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Current major event

Cholera cases imported to the United Arab Emirates

On 25 March 2021 the United Arab Emirates (UAE) IHR national focal point reported to WHO 8 suspected cholera cases who arrived in UAE from Bangladesh. Three of the cases were subsequently confirmed by stool culture and sensitivity to carry *Vibrio cholerae* (sero group unknown). The cases arrived on different days and on different airlines and developed symptoms within 24-48 hours of arrival. The onset of symptoms ranged from 7 to 25 March.

Editorial note

Cholera is an acute infection caused by the ingestion of water or food contaminated with the bacterium *Vibrio cholerae*. Cholera is closely linked to inadequate access to clean water and sanitation facilities. Most people infected with *V. cholerae* do not develop symptoms, or have mild diarrhoea, however severe cases develop profuse watery diarrhoea. Cholera is easily preventable and treatable, with the majority of patients successfully managed through the prompt administration of oral rehydration solution.

The Global Task Force on Cholera Control defines a cholera outbreak as the occurrence of at least one confirmed case of cholera and evidence of local transmission. People who have been exposed to *V. cholerae* and developed symptoms have boarded commercial flights or other modes of transportation in the past without informing authorities of their status.

While reported cases of cholera in travellers are rare, it is important for clinicians in countries where cholera is not endemic to suspect this diagnosis in travellers having acute watery diarrhoea due to the risk posed by severe disease. Early testing, confirmation and initiation of treatment is essential, including through rehydration and empiric antibiotics for patients with moderate to severe symptoms of watery diarrhoea. Early detection also allows comprehensive public health measures to be applied in time to prevent local transmission.

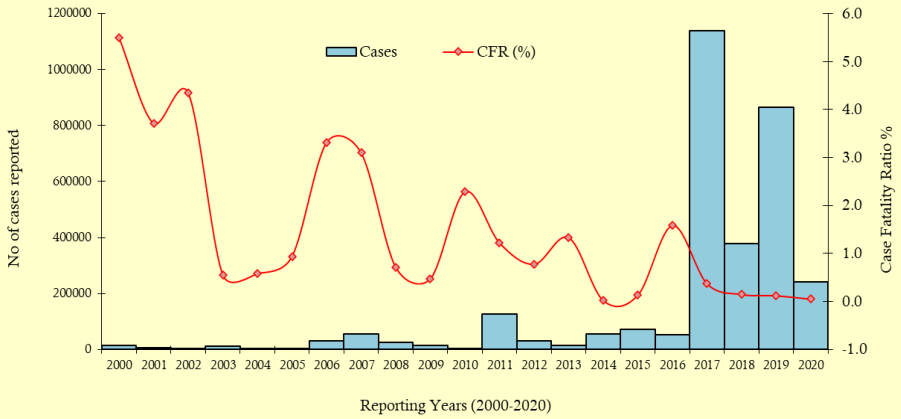
WHO advises against the application of routine screening for cholera at points of entry, or any other restrictions on movements, such as quarantine of travellers coming from areas experiencing an outbreak of cholera as these measures have not proven to be effective in the control of the disease. Chemoprophylaxis for travellers going to or coming from cholera-affected areas has also not demonstrated to have any effect on the spread of cholera, but can have adverse effects by increasing antimicrobial resistance, and provides a false sense of security. Therefore, WHO does not advise requiring prophylactic administration of antibiotics or proof of such administration for travellers coming from or going to a country affected by cholera.

Case management by rehydration remains the primary therapy in the treatment of cholera. Antibiotic use should remain selective and should target those patients who are likely to benefit clinically the most. Antibiotics should be given to suspected cholera patients who require hospitalization for severe dehydration, those who have high purging or those who have treatment failure following the initial 4 hours of rehydration therapy. The antibiotic options for cholera are the tetracyclines, fluoroquinolones and macrolides. The rationale for choosing an antibiotic should be based on efficacy, safety, feasibility, availability, cost and local resistance patterns.

Cholera surveillance is passive in non-endemic settings, but this should turn to active case-finding during suspected outbreaks to allow for the detection and quantification of local transmission; the identification of cholera patients at an early stage of the disease; and for advice to be given to family members and the community about protecting themselves from contamination.

While cholera can be imported from areas where it is endemic or epidemic to cholera-free countries, it is widely recognized that there may be widespread under-reporting and under-diagnosis of cholera due to economic, social and political disincentives, as well as inadequate public health surveillance. Any health measure on arrival or departure, or relating to entry of travellers, should be applied in compliance with the provisions of the International Health Regulations (2005).

Cholera cases reported by member states during 2000– 2020



Update on outbreaks

in the Eastern Mediterranean Region

COVID-19 in 22 EMR countries

Current public health events of concern

[cumulative N° of cases (deaths), **CFR %**]

Coronavirus disease 2019 (COVID-19): 2019-2021	
Afghanistan	[56 322 (2472), 4.4%]
Bahrain	[140 818 (513), 0.4%]
Djibouti	[7249 (66), 0.9%]
Egypt	[199 364 (11 845), 5.9%]
Iran (Islamic Republic of)	[1 846 923 (62 308), 3.4%]
Iraq	[827 157 (14 177), 1.7%]
Jordan	[582 133 (6472), 1.1%]
Kuwait	[227 178 (1279), 0.6%]
Lebanon	[458 338 (6058), 1.3%]
Libya	[156 849 (2618), 1.7%]
Morocco	[494 358 (8798), 1.8%]
occupied Palestinian territory (oPt)	[263 220 (2810), 1.1%]
Oman	[153 838 (1650), 1.1%]
Pakistan	[654 591 (14 215), 2.2%]
Qatar	[177 135 (284), 0.2%]
Saudi Arabia	[387 794 (6643), 1.7%]
Somalia	[10 838 (488), 4.5%]
Sudan	[31 712 (2060), 6.5%]
Syrian Arab Republic	[18 356 (1227), 6.7%]
Tunisia	[250 565 (8735), 3.5%]
United Arab Emirates	[453 069 (1477), 0.3%]
Yemen	[3973 (833), 21%]