WEEKLY BULLETIN

Communicable Disease Threats Report

Week 47, 15–21 November 2025

This week's topics

Executive summary

Overview of respiratory virus epidemiology in the EU/EEA

- The number of patients presenting to primary care with symptoms of respiratory illness remains at baseline or low levels, however influenza detections are now increasing rapidly which is unusually early compared to previous seasons. SARS-CoV-2 circulation is decreasing in all age groups. Respiratory syncytial virus (RSV) circulation is low but increasing slowly. The impact on hospitalisations remains limited at this stage.
- This year's influenza season has begun three to four weeks earlier than in the last two years. As usual, the epidemiology varies between individual countries, but all are reporting dominance of influenza A, with A(H3N2) largely driving the increasing trend in recent weeks. Circulation is highest in children aged 5–14 years. Early increases in hospitalisation are being observed in some countries, affecting all age groups, but primarily adults aged 65 years and above.
- On 20 November 2025, ECDC published a Threat Assessment Brief assessing the risk of influenza for the EU/EEA in the context of increasing circulation of A(H3N2) subclade K.
- Slowly increasing trends in RSV circulation are currently around one week later than last season. Increases are visible in both primary care and hospital surveillance data from a few countries, with children under five years predominantly affected.

Threat Assessment Brief under production

- ECDC published a Threat Assessment Brief titled: Assessing the risk of influenza for the EU/EEA in the context of increasing circulation of A(H3N2) subclade K, on Thursday 20 November 2025, together with a relevant news item.

Mass gathering monitoring – Jubilee of 2025 in Italy

- ECDC conducted enhanced monitoring of the Jubilee through its epidemic intelligence activities between 10 and 21 November 2025, on the occasion of the Jubilee of the Poor.
- Since the beginning of the surveillance, and as of 21 November 2025, no relevant public health events associated with infectious diseases have been detected in connection with the Jubilee of the Poor.
- ECDC's epidemic intelligence team acknowledges the excellent collaboration with the Italian National Institute of Health (Istituto Superiore di Sanita' - ISS), the Italian Ministry of Health, SERESMI (National Institute for Infectious Diseases 'L.Spallanzani' – Lazio Region), and other partners.

Seasonal surveillance of dengue – 2025

- Since the beginning of 2025 and as of 19 November 2025, three countries in Europe have reported cases of dengue: France (29), Italy (four) and Portugal (two).
- This week, no new cases of dengue have been reported to ECDC, and all clusters are currently inactive.
- This week (week 47), ECDC is concluding its weekly reports for the 2025 season.

Weekly seasonal surveillance of West Nile virus infection – 2025

- Since the beginning of 2025, and as of 19 November 2025, 14 countries in Europe have reported human cases of West Nile virus infection: Albania, Bulgaria, Croatia, France, Germany, Greece, Hungary, Italy, Kosovo*, North Macedonia, Romania, Serbia, Spain, and Türkiye.

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

Seasonal surveillance of chikungunya virus disease – 2025

- Since the beginning of 2025 and as of 19 November 2025, two countries in Europe have reported cases of chikungunya virus disease: France (780) and Italy (385).
- In week 47, France reported four locally acquired cases of chikungunya virus disease. France did not report in week 46, and in week 45 it reported eight cases. Italy has reported one new case in week 47. In week 46, Italy reported ten new cases.

Marburg virus disease (MVD) - Ethiopia - 2025

- A Marburg virus disease (MVD) outbreak was confirmed on 14 November 2025 by the MoH of Ethiopia after a suspected event in Jinka city on 12 November 2025 was reported. As of 20 November 2025, six confirmed cases of MVD have been reported in Ethiopia. There have been a total of six deaths, three of which have been among laboratory confirmed cases and three among suspected cases.
- As of 17 November, there were 129 contacts reported as under monitoring, according to the Ministry of Health.
- This is the first MVD outbreak ever reported in Ethiopia.
- The likelihood of exposure to MVD for EU/EEA citizens visiting or living in Ethiopia is assessed as low, with uncertainties connected to the limited epidemiological information available. The impact, assessed at population level is low since the number of MVD cases in EU/EEA citizens in Ethiopia is expected to be very small. Therefore, the overall risk for EU/EEA citizens visiting or living in Ethiopia is low.
- In the event of MVD cases being imported into the EU/EEA, we consider the likelihood of further transmission to be very low, and the associated impact low. Therefore, the overall risk for the EU/EEA is assessed as low.

Ebola virus disease – Democratic Republic of the Congo – 2025

- Since the last update, and as of 20 November 2025, no new Ebola virus disease cases have been reported in the Democratic Republic of the Congo (DRC). All patients have been discharged and there are no contacts under active monitoring.
- The 42-day countdown for declaring the outbreak over was initiated on 19 October, following the discharge of the last patient being treated.
- Since the start of the outbreak, and as of 20 November, 64 cases (53 confirmed and 11 probable) of Ebola virus disease (EVD) have been reported in Kasai Province, DRC, including 45 deaths (34 confirmed and 11 probable; case fatality rate (CFR) among all cases: 70.3%).
- All confirmed cases were reported from Bulape health zone.
- The current risk for people from the EU/EEA living in or travelling to Kasai province in DRC is estimated to be low, due to the current low likelihood of exposure. For people living in the EU/EEA, the risk is very low, as the likelihood of introduction and secondary transmission within the EU/EEA is very low.

Rift Valley fever in Western Africa – 2025

- Since 21 September 2025, and as of 20 November, 482 human cases (including 31 deaths) of Rift Valley fever (RVF) have been reported in Senegal.
- Since 27 September 2025, and as of 9 November, 52 human cases (including 14 deaths) of RVF have been reported in Mauritania.
- On 5 November, media quoting health officials reported one human case of RVF in The Gambia, close to the border with Senegal.
- All three countries have reported outbreaks among livestock.
- To date, no human-to-human transmission of RVF has been documented.

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

- On 16 November 2025, a fatal human case of avian influenza A(H5N1) virus infection was reported in an adult man from Chroy Changvar District in the autonomous municipality of Phnom Penh, Cambodia.
- The infection was laboratory-confirmed on 15 November 2025, and the patient passed away the same day.
- Since 2003, and as of 17 November 2025, a total of 993 confirmed human cases of A(H5N1) have been reported worldwide, including 476 deaths (case fatality rate (CFR): 48%). Of these, 90 cases were reported from Cambodia, including 52 deaths (CFR: 58%).
- ECDC's risk assessment for A(H5N1) remains unchanged although information on the current case is limited. Overall, the risk related to zoonotic influenza for the general population in the EU/EEA is considered low.

Influenza A(H5N5) - Multi country (World) - Monitoring human cases

- The first human case of avian influenza A(H5N5) has been confirmed in Washington State, USA.
- The case, an older adult with underlying conditions, was hospitalised in early November 2025.
- The likely source of exposure is mixed backyard poultry that had contact with wild birds.
- The US CDC assesses the risk of avian influenza A(H5) to the general public as low.
- HPAI A(H5N5) has recently been circulating in wild birds in northern Europe, with occasional detections and outbreaks in wild mammals and domestic poultry.
- The virus was identified as belonging to clade 2.3.4.4b, genotype A6/EA-2021-I, which has been detected in birds and mammals in North America. No markers associated with mammalian adaptations of significance were observed.

Infant botulism - United States - 2025

- A multistate outbreak of infant botulism has been reported by the US authorities in November 2025, linked to the consumption of contaminated infant formula (ByHeart Whole Nutrition Infant Formula).
- As of 19 November 2025, infant botulism was confirmed or suspected in 31 infants across 15 states, all were hospitalised, no deaths have been reported.
- Control measures have been put in place in the US and for online customers which should significantly reduce the likelihood of exposure to the contaminated products.
- Based on the currently available information, the risk in the EU/EEA of infant botulism associated with this product is restricted to any individual consumers who may have bought the product online.

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

Overview

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.

Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

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

Maps and graphs

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

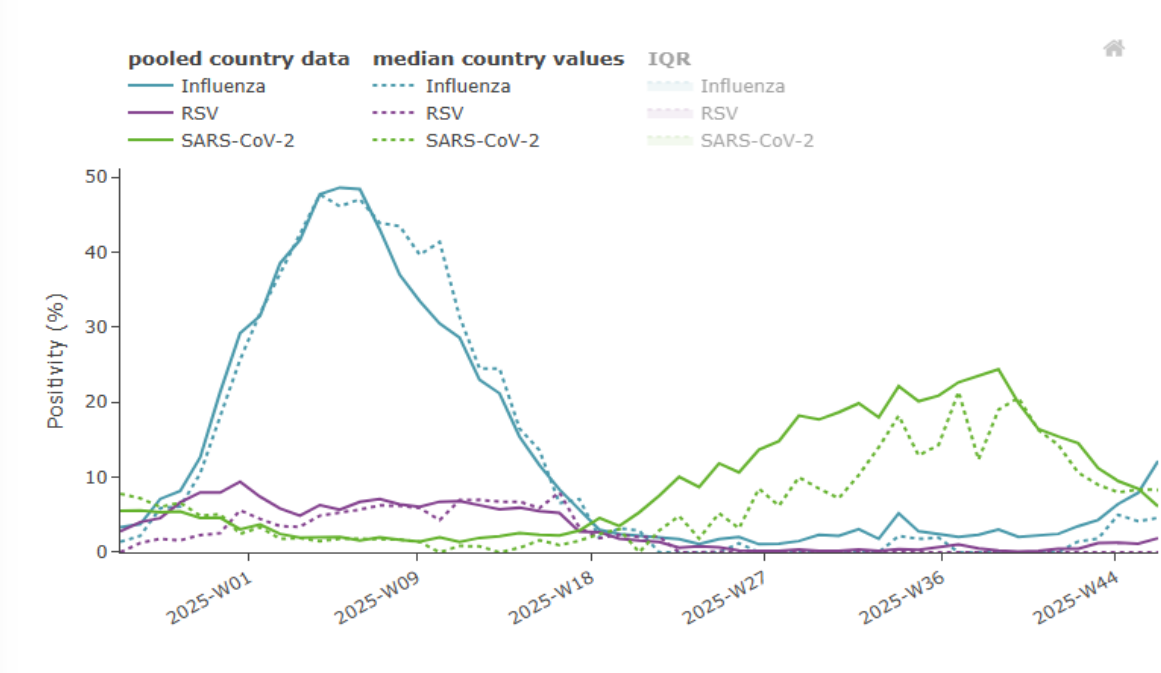

Figure 2. SARI virological surveillance in hospitals – weekly test positivity

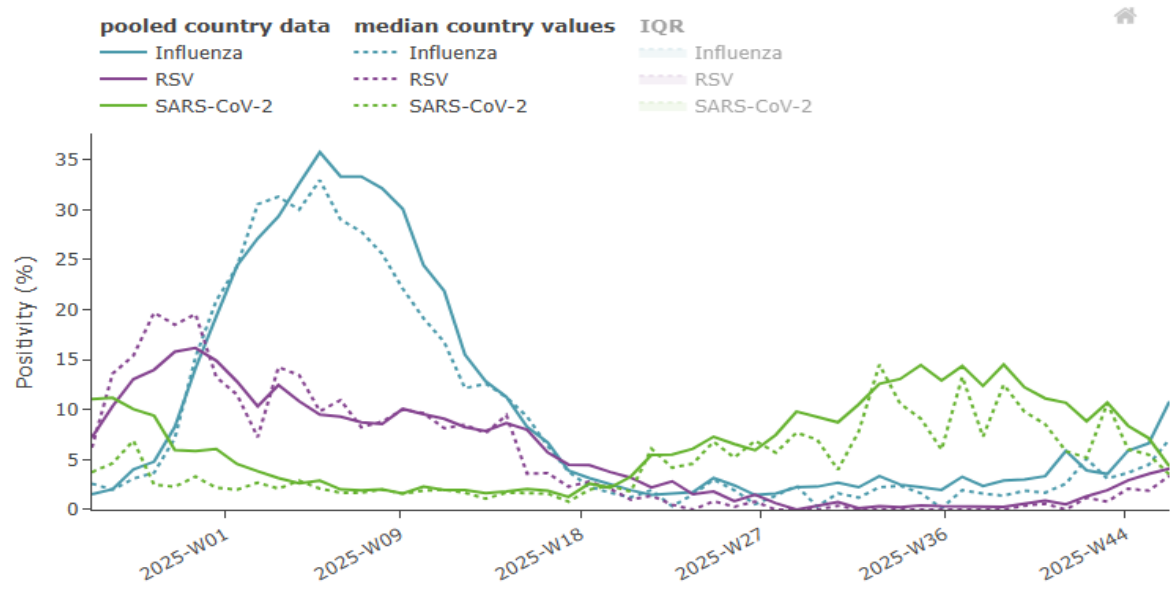

Figure 3. **ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution**

	Week 46, 2025		Week 40, 2025 – week 46, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**211**	**–**	**891**	**–**
Influenza A	197	99	849	99
A(H1)pdm09	39	25	297	41
A(H3)	119	75	427	59
A (unknown)	39	–	125	–
Influenza B	2	1	12	1
B/Vic	0	–	0	–
B (unknown)	2	–	12	–
Influenza untyped	12	–	30	–
RSV	**32**	**–**	**140**	**–**
RSV-A	9	69	33	55
RSV-B	4	31	27	45
RSV untyped	19	–	80	–
SARS-CoV-2	**103**	**–**	**1719**	**–**

[a] Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.

Figure 4. **SARI virological surveillance in hospitals – pathogen type and subtype distribution**

	Week 46, 2025		Week 40, 2025 – week 46, 2025	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**115**	**–**	**547**	**–**
Influenza A	89	99	424	98
A(H1)pdm09	12	52	109	65
A(H3)	11	48	58	35
A (unknown)	66	–	257	–
Influenza B	1	1	9	2
B/Vic	0	–	1	100
B (unknown)	1	–	8	–
Influenza untyped	25	–	114	–
RSV	**43**	**–**	**181**	**–**
RSV-A	8	67	38	61
RSV-B	4	33	24	39
RSV untyped	31	–	119	–
SARS-CoV-2	**45**	**–**	**931**	**–**

[a] Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.

Figure 5. **Genetically characterised influenza virus distribution, weeks 40–45, 2025**

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	141	64	5a.2a.1(D.3.1)	139	99
			5a.2a(C.1.9.3)	2	1
A(H3)	80	36	2a.3a.1(K)	66	82
			2a.3a.1(J.2.2)	6	8
			2a.3a.1(J.2)	4	5
			2a.3a.1(J.2.4)	4	5
B/Vic	1	0.5	V1A.3a.2(C.5.6)	1	100

Figure 6. SARS-CoV-2 variant distribution, weeks 43–44, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	4	13	6% (5–19%)
XFG	VUM	4	82	66% (45–81%)
NB.1.8.1	VUM	3	14	12% (3–21%)

[a] *Data are sorted by classification then median distribution. For information on SARS-CoV-2 variant classification visit ECDC's variant page.*

2. Threat Assessment Brief under production

Overview

ECDC published a Threat Assessment Brief titled: Assessing the risk of influenza for the EU/EEA in the context of increasing circulation of A(H3N2) subclade K, on Thursday 20 November 2025, together with a relevant news item.

Last time this event was included in the Weekly CDTR: 19 September 2025

3. Mass gathering monitoring – Jubilee of 2025 in Italy

Overview

Updates

On the occasion of the Jubilee of the Poor between 10 and 21 November 2025, ECDC has been conducting enhanced monitoring through its epidemic intelligence activities.

During the monitoring period, no relevant public health events associated with infectious diseases were detected in connection with the Jubilee of the Poor.

Summary

The Jubilee 2025 is a special holy year which occurs once every 25 years, involving major religious mass gathering events in Rome that are attended by millions of pilgrims from all around the world. During 2025, starting from 24 December 2024 and running until December 2025, it is estimated that more than 35 million pilgrims will visit Rome.

In 2000, 26 million pilgrims attended the Jubilee in Rome. Although there were visitors from all continents, the majority were from Italy. Although there was no noted increase in the incidence of communicable diseases during that year, cases of Legionnaires' disease and foodborne outbreaks increased among tourists, with limited impact at regional level. Outside of Italy, no public health events were reported that were linked to attending the Jubilee.

ECDC assessment

Mass gathering events involve a large number of visitors in one area at the same time. Multiple factors can lead to the emergence of a public health threat, such as an imported disease, increased numbers of susceptible people, risk behaviour, sale of food and beverages by street vendors, etc. At the same time, non-communicable health risks, including heat stroke, crowd injury, and drug- and alcohol-related conditions, should also be considered by the organisers and the public health authorities of the hosting country.

The Jubilee is a mass gathering that comprises multiple events which take place throughout the year. Therefore, the context differs slightly from other mass gatherings. The general assessment provided below refers to the probability of EU/EEA citizens becoming infected with communicable diseases during the Jubilee. However, if specific public health events with potential impact at local, national and EU/EEA levels are identified, they will be assessed separately.

The probability of EU/EEA citizens becoming infected with communicable diseases during the Jubilee 2025 is low, if general preventive measures are applied (e.g. being fully vaccinated according to national immunisation schedules, following advice regarding hand and food hygiene and respiratory etiquette, self-isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, applying personal protective measures against mosquito bites, seeking prompt testing and medical advice as needed, and practising safe sex). This is particularly important in relation to vaccine-preventable diseases that may be on the rise in the EU/EEA, such as measles, whooping cough, and COVID-19. In view of the earlier start of the influenza season 2025-26 in November 2025, ECDC urges those eligible for vaccination to get vaccinated without delay, including people planning to participate in the Jubilee celebrations until January 2026.

Actions

ECDC is monitoring this mass gathering event through epidemic intelligence activities and will report any relevant updates in collaboration with the Italian National Institute of Health (Istituto Superiore di Sanita'), the Italian Ministry of Health, SERESMI (National Institute for Infectious Diseases 'L.Spallanzani' – Lazio Region) and other partners.

Last time this event was included in the Weekly CDTR: 8 August 2025.

4. Seasonal surveillance of dengue – 2025

Overview

Since the beginning of 2025, and as of 19 November 2025, three countries in Europe have reported cases of dengue: France (29), Italy (four), and Portugal (two).

No new dengue cases have been reported since week 43, and all clusters are inactive. As further cases are unlikely, given the current unfavourable seasonal weather conditions for vector-borne transmission, ECDC is concluding its weekly reports for the 2025 season.

For more information on locally acquired dengue virus disease cases, see ECDC's seasonal surveillance report for dengue. This report covers mainland EU/EEA and the outermost regions of Portugal and Spain.

ECDC assessment

The current dengue risk assessment for mainland EU/EEA can be found on ECDC's dedicated dengue webpage.

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

5. Weekly seasonal surveillance of West Nile virus infection – 2025

Overview

Since the beginning of 2025, and as of 19 November 2025, 14 countries in Europe have reported human cases of West Nile virus infection: Albania, Bulgaria, Croatia, France, Germany, Greece, Hungary, Italy, Kosovo*, North Macedonia, Romania, Serbia, Spain, and Türkiye.

A total of 156 areas are currently known to be affected.

The report is available online.

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

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

6. Seasonal surveillance of chikungunya virus disease – 2025

Overview

Since the beginning of 2025, and as of 19 November 2025, two countries in Europe have reported cases of chikungunya virus disease: France (780) and Italy (385).

France has reported four new locally acquired cases of chikungunya virus disease since their last report from week 45. The cumulative number of locally acquired cases in France has reached 780, distributed across 79 clusters. Ten clusters are currently active. The largest cluster is located in Antibes.

Italy reported one new locally acquired case of chikungunya virus disease in Bellaria-Igea Marina, with date of onset 11 November. The cumulative number of locally acquired cases in Italy is 385, distributed across seven clusters. Two clusters are currently active. The largest cluster is in Carpi, San Prospero, Soliera, Novellara, Cavezzo, Modena, Nonantola, Correggio, Novi di Modena, and Cesenatico.

Seasonal weather conditions for vector-borne transmission are currently unfavourable in most parts of mainland Europe. However, due to delays in diagnosis and reporting, there may be further cases reported to ECDC in the coming weeks.

For more information on locally acquired chikungunya virus disease cases, see ECDC's seasonal surveillance report for chikungunya virus disease. This report covers mainland EU/EEA and the outermost regions of Portugal and Spain.

ECDC assessment

The current chikungunya virus disease risk assessment for mainland EU/EEA can be found on ECDC's dedicated chikungunya webpage.

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

7. Marburg virus disease (MVD) - Ethiopia - 2025

Overview

Event summary

As of 20 November 2025, six confirmed cases of Marburg Virus Disease (MVD) have been reported in Ethiopia, according to the Ministry of Health (MoH). A total of six deaths have been reported, three of which have been among laboratory confirmed cases and three among suspected cases. A total of three cases are being treated and 33 suspected cases are under investigation. Cases have presented with symptoms including sudden fever, muscle pain, severe fatigue, headache, diarrhoea, vomiting and, in later stages, unexplained bleeding.

Media reported that the deaths include two healthcare workers. According to a press release from the Ministry of Health of Ethiopia on 17 November, 129 contacts are being monitored.

On 14 November 2025, the MoH of Ethiopia confirmed an MVD outbreak in Jinka city, southern Ethiopia and reported that there were 17 suspected cases. Jinka is in south-west Ethiopia, which is close to the border with South Sudan and Kenya. Jinka is a small market town with about 30 000 inhabitants. It is also the capital of South Omo region and a tourist hub for the area. It is two days away from Addis. A small airport has recently been inaugurated there.

According to WHO, the virus strain shows similarities to those previously identified in East Africa.

In response to the outbreak, the Ministry of Health of Ethiopia reported that community-level monitoring, contact tracing, and house-to-house case finding had been intensified. Response efforts to this event are underway 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. In 2025, Tanzania also reported its second MVD outbreak (two confirmed and eight probable cases, all fatal).

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

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

Actions

ECDC is monitoring the event through epidemic intelligence activities and is in contact with partners to gather additional information.

8. Ebola virus disease – Democratic Republic of the Congo – 2025

Overview

On 19 October 2025, WHO announced that the last Ebola virus disease patient in DRC was discharged and initiated the 42-day countdown for declaring the outbreak over.

A total of 19 patients recovered from the disease (29.7%) and no new cases have been reported since 26 September. As of 20 November, of the 1 735/1 787 (97.3%) contacts that were followed up, none are under active monitoring.

Since the outbreak was declared on 4 September 2025, and as of 20 November, there have been 64 cases (53 confirmed and 11 probable) and 45 deaths (34 confirmed and 11 probable) (CFR among all cases: 70.3%). All cases were reported in six health areas in Bulape health zone, Kasai Province.

Summary

On 1 September 2025, WHO received an alert regarding probable cases of Ebola virus disease (EVD) from Bulape health zone, Kasai Province. Following this alert, on 4 September, the DRC Minister of Public Health, Hygiene and Social Security declared an outbreak of EVD in the country.

The first reported case was in a pregnant woman, who was admitted to Bulape General Reference Hospital on 20 August with symptoms including fever, bloody diarrhoea, vomiting, asthenia, and anal, oral, and nasal haemorrhage.

The woman later died due to multiple organ failure. Samples tested on 3 September at the country's National Institute of Biomedical Research in the capital, Kinshasa, confirmed the cause of the outbreak as Zaire ebolavirus. Based on whole genome sequencing analysis, the causative strain is not linked to previous outbreaks and therefore this is probably a new zoonotic spill-over event. The initial phase of the outbreak was characterised by nosocomial spread and a superspreading event linked to the presumptive index case's funeral.

On 28 September, WHO reported that the majority of cases have occurred in women (37 cases; 57.8%), with patients' ages ranging from under one year to 65 years. Children aged from under one year to nine years and individuals aged 20–29 years accounted for 25.0% (16) and 23.4% (15) of cases, respectively. The most affected populations included children, housekeepers and farmers. From the beginning of the outbreak in epidemiological week 36 to epidemiological week 39, the median time between symptom onset and isolation shortened from five days to two.

Women represent 60% of reported deaths. At the beginning of the outbreak, a high proportion of cases and deaths occurred among children aged under one year to four years, and the CFR was very high. As the outbreak progressed, the number of cases among children decreased and the CFR has gradually declined. Four of the deaths were reported among healthcare workers. In Bulape health zone, the health areas of Dikolo (26 cases, 15 deaths) and Bulape (24 cases, 22 deaths) are considered the epicentres of the outbreak, together accounting for 78.1% of reported cases and 82.2% of all deaths.

Vaccination began in Kasai Province on 13 September. As of 16 November, a total of 44 453 people have been vaccinated. Alongside ring vaccination, geographically targeted vaccination began on 27 September for groups at high risk of infection in hotspots reporting confirmed cases. A total of 31 patients have been treated with monoclonal antibody (mAb114).

The last reported date of symptom onset was 23 September and the last cases were reported on 26 September in Bulape and Dikolo health areas, Bulape health zone.

Background and additional information

Ebola virus disease outbreaks in the DRC are recurrent, as the virus is present in animal reservoirs in many parts of the country. This is the sixteenth outbreak recorded since 1976 in DRC and the eighth since 2018.

The last EVD outbreak documented in DRC was in August 2022, in Beni health zone, North Kivu province, but this concerned only one case. In the same year, another five cases were reported from Mbandaka city, Equateur province. In 2007 and 2008, there were EVD outbreaks affecting Kasai province, including the Bulape and Mweka health zones in 2007. In the country overall, there have been 15 outbreaks since the disease was first identified in 1976.

Earlier in this outbreak, WHO AFRO reported that Bulape health zone is linked to large population centres such as Tshikapa and Kananga, and as there is ongoing cross-provincial and cross-border movement there is a risk of further geographical spread.

The Ministry of Health is leading the outbreak response and is supported technically by WHO and other partners. A regional strategic response plan has been developed to guide coordinated efforts across affected and at-risk areas, focusing on surveillance, diagnostics, vaccination, infection prevention and control (IPC) and community engagement.

ECDC assessment

Ebola virus causes a severe, often fatal, disease. The current risk for people from the EU/EEA living in or travelling to Kasai province in DRC is estimated to be low, due to the low likelihood of exposure. For people living in the EU/EEA, the risk is very low, as the likelihood of introduction and secondary transmission within the EU/EEA is very low.

Intense surveillance and contact tracing are essential to rapidly control outbreaks of viral haemorrhagic fevers.

Actions

ECDC is monitoring the situation through its epidemic intelligence activities. In addition, ECDC is in contact with Africa CDC, the Global Outbreak Alert Response Network (GOARN), and the European Commission (DG ECHO, DG SANTE, DG HERA).

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

9. Rift Valley fever in Western Africa – 2025

Overview

Update

Since the last update in the CDTR, and as of 20 November, there have been 85 additional cases of Rift Valley fever (RVF) and three additional deaths reported in Senegal, according to the country's Ministry of Health. There have been cases reported in two additional regions (Kaffrine and Kolda).

Since the last update in the CDTR, and as of 9 November, there have been six additional cases of RVF and one additional death reported in Mauritania, according to WHO. No new regions have been reported as affected.

There have been no additional cases reported in The Gambia since media quoting health officials reported the first case in the country on 5 November.

Summary

Senegal

As of 20 November 2025, there have been a total of 482 confirmed human cases of RVF and 31 deaths (case fatality rate (CFR): 6.4%) reported since the beginning of the outbreak on September 21. A total of 419 cases have recovered and one person is hospitalised. According to Africa CDC, most cases occurred in males and the most affected age group is individuals aged 15–35 years.

The 11 affected regions are Saint-Louis (344), Louga (21), Matam (34), Fatick (32), Dakar (13), Kaolack (24), Thiès (2), Tambacounda (5), Kèdougou (2), Kaffrine (2) and Kolda (1). Many of the affected regions are in the north of the country, bordering Mauritania. On 20 November, Africa CDC reported that cases are now spreading to the southern parts of the country with potential new cross border transmission to The Gambia, Mali, Guinea and Guinea- Bissau.

On 30 September 2025, the World Organisation for Animal Health (WOAH) reported cases in terrestrial animals in Senegal and indicated that the area is at high risk of experiencing outbreaks in domestic and wild animals during the winter period, citing notable outbreaks in 2013 and 2023. On 20 November, Africa CDC, reported that there have been 390 cases among animals in Senegal. There have been 1 997 animal abortions and 29 980 animals have been vaccinated.

Mauritania

In Mauritania, the first human cases of RVF in this outbreak were reported on 2 October. As of 9 November, according to WHO, there have been 52 cases and 15 deaths reported (CFR: 28.8%). The 13 affected regions are mainly concentrated in the south near the border with Senegal, with three of the regions sharing international borders: Assaba (bordering Mali to the south), Brakna and Trarza (both bordering Senegal along the Senegal River).

According to a WHO report, as of 30 October there have been 235 confirmed cases and 71 deaths among animals in the south of the country since the first outbreak was recorded on 15 September 2025.

The cases in both Senegal and Mauritania are mainly located around the Senegal River delta and valley, and the early autumn months are considered a high-risk period for RVF in the region.

The Gambia

On 5 November, media quoting health officials reported the first human case of RVF in The Gambia, in the Sengalese border village of Ker Ayib. On 28 October, WOAH reported that there have been four cases reported in livestock in The Gambia.

Genomic analysis suggests that the current outbreak in Senegal is linked to previous detections in Senegal (in Fatick in 2020 and in Matam in 2022) and in Mauritania (2020). The last reported outbreak of RVF in Senegal was in the Fatick region in November 2021. There were three cases reported and no associated deaths. Mauritania has previously reported outbreaks in 1987, 2010, 2012, 2015, 2020 and 2022. The most recent outbreak involved 47 cases and 23 deaths. Animal breeders were most affected, and cases were reported in nine regions. The last reported animal cases of RVF in The Gambia were in livestock in 2003.

Disease information

RVF is an acute viral disease that mostly affects domestic animals (such as cattle, buffalo, sheep, goats and camels). The disease is caused by the RVF virus, generally found in regions of eastern and southern Africa, but also in most countries of sub-Saharan Africa and Madagascar. Outbreaks have also been reported in Saudi Arabia and Yemen in the early 2000s.

Humans may become infected through direct or indirect contact with the blood or organs of infected animals. Virus transmission may also occur through mosquito vectors. While most human cases are relatively mild, a small percentage of patients develop a much more severe form of the disease. Uncomplicated cases are characterised by acute influenza-like illness, leading to full recovery. In some patients the illness can progress to a severe form with haemorrhagic manifestations and hepatitis; possible complications include retinitis and encephalitis.

In endemic areas, vaccination of at-risk animals is the most important measure to prevent infection in humans.

ECDC assessment

Outbreaks of RVF are regularly reported in Senegal and Mauritania, and the early autumn is a period of high RVF epidemic potential in northern Senegal (Cecilia et al., 2020).

Travellers to and residents of Senegal or Mauritania are at low risk of infection if they apply appropriate preventive measures. Those who are in contact with potentially infected animals (e.g. veterinarians and those involved in livestock farming, butchering and slaughtering of animals in RVF-affected areas) have an increased risk of infection with RVF virus and should ensure safe animal husbandry and slaughtering practices. Visitors to affected areas should apply personal protective measures against mosquito bites.

The likelihood of RVF virus from the current outbreak in Western Africa being introduced into EU/EEA countries is very low, as the importation of live ruminants and raw animal products is not allowed. Importation of the virus via travellers or vectors is also unlikely.

Should the virus be introduced into mainland EU/EEA, further vector-borne transmission among animals or humans cannot be excluded. However, the likelihood is very low during the late autumn and winter season due to low numbers of competent mosquito vectors and low levels of vector activity in mainland EU/EEA countries.

Transmission of RVF virus through substances of human origin (SoHO) has not been reported to date, but the possibility of transmission cannot be excluded. However, as both Senegal, Mauritania and The Gambia are countries endemic for malaria, the deferral period for donors returning from areas affected by malaria would mitigate the risk of RVF virus transmission through SoHO.

Actions

ECDC will continue monitoring this event through its epidemic intelligence activities and report again if there is a significant change in the epidemiological situation.

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

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

Overview

On 16 November 2025, the Cambodian Ministry of Health reported a new fatal human case of avian influenza A(H5N1) virus infection in an adult man from Chroy Changvar District in the autonomous municipality of Phnom Penh.

The case developed symptoms including fever, cough, fatigue, and difficulty breathing. Despite receiving medical care, the patient passed away on 15 November 2025. On the same day, the National Institute of Public Health confirmed infection with avian influenza A(H5N1).

No additional information is available at this time.

National and local authorities are actively investigating the event and implementing response measures. As part of the response, close contacts of the case have received antiviral prophylaxis (Tamiflu), and health education campaigns are ongoing in the affected villages.

Summary

In 2025, Cambodia reported 18 human cases of avian influenza A(H5N1) virus infection, including 15 deaths. Overall, since 2003, Cambodia has reported 90 cases, including 52 deaths (CFR: 48%).

Since 2003, and as of 17 November 2025, there have been 993 human cases of avian influenza A(H5N1) infection worldwide*, including 476 deaths (CFR: 48%). These cases have been reported in 25 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, India, Indonesia, Iraq, Laos, Mexico, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Viet Nam, the United Kingdom (UK), and the United States (US)). To date, no sustained human-to-human transmission has been detected.

* This includes detections due to suspected environmental contamination, with no evidence of infection, that were reported in 2022 and 2023 by Spain (two detections), the US (one), and the UK (four, one of which was inconclusive). Human cases of A(H5) epidemiologically linked to A(H5N1) outbreaks in poultry and dairy cattle in the US are included in the reported number of cases of A(H5N1).

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ECDC assessment

Sporadic human cases of different avian influenza A(H5Nx) subtypes have previously been reported globally. Current virological evidence suggests that circulating A(H5N1) viruses retain genetic characteristics consistent with avian-adapted influenza viruses. Despite the widespread transmission of avian influenza viruses in animals, transmission to humans remains infrequent and no sustained transmission between humans has been observed.

Limited Information is available on the case reported above. Although no additional human cases have been reported so far, no data is available on exposure or genetic characteristics and contact tracing is ongoing. Based on the information currently available, the overall risk related to zoonotic influenza for the general population in the EU/EEA is considered low. This assessment will be reviewed as more information becomes available.

Direct contact with birds and other infected animals, their secretions or a contaminated environment is the most likely source of infection, and the use of personal protective measures for people exposed to dead animals or their secretions will minimise the associated 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 avian influenza overview. The most recent report was published in September 2025.

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

11. Influenza A(H5N5) - Multi country (World) - Monitoring human cases

Overview

On 14 November 2025, the Washington State Department of Health DOH), reported a confirmed human infection with avian influenza A(H5N5) in a resident of Grays Harbor County, Washington, USA. This is the first human infection with avian influenza of subtype A(H5N5) reported globally. The individual, an older adult with underlying health conditions, was hospitalised in early November 2025 and remains in care. The likely source of exposure is a mixed backyard flock of domestic poultry that had contact with wild birds. Public health investigations are ongoing. The Washington State Department of Health is collaborating with local health authorities and the State Department of Agriculture to assess human and animal health risks.

The US Centers for Disease Control and Prevention (CDC) and state authorities currently assess the risk of avian influenza A(H5) to the general public as low, and no increased risk has been identified by the Department of Health.

As of 14 November 2025, the US CDC have reported 71 human cases with avian influenza A(H5) (Note: mainly with avian influenza A(H5N1) virus infection), including one death.

Avian influenza A(H5N5) situation in animals in Europe and North America

Highly pathogenic avian influenza (HPAI) A(H5N5) virus of clade 2.3.4.4b has been circulating in wild birds in northern Europe and North America, where the geographical and species range in wild birds has recently expanded, causing spill-overs to wild mammals, domestic birds and, occasionally, domestic cats. HPAI A(H5N5) of clade 2.3.4.4b has also been detected in wild birds in Japan (EFSA, ECDC, EURL for Avian Influenza et al., 2024a; 2024b; 2025).

During the past epidemiological year (October 2024 - September 2025), seven countries in the EU/EEA (Belgium, Estonia, Finland, Germany, Iceland, Norway, Sweden) have reported detections of HPAI A(H5N5) in wild birds. Two countries (Iceland and Norway) have also reported outbreaks in domestic birds (EFSA, ECDC, EURL for avian influenza, et al., 2025). In addition, there have been detections of A(H5N5) in wild mammals in Europe since early 2024, such as Arctic and red fox (Iceland, Norway), lynx (Norway), American mink (Iceland), otter (Norway), and pine marten (Netherlands). Iceland has also reported A(H5N5) detection in domestic cats (EFSA, ECDC, EURL for avian influenza, et al., 2024; 2025).

In North America, Canada has reported eight detections of HPAI A(H5N5) in wild birds and one outbreak in domestic poultry to the World Organisation for Animal Health during the past epidemiological year. Canada has also reported detections in wild mammals, such as bobcat, skunk, grey seal, and racoon, as well as in domestic cats (EFSA, ECDC, EURL for avian influenza, et al., 2025). Since the beginning of 2025, there have been 11 detections of HPAI A(H5N5) in wild birds in the United States reported by the US Department of Agriculture (USDA).

Genetic characteristics of avian influenza A(H5N5) virus

The sequenced isolate (A/Washington/2148/2025) from the Washington case reported on 14 November 2025 was released the same day on NCBI GenBank under accessions PX508201-PX508208. It belongs to clade 2.3.4.4b, genotype A6, which has commonly been reported for recent A(H5N5) bird and mammalian viruses from North America, and referred to as EA-2021-I for European isolates. The HA segment of A/Washington/2148/2025 clusters closely with clade 2.3.4.4b strains of the same subtype but is distinct from the A(H5N1) genotypes B3.13 and D1.1, which include strains from human infections in the United States. A/Washington/2148/2025 does not contain any key mutations associated with mammalian adaptations or markers different from those already established in similar strains from birds.

During the past epidemiological year (Oct 2024 – Sep 2025), HPAI A(H5N5) genotype EA-2021-I had been reported in Iceland, Norway, the United Kingdom, and occasionally in Belgium, the Netherlands, Finland and probably in Germany (partial genome). All the A(H5N5) viruses belonging to this genotype detected in Europe in 2025 contained a molecular marker of virus adaptation to mammals, belonging to one of two distinct clusters, characterised by substitutions in the PB2 segment of either PB2-E627K or PB2-E627V. HPAI A(H5N5) viruses belonging to these two clusters have been circulating in Norway, the United Kingdom, Finland and Iceland since November 2024, and were also identified in Canada in late 2024 (EFSA, ECDC, EURL for avian influenza, et al., 2025). However, these markers of mammalian adaptation in the PB2 segment were not seen in the virus sequence of the human case reported in the United States on 14 November 2025 (A/Washington/2148/2025).

ECDC assessment

This is the first human case of avian influenza A(H5N5) reported globally. Sporadic human cases of different avian influenza A(H5) subtypes have previously been reported globally. Despite the widespread transmission of avian influenza viruses in animals, transmission to humans remains infrequent and no sustained transmission between humans has been observed.

Overall, the risk related to avian influenza A(H5) for the general population in the EU/EEA is considered low. The assessment for zoonotic avian influenza A(H5N5) virus will be reviewed when more information becomes available.

Direct contact with birds and other infected animals, their secretions or a contaminated environment is the most likely source of infection, and the use of personal protective measures for people exposed to dead animals or their secretions will minimise the associated 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 is closely monitoring this event and 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 avian influenza overview. The most recent report was published in September 2025.

12. Infant botulism - United States - 2025

Overview

The US Food and Drug Administration (FDA) and US Centers for Disease Control and Prevention (CDC), in collaboration with state and local partners, are investigating a multistate outbreak of infant botulism linked to ByHeart Whole Nutrition infant formula. As of 19 November 2025, 31 cases of infant botulism from 15 states (a further eight cases and two states since 14 November 2025) are suspected or confirmed and exposure to various lots of the formula have been reported; all infants have been hospitalised, and no deaths occurred. Illness onset dates range from 9 August to 13 November 2025, and affected infants range in age from 16 to 200 days, with 45% female. Caregivers are being interviewed by local health authorities about the food given to babies one month before they became ill.

Preliminary testing by the California Department of Public Health (CDPH) detected botulinum neurotoxin type A in an open can of formula ByHeart powdered infant formula (lot 206VABP/251131P2) that was fed to an infant with laboratory-confirmed infant botulism. In addition, identification of Clostridium botulinum was confirmed through culture by the CDPH. 'Detection of Clostridium botulinum in infant formula is difficult, and a negative test result does not rule out the presence of the bacteria in the product.'

FDA inspections and sampling of unopened product cans are continuing, as well as investigations to determine the contamination source. The new information will be updated as soon it becomes available. According to the US Food and Drug Administration (FDA), all lots and all sizes of cans and single-serve packets have been recalled and are being withdrawn from stores and online. Products sold online were also shipped outside of the US.

At the time of reporting, the product is not known to be sold on the European market.

ECDC assessment

This is a severe event with infant botulism, affecting infants across several states in the US with a suspected association with infant formula. Infant botulism is a rare but serious illness caused by the ingestion of spores from the bacterium Clostridium botulinum, leading to muscle weakness and potential respiratory failure in infants.

Control measures have been put in place in the US and for online customers on at least one of the largest online platforms, this should significantly reduce the likelihood of exposure to the contaminated products.

Based on the currently available information, the risk in the EU/EEA of infant botulism associated with this product is restricted to any individual consumers who may have bought the product online.

Actions

ECDC is closely monitoring this event through epidemic intelligence and food and water-borne disease group activities in collaboration with INFOSAN and EFSA.

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 21 November 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 21 November 2025
- Mass gathering monitoring – Jubilee of 2025 in Italy - last reported on 21 November 2025
- Threat Assessment Brief under production - last reported on 21 November 2025
- Seasonal surveillance of dengue – 2025 - last reported on 21 November 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 21 November 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 21 November 2025
- Ebola virus disease – Democratic Republic of the Congo – 2025 - last reported on 21 November 2025
- Rift Valley fever in Western Africa – 2025 - last reported on 21 November 2025
- Marburg virus disease (MVD) - Ethiopia - 2025 - last reported on 21 November 2025
- Influenza A(H5N5) - Multi-country (World) - Monitoring human cases - last reported on 21 November 2025
- Infant botulism - United States - 2025 - last reported on 21 November 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 14 November 2025
- Detection of wild poliovirus type 1 (WPV1) in a wastewater sample in Germany - last reported on 14 November 2025
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 14 November 2025
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 14 November 2025
- Seasonal surveillance of West Nile virus infections – 2025 - last reported on 14 November 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 14 November 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 7 November 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 7 November 2025
- SARS-CoV-2 variant classification - last reported on 7 November 2025.