WEEKLY BULLETIN

Communicable Disease Threats Report

Week 49, 29 November – 5 December 2025

This week's topics

Executive summary

Recurrent multi-country outbreak of shigellosis in travellers returning from Cape Verde

- Reports of shigellosis cases among travellers returning from Cape Verde have been observed in the EU/EEA countries, the UK, and the US since September 2022. At the end of November 2025, five countries reported new increases in the number of cases infected with the outbreak strain in travellers returning from Cape Verde.
- Specific regions and locations within Cape Verde are reported to be affected. Available case interviews from 2025 indicate that the same hotel/resort chain as previously described is involved.
- The infections are primarily caused by a specific *S. sonnei* strain, as identified by whole genome sequencing, suggesting a common source, or a persistent route of transmission throughout the outbreak period.
- This is a recurrent outbreak of gastrointestinal diseases, where the underlying cause of transmission warrants further investigation so mitigation measures can be put in place to prevent further cases.

Overview of respiratory virus epidemiology in the EU/EEA

- The number of patients presenting to primary care with symptoms of respiratory illness above the baseline in approximately half of the reporting countries. This indicates that there is currently significant respiratory virus circulation in the European Union/European Economic Area (EU/EEA).
- **Influenza virus** circulation continues to increased with most countries now reporting widespread activity at low-to-medium intensity. 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. Increases in hospitalisation are being observed in some countries, affecting all age groups, but primarily in 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.
- **Respiratory syncytial virus (RSV)** circulation is slowly increasing from low levels, but remains below what was observed at this time in the past four seasons. Hospital data show rising RSV-related admissions in a few countries, primarily among children under five years.
- **SARS-CoV-2** continues to circulate but is decreasing in all age groups, and the impact on hospitalisations is currently limited.

HIV/AIDS surveillance 2025 - 2024 data

- HIV continues to impact health and well-being in the EU/EEA countries; 24 164 diagnoses were reported in 2024, which represents a rate of 5.3 per 100 000 population. This rate has decreased by 14.5% since 2015 when it was 6.2 per 100 000.
- The HIV epidemic is mainly driven by sexual transmission (96.0%), with 48.3% resulting from sex between men and 45.7% from heterosexual contact.
- When excluding cases with an unknown region of origin, the proportion of migrants among all reported HIV diagnoses in EU/EEA countries was of 55.7%.
- Late diagnosis (CD4 < 350 cells/mm³) remains high. In 2024, 48.0% of those reported were diagnosed late.
- High-impact combination prevention remains essential for populations at highest risk of HIV acquisition. This includes sexual health education, pre-exposure prophylaxis (PrEP), needle and syringe programmes (NSP), and opioid substitution therapy (OST). Equally critical are improved early diagnosis, expanded testing, seamless linkage to care, and rapid initiation of ART.

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

- As of 1 December 2025, additional results are available from genetic analysis for the sample from the second human case with influenza A(H5N2) infection.
- On 24 November 2025, the World Health Organization's Pan American Health Organization (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 her 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.

Weekly seasonal surveillance of West Nile virus infection – 2025

Since the beginning of 2025, and as of 3 December 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.*

Seasonal surveillance of chikungunya virus disease – 2025

- Since the beginning of 2025 and as of 3 December 2025, two countries in Europe have reported cases of chikungunya virus disease: **France** (788) and **Italy** (384).
- In week 49, no new cases were reported, and eight cases were eliminated after epidemiological review.
- As further cases are unlikely, given the current unfavourable seasonal weather conditions for vector-borne transmission, ECDC is concluding its weekly reports for the 2025 season.

Ebola virus disease – Democratic Republic of the Congo – 2025

- On 1 December 2025, WHO published a Disease Outbreak News Item announcing the end of the Ebola virus disease outbreak in the Democratic Republic of Congo (DRC).
- The 42-day countdown for declaring the outbreak over was initiated on 19 October 2025, following the discharge of the last patient being treated.
- A total of 64 cases (53 confirmed and 11 probable) of Ebola virus disease (EVD) were 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, Kasai Province.
- This was the sixteenth Ebola outbreak reported in DRC.

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 4 December, 16 cases (13 confirmed and three probable) of MVD have been reported, including 11 deaths (eight confirmed and three probable (case fatality rate (CFR): 61.5%)).
- Cases have been reported in two regions; Jinka city, Omo Zone, South Ethiopia Regional State and Hawassa City, Sidama Region.
- 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.

MERS-CoV - France ex. Arabian Peninsula - 2025

- On 3 December, French Ministry of Health reported two imported human Middle East respiratory syndrome coronavirus (MERS-CoV) cases with travel history to the Arabian Peninsula.
- Contact tracing and monitoring, and laboratory tests are ongoing. No secondary cases have been identified so far.
- The majority of MERS-CoV cases have been reported in the Middle East, with the latest imported case in the EU/EEA in 2014 and the most recent imported case in Europe in 2018, prior to the new cases.
- The probability of sustained human-to-human transmission among the general population in Europe remains very low and the impact of the disease in the general population is considered low.

1. Recurrent multi-country outbreak of shigellosis in travellers returning from Cape Verde

Overview

Event background

Reports of shigellosis cases, mainly caused by *Shigella sonnei*, among travellers returning from Cabo Verde, a group of islands close to Western coast of Africa, have been observed in the EU/EEA countries, the UK, and the US since September 2022. The outbreak evolved rapidly during November and December 2022 and ECDC published a Rapid Risk Assessment (RRA) in February 2023. At the time 10 EU/EEA countries, as well as the UK and the US, reported at total of 258 cases linked to recent travel to Cape Verde and/or isolates clustering by whole genome sequencing. As described in the RRA, most cases had stayed in five-star, all-inclusive hotels in the Santa Maria region of the island Sal. Co-infections with other bacterial and parasitic gastrointestinal pathogens were also reported.

Upsurge in cases in 2025

At the end of November 2025, four EU/EEA countries and the UK notified ECDC of a recent increase in travel-related cases infected with the implicated *S. sonnei* outbreak strain, mainly observed during the period September-November 2025.

- **The Netherlands** reported a total of **eight** cases occurring in September and October 2025. Case interviews indicate the same hotel/resort chain as in 2022, with a possible extension to the same chain on the island Boa Vista. Five cases are female, two are male, and one case has no information on gender.
- **Sweden** reported an increase in shigellosis cases among travellers returning from Cape Verde with **26 cases** in 2025 (until 3 Dec 2025) 23 of which have been reported since 24 of October (15 confirmed and eight suspected). Median age was 52 years (range: 14–77 years), and the majority were women (n=16). According to available information, most cases stayed at various hotels on the islands of Sal (Santa Maria area) or Boa Vista, and contaminated food is the most reported route of transmission. During this period, cases of other gastrointestinal infections (n=4 salmonellosis and n=1 campylobacteriosis) were also reported among returning travellers. No co-infections were reported.
- **France** reported, after two years with lower numbers of cases (n=6 in 2023 and n=5 in 2024) an increase in 2025 (n=**21**). Ten cases were female and 11 were male with age range 2-62 years. The majority (n=16) reported recent travel to Cape Verde, two indicated no recent travel abroad and for three cases travel information was not available.
- **The UK** reported an increase in cases associated with travel to Cape Verde, with most cases reported in October. As of 4 December 2025, a total of 137 confirmed cases have been reported in the UK since 1 October 2025. Of these, **116** cases reported international travel, with 94% reporting recent travel to Cape Verde (=**109 cases**). For those with hotel information available (n=75 cases), 71 reported staying at hotels in the Santa Maria and Boa Vista areas.
- **Ireland** reported one case infected with the outbreak strain, with travel history to Cape Verde in mid-January 2025.

In total, for 2025, at least 193 cases of shigellosis have been reported to ECDC to be associated to the outbreak as of 3 December.

The outbreak strain shows limited genetic antibiotic resistance markers, however, most isolates harbour *dfrA1* predicting resistance to trimethoprim. **SRA accessions** for representative outbreak sequences available for download for comparison are SRR22099609, SRR18143656 and SRR22085217. The outbreak strain belongs to hierarchical cluster profile HC5_181425 (EnteroBase).

The infections are primarily caused by a specific *S. sonnei* strain suggesting a common source, or a persistent route of transmission throughout the outbreak period. Gastrointestinal infections caused by other pathogens have also been noted. Country reports show affected travellers stayed in 5-star, all-inclusive hotels located in the region Santa Maria on the island Sal or the island Boa vista.

Information on possible vehicles of infection or common exposures have not yet been reported. Multiple modes of transmission are plausible, with the most likely being foodborne, but person-to-person transmission cannot be excluded.

Given that the same strain has been implicated over several years, the underlying cause of transmission warrants further investigation.

ECDC assessment

Based on limited data as of December 2025, and with a degree of uncertainty, the risk for EU/EEA citizens travelling to Cape Verde of contracting shigellosis is assessed to be moderate.

Actions

ECDC is monitoring the event in EpiPulse, following epidemiological updates and the genomic cluster of the outbreak strain. The centre also liaises with WHO Euro and INFOSAN to further inform local authorities.

If countries identify isolates clustering with the representative outbreak sequences, a possible connection with travel to Cape Verde should be considered.

Sources: Rapid Risk Assessment was published on 17 February 2023 on ECDC's website: | Outbreak of *Shigella sonnei* in the EU/EEA, the United Kingdom, and the United States | https://www.ecdc.europa.eu/en/publications-data/outbreak-shigella-sonnei-eueea-united-kingdom-and-united-states-among-travellers | Outbreak of *Shigella sonnei* associated with travel to Cape Verde HPR volume 19 issue 11: news (4 December 2025) - GOV.UK

Last time this event was included in the Weekly CDTR: 11 November 2022.

2. 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.

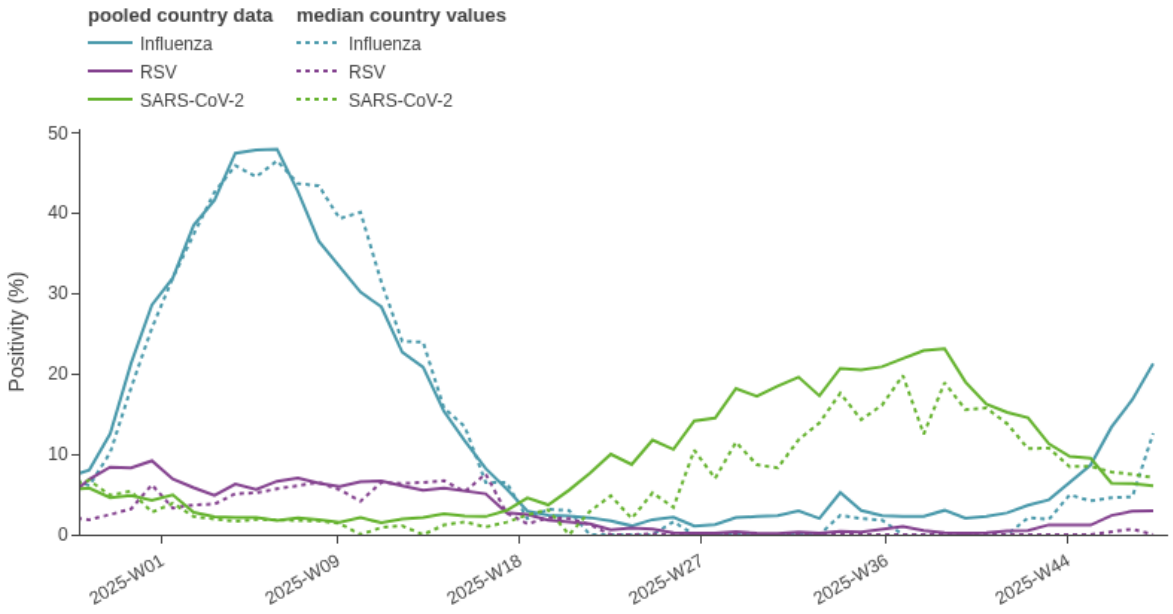
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

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

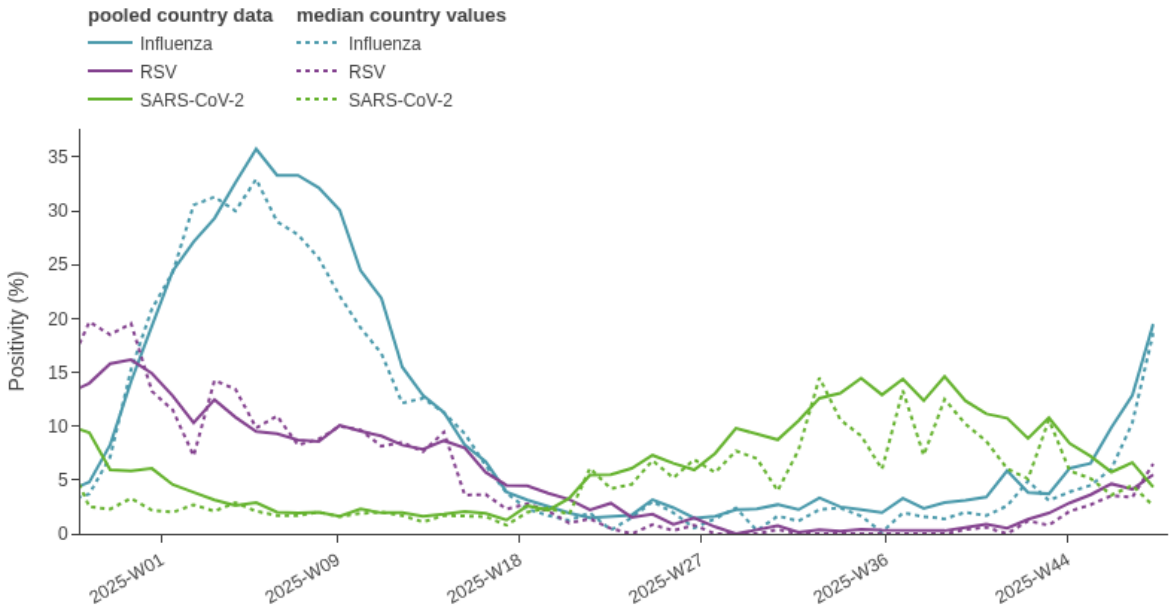
Maps and graphs

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 48**	**Week 47**	**Description**	**Value**
ILI/ARI consultation rates in primary care	ARI	14 rates (9 MEM)	18 rates (12 MEM)	Distribution of country MEM categories	7 Baseline 2 Low
	ILI	19 rates (19 MEM)	21 rates (21 MEM)		9 Baseline 6 Low 4 Medium
ILI/ARI test positivity in primary care	Influenza	17	22	Pooled (median; IQR)	21% (13; 8.1–24%)
	RSV	17	20		3% (0; 0–2.8%)
	SARS-CoV-2	16	20		6.1% (7.1; 3.1–14%)
SARI rates in hospitals	SARI	9	11	–	–
SARI test positivity in hospitals	Influenza	8	9	Pooled (median; IQR)	19% (19; 12–26%)
	RSV	8	9		5.5% (6.5; 2.5–11%)
	SARS-CoV-2	8	8		4.3% (2.6; 1.7–5.1%)
Intensity (country-defined)	Influenza	22	26	Distribution of country qualitative categories	5 Baseline 12 Low 5 Medium
Geographic spread (country-defined)	Influenza	21	25	Distribution of country qualitative categories	1 No activity 5 Sporadic 1 Local 3 Regional 11 Widespread

Source: ECDC

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

	Week 48, 2025		Week 40, 2025 – week 48, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**591**	**–**	**2161**	**–**
Influenza A	584	99	2109	99
A(H1)pdm09	78	16	526	29
A(H3)	402	84	1281	71
A (unknown)	104	–	302	–
Influenza B	3	0.5	18	0.8
B/Vic	0	–	0	–
B (unknown)	3	–	18	–
Influenza untyped	4	–	34	–
RSV	**74**	**–**	**322**	**–**
RSV-A	13	59	76	58
RSV-B	9	41	56	42
RSV untyped	52	–	190	–
SARS-CoV-2	**149**	**–**	**2129**	**–**

Source: ECDC

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

	Week 48, 2025		Week 40, 2025 – week 48, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**305**	**–**	**1132**	**–**
Influenza A	240	99	904	98
A(H1)pdm09	21	31	171	52
A(H3)	46	69	156	48
A (unknown)	173	–	577	–
Influenza B	2	0.8	14	2
B/Vic	0	–	3	100
B (unknown)	2	–	11	–
Influenza untyped	63	–	214	–
RSV	**66**	**–**	**330**	**–**
RSV-A	7	70	67	60
RSV-B	3	30	44	40
RSV untyped	56	–	219	–
SARS-CoV-2	**70**	**–**	**1185**	**–**

Source: ECDC

Figure 6. **Genetically characterised influenza virus distribution, week 40, 2025 – week 48, 2025**

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	322	66	5a.2a.1(D.3.1)	315	98
			5a.2a.1(D)	5	2
			5a.2a(C.1.9.3)	2	0.6
A(H3)	163	33	2a.3a.1(K)	143	88
			2a.3a.1(J.2.2)	7	4
			2a.3a.1(J.2.4)	7	4
			2a.3a.1(J.2)	6	4
B/Vic	3	0.6	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 46, 2025 - week 47, 2025**

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	3	3	4% (4–5%)
XFG	VUM	3	55	83% (75–86%)
NB.1.8.1	VUM	3	10	9% (7–16%)

Source: ECDC

3. HIV/AIDS surveillance 2025 - 2024 data

Overview

In 2024, a total of 24 164 HIV diagnoses were reported across 30 EU/EEA countries, resulting in a rate of 5.3 per 100 000 population. This rate has decreased by 14.5% since 2015 when it was 6.2 per 100 000.

Sex between men was the most reported mode of transmission in the EU/EEA in 2024, accounting for 48.3% (8 614) of all reported diagnoses and 53.2% of cases where the mode of transmission was known. Between 2015 and 2024, the proportion of HIV diagnoses attributed to sex between men declined from 52.9% to 48.3% of all diagnoses in countries reporting consistently. Heterosexual transmission was the second most common mode of HIV transmission in the EU/EEA, accounting for 33.6% (8 115) of all HIV diagnoses and 45.7% of diagnoses with a known mode of transmission. Injecting drug use accounts for 3.5% of all reported diagnoses and 4.7% of diagnoses with known mode of transmission, while mother-to-child transmission accounts for 0.8%. Information regarding mode of transmission was not available for 26.1% of the cases diagnosed in 2024.

In 2024, migrants (defined as people born outside the reporting country) comprised 47.2% of all HIV diagnoses in the EU/EEA. Among the migrant population, 32.2% were from Sub-Saharan Africa, 26.4% from Central and Eastern Europe, 24.4% from Latin America and the Caribbean, 5.2% from Western Europe, 5.3% from South and South-East Asia, and 6.5% from other regions. When excluding cases with an unknown region of origin, the proportion of migrants among all reported HIV diagnoses in EU/EEA countries reporting consistently rose from 33.1% in 2015 to 55.7% in 2024: a 45.4% increase over this period.

In 2024, 27 EU/EEA countries reported CD4 cell count data at the time of HIV diagnosis (11 796 cases). Among these, 48.0% were classified as late diagnoses (CD4 < 350 cells/mm³) at the time of diagnosis. Late diagnosis was higher among women, adults over 40, people who acquired HIV through heterosexual transmission, people who inject drugs and migrants from South and South-East Asia and Sub-Saharan Africa.

In 2024, 2 215 AIDS diagnoses were reported across 25 EU/EEA countries, resulting in a crude rate of 0.7 cases per 100 000 people. Over the past decade, the rate of reported AIDS cases decreased by 30.0%. In 2024, *Pneumocystis jirovecii* pneumonia represented the most frequent AIDS-defining illness (22.4% of cases), while tuberculosis (pulmonary and extrapulmonary) accounted for 11.7%.

ECDC assessment

The decreasing trend should be interpreted with caution, as it may reflect reporting artefacts rather than a true epidemiological reduction, since standard reporting-delay adjustments were not applied. At the same time, it could also indicate a genuine decline in transmission driven by expanded antiretroviral therapy, wider test-and-treat implementation, increased pre-exposure prophylaxis (PrEP) use, more frequent testing among key populations, strengthened harm-reduction services, and the post-COVID-19 restoration of prevention and care.

Interventions to control the epidemic should be based on evidence and adapted to national and local epidemiology, including:

1. Expansion of HIV testing. WHO and ECDC recommend innovative approaches to expand the possibilities for HIV testing to key population groups including migrants, both within healthcare settings and in the community, using methods such as self-testing and community testing by lay providers (1,2,3).
2. Ensure rapid linkage to care and early initiation of antiretroviral therapy (ART) after diagnosis. This will lead to improved health outcomes for individuals receiving treatment and a significant reduction in onward HIV transmission (4,5,6).
3. To enhance HIV prevention among migrants, countries should expand access to primary services such as condom distribution, sexuality education, and PrEP. It is crucial to ensure that testing and treatment are available regardless of residency or migration status. To reduce structural barriers, prevention and testing services must be inclusive, accessible, and free of stigma. This includes offering migrant-inclusive community services, ensuring rapid linkage to care, and providing prevention that is culturally and linguistically adapted.
4. Countries should explore the feasibility of expanding primary HIV prevention services, including condom provision programmes and pre-exposure prophylaxis (PrEP) implementation in key populations. To reach a broader population, consider reviewing and expanding the settings where PrEP is available. Integrating PrEP provision with regular testing and facilitating prompt linkage to care can effectively contribute to reducing HIV incidence among MSM and other key populations.
5. Heterosexual transmission is increasing in the EU/EEA countries, becoming a significant mode of transmission, with a notable prevalence of late diagnoses in this group. Expanding targeted testing, including indicator condition-guided testing, emergency department testing and awareness-raising among healthcare workers to encourage them to carry out risk-based targeted screening can all improve early HIV detection in this population.
6. Countries should expand or maintain comprehensive harm-reduction services, including needle syringe exchange and opioid substitution programmes, while ensuring accessible testing for blood-transmitted infections, such as hepatitis B and C among individuals who inject drugs. This integrated preventive approach is crucial in order to achieve the Sustainable Development Goal (SDG) for this population by 2030.
7. Improved monitoring and surveillance, particularly of previous positive cases, CD4 cell count, and country of birth, is needed to adequately capture and report HIV cases in the context of changing epidemiology.

Actions

ECDC, together with its partners, will continue to support Member States in their efforts to accelerate progress towards achieving the Sustainable Development Goal 3.3 and UNAIDS targets for HIV through dedicated guidance, workshops, training, webinars, and other technical support focused on high-impact surveillance, monitoring, treatment, and prevention activities.

Further information

For the latest update on HIV surveillance 2025 (2024 data) please see ECDC's webpage.

Last time this event was included in the Weekly CDTR: 29 November 2024.

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

Overview

Genetic analysis

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. The HA segment is highly divergent from the LPAI A(H5N2) strains collected from the human case and birds in Mexico in 2024. The recent case clusters more closely with A(H5N1) viruses of clade 2.3.4.4b genotype B3.2.

In a recent pre-print, the authors suggest that the strain is a result of a reassortment event between an enzootic LPAI A(H5N2) virus ancestor from 2024, detected in Central Mexico, and A(H5N1) clade 2.3.4.4b genotype B3.2 viruses. A new genotype designation, B3.14, is also proposed.

Although no mutations known to increase its zoonotic potential were found in the consensus sequence deposited on GISAID, minor variants of K526R and E627K in PB2 are reported from deeper analysis of sequencing reads. Isolates carrying both 526R and 627K replicate more efficiently in mammalian cells.

Background

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 of the sample from the first case 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) were observed in poultry in the State of Mexico in 2024. It was not possible to establish an epidemiological link between the first human case and the outbreak in the State of Mexico.

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

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 - for having shared 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 November 2025.

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

Overview

Since the beginning of 2025, and as of 3 December 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: 28 November 2025.

6. Seasonal surveillance of chikungunya virus disease – 2025

Overview

Since the beginning of 2025 and as of 3 December 2025, two countries in Europe have reported cases of chikungunya virus disease: **France** (788) and **Italy** (384). This week, no new cases of chikungunya virus disease have been reported to ECDC.

No new locally acquired cases have been reported by France this week. France eliminated seven cases and one cluster (in Orléans) after epidemiological review. The cumulative number of locally acquired cases in France is therefore 788, distributed across 78 clusters. Three 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. Italy discarded one case and its cluster (in Scanzano Jonico). The cumulative number of locally acquired cases in Italy is therefore 384, distributed across six clusters. Two clusters are currently active, with the latest reported date of onset 11 November. The largest cluster is located across the towns of Carpi, San Prospero, Soliera, Novellara, Cavezzo, Modena, Nonantola, Correggio, Novi di Modena, and Cesenatico.

As further cases are unlikely, given the current unfavourable seasonal weather conditions for vector-borne transmission, ECDC is concluding its weekly reports for the 2025 season.

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: 28 November 2025.

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

Overview

Update

On 1 December 2025, WHO published a Disease Outbreak News (DON) Item announcing the end of the Ebola virus disease outbreak in DRC. According to the DON, no new cases have been detected in the past 42 days, since the last confirmed case was discharged from treatment on 19 October 2025. The country is now beginning a 90-day period of enhanced disease surveillance.

Event 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. Since the outbreak was declared on 4 September 2025, there were 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.

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 recovered from the disease (29.7%) and the last case was reported on 26 September. All 1 735/1 787 (97.3%) contacts that were followed up, completed their monitoring.

The first reported case was in a pregnant woman, who was admitted to Bulape General Reference Hospital on 20 August 2025 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 2025 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.

Vaccination began in Kasai Province on 13 September 2025. According to WHO, as of 1 December 2025, a total of 48 000 people have been vaccinated. Alongside ring vaccination, geographically targeted vaccination began on 27 September 2025 for groups at high risk of infection in hotspots reporting confirmed cases. A total of 31 patients were treated with monoclonal antibody (mAb114).

The last reported date of symptom onset was 23 September 2025 and the last cases were reported on 26 September 2025 in Bulape and Dikolo health areas, Bulape health zone. According to WHO AFRO, The 42-day countdown for declaring the outbreak over was initiated on 19 October, following the discharge of the last patient being treated.

Background and additional information

Background

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 related to 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.

Additional information

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 was a risk of further geographical spread.

On 28 September 2025, WHO reported that the majority of cases 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 2025, the median time between symptom onset and isolation shortened from five days to two.

Women represented 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 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.

The Ministry of Health led the outbreak response and was supported technically by WHO and other partners. A regional strategic response plan was 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. During the outbreak, the risk for people from the EU/EEA living in or travelling to Kasai province in DRC was estimated to be low, due to the low likelihood of exposure. For people living in the EU/EEA, the risk was 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 was monitoring the situation through its epidemic intelligence activities. In addition, ECDC was 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: 28 November 2025.

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

Overview

Event summary

Since 28 November 2025, there has been one additional confirmed case of Marburg Virus Disease (MVD) reported in Ethiopia. The total number of contacts listed is 349, of which 119 (34.1%) have completed their monitoring, according to a press release from the Ethiopian Public Health Institute on 26 November 2025.

Since the outbreak was confirmed on 14 November 2025 and as of 4 December 2025, 16 cases (13 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 in laboratory-confirmed cases and three in probable cases (case fatality rate (CFR) among confirmed cases: 61.5%). According to media, the deaths include two healthcare workers.

Cases have presented with symptoms including sudden fever, muscle pain, severe fatigue, headache, diarrhoea, vomiting and, in later stages, unexplained bleeding. As of 4 December, a total of four cases have recovered and one is being treated, according to the Ministry of Health.

Cases have been reported in two regions; Jinka city, Omo Zone, South Ethiopia Regional State and Hawassa City, Sidama Region. Jinka city, is considered the epicentre of the outbreak, according to Africa CDC. According to media quoting the Ethiopian Ministry of Health on 27 November, one of the cases was confirmed in Hawassa City, Sidama Region, after returning from Jinka City.

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 Ababa. 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: 28 November 2025.

9. MERS-CoV- France ex. Arabian Peninsula - 2025

Overview

Summary: On 3 December 2025, the French Ministry of Health reported two imported human Middle East respiratory syndrome coronavirus (MERS-CoV) cases with travel history to the Arabian Peninsula. The two cases were part of the same group trip.

The following measures have been taken: identifying and monitoring of close contacts, contacting and monitoring high-risk contacts and testing (pauci-)symptomatic persons. No secondary cases have been identified so far.

Background: Since the beginning of 2025, and as of 1 December 2025, 12 MERS-CoV cases have been reported in Saudi Arabia with date of onset in 2025, including three fatalities.

Since April 2012, and as of 1 December 2025, a total of 2 640 cases of MERS-CoV, including 958 deaths, have been reported by health authorities worldwide. The majority of these have been reported in the Middle East, with the latest imported case in the EU/EEA in 2014 and the latest imported case in Europe in 2018, prior to the new cases.

ECDC assessment

The majority of the human cases of MERS-CoV continue to be reported in the Arabian Peninsula. Moreover, the number of new cases detected and reported through surveillance has dropped to the lowest level since 2014. Sporadic MERS-CoV cases in travellers returning to EU/EEA can be expected.

European public health authorities should remain vigilant, continue surveillance of acute respiratory infections and maintain preparedness for travel-related MERS-CoV cases entering the EU/EEA. Information about the risk should be shared with clinicians to maintain increased awareness for early identification, isolation and diagnosis of possible MERS-CoV. Adherence to strict infection control protocols through contact with possible cases is critical to prevent the further spread of MERS-CoV in healthcare settings. Previously issued advice for travellers, including pilgrims and healthcare workers, remains valid. Close contact with dromedary camels, consumption of raw/undercooked camel products, such as milk, and transmission in hospital settings are the main sources of infection.

Countries should advise travellers returning from all areas affected by MERS-CoV to seek medical attention if they develop a respiratory illness with fever and cough or diarrhoea during the two weeks following their return and to disclose their recent travel history to their healthcare provider.

The probability of sustained human-to-human transmission among the general population in Europe remains very low and the impact of the disease in the general population is considered low. The current MERS-CoV situation poses a low risk to the EU/EEA, as stated in the Rapid Risk Assessment published by ECDC on 29 August 2018.

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

Actions

ECDC is in contact with French authorities and WHO and has published a news item on its website.

ECDC is monitoring this event through its epidemic intelligence activities, and will report when new epidemiological information is available.

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
- Recurrent multi-country outbreak of shigellosis in travellers returning from Cabo Verde - last reported on 5 December 2025
- HIV/AIDS surveillance 2025 - 2024 data - last reported on 5 December 2025
- MERS-CoV - France ex. Arabian Peninsula - 2025 - last reported on 5 December 2025.