

# Communicable disease threats report

Week 8, 15–21 February 2025

## This week's topics

- [1. Cholera – Multi-country \(World\) – Monitoring global outbreaks - Monthly update](#)
- [2. Avian influenza A\(H9N2\) – Multi-country \(World\) – Monitoring human cases](#)
- [3. Overview of respiratory virus epidemiology in the EU/EEA](#)
- [4. Avian influenza A\(H5N1\) human cases – United States – 2024](#)
- [5. Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025](#)
- [6. Ebola disease – Uganda – 2025](#)
- [7. Legionnaires' disease outbreak - Vorarlberg, Austria - 2025](#)
- [8. Locally acquired dengue cases in Madeira - Portugal - 2025](#)
- [9. Unknown disease - DRC -2025](#)

## Executive summary

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

- Since 1 January 2025, and as of 20 February 2025, 45 731 new cholera cases, including 491 new deaths, have been reported worldwide. In 2024, 791 755 new cholera cases, including 5 374 new deaths, have been reported worldwide.
- In 2025, new cases have been reported from Afghanistan, Angola, Bangladesh, Burundi, Cameroon, Democratic Republic of the Congo, Ethiopia, Ghana, Malawi, Mozambique, Myanmar, Niger, Nigeria, Pakistan, Somalia, South Sudan, Sudan, Thailand, Togo, Uganda, United Republic of Tanzania, Yemen, Zambia, and Zimbabwe.
- In 2025, cholera cases continue to be reported in Africa, Asia, and the Middle East. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

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

- On 18 February 2025, two human cases of avian influenza A(H9N2) virus infections were reported by Hong Kong's Centre for Health Protection. Both were attributed to Guangdong Province in China.
- No details about disease severity or exposure are available.

- Six cases of H9N2 in China have been reported in 2025. Since 2015, a total of 116 cases of human avian influenza A(H9N2) infection, including two deaths, have been reported from China to the World Health Organization (WHO).
- The risk to human health in the EU/EEA is currently considered very low.

### **Overview of respiratory virus epidemiology in the EU/EEA**

- There is currently significant respiratory virus activity in the EU/EEA. Intense seasonal influenza activity is reported together with a respiratory syncytial virus (RSV) epidemic, while SARS-CoV-2 activity is at a very low level. The biggest impact in secondary care has been in adults aged 65 years and above for influenza and SARS-CoV-2 and in children aged below five years for RSV.
- For influenza, increasing trends in activity continue to be observed in around one third of the EU/EEA countries, while the remainder appear to be reaching, or have passed, peak activity. Hospital admissions due to influenza are currently at similar levels to those observed at the peak of the previous winter season.

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

- Two states in the United States (US) reported human A(H5N1) influenza virus infections for the first time: Nevada and Wyoming.
- The individual from Wyoming is an adult with exposure related to backyard flocks.
- The individual from Nevada is an adult with occupational exposure to infected dairy cattle and presented with conjunctivitis. This is the first instance of transmission of genotype D1.1 from dairy cattle to humans.
- Since 1 April 2024, and as of 10 February 2025, a total of 69 human cases of avian influenza A(H5) have been reported from 12 states in the United States (US). Of these, 41 were people 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 two had exposure to other animals, such as backyard flocks, wild birds, or other mammals.
- According to the 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).

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

- France 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, and as of 16 February 2025, 1069 cases of autochthonous chikungunya virus disease have been confirmed in La Réunion.

### **Ebola disease – Uganda – 2025**

- On 30 January 2025, the public health authorities of Uganda declared an outbreak of Ebola disease caused by the Sudan virus (Sudan virus disease) in Kampala.
- On 18 February, the World Health Organization reported that eight remaining confirmed cases that were hospitalized have recovered and discharged.
- As of 18 February, nine confirmed cases, including one death, have been reported. All cases are divided into two clusters.
- Since the index case was 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 to the EU/EEA is very low.

### **Legionnaires' disease outbreak - Vorarlberg, Austria - 2025**

- On 12 February 2025, Austrian authorities reported an outbreak of Legionnaires' disease in the state of Vorarlberg in Western Austria.
- As of 19 February 2025, a total of 26 cases of Legionnaires' disease are reported.
- Investigations are ongoing to identify the source of this outbreak.

### Locally acquired dengue cases in Madeira - Portugal - 2025

- In 2025, as of 18 February, two locally acquired dengue cases have been reported on Madeira.
- In addition, entomological investigations confirmed the presence of dengue in mosquitoes captured on Madeira.
- The risk of further transmission for Madeira is considered low, as the mosquito active season would normally start around late May.
- The environmental conditions in the areas of mainland EU/EEA where *Ae. albopictus* is established are currently unfavourable for mosquito activity and virus replication in mosquitoes.

### Unknown disease - DRC -2025

- Two clusters of an unknown disease were reported from the Bolomba and Basankusu health zones in Équateur Province, the Democratic Republic of the Congo (DRC). No epidemiological link has been established between the two clusters.
- First three fatalities occurred between 10 and 13 January 2025 in children who consumed a bat carcass.
- As of 15 February 2025, a total of 431 cases with 53 deaths (CFR 12.2%) have been reported.
- Diagnostic tests conducted on active cases and deceased individuals were negative for Zaire ebolavirus and Marburg virus.
- Additional investigation is ongoing, including metagenomic sequencing of collected samples, as well as case investigations and active case finding in the affected communities.
- 

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

### Overview:

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

### Summary

Since 1 January 2025 and as of 20 February 2025, 45 731 cholera cases, including 491 deaths, have been reported worldwide. In comparison, since 01 January 2024 and as of 20 February 2024, 69 825 cholera cases, including 1 099 deaths, were reported worldwide.

New cases have been reported from Afghanistan, Angola, Bangladesh, Burundi, Democratic Republic of the Congo, Ethiopia, Ghana, Malawi, Mozambique, Myanmar, Niger, Nigeria, Pakistan, Somalia, South Sudan, Sudan, Thailand, Togo, Uganda, United Republic of Tanzania, Yemen, Zambia and Zimbabwe.

The five countries reporting most cases are South Sudan (13 882), Afghanistan (9 456), Yemen (6 110), Democratic Republic of the Congo (4 771) and Angola (3 147).

New deaths have been reported from Afghanistan, Angola, Democratic Republic of the Congo, Ethiopia, Ghana, Malawi, Niger, Nigeria, Somalia, South Sudan, Sudan, Togo, Uganda, United Republic of Tanzania, Yemen, Zambia, and Zimbabwe.

The five countries reporting most new deaths are South Sudan (193), Angola (108), Democratic Republic of the Congo (85), Sudan (53) and Nigeria (14).

**In 2025, new cholera cases and new deaths have been reported from:****Africa**

**Angola:** Since 1 January 2025 and as of 18 February 2025, 3 147 cases, including 108 deaths, have been reported. In comparison, in 2024 and as of 20 February 2024, no cases were reported. The last time cases were reported was in February 2019.

**Burundi:** Since 1 January 2025 and as of 3 February 2025, 74 cases have been reported. In comparison, in 2024 and as of 31 January 2024, 33 cases were reported.

**Democratic Republic of the Congo:** Since 1 January 2025 and as of 27 January 2025, 4 771 cases, including 85 deaths, have been reported. In comparison, in 2024 and as of 31 January 2024, 31 135 cases, including 430 deaths were reported.

**Ethiopia:** Since 1 January 2025, and as of 3 February 2025, 177 cases, including three deaths have been reported. In comparison, in 2024 and as of 31 January 2024, 779 cases, including 12 deaths were reported.

**Ghana:** Since 1 January 2025, and as of 18 February 2025, 1 479 cases, including nine deaths, have been reported. In comparison, in 2024 and as of 20 February 2024, no cases were reported.

**Malawi:** Since 1 January 2025 and as of 18 February 2025, 83 cases, including two deaths, have been reported. In comparison, in 2024 and as of 31 January 2024, 11 cases were reported.

**Mozambique:** Since 1 January 2025 and as of 3 February 2025, 64 cases have been reported. In comparison, in 2024 and as of 31 January 2024, 2 563 cases, including six deaths, were reported.

**Niger:** Since 1 January 2025 and as of 31 December 2024, 1 066 cases, including 23 deaths, have been reported. In comparison, in 2024, and as of 20 February 2024, no cases were reported.

**Nigeria:** Since 1 January 2025 and as of 10 February 2025, 889 cases, including 14 deaths, have been reported. In comparison, in 2024 and as of 20 February 2024, no cases were reported.

**Somalia:** Since 1 January 2025 and as of 20 January 2025, 777 cases, including one death, have been reported. In comparison, in 2024 and as of 31 January 2024, 1 406 cases, including 18 deaths, were reported.

**South Sudan:** Since 1 January 2025 and as of 10 February 2025, 13 882 cases, including 193 deaths, have been reported. In comparison, in 2024 and as of 20 February 2024, no cases were reported.

**Sudan:** Since 1 January 2025 and as of 18 February 2025, 2 437 cases, including 53 deaths, have been reported. In comparison, in 2024 and as of 20 February 2024, no cases were reported.

**Togo:** Since 1 January 2025 and as of 3 February 2025, 138 cases, including four deaths, have been reported. In comparison, in 2024 and as of 20 February 2024, no cases were reported.

**Uganda:** Since 1 January 2025 and as of 3 February 2025, 87 cases, including one death, have been reported. In comparison, in 2024 and as of 29 January 2024, 13 cases were reported.

**United Republic of Tanzania:** Since 1 January 2025 and as of 31 December 2024, 12 148 cases, including 145 deaths, have been reported. In comparison, in 2024 and as of 20 January 2024, 164 cases, including one death, was reported.

**Zambia:** Since 1 January 2025 and as of 18 February 2025, 224 cases, including nine deaths, have been reported. In comparison, in 2024 and as of 31 January 2024, 13 015 cases, including 488 deaths were reported.

**Zimbabwe:** Since 1 January 2025 and as of 18 February 2025, 133 cases, including two deaths, have been reported. In comparison, in 2024 and as of 31 January 2024, 7 219 cases, including 124 deaths, were reported.

## Asia

**Afghanistan:** Since 1 January 2025 and as of 3 February 2025, 9 456 cases, including three deaths, have been reported. In comparison, in 2024 and as of 27 January 2024, 8 402 cases, including eight deaths, were reported.

**Bangladesh:** Since 1 January 2025 and as of 3 February 2025, 83 cases have been reported. In comparison, in 2024 and as of 20 February 2024, no cases were reported.

**Myanmar:** Since 1 January 2025 and as of 20 January 2025, 553 cases have been reported. In comparison, in 2024 and as of 20 February 2024, no cases were reported.

**Pakistan:** Since 1 January 2025 and as of 6 January 2025, 1 162 cases have been reported. In comparison, in 2024 and as of 30 January 2024, 2 405 cases were reported.

**Thailand:** Since 1 January 2025 and as of 20 January 2025, 5 cases have been reported. In comparison, in 2024 and as of 31 January 2024, no cases were reported.

**Yemen:** Since 1 January 2025 and as of 20 January 2025, 6 110 cases, including four deaths, have been reported. In comparison, in 2024 and as of 20 February 2024, no cases were reported.

## ECDC assessment:

In 2025, cholera cases have continued to be reported in Africa and Asia. Within the last six months, cholera outbreaks have also been reported in parts of the Middle East and the Americas.

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

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

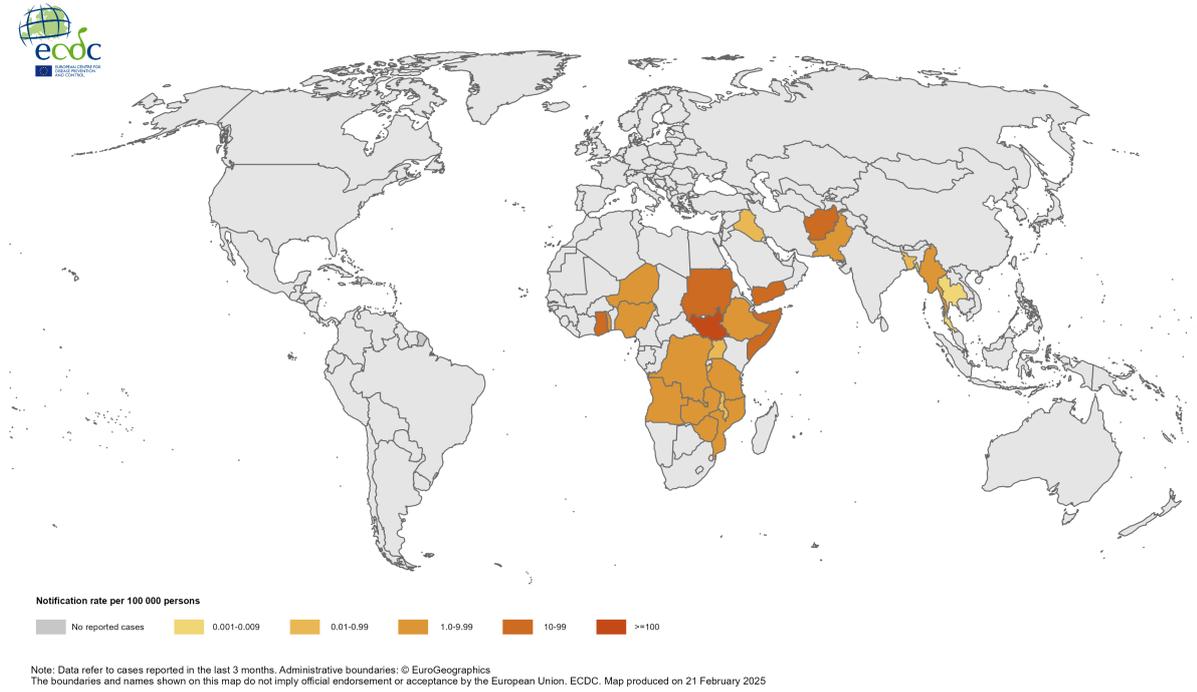
According to the World Health Organization (WHO), vaccination should be considered for travellers at higher risk, such as emergency and relief workers who may be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek advice from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

## Actions:

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

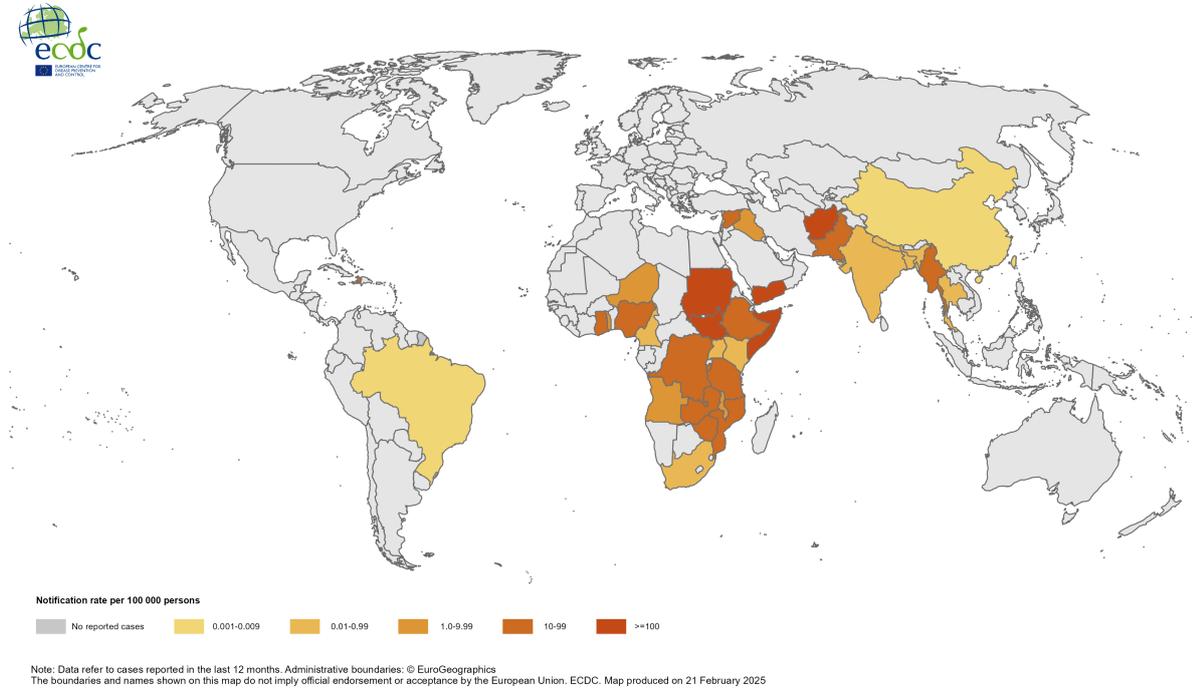
**Last time this event was included in the Weekly CDTR:** 29 November 2024

**Figure 1. Geographical distribution of cholera cases reported worldwide from December 2024 to February 2025**



Source: ECDC

**Figure 2. Geographical distribution of cholera cases reported worldwide from March 2024 to February 2025**



Source: ECDC

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

### Overview:

**Update:** On 18 February 2025, Hong Kong's Centre for Health Protection reported two human cases of avian influenza A(H9N2) virus infections ([Avian Influenza Report](#)). Both cases are adults reported by Guangdong Province. The first case is a woman in her seventies with onset of disease on 26 December 2024, while the second is a woman in her fifties who had symptom onset on 20 January 2025.

**Background:** Four cases of H9N2 have been reported in China in 2025. Since 2015, a total of 114 cases of human avian influenza A(H9N2) infection, including two deaths, have been reported from China to WHO.

### ECDC assessment:

Sporadic human cases of avian influenza A (H9N2) have been observed outside the EU/EEA, mainly in young children. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses. Influenza A(H9N2) in most cases leads to mild clinical illness. To date, no clusters of human A(H9N2) infections have been reported. According to WHO, the likelihood of human-to-human transmission of A(H9N2) is low, as there is no evidence that the virus has acquired the ability for sustained transmission among humans.

To date, there have been no human cases of avian influenza A(H9N2) reported in the EU/EEA, and the risk to human health in the region is currently considered very low.

### Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities. Together with the European Food Safety Authority and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly [report on the avian influenza situation](#). The [most recent report](#) was published in December 2024.

**Sources:** [Event Information Site for IHR National Focal Points](#)

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

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

### Overview:

- Based on data reported to week 7, 2025, primary and secondary care consultation rates reported by countries indicate that there are still significant levels of respiratory virus activity in the EU/EEA. Intense seasonal influenza activity is reported together with a respiratory syncytial virus (RSV) epidemic, while SARS-CoV-2 activity is at a very low level.
- All indicators point to continued widespread, intense influenza activity in the EU/EEA, driven by co-circulating A(H1)pdm09, A(H3) and B/Vic viruses, with patterns of dominance varying greatly across countries. Increasing trends in activity continue to be observed in around one third of the EU/EEA countries, while the remainder appear to be reaching, or have passed, peak activity. Hospital admissions due to influenza are currently at similar levels to those observed at the peak of the previous winter season.

- Since peaking in week 52, 2024, RSV activity in the EU/EEA has decreased. However, at country level the picture is mixed, with approximately half of the reporting countries showing decreases and the remainder reporting stable or increasing levels of activity.

### ECDC assessment:

- Since week 40, 2024, the winter respiratory virus season in the EU/EEA has been characterised by an intense influenza season, a concurrent RSV epidemic and steadily declining SARS-CoV-2 activity. The biggest impact in secondary care has been in adults aged 65 years and above for influenza and SARS-CoV-2 and in children aged below five years for RSV. Since week 51, 2024, [EuroMOMO](#) has reported all-cause mortality above expected levels, mostly in adults aged 65 years and above.
- The levels of respiratory virus activity currently observed in the EU/EEA, with intense influenza activity and co-circulation of RSV, are expected to continue to place pressure on healthcare systems and hospital capacity, particularly where this is already limited.

### Actions:

- ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary ([ERVISS.org](#)), which is updated weekly.
- ECDC has published recommended public health actions to mitigate against the impact of respiratory virus circulation during winter 2024/2025 in an [epidemiological update](#). Countries should be prepared for continued pressure on healthcare systems, ensuring that [infection prevention and control practices in healthcare settings](#) are implemented.
- 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 in line with national recommendations.
- Interim [influenza vaccine effectiveness](#) estimates are available for the 2024/2025 season. Analysis of data submitted from multi-country primary care and hospital study sites indicate that influenza vaccination prevented between one third and more than three-quarters of the influenza infections medically attended in primary care or hospital settings, although protection varied by age group and study site.
- Clinicians should be reminded that, when indicated, the early use of antivirals against influenza may reduce symptom duration and prevent disease progression in groups at high risk of severe outcomes. Frequent handwashing, physical distancing, avoiding large gatherings and wearing masks in healthcare settings can all help to reduce transmission and protect groups at high risk of severe disease.

Sources: [ERVISS](#)

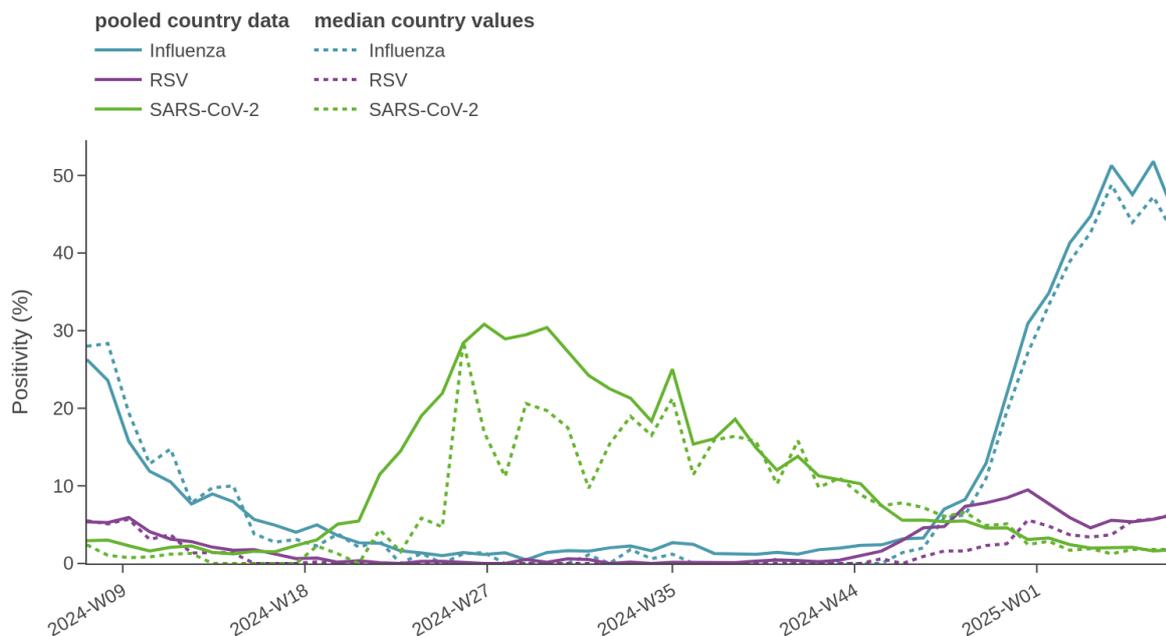
Last time this event was included in the Weekly CDTR: 14 February 2025

**Table 1. Overview of key indicators of activity and severity in week 8**

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 7	Week 6	Description	Value	
ILI/ARI consultation rates in primary care	ARI	15 rates (11 MEM)	16 rates (12 MEM)	Distribution of country MEM categories	3 Baseline 2 Low 2 Medium 3 High 1 Very High	
	ILI	20 rates (18 MEM)	21 rates (19 MEM)		2 Baseline 1 Low 10 Medium 3 High 2 Very High	Medium to very high levels based on the Moving Epidemic Method (MEM) in the majority of countries reflect the intensity of influenza activity. Seven countries are reporting ILI consultation rates that exceed the peak observed in each of the past four seasons.
ILI/ARI test positivity in primary care	Influenza	19	21	Pooled (median; IQR)	45% (42; 37–56%)	Current pooled EU/EEA level positivity exceeds the peak observed in each of the past four seasons. However, positivity has stabilised since week 4, indicating a possible peak in activity. This plateau in positivity is observed in all age groups. The EU/EEA level data mask considerable heterogeneity between countries, with some having peaked while others continue to show increases.
	RSV	17	19		6.3% (6.3; 4.3–9%)	EU/EEA level positivity is lower than the peak level observed in week 52 (9.5%), with the trend driven mainly by the 0–4 years age group. As with influenza, the country picture is extremely mixed.
	SARS-CoV-2	16	18		1.8% (1.8; 0.3–2.7%)	Activity is low in all countries.
SARI rates in hospitals	SARI	9	11		–	
SARI test positivity in hospitals	Influenza	9	11	Pooled (median; IQR)	31% (25; 23–29%)	In terms of overall trend and country heterogeneity, the picture is similar to that for primary care. Positivity continues to increase among those aged 5–14 years. The overall age distribution in the season to date does not differ substantially from that observed in the 2023–2024 season.
	RSV	8	10		8.5% (8.7; 6.8–13%)	In terms of overall trend and country heterogeneity, the picture is similar to that for primary care.
	SARS-CoV-2	8	10		1.5% (0; 0–0.7%)	
Intensity (country-defined)	Influenza	21	24	Distribution of country qualitative categories	1 Baseline 1 Low 13 Medium 5 High 1 Very High	
Geographic spread (country-defined)	Influenza	21	23	Distribution of country qualitative categories	1 Local 3 Regional 17 Widespread	

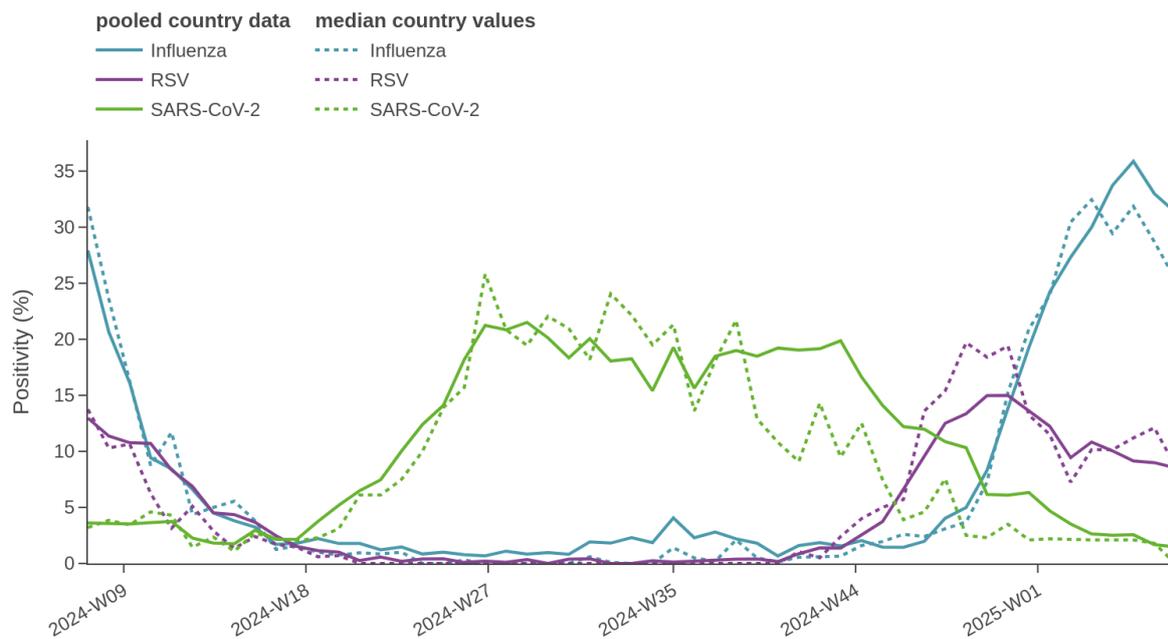
Source: ECDC

**Figure 3. ILI/ARI virological surveillance in primary care – weekly test positivity**



Source: ECDC

**Figure 4. ILI/ARI virological surveillance in hospitals – weekly test positivity**



Source: ECDC

**Table 2. ILI/ARI virological surveillance in primary care - pathogen type and subtype distribution**

Pathogen	N	Week 7, 2025		Week 40, 2024 - week 7, 2025	
		N	% <sup>a</sup>	N	% <sup>a</sup>
<b>Influenza</b>	<b>1752</b>		-	<b>15463</b>	-
Influenza A	913		53	9792	64
A(H1)pdm09	327		47	4986	62
A(H3)	370		53	3046	38
A (unknown)	216		-	1760	-
Influenza B	824		47	5475	36
B/Vic	303		100	1987	100
B/Yam	0		0.0	1	0.1
B (unknown)	521		-	3487	-
Influenza untyped	15		-	196	-
<b>RSV</b>	<b>182</b>		-	<b>2419</b>	-
RSV-A	27		43	368	41
RSV-B	36		57	530	59
RSV untyped	119		-	1521	-
<b>SARS-CoV-2</b>	<b>50</b>		-	<b>2618</b>	-

Source: ECDC

**Table 3. SARI virological surveillance in hospitals – pathogen type and subtype distribution**

Figure Table

Pathogen	Week 7, 2025		Week 40, 2024 - week 7, 2025	
	N	% <sup>a</sup>	N	% <sup>a</sup>
<b>Influenza</b>	<b>599</b>	-	<b>7305</b>	-
Influenza A	165	87	3099	88
A(H1)pdm09	29	54	1118	66
A(H3)	25	46	574	34
A (unknown)	111	-	1407	-
Influenza B	24	13	428	12
B/Vic	0	-	38	100
B (unknown)	24	-	390	-
Influenza untyped	410	-	3778	-
<b>RSV</b>	<b>160</b>	-	<b>3282</b>	-
RSV-A	8	57	544	49
RSV-B	6	43	556	51
RSV untyped	146	-	2182	-
<b>SARS-CoV-2</b>	<b>27</b>	-	<b>3139</b>	-

Source: ECDC

**Table 4. Genetically characterised influenza virus distribution, week 40, 2024 to week 7, 2025**

Subtype	Subtype distribution		Subclade	Subclade distribution	
	N	%		N	%
A(H1)pdm09	1700	49	5a.2a(C.1.9)	1507	89
			5a.2a.1(D)	136	8
			5a.2a(C.1)	57	3
A(H3)	791	23	2a.3a.1(J.2)	544	70
			2a.3a.1(J.2.1)	111	14
			2a.3a.1(J.2.2)	105	13
			2a.3a.1(J)	10	1
			2a.3a.1(J.1)	7	0.9
			2a.3a.1(J.4)	2	0.3
			Not assigned	12	-
B/Vic	987	28	V1A.3a.2(C.5.1)	651	67
			V1A.3a.2(C.5.7)	157	16
			V1A.3a.2(C.5.6)	143	15
			V1A.3a.2(C)	22	2
			V1A.3a.2(C.5)	2	0.2
			Not assigned	12	-

Source: ECDC

**Figure 5. SARS-CoV-2 variant distribution, weeks 5–6, 2025**

Variant	Classification <sup>a</sup>	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	6	28	20% (13–28%)
KP3	VOI	6	16	17% (8–19%)
XEC	VUM	7	75	65% (48–66%)

Source: ECDC

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

### Overview:

#### Update:

##### Nevada:

On 10 February 2025, the US CDC ([H5 Bird Flu: Current Situation | CDC](#)) and the Central Nevada Health District ([Community Alerts - Central Nevada Health District](#)) reported one human case of A(H5N1) infection in the state of Nevada, US. The case is an adult who had occupational exposure to infected dairy cattle. The individual experienced conjunctivitis and is now recovering. In response to this event, health authorities are monitoring close contacts of the person for symptoms and are offering personal protective equipment (PPE), testing and antiviral treatment.

On 14 February 2025, the sequence of the human case from Nevada was released on GISAID EpiFlu assigned to clade 2.3.4.4b and genotype D1.1. Out of the 302 influenza A(H5N1) strains of the same genotype available as of 18 February 2025, the majority (93%, n=282) are collected from birds. There are eight virus sequences assigned to genotype D1.1 from humans, all collected in the United States, including the strain A/Nevada/10/2025 from the recent human case of influenza A(H5N1) from Nevada. Mutation analysis of A/Nevada/10/2025 revealed the presence of mutation D701N in the PB2 segment, which is associated with several mammalian adaptations such as increased virulence and contact transmission in guinea pigs and increased virulence in mice. This is the first observation of PB2:D701N in genotype D1.1 from a human infection and the mutation is not present in any of the D1.1 strains from birds. The USDA Animal and Plant Health Inspection Service (APHIS) announced the first detections of genotype D1.1 in dairy cattle in Nevada, US, on January 31 2025, with presence of PB2:D701N in sequenced specimens. The PA segment of A/Nevada/10/2025 has the change S421I, which, although has been associated with increased virulence in mice, is common in isolates from birds.

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

##### Wyoming:

On 19 February 2025, the US CDC ([H5 Bird Flu: Current Situation | CDC](#)) and the Wyoming department of Health ([health.wyo.gov](#)) reported one human case of A(H5N1) infection in the state of Wyoming, US. The case is an adult woman with pre-existing medical conditions from Platte County and had reportedly had exposure to backyard poultry around her house. The individual is currently hospitalised, this is the third confirmed hospitalization related to H5N1 in the United States. Currently, there is no evidence of human-to-human virus spread or of any additional human cases.

According to the US CDC ([H5 Bird Flu Response | Bird Flu | 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).

**Background:** Since 1 April 2024, and as of 20 January 2025, 69 human cases of avian influenza A(H5N1), including one death, have been confirmed by the US CDC from 12 states. 41 cases reported exposure to dairy cattle in the following states: California (36), Colorado (1), Michigan (2), Nevada (1) and Texas (1). 23 cases reported exposure to poultry farms and culling operations in the following states: Colorado (9), Iowa (1), Oregon (1), Washington (11), and Wisconsin (1). Two cases whose exposure was related to other animals such as backyard flocks, wild birds, or other mammals, one in [Louisiana](#) who died and one in Wyoming. Three additional cases have been identified with unknown exposure: two in California and one in Missouri.

### 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 whose activities 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 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 used 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:** [FAO](#) | [2024-e000168](#) | [Event Information Site for IHR National Focal Points](#)

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

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

### Overview:

#### Update:

According to the [French National Health Authority](#), as of 16 February 2025, 1 069 cases (of which 927 in 2025) of autochthonous chikungunya virus disease have been reported in La Réunion. In week 6, 362 new confirmed cases were reported.

Cases are now reported in 21 municipalities. The increase continues at a steady pace.

The municipalities reporting the most cases since the start of the epidemic are:

- Le Tampon (228 cases, the increase remains strong).
- L' Étang-Salé (169 cases)

Virus circulation is also progressing strongly in Les Avirons, Petite-Île, Saint-Joseph, Saint-Louis (south), Saint-Paul (west), Saint-Denis (north).

Several outbreaks of chikungunya virus disease are spreading on the island, and widespread occurrence of the disease is likely. Currently, the reported cases have had a relatively low health impact, with only seven hospitalisations of more than 24 hours reported, and some 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. 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; the current period of austral summer is very favourable for the spread of arboviruses. Given the current epidemic dynamics, the likelihood of further 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.

Currently, 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.

#### 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:

- The 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,
- The distribution of repellents to priority groups around cases,

- Searching 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.

### Further information:

For travellers to La Réunion, it is advised to apply personal protective measures to avoid the risk of being bitten by mosquitoes.

*Aedes* mosquitoes have diurnal biting activities in both indoor and outdoor environments. Personal protective measures should therefore be applied all day long and especially during the hours of highest mosquito activity (mid-morning and late afternoon to twilight). Personal protective measures to reduce the risk of mosquito bites include wearing long sleeves and pants, impregnated with insect repellent, the use of repellent sprays applied in accordance with the instructions indicated on the product label and limiting activities that increase mosquito exposure. In addition, it is recommended to sleep or rest in screened or air-conditioned rooms and to use mosquito bed nets (preferably insecticide-treated nets).

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

## 6. Ebola disease – Uganda – 2025

### Overview:

#### Update

On 18 February, the World Health Organization (WHO) [informed](#) that all remaining confirmed cases under hospitalisation have recovered and have been discharged after two consecutive negative tests taken 72 hours apart.

Currently, a total of 216 contacts remain quarantined and under monitoring.

#### Summary

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 was a 32-year-old male 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.

As of 18 February 2025, nine confirmed cases were reported by the Ugandan Ministry of Health. Of these, one patient passed away and eight have recovered. All these cases were [reported](#) from five districts in the country: Wakiso (4), Kampala (2), Mbale (1), Jinja (1), and Mukono (1).

The cases belonged to the same transmission chain and were divided into two clusters. One cluster included five family members of the index case and the other three healthcare workers involved in the management of the index case.

The [phylogenetic analysis](#) performed from samples taken from the index case showed genetically close to sequences from the 2012 Sudan Ebola outbreak in Luwero District (Uganda).

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

Additionally, authorities in Uganda have taken the following actions:

- Activate the Incident Management Team and dispatch Rapid Response Teams to both Mbale City and Saidina Abubakar Islamic Hospital in Matugga.
- Implement contact tracing.
- Provide a safe and dignified burial to the deceased to prevent the spread of the disease.
- Vaccination of all contacts.
- Inform 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 to citizens in the EU/EEA as very low. The assessment, including ECDC's options for response, remains valid.

The current outbreak started in the densely populated capital of Uganda, so there is a higher probability of local transmission despite the currently 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 to 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:** 14 February 2025

## 7. Legionnaires' disease outbreak - Vorarlberg, Austria - 2025

### Overview:

#### Summary

As of 19 February 2025, a total of 26 cases of Legionnaires' disease (LD) have been identified as part of the outbreak by the local public health authorities in the state of Vorarlberg in Western Austria. The most recent case was a person who developed symptoms on 14 February 2025. No Travel-Associated Legionnaires' Disease (TALD) or other travel-related cases have been reported to ECDC associated with the outbreak.

An epidemiological investigation is underway by authorities to identify the source. Several water samples have already been collected from various sources in the state and are being tested for *Legionella pneumophila*. Environmental samples have been collected from several sampling sites. Collection of respiratory samples from patients and typing of isolated *Legionella* strains will assist ongoing investigations to determine the outbreak source.

Information on the outbreak and precautionary measures to reduce the risk of infection from *Legionella* is available from <https://presse.vorarlberg.at/land/public/Legionellen-Weiterhin-intensive-Suche-nach-den-Ursachen>.

### Background

Community outbreaks of Legionnaires' disease are reported annually by countries across the EU/EEA.

Legionnaires' disease is caused by inhaling *Legionella* bacteria present in an aerosolised environmental source, involving water or soil. People aged over 50 years are more at risk of developing Legionnaires' disease than younger people, as are those who are immunocompromised or have underlying illness.

### ECDC assessment:

Investigations by authorities are ongoing to identify the possible environmental source of this community outbreak in the state of Vorarlberg. Any risk for developing Legionnaires' disease associated to this outbreak is limited to persons visiting or residing in this area.

### Actions:

Information on the outbreak and precautionary measures to reduce the risk of infection from *Legionella* is available from: <https://presse.vorarlberg.at/land/public/Legionellen-Weiterhin-intensive-Suche-nach-den-Ursachen>.

ECDC is in contact with Austria through the European Legionnaires' disease surveillance network (ELDSNet).

**Last time this event was included in the Weekly CDTR: -**

## 8. Locally acquired dengue cases in Madeira - Portugal - 2025

### Overview:

#### Background

On 18 February 2025, the Regional Health Authority of Madeira (RAM) confirmed the detection of two locally acquired cases of dengue with symptom onset in January 2025.

No further suspected cases have been identified.

In the third week of January, entomological investigations confirmed the presence of dengue in mosquitoes captured on Madeira.

No further positive detections in mosquitoes were made thereafter.

### ECDC assessment:

The last outbreak of locally acquired dengue cases on Madeira, an outermost region of Portugal, occurred in 2012-2013, with over 1 000 confirmed cases. Since then, no locally acquired cases of dengue have been reported. During the outbreak, the first cases were notified in October 2012, and the last cases in February 2013.

*Aedes aegypti* is known to be established on Madeira. The current outbreak could not be considered unexpected due to entomological activity persisting until the end of January. However, the risk of further transmission is considered low, as the mosquito active season would normally start around late May.

In mainland Europe, the dengue virus is transmitted by the mosquito vector *Aedes albopictus*, which is established in a large part of Europe. The environmental conditions in the areas of mainland EU/EEA where *Ae. albopictus* is established are currently unfavourable for mosquito activity and virus replication in mosquitoes; therefore, it is unlikely that local transmissions will occur until conditions become favourable in early summer.

More information is available on ECDC's dedicated webpage on locally acquired transmission of dengue virus in the EU/EEA and in ECDC's dengue factsheet.

### **Actions:**

The Regional Health Authority of Madeira has implemented response measures, including strengthening entomological and epidemiological surveillance with active case-finding.

ECDC continues monitoring locally acquired dengue cases in the EU/EEA.

**Last time this event was included in the Weekly CDTR: -**

## **9. Unknown disease - DRC -2025**

### **Overview:**

WHO Afro Weekly Bulletin on Outbreaks and Other Emergencies reports two clusters of unknown disease in two health zones in Équateur Province, DRC. According to the report, a total of 431 cases with 53 deaths (CFR 12.2%) have been reported in Bolomba Health Zone and Basankusu Health Zone. No epidemiological link has been established between the two clusters.

The first cluster was reported from Bolomba Health Zone to Equator provincial health authorities on 21 January 2025. The outbreak was traced back to three children from Boloko village who consumed a bat carcass prior to symptoms onset. The children developed fever, headache, diarrhoea, and fatigue, which later progressed to haemorrhagic signs and symptoms, including subconjunctival haemorrhage, epistaxis, and haematemesis. All three children died between 10 and 13 January. Between 15 and 22 January 2025, there were four additional fatalities among children from the same village, as well as additional fatality and four active cases in a neighbouring Danda village. The active cases experienced the following symptoms: fever, vomiting, diarrhoea, fatigue, abdominal pain, myalgia, and headache, with three cases showing haemorrhagic signs such as epistaxis, haematemesis, and melena. PCR tests conducted in the National Institute of Biomedical Research (INRB) in Kinshasa on blood samples from the four active cases and a post-mortem swab from a deceased case from Danda village were negative for Zaire ebolavirus and Marburg virus. A total of 12 cases and 8 deaths (CFR 66.7%) was reported in this cluster by 27 January 2025.

The second cluster was reported from Basankusu Health Zone to provincial health authorities on 9 February 2025. The primary clinical manifestations include fever, chills, headache, myalgia, body aches, sweating, rhinorrhoea, neck stiffness, cough, vomiting, diarrhoea, and abdominal cramps. Around half of deaths (n=22) occurred within 48 hours of symptoms onset. Samples from 13 cases, 12 active and one deceased, were analysed by INRB and were negative for Zaire ebolavirus and Marburg virus in PCR test. As of 15 February 2025, a total of 419 cases and 45 deaths (CFR 10.7%) was reported in this cluster. No exposure details are known at the moment.

Additional investigation is ongoing, including metagenomic sequencing of collected samples, as well as case investigations and active case finding in the affected communities.

### **ECDC assessment:**

Although the cause of this cluster of cases has not yet been defined and investigations are ongoing, we know that it is causing severe illness only in individuals with malnutrition. We also know that the likely reason why the causative agent was not determined promptly was the lack of local diagnostic capacity. Considering these elements and pending the results of the laboratory investigations, ECDC assesses that the risk posed by this event to EU/EEA countries is low. ECDC will reassess the risk once the results of the ongoing microbiological investigations become available.

## Actions:

ECDC is monitoring the signal through epidemic intelligence activities and is in contact with WHO, Africa CDC, and EU services in the field to gather additional information.

**Last time this event was included in the Weekly CDTR: -**

## Events under active monitoring

- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 31 January 2025
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - 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
- Marburg virus disease - Tanzania - 2025 - last reported on 31 January 2025
- Suspected viral haemorrhagic fever - Democratic Republic of the Congo - 2025 - last reported on 31 January 2025
- Ebola disease – Uganda – 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 21 February 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 21 February 2025
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 21 February 2025
- Legionnaires' disease outbreak - Vorarlberg, Austria - 2025 - last reported on 21 February 2025
- Locally acquired dengue cases in Madeira - Portugal - 2025 - last reported on 21 February 2025
- Unknown disease - DRC - 2025 - last reported on 21 February 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - 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
- Community-associated outbreaks of impetigo by fusidic acid-resistant MRSA - multi-country - 2024 - last reported on 17 January 2025
- Mass gathering monitoring - Jubilee of 2025 in Italy - last reported on 17 January 2025
- Human cases with avian influenza A(H10N3) – Multi-country (World) - last reported on 14 February 2025
- Human cases infected with swine influenza A(H1N2) variant virus – Multi-country – 2024 - last reported on 14 February 2025
- STI cases continue to rise across Europe - last reported on 14 February 2025
- Mpox due to monkeypox virus clade I – Ireland – 2025 - last reported on 07 February 2025
- Yellow fever – South America – 2024–2025 - last reported on 07 February 2025
- SARS-CoV-2 variant classification - last reported on 07 February 2025
- Shigella sonnei ST152 outbreak associated with international travel on long-haul flights - last reported on 07 February 2025