

WEEKLY BULLETIN

Communicable Disease Threats Report

Week 38, 12–18 September 2026

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Executive summary

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

- On 17 September 2026, the Democratic Republic of the Congo (DRC) reported a total of 7 475 confirmed cases, including 3 605 related deaths (from data up until 16 September). Since the beginning of the outbreak, seven provinces have been affected: Ituri, North Kivu, South Kivu, Tshopo, Haut-Uele, Bas Uele and Sud Ubangi.
- In Uganda, a total of 20 cases were reported between May and June 2026. On 25 August, the World Health Organization (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 European Union/European Economic Area (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 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.

Airport malaria in Frankfurt, Germany – 2026

- As of 18 September 2026, eight cases of *Plasmodium falciparum* malaria have been reported among six airport workers and two people living near Frankfurt international airport. The cases occurred from early July to early September and none reported travel to a malaria-endemic area. Three of the affected individuals have died.
- The cases are consistent with airport-associated malaria. Multiple introductions of infectious mosquitoes are considered likely, while the possible involvement of local *Anopheles* mosquitoes cannot be excluded.
- Investigations are ongoing to clarify the circumstances of transmission and possible links between the cases.
- The German public health authorities have alerted healthcare professionals to consider malaria in people with unexplained fever and a possible connection to Frankfurt airport or its vicinity, even if they have not travelled to a malaria-endemic area.
- The risk to the general population remains very low.

Iatrogenic botulism - Denmark - 2026

- Six severe cases of botulism have recently been reported in Denmark following cosmetic or hyperhidrosis treatments with botulinum toxin.
- Information remains limited and further investigations are needed to identify the source of exposure and assess whether additional cases might have occurred in other countries.
- Based on currently available information, the current risk to the general population in the EU/EEA is assessed as low.

Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

- One new laboratory-confirmed human case of avian influenza A(H9N2) virus infection in Guangxi Zhuang Autonomous Region, China, was reported by the World Health Organization (WHO) in the [Avian Influenza Weekly Update Number 1061](#), published on 11 September 2026.
- The case involved a child who developed symptoms on 23 August 2026 and subsequently recovered.
- The child had exposure to household poultry and their environment. No additional cases have been identified among close contacts.
- The risk related to zoonotic avian influenza due to A(H9N2) virus for the general population in the EU/EEA is currently considered very low.

Influenza A(H5) - Multi-country (World) - Monitoring human cases

- One new laboratory-confirmed human case of avian influenza A(H5N1) virus infection in Bangladesh was reported by the World Health Organization (WHO) in the [Influenza at the human-animal interface, Summary and risk assessment, from 8 August to 6 September 2026](#) (published on 6 September 2026).
- The case is a child from Rangpur Division who developed symptoms on 15 August 2026 and was hospitalised on 17 August 2026.
- Infection with avian influenza A(H5) virus was detected using real-time RT-PCR on 18 August 2026. Further testing subsequently confirmed the viral subtype as influenza A(H5N1).
- The case had exposure to household ducks and chickens, including some that were sick. Environmental samples tested negative.
- No additional cases have been detected among close contacts of the case.
- The risk related to zoonotic avian influenza due to A(H5N1) virus for the general population in the EU/EEA is considered low.

Overview of respiratory virus epidemiology in the EU/EEA, week 37, 2026

- Consultation rates for respiratory illness in both primary and secondary care settings remain at baseline levels across most EU/EEA countries. Denmark continues to report low activity in primary care settings.
- **SARS-CoV-2** activity is increasing slightly in primary and secondary care in several EU/EEA countries. Detections in primary care are mainly related to individuals aged 15 years and above, while in secondary care, they primarily concern adults aged over 65 years.
- **Influenza virus** activity is low overall, with only a few countries reporting detection. Detections in secondary care mainly relate to adults aged over 65 years and most detections are influenza A viruses.
- **Respiratory syncytial virus (RSV)** activity is low and at expected inter-epidemic levels.

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

- Since the beginning of the 2026 transmission season, and as at 17 September, 180 areas affected by West Nile virus (WNV) have been identified in 16 countries across Europe.
- This week, 19 areas are reported as affected for the first time this season.
- The 16 countries have reported 1 482 locally acquired human cases of WNV infection.

Seasonal surveillance of chikungunya virus disease – 2026 (weekly)

- Since the beginning of 2026 and as at 16 September 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (75 cases) and Italy (one case).

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

- Since the beginning of 2026 and as at 16 September 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (37 cases) and France (five cases).

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

- Since the beginning of 2026 and as at 16 September 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 monitoring of environmental suitability for Vibrio spp. risk in coastal waters – Bathing season 2026

- Based on forecasts from the Vibrio Viewer, over the next five days (until 23 September 2026), 12 municipalities across four regions in three countries are expected to have high environmental suitability for Vibrio spp.
- 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.

Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring

- In July 2026, 29 EU/EEA countries reported measles data. Thirteen countries reported 118 cases and 16 countries reported zero cases.
- During the previous 12-month period, zero deaths attributable to measles were reported to ECDC.
- Overall, case numbers decreased compared with the previous month.
- Complementary epidemic intelligence surveillance was performed on 15-16 September 2026. Outbreaks have been reported in Bulgaria and Sweden. Sporadic cases and clusters have been reported in several EU/EEA countries. Updates are provided for several countries and regions outside 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.
- Since 10 September 2026, 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. Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo – 2026

Latest epidemiological information

Democratic Republic of the Congo

On 17 September 2026, the [Democratic Republic of the Congo \(DRC\)](#) reported a total of 7 475 confirmed cases, including 3 605 related deaths (from data up until 16 September). A total of 905 patients are hospitalised in isolation. This represents an increase of 71 new confirmed cases and 32 deaths since the previous report on 16 September (reporting data up until 15 September). The 71 new cases have been reported from Ituri (41 cases), North Kivu (27 cases), Haut-Uélé (two cases), and Tshopo (one case). Among the individuals who tested positive for Bundibugyo virus, 1 798 have recovered. In total, 87.6% of identified case contacts are under follow-up in the affected provinces.

Ituri province remains the most affected, with 5 792 cases, including 2 642 deaths, reported from 28 of 36 health zones. In North Kivu, 1 350 cases, including 828 deaths, have been reported from 16 of 34 health zones. In South Kivu, three cases, including one death, have been reported from one of 34 health zones. In Haut-Uélé, 292 cases, including 118 deaths, have been reported from six of 13 health zones. In Tshopo, 30 cases, including 11 deaths, have been reported from seven of 23 health zones. In Bas-Uélé, seven cases, including four deaths, have been reported from three of 11 health zones. In Sud Ubangi, one case and one death have been reported from one of 16 health zones. Overall, 62 of 167 health zones are currently affected across the seven provinces.

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

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 who has tested positive in DRC during this outbreak and the patient 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 had been 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. As of 28 July 2026, a total of 20 confirmed cases, including two deaths, had 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 after the last case was discharged, the [Uganda's Ministry of Health](#) declared the end of the Ebola disease outbreak. On 27 August, [WHO declared the end of the Ebola disease outbreak in Uganda](#) following 42 days without a new confirmed case being reported.

Genomes from DRC and Uganda have been published and preliminary analysis shows sequences distinct from previous outbreaks ([Virological Ebola virus/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 previous outbreak occurred in 2025 in Kasai Province and was caused by the 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.

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 [suspended again from 6 June](#) onwards as part of health security arrangements in response to the Ebola disease outbreak, according to the [media](#).

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.

Uganda maintained enhanced screening and preparedness measures during the outbreak response. Since the completion of the 42-day period without new identified cases, [Uganda's Ministry of Health has continued to maintain active screening measures at ports of entry, and temporary travel bans to and from the DRC](#).

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](#)).

[South Sudan](#) is maintaining targeted temperature screening and health declaration forms at Juba International Airport and key entry points.

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](#), [Bahrain](#), [Botswana](#), [Taiwan](#), [El Salvador](#), [Hong Kong](#), [India](#), [Israel](#), [Italy](#), [Jordan](#), [Kenya](#), [Kuwait](#), [Lebanon](#), [Malawi](#), [Mauritius](#), [Mexico](#), [Nigeria](#), [Oman](#), [Pakistan](#), [Philippines](#), [Qatar](#), [Saudi Arabia](#), [St Maarten](#), [St Vincent and the Grenadines](#), [Thailand](#), [Trinidad and Tobago](#), [Tunisia](#), [United Arab Emirates](#) ([Ebola Update - Travel Measures and Ongoing Monitoring](#)).

The [World Health Organization](#) explicitly advises against bans on international travel or trade, recommending targeted health screening at points of entry instead.

Therapeutics and vaccines

No licenced vaccines or specific therapeutics are currently available for Ebola virus disease caused by Bundibugyo ebolavirus. Ongoing research initiatives, including programmes supported by the [Coalition for Epidemic Preparedness Innovations \(CEPI\)](#), are advancing the development of vaccines using different technological platforms. Current candidates under investigation include the [ChAdOx1-BDBV](#) candidate (developed by the University of Oxford), an [mRNA-based candidate](#) (developed by Moderna), two rVSV-based candidates (developed by [IAVI](#) and [PHV](#)), and the most recent [MVA-CR19 vaccine candidate](#) (developed by Minapharm). These candidate vaccines are currently in pre-clinical development or early-stage clinical trials.

The [recent WHO emergency guidance and SAGE recommendations](#) propose the use of the licenced rVSV-ZEBOV (Ervebo) vaccine during Bundibugyo virus disease outbreaks, primarily within the context of a research protocol, to establish potential cross-protection and clinical efficacy.

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).

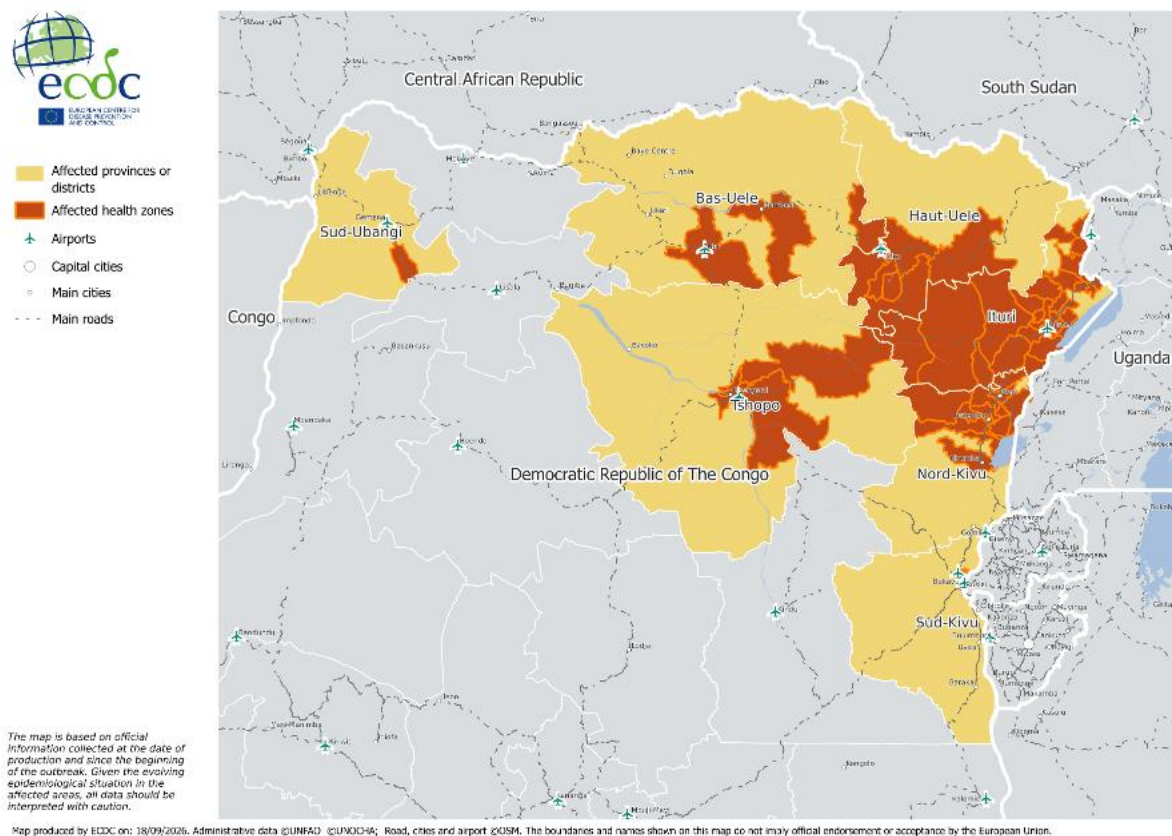
ECDC is actively liaising with key partners, including Africa CDC, the European Commission, and WHO to provide further support through the EU Health Task Force in response to this outbreak.

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: 11 September 2026.

Maps and graphs

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



2. Airport malaria in Frankfurt, Germany – 2026

Overview

As of 18 September 2026, eight cases of *Plasmodium falciparum* malaria have been reported among people working at or living in the vicinity of Frankfurt international airport. Six cases occurred among airport workers. Five of these cases developed symptoms in early July and one in mid-August. Two additional cases were subsequently reported among residents of different households living within 5 km of the airport, who developed symptoms in early September. None reported travel to a malaria-endemic area.

Three of the eight affected individuals have died, including one of the two residents living near the airport.

The German public health authorities are conducting epidemiological investigations, mosquito monitoring and genetic characterisation of parasites from patient samples. These investigations aim to clarify possible links between the cases and the likely source of infection.

The authorities have informed airport workers, expanded risk communication to residents living in the vicinity of Frankfurt airport, and alerted healthcare professionals. Clinicians should consider malaria in people with unexplained fever or compatible symptoms who work at or live in the vicinity of Frankfurt airport, even if they have not travelled to a malaria-endemic area. Prompt testing and treatment are important because *P. falciparum* malaria can rapidly become severe.

ECDC assessment

The absence of recent travel to a malaria-endemic area suggests that these infections were locally acquired in or around Frankfurt airport. Airport malaria occurs when one or more infectious *Anopheles* mosquitoes are inadvertently transported by aircraft from a malaria-endemic area and subsequently transmit a *Plasmodium* parasite after arrival.

The geographical and temporal distribution of the cases suggests that multiple introductions of infectious mosquitoes are likely to have occurred. The possible involvement of local *Anopheles* mosquitoes cannot be excluded at this stage. Epidemiological, entomological and genetic investigations are ongoing to clarify the circumstances of transmission.

Although airport malaria is uncommon, it has been reported sporadically in Europe. [A 2024 systematic review](#) identified 105 airport malaria cases reported between 1969 and 2022. Most occurred between June and September, when warmer conditions may favour the survival and activity of imported mosquitoes. Cases may occur individually or in clusters, with clusters of up to six cases previously reported.

P. falciparum malaria can progress rapidly to severe disease and death if diagnosis and treatment are delayed. In airport-associated malaria events, the absence of travel to a malaria-endemic area may reduce clinical suspicion and contribute to delayed diagnosis.

Despite the increase in number of cases reported, the risk to the general population remains very low.

Actions

ECDC is in contact with the German public health authorities and is closely following the situation.

Last time this event was included in the Weekly CDTR: 4 September 2026.

3. Iatrogenic botulism - Denmark – 2026

Overview

On 9 September 2026, the [Danish Patient Safety Authority](#) reported six cases of severe iatrogenic botulism in Denmark following botulinum toxin treatments for hyperhidrosis or cosmetic purposes. The cases are hospitalised and have not disclosed where or by whom they received the treatment.

An unapproved botulinum toxin product administered at an unregistered clinic or by an unauthorised provider is suspected, although investigations are ongoing and the source has not been confirmed.

ECDC assessment

This event represents a potentially serious public health concern due to the severity of illness and the possibility that an unapproved botulinum toxin product may be circulating and being administered in Europe.

The current risk to the general population in the EU/EEA is assessed as low, particularly as it is not connected to a foodborne exposure. The risk can be higher for people undergoing cosmetic or therapeutic procedures in informal or unregistered sites.

Information remains limited, and further investigations are needed to identify the source of exposure, assess whether additional cases might have occurred in other countries, and determine whether this event could represent a cross-border health threat.

Actions

ECDC is in contact with Danish health authorities and has informed the European Medicines Agency. ECDC continues to follow this event via its epidemic intelligence activities.

4. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases

Summary

One new laboratory-confirmed human case of avian influenza A(H9N2) virus infection in China was reported by the World Health Organization (WHO) Western Pacific Region in the [Avian Influenza Weekly Update Number 1061](#), published on 11 September 2026.

The case is a child from the Guangxi Zhuang Autonomous Region, who developed symptoms on 23 August 2026 and subsequently recovered without requiring hospitalisation. The child had exposure to household poultry and their environment. No additional cases have been identified among close contacts of the case.

Background

Since 2015, a total of 178 laboratory-confirmed human cases of avian influenza A(H9N2) virus infection have been reported to WHO from China.

ECDC assessment

Sporadic human infections with avian influenza A(H9N2) have been observed outside of the EU/EEA. One case has also been reported in the EU/EEA, with exposure history during travel outside of Europe. Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza viruses. In most cases, influenza A(H9N2) leads to mild clinical illness. To date, no clusters of human A(H9N2) infection have been reported. There is no evidence that the virus has acquired the ability for sustained transmission among humans. The risk related to zoonotic avian influenza (due to A(H9N2) viruses) for the general population in the EU/EEA is currently considered very low.

Actions

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities. Together with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza, ECDC produces a [quarterly report on the avian influenza situation](#). The most recent report was published in June 2026.

Sources: [Event Information Site for IHR National Focal Points](#)

Last time this event was included in the Weekly CDTR: 11 September 2026.

5. Influenza A(H5) - Multi-country (World) - Monitoring human cases

Summary

One new laboratory-confirmed human case of avian influenza A(H5N1) virus infection was reported in Bangladesh by the World Health Organization (WHO) in the [Influenza at the human-animal interface, Summary and risk assessment, from 8 August to 6 September 2026](#), published on 6 September 2026.

The case involved a child from Rangpur Division, who developed symptoms (fever, cough and rhinitis) on 15 August 2026 and was hospitalised on 17 August 2026. Respiratory specimens collected as part of influenza surveillance tested positive for influenza A(H5) virus by real-time RT-PCR at the icddr,b Diagnostic Laboratory on 18 August 2026. Testing performed at the Molecular and Genomic Laboratory Department of Institute of Epidemiology, Disease Control and Research (IEDCR) and National Influenza Centre (NIC) of Bangladesh confirmed infection with influenza A(H5N1) virus. At the time of reporting, genetic sequencing was ongoing and the child remained in hospital, but was improving clinically.

The child had exposure to ducks and chickens, including some that were sick, in the household and neighbouring households. Environmental samples from poultry meat and oropharyngeal swabs collected from several backyard chickens tested negative for influenza A(H5) virus. The case had no reported history of travel.

Close contacts of the case were identified and monitored. All identified contacts remained asymptomatic, except for two healthcare workers. Respiratory specimens collected from the two tested negative for influenza A viruses.

Background

[According to WHO](#), since 2003, 15 human cases of avian influenza A(H5N1) have been reported to WHO from Bangladesh, including two deaths (Case Fatality Rate (CFR): 13.3%).

ECDC assessment

Sporadic human cases of different avian influenza A(H5) subtypes have previously been reported worldwide. Given the widespread transmission of avian influenza viruses in animals, transmission to humans remains infrequent and no sustained transmission between humans has been observed.

Overall, the risk related to zoonotic avian influenza due to A(H5N1) virus for the general population in the EU/EEA is considered low.

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

Actions

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities. Together with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza, ECDC produces a [quarterly report on the avian influenza situation](#). The most recent report was published in June 2026.

Last time this event was included in the Weekly CDTR: 11 September 2026.

6. Overview of respiratory virus epidemiology in the EU/EEA, week 37, 2026

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.

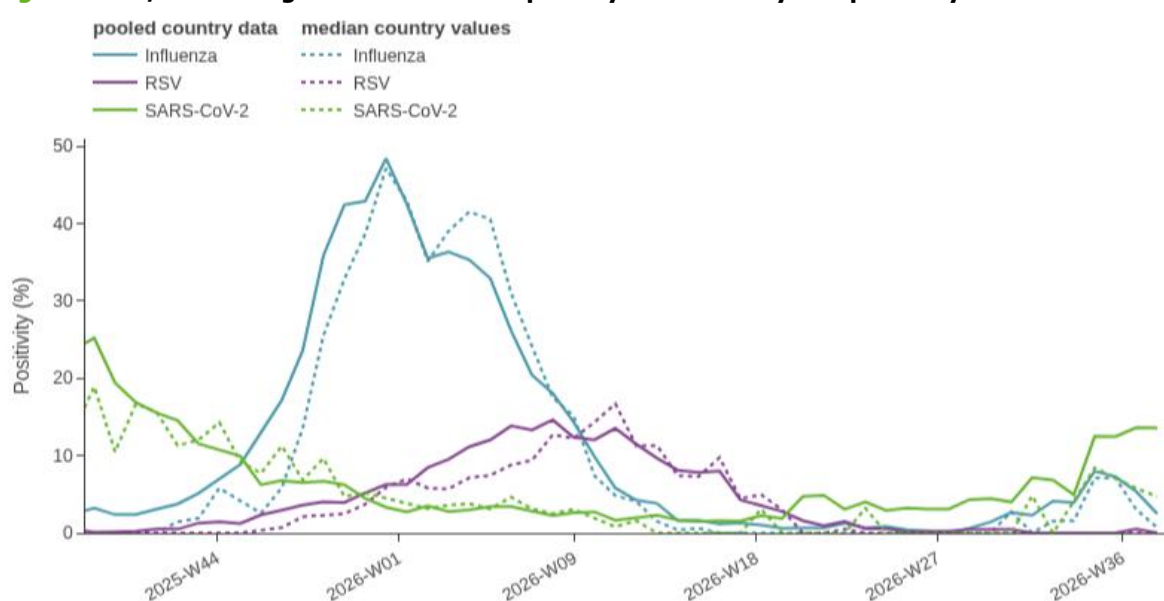
All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

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

Last time this event was included in the Weekly CDTR: 11 September 2026.

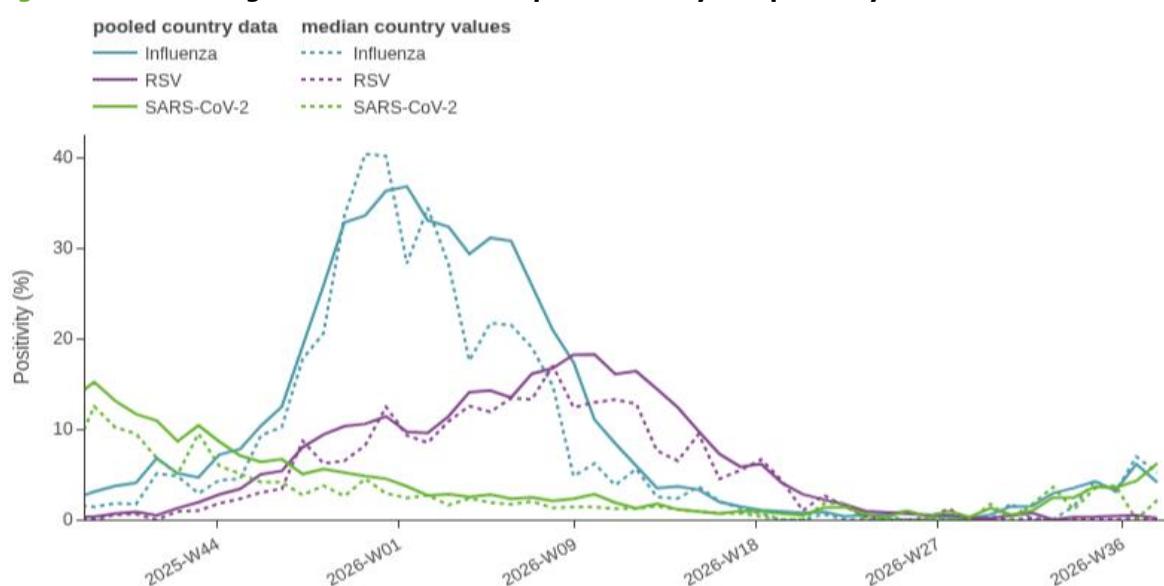
Maps and graphs

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 37	Week 36	Description	Value
ILI/ARI consultation rates in primary care	ARI	13 rates (8 MEM)	16 rates (11 MEM)	Distribution of country MEM categories	8 Baseline
	ILI	13 rates (12 MEM)	17 rates (16 MEM)		11 Baseline 1 Low
ILI/ARI test positivity in primary care	Influenza	14	17	Pooled (median; IQR)	2.5% (0.7; 0–3%)
	RSV	13	16		0% (0; 0–0%)
	SARS-CoV-2	14	18		14% (4.7; 0–11%)
SARI rates in hospitals	SARI	7 rates (2 MEM)	10 rates (5 MEM)	Distribution of country MEM categories	2 Baseline
SARI test positivity in hospitals	Influenza	6	8	Pooled (median; IQR)	4.1% (5.2; 2.2–10%)
	RSV	6	8		0.2% (0; 0–0%)
	SARS-CoV-2	6	7		6.2% (2.1; 0–6.3%)
Intensity (country-defined)	Influenza	10	12	Distribution of country qualitative categories	9 Baseline 1 Low

Source: ECDC

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

Pathogen	Week 37, 2026		Week 40, 2025 – week 37, 2026	
	N	% ^a	N	% ^a
Influenza	9	–	17931	–
Influenza A	9	100	17318	99
A(H1)pdm09	1	14	4054	28
A(H3)	6	86	10351	72
A (unknown)	2	–	2913	–
Influenza B	0	0.0	123	0.7
B/Vic	0	–	36	100
B (unknown)	0	–	87	–
Influenza untyped	0	–	490	–
RSV	0	–	5340	–
RSV-A	0	–	935	44
RSV-B	0	–	1192	56
RSV untyped	0	–	3213	–
SARS-CoV-2	104	–	4829	–

Source: ECDC

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

Pathogen	Week 37, 2026		Week 40, 2025 – week 37, 2026	
	N	% ^a	N	% ^a
Influenza	27	–	15901	–
Influenza A	14	100	7696	99
A(H1)pdm09	0	0.0	1258	34
A(H3)	6	100	2433	66
A (unknown)	8	–	4005	–
Influenza B	0	0.0	69	0.9
B/Vic			10	100
B (unknown)	0	–	59	–
Influenza untyped	13	–	8136	–
RSV	1	–	7218	–
RSV-A			1159	52
RSV-B			1062	48
RSV untyped	1	–	4997	–
SARS-CoV-2	40	–	3211	–

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 37, 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 35, 2026 - week 36, 2026

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	10	6% (6–6%)
XFG	VUM	1	105	68% (68–68%)
NB.1.8.1	VUM	1	6	4% (4–4%)
BA.3.2	VUM	0	0	0%

Source: ECDC

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

Overview

Since the beginning of the 2026 transmission season, and as at 17 September, 180 areas affected by West Nile virus (WNV) have been identified in 16 countries across Europe.

These areas are located in Italy (65), Greece (22), Romania (22), France (19), the Netherlands (13), Serbia (8), Croatia (5), Spain (5), Belgium (4), North Macedonia (4), Germany (3), Hungary (3), Austria (2), Kosovo* (2), Albania (1) and Cyprus (1).

This week, 19 areas are reported as being affected for the first time this season.

The 16 countries have reported 1 482 locally acquired human cases of WNV infection.

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 of WNV and 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: 11 September 2026.

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

Overview

Since the beginning of 2026 and as at 16 September 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (75 cases) and Italy (one case).

A total of 18 additional locally acquired cases have been reported in Europe since the last update was published on 11 September.

Of the 13 clusters reported in France in 2026, 11 are currently active, including two new clusters, with one case in Créon and three cases in Biscarosse. The largest active cluster is still in Prignac-et-Marcamps in the department of Gironde, with a total of 30 cases. No new cases have been reported in Italy.

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 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 – are 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: 11 September 2026.

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

Overview

Since the beginning of 2026 and as at 16 September 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (37 cases) and France (five cases).

This week, Italy reported an additional 13 locally-acquired cases, including six cases in the Lecce area and five cases in the Livorno area. Both clusters were already active. One new cluster has been identified in the Milan area, with two cases. No new cases were reported in France.

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 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 – are 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: 11 September 2026.

10. Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (weekly report)

Overview

Since the beginning of 2026 and as at 16 September 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

For the general population, the risk of contracting CCHF 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: 11 September 2026.

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

Update

Based on forecasts from the [Vibrio Viewer](#), over the next five days (until 23 September 2026), 12 municipalities across four regions in three countries are expected to have high environmental suitability* for *Vibrio* spp.

A list of areas expected to have high environmental suitability* for *Vibrio* spp. until 23 September 2026 is provided below.

Bulgaria: nine municipalities in two regions:

- **Varna:** Avren, Dolni Chiflik, Varna
- **Burgas:** six municipalities above the threshold.

Italy: two municipalities in one region:

- **Gorizia:** Grado, Staranzano.

Romania: one municipality in one region:

- **Tulcea:** Oras Sulina.

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](#).

* 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 event of accidental contact with 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: 11 September 2026.

12. Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring

Overview

In July 2026, 29 EU/EEA countries reported measles data. Thirteen countries reported 118 cases and 16 countries reported zero cases.

Overall, case numbers decreased compared with the previous month, however, this may be subject to change in the event of a future retrospective update. The highest case counts were reported by Bulgaria (61), Italy (29), Spain (seven), Poland (seven) and Belgium (four).

In the most recent 12-month period, from 1 August 2025 to 31 July 2026, 30 EU/EEA Member States reported a total of 2 339 cases of measles, 2 012 (86.0%) of which were laboratory confirmed

Of the 2 339 cases with known age, 669 (28.6%) were in children under five years; 1 197 (51.2%) cases were in those aged 15 years and above. The highest notification rates were observed among infants under one year (59.3 cases per million) and children aged 1–4 years (28.6 cases per million).

Of 2 052 individuals (87.7% of all cases) with a known age and vaccination status, 1 501 (73.1%) were unvaccinated, 325 (15.8%) were vaccinated with one dose of a measles-containing vaccine, 184 (9.0%) were vaccinated with two or more doses, and 41 (2.0%) were vaccinated with an unknown number of doses.

During the 12-month period, zero deaths attributable to measles were reported to ECDC by any country. Detailed data are available in [ECDC's Surveillance Atlas of Infectious Diseases](#).

Complementary epidemic intelligence surveillance was performed on 15–16 September 2026. Outbreaks continue in Bulgaria, and Sweden. Sporadic cases and clusters were reported in several EU/EEA countries. Updates are provided for several countries and regions outside the EU/EEA: England, Ukraine, Africa CDC, the World Health Organization Pan American Health Organization (WHO PAHO), Japan, Canada, the United States (US) and Mexico.

Disclaimer: The [monthly measles report published in the CDTR](#) provides the most recent data on cases and outbreaks based on information made publicly available by the national public health authorities or the media. Sometimes this information is made available retrospectively. This report is a supplement to [ECDC's monthly measles and rubella monitoring report](#), based on data routinely submitted by 30 EU/EEA countries to EpiPulse Cases. Data presented in the two monthly reports may differ.

Epidemiological summary for EU/EEA countries with relevant epidemic intelligence updates:

[Austria](#) reported eight confirmed or probable cases in 2026 and as of 9 September 2026 (an increase by one case since June).

[Bulgaria](#) has seen a [decline](#) in outbreak-related cases, with a total of 555 cases of measles reported by the end of August 2026 (reported on 2 September 2026). The cases have been reported in twelve districts of the country. Most of the cases and highest incidence are reported in Vratsa region (276, 191 000 per 100 000 population), followed by Pleven (163), Lovech (85), Montana (11), Sofia-city (9), Varna (3), Ruse (3), Vidin (1), Pazardzhik (1), Pernik (1), Sofia-region (1) and Targovishte (1). Most of the cases are children (85.6%, 470/555) with the highest incidence among those under one year. Over a half of the cases were not vaccinated due to age limitations or for other reasons (n=283). Immunisation status was unknown for 41 individuals, and others had evidence of immunisation. Since the beginning of the outbreak, 80 213 MMR vaccine doses have been administered in the country. In 2025, Bulgaria reported two cases.

[Estonia](#) reported four cases in 2026, as of end of August.

[Finland](#) reported one measles case in 2026, as of 15 September 2026.

[France](#) reported 113 cases of measles and no deaths from January to August 2026, an increase of 36 cases since end of April 2026. The three most affected age groups are adults aged 40 years and over (15%), adults aged 20–24 years (14%) and children aged 1–4 years (13%). Over half of the cases with known vaccination status (e.g. individuals who are not eligible for vaccination due to age) (41/76, 54%) were unvaccinated, and 35 (46%) individuals were vaccinated with two doses. At least one case was reported in 34 departments of France, with most of the cases reported in Yvelines (10%), Hauts-de-Seine (9%), Moselle (8%), Haute-Savoie (7%) and Paris (7%). No measles cases have been reported in overseas departments and regions.

[Germany](#) reported 125 confirmed and probable measles cases in 2026 (week 1 to 36), an increase of 30 cases from week 24.

[Lithuania](#) reported ten cases from January to 2 July 2026.

[Poland](#) reported 31 cases from 1 January to 31 August 2026.

[Portugal](#) reported nine cases from 1 January to end of August 2026, an increase of two cases since 21 May 2026. Of the reported cases, three confirmed cases were imported and three were from Portugal. The origin of the remaining cases is under investigation.

[Spain](#) reported 160 cases of measles from 1 January to 13 September 2026, including 15 imported cases.

[Sweden](#) Since January 2026 and as of 16 September, 47 cases of measles have been reported, 40 of which are related to the outbreak reported in mid-August, linked to a musical festival (data as of 9 September). The vast majority of affected individuals were unvaccinated school-age children and young adults.

Epidemiological summary for EU/EEA outermost territories with relevant epidemic intelligence updates:

No new outbreaks or cases have been detected in the reporting period.

Western Balkans countries and Türkiye

No new outbreaks have been detected in the reporting period.

[Albania](#) reported 169 cases in from January to June 2026 ([provisional WHO data](#)).

[Serbia](#) reported two cases of measles from January to July 2026 ([provisional WHO data](#)).

[Türkiye](#) reported 677 measles cases during January and June 2026, according to [provisional WHO data](#).

Epidemiological summary for selected countries outside of the EU/EEA with relevant epidemic intelligence updates:

[England](#): between 1 January 2026 and 31 August 2026, there have been 983 laboratory-confirmed measles cases reported in England. The majority (599 out of 983, 61%) of these cases were in children aged 10 years and under, and 51% (501 out of 983) of these cases have been in London. Three deaths have been reported; two children and one adult.

[Scotland](#) 13 laboratory-confirmed measles cases have been reported in Scotland in 2026.

[Ukraine](#) has reported 627 cases since January 2026 (up until July 2026).

[Australia](#) has reported 113 cases in 2026, as of 15 September 2026.

[Bangladesh](#) is experiencing a major measles outbreak ([WHO DON](#)). According to the Directorate General of Health Services (DGHS), by 14 September 2026 there had been 172 720 suspected measles cases, including 20 124 laboratory-confirmed cases, with 1 030 suspected or confirmed measles-related deaths (100 laboratory-confirmed and 930 suspected). The majority of cases are children under 5 years (79%).

[Israel](#) an ongoing measles outbreak has resulted in 3 729 cases, 1 253 hospitalisations and 17 deaths as of 2 September 2026, according to the [Israeli Ministry of Health](#).

[Africa CDC](#) reported on 30 August 2026, 9 401 confirmed and 143 222 suspected cases of measles and 1 392 deaths from 23 AU Member State countries, with the Democratic Republic of Congo (102 163 cases and 1 277 deaths), Somalia (11 834 cases and 42 deaths), and Burkina Faso (10 471 cases and 31 deaths) having the highest numbers in terms of case counts.

According to the WHO Pan American Health Organization ([WHO PAHO](#)) report published on 7 September, 52 480 confirmed measles cases have been reported by 16 countries, the majority of which have been reported from Guatemala (33 490).

[Mexico](#) reported 12 939 confirmed cases of measles and 20 deaths in 2026 and as of 14 September. The number of cases has declined in the last couple of months. Since the start of the outbreak in 2025, Mexico has reported 19 553 confirmed cases of measles and 47 deaths.

[Canada](#) reported 1 119 measles cases (1 038 confirmed) and no deaths across nine jurisdictions in 2026 and as of 14 September 2026. The country remains in active transmission across multiple provinces due to an ongoing multi-jurisdictional outbreak, and the vast majority of the cases reported in 2026 are linked to this outbreak.

[The US](#) as of September 10, the US has reported 3 294 confirmed measles cases in 47 jurisdictions since January 2026. The majority of cases have occurred in school-age children and adults (82%) and unvaccinated individuals (95%). [Pennsylvania](#) is currently experiencing the largest ongoing measles outbreak, reporting a total of 731 cases and four associated deaths (16 September 2026). Over 31% of the reported cases are children under 18 years of age.

For more information on the provisional number of cases outside the EU/EEA region, please visit the World Health Organization ([WHO](#)) [website](#).

The numbers provided to WHO for EU/EEA countries are from EpiPulse Cases data, which are updated monthly and available on the [ECDC Surveillance Atlas of Infectious Diseases](#). Due to differences in reporting times, the numbers may not correspond to the data from epidemic intelligence screening.

ECDC assessment

Although most recent cases were acquired through local or community transmission, travel-related cases continue to be reported.

Continued vigilance is essential due to sub-optimal vaccination coverage for measles-containing vaccines (MCV) in several EU/EEA countries, possible introduction from areas with ongoing transmission, and increased travel and population movement during holiday periods.

Actions

ECDC is monitoring the measles situation through its epidemic intelligence activities. Data collected via epidemic intelligence supplement the monthly outputs of measles surveillance data from EpiPulse Cases, which are routinely submitted by 30 EU/EEA countries.

ECDC urges EU/EEA public health authorities to focus on the following areas:

- **Close immunity gaps, achieve and maintain high vaccination coverage for measles-containing vaccines** (>95% with the second dose). It is vital to ensure first and second dose vaccinations are administered on time, as per national schedules among infants and children. It is also important to identify and vaccinate eligible individuals (for example, non-immune adolescents and adults) in immunisation catch-up programmes (as recommended by local and national authorities).
- **Strive towards high-quality surveillance** and adequate public health capacity, especially for early detection, diagnosis, response and control of outbreaks.
- **Increase the clinical awareness of health professionals**, including reminding them of the importance of checking individuals' vaccination status ahead of travel.
- **Healthcare professionals should be fully vaccinated.**
- **Promote vaccine acceptance and uptake** by employing specific risk communication strategies and identifying drivers of suboptimal MMR vaccine acceptance and uptake to ensure that tailored interventions are implemented in response.
- **Address barriers and engage with populations underserved by healthcare services.** Systemic barriers that affect vaccine uptake in populations that are isolated and underserved by healthcare services need to be monitored and addressed with targeted strategies in order to reduce inequalities in vaccine uptake.
- In light of the summer holiday season, **travellers should check their vaccination status** and consult their general practitioner to ensure they are up-to-date with recommended immunisations prior to departure.

ECDC's latest advice on measles is available in the Threat Assessment Brief '[Measles on the rise in the EU/EEA: Considerations for a public health response](#)', published in February 2024, and its conclusions remain valid. Additional information on the risk classification and ECDC recommendations can be found in this report.

Last time this event was included in the Weekly CDTR: 12 June 2026.

13. 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 World Health Organization (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 priority risk communication and community engagement gaps in high-risk areas. Between 14 July and 27 August 2026, two ECDC fellows were deployed through GOARN to the WHO's 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: 11 September 2026.

Events under active monitoring

- 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
- 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
- Salmonella Enteritidis ST11- multi country-2025-2026 - last reported on 21 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
- Seasonal monitoring of environmental suitability for Vibrio spp. risk in coastal waters – Bathing season 2026 - last reported on 18 September 2026
- Airport malaria in Frankfurt, Germany – 2026 - last reported on 18 September 2026
- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo – 2026 - last reported on 18 September 2026
- Expert deployment - last reported on 18 September 2026
- Seasonal surveillance of chikungunya virus disease – 2026 (weekly) - last reported on 18 September 2026
- Seasonal surveillance of dengue in the EU/EEA, weekly report - last reported on 18 September 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (weekly report) - last reported on 18 September 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (weekly report) - last reported on 18 September 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring - last reported on 18 September 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 18 September 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 37, 2026 - last reported on 18 September 2026
- Influenza A(H5)- Multi-country (World)- Monitoring human cases - last reported on 18 September 2026
- Iatrogenic botulism - Denmark - 2026 - last reported on 18 September 2026
- Aedes aegypti incursion in East London, United Kingdom, Aug 2026 - last reported on 11 September 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report) - last reported on 11 September 2026
- SARS-CoV-2 variant classification - last reported on 4 September 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 4 September 2026.