

WEEKLY BULLETIN

Communicable disease threats report

Week 32, 1 - 7 August 2026

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Executive summary

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

- As of 6 August 2026, the Democratic Republic of the Congo (DRC) reported a total of 4 053 confirmed cases of Ebola disease and 1 850 confirmed related deaths (based on data until 5 August). Since the beginning of the outbreak, five provinces have been affected: Ituri, North Kivu, South Kivu, Tshopo, and Haut-Uele.
- In Uganda, no new cases have been reported since 21 June 2026. The country has reported a total of 20 confirmed cases, including two deaths. On 28 July 2026, Uganda's Ministry of Health declared the end of the Ebola disease outbreak.
- On the basis of the available information, and given the 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 for people living in the European Union/European Economic Area (EU/EEA) is estimated to be very low. This assessment will be reviewed as further information becomes available.
- ECDC is monitoring the outbreak through epidemic intelligence activities and actively liaising with partners to support the response.

Seasonal surveillance of chikungunya virus disease - 2026 (weekly)

- Since the beginning of 2026 and as at 5 August 2026, only France has reported locally acquired cases (seven cases) of chikungunya in Europe.
- In the past week, France reported six new cases of locally acquired cases of chikungunya virus disease.

Seasonal surveillance of dengue in the EU/EEA, weekly report

- Since the beginning of 2026 and as at 5 August 2026, only France has reported a locally acquired case of dengue in Europe.
- This week, no new cases of dengue have been reported to ECDC.

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

- Since the beginning of the 2026 transmission season, and as at 5 August, 59 areas affected by West Nile virus (WNV) have been identified in seven countries across Europe.
- These areas are located in Italy (36), Greece (nine), Romania (six), North Macedonia (three), Spain (two), France (two), and Germany (one).

Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report)

- Since the beginning of 2026, and as at 5 August 2026, only Spain has reported locally-acquired cases (three cases) of Crimean-Congo haemorrhagic fever (CCHF) in Europe.
- In the past week, no new cases have been reported to ECDC.

Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters - Bathing season 2026

- Vibriosis is caused by naturally occurring *Vibrio* bacteria found in coastal waters, particularly in warm, brackish environments. In Europe, *Vibrio* bacteria are most frequently detected during the summer season, with the Baltic Sea being particularly favourable due to its low salinity levels.
- A warmer climate is expected to increase the suitability of coastal areas for *Vibrio* growth and expansion.
- ECDC monitors environmental suitability for *Vibrio* growth in EU/EEA coastal waters and publishes regular updates through the [Vibrio Viewer](#) and the [Communicable Disease Threat Reports](#) to assess and communicate the potential risk to human health across the EU/EEA.

Overview of respiratory virus epidemiology in the EU/EEA, week 31, 2026

Respiratory virus activity across EU/EEA countries remains at baseline levels, indicating limited circulation of respiratory viruses.

SARS-CoV-2 activity remains low across all age groups. A slight upward trend in SARS-CoV-2 activity in both primary and secondary care settings is observed across several countries.

Respiratory syncytial virus (RSV) activity is low and at inter-seasonal levels.

Influenza virus activity is low and at inter-seasonal levels in most countries. However, an upward trend in influenza activity has been observed among adults in Malta outpatient care settings.

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'.

World Pride - Netherlands - 2026

- Since the start of the monitoring period on 20 July, and as of 7 August, no relevant events related to communicable diseases have been detected in the context of World Pride 2026.
- World Pride 2026 will take place in Amsterdam, the Netherlands, from 25 July to 8 August 2026. The event is expected to attract a high number of participants, including international visitors from across the European Union/European Economic Area (EU/EEA).
- The probability of acquiring a sexually transmitted infection (STI) or other infection that can spread through sexual contact is increased for people attending World Pride 2026 who engage in sex with non-steady and multiple partners, particularly if preventive measures are not consistently applied.

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

- Since the start of 2026, and as of 5 August 2026 (data collection period 2–5 August, data available until 28 July), 219 522 chikungunya virus disease (CHIKVD) cases and 81 associated deaths have been detected from 25 countries (not including EU/EEA countries and territories).
- Cases reported in July (6 746 cases) decreased compared with June, when 41 959 cases were reported. Deaths reported in July (four deaths) also decreased compared with the previous month, when 23 deaths were reported.

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

- Since the beginning of 2026, and as of 31 July 2026, over 1.5 million cases of dengue and over 500 dengue-related deaths were reported globally, according to information from publicly available sources. This is a decrease compared to the same period in 2025.
- In 2026, one case has been reported in the EU/EEA by France. Cases have also been reported by Martinique, Guadeloupe, Reunion, and by French Guiana (French outermost regions).

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

- Since the previous update on 2 July 2026, and as of 3 August 2026, no new MERS cases have been reported by the World Health Organization (WHO) or by national health authorities.
- Since the beginning of 2026, and as of 3 August 2026, two MERS cases, including one fatality, have been reported in Saudi Arabia.
- The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in the general population is also considered to be low. The current MERS-CoV situation remains unchanged and poses a low risk to the EU/EEA.

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.
- One expert is currently deployed to support Africa CDC within the Continental Incident Management Support Team (IMST) in Uganda. These 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).
- Since 14 July, two ECDC fellows have also been deployed through the Global Outbreak Alert and Response Network (GOARN) to the WHO country office in Juba, South Sudan, to support surveillance and data analysis activities.
- These activities are being conducted in close coordination with national authorities and the EU delegations, and in collaboration with the Directorate-General for European Civil Protection and Humanitarian Aid Operations and the Directorate-General for International Partnerships.

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

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

On 6 August 2026, the [Democratic Republic of the Congo \(DRC\) published a situation update](#) reporting a total of 4 053 confirmed cases, including 1 850 related deaths (from data up until 5 August). A total of 694 patients are hospitalised in isolation. This represents an increase of 80 new confirmed cases and 49 deaths since the previous report of 5 August (reporting data up until 4 August). In total, 77.7% of identified case contacts are under follow-up in the Ituri, North Kivu, South Kivu, Haut-Uele and Tshopo provinces. Overall, 53 of 140 health zones are currently affected across the five provinces.

Data reported by DRC on confirmed cases and deaths are under continuous review and harmonisation.

The next epidemiological update will be published on 10 August 2026.

Uganda

As of 28 July 2026, a total of 20 confirmed cases, including two deaths, have 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, twelve days since the last case was discharged, the [Uganda's Ministry of Health](#) declared the end of the Ebola disease outbreak.

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 case 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.

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](#)). 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 10 July 2026, [the US CDC reported](#) that a US citizen who was working for a humanitarian organisation in DRC has 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 during this outbreak that has tested positive in DRC and is receiving treatment in Germany.

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 is currently isolated in a London hospital. The individual showed no symptoms and this was deemed a precautionary measure.

The first case reported in Uganda was travel-related and the patient later died ([Democratic Republic of the Congo confirms new Ebola outbreak, WHO scales up support | WHO AFRO, 15 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](#)). Health authorities [reported](#) that 15 confirmed cases in Uganda had travel links to DRC. Additional cases were identified following [contact tracing activities](#). Uganda postponed a large religious event (Martyr's Day) that normally takes place on 3 June and has also suspended cross-border transport activities (Government of Uganda on X: 21 May 2025). On 16 July, Uganda discharged the last Ebola patient who had been receiving treatment at the Mulago National Referral Isolation Centre. [Uganda's Ministry of Health](#) announced the start of the 42-day countdown to declaring the end of the outbreak.

Genomes from DRC and Uganda have been published and preliminary analysis shows sequences distinct from the 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 prior outbreak occurred in 2025 in Kasai Province due to 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.

Exit screening has been implemented in DRC, Uganda and South Sudan. 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 temporarily [suspended again as of 6 June](#), as part of health security arrangements in response to the Ebola disease outbreak, according to the [media](#).

Uganda's Ministry of Health announced on 15 June 2026 ([press release](#)) that the general public, travellers, recruitment agencies, travel agents, and all stakeholders departing from Uganda do not require an 'Ebola-Free Certificate'. The 'Ebola-Free Certificate' is not a requirement for visa applications to any country. Ebola testing is recommended for symptomatic individuals who develop symptoms consistent with Ebola virus disease, or those who are identified as contacts of confirmed Ebola virus disease cases, based on a clinical and epidemiological assessment by health authorities.

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](#)).

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](#) ([Ebola Update - Travel Measures and Ongoing Monitoring](#)).

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.

Therapeutics and Vaccines

The [University of Oxford's Oxford Vaccine Group](#) has successfully vaccinated the first volunteer in the world's first Bundibugyo ebolavirus vaccine trial. The vaccine was developed by scientists at the University of Oxford's Oxford Vaccine Group and Pandemic Sciences Institute.

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).

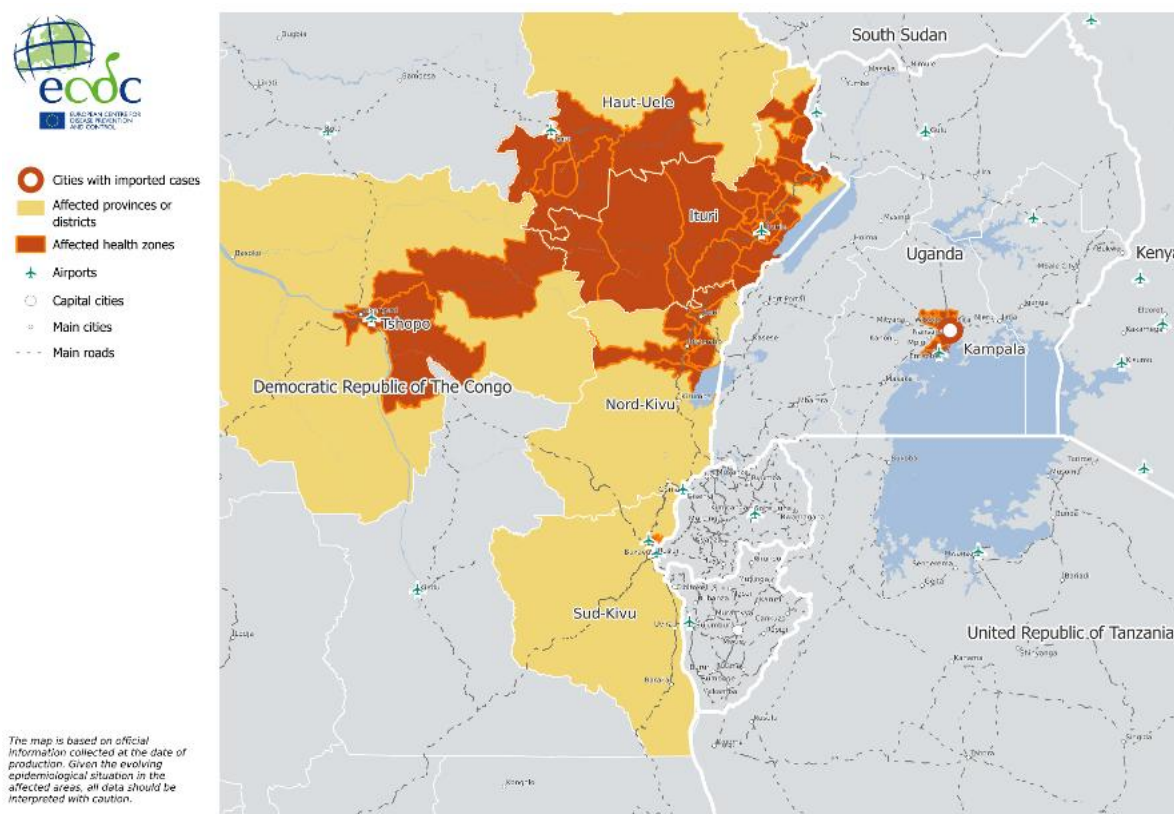
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

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: 31 July 2026

Maps and graphs

Figure 1. Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda - 2026 - Map of the affected areas



Map produced by ECDC on: 07/08/2026. Administrative data (©UNFPA) (©UNODC-HQ); Road, cities and airport (©OSM). The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union.

2. Seasonal surveillance of chikungunya virus disease - 2026 (weekly)

Overview:

Since the beginning of 2026 and as at 5 August 2026, only France has reported locally acquired cases (seven cases) of chikungunya in Europe.

In the past week, France reported six new cases of locally acquired cases of chikungunya virus disease. Currently there are two active clusters.

The report is available [online](#)

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 the light of this development, the European Centre for Disease Prevention and Control 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 – have been 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: 31 July 2026

3. Seasonal surveillance of dengue in the EU/EEA, weekly report

Overview:

Since the beginning of 2026 and as at 5 August 2026, only France has reported a locally acquired case of dengue in Europe. This week, no new cases of dengue have been reported to ECDC.

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 the 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 – have been 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: 31 July 2026

4. Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report)

Overview:

- Since the beginning of the 2026 transmission season, and as at 5 August, 59 areas affected by West Nile virus (WNV) have been identified in seven countries across Europe. These areas are located in Italy (36), Greece (nine), Romania (six), North Macedonia (three), Spain (two), France (two), and Germany (one). This week, ten new areas have been reported as affected for the first time this season.

The report is available [online](#).

Throughout the season, ECDC will publish a [weekly report](#) with updates on risk areas for locally acquired WNV infections. A [monthly report](#) will also be published.

WNV infection in humans is a notifiable disease at 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.

ECDC assessment:

Seasonal weather conditions are currently favourable for mosquito-borne transmission, therefore more cases are expected to occur in the coming weeks.

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: 31 July 2026

5. Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report)

Overview:

Since the beginning of 2026, and as at 5 August 2026, only Spain has reported locally-acquired cases (three cases) of Crimean-Congo haemorrhagic fever (CCHF) in Europe. In the past week, no new case of CCHF have been reported to ECDC.

The report is available [online](#).

ECDC assessment:

Although the risk of contracting CCHF for the general population in the areas where the virus is known to be present in Spain is low, this risk increases for people undertaking outside 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 transmitted to humans mainly 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 the light of this development, the European Centre for Disease Prevention and Control 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 – have been 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: 31 July 2026

6. Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters - Bathing season 2026

Overview:

Update

Based on forecasts from the [Vibrio Viewer](#), in the next five days (until 12 August 2026), 47 municipalities across 12 regions in five countries are expected to have high environmental suitability* for *Vibrio* spp. The highest numbers of municipalities above the threshold have been identified in France (16), Bulgaria (13) and Romania (12).

A list of areas expected to have high environmental suitability* for *Vibrio* spp. until 12 August 2026 is provided below.

Bulgaria: 13 municipalities in three regions:

- **Varna:** Avren, Byala, Dolni chiflik, Varna
- **Dobrich:** Balchik, Kavarna, Shabla
- **Burgas:** six municipalities above the threshold

France: 16 municipalities in five regions:

- **Gironde:** Eight municipalities above the threshold
- **Landes :** Tarnos
- **Pyrénées-Atlantiques:** Anglet

- **Charente-Maritime:** Chenac-Saint-Seurin-d'Uzet, Le Château-d'Oléron, Le Verdon-sur-Mer, Royan, Talmont-sur-Gironde
 - **Bouches-du-Rhône:** Arles
- Germany:** three municipalities in one region:
- **Vorpommern-Greifswald:** Altwarp, Luckow, Vogelsang-Warsin
- Poland:** three municipalities in one region:
- **Szczeciński:** Altwarp, Luckow, Nowe Warpno
- Romania:** 12 municipalities in two regions:
- **Constanța:** Eight municipalities above the threshold
 - **Tulcea:** Jurilovca, Murighiol, Oras Sulina, Sfantu Gheorghe

Countries are listed in alphabetical order; municipalities are listed only for areas (at NUTS3 level) with five or less affected municipalities. To explore the daily risk for individual municipalities and specific areas in greater detail, please refer to the [interactive Vibrio Viewer map tool](#).

*Note: high environmental suitability for *Vibrio* spp. is defined by a suitability index >16.

Background

Vibriosis is an infection caused by species of *Vibrio* bacteria, which occur naturally in coastal waters, particularly in warm, brackish environments where freshwater and seawater mix. Environmental conditions that favour bacterial growth include higher water temperatures and lower salinity [1]. In Europe, *Vibrio* bacteria are most frequently detected during the summer season. The Baltic Sea provides particularly favourable conditions due to its relatively low salinity, although *Vibrio* species are also found in the North Sea, the Black Sea and other coastal and estuarine bathing waters [1, 2, 3, 4, 5, 6].

Human infection may occur through the consumption of raw or under-cooked seafood, particularly shellfish, or the exposure of open wounds to contaminated water. Clinical manifestations range from self-limiting gastroenteritis to wound infections, otitis, and severe invasive disease, including septicaemia and necrotising soft tissue infections. Individuals with underlying medical conditions, such as diabetes, chronic liver disease, and immunosuppression, are at increased risk of severe illness [7, 8].

ECDC assessment:

Climate-driven warming is expected to increase the suitability of coastal areas for bacterial growth. As sea surface temperatures continue to rise across parts of Europe, environmental conditions facilitating the potential for *Vibrio* proliferation and geographical expansion are becoming increasingly common [2, 9, 10].

Vibriosis remains relatively uncommon in the EU/EEA. However, locally acquired cases may occur during summer months, particularly when temperatures are exceptionally high [11, 12].

To reduce the risk of *Vibrio* infections through food, it is recommended that seafood should be cooked thoroughly before consumption. Individuals who have open wounds, recent piercings, cuts or scrapes should avoid swimming in brackish or coastal waters, or cover the affected area with a waterproof dressing. In case of accidental contact with coastal water, the affected area should be disinfected and cleaned thoroughly.

Actions:

ECDC monitors the environmental suitability for *Vibrio* spp. growth in coastal waters during the summer season. Regular updates are published in the [Vibrio Viewer](#) and the [Communicable Disease Threat Reports](#) to assess and communicate potential risks to human health across the EU/EEA.

ECDC publishes scientific information and advice on this topic on its dedicated webpage [Vibriosis](#).

Last time this event was included in the Weekly CDTR: 31 July 2026

7. Overview of respiratory virus epidemiology in the EU/EEA, week 31, 2026

Overview:

Important: This European Respiratory Virus Surveillance Summary (ERVISS) publication follows the recent transition of reporting surveillance data from The European Surveillance System (TESSy) to EpiPulse Cases (EPC). As a result of this transition, we have identified a few data inconsistencies. We are actively working with individual countries to resolve these and any other issue that may arise to ensure high data quality. Thank you for your patience and understanding.

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://www.ecdc.europa.eu/en/ermiss)), which is updated weekly.

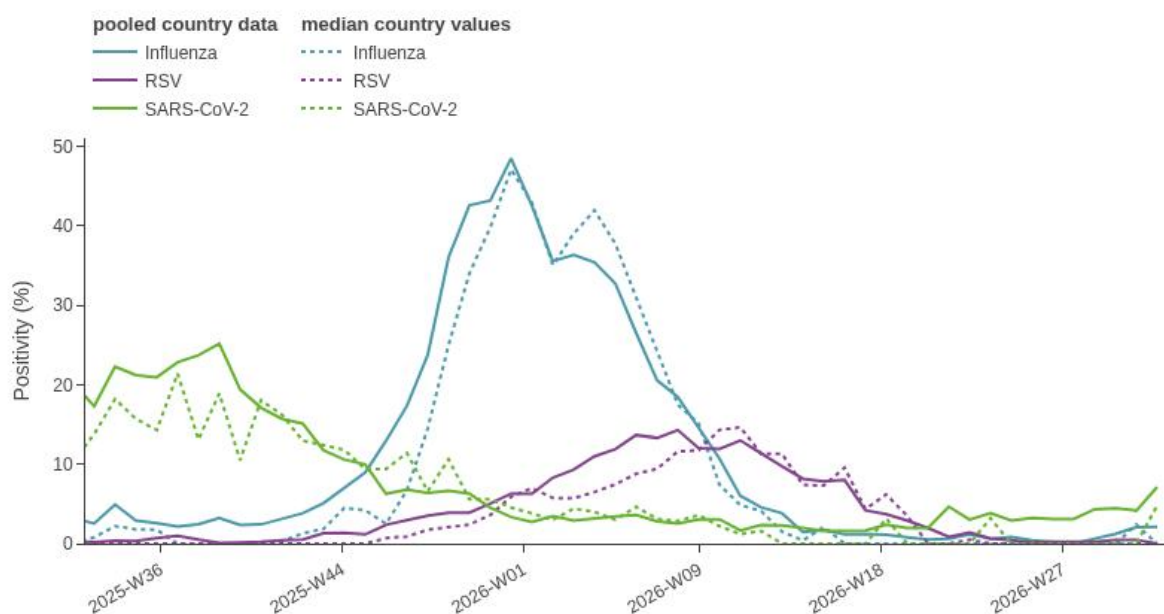
Key visualisation from the weekly bulletin are included below.

Sources: [ERVISS](https://www.ecdc.europa.eu/en/ermiss)

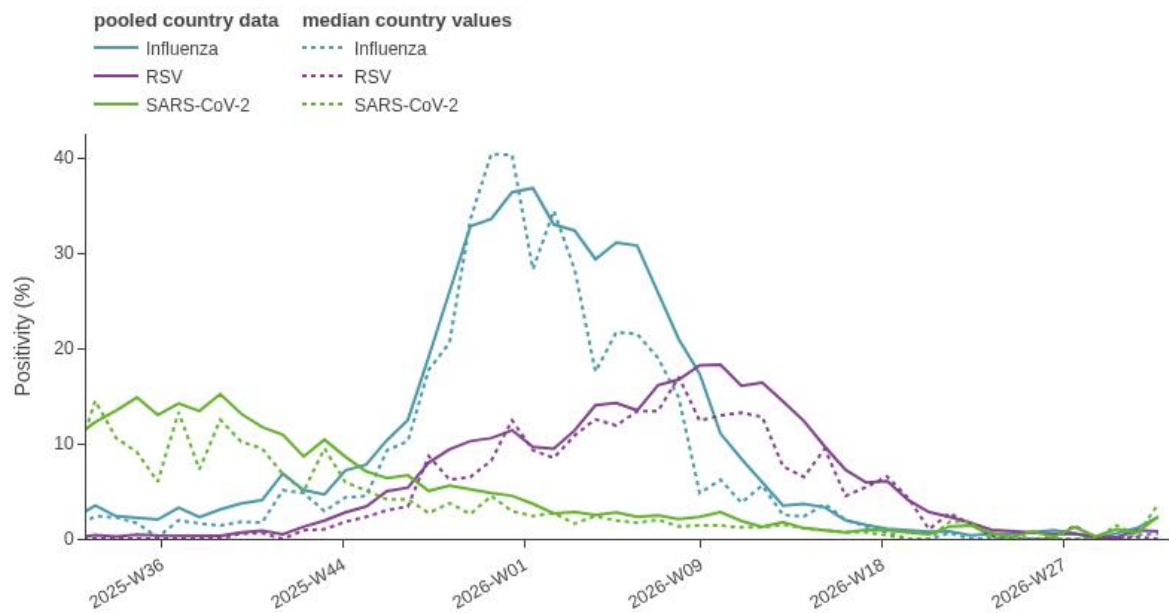
Last time this event was included in the Weekly CDTR: 31 July 2026

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 31	Week 30	Description	Value
ILI/ARI consultation rates in primary care	ARI	12 rates (8 MEM)	12 rates (8 MEM)	Distribution of country MEM categories	8 Baseline
	ILI	13 rates (12 MEM)	14 rates (13 MEM)		11 Baseline 1 Low
ILI/ARI test positivity in primary care	Influenza	11	12	Pooled (median; IQR)	2.1% (0; 0–0.8%)
	RSV	10	10		0% (0; 0–0%)
	SARS-CoV-2	11	12		7.1% (4.8; 2.8–7.8%)
SARI rates in hospitals	SARI	7 rates (3 MEM)	9 rates (5 MEM)	Distribution of country MEM categories	3 Baseline
SARI test positivity in hospitals	Influenza	5	7	Pooled (median; IQR)	2.3% (0.6; 0–4.4%)
	RSV	5	6		0.8% (0; 0–1.9%)
	SARS-CoV-2	5	7		2.3% (3.6; 3.1–4.7%)
Intensity (country-defined)	Influenza	9	11	Distribution of country qualitative categories	9 Baseline

Source: ECDC

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

Pathogen	Week 31, 2026		Week 40, 2025 – week 31, 2026	
	N	% ^a	N	% ^a
Influenza	9	–	17992	–
Influenza A	8	89	17389	99
A(H1)pdm09	0	0.0	4063	28
A(H3)	7	100	10343	72
A (unknown)	1	–	2983	–
Influenza B	1	11	123	0.7
B/Vic	0	–	37	100
B (unknown)	1	–	86	–
Influenza untyped	0	–	480	–
RSV	0	–	5374	–
RSV-A	0	–	933	44
RSV-B	0	–	1192	56
RSV untyped	0	–	3249	–
SARS-CoV-2	40	–	4394	–

Source: ECDC

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

Pathogen	Week 31, 2026		Week 40, 2025 – week 31, 2026	
	N	% ^a	N	% ^a
Influenza	6	–	15724	–
Influenza A	6	100	7613	99
A(H1)pdm09	0	0.0	1321	35
A(H3)	1	100	2424	65
A (unknown)	5	–	3868	–
Influenza B	0	0.0	72	0.9
B/Vic			10	100
B (unknown)	0	–	62	–
Influenza untyped	0	–	8039	–
RSV	2	–	7197	–
RSV-A			1151	52
RSV-B			1060	48
RSV untyped	2	–	4986	–
SARS-CoV-2	6	–	3050	–

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 31, 2026

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

Source: ECDC

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

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	0	0	0%
XFG	VUM	1	4	36% (36–36%)
BA.3.2	VUM	0	0	0%
NB.1.8.1	VUM	0	0	0%

Source: ECDC

8. World Pride - Netherlands - 2026

Overview:

Update

Since the start of the monitoring period on 20 July, and as of 7 August, no relevant events related to communicable diseases have been detected in the context of World Pride 2026.

Summary

[World Pride 2026](#) will take place in Amsterdam, the Netherlands, from 25 July to 8 August 2026. The event is expected to attract a large number of participants, including international visitors from across the EU/EEA and other regions of the world. Activities will include cultural and artistic performances, and large-scale social gatherings, culminating in a public parade on 8 August in central Amsterdam. The event will be hosted across multiple indoor and outdoor venues, some of which are expected to have high crowd density and prolonged contact among attendees.

In recent years, rates of STIs, such as gonorrhoea and syphilis, have [continued to increase](#) among gay, bisexual and other men who have sex with men in the EU/EEA. In addition, clusters and outbreaks of other infections that may be transmitted through intimate contact have been reported among this population group, including mpox, [dermatophilosis](#), viral hepatitis and [multi-drug and extensively drug-resistant Shigella](#).

For this year's World Pride event in Amsterdam, the main recommendations stated in the [2017 ECDC risk assessment](#), ECDC's guidance on [HIV and STI prevention among men who have sex with men](#), ECDC's [public health considerations on mpox](#), and [ECDC's guidance on PrEP](#) remain relevant. Additional considerations regarding Shigella prevention are outlined in ECDC's [epidemiological update 2026](#).

[A joint public health advice for WorldPride events in the Netherlands, 2026](#) was published on 21 July by ECDC, together with the World Health Organization (WHO) Regional Office for Europe and the National Institute for Public Health and the Environment of the Netherlands. This aim of this advice is to help make sure everyone can enjoy the festivities safely, and to raise awareness of health recommendations on a range of health topics, from sexually transmitted infections through to vaccination, respiratory illnesses, and food and water safety.

The local and regional public health authorities in Amsterdam have reinforced facilities for early detection, epidemiological surveillance, diagnostics, sampling and sequencing and preventive community measures for those populations most at risk and in spaces where exposure may occur.

Building on these preparedness measures, ECDC recommends that public health authorities work with civil society organisations and other partners to ensure that gay, bisexual and other men who have sex with men have access to accurate information and services. Participants attending World Pride events are advised to be mindful of the following:

- Ensure that routine vaccination and boosters are up-to-date in accordance with the national immunisation recommendations in the country of residence, including hepatitis A vaccination. It is advised that participants discuss the need for additional vaccinations, such as mpox, or booster doses, with their healthcare providers.
- Ensure coverage with valid health insurance or obtain a European Health Insurance Card.
- Educate themselves prior to attendance on the prevention of STIs, including recommendations on HIV pre-exposure prophylaxis, and familiarise themselves with additional advice and information on the event website.
- Consult a healthcare provider in the home country to discuss other precautions based on a sexual health risk assessment: they may recommend pre-exposure prophylaxis (PrEP) for HIV, but remember that PrEP does not protect against other STIs.
- Practise safer sex using condoms to prevent STIs, including HIV and hepatitis B and C.
- Although using a condom is an important protective measure, it does not provide full protection against mpox, as mpox can be transmitted through close skin-to-skin contact, especially if there are rashes, sores, or lesions on the skin. This is also valid for dermatophilosis.
- Avoid sexual activity and seek healthcare in the event of STI symptoms, including gastrointestinal symptoms and symptoms suggestive of mpox and dermatophilosis, in themselves or any sexual partner.
- Avoid faecal-oral exposure during sexual activity in order to prevent other infections such as shigellosis and hepatitis A (i.e. washing hands, genital and anal areas before and after sexual contact, always using a condom, changing condoms between anal and oral sex, using gloves or condoms on sex toys, using dental dams for oral sex and latex gloves for fingering or fisting). If gastrointestinal symptoms appear, inform healthcare providers of sexual activities, and abstain from sex until symptoms resolve.

- Follow standard hygiene measures and advice on the prevention of food and waterborne diseases to decrease the risk of gastrointestinal illnesses and consider general hygiene/food safety practices when consuming food and drink.
- If exposed to HIV, hepatitis A or B, or mpox infection, participants should contact a healthcare provider as soon as possible for advice, as post-exposure prophylaxis (PEP) is available for some infections in the form of vaccination or tablets and should be started as soon as possible (within 72 hours for HIV).
- If experiencing symptoms suggestive of an infection, participants should contact a healthcare provider at the event. People with STIs may not have any symptoms, but common symptoms include: unusual discharge from the genitals or rectum, itching, pain during urination, rectal pain, skin changes (including rashes or blister-like lesions), yellowing of the skin, pain during sex, and influenza-like symptoms. If participants have any of these symptoms, or experience severe diarrhoea (which can be caused by shigella or hepatitis A), they should avoid sexual activity and seek healthcare promptly.
- In general, if they have engaged in unprotected sexual activity with a casual partner, participants should consider contacting a healthcare provider for advice on testing for STIs, including mpox, HIV and hepatitis, as STIs can be present without causing any symptoms.
- Alternatively, the [European Test Finder tool](#) can be used to identify the most conveniently located testing centre. Known partners of those diagnosed should be notified, and offered testing and treatment according to clinical guidelines.

People attending World Pride who acquire an infection may contribute to onward transmission of infections within sexual networks in their home countries. The EU/EEA countries should consider raising awareness among clinicians and laboratory professionals accordingly and prepare to provide post-exposure prophylaxis (where indicated), testing, treatment, and partner management of identified cases.

ECDC assessment:

STIs, HIV, hepatitis, mpox and shigellosis continue to be reported in sexual networks among gay, bisexual and other men who have sex with men in Europe. People attending World Pride 2026 who have sex with non-steady or multiple partners may have an increased probability of acquiring an STI or another infection transmitted through sexual contact, particularly if preventive measures are not taken consistently.

The probability of EU/EEA citizens becoming infected with other communicable diseases while attending World Pride 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 practising safe sex).

In 2017, ECDC published a [rapid risk assessment](#) on communicable disease risks associated with WorldPride in Madrid. Its main recommendations remain relevant, alongside [ECDC guidance on HIV and STI prevention among men who have sex with men](#), ECDC's [public health considerations for mpox](#), and [ECDC guidance on PrEP](#). Additional prevention advice is available in the [Joint public health advice for WorldPride events in the Netherlands, 2026](#).

Actions:

ECDC will monitor this event through its epidemic intelligence activities between 20 July and 14 August 2026 in collaboration with the Dutch health authorities and WHO's Regional Office for Europe, and will include weekly updates in the Communicable Disease Threats Report (CDTR).

Further information:

- [Joint public health advice for WorldPride events in the Netherlands, 2026](#)
- [Rapid Risk Assessment: Potential public health risks related to communicable diseases at the WorldPride festival in Madrid, 23 June–2 July 2017](#)
- [ECDC STI Annual Epidemiological Reports for 2024 data](#)
- [Public health guidance on HIV and STI prevention among men who have sex with men](#)
- [ECDC HIV Pre-Exposure Prophylaxis in the EU/EEA and the UK: implementation, standards and monitoring](#)
- [Clusters of dermatophilosis in five EU/EEA countries in 2025–2026](#)

Last time this event was included in the Weekly CDTR: 31 July 2026

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

Overview:

Monthly update overview

Since the start of 2026, and as of 5 August 2026 (data collection period 3–5 August, data available up to 28 July), 219 522 chikungunya virus disease (CHIKVD) cases and 81 associated deaths have been detected in 25 countries, excluding EU/EEA countries and territories. Cases reported in July (6 746 cases) decreased compared with June, when 41 959 cases were reported. Deaths reported in July (four deaths) also decreased compared with the previous month, when 23 deaths were reported.

New outbreaks

The Philippines have reported CHIKVD cases for the first time in 2026.

Epidemiological overview

In 2026, 12 countries have ongoing CHIKVD outbreaks. Of these, the majority are in the Americas. Below is a description of ongoing outbreaks:

Americas

In 2026, there have been 173 655 CHIKVD cases and nine associated deaths reported in the region. The most affected subcontinental region is South America, with Brazil reporting the highest number of cases in 2026.

- **Argentina:** [CHIKVD cases](#) are reported through the year in the country. Since the start of the year and as of epidemiological week 28 (12–18 July), CHIKVD cases have been reported from ten jurisdictions (Buenos Aires, Autonomous City of Buenos Aires, Cordoba, Entre Rios, Chaco, Catamarca, Jujuy, Salta, Santiago del Estero, Tucuman). Most cases have been reported by Salta and Tucuman. Reported cases have been decreasing since epidemiological week 16.
- **Bolivia:** CHIKVD cases have been extensively reported in the country since the start of 2026. The most affected departments are Santa Cruz, Cochabamba, Tarija and La Paz. Santa Cruz reported most of CHIKVD cases in Bolivia. At the national level, the number of reported cases has continued to decrease in the past few weeks.
- **Brazil:** [CHIKVD cases](#) continue to be reported in all regions (Centro-Oeste, Nordeste, Norte, Sudeste, and Sul) and in most federal units of the country. The Centro-Oeste, Sudeste, and Nordeste regions continue to account for the highest number of cases in the last four epidemiological weeks (25–28), where Bahia, Alagoas, Pernambuco, Mato Grosso Do Sul, and Minas Gerais are the most affected federal units. Since the start of 2026, CHIKVD cases have continuously increased in Brazil until epidemiological week 14. This year, most of the cases have been reported among females (58%), being the 20 to 29 years age group the most affected one.
- **Colombia:** CHIKVD cases have been sporadically reported during the year. Confirmed CHIKVD cases have been reported from Antioquia, Huila, and Santander departments.
- **Costa Rica:** In 2026, 82 CHIKVD cases have been reported from Puntarenas city, Esparza region. The [current outbreak](#) is located in the North-West of the country, affecting San Jose, Puntarenas, Guanacaste, Alajuela, and Heredia provinces. In 2025, a total of eight CHIKVD cases were reported.
- **El Salvador:** In 2026, twelve suspected CHIKVD cases have been reported in the country. In 2025, 11 CHIKVD cases were reported in the same period.
- **Guatemala:** In 2026, one confirmed CHIKVD case has been reported in the country. The case was reported from San Marcos department, bordering with the Mexican Chiapas State, where CHIKVD cases have also been reported in 2026. In 2025, no confirmed CHIKVD cases were reported in Guatemala.
- **Paraguay:** In 2026, there have been 19 confirmed cases in the country. In the same time period in 2025, 48 confirmed cases were reported.
- **Venezuela:** In 2026, four confirmed CHIKVD cases have been [reported](#) in the country. Confirmed cases have been reported by Distrito Federal and Sucre federal jurisdictions.

Asia

In 2026, 45 435 CHIKVD cases and no associated deaths have been reported in the region. The most affected subcontinental region is Southeast Asia, with India being the country reporting the highest number of cases in 2026.

- [China](#): In 2026, 88 CHIKVD cases have been reported in the country. In 2025, approximately 400 cases were reported in the same period.
- [Pakistan](#): A total of 28 CHIKVD cases have been reported in the country in 2026. All cases have been reported from Sindh and Khyber Pakhtunkhwa regions. CHIKVD cases are reported throughout the year in Pakistan, concentrated in Baluchistan, Khyber Pakhtunkhwa, and Sindh provinces. These provinces are located in the Southwest of the country.
- [Philippines](#): In 2026, CHIKVD cases have been reported by Gandara Municipal Health Officer. A total of two outbreaks have been identified, with a total of 84 cases reported.

Africa

In 2026, approximately 432 CHIKVD cases and no associated deaths have been reported in the region. The most affected subcontinental region is East Africa, with Mauritius being the country reporting the highest number of cases in 2026.

Europe

Since the beginning of 2026 and as of 5 August 2026, France was the only European country to report locally acquired chikungunya virus disease transmission, with seven locally acquired CHIKVD cases identified. For more information on CHIKVD cases reported in mainland EU/EEA, please visit the [dedicated ECDC website](#). CHIKVD cases have been reported from the French outermost regions of [French Guiana](#), [Mayotte](#) and [Réunion](#).

Note

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

ECDC assessment:

Since the beginning of 2026 and as of 5 August 2026, France was the only European country to report locally acquired chikungunya virus disease transmission, with seven locally acquired CHIKVD cases identified. The likelihood of onward transmission of chikungunya virus in mainland Europe is linked to importation of the virus by viraemic travellers into receptive areas with established and active competent mosquito vectors (e.g. [Aedes albopictus](#) and [Aedes aegypti](#)). [Aedes albopictus](#) mosquito is [established](#) in a large part of Europe. In Europe and neighbouring areas, [Aedes aegypti](#) mosquito is [established](#) in Cyprus, on the eastern shores of the Black Sea, and in the outermost region of Madeira.

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

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

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

Actions:

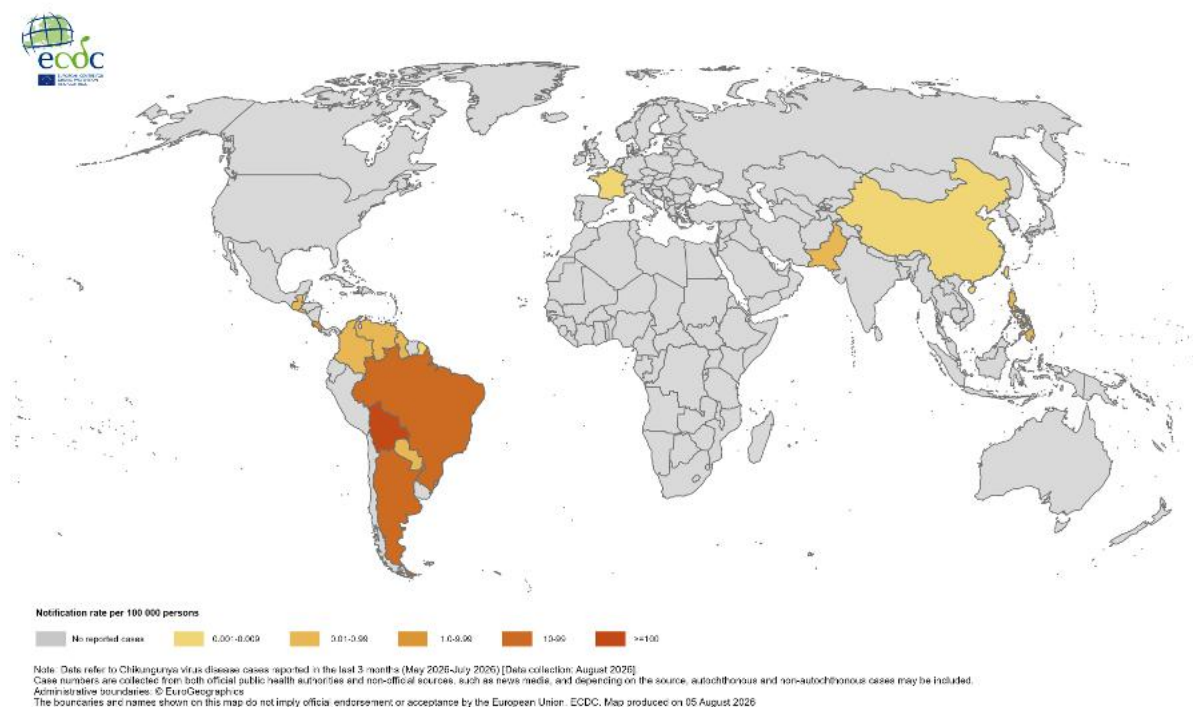
ECDC monitors this threat through its epidemic intelligence activities and reports on it on a monthly basis. A summary of the worldwide overview of [CHIKVD](#) is available on ECDC's website.

Sources: [Epidemiological alert Chikungunya](#)

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

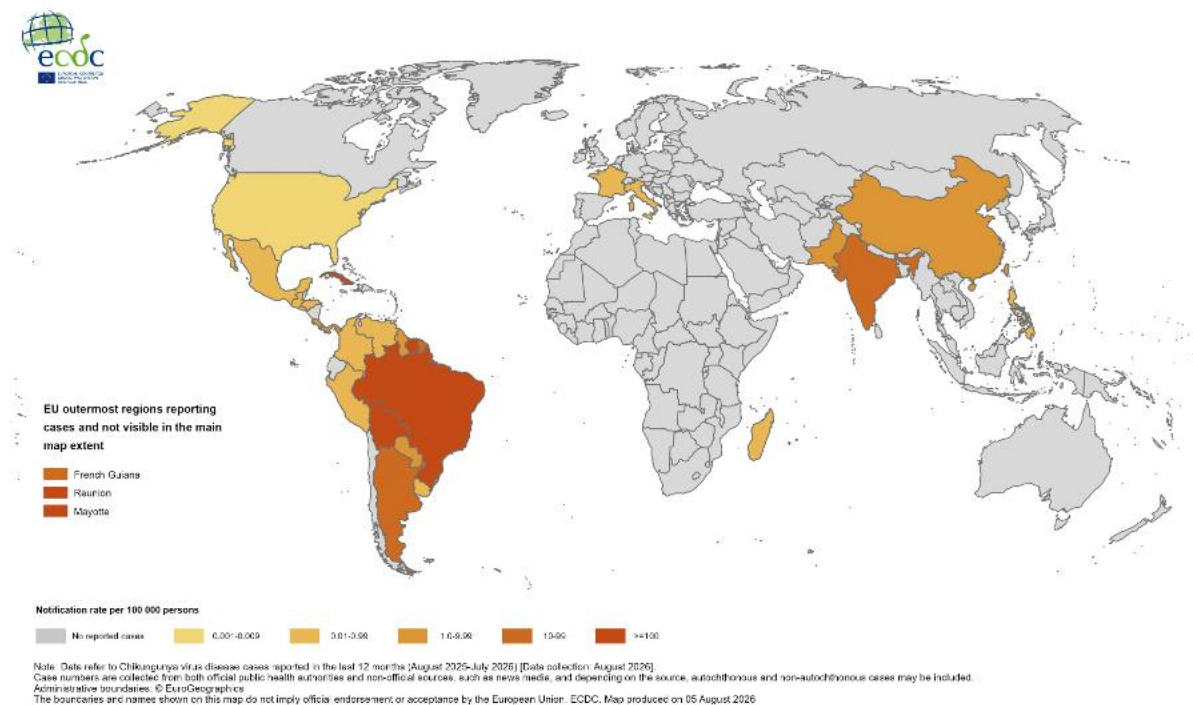
Maps and graphs

Figure 1. Three-month Chikungunya virus disease case notification rate per 100 000 population, May - July 2026



Source: ECDC

Figure 2. 12-month Chikungunya virus disease case notification rate per 100 000 population, August 2025-July 2026



Source: ECDC

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

Overview:

Since the beginning of 2026, and as of 31 July 2026, over 1.5 million cases of dengue and over 500 dengue-related deaths had been reported globally according to information from publicly available sources.

Epidemiological overview

Over 90 countries/ territories have reported dengue cases between January and July 2026. An overview based on publicly available information from official sources and reports from different regions highlighting trends in different countries/ territories is presented below. The country/ territory trends summarised are based on data availability at the time the report was prepared; more detailed analyses are therefore only provided for countries/ territories with sufficient data.

Americas

In the Americas, as of week 26 of 2026 (update: 23 July 2026), 1 373 756 dengue cases have been reported, of which 28.9% were laboratory-confirmed, according to [the WHO PAHO report published on 23 July 2026](#). The current reported cases are 61% fewer than during the same period in 2025 and 67% below the five-year average. While all four serotypes have been reported in the region to date in 2026, their distribution varies across the different countries of PAHO ([Report on the epidemiological situation of dengue in the Americas](#)).

South-East Asia

According to the WHO SEARO epidemiological bulletin published on in [June](#) and [July](#), since July 2025 and as of July 2026, dengue has been reported in Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor-Leste. Available information on epidemiological trends is summarised below:

- In 2026 and as of 31 July 2026, Bangladesh has reported 15 310 cases. Monthly cases have been increasing since April 2026. The total number of cases reported in July 2026 is 9 206 while 2 907 cases were reported in June 2026. The increase follows seasonal patterns and the total monthly cases are at levels lower compared 2025 ([Bangladesh Daily Dengue Press Release, 31 July 2026](#), [Bangladesh Daily Dengue Press Release, 31 July 2025](#) and [WHO South-East Asia Region Epidemiological Bulletin, 29 July 2026](#)).
- In 2026 and as of June 2026, India has reported 22 938 cases. In June 2026, 6 625 cases were reported. In May 2026 3 747 cases had been reported. The cases reported in June are a 77% increase compared to the cases reported in May. The case trend follows similar patterns to 2025 when increases started being reported after April ([WHO South-East Asia Region Epidemiological Bulletin, 29 July 2026](#)).
- Maldives had reported over 100 dengue cases weekly since January 2026, with week-to-week fluctuations based on data provided in WHO SEARO report of 3 June 2026 ([WHO South-East Asia Region Epidemiological Bulletin, 3 June 2026](#)). At the time, the weekly reported number of dengue cases exceeded the expected seasonal baseline. The cumulative number of cases reported since the beginning of 2026 was over 2 900 (as of week 21, ending 24 May 2026) and higher than the same period in 2025.
- Nepal reported 292 cases in June and 247 cases in May 2026 which is within the expected levels for the season ([WHO South-East Asia Region Epidemiological Bulletin, 29 July 2026](#)).
- Sri Lanka has reported increases in weekly cases since mid-April 2026. During week 30 (ending 26 July 2026), 6 014 cases were reported, which is 18% lower than the number of cases reported the previous week. The total number of cases reported as of week 30 in 2026 is 82 007. During the same period in 2025, 33 374 cases were reported ([Sri Lanka Weekly Dengue Update; week 30 \(20-26 July 2026\)](#) and [WHO South-East Asia Region Epidemiological Bulletin, 29 July 2026](#)).
- Thailand reported 752 cases during week 30 (ending 26 July 2026) which is a decrease of 44% compared to the cases reported the week before. Overall, besides recent weekly increases, cases remain at lower levels compared to 2025 with some week-to-week fluctuations ([WHO South-East Asia Region Epidemiological Bulletin, 29 July 2026](#)).
- Timor-Leste continued reporting a decrease in monthly case numbers since April. In June 2026, 83 cases were reported vs 126 cases reported in May. Overall cases are higher in 2026 compared to the same period in 2025 and follow a decreasing trend after increases in the beginning of the year ([WHO South-East Asia Region Epidemiological Bulletin, 15 July 2026](#)).

Western Pacific Region

In the WHO Western Pacific Region, dengue cases have been reported by several countries according to the report of 23 July ([WHO WPRO Dengue Situation Update #750: 23 July 2026](#)). Available information from the WHO WPRO report and national official reports on ongoing trends are summarised below:

- Cambodia reported increasing trends of dengue since week 14 (ending 5 April). with a sharp increase reported since week 24 (ending 14 June). The week 28 (6-12 July), 5 222 cases were reported. As of 12 July, 28 074 cases had been reported in 2026. In the same period in 2025 17 760 cases had been reported ([WHO WPRO Dengue Situation Update #750: 23 July 2026](#)).
- China reported 255 cases in June 2026, and 222 cases reported in May 2026. Although cases remain at low levels, the number of cases reported in June 2026 is 13.3% higher than reported in June 2025 ([WHO WPRO Dengue Situation Update #750: 23 July 2026](#)).
- In Indonesia, the decreasing trend since October 2025 has continued until June 2026. The period January-June 2026, 58 357 cases had been reported ([WHO WPRO Dengue Situation Update #750: 23 July 2026](#)).
- In Laos, the week 12-18 July 373 cases were reported. Although an increasing trend is being observed, the 2 647 cases reported until 18 July represent a 26.8% decrease compared to the same period in 2025 ([WHO WPRO Dengue Situation Update #750: 23 July 2026](#)).
- In Malaysia, cases have been showing an increasing trend since week 22 to 28 March (week 13). In the week 7-13 June 2026, 2 732 cases were reported. A total of 33 679 cases have been reported in 2026 ([WHO WPRO Dengue Situation Update #750: 23 July 2026](#)). According to the Ministry of Health over 50 000 cases had been reported in the country as of 3 August 2026 ([iDengue Versi 3.0, accessed 4 August 2026](#)).
- Singapore reported cases at lower levels compared to 2025 ([WHO WPRO Dengue Situation Update #750: 23 July 2026, Singapore Weekly Infectious Disease Bulletin Week 29 2026](#)). The week 19-25 July 2026, 123 dengue notification were reported. Cumulatively, 1656 cases have been reported until 25 July 2026 ([Singapore Weekly Infectious Disease Bulletin Week 29 2026](#)).
- Vietnam reported 41 684 cases between January and June 2026. In June, 6 998 cases were reported in a 55% increase compared to May, according to the WHO report. It was also noted that the weekly average of cases in June was lower compared to the average of the first weeks of 2026 ([WHO WPRO Dengue Situation Update #750: 23 July 2026](#)).
- In French Polynesia, dengue transmission has remained low in 2026, with two cases reported the week 29 June to 5 July 2026 and 34 confirmed cases reported since the beginning of the year and as of mid-June (week 25) ([WHO WPRO Dengue Situation Update #750: 23 July 2026](#)).
- In New Caledonia 2 202 cases have been reported in 2026 and as of 19 July, with weekly cases showing a decreasing trend after mid-April (week 17) ([WHO WPRO Dengue Situation Update #750: 23 July 2026](#)).

Africa

According to [the Africa CDC Epidemic Intelligence Report of 19 July 2026](#), a total of 3 650 cases have been reported in the continent from the Central African Republic (1), Kenya (1 583), Mali (1 861), Mauritania (38), Nigeria (95) and Senegal (72).

EU/EEA

Since the beginning of 2026 and as of 05 August 2026, France was the only European country to report locally acquired dengue transmission, with one locally acquired dengue case identified.

For more information on locally acquired dengue cases reported in the EU/EEA excluding the outermost regions by France, please visit the [dedicated ECDC website](#). With regards to EU/EEA outermost regions, a summary of recent trends is presented below:

- In Martinique, transmission of dengue is at low levels without impact on hospitalisations. According to the [Dengue Surveillance Report published on 18 June 2026](#), one confirmed case was reported during the week of 8 to 14 June, while an average of 14 confirmed cases per week was recorded between 11 May and 7 June. In Guadeloupe and Saint Martin dengue circulation remains at low levels ([Antilles Dengue Surveillance Report published on 18 June 2026](#)).
- In La Réunion, 331 cases of dengue have been reported since the beginning of 2026 and as of 26 July 2026 ([La Reunion Surveillance Report 3 August 2026](#)).
- In French Guiana, dengue activity remains at a low level ([French Guiana Surveillance Report 30 July 2026](#)).

Global overview

Since the beginning of 2026 and as of 31 July 2026, over 1.5 million cases of dengue and over 500 dengue-related deaths had been reported. This corresponds to a decrease compared with the same period in 2025 ([Communicable disease threats report, 19-25 July 2026](#) and [Communicable disease threats report, 16-22 August 2025](#)).

Note: the data presented in this report originate from both official public health authorities and non-official sources, such as news media, and depending on the source, autochthonous and non-autochthonous cases may be included. Data completeness depends on the availability of reports from surveillance systems and their accuracy, which varies between countries. All data should be interpreted with caution and comparisons, particularly across

countries, should be avoided due to under-reporting, variations in surveillance system structure, different case definitions from country to country and over time, and use of syndromic definitions

ECDC assessment:

Since the beginning of 2026 and as of 05 August 2026, only France has reported a locally acquired case of dengue in Europe.

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

The environmental conditions in most areas of the EU/EEA where *Ae. albopictus* or *Ae. aegypti* are established are now favourable for mosquito activity and virus replication in mosquitoes; therefore, locally acquired dengue cases may occur in the coming weeks.

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

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

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

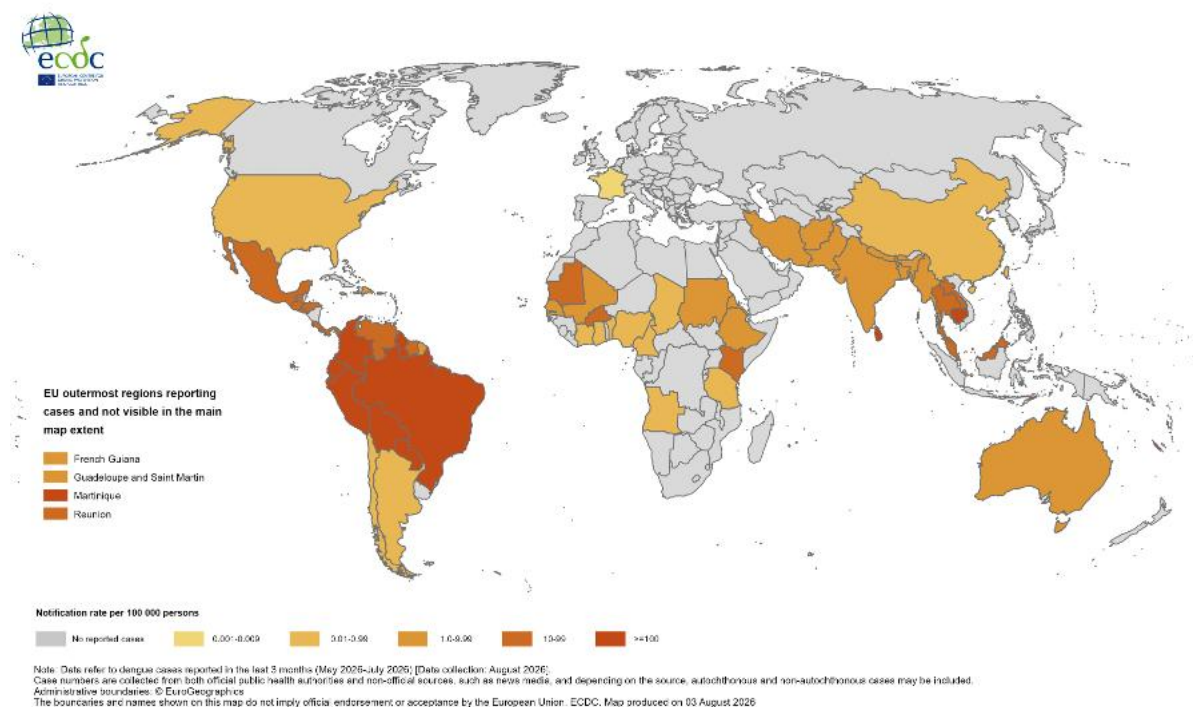
Actions:

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

Last time this event was included in the Weekly CDTR: 26 June 2026

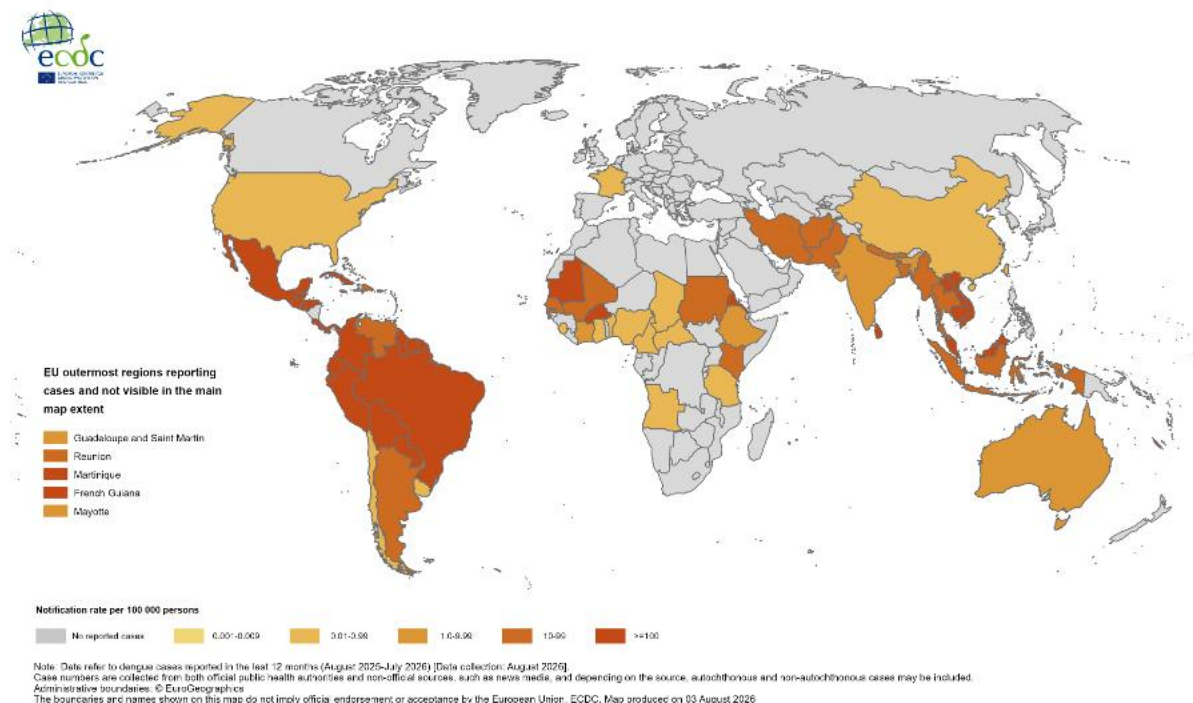
Maps and graphs

Figure 1. Three-month dengue virus disease case notification rate per 100 000 population, May-July 2026



Source: ECDC

Figure 2. 12-month dengue virus disease case notification rate per 100 000 population, August 2025-July 2026



Source: ECDC

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

Overview:

Update: Since the previous update on 2 July 2026, and as of 3 August 2026, no new MERS cases have been reported by the World Health Organization (WHO) or by national health authorities.

Summary: Since the beginning of 2026, and as of 3 August 2026, two MERS cases, including one fatality, have been reported in Saudi Arabia. No information is available on the regions in Saudi Arabia affected by these cases.

Since April 2012, and as of 3 August 2026, a total of 2 649 MERS cases including 960 deaths, have been reported by health authorities worldwide.

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

ECDC assessment:

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

In October 2019, ECDC published a technical report, '[Health emergency preparedness for imported cases of high-consequence infectious diseases](#)' that is still useful for EU 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.

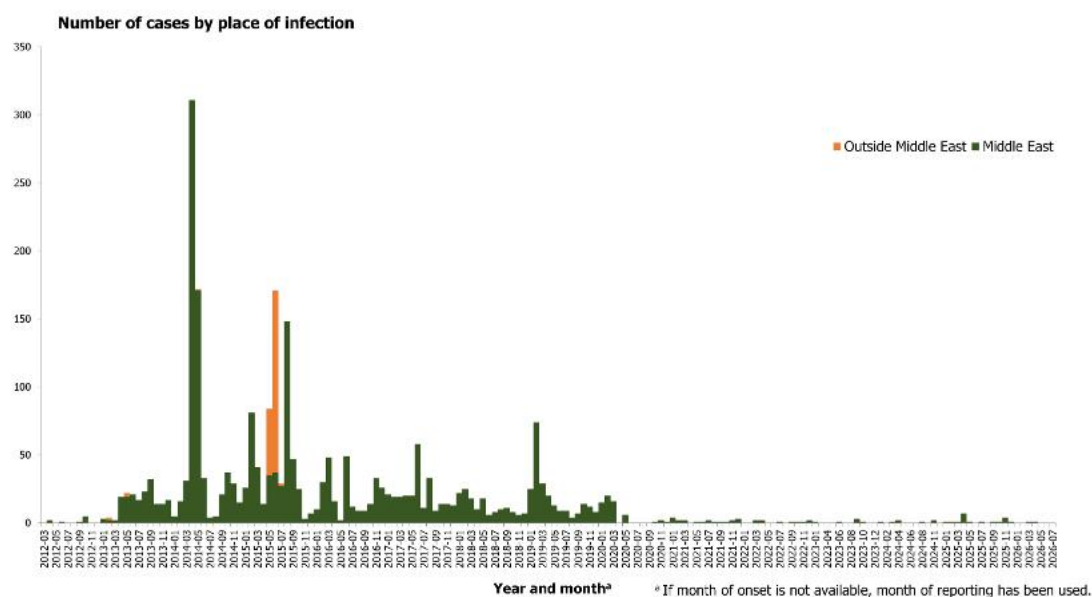
Actions:

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: 3 July 2026

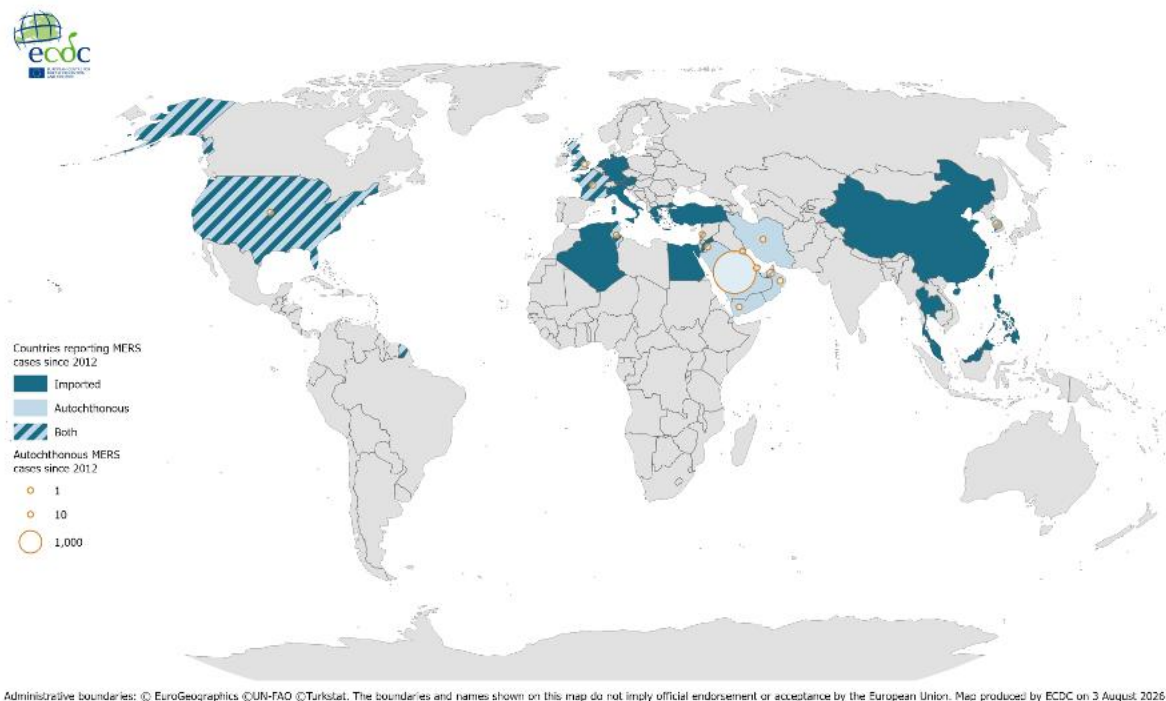
Maps and graphs

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



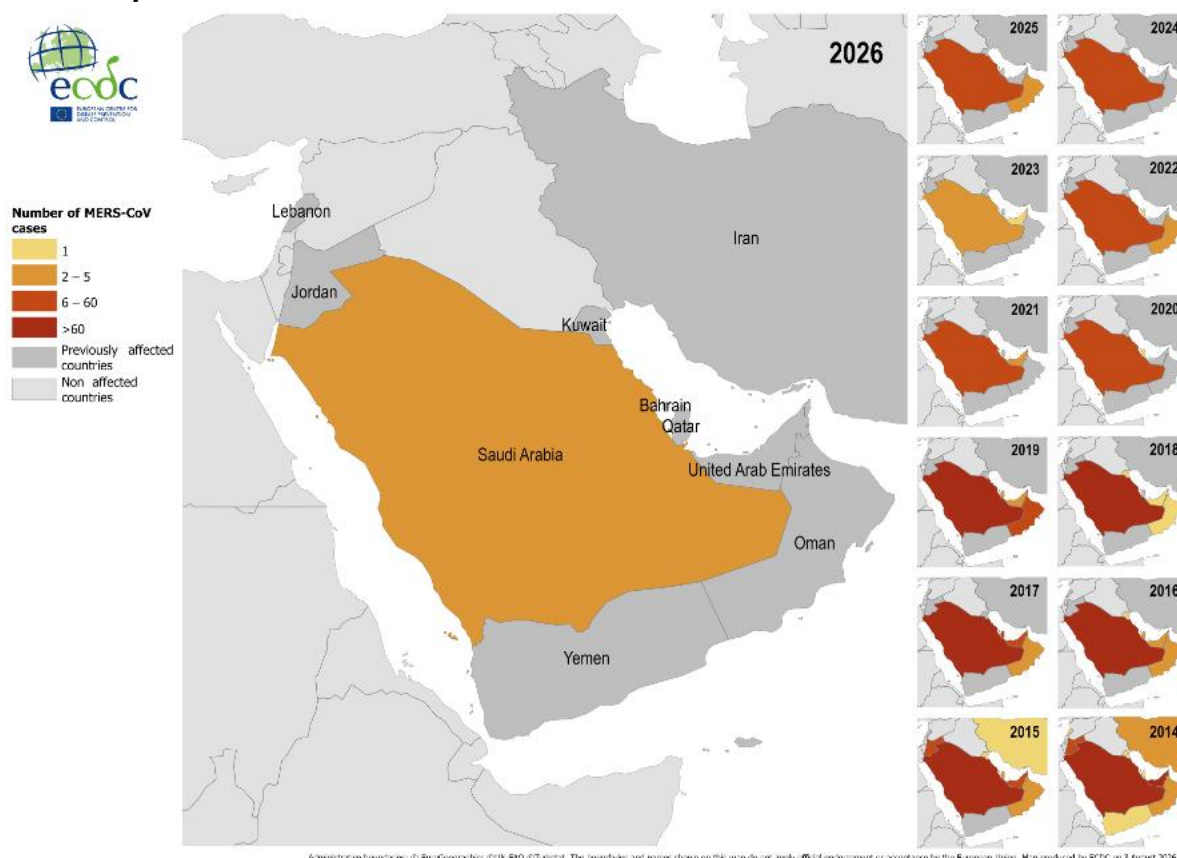
Source: ECDC

Figure 2. Geographical distribution of confirmed cases of MERS-CoV by reporting country, April 2012 - July 2026



Source: ECDC

Figure 3. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2014 – July 2026



Source: ECDC

12. Expert deployment

Overview:

Since 19 May 2026, the EU Health Task Force (EUHTF) has been supporting preparedness and response efforts related to the Ebola disease outbreak caused by Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda.

Seven ECDC experts have been deployed on a rotational basis to support Africa CDC, initially at its headquarters in Addis Ababa and, since 23 June 2026, within the Continental Incident Management Support Team (IMST) in Uganda. The 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. The experts have provided support for surveillance and liaison activities.

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

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 the Global Outbreak Alert and Responses Network (GOARN). The expert supported the implementation of the country's RCCE field plan to strengthen community engagement and address the priority risk communication and community engagement gaps in the high-risk areas. Since 14 July, two ECDC fellows have also been deployed through GOARN to the WHO country office in Juba, South Sudan, to support surveillance and data analysis activities.

These activities are being conducted in close coordination with national authorities and the EU delegations, and in collaboration with the Directorate-General for European Civil Protection and Humanitarian Aid Operations and the Directorate-General for International Partnerships.

Last time this event was included in the Weekly CDTR: 31 July 2026

Events under active monitoring

- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 31 July 2026
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 31 July 2026
- Airport malaria in Germany - last reported on 24 July 2026
- Cyclosporiasis - USA - 2026 - last reported on 17 July 2026
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 17 July 2026
- Risk assessments under production - last reported on 17 July 2026
- Human cases of swine influenza A(H3N2) variant virus – Multi-country - last reported on 17 July 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 17 July 2026
- Influenza A(H5)- Multi-country (World)- Monitoring human cases - last reported on 17 July 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 07 August 2026
- Expert deployment - last reported on 07 August 2026
- Seasonal surveillance of chikungunya virus disease - 2026 (weekly) - last reported on 07 August 2026
- Seasonal surveillance of dengue in the EU/EEA, weekly report - last reported on 07 August 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever - 2026 (Weekly report) - last reported on 07 August 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Weekly report) - last reported on 07 August 2026
- Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters - Bathing season 2026 - last reported on 07 August 2026
- World Pride - Netherlands - 2026 - last reported on 07 August 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 31, 2026 - last reported on 07 August 2026
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 07 August 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 07 August 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 07 August 2026