WEEKLY BULLETIN

Communicable Disease Threats Report

Week 14, 29 March –4 April 2025

This week's topics

Executive summary

Overview of respiratory virus epidemiology in the EU/EEA

Respiratory virus activity remains elevated in the European Union/European Economic Area (EU/EEA). Overall influenza activity peaked in week 6, 2025, with decreasing trends being observed in almost all countries. Co-circulation of influenza A and B viruses continues. RSV activity remains elevated. The greatest impact in secondary care has been in adults aged 45 years and above for influenza (with the impact increasing with age) and in children under five years for RSV. Excess mortality has been observed since week 51, 2024, affecting adults aged 45 years and above, with levels now having returned to the expected range. SARS-CoV-2 activity has been steadily declining since summer 2024, with no winter epidemic observed to date, and remains at a low level.

SARS-CoV-2 variant classification

- Since the last update on 28 February 2025, and as of 28 March 2025, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) and de-escalated variants.
- Note that for this update, sufficient data for estimating variant proportions during the reporting weeks is only available from one EU/EEA country (Spain). The statistics below therefore only represent a limited part of the EU/EEA.
- The VOI and VUM median proportions in the EU/EEA for weeks 10-11, based on one reporting country, are currently:
  - KP.3 14.5% (range: 14.5–14.5%)
  - BA.2.86 20.0% (range: 20.0–20.0%)
  - XEC 29.1% (range: 29.1–29.1%)
  - LP.8.1 34.5% (range: 34.5–34.5%).

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

- A fatal case of A(H5N1) avian influenza has been reported in a two-year-old girl from Palnadu district, Andhra Pradesh, India, marking the country's second confirmed human case and death from A(H5N1) since 2003.
- The infection was reportedly linked to consumption of raw chicken, with symptom onset occurring two days after the suspected exposure; the child died on 15 March 2025 at AIIMS Mangalagiri.
- Confirmation of the A(H5N1) virus was issued by the National Institute of Virology (NIV), Pune, following influenza A detection during hospitalisation.
- Authorities have initiated enhanced surveillance, fever screenings, and poultry monitoring in multiple districts, though no evidence of a concurrent outbreak has been found to date.

Autochthonous chikungunya virus disease - Réunion and Mayotte, France, 2024-2025

- In August 2024, France reported the first autochthonous case of chikungunya virus disease in 10 years in Réunion, with onset of symptoms on 12 August.
- Since then and up to 23 March 2025, 20 242 autochthonous cases of chikungunya virus disease have been confirmed in Réunion.
- On 21 March 2025, two deaths were reported in older individuals with comorbidities.
- The Haute Autorité de Santé (HAS) has advised public decision-makers to vaccinate groups who are at higher risk of severe disease and vector control professionals. The regional health agency is preparing to provide vaccine access to prioritised individuals from the beginning of April.
- On 26 March 2025, an autochthonous case of chikungunya virus disease was reported in Mayotte.

Ebola disease – Uganda – 2025

- Since the last update and as of 3 April, no new cases have been reported. All cases have been discharged and there are no active contacts under follow-up.
- The countdown for declaring the outbreak over was initiated following the discharge of the last patient who was on treatment.
- Since the beginning of the outbreak and as of 3 April, 12 confirmed and two probable cases have been reported, including four deaths (two confirmed and two probable cases). The total number of individuals who have recovered is 10 (83%).
- 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.

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

Overview

Based on data reported to week 13, 2025, pooled estimates of primary and secondary care consultation rates reported by countries indicate elevated levels of respiratory virus activity in the EU/EEA. Decreasing trends in influenza activity are being observed in almost all countries, with half reporting having returned to baseline or low levels of intensity. Influenza A(H3) and B viruses were most commonly reported in week 13. RSV activity in the EU/EEA remains elevated. Around one third of EU/EEA countries are still experiencing elevated or increasing RSV activity. SARS-CoV-2 activity remains at low levels in all countries.

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. SARS-CoV-2 activity has declined to low levels, with no winter epidemic observed to date. Although RSV activity peaked in the EU/EEA in week 52, 2024 and has since decreased, it has remained elevated. This elevated plateau is the result of considerable variation between countries in the timing of the RSV season, with a mixture of increasing and decreasing trends being reported. Overall influenza activity peaked in week 6, 2025 and decreasing trends are now being observed in each of the influenza A(H1)pdm09, A(H3) and B/Vic viruses. Most countries have moved from an early season dominated by influenza A to A/B co-dominance or B dominance, while for a small number the opposite has applied. The greatest impact in secondary care has been in adults aged 45 years and above for influenza (with the impact increasing with age) and in children under five years for RSV. EuroMOMO reported all-cause mortality above expected levels from week 51, 2024, affecting adults aged 45 years and over, with levels of mortality now having returned to the expected range.

Although the level of virus activity is decreasing in many settings, countries with ongoing circulation may continue to experience pressure on healthcare systems and hospital capacity, particularly where this is already limited.

Actions

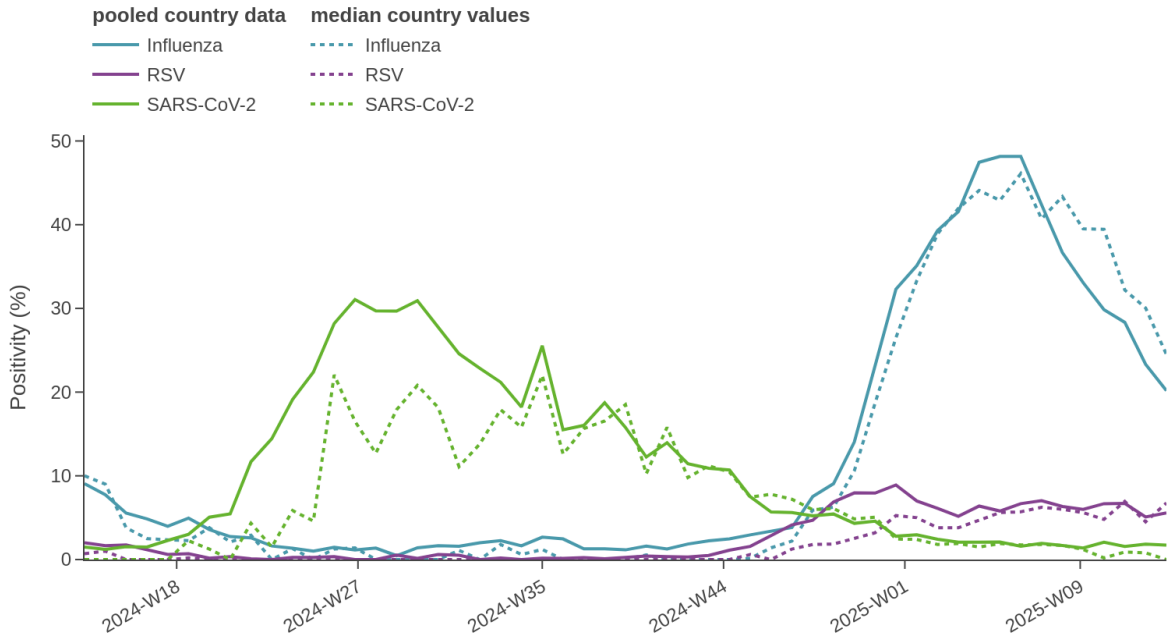
- ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary (ERVISS.org), which is updated weekly.
- ECDC has published recommended public health actions to mitigate against the impact of respiratory virus circulation during winter 2024/2025 in an epidemiological update. Countries with ongoing transmission should be prepared for a continued impact on healthcare and ensure that infection prevention and control practices in healthcare settings are implemented.
- Vaccination is the most effective measure for protecting 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 indicates 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: 28 March 2025.

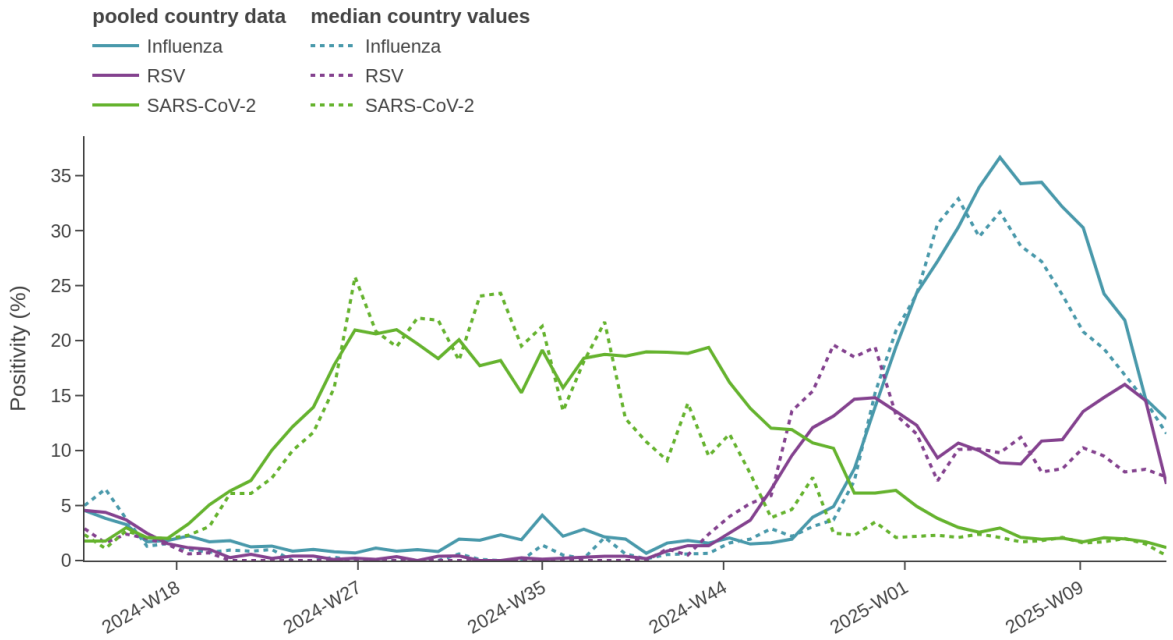
Maps and graphs

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 13, 2025

		Reporting countries		EU/EEA summary		
Indicator	**Syndrome or pathogen**	**Week 13**	**Week 12**	**Description**	**Value**	**Comment**
ILI/ARI consultation rates in primary care	ARI	15 rates (11 MEM)	16 rates (12 MEM)	Distribution of country MEM categories	9 Baseline 1 Low 1 Medium	
	ILI	19 rates (18 MEM)	21 rates (19 MEM)		7 Baseline 7 Low 4 Medium	
ILI/ARI test positivity in primary care	Influenza	15	20	Pooled (median; IQR)	20% (24; 16–36%)	At the EU/EEA level, the overall pooled influenza positivity remains elevated but continues to decrease.
	RSV	15	18		5.6% (6.8; 5.5–10%)	At EU/EEA level, RSV positivity continues to level off after reaching a peak in week 52, 2024 (9%). The country picture remains mixed due to considerable variation in the timing of the epidemic between countries.
	SARS-CoV-2	15	18		1.7% (0; 0–1%)	Activity is low in all countries. Non-sentinel laboratory-based data also indicate continued low levels of activity.
SARI rates in hospitals	SARI	7	12	–	–	
SARI test positivity in hospitals	Influenza	6	11	Pooled (median; IQR)	13% (12; 6–16%)	At the EU/EEA level, the overall pooled influenza positivity remains elevated but continues to decrease in all age groups.
	RSV	6	11		7% (7.6; 6.6–8.4%)	At EU/EEA level, a marked decrease was observed in RSV positivity between week 11 and 13. The observed reduction in positivity can probably partially be attributed to reporting artifacts, and the picture is still mixed at country level.
	SARS-CoV-2	6	10		1.2% (0.4; 0–1.6%)	Activity is low in all countries across all indicators of severity.
Intensity (country-defined)	Influenza	22	24	Distribution of country qualitative categories	4 Baseline 7 Low 8 Medium 2 High 1 Very high	Norway reported that they assessed overall intensity as medium, even though their ILI rate was low according to MEM.
Geographic spread (country-defined)	Influenza	21	23	Distribution of country qualitative categories	1 No activity 1 Sporadic 1 Local 4 Regional 14 Widespread	

Source: ECDC

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

	Week 13, 2025		Week 40, 2024 - week 13, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**391**	**-**	**23620**	**-**
Influenza A	217	57	14100	60
A(H1)pdm09	42	24	6799	57
A(H3)	135	76	5031	43
A (unknown)	40	–	2270	–
Influenza B	167	43	9258	40
B/Vic	46	100	3919	100
B/Yam	0	0.0	1	0.0
B (unknown)	121	–	5338	–
Influenza untyped	7	–	262	–
RSV	**107**	**-**	**4240**	**-**
RSV-A	20	44	774	43
RSV-B	25	56	1015	57
RSV untyped	62	–	2451	–
SARS-CoV-2	**28**	**-**	**2968**	**-**

Source: ECDC

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

	Week 13, 2025		Week 40, 2024 - week 13, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**164**	**-**	**12286**	**-**
Influenza A	51	80	4916	83
A(H1)pdm09	2	17	1428	61
A(H3)	10	83	904	39
A (unknown)	39	-	2584	-
Influenza B	13	20	1035	17
B/Vic	0	-	125	100
B (unknown)	13	-	910	-
Influenza untyped	100	-	6335	-
RSV	**87**	**-**	**5215**	**-**
RSV-A	2	67	671	49
RSV-B	1	33	697	51
RSV untyped	84	-	3847	-
SARS-CoV-2	**15**	**-**	**3591**	**-**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2024 to week 13, 2025

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	2564	46	5a.2a(C.1.9)	2283	89
			5a.2a.1(D)	224	9
			5a.2a(C.1)	57	2
A(H3)	1414	25	2a.3a.1(J.2)	1036	74
			2a.3a.1(J.2.2)	202	14
			2a.3a.1(J.2.1)	136	10
			2a.3a.1(J.1)	13	0.9
			2a.3a.1(J)	10	0.7
			2a.3a.1(J.4)	2	0.1
			Not assigned	15	-
B/Vic	1606	29	V1A.3a.2(C.5.1)	1055	66
			V1A.3a.2(C.5.6)	260	16
			V1A.3a.2(C.5.7)	251	16
			V1A.3a.2(C)	22	1
			V1A.3a.2(C.5)	3	0.2
			Not assigned	15	-

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 11–12, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	2	22	32% (32-33%)
KP.3	VOI	2	12	14% (11-17%)
XEC	VUM	2	23	37% (34-39%)
LP.8.1	VUM	2	11	13% (11-15%)

Source: ECDC

2. SARS-CoV-2 variant classification

Overview

Since the last update on 28 February 2025, and as of 28 March 2025, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) and De-escalated variants.

Note that for this update, sufficient data for estimating variant proportions during the reporting weeks is only available from one EU/EEA country (Spain). The statistics below therefore only represent a limited part of the EU/EEA.

The VOI median proportions in the EU/EEA for weeks 10−11, based on one reporting country, are currently:

KP.3: 14.5% (range: 14.5−14.5%; IQR: 14.5−14.5%)
BA.2.86: 20.0% (range: 20.0−20.0%, IQR: 20.0−20.0%).

The VUM median proportions in the EU/EEA for weeks 10−11, based on one reporting country, are currently:

XEC: 29.1% (range: 29.1−29.1%, IQR: 29.1−29.1%)
LP.8.1: 34.5% (range: 34.5−34.5%, IQR: 34.5−34.5%).

The calculations are based on data reported to GISAID, as of 23 March 2025.

The currently circulating variants that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and individuals who were previously not infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (e.g. older adults) remains important.

ECDC assessment

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation. The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. The variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and individuals who have previously not been infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (e.g. older adults) remains important.

Actions

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

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

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

Last time this event was included in the Weekly CDTR: 7 March 2025.

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

Overview

Media sources in India have reported a fatal human case of avian influenza A(H5N1) in Andhra Pradesh (www.theweek.in; www.indianexpress.com). The event was confirmed via restricted sources. The case, involving a two-year-old child from Narasaraopet town in Palnadu district, was confirmed as A(H5N1) by the National Institute of Virology (NIV) in Pune on 31 March 2025. Despite nearly two weeks of clinical care, including respiratory support and antimicrobial treatment, the child died on 15 March while receiving treatment at the All India Institute of Medical Sciences (AIIMS), Mangalagiri, south-east India.

According to statements from health officials and the child's father, the likely exposure occurred on 27 February, when the child reportedly chewed on a piece of raw chicken. Within two days, the child developed high fever and diarrhoea and was taken to a local hospital on 28 February. As the symptoms progressed, including respiratory distress, the patient was admitted to the Paediatric Intensive Care Unit at AIIMS Mangalagiri on 4 March. Clinical investigations revealed a diagnosis of leptospirosis, alongside a positive influenza A result from a nasopharyngeal swab collected on 7 March. The sample was sent to NIV Pune for subtyping, which subsequently confirmed the presence of avian influenza A(H5N1).

Local health authorities noted that the child's parents and other household members, all of whom consumed only cooked meat, remained asymptomatic. While test results for close contacts were pending at the time of reporting, no secondary cases have been identified.

In response, the Andhra Pradesh government activated emergency public health protocols, including fever screenings at health facilities across the state. District medical officers have been instructed to monitor visitors to clinics and hospitals for flu-like symptoms. Simultaneously, intensive surveillance of poultry farms and backyard flocks has been conducted across Palnadu, Guntur, and Prakasam districts. To date, no evidence of A(H5N1) circulation has been detected in the local avian population.

According to authorities, the case is a sporadic, isolated instance of influenza A(H5N1), and they have stressed that there is currently no indication of a wider outbreak. However, authorities remain vigilant, maintaining enhanced surveillance and urging the public to follow strict food safety and hygiene protocols.

The incident marks the second confirmed human case and fatality from A(H5N1) in India since the virus was first tracked globally in 2003. The previous case was an 11-year-old boy who died in 2021, also while under treatment at AIIMS.

Summary

Since 2003, and as of 4 April 2025, there have been 971 human cases worldwide*, including 469 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: 28 March 2025.

4. Autochthonous chikungunya virus disease - Réunion and Mayotte, France, 2024-2025

Overview

Update

According to the French National Health Authority, up to 23 March 2025, 20 242 autochthonous cases (20 099 in 2025) of chikungunya virus disease have been reported in Réunion. In week 12, 5 832 new confirmed cases were reported. This slowdown in the increase of confirmed cases is potentially linked to the cessation of systematic laboratory confirmation for each suspected case, particularly in areas where the disease is circulating most.

Cases have been reported in all municipalities. The municipalities reporting the most cases since the start of the epidemic are those in the south, particularly Le Tampon.

So far, 129 people with the disease have been hospitalised for more than 24 hours. Among these cases, a quarter were under six months of age and nearly half (47%) were over 65 years. Most of the hospitalised patients (78%) had at least one comorbidity constituting a risk factor for severe disease.

To date, 31 severe cases (i.e. those with at least one organ failure) have been reported. These cases were in 17 adults over 65 years and 14 infants under two months (seven new cases reported since the previous update).

On 21 March 2025, two deaths were reported in older individuals with comorbidities. Several deaths are currently under investigation with the possibility of chikungunya virus disease being the cause of death.

The Haute Autorité de Santé (HAS) has advised public decision-makers to vaccinate people over 65 years of age, those over 18 years with comorbidities, and vector control professionals with the IXCHIQ vaccine, as a reactive short-term measure to prevent severe disease. The regional health agency is preparing to provide vaccine access for prioritised individuals from the beginning of April.

On 26 March 2025, an autochthonous cases of chikungunya virus disease was also reported in Mayotte.

Background

In August 2024, France reported the first autochthonous case of chikungunya virus disease for 10 years in Réunion, with onset of symptoms on 12 August. 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 Réunion was in 2005–2006. The mosquito Aedes albopictus, which is a known vector of chikungunya virus (CHIKV), is established in Réunion.

The probability of infection for residents and travellers to 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 population is being encouraged to remove objects around homes that could contain water and serve as potential mosquito propagation sites, to protect themselves against mosquito bites, and to consult a doctor if symptoms occur.

Pregnant women, especially in the third trimester, are strongly advised to protect themselves from mosquito bites by using effective, pregnancy-safe repellents and to sleep under a mosquito net. This precautionary measure is useful throughout pregnancy, given that fever during pregnancy can also lead to miscarriages. New-borns and infants should also be protected from mosquito bites by using effective and age-appropriate mosquito repellents (from three months of age) and nets.

ECDC is monitoring the situation through its epidemic intelligence activities.

Further information

Travellers to Réunion are advised to apply personal protective measures to avoid the risk of being bitten by mosquitoes.

Aedes mosquitoes have diurnal biting activities, both in 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 a 28-day temporary deferral period, for travellers who have stayed at least one night in Réunion 28 days prior to donation.

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

5. Ebola disease – Uganda – 2025

Overview

According to the Africa CDC press briefing on 3 April and since the last update, no new Ebola cases have been reported. As of 3 April, of the 340 contacts that were being followed-up, none are active. The last case was discharged on 15 March and therefore the countdown for declaring the outbreak over has been initiated. As of 3 April, 20 of the 42 days in the countdown period have been completed.

Since the beginning of the outbreak and as of 3 April, 12 confirmed and two probable cases have been reported, including four deaths (two confirmed and two probable). According to WHO, there were six regions affected (Jinja, Kampala, Kyegegwe, Mbale, Ntoroko and Wakiso).

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. The patient 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 as in Mbale City and from a traditional healer.

All eight of the initial secondary 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 having treated the patient who was the index case. They had symptom onset between 29 January and 6 February. On 18 February, WHO reported that they were all discharged.

On 1 March, WHO reported a new case (Case 10) with no epidemiological links to the previous cluster, although genetically linked. The case was a child who died on 25 February 2025 in Mulago Hospital (Kampala). On 6 March 2025, Africa CDC reported two new confirmed cases and two probable deaths linked to Case 10. The age range of the individuals involved in the confirmed cases is 1.5 years to 55 years, the mean age is 27 years and males account for 55% of the total cases.

The last case was discharged on 15 March when the countdown period began.

Event background and additional information

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 has announced that the first ever vaccination trial of a vaccine against SVD is 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 being led by the Ministry of Health, with support from partners.

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 which evaluated 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: 28 March 2025.

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 28 March 2025
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 28 March 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 28 March 2025
- Autochthonous chikungunya virus disease - Réunion and Mayotte, France, 2024-2025 - last reported on 28 March 2025
- Ebola disease – Uganda – 2025 - last reported on 28 March 2025
- World Tuberculosis Day - 2025 - last reported on 28 March 2025
- Risk of severe infections, carriage and cross-border transfer of carbapenem-resistant bacteria in victims of the fire at Pulse nightclub (Kocani) – North Macedonia - last reported on 21 March 2025
- Avian influenza A(H5N1) human cases – United States – 2024 - last reported on 21 March 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 21 March 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 21 March 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - 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
- Legionnaires' disease outbreak - Vorarlberg, Austria - 2025 - last reported on 14 March 2025
- Cholera associated with holy well water from Ethiopia - last reported on 7 March 2025
- Avian flu detected in cats - Belgium - 2025 - last reported on 7 March 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 7 March 2025
- SARS-CoV-2 variant classification - last reported on 7 March 2025.