YELLOW FEVER - GLOBAL

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Overall Global risk and confidence

Overall Public Health risk	
Global	**WHO African Region & WHO Region of the Americas (countries/areas with history of yellow fever transmission)**
Low	**Moderate**
Confidence in available information	
Moderate	**High**

Overall Risk Statement

This rapid risk assessment (RRA) aims to assess the overall public health risk at the global level associated with the increase in yellow fever (YF) transmission in the Region of the Americas alongside ongoing YF activity reported in the WHO African Region, documented from the fourth quarter of 2025 through 2026 to date. Together these events involve 13 out of the 40 countries[1][2] with areas at high risk for YF transmission globally (currently 27 in Africa and 13 in the Americas under the Global Strategy to Eliminate Yellow Fever Epidemics (EYE) classification). For this risk assessment, the WHO Secretariat considered the public health impact of YF, the risk of geographical spread to other WHO regions, and the risk associated with insufficient control capacities. This RRA also provides an assessment of the overall risk in regions with a history of YF transmission, and other regions where the primary vector for urban YF transmission (*Aedes aegypti*) is present. The overall public health risk also incorporates differences in vaccination status and the availability of epidemiological evidence of YF or arboviral circulation. Unvaccinated populations in at-risk areas constitute the highest risk group; vaccinated populations in the same areas are considered low risk; and populations in areas with no available evidence of YF or indicative arboviral circulation are classified as low risk, albeit with low confidence due to limited surveillance data. The assessment further integrates seasonal ecological dynamics, recognizing that although YF virus transmission can occur year-round in certain ecological zones, marked intra-annual variability exists. In addition, the RRA assesses the risk to countries who do not have competent vectors, as well as the risk to travellers, considering their YF vaccination status.

YF outbreaks must be interpreted within their epidemiological and geographic context, as the dynamics of transmission, population immunity, and public health implications differ markedly between high risk and non- risk areas for YF transmission. In high-risk areas, where the virus circulates continuously and population immunity varies, outbreaks may reflect seasonal patterns, gaps in routine immunization, or fluctuations in vector populations. In contrast, outbreaks occurring in areas with no evidence available for YF—where population immunity is typically low and YF virus is not expected to circulate—raise additional concerns regarding viral introduction, the potential for rapid urban transmission, and the need for immediate vaccination and vector control measures, especially in urban settings, to prevent wider spread. Understanding these contextual differences is essential for interpreting the epidemiology, identifying risk factors for severe disease, and determining the relevance and effectiveness of prevention and control strategies.

GLOBAL OVERVIEW

YF transmission in both Africa and the Americas is strongly shaped by seasonal ecological factors, particularly rainfall, temperature, and vector dynamics. Although the virus can circulate year-round in some areas, distinct seasonal peaks occur due to fluctuations in mosquito abundance and human exposure patterns.

[1] https://iris.who.int/server/api/core/bitstreams/962a002f-ac2f-4ba1-bcf5-825a6d2fd36d/content
[2] In this document, the terms “country” and “countries” refer to countries, territories and areas.

During the 2025 YF transmission season, the YF global epidemiological profile was characterized by two concurrent, but distinct transmission YF dynamics: a sustained transmission in areas across the WHO African Region, and a marked increase in transmission in the WHO Region of the Americas, where the viral activity extended into areas historically considered at lower risk[3].

The global YF situation in 2026 remains concerning, with persistent transmission risks in both the African and American regions. Although only 16 confirmed human cases have been reported across three countries in the African Region this year (as of 25 May), an additional five countries have reported suspected cases with YF Plaque Reduction Neutralization Test(-PRNT-) positive results (all sampled in 2026 with symptom onset between January and May 2026 and pending final classification). Despite these relatively low confirmed numbers, structural vulnerabilities continue to sustain a high underlying risk. In the Americas, six countries have reported human cases, and several have detected epizootics (defined as significant increase in the occurrence of a disease among animal populations (monkeys) in a particular region and over a short period of time)- including one with epizootic activity but no human infections, indicating active sylvatic circulation. While no imported cases have been identified in other WHO regions as of 26 May 2026, expanding ecological suitability for vectors, rapid urbanization, climatic shifts, and increasing population mobility represent a risk of international spread.

WHO REGIONAL OVERVIEWS

AFRICAN REGION

The WHO African Region accounts for the majority of the worldwide estimated YF disease burden, with 26 countries[4] classified as high-risk under the Eliminate Yellow Fever Epidemics (EYE) Strategy due to ecological suitability, history of outbreaks, and population immunity gaps.

The detection of YF cases in eight countries with no documented YF transmission in recent years, namely Angola (2024-2025), Burkina Faso (2024-2025), Gabon (2023-2024), Gambia (2024), Liberia (2025), Mali (2024-2025), Niger (2023-2025) and Togo (2023-2025) reflects ongoing virus circulation, unprotected population groups, and limitations in surveillance. Past preventive and reactive vaccination campaigns have contributed to reducing the risk of large-scale outbreaks in several countries. However, suboptimal routine immunization coverage, the need for confirmatory and differential testing (and thus international specimen referral of all IgM-positive, IgM-equivocal and IgM-indeterminate sera), poor documentation of vaccination history and associated delays in case classification following communication of confirmed PRNT-positive test results, poor sample quality and delays with transportation, insecurity, suboptimal access to health care, financial constraints impacting timeliness and completeness of investigations, and suboptimal response activities continue to undermine timely detection and control. Concurrent outbreaks, rapid urbanization, population movement, and exposure to *Aedes aegypti* mosquitoes in densely populated settings further heighten the risk of transmission, including urban spread, and regional spread.

During 2025, two outbreaks were formally documented, in Angola (Cuanza Norte cluster) and in Central African Republic (Bossembele district), along with 14 events with epidemic potential that warranted reactive vaccination campaigns via the International Coordinating Group (ICG) on Vaccine Provision mechanism in five countries (three in Burkina Faso, six in Cameroon, three in Côte d'Ivoire, one in Liberia and one in Mali).

From 1 January to 26 May 2026, a total of 16 confirmed YF cases have been reported across three countries: Burkina Faso (five confirmed cases, including two deaths in unvaccinated adults, symptom onset documented between January to February 2026), Central African Republic (two confirmed cases, with one from an urban setting) and Cameroon (nine confirmed cases including two situations with epidemic potential). In addition, five countries – Angola, Côte d'Ivoire, Gabon, Ghana, and Nigeria have reported a combined total of 32 PRNT YF positive cases that remain under review pending final classification, with symptom onset between January and May 2026. These events are indicative of sustained sylvatic transmission, with periodic spillover into human populations occurring primarily in rural areas where vaccination coverage remains suboptimal and vector densities are high. This pattern aligns with the broader regional risk landscape, in which extensive areas of suitable habitat for *Aedes* vectors, heterogeneous population immunity, and persistent challenges in achieving and maintaining high routine immunization coverage continue to facilitate viral circulation. The recurrent detection of YF cases across multiple countries underscores the ongoing vulnerability of communities living at the interface of forested ecosystems and expanding human settlements, where human–vector contact rates are elevated.

The public-health impact of these outbreaks or situations with epidemic potential requiring reactive vaccination extends beyond the immediate morbidity and mortality observed at the community level. Recurrent transmission places sustained operational

[3] https://www.paho.org/sites/default/files/2025-05/2025-may-31-phe-epi-alert-yellow-fever-final.pdf

[4] According to the Eliminate Yellow Fever Epidemics (EYE) Strategy, 26 countries in the WHO African Region and one country in the WHO Eastern Mediterranean Region are classified as high risk for YF transmission.

and logistical pressure on national health systems, requiring repeated reactive vaccination interventions and diverting resources from routine immunization and other essential services. In addition, continued circulation heightens the risk of cross-border spread within a region characterized by substantial population mobility, thereby amplifying the potential for wider geographic dissemination and increasing the complexity of regional control efforts.

REGION OF THE AMERICAS

All 13 countries with histories of YF transmission in the Region of the Americas have incorporated YF vaccine into their routine immunization programmes. However, in 2024, only one country (Guyana) achieved vaccination coverage above 95%, while only two countries (Colombia and Trinidad & Tobago) reached coverage levels between 90% and 94%.

YF activity in the Region of the Americas has shown a deviation from historical patterns over the past two years.

In 2024, transmission remained confined to five countries within the Amazon Basin: Bolivia, Brazil, Colombia, Guyana, and Peru, which together reported 61 confirmed human cases, including 30 deaths (case fatality rate, CFR: 50%).

In comparison, in 2025, confirmed cases were reported in seven countries (Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, and Venezuela), but with transmission documented outside the traditional Amazonian zone in both Brazil and Colombia. Three countries, Brazil, Colombia, and Ecuador, experienced outbreaks, and re-emerging foci were detected in areas such as São Paulo State (Brazil) and the departments of Tolima and Caldas in the Magdalena Valley (Colombia), where the last reported cases dated back to the 1920s. Between late December 2024 and late April 2025 (epidemiological weeks 1–20), the region recorded 241 confirmed cases and 100 deaths (CFR: 41%), representing an over eightfold increase compared with the same period in 2024 (27 cases). All confirmed infections resulted from sylvatic transmission, increasing the risk of YF reintroduction into urban settings.

Venezuela reported a similar situation since June 2025, with human cases of YF occurring in an expanded geographical area that included 22 parishes in four states of the country (Aragua, Barinas, Lara, and Portuguesa) that had not previously been classified as YF high risk areas. The states close to the expansive enzootic wave of San Camilo (Apure, Táchira, Lara, Mérida, Barinas, Portuguesa, Cojedes, and Guárico) accounted for 61% of the cases reported in 2025. In addition, travel related cases were also reported in Costa Rica (two cases, imported from Peru) and in Colombia (three cases, imported from Venezuela).

From 1 January to 26 May 2026, a cumulative of 79 confirmed cases, including 31 deaths, were reported from six countries: Bolivia, Brazil, Colombia, Ecuador, Peru, and Venezuela.

Colombia, the most affected country over the past two years, accounted for 48 laboratory confirmed cases including 19 deaths. The increase has been observed since December 2025, with all cases linked to sylvatic exposure in Tolima Department. This rise was further amplified by an influx of unvaccinated domestic travellers from low-risk YF areas during holiday periods, as well as by persistent subnational immunity gaps despite overall high population level vaccination coverage.

These developments occur against a backdrop of increasing YF activity across multiple countries in the Americas, where ecological suitability for *Aedes* and *Haemagogus* vectors, heterogeneous vaccination coverage, and expanding human mobility continue to create conditions conducive to viral amplification. Although the confirmed cases in Colombia primarily reflect localized transmission dynamics, they also contribute to broader regional public health impact, including a likelihood of cross-border spread, increased demand for vaccination interventions, and a need for reinforced surveillance and rapid response capacities.

OTHER WHO REGIONS -WHO EASTERN MEDITERRANEAN (EMR), EUROPEAN REGION (EUR), SOUTH-EAST ASIA (SEAR), AND WESTERN PACIFIC REGIONS (WPR)

Beyond the areas at risk for YF transmission in Africa and the Americas, YF occurrence in the WHO Eastern Mediterranean, European, South-East Asia, and Western Pacific regions is primarily associated with imported cases. YF transmission has not been documented in these regions, in part because a stable sylvatic cycle has never been established, however, the presence of competent *Aedes* vectors in several countries, combined with substantial international movement of people and goods, sustains the risk of introduction and limited onward transmission. Thirty-eight countries and territories in these regions require proof of vaccination against YF as a condition for granting entry to travellers arriving from, or having transited through, countries with areas at risk for YF transmission.[5],[6]

As of 26 May 2026, no imported cases have been detected encompassing both the 2025 and 2026 periods. Nonetheless, the continued circulation of YF virus in known areas at risk for YF transmission, expanding ecological suitability for competent vectors, driven in part by rapid unplanned urbanization, climatic changes and increasing population mobility underlines that the risk of importation remains present, particularly for countries with travel links to high-risk countries. This risk is also influenced by cross border movements from high-risk countries and the presence of moderate risk areas where surveillance capacity may vary. If an importation event were to occur, the consequences could be significant should the local vectors be competent for the imported

[5] "Countries with risk of yellow fever transmission and countries requiring yellow fever vaccination" is available at https://cdn.who.int/media/docs/default-source/travel-and-health/countries-with-risk-of-yellow-fever-transmission.pdf?sfvrsn=bf42ac59_4&download=true (18 November 2022, revised on 3 January 2023) [accessed on 13 March 2026]

[6] "Country list - Country vaccination requirements and WHO recommendations for international travellers and malaria prophylaxis per country" is available at https://cdn.who.int/media/docs/default-source/travel-and-health/vaccination-requirements-and-who-recommendations-ith-2022-country-list.pdf?sfvrsn=be429f2_4&download=true (18 November 2022, revised on 3 January 2023) [accessed on 13 March 2026]

virus, particularly in settings where vector populations are established and environmental conditions favour transmission, as the potential impact would depend on the timeliness of detection, the capacity for rapid laboratory confirmation, and the ability to initiate an effective public health response

ASSESSMENT OF RISK FOR DIFFERENT GEOGRAPHICAL CONTEXTS:

1. **Risk to WHO regions with history of YF transmission (Africa and South America)**
   - The likelihood of continued transmission is **High** in affected countries, driven by ongoing viral circulation among non-human primates (with epizootics reported in the Americas), frequent exposure of local population, including underserved and mobile groups, to sylvatic environments, and recurrent human cases resulting from sylvatic spillover. This risk is further amplified by the presence of competent vectors (*Aedes* and *Haemagogus spp*.) and evidence of expansion into new ecological and peri urban interfaces. Risk of further geographic expansion is moderate to high, particularly in areas with low population immunity and suitable vector habitats, including in urban areas. There is a potential high risk for human health at both local and national levels, given the high CFRs (40–50%), the likelihood of outbreaks in under-immunized populations, and the possibility of spillover into densely populated urban centres. At the Regional level, consequences may include cross-border spread, placing increased pressure on vaccine supply, as well as on surveillance systems and clinical management capacity.
   - Population mobility, sustained transmission, ecological suitability, and immunity gaps maintain a high risk of urban outbreaks.
   - The surge in the Americas indicates increased viral circulation with maintained human transmission over an extended period (>16 months as observed in Colombia), risk of introduction of YF in urban areas, and expanding geographic range.
   - Higher than usual case fatality rate (CFR) among severe cases amplifies the public health impact, suggesting critical delays in early detection and timely access to appropriate healthcare. The CFR may also be influenced by the age groups most affected, with more vulnerable populations at greater risk of severe outcomes. Delays may be exacerbated by limited risk awareness, suboptimal communication, and health-seeking behaviours in which individuals postpone care or rely on self-medication. In addition, cases among travellers returning to areas where YF is not routinely suspected, such as certain regions of Colombia, further increase the likelihood of missed or delayed diagnosis, thereby elevating the risk of severity disease and death.
   - Fragile health systems, insecurity, and low vaccination coverage in underserved groups are compounding transmission risk. This has been recently observed in security-compromised areas of Central African Republic, Cameroon, and Burkina Faso, where limited access and operational constraints have substantially hindered field investigation and response efforts.
   - Cross-border transmission, including international exportation and importation of cases, underscoring the global nature of the threat.
   - Detection capacity remains limited, including insufficient laboratory diagnostic capacity for differential diagnosis, particularly given the complexity of YF clinical presentation, alongside constrained financial resources for field investigations in several countries in Africa and shortages in trained healthcare and public health personnel.
   - Underdiagnosis of YF persists in remote and underserved areas, where limited access to health care services reduces timely detection and reporting.
   - Funding constraints at country level have hindered timely epidemiological and entomological field investigations.
   - Surveillance gaps and under-reporting persist, limiting real-time visibility of outbreaks across multiple geographical areas and hindering rapid detection and response.
   - Gaps in community engagement, rumour management and trusted communication with at-risk communities reduce vaccination uptake, limit effective vector-control behaviours and prevent timely identification and resolution of local barriers to rapid and appropriate care.
   - Competing health emergencies, stretching already limited national and regional resources.
   - Climate variability and extreme weather events, including prolonged and heavy rainfalls, are likely to increase YF risk in some regions by enhancing vector breeding conditions.

Risk determinants for YF high risk areas:

- Low or heterogeneous vaccination coverage resulting in immunity gaps, particularly among rural, peri-urban, and mobile populations (refugees, internally displaced persons (IDPs), migrant workers, etc), and some urban centres.
- Favourable ecological and climatic conditions, driven by rapid urbanization and climate variability, particularly in forested and transitional zones, along with expanding vector ranges that favour sylvatic transmission and potential urban spillover.
- High levels of human mobility, particularly migrant workers moving into or near forested areas, increase their exposure and risk of YF.
- Variable surveillance sensitivity and health system constraints, including delayed case detection, underreporting, and limited access to intensive care may amplify morbidity and mortality, and compromise the health system capacity.

- Populations and settings at highest risk:
  - Unvaccinated or under-vaccinated groups in affected and neighbouring areas.
  - Rural and forest fringe communities with occupational or recreational exposure to sylvatic vectors.
  - Peri-urban and urban populations in newly affected states/departments where competent *Aedes* vectors are present and prior population immunity is low.
  - Unvaccinated domestic and international travellers to and from or at-risk areas.

2. Risk to regions with no evidence of YF transmission and with presence of *Aedes aegypti*

- Shifts in major outbreak drivers—including rapid urbanization and peri-urban expansion, increased volume and speed of population movement, and evolving labour migration patterns (such as large-scale international recruitment for mining and construction) combined with inadequate vector control and the effects of climate change (including altered rainfall patterns), are creating ecological and demographic conditions that heighten the risk of YF exportation. These dynamics not only increase the risk of large urban outbreaks but also raise concern for potential emergence in regions without history of YF transmission (should the local vectors be competent for the imported virus), particularly Asia (e.g., India and China), where *Aedes aegypti* is widespread. Large populations in Asia remain immunologically naïve to YF, with some estimates suggesting up to two billion people.
- There is a risk of YF introduction into regions where *Aedes aegypti* is present. This risk is driven by population mobility from high-transmission settings and exacerbated by gaps in vaccination coverage among travellers, particularly those from settings with limited access to vaccination services, thereby increasing the potential for onward transmission through *Aedes aegypti*.
- There is a risk of urban local transmission if an infected viraemic traveller arrives in an area with competent vectors.
- Although there is no evidence of ongoing urban transmission of YF in high-risk countries, limited vector control capacity, particularly in urban settings, including limited routine entomological surveillance and suboptimal implementation of vector control interventions (e.g. adulticiding, larviciding, environmental management) may increase the risk of urban transmission. Vector control is operationally challenging in urban settings due to population density, informal settlements, and poorly managed water storage. However, vector control has limited impact on sylvatic transmission cycle.
- A sylvatic (jungle) cycle is not considered established in regions without evidence of YF transmission. However, risk remains in African countries classified as moderate risk as per the EYE Strategy, particularly those contiguous with areas with history of YF transmission, where cross border population movement may increase exposure. This risk is supported by epidemiological indicators, vector ecological suitability, presence of non-human primates, and mobility patterns, as well as documented gaps in population immunity and surveillance sensitivity.

3. Risk to Countries without competent vectors

- Imported travel-related cases may occur, but onward transmission is unlikely.
- The risk is primarily limited to potential diagnostic or surveillance challenges if clinicians are unfamiliar with YF.

4. Risk to Travelers

- Travellers to countries with high YF transmission remain at risk of infection, particularly if unvaccinated and engaged in activities that increase exposure to mosquito vectors (e.g., outdoor or forest-related activities that heighten vector–host contact).

5. Impact of vaccination by risk level

- Assessed by vaccination status of the population, divided into three groups:

(1) unvaccinated populations residing in at-risk areas, who represent the highest vulnerability due to susceptibility and potential exposure;
(2) vaccinated populations in at-risk areas, for whom the risk is low given the high and sustained protection provided by YF vaccination; and
(3) populations living in areas where no evidence is available of YF or indicative arbovirus circulation, who are classified as low risk but with low confidence due to limited or absent surveillance data, meaning undetected transmission cannot be excluded.

Confidence in the available information

- Under diagnosis and reporting in high-risk regions, particularly in areas with insecurity and/or suboptimal access to health care, limits the accuracy of incidence estimates. Generally, only severe cases are tested and detected, leading to substantial underestimation of true case burden and weakening surveillance data used to inform response efforts.
- Climate and environmental-driven changes have increased the frequency of natural hazards in several areas in AFR and AMR regions, introducing uncertainty regarding the distribution of vectors and non-human primate reservoir.
- Limited surge capacity due to a narrow balance between supply and demand may further affect the ability to scale up outbreak control measures during periods of increased transmission.

The overall risk associated with the YF situation is classified as “Low” globally, and as ¨Moderate ¨ in the regions affected by YF (WHO African Region & WHO Region of the Americas /Areas with history of YF transmission) with respectively ¨Moderate¨ and “High” level of confidence based on the available information.

The rapid risk assessment will be updated as new epidemiological, clinical, or virological information becomes available.

Major actions recommended by the risk assessment team

	Action
☐	Refer the event for review by IHR Emergency Committee for consideration as a PHEIC by DG (Art 12, IHR)
☐	Immediate activation of ERF response mechanism (IMS) as urgent public health response is required
☐	Recommend setting up of grading call (funding can be accessed before grading completed)
☐	Immediate support to response, but within limit of CFE (no grading recommended at this point in time)
☐	Rapidly seek further information and repeat RRA (including field risk assessment)
☒	Support Member State to undertake preparedness measures
☒	Continue to closely monitor
☐	No further risk assessment required for this event, return to routine activities

Risk questions

Risk question		Assessment		Risk	Rationale
	Geographical level	Likelihood	Consequences	Risk level	
Potential risk for human health?	Global	Unlikely	Minor	Low	At the global level, the risk of yellow fever (YF) to human health is low, as sustained transmission remains geographically limited and effective vaccination provides long-lasting individual protection. In countries classified as having no evidence available for YF or indicative arbovirus circulation, the likelihood of human infection is minor. However, increasing international travel and the widespread presence of competent *Aedes* vectors maintain a credible, but low probability of importation and localized transmission. Confidence in this assessment is moderate due to surveillance gaps in many settings and the potential for undetected introduction. For most of the global population, the probability of exposure is low, and vaccination reduces individual risk to negligible levels. Although YF infection can lead to severe clinical outcomes—including jaundice, haemorrhage, multi-organ failure, and high case-fatality ratios—the likelihood of infection for the general global population remains low, resulting in a low overall risk for human health.
	WHO African Region & WHO Region of the Americas (Countries / areas with history of YF transmission)	Likely	Minor	Moderate	In regions with history of YF transmission, the risk to human health is moderate, driven by ongoing transmission, recurrent outbreaks, and the presence of susceptible unvaccinated populations. For unvaccinated individuals living in or travelling to these areas, the likelihood of infection is high due to frequent exposure to infected vectors. Vaccinated individuals remain at low risk because of the high efficacy of the YF vaccine. Current outbreaks across multiple affected countries increase the risk for human health, particularly where health systems are fragile or have limited experience with YF detection and case management. High proportions of severe cases and deaths in some areas suggest delayed diagnosis, limited access to appropriate clinical care, and under-recognition of mild infections, all of which increase the probability of severe outcomes among those infected. Additional factors, such as insecurity, weak infrastructure, and climate-related disruptions that enhance vector breeding or displace populations, further increase the likelihood of human exposure and

					worsen clinical outcomes. Countries without recent YF experience are especially vulnerable, as limited awareness among health workers and communities can delay recognition and response, thereby increasing the risk of severe disease and mortality.
Risk of geographical spread of the event?	**Global**	**Unlikely**	**Minor**	**Low**	At the global level, the risk of geographical spread of yellow fever (YF) is low, as sustained transmission remains largely confined to areas in Africa and the Americas with history of YF transmission. Although international travel continues to increase, the probability of global dissemination remains limited due to the restricted distribution of competent sylvatic vectors (*Haemagogus and Sabethes spp.)* and the variable, but generally lower suitability of *Aedes aegypti* populations outside regions with history of YFr transmission. Importation of YF by infected travellers remains possible, particularly among unvaccinated individuals visiting forested or peri-urban areas in countries with YF transmission. However, secondary transmission following importation is unlikely in most settings without history of YF transmission due to vaccination coverage among travellers, limited ecological suitability, and the absence of established sylvatic transmission cycles. While global mobility, climate change, and vector expansion create theoretical

	WHO African Region & WHO Region of the Americas (Countries / areas with history of YF transmission**)**	**Likely**	**Minor**	**Moderate**	opportunities for spread beyond traditional boundaries, the overall likelihood of sustained geographical expansion at the global level remains low. In regions currently experiencing transmission, in Africa and the Americas, the risk of further geographical spread is moderate. This is driven by a combination of ecological suitability, active sylvatic cycles, immunity gaps, and extensive human mobility. In the Americas, transmission intensified in 2025, with 346 confirmed human cases and 143 deaths reported by year's end. High case fatality ratios (41% by April–May 2025) and widespread transmission across Bolivia, Brazil, Colombia, Ecuador, and Peru reflect active sylvatic circulation along the Andean–Amazonian corridor. Agricultural expansion, forest fragmentation, and cross border population movement continue to create sustained opportunities for spread into 2026, particularly at forest–agriculture–urban interfaces. In Africa, recurrent outbreaks in West, Central, and parts of East Africa persist where vaccination coverage is incomplete and surveillance capacity varies. High risk forest–urban interfaces, major transport corridors, and porous borders facilitate movement between sylvatic foci and densely populated urban centres. The widespread presence of *Aedes aegypti*, ecological suitability, and immunity gaps, driven by inconsistent routine immunization, population growth, and mobility, further elevate the likelihood of spread. For 2026, the risk of geographical expansion within affected regions is considered moderate, supported by evidence of suspected and confirmed cases in new subnational areas, cross-border links, and the presence of competent vector populations (*Aedes* and *Haemagogus* spp.). Spread into new ecological zones and peri-urban or urban interfaces remains plausible, particularly where population immunity is low. Internationally, movement of infected individuals from these regions to countries with competent vectors poses a credible, but lower probability risk of cross-border transmission.

Risk of insufficient control capacities	**Global**	**Unlikely**	**Minor**	**Low**	At the global level, the risk arising from insufficient yellow fever (YF) control capacities is low, supported by the availability of a highly effective vaccine and the maintenance of a six million dose emergency stockpile managed by the International Coordinating Group (ICG). Global vaccine supply has more than doubled since 2017 under the EYE Strategy, and recent years have not seen shortages for emergency use. Although the system remains sensitive to fluctuations in outbreak demand, the global stockpile has consistently met ICG requests. Nevertheless, several structural vulnerabilities persist. Reliance on four WHO-prequalified manufacturers, unpredictable outbreak dynamics, and the

					resurgence of YF in both Africa and the Americas require careful supply-demand management. Decision-making delays and competing public-health priorities can slow the implementation of reactive vaccination campaigns, and surveillance and laboratory capacities remain uneven across regions. Climate change, rapid urbanization, and population mobility further complicate prevention and preparedness, underscoring the need for sustained investment in immunization systems, vector control, and emergency readiness. Despite these challenges, the overall global risk of insufficient control capacity remains low, as global mechanisms for vaccine allocation, outbreak response, and stockpile management continue to function effectively, and most countries without history of YF transmission maintain adequate preparedness to prevent onward transmission following importation.
	WHO African Region & WHO Region of the Americas (Countries / areas with history of YF transmission**)**	**Likely**	**Moderate**	**High**	In affected regions of Africa and the Americas, the risk posed by insufficient control capacities is high, driven by persistent immunity gaps, limited surveillance, and constrained outbreak response systems. Routine immunization coverage remains low and uneven in many countries with history of YF transmission, with weak data systems and logistical barriers to reaching target populations. Delays in case detection, specimen transport, laboratory confirmation, and outbreak investigation frequently hinder timely response. The persistence of human cases in the same areas over multiple weeks reflects these systemic weaknesses. In the Americas, limited epizootic surveillance in some countries hampers early detection of viral circulation in non-human primates, while concerns about fractional dosing have affected vaccine uptake in some demographic groups. In Africa, recurrent outbreaks in West, Central, and parts of East Africa highlight gaps in surveillance, laboratory capacity, and vector control operations. Concurrent public health emergencies, such as dengue, cholera, and other high burden diseases, further strain already limited health system resources. Seasonal surges in vector populations, particularly during rainy periods, place additional pressure on response systems

					to act within narrow windows of opportunity. Insecurity, poor infrastructure, and centralized treatment models restrict access to care, especially in remote or conflict-affected areas. These conditions allow YF to circulate undetected for prolonged periods, increasing the likelihood of rapid amplification and spread into new ecological or urban peri-urban interfaces. If a major outbreak were to occur in a previously unaffected area within these regions, existing control capacities would likely be overwhelmed. Without urgent investment in surveillance, decentralized care, and vaccine delivery, the risk of uncontrolled spread and high mortality remains substantial.

WHO immediate actions:

WHO to continue supporting:

- Sustain global monitoring of YF epidemiology and risk patterns.
- Provide technical support to countries across surveillance, case-based surveillance, laboratory testing capacity, vaccination strategy, case management, and Infection Prevention and Control (IPC), and International coordination Group (ICG) request preparation.
- Strengthen collaboration and coordination with partners at global, regional, and country levels.
- Sustain and reinforce supply pipelines, including revolving emergency vaccine stockpile, pre-ordering essential items, and identifying additional suppliers (currently there are four WHO-prequalified yellow fever vaccine manufacturers globally)
- .
- Coordinate supply management with partners to ensure timely delivery of medical and non-medical items.
- Ensure WHO Country Offices, Regional Offices, and HQ continue to lead and support operational response management.
- Support countries to conduct immunity gap analyses and to design and implement targeted vaccination strategies.
- Support countries for urban YF preparedness and response.

Proposed Immediate Actions by WHO Region

WHO Region	Proposed Immediate Actions
Africa	**WHO to continue supporting to:** • Strengthen surveillance, including early identification of suspects, documentation of vaccination history, adherence to the WHO recommended laboratory testing algorithms, collection of samples of sufficient volume, adequate in-country sample transport to ensure specimen integrity, sustained proficient laboratory capacity, including within-country capacity for YF molecular testing, and outbreak investigation and risk assessment capacity. • Support identification of target populations for vaccination and facilitate ICG vaccine requests, and speedy implementation of reactive vaccination campaigns. • Enhance case management capacity and improve access to supportive care treatment. • Reinforce infection prevention and control (IPC) in treatment facilities such as placing patients under bed nets, vaccinating health personnel and patients, vector control if viraemic patients are hospitalized. • Strengthen cross border public health capacities and points of entry preparedness. • Strengthen preparedness in moderate-risk countries as per the EYE Strategy classification, especially in large urban centres. • Intensify risk communication, community engagement, and infodemic management. • Improve country-level supply management to ensure continuity of response services.

WHO Region	Proposed Immediate Actions
	• Strengthen partner collaboration to enable coordinated decision-making, alignment of resources and response actions across the region.
Americas	**WHO to continue supporting to:** • Provide technical support for surveillance strengthening and laboratory surveillance testing. • Support targeted vaccination strategies and ICG requests. • Enhance case management and IPC in affected areas. • Strengthen cross-border coordination due to high population mobility. • Reinforce risk communication and community engagement (RCCE) and supply chain management. • Strengthen preparedness in lower-risk areas, including urban centres.
Eastern Mediterranean	**WHO to continue supporting to:** • Maintain surveillance for importation through strengthened surveillance at points of entry. • Support laboratory readiness and rapid laboratory surveillance testing capacity. • Provide guidance on vaccination recommendations for travellers. • Strengthen RCCE and preparedness planning
Europe	**WHO to continue supporting to:** • Provide guidance on vaccination recommendations for travellers. • Support RCCE and supply preparedness for potential response needs.
WHO South-East Asia Region - East Asia	**WHO to continue supporting to:** • Strengthen surveillance and laboratory capacity for early detection of imported cases. • Support preparedness planning in countries with competent vectors. • Reinforce RCCE • Provide guidance on vaccination recommendations for travellers.
Western Pacific	**WHO to continue supporting to:** • Enhance surveillance including vector surveillance • Strengthen laboratory readiness • Support preparedness for potential local transmission in areas with presence of competent vectors. • Provide guidance on vaccination recommendations for travellers. • Reinforce RCCE and supply chain readiness.

Supporting information

Hazard assessment

YF is a mosquito-borne, acute viral haemorrhagic disease caused by the yellow fever virus (YFV), a member of the genus *Flavivirus* (family *Flaviviridae*). The disease is primarily transmitted by day-biting mosquitoes such as *Aedes*, *Haemagogus*, and *Sabethes* species. It is maintained in nature through mosquito–primate transmission cycles and can spill over into human populations, causing sporadic cases, outbreaks, or large epidemics. It is considered an epidemic-prone (high potential to cause sudden outbreaks affecting large numbers of people in a short period of time), vaccine-preventable disease that poses a significant threat to global health security due to its potential for international spread.

The incubation period ranges from 3 to 6 days. Humans are infectious and can transmit the virus to mosquitoes shortly before symptom onset and for several days thereafter. Seasonal patterns correspond to mosquito abundance, with increased transmission during rainy seasons in regions with history of YF transmission. YF infection ranges from asymptomatic to severe, life-threatening disease. Typical symptoms include fever, headache, myalgia, nausea, and malaise. A proportion of patients progress to a toxic phase characterized by jaundice, bleeding, shock, and multiorgan failure. The case fatality ratio (CFR) among severe cases ranges from 20% to up to 60%. Risk factors for severe disease include lack of prior immunity, extremes of age, and certain comorbidities, as well as delayed access to specialized care.

YF Transmission Cycles by Region

Three transmission cycles have been described, with the intermediate/savannah cycle reported exclusively in Africa.

Region	Transmission Cycles	Key Vectors	Main Characteristics

Africa	**Sylvatic (jungle)**	*Aedes africanus*	Virus circulates between non-human primates and humans at forest edges; human infection occurs during activities in or near forests.
	Savannah (intermediate)	Tree-hole breeding *Aedes* spp. such as: • *Aedes luteocephalus*, • *Aedes furcifer*, • *Aedes bromeliae*, • *Aedes taylori*	Acts as a bridge between sylvatic and urban cycles; Transmission occurs in rural and savannah regions where humans and vectors overlap.
	Urban	*Aedes aegypti*	Virus spreads between humans in densely populated areas; potential for large outbreaks where vaccination coverage is low.
Americas	**Sylvatic (jungle)**	*Haemagogus* spp. • *Hg. janthinomys*, • *Hg. leucocelaenus* *Sabethes* spp.	Maintains transmission among monkeys; spillover to humans occurs in forested zones, especially during occupational or recreational exposure.
	Urban	*Aedes aegypti*	Drives human-to-human transmission in urban settings;
Other Regions (Europe, South-East Asia, Western Pacific)	**Potential Urban Transmission (if virus introduced)**	*Aedes aegypti*	No history of YF transmission, but *Aedes aegypti* is present in many areas. *Aedes aegypti* is widespread in tropical/subtropical Asia Pacific and parts of southern Europe.

Laboratory confirmation relies on: Reverse Transcription Polymerase Chain Reaction (RT- PCR) during the acute viraemic phase, followed by serology antibody detection (IgM), with consideration of cross reactivity with other flaviviruses and the need for differential testing, and with Plaque Reduction Neutralization Test (PRNT) for confirmation, histopathology and immunohistochemistry in fatal cases. Laboratory surveillance testing challenges include short viraemia, cross reactivity, and limited laboratory capacity. YF laboratory testing is essential for surveillance and outbreak confirmation; however, inherent methodological constraints, particularly serological cross reactivity and the standard duration required for confirmatory and differential assays such as PRNT, which involve the cultivation of live cells and virus, naturally result in extended turnaround times for definitive results. Consequently, laboratory findings should be interpreted with caution and are not always sufficient on their own to guide individual clinical management.

There is no specific antiviral treatment for YF. Clinical management is supportive and includes fluid balance, organ support, and treatment of complications such as bleeding or renal failure. Use of hepatotoxic medications (e.g., certain Nonsteroidal Anti-inflammatory Drugs (NSAIDs)) is contraindicated. Early recognition and supportive care improve outcomes. Prevention and Control Measures rely on highly effective live attenuated vaccine (17D strain). A single dose provides lifelong protection for most individuals. The recommendations by the WHO Secretariat for vaccination against YF for international travellers are available here.

Exposure assessment

YF transmission in both Africa and the Americas is strongly shaped by seasonal ecological factors, particularly rainfall, temperature, and vector dynamics. Although the virus can circulate year-round in some areas, distinct seasonal peaks occur due to fluctuations in mosquito abundance and human exposure patterns.

During the 2025 YF transmission season, the YF global epidemiological profile has been characterized by two concurrent, but distinct transmission YF dynamics: a sustained risk of transmission in areas across Africa, and a marked increase in transmission risk in the Region of the Americas, where the viral activity has extended into areas historically considered at lower risk[7]. During this period, the Region of the Americas experienced a pronounced intensification of YF activity, representing the most substantial increase since the 2017–2018 outbreak in Brazil and the second largest surge since the 1995 Peru outbreak. Transmission expanded geographically, with sylvatic circulation documented beyond the Amazon basin in both Brazil and Colombia, reflecting shifting in ecological suitability and in epidemiological conditions. In early 2025, the Region reported a sharp rise in confirmed cases, contributing to a global total of 346 confirmed cases and 148 associated deaths from the Americas alone. In contrast, the WHO African Region exhibited a persistently elevated yet epidemiologically stable pattern of

[7] https://www.paho.org/sites/default/files/2025-05/2025-may-31-phe-epi-alert-yellow-fever-final.pdf

YF activity over the same period, with outbreaks and localized transmission occurring primarily in countries where large-scale preventive mass vaccination campaigns were conducted more than a decade ago and where routine childhood immunization coverage remains suboptimal, resulting in enduring immunity gaps.

Although no areas in countries in other WHO regions are currently classified as at risk for YF transmission, expanding ecological suitability for competent *Aedes* vectors and high international travel volumes from at risk areas continue to sustain the potential for importation of viraemic travellers and sporadic autochthonous transmission in countries without recognized risk areas.

Table 1: Yellow Fever (YF) Epidemiological Comparison by WHO Region, 2025–2026

WHO Region	2026 Season	2025 Season
Africa	• No new outbreaks reported, however confirmed YF cases have been reported across three countries: Burkina Faso (five PRNT-confirmed cases, including two deaths in unvaccinated adults, symptoms onset documented between January to February 2026), Central African Republic with two PRNT confirmed case (one from an urban setting) and Cameroon reporting nine confirmed cases (including two situations with epidemic potential). In addition, five countries – Angola, Côte d'Ivoire, Gabon, Ghana, and Nigeria – have reported PRNT yellow fever positive cases that remain under review pending final classification, with symptom onset between January and May 2026. • High baseline risk Long-standing systemic challenges, present before 2025 and continuing to persist, include: • Suboptimal routine immunization coverage • Requirement for confirmatory and differential testing (and thus international specimen referral of all IgM-positive sera), • Inadequate documentation of vaccination history which complicates the case classification and contributes to delays in finalizing case classification following communication of confirmed PRNT-positive test results, • Contextual constrains. Including insecurity, suboptimal access to health care, financial constraints, • Resulting impact on the timeliness and completeness of field investigations, and suboptimal response activities continue to undermine timely detection and control. • Ongoing EYE strategy vaccination campaigns	• Continues to represent the highest global burden, according to available estimates • 26 countries classified as high-risk within the WHO African Region (with the exception of Sudan, which is classified under the WHO Eastern Mediterranean Region for reporting and administrative purposes)) • Persistent small-scale outbreaks (Ghana, Nigeria, Cameroon, DRC, Angola, Côte d'Ivoire) and larger outbreaks (Ghana, Nigeria, Cameroon, DRC, Angola, Côte d'Ivoire). • Two YF outbreaks reported in Angola (Cuanza Norte cluster) and in Central African Republic (Bossembele district), along with 14 additional events with epidemic potential that warranted reactive vaccination campaigns in five countries (three in Burkina Faso, six in Cameroon, three in Côte d'Ivoire, one in Liberia and one in Mali).
Americas (AMR)	• 79 confirmed cases, 31 deaths • Expansion beyond the Amazon basin: São Paulo State (Brazil), Tolima department (Colombia), • WHO/PAHO supporting intensified response	•, Confirmed case counts in the Americas surpassed those reported in Africa in 2024–2025, with 346 confirmed cases and 143 deaths • Transmission documented in seven countries: in Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, Venezuela • 2 imported cases from Peru) • Reemergence in Colombia's Magdalena Valley 22 parishes that had not previously been classified as risk areas in four states of Venezuela • Fivefold increase vs. 2024

Eastern Mediterranean (EMR)	• No outbreaks reported • Monitoring continues	•One high-risk country (Sudan) EYE Strategy classification •No transmission • Vaccination recommendations for travellers
Europe (EUR)	• Situation unchanged • Importation risk only	• No transmission • Occasional imported cases • Vaccination recommendations for travellers • Compliance with requirements established by other countries
South-East Asia Region - East Asia (SEAR)	• No changes • Focus on preventing importation	• No transmission • Compliance with requirements established by other countries
Western Pacific (WPR)	• No outbreaks • Continued emphasis on importation prevention	• No transmission • Surveillance focused on travel-related risk

AFRICAN REGION

In 2025, a total of 120 confirmed yellow fever (YF) cases and 16 deaths have been reported from 14 countries in the WHO African Region. The case fatality rate (CFR) was 15% (16 deaths/ 120 confirmed cases). Eight cases were confirmed by PCR and 102 cases were confirmed through PRNT. Case burden was highest in Burkina Faso (44 cases) and Cameroon (37), followed by Angola (11) and Nigeria (7). Côte d'Ivoire reported 5 cases, Uganda, Togo, and Central African Republic 3 cases. Liberia had 2 cases. Ghana, Mali, Niger, Republic of Congo, and Senegal all reported one case.
Among 113 cases with available age data, 17% were under 10 years, 72% were between 10 and 49 years, and 11% were aged 50 years and above. The male-to-female ratio among confirmed cases was 1.4:1.

In addition to confirmed cases, several countries have reported probable cases and PRNT-positive samples in patients with symptom onset in 2025 that are awaiting final classification. The number of confirmed cases may be revised following the availability of additional epidemiological data and the classification of these PRNT-positive cases. The emergence of cases in countries with no recent transmission (2023-2025), such as Angola, Burkina Faso, Gabon, Gambia, Liberia, Mali, Togo, and Niger, reflects ongoing virus circulation, increased immunity gap due to suboptimal RI, and, potentially, limitations in surveillance. Past preventive and reactive vaccination campaigns have contributed to reducing the risk of large-scale outbreaks in several countries; however, suboptimal routine immunization coverage, delays in classifying PRNT-positive cases, and incomplete response activities continue to undermine timely detection and control. Concurrent outbreaks, rapid urbanization, population movement, and exposure to *Aedes aegypti* mosquitoes in densely populated settings further heighten the risk of transmission and regional spread.
Moderate risk countries bordering high-risk countries are at risk of introduction of viraemic individuals with subsequent autochthonous transmission. Risk of YF importation has increased in countries such as Burundi and Eritrea due to influx of refugees from DRC and Sudan respectively.

In 2026, and as of 26 May, no new active outbreaks have been detected. 16 YF confirmed cases with symptom onset after 1 January 2026 were reported from three countries: Burkina Faso (5), Cameroon (9) and Central African Republic (2). However, final laboratory confirmation and classification remain pending for around 32 suspected cases with onset of symptoms in 2026 and with a positive YF-specific serology and positive YF PRNT results in several countries (Angola, Burkina Faso, Cameroon, Central African Republic, Cote d'Ivoire, Gabon, Ghana and Nigeria) indicating probable ongoing transmission. Uganda also reported several positive YF IgM results in suspected cases sampled in 2026. Immunity gaps in subnational areas with suboptimal vaccination coverage, coupled with persistent vector presence and sylvatic reservoirs, sustain the potential for re-emergence and localized outbreaks.

REGION OF THE AMERICAS

In the Region of the Americas, a marked increase in cases has been detected compared with 2022–2024, including transmission in newly affected areas within countries with history of YF transmission.
Between epidemiological week (EW) 1 and EW 52 of 2025, 346 confirmed human cases have been reported, including 143 fatal cases (CFR= 41%) among six countries. This represents a fivefold increase compared to 2024. The 2025 cases have been reported in: Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru and Venezuela. In 2024, most cases were reported in the Amazon region of Bolivia, Brazil, Colombia, Guyana, and Peru. In contrast, in 2025, cases have been reported outside the Amazon region such as São Paulo State in Brazil and Tolima Department in Colombia. The risk of introduction into urban settings exists whenever sylvatic transmission cycles are intensified.
In 2026 and as of 26 May, a cumulative total of 79 confirmed YF cases and 31 associated deaths were reported across six countries: Bolivia (Plurinational state of), Brazil, Colombia, Ecuador, Peru, and Venezuela. Early season confirmed cases and

deaths reported from multiple countries in the Americas, including evidence of nonseasonal transmission in Colombia, point to sustained viral circulation in both areas with and without history of YF transmission. This pattern, combined with historical expansion of transmission into new ecological zones, suggests a continued risk of further geographic spread and additional human cases.

WHO EASTERN MEDITERRANEAN REGION, EUROPEAN REGION, SOUTH-EAST ASIA REGION, WESTERN PACIFIC REGION, -EAST ASIA REGION, WESTERN PACIFIC REGION. YF transmission is not documented in WHO EUR, SEAR, or WPR regions, and only one country—Sudan—in EMR is classified as a high-risk country (EYE Strategy classification). While no recent local transmission has been reported in these regions, all remain at risk of importation due to increasing global travel, trade, and migration from areas in Africa and South America with history of YF transmission.
Environmental factors, rapid urbanization, and the widespread presence of *Aedes aegypti* in parts of these regions create ecological conditions that could, in principle, support transmission if YF virus were introduced. Although past importation events—particularly in Asia—have not resulted in onward transmission, the possibility of localized spread cannot be entirely excluded. Surveillance systems and compliance of travellers with recommendations for vaccination against YF remain central to preventing introduction. However, uneven preparedness, variable laboratory capacity, and limited access to timely healthcare in some settings continue to pose challenges.

Context assessment

BACKGROUND

YF transmission occurs in tropical regions of Africa and South America. 27 African countries and 13 countries in the Americas Region are classified as high-risk for YF transmission. The estimated burden is heavily concentrated in Africa. Each year, an estimated 67 000 to 173 000 severe infections and 31 000 to 82 000 deaths occur in Africa and the Americas[8]. There is no transmission in Europe, the Middle East, South-East Asia or the Western Pacific, although imported cases occur. YF is reemerging as a significant global health threat, driven by a convergence of environmental change, geopolitical instability, expanding vector habitats and increasing human mobility. The Americas experienced intensified transmission in 2025, with the risk expected to remain elevated throughout 2026. Persistent outbreaks in regions with history of YF transmission, geographic expansion into previously unaffected neighbouring areas, and the movement of travellers across continents underscore the growing potential for transmission. In contrast, there was no epidemiological evidence of increased transmission in Africa in 2025; rather, transmission persisted at low to moderate levels, including in countries that had not reported cases for several years. Large outbreaks have declined in Africa in recent years. Despite the availability of an effective vaccine, regional supply constraints in the Americas, gaps in routine immunization including vaccine hesitancy and misunderstanding of the vaccines, underserved communities, and under-resourced health systems continue to limit the ability of countries to prevent, detect and respond to outbreaks. Both Africa and the Americas experienced intensified transmission in 2025, driven by a convergence of environmental change, geopolitical instability, expanding vector habitats and increasing human mobility.

Changes in transmission dynamics:

The Latin America and Caribbean (LAC) region has historically reported almost exclusively sylvatic YF cases, while the last documented outbreak involving urban transmission by *Aedes aegypti* occurring in 1942 in Brazil. Although the large 2017-2018 YF outbreak in Brazil occurred in peri-urban densely population areas, it was characterized by sylvatic transmission only. However, it underscored the potential for urban spread and the possible re-introduction of the urban transmission cycle. In the Americas, YF cases have been detected in peri-urban areas where human populations intersect with forested environments, enabling sylvatic spill over. The confirmation of cases in these settings, often at the expanding edges of cities, signals an increased risk of transition to an urban YF transmission cycle with potential onward spread mediated by *Aedes aegypti*.
In Africa, most recent cases are associated with sylvatic transmission, and available information is often insufficient to determine whether the intermediate transmission cycle is involved. Although the last major outbreak involving the urban transmission cycle occurred in Angola in 2016, with extension to the Democratic Republic of Congo, limited probable urban transmission was documented in Cameroon in 2023-2024 in the city of Douala.

[8] World Health Organization. Yellow fever: fact sheet. Geneva: WHO; 2024. Available from: https://www.who.int/news-room/fact-sheets/detail/yellow-fever

Vectors:

The global resurgence of *Aedes* mosquitoes, the primary vectors for urban YF, has expanded the number of settings at risk. Ongoing transmission of chikungunya and dengue illustrates the widespread presence and efficiency of *Aedes aegypti*. The presence of *Aedes* borne viruses may indicate ecological suitability and potential for YF transmission in immunologically susceptible populations.

Environmental risk:

YF transmission in both Africa and the Americas is strongly shaped by seasonal ecological factors, particularly rainfall, temperature, and vector dynamics. Although the virus can circulate year-round in some areas, distinct seasonal peaks occur due to fluctuations in mosquito abundance and human exposure patterns.

In the **African Region**, YF is present across much of sub-Saharan Africa, and transmission follows seasonal trends. The highest transmission typically occurs during and immediately after the rainy season, when mosquito populations expand and environmental conditions favour viral amplification. The timing of this seasonality varies by sub-region. In West Africa, the rainy season generally spans May to October, and YF transmission increases during this period. Central Africa often experiences two rainy seasons, which can result in two corresponding peaks in transmission. East Africa shows more variability, with seasonal patterns depending on local rainfall and ecological conditions. These trends are driven by increased vector density during rainy periods, higher temperatures that accelerate mosquito development and viral replication, and environmental conditions that support mosquito survival. Human exposure linked to agricultural and outdoor activities also contributes. Vaccination remains essential throughout the year, but surveillance and vector control efforts intensify during rainy seasons, when outbreak risk is highest.

In the **Americas**, YF transmission is dominated by the sylvatic (jungle) cycle involving *Haemogogus* and *Sabethes* mosquitoes and non-human primates. This cycle exhibits a well-defined seasonal pattern, with peak transmission from January to May and the highest incidence typically observed in February and March. Transmission decreases from June to December, although low-level circulation persists in forested regions. Seasonal variation is driven by the expansion of sylvatic mosquito populations during the rainy season, higher humidity and temperature that enhance mosquito breeding and viral replication, increased viral circulation among non-human primates, and greater human exposure during forest-related activities such as agriculture, logging, and extractive work. Geographic variation exists: the Amazon Basin maintains year-round risk with rainy-season peaks, southeastern Brazil has shown strong seasonal peaks between December and April during recent epizootics, and Andean countries such as Peru and Bolivia typically experience peaks during their wet season from January to March. Public health measures focus on vaccination for all at-risk areas regardless of season, enhanced surveillance during the January–May peak, and monitoring primate die-offs as an early warning signal.

Across both regions, rainfall and temperature are the dominant ecological drivers of seasonal YF transmission. Although the timing differs between Africa and the Americas, the epidemiological pattern is consistent: rainy seasons lead to increased vector abundance, greater viral circulation, and higher human risk, while dry seasons correspond to reduced vector activity and lower transmission.

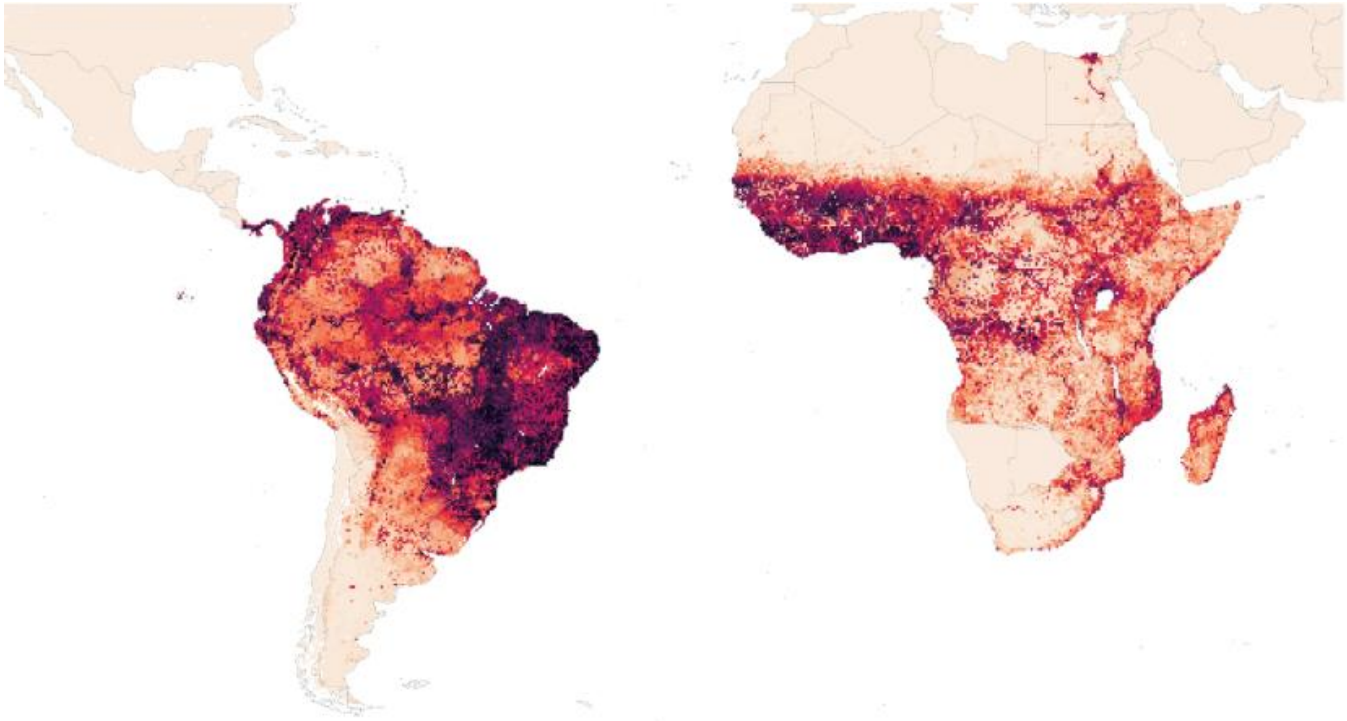
The geographic spread of YF outside the Amazon basin into previously low-risk areas in countries such as Brazil, Colombia, and more recently Venezuela is most likely driven by the expansion of sylvatic transmission along forest-urban and peri-urban interfaces, facilitated by deforestation and land-use change, climate variability affecting vector distribution, human mobility and occupational exposure in previously unaffected areas, and immunity gaps due to suboptimal vaccination coverage.

Environmental changes such as deforestation, climate variability, and the expansion of human activities into forested areas, are increasing contact between humans, non-human primate reservoirs, and mosquito vectors, thereby heightening the risk of YF spillovers. In parallel, the frequent movement of exposed workers between forest zones and urban centres, together with rapid urbanization and largescale population mobility, is increasing opportunities for viral introduction and amplification in urban settings, contributing to a shift in the epidemiological profile of YF.

Human risk:

Population movements driven by trade, migration, and episodes of civil unrest can erode community immunity, particularly in major urban centres, as unvaccinated individuals relocate into areas that previously achieved high coverage through mass vaccination.

Figure 1: Model-predicted environmental suitability for *Aedes aegypti* for spatial variation in surveillance capacity in Africa and the Americas.



Source: Lim, A., Shearer, F.M., Sewalk, K. *et al.* The overlapping global distribution of dengue, chikungunya, Zika and yellow fever. *Nat Commun* **16**, 3418 (2025). https://doi.org/10.1038/s41467-025-58609-5

Social:

The YF risk is rising in settings marked by high population mobility, mass displacement, and rapid urbanization. In both Africa and the Americas, people are increasingly moving between forested zones with active sylvatic transmission and densely populated urban areas where *Aedes aegypti* thrives. Large numbers of unvaccinated or under immunized individuals—particularly in conflict-affected regions, informal settlements, and frontier agricultural zones—are contributing to expanding pools of susceptible populations.

Technological:

Surveillance and laboratory capacity remain uneven, especially in rural, remote, and conflict affected areas, leading to under detection and delayed confirmation of cases. While some countries have strengthened preparedness under the International Health Regulations (IHR), many still lack robust vector surveillance, effective urban mosquito control programmes, and the operational capacity to rapidly scale up mass vaccination campaigns. Limited disease suspicion and specimen referral to the national laboratory in high-risk areas continues to hinder early outbreak detection and response in affected areas, leading to under detection and delayed confirmation of cases.

Economic:

Under resourced health systems, constrained national budgets exacerbated in 2025 with withdrawal of US funds, and competing public health priorities limit the ability of countries to maintain routine immunization, conduct timely field epidemiological and entomological investigations, conduct preventive campaigns funded by GAVI in Africa, or introduce or sustain vector control operations. Since 2016, there has been no shortage of vaccines in the global ICG stockpile for reactive (outbreak response) or preventive campaigns. However, there will be limited funds for countries that need to conduct targeted vaccination campaigns to bridge the immunity gap detected in 14 high-risk countries in Africa. This will reduce the risk of

outbreaks. Economic pressures linked to migration, mining, logging, and agricultural expansion also drive human movement into high-risk forested areas, increasing exposure.

Environmental:
Climate change is amplifying YF risk through shifting rainfall patterns, droughts, flooding, and ecological disruption. These changes expand the geographic range and seasonal activity of *Aedes* mosquitoes and increase the probability of human–vector contact. Deforestation, agricultural expansion, and settlement at forest edges intensify interactions with sylvatic transmission cycles. In both Africa and the Americas, ecological suitability for *Aedes aegypti* is increasing in peri-urban and urban environments, supporting the potential for wider spread. urban and urban environments, supporting the potential for wider spread.

YF can spread easily in settings where disrupted water, sanitation and waste management systems create favourable breeding sites for *Aedes* mosquitoes. In such contexts, inadequate solid waste disposal, unmanaged water storage and damaged infrastructure often lead to an increase in stored water for household usage, where vectors may thrive. Effective WASH measures play a critical role in reducing transmission risk by ensuring safe water storage, eliminating standing water, improving solid waste management, and promoting community level hygiene behaviours that limit mosquito breeding. When combined with vector control activities and strong community engagement, these interventions help protect displaced or crises affected populations from outbreaks of YF[9].

Political:
Conflict and political instability, undermine routine immunization, surveillance, access to health care, and outbreak response. Porous borders and limited cross-border coordination facilitate regional spread. Globally, suboptimal compliance of travellers with vaccination recommendations, inconsistent application of entry requirements by countries that have established those, and the possible use of counterfeit international certificates of vaccination or prophylaxis, might allow infected individuals to enter regions without history of YF transmission such as Asia. Since the 2016 amendment to the International Health Regulations (IHR, 2005), a single full dose of WHO-prequalified yellow fever vaccine is recognized as providing lifelong protection, and booster doses can no longer be required as a condition for international travel. However, fractional-dose yellow fever vaccination—while effective for emergency outbreak response—does not meet IHR requirements for international travel certification. Individuals vaccinated with a fractional dose must therefore receive a standard full dose to obtain a valid International Certificate of Vaccination or Prophylaxis (ICVP). Between 2016 and 2018, several million individuals received fractional doses during large-scale outbreak response campaigns in AFR. These individuals may be unaware that their vaccination status is not compliant with IHR travel requirements, potentially leading to gaps in documentation, increased demand for revaccination, and operational challenges at points of entry.

Overall, the burden of disease is falling disproportionately on communities with limited access to health services, including remote, marginalized, and conflict-affected populations. Weak surveillance systems, low awareness among healthcare workers, and restricted diagnostic capacity impede early detection. In many settings, centralized care models delay treatment for rural populations who face long travel times or insecurity. Climate-vulnerable areas with poor infrastructure are particularly affected, as flooding and drought simultaneously increase mosquito density and strain already limited health services. Populations in countries with prolonged periods of minimal or undetected viral circulation are particularly vulnerable, owing to low population immunity and reduced institutional experience with outbreak detection and response.

9 Water, Sanitation, Hygiene and Health (WSH). (2024, April 10). Water and sanitation interventions to prevent and control mosquito borne disease: focus on emergencies. https://www.who.int/publications/i/item/9789240090644

YF Outside Africa and the Americas

Topic	Summary
Imported Cases in Europe	YF cases in Europe occur only in travellers returning from regions with history of YF transmission. In 2018, the EU/EEA recorded 13 travel associated cases—mostly linked to Brazil—with France reporting the highest number, followed by Germany, Czechia, the Netherlands, Romania and the United Kingdom of Great Britain and Northern Ireland. No cases were reported in 2019.
Local Transmission in Europe	Despite repeated importations, Europe has never documented local YF transmission. The main vector, *Aedes aegypti*, has a limited distribution, and strong surveillance systems support rapid detection and containment of imported infections.
Imported Cases in Asia	Asia has never experienced local transmission of YF despite widespread *Aedes aegypti*. Several imported cases have occurred, including infections detected in Chinese workers returning from the 2016 Angola outbreak. No onward transmission followed, likely due to cross-immunity from other flaviviruses, lower vector competence and limited introduction events. Immunity from other flaviviruses, lower vector competence and limited introduction events. Modelling based on global air travel patterns suggests that around 25 major Asian cities had a measurable probability of receiving a viraemic traveller in 2016. However, the likelihood of sustained local transmission remained below 50%, largely because introduction events were rare. Although no local outbreaks have occurred, the Asia–Pacific region is increasingly considered vulnerable. Climate change, rapid urbanization and high travel volumes may create conditions that could allow YF to establish if introduced. Travel patterns suggests that around 25 major Asian cities had a measurable probability of receiving a viraemic traveller in 2016. However, the likelihood of sustained local transmission remained below 50%, largely because introduction events were rare. Although no local outbreaks have occurred, the Asia–Pacific region is increasingly considered vulnerable. Climate change, rapid urbanization and high travel volumes may create conditions that could allow YF to establish if introduced.

Capacities and Vulnerabilities by WHO Region

WHO Region	Capacities	Vulnerabilities
Africa (AFR)	• Established EYE strategy implementation • Existing vector control programmes, but mainly for malaria vectors • Longstanding experience managing YF outbreaks and control programs • Routine immunization in 25/27 high-risk countries • Capacity to conduct reactive vaccination campaigns	• Large immunity gaps in several countries: high-risk countries that have not yet conducted a Preventive Mass Vaccination Campaign (PMVC) and high-risk countries with immunity gaps following PMVCs conducted over ten years ago. • Limited disease suspicion and specimen referral logistics in some areas • High vector density and favourable climate •Limited entomological surveillance of *Aedes* vectors •Urbanization without adequate vector control •Under-reporting and surveillance gaps •Given the nonspecific clinical presentation of YF, laboratory confirmation remains indispensable for case classification. Reliance on PCR alone is insufficient, as a negative result cannot exclude infection; viral RNA is detectable only within a narrow temporal window, and even in countries with established molecular capacity, successful detection is often hampered by suboptimal specimen transport conditions that contribute to RNA degradation. For this reason, serological testing is always required to complement molecular diagnostics, as different markers—viral RNA, IgM antibodies, and neutralizing antibodies—emerge at distinct stages of the disease course. •However, the diagnostic value of IgM remains limited by known cross reactivity with other flaviviruses, meaning that positive IgM results are not definitive and require confirmatory and differential testing in specialized reference laboratories. While this additional step is essential to ensure diagnostic accuracy, it continues to pose operational challenges for timely case confirmation. Prior vaccination

WHO Region	Capacities	Vulnerabilities
		history may also affect the interpretation of IgM, as vaccine-induced immune responses may lead to detectable IgM antibodies independent of recent infection. Although a capacitated network exists through training and provision of commodities, specimens are often not referred promptly, in adequate volume, or under appropriate cold chain conditions, rendering them unusable, as viral RNA is highly susceptible to degradation.
Americas (AMR)	• Strong laboratory networks in many countries • PAHO supported surveillance systems • Ability to conduct reactive vaccination campaigns and routine immunization programmes • Experience with recent outbreaks	• Geographic expansion into new areas • Uneven vaccination coverage • High vector presence (*Aedes aegypti*) in urban areas • Risk of rapid urban amplification • Limited country-level readily available vaccine supply to address surges /challenged timely access to global stockpile
Eastern Mediterranean (EMR)	• Surveillance for imported cases • Vector control programmes in some countries	• Presence of *Aedes aegypti* in parts of the region • Conflict affected areas with weak health systems • Risk of importation from Africa • Limited YF specific clinical experience in affected areas with weak health systems
Europe (EUR)	• Strong surveillance and laboratory capacity • High clinical management capacity • Yellow fever virus is a Risk Group 3 pathogen and must be handled in BSL3 laboratories because it can infect humans through accidental exposure (such as needlesticks, aerosol generation, or contact with infectious materials).	• Imported cases possible • *Aedes aegypti* established in some southern areas • No population immunity • Potential for delayed detection of rare cases
South- East Asia Region -East Asia (SEAR)	• Strong border health measures • Established vector control programmes • High awareness of arboviral disease control programmes	• Widespread *Aedes aegypti* distribution • No population immunity • High travel volume from regions with history of YF transmission • Potential for urban introduction if importation occurs
Western Pacific (WPR)	• Strong surveillance systems • Experience with dengue and other arboviruses • Vector control infrastructure	• Competent vectors widely present • No population immunity • High travel connectivity • Risk of delayed recognition of imported cases

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ANNEX 1: Yellow fever cases and deaths per country, WHO African Region, 1 January – 31 December 2025

Country	Confirmed cases	Deaths	First symptoms onset date	Epidemiological week	Date of arrival to the Regional Reference Laboratory	Date of last Regional Reference Laboratory results	Number of weeks without cases
Angola	**11**	**1**	**05-Feb-2025**	**6**	**08-Apr-25**	**13-Feb-26**	
Benin	**0**	**0**				**05-May-26**	**52**
Burkina Faso	**44**	**6**	**05- Jan- 2025**	**2**	**11-Jan-25**	**08-Dec-25**	**2**
Cameroon	**37**	**3**	**13-Apr-25**	**16**		**29-Jan-2026**	
Central African Republic	**3**	**3**	**30- Nov- 2025**	**49**		**5-Feb-2026**	An outbreak identified in Bossembele district in Q4, 2025 is affecting a mining and military-associated population. Implementation of the immunization response has been delayed, primarily due to pending clarification of the size of the population at risk. To date, four cases have been confirmed, with symptom onset ranging from 30 November 2025 and 6 January 2026.
Chad	**0**	**0**					**52**
Congo, DR	**0**	**0**				**23-Jul-2025**	**52**
Congo, Rep	**1**	**0**	**09-Mar-25**	**11**	**16-Mar-25**	**23-Dec-25**	**41**
Côte d'Ivoire	**5**	**1**	**15-Sep-2025**	**38**		**28-Apr-26**	
Gabon	**0**	**0**				**14-Aug-25**	**52**
Gambia	**0**	**0**	**-**			**30-Dec-25**	**52**
Ghana	**1**	**0**	**05-May-25**	**19**	**23-Jun-25**	**10-Apr-26**	**33**
Guinea	**0**	**0**				**20-Nov-25**	**52**
Liberia	**2**	**0**	**14-Jan-25**	**3**	**3-Mar-25**	**29-Dec-25**	**5**

Mali	1	0	26-Nov-25	48	8-Dec-25	9-Dec-25	4
Niger	1	0	16-Feb-25	8	14-Mar-25	28-May-25	44
Nigeria	7	1	28-Apr-25	18	20-Jun-25	06-May-26	34
Senegal	1	0	14-Oct-2025	42	17-Oct-25	30-Oct-25	10
Togo	3	1	15-Feb-25	7	13-May-25	31-Mar-26	45
Uganda	3	0	24-May-25	21	02-Sep-25	30-Sep-25	31
Total	120	16	30-Nov-25	49	8-Dec-25	13-Feb-26	3

ANNEX 2: Yellow fever cases and deaths per country, WHO African Region, 1 January – 26 May 2026 (data as of EW 20,2026)

Country	PRNT+ awaiting classification	Probable cases	Confirmed cases	Deaths in probable	Deaths in confirmed	Total deaths	CRF (%): confirmed cases only	CRF (%):confirmed and probable cases	Date of onset in last probable case	Date of onset in last confirmed case	Date of last RRL results
Angola	2	0	0	0	0	0	-	-	-	-	4/2/2026
Burkina Faso	3	2	5	0	2	2	29	29	1/3/2026	2/24/2026	5/5/2026
Cameroon	1	0	9	0	0	0	0	0	-	3/17/2026	5/13/2026
Central African Republic	0	0	2	0	0	0	0	0	-	2/5/2026	4/14/2026
Cote d'Ivoire	8	0	0	0	0	0	-	-	-	-	4/28/2026
Gabon	2	0	0	0	0	0	-	-	-	-	5/13/2026
Ghana	12	0	0	0	0	0	-	-	-	-	5/6/2026
Nigeria	4	0	0	0	0	0	-	-	2/15/2026	-	5/6/2026
Overall	32	2	16	0	2	2	11.1	11.1	2/15/2026	2/24/2026	5/13/2026

ANNEX 3: Yellow fever cases, deaths and epizootics, per country, WHO Region of the Americas, 1 January 2025 – 31 December 2025

Country	Confirmed human cases	Deaths
Bolivia	8	2
Brazil	120	48
Colombia	125	46
Ecuador	11	8
Guyana	1	1
Peru	49	19
Venezuela	32	19
Total	**346**	**143**
Country	**Confirmed epizootics**	**Deaths**
Bolivia	**3**	
Brazil	**124**	
Colombia	**77**	
Venezuela	**8**	**8**

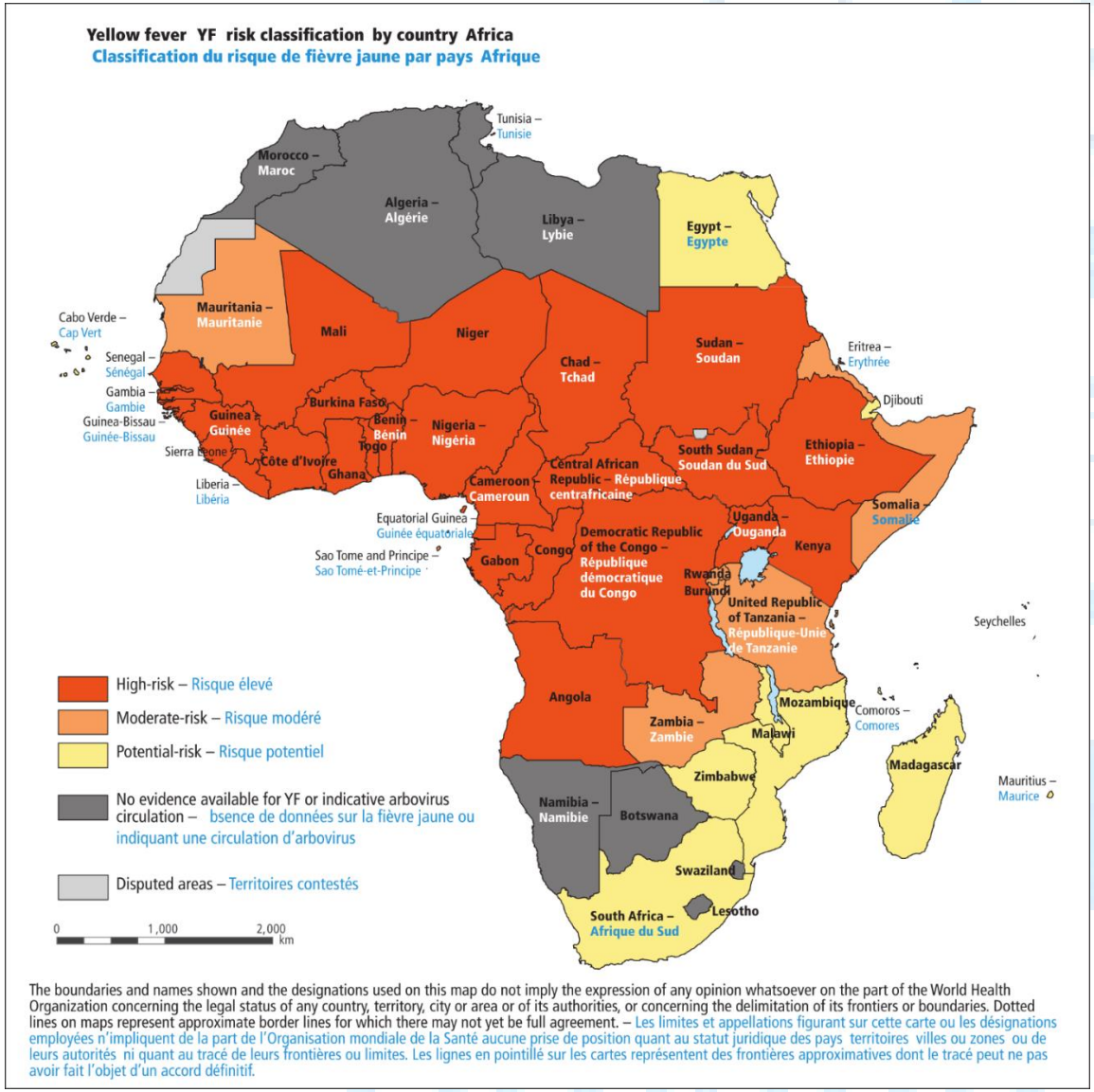
ANNEX 4: YF cases, deaths and epizootics, per country, WHO Region of the Americas, 1 January – 26 May 2026

Country	Confirmed human cases	Deaths
Bolivia	5	2
Brazil	11	6
Colombia	48	19
Ecuador	1	1
Peru	6	1
Venezuela	8	2
Total	**79**	**31**

Country	Epizootics
Brazil	31
Colombia	17
Trinidad and Tobago	1

Source: https://shiny.paho-phe.org/yellowfever/

ANNEX 5: Yellow fever Risk classification by country



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement. – Les limites et appellations figurant sur cette carte ou les désignations employées n'impliquent de la part de l'Organisation mondiale de la Santé aucune prise de position quant au statut juridique des pays territoires villes ou zones ou de leurs autorités ni quant au tracé de leurs frontières ou limites. Les lignes en pointillé sur les cartes représentent des frontières approximatives dont le tracé peut ne pas avoir fait l'objet d'un accord définitif.

Yellow fever (YF) risk classification, by country: LAC countries,[a] 2016
Classification du risque de fièvre jaune par pays: ALC,[a] 2016

[a] LAC: Latin American and Caribbean – ALC: pays d'Amérique latine et des Caraïbes

This map illustrates a public-health-intervention oriented YF risk approach at country level. Its purpose is different from the YF risk area maps for travellers in the context of IHR, e.g. http://gamapserver.who.int/mapLibrary/Files/Maps/ITH_YF_vaccination_americas.png – Cette carte illustre une approche de classification des risques de fièvre jaune axée sur les interventions de santé publique au niveau des pays. Cela diffère de l'approche utilisée dans les cartes des zones à risque de fièvre jaune destinées aux voyageurs au titre du RSI, telles que: http://gamapserver.who.int/mapLibrary/Files/Maps/ITH_YF_vaccination_americas.png