

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 30, 18–24 July 2026

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Executive summary

Overview of respiratory virus epidemiology in the EU/EEA, week 29, 2026

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

- **SARS-CoV-2** activity remains low across all age groups in both primary and secondary care settings.
- **Respiratory syncytial virus (RSV)** activity is low, at inter-seasonal levels.
- **Influenza virus** activity is low, at inter-seasonal levels.

Pooled [EuroMOMO](#) estimates of all-cause mortality from the 26 participating European countries indicate substantially increased mortality in weeks 26, 27 and 28, 2026. The increase is mainly observed in age groups above 45 years and affects several countries.

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'.

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

- As of 23 July 2026, the Democratic Republic of the Congo (DRC) reported a total of 2 905 confirmed cases and 1 269 confirmed related deaths (based on data until 22 July). This represents an increase of 97 new confirmed cases and 62 deaths since the previous day. Since the beginning of the outbreak, five provinces have been affected, Ituri, North Kivu, South Kivu, Tsopo and Haut-Uele.
- In Uganda, no new cases have been reported since 21 June 2026. The country has reported a total of 20 confirmed cases, including two deaths. On 16 July 2026, Uganda's Ministry of Health announced the start of the 42-day countdown to declaring the end of the outbreak.
- 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.

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.
- Seven 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.
- Between 16 June and 8 July, 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 Response Network request for assistance, to support community engagement activities and address key RCCE gaps in high-risk areas. Since 14 July, two ECDC fellows have also been deployed through the Global Outbreak Alert and Response Network (GOARN) to the WHO country office in Juba, South Sudan, to support surveillance and data analysis activities.
- 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.

Seasonal surveillance of dengue in the EU/EEA, weekly report

- Since the beginning of 2026 and as at 22 July 2026, one country in Europe has reported locally acquired¹ cases of dengue: France (one case). This week, one new case of dengue has been reported to ECDC.

¹ [Seasonal surveillance of dengue in the EU/EEA, weekly report](#)

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

- Since the beginning of 2026, and as at 22 July 2026, one country in Europe has reported locally-acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (two cases).

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

- Since the beginning of the 2026 transmission season, and as at 22 July, 35 areas affected by West Nile virus (WNV) have been identified in six countries across Europe. These areas are located in Italy (20), Greece (six), Romania (four), North Macedonia (two), Spain (two) and France (one).

World Pride - Netherlands - 2026

- Since the start of the monitoring period on 20 July, and as of 23 July, no relevant events related to communicable diseases have been detected in the context on the World Pride 2026.
- World Pride 2026 will take place in Amsterdam, the Netherlands, from 25 July to 8 August 2026. The event is expected to attract a high number of participants, including international visitors from across the EU/EEA.
- The probability of acquiring a sexually transmitted infection (STI) or other infections that can spread through sexual contact is increased for people attending World Pride 2026 who engage in sex with non-steady and multiple partners, particularly if preventive measures are not consistently applied.

Airport malaria in Germany

- A cluster of four Plasmodium falciparum malaria cases has been reported among individuals who worked at Frankfurt International Airport before symptom onset, which occurred between 4 and 6 July 2026. None of the cases reported travel to malaria-endemic areas. Three cases were diagnosed in Germany, one in another EU/EEA country.
- The event is compatible with airport-associated malaria, most likely caused by bites from an infected Anopheles mosquito introduced through international air traffic.
- Public health investigations are ongoing, and include potential identification of additional compatible cases, risk communication, vector monitoring and genomic analyses.
- Clinicians should consider airport-associated malaria in the differential diagnosis of unexplained fever in individuals with relevant airport exposure, even in the absence of recent travel to malaria-endemic areas.

1. Overview of respiratory virus epidemiology in the EU/EEA, week 29, 2026

Important: This European Respiratory Virus Surveillance Summary (ERVISS) publication follows the recent transition of reporting surveillance data from The European Surveillance System (TESSy) to EpiPulse Cases (EPC). As a result of this transition, we have identified a few data inconsistencies. We are actively working with individual countries to resolve these and any other issue that may arise to ensure high data quality. **During this period, data updates to the GitHub repository will be paused.** Thank you for your patience and understanding.

ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary ([ERVISS.org](https://www.ecdc.europa.eu/en/ermiss)), which is updated weekly.

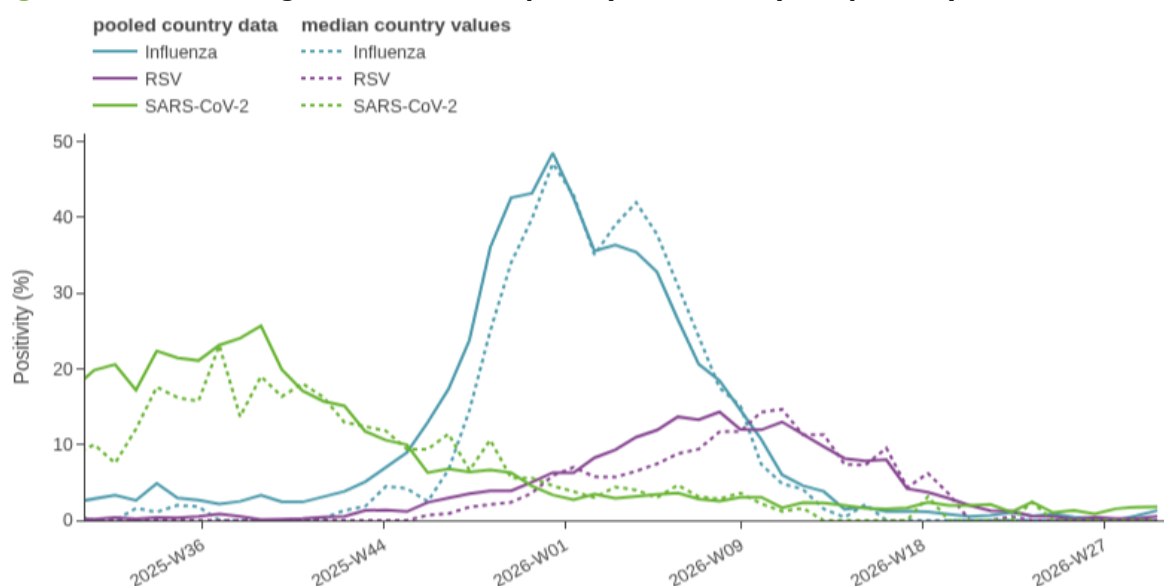
Key visualisation from the weekly bulletin are included below.

Sources: [ERVISS](https://www.ecdc.europa.eu/en/ermiss)

Last time this event was included in the Weekly CDTR: 17 July 2026.

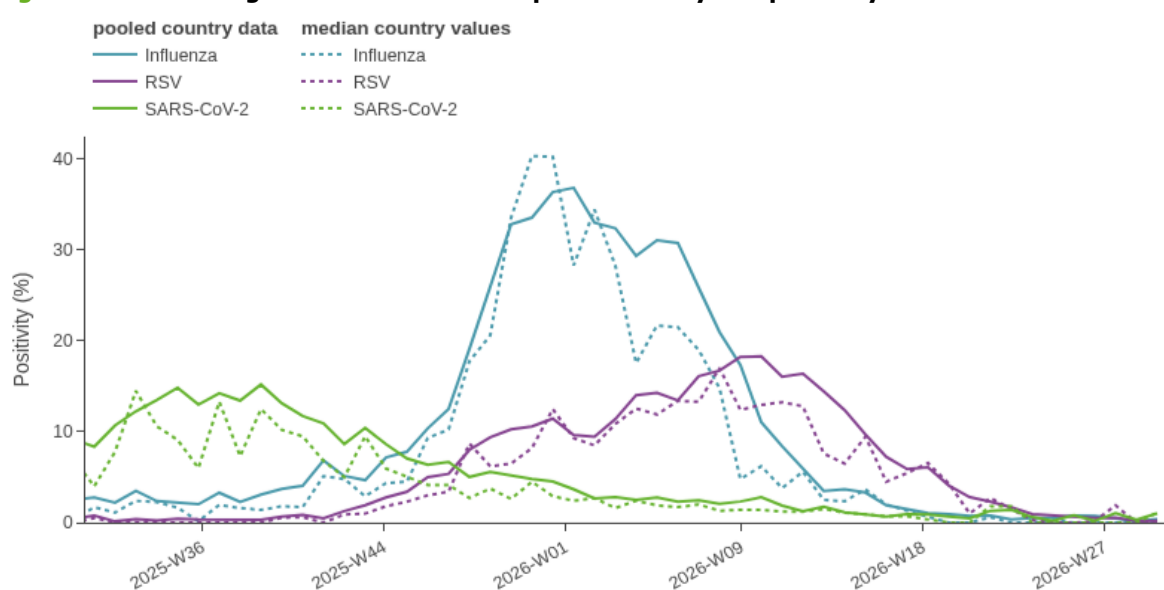
Maps and graphs

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

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary	
		Week 29	Week 28	Description	Value
ILI/ARI consultation rates in primary care	ARI	10 rates (6 MEM)	10 rates (6 MEM)	Distribution of country MEM categories	6 Baseline
	ILI	12 rates (11 MEM)	12 rates (11 MEM)		10 Baseline 1 Medium
ILI/ARI test positivity in primary care	Influenza	11	13	Pooled (median; IQR)	1.3% (0; 0–0%)
	RSV	11	11		0.5% (0; 0–0%)
	SARS-CoV-2	11	12		1.8% (0; 0–1.2%)
SARI rates in hospitals	SARI	8 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)	0.4% (0; 0–0%)
	RSV	7	7		0.2% (0; 0–0%)
	SARS-CoV-2	7	7		1% (1.1; 0–5%)
Intensity (country-defined)	Influenza	8	9	Distribution of country qualitative categories	8 Baseline

Source: ECDC

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

Pathogen	Week 29, 2026		Week 40, 2025 – week 29, 2026	
	N	% ^a	N	% ^a
Influenza	5	–	17975	–
Influenza A	4	100	17372	99
A(H1)pdm09	0	0.0	4062	28
A(H3)	1	100	10329	72
A (unknown)	3	–	2981	–
Influenza B	0	0.0	121	0.7
B/Vic	0	–	36	100
B (unknown)	0	–	85	–
Influenza untyped	1	–	482	–
RSV	2	–	5377	–
RSV-A	0	–	933	44
RSV-B	0	–	1192	56
RSV untyped	2	–	3252	–
SARS-CoV-2	7	–	4137	–

Source: ECDC

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

Pathogen	Week 29, 2026		Week 40, 2025 – week 29, 2026	
	N	% ^a	N	% ^a
Influenza	2	–	15700	–
Influenza A	0	–	7594	99
A(H1)pdm09	0	–	1311	35
A(H3)	0	–	2417	65
A (unknown)	0	–	3866	–
Influenza B	0	–	70	0.9
B/Vic			10	100
B (unknown)	0	–	60	–
Influenza untyped	2	–	8036	–
RSV	1	–	7190	–
RSV-A			1151	52
RSV-B			1059	48
RSV untyped	1	–	4980	–
SARS-CoV-2	5	–	3033	–

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 29, 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)	20	19
			.1)		
			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

Figure 7. SARS-CoV-2 variant distribution, week 27, 2026 - week 28, 2026

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	3	21% (21–21%)
XFG	VUM	1	6	43% (43–43%)
BA.3.2	VUM	1	3	21% (21–21%)
NB.1.8.1	VUM	1	2	14% (14–14%)

Source: ECDC

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

Latest epidemiological information

Democratic Republic of the Congo

On 23 July 2026, the [Democratic Republic of the Congo \(DRC\) reported](#) a total of 2 905 confirmed cases, including 1 269 related deaths (from data up until 22 July). A total of 722 patients are hospitalised in isolation. This represents an increase of 97 new confirmed cases and 62 deaths since the previous day. The 97 new cases have been reported from Ituri (73 cases), North Kivu (18 cases) and Haut Uele (three cases). Among the individuals that tested positive for Bundibugyo virus, 519 have recovered. In total 74.5 % of identified case contacts are under follow-up in the Ituri, North Kivu and Tshopo provinces.

Ituri province remains the most affected, with 2 595 cases, including 1 077 deaths, reported from 28 of 36 health zones. In North Kivu, 275 cases, including 172 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. In Haut-Uele, 27 cases (including 15 deaths) have been reported from four of 13 health zones and in Tshopo five cases (including four deaths) from three of 23 health zones. Overall, 47 of 140 health zones are currently affected across the five provinces.

Data reported by DRC on confirmed cases and deaths are under continuous review and harmonisation.

Uganda

As of 17 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. On 16 July, Uganda discharged the last Ebola patient who had been receiving treatment at the Mulago National Referral Isolation Centre. [Uganda's Ministry of Health](#) announced the start of the 42-day countdown to declaring the end of the outbreak.

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 to one of the areas affected by the ongoing outbreak in DRC.

On 10 July 2026, [the US CDC reported](#) that a US citizen who was working for a humanitarian organisation in DRC has tested positive for Bundibugyo virus. The patient was [medically evacuated to Germany on 13 July 2026](#) and is currently under treatment. This is the second US citizen that tested positive in DRC receiving treatment in Germany during this outbreak.

On 21 July, the [United Kingdom Ministry of Health](#) reported that an UK resident who had been treating patients with Ebola in the DRC, was evacuated and is currently isolated in a London hospital. The individual showed no symptoms and this was deemed as a precautionary measure.

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). On 16 July, Uganda discharged the last Ebola patient who had been receiving treatment at the Mulago National Referral Isolation Centre. [Uganda's Ministry of Health](#) announced the start of the 42-day countdown to declaring the end of the outbreak.

Genomes from DRC and Uganda have been published and preliminary analysis shows sequences distinct 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 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, although 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/areas.

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) at Africa CDC's headquarters, and Kampala (Uganda).

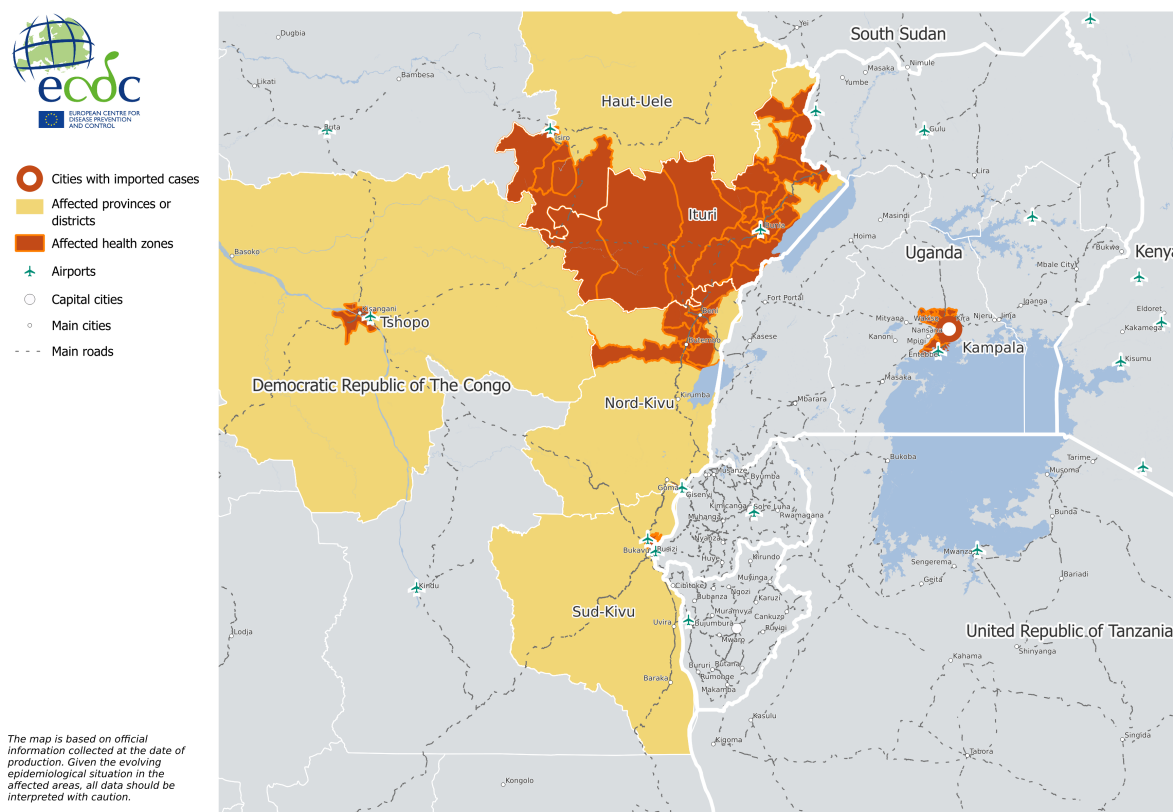
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

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: 17 July 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: 24/07/2026. 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.

3. Expert deployment

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.

Seven 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.

Between 16 June and 8 July 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 supported the implementation of the country's RCCE field plan to strengthen community engagement and address the priority risk communication and community engagement gaps in the high-risk areas. Since 14 July, two ECDC fellows have also been deployed through GOARN to the WHO country office in Juba, South Sudan, to support surveillance and data analysis activities.

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: 17 July 2026

4. Seasonal surveillance of dengue in the EU/EEA, weekly report

Overview

Since the beginning of 2026 and as at 22 July 2026, one country in Europe has reported locally acquired¹ cases of dengue: France (one case). This week, one new case of dengue has been reported to ECDC.

¹ [Seasonal surveillance of dengue in the EU/EEA, weekly report](#)

The report is available [online](#).

ECDC assessment

Please find the current [dengue risk assessment](#) for mainland EU/EEA on ECDC's dedicated [dengue webpage](#).

Actions

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

Further information

Dengue is a mosquito-borne viral disease that is increasingly emerging in Europe, with locally acquired cases reported in several EU/EEA countries. In the light of this development, the European Centre for Disease Prevention and Control has implemented seasonal enhanced weekly surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures. This includes assessing the risk of dengue transmission through Substances of Human Origin (SoHO).

Dengue is a notifiable disease at the EU level and cases are reported in accordance with the [EU case definition](#). The table and map in this report show the countries and areas where dengue cases – and their corresponding case numbers – have been reported to the European surveillance portal for infectious diseases (EpiPulse Cases). Please note that cases acquired in Portuguese and Spanish Outermost Regions are included. However, due to the distinct epidemiological situation and differences in surveillance systems, cases acquired in the French Outermost Regions are not included.

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

Overview

Since the beginning of 2026 and as at 22 July 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (two cases).

The report is available [online](#).

ECDC assessment

The cases in Salamanca (Spain) are 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 these cases aligns with the expected seasonal pattern of CCHF in Spain.

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 November 2026.

Last time this event was included in the Weekly CDTR: 17 July 2026

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

Overview

Since the beginning of the 2026 transmission season, and as at 22 July, 35 areas affected by West Nile virus (WNV) have been identified in six countries across Europe. These areas are located in Italy (20), Greece (six), Romania (four), North Macedonia (two), Spain (two) and France (one).

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 in accordance with the [EU case definition](#). According to Commission Directives [2004/33/EC](#) and [2014/110/EU](#) on blood safety, blood establishments in European Union/European Economic Area (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 information on 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: 17 July 2026.

7. World Pride - Netherlands - 2026

Update

Since the start of the monitoring period on 20 July, and as of 23 July, no relevant events related to communicable diseases have been detected in the context on the World Pride 2026.

Summary

[World Pride 2026](#) will take place in Amsterdam, the Netherlands, from 25 July to 8 August 2026. The event is expected to attract a large number of participants, including international visitors from across the EU/EEA and other regions of the world. Activities will include cultural and artistic performances, and large-scale social gatherings, culminating in a public parade on 8 August in central Amsterdam. The event will be hosted across multiple indoor and outdoor venues, some of which are expected to have high crowd density and prolonged contact among attendees.

In recent years, rates of STIs such as gonorrhoea and syphilis have [continued to increase](#) among gay, bisexual and other men who have sex with men in the EU/EEA. In addition, clusters and outbreaks of other infections that may be transmitted through intimate contact have been reported among gay, bisexual and other men who have sex with men, including mpox, [dermatophilosis](#), viral hepatitis and [multi-drug and extensively drug-resistant Shigella](#).

For this year's World Pride event in Amsterdam, the main recommendations stated in the [2017 ECDC risk assessment](#), ECDC's guidance on [HIV and STI prevention among men who have sex with men](#), ECDC's [public health considerations on mpox](#), and [ECDC's guidance on PrEP](#) remain relevant. Additional considerations regarding Shigella prevention are outlined in the ECDC [epidemiological update 2026](#).

[A joint public health advice for WorldPride events in the Netherlands, 2026](#) has been published on 21 July by ECDC, together with World Health Organization Regional Office for Europe and the Netherlands' National Institute for Public Health and the Environment. This advice is to help make sure everyone can enjoy the festivities safely, and raises awareness of health recommendations on a range of health topics, from sexually transmitted infections through to vaccination, respiratory illnesses, and food and water safety.

The local and regional public health authorities in Amsterdam have reinforced early detection, epidemiological surveillance, diagnostics, sampling and sequencing and preventive community measures for those populations most at risk and in spaces where exposure may occur.

Building on these preparedness measures, ECDC recommends that public health authorities work with civil society organisations and other partners to ensure that gay, bisexual and other men who have sex with men have access to accurate information and services. Participants attending World Pride events are advised to be mindful of the following:

- Ensure that routine vaccination and boosters are up-to-date in accordance with the national immunisation recommendations in the country of residence, including hepatitis A vaccination. It is advised that participants discuss the need for additional vaccinations, such as mpox, or booster doses with their healthcare providers.
- Ensure coverage with valid health insurance or obtain a European Health Insurance Card.
- Educate themselves prior to attendance on the prevention of STIs, including recommendations on HIV pre-exposure prophylaxis, and familiarise themselves with additional advice and information on the event website.
- Consult a healthcare provider in the home country to discuss other precautions based on a sexual health risk assessment: they may recommend pre-exposure prophylaxis (PrEP) for HIV, but remember that PrEP does not protect against other STIs.
- Practise safer sex using condoms to prevent STIs, including HIV and hepatitis B and C.
- Although using a condom is an important protective measure, it does not provide full protection against mpox, as mpox can be transmitted through close skin-to-skin contact, especially if there are rashes, sores, or lesions on the skin. This is also valid for dermatophilosis.
- Avoid sexual activity and seek healthcare if symptoms of STIs are present, including gastrointestinal symptoms and symptoms suggestive of mpox and dermatophilosis, in themselves or any sexual partner.
- Avoid faecal-oral exposure during sexual activity in order to prevent other infections such as shigellosis and hepatitis A (i.e. washing hands, genital and anal areas before and after sexual contact, always using a condom, changing condoms between anal and oral sex, using gloves or condoms on sex toys, using dental dams for oral sex and latex gloves for fingering or fisting). If gastrointestinal symptoms appear, inform healthcare providers of sexual activities, and abstain from sex until symptoms resolve.
- Follow standard hygiene measures and advice on the prevention of food and waterborne diseases to decrease the risk of gastrointestinal illnesses and consider general hygiene/food safety practices when consuming food and drink.
- If exposed to HIV, hepatitis A or B, or mpox infection, participants should contact a healthcare provider as soon as possible for advice, as post-exposure prophylaxis (PEP) is available for some infections in the form of vaccination or tablets and should be started as soon as possible (within 72 hours for HIV).
- If experiencing symptoms suggestive of an infection, participants should contact a healthcare provider at the event. People with STIs may not have any symptoms, however common symptoms include unusual discharge from the genitals or rectum, itching, pain during urination, rectal pain, skin changes (including rashes or blister-like lesions), yellowing of the skin, pain during sex or influenza-like symptoms. If participants have any of these symptoms, or experience severe diarrhoea (which can be caused by shigella or hepatitis A), they should avoid sexual activity and seek healthcare promptly.

- In general, if they have engaged in unprotected sexual activity with a casual partner, participants should consider contacting a healthcare provider for advice on testing for STIs, including mpox, HIV and hepatitis, as STIs can be present without causing any symptoms.
- Alternatively, the [European Test Finder tool](#) can be used to identify the most conveniently located testing centre. Known partners of those diagnosed should be notified as well as offered testing and treatment according to clinical guidelines.

People attending World Pride who acquire an infection may contribute to onward transmission of infections within sexual networks in their home countries. The EU/EEA countries should consider raising awareness among clinicians and laboratory professionals accordingly and prepare to provide post-exposure prophylaxis (where indicated), testing, treatment, and partner management of identified cases.

ECDC assessment

STIs, HIV, hepatitis, mpox and shigellosis continue to be reported in sexual networks among gay, bisexual and other men who have sex with men in Europe. People attending World Pride 2026 who have sex with non-steady or multiple partners may have an increased probability of acquiring an STI or another infection transmitted through sexual contact, particularly if preventive measures are not used consistently.

The probability of EU/EEA citizens becoming infected with other communicable diseases while attending World Pride 2026 is low if general preventive measures are applied (e.g. being fully vaccinated according to national immunisation schedules, following advice regarding hand and food hygiene and respiratory etiquette, self-isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, seeking prompt testing and medical advice as needed, and practising safe sex).

In 2017, ECDC published a [rapid risk assessment](#) on communicable disease risks associated with WorldPride in Madrid. Its main recommendations remain relevant, alongside [ECDC guidance on HIV and STI prevention among men who have sex with men](#), ECDC's [public health considerations for mpox](#), and [ECDC guidance on PrEP](#). Additional prevention advice is available in the [Joint public health advice for WorldPride events in the Netherlands, 2026](#).

Actions

ECDC will monitor this event through its epidemic intelligence activities between 20 July and 14 August 2026 in collaboration with the Dutch health authorities and WHO's Regional Office for Europe, and will include weekly updates in the Communicable Disease Threats Report (CDTR).

Further information

[Joint public health advice for WorldPride events in the Netherlands, 2026](#)

[Rapid Risk Assessment: Potential public health risks related to communicable diseases at the WorldPride festival in Madrid, 23 June–2 July 2017](#)

[ECDC STI Annual Epidemiological Reports for 2024 data](#)

[Public health guidance on HIV and STI prevention among men who have sex with men](#)

[ECDC HIV Pre-Exposure Prophylaxis in the EU/EEA and the UK: implementation, standards and monitoring](#)

[Clusters of dermatophilosis in five EU/EEA countries in 2025–2026](#)

Last time this event was included in the Weekly CDTR: 17 July 2026.

8. Airport malaria in Germany

Overview

Four cases of *Plasmodium falciparum* malaria have been reported among individuals who worked at Frankfurt International Airport before symptom onset, which occurred between 4 and 6 July 2026. Some of the cases were mobile workers, including sub-contractors. Three cases were diagnosed in Germany and one in another EU/EEA country. None of the cases reported travel to malaria-endemic areas. All cases were hospitalised, with at least one admitted to an intensive care unit.

The infections are presumed to be from the bites of an infected *Anopheles* mosquito, probably imported by aircraft. The event is currently being investigated by the competent public health authorities in Germany to identify whether additional cases may be linked to this cluster.

ECDC assessment

The cluster is compatible with airport-associated malaria, most likely caused by bites from an infectious imported *Anopheles* mosquito introduced through international air traffic. Such events are rare in Europe, but they can occur around airports receiving intercontinental passenger or cargo flights, particularly during the summer months when climatic conditions may allow imported mosquitos to survive for a limited period. About half of reported airport-and luggage (Odyssean) malaria cases occur as part of clusters, with up to five cases infected with the same malaria species per cluster.

Previous clusters of malaria among people working at Frankfurt International Airport were identified in 2019 (a cluster of two cases) and 2022 (a cluster of three cases). Although *Anopheles* mosquitoes tend to take a single blood meal per gonotrophic cycle, a single mosquito may bite several people, especially if frequently disturbed while feeding. Cases in such clusters in Europe were probably bitten by the same infectious mosquito within a short period of a few days, and there is no indication that these cases have led to onward vector-borne transmission.

As airport-associated malaria is relatively rare, the probability of infection is a very low for airport workers and for people spending prolonged periods in or near affected airport areas. The risk is therefore assessed as very low. However, because malaria is usually associated with travel to endemic areas, the absence of a travel history may delay clinical suspicion, diagnosis and treatment, thereby increasing the likelihood of severe disease, particularly for *P. falciparum* malaria.

Actions

Public health investigations are ongoing, including identification of additional compatible cases, vector monitoring and genomic analysis of patient samples to support epidemiological interpretation. Risk communication measures have been initiated by public health authorities in Germany for relevant stakeholders, including clinicians. Clinicians should be alerted so that they consider airport-associated malaria in the differential diagnosis of unexplained fever in individuals who work at, transit through, or spend time near airports with international traffic, even in the absence of travel to malaria-endemic countries. Early testing and prompt treatment are essential. Authorities should continue information exchange through appropriate public health channels and request notification of any additional compatible cases that may be epidemiologically linked to the reported cluster.

ECDC is monitoring the situation regarding autochthonous cases of malaria, including airport-associated malaria. To facilitate the monitoring, particularly of airport-associated malaria cases, such cases should be reported through EpiPulse.

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
- 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
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - last reported on 26 June 2026
- World Pride - Netherlands - 2026 - last reported on 24 July 2026
- Airport malaria in Germany - last reported on 24 July 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 24 July 2026
- Expert deployment - last reported on 24 July 2026
- Seasonal surveillance of dengue in the EU/EEA, weekly report - last reported on 24 July 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report) - last reported on 24 July 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report) - last reported on 24 July 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 29, 2026 - last reported on 24 July 2026
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 17 July 2026
- Human cases of swine influenza A(H3N2) variant virus – Multi-country - last reported on 17 July 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 17 July 2026
- Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters - Bathing season 2026 - last reported on 17 July 2026
- Cyclosporiasis - USA - 2026 - last reported on 17 July 2026
- Risk assessments under production - last reported on 17 July 2026
- Influenza A(H5)- Multi-country (World)- Monitoring human cases - last reported on 17 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.