WEEKLY BULLETIN

Communicable disease threats report

Week 2, 3 - 9 January 2026

This week's topics

Executive summary

Overview of respiratory virus epidemiology in the EU/EEA, week 01, 2026

The number of patients presenting to primary care with symptoms of respiratory illness is elevated in most reporting countries. This indicates that there is currently significant respiratory virus circulation in the European Union/European Economic Area (EU/EEA).

Influenza virus circulation continues to increase in most countries in the EU/EEA, although for some countries, the peak appears to have passed. Influenza A(H3N2) remains the dominant subtype at the EU/EEA level, but A(H1N1)pdm09 is also being detected. All age groups are affected. Increases in hospitalisation are observed in many countries, primarily in adults aged 65 years and above.

Early estimates of seasonal influenza vaccine effectiveness in the EU/EEA for the season 2025-2026 were published by ECDC on 19 December 2025, and match those published for A(H3N2) viruses by the United-Kingdom and Canada.

Respiratory syncytial virus (RSV) circulation continues to slowly increase in several countries. Hospital data show rising RSV-related admissions in a few countries, primarily among children under five years of age. At EU/EEA level, RSV-related hospitalisations are at levels below those observed at this time in the past four seasons.

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

SARS-CoV-2 circulation continues to decrease in all age groups, and the impact on hospitalisations is currently limited.

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'.

Marburg virus disease (MVD) - Ethiopia - 2025/26

- Since the CDTR update on 19 December 2025, there has been no additional confirmed cases and no additional deaths of Marburg Virus Disease (MVD) reported in Ethiopia.
- Since the start of the outbreak, and as of 5 January 2026, 17 cases (14 confirmed and three probable) of MVD have been reported, including 12 deaths (nine confirmed and three probable (case fatality rate (CFR): 64.3%)).
- Two areas have been affected across two regions; Jinka town, South Ethiopia Regional State and Hawassa City, Sidama Region.
- The total number of contacts who were monitored is 886, according to a press release from the Ethiopian Ministry of Health on 5 January 2026.
- As of 5 January 2026, there has been no new cases of MVD and no contacts have been monitored for 21 days. The outbreak will be declared over 42 days after the last Marburg patient tests negative and is discharged.
- This is the first MVD outbreak ever reported in Ethiopia.
- The likelihood of exposure to MVD for EU/EEA citizens visiting or living in Ethiopia is assessed as low, with uncertainties connected to the limited epidemiological information available. The impact at population level is assessed to be low as it is not expected that there will be significant numbers of MVD cases among EU/EEA citizens in Ethiopia. Therefore, the overall risk for EU/EEA citizens visiting or living in Ethiopia is low.
- In the event of MVD cases being imported into the EU/EEA, we consider the likelihood of further transmission to be very low, and the associated impact low. Therefore, the overall risk for the EU/EEA is assessed as low.

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

- Since 1 January 2025 and as of 24 December 2025, 601 845 cholera cases, including 7 671 deaths, have been reported worldwide.
- Since 24 November 2025 and as of 24 December 2025, 30 611 new cholera cases, including 275 new deaths have been reported worldwide.
- The five countries reporting most cases are Democratic Republic of the Congo (8 374), Afghanistan (7 942), Yemen (7 820), South Sudan (1 599) and Angola (1 398). The five countries reporting most new deaths are the Democratic Republic of the Congo (192), Mozambique (20), Angola (15), Yemen (13) and Nigeria (9).
- In 2025, cholera cases have continued to be reported in Africa and Asia, the Middle East and the Americas. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

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

- Since the previous update on 10 December 2025, and as of 5 January 2026, five new MERS cases (including one fatality) have been reported in Saudi Arabia.
- Since the beginning of 2025, and as of 5 January 2026, 19 MERS cases (including four fatalities) have been reported with date of onset in 2025. Among these, 17 cases (including four fatalities) were reported in Saudi Arabia, and two imported cases were reported in France.
- The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in the general population is also considered to be low. The current MERS-CoV situation poses a low risk to the EU/EEA.

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

- Since the beginning of November and as of 19 December 2025, WHO reported seven new cases of human infection with avian influenza A(H9N2), all in China.
- The cases had onset of symptoms in September (n=1), October (n=3) and November (n=3) 2025.
- Five cases were in children and two were in adults.
- Five individuals had mild disease. Two elderly persons were hospitalised, one of whom had underlying conditions and was hospitalised with severe pneumonia.
- All but one had exposure to birds (backyard poultry or live poultry market). Investigations are ongoing for one case.
- No new cases have been reported among contacts of these cases.

- Overall, 190 human cases, including two deaths, of avian influenza A(H9N2) have been reported since 1998 from 10 countries. Since 2015, China has reported 149 human cases of avian influenza A(H9N2) virus infection to WHO, including two deaths (case fatality rate (CFR): 1.4%).
- The risk to human health in the EU/EEA is currently considered very low.

Human cases of swine influenza A(H1N1) virus variant - Multi-country - 2024

- On 19 December 2025, WHO reported a human case with Eurasian avian-like swine influenza A(H1N1) variant virus infection in China.
- The patient who is in his sixties was hospitalised, though reported as having a mild disease.
- Exposure to backyard pigs was reported.

1. 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.

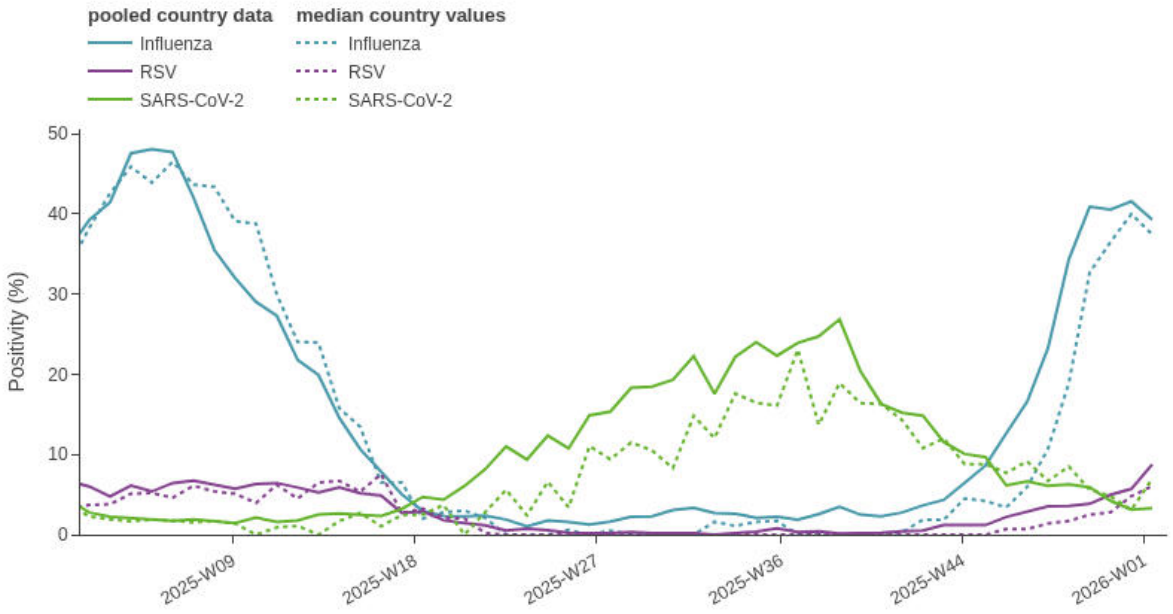
Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

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

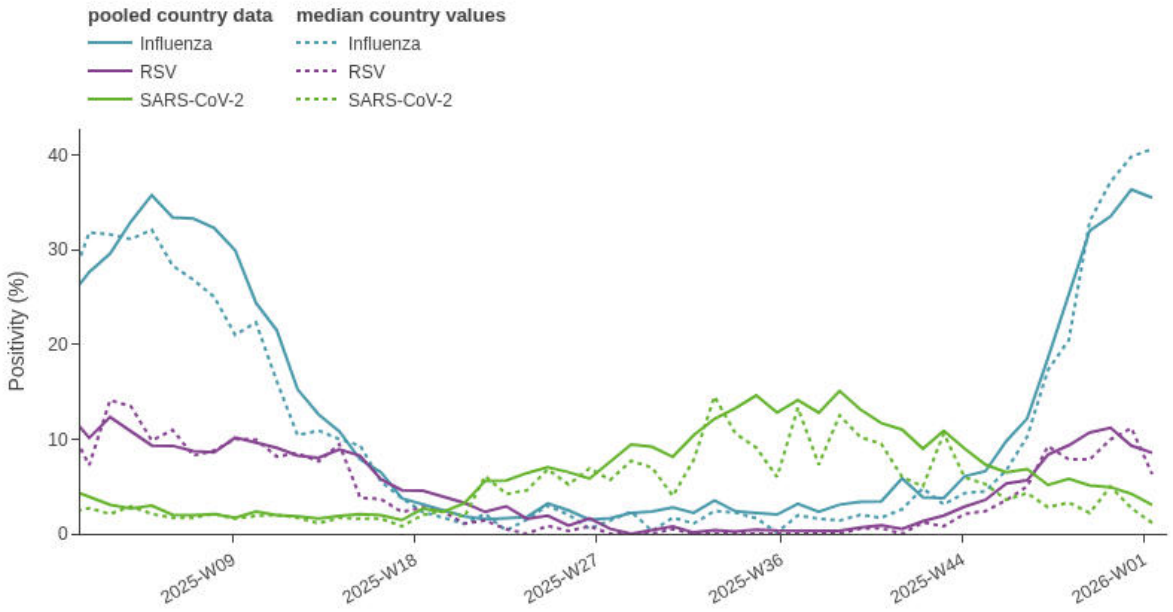
Maps and graphs

Figure 1. ILI/ARI virological surveillance in primary care - weekly test positivity



Source: ECDC

Figure 2. SARI virological surveillance in hospitals - weekly test positivity



Source: ECDC

Figure 3. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	Syndrome or pathogen	Week 1	Week 52	Description	Value
ILI/ARI consultation rates in primary care	ARI	16 rates (9 MEM)	17 rates (10 MEM)	Distribution of country MEM categories	8 Baseline 1 Low
	ILI	18 rates (18 MEM)	19 rates (19 MEM)		6 Baseline 4 Low 8 Medium
ILI/ARI test positivity in primary care	Influenza	15	17	Pooled (median; IQR)	39% (37; 30–48%)
	RSV	15	18		8.8% (6; 4.1–11%)
	SARS-CoV-2	15	18		3.3% (7; 0.8–7.4%)
SARI rates in hospitals	SARI	9	12	–	–
SARI test positivity in hospitals	Influenza	8	10	Pooled (median; IQR)	35% (41; 28–46%)
	RSV	8	11		8.5% (6.3; 2.9–15%)
	SARS-CoV-2	9	10		3% (1.1; 0–2.2%)
Intensity (country-defined)	Influenza	22	22	Distribution of country qualitative categories	2 Baseline 5 Low 9 Medium 5 High 1 Very high
Geographic spread (country-defined)	Influenza	21	22	Distribution of country qualitative categories	3 Sporadic 1 Regional 17 Widespread

Source: ECDC

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

	Week 1, 2026		Week 40, 2025 – week 1, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**326**	**–**	**8013**	**–**
Influenza A	326	100	7897	100
A(H1)pdm09	46	21	1601	24
A(H3)	170	79	5120	76
A (unknown)	110	–	1176	–
Influenza B	0	0.0	30	0.4
B/Vic	0	–	4	100
B (unknown)	0	–	26	–
Influenza untyped	0	–	86	–
RSV	**72**	**–**	**983**	**–**
RSV-A	12	60	247	62
RSV-B	8	40	153	38
RSV untyped	52	–	583	–
SARS-CoV-2	**27**	**–**	**2861**	**–**

Source: ECDC

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

	Week 1, 2026		Week 40, 2025 – week 1, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**844**	**–**	**5785**	**–**
Influenza A	482	99	4045	99
A(H1)pdm09	25	36	438	34
A(H3)	45	64	862	66
A (unknown)	412	–	2745	–
Influenza B	5	1	33	0.8
B/Vic	0	–	3	100
B (unknown)	5	–	30	–
Influenza untyped	357	–	1707	–
RSV	**157**	**–**	**1537**	**–**
RSV-A	14	45	390	60
RSV-B	17	55	257	40
RSV untyped	126	–	890	–
SARS-CoV-2	**71**	**–**	**1932**	**–**

Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, week 40, 2025 – week 1, 2026

Subtype distribution			Subclade distribution		
Subtype	**N**	**%**	**Subclade**	**N**	**%**
A(H1)pdm09	905	55	5a.2a.1(D.3.1)	895	99
			5a.2a(C.1.9.3)	5	0.6
			5a.2a.1(D)	5	0.6
A(H3)	736	45	2a.3a.1(K)	672	91
			2a.3a.1(J.2)	33	4
			2a.3a.1(J.2.4)	16	2
			2a.3a.1(J.2.2)	15	2
B/Vic	5	0.3	V1A.3a.2(C.5.6)	3	60
			V1A.3a.2(C.5)	1	20
			V1A.3a.2(C.5.1)	1	20

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, week 29, 2022 - week 30, 2022

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	0	0	0%
XFG	VUM	1	11	85% (85–85%)
NB.1.8.1	VUM	1	1	8% (8–8%)

Source: ECDC

2. Marburg virus disease (MVD) - Ethiopia - 2025/26

Overview:

Update
Since the CDTR update on 19 December 2025, and as of 5 January 2026, there have been no additional confirmed cases of Marburg Virus Disease (MVD) reported in Ethiopia. The most recent confirmed case was reported on 12 December 2025. According to a press release published by the MoH on January 5 2026, there has been no new cases of MVD and no contacts being monitored for 21 days. In alignment with the WHO and Ethiopian Marburg Disease Surveillance and Response Guidelines, the outbreak will be declared over 42 days after the last Marburg patient tests negative and is discharged.

Summary
Since the outbreak was confirmed on 14 November 2025, and as of 5 January 2026, 17 cases (14 laboratory confirmed and three probable) of Marburg Virus Disease (MVD) have been reported in Ethiopia, according to the Ministry of Health. A total of 12 deaths have been reported, nine of which were in laboratory-confirmed cases and three in probable cases (case fatality rate (CFR) among confirmed cases: 64.3%), as of 5 January 2026. According to media quoting health officials, the deaths include two healthcare workers.

According to an Africa CDC press briefing, as of 16 December, two areas have been affected across two regions; Jinka town, South Ethiopia Regional State and Hawassa City, Sidama Region. According to media quoting the Ethiopian Ministry of Health on 27 November, one of the cases was confirmed in Hawassa City, Sidama Region, after returning from Jinka town. Jinka town is considered to be the epicentre of the outbreak, according to Africa CDC.

Cases have presented with symptoms including sudden fever, muscle pain, severe fatigue, headache, diarrhoea, vomiting and, in later stages, unexplained bleeding. As of 5 January 2026, a total of five cases have recovered and none are currently in treatment, according to the Ministry of Health.

According to a press release from the Ethiopian Ministry of Health on 5 January 2026, a total of 886 contacts were monitored and preventative treatment provided.

On 8 December 2025, the Ethiopian Ministry of Health reported that a vaccine trial had begun in the two affected regions; South Ethiopia Regional State and Sidama region. According to an Africa CDC press briefing on 11 December, 2 500 doses of the cAd3-Marburg vaccine have been provided and are being offered to healthcare professionals and contacts of cases. The use of monoclonal antibody treatment has been implemented.

According to WHO, the virus strain shows similarities to those previously identified in East Africa.

In response to the outbreak, the Ministry of Health of Ethiopia reported that community-level monitoring, contact tracing, and house-to-house case finding were being intensified. Response efforts to this event are underway by international partners.South Sudan, Kenya and Somalia have intensified their preparedness efforts, according to a Africa CDC press briefing on 18 December.

Background and additional information

On 14 November 2025, the Ministry of Health of Ethiopia confirmed an MVD outbreak in Jinka city, South Ethiopia Regional State, and reported that there were 17 suspected cases. Jinka is in south-west Ethiopia, which is close to the border with South Sudan and Kenya. Jinka is a small market town with about 30 000 inhabitants. It is two days away from Addis Ababa. A small airport has recently been inaugurated there.

MVD is a severe disease in humans caused by Marburg marburgvirus (MARV). A case fatality ratio of up to 88% has been observed previously. MVD is not an airborne disease and is not considered contagious before symptoms appear. Direct contact with the blood and other bodily fluids of a person or animal with the infection is the most frequent route of transmission. The incubation period for MVD is usually five to ten days (range 3–21 days). If proper infection prevention and control measures are strictly adhered to, the likelihood of infection is considered very low. To date, there is no specific antiviral treatment and no approved vaccine for MVD.

All recorded MVD outbreaks have originated in Africa. Since 1967, when MVD was first detected, approximately 600 MVD cases have been reported as a result of outbreaks in Angola, the Democratic Republic of the Congo, Ghana, Guinea, Equatorial Guinea, Kenya, South Africa, Tanzania, and Uganda. In 2024, Rwanda reported its first MVD outbreak (66 cases including 15 deaths) which was declared over on 20 December 2024. In 2025, Tanzania reported its second MVD outbreak (two confirmed and eight probable cases, all fatal).

More information on MVD can be found in the ECDC Factsheet on Marburg virus disease.

ECDC assessment:

The likelihood of exposure to MVD for EU/EEA citizens visiting or living in Ethiopia is assessed as low, with uncertainties connected to the limited epidemiological information available. The impact at population level is assessed to be low as it is not expected that there will be significant numbers of MVD cases among EU/EEA citizens in Ethiopia. Therefore, the overall risk for EU/EEA citizens visiting or living in Ethiopia is low.

In the event of MVD cases being imported into the EU/EEA, we consider the likelihood of further transmission to be very low, and the associated impact low. Therefore, the overall risk for the EU/EEA is assessed as low.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities and is in contact with partners to gather additional information.

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

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

Overview:

Data presented in this report originate from several sources, both official public health authorities and non-official sources, such as the media. Case definitions, testing strategies, and surveillance systems vary between countries. In addition, data completeness and levels of under-reporting vary between countries. All data should therefore be interpreted with caution. For details on the epidemiological situation and more information regarding the case definitions in use, refer to the original sources.

Update

Since 24 November 2025 and as of 24 December 2025, 30 611 new cholera cases, including 275 new deaths, have been reported worldwide:

New cases have been reported from Afghanistan, Angola, Burundi, Cameroon, Chad, Congo, Democratic Republic of The Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Myanmar/Burma, Namibia, Nigeria, Somalia, South Sudan, Sudan, Yemen, Zambia and Zimbabwe. These countries had all previously reported cholera cases during 2025.

The five countries reporting most cases are Democratic Republic of The Congo (8 374), Afghanistan (7 942), Yemen (7820), South Sudan (1 599) and Angola (1 398).

New deaths have been reported from Afghanistan, Angola, Burundi, Chad, Congo, Democratic Republic of The Congo, Ethiopia, Mozambique, Namibia, Nigeria, South Sudan, Sudan, Yemen, Zambia and Zimbabwe.

The five countries reporting most new deaths are Democratic Republic of The Congo (192), Mozambique (20), Angola (15), Yemen (13) and Nigeria (9).

In the previous reporting period (29 October 2025 to 25 November 2025), there were 15 394 new cholera cases, including 194 new deaths, reported worldwide.

In addition, 30 905 new cases were reported or collected retrospectively from before the last update on 24 November 2025.

Since 1 January 2025 and as of 24 December 2025, 601 845 cholera cases, including 7 671 deaths, have been reported worldwide. In comparison, since 01 January 2024 and as of 24 December 2024, 733 355 cholera cases, including 4 834 deaths, were reported worldwide.

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

Asia:

Afghanistan:Since 10 November 2025 and as of 8 December 2025, 7 942 new cases, including five new deaths have been reported. Since 1 January 2025 and as of 8 December 2025, 161 791 cases, including 79 deaths have been reported. In comparison, in 2024 and as of 9 November 2024, 160 794 cases, including 80 deaths were reported.

Myanmar/Burma:
Since 3 November 2025 and as of 8 December 2025, 77 new cases have been reported. Since 1 January 2025 and as of 8 December 2025, 2 378 cases have been reported. In comparison, in 2024 and as of 11 November 2024, 7 498 cases were reported.

Yemen:

Since 13 October 2025 and as of 1 December 2025, 7 820 new cases, including 13 new deaths have been reported. Since 1 January 2025 and as of 1 December 2025, 92 352 cases, including 243 deaths have been reported. In comparison, in 2024 and as of 23 December 2024, 260 552 cases, including 879 deaths were reported.

Since the previous update, no new cases or deaths have been reported by Bangladesh, India, Nepal, Pakistan, Philippines and Thailand.

Africa:

Angola:

Since 22 November 2025 and as of 24 December 2025, 1 398 new cases, including 15 new deaths have been reported. Since 1 January 2025 and as of 24 December 2025, 36 077 cases, including 892 deaths have been reported. In comparison, in 2024 and as of 24 December 2024, no cases were reported.

Burundi:

Since 22 November 2025 and as of 24 December 2025, 387 new cases, including two new deaths have been reported. Since 1 January 2025 and as of 24 December 2025, 2 984 cases, including 13 deaths have been reported. In comparison, in 2024 and as of 6 December 2024, 2 216 cases, including 12 deaths were reported.

Cameroon:

Since 25 November 2024 and as of 24 December 2025, 11 new cases have been reported. Since 1 January 2025 and as of 24 December 2025, 11 cases have been reported. In comparison, in 2024 and as of 25 November 2024, 287 cases were reported.

Chad:

Since 22 November 2025 and as of 7 December 2025, three new cases have been reported. Since 1 January 2025 and as of 7 December 2025, 3 091 cases, including 167 deaths have been reported. In comparison, in 2024 and as of 24 December 2024, no cases were reported.

Congo:
Since 27 October 2025 and as of 24 December 2025, seven new cases have been reported. Since 1 January 2025 and as of 24 December 2025, 815 cases, including 67 deaths have been reported. In comparison, in 2024 and as of 24 December 2024, no cases were reported.

Democratic Republic of The Congo: Since 27 October 2025 and as of 24 December 2025, 8 374 new cases, including 192 new deaths have been reported. A backlog of 1 133 cases and 22 deaths were reported since the last update. Since 1 January 2025 and as of 24 December 2025, 67 124 cases, including 1 939 deaths have been reported. In comparison, in 2024 and as of 18 November 2024, 28 618 cases, including 385 deaths were reported.

Ethiopia:
Since 27 October 2025 and as of 24 December 2025, 144 new cases, including seven new deaths have been reported. Since 1 January 2025 and as of 24 December 2025, 8 393 cases, including 84 deaths have been reported. In comparison, in 2024 and as of 26 October 2024, 25 383 cases, including 245 deaths were reported.

Kenya:
Since 22 November 2025 and as of 24 December 2025, 20 new cases have been reported. Since 1 January 2025 and as of 24 December 2025, 686 cases, including 26 deaths have been reported. In comparison, in 2024 and as of 09 August 2024, 300 cases, including three deaths were reported.

Malawi:
Since 7 April 2025 and as of 11 December 2025, 2 new cases have been reported. Since 1 January 2025 and as of 11 December 2025, 93 cases, including three deaths have been reported. In comparison, in 2024 and as of 18 November 2024, 355 cases, including nine deaths were reported.

Mozambique:
Since 22 November 2025 and as of 24 December 2025, 549 new cases, including 20 new deaths have been reported. Since 1 January 2025 and as of 24 December 2025, 5 265 cases, including 66 deaths have been reported. In comparison, in 2024 and as of 02 August 2024, 8 183 cases, including 17 deaths were reported.

Namibia:
Since 27 October 2025 and as of 24 December 2025, 46 new cases have been reported. Since 01 January 2025 and as of 24 December 2025, 64 cases, including 1 death has been reported. In comparison, in 2024 and as of 24 December 2024, no cases were reported.

Nigeria:
Since 27 October 2025 and as of 24 December 2025, 894 new cases, including nine new deaths have been reported. Since 1 January 2025 and as of 24 December 2025, 22 196 cases, including 505 deaths have been reported. In comparison, in 2024 and as of 23 December 2024, 24 721 cases, including 726 deaths were reported.

Somalia:
Since 29 October 2025 and as of 24 December 2025, 691 new cases have been reported. A backlog of 75 cases were reported from Somalia, since the last update. Since 1 January 2025 and as of 24 December 2025, 8 763 cases, including nine deaths have been reported. In comparison, in 2024 and as of 18 October 2024, 19 640 cases, including 138 deaths were reported.

South Sudan: Since 22 November 2025 and as of 24 December 2025, 1 599 new cases, including one new death has been reported. Since 1 January 2025 and as of 24 December 2025, 79 633 cases, including 1 277 deaths have been reported. In comparison, in 2024 and as of 18 November 2024, 114 cases, including two deaths were reported.

Sudan:
Since 22 November 2025 and as of 24 December 2025, 57 new cases, including three new deaths have been reported. Since 1 January 2025 and as of 24 December 2025, 72 057 cases, including 2 077 deaths have been reported. In comparison, in 2024 and as of 18 November 2024, 35 675 cases, including 794 deaths were reported.

Zambia:
Since 27 October 2025 and as of 24 December 2025, 590 new cases, including eight new deaths have been reported. Since 1 January 2025 and as of 24 December 2025, 1 095 cases, including 18 deaths have been reported. In comparison, in 2024 and as of 19 July 2024, 20 063 cases, including 612 deaths were reported. Since the previous update, no new cases or deaths have been reported by Comoros, Côte D'Ivoire, Ghana, Rwanda, Togo, Uganda, United Republic of Tanzania and Zimbabwe.

ECDC assessment:

In 2025, cholera cases have continued to be reported in Africa and Asia, the Middle East and the Americas.

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

In the EU/EEA, cholera is rare and primarily associated with travel to endemic countries. Cholera reporting at the EU level is done on an annual basis, at the end of May for the previous year. In 2023, 12 confirmed cases were reported by five EU/EEA countries, while 29 were reported in 2022, two in 2021, and none in 2020. In 2019, 25 cases were reported in EU/EEA countries (including the United Kingdom). All cases had a travel history to cholera-affected areas.

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

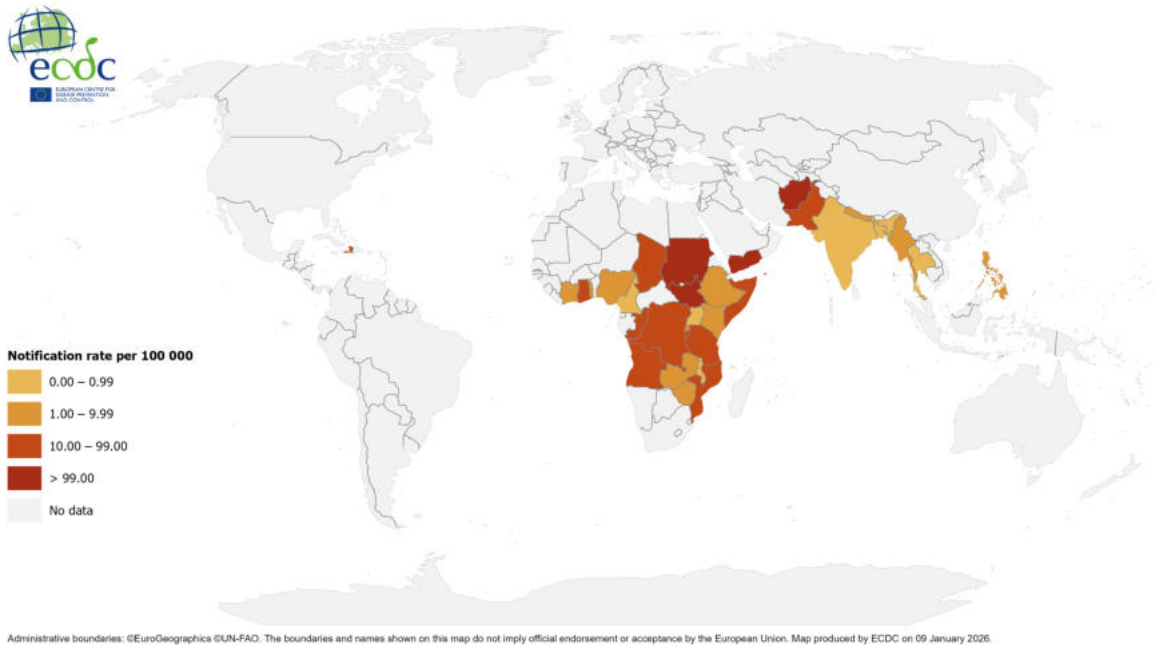
Actions:

- ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities.
- Reports are published on a monthly basis. The worldwide overview of cholera outbreaks is available on ECDC's website.

Last time this event was included in the Weekly CDTR: 28 November 2025

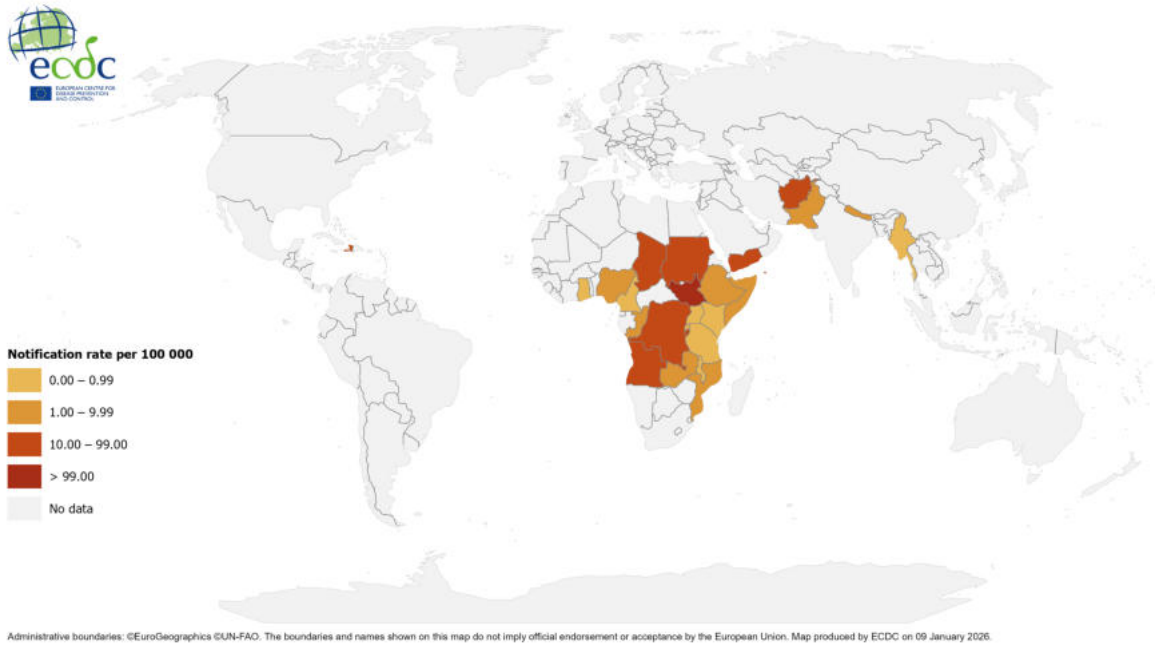
Maps and graphs

Figure 1. Geographical distribution of cholera cases reported worldwide from December 2024 to December 2025



Source: ECDC

Figure 2. Geographical distribution of cholera cases reported worldwide from October 2025 to December 2025



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

Overview:

Update: Since the previous update on 10 December 2025, and as of 5 January 2026, five new MERS cases (including one fatality) have been reported in Saudi Arabia with date of onset between September and December 2025. The patients reside in Makkah (2), Riyad (2) and Najran (1) regions in Saudi Arabia. All patients are adults, three of whom are over 65 years of age. Two patients had direct contact with camels and there was no known contact with camels or camel products reported by the other cases. No secondary cases have been detected so far.

Summary: Since the beginning of 2025, and as of 5 January 2026, 19 MERS cases (including four fatalities) have been reported with date of onset in 2025. Among these, 17 cases (including four fatalities) have been reported in Saudi Arabia, and two imported cases have been reported in France.

Since April 2012, and as of 5 January 2025, a total of 2 647 MERS cases, including 959 deaths, have been reported by health authorities worldwide.

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

ECDC assessment:

Human MERS cases continue to be reported in the Arabian Peninsula. However, the number of new cases detected and reported through surveillance has dropped to the lowest level since 2014. The probability of sustained human-to-human transmission among the general population in Europe remains very low and the impact of the disease in

the general population is considered low. The current MERS-CoV situation poses a low risk to the EU/EEA, as stated in the Rapid Risk Assessment published by ECDC on 29 August 2018.

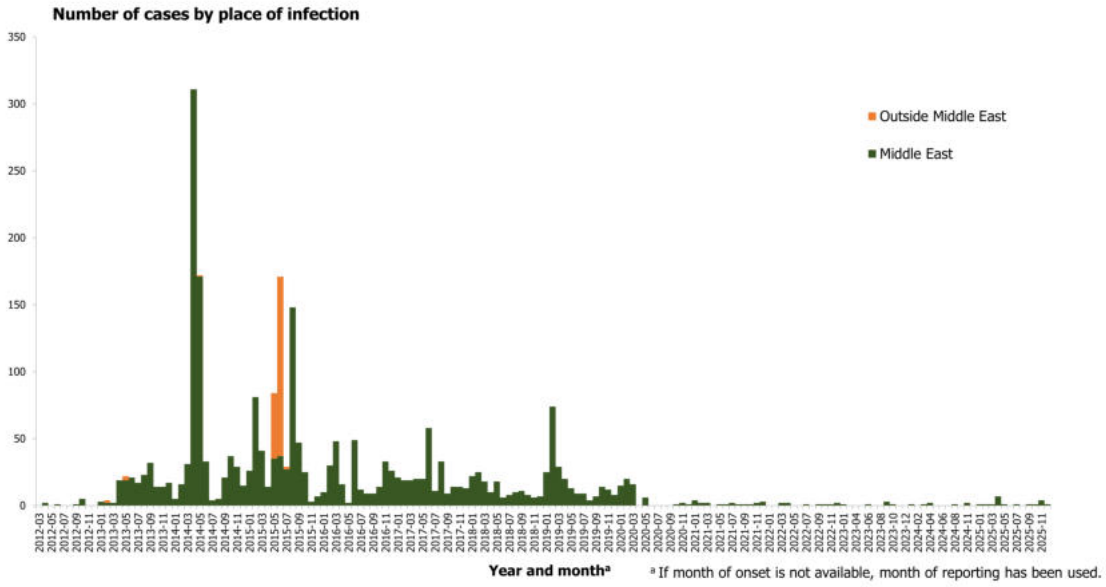
ECDC published a technical report, 'Health emergency preparedness for imported cases of high-consequence infectious diseases', in October 2019 that is still useful for EU Member States wishing to assess their level of preparedness for a disease such as MERS. ECDC also published 'Risk assessment guidelines for infectious diseases transmitted on aircraft (RAGIDA) – Middle East respiratory syndrome coronavirus (MERS-CoV)' on 22 January 2020.

Actions:

ECDC is monitoring this situation through its epidemic intelligence activities, and reports on a monthly basis or when new epidemiological information is available.
Last time this event was included in the Weekly CDTR: 12 December 2025

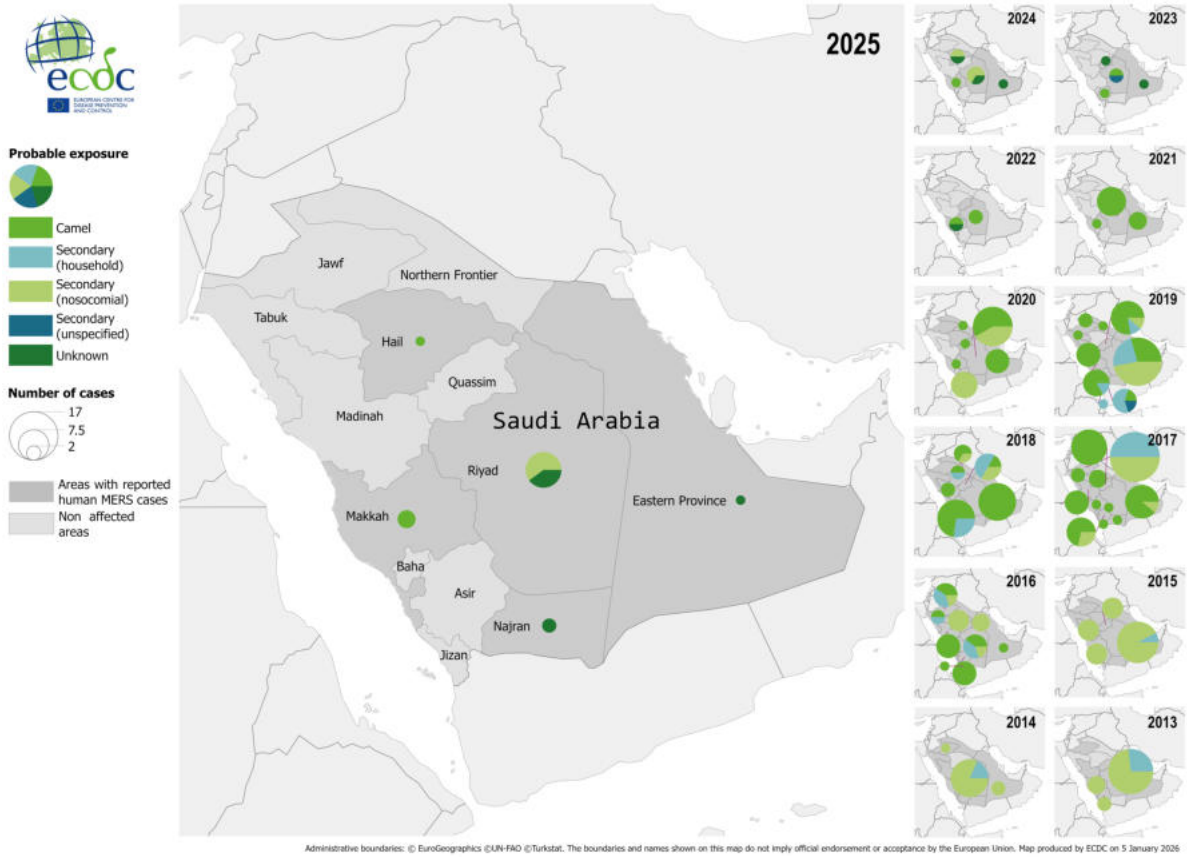
Maps and graphs

Figure 1. Distribution of confirmed cases of MERS by place of infection and month of onset, April 2012 – December 2025



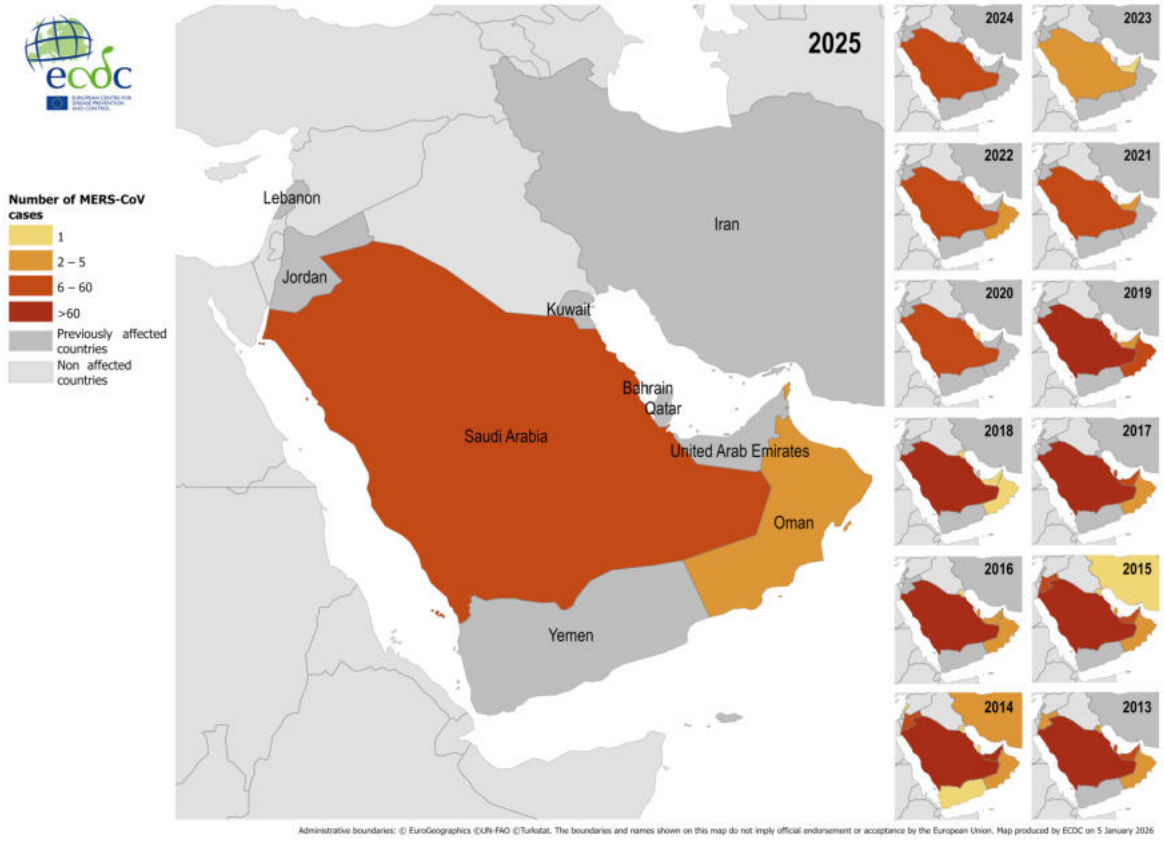
Source: ECDC

Figure 2. Geographical distribution of confirmed cases of MERS in Saudi Arabia by probable region of infection and exposure, with dates of onset from January 2013 to December 2025



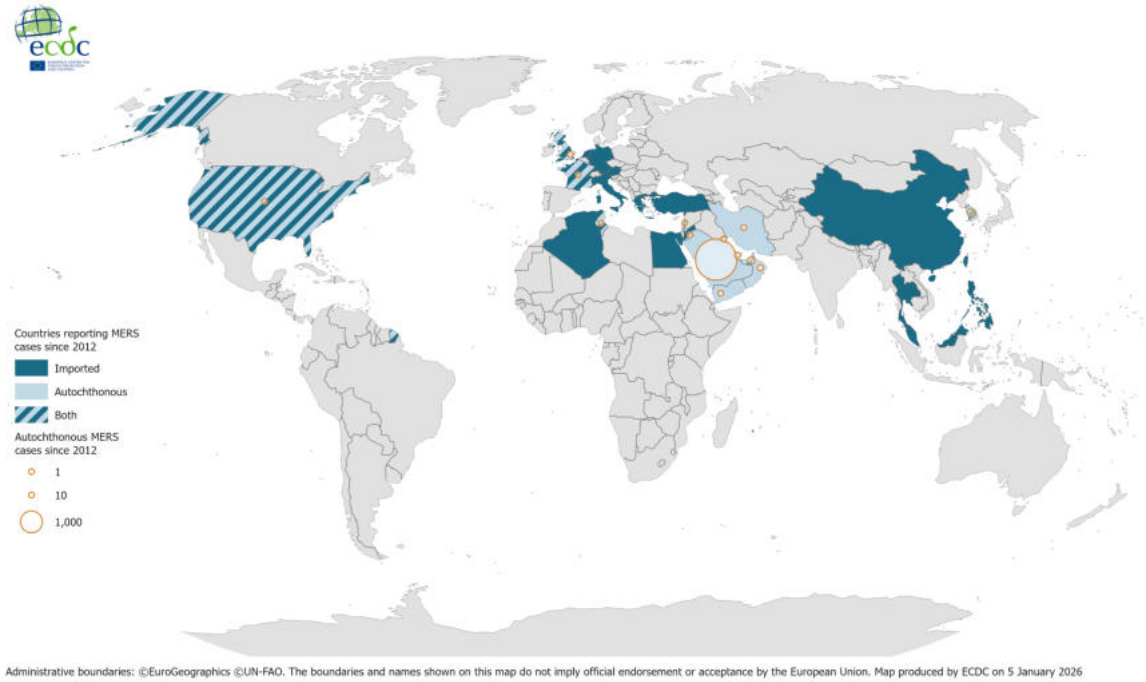
Source: ECDC

Figure 3. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2013 – December 2025



Source: ECDC

Figure 4. Geographical distribution of confirmed cases of MERS-CoV by reporting country, April 2012 - December 2025



Source: ECDC

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

Overview:

According to WHO monthly Influenza at the human-animal interface summary and assessment report, published on 19 December 2025, since 5 November and as of 19 December 2025, WHO reported seven new cases of human infection with avian influenza A(H9N2), all in China.

The cases were reported in Guangdong (1), Guangxi (3), Henan (1) and Hubei (2) provinces with onset of symptoms in September, October and November 2025. Five patients were children and two were adults. Five of the seven individuals had mild disease, two elderly individuals were hospitalised, of whom one with underlying conditions was hospitalised with severe pneumonia. All but one had exposure to birds either in backyard poultry (4) or live poultry market (2). Investigations are ongoing for one case to determine the source of infection.

No new cases have been reported among contacts of these cases. For some of the individuals, environmental samples tested positive to A(H9). All these cases are not epidemiologically related.

Background:
Overall, 190 human cases, including two deaths, of avian influenza A(H9N2) have been reported since 1998 from 10 countries. Since 2015, China has reported 149 human cases of avian influenza A(H9N2) virus infection to WHO, including two deaths (case fatality rate (CFR): 1.4%).

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.

Actions:

ECDC monitors avian influenza strains through its epidemic intelligence and disease network activities. Together with 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: 14 November 2025

6. Human cases of swine influenza A(H1N1) virus variant - Multi-country - 2024

Overview:

On 19 December 2025, WHO reported through it's monthly Influenza at the human-animal interface summary and assessment, a human case with Eurasian avian-like swine influenza A(H1N1) variant virus infection in China. The case is a man in his sixties who is a farmer from Yunnan Province, who developed symptoms on 2 November 2025. The patient had exposure to a backyard pig prior to illness onset. He was admitted to hospital on 6 November with a mild clinical presentation and was discharged on 10 November 2025.

ECDC assessment:

Sporadic human cases with influenza virus of swine origin have previously been reported from several countries globally, including EU/EEA. Infection following exposure to pigs represents the most common risk factor. Limited, non-sustained human-to-human transmission of variant influenza viruses has previously been documented, but is rare. All cases need to be thoroughly followed up to exclude human-to-human transmission and implement control measures. Novel influenza viruses in humans, including zoonotic influenza viruses, should be further characterised, as well as shared with the national influenza reference laboratories and the World Health Organization (WHO) Collaborating Centres.

Actions:

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

ECDC guidance: Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work; Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA.

Sources: 2022-E000398

Last time this event was included in the Weekly CDTR: 26 September 2025

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 28 November 2025
- Human cases infected with swine influenza A(H1N2) variant virus – Multi-country – 2024 - last reported on 28 November 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 28 November 2025
- Influenza A(H5N2) - Multi-country (World) - Monitoring human cases - last reported on 28 November 2025
- Hepatitis A - Multi-country (EU) - 2024-2025 - last reported on 28 November 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 28 November 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 28 November 2025
- Marburg virus disease (MVD) - Ethiopia - 2025/26 - last reported on 28 November 2025
- Influenza A(H5N5) - Multi-country (World) - Monitoring human cases - last reported on 28 November 2025
- Monkeypox virus clade Ib – Multi-country – 2025 - last reported on 26 November 2025
- SARS-CoV-2 variant classification - last reported on 19 December 2025
- Leprosy - Romania ex. Indonesia - 2025 - last reported on 19 December 2025
- Mpox clade Ib and clade IIb recombinant strain detected in UK traveller returning from Asia - last reported on 19 December 2025
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 19 December 2025
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2025 - last reported on 19 December 2025
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 19 December 2025
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 19 December 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 12 December 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 12 December 2025
- Seasonal surveillance of West Nile virus infections – 2025 - last reported on 12 December 2025
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 09 January 2026
- Human cases of swine influenza A(H1N1) virus variant - Multi-country - 2024 - last reported on 09 January 2026
- Recurrent multi-country outbreak of shigellosis in travellers returning from Cabo Verde - last reported on 05 December 2025
- HIV/AIDS surveillance 2025 - 2024 data - last reported on 05 December 2025