WEEKLY BULLETIN

Communicable Disease Threats Report

Week 23, 30 May–5 June 2026

This week's topics

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Executive summary

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

- A total of 381 confirmed cases, including 64 confirmed related deaths (an increase of 18 new cases and two deaths since the previous report) have been reported in the Democratic Republic of the Congo (Ituri, North Kivu and South Kivu Provinces); a total of 16 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.
- Given 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.

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

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

In Europe, since the beginning of 2026, and as of 3 June, only North Macedonia has reported one human case of West Nile virus infection.

P. falciparum malaria - Mayotte, France - 2026

- Since January 2026 and as of 21 May 2026, 171 malaria cases have been reported in Mayotte, France.
- Of these, 63 were suspected to be autochthonous.
- A marked increase in cases was observed in weeks 18–20 (27 April–17 May), with an average of 25 cases per week compared to six cases per week earlier in the year.
- Most recent cases have been reported in the southern municipalities, particularly Chirongui.
- All cases were caused by Plasmodium falciparum.

- The likelihood of infection for travellers to Mayotte is considered low; the likelihood of onward transmission in mainland Europe is considered very low.
- Travellers and residents should be advised to take enhanced prevention measures against mosquito bites. Prophylactic medication may be considered based on national recommendations.

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

- In April 2026, 102 mpox cases caused by monkeypox virus (MPXV) clade I were reported by 11 EU/EEA countries, indicating a relatively stable trend compared to previous months. In the same period, 23 mpox cases caused by MPXV clade II were reported by seven countries, continuing a decreasing trend.
- Transmission for both clades occurs predominantly within networks of men who have sex with men, with ongoing circulation across the EU/EEA and most cases reported among unvaccinated individuals.
- Disease severity remains generally mild, with low hospitalisation rates reported for both clades.
- With the start of the spring and summer season and increased travel and mass gatherings, there is a risk of further spread.

Spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA - 2026

- Three countries have reported 50 cases of skin infections with Dermatophilus congolensis via EpiPulse (France and Germany) or peer-review publications (Spain). Cases are reported to be mild, with complete recovery and no complications after a course of antibiotics.
- Cases were reported predominantly among men who have sex with men who visited sex-on-premises saunas, with the majority diagnosed between December 2025 and May 2026.
- Considering that Dermatophilus congolensis is a bacterium historically associated with animals and only rarely causes human infection, these reports may indicate a shift in transmission, with evidence suggesting human-to-human spread, particularly in humid and hot environments.

SARS-CoV-2 variant classification

- Since the last update on 24 April 2026, and as of 29 May 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 one EU/EEA country. Therefore, the statistics below represent a very limited part of the EU/EEA.
- The VOI and VUM median proportions in the EU/EEA for weeks 18–19, 2026 were:
  - BA.2.86 (VOI): 0.0%
  - NB.1.8.1 (VUM): 0.0%
  - XFG (VUM): 18.2%
  - BA.3.2 (VUM): 50.0%.

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

- Since the previous update on 4 May 2026, and as of 1 June 2026, two new MERS cases, including one fatality, in Saudi Arabia have been reported by the World Health Organization (WHO) Eastern Mediterranean Regional Office.
- Since the beginning of 2026, and as of 1 June 2026, two MERS cases, including one fatality, have been reported in Saudi Arabia.
- 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 remains unchanged and poses a low risk to the EU/EEA.

Multi-country cluster of Salmonella Stanley ST2045

- A multi-country cluster of Salmonella Stanley ST2045 is being investigated which currently involves 83 cases reported between the end of December 2025 and May 2026. Children and young adults are disproportionally represented among the cases. The outbreak is still ongoing.
- The confirmed cases with clustering isolate sequences linked to the Danish outbreak strain have been reported from Austria, Czechia, Denmark, Estonia, France, Germany, Lithuania, the Netherlands, and the UK.
- Epidemiological and microbiological investigations in the countries point towards chicken-flavoured instant noodles and/or processed chicken products as the suspected sources of infection, possibly through a shared ingredient.

Risk assessments under production

ECDC, jointly with the European Food Safety Authority (EFSA), is developing a 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.
ECDC, jointly with the European Food Safety Authority (EFSA), is developing a Rapid Outbreak Assessment for the Salmonella Stanley outbreak. The expected publication date is 1 July 2026.

ECDC is developing a Rapid Risk Assessment (RRA) on the spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA – 2026. The expected publication date is 23 June 2026.

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

Latest epidemiological information

Democratic Republic of the Congo

According to the official report published on 4 June 2026, based on data available until 3 June, a total of 381 confirmed cases, including 64 confirmed related deaths, have been reported. This is an increase of 18 new cases and two deaths compared to the report of 3 June. All new cases were reported from Ituri.

Among the confirmed cases, 359 have been reported in the Ituri province, 19 in North Kivu and three in South Kivu. In addition, 233 patients are reported to have been hospitalised in isolation. Seven individuals who previously tested positive have recovered and 55.5% of identified contacts are under follow-up.

Within the three provinces, 25/104 health zones are currently affected, including 17/36 in Ituri, 7/34 in North Kivu, and 1/34 in South Kivu. Of the 359 confirmed cases reported in Ituri, 94 have not been assigned to a health zone.

Laboratory capacity in DRC is being strengthened with the deployment of a new diagnostic device (RADIONE machine) in Mongbwalu Health Zone (Ituri province).

Uganda

Since the previous update of 2 June 2026 provided by the Ministry of Health of Uganda, one new case has been reported. As of 4 June, a total of 16 confirmed cases, including one death, had been reported by the Ministry of Health. Two individuals have been discharged from hospital.

Among the confirmed cases, at least seven were associated with local transmission events and four had travel links to DRC, according to health officials. The new case reported on 4 June by the Minister of Health had travel links to DRC. Of nine cases with known geographical information, eight were reported in Kampala and one was reported in Wakiso (neighbouring Kampala).

A case reported by Uganda had travel history to United Arab Emirates (UAE) (Media reports on 1 June 2026, WHO media briefing on 3 June 2026). WHO is coordinating with Uganda and UAE for information gathering, assessment and to facilitate contact tracing. On 3 June, the Ministry of Health and Prevention in the UAE stated that no cases of Ebola disease had been reported in the country.

Several symptomatic travellers from affected areas have been tested in the EU/EEA and non-EU/EEA countries, all of whom have been negative so far.

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, given the number of cases and the geographical spread.

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

On 18 May 2026, a US citizen working in healthcare in the affected areas tested positive and was transferred to Germany, together with six high-risk contacts (US CDC Update on Ebola Outbreak, 18 May 2026, Serge News and Updates, 18 May 2026). Another contact of US nationality was transferred to Czechia (US CDC Transcript -19 May 2026).

The first case reported in Uganda was travel-related and the patient later died (Democratic Republic of the Congo confirms new Ebola outbreak, WHO scales up support | WHO AFRO, 15 May 2026, Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026). At least four 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 insecurity and humanitarian challenges in the affected areas. According to WHO, neighbouring countries sharing land borders with DRC are considered at high risk of further spread due to population mobility, trade and travel links, and uncertainty about the transmission chains. The outbreak may also be larger than currently detected. There are also concerns related to this outbreak because it is caused by Bundibugyo virus, rather than the more commonly detected Zaire ebolavirus. Unlike Zaire ebolavirus, there are currently no licensed vaccines or specific treatments for Bundibugyo virus disease.

Given the information available, the complicated context and the uncertainties regarding epidemiological information, WHO declared a Public Health Emergency of International Concern on 17 May 2026 (Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026). On 18 May 2026, Africa CDC declared the outbreak a Public Health Emergency of Continental Security (Africa CDC Declares the Ongoing Bundibugyo Ebola Outbreak a Public Health Emergency of Continental Security – Africa CDC, 18 May 2026).

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

Enhanced control and screening protocols have been activated by authorities in several countries to limit the risk of viral spread.

Exit screening has been implemented in DRC, Uganda and South Sudan. In DRC, points of entry (PoE) and points of control (PoC) have been activated at key locations, including airports (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 Ministry of Health, 22 May on X).

Several countries have also implemented entry restrictions and health screening for individuals travelling from high-risk countries, including United States, Canada, Tunisia, Thailand, Mauritius and the Bahamas (Ebola Update - Travel Measures and Ongoing Monitoring).

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 is currently being reported – not only in terms of the number of affected cases, but also its geographical extent.

Given all the available information and uncertainties surrounding this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. 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 donor population for substances of human origin 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 they board flights to prevent them travelling while symptomatic. Exit screening also helps dissuade people with symptoms from travelling and enhances public and stakeholder confidence. However, it cannot fully prevent exportation of cases, because the absence of symptoms at departure does not exclude subsequent onset of disease. ECDC considers that screening of returning travellers from affected areas (DRC, Uganda) would not be effective in preventing introduction to Europe. This consideration is based on the lessons learned and results of the large EVD outbreak in West Africa between 2013 and 2016, where tens of thousands of cases were reported, transmission was ongoing in large urban centres, and hundreds of EU/EEA humanitarian and military personnel were deployed to the affected areas. Screening incoming travellers is time- and resource-consuming and will not effectively identify people with the infection. Priority should instead be given to providing travellers with clear information on symptoms, routes of transmission, and what to do if symptoms develop after arrival in the EU/EEA.
Detailed assessment of the event can be found in 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 continues to monitor 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.

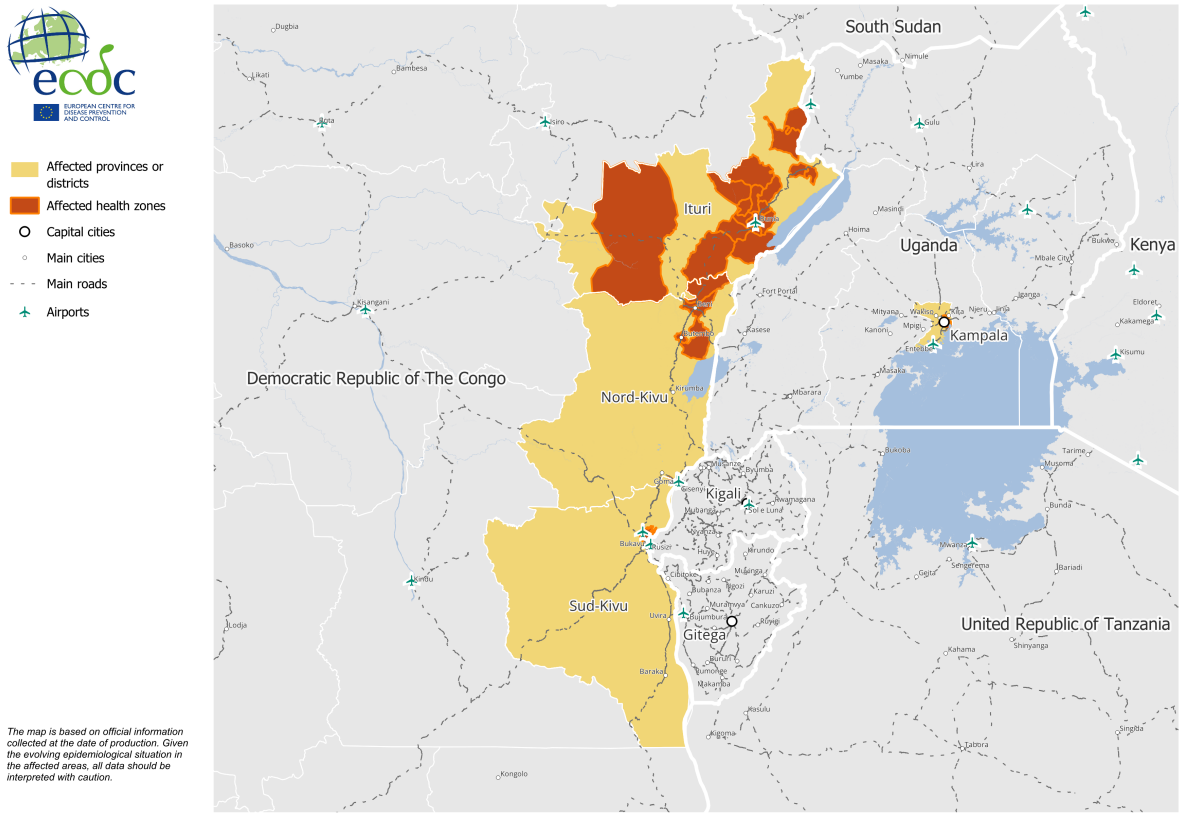
ECDC is actively liaising with key partners, including Africa CDC, the European Commission and WHO, to provide further support through the EU Health Task Force in response to this outbreak.

ECDC is regularly re-evaluating the situation as new information becomes available and continues to provide epidemiological updates and scientific advice on its website. A Threat Assessment Brief and Laboratory guidance and resources on the Ebola outbreak were published on 21 May 2026 and 27 May 2026, respectively.

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

Maps and graphs

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



Source: ECDC

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

Overview

Throughout the season, ECDC will publish a weekly report with updates 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 second report of the weekly seasonal surveillance of WNV infections in 2026.

In Europe, since the beginning of 2026, and as of 3 June, only North Macedonia has 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 until 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 the European Food Safety Authority (EFSA), which includes the number 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.

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

3. P. falciparum malaria - Mayotte, France - 2026

Overview

Since January 2026, and as of 21 May 2026, a total of 171 malaria cases has been reported in Mayotte.
Of these, 97 cases were imported, mainly from the Comoros islands where malaria transmission is ongoing, 63 were suspected to be autochthonous, and 11 were of unknown origin.

A notable increase in malaria activity has been observed during epidemiological weeks 18 to 20 (27 April to 17 May), with 75 cases reported during this period (average of 25 per week), compared with an average of six cases per week between weeks 1 and 17.

The majority of the recent cases have been reported in the southern part of the island, particularly in Chirongui municipality (41 cases), followed by Bandrélé (nine cases) and Dembéni (eight cases).

All reported cases have been confirmed by PCR and were due to Plasmodium falciparum.

The primary vector, Anopheles gambiae, is present in Mayotte with a heterogeneous distribution. Its presence has been confirmed in affected areas, including Chirongui, where environmental and behavioural factors (e.g. water retention creating breeding sites) facilitate transmission.

Control measures implemented include vector control activities (indoor residual spraying, larval source management), distribution of insecticide-treated nets, active case finding, and public health communication campaigns.

In 2025, 111 malaria cases were identified on the island of Mayotte, France, five of which were suspected to be autochthonous. These five autochthonous cases marked the first detection of local transmission in Mayotte

following a four-year period (2021–2024) during which no autochthonous cases were detected, and progress was made towards malaria elimination, with guidance and support from the World Health Organization.

ECDC assessment

The current dry season in Mayotte is less favourable for mosquito proliferation and may limit further transmission. However, the occurrence of autochthonous cases indicates that conditions remain sufficient to sustain local transmission. The likelihood of malaria infection for travellers to Mayotte is assessed as low, even for those visiting affected southern areas or staying for prolonged periods.

The likelihood of onward transmission of malaria in mainland EU/EEA following introduction by a parasitaemic traveller is currently considered very low.

The increase in malaria cases during weeks 18–20 of 2026, particularly the rise in suspected autochthonous cases, indicates intensification of local transmission in Mayotte.

The risk of further spread on the island remains, driven by several factors:

- the presence of a competent vector (Anopheles gambiae);
- ongoing importation of cases from neighbouring endemic areas, particularly the Comoros islands;
- increasing numbers and geographical spread of suspected autochthonous cases.

However, several mitigating factors are in place, including a robust surveillance system and rapid implementation of targeted control measures.

Continued vigilance is warranted, particularly with regard to early detection of cases, vector control, and public awareness.

It is important to strengthen communication to travellers and travel medicine clinics regarding the ongoing situation and the need for reinforced preventive measures. Protective measures include avoiding mosquito bites through the use of insect repellent, sleeping under insecticide-treated mosquito nets or in screened or air-conditioned rooms, and wearing clothing that covers most of the body, particularly during evening and night-time hours when Anopheles mosquitoes are most active. Depending on individual risk and national guidelines, chemoprophylaxis (antimalarial medication) should also be considered for travellers.

Actions

ECDC is monitoring the event through its epidemic intelligence activities.

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

Overview

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

April 2026 update

In April 2026, 102 mpox clade I cases were reported by 11 countries, with the highest numbers reported by Spain (33) and Germany (30). Following increases observed in late 2025, clade I transmission has remained relatively stable in 2026, with 90 cases reported in January, 82 in February, and 98 in March.

In April 2026, 23 mpox clade II cases were reported by seven countries, continuing a decreasing trend compared with previous months (31 cases in March and 64 cases in February). Germany reported the highest number of cases (12) – one case from Germany had co-infection with clades I and II and was coded as clade II in the database.

Overview of the past 12 months (May 2025–April 2026)
In the past 12 months, 16 countries have reported 458 mpox clade I cases and 18 countries have reported 921 mpox clade II cases. Interpretation of trends is limited due to missing clade information for approximately 39% of reported cases.

Among cases with complete information:

- 92% of clade I cases and 91% of clade II cases were reported among men who have sex with men.
- 13% of clade I cases and 8% of clade II cases were hospitalised. One death was reported associated with clade II infection; no deaths were reported among clade I cases.
- 22% of clade I cases and 17% of clade II cases with known vaccination status had received two vaccine doses.

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

ECDC assessment

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

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

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

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

Actions

The ECDC Threat Assessment Brief outlines actions that EU/EEA countries can take. ECDC continues to monitor mpox in the EU/EEA and globally through event- and indicator-based surveillance and collaboration with partners.

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

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

Further response options for EU/EEA countries include:

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

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

Further information

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

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

Maps and graphs

Figure 1. Total number of mpox cases by clade, by month of diagnosis in the past 12 months (May 2025 to April 2026), EU/EEA

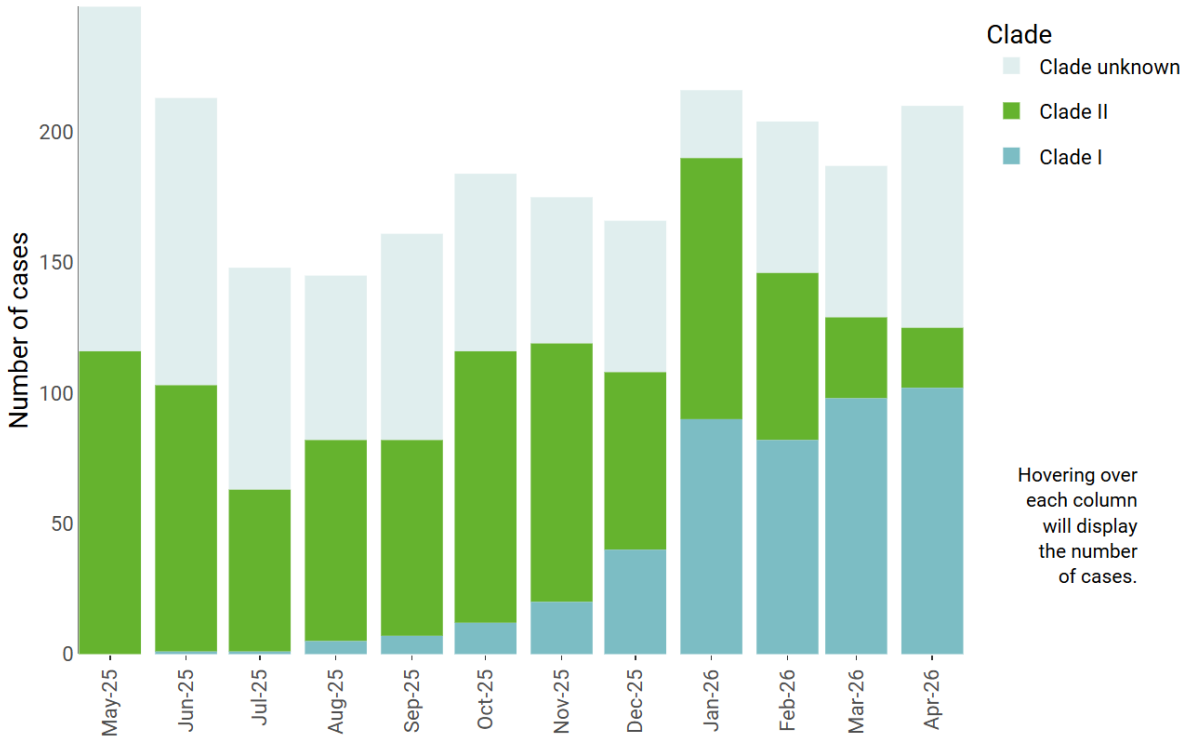


Figure 2. Mpox cases by clade in the past 12 months (May 2025 to April 2026), and past calendar month (April 2026), EU/EEA and Western Balkans and Türkiye

Country	Clade I		Clade II		Clade Unknown	
	Past 12 months	Past month	Past 12 months	Past month	Past 12 months	Past month
Austria	8	1	16			
Belgium	39	12	18		59	33
Croatia					2	
Czechia	4		7			
Denmark			6			
France	24	1	39	1	63	
Germany	92	30	183	12	212	25
Greece	2		3			
Hungary			2			
Iceland					1	
Ireland	9	1	34	1		
Italy	43	3	3		153	8
Lithuania					1	1
Luxembourg	1		5	1		
Malta			5			
Netherlands	30	12	116	3	9	2
Norway			14			
Poland	1				17	
Portugal	9	6	62	1	83	1
Romania	2	1			1	
Slovakia	4	2			1	1
Slovenia			2			
Spain	183	33	395	4	273	14
Sweden	7		11		3	
EU/EEA total	**458**	**102**	**921**	**23**	**878**	**85**
Albania			1			
North Macedonia			2			
Türkiye	3		3		3	

5. Spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA - 2026

Overview

On 11 May 2026 France reported 25 cases of Dermatophilus congolensis infections om EpiPulse. These cases were among men who have sex with men in the Lyon area. Most cases had visited a sauna, but the source of infection remains under investigation. The infection was successfully treated with amoxicillin, with full recovery and no complications. Whole-genome sequencing of isolates from eight patients in Lyon showed closely related strains (1–5 Single Nucleotide Polymorphism differences), suggesting recent transmission from a common source (Degrèze et al.).

A further nine cases of dermatophilosis were reported among men who have sex with men in Barcelona, Spain, between December 2025 and March 2026 (Descalzo et al.). All cases reported having visited venues for sexual encounters within the week preceding symptom onset, including eight who had visited a sauna. Skin lesions appeared on multiple anatomic sites, most commonly the genitals, thighs, groin, and beard area. Symptoms resolved after a course of antibiotics.

On 20 May 2026, Germany reported 16 cases of Dermatophilus congolensis infection in EpiPulse among men living in Berlin (14) and in the adjacent federal state of Brandenburg (2), with symptoms onset between December 2025 and April 2026. Of the 10 cases with available information, all self-identified as men who have sex with men and reported sauna visits in Germany (9) or Spain (1) during the incubation period. No additional epidemiological links were found between the cases identified in Germany.

As of 1 June 2026, the total number of cases was updated to 40 in France, including cases in additional regions, and to 17 in Germany. In Spain, three cases are under investigation in regions other than Catalonia, including one associated with travel to Asia in July 2025. Sequencing is ongoing in all three countries.

Sources: EpiPulse and two peer reviewed publications:

Descalzo V, et al. Suspected sexual transmission of dermatophilosis among men who have sex with men, Barcelona, Spain, 2025–2026. Emerg Infect Dis. 2026;32(6).

Degrèze N, et al. Suspected sexual transmission of dermatophilosis among men who have sex with men, Lyon and Paris, France, 2025–2026. Emerg Infect Dis. 2026;32(6).

ECDC assessment

Dermatophilus congolensis is a bacterium historically associated with animals which only rarely causes human infection. This increase may indicate a shift in transmission, with evidence suggesting human-to-human spread, particularly in humid and hot environments. Skin-to-skin contact appears to be the predominant mode of transmission; however, other routes, including transmission via contaminated surfaces, cannot be excluded. Closely related strains identified in Lyon suggest recent transmission from a common source for those cases. As this is the first reported event of such nature, there is uncertainty as to its future evolution. Reported infections have been mild, with full resolution of skin lesions after treatment. The preliminary risk assessment for the general population in the EU/EEA is very low. The preliminary risk assessment for men who have sex with men attending sex-on-premises saunas in the areas where cases have been reported is moderate.

Actions

ECDC is gathering more information on this event and preparing a Rapid Risk Assessment (RRA).
On 1 June 2026, ECDC held a teleconference with France, Germany and Spain to exchange information on cases, transmission hypotheses, clinical management and response measures.
ECDC has informed the International Union against Sexually Transmitted Infections (IUSTI) Europe of these cases to raise awareness among the European network of clinicians.
Preliminary recommendation for countries reporting cases include continued epidemiological investigations, enhanced surveillance, laboratory confirmation and genomic sequencing. Awareness-raising among clinicians and laboratories is also warranted. Countries are encouraged to share national investigations and compare genetic sequencing data by sharing genome assembly or accession numbers in EpiPulse. Targeted risk communication and prevention advice for men who have sex with men and sauna operators is advised, including messaging on dermatophilosis ahead of the upcoming Pride season.

6. SARS-CoV-2 variant classification

Overview

Since the last update on 24 April 2026, and as of 29 May 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.

The VOI median proportions in the EU/EEA for weeks 18–19, based on one reporting country:

- BA.2.86 (VOI): 0.0%.

The VUM median proportions in the EU/EEA for weeks 18-19 2026, based on one reporting country:

- NB.1.8.1 (VUM): 0.0%
- XFG (VUM): 18.2%
- BA.3.2 (VUM): 50.0%.

The calculations are based on data reported to GISAID, as of 25 May 2026. Note that for this update, sufficient data for estimating variant proportions during the reporting weeks were only available from one EU/EEA country. 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 (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: 30 April 2026

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

Overview

Update: Since the previous update on 4 May 2026, and as of 1 June 2026, two new MERS cases, including one fatality, in Saudi Arabia have been reported by the World Health Organization (WHO) Eastern Mediterranean Regional Office (EMRO). Both cases are male adults and have unknown source of infection. One case had date of reporting in March 2026 and the fatal case had date of reporting in April 2026.

Summary: Since the beginning of 2026, and as of 1 June 2026, two MERS cases, including one fatality, have been reported in Saudi Arabia.

Since April 2012, and as of 1 June 2026, a total of 2 649 MERS cases, including 960 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 remains unchanged and 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.

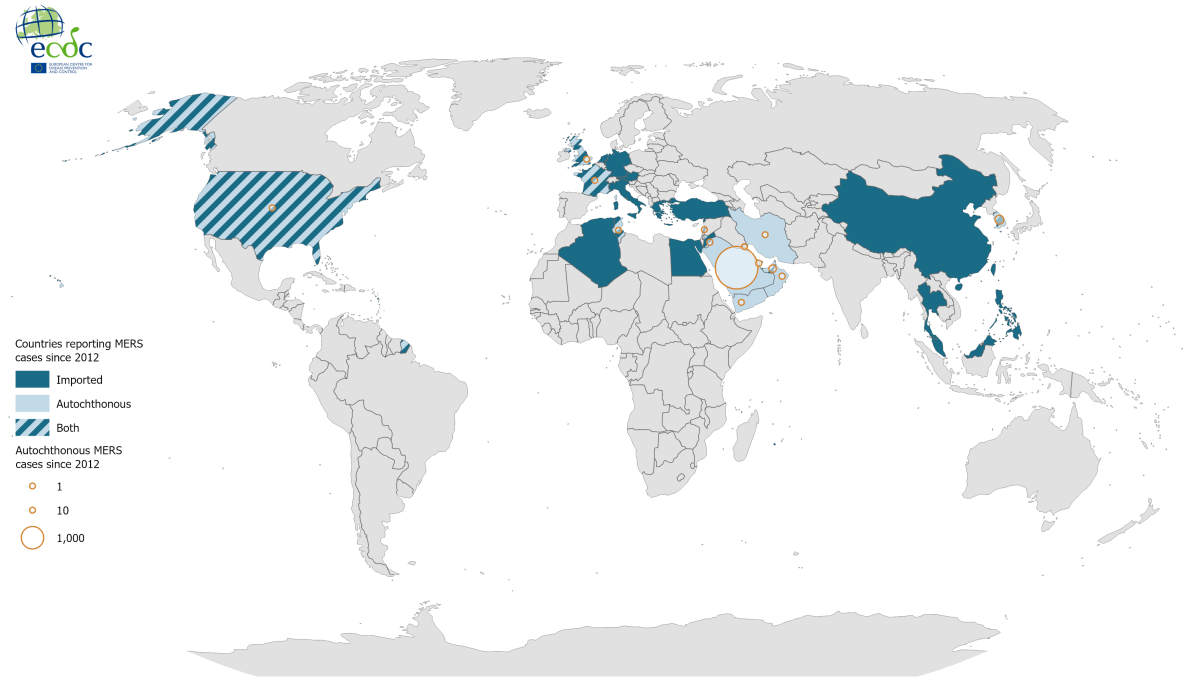
Actions

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: 8 May 2026.

Maps and graphs

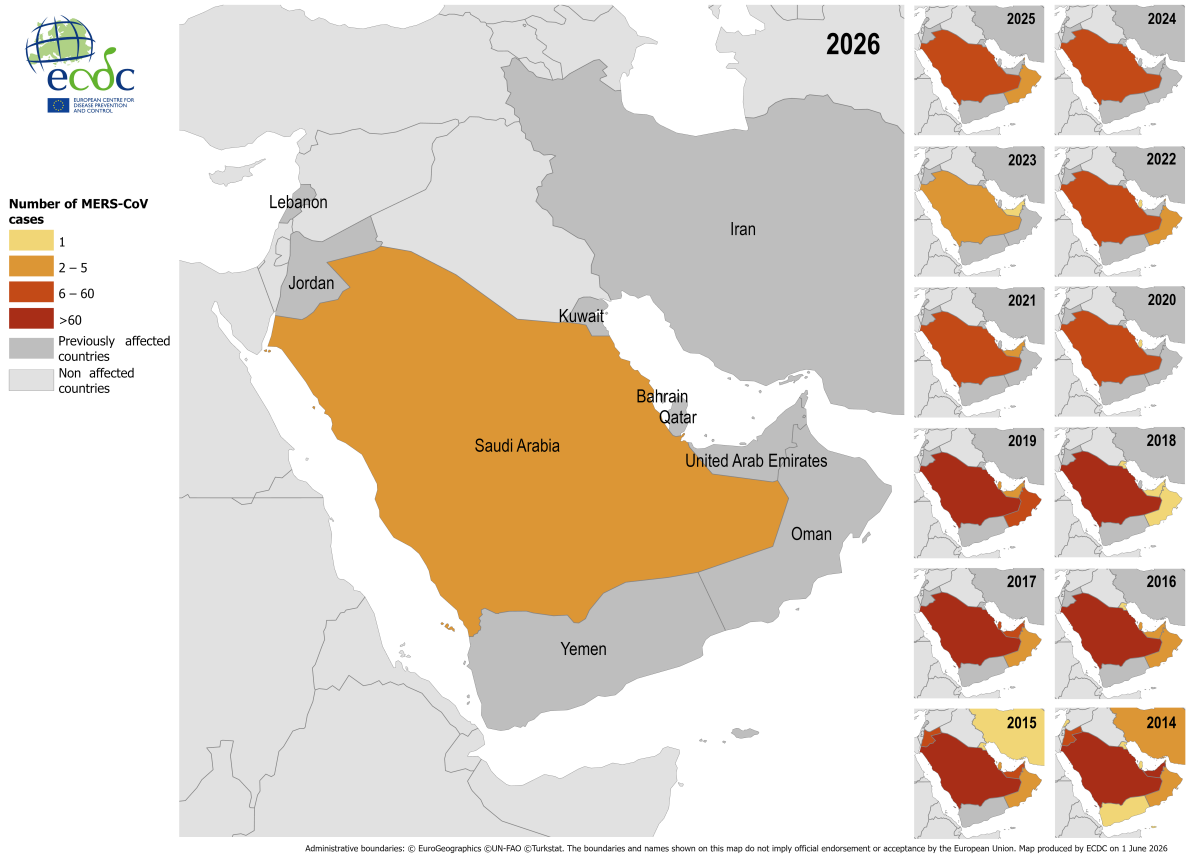
Figure 1. Geographical distribution of confirmed cases of MERS-CoV by reporting country, April 2012 - May 2026



Administrative boundaries: © EuroGeographics ©UN-FAO ©Turkstat. The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union. Map produced by ECDC on 1 June 2026

Source: ECDC

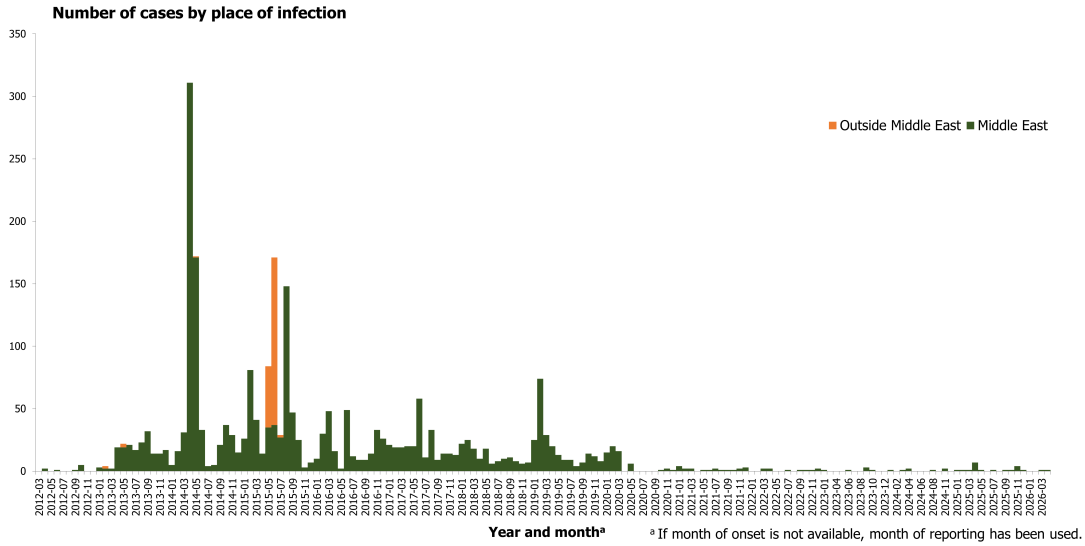
Figure 2. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2014 – May 2026



Administrative boundaries: © EuroGeographics ©UN-FAO ©Turkstat. The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union. Map produced by ECDC on 1 June 2026

Source: ECDC

Figure 3. Distribution of confirmed cases of MERS by place of infection and month of onset, April 2012 – May 2026



Source: ECDC

8. Multi-country cluster of Salmonella Stanley ST2045

Overview

The multi-country outbreak of Salmonella Stanley ST2045 reported in the Communicable disease threats report, 2-8 May 2026, Week 19 is still ongoing. The outbreak is predominantly affecting children and young adults, with at least 20 hospitalised cases, indicating a significant public health impact.

As of 5 June 2026, 83 confirmed cases have been reported with symptom onset between December 2025 and mid-May 2026. In addition, 24 further Salmonella Stanley cases identified in 2026 have not yet been sequenced and may be linked. New cases continue to be identified, suggesting ongoing exposure.

Denmark initially detected the outbreak and posted a notification in EpiPulse on 23 March 2026. The cases belong to a tight genetic cluster and have been identified in Austria, Czechia, Denmark, Estonia, France, Germany, Lithuania, the Netherlands, and the United Kingdom.

Epidemiological investigations indicate a suspected link to chicken-flavoured instant noodles and/or processed chicken products. Some cases reported consuming instant noodles without preparation (i.e. uncooked, just with the seasoning that comes with the noodles).

There are currently 19 S. Stanley human isolates clustering in the ECDC's Molecular Typing Tool (MTT). The isolates are all from 2026 and from three of the European countries that have reported cases in the EpiPulse event.

ECDC assessment

The identification of a tight genetic cluster of Salmonella Stanley ST2045 involving multiple countries, combined with the temporal distribution of cases, suggests a common source of the outbreak. The predominance of young age groups may indicate a specific exposure pattern, food preference or consumption habits. Several cases report having consumed instant noodles of the same brand. However, not all cases can be explained by this exposure. Investigations are still ongoing and more cases might be expected. Based on what is currently known, the overall risk of Salmonella Stanley infection is assessed as very low for the general population and low for children and young adults, as long as cooking instructions are adhered to.

Actions

Consumers should follow the manufacturer's instructions when preparing and consuming instant noodles and the related spice mix, which are not ready to eat food.

Continued coordinated investigations are essential to identify the source(s) and prevent further transmission. ECDC and the European Food Safety Authority (EFSA) will coordinate a joint rapid outbreak assessment to further assess the source of the outbreak.

Countries are encouraged to share epidemiological and microbiological information in the EpiPulse event, and to report isolate sequencing data to ECDC.

ECDC is monitoring the event via EpiPulse and collaborating closely with the affected countries and with EFSA.

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

9. Risk assessments under production

ECDC, jointly with the European Food Safety Authority (EFSA), is developing a 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.

ECDC, jointly with the European Food Safety Authority (EFSA), is developing a Rapid Outbreak Assessment for the Salmonella Stanley outbreak. The expected publication date is 1 July 2026.

ECDC is developing a Rapid Risk Assessment (RRA) on the spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA – 2026. The expected publication date is 23 June 2026.

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

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 29 May 2026
- Hantavirus disease outbreak on cruise ship – South Atlantic – 2026 - last reported on 29 May 2026
- Expert deployment - last reported on 22 May 2026
- Chikungunya virus disease – French Guiana, France – 2026 - last reported on 22 May 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring - last reported on 22 May 2026
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 22 May 2026
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - last reported on 13 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 in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 5 June 2026
- Spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA - 2026 - last reported on 5 June 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 5 June 2026
- Seasonal surveillance of West Nile Virus infections - 2026 (Weekly report) - last reported on 05 June 2026
- P. falciparum malaria - Mayotte, France - 2026 - last reported on 5 June 2026
- SARS-CoV-2 variant classification - last reported on 5 June 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 5 June 2026
- Risk assessments under production - last reported on 5 June 2026
- Multi-country cluster of Salmonella Stanley ST2045 - Europe - 2026 - last reported on 5 June 2026.