WEEKLY BULLETIN

# Communicable Disease Threats Report

**Week 25, 13 – 19 June 2026**

## This week's topics



## Executive summary

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

- As of 18 June 2026, a total of 875 confirmed cases, including 202 confirmed related deaths (an increase of 40 new cases and four new deaths since the previous update) 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 (WHO) 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.
- Considering 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 European Union/European Economic Area (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.

**Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases**

- On 15 June 2026, the Hong Kong authorities provided an update on a previously reported case (12 June). The case is now confirmed to have been infected with avian influenza A(H9N2) virus with no significant genetic variations.
- The patient is a child, with no known underlying comorbidities, who presented with mild symptoms on 9 June 2026 and remains in isolation in hospital.
- The patient probably had exposure to live poultry in a market.
- Environmental sampling revealed presence of A(H9) at a shop which had been visited by the patient.
- No additional cases were detected among close contacts of the patient.
- The risk to human health in the EU/EEA is considered very low.

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

- In Europe, since the beginning of 2026, and as of 17 June, two countries have reported three human cases of West Nile virus infection: Italy and North Macedonia.

**Expert deployment**

- Since 19 May 2026, the EU Health Task Force (EUHTF) has deployed four ECDC experts on rotation to the headquarters of Africa CDC in Addis Ababa.
- The deployments are part of the project 'Health Security and One Health in Africa - Africa CDC' in partnership with ECDC and EFSA (PHASE II), funded by the Directorate-General for International Partnerships (DG INTPA).
- On 15 June 2026, a group of three ECDC and two Member State experts were deployed by the EUHTF to Kinshasa, Democratic Republic of the Congo (DRC) and Kampala, Uganda, where they are conducting assessments of the exit screening strategies at points of entry.
- On 16 June 2026, an ECDC Risk Communication and Community Engagement (RCCE) expert was deployed to the World Health Organization (WHO) country office in Juba, South Sudan, in response to a Global Outbreak Alert and Responses Network (GOARN) request for assistance. The expert will support the implementation of the country's RCCE field plan, strengthen community engagement and address the priority RCCE gaps in the high-risk areas.
- These activities are being conducted in close coordination with national authorities and the EU delegations and in collaboration with the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO) and DG INTPA.

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

## Latest epidemiological information

As of the morning of 18 June 2026, there were no new updates available.

## Democratic Republic of the Congo

According to the official report published on 18 June 2026 (data as of 16 June), a total of 875 confirmed cases, including 202 confirmed related deaths, have been reported in the Democratic Republic of the Congo (DRC). Since the previous Communicable Disease Threats Report published on 17 June 2026, (data as of 15 June), an additional 40 new cases and four new deaths have been reported. Among the confirmed cases, 799 cases (including 158 deaths) have been reported in the Ituri province, 73 cases (including 43 deaths) in North Kivu, and three cases (including one death) in South Kivu. In addition, 379 patients are reported to have been hospitalised in isolation. Sixty-seven individuals who previously tested positive for Bundibugyo virus have recovered and 71.6% of identified contacts are under follow-up.

Within the three affected provinces, 33/104 health zones are currently affected, including 21/36 in Ituri, 11/34 in North Kivu, and 1/34 in South Kivu. Two new affected health zones were reported on 16 June: Fataki (Ituri province) and Musienene (North Kivu). Of the 799 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 13 June involved health and care workers.

## Uganda

As of 17 June 2026 (data as of 16 June), a total of 19 confirmed cases, including two deaths, have been reported by the Ministry of Health in Uganda. Seven 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 a 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 with 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 Orthoebolavirus zairense. Unlike Orthoebolavirus zairense, there are currently no licenced 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 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 were temporarily suspended again as of 6 June, as part of health security arrangements in response to the Ebola disease outbreak, as reported by media.

The Ugandan Ministry of Health announced on 15 June 2026 (press release) that the general public, travellers, recruitment agencies, travel agents, and all stakeholders departing from Uganda do not require an 'Ebola-Free Certificate'. The 'Ebola-Free Certificate' is not a requirement for visa applications to any country. Ebola testing is recommended for symptomatic individuals who develop symptoms consistent with Ebola virus disease or those who are identified as contacts of confirmed Ebola virus disease cases, based on a clinical and epidemiological assessment by health authorities.

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

Given the gaps in epidemiological information and limited follow-up of contacts it is likely that the outbreak is larger than is currently being reported in terms of the number of affected cases.

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 overall risk of Bundibugyo virus transmission through substances of human origin (SoHO) in the EU/EEA is currently assessed as very low (Risk of Bundibugyo virus transmission through substances of human origin in the European Union/European Economic Area (EU/EEA). 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.

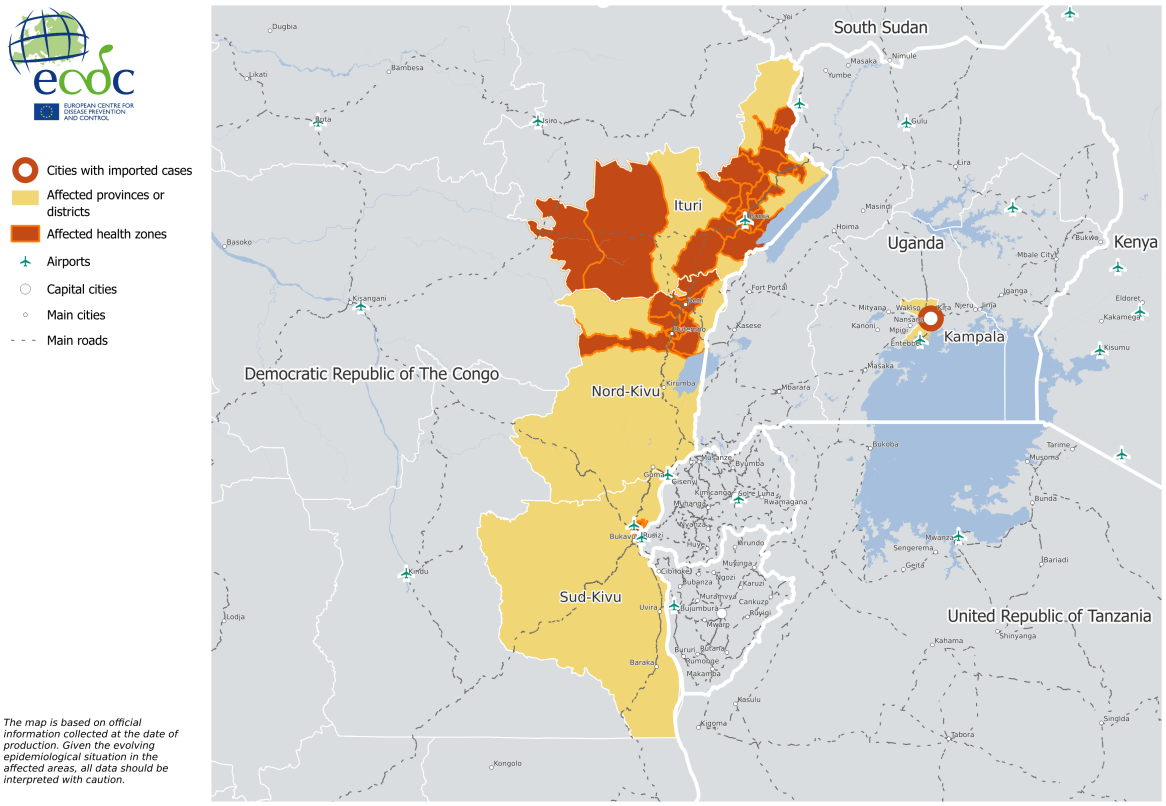
ECDC is actively liaising with key partners, including Africa CDC, the European Commission and WHO, to provide further support through the EU Health Task Force in response to this outbreak.

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**: 12 June 2026.

# Maps and graphs

**Figure 1. Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda - 2026 – map of the affected areas**




Map produced by ECDC on: 18/06/2026. Administrative data ©UNFAO ©UNOCHA; Road, cities and airport ©OSM. The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union.

# 2. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

## Overview

**Update on the case presented on 15 June 2026**

On 15 June 2026, the health authorities in Hong Kong reported the results of whole-genome sequencing of clinical specimens collected from the previously reported case, confirming infection with low-pathogenic avian influenza A(H9N2) virus. Genomic analysis revealed that all of the virus genes were of avian origin and there were no significant genetic variations in the detected virus. No additional cases have been identified among household contacts. Staff at the shop also remain asymptomatic.

Of the environmental samples collected during the investigation, one sample obtained from a metal tray located beneath a live chicken cage in the implicated shop tested positive for A(H9) avian influenza virus. Further laboratory analysis of environmental samples is underway.

The patient remains clinically stable with mild symptoms.

**Summary**

On 12 June 2026, one new human case of avian influenza A(H9) virus infection was reported in Hong Kong, according to a press release from the Government of Hong Kong Special Administrative Region. On 9 June 2026, a child from Sha Tin District in Hong Kong developed mild symptoms (fever, diarrhoea). On 10 June, the patient was admitted to a hospital. A respiratory specimen tested by the Public Health Laboratory Services Branch (PHLSB) of the Centre for Health Protection (CHP) was positive for influenza A (H9). The patient is currently in a stable condition and has been transferred to an isolation ward at Princess Margaret Hospital.

Preliminary investigation indicated no travel history during the incubation period; the case is therefore classified as locally acquired. The patient does not attend school or daycare and is mainly looked after at home by family members. The household does not keep poultry. According to family members, the patient did not consume undercooked poultry and had no known contact with symptomatic individuals. In early June, the patient visited Wo Che Market on two occasions, where he entered a shop selling live poultry and had contact with the shop environment. Environmental sampling has been conducted at the premises by CHP in collaboration with the Food and Environmental Hygiene Department (FEHD). Staff at the shop remain asymptomatic.

The patient has six household contacts, all of whom remain asymptomatic. They have been placed under medical surveillance and provided with antiviral prophylaxis.

**Background**

Overall, since 1998, 207 human cases of avian influenza A(H9N2), including two deaths (case fatality rate (CFR): 0.97%), have been reported by 11 countries. Since 2015, China has reported 165 human cases of avian influenza A(H9N2) virus infection to the World Health Organization (WHO), including two deaths (CFR: 1.2%).

## ECDC assessment

Sporadic human infections with avian influenza A(H9N2) have been observed outside of the EU/EEA. One case has also been reported in the EU/EEA, with exposure history during travel outside of Europe. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses. In most cases, influenza A(H9N2) leads to mild clinical illness. To date, no clusters of human A(H9N2) infections have been reported. There is no evidence that the virus has acquired the ability for sustained transmission among humans. The risk to human health in the EU/EEA is currently considered very low.

## Actions

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities. Together with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly report on the avian influenza situation. The most recent report was published in March 2026.

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

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

## Overview

In Europe, since the beginning of 2026, and as of 17 June, two countries have reported three human cases of West Nile virus (WNV) infection: Italy and North Macedonia.

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

The report is available online.

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 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.

## ECDC assessment

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 locally acquired human cases reported, 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**: 12 June 2026.

# 4. Expert deployment

Since 19 May 2026, the EU Health Task Force (EUHTF) has deployed four ECDC experts on rotation to the headquarters of Africa CDC in Addis Ababa. The deployments are part of the project 'Health Security and One Health in Africa - Africa CDC' in partnership with ECDC and EFSA (PHASE II), funded by the Directorate-General for International Partnerships (DG INTPA). The experts have provided support for surveillance and liaison activities in response to the Ebola outbreak caused by Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda.

On 15 June 2026, a group of three ECDC and two Member State experts were deployed by the EUHTF to Kinshasa, DRC and Kampala, Uganda, where they are conducting assessments of the exit screening strategies at points of entry.

On 16 June 2026, an ECDC Risk Communication and Community Engagement (RCCE) expert was deployed to the World Health Organization (WHO) country office in Juba, South Sudan, in response to a Global Outbreak Alert and Responses Network (GOARN) request for assistance. The expert will support the implementation of the country's RCCE field plan, strengthen community engagement and address the priority RCCE gaps in the high-risk areas.

These activities are being conducted in close coordination with national authorities and the EU delegations and in collaboration with the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO) and DG INTPA.

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

# Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 29 May 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 18 June 2026
- Expert deployment - last reported on 18 June 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (weekly report) - last reported on 18 June 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 18 June 2026
- Measles outbreak in Latvia 2026 - last reported on 16 June 2026
- Multi-country cluster of Salmonella Stanley ST2045 - Europe - 2026 - last reported on 16 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
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring - last reported 12 June 2026
- Nipah virus disease – India and Bangladesh – 2026 - last reported on 12 June 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 5 June 2026
- P. falciparum malaria - Mayotte, France - 2026 - 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
- SARS-CoV-2 variant classification - last reported on 5 June 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 5 June 2026
- Risk assessments under production - last reported on 5 June 2026.