WEEKLY BULLETIN

Communicable disease threats report

Week 11, 8 - 14 March 2025

This week's topics

Executive summary

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 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. Excess mortality has been observed since week 51, 2024, affecting adults aged 45 years and above. SARS-CoV-2 activity has been steadily declining since summer 2024 with no winter epidemic observed to date.
- For influenza, the peak in activity, marked by the co-circulation of influenza A and B viruses, has passed. A decreasing trend in influenza hospital admissions continues to be observed in most reporting countries.

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 13 March 2025, a total of 47 cases of Legionnaires' disease have been reported from the region.
- Investigations have been able to identify that the likely source of this outbreak is a cooling tower and control measures have been implemented.
- No additional cases are reported where exposure occurred after the implemented control measures.

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

- France reported the first autochthonous case of chikungunya virus disease in 10 years in the Department of La Réunion, with onset of symptoms on 12 August 2024.
- Since then and up to 2 March 2025, 5 184 cases of autochthonous chikungunya virus disease have been confirmed in La Réunion.
- The Haute Autorité de santé (HAS) has advised public decision makers to vaccinate groups who are at a higher risk and vector control professionals.

Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025

- Since the last update on 12 February 2025, and as of 12 March 2025, 63 mpox cases have been reported from 12 EU/EEA countries: Germany (19), France (8), Spain (8), Italy (5), Sweden (5), Netherlands (4), Austria (3), Poland (3), Belgium (2), Greece (2), Ireland (2) and Portugal (2). Since 12 February 2025, no new countries have reported confirmed cases.
- Since the start of the mpox outbreak and as of 12 March 2025, 24 059 confirmed cases of mpox (MPX) have been reported from 29 EU/EEA countries.
- Seventeen MPXV clade I cases have been reported in the EU/EEA since August 2024 from Sweden, Germany, Belgium, Ireland and France. All were clade Ib, except Ireland which was clade Ia.
- The overall risk of infection remains low for men who have sex with men and low for the broader EU/EEA population.

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

- Monkeypox virus (MPXV) clade I and clade II are circulating in multiple countries, with the epidemiological trends remaining largely unchanged.
- The Democratic Republic of the Congo (DRC), Burundi, and Uganda are the countries that have reported the most mpox clade Ib cases in Africa in the past six weeks, according to WHO.
- The classification of transmission patterns has been updated (details are provided in the overview).
- ECDC is closely monitoring and assessing the epidemiological situation, and additional related information can be found in the Centre's rapid risk assessment published on 16 August 2024 ('Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries') and its 'Rapid scientific advice on public health measures'.

Ebola disease – Uganda – 2025

- On 8 March 2025, WHO released a Disease Outbreak News (DON) piece, including data until 5 March 2025. They reported that 192 contacts associated with the second cluster are currently under follow-up.
- As of 13 March 2025, 12 confirmed cases and two probable have been reported in total, including two confirmed deaths. Two deaths are also investigated as being probable cases.
- EU/EEA citizens working in healthcare settings in Uganda should be aware of the ongoing outbreak and take appropriate personal protective measures.
- In light of evidence from previous larger outbreaks, the importation of the disease to the EU/EEA through someone with the infection is very unlikely and, should that happen, the likelihood of further transmission is considered very low.

Marburg virus disease - Tanzania - 2025

- On 13 March 2025, WHO published a Disease Outbreak News Item announcing the end of the Marburg virus disease outbreak in Tanzania.
- The outbreak was confirmed on 20 January by Tanzania. Since the start of the outbreak and until 28 January 2025, two confirmed and eight probable MVD cases were reported in Kagera Region. All these individuals passed away.
- This was the second MVD outbreak ever reported in Tanzania. Kagera Region experienced an MVD outbreak in March 2023.

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

Overview:

Based on data reported to week 10, 2025, primary and secondary care consultation rates reported by countries indicate elevated levels of respiratory virus activity in the EU/EEA. Intense seasonal influenza activity is reported together with an ongoing respiratory syncytial virus epidemic, while SARS-CoV-2 activity remains at low levels in all countries.

Pooled data from primary care surveillance in the EU/EEA suggest that the peak in influenza activity, dominated by influenza A viruses, has passed. A decreasing trend in influenza hospital admissions continues to be observed in most reporting countries. Co-circulation of influenza A(H1)pdm09, A(H3) and B/Vic viruses continues to be observed in the EU/EEA, with influenza A and B viruses reported in equal proportions in week 10.

Following the peak in week 52, 2024, RSV activity in the EU/EEA has decreased slightly but remains elevated, with little change in recent weeks. There is nonetheless considerable variation between countries in the timing of the RSV season, so some countries are still observing an elevated and increasing circulation of RSV.

ECDC assessment:

Since week 40, 2024, the winter season in the European Union/European Economic Area (EU/EEA) has been characterised by an intense influenza season and a concurrent respiratory syncytial virus (RSV) epidemic. Most countries have moved from an influenza A-dominated early season to A/B co-dominance or B dominance, but some observed the opposite with an early season marked by influenza B dominance. The biggest impact in secondary care has been in adults aged 65 years and above for influenza and in children aged under five years for RSV. EuroMOMO has reported all-cause mortality above expected levels since week 51, 2024, affecting adults aged 45 years and over. SARS-CoV-2 activity has been steadily declining since summer 2024, with no winter epidemic observed to date.

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:

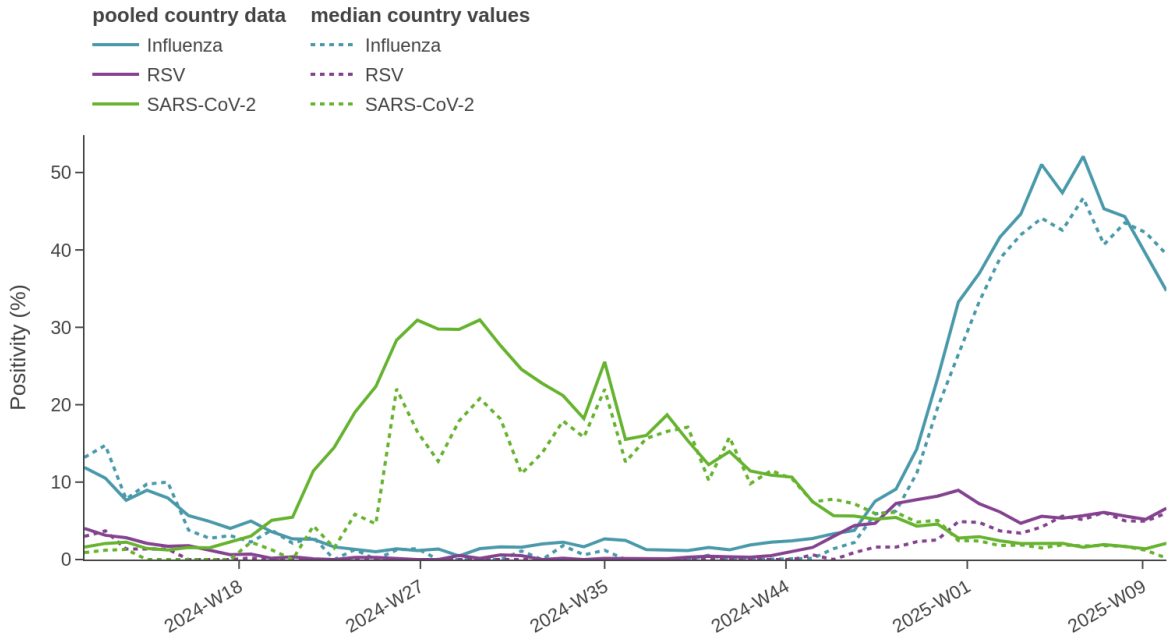
- ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary (ERVISS.org), which is updated weekly.
- ECDC has published recommended public health actions to mitigate against the impact of respiratory virus 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: 07 March 2025

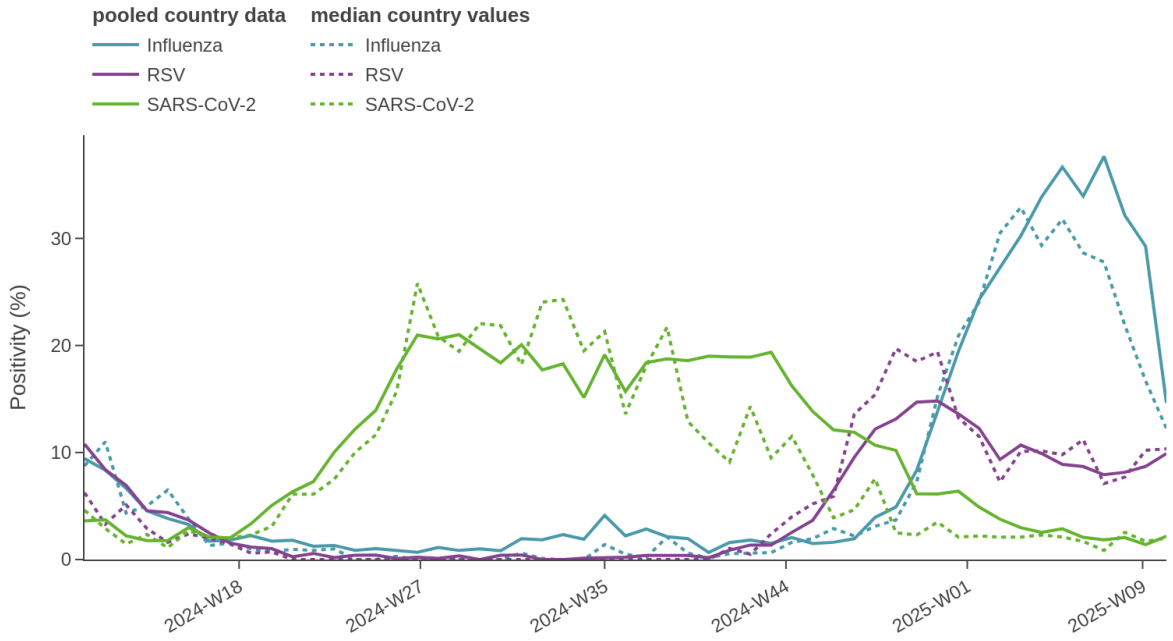
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 3. Overview of key indicators of activity and severity in week 10, 2025

		Reporting countries		EU/EEA summary		
Indicator	Syndrome or pathogen	Week 10	Week 9	Description	Value	Comment
ILI/ARI consultation rates in primary care	ARI	15 rates (11 MEM)	15 rates (11 MEM)	Distribution of country MEM categories	5 Baseline 4 Low 2 Medium	
	ILI	20 rates (18 MEM)	20 rates (18 MEM)		5 Baseline 3 Low 8 Medium 2 High	Medium to high levels based on the Moving Epidemic Method (MEM) in the majority of countries reflect the intensity of influenza activity.
ILI/ARI test positivity in primary care	Influenza	21	21	Pooled (median; IQR)	35% (39; 31–45%)	At the EU/EEA level, the overall pooled influenza positivity continues to decrease, with both influenza A and B activities decreasing. However, the EU/EEA level pooled data mask considerable heterogeneity between countries.
	RSV	19	19		6.6% (6; 4.2–7.4%)	At EU/EEA level, RSV positivity continues to plateau in all age groups, after reaching a peak in week 52, 2024 (9.5%). The country picture remains mixed due to considerable variation in the timing of the epidemic between countries.
	SARS-CoV-2	19	19		2.1% (0.2; 0–1.8%)	Activity is low in all countries.
SARI rates in hospitals	SARI	8	11	–	–	
SARI test positivity in hospitals	Influenza	6	9	Pooled (median; IQR)	15% (12; 11–24%)	The pooled influenza positivity at EU/EEA level continues to decrease in all age groups. However, the data from one of the major contributors (Germany, with around 1 000 samples tested per week) was not reported in week 10 and the weekly pooled influenza positivity might currently be underestimated.
	RSV	6	9		9.9% (10; 8.3–13%)	At EU/EEA level, RSV positivity continues to plateau.
	SARS-CoV-2	6	8		2.2% (2; 1.9–2.1%)	Activity is low in all countries across all indicators of severity.
Intensity (country-defined)	Influenza	23	23	Distribution of country qualitative categories	2 Baseline 4 Low 12 Medium 4 High 1 Very high	
Geographic spread (country-defined)	Influenza	22	22	Distribution of country qualitative categories	1 Local 2 Regional 19 Widespread	

Source: ECDC

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

	Week 10, 2025		Week 40, 2024 - week 10, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**1037**	**-**	**20906**	**-**
Influenza A	474	46	12755	62
A(H1)pdm09	130	36	6336	60
A(H3)	235	64	4262	40
A (unknown)	109	-	2157	-
Influenza B	554	54	7917	38
B/Vic	253	100	3162	100
B/Yam	0	0.0	1	0.0
B (unknown)	301	-	4754	-
Influenza untyped	9	-	234	-
RSV	**139**	**-**	**3028**	**-**
RSV-A	26	43	490	40
RSV-B	34	57	736	60
RSV untyped	79	-	1802	-
SARS-CoV-2	**43**	**-**	**2847**	**-**

Source: ECDC

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

Figure Table

	Week 10, 2025		Week 40, 2024 - week 10, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**95**	**-**	**9637**	**-**
Influenza A	66	77	3923	87
A(H1)pdm09	6	46	1324	63
A(H3)	7	54	793	37
A (unknown)	53	-	1806	-
Influenza B	20	23	611	13
B/Vic	0	-	84	100
B (unknown)	20	-	527	-
Influenza untyped	9	-	5103	-
RSV	**61**	**-**	**3831**	**-**
RSV-A	1	12	616	49
RSV-B	7	88	631	51
RSV untyped	53	-	2584	-
SARS-CoV-2	**14**	**-**	**3341**	**-**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 10, 2025

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	2234	46	5a.2a(C.1.9)	1986	89
			5a.2a.1(D)	191	9
			5a.2a(C.1)	57	3
A(H3)	1280	26	2a.3a.1(J.2)	937	74
			2a.3a.1(J.2.2)	174	14
			2a.3a.1(J.2.1)	131	10
			2a.3a.1(J.1)	11	0.9
			2a.3a.1(J)	10	0.8
			2a.3a.1(J.4)	2	0.2
			Not assigned	15	-
B/Vic	1376	28	V1A.3a.2(C.5.1)	944	69
			V1A.3a.2(C.5.7)	206	15
			V1A.3a.2(C.5.6)	190	14
			V1A.3a.2(C)	22	2
			V1A.3a.2(C.5)	2	0.1
			Not assigned	12	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 8–9, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	3	21	31% (17–41%)
KP.3	VOI	2	8	5% (0–13%)
XEC	VUM	4	42	61% (45–74%)
LP.8.1	VUM	4	6	8% (6–10%)

Source: ECDC

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

Overview:

Update

- Since the last CDTR update of 26 February, the total number of cases reported by the region increased by ten. No additional cases have been reported where exposure occurred after the implemented control measures.

Summary

As of 13 March 2025, a total of 47 cases of Legionnaires' disease (LD) are reported by regional public health authorities in the state of Vorarlberg in Western Austria. The most recent case currently associated with the outbreak was a person who developed symptoms on 22 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 and Legionellen: Eine mögliche Quelle saniert.

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 persons visiting or residing in this area to develop Legionnaires' disease associated with this outbreak has been significantly reduced. Continued surveillance for any additional cases remains important to determine the successful implementation of control measures.

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 (12 February 2025) and Legionellen: Eine mögliche Quelle saniert (7 March 2025).

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

Sources: Gehäuftes Auftreten von Legionellen-Fällen im Unteren Rheintal – mögliche Quelle gefunden (dated 26.02.2025)

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

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

Overview:

Update:
According to the French National Health Authority, until 2 March 2025, 5 184 cases (5 039 in 2025) of autochthonous chikungunya virus disease have been reported in La Réunion. In week 9, 1 766 new confirmed cases were reported, representing an 18% increase compared to week 8, when 1 300 cases were reported.

Cases have now been reported in 23 of 24 municipalities.

The municipalities reporting the most cases since the start of the epidemic are:
- Le Tampon
- L' Étang-Salé

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 individuals with the disease is relatively low, with 20 of them hospitalised for more than 24 hours.

The Haute Autorité de santé (HAS) has advised public decision makers to vaccinate people over 65 years of age, people over 18 years of age with comorbidities and vector control professionals with the IXCHIQ vaccine, as a reactive short-term measure to prevent severe disease.

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. 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).

In the context of the outbreak, following the recommendations of the French health authorities, the national blood services have put the following measures in place for blood safety:

- CHIKV NAT for all donors in the overseas department of La Réunion;
- CHIKV-NAT, or 28-day temporary deferral period, for travellers who have stayed at least one night in La Réunion 28 days prior to their donations.

Last time this event was included in the Weekly CDTR: 07 March 2025

4. Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025

Overview:

Since the last update on 12 February 2025, and as of 12 March 2025, 63 mpox cases have been reported from 12 EU/EEA countries: Germany (19), France (8), Spain (8), Italy (5), Sweden (5), Netherlands (4), Austria (3), Poland (3), Belgium (2), Greece (2), Ireland (2) and Portugal (2). Since 12 February 2025, no new countries have reported confirmed cases.

The total number of cases reported for the current period is significantly lower than to the number of cases reported on Feb 12 (124 cases).

Since the start of the mpox outbreak and as of 12 March 2025, 24 059 confirmed cases of mpox (MPX) have been reported from 29 EU/EEA countries: Spain (8 585), France (4 405), Germany (4 166), Netherlands (1 450), Portugal (1 214), Italy (1 123), Belgium (859), Austria (370), Sweden (340), Ireland (283), Poland (238), Denmark (216), Greece (145), Norway (121), Czechia (101), Hungary (85), Luxembourg (62), Romania (49), Slovenia (47), Malta (44), Finland (43), Croatia (37), Slovakia (19), Iceland (17), Bulgaria (11), Estonia (11), Cyprus (6), Latvia (6) and Lithuania (6). Deaths have been reported from: Spain (3), Belgium (2), Portugal (2), Austria (1) and Czechia (1).

Since the start of the mpox outbreak and as of 12 February 2025, the following Western Balkan countries have reported confirmed cases of mpox: Serbia (40), Bosnia and Herzegovina (9), Kosovo* (1) Montenegro (2). In addition, 32 cases have been reported from Türkiye.

A total of 17 MPXV clade I cases have been reported in the EU/EEA since August 2024. On 15 August 2024, Sweden reported the first imported case of mpox due to MPXV clade Ib in EU/EEA countries. Eight cases have been reported by Germany (one in October, five in December 2024, one in January 2025 and one in February 2025), four cases by Belgium (two in December 2024, one in January 2025 and two in February 2025), two cases by France (one in December 2024 and one in February 2025), and one case by Ireland in February 2025. All were clade Ib, except Ireland which was clade Ia. All individuals had mild disease. Confirmed secondary transmission events were reported by Germany and Belgium among household contacts.

All other mpox cases with available information on clade reported in the EU/EEA were MPXV clade IIb.

Cases reported in 2024 share the same epidemiological profile as those reported since the beginning of the outbreak in the EU/EEA, with the majority of cases being men, and sexual contact among men who have sex with men remaining the primary mode of transmission.

On 13 August 2024, Africa CDC declared mpox a Public Health Emergency of Continental Security. On 14 August 2024, WHO convened a meeting of the IHR Emergency Committee to discuss the mpox upsurge and declared the current outbreak of mpox due to MPXV clade I a Public Health Emergency of International Concern (PHEIC).

For more information on the global update regarding MPXV clade Ib, please refer to the weekly Communicable Diseases Threats Report.

A detailed summary and analysis of data reported to TESSy can be found in the Joint ECDC-WHO Regional Office for Europe Mpox Surveillance Bulletin.

*This designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the Internati onal Court of Justice (ICJ) Opinion on the Kosovo declaration of independence.

ECDC assessment:

The number of new infections has decreased relative to earlier months and the overall number remains relatively low in the EU/EEA .

It is likely that more mpox cases due to MPXV clade I will continue to be introduced into the EU/EEA and other countries in the coming weeks, and it is important to raise awareness concerning the possible importation of cases, both among returning travellers from affected African countries and among healthcare professionals who may see such patients. Furthermore, it is important for public health authorities to be prepared to carry out contact tracing and infection prevention and control measures if cases are diagnosed. An ECDC epidemiological update and news item, published on 14 January, highlighted the options for response.

The overall risk of MPXV infection is assessed as low for men who have sex with men and low for the broader population in the EU/EEA.

Response options for EU/EEA countries include raising awareness among healthcare professionals; supporting sexual health services in case detection, contact tracing, and case management; continuing to offer orthopoxvirus testing; implementing vaccination strategies and maintaining risk communication and community engagement, despite the decreasing number of cases. EU/EEA countries are also encouraged to sequence and report clades and subclades to identify new cases of mpox, particularly those linked to clade Ib or Ia.

Primary preventive vaccination (PPV) and post-exposure preventive vaccination (PEPV) strategies may be combined to focus on individuals at substantially higher risk of exposure and close contacts of cases, respectively, particularly in the event of limited vaccine supply. PPV strategies should prioritise gay, bisexual, and transgender people, and men who have sex with men, who are at higher risk of exposure, as well as individuals at risk of occupational exposure, based on epidemiological or behavioural criteria. Health promotion interventions and community engagement are also critical to ensure effective outreach, high vaccine acceptance and uptake among those most at risk of exposure.

Actions:

ECDC is closely monitoring the mpox epidemiological situation through indicator- and event-based surveillance.

A rapid risk assessment, 'Mpox multi-country outbreak', was published on 23 May 2022. The first update to the rapid risk assessment was published on 8 July 2022, and a second update was published on 18 October 2022. ECDC published a report on public health considerations for mpox in EU/EEA countries on 14 April 2023. ECDC published a Threat Assessment Brief on MPXV clade I in the Democratic Republic of the Congo (DRC) on 5 December 2023, an epidemiological update on 5 April 2024 and another on 14 January 2025 together with a news item. A risk assessment for the EU/EEA on the mpox epidemic caused by mpox virus clade I in affected African countries was published on 16 August 2024, and rapid scientific advice on public health measures was released on 9 September 2024 and updated on 14 January 2025.

A resource toolkit for event organisers and social media materials on mpox related to events are also available. Member States can use these materials to work with event organisers ahead of Pride events to ensure that attendees have access to the right information.

Member States can also consider providing those who travel to Pride events abroad with updated information on how to protect themselves and others from mpox.

For the latest updates, visit ECDC's mpox page.
Last time this event was included in the Weekly CDTR: 14 February 2025

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

Overview:

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

Following the epidemic of MPXV clade I in the DRC, and since the beginning of 2024, MPXV clade I was first detected in Angola, Burundi, Rwanda, South Sudan, Uganda, and Zambia (all countries neighbouring the DRC), as well as in Kenya, Zimbabwe and South Africa. Overall, on the African continent in 2024 and in 2025 until the beginning of March 2025, most confirmed and suspected clade I cases have been reported from the DRC. DRC along with Uganda and Burundi have reported most cases in 2025 (as of the beginning of March). However different trends have been observed recently in each country.

In DRC, clade Ia and Ib co-circulate to different degrees. There has been a decline in the number of cases in the past five weeks and testing coverage also has declined during the same period (Africa CDC Special Briefing on Mpox and other Health Emergencies, 13 March 2025). According to the WHO External Situation report published on 10 March 2025, clade Ib has been detected in 10 provinces, mostly in the east of the country, and in five provinces, clade Ib co-circulates with clade Ia (Mpox: multi-country external situation report no. 48, 10 March 2024). In Kinshasa, epidemiological data and sequencing suggest there is human-to-human transmission of clade Ia with high rates of APOBEC3-driven mutations. Similar signals have not been reported in provinces outside Kinshasa where clade Ia is circulating in DRC. However, the number of samples sequenced and analysed varies across provinces in DRC (Mpox: multi-country external situation report no. 48, 10 March 2024). APOBEC3 mutations have also been noted in clade Ib. Based on the available information from clade Ia circulation in Kinshasa there is currently no evidence that the strain is inherently more transmissible than other clade Ia strains or clade Ib according to WHO (Mpox: multi-country external situation report no. 48, 10 March 2024).

In Burundi, the decreasing trend observed in the last weeks in the number of reported mpox cases continues and only clade Ib has been detected (Mpox: multi-country external situation report no. 48, 10 March 2024). In the past six weeks, 640 cases have been reported and no deaths, according to WHO (9 March 2025).

In Uganda, where clade Ib has been detected, over 1 600 cases have been reported in the past six weeks, including 12 deaths (according to WHO as of 9 March 2025). The number of cases has been showing an increasing trend with a total of 3 685 cases and 31 deaths reported overall as of beginning of March 2025 (Africa CDC Special Briefing on Mpox and other Health Emergencies, 13 March 2025). The age group mainly affected in Uganda is 18-39 year-olds, transmission amongst sexual networks is reported and high incidence is reported in and around Kampala (Africa CDC Special Briefing on Mpox and other Health Emergencies, 13 March 2025, Mpox: multi-country external situation report no. 48, 10 March 2024).

Other countries in Africa which have reported mpox clade I cases since 2024 (for the first time) include, Rwanda (104 cases), Kenya (53), Zambia (24) and Zimbabwe (2)(WHOGlobal report on mpox (data as of 9 March 2025)). Additionally, South Africa reported three clade I cases all in 2025. Previously, in 2024, South Africa had reported clade II cases (WHO Global Report with data until 9 March 2025). South Sudan also has reported seven cases of mpox in 2025 (WHO Global Report with data until 9 March 2025, clade Ib).

Outside Africa, travel-associated cases or sporadic cases reporting epidemiological links with travel-associated cases of MPXV clade I have been reported in the EU/EEA by: Sweden (in 2024) and Germany, Belgium (in 2024 and 2025) and France and Ireland (in 2025).

In addition to Africa and the EU/EEA, since August 2024, clade I cases have been reported by Thailand, India, the UK, the United States (US), Canada, Pakistan, Oman, China, the United Arab Emirates and Qatar. In March, Brazil also reported one case which had no travel history but was a contact of a person with travel history to DRC.

Most travel-associated cases who reported travel to non-African countries had links to affected countries in Africa. However, China, India, Oman, Pakistan and Thailand have reported at least one case each with travel links to the United Arab Emirates (Mpox: Multi-country external situation report 44, 23 December 2024, Mpox: multi-country external situation report no. 46, 28 January 2025, Mpox: multi-country external situation report no. 47, 13 February 2025, Mpox: multi-country external situation report no. 48, 10 March 2024).

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

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

Transmission patterns of mpox due to monkeypox virus clade I – update 13 March 2025 *

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

- Countries reporting only travel-associated cases or cases with a clear link to travel-associated cases: Angola, Belgium, Brazil, Canada, China, Germany, France, India, Ireland, Oman, Pakistan, Qatar, South Africa, South Sudan, Sweden, Thailand, the UK, the US, and Zimbabwe;
- Clusters of cases or limited transmission: Tanzania, the United Arab Emirates, and Zambia;
- Community transmission: Burundi, Central African Republic, Congo, the DRC, Kenya, Rwanda, and Uganda.

The categorisation was last updated on 13 March 2025 to include Brazil (category of countries with travel associated cases or cases with links to travel associated cases).

Below you can find some notes on the interpretation of the different trends reported in countries included:

- The United Arab Emirates have reported a single case with travel history to Uganda, however a number of other countries have reported cases with travel history to the United Arab Emirates. Although there is no evidence of wider community transmission in the United Arab Emirates, it is presumed that undetected transmission is ongoing (Mpox: multi-country external situation report no. 48, 10 March 2024). The United Arab Emirates have therefore been added in the second category of the transmission classification.
- Undetected transmission may be ongoing in Tanzania, given that mpox clade Ib cases with travel links to Tanzania have been reported elsewhere and recently the country reported two confirmed mpox cases (Mpox: multi-country external situation report no. 47, 13 February 2025 and Press Release MoH Tanzania, 10 March 2025).
- Congo has reported clade Ib detection (Congo is endemic for clade Ia) (Africa CDC Press Briefing of 20 February 2025). A total of 20 confirmed cases have been reported in 2025 (weeks 1 to 9 of 2025 (ending 28 February 2025) according to the National Situation Report published on 10 March 2025 (Epidémie de Mpox : Rapport de Situation (SITREP) N°45 du 10 mars 2025 | OMS | Bureau régional pour l'Afrique). The total number of confirmed cases reported in 2024 was 24. Most cases have been reported close to the border with DRC. Based on the national report, there is a large number of suspected cases in different areas of the country.
- South Sudan has been included in the classification since the clade detected in the recently reported cases is clade Ib. The first case reported in 2025 was travel-associated case. The case is a person with travel history to Uganda. According to the press release from the Ministry of Health the strain is consistent with the one circulating in East Africa. As of 9 March 2025, seven cases had been reported by South Sudan from at least two counties 2025 (WHO Mpox Global Mpox Trends, 9 March 2025, WHO AFRO Weekly Bulletin, 2 March 2025).

**The item has been updated since the version published on 14 March 2025. The previously published text did not include recent updates to the transmission patterns categorisation.*

ECDC assessment:

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

The risk for EU/EEA citizens travelling to or living in the affected areas is considered to be moderate if they have close contact with affected persons, or low if they do not have contact with affected individuals. The overall risk to the general population in the EU/EEA is currently assessed as low. However, more imported mpox cases due to MPXV clade I are likely to be reported by the EU/EEA and other countries.

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

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

Actions:

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

Reporting through the Communicable Disease Threats Report will be monthly.

Sources: ECDC rapid risk assessment

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

6. Ebola disease – Uganda – 2025

Overview:

Update

On 8 March 2025, WHO released a Disease Outbreak News (DON) piece, including data until 5 March 2025. The DON updates the number of contacts relating to the second cluster to 192, who are under follow up, and the number of affected regions to six (Jinja, Kampala, Kyegegwe, Mbale, Ntoroko and Wakiso).

Two confirmed cases from the latest reported cluster are adult females and are known contacts of previous confirmed and probable cases.

According to media sources, 264 contacts have been vaccinated so far.

Summary

On 30 January 2025, public health authorities in Uganda declared an outbreak of Ebola 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. As of 13 March 2025, 12 confirmed and two probable cases have been reported in total, including two confirmed deaths. Two deaths are also investigated as being probable cases. The age range of confirmed cases is 1.5 years to 55 years, the mean age is 27 years and males account for 55% of the total cases.

Event background and additional information

The patient identified as the index case presented with symptoms on 19 January 2025 and passed away on 29 January 2025. The patient sought treatment at multiple health facilities in the Central district, as well Mbale City, and also from a traditional healer.

As of 20 February 2025, nine confirmed cases had been reported. 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.

All initial cases belonged to the same transmission chain and were divided into two sub-clusters. One included five family members of the index case and the other 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 at the time the remaining confirmed cases under hospitalisation had recovered and been discharged after two consecutive negative tests taken 72 hours apart.

A new case was then reported on 1 March 2025 in Mulago Hospital (Kampala) in a child (4.5 years old) who died on 25 February 2025. Two other deaths are being investigated due to their links with the tenth case. These two individuals were classified as probable cases by WHO.

On 6 March 2025, Africa CDC reported two new confirmed cases. A new cluster has been identified around the previously reported four-year-old male (the tenth overall case). This cluster is not epidemiologically linked to the previous one, but the clusters are genetically linked. The Africa CDC briefing mentioned that community transmission is highly likely, and that there are concerns since cases have been reported in Kampala.

The phylogenetic analysis of samples taken from the index case showed them to be genetically close to sequences from the 2012 SVD 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.

The response in Uganda is lead by the Ministry of Health with support from partners (WHO AFRO Weekly Bulletin, Week 9: 24 February-2 March 2025).

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 index case and several subsequent cases involved 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 as well as Africa CDC.
Sources: WCO-Uganda

Last time this event was included in the Weekly CDTR: 07 March 2025

7. Marburg virus disease - Tanzania - 2025

Overview:

Update

On 13 March 2025, WHO published a Disease Outbreak News (DON) item announcing the end of the MVD outbreak in Tanzania. According to the DON, no new cases have been detected over the last 42 days since the last confirmed case passed away on 28 January 2025.

Event summary

The outbreak was confirmed on 20 January by Tanzania after one patient tested positive. Since the start of the outbreak and until 28 January 2025, two confirmed and eight probable MVD cases were reported in Kagera Region, Tanzania. All these individuals passed away meaning the case fatality rate (CFR) was 100%.

The suspected index case was a 24-weeks pregnant woman who was treated at the district hospital, where she died on 16 December 2024. A healthcare worker who attended the suspected index case also fell ill and died on 27 December 2024. The individuals presented with similar symptoms of headache, high fever, back pain, diarrhoea, vomiting blood, body weakness and at a later stage bleeding from orifices. Approximately 300 contacts were followed up, including 56 health workers of which sixteen of them had direct contact with cases.

In response to the outbreak, Tanzania issued a national travel advisory. The measures included the following: travellers leaving Kagera Region should fill in surveillance forms, temperature checks at points of entry, hotlines that provided advice to travellers, and advice on infection prevention and control measures.

Response efforts to this event were followed up by international partners.

Background on Marburg virus disease disease and previous outbreaks

MVD is a severe disease in humans caused by Marburg marburgvirus (MARV). A case fatality ratio of up to 88% has been observed previously. MVD is not an airborne disease and is not considered contagious before symptoms appear. Direct contact with the blood and other body fluids of an infected person or animal is the most frequent route of transmission. The incubation period of MVD is usually five to ten days (range 3–21 days). If proper infection prevention and control measures are strictly adhered to, the likelihood of infection is considered very low. To date, there is no specific antiviral treatment and no approved vaccine for MVD.

All recorded MVD outbreaks have originated in Africa. Since 1967, when MVD was first detected, approximately 600 MVD cases have been reported as a result of outbreaks in Angola, the Democratic Republic of the Congo, Ghana, Guinea, Equatorial Guinea, Kenya, South Africa, Tanzania, and Uganda. In 2024, Rwanda reported its first MVD outbreak (66 cases including 15 deaths) which was declared over on 20 December 2024.

Kagera Region experienced an earlier MVD outbreak in March 2023, during which nine cases and six deaths were reported.

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

ECDC assessment:

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

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

Actions:

ECDC monitored the event through its epidemic intelligence activities and was following up with relevant stakeholders.
Last time this event was included in the Weekly CDTR: 31 January 2025

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 28 February 2025
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 28 February 2025
- Poliomyelitis – Multi-country – Monthly monitoring of global outbreaks - last reported on 28 February 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
- Autochthonous chikungunya virus disease – Department of La Réunion, France – 2024–2025 - last reported on 28 February 2025
- Ebola disease – Uganda – 2025 - 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
- Marburg virus disease - Tanzania - 2025 - last reported on 14 March 2025
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024–2025 - last reported on 14 March 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 14 March 2025
- STI cases continue to rise across Europe - 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
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 14 February 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 07 March 2025
- SARS-CoV-2 variant classification - last reported on 07 March 2025
- Cholera associated with holy well water from Ethiopia - last reported on 07 March 2025
- Avian flu detected in cats - Belgium - 2025 - last reported on 07 March 2025