REPORT ON THE 2025–2026 NATIONAL CHOLERA OUTBREAK AFTER-ACTION REVIEW OF THE CHOLERA OUTBREAK



Venue: Mango Lodge, Zomba

Review period: 14–18 September 2026

Supported by: World Health Organization, JHPIEGO, FHI

Reported by: Public Health Institute of Malawi, Ministry of Health

EXECUTIVE SUMMARY

Malawi experienced a cholera outbreak during the 2025–2026 cholera season. The outbreak occurred in the context of seasonal rainfall, flooding, population movement, inadequate access to safe water and sanitation in some communities, and cross-border movement.

The first cases were reported on 11 December 2025 from Balaka and Lilongwe Districts and outbreak declaration was on 28 December 2026. The response required activation of national and district public health emergency management structures. The national and district Incident Management System (IMS) supported coordination across surveillance, laboratory, case management, IPC, WASH, RCCE, vaccination, operations and logistics, and other response functions. The last confirmed cases were reported on 12 June 2026 by Mulanje and Zomba. Cumulatively, the country reported 3013 local cases, 319 laboratory-confirmed cases with 5 deaths (Case Fatality Rate of 1.56%), 2694 suspected cases including 25 deaths (13 facility & 12 community). For imported cases; cumulatively, 187 imported cases were reported; 88 laboratory confirmed imported cases (including 2 facility deaths);99 suspected cases including 2 deaths (1 community and 1 facility). Twenty-six of 29 districts had reported at least one suspected case. Oral cholera vaccination was implemented in selected hotspot districts, with 612,477 doses administered, reported as 101.3% of target.

The outbreak was officially declared over on 31 August 2026 after more than 28 consecutive days without a laboratory-confirmed case. The AAR reviewed preparedness, response operations and the transition toward recovery and future preparedness.

Key Strengths

- Early preparedness: Prepositioning of cholera supplies in hotspot areas.
- Rapid response: Timely activation of emergency coordination structures and deployments
- Dedicated workforce: Committed health workers and response teams.
- Guidance and supplies: Availability of cholera guidelines and essential supplies in many settings.
- Strong surveillance: Early IDSR notification, RDT availability, active case finding and community surveillance.
- Case management: Establishment of oral rehydration points and availability of case-management supplies
- OCV implementation: Oral cholera vaccination was successfully administered in affected areas within 30 days of outbreak.
- WASH/RCCE coordination: good collaboration between WASH, RCCE and health response actors.
- Supportive supervision: Supervision and mentorship conducted in some affected areas.
- Cross-border surveillance: Mechanisms for surveillance and sharing information across borders.

Key Weaknesses

- Logistics and supplies: Delays in last-mile distribution and inadequate emergency stock buffers.

- Emergency financing: Limited funding for community-based preparedness and response activities
- Laboratory systems: Stock out of transport media in some facilities, unavailability of a courier to transport cholera samples, poor tracking of laboratory results and long turnaround times.
- Surveillance: Incomplete line lists and suboptimal use of electronic surveillance platforms.
- Workforce capacity: uneven training, mentorship and supportive supervision.
- Coordination: variable functionality of district PHEOCs and multisectoral coordination mechanisms.
- Case-management infrastructure: Inadequate standard CTU infrastructure in some settings and limited surge capacity.
- Community factors: low risk perceptions, religious beliefs, self-medication, myths, misconceptions, vaccine hesitancy and inappropriate chlorine use.
- Delayed WASH interventions; WASH activities were sometimes implemented after transmission had already increased, rather than being triggered early by surveillance and risk assessment
- Inadequate access to safe and reliable water; some communities experienced water shortages, low pressure, long distances to water points, and high costs of water, particularly in densely populated and informal settlements.
- Limited household water treatment – Inconsistent use of chlorine and other household water-treatment methods, with gaps in availability, affordability, correct dosing, and sustained use.
- Poor sanitation coverage – Inadequate access to improved latrines, open defecation in some communities, and poorly maintained sanitation facilities increased the risk of faecal contamination.
- Poor management of faecal sludge and wastewater – Limited capacity for safe collection, transportation, treatment and disposal of faecal sludge and wastewater, particularly in high-density areas.
- Cross-border coordination: Gaps in coordination and information sharing across borders.

Key Challenges to Cholera Outbreak

1. Inadequate access to safe water; water shortages, low water pressure, high cost of water and unreliable supply in some communities increased exposure to contaminated water.
2. Poor sanitation and hygiene; inadequate latrine coverage, poor maintenance of sanitation facilities, open defecation in some areas, and limited handwashing facilities contributed to continued transmission.
3. Persistent transmission in hotspot areas; some districts and communities continued reporting cases despite overall reductions, making it difficult to interrupt transmission completely.
4. Flooding and environmental contamination; floods damaged water and sanitation infrastructure and increased the risk of contamination of water sources and displacement of populations.
5. Delayed health-seeking behavior; some patients presented late to health facilities, increasing the risk of complications and deaths and contributing to community transmission.
6. Unsafe food handling and vending practices; inadequate food hygiene, unsafe water use and poor sanitation among some food vendors and in markets created additional transmission risks.
7. Limited WASH resources; gaps in funding, WASH commodities, water-treatment supplies, sanitation infrastructure and logistical capacity constrained implementation of preventive measures.

8. Weak sustainability of WASH interventions; some emergency interventions were difficult to maintain after initial external support, particularly in communities with limited resources.
9. Coordination and implementation gaps; although emergency coordination structures were activated, challenges remained in tracking action points, ensuring timely follow-up and coordinating activities across health, WASH, local government and other sectors.
10. Gaps in community engagement; behavior change messages did not always translate into sustained practices, particularly around household water treatment, handwashing, sanitation and early care-seeking.
11. Limited data for targeted WASH action; gaps in timely, community-level WASH information made it difficult to rapidly identify contaminated water sources and prioritize interventions.
12. Human resource and operational constraints; district teams faced competing priorities, workload pressures and limitations in transport, logistics and personnel, particularly during prolonged response periods.
13. Cross-border and population-movement risks; movement of people between affected and unaffected areas created challenges for surveillance, risk communication and continuity of preventive measures.
14. Funding gaps and dependence on partners; limited domestic resources and gaps between response requirements and available funding affected the scale and continuity of interventions.
15. Difficulty transitioning from response to prevention; sustaining preparedness and prevention activities after the decline in cases remained challenging, creating a risk of resurgence

Priority Activities

Priority area	**Key activities**
Preparedness and coordination	Institutionalize district PHEOC and IMS; update preparedness and response plans, SOPs and checklists; conduct regular simulation exercises.
Financing	Develop one plan one budget for cholera and engage all partners and sectors to mobilize resource for cholera preparedness and response
Supplies and logistics	Forecast cholera supplies, maintain emergency stock buffers, preposition supplies in hotspots and distribute supplies to last-mile before rainy season
Laboratory readiness	Procurement of lab supplies; preposition transport media, confirmation supplies, and courier for specimen transportation, have a platform for laboratory result tracking and have a roster of staff to reduce turnaround time.
Surveillance	Conduct review meetings with IDSR/EBS volunteers and HSAs, procure patient registers for cholera to improve line-list completeness, daily reporting should be uploaded in electronic surveillance platforms and conduct data quality reviews to validate data
Workforce capacity	Conduct continuous training, mentorship and supportive supervision for surveillance, laboratory, case management, IPC, WASH and RCCE teams.
Case management	Conduct supportive supervision on CTU/ORP readiness, and check availability of essential case-management supplies. Develop a roster for surge staff for all districts
WASH and RCCE	Conduct WASH promotions and demonstrations, address issues to do with chlorine-use challenges, intensify community engagement and conduct rumor/misinformation management.

OCV preparedness	Request OCV for reactive and preventive campaigns, conduct microplanning, logistics, conduct community mobilization and vaccine acceptance.
Cross-border preparedness	Conduct joint preparedness reviews, deploy staff for PoE surveillance and develop a daily report for timely cross-border information sharing.
Monitoring and accountability	Conduct meeting to review progress in terms of implementation of AAR activities

The AAR showed that Malawi has cholera response capacities, particularly in coordination, surveillance, community engagement and rapid response. However, persistent gaps in financing, logistics, laboratory systems, workforce capacity, infrastructure, data management and multisectoral coordination need to be addressed before the next outbreak. The post-AAR priority should therefore be to institutionalize preparedness, close identified system gaps and regularly monitor implementation of corrective actions.

ACRONYMS

1. AAR	After Action Review
2. CATI	Case Area Targeted Intervention
3. CFR	Case Fatality Rate
4. CHAG	Community Health Action Group
5. CLTS	Community Led Total Sanitation
6. CTC	Cholera Treatment Centre
7. CTU	Cholera Treatment Unit
8. DCT	District Coordination Team
9. DHIS 2	Demographic Health Information System 2
10. DHO	District Health Office
11. DHSS	District Health and Social Services
12. DRRT	District Rapid Response Team
13. eLIM	electronic Laboratory Information Management Systems
14. EPI	Expanded Program on Immunization
15. FRRT	Facility Rapid Response Team
16. IDSR	Integrated Disease Surveillance and Response
17. IHR	International Health Regulations
18. IPC	Infection Prevention and Control
19. IV	Intravenous
20. JBC	Joint Border Committee
21. NRRT	National Rapid Response Team
22. OCV	Oral Cholera Vaccine
23. ORS	Oral Rehydrated Salts
24. OSL	Operations Supplies and Logistics
25. PAMIs	Priority Areas for Multi-Sectoral Interventions

26. PHEMC	Public Health Emergency Management Committee
27. PHEOC	Public Health Emergency Operation Centre
28. PHIM	Public Health Institute of Malawi
29. POE	Points of Entry
30. PPE	Personal Protective Equipment
31. RCCE	Risk Communication and Community Engagement
32. SOPs	Standard Operating Procedures
33. SURGE	Strengthening Utilization Response Group for Emergency
34. WASH	Water Sanitation Hygiene
35. WHO	World Health Organization

1. Background

Cholera remains an important public health threat in Malawi, especially during the rainy season. The 2025–2026 cholera season, occurred following continued transmission of cholera in the country during the preceding year. The outbreak occurred against a background of seasonal cholera transmission associated with the rainy season, inadequate access to safe water and sanitation in some communities, population movement, flooding and other environmental and socioeconomic factors. It occurred within Malawi's existing preparedness and response frameworks, including the Malawi Multi-Sectoral Cholera Control Plan, national cholera preparedness and response plans, the national and district Public Health Emergency Operation Centers (PHEOC).

The first cases were reported on 11 December 2025 from Balaka and Lilongwe Districts and outbreak declaration was on 28 December 2026. The NPHEOC and DPHEOCs were activated through IMS The IMS supported coordination across surveillance, laboratory, case management, IPC, WASH, RCCE, vaccination, operations and logistics, and other response functions. Cumulatively, the country reported 3200 cases, of these 3013 were locally acquired with 25 deaths, (13 facility, 12 community) cases and 187 were imported cases with 2 deaths (1 community ,1 facility). Of the locally acquired cases, 319 were laboratory-confirmed cases and 88 of the imported cases laboratory confirmed. The overall case fatality rate was 0.78%. Eighteen of 29 districts had reported at least one cholera case. The last confirmed cases were reported on 12 June 2026 by Mulanje and Zomba districts, outbreak over declaration was on 30 August, 2026.

Cholera cases by district from 11 December 2025 to 31 August 2026.

Table 1: Cholera cases by district from 11 December 2025 to 31 August 2026

Rank	District	Suspected cases	Confirmed cases	Total cases	Suspected deaths	Confirmed deaths
1	Blantyre	1,029	131	1,160	10	3
2	Chikwawa	514	23	537	5	1
3	Chiradzulu	182	30	212	0	0
4	Neno	164	18	182	0	0
5	Lilongwe	161	5	166	0	0
6	Mulanje	112	32	143	3	1
7	Phalombe	82	3	85	3	0

8	Mwanza	79	17	96	2	0
9	Nsanje	93	14	107	0	0
10	Zomba	55	22	76	1	0
11	Kasungu	66	1	67	0	0
12	Thyolo	48	16	64	0	0
13	Machinga	42	1	43	0	0
14	Balaka	30	2	32	1	0
15	Karonga	9	1	10	0	0
16	Dowa	6	1	7	0	0
17	Chitipa	5	1	6	0	0
18	Dedza	5	0	5	0	0
19	Salima	3	0	3	0	0
20	Likoma	2	0	2	0	0
21	Mchinji	2	0	2	0	0
22	Mzimba South	2	0	2	0	0
23	Mangochi	2	0	2	0	0
24	Mzimba North	1	1	2	0	0
	Totals	**2,694**	**319**	**3,013**	**25**	**5**

Cholera outbreak progression in the country from 11 Dec 2025 to 30 August,2026 2026

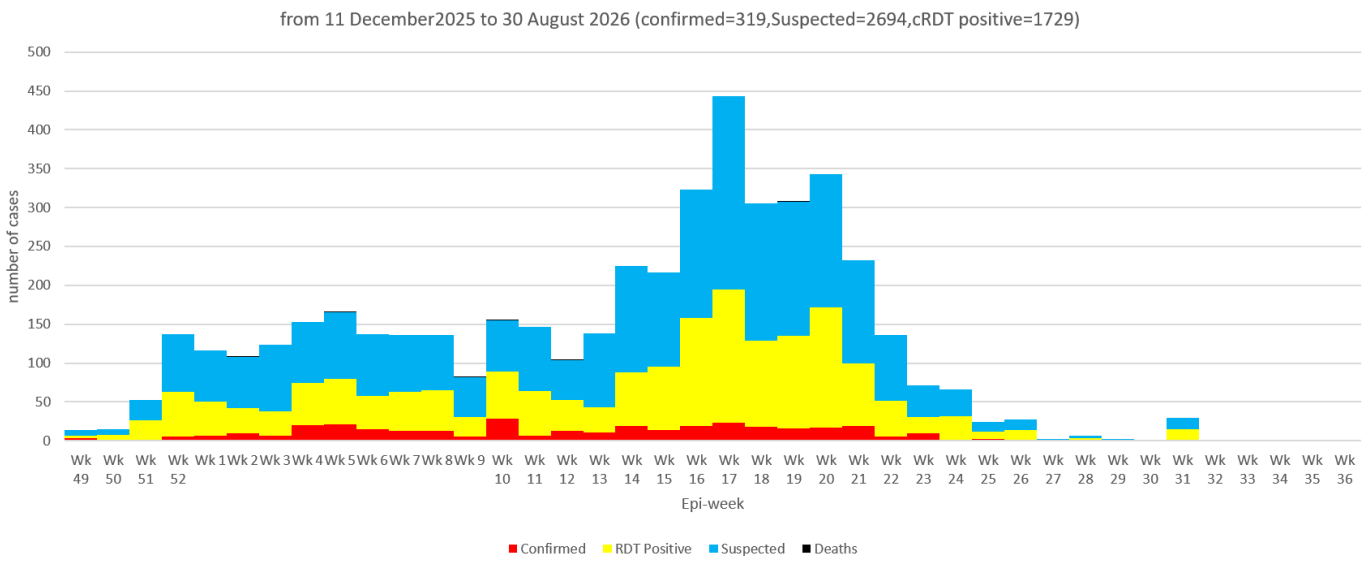


Figure 1: Cholera outbreak progression in the country from 1st Nov 2025 to 31st August 2026

The 2025/26 cholera outbreak was protracted, driven by ongoing person-to-person transmission and persistent environmental contamination of water and sanitation systems.

In December,2025, the cases were very low and sporadic. This was followed by a progressive increase in cases from January to February 2026 reflecting expanding community spread, likely associated with seasonal rainfall and flooding that increased exposure to contaminated water sources.

The country, especially the southern region, received continuous heavy rains from March to April 2026, and the cases increased sharply for both suspected and confirmed cases, and deaths became more frequent, indicating pressure on health services and possible delays in access to timely treatment.

Beyond April ,2026 there was sustained transmission es, due to damaged WASH infrastructure population displacement and poor access to safe water.

Overall, the epidemic curve reflects a high-intensity, expanding outbreak, demonstrating that cholera transmission in Malawi remained active over the reporting period and required sustained, large-scale interventions across all response pillars.

Cumulative cholera deaths from 11 Dec,2025 to-30 August 2026

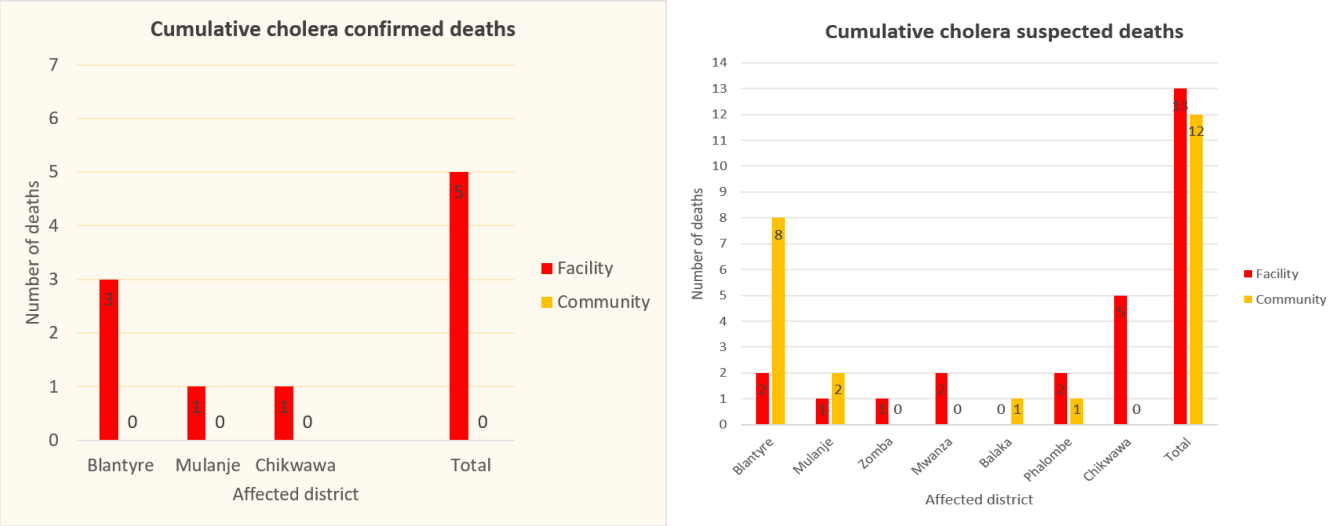


Figure 2: Cumulative cholera deaths from 11 Dec 2025 to 30 August 2026

The graphs above show that 18 deaths occurred at health facilities and 12 occurred at community level. Blantyre reported most of the deaths. Some cases reported very late to the facility with complication and health staff could not manage to provide the required care. Some health care had limited skills in management of severe dehydrated cases. Self-medication, late presentation to the health facility and religious beliefs were some of the causes of community deaths.

The compounding effects of the flooding in southern regions during existing outbreaks that affected implementation of response plans and that placed a significant strain on health service delivery. Despite access to health services, timely provision was impacted due to disruption of essential health services.

The cholera outbreak affected more males and females in the 2025-26. The graph below shows age distribution that cholera cases occurred across all age groups, with the highest burden among young adults aged 20–24 years, followed by those aged 15–19 years, while children aged 0–4 years also represent an important, affected group. More males were affected males (51%)

The concentration among adolescents and young adults suggests the need to strengthen targeted RCCE, safe water, hygiene, and sanitation interventions in settings where these groups interact, while maintaining protection for young children. Therefore, there is need to prioritize age-specific prevention messaging, hotspot-focused WASH interventions, and early care-seeking, with continued surveillance to detect shifts in the affected age groups.

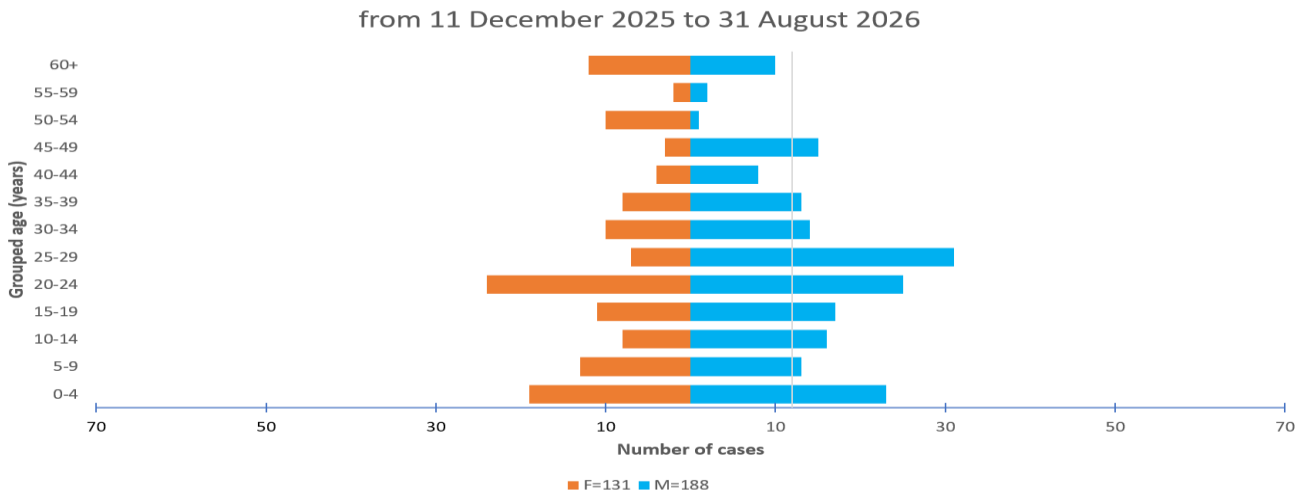


Figure 3: Age distribution of cholera cases across all age groups

1.3 Cholera response Timelines at national level

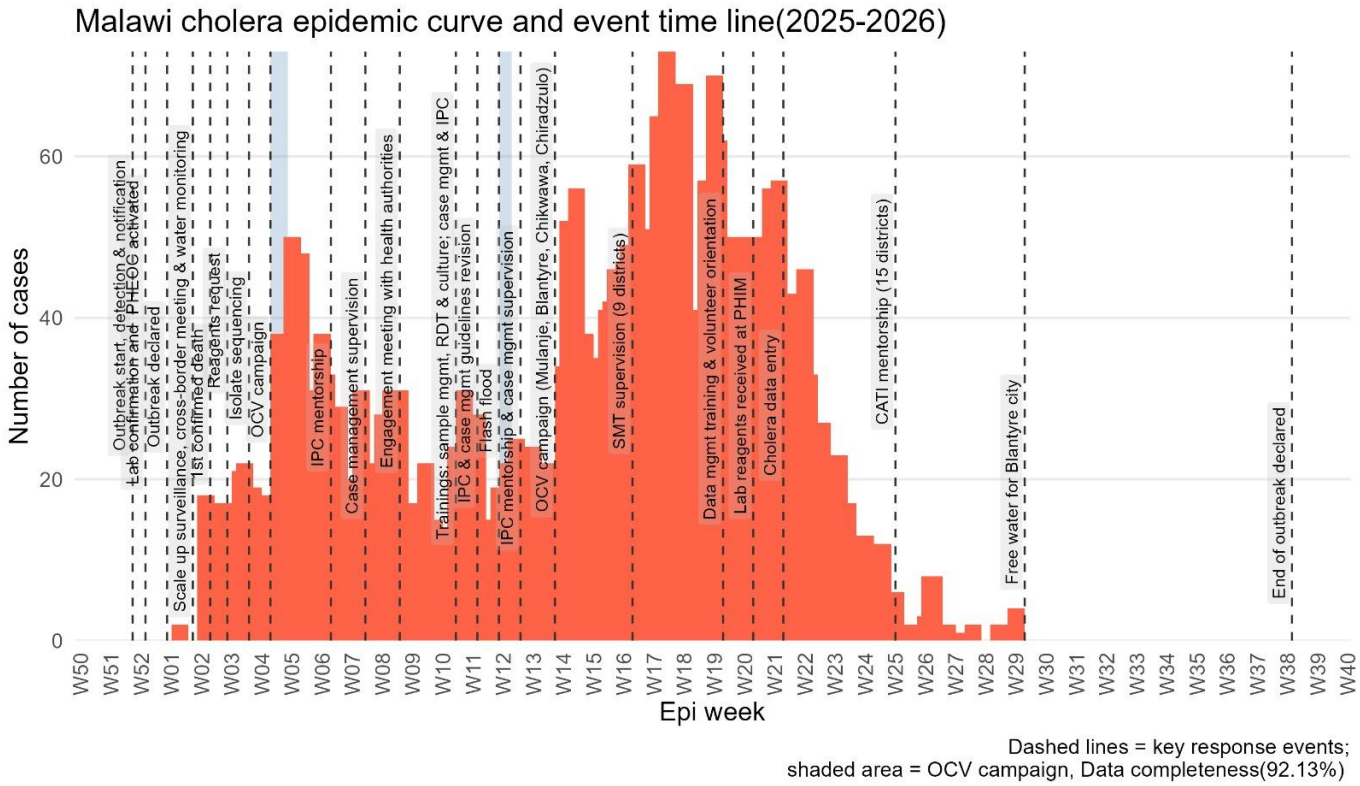


Figure 4: Cholera response Timeliness

2. Purpose and Objectives of AAR

2.1 Purpose

To assess the effectiveness of Malawi's preparedness and response to the 2025–2026 cholera outbreak and identify priority actions for strengthening cholera prevention, preparedness, response, recovery and long-term control

2.2 Objectives

1. Assess the effectiveness and timeliness of Malawi's cholera preparedness, detection, coordination and response at national, district and community levels during the 2025–2026 outbreak.
2. Identify strengths, weaknesses, challenges and best practices across key response functions, including surveillance, laboratory, case management, IPC, WASH, RCCE, OCV, logistics, coordination and resource mobilization.
3. Document lessons learnt and determined the underlying factors that enabled or constrained effective implementation of cholera prevention and response interventions.
4. Develop a prioritized corrective action plan with clear responsibilities, timelines and measurable actions to strengthen Malawi's cholera prevention, preparedness, response and recovery for future outbreaks.
5. Generate evidence to inform review and updating of Malawi's cholera preparedness and response plans and the Cholera Elimination Roadmap

3. Scope and Methodology

The review covered preparedness activities, outbreak response and the transition from response to the end of the outbreak. It used a qualitative, participatory AAR approach informed by WHO AAR guidance and facilitator/participant materials. Participants represented government ministries and departments, districts, and partners involved in the response.

Working groups reviewed five functional areas: coordination, surveillance cross-border collaboration/Points of Entry and laboratory, case management and IPC, vaccination and operations, support and logistics, WASH and RCCE. Facilitated group work, presentations, discussion and consensus-building were used to identify preparedness status, response actions, enabling factors, challenges and corrective actions.

The cholera AAR was conducted in three days and covered five sessions. Facilitators' briefing took place two days before the review

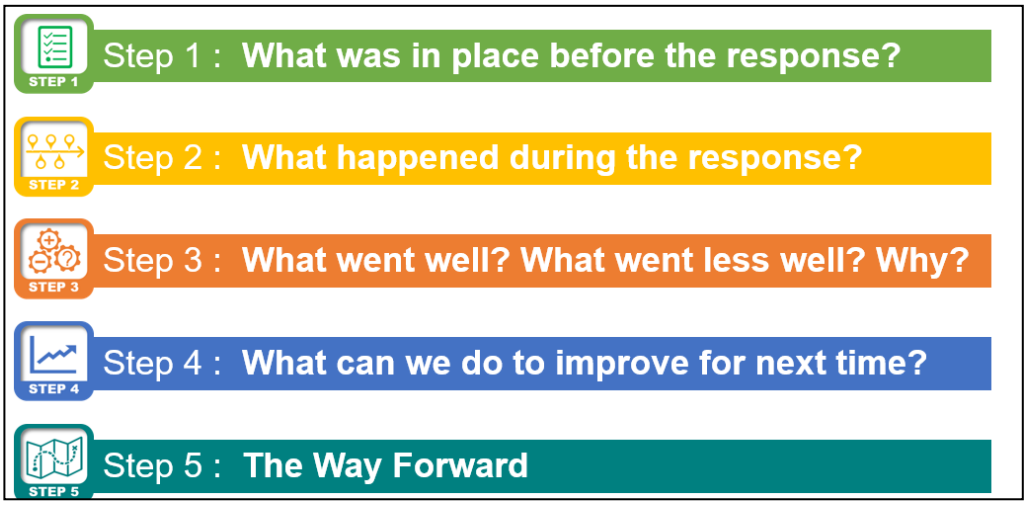


Figure 5: An AAR 5 steps

4. Key Findings

Below are the key findings from the response pillars highlighting resources and functionality of systems that were in place prior to the outbreak (plans and procedures, coordination mechanism, resources, preparedness activities etc.), timelines, best practices, challenges, and activities for implementation. Findings were obtained from the five working groups highlighted above.

4.1 COORDINATION

This function assessed the strategic, tactical and operational coordination of the cholera response, including the activation and functionality of the PHEOCs. It examined coordination among government sectors, partners and stakeholders, focusing on information sharing, resource mobilization, decision-making, role clarity and implementation of response activities. The review also assessed the effectiveness of coordination mechanisms at national, district and community levels in facilitating a timely, integrated and effective response.

Table below shows what was in place before the outbreak for coordination

PLANS/ POLICIES	RESOURCES	OTHER
• National Cholera preparedness and response plan 2025-2026 • District Cholera preparedness and response plans;2025-26 • District Multi-Hazard Contingency Plan- Overarch all emergencies, Championed by DODMA • Malawi Multi-Hazard Emergency Response plan- concentrate on Public Health sector • Cholera manual for health workers • NPHEOC handbook • Disaster management act • Health Sector Strategic Plan (HSSPIII) • District Implementation Plans (DIPs) • PAMI booklet	• Human Resource-Incident managers, epidemiology officers, surveillance coordinators, data officers, planning officers, nurses, clinicians, environmental health officers, HSAS, volunteers, Health Promotion Officers, logistic officers both at PHIM and in the districts • Cholera supplies • Finances/Funding-Budget line for ORT at ministry level, PHIM and districts • Vehicles and infrastructure (CTUs and CTCs) • Health facilities	
COORDINATION MECHANISMS	**PREPAREDNESS ACTIVITIES**	
• National Health cluster WhatsApp groups for coordination • IDSR coordination group • Cholera IMT WhatsApp forum	• Distribution of cholera supplies to all districts • Cholera readiness and supportive supervision • Cholera readiness checklist-completed	

• PHEMC WhatsApp group; at district level • Cross-border committees and WhatsApp forums	• Training of EBS volunteers and community health workers for early detection • Capacity building of health workers in case management and detection • Partner mapping for coordination (5Ws) • Cross-border meetings	

The table below summarizes the best practices before and during outbreaks

BEST PRACTICES FOR COORDINATION		
BEST PRACTICES	**IMPACT/S**	**ENABLING FACTORS**
1. Strong linkage between National and District IMTs held weekly, meetings with disseminated contact lists, and. informal communication platforms alongside formal PHEOC reporting.	• Faster identification and resolution of critical gaps in supplies, staffing, WASH, and other logistics. • Reduced delays in information flow and allowed emerging issues to be addressed before formal reports were finalized	• Strong relationships between national and district teams; accessible leadership; functional communication channels. • Widespread access to mobile phones; responsive technical teams; established professional networks
2. Scheduled deep dive meetings highlighted critical gaps, linking epidemiological information directly to operational coordination decisions. Changes in case trends and hotspot locations were mapped alongside operational needs to determine where additional support was required.	• Improved prioritization of resources and interventions towards areas experiencing increased transmission.	• Availability of surveillance data; epidemiological expertise; regular technical discussions.

3. Flexible redistribution of available resources between affected districts. Resources were redirected according to changing outbreak needs rather than remaining strictly within the original allocation.	• Enabled districts with emerging needs to receive additional support and reduced delays caused by fixed resource allocations.	• Partner flexibility; national oversight; communication between districts and national structures.
4.Partner mapping and use of existing partner networks and relationships both at national and district levels to rapidly mobilize support during emerging needs	• Reduced the time required to identify technical and operational support and contributed to continuity of response activities.	• Established partnerships; trust between government and partners; experienced coordination teams.

CHALLENGES FOR COORDINATION		
CHALLENGES	**IMPACT**	**LIMITING FACTORS**
1. Insufficient emergency financing	• Delayed or reduced preparedness, training, supervision and response activities.	• Limited dedicated cholera funds and dependence on partner funding.
2. Inadequate follow-up of IMT action points	• Some agreed actions were delayed or not fully implemented, reducing accountability and the effectiveness of coordination meetings.	• Heavy workloads, competing priorities, unclear ownership of some actions and limited action-tracking mechanisms. • Limited incorporation of monitoring and evaluation in the IMS

3. Weak multisectoral coordination at operational level	• WASH, community health, environmental health and community interventions were not always implemented in a sufficiently integrated manner, contributing to continued transmission in some hotspots.	• Different sector mandates, priorities, planning cycles and resource constraints.
4. Uneven coordination capacity intra district, inter-district; cross-border and partner involvement	• Differences in the speed and quality of response implementation, resulting in variable performance between districts. • Increased difficulty in monitoring population movement and responding to cases or risks occurring across administrative boundaries. • Potential duplication of activities in some areas and gaps in others, particularly where partner activities were not fully aligned with district priorities	• Limited trained staff, staff turnover, competing routine responsibilities and differences in district resources and experience. • Population mobility, different administrative structures, and variable information-sharing mechanisms. • Multiple partners, different funding streams, reporting requirements and implementation timelines

4.1.1 ACTIVITIES FOR COORDINATION

ACTIVITY	DATE OF DESIRED ACHIEVEMENT	RESPONSIBLE AND FOCAL POINT	INDICATORS	IMPACT Mark either +, ++ or +++	DIFFICULTY Mark either +, ++ or +++	PRIORITY # dots allocated
1. Conduct partner meetings to mobilise financial resources for cholera preparedness and response based on costed plans	15 Oct,2026, ongoing monthly	PHIM	Number of partners meetings conducted	+++	+++	●●●
2. Conduct partner resource-mapping linking partner support to identified districts and national response gaps.	15 Oct,2026 Ongoing, monthly	PHIM/MoH Coordination Unit; Partner Coordination focal person	Updated partner/resource map; % of identified gaps linked to a partner/support mechanism	+++	+++	●●●
3. Conduct regular joint operational reviews involving Health, WASH, Environmental Health, Water, Local Government and other relevant sectors	Oct 2026 ongoing, monthly	PHIM/MoH; WASH and Environmental Health focal persons	Number of districts conducting multisectoral reviews;	+++	++	●●●

			% of agreed joint actions implemented Number of SOPs			
4. Conduct refresher training and mentorship on PHEOC/IMS coordination, action tracking, and operational decision-making.	30 November, 2026	PHEOC Managers	Number of districts trained/mentored ; % of targeted districts meeting minimum coordination standards	+++	++	●●●
5. Establish IMS action tracking system to document decisions, responsible people, timelines and completion status from national and district coordination meetings.	30 October, 2026	Research pillar	Established tracking system	+++	++	●●
6. Conduct regular national, district coordination meetings using epidemiological and operational data to guide resource allocation and response prioritization.	Weekly during outbreaks	Incident Manager/PHEOC; Surveillance and Planning focal persons	Number of data-driven coordination reviews conducted % of decisions linked to	+++	++	●●

			identified epidemiological/ operational risks			
7. Train district staff on integrated cholera response	Nov 2027	National Operation Chief	Number of district staff trained	+++	++	●●

4.2 SURVEILLANCE AND LABORATORY

The review assessed cholera surveillance functions, including case detection and notification, active case finding, IDSR reporting, data collection and analysis, outbreak investigation, hotspot identification, and epidemiological monitoring. It also assessed laboratory functions, including specimen collection, packaging and transportation, testing and confirmation, turnaround time, quality assurance and reporting of laboratory results.

The review further examined how surveillance and laboratory information are integrated to support timely outbreak detection, confirmation, risk assessment, decision-making, and targeting response interventions.

PLANS/POLICIES	RESOURCES	OTHER
• Budget line for response in District plans • SOPs for sample collection • Cholera contingency plan • EBS guidelines • District multi-hazard plan • IDSR Technical guidelines • District PHEOC handbook • PAMI booklet	• Reporting tools • Trained health care workers • Standard case definitions and EBS signals • Laboratory supplies • Transport (G4S, fuel) • Surveillance and lab infrastructure and equipment	Partner support
COORDINATION MECHANISM	**PREPAREDNESS ACTIVITIES**	

• District Public Health Emergency Rapid Response Team (DPHRRT) • Public Health Emergency Management Committee (PHEMC) WhatsApp group • IDSR coordination WhatsApp group	• Distribution of lab supplies • Risk mapping • PHEOC training • Surveillance meetings • IDSR and EBS trainings • Training trainers on cholera Rapid Diagnostic Testing • Resource mapping and mobilization	

BEST PRACTICES FOR SURVEILLANCE AND LABORATORY		
BEST PRACTICES	**IMPACT/S**	**ENABLING FACTORS**
1. Use of multiple communication channels to rapidly escalate cholera alerts, including telephone and digital platforms alongside formal IDSR reporting.	• Reduced delays in communicating alerts and facilitated faster verification and response.	• Mobile phone access established professional networks and availability of IDSR focal persons in all health facilities, responsive surveillance teams.
2. Closer linkage of epidemiological data with operational decision-making, particularly for identifying persistent transmission areas and emerging hotspots.	• Supported prioritization of investigations, active case finding and response resources to higher-risk areas.	• Availability of surveillance data, experienced epidemiologists and regular technical reviews.
3. Use of active case finding and community-level reporting to complement routine facility-based surveillance.	• Improved identification of suspected cases that might otherwise have been missed	• Community health structures; trained EBS volunteers, trained

	through passive surveillance alone.	surveillance personnel and community engagement.
4. Integration of information on surveillance, WASH and environment in areas experiencing persistent transmission.	• Improved understanding of potential transmission drivers and supported more targeted interventions.	• Multisectoral collaboration, hotspot information and availability of environmental/WASH data.
5. Timely communication between district surveillance teams and laboratory personnel for urgent specimen collection and results.	• Supported faster confirmation and improved linkage between surveillance and laboratory pillars	• Good working relationship between laboratory and surveillance, communication access and committed staff.

CHALLENGES FOR SURVEILLANCE AND LABORATORY		
CHALLENGES	**IMPACT**	**LIMITING FACTORS**
1. Gaps in lab readiness and specimen referral	• Delayed confirmation and incomplete surveillance information.	• Transport media gaps, transport delays, long distances, limited capacity and weak result tracking.
2. Incomplete surveillance data and weak data reconciliation	• Reduced ability to characterize transmission and monitor response.	• Delayed reporting, weak laboratory-surveillance linkage and limited use of electronic systems.
3. Limited human and operational resources for surveillance	• Reduced frequency of active case finding, supervision, data analysis and field	• Staff shortages, competing emergencies, limited transport, funding constraints and large geographic areas.

	investigations, particularly in high-burden areas.	
4. Limited laboratory capacity at peripheral and district levels	• Increased dependence on referral laboratories and potential delays in confirmation during periods of increased demand.	5. Limited supplies /equipment, trained personnel, infrastructure and quality-assurance capacity at peripheral and district levels
5.Gaps in specimen collection, packaging and documentation in some facilities	• Poor quality or rejected specimens, repeat collection and delays in obtaining reliable laboratory results.	• Variable adherence to procedures, limited refresher training, high workload, and inadequate supervision.
6. Delays and inconsistencies in surveillance reporting from some facilities and districts	• Delayed situational awareness, verification of alerts and identification of emerging hotspots.	• Heavy workload, staff shortages, multiple reporting requirements and connectivity challenges
7. Cross-border coordination gaps.	• Risk of increased cross-border cases	• Inconsistent coordination mechanisms and communication

4.2.1 ACTIVITIES FOR SURVEILLANCE AND LABORATORY

ACTIVITY	DATE OF DESIRED ACHIEVEMENT	RESPONSIBLE AND FOCAL POINT	INDICATORS	IMPACT Mark either +, ++ or +++	DIFFICULTY Mark either +, ++ or +++	PRIORITY # dots allocated
1. Conduct active case finding in the communities, especially in cholera hotspots	Nov,2026 and ongoing	PHIM + District Health Offices – Surveillance focal persons	Number of hotspot districts conducting active case finding; number of alerts generated and investigated	+++	++	●●●
2. Print and distribute disease outbreak booklets (line lists)	Oct,2026	PHIM + District Health Offices – Surveillance focal persons	Number of copies printed Number of health facilities with disease outbreak booklets	+++	++	●●●

3. Mentorship on data management (from data capturing to analysis)	Oct 2026	PHIM DISTRICT	Number of officers mentored per district	+++	++	●●●
4. Procure and pre-position essential cholera laboratory supplies and consumables before and during the cholera season.	Oct, 30	NPHL + Procurement/Logistics – Laboratory commodities focal person	% availability of essential laboratory supplies; number of stock-out days	+++	++	●●●
5. Cascade training on national cholera (GTFCC) Testing guidelines	17 November 2026	PHIM LAB	Number of trained staff on national cholera testing guidelines	+++	++	●●●
6. Establish a platform for tracking of laboratory turnaround time for cholera testing and communication of results to surveillance teams.	November 2026	NPHL/Laboratory Services – Laboratory focal person	Availability of a tracking platform Median laboratory turnaround time; % results communicated within agreed timeframe	+++	++	●●●
7. Mentor staff on specimen collection, packaging, storage and transportation	November 2026	NPHL + PHIM + District Health Offices		+++	++	●●●

from districts to designated laboratories.		– Laboratory/Surveillance focal persons	Number of staff of mentored per district			
8. Conduct routine surveillance data-quality checks and feedback mechanisms at national and district levels.	November and ongoing	PHIM Surveillance/Data Management Unit – Data quality focal person	Number of data quality sessions conducted number of feedback sessions conducted	+++	++	●●
9. Procure airtime for IDSR focal, IDSR data managers, lab managers, DPHERRT, cluster supervisors	30th October 2026	IDSR Coordinator	Number of officers provided with airtime	++	+	●●●
10. Conduct cross-border coordination meetings	Nov 2026	Cross-border surveillance officer	Number of meetings conducted	++	+	●●●

4.3 CASE MANAGEMENT AND IPC

The review assessed the capacity to provide timely and quality cholera case management, including early recognition, triage, referral, rehydration, antibiotic treatment where needed, monitoring of patients, management of severe cases and clinical outcomes. It also examined the availability and functionality of cholera treatment centers and oral rehydration points, trained health workers, clinical guidelines, essential medicines, supplies and referral systems. The review also assessed implementation of IPC measures in health facilities and cholera treatment settings, including hand hygiene, use of appropriate PPE, environmental cleaning and disinfection, safe handling of body fluids and contaminated materials, waste management, patient isolation and safe movement of patients and health workers. It also assessed availability of IPC supplies, adherence to standard precautions, IPC training and supervision, and measures to prevent health care acquired transmission.

PLANS/POLICIES	RESOURCES	OTHER
• IPC and Case management guidelines. • District Cholera response plan (Blantyre, Chiradzulu, and Nsanje) 2025/2026 • Cholera manual for Health Care Workers 2024 • GTFCC guidelines for case management and IPC 2024 • CTU and CTCs SOPs. • Oral Rehydration Point guidelines	• Basic IPC supplies like Gloves, Aprons, and Masks • Case management supplies like ORS, IV fluids • Human resources	• Allocation of staff to CTCs.
COORDINATION MECHANISM	**PREPAREDNESS ACTIVITIES**	
• Bi-weekly IPC coordination meetings. • Public Health Emergency Management committee meetings • District Rapid Response Team meetings	• Pasting of relevant Standard Operation Procedures in Cholera Treatment Units (CTUs). • Development of Cholera response plan. • Partner mapping • Mobilization of resources from Ministry of Health and partners • Setting up isolation units. • Needs assessment for CTU	

BEST PRACTICES FOR CASE MANAGEMENT AND IPC		
BEST PRACTICES	**IMPACT/S**	**ENABLING FACTORS**

1. Use of existing health facilities and temporary spaces to rapidly expand cholera treatment capacity where required.	• Increased access to treatment without waiting for construction of permanent facilities.	• Availability of existing infrastructure, local leadership and partner support.
2. Integration of case management and IPC teams during supervision and mentorship.	• Reduced the risk of healthcare-associated transmission.	• Multidisciplinary teams, experienced supervisors and collaboration between clinical and IPC staff.
3. Use of ORPs closer to affected communities and treatment facilities to provide early rehydration and facilitate referral of severe cases.	• Reduced severe cases and deaths.	• Availability of trained health workers, community volunteers, supplies and district-level coordination.
4. Use of practical on-site coaching and mentorship rather than relying only on classroom training.	• Improved health workers' ability to apply rehydration, triage, PPE use, environmental cleaning and other procedures correctly.	• Experienced experts from Central Hospitals • Availability of Clinical/IPC teams. • Availability of funds for supportive supervision and availability of treatment sites.
5. Use of rapid communication between treatment facilities and district coordination teams to escalate clinical, staffing, commodity and IPC gaps. 6. Rapid redistribution of available cholera treatment and IPC supplies between facilities according to need.	• Faster resolution of critical operational problems affecting patient care and safety. • Reduced the effect of localized shortages and maintained	• Mobile communication, responsive district teams and established coordination structures. • District coordination, commodity visibility and flexibility of facilities, partners/supply teams.

	continuity of patient care and infection prevention measures.	

CHALLENGES FOR CASE MANAGEMENT AND IPC		
CHALLENGES	**IMPACT**	**LIMITING FACTORS**
1. Inadequate availability of trained case-management and IPC personnel in some affected facilities	Increased workload, reduced quality of patient care and inconsistent application of IPC measures.	• Staff turnover(attrition), competing health priorities, workload and limited surge capacity
2. Inconsistent availability of essential case-management and IPC supplies .	Delays or interruptions in treatment and reduced adherence to IPC measures, increased the risk of healthcare-associated transmission	• Procurement delays, funding gaps, supply-chain challenges and dependence on partner support.
3. Delays in referral and access to appropriate cholera treatment	Delayed rehydration and management of severe cases, potentially contributing to complications and deaths.	• Transport constraints, geographical barriers, poor road access and limited community resources.
4. Variable adherence to IPC and WASH practices in some facilities	Increased risk of transmission among patients, caregivers and health workers.	• High workload, inadequate supervision, limited supplies, infrastructure constraints and inconsistent refresher training. • Inadequate WASH infrastructure in some treatment facilities

		• Water shortages, inadequate sanitation infrastructure, limited funding and unreliable water supply
5. Limited space and infrastructure for appropriate patient separation	Increased risk of cross-transmission and challenges in managing patient flow during periods of high caseload.	• Overcrowded facilities, limited dedicated treatment spaces and rapid increases in admissions.
6. Variable quality and timeliness of clinical monitoring and documentation	Increased CFR Prolonged stay in CTUs and CTCs	• High patient workload, staff shortages, incomplete records and competing responsibilities.
7. Limited routine monitoring and feedback on IPC compliance	Increased transmission of infections acquired within the treatment facilities	• Limited IPC supervision capacity, competing priorities and inadequate monitoring tools.

4.3.1 ACTIVITIES FOR CASE MANAGEMENT AND IPC

ACTIVITY	DATE OF DESIRED ACHIEVEMENT	RESPONSIBLE AND FOCAL POINT	INDICATORS	IMPACT Mark either +, ++ or +++	DIFFICULTY Mark either +, ++ or +++	PRIORITY # dots allocated
1. Map, establish and supervise ORPs and provide supplies to ensure early rehydration	Oct 2026	District Health Offices – Case Management focal person	Number of functional ORPs; % severe cases referred within	+++	++	●●●

and timely referral of severe cases.			agreed timeframe			
2. Pre-position essential cholera treatment commodities and IPC supplies at identified high-risk facilities, ORPs, and districts.	Oct 2026	National and district Logistics focal persons	% priority facilities with minimum stock; number of stock-out days	+++	++	●●●
3. Conduct a national and district readiness assessment of cholera case-management and IPC capacity before the cholera season.	Nov 2026	PHIM/MoH – Case Management & IPC focal persons	% targeted facilities assessed; % identified gaps addressed	+++	++	●●●
4. Provide safe water, sanitation, hand-hygiene facilities and waste-management systems in CTCs/CTUs and ORPs.	Nov,2026	District Health Offices WASH/IPC teams – IPC focal person	% treatment sites meeting minimum WASH/IPC standards	+++	++	●●●
5. Develop a cholera case-management and IPC surge plan covering staffing, treatment space, supplies, referral and supervision.	Nov 2026 and ongoing	MoH/PHIM – Case Management & IPC leads	Approved surge plan; evidence of annual review/simulation	+++	++	●●●

6. Orient staff on clinical monitoring and documentation of cholera patients, including dehydration status, treatment, referral and outcomes.	Nov 2026, ongoing	Case Management focal persons/Facility in-charges	% patient records meeting minimum documentation standards; case fatality rate	+++	++	●●
7. Conduct joint Case Management–IPC–WASH reviews during outbreaks to identify and address risks of healthcare-associated transmission.	Monthly during outbreaks	PHIM/MoH + Districts – Case Management, IPC & WASH focal persons	Number of joint reviews conducted; % corrective actions completed	++	++	●●
8. Conduct targeted mentorship and supervision on case management and IPC	30 October 2026 - onwards	Case Management and IPC coordinators	Number of targeted mentorship and supervision conducted	+++	++	●●●

4.4 WASH AND RCCE

The review assessed RCCE functions, including dissemination of key cholera prevention messages, community feedback mechanisms, and engagement with community leaders and structures. It examined the timeliness, consistency and reach of RCCE activities, including the use of different communication channels and approaches for high-risk and affected communities.

For WASH, the review assessed access to safe water, household water treatment, sanitation, hygiene promotion, environmental cleaning, waste management and WASH interventions in cholera hotspots. It also assessed coordination, targeting, monitoring and timeliness of RCCE and WASH interventions and their contribution to reducing cholera transmission and promoting early care-seeking and preventive practices.

PLANS/ POLICIES	RESOURCES	OTHER
• National Cholera preparedness and response plan 2025-2026 • District Cholera preparedness and response plans;2025-26 • District Multi-Hazard Contingency Plan- overarching all emergencies, championed by DODMA • Malawi Multi-Hazard Emergency Response plan-concentrate on Public Health sector • Cholera manual for health workers • NPHEOC handbook • National risk communication and community engagement guidance; district RCCE preparedness plans • District Implementation Plans (DIPs • PAMI booklet	• Environmental health officers, water and sanitation specialists, health surveillance assistants, WASH partner staff and community volunteers. • Chlorine and water-treatment supplies, water-quality testing kits, handwashing facilities, PPE, sanitation materials, waste-management supplies and hygiene-promotion materials. • Vehicles/motorcycles for water-quality monitoring, hotspot assessments, supervision and emergency WASH interventions. • WASH hotspot maps, water-source information, sanitation data and community risk information. • Water-quality testing capacity, including chlorine/residual chlorine and microbiological testing where applicable • Health promotion officers, HSAs, community volunteers, traditional and religious leaders, CSOs and partner communication teams. • Community radios, national radio/TV, mobile phones, social media, community meetings, religious gatherings, traditional leadership structures and health facilities.	

	• Cholera message guides, frequently asked questions, rumour-management tools, community feedback tools and communication checklists • Vehicles/motorcycles, mobile phones, airtime/data, megaphones/public-address systems and other equipment required for community mobilisation and communication.	
COORDINATION MECHANISMS	**PREPAREDNESS ACTIVITIES**	
• National RCCE TWG WhatsApp group • Health Journalist WhatsApp group • Cholera IMT WhatsApp forum • PHEMC WhatsApp group; at district level • WASH cluster WhatsApp group • WESNET WhatsApp forum	• Development and pre-testing of key cholera messages; identification of priority audiences and communication channels • Orientation/training of RCCE personnel and community volunteers; • Mapping of community structures; • Distribution of IEC materials. • Assessment of water and sanitation risks; pre-positioning of chlorine, water-treatment supplies and WASH commodities; • Identification of alternative water sources; preparation of emergency WASH interventions; hygiene promotion; WASH readiness assessments.	

BEST PRACTICES FOR WASH AND RCCE		
BEST PRACTICES	**IMPACT/S**	**ENABLING FACTORS**
1. Qualitative rapid RCCE assessments in affected and high-risk communities to identify knowledge gaps, perceptions, misinformation, behaviors, barriers to	• Improved targeting of communication activities and identification of priority groups;	• Availability of trained RCCE personnel and community health workers

safe water and hygiene practices, and factors affecting care-seeking.		• Availability of communication resources and partner support.
2. Adaptation of RCCE messages to hotspot-specific risks and community concerns.	• Made messages more relevant to local water, sanitation, hygiene and care-seeking challenges and improved community engagement.	• Local knowledge, community feedback and involvement of district RCCE teams.
3. Provision of free water to vulnerable populations in Blantyre, particularly communities experiencing water shortages, low water pressure and affordability barriers during the cholera outbreak.	• Improved access to safe water and contributed to the use of safe water for domestic purposes.	• Collaboration between the health sector, water utility, local authorities and partners; identification of vulnerable/high-risk communities; partner support; and coordination through the cholera response/IMS structures.
4. Installation and use of chlorine dispensers at community water points to enable users to chlorinate drinking water at the point of collection.	• Improved access to treated water at community level; increased household water treatment practices; reduced the risk of consuming contaminated water;	• Availability of chlorine and functional dispensers; identification of high-risk water points; WASH partner and district support; community engagement and sensitisation; involvement of water-point committees/volunteers; regular monitoring and replenishment of chlorine; and coordination between health, water and environmental health teams.

5. Strong collaboration between WASH and RCCE Partners	• Mobilized WASH supplies and supported RCCE activities	• Availability of WASH and RCCE partners

4.4.1 CHALLENGES FOR WASH AND RCCE

WASH AND RCCE ACTIVTIES						
ACTIVITY	**DATE OF DESIRED ACHIEVEMENT**	**RESPONSIBLE AND FOCAL POINT**	**INDICATORS**	**IMPACT** Mark either +, ++ or +++	**DIFFICULTY** Mark either +, ++ or +++	**PRIORITY** # dots allocated
1. Procure and pre-position adequate chlorine, water-treatment products and essential WASH supplies at national, district and hotspot levels.	1 Oct 2026	Water Supply focal points at National and district level	% of districts with minimum WASH buffer stocks; stock-out rate	+++	++	●●●
2. Installation, monitoring, maintenance and replenishment of chlorine dispensers at priority community water points.	1 Oct ,2026	District WASH focal person	% of priority water points with functional dispensers and adequate chlorine; frequency of monitoring	+++	++	●●●

3. Develop and maintain district-level emergency WASH response plans, including rapid water supply, sanitation, hygiene and chlorine distribution mechanisms.	1 Oct, 2026	District Councils, MoH/PHIM, Water Sector and WASH partners	% of high-risk districts with updated emergency WASH plans and response arrangements	+++	++	●●●
4. Conduct community engagement through HSAs, community volunteers, traditional religious leaders, schools and other community structures on household water treatment, safe water storage, hand hygiene and sanitation practices.	30 Oct 2026	Health Promotion/RCCE, Environmental Health, HSAs, community leaders and WASH partners	% of targeted communities receiving WASH prevention messages; % of households practicing recommended measures	++	+	●●●
5. Develop and regularly update a national and district RCCE preparedness plan, including priority audiences, communication channels, key messages and response triggers.	Before the next cholera season	MoH/PHIM Health Promotion & RCCE; District Health Promotion Focal Points	% of high-risk districts with updated RCCE plans	+++	++	●●●

6. Conduct rapid RCCE risk assessment mechanisms to identify community perceptions, knowledge gaps, rumors, misinformation and barriers to prevention and care-seeking.	Within 48–72 hours of hotspot identification and continuously during outbreaks	Health Promotion/ HSAs	% of priority hotspots with completed RCCE risk assessments	+++	++	●●●
7. Pre-position RCCE materials and communication resources at national and district levels before the cholera season.	At least 3 months before cholera season	MoH/PHIM, District Health Offices and partners; RCCE/logistics focal points	% of high-risk districts with minimum RCCE materials available	++	++	●●
8. Conduct community dialogues with HSAs and community leaders for community feedback and accountability mechanisms	Continuous; reviewed monthly during outbreaks	RCCE/Health Promotion, District Health Offices, HSAs, community leaders and CSOs	Number of feedback reports received, analysed and acted upon	+++	++	●●●

9. Conduct targeted RCCE for vulnerable and underserved groups, including people in informal settlements, flood-affected communities, women, children, older persons and persons with disabilities.	Within 72 hours of identifying high-risk groups	District RCCE/Health Promotion, HSAs, CSOs and community leaders	% of identified vulnerable groups reached with tailored RCCE interventions	+++	++	●●●
10. Conduct media engagement	Before and throughout cholera season	National Health Promotion officer	Number/% of priority communities reached through at least two communication channels	++	++	●●

4.5 ORAL CHOLERA VACCINATION AND OPERATIONS/LOGISTICS

The review assessed oral cholera vaccination (OCV) functions, including microplanning, target population identification, vaccine allocation, cold-chain management, community mobilization, vaccine administration, coverage monitoring, adverse event surveillance, and reporting. It also assessed the availability and management of essential supplies, including forecasting, quantification, procurement, pre-positioning, storage, distribution, stock monitoring and replenishment of cholera response commodities. The review examined logistics and supply-chain coordination, including transportation, last-mile distribution, inventory management, communication and coordination among national, district and partner structures. It further assessed the timeliness, adequacy and effectiveness of OCV and logistics systems in ensuring that vaccines and essential commodities reached priority populations and response sites when needed.

PLANS/PROCEDURES	RESOURCES	OTHER

➢ Training Manual on OCV ➢ OCV application to ICG ➢ National immunization strategy (NIS) ➢ Distribution plan for supplies and vaccines ➢ Procurement plan ➢ Advocacy ➢ Cholera control plan ➢ Budgeting, MHCLS(SOP) guidelines ➢ MoH/PHIM procurement, warehousing, inventory and distribution procedures. ➢ PAMI booklet	➢ GAVI funding for reactive and preventive campaigns ➢ PPEs, ➢ Vaccines ➢ Human resources ➢ Drug budget under MOH ➢ Cold chain equipment, ➢ Transport (vehicles, boats) ➢ IEC materials ➢ Tents ➢ Cholera beds and mobile toilets ➢ Drug and supplies (HTH, DCN, ORS Cannula, ➢ lingers lactate). ➢ Normal saline ➢ Reporting tools ➢ PHEMIC PHIM EPI	➢ IHR
COORDINATION MECHANISM	**PREPAREDNESS ACTIVIIES**	
➢ PHEMC ➢ MAITAG	➢ Procurement of supplies ➢ Propositioning of supplies	

➢ PMRA ➢ Pharmaceuticals division (MOH) ➢ Cross-border meetings ➢ DTC (Drug and therapeutics Committee) ➢ Cluster Meetings	➢ Training of health workers ➢ Stock status analysis ➢ Stakeholders meeting ➢ OCV application ➢ Quantification ➢ Partners support meetings	

BEST PRACTICES FOR OCV AND OSL		
BEST PRACTICES	**IMPACT/S**	**ENABLING FACTORS**
1. Pre-positioning of essential cholera commodities in high-risk areas	• Reduced delays in accessing critical supplies and enabled faster initiation and continuity of response activities.	• Risk-based planning, commodity forecasting, partner support, available storage facilities and coordination through the preparedness and response structures.
2. Rapid redistribution of commodities between districts according to changing needs	• Helped address localized shortages and ensured available supplies were directed to areas experiencing increased caseloads or operational needs.	• Real-time information on stock and caseloads, coordination among districts and partners, flexible logistics arrangements and transport availability.
3. Rapid mobilization of supplies through government and partners	• Enabled critical gaps in commodities, transport and operational resources to be addressed more quickly during the response.	• Existing government-partner relationships, emergency coordination mechanisms, partner

		resources and rapid communication channels.
4. Use of local/community structures to support distribution of selected WASH and prevention commodities	• Improved reach of preventive supplies to vulnerable and hard-to-reach populations	• Community leadership, HSAs, volunteers, established community structures and partner support.
5. Administration of reactive OCV to identified high-risk hotspots	• Reduced cholera cases in the targeted areas	• Availability of vaccine, government/partner coordination and expedited microplanning. • PHEOC/IMS coordination, multisectoral collaboration, epidemiological information and partner engagement

CHALLENGES FOR OCV AND OSL		
CHALLENGES	**IMPACT**	**LIMITING FACTORS**
1. Delays in procurement and delivery of essential commodities	• Delayed availability of critical supplies at treatment and response sites, potentially affecting continuity of response activities.	• Procurement procedures, funding gaps, supplier lead times and dependence on partner support.

2. Inadequate or uneven availability of essential cholera supplies at district level	• Some facilities or response sites experienced shortages while supplies were available in other locations. • Delays in last-mile distribution • Commodities did not always reach peripheral facilities and affected communities when required.	• Inadequate forecasting, changing caseloads, delayed redistribution and limited buffer stocks.
3. Weak real-time visibility of commodity stocks	• Delayed identification of stock-outs and difficulty making timely redistribution decisions.	• Inconsistent stock reporting, parallel reporting systems, limited digital tools and data-quality gaps.
4. Storage and warehousing limitations in some districts	• Risk of delayed distribution, inappropriate storage or inadequate buffer stocks.	• Limited warehouse space, inadequate storage infrastructure and insufficient stock-management capacity.
5. Dependence on partners for some commodities and logistics resources	• Response continuity was affected when partner resources were delayed, insufficient or not aligned with emerging needs.	• Funding gaps, fragmented partner supply chains and varying procurement/disbursement timelines.
6. Inadequate documentation and tracking of emergency logistics activities	• Reduced accountability and limited ability to assess efficiency, gaps and lessons for future outbreaks.	• Multiple reporting systems, workload, manual documentation and inconsistent use of standard logistics tools.
7. Limited availability of reactive OCV relative to population at risk	• Incomplete vaccination of some high-risk populations.	• Limited global vaccine supply, allocation processes and competing outbreak demands.

8. Delays in vaccine allocation and delivery	• Delayed commencement or expansion of vaccination activities in some priority areas. • Difficulty maintaining vaccination targeting as transmission patterns changed geographically	• Approval processes, international procurement/delivery timelines, transportation and coordination challenges. • Changing cholera hotspots • Rapidly changing epidemiological information, population movement and limited lead time for campaign planning

OCV AND OSL ACTIVITIES						
ACTIVITY	**DATE OF DESIRED ACHIEVEMENT**	**RESPONSIBLE AND FOCAL POINT**	**INDICATORS**	**IMPACT** **Mark either +, ++ or +++**	**DIFFICULTY** **Mark either +, ++ or +++**	**PRIORITY** **# dots allocated**
1. Develop a joint supply plan covering government, partners, procurement, warehousing and last-mile distribution.	15 Oct 2026 and ongoing	CMST, OSL focal point	% of priority districts with minimum emergency stocks available	+++	++	●●●

2. Procure and pre-position essential cholera commodities at national, district and identified hotspot levels based on risk and consumption estimates.	15 Oct 2026 and ongoing	CMST, OSL focal point	% of priority districts with minimum emergency stocks available	+++	++	●●●
3. Conduct commodity forecasting and quantification using epidemiological trends, population at risk and consumption data.	Oct 2026	PHIM/MoH, CMST, District Health Offices; OSL/forecasting focal point	% of priority commodities accurately forecast and quantified	+++	++	●●●
4. Conduct last-mile distribution and emergency redistribution mechanisms to move commodities rapidly to emerging hotspots and facilities.	During outbreak Within 72 hours of identified need	CMST, District Health Offices; Logistics focal point	% of urgent commodity requests fulfilled within 72 hours	+++	+++	●●●
5. Establish real-time stock monitoring and early warning for stock-outs at national, district and facility levels.	Nov, 2026	CMST, Logistics focal points	% of priority sites submitting timely stock reports; number of stock-outs	+++	++	●●●

6. Develop a request for OCV preparedness and deployment plan, including target populations, priority hotspots, vaccination teams, logistics and timelines.	Nov 2026	EPI/ OCV focal point	% of high-risk districts with updated OCV microplans	+++	++	●●●
7. Implement OCV campaign (Reactive and preventive)	Nov 2026	EPI/ OCV focal point	% of high-risk districts with updated OCV microplans	+++	++	●●●
8. Conduct post-campaign and post-outbreak OCV/OSL reviews to document coverage, wastage, logistics gaps and lessons learned.	Within 2–4 weeks after each campaign/outbreak	MoH/PHIM, EPI, OSL, districts and partners	Post-campaign review completed; % of recommendations implemented	++	+	●●

5. CONCLUSIONS

The 2025–2026 cholera response demonstrated that Malawi has important foundations for effective outbreak management, including emergency coordination structures, IDSR, laboratory capacity, trained health workers, community structures, WASH/RCCE mechanisms and partner collaboration. The response also exposed recurrent preparedness and operational gaps that can delay detection, confirmation, intervention, and sustained control.

The central lesson is that preparedness must be converted into operational readiness before the next outbreak. The priorities identified by this AAR functional emergency coordination, reliable surveillance and laboratory systems, pre-positioned supplies, competent and supervised personnel, effective WASH and RCCE, strengthened case-management readiness, OCV preparedness, cross-border coordination and systematic follow-up of corrective actions—should therefore be incorporated into routine health-system planning and budgeting.

Successful implementation will require clear ownership, predictable financing, coordinated partner support and regular monitoring. The AAR action plan should remain a live management tool and be reviewed routinely through national and district preparedness structures.

6.WAY FORWARD

The AAR should be treated as a preparedness improvement mechanism rather than a stand-alone report. The following actions should guide implementation after the review:

- Convert the AAR action plan into a single national tracker with one accountable focal point for each action, a deadline, indicator, required resources and evidence of completion.
- Prioritize activities that must be completed before the next rainy season, particularly supplies, laboratory readiness, district PHEOC/IMS functionality, WASH readiness, workforce capacity and community engagement.
- Establish a coordinated 'one cholera plan, one resource picture and one action tracker' approach across government and partners.
- Strengthen district-level preparedness so that response capacity is available before cases increase rather than being built after outbreak declaration.
- Maintain emergency buffers for essential laboratory materials, cholera treatment supplies, IPC commodities, chlorine and operational resources, with clear replenishment triggers.
- Strengthen data use by routinely reconciling line lists, laboratory results and electronic reporting systems and using the information to guide hotspot interventions.
- Embed community feedback and rumour monitoring into RCCE activities so that misinformation and vaccine hesitancy are identified and addressed early.

- Strengthen water utilities and WASH actors as active preparedness and response partners, including water-quality monitoring, continuity of safe water services and emergency communication.
- Use simulation exercises to test plans, especially PHEOC activation, IMS roles, laboratory referral, supply distribution, OCV deployment, cross-border alerts and WASH/RCCE coordination.
- Conduct periodic reviews of progress and document evidence of action completion. Unresolved high-priority actions should be escalated through the appropriate PHEOC/PHEMC governance mechanism.

Annex 2: LIST OF PARTICIPANTS

Name	Institution (Workstation)
1. Albert Chafunya	NENO DHO
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Annex 2: 2025-26 CHOLERA AAR IN PICTURES










NEAO


Step 3 : What went well? What went less well? Why?
THEORY
CHALLENGES
5 WHY's
STRENGTHS
EFFECTS
CAUSES
LIMITING & ENABLING
FACTORS







