

WEEKLY BULLETIN

Communicable disease threats report

Week 35, 22–28 August 2026

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Executive summary

Fatal case of respiratory diphtheria in an unvaccinated child in Italy

- On 20 August 2026, media sources reported a fatal case of diphtheria in Palermo (Sicily).
- The case involved an unvaccinated, four-year-old child with symptom onset on 10–11 August who was later hospitalized and died on 20 August. On 25 August, Italy's National Institute of Health confirmed the detection of *Corynebacterium diphtheriae* and the presence of the diphtheria toxin gene.
- A second probable case was reported in a four-year-old cousin of the first case, who was hospitalised with milder symptoms. Contact tracing, monitoring and management of identified contacts have been initiated by public health authorities.
- Diphtheria remains a relatively rare disease in the EU/EEA due to high vaccination coverage, although sporadic cases and localized transmission can occur, particularly among vulnerable groups.
- The overall risk of widespread transmission among the general population in the EU/EEA is considered low.

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

- As of 27 August 2026, the Democratic Republic of the Congo (DRC) reported a total of 5 794 confirmed cases, including 2 786 confirmed related deaths (based on data until 26 August). Since the beginning of the outbreak, six provinces have been affected: Ituri, North Kivu, South Kivu, Tshopo, Haut-Uele and Bas 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 25 August, WHO declared the end of the outbreak following 42 days without a new confirmed case being reported.
- On the basis of the available information, and given the uncertainties surrounding this outbreak, the likelihood of infection for people from the 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 its epidemic intelligence activities and actively liaising with partners to support the response.

Human cases of swine influenza A(H1N2) variant virus infection – Multi-country

- The United States' Centers for Disease Control and Prevention (US CDC) reported a new human infection of swine-origin influenza A(H1N2)v virus.
- This is the second case linked to the Kent County Youth Fair, held from 3 to 8 August in Michigan. The first case was reported in the CDTR of week 34.
- Epidemiological investigation showed no contact between the two infected individuals. Sick pigs were reported at the fairgrounds prior to the onset of human symptoms.
- There are currently no further human infections related to the two cases or the agricultural fair.
- Human infections with influenza virus of swine origin are rare, but sporadic infections can occur in individuals exposed to infected animals.

Overview of respiratory virus epidemiology in the EU/EEA, week 34, 2026

- Respiratory virus activity remains at baseline levels across EU/EEA countries reporting rates of influenza-like illness (ILI) and/or acute respiratory infection (ARI), however, increases are observed in SARS-CoV-2 and influenza virus circulation.
- **SARS-CoV-2** activity is low but increasing in primary and secondary care across all age groups in several countries. Although numbers of hospital admissions remain very low, a few countries are reporting a clear increase, mainly in those over 65 years of age.
- **Influenza virus** activity is low overall but increasing in both primary and secondary care in several countries. In a few countries, hospitalisations associated with influenza A virus detections have increased and are mainly affecting adults over 65 years of age.
- **Respiratory syncytial virus (RSV)** activity is low and at expected inter-seasonal levels.

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

- Since the beginning of 2026, and as at 26 August 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (four cases).
- In the past week, no new cases have been reported to ECDC.

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

- Since the beginning of 2026, and as at 26 August 2026, one country in Europe has reported locally acquired cases of dengue: France (five cases).
- Since the last update, one new cluster has been reported.
- Two of the four reported clusters are active.

Seasonal surveillance of chikungunya virus disease – 2026 (weekly)

- Since the beginning of 2026, and as at 26 August 2026, one country in Europe has reported locally acquired cases of chikungunya virus disease: France (33 cases).
- Since the last update, eight additional locally acquired cases and four new clusters have been reported.

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

- Based on forecasts from the Vibrio Viewer, in the next five days (until 2 September 2026), 37 municipalities across nine regions in four countries are expected to have high environmental suitability for *Vibrio* spp. The highest numbers of municipalities above threshold have been identified in Bulgaria (13), Romania (12), and France (11).
- 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 Threats Reports](#) to assess and communicate the potential risk to human health across the EU/EEA.

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

- Since the beginning of the 2026 transmission season, and as at 26 August, 124 areas affected by West Nile virus (WNV) have been identified in 15 countries across Europe.
- These areas are located in Italy (55), Greece (17), Romania (15), France (13), Serbia (six), Spain (four), North Macedonia (three), Croatia (two), Germany (two), Albania (one), Austria (one), Cyprus (one), Hungary (one), Kosovo* (one), and the Netherlands (one).

**This designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the ICJ Opinion on the Kosovo declaration of independence.*

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

- Since 1 January 2026 and as of 26 August 2026, 212 857 cholera cases, including 1 943 deaths, have been reported worldwide.
- Since 27 July 2026 and as of 26 August 2026, 42 717 new cholera cases, including 257 new deaths, have been reported worldwide.
- The five countries reporting most cases between 27 July 2026 and 26 August 2026 are Nigeria (41 296), Angola (524), Somalia (489), Mozambique (319) and Chad (47).
- The five countries reporting most new deaths in the same reporting period are Nigeria (242), Chad (9), Angola (4), Mozambique (1) and Somalia (1).
- Cholera cases have continued to be reported in Africa, Asia, the Middle East, and the Americas. The risk of cholera infection for travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

Poliovirus – Multi-Country Updates

The World Health Organization (WHO) has reaffirmed that the international spread of poliovirus continues to constitute a Public Health Emergency of International Concern (PHEIC) and extended the IHR Temporary Recommendations for another three months.

Germany remains the only EU/EEA country currently classified as infected, following detections of wild poliovirus type 1 (WPV1) and circulating vaccine-derived poliovirus type 2 (cVDPV2) in wastewater in 2025, although no evidence of sustained local transmission has been reported. No other EU/EEA countries are currently classified as infected. However, France (French Guiana), Finland, Poland and Spain remain under WHO monitoring as countries previously infected within the last 24 months.

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.
- Since 18 August, one expert has been deployed to support Africa CDC within the Continental Incident Management Support Team (IMST) in Uganda. Such deployments are part of the project 'Health Security and One Health in Africa - Africa CDC' in partnership with ECDC and EFSA (PHASE II) and funded by the European Commission's Directorate-General for International Partnerships.
- These activities are being conducted in close coordination with national authorities and 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. Fatal case of respiratory diphtheria in an unvaccinated child in Italy

Overview:

Summary

On 20 August 2026, media sources reported a fatal case of diphtheria in Palermo, Sicily, involving a four-year-old. According to [media reports](#), the case manifested initial symptoms, including fever, reduced appetite and vomiting between 10 and 11 August. The patient's condition deteriorated progressively, with the development of high fever and respiratory distress on 15 August. Owing to the worsening clinical presentation, the child was hospitalised in the intensive medical care unit. Despite receiving organ-supportive treatment and diphtheria antitoxin, the patient died on 20 August. The child had not been vaccinated against diphtheria.

Clinical specimens were submitted to Italy's National Institute of Health (Istituto Superiore di Sanità, ISS) for laboratory confirmation of suspected diphtheria. On 25 August, the ISS [confirmed](#) the detection of *Corynebacterium diphtheriae* and identified the presence of the diphtheria toxin gene, indicating infection with a toxigenic strain capable of causing respiratory diphtheria.

A second probable case was reported in a four-year-old cousin of the first case, who was admitted to hospital with milder symptoms. According to [media reports](#), the child had been previously vaccinated against diphtheria. The patient is being managed in isolation and is reported to be in a stable clinical condition.

[Local health authorities](#) have initiated an epidemiological investigation, including contact tracing and active monitoring of contacts to identify potential additional cases and limit further transmission. [Public health measures](#) have also been implemented, including chemoprophylaxis of contacts and vaccination of the siblings of the first case.

[Media sources](#) have reported that 10 additional family members have tested positive for *C. diphtheriae*. These individuals were reported to be vaccinated and in good clinical condition. However, as of 25 August, no additional cases besides the two described above have been reported officially by [local health authorities](#).

Background

Diphtheria is a vaccine-preventable bacterial disease caused by *Corynebacterium diphtheriae*. Transmission can occur from person to person through respiratory droplets, direct contact with respiratory secretions, contact with exudate from infected skin lesions or contaminated surfaces. Infection may present as respiratory or cutaneous diphtheria. Asymptomatic infection is also common, particularly in highly vaccinated populations. The pathogenicity of *C. diphtheriae* is primarily related to the production of the diphtheria toxin, which can cause local tissue damage, severe systemic complications and even death. Diphtheria is largely preventable through vaccination, and unvaccinated or under-vaccinated individuals are at higher risk of severe disease and death. Without timely diagnosis and treatment, respiratory diphtheria can be life-threatening, especially in unvaccinated, young children.

Diphtheria remains a relatively rare disease in the EU/EEA due to high vaccination coverage. In 2022, a large multi-country outbreak was recorded, primarily affecting migrants and asylum seekers, with limited evidence of spread to the general population. Reported cases declined in subsequent years, although sporadic cases and localised transmission continue to occur, particularly among vulnerable populations, including migrants, people experiencing homelessness, and unvaccinated or under-vaccinated individuals.

ECDC assessment:

The probability of widespread transmission of diphtheria in the general population in the EU/EEA is considered low, due to high levels of population immunity achieved through routine vaccination programmes. The impact on the general population is also assessed as low, as high vaccination coverage reduces the risk of severe disease and death. Therefore, the overall risk to the general population in the EU/EEA is considered low.

Nevertheless, sporadic cases and localised clusters may occur in settings where vaccination coverage is suboptimal or where conditions facilitate transmission, such as overcrowded environments and settings with poor hygiene. Imported cases may also occur among individuals travelling from endemic geographical areas. Severe disease is more likely among susceptible groups, including unvaccinated or under-vaccinated individuals, young children, older adults, and immunocompromised individuals.

Achieving and sustaining high vaccination coverage in the population is crucial to prevent serious or fatal disease. In the event of cases, rapid clinical recognition, prompt laboratory confirmation, timely administration of appropriate treatment, and the identification and management of close contacts are essential to reduce morbidity, mortality, and onward transmission.

Actions:

ECDC continues to monitor this event through epidemic intelligence activities and is liaising with the relevant national public health authorities to collect additional information on the case and ongoing contact tracing and contact follow-up activities.

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

Overview:

Latest epidemiological information

Democratic Republic of the Congo

On 27 August 2026, the [Democratic Republic of the Congo \(DRC\) published a situation update](#) reporting a total of 5 794 confirmed cases, including 2 786 related deaths (from data up until 26 August). A total of 843 patients are hospitalised in isolation. This represents an increase of 81 new confirmed cases and 42 deaths since the previous report on 26 August (reporting data up until 25 August). In total, 82.3% of identified case contacts are under follow-up in the affected provinces. Overall, 60 of 151 health zones are currently affected across the six provinces.

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

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, 12 days since

the last case was discharged, the [Uganda's Ministry of Health](#) declared the end of the Ebola disease outbreak. On 26 August, [WHO declared the end of the Ebola disease outbreak in Uganda](#) following 42 days without a new confirmed case being reported.

Summary

On 15 May 2026, Africa CDC reported an outbreak of Ebola disease in Ituri Province, DRC ([Africa CDC Calls Urgent Regional Coordination Meeting Following Ebola Virus Disease Outbreak in Ituri, 15 May 2026](#), [Africa CDC Special Briefing on Ebola Virus Disease Outbreak Status, 16 May 2026](#)). Laboratory analysis at the Institut National de Recherche Biomedicale of DRC identified Bundibugyo virus ([Democratic Republic of the Congo confirms new Ebola outbreak, WHO scales up support | WHO AFRO, 15 May 2026](#)).

Clusters of community deaths have been reported, including deaths among healthcare workers in DRC ([Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026](#), [Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo \(The\) & Uganda](#)).

The Ministry of Health of DRC reported that the index case was a nurse (age unknown) who died in a healthcare facility in Bunia (capital of Ituri Province). The individual presented with fever, bleeding, vomiting and weakness ([Ministère de la Santé RDC Declaration of Ebola Outbreak 15 May 2025](#)). However, the outbreak is likely to have started many weeks before, given the number of cases and the geographical spread.

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 had tested positive for Bundibugyo virus. The patient was [medically evacuated to Germany on 13 July 2026](#) and is currently under treatment. This is the second US citizen during this outbreak who 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 was 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's Oxford Vaccine Group and Pandemic Sciences Institute.

On 27 August, the [Minister of Public Health of the DRC](#) launched a vaccination campaign for frontline workers against Ebola virus disease using the ERVEBO vaccine in Kisangani. The campaign is primarily being implemented in the affected provinces of Tshopo, Bas-Uele and Haut-Uele.

ECDC assessment:

Given the gaps in epidemiological information and limited follow-up of contacts, it is likely that the outbreak is larger than is currently being reported in terms of the number of affected cases/areas.

Given all the available information and uncertainties surrounding this outbreak, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is estimated to be low. Given the very low likelihood of importation and secondary transmission, the likelihood of infection is estimated to be very low for people living in the EU/EEA. The overall risk of Bundibugyo virus transmission through substances of human origin (SoHO) in the EU/EEA is currently assessed as very low ([Risk of Bundibugyo virus transmission through substances of human origin in the European Union/European Economic Area \(EU/EEA\)](#)). This assessment will be reviewed as further information becomes available.

Exit screening in affected countries, including symptom checks and exposure assessment, is important as it contributes to risk reduction by identifying symptomatic travellers before they board flights, to prevent them travelling while symptomatic. Exit screening also helps dissuade people with symptoms from travelling and enhances public and stakeholder confidence. However, it cannot fully prevent exportation of cases, because the absence of symptoms at departure does not exclude subsequent onset of disease.

ECDC considers that screening of returning travellers from affected areas (DRC, Uganda) would not be effective in preventing introduction to Europe. This consideration is based on the lessons learned and results of the large EVD outbreak in West Africa between 2013 and 2016, where tens of thousands of cases were reported, transmission was ongoing in large urban centres, and hundreds of EU/EEA humanitarian and military personnel were deployed to the affected areas. Screening incoming travellers is time- and resource-consuming and will not effectively identify people with the infection. Priority should instead be given to providing travellers with clear information on symptoms, routes of transmission, and what to do if symptoms develop after arrival in the EU/EEA.

Detailed assessment of the event can be found in ECDC's Threat Assessment Brief published on 21 May 2026 ([Threat assessment brief: Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026](#)).

Actions:

ECDC continues to monitor the outbreak through its epidemic intelligence activities to provide epidemiological updates, situational awareness and risk assessment for the EU/EEA.

Since 19 May 2026, the EU Health Task Force, in collaboration with the European Civil Protection and Humanitarian Aid Operations (DG ECHO), the Directorate-General for International Partnerships (DG

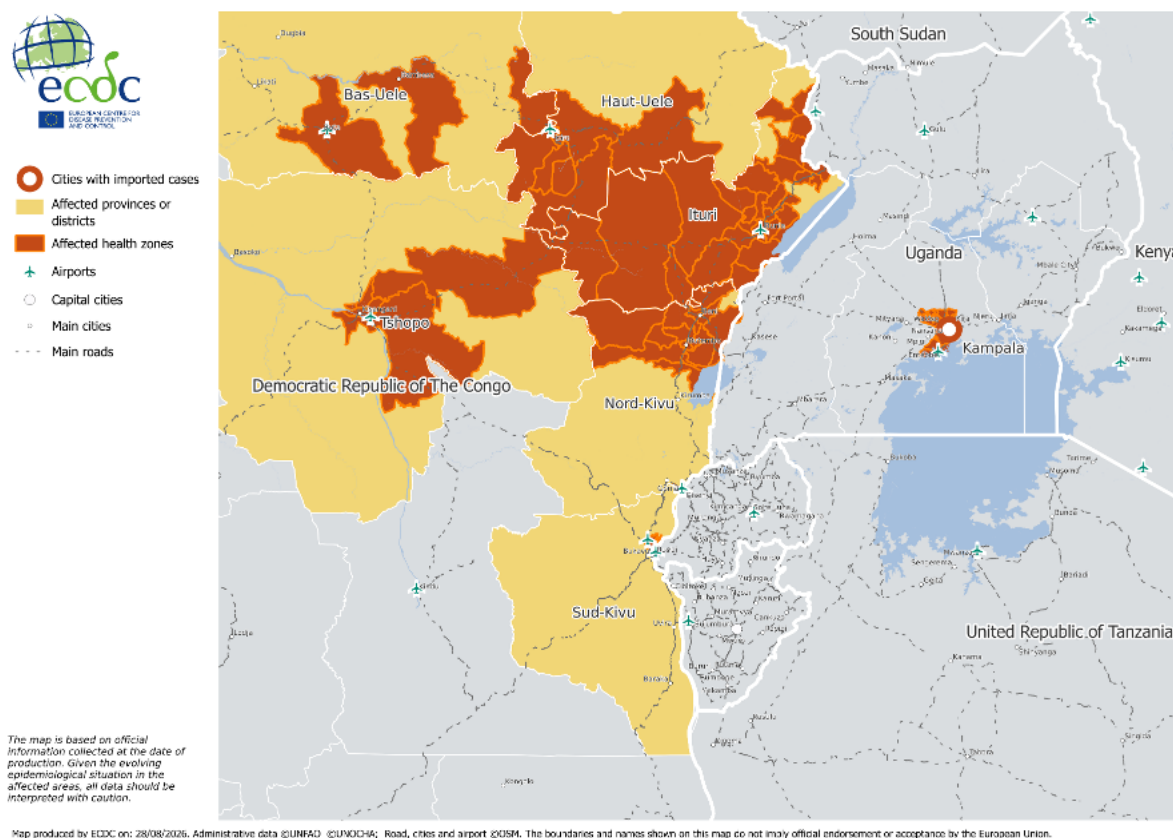
INTPA) and the Global Outbreak Alert and Response Network (GOARN), has been deploying ECDC experts to Addis Ababa (Ethiopia) at Africa CDC's headquarters, and Kampala (Uganda).

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

ECDC is regularly re-evaluating the situation as new information becomes available and continues to provide updated epidemiological information, scientific assessments and advice on its website [Ebola disease outbreak in the Democratic Republic of the Congo and Uganda](#).

Last time this event was included in the Weekly CDTR: 21 August 2026

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



3. Human cases of swine influenza A(H1N2) variant virus infection – Multi-country

Overview:

On 21 August, US CDC reported a human case of swine influenza A(H1N2)v virus infection in its Weekly US Influenza Surveillance Report ([Weekly US Influenza Surveillance Report: Week 32, 2026 | CDC](#)). This marks the second case linked to the Kent County Youth Fair, which took place from 3 to 8 August at the Grand Agricultural Center of West Michigan in Lowell ([MDHHS confirms detection of influenza A H1N2 variant \(swine flu\) in Michigan resident](#)). The first case was reported in the CDTR of week 34.

Both cases are aged under 18 years and developed symptoms during the week ending 15 August 2026. Neither required hospitalisation, both are currently recovering, and one received antiviral treatment. Although the two individuals had no contact with each other, sick pigs were reported at the fair before the onset of their symptoms. No further human infections linked to these cases or the agricultural fair have been identified.

State and county health officials are tracking potential influenza illnesses among swine exhibitors and visitors from the Kent County Youth Fair. Local doctors are on alert for respiratory symptoms in anyone who visited the fair or was exposed to pigs there.

MDHHS has issued comprehensive public health guidance to help the public prevent variant influenza exposure, recognise influenza symptoms, protect populations at high risk of infection, and seek timely medical help.

Sequences from the two viruses from Michigan (GISAID virus names A/Michigan/74/2026 and A/Michigan/75/2026) are highly similar in the examined HA, NA and PB2 segments. The viruses cluster with virus sequences from swine (and two virus sequences from turkey) from the United States submitted recently in 2025. The two viruses do not display reassortment compared to their closest viruses of swine origin in examined NA and PB2 segments.

Summary: Four human infections with influenza A(H1N2)v virus have been reported in the US in the current 2025-26 season. Overall, 36 cases of human A(H1N2)v infection have been reported globally since 2019, four of which were reported in the EU/EEA: Austria (2021), Denmark (2019), France (2021), and the Netherlands (2022). Outside the EU/EEA, cases have been reported in Brazil (3), Canada (3), Taiwan (3), the United Kingdom (1), the US (21), and mainland China (1).

We gratefully acknowledge all data contributors - i.e. the authors and their originating laboratories responsible for obtaining the specimens, and the submitting laboratories, responsible for generating the genetic sequence and metadata on which this research is based - for having shared via the GISAID Initiative.

ECDC assessment:

Sporadic cases of human infection with an influenza virus of swine origin have been reported from several countries around the world. Infection following exposure to pigs represents the most common risk factor. Limited, non-sustained, human-to-human transmission of variant influenza viruses has previously been documented, but is rare. All cases need to be carefully followed up to exclude human-to-human transmission and implement control measures.

Actions:

ECDC monitors zoonotic influenza events through its epidemic intelligence activities and with disease experts in order to identify significant changes in the epidemiology of the virus. Cases in the EU/EEA should be immediately reported to the Early Warning and Response System (EWRS) and in accordance with the International Health Regulations (IHR).

Novel influenza viruses in humans, including zoonotic influenza viruses, should be further characterised and shared with the national influenza reference laboratories and the World Health Organization (WHO) Collaborating Centres.

ECDC guidance: [Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work](#).

An annual summary of human infections with influenza A variant viruses of swine origin reported globally is provided in the [Zoonotic influenza - Annual Epidemiological Report 2024](#).

Last time this event was included in the Weekly CDTR: 21 August 2026

4. Overview of respiratory virus epidemiology in the EU/EEA, week 34, 2026

Overview:

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

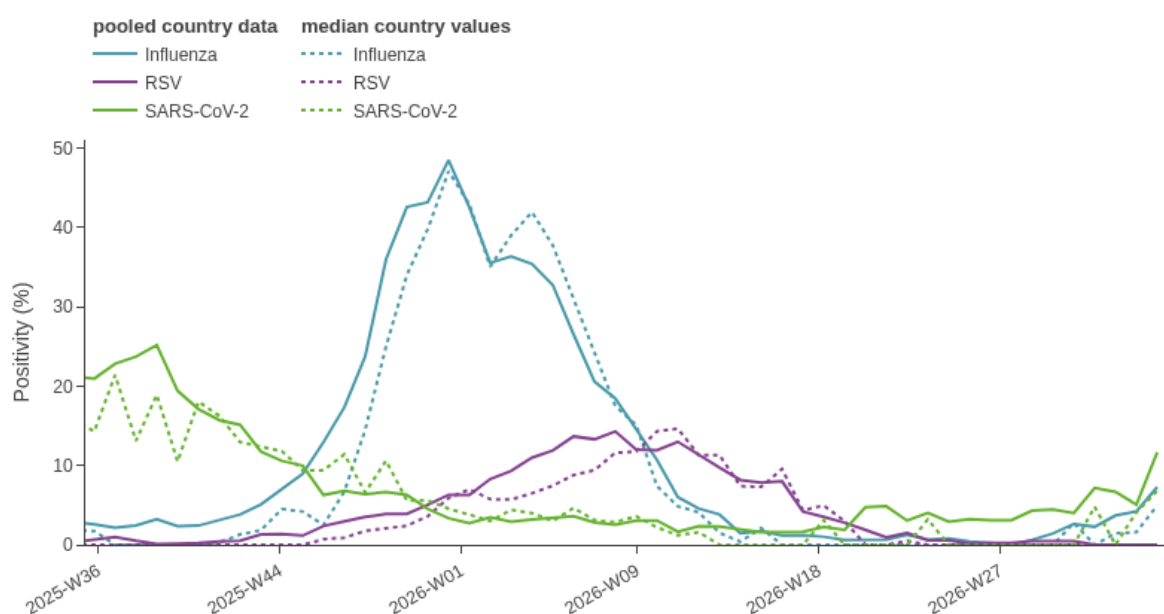
Key visualisation from the weekly bulletin are included below.

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

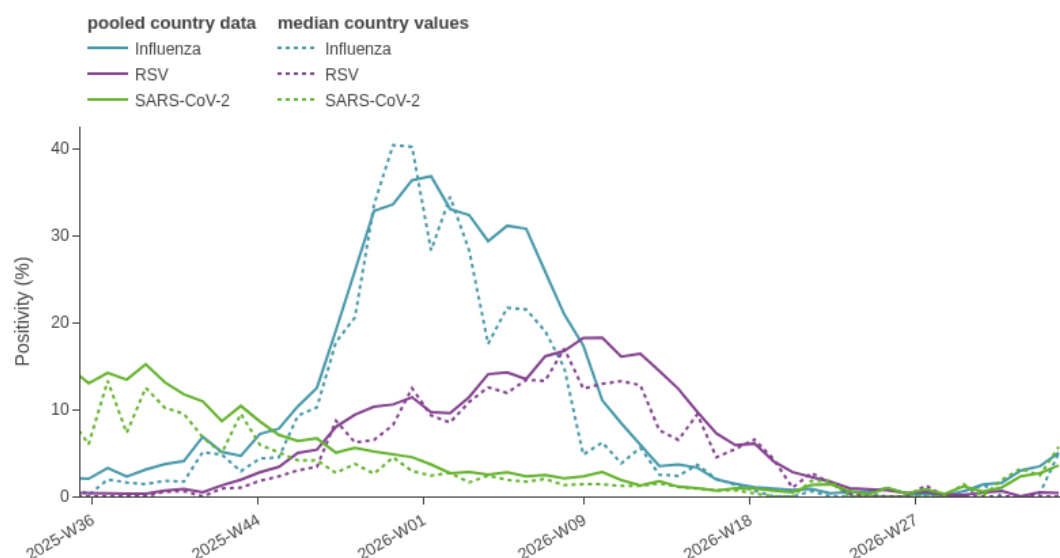
Sources: [ERVISS](https://eriss.org)

Last time this event was included in the Weekly CDTR: 21 August 2026

Figure 2. ILI/ARI virological surveillance in primary care - weekly test positivity



Source: ECDC

Figure 3. SARI virological surveillance in hospitals – weekly test positivity

Source: ECDC

Figure 4. Key indicators

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary	
		Week 34	Week 33	Description	Value
ILI/ARI consultation rates in primary care	ARI	12 rates (7 MEM)	13 rates (8 MEM)	Distribution of country MEM categories	7 Baseline
	ILI	12 rates (11 MEM)	13 rates (12 MEM)		11 Baseline
ILI/ARI test positivity in primary care	Influenza	13	14	Pooled (median; IQR)	7.3% (5; 0.8–8.4%)
	RSV	12	13		0% (0; 0–0%)
	SARS-CoV-2	13	14		12% (6.8; 1.5–9.8%)
SARI rates in hospitals	SARI	9 rates (4 MEM)	10 rates (5 MEM)	Distribution of country MEM categories	4 Baseline
SARI test positivity in hospitals	Influenza	7	8	Pooled (median; IQR)	5% (5; 5–19%)
	RSV	7	7		0.4% (0; 0–0%)
	SARS-CoV-2	7	7		3.6% (5.7; 4.1–7%)
Intensity (country-defined)	Influenza	7	9	Distribution of country qualitative categories	6 Baseline 1 Low

Source: ECDC

Figure 5. ILI/ARI virological surveillance in primary care - pathogen type and subtype distribution

Pathogen	Week 34, 2026		Week 40, 2025 – week 34, 2026	
	N	% ^a	N	% ^a
Influenza	28	–	18057	–
Influenza A	24	92	17454	99
A(H1)pdm09	0	0.0	4070	28
A(H3)	16	100	10388	72
A (unknown)	8	–	2996	–
Influenza B	2	8	121	0.7
B/Vic	0	–	37	100
B (unknown)	2	–	84	–
Influenza untyped	2	–	482	–
RSV	0	–	5366	–
RSV-A	0	–	935	44
RSV-B	0	–	1192	56
RSV untyped	0	–	3239	–
SARS-CoV-2	64	–	4572	–

Source: ECDC

Figure 6. SARI virological surveillance in hospitals - pathogen type and subtype distribution

Pathogen	Week 34, 2026		Week 40, 2025 – week 34, 2026	
	N	% ^a	N	% ^a
Influenza	26	–	15791	–
Influenza A	17	100	7659	99
A(H1)pdm09	1	14	1317	35
A(H3)	6	86	2453	65
A (unknown)	10	–	3889	–
Influenza B	0	0.0	68	0.9
B/Vic			10	100
B (unknown)	0	–	58	–
Influenza untyped	9	–	8064	–
RSV	2	–	7207	–
RSV-A	1	100	1154	52
RSV-B			1062	48
RSV untyped	1	–	4991	–
SARS-CoV-2	18	–	3097	–

Source: ECDC

Figure 7. Genetically characterised influenza virus distribution, week 40, 2025 – week 34, 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 8. SARS-CoV-2 variant distribution, week 32, 2026 - week 33, 2026

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	2	6% (6–6%)
XFG	VUM	1	21	62% (62–62%)
BA.3.2	VUM	1	1	3% (3–3%)
NB.1.8.1	VUM	0	0	0%

Source: ECDC

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

Overview:

Since the beginning of 2026, and as at 26 August 2026, one country in Europe has reported locally acquired cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (four cases). In the past week, no new cases have been reported to ECDC.

The report is available [online](#).

ECDC assessment:

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 outdoor activities that expose them to tick bites (e.g. hunting, forestry work, hiking, animal surveillance). As a general precaution against CCHF, but also against other tick-borne diseases, people who may potentially be exposed to ticks should apply personal protective measures ([ECDC Protective Measures against ticks](#)). In Spain, CCHF virus is 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 light of this development, ECDC has implemented seasonal enhanced surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures.

CCHF is a notifiable disease at the EU level and cases are reported in accordance with the [EU case definition](#). CCHF cases – and their corresponding case numbers – 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: 21 August 2026

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

Overview:

Since the beginning of 2026, and as at 26 August 2026, one country in Europe has reported locally acquired cases of dengue: France (five cases). Since the last update, one new cluster has been reported. Four clusters were reported, of which two are active.

The report is available [online](#).

ECDC assessment:

The current [dengue risk assessment](#) for mainland EU/EEA is available on ECDC's dedicated [dengue webpage](#).

Actions:

ECDC will continue to monitor the situation and will publish a weekly report on the occurrence of dengue in the EU/EEA until November 2026.

Further information:

Dengue is a mosquito-borne viral disease that is increasingly emerging in Europe with locally acquired cases reported in several EU/EEA countries. In 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: 21 August 2026

7. Seasonal surveillance of chikungunya virus disease – 2026 (weekly)

Overview:

Since the beginning of 2026, and as at 26 August 2026, one country in Europe has reported locally acquired cases of chikungunya virus disease: France (33 cases).

Since the last update, eight additional locally acquired cases and four new clusters have been reported.

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, ECDC has implemented seasonal enhanced surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures.

Chikungunya virus disease is a notifiable disease at the EU level and cases are reported in accordance with the [EU case definition](#). Chikungunya virus disease cases – and their corresponding case numbers – 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: 21 August 2026

8. 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 2 September 2026), 37 municipalities across nine regions in four countries are expected to have high environmental suitability* for *Vibrio* spp. The highest numbers of municipalities above threshold have been identified in Bulgaria (13), Romania (12), and France (11).

A list of areas expected to have high environmental suitability* for *Vibrio* spp. until 2 September 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: 11 municipalities in three regions:

- **Gironde:** Eight municipalities above the threshold
- **Charente-Maritime:** Chenac-Saint-Seurin-d'Uzet, Talmont-sur-Gironde
- **Bouches-du-Rhône:** Arles

Italy: one municipality in one region:

- **Ferrara:** Goro

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 regions (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 septicæmia 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 can 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 be cooked thoroughly before consumption. People 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 the 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: 21 August 2026

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

Overview:

Since the beginning of the 2026 transmission season, and as at 26 August, 124 areas affected by West Nile virus (WNV) have been identified in nine countries across Europe.

These areas are located in Italy (55), Greece (17), Romania (15), France (13), Serbia (six), Spain (four), North Macedonia (three), Croatia (two), Germany (two), Albania (one), Austria (one), Cyprus

(one), Hungary (one), Kosovo* (one), and the Netherlands (one). This week, 25 areas are 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](#) is also published.

WNV infection in humans is a notifiable disease at the EU level and cases should be reported by national public health authorities through the EpiPulse Cases platform in accordance with the [EU case definition](#). According to Commission Directives [2004/33/EC](#) and [2014/110/EU](#) on blood safety, blood establishments in European Union/European Economic Area (EU/EEA) countries should apply temporary deferral criteria for donors of allogeneic blood donation for 28 days after they have left a risk area for locally acquired WNV, unless an individual nucleic acid test (NAT) is negative. WNV surveillance activities carried out by ECDC support the competent authorities responsible for blood safety in the implementation of these directives.

** This designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the ICJ Opinion on the Kosovo declaration of independence.*

ECDC assessment:

Seasonal weather conditions are currently favourable for mosquito-borne transmission; more cases are expected to occur in the coming weeks as a result.

Actions:

ECDC will provide weekly and monthly updates with the latest reports on cases of WNV infections in Europe. A map and table will be updated every Friday from now until November, as this is the time of year when WNV infections are most likely to be reported.

ECDC will provide an enhanced analysis of the current WNV epidemiology on a monthly basis together with the European Food Safety Authority (EFSA), which includes information on the number of locally acquired human cases reported, outbreaks of West Nile fever in equids and birds notified to the Animal Disease Information System (ADIS) of the European Commission, and an assessment of the situation.

Last time this event was included in the Weekly CDTR: 21 August 2026

10. 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 27 July 2026 and as of 26 August 2026, 42 717 new cholera cases, including 257 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Burundi, Cameroon, Central African Republic, Chad, Democratic Republic of The Congo, Haiti, Kenya, Malawi, Mozambique, Myanmar/Burma, Nigeria, Pakistan, Somalia, South Africa, South Sudan, Sudan and Yemen

The five countries reporting most cases are Nigeria (41 296), Angola (524), Somalia (489), Mozambique (319) and Chad (47).

New deaths have been reported from Afghanistan, Angola, Burundi, Cameroon, Central African Republic, Chad, Democratic Republic of The Congo, Haiti, Mozambique, Nigeria, Somalia, South Sudan and Sudan.

The five countries reporting most new deaths are Nigeria (242), Chad (9), Angola (4), Mozambique (1) and Somalia (1).

In addition, 46 246 new cases were reported or collected retrospectively from before 27 July 2026.

In the previous reporting period (22 June 2026 to 27 July 2026), 8 247 new cholera cases, including 326 new deaths, were reported worldwide.

Since 1 January 2026 and as of 26 August 2026, 212 857 cholera cases, including 1 943 deaths, have been reported worldwide.

In comparison, since 01 January 2025 and as of 26 August 2025, 338 340 cholera cases, including 4 324 deaths, were reported worldwide.

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

Asia:

Afghanistan:

Since 15 June 2026 and as of 20 July 2026, 24 306 new cases, including 17 new deaths, have been reported. Since 1 January 2026 and as of 20 July 2026, 80 968 cases, including 45 deaths, have been reported. In comparison, in 2025 and as of 23 June 2025, 68 031 cases, including 26 deaths, were reported.

Myanmar/Burma:

Since 15 June 2026 and as of 22 June 2026, 15 new cases have been reported. Since 1 January 2026 and as of 22 June 2026, 272 cases have been reported. In comparison, in 2025 and as of 16 June 2025, 1 888 cases were reported.

Pakistan:

Since 18 May 2026 and as of 6 July 2026, 1 048 new cases have been reported. Since 1 January 2026 and as of 6 July 2026, 4 353 cases have been reported. In comparison, in 2025 and as of 21 July 2025, 14 760 cases were reported.

Yemen:

Since 8 June 2026 and as of 29 June 2026, 389 new cases have been reported. Since 1 January 2026 and as of 29 June 2026, 5 443 cases, including seven deaths, have been reported. In comparison, in 2025 and as of 23 June 2025, 41 510 cases, including 129 deaths, were reported.

Since 22 June 2026, no updates have been reported by: India and Taiwan.

Africa:

Angola:

Since 12 July 2026 and as of 9 August 2026, 524 new cases, including four new deaths, have been reported. Since 1 January 2026 and as of 9 August 2026, 5 903 cases, including 120 deaths, have been reported. In comparison, in 2025 and as of 4 August 2025, 27 666 cases, including 773 deaths, were reported.

Burundi:

Since 12 July 2026 and as of 09 August 2026, 40 new cases have been reported. Since 1 January 2026 and as of 9 August 2026, 1 578 cases, including four deaths, have been reported. In comparison, in 2025 and as of 8 July 2025, 217 cases were reported.

Cameroon:

Since 31 December 2025 and as of 12 July 2026, 331 new cases, including 12 new deaths, have been reported. Since 1 January 2026 and as of 12 July 2026, 331 cases, including 12 deaths, have been reported. In comparison, in 2025 and as of 27 July 2025, no cases were reported.

Central African Republic:

Since 12 July 2026 and as of 9 August 2026, two new cases have been reported. Since 1 January 2026 and as of 9 August 2026, 447 cases, including 36 deaths, have been reported. In comparison, in 2025 and as of 26 August 2025, no cases were reported.

Chad:

Since 12 July 2026 and as of 9 August 2026, 47 new cases, including nine new deaths have been reported. Since 1 January 2026 and as of 9 August 2026, 167 cases, including 13 deaths, have been reported. In comparison, in 2025 and as of 4 August 2025, 77 cases, including four deaths, were reported.

Mozambique:

Since 12 July 2026 and as of 09 August 2026, 319 new cases, including one new death, has been reported. Since 1 January 2026 and as of 9 August 2026, 7 698 cases, including 65 deaths, have been reported. In comparison, in 2025 and as of 4 August 2025, 4 167 cases, including 43 deaths, were reported.

Nigeria:

Since 12 July 2026 and as of 9 August 2026, 41 296 new cases, including 242 new deaths, have been reported. Since 1 January 2026 and as of 09 August 2026, 50 290 cases, including 338 deaths have been reported. In comparison, in 2025 and as of 25 August 2025, 9 738 cases, including 234 deaths, were reported.

Somalia:

Since 12 July 2026 and as of 09 August 2026, 489 new cases, including one new death, has been reported. Since 1 January 2026 and as of 9 August 2026, 2 657 cases, including one death, has been reported. In comparison, in 2025 and as of 25 August 2025, 7 484 cases, including nine deaths, were reported.

South Africa:

Since 30 April 2024 and as of 13 July 2026, two new cases have been reported. Since 1 January 2026 and as of 13 July 2026, two cases have been reported. In comparison, in 2025 and as of 26 August 2025, no cases were reported.

South Sudan:

Since 12 July 2026 and as of 20 July 2026, 11 954 new cases, including 113 new deaths, have been reported. Since 1 January 2026 and as of 20 July 2026, 12 411 cases, including 119 deaths, have been reported. In comparison, in 2025 and as of 4 August 2025, 67 064 cases, including 1 142 deaths, were reported.

Since 27 July 2026, no updates have been reported by: Cameroon, Congo, Democratic Republic of The Congo, Ethiopia, Kenya, Malawi, Namibia, Rwanda, Sudan, United Republic of Tanzania, Zambia and Zimbabwe.

Americas:**Haiti:**

Since 18 May 2026 and as of 8 June 2026, 113 new cases have been reported. Since 1 January 2026 and as of 8 June 2026, 642 cases, including two deaths, have been reported. In comparison, in 2025 and as of 23 June 2025, 2 496 cases, including 31 deaths, were reported.

ECDC assessment:

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

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

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

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

Actions:

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

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

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

Figure 9. Geographical distribution of cholera cases reported worldwide from August 2025 to August 2026

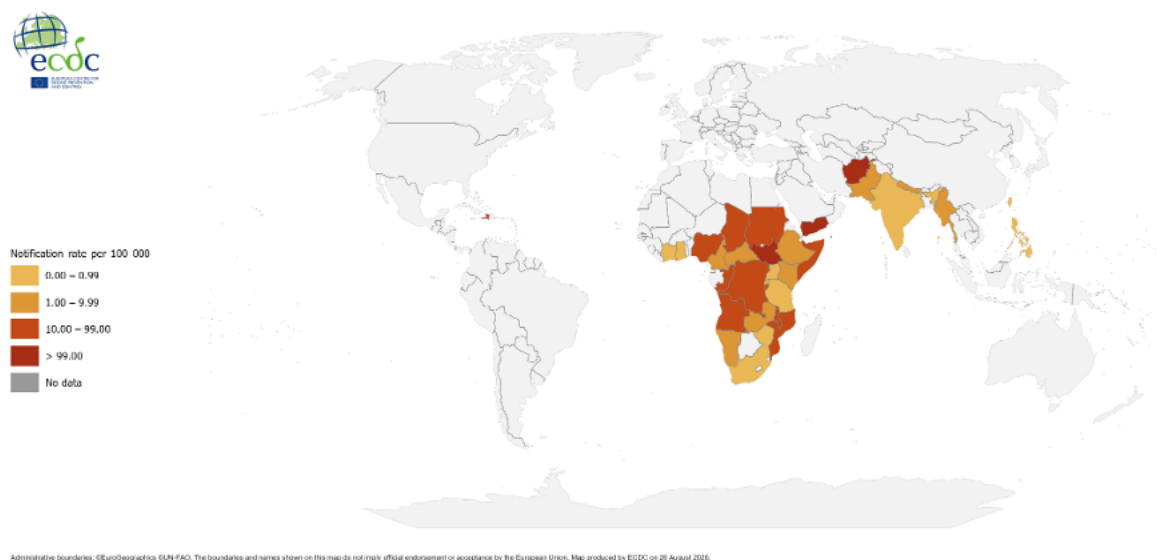
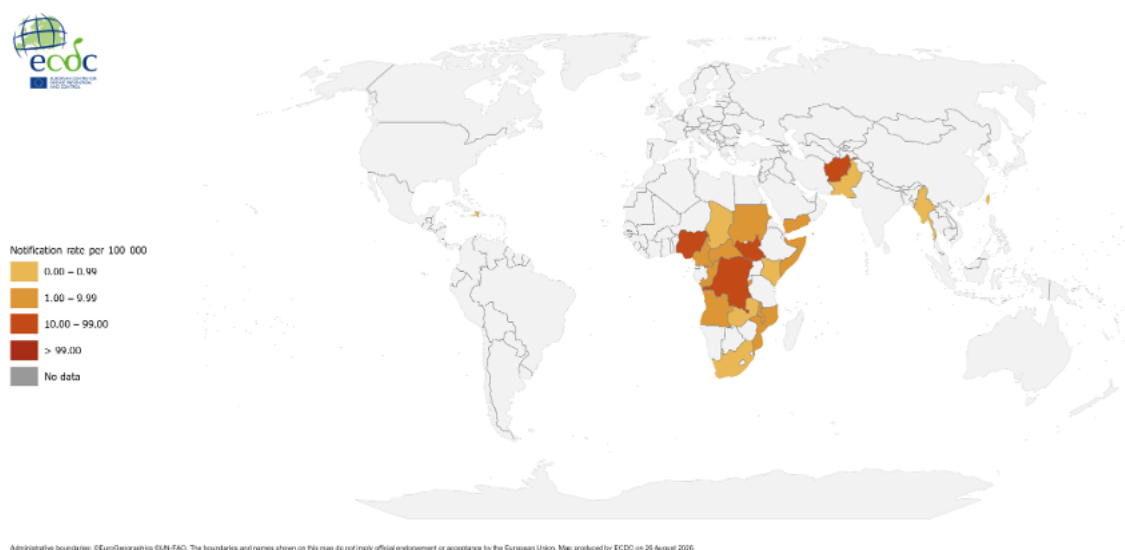


Figure 10. Geographical distribution of cholera cases reported worldwide from June 2026 to August 2026



11. Poliovirus - multi-country updates

Overview:

On 25 August 2026, WHO published a statement the 45th IHR Emergency Committee on polioviruses following a meeting held on 14 May 2026. The Committee concluded that the international spread of poliovirus continues to constitute a Public Health Emergency of International Concern (PHEIC). On 21 August 2026, WHO extended the Temporary Recommendations under the IHR for another three months.

Using data available 30 April 2026, Germany remains classified as a *States infected with WPV1, cVDPV1 or cVDPV3 with or without evidence of local transmission* following the detection of two positive wastewater environmental samples in 2025, with the most recent detection reported on 13 October 2025. No further WPV1 detections have been reported and there is no evidence of sustained local transmission. Germany is also classified as a *States infected with cVDPV2, with or without evidence of local transmission*, with the most recent detection reported on 6 October 2025.

No other EU/EEA country is currently categorised as infected with poliovirus. However, France (French Guiana), Finland, Poland and Spain remain on the WHO monitoring list of countries that were infected with vaccine-derived poliovirus within the previous 24 months and are now considered no longer infected.

The report is available [online](#).

ECDC assessment:

The WHO risk assessment and PHEIC classification highlight that poliovirus remains a global public health concern.

Actions:

ECDC continues to monitor developments related to poliovirus transmission and WHO recommendations under the IHR framework.

Further information:

The WHO Committee noted that WPV1 transmission remains endemic in Afghanistan and Pakistan and that vaccine-derived poliovirus outbreaks continue in several countries globally. The Committee highlighted the importance of maintaining high vaccination coverage and sensitive surveillance systems to detect poliovirus emergence and importations as well as prevent re-establishment of transmission. Humanitarian conflict, complex emergencies, and lack of political commitment to polio eradication continue to elevate outbreak risk.

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.

Nine 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. Between 14 July and 27 August 2026, two ECDC fellows were 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 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: 21 August 2026

Events under active monitoring

- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 - last reported on 28 August 2026
- Expert deployment - last reported on 28 August 2026
- Seasonal surveillance of chikungunya virus disease – 2026 (weekly) - last reported on 28 August 2026
- Seasonal surveillance of dengue in the EU/EEA, weekly report - last reported on 28 August 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (Weekly report) - last reported on 28 August 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (weekly report) - last reported on 28 August 2026
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 28 August 2026
- Human cases of swine influenza A(H1N2) variant virus infection – Multi-country - last reported on 28 August 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 34, 2026 - last reported on 28 August 2026
- Seasonal monitoring of environmental suitability for *Vibrio* spp. risk in coastal waters – Bathing season 2026 - last reported on 28 August 2026
- Poliovirus - Multi-Country Updates - last reported on 28 August 2026
- Fatal case of respiratory diphtheria in an unvaccinated child in Italy - last reported on 28 August 2026
- Spread of *Dermatophilus congolensis* infection predominantly affecting men who have sex with men - EU/EEA - 2026 - last reported on 21 August 2026

- Measles outbreak linked to a festival - Sweden and Finland - 2026 - last reported on 21 August 2026
- Salmonella Enteritidis ST11- multi country-2025-2026 - last reported on 21 August 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report) - last reported on 14 August 2026
- Crimean-Congo haemorrhagic fever in Albania, 2026 - last reported on 14 August 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 14 August 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 7 August 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 7 August 2026
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 7 August 2026