World Health Organization
Regional Office for the Eastern Mediterranean

Weekly Epidemiological Monitor

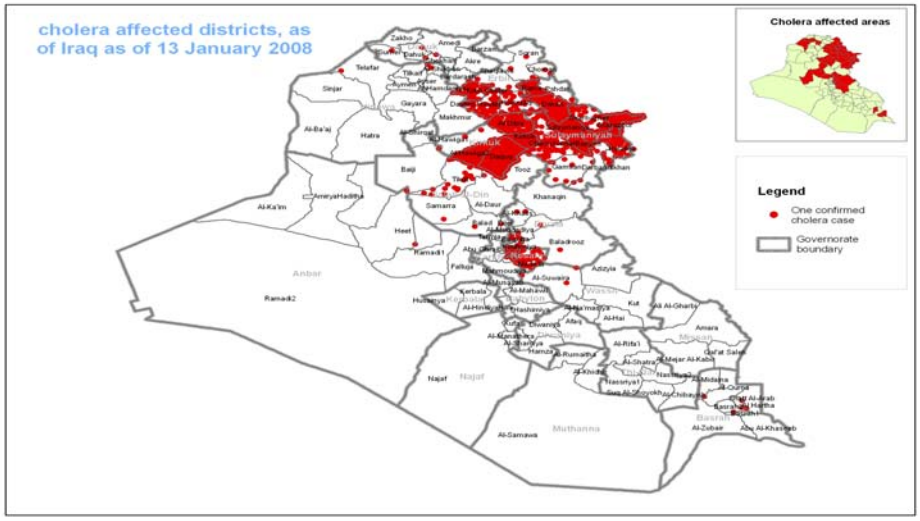
Volume 1, Issue 4, Sunday 27 January 2008

Current major events

Cholera in Iraq
(August 2007 - January 2008)

During the period between 14th of September, 2007 and 13th of January, 2008 a total of 4,697 laboratory-confirmed cases of cholera were reported from 46 districts in eleven provinces of Iraq (Kirkuk, Sulaimaniyah, Erbil, Dahuk, Tikrit, Ninewa, Baghdad, Basra, Wasit, Anbarand Diyala). Twenty-four of these cases were fatal (CFR = 0.51%.). *V. Cholerae* biotype Inaba was isolated in 99% of all samples tested.

The outbreak was first reported from Kirkuk, Sulaimaniyah and Erbil provinces in the Northern part of the Country. The three provinces account for 98% (4,520) of the total reported cases of cholera in the Country. However, in the last few weeks the number of cases has been slowly coming down in these three provinces. In the last six weeks, most of the cases were reported from the capital city, Baghdad. Contaminated water was identified as the commonest vehicle of transmission of this outbreak.



In response to the outbreak, Ministry of Health, Iraq, with the support of WHO Country and Regional offices and in collaboration with other partners have put in place control measures to contain the spread of the outbreak.

Spread of cholera outbreaks could be controlled using simple interventions that emphasize health education to the general pubic on personal hygiene and other risk factors for transmission of the disease, as well as rapid information sharing and better coordination between all partners.

Editorial note

Cholera reemerged in Iraq after nearly a decade affecting almost two thirds of the provinces, including to the capital city of Baghdad. The wide and rapid spread of the outbreak could partially be attributed to the weak health systems as reflected in late detection of cases and delayed response to the outbreak. Moreover, it has been difficult to reach the affected areas because of security concerns. Lack of safe water supply and poor environmental sanitation in war ravaged areas of the country are formidable challenges.

Presently, there are a number of countries in the Eastern Mediterranean Region that are at state of complex emergency. During natural and man-made disasters, public health emergencies are likely to occur. This necessitates development of preparedness plans for epidemic-prone diseases and disease early warning systems to cope with such events.

Travel, trade and cholera

Today, no country requires proof of cholera vaccination as a condition for entry. Past experience clearly showed that quarantine measures and embargoes on movements of people and goods - especially food products - are unnecessary. At present, WHO has no information that food commercially imported from affected countries has been implicated in outbreaks of cholera in importing countries. Isolated cases of cholera that have been related to imported food were associated with food in the possession of individual travellers.

Update on outbreaks
in the Eastern Mediterranean Region

Diminishing Rift Valley Fever in Sudan, and cholera in Iraq (see below)

Current public health emergencies of international concern
[cumulative N° of cases/deaths, **CFR %**]

Avian influenza	
Egypt	[43/19, **44.2%**]
Indonesia	[120/98, **81.7%**]
Viet Nam	[102/48, **47.1%**]
Cholera	
D.R. Congo	[200/11, **5.5%**]
Nigeria	[36/12, **33.3%**]*
Laos	[365/3, **0.8%**]
Iraq	[4,697/ 24, **0.5%**]
Ebola	
Uganda	[149/37, **24.8%**]
Meningitis	
Uganda	[111/19, **17.1%**]
Rift Valley Hemorrhagic Fever	
Sudan	[698/222, **31.8%**]
Yellow Fever	
Brazil	[18/9, **50%**]
Poliomyelitis	
Nepal	[1/0, **0%**]

(=Unofficial figures)*
CFR=Case-Fatality Rate