

WEEKLY BULLETIN

Communicable disease threats report

Week 42, 10–16 October 2026

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Executive summary

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

- As of 15 October, the Democratic Republic of the Congo (DRC) has reported a total of 9 277 confirmed cases, including 4 478 related deaths (from data up until 14 October). Since the beginning of the outbreak, seven provinces have been affected: Ituri, Nord-Kivu, Sud-Kivu, Tshopo, Haut-Uélé, Bas-Uélé and Sud Ubangi. According to media reports quoting officials, two cases have been confirmed in North Ubangi, making it the eighth affected province in DRC.
- A second confirmed case was reported in Kenya on 14 October. The case is a close contact of the first case who was imported from DRC and reported on 6 October.
- 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.

Pneumonia of unknown aetiology - Russia - 2026

- Russian health authorities have reported no recent plague case in Irkutsk Oblast and report a case of pneumonia of unknown aetiology in a laboratory employee.
- Russian health authorities reported that preventive measures, including epidemiological investigations, medical observation and testing of contacts have been implemented according to national legislation and are now completed; and no high-threat pathogen was detected in any of the identified contacts.
- Following WHO's request for further information, Russian health authorities reported that no laboratory biosafety or biosecurity incident had occurred in the laboratory where the case was employed and determined that the cause of death of the case was pneumonia of unknown aetiology.
- ECDC is actively monitoring this event and is in close contact with WHO EURO and other international stakeholders, including global CDCs, to obtain additional information as it becomes available.
- The available information on this event is not sufficient to draw a firm conclusion regarding the potential risk to the EU population. The assessment will be reviewed should additional information become available.

Overview of respiratory virus epidemiology in the EU/EEA, week 41, 2026

- Consultation rates for respiratory illness in both primary and secondary care remain at low or baseline levels in all reporting EU/EEA countries. However, rates are increasing in many countries, as expected at this time of year.
- Overall, SARS-CoV-2 and influenza contributed similarly to respiratory virus activity in both primary and secondary care this week. Median test positivity was 4.3% for SARS-CoV-2 and 3.4% for influenza in primary care and 5% and 4%, respectively, in secondary care.
- **SARS-CoV-2** test positivity remains low in primary and secondary care in most countries, with most detections reported by two countries with higher rates of test positivity. 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 at baseline levels overall, with countries reporting few detections in primary and secondary care. Detections in primary care are mainly related to individuals aged 15 years and above, while in secondary care they mainly concern adults aged over 65 years. Most detections are influenza A viruses.
- **Respiratory syncytial virus (RSV)** activity is very low.

Seasonal surveillance of chikungunya virus disease in the EU/EEA – 2026 (weekly)

- Since the beginning of 2026, and as at 14 October 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (163 cases) and Italy (1 case).

Seasonal surveillance of dengue in the EU/EEA – 2026 (weekly report)

- Since the beginning of 2026 and as at 14 October 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (70 cases) and France (6 cases).

Seasonal surveillance of Crimean-Congo haemorrhagic fever in the EU/EEA – 2026 (weekly report)

- Since the beginning of 2026, and as at 14 October 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 West Nile Virus infections – 2026 (weekly report)

- Since the beginning of the 2026 transmission season, and as at 14 October, 222 areas affected by West Nile virus (WNV) have been identified in 19 countries across Europe.
- These 19 countries have reported 1 926 locally acquired human cases of WNV infection.
- This week, 14 areas are reported as affected for the first time this season.

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

- The 2026 WNV season has affected a broader geographical area than any previous season, with the numbers of human cases and animal outbreaks exceeding levels reported in previous years.
- Overall, there is no indication of increased disease severity in humans in Europe.
- **Italy** remains the most affected country, reporting the highest numbers of human cases and avian outbreaks.
- **Greece** and **France** reported their highest numbers of human WNV cases ever, with **France** also reporting a record number of equid outbreaks.
- The geographical distribution of reported WNV activity expanded in northern Europe. Human cases and animal outbreaks were detected across multiple regions in **Belgium** and **the Netherlands**, with **Belgium** reporting its first ever human WNV infections.
- WNV activity has declined since its August–September peak, but further cases may still be reported.

Mpox in the EU/EEA, Western Balkans and Türkiye – 2026

- In September 2026, 342 mpox cases caused by monkeypox virus (MPXV) clade I were reported by 17 EU/EEA countries, continuing the increase observed over summer months. Three mpox cases caused by MPXV clade II were reported by three countries, continuing a decreasing trend.
- Transmission for both clades occurs predominantly within networks of men who have sex with men, with ongoing circulation across the EU/EEA and most cases reported among unvaccinated individuals.
- Disease severity remains generally mild, with low hospitalisation rates reported for both clades.

Diphtheria - Africa - 2026

- Since the beginning of 2026, and as of October 2026, diphtheria outbreaks have been reported in nine African countries, with considerable variation in reported case numbers, epidemiological trends and geographical distribution.
- In 2026, as of October 2026, Nigeria reported the highest number of cases, followed by Chad. Reported case numbers declined substantially in Mali but increased in Guinea. Transmission remained geographically widespread in Mali, Mauritania, Niger and Nigeria, while South Africa reported localised clusters and sporadic cases. A recent outbreak in Senegal and localised clusters in Morocco were also reported.
- Most EU/EEA countries have very high vaccination coverage for the primary course of diphtheria-containing vaccines. In countries with high vaccination coverage, the risk to the general population is assessed as very low. Travellers to the regions with active case transmission should ensure they are up to date with vaccinations.
- ECDC monitors diphtheria events worldwide, including in Africa and the EU/EEA, through routine epidemic intelligence activities and disease network surveillance.

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. The deployments are being conducted in close coordination with national authorities, EU delegations, the European Commission and the World Health Organization (WHO).
- Since 22 September, two ECDC experts have been deployed through the Global Outbreak Alert and Responses Network (GOARN), to provide epidemiological support to WHO operations in Bunia, Ituri Province and DRC. The deployments are financed with funds made available by the Directorate-General for European Civil Protection (DG ECHO) of the European Commission.
- Since 11 October, an ECDC expert has been deployed to the Continental Incident Management Support Team (IMST) in Kampala, Uganda. This is the 12th deployment in a series of rotational deployments to support Africa CDC within the IMST in Addis Ababa, Ethiopia and Kampala, 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 (DG INTPA).

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

Overview:

Latest epidemiological information

Kenya

On 6 October 2026, [Kenya's Cabinet Secretary for Health](#) announced the country's first confirmed imported Ebola virus disease case. The patient, a Kenyan citizen who had been residing in DRC, reportedly travelled from DRC to Kenya, via Uganda, on 3 October. The patient subsequently died. According to the [MoH](#), 113 of the patient zero's 128 listed contacts were traced; 108 are in quarantine while five are outside Kenya. On [14 October](#) a second case was reported, who was one of the close family contacts in quarantine. The newly reported case is currently in a treatment centre.

Democratic Republic of the Congo

As of 15 October 2026, the [Democratic Republic of the Congo \(DRC\)](#) reported a total of 9 277 confirmed cases, including 4 478 related deaths (from data up until 14 October). A total of 924 patients are hospitalised in isolation. On 14 October, 65 new confirmed cases and 37 deaths were reported. The 65 new cases have been reported from Ituri (31 cases), North Kivu (28 cases), Haut-Uele (5 cases), and Tshopo (1 case). Among the individuals who tested positive for Bundibugyo virus, 2 486 have recovered. In total, 78.0% of identified case contacts are under follow-up in the affected provinces.

Since the previous ECDC update that was reporting on the DRC data [until 12 October 2026](#) (9 144 cases; 4 410 deaths), 133 cases and 68 deaths have been reported.

Overall, [as of 15 October](#), Ituri province remains the most affected, with 6 806 cases, including 3 148 deaths, reported from 28 of 36 health zones. In Nord-Kivu, 1 991 cases, including 1 133 deaths, have been reported from 17 of 34 health zones. In Sud-Kivu, three cases, including one death, have been reported from one of 34 health zones. In Haut-Uélé, 398 cases, including 167 deaths, have been reported from seven of 13 health zones. In Tshopo, 64 cases, including 24 deaths, have been reported from seven of 23 health zones. In Bas-Uélé, 13 cases, including four deaths, have been reported from four of 11 health zones. In Sud Ubangi, two cases and one death have been reported from one of 16 health zones. Overall, 65 of 167 health zones are currently affected across the seven provinces.

According to [media reports](#) citing officials, two cases have been confirmed in North Ubangi, making it the eighth affected province. Laboratory tests were conducted, following a series of suspected deaths in a mining area in the Wapinda health zone, bordering Bas-Uele.

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

Monitoring cases that were medically evacuated or imported to Europe

- A [healthcare worker based in DRC](#) who tested positive for Bundibugyo virus on 29 September was medically evacuated to the Netherlands to receive specialised care. The patient was admitted to the high-level isolation unit at [Leiden University Medical Center](#) on 1 October.
- 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.
- 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 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 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](#)).

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.

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 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 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

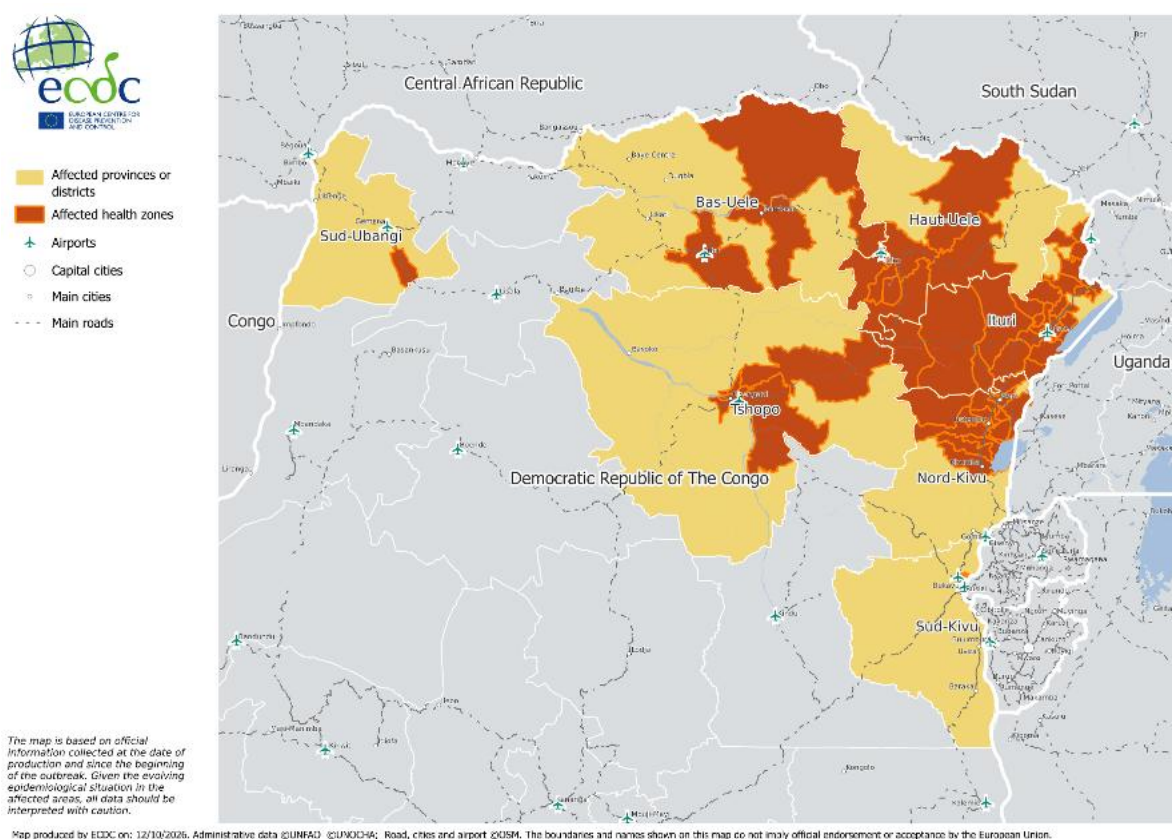
INTPA) and the Global Outbreak Alert and Response Network (GOARN), has been deploying ECDC experts to Addis Ababa (Ethiopia) at Africa CDC's headquarters, and Kampala (Uganda).

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: 9 October 2026

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



Source: ECDC

2. Pneumonia of unknown aetiology – Russia – 2026

Overview:

Update:

According to WHO's Disease Outbreak News (DON) on pneumonia of undetermined aetiology in Russian Federation from 10 October 2026 and referring to information shared with WHO by the IHR NFP of the Russian Federation, the case presented with respiratory symptoms and was initially diagnosed with acute respiratory viral infection (ARVI) before she died.

Due to her employment at the Irkutsk Antiplague Research Institute (APRI), comprehensive control measures were immediately implemented upon receipt of the information of this case, in accordance

with national sanitary legislation. Contacts were identified, placed under medical observation and tested for high threat pathogens.

As of 9 October, medical monitoring has been completed for all identified contacts, all of whom with no reported symptoms. More than 5 000 laboratory tests were performed in identified contacts. According to Russian authorities, the researcher and all identified contacts were tested for several pathogens, including influenza, SARS-CoV-2, plague, and streptococcus, also stating that no dangerous pathogenic microorganisms were identified. Russian authorities report that the researcher was vaccinated and possessed immunity to the hazardous infectious agents with which she worked. It is also reported that the researcher did not travel outside of Irkutsk in the two weeks prior to clinical presentation. Given that no pathogen was identified in the tests performed, Russian health authorities determined that the cause of death of the case was pneumonia of unknown aetiology.

Inspections were carried out at APRI by two commissions responsible for monitoring compliance with biological safety requirements, which reported that appropriate controls were maintained in work involving pathogenic microorganisms and did not identify any incidents or accidents involving pathogenic microorganisms. Preventive and anti-epidemic measures have been implemented and there are no epidemiological risks to the population of the city of Irkutsk or Irkutsk Oblast.

Background: On 2 October 2026, according to multiple media reports pending verification, authorities in Irkutsk Oblast, Russia, initiated emergency anti-epidemic measures following the death of a 28-year-old laboratory technician, employed at the Irkutsk Research Anti-Plague Institute of Siberia and the Far East. Russian authorities have officially classified the case as 'pneumonia of unknown aetiology'.

According to media reports, the patient allegedly experienced a laboratory incident on 25 September 2026, when she reportedly broke a tube containing *Yersinia pestis* while working with live biological material. These reports have not been confirmed. Russian health authorities have reported no recent plague case in Irkutsk Oblast. Following the alleged incident, she reportedly became unwell within several days and was admitted to Shelekhov District Hospital on 29 September 2026 with severe pneumonia. Initial clinical suspicion reportedly included severe COVID-19; however, her condition deteriorated rapidly, requiring intensive care and mechanical ventilation. She died during the night of 1-2 October 2026 in the intensive care unit of Shelekhov District Hospital.

On 2 October 2026, the Governor announced that a suspected case of a 'particularly dangerous infection' was under investigation and confirmed that a full package of anti-epidemic measures had been initiated. An extraordinary meeting of the regional sanitary and anti-epidemic commission was convened with participation of Head of Rospotrebnadzor (the Federal Service for the Oversight of Consumer Protection and Welfare in Russia) and Chief State Sanitary Physician of the Russian Federation. An operational response plan was approved and contact tracing was initiated.

Public health measures included quarantine restrictions at Shelekhov District Hospital, suspension of admissions and discharges in affected departments, enhanced epidemiological investigations and medical monitoring of contacts. Russian media reported that approximately 189 to 200 contacts were placed under observation, including institute staff, healthcare workers, ambulance personnel and hospital patients. Identified contacts have been isolated in medical institutions, of which 114 patients are in one hospital, 63 in another, and another 12 people are kept in the anti-plague institute. The Governor stated that all identified contacts were under medical supervision and had negative laboratory test results at the time of reporting.

Additional precautionary measures reported by Russian and independent media included cancellation of public events in Irkutsk, mandatory mask use at some workplaces, quarantine of several healthcare facilities, including the Shelekhov hospital, where the deceased person was hospitalised, and isolation of contacts in designated hospitals.

On 4-5 October 2026, according to media reports, Rospotrebnadzor, reported that expanded laboratory investigations did not identify microorganisms associated with the deceased patient's professional activities. The agency stated that no laboratory accidents involving pathogenic microorganisms had been documented at the institute, no infectious disease clusters had been identified among staff, and the patient had been diagnosed with 'pneumonia of unknown aetiology'. Rospotrebnadzor further described the sanitary-epidemiological situation in Irkutsk and Shelekhov as stable.

On 6 October 2026, the World Health Organization's Director-General reported that, in response to WHO's verification request, Russian health authorities reported no recent plague case in Irkutsk Oblast. They reported that preventive measures, including epidemiological investigations and medical observation and testing of contacts have been completed. Moreover, Russian health authorities reported no high-threat pathogen detected in any of the identified contacts.

For information, no autochthonous plague cases have been reported in the EU/EEA in the last few decades. Please consult the [ECDC factsheet](#) for further information on this disease.

Sources: [media source 1](#), [media source 2](#), [media source 3](#), [media source 4](#), [WHO's Director General post](#), [WHO DON](#)

ECDC assessment:

The available information of this event (absence of a confirmed diagnosis, no identification of the causative agent, uncertainty regarding the source and mode of exposure) is not sufficient to draw a firm conclusion regarding the potential risk to the EU population. The assessment will be reviewed should additional information become available.

Actions:

ECDC is actively monitoring this event, and is in close contact with WHO EURO and other international stakeholders, including global CDCs, to obtain additional information as it becomes available.

Last time this event was included in the Weekly CDTR: 9 October 2026

3. Overview of respiratory virus epidemiology in the EU/EEA, week 41, 2026

Overview:

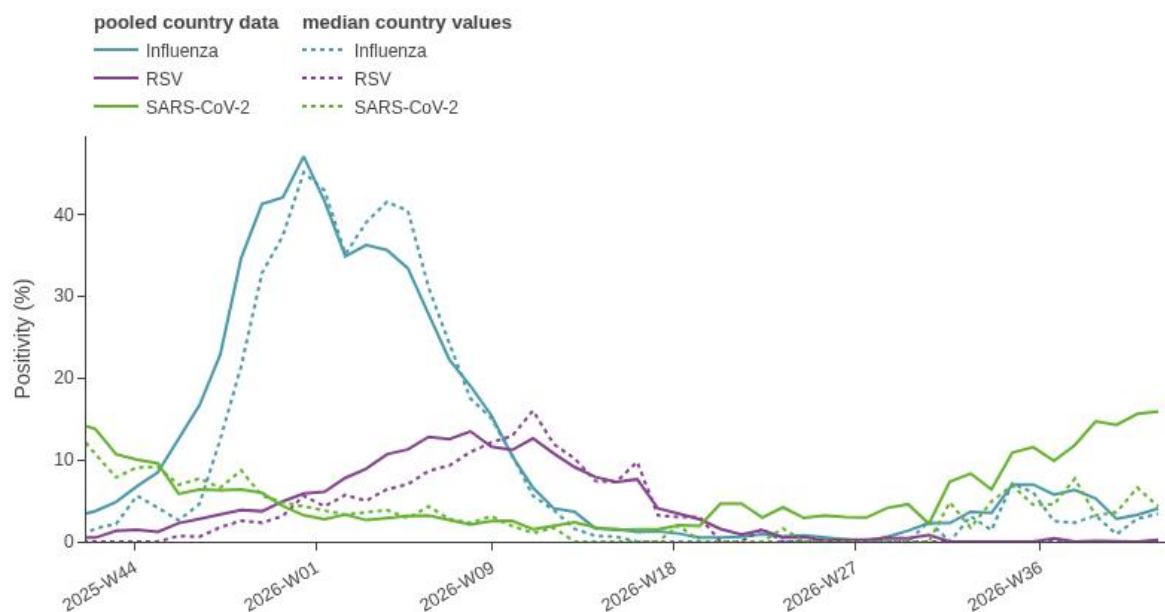
ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary ([ERVISS.org](#)), which is updated weekly.

Key visualisation from the weekly bulletin are included below.

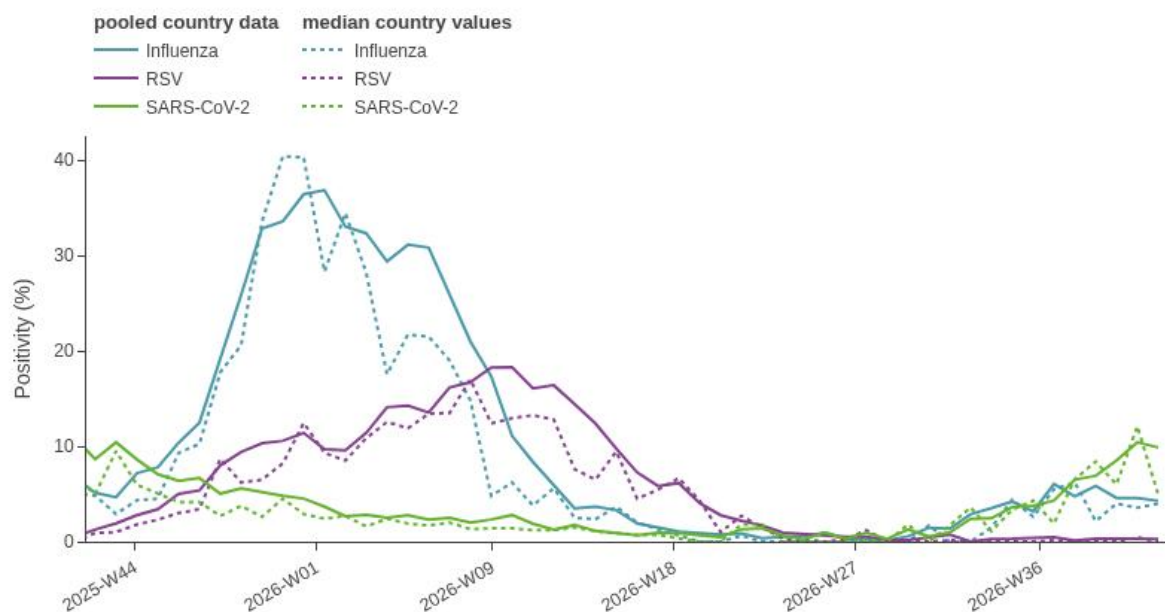
All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

Sources: [ERVISS](#)

Last time this event was included in the Weekly CDTR: 9 October 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 41	Week 40	Description	Value
ILI/ARI consultation rates in primary care	ARI	16 rates (13 MEM)	18 rates (13 MEM)	Distribution of country MEM categories	7 Baseline 6 Low
	ILI	17 rates (15 MEM)	20 rates (17 MEM)		14 Baseline 1 Low
ILI/ARI test positivity in primary care	Influenza	17	19	Pooled (median; IQR)	4% (3.4; 2.2–6.4%)
	RSV	16	18		0.2% (0; 0–0%)
	SARS-CoV-2	16	18		16% (4.3; 0–11%)
SARI rates in hospitals	SARI	10 rates (7 MEM)	12 rates (8 MEM)	Distribution of country MEM categories	6 Baseline 1 Low
SARI test positivity in hospitals	Influenza	6	8	Pooled (median; IQR)	4.3% (4; 4–13%)
	RSV	6	8		0.3% (0; 0–0%)
	SARS-CoV-2	6	8		9.9% (5; 3.2–9.3%)
Intensity (country-defined)	Influenza	12	13	Distribution of country qualitative categories	11 Baseline 1 Low

Source: ECDC

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

Pathogen	Week 41, 2026		Week 40, 2026 – week 41, 2026	
	N	% ^a	N	% ^a
Influenza	59	–	117	–
Influenza A	52	93	104	95
A(H1)pdm09	33	85	53	65
A(H3)	6	15	29	35
A (unknown)	13	–	22	–
Influenza B	4	7	6	5
B/Vic	0	–	0	–
B (unknown)	4	–	6	–
Influenza untyped	3	–	7	–
RSV	3	–	3	–
RSV-A	0	–	0	–
RSV-B	0	–	0	–
RSV untyped	3	–	3	–
SARS-CoV-2	313	–	676	–

Source: ECDC

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

Pathogen	Week 41, 2026		Week 40, 2026 – week 41, 2026	
	N	% ^a	N	% ^a
Influenza	30	–	72	–
Influenza A	20	100	45	98
A(H1)pdm09	1	33	7	54
A(H3)	2	67	6	46
A (unknown)	17	–	32	–
Influenza B	0	0.0	1	2
B (unknown)	0	–	1	–
Influenza untyped	10	–	26	–
RSV	2	–	5	–
RSV-A			2	67
RSV-B			1	33
RSV untyped	2	–	2	–
SARS-CoV-2	68	–	163	–

Source: ECDC

Figure 7. Genetically characterised influenza virus distribution, week 40, 2026 – week 41, 2026

No data available

Source: ECDC

Figure 8. SARS-CoV-2 variant distribution, week 43, 2025 – week 44, 2025

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	15	22% (22–22%)
XFG	VUM	1	42	62% (62–62%)
NB.1.8.1	VUM	1	2	3% (3–3%)
BA.3.2	VUM	0	0	0%

Source: ECDC

4. Seasonal surveillance of chikungunya virus disease in the EU/EEA – 2026 (weekly)

Overview:

Since the beginning of 2026 and as at 14 October 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (163 cases) and Italy (1 case).

Since last week's update, France has reported 17 new locally acquired chikungunya virus disease cases, bringing the total to 163 cases. These cases are distributed across 21 clusters, with one new cluster identified (municipality of Sainte-Eulalie, Gironde department). Seventeen clusters are currently active, including the largest two clusters in Prayssac, Lot department (35 cases) and Prignac-et-Marcamps, Gironde department (30 cases).

No new locally acquired chikungunya virus disease cases have been reported by Italy since last week's update. To date, Italy has reported one locally acquired chikungunya virus disease case in Rome. The associated cluster is closed.

The report is available [on line](#).

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: 9 October 2026

5. Seasonal surveillance of dengue in the EU/EEA – 2026 (weekly report)

Overview:

Since the beginning of 2026 and as at 14 October 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (70 cases) and France (6 cases).

Since last week's update, Italy has reported two new locally acquired dengue cases. The cumulative number of locally acquired cases in Italy is 70, distributed across seven clusters. Among these, one newly identified cluster was reported: 'Roma_2' (a second cluster in the Rome NUTS 3 region). All clusters are currently active.

No new locally acquired cases were reported by France since last week's update. The cumulative number of locally acquired cases in France is still six cases, distributed across four clusters. No clusters are currently 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 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: 9 October 2026

6. Seasonal surveillance of Crimean-Congo haemorrhagic fever in the EU/EEA – 2026 (weekly report)

Overview:

Since the beginning of 2026, and as at 14 October 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 mainly transmitted to humans 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 – 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 but, 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: 9 October 2026

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

Overview:

Since the beginning of the 2026 transmission season, and as at 14 October, 222 areas affected by West Nile virus (WNV) have been identified in 19 countries across Europe.

These areas are located in Italy (70), France (28), Greece (25), Romania (24), the Netherlands (15), Serbia (10), Belgium (6), Bulgaria (6), Croatia (6), Germany (6), Spain (6), North Macedonia (5), Hungary (4), Kosovo* (4), Austria (3), Albania (2), Cyprus (1), and Slovenia (1).

This week, 14 areas are reported as affected for the first time this season.

The 19 countries have reported 1 926 locally acquired human cases of WNV infection: Italy (764 cases), Greece (455 cases of which 6 had an unknown place of infection), France (159 cases), Spain (141 cases), Romania (121 cases), North Macedonia (70 cases), the Netherlands (59 cases of which 1 had an unknown place of infection), Serbia (57 cases), Cyprus (21 cases), Croatia (18 cases), Belgium (15 cases), Austria (8 cases), Kosovo* (8 cases), Albania (7 cases), Bulgaria (7 cases), Germany (7 cases), Hungary (5 cases), Slovenia (3 cases), and Moldova (1 case, which had an unknown place of infection).

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:

Although environmental conditions for WNV transmission are becoming less favourable, low-level transmission may continue in the coming weeks, and additional cases are still expected to be reported.

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 provides 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: 9 October 2026

8. Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report)

Overview:

Findings from human surveillance

EU/EEA countries

In 2026, and as at 7 October, 13 countries in the EU/EEA have reported 1 715 locally acquired human cases of West Nile virus (WNV) infection. The earliest and latest dates of symptom onset among human cases were 22 May in Italy and 30 September in Italy, respectively. Locally acquired cases have been reported by **Italy** (748 cases, of which 1 had an unknown place of infection), **Greece** (445 cases, of which 6 had an unknown place of infection), **France** (144 cases), **Spain** (139 cases), **Romania** (117 cases), **the Netherlands** (59 cases, of which 1 had an unknown place of infection), **Croatia** (16 cases), **Belgium** (15 cases), **Cyprus** (13 cases), **Austria** (8 cases), **Hungary** (5 cases), **Germany** (4 cases) and **Bulgaria** (2 cases). A total of 130 deaths have been reported by **Italy** (56 deaths), **Greece** (46 deaths), **the Netherlands** (10 deaths), **Romania** (7 deaths), **Spain** (6 deaths), **France** (3 deaths), **Croatia** (1 death) and **Hungary** (1 death).

The number of human cases reported in the EU/EEA to date (1 715 cases) exceeds the average number reported during the same period over the past decade (693 cases), and is the highest number of WNV infections in humans ever reported in the EU/EEA.

As at 7 October 2026, locally acquired human cases have been reported in 187 NUTS 3 regions across 13 EU/EEA countries, making it the most geographically widespread WNV season on record.

As in previous years, most cases were reported among males aged 65 years and above. Overall, 77% of cases were hospitalised and 57% presented with neurological symptoms, compared with 10-year averages of 84% and 62%, respectively. The case fatality rate was approximately 8%, below the 10-year average of 10%. These findings are within expected levels and do not indicate increased disease severity. Country-specific case fatality rates are affected by the sensitivity of the surveillance system, including screening practices of blood donors, therefore direct comparisons between countries should be made with caution.

EU candidate countries

In 2026, and as at 7 October, the following EU candidate countries have reported 140 locally acquired human cases of WNV infection: **North Macedonia** (70 cases), **Serbia** (57 cases), **Kosovo*** (8 cases), **Albania** (4 cases) and **Moldova** (1 case, of which 1 had an unknown place of infection). The earliest and latest dates of symptom onset among human cases were 12 May in North Macedonia and 28 September in Serbia, respectively. A total of 11 deaths have been reported by **North Macedonia** (10 deaths) and **Kosovo*** (1 death).

Findings from veterinary surveillance

EU/EEA countries

From the veterinary perspective, 13 countries in the EU/EEA have reported 510 WNV outbreaks among equids and 591 outbreaks among birds in 2026. The earliest reported WNV outbreak among equids had a suspected start date of 30 March 2026 in France, while the most recent had a suspected start date of 2 October 2026 in Germany. Outbreaks among equids have been reported by **France** (307 outbreaks), **Italy** (72 outbreaks), **Belgium** (45 outbreaks), **the Netherlands** (24 outbreaks), **Spain** (18 outbreaks), **Greece** (14 outbreaks), **Germany** (13 outbreaks), **Croatia** (5 outbreaks), **Austria** (4 outbreaks), **Portugal** (4 outbreaks), **Hungary** (3 outbreaks) and **Cyprus** (1 outbreak). Among birds, the earliest reported WNV outbreak had a suspected start date of 31 March 2026 in Italy, while the most recent had a suspected start date of 29 September 2026 in Austria. Outbreaks among birds have been reported by **Italy** (353 outbreaks), **Belgium** (166 outbreaks), **Germany** (18 outbreaks), **France** (14 outbreaks), **Croatia** (13 outbreaks), **Spain** (12 outbreaks), **Austria** (10 outbreaks), **Slovenia** (4 outbreaks) and **the Netherlands** (1 outbreak).

No information was available on the equid species involved in the outbreaks reported in ADIS. The bird species most frequently associated with the reported outbreaks were the hooded crow (138 outbreaks) and the common magpie (104), followed by the carrion crow (80), the Eurasian jackdaw (45), the Northern goshawk (27), common wood-pigeon (20), the Eurasian blackbird (19), the little

owl (18), and the common kestrel (15). Several other bird species were also reported, each associated with up to 13 outbreaks.

As at 7 October 2026, the numbers of equid and bird outbreaks reported in July, August and September notably exceeded their respective historical monthly averages (2016–2025 for equids and 2022–2025 for birds), ranging from about two to more than five times the historical monthly averages for equids and remaining at about twice the corresponding averages for birds. The cumulative number of bird and equid outbreaks reported so far in 2026 is the highest recorded for the same period in previous years.

Overall, so far in 2026, outbreaks in birds and/or equids have been reported in 186 NUTS 3 regions across 13 EU/EEA countries. This exceeds the geographical spread observed during this period in 2025, when outbreaks were reported in 113 NUTS 3 regions across 11 countries, as well as what has been observed in most previous years. The 2026 season was instead comparable to 2024, which was one of the most geographically widespread WNV seasons for animal outbreaks, with outbreaks in birds and/or equids reported in 188 regions across 14 countries.

Of the 13 EU/EEA countries that submitted data to ADIS in 2026, all had previously reported WNV outbreaks in birds and/or equids, consistent with endemic WNV circulation.

EU candidate countries and other European countries

In 2026, as at 7 October, one EU candidate country (North Macedonia) and Switzerland had reported WNV outbreaks in birds and/or equids. Switzerland reported one outbreak in equids, with a suspected start date of 21 July 2026. North Macedonia reported four outbreaks in birds, with suspected start dates ranging from 18 August to 7 September 2026.

If outbreaks reported by both EU/EEA and other European countries are considered, the geographical spread observed to date in 2026 in Europe is slightly greater than what was observed during the corresponding period in 2024.

Patterns across human and veterinary surveillance

EU/EEA countries

Most affected EU/EEA countries reported both human WNV infections and outbreaks in equids and/or birds. Romania only reported human WNV infections, while Portugal and Slovenia only reported outbreaks among equids and birds, respectively.

Differences in WNV patterns across European countries may reflect a combination of ecological, climatic and surveillance-related factors. Climatic conditions, habitat characteristics and the local abundance and distribution of competent mosquito vectors and bird hosts can influence WNV circulation. Differences in surveillance design, intensity, diagnostic practices and reporting may also affect the number of human infections and animal outbreaks detected.

Most human WNV infections are asymptomatic or subclinical. Consequently, the case numbers reported by EU/EEA countries represent only a fraction of the true number of infections. Furthermore, the reported numbers for of human cases and animal outbreaks, particularly for September, should be considered provisional, as reporting delays may lead to additional notifications in October or later.

A selection of country-specific findings is presented below to further illustrate the heterogeneity of WNV activity across Europe.

Italy

Italy remains the most affected country in 2026, reporting the highest number of WNV human cases (748, 44% of all reported human cases in the EU/EEA), including 56 deaths (case fatality rate: 7.5%). Italy also reported the highest number of outbreaks in birds (353; 59% of all avian outbreaks reported in the EU/EEA) and 72 outbreaks in equids (14% of all equid outbreaks reported in the EU/EEA). Nevertheless, the number of human cases reported was slightly lower than what was reported during the same period in 2025. As at 7 October 2026, the number of bird outbreaks notified to ADIS was the highest for the corresponding period since reporting became mandatory in 2021, while the number of equid outbreaks was higher than in the corresponding period of all previous years except 2018 and 2025. Overall, 79 of Italy's 107 NUTS 3 regions are currently affected, with WNV human cases and/or animal outbreaks reported.

Greece

Greece has reported its highest number of human WNV cases for this time of year, with 445 cases, including 46 deaths (case fatality rate: 10%). WNV transmission is currently most intense in the Attica NUTS 2 region, which accounts for 218 cases, with the highest numbers reported in Anatoliki Attiki (East Attica, 102 cases) and Voreios Tomeas Athinon (North Athens, 63 cases). The Larisa NUTS 3 region accounts for 73 cases. Despite accounting for 26% of all reported human cases in the EU/EEA, Greece has reported only 14 outbreaks in equids, representing 2.7% of all reported equid outbreaks, and no outbreaks in birds.

France

France had reported 144 locally acquired human WNV infections, including three deaths (case fatality rate: 2%), accounting for 8.4% of all cases in the EU/EEA. This is by far the highest number of cases ever reported by France. France reported the highest number of equid outbreaks among EU/EEA countries, with 307 outbreaks, accounting for 52% of the 595 reported outbreaks. This was also the highest number of WNV outbreaks in equids ever notified by France. A further 45 outbreaks were reported in birds.

The Netherlands

Fifty-nine human WNV infections have been reported in the Netherlands, including ten deaths (case fatality rate: 17%). The Netherlands previously reported locally acquired human WNV infections in 2020, when the country documented its first human cases, with seven cases reported in Utrecht (previously NL310) and one in the Arnhem/Nijmegen region (NL226). In addition, 24 outbreaks in equids and one in birds were reported in 2026. WNV was first reported in animals in the Netherlands in 2025, with a single equid outbreak. Overall, WNV infections in humans and/or animals were detected across 16 of the 40 NUTS 3 regions in the Netherlands this year.

Belgium

Belgium has reported 15 human WNV infections, representing the country's first-ever reported human cases of WNV infection; no deaths were reported. Most cases had symptom onset in the second half of August. WNV was first detected in Belgium in 2025 through avian surveillance, with seven bird outbreaks reported in Arr. Mechelen (BE212), Arr. Dendermonde (BE232) and Arr. Halle-Vilvoorde (BE241). In 2026, WNV was again detected in birds in these three regions and spread to 15 additional NUTS 3 regions that had not previously reported WNV activity. Overall, 14 outbreaks in equids and 26 outbreaks in birds were reported across 18 of Belgium's 44 NUTS 3 regions in 2026.

*Other European countries***North Macedonia**

North Macedonia is reporting an unprecedented number of human WNV infections, with 70 cases and 10 deaths (case fatality rate: 14 %) reported from five NUTS 3 regions. Two of these regions have also reported outbreaks among birds. The Skopski region, which includes the capital city of Skopje, is by far the most affected, accounting for 61 human WNV infections and three bird outbreaks. In 2026, North Macedonia reported WNV outbreak data to ADIS for the first time, with four bird outbreaks across two regions. In the past decade, the country had reported a maximum of five human WNV infections per year.

More information

The full monthly epidemiological report on human and animal surveillance data including maps and graphs is available at: [Monthly updates: 2026 West Nile virus transmission season \(europa.eu\)](#).

Updated figures on human WNV infections are published weekly at: [\(Weekly updates: 2026 West Nile virus transmission season \(europa.eu\)\)](#).

More background information on the Commission Directives on blood safety and EU/EEA notifications of WNV infections can be found [here](#).

ECDC assessment:

In 2026, WNV activity peaked in humans at the end of August and in birds and equids in early September across Europe, followed by a marked decline. Though environmental conditions for WNV transmission are becoming less favourable, low-level transmission may continue in the coming weeks and additional cases are still expected to be reported.

Actions:

ECDC is monitoring WNV infections through indicator- and event-based surveillance activities.

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

9. Mpox in the EU/EEA, Western Balkans and Türkiye – 2026

Overview:

The [monthly surveillance report on mpox in the EU/EEA, Western Balkans and Türkiye](#), covering the period up to September 2026 has been published on ECDC's website.

September 2026 update

A total of 342 mpox cases caused by clade I MPXV were reported by 17 countries, with the largest number of cases reported by Spain (94).

A total of three mpox clade II cases were reported by three countries: Denmark, France and Portugal.

Overview of the past 12 months (October 2025 to September 2026)

In the past 12 months, 23 countries have reported 1 939 clade I mpox cases and 19 countries have reported 751 clade II mpox cases.

Among cases with complete information:

- In total, 91% of clade I mpox cases and 91% of clade II mpox cases were reported among men who have sex with men.
- Overall, 13% of clade I mpox cases and 7% of clade II mpox cases were hospitalised. One death has been reported among people infected with clade I MPXV and two deaths have been reported among people infected with clade II MPXV.
- A total of 18% of clade I mpox cases and 18% of clade II mpox cases with known vaccination status had received two vaccine doses.

Since June 2026, the number of reported mpox cases in the EU/EEA has increased, driven primarily by an increase in reported clade I cases, while the number of reported clade II mpox cases has continued to decline.

However, interpretation of trends is limited due to missing clade information for a substantial proportion of reported cases and that case and epidemiological information may be updated retrospectively.

Based on information provided by Member States, clinical presentation is generally mild, including among hospitalised cases. Clades Ib and IIb account for the vast majority of reported mpox cases. Among cases with known clade, only one case of clade Ia and two cases of clade IIa have been reported in the EU/EEA since the start of surveillance in 2022.

ECDC assessment:

Both clade I and clade II mpox cases continue to be reported across the EU/EEA, with generally mild clinical presentation.

While early clade I cases were mainly imported from outside the EU/EEA and reported among heterosexual individuals and their close contacts, most cases are now reported among men who have sex with men. Transmission in these networks is observed for both clades and occurs predominantly among unvaccinated individuals.

The risk assessment in ECDC's [Threat Assessment Brief](#) published on 24 October 2025 remains valid: 'The risk of clade Ib infection is assessed as moderate for men who have sex with men and low for the general population in the EU/EEA. The risk for clade IIb infection remains low for men who have sex with men and very low for the general population in the EU/EEA.'

Actions:

ECDC's [Threat Assessment Brief](#) outlines actions that EU/EEA countries can take. ECDC continues to monitor mpox in the EU/EEA and globally through event- and indicator-based surveillance and collaboration with partners.

EU/EEA countries are encouraged to **increase vaccination uptake**, particularly among populations at higher risk of exposure, including men who have sex with men. Increasing vaccination coverage remains the most important intervention to mitigate the spread of both clades, particularly during the spring and summer season. **Health promotion and community engagement** are also critical to ensure effective outreach and high vaccine acceptance and uptake among those most at risk of exposure.

Primary preventive vaccination (PPV) and post-exposure preventive vaccination (PEPV) strategies may be combined to target individuals at substantially higher risk of exposure and close contacts of cases, respectively, particularly in the event of limited vaccine supply. PPV strategies should prioritise gay, bisexual, and transgender people, and men who have sex with men, who are at higher risk of exposure. Strategies should also prioritise individuals at risk of occupational exposure, based on epidemiological or behavioural criteria.

Further response options for EU/EEA countries include:

- raising awareness among healthcare professionals;
- supporting sexual health services in case detection, contact tracing, and case management;
- ensuring that testing is easily accessible.

Countries should **continue efforts to sequence** all confirmed cases and ensure that sequences are deposited in public repositories (European Nucleotide Archive (ENA), Sequence Read Archive (SRA), and/or GISAID EpiPox (GISAID's mpox genomic surveillance platform)) or shared with ECDC through the EpiPulse platform.

Further information:

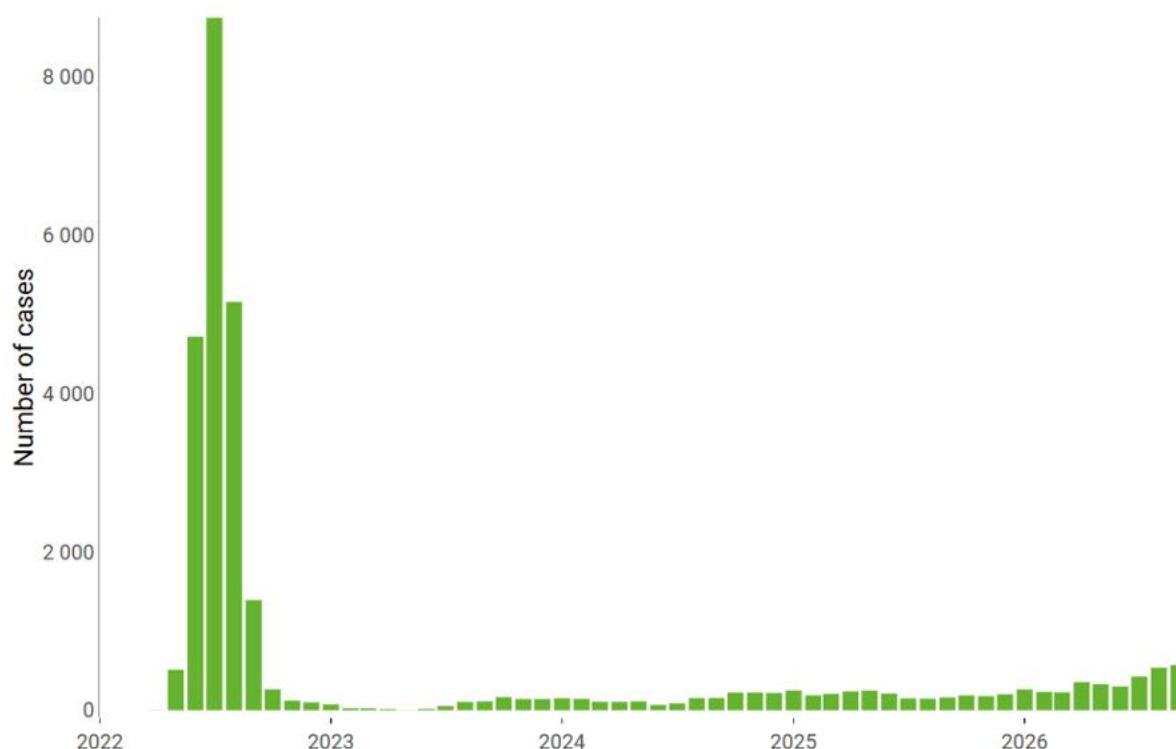
- The [Weekly Communicable Diseases Threats Report](#) and ECDC's [Mpox worldwide overview webpage](#) provide further information about the global epidemiological situation of mpox caused by clades I and II MPXV.
- ECDC's [Threat Assessment Brief on the detection of autochthonous transmission of monkeypox virus \(MPXV\) clade Ib in the EU/EEA](#), published on 24 October 2025, summarises the epidemiological situation, outlines recommended response measures, and highlights remaining knowledge gaps.

Last time this event was included in the Weekly CDTR: 14 August 2026

Figure 9. Mpox cases by clade in the past 12 months (October 2025 to September 2026), and past calendar month (September 2026), EU/EEA

Country	Clade I		Clade II		Clade Unknown	
	Past 12 months	Past month	Past 12 months	Past month	Past 12 months	Past month
Austria	42	19	8		9	6
Belgium	44	1	4		168	18
Bulgaria					5	2
Croatia					3	
Czechia	11		2			
Denmark	13	3	2	1		
Estonia	1					
Finland					6	
France	136	17	46	1	232	42
Germany	290	69	133		179	43
Greece	14	7	1		1	
Hungary	10	6	2			
Iceland	1				1	
Ireland	37	7	19			
Italy	106	17	7		82	17
Latvia					1	
Lithuania	1				2	
Luxembourg	3		1			
Malta	8	3	3			
Netherlands	107	28	53		16	5
Norway	5	3	6			
Poland	21	9	2		21	7
Portugal	282	50	60	1	56	
Romania	4	2				
Slovakia	5				2	
Slovenia			1			
Spain	741	94	397		317	82
Sweden	57	7	4		11	4
EU/EEA total	1 939	342	751	3	1 112	226

Figure 10. Total number of mpox cases – all clades – from January 2022 and as of 13 October, EU/EEA



10. Diphtheria – Africa – 2026

Overview:

Epidemiological overview

Between 2000 and 2025, a total of 96 036 diphtheria cases have been reported in nine countries of the WHO African Region ([WHO](#)), including Algeria, Chad, Gabon, Guinea, Mali, Mauritania, Niger, Nigeria, and South Africa ([WHO RRA v.1](#)). Since the beginning of 2026, and as of September 2026, persistent transmission of diphtheria has continued in Chad, Guinea, Mali, Mauritania, Niger, Nigeria, and South Africa ([WHO RRA v.3](#)). Senegal reported a new outbreak in July-August 2026 ([WHO RRA v.3](#)) and localised clusters were detected in Morocco in September 2026 ([Morocco World News](#)).

Reported case numbers, geographical distribution and epidemiological trends varied considerably across countries. An overview of the epidemiological situation of diphtheria in the WHO African Region is provided below, drawing on publicly available official sources from the World Health Organization (WHO) and national epidemiological reports, and media.

Chad: Between 1 January and 26 July 2026, 1 251 suspected cases, including eight laboratory-confirmed cases and five deaths (Case Fatality Ratio [CFR]: 0.4%), were reported across four of 23 provinces. Chad reported the second highest number of suspected cases in the WHO African Region, after Nigeria. Reported case numbers remained relatively stable during 2026 ([WHO RRA v.3](#)).

Guinea: As of epidemiological week 33, 600 suspected cases were reported, including 49 laboratory-confirmed cases and 89 deaths (CFR: 14.8%). This represented an additional 463 cases and 78 deaths since 1 March 2026. Laboratory-confirmed cases were reported in Siguiri, Kankan, Mandiana, and Mamou prefectures. During week 31, 34 suspected cases, including 17 laboratory-confirmed cases and eight deaths, were reported. All deaths occurred in unvaccinated children aged 12 months to 14 years, and 72% of cases were children older than five years ([WHO RRA v.3](#)). Between 1 January 2025 and 22 February 2026, a total of 795 suspected cases, including 151 deaths (CFR: 19%), had been reported ([WHO RRA v.2](#)).

Mali: As of epidemiological week 33, 192 suspected cases, including 30 confirmed cases and nine deaths (CFR: 4.7%) were reported. Suspected cases were reported from 41 health districts in nine regions (increasing from 37 health districts up until 1 March 2026), and confirmed cases were reported from 25 health districts in eight regions ([WHO RRA v.3](#)). From 1 January 2025 to 1 March 2026, a total of 636 suspected cases had been reported, including 35 deaths (CFR: 5.5%) ([WHO RRA v.2](#)). Reported case numbers declined in 2026 following a peak recorded in week 19 of 2025. Children aged 5–14 years remained the most affected age group ([WHO RRA v.3](#)).

Mauritania: As of epidemiological week 33, Mauritania reported 448 suspected cases, including 19 laboratory-confirmed cases and 25 deaths (CFR: 5.6%). Cases were reported across 36 of 63 moughataas (health districts) (increasing from 34 affected moughataas up until 1 March 2026), with the largest number reported in the Hodh El Chargui region ([WHO RRA v.3](#)). From 1 January 2025 to 1 March 2026, a total of 1 415 suspected cases, including 12 laboratory-confirmed cases and 54 deaths (CFR: 3.8%), had been reported ([WHO RRA v.2](#)). A substantial increase in weekly case numbers was recorded between weeks 39 and 44 of 2025, reaching a peak of 179 cases in week 41, before declining in 2026 ([WHO RRA v.2](#), [WHO RRA v.3](#)).

Morocco: On 28 September 2026, according to media sources quoting the Ministry of Health and Social Protection of Morocco, two family clusters of diphtheria were reported in the Souss-Massa region. One case was laboratory-confirmed and eight cases, including two deaths, were suspected. Further laboratory investigations were ongoing at the time of reporting ([Morocco World News](#), [The North Africa Post](#)).

Niger: As of epidemiological week 33, 818 suspected cases, including 313 laboratory-confirmed cases and 27 deaths (CFR: 3.3%), were reported across 45 of 72 health districts. This represented an increase of 543 suspected cases and 12 deaths since 1 March 2026. The number of affected areas also increased from 34 health districts up until 1 March 2026 ([WHO RRA v.3](#)). From 1 January 2025 to 1 March 2026, a total of 2 456 suspected cases, including 166 deaths (CFR: 6.8%), had been reported ([WHO RRA v.2](#)). Following an increase during the first six weeks of 2026, weekly case numbers generally declined, although fluctuations continued. Reported case and deaths counts, as well as the CFR, were lower than during the corresponding period in 2025 ([WHO RRA v.2](#), [WHO RRA v.3](#)).

Nigeria: As of epidemiological week 34, Nigeria reported 16 997 suspected cases, including 12 491 laboratory-confirmed cases and 596 deaths (CFR: 3.51%), recording the highest number of cases in the WHO African Region. Cases were reported across 24 of 36 states, with the highest numbers in the Kano (7 830), Bauchi (2 696), Katsina (2 144), Borno (1 907) and Sokoto (787) states. Cases reported from these five states accounted for 90% of all cases. The weekly CFR increased from 2.9% early in 2026 to 7.9% in recent weeks ([WHO Weekly Bulletin on Outbreak and other Emergencies](#), [WHO RRA v.3](#)). In 2025, a total of 15 273 confirmed cases had been reported from 25 states and in 2024, a total of 10 714 confirmed cases had been reported from 19 states ([WHO RRA v.2](#)).

Senegal: Following notification of the first case in epidemiological week 30 of 2026, 13 laboratory-confirmed cases and two deaths, including one probable death (CFR: 15.4%), were reported to WHO between 20 July and 16 August 2026. All cases were younger than 15 years, with a median age of 5 years. The outbreak initially affected the Kedougou and Saraya health districts ([WHO Weekly Bulletin on Outbreak and other Emergencies](#), [WHO RRA v.3](#)). In an update provided by the Ministry of Health in Senegal, as of 4 October 2026, a total of 248 confirmed cases, including 11 deaths, were reported across 51 health districts in 13 regions. The highest number of cases were recorded in the Dakar (42), Kedougou (35) and Diourbel (33) regions ([Ministry of Health and Social Action Senegal, Seneweb](#)).

South Africa: Between 29 December 2025 and 20 August 2026, 43 suspected cases of respiratory diphtheria were reported to WHO, including 38 laboratory-confirmed and five probable cases. Eight deaths (CFR: 18.6%) were reported. Laboratory-confirmed cases were reported mostly in Western Cape, Limpopo, and Gauteng provinces. Their median age was 23 years (range: 5–72 years), and 68% were adults ([WHO RRA v.3](#)). As of 13 September 2026, one additional laboratory-confirmed case was reported in the [diphtheria situational report](#) published by the National Institute of Communicable Diseases, South Africa (NICD), resulting in a total of 39 confirmed cases of respiratory diphtheria detected in the country since 29 December 2025.

Algeria: To date, no updated epidemiological data is available for Algeria for 2026. However, according to historical data submitted to WHO up until October 2025, a total of 13 suspected cases, including eight laboratory-confirmed cases and two deaths (CFR: 15.4%), were reported between

8 and 19 October 2025. Previously, as of 25 May 2025, 915 suspected cases had been reported, including 299 laboratory-confirmed cases and 119 deaths (CFR: 13%) ([WHO RRA v.2](#)).

Several surveillance gaps and data limitations affect the interpretation of epidemiological trends, including reporting delays, case reclassifications, delayed, incomplete or retrospective reporting, low laboratory confirmation rates, challenges in case management, and missing demographic and vaccination-status data. Additionally, differences in reporting periods and case definitions mean that comparisons across countries should be interpreted cautiously.

ECDC assessment:

Most EU/EEA countries have very high vaccination coverage for the primary course of diphtheria-containing vaccines. In the countries with high vaccination coverage, the risk to the general population is assessed as very low, but there could be sporadic cases among unvaccinated individuals or those with incomplete vaccination. Travellers to the regions with active case transmission should ensure they are up to date with vaccinations.

Actions:

ECDC monitors diphtheria events worldwide, including in Africa and the EU/EEA, through routine epidemic intelligence activities and disease network surveillance.

11. Expert deployment

Overview:

Since 19 May 2026, the EUHTF has been supporting preparedness and response efforts related to the Ebola disease outbreak caused by Bundibugyo virus in DRC and Uganda. These activities are being conducted in close coordination with national authorities and EU delegations, and in collaboration with the European Commission and the WHO.

DRC – WHO Incident Management Team in Bunia

Since 22 September, two ECDC experts have been deployed through the Global Outbreak Alert and Responses Network (GOARN), to provide epidemiological support to WHO operations in Bunia, Ituri Province and DRC. The deployments are financed with funds made available by the Directorate-General for European Civil Protection (DG ECHO).

Africa CDC and Continental Incident Management Support Team

Five experts were deployed on a rotational basis to support Africa CDC at its headquarters in Addis Ababa. Since 23 June 2026, seven experts have been deployed to support Africa CDC within the Continental Incident Management Support Team (IMST) in Uganda. The experts have provided support for surveillance, preparedness and liaison activities. 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 (DG INTPA).

South Sudan – WHO Country Office

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 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 areas considered at [high risk](#) of importation and transmission. Between 14 July and 27 August 2026, two ECDC fellows were also deployed through GOARN, to support surveillance and data analysis activities. All deployments to South Sudan were funded by DG ECHO.

Fact-finding mission to the DRC and Uganda

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

Last time this event was included in the Weekly CDTR: 9 October 2026

Events under active monitoring

- Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo – 2026 - last reported on 16 October 2026
- Expert deployment - last reported on 16 October 2026
- Seasonal surveillance of chikungunya virus disease in the EU/EEA – 2026 (weekly) - last reported on 16 October 2026
- Seasonal surveillance of dengue in the EU/EEA – 2026 (weekly report) - last reported on 16 October 2026
- Seasonal surveillance of Crimean-Congo haemorrhagic fever in the EU/EEA – 2026 (weekly report) - last reported on 16 October 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (weekly report) - last reported on 16 October 2026
- Seasonal surveillance of West Nile Virus infections – 2026 (Monthly report) - last reported on 16 October 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2026 - last reported on 16 October 2026
- Overview of respiratory virus epidemiology in the EU/EEA, week 41, 2026 - last reported on 16 October 2026
- Pneumonia of unknown aetiology - Russia - 2026 - last reported on 16 October 2026
- Diphtheria - Africa - 2026 - last reported on 16 October 2026
- Multi-country outbreak of Salmonella Strathcona - EU/EEA - 2023-2026 - last reported on 09 October 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – Monthly monitoring - last reported on 09 October 2026
- Symptomatic Sindbis case in Germany, 2026 - last reported on 09 October 2026
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 October 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 October 2026
- SARS-CoV-2 variant classification - last reported on 02 October 2026
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 02 October 2026
- Seasonal monitoring of environmental suitability for Vibrio spp. risk in coastal waters – Bathing season 2026 - last reported on 02 October 2026
- Carbapenem-resistant Enterobacterales – Multi-country (EU/EEA) – 2025 - last reported on 02 October 2026