WEEKLY BULLETIN

Communicable disease threats report

Week 21, 16–22 May 2026

This week's topics

Executive Summary

Hantavirus disease outbreak on cruise ship – South Atlantic – 2026

- As of 22 May 2026, a total of 11 cases of Andes virus (ANDV) disease have been reported, including nine confirmed and two probable. No new cases or deaths have been reported since the previous update.
- Disembarkation and evacuation of passengers and crew from the cruise ship *M/V Hondius* were carried out in Tenerife, Canary Islands between 10–11 May and in Rotterdam, the Netherlands on 18 May. The ship has been docked in Rotterdam undergoing disinfection since 18 May.
- Preliminary genome sequencing analysis from some of the positive cases confirmed a high level of genetic similarity between isolates, likely indicating an initial zoonotic spillover event followed by human-to-human transmission.
- The risk to the general population in the EU/EEA from ANDV spreading from this cruise ship outbreak remains very low.

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

- Based on the available information as of 21 May 2026, over 650 suspected cases, including 160 related deaths, have been reported in the Democratic Republic of the Congo (DRC; Ituri and

North Kivu Provinces) and Uganda. Sixty four confirmed cases have been reported from DRC and two from Uganda.
- Preliminary genomic analysis shows that the sequences are distinct from the 2007 and 2012 Bundibugyo virus outbreaks.
- On 17 May 2026, WHO declared that the Ebola disease outbreak due to Bundibugyo virus constitutes a Public Health Emergency of International Concern and on 18 May 2026 Africa CDC declared a Public Health Emergency of Continental Security.
- Considering all the available information and uncertainties about this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. For people living in the EU/EEA, the likelihood of infection is estimated to be very low, given the very low likelihood of importation and secondary transmission. This assessment will be reviewed as further information becomes available.
- ECDC is monitoring the outbreak through epidemic intelligence activities and liaising with partners.

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

- On 15 May 2026, one new human case of avian influenza A(H9N2) virus infection was reported in China, with symptom onset in April 2026.
- The patient is a child from Sichuan Province.
- The patient had exposure to a live poultry market.
- No additional cases were detected among close contacts of the patient.
- Overall, 203 human cases of avian influenza A(H9N2), including two deaths (CFR 0.98%), have been reported globally since 1998 by 11 countries.
- The risk to human health in the EU/EEA is currently considered very low.

Overview of respiratory virus epidemiology in the EU/EEA

Important: *The European Surveillance System (TESSy) is being decommissioned and replaced by EpiPulse Cases. ERVISS data cannot be updated during this transition, but publication will resume on 22 June. Thank you for your patience and understanding.*

Summary
In week 20, the number of people reporting symptoms of viral respiratory illness is at baseline levels. This shows limited circulation of respiratory viruses across the EU/EEA.

Respiratory syncytial virus (RSV) activity has returned to baseline inter-seasonal levels.

SARS-CoV-2 activity is stable and at very low levels.

Influenza virus activity has remained at baseline levels for several weeks.

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'.

Chikungunya virus disease – French Guiana, France – 2026

- There is ongoing chikungunya virus circulation in French Guiana, with 249 cases reported since January 2026 and as of 7 May.
- Eighty per cent of these cases were confirmed in the Littoral ouest sector. On 23 April, this sector was declared to be in the 'epidemic' phase of the outbreak.
- The Ile de Cayenne sector is now in the 'outbreak clusters' phase.
- The current likelihood of chikungunya virus infection for travellers to French Guiana is assessed as low; the likelihood of onward transmission in mainland Europe following introduction by a viraemic traveller is considered low.
- Travellers should be advised to take enhanced mosquito bite prevention measures. Vaccination may be considered based on national recommendations.

Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring

- In March 2026, 30 EU/EEA countries reported measles data. Twelve countries reported 172 cases and 18 countries reported zero cases.

- During the 12-month period, five deaths attributable to measles were reported to ECDC by France (3), the Netherlands (1) and Romania (1).
- Overall, case numbers increased compared with the previous month.
- Complementary epidemic intelligence surveillance was performed on 20 May 2026. Outbreaks have been reported in Bulgaria, France and Portugal. Sporadic cases and clusters were reported in several EU/EEA countries. Updates are provided for several countries and regions outside the EU/EEA.

Rapid Outbreak Assessment under production

ECDC, jointly with the European Food Safety Authority (EFSA), is developing the Rapid Outbreak Assessment 'Multi-country outbreak of *Salmonella* Bovismorbificans infection linked to the consumption of sprouted seeds'. The expected publication date is 25 June 2026.

Expert deployment

On 19 May 2026, the EU Health Task Force deployed an ECDC expert to Africa CDC headquarters in Addis Ababa. This deployment was in collaboration with the European Commission's Directorate-General for 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). The expert will support the response to the Ebola outbreak caused by Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda.

1. Hantavirus disease outbreak on cruise ship – South Atlantic – 2026

Overview:

Update

No new cases or deaths have been reported since the previous update. As of 22 May 2026, a total of 11 cases have been reported, including nine confirmed and two probable.

Summary

As of 22 May 2026 and since the start of the outbreak, 11 cases (nine confirmed and two probable) have been reported. Of these, three people have passed away.

After arrival of the cruise ship *M/V Hondius* in Tenerife, Canary Islands on 10 May, a total of 122 people (including 87 guests and 35 crew members) were disembarked from the vessel and repatriated between 10–11 May. Evacuation flights were carried out by several EU countries (the Netherlands, Spain, France, Ireland and Greece) and non-EU countries (United Kingdom (UK), Türkiye, Canada, United States (US) and Australia).

Following evacuations, the vessel departed Tenerife on 11 May and arrived in Rotterdam, the Netherlands on 18 May with 27 people (25 crew members and two medical professionals) on board. The asymptomatic individuals remaining on the vessel disembarked and are currently in quarantine; vessel disinfection is ongoing.

Preliminary analysis of genome sequences from some of the positive cases confirmed a high level of genetic similarity between isolates, likely indicating an initial zoonotic spillover event followed by human-to-human transmission. Further results from genomic sequences are pending.

Infection prevention measures – including the use of personal protective equipment, isolation of symptomatic individuals and asymptomatic contacts, and social distancing – have been recommended.

Further investigations are ongoing to identify a potential source of exposure.

Background

On 2 May 2026, the Netherlands informed ECDC about an outbreak of unknown aetiology on a cruise liner under the Dutch flag, the *M/V Hondius*. The ship had been on a cruise in the Southern Atlantic after departing from Argentina on 1 April and was en route to Cabo Verde. The cruise followed an

itinerary including stops on mainland Antarctica, South Georgia, Nightingale Island, Tristan da Cunha, St Helena and Ascension Island, with Cabo Verde as the next port of call.

A total of 149 people embarked the ship at the beginning of the journey, including 88 passengers and 61 crew. Passengers and crew represented 23 nationalities, including nine EU/EEA countries and the following other countries: Argentina, Australia, Belgium, Canada, France, Germany, Greece, Guatemala, India, Ireland, Japan, Montenegro, the Netherlands, New Zealand, the Philippines, Poland, Portugal, the Russian Federation, Spain, Türkiye, Ukraine, the UK, and the US.

Other sources: WHO DON 8 May 2026, WHO DON 13 May 2026, first Press statement from the cruise ship company on 4 May, second Press statement from the cruise ship company on 4 May

ECDC assessment:

Person-to-person transmission of ANDV has only been documented following close and prolonged contact. The current hypothesis is that some passengers were exposed to ANDV while spending time in Argentina (where ANDV is endemic) before embarking the ship, and may subsequently have transmitted the virus to other passengers onboard.

Control and preventive measures are being implemented on board to reduce the likelihood of infection among crew members who remain on the ship, as well as on land by Member States to limit the potential spread of infection to the general population. The cruise ship company and the relevant port authorities have also been advised on how to prepare for the management of cases and contacts (e.g. isolation of cases, use of appropriate personal protective equipment, testing, etc.).

Hantavirus has been circulating in some regions of the world, including South America, causing both sporadic infections and outbreaks in humans. The first documented cases of ANDV infection were reported in humans in 1996 in Argentina causing hantavirus pulmonary syndrome (HPS). In Europe, two cases of ANDV infection presenting with HPS were detected in travellers returning to Switzerland from South America in 2016.

The natural reservoir for ANDV is not present in Europe, so introduction to the rodent population and potential rodent-to-human transmission in Europe is not expected.

The risk to the general population in the EU/EEA from ANDV spreading from this cruise ship outbreak remains very low.

The likelihood of ANDV affecting the SoHO donor population in the context of this outbreak is currently assessed as negligible.

Actions:

ECDC is constantly liaising with Member States, WHO and the European Commission to collect more information on the outbreak and support response operations in coordination with the affected countries.

As part of the outbreak investigation, ECDC is undertaking epidemiological activities to collect information on tracing and monitoring of contacts, laboratory testing strategies and results, and public health measures being implemented in Member States.
Epidemiological studies are being conducted to understand the characteristics and modalities of viral infection and transmission.

ECDC published updated scientific advice on infection prevention and control measures for patients in healthcare settings, as well as recommendations on self-quarantine of asymptomatic contacts at home.

ECDC published a Threat Assessment Brief on 6 May 2026, and is providing regular updates on its website.

Sources: Press update of Oceanwide

Last time this event was included in the Weekly CDTR: 13 May 2026

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

Overview:

Update

According to the Ministry of Health of the Democratic Republic of the Congo (DRC), 13 confirmed Ebola cases have been reported since the update on 19 May 2026 (MoH DRC on X: Epidemiological Update 20 May 2026). The new confirmed cases have been reported from Ituri (12 cases) and North Kivu (1). Over 1 000 contacts are being followed up in Ituri.

Overall, according to the Ministry of Health of DRC, there are over 650 suspected cases, including 160 deaths. Sixty-four confirmed cases have been reported in DRC, including six deaths.The confirmed cases have been reported from Ituri (60 confirmed cases; four deaths) and from North Kivu (four confirmed cases; two deaths). Cases have been reported in the capitals of Ituri (Bunia) and North Kivu (Goma).

Media have reported that a case has been confirmed in South Kivu Province in a person that had traveled from Tsopo Province (BBC Ebola outbreak in DR Congo, 21 May 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).

According to the World Health Organization (WHO), as of 20 May 2026, approximately 600 suspected cases had been reported, including 139 deaths among suspected cases. Overall, 51 confirmed cases have been reported in DRC and two imported cases in Uganda. In DRC, cases have been reported in both Bunia and Goma, the capital cities of Ituri and North Kivu, respectively (WHO Director-General's opening remarks at the media briefing on Ebola outbreak in DRC and Uganda – 20 May 2026).

Based on provisional data published by WHO as of 18 May 2026, a total of 516 suspected cases have been reported from DRC, including 131 suspected deaths. Most suspected cases have been reported in the Mongbwalu (302 suspected cases, 74 deaths) and Rwampara (136 suspected cases, 38 deaths) in Ituri Province. As of 18 May 2026, 35 cases have been confirmed, 33 in DRC and two in Uganda, including five deaths (four in DRC and one in Uganda). The confirmed cases from DRC have been reported from four health zones in Ituri Province ((Rwampara (19), Bunia (6), Nyankunde (4) and Mongbwalu (1)) and from three health zones in North Kivu (Butembo (1), Goma (1) and Katwa (1)). Over 500 contacts are being followed up in DRC and over 100 contacts are being followed up in Uganda (WHO AFRO: Ebola Bundibugyo virus disease outbreak, DRC and Uganda, data as of 18 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 is 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).

The confirmed cases reported in Uganda had travel links to DRC. The first patient reported in Uganda was under treatment in Uganda and 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).

On 18 May 2026, an American citizen working in healthcare in the affected areas tested positive and was transfered to Germany with six high-risk contacts who were also to be transferred to Germany (US CDC Update on Ebola Outbreak, 18 May 2026, Serge News and Updates, 18 May 2026). Another contact was to be transfered to Czechia (US CDC Transcript -19 May 2026).

Genomes from DRC and Uganda have been published and preliminary analysis shows distinct sequences from the previous outbreaks (Virological Ebolavirus/Bundibugyo ebolavirus, 18 May 2026).

Information regarding transmission chains and affected population groups is currently limited, partly due to the complex context of ongoing insecurity and humanitarian challenges in the affected areas. According to WHO, neighbouring countries sharing land borders with DRC are considered at high risk for 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 Zaire ebolavirus. Unlike for Zaire ebolavirus, there are currently no licensed vaccines or specific treatments for Bundibugyo virus disease.

Considering the available information, complicated context and the uncertainties on the 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).

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 (species *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 reporting of laboratory-confirmed cases in North Kivu Province. Investigation 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. At the time, WHO had 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).

ECDC assessment:

Due to the very recent declaration of the outbreak and the uncertainties related to the epidemiological information, it is probable that the outbreak is much larger than what is currently being reported – not only in regards to the number of affected cases, but also to its geographical extent.

Considering all the available information and uncertainties about this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. For people living in the EU/EEA, the likelihood of infection is estimated to be very low, given the very low likelihood of importation and secondary transmission. The likelihood of Bundibugyo virus affecting the substances of human origin donor population in the context of this outbreak is currently assessed as very low. This assessment will be reviewed as further information becomes available.

ECDC considers that screening of returning travellers from affected areas (DRC, Uganda) would not be an effective measure to prevent 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 infected cases. Instead, both experience and evidence show that exit screening can be an effective measure to support the containment of the disease spread.

Detailed assessement of the event can be found in the ECDC 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 is monitoring the outbreak through its epidemic intelligence activities to provide epidemiological updates, situational awareness and risk assessment for the EU/EEA.

On 19 May 2026, the EU Health Task Force deployed an ECDC expert to Africa CDC headquarters in Addis Ababa. The expert will support the response to the Ebola outbreak caused by Bundibugyo virus in DRC and Uganda.

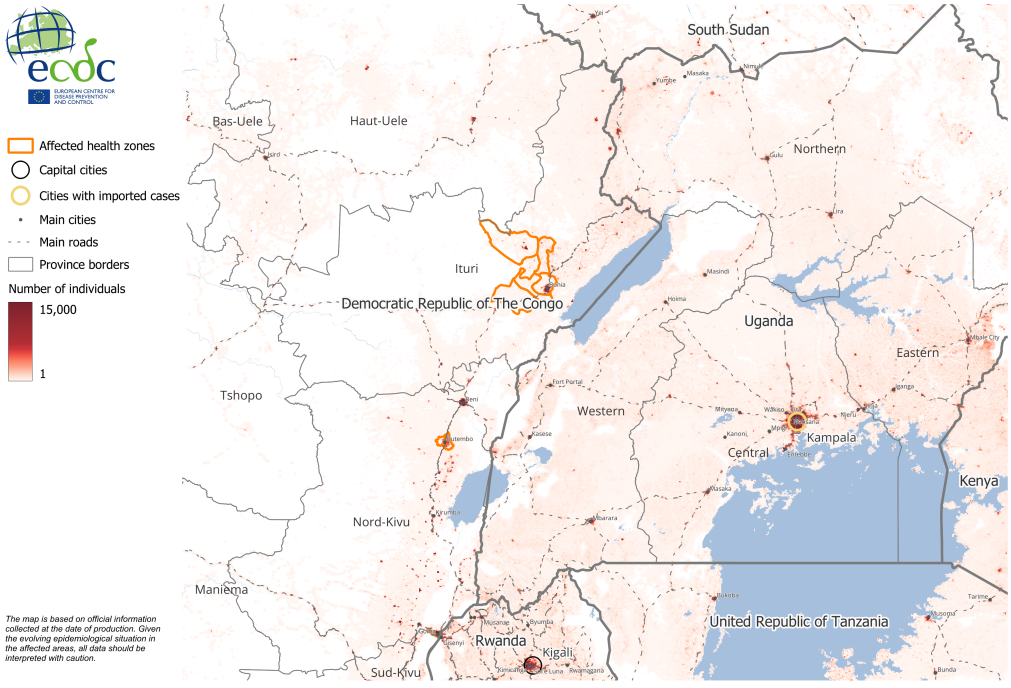
ECDC is actively liaising with key partners, including Africa CDC, the European Commission and WHO to provide further support through the EU Health Task Force in response to this outbreak.

ECDC will be providing updates and re-evaluating the situation as new information becomes available. A threat assessment brief was published on 21 May 2026 (Threat assessment brief: Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026).

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

Maps and graphs

Figure 1. Areas in the Democratic Republic of the Congo and Uganda affected by the ongoing Ebola disease outbreak, using data available as of 21 May 2026



Source: ECDC

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

Overview:

The WHO and the Hong Kong Centre for Health Protection reported a new human infection with avian influenza A(H9N2) in China on 15 May and 16 May, respectively. A girl under five years of age form Sichuan Province had onset of symptoms (fever) on 25 April 2026. The symptoms self resolved. Exposure to live-poultry market was reported prior to the onset of symptoms. There were no reports of cases among contacts of this case.

Background

Overall, 203 human cases of avian influenza A(H9N2), including two deaths, have been reported since 1998 by 11 countries. Since 2015, China has reported 161 human cases of avian influenza A(H9N2) virus infection to WHO, including two deaths (case fatality rate (CFR): 1%).

ECDC assessment:

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

Actions:

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

Sources: Event Information Site for IHR National Focal Points

Last time this event was included in the Weekly CDTR: 30 April 2026

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

Overview:

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

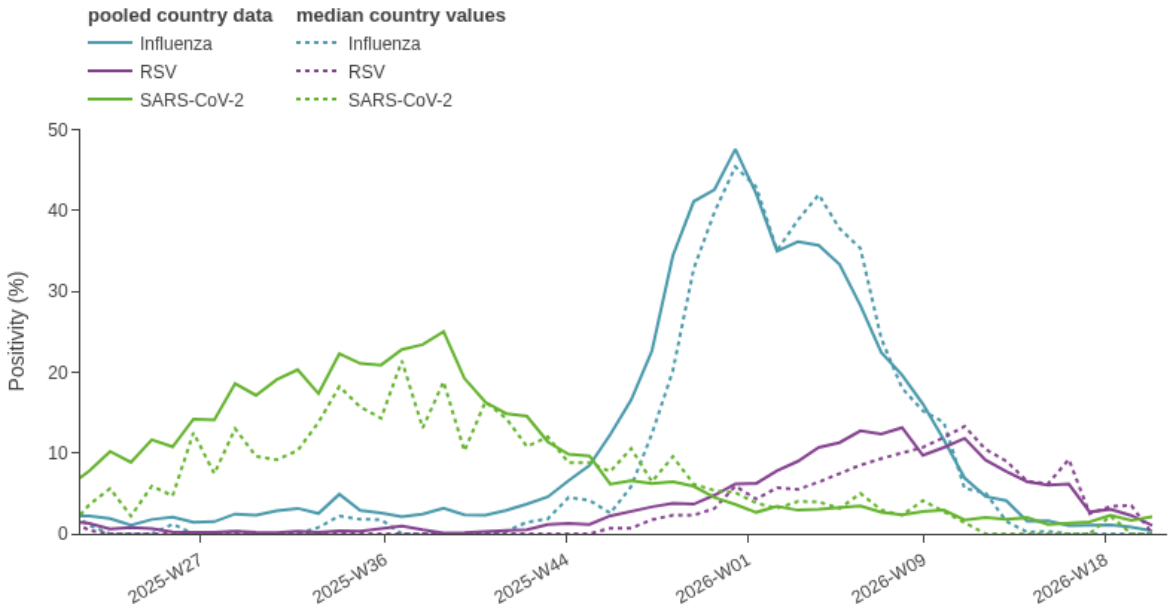
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 8 May 2026

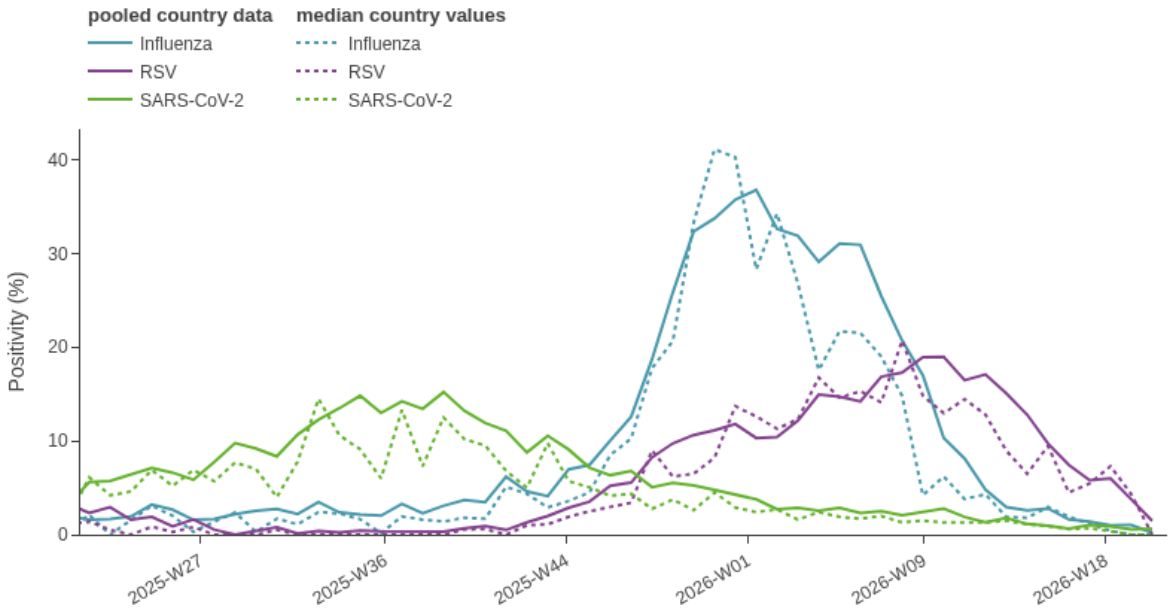
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 4. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 20	Week 19	Description	Value
ILI/ARI consultation rates in primary care	ARI	13 rates (9 MEM)	16 rates (11 MEM)	Distribution of country MEM categories	9 Baseline
	ILI	16 rates (15 MEM)	19 rates (18 MEM)		15 Baseline
ILI/ARI test positivity in primary care	Influenza	17	19	Pooled (median; IQR)	0.4% (0; 0–0%)
	RSV	15	18		1.1% (0; 0–0.2%)
	SARS-CoV-2	15	18		2.1% (0; 0–0%)
SARI rates in hospitals	SARI	10 rates (5 MEM)	13 rates (7 MEM)	Distribution of country MEM categories	4 Baseline 1 Medium
SARI test positivity in hospitals	Influenza	7	10	Pooled (median; IQR)	0.2% (0; 0–0%)
	RSV	7	9		1.5% (0; 0–5.2%)
	SARS-CoV-2	6	10		0.6% (0; 0–0%)
Intensity (country-defined)	Influenza	19	22	Distribution of country qualitative categories	18 Baseline 1 Low
Geographic spread (country-defined)	Influenza	18	21	Distribution of country qualitative categories	7 No activity 9 Sporadic 1 Local 1 Regional

Source: ECDC

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

	Week 20, 2026		Week 40, 2025 – week 20, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**3**	**–**	**18678**	**–**
Influenza A	2	67	18085	99
A(H1)pdm09	1	50	4182	28
A(H3)	1	50	10713	72
A (unknown)	0	–	3190	–
Influenza B	1	33	119	0.7
B/Vic	0	–	33	100
B (unknown)	1	–	86	–
Influenza untyped	0	–	474	–
RSV	**8**	**–**	**4975**	**–**
RSV-A	2	33	882	45
RSV-B	4	67	1057	55
RSV untyped	2	–	3036	–
SARS-CoV-2	**16**	**–**	**4055**	**–**

Source: ECDC

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

	Week 20, 2026		Week 40, 2025 – week 20, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**1**	**–**	**15097**	**–**
Influenza A	0	0.0	8832	99
A(H1)pdm09	0	–	1287	35
A(H3)	0	–	2355	65
A (unknown)	0	–	5190	–
Influenza B	1	100	74	0.8
B/Vic	0	–	7	100
B (unknown)	1	–	67	–
Influenza untyped	0	–	6191	–
RSV	**7**	**–**	**7154**	**–**
RSV-A			1287	54
RSV-B			1098	46
RSV untyped	7	–	4769	–
SARS-CoV-2	**3**	**–**	**2938**	**–**

Source: ECDC

Figure 7. Genetically characterised influenza virus distribution, week 40, 2025 – week 20, 2026

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

Source: ECDC

5. Chikungunya virus disease – French Guiana, France – 2026

Overview:

There is ongoing chikungunya virus circulation in French Guiana. Since January 2026, and as of 7 May, 249 confirmed autochthonous cases have been identified, with 40 cases in week 18, 61 cases in week 17, 33 cases in week 16, and 15 cases in week 15.

Most cases (198; 80%) were detected in the Littoral ouest sector, located on the western side of French Guiana, near the border with Suriname. This sector entered the 'epidemic' phase of the outbreak on 23 April; this phase is the highest level, one higher than the 'isolated clusters' phase. In addition, the health authorities have activated level 3 (low-intensity epidemic) of the Organisation de la Réponse de Sécurité Civil (ORSEC) plan of arboviroses control in this sector.

The Ile de Cayenne sector is now in a phase of 'outbreak clusters'. The Maroni and Savanes sectors are in phases of 'sporadic transmission', while the Intérieur, Intérieur Est, and Oyapock sectors remain in a 'surveillance' phase, with no cases identified to date.

All cases were confirmed by RT-PCR and the identified strain in French Guiana belongs to the ECSA genotype but lacks the E1-A226V mutation. It shows a close genetic relationship with recent sequences from Cuba and Brazil.

Suriname, which shares a border with western French Guiana, reported 2 579 cases between 1 January and mid-March 2026. The last chikungunya virus disease outbreak in French Guiana occurred in 2014. During the 2014–2015 outbreak in French Guiana, more than 16 000 suspected cases and 500 hospitalisations were reported, resulting in an estimated chikungunya virus disease seroprevalence of 20% in 2017.

ECDC assessment:

The rainy season in French Guiana, which occurs from January to July, is currently ongoing and favours *Aedes* mosquitoes proliferation and chikungunya virus transmission. The likelihood of infection for travellers is assessed as low. The likelihood of onward transmission of chikungunya virus in mainland Europe following introduction by a viraemic traveller is currently considered low, but environmental conditions are becoming favourable for *Aedes* mosquito activity and virus replication in mosquitoes.

The outbreak is expected to continue over the coming months due to favourable environmental conditions. Therefore, it is important to strengthen communication with 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 screened or air-conditioned accommodation, and wearing clothing that covers most of the body. Vaccination may also be considered, in line with recommendations in the traveller's country of origin.

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: 12 May 2026

6. Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring

Overview:

In March 2026, 30 EU/EEA countries reported measles data. Twelve countries reported a total of 172 cases and 18 countries reported zero cases.

Overall, case numbers increased compared with the previous month; however, this may be subject to change in the event of a future retrospective update. The highest case counts were reported by Bulgaria (52), Italy (44), Spain (24), France (15) and Germany (11).

In the most recent 12-month period, from 1 April 2025 to 31 March 2026, 30 EU/EEA countries reported a total of 3 607 cases of measles, 3 098 (85.9%) of which were laboratory confirmed.

Of the 3 607 cases with known age, 1 143 (31.7%) were in children under five years; 1 627 (45.1%) cases were in those aged 15 years or above. The highest notification rates were observed among infants under one year of age (90.8 cases per million) and children aged 1-4 years (48.9 cases per million).

Of 3 029 individuals (84.0% of all cases) with a known age and vaccination status, 2 369 (78.2%) were unvaccinated, 320 (10.6%) were vaccinated with one dose of a measles-containing vaccine, 301 (9.9%) were vaccinated with two or more doses, and 32 (1.1%) were vaccinated with an unknown number of doses.

During the 12-month period, five deaths (case fatality rate (CFR): 0.139%) attributable to measles were reported to ECDC by France (3), the Netherlands (1) and Romania (1). Detailed data are available in ECDC's Surveillance Atlas of Infectious Diseases.

Complementary epidemic intelligence surveillance was performed on 20 May 2026. Outbreaks have been reported in Bulgaria, France and Portugal. Sporadic cases and clusters were reported in several EU/EEA countries. Updates are provided for several countries and regions outside the EU/EEA. Outside the EU/EEA, updates have been provided by England, Bangladesh, Ukraine, Africa CDC, the World Health Organization Pan American Health Organization (WHO PAHO), Canada, the United States (US), Mexico and Japan.

Disclaimer: *The monthly measles report published in the CDTR provides the most recent data on cases and outbreaks based on information made publicly available by the national public health authorities or the media. Sometimes this information is made available retrospectively. This report is a supplement to ECDC's monthly measles and rubella monitoring report, based on data routinely submitted by 30 EU/EEA countries to EpiPulse Cases. Data presented in the two monthly reports may differ.*

Epidemiological summary for EU/EEA countries with relevant epidemic intelligence updates:

Bulgaria is experiencing an ongoing outbreak, with 277 cases of measles reported from 1 January to week 20 2026 (week ending 17 May). According to media, quoting the Ministry of Health on 4 May 2026, most of the cases are reported in the Vratsa region (150), followed by Pleven (48), Lovech (18), Sofia city (4), Varna (3), Montana (1) and Sofia (1). The majority of the cases are in children (189/225). The outbreak began on 19 March 2026. Over 28 000 MMR vaccine doses have been administered in response to the outbreak. In 2025, Bulgaria reported two cases.

Estonia reported one new case since 10 March 2026, with three cases reported in total as of 20 May 2026.

France reported 77 cases of measles and no deaths between 1 January and April 2026, an increase of 49 cases since the end of February. The cases were reported among both children and adults. The number of cases in the reporting period is lower than in the same period last year. Half of the cases (54%) for whom vaccination status was known (28/52), were not fully vaccinated. At least one case was reported in 24 departments of France, with most of the cases reported in Yvelines (10%), Moselle (9%), Hauts-de-Seine (9%), Meurthe-et-Moselle (8%), Paris (8%) and Essonne (8%). No cases have been reported in overseas territories of France. Overall, 12 outbreaks were reported and three outbreaks are still active.

Germany reported 82 confirmed and probable measles cases in 2026 (weeks 1 to 21), an increase of 23 cases since week 15.

Latvia reported 49 confirmed measles cases related to an outbreak, as of data from 15 April 2026, an increase of two case since the previous report on 10 April. No new cases were reported since then.

Lithuania reported seven cases from 1 January to 19 May 2026.

Poland reported 17 cases from 1 January to 15 May 2026.

Portugal is experiencing an outbreak of measles, with three cases and around 500 identified contacts reported in Beja (according to a media report on 18 May 2026).

Spain reported 118 cases of measles from 1 January to 17 May 2026, including 10 imported cases and 25 cases related to imported cases. This represents an increase of 21 cases since April 2026.

Sweden reported five cases in 2026, as of 20 May 2026.

Epidemiological summary for EU/EEA outermost territories with relevant epidemic intelligence updates:

No new outbreaks or cases have been detected in the reporting period.

Western Balkan countries and Türkiye
No new outbreaks or cases have been detected in the reporting period.

Epidemiological summary for selected countries outside of the EU/EEA with relevant epidemic intelligence updates:

Ukraine reported 132 cases from January to March 2026. In 2025, Ukraine reported 1 502 measles cases from January to December 2025.

England reported 542 laboratory-confirmed cases and no deaths, between 1 January and 27 April 2026.

Bangladesh is experiencing the following: On 20 May 2026, media, quoting health authorities, reported 57 856 children with measles-like symptoms, including 8 067 with confirmed measles diagnosis since 15 March (an increase of over 6 000 cases since the report on 13 May). Among the reported cases, there are 481 deaths, including 80 deaths with confirmed measles. During this period, 45 128 children were hospitalised, the vast majority of whom have recovered. Measures are being implemented by national authorities in collaboration with international organisations.

Africa CDC reported on 3 May 2026 that, overall, in 2026 there have been 3 422 confirmed and 92 537 suspected cases of measles and 633 deaths from 21 African Union Member State countries. High risk of measles spread is listed for Mali and Senegal, and moderate risk in Burundi, the Democratic Republic of the Congo and Mozambique.

According to the WHO Pan American Health Organization (WHO PAHO) report published on 25 April 2026, 18 088 confirmed measles cases have been reported by 14 countries, of which the majority of cases are reported in Mexico (10 049), Guatemala (5 112), the US (1 811) and Canada (944). Due to the upcoming FIFA World Cup 2026, a more detailed overview is provided for the hosting countries: Canada, Mexico and the US.

Canada reported 1 018 measles cases (941 confirmed) and no deaths across seven jurisdictions in 2026 and as of 19 May 2026. The country remains in active transmission across multiple provinces due to an ongoing multijurisdictional outbreak. The vast majority of the cases reported in 2026 are linked to this outbreak.

The US continues to face multiple concurrent outbreaks, including several that began in 2025 and continue into 2026. Overall, the US Centers for Disease Control and Prevention (US CDC) reported 1 893 cases and no deaths between January and 14 May 2026 (vs a total of 2 287 cases, including three deaths, in 2025). In the same period, there were 27 new outbreaks reported and 93% of confirmed cases are outbreak associated. The majority of the cases are in children (72%) and unvaccinated individuals (92%).

Mexico reported on 19 May 2026, that overall since the beginning of the outbreak in 2025, 17 553 confirmed cases were reported, including 40 deaths. In 2026, Mexico reported 10 945 confirmed cases and 13 deaths. The number of cases is declining after a peak reported in week 6 in 2026. The most-affected state in 2026 is still Jalisco (9 847 cases; three deaths).

Japan is experiencing an increase of measles cases in 2026. With 479 cases reported in weeks 1–19, the number of cases exceeds the total reported in the whole year of 2025 (N=265). The

largest number of cases (70) was reported in week 17. Preliminary data suggest 86% of the cases are in teenagers and adults. Of the reported cases, 38 were imported and 351 are considered as domestic cases.

For more information on the provisional number of cases outside the EU/EEA region, please visit the World Health Organization (WHO) website.

The numbers provided to WHO for EU/EEA countries are from EpiPulse Cases data, which are updated monthly and available on the ECDC Surveillance Atlas of Infectious Diseases. Due to differences in reporting times, the numbers may not correspond to the data from epidemic intelligence screening.

ECDC assessment:

Although most recent cases were acquired through local or community transmission, travel-related cases continue to be reported.

Continued vigilance is essential due to sub-optimal vaccination coverage for measles-containing vaccines (MCV) in several EU/EEA countries, possible introduction from areas with ongoing transmission, and increased travel and population movement during holiday periods.

Actions:

ECDC is monitoring the measles situation through its epidemic intelligence activities. Data collected via epidemic intelligence supplement the monthly outputs of measles surveillance data from EpiPulse Cases, which are routinely submitted by 30 EU/EEA countries.

ECDC urges EU/EEA public health authorities to focus on the following areas:

- **Close immunity gaps, achieve and maintain high vaccination coverage for measles-containing vaccines** (>95% with the second dose). It is vital to ensure first and second dose vaccinations are administered on time, as per national schedules among infants and children. It is also important to identify and vaccinate eligible individuals (for example, non-immune adolescents and adults) in immunisation catch-up programmes (as recommended by local and national authorities).
- **Strive towards high-quality surveillance** and adequate public health capacity, especially for early detection, diagnosis, response and control of outbreaks.
- **Increase the clinical awareness of health professionals**, including reminding them of the importance of checking individuals' vaccination status ahead of travel.
- **Healthcare professionals should be fully vaccinated.**
- **Promote vaccine acceptance and uptake** by employing specific risk communication strategies and identifying drivers of suboptimal MMR vaccine acceptance and uptake to ensure that tailored interventions are implemented in response.
- **Address barriers and engage with populations underserved by healthcare services.** Systemic barriers that affect vaccine uptake in populations that are isolated and underserved by healthcare services need to be monitored and addressed with targeted strategies in order to reduce inequalities in vaccine uptake.
- In light of the upcoming summer holiday season, **travellers should check their vaccination status** and consult their general practitioner to ensure they are up-to-date with recommended immunisations prior to departure.

ECDC's latest advice on measles is available in the Threat Assessment Brief '**Measles on the rise in the EU/EEA: Considerations for a public health response**', published in February 2024 and the conclusions remain valid. Additional information on the risk classification and ECDC recommendations can be found in this report.

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

7. Rapid Outbreak Assessment under production

Overview:

ECDC, jointly with the European Food Safety Authority (EFSA), is developing a Rapid Outbreak Assessment for the *Salmonella* Bovismorbificans outbreak. The expected publication date is 25 June 2026.

Last time this event was included in the Weekly CDTR: 13 February 2026

8. Expert deployment

Overview:

On 19 May 2026, the EU Health Task Force deployed an ECDC expert to Africa CDC headquarters in Addis Ababa. This deployment was in collaboration with the European Commission's Directorate-General for 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). The expert will support the response to the Ebola outbreak caused by Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda.

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

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 30 April 2026
- SARS-CoV-2 variant classification - last reported on 30 April 2026
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 22 May 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring - last reported on 22 May 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 22 May 2026
- Chikungunya virus disease – French Guiana, France – 2026 - last reported on 22 May 2026
- Hantavirus disease outbreak on cruise ship – South Atlantic – 2026 - last reported on 22 May 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 22 May 2026
- Expert deployment - last reported on 22 May 2026
- Rapid Outbreak Assessment under production - last reported on 22 May 2026
- Avian influenza A(H5N6) – Multi-country – Monitoring human cases - last reported on 13 May 2026
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - last reported on 13 May 2026
- Human cases of swine influenza A(H1N2) variant virus infection – Multi-country - last reported on 13 May 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 08 May 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 08 May 2026
- Multi-country cluster of Salmonella Stanley ST2045 - last reported on 08 May 2026