WEEKLY BULLETIN

Communicable disease threats report

Week 34, 15 - 21 August 2026

This week's topics

Executive summary

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

- One human case of influenza A(H9N2) virus infection in China was reported in the "Influenza at the human-animal interface" report by WHO.
- The case was in a female child under five years of age from Yunnan Province, who had underlying medical conditions.
- The child developed symptoms on 28 July 2026, was hospitalised, recovered, and was discharged.
- No further information is available at this time.
- The risk related to zoonotic avian influenza due to A(H9N2) virus for the general population in the EU/EEA is currently considered very low.

Human cases of swine influenza A(H1N2) variant virus infection – Multi-country
One human infection with influenza A(H1N2) variant (v) virus of swine origin was reported in the United States by The Michigan Department of Health and Human Services (MDHHS).

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- The patient, who is a resident of Ionia County was a swine exhibitor at an agricultural fair, which took place from 3 to 8 August 2026.
- The case was confirmed positive by the US CDC on 14 August 2026.
- At the moment, there are no further human infections related to this person or the agricultural fair.
- Human infections with influenza virus of swine origin are rare, but sporadic infections may occur in individuals exposed to infected animals.

Overview of respiratory virus epidemiology in the EU/EEA, week 31, 2026

- Respiratory virus activity across EU/EEA countries remains at baseline levels, indicating limited circulation of respiratory viruses.
- **SARS-CoV-2** activity remains low across all age groups but is slowly increasing in some countries. Although numbers of hospital admissions remain very low, a few countries are reporting a small increase.
- **Influenza virus** activity is low and at expected inter-seasonal levels in most countries. In Malta, a recent increase in activity and hospitalisations has been observed, similar to increases seen during the same period in previous summers.
- **Respiratory syncytial virus (RSV)** activity is low and at expected inter-seasonal levels.

Spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA - 2026

- As of 20 August 2026, human skin infections with Dermatophilus congolensis have been reported in ten European countries: Austria, Denmark, France, Germany, the Netherlands, Norway, Spain, Sweden, Switzerland and the United Kingdom. Compared with the ECDC Rapid Risk Assessment (RRA) published on 17 June, four new countries have reported cases (Denmark, Netherlands, Switzerland and the UK) and the overall case count has been updated to 126 confirmed cases.
- Reported infections have generally been mild, with localised papular, pustular, scaly, crusted or folliculitis-like skin lesions and recovery after topical or oral antibiotic treatment.
- Most reported cases remain among gay, bisexual and other men who have sex with men, particularly those reporting recent attendance at sex-on-premises venues such as saunas; however, cases linked to martial arts or other close-contact settings have also been described, including in Norway, Spain and Switzerland.
- Whole genome sequencing analyses indicate relatedness between isolates available from Austria, Denmark, France, the Netherlands, Spain, Sweden and Switzerland.
- Reported infections have generally been mild, with localised papular, pustular, scaly, crusted or folliculitis-like skin lesions and recovery after topical or oral antibiotic treatment. The event continues to suggest a possible change in the epidemiology of D. congolensis, with evidence supporting human-to-human transmission through close skin-to-skin contact, particularly in humid environments, while indirect transmission via shared surfaces cannot be excluded.
- The recommendations issued in the RRA on 17 June remain valid.

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

- As of 20 August 2026, the Democratic Republic of the Congo (DRC) reported a total of 5 290 confirmed cases, including 2 516 confirmed related deaths (based on data until 19 August). Since the beginning of the outbreak, six provinces have been affected: Ituri, North Kivu, South Kivu, Tshopo, Haut-Uele and Bas Uele.
- 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 28 July 2026, Uganda's Ministry of Health declared the end of the Ebola disease outbreak.
- 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.

- Since 14 July, two ECDC fellows have also been deployed through the Global Outbreak Alert and Response Network (GOARN) to the WHO country office in Juba, South Sudan, to support surveillance and data analysis activities.
- Since 18 August, one expert is currently deployed to support Africa CDC 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 European Commission's Directorate-General for International Partnerships.
- 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 and the Directorate-General for International Partnerships.

Seasonal surveillance of chikungunya virus disease – 2026 (weekly)

- Since the beginning of 2026 and as at 19 August 2026, only France has reported locally acquired cases (25 cases) of chikungunya virus disease in Europe.
- In the past week, France reported ten new cases of locally acquired chikungunya virus disease.

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

- Since the beginning of 2026 and as at 19 August 2026, one country in Europe has reported locally acquired cases of dengue: France (four cases).
- Three clusters were reported, of which two are closed.
- One new case was reported in the active cluster.

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

- Since the beginning of 2026, and as at 19 August 2026, only Spain has reported locally acquired cases (four cases) of Crimean-Congo haemorrhagic fever (CCHF) in Europe.
- In the past week, one new case has been reported to ECDC.

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

- Since the beginning of the 2026 transmission season, and as at 21 August, 98 areas affected by West Nile virus (WNV) have been identified in 12 countries across Europe.
- These areas are located in Italy (46), Greece (16), Romania (14), France (eight), North Macedonia (three), Spain (three), Albania (one), Austria (one), Germany (one), Kosovo* (one), Serbia (three), and the Netherlands (one).

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

Salmonella Enteritidis ST11- multi country-2025-2026

- A multi-country cluster of Salmonella Enteritidis ST11 involving 341 cases has been reported between May 2025 and August 2026. The outbreak is ongoing with new cases being reported in the beginning of August 2026.
- Confirmed cases with isolate sequences clustering with the outbreak strain in the United Kingdom have been reported in Austria, Belgium, Denmark, France, Germany and the Netherlands.
- The majority of the cases are reported by the United Kingdom (61%) and the Netherlands (31 %).
- Epidemiological investigations in the United Kingdom point to eggs as the suspected source of infection.

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.
- ECDC monitors environmental suitability for Vibrio growth in EU/EEA coastal waters and publishes regular updates through the Vibrio Viewer and the Communicable Disease Threats Reports to assess and communicate the potential risk to human health across the EU/EEA.

Measles outbreak linked to a festival - Sweden and Finland - 2026

- As of 21 August 2026, a total of 27 epidemiologically linked measles cases have been identified across nine regions in Sweden and one in Finland. All cases are linked to a music festival held in northern Sweden.
- The majority of the cases are unvaccinated school-age children and young adults.
- Swedish public health authorities are working closely with regional communicable disease control units to limit further transmission and identify any additional cases.
- The Finnish health authorities reported one measles case in Åland linked to the festival.
- The Swedish festival was attended by approximately 10 000 people, approximately 10% of whom were international visitors primarily from Norway. Given the presence of international attendees, additional cases associated with the event may be identified in other countries.
- The likelihood of additional secondary cases occurring linked to this event is high for individuals who are not vaccinated who come in contact with someone who has measles. The risk of measles transmission to the highly vaccinated general population is low.
- This outbreak highlights the importance of strengthening surveillance, improving clinical awareness, ensuring healthcare worker vaccination, enhancing vaccine acceptance, and closing immunity gaps.

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

Overview:

Summary
On 7 August, WHO reported a human case of influenza A(H9N2) in its "Influenza at the human-animal interface" report (WHO | Influenza-at-the-human-animal-interface). The case was a female child under five years of age from Yunnan Province, China, with underlying medical conditions. The case developed symptoms on 28 July 2026, required hospitalisation, and has since recovered and been discharged. No further case details are currently available.

The risk of zoonotic avian influenza A(H9N2) to the general population in the EU/EEA is currently considered very low.

Background
Since 2015, a total of 175 laboratory-confirmed human cases of avian influenza A(H9N2) virus infection have been reported from China to WHO.

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) infection have been reported. There is no evidence that the virus has acquired the ability for sustained transmission among humans. The risk related to zoonotic avian influenza (due to A(H9N2) viruses) for the general population 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 June 2026.

Sources: Event Information Site for IHR National Focal Points

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

2. Human cases of swine influenza A(H1N2) variant virus infection – Multi-country

Overview:

On 14 August, one case of human infection with swine influenza A(H1N2) variant (v) virus was reported in the United States by MDHHS (MDHHS confirms detection of influenza A H1N2 variant (swine flu) in Michigan resident). The patient was a swine exhibitor at the Kent County Youth Fair - an agricultural fair, which took place from 3 to 8 August at the Grand Agricultural Center of West Michigan in Lowell. The person tested presumptive positive for swine influenza at the the MDHHS Bureau of Laboratories and was confirmed positive by the US CDC on 14 August 2026.

State and county health officials are tracking potential influenza illnesses among swine exhibitors and visitors from the Kent County Youth Fair. Local doctors are on alert for respiratory symptoms in anyone who visited the fair or was exposed to pigs there.

MDHHS has issued comprehensive public health guidance to help the public prevent variant influenza exposure, recognise influenza symptoms, protect populations at high risk of infection, and seek timely medical help.

Summary: Overall, 35 cases of human A(H1N2)v infection have been reported globally since 2019, four of which were reported in the EU/EEA: Austria (2021), Denmark (2019), France (2021), and the Netherlands (2022). Outside the EU/EEA, cases have been reported in Brazil (3), Canada (3), Taiwan (3), the United Kingdom (1), the US (20), and mainland China (1).

ECDC assessment:

Sporadic cases of human infection with an influenza virus of swine origin have been reported from several countries around the world. Infection following exposure to pigs represents the most common risk factor. Limited, non-sustained, human-to-human transmission of variant influenza viruses has previously been documented, but is rare. All cases need to be carefully followed up to exclude human-to-human transmission and implement control measures.

Actions:

ECDC monitors zoonotic influenza events through its epidemic intelligence activities and with disease experts in order to identify significant changes in the epidemiology of the virus. Cases should be immediately reported to the Early Warning and Response System (EWRS) and in accordance with the International Health Regulations (IHR).

Novel influenza viruses in humans, including zoonotic influenza viruses, should be further characterised and shared with the national influenza reference laboratories and the World Health Organization (WHO) Collaborating Centres.

ECDC guidance: Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work; Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA.

An annual summary of human infections with influenza A variant viruses of swine origin reported globally is provided in the Zoonotic influenza - Annual Epidemiological Report for 2023.

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

3. Overview of respiratory virus epidemiology in the EU/EEA, week 31, 2026

Overview:

Important: This European Respiratory Virus Surveillance Summary (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. Thank you for your patience and understanding.

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

Key visualisation from the weekly bulletin are included below.

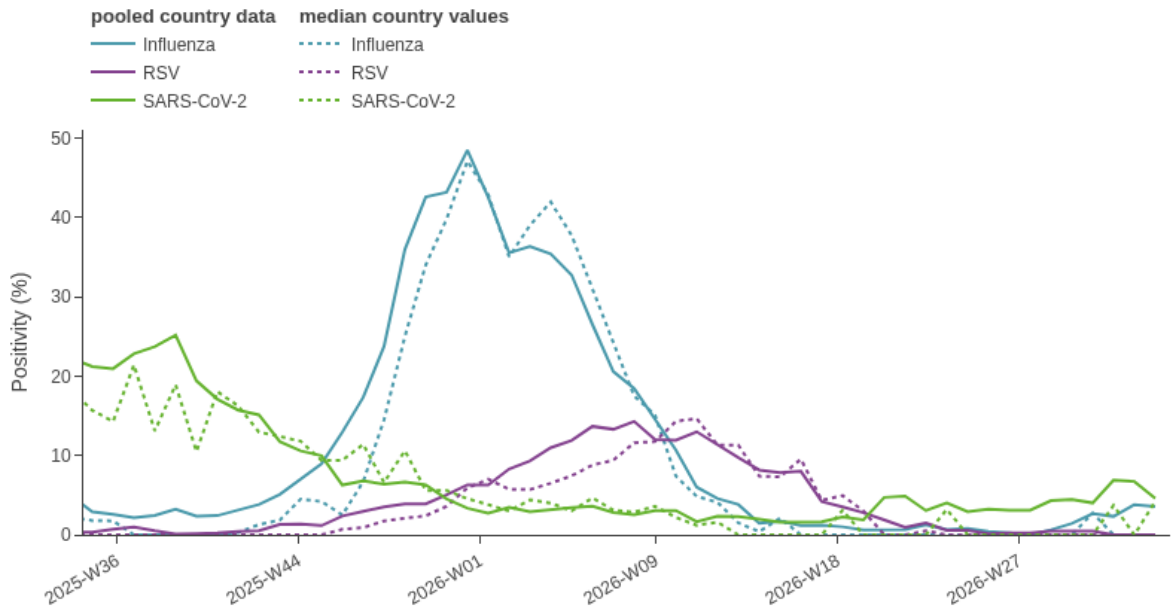
All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

Sources: ERVISS

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

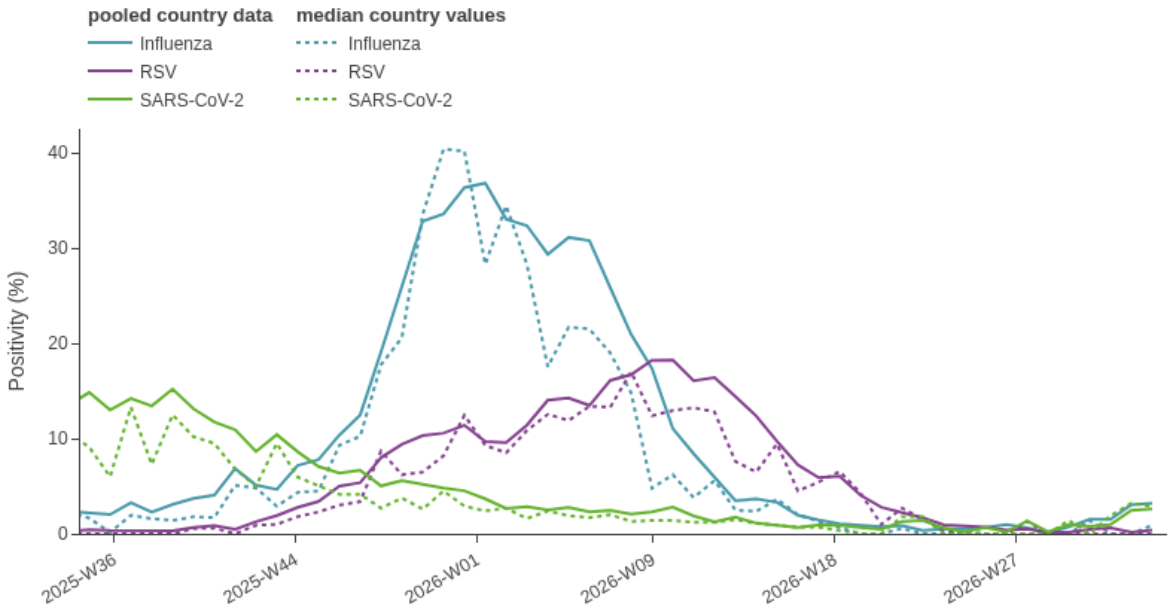
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 3. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 33	Week 32	Description	Value
ILI/ARI consultation rates in primary care	ARI	12 rates (8 MEM)	14 rates (9 MEM)	Distribution of country MEM categories	8 Baseline
	ILI	13 rates (12 MEM)	15 rates (14 MEM)		12 Baseline
ILI/ARI test positivity in primary care	Influenza	12	13	Pooled (median; IQR)	3.6% (0; 0–5.2%)
	RSV	12	13		0% (0; 0–0%)
	SARS-CoV-2	13	14		4.6% (4.2; 0–6.1%)
SARI rates in hospitals	SARI	7 rates (4 MEM)	8 rates (5 MEM)	Distribution of country MEM categories	4 Baseline
SARI test positivity in hospitals	Influenza	6	7	Pooled (median; IQR)	3.2% (0.9; 0–2.6%)
	RSV	6	6		0.4% (0; 0–0%)
	SARS-CoV-2	6	8		2.6% (2.9; 0.9–3.7%)
Intensity (country-defined)	Influenza	8	8	Distribution of country qualitative categories	7 Baseline 1 Low

Source: ECDC

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

	Week 33, 2026		Week 40, 2025 – week 33, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**14**	**–**	**18022**	**–**
Influenza A	13	93	17423	99
A(H1)pdm09	2	18	4070	28
A(H3)	9	82	10365	72
A (unknown)	2	–	2988	–
Influenza B	1	7	119	0.7
B/Vic	0	–	37	100
B (unknown)	1	–	82	–
Influenza untyped	0	–	480	–
RSV	**0**	**–**	**5366**	**–**
RSV-A	0	–	934	44
RSV-B	0	–	1192	56
RSV untyped	0	–	3240	–
SARS-CoV-2	**26**	**–**	**4499**	**–**

Source: ECDC

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

	Week 33, 2026		Week 40, 2025 – week 33, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**16**	**–**	**15778**	**–**
Influenza A	14	100	7650	99
A(H1)pdm09	0	0.0	1327	35
A(H3)	4	100	2445	65
A (unknown)	10	–	3878	–
Influenza B	0	0.0	74	1.0
B/Vic			10	100
B (unknown)	0	–	64	–
Influenza untyped	2	–	8054	–
RSV	**2**	**–**	**7204**	**–**
RSV-A			1149	52
RSV-B			1061	48
RSV untyped	2	–	4994	–
SARS-CoV-2	**13**	**–**	**3088**	**–**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 33, 2026

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

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, week 31, 2026 - week 32, 2026

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	2	12% (12–12%)
XFG	VUM	1	8	47% (47–47%)
NB.1.8.1	VUM	1	1	6% (6–6%)
BA.3.2	VUM	1	1	6% (6–6%)

Source: ECDC

4. Spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA - 2026

Overview:

On 17 June 2026, ECDC published a rapid risk assessment on clusters of dermatophilosis caused by Dermatophilus congolensis in five EU/EEA countries in 2025–2026. At that time, 70 confirmed cases were reported in France (40), Germany (17), Spain (9) and Sweden (4), predominantly, but not exclusively, among gay, bisexual and other men who have sex with men, often reporting recent attendance at sex-on-premises venues, including saunas. Reported infections were mild skin infections, at multiple anatomical sites, particularly the genitals, thighs, groin and beard area; with recovery after topical or oral antibiotic treatment and no serious complications reported. Ten cases were also reported in Norway, linked to an outbreak among martial arts practitioners in Trondheim in summer 2025, with one additional case in a person returning from martial arts training in Thailand in December 2025. In addition, Austria identified 17 laboratory diagnoses of D. congolensis in 2025-June 2026 in Vienna, with limited epidemiological details.

After publication of the RRA and as of 20 August 2026, additional information has become available through EpiPulse and/or scientific literature.

Four new countries identified/reported cases.
Denmark: reported one confirmed case (EpiPulse).
Netherlands: reported three confirmed cases (EpiPulse)
Switzerland: six cases were identified in Basel between May 2025 and March 2026 (Keller PM et al., 2026). The first case occurred in a man after attending a Muay Thai camp in Thailand in May 2025. The second case was identified in a man after travel to Indonesia in July 2025. Four locally acquired cases were diagnosed between December 2025 and March 2026 among men with genital or inguinal folliculitis-like lesions with no travel history and no contact with animals. Whole-genome sequencing showed that all Basel isolates belonged to the same human-associated Dermatophilus lineage and clustered with previously reported French isolates.
United Kingdom: reported one case (EpiPulse).

Updates on case counts and/or further details were available from four countries.
Austria: The updated total is 20 laboratory diagnoses of D. congolensis identified between 2025 and July 2026, including 18 cases reported in Vienna and two in Salzburg. Isolates from one case in Vienna in June 2026 and one case in Salzburg in July 2026 were sequenced.
Norway: Further details became available for the nine cases identified among contact sport practitioners in Trondheim between July to September 2025(Pape K et al., 2026). Symptoms were mild and mainly consisted of pustular lesions on the face, arms, back and chest. Six individuals reported travel abroad within Europe in the three months before onset, and none reported animal contact. No further transmission to household members of the individuals was reported. The isolates clustered with strains associated with recent outbreaks in Spain and France, suggesting wider dissemination of a related clone. The tenth individual, identified in December 2025, reported participation in contact sport at a Muay Thai training in Thailand. Although this case was not epidemiologically linked to the Trondheim sports club outbreak, genomic analysis showed that the isolate clustered closely with the outbreak strain.
Spain: updated its total to 23 confirmed cases by August 2026, with cases identified between July 2025 and July 2026 mostly linked to sex-on-premises venues (EpiPulse). Separately, a published case report described D. congolensis infection in a Muay Thai fighter diagnosed in summer 2025 with recurrent folliculitis after returning from Thailand (Martínez-Carrión et al., 2026).
Sweden: more details provided for the four cases among gay, bisexual and other men who have sex with men diagnosed in Stockholm by June 2026, who likely acquired the infection in Sweden, Japan and Spain (Filén et al., 2026).

As of 20 August 2026, 123 cases of D. congolensis infection have been reported in ten European countries: Austria, Denmark, France, Germany, the Netherlands, Norway, Spain, Sweden, Switzerland and the United Kingdom. The overall epidemiological pattern suggests two main contexts of transmission: clusters among gay, bisexual and other men who have sex with men, often associated with sex-on-premises venues such as saunas, and clusters or sporadic cases among people practising contact sports or martial arts, including travel-associated cases linked to South-East Asia.

Across countries, infections were generally mild, presented as localised papular, pustular, scaly or folliculitis-like skin lesions, and resolved with topical or oral antibiotic treatment. No serious complications were reported. Genomic evidence from several countries indicates close relatedness between isolates, suggesting wider dissemination of a related clone and supporting human-to-human transmission through close physical contact, although indirect transmission via contaminated surfaces or fomites may also contribute in some settings.

Whole genome sequence data from 31 isolates deriving from seven European countries analysed with Ridom cgMLST scheme with 1586 loci indicate close genomic relatedness, with isolates showing only 0-7 differing core genome loci from at least one other isolate in the cluster (Figure 1). In addition, a publication from Pape et al., 2026 reports on clustering of Norwegian outbreak isolates with the before-mentioned isolates from Spain and France within core genome SNP distances ranging from 1-7 and 3-52, respectively, supporting wider dissemination of a related clone. However, when interpreting the results, it should be noted that the rate of mutations typically seen for D. congolensis is not well known and no clear thresholds for sequence-based analysis can be set to verify transmission chains.

Figure 1. Single-linkage tree of 31 human D. congolensis isolates showing numbers of differing loci, 2025-2026, as of 19 August 2026.

ECDC assessment:

Dermatophilus congolensis is a bacterium historically associated with animals and only rarely reported as a cause of human skin infection. The increase in cases across multiple European countries, together with epidemiological links and genomic relatedness between isolates, supports a change in the observed epidemiology and is consistent with human-to-human transmission through close skin-to-skin contact.

Most cases have been reported among gay, bisexual and other men who have sex with men, particularly those reporting recent attendance at sex-on-premises venues such as saunas. However, the updated information indicates that this is not the only relevant exposure. Cases linked to martial arts and other close-contact settings reported from Norway, Spain and Switzerland suggest that sustained non-sexual skin-to-skin contact may also facilitate transmission. Indirect transmission through contaminated surfaces or fomites cannot be excluded, particularly in warm and humid environments. Furthermore, infections have also been diagnosed in individuals with reported animal contact or recent travel, including travel to Thailand and Indonesia.

Available sequencing data indicate that several country clusters are linked or related: isolates from Denmark and the Netherlands were closely related to French and Spanish isolates, and the Norwegian outbreak isolates clustered with strains from Spain and France.
Reported infections have generally been mild, presenting as localised papular, pustular, scaly, crusted or folliculitis-like skin lesions, and have resolved after topical or oral antibiotic treatment. No serious complications have been reported.

D. congolensis infection can be suspected based on compatible skin lesions and confirmed by microbiological testing of clinical specimens. However, MALDI-TOF may give inconclusive or low-confidence results (as reported by Denmark, the Netherlands and Switzerland), so additional molecular methods such as ribosomal 16S sequencing and whole genome sequencing may be needed for species confirmation and comparison of isolates.

The overall risk for the general population remains very low, given the very low probability of infection and the mild clinical course observed to date.
For gay, bisexual and other men who have sex with men with multiple sexual partners, the overall risk remains low; within this group the probability of exposure is moderate among those attending sex-on-premises venues.

People participating in close-contact sports or activities, particularly in humid settings or where skin lesions and shared surfaces are present, may also be at increased exposure risk; however, the available evidence is still limited.

Actions:

On 17 June 2026, ECDC published a Rapid Risk Assessment (RRA). The recommendations from the RRA remain valid and should be maintained in light of the updated information.

Countries reporting cases should continue epidemiological and microbiological investigations, including collection of detailed exposure information, laboratory confirmation and WGS where possible, to better characterise transmission routes, risk factors and spread. National findings and sequencing information, including genome

assemblies or accession numbers, should be shared through EpiPulse to support comparison of isolates across countries. If needed, ECDC can provide WGS support through a laboratory contractor.

Awareness should be raised among clinicians, sexual health services and laboratories to support timely recognition, testing and reporting of compatible skin infections.

Consideration should be given to using alternative or complementary methods for species identification, as MALDI-TOF has been reported to produce inconclusive or low-confidence results for D. congolensis.

Targeted risk communication and prevention advice should be provided for gay, bisexual and other men who have sex with men and for operators of sex-on-premises venues, in collaboration with community organisations to avoid stigma. Messages should promote early healthcare-seeking for compatible skin lesions, avoidance of direct contact with active lesions, and reinforcement of hygiene and cleaning measures in saunas and other sex-on-premises settings.

For close-contact sport premises, recommended measures include reinforcing hygiene practices, prompt cleaning of shared equipment and surfaces, and avoiding participation when active skin lesions are present.

Further information:

ECDC RRA https://www.ecdc.europa.eu/sites/default/files/documents/Clusters-of-dermatophilosis-in-five-countries.pdf

Scientific publications:

Descalzo V, et al. Suspected sexual transmission of dermatophilosis among men who have sex with men, Barcelona, Spain, 2025–2026. Emerg Infect Dis. 2026;32(6).

Degrèze N, et al. Suspected sexual transmission of dermatophilosis among men who have sex with men, Lyon and Paris, France, 2025–2026. Emerg Infect Dis. 2026;32(6).

Filén F, Loo E, Haij Bhattarai K. Dermatophilosis among men who have sex with men, Stockholm, Sweden, March to June, 2026. Euro Surveill. 2026;31(25):2600520.

Keller PM, Di Nicola R, Marković L, Köster M, Lang C, Ruf MT, Field CM, Tschudin-Sutter S, Navarini A, Weisser M. Human infections with Dermatophilus sp.: travel-associated first case and a local cluster in the context of emerging European outbreaks, Basel, Switzerland, 2025 to 2026. Euro Surveill. 2026;31(29):2600552.

Martínez-Carrión G, Fernández-Ciriza L, Razquin I, del Río-Poza MA, Portillo ME. A rare cause of folliculitis by Dermatophilus congolensis in a tropical martial arts fighter. Trop Med Infect Dis. 2026;11(7):196.

Pape K, Javnes S, Aas CG, Sagvik EO, Larssen KW, Jore S. Outbreak of Dermatophilus congolensis skin infection among contact sport practitioners, Norway, summer 2025. bioRxiv. 2026.

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

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

Latest epidemiological information

Democratic Republic of the Congo

On 20 August 2026, the Democratic Republic of the Congo (DRC) reported a total of 5 290 confirmed cases, including 2 516 related deaths (from data up until 19 August). A total of 837 patients are hospitalised in isolation. This represents an increase of 81 new confirmed cases and 40 deaths since the previous report on 19 August (reporting data up until 18 August). The 81 new cases have been reported from Ituri (56 cases), North Kivu (18 cases), and Haut Uele (seven cases). Among the individuals that tested positive for Bundibugyo virus, 1 152 have recovered. In total, 82.9% of identified case contacts are under follow-up in the affected provinces.

Ituri province remains the most affected, with 4 447 cases, including 1 984 deaths, reported from 28 of 36 health zones. In North Kivu, 663 cases, including 452 deaths, have been reported from 12 of 34 health zones. In South Kivu, three cases, including one death, have been reported from one of 34 health zones. In Haut-Uele, 160 cases (including 71 deaths) have been reported from six of 13 health zones. In Tshopo, 15 cases (including seven deaths) have been reported from seven of 23 health zones. In Bas Uele, two cases (including one death) have been reported from two of 11 health zones. Overall, 56 of 151 health zones are currently affected across the six provinces.

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

Uganda

As of 28 July 2026, a total of 20 confirmed cases, including two deaths, have been reported by the Ministry of Health in Uganda. The last confirmed case was reported on 21 June and no new cases have been reported since then. On 16 July, Uganda discharged the last Ebola patient who had been receiving treatment at the Mulago National Referral Isolation Centre. On 28 July 2026, 12 days since the last case was discharged, the Uganda's Ministry of Health declared the end of the Ebola disease outbreak.

The next epidemiological update will be published on 24 August 2026.

Summary

On 15 May 2026, Africa CDC reported an outbreak of Ebola disease in Ituri Province, DRC (Africa CDC Calls Urgent Regional Coordination Meeting Following Ebola Virus Disease Outbreak in Ituri, 15 May 2026, Africa CDC Special Briefing on Ebola Virus Disease Outbreak Status, 16 May 2026). Laboratory analysis at the Institut National de Recherche Biomedicale of DRC identified Bundibugyo virus (Democratic Republic of the Congo confirms new Ebola outbreak, WHO scales up support | WHO AFRO, 15 May 2026).

Clusters of community deaths have been reported, including deaths among healthcare workers in DRC (Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026, Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo (The) & Uganda).

The Ministry of Health of DRC reported that the index case was a nurse (age unknown) who died in a healthcare facility in Bunia (capital of Ituri Province). The individual presented with fever, bleeding, vomiting and weakness (Ministère de la Santé RDC Declaration of Ebola Outbreak 15 May 2025). However, the outbreak is likely to have started many weeks before, given the number of cases and the geographical spread.

On 18 May 2026, a US citizen working in healthcare in the affected areas tested positive and was transferred to Germany, together with six high-risk contacts (US CDC Update on Ebola Outbreak, 18 May 2026, Serge News and Updates, 18 May 2026). The American doctor subsequently recovered well and was discharged from the hospital in Berlin, where he was treated (Ebola patient discharged from Charite hospital in Berlin in good health, 6 June 2026). Another contact of US nationality was transferred to Czechia (US CDC Transcript -19 May 2026). On 24 June, the

Ministry of Health in France reported a first positive case of Ebola virus disease, identified in a doctor returning from a humanitarian mission to one of the areas affected by the ongoing outbreak in DRC.

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

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

The first case reported in Uganda was travel related and the patient later died (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). 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.

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.

Therapeutics and Vaccines

The University of Oxford's Oxford Vaccine Group has successfully vaccinated the first volunteer in the world's first Bundibugyo ebolavirus vaccine trial. The vaccine was developed by scientists at the University of Oxford's Oxford Vaccine Group and Pandemic Sciences Institute.

ECDC assessment:

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

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

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

ECDC considers that screening of returning travellers from affected areas (DRC, Uganda) would not be effective in preventing introduction to Europe. This consideration is based on the lessons learned and results of the large EVD outbreak in West Africa between 2013 and 2016, where tens of thousands of cases were reported, transmission was ongoing in large urban centres, and hundreds of EU/EEA humanitarian and military personnel were deployed

to the affected areas. Screening incoming travellers is time- and resource-consuming and will not effectively identify people with the infection. Priority should instead be given to providing travellers with clear information on symptoms, routes of transmission, and what to do if symptoms develop after arrival in the EU/EEA.

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

Actions:

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

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

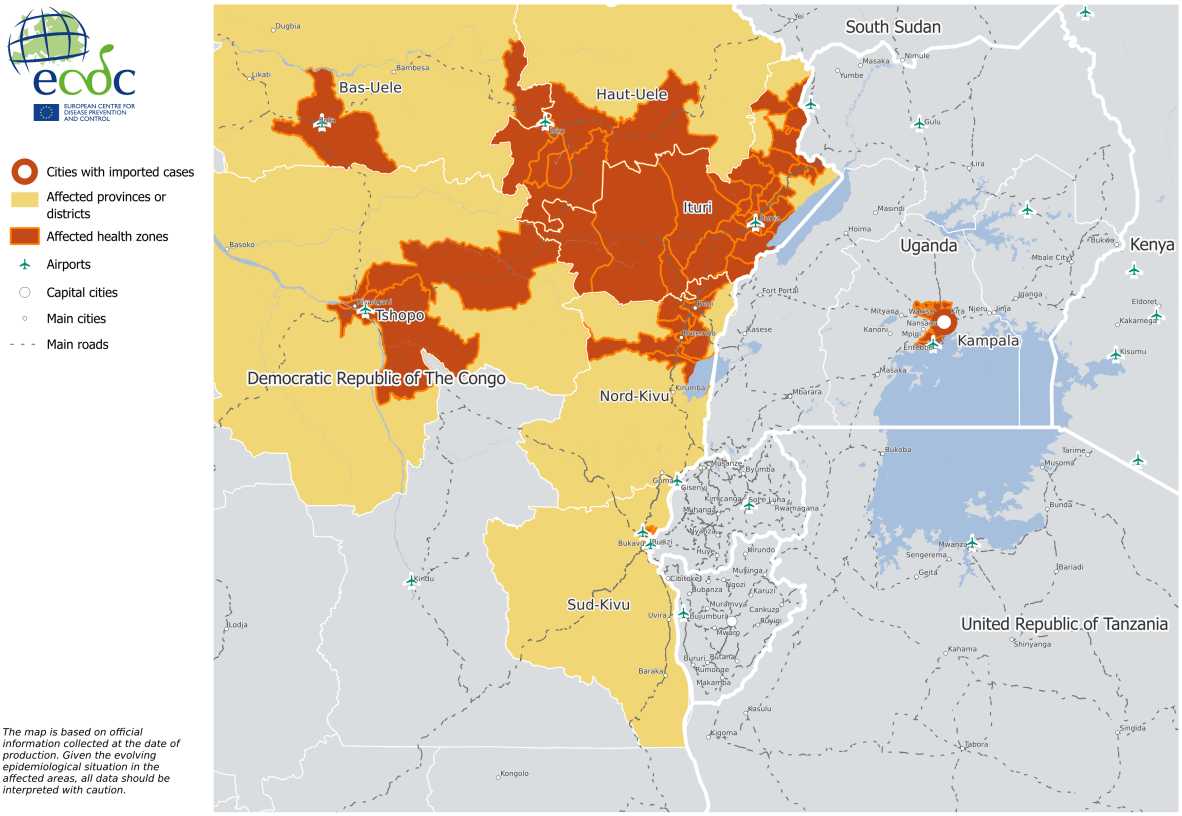
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

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

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



6. Expert deployment

Overview:

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

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

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

Between 16 June and 8 July 2026, an ECDC Risk Communication and Community Engagement (RCCE) expert was deployed to the WHO country office in Juba, South Sudan, in response to a request for assistance from the Global Outbreak Alert and Responses Network (GOARN). The expert supported the implementation of the country's RCCE field plan to strengthen community engagement and address 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 and the Directorate-General for International Partnerships.

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

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

Overview:

Since the beginning of 2026 and as at 19 August 2026, only France has reported locally acquired cases (25 cases) of chikungunya virus disease in Europe.

In the past week, France reported ten new cases of locally acquired chikungunya virus disease. France currently has two active clusters among three which have been identified.

The report is available online

ECDC assessment:

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

Actions:

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

Further information:

Chikungunya is a mosquito-borne viral disease that is emerging in Europe, with locally acquired cases reported in several EU/EEA countries. In the light of this development, ECDC has implemented seasonal enhanced surveillance

to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures.

Chikungunya virus disease is a notifiable disease at the EU level and cases are reported in accordance with the EU case definition. Chikungunya virus disease cases – and their corresponding case numbers – have been reported to the European surveillance portal for infectious diseases (EpiPulse Cases).
Please note that cases acquired in Portuguese and Spanish Outermost Regions are included. However, due to the distinct epidemiological situation and differences in surveillance systems, cases acquired in the French Outermost Regions are not included.

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

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

Overview:

Since the beginning of 2026 and as at 19 August 2026, one country in Europe has reported locally acquired cases of dengue: France (four cases). Three clusters were reported, of which two are closed. One new case was reported in the active cluster.

The report is available online.

ECDC assessment:

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

Actions:

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

Further information:

Dengue is a mosquito-borne viral disease that is increasingly emerging in Europe with locally acquired cases reported in several EU/EEA countries. In the light of this development, ECDC has implemented seasonal enhanced weekly surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures. This includes assessing the risk of dengue transmission through Substances of Human Origin (SoHO).
Dengue is a notifiable disease at the EU level and cases are reported in accordance with the EU case definition. Dengue cases – and their corresponding case numbers – have been reported to the European surveillance portal for infectious diseases (EpiPulse Cases).
Please note that cases acquired in Portuguese and Spanish Outermost Regions are included. However, due to the distinct epidemiological situation and differences in surveillance systems, cases acquired in the French Outermost Regions are not included.

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

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

Overview:

Since the beginning of 2026, and as at 19 August 2026, only Spain has reported locally acquired cases (four cases) of Crimean-Congo haemorrhagic fever (CCHF) in Europe. In the past week, one new case of CCHF has been reported to ECDC.

The report is available online.

ECDC assessment:

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 outdoor activities that expose them to tick bites (e.g. hunting, forestry work, hiking, animal surveillance). As a general precaution against CCHF, but also against other tick-borne diseases, people who may potentially be exposed to ticks should apply personal protective measures (ECDC Protective Measures against ticks). In Spain, CCHF virus is transmitted to humans mainly by ticks of the genus Hyalomma. While Hyalomma lusitanicum plays a key role in virus maintenance and transmission dynamics, Hyalomma marginatum is generally considered to be the principal species involved in transmission to humans. Hyalomma marginatum is widely present in southern and eastern Europe and Hyalomma lusitanicum is present in parts of southern Europe.

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

Actions:

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

Further information:

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

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

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

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

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

Overview:

Since the beginning of the 2026 transmission season, and as at 21 August, 98 areas affected by West Nile virus (WNV) have been identified in nine countries across Europe.

These areas are located in Italy (46), Greece (16), Romania (14), France (eight), North Macedonia (three), Spain (three), Albania (one), Austria (one), Germany (one), Kosovo* (one), Serbia (three), and the Netherlands (one). This week, 21 areas are reported as affected for the first time this season.

The report is available online.

Throughout the season, ECDC will publish a weekly report with updates on risk areas for locally acquired WNV infections. A monthly report is also published.

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

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

ECDC assessment:

Seasonal weather conditions are currently favourable for mosquito-borne transmission; 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: 14 August 2026

11. Salmonella Enteritidis ST11- multi country-2025-2026

Overview:

A multi-country cluster of Salmonella Enteritidis ST11 has been identified across seven European countries. Between May 2025 and August 2026, 341 confirmed cases were reported, with a notable increase in notifications since May 2026.

Cases have been identified in Austria (2), Belgium (15), Denmark (1), France (4), Germany (6), the Netherlands (106) and the United Kingdom (207). Of the total number of outbreak cases, 152 (45%) were reported since May 2026. All but seven of these cases were reported in the Netherlands and the United Kingdom. Cases range in age from 0 to 90 years (median 31 years). At least 34 cases have been hospitalised.

Epidemiological investigations in the United Kingdom point to imported eggs as the suspected source of infection. The Netherlands observed a peak in August - September 2025. The investigation done in the Netherlands in 2026 pointed towards chicken meat, although it is based on a small number of patient interviews.

As of 20 August, there are eight isolates in the ECDC WGS database clustering within 5 allelic distances, single linkage, to the representative outbreak sequence (accession ID SRR38967854). The isolates are from 2025 - 2026, from four European countries. The outbreak strain has been involved in a previous outbreak reported by the

Netherlands to ECDC (2025-FWD-00071). At that time, egg/poultry was suspected to be the cause. There are no matching isolates within 10 allelic distances in the EFSA WGS database.

ECDC assessment:

The multi-country outbreak of Salmonella Enteritidis ST11 remains ongoing, with increasing case numbers since May 2026, particularly in the Netherlands and the United Kingdom. Epidemiological investigations are ongoing and indicate eggs and chicken products as potential sources of infection. More cases are expected until proper control measures are implemented on the source.

Actions:

ECDC is monitoring the event via EpiPulse including the Molecular Typing Tool.

Countries are encouraged to share epidemiological and microbiological information in the EpiPulse event, and to report isolate sequencing data to ECDC.

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

Overview:

Update
Based on forecasts from the Vibrio Viewer, in the next five days (until 26 August 2026), 40 municipalities across eight regions in three countries are expected to have high environmental suitability* for Vibrio spp.

A list of areas expected to have high environmental suitability* for Vibrio spp. until 26 August 2026 is provided below.

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

France: 15 municipalities in three regions:
- **Gironde**: Eight municipalities above the threshold
- **Charente-Maritime**: Six municipalities above the threshold
- **Bouches-du-Rhône**: Arles

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

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

*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 due to its relatively low salinity, although Vibrio species are also found in the North Sea, the Black Sea and other coastal and estuarine bathing waters [1, 2, 3, 4, 5, 6].

Human infection may occur through the consumption of raw or under-cooked seafood, particularly shellfish, or the exposure of open wounds to contaminated water. Clinical manifestations range from self-limiting gastroenteritis to

wound infections, otitis, and severe invasive disease, including septicaemia and necrotising soft tissue infections. Individuals with underlying medical conditions, such as diabetes, chronic liver disease, and immunosuppression, are at increased risk of severe illness [7, 8].

ECDC assessment:

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

Vibriosis remains relatively uncommon in the EU/EEA. However, locally acquired cases 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 the case of accidental contact with coastal water, the affected area should be disinfected and cleaned thoroughly.

Actions:

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

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

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

13. Measles outbreak linked to a festival - Sweden and Finland - 2026

Overview:

As of 21 August 2026, a total of 27 measles cases have been identified across nine regions in Sweden and one in Finland. All cases are linked to a music festival that took place in the Västernorrland Region from 30 July to 1 August. Most cases are unvaccinated children and adolescents under 18 years of age. The festival was attended by approximately 10 000 people, approximately 10% of whom were from countries other than Sweden (mainly Norway). Swedish public health authorities are working closely with regional communicable disease control units to reduce the risk of further transmission. Mässling i Sverige, augusti 2026– — Folkhälsomyndigheten

On 21 August 2026, the public health authorities in Finland reported a case of measles in Åland who had an epidemiological link to the festival. The case reported having travelled on board two ferries between Åland and Sweden following exposure and was vaccinated on 13 and 15 August. En person som insjuknat i mässling reste med färjor mellan Åland och Sverige – THL ger anvisningar till passagerare som rest med samma avgångar - THL

ECDC assessment:

The likelihood for additional secondary cases occurring linked to this event is high for individuals who are unvaccinated and who come into contact with someone with measles. The risk of measles transmission to the highly vaccinated general population is low.

The measles risk in Europe remains unchanged, with moderate risk for infants <12 months, young children, and immunocompromised individuals, low–moderate risk for older unvaccinated persons, and very low for immunised people.

Actions:

ECDC is closely monitoring the situation and is in contact with the national authorities in affected countries.

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 31 July 2026
- Airport malaria in Germany - last reported on 24 July 2026
- Measles outbreak linked to a festival - Sweden and Finland - 2026 - last reported on 21 August 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 21 August 2026
- Human cases of swine influenza A(H1N2) variant virus infection – Multi-country - last reported on 21 August 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 31, 2026 - last reported on 21 August 2026
- Seasonal monitoring of environmental suitability for Vibrio spp. risk in coastal waters – Bathing season 2026 - last reported on 21 August 2026
- Spread of Dermatophilus congolensis infection predominantly affecting men who have sex with men - EU/EEA - 2026 - last reported on 21 August 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 21 August 2026
- Expert deployment - last reported on 21 August 2026
- Seasonal surveillance of chikungunya virus disease – 2026 (weekly) - last reported on 21 August 2026
- Seasonal surveillance of dengue in the EU/EEA, weekly report - last reported on 21 August 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (Weekly report) - last reported on 21 August 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (weekly report) - last reported on 21 August 2026
- Salmonella Enteritidis ST11- multi country-2025-2026 - last reported on 21 August 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report) - last reported on 14 August 2026
- World Pride – Netherlands – 2026 - last reported on 14 August 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 14 August 2026
- Crimean-Congo haemorrhagic fever in Albania, 2026 - last reported on 14 August 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 07 August 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 07 August 2026
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 07 August 2026