

WEEKLY BULLETIN

Communicable disease threats report

Week 45, 1–7 November 2025

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Executive Summary

Overview of respiratory virus epidemiology in the EU/EEA

- In the EU/EEA, the number of patients visiting primary care with symptoms of respiratory illness remains low. However, as expected for this time of year, most countries are reporting an increase. To date, similar increases have not been observed in patients admitted to hospital with respiratory illness.
- Circulation of influenza and respiratory syncytial virus (RSV) remains low but is beginning to increase in some countries. SARS-CoV-2 circulation is still widespread but continues to decrease, following a trend similar to this time last season.
- The increase in circulation of RSV is primarily seen in children aged below five years, while influenza circulation is primarily observed in children aged below 15 years.

SARS-CoV-2 variant classification

- Since the last update on 26 September 2025, and as of 31 October 2025, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) and De-escalated variants.

- For this update, sufficient data for estimating variant proportions during the reporting weeks are only available from six EU/EEA countries. Therefore, the statistics below only represent a limited part of the EU/EEA.
- The VOI and VUM median proportions in the EU/EEA for weeks 41–42, based on five reporting countries, are currently:
 - BA.2.86 (VOI): 4.4% (range: 0.0–14%; interquartile range (IQR): 2.9–7.3%);
 - NB.1.8.1 (VUM): 10.5% (range: 2.3–30.0%; IQR: 4.6%–12.9%);
 - XFG (VUM): 85% (range: 60.0–86.5%; IQR: 82.2–86.2%).

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

- Since the previous update on 6 October 2025, and as of 3 November 2025, no new MERS-CoV cases have been reported by the World Health Organization (WHO) or national health authorities.
- Since the beginning of 2025, and as of 3 November 2025, 12 MERS cases have been reported in Saudi Arabia with date of onset in 2025, including three fatalities.
- The probability of sustained human-to-human transmission among the general population in Europe remains very low, and the impact of the disease in the general population is also considered to be low. The current MERS-CoV situation poses a low risk to the EU/EEA.

Seasonal surveillance of chikungunya virus disease – 2025

- Since the beginning of 2025, and as of 5 November 2025, two countries in Europe have reported cases of chikungunya virus disease: France (776) and Italy (374).
- In the past week, France has reported eight new locally acquired cases of chikungunya virus disease and Italy has reported four. In the week before, France reported 13 new cases and Italy reported one new case.

Seasonal surveillance of dengue – 2025

- Since the beginning of 2025, and as of 5 November 2025, three countries in Europe have reported cases of dengue: France (29), Italy (four), and Portugal (two).
- This week, no new cases of dengue have been reported to ECDC. All clusters are currently closed.

Weekly seasonal surveillance of West Nile virus infection – 2025

- Since the beginning of 2025, and as of 5 November 2025, 14 countries in Europe have reported human cases of West Nile virus infection: Albania, Bulgaria, Croatia, France, Germany, Greece, Hungary, Italy, Kosovo*, North Macedonia, Romania, Serbia, Spain, and Türkiye.

**This designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the ICJ Opinion on the Kosovo declaration of independence.*

Ebola virus disease – Democratic Republic of the Congo – 2025

- Since the last update, and as of 6 November 2025, no new Ebola cases have been reported in the Democratic Republic of the Congo (DRC). All patients have been discharged and there are no contacts under active monitoring.
- The 42-day countdown for declaring the outbreak over was initiated on 19 October, following the discharge of the last patient being treated.
- Since the start of the outbreak, and as of 6 November, 64 cases (53 confirmed and 11 probable) of Ebola virus disease (EVD) have been reported in Kasai Province, DRC, including 45 deaths (34 confirmed and 11 probable; case fatality rate (CFR) among all cases: 70.3%).
- All confirmed cases were reported from Bulape health zone.
- The current risk for people from the EU/EEA living in or travelling to Kasai province in DRC is estimated to be low, due to the current low likelihood of exposure. For people living in the EU/EEA, the risk is very low, as the likelihood of introduction and secondary transmission within the EU/EEA is very low.

Rift Valley fever – Western Africa – 2025

- Since 21 September 2025, and as of 6 November, 397 human cases (including 29 deaths) of Rift Valley fever (RVF) have been reported in Senegal.

- Since 27 September 2025, and as of 30 October, 46 human cases (including 14 deaths) of RVF have been reported in Mauritania.
- On 5 November, media quoting health officials reported one human case of RVF in Gambia, close to the border with Senegal.
- All three countries have reported outbreaks among live animals.
- To date, no human-to-human transmission of RVF has been documented.

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

- Since 1 January 2025 and as of 29 October 2025, 562 449 cholera cases, including 7 201 deaths, have been reported worldwide.
- Since 2 May 2025 and as of 29 October 2025, 450 783 new cholera cases, including 5 642 new deaths, have been reported worldwide.
- The five countries reporting most new cases are Afghanistan (123 416), Yemen (74 452), Sudan (62 315), South Sudan (53 602) and Democratic Republic of The Congo (46 832). The five countries reporting most new deaths are Sudan (1 749), Democratic Republic of The Congo (1 507), South Sudan (862), Nigeria (468) and Angola (344).
- In 2025, cholera cases have continued to be reported in Africa and Asia, the Middle East and the Americas. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

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

Overview:

ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary ([ERVISS.org](https://eriss.org)), which is updated weekly.

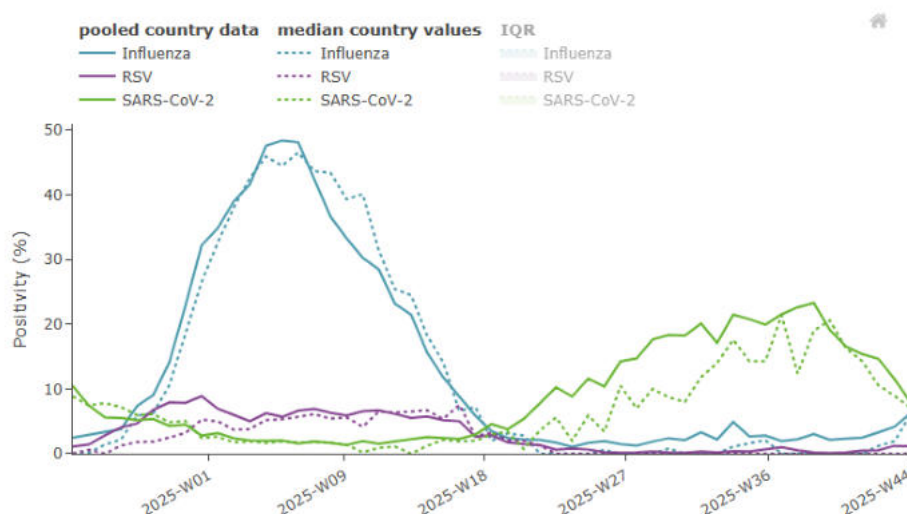
Key visualisation from the weekly bulletin are included below.

Sources: [ERVISS](https://eriss.org)

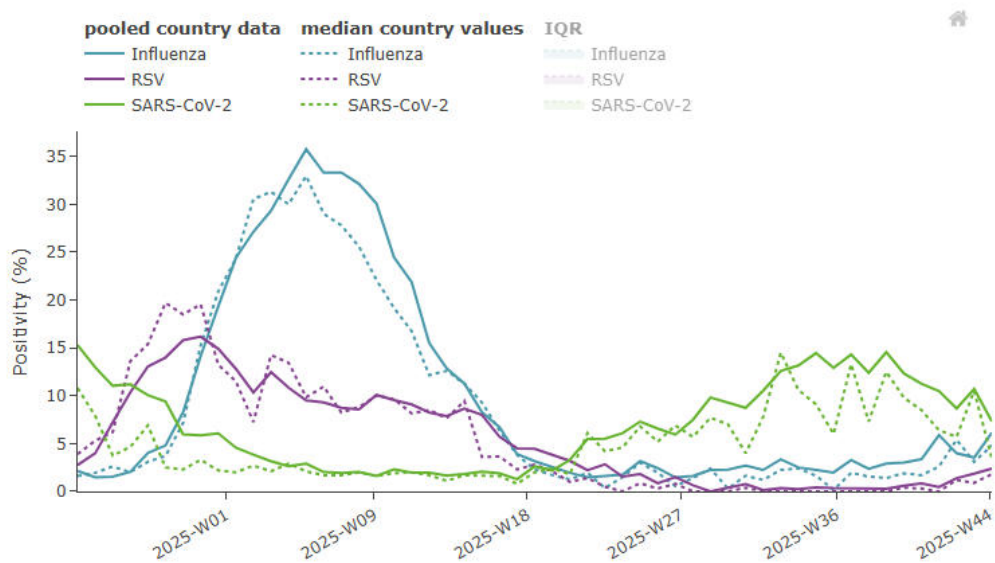
Last time this event was included in the Weekly CDTR: 31 October 2025

Maps and graphs

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



Source: ECDC

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

Source: ECDC

Figure 3. ILI/ARI virological surveillance in primary care – pathogen type and subtype distribution

Pathogen	Week 44, 2025		Week 40, 2025 – week 44, 2025	
	N	% ^a	N	% ^a
Influenza	105	–	397	–
Influenza A	103	99	377	98
A(H1)pdm09	36	41	164	52
A(H3)	51	59	150	48
A (unknown)	16	–	63	–
Influenza B	1	1.0	8	2
B/Vic	0	–	0	–
B (unknown)	1	–	8	–
Influenza untyped	1	–	12	–
RSV	18	–	68	–
RSV-A	3	33	11	41
RSV-B	6	67	16	59
RSV untyped	9	–	41	–
SARS-CoV-2	123	–	1322	–

^a Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.

Source: ECDC

Figure 4. SARI virological surveillance in hospitals – pathogen type and subtype distribution

Pathogen	Week 44, 2025		Week 40, 2025 – week 44, 2025	
	N	% ^a	N	% ^a
Influenza	53	–	299	–
Influenza A	33	100	219	97
A(H1)pdm09	4	57	66	69
A(H3)	3	43	30	31
A (unknown)	26	–	123	–
Influenza B	0	0.0	7	3
B/Vic	0	–	0	–
B (unknown)	0	–	7	–
Influenza untyped	20	–	73	–
RSV	20	–	77	–
RSV-A			7	64
RSV-B	1	100	4	36
RSV untyped	19	–	66	–
SARS-CoV-2	62	–	695	–

^a Percentages show either the relative proportion of influenza and RSV types (A and B) or influenza A subtypes and influenza B lineages.

Source: ECDC

Figure 5. SARS-CoV-2 variant distribution

Variant	Classification ^a	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	3	6	5% (2–9%)
XFG	VUM	4	117	81% (77–87%)
NB.1.8.1	VUM	4	14	10% (7–12%)

^a Data are sorted by classification then median distribution. For information on SARS-CoV-2 variant classification visit [ECDC's variant page](#).

Source: ECDC

2. SARS-CoV-2 variant classification

Overview:

Since the last update on 26 September 2025, and as of 31 October 2025, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) and De-escalated variants.

The VOI median proportions in the EU/EEA for weeks 41–42, based on six reporting countries, are currently:

- BA.2.86 (VOI): 4.4% (range: 0.0–14%; IQR: 2.9–7.3%).

The VUM median proportions in the EU/EEA for weeks 41–42, based on six reporting countries, are currently:

- NB.1.8.1 (VUM): 10.5% (range: 2.3–30.0%; IQR: 4.6–12.9%) and
- XFG (VUM): 85% (range: 60.0–86.5%; IQR: 82.2%–86.2%).

The calculations are based on data reported to GISAID, as of **26 October 2025**. Note that for this update, sufficient data for estimating variant proportions during the reporting weeks are only available from **six EU/EEA countries**. The statistics therefore only represent a limited part of the EU/EEA.

ECDC assessment:

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation.

The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. The variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older adults (aged 65 years old and above), those with underlying conditions, and people who have previously not been infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of people at high risk of severe outcomes (e.g. older adults) remains important.

Actions:

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

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

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

Last time this event was included in the Weekly CDTR: 4 October 2025

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

Overview:

Update: Since the previous update on 6 October 2025, and as of 3 November 2025, no new MERS-CoV cases have been reported by the World Health Organization (WHO) or national health authorities.

Summary: Since the beginning of 2025, and as of 3 November 2025, 12 MERS cases have been reported in Saudi Arabia with date of onset in 2025, including three fatalities.

Since April 2012, and as of 3 November 2025, a total of 2 640 cases of MERS, including 958 deaths, have been reported by health authorities worldwide.

Sources: [ECDC MERS-CoV page](#) | [WHO MERS-CoV](#) | [ECDC factsheet for professionals](#) | [Qatar MoPH Case #1](#) | [Qatar MoPH Case #2](#) | [FAO MERS-CoV situation update](#) | [WHO DON Oman](#) | [WHO DON Saudi Arabia](#) | [WHO DON UAE](#) | [WHO DON Saudi Arabia 1](#) | [WHO IHR](#) | [WHO EMRO MERS Situation report](#) | [WHO DON Saudi Arabia 2](#) | [WHO DON Saudi Arabia 3](#) | [WHO DON Saudi Arabia 4](#) | [WHO DON Saudi Arabia 5](#) | [MERS-CoV Dashboard](#)

ECDC assessment:

Human cases of MERS continue to be reported in the Arabian Peninsula. However, the number of new cases detected and reported through surveillance has dropped to the lowest level since 2014. The probability of sustained human-to-human transmission among the general population in Europe remains very low and the impact of the disease in the general population is considered low. The current MERS-CoV situation poses a low risk to the EU/EEA, as stated in the [Rapid Risk Assessment](#) published by ECDC on 29 August 2018, which also provides details on the last person reported with the disease in Europe.

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

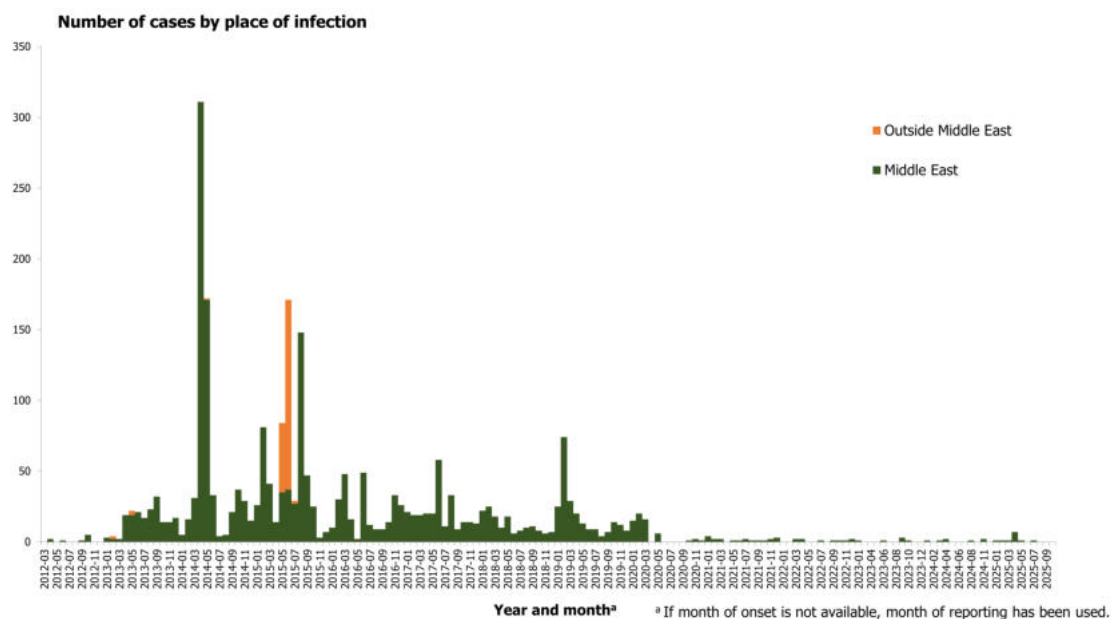
Actions:

ECDC is monitoring this situation through its epidemic intelligence activities, and reports on a monthly basis or when new epidemiological information is available.

Last time this event was included in the Weekly CDTR: 10 October 2025

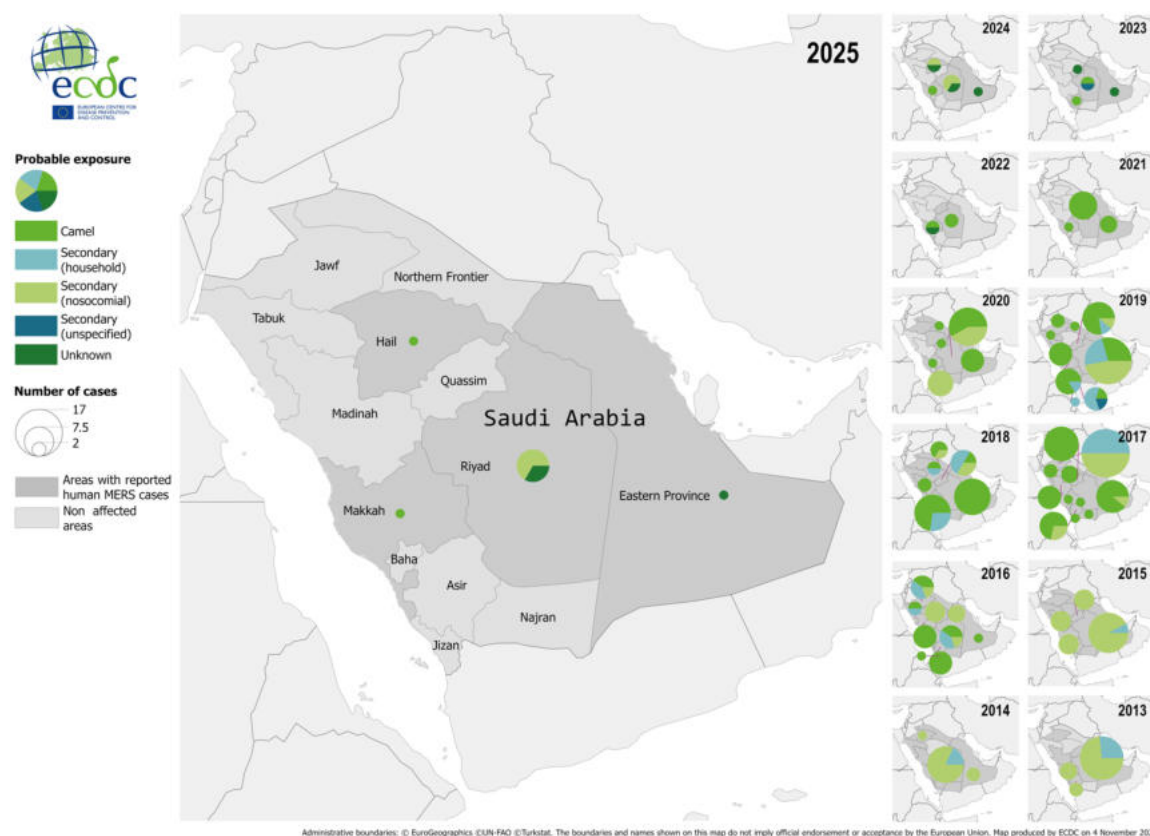
Maps and graphs

Figure 6. Distribution of confirmed cases of MERS by place of infection and month of onset, April 2012 to October 2025



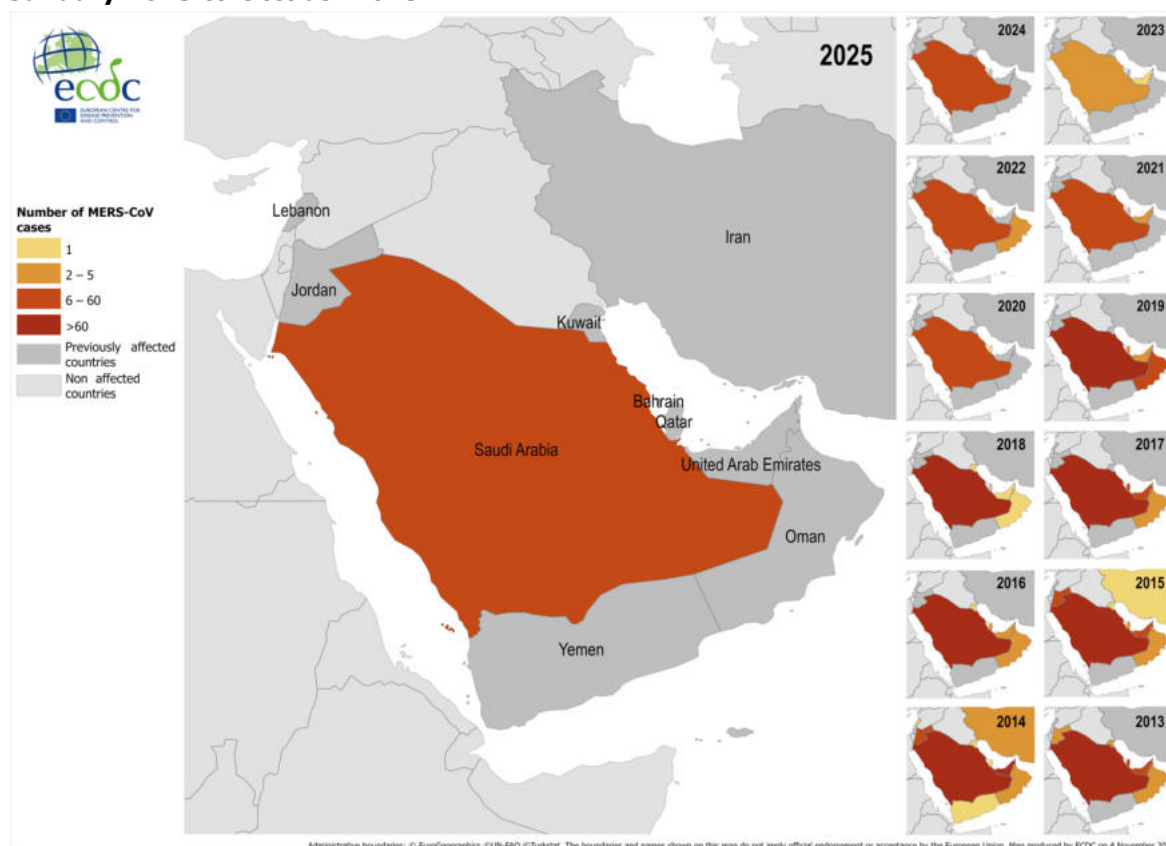
Source: ECDC

Figure 7. Geographical distribution of confirmed cases of MERS in Saudi Arabia by probable region of infection and exposure, with dates of onset from January 2013 to October 2025



Source: ECDC

Figure 8. Distribution of confirmed cases of MERS by place of infection and year of onset, January 2013 to October 2025



Source: ECDC

4. Seasonal surveillance of chikungunya virus disease – 2025

Overview:

Since the beginning of 2025, and as of 5 November 2025, two countries in Europe have reported cases of chikungunya virus disease: France (776) and Italy (374).

In the past week, France has reported eight new locally acquired cases of chikungunya virus disease. The cumulative number of locally acquired cases in France has reached 776, distributed across 77 clusters. Eighteen clusters are currently active. The largest cluster is located in Antibes.

Italy reported four new locally acquired cases of chikungunya virus disease. The cumulative number of locally acquired cases in Italy is 374, distributed across six clusters. Three clusters are currently active. The largest cluster is located in Carpi, San Prospero, Soliera, Novellara, Cavezzo, Modena, Nonantola, Correggio, Novi di Modena, and Cesenatico.

For more information on locally acquired chikungunya virus disease cases, see ECDC's [seasonal surveillance report for chikungunya virus disease](#). This report covers mainland EU/EEA and the outermost regions of Portugal and Spain.

ECDC assessment:

The current [chikungunya virus disease risk assessment](#) for mainland EU/EEA can be found on ECDC's dedicated [chikungunya webpage](#).

Last time this event was included in the Weekly CDTR: 31 October 2025

5. Seasonal surveillance of dengue – 2025

Overview:

Since the beginning of 2025, and as of 5 November 2025, three countries in Europe have reported cases of dengue: France (29), Italy (four), and Portugal (two).

This week, no new cases of dengue have been reported to ECDC. All clusters are currently closed.

For more information on locally acquired dengue virus disease cases, see [ECDC's seasonal surveillance report for dengue](#). This report covers mainland EU/EEA and the outermost regions of Portugal and Spain.

ECDC assessment:

The current [dengue risk assessment](#) for mainland EU/EEA can be found on ECDC's dedicated [dengue webpage](#).

Last time this event was included in the Weekly CDTR: 31 October 2025

6. Weekly seasonal surveillance of West Nile virus infection – 2025

Overview:

Since the beginning of 2025, and as of 5 November 2025, 14 countries in Europe have reported human cases of West Nile virus infection: Albania, Bulgaria, Croatia, France, Germany, Greece, Hungary, Italy, Kosovo*, North Macedonia, Romania, Serbia, Spain, and Türkiye.

A total of 155 areas are currently known to be affected.

The report is available [online](#).

**This designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the ICJ Opinion on the Kosovo declaration of independence.*

Last time this event was included in the Weekly CDTR: 31 October 2025

7. Ebola virus disease – Democratic Republic of the Congo – 2025

Overview:

On 19 October 2025, WHO [announced](#) that the last Ebola patient in DRC was discharged and initiated the 42-day countdown for declaring the outbreak over. According to WHO, the outbreak will be declared over in early December 2025, if no new cases are detected.

A total of 19 patients recovered from the disease (29.7%) and no new cases have been reported since 26 September. As of 6 November, of the 1 735/1 787 (97.3%) contacts that were followed up, [none are under active monitoring](#).

Since the outbreak was declared on 4 September 2025, and as of 6 November, there have been 64 cases (53 confirmed and 11 probable) and 45 deaths (34 confirmed and 11 probable) (CFR among all cases: 70.3%). All cases were reported in six health areas in Bulape health zone, Kasai Province.

Summary

On 1 September 2025, WHO received an alert regarding probable cases of Ebola virus disease (EVD) from Bulape health zone, Kasai Province. Following this alert, on 4 September, the DRC Minister of Public Health, Hygiene and Social Security declared an outbreak of EVD in the country.

The first reported case was in a pregnant woman, who was admitted to Bulape General Reference Hospital on 20 August with symptoms of fever, bloody diarrhoea, vomiting, asthenia, and anal, oral, and nasal haemorrhage.

The woman later died due to multiple organ failure. Samples tested on 3 September at the country's National Institute of Biomedical Research in the capital, Kinshasa, confirmed the cause of the outbreak as Ebola Zaire. Based on whole genome sequencing analysis, the causative strain is not linked to previous outbreaks and therefore this is probably a new zoonotic spill-over event. The initial phase of the outbreak was characterised by nosocomial spread and a superspreading event linked to the presumptive index case's funeral.

On 28 September, WHO reported that the majority of cases have occurred in women (37 cases; 57.8%), with patients' ages ranging from under one year old to 65 years old. Children aged from under one year old to nine years old and individuals 20–29 years old accounted for 25.0% (16) and 23.4% (15) of cases, respectively. The most affected populations included children, housekeepers, and farmers. From the beginning of the outbreak in epidemiological week 36 to epidemiological week 39, the median time between symptom onset and isolation shortened from five days to two.

Women represent 60% of the reported deaths. At the beginning of the outbreak, a high proportion of cases and deaths occurred among children aged under one year old to four years old, and the CFR was very high. As the outbreak progressed, the number of cases among children has decreased and the CFR has gradually declined. Four of the deaths were reported among healthcare workers. In Bulape health zone, the health areas of Dikolo (26 cases, 15 deaths) and Bulape (24 cases, 22 deaths) are considered the epicentres of the outbreak, together accounting for 78.1% of reported cases and 82.2% of all deaths.

Vaccination began in Kasai Province on 13 September. As of 6 November, a total of 37 178 people have been vaccinated. Alongside ring vaccination, geographically targeted vaccination began on 27 September for groups at high risk of infection in hotspots reporting confirmed cases. A total of 31 patients have been treated with monoclonal antibody (mAb114).

The last reported date of symptom onset was 23 September and the last cases were reported on 26 September in Bulape and Dikolo health areas, Bulape health zone.

Background and additional information

Ebola outbreaks in the DRC are recurrent, as the virus is present in animal reservoirs in many parts of the country. This is the sixteenth outbreak recorded since 1976 in DRC and the eighth since 2018.

The last EVD outbreak documented in DRC was in August 2022, in Beni health zone, North Kivu province, but related to only one case. In the same year, another five cases were reported from Mbandaka city, Equateur province. In 2007 and 2008, there were EVD outbreaks affecting Kasai province, including the Bulape and Mweka health zones in 2007. In the country overall, there have been 15 outbreaks since the disease was first identified in 1976.

Earlier in this outbreak, WHO AFRO reported that Bulape health zone is linked to large population centres such as Tshikapa and Kananga, and as there is ongoing cross-provincial and cross-border movement there is a risk of further geographical spread.

The Ministry of Health is leading the outbreak response and is supported technically by WHO and other partners. A regional strategic response plan has been developed to guide coordinated efforts across affected and at-risk areas, focusing on surveillance; diagnostics; vaccination; infection, prevention and control (IPC); and community engagement.

ECDC assessment:

Ebola virus causes a severe, often fatal, disease. The current risk for people from the EU/EEA living in or travelling to Kasai province in DRC is estimated to be low, due to the current low likelihood of exposure. For people living in the EU/EEA, the risk is very low, as the likelihood of introduction and secondary transmission within the EU/EEA is very low.

Intense surveillance and contact tracing are essential to rapidly control outbreaks of viral haemorrhagic fevers.

Actions:

ECDC is monitoring the situation through its epidemic intelligence activities. In addition, ECDC is in contact with Africa CDC, the Global Outbreak Alert Response Network (GOARN), and the European Commission (DG ECHO, DG SANTE, DG HERA).

Last time this event was included in the Weekly CDTR: 31 October 2025

8. Rift Valley fever in Western Africa – 2025

Overview:**Update**

Since the [last update in the CDTR](#), and as of 6 November, there have been 69 additional cases of Rift Valley fever (RVF) and one additional death reported in Senegal, according to the country's Ministry of Health. There have been cases reported in one additional region (Kédougou).

Since the last update in the CDTR, and as of 30 October, there have been four additional cases of RVF and one additional death reported in Mauritania, [according to WHO](#). No new regions have been reported as affected.

On 5 November, [media quoting health officials](#) reported the first human case of RVF in Gambia, on the Senegalese border village of Ker Ayib. On 28 October, the World Organisation for Animal Health (WOAH) [reported](#) that there have been four cases reported in livestock in Gambia.

Summary**Senegal**

As of 6 November 2025, there have been a total of 397 confirmed human cases of RVF and 29 deaths (case fatality rate (CFR): 7.3%) [reported](#) since the [beginning of the outbreak](#) on September 21. The eight affected regions are Saint-Louis (304), Louga (18), Matam (27), Fatick (18), Dakar (9), Kaolack (14), Thiès (2), Tambacounda (3) and Kédougou (2). The affected regions are mainly in the north of the country, bordering Mauritania.

[According to Africa CDC](#), most cases occurred in males and the most affected age group is individuals 15–35 years old.

On 30 September 2025, WOAH [reported](#) cases in terrestrial animals in Senegal and indicated that the area is at high-risk of experiencing outbreaks in domestic and wild animals during the winter period, citing notable outbreaks in 2013 and 2023. On 6 November, WHO [reported](#) that there have been 160 cases among animals in Senegal and no deaths. There have also been 640 animal abortions [reported](#) and 11 644 animals have been [vaccinated](#).

Mauritania

In Mauritania, the first human cases of RVF in this outbreak were [reported](#) on 2 October. As of 30 October, according to WHO, there have been 46 cases and 14 deaths [reported](#) (CFR: 30.4%). The 13 affected regions are mainly concentrated in the south near the Senegal border, three of which share international borders: Assaba (bordering Mali to the south), Brakna and Trarza (both bordering Senegal along the Senegal River).

According to a [WHO report](#), as of 30 October there have been 235 confirmed cases and 71 deaths among animals in the south of the country since the first outbreak was recorded on 15 September 2025.

The cases in both Senegal and Mauritania are mainly located around the Senegal River delta and valley, and early autumn months are considered a high-risk period for RVF in the region.

Gambia

On 5 November, [media quoting health officials](#) reported the first human case of RVF in Gambia, in the Sengalese border village of Ker Ayib. On 28 October, WOA [reported](#) that there have been four cases reported in livestock in Gambia.

Genomic analysis [suggests](#) that the current outbreak in Senegal is linked to previous detections in Senegal (in Fatick in 2020 and in Matam in 2022) and in Mauritania (2020). The last [reported](#) outbreak of RVF in Senegal was in the Fatick region in November 2021. There were three cases reported and no associated deaths. Mauritania has previously [reported outbreaks](#) in 1987, 2010, 2012, 2015, 2020 and 2022. The most recent outbreak involved 47 cases and 23 deaths. Animal breeders were most affected, and cases were reported in nine regions.

Disease information

RVF is an acute viral disease that mostly affects domestic animals (such as cattle, buffalo, sheep, goats and camels). The disease is caused by the RVF virus, generally found in regions of eastern and southern Africa, but also in most countries of sub-Saharan Africa and Madagascar. Outbreaks have also been reported in Saudi Arabia and Yemen in the early 2000s.

Humans may become infected through direct or indirect contact with the blood or organs of infected animals. Virus transmission may also occur through mosquito vectors. While most human cases are relatively mild, a small percentage of patients develop a much more severe form of the disease. Uncomplicated cases are characterised by acute influenza-like illness leading to full recovery. In some patients the illness can progress to a severe form with haemorrhagic manifestations and hepatitis; possible complications include retinitis and encephalitis.

In endemic areas, vaccination of at-risk animals is the most important measure to prevent infection in humans.

ECDC assessment:

Outbreaks of RVF are regularly reported in Senegal and Mauritania, and the early autumn is a period of high RVF epidemic potential in northern Senegal ([Hélène et al., 2020](#)).

Travellers to and residents of Senegal or Mauritania are at low risk of infection if they apply appropriate preventive measures. Those who are in contact with potentially infected animals (e.g. veterinarians and those involved in livestock farming, butchering and slaughtering of animals in RVF-affected areas) have an increased risk of infection with RVF virus and should ensure safe animal husbandry and slaughtering practices. Visitors to affected areas should apply personal protective measures against mosquito bites.

The likelihood of introduction of RVF virus from the current outbreak in Western Africa to EU/EEA countries is very low, as the importation of live ruminants and raw animal products is not allowed. Importation of the virus via travellers or vectors is also unlikely.

Should the virus be introduced into mainland EU/EEA, further vector-borne transmission among animals or humans cannot be excluded. However, the likelihood is very low during the late autumn and winter season due to low numbers of competent mosquito vectors and low levels of vector activity in mainland EU/EEA countries.

Transmission of RVF virus through substances of human origin (SoHO) has not been reported to date, but the possibility of transmission cannot be excluded. However, as both Senegal and Mauritania are countries endemic for malaria, the deferral period for donors returning from areas affected by malaria would mitigate the risk of RVF virus transmission through SoHO.

Actions:

ECDC will continue monitoring this event through its epidemic intelligence activities and report again if there is a relevant epidemiological update.

Last time this event was included in the Weekly CDTR: 31 October 2025

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

Overview:

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

Update

Since 2 May 2025 and as of 29 October 2025, 450 783 new cholera cases, including 5 642 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Bangladesh, Burundi, Chad, Comoros, Congo, Côte D'Ivoire, Democratic Republic of The Congo, Ethiopia, Ghana, Haiti, India, Kenya, Mozambique, Myanmar/Burma, Namibia, Nepal, Nigeria, Pakistan, Philippines, Rwanda, Somalia, South Sudan, Sudan, Togo, Uganda, United Republic of Tanzania, Yemen, Zambia and Zimbabwe.

The five countries reporting most new cases are Afghanistan (123 416), Yemen (74 452), Sudan (62 315), South Sudan (53 602) and Democratic Republic of The Congo (46 832).

New deaths have been reported from Afghanistan, Angola, Burundi, Chad, Congo, Côte D'Ivoire, Democratic Republic of The Congo, Ethiopia, Haiti, India, Kenya, Mozambique, Namibia, Nigeria, Philippines, Somalia, South Sudan, Sudan, Uganda, United Republic of Tanzania, Yemen, Zambia and Zimbabwe.

The five countries reporting the most new deaths are Sudan (1 749), Democratic Republic of The Congo (1 507), South Sudan (862), Nigeria (468) and Angola (344).

Summary

Since 1 January 2025 and as of 29 October 2025, 562 449 cholera cases, including 7 201 deaths, have been reported worldwide.

In comparison, since 1 January 2024 and as of 29 October 2024, 462 096 cholera cases, including 3 434 deaths, were reported worldwide.

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

Asia:

Afghanistan: Since 17 March 2025 and as of 13 October 2025, 13 743 new cases, including four new deaths have been reported. Since 1 January 2025 and as of 13 October 2025, 143 068 cases, including 68 deaths have been reported. In comparison, in 2024 and as of 12 October 2024, 149 622 cases, including 72 deaths were reported.

Bangladesh: Since 24 February 2025 and as of 01 September 2025, 13 less cases have been reported. Since 1 January 2025 and as of 1 September 2025, 67 cases have been reported. In comparison, in 2024 and as of 21 October 2024, 278 cases were reported.

India: Since 28 April 2025 and as of 25 August 2025, 147 new cases, including four new deaths have been reported. Since 1 January 2025 and as of 25 August 2025, 1 389 cases, including five deaths have been reported. In comparison, in 2024 and as of 29 July 2024, 8 519 cases, including 43 deaths were reported.

Myanmar/Burma: Since 10 March 2025 and as of 13 October 2025, 50 new cases have been reported. Since 1 January 2025 and as of 13 October 2025, 2 259 cases have been reported. In comparison, in 2024 and as of 21 October 2024, 6 052 cases were reported.

Nepal: Since 3 March 2025 and as of 6 October 2025, 226 new cases have been reported. Since 1 January 2025 and as of 6 October 2025, 1 801 cases have been reported. In comparison, in 2024 and as of 23 September 2024, 95 cases were reported.

Pakistan: Since 10 February 2025 and as of 21 July 2025, 1 559 new cases have been reported. Since 1 January 2025 and as of 21 July 2025, 14 760 cases have been reported. In comparison, in 2024 and as of 7 October 2024, 65 995 cases were reported.

Philippines: Since 14 October 2023 and as of 30 June 2025, 357 new cases, including three new deaths have been reported. Since 1 January 2025 and as of 30 June 2025, 1 268 cases, including 13 deaths have been reported. In comparison, in 2024 and as of 29 October 2024, no cases were reported.

Yemen: Since 24 February 2025 and as of 13 October 2025, 8 185 new cases, including 14 new deaths have been reported. Since 1 January 2025 and as of 13 October 2025, 84 532 cases, including 230 deaths have been reported. In comparison, in 2024 and as of 9 September 2024, 36 404 cases, including 159 deaths were reported.

In 2025, no updates have been reported by: Thailand.

Africa:

Angola: Since 30 April 2025 and as of 27 October 2025, 2 011 new cases, including 17 new deaths have been reported. Since 1 January 2025 and as of 27 October 2025, 32 186 cases, including 849 deaths have been reported. In comparison, in 2024 and as of 29 October 2024, no cases were reported.

Burundi: Since 17 March 2025 and as of 27 October 2025, 458 new cases have been reported. Since 1 January 2025 and as of 27 October 2025, 2 030 cases, including six deaths have been reported. In comparison, in 2024 and as of 18 October 2024, 762 cases, including three deaths were reported.

Chad: Since 12 September 2019 and as of 27 October 2025, 105 new cases, including seven new deaths have been reported. Since 1 January 2025 and as of 27 October 2025, 2 853 cases, including 156 deaths have been reported. In comparison, in 2024 and as of 29 October 2024, no cases were reported.

Congo: Since 31 December 2023 and as of 27 October 2025, 621 new cases, including 46 new deaths have been reported. Since 1 January 2025 and as of 27 October 2025, 808 cases, including 67 deaths have been reported. In comparison, in 2024 and as of 29 October 2024, no cases were reported.

Côte D'Ivoire: Since 1 August 2017 and as of 11 August 2025, 450 new cases, including 13 new deaths have been reported. Since 1 January 2025 and as of 11 August 2025, 503 cases, including 20 deaths have been reported. In comparison, in 2024 and as of 29 October 2024, no cases were reported.

Democratic Republic of The Congo: Since 10 March 2025 and as of 27 October 2025, 26 294 new cases, including 1 010 new deaths have been reported. Since 1 January 2025 and as of 27 October 2025, 58 750 cases, including 1 747 deaths have been reported. In comparison, in 2024 and as of 06 October 2024, 25 200 cases, including 344 deaths were reported.

Ethiopia: Since 30 April 2025 and as of 27 October 2025, 166 new cases, including one new death has been reported. Since 1 January 2025 and as of 27 October 2025, 7 836 cases, including 74 deaths have been reported. In comparison, in 2024 and as of 26 October 2024, 25 383 cases, including 245 deaths were reported.

Ghana: Since 25 April 2025 and as of 27 October 2025, 103 new cases have been reported. Since 1 January 2025 and as of 27 October 2025, 2 870 cases, including 14 deaths have been reported. In comparison, in 2024 and as of 18 October 2024, 102 cases, including one death was reported.

Kenya: Since 30 April 2025 and as of 27 October 2025, 74 new cases have been reported. Since 1 January 2025 and as of 27 October 2025, 555 cases, including 25 deaths have been reported. In comparison, in 2024 and as of 9 August 2024, 300 cases, including three deaths were reported.

Mozambique: Since 30 April 2025 and as of 27 October 2025, 131 new cases, including one new death has been reported. Since 01 January 2025 and as of 27 October 2025, 4 551 cases, including 45 deaths have been reported. In comparison, in 2024 and as of 02 August 2024, 8 183 cases, including 17 deaths were reported.

Namibia: Since 2 March 2025 and as of 27 October 2025, 17 new cases, including one new death has been reported. Since 1 January 2025 and as of 27 October 2025, 18 cases, including one death has been reported. In comparison, in 2024 and as of 29 October 2024, no cases were reported.

Nigeria: Since 17 March 2025 and as of 27 October 2025, 21 564 new cases, including 262 new deaths have been reported. Since 1 January 2025 and as of 27 October 2025, 31 302 cases, including 496 deaths have been reported. In comparison, in 2024 and as of 6 October 2024, 10 837 cases, including 359 deaths were reported.

Rwanda: Since 4 April 2025 and as of 27 October 2025, 41 new cases have been reported. Since 1 January 2025 and as of 27 October 2025, 325 cases have been reported. In comparison, in 2024 and as of 29 October 2024, no cases were reported.

Somalia: Since 17 February 2025 and as of 29 October 2025, 588 new cases have been reported. Since 1 January 2025 and as of 29 October 2025, 8 072 cases, including nine deaths have been reported. In comparison, in 2024 and as of 18 October 2024, 19 640 cases, including 138 deaths were reported.

South Sudan: Since 17 March 2025 and as of 27 October 2025, 11 717 new cases, including 109 new deaths have been reported. Since 1 January 2025 and as of 27 October 2025, 78 781 cases, including 1 251 deaths have been reported. In comparison, in 2024 and as of 29 October 2024, no cases were reported.

Sudan: Since 30 April 2025 and as of 27 October 2025, 1 316 new cases, including 36 new deaths have been reported. Since 1 January 2025 and as of 27 October 2025, 70 883 cases, including 1 960 deaths have been reported. In comparison, in 2024 and as of 18 October 2024, 26 393 cases, including 635 deaths were reported.

Uganda: Since 3 March 2025 and as of 27 October 2025, 37 new cases, including two new deaths have been reported. Since 1 January 2025 and as of 27 October 2025, 136 cases, including three deaths have been reported. In comparison, in 2024 and as of 17 May 2024, 52 cases, including three deaths were reported.

United Republic of Tanzania: Since 17 March 2025 and as of 27 October 2025, 234 new cases, including six new deaths have been reported. Since 1 January 2025 and as of 27 October 2025, 4 063 cases, including 45 deaths have been reported. In comparison, in 2024 and as of 30 September 2024, 5 798 cases, including 97 deaths were reported.

Zambia: Since 15 April 2025 and as of 27 October 2025, 42 new cases, including one new death has been reported. Since 1 January 2025 and as of 27 October 2025, 505 cases, including 10 deaths have been reported. In comparison, in 2024 and as of 19 July 2024, 20 063 cases, including 612 deaths were reported.

Zimbabwe: Since 30 April 2025 and as of 27 October 2025, five new cases have been reported. Since 1 January 2025 and as of 27 October 2025, 606 cases, including 23 deaths have been reported. In comparison, in 2024 and as of 6 July 2024, 19 412 cases, including 386 deaths were reported.

In 2025, no updates have been reported by: Comoros, Malawi and Togo.

Americas:

Haiti: Since 7 April 2025 and as of 29 September 2025, 2 857 new cases, including 47 new deaths have been reported. Since 01 January 2025 and as of 29 September 2025, 5 353 cases, including 78 deaths have been reported. In comparison, in 2024 and as of 05 October 2024, 10 250 cases, including 145 deaths were reported.

ECDC assessment:

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

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

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

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

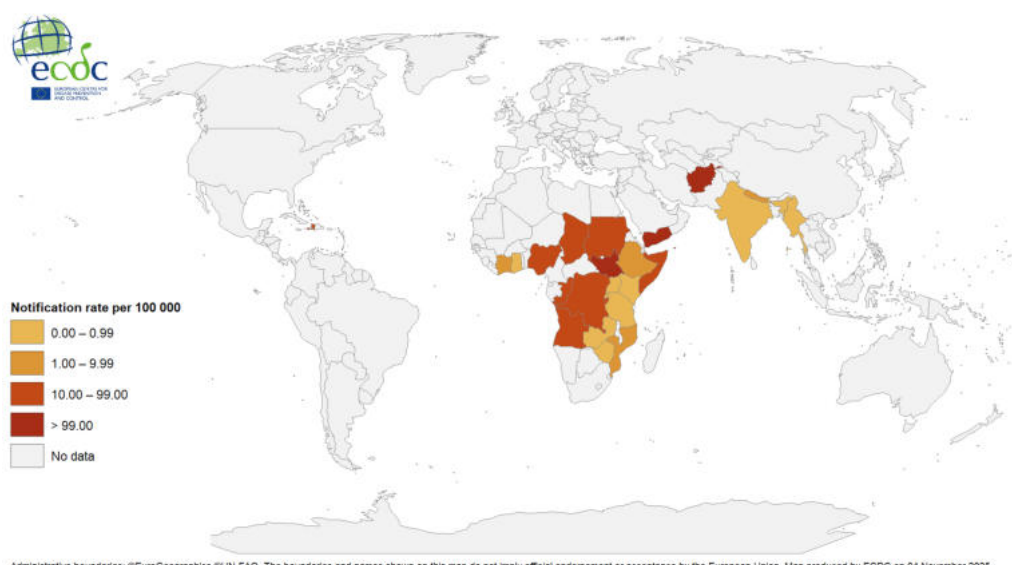
Actions:

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

Last time this event was included in the Weekly CDTR: 2 May 2025

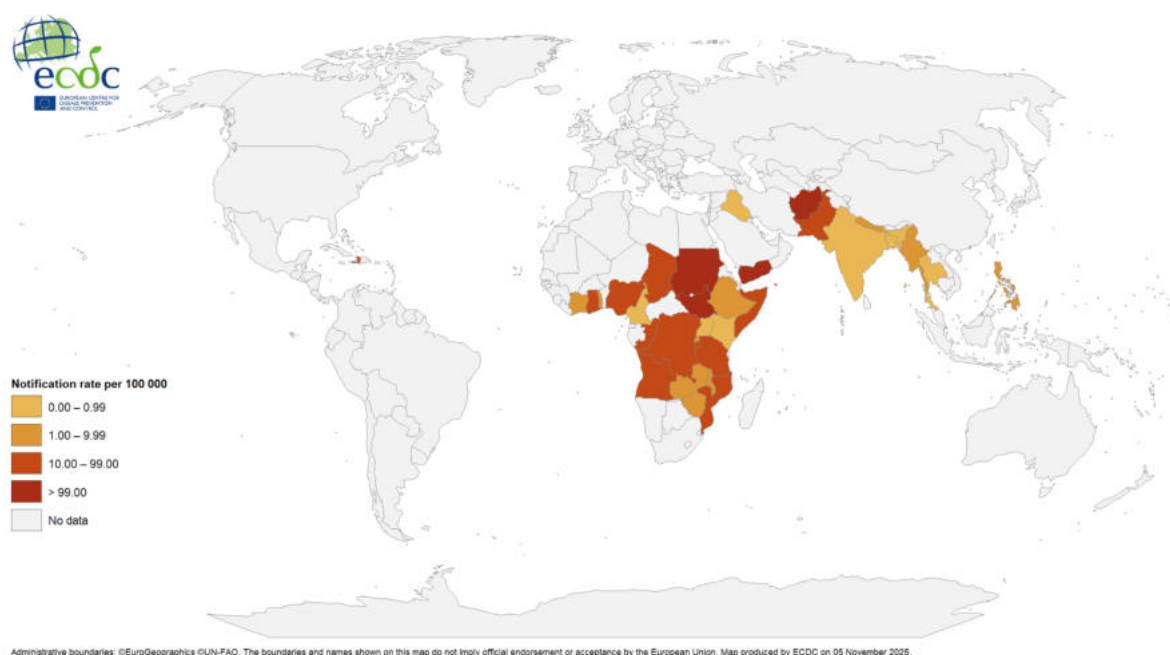
Maps and graphs

Figure 9. Geographical distribution of cholera cases reported worldwide from August to October 2025



Source: ECDC

Figure 10. Geographical distribution of cholera cases reported worldwide from October 2024 to October 2025



Source: ECDC

Events under active monitoring

- Mpox in the EU/EEA, Western Balkan countries and Türkiye – 2022–2025 - last reported on 31 October 2025
- Overview of respiratory virus epidemiology in the EU/EEA - last reported on 31 October 2025
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2025 - last reported on 31 October 2025
- Seasonal surveillance of dengue – 2025 - last reported on 31 October 2025
- Weekly seasonal surveillance of West Nile virus infection – 2025 - last reported on 31 October 2025
- Seasonal surveillance of chikungunya virus disease – 2025 - last reported on 31 October 2025
- Ebola virus disease – Democratic Republic of the Congo – 2025 - last reported on 31 October 2025
- Rift Valley fever in Western Africa – 2025 - last reported on 31 October 2025
- Expert deployment - last reported on 31 October 2025
- Monkeypox virus clade Ib – Multi-country – 2025 - last reported on 24 October 2025
- Human infection with avian influenza A(H5) virus - Mexico - 2025 - last reported on 17 October 2025
- Early start of influenza season - Japan - 2025 - last reported on 17 October 2025
- Medical Product Alert N 5/2025: Substandard (contaminated) oral liquid medicines - last reported on 17 October 2025
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 10 October 2025
- Seasonal surveillance of West Nile virus infections – 2025 - last reported on 10 October 2025
- Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2025 - last reported on 10 October 2025
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring - last reported on 10 October 2025
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update - last reported on 10 October 2025
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 10 October 2025
- SARS-CoV-2 variant classification - last reported on 7 November 2025
- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update - last reported on 7 November 2025