

WEEKLY BULLETIN

Communicable disease threats report

Week 33, 8–14 August 2026

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Executive Summary

Overview of respiratory virus epidemiology in the EU/EEA, week 31, 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 but is slowly increasing in some countries. Although numbers of hospital admissions remain very low, a few countries are reporting a small increase.
- **Influenza virus** activity is low and at expected inter-seasonal levels in most countries. In Malta, a recent increase in activity and hospitalisations has been observed, similar to increases seen during the same period in previous summers.
- **Respiratory syncytial virus (RSV)** activity is low and at expected 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'.

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

- As of 13 August 2026, the Democratic Republic of the Congo (DRC) reported a total of 4 665 confirmed cases, including 2 184 confirmed related deaths (based on data until 12 August). Since the beginning of the outbreak, six provinces have been affected: Ituri, North Kivu, South Kivu, Tshopo, Haut-Uele and Bas-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.

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.
- Since 14 July, two ECDC fellows have also been deployed through the Global Outbreak Alert and Response Network (GOARN) to the World Health Organization (WHO) country office in Juba, South Sudan, to support surveillance and data analysis activities.
- In total, eight 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 the European Food Safety Authority (PHASE II), funded by the European Commission's Directorate-General for International Partnerships. The experts have provided support for surveillance and liaison 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 and the Directorate-General for International Partnerships.

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 Threats Reports](#) to assess and communicate the potential risk to human health across the EU/EEA.

World Pride – Netherlands – 2026

- As of 14 August 2026, no major public health events related to communicable diseases have been detected in the context of World Pride 2026.
- World Pride 2026 took place in Amsterdam, the Netherlands, from 25 July to 8 August 2026. ECDC monitored this mass gathering event from 20 July to 14 August 2026 through epidemic intelligence activities, in collaboration with the Dutch health authorities and WHO's Regional Office for Europe.
- Previous weekly updates related to this event are available in the [Communicable Disease Threats Report \(CDTR\)](#).

Seasonal surveillance of chikungunya virus disease – 2026 (weekly)

- Since the beginning of 2026 and as at 12 August 2026, only France has reported locally acquired cases (15 cases) of chikungunya virus disease in Europe.
- In the past week, France reported eight new cases of locally acquired cases of chikungunya virus disease.

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

- Since the beginning of 2026 and as at 12 August 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 13 August, 77 areas affected by West Nile virus (WNV) have been identified in nine countries across Europe.
- These areas are located in Italy (40), Greece (13), Romania (12), France (four), North Macedonia (three), Spain (two), Germany (one), Kosovo (one) and Serbia (one).

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

- The first human cases of West Nile Virus (WNV) infections this year were reported with date of symptom onset in mid-May, which is similar to previous years.
- Countries reporting human cases of WNV infection this year also had cases in previous years.
- The geographical expansion of WNV observed in previous years continues, with several NUTS 3 regions in France, Germany, Italy and North Macedonia reporting human cases for the first time ever.

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

- Since the beginning of 2026, and as at 12 August 2026, only Spain has reported locally acquired cases (three cases) of Crimean-Congo haemorrhagic fever (CCHF) in Europe.
- In the past week, no new cases have been reported to ECDC.

Crimean-Congo haemorrhagic fever in Albania, 2026

- A case of Crimean-Congo haemorrhagic fever (CCHF) has been reported by Albania on 11 August 2026.
- The patient is a livestock farmer and owns animals.
- The date of disease onset was 22 July 2026, and the patient was hospitalised on 24 July 2026. Subsequently the patient has recovered and been discharged from hospital.
- The patient lives in the Tropojë district of North Albania, which has not previously been recognised as endemic for CCHF in the country.
- The likelihood of CCHF virus infection for EU/EEA citizens travelling to or residing in Albania is very low.

Mpox in the EU/EEA, Western Balkans and Türkiye – 2026

- In July 2026, 153 mpox cases caused by monkeypox virus (MPXV) clade I were reported by 12 EU/EEA countries, indicating a relatively stable transmission following increases observed earlier in 2026. In the same period, 12 mpox cases caused by MPXV clade II were reported by five countries, continuing a decreasing trend.
- Transmission for both clades occurs predominantly within networks of men who have sex with men, with ongoing circulation across the EU/EEA and most cases reported among unvaccinated individuals.
- Disease severity remains generally mild, with low hospitalisation rates reported for both clades.
- With increased travel and mass gatherings during summer, there is a risk of further spread.

1. Overview of respiratory virus epidemiology in the EU/EEA, week 31, 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. 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/erviss)), which is updated weekly.

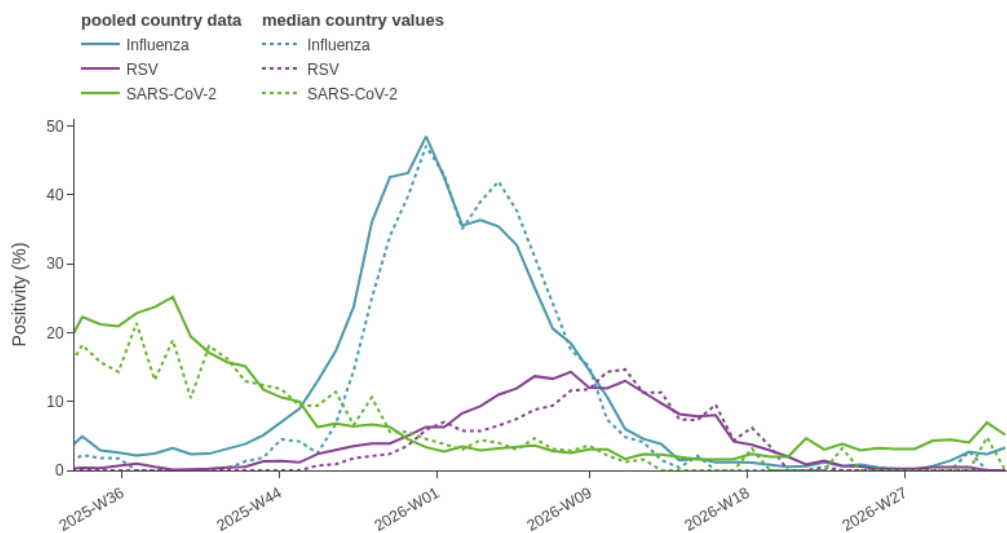
Key visualisation from the weekly bulletin are included below.

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

Last time this event was included in the Weekly CDTR: 7 August 2026

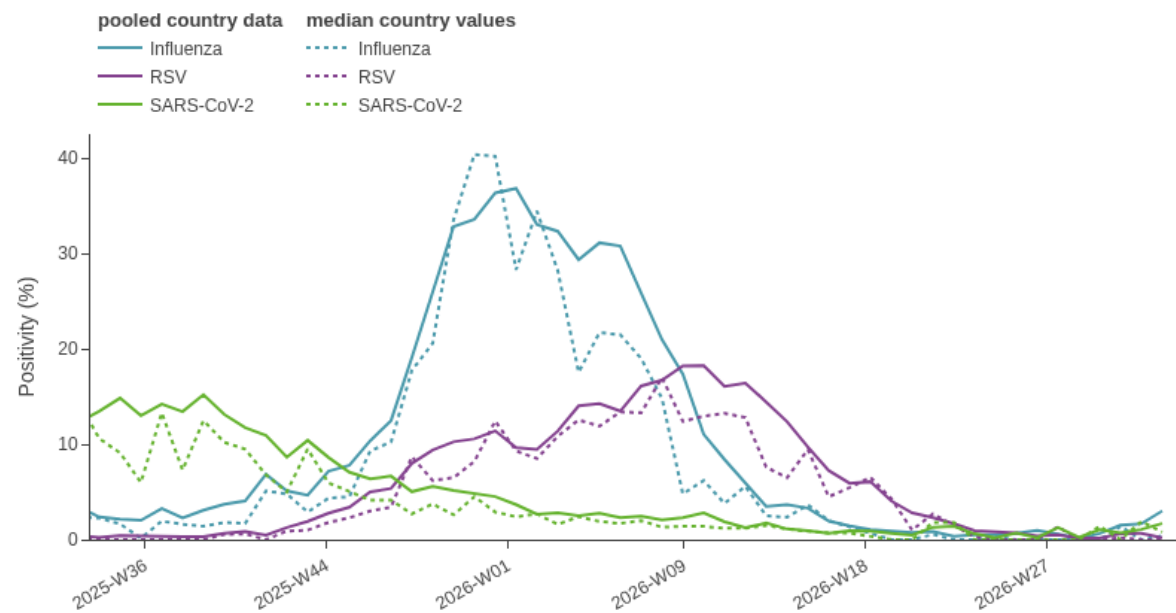
Maps and graphs

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 32	Week 31	Description	Value
ILI/ARI consultation rates in primary care	ARI	13 rates (8 MEM)	13 rates (8 MEM)	Distribution of country MEM categories	8 Baseline
	ILI	14 rates (13 MEM)	14 rates (13 MEM)		13 Baseline
ILI/ARI test positivity in primary care	Influenza	11	12	Pooled (median; IQR)	3.3% (0; 0–3.9%)
	RSV	11	11		0% (0; 0–0%)
	SARS-CoV-2	11	12		5.2% (0; 0–0%)
SARI rates in hospitals	SARI	7 rates (4 MEM)	9 rates (5 MEM)	Distribution of country MEM categories	4 Baseline
SARI test positivity in hospitals	Influenza	6	7	Pooled (median; IQR)	3% (0.4; 0–2.1%)
	RSV	6	6		0.2% (0; 0–0%)
	SARS-CoV-2	7	7		1.7% (0.8; 0–2.5%)
Intensity (country-defined)	Influenza	7	9	Distribution of country qualitative categories	7 Baseline

Source: ECDC

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

Pathogen	Week 32, 2026		Week 40, 2025 – week 32, 2026	
	N	% ^a	N	% ^a
Influenza	14	–	18011	–
Influenza A	14	100	17408	99
A(H1)pdm09	2	18	4066	28
A(H3)	9	82	10357	72
A (unknown)	3	–	2985	–
Influenza B	0	0.0	123	0.7
B/Vic	0	–	37	100
B (unknown)	0	–	86	–
Influenza untyped	0	–	480	–
RSV	0	–	5376	–
RSV-A	0	–	934	44
RSV-B	0	–	1192	56
RSV untyped	0	–	3250	–
SARS-CoV-2	22	–	4418	–

Source: ECDC

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

Pathogen	Week 32, 2026		Week 40, 2025 – week 32, 2026	
	N	% ^a	N	% ^a
Influenza	16	–	15755	–
Influenza A	14	100	7630	99
A(H1)pdm09	0	–	1322	35
A(H3)	0	–	2426	65
A (unknown)	14	–	3882	–
Influenza B	0	0.0	73	0.9
B/Vic			10	100
B (unknown)	0	–	63	–
Influenza untyped	2	–	8052	–
RSV	1	–	7198	–
RSV-A			1152	52
RSV-B			1062	48
RSV untyped	1	–	4984	–
SARS-CoV-2	9	–	3064	–

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 32, 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
			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 43, 2025 – week 44, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	0	0	0%
XFG	VUM	1	3	30% (30–30%)
BA.3.2	VUM	0	0	0%
NB.1.8.1	VUM	0	0	0%

Source: ECDC

2. 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 13 August 2026, the [Democratic Republic of the Congo \(DRC\) reported](#) a total of 4 665 confirmed cases, including 2 184 related deaths (from data up until 12 August). A total of 634 patients are hospitalised in isolation. This represents an increase of 99 new confirmed cases and 56 deaths since the previous report on 12 August (reporting data up until 11 August). In total, 84.2% of identified case contacts are under follow-up in the affected provinces.

On 13 August, [Africa CDC reported during its press briefing](#) that the outbreak had expanded to a sixth province, Bas-Uele. An imported case from neighbouring Haut-Uele was identified in Buta, the provincial capital of Bas Uele, where the affected individual subsequently died.

[As of 13 August](#), in total 54 of 151 health zones are affected across the six provinces.

Data on the number of cases and deaths by province and health zone are only available for cases reported until [11 August](#). On a total of 4 566 confirmed cases and 2 128 confirmed deaths, Ituri province remains the most affected, with 3 912 cases, including 1 702 deaths, reported from 28 of 36 health zones. In North Kivu, 528 cases, including 369 deaths, have been reported from 12 of 34 health zones. In South Kivu, three cases, including one death, have been reported from one of 34 health zones. In Haut-Uele, 115 cases, including 51 deaths, have been reported from 6 of 13 health zones. In Tshopo, nine cases, including five deaths, have been reported from 6 of 23 health zones.

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

Uganda

As of 28 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, 12 days since the last case was discharged, the [Uganda's Ministry of Health](#) declared the end of the Ebola disease outbreak.

The next epidemiological update will be published on 17 August 2026.

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 had 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 who 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 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.

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).

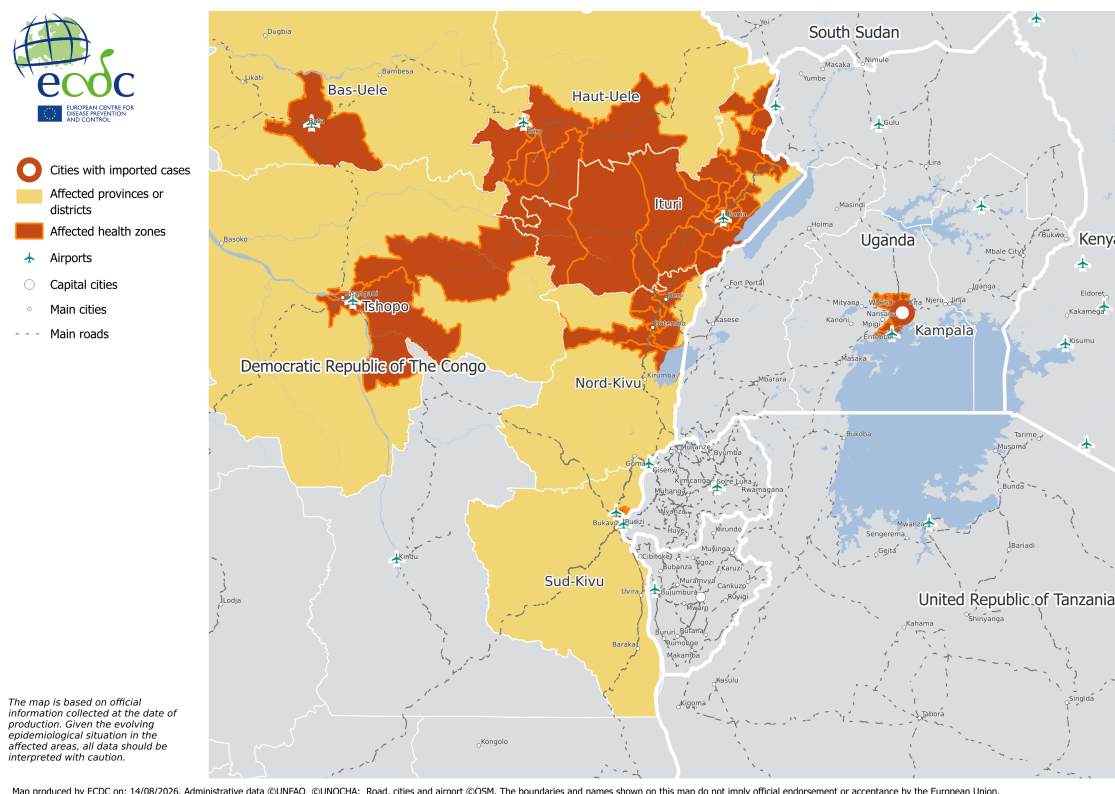
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

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: 7 August 2026

Maps and graphs

Figure 8. Map of the affected areas in the Ebola disease outbreak caused by Bundibugyo virus, Democratic Republic of the Congo and Uganda, 2026



Source: ECDC

3. 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.

Eight 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 the European Food Safety Authority (PHASE II), funded by the European Commission's Directorate-General for International Partnerships. 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 to evaluate 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 World Health Organization (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 and the Directorate-General for International Partnerships.

Last time this event was included in the Weekly CDTR: 7 August 2026

4. 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 19 August 2026), 41 municipalities across nine regions in four countries are expected to have high environmental suitability* for *Vibrio* spp. The highest numbers of municipalities above the threshold have been identified in France (14), Bulgaria (13) and Romania (12).

A list of areas expected to have high environmental suitability* for *Vibrio* spp. until 19 August 2026 is provided below.

Bulgaria: 13 municipalities in three regions:

- **Varna:** Avren, Byala, Dolni chiflik, Varna
- **Dobrich:** Balchik, Kavarna, Shabla
- **Burgas:** six municipalities above the threshold

France: 14 municipalities in three regions:

- **Gironde:** Eight municipalities above the threshold
- **Charente-Maritime:** Chenac-Saint-Seurin-d'Uzet, Le Château-d'Oléron, Le Verdon-sur-Mer, Royan, Talmont-sur-Gironde
- **Bouches-du-Rhône:** Arles

Italy: two municipalities in one region:

- **Gorizia:** Grado, Staranzano

Romania: 12 municipalities in two regions:

- **Constanța:** Eight municipalities above the threshold
- **Tulcea:** Jurilovca, Murighiol, Oras Sulina, Sfantu Gheorghe

Countries are listed in alphabetical order; municipalities are listed only for regions(at NUTS3 level) with five or less 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: 7 August 2026

5. World Pride – Netherlands – 2026

Overview:

Update

Since the start of the monitoring period on 20 July and as of 14 August, no major public health events related to communicable diseases have been detected in the context of World Pride 2026.

Summary

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

Background

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 this population group, 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](#).

[Joint public health advice for World Pride 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. The aim of this advice was to help make sure everyone could 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 their 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 or symptoms suggestive of mpox or 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, they 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:

World Pride 2026 in Amsterdam is now over; however, for information purposes, ECDC's assessment for this mass gathering was as follows:

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 World Pride 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 World Pride events in the Netherlands, 2026](#).

Actions:

ECDC monitored this mass gathering event through epidemic intelligence activities between 20 July and 14 August 2026, in collaboration with the Dutch health authorities and WHO's Regional Office for Europe.

Previous weekly updates related to World Pride 2026 are available 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: 7 August 2026

6. Seasonal surveillance of chikungunya virus disease – 2026 (weekly)

Overview:

Since the beginning of 2026 and as at 12 August 2026, only France has reported locally acquired cases (15 cases) of chikungunya virus disease in Europe.

In the past week, France reported eight new cases of locally acquired cases of chikungunya virus disease. Currently there are two active clusters.

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, ECDC 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.

Last time this event was included in the Weekly CDTR: 7 August 2026

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

Overview:

Since the beginning of 2026 and as at 12 August 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](#). 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: 7 August 2026

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

Overview:

Since the beginning of the 2026 transmission season, and as at 13 August, 77 areas affected by West Nile virus (WNV) have been identified in nine countries across Europe.

These areas are located in Italy (40), Greece (13), Romania (12), France (four), North Macedonia (three), Spain (two), Germany (one), Kosovo (one) and Serbia (one). This week, 19 areas are reported as affected for the first time this season.

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](#) is also published.

WNV infection in humans is a notifiable disease at the EU level and cases should be reported by national public health authorities through the EpiPulse Cases platform 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: 7 August 2026

9. Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report)

Overview:***Findings from human surveillance***

In 2026, and as at 5 August, seven countries in Europe have reported 245 locally acquired [1] human cases of West Nile Virus (WNV) infection. The earliest and latest dates of onset were 12 May 2026 and 1 August 2026, respectively. Locally acquired cases have been reported by **Italy** (139 cases), **Greece** (65, of which four with unknown place of infection), **Spain** (17 cases), **North Macedonia** (13 cases), **Romania** (six cases), **France** (four cases) and **Germany** (one case). In Europe, 12 deaths have been reported by **Greece** (six deaths), **Italy** (five deaths) and **Romania** (one death).

The number of human cases reported so far (245 cases) is below the average for the corresponding period over the past decade (403 cases). However, reporting delays may result in an under-estimation of the current burden.

As at 5 August 2026, locally acquired human cases of WNV infection had been reported in 58 NUTS 3 regions across seven countries. This is higher than at the same point in 2025, when cases were reported in 40 NUTS 3 regions across six countries.

This year, six regions reported locally acquired human cases of WNV infection for the first time ever: **France** in Pyrénées-Orientales (FRJ15); **Germany** in Rhein-Pfalz-Kreis (DEB3I); **Italy** in Campobasso (ITF22) and Viterbo (ITI41); and **North Macedonia** in Pelagoniski (MK005) and Vardarski (MK001).

Similar to previous years, most cases were reported in men aged 65 years old and above. Most cases were hospitalised (72%) and presented with neurological symptoms (58%). The proportion hospitalised was lower than the average reported during the previous decade (87%), and the proportion with neurological symptoms was also slightly lower than the historical 10-year average (64%). The case fatality rate was approximately 5%, lower than the average reported during the previous decade (11%). However, this estimate should be interpreted with caution, as clinical outcomes may not yet be known for all reported cases and additional deaths may be recorded as the season progresses and data are consolidated.

Findings from veterinary surveillance

From the veterinary perspective, 17 WNV outbreaks among equids and 74 outbreaks among birds have been reported in Europe in 2026. The earliest start date of an outbreak among equids and birds was 30 March 2026 in France and 31 March 2026 in Italy, while the latest onset of an outbreak among equids and birds was on 31 July 2026 in the Netherlands and 28 July 2026 in Italy. Outbreaks among equids have been reported by **France** (five outbreaks), **Greece** (five outbreaks), **Italy** (five outbreaks), **the Netherlands** (one outbreak) and **Spain** (one outbreak). Outbreaks among birds have been reported by **Italy** (64 outbreaks), **France** (five outbreaks), **Spain** (three outbreaks), **Austria** (one outbreak) and **Belgium** (one outbreak).

Patterns across human and veterinary surveillance

Four countries – **France**, **Greece**, **Italy** and **Spain** – reported both human WNV infections and outbreaks in equids and/or birds. As at 5 August, **Italy** accounted for most of the reported human cases (56.7%) and animal outbreaks (75.8%). **Greece** reported the second largest share of human cases (26.5%) but only five equid outbreaks and no bird outbreaks, representing 5.5% of all reported animal outbreaks.

Differences in the patterns observed across European countries may reflect a combination of ecological, climatic and surveillance-related factors. Favourable climatic conditions and the presence of ecological hotspots, such as wetlands and agricultural areas, may support mosquito vector populations and influence the distribution and behaviour of animal hosts, thereby facilitating WNV circulation. At the same time, differences in WNV surveillance systems across Europe may affect detection and reporting rates.

In **France** (Pyrénées-Orientales, FRJ15), **Greece** (Drama, EL514), and **Italy** (Genova, ITC33), human cases were reported before, or in the absence of, notified outbreaks in birds or equids. Conversely, in **Belgium** (Arr. Namur, BE352), **France** (Hauts-de-Seine, FR105 and Seine-et-Marne, FR102) and **the Netherlands** (Delft en Westland, NL362), animal detections preceded human cases. **Belgium** is a relevant example, as WNV was first reported in the country in 2025 through avian surveillance, with no previous detections in humans or animals. In 2026, it has again been identified in birds in a previously unaffected region, highlighting the role of avian surveillance in detecting local virus circulation and geographical spread.

More information

The full monthly epidemiological report on human and animal surveillance data including maps and graphs is available at: [Monthly updates: 2026 West Nile virus transmission season \(europa.eu\)](#).

Updated figures on human WNV infections are published weekly at: ([Weekly updates: 2026 West Nile virus transmission season \(europa.eu\)](#)).

More background information on the Commission Directives on blood safety and EU/EEA notifications of WNV infections can be found [here](#).

ECDC assessment:

Given the favourable weather conditions for WNV transmission in Europe, ECDC and EFSA expect further human cases and outbreaks in equids and birds to be reported in the coming weeks. In previous years, transmission has typically peaked in August and September.

Actions:

ECDC is monitoring WNV infections through indicator- and event-based surveillance activities.

Last time this event was included in the Weekly CDTR: 3 July 2026

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

Overview:

Since the beginning of 2026, and as at 12 August 2026, only Spain has reported locally acquired cases (three cases) of Crimean-Congo haemorrhagic fever (CCHF) in Europe. In the past week, no new case of CCHF have been reported to ECDC.

The report is available [online](#).

ECDC assessment:

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 outdoor 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, ECDC 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: 7 August 2026

11. Crimean-Congo haemorrhagic fever in Albania, 2026

Overview:

The Albanian public health authorities reported a case of Crimean-Congo haemorrhagic fever (CCHF) in the Tropojë district at the northern part of the country. The patient is a livestock farmer and owns animals. The date disease onset was 22 July 2026, and the patient was hospitalised on 24 July 2026. Subsequently the patient has recovered and been discharged from hospital. Samples from the case tested positive for both CCHF virus RNA by RT-PCR and CCHF-specific antibodies by serology test. The diagnosis was confirmed on 4 August 2026. Entomological investigations are ongoing.

ECDC assessment:

The case was reported in a region which has not previously been recognised as endemic for CCHF in Albania. However, CCHF cases were reported in the same county (Kukës); the latest one in 2023. The tick species *Hyalomma marginatum*, which is the principal vector of the CCHF virus, has been [detected in almost all regions of the country](#).

The likelihood of infection for EU/EEA citizens travelling to or residing in Albania is very low. However, considering the potentially severe or lethal disease outcome, personal protective measures against tick bites should be applied, infesting ticks should be removed, and in case of febrile clinical symptoms, patients should seek medical care. General practitioners should be informed about the patients' history of previous travel and tick bites.

Actions:

ECDC continues monitoring this event.

Further information:

Further details on CCHF are available in [ECDC's website](#).

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

12. Mpox in the EU/EEA, Western Balkans and Türkiye – 2026

Overview:

The [monthly surveillance report on mpox in the EU/EEA, Western Balkans and Türkiye](#), covering the period up to July 2026 has been published on ECDC's website.

July 2026 update

In July 2026, 153 mpox cases caused by clade I MPXV were reported by 12 countries, with the largest number of cases reported by Portugal (68).

In July 2026, 12 mpox clade II cases were reported by five countries, with the largest number of cases reported by France (7).

[Overview of the past 12 months \(August 2025 to July 2026\)](#)

In the past 12 months, 20 countries have reported 1 083 clade I mpox cases and 19 countries have reported 888 clade II mpox cases.

Among cases with complete information:

- In total, 89% of clade I mpox cases and 91% of clade II mpox cases were reported among men who have sex with men.
- Overall, 12% of clade I mpox cases and 8% of clade II mpox cases were hospitalised. Two deaths have been reported among people infected with clade II MPXV; no deaths have been reported in people infected with clade I MPXV.
- A total of 22% of clade I mpox cases and 20% of clade II mpox cases with known vaccination status had received two vaccine doses.

Following increases observed in late 2025 and early 2026, the number of clade I mpox cases reported in the EU/EEA remains relatively stable, while the number of reported clade II mpox cases continues to decline.

However, interpretation of trends is limited due to missing clade information for a substantial proportion of reported cases, and case and epidemiological information may be updated retrospectively.

Based on information provided by Member States, clinical presentation is generally mild, including among hospitalised cases. Clades Ib and IIb account for the vast majority of reported mpox cases. Among cases with known clade, only one case of clade Ia and three cases of clade IIa have been reported in the EU/EEA since the start of surveillance in 2022.

ECDC assessment:

Both clade I and clade II mpox cases continue to be reported across the EU/EEA, with generally mild clinical presentation.

While early clade I cases were mainly imported from outside the EU/EEA and reported among heterosexual individuals and their close contacts, most cases are now reported among men who have sex with men. Transmission in these networks is observed for both clades and occurs predominantly among unvaccinated individuals.

With increased travel over the summer and attendance at mass gatherings such as Pride events, there is a risk for further spread of both clade I and clade II mpox.

The risk assessment in ECDC's [Threat Assessment Brief](#) published on 24 October 2025 remains valid: 'The risk of clade Ib infection is assessed as moderate for men who have sex with men and low for the general population in the EU/EEA. The risk for clade IIb infection remains low for men who have sex with men and very low for the general population in the EU/EEA.'

Actions:

ECDC's [Threat Assessment Brief](#) outlines actions that EU/EEA countries can take. ECDC continues to monitor mpox in the EU/EEA and globally through event- and indicator-based surveillance and collaboration with partners.

EU/EEA countries are encouraged to **increase vaccination uptake**, particularly among populations at higher risk of exposure, including men who have sex with men. Increasing vaccination coverage remains the most important intervention to mitigate the spread of both clades, particularly during the spring and summer season. **Health promotion and community engagement** are also critical to ensure effective outreach and high vaccine acceptance and uptake among those most at risk of exposure.

Primary preventive vaccination (PPV) and post-exposure preventive vaccination (PEPV) strategies may be combined to target individuals at substantially higher risk of exposure and close contacts of cases, respectively, particularly in the event of limited vaccine supply. PPV strategies should prioritise gay, bisexual, and transgender people, and men who have sex with men, who are at higher risk of exposure. Strategies should also prioritise individuals at risk of occupational exposure, based on epidemiological or behavioural criteria.

Further response options for EU/EEA countries include:

- raising awareness among healthcare professionals;
- supporting sexual health services in case detection, contact tracing, and case management;
- ensuring testing is easily accessible.

Countries should **continue efforts to sequence** all confirmed cases and ensure that sequences are deposited in public repositories (European Nucleotide Archive (ENA), Sequence Read Archive (SRA), and/or GISAID EpiPox (GISAID's mpox genomic surveillance platform)) or shared with ECDC through the EpiPulse platform.

Further information:

- The [Weekly Communicable Diseases Threats Report](#) and ECDC's [Mpox worldwide overview webpage](#) provide further information about the global epidemiological situation of mpox caused by clades I and II MPXV.
- ECDC's [Threat Assessment Brief on the detection of autochthonous transmission of monkeypox virus \(MPXV\) clade Ib in the EU/EEA](#), published on 24 October 2025, summarises the epidemiological situation, outlines recommended response measures, and highlights remaining knowledge gaps.

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

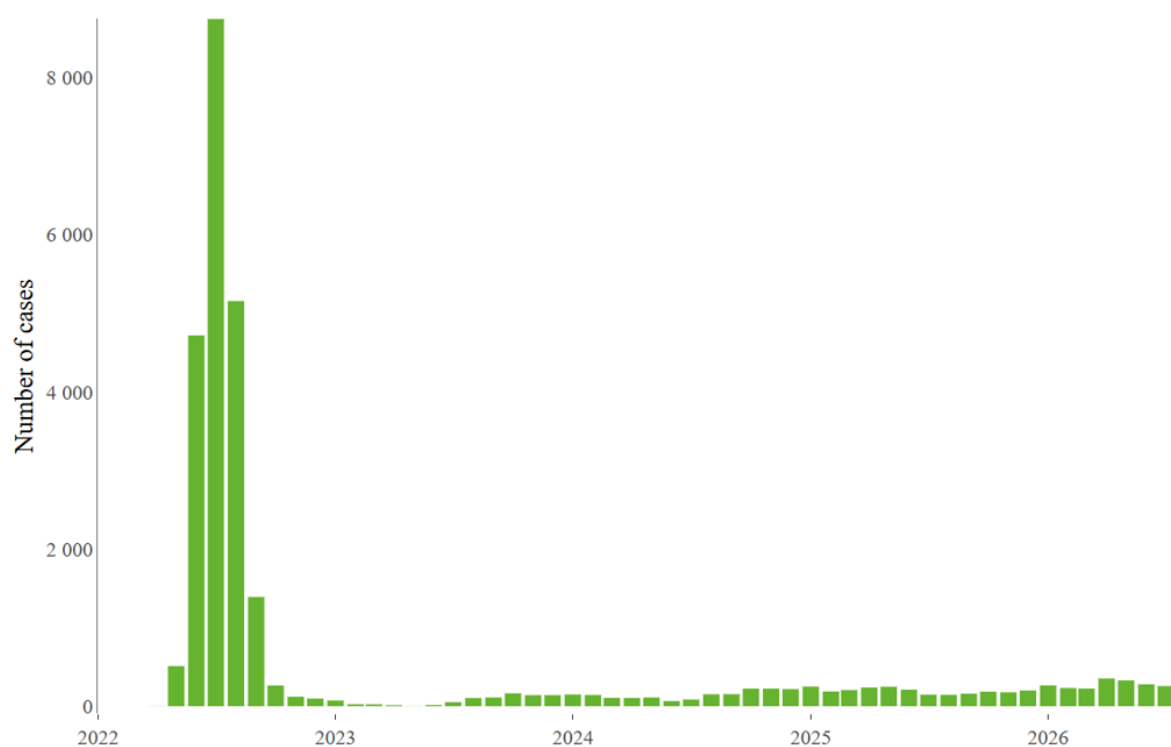
Maps and graphs

Figure 9. Mpox cases by clade in the past 12 months (August 2025 to July 2026), and past month (July 2026), EU/EEA

Country	Clade I		Clade II		Clade Unknown	
	Past 12 months	Past month	Past 12 months	Past month	Past 12 months	Past month
Austria	14	1	10			
Belgium	43		8		131	4
Croatia					2	
Czechia	7		2			
Denmark	8	1	1			
Finland					1	
France	170	19	60	7	84	19
Germany	151	26	147	2	155	11
Greece	8		1		1	
Hungary	1	1	2			
Iceland					1	
Ireland	25	11	24		1	1
Italy	79	5	8	1	81	4
Lithuania	1				1	
Luxembourg	3		4			
Malta			3			
Netherlands	54	10	68	1	11	5
Norway	1		9			
Poland	3	1	2		16	1
Portugal	172	68	63		64	
Romania	2					
Slovakia	4				1	
Slovenia			1			
Spain	303	7	468	1	285	43
Sweden	34	3	7		7	4
EU/EEA total	1 083	163	888	12	842	92

Source: ECDC

Figure 10. Total number of mpox cases (all clades) from January 2022 and as of August 11, EU/EEA



Source: ECDC

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - 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
- Human cases of swine influenza A(H3N2) variant virus – Multi-country - last reported on 17 July 2026
- Influenza A(H5)- Multi-country (World)- Monitoring human cases - last reported on 17 July 2026
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 17 July 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 14 August 2026
- Expert deployment - last reported on 14 August 2026
- Seasonal surveillance of chikungunya virus disease – 2026 (weekly) - last reported on 14 August 2026
- Seasonal surveillance of dengue in the EU/EEA, weekly report - last reported on 14 August 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (Weekly report) - last reported on 14 August 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report) - last reported on 14 August 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report) - last reported on 14 August 2026
- Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters – Bathing season 2026 - last reported on 14 August 2026
- World Pride – Netherlands – 2026 - last reported on 14 August 2026

- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 14 August 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 31, 2026 - last reported on 14 August 2026
- Crimean-Congo haemorrhagic fever in Albania, 2026 - last reported on 14 August 2026
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 07 August 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 07 August 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 07 August 2026