WEEKLY BULLETIN

Communicable disease threats report

Week 7, 7–13 February 2026

This week's topics

Executive Summary

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

- In December 2025, 11 EU/EEA countries reported 97 measles cases. Seventeen countries reported zero cases.
- During the last 12-month period, eight deaths attributable to measles were reported to ECDC by France (4), Romania (3) and the Netherlands (1).
- Overall, case numbers decreased compared with the previous months, which is consistent with the seasonality of measles.
- Complementary epidemic intelligence surveillance was performed on 12 and 13 February 2026. Two outbreaks have been detected in France and Spain. Sporadic cases and clusters were reported in several EU/EEA countries. Updates are provided for some countries outside the EU/EEA.

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

- In January 2026, over 100 000 cases of dengue and over 10 dengue-related deaths were reported from 39 countries/territories globally according to information from publicly available sources.
- In 2026, no cases have been reported in the EU/EEA excluding the outermost regions. Cases have been reported by Martinique, Guadeloupe, Reunion and by French Guiana (French outermost regions).

European Centre for Disease Prevention and Control, Solna, Sweden
www.ecdc.europa.eu

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

- On 10 February 2026, Hong Kong reported two new human cases of avian influenza A(H9N2) virus infection in China, with symptom onset in December 2025 and January 2026.
- No further epidemiological information was reported for the two cases.
- Overall, 195 human cases of avian influenza A(H9N2), including two deaths, have been reported since 1998 from 10 countries.
- The risk to human health in the EU/EEA is currently considered very low.

Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases

- A new human case of avian influenza A(H10N3) virus infection was reported in Guangdong province, China.
- The case was in a 34-year-old man who had onset of symptoms on 29 December 2025.
- No additional epidemiological information was provided.
- No human-to-human transmission has been documented.
- The risk to human health in the EU/EEA is considered very low.

Overview of respiratory virus epidemiology in the EU/EEA

Summary

The number of people visiting primary care with symptoms of respiratory illness remains elevated in most reporting countries, suggesting widespread respiratory virus circulation across much of the European Union/European Economic Area (EU/EEA).

Influenza virus circulation remains elevated but has shown a general decrease in recent weeks. Overall, hospitalisations have decreased since the beginning of the year, with adults 65 years old and above accounting for the most admissions during the season. Influenza A(H3) remains the dominant subtype, followed by A(H1)pdm09.

Early estimates of seasonal influenza vaccine effectiveness in the EU/EEA for the 2025/26 season were published by ECDC on 19 December 2025, and match those published for A(H3N2) viruses by other countries.

Respiratory syncytial virus (RSV) circulation remains elevated and continues to increase, with the start of RSV season beginning later than in the previous two seasons. Hospitalisations are showing an overall increasing trend, with children under five years old accounting for the most admissions.

SARS-CoV-2 circulation remains low in all age groups, and the number of hospitalisations due to SARS-CoV-2 is currently limited compared with influenza and RSV.

EuroMOMO reports elevated levels of all-cause mortality, both overall and in those 45 years old and above.

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'.

Rapid Outbreak Assessment under production

ECDC, jointly with the European Food Safety Authority (EFSA), is developing a Rapid Outbreak Assessment 'Multi-country food-borne incident caused by cereulide linked to infant formula products'. The expected publication date is 19 February 2025.

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

- Since the beginning of 2026, and as of 31 January (last day with available data), approximately 2 882 chikungunya virus disease (CHIKVD) cases and one CHIKVD-related death has been reported in 11 countries/territories.
- Cases have been reported in the Americas, Africa, Asia and Europe (France – outermost regions, i.e. Réunion, Mayotte, and French Guiana).

Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

- Since the previous update and as of 12 February, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic Games.
- The probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games 2026 is low, if general preventive measures are applied.

Nipah virus disease – India and Bangladesh – 2026

- On 6 February 2026, WHO posted a DON about a confirmed death due to Nipah virus (NiV) infection that occurred in Rajshahi Division, northwestern Bangladesh.The patient reported repeated consumption of raw date palm sap.
- On 26 January 2026, the National International Health Regulation Focal Point of India reported to WHO that there had been two confirmed cases of NiV infection reported in the state of West Bengal, India. Both confirmed cases are in healthcare workers at the same hospital.
- Contact tracing has been performed for both events and no additional cases have been identified so far.
- Thailand, Nepal, Cambodia and other neighbouring countries have initiated measures, including information campaigns and screening for passengers arriving from India at airports.
- The likelihood of exposure and infection with NiV for EU/EEA residents travelling to or residing in India or Bangladesh is currently very low, given the low number of infections in areas where cases have been identified to date.

1. Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring

Overview:

Since March 2025, there has been an overall decrease in reported measles cases. As expected, the number of cases declined over the summer months, in line with the known seasonality of the disease.

In December 2025, 28 EU/EEA countries reported measles data, with 11 countries reporting 97 cases. Seventeen countries reported zero cases.

Overall, case numbers decreased compared with the previous month; however, this is subject to change in the event of a future retrospective update. The highest case counts were reported by Poland (27), Italy (25), Romania (12), France (10) and Spain (6).

Between 1 January 2025 and 31 December 2025, 30 EU/EEA countries reported a total of 7 655 measles cases, 5 762 (75.3%) of which were laboratory confirmed.

Of the 7 655 cases with known age, 3 072 (40.1%) were in children under five years old; 2 674 (34.9%) cases were in individuals 15 years old or above. The highest notification rates were observed among infants under one year old (261.6 cases per million population) and children one to four years old (127.4 cases per million population).

Of 7 210 cases (94.2% of all cases) with known age and vaccination status, 5 764 (79.9%) were unvaccinated, 743 (10.3%) were vaccinated with one dose of a measles-containing vaccine, 571 (7.9%) were vaccinated with two or more doses, and 122 (1.7%) were vaccinated with an unknown number of doses.

During the 12-month period, eight deaths (case fatality rate (CFR): 0.105%) attributable to measles were reported to ECDC by France (4), Romania (3) and the Netherlands (1). Detailed data are available in ECDC's Surveillance Atlas of Infectious Diseases.

Complementary epidemic intelligence surveillance was performed on 12 and 13 February 2026. Two outbreaks have been detected in France and Spain. Sporadic cases and clusters were reported in several EU/EEA countries. Outside the EU/EEA, updates have been provided for England, Israel, Ukraine, Africa CDC and the World Health Organization Pan American Health Organization (WHO PAHO) regions.

In January 2026, WHO announced that six countries in the World Health Organization's European region, including the United Kingdom and Spain, have re-established endemic measles transmission based on reporting from 2024.

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:

Bulgaria reported one new case in 2026 in week 7. In 2025, Bulgaria reported two cases.

Czechia reported three cases in 2026, as of 2 February.

France reported 12 cases and no deaths in January 2026. The cases were related to three clusters and are detected among adults and children.

An ongoing outbreak is reported in Val Thorens ski resort in Auvergne-Rhône-Alpes, involving four young adults. Cases were reported between 12 January and 4 February 2026. Two of the cases were not vaccinated, one was vaccinated and one had an unknown vaccination status. One of the four individuals was hospitalised.

Ireland reported three cases in weeks 4 and 5 in 2026. Data from Ireland (National Notifiable Disease Hub) includes confirmed, probable and possible measles cases.

Italy reported 529 cases of measles (497 laboratory confirmed, 11 probable and 21 possible cases) from 1 January to 31 December 2025, an increase by 44 cases since 30 November 2025. Of the reported cases, 53 were in healthcare workers. Genotype D8 and B3 were detected in 144 and 145 samples, respectively.

The Netherlands reported one measles case in 2026 and as of 7 February. There is currently no indication of a national outbreak. In 2025, a total of 539 measles cases were reported to the National Institute for Public Health and the Environment (RIVM), of which 62 were contracted abroad.

Poland reported two cases of measles in January 2026.

Spain reported 32 cases of measles from 1 January to 8 February 2026, including three imported cases and two cases related to imported cases.

On 6 February 2026, according to a media report, the General Directorate of Public Health (DGSP) reported a workplace-associated measles outbreak involving employees of two companies located in the same building in the city of Alicante, Spain. Among 28 suspected cases, 16 have been laboratory confirmed, while nine remain under investigation. Public health authorities have implemented control measures, including isolation of confirmed and suspected cases and vaccination of identified contacts, to limit further transmission.

Sweden reported two cases in 2026, as of 13 February.

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

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

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

England reported 96 laboratory-confirmed cases since the start of 2026. Cases have increased in January, mostly driven by the ongoing outbreak in North London. The majority of cases involve children under 10 years old (77%).

Israel reported 988 measles hospitalisations since 2025 and as of 13 February 2026, including 14 deaths from measles.

Ukraine reported 1 502 measles cases from January to December 2025, an increase of 46 cases since November 2025.

According to a report by Africa CDC published on 28 January 2026, Mozambique and Liberia experienced measles outbreaks with moderate risk.

According to WHO PAHO, in 2026 (week 1–3), 1 031 measles cases and no deaths were reported in the Americas Region. Cases were notified by Mexico (740), the United States (US) (171), Canada (67), Bolivia (10), Guatemala (41), Chile (1) and Uruguay (1). This represents a 45-fold increase compared with the same period in 2025 (23 cases). In 2025, the Region reported 14 891 confirmed cases and 29 deaths, 73% of which occurred in Indigenous populations. This represents a 32-fold increase compared with 2024 (466 cases) and the highest annual total since 2019. Countries with the highest number of cases in 2025: Mexico (6 428 cases, 24 deaths), Canada (5 436 cases, two deaths), and the US (2 242 cases, three deaths)

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 upcoming 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 the 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: 16 January 2026

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

Overview:

In January 2026, over 100 000 cases of dengue and over 10 dengue-related deaths were reported from 39 countries/territories globally according to information from publicly available sources in the Americas, Africa and the Western Pacific. No cases have been reported in the EU/EEA, excluding the outermost regions. With regards to outermost regions, cases have been reported by Martinique, Guadeloupe, Reunion and by French Guiana the last weeks of January 2026.

In Martinique, transmission of dengue continues at high and stable levels the past four weeks, with 36 cases reported the week of 19–25 January 2026, according to the Dengue Surveillance Report published on 29 January 2026. In the other French outermost regions, dengue cases have been reported but at expected levels. In Guadeloupe, according to the same report, dengue is circulating at expected levels for the season, with 12 confirmed cases reported in the two-week period from 12–25 January 2026. In Saint Martin, no cases were reported the week of 19–25 January 2026 (Dengue aux Antilles. Bulletin du 29 janvier 2026). In Reunion, 10 cases of dengue have been reported since the beginning of 2026 and as of 1 February, with six of them reported between 19 January and 1 February 2026 (Surveillance sanitaire à La Réunion. Bulletin du 6 février 2026). In French Guiana, dengue activity remains low, with one case reported between 19 January and 1 February 2026 (Surveillance sanitaire en Guyane. Bulletin du 5 février 2026).

A summary of recent epidemiological trends of dengue outside the EU/EEA for January 2026 is presented below. The summary is based on available information from official sources and reports from different countries/territories.

In the Americas, according to PAHO, as of week 2 2026 (ending 11 January 2026), 69 772 cases have been reported, of which 18% were laboratory confirmed. The currently reported number of cases is 60% less than the number of cases reported in the same period in 2025 and 44% less than the average for the last five years, according to the WHO PAHO report published on 8 February 2026. While all serotypes have been reported so far in 2026, their distribution differs in the different PAHO countries (Report on the epidemiological situation of dengue in the Americas).

According to the WHO SEARO epidemiological bulletin published on 11 February, dengue cases have been reported in January 2026 in the region by Bangladesh, India, Nepal, Sri Lanka, Thailand and Timor-Leste. Thailand and India reported 1 903 and 3 544 cases, respectively, in January 2026. In both countries, the total number of cases reported in January 2026 was less than the total number of cases reported for the same period in 2025. Bangladesh, Nepal and Sri Lanka have also reported cases in comparable levels to previous years and in all countries the case numbers reported for the most recent weeks showed a decreasing trend. Bangladesh reported 1 502 cases as of 8 February 2026 (108 cases the week 2–8 February vs 136 cases the week 26 January to 1 February 2026). Nepal reported 178 cases in January 2026 and 317 cases in December 2025. Sri Lanka reported 8 014 cases as of 1 February 2026 (1 511 cases the week 26 January to 1 February vs 1 785 cases the week 19–25 January 2026). An increasing trend in the case numbers has been reported in Timor Leste in January, which is over four times the number of cases reported in December (1 281 cases reported in January 2026 vs 279 cases reported in December 2025).

Meanwhile, Maldives continued reporting increases of cases until end of 2025 (411 cases reported in December vs 382 cases reported in November 2025); however, for January 2026, no data have been made available publicly (according to the SEARO report).

In the Western Pacific WHO Region, cases of dengue have been reported by Cambodia, Indonesia, Laos, Singapore and Vietnam, in the report of 5 February 2026 (WHO WPRO Dengue Situation Update #739: 5 February 2026). The following trends were highlighted by country:

- **Cambodia**: there is a decreasing weekly trend since the beginning of 2026 and a total of 2 345 cases for the period 1–25 January 2026.
- **Indonesia**: a decreasing trend has been noted compared with the previous few months (403 cases reported in January, as of 21 January 2026).
- **Laos**: a decreasing weekly trend has been observed, with 80 cases reported the week 19–25 January vs 88 cases reported the week before.
- **Singapore**: 99 cases were reported as of 24 January 2026; this is 64.6% less than the number of cases reported for the same period in 2025.
- **Vietnam**: over 20 000 cases have been reported since 18 December 2025 and up to 17 January 2026, showing an increasing trend.

Lastly, in Africa and as of 4 February 2026, 209 cases have been reported by Mali (193), Mauritania (13) and Senegal (3) (Africa CDC Epidemic Intelligence Weekly Report, February 2026 – Africa CDC).

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

ECDC assessment:

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

For the risk related to dengue in mainland EU/EEA, please see ECDC's Dengue risk assessment for mainland EU/EEA.

More information on autochthonous transmission of dengue virus in 2025 in the EU/EEA is available on ECDC's website, and in ECDC's factsheets on dengue.

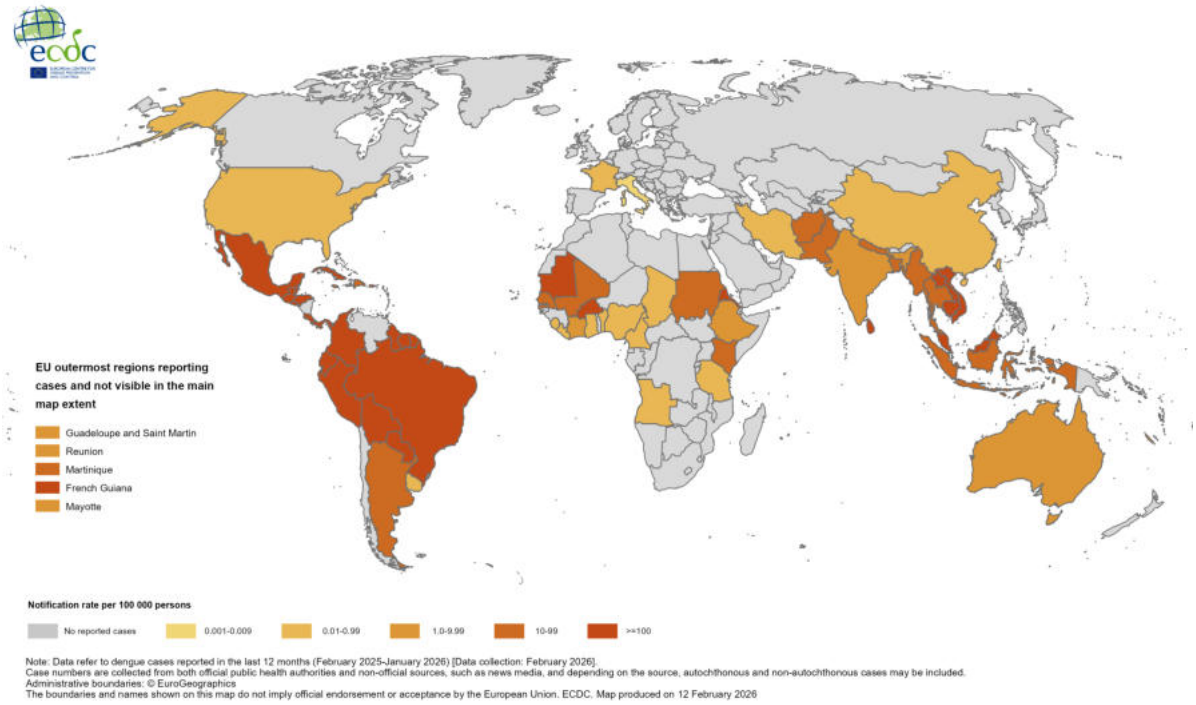
Actions:

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

Last time this event was included in the Weekly CDTR: 19 December 2025

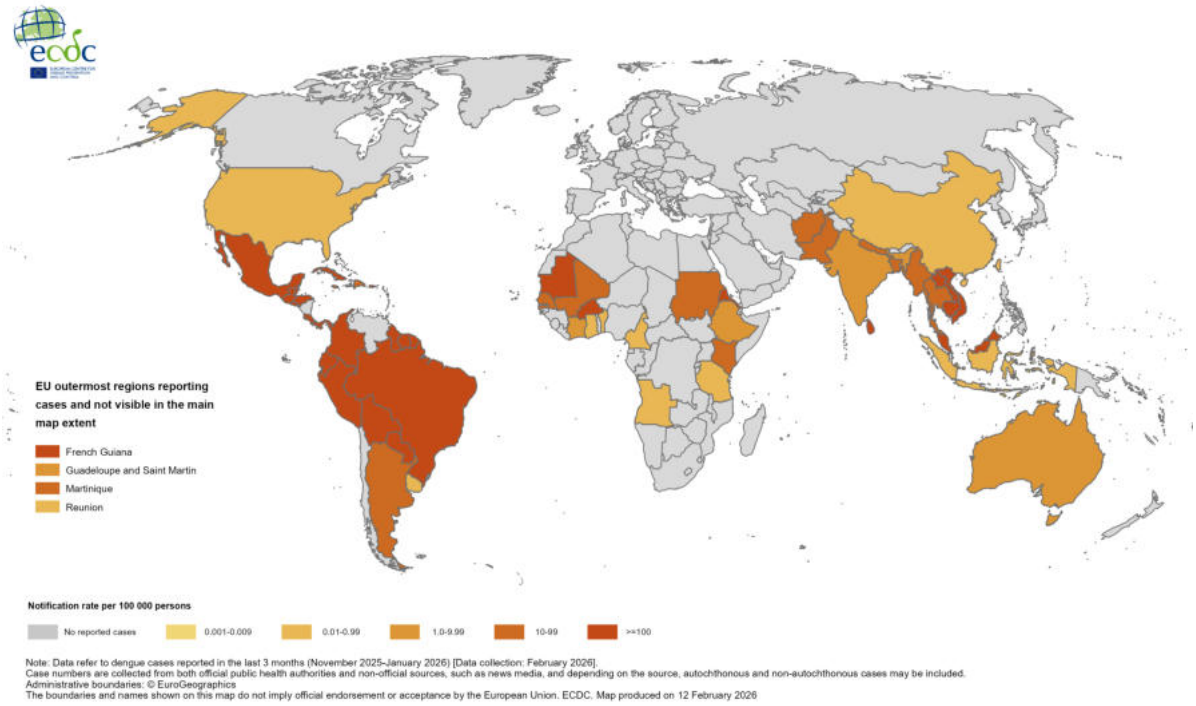
Maps and graphs

Figure 1. Twelve-month dengue virus disease case notification rate per 100 000 population, February 2025 to January 2026



Source: ECDC

Figure 2. Three-month dengue virus disease case notification rate per 100 000 population, November 2025 to January 2026



Source: ECDC

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

Overview:

According to the Hong Kong Centre for Health Protection's Avian Influenza Report from 10 February 2026, two human infections with avian influenza A(H9N2) were reported in China. The first case was in a 73-year-old woman from Guangdong Province who developed symptoms on 17 January 2026. The second case was in a two-year-old boy from Hunan Province with symptom onset on 29 December 2025. No further epidemiological information was provided for either case.

Background:
Overall, 195 human cases of avian influenza A(H9N2), including two deaths, have been reported since 1998 from 10 countries. Since 2015, China has reported 154 human cases of avian influenza A(H9N2) virus infection to the World Health Organization (WHO), including two deaths (case fatality rate (CFR): 1%).

ECDC assessment:

Sporadic human cases of avian influenza A (H9N2) have been observed outside the EU/EEA. 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) infections have been reported. According to WHO, the likelihood of human-to-human transmission of A(H9N2) is low, as there is no evidence that the virus has acquired the ability for sustained transmission among humans.

To date, there have been no human cases of avian influenza A(H9N2) reported in the EU/EEA, and the risk to human health in the region is currently considered very low. This assessment will be revised when more epidemiological information is available.

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 December 2025.

Sources: Event Information Site for IHR National Focal Points

Last time this event was included in the Weekly CDTR: 23 January 2026

4. Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases

Overview:

On 10 February 2026, the Hong Kong Centre for Health Protection reported a human case of avian influenza A(H10N3) virus infection in a 34-year-old man from Guangdong Province, China in its Avian Influenza Report. The patient developed symptoms on 29 December 2025. No additional epidemiological information was provided. This is the third case reported in 2025.

Summary

Since 2021 and as of 10 February 2026, seven human cases of avian influenza A(H10N3) virus infection have been reported globally, all in China (from different provinces), with no associated deaths. All reported cases occurred in adults. All but one of the cases had severe or critical infections and reported history of exposure to live animals or a contaminated environment. The cases were reported from the following provinces in China: Jiangsu, Zhejiang, Yunnan, Guangxi Zhuang Autonomous Region, Shaanxi (1, 2), Guangdong.

ECDC assessment:

Based on the limited information about the current case, it is difficult to provide an assessment. It will be revised when more information is available.

Sporadic human cases of avian influenza A(H10N3) have been observed, but no human-to-human transmission has been documented. The risk to human health in the EU/EEA is currently considered very low.

Direct contact with infected birds or contaminated environments is the most likely source of human infection with avian influenza.

Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and influenza surveillance activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza to identify significant changes in the epidemiology and characteristics of the virus. Together with EFSA and the EU reference laboratory, ECDC produces a quarterly Avian influenza review. The most recent report was published in December 2025.

Last time this event was included in the Weekly CDTR: 27 June 2025

5. Overview of respiratory virus epidemiology in the EU/EEA

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.

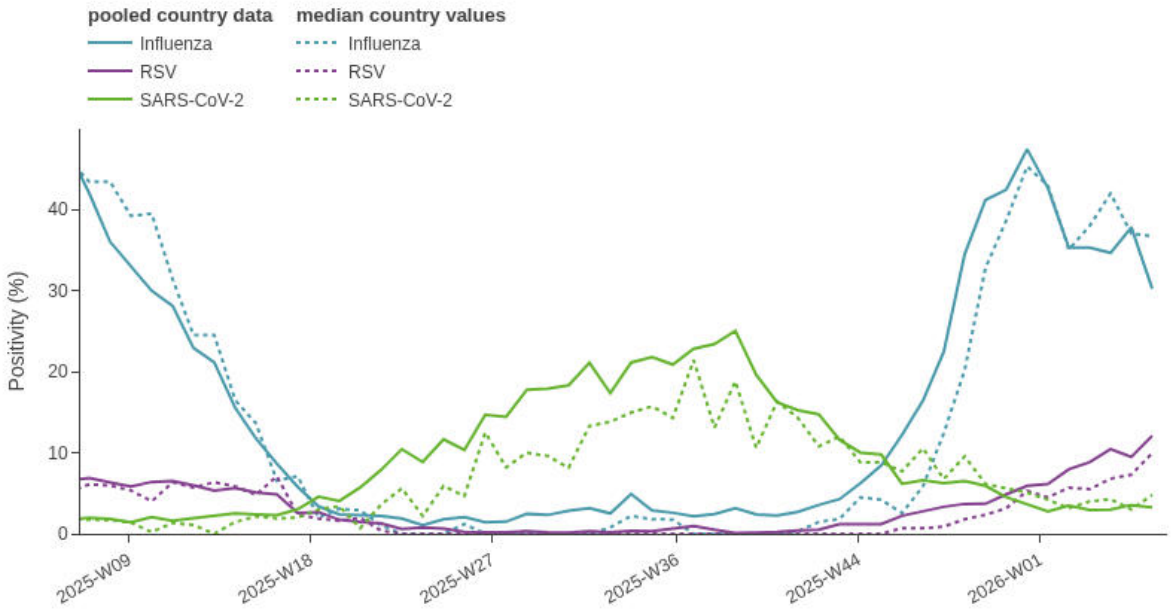
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

Last time this event was included in the Weekly CDTR: 6 February 2026

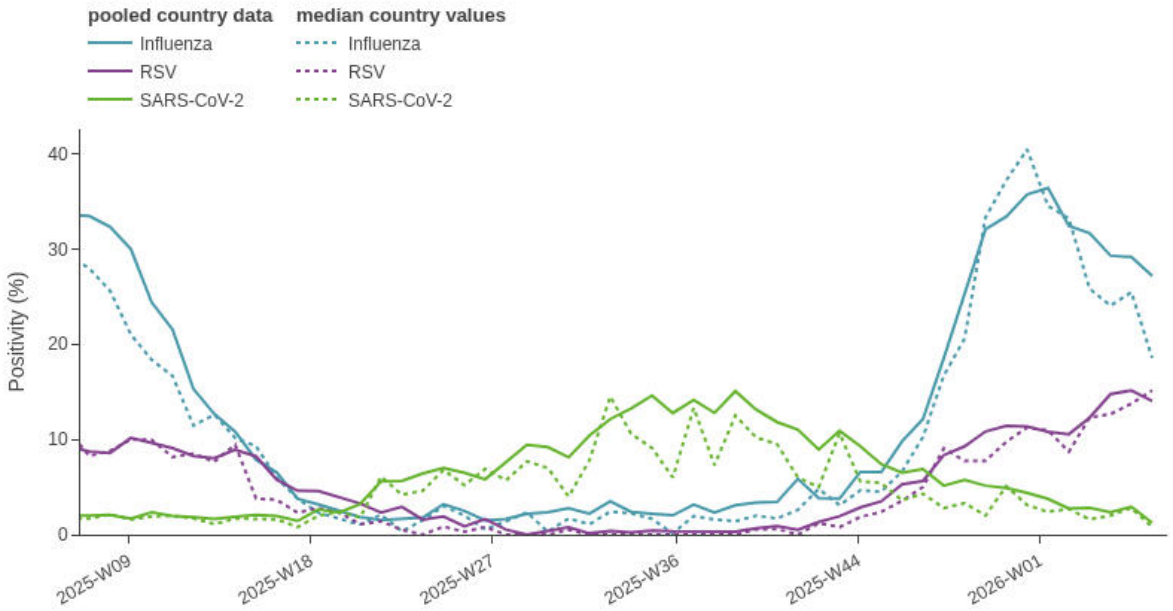
Maps and graphs

Figure 3. ILI/ARI virological surveillance in primary care – weekly test positivity



Source: ECDC

Figure 4. SARI virological surveillance in hospitals – weekly test positivity



Source: ECDC

Figure 5. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 6	Week 5	Description	Value
ILI/ARI consultation rates in primary care	ARI	16 rates (10 MEM)	18 rates (10 MEM)	Distribution of country MEM categories	6 Baseline 3 Low 1 Medium
	ILI	20 rates (18 MEM)	21 rates (19 MEM)		5 Baseline 5 Low 7 Medium 1 High
ILI/ARI test positivity in primary care	Influenza	18	21	Pooled (median; IQR)	30% (37; 21–52%)
	RSV	18	20		12% (9.9; 5.7–14%)
	SARS-CoV-2	16	19		3.3% (4.8; 1.4–7.6%)
SARI rates in hospitals	SARI	10 rates (5 MEM)	12 rates (6 MEM)	Distribution of country MEM categories	4 Baseline 1 Low
SARI test positivity in hospitals	Influenza	9	11	Pooled (median; IQR)	27% (19; 8–37%)
	RSV	10	12		14% (15; 11–25%)
	SARS-CoV-2	9	10		1.2% (0.8; 0–1.6%)
Intensity (country-defined)	Influenza	22	24	Distribution of country qualitative categories	3 Baseline 5 Low 10 Medium 3 High 1 Very high
Geographic spread (country-defined)	Influenza	21	23	Distribution of country qualitative categories	1 Sporadic 3 Regional 17 Widespread

Source: ECDC

Figure 6. ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution

	Week 6, 2026		Week 40, 2025 – week 6, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**753**	**–**	**15275**	**–**
Influenza A	731	99	14743	100
A(H1)pdm09	161	31	3128	26
A(H3)	354	69	9017	74
A (unknown)	216	–	2598	–
Influenza B	4	0.5	65	0.4
B/Vic	1	100	15	100
B (unknown)	3	–	50	–
Influenza untyped	18	–	467	–
RSV	**259**	**–**	**2543**	**–**
RSV-A	22	37	449	50
RSV-B	38	63	450	50
RSV untyped	199	–	1644	–
SARS-CoV-2	**68**	**–**	**3454**	**–**

Source: ECDC

Figure 7. SARI virological surveillance in hospitals – pathogen type and subtype distribution

	Week 6, 2026		Week 40, 2025 – week 6, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**537**	**–**	**11116**	**–**
Influenza A	109	100	6903	99
A(H1)pdm09	9	41	1037	36
A(H3)	13	59	1841	64
A (unknown)	87	–	4025	–
Influenza B	0	0.0	41	0.6
B/Vic	0	–	4	100
B (unknown)	0	–	37	–
Influenza untyped	428	–	4172	–
RSV	**272**	**–**	**3543**	**–**
RSV-A	29	54	811	55
RSV-B	25	46	654	45
RSV untyped	218	–	2078	–
SARS-CoV-2	**23**	**–**	**2386**	**–**

Source: ECDC

Figure 8. **Genetically characterised influenza virus distribution, week 40, 2025 – week 6, 2026**

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	1822	42	5a.2a.1(D.3.1)	1790	98
			5a.2a.1(D)	26	1
			5a.2a(C.1.9.3)	6	0.3
A(H3)	2540	58	2a.3a.1(K)	2293	90
			2a.3a.1(J.2)	176	7
			2a.3a.1(J.2.4)	34	1
			2a.3a.1(J.2.2)	24	0.9
			2a.3a.1(J)	13	0.5
B/Vic	19	0.4	V1A.3a.2(C.5.6)	9	47
			V1A.3a.2(C.5.6.1)	4	21
			V1A.3a.2(C.5.1)	3	16
			V1A.3a.2(C.5)	2	11
			V1A.3a.2(C.5.7)	1	5

Source: ECDC

Figure 9. **SARS-CoV-2 variant distribution, week 4, 2026 - week 5, 2026**

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	1	1	4% (2–6%)
NB.1.8.1	VUM	2	13	52% (40–63%)
XFG	VUM	2	12	44% (30–58%)
BA.3.2	VUM	0	0	0%

Source: ECDC

6. Rapid Outbreak Assessment under production

Overview:

ECDC, jointly with EFSA, is developing a Rapid Outbreak Assessment "Multi-country food-borne incident caused by cereulide linked to infant formula products". The expected publication date is 19 February 2025.

Last time this event was included in the Weekly CDTR: 6 February 2026

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

Overview:

Monthly update overview

Since the start of 2026, and as of 31 January 2026 (data collection period 2–6 February, data available until 31 January), 2 881 Chikungunya virus disease (CHIKVD) cases and no associated deaths have been detected from 11 countries (not including EU/EEA countries and territories).

New countries reporting cases

Seychelles and Suriname have reported CHIKVD cases for the first time in January 2026.

Epidemiological overview

In 2026, 11 countries have ongoing CHIKV outbreaks. Of these, the majority are in the Americas and Africa. Below is a description of ongoing outbreaks:

Americas

In 2026, there have been 2 879 CHIKVD cases and one associated death reported in the region. The most affected subcontinental region is South America, with Brazil reporting the highest number of cases in 2026.

Argentina: CHIKVD cases are reported throughout the year in the country. Since the start of the year and as of epidemiological week 4 (25–31 January), there are no confirmed autochthonous cases reported in the country, with all confirmed cases related to travel outside of Argentina. Most of these cases have been reported from Buenos Aires and Cordoba jurisdictions.

Bolivia: CHIKVD cases have been increasing since the start of 2026 and have been reported in seven of nine departments: Santa Cruz, Beni, Pando, Chuquisaca, Cochabamba, Chuquisaca, and Tarija. These departments are located in eastern Bolivia, in the Andean region. Santa Cruz continues to be the most affected department, reporting most of the CHIKVD cases in Bolivia, as well as all CHIKVD associated deaths. Guillain-Barre syndrome cases associated to CHIKVD were reported in Bolivia in 2025.

Brazil: CHIKVD cases continue to be reported in all regions (Centro-Oeste, Nordeste, Norte, Sudeste and Sul) and in most federal units of the country. The Centro-Oeste, Nordeste and Sudeste regions account for the highest number of cases in the last four epidemiological weeks (weeks 1–4), where Mato Grosso Do Sul, Minas Gerais and Sao Paulo are the most affected federal units. Since the start of 2026, CHIKVD cases have continuously increased until epidemiological week 3, showing a decline in epidemiological week 4 when compared with the previous week. This year, most of the cases have been reported among women (57%), and the 20–29 years old age group is most affected.

Costa Rica: In 2026, two CHIKVD cases have been reported from Puntarenas city, Esparza region. Early epidemiological investigations suggest that these two cases might be epidemiologically linked, and could have been infected during the same time period. No further CHIKVD cases have been reported in other regions of Costa Rica in 2026.

El Salvador: In 2026, one suspected CHIKVD case has been reported in the country. Currently, the case is awaiting laboratory confirmation. This suspected case was detected in a context where other suspected cases of arboviruses, such as dengue, are showing a declining trend since the start of the year.

Honduras: In 2026, one CHIKVD case has been reported in the country. Chikungunya cases are sporadically reported in the country, and in 2025 there were a total of 12 cases reported.

Mexico: In 2026 and as of epidemiological week 4, locally acquired CHIKVD cases have been reported in the country from Chiapas and Quintana Roo. In 2025, CHIKVD cases were reported from Chiapas, Quintana Roo and Yucatan. No deaths have been reported in 2025. In 2024, no CHIKVD cases were reported, while in 2023 two cases were reported from Baja California Sur and Chiapas.

Suriname: In 2026, CHIKVD cases have been reported in the country. The cases occurred in the regions of Paramaribo, Nickerie, Wanica and Commewijne. In Suriname, in week 51 of 2025, the first autochthonous case of CHIKVD was reported since 2016. Between week 51 2025 and week 4 2026, a total of 712 suspected cases were reported, of which 327 were laboratory confirmed, including one death. The rainy season is still ongoing, and it is expected that cases will continue to be reported in the coming weeks.

United States (US): In December 2025, one CHIKVD case has been reported in the Miami-Dade County, Florida. Most CHIKVD cases reported in the US are travel associated, with very few locally acquired cases reported.

Asia

In 2026, one CHIKVD case and no associated deaths have been reported in the region. The most affected subcontinental region is Southeast Asia, with Pakistan being the only country reporting cases in 2026.

Pakistan: One CHIKVD case has been reported in the country in 2026. The case was reported in the Sindh region. CHIKVD cases are reported throughout the year in Pakistan, concentrated in the Baluchistan, Khyber Pakhtunkhwa and Sindh provinces. These provinces are located in the southwest of the country. In 2025, the highest number of CHIKVD cases were reported from Sindh, a province bordering with India.

Africa

In 2026, an unconfirmed number of CHIKVD cases and no associated deaths have been reported in the region. The most affected subcontinental region is East Africa, with Seychelles being the only country reporting cases in 2026.

Seychelles: In 2026, an unconfirmed number of CHIKVD cases have been reported in the archipelago. According to local health authorities, CHIKV has become more prevalent in the country when compared with other arboviruses. It is expected that CHIKVD cases will continue to be reported in the country. ECDC is aware of a number of reports in EU/EEA countries of imported cases linked to travel to the Seychelles since December 2025.

Europe

For CHIKVD cases reported in mainland EU/EEA, please refer to the dedicated ECDC website.

CHIKVD cases have been reported from the French outermost regions of French Guiana (4), Mayotte (44) and Réunion (8).
In French Guiana, these are the first autochthonous cases reported since 2015. In Mayotte, a recent increase in case numbers has been reported since week 3 of 2026.

Global overview

In 2026, there have been 2 882 CHIKVD cases and one associated death reported worldwide. Cases have decreased when compared with the same period in 2025.

Note

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

ECDC assessment:

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

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

More information on autochthonous transmission of chikungunya virus in 2025 in the EU/EEA is available on ECDC's website, and in ECDC's factsheets on CHIKVD.

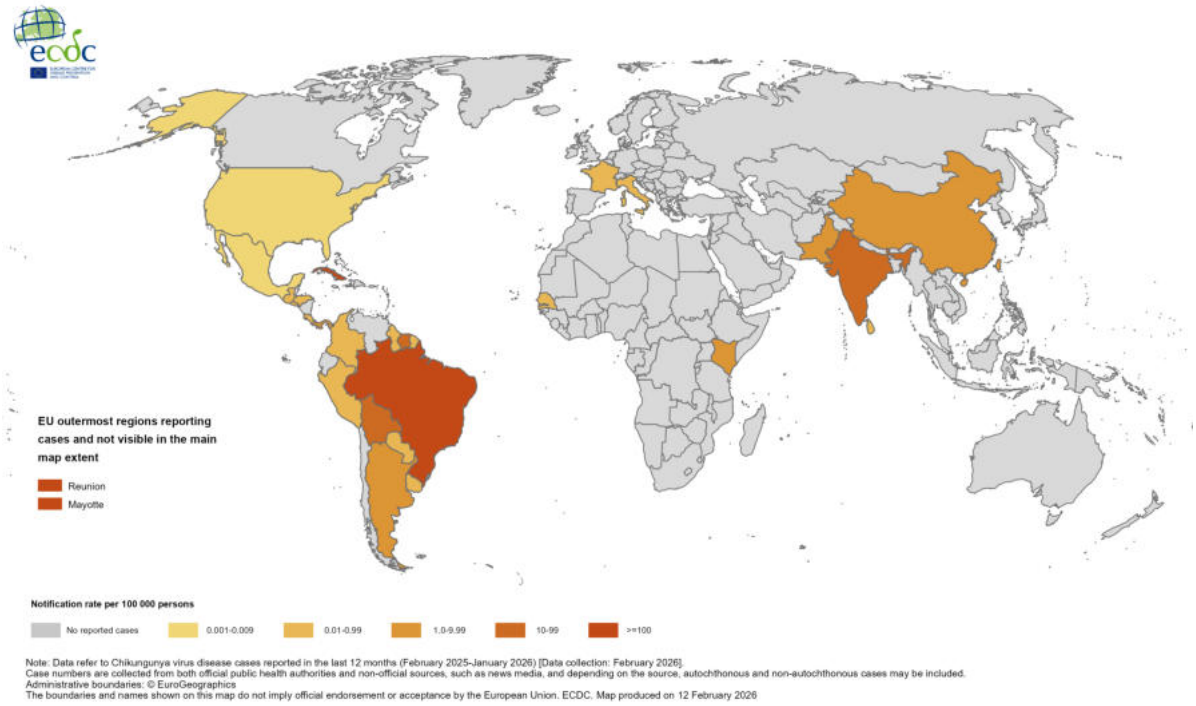
Actions:

ECDC monitors these threats through its epidemic intelligence activities and reports on these on a monthly basis. A summary of the worldwide overview of CHIKVD is available on ECDC's website.

Last time this event was included in the Weekly CDTR: 19 December 2025

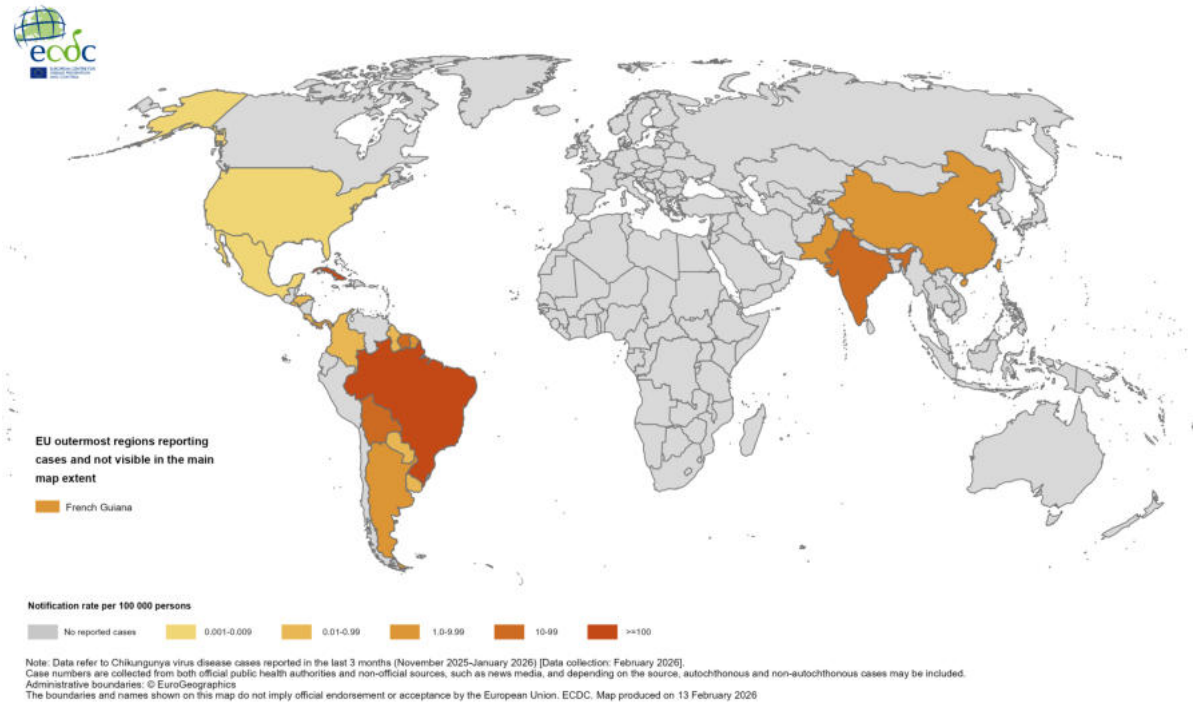
Maps and graphs

Figure 10. Twelve-month Chikungunya virus disease case notification rate per 100 000 population, February 2025 to January 2026



Source: ECDC

Figure 11. Three-month Chikungunya virus disease case notification rate per 100 000 population, November 2025 to January 2026



Source: ECDC

8. Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

Overview:

Summary

Since the previous update and as of 12 February, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic Games.

Background

The Winter Olympic Games Milano Cortina 2026 are taking place between 4–22 February 2026. The competitions will start on 4 February, with the Opening Ceremony on 6 February at San Siro Stadium, Milan and the Closing Ceremony on 22 February at Verona Arena. The Games will be spread across Northern Italy, primarily in Milan and Cortina d'Ampezzo, with additional clusters in Valtellina, Val di Fiemme, and Anterselva/Antholz. More than 2 900 athletes are expected and participants are expected from over 90 countries. Organisers anticipate hundreds of thousands of spectators across venues. Exact numbers are not finalised but are expected to surpass one million cumulative attendees based on previous Winter Games trends.

The Paralympic Winter Games will take place from 6–15 March 2026 with more than 600 athletes competing. The Opening Ceremony will take place at Verona's Olympic Arena. Milano will host the Para ice hockey tournament. Wheelchair curling, Para Alpine skiing, Para snowboard competitions and the Closing Ceremony will be hosted in Cortina, and Val di Fiemme will host the Para cross-country skiing and biathlon.

ECDC assessment:

Mass gathering events involve a large number of visitors in one area at the same time. Multiple factors can lead to the emergence of a public health threat, such as an imported disease, increased numbers of susceptible people, risk behaviour, sale of food and beverages by street vendors, etc. At the same time, non-communicable health risks, including crowd or extreme weather-related injuries and drug- and alcohol-related conditions, should also be considered by the organisers and the public health authorities of the hosting country.

The Winter Olympic and Paralympic Games 2026 is a mass gathering that comprises multiple events in different event locations that take place from February to March. The general assessment provided below refers to the probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games. However, if specific public health events with potential impact at local, national and EU/EEA levels are identified, they will be assessed separately.

The probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games 2026 is low, if general preventive measures are applied, e.g. being fully vaccinated according to national immunisation schedules, following advice regarding hand and food hygiene and respiratory etiquette, self-isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, seeking prompt testing and medical advice as needed, and practising safe sex. This is particularly important in relation to vaccine-preventable diseases that may be on the rise in the EU/EEA, such as measles, whooping cough and respiratory infections including influenza and COVID-19. In view of the earlier start of the influenza season 2025/26 in November 2025, ECDC urges those eligible for vaccination to get vaccinated without delay.

Actions:

ECDC is monitoring this mass gathering event through epidemic intelligence activities through a close collaboration with the Italian National Institute of Health (Istituto Superiore di Sanita') and other partners. Updates with relevant signals and events are being provided on a weekly basis.

Last time this event was included in the Weekly CDTR: 6 February 2026

9. Nipah virus disease – India and Bangladesh – 2026

Overview:

Update:

Bangladesh: On 6 February 2026, WHO posted a Disease Outbreak News (DON) item about a confirmed death due to NiV infection that occurred in Rajshahi Division, northwestern Bangladesh. The patient was a woman in her forties residing in Naogaon District, Rajshahi Division. She developed symptoms compatible with NiV infection on 21 January, beginning with fever, headache, muscle cramps, anorexia, weakness and vomiting, which progressed to hypersalivation, disorientation and convulsions. She became unconscious on 27 January and was referred to a tertiary hospital, where she was admitted on 28 January; samples were collected on admission and she died later the same day.

The patient had repeatedly consumed raw date palm sap between 5–20 January, considered the likely exposure source. An outbreak investigation involving One Health partners began on 30 January. Investigators identified 35 contacts, and six symptomatic contacts were sampled; all tested negative for NiV by PCR and IgM ELISA. As of 3 February, no additional cases have been detected, and all contacts remain under monitoring.

Summary:

India: According to the National IHR Focal Point for India reporting to the World Health Organization (WHO) on 26 January 2026, there have been two confirmed cases of NiV reported in the state of West Bengal, India. A total of 196 contacts of the confirmed cases were identified and tested negative for NiV. No additional cases have been reported as of 27 January 2026, according to the Indian Ministry of Health.

Several media outlets, quoting India's health authorities, have reported five NiV disease cases in the same outbreak in healthcare workers at the same hospital, in the district of North 24 Parganas, in the West Bengal State, India.

Both individuals are between the ages of 20 and 30 years old, one male and one female, working as nurses at the same private hospital in Barasat, located in North 24 Parganas district, West Bengal State. Both of them developed symptoms typical of severe NiV infection in late December 2025 and were admitted to hospital in early January 2026. As of 21 January 2026, the second individual showed clinical improvement, while the first remained under critical care.

The cases were identified as suspected NiV infections in preliminary testing and were confirmed at the National Institute for Virology in Pune, on 13 January 2026. They were laboratory confirmed using Real-Time Polymerase Chain Reaction (RT-PCR) and Enzyme-Linked Immunosorbent Assay (ELISA) testing.

On 30 January 2025, WHO reported that investgations into the source of exposure are ongoing. According to media reporting, both individuals had attended to a patient with NiV-like symptoms at the hospital they worked at, although this has not been reported through official sources. Furthermore, one of two nurses recently travelled to a village in Nadia district, close to the Bangladesh border and might have consumed raw date palm sap, according to media reports. This information on possible exposure has not been reported in official sources.

Following confirmation of the two cases, the Government of India, working closely with the Government of West Bengal, implemented comprehensive public health measures in line with established protocols, according to the MoHFW. Enhanced surveillance, laboratory testing, and field investigations were carried out through coordinated action by Central and State health agencies.

In West Bengal, previous outbreaks occurred in 2001 (Siliguri) and 2007 (Nadia district). In 2025, a total of four NiV disease cases have been reported in India from the Palakkad (2) and Malappuram (2) districts. Of these, two have died, both from the Palakkad district.

Thailand, Nepal, Cambodia, and other neighbouring countries have initiated measures including information campaigns and screening for passengers arriving from India at airports.

Background:

Nipah virus (Henipavirus nipahense) is a highly pathogenic virus of the family Paramyxoviridae, genus Henipavirus. It was first isolated and identified in 1999 during an outbreak in Malaysia and Singapore. Since then, several outbreaks of NiV disease in Southern and South East Asia have been reported, with most cases in Bangladesh.

The virus spreads between animals and humans, with most human cases having had direct contact with pigs or bats. NiV can also be transmitted between people through direct contact or indirectly via contaminated food (e.g. date palm sap contaminated by bat saliva) or through aerosols. The incubation period is usually 4 to 14 days. Symptoms range from mild (fever, headache, muscle pain and nausea) to more serious, including severe respiratory symptoms and encephalitis.

For more information on the disease and its epidemiology, please read ECDC's factsheet about Nipah virus Disease.

ECDC assessment:

Although the disease is severe and has a high fatality rate, the likelihood of exposure to and infection with NiV for EU/EEA citizens travelling to or residing in India or Bangladesh is currently very low, given the low number of infections in the affected areas in which cases have been identified to date.

The most likely route for the virus to be introduced into the EU/EEA would be via infected travellers. While importation of the virus cannot be excluded, its likelihood is currently very low. Although the virus can be transmitted through direct contact with infected wild or domesticated animals, because the natural hosts are not present in Europe, the likelihood of the virus spreading in the current context within the EU/EEA after importation is considered to be very low.

As a general precaution, EU/EEA travellers and residents visiting or living in the affected areas should not handle domestic or wild animals and avoid contact with their excreta. The virus may be present on food items contaminated by bats. Washing, peeling, and cooking fruit and vegetables before consumption is generally recommended. Raw date palm sap (juice) should not be consumed.

Actions:

ECDC is monitoring this event through its epidemic intelligence activities.

Sources: ECDC press release published 29 January 2026: Nipah virus disease cases reported in West Bengal, India: very low risk for Europeans | DON

Last time this event was included in the Weekly CDTR: 6 February 2026

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 30 January 2026
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 30 January 2026
- Bacillus cereus toxin in infant formula - last reported on 30 January 2026
- Nipah virus disease – India and Bangladesh – 2026 - last reported on 30 January 2026
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 23 January 2026
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 16 January 2026
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2025 - last reported on 16 January 2026
- Rapid Outbreak Assessment under production - last reported on 13 February 2026
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 13 February 2026
- Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026 - last reported on 13 February 2026
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 13 February 2026
- Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases - last reported on 13 February 2026
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026 - last reported on 06 February 2026
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 06 February 2026
- SARS-CoV-2 variant classification - last reported on 06 February 2026