

WEEKLY BULLETIN

Communicable disease threats report

Week 40, 26 September to 2 October 2026

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Executive summary

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

- A healthcare worker based in DRC who tested positive for Bundibugyo virus on 29 September was medically evacuated to the Netherlands to receive specialised care on 1 October.
- On 30 September 2026, the Democratic Republic of the Congo (DRC) reported a total of 8 224 confirmed cases, including 3 982 related deaths (from data up until 29 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.

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

- On 28 September 2026, one laboratory-confirmed human case of avian influenza A(H5N1) virus infection was reported in Oddar Meanchey Province, Cambodia.
- The case involved a man in his forties who was hospitalised. It was confirmed positive on 27 September 2026.
- The patient is a poultry farmer who reportedly had exposure to sick and dead poultry. An outbreak of avian influenza among poultry was confirmed on 23 September 2026.
- The investigation is ongoing to identify the source of infection, including contact tracing.
- Contacts that have been identified received prophylactic treatment with antivirals (oseltamivir).
- No evidence of human-to-human transmission has been detected to date.
- The overall risk related to zoonotic avian influenza due to A(H5N1) virus for the general population in the EU/EEA is considered very low.

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

- Two new laboratory-confirmed human cases of avian influenza A(H9N2) virus infection were reported by the World Health Organization (WHO) in Guangdong and Hunan provinces on 25 September 2026.
- Both cases involved children, with symptom onset on 30 August and 7 September 2026, and both fully recovered without hospitalisation.
- One child had direct exposure to poultry and the other visited a live poultry market.
- 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.

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 and Spain, which reported low activity in primary care settings.
- **SARS-CoV-2** activity is increasing slightly in primary care and has also increased 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 have slightly increased in comparison to last week and mainly concern adults aged over 65 years. Most detections are influenza A viruses.
- **Respiratory syncytial virus (RSV)** activity is low and at expected inter-epidemic levels.

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

- Since the beginning of the 2026 transmission season, and as at 30 September, 202 areas affected by West Nile virus (WNV) have been identified in 16 countries across Europe.
- This week, 16 areas are reported as affected for the first time this season.
- The 16 countries have reported 1 765 locally acquired human cases of WNV infection.

Seasonal surveillance of Crimean-Congo haemorrhagic fever in the EU/EEA – 2026 (weekly report)

- Since the beginning of 2026, and as at 30 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 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 7 October 2026), one municipality in one region in one country is 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.
- This is the last weekly update for the 2026 Summer season. ECDC monitors environmental suitability for *Vibrio* growth in coastal waters during the summer season to assess and communicate potential risks to human health across the EU/EEA. Previous weekly updates related to this topic are available in the [Communicable Disease Threat Report](#) (CDTR).

Seasonal surveillance of dengue in the EU/EEA – 2026 (weekly report)

- Since the beginning of 2026 and as at 30 September 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (59 cases) and France (6 cases).

Seasonal surveillance of chikungunya virus disease in the EU/EEA – 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).

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

- Since 1 January 2026 and as of 28 September 2026, 249 136 cholera cases, including 1 970 deaths, have been reported worldwide.
- Since 26 August 2026 and as of 28 September 2026, 46 153 new cholera cases, including 140 new deaths, have been reported worldwide.
- The five countries reporting most cases between 26 August and 28 September 2026 are Afghanistan (34 378), Democratic Republic of the Congo (DRC) (8 505), Yemen (1 885), Angola (748) and Congo (299).
- The five countries reporting the most new deaths in the same reporting period are DRC (107), Yemen (13), Afghanistan (10), Angola (7) and Congo (5).
- Cholera cases have continued to be reported in Africa, Asia, the Middle East and the Americas. The risk of cholera infection for travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update

- Since the previous update on 31 August 2026, and as of 29 September 2026, no new MERS cases have been reported by the World Health Organization (WHO) or national health authorities.
- Since the beginning of 2026, and as of 29 September 2026, two MERS cases, including one fatality, have been reported in Saudi Arabia.
- The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in this population is also considered to be low. The current MERS-CoV situation remains unchanged and poses a low risk to the EU/EEA.

SARS-CoV-2 variant classification

- Since the last update on 28 August 2026, and as of 25 September 2026, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) or de-escalated variants.
- For this update, sufficient data to estimate variant proportions in the most recent reporting weeks were only available from three EU/EEA countries. Therefore, the statistics below represent a very limited part of the EU/EEA.
- The VOI and VUM median proportions in the EU/EEA for weeks 34–35, 2026 were:
 - BA.2.86 (VOI): 12.0% (range: 0.0–15.4%; interquartile range (IQR): 6.0–13.7%)
 - NB.1.8.1 (VUM): 3.4% (range: 0.0–5.3%; IQR: 1.7–4.3%)
 - XFG (VUM): 53.8% (range: 52.6–65.0%; IQR: 53.2–59.4%)
 - BA.3.2 (VUM): 0.4% (range: 0.0–5.3%; IQR: 0.2–2.8%).

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

- Since the beginning of 2026, and as of September 2026, over two million cases of dengue and over 1 000 dengue-related deaths have been reported globally, according to information from publicly available sources. This is a decrease compared with the same period in 2025.
- In 2026, cases have been reported in the EU/EEA by Italy and France. Cases have also been reported by Martinique, Guadeloupe, Reunion, and by French Guiana (French outermost regions).

Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update

- Since the start of 2026, and as of 30 August 2026 (data available until 30 August), 250 051 chikungunya virus disease (CHIKVD) cases and 87 associated deaths have been detected from 26 countries (not including EU/EEA countries and territories).
- Cases reported in August (29 268 cases) increased compared with July, when 6 748 cases were reported. However, deaths reported in August (two deaths) decreased compared with the previous month, when four deaths were reported.

Carbapenem-resistant Enterobacterales – Multi-country (EU/EEA) – 2025

- New data from a recent European genomic survey of carbapenem-resistant Enterobacterales (CRE) and additional European Antimicrobial Resistance Genes Surveillance Network (EURGen-Net) investigations show a substantially worsening epidemiological situation in the EU/EEA, with an increase of NDM carbapenemases and virulence factors in *Klebsiella pneumoniae*.
- ECDC plans to update its [Rapid risk assessment – Carbapenem-resistant Enterobacterales – third update](#), previously published on 3 February 2025.

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. The deployments are being conducted in close coordination with national authorities, EU delegations, the European Commission and the World Health Organization (WHO).
- Since 22 September, two ECDC experts have been deployed through the Global Outbreak Alert and Responses Network (GOARN), to provide epidemiological support to WHO operations in Bunia, Ituri Province and DRC. The deployments are financed with funds made available by the Directorate-General for European Civil Protection (DG ECHO).
- As of 28 September 2026, one expert is currently deployed to support Africa CDC within the Continental Incident Management Support Team (IMST) in Uganda. This deployment represents the tenth in a series of rotational deployments. 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 (DG INTPA).

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

Overview:**Latest epidemiological information****Democratic Republic of the Congo**

On 30 September 2026, the [Democratic Republic of the Congo \(DRC\)](#) reported a total of 8 224 confirmed cases, including 3 982 related deaths (from data up until 29 September). A total of 851 patients are hospitalised in isolation. This represents an increase of 53 new confirmed cases and 28 deaths since the previous report on 29 September (reporting data up until 28 September). The 53 new cases have been reported from Ituri (32 cases), North Kivu (17 cases), and Haut-Uélé (4 cases).

Among the individuals who tested positive for Bundibugyo virus, 2 121 have recovered. In total, 78.7% of identified case contacts are under follow-up in the affected provinces.

Ituri province remains the most affected, with 6 250 cases, including 2 885 deaths, reported from 28 of 36 health zones. In North Kivu, 1 570 cases, including 931 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, 344 cases, including 144 deaths, have been reported from seven of 13 health zones. In Tshopo, 45 cases, including 16 deaths, have been reported from seven of 23 health zones. In Bas-Uélé, 10 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.

Monitoring medically evacuated and imported cases to/in Europe

- A [healthcare worker based in DRC](#) who tested positive for Bundibugyo virus on 29 September was medically evacuated to the Netherlands to receive specialised care. The patient was admitted to the high-level isolation unit at [Leiden University Medical Center](#) on 1 October.
- 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.
- 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 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 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](#)).

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.

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).

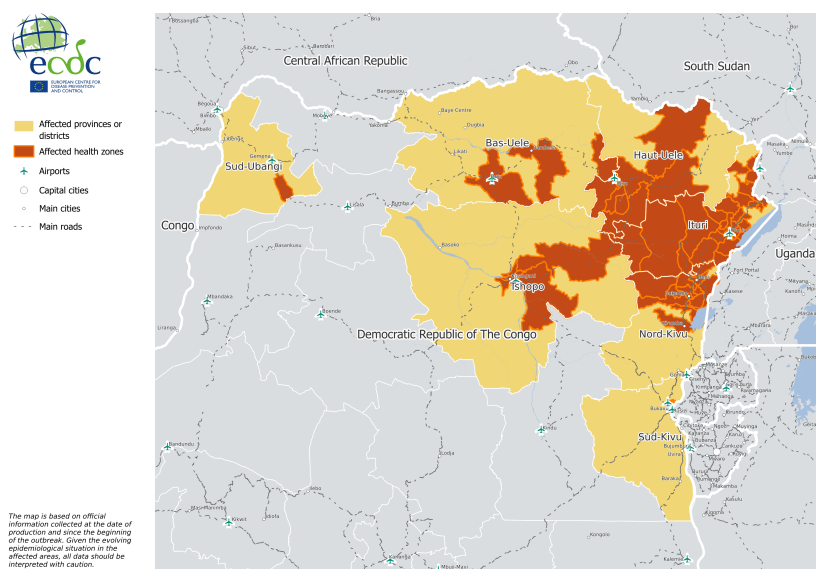
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

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

Maps and graphs

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



Source: ECDC

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

Overview:

Summary

On 27 September 2026, the Ministry of Health of Cambodia reported a laboratory-confirmed human case of avian influenza A(H5N1) in a man in his forties from Trapeang Prasat district, Oddar Meanchey Province, Cambodia.

Infection was confirmed by the National Institute of Public Health and the Institut Pasteur du Cambodge. The patient is a poultry farmer who reportedly had direct contact with sick and dead chickens. The poultry outbreak was confirmed as avian influenza on 23 September 2026 by the National Animal Health and Production Research Institute. The patient is currently hospitalised in isolation and receiving treatment. Public health investigations are ongoing to identify the source of infection, detect additional human cases, and trace contacts. National and sub-national health authorities are working in collaboration with agricultural authorities and local officials. Antiviral prophylaxis (oseltamivir) is being provided to close contacts, and risk communication and health education activities have been implemented in the affected community.

Background

This is the sixth human case of avian influenza A(H5N1) infection reported in Cambodia in 2026. Previously Cambodia reported sporadic human cases between 2003 and 2014, with exposure history to infected poultry or contaminated environments. Human cases re-emerged in 2023. Overall, 40 laboratory-confirmed cases, including 15 deaths (CFR: 37.5%) have been reported in Cambodia.

Since 2003, there have been 1 002 human cases of avian influenza A(H5N1) infection worldwide*, including 478 deaths (CFR: 47.7%). These cases have been reported in 25 countries (Australia (exposure occurred in India), Azerbaijan, Bangladesh, Cambodia, Canada, Chile, China, Djibouti, Ecuador, Egypt, India, Indonesia, Iraq, Laos, Mexico, Myanmar, Nepal, Nigeria, Pakistan, Spain, Thailand, Türkiye, Viet Nam, the United Kingdom (UK), and the United States (US)). To date, no sustained human-to-human transmission has been detected.

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

ECDC assessment:

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

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

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

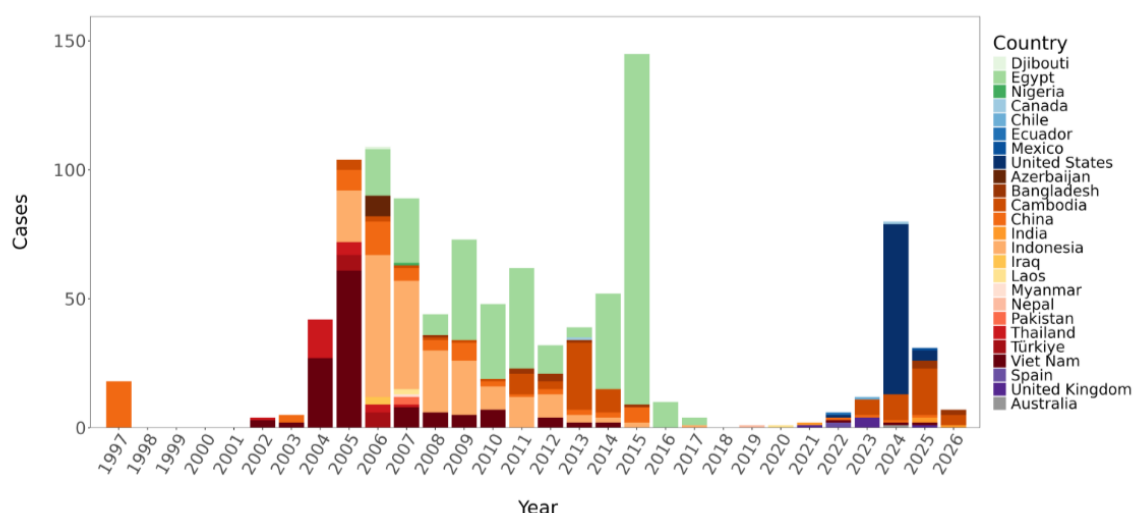
Actions:

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

Last time this event was included in the Weekly CDTR: 17 July 2026

Maps and graphs

Figure 2. Distribution of reported human cases of Influenza A(H5N1) virus infection by year of onset or detection and reporting country, 1997 to 29 September 2026



Source: ECDC

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

Overview:

Summary

Two new laboratory-confirmed human cases of avian influenza A(H9N2) virus infection in China were reported by the WHO Western Pacific Region in the [Avian Influenza Weekly Update Number 1063](#), published on 25 September 2026.

Both cases involved one-year-old children. One child from Guangdong province developed symptoms on 7 September 2026 and another child from Hunan province on 30 August 2026. Direct exposure to poultry was reported for the child from Hunan province, and the child from Guangdong province visited a live poultry market. Both children recovered without requiring hospitalisation and did not receive specific treatment with antivirals. The two cases are not epidemiologically linked.

Background

Since 2015, a total of 183 laboratory-confirmed human cases of avian influenza A(H9N2) virus infection, including two deaths (CFR: 1.0%) have been reported to WHO. Of these, 180 cases were reported from China.

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:

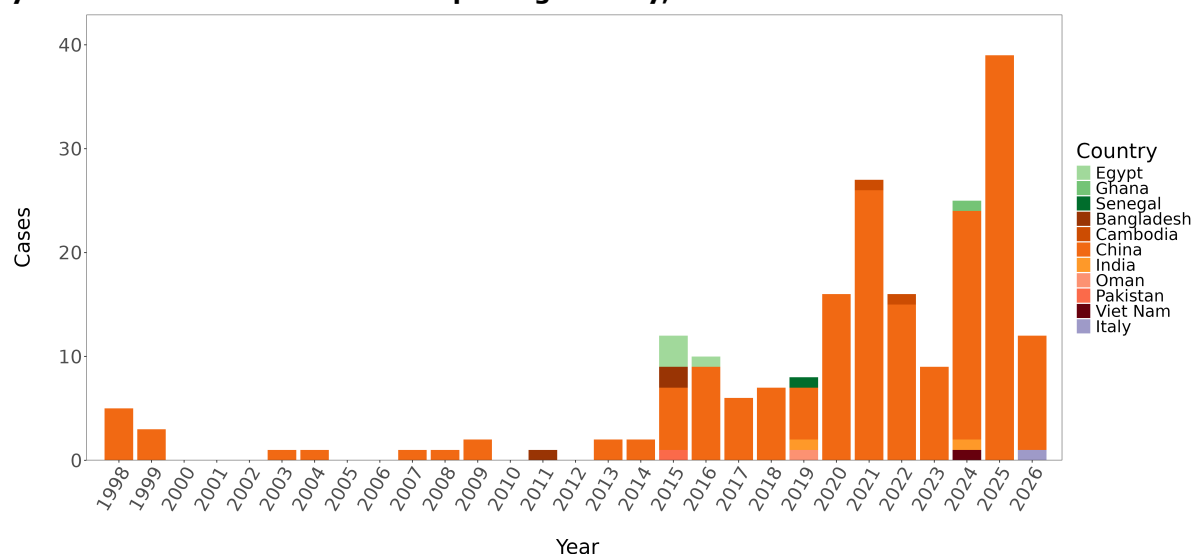
ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities. Together with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza, ECDC produces a [quarterly report on the avian influenza situation](#). The most recent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

Sources: [Event Information Site for IHR National Focal Points](#)

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

Maps and graphs

Figure 3. Distribution of reported human cases of influenza A(H9N2) virus infection by year of onset or detection and reporting country, 1998 to 1 October 2026



Source: ECDC

4. 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](#)), which is updated weekly.

Key visualisation from the weekly bulletin are included below.

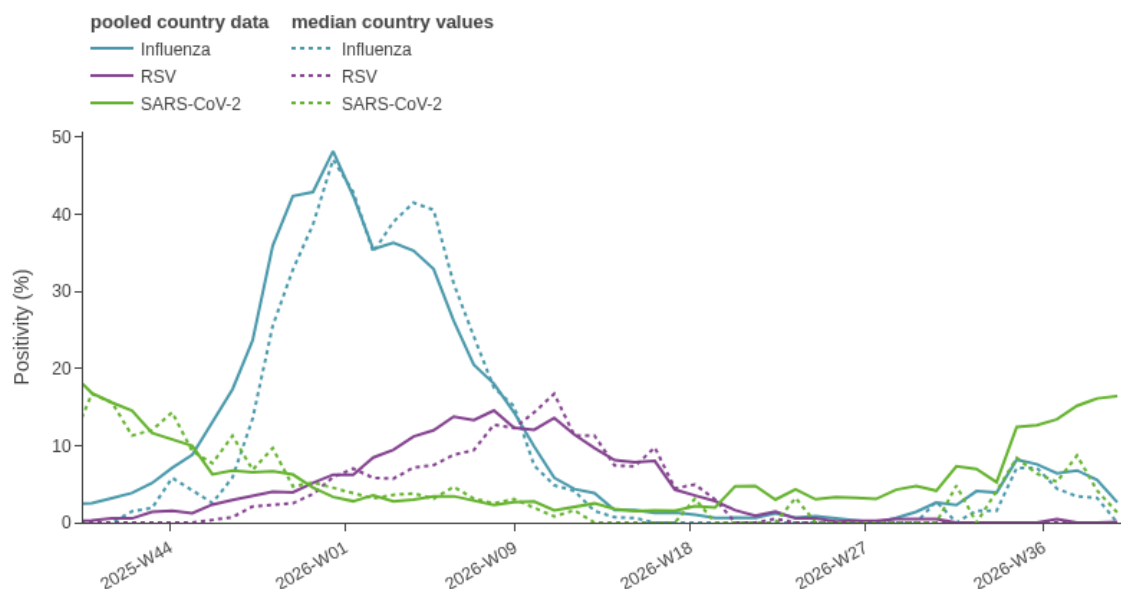
All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

Sources: [ERVISS](#)

Last time this event was included in the Weekly CDTR: 30 September 2026

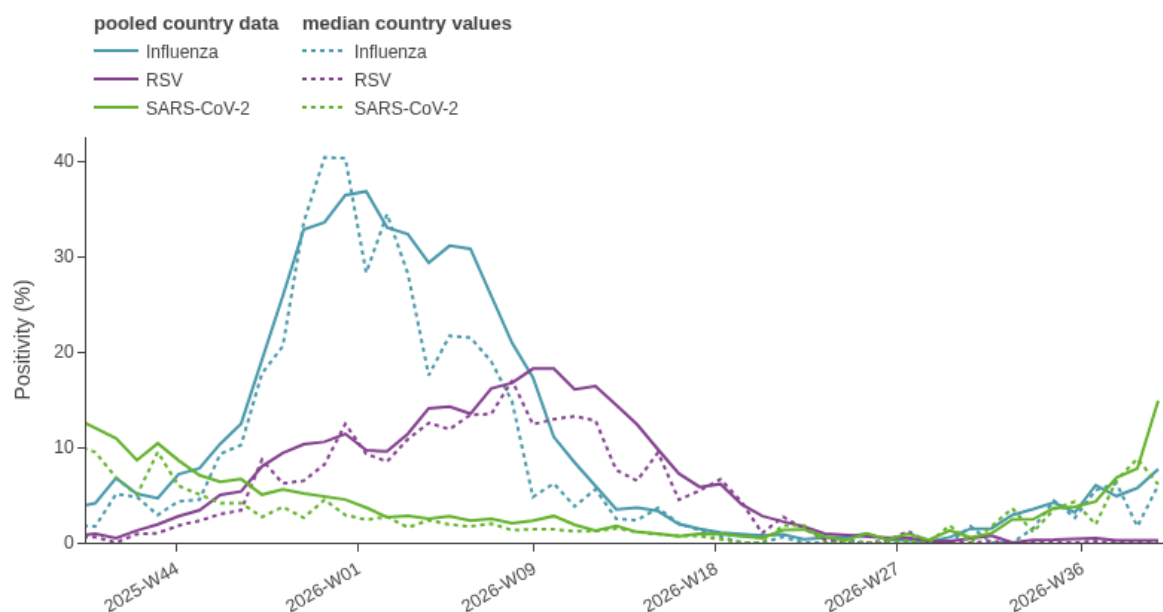
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 6. Key indicators

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary	
		Week 39	Week 38	Description	Value
ILI/ARI consultation rates in primary care	ARI	12 rates (8 MEM)	13 rates (9 MEM)	Distribution of country MEM categories	7 Baseline 1 Low
	ILI	14 rates (13 MEM)	15 rates (14 MEM)		12 Baseline 1 Low
ILI/ARI test positivity in primary care	Influenza	14	13	Pooled (median; IQR)	2.6% (0; 0–2.5%)
	RSV	13	12		0.1% (0; 0–0%)
	SARS-CoV-2	15	13		16% (1.3; 0–6.1%)
SARI rates in hospitals	SARI	8 rates (4 MEM)	10 rates (6 MEM)	Distribution of country MEM categories	4 Baseline
SARI test positivity in hospitals	Influenza	5	7	Pooled (median; IQR)	7.7% (6; 0–6.1%)
	RSV	5	7		0.2% (0; 0–0%)
	SARS-CoV-2	6	8		15% (6.1; 0–8.7%)
Intensity (country-defined)	Influenza	12	12	Distribution of country qualitative categories	11 Baseline 1 Low

Source: ECDC

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

Pathogen	Week 39, 2026		Week 40, 2025 – week 39, 2026	
	N	% ^a	N	% ^a
Influenza	34	–	18104	–
Influenza A	33	97	17492	99
A(H1)pdm09	9	43	4096	28
A(H3)	12	57	10517	72
A (unknown)	12	–	2879	–
Influenza B	1	3	124	0.7
B/Vic	1	100	39	100
B (unknown)	0	–	85	–
Influenza untyped	0	–	488	–
RSV	1	–	5331	–
RSV-A	0	–	936	44
RSV-B	0	–	1192	56
RSV untyped	1	–	3203	–
SARS-CoV-2	312	–	5548	–

Source: ECDC

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

Pathogen	Week 39, 2026		Week 40, 2025 – week 39, 2026	
	N	% ^a	N	% ^a
Influenza	34	–	16010	–
Influenza A	31	100	7833	99
A(H1)pdm09	0	0.0	1336	35
A(H3)	6	100	2510	65
A (unknown)	25	–	3987	–
Influenza B	0	0.0	69	0.9
B/Vic			11	100
B (unknown)	0	–	58	–
Influenza untyped	3	–	8108	–
RSV	1	–	7225	–
RSV-A			1160	52
RSV-B			1065	48
RSV untyped	1	–	5000	–
SARS-CoV-2	66	–	3366	–

Source: ECDC

Figure 9. Genetically characterised influenza virus distribution, week 40, 2025 – week 39, 2026

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

Source: ECDC

Figure 10. SARS-CoV-2 variant distribution, week 37, 2026 – week 38, 2026

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	17	13% (13–13%)
XFG	VUM	1	86	68% (68–68%)
NB.1.8.1	VUM	1	4	3% (3–3%)
BA.3.2	VUM	0	0	0%

Source: ECDC

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

Overview:

Since the beginning of the 2026 transmission season, and as at 30 September, 202 areas affected by West Nile virus (WNV) have been identified in 16 countries across Europe.

These areas are located in Italy (67), France (25), Greece (24), Romania (24), the Netherlands (15), Serbia (10), Spain (6), Belgium (5), Croatia (5), North Macedonia (5), Hungary (4), Kosovo* (4), Austria (3), Germany (3), Albania (1) and Cyprus (1).

The 16 countries have reported 1 765 locally acquired human cases of WNV infection.

This week, 16 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 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

6. Seasonal surveillance of Crimean-Congo haemorrhagic fever in the EU/EEA – 2026 (weekly report)

Overview:

Since the beginning of 2026, and as at 30 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

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 7 October 2026), one municipality in one region in one country is expected to have high environmental suitability* for *Vibrio* spp.:

France: one municipality in one region:

- **Bouches-du-Rhône:** Arles

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 septicæmia 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 monitored the environmental suitability for *Vibrio* spp. growth in coastal waters during the summer season to assess and communicate potential risks to human health across the EU/EEA. Previous weekly updates related to this topic are available in the [Communicable Disease Threat Report](#) (CDTR).

This is the final seasonal update on this topic in the CDTR. ECDC will continue monitoring through its epidemic intelligence activities. The [Vibrio Viewer](#) remains available for information on environmental suitability of *Vibrio* spp. growth in coastal areas in the EU/EEA.

ECDC also provides 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. Seasonal surveillance of dengue in the EU/EEA – 2026 (weekly report)

Overview:

Since the beginning of 2026, and as at 30 September 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (59 cases) and France (6 cases).

Since last week's update, Italy reported 12 new locally acquired dengue cases. The cumulative number of locally acquired cases in Italy is 59, distributed across nine clusters, two of which are newly identified: one in the Firenze NUTS 3 region (Firenze) and one in the Vicenza NUTS 3 region (Cartigliano). All clusters are currently active.

One new locally acquired dengue case has been reported by France since last week's update. The cumulative number of locally acquired cases in France is six, 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

9. Seasonal surveillance of chikungunya virus disease in the EU/EEA – 2026 (weekly)

Overview:

Since the beginning of 2026 and as at 30 September 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (124 cases) and Italy (1 case).

Since last week's update, France reported 34 new locally acquired chikungunya virus disease cases, including 18 in the municipality of Prayssac (Lot department), bringing the total to 124 cases. These cases are distributed across 19 clusters, with six new clusters identified. Seventeen 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: 30 September 2026

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

Overview:

Update

Since 26 August 2026 and as of 28 September 2026, 46 153 new cholera cases, including 140 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Bangladesh, Congo, DRC, Haiti, Mozambique, Pakistan, Somalia, Yemen and Zambia. The five countries reporting the most cases are Afghanistan (34 378), DRC (8 505), Yemen (1 885), Angola (748) and Congo (299).

New deaths have been reported from Afghanistan, Angola, Congo, DRC, Mozambique, South Sudan, Yemen and Zambia. The five countries reporting the most new deaths are DRC (107), Yemen (13), Afghanistan (10), Angola (7) and Congo (5).

In the previous reporting period (27 July to 26 August 2026), 42 717 new cholera cases, including 257 new deaths, were reported worldwide.

In addition, 2 080 new cases were reported or collected retrospectively from before 26 August 2026.

Since 1 January 2026 and as of 28 September 2026, 249 136 cholera cases, including 1 970 deaths, have been reported worldwide. In comparison, since 1 January 2025 and as of 28 September 2025, 436 268 cholera cases, including 4 449 deaths, were reported worldwide.

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

Asia:

Afghanistan: Since 20 July 2026 and as of 14 September 2026, 34 378 new cases, including 10 new deaths have been reported. Since 1 January 2026 and as of 14 September 2026, 115 346 cases, including 55 deaths have been reported. In comparison, in 2025 and as of 15 September 2025, 129 325 cases, including 64 deaths, were reported.

Bangladesh: Since 28 December 2025 and as of 31 August 2026, 24 new cases have been reported. Since 1 January 2026 and as of 31 August 2026, 24 cases have been reported. In comparison, in 2025 and as of 1 September 2025, 67 cases were reported.

Pakistan: Since 6 July 2026 and as of 24 August 2026, 2 000 new cases have been reported. Since 1 January 2026 and as of 24 August 2026, 6 353 cases have been reported. In comparison, in 2025 and as of 21 July 2025, 14 760 cases were reported.

Yemen: Since 29 June 2026 and as of 7 September 2026, 1 885 new cases, including 13 new deaths have been reported. Since 1 January 2026 and as of 7 September 2026, 7 328 cases, including 20 deaths, have been reported. In comparison, in 2025 and as of 8 September 2025, 76 347 cases, including 216 deaths, were reported.

Since 26 August 2026, no updates have been reported by: India, Myanmar/Burma, Taiwan and the Province of China.

Africa:

Angola: Since 9 August 2026 and as of 13 September 2026, 748 new cases, including 7 new deaths, have been reported. Since 1 January 2026 and as of 13 September 2026, 6 651 cases, including 127 deaths, have been reported. In comparison, in 2025 and as of 4 August 2025, 27 666 cases, including 773 deaths, were reported.

Congo: Since 9 August 2026 and as of 13 September 2026, 299 new cases, including 5 new deaths, have been reported. Since 1 January 2026 and as of 13 September 2026, 988 cases, including 65 deaths, have been reported. In comparison, in 2025 and as of 4 August 2025, 187 cases, including 21 deaths, were reported.

Democratic Republic of The Congo: Since 9 August 2026 and as of 13 September 2026, 8 505 new cases, including 107 new deaths, have been reported. Since 1 January 2026 and as of 13 September 2026, 41 687 cases, including 1 050 deaths, have been reported. In comparison, in 2025 and as of 8 July 2025, 32 456 cases, including 737 deaths, were reported.

Mozambique: Since 9 August 2026 and as of 13 September 2026, 116 new cases, including 1 new death, have been reported. Since 1 January 2026 and as of 13 September 2026, 7 814 cases, including 66 deaths, have been reported. In comparison, in 2025 and as of 4 August 2025, 4 167 cases, including 43 deaths, were reported.

Somalia: Since 9 August 2026 and as of 13 September 2026, 121 new cases have been reported. Since 1 January 2026 and as of 13 September 2026, 2 778 cases, including 1 death, have been reported. In comparison, in 2025 and as of 25 August 2025, 7 484 cases, including 9 deaths, were reported.

South Sudan: Since 20 July 2026 and as of 13 September 2026, no new cases, including a retrospective correction of six deaths less, have been reported. Since 1 January 2026 and as of 13 September 2026, 457 cases have been reported. In comparison, in 2025 and as of 4 August 2025, 67 064 cases, including 1 142 deaths, were reported.

Zambia: Since 9 August 2026 and as of 13 September 2026, 77 new cases, including 3 new deaths, have been reported. Since 1 January 2026 and as of 13 September 2026, 1 074 cases, including 19 deaths, have been reported. In comparison, in 2025 and as of 8 July 2025, 463 cases, including 9 deaths, were reported.

Since 26 August 2026, no updates have been reported by: Burundi, Cameroon, Central African Republic, Chad, Ethiopia, Kenya, Malawi, Namibia, Nigeria, Rwanda, South Africa, Sudan, United Republic of Tanzania or Zimbabwe.

Americas:

Haiti:

Since 8 June 2026 and as of 3 July 2026, 80 new cases have been reported. Since 1 January 2026 and as of 3 July 2026, 722 cases, including 2 deaths, have been reported. In comparison, in 2025 and as of 23 June 2025, 2 496 cases, including 31 deaths, were reported.

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

ECDC assessment:

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

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

In the EU/EEA, cholera is rare and primarily associated with travel to endemic countries. Since 2025, only events of locally acquired cholera cases are reported at the EU/EEA level; however, imported and locally acquired cholera cases are reported to the World Health Organization (WHO) on an annual basis. In 2024, 16 imported cases were reported by eight EU/EEA countries, while 12 were reported in 2023, 29 in 2022, two in 2021, and none in 2020. In 2019, 25 cases were reported in EU/EEA countries (including the United Kingdom). All cases had a travel history to cholera-affected areas.

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

Actions:

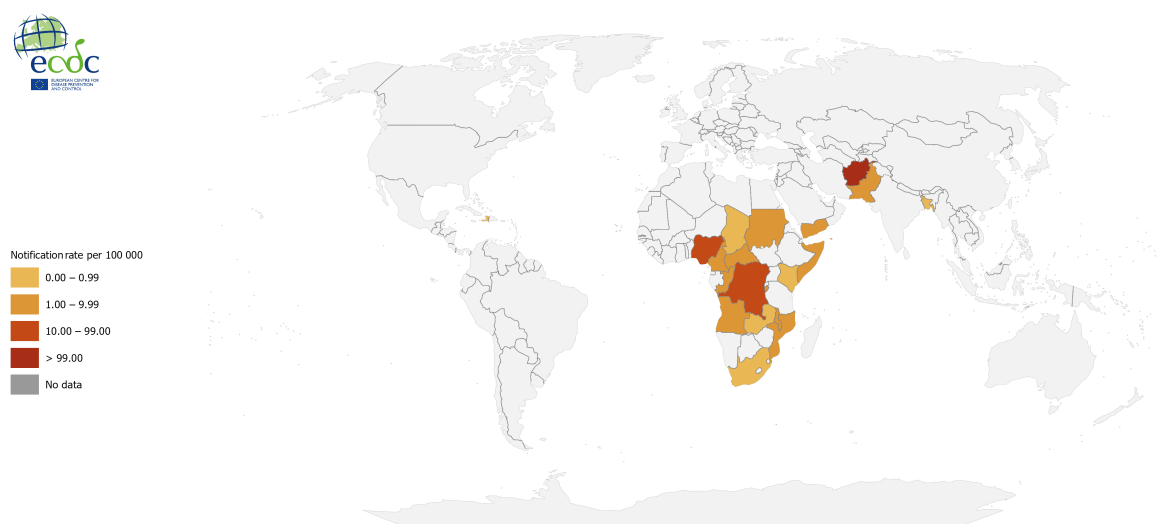
ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities.

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

Last time this event was included in the Weekly CDTR: 28 August 2026

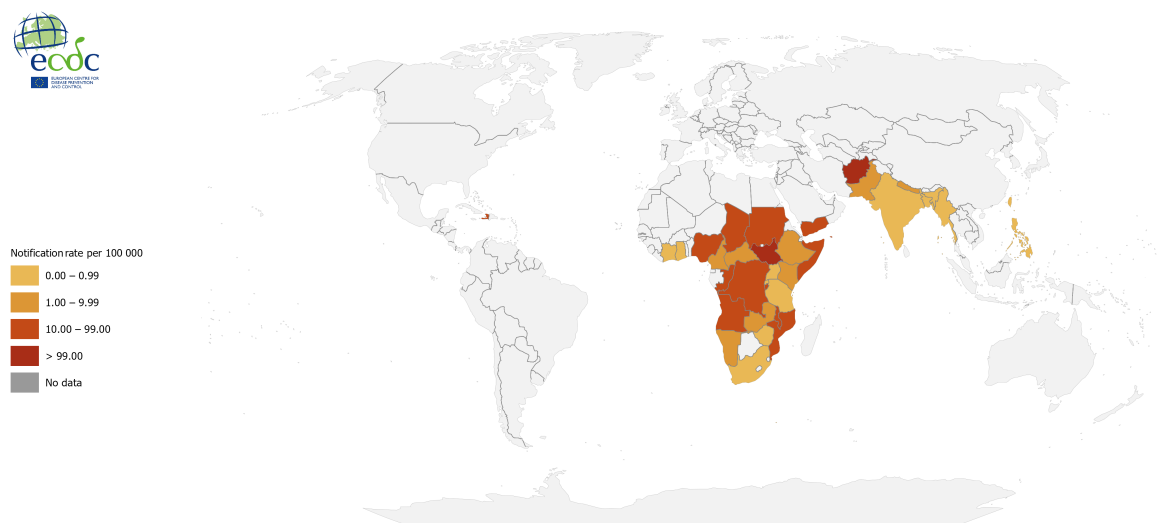
Maps and graphs

Figure 11. Geographical distribution of cholera cases reported worldwide, July 2026 to September 2026



Administrative boundaries: ©EuroGeographics ©UN-FAO. The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union. Map produced by ECDC on 28 September 2026.

Source: ECDC

Figure 12. Geographical distribution of cholera cases reported worldwide, September 2025 to August 2025

Administrative boundaries: ©EuroGeographics GUN-FAO. The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union. Map produced by ECDC on 28 September 2026.

Source: ECDC

11. Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update

Overview:

Update

Since the previous update on 31 August 2026, and as of 29 September 2026, no new MERS cases have been reported by WHO or national health authorities.

Summary

Since the beginning of 2026, and as of 29 September 2026, two MERS cases, including one fatality, have been reported in Saudi Arabia. No information is available on the regions in Saudi Arabia affected by these cases.

Since April 2012, and as of 29 September 2026, a total of 2 649 MERS cases, including 960 deaths, have been reported by health authorities worldwide.

Sources: [ECDC MERS-CoV page](#) | [WHO MERS-CoV](#) | [ECDC factsheet for professionals](#) | [Qatar MoPH Case #1](#) | [Qatar MoPH Case #2](#) | [FAO MERS-CoV situation update](#) | [WHO DON Oman](#) | [WHO DON Saudi Arabia](#) | [WHO DON UAE](#) | [WHO DON Saudi Arabia 1](#) | [WHO IHR](#) | [WHO EMRO MERS Situation report](#) | [WHO DON Saudi Arabia 2](#) | [WHO DON Saudi Arabia 3](#) | [WHO DON Saudi Arabia 4](#) | [WHO DON Saudi Arabia 5](#) | [MERS-CoV Dashboard](#) | [French Ministry of Health](#) | [WHO DON France & Saudi Arabia](#)

ECDC assessment:

Human MERS cases continue to be reported in the Arabian Peninsula. However, the number of new cases detected and reported through surveillance has dropped to the lowest level since 2014. The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in this population is considered low. The current MERS-CoV situation remains unchanged and poses a low risk to the EU/EEA, as stated in the [Rapid Risk Assessment](#) published by ECDC on 29 August 2018.

In October 2019, ECDC published a technical report, '[Health emergency preparedness for imported cases of high-consequence infectious diseases](#)' that is still useful for EU/EEA countries that would like to assess their level of preparedness for a disease such as MERS. ECDC also published '[Risk assessment guidelines for infectious diseases transmitted on aircraft \(RAGIDA\) – Middle East respiratory syndrome coronavirus \(MERS-CoV\)](#)' on 22 January 2020.

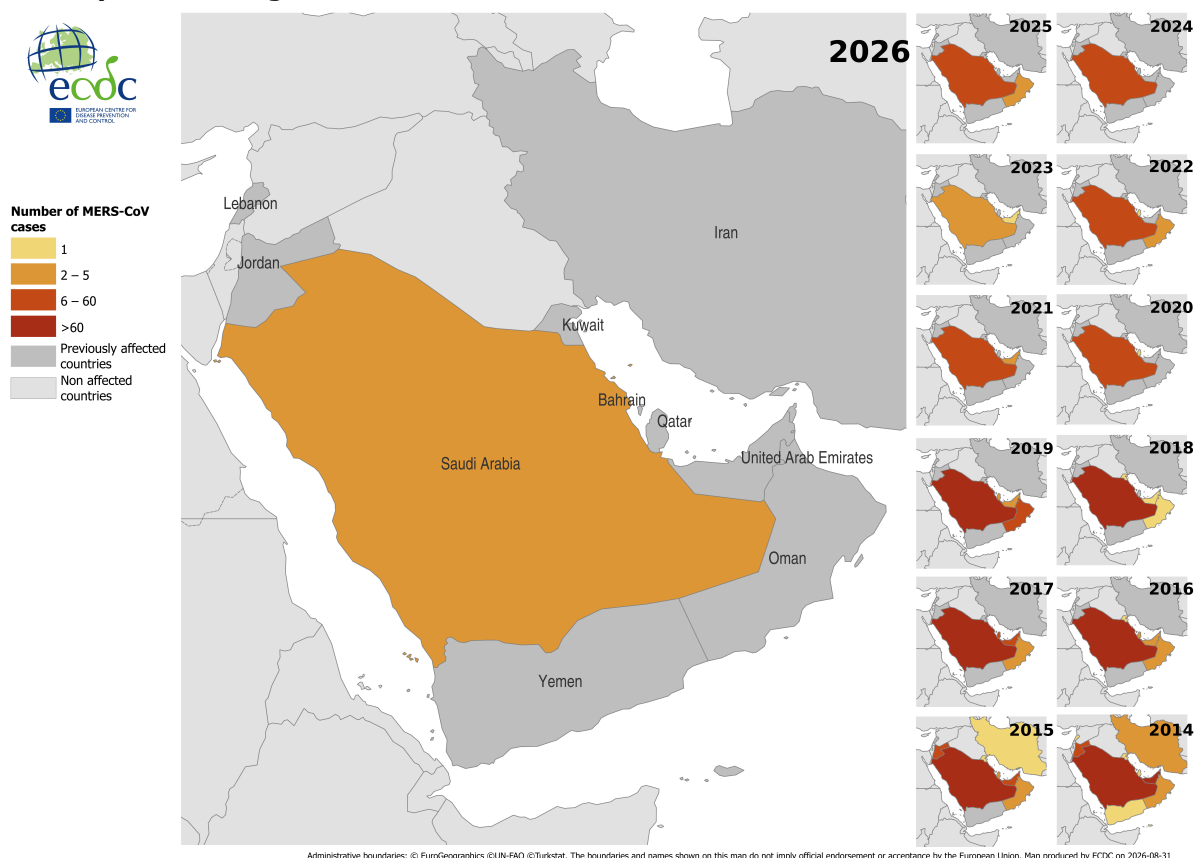
Actions:

ECDC is monitoring this situation through its epidemic intelligence activities and reports on a monthly basis or when new epidemiological information is available.

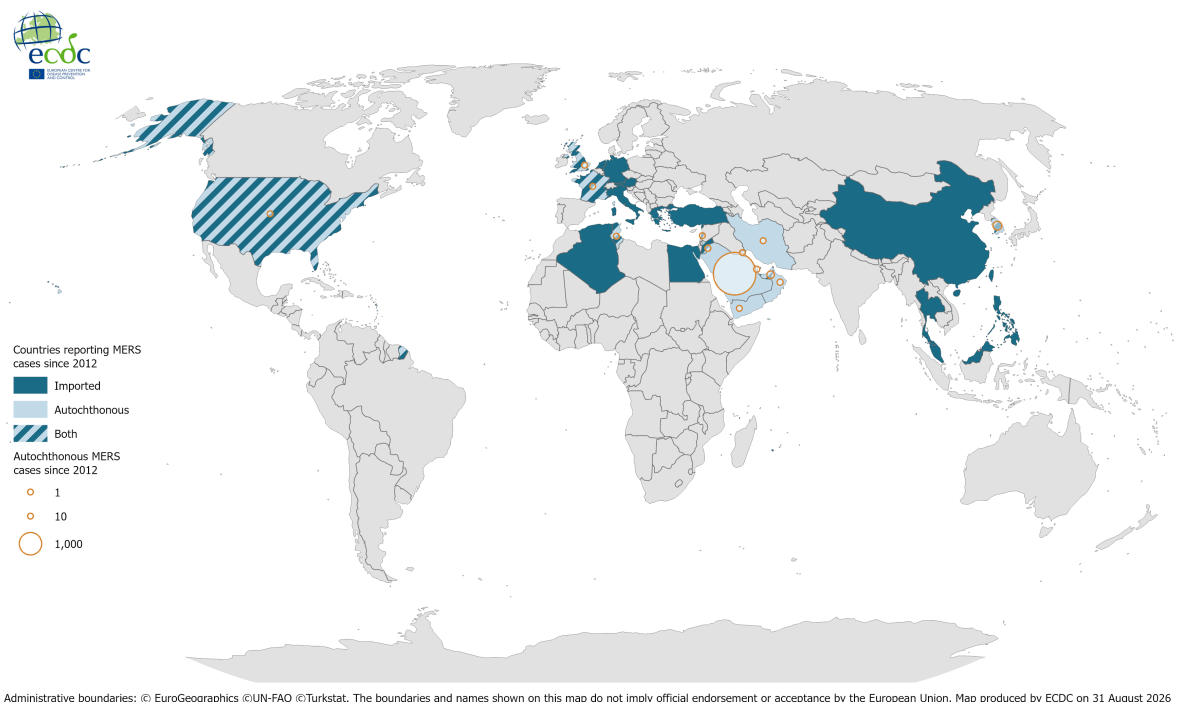
Last time this event was included in the Weekly CDTR: 30 September 2026

Maps and graphs

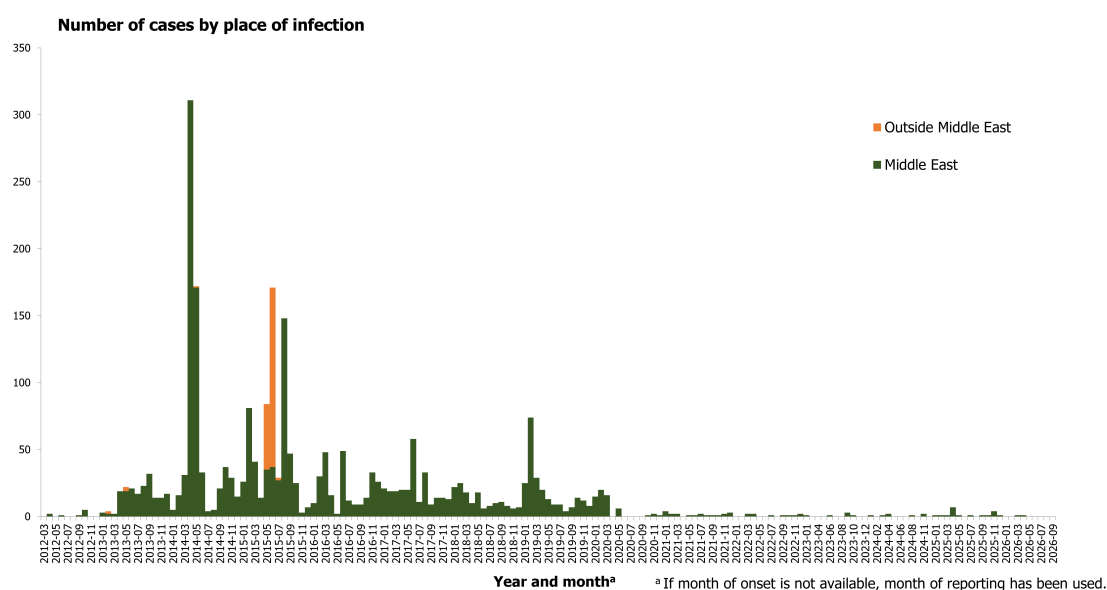
Figure 13. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2014 to August 2026



Source: ECDC

Figure 14. Geographical distribution of confirmed cases of MERS-CoV by reporting country, April 2012 to August 2026

Source: ECDC

Figure 15. Distribution of confirmed cases of MERS by place of infection and month of onset, April 2012 to September 2026

Source: ECDC

12. SARS-CoV-2 variant classification

Overview:

Since the last update on 28 August 2026, and as of 25 September 2026, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) or de-escalated variants.

VOI median proportions in the EU/EEA for weeks 34–35, based on three reporting countries:

- BA.2.86 (VOI): 12.0% (range: 0.0–15.4%; IQR: 6.0–13.7%).

VUM median proportions in the EU/EEA for weeks 34–35 2026, based on three reporting countries:

- NB.1.8.1 (VUM): 3.4% (range: 0.0–5.3%; IQR: 1.7–4.3%)
- XFG (VUM): 53.8% (range: 52.6–65.0%; IQR: 53.2–59.4%)
- BA.3.2 (VUM): 0.4% (range: 0.0–5.3%; IQR: 0.2–2.8%).

The calculations are based on data reported to GISAID, as of 20 September 2026. It should be noted that for this update, sufficient data to estimate variant proportions in the most recent reporting weeks were only available from three EU/EEA countries. The statistics therefore only represent a very limited part of the EU/EEA.

ECDC assessment:

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation.

The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. Compared with previously circulating variants, the variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity, or a reduction in vaccine effectiveness against severe disease. However, older adults (65 years old and above), those with underlying conditions, and people who have previously not been infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of people at high risk of severe outcomes (e.g. older adults) remains important.

Actions:

In order to assess the impact of emerging SARS-CoV-2 sub-lineages and their possible correlation with increases in COVID-19 epidemiological indicators, it is important that countries sequence positive clinical specimens and report to GISAID and/or TESSy.

For the latest update on SARS-CoV-2 variant classifications, please see [ECDC's webpage on variants](#). Variant surveillance data, including the distribution of VOC and VOI proportions in the EU/EEA and detailed country-specific COVID-19 updates, are available as part of the [European Respiratory Virus Surveillance Summary \(ERVISS\)](#).

Routine updates on the SARS-CoV-2 variant classification will be provided on a monthly basis through the Communicable Diseases Threats Report (CDTR) as a minimum.

Last time this event was included in the Weekly CDTR: 04 September 2026

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

Overview:

Since the beginning of 2026, and as of September 2026, over two million cases of dengue and over 1 000 dengue-related deaths have been reported globally, according to information from publicly available sources. This is a decrease compared with the same period in 2025 ([Communicable disease threats report, 4-10 October 2026](#)).

Epidemiological overview

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

EU/EEA

Since the beginning of 2026, and as of September 2026, France and Italy have reported locally acquired dengue transmission. For more information on locally acquired dengue cases reported in the EU/EEA, excluding France's outermost regions, please visit the [dedicated ECDC website](#).

For the EU/EEA's outermost regions, a summary of recent trends is as follows:

- **Martinique, Guadeloupe and Saint Martin:** In Martinique, dengue activity remained low as of early September 2026. The epidemiological situation was stable with isolated clusters. From 31 August to 6 September 2026, eight confirmed dengue cases were reported. In Guadeloupe, dengue circulation also remained low, with sporadic cases. In Saint Martin, no confirmed dengue cases were identified during the previous four weeks, and the situation has remained calm since May 2026. ([Santé publique France, Dengue aux Antilles. Bulletin du 10 septembre 2026](#)).
- **La Réunion:** Dengue transmission remained at a low level, with sporadic cases only. A total of 341 confirmed dengue cases were reported since the beginning of 2026 and as of 30 August. According to the bulletin published on 18 September 2026, dengue activity remains low with sporadic cases and no evidence of sustained dengue transmission ([Surveillance sanitaire à La Réunion. Bulletin du 4 septembre 2026](#); [Surveillance sanitaire à La Réunion. Bulletin du 18 septembre 2026](#), [Surveillance sanitaire à La Réunion. Bulletin du 25 septembre 2026](#)).
- **French Guiana:** Dengue activity remained low as of 13 September 2026 ([Santé publique France, Chikungunya et dengue en Guyane. Bulletin du 17 septembre 2026](#)).

Americas

In the Americas, as of week 35 2026 (ending 30 August), 1 658 783 dengue cases have been reported; of these, 30% were laboratory confirmed, according to [the WHO PAHO report published on 25 September 2026](#). The current number of reported cases is 57% lower than during the same period in 2025 and 64% lower than the five-year average. While all four serotypes have been reported in the region to date in 2026, their distribution varies across the different PAHO countries ([Report on the epidemiological situation of dengue in the Americas](#)). In 2026, and as of week 36, most cases have been reported by Brazil (1 294 963), Colombia (79 304), Bolivia (58 628), Peru (55 943), and Mexico (50 819) ([Dengue: analysis by country - PAHO/WHO | Pan American Health Organization](#); accessed 28 September 2026).

South-East Asia

According to the [WHO South-East Asia Region Epidemiological Bulletin, 19th edition, 23 September 2026](#) and earlier 2026 bulletins, dengue has been reported in Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste since July 2025.

For South-East Asia, a summary of available information on epidemiological trends is as follows:

- **Bangladesh:** Bangladesh has experienced an increase in dengue activity since early July 2026. Between 14 and 20 September, 10 135 suspected cases were reported, 10% more than between 7 and 13 September (9 247) and 1.6 times the number reported in the corresponding week of 2025 (3 940). Thirty-five dengue-related deaths were reported in week 38, compared with 32 in week 37. ([WHO South-East Asia Region Epidemiological Bulletin, 19th edition, 23 September 2026](#); [Bangladesh DGHS Health Emergency Operations Centre Dengue Dashboard](#)).
- **India:** India reported increasing dengue activity during the first half of 2026, at levels comparable to 2025. As of August 2026, 46 670 cases were reported, while 49 553 were reported during the same period in 2025 ([WHO South-East Asia Region Epidemiological Bulletin, 19th edition, 23 September 2026](#)).
- **Maldives:** The most recent country-specific information identified in the SEARO bulletins was published on 3 June 2026. More than 100 cases had been reported weekly since January, with week-to-week fluctuations, and the weekly totals exceeded the expected seasonal baseline. More than 2 900 cases had been reported by week 21 (ending 24 May), above the level observed during the same period in 2025 ([WHO South-East Asia Region Epidemiological Bulletin, 11th edition, 3 June 2026](#); [WHO SEAR Epidemiological Bulletins](#)).
- **Nepal:** Dengue activity shows an increasing trend since May 2026. In August 2026, 1 776 cases were reported, which is a 93.5% increase compared with the 918 cases reported in July ([WHO South-East Asia Region Epidemiological Bulletin, 19th edition, 23 September 2026](#)).
- **Sri Lanka:** Sri Lanka has reported a high dengue burden in 2026. As of 27 September, 100 127 cases had been reported. July was the peak month, with 29 964 cases, followed by 10 155 cases in August and 4 637 cases between 1 and 27 September. The Western Province accounted for 52.5% of reported cases, with Gampaha and Colombo the most affected districts ([Sri Lanka National Dengue Control Unit, Daily Update, 27 September 2026](#); [WHO South-East Asia Region Epidemiological Bulletin, 19th edition, 23 September 2026](#)).
- **Thailand:** Thailand continues to report seasonal dengue transmission, with fluctuating weekly activity. Available 2026 reports indicate that cumulative activity remained below the corresponding level in 2025, despite increases reported earlier in the year. From 14 to 20 September, 560 cases were reported, which is 48% less compared with the cases reported the week before and 47% less compared with the cases reported the same week in 2025 ([WHO South-East Asia Region Epidemiological Bulletin, 19th edition, 23 September 2026](#); [WHO SEAR Epidemiological Bulletins](#)).
- **Timor-Leste:** Monthly cases have decreased since April and as of July in Timor-Leste; 83 cases were reported in June compared with 126 in May. Although cumulative activity was higher than during the corresponding period in 2025, the trend had been decreasing after increases earlier in the year ([WHO South-East Asia Region Epidemiological Bulletin, 14th edition, 15 July 2026](#)).

Western Pacific Region

In the WHO Western Pacific Region, dengue transmission continues to be reported by several countries and territories, according to [WHO WPRO Dengue Situation Update #754 \(17 September 2026\)](#). Cambodia, Malaysia and Viet Nam report increasing trends compared with previous years, with some fluctuations.

For the Western Pacific Region, a summary of available information from the WHO WPRO report and national surveillance systems on ongoing trends are summarised as follows:

- **Cambodia:** High dengue activity continues to be reported in Cambodia. As of 6 September 2026, a total of 85 920 dengue cases, including 104 deaths, have been reported. This is a 120% increase compared with the same period in 2025 (39 063 cases). A sustained increasing trend was recorded since week 23 with a slight decrease in week 36. Overall, according to the WHO report, transmission remained well above the epidemic threshold ([WHO WPRO Dengue Situation Update #754: 17 September 2026](#)).
- **China:** Overall, 836 dengue cases were reported in August 2026 in China, compared with 1 120 cases in July 2026. The number of cases reported in August 2026 remained under the levels observed during the same period in 2025, representing a 50.9% decrease compared with August 2025 (1 702 cases) ([WHO WPRO Dengue Situation Update #754: 17 September 2026](#)).

- **Indonesia:** A decreasing trend in dengue activity continues to be reported in Indonesia. As of August 2026, a cumulative total of 79 144 cases and 214 deaths have been reported nationwide. The monthly number of reported cases has steadily decreased since January 2026, with 67 cases (no deaths) reported in August ([WHO WPRO Dengue Situation Update #754: 17 September 2026](#)).
- **Laos:** Overall, 263 dengue cases were reported in Laos between 6 and 12 September 2026, compared to 269 cases the previous week. Cumulatively, 4 577 cases have been reported in 2026 as of 12 September. This is a 44.1% decrease compared with the 8 193 cases reported during the same period in 2025 ([WHO WPRO Dengue Situation Update #754: 17 September 2026](#)).
- **Malaysia:** Elevated dengue transmission was reported in Malaysia, despite recent decreases in case numbers. In epidemiological week 34 (23–29 August 2026), 2 585 new dengue cases and two deaths were reported. Weekly case numbers have shown an overall increasing trend since week 12 and remain above both 2025 levels and the five-year median. As of week 34, a cumulative total of 63 752 cases and 60 deaths have been reported in 2026 ([WHO WPRO Dengue Situation Update #754: 17 September 2026](#)).
- **Singapore:** A total of 87 dengue cases were reported between 30 August and 5 September 2026 in Singapore. Although overall dengue activity remains relatively low, the number of cases reported this year so far is 70.6% higher than in the same period in 2025 (51 cases). Cumulatively, 2 265 dengue cases have been reported in 2026 as of 10 September ([WHO WPRO Dengue Situation Update #754: 17 September 2026](#)).
- **Viet Nam:** Increases in dengue activity have been reported in Viet Nam. From 31 August to 6 September 2026, 7 061 cases were reported. This is a 7.6% increase compared with the average from the previous four weeks. As of 6 September, 115 967 cases and 16 deaths have been reported nationwide in 2026, a 41.7% increase compared with the same period in 2025 (81 841 cases). The southern region is the most affected areas, with approximately 73% of all reported cases ([WHO WPRO Dengue Situation Update #754: 17 September 2026](#)).
- **French Polynesia:** Low dengue activity was reported in French Polynesia. One new dengue case was reported between 31 August and 6 September 2026. Since the beginning of 2026, 38 confirmed dengue cases have been reported ([WHO WPRO Dengue Situation Update #754: 17 September 2026](#)).
- **New Caledonia:** Two additional dengue cases were reported in New Caledonia between 31 August and 6 September 2026, bringing the cumulative total for 2026 to 2 234 cases. Weekly case numbers have remained low in recent weeks, indicating continued declining transmission following the earlier outbreak. Most cases reported in 2026 (2 229 cases) were locally acquired ([WHO WPRO Dengue Situation Update #754: 17 September 2026](#)).

Africa

According to [the Africa CDC Epidemic Intelligence Report of 30 August 2026](#), a total of 4 170 cases have been reported on the continent from the Central African Republic (1), Kenya (1 583), Mali (2 308), Mauritania (110), Nigeria (95) and Senegal (73).

Note: the data presented in this report originate from both official public health authorities and non-official sources, such as news media, and depending on the source, autochthonous and non-autochthonous cases may be included. Data completeness depends on the availability of reports from surveillance systems and their accuracy, which varies between countries. All data should be interpreted with caution and comparisons, particularly across countries, should be avoided due to under-reporting, variations in surveillance system structure, different case definitions from country to country and over time, and use of syndromic definitions.

ECDC assessment:

Since the beginning of 2026 and as of September 2026, in the EU/EEA (excluding outermost regions), France and Italy have reported locally acquired cases of dengue.

The likelihood of onward transmission of dengue virus in mainland Europe is linked to importation of the virus by viraemic travellers into receptive areas with established and active competent mosquito vectors (e.g. *Aedes albopictus* and *Aedes aegypti*). The *Aedes albopictus* mosquito is established in a large part of Europe. In Europe and neighbouring areas, the *Aedes aegypti* mosquito is established in Cyprus, on the eastern shores of the Black Sea, and in the outermost region of Madeira.

For the risk related to dengue in mainland EU/EEA, please see ECDC's [dengue risk assessment for mainland EU/EEA](#).

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

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

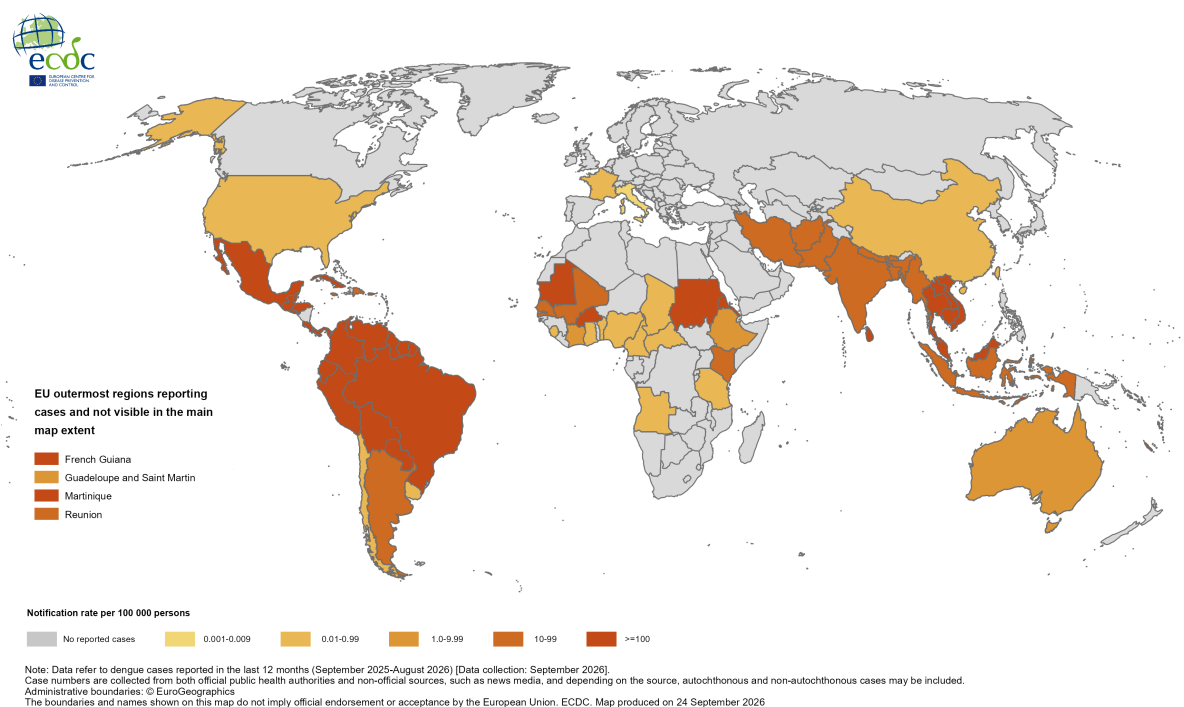
Actions:

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

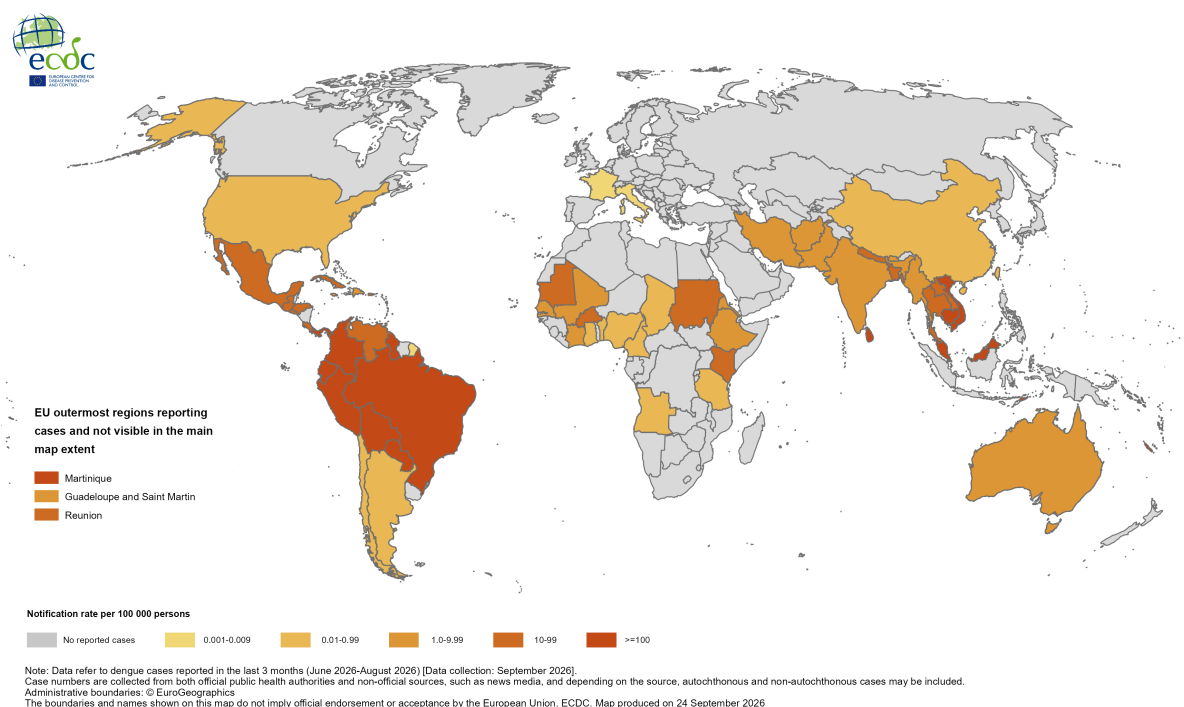
Last time this event was included in the Weekly CDTR: 7 August 2026

Maps and graphs

Figure 16. Twelve-month dengue virus disease case notification rate per 100 000 population, September 2025 to August 2026



Source: ECDC

Figure 17. Three-month dengue virus disease case notification rate per 100 000 population, June to August 2026

Source: ECDC

14. Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update

Overview:

Monthly update overview

Since the previous update (data collection period 3–5 August, data available up to 28 July) and as of 30 August (data collection period 22–24 September, data available up to 30 August), 29 268 chikungunya virus disease (CHIKVD) cases and two associated deaths have been detected in nine countries, excluding EU/EEA countries and territories. Cases reported in August (29 268 cases) increased compared with July, when 6 748 cases were reported. However, deaths reported in August (two deaths) decreased compared with the previous month, when four deaths were reported. In 2026, a total of 250 051 CHIKVD cases has been reported and 87 associated deaths.

Epidemiological overview

In 2026, several countries have ongoing CHIKVD outbreaks. Of these, the majority are in the Americas. Below is a description of ongoing outbreaks:

Americas

In 2026, there have been 197 497 CHIKVD cases and 87 associated deaths reported in the region. The most affected subcontinental region is South America, with Brazil reporting the highest number of cases in 2026.

- *Argentina: CHIKVD cases* are reported through the year in the country. Since epidemiological week 31 (2–8 August), the country has started seasonal surveillance for the period 2026/2027. As of epidemiological week 34 (23–29 August) no confirmed cases have been reported for the new season. In the previous season, CHIKVD cases were reported from ten jurisdictions

(Buenos Aires, Autonomous City of Buenos Aires, Cordoba, Entre Rios, Chaco, Catamarca, Jujuy, Salta, Santiago del Estero, Tucuman), being Salta and Tucuman the most affected provinces.

- **Barbados:** In 2026, seven confirmed CHIKVD cases have been reported in the country. In 2025, nine CHIKVD cases were reported during the same period.
- **Bolivia:** CHIKVD cases have been extensively reported in the country since the start of 2026, being the most affected departments Santa Cruz, Cochabamba, Tarija and La Paz. Santa Cruz reported most of CHIKVD cases in Bolivia. At national level, the number of reported cases has increased over the past weeks.
- **Brazil:** CHIKVD cases continue to be reported in all regions (Centro-Oeste, Nordeste, Norte, Sudeste, and Sul) and in most federal units of the country. The Centro-Oeste, Sudeste, and Nordeste regions continue to account for the highest number of cases in the last four epidemiological weeks (31-34), where Bahia, Alagoas, Pernambuco, Mato Grosso Do Sul, and Minas Gerais are the most affected federal units. Since the start of 2026, CHIKVD cases have continuously increased in Brazil until epidemiological week 14. This year, most of the cases have been reported among females (59%), being the 20 to 29 years age group the most affected one. In 2026, a total of 127 676 CHIKVD cases has been reported from Brazil by the end of epidemiological week 34.
- **Costa Rica:** In 2026, 300 CHIKVD cases have been reported with a significant increase in case reporting during the second half of August. Local transmission has been *reported* from Alajuela and Guanacaste provinces. In 2025, a total of eight CHIKVD cases were reported.
- **El Salvador:** In 2026, 13 CHIKVD case have been reported in the country. In 2025, 12 CHIKVD cases were reported in the same period.
- **Honduras:** In 2026, two CHIKVD cases have been reported in the country. In 2025, 11 CHIKVD cases were reported in the same period.
- **Paraguay:** In 2026, 19 CHIKVD cases have been notified in the country until July. In 2025, 48 CHIKVD cases were reported in the same period.

Asia

In 2026, 45 633 CHIKVD cases and no associated deaths have been reported in the region. The most affected subcontinental region is Southeast Asia, with India being the country reporting the highest number of cases in 2026.

- **India:** Additional 167 CHIKVD cases have been reported in August in the country. These cases have been reported from State of Kerala, most of them concentrated at Thiruvananthapuram city. Local authorities have pointed out the monsoon season as the expected driver of this outbreak.
- **Pakistan:** A total of 59 CHIKVD cases has been reported in the country in 2026. Cases have doubled since July, with Sindh and Khyber Pakhtunkhwa regions showing the highest case counts. In addition, Baluchistan region has also reported cases in August. In general, CHIKVD cases are reported throughout the year in Pakistan, mainly concentrated in Baluchistan, Khyber Pakhtunkhwa, and Sindh provinces. These provinces are located in the Southwest of the country.
- **Philippines:** In July 2026, CHIKVD cases were reported by Gandara Municipal Health Officer. Two outbreaks were identified, with a total of 84 cases reported.

Africa

In 2026, approximately 6 921 CHIKVD cases and no associated deaths have been reported in the region. The most affected subcontinental region is East Africa, with Mauritius being the country reporting the highest number of cases in 2026.

- **Mauritius:** Since January 2026, the country has reported a total of 6 891 CHIKVD cases from Mauritius Island and Rodrigues Island. Most of the cases are reported from Mauritius Island.

Europe

Since the beginning of 2026 and as of September 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France and Italy. For more information on CHIKVD cases reported in mainland EU/EEA, please visit the [dedicated ECDC website](#). CHIKVD cases have been reported from the French outermost regions of [French Guiana](#), [Mayotte](#) and [Réunion](#).

Note

The data presented in this report originate from both official public health authorities and non-official sources, such as news media, and depending on the source, autochthonous and non-autochthonous cases may be included. Data completeness depends on the availability of reports from surveillance systems and their accuracy, which varies between countries. All data should be interpreted with caution and comparisons, particularly across countries, should be avoided due to under-reporting, variations in surveillance system structure, different case definitions from country to country and over time, and use of syndromic definitions.

ECDC assessment:

Since the beginning of 2026 and as of September 2026, France and Italy were the only European country to report locally acquired chikungunya virus disease transmission.

The likelihood of onward transmission of chikungunya virus in mainland Europe is linked to importation of the virus by viraemic travellers into receptive areas with established and active competent mosquito vectors (e.g. *Aedes albopictus* and *Aedes aegypti*). *Aedes albopictus* mosquito is established in a large part of Europe. In Europe and neighbouring areas, *Aedes aegypti* mosquito is established in Cyprus, on the eastern shores of the Black Sea, and in the outermost region of Madeira.

For the risk related to CHIKVD in mainland EU/EEA, please see the dedicated webpage: [Chikungunya virus disease risk assessment for mainland EU/EEA](#).

More information on autochthonous transmission of [chikungunya](#) virus in 2026 in the EU/EEA is available on ECDC's website, and in ECDC's factsheets on [CHIKVD](#).

Mosquito bite prevention is strongly recommended for travellers to countries with reported cases of dengue and chikungunya. Travel health advice is advised for travellers to areas with active outbreaks or elevated risk. Pregnant travellers, older adults and people with chronic conditions may be at higher risk of complications associated with these diseases.

Actions:

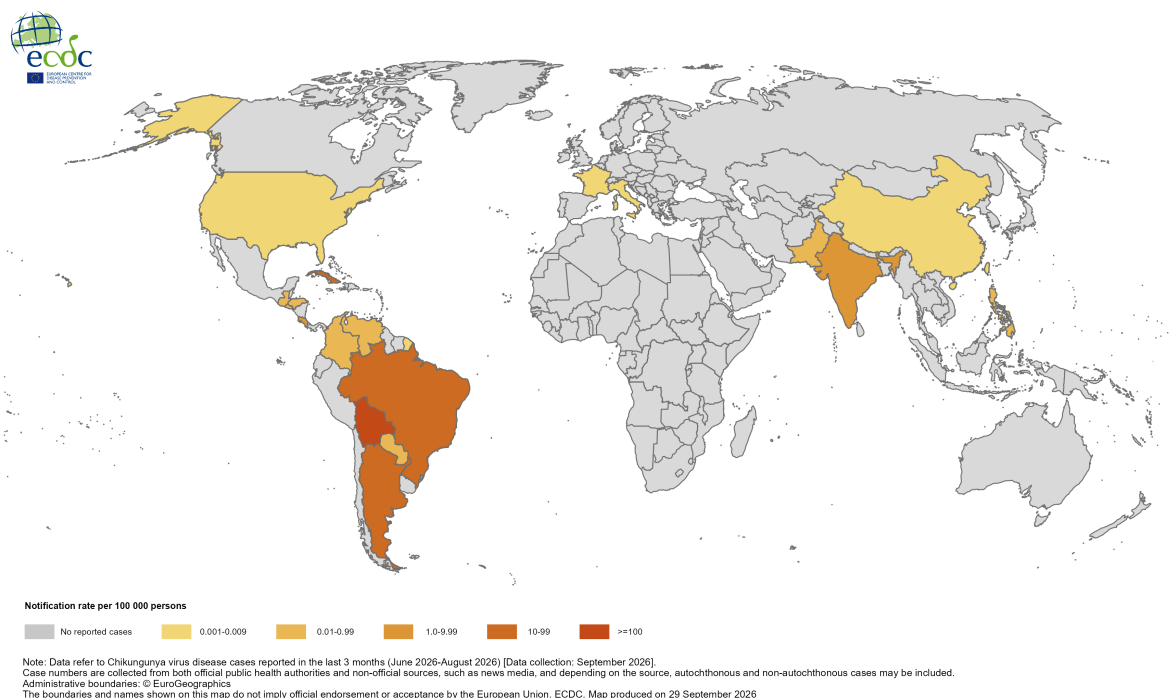
ECDC monitors this threat through its epidemic intelligence activities and reports on it on a monthly basis. A summary of the worldwide overview of [CHIKVD](#) is available on ECDC's website.

Sources: [Epidemiological alert Chikungunya](#)

Last time this event was included in the Weekly CDTR: 7 August 2026

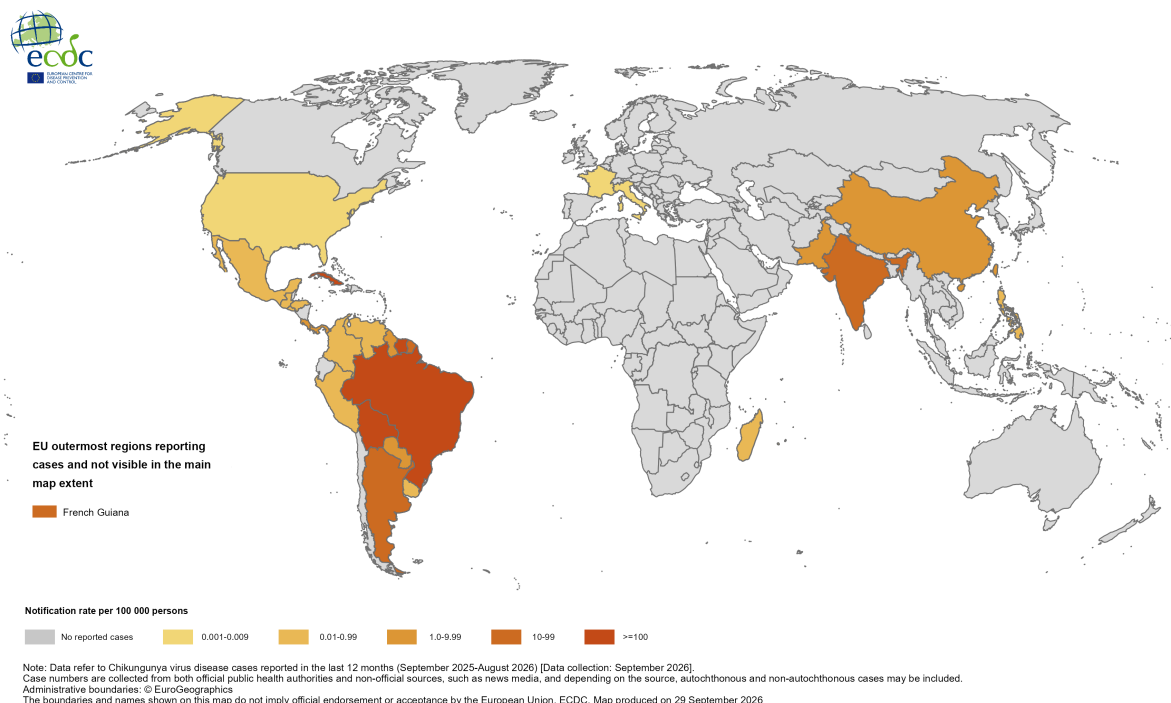
Maps and graphs

Figure 18. Three-month Chikungunya virus disease case notification rate per 100 000 population, June to August 2026



Source: ECDC

Figure 19. Twelve-month Chikungunya virus disease case notification rate per 100 000 population, September 2025 to August 2026



Source: ECDC

15. Carbapenem-resistant Enterobacterales – Multi-country (EU/EEA) – 2025

Overview:

Since the last ECDC [rapid risk assessment on carbapenem-resistant Enterobacterales \(CRE\)](#) on 3 February 2025, new data from a recent European-level genomic CRE survey (the CRE25 survey) and multi-country EURGen-Net investigations have become available.

These data show several concerning findings including:

- An increasing proportion and geographical spread of carbapenem-resistant *Klebsiella pneumoniae* isolates carrying NDM carbapenemases.
- An increasing proportion and geographical spread of carbapenem-resistant *K. pneumoniae* isolates carrying genes encoding the siderophores (iron chelators) yersiniabactin and aerobactin, which are associated with increased bacterial virulence.
- Documented cross-border spread of mosaic plasmids carrying both carbapenemase and virulence genes in *K. pneumoniae*.
- Rapid spread of new *K. pneumoniae* sequence types (such as ST6668) to several EU countries.
- Increasing detection and geographical spread of *E. coli* isolates carrying carbapenemase genes such as *bla*OXA-244.

ECDC assessment:

The epidemiological situation regarding CRE continues to worsen rapidly in the EU/EEA. NDM carbapenemases are conferring broad spectrum beta-lactam resistance, including to several antimicrobials (ceftazidime-avibactam, imipenem-relebactam, meropenem-vaborbactam) developed for the treatment of CRE infections and introduced in the EU/EEA only within the last 10 years.

The increasing co-carriage of carbapenemase and virulence genes is concerning, as this simultaneously increases the likelihood of *K. pneumoniae* infections and of treatment failure. The convergence of resistance and virulence in *K. pneumoniae* is partly due to the spread of plasmids carrying both carbapenemase and virulence genes.

Recent EURGen-Net data documents the frequent introduction and rapid healthcare-associated spread of these plasmids and of newly emerging *K. pneumoniae* STs due to cross-border patient transfers, healthcare referral networks and patient mobility. At the same time, there is also an increasing detection of *E. coli* isolates with OXA-244, which have started spreading in community settings.

Actions:

ECDC will update its [Rapid risk assessment - Carbapenem-resistant Enterobacterales – third update](#), published on 3 February 2025.

Last time this event was included in the Weekly CDTR: –

16. Expert deployment

Overview:

Since 19 May 2026, the EUHTF has been supporting preparedness and response efforts related to the Ebola disease outbreak caused by Bundibugyo virus in DRC and Uganda. These activities are being conducted in close coordination with national authorities and EU delegations, and in collaboration with the European Commission and the WHO.

DRC – WHO Incident Management Team in Bunia

Since 22 September, two ECDC experts have been deployed through the Global Outbreak Alert and Responses Network (GOARN), to provide epidemiological support to WHO operations in Bunia, Ituri Province and DRC. The deployments are financed with funds made available by the Directorate-General for European Civil Protection (DG ECHO).

Africa CDC and Continental Incident Management Support Team

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 experts have provided support for surveillance, preparedness and liaison activities. 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 (DG INTPA).

South Sudan – WHO Country Office

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 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 areas considered at **high risk** of importation and transmission. Between 14 July and 27 August 2026, two ECDC fellows were also deployed through GOARN, to support surveillance and data analysis activities. All deployments to South Sudan were funded by DG ECHO.

Fact-finding mission to the DRC and Uganda

Between 15 and 22 June 2026, the EUHTF deployed a team of three ECDC experts and two EU 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.

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

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 02 October 2026
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 October 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 02 October 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 October 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 02 October 2026
- SARS-CoV-2 variant classification - last reported on 02 October 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 38, 2026 - last reported on 02 October 2026
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 October 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo – 2026 - last reported on 02 October 2026
- Expert deployment - last reported on 02 October 2026
- Seasonal surveillance of chikungunya virus disease in the EU/EEA – 2026 (weekly) - last reported on 02 October 2026
- Seasonal surveillance of dengue in the EU/EEA – 2026 (weekly report) - last reported on 02 October 2026

- Seasonal surveillance of Crimean-Congo haemorrhagic fever in the EU/EEA – 2026 (weekly report) - last reported on 02 October 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (weekly report) - last reported on 02 October 2026
- Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters – Bathing season 2026 - last reported on 02 October 2026
- Carbapenem-resistant Enterobacterales – Multi-country (EU/EEA) – 2025 - last reported on 02 October 2026