WEEKLY BULLETIN

Communicable disease threats report

Week 24, 6–12 June 2026

This week's topics

Executive Summary

Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026

- A total of 676 confirmed cases, including 136 confirmed related deaths (an increase of 41 new cases and 9 new deaths since the previous report) have been reported in the Democratic Republic of the Congo (Ituri, North Kivu and South Kivu Provinces); a total of 19 confirmed cases, including two deaths, have been reported in Uganda.
- On 17 May 2026, the World Health Organization declared that the Ebola disease outbreak due to Bundibugyo virus constitutes a Public Health Emergency of International Concern, and on 18 May 2026 Africa CDC declared a Public Health Emergency of Continental Security.
- Given all the available information and uncertainties about this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. For people living in the EU/EEA, the likelihood of infection is estimated to be very low, given the very low likelihood of importation and secondary transmission. This assessment will be reviewed as further information becomes available.
- ECDC is monitoring the outbreak through epidemic intelligence activities and liaising with partners.

European Centre for Disease Prevention and Control, Solna, Sweden
www.ecdc.europa.eu

Hantavirus disease outbreak on cruise ship – South Atlantic – 2026

- As of 11 June 2026, a total of 13 cases of Andes virus (ANDV) disease have been reported, including 12 confirmed and one probable cases. No new deaths have been reported since the previous update.
- Disembarkation and evacuation of passengers and crew from the cruise ship *M/V Hondius* were carried out in Tenerife, Canary Islands between 10–11 May and in Rotterdam, the Netherlands on 18 May.
- Genome sequencing analysis from some of the positive cases confirmed a high level of genetic similarity between isolates, likely indicating an initial zoonotic spillover event followed by human-to-human transmission.
- The risk to the general population in the EU/EEA from ANDV spreading from the cruise ship outbreak remains very low.

Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report)

- This is the third weekly seasonal surveillance report of West Nile Virus (WNV) infections in 2026.
- In Europe, since the beginning of 2026 and as of 10 June, only North Macedonia has reported one human case of West Nile virus infection.

Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring

- In April 2026, 29 EU/EEA countries reported measles data. Seventeen countries reported 451 cases and 12 countries reported zero cases.
- During the previous 12-month period, three deaths attributable to measles were reported to ECDC by France (2) and the Netherlands (1).
- Overall, case numbers increased compared with the previous month.
- Complementary epidemic intelligence surveillance was performed on 11 June 2026. Outbreaks have been reported in Bulgaria. Sporadic cases and clusters were reported in several EU/EEA countries. Updates are provided for several countries and regions outside the EU/EEA.

Chikungunya virus disease – French Guiana, France – 2026

- There is ongoing chikungunya virus circulation in French Guiana, with 621 cases reported since 1 January 2026 and as of 31 May.
- Seventy per cent of these cases were confirmed in the Littoral ouest sector. On 23 April, this sector was declared to be in the 'epidemic' phase of the outbreak.
- Savanes and Ile de Cayenne sectors are now in the 'outbreak clusters' phase.
- The current likelihood of chikungunya virus infection for travellers to French Guiana is assessed as low; the likelihood of onward transmission in mainland Europe following introduction by a viraemic traveller is considered low.
- Travellers should be advised to take enhanced mosquito bite prevention measures. Vaccination may be considered based on national recommendations.

Nipah virus disease – India and Bangladesh – 2026

- On 10 June 2026, a Nipah virus (NiV) case was reported in Kozhikode district, Kerala, India, involving a person in their forties with encephalitis. The case tested positive for NiV and confirmatory results are pending.
- The patient is hospitalised in stable condition, and the infection is suspected to have been acquired while cleaning a warehouse, although the source has not been confirmed.
- A total of 77 contacts have been identified, with high-risk contacts placed under quarantine; no secondary cases have been reported to date.
- Previous cases were reported in Bangladesh (death in Rajshahi Division on 6 February 2026) and in India (two cases in West Bengal on 26 January 2026).
- The likelihood of exposure and infection with NiV for EU/EEA residents travelling to or residing in India or Bangladesh is currently very low, given the low number of infections in areas where cases have been identified to date.

1. Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026

Overview:

Latest epidemiological information

Democratic Republic of the Congo

According to the official report published on 11 June 2026, based on data available as of 10 June, a total of 676 confirmed cases, including 136 confirmed related deaths, have been reported in Democratic Republic of the Congo (DRC). This is an increase of 41 new cases and nine new deaths compared with the report on 10 June. As of 11 June, among the confirmed cases, 629 cases (including 109 deaths) have been reported in the Ituri province, 44 cases (including 26 deaths) in North Kivu and three cases (including one death) in South Kivu. In addition, 262 patients are reported to have been hospitalised in isolation. Thirty two individuals who previously tested positive for Ebola disease have recovered and 71.8% of identified contacts are under follow-up.

Within the three affected provinces, 29/104 health zones are currently affected, including 19/36 in Ituri, 9/34 in North Kivu, and 1/34 in South Kivu. In Ituri province, one new affected health zone has been reported, with one new case; in North Kivu, two new affected health zones have been reported, with two new cases. Of the 629 confirmed cases reported in Ituri, 94 have not been assigned to a health zone.

According to the World Health Organization (WHO), 16 of the confirmed cases reported as of 8 June involved health and care workers.

Uganda

As of 11 June, a total of 19 confirmed cases, including two deaths, have been reported by the Ministry of Health in Uganda. Five individuals have recovered. The last confirmed cases were reported on 5 June by the Ministry of Health and no new cases have been reported since.

Among the confirmed cases, 14 had travel links to DRC and five were associated with local transmission events, according to health officials. Of nine cases with known geographical information, eight were reported in Kampala and one was reported in Wakiso (a district that neighbours Kampala).

One case reported by Uganda had travel history to the United Arab Emirates (UAE), arriving on 24 May (Media reports on 1 June 2026, WHO media briefing on 3 June 2026, WHO DON 8 June 2026). According to WHO, as of 8 June, no cases of Ebola disease have been reported in the UAE; public health measures including risk assessment activities, contact tracing and follow-up, and strengthened preparedness measures at points of entry have been implemented in coordination between WHO, UAE and international partners.

Several symptomatic travellers from affected areas have been tested in EU/EEA and non-EU/EEA countries, all of whom have tested negative so far.

Summary:

On 15 May 2026, Africa CDC reported an outbreak of Ebola disease in Ituri Province, DRC (Africa CDC Calls Urgent Regional Coordination Meeting Following Ebola Virus Disease Outbreak in Ituri, 15 May 2026, Africa CDC Special Briefing on Ebola Virus Disease Outbreak Status, 16 May 2026). Laboratory analysis at the Institut National de Recherche Biomedicale of DRC identified Bundibugyo virus (Democratic Republic of the Congo confirms new Ebola outbreak, WHO scales up support | WHO AFRO, 15 May 2026).

Clusters of community deaths have been reported, including deaths among healthcare workers in DRC (Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026, Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo (The) & Uganda).

The Ministry of Health of DRC reported that the index case was a nurse (age unknown) who died in a healthcare facility in Bunia (capital of Ituri Province). The case presented with fever, bleeding, vomiting and weakness (Ministère de la Santé RDC Declaration of Ebola Outbreak 15 May 2025). However, the outbreak is likely to have started many weeks before, given the number of cases and the geographical spread.

On 18 May 2026, a US citizen working in healthcare in the affected areas tested positive and was transferred to Germany, together with six high-risk contacts (US CDC Update on Ebola Outbreak, 18 May 2026, Serge News and Updates, 18 May 2026). The American doctor subsequently recovered well and was discharged from the hospital in Berlin where he was treated (Ebola patient discharged from Charite hospital in Berlin in good health, 6 June 2026). Another contact of US nationality was transferred to Czechia (US CDC Transcript -19 May 2026).

The first case reported in Uganda was travel related and the patient later died (Democratic Republic of the Congo confirms new Ebola outbreak, WHO scales up support | WHO AFRO, 15 May 2026, Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026). Health authorities reported that 14 confirmed cases in Uganda had travel links to DRC. Additional cases were identified following contact tracing activities. Uganda has postponed a large religious event (Martyr's day) that normally takes place on 3 June and has suspended cross-border transport activities (Government of Uganda on X: 21 May 2025).

Genomes from DRC and Uganda have been published and preliminary analysis shows distinct sequences from the previous outbreaks (Virological Ebolavirus/Bundibugyo ebolavirus, 18 May 2026).

Information regarding transmission chains and affected population groups is currently limited, partly due to the complex context of insecurity and humanitarian challenges in the affected areas. According to WHO, neighbouring countries sharing land borders with DRC are considered at high risk of further spread due to population mobility, trade and travel links, and uncertainty about the transmission chains. The outbreak may also be larger than currently detected. There are also concerns related to this outbreak because it is caused by Bundibugyo virus, rather than the more commonly detected Zaire ebolavirus. Unlike Zaire ebolavirus, there are currently no licensed vaccines or specific treatments for Bundibugyo virus disease.

Given the information available, the complicated context and the uncertainties regarding epidemiological information, WHO declared a Public Health Emergency of International Concern on 17 May 2026 (Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026). On 18 May 2026, Africa CDC declared the outbreak a Public Health Emergency of Continental Security (Africa CDC Declares the Ongoing Bundibugyo Ebola Outbreak a Public Health Emergency of Continental Security – Africa CDC, 18 May 2026). On 5 June, WHO and Africa CDC launched a joint continental preparedness and response plan to support African countries in the response to the ongoing outbreak.

This is the 17th Ebola disease outbreak reported in DRC. The most recent prior outbreak occurred in 2025 in Kasai Province due to Ebola virus species *Orthoebolavirus zairense* (WHO DON Ebola virus disease – Democratic Republic of the Congo, 5 September 2025). In Ituri province specifically, Ebola disease due to Ebola virus *Orthoebolavirus zairense* was last documented during the 2018–2020 outbreak. This outbreak was declared on 1 August 2018 following reports of laboratory-confirmed cases in North Kivu province. Investigations identified cases in Ituri and North Kivu with symptom onset from May 2018. The outbreak also spread to South Kivu. Between 1 August 2018 and 25 June 2020, when the outbreak was declared over, a total of 3 470 cases were reported, including 3 317 confirmed cases and 153 probable cases. At the time, WHO declared the outbreak a Public Health Emergency of International Concern (Disease Outbreak News Ebola virus disease – Democratic Republic of the Congo, 26 June 2020, Medical countermeasures during the 2018 Ebola virus disease outbreak in the North Kivu and Ituri Provinces of the Democratic Republic of the Congo: a rapid genomic assessment - ScienceDirect).

Bundibugyo virus was first reported in 2007 in Bundibugyo district in Uganda, during an outbreak. The most recent outbreak due to Bundibugyo virus was in 2012 in DRC (Uganda: Ebola outbreak press statement - 20 Dec 2007 - Uganda | ReliefWeb, WHO | Ebola outbreak in Democratic Republic of Congo, 12 August 2012).

Travel restrictions

Enhanced control and screening protocols have been activated by authorities in several countries to limit the risk of viral spread.

Exit screening has been implemented in DRC, Uganda and South Sudan. In DRC, points of entry (PoE) and points of control (PoC) have been activated at key locations, including airports, road checkpoints and towns or local transit points, such as Nizi and Irumu (Ituri), Mudzibala (Bunia), Dele and Chai (Rwampara). Bunia airport in the Ituri province was temporarily closed on 23 May and re-opened on 2 June with the implementation of health screening measures. Commercial flights to and from Bunia airport have been temporarily suspended again as of 6 June, as part of health security arrangements in response to the Ebola outbreak, as also reported by media.

The Rwandan Ministry of Health has reinforced health screening and vigilance at land points of entry along the border with DRC. Enhanced entry control measures have been implemented at Kigali International Airport for inbound travellers to Rwanda (Rwanda Ministry of Health, 22 May on X).

Several countries have also implemented entry restrictions and health screening for individuals travelling from high-risk countries, including the US, Canada, Tunisia, Thailand, Mauritius and the Bahamas (Ebola Update - Travel Measures and Ongoing Monitoring).

ECDC assessment:

Considering the remaining gaps in the epidemiological information and limited follow-up of contacts, it is expected that the outbreak is much larger than is currently being reported – not only in terms of the number of affected cases, but also its geographical extent.

Given all the available information and uncertainties surrounding this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. For people living in the EU/EEA, the likelihood of infection is estimated to be very low, given the very low likelihood of importation and secondary transmission. The likelihood of Bundibugyo virus affecting the donor population for substances of human origin in the context of this outbreak is currently assessed as very low. This assessment will be reviewed as further information becomes available.

Exit screening in affected countries, including symptom checks and exposure assessment, is important as it contributes to risk reduction by identifying symptomatic travellers before they board flights to prevent them travelling while symptomatic. Exit screening also helps dissuade people with symptoms from travelling and enhances public and stakeholder confidence. However, it cannot fully prevent exportation of cases, because the absence of symptoms at departure does not exclude subsequent onset of disease.

ECDC considers that screening of returning travellers from affected areas (DRC, Uganda) would not be effective in preventing introduction to Europe. This consideration is based on the lessons learned and results of the large EVD outbreak in West Africa between 2013 and 2016, where tens of thousands of cases were reported, transmission was ongoing in large urban centres, and hundreds of EU/EEA humanitarian and military personnel were deployed to the affected areas. Screening incoming travellers is time- and resource-consuming and will not effectively identify people with the infection. Priority should instead be given to providing travellers with clear information on symptoms, routes of transmission, and what to do if symptoms develop after arrival in the EU/EEA.

Detailed assessment of the event can be found in the ECDC Threat Assessment Brief published on 21 May 2026 (Threat assessment brief: Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026).

Actions:

ECDC continues to monitor the outbreak through its epidemic intelligence activities to provide epidemiological updates, situational awareness and risk assessment for the EU/EEA.

Since 19 May 2026, the EU Health Task Force, in collaboration with DG ECHO, DG INTPA and GOARN, is deploying ECDC experts to Africa CDC headquarters in Addis Ababa.

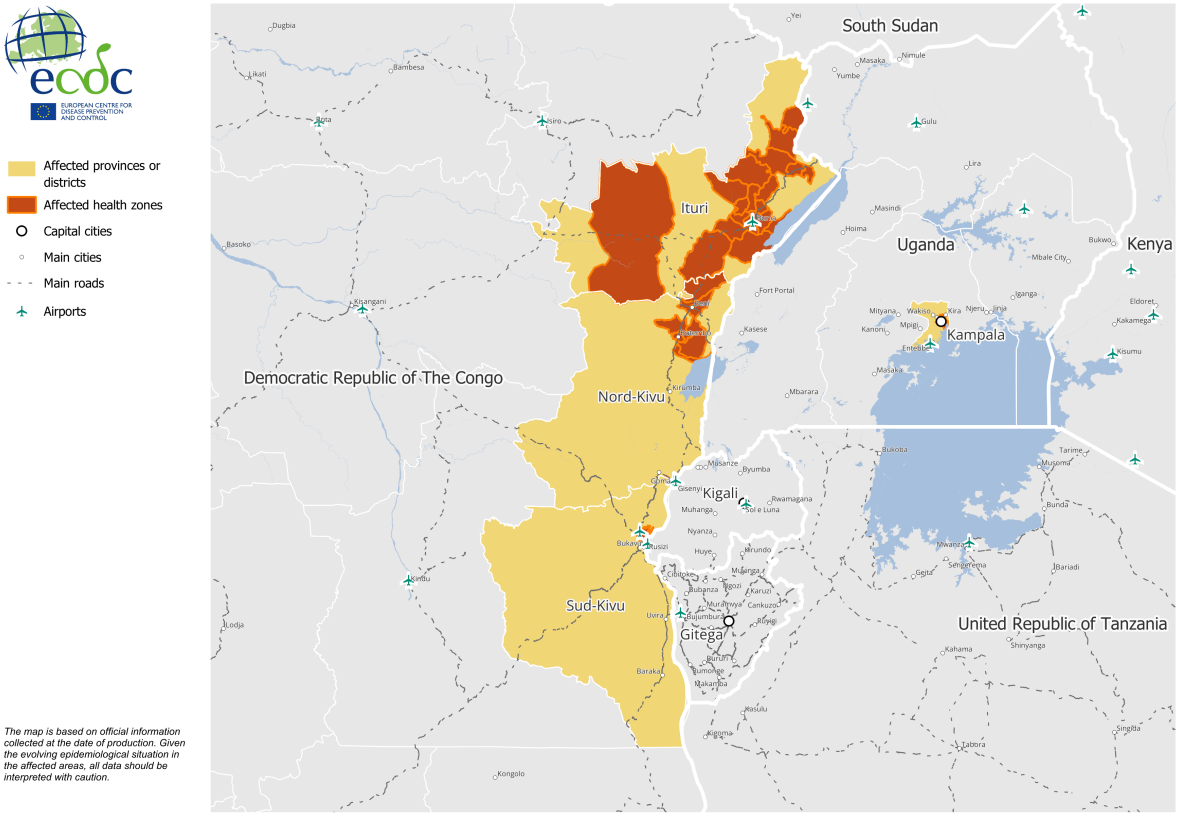
ECDC is actively liaising with key partners, including Africa CDC, the European Commission and WHO, to provide further support through the EU Health Task Force in response to this outbreak.

ECDC is regularly re-evaluating the situation as new information becomes available and continues to provide epidemiological updates and scientific advice on its website. A Threat Assessment Brief and Laboratory guidance and resources on the Ebola outbreak were published on 21 May 2026 and 27 May 2026, respectively.

Last time this event was included in the Weekly CDTR: 5 June 2026

Maps and graphs

Figure 1. Map of the affected areas, Ebola disease outbreak caused by Bundibugyo virus, Democratic Republic of the Congo and Uganda, 2026



Source: ECDC

2. Hantavirus disease outbreak on cruise ship – South Atlantic – 2026

Overview:

Update

On 10 June 2026, one previously reported probable case of ANDV, involving an individual in Tristan de Cunha who was exposed on the ship, was confirmed by laboratory testing (UKHSA, WHO).

This case has now been reclassified as confirmed. As of 11 June, a total of 13 cases, including 12 confirmed and one probable, have been reported.

Background

On 2 May 2026, the Netherlands informed ECDC about an outbreak of unknown aetiology on a cruise liner under the Dutch flag, the *M/V Hondius*. The ship had been on a cruise in the Southern Atlantic after departing from Argentina on 1 April and was en route to Cabo Verde. The cruise followed an itinerary including stops on mainland Antarctica, South Georgia, Nightingale Island, Tristan da Cunha, St Helena and Ascension Island, with Cabo Verde as the next port of call.

A total of 149 people boarded the ship at the beginning of the journey, including 88 passengers and 61 crew. Passengers and crew represented 23 nationalities, including the following nine EU/EEA countries and others: Argentina, Australia, Belgium, Canada, France, Germany, Greece, Guatemala, India, Ireland, Japan, Montenegro, the Netherlands, New Zealand, the Philippines, Poland, Portugal, the Russian Federation, Spain, Türkiye, Ukraine, the UK, and the US.

The cruise ship *M/V Hondius* arrived in Tenerife, Canary Islands on 10 May, where a total of 122 people (including 87 passengers and 35 crew members) disembarked from the vessel and were subsequently repatriated via evacuation flights between 10–11 May. Following evacuations, the vessel departed Tenerife on 11 May and arrived in Rotterdam, the Netherlands on 18 May with 27 people on board. The remaining individuals disembarked and the ship underwent cleaning and disinfection.

Preliminary analysis of genome sequences from some of the positive cases confirmed a high level of genetic similarity between isolates, likely indicating an initial zoonotic spillover event followed by human-to-human transmission. Further results from genomic sequences are pending.

Other sources: WHO DON 8 May 2026, WHO DON 13 May 2026, first Press statement from the cruise ship company on 4 May, second Press statement from the cruise ship company on 4 May

ECDC assessment:

Person-to-person transmission of ANDV has only been documented following close and prolonged contact. The current hypothesis is that some passengers were exposed to ANDV while spending time in Argentina (where ANDV is endemic) before boarding the ship, and may subsequently have transmitted the virus to other passengers onboard.

Control and preventive measures are being implemented by public health authorities from countries who received returning passengers and crew members after the disembarkement (e.g. use of appropriate personal protective equipment, quarantine, testing, isolation of cases, etc.) to limit the potential spread of infection to the general population.

Hantavirus has been circulating in some regions of the world, including South America, causing both sporadic infections and outbreaks in humans. The first documented cases of ANDV infection were reported in humans in 1996 in Argentina, causing hantavirus pulmonary syndrome (HPS). In Europe, two cases of ANDV infection presenting with HPS were detected in travellers returning to Switzerland from South America in 2016.

The natural reservoir for ANDV is not present in Europe, so introduction to the rodent population and potential rodent-to-human transmission in Europe is not expected.

The risk to the general population in the EU/EEA from ANDV spreading from this cruise ship outbreak remains very low.

The likelihood of ANDV affecting the SoHO donor population in the context of this outbreak is currently assessed as negligible.

Actions:

ECDC routinely monitors the evolution of the outbreak through epidemic intelligence activities and continues to liaise with Member States, WHO and the European Commission to collect further information on the outbreak and support the affected countries.

ECDC regularly collects information on monitoring and follow-up of contacts, laboratory testing and public health measures implemented in Member States. Epidemiological studies are being conducted to understand the characteristics and modalities of viral infection and transmission.

A list of scientific guidance and risk assessments produced by ECDC since the beginning of the outbreak can be found on the website (Andes hantavirus outbreak in cruise ship).

Sources: Press update of Oceanwide

Last time this event was included in the Weekly CDTR: 29 May 2026

3. Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report)

Overview:

Throughout the season, ECDC will publish a weekly report with updates on risk areas for locally acquired WNV infections. In addition, a monthly report will be published.

WNV infection in humans is a notifiable disease at the EU level and cases should be reported by national public health authorities through the EpiPulse Cases platform according to the EU case definition. According to Commission Directives 2004/33/EC and 2014/110/EU on blood safety, blood establishments in EU/EEA countries should apply temporary deferral criteria for donors of allogeneic blood donation for 28 days after they have left a risk area for locally acquired WNV, unless an individual nucleic acid test (NAT) is negative. WNV surveillance activities carried out by ECDC support the competent authorities responsible for blood safety in the implementation of these directives.

This is the third report of the weekly seasonal surveillance of WNV infections in 2026.

In Europe, since the beginning of 2026 and as of 10 June, only North Macedonia has reported one human case of West Nile virus infection.

ECDC assessment:

Currently, one area in North Macedonia is known to be affected (Vardarski).

The report is available online.

Seasonal weather conditions are currently favourable for mosquito-borne transmission; therefore, more cases are expected to occur in the coming weeks.

Actions:

ECDC will provide weekly and monthly updates with the latest reports on cases of WNV infections in Europe. A map and table will be updated every Friday from now until November, as this is the time of year when WNV infections are most likely to be reported.

ECDC will provide an enhanced analysis of the current WNV epidemiology on a monthly basis together with the European Food Safety Authority (EFSA), which includes the number of reported locally acquired human cases, outbreaks of West Nile fever in equids and birds notified to the Animal Disease Information System (ADIS) of the European Commission, and an assessment of the situation.

Last time this event was included in the Weekly CDTR: 5 June 2026

4. Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring

Overview:

In April 2026, 29 EU/EEA countries reported measles data. Seventeen countries reported 451 cases and 12 countries reported zero cases.

Overall, case numbers increased compared with the previous month; however, this may be subject to change in the event of a future retrospective update. The highest case counts were reported by Bulgaria (163), Italy (133), Latvia (38), France (32) and Spain (23).

In the most recent 12-month period, from 1 May 2025 to 30 April 2026, 30 EU/EEA countries reported a total of 3 779 cases of measles, 3 161 (83.6%) of which were laboratory confirmed.

Of the 3 779 cases with known age, 1 267 (33.5%) were in children under five years old; 1 655 (43.8%) cases were in those aged 15 years old or above. The highest notification rates were observed among infants under one year old (112.9 cases per million) and children aged 1–4 years old (53.8 cases per million).

Of 3 266 individuals (86.4% of all cases) with known age and vaccination status, 2 551 (78.1%) were unvaccinated, 396 (12.1%) were vaccinated with one dose of a measles-containing vaccine, 283 (8.7%) were vaccinated with two or more doses, and 32 (1.0%) were vaccinated with an unknown number of doses.

During the 12-month period, three deaths attributable to measles were reported to ECDC by France (2) and the Netherlands (1). Detailed data are available in ECDC's Surveillance Atlas of Infectious Diseases.

Complementary epidemic intelligence surveillance was performed on 11 June 2026. Outbreaks continue in Bulgaria. Sporadic cases and clusters were reported in several EU/EEA countries. Updates are provided for several countries and regions outside the EU/EEA. Outside the EU/EEA, updates have been provided by England, Ukraine, Africa CDC, the World Health Organization Pan American Health Organization (WHO PAHO), Japan, Canada, the United States (US), and Mexico.

Disclaimer: *The monthly measles report published in the CDTR provides the most recent data on cases and outbreaks based on information made publicly available by the national public health authorities or the media. Sometimes this information is made available retrospectively. This report is a supplement to ECDC's monthly measles and rubella monitoring report, based on data routinely submitted by 30 EU/EEA countries to EpiPulse Cases. Data presented in the two monthly reports may differ.*

Epidemiological summary for EU/EEA countries with relevant epidemic intelligence updates:

Austria reported seven confirmed or probable cases in 2026 and as of 10 June 2026.

Bulgaria is experiencing an ongoing outbreak, with 364 cases of measles reported from 1 January to 8 June 2026. The cases have been reported in nine districts, most of which are bordering Romania. Most of the cases are reported in the Vratsa region (198), as well as the Pleven (101) and Lovech (41) regions; cases have also been reported in the Sofia City (7), Varna (3), Vidin (1), Sofia (1) and Targovishte (1) regions. Most of the cases are in children under 10 years old (231/364), with highest incidence in those under one year old (73 cases per 100 000 population), followed by 1–4 years old (46 per 100 000 population), 5–9 years old (29 per 100 000 population), and 10–14 years old (16 per 100 000 population). From the 331 cases with known vaccination status, 187 cases were not vaccinated. Over 39 799 MMR vaccine doses have been administered in response to the outbreak. From January to December 2025, Bulgaria reported two cases.

Czechia reported four cases between 1 January and 1 June 2026.

Germany reported 95 confirmed and probable measles cases in 2026 (weeks 1 to 24), an increase of 13 cases from week 21.

Lithuania reported nine cases from 1 January to 5 June 2026.

The Netherlands reported eight measles cases in 2026 and as of 3 June. There is currently no indication of a national outbreak. Of the reported cases, four were imported from abroad (Indonesia, Iraq and Türkiye).

Norway reported one case of measles in 2026.

Poland reported 22 cases of measles from 1 January to 31 May 2026.

Portugal reported seven measles cases on 21 May 2026, in the Northern region, Lisbon Tagus Valley, Alentejo and Algarve.

Spain reported 129 cases of measles from 1 January to 7 June 2026, including 11 imported cases and 26 cases related to imported cases. This represents an increase of 11 cases since 17 May 2026.

Epidemiological summary for EU/EEA outermost territories with relevant epidemic intelligence updates:

No new outbreaks or cases have been detected in the reporting period.

Western Balkans countries and Türkiye
No new outbreaks or cases have been detected in the reporting period.

Epidemiological summary for selected countries outside of the EU/EEA with relevant epidemic intelligence updates:
England reported 736 confirmed measles cases, including two deaths, from 1 January to 8 June 2026. Between January and December 2025, England reported 959 confirmed measles cases.

Ukraine reported 201 cases from January to April 2026. From January to December 2025, Ukraine reported 1 502 measles cases.

Africa CDC reported on 24 May 2026 that, in 2026, there have been 4 475 confirmed and 109 199 suspected cases of measles, including 784 deaths from 21 African Union Member State countries. High risk of measles spread is listed for Senegal, and moderate risk in Burundi and Mozambique.

Japan is experiencing an increase of measles cases in 2026. With 523 cases reported in weeks 1–22, the number of cases exceeds the total reported in the whole year of 2025 (265). The largest number of cases (70) was reported in week 17. Of the reported cases, 49 were imported.

According to the WHO Pan American Health Organization (WHO PAHO) report published on 23 May 2026, 21 153 confirmed measles cases have been reported by 17 countries. Most of these cases were reported in Mexico (11 006), Guatemala (6 622), the US (1 978) and Canada (1 052). Due to the upcoming FIFA World Cup 2026, a more detailed overview is provided for the hosting countries: Canada, Mexico and the US.

FIFA World Cup 2026 hosting countries:
Canada reported 1 063 measles cases, including 982 confirmed cases, and no deaths across seven jurisdictions in 2026 and as of 30 May 2026. The country remains in active transmission across multiple provinces due to an ongoing multijurisdictional outbreak. The vast majority of the cases reported in 2026 are linked to this outbreak.

The US continues to face multiple concurrent outbreaks, including several that began in 2025 and have continued into 2026. Overall, the US Centers for Disease Control and Prevention (US CDC) reported 2 030 confirmed cases and no deaths between 1 January and 5 June 2026. In comparison, between January and December 2025, US CDC reported 2 288 cases of measles, including three deaths. There have been 30 new outbreaks reported in 2026 and 93% of confirmed cases are outbreak associated. The majority of the cases are in children (72%) and unvaccinated individuals (92%).

Mexico reported, on 9 June 2026, 11 569 confirmed cases and 14 deaths in 2026 only. Overall, since the beginning of the outbreak in 2025, 18 183 confirmed cases were reported, including 41 deaths. The number of cases is declining after a peak reported in week 6 in 2026. The most affected state in 2026 remains Jalisco (6 416 cases; three deaths).

For more information on the provisional number of cases outside the EU/EEA region, please visit the World Health Organization (WHO) website.

The numbers provided to WHO for EU/EEA countries are from EpiPulse Cases data, which are updated monthly and available on the ECDC Surveillance Atlas of Infectious Diseases. Due to differences in reporting times, the numbers may not correspond to the data from epidemic intelligence screening.

ECDC assessment:

Although most recent cases were acquired through local or community transmission, travel-related cases continue to be reported.

Continued vigilance is essential due to sub-optimal vaccination coverage for measles-containing vaccines (MCV) in several EU/EEA countries, possible introduction from areas with ongoing transmission, and increased travel and population movement during holiday periods.

Actions:

ECDC is monitoring the measles situation through its epidemic intelligence activities. Data collected via epidemic intelligence supplement the monthly outputs of measles surveillance data from EpiPulse Cases, which are routinely submitted by 30 EU/EEA countries.

ECDC urges EU/EEA public health authorities to focus on the following areas:

- **Close immunity gaps, achieve and maintain high vaccination coverage for measles-containing vaccines** (>95% with the second dose). It is vital to ensure first and second dose vaccinations are administered on time, as per national schedules among infants and children. It is also important to identify and vaccinate eligible individuals (for example, non-immune adolescents and adults) in immunisation catch-up programmes (as recommended by local and national authorities).

- **Strive towards high-quality surveillance** and adequate public health capacity, especially for early detection, diagnosis, response and control of outbreaks.
- **Increase the clinical awareness of health professionals**, including reminding them of the importance of checking individuals' vaccination status ahead of travel.
- **Healthcare professionals should be fully vaccinated.**
- **Promote vaccine acceptance and uptake** by employing specific risk communication strategies and identifying drivers of suboptimal MMR vaccine acceptance and uptake to ensure that tailored interventions are implemented in response.
- **Address barriers and engage with populations underserved by healthcare services.** Systemic barriers that affect vaccine uptake in populations that are isolated and underserved by healthcare services need to be monitored and addressed with targeted strategies in order to reduce inequalities in vaccine uptake.
- In light of the upcoming summer holiday season, **travellers should check their vaccination status** and consult their general practitioner to ensure they are up-to-date with recommended immunisations prior to departure.

ECDC's latest advice on measles is available in the Threat Assessment Brief '**Measles on the rise in the EU/EEA: Considerations for a public health response**', published in February 2024 and the conclusions remain valid. Additional information on the risk classification and ECDC recommendations can be found in this report.

Last time this event was included in the Weekly CDTR: 22 May 2026

5. Chikungunya virus disease – French Guiana, France – 2026

Overview:

There is ongoing chikungunya virus circulation in French Guiana. Since 1 January 2026, and as of 31 May, 621 confirmed autochthonous cases have been identified, with 40 cases in week 18, 61 cases in week 17, 33 cases in week 16, and 15 cases in week 15.

Most cases (437; 70%) were detected in the Littoral ouest sector, located on the western side of French Guiana, near the border with Suriname. This sector entered the 'epidemic' phase of the outbreak on 23 April; this phase is the highest level, one higher than the 'isolated clusters' phase. In addition, the health authorities have activated level 3 (low-intensity epidemic) of the Organisation de la Réponse de Sécurité Civil (ORSEC) plan of arboviroses control in this sector.

The Savanes and Ile de Cayenne sectors are now in the 'outbreak clusters' phase, the Maroni sector is in the 'sporadic transmission' phase, and the Intérieur, Intérieur Est, and Oyapock sectors remain in the 'surveillance' phase, with no cases identified to date.

All cases were confirmed by RT-PCR and the identified strain in French Guiana belongs to the ECSA genotype but lacks the E1-A226V mutation. It shows a close genetic relationship with recent sequences from Cuba and Brazil.

Suriname, which shares a border with western French Guiana, reported 2 579 cases between 1 January and mid-March 2026.

The last chikungunya virus disease outbreak in French Guiana occurred in 2014. During the 2014–2015 outbreak in French Guiana, more than 16 000 suspected cases and 500 hospitalisations were reported, resulting in an estimated chikungunya virus disease seroprevalence of 20% in 2017.

ECDC assessment:

The rainy season in French Guiana, which occurs from January to July, is currently ongoing and favours *Aedes* mosquito proliferation and chikungunya virus transmission. The likelihood of infection for travellers is assessed as low. The likelihood of onward transmission of chikungunya virus in mainland Europe following introduction by a viraemic traveller is currently considered low, but environmental conditions are becoming favourable for *Aedes* mosquito activity and virus replication in mosquitoes.

The outbreak is expected to continue over the coming months due to favourable environmental conditions. Therefore, it is important to strengthen communication with travellers and travel medicine clinics regarding the ongoing outbreak and the need for reinforced preventive measures.

Protective measures include using mosquito repellent, sleeping under a mosquito net or in screened or air-conditioned accommodations, and wearing clothing that covers most of the body. Vaccination may also be considered, in line with recommendations in the traveller's country of origin.

See ECDC's chikungunya virus disease risk assessment for mainland EU/EEA.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities.

Last time this event was included in the Weekly CDTR: 22 May 2026

6. Nipah virus disease – India and Bangladesh – 2026

Overview:

Update

On 10 June 2026, media quoting healthcare authorities reported a case of Nipah virus infection in Kozhikode district, Kerala, India, involving a person in their forties from Ramanattukara who presented with encephalitis symptoms. A sample from the patient preliminarily tested positive for Nipah virus (NiV) and the confirmation from the National Institute of Virology is expected on Thursday.

The patient was initially managed at a private hospital and was subsequently transferred on the night of 10 June 2026 to the Government Medical College Hospital (MCH), Kozhikode, where he remains hospitalised in stable condition on ventilator support. Prior to admission to MCH, the patient had visited multiple healthcare facilities from 10 May onwards, including two private hospitals and diagnostic centres for MRI and echocardiography. Health authorities are currently developing a detailed route map of the patient's movements to support the epidemiological investigation.

A total of 77 contacts have been identified, including 58 healthcare workers, 14 family members, and five co-workers or friends. Risk stratification classified two contacts as highest risk, 13 as high risk, and 62 as low risk. All individuals in the highest and high risk categories have been placed under immediate quarantine, and none of the identified contacts have developed symptoms to date. Public health authorities have prioritised measures to prevent nosocomial and human-to-human transmission, and no containment zone has been established at this stage due to the absence of secondary cases.

The infection is suspected to have been acquired while cleaning a warehouse; however, the exact source has not been confirmed.

The Rapid Response Team in Kozhikode has been activated and adequate stocks of personal protective equipment and medicines are being ensured. A control room has been established at the district medical administration office to coordinate response activities. Ongoing actions include monitoring of all contacts, continued exposure assessment, and reinforcement of infection prevention and control measures in healthcare settings.

Summary

Bangladesh
On 6 February 2026, WHO posted a Disease Outbreak News (DON) item about a confirmed death due to NiV infection that occurred in Rajshahi Division, northwestern Bangladesh. The patient was a woman in her forties residing in Naogaon District, Rajshahi Division. She developed symptoms compatible with NiV infection on 21 January, beginning with fever, headache, muscle cramps, anorexia, weakness and vomiting, which progressed to hypersalivation, disorientation and convulsions. She became unconscious on 27 January and was referred to a tertiary hospital, where she was admitted on 28 January; samples were collected on admission and she died later the same day.

The patient repeatedly consumed raw date palm sap between 5–20 January, considered the likely exposure source. An outbreak investigation involving One Health partners began on 30 January. Investigators identified 35 contacts, and six symptomatic contacts were sampled; all tested negative for NiV by PCR and IgM ELISA. As of 3 February, no additional cases have been detected, and all contacts remain under monitoring.

India
According to the National IHR Focal Point for India reporting to the World Health Organization (WHO) on 26 January 2026, there were two confirmed cases of NiV infection reported in the state of West Bengal, India. A total of 196 contacts of the confirmed cases were identified and all tested negative for NiV.

The cases were identified as suspected NiV infections in preliminary testing and were confirmed at the National Institute for Virology in Pune, on 13 January 2026. They were laboratory confirmed using Real-Time Polymerase Chain Reaction (RT-PCR) and Enzyme-Linked Immunosorbent Assay (ELISA) testing.

On 30 January 2025, WHO reported that investigations into the source of exposure are ongoing. According to media reporting, both individuals had attended to a patient with NiV-like symptoms at the hospital they worked at, although this has not been reported through official sources. Furthermore, one of two nurses recently travelled to a village in Nadia district, close to the Bangladesh border, and might have consumed raw date palm sap, according to media reports. This information on possible exposure has not been reported in official sources.

Following confirmation of the two cases, the Government of India, working closely with the Government of West Bengal, implemented comprehensive public health measures in line with established protocols. Enhanced surveillance, laboratory testing and field investigations were carried out through coordinated action by Central and State health agencies.

In West Bengal, previous outbreaks occurred in 2001 (Siliguri) and 2007 (Nadia district). In 2025, a total of four NiV disease cases have been reported in India from the Palakkad (2) and Malappuram (2) districts. Of these, two have died, both from the Palakkad district.

Background
Nipah virus (Henipavirus nipahense) is a highly pathogenic virus of the family *Paramyxoviridae*, genus *Henipavirus*. It was first isolated and identified in 1999 during an outbreak in Malaysia and Singapore. Since then, several outbreaks of NiV disease in Southern and South East Asia have been reported, with most cases in Bangladesh.

The virus spreads between animals and humans, with most human cases having had direct contact with pigs or bats. NiV can also be transmitted between people through direct contact or indirectly via contaminated food (e.g. date palm sap contaminated by bat saliva) or through aerosols.

The incubation period is usually 4 to 14 days. Symptoms range from mild (fever, headache, muscle pain and nausea) to more serious, including severe respiratory symptoms and encephalitis.

For more information on the disease and its epidemiology, please read ECDC's factsheet about Nipah virus Disease.

ECDC assessment:

Although the disease is severe and has a high fatality rate, the likelihood of exposure to and infection with NiV for people from the EU/EEA travelling to or residing in India or Bangladesh is currently very low, given the low number of infections in the affected areas in which cases have been identified to date.

The most likely route for the virus to be introduced into the EU/EEA would be via infected travellers. While importation of the virus cannot be excluded, its likelihood is currently very low. Although the virus can also be transmitted through direct contact with infected wild or domesticated animals, the natural hosts are not present in Europe; therefore, the likelihood of the virus spreading in the current context within the EU/EEA after importation is considered to be very low.

As a general precaution, people from the EU/EEA who are visiting or living in the affected areas should not handle domestic or wild animals and should avoid contact with their excreta. As the virus may be present on food items contaminated by bats, washing, peeling, and cooking fruit and vegetables before consumption is generally recommended. Raw date palm sap (juice) should not be consumed.

Actions:

ECDC is monitoring this event through its epidemic intelligence activities.

Sources: ECDC press release published 29 January 2026: Nipah virus disease cases reported in West Bengal, India: very low risk for Europeans | DON

Last time this event was included in the Weekly CDTR: 13 February 2026

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 29 May 2026
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 22 May 2026
- Expert deployment - last reported on 22 May 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report) - last reported on 12 June 2026
- Chikungunya virus disease – French Guiana, France – 2026 - last reported on 12 June 2026
- Hantavirus disease outbreak on cruise ship – South Atlantic – 2026 - last reported on 12 June 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 12 June 2026
- Nipah virus disease – India and Bangladesh – 2026 - last reported on 12 June 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring - last reported on 12 June 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 5 June 2026
- SARS-CoV-2 variant classification - last reported on 05 June 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 5 June 2026
- Multi-country cluster of Salmonella Stanley ST2045 - Europe - 2026 - last reported on 5 June 2026
- Risk assessments under production - last reported on 5 June 2026
- Spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA - 2026 - last reported on 5 June 2026
- P. falciparum malaria - Mayotte, France - 2026 - last reported on 5 June 2026