WEEKLY BULLETIN

Communicable Disease Threats Report

Week 48, 22–28 November 2025

This week's topics

Executive summary

Hepatitis A - Multi-country (EU) - 2024-2025

- Outbreaks of hepatitis A virus (HAV) infection have been ongoing in Austria, Czechia, Hungary, and Slovakia for at least two years, affecting different populations, including both children and adults.
- Groups with limited access to proper sanitation and/or healthcare services are in general disproportionately affected.
- Cumulatively there have been 39 deaths and more than 6 000 HAV cases reported in 2025.
- Sequencing analyses of a subset of the samples have identified two closely-related clusters, with one nt difference. One cluster consists of cases from Austria, Germany, Hungary and Sweden. The other cluster consists of cases from Austria, Slovakia, Czechia, Sweden, England, Wales and Northern Ireland.
- No food source is suspected at this point, but rather person-to-person transmission among groups of people living in poor sanitary conditions.
- ECDC published a rapid risk assessment in June 2025 (Rapid Risk Assessment: Multi-country outbreak of hepatitis A in the EU/EEA).

Seasonal surveillance of chikungunya virus disease – 2025

- Since the beginning of 2025 and as of 26 November 2025, two countries in Europe have reported cases of chikungunya virus disease: France (795) and Italy (385).
- In week 48, France reported 15 locally acquired cases of chikungunya virus disease. Italy has not reported new cases this week.

Weekly seasonal surveillance of West Nile virus infection – 2025

Since the beginning of 2025, and as of 26 November 2025, 14 countries in Europe have reported human cases of West Nile virus infection: Albania, Bulgaria, Croatia, France, Germany, Greece, Hungary, Italy, Kosovo*, North Macedonia, Romania, Serbia, Spain, and Türkiye.

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

Influenza A(H5N5) - Multi country (World) - Monitoring human cases

- The first human case of avian influenza A(H5N5) was confirmed in Washington State, USA.
- The case, an older adult with underlying conditions, was hospitalised in early November 2025 and died on 21 November 2025.
- The likely source of exposure was mixed backyard poultry which had contact with wild birds.
- The US CDC assesses the risk of avian influenza A(H5) to the general public as low.
- No new cases have been detected among contacts of the patient. So far, there is no evidence of human-to-human transmission.
- HPAI A(H5N5) has recently been circulating in wild birds in northern Europe, with occasional detections and outbreaks in wild mammals and domestic poultry.
- The virus was identified as belonging to clade 2.3.4.4b, genotype A6 (US) /EA-2021-I (EU), which has been detected in birds and mammals in North America. No markers associated with mammalian adaptations of significance were observed.

Human cases infected with swine influenza A(H1N2) variant virus – Multi-country – 2024

- One new case of human infection with influenza A(H1N2) variant (v) virus of swine origin has been reported in Vermont, USA.
- The patient, an adult, developed symptoms on week 40, 2025, was hospitalised and discharged the same day.
- The public health officials could not determine whether the patient had been exposed to swine or other animals.
- No further human-to-human transmission was identified in relation to this case.
- This is the second human case of infection with a variant influenza virus reported in the US this year.
- Since 2019, 18 cases of swine influenza A(H1N2)v infections in humans have been reported in the US: two cases in 2025, four in 2024, two in 2023, six in 2022 and four in 2021. The cases were from different regions of the US and were considered sporadic.
- Human infections with influenza virus of swine origin are rare, but sporadic infections may occur in individuals exposed to infected animals.

Influenza A(H5N2) - Multi-country (World) - Monitoring human cases

- On 24 November 2025, WHO PAHO announced that a human case infected with avian influenza A(H5) reported earlier in September 2025 in Mexico City, was confirmed to have been infected with avian influenza A(H5N2) virus.
- The case had had exposure to infected birds and a dog in their residential area.
- This is the second human infection with avian influenza A(H5N2) virus reported in Mexico and globally, the first case having been reported in April 2024.
- The sequenced strain belongs to clade 2.3.4.4b and contains no mutations known to increase its zoonotic potential.
- No human-to-human transmission associated with this event has been reported.
- The risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered low.

Marburg virus disease (MVD) - Ethiopia - 2025

- A Marburg virus disease (MVD) outbreak was confirmed on 14 November 2025 by the Ministry of Health of Ethiopia after a suspected event was reported in Jinka city on 12 November 2025.
- Since the start of the outbreak, and as of 27 November, 15 cases (12 confirmed and three probable) of MVD have been reported, including 11 deaths (eight confirmed and three probable (case fatality rate (CFR): 66.7%)).
- According to media quoting the Ethiopian Ministry of health on 27 November, one of the cases in Hawassa City, Sidama Region has been confirmed after returning from Jinka City.
- As of 26 November, 349 contacts have been identified, according to the Ethiopian Public Health Institute.
- This is the first MVD outbreak ever reported in Ethiopia.
- The likelihood of exposure to MVD for EU/EEA citizens visiting or living in Ethiopia is assessed as low, with uncertainties connected to the limited epidemiological information available. The impact, assessed at population level, is low since the number of MVD cases in EU/EEA citizens in Ethiopia is expected to be very small. Therefore, the overall risk for EU/EEA citizens visiting or living in Ethiopia is low.
- In the event of MVD cases being imported into the EU/EEA, we consider the likelihood of further transmission to be very low, and the associated impact low. Therefore, the overall risk for the EU/EEA is assessed as low.

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

- Since 1 January 2025 and as of 25 November 2025, 577 843 cholera cases, including 7 395 deaths, have been reported worldwide.
- Since 29 October 2025 and as of 25 November 2025, 15 394 new cholera cases, including 194 new deaths, have been reported worldwide.
- The five countries reporting most cases are Afghanistan (10 781), Angola (2 493), Sudan (1 117), Burundi (567) and Ethiopia (413). The five countries reporting most new deaths are Sudan (114), Angola (28), South Sudan (25), Chad (11) and Afghanistan (6).
- In 2025, cholera cases have continued to be reported in Africa and Asia, the Middle East and the Americas. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

Ebola virus disease – Democratic Republic of the Congo – 2025

- Since the last update, and as of 27 November 2025, no new Ebola virus disease cases have been reported in the Democratic Republic of the Congo (DRC). All patients have been discharged and there are no contacts under active monitoring.
- The 42-day countdown for declaring the outbreak over was initiated on 19 October, following the discharge of the last patient being treated.
- Since the start of the outbreak, and as of 27 November, 64 cases (53 confirmed and 11 probable) of Ebola virus disease (EVD) have been reported in Kasai Province, DRC, including 45 deaths (34 confirmed and 11 probable; case fatality rate (CFR) among all cases: 70.3%).
- All confirmed cases were reported from Bulape health zone.
- The current risk for people from the EU/EEA living in or travelling to Kasai province in DRC is estimated to be low, due to the current low likelihood of exposure. For people living in the EU/EEA, the risk is very low, as the likelihood of introduction and secondary transmission within the EU/EEA is very low.

Overview of respiratory virus epidemiology in the EU/EEA

- The number of patients presenting to primary care with symptoms of respiratory illness remains at baseline or low levels in most countries. Although the influenza season started unusually early, circulation is still at relatively low levels in most countries, but detections are increasing rapidly. SARS-CoV-2 continues to circulate quite widely but is decreasing in all age groups. Respiratory syncytial virus (RSV) circulation is low but increasing slowly. The impact on hospitalisations remains limited at this stage.
- This year's influenza season began three to four weeks earlier than in the last two years, with over half of the countries now reporting above-baseline activity. Influenza A is dominant in all countries, with A(H3N2) driving the increasing trend in recent weeks. Circulation is highest in children aged 5–14 years. Early increases in hospitalisation are being observed in some countries, affecting all age groups, but primarily adults aged 65 years and above.
- On 20 November 2025, ECDC published a Threat Assessment Brief assessing the risk of influenza for the EU/EEA in the context of increasing circulation of A(H3N2) subclade K.
- Trends in RSV circulation, which is slowly increasing from low levels, are currently around one week later than last season. Increases are visible in both primary care and hospital surveillance data from a few countries, with children under five years predominantly affected.

1. Hepatitis A - Multi-country (EU) - 2024-2025

Overview

This CDTR provides an update of the HAV situation in the countries covered by the Rapid Risk Assessment published in June 2025, as well as in countries reporting HAV sub-genotype IB cases identical to one of the two outbreak clusters.

Between January and May 2025, Austria, Czechia, and Hungary reported a higher-than-expected number of hepatitis A virus (HAV) sub-genotype IB cases to EpiPulse. Slovakia started to observe an increase in hepatitis A cases at the end of 2022. It has been reported that the rise in HAV infections in these countries primarily affects adults experiencing homelessness, people who use or inject drugs, and those living in poor sanitary conditions. In addition, cases have been reported among members of the Roma communities in both Czechia and Slovakia. ECDC published a Rapid Risk Assessment in June 2025, to further support the public health response in affected countries. By June 2025, a total of 2 100 cases had been reported from Austria (87), Czechia (600), Hungary (530), Slovakia (880) and Germany (3).

The outbreaks of hepatitis A are still ongoing, and the cumulative number of reported cases of HAV in 2025 is now over 6 000, with most cases reported from Austria (216), Czechia (2 310), Hungary (1 548), and Slovakia (2 482). A total of 39 fatalities have been reported in 2025.

The situation differs between the most affected countries: Czechia and Slovakia have the highest case counts and fatalities; Hungary and Slovakia are seeing more cases in children, whereas Czechia and Austria are reporting most cases among adults. The main groups affected differ by country: Austria and Czechia are seeing a significant number of cases among people experiencing homelessness and/or people who use drugs; Hungary and Slovakia have identified cases in Roma communities and those living in poor sanitary conditions. None of the countries have identified any signals of food-borne transmission.

Sequencing analyses of a subset of the samples have previously identified two closely related clusters, with one nt difference. The countries report continued circulation of the sub-genotype IB strains addressed in the most recent rapid risk assessment. One cluster (cluster A) currently consists of cases from Austria, Germany, Hungary and Sweden. The reference strain is 3256048 HUN 2025 reported from Hungary. The other cluster (cluster B) now consists of cases from Austria, Czechia, Slovakia, Sweden, England, Wales and Northern Ireland. The reference strain is ENA: ERS23282329/GenBank: OZ223852 reported from Slovakia.

Austria: By the end of October 2025, the total annual number of HAV cases reported in Austria was 216. Among the cases, 64% were males, with a median age of 36 years and 50% were hospitalised. People experiencing homelessness and people who use drugs are seen among the cases of clusters A and B (33% and 20% among those where information is available, not mutually exclusive). An outbreak has been reported in a shelter for people experiencing homelessness, involving the HAV strain of cluster B. Among the cases, some individuals reported alcohol dependence. There are also reports of sexual transmission, including among men who have sex with men and one person who was engaged in sex work. Secondary transmission was suspected for 18 cases and confirmed for 16 cases. Four deaths have been reported in 2025. Vienna is considered the centre of the outbreak in Austria.

Sequencing results in Austria, 2025: sequencing of the 460 bp region VP1-2A in a subset of samples (n=120) identified two clusters, cluster A and cluster B, differing with one nt:

- Cluster A: the 40 Austrian cases in this cluster include ten females and 30 males; 33 cases are from Vienna. The median age is 35 years. Twelve cases have been hospitalised and there have been no deaths reported. Six cases are in individuals experiencing homelessness; three individuals had contact with other known hepatitis A cases prior to their infection.
- Cluster B: There are 80 Austrian cases in this cluster: 17 are female, 63 are male, and the median age is 38.5. The majority of the cases are from Vienna (five cases). A total of 35 cases have been hospitalised, and five deaths reported. In all, 24 cases are in people experiencing homelessness; 13 cases are in people reported to be users of intravenous drugs; 13 cases are in people who had contact with others infected with hepatitis A or people experiencing diarrhoea prior to their infection.

Czechia: There is a continued rapid spread of hepatis A across the country, with 2 310 cases and 27 deaths reported by end of October 2025. As a comparison, the total number of reported cases in 2024 was 636. Cases have been reported in all regions and age groups, most commonly among people aged 30–39, and 5–9 years. Approximately 60% of the cases are among males.

The highest case counts were detected in Prague (636), Central Bohemia (262), and Moravia-Silesia (139) regions. Of all cases, 294 (16%) reported in 2025 were linked to outbreaks, and 393 cases involved risk factors such as intravenous drug use (178 cases), homelessness (188), or incarceration (27). So far in 2025, 17 outbreaks have been identified, seven of which are still ongoing. Hospitalisation was reported in 80% of cases. The reported cases are probably under-representive of the true situation due to the existence of asymptomatic cases or mild disease and the fact that testing is based on people seeking care in hospitals.

Among the 27 deaths, where data were available, 16 were men and two were women and all were among adults. The majority of fatalities occurred in individuals aged 55–74 years, and mostly involved people using alcohol and/or

experiencing homelessness. Most deaths occurred in the second half of September and at the beginning of October, highlighting the fact that this is an ongoing public health threat.

In response to the ongoing increase in hepatitis A cases in Czechia, several measures are being implemented, including the initiation of targeted vaccination campaigns by the public health protection authority in areas experiencing local outbreaks. Vaccination is also being offered to individuals in groups at high risk of exposure. Public health authorities are enhancing surveillance and enforcing hygiene measures in public spaces, with a focus on food establishments, public transportation, and communal areas. Local outbreaks are promptly reported and monitored. In addition, efforts are underway to raise awareness of the importance of vaccination and hygiene, including targeted campaigns in high-risk communities to help prevent further spread of the disease.

Sequencing results in Czechia: a total of 112 hepatitis A virus (HAV) cases have been sequenced to date, 55 from 2024 and 57 from January to June 2025, revealing 20 distinct HAV strains. Nine sub-genotype IB strains were identified, with the majority of cases (n=70) belonging to a single cluster. Samples from cases within this cluster were either identical to the cluster B sequence (e.g. ENA: ERS23282329/GenBank: OZ223852, n=50) reported from Slovakia, or differed by one nucleotide (n=20). Cases from this cluster were reported in Prague (14), the Moravian-Silesian Region (39), and the Central Bohemian Region (4). In addition, sequencing revealed smaller clusters involving sub-genotype IA strains (identical to Genbank IDs PO682620 and KY292293, 11 cases each) and one sub-genotype IIIA strain (identical to GenBank ID KU570292, four cases). Sequencing of a further 120 samples collected between July and September 2025 is currently in progress.

Germany: Four cases with HAV sequences identical to the Hungarian cases (cluster A) have been detected in Germany in 2025. One individual with onset in September had previously travelled to Croatia. The other three acquired the infection in Germany and were reported between January and March 2025. Two of them were drug users.

Hungary: An increase in HAV cases has been observed in Hungary since November 2024. In 2025, a total of 1 548 cases were reported between January and end of October. Of the cases reported so far in 2025, 55% are male and 65% were hospitalised. The age-specific incidence rate was highest among children aged 3-5 years and 6-9 years, but cases were reported in all age groups except neonates. Four fatalities were reported among hospitalised adult cases with co-morbidities. Most cases have been reported from Budapest, however, the highest county-specific incidence rates are observed in the two most north-easterly counties (Borsod-Abaúj-Zemplén and Szabolcs-Szatmár-Bereg), as well as in Budapest. Reports from epidemiological investigations also confirm an increase in HAV cases among people living in Roma communities, and to a much lesser extent, among people experiencing homelessness.

In response to the outbreak in Hungary, surveillance activities have been strengthened, and a nationwide public communication has been issued in 2025. An information letter was distributed to healthcare providers in spring 2025. Post-exposure prophylaxis (free-of-charge vaccination) was provided to contacts of HAV cases. In the affected towns and communities, awareness-raising campaigns were launched, with the support of local municipalities, including the distribution of educational materials in kindergartens and schools. These efforts focused on emphasising the importance of personal hygiene and ensuring access to handwashing facilities. Vaccination was recommended for individuals belonging to risk groups. All these activities are ongoing and are being adjusted as necessary, based on the local epidemiological situation.

Sequencing results in Hungary: A subset of 66 samples have been sequenced in 2024 and 2025 (460 bp region), 63 of them were subtype 1B, 57 sequences were identical and four differed in one position each. Two 1B sequences were unrelated. The sequences are similar to the sequence of the 1B strain associated with the outbreak in Slovakia in 2023. The 57 identical Hungarian sequences are also identical to the Austrian sequences in cluster A. In addition, sequencing was conducted in Hungary in previous years, and the current predominant sequence is similar to a sequence already observed in 2022.

Slovakia: An increase in reported HAV cases has been observed since the end of 2022. The situation was most critical in 2023 and 2024, especially in Roma communities in eastern Slovakia, where mainly children were affected. Approximately 40% of the children up to 15 years were vaccinated as part of the outbreak response. At the end of 2024, an increased number of viral hepatitis A cases was observed in one smaller city in the western part of Slovakia, and most of the cases were in people experiencing homelessness or people who used drugs.

The epidemiological situation has been improving in 2025, but many cases continue to be reported, and people living in conditions of poor sanitation and the Roma population are still disproportionally affected. A total of 2 482 cases of HAV have been reported in Slovakia between January and October 2025, corresponding to an increase of 1 602 cases since the Rapid Risk Assessment was published in June. Among cases reported in 2025, 54% were males and 41% were hospitalised. Four deaths have been reported during 2025, all among older adults, two of whom had underlying chronic disease. In 2025, by the end of October, 3.1% of reported cases were among people experiencing homelessness and/or people using drugs.

Increasing vaccine coverage of the recommended vaccine to two-year olds in areas with poor sanitary conditions has been challenging, which has led to recurring epidemics in these localities.

Sequencing results in Slovakia: Between October 2023 and mid-June 2025, a total of 135 samples were sequenced. The predominate genotype was 1B (132 cases in total), but 1A was also detected (two cases in 2025, one imported from Cuba and one case probably linked to a foreign visitor, one imported case from Cyprus in 2024). Most of the HAV IB sequences posted by Slovakia in EpiPulse are identical to the cluster B sequences submitted from Austria. Sequencing of an additional 92 samples, with dates of sampling from June 2025 onwards, is in progress.

Sweden: A total of six travel-related cases, four adults and two children, were reported in 2025. Of these, two had sequences identical to cluster A and four to cluster B, three of which originated in the same family. The cases in cluster A reported travel to Hungary in July-August 2025. The cases in cluster B had travelled to Czechia in August 2025.

England, Wales and Northern Ireland: A total of 41 cases identical to the reference strain from Slovakia (ERS23282329, cluster B) have been reported during the period 2023-2025. Many of the cases were confirmed as travel-related: Czechia (two cases, February and May 2025), Slovakia (12 cases in 2024, two cases in 2023).

ECDC assessment

The outbreak is driven by person-to-person transmission among people living in poor sanitary conditions. Among the cases reported are people experiencing homelessness, those with co-morbidities, and people who use drugs or report alcohol dependence, making the exposed population vulnerable to severe disease. There are currently no signals of foodborne transmission reported from the affected countries. The chain of transmission is ongoing, and new cases are likely to occur.

In the most affected countries, the risk remains moderate-to-high for people in the groups who have limited access to proper sanitation and/or healthcare, and low-to-moderate for people living in areas with good sanitation standards who have access to healthcare services. The risk is very low for people who are vaccinated against hepatitis A or have known immunity to the disease.

The recommendations in the previously published ECDC Rapid Risk Assessment from June 2025 on hepatitis A are still valid. ECDC encourages the public health authorities of the affected countries to focus on the following activities in view of the current multi-country outbreak of hepatitis A:

- enhance surveillance and case detection;
- promote vaccination and strengthen activities to boost vaccination coverage for people who have limited access to proper sanitation and/or healthcare;
- strengthen community engagement and outreach activities to populations more likely to be exposed to the virus.

The same recommendations also apply for countries experiencing outbreaks associated with other HAV strains but affecting populations with similar characteristics. Further details related to the recommended activities are available in the ECDC Rapid Risk Assessment published in June.

Countries are implementing different health protection measures, including public health and social measures and information campaigns. However, there are challenges in community engagement and implementing measures in specific communities, which should be considered from a wider communicable disease perspective when planning and implementing measures for other infectious diseases (e.g. tuberculosis). Availability of the hepatitis A vaccine is also an ongoing issue, although this varies among countries and regions.

Actions

- ECDC published a rapid risk assessment in June 2025 (Rapid Risk Assessment: Multi-country outbreak of hepatitis A in the EU/EEA).
- ECDC is monitoring this situation through EpiPulse and epidemic intelligence, and continuously assessing the available epidemiological and microbiological information.
- During the week 27-31 October, ECDC's IRT organised bilateral meetings with NFPs for hepatitis and/or FWD in Austria, Hungary, Slovakia and Czechia.
- ECDC offers sequencing support to the affected countries to determine circulating strains.
- ECDC has provided the countries with a collection of documents, tools and e-learning courses that could be useful to health professionals responding to the outbreak at local and national level.
- The EU Health Task Force is ready to provide support to individual countries and coordinate further cross-border outbreak investigations with affected countries.
- Countries are kindly requested to keep the event information in EpiPulse continuously updated and share sequence data if available.

Further information

HAV is highly transmissible through contaminated water, food, and via the faecal–oral route among close contacts (e.g. household contacts, sexual contacts, and contacts in day-care centres or schools), with an average incubation period of four weeks, ranging from two to six weeks. The virus is highly resistant to environmental conditions, and to preservation methods such as acidification or freezing. The primary methods for preventing infection are to practice good hand hygiene and ensure the provision of vaccination to groups at risk of exposure.
Sources: RAPID RISK ASSESSMENT Multi-country outbreak of hepatitis A in the EU/EEA 18 June 2025. Available at: https://www.ecdc.europa.eu/sites/default/files/documents/Multi-country_outbreak_of_HepA_June_2025.pdf | Ministry of Health, Czechia. V České republice významně roste počet případů žloutenky typu A. 2025. Available at: https://mzd.gov.cz/tiskove-centrum-mz/v-ceske-republice-vyznamne-roste-pocet-pripadu-zloutenky-typu-a/ | National Centre for Public Health and Pharmacy (NNGYK), Hungary. Hepatitis A: Fontos tudnivalók és megelőzési tanácsok. Budapest: NNGYK; 2025. Available at: https://www.nnk.gov.hu/index.php/jarvanyugy/lakossagi-tajekoztatok/altalanos-tajekoztatok/hepatitis-a-fontostudnivalok-es-megelozesi-tanacsok.html

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

2. Seasonal surveillance of chikungunya virus disease – 2025

Overview

Since the beginning of 2025, and as of 19 November 2025, two countries in Europe have reported cases of chikungunya virus disease: France (780) and Italy (385).

France has reported 15 new locally acquired cases of chikungunya virus disease since their last report from week 47. The cumulative number of locally acquired cases in France has reached 795, distributed across 79 clusters. Nine clusters are currently active, with the latest reported date of onset 30 October. The largest cluster is located in Antibes.

No new locally acquired cases were reported by Italy this week. The cumulative number of locally acquired cases in Italy remains 385, distributed across seven clusters. Three clusters are currently active, with latest reported date of onset 11 November. The largest clusters are in Carpi, San Prospero, Soliera, Novellara, Cavezzo, Modena, Nonantola, Correggio, Novi di Modena, and Cesenatico.

Seasonal weather conditions for vector-borne transmission are currently unfavourable in most parts of mainland Europe. However, due to delays in diagnosis and reporting, there may be further cases reported to ECDC in the coming weeks.

For more information on locally acquired chikungunya virus disease cases, see ECDC's seasonal surveillance report for chikungunya virus disease. This report covers mainland EU/EEA and the outermost regions of Portugal and Spain.

ECDC assessment

The current chikungunya virus disease risk assessment for mainland EU/EEA can be found on ECDC's dedicated chikungunya webpage.

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

3. Weekly seasonal surveillance of West Nile virus infection – 2025

Overview

Since the beginning of 2025, and as of 26 November 2025, 14 countries in Europe have reported human cases of West Nile virus infection: Albania, Bulgaria, Croatia, France, Germany, Greece, Hungary, Italy, Kosovo*, North Macedonia, Romania, Serbia, Spain, and Türkiye.

A total of 157 areas are currently known to be affected.

The report is available online.

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

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

4. Influenza A(H5N5) - Multi country (World) - Monitoring human cases

Update

According to the press release from the Washington State Department (DOH) on 21 November 2025, the patient has died. The individual, an older adult with underlying health conditions, had onset of symptoms during week 43 (ending 25 October 2025) and was hospitalised in week 45 (ending 8 November 2025) (US CDC Weekly Influenza Surveillance Report for week 46).

The person had a backyard flock of mixed domestic birds. The environmental samples tested by DOH were positive for avian influenza (note that the subtype is not specified). Based on these results, the public health officials report that the most likely source of exposure for this patient was the domestic poultry, their environment, or wild birds. The authorities are continuing to monitor other people who may have had contact with the backyard poultry and environment for symptoms, as well the identified contacts of the patient. As of 21 November 2025, no new cases had been detected among contacts. So far, no human-to-human transmission has been detected and the US public health authorities have evaluated the risk to the public as low.

The Washington State Department of Health is collaborating with local health authorities and the State Department of Agriculture to assess human and animal health risks.

Background

On 14 November 2025, the Washington State Department of Health DOH), reported a confirmed human infection with avian influenza A(H5N5) in a resident of Grays Harbor County, Washington, USA. This is the first human infection with avian influenza of subtype A(H5N5) reported globally. Testing at the UW Medicine Clinical Virology Lab identified the virus and the result was confirmed by the US Centers for Disease Control and Prevention (CDC) in Atlanta.

The US Centers for Disease Control and Prevention (CDC) and state authorities have assessed the risk of avian influenza A(H5) to the general public as low, and no increased risk has been identified by the Department of Health.

As of 14 November 2025, the US CDC has reported 71 human cases with avian influenza A(H5), including the recent case with A(H5N5) infection (note: other reported cases involved avian influenza A(H5N1) virus infection), and two deaths - which includes the recent death.

Avian influenza A(H5N5) situation in animals in Europe and North America

Highly pathogenic avian influenza (HPAI) A(H5N5) virus of clade 2.3.4.4b has been circulating in wild birds in northern Europe and North America, where the geographical and species range in wild birds has recently expanded, causing spill-overs to wild mammals, domestic birds and, occasionally, domestic cats. HPAI A(H5N5) of clade 2.3.4.4b has also been detected in wild birds in Japan (EFSA, ECDC, EURL for Avian Influenza et al., 2024a; 2024b; 2025).

During the past epidemiological year (October 2024 - September 2025), seven countries in the EU/EEA (Belgium, Estonia, Finland, Germany, Iceland, Norway and Sweden) have reported detections of HPAI A(H5N5) in wild birds. Two countries (Iceland and Norway) have also reported outbreaks in domestic birds (EFSA, ECDC, EURL for avian influenza, et al., 2025). In addition, there have been detections of A(H5N5) in wild mammals in Europe, such as Arctic and red fox (Iceland, Norway), lynx (Norway), American mink (Iceland), otter (Norway), and pine marten (Netherlands) since early 2024. Iceland has also reported A(H5N5) detection in domestic cats (EFSA, ECDC, EURL for avian influenza, et al., 2024; 2025).

In North America, Canada has reported eight detections of HPAI A(H5N5) in wild birds and one outbreak in domestic poultry according to the World Organisation for Animal Health (WOAH) during the past epidemiological year. Canada has also reported detections in wild mammals, such as bobcat, skunk, grey seal, and racoon, as well as in domestic cats (EFSA, ECDC, EURL for avian influenza, et al., 2025). Since the beginning of 2025, there have been 11 detections of HPAI A(H5N5) in wild birds in the United States reported by the US Department of Agriculture (USDA).

Genetic characteristics of avian influenza A(H5N5) virus

The sequenced isolate (A/Washington/2148/2025) from the Washington case reported on 14 November 2025 was released the same day on NCBI GenBank under accessions PX508201-PX508208. It belongs to clade 2.3.4.4b, genotype A6, which has commonly been reported for recent A(H5N5) bird and mammalian viruses from North America, and referred to as EA-2021-I for European isolates. The HA segment of A/Washington/2148/2025 clusters closely with clade 2.3.4.4b strains of the same subtype but is distinct from the A(H5N1) genotypes B3.13 and D1.1, which include strains from human infections in the United States. A/Washington/2148/2025 does not contain any key mutations associated with mammalian adaptations, or markers different from those already established in similar strains from birds.

During the past epidemiological year (Oct 2024 – Sep 2025), HPAI A(H5N5) genotype EA-2021-I has been reported in Iceland, Norway, the United Kingdom, and occasionally in Belgium, the Netherlands, Finland and probably Germany (partial genome). All the A(H5N5) viruses belonging to this genotype detected in Europe in 2025 contained a molecular marker of virus adaptation to mammals, belonging to one of two distinct clusters, characterised by substitutions in the PB2 segment of either PB2-E627K or PB2-E627V. HPAI A(H5N5) viruses belonging to these two clusters have been circulating in Norway, the United Kingdom, Finland and Iceland since November 2024, and were also identified in Canada in late 2024 (EFSA, ECDC, EURL for avian influenza, et al., 2025). However, these markers of mammalian adaptation in the PB2 segment were not seen in the virus sequence of the human case reported in the United States on 14 November 2025 (A/Washington/2148/2025).

ECDC assessment

This is the first human case of avian influenza A(H5N5) reported globally. Sporadic human cases of different avian influenza A(H5) subtypes have previously been reported globally. Despite the widespread transmission of avian influenza viruses in animals, transmission to humans remains infrequent and no sustained transmission between humans has been observed.

Overall, the risk related to avian influenza A(H5) for the general population in the EU/EEA is considered low. The assessment for zoonotic avian influenza A(H5N5) virus will be reviewed when more information becomes available.

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

Actions

ECDC is closely monitoring this event and avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces an avian influenza overview which is updated on a quarterly basis. The most recent report was published in September 2025.

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

5. Human cases infected with swine influenza A(H1N2) variant virus – Multi-country – 2024

Overview

On 21 November 2025, the US Centers for Disease Control and Prevention (US CDC) reported one human infection with influenza A(H1N2)v virus of swine origin in the state of Vermont. The case was an adult who developed symptoms and sought healthcare on week 40 (week ending on 4 October 2025). The person was hospitalised and discharged the same day and has recovered from their illness.

Epidemiological investigation did not identify direct or indirect contact with swine by the patient. There was no additional illness among close contacts of the case. No further human-to-human transmission was identified in relation to this case.

This is the second human infection with a variant influenza virus A(H1N2)v reported in US this year. Since 2019, 18 cases of A(H1N2)v, including the one reported here, have been reported in the country. All cases were from different regions in the US and were considered sporadic.

Summary: Overall, 32 cases have been reported globally since 2019, four of which were reported in the EU/EEA: Austria (in 2021), Denmark (in 2019), France (in 2021) and the Netherlands (in 2022). Outside the EU/EEA, cases have been reported in Brazil (three cases), Canada (three cases), Taiwan (three cases), the United Kingdom (one case) and the US (18 cases).

ECDC assessment

Sporadic human cases infected with an influenza virus of swine origin have been reported from several countries around the world. Infection following exposure to pigs represents the most common risk factor. Limited, non-sustained human-to-human transmission of variant influenza viruses has previously been documented, but is rare. All cases need to be carefully followed up to exclude human-to-human transmission and implement control measures. Novel influenza viruses in humans, including zoonotic influenza viruses, should be further characterised, as well as shared with the national influenza reference laboratories and the World Health Organization (WHO) Collaborating Centres.

Actions

ECDC is monitoring zoonotic influenza events through its epidemic intelligence activities and disease experts in order to identify significant changes in the epidemiology of the virus. Cases should be immediately reported to the Early Warning and Response System (EWRS) and in accordance with the International Health Regulations (IHR).

ECDC guidance: Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work; Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA. An annual summary of human infections with influenza A variant viruses of swine origin reported globally is provided in the Zoonotic influenza - Annual Epidemiological Report for 2023.

Sources: 2022-E000482

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

6. Influenza A(H5N2) - Multi-country (World) - Monitoring human cases

Overview

On 24 November 2025, WHO PAHO announced that an individual with avian influenza A(H5) infection, reported on 30 September 2025 by WHO and in the CDTR on 17 October 2025, was confirmed to be the second human case infected with avian influenza A(H5N2) virus in Mexico and globally. The infection was detected in a young woman with no underlying conditions. She was probably exposed to birds and a dog that were confirmed to have tested positive for avian influenza A(H5) in her residential area in Mexico City.

The first case was reported in a 59-year-old man from Mexico State in May 2024, with date of symptom onset 17 April 2024, who had underlying conditions and no travel history three weeks before disease onset, or any known exposure to poultry or animals. The patient was reported to have died due to complications associated with other underlying conditions. The infection was confirmed from a respiratory sample. Genetic analysis found that the HA segment of the virus had a 99% similarity to low pathogenic avian influenza A(H5N2) strains from birds in Texcoco, State of Mexico. Outbreaks of low pathogenic avian influenza A(H5N2) have been observed in poultry in the State of Mexico in 2024. It was not possible to establish an epidemiological link between the human case and the outbreak in poultry.

No new cases have been identified through epidemiological investigations among contacts of both cases. No human-to-human transmission has been detected.

The sequenced strain of the second case, A/Mexico City/INER_INF1427/2025 (EPI_ISL_20215425), belongs to clade 2.3.4.4b and, unlike the strain from the first case, has a highly pathogenic avian influenza signature in the HA segment. All segments were available but no mutations known to increase its zoonotic potential were found. As of 25 November 2025, there are no highly similar strains in the GISAID EpiFlu database.

We gratefully acknowledge all data contributors - i.e. the authors and their originating laboratories responsible for obtaining the specimens, and the submitting laboratories, responsible for generating the genetic sequence and metadata on which this research is based, and sharing via the GISAID Initiative.

Source: WHO PAHO, WHO Influenza at the human-animal interface summary and assessment, WHO DON, WAHIS, WHO DON

ECDC assessment

This is the second laboratory-confirmed human infection with avian influenza A(H5N2). Sporadic human cases of avian influenza A(H5Nx) have previously been reported globally. Despite the widespread transmission of avian influenza viruses in animals, transmission to humans remains infrequent and no sustained transmission between humans has been observed. Overall, the risk related to avian influenza A(H5) for the general population in the EU/EEA is considered low.

Direct contact with birds and other infected animals, their secretions or a contaminated environment is the most likely source of infection with zoonotic avian influenza viruses. The implementation of personal protective measures for people directly exposed to animals potentially infected with avian influenza viruses will reduce the associated risk.

Actions

ECDC monitors avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces an avian influenza overview which is updated on a quarterly basis. The most recent report was published in September 2025.

Last time this event was included in the Weekly CDTR: 28 June 2024.

7. Marburg virus disease (MVD) - Ethiopia - 2025

Update

Since the last update in the weekly CDTR on 21 November 2025, there has been six additional confirmed of Marburg Virus Disease (MVD) and cases and 5 additional deaths reported in Ethiopia.

According to media quoting the Ethiopian Ministry of health on 27 November, one of the cases has been confirmed in Hawassa City, Sidama Region after returning from Jinka City.

Event summary

Since the outbreak was confirmed on 14 November 2025 and as of 27 November 2025, 15 cases (12 laboratory confirmed and three probable) of Marburg Virus Disease (MVD) have been reported in Ethiopia, according to the Ministry of Health. A total of 11 deaths have been reported, eight of which have been among laboratory confirmed cases and three among probable cases (case fatality rate (CFR) among confirmed cases: 66.7%). According to media, the deaths include two healthcare workers.

As of 27 November, a total of three cases are being treated and two have recovered, according to the Ministry of Health. Cases have presented with symptoms including sudden fever, muscle pain, severe fatigue, headache, diarrhoea, vomiting and, in later stages, unexplained bleeding.

According to a press release from the Ethiopian Public Health Institute on 26 November 2025, 349 contacts have been identified, of which 119 have completed their 21 days of monitoring.

On 14 November 2025, the Ministry of Health of Ethiopia confirmed an MVD outbreak in Jinka city, southern Ethiopia and reported that there were 17 suspected cases. Jinka is in south-west Ethiopia, which is close to the border with South Sudan and Kenya. Jinka is a small market town with about 30 000 inhabitants. It is also the capital of South Omo region and a tourist hub for the area. It is two days away from Addis. A small airport has recently been inaugurated there.

According to WHO, the virus strain shows similarities to those previously identified in East Africa.

In response to the outbreak, the Ministry of Health of Ethiopia reported that community-level monitoring, contact tracing, and house-to-house case finding were being intensified. Response efforts to this event are underway by international partners.

Background on Marburg virus disease disease and previous outbreaks

MVD is a severe disease in humans caused by Marburg marburgvirus (MARV). A case fatality ratio of up to 88% has been observed previously. MVD is not an airborne disease and is not considered contagious before symptoms appear. Direct contact with the blood and other body fluids of an infected person or animal is the most frequent route of transmission. The incubation period for MVD is usually five to ten days (range 3–21 days). If proper infection prevention and control measures are strictly adhered to, the likelihood of infection is considered very low. To date, there is no specific antiviral treatment and no approved vaccine for MVD. All recorded MVD outbreaks have originated in Africa. Since 1967, when MVD was first detected, approximately 600 MVD cases have been reported as a result of outbreaks in Angola, the Democratic Republic of the Congo, Ghana, Guinea, Equatorial Guinea, Kenya, South Africa, Tanzania, and Uganda. In 2024, Rwanda reported its first MVD outbreak (66 cases including 15 deaths) which was declared over on 20 December 2024. In 2025, Tanzania reported its second MVD outbreak (two confirmed and eight probable cases, all fatal).

More information on MVD can be found in the ECDC Factsheet on Marburg virus disease.

ECDC assessment

The likelihood of exposure to MVD for EU/EEA citizens visiting or living in Ethiopia is assessed as low, with uncertainties connected to the limited epidemiological information available. The impact, assessed at population level, is low since the number of MVD cases in EU/EEA citizens in Ethiopia is expected to be very small. Therefore, the overall risk for EU/EEA citizens visiting or living in Ethiopia is low.

In the event of MVD cases being imported into the EU/EEA, we consider the likelihood of further transmission to be very low, and the associated impact low. Therefore, the overall risk for the EU/EEA is assessed as low.

Actions

ECDC is monitoring the event through epidemic intelligence activities and is in contact with partners to gather additional information.

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

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

Overview

Data presented in this report originate from several sources, both official public health authorities and non-official sources, such as the media. Case definitions,
testing strategies, and surveillance systems vary between countries. In addition, data completeness and levels of under-reporting vary between countries. All data should therefore be interpreted with caution. For details on the epidemiological situation and more information regarding the case definitions in use, refer to the original sources.

Update

Since 29 October 2025 and as of 25 November 2025, 15 394 new cholera cases, including 194 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Burundi, Chad, Ethiopia, Kenya, Mozambique, Myanmar/Burma, Nepal, South Sudan and Sudan

The five countries reporting most cases are Afghanistan (10 781), Angola (2 493), Sudan (1 117), Burundi (567) and Ethiopia (413).

New deaths have been reported from Afghanistan, Angola, Burundi, Chad, Ethiopia, Kenya, Mozambique, South Sudan and Sudan.

The five countries reporting most new deaths are Sudan (114), Angola (28), South Sudan (25), Chad (11) and Afghanistan (6).

Summary

Since 29 October 2025 and as of 25 November 2025, 15 394 new cholera cases, including 194 new deaths, have been reported worldwide. Since 1 January 2025 and as of 25 November 2025, 577 843 cholera cases, including 7 395 deaths, have been reported worldwide.

In comparison, between 1 January 2024 and 25 November 2024, 494 930 cholera cases, including 3 719 deaths, were reported worldwide.

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

Asia

Afghanistan

Since 13 October 2025 and as of 10 November 2025, 10 781 new cases, including six new deaths have been reported. Since 1 January 2025 and as of 10 November 2025, 153 849 cases, including 74 deaths have been reported. In comparison, in 2024, up to 9 November 2024, 160 794 cases, including 80 deaths were reported.

Myanmar/Burma

Since 13 October 2025 and as of 3 November 2025, 42 new cases have been reported. Since 1 January 2025 and as of 3 November 2025, 2 301 cases have been reported. In comparison, in 2024 and as of 11 November 2024, 7 498 cases were reported.

Nepal

Since 06 October 2025 and as of 17 November 2025, 217 new cases have been reported. Since 1 January 2025 and as of 17 November 2025, 2 018 cases have been reported. In comparison, in 2024 up to 23 September 2024, 95 cases were reported.

Africa

Angola

Since 27 October 2025 and as of 22 November 2025, 2 493 new cases, including 28 new deaths have been reported. Since 1 January 2025 and as of 22 November 2025, 34 679 cases, including 877 deaths have been reported. In comparison, in 2024 up to 25 November 2024, no cases were reported.

Burundi

Since 27 October 2025 and as of 22 November 2025, 567 new cases, including five new deaths have been reported. Since 1 January 2025 and as of 22 November 2025, 2 597 cases, including 11 deaths have been reported. In comparison, in 2024 up to 10 November 2024, 2 200 cases, including 12 deaths were reported.

Chad

Since 27 October 2025 and as of 22 November 2025, 235 new cases, including 11 new deaths have been reported. Since 1 January 2025 and as of 22 November 2025, 3 088 cases, including 167 deaths have been reported. In comparison, in 2024 up to 25 November 2024, no cases were reported.

Ethiopia

Since 27 October 2025 and as of 24 November 2025, 413 new cases, including three new deaths have been reported. Since 1 January 2025 and as of 24 November 2025, 8 249 cases, including 77 deaths have been reported. In comparison, in 2024 up to 26 October 2024, 25 383 cases, including 245 deaths were reported.

Kenya

Since 27 October 2025 and as of 22 November 2025, 111 new cases, including one new death has been reported. Since 1 January 2025 and as of 22 November 2025, 666 cases, including 26 deaths have been reported. In comparison, in 2024 up to 9 August 2024, 300 cases, including three deaths were reported.

Mozambique

Since 27 October 2025 and as of 22 November 2025, 165 new cases, including one new death has been reported. Since 1 January 2025 and as of 22 November 2025, 4 716 cases, including 46 deaths have been reported. In comparison, in 2024 up to 2 August 2024, 8 183 cases, including 17 deaths were reported.

South Sudan

Since 27 October 2025 and as of 22 November 2025, 747 less cases have been reported. Since 1 January 2025 and as of 22 November 2025, 78 034 cases, including 1 276 deaths have been reported. In comparison, in 2024 up to 18 November 2024, 114 cases, including two deaths were reported.

Sudan

Since 27 October 2025 and as of 22 November 2025, 1 117 new cases, including 114 new deaths have been reported. Since 1 January 2025 and as of 22 November 2025, 72 000 cases, including 2 074 deaths have been reported. In comparison, in 2024 up to 18 November 2024, 35 675 cases, including 794 deaths were reported.

No updates have been reported by Malawi to enable comparisons of cholera reporting in 2024 and 2025.

ECDC assessment

In 2025, cholera cases have continued to be reported in Africa and Asia, the Middle East and the Americas.

In this context, although the likelihood of cholera infection for travellers visiting these countries remains low, sporadic importation of cases to the EU/EEA is possible.

In the EU/EEA, cholera is rare and primarily associated with travel to endemic countries. Cholera reporting at the EU level is done on an annual basis, at the end of May for the previous year. In 2023, 12 confirmed cases were reported by five EU/EEA countries, while 29 were reported in 2022, two in 2021, and none in 2020. In 2019, 25 cases were reported in EU/EEA countries (including the United Kingdom). All cases had a travel history to cholera-affected areas.

According to the World Health Organization (WHO), vaccination should be considered for travellers at higher risk, such as emergency and relief workers who may be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek advice from travel health clinics to assess their personal risk and apply precautionary sanitary and hygiene measures to prevent infection. Such measures can include drinking bottled water or water treated with chlorine, carefully washing fruit and vegetables with bottled or chlorinated water before consumption, regularly washing hands with soap, eating thoroughly cooked food, and avoiding the consumption of raw seafood products.

Actions

- ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities.
- Reports are published on a monthly basis. The worldwide overview of cholera outbreaks is available on ECDC's website.

Last time this event was included in the Weekly CDTR: 7 November 2025.

Maps and graphs

Figure 1. Geographical distribution of cholera cases reported worldwide from September to November 2025

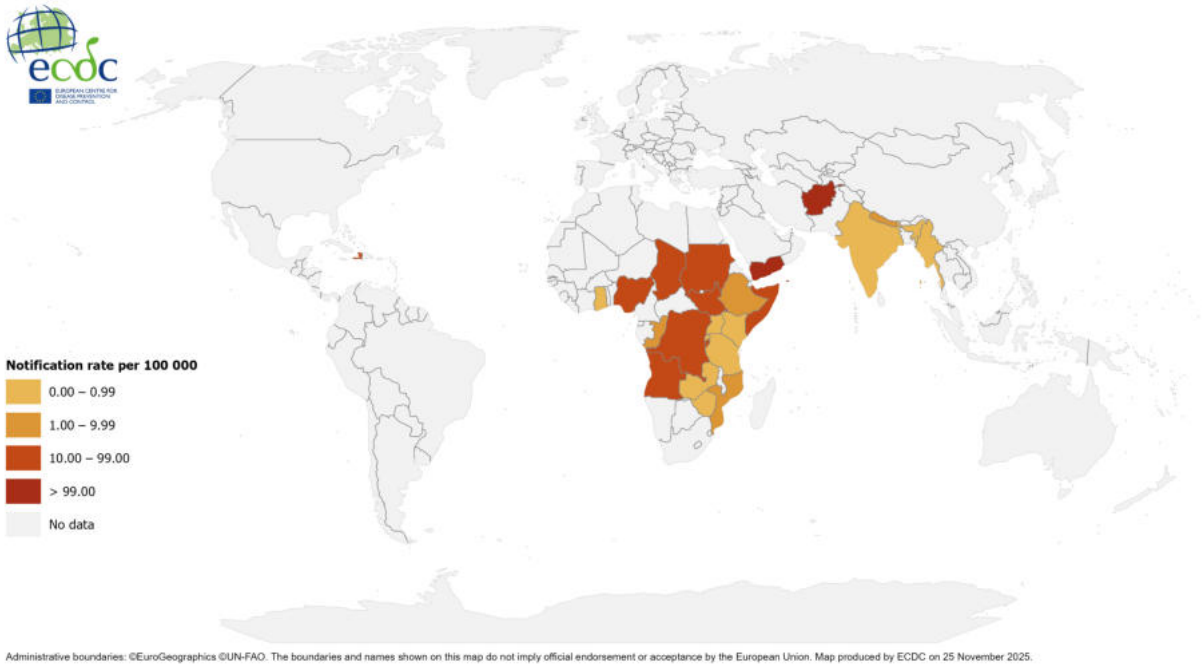
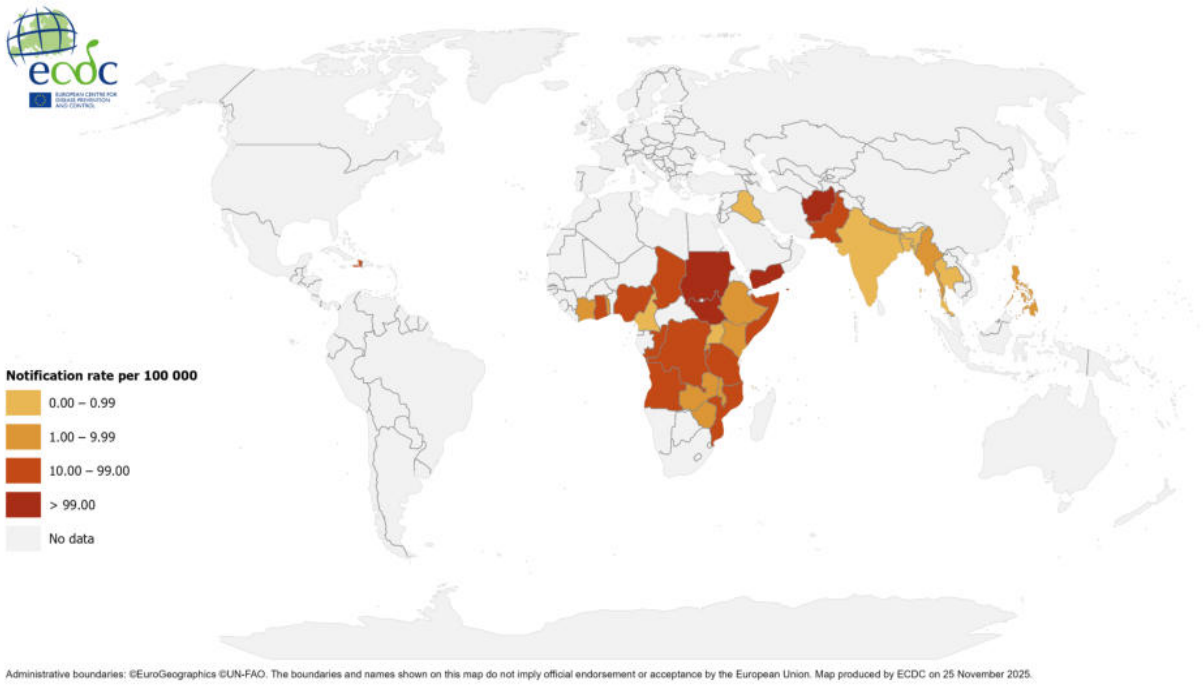


Figure 2. Geographical distribution of cholera cases reported worldwide from November 2024 to November 2025



9. Ebola virus disease – Democratic Republic of the Congo – 2025

Overview

On 19 October 2025, WHO announced that the last Ebola virus disease patient in DRC was discharged and initiated the 42-day countdown for declaring the outbreak over.

A total of 19 patients have recovered from the disease (29.7%) and no new cases have been reported since 26 September. As of 27 November, of the 1 735/1 787 (97.3%) contacts that were followed up, none are under active monitoring.

Since the outbreak was declared on 4 September 2025, and as of 27 November, there have been 64 cases (53 confirmed and 11 probable) and 45 deaths (34 confirmed and 11 probable) (CFR among all cases: 70.3%). All cases were reported in six health areas in Bulape health zone, Kasai Province.

Summary

On 1 September 2025, WHO received an alert regarding probable cases of Ebola virus disease (EVD) from Bulape health zone, Kasai Province. Following this alert, on 4 September, the DRC Minister of Public Health, Hygiene and Social Security declared an outbreak of EVD in the country.

The first reported case was in a pregnant woman, who was admitted to Bulape General Reference Hospital on 20 August with symptoms including fever, bloody diarrhoea, vomiting, asthenia, and anal, oral, and nasal haemorrhage.

The woman later died due to multiple organ failure. Samples tested on 3 September at the country's National Institute of Biomedical Research in the capital, Kinshasa, confirmed the cause of the outbreak as Zaire ebolavirus. Based on whole genome sequencing analysis, the causative strain is not linked to previous outbreaks and therefore this is probably a new zoonotic spill-over event. The initial phase of the outbreak was characterised by nosocomial spread and a superspreading event linked to the presumptive index case's funeral.

On 28 September, WHO reported that the majority of cases have occurred in women (37 cases; 57.8%), with patients' ages ranging from under one year to 65 years. Children aged from under one year to nine years and individuals aged 20–29 years accounted for 25.0% (16) and 23.4% (15) of cases, respectively. The most affected populations included children, housekeepers and farmers. From the beginning of the outbreak in epidemiological week 36 to epidemiological week 39, the median time between symptom onset and isolation shortened from five days to two.

Women represent 60% of reported deaths. At the beginning of the outbreak, a high proportion of cases and deaths occurred among children aged under one year to four years, and the CFR was very high. As the outbreak progressed, the number of cases among children decreased and the CFR has gradually declined. Four of the deaths were reported among healthcare workers. In Bulape health zone, the health areas of Dikolo (26 cases, 15 deaths) and Bulape (24 cases, 22 deaths) are considered to be the epicentres of the outbreak, together accounting for 78.1% of reported cases and 82.2% of all deaths.

Vaccination began in Kasai Province on 13 September. As of 16 November, a total of 44 453 people have been vaccinated. Alongside ring vaccination, geographically targeted vaccination began on 27 September for groups at high risk of infection in hotspots reporting confirmed cases. A total of 31 patients have been treated with monoclonal antibody (mAb114).

The last reported date of symptom onset was 23 September and the last cases were reported on 26 September in Bulape and Dikolo health areas, Bulape health zone.

Background and additional information

Ebola virus disease outbreaks in the DRC are recurrent, as the virus is present in animal reservoirs in many parts of the country. This is the sixteenth outbreak recorded since 1976 in DRC and the eighth since 2018.

The last EVD outbreak documented in DRC was in August 2022, in Beni health zone, North Kivu province, but this concerned only one case. In the same year, another five cases were reported from Mbandaka city, Equateur province. In 2007 and 2008, there were EVD outbreaks affecting Kasai province, including the Bulape and Mweka health zones in 2007. In the country overall, there have been 15 outbreaks since the disease was first identified in 1976.

Earlier in this outbreak, WHO AFRO reported that Bulape health zone is linked to large population centres such as Tshikapa and Kananga, and as there is ongoing cross-provincial and cross-border movement, there is a risk of further geographical spread.

The Ministry of Health is leading the outbreak response and is supported technically by WHO and other partners. A regional strategic response plan has been developed to guide coordinated efforts across affected and at-risk areas, focusing on surveillance, diagnostics, vaccination, infection prevention and control (IPC) and community engagement.

ECDC assessment

Ebola virus causes a severe, often fatal, disease. The current risk for people from the EU/EEA living in or travelling to Kasai province in DRC is estimated to be low, due to the low likelihood of exposure. For people living in the EU/EEA, the risk is very low, as the likelihood of importation and secondary transmission within the EU/EEA is very low.

Intense surveillance and contact tracing are essential to rapidly control outbreaks of viral haemorrhagic fevers.

Actions

ECDC is monitoring the situation through its epidemic intelligence activities. In addition, ECDC is in contact with Africa CDC, the Global Outbreak Alert Response Network (GOARN), and the European Commission (DG ECHO, DG SANTE, DG HERA).

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

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

Overview

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.

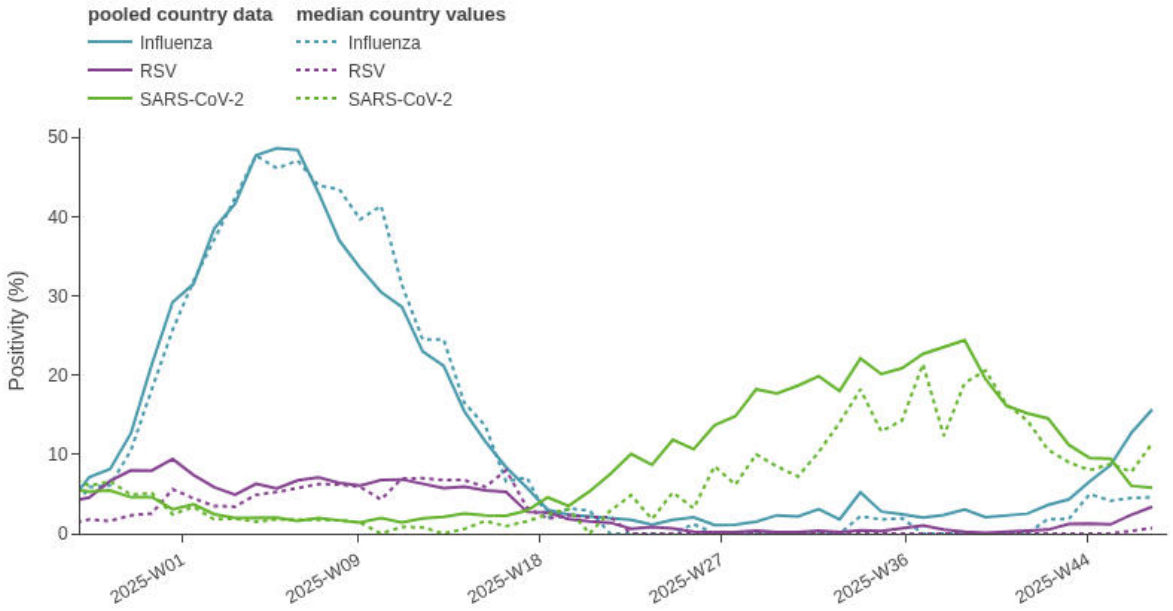
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

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

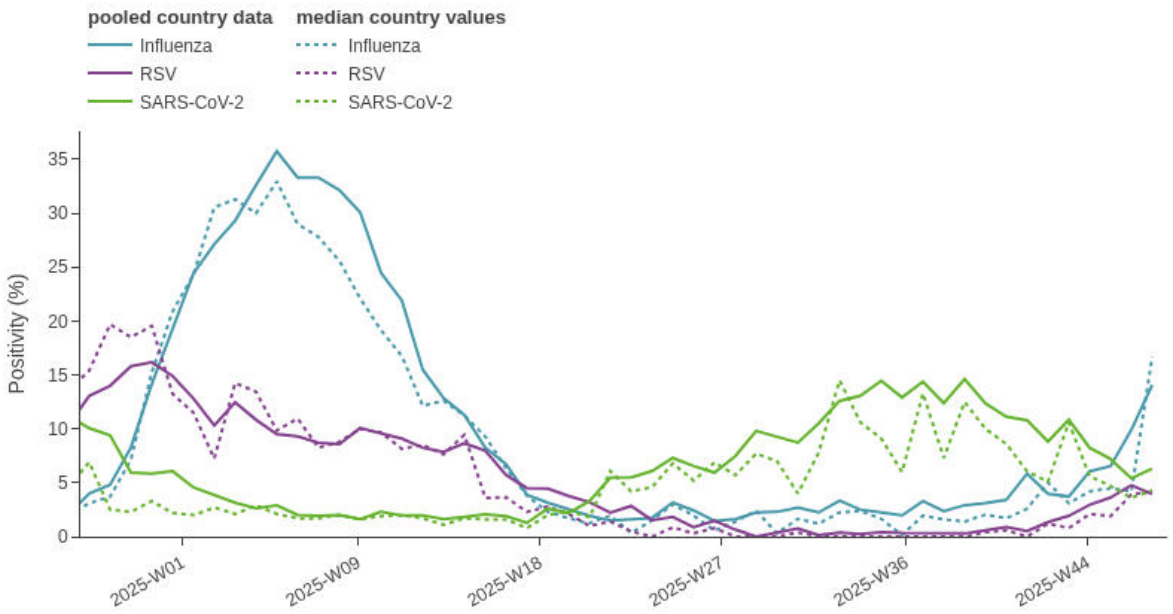
Maps and graphs

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. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 47	Week 46	Description	Value
ILI/ARI consultation rates in primary care	ARI	11 rates (9 MEM)	16 rates (11 MEM)	Distribution of country MEM categories	6 Baseline 3 Low
	ILI	15 rates (15 MEM)	20 rates (20 MEM)		10 Baseline 4 Low 1 Medium
ILI/ARI test positivity in primary care	Influenza	15	20	Pooled (median; IQR)	16% (4.6; 2.9–8.3%)
	RSV	15	19		3.4% (0.7; 0–3.6%)
	SARS-CoV-2	13	19		5.8% (11; 3.8–17%)
SARI rates in hospitals	SARI	8	11	–	–
SARI test positivity in hospitals	Influenza	7	9	Pooled (median; IQR)	14% (17; 8.7–22%)
	RSV	7	9		4% (4.2; 0.8–5.4%)
	SARS-CoV-2	7	8		6.3% (4.3; 3.3–5%)
Intensity (country-defined)	Influenza	18	24	Distribution of country qualitative categories	8 Baseline 8 Low 2 Medium
Geographic spread (country-defined)	Influenza	17	24	Distribution of country qualitative categories	1 No activity 5 Sporadic 2 Local 4 Regional 5 Widespread

Source: ECDC

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

	Week 47, 2025		Week 40, 2025 – week 47, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**256**	**–**	**1276**	**–**
Influenza A	251	99	1215	99
A(H1)pdm09	42	23	359	35
A(H3)	144	77	674	65
A (unknown)	65	–	182	–
Influenza B	2	0.8	14	1
B/Vic	0	–	0	–
B (unknown)	2	–	14	–
Influenza untyped	3	–	47	–
RSV	**55**	**–**	**221**	**–**
RSV-A	19	70	60	58
RSV-B	8	30	43	42
RSV untyped	28	–	118	–
SARS-CoV-2	**93**	**–**	**1856**	**–**

Source: ECDC

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

	Week 47, 2025		Week 40, 2025 – week 47, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**139**	**–**	**719**	**–**
Influenza A	103	100	553	98
A(H1)pdm09	11	30	140	60
A(H3)	26	70	95	40
A (unknown)	66	–	318	–
Influenza B	0	0.0	12	2
B/Vic	0	–	3	100
B (unknown)	0	–	9	–
Influenza untyped	36	–	154	–
RSV	**38**	**–**	**244**	**–**
RSV-A	5	62	59	60
RSV-B	3	38	40	40
RSV untyped	30	–	145	–
SARS-CoV-2	**63**	**–**	**1036**	**–**

Source: ECDC

Figure 6. **Genetically characterised influenza virus distribution, week 40, 2025 – week 47, 2025**

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	290	70	5a.2a.1(D.3.1)	283	98
			5a.2a.1(D)	5	2
			5a.2a(C.1.9.3)	2	0.7
A(H3)	119	29	2a.3a.1(K)	101	85
			2a.3a.1(J.2.4)	7	6
			2a.3a.1(J.2.2)	6	5
			2a.3a.1(J.2)	5	4
B/Vic	3	0.7	V1A.3a.2(C.5)	1	33
			V1A.3a.2(C.5.1)	1	33
			V1A.3a.2(C.5.6)	1	33

Source: ECDC

Figure 7. **SARS-CoV-2 variant distribution, week 45, 2025 - week 46, 2025**

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	2	8	2% (0–7%)
XFG	VUM	4	113	84% (72–94%)
NB.1.8.1	VUM	3	11	4% (2–8%)

Source: ECDC

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 28 November 2025
- Human cases infected with swine influenza A(H1N2) variant virus – Multi-country – 2024 - last reported on 28 November 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 28 November 2025
- Influenza A(H5N2) - Multi-country (World) - Monitoring human cases - last reported on 28 November 2025
- Hepatitis A - Multi-country (EU) - 2024-2025 - last reported on 28 November 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 28 November 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 28 November 2025
- Ebola virus disease – Democratic Republic of the Congo – 2025 - last reported on 28 November 2025
- Marburg virus disease (MVD) - Ethiopia - 2025 - last reported on 28 November 2025
- Influenza A(H5N5) - Multi-country (World) - Monitoring human cases - last reported on 28 November 2025
- Monkeypox virus clade Ib – Multi-country – 2025 - last reported on 26 November 2025
- Seasonal surveillance of dengue – 2025 - last reported on 21 November 2025
- Rift Valley fever in Western Africa – 2025 - last reported on 21 November 2025
- Mass gathering monitoring – Jubilee of 2025 in Italy - last reported on 21 November 2025
- Threat Assessment Brief under production - last reported on 21 November 2025
- Infant botulism - United States - 2025 - last reported on 21 November 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 14 November 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 14 November 2025
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 14 November 2025
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 14 November 2025
- Seasonal surveillance of West Nile virus infections – 2025 - last reported on 14 November 2025.