikungunya virus disease were detected in 15 of the 17 communes of Mayotte, with a higher concentration in the communes of Mamoudzou, Pamandzi, Dzaoudzi and Koungou. Since the detection of the first confirmed case, seven cases have been hospitalised. Five of these were pregnant women, admitted for monitoring due to the increased risk of infection. The other two cases were a man with no comorbidities and a child under one year. No admissions to intensive care have been recorded, and no deaths have been reported. Due to the intensification of the circulation of locally acquired cases of chikungunya the ORSEC plan has transitioned to phase 2B. Several management and surveillance measures will be implemented to control the outbreak and better prepare for a possible epidemic phase.

Background

In August 2024, France reported the first autochthonous case of chikungunya virus disease for 10 years in Réunion, with onset of symptoms on 12 August. In recent weeks, the number of cases has increased sharply, as well as the geographical spread.

ECDC assessment

The last major chikungunya virus disease epidemic in Réunion was in 2005–2006. The mosquito Aedes albopictus, which is a known vector of chikungunya virus (CHIKV), is established in Réunion.

The probability of infection for residents and travellers to Réunion is currently 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.

In Mayotte, surveillance data indicate increasing intensity of the outbreak.

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, using 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: 16 May 2025.

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

Overview

Based on data reported in week 20, 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 have decreased to low levels.

RSV activity in the EU/EEA has fallen to low levels in 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 number of countries. No significant impact in secondary care indicators or in COVID-19 deaths has been observed so far.

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.

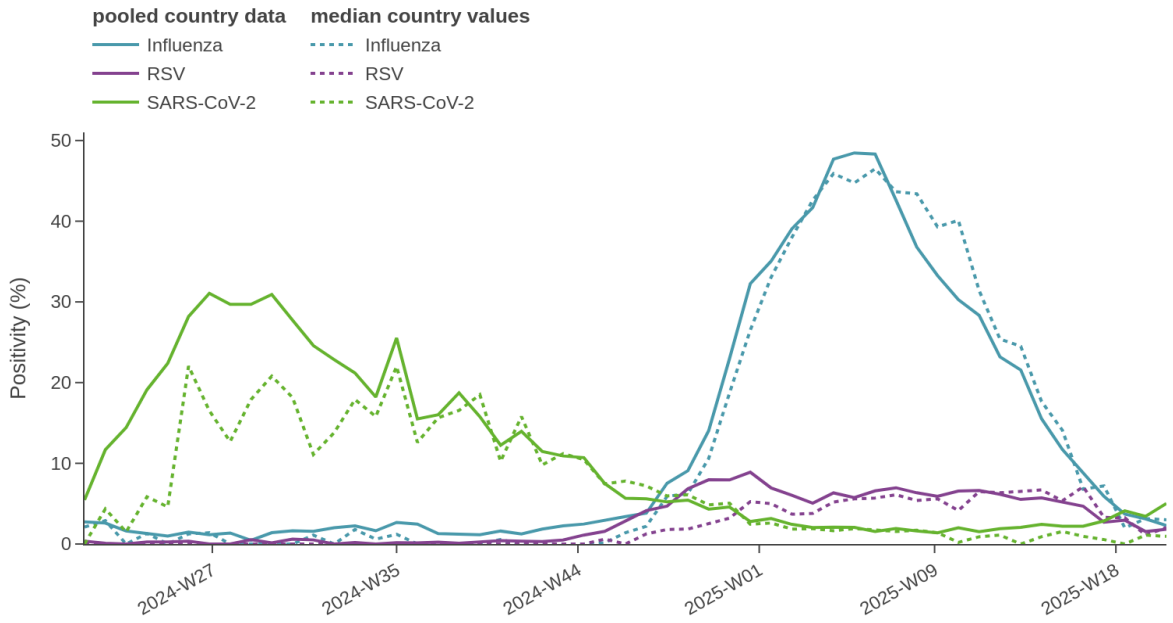
Frequent handwashing, physical distancing, avoiding large gatherings and wearing masks in healthcare settings can all help to reduce transmission of circulating respiratory viruses and protect groups at high risk of severe disease.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 16 May 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 20, 2025

		Reporting countries		EU/EEA summary		
Indicator	**Syndrome or pathogen**	**Week 20**	**Week 19**	**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	15 rates (15 MEM)	18 rates (17 MEM)		15 Baseline	
ILI/ARI test positivity in primary care	Influenza	16	17	Pooled (median; IQR)	2.3% (3; 0.8–3.6%)	At the EU/EEA level, the overall pooled influenza positivity continues to decrease in all age groups.
	RSV	15	16		1.8% (2; 0.6–7.7%)	At the EU/EEA level, the overall pooled RSV positivity continues to decrease in all age groups.
	SARS-CoV-2	15	15		5% (0.9; 0–3.1%)	At the EU/EEA level, the overall pooled SARS-CoV-2 positivity is increasing, driven by one country (Spain), but remains low across all age groups. Several countries are reporting increasing SARS-CoV-2 test positivity trends in the non-sentinel laboratory-based data (from a mix of primary care and other sources). Test positivity remains at low levels.
SARI rates in hospitals	SARI	10	11	-	-	
SARI test positivity in hospitals	Influenza	8	9	Pooled (median; IQR)	1.4% (1.4; 0–3.4%)	At the EU/EEA level, the overall pooled influenza positivity remains low and stable across all age groups.
	RSV	8	8		1.6% (0.4; 0–1.6%)	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 (7%).
	SARS-CoV-2	7	8		3.6% (2; 0.9–4.5%)	Activity for SARS-CoV-2 remains low in all countries across all indicators of severity. The small increasing trend is mainly driven by one country (Spain).
Intensity (country-defined)	Influenza	18	21	Distribution of country qualitative categories	13 Baseline 4 Low 1 Medium	
Geographic spread (country-defined)	Influenza	17	20	Distribution of country qualitative categories	5 No activity 6 Sporadic 1 Local 3 Regional 2 Widespread	

Source: ECDC

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

	Week 20, 2025		Week 40, 2024 - week 20, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**20**	**-**	**25184**	**-**
Influenza A	16	80	14906	60
A(H1)pdm09	10	77	7146	57
A(H3)	3	23	5454	43
A (unknown)	3	-	2306	-
Influenza B	4	20	10017	40
B/Vic	0	-	4455	100
B/Yam	0	-	1	0.0
B (unknown)	4	-	5561	-
Influenza untyped	0	-	261	-
RSV	**15**	**-**	**4726**	**-**
RSV-A	1	17	850	44
RSV-B	5	83	1102	56
RSV untyped	9	-	2774	-
SARS-CoV-2	**41**	**-**	**3249**	**-**

Source: ECDC

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

Figure Table

	Week 20, 2025		Week 40, 2024 - week 20, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**12**	**-**	**13566**	**-**
Influenza A	8	80	5537	80
A(H1)pdm09	0	0.0	1496	59
A(H3)	1	100	1026	41
A (unknown)	7	-	3015	-
Influenza B	2	20	1386	20
B/Vic	0	-	159	100
B (unknown)	2	-	1227	-
Influenza untyped	2	-	6643	-
RSV	**13**	**-**	**5415**	**-**
RSV-A			699	47
RSV-B			787	53
RSV untyped	13	-	3929	-
SARS-CoV-2	**29**	**-**	**3858**	**-**

Source: ECDC

Figure 5. Genetically characterised influenza virus distribution, week 40, 2024 to week 20, 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	2959	31	V1A.3a.2(C.5.1)	1845	63
			V1A.3a.2(C.5.6)	552	19
			V1A.3a.2(C.5.7)	467	16
			V1A.3a.2(C)	72	2
			V1A.3a.2(C.5)	8	0.3
			Not assigned	15	-

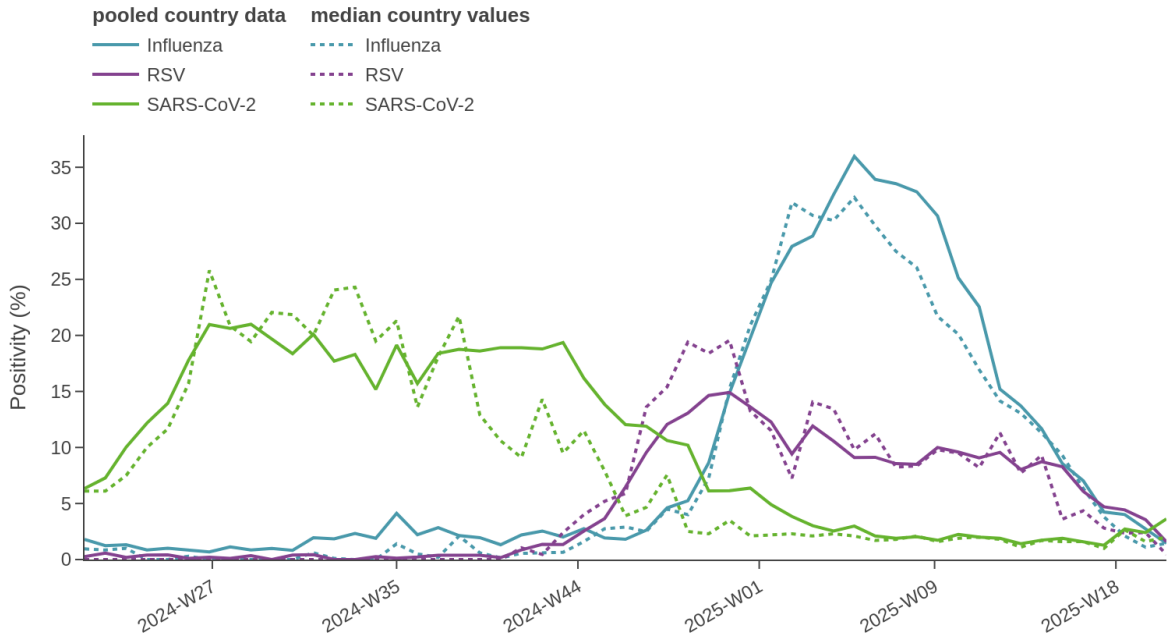
Source: ECDC

Figure 6. SARS-CoV-2 variant distribution, weeks 18–19, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	3	21	21% (15–26%)
KP.3	VOI	1	1	0% (0–0.9%)
LP.8.1	VUM	3	43	53% (48–58%)
XEC	VUM	2	5	7% (4–7%)

Source: ECDC

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



Source: ECDC

Events under active monitoring

- 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
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 23 May 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 23 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
- Nipah virus disease – India – 2025 - last reported on 16 May 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
- 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.