WEEKLY BULLETIN

Communicable disease threats report

Week 5, 24 – 30 January 2026

This week's topics

Executive summary

Overview of respiratory virus epidemiology in the EU/EEA, week 3, 2026
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 remains high. Following four weeks of decreasing trends from the initial peak, data from surveillance in general practice show an increase compared to the previous week, mainly affecting children. Influenza A(H3N2) remains the dominant subtype, followed by A(H1N1)pdm09. While overall hospital admissions continue to decrease, recent increases among hospitalised children aged five to 14 years reflect the picture observed in primary care. Adults aged 65 years and above account for the highest numbers of admissions to hospital, ICU and in-hospital deaths during the season.

Early estimates of seasonal influenza vaccine effectiveness in the EU/EEA for the 2025/26 season 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 increase in most countries. This season's RSV epidemic is several weeks later than in the last two years. Hospital admissions are rising in most reporting countries, primarily among children aged under five years.

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

Classified as ECDC NORMAL

SARS-CoV-2 circulation remains low in all age groups, and the number of hospitalisations due to SARS-CoV-2 is currently limited compared to influenza and RSV.

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

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'.

Bacillus cereus in infant formula

- A multi-country recall of several infant nutrition products (different batches, products, and brands) was initiated following the detection of cereulide, the emetic toxin produced by *Bacillus cereus*.
- The precautionary recall was initiated in December 2025 and is still ongoing in January 2026 as a preventive measure to protect public health. The root cause analysis undertaken by the company identified the ingredient (arachidonic acid (ARA) oil) leading to the contamination event.
- ECDC has received some reports of diarrhoea cases in infants and one confirmed case related to *B. cereus* toxin detection.

Avian influenza A(H5N1) antibodies in cattle – the Netherlands – 2026

- Authorities in the Netherlands report that antibodies against avian influenza A(H5N1) have been detected in the milk of a cow in a dairy farm in Friesland.
- This is the first such detection in cattle in the EU/EEA and outside of the United States, where avian influenza was first detected in cattle in March 2024.
- People at the farm and a veterinarian have been offered testing (PCR and serology) and results are pending.

Nipah virus disease- India- 2026

- According to India's Ministry of Health and Family Welfare (MoHFW) on 27 January 2026, there have been two confirmed cases of Nipah Virus (NiV) reported in the state of West Bengal.
- Several media outlets, quoting India's health authorities, have reported five NiV disease cases in the district of North 24 Parganas, in the state of West Bengal.
- Both confirmed cases are healthcare workers at the same hospital, according to media reporting.
- As of 27 January 2026, total of 196 contacts of the confirmed cases were identified and tested negative for NiV, according to the Indian Ministry of Health and Family Welfare, (MoHFW).
- Thailand, Nepal, Cambodia, and other neighbouring countries have initiated measures, including information campaigns and screening for passengers arriving from India at airports.
- The likelihood of exposure and infection with NiV for EU/EEA citizens travelling to or residing in India is currently very low, given the low number of infections in areas where cases have been identified to date.

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

- On 26 January 2026, the Ethiopian Ministry of Heath declared the end of the Marburg virus disease (MVD) outbreak in the country.
- The 42-day countdown for declaring the outbreak over was initiated on 14 December 2025, following the death of the last confirmed MVD patient.
- Since the outbreak was declared on 14 November 2025, a total of 19 cases (14 confirmed and five probable) of MVD were reported, including 14 deaths (nine confirmed and five probable; case fatality rate (CFR): 64.3%).
- The cases were reported in four woredas (areas) across two regions: Jinka, Malle and Dasenech in the South Ethiopia Regional State, and Hawassa in the Sidama Region.
- This was the first MVD outbreak ever reported in Ethiopia.
- The overall risk for EU/EEA residents visiting or living in Ethiopia was assessed as low.

Classified as ECDC NORMAL

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

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

- Since 1 January 2026, and as of 27 January 2026, 1 203 cholera cases, including seven deaths, have been reported in six countries (Angola, Malawi, Mozambique, Namibia, Somalia, and Zambia). No data are available on cases reported in other countries in 2026.
- Since 24 December 2025, and as of 28 January 2026, 11 965 new cholera cases, including 126 new deaths, have been reported worldwide.
- The five countries reporting the most cases are: the Democratic Republic of the Congo (4 522), Afghanistan (3 029), Yemen (1 144), Mozambique (896), and India (878).
- The five countries reporting the most new deaths are: the Democratic Republic of the Congo (89), the Philippines (14), India (6), Yemen (5), and Côte D'Ivoire (4).
- Cholera cases have continued to be reported in Africa and Asia, the Middle East, and the Americas. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

1. 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.

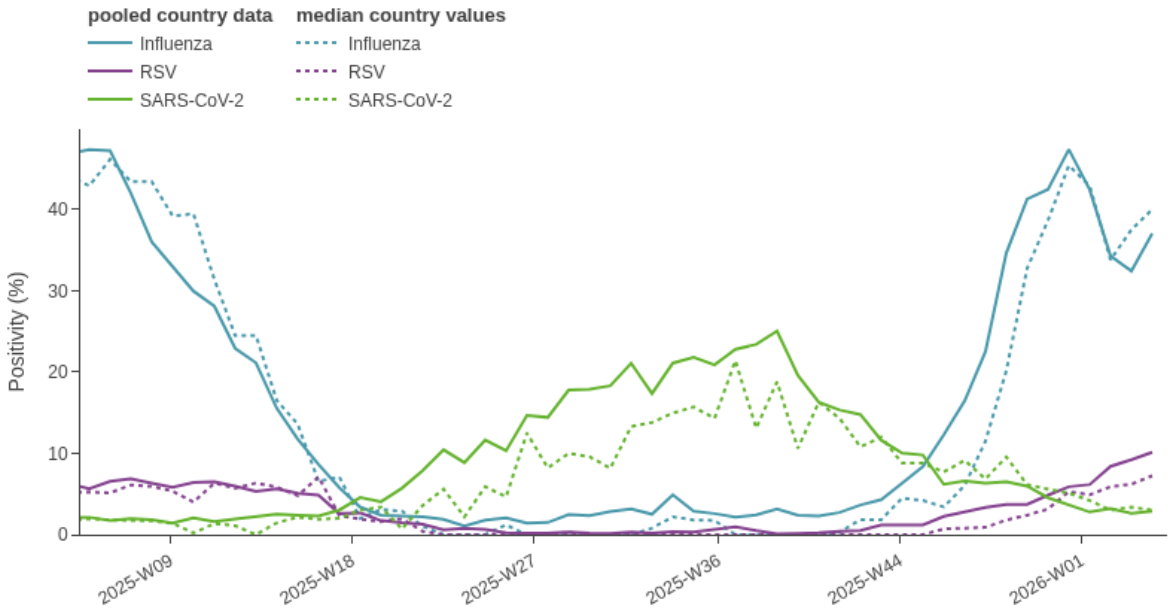
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 23 January 2026

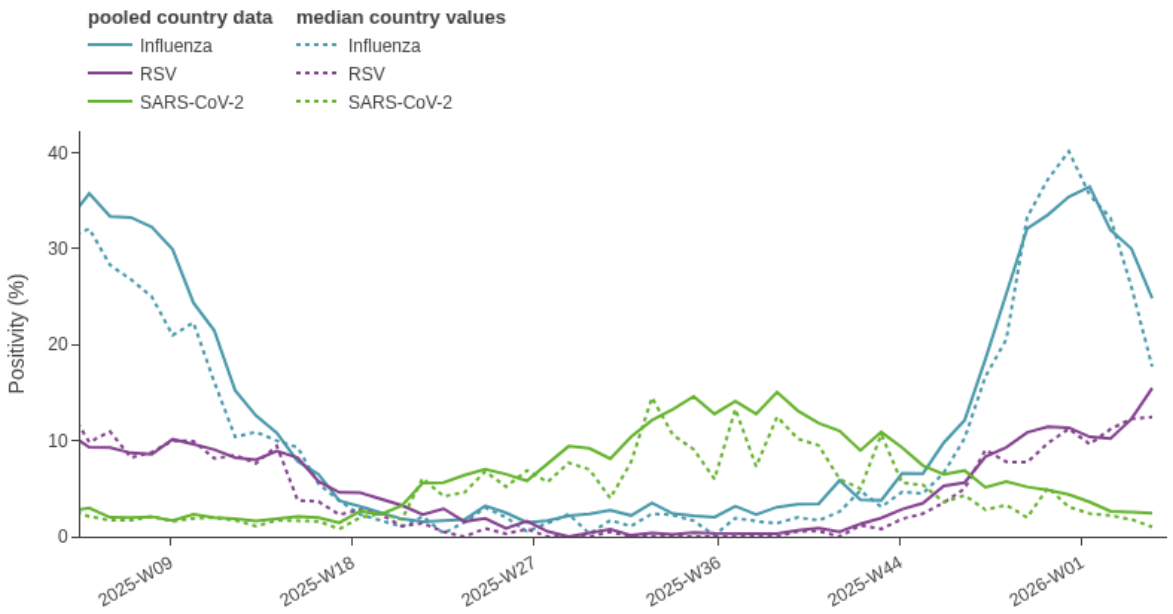
Classified as ECDC NORMAL

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

Classified as ECDC NORMAL

Figure 3. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 4	Week 3	Description	Value
ILI/ARI consultation rates in primary care	ARI	15 rates (9 MEM)	17 rates (9 MEM)	Distribution of country MEM categories	5 Baseline 4 Low
	ILI	20 rates (19 MEM)	21 rates (20 MEM)		3 Baseline 9 Low 5 Medium 2 High
ILI/ARI test positivity in primary care	Influenza	19	21	Pooled (median; IQR)	37% (40; 23–55%)
	RSV	18	20		10% (7.2; 4.5–12%)
	SARS-CoV-2	17	19		2.9% (3; 0.3–6.2%)
SARI rates in hospitals	SARI	10	12	–	–
SARI test positivity in hospitals	Influenza	8	10	Pooled (median; IQR)	25% (18; 14–38%)
	RSV	9	10		15% (12; 8–20%)
	SARS-CoV-2	8	10		2.5% (1; 0–2.8%)
Intensity (country-defined)	Influenza	24	25	Distribution of country qualitative categories	2 Baseline 5 Low 14 Medium 3 High
Geographic spread (country-defined)	Influenza	23	24	Distribution of country qualitative categories	1 Sporadic 1 Local 1 Regional 20 Widespread

Source: ECDC

Classified as ECDC NORMAL

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

	Week 4, 2026		Week 40, 2025 – week 4, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**896**	**–**	**12424**	**–**
Influenza A	889	99	12098	100
A(H1)pdm09	174	28	2541	25
A(H3)	438	72	7558	75
A (unknown)	277	–	1999	–
Influenza B	7	0.8	55	0.5
B/Vic	0	–	12	100
B (unknown)	7	–	43	–
Influenza untyped	0	–	271	–
RSV	**212**	**–**	**1814**	**–**
RSV-A	25	50	366	53
RSV-B	25	50	322	47
RSV untyped	162	–	1126	–
SARS-CoV-2	**55**	**–**	**3208**	**–**

Source: ECDC

Classified as ECDC NORMAL

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

	Week 4, 2026		Week 40, 2025 – week 4, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**570**	**–**	**9034**	**–**
Influenza A	268	99	5992	99
A(H1)pdm09	23	52	843	35
A(H3)	21	48	1548	65
A (unknown)	224	–	3601	–
Influenza B	2	0.7	39	0.6
B/Vic	0	–	4	100
B (unknown)	2	–	35	–
Influenza untyped	300	–	3003	–
RSV	**273**	**–**	**2684**	**–**
RSV-A	24	47	648	56
RSV-B	27	53	516	44
RSV untyped	222	–	1520	–
SARS-CoV-2	**55**	**–**	**2231**	**–**

Source: ECDC

Classified as ECDC NORMAL

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 4, 2026

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	1384	43	5a.2a.1(D.3.1)	1373	99
			5a.2a(C.1.9.3)	6	0.4
			5a.2a.1(D)	5	0.4
A(H3)	1799	56	2a.3a.1(K)	1657	92
			2a.3a.1(J.2)	94	5
			2a.3a.1(J.2.4)	25	1
			2a.3a.1(J.2.2)	23	1
B/Vic	15	0.5	V1A.3a.2(C.5.6)	7	47
			V1A.3a.2(C.5.6.1)	4	27
			V1A.3a.2(C.5)	2	13
			V1A.3a.2(C.5.1)	2	13

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, week 2, 2026 – week 3, 2026

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	2	5	0% (0–7%)
XFG	VUM	5	52	48% (27–50%)
NB.1.8.1	VUM	4	18	23% (20–27%)

Source: ECDC

2. *Bacillus cereus* in infant formula

Overview:

In January 2026 the company expanded the recall of infant nutrition products after cereulide, the emetic toxin produced by *Bacillus cereus*, was detected in the products. Cereulide is a highly thermostable emetic toxin capable of causing sudden-onset nausea and vomiting shortly after ingestion. The root cause analysis carried out so far by the company led to the identification of the contaminated ingredient.

The recall is global, including the EU/EEA market. The preventive recall is a risk-management action, taken following the detection of the toxin.

ECDC has received reports of diarrhoea cases in infants following consumption of the products, no severe cases have been reported.

Classified as ECDC NORMAL

One young infant has tested positive for the toxin in a faecal sample using a mass spectrometry protocol. The child had consumed milk from a recalled batch of formula. Leftover formula from the same tin will be tested at the reference laboratory. The infant presented vomiting and diarrhoea following consumption, with a favourable clinical outcome.

There was a report shared with ECDC of a sample of formula from a recalled batch that has tested positive for cereulide toxin. The sampled formula was taken from an unopened tin collected from the household of an infant who reported symptoms of vomiting and diarrhoea following consumption of the implicated batch.

ECDC assessment:

The particular products are widely distributed in EU/EEA and other countries, and the likelihood of exposure to a contaminated formula batch is therefore moderate to high for infants drinking formula. The impact of potential exposure/ingestion to the toxin is low to moderate depending on the age of the child. Neonates and young infants less than six months may be more likely to develop symptoms and even have complications like dehydration, electrolyte abnormalities etc. Therefore, the overall risk to infants less than one year in the EU/EEA would be assessed as moderate in this incident. As the voluntary withdrawals and recalls of these products are ongoing in many countries the likelihood of exposure is decreasing, and this will also decrease the risk.

Actions:

Member States are encouraged to work closely with food safety authorities on national investigations if suspected cases are identified.

ECDC is monitoring the event through its epidemic intelligence activities and is liaising with other stakeholders including affected countries, EFSA and the European Commission.

EFSA is monitoring the food incident in close co-operation with the European Commission and ECDC.

Consumers are recommended to follow the advice and instructions provided by national food safety authorities. Parents, guardians and caregivers who have affected products should not feed them to infants and young children.

Sources: Link to ECDC news item published 28 January 2026: Precautionary global recall of infant nutrition products following detection of Bacillus cereus toxin

3. Avian influenza A(H5N1) antibodies in cattle – the Netherlands – 2026

Overview:

On 23 January 2026, authorities in the Netherlands reported the detection of antibodies against avian influenza A(H5N1) in the milk of a cow in a dairy farm in Friesland. After detection of avian influenza A(H5N1) virus infection in a cat at a dairy farm in December 2025, 20 dairy cattle on the farm were randomly sampled on the 15th of January and tested for avian influenza A(H5N1). Diagnostic tests performed by Wageningen Bioveterinary Research found no active avian influenza A(H5N1) virus in the milk samples, but one cow had antibodies against avian influenza virus based on ELISA and Luminex test results, suggesting previous exposure to the infection. The cow had signs of mastitis in mid-December and, as a result, milk from the affected cow was excluded from the human food chain. Milk from the farm is only used in pasteurised products, which inactivates the virus.

All dairy cows at the farm were subsequently sampled on 22 January and tested for the presence of avian influenza A(H5N1) virus, all which have been negative so far. Results from serological testing for antibodies against avian influenza virus are still pending. Currently, there is no indication of active circulation of the virus on the farm or onward transmission to other farms.

Classified as ECDC NORMAL

People on the farm and the veterinarian have been offered testing by PCR and serology for A(H5N1) by the Municipal Health Service (GGD), for which results are pending. None of the individuals had experienced recent symptoms consistent with avian influenza infection.

An A(H5N1) virus isolate from the region Province Friesland in the Netherlands from a domestic cat was submitted to GISAID on 7 January 2026 with a collection date of 24 December 2025.

The isolate, A/Domestic cat/Netherlands/25021875-005/2025, is of clade 2.3.4.4b and genotype EA-2024-DI (subgroup DI.2). All HPAI A(H5Nx) viruses in avian species detected in Europe since 2016 belong to clade 2.3.4.4b, and during the 2024–2025 epidemiological year, DI.2 was the most frequent and widespread genotype among HPAI A(H5N1) viruses.

Phylogenetically, the virus falls into a branch with other DI-2 strains collected from wild and captive birds in Europe in 2025, including strains from wild birds in the Netherlands. The isolate from the cat has one nucleotide difference in the HA to the bird strains of this branch.

Furthermore, the isolate has acquired substitution E627K in the PB2 segment, which is associated with increased activity of the viral polymerases in mammalian hosts. This mutation is observed in approximately 47% of mammalian isolates but less than 1% in bird isolates (EFSA Panel on Animal Health and Animal Welfare, ECDC et al., 2025).

Acknowledgements: we gratefully acknowledge all data contributors - i.e. the authors and their originating laboratories responsible for obtaining the specimens, and the submitting laboratories for generating the genetic sequence and metadata and sharing via the GISAID Initiative.

ECDC assessment:

To date, there have been no confirmed human cases of influenza A(H5N1) infection in the Netherlands or other EU/EEA countries. Transmission of avian influenza from cattle to humans has only been reported in the United States in farm workers with exposure to infected cattle or contaminated environments, all who experienced mild symptoms and none of the cases required hospitalisation (see ECDC's Zoonotic influenza - Annual Epidemiological Report 2024 for further details). Transmission of avian influenza virus via pasteurised milk and dairy products is considered unlikely.

The lack of information on the virus characteristics and the clade of this particular virus limits the investigation. However, it is expected that it would be similar to avian influenza viruses circulating in the geographical area.

With the currently available information, ECDC has assessed the risk from avian influenza A(H5N1) clade 2.3.4.4b viruses currently circulating in Europe as low for the general population and low-to-moderate for those are occupationally or otherwise exposed to infected animals, including cattle, or contaminated environments.

Actions:

ECDC is monitoring the situation together with partner organisations in Europe and will continue to update its assessment of the risk for humans in the EU/EEA as new information becomes available.

In addition to enhanced surveillance, active monitoring and testing of exposed individuals is recommended for early detection of human cases of avian influenza and to assess the possibility of human-to-human transmission, according to relevant ECDC guidance documents ('Testing and detection of zoonotic influenza virus infections in humans'; 'Investigation protocol of human cases of avian influenza virus'; 'Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA').

It is important to raise awareness, including among all primary care workers, of the need to enquire about animal exposure and symptoms compatible with avian influenza infections and to test symptomatic individuals with a history of exposure, following a risk-based approach. It is also important to communicate the epidemiological situation so as not to miss or delay diagnosis of potential human cases.

Classified as ECDC NORMAL

Given the uncertainties related to mammal-to-mammal transmission and depending on the epidemiological situation, a low threshold can be considered for testing individuals exposed to potentially infected mammals (e.g. symptomatic individuals with conjunctivitis or respiratory symptoms). Due to the higher risk of infection for individuals exposed to infected animals and contaminated environments, appropriate personal protective measures and other precautionary measures should always be taken to mitigate the risk.

Relevant ECDC publications:

- Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work
- Investigation protocol of human cases of avian influenza virus infections in the EU/EEA
- Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA
- Joint ECDC-EFSA Drivers for a pandemic due to avian influenza and options for One Health mitigation measures
- Coordinated One Health investigation and management of outbreaks in humans and animals caused by zoonotic avian influenza viruses
- Preparedness, prevention and control related to zoonotic avian influenza
- Scenarios for pre-pandemic zoonotic influenza preparedness and response

ECDC is in contact with the authorities in the Netherlands, the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza as well as DG SANTE, and is closely following any updates on the event.

ECDC monitors zoonotic avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with EFSA and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly updated report on the avian influenza situation.

Further information:

A recently published Scientific Opinion by the European Food Safety Authority provides further information on surveillance in cattle and biosecurity measures: Risk of infection of dairy cattle in the EU with highly pathogenic avian influenza virus affecting dairy cows in the United States of America (H5N1, Eurasian lineage goose/Guangdong clade 2.3.4.4b. genotype B3.13)

4. Nipah virus disease – India – 2026

Overview:

Summary

According to a press release from India's Ministry of Health and Family Welfare (MoHFW) on 27 January 2026, there have been two confirmed cases of Nipah Virus (NiV) reported in the state of West Bengal. A total of 196 contacts of the confirmed cases were identified and tested negative for NiV, according to the MoHFW, as of 27 January 2026.

Several media outlets, quoting India's health authorities, have reported five NiV disease cases in the same outbreak in healthcare workers at the same hospital, in the district of North 24 Parganas, in the West Bengal State, India. The two confirmed cases are nurses working in Basarat, near Kolkata, according to media.

According to media reporting, both cases had attended to a patient with NiV-like symptoms at the hospital they work at, although this has not been reported in official sources. Furthermore, one of two nurses recently travelled to a village in Nadia district, close to the Bangladesh border and might have consumed raw date palm sap, according to media reports. This information on possible exposures has not been reported in official sources.

Following confirmation of the two cases, the Government of India, working closely with the Government of West Bengal, implemented comprehensive public health measures in line with

Classified as ECDC NORMAL

established protocols, according to the MoHFW. Enhanced surveillance, laboratory testing, and field investigations were carried out through coordinated action by Central and State health agencies.

In West Bengal, previous outbreaks occurred in 2001 (Siliguri) and 2007 (Nadia district). In 2025, a total of four NiV disease cases have been reported in India from the Palakkad (2) and Malappuram (2) districts. Of these, two have died, both from the Palakkad district.

Thailand, Nepal, Cambodia, and other neighbouring countries have initiated measures including information campaigns and screening for passengers arriving from India at airports.

Background:
Nipah virus (Henipavirus nipahense) is a highly pathogenic virus of the family Paramyxoviridae, genus Henipavirus. It was first isolated and identified in 1999 during an outbreak in Malaysia and Singapore. Since then, several outbreaks of NiV disease in Southern and South East Asia have been reported, with most cases in Bangladesh.

The virus spreads between animals and humans, with most human cases having had direct contact with pigs or bats. NiV can also be transmitted between people through direct contact or indirectly via contaminated food (e.g. date palm sap contaminated by bat saliva) or through aerosols. The incubation period is usually four to 14 days. Symptoms range from mild (fever, headache, muscle pain, and nausea) to more serious, including severe respiratory symptoms and encephalitis.

For more information on the disease and its epidemiology, please read ECDC's factsheet about Nipah virus Disease.

ECDC assessment:

Although the disease is severe and has a high fatality rate, the likelihood of exposure to and infection with NiV for EU/EEA citizens travelling to or residing in India is currently very low, given the low number of infections in the affected area in which cases have been identified to date.

The most likely route for the virus to be introduced into the EU/EEA would be via infected travellers. While importation of the virus cannot be excluded, its likelihood is currently very low. Although the virus can be transmitted through direct contact with infected wild or domesticated animals, because the natural hosts are not present in Europe, the likelihood of the virus spreading in the current context within the EU/EEA after importation is considered to be very low.

As a general precaution, EU/EEA travellers and residents in West Bengal state, India, should not handle domestic or wild animals and avoid contact with their excreta. The virus may be present on food items contaminated by bats. Washing, peeling, and cooking fruit and vegetables before consumption is generally recommended. Raw date palm sap (juice) should not be consumed.

Actions:

ECDC is monitoring this event through its epidemic intelligence activities.

Sources: ECDC press release published 29 January 2026: Nipah virus disease cases reported in West Bengal, India: very low risk for Europeans

Classified as ECDC NORMAL

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

Overview:

Update

On 26 January 2026, the Ministry of Health of Ethiopia declared the end of the Marburg virus disease (MVD) outbreak in the country. According to a WHO Disease Outbreak News (DON) item published on 26 January, no new cases have been detected in the past 42 days, since the death of the last confirmed case on 14 December 2025.

Since the CDTR update of 23 January 2026, two additional probable cases of MVD have been retrospectively reported in Ethiopia, following the publication of a WHO Disease Outbreak News (DON) report on 26 January 2026.

Summary

Case information

Since the outbreak was confirmed by the Ethiopian Ministry of Health on 14 November 2025, 19 cases of MVD (14 laboratory confirmed and five probable) have been reported in Ethiopia, according to WHO. A total of 14 deaths were reported (nine laboratory confirmed and five in probable cases) (CFR among confirmed cases: 64.3%).

Cases presented with symptoms including sudden fever, muscle pain, severe fatigue, headache, diarrhoea, vomiting and, in later stages, unexplained bleeding. According to the Ministry of Health, a total of five cases recovered (29.4%).

According to a WHO DON item, the first known case was an adult from Jinka town who developed symptoms on 23 October 2025. The patient presented to the General Hospital on 24 October 2025 with symptoms including vomiting, abdominal cramps and loss of appetite.

Geographical spread

The cases were reported in four woredas (areas) across two regions: Jinka, Malle and Dasenech in the South Ethiopia Regional State, and Hawassa in the Sidama Region according to a WHO DON item. Jinka town was considered to be the epicentre of the outbreak.

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 were still underway. Furthermore, an alert was reported in Wajaale, a major border city of the Somaliland region, according to Africa CDC.

Response activities

In accordance with the WHO and Ethiopian Marburg Disease Surveillance and Response guidelines, the outbreak was declared over 42 days (length of two incubation periods) after the death of the last laboratory-confirmed MVD patient.

According to a WHO DON item on 26 January 2026, a total of 857 listed contacts had completed their 21-day follow-up; 760 from the South Ethiopia Regional State and 97 from the Sidama Region.

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.

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 were supported by international partners. South Sudan, Kenya, and Somalia intensified their preparedness efforts, according to an Africa CDC press briefing on 18 December. According to WHO, the virus strain shows similarities to those previously identified in East Africa.

Classified as ECDC NORMAL

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:

During the outbreak, the likelihood of exposure to MVD for EU/EEA residents visiting or living in Ethiopia was assessed as low, with uncertainties connected to the limited epidemiological information available. The impact at population level was assessed to be low as it was not expected that there would 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 was low.

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

Actions:

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

Last time this event was included in the Weekly CDTR: 23 January 2026

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

Overview:

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

Update
Since 24 December 2025, and as of 28 January 2026, 11 965 new cholera cases, including 126 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Burundi, Cameroon, Chad, Congo, Côte D'Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Malawi, Mozambique, Myanmar/Burma, Namibia, Nepal, Nigeria, Pakistan, the Philippines, Somalia, South Sudan, Sudan,

Classified as ECDC NORMAL

Yemen, Zambia, and Zimbabwe. These countries had all previously reported cholera cases during 2025.

The five countries reporting the most cases are: the Democratic Republic of the Congo (4 522), Afghanistan (3 029), Yemen (1 144), Mozambique (896), and India (878).

New deaths have been reported from Afghanistan, Angola, Burundi, Chad, Congo, Côte D'Ivoire, the Democratic Republic of the Congo, Ethiopia, India, Malawi, Mozambique, Namibia, Nigeria, the Philippines, South Sudan, Sudan, Yemen, Zambia, and Zimbabwe. These countries had all previously reported cholera deaths during 2025.

The five countries reporting the most new deaths are: the Democratic Republic of the Congo (89), the Philippines (14), India (6), Yemen (5), and Côte D'Ivoire (4).

In the previous reporting period (24 November 2025 to 24 December 2025), 30 611 new cholera cases, including 275 new deaths, were reported worldwide.

In addition, 144 new cases were reported or collected retrospectively from before 24 December 2025.

Since 1 January 2026, and as of 27 January 2026, 1 203 cholera cases, including seven deaths, have been reported in eight countries (Angola, Burundi, Ethiopia, Malawi, Mozambique, Namibia, Somalia, and Zambia). No data are available on cases reported in other countries in 2026. In comparison, since 1 January 2025, and as of 27 January 2025, 10 043 cholera cases, including 32 deaths, were reported worldwide.

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

Asia:

Afghanistan:
Since 8 December 2025, and as of 28 December 2025, 3 029 new cases, including one new death, have been reported. Since 1 January 2025, and as of 28 December 2025, 164 820 cases, including 80 deaths, have been reported. In comparison, in 2024 and as of 28 December 2024, 175 262 cases, including 88 deaths, were reported.

India:
Since 25 August 2025, and as of 28 December 2025, 878 new cases, including six new deaths, have been reported. Since 1 January 2025, and as of 28 December 2025, 2 267 cases, including 11 deaths, have been reported. In comparison, in 2024 and as of 11 November 2024, 11 140 cases, including 58 deaths, were reported.

Myanmar/Burma:
Since 8 December 2025, and as of 28 December 2025, 12 new cases have been reported. Since 1 January 2025, and as of 28 December 2025, 2 390 cases have been reported. In comparison, in 2024 and as of 11 November 2024, 7 498 cases were reported.

Nepal:
Since 6 October 2025, and as of 28 December 2025, 98 new cases have been reported. Since 1 January 2025, and as of 28 December 2025, 1 899 cases have been reported. In comparison, in 2024 and as of 23 September 2024, 95 cases were reported.

Pakistan:
Since 17 November 2025, and as of 28 December 2025, 843 new cases have been reported. Since 1 January 2025, and as of 28 December 2025, 19 017 cases have been reported. In comparison, in 2024 and as of 30 December 2024, 77 785 cases were reported.

Philippines:
Since 30 June 2025, and as of 28 December 2025, 183 new cases, including 14 new deaths, have been reported. Since 1 January 2025, and as of 28 December 2025, 1 451 cases, including 27 deaths, have been reported. In comparison, in 2024 and as of 31 December 2024, no cases were reported.

Classified as ECDC NORMAL

Yemen:
Since 1 December 2025, and as of 28 December 2025, 1 144 new cases, including five new deaths, have been reported. Since 1 January 2025, and as of 28 December 2025, 93 496 cases, including 248 deaths, have been reported. In comparison, in 2024 and as of 23 December 2024, 260 552 cases, including 879 deaths were reported.

Since 24 December 2025, no updates have been reported by Bangladesh or Thailand.

Africa:

Angola:
Since 24 December 2025, and as of 27 January 2026, 152 new cases, including two new deaths, have been reported. Since 1 January 2026, and as of 27 January 2026, 152 cases, including two deaths, have been reported. In comparison, in 2025 and as of 28 January 2025, no cases were reported.

Burundi:
Since 24 December 2025, and as of 27 January 2026, 23 new cases have been reported. Since 1 January 2026, and as of 27 January 2026, 23 cases have been reported. In comparison, in 2025 and as of 28 January 2025, no cases were reported.

Côte D'Ivoire: Since 11 August 2025, and as of 31 December 2025, 53 new cases, including four new deaths, have been reported. Since 1 January 2025, and as of 31 December 2025, 556 cases, including 24 deaths, have been reported. In comparison, in 2024 and as of 31 December 2024, no cases were reported.

Democratic Republic of the Congo: Since 24 December 2025, and as of 31 December 2025, 4 522 new cases, including 89 new deaths, have been reported. Since 1 January 2025, and as of 31 December 2025, 71 646 cases, including 2 028 deaths, have been reported. In comparison, in 2024 and as of 18 November 2024, 28 618 cases, including 385 deaths were reported.

Ethiopia:
Since 24 December 2025, and as of 27 January 2026, 15 new cases have been reported. Since 1 January 2026, and as of 27 January 2026, 15 cases have been reported. In comparison, in 2025 and as of 28 January 2025, no cases were reported.

Malawi:
Since 11 December 2025, and as of 27 January 2026, 12 new cases, including two new deaths, have been reported. Since 1 January 2026, and as of 27 January 2026, 12 cases, including two deaths, have been reported. In comparison, in 2025 and as of 28 January 2025, no cases were reported.

Mozambique:
Since 24 December 2025, and as of 27 January 2026, 896 new cases, including three new deaths, have been reported. Since 1 January 2026 and as of 27 January 2026, 896 cases, including three deaths, have been reported. In comparison, in 2025 and as of 28 January 2025, no cases were reported.

Namibia:
Since 24 December 2025, and as of 27 January 2026, 18 new cases have been reported. Since 1 January 2026, and as of 27 January 2026, 18 cases have been reported. In comparison, in 2025 and as of 28 January 2025, no cases were reported.

Somalia:
Since 24 December 2025, and as of 27 January 2026, 82 new cases have been reported. Since 1 January 2026, and as of 27 January 2026, 82 cases have been reported. In comparison, in 2025 and as of 20 January 2025, 777 cases, including 1 death was reported.

Zambia:
Since 24 December 2025, and as of 27 January 2026, five new cases have been reported. Since 1 January 2026, and as of 27 January 2026, 5 cases have been reported. In comparison, in 2025 and as of 28 January 2025, no cases were reported.

Classified as ECDC NORMAL

Since 24 December 2025, no updates have been reported by Cameroon, Chad, Comoros, Congo, Ghana, Kenya, Nigeria, Rwanda, South Sudan, Sudan, Togo, Uganda, United Republic of Tanzania, or Zimbabwe.

Americas:
No new cases or new deaths have been reported.

ECDC assessment:

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

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

In the EU/EEA, cholera is rare and primarily associated with travel to endemic countries. Cholera reporting at the EU level is done on an annual basis, at the end of May for the previous year. In 2023, 12 confirmed cases were reported by five EU/EEA countries, while 29 were reported in 2022, two in 2021, and none in 2020. In 2019, 25 cases were reported in EU/EEA countries (including the United Kingdom). All cases had a travel history to cholera-affected areas.

According to the World Health Organization (WHO), vaccination should be considered for travellers at higher risk of infection, such as emergency and relief workers who may be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek advice from travel health clinics to assess their personal risk and apply precautionary sanitary and hygiene measures to prevent infection. Such measures can include drinking bottled water or water treated with chlorine, carefully washing fruit and vegetables with bottled or chlorinated water before consumption, regularly washing hands with soap, eating thoroughly cooked food, and avoiding the consumption of raw seafood products.

Actions:

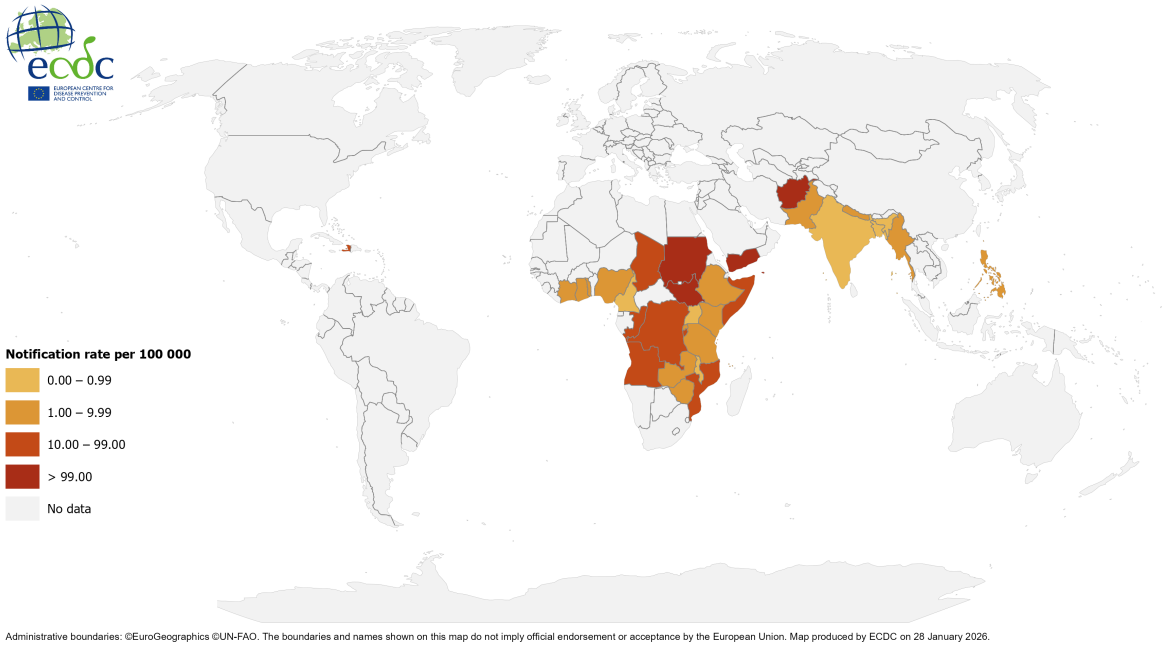
ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities.

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

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

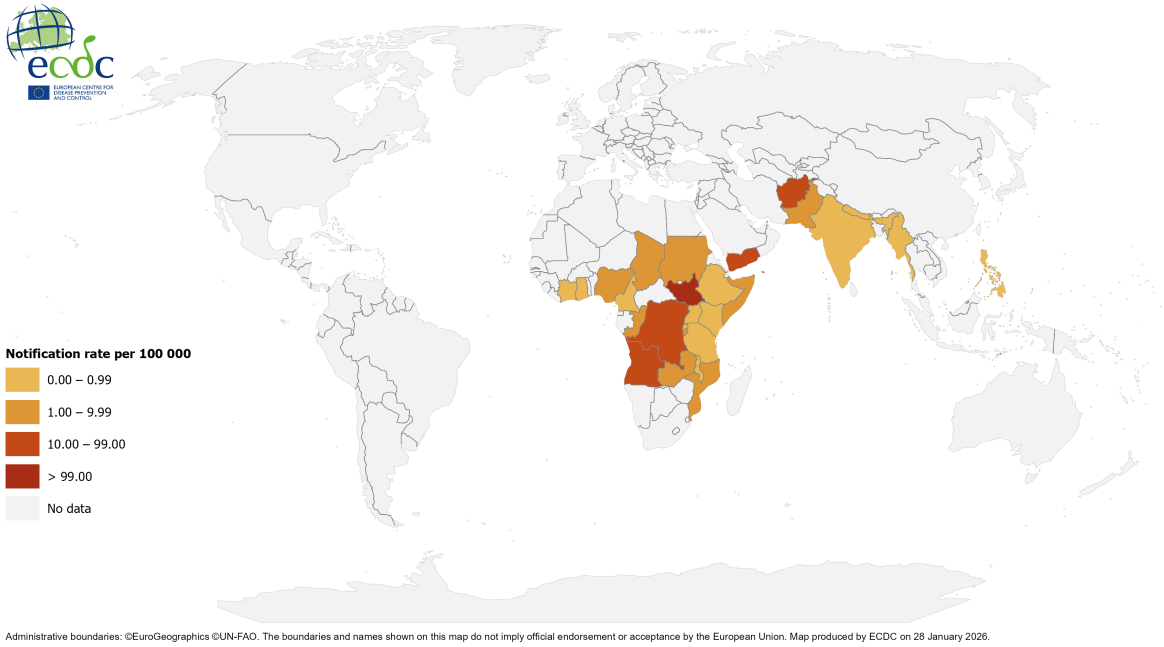
Classified as ECDC NORMAL

Figure 8. Geographical distribution of cholera cases reported worldwide from January 2025 to January 2026



Source: ECDC

Figure 9. Geographical distribution of cholera cases reported worldwide from November 2025 to January 2026



Source: ECDC

Classified as ECDC NORMAL

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 30 January 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 3, 2026 - last reported on 30 January 2026
- Marburg virus disease (MVD) – Ethiopia – 2025/26 - last reported on 30 January 2026
- Bacillus cereus in infant formula - last reported on 30 January 2026
- Nipah virus disease – India – 2026 - last reported on 30 January 2026
- Avian Influenza A(H5N1) antibodies in cattle - the Netherlands- 2026 - last reported on 30 January 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 23 January 2026
- 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
- 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
- Mpox clade Ib and clade IIb recombinant strain detected in UK traveller returning from Asia - last reported on 19 December 2025
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - 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 09 January 2026
- Human cases of swine influenza A(H1N1) virus variant - Multi-country - 2024 - last reported on 09 January 2026

Classified as ECDC NORMAL