WEEKLY BULLETIN

Communicable disease threats report

Week 22, 23 - 29 May 2026

This week's topics

1. Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026
2. Hantavirus disease outbreak on cruise ship – South Atlantic – 2026
3. Seasonal surveillance of West Nile Virus infections - 2026 (Weekly report)
4. Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update

Executive summary

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

- As of 29 May 2026, a total of 125 confirmed and 906 suspected cases, including 17 confirmed and 223 suspected related deaths, have been reported in the Democratic Republic of the Congo (DRC; Ituri, North Kivu and South Kivu Provinces); a total of nine confirmed cases, including one death, have been reported in 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.

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

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Hantavirus disease outbreak on cruise ship – South Atlantic – 2026

- As of 29 May 2026, a total of 13 cases of Andes virus (ANDV) disease have been reported, including 11 confirmed and two probable cases. No new 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.
- 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 the cruise ship outbreak remains very low.

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

This is the first weekly seasonal surveillance report of West Nile Virus (WNV) infections in 2026.

In Europe, since the beginning of 2026, and as of 27 May, only North Macedonia reported one human case of West Nile virus infection.

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

- Since 1 January 2026 and as of 26 May 2026, 68 749 cholera cases, including 944 deaths, have been reported worldwide.
- Since 28 April 2026 and as of 26 May 2026, 3 596 new cholera cases, including 176 new deaths, have been reported worldwide.
- The five countries reporting most cases are Angola (2 120), Mozambique (413), Somalia (271), Burundi (224) and Democratic Republic of The Congo (172).
- The five countries reporting most new deaths are Democratic Republic of The Congo (115), Angola (36), Congo (21), Zambia (3) and Mozambique (1).
- Cholera cases have continued to be reported in Africa, Asia, the Middle East and the Americas. The risk of cholera infection for travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

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

Overview:

Update

The updated number of confirmed and suspected Ebola disease cases and deaths in the Democratic Republic of Congo (DRC) and Uganda are reported below:

DRC: According to the official report published on 28 May 2026, a total of 125 confirmed cases (including 17 confirmed related deaths) were reported in the three provinces currently affected, including 110 cases in Ituri, 14 in North Kivu and one in South Kivu. A total of 906 suspected cases (including 223 suspected related deaths) were reported in the same provinces, including 885 cases in Ituri, 20 in North Kivu and one in South Kivu. Note that the number of suspected cases and deaths has decreased compared with the previous report following a data revision by the DRC authorities, which removed non-cases and reclassified some cases as confirmed.
One individual previously tested positive has recovered.
Within the three provinces, the affected health zones are 7/36 in Ituri (Aru, Bunia, Kilo, Rwampara, Mongbwalu, Nizi, and Nyankunde); 5/35 in North Kivu (Goma, Butembo, Oicha, Kalunguta, and Katwa); 1/34 in South Kivu (Miti-Murhesa).
Over 2 231 contacts were identified as of 25 May and 20% are under follow-up (based on the official report on 24 May).

Uganda: On 29 May, the Ministry of Health reported two new cases. A total of nine confirmed cases have been reported to date, including one death.

The two new confirmed cases involve two Congolese nationals, including one who was isolated upon symptom onset and one who is a close contact to a previously confirmed case.

A suspected case of Ebola disease was reported in Austria, involving a woman who had been working as a volunteer development worker in Uganda and developed symptoms consistent with Ebola disease after travelling from Uganda earlier this week. Upon initial laboratory testing for Ebola virus, she resulted negative; currently, she remains in isolation in hospital awaiting further confirmatory laboratory testing.

In India, four people were quarantined in the state of Gujarat, including one person presenting with fever who travelled from DRC and three contacts of this individual. On 29 May, the suspected case tested negative for Ebola virus.

Other events
According to an official press release on 28 May, coordinated public health measures will be implemented by the United States, Mexico and Canada for individuals travelling from high-risk areas in view of the upcoming FIFA World Cup 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 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). However, the outbreak is likely to have started many weeks before, considering the number of cases and the geographical spread.

Media sources have reported local protests and arson attacks targeting treatment centres from residents in DRC. Citizens reportedly burned two tents within a hospital section treating Ebola patients. Volunteers have been faced intimidation and threats from armed groups in Bunia.

On 18 May 2026, an American citizen working in healthcare in the affected areas tested positive and was transferred 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 transferred to Czechia (US CDC Transcript -19 May 2026).

The first patient reported in Uganda was travel-related 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). At least three confirmed cases reported in Uganda had travel links to DRC. Additional cases were identified following contact tracing activities. Uganda has postponed a large religious event (Martyr's day) that normally takes place on 3 June and suspended cross-border transport activities (Government of Uganda on X: 21 May 2025).

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

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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 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 had been reported, including 3 317 confirmed and 153 probable. 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).

Travel restrictions

Bunia airport (DRC) has been temporarily closed (Ministry of transport and communication, 23 May, Ministère de la Santé RDC on X).

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 in key locations, including at the airport (international travel screening), road checkpoints and towns or local transit points, such as Nizi (Ituri), Mudzibala (Bunia), Dele and Chai (Rwampara). The Rwandan 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 MoH, 22 May on X).

Other countries have also implemented entry restrictions and health screening for individuals travelling from high-risk countries, including United States, Canada, Tunisia, Thailand, Mauritius and the Bahamas.

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 in 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.

Exit screening in affected countries, including symptom checks and exposure assessment is crucial as it contributes to risk reduction by identifying symptomatic travellers before boarding and preventing travel 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 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 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 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, in collaboration with DG ECHO, DG INTPA and GOARN, deployed an ECDC expert to Africa CDC headquarters in Addis Ababa.

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 on the Ebola outbreak was published on 21 May 2026. Laboratory guidance was published on 27 May 2026, including recommendations on sampling and diagnostics, biosafety measures for handling, processing and transport of samples, and diagnostic support offered at EU/EEA level.

Last time this event was included in the Weekly CDTR: 22 May 2026

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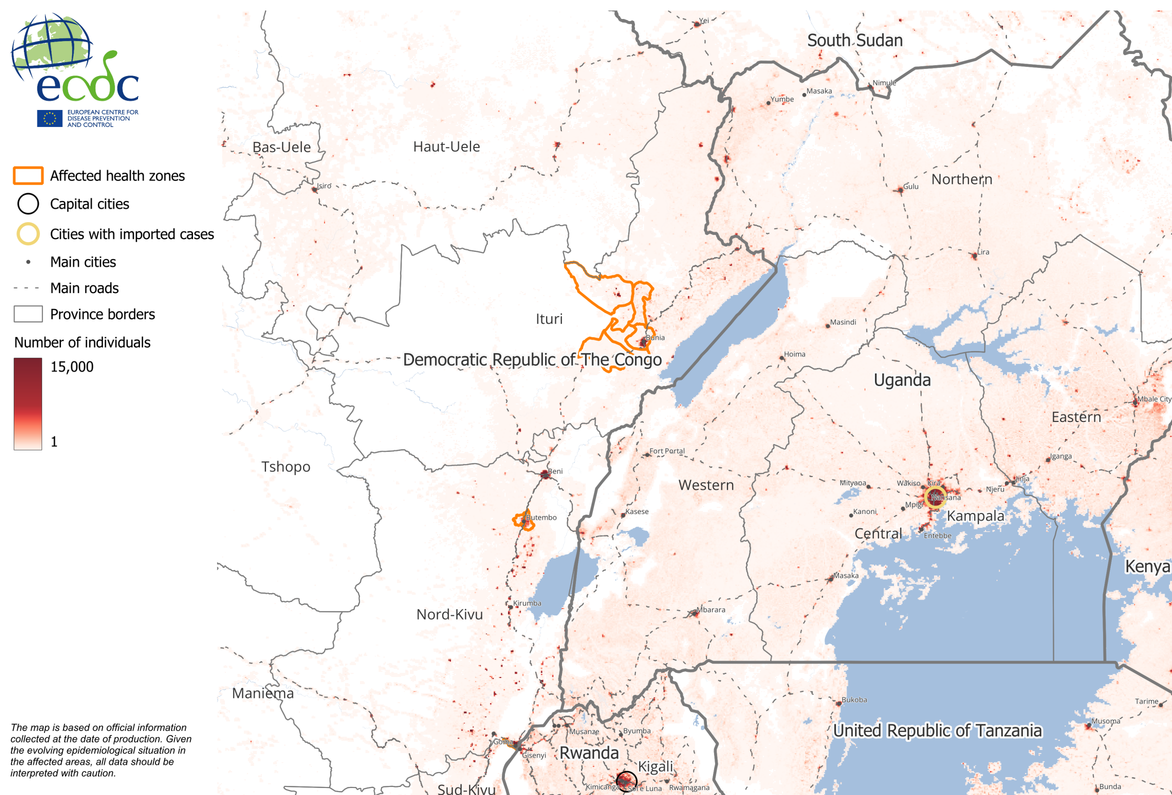
Maps and graphs

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.



Map produced by ECDC on: 22/05/2026. Administrative data ©UNFAO ©UNOCHA; Road, cities and airport ©OSM; Population estimates ©GHS - Global Human Settlement. The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union.

Source: ECDC

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

Overview:

Update
Since the previous weekly update (Week 21, 16-22 May 2026), two new cases and no new deaths have been reported. Further information about the two cases is provided below.

One case, reported on 22 May, was a Dutch citizen who was in home quarantine after close contact with people with ANDV on board the ship.
One case, reported on 25 May, was a Spanish citizen, and a previous passenger of the cruise ship who was evacuated from Tenerife to Spain on 10 May; the individual was asymptomatic and placed under quarantine in hospital.

The two recently reported asymptomatic cases (reported in the Netherlands and Spain) have been classified as confirmed following a revision of the case definition. A confirmed case is now defined, in alignment with WHO, as a person with laboratory confirmation of ANDV by PCR and/or serology.

As of 29 May 2026 and since the start of the outbreak, a total of 13 cases of ANDV disease have been reported, including 11 confirmed and two probable cases. Of these, three people have passed away.

Summary
After arrival of the cruise ship M/V Hondius in Tenerife, Canary Islands on 10 May, a total of 122 people (including 87 passengers and 35 crew members) disembarked from the vessel and were 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. The vessel is undergoing disinfection.

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 individuals who are symptomatic and contacts who are asymptomatic, 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 boarded 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 boarding the ship, and may subsequently have transmitted the virus to other passengers onboard.

Control and preventive measures are being implemented by public health authorities from countries who received returning passengers and crew members after the disembarkement (e.g. use of appropriate personal protective equipment, quarantine, testing, isolation of cases, etc.) to limit the potential spread of infection to the general population.

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

As part of the outbreak investigation, ECDC is collecting 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: 28 May 2026

3. Seasonal surveillance of West Nile Virus infections - 2026 (Weekly report)

Overview:

Throughout the season, ECDC will publish a weekly report updating on risk areas for locally acquired WNV infections. In addition, a monthly report will be 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 according to the EU case definition. According to Commission Directives 2004/33/EC and 2014/110/EU on blood safety, blood establishments in 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.

This is the first report of the weekly seasonal surveillance of WNV infections in 2026.

In Europe, since the beginning of 2026, and as of 27 May, only North Macedonia reported one human case of West Nile virus infection.

ECDC assessment:

Currently one area is known to be affected (Vardarski).

The report is available online.

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 onwards to November, which 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 EFSA, which includes the numbers of reported locally acquired human cases, 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.

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Last time this event was included in the Weekly CDTR: 29 May 2026

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

Overview:

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

Update

Since 28 April 2026 and as of 26 May 2026, 3 596 new cholera cases, including 176 new deaths, have been reported worldwide.

New cases have been reported from Angola, Burundi, Congo, Democratic Republic of The Congo, Malawi, Mozambique, Rwanda, Somalia, South Sudan and Zambia

The five countries reporting most cases are Angola (2 120), Mozambique (413), Somalia (271), Burundi (224) and Democratic Republic of The Congo (172).

New deaths have been reported from Angola, Congo, Democratic Republic of The Congo, Mozambique and Zambia.

The five countries reporting most new deaths are Democratic Republic of The Congo (115), Angola (36), Congo (21), Zambia (3) and Mozambique (1).

In the previous reporting period (30 March to 28 April 2026), 20 028 new cholera cases, including 272 new deaths, were reported worldwide.

Since 1 January 2026 and as of 26 May 2026, 68 749 cholera cases, including 944 deaths, have been reported worldwide.

In comparison, since 01 January 2025 and as of 26 May 2025, 119 702 cholera cases, including 1 570 deaths, were reported worldwide.

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

Asia:

Since 28 April 2026, no updates have been reported by: Afghanistan, Myanmar/Burma, Pakistan, Yemen and India.

Africa:

Angola:
Since 12 April 2026 and as of 10 May 2026, 2 120 new cases, including 36 new deaths have been reported. Since 1 January 2026 and as of 10 May 2026, 3 146 cases, including 62 deaths have been reported. In comparison, in 2025 and as of 30 April 2025, 14 090 cases, including 505 deaths were reported.

Burundi:
Since 12 April 2026 and as of 10 May 2026, 224 new cases have been reported. Since 1 January 2026 and as of 10 May 2026, 1 015 cases, including two deaths have been reported. In comparison, in 2025 and as of 17 March 2025, 129 cases were reported.

Congo:

Since 12 April 2026 and as of 10 May 2026, 122 new cases, including 21 new deaths have been reported. Since 1 January 2026 and as of 10 May 2026, 391 cases, including 33 deaths have been reported. In comparison, in 2025 and as of 26 May 2025, no cases were reported.

Democratic Republic of The Congo: Since 12 April 2026 and as of 10 May 2026, 172 new cases, including 115 new deaths have been reported. Since 1 January 2026 and as of 10 May 2026, 21 418 cases, including 726 deaths have been reported. In comparison, in 2025 and as of 10 March 2025, 11 918 cases, including 240 deaths were reported.

Malawi:
Since 12 April 2026 and as of 10 May 2026, 157 new cases have been reported.Since 1 January 2026 and as of 10 May 2026, 1 733 cases, including five deaths have been reported. In comparison, in 2025 and as of 7 April 2025, 91 cases, including three deaths were reported.

Mozambique:
Since 12 April 2026 and as of 10 May 2026, 413 new cases, including one new death has been reported. Since 01 January 2026 and as of 10 May 2026, 7 016 cases, including 59 deaths have been reported. In comparison, in 2025 and as of 30 April 2025, 2 851 cases, including 29 deaths were reported.

Rwanda:
Since 12 April 2026 and as of 10 May 2026, 11 new cases have been reported. Since 01 January 2026 and as of 10 May 2026, 29 cases have been reported. In comparison, in 2025 and as of 4 April 2025, four cases were reported.

Somalia:
Since 12 April 2026 and as of 10 May 2026, 271 new cases have been reported. Since 1 January 2026 and as of 10 May 2026, 1 206 cases have been reported. In comparison, in 2025 and as of 17 February 2025, 1 409 cases, including one death was reported.

South Sudan: Since 12 April 2026 and as of 10 May 2026, 2 new cases have been reported. Since 1 January 2026 and as of 10 May 2026, 457 cases, including six deaths have been reported. In comparison, in 2025 and as of 17 March 2025, 25 179 cases, including 389 deaths were reported.

Zambia:
Since 12 April 2026 and as of 10 May 2026, 104 new cases, including three new deaths have been reported. Since 1 January 2026 and as of 10 May 2026, 987 cases, including 16 deaths have been reported. In comparison, in 2025 and as of 15 April 2025, 463 cases, including nine deaths were reported.

Since 28 April 2026, no updates have been reported by: Ethiopia, Namibia, Nigeria, Sudan, United Republic of Tanzania and Zimbabwe.

Americas:

Since 28 April 2026, no updates have been reported by Haiti.

ECDC assessment:

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

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

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

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

regularly washing hands with soap, eating thoroughly cooked food, and avoiding the consumption of raw seafood products.

Actions:

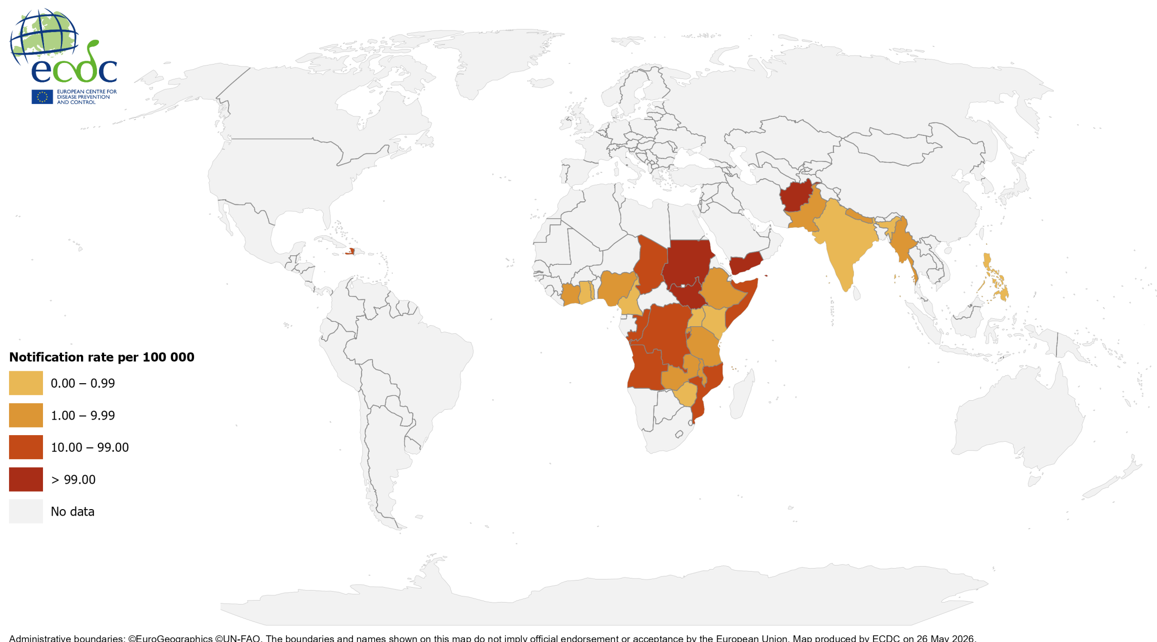
ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities.

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

Last time this event was included in the Weekly CDTR: 28 May 2026

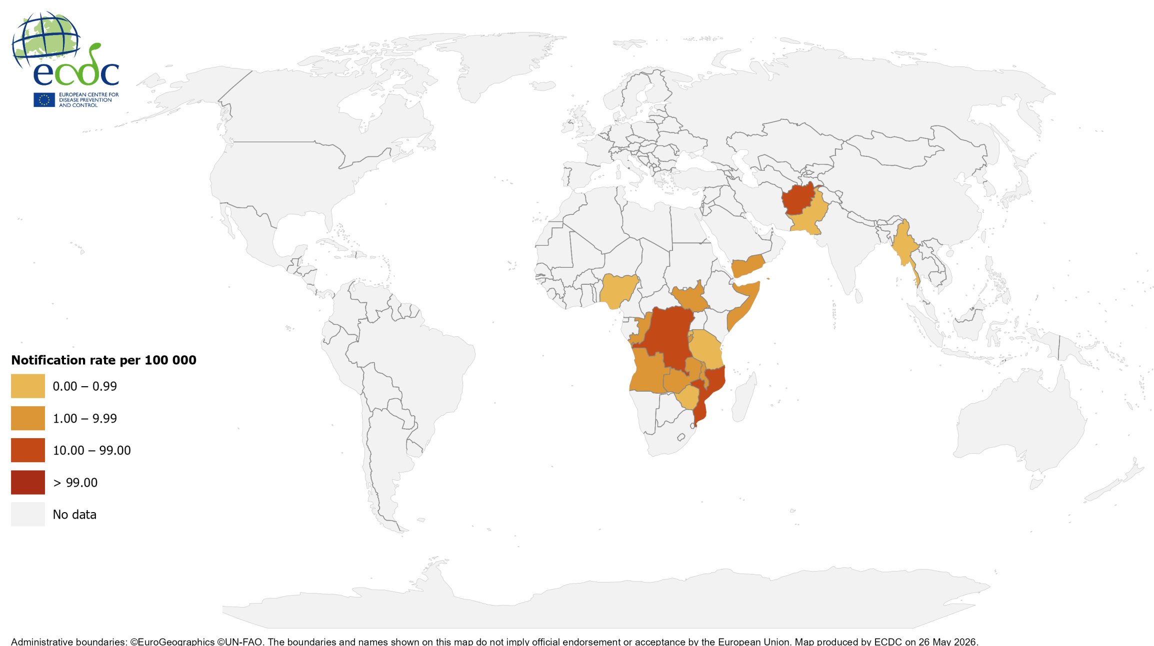
Maps and graphs

Figure 1. Geographical distribution of cholera cases reported globally from May 2025 to May 2026



Source: ECDC

Figure 2. Geographical distribution of cholera cases reported worldwide from March 2026 to May 2026



Source: ECDC

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 29 May 2026
- Multi-country cluster of Salmonella Stanley ST2045 - last reported on 29 May 2026
- Hantavirus disease outbreak on cruise ship – South Atlantic – 2026 - last reported on 29 May 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 29 May 2026
- Seasonal surveillance of West Nile Virus infections - 2026 (Weekly report) - last reported on 29 May 2026
- Rapid Outbreak Assessment under production - last reported on 22 May 2026
- Expert deployment - last reported on 22 May 2026
- Chikungunya virus disease – French Guiana, France – 2026 - last reported on 22 May 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(H5N6) – Multi-country – Monitoring human cases - 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 due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - last reported on 13 May 2026

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