WEEKLY BULLETIN

Communicable disease threats report

Week 26, 20–26 June 2026

This week's topics

Executive summary

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

- As of 26 June 2026, a total of 1 155 confirmed cases, including 304 confirmed related deaths, have been reported in the Democratic Republic of the Congo (DRC) (Ituri, North Kivu and South Kivu Provinces). Within the previous 24 hours, 37 new cases and five new deaths were reported. A total of 20 confirmed cases, including two deaths, have been reported in Uganda.
- On 24 June 2026, the Ministry of Health in France reported a first identified case of Ebola virus disease in a humanitarian doctor returning from a mission in DRC; the case is in isolation and contact tracing has been initiated. Five contacts have been identified and placed in isolation to date.
- The World Health Organization (WHO) published a Disease Outbreak News report on 19 June 2026, with WHO's risk assessment for DRC as very high, high for Uganda and high for countries

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

with land borders adjoining; the risk for the rest of Africa region and at the global level was assessed as low.
- On 17 May 2026, WHO declared that the Ebola disease outbreak due to Bundibugyo virus constituted a Public Health Emergency of International Concern, and on 18 May 2026, Africa CDC declared a Public Health Emergency of Continental Security.
- Considering all the available information and uncertainties about this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. For people living in the European Union/European Economic Area (EU/EEA), the likelihood of infection is estimated to be very low, given the very low likelihood of importation and secondary transmission. This assessment will be reviewed as further information becomes available.
- ECDC is monitoring the outbreak through epidemic intelligence activities and actively liaising with partners to support the response.

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

- In Europe, since the beginning of 2026, and as of 24 June, two countries have reported three human cases of West Nile virus (WNV) infection: Italy and North Macedonia.

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

- Since the beginning of 2026, and as of 24 June 2026, one country in Europe has reported locally acquired cases of CCHF: Spain (one case).

Dengue cases – EU/EEA ex. Maldives – 2025-2026

- Following a peak of dengue cases associated with travel from the Maldives in late 2025 and early 2026, several EU/EEA countries have reported a recent decline in dengue cases associated with travel to the Maldives.
- The environmental conditions in most areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti*, the vectors of dengue virus, are established are now favourable for mosquito activity and virus replication in mosquitoes; therefore, locally acquired dengue cases may occur in the coming weeks following introduction of the virus by viraemic travellers returning from affected areas.
- Public health efforts should focus on communication with travellers and healthcare providers.

Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles

- As of June 2026, several EU/EEA countries reported fewer imported chikungunya cases, compared with the period November 2025 to April 2026, with the most recent symptom onset occurring in mid-May.
- The environmental conditions in most areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti*, the vectors of chikungunya virus are established, are now favourable for mosquito activity and virus replication in mosquitoes; therefore, locally acquired chikungunya virus disease cases may occur in the coming weeks following introduction of the virus by viraemic travellers returning from affected areas.
- Travellers should be advised to apply mosquito bite prevention measures. Vaccination may be considered in accordance with national recommendations.

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

- In May 2026, 94 mpox cases caused by monkeypox virus (MPXV) clade I were reported by 12 EU/EEA countries, indicating a potential slowdown following the increase observed earlier in 2026. In the same period, 22 mpox cases caused by MPXV clade II were reported by six countries, continuing a decreasing trend.
- Transmission for both clades occurs predominantly within networks of men who have sex with men, with ongoing circulation across the EU/EEA and most cases reported among unvaccinated individuals.
- Disease severity remains generally mild, with low hospitalisation rates reported for both clades.
- With the start of the spring and summer season and increased travel and mass gatherings, there is a risk of further spread.

Overview of respiratory virus epidemiology in the EU/EEA

Important: This is the first publication of ERVISS following the transition of reporting surveillance data from The European Surveillance System (TESSy), which has been decommissioned, to EpiPulse Cases (EPC). As a result of this transition, we have identified some inconsistencies in data from individual countries. We are actively working to identify and resolve these and any new issues that may arise to ensure data completeness and accuracy. During this period, updates of data for download from GitHub will be paused. Thank you for your patience and understanding.

Summary

Respiratory virus activity across the EU/EEA is at baseline levels, indicating limited respiratory virus circulation.

SARS-CoV-2 activity in all age groups in primary and secondary care remains low.

Respiratory syncytial virus (RSV) activity is at inter-seasonal levels.

Influenza virus activity is at inter-seasonal levels.

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'.

Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

- On 23 June 2026, one new human case of avian influenza A(H9N2) was reported in the Guangxi Zhuang Autonomous Region in China.
- The case involves a child with disease onset on 31 May 2026.
- The risk to human health in the EU/EEA is considered very low.

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

- Since 1 January 2026 and as of 22 June 2026, 105 813 cholera cases, including 1 216 deaths, have been reported worldwide.
- Since 26 May 2026 and as of 22 June 2026, 19 659 new cholera cases, including 261 new deaths, have been reported worldwide.
- The five countries reporting most cases are Nigeria (8 051), the Democratic Republic of the Congo (DRC) (7 923), Angola (1 930), Malawi (882), and Burundi (358).
- The five countries reporting most new deaths are DRC (112), Nigeria (77), Angola (42), Congo (27), and Mozambique (2).
- In addition, on 23 June 2026, Taiwan Centers for Disease Control reported a locally-acquired case of cholera in a woman in her 70s with no recent travel history. The patient was hospitalised and, following treatment, her condition improved and she was discharged.
- Cholera cases have continued to be reported in Africa, Asia, the Middle East, and the Americas. The risk of cholera infection for travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026

- Monkeypox virus (MPXV) clades I and II are circulating in multiple countries. While the epidemiological trends of mpox cases due to MPXV clades I and II generally remain similar to previous weeks, a number of mpox clade I cases have been reported outside countries with community transmission and among men who have sex with men.
- Since the previous update, no major epidemiological changes have been reported for mpox clade I or clade II.
- ECDC will continue monitoring the transmission of mpox clade I and clade II trends through event- and indicator-based surveillance and report in the Communicable Disease Threats Report. Monthly updates on mpox in the EU/EEA, Western Balkans and Türkiye are also available on the dedicated website.

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

- Since the beginning of 2026, and as of 22 June 2026, over 1 million cases of dengue and over 1 000 dengue-related deaths had been reported globally, according to information from publicly available sources. This is a decrease compared to the same period in 2025.
- In 2026, no cases have been reported in the EU/EEA, excluding the outermost regions. Cases have been reported by Martinique, Guadeloupe, Reunion, and by French Guiana (French outermost regions).

Risk assessments under production

On 25 June 2026, ECDC published, jointly with the European Food Safety Authority (EFSA), a Rapid Outbreak Assessment: 'Multi-country outbreak of *Salmonella* Bovismorbificans infection linked to the consumption of sprouted seeds'.

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

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.
- Four experts have been deployed on a rotating basis to support Africa CDC, initially at its headquarters in Addis Ababa and, since 22 June, within the Continental Incident Management Support Team (IMST) in Uganda. These 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 Directorate-General for International Partnerships (DG INTPA).
- Between 15 and 22 June, 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.
- On 16 June 2026, an ECDC Risk Communication and Community Engagement (RCCE) expert was deployed to the WHO country office in Juba, South Sudan, in response to a Global Outbreak Alert and Responses Network request for assistance, to support community engagement activities and address key RCCE gaps in high-risk areas.
- These activities are being conducted in close coordination with national authorities, the EU delegations and in collaboration with the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO) and DG INTPA.

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

Overview:

Latest epidemiological information

Update in the EU/EEA

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 in one of the areas affected by the ongoing outbreak in the Democratic Republic of the Congo (DRC). The patient is reported to be in isolation in a designated healthcare facility and contact tracing has been initiated by health authorities. ECDC is in close contact with health authorities in France to collect further information on the case.

In a media interview on 24 June, the French Health Minister reported that five contacts who were on the plane from Kinshasa with the case had been identified as of the evening of 24 June and have been placed in isolation.

As reported in media sources quoting the airline company of the plane the case travelled on from Kinshasa to Paris, a passenger list was provided to health authorities to proceed with contact tracing.

Health authorities in France and DRC are cooperating to identify and monitor possible contacts, as stated by a press release from the French embassy in DRC on 25 June.

Democratic Republic of the Congo

According to the official report published on 25 June 2026 (data as of 24 June), a total of 1 155 confirmed cases, including 304 confirmed related deaths, have been reported in the Democratic Republic of the Congo (DRC). An additional 37 new confirmed cases and five new deaths were reported in the previous 24 hours. In addition, 385 patients are reported to have been hospitalised in isolation. Among the individuals who tested positive for Bundibugyo virus, 138 people have recovered and 79.2% of identified contacts are under follow-up.

Among the confirmed cases, 1 054 cases (including 250 deaths) were reported in the Ituri province, 98 cases (including 53 deaths) in North Kivu, and three cases (including one death) in South Kivu. In South Kivu, the last case was reported on 26 May and active surveillance is ongoing.

Within the three affected provinces, 34/104 health zones are currently affected, including 22/36 in Ituri, 11/34 in North Kivu, and 1/34 in South Kivu. No new affected health zones have been reported in the last 24 hours. Of the 1 054 confirmed cases reported in Ituri, 17 have not been assigned to a health zone.

According to media report quoting the Ministry of Health in DRC, 75 of the confirmed cases reported as of 18 June involved health and care workers, 17 of whom have died.

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, though 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 obligations for cases themselves.) In addition, outbound international travellers are required to complete a mandatory health declaration form issued by border health authorities.

Uganda

As of 25 June 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. Fifteen individuals have recovered. Overall, 831 all-time contacts have been identified, of which 9 contacts are under follow-up and 814 individuals have completed the 21-day follow-up.

Among the confirmed cases, 15 had travel links to DRC and five were associated with local transmission events.

Of nine cases with known geographical information, eight were reported in Kampala and one was reported in Wakiso (a district that neighbours Kampala).

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 case presented with fever, bleeding, vomiting and weakness (Ministère de la Santé RDC Declaration of Ebola Outbreak 15 May 2025). However, the outbreak is likely to have started many weeks before, given the number of cases and the geographical spread.

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).

The first case reported in Uganda was travel-related and the patient later died (Democratic Republic of the Congo confirms new Ebola outbreak, WHO scales up support | WHO AFRO, 15 May 2026, Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026). Health authorities reported that 14 confirmed cases in Uganda had travel links to DRC. Additional cases were identified following contact tracing activities. Uganda has postponed a large religious event (Martyr's Day) that normally takes place on 3 June and has suspended cross-border transport activities (Government of Uganda on X: 21 May 2025).

Genomes from DRC and Uganda have been published and preliminary analysis shows distinct sequences from the previous outbreaks (Virological Ebolavirus/Bundibugyo ebolavirus, 18 May 2026).

Information regarding transmission chains and affected population groups is currently limited, partly due to the complex context of insecurity and humanitarian challenges in the affected areas. According to WHO, neighbouring countries sharing land borders with DRC are considered at high risk of further spread due to population mobility, trade and travel links, and uncertainty about the transmission chains. The outbreak may also be larger than currently detected. There are also concerns related to this outbreak because it is caused by Bundibugyo virus, rather than the more commonly detected *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 prior outbreak occurred in 2025 in Kasai Province due to 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 cases 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, one case reported by Uganda 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 measures at points of entry have been implemented, in coordination with WHO, UAE and international partners.

On 19 June 2026, WHO published an updated Disease Outbreak News report with the following risk assessment:
"The risk in the Democratic Republic of the Congo remains assessed as very high due to ongoing transmission and the continued expansion of the outbreak into new health zones, increasing the potential for further national and regional spread.

The risk in Uganda is still assessed as high due to confirmed cross-border spread through imported cases and ongoing epidemiological links along the eastern Democratic Republic of the Congo–western Uganda corridor, historically affected by Ebola outbreaks, including Bundibugyo and Sudan virus disease outbreaks.

The risk for countries with land borders adjoining countries with documented BDBV detection is assessed as high due to sustained population mobility linked to cross-border trade and mining activities, variation in capacities and experience of BVD response, and variable levels of readiness. The risk for the rest of the Africa region and at the global level is assessed as low."

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

Exit screening has been implemented in DRC, Uganda and South Sudan. In DRC, points of entry (PoE) and points of control (PoC) have been activated at key locations, including airports, 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 temporarily suspended again as of 6 June, as part of health security arrangements in response to the Ebola disease outbreak, as reported by media.

Uganda's Ministry of Health announced on 15 June 2026 (press release) that the general public, travellers, recruitment agencies, travel agents, and all stakeholders departing from Uganda do not require an 'Ebola-Free Certificate'. The 'Ebola-Free Certificate' is not a requirement for visa applications to any country. Ebola testing is recommended for symptomatic individuals who develop symptoms consistent with Ebola virus disease or those who are identified as contacts of confirmed Ebola virus disease cases, based on a clinical and epidemiological assessment by health authorities.

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).

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 (Ebola Update - Travel Measures and Ongoing Monitoring).

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.

Given all the available information and uncertainties surrounding this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. For people living in the EU/EEA, the likelihood of infection is estimated to be very low, given the very low likelihood of importation and secondary transmission. The 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 DG ECHO, DG INTPA and GOARN, is deploying ECDC experts to Addis Ababa (Ethiopia) in Africa CDC headquarters, and Kampala (Uganda).

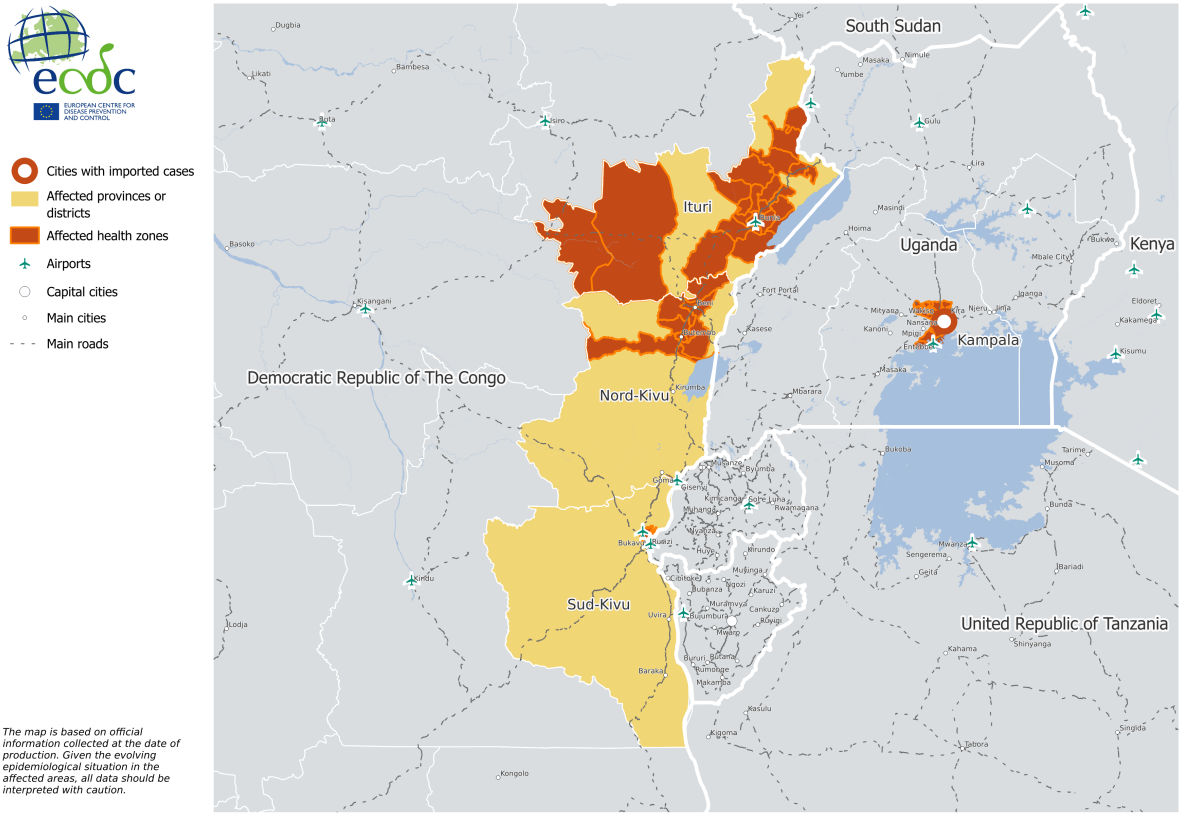
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO, to provide further support through the EU Health Task Force in response to this outbreak.

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

Among the official documents published to date, the following are included: Threat Assessment Brief (21 May 2026); Risk assessment for infectious diseases transmitted on aircraft (RAGIDA) (30 May 2026); Rapid ECDC advice on infection prevention and control measures for Ebola disease in EU/EEA healthcare settings (2 June 2026); Risk of Bundibugyo virus transmission through substances of human origin in the EU/EEA (11 June 2026); Risk classification and contact tracing of travellers returning from affected areas (15 June 2026); Overview of available modelling evidence to inform the scale and potential spread of Bundibugyo virus in the current Ebola disease outbreak (17 June 2026); Preparedness and response for imported cases of Ebola disease into EU/EEA county (18 June 2026).

Last time this event was included in the Weekly CDTR: 18 June 2026

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



Source: ECDC

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

Overview:

In Europe, since the beginning of 2026, and as of 24 June, two countries have reported three human cases of West Nile virus (WNV) infection: Italy and North Macedonia.

A total of three areas are currently known to be affected.

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 will also be published.

WNV infection in humans is a notifiable disease at EU level and cases should be reported by national public health authorities through the EpiPulse Cases platform according to the EU case definition. According to Commission Directives 2004/33/EC and 2014/110/EU on blood safety, blood establishments in EU/EEA countries should apply temporary deferral criteria for donors of allogeneic blood donation for 28 days after they have left a risk area for locally acquired WNV, unless an individual nucleic acid test (NAT) is negative. WNV surveillance activities carried out by ECDC support the competent authorities responsible for blood safety in the implementation of these directives.

ECDC assessment:

Seasonal weather conditions are currently favourable for mosquito-borne transmission; therefore more cases are expected to occur in the coming weeks.

Actions:

ECDC will provide weekly and monthly updates with the latest reports on cases of WNV infections in Europe. A map and table will be updated every Friday from now 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 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: 18 June 2026

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

Overview:

Since the beginning of 2026, and as of 24 June 2026, one country in Europe has reported locally acquired cases of CCHF: Spain (one case).

The report is available online.

ECDC assessment:

The case in Salamanca (Spain) is not unexpected as *Hyalomma* spp. – the main vectors of CCHF virus – are widely distributed across the region. In addition, CCHF virus is known to circulate in local animal populations, and human cases have previously been reported there. The timing of this case aligns with the expected seasonal pattern of CCHF in Spain, and is probably linked to increased tick activity.

Although the risk of contracting CCHF for the general population in the areas where the virus is known to be present in Spain is low, this risk increases for people undertaking outside 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 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 approximately November 2026.

4. Dengue cases – EU/EEA ex. Maldives – 2025-2026

Overview:

Since 2025, several EU/EEA countries reported an increasing number of travel-associated cases of dengue linked to returning travellers from the Maldives. As of early 2026, four countries have reported at least 107 imported dengue cases linked to travellers returning from the Maldives. No unusual severity has been reported among the cases in the EU/EEA countries.

This trend corresponded to an increase in locally reported dengue cases in the Maldives since March 2025. Although dengue virus is endemic in the Maldives, the country reported an unusual increase in the number of dengue cases, with 2 969 confirmed cases notified as of May 2026 (week 20-21), compared to 347 in April 2025 and 641 in April 2024.

However, recent data from three EU/EEA countries indicate a declining trend in imported cases since spring 2026, based on currently available information.

ECDC assessment:

The environmental conditions in most areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti* are established are now favourable for mosquito activity and virus replication in mosquitoes; therefore, locally acquired dengue cases may occur in the coming weeks following introduction of the virus by viraemic travellers returning from affected areas.
Individuals planning to travel to the Maldives, or other areas with dengue transmission, can discuss dengue vaccination with a travel medicine specialist.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities. Monthly updates are provided on ECDC's dedicated dengue webpage. For more information on locally acquired dengue cases, see ECDC's seasonal surveillance report for dengue.

Last time this event was included in the Weekly CDTR: 18 June 2026

5. Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles

Overview:

Since November 2025 as of June 2026, more than 166 travel-related cases of chikungunya virus disease have been reported by 13 EU/EEA countries among travellers returning from the Seychelles, based on data submitted through event-based surveillance. This represents a marked increase compared with earlier months of 2025, and no cases were reported in preceding years.
However, recent data from three EU/EEA countries indicate a declining trend, with no cases reported with symptom onset after mid-May based on currently available information.

The emergence of chikungunya virus disease in the Seychelles aligns with a broader regional spread throughout the Indian Ocean. Notably, La Réunion (France) experienced a major outbreak in 2025.

According to local health authorities, chikungunya virus has become more prevalent in the Seychelles compared with other circulating arboviruses.

ECDC assessment:

The environmental conditions in most areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti* are established are now favourable for mosquito activity and virus replication in mosquitoes; therefore, locally acquired chikungunya virus disease cases may occur in the coming weeks following introduction of the virus by viraemic travellers returning from affected areas.

Preventive measures, including mosquito bite avoidance, should continue to be recommended to travellers. Vaccination may be considered in accordance with national recommendations.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities. Monthly updates are provided on ECDC's dedicated chikungunya webpage.

For more information on locally acquired chikungunya cases, see ECDC's seasonal surveillance report for chikungunya.

Last time this event was included in the Weekly CDTR: 18 June 2026

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

Overview:

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

May 2026 update
In May 2026, 94 mpox cases caused by clade I MPXV were reported by 12 countries, with the most cases being reported by Spain (19). Following increases observed in late 2025, clade I transmission has continued to rise in early 2026, with 87 cases reported in February, 111 in March and 140 in April, before decreasing in May

In May 2026, 22 mpox clade II cases were reported by six countries, continuing a decreasing trend compared with previous months (40 cases in March and 34 cases in April). Germany reported the highest number of cases (13).

Overview of the past 12 months (June 2025 to May 2026)
In the past 12 months, 18 countries have reported 608 clade I mpox cases and 19 countries have reported 854 clade II mpox cases. Interpretation of trends is limited due to missing clade information for approximately 38% of reported cases.

Among cases with complete information:

- 92% of clade I cases and 92% of clade II cases were reported among men who have sex with men.
- 14% of clade I cases and 8% of clade II cases were hospitalised. One death was reported associated with clade II infection; no deaths were reported among clade I cases.
- 21% of clade I cases and 17% of clade II cases with known vaccination status had received two vaccine doses.

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

ECDC assessment:

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

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

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

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

Actions:

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

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

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

Further response options for EU/EEA countries include:
- raising awareness among healthcare professionals;
- supporting sexual health services in case detection, contact tracing, and case management; and
- ensuring testing is easily accessible.

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

Further information:

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

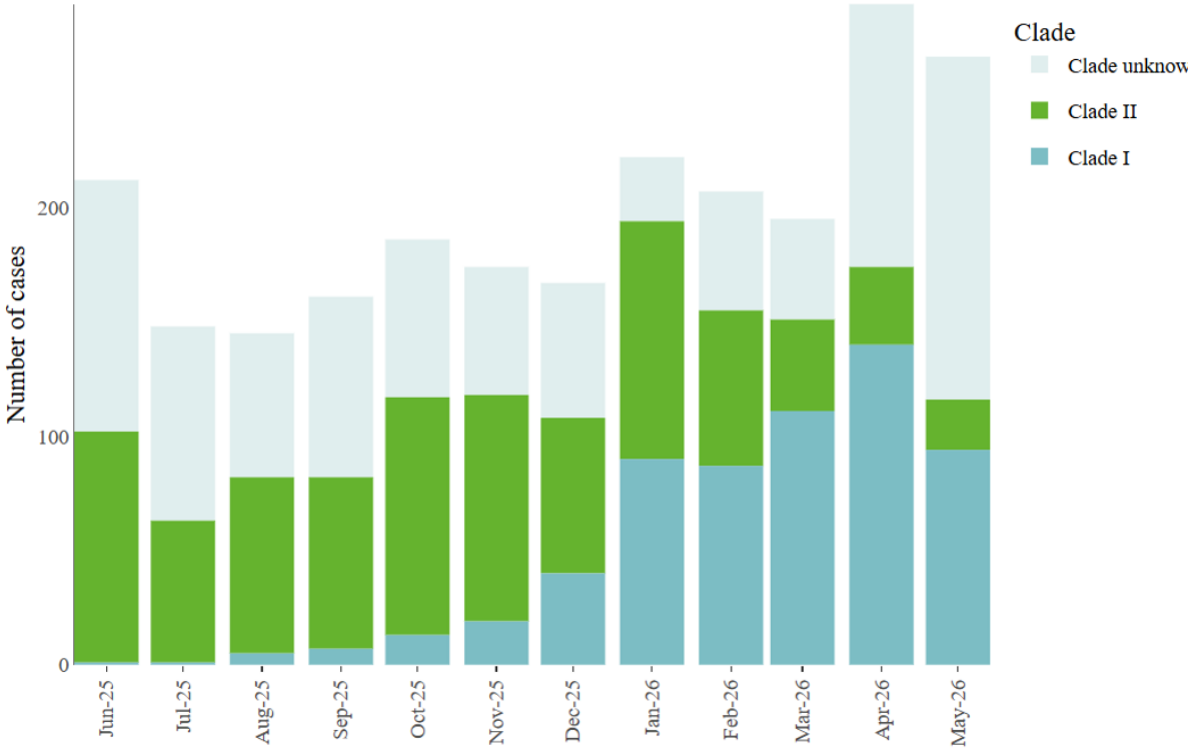
Last time this event was included in the Weekly CDTR: 5 June 2026

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

Country	Clade I		Clade II		Clade Unknown	
	Past 12 months	Past month	Past 12 months	Past month	Past 12 months	Past month
Austria	13	3	12	1		
Belgium	42	3	17	1	118	54
Croatia					3	1
Czechia	5		5			
Denmark			2			
France	71	17	52	4	111	52
Germany	111	17	168	13	196	15
Greece	6	4	2		1	1
Hungary			2			
Iceland					1	
Ireland	10	1	32		1	1
Italy	49	8	4		119	7
Lithuania	1					
Luxembourg	3	2	4			
Malta			2			
Netherlands	33	3	97		14	6
Norway	1		10			
Poland	1		1		19	5
Portugal	24	13	61		80	2
Romania	2				1	
Slovakia	4				1	
Slovenia			2			
Spain	207	19	371	2	242	5
Sweden	25	4	10	1	3	1
EU/EEA total	**608**	**94**	**854**	**22**	**910**	**150**

Source: ECDC

Figure 3. Total number of mpox cases by clade, by month of diagnosis in the past 12 months (June 2025 to May 2026), EU/EEA



Source: ECDC

7. Overview of respiratory virus epidemiology in the EU/EEA

Overview:

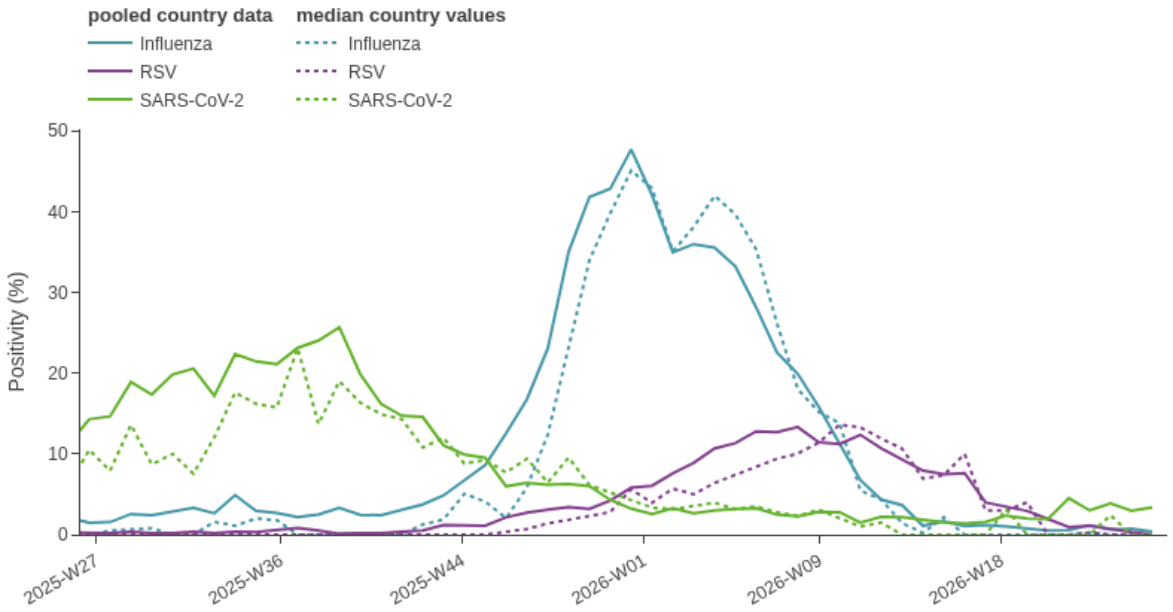
ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary (ERVISS.org), which is updated weekly.

Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

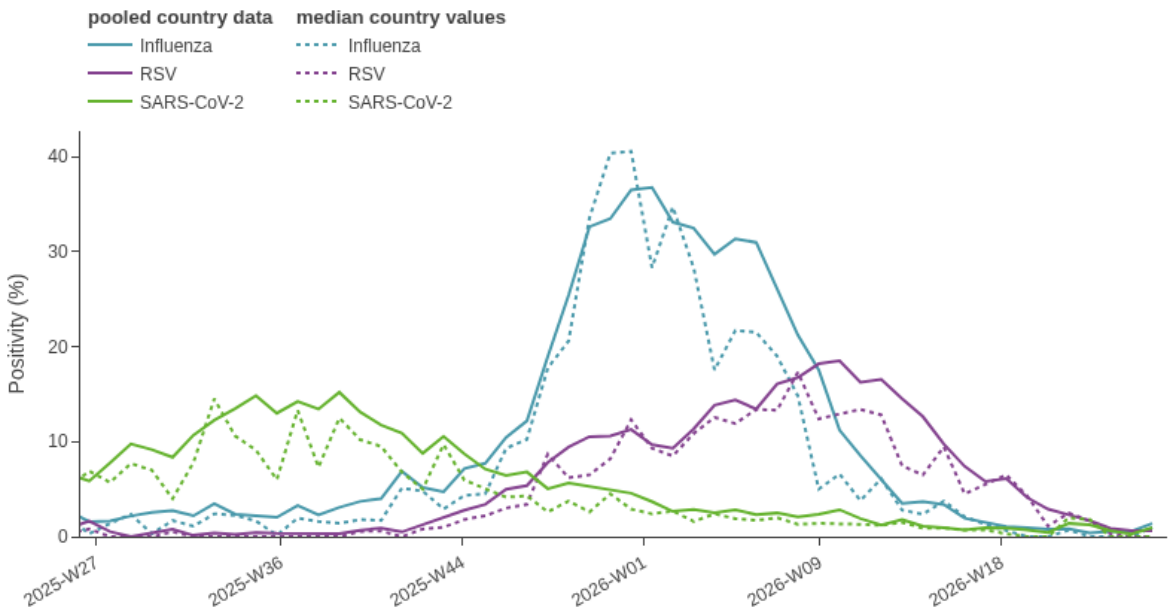
Last time this event was included in the Weekly CDTR: 22 May 2026

Figure 4. ILI/ARI virological surveillance in primary care – weekly test positivity



Source: ECDC

Figure 5. SARI virological surveillance in hospitals – weekly test positivity



Source: ECDC

Figure 6. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	**Syndrome or pathogen**	**Week 25**	**Week 24**	**Description**	**Value**
ILI/ARI consultation rates in primary care	ARI	10 rates (7 MEM)	11 rates (6 MEM)	Distribution of country MEM categories	6 Baseline 1 High
	ILI	11 rates (10 MEM)	12 rates (11 MEM)		10 Baseline
ILI/ARI test positivity in primary care	Influenza	10	11	Pooled (median; IQR)	0.4% (0; 0–0.1%)
	RSV	9	10		0% (0; 0–0%)
	SARS-CoV-2	10	11		3.4% (0; 0–1.6%)
SARI rates in hospitals	SARI	8 rates (4 MEM)	9 rates (5 MEM)	Distribution of country MEM categories	3 Baseline 1 Low
SARI test positivity in hospitals	Influenza	6	7	Pooled (median; IQR)	1.4% (1; 0–1.5%)
	RSV	6	7		0.6% (0; 0–0%)
	SARS-CoV-2	6	7		0.9% (0; 0–0%)
Intensity (country-defined)	Influenza	6	7	Distribution of country qualitative categories	6 Baseline

Source: ECDC

Figure 7. ILI/ARI virological surveillance in primary care - pathogen type and subtype distribution

	Week 25, 2026		Week 40, 2025 – week 25, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**2**	**–**	**18459**	**–**
Influenza A	1	50	17854	99
A(H1)pdm09	1	100	4156	28
A(H3)	0	0.0	10701	72
A (unknown)	0	–	2997	–
Influenza B	1	50	126	0.7
B/Vic	0	–	35	100
B (unknown)	1	–	91	–
Influenza untyped	0	–	479	–
RSV	**0**	**–**	**5166**	**–**
RSV-A	0	–	823	42
RSV-B	0	–	1126	58
RSV untyped	0	–	3217	–
SARS-CoV-2	**26**	**–**	**4113**	**–**

Source: ECDC

Figure 8. SARI virological surveillance in hospitals - pathogen type and subtype distribution

	Week 25, 2026		Week 40, 2025 – week 25, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**9**	**–**	**15481**	**–**
Influenza A	6	100	6245	99
A(H1)pdm09	0	–	743	30
A(H3)	0	–	1749	70
A (unknown)	6	–	3753	–
Influenza B	0	0.0	58	0.9
B/Vic			4	100
B (unknown)	0	–	54	–
Influenza untyped	3	–	9178	–
RSV	**4**	**–**	**7052**	**–**
RSV-A			626	49
RSV-B	1	100	658	51
RSV untyped	3	–	5768	–
SARS-CoV-2	**6**	**–**	**2986**	**–**

Source: ECDC

Figure 9. Genetically characterised influenza virus distribution, week 40, 2025 – week 25, 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 10. SARS-CoV-2 variant distribution, week 23, 2026 - week 24, 2026

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	0	0	0%
BA.3.2	VUM	1	6	60% (60–60%)
XFG	VUM	1	4	40% (40–40%)
NB.1.8.1	VUM	0	0	0%

Source: ECDC

8. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

Overview:

Summary
On 23 June 2026, one new human case of avian influenza A(H9N2) was reported in China according to the Avian Influenza Report (Volume 22, Number 25) published by the Hong Kong's Centre for Health Protection.

The case involves a girl under five years old from the Guangxi Zhuang Autonomous Region in southern China, who developed symptoms on 31 May 2026. The case was confirmed to have been infected with avian influenza A(H9N2).

The previous confirmed case of avian influenza A(H9N2) in the same region was reported in May 2026.

ECDC assessment:

Sporadic human infections with avian influenza A(H9N2) have been observed outside of the EU/EEA. One case has also been reported in the EU/EEA, with exposure history during travel outside of Europe. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses. In most cases, influenza A(H9N2) leads to mild clinical illness. To date, no clusters of human A(H9N2) infections have been reported. There is no evidence that the virus has acquired the ability for sustained transmission among humans. The risk to human health in the EU/EEA is currently considered very low.

Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities. Together with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly report on the avian influenza situation. The most recent report was published in March 2026.

Last time this event was included in the Weekly CDTR: 18 June 2026

9. 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 26 May 2026 and as of 22 June 2026, 19 659 new cholera cases, including 261 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Burundi, Congo, Democratic Republic of The Congo, Haiti, India, Kenya, Malawi, Mozambique, Nigeria, Pakistan, Yemen and Zambia.

The five countries reporting most cases are Nigeria (8 051), the Democratic Republic of the Congo (DRC) (7 923), Angola (1 930), Malawi (882), and Burundi (358).

New deaths have been reported from Afghanistan, Angola, Burundi, Congo, DRC, Haiti, Mozambique, Nigeria, and Yemen.

The five countries reporting most new deaths are DRC (112), Nigeria (77), Angola (42), Congo (27), and Mozambique (2).

In addition, 17 405 new cases were reported or collected retrospectively from before 26 May 2026.

In the previous reporting period (28 April to 26 May 2026), 3 596 new cholera cases, including 176 new deaths, were reported worldwide.

Since 1 January 2026 and as of 22 June 2026, 105 813 cholera cases, including 1 216 deaths, have been reported worldwide.

In comparison, since 1 January 2025 and as of 22 June 2025, 121 736 cholera cases, including 1 576 deaths, were reported worldwide.

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

Asia:
Afghanistan: Since 13 April 2026 and as of 18 May 2026, 15 421 new cases, including nine new deaths, have been reported. Since 1 January 2026 and as of 18 May 2026, 40 085 cases, including 16 deaths, have been reported. In comparison, in 2025 and as of 17 March 2025, 19 652 cases, including eight deaths, were reported.

India: Since 9 February 2026 and as of 9 March 2026, 10 new cases have been reported. Since 1 January 2026 and as of 09 March 2026, 36 cases have been reported. In comparison, in 2025 and as of 28 April 2025, 440 cases were reported.

Pakistan: Since 16 March 2026 and as of 20 April 2026, 957 new cases have been reported. Since 1 January 2026 and as of 20 April 2026, 2 604 cases have been reported. In comparison, in 2025 and as of 19 May 2025, 11 181 cases were reported.

Yemen: Since 6 April 2026 and as of 4 May 2026, 872 new cases, including three new deaths, have been reported. Since 1 January 2026 and as of 4 May 2026, 4 358 cases, including six deaths, have been reported. In comparison, in 2025 and as of 24 February 2025, 10 080 cases, including 10 deaths, were reported.

Since 26 May 2026, no updates have been reported by: Myanmar/Burma.

In addition, on 23 June 2026, Taiwan Centers for Disease Control reported a locally-acquired case of cholera in a woman in her 70s with no recent travel history. The patient developed diarrhea, vomiting and convulsions in early June and was later hospitalised when her condition worsened. Samples from the patient tested positive to *Vibrio cholerae* O1 (Hikojima serotype). The patient was hospitalised and, following treatment, her condition improved and she was discharged. Taiwan has reported single locally-acquired cases of cholera in 2020, 2022 and 2023.

Africa:
Angola: Since 10 May 2026 and as of 14 June 2026, 1 930 new cases, including 42 new deaths, have been reported. Since 1 January 2026 and as of 14 June 2026, 5 076 cases, including 104 deaths, have been reported. In comparison, in 2025 and as of 30 April 2025, 14 090 cases, including 505 deaths, were reported.

Burundi: Since 10 May 2026 and as of 14 June 2026, 358 new cases, including one new death, has been reported. Since 01 January 2026 and as of 14 June 2026, 1 373 cases, including three deaths have been reported. In comparison, in 2025 and as of 17 March 2025, 129 cases were reported.

Congo: Since 10 May 2026 and as of 14 June 2026, 298 new cases, including 27 new deaths, have been reported. Since 1 January 2026 and as of 14 June 2026, 689 cases, including 60 deaths, have been reported. In comparison, in 2025 and as of 22 June 2025, no cases were reported.

Democratic Republic of The Congo: Since 10 May 2026 and as of 14 June 2026, 7 923 new cases, including 112 new deaths, have been reported. Since 1 January 2026 and as of 14 June 2026, 29 341 cases, including 838 deaths, have been reported. In comparison, in 2025 and as of 10 March 2025, 11 918 cases, including 240 deaths, were reported.

Kenya: Since 31 December 2025 and as of 14 June 2026, 37 new cases have been reported. Since 1 January 2026 and as of 14 June 2026, 37 cases have been reported. In comparison, in 2025 and as of 30 April 2025, 125 cases, including six deaths, were reported.

Malawi: Since 10 May 2026 and as of 14 June 2026, 882 new cases have been reported. Since 1 January 2026 and as of 14 June 2026, 2 615 cases, including five deaths, have been reported. In comparison, in 2025 and as of 7 April 2025, 91 cases, including three deaths, were reported.

Mozambique: Since 10 May 2026 and as of 14 June 2026, 170 new cases, including two new deaths, have been reported. Since 1 January 2026 and as of 14 June 2026, 7 186 cases, including 61 deaths, have been reported. In comparison, in 2025 and as of 30 April 2025, 2 851 cases, including 29 deaths, were reported.

Nigeria: Since 10 May 2026 and as of 14 June 2026, 8 051 new cases, including 77 new deaths, have been reported. Since 1 January 2026 and as of 14 June 2026, 8 994 cases, including 96 deaths, have been reported. In comparison, in 2025 and as of 17 March 2025, 1 214 cases, including 28 deaths, were reported.

Zambia: Since 10 May 2026 and as of 14 June 2026, 10 new cases have been reported. Since 1 January 2026 and as of 14 June 2026, 997 cases, including 16 deaths, have been reported. In comparison, in 2025 and as of 15 April 2025, 463 cases, including nine deaths, were reported.

Since 26 May 2026, no updates have been reported by: Ethiopia, Namibia, Rwanda, Somalia, South Sudan, Sudan, United Republic of Tanzania, or Zimbabwe.

Americas:
Haiti: Since 16 February 2026 and as of 06 April 2026, 145 new cases have been reported. One death previously reported in Haiti has been retrospectively removed. Since 1 January 2026 and as of 6 April 2026, 357 cases, including one death, has been reported. In comparison, in 2025 and as of 26 May 2025, 1 879 cases, including 31 deaths, were 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. Since 2025, only events of locally acquired cholera cases are reported at the EU/EEA level; however, imported and locally acquired cholera cases are reported to the World Health Organization (WHO) on an annual basis. In 2024, 16 imported cases were reported by eight EU/EEA countries, while 12 were reported in 2023, 29 in 2022, two in 2021, and none in 2020. In 2019, 25 cases were reported in EU/EEA countries (including the United Kingdom). All cases had a travel history to cholera-affected areas.

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

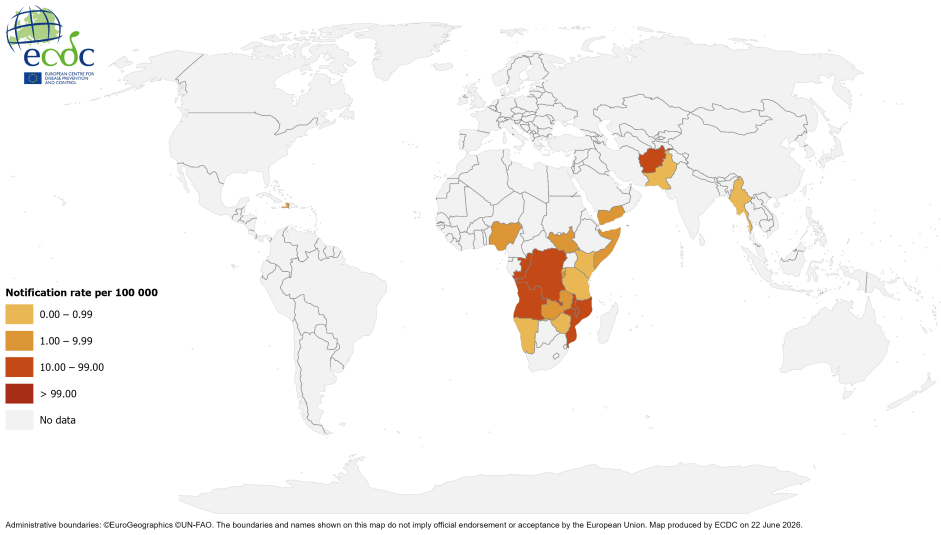
Actions:

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

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

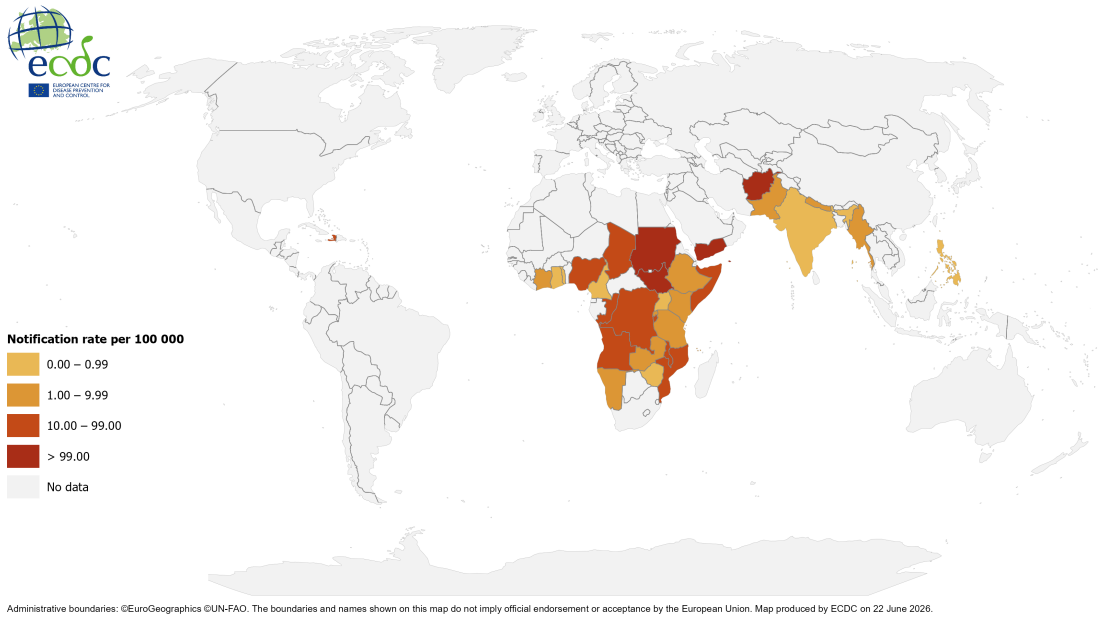
Last time this event was included in the Weekly CDTR: 29 May 2026

Figure 11. Geographical distribution of cholera cases reported worldwide from April to June 2026



Source: ECDC

Figure 12. Geographical distribution of cholera cases reported globally from June 2025 to June 2026



Source: ECDC

10. Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026

Overview:

Monkeypox virus (MPXV) clades I and II are circulating in multiple countries globally. The epidemiological profile of mpox cases due to MPXV clade II cases reported outside Africa since 2022 remains similar to previous weeks. With regards to mpox clade I, cases have been reported by several countries outside Africa with and without travel history to countries with ongoing clade I transmission. For both clade I and II, sexual contacts have been described as drivers of transmission.

A summary of the recently observed global trends of clades I and II is provided below.

Mpox clade II summary

Mpox clade II has been circulating globally since 2022. In African countries with mpox clade II outbreaks in 2025-2026 (e.g. Ghana, Guinea, Liberia), cases have been reported among young adults, affecting both males and females. Sexual contact has been described as a main driver of transmission (Multi-country outbreak of mpox, External situation report #60 - 8 December 2025, Multi-country outbreak of mpox, External situation report #62-23 January 2026, Multi-country external situation report #63 – 24 February 2026, Multi-country outbreak of mpox, External situation report #66 - 31 May 2026). According to WHO data published on 22 June including cases as of 14 June 2026, Guinea has reported 15 cases the past six weeks, as of 14 June. Outside Africa, cases were mostly reported in adults (99%) and males (97%), the majority of whom reported having had sex with men (89%) (Global Mpox Trends published 22 June 2026).

Mpox clade I summary

In Africa, since 2025, the five countries that reported most confirmed mpox clade I cases are DRC, Uganda, Madagascar Burundi, and Kenya. According to WHO, in the past six weeks, and as of 14 June 2026, most confirmed cases of clade I were reported by Madagascar (689 cases). All other countries in Africa with clade I detections, including DRC, have reported fewer than 100 cases during the last six weeks. Overall, a decreasing trend in mpox clade I cases that has been reported in Africa since May 2025 continues in June 2026 (Global Mpox Trends published 22 June 2026).

Since August 2024 and as of May 2026 in EU/EEA travel-associated mpox clade I cases, or locally-acquired mpox clade I cases have been reported by several EU/EEA countries (Surveillance of Mpox in the EU/EEA, monthly report). In addition to Africa and the EU/EEA, since August 2024, mpox clade I cases have been reported by Thailand, India, Türkiye, the United Kingdom, the United States, Canada, Pakistan, Oman, China, the United Arab Emirates, Qatar, Brazil, Switzerland, Australia, Japan, Nepal, Mexico, Israel, Argentina, Singapore, Ecuador, Colombia, Argentina, and Ecuador (Global Mpox Trends published 22 June 2026). Most travel-associated cases reported outside African countries had links to affected countries in Africa. Imported cases with a travel history to Asia, the European Region (including EU/EEA countries) and the Eastern Mediterranean Region have also been reported (Global Mpox Trends published 22 June 2026).

ECDC mpox reporting

ECDC will continue monitoring the transmission of mpox clade I and clade II trends through event- and indicator-based surveillance.
A monthly surveillance report on mpox in the EU/EEA, Western Balkans and Türkiye is published on the ECDC website and the Communicable Disease Threats Report. Events outside the EU/EEA such as those indicating changes in mpox epidemiology, including unusual/unexpected incidence or severity, will be reported on an ad hoc basis in the Communicable Disease Threats Report.

ECDC assessment:

The epidemiological situation regarding mpox due to MPXV clade I remains similar to previous weeks. The cases of clade I that have been reported outside of Africa, including secondary transmission, are not unexpected. A new pattern of transmission is emerging in countries outside Africa, including in the EU/EEA, among men who have sex with men.

ECDC published a Threat Assessment Brief on 24 October 2025 to assess the new situation. The risk of clade Ib infection is assessed as moderate for men who have sex with men and low for the general population in the EU/EEA, reflecting current evidence and considerable uncertainties around transmissibility and severity of clade Ib infection relative to clade IIb. The risk for clade IIb infection remains low for men who have sex with men and very low for the general population in the EU/EEA.

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

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

Primary preventive vaccination (PPV) and post-exposure preventive vaccination (PEPV) strategies may be combined to focus on individuals at substantially higher risk of exposure and close contacts of cases, respectively, particularly in the event of limited vaccine supply. PPV strategies should prioritise gay, bisexual, and transgender people, and men who have sex with men, who are at higher risk of exposure, as well as individuals at risk of occupational exposure, based on epidemiological or behavioural criteria. Health promotion interventions and community engagement are also critical to ensure effective outreach and high vaccine acceptance and uptake among those most at risk of exposure.

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

EU/EEA countries should consider raising awareness in travellers to/from areas with ongoing MPXV transmission and among primary and other healthcare providers who may be consulted by such patients. If mpox is detected, the main public health response measures are contact tracing, partner notification, and post-exposure preventive vaccination of eligible contacts. Clade identification and virus sequencing should also be prioritised.

Please see the latest ECDC 'Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries' and the Threat Assessment Brief 'Detection of autochthonous transmission of monkeypox virus clade Ib in the EU/EEA'.

Actions:

- ECDC is monitoring mpox through event- and indicator-based surveillance.
- ECDC's recommendations are available on the dedicated mpox webpage.

Sources: ECDC rapid risk assessment

Last time this event was included in the Weekly CDTR: 13 May 2026

11. Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update

Overview:

Since the beginning of 2026, and as of 22 June 2026, over 1 million cases of dengue and over 1 000 dengue-related deaths had been reported globally according to information from publicly available sources.

Epidemiological overview

Over 80 countries/territories have reported dengue cases between January and June 2026. An overview based on publicly available information from official sources and reports from different regions highlighting trends in different countries/territories is presented below. The country/territory trends summarised are based on data availability at the time the report was prepared; more detailed analyses are therefore only provided for countries/territories with sufficient data.

Americas

In the Americas, as of week 20 of 2026 (17 May 2026), 1 105 019 dengue cases have been reported, of which 26% were laboratory-confirmed, according to the WHO PAHO report published on 10 June 2026. The current reported cases are 64% fewer than during the same period in 2025 and 70% below the five-year average. While all four serotypes have been reported in the region to date in 2026, their distribution varies across the different countries of PAHO (Report on the epidemiological situation of dengue in the Americas).

South-East Asia

According to the WHO SEARO epidemiological bulletins published on 3 June and 17 June 2026, since June 2025 and as of May 2026, dengue has been reported in Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor-Leste. The available information on epidemiological trends is summarised below:

- In 2026 and as of 21 June 2026, Bangladesh has reported 4 900 cases. Monthly cases have been increasing since April 2026 but they follow expected seasonal trends (Bangladesh Daily Dengue Press Release, 21 June 2026 and WHO South-East Asia Region Epidemiological Bulletin, 17 June 2026).
- In 2026 and as of May 2026, India has reported 16 313 cases. In April 2026 alone, 2 918 cases were reported (a decrease of 5% compared to March) (WHO South-East Asia Region Epidemiological Bulletin, 17 June 2026).
- Maldives has reported over 100 dengue cases weekly since January 2026, with week-to-week fluctuations. Overall, the weekly reported number of dengue cases exceeds the expected seasonal baseline. The cumulative number of cases reported since the beginning of 2026 is over 2 900 (as of week 21, ending 24 May 2026) and higher than the same period in 2025 (WHO South-East Asia Region Epidemiological Bulletin, 17 June 2026).
- Nepal reported 216 cases in May and 215 cases in April 2026 which is within the expected levels for the season (WHO South-East Asia Region Epidemiological Bulletin, 17 June 2026).
- Sri Lanka has reported increases in weekly cases (with some fluctuations) since mid-April 2026. During week 23 (ending 7 June 2026), 3 265 cases were reported, which is 34% higher than the number of cases reported the previous week. The total number of cases reported to date in 2026 is 37 118. During the same period in 2025, 25 153 cases were reported (Sri Lanka Weekly Dengue Update; 7 June 2026 and WHO South-East Asia Region Epidemiological Bulletin, 17 June 2026).
- Thailand reported 489 cases during week 24 (ending 14 June 2026) which is a decrease of 26% compared to the cases reported the week before. Overall, cases remail at lower levels compared to 2025 with some week-to-week fluctuations (WHO South-East Asia Region Epidemiological Bulletin, 17 June 2026).
- Timor-Leste reported a decrease in case numbers in May compared to April (126 cases versus 203 cases, respectively). Overall cases are higher in 2026 compared to the same period in 2025 and follow a decreasing trend after increases in the beginning of the year (WHO South-East Asia Region Epidemiological Bulletin, 17 June 2026.

Western Pacific Region

In the WHO Western Pacific Region, dengue cases have been reported by several countries in the reports of 28 May and 11 June (WHO WPRO Dengue Situation Update #746: 28 May 2026 and WHO WPRO Dengue Situation Update #747: 11 June 2026). The following trends were highlighted by countries:

- Cambodia: increasing trends have been reported since week 14 (ending 5 April) with over 400 cases reported each week, with some fluctuations. As of 31 May, 10 126 cases had been reported in 2026. In the same period in 2025 5 930 cases had been reported.
- China: 222 cases were reported in May 2026, and 137 cases were reported in April 2026. Although cases remain at low levels, the number of cases reported in May 2026 is 76.1% higher than reported in May 2025.
- Indonesia: the decreasing trend since October 2025 continued until May 2026. As of 11 June 2026, 42 179 cases had been reported since the beginning of the year.
- Laos: Week-to-week fluctuations in case numbers are reported (80 cases were reported the week 31 May to 6 June 2026, 56 for the week 24 to 30 May). The 1 343 cases reported as of 6 June represent a 12% increase compared to the same period in 2025.
- Malaysia: cases have been showing an increasing trend since week 22 to 28 March (week 13). In the week 17 to 23 May, 2 053 cases were reported. A total of 26 973 cases have been reported in 2026.
- Singapore: Cases remain at lower levels compared to previous years with 67 cases reported
- the week 24-30 May. Overall, 739 cases were reported until 30 May 2026.
- Vietnam: 44 965 cases were reported from 14 December 2025 and until 18 April 2026.
- In French Polynesia, dengue transmission has remained low in 2026, with one case reported in 10-16 May 2026 and 25 confirmed and five probable cases reported since the beginning of the year.
- New Caledonia: 2 021 cases have been reported in 2026 and as of 6 June, with weekly cases showing a decreasing trend after mid-April (week 17).

Africa

According to the Africa CDC Epidemic Intelligence Report of 24 May 2026, a total of 1 337 cases have been reported in the region as of 24 May 2026 from the Central African Republic (1), Mali (1 233), Mauritania (38), and Senegal (65).

EU/EEA

No locally acquired dengue cases have been reported in the EU/EEA excluding the outermost regions. With regards to EU/EEA outermost regions, a summary of recent trends is presented below:

- In Martinique, transmission of dengue is at low levels without impact on hospitalisations. According to the Dengue Surveillance Report published on 18 June 2026, one confirmed case was reported during the week of 8 to 14 June, while an average of 14 confirmed cases per week was recorded between 11 May and 7 June. In Guadeloupe and Saint Martin dengue circulation remains at low levels (Antilles Dengue Surveillance Report published on 18 June 2026).
- In La Réunion, 273 cases of dengue have been reported since the beginning of 2026 and as of 14 June 2026. Weekly case numbers remain stable with fluctuations. In week 8-14 June, 10 cases were reported. In the previous two weeks, i.e. week 1 to 7 June and week 25 to 31 May, 15 and 24 cases were reported respectively (La Reunion Surveillance Report 19 June 2026).
- In French Guiana, dengue activity remains at a low level (French Guiana Surveillance Report 18 June 2026).

Global overview

Since the beginning of 2026 and as of 22 June 2026, over 1 million cases of dengue and over 1 000 dengue-related deaths had been reported. This corresponds to a decrease compared with the same period in 2025 (Communicable disease threats report, 31 May-5 June 2026 and Communicable disease threats report, 19–25 July 2025).

Note: the data presented in this report originate from both official public health authorities and non-official sources, such as news media, and depending on the source, autochthonous and non-autochthonous cases may be included. Data completeness depends on the availability of reports

from surveillance systems and their accuracy, which varies between countries. All data should be interpreted with caution and comparisons, particularly across countries, should be avoided due to under-reporting, variations in surveillance system structure, different case definitions from country to country and over time, and use of syndromic definitions

ECDC assessment:

There are currently no cases of dengue reported in EU/EEA countries in 2026, excluding some of the outermost regions. The likelihood of onward transmission of dengue virus in mainland Europe is linked to importation of the virus by viraemic travellers into receptive areas with established and active competent mosquito vectors (e.g. *Aedes albopictus* and *Aedes aegypti*). The *Aedes albopictus* mosquito is established in a large part of Europe. In Europe and neighbouring areas, the *Aedes aegypti* mosquito is established in Cyprus, on the eastern shores of the Black Sea, and in the outermost region of Madeira.

The environmental conditions in most areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti* are established are now favourable for mosquito activity and virus replication in mosquitoes; therefore, locally acquired dengue cases may occur in the coming weeks.

For more information on the risk related to dengue in mainland EU/EEA, please see ECDC's dengue risk assessment for mainland EU/EEA.

Additional information on locally acquired dengue cases in 2026 in the EU/EEA is available in ECDC's seasonal surveillance reports for dengue, and in ECDC's factsheets on dengue.

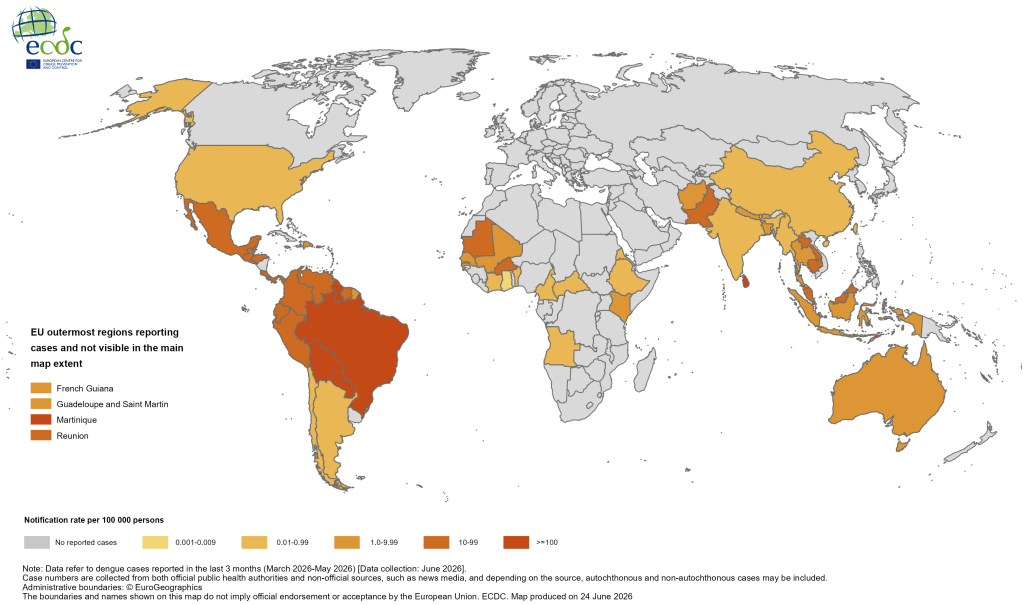
Mosquito-bite prevention is strongly recommended for travellers to countries with reported cases of dengue. Travellers to areas with active outbreaks or elevated risk should follow travel health advice. Pregnant travellers, older adults and people with chronic conditions may be at higher risk of complications associated with dengue.

Actions:

ECDC monitors this threat through its epidemic intelligence activities and reports on it on a monthly basis. A summary of the worldwide overview of dengue is available on ECDC's website.

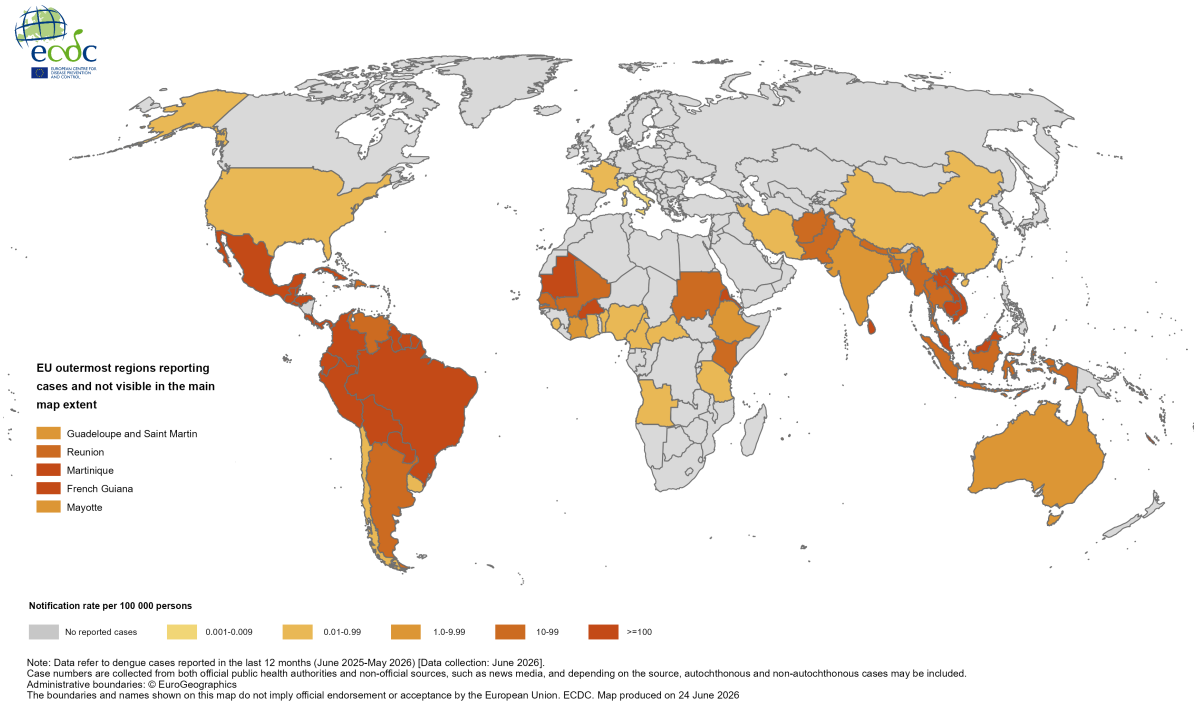
Last time this event was included in the Weekly CDTR: 27 March 2026

Figure 13. Three-month dengue virus disease case notification rate per 100 000 population, April–June 2026



Source: ECDC

Figure 14. 12-month dengue virus disease case notification rate per 100 000 population, July 2025–June 2026



Source: ECDC

12. Risk assessments under production

Overview:

On 25 June 2026, ECDC published, jointly with the European Food Safety Authority (EFSA), a Rapid Outbreak Assessment: 'Multi-country outbreak of Salmonella Bovismorbificans infection linked to the consumption of sprouted seeds'.

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

Last time this event was included in the Weekly CDTR: 5 June 2026

13. 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.

Four ECDC experts have been deployed on a rotational basis to support Africa CDC, initially at its headquarters in Addis Ababa and, since 22 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 Directorate-General for International Partnerships (DG INTPA). 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 aimed to evaluate the implementation and operational performance of exit screening procedures.

On 16 June 2026, an ECDC Risk Communication and Community Engagement (RCCE) expert was deployed to the WHO country office in Juba, South Sudan, in response to a Global Outbreak Alert and Responses Network (GOARN) request for assistance. The expert will support the implementation of the country's RCCE field plan, strengthen community engagement and address the priority RCCE gaps in the high-risk areas.

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

Last time this event was included in the Weekly CDTR: 18 June 2026

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 26 June 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 26 June 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 26 June 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 26 June 2026
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 26 June 2026
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - last reported on 26 June 2026
- Risk assessments under production - last reported on 26 June 2026
- Dengue cases – EU/EEA ex. Maldives – 2025-2026 - last reported on 26 June 2026
- Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles - last reported on 26 June 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 26 June 2026
- Expert deployment - last reported on 26 June 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report) - last reported on 26 June 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report) - last reported on 26 June 2026
- Measles outbreak in Latvia 2026 - last reported on 16 June 2026
- Multi-country cluster of Salmonella Stanley ST2045 - Europe - 2026 - last reported on 16 June 2026
- Chikungunya virus disease – French Guiana, France – 2026 - last reported on 12 June 2026
- Hantavirus disease outbreak on cruise ship – South Atlantic – 2026 - last reported on 12 June 2026
- Nipah virus disease – India and Bangladesh – 2026 - last reported on 12 June 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring - last reported on 12 June 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 05 June 2026
- SARS-CoV-2 variant classification - last reported on 05 June 2026
- Spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA - 2026 - last reported on 05 June 2026
- P. falciparum malaria - Mayotte, France - 2026 - last reported on 05 June 2026