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CHOLERA - GLOBAL

Date and version of current assessment: 18 March 2025, v7

Date(s) and version(s) of previous assessment(s):

Overall Global risk and confidence

Overall risk
Global
Very High

Confidence in available information
Global
Moderate

Overall Risk Statement

Since October 2022, the global risk for cholera has been continuously assessed as very high in six consecutive RRAs. This RRA (v7) reassesses the current global risk level, considering ongoing cholera outbreaks, new countries affected, and the global response capacity (e.g., technical expertise, oral cholera vaccine (OCV) availability, and essential cholera supplies). Country and region-specific risk assessments are provided within the document.

From 1 October 2024 to 28 February 2025 (period since previous RRA v6), a total of 290 609 cholera cases and 2615 deaths (case fatality rate (CFR) 1%) were reported across 32 countries – slightly higher than the same period in the previous year (1 October 2023 to 29 February 2024), when around 270 000 cases and 2500 deaths were recorded across 29 countries.

During this period, the Eastern Mediterranean Region (EMR) recorded the highest number of cases (196 721 cases, nine countries), followed by the African Region (AFR) (88 156 cases, 17 countries), the South-East Asia Region (SEAR) (3878 cases, five countries), and the Region of the Americas (AMR) (1854 cases, one country). Cholera-related deaths were highest in AFR (1548 deaths, CFR 1.7%), followed by EMR (999 deaths, CFR 0.3%), AMR (62 deaths, CFR 3.3%), and SEAR (6 deaths, CFR 0.3%). Meanwhile, the European and Western Pacific regions have not reported any outbreaks since the last RRA. These figures should be interpreted with caution due to data inconsistencies, reporting delays, and surveillance gaps that likely contribute to under-reporting and hinder direct comparisons across regions and countries.

In 2025, some countries have reported a decline in cases (e.g., Bangladesh, Malawi, Nigeria, Tanzania, and Togo), however, the global cholera burden remains significant, with 27 countries reporting active outbreaks from 1 January to 28 February 2025, compared to 23 during the same period in 2024. Among the 27 countries, six (Angola, Democratic Republic of the Congo [DRC], Myanmar, South Sudan, Sudan, Yemen) are currently classified by WHO as being in "acute crisis" – a designation signalling rapidly escalating outbreaks that threaten to overwhelm health systems, requiring urgent intervention to prevent further spread and fatalities.

Crucially, cholera has re-emerged in countries that had not reported cases for years, such as Angola and Ghana, while Ethiopia, and Mozambique (both of which experienced large outbreaks in 2024) are now facing renewed and increasing transmission. Additionally, even in countries with ongoing outbreaks, the disease is spreading into previously unaffected areas, further complicating response efforts. For instance, in DRC, transmission has surged in non-endemic provinces, including remote and hard-to-reach areas, making containment more challenging and placing additional strain on an already fragile health system.

Case fatality rates (CFRs) remain alarmingly high in several countries, with 11 now reporting rates above 1%, up from eight countries in early 2024. Additionally, multiple countries have also reported an elevated number of community deaths. These trends highlight significant systemic weaknesses across health, WASH (Water, Sanitation, and Hygiene), environmental, and broader public health and civic infrastructure., including critical gaps in community-based response and access to timely treatment, overstretched healthcare facilities, and insufficient surveillance – factors that continue to drive preventable deaths.

Compounding these challenges, many of the hardest-hit countries are grappling with complex humanitarian crises, where sociopolitical instability, fragile healthcare infrastructures, and inadequate access to clean water and sanitation fuel the spread of cholera. The situation is particularly challenging in countries like DRC, Ethiopia, Myanmar, Somalia, South Sudan, Sudan, Syria, and Yemen, where limited response capacity further heightens the risk of uncontrolled transmission.

Cross-border transmission remains another major concern, with confirmed spread between Myanmar and Thailand, and more recently Ethiopia, South Sudan and Djibouti. These patterns underscore the ease with which cholera can spread beyond national borders, especially in areas with porous crossings and limited healthcare resources. Adding to the challenge, cases have also been exported from Tanzania to France and from Ethiopia to Germany and the United Kingdom, raising concerns about potential under-detection in other countries. Surveillance gaps, along with delays and inconsistencies in reporting, further increase the risk of silent transmission, which could allow outbreaks to escalate unnoticed.

REGIONAL OVERVIEWS

AFR: Cholera cases in the WHO African Region have increased since the last RRA, with Angola and Ghana experiencing new epidemics, while Malawi, Zambia and Zimbabwe have reported new outbreaks and Ethiopia and Mozambique a resurgence of the disease. In 2025, the highest case numbers have been reported in South Sudan (19 122) and DRC (8762), both facing humanitarian crises and insecurity. And with poor WASH infrastructure. The potential risk of cholera outbreaks remains very high across the region.

AMR: In Haiti, cholera cases (7726) and deaths (131) dropped significantly in 2024, by 86% and 82% respectively, compared to 2023 (54 767 cases, 711 deaths). The response in Haiti remains hampered by insecurity. In the Dominican Republic, the last confirmed case was in March 2024.

EMR: Cholera resurgence in the Eastern Mediterranean Region continues to be driven by climate change, conflict, fragile health systems, poor WASH infrastructure, and increased population movement. Since the last RRA, 196 721 AWD/suspected cholera cases have been reported across nine countries, with the highest numbers from Afghanistan (14 404), Djibouti (13 946), Lebanon (12084), Yemen ((South, in Internationally Recognized Government areas) 9784)), and Sudan (6512), where 89 % of the total regional deaths occurred, with 127 deaths out of 143 regional deaths (CFR 2%).

EUR: Cholera is not endemic in the WHO European Region, but Israel and Turkey, bordering Syria, face a heightened risk due to large outbreaks there, particularly among refugees and displaced persons. Since the last RRA, imported cases have been reported in Bulgaria, Russia, Spain, and France (2025), while Germany and the UK have identified cases linked to independently bottled well water imported from Ethiopia, including among non-travellers, underscoring the risk of transmission via this route.

SEAR: Bangladesh, India, Myanmar, Nepal, and Thailand have reported cholera cases since the last RRA, with Myanmar in "acute crisis" due to humanitarian challenges as well as limited surveillance, testing and WASH capacities. Bangladesh and Nepal show declining trends in case numbers, while four of five cases in Thailand (2025) were imported. However, the overall risk in SEAR remains high due to endemicity, weak WASH systems, conflict, and climate change.

WPR: No major outbreak has been reported in WPR since the last RRA. In this reporting period based on information publicly available cases have been reported in: Australia (three cases), Japan (three imported cases from Myanmar), Singapore (two cases) and New Zealand (one case).

RESPONSE CAPACITY

The global cholera response remains severely strained by simultaneous outbreaks, limited OCV supply, and overstretched public health personnel. Despite increased production, the one-dose strategy, introduced in 2022, remains in effect. Stockpile levels were below the five million-dose emergency thresholds for most of 2023–2024 and were completely depleted twice in 2024, including a two-month shortage at the start of 2024.

A record surge in cases led to ICG requests rising from 10 in 2021 to 33 in 2024. Between October 2024 and March 2025, 34 new requests were submitted—despite this typically being a low transmission period. However, the increase in vaccine supply, along with timelier submissions and more targeted requests, have contributed to maintaining the stockpile at a stable level of five million doses in recent months.

With peak cholera season approaching in East Africa, the Middle East, South Asia, and West Africa, further increases in vaccine requests are expected. Sustained support for timely and strategic submissions is crucial to avoid a recurrence of the 2024 crisis, when countries were placed on waiting lists for approved vaccines.

While coordination has improved, the decline in global humanitarian funding threatens this fragile balance. As a last resort responder, WHO may need to step in to fill critical gaps. Despite some progress, ongoing humanitarian crises, climate change, and underdevelopment continue to drive outbreaks, requiring sustained vigilance and investment.

SUMMARY

Despite some improvements in reporting and declining trends in certain countries, cholera remains a severe global public health threat. Key risk factors include:

1) Sustained outbreaks in 27 countries, including some that had not reported cholera for years.
2) Six countries in different regions currently in acute crisis, facing multiple compounding health and humanitarian challenges.
3) High mortality associated with cholera, including a significant number of community deaths, indicating critical delays in healthcare access.
4) Fragile health systems and lack of clean water and sanitation, exacerbating transmission.
5) Cross-border transmission and international exportation of cases, underscoring the global nature of the threat.
6) Limited response capacity, including supply constraints on OCV, essential cholera supplies, and human resources.
7) Climate-related flooding and extreme weather events increasing cholera vulnerability in multiple regions.
8) Surveillance gaps and under-reporting, limiting real-time visibility of outbreaks.
9) Competing health emergencies, stretching already limited national and regional resources.
10) Global funding constraints, including reductions in emergency response funding, are preventing an adequate scale-up of response activities.

Based on these factors, the **risk at the global level is re-assessed and remains unchanged as very high.** Cholera remains a clear indicator of social inequity and underdevelopment, requiring sustained global action and investment to mitigate its long-term impact.

Major actions recommended by the risk assessment team

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

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Risk questions

Risk question	Assessment		Risk	Rationale
	Likelihood	Consequences		
Potential risk for human health?	Highly likely	Major	Very high	According to WHO's internal risk categorization, six of the 27 affected countries are currently classified as being in acute crisis. As of 2 March 2025, 11 of the 27 countries experiencing active outbreaks have reported a CFR above 1%, an indicator of inadequate case management and delayed access to care. Angola is reporting the highest CFR at 3.9%, followed by Zambia at 3.1%. A particularly concerning trend is the high proportion of community deaths, suggesting that many individuals are dying before reaching healthcare facilities. In Angola, almost 32% (64 of the 204 recorded deaths) occurred in the community, while in Zambia almost 78%, (seven out of nine deaths) were reported outside health facilities. In DRC, recent figures from Haut Katanga province indicate that at least two-thirds of reported deaths over the past two weeks also took place in the community, highlighting severe gaps in healthcare access and timely response. Many affected countries struggle with weak surveillance systems, insufficient knowledge of cholera among healthcare workers, and a lack of decentralized treatment options. These challenges, coupled with the sheer scale of ongoing outbreaks, have stretched response capacities, leading to delays in both reporting and intervention. Countries that have not reported cholera for many years face additional difficulties, as both healthcare staff and the general population have little familiarity with the disease. This lack of experience can result in delayed detection, inadequate case management, and an increased risk of fatalities. Access to healthcare remains severely constrained in areas affected by insecurity, poor infrastructure, and logistical challenges. Some of the most concerning examples include outbreaks in remote and hard-to-reach locations such as Maniema province in DRC, where CFR exceeds 10%. In conflict-affected settings like Myanmar, access is even more restricted. Limited information on cholera-related deaths from the de facto authorities make it difficult to assess the true scale of the crisis, but existing evidence from various sources suggests that insufficient healthcare availability is leading to high mortality. Despite ongoing advocacy efforts, treatment remains centralized, which further limits access and increases the likelihood of deaths occurring in the community. In areas outside the control of the de facto authorities, access to healthcare is even more precarious, with little to no information available on the outbreak's status or the populations affected. The combination of poor surveillance, delayed responses, and systemic barriers to healthcare is driving excess mortality, particularly in communities that are geographically or politically marginalized. As the outbreaks continue to escalate, urgent efforts are needed to strengthen surveillance, decentralize treatment, and improve access to lifesaving care.
Risk of geographical spread of the event?	Highly Likely	Major	Very High	Cholera continues to expand, with 27 countries and territories affected, an increase from 24 affected as of September 2024. While some countries report stabilization in the number of cases reported, transmission remains widespread, with outbreaks

				intensifying in several regions and increasing the risk of international spread. In Africa, cholera is spreading across multiple subregions, driven by insecurity, displacement, weak healthcare access, and limited WASH infrastructure. In DRC, over 1000 cases are reported weekly, with transmission reaching previously unaffected areas, raising concerns for major cities and cross-border spread to Burundi, Rwanda, Uganda, Tanzania, and Zambia. Ghana's outbreak remains persistent in coastal fishing communities, a known transmission driver along the Gulf of Guinea, with risks expected to rise as the rainy season approaches. South Sudan and Ethiopia continue to report cases, with Ethiopia exporting cases to Europe, underscoring international spread risks. In Angola, cholera has reached 14 of 21 provinces. Namibia confirmed its first case in nearly a decade, signaling further regional transmission. Mozambique's response efforts are being undermined by violence, misinformation, and attacks on cholera treatment centers (CTCs), complicating containment efforts. The risk of geographical spread remains very high in the Eastern Mediterranean Region. From October 2024 to February 2025, Yemen alone surpassed 60 000 cases, while Afghanistan and Sudan exceeded 43 000 and 33 000, respectively. Transmission persists in several other countries in the region, particularly in fragile settings with poor WASH infrastructure, although surveillance challenges and underreporting obscure the true morbidity and mortality associated with cholera. In South-East Asia, Myanmar's outbreak has spread to at least nine State/Regions, including areas outside de facto authority control. The country has also exported cases to Thailand and Japan, highlighting cross-border transmission risks. The cholera outbreak in the border areas between Myanmar and Thailand reported in December 2024 purportedly triggered restrictions at entry points in the affected areas. Internationally, cholera cases have been imported into Germany, France, the UK, Japan, and Thailand in 2025, following similar detections in Bulgaria, Russia, and Spain in 2024. Some cases originate from non-reporting areas such as Zanzibar (Tanzania) and Egypt, indicating undetected transmission and surveillance gaps. With cholera continuing to spread both regionally and globally, the risk of further expansion remains concerning, requiring urgent action to strengthen surveillance, improve cross-border coordination, and enhance outbreak response efforts.
Risk of insufficient control capacities?	Highly likely	Major	Very high	WHO's technical teams are increasingly overwhelmed, struggling to provide adequate support in the face of simultaneous large-scale outbreaks. This situation has been exacerbated by recent reductions in foreign aid, further limiting available resources. The ongoing worldwide mpox epidemic and persistent conflict in eastern DRC are additional factors diverting attention and response capacity away from cholera control efforts. The global supply of OCV remains constrained despite increased production. The ICG continues to rely on a one-dose strategy due to supply limitations. Throughout 2023 and 2024, OCV stockpile levels consistently fell below the emergency threshold of five million

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				doses, with total depletion at times during 2024. The surge in cholera cases has led to a record number of ICG requests, rising from ten in 2021 to 33 in 2024, and reaching 34 since October 2024. While requests are now submitted more promptly, allowing for better stockpile management, vaccine availability remains precarious. With peak cholera season approaching in several regions, ensuring timely and targeted vaccine distribution will be critical to avoiding the 2024 scenario, when multiple countries were placed on a waiting list for vaccines due to shortages. In addition to vaccine constraints, cholera kit supplies are also limited. Increasingly complex administrative processes and flight shortages have further delayed the delivery of essential medical supplies, even when they are available. Although systems have been developed to improve cholera kit distribution, much of the coordination remains dependent on WHO's IMST. Diagnostic capacity also remains inadequate in many settings, delaying outbreak detection and confirmation. The lack of reliable laboratory data has led to gaps in mapping priority intervention areas, resulting in inefficient resource allocation. If a major outbreak were to occur in a previously unaffected area due to conflict or natural disaster, global supply chains would be severely overstretched, further undermining response efforts.

Current RRA v7, March 2025	
Capacities	**Vulnerabilities**
Coordination • Experts deployed through GOARN, SBP, and Emergency Medical Teams (EMT) to support cholera response in high-burden countries. • As of 26 January, 22 experts deployed through GOARN and 25 experts through SBP for critical cholera response roles, including case management, surveillance, and logistics. • Enhanced coordination with UNICEF, MSF, GAVI, and regional stakeholders to improve supply chain management and outbreak response. **Laboratory** • GTFCC guidance and tools published for cholera testing, covering surveillance, environmental testing, and diagnostics. • Cholera RDT procurement through GAVI continues, improving outbreak monitoring and surveillance. • Training materials on RDT sample collection and testing available, with translations in progress to increase accessibility. • Technical assistance provided to countries for defining and implementing testing strategies during outbreaks.	**Coordination** • Overstretched emergency response capacity due to multiple concurrent outbreaks and other public health crises. • Limited availability of cholera-experienced personnel for field deployments, affecting surge response. • Funding constraints impacting deployment and operational coordination in some high-burden countries. **Laboratory** • Diagnostic capacity remains inadequate in some countries, leading to delays in outbreak detection and confirmation. • Insufficient laboratory data for mapping high-risk areas results in inefficient allocation of response resources. • Inconsistent sample collection and transportation impact testing accuracy and timeliness.

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Surveillance • The GTFCC published updated cholera reporting recommendations in 2025, including standardized templates available in French and English. • Revised public health surveillance guidance and new online training courses for health authorities and healthcare workers have been released in Arabic, English, French, and Portuguese. • Support for data management and outbreak monitoring is provided on a case-by-case basis. • The GTFCC has also launched three online courses on Priority Areas for Multisectoral Interventions (PAMIs), enhancing the use of surveillance data for National Cholera Plan development.	**Surveillance** • Data quality and reporting remain inconsistent, with limited disaggregation for vulnerable populations, particularly children under five. • Underreporting and delays persist due to weak surveillance infrastructure in some affected areas. • Limited use of digital tools for data collection and analysis restricts rapid response capabilities.
Vaccination • OCV production increased following the introduction of a new vaccine formulation in 2024. As of January 2025, the global OCV stockpile averaged 5.4 million doses, with only one week below the 5M-dose target. • Nine new emergency OCV requests submitted in January 2025, collectively seeking 9 million doses. • Five countries (Bangladesh, Malawi, Mozambique, South Sudan, and Zambia) have conducted seven reactive vaccination campaigns, targeting four million people.	**Vaccination** • Severe OCV stockpile shortages prevent preventive vaccination campaigns and force reliance on one-dose reactive campaigns. • The rising demand for vaccines amid a growing number of cholera outbreaks is outpacing supply capacity.
Case management **IPC and WASH** • Increasing package of technical tools for case management includes the sharing of the recently completed clinical management job aids/posters and indicators designed to help teams identify and follow up on weaknesses and follow progress (South Sudan, Angola).	**Case management, IPC and WASH** • Persistent gaps in country-level knowledge due to outbreaks in regions with no recent history of cholera (e.g., Angola) or the spread into non-endemic areas within countries experiencing ongoing outbreaks (e.g., DRC). • High staff turnover, impacting continuity and expertise. • Competing priorities from other health emergencies, such as mpox and Sudan Viral Disease, increasing the demand for global support. • Limited implementation of community-based treatment programmes, resulting in a high number of preventable community deaths.
Risk communication and community engagement and Infodemic Management (RCCE-IM) • Regular RCCE coordination and technical support provided at regional and country levels. • Support provided for social behavioral data collection and community listening mechanisms to improve targeted messaging.	**Risk communication and community engagement and Infodemic Management (RCCE-IM)** • There are insufficient RCCE personnel and funding, limiting the scale and effectiveness of community engagement efforts. • Advocacy efforts to raise awareness and secure necessary resources for RCCE interventions remain weak. • Misinformation and vaccine hesitancy persist in some affected communities, impacting intervention uptake.
OSL • Cholera response supplies shipped via air and sea to high-burden countries, including DRC,	**OSL** • Financial constraints in key affected areas are limiting timely operational response and procurement of essential

Mozambique, Myanmar, Niger, Nigeria, South Sudan, Sudan, Syria, Yemen, and Zambia. • New tracking tools developed to improve stockpile visibility and response efficiency.	supplies. • Some countries have limited cold chain storage capacity, affecting vaccine storage and distribution.

Immediate actions

1. Review the existing grade of the global cholera crisis.
2. Continue to leverage resources to support global monitoring of the cholera pandemic, provide technical support to countries, enhance data collection and reporting, strengthen advocacy, and provide medical and non-medical items to countries in need, especially for case management and diagnosis.
3. Continue to strengthen collaboration and coordination with partners.
4. Maintain the supply pipeline by replenishing emergency bulk item stock, pre-ordering supplies, and identifying additional suppliers for key bulk items (OSL).
5. Continue efforts to coordinate supply coordination with partners.
6. Management of response in each country to remain with WHO Country and Regional offices.
7. WCOs, ROs, HQ, and partners to continue to provide technical support to countries to:
    - Strengthen surveillance including strengthening diagnostic algorithms, use of RDTs, collecting and transporting of samples and strengthening laboratory capacity to culture *V. cholerae;*
    - Provide guidance on identifying target populations for vaccination and requesting vaccine through the ICG mechanism, in the context of grossly limited supply;
    - Continue to strengthen case management capacity and improve access to treatment for patients, including working with RCCE for the setup of oral rehydration points in the community, to improve access to care, recently published guidance on Oral Rehydration Points will help support this work;
    - Strengthen infection prevention and control in treatment structures, including cleaning practices, hand hygiene, waste management, and rational use of personal protective equipment (PPE)
    - Strengthen water, hygiene and sanitation systems through multi-sectoral mechanisms, including IPC and guidance on water quality monitoring;
    - Continue developing a toolkit box for WASH emergency response; More elaborated actions for WASH are needed to be implemented; more WASH coordination, grass root level activities to improve the WASH in the communities;
    - Strengthen risk communication, community engagement and infodemic management interventions, based on social behavioural data and community listening, to be included in other response pillars;
    - Strengthen country-level supply management to ensure continuity of response services.

Supporting information

Hazard assessment

Cholera is an acute diarrheal infection caused by ingesting food or water contaminated with the bacterium *Vibrio cholerae* either type O1 or type O139. Infection has a short incubation period of two hours to five days. The bacterium produces an enterotoxin that causes copious watery diarrhoea that can quickly lead to severe dehydration and death if treatment is not promptly given. Vomiting also occurs especially in the early stages of cholera and can last for hours. Cholera affects both children and adults and can kill within hours. Person-to-person transmission is not common.

About 20% of those who are infected with *V. cholerae* develop acute watery diarrhoea; approximately 20% of these individuals develop severe watery diarrhoea, many also with vomiting. If these patients are not promptly and adequately treated, the loss of fluid and salts can lead to severe dehydration and death within hours. The fatality rate in untreated cases may be 30–50%. However, treatment is straightforward (rehydration) and, if provided rapidly and appropriately, the case fatality rate should remain below 1%.

People with low immunity, such as malnourished children or people living with HIV, are at greater risk of death if infected.

The *V. cholerae* O1 has caused all recent outbreaks. *V. cholerae* O139 – first identified in Bangladesh in 1992 – caused outbreaks in the past but recently has only been identified in sporadic cases. It has never been identified outside Asia. There is no difference in the illness caused by the two serogroups.

Cholera is transmitted by ingestion of faecally contaminated water or food and remains an ever-present risk in many countries. Cholera transmission is closely linked to inadequate access to clean water and sanitation facilities. Typical at-risk areas include peri-urban slums and camps for internally displaced persons or refugees, where minimum clean water and sanitation requirements are unmet. The consequences of a humanitarian crisis – such as disruption of water and sanitation systems or the displacement of populations to inadequate and overcrowded camps – can increase the risk of cholera transmission should the bacteria be present or introduced. Uninfected dead bodies have never been reported as the source of epidemics.

Cholera is an easily treatable disease. Most of the affected people can be treated successfully by promptly administering oral rehydration solution (ORS). The WHO/UNICEF ORS standard sachet is dissolved in 1 litre (L) of clean water. Adult patients may require up to 6 L of ORS to treat moderate dehydration on the first day. Currently, two WHO pre-qualified oral cholera vaccines (OCV), Shanchol™ and Euvichol-Plus®, are available through the Global OCV Stockpile. Both two-dose vaccines, with a single dose providing up to 6 months of protection and two doses providing at least three years of protection.

Exposure assessment

Based on available information, cholera outbreaks have been reported in the following countries and areas since the last RRA (Table 1).

Table 1. Summary of cholera outbreaks ongoing and/or reported since the previous RRA

Region	Country/Area	Context
AFRO	**Angola**	Since the last RRA, on 7 January 2025, Angola reported a suspected cholera outbreak in the Paraíso neighbourhood of Cacuaco, located in Luanda Province. Since 05 January 2025 02 March 2025, a total of 5990 suspected cases were reported, including 1014 confirmed cases and 211 deaths (CFR 3.5%). Thirteen out of 21 provinces have been affected, with 97% of cases reported in Luanda (3113), Bengo (2053), and Icolo e Bengo (662) with ages ranging from 2 to 100 years of age, with 56% of them being male. Most deaths also occurred among males (67%), mainly in Luanda (111 deaths) and Bengo (75 deaths). During epi-week 9 (ending on 02 March 2025) 835 cases and 24 deaths were reported (CFR: 2.9%). Eighty-six percent of cases were reported in Luanda (560) and Bengo (162). Since the beginning of the outbreak, the country has experienced an increasing trend, reporting over 800 cases per week over the last month.
AFRO	**Burundi**	Since January 2024, and as of 28 February 2025, the country has reported 987 suspected cases and three deaths (CFR 0.3%). A total of eight districts have been affected, with five remaining active over the past four weeks. Over the last 28 days, 27 cases have been reported in Bujumbura Nord (19), followed by Isale (five), Bujumbura Centre (one), Bujumbura Sud (one), and Kabezi (one). The trend in new cases has been relatively low with intermittent spikes since the last RRA was finalized in September 2024.

AFRO	**Cameroon**	Since January 2024, and as of 2 December 2024, the country reported 33 suspected cases (including two confirmed cases) and one community death (CFR 3%) from three districts: Maroua 3 (88%), Maroua 2 (6%) and Bogo (6%). Only one district was in active outbreak (Maroua 3), compared to the previous RRA in which ten health districts had active outbreaks. . As of 28 February 2025, no cases have been reported in the country.
AFRO	**Comoros**	The start of the outbreak was declared on 2 February 2024 when cases linked to a ship from Tanzania were identified in Comoros. The first local cases were reported on 4 February. Since 2 February 2024, and as of 1 February 2025 (latest data available), a total of 11 220 suspected and 153 deaths were reported (CFR 1.4%) including 65 in healthcare facilities and 88 in the community. All three regions have been affected: Ngazidja (1140), Ndzuwani (9126), and Mwali (654). Since September, most suspected cases have been reported in Ngazidja (805), while Mwali has also recorded cases since November.
AFRO	**Democratic Republic of the Congo**	From 1 January 2024 to 23 February 2025, the country reported 8762 suspected cases, including 185 deaths (CFR 2.1%). Ten out of 26 provinces have been affected, with 87% of cases reported in Haut-Lomami (3248 cases), Haut Katanga (1936 cases), Nord-Kivu (1497 cases) and Tanganyika (929 cases). As of epiweek 8 (ending 22 February) 1378 suspected cases and 30 deaths (CFR: 2.2%), with 78% of cases from Haut Katanga (366 cases), Haut-Lomami (324 cases), Nord Kivu (236) and Sud-Kivu (146 cases). In the last RRA conducted in September 2024, approximately 500 suspected cases were reported per week. However, since the beginning of 2025, there has been an increasing trend, with more than 1,000 suspected cases reported weekly. The outbreak in Nord-Kivu continuous to be exacerbated by high insecurity and population displacement, further compounded by insufficient financial resources for the response (particularly in Haut-Lomami), stock out of Cary-Blair transport medium and cholera Rapid Diagnostic Tests (RDTs), and suboptimal WASH infrastructure.
AFRO	**Ethiopia**	From 1 January 2024 to 2 February 2025, 27 273 cholera cases and 272 deaths (CFR: 1%) reported across 11 regions. Nevertheless, after September 2024, Ethiopia reported a declining trend in cases with less than 500 cases throughout the end of the year. From 1 January 2025 to 27 February 2025, 830 cholera cases and 24 deaths (CFR 2.9%) were reported across 17 woredas, with 75% of the cases from Gambella and 25% from Amhara region. The outbreak has affected 4 refugee camps, 9 woredas and 2 Towns from Gambella and Amhara regions. One of the major contributing factors for the rapid spread, especially in the Gambella region, is the cross-border movement with South Sudan and within woredas cross community movement. On 10 February, AWD cases were reported in Gambella, all with travel history to South Sudan.

		Additionally, an outbreak started on 3 January 2025, linked to the Bermel Georgis holy water site in Quara, Amhara region, a well-known pilgrimage destination and source of a major outbreak in 2023.
AFRO	**Ghana**	The last outbreak in Ghana was recorded in 2016 with 704 cases. In the last RRA, on 23 August 2024, the first two confirmed cases were reported. As of 21 February 2025, 6513 suspected cholera cases were reported, including 573 confirmed cases, with a total 49 deaths (CFR 0.8%). Suspected cases have been reported in five of the country's 16 regions, covering 119 districts. Most of the suspected cases (98%) have been recorded in Western (2242), Central (2645), and Greater Accra (1492) regions.
AFRO	**Malawi**	The Government of Malawi declared the end of a protracted cholera outbreak in July 2024, following zero reports of cholera for more than four weeks. However, in early September Malawi reported ten suspected cases and one confirmed case in the Chitipa District. A new outbreak was confirmed in Lilongwe District with the first cholera culture reported on 26 August from Lumbadzi Health Centre. Since 8 September 2024, and as of 27 February 2025, Malawi has reported 305 confirmed cases, including 15 deaths (CFR 4.9%), with four in the community. Of the total cases, 129 (42%) were confirmed through culture, while the rest were epidemiologically linked. Five out of 29 districts have been affected: Balaka (91), Chitipa (61), Machinga (59), Karonga (60), and Mzimba North (34). The outbreak has now been successfully contained in the Chitipa. Since the beginning of the year, cases have showed a declining trend with the last 3 weeks reporting less than ten cases.
AFRO	**Mozambique**	Although Mozambique was downgraded from an active to a preparedness status in the last RRA, a cholera outbreak was declared in Mogovolas district, Nampula province on 28 October 2024, and in Mopeia district, Zambezia province on 6 February 2025. As of 2 March, 777 suspected cases and 29 deaths (including 25 in the community) were reported in 4 districts of Nampula and Zambezia provinces. During epi-weeks 8 and 9 (ending 1 March 2025), 331 new cases and 0 deaths were reported. Murrupula (Nampula province), a newly affected district, accounted for 167 cases (50%), followed by 129 cases (39%) in Nampula district (Nampula province) and 35 cases (11%) in Mopeia district (Zambezia province). No data was reported from Mogovolas in 2024 and beginning of 2025, due to the destruction of the Cholera Treatment Center (CTC) and health facility in Mogovolas District, which partially reopened 20 February but was vandalized again 2 March. Misinformation, threats of violence to health workers and vandalization of the CTC have impacted health seeking behaviours and hindered response efforts. Furthermore, while predicted cyclones have weakened, the country remains affected by rainfall and flooding.
AFRO	**Niger**	In September 2024, Niger recorded its first cases, with 72 suspected cases and 5 deaths (CFR 6.9%). This was reported on the last RRA.

		From 6 September 2024 to 19 January 2025, 1066 cases, including 23 deaths, were reported. Of the 289 samples tested, 112 (38.8%) were positive by culture. Cases were reported across 7 regions: Tahoua (451 cases; 14 deaths), Zinder (331; 2), Maradi (239; 5), Diffa (33; 1), Agadez (6; 1), Tillabéri (5; 0) and Dosso (1; 0). Since 19 January 2025, no additional cases or deaths have been reported.
AFRO	**Nigeria**	A total of 1113 suspected cholera cases were reported between 1 January and 2 March 2025, with 27 cases confirmed by culture and 28 deaths reported (CFR 2.5%). The outbreak spans 25 states and 65 LGAs, with 77% of cases reported in Baylesa (748) and Rivers (107). Since epi-week 3 (ending in 18 January 2025), cases and deaths have been in decline. In epi-week 9 (ending 1 March) only two suspected cases and no deaths were reported from Bauchi (one) and Osun (one) states.
AFRO	**South Sudan**	From 28 September 2024 to 2 March 2025, a total of 35 101 cases and 590 deaths (CFR 1.7%) have been reported. The outbreak spans 39 counties across nine states and 1 administrative area, with Western Equatoria the only state to not have reported any cases. The highest case burden has been reported in Unity, Jonglei, and Central Equatoria (Juba). Weekly cases peaked at over 5000 in mid-December, before declining and stabilizing, with 2210 cases reported in week 9. Majority (72%) of the cases are from the host community, 4,473 (12.7%) are from IDP camps, 2,265 (6.5%) among refugees and 427 (1.2%) among returnees. The impact of the Sudan crises and the poor WASH infrastructure are factors attributed to the increase in transmission of the disease.
AFRO	**Tanzania**	Since January 2024, and as of 23 February 2025, cumulatively 13 190 cases and 158 deaths have been reported. Twenty-three regions have reported outbreaks since 2024, with the outbreak ongoing in 7 regions; Lindi, Mara, Mbeya, Rukwa, Simiyu, Songwe and Tabora. Since the beginning of the year (2025), cases have been decreasing. During epi-week 7 (ending on 15 February), a total of 84 suspected cases and 0 deaths were reported. Most of the cases were recorded in Ruwka and Mara.
AFRO	**Togo**	Since 12 August 2024, and as of 28 February 2025, the country has reported 443 suspected cases including 124 confirmed by culture and 21 deaths (CFR 4.7%). The epidemic affected four of 39 districts and two of six health regions, with 67% in Grand Lomé (296 cases) and 33% in Maritime (147 cases). The beginning of the outbreak, which was reported in the last RRA, had an increasing trend with significant spikes reaching up to more than 35 suspected cases per week, suggesting ongoing transmission. However, as of epi-week 9 (ending 1 March) only two new cases and no deaths were reported and only one district Agoè continues to report active outbreaks. .
AFRO	**Uganda**	From January to 28 February 2025, a total of 139 cases and three deaths (CFR 2.2%), including one community death, have been reported. Since the last RRA, two new cholera outbreaks were reported in February, in Lamwo and Kiryandogo districts (refugee hosting), with frequent cross-border movement with South Sudan. The situation in Uganda appears to remain stable with limited community transmission.

World Health Organization

AFRO	**Zambia**	In the last RRA Zambia was downgraded from active to preparedness after an outbreak with widespread transmission which started in October 2023. However, on 24 December 2024 new cases were identified. From 24 December 2024 to 6 March 2025, a total of 328 cases and nine deaths (CFR: 0.6%), including seven community deaths, have been reported. Cases have been reported across six provinces: Copperbelt (265), Muchinga (27), Central (five), North-Western (4), Lusaka (24) and Eastern (one).
AFRO	**Zimbabwe**	On 30 July 2024, the Zimbabwe Ministry of Health officially declared the end of the cholera outbreak, which was reported on the latest RRA. However, new cases were identified close to the end of the year. From 3 November 2024 to 26 February 2025, 439 suspected cases were reported, including 74 confirmed by culture, and 8 deaths, two of which occurred in the community. The outbreak spans 16 districts of 7 provinces, with Mashonaland Central (235) and Mashonaland West (128) accounting for 83% of the cases. During epi-week 8 (ending 22 February) 26 suspected cases and one death (CFR 3.8%) were reported.
AFRO Summary	There are several concurrent graded emergencies, delayed detailed investigation leading to stretched human capacity due to other public health emergencies. Some affected areas are highly insecure, and the population has limited access to healthcare. Climate change leads to drought in some areas, and floods in others, resulting in increased population displacement and reduced access to clean water. High CFR was reported from multiple outbreaks. Since the last RRA, Angola and Ghana are experiencing new epidemics, while Ethiopia, Mozambique, Zambia, and Zimbabwe have reported a resurgence of the disease. However, Cameroon, Niger and South Africa declared the end of the previous outbreaks.	
AMRO/PAHO	**Haiti**	Since January 2024 to 28 February 2025, a total of 8087 cholera cases were reported, including 139 confirmed cases and 132 deaths (CFR 1.7%), of which 70 deaths (53%) occurred in the community. Cases have been reported in 10 departments, with Artibonite (n=2917), Centre (n=2568), and Ouest (n=1310) accounting for 69% of total cases. During week 2 (ending 11 January 2025) 80 new suspected cases were reported, including 18 suspected cases across eight IDP camps (all of which were RDT negative). In 2023, 54767 cases and 711 deaths were reported from Haiti. This marks a significant reduction in the number of reported cases and deaths compared with 2024. However, significant epidemiological surveillance challenges likely resulted in the underreporting of cases. Throughout 2023, a reactive vaccination campaign was carried out. Complex humanitarian crises are ongoing in the context of gang violence, lack of fuel hampering all aspects of daily life, lack of access to electricity and clean water, limited medical care, lack of access to food (even through humanitarian corridors), and high prevalence of acute malnutrition. Risk for further exported cases to countries within the region is possible, as observed during 2010–2018, during the mass exodus of the population from the country.
AMRO/PAHO Summary	Haiti saw a significant reduction in the number of reported cholera cases (suspected and confirmed) and deaths in 2024 compared to 2023. However, the ongoing humanitarian crisis in Haiti continues to severely limit access to healthcare, directly impacting the country's cholera response. The persistence of internally displaced and highly mobile populations increases the risk of further spread and creates significant challenges for surveillance, leading to the likely	

	underreporting of suspected cases. Furthermore, the risk of additional cholera exportation from Haiti to other countries in the Region of the Americas cannot be ruled out.	
EMRO	**Afghanistan**	Authorities do not recognize cholera and instead refer to AWD. The country is facing a prolonged widespread outbreak. From 1 January 2024 to 1 March 2025, a cumulative of 189 665 AWD with dehydration cases were reported. The highest cumulative incidence of AWD per 10 000 has been reported in the provinces of Paktya (154.4), Nimroz (151.6), Logar (107.3), and Kabul (96.1). Since January 2025, and as of 1 March, a total of 14,403 suspected cases and six deaths (CFR 0.04%) have been reported. Of these cases, 59.2% are children under the age of 5 years and 48.5% are female. In total, 711 Rapid Diagnostic Tests have been conducted, with 34 (4.8%) testing positive. In epi week 9 (ended 2 March), 1,742 new suspected cases and one death were reported from 11 districts.
EMRO	**Djibouti**	Authorities do not recognize cholera and instead refer to AWD. Cholera cases have not been officially reported in Djibouti. Since October 2024, as of week 3 of 2025, a total of 13 946 cases of AWD were reported across the country, of which, 2563 cases were reported in 2025. The cases have decreased since week 52 of 2024, with a 32% decrease in week 3 compared to week 2 of 2025. Most of the cases (1958, 76%) were reported from Djibouti city. No information about new cases has been available since then.
EMRO	**Iraq**	Iraq reports cholera cases every year, with an increase in the number of cases observed since week 33 of 2024, with a peak on week 37 when 137 confirmed cases were reported. A decrease in the number of weekly cases has been observed since then. Since 1 October 2024, a total of 211 confirmed cholera cases have been reported, and no cases were reported since week 49 of 2024.
EMRO	**Lebanon**	On 16 October 2024, the Ministry of Public Health reported a confirmed cholera case (O1) in an 82-year-old Lebanese female who had not travelled abroad recently. This was the only culture-confirmed case reported in the country in 2024. However, from 1 October to 29 December 2024, a total of 12 084 acute watery diarrhoea cases were reported across the country.
EMRO	**Pakistan**	From 1 January 2024 to 26 January 2025 (latest data available), a total of 79 446 cholera/AWD cases have been reported. Since 1 January 2025, a total of 2229 cases have been reported. In epi week 4 527 suspected cholera/AWD cases have been reported. According to the weekly provincial breakdown, Punjab is the most affected region (417 cases), followed by Balochistan (80 cases), Sindh (11 cases), Khyber Pakhtunkhwa (ten cases), Azad Jammu and Kashmir (six cases), and Gilgit-Baltistan (three cases).
EMRO	**Somalia**	Somalia has been experiencing uninterrupted cholera transmission in the Banadir region since 2017 in the context of severe drought and high prevalence of severe acute malnutrition. From 1 January 2025 and as of 23 February, a total of 1 409 cumulative cases and one death (CFR 0.1%) have been reported. There were reported from five regions: Lower Juba (500 cases), Lower Shabelle (440 cases), Bay (244 cases), Banadir (121 cases), and Middle Shabelle (104 cases).

		In epi week 8 (starting 17 February), 2025 there were 155 cases (-5% vs week 7).
EMRO	**Syria**	On 11 October 2024, WHO was notified of a cholera outbreak in Al Hol Camp in Al-Hasakah Governorate. From 1 October to 16 November 2024, a total of 161 cases of acute watery diarrhoea, including one death were reported in the camp, of which 46 were RDT-positive cases and 10 were confirmed by culture. The last culture-confirmed case was reported on 18 October 2024. From 1 October to 31 December 2024, a total of 770 acute watery diarrhoea cases were reported countrywide, most of them (274 cases) reported in Hasakah governorate due to the outbreak in Al-Hol camp, followed by Aleppo (246 cases) and Lattakia (118 cases) governorates. No culture-confirmed cases were reported outside of Al-Hol camp.
EMRO	**Yemen**	Cholera established its endemicity in Yemen after the worst reported outbreak in 2017. A total of 9,784 suspected cholera/AWD cases have been reported from 1 January to 23 February 2025. Cumulatively in 2025, 66 culture confirmed and 553 RDT confirmed cases have been reported. Nine deaths have been reported nationwide (CFR: 0.01%). In epi week 8 (starting 17 February), a total of 488 new suspected cases, with four deaths, have been reported. The ongoing conflict and poor WASH conditions are among the factors that contribute to the risk of cholera upsurge in Yemen.
EMRO	**Sudan**	The cholera outbreak was officially declared under Article 6 of IHR by the Sudan National IHR Focal point on 12 August 2024. Cumulatively between 26 July 2024 through 3 March 2025, a total of 57 135 cases with 1,506 deaths (CFR 2.6%), including 119 community deaths, have been reported across 12 of 18 states. In epi week 8 (starting 17 February) of 2025, 1,788 cases were reported, with 84% of the cases concentrated in White Nile (1509 cases). The recent case surge in weeks 7 and 8 has been linked to a paramilitary attack on a water plant in Kotsi, White Nile State. Between 20 and 22 February, 1411 cases and 32 deaths (CFR 2.3%) were reported in Kotsi and neighbouring cities.
EMRO Summary	Weak surveillance systems make the interpretation of data challenging (e.g. sentinel, hospital-based surveillance). Staff capacity is stretched due to complex humanitarian crises and the emigration of trained staff. Population movement exacerbated by climate change, droughts, and flooding increases the risk. However, the number of reported cases has been decreasing in most countries. At the same time, the ongoing outbreak in Sudan is of concern and demonstrates an increasing trend.	
EURO Summary	Cholera is not endemic in the WHO European region. Strong public health systems, including access to adequate hygiene and sanitation standards and surveillance and response capacities, lower the risk of transmission following importation. However, countries bordering Syria and Lebanon (Israel, Türkiye), where large ongoing outbreaks are reported, may have a heightened risk of introduction and onward transmission in particular settings (e.g., amongst refugees and displaced persons). Over the past year, the conflict situation in Ukraine has continued with hostilities occurring across the country, causing significant infrastructure damage, compromised healthcare and worsening of general living conditions, including access to shelter, safe water and	

	food for those who have remained in the country. While no confirmed local cases of cholera have yet been reported in the European region in 2025, the continued impacts on access to safe drinking water, and adequate sanitation and hygiene measures can exacerbate this risk of outbreaks in the region. The last cholera outbreak reported in Ukraine was in 2011, however, the ongoing war in Ukraine stands to worsen environmental and sanitary conditions further and weaken health infrastructure in this area. There were several cholera cases imported to the European Region from other cholera-affected countries across the globe.	
SEARO	**Bangladesh**	Cholera is endemic, with year-round low-level transmission in Bangladesh and predictable spikes during pre-monsoon (April-May) and post-monsoon (August-September) seasons. Since the RRA v6, country-wide data shows a decline in cholera positivity among diarrhoea cases. Among the Rohingya population and host community in Cox's Bazar, from 23 June to 1 March 2025, 581 culture-confirmed cases and 65 RDT-positive cases reported. Since September 2024, 376 new culture-confirmed cholera cases and 48 RDT-positive AWD cases (with pending culture results) have been reported in Cox's Bazar. The number of reported confirmed and suspected cases peaked in December 2024, consistently decreasing since the beginning of 2025. Of the culture-confirmed cases, 94% (545 cases) are from Rohingya refugee camps, with 36 cases reported among the host population in Ukhiya (21), Teknaf (12), Ramu (two) and Bandarban (one). Children aged 0–9 years (59%) and males (53%) are most affected. No confirmed cholera deaths have been reported during the outbreak. OCV campaigns were implemented starting in mid-January.
SEARO	**India**	Cholera is endemic in India, and outbreaks are reported across many states throughout the year. Most outbreaks are managed swiftly. From 1 January to 29 December 2024 (the latest data available), public reports from the Integrated Disease Surveillance Program (IDSP) include a total of 10 834 suspected cases, 569 confirmed cases and 58 deaths (CFR 0.5%) from 19 states: Andhra Pradesh, Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Goa, Gujarat, Haryana, Jammu & Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Pondicherry, Punjab, Tamil Nadu, Uttar Pradesh and West Bengal.
SEARO	**Myanmar**	Since July 2024, acute watery diarrhea (AWD)/cholera have affected increasing areas of Myanmar, with at least nine states/regions having been affected to date (Ayeyarwady, Bago, Kayin, Magway, Mandalay, Mon, Rakhine, Tanintharyi and Yangon). Affected townships have also increased from 8 in 2023 to 85 in 2024. According to the health authorities , from 22 June 2024 to 9 March 2025, a total of 11 995 AWD cases (not confirmed as cholera) across nine States/Regions; three deaths among AWD patients reported (causes of deaths not ascertained); while according to informal sources, cholera/AWD-related deaths have been reported in multiple States/Regions. This is an increase of 8574 AWD cases since the RRA v6 was conducted in September 2024. In Kayin, an outbreak started in Shwe Kokko Hospital in the beginning of December 2024 with 1631 AWD cases as of 9 February 2025, including 309 severe cases (19%) requiring hospitalization (according to the informal sources). Laboratory-confirmed cholera (O1 Ogawa serotype) cases with travel history to Myanmar were reported by Japan and Thailand in 2025.

		In Yangon, the weekly numbers of the cases reported by the health authorities has been low in 2025 (less than 100 cases per week) relative to the weekly numbers reported in July to August 2024 (300 to 500 cases per week). Myanmar implemented an OCV campaign with 2.4 million doses.
SEARO	**Nepal**	From 1 January 2024 to 28 February 2025, Nepal reported 437 suspected cases, according to the Ministry of Health EWARS weekly bulletin. The most recent cases reported this year were in week 8 (starting 17 February 2025). These are four cases reported from three districts: Khotang (two cases), Achham (one case), and Parbat (one case).
SEARO	**Thailand**	According to the Ministry of Public Health of Thailand, *V. cholerae* serogroup O1, serotype Ogawa was detected among imported cases in December 2024. Between 21 December 2024 and 4 January 2025, Tak Province reported four confirmed cholera cases. The cases included two Thai nationals and two foreign residents, all residing within the province. All cases fully recovered. Additionally, 11 and five cases (16 cases in total) have been reported across Thailand in 2024 and 2025, respectively.
SEARO Summary	Four countries (Bangladesh, Myanmar, Nepal and Thailand) have reported cases in 2025 while three countries (Bangladesh, Myanmar, Nepal) reported cases as recently as February. Myanmar is currently categorised as a country in an "acute crisis" due to the continuous recording of suspected cases, challenging humanitarian situation and lack of capacity to test and respond. There are limited surveillance systems, low reporting or limited transparency in many countries in the region. Ongoing transmission implies continued risk of export to other regions.	
WPRO Summary	No major outbreak has been reported in WPR since RRA v6 was finalised in September 2024. In this reporting period, based on publicly available information, cases have been reported in: Australia (three cases), Japan (three imported cases from Myanmar), Singapore (two cases) and New Zealand (one case).	

Context assessment

Increasing humanitarian crises due to conflict, climate change (drought and flooding), political instability, and underdevelopment are leaving an increasing number of people at risk for cholera across all WHO regions. Many countries with active outbreaks are experiencing conflict or political violence, including DRC, Myanmar, Nigeria, Somalia, and Syria. In Ethiopia, religious pilgrimage to the Bermel Georgis holy water site in Quara, Amhara region poses a significant risk for spread within and beyond the region, as it was the source of a significant outbreak in 2023. Additionally, multiple countries—including DRC, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, and Somalia—are facing climate-related disasters such as flooding and prolonged droughts, further exacerbating cholera transmission risks.

Other major aggravating factors include financial crises, mass displacement of internally displaced persons (IDPs) and refugees, and chronic underdevelopment, which have left large populations across multiple regions without access to clean water, sanitation, and healthcare, making them highly vulnerable to cholera. Even in countries with ongoing outbreaks, cholera expands into previously unaffected areas, making containment more difficult and stretching response capacities. Additionally, cross-border transmission remains a critical concern, with confirmed spread between Myanmar and Thailand, and most recently Ethiopia and South Sudan. Imported cases from Ethiopia to Germany and the United Kingdom further underscore the risk of undetected transmission in countries with weaker surveillance systems.

The global medical supply chain remains under strain, with insufficient OCV stockpiles to meet all requests for two-dose preventive vaccination and even one-dose vaccination reactive campaigns. Hence, the decision of the International Coordinating Group (ICG) to limit all reactive OCV campaigns to a one-dose strategy remains in effect in 2025 and beyond due to persistent supply constraints. This one-dose strategy endorsed by SAGE for outbreak response has proven effective in responding to outbreaks, even though evidence on the exact duration of protection is limited, and protection appears to be lower in children. Currently, only one-dose courses have been validated and implemented in these reactive campaigns.

Other ongoing response activities include:

- A Global Cholera IMST has been established to support outbreak response across all regions. This IMST coordinated with regional offices and IMSTs.
- Global cholera situation presented to WHE in Acute Events Management (AEM) meeting and presented to GOARN partners bi-weekly.
- Collaboration with key partners (UNICEF, MSF) to coordinate supply and optimal supply access.
- OSL coordination with EPI teams, regional hubs and other operational partners.
- Provide technical support for ongoing outbreaks (laboratory, case management, OCV, WASH, and IPC).
- Deployment support through GAVI, GOARN, and Standby Partners.
- Advocacy to increase global OCV production and improve emergency stockpile levels.

Reference documents used for risk assessment

- Sitreps
- Cholera fact sheet
- Ending Cholera, A Global Roadmap To 2030
- Global cholera strategic preparedness, readiness, and response plan 2023/24
- WHO's Call for urgent and collective action to fight cholera
- Disease outbreak news Cholera – Democratic Republic of the Congo
- Disease outbreak news Cholera – Haiti
- Disease outbreak news Cholera – Malawi
- Disease outbreak news Cholera - Mozambique
- Disease outbreak news Cholera-Global situation
- Global Task Force on Cholera Control (GTFCC)
- Public health surveillance for cholera- Interim guidance, February 2023 [EN] [FR]
- AFRO Weekly outbreaks and emergency bulletin
- PAHO Situation Reports Cholera Outbreak in Hispaniola. 2022 - Actual
- Cholera upsurge (2021-present) web page
- WHO Cholera dashboards
- Multi-country outbreak of cholera, External situation report #11 - 12 February 2024