WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health & Mass Media

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WEER SRI LANKA 2025

Vol. 52 No. 28 05th June – 11th July 2025

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

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

History and strains

Cholera has been documented for centuries. The first pandemic was recorded in the 19th century, and since then, six pandemics have killed millions worldwide. The current **seventh pandemic** began in South Asia in 1961 and continues today, affecting populations globally.

Of the many strains of *Vibrio cholerae*, only two serogroups, **O1 and O139,** cause outbreaks. Recent outbreaks are almost exclusively due to **V. cholerae O1**. While O139 caused outbreaks in Asia in the past, it now appears only sporadically. Importantly, the illness caused by both serogroups is clinically indistinguishable.

Risk factors and disease burden

Cholera outbreaks occur regularly in some countries, while in others they appear sporadically after years of low transmission. Risk is highest in settings with **limited access to safe water, sanitation facilities, and hygiene practices,** conditions often linked to poverty, conflict, displacement, and climate events such as cyclones, floods, or droughts.

WHO data show that cholera reports have increased in recent years. In 2023, 535,321 cases and 4,007 deaths were officially reported to the WHO from 45 countries. However, researchers estimate the true burden is far higher, given gaps in surveillance and under-reporting.

Prevention and control

Cholera control requires a **multisectoral approach**. Preventing and controlling outbreaks depends on:

- **Strengthened surveillance** to rapidly detect and monitor outbreaks
- **Improved WASH services**, including safe drinking water, sanitation, and hygiene
- **Risk communication and community engagement** to promote protective practices and early care-seeking
- **Timely access to effective treatment**, including ORS, intravenous fluids, and antibiotics for severe cases
- **Oral cholera vaccine campaigns** to protect at-risk communities

Sustained investment in WASH infrastructure and universal access to safe water remain the long-term solution.

Surveillance

Effective surveillance is central to cholera control. WHO recommends integrating cholera into national **disease surveillance systems** to enable rapid detection, timely response, and data sharing from local to global levels. Rapid diagnostic tests (RDTs) can provide early warning of probable outbreaks, but confirmation still requires laboratory testing such as culture, seroagglutination, or PCR. Countries are encouraged to follow the **Global Task Force on Cholera Control (GTFCC)** recommendations to strengthen both epidemiological and laboratory capacity.

Treatment

Cholera is an **easily treatable disease** if patients receive prompt care. The mainstay of treatment is ORS, which can successfully manage most cases. Patients with severe dehydration require rapid administration of intravenous fluids, ORS, and antibiotics. With timely care, the CFR in treatment centres should remain below 1%.

Community-level access to ORS is vital during outbreaks, particularly in remote or conflict-affected areas. WHO does not recommend mass antibiotic prophylaxis, as it is ineffective in preventing spread and risks promoting antimicrobial resistance.

Prevention:

Before travelling, check whether cholera is common or if outbreaks are ongoing in the destination. If cholera is present, key preventive measures include:

- Washing hands frequently with soap and safe water. Drinking only treated or bottled water.
- Eating food that is thoroughly cooked and served hot. Getting vaccinated against cholera is recommended.

Community engagement

Community engagement is essential for effective outbreak control. Communities need to be informed about **risks, symptoms, prevention practices, and where to seek care**. Local beliefs and practices must be respected, while promoting behaviours such as hand washing with soap, safe food preparation, clean water storage, and safe disposal of faeces.

Funeral practices may need adaptation to prevent transmission from the bodies of cholera victims. Communities should also be involved in decisions about the placement of oral rehydration points and cholera treatment centres to improve accessibility and trust.

Oral cholera vaccines (OCV)

Oral cholera vaccine (OCV) remains a critical tool for controlling outbreaks when combined with improvements in water, sanitation, and hygiene. Reactive OCV campaigns can protect affected communities, reduce transmission, and lessen the overall impact of outbreaks, especially when implemented promptly. Currently, single-dose strategies are being used in outbreak settings. However, preventive vaccination campaigns have been suspended since late 2022, and ongoing global shortages are now limiting even reactive vaccination efforts.

Infection Prevention and Control (IPC) / WASH

WHO emphasises strengthening WASH and IPC in health facilities and communities. Key measures include:

- Ensuring safe water supply and adequate sanitation in health facilities
- Implementing infection prevention protocols in cholera treatment centres
- Monitoring water quality and distributing WASH kits in communities
- Promoting protective hygiene practices such as handwashing and safe food handling

Such interventions are crucial both during outbreaks and as long-term strategies for cholera prevention and broader health improvement.

Situation in Sri Lanka

Although cholera has not been reported in Sri Lanka since 2003, it remains a **notifiable disease** with ongoing surveillance. The country's geographic proximity to endemic regions and rising outbreaks in South and South-East Asia places it at continued risk of importation. Past experiences with cholera highlight the importance of maintaining preparedness, including surveillance at points of entry, laboratory capacity, WASH improvements, and readiness for rapid outbreak response.

Cholera remains both a **disease of inequity** and a persistent public health threat. While it is preventable and treatable, outbreaks continue to occur where safe water, sanitation, and health services are inadequate. Current surges in Africa and parts of Asia highlight the devastating impact of fragile health systems, displacement, and climate shocks.

Ending cholera requires sustained investments in WASH, stronger surveillance, timely case management, expanded OCV access, and meaningful community engagement. Global coordination efforts such as the Africa CDC–WHO Preparedness and Response Plan are encouraging, but the escalating burden underscores the need for urgent and collective action. With proven tools and strategies, eliminating cholera as a public health threat by 2030 remains an achievable but challenging goal.

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3. World Health Organization. (2024, December 5). Cholera. Who.int; World Health Organization: WHO. https://www.who.int/news-room/fact-sheets/detail/cholera
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Table 1: Selected notifiable diseases reported by Medical Officers of Health 28th–04th July 2025 (27th Week)

RDHS	Dengue Fever		Dysentery		Encephalitis		En. Fever		F. Poisoning		Leptospirosis		Typhus F.		Viral Hep.		H. Rabiies		Chickenpox		Meningitis		Leishmania-		Tuberculosis		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	285	7089	0	18	0	4	1	7	0	5	8	270	0	5	0	12	0	0	11	302	3	38	1	3	40	1053	100	100
Gampaha	181	4545	0	26	0	24	0	1	7	121	8	461	0	8	1	11	0	0	19	500	2	90	0	23	18	599	100	100
Kalutara	57	1423	0	28	0	6	1	11	0	41	11	392	1	2	0	4	0	0	19	522	3	27	0	1	19	332	65	100
Kandy	174	2309	0	37	0	3	0	5	0	19	6	171	2	36	0	7	0	0	24	287	0	15	0	38	7	368	96	100
Matale	14	789	0	15	0	1	0	0	0	50	6	148	0	4	1	7	0	0	3	74	1	7	11	162	2	84	100	100
Nuwara Eliya	8	166	4	48	1	5	0	4	1	47	3	71	3	40	0	0	0	0	8	154	0	18	0	0	7	153	100	100
Galle	47	1198	1	26	0	3	1	2	0	41	21	491	3	51	0	8	0	1	13	442	2	100	0	3	12	263	95	100
Hambantota	24	512	0	16	0	4	0	0	0	4	8	250	0	20	0	4	0	0	4	195	1	14	4	165	4	82	100	100
Matara	39	988	1	10	0	2	0	1	0	7	10	297	0	12	1	10	0	0	4	235	0	25	3	60	3	89	88	100
Jaffna	17	778	4	55	0	2	0	11	2	34	2	123	9	375	0	2	1	2	1	235	0	16	0	0	7	120	93	93
Kilinochchi	2	66	1	11	0	0	0	4	0	5	1	60	0	11	0	1	0	0	0	4	0	0	0	1	0	31	100	100
Mannar	2	114	0	5	0	0	0	0	0	2	0	20	0	14	0	0	0	0	0	17	0	12	0	1	1	26	100	100
Vavuniya	3	59	0	9	0	0	0	1	0	36	1	62	0	7	0	0	0	0	1	32	1	15	0	14	2	30	100	100
Mullaitivu	2	48	0	5	0	0	0	1	0	23	1	51	0	7	0	0	0	0	0	20	0	5	0	2	0	18	100	100
Batticaloa	20	1464	1	91	0	12	0	0	24	145	3	76	1	2	0	17	0	0	6	129	0	24	0	1	3	82	86	100
Ampara	11	159	2	30	1	10	0	0	0	11	2	136	0	2	2	5	0	1	6	111	2	28	0	16	0	33	100	100
Trincomalee	8	847	1	31	0	2	0	1	1	29	2	105	0	9	0	5	0	0	2	80	0	10	0	4	0	68	100	100
Kurunegala	51	962	1	31	0	12	0	1	0	25	7	475	1	23	0	6	0	1	30	463	4	98	18	325	7	184	97	100
Puttalam	12	418	2	22	0	3	0	0	0	5	4	190	1	31	0	1	0	1	1	98	3	59	0	20	11	112	100	100
Anuradhapura	8	385	1	25	0	6	0	3	0	17	6	286	1	17	1	11	0	0	6	198	0	44	23	428	13	159	78	100
Polonnaruwa	14	213	0	12	0	4	0	1	0	8	3	196	0	1	1	18	0	0	5	110	1	12	12	229	1	46	88	90
Badulla	17	477	1	22	0	8	0	3	0	2	4	191	1	18	2	33	0	0	4	250	1	45	1	29	2	161	94	100
Monaragala	12	549	0	13	0	3	0	0	0	4	4	393	0	23	0	18	0	0	1	89	0	34	6	117	7	74	82	100
Ratnapura	104	3159	1	79	0	6	0	3	0	37	15	918	0	19	1	9	0	1	8	259	2	71	8	121	6	225	95	100
Kegalle	39	921	1	44	0	11	0	9	1	32	23	461	0	8	0	11	0	0	21	516	3	71	1	20	6	161	100	100
Kalmunai	11	280	0	21	0	4	0	0	0	18	1	74	0	1	0	2	0	1	0	95	0	29	0	0	1	73	100	100
SRILANKA	**1162**	**29918**	**22**	**730**	**2**	**135**	**3**	**69**	**36**	**768**	**160**	**6368**	**23**	**746**	**10**	**202**	**1**	**8**	**197**	**5417**	**29**	**907**	**88**	**1783**	**179**	**4626**	**95**	**99**

Source: Weekly Returns of Communicable Diseases (esurvillance.epid.gov.lk). **T=**Timeliness refers to returns received on or before 27th June, 2025 Total number of reporting units 361 Number of reporting units data provided for the current week: 360 **C****-Completeness

A = Cases reported during the current week. B = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP

28th – 04th July 2025 (27th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2025	Number of cases during same week in 2024	Total number of cases to date in 2025	Total number of cases to date in 2024	Difference between the number of cases to date in 2025 & 2024
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	0	00	00	00	00	00	31	39	-20.5%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps	00	00	01	00	00	02	01	00	00	04	04	130	154	-15.5 %
Measles	00	00	00	00	00	00	00	00	00	00	04	01	220	-99.5%
Rubella	00	01	00	00	00	00	00	00	00	01	00	04	02	-100%
CRS**	00	00	00	00	00	00	00	00	00	00	00	01	00	0 %
Tetanus	00	00	00	00	00	00	00	00	00	00	00	04	04	0 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Enceph-alitis	00	00	00	00	00	00	00	00	00	00	00	04	01	300 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	04	13	29	-55.1 %

Key to Table 1 & 2

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

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

Data Sources:

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

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

CRS =**Congenital Rubella Syndrome

NA = Not Available

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

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

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

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