

WEEKLY BULLETIN

Communicable disease threats report

Week 39, 19–25 September 2026

This week's topics

- [1. Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo – 2026](#)
- [2. Overview of respiratory virus epidemiology in the EU/EEA, week 38, 2026](#)
- [3. Seasonal surveillance of chikungunya virus disease – 2026 \(weekly\)](#)
- [4. Seasonal surveillance of dengue in the EU/EEA, weekly report](#)
- [5. Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 \(weekly report\)](#)
- [6. Seasonal surveillance of West Nile Virus infections – 2026 \(weekly report\)](#)
- [7. Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters – Bathing season 2026](#)
- [8. Expert deployment](#)

Executive summary

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

- On 24 September 2026, the Democratic Republic of the Congo (DRC) reported a total of 7 890 confirmed cases, including 3 799 related deaths (from data up until 23 September). Since the beginning of the outbreak, seven provinces have been affected: Ituri, North Kivu, South Kivu, Tshopo, Haut-Uélé, Bas Uélé and Sud Ubangi.
- In Uganda, a total of 20 cases were reported between May and June 2026. On 25 August, the World Health Organization (WHO) declared the end of the outbreak following 42 days without a new confirmed case being reported.
- On the basis of the available information, and given the uncertainties surrounding this outbreak, the likelihood of infection for people from the European Union/European Economic Area (EU/EEA) living in or travelling to affected areas is estimated to be low. Given the very low likelihood of importation and secondary transmission, the likelihood of infection for people living in the EU/EEA is estimated to be very low. This assessment will be reviewed as further information becomes available.
- ECDC is monitoring the outbreak through its epidemic intelligence activities and actively liaising with partners to support the response.

Overview of respiratory virus epidemiology in the EU/EEA, week 38, 2026

- Consultation rates for respiratory illness in both primary and secondary care settings are increasing in some Member States, yet remain at baseline levels across all EU/EEA countries, except for Denmark that continues to report low influenza-like illness activity in primary care settings.
- **SARS-CoV-2** activity is increasing slightly in primary care and has slightly decreased in secondary care in comparison to last week. Detections in primary care are mainly related to individuals aged 15 years and above, while in secondary care, they primarily concern adults aged over 65 years.
- **Influenza virus** activity is at baseline levels overall, with only a few countries reporting detections in primary or secondary care. Detections in secondary care mainly relate to adults aged over 65 years and most detections are influenza A viruses.
- **Respiratory syncytial virus (RSV)** activity is low and at expected inter-epidemic levels.

Seasonal surveillance of chikungunya virus disease – 2026 (weekly)

- Since the beginning of 2026, and as at 23 September 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (90 cases) and Italy (1 case).

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

- Since the beginning of 2026, and as at 23 September 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (47 cases) and France (5 cases).

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

- Since the beginning of 2026, and as at 23 September 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (4 cases).
- In the past week, no new cases have 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 23 September, 186 areas affected by West Nile virus (WNV) have been identified in 16 countries across Europe.
- This week, six areas are reported as affected for the first time this season.
- The 16 countries have reported 1 569 locally acquired human cases of WNV infection.

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

- Based on forecasts from the *Vibrio* Viewer, over the next five days (until 30 September 2026), two municipalities across two regions in two countries are expected to have high environmental suitability for *Vibrio* spp.
- Vibriosis is caused by naturally occurring *Vibrio* bacteria found in coastal waters, particularly in warm, brackish environments. In Europe, *Vibrio* bacteria are most frequently detected during the summer season, with the Baltic Sea being particularly favourable due to its low salinity levels.
- A warmer climate is expected to increase the suitability of coastal areas for *Vibrio* growth and expansion.
- ECDC monitors environmental suitability for *Vibrio* growth in EU/EEA coastal waters and publishes regular updates through the [Vibrio Viewer](#) and the [Communicable Disease Threats Reports](#) to assess and communicate the potential risk to human health across the EU/EEA.

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 10 September 2026, one expert has been deployed to support Africa CDC within the Continental Incident Management Support Team (IMST) in Uganda. Such deployments are part of the project 'Health Security and One Health in Africa – Africa CDC' in partnership with ECDC and EFSA (PHASE II) and funded by the European Commission's Directorate-General for International Partnerships.
- These activities are being conducted in close coordination with national authorities and EU delegations, and in collaboration with the Directorate-General for European Civil Protection and Humanitarian Aid Operations and the Directorate-General for International Partnerships.

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

Overview:

Latest epidemiological information

Democratic Republic of the Congo

On 24 September 2026, the [Democratic Republic of the Congo \(DRC\)](#) reported a total of 7 890 confirmed cases, including 3 799 related deaths (from data up until 23 September). A total of 893 patients are hospitalised in isolation. This represents an increase of 70 new confirmed cases and 20 deaths since the previous report on 23 September (reporting data up until 22 September). The 70 new cases have been reported from Ituri (31 cases), North Kivu (31 cases), Haut-Uélé (six cases), Bas-Uélé (one case) and Tshopo (one case). Among the individuals who tested positive for Bundibugyo virus, 1 966 have recovered. In total, 83.4% of identified case contacts are under follow-up in the affected provinces.

Ituri province remains the most affected, with 6 032 cases, including 2 764 deaths, reported from 28 of 36 health zones. In North Kivu, 1 480 cases, including 884 deaths, have been reported from 16 of 34 health zones. In South Kivu, three cases, including one death, have been reported from one of 34 health zones. In Haut-Uélé, 322 cases, including 130 deaths, have been reported from seven of 13 health zones. In Tshopo, 43 cases, including 15 deaths, have been reported from seven of 23 health zones. In Bas-Uélé, eight cases, including four deaths, have been reported from three of 11 health zones. In Sud Ubangi, two cases and one death have been reported from one of 16 health zones. Overall, 63 of 167 health zones are currently affected across the seven provinces.

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

Summary

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

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

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

On 18 May 2026, a US citizen working in healthcare in the affected areas tested positive and was transferred to Germany, together with six high-risk contacts ([US CDC Update on Ebola Outbreak, 18 May 2026](#), [Serge News and Updates, 18 May 2026](#)). The American doctor subsequently recovered well and was discharged from the hospital in Berlin where he was treated ([Ebola patient discharged from Charite hospital in Berlin in good health, 6 June 2026](#)). Another contact of US nationality was transferred to Czechia ([US CDC Transcript -19 May 2026](#)). On 24 June, the [Ministry of Health in France reported](#) a first positive case of Ebola virus disease, identified in a doctor returning from a humanitarian mission to one of the areas affected by the ongoing outbreak in DRC.

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

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

The first case reported in Uganda was travel-related and the patient later died. As of 28 July 2026, a total of 20 confirmed cases, including two deaths, had 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 after the last case was discharged, the [Uganda's Ministry of Health](#) declared the end of the Ebola disease outbreak. On 27 August, [WHO declared the end of the Ebola disease outbreak in Uganda](#) following 42 days without a new confirmed case being reported.

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

Information regarding transmission chains and affected population groups is currently limited, partly due to the complex context of insecurity and humanitarian challenges in the affected areas. According to WHO, neighbouring countries sharing land borders with DRC are considered at high risk of further spread due to population mobility, trade and travel links, and uncertainty about the transmission chains. The outbreak may also be larger than currently detected. There are also concerns related to this outbreak because it is caused by Bundibugyo virus, rather than the more commonly detected *Orthoebolavirus zairense*. Unlike *Orthoebolavirus zairense*, there are currently no licenced vaccines or specific treatments for Bundibugyo virus disease.

Given the information available, the complicated context and the uncertainties regarding epidemiological information, WHO declared a Public Health Emergency of International Concern on 17 May 2026 ([Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026](#)). On 18 May 2026, Africa CDC declared the outbreak a Public Health Emergency of Continental Security ([Africa CDC Declares the Ongoing Bundibugyo Ebola Outbreak a Public Health Emergency of Continental Security – Africa CDC, 18 May 2026](#)). On 5 June, WHO and Africa CDC launched a [joint continental preparedness and response plan](#) to support African countries in the response to the ongoing outbreak.

This is the 17th Ebola disease outbreak reported in DRC. The most recent previous outbreak occurred in 2025 in Kasai Province and was caused by the Ebola virus *Orthoebolavirus zairense* ([WHO DON Ebola virus disease – Democratic Republic of the Congo, 5 September 2025](#)). In Ituri province specifically, Ebola disease due to Ebola virus *Orthoebolavirus zairense* was last documented during the 2018–2020 outbreak. This outbreak was declared on 1 August 2018 following reports of laboratory-confirmed cases in North Kivu province. Investigations identified cases in Ituri and North Kivu with symptom onset from May 2018. The outbreak also spread to South Kivu. Between 1 August 2018 and 25 June 2020, when the outbreak was declared over, a total of 3 470 cases were reported, including 3 317 confirmed and 153 probable cases. At the time, WHO declared the outbreak a Public Health Emergency of International Concern ([Disease Outbreak News Ebola virus disease – Democratic Republic of the Congo, 26 June 2020](#), [Medical countermeasures during the 2018 Ebola virus disease outbreak in the North Kivu and Ituri Provinces of the Democratic Republic of the Congo: a rapid genomic assessment - ScienceDirect](#)).

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

On 1 June 2026, a case was reported by Uganda as having had a travel history to the United Arab Emirates (UAE), arriving on 24 May ([Media reports on 1 June 2026, WHO media briefing on 3 June 2026, WHO DON 8 June 2026](#)). According to WHO, as of 8 June, no cases of Ebola disease have been reported in the UAE. Public health measures, including risk assessment activities, contact

tracing and follow-up, and strengthened preparedness at points of entry, have been implemented in coordination with WHO, UAE and international partners.

Travel restrictions

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

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

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

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

Rwanda's Ministry of Health has reinforced health screening and vigilance at land points of entry along the border with DRC. Enhanced entry control measures have been implemented at Kigali International Airport for inbound travellers to Rwanda ([Rwanda Ministry of Health, 22 May on X](#)).

[South Sudan](#) is maintaining targeted temperature screening and health declaration forms at Juba International Airport and key entry points.

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

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

Therapeutics and vaccines

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

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

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

ECDC assessment:

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

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

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

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

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

Actions:

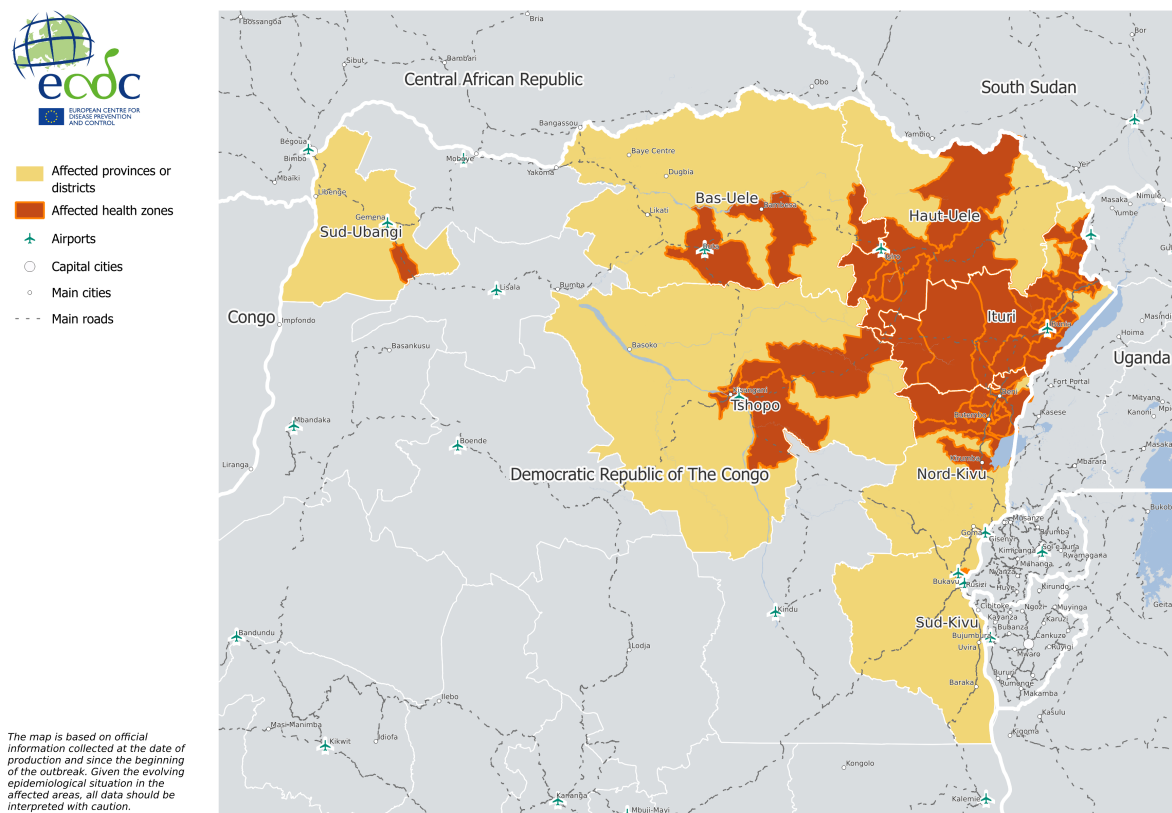
ECDC continues to monitor the outbreak through its epidemic intelligence activities to provide epidemiological updates, situational awareness and risk assessment for the EU/EEA.

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

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

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

Last time this event was included in the Weekly CDTR: 25 September 2026

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

2. Overview of respiratory virus epidemiology in the EU/EEA, week 38, 2026

Overview:

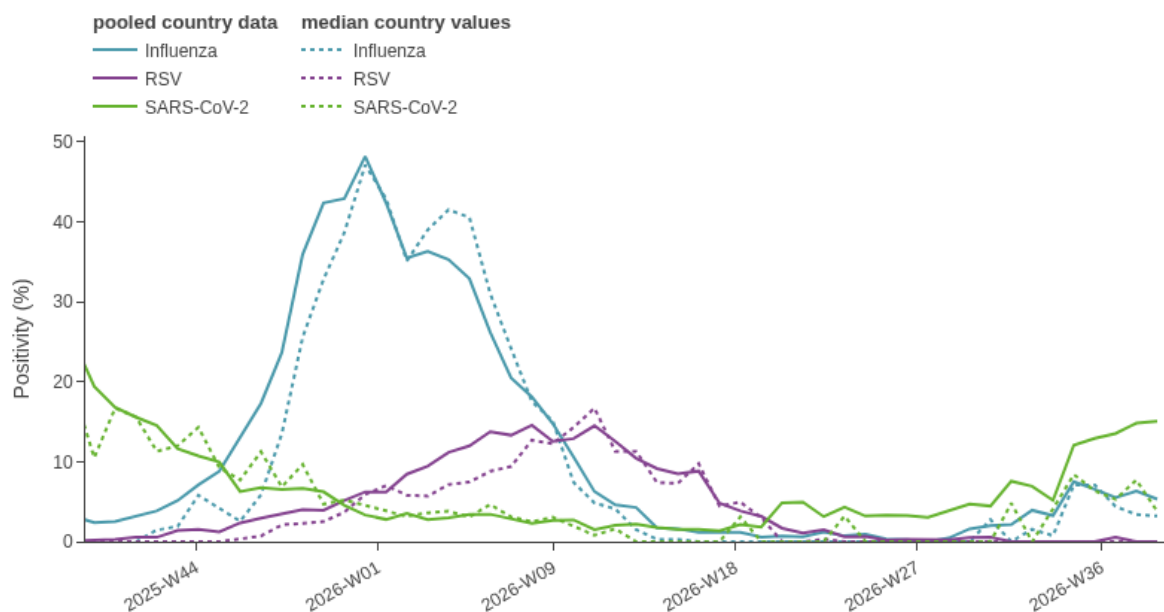
ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary ([ERVISS.org](https://ecdc.europa.eu/en/eriss)), which is updated weekly.

Key visualisation from the weekly bulletin are included below.

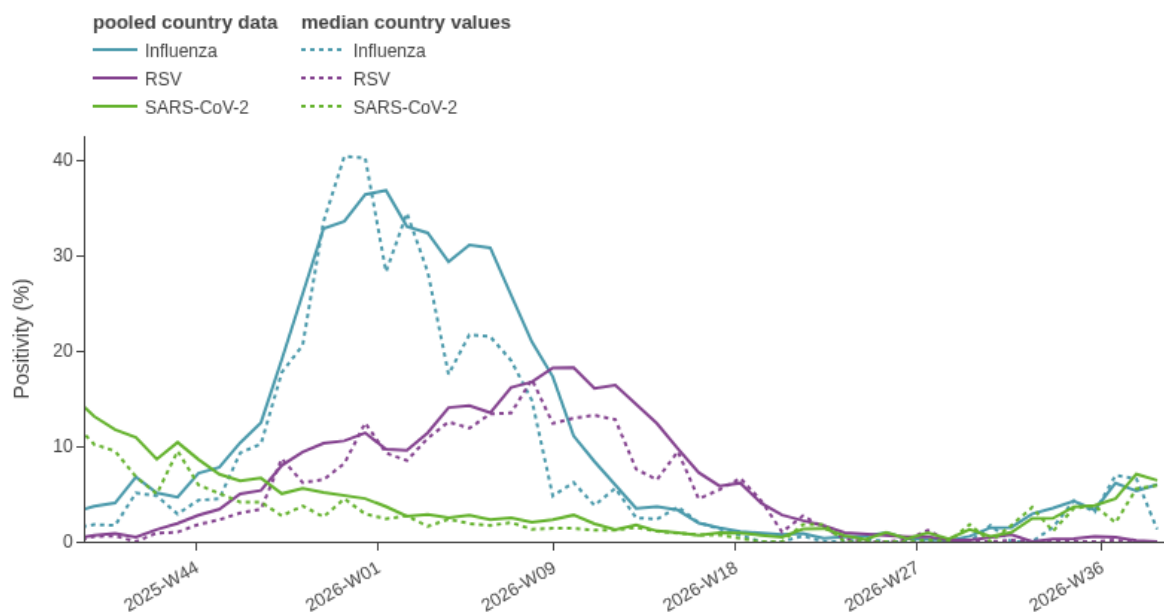
All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

Sources: [ERVISS](https://ecdc.europa.eu/en/eriss)

Last time this event was included in the Weekly CDTR: 25 September 2026

Figure 2. ILI/ARI virological surveillance in primary care – weekly test positivity

Source: ECDC

Figure 3. SARI virological surveillance in hospitals – weekly test positivity

Source: ECDC

Figure 4. Key indicators

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary	
		Week 38	Week 37	Description	Value
ILI/ARI consultation rates in primary care	ARI	11 rates (8 MEM)	14 rates (9 MEM)	Distribution of country MEM categories	8 Baseline
	ILI	12 rates (11 MEM)	15 rates (14 MEM)		10 Baseline 1 Low
ILI/ARI test positivity in primary care	Influenza	11	16	Pooled (median; IQR)	5.3% (3.2; 0–4.8%)
	RSV	10	15		0% (0; 0–0%)
	SARS-CoV-2	11	16		15% (3.8; 1.6–15%)
SARI rates in hospitals	SARI	8 rates (4 MEM)	11 rates (6 MEM)	Distribution of country MEM categories	4 Baseline
SARI test positivity in hospitals	Influenza	5	8	Pooled (median; IQR)	6% (1.3; 0–10%)
	RSV	5	8		0% (0; 0–0%)
	SARS-CoV-2	6	8		6.4% (5.9; 5.3–7.1%)
Intensity (country-defined)	Influenza	10	12	Distribution of country qualitative categories	9 Baseline 1 Low

Source: ECDC

Figure 5. ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution

Pathogen	Week 38, 2026		Week 40, 2025 – week 38, 2026	
	N	% ^a	N	% ^a
Influenza	38	–	17960	–
Influenza A	38	100	17350	99
A(H1)pdm09	9	39	4064	28
A(H3)	14	61	10420	72
A (unknown)	15	–	2866	–
Influenza B	0	0.0	122	0.7
B/Vic	0	–	38	100
B (unknown)	0	–	84	–
Influenza untyped	0	–	488	–
RSV	0	–	5280	–
RSV-A	0	–	936	44
RSV-B	0	–	1192	56
RSV untyped	0	–	3152	–
SARS-CoV-2	207	–	5036	–

Source: ECDC

Figure 6. SARI virological surveillance in hospitals – pathogen type and subtype distribution

Pathogen	Week 38, 2026		Week 40, 2025 – week 38, 2026	
	N	% ^a	N	% ^a
Influenza	40	–	15969	–
Influenza A	31	100	7796	99
A(H1)pdm09	0	0.0	1336	35
A(H3)	3	100	2496	65
A (unknown)	28	–	3964	–
Influenza B	0	0.0	70	0.9
B/Vic			11	100
B (unknown)	0	–	59	–
Influenza untyped	9	–	8103	–
RSV	0	–	7221	–
RSV-A			1158	52
RSV-B			1062	48
RSV untyped	0	–	5001	–
SARS-CoV-2	43	–	3281	–

Source: ECDC

Figure 7. Genetically characterised influenza virus distribution, week 40, 2025 – week 38, 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 8. SARS-CoV-2 variant distribution, week 36, 2026 – week 37, 2026

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	16	9% (9–9%)
XFG	VUM	1	132	74% (74–74%)
NB.1.8.1	VUM	1	3	2% (2–2%)
BA.3.2	VUM	0	0	0%

Source: ECDC

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

Overview:

Since the beginning of 2026, and as at 23 September 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (90 cases) and Italy (1 case).

Since last week's update, France has reported 15 new locally acquired chikungunya virus disease cases, including nine in the municipality of Prayssac (Lot department), bringing the total to 90 cases. These cases are distributed across 13 clusters, with no new clusters identified. Eleven clusters are currently active, including the largest cluster in Prignac-et-Marcamps (Gironde department), which consists of 30 cases.

No new locally acquired chikungunya virus disease cases have been reported by Italy since last week's update. To date, Italy has reported one locally acquired chikungunya virus disease case in Rome. The associated cluster remains active.

The report is available [on line](#).

ECDC assessment:

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

Actions:

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

Further information:

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

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

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

Last time this event was included in the Weekly CDTR: 25 September 2026

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

Overview:

Since the beginning of 2026, and as at 23 September 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (47 cases) and France (5 cases).

Since last week's update, Italy has reported 10 new locally acquired dengue cases. The cumulative number of locally acquired cases in Italy is 47, distributed across seven clusters, four of which are newly identified: three in the Firenze NUTS 3 region (Campi Bisenzio, Signa and Sesto Fiorentino) and one in the Napoli NUTS 3 region (Ischia). All clusters are currently active.

No new locally acquired dengue cases have been reported by France since last week's update. The cumulative number of locally acquired cases in France remains five, distributed across four clusters. No clusters are currently active.

The report is available [online](#).

ECDC assessment:

The current [dengue risk assessment](#) for mainland EU/EEA is available on ECDC's dedicated [dengue webpage](#).

Actions:

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

Further information:

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

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

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

Last time this event was included in the Weekly CDTR: 25 September 2026

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

Overview:

Since the beginning of 2026, and as at 23 September 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (4 cases). In the past week, no new cases have been reported to ECDC.

The report is available [online](#).

ECDC assessment:

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

In Spain, CCHF virus is mainly transmitted to humans 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 – are reported to the European surveillance portal for infectious diseases (EpiPulse Cases).

Please note that cases acquired in Portuguese and Spanish Outermost Regions are included but, 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: 25 September 2026

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

Overview:

Since the beginning of the 2026 transmission season, and as at 23 September, 186 areas affected by West Nile virus (WNV) have been identified in 16 countries across Europe.

These areas are located in Italy (65), Greece (22), Romania (22), France (21), the Netherlands (13), Serbia (8), Spain (6), Croatia (5), North Macedonia (5), Belgium (4), Hungary (4), Austria (3), Germany (3), Kosovo* (3), Albania (1) and Cyprus (1). This week, six areas are reported as being affected for the first time this season.

The 16 countries have reported 1 569 locally acquired human cases of WNV infection.

The report is available [online](#).

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

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

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

ECDC assessment:

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

Actions:

ECDC will provide weekly and monthly updates with the latest reports on cases of WNV infections in Europe. A map and table will be updated every Friday from now until November, as this is the time of year when WNV infections are most likely to be reported.

ECDC will provide an enhanced analysis of the current WNV epidemiology on a monthly basis together with the European Food Safety Authority (EFSA), which includes information on the number of locally acquired human cases reported, outbreaks of West Nile fever in equids and birds notified to the Animal Disease Information System (ADIS) of the European Commission, and an assessment of the situation.

Last time this event was included in the Weekly CDTR: 25 September 2026

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

Overview:

Update

Based on forecasts from the [Vibrio Viewer](#), over the next five days (until 30 September 2026), two municipalities across two regions in two countries are expected to have high environmental suitability* for *Vibrio* spp.

A list of areas expected to have high environmental suitability* for *Vibrio* spp. until 30 September 2026 is provided below.

France: one municipality in one region:

- **Bouches-du-Rhône:** Arles

Spain: one municipality in one region:

- **Tarragona:** Sant Jaume d'Enveja

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

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

Background

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

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

ECDC assessment:

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

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

To reduce the risk of *Vibrio* infections through food, it is recommended that seafood be cooked thoroughly before consumption. People who have open wounds, recent piercings, cuts or scrapes should avoid swimming in brackish or coastal waters, or cover the affected area with a waterproof dressing. In the event of accidental contact with 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: 25 September 2026

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.

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

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

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

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

Last time this event was included in the Weekly CDTR: 25 September 2026

Events under active monitoring

- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo – 2026 - last reported on 25 September 2026
- Expert deployment - last reported on 25 September 2026
- Seasonal surveillance of chikungunya virus disease – 2026 (weekly) - last reported on 25 September 2026
- Seasonal surveillance of dengue in the EU/EEA, weekly report - last reported on 25 September 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (weekly report) - last reported on 25 September 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (weekly report) - last reported on 25 September 2026
- Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters – Bathing season 2026 - last reported on 25 September 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 38, 2026 - last reported on 25 September 2026
- Influenza A(H5)- Multi-country (World)- Monitoring human cases - last reported on 18 September 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring - last reported on 18 September 2026
- Airport malaria in Frankfurt, Germany – 2026 - last reported on 18 September 2026
- Iatrogenic botulism - Denmark - 2026 - last reported on 18 September 2026
- *Aedes aegypti* incursion in East London, United Kingdom, Aug 2026 - last reported on 11 September 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report) - last reported on 11 September 2026