

This epidemiological bulletin aims to inform all stakeholders – both local and global – about disease trends, public health surveillance, disease outbreaks, and emergencies in Malawi to prompt action. In this issue (Volume 2, Issue 24 of 2026), we present the following updates:

- Key highlights on events of public health significance in Epidemiological (Epi) week 24
- Performance of Integrated Disease Surveillance and Response (IDSR)
- Reported Event-Based Surveillance (EBS) signals
- Reported Diseases and Conditions of Public Health Importance
- Ongoing outbreaks and emergencies.

1. Key Highlights on Events of Public Health Significance in Epi-week 24, 2026

- IDSR reporting achieved 94% for completeness and 93% for timeliness on the One Health Surveillance Platform (OHSP).
- Forty-two (42) suspected cholera cases were reported with zero (0) confirmed cases and zero (0) cholera-related deaths.
- One hundred and eight (108) Event-Based Surveillance (EBS) signals were reported, of which forty-eight (48) were verified as events.
- Zero (0) new confirmed Mpox cases and zero (0) Mpox alerts were reported.
- Other alerts generated included malaria (25,225 cases with 10 deaths), diarrhoea with blood (671 cases), Severe Acute Respiratory Infections (99 cases, including 4 deaths), typhoid fever (108 cases), Adverse Events Following Immunization (AEFI) (86 cases), measles (49 cases), Acute Flaccid Paralysis (AFP) (3 cases), meningococcal meningitis (14 cases), and maternal deaths (5), as shown in Figure 1.

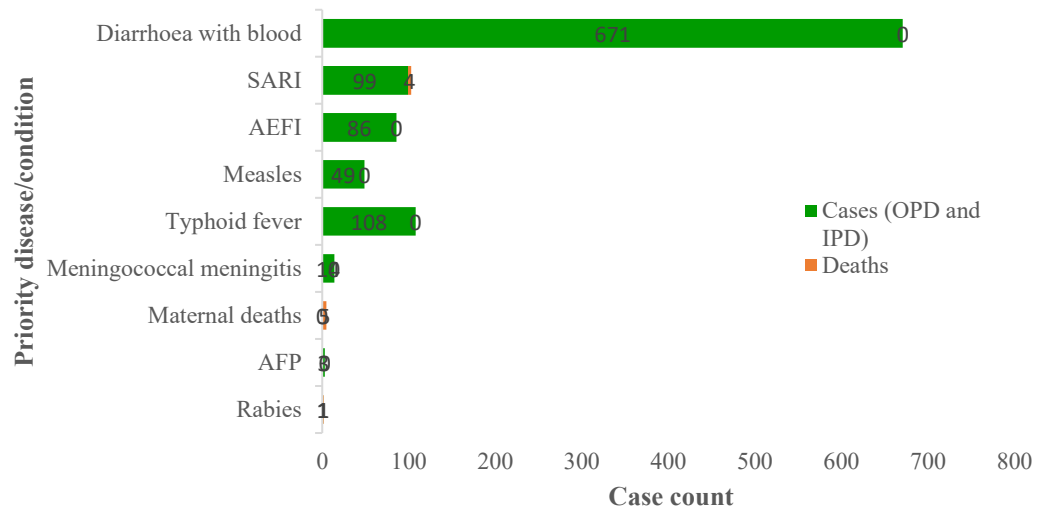


Figure 1. Notifiable diseases or conditions alerts reported in Epi-week 24 in Malawi (data accessed on 18 June, 2026)

2. Performance of the Integrated Disease Surveillance and Response up to Epi-week 24

2.1. Timeliness and Completeness

2.1.1. Trends of Reporting rate at the national level as of Epi-week 24

In week 24, reporting completeness decreased to 94% from 96% in week 23, while timeliness remained the same at 93% over the same period (see Figure 2).

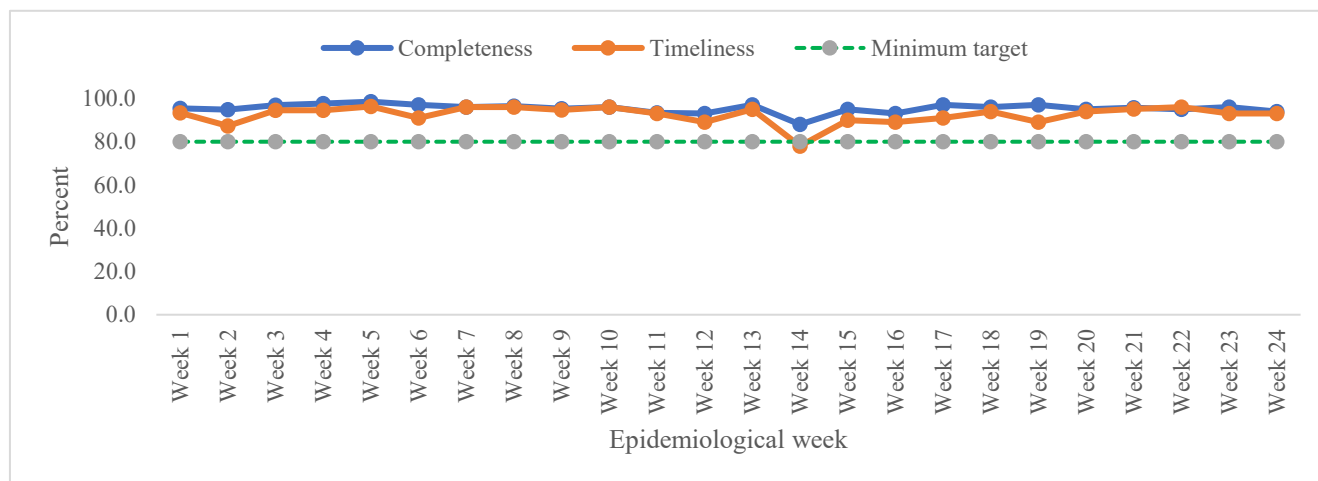


Figure 2. Trend of National IDSR weekly reporting rates in Malawi, up to Epi-week 24, 2026 (data accessed on 18 June, 2026)

2.1.2. Reporting rates at the Zonal level, including Central Hospitals for Epi-week 24

Figure 3 illustrates the reporting rates across various health zones, including Central Hospitals, during epidemiological week 24. All health zones except Central Hospitals met the minimum target of 80% for both reporting completeness and timeliness as shown in Figure 3 below.

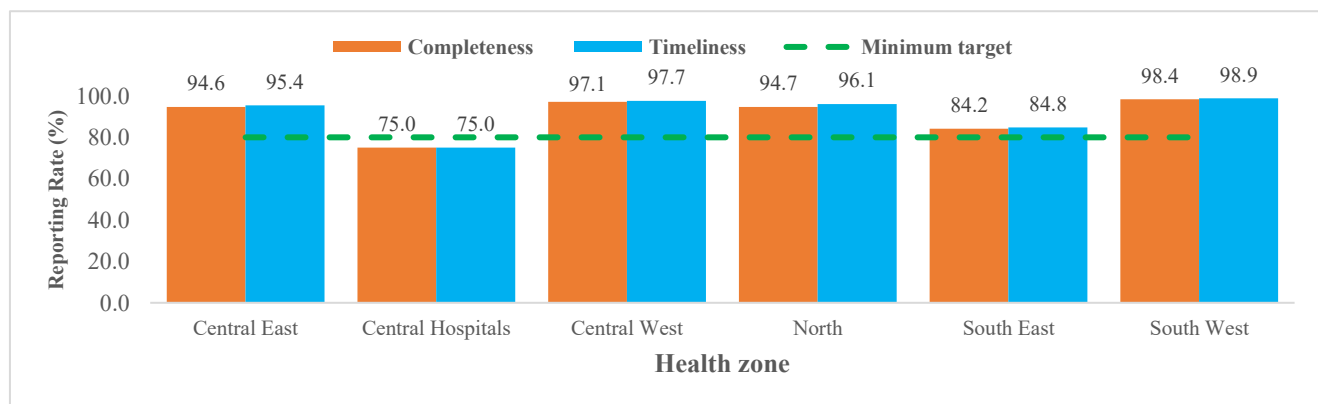


Figure 3. Reporting rates of IDSR weekly reports by zones, Epi-week 24 (data accessed on 18 June 2026)

2.1.3. Reporting rates at the district level for Epi-week 24

Among the 33 reporting sites (Districts and Central Hospitals), 29 (88%) achieved the national minimum reporting target of 80% for both completeness and timeliness. Zomba and Balaka districts, and Mzuzu Central Hospital failed to surpass the minimum reporting targets for both completeness and timeliness, as shown in Figure 4.

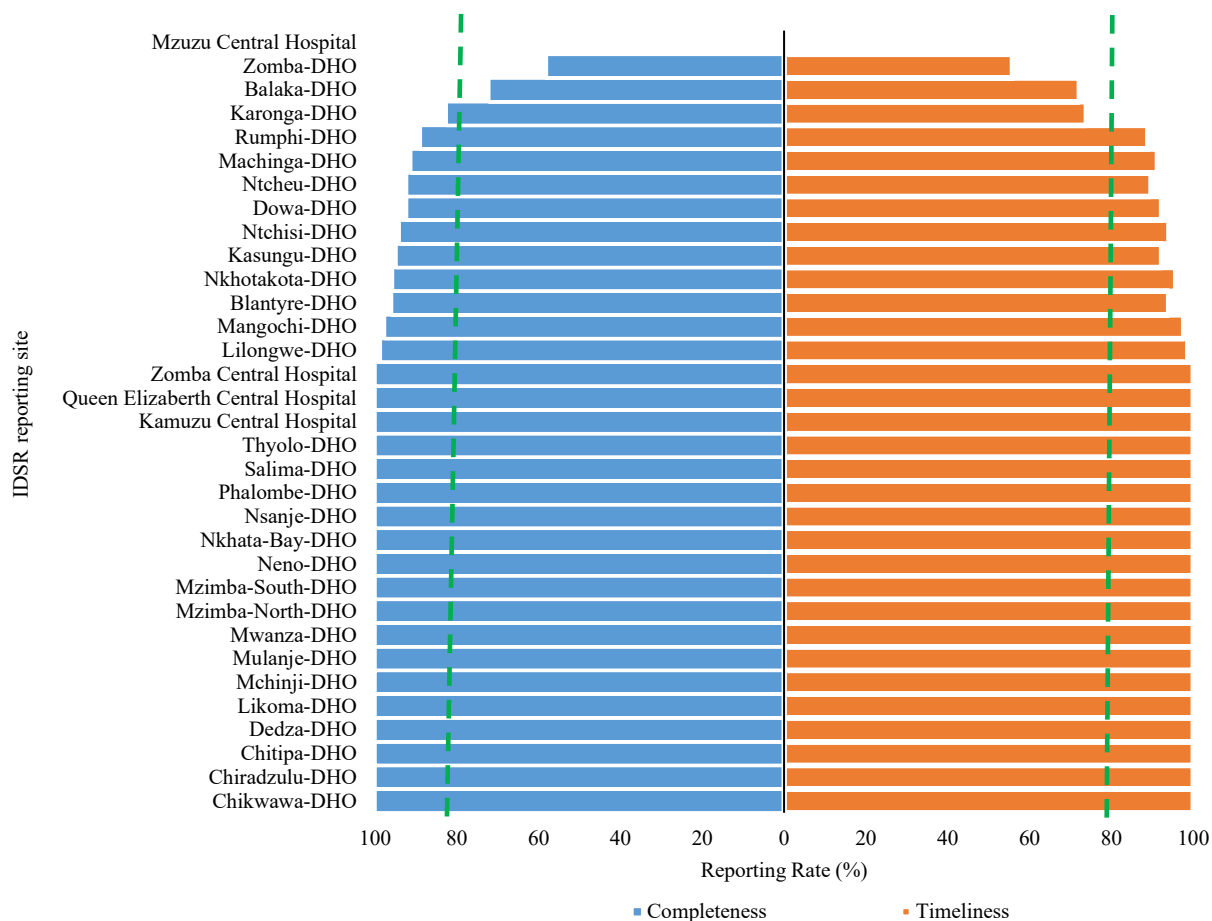


Figure 4. Reporting rates (completeness and timeliness) by reporting sites for Epi-week 24 (data accessed on 18 June, 2026)

3. Event-Based Surveillance (EBS)

3.1 Community EBS signals reported in Epi-week 24

Figure 5 presents the signals reported during epidemiological week 24. A total of one hundred and eight (108) signals were reported from sixteen (16) districts. Of these, forty-eight (44%) signals were verified

as events, one (1%) was discarded, while fifty-nine (55%) signals were not verified. The number of reports under each signal category is presented in Figure 5 below.

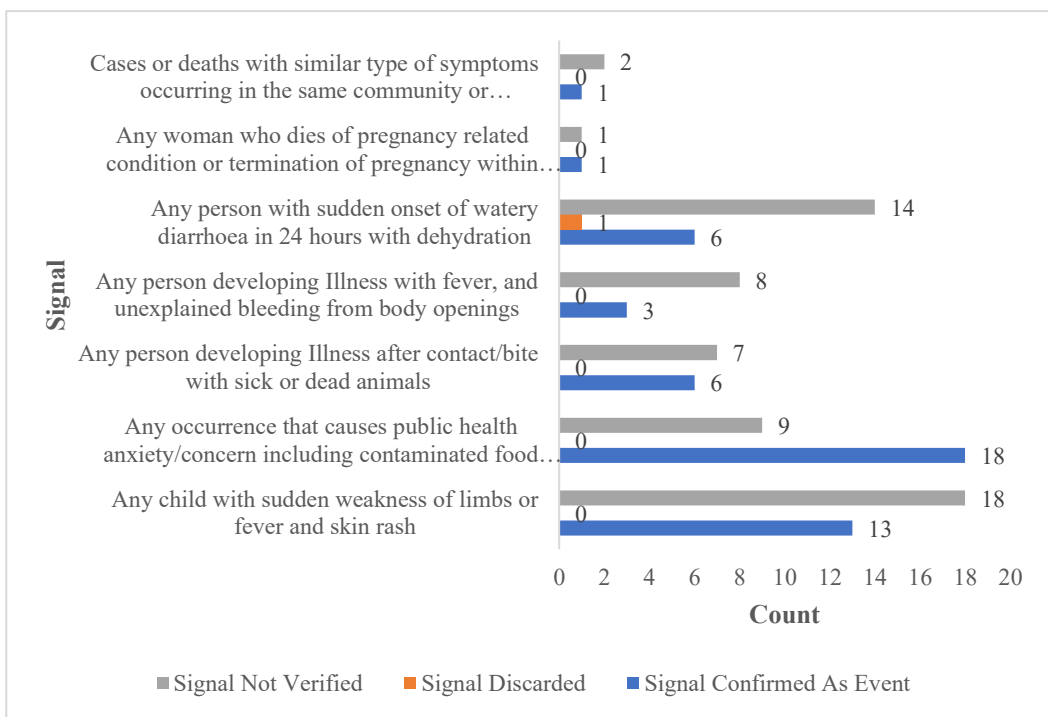


Figure 5. Event-based signals reported in Epi-week 24 (data accessed on 18 June, 2026)

3.2. Risk Assessment Level of the Community Signals

Risk assessments were conducted for forty-six (46) of the forty-eight (48) verified events. The distribution of Event-Based Surveillance (EBS) signals by risk level is shown in Figure 6, with further details provided in Annex 2.

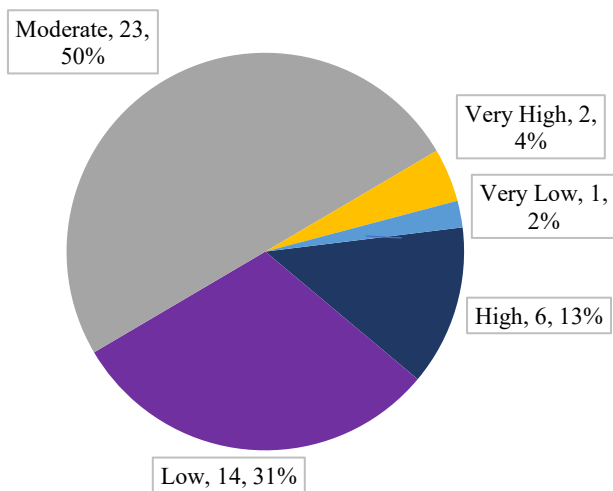


Figure 6. Distribution of the verified EBS signals by risk level, reported in Epi-week 24 (data accessed on 18 June, 2026)

4. Diseases and Conditions of Public Health Importance in Epi-week 24

4.1 Summary of Diseases and Conditions

Table 1 highlights alerts related to diseases and public health conditions recorded during epidemiological week 24. Among epidemic-prone diseases, diarrhea with blood (671 cases) was the most prevalent, followed by Typhoid fever (108 cases, including), while measles (49 cases) recorded the highest number of cases among diseases targeted for eradication or elimination. For further details on diseases and conditions of public health importance, refer to Annex 3.

Table 1. Reported alerts of diseases and conditions of public health importance in Malawi.

	Suspected cases	Deaths
<i>EPIDEMIC PRONE DISEASES</i>		
Diarrhea with blood	671	0
Meningococcal meningitis	14	0
Typhoid Fever	108	0
SARI	99	4
Cholera	42	0
Mpox	0	0
<i>DISEASES TARGETED FOR ERADICATION/ELIMINATION</i>		
Measles	49	0
Acute Flaccid Paralysis	3	0
Neonatal tetanus	2	1
<i>CONDITIONS OF PUBLIC HEALTH IMPORTANCE</i>		
Food-borne illnesses	0	0
Maternal death		5
Yellow fever	0	0
Rabies	1	1

4.2 Bloody diarrhoea outbreak in Nkhata Bay

Following an alert regarding six unusual deaths reported in communities surrounding Usisya Health Facility in Traditional Authority (T/A) Mbwana, Nkhata Bay District, the District Public Health Emergency Rapid Response Team conducted a field investigation on 26 May 2026. The investigation identified a suspected outbreak of acute enteric illness characterized by fever, abdominal pain, vomiting, and diarrhoea. Environmental assessments revealed several risk factors, including the use of unsafe water sources, poor sanitation and hygiene practices, delayed healthcare-seeking behaviour, and reliance on informal care options such as certain faith-based groups and traditional healers.

In Epi-week 24, 20 new diarrhea cases were reported with zero (0) bloody diarrhea cases. As of 14 June 2026, a cumulative total of 185 diarrhoea cases, including 26 cases of bloody diarrhoea, and six suspected deaths had been reported from the affected communities. In response, the district strengthened

surveillance, conducted active case finding and community awareness activities, distributed 1% stock solution for household water treatment in hotspot areas, prepositioned outbreak response supplies at health facilities, and collected clinical specimens for laboratory analysis.

Laboratory investigations identified *Escherichia coli* (E. coli) in stool specimens collected from outbreak-associated cases, with all submitted isolates subsequently confirmed by the National Reference Laboratory. Further characterization to determine whether the isolates belonged to known diarrhoeagenic E. coli pathotypes could not be performed due to the unavailability of required reagents and materials. Consequently, the specific pathogenic strain associated with the outbreak could not be determined. Blood cultures were also performed on selected patients, with one specimen yielding *Pseudomonas aeruginosa*, while no significant bacterial growth was detected in the remaining samples.

Although the repeated isolation of E. coli suggests a possible association with the outbreak, the laboratory findings were insufficient to definitively identify the causative pathogen. While the outbreak appears to be stabilizing, continued surveillance, risk communication, water safety interventions, environmental health monitoring, health worker capacity strengthening, and logistical support for hard-to-reach areas remain essential to prevent further transmission and avert additional deaths.

5. Ongoing outbreaks and emergencies in Malawi as of week 24, 2026.

5.1. Mpox

In Epi-week 24, Malawi did not record any new Mpox confirmed case. Since Epi-week 12 of 2025 through Epi-week 24 of 2026, Malawi has recorded 158 confirmed Mpox cases and four (4) cross-border cases. One (1) death was reported on 10 August 2025 in Lilongwe district, representing a case fatality rate (CFR) of 0.63%. Lilongwe district accounts for 75.8% (119) of the reported cases, as shown in Table 2. Further outbreak details are provided in Annex 4.

Table 2. Confirmed Mpox cases from Epi-week 12 of 2025 to Epi-week 24 of 2026 in Malawi

District	Confirmed cases	Per cent of total	Cross-border cases
Blantyre	4	2.5	0
Karonga	8	5.1	1 (TZ)
Lilongwe	119	75.8	0
Mangochi	4	1.9	0
Mzimba South	4	2.5	0
Nkhatabay	1	0.6	0
Ntcheu	9	5.7	1 (Moz)
Ntchisi	1	0.6	0
Salima	4	2.5	0
Zomba	3	1.9	0
Likoma	1	0.6	1 (Moz)
Chitipa	0	0.0	1 (TZ)
Grand Total	158	100	4

Interventions

- Coordination of the outbreak through the public health emergency operation centre

- Enhanced surveillance
- Collection and analysis of samples
- Case management
- Infection prevention and control activities
- Risk communication and community engagement
- Vaccination of at-risk groups

5.2. Measles

In Epi-week 24, Malawi reported 49 new suspected measles alerts. From week 1 to week 24 of 2026, a total of 1,591 cumulative measles alerts were reported with 414 confirmed measles-rubella cases (laboratory-confirmed, epidemiologically linked, and clinically compatible). The laboratory confirmed cases were distributed across twenty-three (23) districts, with Balaka and Kasungu reporting the highest proportions at 20.4% (58 cases) and 15.4% (44 cases), respectively. Dowa, Nkhata Bay, Ntchisi, and Salima each reported the lowest proportion at 0.7% (2 cases). Further details are provided in Annex 5.

The weekly cumulative number of measles alerts and confirmed cases is shown in Figure 7 below.

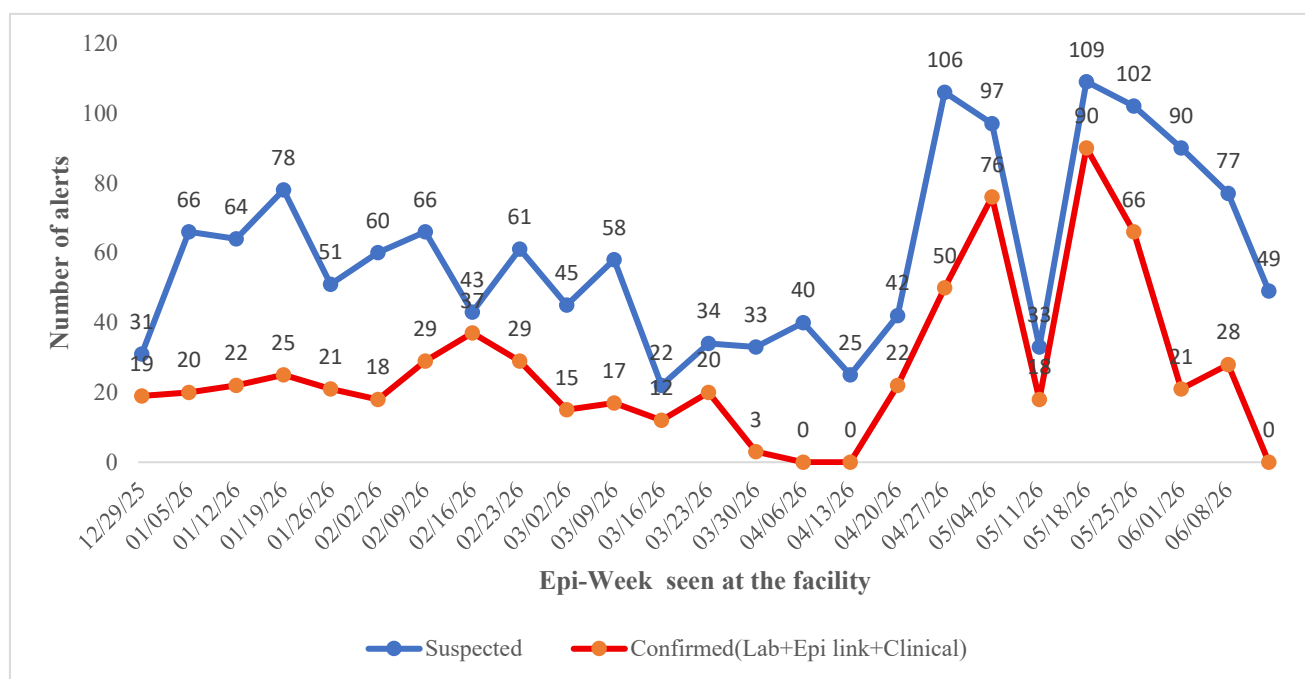


Figure 7. Measles disease alerts by epi-week of onset in Malawi, from week 1 to Week 24 of 2026. Source: OHSP and Measles Line list.

Interventions

- Case management
- Active case search
- Sample collection and laboratory analysis
- Intensification of routine immunisation

- Supportive supervision
- Community engagement and mobilisation

5.3. Cholera

In Epi-week 24, 42 new suspected cholera cases with zero (0) new confirmed cases were reported. Since the start of the 2025/26 cholera season on 1 November 2025, Malawi has recorded a cumulative total of 3,000 suspected cases with 776 confirmed cholera cases (excluding imported cases), comprising 315 laboratory-confirmed cases and 461 epidemiologically linked cases, as shown in Annex 6. Of the total confirmed cases, 449 were male and 327 were female, with ages ranging from 1 to 80 years. A total of 771 patients have recovered and been discharged, while five deaths were recorded between 9 January and 29 March 2026, resulting in a case fatality rate (CFR) of 0.65%. Figure 8 presents the epidemic curve showing the distribution of cholera cases and deaths by date of onset throughout the reporting period.

In addition to locally reported cases, Malawi has recorded 186 cross-border cholera cases, of which 97 were laboratory-confirmed. These cases were reported from Dedza (2), Nsanje (16), Chikwawa (14), Ntcheu (3), Mulanje (10), Thyolo (1), Phalombe (12), and Mwanza (128). Among the cross-border cases, four deaths, including two suspected cholera deaths, were reported between 23 December 2025 and 17 February 2026.

Geographically, 26 of Malawi’s 29 districts have reported at least one suspected cholera case, as illustrated in Annex 7. The map on the left shows the distribution of suspected and confirmed cholera cases by district since 1 November 2025, while the map on the right presents the number of deaths reported during the same period. Districts reporting more than one confirmed cholera case include Lilongwe, Blantyre, Chiradzulu, Kasungu, Chikwawa, Zomba, Mulanje, Balaka, Neno, Mwanza, Thyolo, Nsanje, and Phalombe.

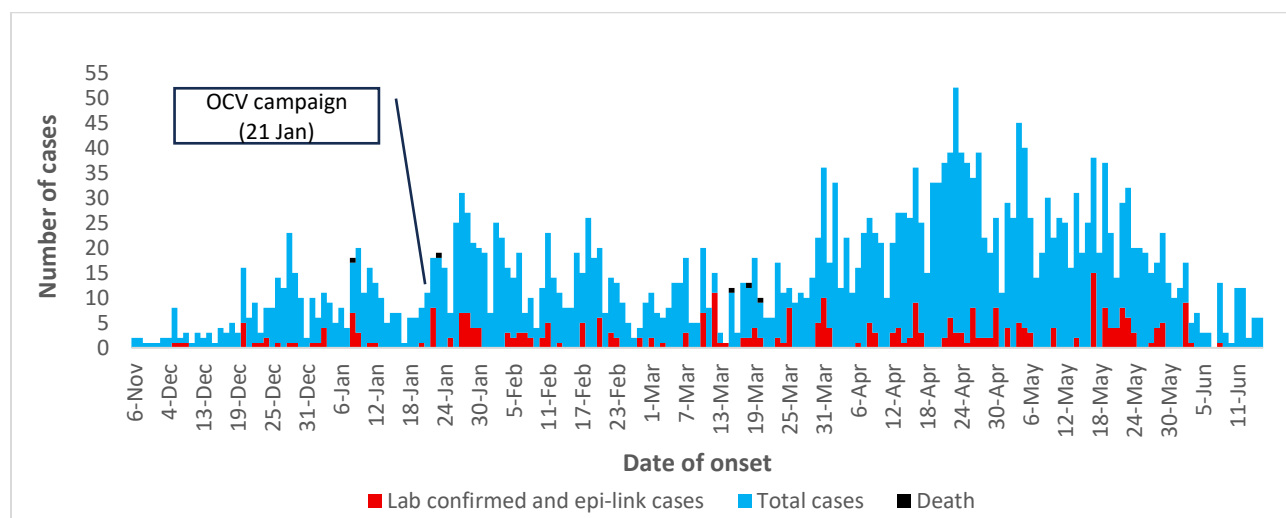


Figure 8. Malawi Cholera Epidemic Curve from 1 November 2025 to Week 24 of 2026. Source: National Cholera line list.

An Oral Cholera Vaccine campaign was conducted in selected hotspot districts, as listed in Table 3, along with their respective coverage.

Table 3. Oral Cholera Vaccine campaign coverage in selected districts, Malawi, 2026

	District	Target population	Total vaccine doses administered	Coverage (%)
1	Blantyre	277,253	277,258	100.0
2	Chikwawa	83,604	83,597	100.0
3	Chiradzulu	20,617	20,612	100.0
4	Kasungu	22,772	20,784	91.3
5	Mulanje	154,070	163,656	106.2
6	Mwanza	20,478	20,478	100.0
7	Neno	26,092	26,092	100.0
	Total	604,886	612,477	101.3

Other interventions¹

- The National Public Health Emergency Operations Centre and Incident Management System (IMS) remain operational.
- Community and facility-based surveillance have been strengthened, with daily case follow-up conducted.
- Cholera rapid diagnostic tests (RDTs) have been distributed, and sample transport systems for laboratory confirmation have been improved.
- Cholera treatment centres have been established, and case management teams have been mentored.
- Chlorine supplies and WASH materials have been provided, and water quality monitoring has been conducted.
- Community sensitization activities have been conducted, and cholera prevention messages have been disseminated.
- Essential medicines and personal protective equipment (PPE) have been distributed, with buffer stocks maintained.
- Cross-border surveillance and coordination with Mozambique have been strengthened.
- Oral cholera vaccine has been administered to target populations in Blantyre, Mwanza, Kasungu, Mulanje, Chikwawa, Chiradzulu, and Neno districts, achieving over 95% coverage.

5.4. Polio and AFP surveillance

Malawi confirmed a polio outbreak following detections from environmental samples, with two (2) circulating vaccine-derived poliovirus type 2 (cVDPV2) isolates identified from sewage treatment plants in Blantyre and Soche, and one (1) vaccine-derived poliovirus type 2 (VDPV2) detected in a 7-year-old Acute Flaccid Paralysis (AFP) case at Queen Elizabeth Central Hospital (QECH). The outbreak was officially confirmed on 22 January 2026, and a Public Health Emergency (PHE) was declared on 23 January 2026.

¹ Other interventions are detailed in the Weekly Cholera Sitrep

Three (3) environmental samples were collected on 20 April 2026, one each from Blantyre, Soche, and Kauma treatment plants. All were subsequently confirmed as positive. This brings the cumulative total to sixteen (16) isolations: twelve (12) detected through environmental surveillance (ES) sites, one (1) identified in a seven-year-old boy from Blantyre, two (2) from his healthy contacts, and one (1) from another healthy community child.

A Sabin-like (SL) poliovirus was detected in an AFP case during the Round 0 SIA campaign; however, this does not constitute an outbreak but rather reflects recent immunization activity, with the child remaining in good health.

Interventions

- Enhanced polio surveillance measures are currently in place.
- Routine immunization (RI) activities have been intensified.
- Communication and Social and Behaviour Change (SBC) interventions have been strengthened.
- Advocacy and coordination with MoHS leadership, partners, and districts are ongoing in preparation for upcoming nOPV2 campaigns.
- The National Emergency Operations Centre (EOC), supported by technical working groups, continues to hold daily coordination meetings.
- The Round Zero (R0) nOPV2 campaign was conducted from 11–14 February 2026, with 1,709,608 doses administered.
- The Round 1 polio vaccination campaign was conducted from 24–27 March 2026, achieving 103% coverage (6,223,422 individuals vaccinated).
- The Round 2 polio vaccination campaign was conducted from 28 April to 1 May 2026, achieving 106% coverage (6,637,979 individuals vaccinated).
- The Round 3 polio vaccination campaign is scheduled for 16–19 June 2026.

6.0. Immediate recommendations

- **IDSR Coordinators and Zonal Epidemiology Officers** must ensure timely verification and validation of data immediately after health facility focal persons or data clerks enter it into OHSP.
- **Zomba, Dowa and Balaka DHOs** must improve on completeness and timeliness. Nkhotakota and Karonga must improve on timeliness.
- **Blantyre, Mchinji, Dedza and Kasungu DHOs** should implement targeted interventions against Typhoid being reported in the districts
- **Mzimba-North and Nkhatabay DHOs** must investigate the reported AEFIs
- **All districts** should strengthen the recording and reporting of detected EBS signals in OHSP
- **District Rapid Response Teams (DRRTs)** must conduct risk assessments for all verified signals (events) without delay.
- **Expanded Programme on Immunisation (EPI)** should strengthen routine immunisation coverage and outreach strategies to enhance population immunity and reduce the incidence of measles and Polio. The measles situation in Balaka district should receive attention.

Annex 1: Timeliness and completeness of IDSR reports by Reporting Site, from Epi-week 14 to Week 24, 2026

District/ Hospital	Completeness											Timeliness										
	W14	W15	W16	W17	W18	W19	W20	W21	W22	W23	W24	W14	W15	W16	W17	W18	W19	W20	W21	W22	W23	W24
National	88	95	93	97	96	97	95	96	95	96	94	78	90	89	91	94	89	94	90	96	93	93
Balaka	67	100	100	83	94	78	89	72	89	78	72	50	100	94	78	94	78	89	72	89	78	72
Blantyre	98	100	90	92	96	98	100	100	100	100	96	94	82	90	88	90	88	100	82	100	100	94
Chikwawa	84	100	91	97	100	97	94	94	94	97	100	53	100	72	91	94	94	94	100	94	94	100
Chiradzulu	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	94	100	100	100	100	100	100
Chitipa	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Dedza	100	100	100	100	100	100	100	100	100	100	100	100	100	100	97	100	95	100	100	100	100	100
Dowa	81	92	100	96	100	85	85	100	69	73	92	62	88	100	73	100	73	69	88	69	65	92
Kamuzu CH	100	100	100	100	100	100	61	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Karonga	91	91	91	87	87	83	78	87	78	91	83	70	83	83	74	70	70	74	57	74	78	74
Kasungu	100	100	100	100	100	100	100	100	100	100	95	100	100	100	100	100	100	97	100	97	100	92
Likoma	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Lilongwe	99	100	100	100	99	100	99	99	99	97	99	99	100	100	99	99	89	99	100	99	97	99
Machinga	95	100	95	100	100	96	96	100	96	100	91	86	100	95	61	83	87	91	100	91	96	91
Mangochi	100	100	100	100	100	100	100	100	100	100	98	100	100	100	100	100	100	100	100	100	100	98
Mchinji	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Mulanje	65	62	100	69	62	100	92	62	92	100	100	100	50	50	65	62	65	88	50	88	100	100
Mwanza	100	20	100	100	100	100	100	100	100	100	100	100	20	100	100	100	100	20	100	100	100	100
Mzimba-North	97	100	100	100	100	100	100	100	100	100	100	97	100	100	100	100	100	100	100	97	100	100
Mzimba-South	94	100	41	100	100	100	100	100	100	100	100	88	97	32	94	97	100	97	100	100	100	100
Mzuzu CH	0	100	100	100	100	100	100	100	100	100	0	0	100	100	100	100	100	0	100	100	100	0
Neno	60	100	60	93	100	100	100	100	100	100	100	47	100	60	93	100	87	100	100	100	100	100
Nkhata-Bay	100	100	100	100	100	100	100	100	100	97	100	96	100	100	100	100	93	100	100	100	97	100
Nkhotakota	61	91	100	87	87	96	91	87	91	83	96	61	87	96	87	87	61	91	87	91	78	96
Nsanje	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	96	100
Ntcheu	90	100	95	100	100	100	95	100	95	97	100	79	95	92	80	97	97	95	95	95	90	100
Ntchisi	71	100	88	100	100	88	94	100	94	100	94	53	100	88	100	100	29	94	100	94	100	94
Phalombe	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
QECH	100	100	100	100	100	100	100	100	100	100	100	0	100	100	100	100	100	100	100	100	100	100
Rumphi	100	100	100	89	100	100	100	100	100	89	89	100	100	100	83	100	100	100	100	100	89	89
Salima	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Thyolo	100	100	100	100	100	98	100	100	100	100	100	100	100	100	100	100	98	100	100	100	100	100
Zomba CH	100	100	0	100	79	100	100	79	100	100	100	100	0	0	100	65	0	100	0	100	100	100
Zomba	65	72	81	79	79	81	65	79	65	72	58	35	70	67	61	65	77	63	70	63	60	56

Key:

	>= 80%
	< 80%

Annex 2: Distribution of EBS signals per reporting unit in Epi-week 24, 2026

District	Any child with sudden weakness of limbs or fever and skin rash	Any occurrence that causes public health anxiety/concern including contaminated food products or water and environmental hazard (flooding, drought), chemical and radio-nuclear events, vaccination, or mass drug administration	Any person developing Illness after contact/bite with sick or dead animals	Any person developing Illness with fever, and unexplained bleeding from body openings	Any person with sudden onset of watery diarrhoea in 24 hours with dehydration	Any woman who dies of pregnancy related condition or termination of pregnancy within 2 months	Cases or deaths with similar type of symptoms occurring in the same community or institution within a week	Grand Total
Balaka	5	0	0	0	0	0	0	5
Blantyre	1	0	1	0	1	0	1	4
Chikhwawa	0	0	1	0	2	0	0	3
Chiradzulu	0	0	1	0	0	0	0	1
Dowa	4	0	1	1	1	0	0	7
Kasungu	0	0	0	0	1	0	0	1
Lilongwe	1	0	0	0	0	0	0	1
Mchinji	1	1	4	0	0	0	0	6
Mwanza	1	17	0	0	1	0	0	19
Neno	0	1	0	0	0	0	0	1
Nkhata Bay	17	8	4	8	11	0	2	50
Nkhotakota	0	0	0	0	0	1	0	1
Nsanje	1	0	1	1	0	0	0	3
Ntcheu	0	0	0	0	2	0	0	2
Rumphi	0	0	0	1	2	0	0	3
Thyolo	0	0	0	0	0	1	0	1
Grand Total	31	27	13	11	21	2	3	108

Annex 3. Priority diseases/conditions/events, including alerts under surveillance, Epi-week 24

District/ Hospital	AEFI cases	AFP	OPD Diarrhoea With Blood (Bacterial) Cases	IPD Diarrhoea With Blood (Bacterial) Cases	OPD Malaria Cases	IPD Malaria Cases	IPD Death Malaria Cases	IPD Maternal death cases	OPD Measles cases	IPD Measles cases	IPD M. Meningitis cases	IPD Neonatal tetanus cases	IPD Neonatal tetanus deaths	IPD Rabies cases	IPD Rabies deaths	IPD SARI cases	IPD SARI deaths	OPD Typhoid fever cases	IPD typhoid fever cases
Kasungu-DHO	1	0	30	0	891	27	0	0	4	1	0	0	0	0	0	0	0	3	0
Nkhotakota-DHO	0	0	11	0	657	6	0	0	0	0	1	0	0	0	0	7	0	1	0
Ntchisi-DHO	0	0	0	0	49	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Salima-DHO	0	1	40	1	1066	36	4	0	0	0	0	0	0	0	0	0	0	0	0
Dowa-DHO	0	0	7	1	471	3	0	0	0	0	0	0	0	0	0	22	0	0	0
Kamuzu CH	0	0	1	1	3	9	0	2	0	0	0	1	1	0	0	24	3	0	0
Queen Elizabeth CH	0	0	0	0	5	5	0	0	0	0	1	0	0	0	0	0	0	0	1
Zomba CH	0	0	2	0	6	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Dedza-DHO	0	0	25	0	703	9	0	0	20	0	0	0	0	0	0	0	0	1	1
Lilongwe-DHO	2	0	43	0	1626	42	1	0	3	0	0	0	0	0	0	0	0	16	0
Ntcheu-DHO	0	0	4	0	868	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Mchinji-DHO	1	0	5	0	775	49	1	0	0	0	0	0	0	0	0	0	0	24	5
Chitipa-DHO	0	0	15	0	376	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Karonga-DHO	0	0	71	0	137	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Likoma-DHO	0	0	8	0	158	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Mzimba-North-DHO	44	0	43	1	178	4	0	0	0	0	0	0	0	0	0	0	0	0	0
Mzimba-South-DHO	0	0	23	0	591	21	0	0	0	0	0	0	0	0	0	0	0	0	0
Nkhata-Bay-DHO	1	0	20	0	1028	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Rumphi-DHO	7	0	14	0	157	5	0	0	0	0	0	0	0	0	0	0	0	0	0
Balaka-DHO	0	1	15	0	602	11	1	0	7	0	0	0	0	1	1	0	0	0	0
Machinga-DHO	1	1	21	0	922	0	0	0	6	0	0	0	0	0	0	0	0	9	0
Mangochi-DHO	7	0	16	0	2309	24	1	2	0	0	0	0	0	0	0	5	0	2	4
Mulanje-DHO	0	0	16	0	1461	13	0	0	0	0	0	1	0	0	0	17	0	0	0
Phalombe-DHO	0	0	15	0	276	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Zomba-DHO	2	0	38	0	446	10	0	0	0	0	0	0	0	0	0	0	0	0	0
Blantyre-DHO	2	0	68	0	2953	3	0	0	0	0	0	0	0	0	0	0	0	32	0
Chikwawa-DHO	6	0	30	1	2254	4	1	0	3	0	8	0	0	0	0	0	0	0	0
Chiradzulu-DHO	2	0	6	0	286	0	0	0	5	0	0	0	0	0	0	0	0	0	0
Mwanza-DHO	0	0	9	0	1252	20	0	0	0	0	0	0	0	0	0	0	0	0	0
Neno-DHO	6	0	21	0	683	19	0	0	0	0	0	0	0	0	0	23	1	4	1
Nsanje-DHO	4	0	18	3	1057	18	1	0	0	0	4	0	0	0	0	1	0	0	0
Thyolo-DHO	0	0	18	0	611	15	0	1	0	0	0	0	0	0	0	0	0	3	0
Total	86	3	653	8	24857	368	10	5	48	1	14	2	1	1	1	99	4	96	12

Annex 5. Distribution of Confirmed² Measles cases by District, 2026

District	Confirmed cases	% of total
Balaka	58	20.2
Blantyre	16	5.6
Chikwawa	16	5.6
Chiradzulu	24	8.4
Chitipa	6	2.1
Dedza	6	2.1
Dowa	2	0.7
Kasungu	44	15.3
Lilongwe	19	6.6
Mangochi	8	2.8
Mchinji	3	1.0
Mulanje	10	3.5
Mwanza	3	1.0
Mzimba	6	2.1
NkhataBay	2	0.7
Nsanje	20	7.0
Ntcheu	10	3.5
Ntchisi	2	0.7
Phalombe	3	1.0
Rumphi	5	1.7
Salima	2	0.7
Thyolo	9	3.1
Zomba	13	4.5
Total	287	100.0

Annex 6. Distribution of Confirmed Cholera Cases by Age-group and Sex, Malawi-2025-2026

Age-group (years)	Sex		Total
	Males	Females	
0-4	58	67	125
5-9	50	26	76
10-14	35	25	60
15-19	60	49	109
20-24	71	33	104
25-29	44	51	95
30-34	44	17	61
35-39	24	20	44
40-44	18	8	26
45-49	22	6	28
50-54	8	11	19
55-59	3	4	7
60-64	2	4	6
65-70	4	2	6
70+	6	4	10
Total	449	327	776

² Laboratory-confirmed, epidemiologically linked, and clinically compatible

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