

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 29, 11–17 July 2026

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Executive summary

Influenza A(H5N1) – Multi-country (World) – Monitoring human cases

- On 11 July 2026, a human case of avian influenza A(H5N1) virus infection was reported in Cambodia by the Ministry of Health.
- The case is nine-month-old child who is currently hospitalised, receiving intensive medical care.
- Infection with avian influenza A(H5N1) virus was laboratory confirmed on 9 July 2026.
- Investigations to identify possible sources of infection and contacts are ongoing.
- Antiviral prophylaxis has been administered to close contacts.
- The risk related to zoonotic avian influenza due to A(H5N1) virus for the general population in the EU/EEA is considered very low.

Human cases of swine influenza A(H3N2) variant virus – Multi-country

- One laboratory-confirmed human infection with swine-origin influenza A(H3N2) variant (v) virus was reported in Brazil (Santa Catarina state) by the World Health Organization (WHO) in the Influenza at the human-animal interface, Summary and risk assessment, from 13 June to 7 July 2026 (published on 7 July 2026).
- The case involved a child who developed symptoms on 12 June 2026.
- Infection with influenza A virus was initially detected through antigen testing. Influenza A(H3) was detected using real-time RT-PCR on 18 June 2026 and the presence of influenza A(H3N2)v virus was confirmed through molecular testing and genome sequencing on 19 June 2026.
- The child's grandfather worked at a swine nursery and the child regularly visited the grandfather's home.
- No additional cases have been detected among identified contacts.
- The overall risk of human infection with swine-origin influenza A(H3N2)v virus in the EU/EEA is considered low.

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

- In June 2026, 129 mpox cases caused by monkeypox virus (MPXV) clade I were reported by nine EU/EEA countries, indicating a relatively stable transmission following increases 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 increased travel and mass gatherings during summer, there is a risk of further spread.

Overview of respiratory virus epidemiology in the EU/EEA, week 27, 2026

Important: This ERVISS publication follows the recent transition of reporting surveillance data from The European Surveillance System (TESSy) to EpiPulse Cases (EPC). As a result of this transition, we have identified a few data inconsistencies. We are actively working with individual countries to resolve these and any other issue that may arise to ensure high data quality. **During this period, data updates to the GitHub repository will be paused.** Thank you for your patience and understanding.

Summary

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

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

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

Influenza virus activity is low, at inter-seasonal levels.

This week's **EuroMOMO** pooled estimates of **all-cause mortality** for the participating 27 European countries show increased mortality around week 26, 2026. This increase is mainly seen in age groups above 45 years and is affecting some countries.

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'.

Risk assessments under production

On 16 July 2026 ECDC published a rapid risk assessment on the upsurge in ceftriaxone-resistant *Neisseria gonorrhoeae* with evidence of domestic transmission in the European Union/European Economic Area (EU/EEA) and the United Kingdom (UK).

Influenza A(H5) - Multi-country (World) - Monitoring human cases

- One laboratory-confirmed human case of avian influenza A(H5) virus infection in Bangladesh was reported by the World Health Organization (WHO) in 'Influenza at the human-animal interface, Summary and risk assessment, from 13 June to 7 July 2026' (published on 7 July 2026).
- The case involved a child who developed respiratory symptoms on 17 May 2026.
- Infection with avian influenza A(H5) virus was detected using real-time RT-PCR on 11 June 2026.
- There is no history of exposure to poultry, although poultry deaths have been reported in the surrounding area. Environmental samples tested negative.
- No additional cases have been detected among close contacts of the patient.
- The risk related to zoonotic avian influenza due to A(H5Nx) viruses for the general population in the EU/EEA is considered low.

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

- As of 16 July 2026, the Democratic Republic of the Congo (DRC) reported a total of 2 124 confirmed cases and 828 confirmed related deaths (based on data until 15 July). This represents an increase of 51 new confirmed cases and 32 deaths since the previous report of 15 July (reporting data up until 14 July). Since the beginning of the outbreak, five provinces have been affected, Ituri, North Kivu, South Kivu, Tsopo and Haut-Uele.
- On 13 July 2026, a US citizen that was working for a humanitarian organisation in the response to the outbreak in DRC was medically evacuated to Germany.
- In Uganda, no new cases have been reported since 21 June 2026. The country has reported a total of 20 confirmed cases, including two deaths.
- On the basis of the available information, and given the uncertainties surrounding this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. Given the very low likelihood of importation and secondary transmission, the likelihood of infection for people living in the European Union/European Economic Area (EU/EEA) is estimated to be very low. 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.

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.
- Seven experts have been deployed on a rotating basis to support Africa CDC, initially at its headquarters in Addis Ababa and, since 23 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.
- Between 16 June and 8 July, an ECDC Risk Communication and Community Engagement 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. Since 14 July, two ECDC fellows have also been deployed through GOARN to the WHO country office in Juba, South Sudan, to support surveillance and data analysis activities.
- These activities are being conducted in close coordination with national authorities and the EU delegations and in collaboration with the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO) and DG INTPA.

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

- Since the beginning of 2026, and as at 15 July 2026, one country in Europe has reported locally-acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (two cases).

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

Since the beginning of the 2026 transmission season, and as at 15 July, 28 areas affected by West Nile virus (WNV) have been identified in five countries across Europe. These areas are located in Italy (17), Greece (five), North Macedonia (two), Romania (two) and Spain (two).

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

- Vibriosis is caused by naturally occurring *Vibrio* bacteria found in coastal waters, particularly in warm, brackish environments. In Europe, *Vibrio* bacteria are most frequently detected during the summer season, with the Baltic Sea being particularly favourable due to its low salinity levels.
- A warmer climate is expected to increase the suitability of coastal areas for *Vibrio* growth and expansion.
- The European Centre for Disease Prevention and Control (ECDC) monitors environmental suitability for *Vibrio* growth in EU/EEA coastal waters and publishes regular updates through the [Vibrio Viewer](#) and the [Communicable Disease Threat Reports](#) to assess and communicate the potential risk to human health across the EU/EEA.

World Pride - Netherlands – 2026

- World Pride 2026 will take place in Amsterdam, the Netherlands, from 25 July to 8 August 2026. The event is expected to attract a high number of participants, including international visitors from across the EU/EEA.
- The probability of acquiring a sexually transmitted infection (STI) or other infections that can spread through sexual contact is increased for people attending World Pride 2026 who engage in sex with non-steady and multiple partners, particularly if preventive measures are not consistently applied.

Cyclosporiasis - USA - 2026

- On 16 July 2026, the US CDC published a [report](#) on a Cyclospora outbreak linked to shredded iceberg lettuce served at a large fast food chain in five states.
- As of 17 July 2026, more than 1 644 cases have been confirmed in the United States, including 141 hospitalisations (8.57%) across 34 states. No deaths were reported.
- Further, an additional 5 100 suspected cases are awaiting further analysis to confirm domestically acquired cyclosporiasis.
- Cases ranged in age from 2-95 years (median: 44 years) and 56% of the cases were female.

1. Influenza A(H5N1) – Multi-country (World) – Monitoring human cases

Summary

One human case of avian influenza A(H5N1) virus infection was reported in Cambodia in a public [press release by the Ministry of Health](#) on 11 July 2026.

The case is a nine-month-old child from Prek Ta Kong village in Phnom Penh. Infection with avian influenza A(H5N1) virus was detected on 9 July 2026 by the National Institute of Public Health and the Pasteur Institute of Cambodia. The patient is hospitalised in isolation and receiving intensive medical care.

According to the Ministry's statement, health officials are investigating possible sources of infection and tracing contacts. Health authorities are also distributing antiviral treatment (Oseltamivir) to close contacts and conducting health education campaigns in the community.

Background

This is the fifth human case of avian influenza A(H5N1) infection reported in Cambodia in 2026.

Since 2003, there have been 1001 human cases of avian influenza A(H5N1) infection worldwide*, including 478 deaths (CFR: 47.7%). These cases have been reported in 25 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, India, Indonesia, Iraq, Laos, Mexico, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Viet Nam, the United Kingdom (UK), and the United States (US)). To date, no sustained human-to-human transmission has been detected.

* This includes detections due to suspected environmental contamination, with no evidence of infection, that were reported in 2022 and 2023 by Spain (two detections), the US (one), and the UK (four, one of which was inconclusive). Human cases of A(H5) epidemiologically linked to A(H5N1) outbreaks in poultry and dairy cattle in the US are included in the reported number of cases of A(H5N1).

ECDC assessment

Sporadic human cases of different avian influenza A(H5) subtypes have previously been reported around the world. Current virological evidence suggests that circulating A(H5N1) viruses retain genetic characteristics consistent with avian-adapted influenza viruses. Despite the widespread transmission of avian influenza viruses in animals, transmission to humans remains infrequent and no sustained transmission between humans has been observed.

Based on the currently available information, the overall risk related to zoonotic avian influenza due to A(H5N1) virus for the general population in the EU/EEA is considered very low.

Direct contact with birds and other infected animals, their secretions or a contaminated environment is the most likely source of infection. Application of personal protective measures in people exposed to infected animals or their environment can reduce the associated risk. The recent severe cases in Asia and the Americas in children and people exposed to infected, sick or dead backyard poultry underline the risk of unprotected contact with infected birds in backyard farm settings. This underlines the importance of using appropriate personal protective equipment.

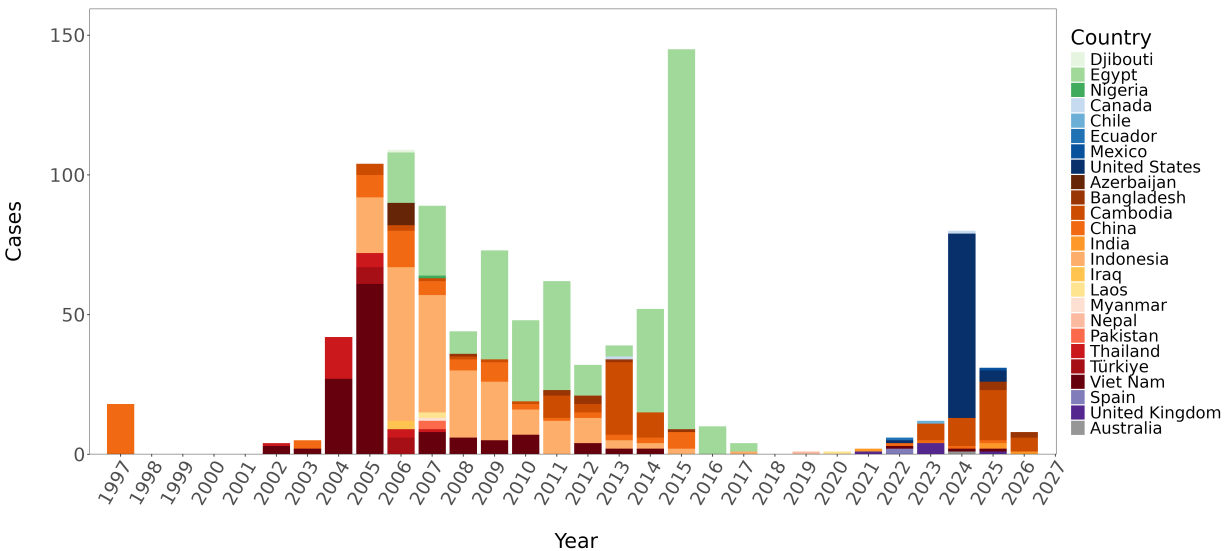
Actions

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 June 2026.

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

Maps and graphs

Figure 1. Distribution of reported human cases of Influenza A(H5N1) virus infection by year of onset or detection and reporting country from 1997 to 16 July 2026



Source: ECDC

2. Human cases of swine influenza A(H3N2) variant virus – Multi-country

Summary

One laboratory-confirmed human infection with swine-origin influenza A(H3N2) variant (v) virus in Santa Catarina state, Brazil, was reported by the World Health Organization (WHO) in the [Influenza at the human-animal interface, Summary and risk assessment, from 13 June to 7 July 2026](#) (published on 7 July 2026).

The case involved a child who developed symptoms on 12 June 2026. On 16 June, medical care was sought due to worsening respiratory symptoms. The patient was admitted to hospital with a diagnosis of Severe Acute Respiratory Infection (SARI). An antigen test was performed upon admission which detected influenza A and the patient was placed in respiratory isolation in a private room. Antiviral therapy was initiated. The case was discharged from hospital on 19 June.

A nasopharyngeal swab was collected on 16 June and submitted to the State public health laboratory for testing using real-time RT PCR. Influenza A(H3) was detected on 18 June with suspicion of a swine-origin influenza H3 variant, and the sample was sent to the Laboratory of Respiratory Viruses, Exanthems, Enteroviruses, and Viral Emergencies (LVRE) at the Oswaldo Cruz Institute (Fiocruz/Rio de Janeiro) for further testing on 19 June. Molecular testing and genomic sequencing analyses confirmed the presence of an influenza A(H3N2)v virus.

An epidemiological investigation established that the child's grandfather worked at a swine nursery with approximately 5 000 animals, although he reported that sanitary barriers were in place. The child frequently visited the grandfather's home, coming into contact with him several days a week.

All identified contacts remained asymptomatic.

Background

To date, sporadic human infections with influenza variant (v) viruses of swine origin have been reported around the world, including A(H1N1)v, A(H1N2)v and A(H3N2)v viruses. According to WHO, this is the first human infection with influenza A(H3N2)v virus detected in Brazil in 2026 and the first case reported in the Santa Catarina state.

ECDC assessment

There is currently no evidence of sustained transmission between humans with swine influenza A viruses, as is also the case for this specific event. Therefore, the likelihood of importation and further circulation in the EU/EEA linked to this event is considered very low.

Swine influenza A viruses continue to circulate in swine populations around the world. This can sporadically lead to infections in humans, most often through contact with infected swine or a contaminated environment.

There is no vaccine against swine influenza A viruses licensed for use in humans. Influenza A viruses circulating in humans differ from those circulating in pig populations. Therefore influenza vaccines against seasonal influenza are not expected to protect people from swine influenza viruses, however antiviral drugs against influenza can be effective for treatment.

Swine influenza virus infection should always be considered in patients with respiratory symptoms who report contact with pigs prior to the onset of disease. This supports early identification of events involving transmission to humans and initiation of follow-up investigations. It is important that these influenza viruses from humans are fully characterised in influenza reference laboratories. Influenza viruses that cannot be sub-typed should be shared with national influenza centres or reference laboratories, as well as WHO Collaborating Centres, for further virus characterisation.

If needed, the assessment will be reviewed should further epidemiological or virological information become available.

Actions

ECDC regularly monitors zoonotic influenza events through its epidemic intelligence activities to identify potential significant changes in the epidemiology of the virus.

ECDC provides scientific information and publishes annual epidemiological reports on zoonotic influenza on its website: [Swine influenza in humans](#).

Last time this event was included in the Weekly CDTR: 3 July 2026.

3. 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 June 2026 has been published on ECDC's website.

June 2026 update

In June 2026, 129 mpox cases caused by clade I MPXV were reported by nine countries, with the largest number of cases being reported by Portugal (57).

In June 2026, 22 mpox clade II cases were reported by six countries, with the largest number of cases being reported by Germany (10).

Overview of the past 12 months (July 2025 to June 2026)

In the past 12 months, 18 countries have reported 829 clade I mpox cases and 18 countries have reported 921 clade II mpox cases.

Among cases with complete information:

- In total, 90% of clade I mpox cases and 91% of clade II mpox cases were reported among men who have sex with men.
- Overall, 14% of clade I mpox cases and 8% of clade II mpox cases were hospitalised. Two deaths have been reported among people infected with clade II MPXV; no deaths have been reported in people infected with clade I MPXV.
- A total of 22% of clade I mpox cases and 21% of clade II mpox cases with known vaccination status had received two vaccine doses.

Following increases observed in late 2025 and early 2026, the number of clade I mpox cases reported in the EU/EEA remains relatively stable, while the number of reported clade II mpox cases continues to decline.

However, interpretation of trends is limited due to missing clade information for a substantial proportion of reported cases, and case and epidemiological information may be updated retrospectively.

Based on information provided by Member States, clinical presentation is generally mild, including among hospitalised cases. Clades Ib and IIb account for the vast 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 the 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 increased travel over the summer 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. Strategies should also prioritise individuals at risk of occupational exposure, based on epidemiological or behavioural criteria.

Further response options for EU/EEA countries include:

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

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

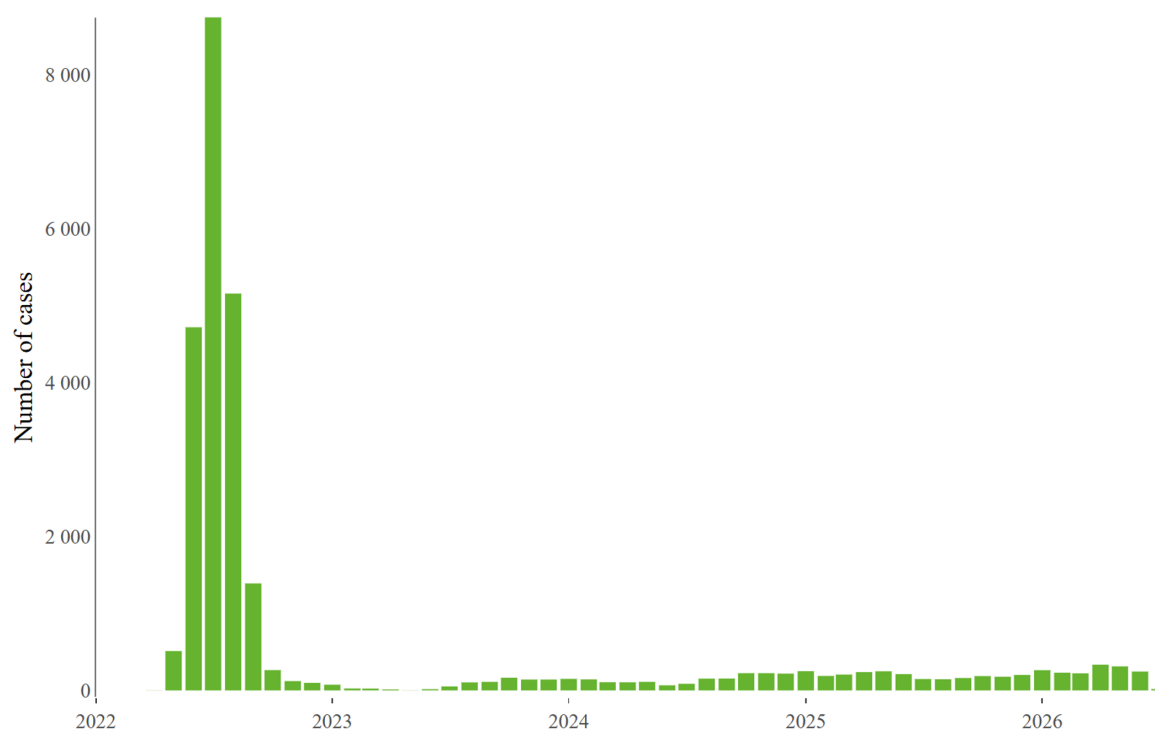
Further information

- 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: 26 June 2026

Maps and graphs

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



Source: ECDC

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

Country	Clade I		Clade II		Clade Unknown	
	Past 12 months	Past month	Past 12 months	Past month	Past 12 months	Past month
Austria	13		12			
Belgium	43		13	1	128	15
Croatia					3	
Czechia	5		3			
Finland					1	1
France	87	17	42	1	137	35
Germany	125	13	157	10	174	10
Greece	8	2	2		1	
Hungary			2			
Iceland					1	
Ireland	14	3	26			
Italy	58	6	4		87	4
Lithuania	1				1	1
Luxembourg	3		4			
Malta			3	2		
Netherlands	42	5	80		8	
Norway	1		9			
Poland	2		2		15	1
Portugal	86	57	60		77	
Romania	2				1	
Slovakia	4				1	
Slovenia			2			
Spain	305	22	490	7	237	26
Sweden	30	4	10	1	3	1
EU/EEA total	829	129	921	22	875	94

Source: ECDC

4. Overview of respiratory virus epidemiology in the EU/EEA, week 27, 2026

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

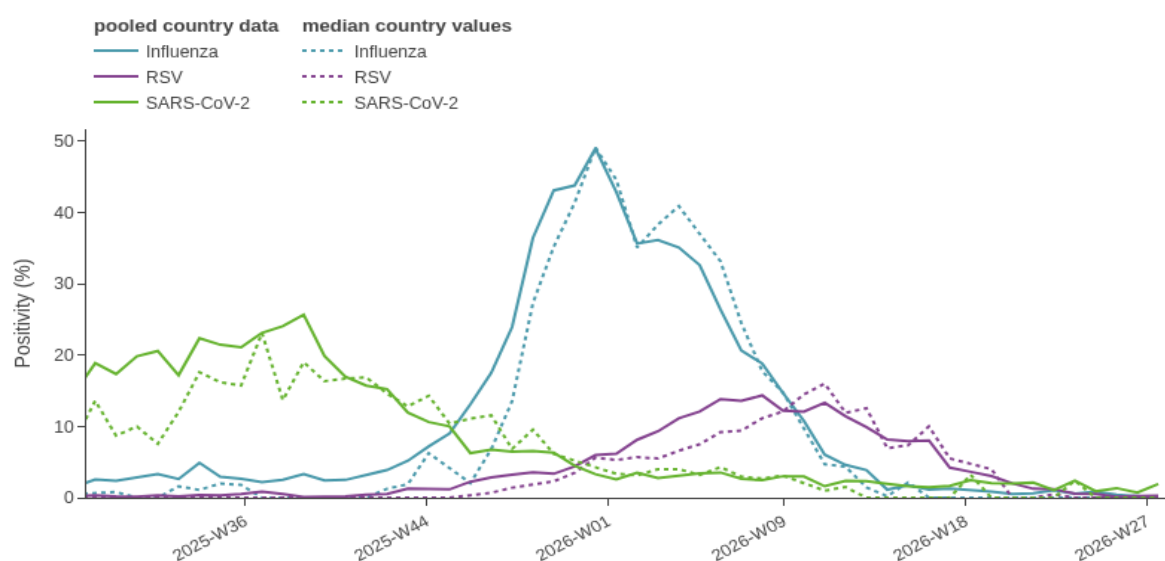
Key visualisation from the weekly bulletin are included below.

Sources: [ERVISS](https://eriss.org)

Last time this event was included in the Weekly CDTR: 10 July 2026

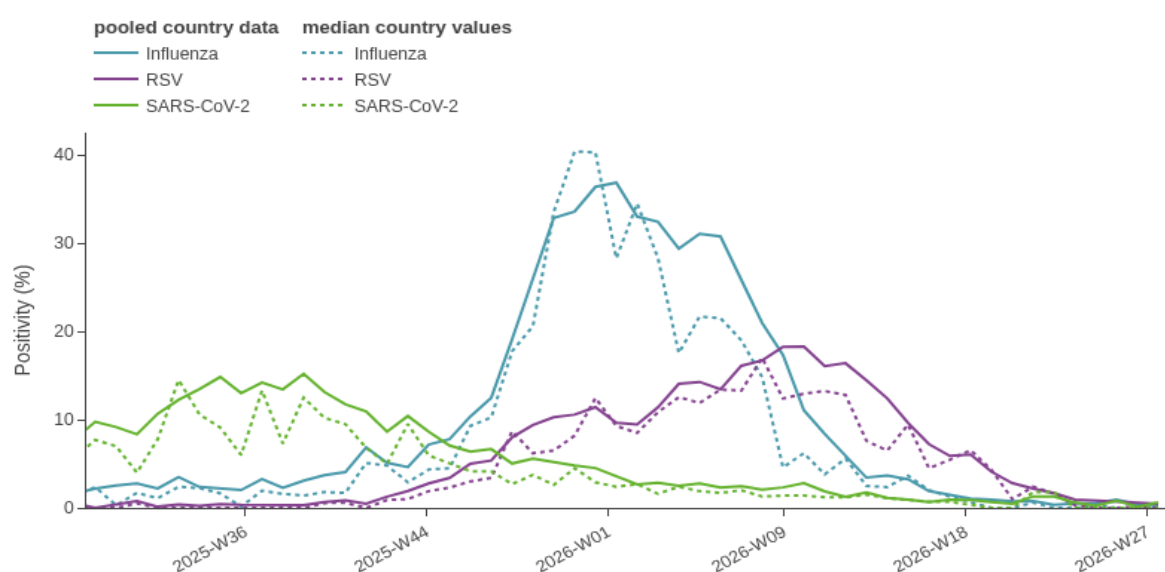
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 3. Key indicators

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary	
		Week 27	Week 26	Description	Value
ILI/ARI consultation rates in primary care	ARI	10 rates (6 MEM)	11 rates (6 MEM)	Distribution of country MEM categories	6 Baseline
	ILI	12 rates (11 MEM)	12 rates (11 MEM)		10 Baseline 1 Low
ILI/ARI test positivity in primary care	Influenza	12	14	Pooled (median; IQR)	0% (0; 0–0%)
	RSV	11	13		0.3% (0; 0–0%)
	SARS-CoV-2	11	13		1.9% (0; 0–0.6%)
SARI rates in hospitals	SARI	8 rates (4 MEM)	10 rates (5 MEM)	Distribution of country MEM categories	4 Baseline
SARI test positivity in hospitals	Influenza	6	8	Pooled (median; IQR)	0.3% (0; 0–0.3%)
	RSV	6	7		0.5% (0; 0–5.4%)
	SARS-CoV-2	6	7		0.6% (0; 0–1.4%)
Intensity (country-defined)	Influenza	7	10	Distribution of country qualitative categories	7 Baseline

Source: ECDC

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

Pathogen	Week 27, 2026		Week 40, 2025 – week 27, 2026	
	N	% ^a	N	% ^a
Influenza	0	–	17603	–
Influenza A	0	–	17003	99
A(H1)pdm09	0	–	3938	28
A(H3)	0	–	10091	72
A (unknown)	0	–	2974	–
Influenza B	0	–	119	0.7
B/Vic	0	–	35	100
B (unknown)	0	–	84	–
Influenza untyped	0	–	481	–
RSV	1	–	5176	–
RSV-A	0	0.0	823	42
RSV-B	1	100	1131	58
RSV untyped	0	–	3222	–
SARS-CoV-2	7	–	3995	–

Source: ECDC

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

Pathogen	Week 27, 2026		Week 40, 2025 – week 27, 2026	
	N	% ^a	N	% ^a
Influenza	2	–	15687	–
Influenza A	1	100	7589	99
A(H1)pdm09	1	100	1307	35
A(H3)	0	0.0	2414	65
A (unknown)	0	–	3868	–
Influenza B	0	0.0	68	0.9
B/Vic			10	100
B (unknown)	0	–	58	–
Influenza untyped	1	–	8030	–
RSV	3	–	7185	–
RSV-A			1149	52
RSV-B			1058	48
RSV untyped	3	–	4978	–
SARS-CoV-2	4	–	3018	–

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 27, 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

5. Risk assessments under production

On 16 July 2026, ECDC published a rapid risk assessment on the [upsurge in ceftriaxone-resistant *Neisseria gonorrhoeae* with evidence of domestic transmission in the EU/EEA and the UK](#).

Last time this event was included in the Weekly CDTR: 3 July 2026.

6. Influenza A(H5) - Multi-country (World) - Monitoring human cases

Summary

One laboratory-confirmed human case of avian influenza A(H5) virus infection in Bangladesh was reported by the World Health Organization (WHO) in the [Influenza at the human-animal interface, Summary and risk assessment, from 13 June to 7 July 2026](#) (published on 7 July 2026).

The case occurred in a child from the Sylhet Division who developed respiratory symptoms on 17 May 2026. The case sought medical care on 20 May 2026. A clinical specimen was collected on the same day and submitted to the Institute of Epidemiology, Disease Control and Research (IEDCR) on 4 June 2026 as part of the national routine influenza surveillance. The sample tested positive for influenza A(H5) virus using real-time reverse transcription polymerase chain reaction (RT-PCR) on 11 June 2026. The patient was managed as an out-patient and had recovered fully at the time of reporting.

According to the epidemiological investigation, the case had no recent history of travel and no reported exposure to poultry. Nevertheless, poultry deaths had been reported in the vicinity of the case's residence.

Close and possible contacts of the case were identified through contact tracing. Samples were collected from selected close contacts, and animal and environmental samples were also obtained. All identified contacts remained asymptomatic, and all collected samples tested negative for influenza virus.

Background

According to WHO, this is the third laboratory-confirmed human case of avian influenza A(H5) reported in Bangladesh in 2026. Since 2008, 15 human cases of avian influenza A(H5) have been reported to WHO from Bangladesh, including two deaths (Case Fatality Rate (CFR): 13.3%).

ECDC assessment

Sporadic human cases of different avian influenza A(H5Nx) subtypes have previously been reported worldwide. Given the widespread transmission of avian influenza viruses in animals, transmission to humans remains infrequent and no sustained transmission between humans has been observed.

Overall, the risk related to zoonotic avian influenza due to A(H5Nx) viruses for the general population in the EU/EEA is considered low.

Direct contact with birds and other infected animals, their secretions or a contaminated environment is the most likely source of infection, and the use of personal protective measures for people exposed to dead animals or their secretions will minimise the associated risk. The recent severe cases in Asia and the Americas in children and people exposed to infected, sick or dead backyard poultry underline the risk of unprotected contact with infected birds in backyard farm settings.

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 June 2026.

Last time this event was included in the Weekly CDTR: 3 July 2026.

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

Latest epidemiological information

Democratic Republic of the Congo

On 16 July 2026, the [Democratic Republic of the Congo \(DRC\) reported](#) a total of 2 124 confirmed cases, including 828 related deaths (from data up until 15 July). A total of 725 patients are hospitalised in isolation. This represents an increase of 51 new confirmed cases and 32 deaths since the previous report of 15 July (reporting data up until 14 July).

The 51 new cases have been reported from Ituri (41 cases) and North Kivu (10 cases).

Among the individuals that tested positive for Bundibugyo virus, 390 have recovered. In total 80.3% of identified case contacts are under follow-up in the Ituri, North Kivu and Tshopo provinces.

Ituri province remains the most affected, with 1 904 cases, including 692 deaths, reported from 27 of 36 health zones. In North Kivu, 199 cases, including 119 deaths, have been reported from 11 of 34 health zones. In South Kivu, three cases, including one death, have been reported from one of 34 health zones. In Haut-Uele, 14 cases (including 13 deaths) have been reported from four of 13 health zones and in Tshopo four cases (including three deaths) from three of 23 health zones. Overall, 46 of 140 health zones are currently affected across the five provinces.

According to [WHO Africa Region situation report reporting on data as of 12 July 2026](#), 92.3% of 430 deaths investigated until 5 July 2026 occurred in the community or before admission to a health facility and this reflects delays in detection, referral, isolation and access to care.

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

Uganda

As of 17 July 2026, a total of 20 confirmed cases, including two deaths, have been [reported by the Ministry of Health](#) in Uganda. The last confirmed case was reported on 21 June and no new cases have been reported since then. Seventeen individuals have recovered. Overall, 831 all-time contacts have been identified, and 821 of these 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.

On 16 July, Uganda discharged the last Ebola patient who had been receiving treatment at the Mulago National Referral Isolation Centre. [Uganda's Ministry of Health](#) announced the start of the 42-day countdown to declaring the end of the outbreak.

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](#)). 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 DRC.

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 15 confirmed cases in Uganda had travel links to DRC. Additional cases were identified following [contact tracing activities](#). Uganda postponed a large religious event (Martyr's Day) that normally takes place on 3 June and has also 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 sequences distinct 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 and 153 probable cases. At the time, WHO declared the outbreak a Public Health Emergency of International Concern ([Disease Outbreak News Ebola virus disease – Democratic Republic of the Congo, 26 June 2020, Medical countermeasures during the 2018 Ebola virus disease outbreak in the North Kivu and Ituri Provinces of the Democratic Republic of the Congo: a rapid genomic assessment - ScienceDirect](#)).

Bundibugyo virus was first reported in 2007 in Bundibugyo district in Uganda, during an outbreak. The most recent outbreak due to Bundibugyo virus was in 2012 in DRC ([Uganda: Ebola outbreak press statement - 20 Dec 2007 - Uganda | ReliefWeb, WHO | Ebola outbreak in Democratic Republic of Congo, 12 August 2012](#)).

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

Travel restrictions

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

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, according to the [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](#)).

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

ECDC assessment

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

Given all the available information and uncertainties surrounding this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. Given the very low likelihood of importation and secondary transmission, the likelihood of infection is estimated to be very low for people living in the EU/EEA. The overall risk of Bundibugyo virus transmission through substances of human origin (SoHO) in the EU/EEA is currently assessed as very low ([Risk of Bundibugyo virus transmission through substances of human origin in the European Union/European Economic Area \(EU/EEA\)](#)). This assessment will be reviewed as further information becomes available.

Exit screening in affected countries, including symptom checks and exposure assessment, is important as it contributes to risk reduction by identifying symptomatic travellers before they board flights, to prevent them travelling while symptomatic. Exit screening also helps dissuade people with symptoms from travelling and enhances public and stakeholder confidence. However, it cannot fully prevent exportation of cases, because the absence of symptoms at departure does not exclude subsequent onset of disease.

ECDC considers that screening of returning travellers from affected areas (DRC, Uganda) would not be effective in preventing introduction to Europe. This consideration is based on the lessons learned and results of the large EVD outbreak in West Africa between 2013 and 2016, where tens of thousands of cases were reported, transmission was ongoing in large urban centres, and hundreds of EU/EEA humanitarian and military personnel were deployed to the affected areas. Screening incoming travellers is time- and resource-consuming and will not effectively identify people with the infection. Priority should instead be given to providing travellers with clear information on symptoms, routes of transmission, and what to do if symptoms develop after arrival in the EU/EEA.

Detailed assessment of the event can be found in ECDC's Threat Assessment Brief published on 21 May 2026 ([Threat assessment brief: Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026](#)).

Actions

ECDC continues to monitor the outbreak through its epidemic intelligence activities to provide epidemiological updates, situational awareness and risk assessment for the EU/EEA.

Since 19 May 2026, the EU Health Task Force, in collaboration with DG ECHO, DG INTPA and GOARN, has been deploying ECDC experts to Addis Ababa (Ethiopia) in Africa CDC headquarters, and Kampala (Uganda).

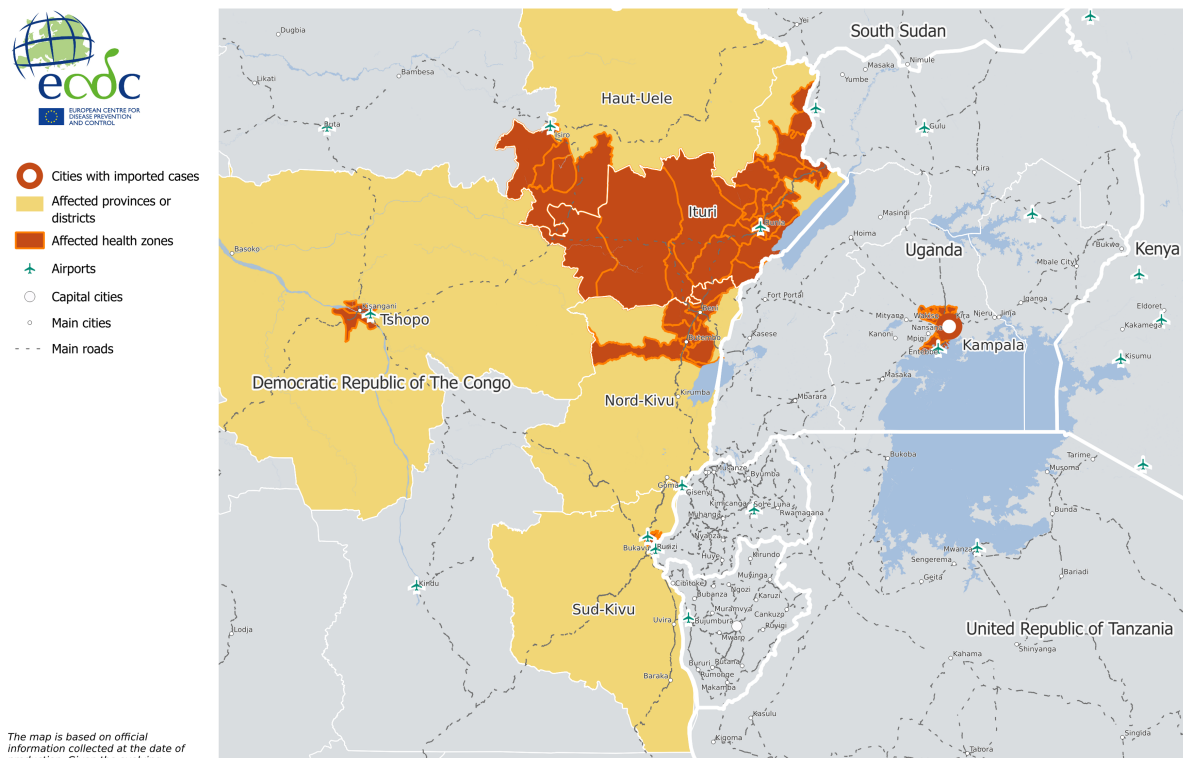
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

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

Last time this event was included in the Weekly CDTR: 10 July 2026.

Maps and graphs

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



Map produced by ECDC on: 17/07/2026. Administrative data ©UNFAO ©UNOCHA; Road, cities and airport ©OSM. The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union.

8. 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.

Seven ECDC experts have been deployed on a rotational basis to support Africa CDC, initially at its headquarters in Addis Ababa and, since 23 June 2026, within the Continental Incident Management Support Team (IMST) in Uganda. The deployments are part of the project 'Health Security and One Health in Africa - Africa CDC' in partnership with ECDC and EFSA (PHASE II), funded by the 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 with a view to evaluating the implementation and operational performance of exit screening procedures.

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

These activities are being conducted in close coordination with national authorities and 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: 10 July 2026.

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

Overview

Since the beginning of 2026 and as at 15 July 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (two cases).

The report is available [online](#).

ECDC assessment

The cases in Salamanca (Spain) are not unexpected as *Hyalomma* spp. – the main vector 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 these cases aligns with the expected seasonal pattern of CCHF in Spain.

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 to be the principal species involved in transmission to humans. *Hyalomma marginatum* is widely [present in southern and eastern Europe](#) and *Hyalomma lusitanicum* is [present in parts of southern Europe](#).

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

Actions

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

Last time this event was included in the Weekly CDTR: 10 July 2026.

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

Overview

Since the beginning of the 2026 transmission season, and as at 15 July, 28 areas affected by West Nile virus (WNV) have been identified in five countries across Europe. These areas are located in Italy (17), Greece (five), North Macedonia (two), Romania (two) and Spain (two).

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 information on the number of locally acquired human cases reported, outbreaks of West Nile fever in equids and birds notified to the Animal Disease Information System (ADIS) of the European Commission, and an assessment of the situation.

Last time this event was included in the Weekly CDTR: 10 July 2026.

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

Update

A list of areas expected to have high environmental suitability* for *Vibrio* spp. in the next five days (until 22 July 2026) is provided below, based on forecasts from the [Vibrio Viewer](#).

For the period in question, 134 unique Local Administrative Units (LAUs) located within 41 NUTS3 regions across 11 countries recorded a suitability score exceeding the threshold value of 16.

Areas with elevated suitability were concentrated primarily in coastal regions bordering the Baltic Sea, North Sea, Black Sea and Atlantic Ocean. The highest numbers of municipalities above the threshold were identified in Denmark (26), Sweden (25) and France (18).

Bulgaria: 13 municipalities in 3 NUTS3 regions:

- **Varna** (4): Avren, Byala, Dolni chiflik, Varna
- **Dobrich** (3): Balchik, Kavarna, Shabla
- **Burgas**: 6 municipalities have locations above the threshold

Denmark: 26 municipalities in 7 NUTS3 regions:

- **Nordsjælland** (3): Frederikssund, Halsnæs, Holbæk
- **Østsjælland** (1): Holbæk
- **Vest-og Sydsjælland**: 6 municipalities have locations above the threshold
- **Fyn** (4): Kerteminde, Langeland, Nordfyns, Svendborg
- **Syddjylland** (5): Fredericia, Hedensted, Kolding, Sønderborg, Vejle
- **Østjylland** (3): Horsens, Norddjurs, Randers
- **Nordjylland** (4): Aalborg, Jammerbugt, Læsø, Mariagerfjord

Estonia: seven municipalities in the **Lääne-Eesti** NUTS3 region

Finland: four municipalities in 3 NUTS3 regions:

- **Helsinki-Uusimaa** (1): Lovisa
- **Etelä-Karjala** (1): Villmanstrand
- **Kymenlaakso** (2): Pyttis, Vederlax

France: 18 municipalities in 6 NUTS3 regions:

- **Loire-Atlantique** (2): Montoir-de-Bretagne, Saint-Brevin-les-Pins
- **Gironde**: 8 municipalities have locations above the threshold
- **Landes** (1): Tarnos
- **Pyrénées-Atlantiques** (1): Anglet
- **Charente-Maritime** (5): Chenac-Saint-Seurin-d'Uzet, Le Château-d'Oléron, Le Verdon-sur-Mer, Royan, Talmont-sur-Gironde
- **Bouches-du-Rhône** (1): Arles

Germany: 11 municipalities in 3 NUTS3 regions:

- **Vorpommern-Rügen**: 6 municipalities have locations above the threshold
- **Nordwestmecklenburg** (2): Blowatz, Insel Poel, Ostseebad
- **Vorpommern-Greifswald** (3): Altwarp, Luckow, Vogelsang-Warsin

Netherlands: nine municipalities in 2 NUTS3 regions:

- **Zeeuwsch-Vlaanderen** (4): Borsele, Hulst, Sluis, Terneuzen
- **Overig Zeeland** (5): Goes, Hulst, Kapelle, Reimerswaal, Tholen

Norway: nine municipalities in 5 NUTS3 regions:

- **Østfold** (2): Halden, Sarpsborg
- **Akershus** (2): Asker, Bærum
- **Agder** (1): Risør
- **Vestfold** (2): Færder, Sandefjord
- **Telemark** (2): Bamble, Kragerø

Poland: three municipalities in 1 NUTS3 region:

- **Szczeciński** (3): Altwarp, Luckow, Nowe Warpno

Romania: 12 municipalities in 2 NUTS3 regions:

- **Constanța** (8): More than five municipalities have locations above the threshold
- **Tulcea** (4): Jurilovca, Murighiol, Oras Sulina, Sfantu Gheorghe

Sweden: 25 municipalities in 8 NUTS3 regions:

- **Stockholms län:** nine municipalities have locations above the threshold
- **Uppsala län** (1): Östhammar
- **Södermanlands län** (1): Trosa
- **Östergötlands län** (3): Norrköping, Söderköping, Valdemarsvik
- **Kalmar län** (2): Oskarshamn, Västervik
- **Skåne län** (1): Vellinge
- **Hallands län** (1): Kungsbacka
- **Västra Götalands län:** 7 municipalities have locations above the threshold

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

*Note: high environmental suitability for *Vibrio* spp. is defined by a suitability index >16.

Background

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

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

ECDC assessment

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

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

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

Actions

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

ECDC publishes scientific information and advice on this topic on its dedicated webpage [Vibriosis](#).

Last time this event was included in the Weekly CDTR: 10 July 2026.

12. World Pride - Netherlands - 2026

Summary

[World Pride 2026](#) will take place in Amsterdam, the Netherlands, from 25 July to 8 August 2026. The event is expected to attract a large number of participants, including international visitors from across the EU/EEA and other regions of the world. Activities will include cultural and artistic performances, and large-scale social gatherings, culminating in a public parade on 8 August in central Amsterdam. The event will be hosted across multiple indoor and outdoor venues, some of which are expected to have high crowd density and prolonged contact among attendees.

In recent years, rates of STIs such as gonorrhoea and syphilis have [continued to increase](#) among gay, bisexual and other men who have sex with men in the EU/EEA. Additionally, clusters and outbreaks of other infections that may be transmitted through intimate contact have been reported among gay, bisexual and other men who have sex with men, including mpox, [dermatophilosis](#), viral hepatitis and [multi-drug and extensively drug-resistant Shigella](#).

For this year's World Pride event in Amsterdam, the main recommendations stated in the [2017 ECDC risk assessment](#), the ECDC guidance on [HIV and STI prevention among men who have sex with men](#), the ECDC [public health considerations on mpox](#), and the [ECDC guidance on PrEP](#) remain relevant. Additional considerations regarding Shigella prevention are outlined in the ECDC [epidemiological update 2026](#).

The local and regional public health authorities in Amsterdam have reinforced early detection, epidemiological surveillance, diagnostics, sampling and sequencing and preventive community measures in at-risk populations and in spaces where exposure may occur.

Building on these preparedness measures, ECDC recommend that public health authorities work with civil society organisations and other partners to ensure that gay, bisexual and other men who have sex with men have access to accurate information and services. Participants attending World Pride events are advised to be mindful of the following:

- Ensure that their routine vaccination and boosters are up to date according to the national immunisation recommendations in their country of residence, including those against hepatitis A. It is advised to discuss the need for additional vaccinations, such as for mpox, or booster doses with their healthcare providers.
- Ensure coverage with valid health insurance or obtain a European Health Insurance Card.
- Educate themselves prior to attendance about the prevention of STIs, including recommendations on HIV pre-exposure prophylaxis, and familiarise themselves with additional advice and information on the website of the event.
- Consult a healthcare provider in the home country to discuss other precautions based on a sexual health risk assessment: they may recommend pre-exposure prophylaxis (PrEP) for HIV, but remember that PrEP does not protect against other STIs.
- Practise safer sex using condoms to prevent STIs, including HIV and hepatitis B and C.
- While using a condom is an important protective measure, it does not provide full protection against mpox, as mpox can be transmitted through close skin-to-skin contact, especially if there are rashes, sores, or lesions on the skin. This is valid also for dermatophilosis
- Avoid sexual activity and seek healthcare if symptoms of STIs are present, including gastrointestinal symptoms and symptoms suggestive of mpox, in themselves or any sexual partner.
- Avoid faecal-oral exposure during sexual activity in order to prevent other infections such as shigellosis and hepatitis A (i.e. washing hands, genital and anal areas before and after sexual contact, always using a condom, changing condoms between anal and oral sex, using gloves or condoms on sex toys, using dental dams for oral sex and latex gloves for fingering or fisting). If gastrointestinal symptoms appear, tell healthcare providers about sexual activities, and abstain from sex until symptoms resolve
- Follow standard hygiene measures and advice on the prevention of food and waterborne diseases to decrease the risk of gastrointestinal illnesses and consider general hygiene/food safety practices when consuming food and drink.
- If you think you have been exposed to HIV, hepatitis A or B, or mpox infection, contact a healthcare provider as soon as possible for advice, as post-exposure prophylaxis (PEP) is available for some infections as vaccination or tablets and should be started as soon as possible (within 72 hours for HIV).
- Contact a healthcare provider at the event if experiencing symptoms suggestive of an infection. People with STIs might have no symptoms; however, common symptoms include unusual discharge from the genitals or rectum, itching, pain during urination, rectal pain, skin changes (including rashes or blister-like lesions), yellowing of the skin, pain during sex or influenza-like symptoms. If you have any of these symptoms, or experience severe diarrhoea (which can be caused by shigella or hepatitis A), avoid sexual activity and seek healthcare promptly.
- In general, if engaged in unprotected sexual activity with a casual partner, consider contacting a healthcare provider for advice on testing for STIs, including mpox, HIV and hepatitis, as STIs can be present without causing any symptoms.
- Alternatively, use the European Test Finder tool to identify the most conveniently located testing centre. Known partners of those diagnosed should be notified as well as offered testing and treatment according to clinical guidelines.

People attending World Pride who acquire an infection may contribute to onward transmission of infections within sexual networks in their home countries. The EU/EEA countries should consider raising awareness among clinicians and laboratory professionals accordingly and prepare to provide post-exposure prophylaxis where indicated, testing, treatment, and carry out partner management of identified cases.

ECDC assessment

STIs, HIV, hepatitis, mpox and shigellosis continue to be reported in sexual networks among gay, bisexual and other men who have sex with men in Europe. People attending World Pride 2026 who have sex with non-steady or multiple partners may have an increased probability of acquiring an STI or another infection transmitted through sexual contact, particularly if preventive measures are not used consistently.

The probability of EU/EEA citizens becoming infected with other communicable diseases while attending World Pride 2026 is low if general preventive measures are applied (e.g. being fully vaccinated according to national immunisation schedules, following advice regarding hand and food hygiene and respiratory etiquette, self-isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, seeking prompt testing and medical advice as needed, and practising safe sex).

In 2017, ECDC published a [rapid risk assessment](#) on communicable disease risks associated with WorldPride in Madrid. Its main recommendations remain relevant, alongside [ECDC guidance on HIV and STI prevention among men who have sex with men](#), ECDC's [public health considerations for mpox](#), and [ECDC guidance on PrEP](#).

Actions

ECDC will monitor this event through its epidemic intelligence activities between 20 July to 14 August 2026 in collaboration with the Dutch health authorities and WHO's Regional Office for Europe, and will include weekly updates in the Communicable Disease Threats Report (CDTR).

Further information

[Rapid Risk Assessment: Potential public health risks related to communicable diseases at the WorldPride festival in Madrid, 23 June–2 July 2017](#)

[ECDC STI Annual Epidemiological Reports for 2024 data](#)

[Public health guidance on HIV and STI prevention among men who have sex with men](#)

[ECDC HIV Pre-Exposure Prophylaxis in the EU/EEA and the UK: implementation, standards and monitoring](#)

[Clusters of dermatophilosis in five EU/EEA countries in 2025–2026](#)

13. Cyclosporiasis - USA - 2026

Overview

In the context of the ongoing FIFA (football) World Cup happening across the United States, Canada and Mexico, travellers may acquire various food and water-borne illnesses. Currently, the United States is reporting an outbreak of cyclosporiasis linked to contaminated shredded iceberg lettuce, affecting 34 states. Currently most of the cases linked to this outbreak are from Indiana, Kentucky, Michigan, Ohio and West Virginia.

Cyclosporiasis is a gastrointestinal illness caused by the parasite *Cyclospora* and infections are acquired by the consumption of contaminated food or water. Human-to-human transmission is unlikely as the excreted oocysts require maturation under favourable environmental conditions before they become infectious. The US CDC considers 1 May - 31 August the annual cyclosporiasis season although cases are common during spring and summer months. Symptoms typically begin one week after exposure, but symptom onset can occur 2-14 days after exposure. Symptoms include watery diarrhea, nausea, loss of appetite, and abdominal cramps. Less common symptoms include low-grade fever and vomiting.

[Previous outbreaks](#) of *Cyclospora* have been associated with the consumption of fresh produce. The parasite is resistant to chlorination and iodination. The detection of *Cyclospora* is conducted from examination of stool samples for oocysts by microscopy (acid-fast or safranin staining or fluorescence) and detection of parasite DNA by PCR.

On 14 July 2026, the US CDC published an official [health advisory](#) confirming 1 645 domestic cases of cyclosporiasis. This is significantly higher than the 249 cases reported between 1 May-16 July in 2025.

On 16 July 2026, the public health authorities in Mexico published a [travel advice](#) for travelers visiting the United States. In the travel advice the risk is assessed as medium and hygiene precautions were advised.

ECDC assessment

The outbreak of cyclosporiasis in the United States has affected 34 states including states hosting FIFA World Cup games. Travellers from the EU may be exposed but pose low risk of domestic transmission as human-to-human transmission is unlikely.

Actions

ECDC keeps monitoring the event via epidemic intelligence activities.

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
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - 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 17 July 2026
- Expert deployment - last reported on 17 July 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report) - last reported on 17 July 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report) - last reported on 17 July 2026
- Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters - Bathing season 2026 - last reported on 17 July 2026
- World Pride - Netherlands - 2026 - last reported on 17 July 2026
- Cyclosporiasis - USA - 2026 - last reported on 17 July 2026
- Risk assessments under production - last reported on 17 July 2026
- Influenza A(H5)- Multi-country (World)- Monitoring human cases - last reported on 17 July 2026
- Human cases of swine influenza A(H3N2) variant virus – Multi-country - last reported on 17 July 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 17 July 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 27, 2026 - last reported on 17 July 2026
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 17 July 2026
- SARS-CoV-2 variant classification - last reported on 3 July 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 3 July 2026.