

Communicable disease threats report

Week 51, 14–20 December 2024

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Executive summary

Cyclone Chido, Mayotte – 2024

- Cyclone Chido crossed Mayotte on 14 December 2024. It made landfall approximately 30 kilometres south of Pemba city, Capo Delgado province.
- Several deaths and injuries have been reported, 100 000 have been sheltered in 70 emergency centres, and 15 000 others have experienced power outages.
- While infectious diseases pose a significant risk following a cyclone, other health hazards must be addressed more urgently. Disruption to healthcare services (including chronic care), environmental hazards, and the psychological stress of displacement can have both acute and long-term health impacts. These factors can contribute to an increase in all-cause mortality in the cyclone-affected areas.
- ECDC is following this event through its epidemic intelligence activities and will report when relevant communicable disease events occur. ECDC is in contact with authorities in France.

Mpox due to monkeypox virus clade I – Germany – 2024

- On 15 December 2024, Germany reported a cluster of four mpox cases due to monkeypox virus clade Ib. The cluster includes one travel-associated case which reported travel to an affected African country and three household members without travel history, including two children.

- Measures have been implemented and epidemiological investigations are ongoing, including contact tracing, informing of contacts and follow-ups. On 16 December, a school related with the cluster switched to distance learning as a precautionary measure in the week ahead of the Christmas holidays.
- Previously, Germany had reported one mpox clade Ib case in October 2024 without secondary transmission.
- This is the second time that transmission of clade I has been reported outside Africa. Similarly to what has been reported in Germany, the United Kingdom reported transmission of clade I in a small family cluster.
- ECDC is monitoring mpox transmission trends and is in contact with Germany to gather more information about the event.

Mpox due to monkeypox virus clade I – Belgium – 2024

- On 18 December 2024, Belgium reported its first confirmed mpox case due to monkeypox virus clade Ib in an individual returning from one of the countries affected by the epidemic in Africa.
- Considering the measures implemented by Belgium, the risk for the general population in the EU/EEA related to this importation remains low, given a very low likelihood of further spread and a low impact. The [ECDC Rapid Risk Assessment Brief](#) published on 16 August 2024 remains valid.

SARS-CoV-2 variant classification

Since the last update on 29 November 2024, and as of 20 December 2024, no changes have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants.

The VOI median proportions in the EU/EEA for week 48-49, based on nine reporting countries are currently:

KP.3: 40.9% (range: 19.0%-47.1%, IQR: 33.9%-42.1%)
BA.2.86: 15.8% (range: 0.0%-27.5%, IQR: 11.8%-20.9%)

The VUM median proportions in the EU/EEA for week 48-49, based on nine reporting countries are currently:

XEC: 49.5% (range: 36.8%-61.9%, IQR: 40.3%-50.0%)

The calculations are based on data reported to GISAID, as of 17 December 2024.

The variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared to previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and previously uninfected individuals could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (such as older people) remains important.

Overview of respiratory virus epidemiology in the EU/EEA

- While the number of patients presenting to primary care and hospitals for respiratory illness remains at expected levels for this time of year, influenza virus and respiratory syncytial virus (RSV) activities continue to increase in the EU/EEA.
- Influenza virus activity has been increasing for four weeks, with the aggregate test positivity rate in primary care in the EU/EEA at 12%. The winter influenza epidemic has officially started in several countries in all parts of the EU/EEA. While hospital admissions due to influenza have been observed in all age groups, individuals aged 65 years and older have the highest risk of hospitalisation and severe outcomes. Influenza B virus currently dominates in Spain, Portugal and Slovakia. Two thirds of the influenza A viruses that have been subtyped are A(H1N1)pdm09 and one third are A(H3N2).
- RSV activity has been rising for six weeks, with the aggregate test positivity rate in primary care in the EU/EEA at 9%. Since week 40, 80% of individuals hospitalised with RSV are children

aged under five years (with 19% being children aged under six months, and 57% children aged between 6 months and 2 years), and 13% are adults aged 65 years and older.

- Following a peak in July, SARS-CoV-2 activity has gradually decreased in most EU/EEA countries that experienced an epidemic wave during the summer. Amongst those who experience SARS-CoV-2 infection, individuals aged 65 years and older remain the age group at the highest risk of hospitalisation and severe outcomes due to COVID-19.
- Countries should be prepared for continued increases in influenza and RSV activity during the coming weeks. Vaccination is the most effective measure to protect against more severe forms of respiratory viral diseases. Vaccination campaigns have started in many EU/EEA countries. People who are eligible for vaccination, particularly those at higher risk of severe outcomes, are encouraged to get vaccinated.
- ECDC has just published specific public health recommendations for winter 2024/2025 in an [epidemiological update](#).

Marburg virus disease (MVD) – Rwanda – 2024

- After 42 days without cases, the outbreak of Marburg virus disease (MVD) in Rwanda has been declared over.
- This outbreak resulted in 66 MVD cases, with 15 deaths, mostly belonging to a single cluster linked to healthcare facilities that treated the index case.
- In response to the outbreak ECDC has deployed one staff and published a [threat assessment brief](#) on the implications for the EU/EEA.

Unknown disease - Democratic Republic of the Congo - 2024

- According to the latest Africa CDC update, the total number of cases of the unknown disease is 592 (including 37 deaths).
- A large proportion of samples collected from cases were positive for malaria, but additional tests and epidemiological investigations are both ongoing.
- According to a World Health Organisation Disease Outbreak News item published on 8 December 2024, most cases presented with fever, headache, cough, runny nose, and body ache. All severe cases occurred among malnourished children.
- The most likely diagnoses that can explain these symptoms include influenza, COVID-19, malaria, and other bacterial pathogens known to cause pneumonia as well as co-infections of these pathogens. Testing for multiple pathogens is ongoing.
- All cases have been reported in a very remote region of the country (48 hours road trip from Kinshasa), with limited diagnostic and healthcare infrastructures, and a high prevalence of risk factors such as malnutrition.
- ECDC is monitoring the event through its epidemic intelligence activities and is in contact with Africa CDC, DG ECHO and the ECDC staff deployed to Kinshasa for the mpox response to gather additional information for the assessment.

Avian influenza A(H5N1) human cases – United States – 2024

- One case of severe zoonotic avian influenza A(H5) was confirmed on 13 December in Louisiana, United States (US). The case was exposed to sick and dead birds in backyard flocks.
- The case has been hospitalised with severe symptoms. This marks the first instance of severe illness linked to the virus in the US.
- Partial viral genome data of the H5N1 avian influenza virus that infected the patient in Louisiana suggest the virus is of the D1.1 genotype.
- On 18 December, the Governor of California declared a state of emergency in the state to further expand monitoring and build on the coordinated approach to contain and mitigate the spread of the H5N1.
- As of 17 December 2024, a total of 61 human cases of avian influenza A(H5) have been reported from seven states in the US during 2024, including the most recent case. Of these, 37 were individuals exposed to dairy cattle known or presumed to be infected with A(H5N1) and 21 were workers exposed to outbreaks of HPAI A(H5) at poultry farms. Two people had no known animal exposure and one case had exposure to other animals such as backyard flocks, wild birds, or other mammals.
- On 6 December 2024, the US Department of Agriculture's (USDA) Animal and Plant Health Inspection Service (APHIS) announced the start of its National Milk Testing Strategy (NMTS).

- According to the United States Centers for Disease Control and Prevention (US CDC), the risk to the general population remains low, while people with exposure to infected poultry, cattle or other potentially infected domestic or wild animals have a higher risk of infection.

Mpox due to monkeypox virus clade I and II – Global outbreak – 2024

- Globally, MPXV clade I and clade II are circulating in different countries, with the epidemiological trends remaining largely unchanged.
- Among the countries that have previously reported clade Ib cases in Africa, new cases have been reported this week by the Democratic Republic of Congo (DRC), Burundi, Kenya and Uganda.
- Outside the affected African countries, new MPXV clade Ib cases have been reported from Germany and Belgium. Secondary transmission of MPXV clade Ib has been reported in the United Kingdom in October and in Germany in December 2024, among the household contacts of the index cases.
- ECDC is closely monitoring and assessing the epidemiological situation and additional related information can be found in the Centre's rapid risk assessment published on 16 August 2024 ([Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#)) and its [Rapid scientific advice on public health measures](#).

1. Cyclone Chido, Mayotte – 2024

Overview:

Cyclone Chido crossed Mayotte on 14 December 2024. It made landfall approximately 30 kilometres south of Pemba city, Capo Delgado province. The cyclone continued towards Mozambique and Malawi.

According to an [ECHO new s flash](#), quoting authorities and media reports, as of 19 December 31 people have died in Mayotte, around 1 500 have been injured and, as of 17 December, approximately 100 000 have been displaced.

ECDC assessment:

Cyclones are among the most impactful natural disasters, causing widespread destruction and disruption. Cyclone Chido in Mayotte has resulted in many deaths and wounded, accompanied with significant other challenges, including damage to infrastructure, displacement of communities, and disruption of essential services such as water supply, food and access to healthcare. Such events have become more frequent and severe in recent years, a trend expected to continue due to climate change. The immediate needs of the affected areas include rescue operations, evacuations, and the restoration of critical services.

Overcrowding increases the risk of infectious diseases and are more easily transmitted among populations temporarily housed in emergency shelters. The potential increase in the number of patients and damage to healthcare infrastructure is likely to temporarily affect the ability to diagnose and confirm infectious diseases. It will also reduce the level of care. Power shortages and damage to the electrical grid may also affect the cold chain required for certain drugs and vaccines, both in healthcare facilities and distribution channels. This may result in a temporary lack of antibiotics and vaccines.

The public health authorities of France have established a community surveillance system in Mayotte, where the communities remain sheltered, to rapidly detect and respond to potential outbreaks.

Mechanisms for early detection and monitoring of disease clusters should be strengthened, given the heightened risk of foodborne and waterborne diseases, as well as vector-borne illnesses. Cyclone-induced disruptions to water and sanitation systems create favourable conditions for the spread of these diseases, making their prevention and early detection a top priority.

Gastrointestinal infections, such as cholera, rotavirus, and hepatitis A, are significant concerns in the wake of compromised water and sanitation systems. Additionally, respiratory viruses (including

influenza, COVID-19, and RSV) are expected to escalate. Vector-borne diseases like chikungunya and dengue, as well as leptospirosis, are critical risks, requiring vigilant monitoring and timely interventions.

There is also an increased risk of wound infections and vaccine-preventable diseases, such as tetanus, especially if vaccination coverage is insufficient.

Measures to prevent outbreaks in cyclone-affected communities may include the following:

- Hand and respiratory hygiene and the use of face masks, particularly for displaced individuals housed in shelters.
- Ensuring access to safe drinking water through water purification, distribution of safe water supplies, and monitoring of water sources to prevent contamination.
- Use of appropriate protective equipment for cleaning debris and contaminated areas.
- Surveillance for cholera, rotavirus, hepatitis A and other foodborne and waterborne diseases, with rapid deployment of response teams to contain any detected cases.
- Vector control measures to monitor and treat flooded areas to reduce mosquito populations, which may increase due to standing water in cyclone-affected areas.
- Risk communication to the affected communities is essential, including messaging on hygiene practices, access to clean water, food safety, and safe cleaning of contaminated areas (avoid walking barefoot in damaged areas). Clear, actionable advice delivered by trusted spokespeople is critical to successfully reaching and protecting the affected populations.

The current health situation in Mayotte has challenges arising from cyclone-related devastation. The lack of security and clean water could increase the vulnerability to infectious disease outbreaks, exacerbating the overall health crisis. French public health authorities have established a community surveillance system in Mayotte, to rapidly detect and respond to potential outbreaks, but now other health hazards must also be addressed. Medical infrastructure remains fragile, disruption to healthcare services (including chronic care), environmental hazards (e.g. exposure to contaminated water and dangerous debris), and the psychological stress of displacement can have both acute and long-term health impacts. These factors can contribute to an increase in all-cause mortality in the cyclone affected areas.

Actions:

ECDC is following this event through its epidemic intelligence activities and will report when relevant communicable disease events occur. French public health authorities are aware of the risks of infectious diseases that the population may face. France made a request for assistance through the Union Civil Protection Mechanism (UCPM) consisting of various shelter items. Several Member States expressed willingness to contribute and are in the course of finalising offers of assistance. ECDC remains in contact with France in support of the situation.

2. Mpox due to monkeypox virus clade I – Germany – 2024

Overview:

On 15 December 2024, Germany [reported](#) a cluster of four mpox cases due to monkeypox virus (MPXV) clade Ib. The cluster includes one travel-associated case which reported travel to an affected African country and three household members without travel history, including two children. Measures have been implemented and epidemiological investigations are ongoing, including contact tracing, informing of contacts and follow-ups. On [16 December](#), a school related with the cluster switched to distance learning as a precautionary measure in the week ahead of the Christmas holidays. This is the first time secondary transmission of mpox clade I is reported in an EU country.

Previously, Germany had reported one other travel-associated case in October 2024.

For more information on the global epidemiological situation regarding MPXV clade Ib are reported weekly in [the Communicable Diseases Threats Report](#).

ECDC assessment:

Considering the measures implemented by Germany, including isolation of the cases and contact tracing as well as implementing distance learning at one school, the risk for the general population in the EU/EEA related to this importation is considered low, given a very low likelihood of further spread and a low impact. The [ECDC Rapid Risk Assessment](#) published on 16 August 2024 remains valid.

Actions:

ECDC is closely monitoring and assessing the evolving epidemiological situation of mpox and is in contact with German authorities and WHO/EURO to gather more information about this event.

ECDC recommendations are available [here](#).

Last time this event was included in the Weekly CDTR: 25 October 2024

3. Mpox due to monkeypox virus clade I – Belgium – 2024

Overview:

On 18 December 2024, Belgium reported its first confirmed mpox case due to monkeypox virus clade Ib. The case was confirmed as clade Ib on 16 December and is an adult who had travel history to an African country where clade Ib circulates. It was reported that the patient had symptoms only in the genital area and that prior to symptom onset had had sexual contacts with a person who had mpox-compatible symptoms.

Upon arrival in Belgium, the case isolated on their own initiative (prior to diagnosis of mpox). No high-risk contacts have been identified in Belgium.

For more information on the global epidemiological situation regarding MPXV clade Ib, see the weekly reports in [the Communicable Diseases Threats Report](#).

ECDC assessment:

Considering the measures implemented by Belgium, the risk for the general population in the EU/EEA related to this importation is considered low, given a very low likelihood of further spread and a low impact. The [ECDC Rapid Risk Assessment](#) published on 16 August 2024 remains valid.

Actions:

ECDC is closely monitoring and assessing the evolving epidemiological situation of mpox in EU/EEA and globally and is in contact with EU/EEA countries and partners. ECDC's recommendations are available [here](#).

4. SARS-CoV-2 variant classification

Overview:

Since the last update on 29 November 2024, and as of 20 December 2024, no changes have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants.

The VOI median proportions in the EU/EEA for week 48-49, based on nine reporting countries are currently:

KP.3: 40.9% (range: 19.0%-47.1%, IQR: 33.9%-42.1%)

BA.2.86: 15.8% (range: 0.0%-27.5%, IQR: 11.8%-20.9%)

The VUM median proportions in the EU/EEA for week 48-49, based on nine reporting countries are currently:

XEC: 49.5% (range: 36.8%-61.9%, IQR: 40.3%-50.0%)

The calculations are based on data reported to GISAID, as of 17 December 2024.

ECDC assessment:

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation. The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. The variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared to previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older individuals, those with underlying conditions, and previously uninfected individuals could develop severe symptoms, if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of individuals at high risk of severe outcomes (e.g. older people) remains important.

Actions:

In order to assess the impact of emerging SARS-CoV-2 sub-lineages and their possible correlation with increases in COVID-19 epidemiological indicators, it is important that countries sequence positive clinical specimens and report to GISAID and/or TESSy.

For the latest update on SARS-CoV-2 variant classifications, please see [ECDC's webpage on variants](#). Variant surveillance data, including the distribution of VOC and VOI variant proportions in the EU/EEA and detailed country-specific COVID-19 updates are available as part of the [European Respiratory Virus Surveillance Summary \(ERVISS\)](#).

Routine updates on the SARS-CoV-2 variant classification through the Communicable Diseases Threats Report will be provided on a monthly basis as a minimum.

Last time this event was included in the Weekly CDTR: 6 December 2024

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

Overview:

Key indicators

All data presented in this summary are provisional. Interpretation of trends, particularly for the most recent weeks, should consider the impact of possible reporting delays, non-reporting by individual countries or overall low testing volumes at primary care sentinel sites. In the footer, known issues with reported data can be found under 'Country notes', with supporting information also available under 'Additional resources'.

- Overall, syndromic indicators in primary and secondary care remain at levels comparable to this period in previous years. Primary care consultation rates for acute respiratory illness (ARI) and for influenza-like illness (ILI) have been increasing in several countries in recent weeks, with 12 countries now reporting activity above baseline. In secondary care, rates of severe acute respiratory illness (SARI) are similar to, or lower than, levels observed at this time during previous years.

- Influenza activity continues to increase, with eight countries reporting primary care test positivity rates at or above 10%. The aggregate test positivity rate in primary care at the EU/EEA level crossed the 10% threshold usually used to indicate the start of the winter influenza epidemic.
- RSV activity is stable in primary care surveillance but continues to increase in secondary care surveillance. Three countries reported primary care test positivity rates at or above 10% and four countries between 5% and 10%. The aggregate test positivity rate at the EU/EEA level was 9% in primary care and 11% in secondary care.
- SARS-CoV-2 activity in primary care and hospitals continues to decrease or remains stable at the EU/EEA level, with lower rates of aggregate test positivity than those observed in 2023 at this time of year. However, the picture remains varied at the country level.

ECDC assessment:

While the number of patients presenting to primary care and hospitals for respiratory illness remains at expected levels for this time of year, sharp increases in influenza virus and respiratory syncytial virus (RSV) activity are being observed in the EU/EEA. Although most reported RSV cases are among very young children, individuals aged 65 years and above are also at risk and can develop severe disease. While hospital admissions due to influenza have been observed in all age groups, individuals aged 65 years and older have the highest risk of hospitalisation and severe outcomes. SARS-CoV-2 activity continues to decrease but remains elevated in some reporting countries, with individuals aged 65 years and above at greatest risk of severe disease.

Actions:

Countries should be prepared for continued increases in influenza and RSV activity during the coming weeks and consider [infection prevention and control practices in healthcare settings](#).

Despite the observed decrease in SARS-CoV-2 activity, it is important to continue monitoring the impact of SARS-CoV-2 at national and regional levels. To assess the impact of emerging SARS-CoV-2 sub-lineages, countries should continue to sequence SARS-CoV-2-positive clinical specimens and report to GISAID and/or the European Surveillance System (TESSy).

Vaccination is the most effective measure to protect against more severe forms of respiratory viral diseases. Vaccination campaigns have started in many EU/EEA countries and these efforts should continue. While COVID-19 vaccination continues to protect against severe disease, its effect wanes over time and individuals at higher risk should stay up-to-date with COVID-19 vaccination, in accordance with national recommendations.

Similarly, vaccination against influenza viruses helps to limit severe disease outcomes for people at high risk. Healthcare workers and individuals at higher risk should stay up-to-date with influenza vaccination, in accordance with national recommendations.

Several countries have made vaccination against RSV available for pregnant women and older adults, as well as immunisation with monoclonal antibodies for newborns. For more information, consult the national vaccination and immunisation recommendations made by each country's competent authorities.

ECDC monitors rates of respiratory illness presentation and respiratory virus activity in the EU/EEA, presenting findings in the European Respiratory Virus Surveillance Summary ([ERVISS.org](#)). Updated weekly, ERVISS describes the epidemiological and virological situation for respiratory virus infections across the EU/EEA and follows the principles of integrated respiratory virus surveillance outlined in '[Operational considerations for respiratory virus surveillance in Europe](#)'.

Further information:

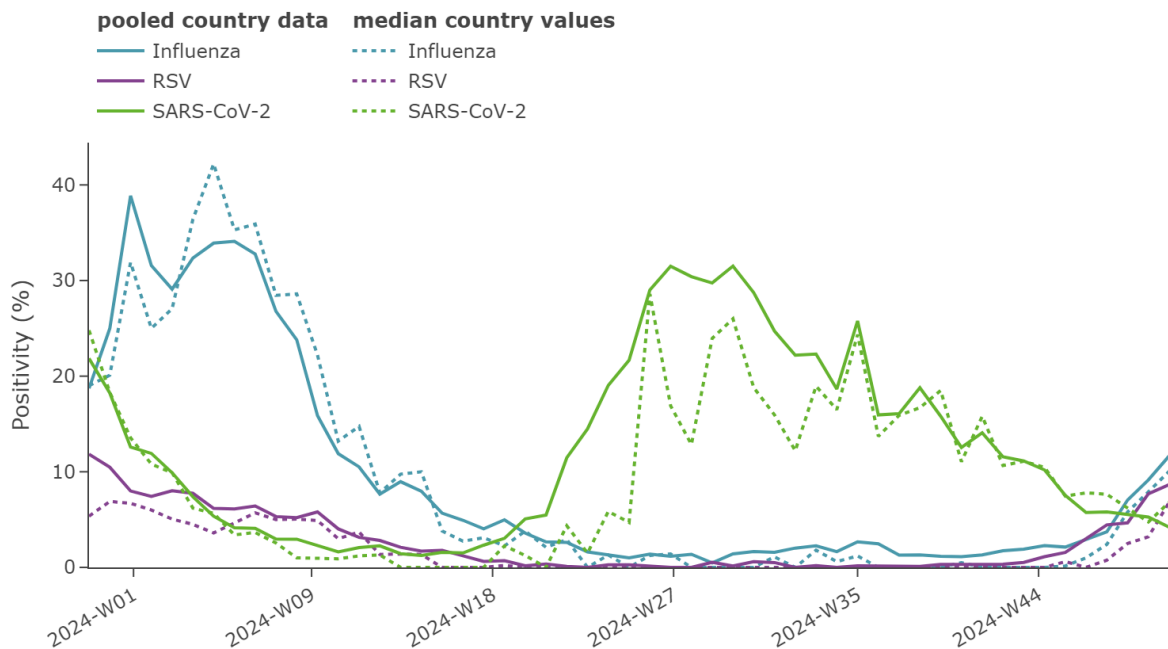
- Short-term forecasts of ILI and ARI rates in EU/EEA countries are published on ECDC's [RespiCast](#).
- [EuroMOMO](#) is a weekly European all-cause mortality monitoring activity, aiming to detect and measure excess deaths related to seasonal influenza, pandemics and other public health threats, based on weekly national mortality statistics from up to 27 reporting European countries or subnational regions.

- WHO [recommends](#) that trivalent vaccines for use during the 2024–2025 influenza season in the northern hemisphere contain the following (egg-based and cell culture or recombinant-based vaccines respectively): an A/Victoria/4897/2022 or A/Wisconsin/67/2022 (H1N1)pdm09-like virus (subclade 5a.2a.1); an A/Thailand/8/2022 or A/Massachusetts/18/2022 (H3N2)-like virus (clade 2a.3a.1 (J)); and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus (subclade V1A.3a.2).
- Antigenic characterisation data presented in the WHO [2025 southern hemisphere vaccine composition meeting](#) report indicate that current northern hemisphere vaccine components are well matched to circulating 5a.2a and 5a.2a.1 A(H1N1)pdm09 subclades and V1A.3a.2 B/Victoria subclades. The components also appear well matched for the A(H3N2) 2a.3a.1 (J) clade viruses, but less well matched for some of the more recent subclade 2a.3a.1 (J2) viruses characterised by S145N, N158K or K189R HA substitutions (alone or in combination). The majority of the A(H3N2) viruses identified worldwide since February 2024 belong to the subclade 2a.3a.1 (J2).

Sources: [ERVISS](#)

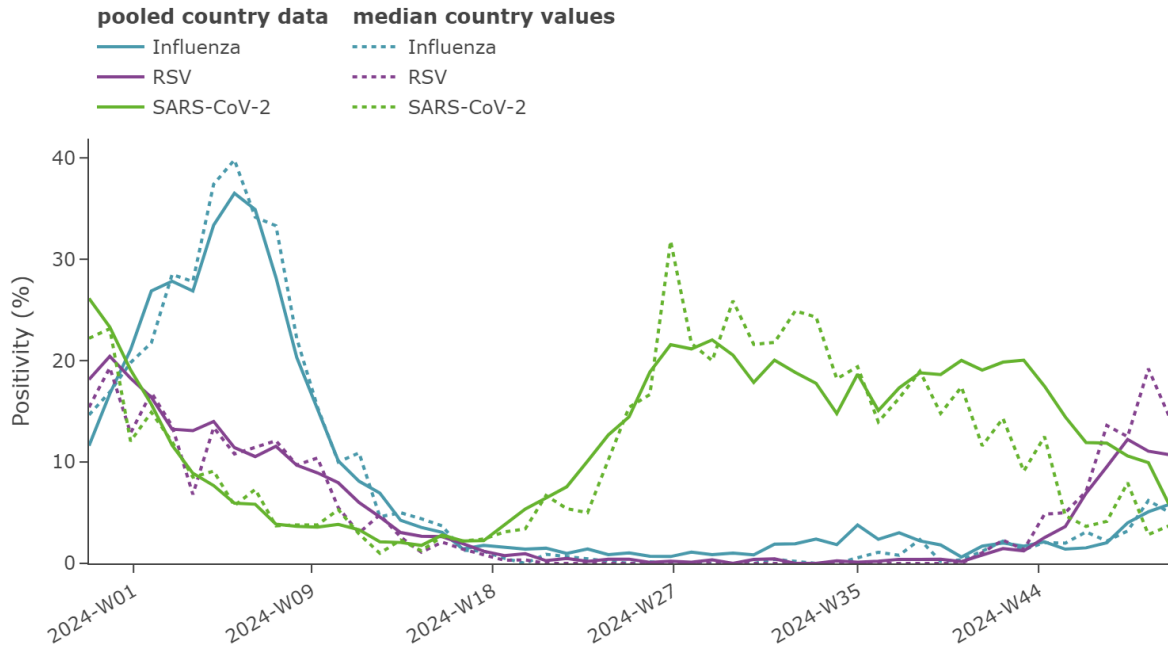
Last time this event was included in the Weekly CDTR: 13 December 2024

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



Source: ECDC

Figure 2. ILI/ARI virological surveillance in hospitals – weekly test positivity



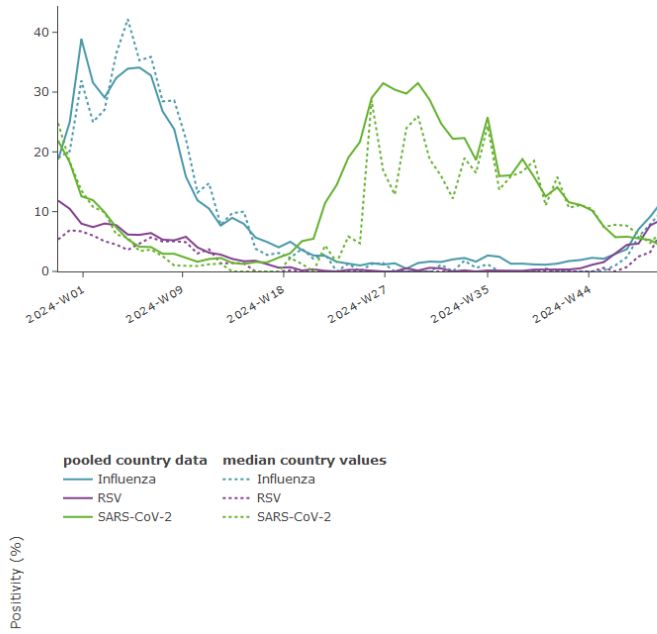
Source: ECDC

Figure 3. Overview of key indicators of activity and severity in week 50, 2024

Indicator	Syndrome or pathogen	Reporting countries		EU/EEA summary		Comment
		Week 50	Week 49	Description	Value	
ILI/ARI consultation rates in primary care	ARI	13 rates (10 MEM)	13 rates (10 MEM)	Distribution of country MEM categories	4 Baseline 5 Low 1 Medium	Overall, ARI activity is at expected levels comparable to the same period in previous years. Six countries reported ARI activity above the baseline level for W50: Belgium, Bulgaria, Czechia, Estonia, Germany and Lithuania.
	ILI	19 rates (17 MEM)	20 rates (18 MEM)		8 Baseline 8 Low 1 Medium	Overall, ILI activity is at expected levels comparable to the same period in previous years. Nine countries reported ILI activity above the baseline level for W50: Belgium, Denmark, Estonia, France, Hungary, Ireland, Italy, Lithuania and Poland.
ILI/ARI test positivity in primary care	Influenza	17	19	Pooled (median; IQR)	12% (10; 5.9–16%)	The pooled EU/EEA test positivity rate in ILI/ARI surveillance increased from 9.5% in W49 to 12% in W50, crossing the 10% positivity threshold for the first time this season. Test positivity rates ≥10% were reported by eight countries: Poland (67%), Portugal (36%), Ireland (28%), Luxembourg (17%), the Netherlands (16%), Greece (15%), Hungary (15%) and Denmark (10%).
	RSV	14	15		8.7% (6.8; 1.9–8.5%)	The pooled EU/EEA test positivity rate in ILI/ARI surveillance remained stable at 9%, but the median test positivity rate increased from 3% in W49 to 7% in W50. Three countries reported test positivity rates ≥10%: Luxembourg (22%), the Netherlands (19%), and Spain (12%).
	SARS-CoV-2	14	16		4.2% (6.8; 4.5–8.3%)	Following a peak in July 2024, the pooled EU/EEA test positivity rate in ILI/ARI surveillance continued to slowly decrease. At national level, seven countries still reported test positivity rates between 5 and 10%, and one country (Greece) reported a test positivity rate of 46% but with only 13 samples tested.
SARI rates in hospitals	SARI	8	9	–	–	SARI consultation rates continue to be reported at levels comparable to, or lower than, the same period in previous years.
SARI test positivity in hospitals	Influenza	7	7	Pooled (median; IQR)	5.8% (5; 3.3–15%)	The pooled EU/EEA test positivity rate in SARI surveillance increased from 4% in W49 to 6% in W50. Only two countries reported test positivity rates ≥10%: Ireland (34%) and Romania (19%). Since W40, about 40% of individuals hospitalised with influenza are aged 65 years and older, about 30% are aged 15–64 years and about 30% are aged 0–14 years.
	RSV	7	7		11% (14; 4.3–18%)	The pooled EU/EEA test positivity rate in SARI surveillance remained stable around 10% in W50. Four countries reported test positivity rates ≥10% for W50: Spain (24%), Ireland (19%), Malta (18%) and Romania (11%). Since W40, 80% of individuals hospitalised with RSV are children aged under five years, and 13% are aged 65 years and older.
	SARS-CoV-2	7	7		5.8% (3.7; 2.6–6.4%)	The pooled EU/EEA test positivity rate in SARI surveillance continued to decrease to reach 6% in W50. Since W40, 84% of individuals hospitalised with COVID-19 are aged 65 years and older. Non-sentinel indicators of severe disease (hospital admissions, ICU admissions, and deaths) remain low at the EU/EEA level.
Intensity (country-defined)	Influenza	22	23	Distribution of country qualitative categories	7 Baseline 11 Low 4 Medium	
Geographic spread (country-defined)	Influenza	21	22	Distribution of country qualitative categories	8 Sporadic 5 Local 5 Regional 3 Widespread	

Source: ECDC

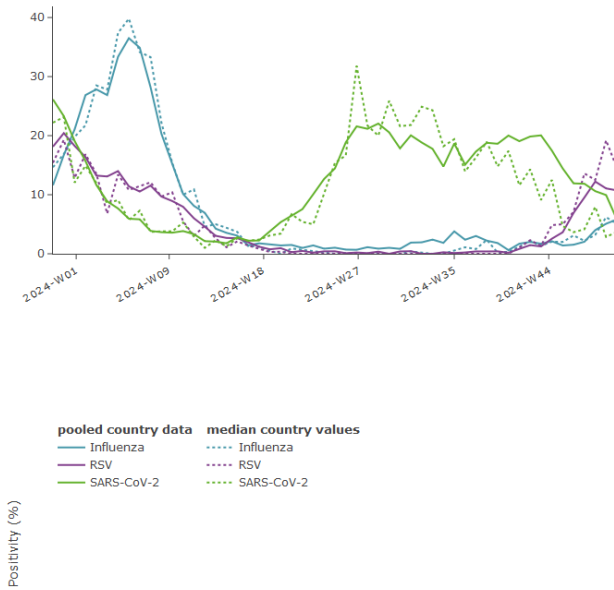
Figure 4. ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution



Source: ECDC

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

Figure Table



Source: ECDC

Figure 6. Genetically characterised influenza virus distribution, weeks 40–50, 2024

Subtype	Subtype distribution		Subclade distribution		
	N	%	Subclade	N	%
A(H1)pdm09	57	61	5a.2a(C.1)	51	89
			5a.2a.1(D)	4	7
			5a.2a(C.1.9)	2	4
A(H3)	31	33	2a.3a.1(J)	30	97
			2a.3a.1(I.2)	1	3
B/Vic	6	6	V1A.3a.2(C.5.1)	6	100

Source: ECDC

Figure 7. SARS-CoV-2 variant distribution, weeks 48–49, 2024

Variant	Classification*	Reporting countries	Detections	Distribution (median and IQR)
KP.3	VOI	9	227	42% (36–47%)
BA.2.86	VOI	6	72	12% (0–19%)

Source: ECDC

6. Marburg virus disease (MVD) – Rwanda – 2024

Overview:

The outbreak of Marburg virus disease (MVD) reported by Rwanda has been [declared over on 20 December 2024](#) after a 42-day period that started on 9 November 2024 (a day after the last patient tested negative) has passed.

No new cases of Marburg virus disease have been reported in Rwanda since 30 October 2024. The last two cases were reported on [26 October](#) and on [30 October 2024](#). All patients who were under care have now recovered. The last patient tested negative on 8 November 2024 and the treatment centre closed after the patient was discharged. ([Africa CDC Special Briefing on Mpox and Other Emergencies | 19 December 2024](#), [Africa CDC Special Briefing on Mpox & other Health Emergencies | 14 November 2024](#) and [WHO Disease Outbreak News Marburg virus disease - Rwanda, 13 November 2024](#)).

Overall, 66 MVD cases were reported since the start of the outbreak. Among these, 51 recovered and 15 died. Over 1 000 contacts were followed up as part of the response.

This was the first MVD outbreak in the country and was declared on 27 September 2024 when the Ministry of Health of Rwanda [reported](#) the detection of MVD cases. [Most cases](#) were males (68%), and aged 30–39 years (45%). All cases were epidemiologically linked and belonged to the same cluster with three major branches: two linked to healthcare facilities and one around the index case ([a male with history of exposure to bats in caves](#)).

A [preprint including the results of the genomic analysis of Marburg virus from the cases was published on 5 November](#). The analysis concluded that the outbreak lineage was most closely related to a sequence sampled in Kampala, Uganda in September 2014 from a [healthcare worker](#). The results support the theory of a single zoonotic event followed by human-to-human transmission among the cases reported during the first two weeks. Investigations of the fruit bats in the area where the index case was exposed (a mining site) continue ([New England Journal of Medicine \(published on 6 November 2024\)](#) and [Africa CDC Special Briefing on Mpox & other Health Emergencies; 14 November 2024](#)).

In the context of the MVD outbreak in Rwanda, [vaccinations for healthcare workers started](#) as part of a Phase 2 rapid response open-label study. The Sabin Vaccine Institute provided the first 700

doses of the investigational Marburg virus vaccine on 5 October 2024, 1 000 doses on [14 October 2024](#), and 1 000 more on [31 October 2024](#).

As part of the response, Rwanda [implemented](#) communicable disease control measures, including: exit screening at the airport, measures in education settings and conferences, ban on hospitals' visitors, strengthening infection prevention and control protocols in hospitals, and measures to limit contact with dead bodies.

Background

Marburg virus is present in certain animal species (e.g. bats) in several sub-Saharan African countries. Transmission from animals to humans is rare. However, such events may initiate outbreaks due to subsequent human-to-human transmission.

MVD is not an airborne disease and is not considered contagious before symptoms appear. Direct contact with the blood and other body fluids of an infected person or animal is the most frequent route of transmission. Indirect contact with surfaces and materials, such as clothing, bedding and medical equipment contaminated with infected blood or body fluids may also result in transmission of the virus. Therefore, if proper infection prevention and control measures are strictly adhered to, the likelihood of infection is considered very low.

The incubation period of MVD is usually five to ten days (range: 3–21 days). The onset of MVD is usually abrupt, with non-specific, flu-like symptoms, such as a high fever (usually 39–40°C), severe headache, chills, muscle pain and malaise. In 50–75% of patients, rapid worsening occurs within two to five days, marked by gastrointestinal symptoms such as anorexia, abdominal discomfort, severe nausea, vomiting and diarrhoea. A maculopapular rash and symptoms of haemorrhagic fever, such as petechiae, mucosal and gastrointestinal bleeding, and bleeding from venipuncture sites may follow in severe cases. Neurological symptoms (disorientation, agitation, seizures and coma) can occur in later stages of the disease. The case fatality of MVD can range from 24–88%, depending on the virus strain, mode and intensity of infection, and the timeliness and level of medical care.

There is no specific antiviral treatment for MVD. Supportive therapy such as intravenous fluids, electrolyte replacement, supplemental oxygen, as well as blood and blood product replacement, may improve the clinical outcome significantly. There is no approved vaccine for MVD to date.

More information can be found in the [ECDC Factsheet about Marburg virus disease](#).

ECDC assessment:

On 10 October 2024, ECDC published a threat assessment brief of the implications of the Marburg virus disease outbreak in Rwanda for the EU/EEA ([Implications of the Marburg virus disease outbreak in Rwanda for the EU/EEA, 2024](#)).

Actions:

ECDC monitored the event through epidemic intelligence activities and communication with international partners. ECDC also deployed an expert through the EU Health Task Force (EUHTF).

Last time this event was included in the Weekly CDTR: 15 November 2024

7. Unknown disease – Democratic Republic of the Congo – 2024

Overview:

Update

On 19 December 2024, [Africa CDC](#) reported that the total number of cases of unknown disease reported in Kwango province in the Democratic Republic of the Congo is 592 including 37 deaths that have occurred in health facilities. Preliminary results from testing include 25/29 samples testing positive for malaria through PCR and 55/88 patients testing positive with RDT for malaria. Additional samples have recently been taken and are being analysed.

A case of an adult male who died with haemorrhagic fever signs is being investigated and samples have been sent to Kinshasa for testing.

The epidemiological investigations continue with active case finding (including deaths) in the community. A reporting mechanism has also been established.

Background

On 4 December 2024, the public health authorities in the Democratic Republic of the Congo issued a [press release](#) about a reported outbreak of unknown origin in the Panzi health zone, Kwango province.

On 8 December 2024, [the World Health Organisation published a Disease Outbreak News \(DON\) item](#) summarising the available information on the undiagnosed disease reported at the Democratic Republic of the Congo (DRC). According to the DON:

- 406 cases were reported including 31 deaths in Panzi health zone in Kwango Province between 24 October and 5 December 2024. The peak of reported cases was on the week ending 9 November 2024 and the outbreak is ongoing.
- There were deaths outside healthcare facilities that are still being investigated.
- The majority of cases are children aged 0–14 years old (64.3%), and 0–59 months old (53%); 59.9% females. Overall, 71% of the deaths were in <15 year-olds with 54.8% in <5 year-olds. All severe cases reported have been malnourished.
- Symptoms reported by the patients included: fever (96.5%), cough (87.9%), fatigue (60.9%) and a running nose (57.8%). Difficulty in breathing, anaemia, and signs of acute malnutrition were the symptoms associated with death.

On [12 December](#), [Africa CDC](#) reported that the total number of cases reached 527 including 32 deaths. The epidemiological and symptoms profile of the cases remains similar to what was previously reported i.e. mostly children and females are affected and with the most frequently reported symptoms being fever, cough and asthenia.

On [19 December](#), [Africa CDC](#) reported that 65 new cases were detected this week and five deaths (total 592 cases, 37 deaths). A large proportion of tested samples were positive for malaria. Epidemiological investigations continue.

The WHO DON provides context on the affected area: food security has deteriorated in recent months, there is low vaccination coverage, limited access to diagnostics and quality case management. Moreover, there is a lack of supplies and transportation means, shortage of health staff and very limited malaria control measures.

According to WHO, given the context and the symptoms reported the diseases that need to be ruled out include influenza, acute pneumonia (respiratory tract infection), COVID-19, malaria and others.

The public health response includes:

- Meetings were convened with partners and coordination meetings are held at national level with the participation of provincial teams.
- A case definition has been developed which includes the clinical symptoms observed. Active case finding is conducted and registers are reviewed. Case finding in the community is being organised while data collection and investigation of the community deaths is ongoing.

- A provincial rapid response team was deployed on 30 November and a multidisciplinary team from national level with WHO experts was deployed on 7 December and [arrived](#) in the area on 10 December 2024.
- Laboratory equipment for sample collection and testing at INRB in Kinshasa was transported. RDTs for malaria and COVID-19 have been provided.

ECDC assessment:

The cause of this cluster of cases has not yet been defined and investigations are ongoing, but we know that several samples tested positive for malaria and that malnutrition is prevalent in the area. We also know that the likely reason why the causative agent was not determined promptly was the lack of local diagnostic capacity. Considering these elements, and pending the results of the laboratory investigations, ECDC assesses that the risk posed by this event to EU/EEA countries is low. ECDC will reassess the risk once the results of the ongoing microbiological investigations become available.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities and is in contact with Africa CDC, DG ECHO and the ECDC staff deployed to Kinshasa for the mpox response to gather additional information and inform the assessment.

Last time this event was included in the Weekly CDTR: 13 December 2024

8. Avian influenza A(H5N1) human cases – United States – 2024

Overview:

Update: On 17 December 2024, US CDC reported one new severe human case of avian influenza A(H5) ([CDC H5 Bird Flu Update](#)). According to [CDC](#), the newly reported case occurred in Louisiana and was confirmed on 13 December. The individual reported exposure to sick and dead birds in backyard flocks, and this is the first case in the US that has been linked to this exposure. The case has been hospitalised with severe symptoms. This marks the first instance of severe illness linked to the virus in the US.

Partial viral genome data of the H5N1 avian influenza virus that infected the patient in Louisiana suggest the virus is of the D1.1 genotype, which is linked to other recent D1.1 strains found in wild birds and poultry across the US, as well as in recent human cases in British Columbia, Canada, and Washington State. This H5N1 strain differs from the B3.13 genotype, which has been detected in dairy cows, isolated human cases in various US states, and some poultry outbreaks. Further genomic sequencing and efforts to isolate the virus from the Louisiana patient's clinical samples are currently underway at CDC.

On 29 April 2024, [CDC recommended](#) against consuming raw milk contaminated with live A(H5N1) virus as a way to develop antibodies against A(H5N1) virus to protect against future disease. Consuming raw milk can lead to serious health risks, especially for certain vulnerable populations.

On 6 December 2024, the US Department of Agriculture's (USDA) Animal and Plant Health Inspection Service (APHIS) announced the start of its [National Milk Testing Strategy](#) (NMTS). In partnership with state veterinarians, USDA implemented a strategy to collect unpasteurised milk samples to better assess where H5N1 is present, with the goal to better inform biosecurity and containment measures, as well as to inform state-led efforts to reduce risk to farm workers who may be in contact with animals infected with H5N1.

On 12 December 2024, [a study](#) showing that influenza virus may remain infectious in refrigerated unpasteurised milk for up to 5 days. The experiment was performed with a strain of human influenza virus H1N1 PR8.

Background: In 2024, as of 17 December 2024, 61 human cases of avian influenza A(H5N1) have been confirmed by the US CDC from seven states. Thirty-seven of the cases reported exposure to dairy cattle in the following states: California (33), Colorado (1), Michigan (2) and Texas (1). Twenty-one cases reported exposure to poultry in the following states: Colorado (9), Oregon (1) and Washington (11). In addition, two cases have been identified with unknown exposure: one in Missouri and one in California; one case have been identified with exposure to other animals such as backyard flocks, wild birds, or other mammals.

US CDC's current [assessment](#) of the human health risk of A(H5N1) to the general public in the US has not changed and continues to be considered low.

ECDC assessment:

To date, there have been no confirmed human cases of influenza A(H5N1) infection and no reports of A(H5N1) infection in cattle in the EU/EEA. The genotype B3.13, identified in cattle and several of the human cases in the US, has not been detected in Europe.

ECDC has assessed the risk from the circulating HPAI A(H5N1) clade 2.3.4.4b viruses as low for the general population and low-to-moderate for those with activities that expose them to infected or dead animals or contaminated environments (e.g. occupational exposure to infected animals).

Actions:

ECDC is monitoring the situation together with partner organisations in Europe and will continue to update its assessment of the risk for humans in the EU/EEA as new information becomes available.

In addition to enhanced surveillance, active monitoring and testing of exposed individuals is recommended for early detection of human cases and to assess the possibility of human-to-human transmission, according to relevant ECDC guidance documents ([Testing and detection of zoonotic influenza virus infections in humans](#); [Investigation protocol of human cases of avian influenza virus](#); [Enhanced surveillance of severe avian influenza virus infections in hospital settings](#)).

It is important to raise awareness, including among all primary care workers, of the need to enquire about animal exposure and symptoms compatible with avian influenza infections and testing of symptomatic people with a history of exposure, following a risk-based approach. It is also important to communicate about the epidemiological situation so as not to miss or delay diagnosis of potential human cases.

Given the uncertainties related to mammal-to-mammal transmission and depending on the epidemiological situation, a low threshold can be considered for testing individuals exposed to potentially infected mammals (e.g. symptomatic individuals with conjunctivitis or respiratory symptoms). Due to the higher risk of infection for individuals exposed to infected animals and contaminated environments, appropriate personal protective measures and other precautionary measures should always be taken to mitigate the risk.

Relevant ECDC publications:

- [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](#)
- [Investigation protocol of human cases of avian influenza virus infections in the EU/EEA](#)
- [Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA](#)
- [Joint ECDC-EFSA Drivers for a pandemic due to avian influenza and options for One Health mitigation measures](#)

ECDC is in contact with the US CDC for further information and is closely following any updates on the event. ECDC monitors avian influenza strains through its influenza surveillance programme and epidemic intelligence activities in collaboration with the European Food Safety Authority (EFSA) and the EU Reference Laboratory for Avian Influenza in order to identify significant changes in the virological characteristics and epidemiology of the virus. Together with EFSA and the EU Reference Laboratory for Avian Influenza, ECDC produces a quarterly updated report on the [avian influenza situation](#).

Sources: [FAO](#) | [2024-e000168](#) | [Event Information Site for IHR National Focal Points](#)

Last time this event was included in the Weekly CDTR: 6 December 2024

9. Mpox due to monkeypox virus clade I and II – Global outbreak – 2024

Overview:

Global update

Globally, MPXV clade I and clade II are circulating in different countries. Global epidemiological data are updated weekly by the World Health Organization (WHO), with the most recent updates from Africa highlighting the recent expansion of clade I cases (2022– 24 Mpox (Monkeypox) Outbreak: Global Trends).

Mpox due to MPXV clade I outside the African continent has been reported by Sweden and Thailand (August 2024), India (September 2024), Germany (October and December 2024), the United Kingdom (October 2024 and November 2024), and more recently the United States and Canada (November 2024) and Belgium (December 2024). Secondary transmission of mpox due to MPXV clade Ib has been reported by the United Kingdom and Germany.

Overall, since monitoring began in 2022 and as of 30 November 2024, 117 663 confirmed mpox cases (MPXV clade I and clade II), including 263 deaths, have been reported from 127 countries ([2022– 24 Mpox \(Monkeypox\) Outbreak: Global Trends](#)).

Epidemiological situation in Africa

Mpox has been reported by Angola, Burundi, Cameroon, the Central African Republic (CAR), the Republic of the Congo (Congo), Cote d'Ivoire, the DRC, Gabon, Ghana, Guinea, Kenya, Liberia, Mauritius, Morocco, Nigeria, Rwanda, South Africa, Uganda, Zambia, and Zimbabwe. According to the [WHO Global Report presenting data as of 15 December 2024](#), although there are some fluctuations the overall case trends with regards to clade I and clade II in Africa remain stable.

With regards to MPXV clade Ib, DRC, Burundi, Kenya, and Uganda have reported cases in the past week, while there are no updates from Rwanda (59 cases in 2024), Zambia (one case in 2024), or Zimbabwe (two cases in 2024).

In the past six weeks, the DRC has reported 137 confirmed cases and Burundi 924, according to the [WHO Global report on mpox \(data as of 15 December\)](#). The DRC continues to report the highest number of cumulative mpox cases in Africa, and clade Ia and Ib are co-circulating.

In the DRC, as of 15 December 2024, 56 518 suspected cases have been reported; of these, 12 516 cases have been confirmed. Some 1 285 deaths have been reported, according to [the Ministry of Health official X page](#).

In Burundi, as of 15 December 2024, the cumulative number of confirmed cases is 2 650, and one death has also been reported, according to the [WHO Global report on mpox \(data as of 15 December\)](#). According to the [WHO Mpox Multi-country external situation report n. 43](#), published on 9 December 2024, mpox cases in Burundi were reported from 45 of 49 districts and the positivity rate among suspected cases is approximately 49%. The 20–29 years age group is the most affected age group in the country. The reported modes of transmission are: household transmission, community transmission, and sexual contact transmission. However, the relative contribution of each to mpox spread is unclear.

According to the [WHO Global report on mpox \(data as of 15 December\)](#), one new confirmed mpox case was reported in Kenya since the previous update on 8 December. A total of 29 confirmed mpox clade Ib cases and one death have been reported in the country.

In Uganda, where clade Ib has been detected, 140 cases have been reported since 10 December and as of 18 December 2024 ([Mpox Daily Situation Report, Uganda, 18 December 2024](#)). Overall, 1 126 cases and six deaths have been reported in the country from over 50 districts since July 2024. Most cases have been reported in the age group 19–39 years and from Kampala (533 cases in total), seven districted have reported over 20 cases each.

With regards to clade Ia, the last six weeks 12 cases were reported by CAR (85 cases and three deaths in 2024) and one in Congo (23 cases in 2024) ([WHO Global report on mpox \(data as of 15 December\)](#)).

In addition, the following countries have reported Mpox cases since the declaration of the PHEIC on 14 August and for which the clade has not been determined based on the [WHO update reported on data as of 15 December](#) and the [Africa CDC Epidemic Intelligence Weekly Report of 16 December 2024](#):

- Gabon: two confirmed cases have been reported as of 1 September 2024;
- Mauritius: one case reported on 27 October 2024;
- Angola: three confirmed cases reported in total, the first on 17 November 2024.

Based on an analysis of the patterns of MPXV transmission observed at national level, and given the limitations and uncertainties, ECDC has used official epidemiological information to classify countries according to whether MPXV clade I is endemic or has been reported for the first time in 2024. The categories are as follows:

- Countries reporting only travel-associated cases or cases with a clear link to travel-associated cases: Belgium, Canada, Germany, India, Sweden, Thailand, the United Kingdom, the United States, Zambia, Zimbabwe;
- Countries reporting clusters of cases: Congo, Kenya;
- Countries reporting community transmission: Burundi, Central African Republic, the DRC, Rwanda and Uganda.

The classification was last updated on 19 December 2024.

On 13 August 2024, Africa CDC [declared](#) Mpox a Public Health Emergency of Continental Security. On 14 August 2024, WHO [convened](#) a meeting of the IHR Emergency Committee to discuss the Mpox upsurge and [declared](#) the current outbreak of mpox due to MPXV clade I a public health emergency of international concern.

Epidemiological situation in the EU/EEA for MPXV clade I

MPXV clade Ib cases have been reported in the EU/EEA. One case was reported by Sweden in August 2024, five by Germany in October and December 2024, and one case by [Belgium in December 2024](#). Secondary transmission of clade Ib has been reported in Germany in December 2024.

Surveillance updates on mpox in EU/EEA are provided through the [Communicable Diseases Threats Report](#) (most recently published on 13 December 2024).

ECDC assessment:

The epidemiological situation regarding mpox due to MPXV clade Ib remains similar to last week. The sporadic cases of mpox clade I that have been reported outside Africa including secondary transmission are not unexpected.

The risk for EU/EEA citizens travelling to or living in the affected areas and having close contact with affected communities is considered moderate, and low if contact with affected communities is avoided. The overall risk for the EU/EEA general population is currently assessed as low. However, more imported mpox cases due to MPXV clade I are likely to be reported by the EU/EEA and other countries.

During the end-of-year period, when there is more travel, EU/EEA countries may consider raising awareness in travellers to/from areas with ongoing MPXV transmission and among primary and other healthcare providers who may be consulted by such patients. If mpox is detected, contact tracing, partner notification and post-exposure preventative vaccination of eligible contacts are important public health response measures.

Please see the latest ECDC [Risk assessment for the EU/EEA of the mpox epidemic caused by monkeypox virus clade I in affected African countries](#).

Actions:

ECDC is closely monitoring and assessing the evolving epidemiological situation of mpox on a global basis. The Centre's recommendations are available [here](#). ECDC has been supporting the mpox outbreak response in DRC through the deployment of experts since 29 July 2024.

Sources: [ECDC rapid risk assessment](#)

Last time this event was included in the Weekly CDTR: 13 December 2024

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks - Monthly update - last reported on 29 November 2024
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 29 November 2024
- HIV/AIDS surveillance 2024 - 2023 data - last reported on 29 November 2024
- Avian influenza A(H5N1) human cases – United States – 2024 - last reported on 29 November 2024
- Detection of avian influenza virus fragments in retail milk - United States - 2024 - last reported on 29 November 2024
- Mpox due to monkeypox virus clade I and II – Global outbreak – 2024 - last reported on 29 November 2024
- Severe flood in Eastern Spain – 2024 - last reported on 29 November 2024
- Circulating vaccine-derived poliovirus type 2 (cVDPV2) - multi-country - 2024 - last reported on 29 November 2024
- Avian influenza A(H5N1) human case – Canada – 2024 - last reported on 29 November 2024
- Identification of cVDPV2 in a sewage sample – Poland – 2024 - last reported on 22 November 2024
- Seasonal surveillance of West Nile virus infections – 2024 - last reported on 22 November 2024
- Chikungunya and dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 22 November 2024
- Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases - last reported on 22 November 2024
- SARS-CoV-2 variant classification - last reported on 20 December 2024
- Marburg virus disease (MVD) – Rwanda – 2024 - last reported on 20 December 2024
- Mpox due to monkeypox virus clade I - Germany - 2024 - last reported on 20 December 2024
- Cyclone Chido, Mayotte - 2024 - last reported on 20 December 2024
- Mpox due to monkeypox virus clade I - Belgium - 2024 - last reported on 20 December 2024
- Unknown disease - Democratic Republic of the Congo - 2024 - last reported on 20 December 2024
- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2024 - last reported on 15 November 2024
- Multistate outbreak with Salmonella Strathcona in Germany - last reported on 15 November 2024
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 15 November 2024
- Hepatitis A - multi-country - 2024 - last reported on 13 December 2024
- Suspected viral haemorrhagic fever - Sierra Leone - 2024 - last reported on 13 December 2024
- Increase in respiratory infections due to Mycoplasma pneumoniae in the EU/EEA during the season 2024/2025 - last reported on 06 December 2024
- Influenza A(H5N1) – Multi-country (World) – Monitoring human cases - last reported on 06 December 2024
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 06 December 2024