CHOLERA - GLOBAL

Date and version of current assessment: 24 September 2024, v6

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

Between October 2022, when the first Global Cholera RRA, v1, was disseminated and March 2024, when the RRA v5 was carried out, the overall risk for cholera at the global level was continuously assessed as very high. As the measures to contain the cholera pandemic continue to be sustained, this RRA aims to reassess the current global risk of multiple ongoing cholera outbreaks, including capacities to support the global response (e.g. technical, oral cholera vaccine, supply). Country and region-specific risk assessments are available within the document.

Since mid-2021, the world has faced a significant cholera upsurge, marked by the number, magnitude, and concurrence of multiple outbreaks, the re-emergence of cholera in areas that had been free of the disease for decades, and alarmingly high mortality rates, which in multiple countries was above 3% in 2023. These multiple ongoing/reoccurring outbreaks, part of the seventh pandemic that has been ongoing since 1961, present several challenges, especially in countries going through complex humanitarian crises and fragile health systems. Climate change leads to the continued risk of spreading to at risk geographical areas/ countries, further complicating the response to the outbreak.

In 2024 until 19 September, over 414 000 acute watery diarrhoea (AWD) and suspected cholera cases and 3100 deaths were reported from 32 countries across the six WHO regions. The region with the highest reported case count was the Eastern Mediterranean Region (269 578 cases; six countries), followed by the African Region (123 265 cases; 17 countries), the South-East Asia Region (10 067 cases; five countries), the Region of the Americas (9 935 cases; two countries), and the European Region (221 cases; one country) and the Western Pacific Region (1 217 cases, one country). During this period, cholera deaths were reported in the African Region (2114 deaths, CFR 1.7%), the Eastern Mediterranean Region (766 deaths, CFR 0.3%), the Region of the Americas (242 deaths, CFR 2.4%), the South-East Asia Region (34 deaths, CFR 0.3%), and the European Region (two deaths, CFR 0.9%) and the Western Pacific Region (nine deaths, CFR 0.7%).

Nevertheless, the data should be interpreted cautiously due to potential reporting delays and misclassification of cases, which may affect the accuracy of the presented figures. Variations in surveillance systems, case definitions, laboratory capacities, and political contexts among countries also make direct comparisons of cholera statistics challenging. As a result, under-reporting is likely to some extent across regions.

Currently, 24 countries and territories have active cholera outbreaks as of 19 September 2024. There has been an improvement, with several countries either declaring the end of their outbreaks or not reporting new cases for over eight consecutive weeks (Dominican Republic, Mozambique, South Africa, Zambia, Zimbabwe). Additionally, a decline in reported cases has been observed in some countries (Burundi, Comoros, Ethiopia, Haiti, Somalia).

* Confidence refers to the level of confidence in the data/information or the quality of the evidence available at the time the RRA is conducted. Poor quality information may increase the overall perceived risk due to the incertitude in the assessment.

In 2024, eight of 31 affected countries reported case fatality ratios (CFR) higher than 1%. However, since RRA v 5 (finalized on 21 March 2024), five countries (the Democratic Republic of the Congo, Ethiopia, Nigeria, Niger, and Sudan) still reported high CFRs in September 2024. In some countries, CFRs have reached alarming levels, with Sudan reporting a CFR of 3.2%, followed by Niger with 3.1% and Nigeria with 2.3%.

Countries that are still in a complex humanitarian crisis, with fragile health systems, inadequate access to clean water and sanitation, and insufficient outbreak capacities, are still reporting cholera cases, including the Democratic Republic of the Congo (DRC) (eastern part of the country), Ethiopia, Myanmar, Somalia, Sudan, Syria, and Yemen.

AFR: There has been a significant reduction in the weekly number of cases reported in the WHO African region since the last RRA. In the Southern sub-region, which recorded the highest number of cases between 2023 and 2024, several countries have controlled the cholera outbreak with zero reporting from South Africa, Zambia, and Zimbabwe for more than four consecutive weeks. However, the potential risk for cholera outbreaks remains very high across the region. As of 19 September, 11 out of the 17 countries affected in 2024 have reported cases in the past 6 weeks. As of 19 September, the highest case numbers in the region have been from the Democratic Republic of the Congo (24 693 cases) and Ethiopia (22 931 cases), both of which are dealing with complex emergencies including humanitarian crises, insecurity, and drought. Nevertheless, with the current flood situation in Western and Central Africa, the risk of increased transmission of cholera remains very high. As of 19 September Nigeria has reported a high number of cases, with 8 475 cases reported since the beginning of the year, the majority occurring following a floods in June in Lagos and currently, there are reports of cases from Cameroon, Ghana, Niger, and Togo.

AMR: A significant drop in suspected (75%) and confirmed (89%) cholera cases in Haiti has been observed between January and August 2024. Compared to the same period in 2023, cholera deaths fell by 46% (444 deaths in 2023 vs. 242 deaths in 2024). Similarly, the cumulative positivity rate of tested suspected cases declined to 30.8% as of August 2024 compared to 35.3% as of August 2023. These figures indicate that while there has been significant progress in reducing the overall number of cholera cases, the persistently high percentage of positive test results and relatively slow decline in deaths highlight ongoing transmission hotspots and continued challenges in ensuring timely access to treatment, particularly for severe cases. The cholera response in Haiti remains complicated by ongoing insecurity in the country. In the Dominican Republic, the last confirmed cholera case was reported in epidemiological week 11 (ending 16 March 2024).

EMR: Cholera resurgence in the EMR is driven by factors such as climate change, conflict, political instability, fragile health systems, increased population movement, poor water and sanitation infrastructure, and low public awareness/ engagement about cholera. From 1 January to 19 September 2024, a total of 269 578 suspected cholera or acute watery diarrhoea (AWD) cases were reported across six countries in the Eastern Mediterranean Region. During this period, the highest numbers of cases were reported from Afghanistan (135 493 cases) reporting AWD with sever dehydration), Pakistan (54 848 cases) and Yemen (36 404 cases from the Internationally Recognized Government areas). During the same period, a total of 766 deaths were reported from four countries, with the highest numbers recorded in Yemen (159 deaths, CFR 0.4%), Somalia (139 deaths, CFR 0.7%), and Sudan (13 272 cases; 405 deaths, CFR 3.1%). The number of cases increased in spring/summer, with the trend in some countries of the region stabilizing. At the same time, the outbreak in Sudan has made a resurgence in the context of a worsening humanitarian crisis, leading to 11 079 cases and 348 deaths from 25 July to 18 September. Additionally, on 7 August 2024, Syria reported the first culture-confirmed cholera case since early January 2024, in a 6-year-old child from Killi, Idlib Governorate, who had no travel history within Syria or abroad.

EUR: Cholera is not endemic in the WHO European Region. Strong public health and sanitation systems lower the risk of transmission following importation. However, countries bordering Syria, Iraq, and Lebanon, where large outbreaks have been reported, may have a heightened risk of introduction and onward transmission, particularly among vulnerable groups (e.g., refugees and displaced persons). Ukraine continues to experience conflict-related disruptions to its health infrastructure, although no cholera cases have been confirmed in 2024. Mayotte experienced an outbreak in March 2024, but the situation has significantly improved, with no new cases reported since July. Bulgaria reported its first cholera case since 1921, involving a man who contracted the disease after returning from India.

SEAR: Cholera is endemic in Bangladesh, India and Nepal. As of 18 September, Bangladesh reported 217 cholera cases, primarily in Rohingya refugee camps. India has reported 5929 suspected cases across 13 states. In 2024, Myanmar reported 5779 acute watery diarrhoea cases and 15 deaths with CFR of 0.3% between 24 June and 14 September. The cases continue to be reported in Yangon and Rakhine, and a few other states/regions. In 2024, Nepal reported, a total of 95 laboratory confirmed cases of cholera, majority associated with flood in Kathmandu Valley. The overall risk in the region remains high due to endemic cholera, systemic weaknesses, sub-optimal WASH interventions, limited transparency, laboratory capacity, health inequality, conflict and the impact of climate change.

WPR: From 1 January to 30 June 2024, a total of 1 217 cases and nine deaths were reported in the Philippines, the Western Pacific Region. Cholera is endemic in parts of the Philippines; however, no major outbreak has been reported in 2024. In July 2024, WHO, UNICEF and the Philippines Department of Health conducted a joint risk assessment in one region that reports the highest number of cholera cases in annual reporting and identified risks and capacities for cholera transmission and public health response. The overall risk remains low in the region. Sufficient response measures and capacity are in place.

SUMMARY:

Continuous cholera outbreaks in the majority of affected countries place a heavy burden on affected communities and public health systems, depleting both local and global resources. The risk of cholera is asymmetrically distributed across regions and countries and increases where access to clean water and sanitation is limited. Climate change, lack of development, cross-border movement, and increased travel following the easing of restrictions related to COVID-19 further increase the risk of international spread.

Based on a probabilistic multi-model ensemble forecast, the climate update for September to November 2024 indicates that East Africa and Southeast Asia are expected to experience above-normal rainfall. Southern Africa is likely to face below normal rainfall. These climatic conditions are anticipated to increase the likelihood of floods and droughts, which in turn could lead to new outbreaks and complicate current transmission control operations. As El Niña transitions from October to February, East Africa and South East Asia are expected to experience increased rainfall, flooding, and cooler ocean temperatures. This will likely lead to overflowing sanitation systems, large population displacements due to floods, and contaminated water sources.

The high number of countries still reporting cholera cases into September 2024 underscores the ongoing challenges posed by cholera globally and the critical need for persistent public health initiatives. The global response capacity is strained by simultaneous outbreaks, shortages of the Oral Cholera Vaccine (OCV) and cholera supplies, and overstretched public health personnel who are dealing with multiple concurrent health emergencies. Due to the global shortage of OCV, the International Coordinating Group (ICG) decided to temporarily suspend the second dose strategy for outbreak response in October 2022. Due to the continuing global shortage of OCV this temporary measure will likely remain in place throughout 2024. From January 2024 to date, the number of urgent requests for OCV surged, with 35.7 million OCV doses requested by 12 countries. The global stockpile of vaccines was empty from 11 January to 4 March, as of 16 September 2024, the global stockpile stands at 948,550 doses – far below the 5 million target. This shortfall means that countries with approved requests must wait for doses to be produced and for the global stock to be replenished before international freight arrangements can be made.

Currently, the global supply of cholera supplies is also still understrain. Stockouts have only been avoided through continued collaboration between WHO, UNICEF, and other partners and require significant resources to enhance reactivity. Despite the establishment of emergency coordination mechanisms, the response capacities are below what is required for an adequate response in terms of human resources and finance both for regional and global technical teams, limiting timely operational support to affected countries. Strengthened coordination and priority-setting with partners remain critical.

While implemented interventions have helped reduce cholera transmission in several countries, exacerbating factors such as humanitarian crises, climate change, and underdevelopment continue to fuel outbreaks in many countries.

Based on the current situation, in particular:
1) a sustained high number of ongoing outbreaks in 24 countries;
2) the complex humanitarian context in many affected countries;
3) continuous risk of spread;
4) lack of vaccines and limited response capacity (supplies, human resources);
5) recent flooding in multiple countries already affected by climate change and at risk for cholera outbreaks;
6) some improvement in the number of reporting countries and declining trends in the number of reported cases in some of the affected countries, however, WHO is aware of under-reporting worldwide due to insufficient surveillance systems and lack of standardized terminology for defining a case of cholera
7) multiple ongoing outbreaks in many countries (e.g. mpox, humanitarian crises) stretching limited resources and limiting both national and regional response capacity

the **risk at the global level is re-assessed and remains unchanged as very high.** Despite some fragile improvement observed in the global epidemiological situation cholera remains a global threat to public health and an indicator of inequity and lack of social development.

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 (funding can be accessed before grading completed)	Immediate
☐	Immediate support to response, but within limit of CFE (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.

Risk questions

Risk question	Assessment		Risk	Rationale
	Likelihood	Consequences		
Potential risk for human health?	Highly likely	Major	Very high	In March 2024, eight of 26 affected countries reported Case Fatality Ratios (CFR) above 1%. By September 2024, five of the 24 countries reporting cholera cases had elevated CFRs. In some instances, such as in Sudan, the CFR rose as high as 49%. Weaknesses in surveillance systems, poor knowledge of cholera by staff and lack of decentralization of treatment in many affected countries and the scale of outbreaks stretching resources, delayed reporting and response all result in higher CFR and risk to human health. The current outbreak in Sudan is spreading with the national CFR at 3.1% (11 079 cases, 348 deaths) as of 18 September. Some states have reported new outbreaks in the past two weeks with Sennar State reporting CFR as high 40% (147 cases, 59 deaths) likely reflecting poor recording of cases, but also the limited access to treatment in conflict zones. In Myanmar, the limited availability of confirmed case and death data makes it challenging to capture the true situation in communities, potentially hindering effective response and containment efforts. Access to healthcare remains constrained, particularly in conflict-affected areas, and is further compounded by limited WASH services and overcrowded living conditions that

				heighten transmission risk. Despite these challenges and worsening of the humanitarian situation, WHO and partners have strengthened preparedness and response efforts. Niger which reported the first case in more than two years in late August 2024 has a national CFR of 3.1% (320 cases, 10 deaths). There is currently significant flooding in the Niger River basin leading to population displacement which may also limit access to treatment and increase risk of further transmission. In addition, many affected populations face barriers to accessing healthcare due to insecurity, distance, and the absence of partners supporting decentralized care (e.g., Myanmar, Sudan, Comoros). In Nepal, sporadic and clustered cases of cholera are reported annually, predominantly during the rainy season. These outbreaks are commonly associated with communities experiencing inadequate sanitation, unsafe drinking water, and flood-related contamination, compounded by limited public awareness. The most recent cholera-related death was reported in 2021(1570 case, 6 deaths).
Risk of geographical spread of the event?	Highly Likely	Major	Very High	Currently, 24 countries and territories are reporting cases, compared to 28 countries reporting cases at the time of RRA v5 in March 2024. According to the WHO internal risk categorization, seven countries are classified as being in acute crisis as of September 2024 - the same number as in March. While some countries are reporting fewer cases than at the time of the last RRA (e.g. Ethiopia, DRC) the global situation has not improved. Since the previous RRA, new outbreaks or signals have been reported between July and August in Ghana and Togo. In early September, Niger recorded its first cholera cases of 2024 and the outbreak has now spread to 3 regions of the country. There are also increasing cases reported from the north of Nigeria with the three humanitarian crises states of Borno, Adamawa and Yobe now reporting cases. This situation is similar to the beginning of the outbreak in the region in 2021 where there was spread of cases from Niger and Nigeria to Mali Burkina Faso and Benin. In addition, there is significant flooding across the Niger River and Lake Chad basin with significant population displacement that also increased the risk of geographic spread within the affected countries and to neighbouring countries including Chad and Cameroon. Similarly, Malawi reported 10 suspected cases and one confirmed case, one month after declaring the end of its cholera outbreak. The predicted La Niña phenomenon increases the risk of transmission within the sub-region. Sudan is seeing a major resurgence with geographical spread in the country with 8 of 18 districts now reporting cases. Sudan has also been affected by floods. Population movement puts neighbouring countries increases risk of transmission to bordering South Sudan and Chad. New cases in Comoros increase the risk of spread in the region to countries including Madagascar. Despite limited surveillance, there are reports of cholera from an increasing number of regions of Bangladesh and Myanmar. This outbreak is occurring earlier than expected (during the monsoon period while the increase of cases is regularly seen pre and post-monsoon). There is a risk of a further surge during the regular post-monsoon peak period and spread.

				Additionally, although there has been a decrease in cases in DRC's North and South Kivu since the last grading, there is traditionally an increase in cases towards the end of the year increasing the risk of spread to neighbouring countries including Burundi, Rwanda and Uganda. In the Horn of Africa, uncontrolled cross-border movement of people, including refugees/asylum seekers movement between Somalia, Kenya and Ethiopia, increases the risk of spreading to neighbouring countries, especially Djibouti and Eritrea. This week there was a signal of an increase in AWD in Djibouti with deaths in adults reported. This is the first such signal from Djibouti in multiple years.
Risk of insufficient control capacities?	Highly likely	Major	Very high	The scale and geographic scope of cholera outbreaks have stretched the capacity of WHO technical teams to provide support and guidance. Concurrent large-scale outbreaks, alongside other public health and humanitarian crises, further strain resources, disrupt multi-sectoral coordination and limit the capacity to provide human resources (HR) support. The global OCV supply is limited, leading to the ICG in 2022 to provide only one dose for outbreak response due to insufficient vaccine dosages to meet high demand. The provision of only one dose is expected to be maintained throughout 2024 and into 2025. The current global OCV stockpile still cannot cover all requests and needs. Efforts are being made to increase OCV supply, but it will be several years before the impact of these efforts is seen. Global cholera Kit supplies are also limited, and increasingly complex administrative processes and lack of flights further delay delivery when supplies are available. While systems have been developed to strengthen cholera kit supply and distribution, significant support is provided by the IMST OSL. Limited diagnostic capacity including availability of Rapid Diagnostic Test Kits and trained health workforce, in some countries creates delays in outbreak detection/confirmation and increases the risk of having insufficient control capacities at the time of response. Insufficient laboratory data can result in inaccurate mapping of areas for priority intervention which in turn leads to inadequate management of response resources. An outbreak in a previously unaffected area due to conflict or natural disaster would severely overstretch global supply.

Current RRA v6, September 2024	
Capacities	**Vulnerabilities**
Coordination • As of 12 September 2024, 20 experts have been deployed to Malawi, Mozambique, Kenya, Lebanon, Haiti, Sudan, Zambia, Comoros and Yemen through GOARN to support the cholera response, specifically Health Operations, Case Management, Social anthropology and Epidemiology/Surveillance, Health Cholera Coordinator and Partner Coordination • As of 12 September, 21 experts have been deployed (for a duration of 3 to 6 months each) to nine countries (Malawi,	**Coordination** • Exhausted national cholera response capacities and overall overstretched emergency response capacity due to numerous parallel large-scale and high-risk outbreaks and other emergencies affecting public health. • Limited experienced cholera response staff available for deployments to support national emergency responses.

Mozambique, Cameroon, Haiti, Turkey, Ethiopia, Zambia, Comoros and Myanmar, including remote global strategic support) through the Standby Partners to support the cholera response for the functions of Information management (IMO), Partner/Cluster Coordinator, Preventing and Responding to Sexual Exploitation, Abuse and Harassment (PRSEAH), Infection Prevention and Control (IPC)/Water Sanitation and Hygiene (WASH), Risk Communication and Community Engagement (RCCE) and Logistics (OSL).	• Reduced Regional capacity due to competing emergencies such as mpox.
Laboratory • Technical support and assistance in the development of laboratory strengthening plans for countries are being provided on a case-by-case basis. • Support was provided to identify laboratory diagnostic supply needs and deployment of laboratory supplies in 11 countries with acute and active outbreaks. Prepositioning of supplies for preparedness and readiness in priority countries are ongoing. • Countries are being supported in defining and implementing testing strategies during outbreaks. • Collaboration with Gavi continues to support the procurement of cholera RDTs for Gavi-eligible countries, enhancing cholera surveillance and outbreak monitoring. • Training materials for cholera diagnostics continue to be developed.	**Laboratory** Limited diagnostic capacity in some countries and/or access to samples has led to delays in outbreak detection/confirmation and increased the risk of having insufficient control capacities at the time of response. Insufficient laboratory data to inform the mapping of areas for priority intervention can also lead to inadequate management of response resources.
Surveillance • The Global Task Force on Cholera Control (GTFCC) has published revised guidance on public health surveillance for cholera, which comes with accompanying tools. In August 2024, this material was released in Arabic, French, and Portuguese to supplement English. • Countries are encouraged to periodically self-assess their cholera surveillance system and strategies using the GTFCC method to assess cholera surveillance to identify priority activities to strengthen their cholera surveillance system/strategies towards meeting the standards set in the GTFCC revised guidance on public health surveillance for cholera. • GTFCC technical recommendations on standard data and metadata sets for cholera reporting at regional and global levels are being promoted. A template is available for cholera reporting at regional and global levels. • Support in data management and analysis is being provided to countries and regions on a case-by-case basis. • Coordination efforts are underway with countries, regions, and partners to strengthen cholera surveillance. • Identification of Priority Areas for Multisectoral Interventions (PAMIs) makes it possible to maximize the impact of control strategies and direct resources to the most affected or vulnerable areas. GTFCC guidance for the identification of PAMIs for cholera control is being disseminated and promoted (in English, Arabic,	**Surveillance** • Data quality and reporting is suboptimal, including issues with reporting consistency and insufficient disaggregation of data for vulnerable groups, especially children under 5 years of age.

French, and Portuguese). This guidance aims to maximize the use of surveillance data for cholera-affected countries in the development or revision of a National Cholera Plan for cholera control.	
Vaccination •14 new requests were received in 2024 from Bangladesh, Comoros, Ethiopia, Kenya, Mozambique, Myanmar, Nigeria, Somalia, Sudan, Yemen, Zambia, and Zimbabwe. Collectively these countries requested 35.7 million doses but 21.2 million doses were approved, by the International Coordinating Group (ICG) on Vaccine Provision. One additional country is currently considering submitting requests. • Since the start of 2024, seven countries (Comoros, Ethiopia, Mozambique, Somalia, Sudan, Zambia, and Zimbabwe) have carried out ten reactive vaccination campaigns in response to cholera outbreaks, targeting a total of 11 million people.	**Vaccination** • The constrained supply of OCVs is severely impacting the capacity to carry out preventive vaccination campaigns. The limited global stockpile of OCVs underscores the need for increased production and strategic stockpile management to ensure that both reactive and preventive needs are adequately met. • Insufficient OCV stocks to respond to all concurrent cholera outbreaks, resulting in the suspension of preventive campaigns and a transition from a two-dose to a one-dose strategy. Between January and March 2024, the vaccine stockpile was entirely depleted. • Given the current context of outbreaks and limited vaccine availability, only single-dose vaccination courses have been validated and utilized in reactive campaigns implemented in 2024.
Case management, IPC and WASH • As part of a support project by the U.S. Centers for Disease Control and Prevention, training on WASH/IPC response, focusing on the implementation of water quality monitoring, has been conducted in Niger. • The development of a WASH toolkit for managing WASH/IPC response is underway. This tool will guide country offices in coordinating and operationalizing their activities. • Support continues to be provided on IPC and WASH to affected countries, including Nigeria, Ethiopia, Myanmar, and Yemen. • The GTFCC modular case management training is being completed. • Technical support 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 (Nigeria, Myanmar, Somalia, Sudan).	**Case management, IPC and WASH** • Access to treatment in the community, especially in complex humanitarian contexts remains an issue with many people not able to reach treatment. • Knowledge of case management is low in countries that have not reported cholera for many years and in some cases leading to slow response, including delayed decentralization requiring additional global support. • The quality of clinical case management varies. High staff turnover and/or insufficient public health staff are additional factors to inadequate clinical response.
Risk communication and community engagement and Infomdemic Management (RCCE-IM) • Risk communication and community engagement (RCCE) • Coordination efforts are continuing with regions and partners, with cholera resources available - here. • Response checklist and key messages are under revision. • Competing emergencies and lack of funding are impacting RCCE technical and surge support, support continues to be provided to RO.	**IPC/WASH** • Lack of capacity in newly affected countries (i.e. Western Africa) to implement WASH/IPC standards specific to cholera response. • Lack of WASH/IPC focal point for response. • Population movement due to natural hazards (rainy season, climate change) and

• An RCCE readiness and response toolkit for cholera is under development. The ultimate goal of this toolkit is to provide RCCE focal points and practitioners with a set of tools to strengthen their work to inform, engage and empower communities at risk from cholera. To support the implementation of this toolkit, a training guide is under development.	insecurity, in Western Africa/conflict areas might result in reduced access to WASH infrastructures. • ENSO WMO predicts 60% chance to have La Niña conditions by the end of the year. Impact on rain and temperatures might exacerbate risk for cholera worldwide (https://wmo.int/media/news/wmo-update-predicts-60-chance-of-la-nina). **Risk communication and community engagement and Infodemic Management (RCCE-IM)** • Lack of RCCE-IM focal point and human resources surge for response. • Lack of funding to support interventions. • Lack of advocacy.
OSL • Stock monitoring and forecasting procedures have been updated. • Country and worldwide consumption are monitored in real-time and analysed monthly. • Buffer stocks as well as emergency stocks have been redefined. • Nairobi and Dakar hub have enhanced their response capacity.	**OSL** • In a continued volatile epidemic context with the potential for renewed big response operation, the operational link between EPI and OSL needs to be continued to ensure reactivity while limiting overstocking with short expiring dates. • Challenges in obtaining fast agreements for importation in certain countries. • Financial challenges in some countries to ensure adequate operational response in time. • Coordination with other partners needs to be continued. **Other** • Exacerbation of cholera outbreaks due to natural disasters and climatic effects. • Increased risk of cross-border cholera transmission due to porous borders with numerous unofficial points of entry points, inadequate surveillance at border areas, and limited cholera awareness in affected communities. • Inadequate financial resources to respond in a timely and effective manner across all levels. • A lack of resources for prevention, readiness, and preparedness activities. • Lack of technical capacity required for effective readiness to respond in Member States.

	• Lack of advocacy to support Cholera prevention, readiness and response.

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 including replenishing emergency bulk item stock and continuing to pre-order supplies and identify 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. Disease 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 case 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 previous RRA (latest data available as of 15 September 2024)

Region	Country/Area	Context
AFRO	**Burundi**	Since January 2024, and as of 15 September, the country has reported 799 cases and 3 deaths (CFR 0.4%). In epidemiological week 37, 11 new cases were reported from Bujumbura Sud (9 cases), Kabezi (1 case) and Isale (1 case). The trend in new cases has been mainly decreasing since the last RRA was finalized in March 2024.
AFRO	**Cameroon**	Since January 2024, and as of 23 May 2024, the country has reported 49 cases and no deaths. The outbreak is active in 10 health districts in the Centre and Littoral regions. No new cases were reported since epidemiological week 18 (ending on 4 May). According to media reports from 15 September, Cameroon recorded its first cholera case since May in Yaoundé. The patient, a 50-year-old man from Bangou in western Cameroon, was identified by volunteers of a nongovernmental organization after his death. A post-mortem test confirmed cholera. Local authorities are implementing public health measures in the affected area. Verification is ongoing with AFRO.
AFRO	**Comoros**	An outbreak was identified in Comoros, with the first cases reported on 2 February 2024. The health minister declared the outbreak on the same day. The first local cases were reported on 4 February. Since 2 February 2024, the Union of the Comoros has faced a cholera outbreak that has affected all three regions; Ndzuwani, Ngazidjan and Mwali. From the date of notification of the first case until 8 August 2024, 10 433 suspected cases of cholera were reported, including 11 imported cases, with 152 deaths, representing a case fatality rate of 1.45%. The region of Ndzuwani (Anjouan),

		which is the most affected, recorded 9126 suspected cases with 126 deaths; the region of Ngazidja (Grande Comore) recorded 635 suspected cases with 18 deaths; and the region of Mwali (Mohéli) recorded 581 suspected cases with 8 deaths.Since epidemiological week 30 (ending 27 July), no new cases or deaths have been reported. A vaccination campaign started on 19 June. As of 12 August, national coverage is 58% (79% in Ndzuwani, 40% in Ngazidja, 73% in Mwali).
AFRO	**Democratic Republic of the Congo**	From 1 January 2024 to 1 September the country reported 24 319 cases, with 321 deaths (CFR 1.3%) across 118 health zones in 16 affected provinces since epidemiological. In epidemiological week 34, 281 cases and 8 deaths were reported (CFR 2.8%). In epidemiological week 36, there were 366 cases, with 4 deaths (CFR 1.1%) and one new health zone impacted in the province of Sankuru. Most cases in week 36 (ending 7 September) were in Nord Kivu (187 cases). The outbreak in Nord-Kivu is exacerbated by high insecurity and poor WASH coverage, particularly in IDP sites, with water access at 42% and latrine coverage at 40% according to a recent analysis. Haut-Katanga, like Nord-Kivu, is also a cholera-endemic province in the northeast. Although the outbreak had been decreasing in recent weeks, in week 32 there was an increase in cases. Nutritional care and operational support are needed at treatment centres post-MSF departure.
AFRO	**Ethiopia**	Since January 2024, and as of 9 September, the country reported 23 931 cases and 218 deaths (CFR 0.9%). The outbreak is currently active in 59 districts (woredas) across four regions: Amhara (20 woredas), Oromia (9 woredas), Tigray (24 woredas), and Somali (6 woredas). In total, 408 woredas from 10 Regions and one City Administration have been affected. The outbreak is controlled in 349 woredas across nine regions, but high risk remains due to proximity to active areas. In week 36 (ending 7 September), 275 new cases were reported, Tigray (51 cases) and Sidama (24 cases) regions. During epidemiological week 36, the highest number of cholera cases were reported from the Northwest zone of Tigray region and the southern part of Sidama region. In week 35, cholera cases and deaths were reduced by 88% and 100%, respectively, compared to the same week last year. In the last 42 days, 1 519 cases and 21 deaths were reported, while 12 cases and no deaths were reported in week 36. Among the total cases over the last 7 days, 5% were from Amhara, and 95% were from Sidama. Recently, a significant expansion of the outbreak has been observed, leading to collaborative attention in the northern regions, particularly in Amhara and Tigray. A vaccination campaign is ongoing in 10 woredas across Oromia (3), Afar (3), Amhara (2), and Somali (2). The current campaign coverage is 67%.
AFRO	**Ghana**	The last outbreak in Ghana was recorded in 2016 with 704 cases. On 23 August 2024, two confirmed cases were reported in a rural area in the Ada East District of the Greater Accra Region in Ghana. There is no travel history or contact with persons presenting with similar symptoms before symptom onset. Both cases are from the same community and ate fish bought from the same vendor. Environmental assessment showed poor sanitary practices in the affected community. As of 31 August, there were six confirmed cases and two suspected cases. Two cases are on admission (one suspected case with RDT negative and one confirmed case).
AFRO	**Kenya**	Since January 2024, and as of 28 July, the country reported 392 cases and 3 deaths (CFR 0.8%) from five of 47 counties. As of 12 July, the country reported 17 cases and 2 deaths (CFR 12%) from Lamu county.

AFRO	**Malawi**	Since January 2024, and as of 1 September, Malawi reported 252 cases and 1 death (CFR 0.4%). 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 10 suspected cases and one confirmed case in the Chitipa District. A new outbreak was confirmed in Lilongwe District with the first cholera culture-confirmed was reported on 26 August from Lumbadzi Health Centre. As of 15 September, a total of 27 new confirmed cases has been reported in the country. These cases were reported from Chitipa (24 cases), Karonga (1 case), Lilongwe (1 case) and Machinga (1 case). The number of new confirmed cases increased in epidemiological week 37 compared with the preceding week. Overall, the number of cases (confirmed and epi link combined) increased from three in epidemiological week 36 to 23 in week 37, representing 85% increase in the number of new cases. One new death was also reported in week 37 (weekly CFR4.3% and cumulative CFR 3.7%).
AFRO	**Mozambique**	Since January 2024, and as of 1 September, the country reported 8 132 cases and 18 deaths (CFR 0.2%). In epidemiological weeks 32 to 35 no cases and deaths were reported. None of the 11 provinces reported active outbreaks in the past month. Mozambique was downgraded from active to preparedness.
AFRO	**Niger**	In September 2024, Niger recorded its first cases for this year, with 72 suspected cases and five deaths (CFR 6.9%) in the Tahoua region in Southern Niger. Suspected cases were reported from Bouza (45 cases), Madaoua (17 cases) and Tahoua (10 cases).
AFRO	**Nigeria**	Since January 2024, and as of 10 September, the country reported 7 924 suspected cholera cases and 229 deaths (CFR 2.9%) across 35 states and the Federal Capital Territory. Most cases were from Lagos (57%) and Jigawa (7%) states. Only Enugu state in south-east Nigeria has reported no cases to date. In July 2024, Nigeria reported 3 198 new cholera cases and 102 associated deaths (CFR 3.2%), marking a 192% increase in cases and a 149% increase in deaths compared with the previous month. While the overall epidemiological situation is improving, the situation remains concerning especially in Lagos state, which accounts for almost 60% of the total cases reported this year. During week 36 (ending 7 September), 1 889 cases and two deaths were reported with a constant declining trend in the number of weekly cases since epidemiological week 26.
AFRO	**Tanzania**	Since January 2024, and as of 12 September, Tanzania reported 5 257 cases and 83 deaths (CFR 1.6%). A total of 23 regions have reported outbreaks in 2024. As of 11 September, nine regions (Kigoma, Mbeya, Arusha, Lindi, Morogoro, Songwe, Tabora, Tanga and Simiyu) have active outbreaks. In epidemiological weeks 35-37, a total of 439 cases with no deaths were reported. The majority of cases (253 cases, 58%) were from the Simiyu region.
AFRO	**Togo**	Since 28 July 2024, and as of 17 August, the country reported five cases and 1 death (CFR 20%). Of nine suspected cases, the five confirmed cases were reported in the Maritime region, in Golfe (4 cases) and Vo (1 case) districts. Of these two cases are among children (2 months old and 6 years old).
AFRO	**Uganda**	Since January 2024, and as of 28 July 2024, the country has reported 89 cases and 5 deaths (CFR 5.6%). Since the last RRA finalized in March 2024 a new outbreak started on 20 April in the Kyotera District.
AFRO	**Zambia**	Since 15 October 2023, and as of 9 August 2024, the country has reported a cumulative of 23 381 cases and 740 deaths (CFR3.2%). Transmission is widespread, with more than half of the deaths (n=436) occurring in community settings, while 304 deaths were facility deaths (CFR 22.6%). The outbreak has affected all of Zambia's 10 provinces. No new cases were reported since 28 June

		2024. The classification of Zambia was downgraded from active to preparedness.
AFRO	**Zimbabwe**	Since January 2024, and as of 30 July, the country reported 20 033 cases and 399 deaths (CFR 2%). The last cholera case in Zimbabwe was reported on 30 June. A month later on 30 July 2024, the Zimbabwe Ministry of Health officially declared the end of the cholera outbreak.
AFRO	**South Africa**	Since January 2024, and as of 28 June, the country reported 11 confirmed cases and no deaths. No new cases have been reported since 3 April 2024.
AFRO	Since the last RRA, several countries have contained cholera outbreaks. There are several concurrent graded emergencies, delayed detailed investigation leading and stretched human capacity due to other public health emergencies. Some affected areas are highly insecure, and there is limited access to healthcare for the population. 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, three new countries, Ghana, Niger and Togo, have reported a cholera outbreak. However, Zimbabwe and Zambia declared the end of the outbreak.	
AMRO/PAHO	**Haiti**	Since December 2022, and as of 17 August 2024, a cumulative of 86,791 suspected cases have been recorded, including 1303 deaths (CFR 1.5%). Suspected cases were reported from all 10 departments, with the Ouest Department continuing to report the highest number of cases (33.3% of all suspected cases recorded). From 1 January to 17 August 2024, Haiti reported a total of 9659 suspected cholera cases, including 250 confirmed cases and 242 deaths. In comparison, during the same time period in 2023 (1 January to 19 August), there were 38686 suspected cases, with 2233 confirmed cases and 444 deaths. This reflects a substantial decrease in cholera incidence in 2024, with a 75% reduction in suspected cases, an 89% decrease in confirmed cases, and a 46% reduction in deaths compared to the same period in 2023. However, the ongoing rainy season and population movements within the metropolitan area of Port-au-Prince (MAPAP) and southern areas could increase the risk of cholera spreading further, worsening the epidemic. Of note, significant epidemiological surveillance challenges likely resulted in the underreporting of cases. In this complex scenario, it will be important to consider possible biases when analysing the epidemiological situation through the available official data. 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	**Dominican Republic**	Between epidemiological weeks 1 and 35 (ending on 31 August) of 2024, the Dominican Republic reported a total of 152 suspected cholera cases, including 15 confirmed cases, with no associated deaths. In contrast, during the same period in 2023, there were 1038 suspected cases, 166 confirmed cases, and five deaths. This represents a significant reduction in 2024, with an 85% decline in suspected cases, a 91% reduction in confirmed cases, and a 100% decrease in deaths compared to the same period in 2023. Of the 15 confirmed cases in 2024, 14 were reported between epidemiological weeks 1 and 5, with the last case recorded in Epi WEEK 11. (ending 16 of March 2024).

		No confirmed cholera cases or deaths have been reported in the Dominican Republic since then. The confirmed cases were distributed across the provinces of Distrito Nacional (5 cases), Santiago (3 cases), Baoruco (2 cases), Monte Cristi (2 cases), Santo Domingo (2 cases), and one case from an imported source.
AMRO/PAHO	Haiti and the Dominican Republic saw a significant reduction in 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. In this complex context, it is crucial to account for potential biases when analysing the epidemiological situation using official data. Furthermore, the risk of additional cholera exportation from Haiti to other countries in the Region of the Americas cannot be ruled out.	
EMRO	**Afghanistan**	Since the beginning of 2024 and as of 24 August, a cumulative of 120 278 suspected AWD cases and 57 associated deaths (CFR 0.1%) were reported. Of these, 66 854 (55.6 %) were children under five years old and 59 427 (49.4%) were female. The highest cumulative incidence of AWD per 10,000 has been reported from Nimroz (91.2), Paktya (90.9), Logar (70.4), and Kabul (59.2) provinces. In epidemiological week 34 (ending 24 August), 6 048 new suspected cases and one new death were reported. A total of 248 districts reported cases (no new district reported AWD in epidemiological week 34). Since the beginning of 2024, 4,260 Rapid Diagnostic Tests (RDTs) have been conducted on AWD with dehydration cases, of which 545 tests were positive (positivity rate 12.8%). The continuous increase in cases since week 16 could partly be due to the start of the summer season and the floods in various provinces. The continued ban on female aid workers impacts response.
EMRO	**Pakistan**	According to the National Institute of Health data, from the beginning of 2024 up until 18 August, a cumulative of 49 619 suspected AWD/cholera cases and no deaths were reported from six provinces. Punjab is the most affected region. In epidemiological week 33 (ending 17 August), 2 388 suspected AWD / Cholera Cases were reported in Punjab (1 572 cases), followed by Balochistan (275 cases), Gilgit-Baltistan (207 cases), Khyber Pakhtunkhwa (187 cases), Azad Jammu and Kashmir (97 cases), and Sindh (50 cases). A major increase in weekly cases has been observed since the first week of May 2024, with more than 2 000 cases reported per week, compared to less than 500 cases per week reported in the previous months. A plateau is observed from May to August 2024.
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. Since the beginning of 2024 and as of 25 August, 18 440 cumulative suspected cholera cases and 138 cumulative deaths (CFR 0.7%) have been reported from 28 districts in seven states. The most affected states have been Jubaland, Southwest State, Hirshabelle, and Banadir. Children under 5 years old represent 59% of the cases. There has been a continuous decrease in reported cases since May 2024. In July 2024, Somalia reported 1490 new cholera cases and five associated deaths with a CFR of 0.3%, marking a 23% decrease in cases and a 50% decrease in deaths compared with the numbers reported in the previous month.
EMRO	**Syria**	Since the beginning of 2024 and up to 28 July (latest data available) 10 420 suspected AWD / cholera cases have been reported. One case was confirmed by

		culture on 13 January, being the last confirmed case reported since then. No deaths have been reported in 2024. There has been a noticeable decline in weekly reported suspected cases beginning in epidemiological week 6, 2024. This trend corresponds with adjusting the suspected AWD /cholera case definition back to the pre-outbreak definition after four consecutive weeks without any culture-positive cases. However, on 7 August 2024, Syria reported the first culture-confirmed cholera case since early January 2024, in a 6-year-old child from Killi, Idlib Governorate, who had no travel history within Syria or abroad.
EMRO	**Yemen**	Cholera established its endemicity in Yemen after the worst reported outbreak in 2017. Since the beginning of 2024 and up to 25 August, 31 809 cumulative suspected cholera cases, including 153 deaths (CFR 0.5%), have been reported in 17 governorates. Nineteen per cent of the cases (6 175) are children under 5 years. The weekly reported number of cases in 2024 peaked in epidemiological week 28 and has decreased since. The ongoing conflict and poor WASH conditions are among the factors that contribute to the risk of cholera upsurge in Yemen.
EMRO	**Iraq**	No data for cholera case numbers has been officially reported from January to August 2024. In August 2024, media reported eight laboratory confirmed cholera cases in Sulaymaniyah province, with dozens of cases of diarrhea and vomiting recorded as well. Upon verification, on 5 September 2024, the IHR-NFP of Iraq confirmed to WHO that the eight cases were confirmed by culture in Sulaymaniyah province, with serotype O1 (Ogawa). However, the IHR highlighted that the cases were sporadic. Iraq has reported sporadic cholera cases to WHO since 2016, with peaks from August to September, except in 2022, when an outbreak was reported starting in June. In 2023, WHO supported Iraq MoH in WASH, RCCE, capacity building, surveillance, laboratory capacity, and logistic supplies. On 25 and 26 September 2023, a series of capacity-building workshops to address detection, verification, and response to common outbreaks in Iraq (including cholera) were held with 89 medical doctors, and surveillance focal points in Sulaymaniyah.
EMRO	**Sudan**	The Cholera outbreak was officially declared under Article 6 of IHR by the Sudan National IHR Focal point on 12 August 2024. Eight States and 46 localities were affected across Sudan as of 14 September. Cumulatively between 22 July 2024 through 14 September 2024, a total of 8,457 cases with 299 deaths (CFR 3.5%) have been recorded. Stable national level trend (2% decrease in week 37 compared to week 36 in 2024). The cases are reported from Kassala State 3864 followed by Gedarif 2064; River Nile 1966; Red Sea 220, Nothern 116, Sennar 112, Aj Jazira 65 and Khartoum 50. Five culture positive cases out of 19 tests from Kassala State (26% culture positivity).
EMRO	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 emigration of trained staff. Population movement exacerbated by climate change, droughts, and flooding increases the risk. However, in most countries, the number of reported cases has been decreasing. At the same time, the ongoing outbreak in Sudan is of concern and demonstrates an increasing trend.	
EURO	**Mayotte**	An outbreak linked to the outbreak in Comoros was identified on 19 March 2024. Since 19 March 2024, and as of 22 August 2024, the country has reported 221 cases and 2 deaths (CFR: 0.9%). Of 221 cases, 214 cases were confirmed by PCR.

		Significant improvement in the epidemiological situation was reported. No new cases have been reported since 12 July.
EURO	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 refugee 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 cases of cholera have yet been reported in the European region, 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.	
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. In Cox Bazar, a total of 205 cholera cases have been detected since the upsurge began on 23 June 2024, with 17 RDT-positive AWD cases and 188 culture-confirmed cholera cases. Currently, 91% (171 of 188) of culture-confirmed cholera cases are from Rohingya Refugee Camps, while the remaining 17 cases are among the host population (Ukhia 10 cases, Teknaf 4 cases, Ramu 2 cases and Bandarban 1 case). Confirmed cases among refugees are spread across 24 camps in Ukhiya and Teknaf, with a recent expansion in Camp 17. No confirmed cholera deaths have been reported since the upsurge began. Discussions are ongoing for the OCV campaign in camps. Bangladesh is also facing flooding following rains in different districts with an increase in AWD cases, at least as detected through media sources.
SEARO	**India**	Cholera is endemic in India and outbreaks are reported time after time across many states throughout the year, while most outbreaks are managed swiftly. From 1 January to 7 July 2024, public reports from the Integrated Disease Surveillance Program (IDSP) include a total of 5 929 suspected cases, 241 confirmed cases and 33 deaths (CFR 0.6%) from 13 states: Andhra Pradesh, Arunachal Pradesh, Assam, Chhattisgarh, Gujarat, Haryana, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Pondichery, Tamil Nadu and West Bengal.
SEARO	**Myanmar**	On 7 July 2024, the de facto Ministry of Health announced in a press release that an AWD outbreak had begun in the Yangon region in early June. As of 25 August 2024 in Yangon, 3 421 AWD cases were reported. The most affected townships are Thaketa, Hlaingtharyar, Botahtaung, Dawbon and Thingangyun. Current challenges include healthcare providers and supplies, limited information and movement, difficulties in sample collection in conflict zones, and limited OCV access. In Rakhine, AWD cases have increased in Sittwe and Rakhine, with a resurgence since mid-June. Between 19 June and 18 September, a total of 2 439 AWD cases are reported. Severe dehydration cases have been reported since 22 July. Cholera infection is confirmed in some of these AWD cases.

		Intensifying armed clashes across the country have severely restricted access to information, especially in conflict-affected areas, creating significant challenges in verifying outbreaks and assessing risk. Additionally, crucial cholera control measures like WASH interventions and Oral Cholera Vaccination face significant implementation challenges, particularly in conflict zones. Pre-existing conditions such as high displacement, overcrowded settings, flooding, poor hygiene practices, and unsafe food and water further increase the risk of cholera transmission. Recent and ongoing heavy rains caused by the monsoon season and remnants of Typhoon Yagi have led to severe flooding in multiple states and regions across Myanmar. Floodwaters have damaged water sources and sanitation facilities, reducing access to clean water and proper sanitation which increases the risk of flood-affected people expose to cholera and onward transmission.
SEARO	**Nepal**	According to an official situation report from the Nepal MoH, from 19 July to 13 September 2024, 81 culture-confirmed cases were reported across 6 districts: Lalitpur (53 cases), Kathmandu (12 cases), Kailali (8 cases), Pyuthan (2 cases), Makawanpur (1 case), Rolpa (4 cases), and Sidhupalchowk (1 case). No epidemiological link has been established between the districts. No deaths have been reported so far. Active circulation of *Vibrio cholerae* O1 Ogawa has been confirmed through culture tests.
SEARO	**Thailand**	From 1 January to 2 August 2024, 5 cholera cases have been reported from six provinces. The last case was reported on 2 August. The infection rate is 0.01 per 100 000 population. No deaths have been reported to date.
SEARO	From 1 January to 18 September, over 12 080 cholera and AWD cases were reported across five countries in the South-East Asia Region. During this period, cases were reported from India (5 929 cases), Myanmar (5 860 cases), Bangladesh (205 cases), Nepal (81 cases), and Thailand (5 cases). During the same period, a total of 33 deaths were reported from India (33 deaths). There are limited surveillance systems (often sentinel-based), low reporting or limited transparency. Ongoing transmission with continued risk of export to other regions.	
WPRO	From 1 January 2024 to 30 June, the Western Pacific Region reported 1 217 new cholera cases and nine deaths. Cholera is endemic in parts of the Philippines. However, no major outbreak has been reported in 2024. In July 2024, WHO, UNICEF and the Philippines Department of Health conducted a joint risk assessment in one region that reports the highest number of cholera cases in annual reporting and established overall good control capacity.	

Context assessment

Increasing humanitarian crises due to conflict, the effects of climate change (drought and flooding), political instability and a lack of development are leaving an increasing number of people at risk for cholera across all WHO regions. Many countries reporting active outbreaks are experiencing conflict or political violence in affected areas (DRC, Haiti, Nigeria, Somalia, and Syria). In Cameroon and Ethiopia, the current outbreaks are not affecting conflict areas, but there is a high risk of spreading into these areas. Other countries are experiencing the effects of climate change with widespread floods or drought (DRC, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Somalia). These factors, along with others, including financial crises, mass migration of IDPs and refugees, and a long-term lack of development, have left large populations across all continents without access to clean water, sanitation, and healthcare and thus at risk for cholera.

Many outbreaks, coupled with major political crises requiring significant health response (Afghanistan, Horn of Africa, Ukraine), put a strain on the global medical kit supply in 2022, including for cholera, from which, in 2024, the systems have still yet to recover. The increasing number of outbreaks is compounding this effect.

The global stockpile of Oral Cholera Vaccine (OCV) continues to be insufficient 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) members (IFRC, MSF, UNICEF, WHO) to limit all reactive OCV campaigns to one single dose remains active in 2024 and for the foreseeable future. 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 much lower in children. In the current outbreak context, only one-dose courses have been validated and implemented in these reactive campaigns. Doses for preventive campaigns cannot be supplied due to the low global stockpile.

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 on a bi-weekly basis.
- Collaboration with key partners (UNICEF, MSF) to coordinate supply and optimal access to supplies
- OSL coordination with EPI teams, regional hubs and other operational partners.
- Provision of technical support to all ongoing outbreaks (laboratory, case management, OCV, WASH and IPC)
- Support deployment through GAVI, GOARN, and Standby Partners
- Advocacy to increase OCV production

Reference documents used for risk assessment

- Cholera Situation Reports
- 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