

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 9, 22–28 February 2025

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Executive Summary

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 26 February 2025, a total of 37 cases of Legionnaires' disease have been reported associated with the outbreak.
- Investigations have been able to identify that the likely source of this outbreak is a cooling tower and control measures have been implemented.

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

- France reported the first autochthonous case of chikungunya virus disease for 10 years in the Department of La Réunion, with onset of symptoms on 12 August 2024.
- Since then, and as of 23 February 2025, 1 773 cases of autochthonous chikungunya virus disease have been confirmed in La Réunion.

Overview of respiratory virus epidemiology in the EU/EEA

- There is currently significant respiratory virus activity in the European Union/European Economic Area (EU/EEA). Intense seasonal influenza activity is being 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 in children under five years for RSV.
- For influenza, most countries have reached, or have passed peak activity, however increasing trends in activity continue to be observed in around a quarter of the EU/EEA countries. Influenza hospital admissions have now started to decrease from very high levels in most reporting countries.

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

- On 26 February, the US CDC published the analysis of the genetic sequence of the avian influenza A(H5N1) virus isolated from the case in Wyoming (case reported in CDTR on 20 February 2025). The isolated virus belongs to clade 2.3.4.4.b, genotype D1.1, with the mutation E627K in the PB2 segment, previously associated with more efficient virus replication in people and other mammals. No additional mutations linked to mammalian adaptation were found in the sequence data.
- Since 1 April 2024, and as of 27 February 2025, a total of 70 human cases of avian influenza A(H5) have been reported from 13 states in the United States (US). Of these, 41 were individuals exposed to dairy cattle known or presumed to be infected with A(H5N1) and 24 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).

Influenza A(H5N1) – Multi-country (World) – Monitoring human cases

- On 25 February 2025, a fatal case of human infection with avian influenza A(H5N1) was reported from Cambodia.
- The case was a child from Prey Veng province in southern Cambodia.
- The case had exposure to sick and dead poultry raised in the family's household prior to symptom onset.
- Since 2003, Cambodia has reported 74 human cases of A(H5N1) avian influenza virus infection, including 45 deaths (case fatality among reported cases: 61%).

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 in individuals who had been hospitalised had recovered and been discharged.
- As of 20 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. Given the current epidemiological situation, the likelihood of importation to the EU/EEA is very low.

Unknown disease - DRC -2025

- Two clusters of an unknown disease have been 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.
- As of 20 February 2025, a total of 943 cases and 52 deaths (CFR 18%) have been reported in Basankusu.
- Diagnostic tests conducted on active cases and deceased individuals were negative for Zaire ebolavirus and Marburg virus.
- Differential diagnoses include malaria, typhoid fever, flu, and potential poisoning from water or food sources.

Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update

- Since the beginning of 2025, over 30 000 chikungunya virus disease (CHIKVD) cases and 14 CHIKVD-related deaths have been reported worldwide. A total of 14 countries/territories have reported CHIKVD cases from the Americas (11), Asia (1), Africa (1), and Europe (1). No autochthonous cases of CHIKVD have been reported in mainland Europe in 2025. La Reunion has reported CHIKVD cases in 2025.
- In 2025, over 600 000 dengue cases and over 150 deaths have been reported from 48 countries/territories globally. As of 24 February 2025, dengue circulation has been reported in Africa, America, South-East Asia and the Western Pacific region.
- The environmental conditions in the areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti* are established are currently unfavourable for mosquito activity and virus replication in mosquitoes. It is therefore unlikely that locally-acquired chikungunya and dengue virus transmission will occur until conditions become favourable in early summer.

Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

- In 2025, as of 25 February 2025, four cases of AFP caused by WPV1 have been reported, three in Pakistan and one in Afghanistan.
- In 2024, as of 25 February 2025, 99 cases of AFP caused by WPV1 have been reported, 74 in Pakistan and 25 in Afghanistan.
- In 2024, as of 25 February 2025, 11 cases of AFP caused by cVDPV1 have been reported by the Democratic Republic of the Congo (DRC) (ten cases), and Mozambique (one case).
- In 2024, as of 25 February 2025, 278 cases of AFP caused by cVDPV2 have been reported from 18 countries: Nigeria (94), Yemen (37), Chad (35), Ethiopia (42), Niger (16), Democratic Republic of Congo (14), South Sudan (10), Angola (7), Indonesia (7), Guinea (5), Somalia (3), Cameroon (2), Algeria (1), Benin (1), Liberia (1), Mali (1), Palestine* (1) and Senegal (1).
- In 2024, as of 25 February 2025, four cases of AFP caused by cVDPV3 have been reported in Guinea.

1. Legionnaires' disease outbreak - Vorarlberg, Austria - 2025

Overview

Summary

As of 26 February 2025, a total of 37 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 26 February 2025. No Travel-Associated Legionnaires' Disease (TALD) or other travel-related cases have been reported to ECDC associated with the outbreak.

An outbreak investigation has identified that the likely source of this outbreak is a cooling tower. More than 300 water samples have been collected from sampling sites, including private residences, workplaces, cooling towers and industrial sites in the state, and tested for *Legionella pneumophila*. Necessary measures have been implemented at sites that tested positive in environmental sampling.

So far, clinical isolates have been recovered from six patient samples and they share the same genomic profile.

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

The likely source of this outbreak is a cooling tower and measures have been implemented. Therefore, any remaining risk for developing Legionnaires' disease associated with this outbreak (considering the incubation period) has been significantly reduced and 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: 21 February 2025

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

Overview

Update

According to the [French National Health Authority](#), as of 23 February 2025, 1 773 cases (1 631 in 2025) of autochthonous chikungunya virus disease have been reported in La Réunion. In week 7, 695 new confirmed cases were reported, representing a strong increase. Cases are now being reported in 22 of 24 municipalities.

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

- Le Tampon (437 cases, the increase remains high).
- L' Étang-Salé (241 cases).

Virus circulation is also increasing considerably in Les Avirons, Petite-Île, Saint-Philippe, Saint-Louis (south), Saint-Paul, Saint-Leu La Possession and Trois-Bassins (west).

At present, the health impact on the reported cases is relatively low, with only 13 hospitalisations of more than 24 hours reported.

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 reported the first autochthonous case of chikungunya virus disease for 10 years in the Department of La Réunion, with onset of symptoms on 12 August 2024. Since then, France has [confirmed](#) 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 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 dynamics of the epidemic, the likelihood of further dissemination of CHIKV across the entire island is high for the coming weeks. The impact is anticipated to be moderate, as a significant number of people are expected to be affected.

At present, environmental conditions in the areas of mainland Europe 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 have been 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 of preventive measures among residents;
- distributing repellents to priority groups in the area around cases;
- searching for other cases in the area around the location of the initial case;
- encouraging people to consult a doctor promptly if symptoms occur;
- encouraging clinicians to carry out laboratory tests.

ECDC is monitoring the situation through its epidemic intelligence activities.

Further information

Travellers to La Réunion are 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 trousers 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: 21 February 2025.

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

Overview

Based on data reported to week 8, 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 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. Most countries have reached, or passed peak activity, however increasing trends in activity continue to be observed in around a quarter of the EU/EEA countries. Influenza hospital admissions have now started to decrease from very high levels in most reporting countries.

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 under five years for RSV. Since week 51, 2024, [EuroMOMO](#) has reported all-cause mortality above expected levels, mostly in adults aged 65 years and over.

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

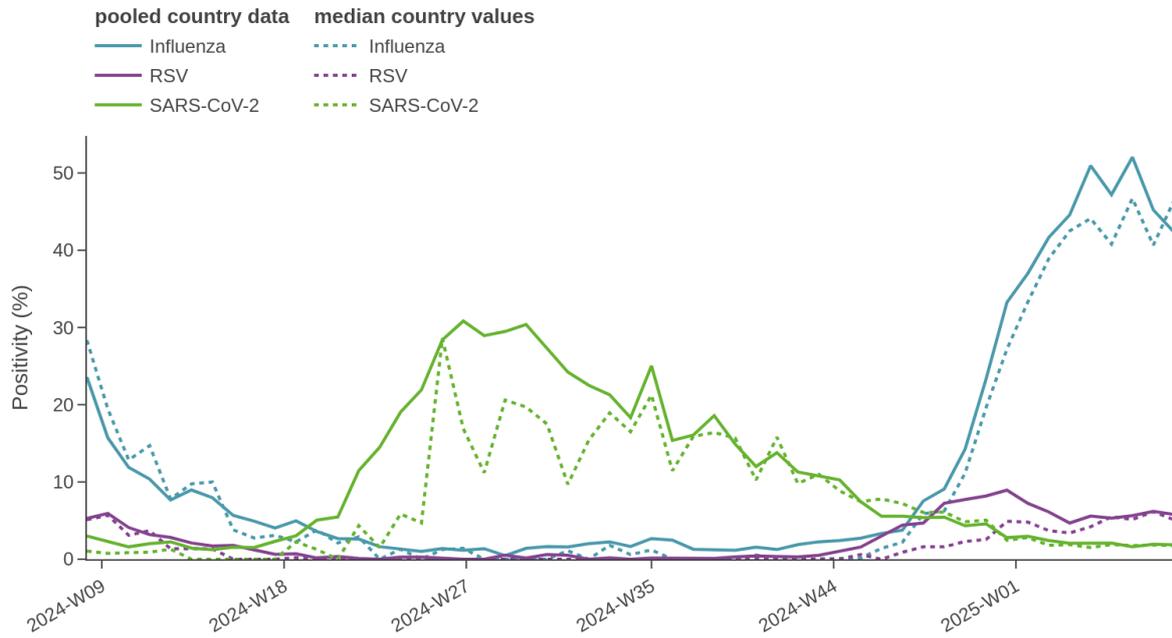
- ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary ([ERVISS.org](#)), which is updated weekly.
- ECDC has published recommended public health actions to mitigate against the impact of respiratory 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: 21 February 2025

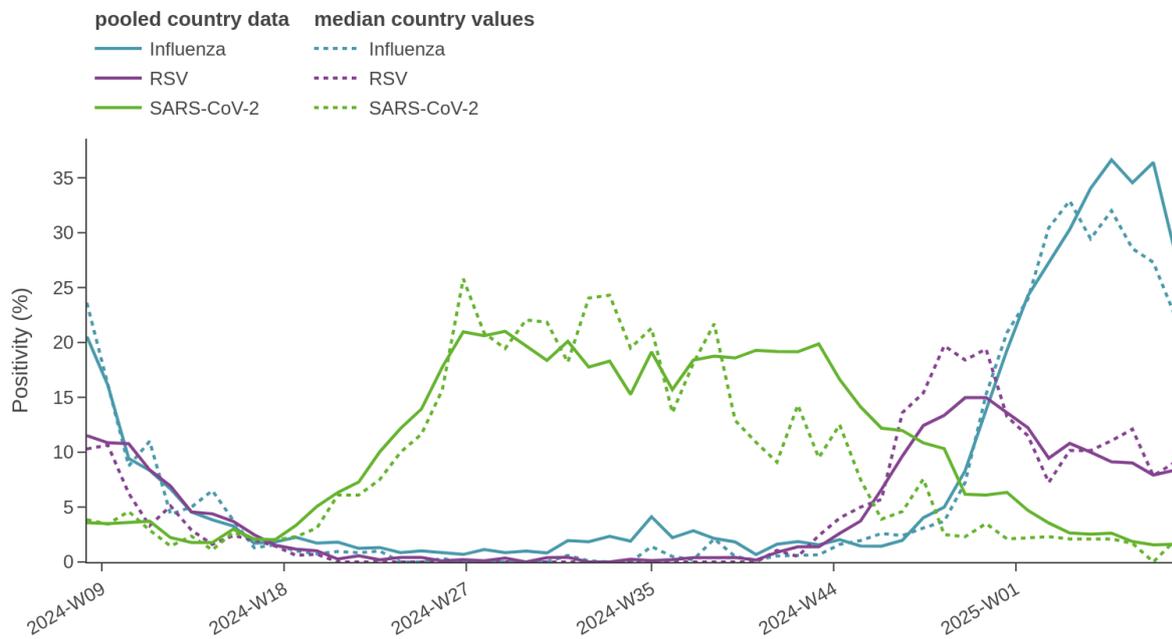
Maps and graphs

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 NA

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		
		Week 8	Week 7	Description	Value	Comment
ILI/ARI consultation rates in primary care	ARI	15 rates (11 MEM)	16 rates (12 MEM)	Distribution of country MEM categories	3 Baseline 1 Low 5 Medium 1 High 1 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. Three countries are reporting ILI consultation rates that exceed the peak observed in each of the past four seasons.
	ILI	18 rates (16 MEM)	21 rates (19 MEM)		2 Baseline 2 Low 9 Medium 2 High 1 Very high	
ILI/ARI test positivity in primary care	Influenza	18	20	Pooled (median; IQR)	42% (46; 39-53%)	Current pooled EU/EEA level positivity exceeds the peak observed in each of the past four seasons. However, positivity has stabilised since week 4. This plateau in positivity is observed in all age groups. The EU/EEA level pooled data mask considerable heterogeneity between countries.
	RSV	17	18		5.8% (5.1; 4-8%)	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. The country picture remains mixed.
	SARS-CoV-2	17	18		1.9% (1.8; 0.1-2.2%)	Activity is low in all countries.
SARI rates in hospitals	SARI	8	10	-	-	
SARI test positivity in hospitals	Influenza	7	10	Pooled (median; IQR)	29% (23; 17-29%)	The pooled positivity has stabilised since week 5 and is now decreasing. The overall age distribution in the season to date does not differ substantially from that observed in the 2023-2024 season.
	RSV	6	9		8.4% (9.1; 8-14%)	In terms of overall trend and country heterogeneity, the picture is similar to that for primary care.
	SARS-CoV-2	7	9		1.6% (1.9; 0.7-2.4%)	
Intensity (country-defined)	Influenza	21	24	Distribution of country qualitative categories	1 Baseline 2 Low 9 Medium 7 High 2 Very high	
Geographic spread (country-defined)	Influenza	20	23	Distribution of country qualitative categories	1 Local 2 Regional 17 Widespread	

Source: ECDC

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

Pathogen	Week 8, 2025		Week 40, 2024 - week 8, 2025	
	N	% ^a	N	% ^a
Influenza	1393	-	18077	-
Influenza A	669	48	11370	64
A(H1)pdm09	267	51	5841	63
A(H3)	258	49	3500	37
A (unknown)	144	-	2029	-
Influenza B	711	52	6494	36
B/Vic	241	100	2418	100
B/Yam	0	0.0	1	0.0
B (unknown)	470	-	4075	-
Influenza untyped	13	-	213	-
RSV	149	-	2729	-
RSV-A	17	32	438	40
RSV-B	36	68	653	60
RSV untyped	96	-	1638	-
SARS-CoV-2	48	-	2740	-

Source: ECDC

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

Figure 5 Table

Pathogen	Week 8, 2025		Week 40, 2024 - week 8, 2025	
	N	% ^a	N	% ^a
Influenza	535	-	8289	-
Influenza A	107	83	3390	88
A(H1)pdm09	13	37	1224	65
A(H3)	22	63	654	35
A (unknown)	72	-	1512	-
Influenza B	22	17	472	12
B/Vic	0	-	50	100
B (unknown)	22	-	422	-
Influenza untyped	406	-	4427	-
RSV	154	-	3479	-
RSV-A	2	67	588	50
RSV-B	1	33	579	50
RSV untyped	151	-	2312	-
SARS-CoV-2	30	-	3189	-

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 8, 2025

Subtype	Subtype distribution		Subclade	Subclade distribution	
	N	%		N	%
A(H1)pdm09	1911	49	5a.2a(C.1.9)	1691	88
			5a.2a.1(D)	163	9
			5a.2a(C.1)	57	3
A(H3)	921	24	2a.3a.1(J.2)	651	72
			2a.3a.1(J.2.2)	123	14
			2a.3a.1(J.2.1)	113	12
			2a.3a.1(J)	10	1
			2a.3a.1(J.1)	9	1.0
			2a.3a.1(J.4)	2	0.2
			Not assigned	13	-
B/Vic	1074	27	V1A.3a.2(C.5.1)	723	68
			V1A.3a.2(C.5.7)	165	16
			V1A.3a.2(C.5.6)	150	14
			V1A.3a.2(C)	22	2
			V1A.3a.2(C.5)	2	0.2
			Not assigned	12	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 6–7, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	3	25	26% (24–31%)
KP3	VOI	3	21	26% (23–32%)
XEC	VUM	3	37	45% (42–46%)

Source: ECDC

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

Overview

Update

On 26 February 2025, the US CDC [published](#) the analysis of the genetic sequence of the avian influenza A(H5N1) virus isolated from the case in Wyoming. The case was reported in the CDTR on 20 February 2025. The isolated virus belongs to clade 2.3.4.4.b, genotype D1.1, the clade and genotype as the virus isolated from the case in Nevada. Mutation analysis of the viral sequence revealed the presence of mutation E627K in the PB2 segment, previously associated with more efficient virus replication in people and other mammals. This mutational change was previously reported in a virus from a different clade isolated from the case in Texas in April 2024. No additional mutations linked to mammalian adaptation were found in the sequence data. The CDC also did not detect any genetic changes that could affect the effectiveness of influenza antiviral medications or existing H5 candidate vaccine viruses. The isolated virus will undergo further testing and analysis.

In response to this and other cases of avian influenza A(H5) infection in humans, the CDC and state public health officials have implemented several response measures, including surveillance, case investigations, and contact tracing. Since March 2024, over 15,200 people have been monitored, and more than 830 tested following exposure to infected animals in the US. The CDC has issued a Health Alert Notice (HAN) and continues to enhance routine surveillance for novel influenza viruses, such as A(H5N1). In addition, the CDC advises that exposed individuals should be monitored for symptoms, symptomatic cases tested, and protective guidelines followed to prevent transmission, including avoiding unprotected contact with potentially infected animals.

At present, 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 are in contact 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 25 February 2025, 70 human cases of avian influenza A(H5N1), including one death, have been confirmed by the US CDC from 13 states. In total, 41 cases reported exposure to dairy cattle in the following states: California (36), Colorado (1), Michigan (2), Nevada (1) and Texas (1) and 24 cases reported exposure to poultry farms and culling operations in the following states: Colorado (9), Iowa (1), Ohio (1), Oregon (1), Washington (11), and Wisconsin (1). Two cases reported exposure to other animals, such as backyard flocks, wild birds, or other mammals: one case in Louisiana, who later died, and one in Wyoming. Three additional cases with unknown exposure have also been identified: 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 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](#).

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

5. Influenza A(H5N1) – Multi-country (World) – Monitoring human cases

Overview

Update

On 25 February 2025, a fatal case of human infection with avian influenza A(H5N1) was reported by the Cambodian Ministry of Health. The case was in a two-year-old child from Prey Veng province in southern Cambodia. The case was laboratory-confirmed by the National Institute of Public Health on the same day. The child was in a serious condition with symptoms including fever, cough, exhaustion and difficulty breathing and passed away shortly after being brought to hospital on 25 February 2025. Investigations revealed that the patient's family raised poultry in their household and recently some of the poultry had become sick and died. The child was reported to have played and slept near or in the chicken coop.

In cooperation with the provincial Department of Agriculture and the local authorities, the Ministry of Health's emergency response team have responded to the incident in accordance with technical methods and protocols. This includes continuing to search for sources of infection in humans and animals, identifying suspected cases and contacts, distributing Tamiflu to close contacts of the case, and conducting a health education campaign in the village where the incident occurred.

Summary

This is the second human case of avian influenza A(H5N1) infection in Cambodia in 2025. Since 2003, Cambodia has reported 74 cases of A(H5N1). Globally, since 2003, and as of 26 February 2025, there have been 969 human cases worldwide*, including 467 deaths (case fatality among reported cases: 48%), with avian influenza A(H5N1) infection reported in 24 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, Indonesia, India, Iraq, Laos, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Vietnam, the United Kingdom and the United States). To date, no sustained human-to-human transmission has been detected.

***Note:** this includes detections due to suspected environmental contamination with no evidence of infection that were reported in 2022 by Spain (two detections), the United States (1) and the United Kingdom (5). Human cases of A(H5) epidemiologically linked to A(H5N1) outbreaks in poultry and dairy cattle in the United States are included in the reported number of cases of A(H5N1).

ECDC assessment

Sporadic human cases of different avian influenza A(H5Nx) subtypes have previously been reported globally. Current epidemiological and virological evidence suggests that A(H5N1) viruses remain avian-like. Transmission to humans remains a rare event and no sustained transmission between humans has been observed.

Overall, the risk of zoonotic influenza transmission to the general public in EU/EEA countries is considered low. The risk to occupationally exposed groups, such as farmers and cullers, is considered low-to-medium.

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

Actions

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

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

6. Ebola disease – Uganda – 2025

Overview

Update

On 21 February, the World Health Organization (WHO) issued a [Disease Outbreak News \(DON\)](#) item reporting that, as of 20 February, no new cases of Ebola disease caused by the Sudan virus had been reported in Uganda. The total number of confirmed cases is nine; of these, one patient has passed away and eight have recovered.

A total of 299 contacts have been identified since the beginning of the outbreak. Of these, 75% have already completed the required follow-up period of 21 days. At present there are still 58 contacts under observation.

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 20 February 2025, nine confirmed cases had been reported by WHO. Of these, one patient had passed away and eight had recovered. All these cases were [reported](#) from five districts in the country: Wakiso (4), Kampala (2), Mbale (1), Jinja (1), and Mukono (1). The age range was from 1.5 to 49 years, with a mean age of 27 years and males accounting for 56% of the total cases.

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 cluster involved three healthcare workers who had treated the index case. The secondary cases had symptom onset between 29 January and 6 February. On 18 February, WHO [reported](#) that all remaining confirmed cases under hospitalisation had recovered and been discharged after two consecutive negative tests taken 72 hours apart.

According to the [WHO guidelines for declaring the end of an Ebola outbreak](#), the countdown to the end of human-to-human transmission begins the day after the last possible exposure, which in this case is the day following negative test results. If no further cases are reported, the outbreak will be declared over after 42 days, equivalent to two incubation periods.

The [phylogenetic analysis](#) of samples taken from the index case showed them to be 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.

In addition, authorities in Uganda have taken the following actions:

- activated the Incident Management Team and dispatched rapid response teams to both Mbale City and Saidina Abubakar Islamic Hospital in Matugga;
- implemented contact tracing;
- provided a safe and dignified burial for the deceased to prevent the spread of the disease;
- vaccinated all contacts;
- informed the public and healthcare workers.

Background

This is the eighth Ebola outbreak in the country, with the [most recent](#) having occurred 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 Kampala, the densely populated capital of Uganda, so there is a greater probability of local transmission, despite the low number of cases currently being 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.

Given 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: 21 February 2025

7. Unknown disease – Democratic Republic of Congo -2025

Overview

Update: As of 18 February 2025, the Basankusu Health Zone in the Equateur Province of the [Democratic Republic of Congo](#) has reported 722 cases of febrile illness, with 48 deaths. The affected areas include four Aires de Santé: Ekoto, Lilangi, Lisafa, and Bafumba, with Ekoto being the most affected. The majority of cases (74%) and deaths (58%) are among individuals aged 5 to 45 years, with women representing 53% of the cases, broadly mirroring the distribution of the general population. Symptoms observed include fever, chills, headaches, muscle pain, joint pain, neck pain, vomiting, abdominal pain, shortness of breath and agitation.

A provincial rapid response team has been conducting field investigations since 16 February, and a national rapid response team, along with WHO staff, is expected to arrive soon. Initial rapid diagnostic tests (RDTs) for malaria have shown a 50.7% positivity rate among the tested individuals. Differential diagnoses include malaria, poisoning (water or food), flu, and typhoid fever. There is no epidemiological link between this outbreak and a recent cluster of deaths in the Bolomba Health Zone, suggesting separate events.

Background: WHO Afro [Weekly Bulletin on Outbreaks and Other Emergencies](#) reports two clusters of unknown disease in two health zones in Equateur 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 further fatalities and four active cases in Danda, a neighbouring 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 at 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 eight deaths (CFR 66.7%) had been 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, rhinorrhea, neck stiffness, cough, vomiting, diarrhoea, and abdominal cramps. Around half of the deaths (n=22) occurred within 48 hours of symptom onset. Samples from 13 cases, 12 active and one deceased, were analysed by INRB and found to be negative for Zaire ebolavirus and Marburg virus in PCR tests. As of 15 February 2025, a total of 419 cases and 45 deaths (CFR 10.7%) had been 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

A single cause of this cluster of cases remains unidentified and investigations are ongoing, however tests for Zaire ebolavirus and Marburg virus have been negative. Given the current laboratory findings, ECDC assesses the risk to EU/EEA countries as low. ECDC will re-evaluate the risk should new information arise.

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: 21 February 2025

8. Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update

Overview

Chikungunya virus disease (CHIKVD)

Since the beginning of 2025, and as of 25 February, over 30 000 CHIKVD cases and 14 CHIKVD-related deaths have been reported in 14 countries/territories from the Americas (11), Africa (1), Asia (1), and Europe (1).

In 2025, the Americas account for the highest number of CHIKVD cases reported worldwide. As of February, CHIKVD cases have been reported from Brazil (31 484), Argentina (512), Bolivia (33) and Paraguay (23). Additional countries in the Americas reporting CHIKVD cases can be found on [PAHO's dedicated website](#).

Outside of the Americas, CHIKVD cases have been reported in Asia from [Pakistan](#) (201). One African country reported CHIKVD cases in 2025: [Senegal](#) (2).

No autochthonous cases of CHIKVD have been reported in mainland Europe in 2025. However, 1 631 CHIKVD cases have been reported from the French overseas department of [La Réunion](#). Cases are now reported in 22 of 24 municipalities. Due to the increase in the number of cases and the spread of outbreaks, Level 3 of the ORSEC 'Arboviruses' system has been activated, which corresponds to the circulation of a low-intensity epidemic.

In 2025, CHIKVD-associated deaths have also been reported from Brazil (14).

Dengue

Since the beginning of 2025, 640 349 dengue cases and 159 dengue-related deaths have been reported from 48 countries/territories. The 15 countries reporting most cases are: Brazil (518 017), Colombia (31 967), Mexico (14 587), Peru (11 833), Vietnam (6 945), Sri Lanka (6 801), Ecuador (6 607), Paraguay (6 597), Guyana (6 012), Nicaragua (5 702), Guatemala (4 439), Thailand (4 005), Bolivia (2 354), Guadeloupe (2 220) and India (1 847).

As of 25 February 2025, dengue circulation has been reported in Africa, America, South-East Asia and the Western Pacific region.

In mainland Europe, no autochthonous cases have been [reported](#) in 2025.

In Madeira, two locally acquired cases were [reported](#) on 18 February, with symptom onset in January 2025. Following the regional response plan, extra active entomological monitoring was initiated upon suspicion of locally acquired cases.

In Guadeloupe, the current situation is classified as an epidemic of phase 4 level 1 (confirmed epidemic) ([Epidemiological Bulletin of French Antilles, published 20 February 2025](#)). Since week 4 there has been a decrease in the number of medical consultations and a decrease in emergency room visits for suspected dengue fever. The most prevalent serotype, according to the recent [Epidemiological Bulletin of French Antilles, published 20 February 2025](#) continues to be DENV-3.

In Martinique, over 50 confirmed cases have been [reported](#) so far in 2025. The [epidemiological situation](#) is characterised as phase 2 (level 2; outbreaks that can evolve or multiple outbreaks with epidemiological links among them).

In Saint-Martin and Saint-Barthélemy dengue circulation continues, but at lower levels (epidemic phase 1), with only sporadic cases or outbreaks without epidemiological links being reported ([Epidemiological Bulletin of French Antilles, 20 February 2025](#)).

In French Guyana, case numbers have decreased in recent months and are showing a stable trend at lower levels. The trends are being monitored ([Health surveillance in French Guiana. Bulletin of 20 February, 2025](#)).

In La Reunion, 12 dengue cases, of which four confirmed by PCR, have been [reported](#) since the beginning of the year and as of 10 February 2025. Circulation is currently continuing at low levels.

A summary of recent epidemiological trends of dengue outside EU/EEA of the first weeks of 2025 is presented below. The summary is based on available information from official sources and reports from different countries/territories.

According to the [country report](#) published on 16 February 2025, in Bangladesh, so far in 2025, overall, the total number of dengue cases in 2025 is higher than during the same period in 2024, while the number of deaths in 2025 is lower (1 493 cases and 14 deaths in the first six weeks of 2025 versus 1 224 cases and 18 deaths in the first six weeks of 2024).

In India, cases continued to be reported during the first weeks of 2025, as mentioned in the [SEARO report published on 12 February 2025](#). In Sri Lanka in 2025 so far, dengue cases have been lower than those reported in 2024 ([SEARO report published on 12 February 2025](#)).

In Laos, Vietnam and Singapore in 2025 so far, dengue cases are lower than those reported in 2024 ([WPRO Dengue Situation update of 20 February 2025](#)). In [China](#), 49 cases and no deaths were reported in January 2025.

In French Polynesia, an increasing number of cases was [reported](#) in January 2025 compared to the same period in 2024.

In 2025, in Africa, over 2 100 cases and one death have been reported from Burkina Faso, Cabo Verde, Mali, Senegal and Sudan ([Africa CDC Epidemic Intelligence Report of 10 February 2025](#)).

Note: the data presented in this report originate from both official public health authorities and non-official sources, such as news media, and depending on the source, autochthonous and non-autochthonous cases may be included. Data completeness depends on the availability of reports from surveillance systems and their accuracy, which varies between countries. All data should be interpreted with caution and comparisons, particularly across countries, should be avoided due to under-reporting, variations in surveillance system structure, different case definitions from country to country and over time, and use of syndromic definitions.

ECDC assessment

The Americas are currently facing the largest ever outbreak of dengue. As a result, there has been a substantial increase in the number of cases of dengue imported to the EU/EEA since the beginning of 2024.

The likelihood of onward transmission of dengue and chikungunya virus in mainland Europe is linked to importation of the virus by viraemic travellers into receptive areas with established and active competent vectors (e.g. [Aedes albopictus](#) and [Aedes aegypti](#)). [Aedes albopictus](#) is [established](#) in a large part of Europe. In Europe and neighbouring areas, [Aedes aegypti](#) is [established](#) in Cyprus, on the eastern shores of the Black Sea, and in the outermost region of Madeira.

The environmental conditions in the areas of mainland Europe where [Ae. albopictus](#) or [Ae. aegypti](#) are established are currently unfavourable for mosquito activity and virus replication in mosquitoes. It is therefore unlikely that locally acquired chikungunya and dengue virus transmissions will occur until conditions become favourable in early summer. All past autochthonous outbreaks of [CHIKVD](#) and [dengue](#) in mainland Europe to date have occurred between June and November.

More information on autochthonous transmission of [chikungunya](#) and [dengue](#) virus in the EU/EEA is available on ECDC's webpages, and in ECDC's factsheets on [dengue](#) and [CHIKVD](#).

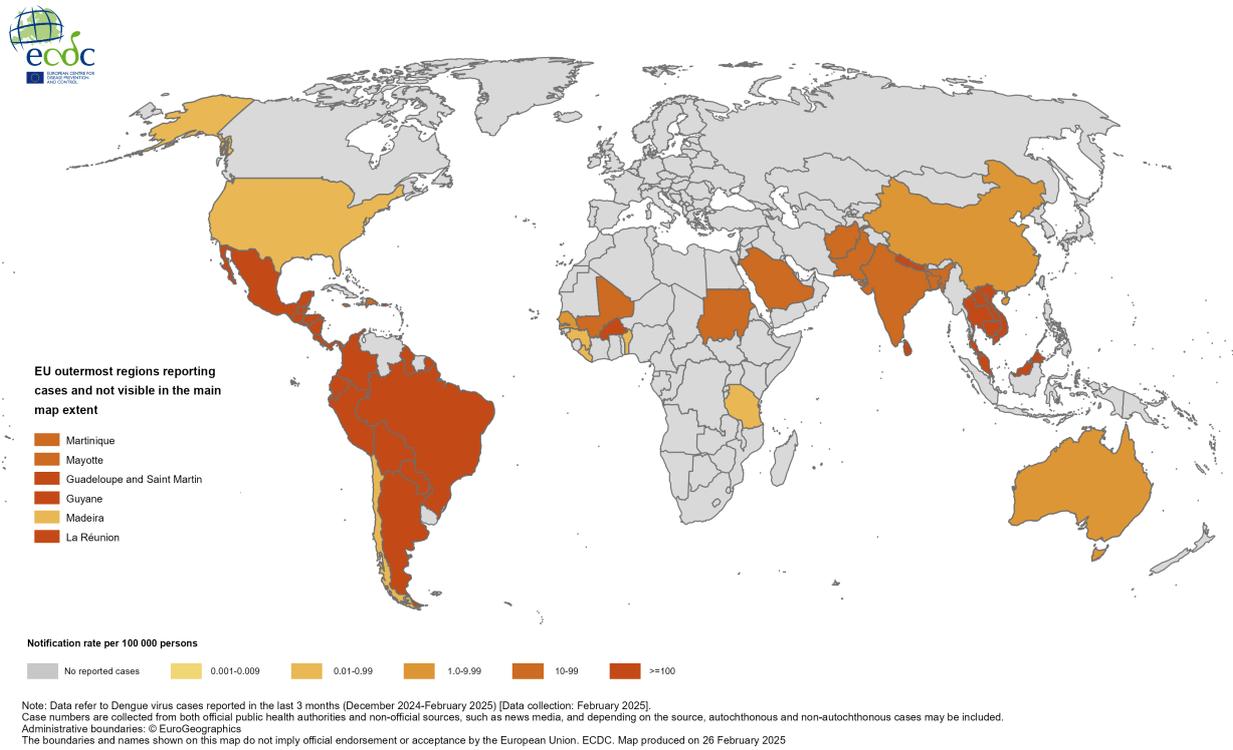
Actions

ECDC monitors these threats through its epidemic intelligence activities, and reports on a monthly basis. A summary of the worldwide overview of [dengue](#) and [CHIKVD](#) is available on ECDC's website.

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

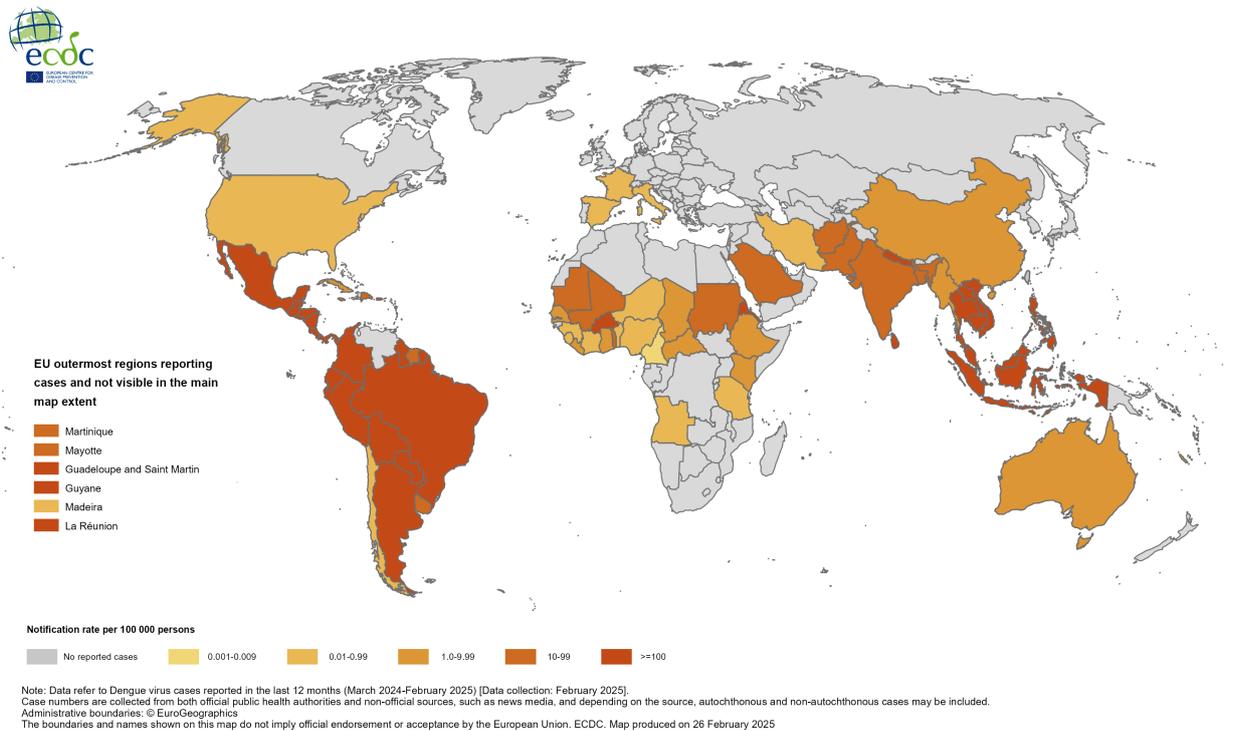
Maps and graphs

Figure 1. Three-month dengue virus disease case notification rate per 100 000 population, December 2024-February 2025



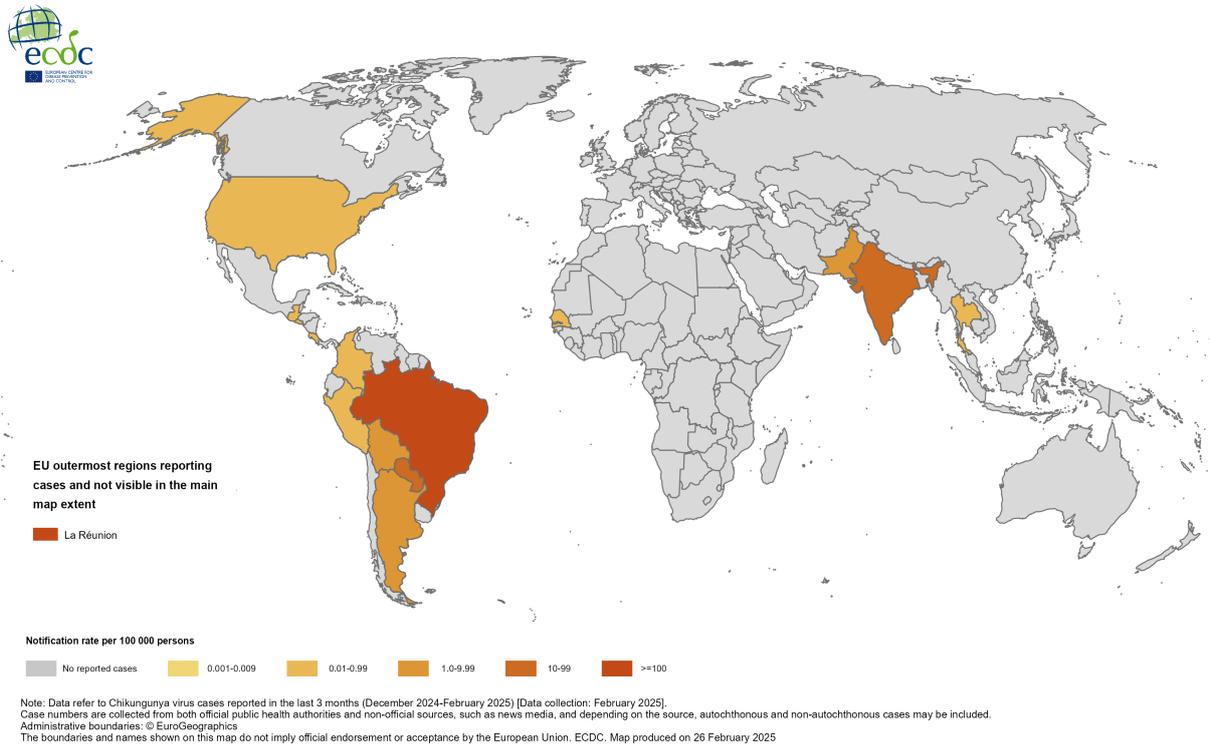
Source: ECDC

Figure 2. 12-month dengue virus disease case notification rate per 100 000 population, March 2024-February 2025



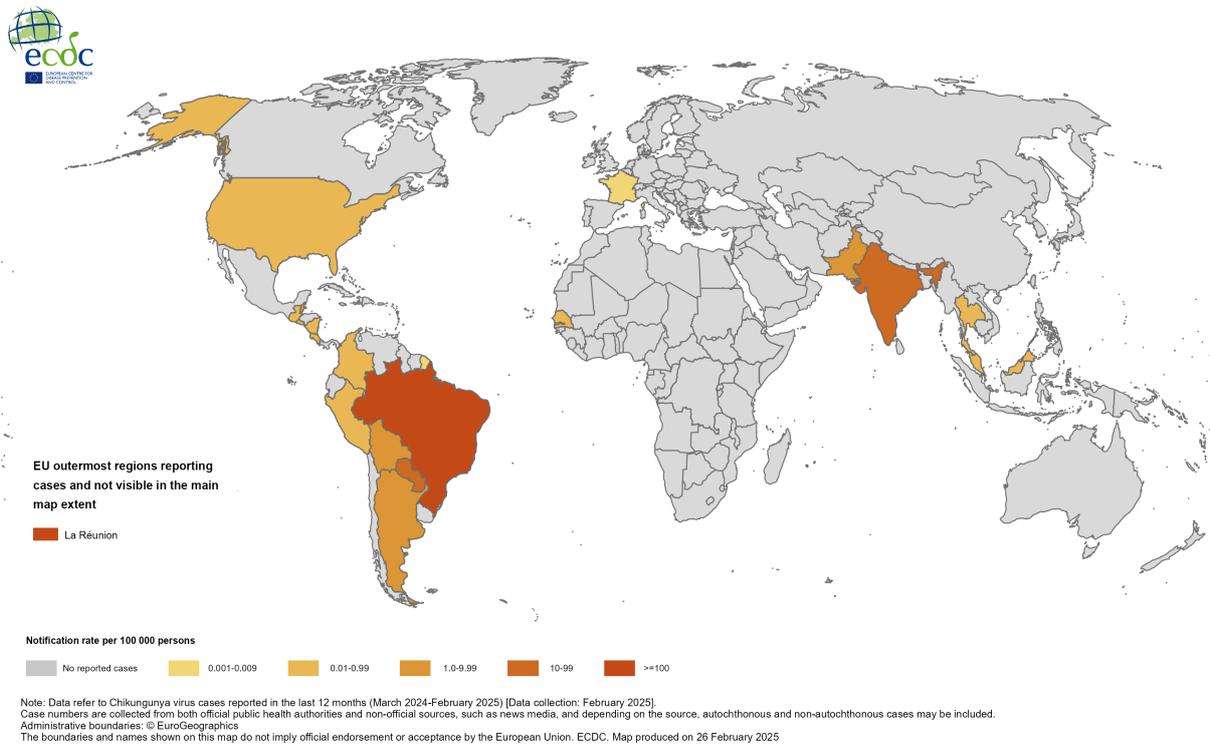
Source: ECDC

Figure 3. Three-month Chikungunya virus disease case notification rate per 100 000 population, December 2024-January 2025



Source: ECDC

Figure 4. 12-month Chikungunya virus disease case notification rate per 100 000 population, March 2024-February 2025



Source: ECDC

9. Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks

Overview

Global public health efforts to eradicate polio are continuing through the immunisation of every child until transmission of the virus stops and the world becomes polio-free. On 5 May 2014, polio was declared a public health emergency of international concern (PHEIC) by the World Health Organization (WHO) due to concerns over the increased circulation and international spread of wild poliovirus in 2014.

On 6 November 2024, the [40th meeting](#) of the Polio Emergency Committee under the International Health Regulations (IHR) (2005) was held to discuss the international spread of poliovirus and it was agreed that it remains a PHEIC. It was decided that the temporary recommendations would be extended for a further three months.

In June 2002, the WHO European Region was officially declared polio-free.

Summary

Wild poliovirus type 1 (WPV1)

In 2025, as of 25 February 2025, four cases of AFP caused by WPV1 have been reported, three in Pakistan and one in Afghanistan.

In 2024, as of 25 February 2025, 99 cases of AFP caused by WPV1 have been [reported](#), 74 in Pakistan and 25 in Afghanistan.

Circulating vaccine-derived poliovirus (cVDPV)

In 2025, as of 25 February 2025, no cases of AFP due to cVDPV1, cVDPV2 or cVDPV3 have been reported.

In 2024, as of 25 February 2025, 11 cases of AFP caused by cVDPV1 have been [reported](#) by the Democratic Republic of the Congo (DRC) (ten cases), and Mozambique (one case).

In 2024, as of 25 February 2025, 278 cases of AFP caused by cVDPV2 have been reported from 18 countries: Nigeria (94), Yemen (37), Chad (35), Ethiopia (42), Niger (16), Democratic Republic of Congo (14), South Sudan (10), Angola (7), Indonesia (7), Guinea (5), Somalia (3), Cameroon (2), Algeria (1), Benin (1), Liberia (1), Mali (1), Palestine* (1) and Senegal (1).

In 2024, as of 25 February 2025, four cases of AFP caused by cVDPV3 have been [reported](#) by Guinea.

Sources: [Global Polio Eradication Initiative](#) | [ECDC](#) | [ECDC dashboard](#) | [WPV3 eradication certificate](#)

*This designation shall not be construed as recognition of a State of Palestine and is without prejudice to the individual positions of the Member States on this issue.

ECDC assessment

The WHO European Region, including the EU/EEA, has remained polio-free since 2002. Inactivated polio vaccines are used in all EU/EEA countries.

As long as there are non-vaccinated or under-vaccinated population groups in European countries and poliomyelitis is not eradicated globally, the risk of the virus being reintroduced in Europe remains. In the EU/EEA, one country (Romania) is considered to be at high risk and five countries (Austria, Estonia, Hungary, Poland and Slovenia) are considered to be at intermediate risk of a sustained polio outbreak following wild poliovirus importation or the emergence of circulating vaccine-derived poliovirus (cVDPV). This is due to suboptimal vaccination programme performance and low population immunity, according to the [European Regional Certification Commission for Poliomyelitis Eradication \(RCC\)](#) report published in December 2024, referring to data from 2023.

The continuing circulation of wild poliovirus type 1 (WPV1) in Pakistan and Afghanistan shows that there is still a risk of the disease being imported into the EU/EEA. The outbreaks of cVDPV that emerge and circulate due to lack of polio immunity in the population also illustrate the potential risk for further international spread.

To limit the risk of reintroduction and sustained transmission of WPV and cVDPV in the EU/EEA, it is crucial to maintain high vaccine coverage in the general population and increase vaccination uptake in pockets of under-immunised populations. EU/EEA countries should review their polio vaccination coverage data and ensure that there are no immunity gaps in the population and that there is capacity to identify virus circulation through well-performing surveillance systems.

ECDC endorses WHO's temporary recommendations for EU/EEA citizens who are residents of or long-term visitors (>4 weeks) to countries categorised by WHO as having the potential risk of causing international spread of polio: an additional dose of poliovirus vaccine should be administered between four weeks and 12 months prior to international travel. Travellers to areas with active transmission of a wild or vaccine-derived poliovirus should be vaccinated according to their national immunisation schedules.

ECDC links: [ECDC comment on risk of polio in Europe](#), [ECDC Risk Assessment 2025](#), [ECDC Risk Assessment 2014](#)

Actions

ECDC provides updates on the polio situation on a monthly basis. ECDC also monitors polio cases worldwide through its epidemic intelligence activities in order to highlight polio eradication efforts and identify events that increase the risk of wild poliovirus being reintroduced into the EU/EEA.

ECDC maintains a [dashboard](#) showing countries that are still endemic for polio and have ongoing outbreaks of cVDPV.

Last time this event was included in the Weekly CDTR: 17 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
- 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 28 February 2025
- Avian influenza A(H5N1) human cases – United States – 2024 - last reported on 28 February 2025
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 28 February 2025
- Legionnaires' disease outbreak - Vorarlberg, Austria - 2025 - last reported on 28 February 2025
- Unknown disease - DRC - 2025 - last reported on 28 February 2025
- Locally acquired dengue cases in Madeira - Portugal - 2025 - last reported on 21 February 2025
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 21 February 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 21 February 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 14 February 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
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - 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 7 February 2025
- SARS-CoV-2 variant classification - last reported on 7 February 2025
- Yellow fever – South America – 2024–2025 - last reported on 7 February 2025
- Shigella sonnei ST152 outbreak associated with international travel on long-haul flights - last reported on 7 February 2025