WEEKLY BULLETIN

Communicable disease threats report

Week 3, 10–16 January 2026

This week's topics

1. Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring
2. Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2025
3. Overview of respiratory virus epidemiology in the EU/EEA
4. Marburg virus disease (MVD) – Ethiopia – 2025/26

Executive Summary

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

- In November 2025, 12 EU/EEA countries reported 83 measles cases. Eighteen countries reported zero cases.
- During the last 12-month period, 10 deaths attributable to measles were reported to ECDC by Romania (5), France (4) and the Netherlands (1).
- Overall, case numbers decreased compared with the previous months, which is consistent with the seasonality of measles.
- Supplementary epidemic intelligence surveillance was performed between 15 and 16 January 2026. Sporadic cases and clusters were reported in several EU/EEA countries. No new outbreaks have been detected . Updates are provided for countries outside the EU/EEA.

Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2025

- Since 1 December 2025, and as of 15 January 2026, 158 mpox cases have been reported to TESSy from 12 EU/EEA countries: Spain (66), Germany (21), Portugal (19), Italy (17), the Netherlands (12), France (11), Poland (5), Belgium (2), Ireland (2), Austria (1), Czechia (1) and Sweden (1).
- Since 1 December 2025, and as of 15 January 2026, 40 mpox cases caused by monkeypox virus (MPXV) clade Ib were reported to TESSy from Spain (28), Italy (5), France (3), the Netherlands (2), Ireland (1) and Germany (1). Two additional cases were reported from Germany through event-based surveillance. One clade Ib mpox case was also reported from Türkiye.

European Centre for Disease Prevention and Control, Solna, Sweden
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- EU/EEA countries have reported 108 mpox cases caused by MPXV clade I to TESSy since August 2024, as of 15 January 2026. Information on sexual behaviour was available for 58 cases; of these, 48 cases were reported among men who have sex with men and all except two cases had symptom onset since October 2025. The majority of cases among men who have sex with men do not have a travel link to a country with clade Ib mpox transmission. This indicates ongoing transmission in sexual networks of gay, bisexual and other men who have sex with men.
- The risk of clade Ib mpox is assessed as moderate for men who have sex with men and low for the general population in the EU/EEA.
- Implementing vaccination strategies is key, with a focus on pre-exposure vaccination and maintaining active risk communication and community engagement.
- Identifying clades should be done where individuals have been diagnosed with mpox. Countries are encouraged to report new clade I mpox cases as soon as possible in EpiPulse Events and to also report the case to TESSy through case-based surveillance.
- Countries should continue efforts to sequence all positive cases and ensure that sequences are deposited in public repositories (ENA, SRA, and/or GISAID EpiPox) or shared with ECDC through the EpiPulse platform or other means.

Overview of respiratory virus epidemiology in the EU/EEA

Summary

The number of people visiting their general practitioner with symptoms of respiratory illness is elevated in most reporting countries. This indicates that there is widespread respiratory virus circulation in the European Union/European Economic Area (EU/EEA).

Influenza virus circulation is high and affecting all age groups, with the peak appearing to have passed in most countries. Influenza A(H3N2) remains the dominant subtype, followed by A(H1N1)pdm09. An overall decreasing trend in hospitalisations reflects what is being observed in primary care; however, hospital admissions remain elevated, with the highest numbers seen in adults 65 years old and above.

Early estimates of seasonal influenza vaccine effectiveness in the EU/EEA for the season 2025-2026 were published by ECDC on 19 December 2025, and match those published for A(H3N2) viruses by other countries.

Respiratory syncytial virus (RSV) circulation is elevated and continues to slowly increase. RSV-related hospitalisations are at lower levels than have been observed at this time of year in the past four seasons. Hospital admissions are rising in a few countries, primarily among children under five years of age.

SARS-CoV-2 circulation remains low in all age groups, and the impact on hospitalisations is currently limited.

EuroMOMO reports elevated levels of all-cause mortality, driven by increased mortality in several countries in age groups above 65 years old.

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'.

Marburg virus disease (MVD) – Ethiopia – 2025/26

- Since the update on 9 January 2026, there have been no additional confirmed cases and no additional deaths from Marburg virus disease (MVD) reported in Ethiopia.
- Since the outbreak was declared on 14 November 2025, and as of 13 January 2026, 17 cases (14 confirmed and three probable) of MVD have been reported, including 12 deaths (nine confirmed and three probable (case fatality rate (CFR): 64.3%)).
- The last confirmed case was reported on 12 December 2025 and, as of 14 December 2025, there are no cases being treated.
- Two areas have been affected across two regions: Jinka town in South Ethiopia Regional State and Hawassa City in Sidama Region.
- The outbreak will be declared over 42 days after the death of the last MVD patient or 42 days after the last MVD patient tests negative and is discharged. This is the first MVD outbreak ever reported in Ethiopia.

- The overall risk for EU/EEA residents visiting or living in Ethiopia is assessed as low.
- In the event of MVD cases being imported into the EU/EEA, we consider the likelihood of further transmission to be very low, and the associated impact low. Therefore, the overall risk for the EU/EEA is assessed as low.

1. Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring

Overview:

Since March 2025, there has been an overall decrease in reported measles cases. As expected, the number of cases further declined over the summer months, in line with the known seasonality of the disease.

In November 2025, 30 EU/EEA countries reported measles data, with 12 countries reporting 83 cases. Eighteen countries reported zero cases.

Overall, case numbers decreased compared with the previous month; however, this is subject to change in the event of a future retrospective update. The highest case counts were reported by Poland (30), Germany (16), Italy (11) and Spain (10).

Between 1 December 2024 and 30 November 2025, 30 EU/EEA countries reported a total of 8 826 measles cases, 6 357 (72.0%) of which were laboratory confirmed.

Of the 8 826 cases with known age, 3 533 (40.0%) were in children under five years old; 2 973 (33.7%) cases were in individuals 15 years old or above. The highest notification rates were observed among infants under one year old (292.9 cases per million population) and children one to four years old (148.3 cases per million population).

Of 8 342 cases (94.5% of all cases) with known age and vaccination status, 6 788 (81.4%) were unvaccinated, 811 (9.7%) were vaccinated with one dose of a measles-containing vaccine, 608 (7.3%) were vaccinated with two or more doses, and 121 (1.5%) were vaccinated with an unknown number of doses.

During the 12-month period, 10 deaths (case fatality rate (CFR): 0.113%) attributable to measles were reported to ECDC by Romania (5), France (4) and the Netherlands (1). Detailed data are available in ECDC's Surveillance Atlas of Infectious Diseases.

Complementary epidemic intelligence surveillance was conducted, with data collection between 15 and 16 January 2026. No new outbreaks have been detected; sporadic cases and clusters have been reported by several EU/EEA countries. Outside the EU/EEA, updates have been provided for Canada, England, Israel, Mexico, Ukraine, and the United States (US), as well as and for the Africa CDC and World Health Organization Pan American Health Organization (WHO PAHO) regions.

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:

Austria reported two new cases in 2026 (from 1 January 2026 to 14 January 2026). In 2025, Austria reported 152 measles cases.

Denmark reported 12 cases in 2025 (data access date: 15 January 2026), an increase of three cases since November 2025.

Estonia reported 11 cases in 2025 (data access: 15 January 2026), an increase of four cases since the previous report.

France reported 868 cases from 1 January to 30 November 2025, including four deaths (all in immunocompromised patients), an increase of 10 cases and two deaths since 31 October 2025. Of the reported cases, 113 were clustered cases.

Germany reported 283 confirmed and probable cases in 2025 (weeks 1–52), an increase by five cases since 9 December 2025. In 2026, 11 confirmed and probable cases have been reported form weeks 1–3. No outbreaks have been detected by the ECDC Epidemic Intelligence group.

Ireland reported two cases in week 53 in 2025 and no new cases in the last 12 weeks.

Italy reported 485 cases (454 laboratory confirmed, 11 probable and 20 possible) from 1 January to 30 November 2025, an increase of 26 cases since 30 September 2025. Of the reported cases, 73 were imported and 26 were related to imported cases. Of the laboratory-confirmed cases, 62% were genotyped, with 131 samples positive for genotype D8 and 144 for genotype B3.

Lithuania reported 11 cases in 2025, an increase of two cases since 7 October 2025. In 2026, and as of 15 January 2026, no new cases have been reported.

The Netherlands reported 539 cases in 2025 and no new cases in 2026 as of 7 January 2026, an increase of one case since 3 December 2025. There is no indication of a national outbreak. In 2025, 62 cases contracted measles abroad, with most of these infections related to travel to Morocco (39). Other cases had travel histories to Greece, Romania, Vietnam, Türkiye, Belgium, Uganda, Iran, Bosnia and Herzegovina, China, Malaysia, France, Somalia and Italy.

Poland reported 127 cases, an increase of 26 cases between 30 November and 31 December 2025. The 26 cases are related to the previously reported outbreak in Podkarpackie Voivodeship.

Romania reported 8 472 cases and eight deaths in 2025 and, as of 31 December 2025, an increase of 18 cases since 30 November 2025. No new deaths were reported in this period. The number of cases has decreased considerably in the past five months, with fewer cases reported per month compared with the same period in 2024.

Spain reported 397 cases in 2025, an increase of seven cases from 30 November to 28 December 2025. Of these reported cases, 108 were imported and 95 were related to imported cases. In 2026, there were no new cases reported as of 11 January 2026.

Sweden reported nine cases in 2025, as of 15 January 2026, a decrease of one case since the beginning of December 2025.

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

No new outbreaks or cases have been detected in the recently reported outbreaks during this reporting period.

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

England reported 957 laboratory-confirmed cases from January 2025 to the week starting on 5 January 2026, 110 more cases since 20 November 2025. The majority of cases involve children under 10 years old (69%). Most of the cases have been reported in Hackney, the City of London, Birmingham and Bristol. In 2024, England reported 2 911 laboratory-confirmed cases, the highest number of cases reported annually.

Israel reported 878 measles hospitalisations in 2025 and as of 12 January 2026, including 13 deaths from measles.

Ukraine reported 1 456 measles cases from January to November 2025, an increase of three cases since October 2025.

Canada reported 5 425 cases (5 045 confirmed, 380 probable) in 2025 (as of 3 January 2026). Two deaths have been reported. Both deaths occurred in congenital cases of measles, where the babies were born pre-term. Cases have been reported in 10 jurisdictions. Overall, the number of cases has decreased in Canada since the peak in week 18 2025.

As of 14 January 2026, the US reported 171 new confirmed cases in 2026, reported from five jurisdictions, and no new outbreaks. In 2025, the US reported 2 242 confirmed cases, including three deaths, in 45 jurisdictions. The majority of the cases in 2025 (89%) were associated with 49 outbreaks.

As of 15 January 2026, Mexico, in 2025, reported 6 427 confirmed cases, including 24 deaths. Most of the cases were reported in the Chihuahua region (4 490 confirmed cases, including 21 deaths). One death was reported in each of the following states: Jalisco, Durango and Sonora. In 2026 (weeks 1–2), 459 cases were reported and no deaths. Most of the cases in 2026, in Mexico, were reported in the Jalisco (252) and Chiapas (111) regions.

According to a report by Africa CDC published on 24 December 2025, Mali and Mozambique are experiencing measles outbreaks with moderate risk.

According to the WHO PAHO report published on 3 January 2026 (data for weeks 1–53, 2025), 14 504 confirmed cases were reported by 13 countries, with the majority of cases being reported in Canada (5 425), Mexico (6 152), the United States (2 144) and Bolivia (595).

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 the holiday period.

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: 12 December 2025

2. Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2025

Overview:

Summary of mpox clade I

Since 1 December 2025, and as of 15 January 2026, 40 clade Ib mpox cases were reported to TESSy from Spain (28), Italy (5), France (3), the Netherlands (2), Ireland (1) and Germany (1). In addition, two cases from Germany were reported in January through event-based surveillance, as well as one case reported by Mayotte (France outermost region) with travel history to Madagascar.

Overall, EU/EEA countries have reported 108 clade I mpox cases to TESSy since August 2024 and as of 15 January 2026: Spain (45), Germany (16), the Netherlands (12), Italy (11), Belgium (8), France (7), Ireland (5), Greece (1), Portugal (1), Romania (1) and Sweden (1). All were clade Ib except the first case in Ireland, which was clade Ia. Of all 103 mpox cases with information on hospitalisation available, 10 were hospitalised for treatment.

Of the 61 cases with information available on sexual behaviour, 51 were reported in men who have sex with men: Spain (34), the Netherlands (10), Germany (3), Belgium (2), Greece (1) and Ireland (1). All cases among men who have sex with men, except the case in Greece and one case in Belgium, had symptom onset since October 2025. The cases reported from Spain are reported from four different regions and the cases from Germany are all from Berlin.

Forty-five cases among men who have sex with men had travel information available and 36 were due to local transmission. One country reported a case in November related to travel to the Netherlands, one country reported a case in December related to travel to Switzerland, and two countries reported one case each in December directly or indirectly related to travel to Germany.

Of the 48 cases among men who have sex with men with known hospitalisation status, four were hospitalised but it is unknown whether the reason for hospitalisation was for treatment or isolation. Of the 45 cases among men who have sex with men with vaccination information available, 33 were unvaccinated, nine were vaccinated with two doses and three with one dose.

These results indicate ongoing transmission of clade I mpox in sexual networks of gay, bisexual and other men who have sex with men, including local transmission in the EU/EEA. Prior to October 2025, all cases were imported or directly related to imported cases, and were related to heterosexual and household transmission.

Overall situation

Since 1 December 2025, and as of 15 January 2025, 158 mpox cases have been reported from 12 EU/EEA countries: Spain (66), Germany (21), Portugal (19), Italy (17), the Netherlands (12), France (11), Poland (5), Belgium (2), Ireland (2), Austria (1), Czechia (1) and Sweden (1). Since 1 December 2025, no new countries have reported confirmed cases.

Since the start of the mpox outbreak and as of 15 January 2026, 25 975 confirmed cases of mpox have been reported from 29 EU/EEA countries: Spain (9 315), Germany (4 594), France (4 480), the Netherlands (1 585), Portugal (1 314), Italy (1 313), Belgium (919), Austria (387), Sweden (374), Ireland (324), Poland (257), Denmark (247), Greece (161), Norway (132), Czechia (110), Hungary (90), Luxembourg (66), Romania (51), Malta (49), Slovenia (48), Finland (43), Croatia (39), Slovakia (19), Iceland (18), Bulgaria (11), Estonia (11), Cyprus (6), Latvia (6) and Lithuania (6). Deaths have been reported from: Spain (4), Belgium (2), Portugal (2), Austria (1) and Czechia (1).

Since the start of the mpox outbreak, and as of 15 January 2026, the following Western Balkan countries have reported confirmed cases of mpox: Serbia (40), Bosnia and Herzegovina (9), Montenegro (2), North Macedonia (2), Albania (1) and Kosovo* (1). In addition, 75 cases have been reported from Türkiye, one of which was caused by clade Ia MPXV and five by clade Ib MPXV, the most recent being reported in December 2025.

Other than the 108 clade I mpox cases, all other mpox cases with available information on clade reported to TESSy in the EU/EEA were MPXV clade IIb. Mpox cases caused by clade II MPXV reported in 2025 share the same epidemiological profile as those reported since the beginning of the outbreak in the EU/EEA, with the majority of cases occurring in men, and sexual contact among men who have sex with men remaining the primary mode of transmission.

For more information on the global update regarding MPXV clades I and II, please refer to the Weekly Communicable Diseases Threats Report and the ECDC webpage: Mpox worldwide overview.

**This designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the International Court of Justice (ICJ) Opinion on the Kosovo declaration of independence.*

ECDC assessment:

The total number of overall new infections reported to ECDC is similar to previous months and the overall number remains relatively low in the EU/EEA. However, the multiple recently reported clade Ib mpox cases among men who have sex with men with no travel links represent a new pattern of transmission and the large number of cases reported in December is concerning.

ECDC published a Threat Assessment Brief on 24 October 2025 to assess the new situation. 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, reflecting current evidence and considerable uncertainties around transmissibility and severity of clade Ib infection relative to clade IIb. 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.

A Threat Assessment Brief on the detection of autochthonous transmission of monkeypox virus (MPXV) clade Ib in the EU/EEA was published on 24 October. It summarises the information on new cases and outlines actions EU/EEA countries can take, including testing, sequencing and contact tracing; promoting vaccination; risk communication; and community engagement activities. The brief also outlines the knowledge gaps that remain, including on transmissibility and severity of MPXV clade Ib compared with clade IIb.

Recommendations for EU/EEA countries include raising awareness among healthcare professionals; supporting sexual health services in case detection, contact tracing, and case management; making testing easily accessible; implementing vaccination strategies with a focus on pre-exposure vaccination and maintaining active risk communication and community engagement.

Primary preventive vaccination (PPV) and post-exposure preventive vaccination (PEPV) strategies may be combined to focus on 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.Health promotion interventions and community engagement are also critical to ensure effective outreach and high vaccine acceptance and uptake among those most at risk of exposure.

In addition to increased risk of local transmission of MPXV clade Ib among men who have sex with men, it is likely that mpox cases caused by MPXV clade I will continue to be introduced into the EU/EEA through returning travellers. This is the case particularly after holiday travel. It is important to raise awareness concerning the possible importation of cases, both among returning travellers from affected African countries and among healthcare professionals who may see such patients.

Actions:

ECDC is continuously monitoring mpox in the EU/EEA and globally through event- and indicator-based surveillance, and remains in contact with partners. ECDC is in contact with affected countries to gather further information.

Countries are encouraged to report new mpox cases caused by MPXV clade I as soon as possible in EpiPulse Events and to also report these cases to TESSy through case-based surveillance as soon as possible, with information on clade and subclade, vaccination status, prior infection, symptoms, hospitalisation status, transmission category, HIV status, etc. Countries can update TESSy records as additional information becomes available, but it is important to submit clade I mpox cases as soon as possible to TESSy even though the overall reporting deadline is the first Wednesday of the month.

Countries should continue efforts to sequence all positive cases and ensure that sequences are deposited in public repositories (ENA, SRA, and/or GISAID EpiPox) or shared with ECDC through the EpiPulse platform or other means.

Countries are also asked to submit as much detailed information as possible on clade II mpox cases, as this will allow us to do a direct comparison of severity between clade I and clade II mpox cases from the same time period.

ECDC has been assessing the risk of mpox in the multi-country outbreak 2022/23 as well as the emergence of clade I. Previous risk assessments and other information can be found at the foot of this page: https://www.ecdc.europa.eu/en/mpox together with a rapid scientific advice on public health measures. A resource toolkit for event organisers and social media materials on mpox related to events are also available.

Last time this event was included in the Weekly CDTR: 19 December 2025

3. 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.

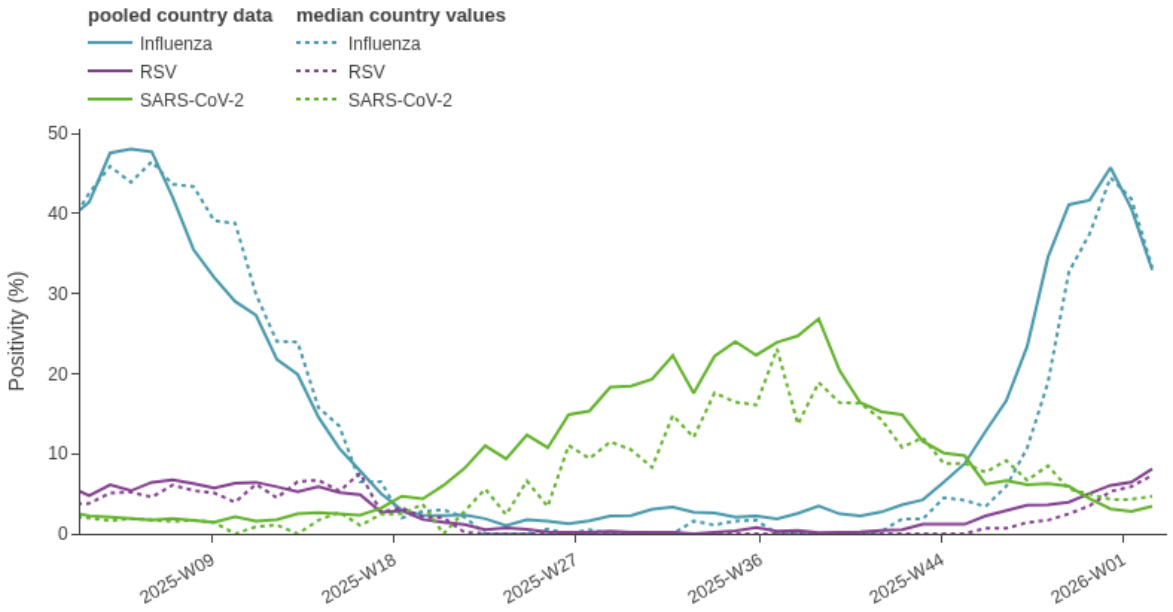
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 9 January 2026

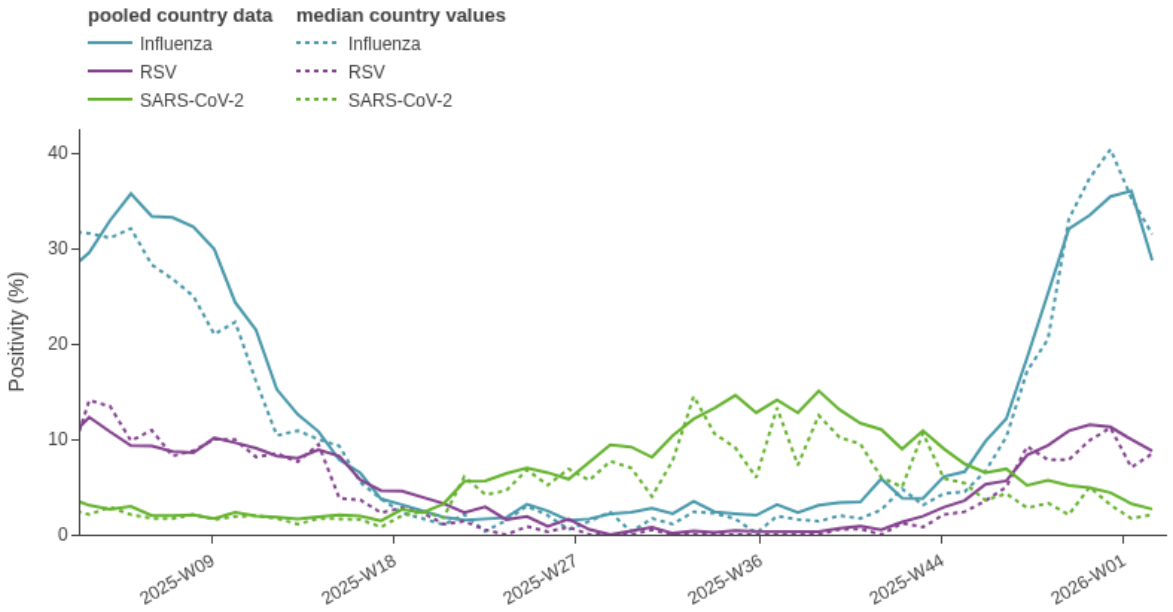
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 3. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 2	Week 1	Description	Value
ILI/ARI consultation rates in primary care	ARI	17 rates (10 MEM)	18 rates (10 MEM)	Distribution of country MEM categories	6 Baseline 4 Low
	ILI	19 rates (18 MEM)	21 rates (20 MEM)		4 Baseline 7 Low 7 Medium
ILI/ARI test positivity in primary care	Influenza	19	20	Pooled (median; IQR)	33% (33; 27–37%)
	RSV	18	19		8.1% (7.3; 2.5–12%)
	SARS-CoV-2	17	19		3.4% (4.7; 2–7.1%)
SARI rates in hospitals	SARI	11	12	–	–
SARI test positivity in hospitals	Influenza	10	11	Pooled (median; IQR)	29% (32; 23–36%)
	RSV	11	11		8.8% (8.5; 8.5–13%)
	SARS-CoV-2	10	11		2.7% (2.1; 0.8–3.6%)
Intensity (country-defined)	Influenza	23	25	Distribution of country qualitative categories	1 Baseline 4 Low 13 Medium 5 High
Geographic spread (country-defined)	Influenza	22	24	Distribution of country qualitative categories	1 Local 3 Regional 18 Widespread

Source: ECDC

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

	Week 2, 2026		Week 40, 2025 – week 2, 2026	
Pathogen	N	%[a]	N	%[a]
Influenza	**653**	**–**	**9491**	**–**
Influenza A	623	100	9297	100
A(H1)pdm09	122	28	1927	24
A(H3)	319	72	6064	76
A (unknown)	182	–	1306	–
Influenza B	3	0.5	37	0.4
B/Vic	1	100	7	100
B (unknown)	2	–	30	–
Influenza untyped	27	–	157	–
RSV	**141**	**–**	**1186**	**–**
RSV-A	30	48	288	59
RSV-B	32	52	204	41
RSV untyped	79	–	694	–
SARS-CoV-2	**58**	**–**	**2956**	**–**

Source: ECDC

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

	Week 2, 2026		Week 40, 2025 – week 2, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**705**	**–**	**7020**	**–**
Influenza A	375	100	4661	99
A(H1)pdm09	43	41	551	35
A(H3)	62	59	1025	65
A (unknown)	270	–	3085	–
Influenza B	1	0.3	36	0.8
B/Vic	0	–	4	100
B (unknown)	1	–	32	–
Influenza untyped	329	–	2323	–
RSV	**171**	**–**	**1931**	**–**
RSV-A	8	44	474	59
RSV-B	10	56	330	41
RSV untyped	153	–	1127	–
SARS-CoV-2	**61**	**–**	**2057**	**–**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 2, 2026

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	1155	44	5a.2a.1(D.3.1)	1145	99
			5a.2a(C.1.9.3)	5	0.4
			5a.2a.1(D)	5	0.4
A(H3)	1458	56	2a.3a.1(K)	1341	92
			2a.3a.1(J.2)	81	6
			2a.3a.1(J.2.4)	19	1
			2a.3a.1(J.2.2)	17	1
B/Vic	6	0.2	V1A.3a.2(C.5.6)	3	50
			V1A.3a.2(C.5)	2	33
			V1A.3a.2(C.5.1)	1	17

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, week 50, 2025 – week 51, 2025

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	1	7% (7–7%)
XFG	VUM	1	8	57% (57–57%)
NB.1.8.1	VUM	1	2	14% (14–14%)

Source: ECDC

4. Marburg virus disease (MVD) – Ethiopia – 2025/26

Overview:

Update

Since the update on 9 January 2026, and as of 13 January 2026, there have been no additional confirmed cases of Marburg virus disease (MVD) reported in Ethiopia. The most recent confirmed case was reported on 12 December 2025.

On 15 January 2026, Africa CDC reported that in December 2025, there were three deaths reported in South Sudan due to suspected MVD and investigations are still underway. Furthermore, an alert was reported in Wajaale, a major border city in Somalialand, according to Africa CDC.

Summary

Case information

Since the outbreak was confirmed by the Ethiopian Ministry of Health on 14 November 2025, and as of 13 January 2026, 17 cases (14 laboratory confirmed and three probable) of MVD have been reported in Ethiopia, according to Africa CDC. A total of 12 deaths have been reported, nine of which were in laboratory-confirmed cases and three in probable cases (CFR among confirmed cases: 64.3%). Investigations into the source of the outbreak are ongoing.

Cases have presented with symptoms including sudden fever, muscle pain, severe fatigue, headache, diarrhoea, vomiting and, in later stages, unexplained bleeding. A total of five cases have recovered (29.4%) and, as of 14 December 2025, there are no cases being treated, according to the Ministry of Health.

Geographical spread

According to an Africa CDC press briefing, as of 16 December, two areas have been affected across two regions: Jinka town in South Ethiopia Regional State and Hawassa City in Sidama Region. Jinka town is considered to be the epicentre of the outbreak. According to media quoting the Ethiopian Ministry of Health on 27 November, one of the cases was confirmed in Hawassa City, Sidama Region, after returning from Jinka town.

Response activities

According to a press release from the Ethiopian Ministry of Health on 5 January 2026, a total of 886 contacts were monitored. In alignment with the World Health Organization (WHO) and Ethiopian Marburg Disease Surveillance and Response Guidelines, the outbreak will be declared over 42 days after the death of the last MVD patient or 42 days after the last MVD patient tests negative and is discharged.

On 8 December 2025, the Ethiopian Ministry of Health reported that a vaccine trial had begun in the two affected regions, South Ethiopia Regional State and Sidama Region. According to an Africa CDC press briefing on 11 December, 2 500 doses of the cAd3-Marburg vaccine have been provided and are being offered to healthcare professionals and contacts of cases. The use of monoclonal antibody treatment has been implemented.

According to WHO, the virus strain shows similarities to those previously identified in East Africa.

In response to the outbreak, the Ethiopian Ministry of Health reported that community-level monitoring, contact tracing, and house-to-house case finding were being intensified. Response efforts to this event are underway by international partners. South Sudan, Kenya and Somalia have intensified their preparedness efforts, according to an Africa CDC press briefing on 18 December.

Background and additional information

MVD is a severe disease in humans caused by *Marburg marburgvirus* (MARV). A case fatality ratio of up to 88% has been observed previously. MVD is not an airborne disease and is not considered contagious before symptoms appear. Direct contact with the blood and other bodily fluids of a person or animal with the infection is the most frequent route of transmission. The incubation period for MVD is usually 5–10 days (range: 3–21 days). If proper infection prevention and control measures are strictly adhered to, the likelihood of infection is considered very low. To date, there is no specific antiviral treatment and no approved vaccine for MVD.

All recorded MVD outbreaks have originated in Africa. Since 1967, when MVD was first detected, approximately 600 MVD cases have been reported as a result of outbreaks in Angola, the Democratic Republic of the Congo, Ghana, Guinea, Equatorial Guinea, Kenya, South Africa, Tanzania and Uganda. In 2024, Rwanda reported its first MVD outbreak (66 cases including 15 deaths), which was declared over on 20 December 2024. In 2025, Tanzania reported its second MVD outbreak (two confirmed and eight probable cases, all fatal).

More information on MVD can be found in the ECDC Factsheet on Marburg virus disease.

ECDC assessment:

The likelihood of exposure to MVD for EU/EEA residents visiting or living in Ethiopia is assessed as low, with uncertainties connected to the limited epidemiological information available. The impact at population level is assessed to be low as it is not expected that there will be significant numbers of MVD cases among EU/EEA residents in Ethiopia. Therefore, the overall risk for EU/EEA residents visiting or living in Ethiopia is low.

In the event of MVD cases being imported into the EU/EEA, we consider the likelihood of further transmission to be very low, and the associated impact low. Therefore, the overall risk for the EU/EEA is assessed as low.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities and is in contact with partners to gather additional information.

Last time this event was included in the Weekly CDTR: 9 January 2026

Events under active monitoring

- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 19 December 2025
- SARS-CoV-2 variant classification - last reported on 19 December 2025
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2025 - last reported on 19 December 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 19 December 2025

- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2025 - last reported on 19 December 2025
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 19 December 2025
- Marburg virus disease (MVD) – Ethiopia – 2025/26 - last reported on 19 December 2025
- Leprosy - Romania ex. Indonesia - 2025 - last reported on 19 December 2025
- Mpox clade Ib and clade IIb recombinant strain detected in UK traveller returning from Asia - last reported on 19 December 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 16 January 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 12 December 2025
- Seasonal surveillance of West Nile virus infections – 2025 - last reported on 12 December 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 12 December 2025
- Human cases of swine influenza A(H1N1) virus variant - Multi-country - 2024 - last reported on 09 January 2026
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 09 January 2026
- Recurrent multi-country outbreak of shigellosis in travellers returning from Cabo Verde - last reported on 05 December 2025
- HIV/AIDS surveillance 2025 - 2024 data - last reported on 05 December 2025
- Influenza A(H5N2) - Multi-country (World) - Monitoring human cases - last reported on 05 December 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 05 December 2025