WEEKLY BULLETIN

Communicable Disease Threats Report

Week 12, 14–20 March 2026

This week's topics

Executive summary

Invasive meningococcal disease - England - 2026

- As of 19 March 2026, an outbreak of invasive meningococcal disease (IMD) has been reported in Kent, England. The outbreak includes 29 cases, including two deaths. French authorities have informed the UK Health Security Agency (UKHSA) of one confirmed case in France in an individual who attended the University of Kent.
- The UK Health Security Agency (UKHSA) investigations have confirmed that 13 (of 18) laboratory-confirmed cases are meningococcal serogroup B.
- UKHSA are responding to the outbreak and implementing public health response measures to prevent further cases and transmission.
- Possible exposure locations include a nightclub in Canterbury (Club Chemistry) during the period 5-7 March, as well as the University of Kent campus.

Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

- Since the previous update and as of 19 March, no major public health events related to communicable diseases have been detected in the context of the Winter Paralympic Games.
- ECDC monitored the Winter Olympic and Paralympic Games 2026 in Milan and Cortina from 2 February to 20 March. During this period, no major public health events related to communicable diseases were detected in the context of this mass gathering.
- ECDC monitored this mass gathering event through epidemic intelligence activities in collaboration with the Italian National Institute of Health (Istituto Superiore di Sanità). Previous weekly updates related to the Winter Olympic and Paralympic Games 2026 in Milan and Cortina are available in the Communicable Disease Threats Report (CDTR).

Dengue cases – EU/EEA ex. Maldives – 2025-2026

- Several EU/EEA countries have reported increasing dengue cases linked to travel from the Maldives, where dengue activity has risen sharply since 2025.
- No unusual severity has been reported.
- The risk of onward transmission in the EU/EEA remains low, while the risk for travellers to the Maldives is moderate.
- Public health efforts should focus on communication with travellers and healthcare providers.

Serious adverse events to IXCHIQ chikungunya virus disease vaccine

Latest update

In March 2026, following a Pharmacovigilance Risk Assessment Committee (PRAC) meeting, EMA recommended a change to the product information for Ixchiq (live attenuated chikungunya vaccine). The product information will now have to include that aseptic meningitis cases have been observed in healthy young adults. This is in response to a safety signal review, triggered by a reported case of aseptic meningitis in a healthy young adult following vaccination with Ixchiq.

Prior to this latest safety review, the product information listed aseptic meningitis as one of the known adverse reactions of unknown frequency, and reported that cases had occurred in those aged over 65 years, or those with multiple long-term medical conditions.

PRAC will carry out a further evaluation (to be concluded by June 2026) to assess whether the updated product information and/or any other emerging safety information, affects the balance of benefits and risks of Ixchiq.

Background of the executive summary

In a **news item** published on 7 May 2025, the European Medicines Agency (EMA) informed of 17 serious adverse events (SAEs) that had been reported worldwide in people aged between 62 and 89 years who had received the live attenuated chikungunya vaccine Ixchiq, including two cases resulting in death. This corresponds to an increase of two cases from the previous information published by EMA as of 30 April 2025. Following the reports of SAEs in older people, the Agency's Pharmacovigilance Risk Assessment Committee (PRAC) had started a review of the Ixchiq vaccine. EMA reported that many of the people affected also had other illnesses, and that the exact cause of these adverse events and their relationship with the vaccine have not yet been determined. PRAC temporarily recommended restricting the use of the vaccine among those aged 65 years and above.

On 11 July 2025, EMA's Pharmacovigilance Risk Assessment Committee (PRAC) concluded its review of the live-attenuated chikungunya vaccine Ixchiq. The temporary age restriction for adults aged 65 years and above was lifted because this is the age group in which chikungunya can be severe. However, PRAC strongly emphasises that **Ixchiq should only be used when there is a significant risk of chikungunya infection and after a careful benefit-risk evaluation** in all age groups.

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

- On 15 March 2026, the Cambodian Ministry of Health reported a new human case of avian influenza A(H5N1) virus infection in an adult woman in her forties from Preah Netr Preah District in Banteay Meanchey province.
- The patient is being isolated and treated with oseltamivir in hospital.
- No new cases have been detected among close contacts of the case.
- The patient had exposure to sick and dead poultry before disease onset.
- Since 2003, a total of 996 confirmed human cases of A(H5N1) have been reported worldwide, including 477 deaths (case fatality rate (CFR): 48%).
- ECDC's risk assessment for A(H5N1) remains unchanged. Overall, the risk related to zoonotic influenza for the general population in the EU/EEA is considered low.

Overview of respiratory virus epidemiology in the EU/EEA

Summary

Primary care consultations for respiratory illness have returned to baseline levels in most of the reporting countries, indicating that respiratory virus circulation has declined across much of the EU/EEA in recent weeks.

Influenza virus circulation continues to decrease across all age groups. Hospitalisations are also decreasing, with adults aged 65 years and above accounting for most admissions. Influenza subtypes A(H1)pdm09 and A(H3) are now co-dominant.

Respiratory syncytial virus (RSV) activity and hospitalisations remain elevated, with children under five years accounting for most admissions.

SARS-CoV-2 circulation remains low in all age groups, with few hospitalisations.

EuroMOMO reported all-cause mortality at expected levels across all age groups.

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'.

1. Invasive meningococcal disease - England – 2026

Overview

Summary

As of 19 March 2026, the UK Health Security Agency (UKHSA) has reported an outbreak of invasive meningococcal disease in Kent, England. The outbreak involves 29 cases (18 laboratory-confirmed), notified since 13 March, including two deaths. According to the media, the cases are aged between 17 and 21 years, and some are students at the University of Kent. UKHSA have confirmed that 13 (of 18) laboratory-confirmed cases were meningococcal serogroup B, sequence type 485 belonging to clonal complex ST-41/44. The Bexsero MenB vaccine should provide protection against this strain.

French authorities have reported one confirmed case in France from an individual who had attended the University of Kent and they have informed UKHSA.

UKHSA reports that public health response activities are ongoing, with investigations identifying a nightclub in Canterbury (Club Chemistry) as a possible exposure site during the period 5-7 March. UKHSA are working with the nightclub and the University of Kent to provide advice, identify close contacts, and arrange prophylactic antibiotics. A targeted vaccination programme has begun for University of Kent students. As of 19 March, 2 360 vaccinations and over 9 000 doses of antibiotics have been administered.

Background

IMD is a rare and severe bacterial infection, with high case fatality. Cases present with meningitis and/or sepsis, often with a rapid progression, requiring medical support and prompt treatment with antibiotics. The highest incidence occurs in young children, adolescents and young adults.

According to routine surveillance data submitted to ECDC, 1 895 IMD cases, including 200 deaths, were reported in EU/EEA countries in 2023. Among cases with serotype information available, serogroup B was the most frequent (57%) reported in 2023, and notification rates of IMD caused by serogroup B have been increasing since 2021.

Invasive meningococcal disease can be prevented through vaccination. A MenB vaccine, specifically targeting meningococcal serogroup B is available and included as part of national immunisation programmes in 15 EU countries. Other vaccines for invasive meningococcal disease, including the MenC (for serogroup C) and/or the MenACWY (for serogroups A, C, W and Y) are also included in some national immunisation programmes, however these vaccines do not provide protection against meningococcal serogroup B.

ECDC assessment

Clusters and outbreaks of serogroup B have been reported before. Serogroup B has been showing an increasing trend in post-COVID-19 across all age groups.

ECDC assesses the risk of IMD to the general population in the EU/EEA as very low. There is a negligible probability of exposure and infection in the general population. For individuals who were exposed to this event in Kent but who have previously been vaccinated with the MenB, the likelihood of infection is low, as they are protected by the vaccine. For unvaccinated and exposed individuals, the risk of infection is moderate. However, if more than 10 days have passed from the date of exposure, the risk of developing the disease becomes very low, as the incubation period of the disease is up to 10 days.

ECDC recommendations:

- Among close contacts of cases, targeted control measures with preventive antibiotics and MenB vaccination should be implemented based on individual risk assessment.
- Close contacts of cases should receive prophylactic antibiotics following individual risk assessment and be monitored for clinical symptoms for at least 10 days from the latest possible exposure. Individual control measures are usually not recommended when contact with cases was more than 10 days ago.
- Healthcare workers managing suspected or confirmed cases should follow the required infection, prevention and control protocols.
- Clinicians should be aware of the possibility of meningitis in returning travellers and include travel history in their assessment of IMD cases, particularly in relation to trips to England (especially Canterbury, or the Kent region).
- Continue surveillance, including molecular surveillance, as well as antibiotic susceptibility testing of all IMD cases, to inform prevention and control measures.

Furthermore, meningococcal isolates should be genotyped by whole genome sequencing and reported to pubmlst.org or to the European Meningococcal Epidemiology in Real Time database (EMERT-II) in order to allow for the rapid identification and control of multinational clusters. ECDC can provide sequencing support upon request.

Actions

ECDC will continue to monitor this event through epidemic intelligence activities, enhanced integrated genomic and epidemiological surveillance, and is in contact with the relevant partners.

2. Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

Overview

Update

Since the previous update and as of 19 March 2026, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic and Paralympic Games.

Summary

No major public health events related to communicable diseases were detected during the Winter Olympic and Paralympic Games 2026 in Milan and Cortina (6–15 March).

During the Winter Olympic Games 2026 in Milan and Cortina (4–22 February) there were a limited number of outbreaks reported among athletes in the Olympic Village. These outbreaks were related to gastrointestinal and influenza-like illnesses. Outside of the Olympic Village, there was no indication of communicable disease transmission among attendees linked to their attendance at Olympic venues.

Background

The Winter Paralympic Games took place during the period 6–15 March 2026, with more than 600 athletes competing. The main venues were located in Verona, Milan, Cortina, and Val di Fiemme.

The Winter Olympic Games 2026 in Milan and Cortina took place during the period 4–22 February 2026. The competitions started on 4 February, with the Opening Ceremony on 6 February at San Siro Stadium, Milan and the Closing Ceremony on 22 February at Verona Arena. The competitions were spread across northern Italy, primarily in Milan and Cortina d'Ampezzo, with additional events in Valtellina, Val di Fiemme, and Anterselva/Antholz. More than 2 900 athletes and participants participated from over 90 countries.

ECDC assessment

The Winter Olympic and Paralympic Games 2026 in Milan and Cortina are now over, however, for information purposes, ECDC's assessment for this mass gathering was as follows:

Mass gathering events involve a large number of visitors in one area at the same time. Several factors can contribute to public health threats, including imported diseases, a larger population of susceptible individuals, high-risk behaviours, and food or beverage sales by street vendors. At the same time, non-communicable health risks, including crowd or extreme weather-related injuries and drug- and alcohol-related conditions, should also be considered by the organisers and the public health authorities of the hosting country.

The Winter Olympic and Paralympic Games 2026 is a mass gathering involving multiple events in different event locations, taking place in March. The general assessment provided below refers to the probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games. However, if specific public health events with potential impact at local, national and EU/EEA levels are identified, they will be assessed separately.

The probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games 2026 is low, if general preventive measures are applied - e.g. being fully vaccinated according to national immunisation schedules, following advice regarding hand and food hygiene and respiratory etiquette, self-isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, seeking prompt testing and medical advice as needed, and adopting safer sexual practices. Adopting general preventive measures is particularly important in relation to vaccine-preventable diseases that may be on the rise in the EU/EEA, such as measles, whooping cough, and respiratory infections including influenza and COVID-19. In view of the earlier start of the influenza season 2025/26 in November 2025, ECDC urges those eligible to get vaccinated without delay. ECDC has published recommendations for those attending this mass gathering event.

Actions

ECDC monitored this mass gathering event through epidemic intelligence activities between 2 February and 20 March 2026, in collaboration with the Italian National Institute of Health (Istituto Superiore di Sanità) and other partners.

Previous weekly updates related to the Winter Olympic and Paralympic Games 2026 in Milan and Cortina are available in the Communicable Disease Threats Report (CDTR).

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

3. Dengue cases – EU/EEA ex. Maldives – 2025–2026

Overview

Since 2025, several EU/EEA countries have reported an increasing number of travel-associated cases of dengue virus disease linked to returning travellers from the Maldives. No unusual severity has been reported among the cases in the EU/EEA countries.

In 2026 to date, four countries have reported at least 46 imported dengue cases linked to travellers returning from the Maldives. This represents a continuation of the increase observed in 2025, when many countries saw a pronounced rise in travel-associated cases returning from the Maldives in the second half of the year. This increase matches the rise in the local number of cases being reported by the Maldives since March 2025. Although dengue virus is endemic in the Maldives, the country is reporting an unusual increase in the number of dengue cases, with 631 confirmed cases notified during January 2026, compared to 72 in January 2025, and 138 in January 2024.

For global epidemiological updates, see ECDC's dedicated dengue webpage and the WHO/SEARO global dengue surveillance dashboard.

ECDC assessment

The likelihood of onward transmission of dengue virus in **mainland Europe** following introduction by a viraemic traveller is currently considered low, as environmental conditions are not favourable for Aedes mosquito activity at this time of year.

The current likelihood of dengue virus infection for **travellers to the Maldives** is moderate.

Countries could reinforce communication to travellers and travel medicine providers regarding the ongoing outbreak in the Maldives. Moreover, clinicians could be alerted to the need to ensure early clinical detection and appropriate case management.

Individuals planning to travel to the Maldives, or other areas with dengue transmission, can discuss dengue vaccination with a travel medicine specialist.

Actions

ECDC is monitoring the event through its epidemic intelligence activities. Monthly updates are provided on ECDC's dedicated dengue webpage.

Public health action should focus on advice and communication with the travel and healthcare sectors.

4. Serious adverse events to IXCHIQ chikungunya virus disease vaccine

Overview

Updated guidance on the chikungunya vaccine (Ixchiq)

March 2026 PRAC update: The current product information for the chikungunya vaccine Ixchiq (from Valneva) lists aseptic meningitis as a potential side effect following vaccination, particularly in males aged 65 years and above or individuals with chronic medical conditions, with an unknown frequency (meaning that the available data do not allow an estimation of how often the side effects occur). Following the identification of a young adult who developed aseptic meningitis post-vaccination, EMA completed a separate review of this safety signal. PRAC has recommended updating Ixchiq's product information to explicitly state that SAEs, such as aseptic meningitis, have also been observed in healthy young adults, and not only in older adults or those with comorbidities.

PRAC is also conducting an evaluation of Ixchiq as part of a regular six-monthly periodic safety update report (PSUR, to conclude in June 2026) which will assess whether the new evidence on aseptic meningitis, or any other emerging safety information, has an impact on the balance of benefits and risks of Ixchiq.

Background

During its 16 April 2025 session, the United States' CDC Advisory Committee on Immunization Practices (ACIP) reported six severe adverse events (SAEs) following administration of the Ixchiq vaccine in people aged 65 years and above. The US CDC advised healthcare providers to discuss the risks and benefits of vaccination with individual travellers based on age, destination, trip duration and planned activities.

On 26 April 2025, the **French Ministry of Health and Access to Care reported** that it was informed on 23 April 2025 by the French National Agency for the Safety of Medicines (ANSM) of the occurrence of two SAEs following vaccination against chikungunya with the IXCHIQ vaccine in Reunion, including one death, and a third SAE on 25 April. The three SAEs occurred in people aged over 80 years with comorbidities. Two of them experienced symptoms similar to those of a severe form of chikungunya a few days after vaccination and one of them died. The third person was discharged from hospital. These cases were detected as part of the reinforced pharmacovigilance system set up for this vaccine by the health authorities. According to the analysis carried out by the Bordeaux Regional Pharmacovigilance Centre (CRPV), the **causal link** with the vaccine seemed very likely, considering the symptoms and their onset after vaccination, as well as the detection of the vaccine virus by PCR in the patients' biological samples. Given the seriousness of these events, the Directorate-General for Health (DGS) urgently referred the matter to the French National Authority of Health (HAS) on 24 April to reassess the indications for vaccination against chikungunya with the IXCHIQ vaccine. On 25 April, the French HAS advised that the vaccination recommendations should be revised. As a result, the health authorities suspended the vaccination of individuals aged 65 years and above, with or without comorbidities, pending a risk/benefit reassessment. Vaccination remained open for people aged 18 to 64 years with comorbidities.

As of 30 April 2025, according to EMA, 15 cases of SAEs were reported following vaccination with Ixchiq, including nine from the European Union (eight from France, including La Réunion) and six from the United States.

On 2 May 2025, PRAC and EMA's Emergency Task Force (ETF) issued '**PRAC-ETF considerations on the use of Ixchiq live attenuated virus vaccine against chikungunya**', stating that they were aware of the SAEs reported with Ixchiq vaccination and were reviewing the available data. They announced that until PRAC communicated further, caution should be used when considering vaccination with Ixchiq in frail older adults, especially those with comorbidities potentially affecting immune responses to the vaccine.

In a **news item** published on 7 May 2025, EMA reported a further two SAEs (bringing the total to 17) that had been reported worldwide in people aged between 62 and 89 years who had received Ixchiq, including two cases resulting in death. This news item also announced that PRAC had started a review of Ixchiq, following the reports of SAEs in older people. EMA reported that many of the people affected also had other illnesses and that the exact cause of these adverse events and their relationship with the vaccine had not yet been determined. Given that studies on Ixchiq mainly involved people aged under 65 years and the vast majority of serious cases were in people aged 65 years and above, PRAC temporarily recommended restricting the use of the vaccine for adults aged 65 years and above.

At its July 7–10 2025 meeting, PRAC concluded its review of Ixchiq and the temporary age restriction for adults aged 65 and above was lifted because this is the age group in which chikungunya can be severe. However, PRAC strongly emphasised that **Ixchiq should only be used when there is a significant risk of chikungunya infection and after a careful benefit-risk evaluation** in all age groups. Healthcare professionals were reminded that Ixchiq must not be given to people whose immune system is weakened because of disease or medical treatment as they are at greater risk of having complications from vaccines containing live attenuated viruses. Updated product information and a Direct Healthcare Professional Communication (DHPC) were produced.

In September 2025, the French National Agency for the Safety of Medicines and Health Products (ANSM) updated their Ixchiq vaccine recommendations to align with the PRAC advice, specifying that regardless of age, Ixchiq vaccine could be administered to individuals at high risk of chikungunya infection following a careful individual risk-benefit assessment.

Actions

No specific action currently ongoing at ECDC on this event.

Last time this event was included in the Weekly CDTR: 18 July 2025.

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

Overview

On 15 March 2026, the Cambodian Ministry of Health reported a new human case of avian influenza A(H5N1) virus infection in an adult woman in her forties from Preah Netr Preah District in Banteay Meanchey province.

The woman is currently isolated in hospital and has received treatment with oseltamivir. Epidemiological investigations revealed that the patient had had contact with poultry and that some of the birds were sick and had died. On 14 March 2026, the National Institute of Public Health confirmed infection with avian influenza A(H5N1). No additional information is available at this time.

National and local authorities are actively investigating the event and implementing response measures. As part of the response, close contacts of the case have received antiviral prophylaxis (oseltamivir), and health education campaigns are ongoing in the affected villages.

This is the second human case reported in Cambodia this year. The previous case (in a male) was reported in February 2026. Clade 2.3.2.1e has been circulating among birds in Cambodia and has been detected in infected humans in the past. Overall, since 2003, Cambodia has reported 92 cases, including 52 deaths (CFR: 48%).

Summary

Since 2003, there have been 996 human cases of avian influenza A(H5N1) infection worldwide*, including 477 deaths (CFR: 48%). 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).

Acknowledgements: we gratefully acknowledge all data contributors, i.e. the authors and their originating laboratories responsible for obtaining the specimens, and the submitting laboratories for generating the genetic sequences and metadata and sharing via the GISAID Initiative.

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 information currently available, the overall risk related to zoonotic influenza for the general population in the EU/EEA is considered low.

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

Actions

ECDC monitors avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly updated avian influenza overview. The most recent report was published in December 2025.

Last time this event was included in the Weekly CDTR: 27 February 2026.

6. Overview of respiratory virus epidemiology in the EU/EEA

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.

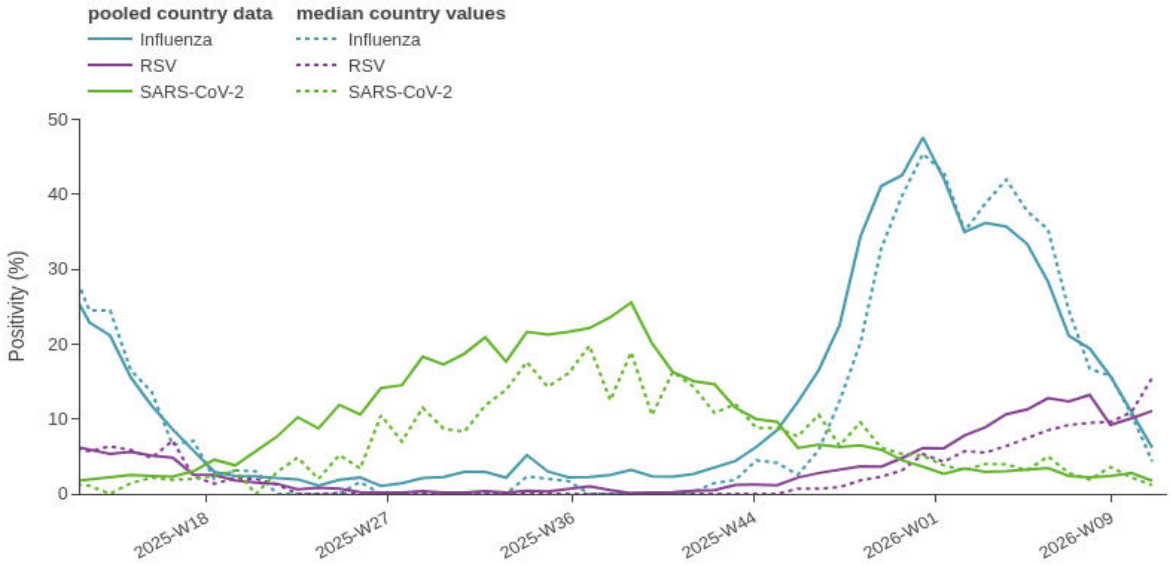
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

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

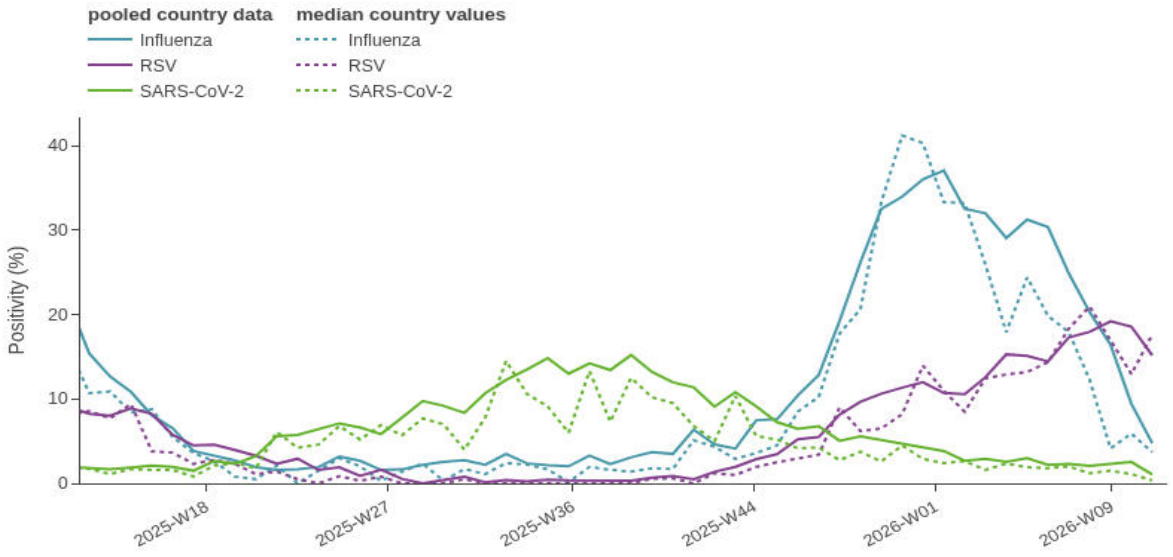
Maps and graphs

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



Source: ECDC

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



Source: ECDC

Figure 3. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	**Syndrome or pathogen**	**Week 11**	**Week 10**	**Description**	**Value**
ILI/ARI consultation rates in primary care	ARI	13 rates (7 MEM)	18 rates (10 MEM)	Distribution of country MEM categories	6 Baseline 1 Low
	ILI	15 rates (13 MEM)	21 rates (19 MEM)		12 Baseline 1 Medium
ILI/ARI test positivity in primary care	Influenza	18	19	Pooled (median; IQR)	6.2% (4.3; 2.4–13%)
	RSV	16	18		11% (16; 7.3–18%)
	SARS-CoV-2	16	18		1.7% (1.1; 0–2.6%)
SARI rates in hospitals	SARI	9 rates (4 MEM)	12 rates (6 MEM)	Distribution of country MEM categories	4 Baseline
SARI test positivity in hospitals	Influenza	8	10	Pooled (median; IQR)	4.8% (3.7; 1–6.4%)
	RSV	8	10		15% (18; 9.2–22%)
	SARS-CoV-2	8	10		1.1% (0.3; 0–0.8%)
Intensity (country-defined)	Influenza	18	24	Distribution of country qualitative categories	8 Baseline 7 Low 2 Medium 1 High
Geographic spread (country-defined)	Influenza	16	22	Distribution of country qualitative categories	1 No activity 5 Sporadic 1 Regional 9 Widespread

Source: ECDC

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

	Week 11, 2026		Week 40, 2025 – week 11, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**91**	**–**	**18145**	**–**
Influenza A	89	98	17605	99
A(H1)pdm09	23	45	4005	28
A(H3)	28	55	10498	72
A (unknown)	38	–	3102	–
Influenza B	2	2	95	0.5
B/Vic	0	–	30	100
B (unknown)	2	–	65	–
Influenza untyped	0	–	445	–
RSV	**147**	**–**	**4234**	**–**
RSV-A	16	55	757	49
RSV-B	13	45	802	51
RSV untyped	118	–	2675	–
SARS-CoV-2	**23**	**–**	**3829**	**–**

Source: ECDC

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

	Week 11, 2026		Week 40, 2025 – week 11, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**58**	**–**	**14568**	**–**
Influenza A	19	95	8640	99
A(H1)pdm09	5	71	1309	36
A(H3)	2	29	2375	64
A (unknown)	12	–	4956	–
Influenza B	1	5	53	0.6
B/Vic	0	–	6	100
B (unknown)	1	–	47	–
Influenza untyped	38	–	5875	–
RSV	**183**	**–**	**5775**	**–**
RSV-A	10	43	1075	55
RSV-B	13	57	871	45
RSV untyped	160	–	3829	–
SARS-CoV-2	**12**	**–**	**2775**	**–**

Source: ECDC

Figure 6. **Genetically characterised influenza virus distribution, week 40, 2025 – week 11, 2026**

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	2723	40	5a.2a.1(D.3.1)	2620	96
			5a.2a.1(D)	97	4
			5a.2a(C.1.9.3)	6	0.2
A(H3)	3985	59	2a.3a.1(K)	3565	89
			2a.3a.1(J.2)	283	7
			2a.3a.1(J.2.4)	83	2
			2a.3a.1(J.2.2)	29	0.7
			2a.3a.1(J)	25	0.6
B/Vic	29	0.4	V1A.3a.2(C.5.6)	10	34
			V1A.3a.2(C.5.6.1)	8	28
			V1A.3a.2(C.5.1)	7	24
			V1A.3a.2(C.5)	2	7
			V1A.3a.2(C.5.7)	2	7

Source: ECDC

Figure 7. **SARS-CoV-2 variant distribution, week 9, 2026 - week 10, 2026**

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	0	0	0%
NB.1.8.1	VUM	1	12	92% (92–92%)
XFG	VUM	1	1	8% (8–8%)
BA.3.2	VUM	0	0	0%

Source: ECDC

Events under active monitoring

- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Human cases of influenza virus A(H1N1) variant of swine origin - Multi-country
- Overview of respiratory virus epidemiology in the EU/EEA
- Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026
- Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles
- Dengue cases – EU/EEA ex. Maldives – 2025-2026
- Invasive meningococcal disease - England - 2026
- Mpox clade Ib and clade IIb recombinant strain
- Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2026
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update
- SARS-CoV-2 variant classification
- Chikungunya virus disease – Mayotte, France – 2026