WEEKLY BULLETIN

Communicable Disease Threats Report

Week 37, 5–11 September 2026

This week's topics

Executive summary

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

- On 10 September 2026, the Democratic Republic of the Congo (DRC) reported a total of 6 842 confirmed cases, including 3 349 related deaths (from data up until 9 September). Since the beginning of the outbreak, six provinces have been affected: Ituri, North Kivu, South Kivu, Tshopo, Haut-Uele and Bas Uele.
- In Uganda, a total of 20 cases were reported between May and June 2026. On 25 August, the World Health Organization (WHO) declared the end of the outbreak following 42 days without a new confirmed case being reported.
- On the basis of the available information, and given the uncertainties surrounding this outbreak, the likelihood of infection for people from the European Union/European Economic Area (EU/EEA) living in or travelling to affected areas is estimated to be low. Given the very low likelihood of importation and secondary transmission, the likelihood of infection for people living in the EU/EEA is estimated to be very low. This assessment will be reviewed as further information becomes available.
- ECDC is monitoring the outbreak through its epidemic intelligence activities and actively liaising with partners to support the response.

Overview of respiratory virus epidemiology in the EU/EEA, week 35, 2026

- Primary care consultations for respiratory illness remain at baseline levels across most EU/EEA countries, with one country reporting low activity. However, recent increases are observed in SARS-CoV-2 and influenza virus circulation.
- **SARS-CoV-2** activity remains low overall but continues to increase in primary and secondary care in several countries. The numbers of hospital admissions remain low, with most detections in secondary care reported among adults over 65 years of age.
- **Influenza virus** activity remains low overall, with signs of increasing circulation in some countries, although detection numbers remain low and mainly driven by a small number of reporting countries. Hospitalisations remain low and have not increased further following slight increases observed in recent weeks in a few countries. Most detections are influenza A viruses, and hospitalised cases are predominantly among adults aged 65 years and older.
- **Respiratory syncytial virus (RSV)** activity is low and at expected inter-seasonal levels.

Seasonal surveillance of chikungunya virus disease – 2026 (weekly)

- Since the beginning of 2026 and as at 9 September 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (57 cases) and Italy (one case).
- Since last Friday's update was published, a total of 12 additional locally-acquired cases have been reported in Europe.
- Italy has also reported for the first time this season, with one case in Rome.
- The current chikungunya virus disease risk assessment for mainland EU/EEA is available on ECDC's dedicated chikungunya webpage.

Seasonal surveillance of dengue in the EU/EEA, weekly report

- Since the beginning of 2026 and as at 9 September 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (24 cases) and France (five cases).
- This week, Italy reported an additional 21 locally-acquired cases, including two cases in the Lecce area and 19 cases in the Livorno area. Both clusters were already active, and no new clusters have been identified.
- No new cases were reported in France.

Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (Weekly report)

- Since the beginning of 2026 and as at 9 September 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (four cases).
- In the past week, no new cases have been reported to ECDC.

Seasonal monitoring of environmental suitability for Vibrio spp. risk in coastal waters – Bathing season 2026

- Based on forecasts from the Vibrio Viewer, in the next five days (until 16 September 2026), 25 municipalities across five regions in two countries are expected to have high environmental suitability for Vibrio spp.
- Vibriosis is caused by naturally occurring Vibrio bacteria found in coastal waters, particularly in warm, brackish environments. In Europe, Vibrio bacteria are most frequently detected during the summer season, with the Baltic Sea being particularly favourable due to its low salinity levels.
- A warmer climate is expected to increase the suitability of coastal areas for Vibrio growth and expansion.
- ECDC monitors environmental suitability for Vibrio growth in EU/EEA coastal waters and publishes regular updates through the Vibrio Viewer and the Communicable Disease Threats Reports to assess and communicate the potential risk to human health across the EU/EEA.

Seasonal surveillance of West Nile Virus infections – 2026 (weekly report)

- Since the beginning of the 2026 transmission season, and as at 10 September, 161 areas affected by West Nile virus (WNV) have been identified in 15 countries across Europe.
- These areas are located in Italy (64), Greece (21), Romania (20), France (14), the Netherlands (10), Serbia (7), Croatia (5), Spain (5), North Macedonia (4), Hungary (3), Austria (2), Germany (2), Albania (1), Cyprus (1) and Kosovo* (1).

Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report)

- The 2026 WNV season is currently seeing an intense level of circulation in both humans and animals in several European countries.
- There is currently no indication of increased disease severity in humans in Europe.
- **Italy** remains the most affected country in 2026, reporting the most human cases and avian outbreaks. **Greece** has reported a record number of human WNV cases for this time of the year.
- **The Netherlands** reported its first human WNV infections since 2020, alongside outbreaks in birds and equids, across a broad geographic area.
- Although no human WNV cases have ever been notified in **Belgium**, ongoing circulation in birds and equids across eight regions suggests a risk for human infections.
- **North Macedonia** is experiencing an unprecedented WNV outbreak in the capital region, with human cases and detections in birds.
- Further human cases and animal outbreaks may be expected in the coming weeks in Europe.

Aedes aegypti incursion in East London, United Kingdom, Aug 2026

- A reproducing population of Aedes aegypti was detected in East London, United Kingdom, in August 2026. The population seems to be highly localised and is thought to have been introduced accidentally through imported plants or other goods from tropical regions.
- Local authorities have initiated vector surveillance and control measures with the aim of eliminating the population.
- In the absence of local transmission of mosquito-borne viruses, the public health risk associated with this event is considered low.
- Early detection through surveillance systems and public reporting mechanisms increases the likelihood of successful elimination before wider establishment occurs.

Expert deployment

- Since 19 May 2026, the EU Health Task Force (EUHTF) has been deploying experts to support preparedness and response efforts related to the Ebola disease outbreak caused by Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda.
- Since 18 August, one expert has been deployed to support Africa CDC within the Continental Incident Management Support Team (IMST) in Uganda. Such deployments are part of the project 'Health Security and One Health in Africa – Africa CDC' in partnership with ECDC and EFSA (PHASE II) and funded by the European Commission's Directorate-General for International Partnerships.
- These activities are being conducted in close coordination with national authorities and EU delegations, and in collaboration with the Directorate-General for European Civil Protection and Humanitarian Aid Operations and the Directorate-General for International Partnerships.

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

Latest epidemiological information

Democratic Republic of the Congo

On 10 September 2026, the Democratic Republic of the Congo (DRC) reported a total of 6 942 confirmed cases, including 3 349 related deaths (from data up until 9 September). A total of 823 patients are hospitalised in isolation. This represents an increase of 99 new confirmed cases and 39 deaths since the previous report on 9 September (reporting data up until 8 September). The 99 new cases have been reported from Ituri (47 cases), North Kivu (46 cases), and Haut Uele (four cases). Among the individuals that tested positive for Bundibugyo virus, 1 647 have recovered. In total, 84.4% of identified case contacts are under follow-up in the affected provinces.

Ituri province remains the most affected, with 5 508 cases, including 2 501 deaths, reported from 28 of 36 health zones. In North Kivu, 1 139 cases, including 725 deaths, have been reported from 16 of 34 health zones. In South Kivu, three cases, including one death, have been reported from one of 34 health zones. In Haut-Uele, 264 cases, including 110 deaths, have been reported from six of 13 health zones. In Tshopo, 24 cases, including nine deaths, have been reported from seven of 23 health zones. In Bas Uele, four cases, including three deaths, have been reported from three of 11 health zones. Overall, 61 of 151 health zones are currently affected across the six provinces.

On 10 September, several media outlets and local politicians reported that a new Ebola case had been confirmed in South-Ubangi Province. According to these reports, the case had a travel history within DRC (to South Kivu, Ituri and Tshopo) as well as in Rwanda and Uganda.

Data reported by DRC on confirmed cases and deaths are under continuous review and harmonisation.

The next epidemiological update will be published on 14 September 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 was a nurse (age unknown) who died in a healthcare facility in Bunia (capital of Ituri Province). The individual 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.

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). The American doctor subsequently recovered well and was discharged from the hospital in Berlin, where he was treated (Ebola patient discharged from Charite hospital in Berlin in good health, 6 June 2026). Another contact of US nationality was transferred to Czechia (US CDC Transcript -19 May 2026). On 24 June, the Ministry of Health in France reported a first positive case of Ebola virus disease, identified in a doctor returning from a humanitarian mission to one of the areas affected by the ongoing outbreak in DRC.

On 10 July 2026, the US CDC reported that a US citizen who was working for a humanitarian organisation in DRC had tested positive for Bundibugyo virus. The patient was medically evacuated to Germany on 13 July 2026 and is currently under treatment. This is the second US citizen who has tested positive in DRC during this outbreak and the patient is receiving treatment in Germany.

On 21 July, the United Kingdom Ministry of Health reported that a UK resident who had been treating patients with Ebola in the DRC was evacuated and had been isolated in a London hospital. The individual showed no symptoms and this was deemed a precautionary measure.

The first case reported in Uganda was travel-related and the patient later died. As of 28 July 2026, a total of 20 confirmed cases, including two deaths, have been reported by the Ministry of Health in Uganda. The last confirmed case was reported on 21 June and no new cases have been reported since then. On 16 July, Uganda discharged the last Ebola patient who had been receiving treatment at the Mulago National Referral Isolation Centre. On 28 July 2026, 12 days since the last case was discharged, the Uganda's Ministry of Health declared the end of the Ebola disease outbreak. On 27 August, WHO declared the end of the Ebola disease outbreak in Uganda following 42 days without a new confirmed case being reported.

Genomes from DRC and Uganda have been published and preliminary analysis shows sequences distinct from 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 Orthoebolavirus zairense. Unlike Orthoebolavirus zairense, there are currently no licenced 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). On 5 June, WHO and Africa CDC launched a joint continental preparedness and response plan to support African countries in the response to the ongoing outbreak.

This is the 17th Ebola disease outbreak reported in DRC. The most recent previous outbreak occurred in 2025 in Kasai Province and was caused by the Ebola virus 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 were reported, including 3 317 confirmed and 153 probable cases. 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).

On 1 June 2026, a case was reported by Uganda as having had a travel history to the United Arab Emirates (UAE), arriving on 24 May (Media reports on 1 June 2026, WHO media briefing on 3 June 2026, WHO DON 8 June 2026). According to WHO, as of 8 June, no cases of Ebola disease have been reported in the UAE. Public health measures, including risk assessment activities, contact tracing and follow-up, and strengthened preparedness at points of entry, have been implemented in coordination with WHO, UAE and international partners.

Travel restrictions

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

In DRC, points of entry (PoE) and points of control (PoC) have been activated at key locations, including airports, road checkpoints and towns or local transit points, such as Nizi and Irumu (Ituri), Mudzibala (Bunia), Dele and Chai (Rwampara). Bunia airport in the Ituri province was temporarily closed on 23 May and re-opened on 2 June with the implementation of health screening measures. Commercial flights to and from Bunia airport were suspended again from 6 June onwards, as part of health security arrangements in response to the Ebola disease outbreak, according to the media.

On 24 June, as part of the response to the ongoing outbreak, the Ministry of Health in DRC issued a decree enforcing the following measures: contacts of confirmed or probable cases face 21-day active self-monitoring and restrictions on both domestic and international movement. Healthcare and response workers returning from affected areas are subject to similar rules, although active monitoring is not explicitly specified and domestic travel remains permitted. Anyone who has stayed in an affected province cannot travel internationally for 21 days (the decree does not address any obligations for actual cases.) In addition, outbound international travellers are required to complete a mandatory health declaration form issued by border health authorities.

Uganda maintained enhanced screening and preparedness measures during the outbreak response. Since the completion of the 42-day period without new identified cases, Uganda's Ministry of Health has continued to maintain active screening measures at ports of entry, and temporary travel bans to and from the DRC.

Rwanda's 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).

South Sudan is maintaining targeted temperature screening and health declaration forms at Juba International Airport and key entry points.

Several countries have also implemented entry restrictions and health screening for individuals travelling from high-risk countries, including the US, Canada, Tunisia, Thailand, Mauritius and the Bahamas, Bahrain, Botswana, Taiwan, El Salvador, Hong Kong, India, Israel, Italy, Jordan, Kenya, Kuwait, Lebanon, Malawi, Mauritius, Mexico, Nigeria, Oman, Pakistan, Philippines, Qatar, Saudi Arabia, St Maarten, St Vincent and the Grenadines, Thailand, Trinidad and Tobago, Tunisia, United Arab Emirates (Ebola Update - Travel Measures and Ongoing Monitoring).

The World Health Organization explicitly advises against bans on international travel or trade, recommending targeted health screening at points of entry instead.

Therapeutics and vaccines

No licensed vaccines or specific therapeutics are currently available for Ebola virus disease caused by Bundibugyo ebolavirus. Ongoing research initiatives, including programmes supported by the Coalition for Epidemic Preparedness Innovations (CEPI), are advancing the development of vaccines using different technological platforms. Current candidates under investigation include the ChAdOx1-BDBV candidate (developed by the University of Oxford), an mRNA-based candidate (developed by Moderna), two rVSV-based candidates (developed by IAVI and PHV), and the most recent MVA-CR19 vaccine candidate (developed by Minapharm). These candidate vaccines are currently in pre-clinical development or early-stage clinical trials.

The recent WHO emergency guidance and SAGE recommendations propose the use of the licensed rVSV-ZEBOV (Ervebo) vaccine during Bundibugyo virus disease outbreaks primarily within the context of a research protocol, to establish potential cross-protection and clinical efficacy.

On 27 August, the Minister of Public Health of the DRC launched a vaccination campaign for frontline workers against Ebola virus disease using the Ervebo vaccine in Kisangani. The campaign is primarily being implemented in the affected provinces of Tshopo, Bas-Uele and Haut-Uele.

ECDC assessment

Given the gaps in epidemiological information and limited follow-up of contacts, it is likely that the outbreak is larger than is currently being reported in terms of the number of affected cases/areas.

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. Given the very low likelihood of importation and secondary transmission, the likelihood of infection is estimated to be very low for people living in the EU/EEA. The overall risk of Bundibugyo virus transmission through substances of human origin (SoHO) in the EU/EEA is currently assessed as very low (Risk of Bundibugyo virus transmission through substances of human origin in the European Union/European Economic Area (EU/EEA). This assessment will be reviewed as further information becomes available.

Exit screening in affected countries, including symptom checks and exposure assessment, is important 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 ECDC's 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.

Since 19 May 2026, the EU Health Task Force, in collaboration with the European Civil Protection and Humanitarian Aid Operations (DG ECHO), the Directorate-General for International Partnerships (DG INTPA) and the Global Outbreak Alert and Response Network (GOARN), has been deploying ECDC experts to Addis Ababa (Ethiopia) at Africa CDC's headquarters, and Kampala (Uganda).

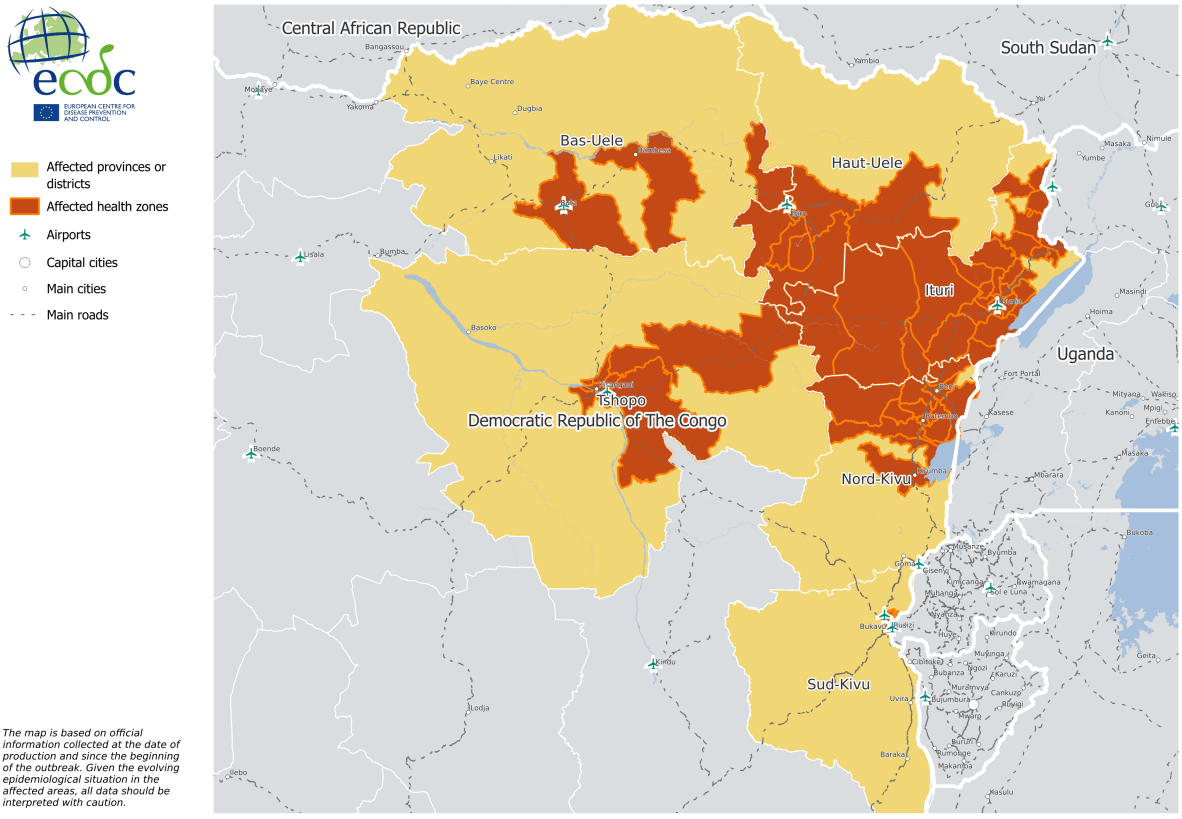
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

ECDC is regularly re-evaluating the situation as new information becomes available and continues to provide updated epidemiological information, scientific assessments and advice on its website: Ebola disease outbreak in the Democratic Republic of the Congo and Uganda.

Last time this event was included in the Weekly CDTR: 4 September 2026.

Maps and graphs

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



2. Overview of respiratory virus epidemiology in the EU/EEA, week 35, 2026

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.

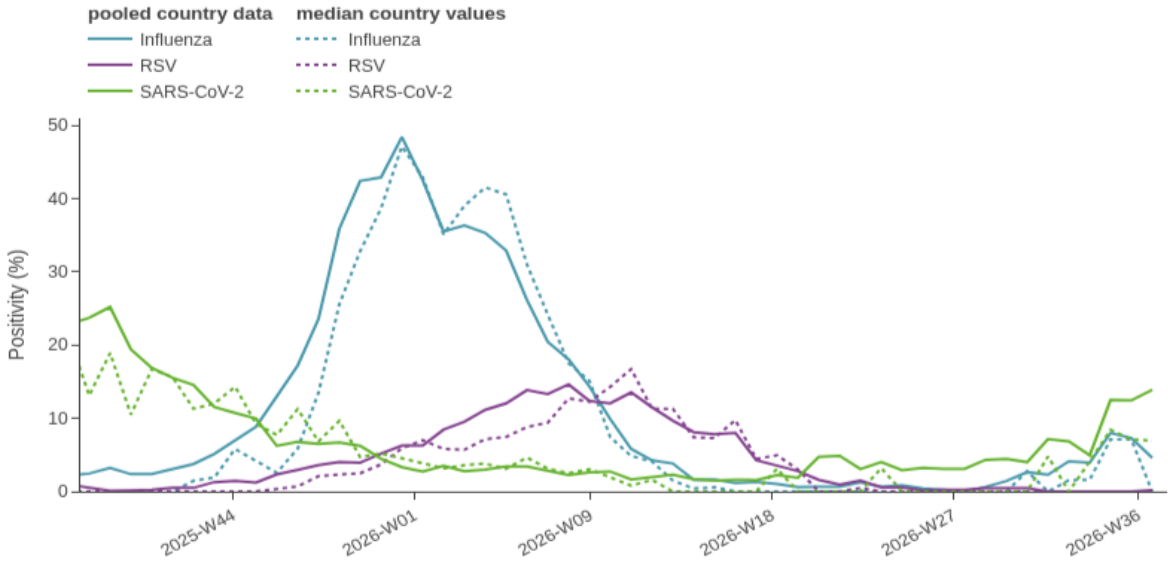
All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 4 September 2026.

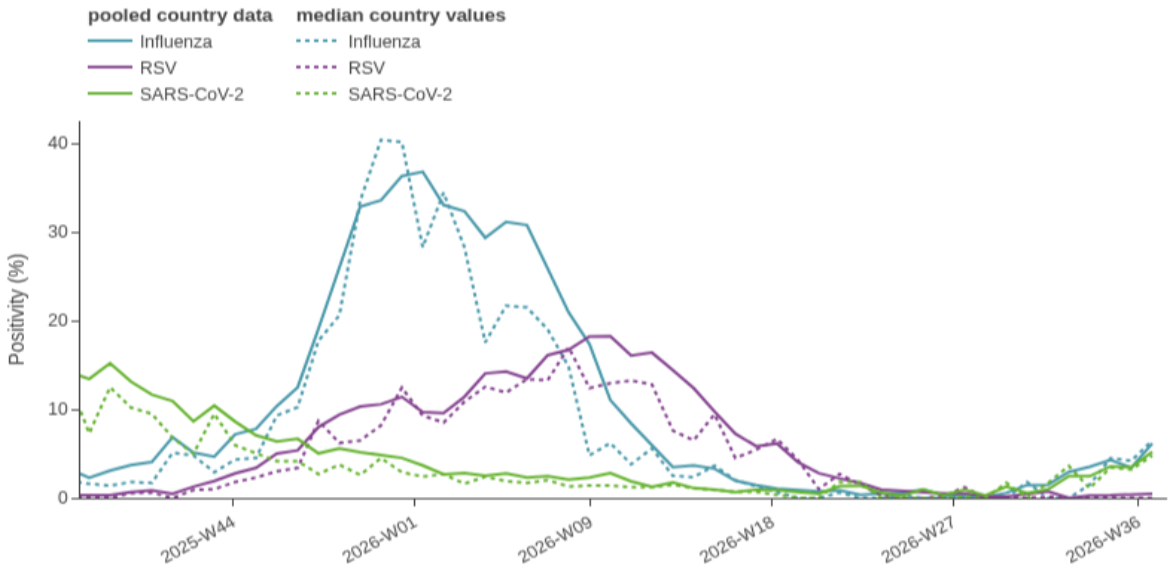
Maps and graphs

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 36**	**Week 35**	**Description**	**Value**
ILI/ARI consultation rates in primary care	ARI	14 rates (9 MEM)	14 rates (9 MEM)	Distribution of country MEM categories	9 Baseline
	ILI	14 rates (13 MEM)	15 rates (14 MEM)		12 Baseline 1 Low
ILI/ARI test positivity in primary care	Influenza	14	15	Pooled (median; IQR)	4.6% (0; 0–6.1%)
	RSV	13	13		0.2% (0; 0–0%)
	SARS-CoV-2	15	15		14% (7; 0–15%)
SARI rates in hospitals	SARI	8 rates (4 MEM)	10 rates (5 MEM)	Distribution of country MEM categories	4 Baseline
SARI test positivity in hospitals	Influenza	7	8	Pooled (median; IQR)	6.2% (6.5; 5.2–13%)
	RSV	7	7		0.5% (0; 0–0.3%)
	SARS-CoV-2	6	7		5.2% (4.8; 0–11%)
Intensity (country-defined)	Influenza	11	12	Distribution of country qualitative categories	10 Baseline 1 Low

Source: ECDC

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

	Week 36, 2026		Week 40, 2025 – week 36, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**27**	**–**	**17916**	**–**
Influenza A	26	100	17303	99
A(H1)pdm09	2	10	4049	28
A(H3)	18	90	10344	72
A (unknown)	6	–	2910	–
Influenza B	0	0.0	123	0.7
B/Vic	0	–	36	100
B (unknown)	0	–	87	–
Influenza untyped	1	–	490	–
RSV	**1**	**–**	**5338**	**–**
RSV-A	0	–	935	44
RSV-B	0	–	1192	56
RSV untyped	1	–	3211	–
SARS-CoV-2	**105**	**–**	**4723**	**–**

Source: ECDC

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

	Week 36, 2026		Week 40, 2025 – week 36, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**40**	**–**	**15867**	**–**
Influenza A	31	97	7677	99
A(H1)pdm09	0	0.0	1258	34
A(H3)	6	100	2423	66
A (unknown)	25	–	3996	–
Influenza B	1	3	69	0.9
B/Vic			10	100
B (unknown)	1	–	59	–
Influenza untyped	8	–	8121	–
RSV	**3**	**–**	**7215**	**–**
RSV-A	1	100	1157	52
RSV-B			1062	48
RSV untyped	2	–	4996	–
SARS-CoV-2	**33**	**–**	**3166**	**–**

Source: ECDC

Figure 6. **Genetically characterised influenza virus distribution, week 40, 2025 – week 36, 2026**

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

Source: ECDC

Figure 7. **SARS-CoV-2 variant distribution, week 43, 2025 - week 44, 2025**

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	9	12% (12–12%)
XFG	VUM	1	52	70% (70–70%)
NB.1.8.1	VUM	1	1	1% (1–1%)
BA.3.2	VUM	0	0	0%

Source: ECDC

3. Seasonal surveillance of chikungunya virus disease – 2026 (weekly)

Overview

Since the beginning of 2026 and as at 9 September 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (57 cases) and Italy (one case).

Since last Friday's update was published, a total of 12 additional locally-acquired cases have been reported in Europe. Italy has also reported for the first time this season, with one case in Rome.

Of the eleven clusters reported in France in 2026, ten are currently active. Three new clusters, with one case each, have been reported in Bordeaux, Etauliers, and Portets in the department of Gironde. The largest active cluster is still the one at Prignac-et-Marcamps in the department of Gironde, consisting of 28 cases.

The report is available online.

ECDC assessment

The current chikungunya virus disease risk assessment for mainland EU/EEA is available on ECDC's dedicated chikungunya virus disease webpage.

Actions

ECDC will continue to monitor the situation and will publish a weekly report on the occurrence of chikungunya virus disease cases in the EU/EEA until November 2026.

Further information

Chikungunya is a mosquito-borne viral disease that is emerging in Europe, with locally acquired cases reported in several EU/EEA countries. In light of this development, ECDC has implemented seasonal enhanced surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures.

Chikungunya virus disease is a notifiable disease at the EU level and cases are reported in accordance with the EU case definition. Chikungunya virus disease cases – and their corresponding case numbers – are reported to the European surveillance portal for infectious diseases (EpiPulse Cases).

Please note that cases acquired in Portuguese and Spanish Outermost Regions are included. However, due to the distinct epidemiological situation and differences in surveillance systems, cases acquired in the French Outermost Regions are not included.

Last time this event was included in the Weekly CDTR: 4 September 2026.

4. Seasonal surveillance of dengue in the EU/EEA, weekly report

Overview

This week, Italy reported an additional 21 locally-acquired cases, including two cases in the Lecce area and 19 cases in the Livorno area. Both clusters were already active, and no new clusters have been identified. No new cases were reported in France.

The report is available online.

ECDC assessment

The current dengue risk assessment for mainland EU/EEA is available on ECDC's dedicated dengue webpage.

Actions

ECDC will continue to monitor the situation and will publish a weekly report on the occurrence of dengue in the EU/EEA until November 2026.

Further information

Dengue is a mosquito-borne viral disease that is increasingly emerging in Europe, with locally acquired cases reported in several EU/EEA countries. In light of this development, ECDC has implemented seasonal enhanced weekly surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures. This includes assessing the risk of dengue transmission through substances of human origin (SoHO).

Dengue is a notifiable disease at the EU level and cases are reported in accordance with the EU case definition. Dengue cases – and their corresponding case numbers – are reported to the European surveillance portal for infectious diseases (EpiPulse Cases).

Please note that cases acquired in Portuguese and Spanish Outermost Regions are included. However, due to the distinct epidemiological situation and differences in surveillance systems, cases acquired in the French Outermost Regions are not included.

Last time this event was included in the Weekly CDTR: 4 September 2026.

5. Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (Weekly report)

Overview

Since the beginning of 2026 and as at 9 September 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (four cases). In the past week, no new cases have been reported to ECDC.

The report is available online.

ECDC assessment

For the general population, the risk of contracting CCHF in the areas where the virus is known to be present in Spain is low. This risk increases for people undertaking outdoor activities that expose them to tick bites (e.g. hunting, forestry work, hiking, animal surveillance). As a general precaution against CCHF, but also against other tick-borne diseases, people who may potentially be exposed to ticks should apply personal protective measures (ECDC Protective Measures against ticks).

In Spain, CCHF virus is transmitted to humans mainly by ticks of the genus Hyalomma. While Hyalomma lusitanicum plays a key role in virus maintenance and transmission dynamics, Hyalomma marginatum is generally considered to be the principal species involved in transmission to humans. Hyalomma marginatum is widely present in southern and eastern Europe and Hyalomma lusitanicum is present in parts of southern Europe.

More information on CCHF can be found in ECDC's factsheet. In December 2023, ECDC published a report on the spatial distribution of CCHF based on predicted ecological suitability.

Actions

ECDC will continue to monitor the situation and will publish a weekly report on the occurrence of CCHF in the EU/EEA until November 2026.

Further information

CCHF is a tick-borne viral disease that is emerging in Europe, with locally acquired cases reported in several EU/EEA countries. In light of this development, ECDC has implemented seasonal enhanced surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures.

CCHF is a notifiable disease at the EU level and cases are reported in accordance with the EU case definition. CCHF cases – and their corresponding case numbers – have been reported to the European surveillance portal for infectious diseases (EpiPulse Cases).

Please note that cases acquired in Portuguese and Spanish Outermost Regions are included, however, due to the distinct epidemiological situation and differences in surveillance systems, cases acquired in the French Outermost Regions are not included.

Last time this event was included in the Weekly CDTR: 4 September 2026.

6. Seasonal monitoring of environmental suitability for Vibrio spp. risk in coastal waters – Bathing season 2026

Update

Based on forecasts from the Vibrio Viewer, in the next five days (until 16 September 2026), 25 municipalities across five regions in two countries are expected to have high environmental suitability* for Vibrio spp.

A list of areas expected to have high environmental suitability* for Vibrio spp. until 16 September 2026 is provided below.

Bulgaria: 13 municipalities in three regions:
- **Varna**: Avren, Byala, Dolni Chiflik, Varna
- **Dobrich**: Balchik, Kavarna, Shabla
- **Burgas**: six municipalities above the threshold

Romania: 12 municipalities in two regions:
- **Constanţa**: Eight municipalities above the threshold
- **Tulcea**: Jurilovca, Murighiol, Oras Sulina, Sfantu Gheorghe

Countries are listed in alphabetical order; municipalities are listed only for regions (at NUTS3 level) with five or less affected municipalities. To explore the daily risk for individual municipalities and specific areas in greater detail, please refer to the interactive Vibrio Viewer map tool.

* High environmental suitability for Vibrio spp. is defined by a suitability index >16.

Background

Vibriosis is an infection caused by species of Vibrio bacteria, which occur naturally in coastal waters, particularly in warm, brackish environments where freshwater and seawater mix. Environmental conditions that favour bacterial growth include higher water temperatures and lower salinity [1]. In Europe, Vibrio bacteria are most frequently detected during the summer season. The Baltic Sea provides particularly favourable conditions due to its relatively low salinity, although Vibrio species are also found in the North Sea, the Black Sea and other coastal and estuarine bathing waters [1, 2, 3, 4, 5, 6].

Human infection may occur through the consumption of raw or under-cooked seafood, particularly shellfish, or the exposure of open wounds to contaminated water. Clinical manifestations range from self-limiting gastroenteritis to wound infections, otitis, and severe invasive disease, including septicaemia and necrotising soft tissue infections. Individuals with underlying medical conditions, such as diabetes, chronic liver disease, and immunosuppression, are at increased risk of severe illness [7, 8].

ECDC assessment

Climate-driven warming is expected to increase the suitability of coastal areas for bacterial growth. As sea surface temperatures continue to rise across parts of Europe, environmental conditions facilitating the potential for Vibrio proliferation and geographical expansion are becoming increasingly common [2, 9, 10].

Vibriosis remains relatively uncommon in the EU/EEA. However, locally-acquired cases can occur during summer months, particularly when temperatures are exceptionally high [11, 12].

To reduce the risk of Vibrio infections through food, it is recommended that seafood be cooked thoroughly before consumption. People who have open wounds, recent piercings, cuts or scrapes should avoid swimming in brackish or coastal waters, or cover the affected area with a waterproof dressing. In the case of accidental contact with coastal water, the affected area should be disinfected and cleaned thoroughly.

Actions

ECDC monitors the environmental suitability for Vibrio spp. growth in coastal waters during the summer season. Regular updates are published in the Vibrio Viewer and the Communicable Disease Threat Reports to assess and communicate potential risks to human health across the EU/EEA.

ECDC publishes scientific information and advice on this topic on its dedicated webpage: Vibriosis.

Last time this event was included in the Weekly CDTR: 4 September 2026.

7. Seasonal surveillance of West Nile Virus infections – 2026 (weekly report)

Overview

Since the beginning of the 2026 transmission season, and as at 10 September, 161 areas affected by West Nile virus (WNV) have been identified in 15 countries across Europe.

These areas are located in Italy (64), Greece (21), Romania (20), France (14), the Netherlands (10), Serbia (7), Croatia (5), Spain (5), North Macedonia (4), Hungary (3), Austria (2), Germany (2), Albania (1), Cyprus (1) and Kosovo* (1).

The report is available online.

Throughout the season, ECDC will publish a weekly report with updates on risk areas for locally acquired WNV infections. A monthly report is also 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 in accordance with the EU case definition. According to Commission Directives 2004/33/EC and 2014/110/EU on blood safety, blood establishments in European Union/European Economic Area (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 designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the ICJ Opinion on the Kosovo declaration of independence.

ECDC assessment

Seasonal weather conditions are currently favourable for mosquito-borne transmission of WNV and more cases are expected to occur in the coming weeks as a result.

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 until November as this 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 information on the number of locally acquired human cases reported, 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: 4 September 2026

8. Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report)

Overview

Findings from human surveillance

In 2026, and as at 3 September, countries in Europe have reported 1 086 locally acquired1 human cases of West Nile Virus (WNV) infection. The earliest and latest dates of symptom onset among human cases were 12 May in North Macedonia and 1 September in Austria, respectively. Locally acquired cases have been reported by **Italy** (516 cases), **Greece** (284 cases, of which 11 had an unknown place of infection), **Spain** (88 cases), **Romania** (56 cases), **North Macedonia** (55 cases), **France** (36 cases), **Serbia** (18 cases), **the Netherlands** (9 cases), **Croatia** (7 cases), **Cyprus** (6 cases), **Austria** (4 cases), **Hungary** (3 cases), **Germany** (2 cases), **Albania** (1 case) and **Kosovo*** (1 case). A total of 61 deaths have been reported by **Italy** (25 deaths), **Greece** (24 deaths), **North Macedonia** (7 deaths), **Romania** (2 deaths), **Spain** (2 deaths) and **the Netherlands** (1 death).

The number of human cases reported to date (1 086 cases) exceeds the average number reported during the same period over the past decade (736 cases), indicating intense WNV circulation this year. Moreover, reporting delays may result in an under-estimation of the current burden.

As at 3 September 2026, locally acquired human cases have been reported in 143 NUTS 3 regions across 15 countries, similar to the same point in 2025. However, 2024 remains the most geographically widespread WNV season on record, with 218 affected regions by the end of the season.

As in previous years, most cases were reported among males aged 65 years and above. Overall, 78% of cases were hospitalised and 60% presented with neurological symptoms, compared with 10-year averages of 87% and 65%, respectively. The case fatality rate was approximately 6%, below the 10-year average of 10%. These preliminary findings are within expected levels and do not indicate increased disease severity, although clinical outcomes are not yet available for all cases and additional deaths may be reported as the season progresses. Country-specific case fatality rates are affected by the sensitivity of the surveillance system, including screening practices of blood donors, therefore direct comparisons between countries should be made with caution.

Findings from veterinary surveillance

From the veterinary perspective, 10 countries in Europe have reported 121 WNV outbreaks among equids and 280 outbreaks among birds in 2026. The earliest reported WNV outbreak among equids had a suspected start date of 30 March 2026 in France, while the most recent had a suspected start date of 29 August 2026 in Belgium. Outbreaks among equids have been reported by **France** (43 outbreaks), **Italy** (34 outbreaks), **Belgium** (14 outbreaks), **Spain** (9 outbreaks), **Greece** (8 outbreaks), **the Netherlands** (5 outbreaks), **Austria** (3 outbreaks), **Croatia** (3 outbreaks) and **Germany** (2 outbreaks). Among birds, the earliest reported WNV outbreak had a suspected start date of 31 March 2026 in Italy, while the most recent had a suspected start date of 31 August 2026 in Austria and Croatia. Outbreaks among birds have been reported by **Italy** (218 outbreaks), **Belgium** (26 outbreaks), **Croatia** (9 outbreaks), **Spain** (8 outbreaks), **Austria** (7 outbreaks), **France** (5 outbreaks), **Germany** (3 outbreaks), **North Macedonia** (3 outbreaks) and **the Netherlands** (1 outbreak). In addition, **Switzerland** submitted outbreak data to Animal Disease Information System (ADIS) for the first time in 2026, reporting one bird outbreak in Aargau (CH033).

Patterns across human and veterinary surveillance

Most affected European countries reported both human WNV infections and outbreaks in equids and/or birds. **Albania**, **Cyprus**, **Hungary**, **Kosovo***, **Romania** and **Serbia** only reported human WNV infections, while **Belgium** only reported outbreaks among equids and birds. EU candidate countries are not required to report animal outbreaks through ADIS.

Differences in WNV patterns across European countries may reflect a combination of ecological, climatic and surveillance-related factors. Climatic conditions, habitat characteristics and the local abundance and distribution of competent mosquito vectors and bird hosts can influence WNV circulation. Differences in surveillance design, intensity, diagnostic practices and reporting may also affect the number of human infections and animal outbreaks detected.

A selection of country-specific findings is presented below to further illustrate the heterogeneity of WNV activity across Europe.

Italy

Italy remains the most affected country in 2026, reporting the highest number of WNV human cases (516, 48% of all reported human cases), including 25 deaths (case fatality rate: 4.8%). It also reported 34 outbreaks in equids (28% of all reported equid outbreaks) and 218 outbreaks in birds (78% of all reported avian outbreaks).

Nevertheless, the number of human cases reported was lower than that reported during the same period in 2018, 2022 and 2025, based on consolidated data. The number of outbreaks in birds and equids reported to ADIS in 2026 was comparable to that reported during the same period in 2025, slightly lower than in 2024, and higher than in 2018 and 2022. Overall, 67 of Italy's 107 NUTS 3 regions are currently affected, with WNV human cases and/or animal outbreaks reported.

Greece

Greece has reported its highest number of human WNV cases for this time of year, with 284 cases, including 24 deaths (case fatality rate: 8.5%). WNV transmission is currently most intense in the Attica NUTS 2 region, which accounts for 162 cases, with the highest numbers reported in Anatoliki Attiki (East Attica, 86 cases) and Voreios Tomeas Athinon (North Athens, 48 cases). Despite accounting for 26% of all reported human cases in Europe, Greece has reported only eight outbreaks in equids, representing 5.5 % of all reported equid outbreaks, and no outbreaks in birds.

The Netherlands

Nine human WNV infections have been reported in the Netherlands, including one death. These are the first human cases reported in the Netherlands since 2020, when the country documented its first-ever locally acquired human WNV infections, with seven cases reported in Utrecht (previously NL310) and one in the Arnhem/Nijmegen region (NL226). In addition, five outbreaks in equids and one in birds were reported in 2026. WNV was first reported in equids in the Netherlands in 2025. Overall, WNV infections in humans and/or animals were detected across eight NUTS 3 regions this year.

Belgium

WNV was first detected in Belgium in 2025 through avian surveillance, having no previous detections reported in humans or animals. That year, seven bird outbreaks were reported in Arr. Mechelen (BE212), Arr. Dendermonde (BE232), and Arr. Halle-Vilvoorde (BE241). In 2026, WNV was again detected in birds in these three regions and in five previously unaffected regions. To date, Belgium has not reported any human WNV infections. However, the ongoing circulation of the virus in animals, with 14 outbreaks among equids and 26 outbreaks among birds reported across eight NUTS 3 regions, is indicative that there is a risk for human infections to occur.

North Macedonia

North Macedonia is reporting an unprecedented number of human WNV infections, with 55 cases and seven deaths (case fatality rate: 13%) reported from three NUTS3 region. Two of these regions have also reported outbreaks among birds. The Skopski region, which includes the capital city of Skopje, is by far the most affected, accounting for 53 human WNV infections and three bird outbreaks. In 2026, North Macedonia reported WNV outbreak data to ADIS for the first time, with three bird outbreaks across two regions. In the past decade, the country had reported a maximum of five human WNV infections per year.

More information

The full monthly epidemiological report on human and animal surveillance data including maps and graphs is available at: Monthly updates: 2026 West Nile virus transmission season (europa.eu).

Updated figures on human WNV infections are published weekly at: (Weekly updates: 2026 West Nile virus transmission season (europa.eu).

More background information on the Commission Directives on blood safety and EU/EEA notifications of WNV infections can be found here.

ECDC assessment

Given the favourable environmental conditions for WNV transmission in Europe, ECDC and EFSA expect further human cases and outbreaks in equids and birds to be reported in the coming weeks. In previous years, transmission has typically peaked in August and early September.

Actions

ECDC is monitoring WNV infections through indicator- and event-based surveillance activities.

Last time this event was included in the Weekly CDTR: 14 August 2026

9. Aedes aegypti incursion in East London, United Kingdom, Aug 2026

Overview

A very localised reproducing population of Aedes aegypti was identified in East London in August 2026. Preliminary investigations suggest the mosquitoes were accidentally introduced through imported plants or other commercial goods originating from tropical areas.

Public health and vector control authorities have implemented enhanced surveillance and control activities to limit the extent of the population and support eradication efforts. Control measures have been implemented to destroy larvae, and the affected area will continue to be monitored. UK HSA is encouraging public participation through the Mosquito Watch surveillance scheme to support early detection of invasive mosquitoes.

Ae. aegypti is not established in the UK however introductions of this species have previously been reported in other regions in Europe.

The initial detection was reported through the UK Health Security Agency (HSA) Mosquito Watch surveillance scheme. This event demonstrates the value of surveillance systems that facilitate reporting by the public, supporting early detection of introduced mosquito populations and increasing the likelihood that control measures can be implemented before wider establishment occurs.

ECDC assessment

Aedes aegypti is a competent vector of dengue, chikungunya, and Zika viruses. Incursions have previously been reported in several European countries, including the Netherlands and Luxembourg, and EU/EEA outermost regions). The detection in east London highlights the continued risk of invasive mosquito species being introduced into Europe through international trade and transport pathways.

At present, there is no evidence that Ae. aegypti is established in the UK, and it is unclear if Ae. aegypti could establish there in the current climate. The public health risk associated with this event is considered low, and there is no evidence of human infections associated with this event.

Actions:

ECDC is monitoring the signal.

10. Expert deployment

Overview

Since 19 May 2026, the EU Health Task Force (EUHTF) has been supporting preparedness and response efforts related to the Ebola disease outbreak caused by Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda.

Nine ECDC experts have been deployed on a rotational basis to support Africa CDC, initially at its headquarters in Addis Ababa and, since 23 June 2026, within the Continental Incident Management Support Team (IMST) in Uganda. The deployments are part of the project 'Health Security and One Health in Africa – Africa CDC' in partnership with ECDC and EFSA (PHASE II), funded by the European Commission's Directorate-General for International Partnerships. The experts have provided support for surveillance and liaison activities.

Between 15 and 22 June 2026, the EUHTF deployed a team of three ECDC experts and two Member State experts to Kinshasa (DRC) and Kampala (Uganda), to conduct a Point of Entry fact-finding mission to evaluate the implementation and operational performance of exit screening procedures.

Between 16 June and 8 July 2026, an ECDC Risk Communication and Community Engagement (RCCE) expert was deployed to the World Health Organization (WHO) country office in Juba, South Sudan, in response to a request for assistance from the Global Outbreak Alert and Responses Network (GOARN). The expert supported the implementation of the country's RCCE field plan to strengthen community engagement and address priority risk communication and community engagement gaps in high-risk areas. Between 14 July and 27 August 2026, two ECDC fellows were deployed through GOARN to the WHO country office in Juba, South Sudan, to support surveillance and data analysis activities.

These activities are being conducted in close coordination with national authorities and EU delegations, and in collaboration with the Directorate-General for European Civil Protection and Humanitarian Aid Operations and the Directorate-General for International Partnerships.

Last time this event was included in the Weekly CDTR: 4 September 2026.

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 28 August 2026
- Human cases of swine influenza A(H1N2) variant virus infection – Multi-country - last reported on 28 August 2026
- Poliovirus - Multi-Country Updates - last reported on 28 August 2026
- Fatal case of respiratory diphtheria in an unvaccinated child in Italy - last reported on 28 August 2026
- Measles outbreak linked to a festival - Sweden and Finland - 2026 - last reported on 21 August 2026
- Salmonella Enteritidis ST11- multi country-2025-2026 - last reported on 21 August 2026
- Spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA - 2026 - last reported on 21 August 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 14 August 2026
- Crimean-Congo haemorrhagic fever in Albania, 2026 - last reported on 14 August 2026
- Aedes aegypti incursion in East London, United Kingdom, Aug 2026 - last reported on 11 September 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report) - last reported on 11 September 2026
- Seasonal monitoring of environmental suitability for Vibrio spp. risk in coastal waters – Bathing season 2026 - last reported on 11 September 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 35, 2026 - last reported on 11 September 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo – 2026 - last reported on 11 September 2026
- Expert deployment - last reported on 11 September 2026
- Seasonal surveillance of chikungunya virus disease – 2026 (weekly) - last reported on 11 September 2026
- Seasonal surveillance of dengue in the EU/EEA, weekly report - last reported on 11 September 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (Weekly report) - last reported on 11 September 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (weekly report) - last reported on 11 September 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 4 September 2026
- SARS-CoV-2 variant classification - last reported on 4 September 2026
- Airport malaria in Frankfurt, Germany – 2026 - last reported on 4 September 2026.