Vibrio cholerae O1 serotype Ogawa Webinar

# Overview of Vibrio cholerae outbreaks in the African Region and implications for South Africa

*Coordinated Action for Effective Cholera Prevention and Response*

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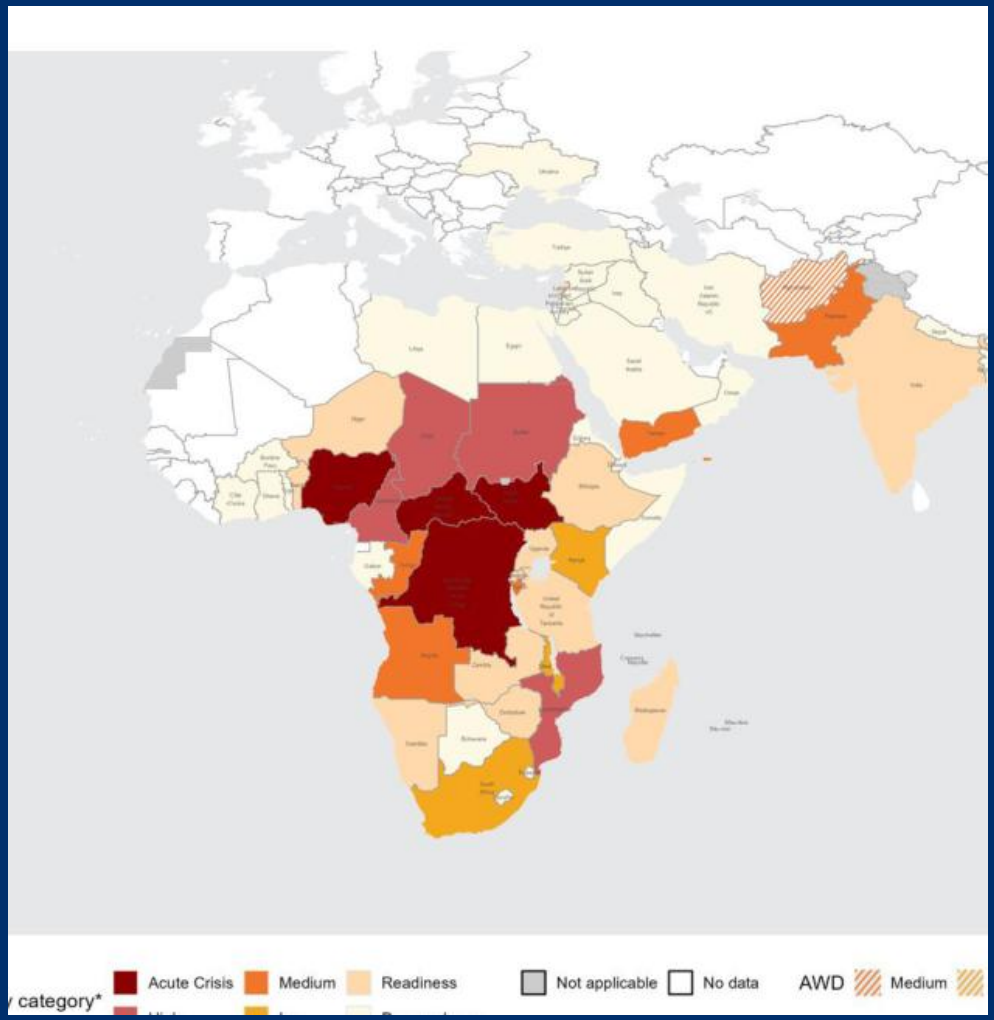
WHO Country Office, Pretoria
06 August 2026 | 13h10–13h30




Data through 26 July 2026; subject to verification and reporting delays.

# What this update will cover

## Three linked questions for the next 20 minutes

1 **What is happening in the African Region?**

Current burden, hotspots, transmission drivers and mortality signals.

2 **What is the South Africa signal?**

Two confirmed Gauteng cases linked to recent travel to Kruger National Park; investigations are ongoing.

3 **What should readiness focus on now?**

A practical readiness agenda: surveillance, laboratory, WASH, case management, RCCE, coordination and escalation triggers.

**Core message**

**Regional transmission remains active and concentrated in a few countries. South Africa's immediate risk is less about the two recovered cases and more about whether an exposure source remains active or secondary transmission is missed.**

**Presentation outcome**

Agree on a precautionary, time-bound, multisectoral readiness posture for Gauteng, Limpopo, Mpumalanga and high-risk travel-linked settings.

Webinar objectives addressed: community/event-based surveillance, multisectoral coordination, evidence-based interventions and RCCE.

Source: Webinar programme, 06 Aug 2026; WHO/GTFCC guidance framing.

# Active transmission remains concentrated, with measurable mortality risk

**118,912**

**Cholera/AWD cases in 2026**

Across 19 of 47 AFRO countries

**1,793**

**Deaths reported in 2026**

CFR calculations affected by reporting methods

**28,829**

**Cases in last 28 days**

Relatively stable vs previous 28 days

**95%**

**Recent regional cases**

Nigeria, DRC and South Sudan

**Mortality signal**

Regional CFR over the last 28 days: 0.9%; five countries exceeded the 1% emergency threshold.

**Summary of Outbreak Indicators in 2026: African Region**

Last 28 days

| Country | Total Cases (in 2026) | Total Deaths (in 2026) | Cases (Last 28d) | Deaths (Last 28d) | Weekly Cases (in 2026) | CFR (28d, %) | Monthly Cases Change (%) | Monthly Cha |
|---|---|---|---|---|---|---|---|---|
| Nigeria | 50 290 | 338 | 23 442 | 157 | | 0.7 | 17.9 | |
| Democratic Republic Of The Congo | 34 156 | 971 | 2 007 | 66 | | 3.3 | -44.0 | |
| South Sudan | 12 411 | 119 | 1 885 | 8 | | 0.4 | -31.2 | |
| Mozambique | 7 979 | 70 | 409 | 4 | | 1.0 | 484.3 | |
| Angola | 5 422 | 118 | 96 | 2 | | 2.1 | -79.7 | |
| Malawi | 3 213 | 30 | 3 | 0 | | 0.0 | -97.5 | |
| Burundi | 1 588 | 4 | 91 | 0 | | 0.0 | -72.8 | |
| Zambia | 999 | 17 | 0 | 0 | | 0.0 | 0.0 | |
| Congo | 849 | 49 | 4 | 0 | | 0.0 | -97.9 | |
| Central African Republic | 697 | 45 | 311 | 14 | | 4.5 | -14.3 | |
| Cameroon | 588 | 19 | 480 | 13 | | 2.7 | 344.4 | |
| Namibia | 213 | 0 | 0 | 0 | | 0.0 | 0.0 | |
| Chad | 208 | 7 | 99 | 4 | | 4.0 | -9.2 | |
| United Republic Of Tanzania | 113 | 2 | 0 | 0 | | 0.0 | 0.0 | |
| Rwanda | 58 | 0 | 0 | 0 | | 0.0 | 0.0 | |
| Ethiopia | 50 | 2 | 0 | 0 | | 0.0 | 0.0 | |
| Kenya | 40 | 0 | 0 | 0 | | 0.0 | -100.0 | |
| Zimbabwe | 36 | 2 | 0 | 0 | | 0.0 | 0.0 | |
| South Africa | 2 | 0 | 2 | 0 | | 0.0 | 100.0 | |
| **Total** | **118 912** | **1 793** | **28 829** | **268** | | **0.9** | **3.0** | |

Data Source: World Health Organization

Selected operational datapack table: African Region outbreak indicators as of 26 July 2026

Source: WHO Global Cholera Situation Update, 31 Jul 2026; data cut-off 26 Jul 2026. Interpret with reporting-delay caution.

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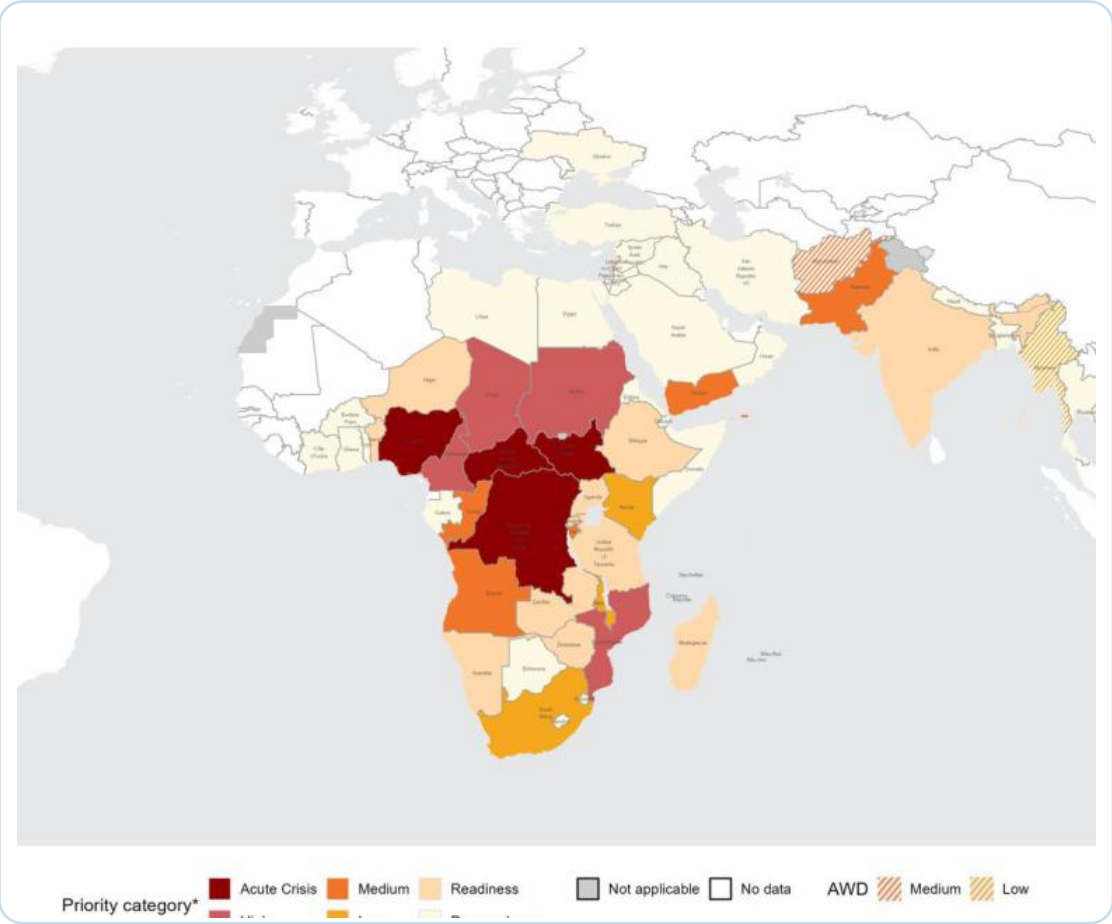
# Regional hotspots: where risk is most acute

## Week 30 risk categorization highlights four acute-crisis countries




ACUTE CRISIS

| | |
|---|---|
| **Nigeria** | 23,442 recent cases; Borno is driving the caseload; Maiduguri, Monguno and Jere are main hotspots. |
| **DRC** | 2,007 recent cases; high concern in Nord-Kivu, Sud-Kivu, Tanganyika and Sud-Ubangi. |
| **South Sudan** | 1,885 recent cases; transmission concentrated in Unity, Upper Nile and Jonglei. |
| **Central African Republic** | 311 recent cases; cross-river risk linked to Sud-Ubangi province in DRC. |

**Operational interpretation**

The risk is shaped by water/sanitation gaps, displacement, mobility, conflict access constraints and delayed access to care.

Source: WHO Global Cholera Situation Update, Week 30/2026; risk categorization as of 26 Jul 2026.

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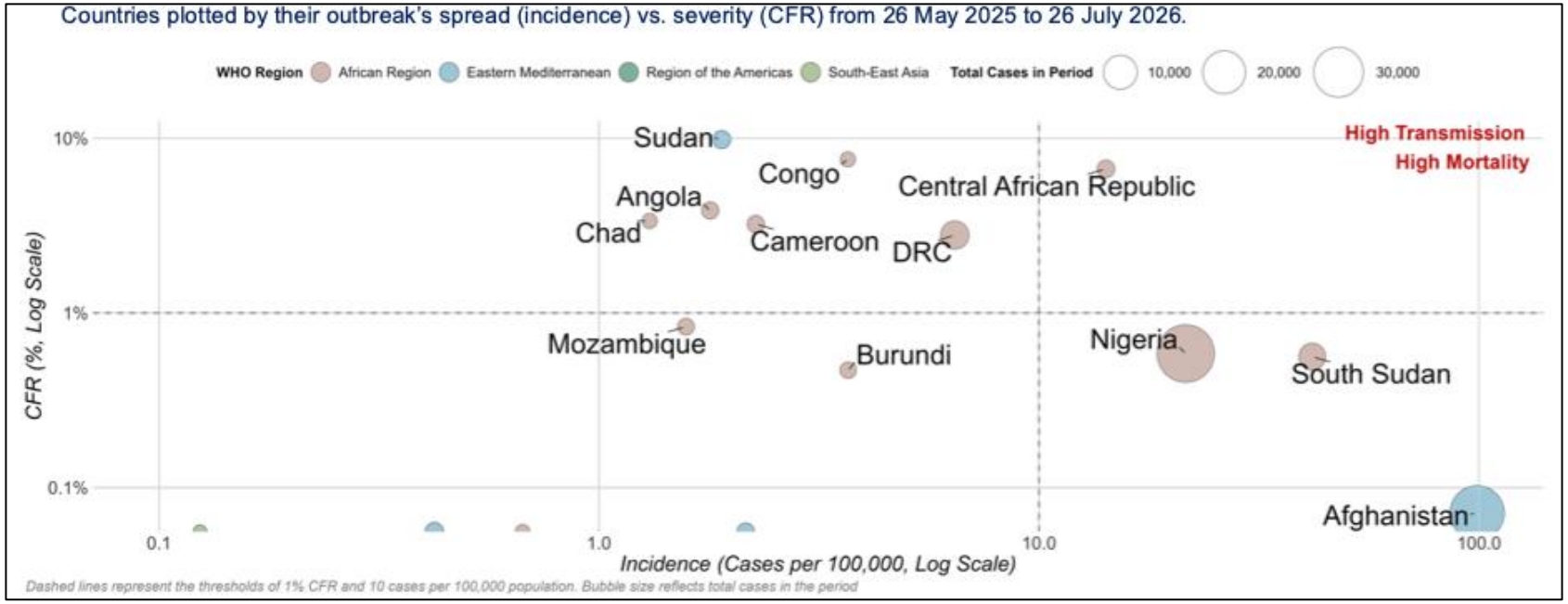
# Risk interpretation: spread and severity vary by context



## Country profiles differ: high burden, high mortality, acceleration and clustered risk signals need different actions




Outbreak profile plot: incidence vs. CFR, 26 May 2025–26 July 2026

### High transmission

Prioritize outbreak scale-up: coordination, WASH, OCV consideration, treatment access and supply surge.

### High mortality

Prioritize faster care-seeking, ORS/ORPs, CTU/CTC readiness, clinical training and community death review.

### Clustered or low-volume signals

Prioritize exhaustive case investigation, source assessment, active case finding among symptomatic exposed persons and daily review.

Source: WHO Global Cholera Situation Update, 31 Jul 2026; GTFCC CFR interpretation guidance.

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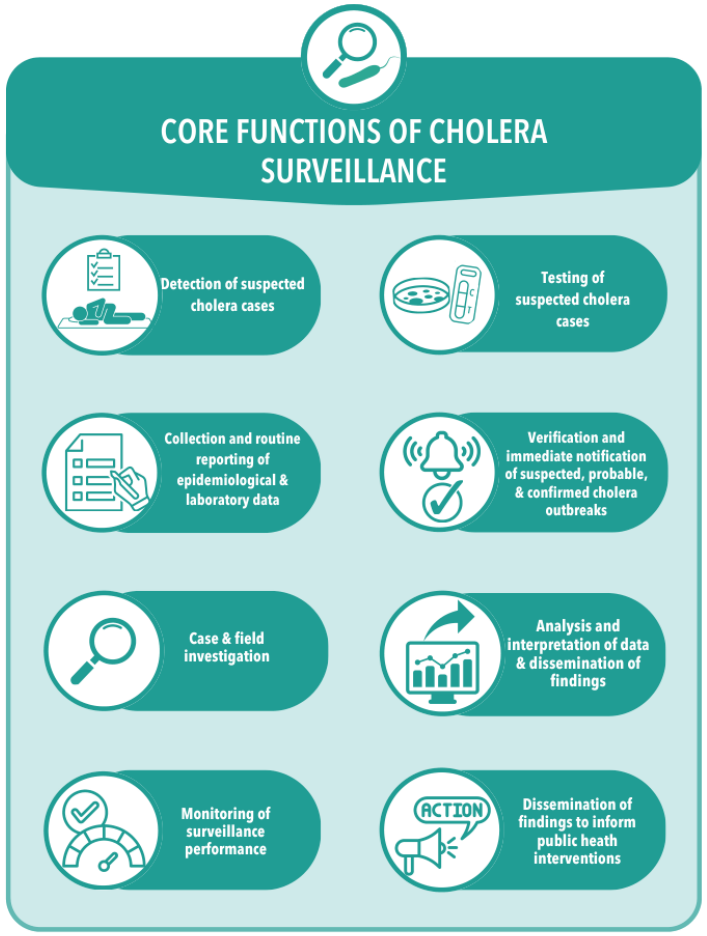
# WHO/GTFCC response posture: move faster than transmission



## The response objective is to limit mortality and interrupt spread through coordinated multisectoral action




**RESPONSE PILLARS**

### Coordination

Activate task team/IMS; daily action review; partner roles.

### Epidemiology + lab

Case-based reporting, daily signal review, testing, AST/WGS where indicated.

### Case management + IPC

ORS/IV rehydration, CTU/CTC readiness, triage by dehydration, CFR <1%.

### WASH

Safe water, FRC/E. coli testing, sanitary inspection and exposure control.

### RCCE + community

Trusted, practical messages on symptoms, safe water, hand hygiene and care-seeking.

### Logistics + OCV readiness

Preposition kits, ORS, IV fluids, chlorine/PPE; prepare OCV decision pathway.

**Practical test: Are coordination, surveillance, WASH, treatment and RCCE moving faster than new exposure or transmission?**

Sources: GTFCC Cholera Outbreak Response Field Manual, 2024; GTFCC Public Health Surveillance for Cholera, 2024.

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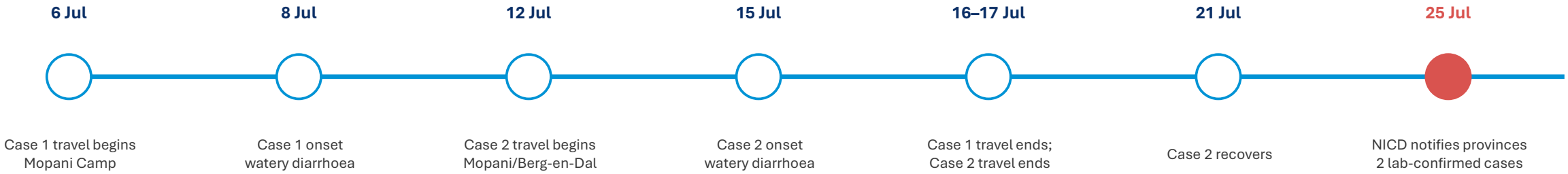
# South Africa update: two confirmed Gauteng cases



## Two laboratory-confirmed V. cholerae O1 serotype Ogawa cases in Gauteng residents with recent travel to Kruger National Park; source remains under investigation




### Case 1

41-year-old female, Krugersdorp
Onset: 8 July; recovered/resolved by 17 July
Reported borehole water exposure; spouse had similar illness but was not tested

### Case 2

38-year-old male, Pretoria
Onset: 15 July; recovered by 21 July
Consumed tap water at Mopani Camp; had contact with Case 1 before onset

**Working hypothesis: common exposure around Mopani Camp/KNP; no confirmed source yet. Investigations and environmental testing are ongoing.**

Source: Limpopo Department of Health update, 27 Jul 2026; NICD notification referenced in the update.

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# Classification and current risk interpretation

## A small cluster can still be a high-priority signal if exposure continues or transmission is missed

### GTFCC DEFINITIONS

| | |
|---|---|
| **Confirmed case** | V. cholerae O1/O139 confirmed by culture/seroagglutination or PCR; toxigenicity if warranted. |
| **Confirmed outbreak** | At least one locally acquired confirmed case in a surveillance unit. |
| **Clustered transmission** | Confirmed cases all epidemiologically linked based on case investigation. |
| **Community transmission** | Confirmed cases not all epidemiologically linked, or links not documented. |

### WORKING INTERPRETATION FOR SOUTH AFRICA

**Gauteng**

Treat as domestically imported confirmed cases unless local Gauteng acquisition or secondary transmission is detected.

**Exposure/source unit**

Manage as a high-priority clustered-transmission signal while acquisition, source and environmental results are finalized.

**Escalation triggers**

Any unlinked confirmed case; incomplete investigations; rising AWD signals; positive water-source evidence; spatial spread beyond known exposure group.

**Current status from Limpopo update: no cases among Limpopo residents, no additional diarrhoeal cases from KNP, and no evidence of ongoing community transmission in Limpopo as of 27 July.**

Sources: GTFCC Surveillance Guidance, 2024; Limpopo DoH case update, 27 Jul 2026.

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# Implications for South Africa



## The event is a readiness stress test: can the system detect, investigate and contain before spread?

**Core decision question**

**Is there an ongoing source of exposure or any evidence of secondary/community transmission?**

### Water-source hypothesis

Do not wait for final attribution before implementing safe-water controls where epidemiology suggests plausible exposure.

### Travel and tourism mobility

Visitors may disperse rapidly across provinces and countries; exposed persons may present to many facilities.

### Multi-province coordination

Gauteng residence, Limpopo/Mpumalanga exposure routes and national/NICD laboratory functions must be integrated.

### Non-endemic context

Low background suspicion can delay detection; active case finding and clinician alerts are essential.

**Principle: act early, communicate carefully, and refine classification as field/lab/WASH evidence arrives.**

Sources: GTFCC field investigation and surveillance guidance; Limpopo DoH case update.

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# Readiness priorities I: detect and confirm quickly



## Surveillance and laboratory readiness should be intensified in Gauteng, Limpopo, Mpumalanga and travel-linked settings

### 1 1. Facility + community detection

Alert clinicians and private facilities on acute watery diarrhoea case definitions.
Institute daily review of severe AWD and diarrhoeal deaths in priority facilities.
Maintain zero reporting from priority reporting sites.

### 2 2. Active case finding

Symptomatic household members and travel companions.
Park staff/visitors and nearby health facilities/laboratories.
No routine tracing of asymptomatic contacts; focus on AWD among plausibly exposed persons.

### 3 3. Laboratory confirmation

Collect stool/rectal swabs from suspected cases promptly.
Send appropriate samples for culture/PCR.
Perform AST on early isolates and preserve isolates for WGS if source attribution is uncertain.

**Minimum surveillance package: line list + case investigation + laboratory results + daily person/place/time review + explicit escalation triggers.**

Sources: GTFCC Surveillance Guidance, 2024; GTFCC Outbreak Response Field Manual, 2024.

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# Readiness priorities II: prevent deaths and interrupt exposure



## Preparedness is operational when treatment, WASH, RCCE and logistics are ready before the next case arrives

### WASH / environmental health

Sanitary inspection of water systems; test free residual chlorine, pH/turbidity and faecal contamination; implement safe-water corrective actions.

### Case management + IPC

Refresh triage by dehydration; confirm ORS/Ringer's lactate/IV supplies, antibiotics as guided, cholera beds and IPC flow if cases present.

### RCCE

Clear public and clinician messages: symptoms, early care-seeking, ORS, safe water, handwashing and food safety; avoid premature source attribution.

### Logistics + readiness

Preposition stool collection/transport supplies, ORS, IV fluids, chlorine, PPE, IEC material and line-list tools in priority sites.

### Coordination

Daily coordination between NDoH, NICD, Gauteng, Limpopo, Mpumalanga, SANParks/Environmental Health and WHO until containment is documented.

### OCV decision pathway

Do not lead with OCV for a contained cluster but prepare criteria for rapid consideration if sustained transmission or high-risk expansion emerges.

**Readiness goal: no preventable deaths; no missed secondary transmission; no ongoing unsafe exposure.**

Sources: GTFCC Outbreak Response Field Manual, 2024; WHO/GTFCC response pillars.

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# Recommended action rhythm for South Africa



## Use a short, time-bound operational cycle to close evidence gaps and prevent missed transmission

### 0–24h

**Verify + align**

Confirm lab method, case details and onset dates
Agree surveillance units and case-origin classification
Activate coordination cell and facility alerts

### 24–48h

**Investigate + control**

Complete case investigations
Continue WASH/environmental assessment
Active case finding among symptomatic exposed persons
Implement immediate safe-water measures

### 48–72h

**Analyse + adapt**

Review line list, zero reports and lab results daily
Share preliminary epi/WASH/lab synthesis
Update risk assessment and public messaging

### 7–14d

**Sustain + document**

Maintain enhanced surveillance and weekly briefings
Document no secondary/community transmission
Decide demobilisation vs escalation based on triggers

**Escalate immediately if any unlinked confirmed case, positive ongoing water exposure, rising AWD signal, or community death is detected.**

Sources: GTFCC field investigation checklist and surveillance strategies; adapted to current South Africa signal.

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# Closing messages for the webinar



## Coordinated action is the difference between an isolated cluster and wider transmission

1

### African Region risk remains active

Transmission is concentrated but dynamic; regional mobility, WASH failures and mortality signals require sustained preparedness.

2

### South Africa should keep a precautionary posture

Two Gauteng cases are a domestic importation/cluster signal; the operational question is whether exposure or secondary transmission persists.

3

### Readiness must be multisectoral

Surveillance and lab confirmation must connect immediately to WASH control, case management, RCCE, logistics and coordination.

4

### Classification should evolve with evidence

Use case investigations, environmental results, active case finding and lab characterization to refine the transmission classification and response scale.

**Immediate ask: keep surveillance sensitive, source investigation active, response coordination daily, and communication evidence-based.**

Key references: WHO Global Cholera Situation Update 31 Jul 2026; GTFCC Surveillance Guidance 2024; GTFCC Field Manual 2024; Limpopo DoH Update 27 Jul 2026.

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