WEEKLY BULLETIN

Communicable Disease Threats Report

Week 27, 27 June – 3 July 2026

This week's topics

Executive summary

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

- On 2 July 2026, the Democratic Republic of the Congo (DRC) reported a total of 1 460 confirmed cases and 438 related deaths (using data until 1 July). This represents an increase of 54 new confirmed cases and 14 new deaths since the last update. Among the newly confirmed cases there are nine deaths. The affected provinces mentioned in the official report are Ituri, North Kivu and South Kivu.
- No new cases have been reported in Uganda since 21 June 2026. The country has reported a total of 20 confirmed cases, including two deaths.
- On 24 June 2026, the Ministry of Health in France reported a first case of Ebola virus disease, identified in a humanitarian doctor returning from a mission in DRC. The case is in isolation and contact tracing has been initiated. Five contacts have been identified and placed in isolation to date.
- On 17 May 2026, the World Health Organization (WHO) declared that the Ebola disease outbreak due to Bundibugyo virus constituted a Public Health Emergency of International Concern, and on 18 May 2026, Africa CDC declared a Public Health Emergency of Continental Security.
- On the basis of the available information, and given the 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. Given the very low likelihood of importation and secondary transmission, the likelihood of infection for people living in the European Union/European Economic Area (EU/EEA) is estimated to be very low. This assessment will be reviewed as further information becomes available.
- ECDC is monitoring the outbreak through epidemic intelligence activities and actively liaising with partners to support the response.

Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report)

- Since the beginning of 2026, and as of 1 July 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (one case).

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

- In Europe, since the beginning of 2026, and as of 1 July, three countries have reported six human cases of West Nile virus (WNV) infection: Italy, Romania and North Macedonia.

Overview of respiratory virus epidemiology in the EU/EEA

Important: This is the second publication of ERVISS following the transition of reporting surveillance data from The European Surveillance System (TESSy), which has been decommissioned, to EpiPulse Cases (EPC). As a result of this transition, we have identified some inconsistencies in data from individual countries. We are actively working to identify and resolve these and any new issues that may arise to ensure data completeness and accuracy. During this period, updates of data for download from GitHub will be paused. Thank you for your patience and understanding.

Summary

Respiratory virus activity across the EU/EEA remains at baseline levels, indicating limited respiratory virus circulation.

SARS-CoV-2 activity is low in all age groups in primary and secondary care.

Respiratory syncytial virus (RSV) activity is low, at inter-seasonal levels.

Influenza virus activity is low, at inter-seasonal levels.

All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

Seasonal monitoring of environmental suitability for Vibrio spp. risk in coastal waters - Bathing season 2026

- Vibriosis is caused by naturally occurring Vibrio bacteria found in coastal waters, particularly warm, brackish environments. In Europe, Vibrio bacteria are most frequently detected during the summer season, with the Baltic Sea being particularly favourable due to its low salinity levels.
- A warmer climate is expected to increase the suitability of coastal areas for Vibrio growth and expansion.
- The European Centre for Disease Prevention and Control (ECDC) monitors environmental suitability for Vibrio growth in EU/EEA coastal waters and publishes regular updates through the Vibrio Viewer and the Communicable Disease Threat Reports to assess and communicate the potential risk to human health across the EU/EEA.

Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update

- Since the previous update on 1 June 2026, and as of 2 July 2026, no new MERS cases have been reported by the World Health Organization (WHO) or by national health authorities.
- Since the beginning of 2026, and as of 2 July 2026, two MERS cases, including one fatality, have been reported in Saudi Arabia.
- The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in the general population is also considered to be low. The current MERS-CoV situation remains unchanged and poses a low risk to the EU/EEA.

SARS-CoV-2 variant classification

- Since the last update on 29 May 2026, and as of 26 June 2026, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) or de-escalated variants.
- For this update, sufficient data to estimate variant proportions in the most recent reporting weeks were only available from one EU/EEA country. Therefore, the statistics below represent a very limited part of the EU/EEA.
- The VOI and VUM median proportions in the EU/EEA for weeks 22–23, 2026 were:
  - BA.2.86 (VOI): 0.0%
  - NB.1.8.1 (VUM): 0.0%
  - XFG (VUM): 27.3%
  - BA.3.2 (VUM): 72.7%.

Risk assessments under production

ECDC and the European Food Safety Authority (EFSA) developed a Rapid Outbreak Assessment 'Multi-country outbreak of Salmonella Stanley ST2045 infections linked to consumption of flavoured noodle products' which was published on 1 July 2026.

An ECDC Internal Response Team has been convened to produce a Risk Assessment on the Increasing number of cases of ceftriaxone-resistant gonorrhoea and evidence of local transmission within the EU/EEA, to be published by 17 July 2026.

Expert deployment

- Since 19 May 2026, the EU Health Task Force (EUHTF) has been deploying experts to support preparedness and response efforts related to the Ebola disease outbreak caused by Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda.
- Five experts have been deployed on a rotating basis to support Africa CDC, initially at its headquarters in Addis Ababa and, since 23 June, within the Continental Incident Management Support Team (IMST) in Uganda. These deployments are part of the project 'Health Security and One Health in Africa - Africa CDC' in partnership with ECDC and EFSA (PHASE II) and funded by the Directorate-General for International Partnerships (DG INTPA).
- Between 15 and 22 June, the EUHTF deployed a team of three ECDC experts and two Member State experts to Kinshasa (DRC) and Kampala (Uganda), to conduct a Point of Entry fact-finding mission.
- On 16 June 2026, an ECDC Risk Communication and Community Engagement (RCCE) expert was deployed to the WHO country office in Juba, South Sudan, in response to a Global Outbreak Alert and Responses Network request for assistance, to support community engagement activities and address key RCCE gaps in 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

Democratic Republic of the Congo

On 2 July 2026, the Democratic Republic of the Congo (DRC) reported a total of 1 460 confirmed cases (from data up until 1 July), with 641 of them reported to be currently hospitalised in isolation. A total of 452 related deaths have been confirmed so far. This represents an increase of 54 new confirmed cases and 14 new deaths reported since the last update. The newly confirmed cases include nine deaths. Among the individuals who tested positive for Bundibugyo virus, 213 people have recovered. In total, 82.7% of identified case contacts are still under follow-up in the Ituri and North Kivu provinces.

Among confirmed cases in DRC, Ituri province remains the most affected, with 1 333 cases, including 380 deaths, reported from 24 of its 36 health zones. In North Kivu, 124 cases, including 71 deaths, have been reported from 11 of 34 health zones. In South Kivu, three cases, including one death, have been reported from one of 34 health zones. Overall, 36 of 104 health zones are currently affected across the three provinces.

Uganda

As of 1 July 2026, a total of 20 confirmed cases, including two deaths, have been reported by the Ministry of Health in Uganda. The last confirmed case was reported on 21 June and no new cases have been reported since then. Fifteen individuals have recovered. Overall, 831 all-time contacts have been identified, and 821 of these individuals have completed the 21-day follow-up.

Among the confirmed cases, 15 had travel links to DRC and five were associated with local transmission events.

Of nine cases with known geographical information, eight were reported in Kampala and one was reported in Wakiso (a district that neighbours Kampala).

EU/EEA

On 24 June, the Ministry of Health in France reported a first positive case of Ebola virus disease, identified in a doctor returning from a humanitarian mission in one of the areas affected by the ongoing outbreak in DRC. The patient is reported to be in isolation in a designated healthcare facility and contact tracing was initiated by health authorities. Five contacts have been identified to date and they have been placed in isolation (Minister of Health, media interview on 24 June).

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). On 24 June, the Ministry of Health in France reported a first positive case of Ebola virus disease, identified in a doctor returning from a humanitarian mission in one of the areas affected by the ongoing outbreak in DRC.

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 15 confirmed cases in Uganda had travel links to DRC. Additional cases were identified following contact tracing activities. Uganda postponed a large religious event (Martyr's Day) that normally takes place on 3 June and has also 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 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).

On 1 June 2026, a case was reported by Uganda as having 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.

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, according to the media.

Uganda's 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.

Rwanda's 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).

On 24 June, as part of the response to the ongoing outbreak, the Ministry of Health in DRC issued a decree enforcing the following measures: contacts of confirmed or probable cases face 21-day active self-monitoring and restrictions on both domestic and international movement. Healthcare and response workers returning from affected areas are subject to similar rules, though active monitoring is not explicitly specified and domestic travel remains permitted. Anyone who has stayed in an affected province cannot travel internationally for 21 days (the decree does not address any obligations for actual cases.) In addition, outbound international travellers are required to complete a mandatory health declaration form issued by border health authorities.

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. Given the very low likelihood of importation and secondary transmission, the likelihood of infection is estimated to be very low for people living in the EU/EEA. 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 ECDC's 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, has been deploying ECDC experts to Addis Ababa (Ethiopia) in Africa CDC headquarters, and Kampala (Uganda).

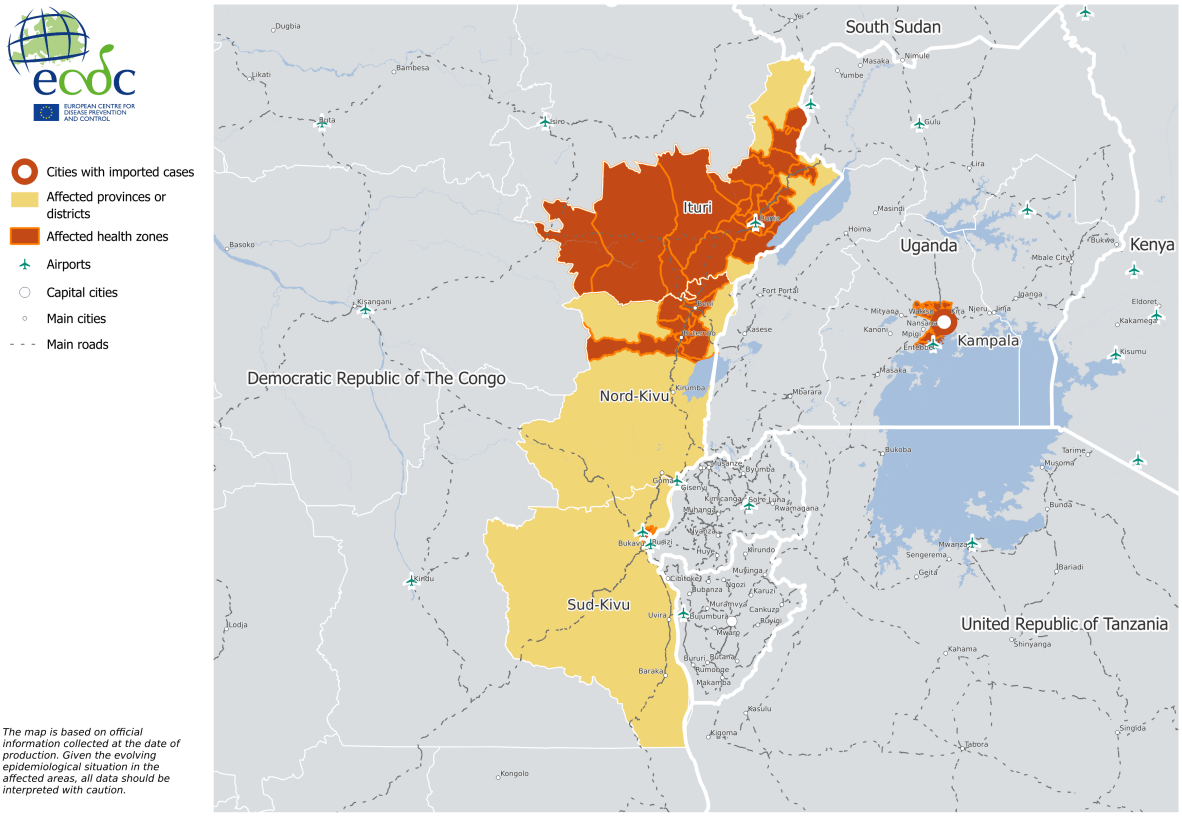
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

ECDC is regularly re-evaluating the situation as new information becomes available and continues to provide updated epidemiological information, scientific assessments and advice on its website Ebola disease outbreak in the Democratic Republic of the Congo and Uganda.

Last time this event was included in the Weekly CDTR: 26 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



Source: ECDC

2. Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report)

Overview

Since the beginning of 2026 and as of 1 July 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (one case).

The report is available online.

ECDC assessment

The case in Salamanca (Spain) is not unexpected as Hyalomma spp. – the main vector of CCHF virus – are widely distributed across the region. In addition, CCHF virus is known to circulate in local animal populations, and human cases have previously been reported there. The timing of this case aligns with the expected seasonal pattern of CCHF in Spain, and is probably linked to increased tick activity.

Although the risk of contracting CCHF for the general population in the areas where the virus is known to be present in Spain is low, this risk increases for people undertaking outside activities that expose them to tick bites (e.g. hunting, forestry work, hiking, animal surveillance). As a general precaution against CCHF, but also against other tick-borne diseases, people who may potentially be exposed to ticks should apply personal protective measures (ECDC Protective Measures against ticks). In Spain, CCHF virus is transmitted to humans mainly by ticks of the genus Hyalomma. While Hyalomma lusitanicum plays a key role in virus maintenance and transmission dynamics, Hyalomma marginatum is generally considered to be the principal species involved in transmission to humans. Hyalomma marginatum is widely present in southern and eastern Europe and Hyalomma lusitanicum is present in parts of southern Europe.

More information on CCHF can be found in ECDC's factsheet. In December 2023, ECDC published a report on the spatial distribution of CCHF based on predicted ecological suitability.

Actions

ECDC will continue to monitor the situation and will publish a weekly report on the occurrence of CCHF in the EU/EEA until approximately November 2026.

Last time this event was included in the Weekly CDTR: 26 June 2026.

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

Overview

In Europe, since the beginning of 2026, and as of 1 July, three countries have reported six human cases of West Nile virus (WNV) infection: Italy, Romania and North Macedonia.

A total of six 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. A monthly report will also 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: 26 June 2026.

4. 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.

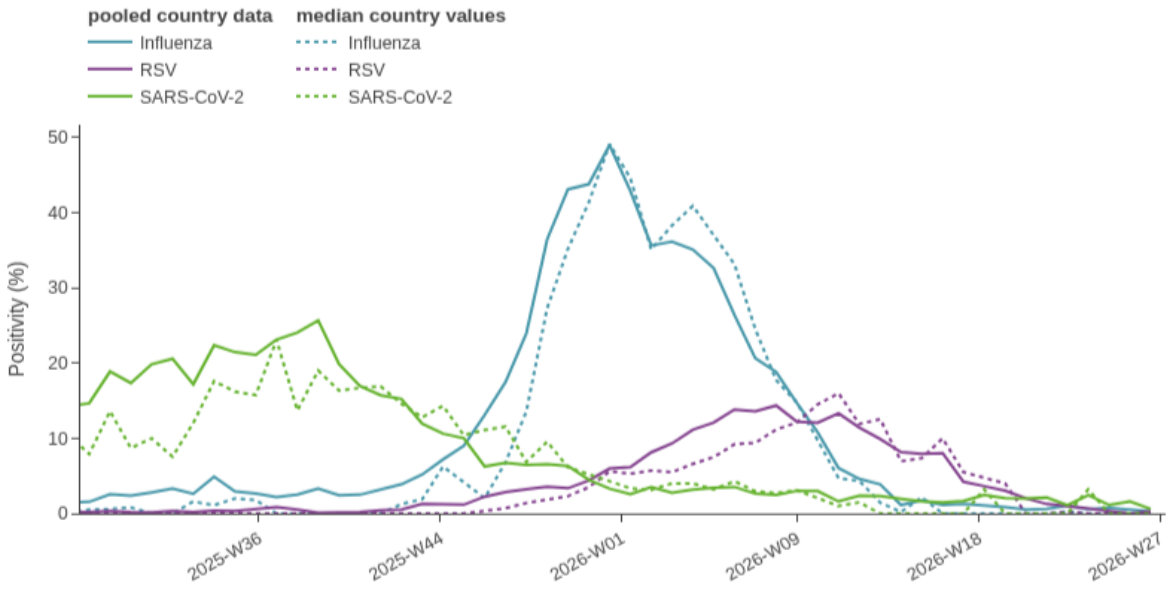
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 26 June 2026

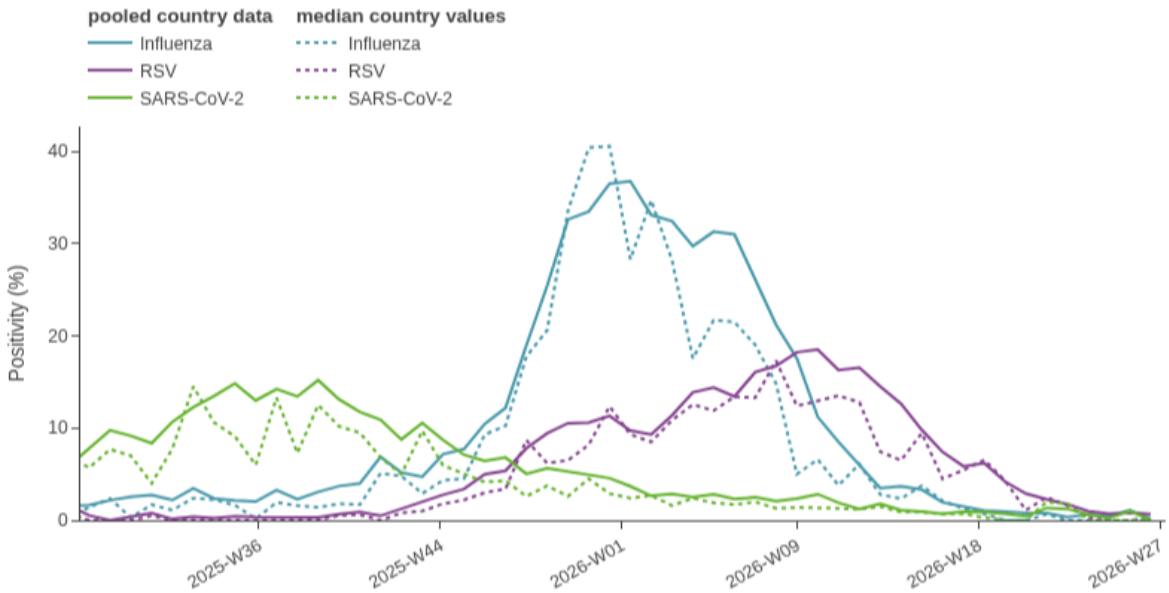
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 3. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	**Syndrome or pathogen**	**Week 26**	**Week 25**	**Description**	**Value**
ILI/ARI consultation rates in primary care	ARI	11 rates (7 MEM)	10 rates (6 MEM)	Distribution of country MEM categories	7 Baseline
	ILI	10 rates (9 MEM)	10 rates (9 MEM)		8 Baseline 1 Low
ILI/ARI test positivity in primary care	Influenza	13	12	Pooled (median; IQR)	0.3% (0; 0–0%)
	RSV	12	11		0.3% (0; 0–0%)
	SARS-CoV-2	12	11		0.6% (0; 0–0.4%)
SARI rates in hospitals	SARI	9 rates (4 MEM)	10 rates (5 MEM)	Distribution of country MEM categories	4 Baseline
SARI test positivity in hospitals	Influenza	7	8	Pooled (median; IQR)	0.2% (0; 0–0%)
	RSV	7	8		0.7% (0.3; 0–0.5%)
	SARS-CoV-2	6	7		0% (0; 0–0%)
Intensity (country-defined)	Influenza	8	8	Distribution of country qualitative categories	8 Baseline

Source: ECDC

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

	Week 26, 2026		Week 40, 2025 – week 26, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**1**	**–**	**17600**	**–**
Influenza A	0	0.0	17001	99
A(H1)pdm09	0	–	3937	28
A(H3)	0	–	10091	72
A (unknown)	0	–	2973	–
Influenza B	1	100	119	0.7
B/Vic	0	–	35	100
B (unknown)	1	–	84	–
Influenza untyped	0	–	480	–
RSV	**1**	**–**	**5170**	**–**
RSV-A	0	–	823	42
RSV-B	0	–	1126	58
RSV untyped	1	–	3221	–
SARS-CoV-2	**2**	**–**	**3986**	**–**

Source: ECDC

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

	Week 26, 2026		Week 40, 2025 – week 26, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**1**	**–**	**15480**	**–**
Influenza A	1	100	7398	99
A(H1)pdm09	0	–	1254	35
A(H3)	0	–	2352	65
A (unknown)	1	–	3792	–
Influenza B	0	0.0	67	0.9
B/Vic			10	100
B (unknown)	0	–	57	–
Influenza untyped	0	–	8015	–
RSV	**4**	**–**	**7071**	**–**
RSV-A			1139	52
RSV-B	2	100	1050	48
RSV untyped	2	–	4882	–
SARS-CoV-2	**0**	**–**	**2987**	**–**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 26, 2026

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	3502	39	5a.2a.1(D.3.1)	3396	97
			5a.2a.1(D)	97	3
			5a.2a(C.1.9.3)	9	0.3
A(H3)	5442	60	2a.3a.1(K)	4825	89
			2a.3a.1(J.2)	320	6
			2a.3a.1(J.2.4)	240	4
			2a.3a.1(J.2.2)	31	0.6
			2a.3a.1(J)	25	0.5
			2a.3a.1(J.2.5)	1	0
B/Vic	106	1	V1A.3a.2(C.5.6)	38	36
			V1A.3a.2(C.5.1)	21	20
			V1A.3a.2(C.5.6.1)	20	19
			V1A.3a.2(C.3.1)	13	12
			V1A.3a.2(C.5.7)	12	11
			V1A.3a.2(C.5)	2	2

Source: ECDC

5. Seasonal monitoring of environmental suitability for Vibrio spp. risk in coastal waters - Bathing season 2026

Update

A list of areas expected to be at high risk* for Vibrio spp. in the next five days (until 8 July 2026) is provided below, based on forecasts from the Vibrio Viewer.

- **Bulgaria,** 13 municipalities in three areas: Varna (Avren, Byala, Dolni chiflik, Varna), Dobrich (Balchik, Kavarna, Shabla) and Burgas (six municipalities).
- **Estonia,** two municipalities in one area: Lääne-Eesti (Hiiumaa vald, Saaremaa vald).
- **France,** 14 municipalities in four areas: Vendée (Beauvoir-sur-Mer), Gironde (8 municipalities), Landes (Ondres, Tarnos) and Charente-Maritime (Chenac-Saint-Seurin-d'Uzet, Le Château-d'Oléron, Talmont-sur-Gironde).
- **Germany,** three municipalities in one area: Vorpommern-Greifswald (Altwarp, Luckow, Vogelsang-Warsin).
- **Lithuania,** two municipalities in one area: Klaipėdos apskritis (Klaipėdos miesto savivaldyb, Neringos savivaldybė).
- **Poland,** eight municipalities in three areas: Szczeciński (Altwarp, Luckow, Nowe Warpno), Elbląski (Elbląg, Tolkmicko) and Gdański (Sztutowo, Tolkmicko, Władysławowo).
- **Romania,** 12 municipalities in two areas: Constanţa (eight municipalities) and Tulcea (Jurilovca, Murighiol, Oras Sulina, Sfantu Gheorghe).
- **Sweden,** eight municipalities in four areas: Stockholms län (Haninge, Norrtälje, Vaxholm, Österåker), Södermanlands län (Trosa), Östergötlands län (Norrköping, Valdemarsvik) and Kalmar län (Västervik).

Countries are listed in alphabetical order; municipalities are listed only for areas (at NUTS3 level) with fewer than five affected municipalities. To explore the daily risk for individual municipalities and specific areas in greater detail, please refer to the interactive Vibrio Viewer map tool.

*Note: high risk refers to environmental suitability for Vibrio spp., defined by a suitability index >16.

Background

Vibriosis is an infection caused by species of Vibrio bacteria, which occur naturally in coastal waters, particularly in warm, brackish environments where freshwater and seawater mix. Environmental conditions that favour bacterial growth include higher water temperatures and lower salinity [1]. In Europe, Vibrio bacteria are most frequently detected during the summer season. The Baltic Sea provides particularly favourable conditions because of its relatively low salinity, although Vibrio species are also found in the North Sea, the Black Sea and other coastal and estuarine bathing waters [1, 2, 3, 4, 5, 6].

Human infection may occur through the consumption of raw or undercooked seafood, particularly shellfish, or through exposure of open wounds to contaminated water. Clinical manifestations range from self-limiting gastroenteritis to wound infections, otitis, and severe invasive disease, including septicaemia and necrotising soft tissue infections. Individuals with underlying medical conditions, such as diabetes, chronic liver disease and immunosuppression, are at increased risk of severe illness [7, 8].

ECDC assessment

Climate-driven warming is expected to increase the suitability of coastal areas for bacterial growth. As sea surface temperatures continue to rise across parts of Europe, environmental conditions facilitating the potential for Vibrio proliferation and geographical expansion are becoming increasingly common [2, 9, 10].

Vibriosis remains relatively uncommon in the EU/EEA. However, locally acquired cases may occur during summer months, particularly in the presence of exceptionally high temperatures [11, 12].

To reduce the risk of Vibrio infections through food, it is recommended to ensure that seafood is cooked thoroughly before consumption. Individuals who have open wounds, recent piercings, cuts or scrapes are recommended to avoid swimming in brackish or coastal waters, or to cover the affected area with a waterproof dressing. In case of accidental contact with coastal water, the affected area should be disinfected and cleaned thoroughly.

Actions

ECDC monitors the environmental suitability for Vibrio spp. growth in coastal waters during the summer season. Regular updates are published in the Vibrio Viewer and the Communicable Disease Threat Reports to assess and communicate potential risks to human health across the EU/EEA.

ECDC publishes scientific information and advice on this topic on its dedicated webpage Vibriosis.

6. Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update

Update: Since the previous update on 1 June 2026, and as of 2 July 2026, no new MERS cases have been reported by the World Health Organization (WHO) or by national health authorities.

Summary: Since the beginning of 2026, and as of 2 July 2026, two MERS cases, including one fatality, have been reported in Saudi Arabia. No information is available on the regions in Saudi Arabia affected by these cases.

Since April 2012, and as of 2 July 2026, a total of 2 649 MERS cases, including 960 deaths, have been reported by health authorities worldwide.

Sources: ECDC MERS-CoV page | WHO MERS-CoV | ECDC factsheet for professionals | Qatar MoPH Case #1 | Qatar MoPH Case #2 | FAO MERS-CoV situation update | WHO DON Oman | WHO DON Saudi Arabia | WHO DON UAE | WHO DON Saudi Arabia 1 | WHO IHR | WHO EMRO MERS Situation report | WHO DON Saudi Arabia 2 | WHO DON Saudi Arabia 3 | WHO DON Saudi Arabia 4 | WHO DON Saudi Arabia 5 | MERS-CoV Dashboard | French Ministry of Health | WHO DON France & Saudi Arabia

ECDC assessment

Human MERS cases continue to be reported in the Arabian Peninsula. However, the number of new cases detected and reported through surveillance has dropped to the lowest level since 2014. The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in the general population is considered low. The current MERS-CoV situation remains unchanged and poses a low risk to the EU/EEA, as stated in the Rapid Risk Assessment published by ECDC on 29 August 2018.

In October 2019, ECDC published a technical report, 'Health emergency preparedness for imported cases of high-consequence infectious diseases' that is still useful for EU Member States wishing to assess their level of preparedness for a disease such as MERS. ECDC also published 'Risk assessment guidelines for infectious diseases transmitted on aircraft (RAGIDA) – Middle East respiratory syndrome coronavirus (MERS-CoV)' on 22 January 2020.

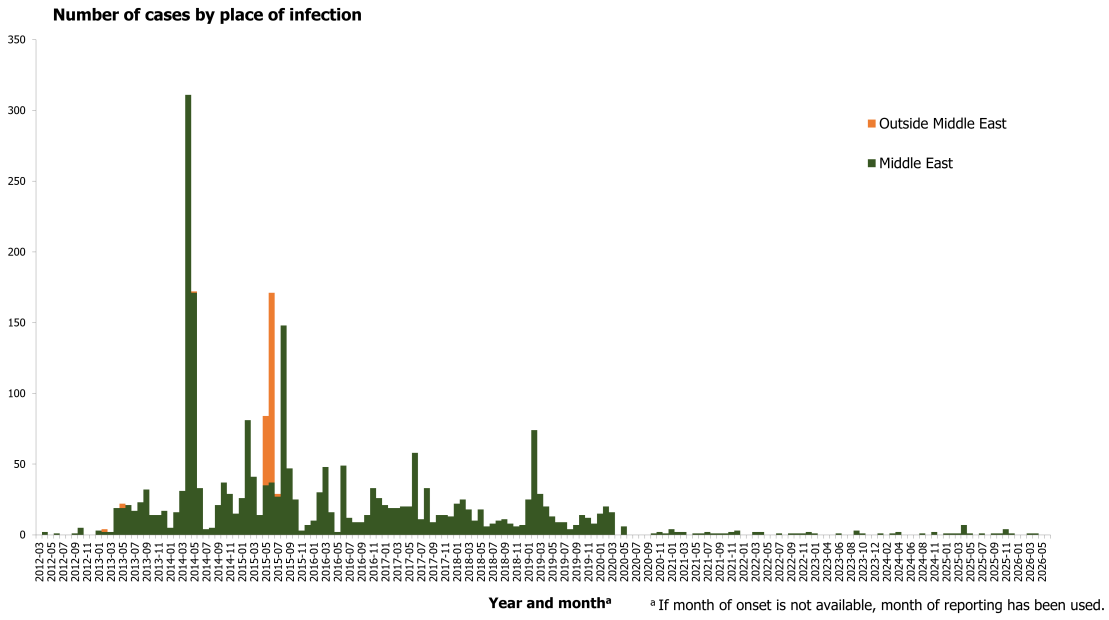
Actions

ECDC is monitoring this situation through its epidemic intelligence activities and reports on a monthly basis or when new epidemiological information is available.

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

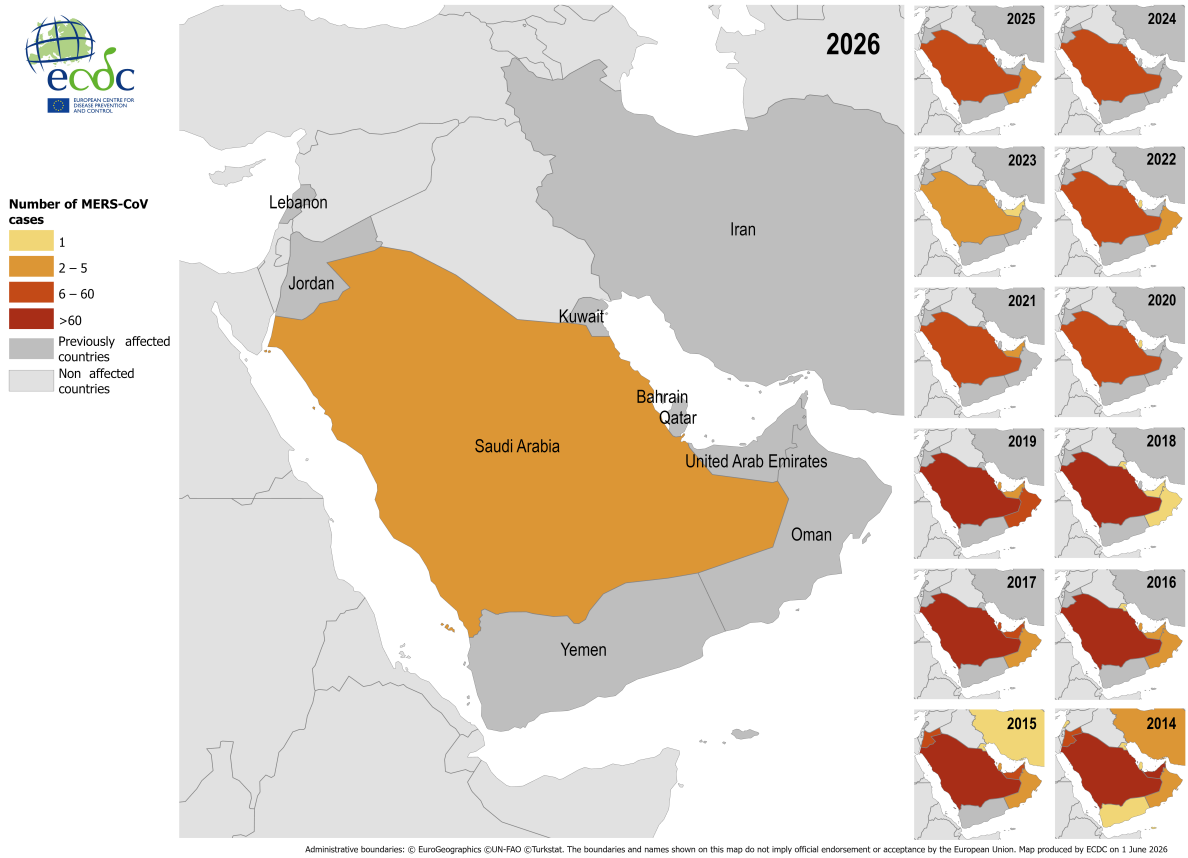
Maps and graphs

Figure 1. Distribution of confirmed cases of MERS by place of infection and month of onset, April 2012 – June 2026



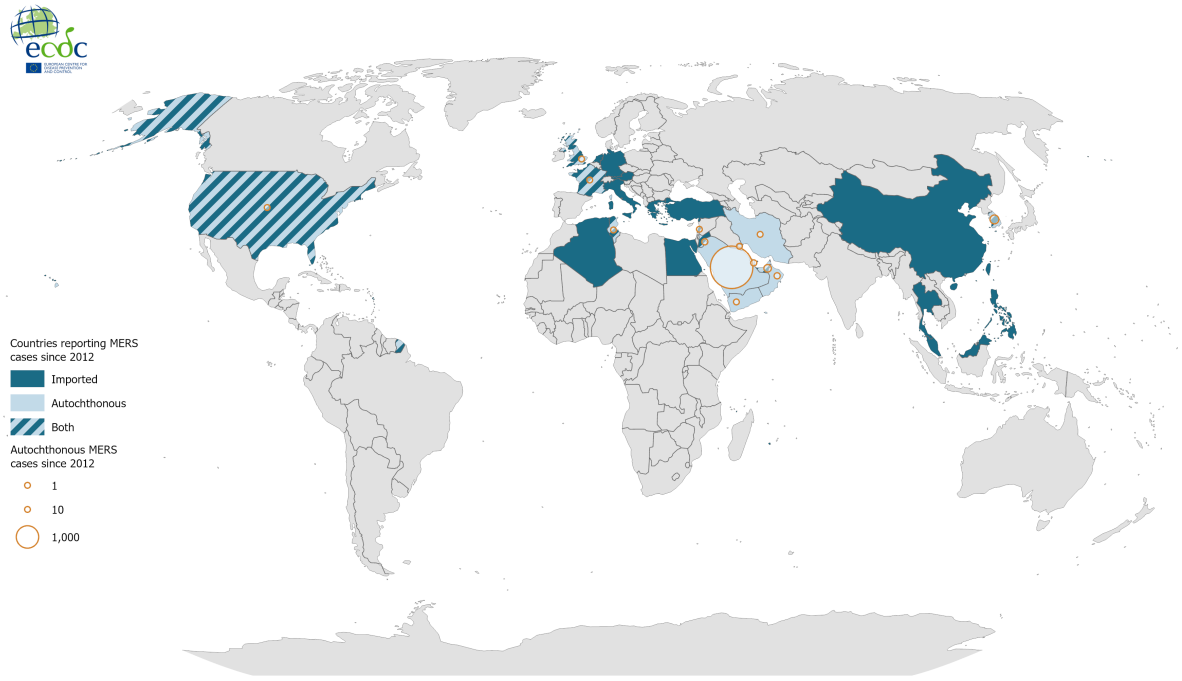
Source: ECDC

Figure 2. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2014 – June 2026



Source: ECDC

Figure 3. Geographical distribution of confirmed cases of MERS-CoV by reporting country, April 2012 - June 2026



Administrative boundaries: © EuroGeographics ©UN-FAO ©Turkstat. The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union. Map produced by ECDC on 1 June 2026

Source: ECDC

7. SARS-CoV-2 variant classification

Overview

Since the last update on 29 May 2026, and as of 26 June 2026, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) or de-escalated variants.

VOI median proportions in the EU/EEA for weeks 22–23, based on one reporting country:

BA.2.86 (VOI): 0.0%.

VUM median proportions in the EU/EEA for weeks 22-23 2026, based on one reporting country:

- NB.1.8.1 (VUM): 0.0%
- XFG (VUM): 27.3%
- BA.3.2 (VUM): 72.7%.

The calculations are based on data reported to GISAID, as of 23 June 2026. It should be noted that for this update, sufficient data to estimate variant proportions in the most recent reporting weeks were only available from one EU/EEA country. The statistics therefore only represent a very limited part of the EU/EEA.

ECDC assessment

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation.

The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. Compared with previously circulating variants, the variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity, or a reduction in vaccine effectiveness against severe disease. However, older adults (65 years and above), those with underlying conditions, and people who have previously not been infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of people at high risk of severe outcomes (e.g. older adults) remains important.

Actions

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

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

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

Last time this event was included in the Weekly CDTR: 01 July 2026

8. Risk assessments under production

ECDC and the European Food Safety Authority (EFSA) developed a Rapid Outbreak Assessment 'Multi-country outbreak of Salmonella Stanley ST2045 infections linked to consumption of flavoured noodle products' which was published on 1 July 2026.

An ECDC Internal Response Team has been convened to produce a Risk Assessment on the Increasing number of cases of ceftriaxone-resistant gonorrhoea and evidence of local transmission within the EU/EEA, to be published by 17 July 2026.

Last time this event was included in the Weekly CDTR: 26 June 2026.

9. Expert deployment

Overview

Since 19 May 2026, the EU Health Task Force (EUHTF) has been supporting preparedness and response efforts related to the Ebola disease outbreak caused by Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda.

Five ECDC experts have been deployed on a rotational basis to support Africa CDC, initially at its headquarters in Addis Ababa and, since 23 June 2026, within the Continental Incident Management Support Team (IMST) in Uganda. 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.

Between 15 and 22 June 2026, the EUHTF deployed a team of three ECDC experts and two Member State experts to Kinshasa (DRC) and Kampala (Uganda), to conduct a Point of Entry fact-finding mission with a view to evaluating the implementation and operational performance of exit screening procedures.

On 16 June 2026, an ECDC Risk Communication and Community Engagement (RCCE) expert was deployed to the 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: 1 July 2026.

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 26 June 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 26 June 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 26 June 2026
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - last reported on 26 June 2026
- Dengue cases – EU/EEA ex. Maldives – 2025-2026 - last reported on 26 June 2026
- Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles - last reported on 26 June 2026
- Measles outbreak in Latvia 2026 - last reported on 16 June 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 3 July 2026
- Expert deployment - last reported on 03 July 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report) - last reported on 3 July 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report) - last reported on 3 July 2026
- Seasonal monitoring of environmental suitability for Vibrio spp. risk in coastal waters - Bathing season 2026 - last reported on 3 July 2026
- Risk assessments under production - last reported on 3 July 2026
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 3 July 2026
- SARS-CoV-2 variant classification - last reported on 3 July 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 3 July 2026.