WEEKLY BULLETIN

Communicable disease threats report

Week 10, 28 February to 6 March 2026

This week's topics

Executive Summary

Overview of respiratory virus epidemiology in the EU/EEA

- **Summary:** Primary care consultations for respiratory illness have returned to baseline levels in more than half of reporting countries, indicating that respiratory virus circulation has declined across much of the EU/EEA in recent weeks.
- **Influenza virus** circulation, while still widespread, continues to decrease in most countries, with over half now reporting baseline or low intensity levels. Hospitalisations are also decreasing, with adults 65 years old and above accounting for most admissions. Influenza A(H3) remains the dominant subtype, followed by A(H1)pdm09.
- **Respiratory syncytial virus (RSV)** circulation remains high but has begun to slowly decline. RSV hospitalisations appear to have peaked overall, but not in children under five years old, who continue to account for most admissions.
- **SARS-CoV-2** circulation remains low in all age groups, with very few hospitalisations reported.
- EuroMOMO reported all-cause mortality shows a declining trend in recent weeks across all age groups, following a period of above-expected mortality from weeks 1–7 of 2026.

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'.

European Centre for Disease Prevention and Control, Solna, Sweden
www.ecdc.europa.eu

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

- Since the previous update on 3 February 2026, and as of 2 March 2026, no new MERS cases have been reported by the World Health Organization (WHO) or national health authorities.
- Since the beginning of 2026, and as of 2 March 2026, no MERS cases have been reported by WHO or national health authorities.
- The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in the general population is also considered to be low. The current MERS-CoV situation poses a low risk to the EU/EEA.

SARS-CoV-2 variant classification

- Since the last update on 30 January 2026, and as of 27 February 2026, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) or De-escalated variants.
- For this update, sufficient data for estimating variant proportions during the reporting weeks were only available from two EU/EEA countries. Therefore, the statistics below only represent a limited part of the EU/EEA.
- The VOI and VUM median proportions in the EU/EEA for weeks 6–7, 2026 were:
  - BA.2.86 (VOI): 0.0% (range: 0.0–0.0%; interquartile range (IQR): 0.0–0.0%)
  - NB.1.8.1 (VUM): 9.1% (range: 0.0–18.2%; IQR: 4.5–13.6%)
  - XFG (VUM): 66% (range: 36.4–95.7%, IQR: 51.2–80.8%)
  - BA.3.2 (VUM): 0% (range: 0.0–0%, IQR: 0.0–0%).

Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

- Since the previous update and as of 5 March, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic and Paralympic Games.
- ECDC continues to monitor this event until 20 March. The Winter Paralympic Games Milano Cortina 2026 start on 6 March 2026 and run until 15 March.
- The probability of EU/EEA residents becoming infected with communicable diseases during the Winter Olympic and Paralympic Games 2026 is low, if general preventive measures are applied.

Chikungunya virus disease – Mayotte, France – 2026

- There is an intensification of chikungunya virus circulation in Mayotte, France, with over 270 cases reported since 1 January 2026.
- The current likelihood of chikungunya virus infection for travellers to Mayotte is moderate. Travellers should be advised to take enhanced mosquito bite prevention measures. Vaccination of travellers may be considered, based on national recommendations.

1. Overview of respiratory virus epidemiology in the EU/EEA

Overview:

ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary (ERVISS.org), which is updated weekly.

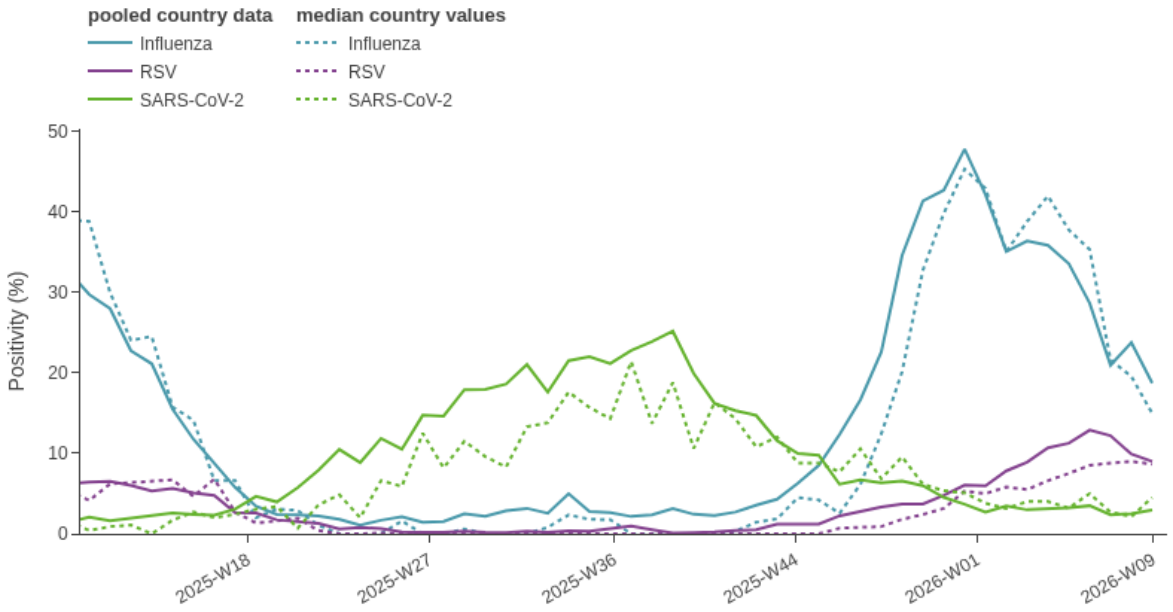
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 27 February 2026

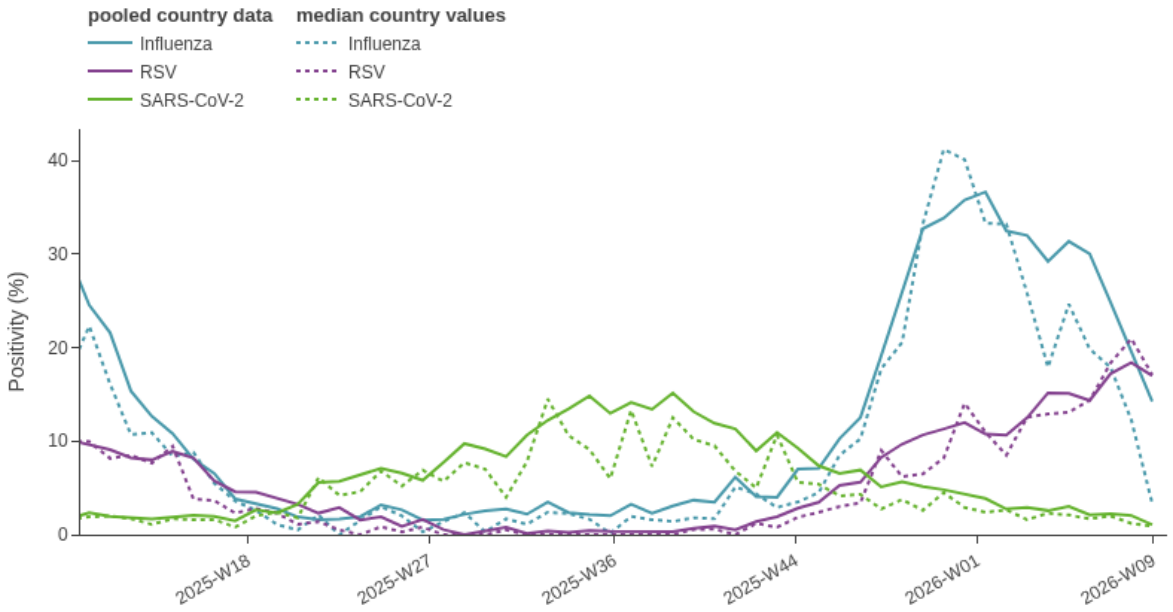
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 3. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 9	Week 8	Description	Value
ILI/ARI consultation rates in primary care	ARI	15 rates (10 MEM)	17 rates (10 MEM)	Distribution of country MEM categories	8 Baseline 2 Low
	ILI	20 rates (18 MEM)	21 rates (19 MEM)		11 Baseline 6 Low 1 Medium
ILI/ARI test positivity in primary care	Influenza	20	19	Pooled (median; IQR)	19% (15; 4.6–35%)
	RSV	19	18		9% (8.7; 5.2–13%)
	SARS-CoV-2	18	17		2.9% (4.5; 1.1–5.8%)
SARI rates in hospitals	SARI	10 rates (5 MEM)	12 rates (6 MEM)	Distribution of country MEM categories	5 Baseline
SARI test positivity in hospitals	Influenza	9	10	Pooled (median; IQR)	14% (3.4; 2–7.8%)
	RSV	9	10		17% (17; 12–29%)
	SARS-CoV-2	8	10		1.1% (0.9; 0–2%)
Intensity (country-defined)	Influenza	22	24	Distribution of country qualitative categories	5 Baseline 12 Low 4 Medium 1 High
Geographic spread (country-defined)	Influenza	20	23	Distribution of country qualitative categories	3 Sporadic 2 Local 2 Regional 13 Widespread

Source: ECDC

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

	Week 9, 2026		Week 40, 2025 – week 9, 2026	
Pathogen	N	%[a]	N	%[a]
Influenza	**382**	–	**17613**	–
Influenza A	369	98	17084	99
A(H1)pdm09	91	36	3815	27
A(H3)	162	64	10261	73
A (unknown)	116	–	3008	–
Influenza B	7	2	86	0.5
B/Vic	2	100	27	100
B (unknown)	5	–	59	–
Influenza untyped	6	–	443	–
RSV	**164**	–	**3632**	–
RSV-A	14	23	656	48
RSV-B	46	77	713	52
RSV untyped	104	–	2263	–
SARS-CoV-2	**52**	–	**3711**	–

Source: ECDC

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

	Week 9, 2026		Week 40, 2025 – week 9, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**229**	**–**	**13612**	**–**
Influenza A	21	91	8020	99
A(H1)pdm09	4	57	1265	36
A(H3)	3	43	2298	64
A (unknown)	14	–	4457	–
Influenza B	2	9	47	0.6
B/Vic	0	–	4	100
B (unknown)	2	–	43	–
Influenza untyped	206	–	5545	–
RSV	**270**	**–**	**4909**	**–**
RSV-A	12	43	990	55
RSV-B	16	57	794	45
RSV untyped	242	–	3125	–
SARS-CoV-2	**16**	**–**	**2614**	**–**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 to week 9, 2026

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	2577	40	5a.2a.1(D.3.1)	2540	99
			5a.2a.1(D)	31	1
			5a.2a(C.1.9.3)	6	0.2
A(H3)	3827	59	2a.3a.1(K)	3462	90
			2a.3a.1(J.2)	242	6
			2a.3a.1(J.2.4)	77	2
			2a.3a.1(J.2.2)	29	0.8
			2a.3a.1(J)	17	0.4
B/Vic	28	0.4	V1A.3a.2(C.5.6)	9	32
			V1A.3a.2(C.5.6.1)	8	29
			V1A.3a.2(C.5.1)	7	25
			V1A.3a.2(C.5)	2	7
			V1A.3a.2(C.5.7)	2	7

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, week 7, 2026 to week 8, 2026

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	0	0	0%
NB.1.8.1	VUM	1	10	62% (62–62%)
XFG	VUM	1	6	38% (38–38%)
BA.3.2	VUM	0	0	0%

Source: ECDC

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

Overview:

Update: Since the previous update on 3 February 2026, and as of 2 March 2026, no new MERS cases have been reported by the World Health Organization (WHO) or national health authorities.

Summary: Since the beginning of 2026, and as of 2 March 2026, no MERS cases have been reported by WHO or national health authorities.

Since April 2012, and as of 2 March 2026, a total of 2 647 MERS cases, including 959 deaths, have been reported by health authorities worldwide.

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

ECDC assessment:

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

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

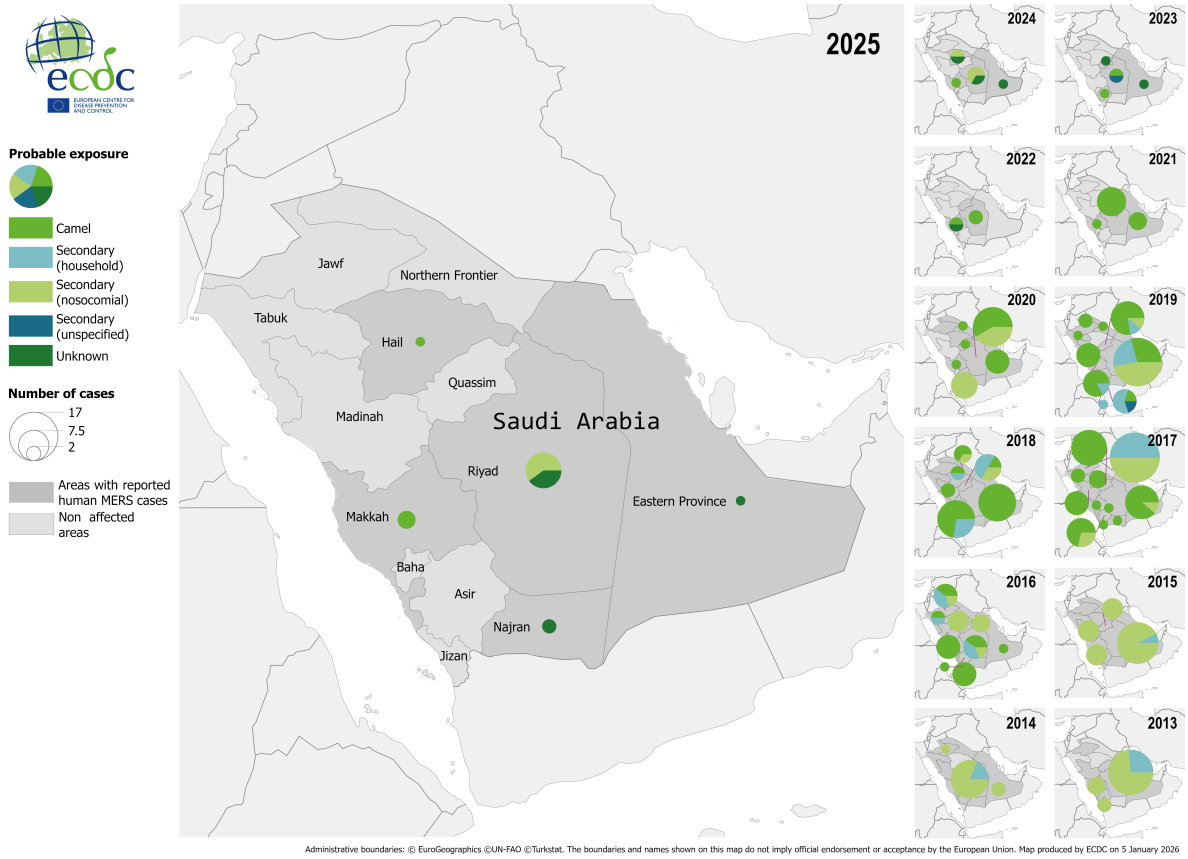
Actions:

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

Last time this event was included in the Weekly CDTR: 6 February 2026

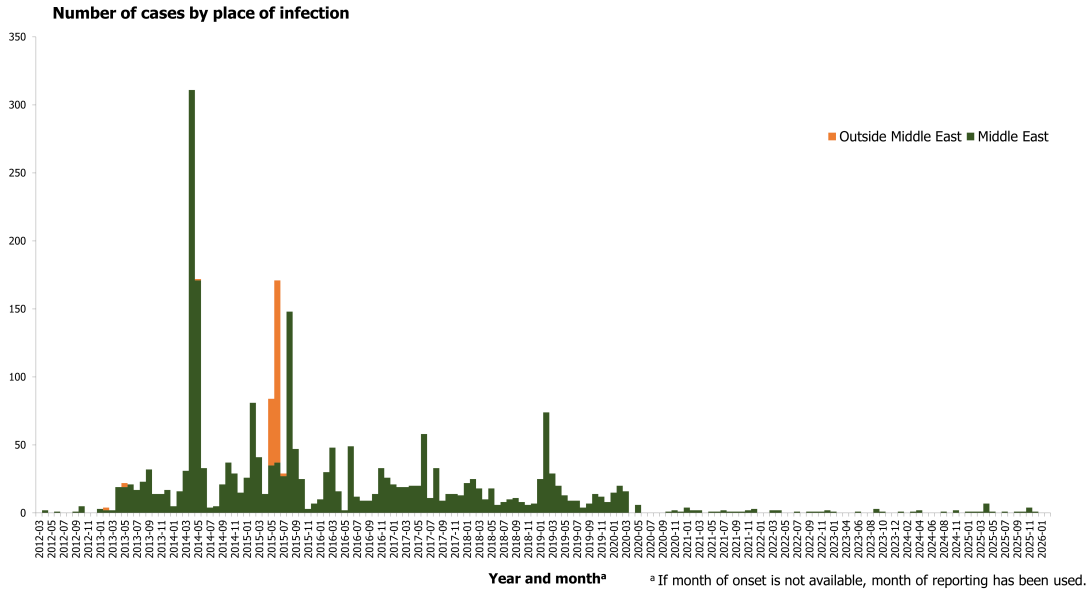
Maps and graphs

Figure 8. Geographical distribution of confirmed cases of MERS in Saudi Arabia by probable region of infection and exposure, with dates of onset from January 2013 to December 2025



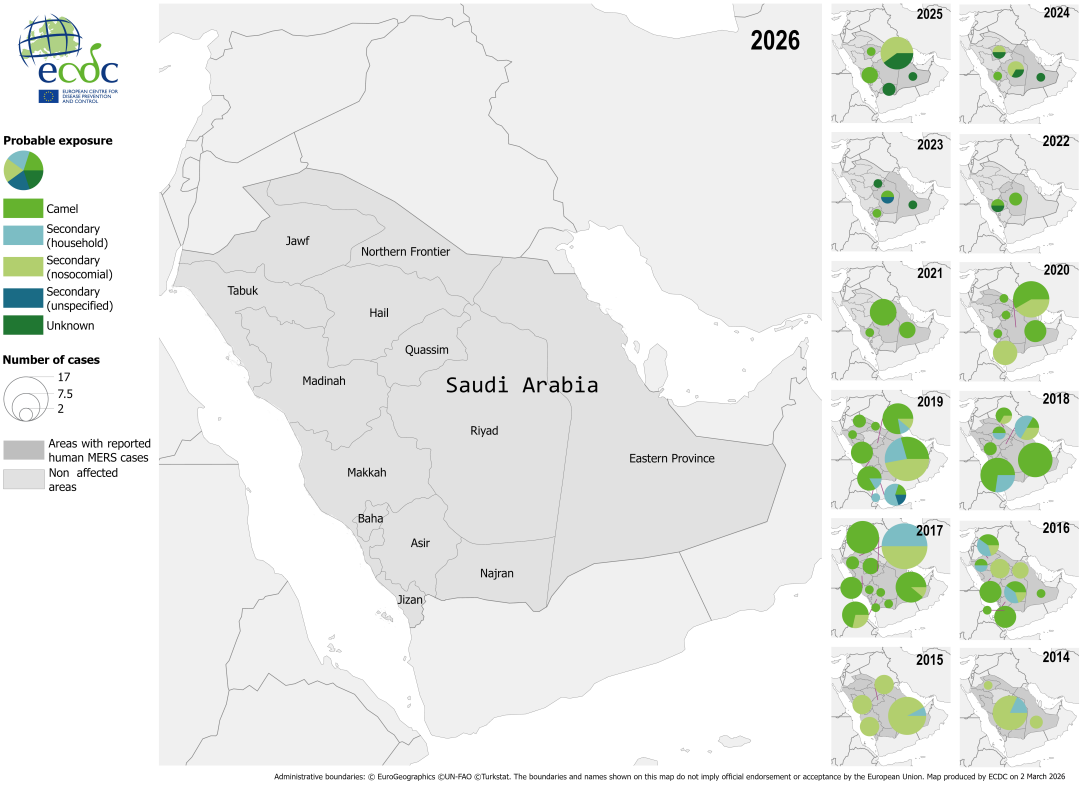
Source: ECDC

Figure 9. Distribution of confirmed cases of MERS by place of infection and month of onset, April 2012 to February 2026



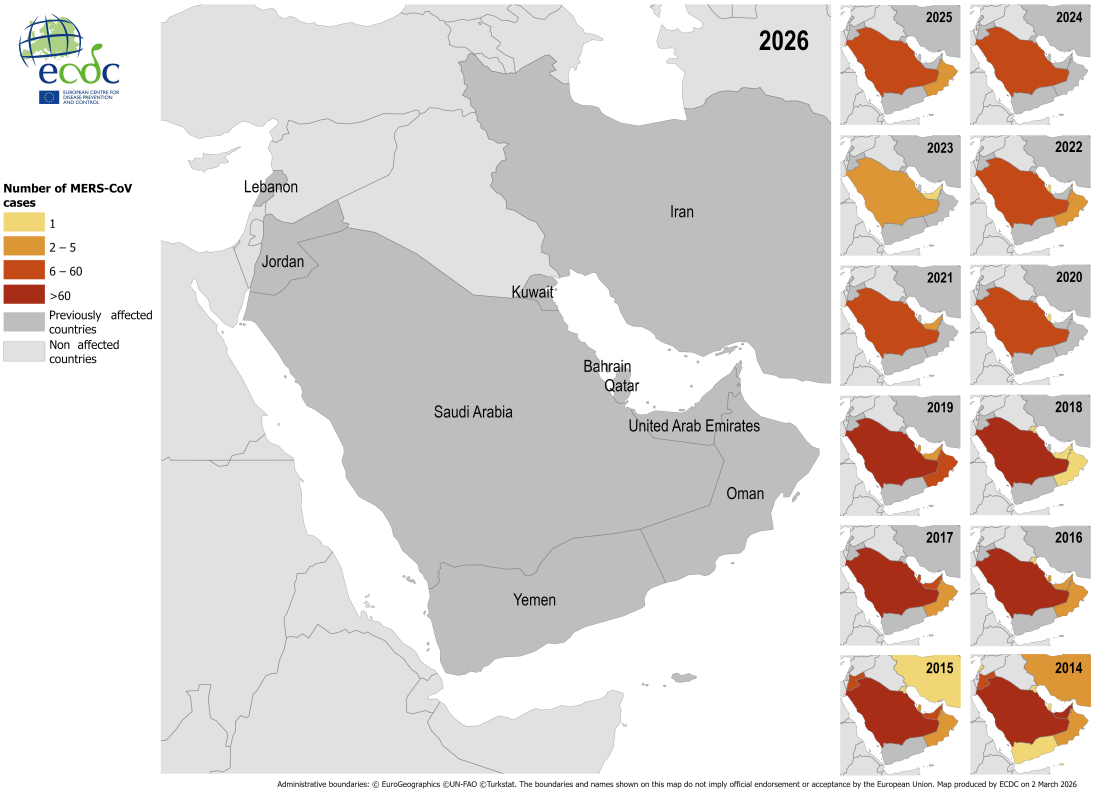
Source: ECDC

Figure 10. Geographical distribution of confirmed cases of MERS in Saudi Arabia by probable region of infection and exposure, with dates of onset from January 2014 to February 2026



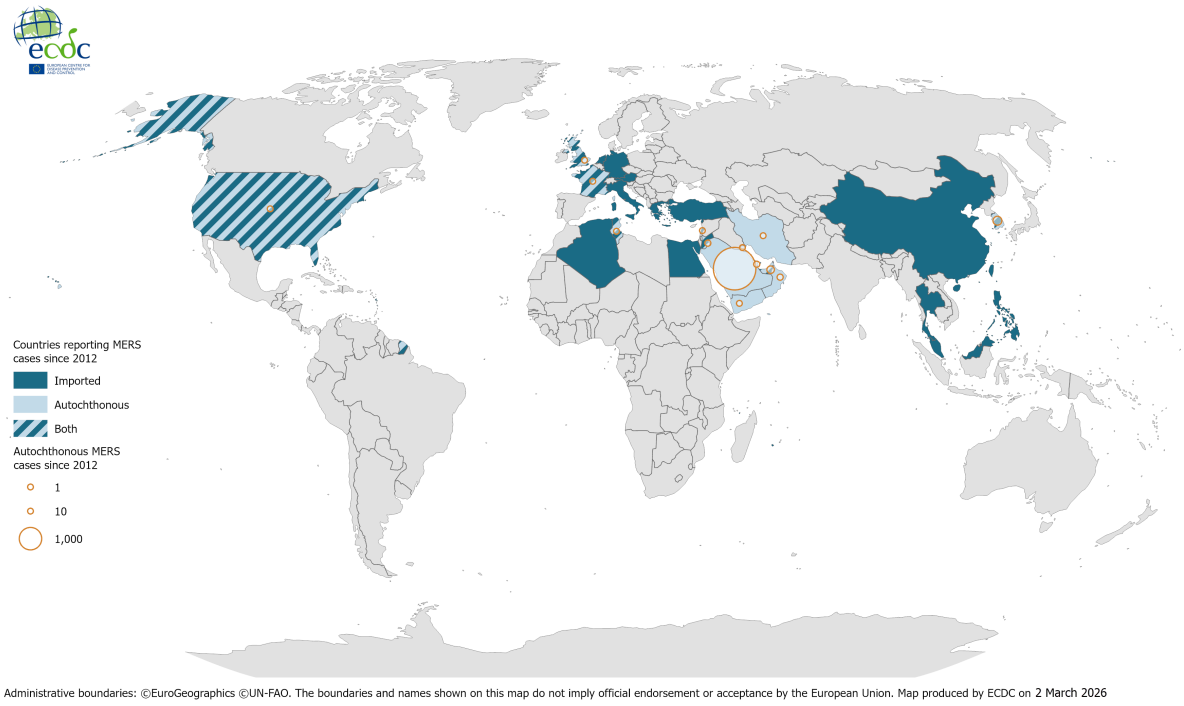
Source: ECDC

Figure 11. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2014 to February 2026



Source: ECDC

Figure 12. Geographical distribution of confirmed cases of MERS by reporting country, April 2012 to February 2026



Source: ECDC

3. SARS-CoV-2 variant classification

Overview:

Since the last update on 30 January 2026, and as of 27 February 2026, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) or De-escalated variants.

An increase in detections of BA.3.2 has been observed in two EU/EEA countries in recent weeks, with the variant circulating at a proportion greater than 40% in Germany and the Netherlands in week 1, 2026. However, estimates are subject to considerable uncertainty due to low levels of SARS-CoV-2 circulation and low numbers of sequence submissions, with no recent submissions belonging to BA.3.2 for weeks 6–7 2026.

The VOI median proportions in the EU/EEA for weeks 6–7 2026, based on two reporting countries:

BA.2.86 (VOI): 0.0% (range: 0.0–0.0%; IQR: 0.0–0.0%).

The VUM median proportions in the EU/EEA for weeks 6–7 2026, based on two reporting countries:

NB.1.8.1 (VUM): 9.1% (range: 0.0–18.2%; IQR: 4.5–13.6%)
XFG (VUM): 66% (range: 36.4–95.7%; IQR: 51.2–80.8%)
BA.3.2 (VUM): 0% (range: 0.0–0%; IQR: 0.0–0%).

The calculations are based on data reported to GISAID, as of 22 February 2026. Note that for this update, sufficient data for estimating variant proportions during the reporting weeks were only available from two EU/EEA countries. The statistics therefore only represent a very limited part of the EU/EEA.

ECDC assessment:

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

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

Actions:

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

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

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

Last time this event was included in the Weekly CDTR: 6 February 2026

4. Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

Overview:

Update
Since the previous update and as of 5 March 2026, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic and Paralympic Games.

Summary
The Winter Olympic Games Milano Cortina 2026 finished on 22 February. During the mass gathering event, no major public health events related to communicable diseases were detected. There were limited outbreaks reported among athletes in the Olympic Village. These outbreaks were related to gastrointestinal and influenza-like illnesses. Outside of the Olympic Village, there was no indication of communicable disease transmission among attendees linked to their attandance at Olympic venues.

ECDC will continuously monitor this mass gathering event until 20 March. The Winter Paralympic Games Milano Cortina 2026 start on 6 March and run until 15 March 2026.

Background
The Paralympic Winter Games take place 6–15 March 2026 with more than 600 athletes competing. The Opening Ceremony will take place at Verona's Olympic Arena. Milan will host the Para ice hockey tournament. Wheelchair curling, Para Alpine skiing, Para snowboard competitions and the Closing Ceremony will be hosted in Cortina. Val di Fiemme will host the Para cross-country skiing and biathlon.

The Winter Olympic Games Milano Cortina 2026 took place 4–22 February 2026. The competitions started on 4 February, with the Opening Ceremony on 6 February at San Siro Stadium, Milan and the Closing Ceremony on 22 February at Verona Arena. The Game spread across northern Italy, primarily in Milan and Cortina d'Ampezzo, with additional events in Valtellina, Val di Fiemme, and Anterselva/Antholz. More than 2 900 athletes and participants participated from over 90 countries. Organisers anticipated hundreds of thousands of spectators at the various venues, surpassing one million cumulative attendees.

ECDC assessment:

Mass gathering events involve a large number of visitors in one area at the same time. Multiple factors can lead to the emergence of a public health threat, such as an imported disease, increased numbers of susceptible people, risk behaviour, sale of food and beverages by street vendors, etc. At the same time, non-communicable health risks, including crowd or extreme weather-related injuries and drug- and alcohol-related conditions, should also be considered by the organisers and the public health authorities of the hosting country.

The Winter Olympic and Paralympic Games 2026 is a mass gathering involving multiple events in different event locations that take place from February to March. The general assessment provided below refers to the probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games. However, if specific public health events with potential impact at local, national and EU/EEA levels are identified, they will be assessed separately.

The probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games 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 adopting safer sexual practice. This is particularly important in relation to vaccine-preventable diseases that may be on the rise in the EU/EEA, such as measles, whooping cough, and respiratory infections including influenza and COVID-19. In view of the earlier start of the influenza season 2025/26 in November 2025, ECDC urges those eligible to get vaccinated without delay. ECDC has published recommendations for those attending this mass gathering event.

Actions:

ECDC is monitoring this mass gathering event through epidemic intelligence activities and close collaboration with the Italian National Institute of Health (Istituto Superiore di Sanità) and other partners. Updates with relevant signals and events are being provided on a weekly basis.

Last time this event was included in the Weekly CDTR: 27 February 2026

5. Chikungunya virus disease – Mayotte, France – 2026

Overview:

There is an intensification of chikungunya virus circulation in Mayotte, France. Since 1 January 2026, over 270 confirmed autochthonous cases were identified, with a weekly average of 65 cases in the last two weeks of February.

Mayotte was also affected by an outbreak in 2025, with 1 270 confirmed chikungunya virus disease cases and a peak during week 21, 2025 with 232 cases. The number of chikungunya virus disease cases in 2025 was likely underestimated due to low access to healthcare in several areas of Mayotte island in the aftermath of the devastating Chido cyclone.

In 2025, a major outbreak affected La Réunion, leading to 66% population immunity on the island. Several autochthonous cases were also registered in other regions of the Indian Ocean.

In 2026, the Seychelles have reported several chikungunya virus disease cases, and chikungunya virus circulation is again identified in La Réunion, Mauritius, Madagascar and Comoros islands.

For global epidemiological updates, see ECDC's dedicated chikungunya virus disease worldwide overview webpage.

ECDC assessment:

It is currently the rainy season in Mayotte, which favours *Aedes* mosquito proliferation and the spread of chikungunya virus; the season is expected to end in April. The probability of infection for travellers is assessed as moderate.

The outbreak is expected to continue for the coming months, making it important to strengthen communication to travellers and travel medicine clinics regarding the ongoing outbreak and the need for reinforced preventive measures. Protective measures include using mosquito repellent, sleeping under a mosquito net or in a screened or air-conditioned room, and wearing clothing that covers most of the body. Vaccination may also be considered in line with recommendations in their country of origin.

The likelihood of onward transmission of chikungunya virus in mainland Europe following introduction by a viraemic traveller is currently considered low, as environmental conditions are not favourable for *Aedes* mosquito activity and virus replication in mosquitoes at this time of year. See ECDC's chikungunya virus disease risk assessment for mainland EU/EEA.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities.

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

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Overview of respiratory virus epidemiology in the EU/EEA
- Bacillus cereus toxin in infant formula
- Nipah virus disease – India and Bangladesh – 2026
- Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles
- Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026
- Human cases of influenza virus A(H1N1) variant of swine origin – Multi-country
- Mpox clade Ib and clade IIb recombinant strain
- Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2026
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Chikungunya virus disease – Mayotte, France – 2026
- SARS-CoV-2 variant classification
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026