



WEEKLY EPIDEMIOLOGICAL REPORT

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Global Surge of Cholera Outbreaks: Current Situation and Response Priorities - Part I

This is the first article of two in a series on “Global Surge of Cholera Outbreaks: Current Situation and Response Priorities”

Global Surge of Cholera Outbreaks: Current Situation and Response Priorities

The global cholera situation is worsening, driven by conflict, displacement, climate change, and poverty. Large-scale outbreaks in the Democratic Republic of the Congo (DRC), South Sudan, and Sudan continue to expand, while Chad and the Republic of the Congo have seen a resurgence after years of low transmission. Floods, poor access to safe water, and fragile health systems are increasing the spread, heightening the risk of cross-border transmission. Individuals residing in communities with limited access to safe drinking water, proper sanitation, and good hygiene practices face the greatest risk of cholera.

Global situation

Between 1 January and 25 May 2025, a total of 211,678 cholera cases and 2,754 deaths were reported from 26 countries across three WHO regions. The African Region recorded the high-

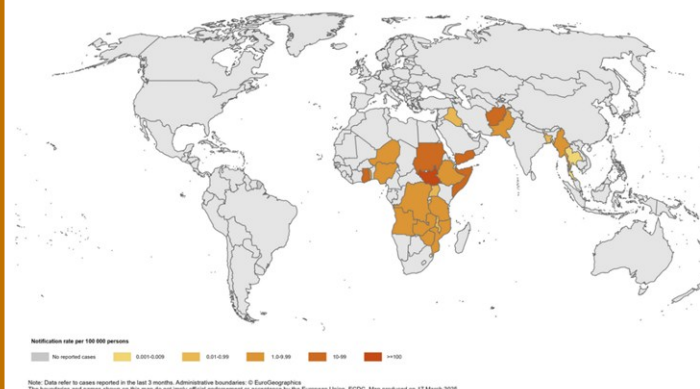
est case load, followed by the Eastern Mediter-

anean and South-East Asia Regions, while no cases were reported from the remaining WHO regions during this period.

In May 2025, case numbers were 24% lower compared to May 2024, but deaths were 122% higher, with 69,520 cases and 249 deaths reported from 22 countries in May 2024. This indicates major gaps in access to timely and effective treatment.

During May 2025 (epidemiological weeks 18–21), 52,589 new cholera and/or acute watery diarrhoea (AWD) cases were reported from 17 countries across three WHO regions; a 35% rise from April. The Eastern Mediterranean Region reported the highest number of cases, followed by the African and South-East Asia Regions. In the same period, 552 deaths were recorded globally, showing a slight (4%) decline from the previous month.

The African Region remains the epicentre of mortality, with persistently high CFRs and frequent cross-border transmission, particularly in central and eastern Africa. Fragile health systems, insecurity, flooding, and weak infrastructure continue to hinder surveillance, case management, and outbreak response. These challenges highlight the urgent need for strengthened regional coordination, expanded access to safe water and sanitation, and wider deployment of oral cholera vaccination (OCV) in high-risk settings. Figure 1 shows the Geographical distribution of cholera cases reported worldwide from February 2025 to April 2025, while Figure 2 highlights Global cholera and Acute Watery Diarrhoea cases by week, 1 January 2024 to 25 May 2025, based on WHO data.



est case load, followed by the Eastern Mediter-

Figure 1. Geographical distribution of cholera cases reported worldwide from February 2025 to April 2025 <https://www.ecdc.europa.eu/en/all-topics-z/cholera/surveillance-and-disease-data/cholera-monthly>

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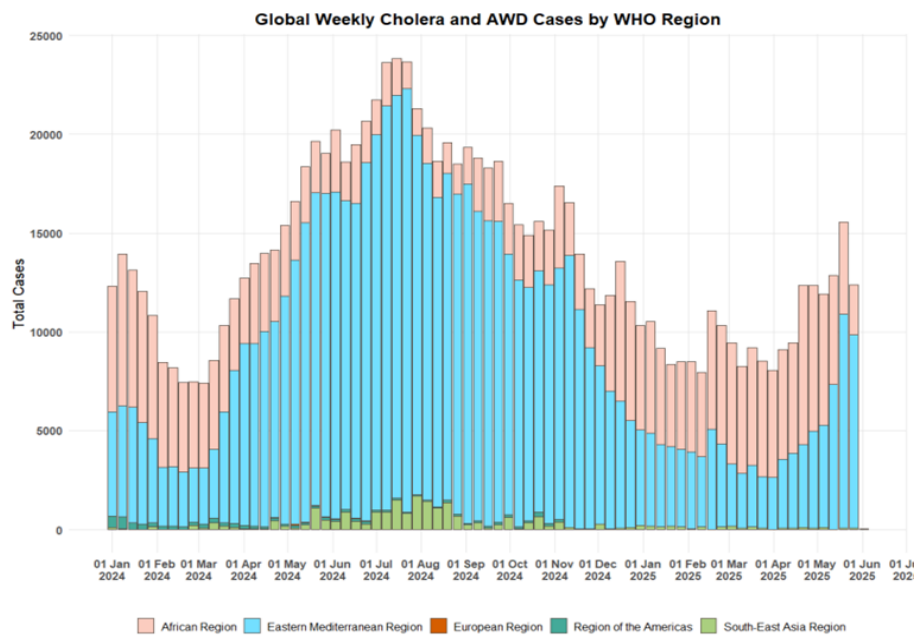


Figure 2. Global cholera and Acute Watery Diarrhoea cases by week, 1 January 2024 to 25 May 2025. Data source: WHO

Epidemiology and key facts

Cholera is an **acute diarrhoeal disease** caused by ingestion of food or water contaminated with *Vibrio cholerae*. It remains a **global public health threat**, strongly linked to inequity, poverty, and lack of access to safe water and sanitation. Researchers estimate between **1.3–4.0 million cases** and **21,000–143,000 deaths** from cholera worldwide each year, though under-reporting remains common due to weak surveillance and concerns over trade and tourism impacts.

Most people infected with *V. cholerae* have no or mild symptoms, but they can shed bacteria in their faeces for up to 10 days, silently fueling transmission. Among symptomatic cases, most experience mild to moderate diarrhoea manageable with oral rehydration solution (ORS). A minority, however, develop profuse watery diarrhoea and vomiting, leading to life-threatening dehydration. Without treatment, cholera can kill within hours, but with timely ORS and intravenous fluids, the case fatality rate can be kept below 1%.

The **incubation period** ranges from 12 hours to 5 days. Both children and adults can be affected, with risk amplified during humanitarian crises, floods, and population displacement, where water and sanitation systems are disrupted.



Figure 3. 3D illustration of cholera bacteria. Image: ktsimage/Getty Images
<https://hms.harvard.edu/news/halting-cholera>

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 21st–27th June 2025 (26th Week)

RDHS	Dengue Fever		Dysentery		Encephalitis		En. Fever		F. Poisoning		Leptospirosis		Typhus F.		Viral Hep.		H. Rabies		Chickenpox		Meningitis		Leishmania-		Tuberculosis		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	276	6804	0	18	0	4	0	6	0	5	21	262	0	5	1	12	0	0	10	291	2	35	1	2	44	1013	64	100
Gampaha	167	4364	0	26	0	24	0	1	47	114	11	453	0	8	0	10	0	0	19	481	5	88	1	23	33	581	70	100
Kalutara	92	1366	3	28	0	6	0	10	13	41	18	381	0	1	0	4	0	0	21	503	0	24	0	1	5	313	40	100
Kandy	161	2135	1	37	0	3	0	5	0	19	12	165	2	34	1	7	0	0	15	263	0	15	0	38	7	361	100	100
Matale	23	775	0	15	0	1	0	0	0	50	4	142	1	4	0	6	0	0	2	71	0	6	3	151	1	82	100	100
Nuwara Eliya	6	158	2	44	0	4	0	4	1	46	3	68	4	37	0	0	0	0	12	146	3	18	0	0	8	146	100	100
Galle	79	1151	1	25	0	3	0	1	2	41	26	470	2	48	1	8	0	1	17	429	2	98	0	3	8	251	95	100
Hambantota	21	488	0	16	0	4	0	0	0	4	8	242	1	20	0	4	0	0	1	191	0	13	5	161	5	78	100	100
Matara	58	949	1	9	0	2	0	1	2	7	13	287	1	12	0	9	0	0	3	231	1	25	0	57	3	86	100	100
Jaffna	12	761	3	51	0	2	1	11	2	32	1	121	8	366	0	2	0	1	2	234	0	16	0	0	3	113	100	93
Kilinochchi	1	64	0	10	0	0	0	4	0	5	0	59	0	11	0	1	0	0	0	4	0	0	0	1	1	31	100	100
Mannar	0	112	0	5	0	0	0	0	0	2	0	20	1	14	0	0	0	0	1	17	0	12	0	1	1	25	100	100
Vavuniya	3	56	0	9	0	0	0	1	0	36	0	61	0	7	0	0	0	0	0	31	0	14	1	14	0	28	100	100
Mullaitivu	3	46	0	5	0	0	0	1	0	23	1	50	0	7	0	0	0	0	1	20	0	5	0	2	0	18	100	100
Batticaloa	16	1444	0	90	1	12	0	0	0	121	2	73	0	1	0	17	0	0	2	123	0	24	0	1	3	79	86	100
Ampara	8	148	0	28	0	9	0	0	3	11	3	134	0	2	0	3	0	1	2	105	1	26	0	16	2	33	86	100
Trincomalee	12	839	0	30	0	2	0	1	1	28	0	103	0	9	0	5	0	0	2	78	0	10	1	4	4	68	100	100
Kurunegala	70	911	2	30	0	12	0	1	0	25	14	468	0	22	0	6	0	1	17	433	7	94	9	307	6	177	100	100
Puttalam	7	406	2	20	0	3	0	0	0	5	9	186	2	30	0	1	0	1	5	97	3	56	2	20	9	101	100	100
Anuradhapura	17	377	1	24	0	6	0	3	0	17	7	280	1	16	0	10	0	0	7	192	2	44	21	405	4	146	70	100
Polonnaruwa	10	199	0	12	0	4	0	1	2	8	4	193	0	1	0	17	0	0	2	105	0	11	11	217	0	45	100	90
Badulla	17	460	1	21	0	8	0	3	0	2	8	187	0	17	6	31	0	0	12	246	0	44	4	28	3	159	88	100
Monaragala	27	537	1	13	0	3	0	0	0	4	4	389	0	23	2	18	0	0	4	88	4	34	7	111	5	67	64	100
Ratnapura	120	3055	1	78	1	6	0	3	11	37	32	903	1	19	0	8	0	1	9	251	3	69	5	113	9	219	85	100
Kegalle	35	882	0	43	0	11	0	9	2	31	13	438	0	8	2	11	0	0	25	495	3	68	1	19	4	155	100	100
Kalmunai	4	269	0	21	0	4	0	0	0	18	3	73	0	1	0	2	0	1	2	95	2	29	0	0	1	72	100	100
SRILANKA	1245	28756	19	708	2	133	1	66	86	732	217	6208	24	723	13	192	0	7	193	5220	38	878	72	1695	169	4447	90	99

Source: Weekly Returns of Communicable Diseases (esurveillance.avid.gov.lk). T=Timeliness refers to returns received on or before 04th July, 2025 Total number of reporting units 361 Number of reporting units data provided for the current week: 360 C**=Completeness - A = Cases reported during the current week, B = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP

21st June–27th July 2025 (26th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2025	Number of cases during same week in 2024	Total number of cases to date in 2025	Total number of cases to date in 2024	Difference between the number of cases to date in 2025 & 2024
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	01	01	00	00	01	0	00	00	00	03	02	31	39	-20.5%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps	00	01	00	00	00	00	01	00	01	03	06	126	150	-16 %
Measles	00	00	00	00	00	00	00	00	00	00	02	01	216	-99.5%
Rubella	00	01	01	00	00	00	00	00	00	02	00	03	02	-50%
CRS**	00	00	00	00	00	00	00	00	00	00	00	01	00	0 %
Tetanus	00	00	00	00	00	00	00	00	00	00	00	04	04	0 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	00	00	00	00	00	00	00	00	00	00	00	04	01	300 %
Whooping Cough	01	00	00	00	00	00	00	00	00	00	00	13	25	-48 %

Key to Table 1 & 2

Provinces: W: Western, C: Central, S: Southern, N: North, E: East, NC: North Central, NW: North Western, U: Uva, Sab: Sabaragamuwa.

RDHS Divisions: CB: Colombo, GM: Gampaha, KL: Kalutara, KD: Kandy, ML: Matale, NE: Nuwara Eliya, GL: Galle, HB: Hambantota, MT: Matara, JF: Jaffna, KN: Killinochchi, MN: Mannar, VA: Vavuniya, MU: Mullaitivu, BT: Batticaloa, AM: Ampara, TR: Trincomalee, KM: Kalmunai, KR: Kurunegala, PU: Puttalam, AP: Anuradhapura, PO: Polonnaruwa, BD: Badulla, MO: Moneragala, RP: Ratnapura, KG: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps., Rubella, CRS,

Special Surveillance: AFP* (Acute Flaccid Paralysis), Japanese Encephalitis

CRS** =Congenital Rubella Syndrome

NA = Not Available

Take prophylaxis medications for leptospirosis during the paddy cultivation and harvesting seasons.

It is provided free by the MOH office / Public Health Inspectors.

Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to chepid@slt.net.lk. **Prior approval should be obtained from the Epidemiology Unit before publishing data in this publication**

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