WEEKLY BULLETIN

Communicable disease threats report

Week 18, 25 April to 1 May 2026

This week's topics

Executive Summary

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

- On 29 April 2026, WHO reported a fatal human case of avian influenza A(H5N1) virus infection in a child from Bangladesh with disease onset on 21 January 2026.
- The patient had exposure to sick and dead poultry before disease onset; environmental samples tested positive for A(H5) from poultry in the community and from frozen chicken meat from the household freezer.
- No new cases have been detected among close contacts of the case.
- Since 2003, a total of 998 confirmed human cases of A(H5N1) have been reported worldwide, including 478 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.

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

- Since 1 January 2026 and as of 28 April 2026, 65 153 cholera cases, including 768 deaths, have been reported worldwide.
- Since 30 March 2026 and as of 28 April 2026, 20 028 new cholera cases, including 272 new deaths, have been reported worldwide.
- The five countries reporting the most cases are Afghanistan (7 446), Democratic Republic of the Congo (6 146), Yemen (1 564), Malawi (1 486) and Mozambique (944).
- The five countries reporting the most new deaths are Democratic Republic of the Congo (216), Angola (17), Nigeria (16), Congo (12) and Zambia (4).

- 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.

SARS-CoV-2 variant classification

- Since the last update on 27 March 2026, and as of 24 April 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.
- The VOI and VUM median proportions in the EU/EEA for weeks 14–15, 2026 were:
  - BA.2.86 (VOI): 0.0%
  - NB.1.8.1 (VUM): 4.0%
  - XFG (VUM): 12.0%
  - BA.3.2 (VUM): 80.0%.

Chikungunya virus disease – French Guiana, France – 2026

- There is ongoing chikungunya virus circulation in French Guiana, with 143 cases reported since January 2026.
- 80% of the cases were confirmed in the Littoral ouest sector and, on 23 April, this sector was declared to be in the epidemic phase of the outbreak.
- The current likelihood of chikungunya virus infection for travellers to French Guiana is assessed as low; the likelihood of onward transmission in mainland Europe following introduction by a viraemic traveller is considered very low.
- Travellers should be advised to take enhanced mosquito bite prevention measures. Vaccination may be considered based on national recommendations.

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

Overview:

On 29 April 2026, WHO reported a fatal human case of avian influenza A(H5N1) virus infection in a child from Chattogram Division, Bangladesh. The child developed symptoms on 21 January 2026, was hospitalised on 28 January and admitted to intensive care on 31 January, and died on 1 February 2026. The patient had no known comorbidities.

A nasopharyngeal swab collected on 29 January 2026 through the hospital-based influenza surveillance platform tested positive for influenza A(H5) by real-time RT-PCR at the National Influenza Centre (IEDCR) on 7 February 2026. Whole genome sequencing at the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) identified A(H5N1) clade 2.3.2.1a (Gs/GD lineage), consistent with strains circulating in poultry in Bangladesh since 2011. Sequence data are available in GISAID (EPI_ISL_20367262; submitted 19 February 2026; IEDCR). Epidemiological investigation identified exposure to household poultry; two ducks and one chicken reportedly died shortly before illness onset. Animal and environmental investigations by icddr,b found influenza A(H5) by RT-PCR in two duck samples from the community and in two chicken meat samples from the household freezer; serology was also performed. Samples from symptomatic close human contacts tested negative for influenza A(H5).

This is the first confirmed human A(H5) case in Bangladesh in 2026. In 2025, four cases were reported in Bangladesh.

Summary:
Since 2003, there have been 998 human cases of avian influenza A(H5N1) infection worldwide*, including 478 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 currently available information, 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. Application of personal protective measures in people exposed to infected animals or their environment can reduce the associated risk. The recent severe cases in Asia and the Americas in children and people exposed to infected, sick or dead backyard poultry underline the risk of unprotected contact with infected birds in backyard farm settings. This 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: 24 April 2026

2. 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 30 March 2026 and as of 28 April 2026, 20 028 new cholera cases, including 272 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Burundi, Congo, Democratic Republic of The Congo, Malawi, Mozambique, Myanmar/Burma, Nigeria, Pakistan, Somalia, Yemen and Zambia

The five countries reporting the most cases are Afghanistan (7 446), Democratic Republic of The Congo (6 146), Yemen (1 564), Malawi (1 486) and Mozambique (944).

New deaths have been reported from Afghanistan, Angola, Congo, Democratic Republic of The Congo, Malawi, Mozambique, Nigeria, Yemen and Zambia.

The five countries reporting the most new deaths are Democratic Republic of The Congo (216), Angola (17), Nigeria (16), Congo (12) and Zambia (4).

In the previous reporting period (25 February to 30 March 2026), 17 723 new cholera cases, including 212 new deaths, were reported worldwide.

In addition, 523 new cases were reported or collected retrospectively from before 30 March 2026.

Since 1 January 2026 and as of 28 April 2026, 65 153 cholera cases, including 768 deaths, have been reported worldwide. In comparison, since 1 January 2025 and as of 28 April 2025, 96 282 cholera cases, including 1 192 deaths, were reported worldwide.

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

Asia:

Afghanistan:
Since 16 March 2026 and as of 13 April 2026, 7 446 new cases, including one new death, have been reported. Since 1 January 2026 and as of 13 April 2026, 24 664 cases, including seven deaths, have been reported. In comparison, in 2025 and as of 17 March 2025, 19 652 cases, including eight deaths, were reported.

Myanmar/Burma:
Since 2 March 2026 and as of 6 April 2026, 12 new cases have been reported. Since 1 January 2026 and as of 6 April 2026, 151 cases have been reported. In comparison, in 2025 and as of 10 March 2025, 1 004 cases were reported.

Pakistan:
Since 9 February 2026 and as of 16 March 2026, 523 new cases have been reported. Since 1 January 2026 and as of 16 March 2026, 1 647 cases have been reported. In comparison, in 2025 and as of 10 February 2025, 4 038 cases were reported.

Yemen:
Since 16 February 2026 and as of 6 April 2026, 1 564 new cases, including two new deaths have been reported. Since 1 January 2026 and as of 6 April 2026, 3 486 cases, including three deaths, have been reported. In comparison, in 2025 and as of 24 February 2025, 10 080 cases, including 10 deaths were reported.

Since 30 March 2026, no updates have been reported by India.

Africa:

Angola:
Since 23 March 2026 and as of 12 April 2026, 636 new cases, including 17 new deaths have been reported. Since 1 January 2026 and as of 12 April 2026, 1 026 cases, including 26 deaths, have been reported. In comparison, in 2025 and as of 14 March 2025, 7 119 cases, including 258 deaths were reported.

Burundi:
Since 23 March 2026 and as of 12 April 2026, 260 new cases have been reported. Since 1 January 2026 and as of 12 April 2026, 791 cases, including two deaths, have been reported. In comparison, in 2025 and as of 17 March 2025, 129 cases were reported.

Congo:
Since 31 December 2025 and as of 12 April 2026, 269 new cases, including 12 new deaths, have been reported. Since 1 January 2026 and as of 12 April 2026, 269 cases, including 12 deaths, have been reported. In comparison, in 2025 and as of 28 April 2025, no cases were reported.

Democratic Republic of The Congo:
Since 23 March 2026 and as of 12 April 2026, 6 146 new cases, including 216 new deaths, have been reported. Since 1 January 2026 and as of 12 April 2026, 21 246 cases, including 611 deaths, have been reported. In comparison, in 2025 and as of 10 March 2025, 11 918 cases, including 240 deaths were reported.

Malawi:
Since 23 March 2026 and as of 12 April 2026, 1 486 new cases, including three new deaths, have been reported. Since 1 January 2026 and as of 12 April 2026, 1 576 cases, including five deaths, have been reported. In comparison, in 2025 and as of 7 April 2025, 91 cases, including three deaths, were reported.

Mozambique:
Since 23 March 2026 and as of 12 April 2026, 944 new cases, including one new death has been reported. Since 1 January 2026 and as of 12 April 2026, 6 603 cases, including 58 deaths, have been reported. In comparison, in 2025 and as of 3 February 2025, 64 cases were reported.

Nigeria:
Since 23 March 2026 and as of 12 April 2026, 692 new cases, including 16 new deaths, have been reported. Since 1 January 2026 and as of 12 April 2026, 943 cases, including 19 deaths have been reported. In comparison, in 2025 and as of 17 March 2025, 1 214 cases, including 28 deaths were reported.

Somalia:
Since 23 March 2026 and as of 12 April 2026, 226 new cases have been reported. Since 1 January 2026 and as of 12 April 2026, 935 cases have been reported. In comparison, in 2025 and as of 17 February 2025, 1 409 cases, including one death, were reported.

Zambia:
Since 23 March 2026 and as of 12 April 2026, 347 new cases, including four new deaths, have been reported. Since 1 January 2026 and as of 12 April 2026, 883 cases, including 13 deaths, have been reported. In comparison, in 2025 and as of 15 April 2025, 463 cases, including nine deaths, were reported.

Since 30 March 2026, no updates have been reported by: Ethiopia, Namibia, Rwanda, South Sudan, Sudan, United Republic of Tanzania and Zimbabwe.

Americas:

Since 30 March 2026, no updates have been reported by Haiti.

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: 1 April 2026

Maps and graphs

Figure 1. Geographical distribution of cholera cases reported worldwide from February 2026 to April 2026

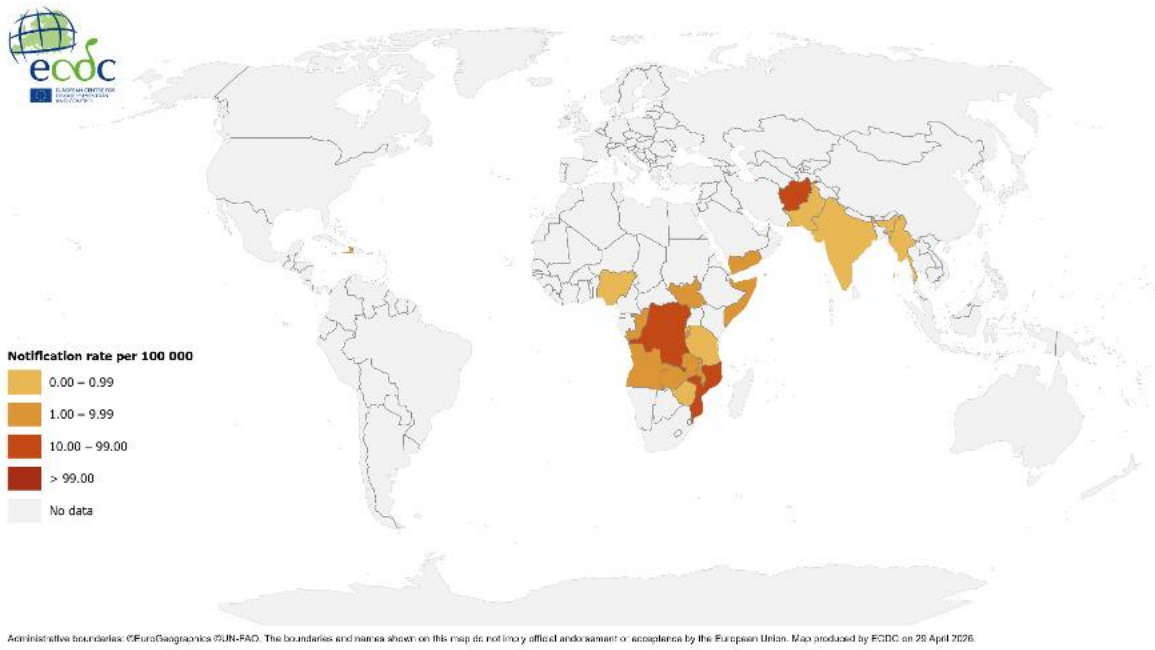
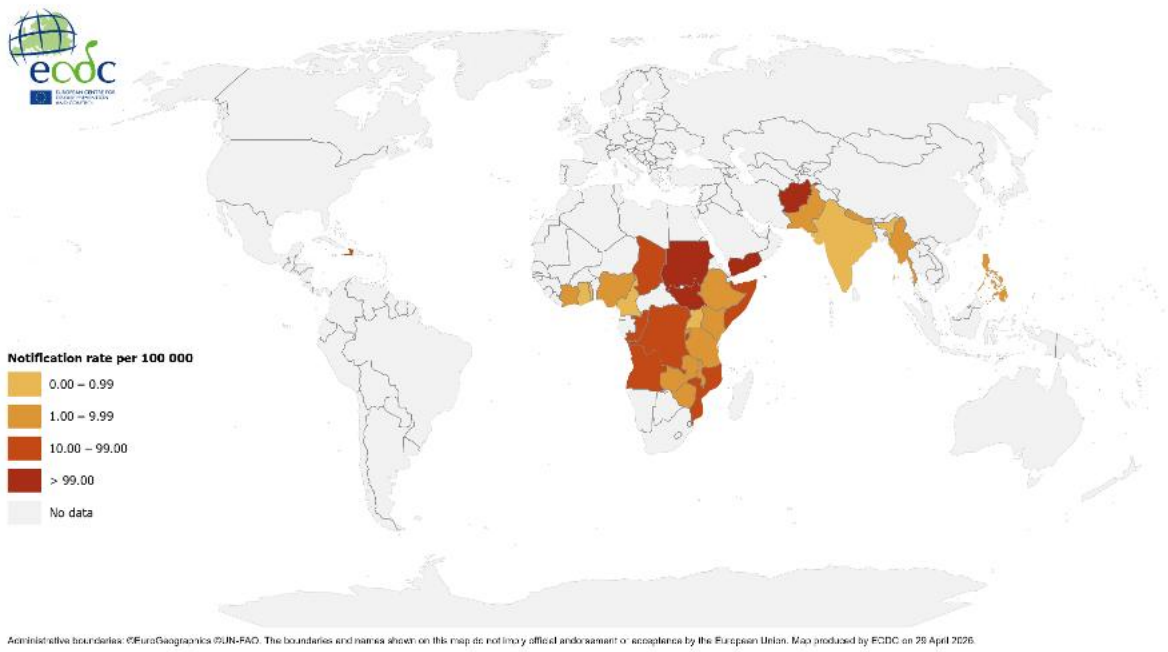


Figure 2. Geographical distribution of cholera cases reported globally from April 2025 to April 2026



3. SARS-CoV-2 variant classification

Overview:

Since the last update on 27 March 2026, and as of 24 April 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 14–15 2026, based on one reporting country:

BA.2.86 (VOI): 0.0%.

The VUM median proportions in the EU/EEA for weeks 14–15 2026, based on one reporting country:

NB.1.8.1 (VUM): 4.0%
XFG (VUM): 12.0%
BA.3.2 (VUM): 80.0%.

The calculations are based on data reported to GISAID, as of 19 April 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: 1 April 2026

4. Chikungunya virus disease – French Guiana, France – 2026

Overview:

There is ongoing chikungunya virus circulation in French Guiana. Since January 2026, 143 confirmed autochthonous cases have been identified, with 33 cases in week 16 2026, compared with 15 cases the previous week. Most cases (n=115; 80%) were detected in Littoral ouest sector, located on the western side of French Guiana, near the border with Suriname. This sector has now entered the outbreak epidemic phase, the highest level, a level higher than the isolated clusters phase.

The Maroni, Savanes, and Ile de Cayenne sectors are in a phase of sporadic transmission, whereas the Intérieur, Intérieur Est, and Oyapock sectors remain in a surveillance phase, with no cases identified to date.

All cases were confirmed by RT-PCR and the identified strain in French Guiana belongs to the ECSA genotype but lacks the E1-A226V mutation. It shows a close genetic relationship with recent sequences from Cuba and Brazil.

Suriname, which shares a border with western French Guiana, reported 2 579 cases between 1 January and mid-March 2026.
The last chikungunya virus disease outbreak in French Guiana occurred in 2014. During the 2014–2015 outbreak in French Guiana, more than 16 000 suspected cases and 500 hospitalisations were reported, resulting in an estimated chikungunya virus disease seroprevalence of 20% in 2017.

ECDC assessment:

The rainy season in French Guiana, which occurs from January to July, is currently ongoing and favours *Aedes* mosquitoes proliferation and chikungunya virus transmission. The likelihood of infection for travellers is assessed as low. The likelihood of onward transmission of chikungunya virus in mainland Europe following introduction by a viraemic traveller is currently considered very low, as environmental conditions are not favourable for *Aedes* mosquito activity or virus replication in mosquitoes at this time of year.

The outbreak is expected to continue over the coming months due to favourable environmental conditions. Therefore, it is important to strengthen communication with travellers and travel medicine clinics regarding the ongoing outbreak and the need for reinforced preventive measures.

Protective measures include using mosquito repellent, sleeping under a mosquito net or in screened or air-conditioned accommodation, and wearing clothing that covers most of the body. Vaccination may also be considered, in line with recommendations in the traveller's country of origin.

See ECDC's chikungunya virus disease risk assessment for mainland EU/EEA.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities.

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

Events under active monitoring

- SARS-CoV-2 variant classification - last reported on 30 April 2026
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 30 April 2026
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 30 April 2026
- Chikungunya virus disease – French Guiana, France – 2026 - last reported on 30 April 2026
- Outbreak of Salmonella Bovismorficians - Multi-country - 2026 - last reported on 24 April 2026
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 24 April 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 17 April 2026
- Travel-associated Zika virus disease - France (ex Indonesia) - 2026 - last reported on 17 April 2026
- Chikungunya virus diseases – Suriname – 2026 - last reported on 17 April 2026
- Hepatitis A - Multi-country (EU) - 2024-2025 - last reported on 16 April 2026
- Human case of avian influenza A(H7N7) - Taiwan - 2026 - last reported on 10 April 2026
- Dengue epidemic in New Caledonia - last reported on 10 April 2026