

## WEEKLY BULLETIN

# Communicable disease threats report

Week 31, 25–31 July 2026

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## Executive summary

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

- As of 29 July 2026, the Democratic Republic of the Congo (DRC) reported a total of 3 442 confirmed cases and 1 521 confirmed related deaths (based on data until 28 July). Since the beginning of the outbreak, five provinces have been affected: Ituri, North Kivu, South Kivu, Tshopo, 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 28 July 2026, Uganda's Ministry of Health declared the end of the Ebola disease 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.

**Seasonal surveillance of chikungunya virus disease - 2026 (weekly)**

- Since the beginning of 2026 and as at 29 July 2026, one country in Europe has reported locally acquired cases of chikungunya: France (one case).
- This is the first locally acquired case of chikungunya reported this season.

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

- Since the beginning of 2026 and as at 29 July 2026, one country in Europe has reported locally acquired cases of dengue: France (one case).
- This week, no new cases of dengue have been reported to ECDC.

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

- Since the beginning of the 2026 transmission season, and as at 29 July, 35 areas affected by West Nile virus (WNV) have been identified in seven countries across Europe.
- These areas are located in Italy (30), Greece (eight), Romania (four), North Macedonia (two), Spain (two), France (two), and Germany (one).

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

- Since the beginning of 2026, and as at 29 July 2026, one country in Europe has reported locally-acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (three cases).
- One new province of Spain is reporting a locally-acquired CCHF case this week.

**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 in 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.
- 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.

**Overview of respiratory virus epidemiology in the EU/EEA, week 30, 2026**

- Respiratory virus activity across EU/EEA countries remains at baseline levels, indicating limited circulation of respiratory viruses.
- **SARS-CoV-2** activity remains low across all age groups in both primary and secondary care settings; Both **Influenza virus** and **Respiratory syncytial virus (RSV)** activity are 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'.*

**World Pride - Netherlands - 2026**

- Since the start of the monitoring period on 20 July, and as of 31 July, no relevant events related to communicable diseases have been detected in the context of 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 European Union/European Economic Area (EU/EEA).
- The probability of acquiring a sexually transmitted infection (STI) or other infection 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.

## 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.
- Two experts are currently deployed to support Africa CDC 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 European Commission's Directorate-General for International Partnerships (DG INTPA).
- 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.

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

- Four human cases of avian influenza A(H9N2) virus infection in China were reported in the [Avian Influenza Weekly Update](#) published on 31 July 2026 by WHO Western Pacific Region.
- The cases, which were geographically distinct from each other, involved two children and two adults. Two cases had mild illness and two were hospitalized; all of them recovered.
- Prior to illness onset, all four cases had either direct or indirect exposure to poultry.
- The risk related to zoonotic avian influenza (due to A(H9N2) viruses) for the general population in the EU/EEA is currently considered very low.

## Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update

- Since 1 January 2026 and as of 27 July 2026, 132 313 cholera cases, including 1 556 deaths, have been reported worldwide.
- Since 22 June 2026 and as of 27 July 2026, 8 247 new cholera cases, including 326 new deaths, have been reported worldwide.
- The five countries reporting most cases are Democratic Republic of the Congo (3 841), Sudan (1 502), Somalia (962), Central African Republic (445) and Malawi (383).
- The five countries reporting most new deaths are Sudan (153), Democratic Republic of the Congo (105), Central African Republic (36), Angola (12) and Cameroon (12).
- In addition, on 23 June 2026, Taiwan Centers for Disease Control reported a locally-acquired case of cholera in a woman in her 70s with no recent travel history. The patient was hospitalised and, following treatment, her condition improved and she was discharged.
- Cholera cases have continued to be reported in Africa, Asia, the Middle East, and the Americas. The risk of cholera infection for travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

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

## Overview:

### Latest epidemiological information

#### Democratic Republic of the Congo

On 29 July 2026, the [Democratic Republic of the Congo \(DRC\)](#) published a [situation update](#) reporting a total of 3 442 confirmed cases, including 1 521 related deaths (from data up until 28 July). A total of 797 patients are hospitalised in isolation. This represents an increase of 82 new confirmed cases and 34 deaths since the previous report of 28 July (reporting data up until 27 July). In total, 78.3 % of identified case contacts are under follow-up in the Ituri, North Kivu, Haut-Uele

and Tshopo provinces. Overall, 49 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. On 28 July 2026, twelve days since the last case was discharged, the [Uganda's Ministry of Health](#) declared the end of the Ebola disease 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 during this outbreak that has tested positive in DRC and is receiving treatment in Germany.

On 21 July, the [United Kingdom Ministry of Health](#) reported that a 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 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 Ebola virus/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 zairensis*. Unlike *Orthoebolavirus zairensis*, 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 zairensis* ([WHO DON Ebola virus disease – Democratic Republic of the Congo, 5 September 2025](#)). In Ituri province specifically, Ebola disease due to Ebola virus *Orthoebolavirus zairensis* 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.

### Therapeutics and Vaccines

The [University of Oxford's Oxford Vaccine Group](#) has successfully vaccinated the first volunteer in the world's first Bundibugyo ebolavirus vaccine trial. The vaccine was developed by scientists at the University of Oxford's Oxford Vaccine Group and Pandemic Sciences Institute.

### **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.

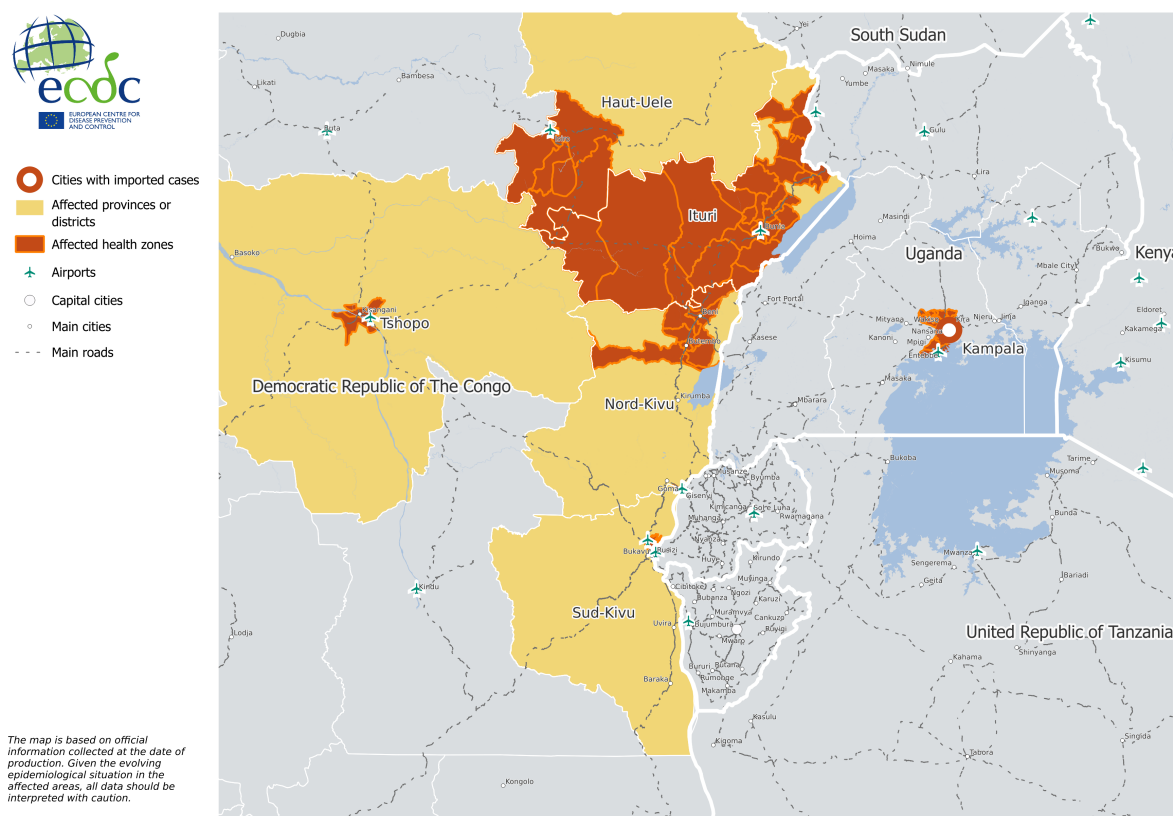
Since 19 May 2026, the EU Health Task Force, in collaboration with the European Civil Protection and Humanitarian Aid Operations (DG ECHO), the Directorate-General for International Partnerships (DG INTPA) and the Global Outbreak Alert and Response Network (GOARN), has been deploying ECDC experts to 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: 24 July 2026

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



## 2. Seasonal surveillance of chikungunya virus disease - 2026 (weekly)

### Overview:

Since the beginning of 2026 and as at 29 July 2026, one country in Europe has reported locally acquired cases of chikungunya: France (one case).

This is the first locally acquired chikungunya virus disease case reported during the season 2026 in mainland EU/EEA.

The report is available [online](#).

### ECDC assessment:

The current [chikungunya virus disease risk assessment](#) for mainland EU/EEA is available on ECDC's dedicated [chikungunya virus disease webpage](#).

### Actions:

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

### Further information:

Chikungunya is a mosquito-borne viral disease that is 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 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.

Chikungunya virus disease is a notifiable disease at the EU level and cases are reported in accordance with the [EU case definition](#). Chikungunya virus disease 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.

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

### Overview:

Since the beginning of 2026 and as at 29 July 2026, one country in Europe has reported locally acquired cases of dengue: France (one case). This week, no new cases of dengue have been reported to ECDC.

The report is available [online](#).

### ECDC assessment:

The current [dengue risk assessment](#) for mainland EU/EEA is available 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, ECDC 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.

**Last time this event was included in the Weekly CDTR:** 24 July 2026

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

**Overview:**

Since the beginning of the 2026 transmission season, and as at 29 July, 49 areas affected by West Nile virus (WNV) have been identified in seven countries across Europe. These areas are located in Italy (30), Greece (eight), Romania (four), North Macedonia (two), Spain (two), France (two), and Germany (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:** 24 July 2026

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

### Overview:

Since the beginning of 2026 and as at 29 July 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (three cases). This week, one new case of CCHF has been reported to ECDC.

The report is available [online](#).

### ECDC assessment:

This is the first time Ciudad Real (province in Spain) has reported a locally acquired human case, while cases have previously been reported in Salamanca. *Hyalomma* spp. – the main vectors of CCHF virus – are widely distributed across the country and CCHF virus is known to circulate in local animal populations. 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.

### Further information:

CCHF is a tick-borne viral disease that is 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 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.

CCHF is a notifiable disease at the EU level and cases are reported in accordance with the [EU case definition](#). CCHF 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.

**Last time this event was included in the Weekly CDTR:** 24 July 2026

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

### Overview:

#### Update

Based on forecasts from the [Vibrio Viewer](#), in the next five days (until 5 August 2026), 98 municipalities across 18 regions in six countries are expected to have high environmental suitability\* for *Vibrio* spp. The highest numbers of municipalities above the threshold have been identified in Germany (41 municipalities), France (16 municipalities), and Poland (14 municipalities).

A list of areas expected to have high environmental suitability\* for *Vibrio* spp. until 5 August 2026 is provided below.

**Bulgaria:** 13 municipalities in three regions:

- **Varna:** Avren, Byala, Dolni Chiflik, Varna
- **Dobrich:** Balchik, Kavarna, Shabla
- **Burgas:** six municipalities

**France:** 16 municipalities in four regions:

- **Gironde:** eight municipalities
- **Landes:** Tarnos
- **Charente-Maritime:** Chenac-Saint-Seurin-d'Uzet, Le Château-d'Oléron, Le Verdon-sur-Mer, Royan, Talmont-sur-Gironde
- **Bouches-du-Rhône:** Arles, Saintes-Maries-de-la-Mer

**Germany:** 41 municipalities in five regions:

- **Vorpommern-Rügen:** Dierhagen, Ostseebad, Ribnitz-Damgarten, Bernsteins
- **Nordwestmecklenburg:** Blowatz, Insel Poel, Ostseebad
- **Pinneberg:** Haseldorf, Hetlingen
- **Stade:** Grünendeich, Steinkirchen, Twielenfleth
- **Vorpommern-Greifswald:** 29 municipalities

**The Netherlands:** two municipalities in one region:

- **Overig Zeeland:** Reimerswaal, Tholen

**Poland:** 14 municipalities in three regions:

- **Szczeciński:** nine municipalities
- **Elbląski:** Elbląg, Sztutowo, Tolkmicko
- **Gdański:** Sztutowo, Tolkmicko

**Romania:** 12 municipalities in two regions:

- **Constanța:** eight municipalities
- **Tulcea:** Jurilovca, Murighiol, Oras Sulina, Sfantu Gheorghe

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 environmental suitability for *Vibrio* spp. is 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 due to 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 under-cooked seafood, particularly shellfish, or the 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 when temperatures are exceptionally high [11, 12].

To reduce the risk of *Vibrio* infections through food, it is recommended that seafood should be cooked thoroughly before consumption. Individuals who have open wounds, recent piercings, cuts or scrapes should avoid swimming in brackish or coastal waters, or 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](#).

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

## 7. Overview of respiratory virus epidemiology in the EU/EEA, week 30, 2026

### Overview:

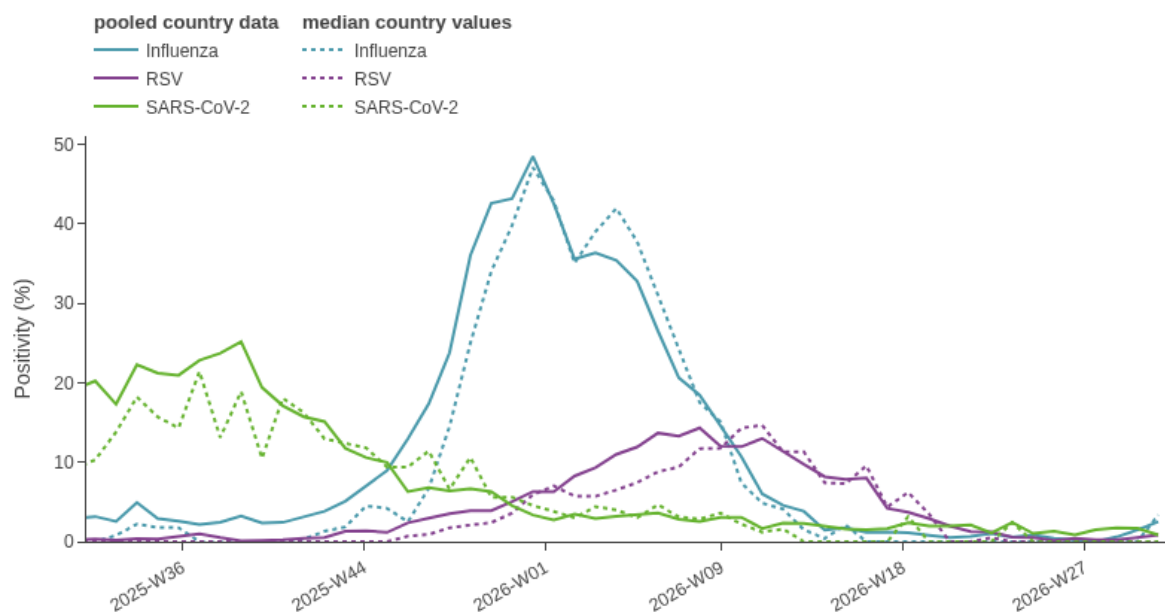
**Important:** This European Respiratory Virus Surveillance Summary (ERVISS) publication follows the recent transition of reporting surveillance data from The European Surveillance System (TESSy) to EpiPulse Cases (EPC). As a result of this transition, we have identified a few data inconsistencies. We 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](#)), which is updated weekly.

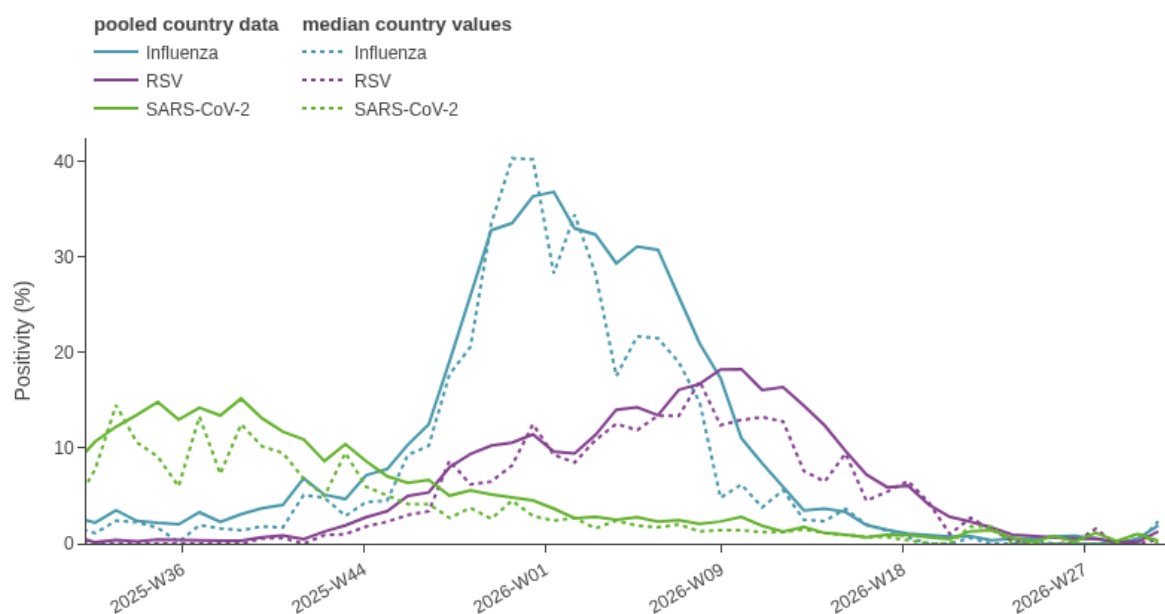
Key visualisation from the weekly bulletin are included below.

**Sources:** [ERVISS](#)

**Last time this event was included in the Weekly CDTR:** 24 July 2026

**Figure 2. ILI/ARI virological surveillance in primary care – weekly test positivity**

Source: ECDC

**Figure 3. SARI virological surveillance in hospitals – weekly test positivity**

Source: ECDC

**Figure 4. Key indicators**

| Indicator                                  | Syndrome or pathogen | Reporting countries |                   | EU/EEA summary                                 |                      |
|--------------------------------------------|----------------------|---------------------|-------------------|------------------------------------------------|----------------------|
|                                            |                      | Week 30             | Week 29           | Description                                    | Value                |
| ILI/ARI consultation rates in primary care | ARI                  | 11 rates (8 MEM)    | 13 rates (8 MEM)  | Distribution of country MEM categories         | 8 Baseline           |
|                                            | ILI                  | 11 rates (10 MEM)   | 14 rates (13 MEM) |                                                | 10 Baseline          |
| ILI/ARI test positivity in primary care    | Influenza            | 6                   | 12                | Pooled (median; IQR)                           | 2.5% (3.4; 1.8–5.5%) |
|                                            | RSV                  | 6                   | 12                |                                                | 0.8% (0; 0–0%)       |
|                                            | SARS-CoV-2           | 6                   | 12                |                                                | 0.8% (0; 0–0%)       |
| SARI rates in hospitals                    | SARI                 | 6 rates (3 MEM)     | 9 rates (5 MEM)   | Distribution of country MEM categories         | 3 Baseline           |
| SARI test positivity in hospitals          | Influenza            | 5                   | 8                 | Pooled (median; IQR)                           | 1.9% (2.4; 0.3–7%)   |
|                                            | RSV                  | 5                   | 7                 |                                                | 1.3% (0.4; 0–1.8%)   |
|                                            | SARS-CoV-2           | 5                   | 8                 |                                                | 0.3% (0; 0–1.1%)     |
| Intensity (country-defined)                | Influenza            | 7                   | 10                | Distribution of country qualitative categories | 7 Baseline           |

Source: ECDC

**Figure 5. ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution**

| Pathogen          | Week 30, 2026 |                | Week 40, 2025 – week 30, 2026 |                |
|-------------------|---------------|----------------|-------------------------------|----------------|
|                   | N             | % <sup>a</sup> | N                             | % <sup>a</sup> |
| <b>Influenza</b>  | <b>3</b>      | –              | <b>17979</b>                  | –              |
| Influenza A       | 3             | 100            | 17376                         | 99             |
| A(H1)pdm09        | 1             | 33             | 4063                          | 28             |
| A(H3)             | 2             | 67             | 10332                         | 72             |
| A (unknown)       | 0             | –              | 2981                          | –              |
| Influenza B       | 0             | 0.0            | 121                           | 0.7            |
| B/Vic             | 0             | –              | 36                            | 100            |
| B (unknown)       | 0             | –              | 85                            | –              |
| Influenza untyped | 0             | –              | 482                           | –              |
| <b>RSV</b>        | <b>1</b>      | –              | <b>5378</b>                   | –              |
| RSV-A             | 0             | –              | 933                           | 44             |
| RSV-B             | 0             | –              | 1192                          | 56             |
| RSV untyped       | 1             | –              | 3253                          | –              |
| <b>SARS-CoV-2</b> | <b>1</b>      | –              | <b>4138</b>                   | –              |

Source: ECDC

**Figure 6. SARI virological surveillance in hospitals – pathogen type and subtype distribution**

| Pathogen          | Week 30, 2026 |                | Week 40, 2025 – week 30, 2026 |                |
|-------------------|---------------|----------------|-------------------------------|----------------|
|                   | N             | % <sup>a</sup> | N                             | % <sup>a</sup> |
| <b>Influenza</b>  | <b>6</b>      | –              | <b>15711</b>                  | –              |
| Influenza A       | 5             | 100            | 7601                          | 99             |
| A(H1)pdm09        | 2             | 50             | 1316                          | 35             |
| A(H3)             | 2             | 50             | 2419                          | 65             |
| A (unknown)       | 1             | –              | 3866                          | –              |
| Influenza B       | 0             | 0.0            | 71                            | 0.9            |
| B/Vic             |               |                | 10                            | 100            |
| B (unknown)       | 0             | –              | 61                            | –              |
| Influenza untyped | 1             | –              | 8039                          | –              |
| <b>RSV</b>        | <b>4</b>      | –              | <b>7194</b>                   | –              |
| RSV-A             |               |                | 1151                          | 52             |
| RSV-B             |               |                | 1059                          | 48             |
| RSV untyped       | 4             | –              | 4984                          | –              |
| <b>SARS-CoV-2</b> | <b>1</b>      | –              | <b>3038</b>                   | –              |

Source: ECDC

**Figure 7. Genetically characterised influenza virus distribution, week 40, 2025 – week 30, 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

**Figure 8. SARS-CoV-2 variant distribution, week 28, 2026 – week 29, 2026**

| Variant  | Classification <sup>a</sup> | Reporting countries | Detections | Distribution (median and IQR) |
|----------|-----------------------------|---------------------|------------|-------------------------------|
| BA.2.86  | VOI                         | 1                   | 3          | 27% (27–27%)                  |
| XFG      | VUM                         | 1                   | 5          | 46% (46–46%)                  |
| NB.1.8.1 | VUM                         | 1                   | 2          | 18% (18–18%)                  |
| BA.3.2   | VUM                         | 1                   | 1          | 9% (9–9%)                     |

Source: ECDC

## 8. World Pride - Netherlands - 2026

### Overview:

#### Update

Since the start of the monitoring period on 20 July, and as of 31 July, no relevant events related to communicable diseases have been detected in the context of 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 ECDC's [epidemiological update 2026](#).

[A joint public health advice for WorldPride events in the Netherlands, 2026](#) was published on 21 July by ECDC, together with the World Health Organization (WHO) Regional Office for Europe and the National Institute for Public Health and the Environment of the Netherlands. This aim of this advice is to help make sure everyone can enjoy the festivities safely, and to raise 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 facilities for 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 in the event of STI symptoms, 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, but 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, and 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, and 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 taken 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:** 24 July 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.

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 European Commission's 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 request for assistance from the Global Outbreak Alert and Responses Network (GOARN). 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:** 24 July 2026

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

### Overview:

#### Summary

On 31 July 2026, four new laboratory-confirmed human cases of avian influenza A(H9N2) virus infection in China were reported in the [Avian Influenza Weekly Update \(Number 1055\) published by WHO Western Pacific Region](#).

The four cases, which were geographically distinct from each other, involved the following:

- A 72-year-old woman from Jiangxi Province with symptom onset on 5 July 2026;
- A 12-year-old boy from Jiangsu Province with symptom onset on 6 July 2026;
- A 3-year-old girl from Gansu Province with symptom onset on 11 July 2026;
- A 58-year-old woman from Yunnan Province with symptom onset on 13 July 2026.

Two cases had underlying chronic respiratory conditions and were hospitalised, while the other two cases had mild symptoms and did not require hospitalisation. All four cases made a full recovery. One case had direct exposure to live poultry, while the other three had potential exposure to live poultry stalls or wet markets.

#### Background

Since 2015, a total of 174 laboratory-confirmed human cases of avian influenza A(H9N2) virus infection have been reported from China to WHO.

#### ECDC assessment:

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

#### Actions:

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

**Sources:** [Event Information Site for IHR National Focal Points](#)

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

# 11. Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update

## Overview:

*Data presented in this report originate from several sources, both official public health authorities and non-official sources, such as the media. Case definitions, testing strategies and surveillance systems vary between countries. In addition, data completeness and levels of under-reporting vary between countries. All data should therefore be interpreted with caution. For details on the epidemiological situation and more information regarding the case definitions in use, refer to the original sources.*

## Update

Since 22 June 2026 and as of 27 July 2026, 8 247 new cholera cases, including 326 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Burundi, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Haiti, Kenya, Malawi, Mozambique, Myanmar/Burma, Pakistan, Somalia, Sudan and Yemen.

The five countries reporting most cases are Democratic Republic of the Congo (3 841), Sudan (1 502), Somalia (962), Central African Republic (445) and Malawi (383).

New deaths have been reported from Afghanistan, Angola, Burundi, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Haiti, Mozambique, Sudan and Yemen.

The five countries reporting most new deaths are Sudan (153), Democratic Republic of the Congo (105), Central African Republic (36), Angola (12) and Cameroon (12).

In addition, 18 253 new cases were reported or collected retrospectively from before 22 June 2026.

In the previous reporting period (26 May to 22 June 2026), 19 659 new cholera cases, including 261 new deaths, were reported worldwide.

Since 1 January 2026 and as of 27 July 2026, 132 313 cholera cases, including 1 556 deaths, have been reported worldwide.

In comparison, since 1 January 2025 and as of 27 July 2025, 306 615 cholera cases, including 3 752 deaths, were reported worldwide.

## Since the last update, new cases and new deaths have been reported from:

### Asia:

#### Afghanistan:

Since 18 May 2026 and as of 15 June 2026, 16 577 new cases, including 12 new deaths have been reported. Since 01 January 2026 and as of 15 June 2026, 56 662 cases, including 28 deaths have been reported. In comparison, in 2025 and as of 23 June 2025, 68 031 cases, including 26 deaths were reported.

#### Myanmar/Burma:

Since 06 April 2026 and as of 15 June 2026, 106 new cases have been reported. Since 1 January 2026 and as of 15 June 2026, 257 cases have been reported. In comparison, in 2025 and as of 16 June 2025, 1 888 cases were reported.

#### Pakistan:

Since 20 April 2026 and as of 18 May 2026, 701 new cases have been reported. Since 1 January 2026 and as of 18 May 2026, 3 305 cases have been reported. In comparison, in 2025 and as of 21 July 2025, 14 760 cases were reported.

**Taiwan:**

Since 09 July 2023 and as of 19 June 2026, 1 new case has been reported. Since 1 January 2026 and as of 19 June 2026, one case has been reported. In comparison, in 2025 and as of 27 July 2025, no cases were reported. This case was briefly described in the previous monthly report.

**Yemen:**

Since 04 May 2026 and as of 08 June 2026, 696 new cases, including one new death, has been reported. Since 1 January 2026 and as of 08 June 2026, 5 054 cases, including seven deaths, have been reported. In comparison, in 2025 and as of 23 June 2025, 41 510 cases, including 129 deaths, were reported.

Since 22 June 2026, no updates have been reported by: India.

**Africa:****Angola:**

Since 14 June 2026 and as of 12 July 2026, 303 new cases, including 12 new deaths, have been reported. Since 1 January 2026 and as of 12 July 2026, 5 379 cases, including 116 deaths, have been reported. In comparison, in 2025 and as of 08 July 2025, 27 008 cases, including 756 deaths were reported.

**Burundi:**

Since 14 June 2026 and as of 12 July 2026, 165 new cases, including one new death, have been reported. Since 1 January 2026 and as of 12 July 2026, 1 538 cases, including four deaths, have been reported. In comparison, in 2025 and as of 08 July 2025, 217 cases were reported.

**Cameroon:**

Since 31 December 2025 and as of 12 July 2026, 331 new cases, including 12 new deaths, have been reported. Since 1 January 2026 and as of 12 July 2026, 331 cases, including 12 deaths, have been reported. In comparison, in 2025 and as of 27 July 2025, no cases were reported.

**Central African Republic:** Since 1 November 2016 and as of 9 July 2026, 445 new cases, including 36 new deaths, have been reported. Since 1 January 2026 and as of 9 July 2026, 445 cases, including 36 deaths, have been reported. In comparison, in 2025 and as of 27 July 2025, no cases were reported.

**Chad:**

Since 31 December 2025 and as of 12 July 2026, 120 new cases, including four new deaths, have been reported. Since 1 January 2026 and as of 12 July 2026, 120 cases, including four deaths, have been reported. In comparison, in 2025 and as of 27 July 2025, no cases were reported.

**Democratic Republic of the Congo:** Since 14 June 2026 and as of 12 July 2026, 3 841 new cases, including 105 new deaths, have been reported. Since 1 January 2026 and as of 12 July 2026, 33 182 cases, including 943 deaths, have been reported. In comparison, in 2025 and as of 8 July 2025, 32 456 cases, including 737 deaths, were reported.

**Kenya:**

Since 14 June 2026 and as of 12 July 2026, two new cases have been reported. Since 1 January 2026 and as of 12 July 2026, 39 cases have been reported. In comparison, in 2025 and as of 30 April 2025, 125 cases, including six deaths, were reported.

**Malawi:**

Since 14 June 2026 and as of 12 July 2026, 383 new cases have been reported. Since 1 January 2026 and as of 12 July 2026, 2 998 cases, including five deaths, have been reported. In comparison, in 2025 and as of 7 April 2025, 91 cases, including three deaths, were reported.

**Mozambique:**

Since 14 June 2026 and as of 12 July 2026, 193 new cases, including three new deaths, have been reported. Since 1 January 2026 and as of 12 July 2026, 7 379 cases, including 64 deaths, have been reported. In comparison, in 2025 and as of 8 July 2025, 3 832 cases, including 41 deaths, were reported.

**Somalia:**

Since 14 June 2026 and as of 12 July 2026, 962 new cases have been reported. Since 1 January 2026 and as of 12 July 2026, 2 168 cases have been reported. In comparison, in 2025 and as of 8 July 2025, 5 414 cases, including eight deaths, were reported.

**Sudan:**

Since 11 January 2026 and as of 12 July 2026, 1 502 new cases, including 153 new deaths, have been reported. Since 1 January 2026 and as of 12 July 2026, 1 511 cases, including 153 deaths, have been reported. In comparison, in 2025 and as of 8 July 2025, 32 230 cases, including 774 deaths, were reported.

Since 22 June 2026, no updates have been reported by: Congo, Ethiopia, Namibia, Nigeria, Rwanda, South Sudan, United Republic of Tanzania, Zambia and Zimbabwe.

**Americas:****Haiti:**

Since 06 April 2026 and as of 18 May 2026, 172 new cases, including one new death, have been reported. Since 1 January 2026 and as of 18 May 2026, 529 cases, including two deaths, have been reported. In comparison, in 2025 and as of 23 June 2025, 2 496 cases, including 31 deaths, were reported.

**ECDC assessment:**

Cholera cases have continued to be reported in Africa and Asia, the Middle East, and the Americas.

In this context, although the likelihood of cholera infection for travellers visiting these countries remains low, sporadic importation of cases to the EU/EEA is possible.

In the EU/EEA, cholera is rare and primarily associated with travel to endemic countries. Since 2025, only events of locally acquired cholera cases are reported at the EU/EEA level; however, imported and locally acquired cholera cases are reported to the World Health Organization (WHO) on an annual basis. In [2024](#), 16 imported cases were reported by eight EU/EEA countries, while 12 were reported in [2023](#), 29 in 2022, two in 2021, and none in 2020. In 2019, 25 cases were reported in EU/EEA countries (including the United Kingdom). All cases had a travel history to cholera-affected areas.

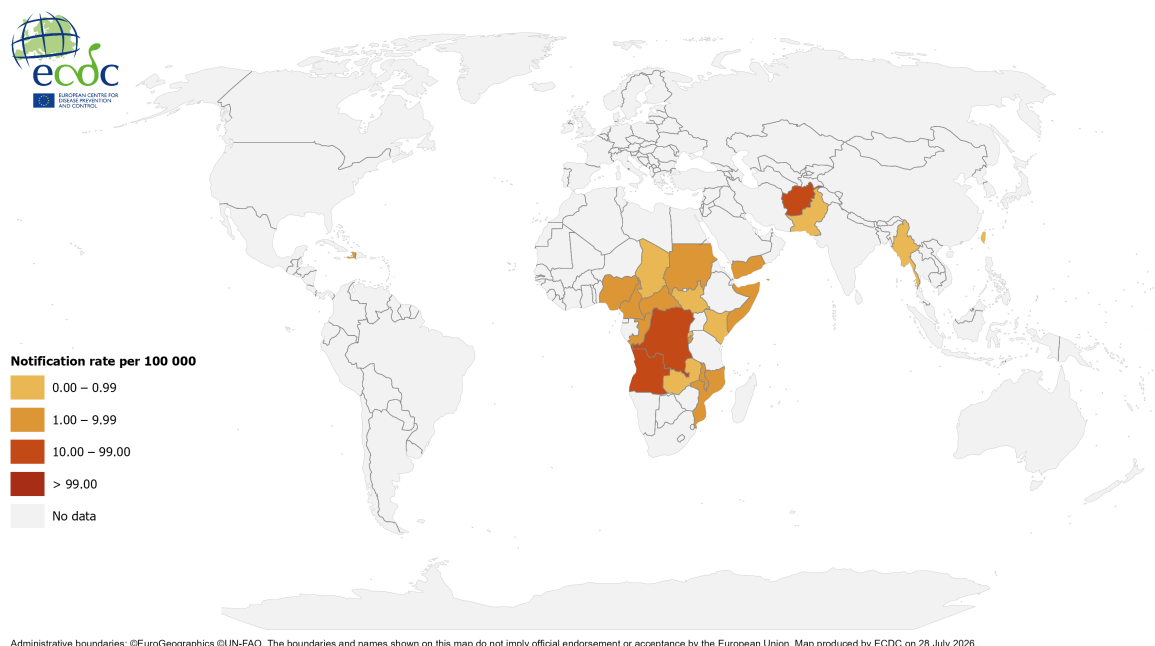
Vaccination should be considered for travellers at higher risk of infection, such as emergency and relief workers who may be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek advice from travel health clinics to assess their personal risk, and apply precautionary sanitary and hygiene measures to prevent infection. Such measures can include drinking bottled water or water treated with chlorine, carefully washing fruit and vegetables with bottled or chlorinated water before consumption, regularly washing hands with soap, eating thoroughly cooked food, and avoiding the consumption of raw seafood products.

**Actions:**

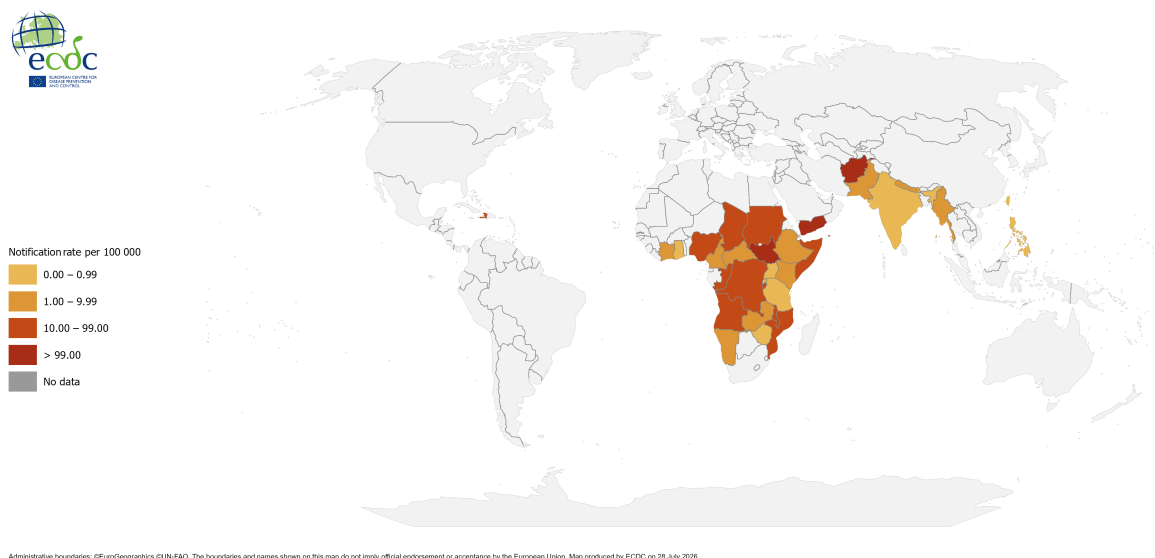
ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities.

Reports are published on a monthly basis. The worldwide overview of cholera outbreaks is available on [ECDC's website](#).

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

**Figure 9. Geographical distribution of cholera cases reported worldwide from May to July 2026**

Source: ECDC

**Figure 10. Geographical distribution of cholera cases reported globally from July 2025 to July 2026**

Source: ECDC

## Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 31 July 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 31 July 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 30, 2026 - last reported on 31 July 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 31 July 2026
- Expert deployment - last reported on 31 July 2026
- Seasonal surveillance of chikungunya virus disease - 2026 (weekly) - last reported on 31 July 2026
- Seasonal surveillance of dengue in the EU/EEA, weekly report - last reported on 31 July 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report) - last reported on 31 July 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report) - last reported on 31 July 2026
- Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters - Bathing season 2026 - last reported on 31 July 2026
- World Pride - Netherlands - 2026 - last reported on 31 July 2026
- Airport malaria in Germany - last reported on 24 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
- 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
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 17 July 2026
- SARS-CoV-2 variant classification - last reported on 03 July 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 03 July 2026