

## WEEKLY BULLETIN

# Communicable disease threats report

**Week 41, 3 - 9 October 2026**

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## Executive summary

### **Pneumonia of unknown aetiology - Russia - 2026**

- Russian health authorities have reported no recent plague case in Irkutsk Oblast.
- They reported that preventive measures, including epidemiological investigations and medical observation and testing of contacts have been completed; and no high-threat pathogen was detected in any of the identified contacts.
- WHO has requested further information on the cause of the severe pneumonia in the 28-year-old laboratory technician, the pathogen that triggered the public health measures and media reports of a second employee with pneumonia of unknown aetiology.
- ECDC is actively monitoring this event and is in close contact with WHO EURO and other international stakeholders, including global CDCs, to obtain additional information as it becomes available.
- The available information on this event is not sufficient to draw a firm conclusion regarding the potential risk to the EU population. The assessment will be reviewed should additional information become available.

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

- On 7 October, the Democratic Republic of the Congo (DRC) reported a total of 8 728 confirmed cases, including 4 205 related deaths (from data up until 6 October). Since the beginning of the outbreak, seven provinces have been affected: Ituri, North Kivu, South Kivu, Tshopo, Haut-Uélé, Bas Uélé and Sud Ubangi.
- On 6 October, Kenya's Cabinet Secretary for Health announced the country's first confirmed Ebola virus disease case imported from DRC.
- 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.

**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 5 October 2026, 11 deployments had taken place as part of a series of rotational deployments to support Africa CDC within the Continental Incident Management Support Team (IMST) in Addis Ababa, Ethiopia and Kampala, Uganda. Such deployments are part of the project 'Health Security and One Health in Africa – Africa CDC' in partnership with ECDC and EFSA (PHASE II) and funded by the European Commission's Directorate-General for International Partnerships (DG INTPA).

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

- Since the beginning of 2026, and as at 7 October 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (146 cases) and Italy (one case).

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

- Since the beginning of 2026 and as at 7 October 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (68 cases) and France (six cases).

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

- Since the beginning of the 2026 transmission season, and as at 7 October, 208 areas affected by West Nile virus (WNV) have been identified in 18 countries across Europe.
- This week, six areas are reported as affected for the first time this season.
- These 18 countries have reported 1 855 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 7 October 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (four cases).
- In the past week, no new cases have been reported to ECDC.

**Multi-country outbreak of Salmonella Strathcona - EU/EEA - 2023-2026**

- The prolonged cross-border outbreak of Salmonella Strathcona ST2559 remains ongoing in the European Union/European Economic Area (EU/EEA), with more than 160 new cases being reported in 2026. Many cases have travelled to Italy prior to falling ill, but the outbreak is not confined to only Italy as domestic cases have also been reported from other countries.

- Between 2023 and 2025, approximately 670 confirmed cases of *Salmonella* Strathcona ST2559 have been reported across EU/EEA countries as well as in countries outside the EU/EEA.
- Genetically close outbreak isolates have been detected since 2011, identifying a recurring public health concern. Based on the outbreak assessment published in 2025, epidemiological, microbiological, traceability and environmental investigations have identified small tomatoes from the Sicily region of Italy as the vehicle of infection.
- The risk for new infections remains if seasonal deliveries of contaminated produce continue. As of September 2026, this outbreak is continuing and the source is not yet fully controlled.

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

- The number of patients presenting to primary care with symptoms of respiratory illness, including acute respiratory infection, remains mostly at low or baseline levels in EU/EEA countries. However, the respiratory illness consultation rates are increasing in most countries.
- **SARS-CoV-2** test positivity has remained approximately at the same level for the fourth week in a row in primary care and has 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 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.

### Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring

- In August 2026, 28 countries reported measles data. Ten countries reported a total of 143 cases and 18 countries reported zero cases.
- During the previous 12-month period, zero deaths attributable to measles were reported to ECDC.
- Overall, case numbers increased compared with the previous month.
- Complementary epidemic intelligence surveillance was performed on 9 October 2026. No new or ongoing outbreaks have been reported in EU/EEA. Sporadic cases and clusters have been reported in several EU/EEA countries. Updates are provided for several countries and regions outside the EU/EEA.

### Symptomatic Sindbis case in Germany, 2026

- In September 2026, a laboratory-confirmed infection with Sindbis virus (SINV) was identified in an individual in south-western Germany.
- This is the first autochthonous case of symptomatic SINV infection reported in Germany.

## 1. Pneumonia of unknown aetiology - Russia - 2026

### Overview:

**Update:** On 6 October 2026, World Health Organization's Director General reported that in response to WHO's verification request, Russian health authorities reported no recent plague case in Irkutsk Oblast. They reported that preventive measures, including epidemiological investigations, medical observation and testing of contacts have been completed. Moreover, Russian health authorities reported no high-threat pathogen detected in any of the identified contacts.

WHO has requested further information on the cause of the severe pneumonia in the 28-year-old laboratory technician, the pathogen that triggered the public health measures and media reports of a second employee with pneumonia of unknown aetiology.

Reports in the media quoting Russian authorities [deny](#) the existence of a possible second case of "suspected plague".

**Background:** On 2 October 2026, according to multiple media reports pending verification, authorities in Irkutsk Oblast, Russia, initiated emergency anti-epidemic measures following the death of a 28-year-old laboratory technician, employed at the Irkutsk Research Anti-Plague Institute of Siberia and the Far East. Media reports, Russian authorities have officially classified the case as "pneumonia of unknown aetiology".

According to media reports, the patient allegedly experienced a laboratory incident on 25 September 2026, when she reportedly broke a tube containing *Yersinia pestis* while working with live biological material. These reports have not been confirmed. Russian health authorities have reported no recent plague case in Irkutsk Oblast. Following the alleged incident, she reportedly became unwell within several days and was admitted to Shelekhov District Hospital on 29 September 2026 with severe pneumonia. Initial clinical suspicion reportedly included severe COVID-19; however, her condition deteriorated rapidly, requiring intensive care and mechanical ventilation. She died during the night of 1-2 October 2026 in the intensive care unit of Shelekhov District Hospital.

On 2 October 2026, the Governor announced that a suspected case of a "particularly dangerous infection" was under investigation and confirmed that a full package of anti-epidemic measures had been initiated. An extraordinary meeting of the regional sanitary and anti-epidemic commission was convened with participation of Head of Rospotrebnadzor (the Federal Service for the Oversight of Consumer Protection and Welfare in Russia) and Chief State Sanitary Physician of the Russian Federation. An operational response plan was approved and contact tracing was initiated.

Public health measures included quarantine restrictions at Shelekhov District Hospital, suspension of admissions and discharges in affected departments, enhanced epidemiological investigations and medical monitoring of contacts. Russian media reported that approximately 189-200 contacts were placed under observation, including institute staff, healthcare workers, ambulance personnel and hospital patients. Identified contacts have been isolated in medical institutions, of which 114 patients are in one hospital, 63 in another, and another 12 people are kept in the anti-plague institute. The Governor stated that all identified contacts were under medical supervision and had negative laboratory test results at the time of reporting.

Additional precautionary measures reported by Russian and independent media included cancellation of public events in Irkutsk, mandatory mask use at some workplaces, quarantine of several healthcare facilities, including the Shelekhov hospital, where the deceased person was hospitalised, and isolation of contacts in designated hospitals.

On 4-5 October 2026, according to media reports, Rospotrebnadzor reported that expanded laboratory investigations did not identify microorganisms associated with the deceased patient's professional activities. The agency stated that no laboratory accidents involving pathogenic microorganisms had been documented at the institute, no infectious disease clusters had been identified among staff, and the patient had been diagnosed with "pneumonia of unknown aetiology". Rospotrebnadzor further described the sanitary-epidemiological situation in Irkutsk and Shelekhov as stable.

For information, no autochthonous plague cases have been reported in the EU/EEA in the last decades. Please consult the [ECDC factsheet](#) for further information on this disease.

**Sources:** [media source 1](#), [media source 2](#), [media source 3](#), [media source 4](#), [WHO's Director General post](#)

### **ECDC assessment:**

The available information of this event is not sufficient to draw a firm conclusion regarding the potential risk to the EU population. The assessment will be reviewed should additional information become available.

### **Actions:**

ECDC is actively monitoring this event, and is in close contact with WHO EURO and other international stakeholders, including global CDCs, to obtain additional information as it becomes available.

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

### Overview:

### Latest epidemiological information

#### Democratic Republic of the Congo

On 7 October 2026, the [Democratic Republic of the Congo \(DRC\)](#) reported a total of 8 728 confirmed cases, including 4 205 related deaths (from data up until 6 October). A total of 1 066 patients are hospitalised in isolation. This represents an increase of 63 new confirmed cases and 27 deaths since the previous report on 6 October (reporting data up until 5 October). The 63 new cases have been reported from Ituri (33 cases), and North Kivu (30 cases). Among the individuals who tested positive for Bundibugyo virus, 2 269 have recovered. In total, 82% of identified case contacts are under follow-up in the affected provinces.

Ituri province remains the most affected, with 6 513 cases, including 3 007 deaths, reported from 28 of 36 health zones. In North Kivu, 1 785 cases, including 1 021 deaths, have been reported from 17 of 34 health zones. In South Kivu, three cases, including one death, have been reported from one of 34 health zones. In Haut-Uélé, 364 cases, including 153 deaths, have been reported from seven of 13 health zones. In Tshopo, 51 cases, including 18 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, 64 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.

On 6 October 2026, [Kenya's Cabinet Secretary for Health](#) announced the country's first confirmed imported Ebola virus disease case. The patient, a Kenyan citizen who had been residing in the DRC, reportedly travelled from the DRC through Uganda and arrived in Nairobi on 3 October. The patient subsequently died. According to the Minister, 28 contacts, including family members and healthcare workers, have been identified and quarantined.

#### 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 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).

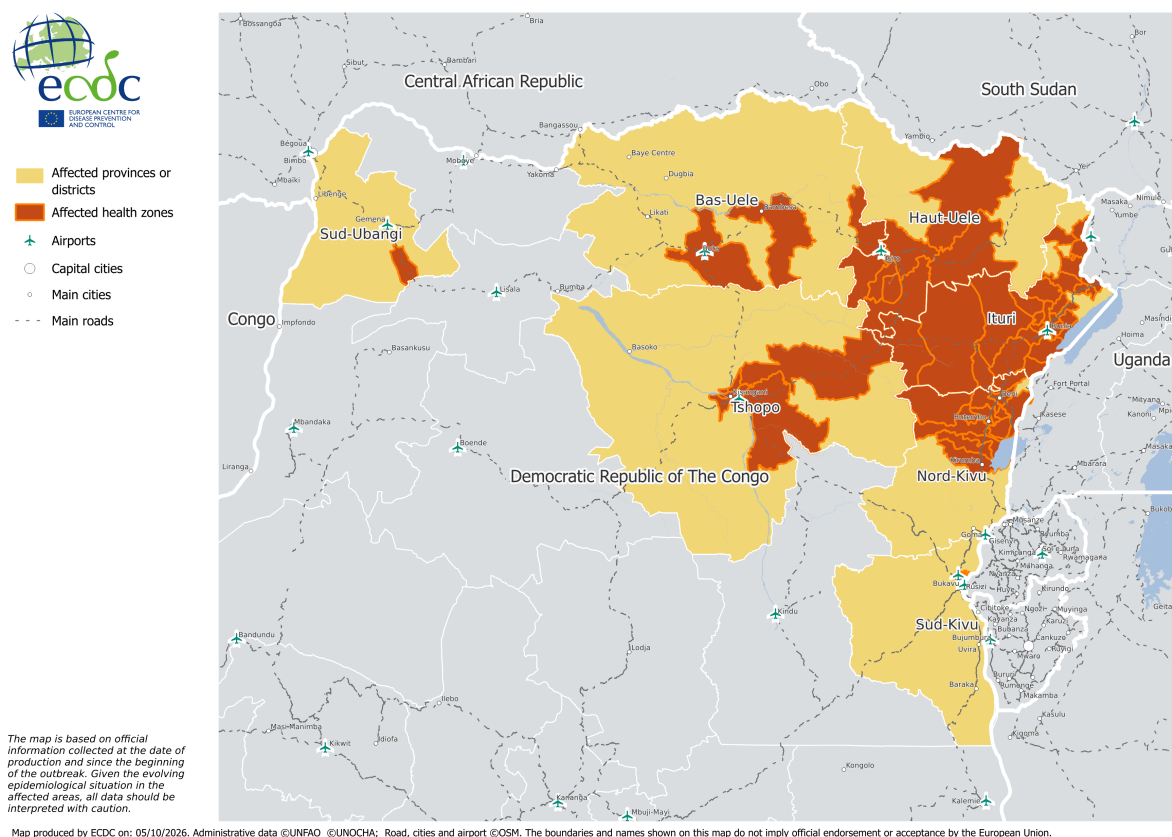
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

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:** 2 October 2026

## Maps and graphs

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



## 3. 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

Five experts were deployed on a rotational basis to support Africa CDC at its headquarters in Addis Ababa. Since 23 June 2026, six experts have been deployed to support Africa CDC 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:** 2 October 2026

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

### Overview:

Since the beginning of 2026, and as at 7 October 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (146 cases) and Italy (one case).

Since last week's update, France has reported 22 new locally acquired chikungunya virus disease cases, bringing the total to 146 cases. These cases are distributed across 20 clusters, with one new cluster identified (municipality of Bellefont-La Rauze, Lot department). Eighteen clusters are currently active, including the largest two clusters in Prayssac (Lot department) and Prignac-et-Marcamps (Gironde department), which respectively consist of 34 and 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:** 2 October 2026

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

### Overview:

Since the beginning of 2026 and as at 7 October 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (68 cases) and France (six cases).

Since last week's update, Italy has reported nine new locally acquired dengue cases. The cumulative number of locally acquired cases in Italy is 68, distributed across six clusters. Among these, one newly identified cluster, 'Roma' (Rome NUTS 3 region), was reported, while several previously reported clusters were consolidated into a single cluster, now referred to as 'Piombino' (Livorno and Firenze NUTS 3 regions). All clusters are currently active.

No new locally acquired dengue cases have been reported by France since last week's update. The cumulative number of locally acquired cases in France remains 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:** 2 October 2026

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

### Overview:

Since the beginning of the 2026 transmission season, and as at 7 October, 208 areas affected by West Nile virus (WNV) have been identified in 18 countries across Europe.

These areas are located in Italy (67), France (26), Greece (25), Romania (24), the Netherlands (15), Serbia (10), Belgium (6), Spain (6), Croatia (5), North Macedonia (5), Hungary (4), Kosovo\* (4), Austria (3), Germany (3), Albania (2), Bulgaria (2) and Cyprus (1).

The 18 countries have reported 1 855 locally acquired human cases of WNV infection.

This week, six areas are reported as affected for the first time this season.

The report will be made available online on Friday afternoon 9 October at the following link: [link](#).

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:** 2 October 2026

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

### Overview:

Since the beginning of 2026, and as at 7 October 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (four 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:** 02 October 2026

## 8. Multi-country outbreak of Salmonella Strathcona - EU/EEA - 2023-2026

### Overview:

The prolonged cross-border outbreak of Salmonella Strathcona ST2559 remains ongoing in the European Union/European Economic Area (EU/EEA). The outbreak strain has been circulating in the EU/EEA since 2011, when a first outbreak was reported in Denmark, with small and elongated datterino tomatoes traded from Sicily (Italy) identified as the source of the infections. From 2023 to 2025, approximately 670 confirmed cases of S. Strathcona ST2559 were identified across EU/EEA. In addition, cases were reported in the United Kingdom (73), Canada (10), the US (24) and in Serbia (2). In 2025, the outbreak investigations carried out in Austria (epidemiological, microbiological and traceability investigations) identified small tomatoes traded from Sicily (Italy) as the source of the infections, as had been the case for the 2023 outbreak in Austria and the 2024 outbreak in Italy. The same conclusion was reached for an outbreak of S. Strathcona ST2559 in Denmark in 2011. This was further supported by the official sampling carried out at a primary producer in Italy sampled in November 2024, in which the outbreak strain was detected in a sample of irrigation water taken from a well. Follow-up investigation carried out in Austria subsequent to the publication of the Rapid Outbreak Assessment in 2025, confirmed the outbreak strain in cherry tomatoes traded from Italy through sequencing (RASFF 2025.9937). Epidemiological investigations conducted in Sweden in December 2025 also pointed to a batch of tomatoes.

As of 9 October 2026, a total of ten EU/EEA countries (Austria, Denmark, France Germany, Ireland, Italy, Luxembourg, the Netherlands, Norway and Sweden) reported in total more than 160 new outbreak cases in the EpiPulse event [2023-FWD-00090](#). The vast majority had onset or sample date between July and September 2026.

Sequencing is pending for approximately 100 additional cases. Several countries reported cases with either residency in, or a travel history, to Italy prior to symptom onset, suggesting a common exposure in Italy. However, the exposure is not confined to Italy only. Domestic cases continue to be reported from other countries. Epidemiological investigations for the cases reported in 2026 are ongoing. So far, Germany and Luxembourg have reported that all interviewed cases in 2026 (eight and three respectively) had consumed cherry tomatoes. Italy also reported tomato consumption among cases.

Overall, this is a recurring, seasonal outbreak with more than 800 confirmed cases reported between January 2023 and September 2026. Most cases have occurred during late summer months, particularly between June and October in all years. Case counts consistently peak during July to September across affected countries, and this seasonal pattern has been observed over multiple years.

The recurrence of cases in 2026, including those without travel history, suggests ongoing transmission and distribution of contaminated produce both in and beyond Italy. Further investigations should continue to verify whether small tomatoes from Italy are the vehicle of the newly reported infections in all countries, as other foods could also be, or become, involved in the transmission.

### ECDC assessment:

The risk for new infections remains as long as the seasonal delivery of contaminated produce continues. New outbreaks are likely to occur in future seasons until the root cause of the contamination has been identified and control measures implemented.

### Actions:

- Two joint ECDC-EFSA Rapid Outbreak Assessments have been produced related to this outbreak: in November [2024](#) and in October [2025](#).
- ECDC is monitoring the event in EpiPulse and is liaising with FWD-Net and EFSA to monitor and coordinate response efforts.
- EFSA continues to work with the competent authorities, facilitating information sharing and maintaining close attention to the evolving situation. Epidemiological updates on the number of cases reported were posted also in RASFF [2024.0384](#) in August and September 2026, concerns about the multi-country outbreak reoccurrence was shared with the risk managers at EU and national level in September 2026. EFSA continues to monitor the outbreak management measures as shared via the RASFF platform
- Countries are encouraged to continue updating EpiPulse with information about new cases, both epidemiological information and sharing of WGS data. This is of particular importance in the present outbreak to enable the investigation of the outbreak cluster in a European centralised analysis since the outbreak strain appears to show slight genetic variation due to the possibility of the environmental component of the root cause. Comparison to only one representative outbreak isolate nationally could limit the understanding of the dynamics of the outbreak cluster.

### Further information:

- [Salmonella detection in/on tomatoes.pdf](#)
- [Müller et al 2016. Outbreak of Salmonella Strathcona caused by datterino tomatoes, Denmark, 2011 \(Epidemiol Infect\)](#)
- ECDC and EFSA joint rapid outbreak assessment (published 12 November 2024): [Prolonged multi-country outbreak of Salmonella Strathcona ST2559 linked to consumption of tomatoes in the EU/EEA and the UK](#)
- First update of the ECDC and EFSA joint rapid outbreak assessment (published 23 October 2025): [Prolonged multi-country outbreak of Salmonella Strathcona ST2559 linked to consumption of tomatoes in the EU/EEA and the UK - first update](#)
- [Brait et al 2025. Insights into recurring multi-country outbreaks of Salmonella Strathcona associated with tomatoes, Europe, 2011 to 2024 \(Euro Surveillance\)](#)
- Due to the possible environmental component of the root cause and reoccurring pattern of the outbreak strain, selected reference outbreak isolate sequences have been shared by Austria, Germany and Denmark from 2025, publicly available on SRA, ENA or Enterobase: SRR36516245; SRR36516241; SRR36516244; SRR36516240; SRR36516243; SRR36516242; SRR36516246; ERR16105255; ERR16105253; ERR16105254; ERR16105250; ERR16105251; ERR16105252; ERR16105256; DE25-09124; DE25-09779; DE25-08096; DE25-09615; DE25-05382; DE25-06220; DE25-04916

Sources: [2024.7763](#)

**Last time this event was included in the Weekly CDTR:** 5 September 2025

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

### Overview:

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

Key visualisation from the weekly bulletin are included below.

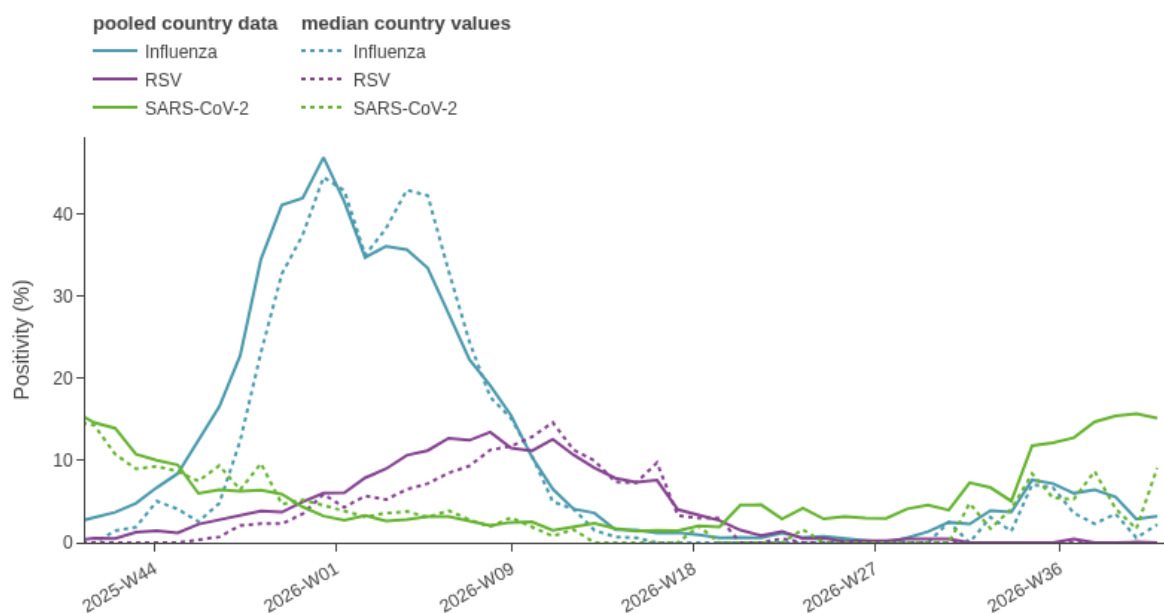
All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

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

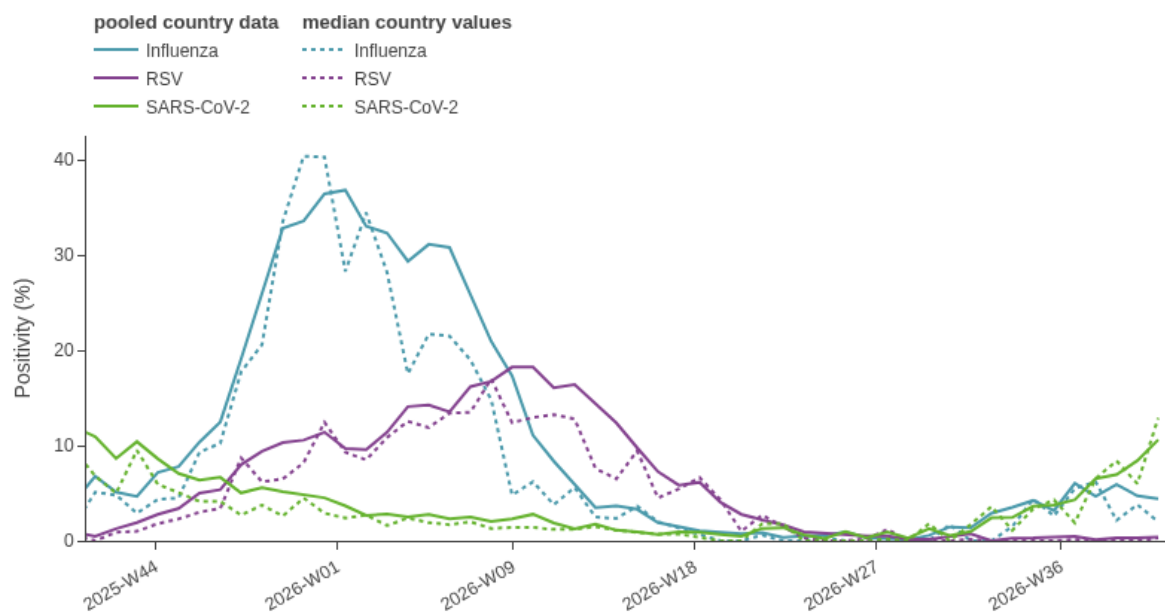
**Last time this event was included in the Weekly CDTR:** 2 October 2026

### Maps and graphs

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



Source: ECDC

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

Source: ECDC

**Figure 3. Key indicators**

| Indicator                                  | Syndrome or pathogen | Reporting countries |                   | EU/EEA summary                                 |                                                |
|--------------------------------------------|----------------------|---------------------|-------------------|------------------------------------------------|------------------------------------------------|
|                                            |                      | Week 40             | Week 39           | Description                                    | Value                                          |
| ILI/ARI consultation rates in primary care | ARI                  | 17 rates (12 MEM)   | 15 rates (9 MEM)  | Distribution of country MEM categories         | 5 Baseline<br>5 Low<br>1 Medium<br>1 Very high |
|                                            | ILI                  | 19 rates (16 MEM)   | 16 rates (16 MEM) |                                                | 16 Baseline                                    |
| ILI/ARI test positivity in primary care    | Influenza            | 15                  | 17                | Pooled (median; IQR)                           | 3.2% (2.2; 0.3–3.9%)                           |
|                                            | RSV                  | 14                  | 16                |                                                | 0% (0; 0–0%)                                   |
|                                            | SARS-CoV-2           | 14                  | 18                |                                                | 15% (9.1; 2.9–13%)                             |
| SARI rates in hospitals                    | SARI                 | 11 rates (7 MEM)    | 11 rates (7 MEM)  | Distribution of country MEM categories         | 6 Baseline<br>1 Low                            |
| SARI test positivity in hospitals          | Influenza            | 7                   | 8                 | Pooled (median; IQR)                           | 4.4% (2; 0–5.2%)                               |
|                                            | RSV                  | 7                   | 8                 |                                                | 0.4% (0.3; 0–3.2%)                             |
|                                            | SARS-CoV-2           | 7                   | 8                 |                                                | 11% (13; 4.5–20%)                              |
| Intensity (country-defined)                | Influenza            | 12                  | 12                | Distribution of country qualitative categories | 11 Baseline<br>1 Low                           |

Source: ECDC

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

| Pathogen          | Week 40, 2026 |                | Week 40, 2026 – week 40, 2026 |                |
|-------------------|---------------|----------------|-------------------------------|----------------|
|                   | N             | % <sup>a</sup> | N                             | % <sup>a</sup> |
| <b>Influenza</b>  | <b>46</b>     | –              | <b>46</b>                     | –              |
| Influenza A       | 41            | 95             | 41                            | 95             |
| A(H1)pdm09        | 16            | 47             | 16                            | 47             |
| A(H3)             | 18            | 53             | 18                            | 53             |
| A (unknown)       | 7             | –              | 7                             | –              |
| Influenza B       | 2             | 5              | 2                             | 5              |
| B (unknown)       | 2             | –              | 2                             | –              |
| Influenza untyped | 3             | –              | 3                             | –              |
| <b>RSV</b>        | <b>0</b>      | –              | <b>0</b>                      | –              |
| RSV-A             | 0             | –              | 0                             | –              |
| RSV-B             | 0             | –              | 0                             | –              |
| RSV untyped       | 0             | –              | 0                             | –              |
| <b>SARS-CoV-2</b> | <b>302</b>    | –              | <b>302</b>                    | –              |

Source: ECDC

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

| Pathogen          | Week 40, 2026 |                | Week 40, 2026 – week 40, 2026 |                |
|-------------------|---------------|----------------|-------------------------------|----------------|
|                   | N             | % <sup>a</sup> | N                             | % <sup>a</sup> |
| <b>Influenza</b>  | <b>33</b>     | –              | <b>33</b>                     | –              |
| Influenza A       | 21            | 95             | 21                            | 95             |
| A(H1)pdm09        | 3             | 50             | 3                             | 50             |
| A(H3)             | 3             | 50             | 3                             | 50             |
| A (unknown)       | 15            | –              | 15                            | –              |
| Influenza B       | 1             | 5              | 1                             | 5              |
| B (unknown)       | 1             | –              | 1                             | –              |
| Influenza untyped | 11            | –              | 11                            | –              |
| <b>RSV</b>        | <b>3</b>      | –              | <b>3</b>                      | –              |
| RSV-A             | 1             | 50             | 1                             | 50             |
| RSV-B             | 1             | 50             | 1                             | 50             |
| RSV untyped       | 1             | –              | 1                             | –              |
| <b>SARS-CoV-2</b> | <b>79</b>     | –              | <b>79</b>                     | –              |

Source: ECDC

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

No data available

Source: ECDC

**Figure 7. SARS-CoV-2 variant distribution, week 29, 2023 - week 30, 2023**

| Variant  | Classification <sup>a</sup> | Reporting countries | Detections | Distribution (median and IQR) |
|----------|-----------------------------|---------------------|------------|-------------------------------|
| BA.2.86  | VOI                         | 1                   | 13         | 13% (13–13%)                  |
| XFG      | VUM                         | 1                   | 65         | 66% (66–66%)                  |
| NB.1.8.1 | VUM                         | 1                   | 2          | 2% (2–2%)                     |
| BA.3.2   | VUM                         | 0                   | 0          | 0%                            |

Source: ECDC

## 10. Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring

### Overview:

In August 2026, 28 countries reported measles data. Ten countries reported a total of 143 cases and 18 countries reported zero cases.

Overall, case numbers increased compared with the previous month, however this may be subject to change in the event of a future retrospective update. The highest case counts were reported by Bulgaria (62), Sweden (41), Italy (18), Spain (nine) and Germany (six).

In the most recent 12-month period, from 1 September 2025 to 31 August 2026, 30 EU/EEA Member States reported a total of 2 335 cases of measles, 2 040 (87.4%) of which were laboratory confirmed.

Of the 2 335 cases with known age, 636 (27.2%) were in children under five years; 1 203 (51.5%) cases were in those aged 15 years and above. The highest notification rates were observed among infants under one year of age (54.8 cases per million) and children aged 1–4 years (27.5 cases per million).

Of 2 068 individuals (88.6% of all cases) with a known age and vaccination status, 1 487 (71.9%) were unvaccinated, 342 (16.5%) were vaccinated with one dose of a measles-containing vaccine, 193 (9.3%) were vaccinated with two or more doses, and 45 (2.2%) were vaccinated with an unknown number of doses.

During the 12-month period, zero deaths attributable to measles were reported to ECDC by any country. Detailed data are available in [ECDC's Surveillance Atlas of Infectious Diseases](#).

Complementary epidemic intelligence surveillance was performed on 9 October 2026. No new or ongoing outbreaks have been detected in EU/EEA. Sporadic cases and clusters were reported in several EU/EEA countries. Updates are provided for several countries and regions outside the EU/EEA: Serbia, Kosovo\*, England, Ukraine, Australia, Bangladesh, Israel, Africa CDC, the World Health Organization Pan American Health Organization (WHO PAHO), Japan, Canada, the United States (US) and Mexico.

**Disclaimer:** The [monthly measles report published in the CDTR](#) provides the most recent data on cases and outbreaks based on information made publicly available by the national public health authorities or the media. Sometimes this information is made available retrospectively. This report is a supplement to [ECDC's monthly measles and rubella monitoring report](#), based on data routinely submitted by 30 EU/EEA countries to EpiPulse Cases. Data presented in the two monthly reports may differ.

#### **Epidemiological summary for EU/EEA countries with relevant epidemic intelligence updates:**

[Austria](#) reported nine confirmed or probable cases in 2026 and as of 7 October 2026 (an increase by one case since September).

[Bulgaria](#) has seen a [decline](#) in outbreak-related cases, with a total of 580 cases of measles reported by week 40 (ending on 4 October 2026), an increase by 25 cases since the end of August 2026. In response to the outbreak more than 80 000 MMR vaccine doses have been administered in the country. In 2025, Bulgaria reported two cases.

[Germany](#) reported 139 confirmed and probable measles cases in 2026 (week 1 to 41).

On 8 October 2026, [Portuguese media](#) reported an additional measles case in an unvaccinated man in Lisbon. More than 400 contacts had reportedly been identified. This brings the total number of reported cases in Portugal in 2026 to ten.

[Spain](#) reported 161 cases of measles from 1 January to 4 October 2026, including 17 imported cases.

[Sweden](#) Since January 2026 and as of 9 October 49 cases of measles have been reported (an increase by two case since mid-September 2026). The majority of the reported cases this year (40) are related to the [outbreak reported in mid-August](#), linked to a musical festival.

#### **Epidemiological summary for EU/EEA outermost territories with relevant epidemic intelligence updates:**

No new outbreaks or cases have been detected in the reporting period.

#### **Western Balkans countries and Türkiye**

No new outbreaks have been detected in the reporting period.

[Serbia](#) has reported two cases of measles in 2026. [According to Serbian media](#), one measles case was confirmed in Serbia in late August 2026. The case was reported from an area with low vaccination coverage.

Kosovo\*: according to media, citing the The National Institute of Public Health of Kosovo, from April 16 to September 27, 2026, [180 cases of measles have been confirmed](#), with over 95 percent of confirmed cases belong to people who have not been vaccinated.

Kosovo (\*) - 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.

#### **Epidemiological summary for selected countries outside of the EU/EEA with relevant epidemic intelligence updates:**

[England](#): between 1 January 2026 and 7 September 2026, there have been 1 003 laboratory confirmed measles cases reported in England. Half of the cases (501 out of 1003) have been in London, 16% in the West Midlands, 11% in the North West and 8.6 in the East England.

[Ukraine](#) has reported 650 cases since January 2026 (up until August 2026).

[Australia](#) has reported 120 cases in 2026, as of 9 October 2026.

[Bangladesh](#) is experiencing a major measles outbreak. According to the [Directorate General of Health Services](#) (DGHS), as of October 2026 there had been 201,625 suspected measles cases, including 22 116 laboratory-confirmed cases, with 1 040 suspected or confirmed measles-related deaths.

[Israel](#): ongoing measles outbreak has resulted in 3 823 cases, 1 262 hospitalisations and 17 deaths as of 2 September 2026, according to the [Israeli Ministry of Health](#).

[Africa CDC](#) reported on 20 September 2026, moderate to high risk of measles in three countries: Burundi (1 411 suspected cases, 13 deaths), Mali (506 suspected and 296 confirmed cases, 0 deaths), Togo (388 suspected, 177 confirmed cases and 0 deaths). Overall, 10 471 confirmed and 173 681 suspected cases of measles and 1 718 deaths (CFR: 0.99%) from 23 AU Member State countries, with the Democratic Republic of Congo (121 138 cases and 1 583 deaths), Somalia (12 438 cases, 51 deaths), and Burkina Faso (10 471 cases and 31 deaths) having the highest numbers in terms of case counts.

According to the WHO Pan American Health Organization ([WHO PAHO](#)) report published on 5 October, 55 285 confirmed measles cases have been reported by 16 countries, the majority of which have been reported from Guatemala (34 134) followed by Mexico, US, Canada and Peru (2 550).

[Mexico](#) reported 13 645 confirmed cases of measles and 23 deaths in 2026 and as of 8 October 2026. The number of cases has declined in the last couple of months. Since the start of the outbreak in 2025, Mexico has reported 20 259 confirmed cases of measles and 50 deaths.

[Canada](#) reported 1 121 measles cases (1 040 confirmed) and no deaths across eight jurisdictions (Alberta, British Columbia, Manitoba, New Brunswick, Nova Scotia, Ontario, Quebec, Saskatchewan) in 2026 and as of 5 October 2026. According to Canadian authorities, there is an ongoing multi-jurisdictional outbreak, and the vast majority of the cases (1 032 cases, 951 confirmed) reported in 2026 are linked to this outbreak. Since the beginning of this outbreak in October 2024, overall 6 417 cases (5 929 confirmed) linked to this outbreak have been reported (data as of 26 September 2026).

[The US](#) as of 2 October, the US has reported 3 887 confirmed measles cases in 47 jurisdictions since January 2026. Of the reported cases, 18 were in international visitors of the US. The majority of cases have occurred in school-age children and adults (82%) and unvaccinated individuals (95%). [Pennsylvania](#) is currently experiencing the largest ongoing measles outbreak, reporting a total of 1 078 cases and five associated deaths (7 October 2026). Over 31% of the reported cases are children under 18 years of age. On 5 October 2026, [the Governor of New York State](#) declared a disaster emergency due an ongoing measles outbreak following an [increase of measles case](#) in the past two months in 18 counties of the state, mainly affecting rural areas. The state of emergency allows to reallocate the resources, to expand the number of health professionals who can administer MMR vaccine and perform testing when needed.

Japan reported a substantial increase in measles activity in 2026. [By week 39 of 2026 \(21-27 September\) 576 cases have been reported.](#) As of September 2026, genotyping data from the [Tokyo Metropolitan Infectious Disease Surveillance Center](#) included approximately 286 laboratory confirmed cases.

For more information on the provisional number of cases outside the EU/EEA region, please visit the World Health Organization ([WHO](#)) [website](#).

The numbers provided to WHO for EU/EEA countries are from EpiPulse Cases data, which are updated monthly and available on the [ECDC Surveillance Atlas of Infectious Diseases](#). Due to differences in reporting times, the numbers may not correspond to the data from epidemic intelligence screening.

## ECDC assessment:

Although most recent cases were acquired through local or community transmission, travel-related cases continue to be reported.

Continued vigilance is essential due to sub-optimal vaccination coverage for measles-containing vaccines (MCV) in several EU/EEA countries, possible introduction from areas with ongoing transmission, and increased travel and population movement during holiday periods.

## Actions:

ECDC is monitoring the measles situation through its epidemic intelligence activities. Data collected via epidemic intelligence supplement the monthly outputs of measles surveillance data from EpiPulse Cases, which are routinely submitted by 30 EU/EEA countries.

ECDC urges EU/EEA public health authorities to focus on the following areas:

- **Close immunity gaps, achieve and maintain high vaccination coverage for measles-containing vaccines** (>95% with the second dose). It is vital to ensure first and second dose vaccinations are administered on time, as per national schedules among infants and children. It is also important to identify

and vaccinate eligible individuals (for example, non-immune adolescents and adults) in immunisation catch-up programmes (as recommended by local and national authorities).

- **Strive towards high-quality surveillance** and adequate public health capacity, especially for early detection, diagnosis, response and control of outbreaks.
- **Increase the clinical awareness of health professionals**, including reminding them of the importance of checking individuals' vaccination status ahead of travel.
- **Healthcare professionals should be fully vaccinated.**
- **Promote vaccine acceptance and uptake** by employing specific risk communication strategies and identifying drivers of suboptimal MMR vaccine acceptance and uptake to ensure that tailored interventions are implemented in response.
- **Address barriers and engage with populations underserved by healthcare services.** Systemic barriers that affect vaccine uptake in populations that are isolated and underserved by healthcare services need to be monitored and addressed with targeted strategies in order to reduce inequalities in vaccine uptake.
- In light of the summer holiday season, **travellers should check their vaccination status** and consult their general practitioner to ensure they are up-to-date with recommended immunisations prior to departure.

ECDC's latest advice on measles is available in the Threat Assessment Brief '[Measles on the rise in the EU/EEA: Considerations for a public health response](#)', published in February 2024, and its conclusions remain valid. Additional information on the risk classification and ECDC recommendations can be found in this report.

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

## 11. Symptomatic Sindbis case in Germany, 2026

### Overview:

In September 2026, an autochthonous case of Sindbis virus (SINV) infection was reported in south-west Germany. Symptom onset was dated 12 July 2026 and the clinical presentation included fever, rash and arthralgia. The patient had no travel history. Diagnosis was confirmed through detection of specific IgM and IgG antibodies with seroconversion.

Infections with SINV are often asymptomatic or cause mild symptoms including fever, rash, and arthritis. Symptomatic SINV infection in humans has almost exclusively been reported in Northern Europe, where it is endemic and outbreaks occur intermittently.

Mosquitoes of genera *Culex* and *Culiseta* are considered the primary vectors to transmit SINV to humans. In Northern Europe, most human infections occur in August and September, when the primary vector species are prevalent.

There is currently no vaccine or prophylactic treatment available for SINV infection.

For more information about Sindbis virus infection, please see the [ECDC factsheet](#)

### ECDC assessment:

This is the first reported autochthonous symptomatic SINV infection in Germany. As there has been earlier evidence of SINV in Germany, including in mosquitoes and birds, and a very low prevalence of antibodies to the virus among blood donors, symptomatic cases are not unexpected.

### Actions:

No further action for ECDC.

## Events under active monitoring

- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo – 2026 - last reported on 09 October 2026
- Expert deployment - last reported on 09 October 2026
- Seasonal surveillance of chikungunya virus disease in the EU/EEA – 2026 (weekly) - last reported on 09 October 2026
- Seasonal surveillance of dengue in the EU/EEA – 2026 (weekly report) - last reported on 09 October 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever in the EU/EEA – 2026 (weekly report) - last reported on 09 October 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (weekly report) - last reported on 09 October 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring - last reported on 09 October 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 38, 2026 - last reported on 09 October 2026
- Multi-country outbreak of Salmonella Strathcona - EU/EEA - 2023-2026 - last reported on 09 October 2026
- Symptomatic Sindbis case in Germany, 2026 - last reported on 09 October 2026
- Pneumonia of unknown aetiology - Russia - 2026 - last reported on 09 October 2026
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 October 2026
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 October 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 October 2026
- SARS-CoV-2 variant classification - 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