

WEEKLY BULLETIN

Communicable disease threats report

Week 6, 1–7 February 2025

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Executive Summary

Mpox due to monkeypox virus clade I – Ireland – 2025

- On 6 February 2025, Ireland reported its first mpox case due to monkeypox clade I. The case reported travel history to the Democratic Republic of Congo (DRC).
- Contact tracing and the epidemiological investigation are ongoing.
- Considering the measures implemented by Ireland, the risk for the general population in the EU/EEA related to this importation remains low, given a very low likelihood of further spread and a low impact. The [ECDC Rapid Risk Assessment](#) published on 16 August 2024 remains valid.

***Shigella sonnei* ST152 outbreak associated with international travel on long-haul flights**

- A multi-country outbreak of *Shigella sonnei* ST152 has been observed, affecting 38 cases in five countries: UK (20), Austria (7), France (7), Ireland (3) and the Netherlands (1), likely caused by a point-source exposure during mid-January 2025.
- Cases reported international intercontinental long-haul travel transiting through a single airport but to different final destinations prior to disease onset.
- Case isolates are very tightly clustered by whole genome sequencing and have isolation or disease onset dates over a restricted 10-day period in mid-January.

Overview of respiratory virus epidemiology in the EU/EEA

- Primary and secondary care consultation rates in several countries in recent weeks indicate that there is significant respiratory virus activity in the EU/EEA. Seasonal influenza and respiratory syncytial virus (RSV) epidemics are ongoing, while SARS-CoV-2 activity is at a very low level.
- All indicators point to widespread and mainly medium influenza activity in the EU/EEA, with most countries continuing to observe an increase in test positivity rates. Hospital admissions due to influenza are currently at levels observed during previous epidemic peaks in most countries. Hospitalisation due to influenza is known to place significant pressure on healthcare systems and to strain hospital capacity. People aged 45 years and above have the highest risk of severe outcomes, highlighting the continued need for targeted prevention measures (e.g. vaccination).
- RSV activity varies across the EU/EEA, with some countries having passed the peak of the epidemic and others continuing to see an increase in test positivity rates. Hospital admissions due to RSV remain at a high level in children aged under five years and people aged 65 years and above.
- ECDC has published recommended actions for response during the winter season 2024/2025 in an [epidemiological update](#). Vaccination is the most effective measure to protect against more severe forms of viral respiratory diseases. Those eligible for vaccination, particularly those at higher risk of severe outcomes, are encouraged to get vaccinated. Clinicians should be reminded that, when indicated, the early use of antivirals against influenza may prevent progression to severe disease in vulnerable groups.
- Non-pharmaceutical interventions such as frequent hand-washing, physical distancing and avoiding large gatherings can also be advantageous for epidemic control in the countries. The wearing of masks in healthcare settings and long-term healthcare facilities during the peak of influenza season could be considered as a way to reduce transmission to vulnerable people.

Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025

- After 10 years since the last occurrence, France reported an autochthonous case of chikungunya virus disease in the Department of La Réunion, with onset of symptoms on 12 August 2024.
- Following that and as of 2 February 2025, 529 cases of autochthonous chikungunya virus disease have been confirmed in La Réunion.

SARS-CoV-2 variant classification

Since the last update on 20 December 2024, and as of 31 January 2025, no changes have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants.

The VOI median proportions in the EU/EEA for weeks 2–3, based on six reporting countries, are currently:

- KP.3: 18.3% (range: 0.0%–44.4%; IQR: 5.9%–24.3%);
- BA.2.86: 19.6% (range: 0.0%–30.8%; IQR: 8.3%–27.1%).

The VUM median proportions in the EU/EEA for weeks 2–3, based on six reporting countries, are currently:

- XEC: 66.5% (range: 27.8%–90.6%; IQR: 52.9%–76.2%).

The calculations are based on data reported to GISAID, as of 26 January 2025.

The currently circulating variants that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and previously uninfected individuals could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (e.g. older adults) remains important.

Ebola virus disease – Uganda – 2025

- On 30 January 2025, the public health authorities of Uganda declared an outbreak of Ebola in Kampala.
- According to the Ministry of Health's press release, the index case occurred in a 32-year-old man working as a nurse at the Mulago National Referral Hospital.
- On 6 February, WHO reported that a total of seven cases, including one death, have been confirmed.

- Since the index case occurred in a healthcare worker in a hospital, EU/EEA citizens working in healthcare settings in Uganda should be aware of the ongoing outbreak and take appropriate personal protection measures. In the current epidemiological situation, the likelihood of importation in the EU/EEA is very low.

Yellow fever – South America – 2024–2025

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

Avian influenza A(H5N1) human cases – United States – 2024

- On 31 January 2025, the United States Department of Agriculture ([USDA](#)) confirmed by whole genome sequencing the first detection of HPAI A(H5N1) clade 2.3.4.4b, genotype D1.1 in dairy cattle (all previous detections of HPAI in cattle have been A(H5N1) clade 2.3.4.4b, genotype B3.13).
- One of the concerns related to this event is that genotype D1.1 is known to cause more severe illness to infected humans. However, it is not yet clear whether viruses of this genotype can transmit efficiently among dairy cattle.
- According to the United States Centers for Disease Control and Prevention (US CDC), the risk to the general population remains low, while farmers and workers who work with infected animals or their by-products, backyard bird flock owners, animal care workers (e.g. veterinarians, wild animal facility workers), and animal health and public health responders are at increased risk of infection with A(H5N1).
- As of 17 January 2025, a total of 67 human cases of avian influenza A(H5) have been reported from 10 states in the United States (US) during 2024. Of these, 40 were individuals exposed to dairy cattle known or presumed to be infected with A(H5N1) and 23 were workers exposed to outbreaks of HPAI A(H5) at poultry farms. Three people had no known animal exposure and one had exposure to other animals, such as backyard flocks, wild birds, or other mammals.

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

- Since the previous update on 8 January 2025, and as of 5 February 2025, no new MERS-CoV cases have been reported by the World Health Organization (WHO) or by national health authorities.
- Since the beginning of 2025, and as of 5 February 2025, no MERS-CoV cases have been reported with date of onset in 2025.
- The risk of sustained human-to-human transmission in Europe remains very low and the current MERS-CoV situation poses a low risk to the EU/EEA.

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

- Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries, with the epidemiological trends remaining largely unchanged.
- The Democratic Republic of the Congo (DRC), Burundi, and Uganda are the countries that have reported most mpox clade Ib cases in Africa. In recent weeks, a plateau in the number of cases has been observed in DRC, a decreasing trend in Burundi and an increasing trend in Uganda.
- Outside Africa, since the previous update published on 31 January 2025, new mpox clade Ib cases have been reported in the United Kingdom (UK), while Ireland has reported a case of mpox clade I.
- ECDC is closely monitoring and assessing the epidemiological situation, and additional related information can be found in the Centre's rapid risk assessment published on 16 August 2024 (['Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries'](#)) and its ['Rapid scientific advice on public health measures'](#).

1. Mpox due to monkeypox virus clade I – Ireland – 2025

Overview:

On 6 February 2025, Ireland [reported](#) its first mpox case due to monkeypox clade I. The case reported travel history to the DRC and is now receiving specialist care in a hospital in Dublin. Contact tracing and an epidemiological investigation are ongoing.

For more information on the global update regarding MPXV clade Ib, please refer to the 'Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025' item in this report.

ECDC assessment:

Considering the measures implemented by Ireland, the risk for the general population in the EU/EEA related to this event is considered low, given a very low likelihood of further spread and a low impact. The [ECDC Rapid Risk Assessment](#) published on 16 August 2024 remains valid.

Actions:

ECDC is closely monitoring and assessing the evolving epidemiological situation of mpox in the EU/EEA and globally and is in contact with EU/EEA countries and partners. ECDC recommendations are available [here](#).

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

2. *Shigella sonnei* ST152 outbreak associated with international travel on long-haul flights

Overview:

A cluster of genetically linked *Shigella sonnei* ST152 cases were reported by the UK (20), falling within a 5 SNP single linkage hierarchical cluster (UK-HSA designation), with the Enterobase cgMLST cluster designation HC5_328030. Following UK's report, as of 7 February 2025, Austria (7), France (7), Ireland (3) and the Netherlands (1) also reported genetically linked cases, with 0–1 allelic differences from the UK reference strain, suggesting a common source.

Of the 38 cases reported, 29 reported recent international travel, with most travelling to countries in Asia (22 cases), including Singapore, Thailand, India, Sri Lanka, United Arab Emirates and Saudi Arabia. Fewer travelled to Africa (4 cases) and Australasia (3 cases). The reported cases had an isolation date or date of onset in January 2025, with the earliest case reported on 8 January 2025 and latest case reported on 17 January 2025. Of the 38 cases, 23 are female. The reported cases ranged in age from 15–70 years.

ECDC assessment:

Taken together, this is indicative of a point-source outbreak where the common exposure is likely to have occurred during international transit (on flights operated by the same airline or with the same caterer, or at the transit airport). Further cases may continue to occur until the vehicle and source of infection has been identified and measures put in place to address it.

Actions:

ECDC is monitoring the event through EpiPulse and is in contact with EU Member States.

Sources: The outbreak strains sequencing data shared by countries are analysed and the clusters are monitored in the [EpiPulse Molecular Typing Tool](#), where possible AMR determinants are also recorded.

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

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

Overview:**Key indicators**

All data presented in this summary are provisional. Interpretation of trends, particularly for the most recent weeks, should consider the impact of possible reporting delays, non-reporting by individual countries or overall low testing volumes at primary care sentinel sites.

- For several countries with historic data, the consultation rates exceeded the levels observed in previous winter periods.
- Influenza activity remained high, with primary care and secondary care test positivity rates well above 10% for most countries testing at least 10 samples per week. Since Week 40 2024, around 50% of severe acute respiratory infection (SARI) cases with influenza were aged 65 years and above. Non-sentinel indicators show that ICU admissions due to influenza virus infection concerned mainly those aged 65 years and above, but in the recent weeks influenza positivity has increased, especially among 5–14-year-olds who have been hospitalised. The season is characterised by the co-circulation of A(H1)pdm09, A(H3) and B/Vic influenza viruses in the region, with patterns of dominance varying greatly across countries.
- RSV test positivity at the EU/EEA level remained elevated in primary and secondary care in all age groups, with 0–4-year-olds being most affected. Since week 40 2024, nearly 65% of SARI cases with RSV were children aged under five years, while about 25% were people aged 65 years and above. Non-sentinel indicators showed similar trends to those observed in the sentinel system with hospital admissions due to RSV continuing at elevated levels.
- SARS-CoV-2 activity in primary care and hospitals remained low and continued to decrease or remained stable in all age groups.
- [EuroMOMO](#) pooled estimates of weekly excess all-cause mortality show increased levels of mortality, primarily driven by high mortality in the 85 years and above age group in several countries.

ECDC assessment:

There is currently significant respiratory virus activity in the EU/EEA. Influenza activity remains high and continues to increase in most EU/EEA countries. RSV activity remains elevated in primary care and hospitals. The levels of respiratory virus activity currently observed may place pressure on healthcare systems and strain hospital capacity, particularly where capacity is already limited. The age of those most impacted by severe disease differs, with RSV cases mostly observed in children below five years of old and severe influenza cases in those aged 45 years and above.

Actions:

Countries should be prepared for continued strain on healthcare systems during the coming weeks and consider [infection prevention and control practices in healthcare settings](#).

Vaccination against influenza viruses helps to limit severe disease outcomes for people at high risk. People eligible for vaccination against influenza, COVID-19 or RSV, particularly those at higher risk of severe outcomes and healthcare workers, are encouraged to get vaccinated without delay, in line

with national recommendations, to have the best chance of being protected. RSV immunoprophylaxis for infants, which has been shown to be safe and effective, can be considered in accordance with national guidelines. In addition, clinicians should be reminded that, if indicated in national guidelines, the early use of antiviral treatments for influenza and COVID-19 may prevent progression to severe disease in vulnerable groups. Monitoring of virological characteristics of influenza and RSV continues to be crucial for understanding the immunisation effectiveness and for selection of vaccine strains.

Despite currently low SARS-CoV-2 activity, it is important to continue monitoring SARS-CoV-2 at national and regional levels. To assess the impact of emerging SARS-CoV-2 sub-lineages, countries should continue to sequence SARS-CoV-2-positive clinical specimens and report to GISAID and/or The European Surveillance System (TESSy).

ECDC monitors rates of respiratory illness presentation and respiratory virus activity in the EU/EEA, presenting findings in the European Respiratory Virus Surveillance Summary ([ERVISS.org](https://www.ecdc.europa.eu/en/er viss)). Updated weekly, ERVISS describes the epidemiological and virological situation for respiratory virus infections across the EU/EEA and follows the principles of integrated respiratory virus surveillance outlined in '[Operational considerations for respiratory virus surveillance in Europe](#)'.

Further information:

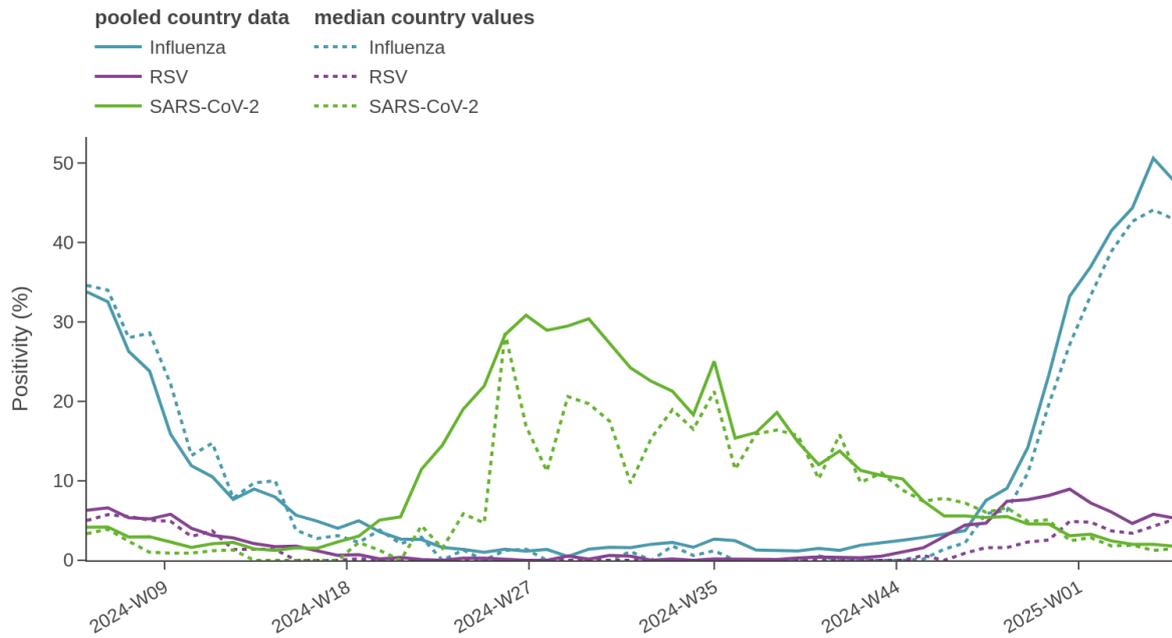
- Short-term forecasts of ILI and ARI rates in EU/EEA countries are published on ECDC's [RespiCast](#).
- [EuroMOMO](#) is a weekly European all-cause mortality monitoring activity, aiming to detect and measure excess deaths related to seasonal influenza, pandemics and other public health threats, based on weekly national mortality statistics from up to 27 reporting European countries or subnational regions.
- WHO [recommends](#) that trivalent vaccines for use during the 2024–2025 influenza season in the northern hemisphere contain the following (egg-based and cell culture or recombinant-based vaccines respectively): an A/Victoria/4897/2022 or A/Wisconsin/67/2022 (H1N1)pdm09-like virus (subclade 5a.2a.1); an A/Thailand/8/2022 or A/Massachusetts/18/2022 (H3N2)-like virus (clade 2a.3a.1 (J)); and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus (subclade V1A.3a.2).
- Antigenic characterisation data presented in the WHO [2025 southern hemisphere vaccine composition meeting](#) report indicate that current northern hemisphere vaccine components are well matched to circulating 5a.2a and 5a.2a.1 A(H1N1)pdm09 subclades and V1A.3a.2 B/Victoria subclades. The components also appear well matched for the A(H3N2) 2a.3a.1 (J) clade viruses, but less well matched for some of the more recent subclade 2a.3a.1 (J2) viruses characterised by S145N, N158K or K189R HA substitutions (alone or in combination). The majority of the A(H3N2) viruses identified worldwide since February 2024 belong to the subclade 2a.3a.1 (J2).

Sources: [ERVISS](#)

Last time this event was included in the Weekly CDTR: 24 January 2025

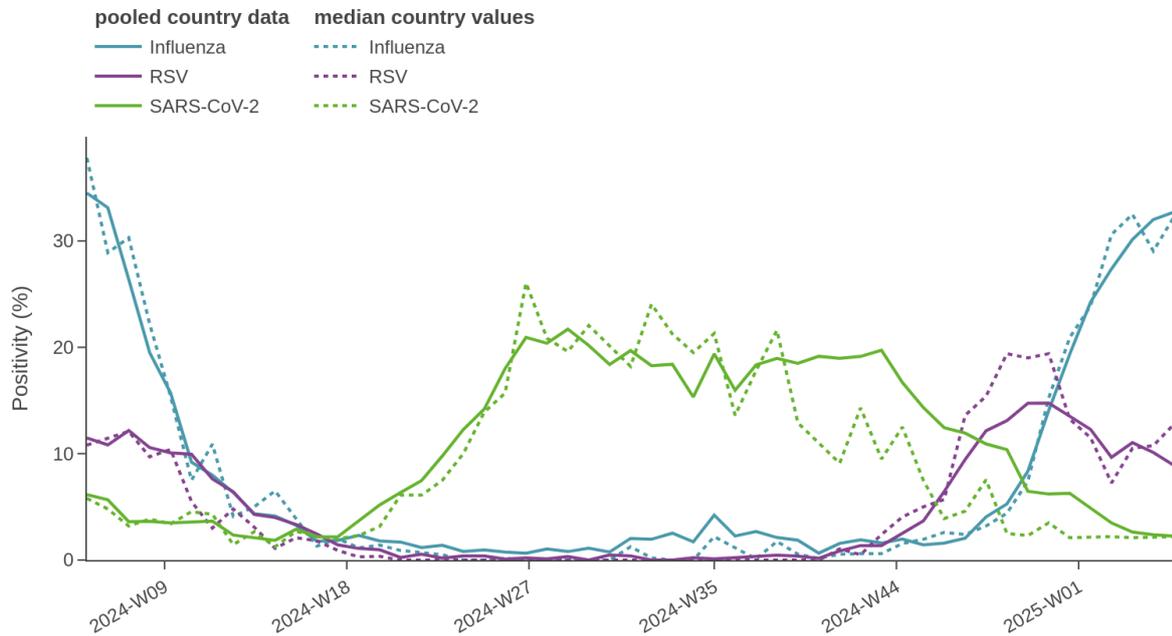
Maps and graphs

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



Source: ECDC

Figure 2. ILI/ARI virological surveillance in hospitals – weekly test positivity



Source: ECDC

Figure 3. Overview of key indicators of activity and severity in week 5, 2025

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary			
		Week 5	Week 4	Description	Value	Comment	
ILI/ARI consultation rates in primary care	ARI	14 rates (10 MEM)	16 rates (12 MEM)	Distribution of country MEM categories	3 Baseline 1 Low 3 Medium 2 High 1 Very high	ARI consultation rates continued to be reported at mixed levels compared to the same period in previous years. Based on the Moving Epidemic Method (MEM), seven countries reported a consultation rate above baseline levels: low by Estonia; medium by Bulgaria, Germany, and Lithuania; high by Czechia and Slovenia; and very high by Hungary. France did not report intensity but reported higher levels than previous years.	
	ILI	19 rates (17 MEM)	22 rates (20 MEM)		2 Baseline 2 Low 7 Medium 4 High 2 Very high		ILI consultation rates continued to be reported at mixed levels compared to the same period in previous years. However, most countries reported steep increases of ILI consultation rates in the past few weeks, except Ireland, whose rates are at decline. Based on the Moving Epidemic Method (MEM), 15 countries reported a consultation rate above baseline levels: low by Ireland and Norway; medium by Czechia, Denmark, Estonia, Greece, Italy, the Netherlands, and Poland; high by France, Hungary, Lithuania and Luxembourg; very high by Belgium and Slovenia.
ILI/ARI test positivity in primary care	Influenza	19	22	Pooled (median; IQR)	48% (43; 32-59%)	The pooled EU/EEA test positivity rate stayed at high level, which corresponds to the increase in detection reported by most countries. Some countries, such as Ireland, have probably passed the epidemic peak.	
	RSV	16	20		5.3% (5.2; 2.6-7.7%)		The pooled EU/EEA test positivity rate remained stable, at around 5% compared to the previous week. Denmark, Germany, and Slovenia continued to see an increase in test positivity rates.
	SARS-CoV-2	16	19		1.8% (1.4; 0.7-2.3%)		The pooled EU/EEA test positivity rate continued to decrease compared to the previous week. Most countries reported test positivity rates around or below 2%.
SARI rates in hospitals	SARI	10	12	-	-	SARI consultation rates were reported at mixed levels compared to the same period in previous years. Belgium and Malta reported a consultation rate above rates previously reported in the past three seasons. Germany reported an increasing trend comparable to last season.	
SARI test positivity in hospitals	Influenza	10	11	Pooled (median; IQR)	33% (32; 28-39%)	The pooled EU/EEA test positivity rate for SARI increased slightly from 32% observed last week.	
	RSV	9	11		8.9% (13; 8.3-16%)		The pooled EU/EEA test positivity rate for SARI remained elevated but stable compared to the previous week.
	SARS-CoV-2	9	10		2.2% (2.2; 1.4-3.5%)		The pooled EU/EEA test positivity rate for SARI remained low compared to the previous week.
Intensity (country-defined)	Influenza	22	25	Distribution of country qualitative categories	1 Baseline 2 Low 11 Medium		

Source: ECDC

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

Pathogen	Week 5, 2025		Week 40, 2024 - week 5, 2025	
	N	% ^a	N	% ^a
Influenza	1895	-	11884	-
Influenza A	1124	60	7864	67
A(H1)pdm09	524	63	4323	67
A(H3)	314	37	2117	33
A (unknown)	286	-	1424	-
Influenza B	756	40	3868	33
B/Vic	230	100	1158	100
B/Yam	0	0.0	1	0.1
B (unknown)	526	-	2709	-
Influenza untyped	15	-	152	-
RSV	153	-	2078	-
RSV-A	23	47	338	42
RSV-B	26	53	476	58
RSV untyped	104	-	1264	-
SARS-CoV-2	49	-	2481	-

Source: ECDC

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

Figure Table

Pathogen	Week 5, 2025		Week 40, 2024 - week 5, 2025	
	N	% ^a	N	% ^a
Influenza	869	-	5465	-
Influenza A	250	79	2358	89
A(H1)pdm09	41	61	815	68
A(H3)	26	39	390	32
A (unknown)	183	-	1153	-
Influenza B	66	21	301	11
B/Vic	0	-	19	100
B (unknown)	66	-	282	-
Influenza untyped	553	-	2806	-
RSV	190	-	2886	-
RSV-A	9	41	500	51
RSV-B	13	59	482	49
RSV untyped	168	-	1904	-
SARS-CoV-2	64	-	3111	-

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 5, 2025

Subtype	Subtype distribution		Subclade	Subclade distribution	
	N	%		N	%
A(H1)pdm09	695	46	5a.2a(C.1.9)	644	93
			5a.2a.1(D)	50	7
			5a.2a(C.1)	1	0.1
A(H3)	306	20	2a.3a.1(J.2)	201	67
			2a.3a.1(J.2.2)	49	16
			2a.3a.1(J.2.1)	43	14
			2a.3a.1(J)	3	1
			2a.3a.1(J.1)	2	0.7
			2a.3a.1(J.4)	2	0.7
			Not assigned	6	-
B/Vic	497	33	V1A.3a.2(C.5.1)	360	74
			V1A.3a.2(C.5.6)	65	13
			V1A.3a.2(C.5.7)	49	10
			V1A.3a.2(C)	10	2
			V1A.3a.2(C.5)	2	0.4
			Not assigned	11	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 3–4, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	4	12	14% (12-16%)
KP3	VOI	3	11	13% (7-18%)
XEC	VUM	4	64	72% (65-81%)

Source: ECDC

4. Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025

Overview:

Update:

According to the [Regional Health Agency \(ARS\) La Réunion](#), as of 2 February 2025, 529 cases of autochthonous chikungunya virus disease have been confirmed in La Réunion. All cases, with the exception of six probable cases, were confirmed by PCR. In week 4, 169 new cases were reported, which is double the number of new cases reported the previous week .

The most affected areas are Ligne des 400 (Tampon/Saint-Pierre), Ravine Sheunon (Étang-Salé) and Bras Creux (Tampon). Other outbreaks have also been reported in Grand Bassin and Trois Mares les Bas (Tampon); La Vallée - Ligne des Bambous (Saint-Pierre); La Rivière (Saint-Louis); Chemin de la Gare (Saint-André); and Le Butor (Saint-Leu).

Several outbreaks of chikungunya virus disease are spreading on the island, and widespread occurrence of the disease is likely soon. Currently, the reported cases have had a relatively low health impact, with only three hospitalisations reported and very limited activity in the emergency wards.

Due to the increase in the number of cases and the spread of outbreaks, Level 3 of the ORSEC 'Arboviruses' system was activated, which corresponds to the circulation of a low-intensity epidemic.

Background:

France has reported the first autochthonous case of chikungunya virus disease in the Department of La Réunion after 10 years, with onset of symptoms on 12 August 2024. Following that, France [announced the confirmation](#) of two more cases from the same neighbourhood. In recent weeks, the number of cases has increased sharply, as well as the geographical spread.

ECDC assessment:

The last major chikungunya virus disease epidemic in La Réunion was in 2005–2006. Population immunity is considered to be low for people born on or arriving on the island after 2014. The mosquito *Aedes albopictus*, which is a known vector of chikungunya virus (CHIKV), is established on La Réunion.

The probability of infection for residents of and travellers to La Réunion is currently moderate; however, the current period of austral summer is very favourable for the spread of arboviruses. Given the current epidemic dynamics, the likelihood of dissemination of CHIKV across the entire island is high for the coming weeks. The impact is considered to be moderate, as a significant number of people are expected to be affected.

In the event that CHIKV is introduced into the continental EU/EEA by infected travellers, the likelihood of further autochthonous transmission is very low. This is because the environmental conditions in the areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti* are established are unfavourable for vector activity and virus replication in vectors at this time of year.

Actions:

To avoid virus spread, reinforced prevention and control measures were implemented by the local authorities.

The vector control and intervention strategy is based on:

- Elimination of mosquito breeding sites around the homes of patients,
- Carrying out insecticide and/or larvicide treatments during the day,
- Raising awareness among residents of preventive measures,
- Distribution of repellents to priority groups around cases,
- Search for other cases within the perimeter of the initially reported case,
- Encouragement to consult a doctor promptly if symptoms occur and to carry out laboratory tests.

ECDC is monitoring the situation through its epidemic intelligence activities.

Last time this event was included in the Weekly CDTR: 31 January 2025

5. SARS-CoV-2 variant classification

Overview:

Since the last update on 20 December 2024, and as of 31 January 2025, no changes have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants.

The VOI median proportions in the EU/EEA for weeks 2–3, based on six reporting countries, are currently:

- KP.3: 18.3% (range: 0.0%–44.4%; IQR: 5.9%–24.3%);
- BA.2.86: 19.6% (range: 0.0%–30.8%; IQR: 8.3%–27.1%).

The VUM median proportions in the EU/EEA for weeks 2–3, based on six reporting countries, are currently:

- XEC: 66.5% (range: 27.8%–90.6%; IQR: 52.9%–76.2%).

The calculations are based on data reported to GISAID, as of 26 January 2025.

ECDC assessment:

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation. The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. The variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and previously uninfected individuals could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (e.g. older adults) remains important.

Actions:

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

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

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

Last time this event was included in the Weekly CDTR: 20 December 2024

6. Ebola virus disease – Uganda – 2025

Overview:

Update

On 6 February, the World Health Organization [reported](#) seven confirmed cases, including one death, of Ebola virus disease caused by Sudan virus. All cases belong to the same transmission chain, including a case identified in [the wife of the index case](#). A total of 234 contacts have been identified and are under monitoring.

Summary

As of 6 February, seven cases of Ebola disease caused by Sudan virus have been reported in Uganda. Of these, one case died.

In the context of the current outbreak, [WHO announced](#) the first ever Ebola vaccination trial of a vaccine against Ebola disease caused by Sudan virus, taking place in Uganda. This is the first time that a clinical trial has been conducted to measure the efficacy of a vaccine against Ebola disease caused by Sudan virus.

On 30 January 2025, the public health authorities in Uganda [declared](#) an outbreak of Sudan virus disease (SVD) in Kampala, Uganda. This follows laboratory confirmation from three national reference laboratories: the Central Public Health Laboratory in Kampala, the Uganda Virus Research Institute in Entebbe, and Makerere University. According to the Ministry of Health's press release, the index case occurred in a 32-year-old man working as a nurse at the Mulago National Referral Hospital.

The patient identified as the index case presented with a five-day history of high fever, chest pain, and difficulty in breathing, which later progressed to bleeding. The patient sought treatment at multiple health facilities in the Central district, as well Mbale City, including a traditional healer. On 29 January 2025, the patient experienced multi-organ failure and died.

Authorities in Uganda have taken the following actions:

1. Activated the Incident Management Team and dispatched Rapid Response Teams to both Mbale City and Saidina Abubakar Islamic Hospital in Matugga.
2. Contact listing: 45 contacts have so far been listed (30 healthcare workers and patients from Mulago, 11 family members of the deceased, and four health workers from Saidina Abubakar Islamic Hospital in Matugga). Facilities for the isolation of contacts who develop symptoms have been designated.
3. The deceased was accorded a safe and dignified burial to prevent the spread of the disease.
4. Vaccination of all contacts of the deceased against EVD is set to commence immediately.
5. Informed the public and healthcare workers.

Background: This is the eighth Ebola outbreak in the country, with the [most recent](#) occurring in 2022. For more information on the disease and its epidemiology, please read the [ECDC Factsheet about Ebola disease](#).

ECDC assessment:

During the previous SVD outbreak in Uganda, ECDC produced a [Rapid risk assessment](#) assessing the risk as very low to citizens in the EU/EEA. Such assessment, including the ECDC options for response, remain valid.

The current outbreak started in the densely populated capital of Uganda, thus there is a higher probability of local transmission despite the current low number of cases reported.

Since the case occurred among healthcare workers in hospital, EU/EEA citizens working in healthcare settings in Uganda should be aware of the ongoing outbreak and take appropriate personal protective measures.

Considering the above, and in light of evidence from previous larger outbreaks, the importation of a case in the EU/EEA is very unlikely, and, should that happen, the likelihood of further transmission is considered very low.

Actions:

ECDC is monitoring the event and is in contact with the EU bodies in Kampala and Africa CDC.

Sources: [WCO-Uganda](#)

Last time this event was included in the Weekly CDTR: 31 January 2025

7. Yellow fever – South America – 2024–2025

Overview:

On 3 February 2025, PAHO/WHO issued an [Epidemiological Alert](#) following an increase of human yellow fever cases in South American countries.

According to PAHO/WHO, in 2024, a total of 61 yellow fever cases, including 30 deaths, were confirmed in five countries: Bolivia, Brazil, Colombia, Guyana and Peru. Between epidemiological weeks 1 and 4 of 2025, 17 cases, including seven deaths, have been reported from three countries: Brazil, Colombia and Peru.

All of these countries are included in the WHO list of '[Countries with risk of yellow fever transmission and countries requiring yellow fever vaccination](#)'. According to the list, these countries do not require travellers arriving from the EU/EEA to show proof of yellow fever vaccination. In general, EU/EEA countries do not require proof of yellow fever vaccination for travellers going to or returning from countries at risk for yellow fever transmission. However, there might be some exceptions, such as travel to/from certain territories.

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

ECDC assessment:

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

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

Actions:

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

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

8. Avian influenza A(H5N1) human cases – United States – 2024

Overview:

Update:

On 31 January 2025, the [USDA](#) confirmed by whole genome sequencing the first detection of HPAI A(H5N1) clade 2.3.4.4b, genotype D1.1 in dairy cattle (all previous detections of HPAI in cattle have been A(H5N1) clade 2.3.4.4b, genotype B3.13). This was a result of state tracing and investigation, following an initial detection on silo testing under the [USDA's National Milk Testing Strategy](#) in Nevada. Further testing and gathering of epidemiological information is ongoing. Genotype D1.1 has been the predominant genotype in the North American flyways during the past autumn and winter and has been identified in wild birds, mammals, and spillovers into domestic poultry.

Background: In 2024, and as of 17 January 2025, 67 human cases of avian influenza A(H5N1), including one death, have been confirmed by the US CDC from 10 states. Forty cases reported exposure to dairy cattle in the following states: California (36), Colorado (1), Michigan (2) and Texas (1). Twenty-three cases reported exposure to poultry in the following states: Colorado (9), Iowa (1), Oregon (1), Washington (11), and Wisconsin (1). One case, the patient reported in [Louisiana](#) who died, had exposure to backyard flocks and other wild birds. Three additional cases have been identified with unknown exposure: one in Missouri and two in California.□

ECDC assessment:

To date, there have been no confirmed human cases of influenza A(H5N1) infection and no reports of A(H5N1) infection in cattle in the EU/EEA. The genotype B3.13, identified in cattle and several of the human cases in the US, has not been detected in Europe. The genotype D1.1, identified in one cow to date, has been found in poultry and a small number of human cases exposed to poultry in the US and Canada.

ECDC has assessed the risk from the circulating HPAI A(H5N1) clade 2.3.4.4b viruses as low for the general population and low-to-moderate for those with activities that expose them to infected animals or contaminated environments (e.g. occupational exposure to infected animals).

Actions:

ECDC is monitoring the situation together with partner organisations in Europe and will continue to update its assessment of the risk for humans in the EU/EEA as new information becomes available.

In addition to enhanced surveillance, active monitoring and testing of exposed individuals is recommended for early detection of human cases and to assess the possibility of human-to-human transmission, according to relevant ECDC guidance documents ('[Testing and detection of zoonotic influenza virus infections in humans](#)'; '[Investigation protocol of human cases of avian influenza virus](#)'; '[Enhanced surveillance of severe avian influenza virus infections in hospital settings](#)').

It is important to raise awareness, including among all primary care workers, of the need to enquire about animal exposure and symptoms compatible with avian influenza infections and to test symptomatic individuals with a history of exposure, following a risk-based approach. It is also important to communicate regarding the epidemiological situation so as not to miss or delay diagnosis of potential human cases.

Given the uncertainties related to mammal-to-mammal transmission and depending on the epidemiological situation, a low threshold can be considered for testing individuals exposed to potentially infected mammals (e.g. symptomatic individuals with conjunctivitis or respiratory symptoms). Due to the higher risk of infection for individuals exposed to infected animals and contaminated environments, appropriate personal protective measures and other precautionary measures should always be taken to mitigate the risk.

Relevant ECDC publications:

- ['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'](#)
- ['Investigation protocol of human cases of avian influenza virus infections in the EU/EEA'](#)
- ['Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA'](#)
- ['Joint ECDC-EFSA Drivers for a pandemic due to avian influenza and options for One Health mitigation measures'](#)

ECDC is in contact with the US CDC for further information and is closely following any updates on the event. ECDC monitors zoonotic avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly updated report on the [avian influenza situation](#).

Sources: [Event Information Site for IHR National Focal Points](#) | [FAO](#) | [2024-e000168](#)

Last time this event was included in the Weekly CDTR: 17 January 2025

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

Overview:

Update: Since the previous update on 8 January 2025, and as of 5 February 2025, no new MERS-CoV cases have been reported by WHO or national health authorities.

Summary: Since the beginning of 2025, and as of 5 February 2025, no MERS-CoV cases have been reported with date of onset in 2025.

Since April 2012, and as of 5 February 2025, a total of 2 626 cases of MERS-CoV, including 953 deaths, have been reported by health authorities worldwide.

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

ECDC assessment:

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

ECDC published a technical report, ['Health emergency preparedness for imported cases of high-consequence infectious diseases'](#), in October 2019, which is still useful for EU Member States wanting 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.

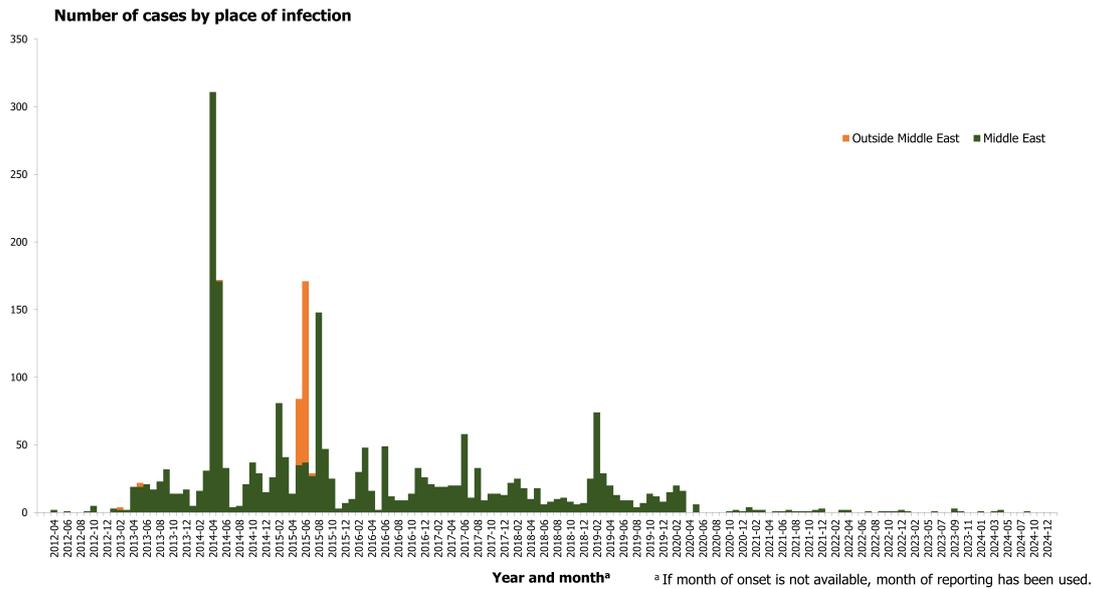
Actions:

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

Last time this event was included in the Weekly CDTR: 10 January 2025

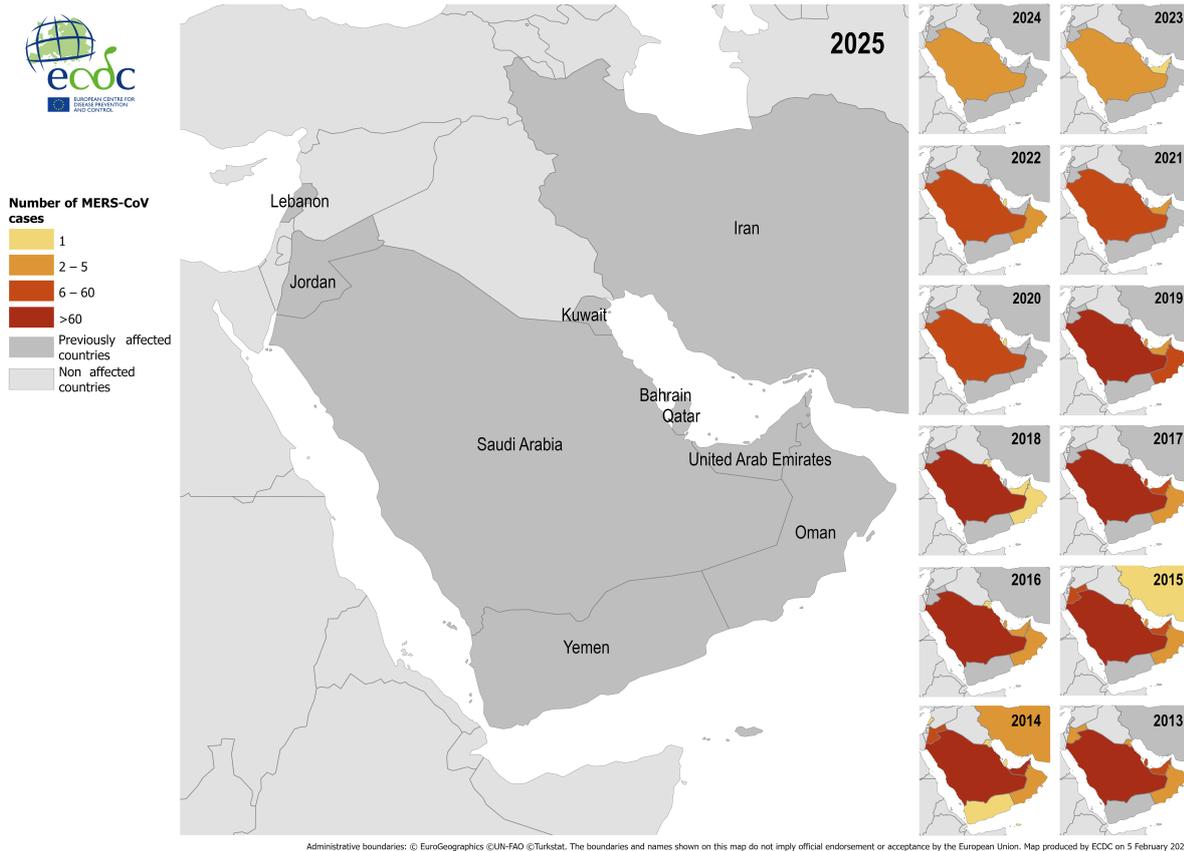
Maps and graphs

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



Source: ECDC

Figure 2. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2013 to January 2025



Source: ECDC

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

Overview:

Update

Since the previous update published on 31 January 2025, new mpox clade Ib cases have been reported in the UK, while Ireland has reported a case of mpox clade I. In both events the cases had travel history to Africa ([UKHSA update on cases of Clade Ib mpox](#) and [Mpox: Current situation - Health Protection Surveillance Centre](#)).

Overall, no major changes in the mpox epidemiological trends have been reported in Africa since the previous week. A decreasing trend continues in Burundi (413 cases the past six weeks) and an increasing trend in Uganda (1 127 cases the past six weeks). The epidemic is ongoing in the DRC. Of the countries that recently reported detection of mpox clade I in Africa, Zambia observed an increase in recent weeks (total: 16 cases, 15 of which were from the past six weeks) from at least two provinces ([Africa CDC Epidemic Intelligence Weekly Report, 3 February 2025](#), [WHO Global report on mpox \(data as of 2 February 2025\)](#)).

The summary below includes more detailed information on epidemiological trends observed since summer 2024 and for the beginning of 2025.

Summary

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

Following the epidemic of MPXV clade I in the DRC in 2024, MPXV clade I was first detected in Burundi, Rwanda, Uganda and Zambia (all neighbouring the DRC), as well as in Kenya and Zimbabwe. Overall, on the African continent in 2024 and in the first weeks of 2025, most confirmed and suspected clade I cases have been reported from the DRC, where a stable trend has been observed in recent weeks ([WHO Global report on mpox \(data as of 26 January 2025\)](#) and [Mpox: multi-country external situation report no. 46, 28 January 2025](#)). In Burundi, a decreasing trend in the number of reported mpox cases has been observed, and over 3 000 confirmed cases and one death have been reported since 2024. In Uganda, the number of cases has been increasing, with the highest incidence reported in Kampala (over 2 400 cases and 16 deaths [reported as of 28 January 2025](#)). Rwanda has reported 87 cases, Kenya 37 cases, Zambia 16 cases, and Zimbabwe two cases ([WHO Global report on mpox \(data as of 2 February 2025\)](#)).

Outside Africa, travel-associated cases or sporadic cases reporting epidemiological links with travel-associated cases of MPXV clade I have been reported in the EU/EEA by:

- Sweden (one case in August 2024);
- Germany (one case in October, five in December 2024 and one in January 2025);
- [Belgium \(two cases in December 2024\)](#);
- France ([one case in January 2025](#)); and
- Ireland ([one case in February 2025](#)).

[In addition to Africa and the EU/EEA](#), since August 2024, clade I cases have been reported by Thailand, India, the UK, the United States (US), Canada, Pakistan, Oman, and [China](#).

Most travel-associated cases that reported travel to non-African countries have reported links to affected countries in Africa. However, China, India, Oman, Pakistan and Thailand have reported at least one case each with travel links to the United Arab Emirates ([Mpox: Multi-country external situation report 44, 23 December 2024](#) and [Mpox: multi-country external situation report no. 46, 28 January 2025](#)).

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

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

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

- Countries reporting only travel-associated cases or cases with a clear link to travel-associated cases: Belgium, Canada, China, Germany, France, India, Ireland, Oman, Pakistan, Sweden, Thailand, the UK, the US, Zambia, and Zimbabwe;
- Countries reporting clusters of cases: Congo and Kenya;
- Countries reporting community transmission: Burundi, Central African Republic, the DRC, Rwanda, and Uganda.

In addition to the countries included in the categorisation, undetected transmission may be ongoing in the United Arab Emirates and Tanzania, given that mpox clade Ib cases with travel links to both the United Arab Emirates and Tanzania have been reported elsewhere ([Mpox: multi-country external situation report no. 46, 28 January 2025](#)).

ECDC assessment:

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

The risk for EU/EEA citizens travelling to or living in the affected areas is considered to be moderate if they have close contact with affected persons, or low if contact with affected individuals is avoided. The overall risk to the general population in the EU/EEA is currently assessed as low. However, more imported mpox cases due to MPXV clade I are likely to be reported by the EU/EEA and other countries.

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

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

Actions:

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

Sources: [ECDC rapid risk assessment](#)

Last time this event was included in the Weekly CDTR: 31 January 2025

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 31 January 2025
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 31 January 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 31 January 2025
- Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025 - last reported on 31 January 2025
- Suspected viral haemorrhagic fever - Democratic Republic of the Congo - 2025 - last reported on 31 January 2025
- Ebola virus disease – Uganda – 2025 - last reported on 31 January 2025
- Marburg virus disease - Tanzania - 2025 - last reported on 31 January 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 24 January 2025
- Avian influenza A(H5N1) human cases – United States – 2024 - last reported on 17 January 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 17 January 2025
- Mass gathering monitoring - Jubilee of 2025 in Italy - last reported on 17 January 2025
- Community-associated outbreaks of impetigo by fusidic acid-resistant MRSA - multi-country - 2024 - last reported on 17 January 2025
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 17 January 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 17 January 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 10 January 2025
- Mpox due to monkeypox virus clade I – Belgium – 2024 - last reported on 10 January 2025

- Increase in respiratory viral infections – China – 2024 - last reported on 10 January 2025
- Mpox due to monkeypox virus clade I – France – 2025 - last reported on 10 January 2025
- SARS-CoV-2 variant classification - last reported on 07 February 2025
- Yellow fever – South America – 2024–2025 - last reported on 07 February 2025
- Mpox due to monkeypox virus clade I – Ireland – 2025 - last reported on 07 February 2025
- Shigella sonnei ST152 outbreak associated with international travel on long-haul flights - last reported on 07 February 2025