WEEKLY BULLETIN

Communicable disease threats report

Week 14, 28 March to 3 April 2026

This week's topics

Executive Summary

Transmission of integrase inhibitor-resistant HIV-1 – Multi country – 2026

- As of March 2026, 33 people from Belgium, Denmark, France, Greece, Hungary, Lithuania, Luxembourg and the Netherlands were reported as having been diagnosed between 2014 and 2025 with HIV infection carrying high-level or major resistance to the antiretroviral treatment class integrase strand transfer inhibitors (INSTI). Ireland, Norway, Romania and Spain reported zero such cases. In the countries reporting cases, all were treatment-naive, and some had additional nucleoside and non-nucleoside reverse transcriptase inhibitor resistance.
- The number of cases reported with high-level INSTI resistance are very few relative to the number of people newly diagnosed with HIV during the period. Therefore, there is no current evidence of widespread transmission of INSTI-resistant HIV in the EU/EEA.
- Close monitoring is essential with increasing use of long-acting cabotegravir pre-exposure prophylaxis (PrEP), as emerging INSTI resistance may impact both treatment and prevention, including potential cross-resistance with the INSTI dolutegravir.

SARS-CoV-2 variant classification

- Since the last update on 27 February 2026, and as of 27 March 2026, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) or De-escalated variants.
- For this update, sufficient data for estimating variant proportions during the reporting weeks were only available from one EU/EEA country. Therefore, the statistics below represent a very limited part of the EU/EEA.

European Centre for Disease Prevention and Control, Solna, Sweden
www.ecdc.europa.eu

Classified as ECDC NORMAL

- The VOI and VUM median proportions in the EU/EEA for weeks 10-11, 2026 were:
  - BA.2.86 (VOI): 0.0%
  - NB.1.8.1 (VUM): 10.0%
  - XFG (VUM): 10.0%
  - BA.3.2 (VUM): 30.0%.

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

- On 31 March 2026, the Cambodian Ministry of Health reported a new human case of avian influenza A(H5N1) virus infection in a child from Banteay Ampil District in Oddar Meanchey province.
- The patient is being isolated and receiving medical treatment 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 997 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.

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

- Since the previous update on 2 March 2026, and as of 30 March 2026, no new MERS cases have been reported by the World Health Organization (WHO) or national health authorities.
- Since the beginning of 2026, and as of 30 March 2026, no MERS cases have been reported by WHO or national health authorities.
- The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in the general population is also considered to be low. The current MERS-CoV situation poses a low risk to the EU/EEA.

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

- Since 1 January 2026 and as of 30 March 2026, 44 602 cholera cases, including 496 deaths, have been reported worldwide.
- Since 25 February 2026 and as of 30 March 2026, 17 723 new cholera cases, including 212 new deaths, have been reported worldwide.
- The five countries reporting the most cases are Afghanistan (7 758), Democratic Republic of the Congo (5 775), Mozambique (2 496), South Sudan (455) and Somalia (386).
- The five countries reporting the most new deaths are Democratic Republic of the Congo (176), Mozambique (20), South Sudan (6), Angola (3) and Afghanistan (2).
- Cholera cases have continued to be reported in Africa, Asia, the Middle East, and the Americas. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

1. Transmission of integrase inhibitor-resistant HIV-1 – Multi country – 2026

Overview:

On 4 March 2026, **the Netherlands** reported two patients with baseline resistance to all currently available integrase strand transfer inhibitors (INSTIs). Both individuals were diagnosed with HIV-1 subtype B in autumn 2025 and had no history of pre-exposure prophylaxis (PrEP) or antiretroviral treatment (ART).

The first patient was a heterosexual man from the Netherlands, who reported no sexual partners since 2022. No resistance mutations were detected in the reverse transcriptase or protease genes; however, mutations associated with INSTI resistance (G140S and Q148H) were identified in the integrase gene.

The second patient was a bisexual man from South America who had immigrated to the Netherlands. In this case, no resistance mutations were found in the protease gene, but several were identified in the reverse transcriptase gene (K101E, Y181C, H221Y), conferring resistance to non-nucleoside reverse transcriptase inhibitors (NNRTIs). Additionally, mutations associated with INSTI resistance (E138K and Q148K) were detected in the integrase gene.

There was no evidence of an epidemiological link between the two cases, and phylogenetic analysis also showed no molecular linkage. There is no ongoing surveillance of HIV drug resistance at the EU-level.

In response to the report from the Netherlands, 11 other EU/EEA countries have provided additional information. Given the differences between countries with regard to laboratory surveillance of HIV drug resistance, the comprehensiveness and period of reporting varies.

Belgium reported that among new diagnoses from 2024, there were no cases of clinically relevant transmitted drug resistance to all INSTIs but that eight people carried mutations conferring low-level resistance to at least one INSTI. Among them, one person carried a mutation conferring high-level resistance to elvitegravir. Three others had low-level transmitted drug resistance to cabotegravir, but no clinically relevant resistance to other second-generation INSTI. One of these three carried a mutation conferring high-level resistance to raltegravir, and additional major mutations conferring resistance to protease inhibitors.

Denmark reported two patients with INSTI resistance. The first patient, diagnosed in 2024, was an individual infected abroad many years earlier through a blood transfusion. This patient showed resistance to nucleoside reverse transcriptase inhibitors (NRTIs) and NNRTIs, as well as high-level resistance to all INSTIs, including raltegravir, elvitegravir, dolutegravir, cabotegravir and bictegravir. The second patient, reported in 2025, also involved an individual infected abroad. This case showed resistance to some INSTIs (raltegravir and elvitegravir), but no resistance to other drug classes. Molecular analysis showed no linkage between these two cases or with any other cases reported in Denmark.

France reported 11 patients with major INSTI resistance. Since 2014, monitoring of INSTI-associated resistance mutations has been implemented in France as part of the surveillance of HIV primary infections. The French HIV National Center analysed 3 913 sequences between 2014 and 2025 and 3.2–7.1%, according to year of inclusion, carried resistance to at least one INSTI. Major INSTI resistance mutations conferring resistance to second generation INSTIs were identified in 11 cases: three R263K (detected in 2014: 2; 2020: 1), seven E138K/T (2016: 2; 2018: 1; 2019: 1; 2023: 3) and one S230R (detected in 2022). However, resistance mutations associated with first-generation INSTIs were detected in 146 patients. Specifically,92 patients presented with an E157Q mutation, 53 patients presented with a T97A mutation and one patient had both mutations. These were polymorphic mutations present in non-B subtype strains prior to the initiation of INSTI therapy.

Greece reported nine ART-naive cases. Of these, two patients identified in 2025 carried major resistance mutations to INSTIs. The first carried the Q148R mutation, with additional mutations including V179I in reverse transcriptase and L74I in integrase. The second included the G140R mutation in integrase, with no additional resistance-associated mutations detected. Between 2021 and 2024, seven cases were reported with major INSTI resistance mutations, including N155H, E138K, E138A, Y143C and S147G.

Hungary reported four newly diagnosed, previously untreated patients (two in 2021 and two in 2023) with major INSTI resistance mutations; however, only two had HIV strains conferring intermediate- or high-level resistance to raltegravir and/or elvitegravir. Additional cases with accessory mutations were also reported.

Lithuania reported two people diagnosed in 2024 with high-level resistance to all four INSTIs (raltegravir, elvitegravir, dolutegravir and bictegravir). Both patients also showed varying levels of resistance to NRTIs. One case involved genotype A, while the other was a recombinant A/B genotype. In 2023, two cases were reported with intermediate resistance to all four INSTIs. One of these cases also exhibited high and intermediate resistance to certain NRTIs and had a mixed genotype (A/B/D). The other case showed no resistance to other antiretroviral drug classes and was classified as genotype A.

Luxembourg reported one patient diagnosed in autumn 2025 with the integrase mutation R263K. The individual was born in Cameroon and had no history of previous treatment.

Norway reported zero cases of resistance to currently available INSTIs. In 2024, polymorphisms or accessory mutations without known clinical significance were identified in a total of 10 samples, all but one from patients infected abroad.

Ireland reported zero cases conferring high-level resistance to all drugs in the integrase inhibitor class and there are no cases matching the specific combinations of DRM reported by the Netherlands from 2023 to 2025.

Spain reported zero cases. It should be noted that Spain does not currently have a national surveillance system for HIV drug resistance. Nevertheless, a 2024 study analysing 624 samples from 29 hospitals participating in the CoRIS cohort found no evidence of INSTI resistance.

Romania reported zero cases.

ECDC assessment:

As of March 2026, 33 treatment-naive patients without PrEP history were reported by Belgium, Denmark, France, Greece, Hungary, Lithuania, Luxembourg and the Netherlands with viruses carrying high-level or major INSTI resistance and varying NNRTI and NRTI resistance. Additional persons with low-level resistance were reported. Findings of resistance in treatment-naive patients are evidence of transmission of INSTI-resistant HIV, which has been historically rare.

Although the number of reported cases remains small, and there is currently no evidence of widespread transmission of INSTI-resistant viruses across the EU/EEA, the absence of epidemiological or molecular linkage between cases reported by countries suggests that these are likely isolated transmission events rather than large transmission clusters. Nevertheless, HIV transmitted drug resistance in the EU/EEA remains an important public health concern, particularly in the context of expanding ART options and the increasing use of INSTIs.

Close monitoring of transmitted drug resistance is particularly important in the context of the increasing use of long-acting cabotegravir for PrEP. The emergence and transmission of INSTI resistance could have significant implications for both treatment effectiveness and prevention strategies (PrEP), including potential cross-resistance with the commonly used INSTI, dolutegravir.

Actions:

- ECDC will continue to closely monitor the situation of HIV drug resistance in the EU/EEA.
- EACS guidelines recommend that clinicians order genotypic resistance testing prior to the initiation of ART, ideally at the time of HIV diagnosis.
- EU/EEA countries are encouraged to share information on unusual patterns of HIV drug resistant cases, including microbiological resistance data – particularly for INSTIs – via EpiPulse to enable early detection of emerging patterns.

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

2. SARS-CoV-2 variant classification

Overview:

Since the last update on 27 February 2026, and as of 27 March 2026, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) or De-escalated variants.

The VOI median proportions in the EU/EEA for weeks 10–11 2026, based on one reporting country:

BA.2.86 (VOI): 0.0%.

The VUM median proportions in the EU/EEA for weeks 10–11 2026, based on one reporting country:

NB.1.8.1 (VUM): 10.0%
XFG (VUM): 10.0%
BA.3.2 (VUM): 30.0%.

The calculations are based on data reported to GISAID, as of 22 March 2026. Note that for this update, sufficient data for estimating variant proportions during the reporting weeks were only available from one EU/EEA country. The statistics therefore only represent a very limited part of the EU/EEA.

ECDC assessment:

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

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

Actions:

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

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

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

Last time this event was included in the Weekly CDTR: 6 March 2026

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

Overview:

On 31 March 2026, the Cambodian Ministry of Health reported a new human case of avian influenza A(H5N1) virus infection in a boy under five years old from Banteay Ampil District in Oddar Meanchey province.

The child is currently isolated in hospital and is receiving treatment. Epidemiological investigations revealed that the patient had played with poultry and that there had been sick and dead poultry both in the household and in the village. On 29 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 third human case reported in Cambodia this year. The previous case (in a woman) was reported on 15 March 2026. Information about the virus clade has not been reported for the recent cases. Clade 2.3.2.1e has been circulating among birds in Cambodia and has been detected in infected humans in the recent past. Overall, since 2003, Cambodia has reported 93 cases, including 52 deaths (CFR: 56%).

Summary:
Since 2003, there have been 997 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 March 2026.

Last time this event was included in the Weekly CDTR: 20 March 2026

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

Overview:

Update: Since the previous update on 2 March 2026, and as of 30 March 2026, no new MERS cases have been reported by WHO or national health authorities.

Summary: Since the beginning of 2026, and as of 30 March 2026, no MERS cases have been reported by WHO or national health authorities.

Since April 2012, and as of 30 March 2026, a total of 2 647 MERS cases, including 959 deaths, have been reported by health authorities worldwide.

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

ECDC assessment:

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

ECDC published a technical report, 'Health emergency preparedness for imported cases of high-consequence infectious diseases', in October 2019 that is still useful for EU Member States wishing to assess their level of preparedness for a disease such as MERS. ECDC also published 'Risk assessment guidelines for infectious diseases transmitted on aircraft (RAGIDA) – Middle East respiratory syndrome coronavirus (MERS-CoV)' on 22 January 2020.

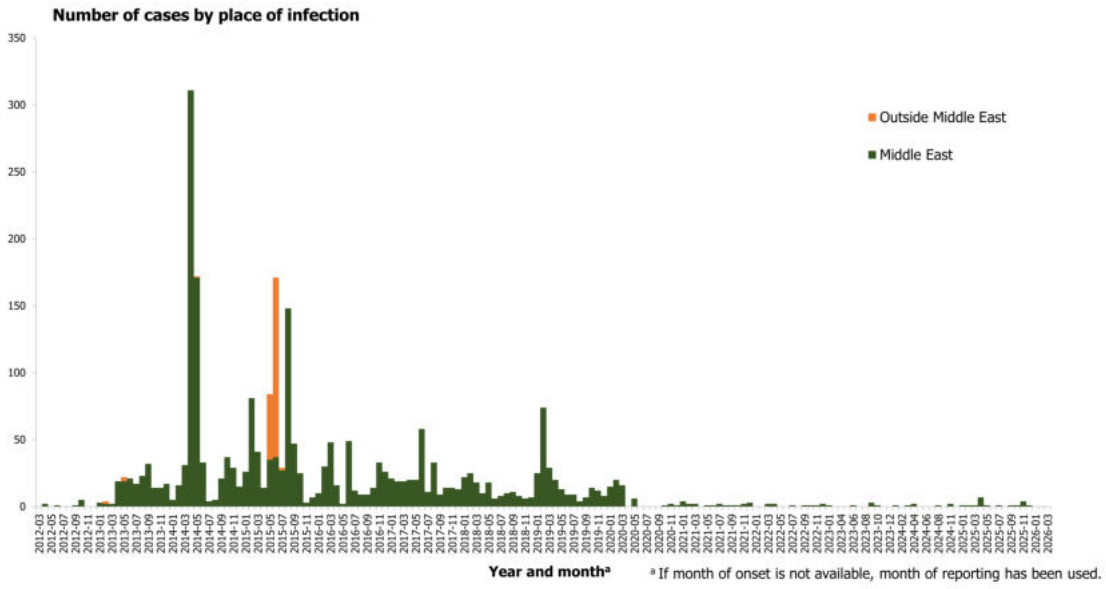
Actions:

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

Last time this event was included in the Weekly CDTR: 6 March 2026

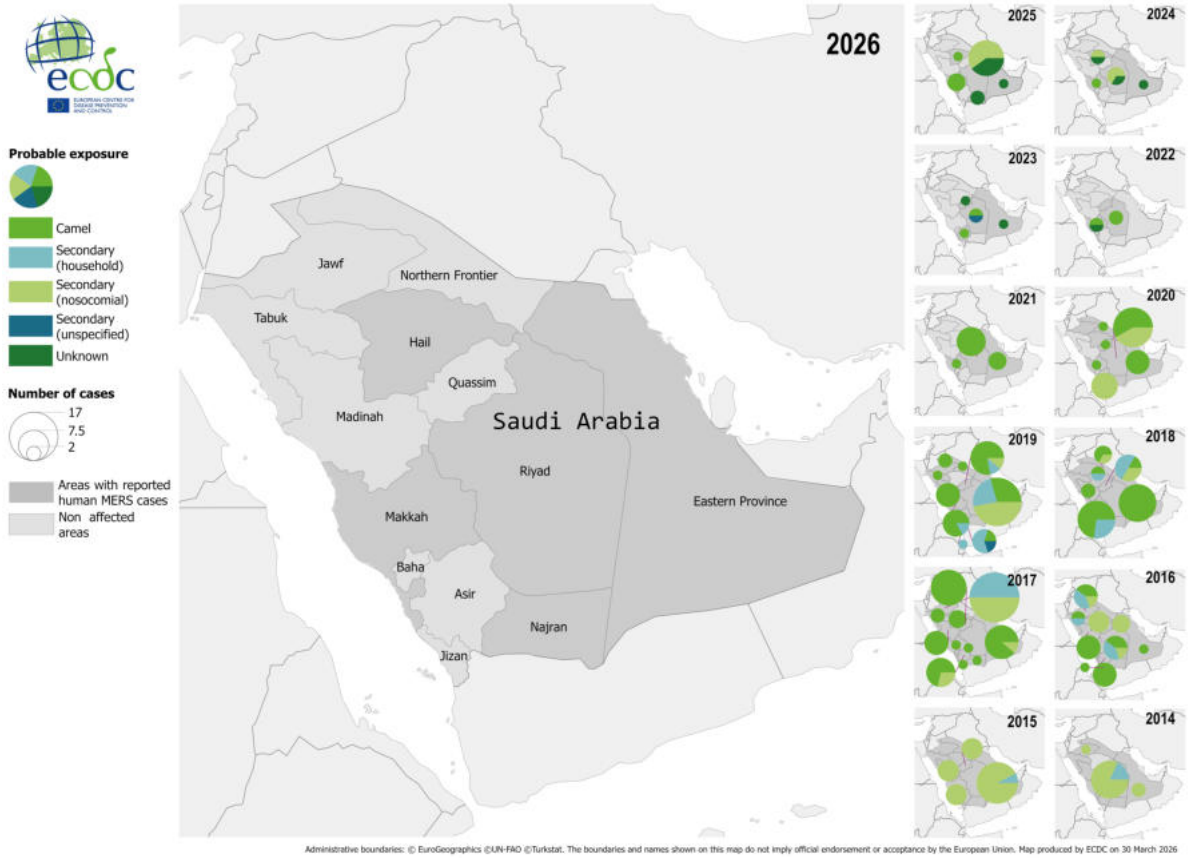
Maps and graphs

Figure 1. Distribution of confirmed cases of MERS by place of infection and month of onset, April 2012 to March 2026



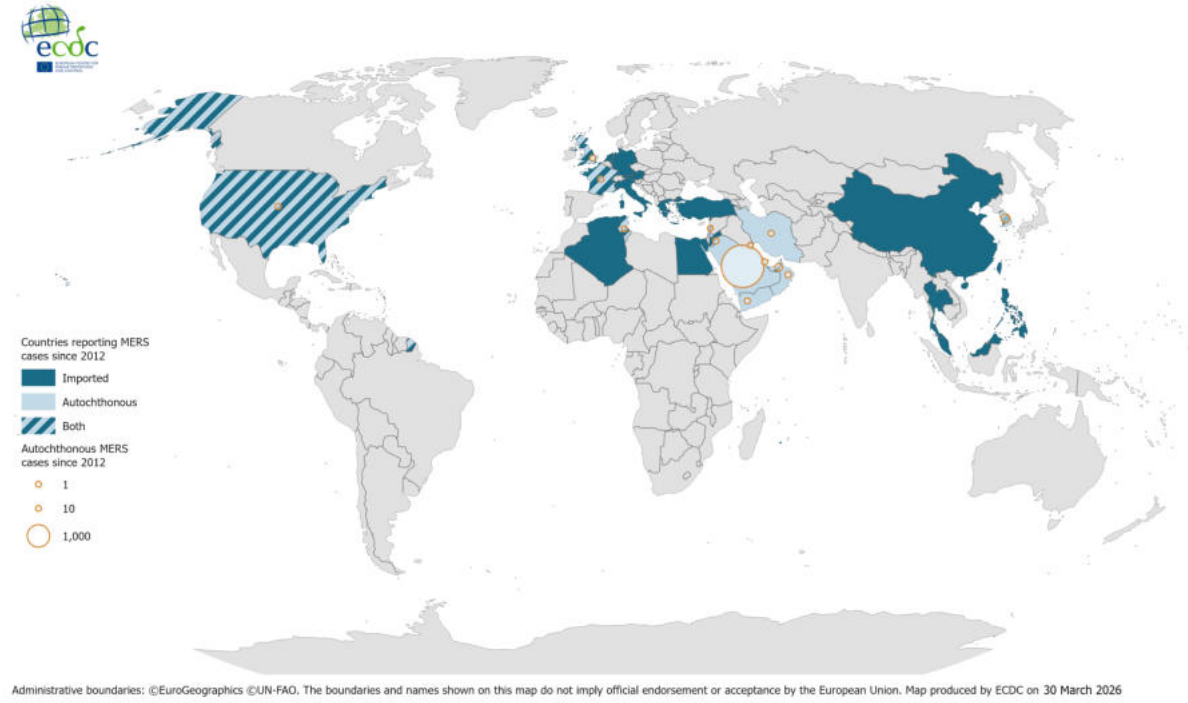
Source: ECDC

Figure 2. Geographical distribution of confirmed cases of MERS in Saudi Arabia by probable region of infection and exposure, with dates of onset from January 2014 to March 2026



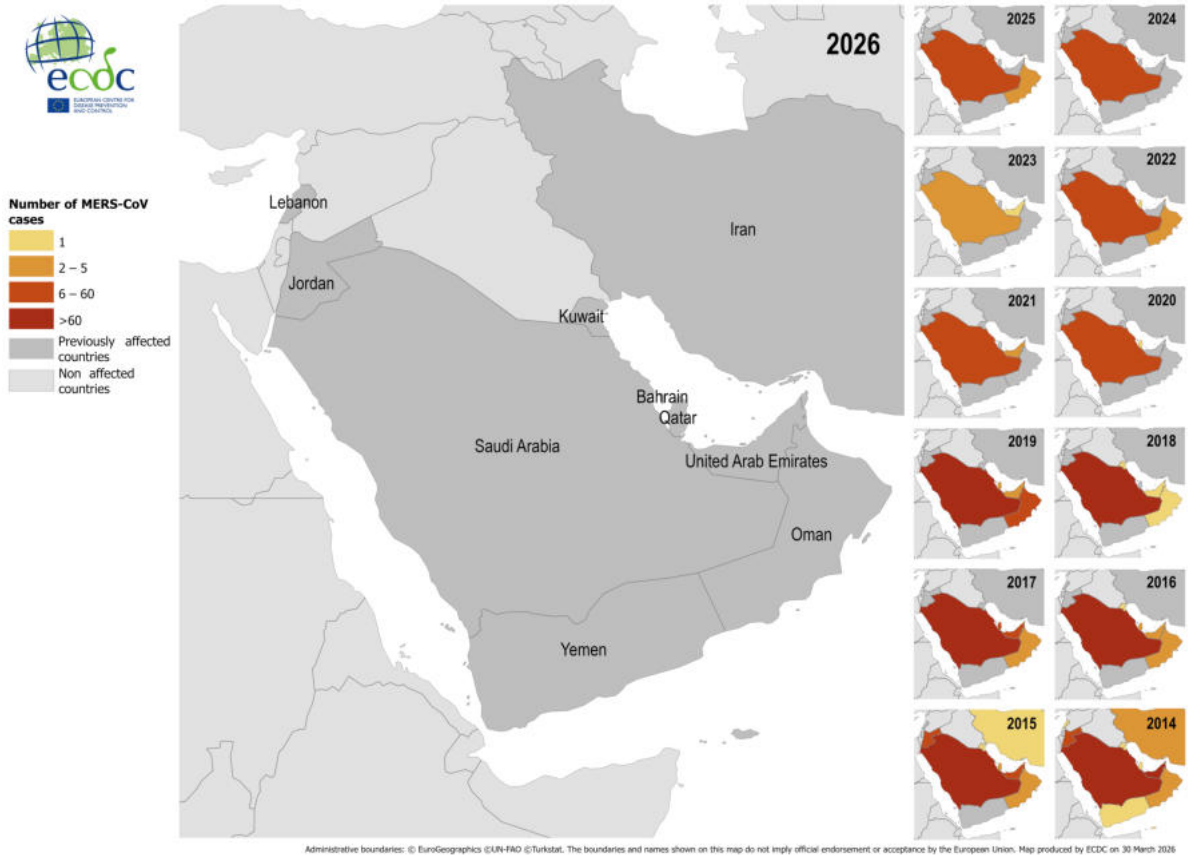
Source: ECDC

Figure 3. Geographical distribution of confirmed cases of MERS by reporting country, April 2012 to March 2026



Source: ECDC

Figure 4. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2014 to March 2026



Source: ECDC

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

Overview:

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

Update

Since 25 February 2026 and as of 30 March 2026, 17 723 new cholera cases, including 212 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Burundi, Democratic Republic of the Congo, Haiti, India, Malawi, Mozambique, Myanmar/Burma, Namibia, Pakistan, Rwanda, Somalia, South Sudan, United Republic of Tanzania, Yemen, Zambia and Zimbabwe.

The five countries reporting most cases are Afghanistan (7 758), Democratic Republic of the Congo (5 775), Mozambique (2 496), South Sudan (455) and Somalia (386).

New deaths have been reported from Afghanistan, Angola, Democratic Republic of the Congo, Haiti, Mozambique, South Sudan, United Republic of Tanzania, Zambia and Zimbabwe.

The five countries reporting most new deaths are Democratic Republic of the Congo (176), Mozambique (20), South Sudan (6), Angola (3) and Afghanistan (2).

In the previous reporting period (28 January to 25 February 2026), 24 009 new cholera cases, including 275 new deaths, were reported worldwide.

In addition, 1 165 new cases were reported or collected retrospectively from before 25 February 2026.

Since 1 January 2026 and as of 30 March 2026, 44 602 cholera cases, including 496 deaths, have been reported worldwide. In comparison, since 1 January 2025 and as of 30 March 2025, 95 191 cholera cases, including 1 188 deaths, were reported worldwide.

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

Asia:

Afghanistan:
Since 9 February 2026 and as of 16 March 2026, 7 758 new cases, including two new deaths, have been reported. Since 1 January 2026 and as of 16 March 2026, 17 218 cases, including six deaths, have been reported. In comparison, in 2025 and as of 17 March 2025, 19 652 cases, including eight deaths, were reported.

India:
Since 28 December 2025 and as of 9 February 2026, 26 new cases have been reported. Since 1 January 2026 and as of 9 February 2026, 26 cases have been reported. In comparison, in 2025 and as of 3 March 2025, 93 cases were reported.

Myanmar/Burma:
Since 9 February 2026 and as of 2 March 2026, 19 new cases have been reported. Since 1 January 2026 and as of 2 March 2026, 139 cases have been reported. In comparison, in 2025 and as of 10 March 2025, 1 004 cases were reported.

Pakistan:
Since 19 January 2026 and as of 9 February 2026, 631 new cases have been reported. Since 1 January 2026 and as of 9 February 2026, 1 124 cases have been reported. In comparison, in 2025 and as of 10 February 2025, 4 038 cases were reported.

Yemen:
Since 9 February 2026 and as of 16 February 2026, 296 new cases have been reported. Since 1 January 2026 and as of 16 February 2026, 1 922 cases, including one death, have been reported. In comparison, in 2025 and as of 24 February 2025, 10 080 cases, including 10 deaths were reported.

Africa:

Angola:
Since 18 February 2026 and as of 23 March 2026, 192 new cases, including three new deaths, have been reported. Since 1 January 2026 and as of 23 March 2026, 390 cases, including nine deaths, have been reported. In comparison, in 2025 and as of 14 March 2025, 7 119 cases, including 258 deaths, were reported.

Burundi:
Since 18 February 2026 and as of 23 March 2026, 126 new cases have been reported. Since 1 January 2026 and as of 23 March 2026, 531 cases, including two deaths, have been reported. In comparison, in 2025 and as of 17 March 2025, 129 cases were reported.

Democratic Republic of the Congo: Since 18 February 2026 and as of 23 March 2026, 5 775 new cases, including 176 new deaths, have been reported. Since 1 January 2026 and as of 23 March 2026, 15 100 cases, including 395 deaths, have been reported. In comparison, in 2025 and as of 10 March 2025, 11 918 cases, including 240 deaths, were reported.

Malawi:
Since 18 February 2026 and as of 23 March 2026, 25 new cases have been reported. Since 1 January 2026 and as of 23 March 2026, 90 cases, including two deaths, have been reported. In comparison, in 2025 and as of 20 March 2025, 91 cases, including three deaths, were reported.

Mozambique:
Since 18 February 2026 and as of 23 March 2026, 2 496 new cases, including 20 new deaths, have been reported. Since 1 January 2026 and as of 23 March 2026, 5 659 cases, including 57 deaths, have been reported. In comparison, in 2025 and as of 3 February 2025, 64 cases were reported.

Namibia:
Since 18 February 2026 and as of 23 March 2026, 29 new cases have been reported. Since 1 January 2026 and as of 23 March 2026, 49 cases have been reported. In comparison, in 2025 and as of 2 March 2025, one case was reported.

Rwanda:
Since 31 December 2025 and as of 23 March 2026, 18 new cases have been reported. Since 1 January 2026 and as of 23 March 2026, 18 cases have been reported. In comparison, in 2025 and as of 30 March 2025, no cases were reported.

Somalia:
Since 18 February 2026 and as of 23 March 2026, 386 new cases have been reported. Since 1 January 2026 and as of 23 March 2026, 709 cases have been reported. In comparison, in 2025 and as of 17 February 2025, 1 409 cases, including one death were reported.

South Sudan: Since 31 December 2025 and as of 23 March 2026, 455 new cases, including six new deaths have been reported. Since 1 January 2026 and as of 23 March 2026, 455 cases, including six deaths, have been reported. In comparison, in 2025 and as of 17 March 2025, 25 179 cases, including 389 deaths were reported.

United Republic of Tanzania: Since 31 December 2025 and as of 23 March 2026, 113 new cases, including two new deaths, have been reported. Since 1 January 2026 and as of 23 March 2026, 113 cases, including two deaths, have been reported. In comparison, in 2025 and as of 17 March 2025, 2 085 cases, including 16 deaths were reported.

Zambia:
Since 18 February 2026 and as of 23 March 2026, 300 new cases, including two new deaths, have been reported. Since 1 January 2026 and as of 23 March 2026, 536 cases, including nine deaths, have been reported. In comparison, in 2025 and as of 3 March 2025, 315 cases, including nine deaths, were reported.

Zimbabwe:
Since 18 February 2026 and as of 23 March 2026, 31 new cases, including one new death, have been reported. Since 1 January 2026 and as of 23 March 2026, 36 cases, including two deaths, have been reported. In comparison, in 2025 and as of 12 March 2025, 248 cases, including seven deaths, were reported.

Since 25 February 2026, no updates have been reported by: Ethiopia, Nigeria and Sudan.

Americas:

Haiti:
Since 28 December 2025 and as of 16 February 2026, 212 new cases, including two new deaths, have been reported. Since 1 January 2026 and as of 16 February 2026, 212 cases, including two deaths, have been reported. In comparison, in 2025 and as of 5 January 2025, 369 cases, including 27 deaths, were reported.

ECDC assessment:

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

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

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

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

Actions:

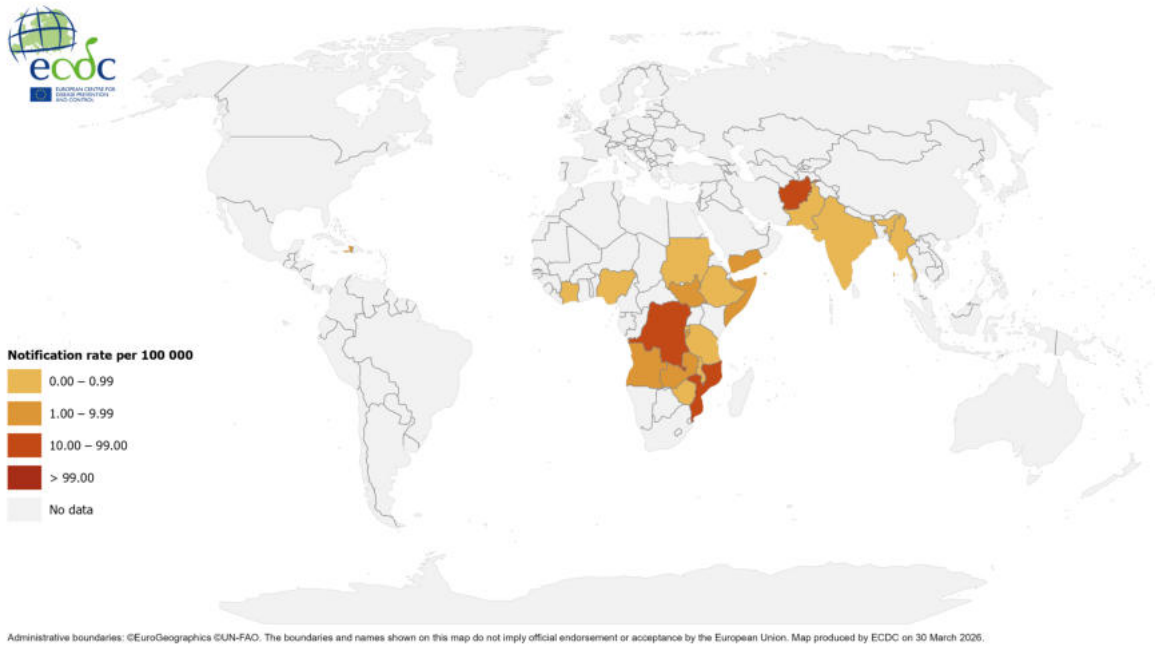
ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities.

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

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

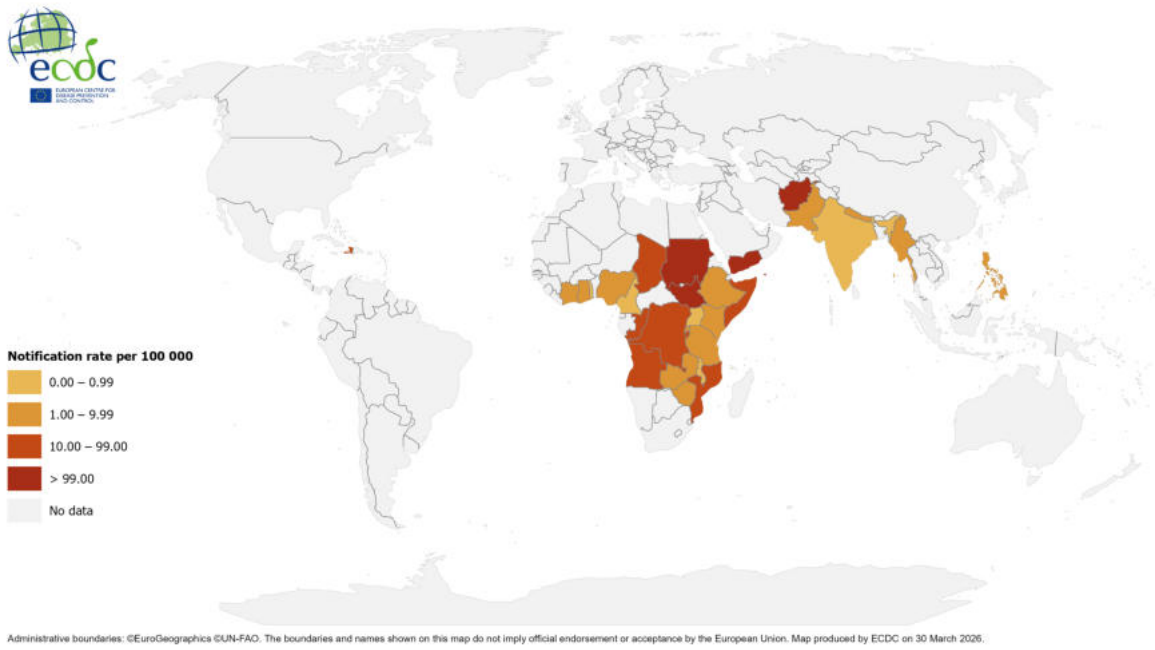
Maps and graphs

Figure 5. Geographical distribution of cholera cases reported worldwide from January to March 2026



Source: ECDC

Figure 6. Geographical distribution of cholera cases reported worldwide from March 2025 to March 2026



Source: ECDC

Events under active monitoring

- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Overview of respiratory virus epidemiology in the EU/EEA
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks
- Invasive meningococcal disease - England - 2026
- Dengue virus detection in mosquitoes - Switzerland - 2024
- Aedes aegypti detection – Luxembourg – 2025
- Measles outbreak in Latvia 2026
- Human case of avian influenza A(H9N2) - Italy (imported) - 2026
- Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026
- Dengue cases – EU/EEA ex. Maldives – 2025-2026
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026
- Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2026
- Chikungunya virus disease – Mayotte, France – 2026
- SARS-CoV-2 variant classification
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Transmission of integrase inhibitor-resistant HIV-1 - Multi country - 2026