AfricaCDC
Centres for Disease Control and Prevention

World Health Organization
African Region

CONTINENTAL CHOLERA EMERGENCY PREPAREDNESS AND RESPONSE PLAN FOR AFRICA 1.0

SEPTEMBER 2025- FEBRUARY 2026

Incident Management Support Team


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Contents

Incident Management Support Team

The Incident Management Support Team (IMST) is Africa's continental effort co-led by Africa CDC and WHO, that collaborates with ministries of Health, regional partners, and global stakeholders to expand vaccination efforts, enhance diagnostic access, and strengthen health system resilience.

Contributors

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Preface

Cholera is a preventable disease, yet it continues to claim lives, undermine development, and strip communities of dignity across Africa. Today, our continent bears more than half of the world's cholera cases and nearly all reported deaths. This is unacceptable in an era when safe water, sanitation, and vaccines are within our collective reach.

As the African Union Champion on Cholera, I convened in June 2025 a landmark meeting of African Heads of State, joined by Ministers of Health and of Water and Sanitation from cholera-affected countries, together with our global partners. From that gathering emerged a historic Call to Action. We committed to accelerate investment, strengthen cross-border collaboration, ensure equitable access to lifesaving vaccines and essential tools, and expand safe water, sanitation, and personal hygiene as the foundation of prevention. United in purpose, we affirmed our ambition: to eliminate cholera from Africa by 2030.

This Continental Cholera Preparedness and Response Plan 1.0 is our direct response to that Call. It represents not only a model of coordination across borders and sectors, swift mobilization of domestic resources, and delivery of results where they matter most—in the lives of our people—but also a demonstration of the power of political leadership at the highest level to overcome a persistent public health challenge requiring sustained multisectoral action.

We must also draw on the lessons of the Mpox response, which proved the value of speed, coordination, and unity of purpose. I recommend that the cholera response be coordinated through the Incident Management Support Team (IMST), co-led by Africa CDC and WHO, bringing together political leadership, strategic direction, and technical expertise in a unified effort. With all partners aligning behind ***One Plan, One Team, One Budget, and One Monitoring and Evaluation Plan***, we have the chance to deliver a truly transformative continental response.

I call for a bold and renewed spirit of solidarity among governments and partners to mobilize urgently the funding, vaccines, case management supplies, and skilled human resources needed to contain current outbreaks and drive us toward our 2030 goal. Just as importantly, I call on our communities to rise as one—embracing the measures that protect their families and safeguard their future. Our strength will come not only from political will and global partnerships, but from the collective resolve of our people to consign cholera to history once and for all.

The elimination of cholera is not only a health goal—it is a moral imperative, a catalyst for economic growth, and a decisive step toward achieving Agenda 2063: ***The Africa We Want***. To succeed, we must act today for a better tomorrow, building a self-reliant Africa that produces its own vaccines and secures its future. Promoting African manufacturing of the oral cholera vaccine is central to this vision, and Zambia stands ready to contribute and to lead.

Together, let us seize this historic moment. Let us ensure that no child, no woman, and no man ever again loses their life to cholera. By 2030, we can—and we must—end this disease once and for all

H.E. Hakainde Hichilema,
President of the Republic of Zambia,
African Union Champion on Cholera

Foreword

Recognizing the escalating threat of cholera, African Heads of State and Government (HoSG) have elevated the disease to a critical public health emergency that demands urgent, coordinated, and sustained multisectoral action. This political commitment was reaffirmed during high-level political meeting of Heads of State and Government from cholera-affected countries, convened on the 4th June 2025 by the President of Zambia in his capacity as the African Union Cholera Champion. At this meeting, leaders endorsed Call to Action to address cholera outbreaks and achieve elimination by 2030. A key outcome was the commitment to operationalize the Continental Incident Management Support Team (IMST), building on the successful mpox response to enhance cross-border coordination. In response, the Africa Centres for Disease Control and Prevention (Africa CDC) and the World Health Organization (WHO), together with key partners, are intensifying efforts to control ongoing outbreaks while building the foundations for long-term elimination strategies.

The urgency of this response is underscored by the alarming rise in cases of cholera across the continent. In 2025 alone, as of epidemiological week 30, a total of 213,586 cases and 4,507 deaths of cholera have been reported from 23 African Union Member States. Countries such as Angola, the Democratic Republic of Congo, Sudan, South Sudan, and Zambia have experienced recurrent and large-scale outbreaks, often exacerbated by conflict, population movement and limited access to clean water sanitation and hygiene (WASH). The hard-earned lessons from the COVID-19 pandemic, as well as the ongoing mpox outbreak, have exposed deep vulnerabilities in Africa's health systems—particularly in fragile, conflict-affected, and underserved settings. These crises have highlighted persistent inequities in access to essential health and WASH services, the need for timely and well-coordinated emergency responses, and the importance of investing in robust preparedness, surveillance, and response systems.

We have learned that only through solidarity, shared responsibility, and regional collaboration can we effectively respond to complex health emergencies like cholera. Thus, to efficiently respond to this outbreak, leveraging the successful model of the Continental Incident Management Support Team (IMST) is critical. The IMST has proven effective in coordinating multi-country responses to mpox with its "4-One" principle—one team, one plan, one budget, and one monitoring framework—which ensures strategic coherence, operational efficiency, and accountability across Member States and partners. The IMST approach, inspired by our experience with mpox and supported by the co-leadership of Africa CDC and WHO, is being adapted for cholera to ensure coherence, synergy, and accountability among all stakeholders.

Bringing from the lessons of mpox response, the cholera response plan integrates comprehensive set of interventions, including leadership and coordination, enhanced surveillance, rapid deployment of oral cholera vaccines, risk communication and community engagement (RCCE), case management, infection prevention and control (IPC), continuity of essential health services, water, sanitation and hygiene (WASH), diagnostics, logistics coordination, and operational research.

In the current context of reduced financing for health, we have established a Continental Cholera Incident Management Support Team (IMST), integrated into the existing mpox IMST platform, to maximize efficiency, streamline coordination, avoid duplication, and leverage existing structures. In parallel, we will establish a Continental Task Force, led by Member States with Africa CDC and WHO providing secretariat support, to coordinate Member States' efforts, cross-border collaboration and drive longer-term

interventions aimed at eliminating cholera as a public health threat across the continent.

This roadmap serves as both a strategic and technical blueprint in direct response to the Call to Action. It embodies the united determination of African Union Member States to eliminate cholera as a public health threat on the continent—by swiftly controlling outbreaks, safeguarding vulnerable communities, and advancing toward a cholera-free Africa.

As the continent advances toward the 2030 elimination target, Africa CDC and WHO reaffirm their commitment to work closely with AU Member States and partners to strengthen health systems, enhance emergency preparedness, and guarantee equitable access to life-saving interventions. Achieving this goal will require bold leadership, sustained investment, and a shared vision—because the health and dignity of every African matter and must be protected, without exception—paving the way for a safer, healthier, and more prosperous Africa in line with Agenda 2063 of the Africa We Want.

H.E Dr Jean Kaseya,
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Acronyms/Abbreviations

Africa CDC	Africa Centres for Disease Control and Prevention
ASLM	African Society for Laboratory Medicine
ATC	Advisory Technical Council
AU	African Union
AVAREF	Africa Vaccine Regulatory Forum
CAR	Central African Republic
CDC	Centres for Disease Control and Prevention
CATI	Case Area Targeted Interventions
CEPI	Coalition for Epidemic Preparedness Innovations
CFR	Case Fatality Rate
CHWs	Community Health Workers
CBOs	Community-based organizations
DRC	Democratic Republic of Congo
ECG	Emergency Consultative Group
EPR	Emergency Preparedness and Response
EU	European Union
FAO	Food and Agriculture Organization
FTM	Financial Tracking Mechanism
GAVI	Global Alliance for Vaccines and Immunization
GB	Governing Board
HSC	Health Services Continuity
IDP	Internally Displaced People
IHR	International Health Regulations
IFRC	International Federation of Red Cross and Red Crescent
IMS	Incident Management System
IOM	International Organization of Migration
IPC	Infection Prevention and Control
KAP	Knowledge, Attitude and Practice
MSF	Médecins Sans Frontières
M&E	Monitoring and Evaluation
NIH	National Institute of Health
NPHI	National Public Health Institute
OCV	Oral Cholera Vaccines
OSL	Operations Support and Logistics
PAMIs	Priority Areas for Multisectoral Interventions
PPE	Personal Protective Equipment
PPPR	Pandemic Prevention and Preparedness Response
PHECS	Public Health Emergency of Continental Security
PHEIC	Public Health Emergency of International Concern
POCT	Point-of-care Testing
RCCE	Risk Communication and Community Engagement
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Executive Summary

Cholera remains a major public health challenge in Africa, accounting for about 82% of global cases and 93.5% of cholera-related deaths. The burden falls disproportionately on fragile, conflict-affected, and underserved areas with limited access to clean water, sanitation, hygiene and essential health services. In response to this growing threat, African Heads of State and Government (HoSG) have elevated cholera to a continental priority, committing—through their recent high-level Call to Action—to control and eliminate outbreaks by 2030.

To translate this commitment into action, Africa CDC and the World Health Organization (WHO) have jointly put together a cholera continental preparedness and response plan for cholera control, while also Africa CDC and WHO jointly establishing a Continental Cholera Incident Management Support Team (IMST), drawing on lessons from the continental mpox IMST. Instead of creating a separate structure, the Continental cholera IMST will be integrated into the existing mpox IMST platform, harnessing shared capacities, technical expertise, and coordination systems. This integrated approach will enhance efficiency, ensure strategic coherence, and optimize resources—critical in an era of rising outbreaks and constrained health financing. Additionally, the plan describes the roadmap towards cholera elimination by 2030 with the establishment of a Continental Task Force, led by Member States with Africa CDC and WHO providing secretariat support, to coordinate Member States' efforts and drive longer-term interventions aimed at eliminating cholera as a public health threat across the continent by 2030. This is in alignment with the global cholera elimination plan. The roadmap envisions an Africa free of cholera outbreaks/epidemics, guided by three overarching goals of a reduction in cholera deaths by 90% and elimination of cholera in more than 20 countries, and maintaining a case fatality rate below 1%. The integrated continental IMST is designed to ensure seamless continuity of emergency response operations across multiple disease threats. It builds on the success of the mpox IMST, which coordinated responses across 26 countries during the 2024/2025 outbreak, under the "4-One" principle: one team, one plan, one budget, and one monitoring framework. This model enables streamlined decision-making, rapid deployment of interventions, joint resources mobilization, and clear accountability across Member States and partners. This document outlines the plan for a continental cholera prevention and control with the implementation framework for the Cholera IMST, detailing its governance structure, strategic priorities, and operational modalities. Key components include:

- Adaptation of Mpox IMST Standard Operating Procedures (SOPs) to incorporate cholera-specific functions and workflows.
- Inclusion of cholera experts in the IMST core team to provide technical leadership and guidance.
- Alignment of response pillars—including surveillance, case management, infection prevention and control (IPC), risk communication and community engagement (RCCE), logistics, and continuity of essential health services—to address cholera emergencies effectively.

Its implementation will be guided by the African Taskforce for Cholera Control, composed of representatives from AU Member States, regional institutions, and technical partners. The Taskforce will focus on advancing the cholera elimination agenda by overseeing implementation, monitoring progress, and facilitating cross-country learning and coordination.

To steer long-term action, this plan will be followed by a Continental Cholera Elimination Roadmap, aligned with the Global Taskforce on Cholera Control (GTFCC) roadmap. This roadmap will provide Member States and partners with a structured pathway for delivering evidence-based interventions, strengthening health systems, and tracking measurable progress toward the 2030 elimination target. It will emphasize critical

enablers including increased domestic financing, community engagement, regional manufacturing of oral cholera vaccines, and integration of WASH interventions into national health strategies.

Africa CDC and WHO reaffirm their commitment to working alongside Member States and partners to build a resilient, inclusive, and coordinated cholera response. The integrated IMST model marks a strategic turning point in Africa's emergency response architecture—adaptive, scalable, and anchored in the principles of equity and shared responsibility.

Between September 2025 and February 2026, Africa is projected to face more than 200,000 cholera cases and 6,020 deaths—a 42% surge in cases and a 98% rise in deaths compared to 2024, if the current interventions are maintained. With delayed intervention, the number of cases is expected to be 182,715 over the six months. The surge is expected to be concentrated in high-burden countries, which are likely to account for more than 80% of total cases. These estimates consider seasonal rainfall patterns in sub-Saharan Africa, particularly between August and February, which have historically been associated with higher cholera transmission. However, with optimal rapid interventions, the number of cases and deaths is projected to decline to 46,764 cases and 418 deaths, respectively.

To respond effectively to the anticipated surge and protect lives, 10 million doses of oral cholera vaccines, based on a two-dose vaccination strategy, will be required for reactive vaccination in hotspot areas, complemented by rapid and coordinated interventions across affected areas. At $1.65/dose for vaccine procurement, $2.8/dose for the vaccine operational cost and technical assistance worth $3,678,303, $48,258,047 is required. Also, the Task Force will need to mobilize an additional $100 million for OCV African manufacturing to ensure progress towards a goal linked to cholera elimination by 2030, while remaining outside the six-month emergency envelope. The response will necessitate the establishment of 365 cholera treatment centers (CTCs), 401,973 liters of Ringer's lactate to manage severe cases, and 311 community or outpatient treatment points with 1.5 million ORS sachets to treat mild to moderate cases. The Continental Cholera Response Plan will be implemented over the same six-month period, with an estimated budget of $231,734,518 to cover operational and technical costs for response activities in cholera-affected Member States, preparedness activities in currently stable countries, and technical assistance from Africa CDC, WHO, UNICEF, and other key partners. The OCV and its operational costs are expected to be covered by donations.

Introduction

At the extraordinary meeting held on 4 June 2025, Heads of State and Government, along with Heads of Delegation from 20 African Union (AU) Member States affected by cholera, issued a Call to Action to end cholera outbreaks and achieve cholera elimination in Africa by 2030.[1] [2]This declaration reflects a unified political commitment to address the escalating cholera crisis, which continues to cause widespread morbidity, mortality, and socio-economic disruption across the continent.

The leaders expressed concern over the ongoing multi-country cholera outbreaks, which are currently affecting approximately 20 AU Member States. These outbreaks are occurring in the context of concurrent and protracted public health emergencies, placing immense strain on already fragile health systems and diverting resources from essential services. The compounded burden of cholera, alongside other emergencies such as mpox, malaria, and displacement-related health crises, underscores the urgent need for a coordinated and sustained continental response.

In response to this call, Africa CDC and the World Health Organization (WHO), in collaboration with key partners, have committed to a Cholera Continental Roadmap for Africa, which aims to reduce cholera deaths by 90%, eliminate cholera in over 20 countries, and maintain cholera case fatality rate below 1%. This includes the establishment of a Continental Cholera Incident Management Support Team (IMST) and the establishment of the African Taskforce on Cholera Control. The Cholera IMST will be integrated into the existing mpox IMST platform, leveraging shared capacities, technical expertise, and operational mechanisms. This integrated model is designed to enhance efficiency, ensure continuity of emergency response operations, and optimize resource utilization across multiple disease threats.

The IMST implementation framework will be guided by a multi-disciplinary and unified approach, incorporating cholera-specific functions into the existing IMST architecture. Key elements include:

- Adaptation of Mpox IMST Standard Operating Procedures (SOPs) to include cholera response protocols.
- Inclusion of cholera experts in the IMST core team to provide technical leadership and coordination.
- Alignment of response pillars—including surveillance, case management, infection prevention and control (IPC), risk communication and community engagement (RCCE), vaccination, logistics, and continuity of essential health services—to address cholera emergencies effectively.

To complement immediate response efforts, the plan also outlines the establishment of a Continental Cholera Taskforce, which will provide strategic oversight and long-term guidance. This task force will be responsible for coordinating multi-sectoral efforts, mobilizing resources, and monitoring progress toward cholera elimination. This will be guided by the Continental Cholera Roadmap, which aligns with the Global Taskforce on Cholera Control (GTFCC) roadmap and provides a structured pathway for Member States to implement evidence-based interventions.

The Continental Roadmap is anchored on the following seven strategic objectives:

1. **Multisectoral Coordination and Sustainable Financing** – Promoting whole-of-government and whole-of-society approaches, institutionalizing national cholera taskforces, and scaling up domestic resource mobilization.
2. **Early Detection and Rapid Response** – Strengthening national and subnational surveillance systems, enhancing

1 https://africacdc.org/news-item/african-leaders-champion-the-call-to-fight-cholera/
2 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)01426-6/fulltext

laboratory capacities, ensuring prompt access to appropriate treatment, and implementing real-time reporting for swift outbreak control.

3. **WASH (Water, Sanitation, and Hygiene)** – Accelerating equitable access to safe water and sanitation services in hotspots, especially among high-risk and displaced populations.

4. **Risk Communication and Community Engagement (RCCE)** – Empowering communities through trust-based communication, engagement of civil society, and behavior change strategies.

5. **Cholera Hotspot and Risk Mapping** – Identifying geographically limited areas with high likelihood of potential impact, including the **identification of PAMIs (Priority Areas for Multisectoral Interventions)**, by integrating epidemiological, environmental, and socio-demographic determinants to inform targeted public health interventions.

6. **Oral Cholera Vaccines (OCV)** – Expanding preventive and reactive use of OCVs, alongside support for African manufacturing and timely global supply.

7. **Case Management and Community Access to Treatment** – Ensuring timely access to lifesaving treatment through strengthened health services, community-based care delivery, pre-positioning of medical supplies, and integration of cholera case management into broader health systems.

A Community Health Worker (CHW) extending services to the population

Epidemiological situation of the multicountry outbreak from January 2022 to July 2025

Globally, 82% of all Cholera cases occur in Africa, alongside 93.5% of all Cholera-associated deaths as of July 2025. African Member States that have reported cholera cases in 2025 include Angola, Burundi, Chad, Côte d'Ivoire, Comoros, DRC, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Somalia, South Sudan, Sudan, Tanzania, Togo, Uganda, Zambia and Zimbabwe, but all countries are at risk particularly with continued climate change and potential for conflict situations. Over the past decade, cholera has re-emerged as a persistent and escalating public health threat across African Union (AU) Member States. Between 2014 and 2024, reported cholera cases surged from 105,287 cases and 1,882 deaths across 19 countries to 254,075 cases and 4,725 deaths across 20 countries—representing a 141% increase in cases and a 151% increase in mortality. This alarming trend reflects not only the growing burden of the disease but also the increasing vulnerability of health systems across the continent. The last four years have seen a particularly sharp rise in cholera incidence. From 2022 to 2023, cases increased by 115%, while mortality rose by 31.4%.

Comparing 2024 to 2023, the number of cases rose by 13%, and deaths increased by a staggering 52.4%, underscoring the severity and impact of outbreaks.

Between January 01, 2025, and July 27, 2025, a total of 213,586 suspected cholera cases have been reported from 23 AU Member States, including 6,877 confirmed and 206,641 suspected cases. Tragically, 4,462 deaths have been recorded, resulting in a case fatality rate (CFR) of 2.10%, which exceeds the emergency threshold (1%) and signals a critical need for intensified response efforts (Table 1). Four countries—Angola, South Sudan, Sudan, and the Democratic Republic of Congo (DRC)—are currently experiencing acute cholera crises, accounting for 85% of all reported cases in Africa. These outbreaks are unfolding in the context of humanitarian emergencies, climate-related disruptions, and fragile health systems with limited capacity to respond. In these settings, displacement, poor access to clean water, sanitation and hygiene, and overstretched health services have created conditions ripe for rapid cholera transmission and high mortality. This data paints a clear picture: cholera is not only resurging—it is evolving into a continental emergency. The convergence of epidemiological trends, systemic vulnerabilities, and environmental pressures demands a coordinated, multisectoral, and sustained response.

Incident Management Support Team

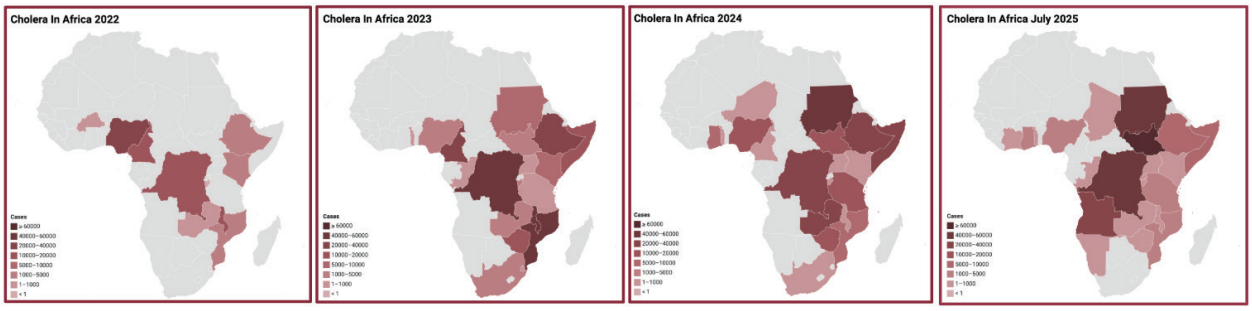


Figure 1. African countries most affected by Cholera 2022 – July 2025.

Table 1: Reported cases of cholera in member states, From January to July 14th,2025

Country	Cases	Deaths	Case Fatality ratio (%)
Angola	27728	776	2,8
Burundi	408	0	0
Chad	364	29	7,97
Comoros	40	0	0
Congo	200	10	5
Cote D'Ivoire	453	19	4,19
DRC	42342	1189	2,81
Ethiopia	5897	56	0,95
Ghana	2780	14	0,5
Kenya	426	20	4,69
Malawi	91	3	3,3
Mozambique	4196	43	1,02
Namibia	18	1	5,56
Nigeria	4709	113	2,4
Rwanda	311	0	0
Somalia	6810	9	0,13
South Sudan	67097	1142	1,7
Sudan	45565	1027	2,25
Tanzania	3892	40	1,03
Togo	165	4	2,42
Uganda	99	1	1,01
Zambia	483	9	1,86
Zimbabwe	601	23	3,83

Basic sanitation and hygiene (WASH), water quality and consuming clean food are essential to prevent cholera

Risk Assessment and Country Categorization

The risk of cholera transmission in Africa remains high and will continue to affect communities on an annual basis without a government-led, multi-sector and united approach.

Categorization of Member States Based on Risk and Vulnerability

Category A: High-priority Countries

These are countries and in-country regions experiencing **active cholera transmission** or **very high risk of outbreak and endemic Cholera** due to multiple risk and vulnerability factors. As of August 2025, these countries include Angola, Burundi, Chad, Congo Republic, Côte d'Ivoire, DRC, Ethiopia, Kenya, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Somalia, South Sudan, Sudan, Tanzania and Uganda. Notable spikes in cases have been observed in DRC and Sudan.

Category B: At-risk Countries

These are countries with no active cases of cholera but with conditions that increase vulnerability to future outbreaks. The following Member States could fit in this category: Benin, Burkina Faso, Cameroon, Central African Republic, Comoros, Djibouti, Gabon, Guinea, Liberia, Madagascar, Mali, Niger, Sierra Leone, South Africa, Togo, Zambia and share borders with the high priority countries and which have reported cases in the recent past.

This categorization is based on the following characteristics of the outbreak:

- **Epidemiological indicators** (Trends, size, severity),
- **Response indicators** (Treatment facility (ORPs/CTUs/CTCs), WASH, OCV, others)
- **Context indicators** (Climate issues, healthcare access, WASH, political stability, others)

Table 2: Categorization of high-priority countries experiencing active transmission for response interventions

Category	Description of category/	Response Level	Key actions
Category A: High priority countries/ regions	• Ongoing or recent (within past 12 months) cholera outbreaks. • Cholera has been endemic (high cholera transmission) or recurrent in the past 5 years. • High case fatality rate (CFR ≥1%). • Poor WASH infrastructure (low access to safe water/sanitation). • High population mobility due to conflicts and trade . • Weak surveillance, lab, and case management capacity. Weak health systemsy. • History of cross-border cholera transmission.	• Continental Cholera IMST in addition to other response mechanisms regionally and nationally • Full-scale emergency response	• Activation of the IMST at all levels • Development of response support and field deployment. • CATI Approach Oral cholera vaccine (OCV) campaigns. Emergency WASH interventions. Risk communication and community engagement (RCCE). • Health system strengthening and partner coordination • Early and intra action reviews

Category	Description of category/	Response Level	Key actions
Category B: At-risk but currently stable Countries / Regions	• No confirmed cholera cases in the past year. • History of cholera, but no recent outbreaks. • Existing WASH or health system weaknesses. • Presence of cross-border movement or seasonal flooding. • Limited public health preparedness capacity. • High vulnerability due to poverty, clipreventivemate events, or food insecurity.	• Continental Taskforce on Cholera control will support preparedness and readiness activities across the Member States • Preparedness and early readiness	• Preparedness and readiness capacity /Risk assessment • Readiness assessment a • Development of contingency plans • Simulation exercise • Prepositioning of supplies • Capacity building of response teams. • Community-based and cross border surveillance, Lack of reagent for lab and RCCE. • Targeted WASH improvements. • Consider preventive OCV if risk is high.

Table 3: Response elements by categories

Response Element	Category A: High Priority	Category B: At-Risk/Stable
Cholera cases	Active transmission	No active cases
IMS	Fully activated	Partial or readiness-level IMS
Case management (CTCs, ORPs)	Fully operational	Prepositioned, on standby
Surveillance	Intensified + active case search	Strengthened IDSR/CBS/EBS
OCV	Reactive or mass campaign	Preventive or Preemptive
WASH	Emergency interventions	Targeted upgrades and planned improvement projectss
RCCE	Emergency messaging + community mobilization	Awareness-building + preparedness messaging
Supply chain	Full deployment + Emergency	Quantification, warehousing, Stockpile and prepositioning
Coordination	Daily or weekly with partners	Monthly or scenario-based

Africa CDC handing over life-saving medical supplies to the Ministry of Health of Zambia in response to Cholera outbreak

Cross-Border Transmission Risks and Regional Priorities

The latest assessment of cholera readiness across the African continent reveals that the overall capacity among AU Member States remains suboptimal, posing significant challenges to effective outbreak prevention and control. While 18 countries demonstrated notable improvements in their cholera preparedness between 2024 and 2025, the majority still face critical gaps in surveillance, response coordination, case management, and access to essential supplies such as oral cholera vaccines and diagnostics.

This limited readiness is particularly concerning given the convergence of multiple risk factors that heighten the threat of cholera transmission. The 2025 rainy season, characterized by normal to above-normal rainfall and an increased likelihood of extreme weather events, is expected to exacerbate flooding and water contamination—conditions that are highly conducive to cholera outbreaks. In parallel, rising insecurity and forced migration across several regions have led to the displacement of vulnerable populations, many of whom now reside in overcrowded settings with limited access to clean water, sanitation, and healthcare services.

These compounding factors—climate variability, humanitarian crises, and fragile health systems—create an environment ripe for the rapid upsurge and cross-border spread of cholera. The risk of transmission across multiple countries and regions is therefore assessed to be very high, demanding urgent, coordinated, and sustained action from national governments, regional institutions, and global partners.

Main Challenges Affecting the Cholera Response

Multiple factors continue to amplify the risk and accelerate the spread of cholera across African Union Member States, with conflict and climate change emerging as key drivers of vulnerability. In conflict-affected regions, the destruction of water infrastructure and sanitation systems has led to widespread collapse of safe water supply networks, severely limiting access to potable water. This is compounded by inadequate latrine coverage, poor waste management, and disrupted healthcare services, which collectively create conditions ripe for cholera transmission.

Humanitarian crises further exacerbate these risks. In many settings, internally displaced persons (IDPs) are forced to live in overcrowded camps with limited access to clean water, sanitation, and medical care. Blocked or insecure access routes often hinder the delivery of essential supplies, including oral cholera vaccines, rehydration therapies, and diagnostics, delaying response efforts and increasing mortality.

In parallel, climate change continues to intensify cholera risks through both flooding and drought. Flooding events contaminate water sources and overwhelm sanitation infrastructure, while droughts reduce water availability, forcing communities to rely on unsafe sources. These environmental stressors are increasingly frequent and severe, driven by shifting rainfall patterns and rising temperatures across the continent.

Together, these factors create a synergistic effect, heightening the risk of cholera outbreaks and complicating containment efforts. Addressing these challenges requires a coordinated, multisectoral approach that integrates emergency response with long-term investments in water, sanitation, healthcare access, and climate resilience.

The Call to Action: Renewed Commitment to End Cholera in Africa

At the extraordinary meeting held on 4 June 2025, Heads of State and Government, along with Heads of Delegation from 20 African Union (AU) Member States affected by cholera, issued a unified Call to Action to end cholera outbreaks and achieve cholera elimination in Africa by 2030. This call to action reflects the growing urgency and political commitment to address the escalating

cholera crisis, which continues to cause widespread morbidity, mortality, and socio-economic disruption across the continent.

During the meeting, leaders expressed grave concern over the ongoing multi-country cholera outbreaks, which are currently affecting approximately 20 AU Member States. These outbreaks are occurring in the context of concurrent and protracted public health emergencies, placing immense strain on national health systems and diverting resources from essential services. The compounded burden of cholera, alongside other emergencies such as mpox, malaria, and displacement-related health crises, underscores the urgent need for a coordinated and sustained continental response.

In response to this call, the following key actions are proposed:

1. The establishment of a Continental Incident Management Support Team (IMST), jointly led by Africa CDC and WHO, in collaboration with other partners. This IMST will coordinate, streamline, and intensify efforts aimed at controlling ongoing cholera outbreaks across the continent, ensuring rapid deployment of resources, technical expertise, and operational support to affected countries.
2. The creation of a Continental Task Force for Cholera Elimination, co-led by Africa CDC and WHO, and aligned with the Global Task Force on Cholera Control (GTFCC). This task force will promote inclusive, coordinated, and sustainable strategies to accelerate progress toward the 2030 elimination target, while ensuring alignment with global best practices and regional priorities.

To realize this ambitious vision, the Africa Centres for Disease Control and Prevention (Africa CDC) and the World Health Organization Regional Office for Africa (WHO-AFRO), in collaboration with key partners such as UNICEF, IFRC, Gavi and others, have committed to developing a Continental Cholera Roadmap. This roadmap will serve as a strategic guide for Member States and partners, outlining evidence-based interventions, priority actions, and measurable milestones to control and ultimately eliminate cholera in Africa.

Cholera Vaccination Drive carried out by WHO

Purpose and Scope of the Plan

This plan is designed to provide a proactive, structured and coordinated immediate short-term (6 months) multisectoral response to prevent, reduce morbidity and mortality and control the ongoing Cholera outbreaks across the continent. It outlines key strategies to complement current efforts by National Governments to prevent and control cholera outbreaks.

Goal and Strategy

Goal:

The overall goal of this continental cholera preparedness and response plan is to support African Union Member States in preventing and controlling cholera outbreaks.

Overall Preparedness and Response Strategy

To effectively address the ongoing cholera outbreaks across the African continent, a comprehensive and adaptive strategy is essential for both immediate containment and long-term mitigation. The Continental Cholera Preparedness and Response Plan, developed under the joint leadership of Africa CDC and WHO, emphasizes a community-centered, well-coordinated, multisectoral and Member State-driven, and differentiated approach tailored to the unique epidemiological profiles and risk categories of AU Member States.

This strategy prioritizes the availability and deployment of critical countermeasures, including oral cholera vaccines (OCVs), diagnostics, and case management supplies, while ensuring the integration of Water, Sanitation, and Hygiene (WASH) interventions as a foundational element of cholera prevention. Recognizing that cholera is both a health and development challenge, the plan promotes cross-sectoral collaboration among health, water, sanitation, education, and humanitarian actors.

This approach is strengthened by the inclusion of risk communication and community engagement (RCCE), which is crucial for building trust and promoting behavior change. The strategy ensures that communities are actively involved in the planning and implementation of all interventions.

Importantly, the plan is designed to build resilient and equitable health systems capable of responding to cholera and other public health threats. It supports Member States in strengthening surveillance systems, enhancing laboratory capacity, improving risk communication and community engagement (RCCE), and ensuring continuity of essential health services during outbreaks.

By aligning with global frameworks such as the Global Task Force on Cholera Control (GTFCC) Roadmap and the Regional Framework for the implementation of the Global Roadmap for cholera prevention and control, the Continental Plan provides a unified and evidence-based pathway toward cholera elimination by 2030.

Building on Mpox IMST Lessons

Several key lessons from the mpox Incident Management Support Team (IMST) response can be effectively leveraged to strengthen cholera response efforts across Africa. These include:

1. **Integrated Incident Management System (IMST):** The mpox response in Africa was guided by a unified coordination framework known as the "Four Ones" principle: one team, one plan, one budget, and one monitoring framework. This structure helped streamline efforts across multiple stakeholders, including Africa CDC, WHO, and 28 partner organizations. For cholera, adopting a similar IMST approach can ensure that all actors—from government agencies to partners—work in harmony, reducing duplication and improving the efficiency of outbreak response. It also facilitates faster decision-making and resource allocation, which is critical during health emergencies.
2. **Strengthening surveillance and laboratory capacity:** During the mpox outbreak, significant investments were made to enhance disease surveillance, including community-based surveillance, and laboratory networks across the continent. These improvements enabled quicker detection, confirmation, and reporting of cases. Applying this lesson to cholera means building robust surveillance systems that can detect outbreaks early and track

their spread in real time. Strengthening laboratory capacity also ensures accurate diagnosis, which is essential for timely treatment and containment of cholera outbreaks.

3. **Access to vaccines and pooled procurement:** One of the key strategies in the mpox response was the increased negotiation and procurement power to influence manufacturers to optimally produce vaccines and supply them at an affordable price. This push has led to a foundation on the need for African production of vaccines and medical supplies. For cholera, African manufacturing of oral cholera vaccines (OCVs), rehydration salts, and other essential supplies can help address shortages and delays, sustainably. Additionally, strengthening regional procurement mechanisms like the African Pooled Procurement system can ensure equitable distribution of resources across countries.

4. **Multi-disease integration and flexibility:** The mpox IMST demonstrated the value of integrating responses to multiple diseases under a single framework. This will be particularly useful in regions facing concurrent outbreaks. It also allows for more holistic and sustainable interventions.

5. **Partner collaboration, risk communication and community engagement:** The mpox response was marked by strong collaboration among international partners like Africa CDC, WHO, UNICEF, Gavi, the IFRC, the Collective Service among others. These partnerships facilitated resource mobilization, technical support, and community outreach. In the context of cholera, engaging similar partners can help scale up and improve WASH programs, deliver vaccines, build individuals/staff/cadres capacities and educate communities about prevention and early treatment. Community engagement is especially vital in building trust and ensuring that interventions are culturally appropriate and widely accepted while leveraging on community existing capacities, knowledge and resources.

6. **Tackling root causes of cholera:** While the IMST focused on outbreak management, experts emphasized the importance of addressing the underlying causes of cholera. These include poor access to clean water, inadequate sanitation, and displacement due to conflict. A long-term cholera strategy must go beyond emergency response to include investments in infrastructure, peacebuilding, social cohesion and development. By tackling these root causes, countries can reduce the frequency and severity of cholera outbreaks and build more resilient health systems. This has also been demonstrated by mpox intensification, integration and legacy plan 2.0.

Basic sanitation and hygiene (WASH), water quality and consuming clean food are essential to prevent cholera

Preparedness and Response Pillars and Strategic Objectives

Swift action by each of the pillars will be relied upon to support Member States successful response to control acute outbreaks of cholera, prevent further spread to neighboring vulnerable areas and bolster current mechanisms to prevent outbreak occurrence and intensity.

Pillar 1: Coordination and Leadership

Strategic Objective

Establish a unified and functional coordination mechanism, integrated within the existing mpox IMST (continental) guided by the principles of one team, one plan, one budget, and one monitoring and evaluation framework.

Priority Actions:

- Strengthen coordination and collaboration among key stakeholders, including efforts for joint resource mobilization.
- Establish a continental-level cholera Incident Management Support Team (IMST) to coordinate support to Member States through their Ministries of Health and enhance implementation capacity. The IMST will be co-chaired by Africa CDC and WHO, with support from UNICEF and other partners
- Establish multidisciplinary and multisectoral teams at the continental level to investigate, assess risks, identify priority actions, and implement initial control measures
- Conduct consultations with key continental stakeholders and partners to promote information sharing, set priorities, and ensure alignment of efforts
- Strengthen national multisectoral coordination mechanism according to " one health" approach comprising sectors of finance, water and sanitation, habitation, local administration and key stakeholders such as ministries, institutions, donors and technical partners for the cholera response, including mapping using the 5W matrix.
- Support MS to establish/strengthen a multidisciplinary and multisectoral national incident Management Team (IMT) to coordinate the response and develop a response plan for resource mobilization.
- Monitor and evaluate the progress and outcome of the response efforts

Category B: At-Risk/Stable Countries

- Map all stakeholders and their scopes of action and capacities at national and subnational levels
- Support Member States to establish a cholera coordination mechanism at both national and subnational levels to enhance collaboration, communication, and response efforts during cholera outbreaks
- Develop/update cholera contingency plans
- Develop and implement a comprehensive resource mobilization strategy aimed at securing essential funding and support for cholera response initiatives
- Support countries to develop/update their cholera contingency plans and National Cholera Plans (NCPs), including Cholera investment cases to ensure readiness and effective response during cholera outbreaks
- Support Member States in conducting Early, Intra, and After-Action Reviews (E/AARs) and simulation exercises to enhance monitoring and evaluation of their preparedness and response efforts

Pillar 2: Risk Communication and Community Engagement

Strategic Objective

Support Member States (MS) to enable at-risk communities to prevent, detect, and respond to cholera transmission through timely, trusted, two-way communication. To promote adoption of key public health measures that drives protective behaviors, care-seeking, and uptake of WASH and OCV interventions.

Priority Actions:

Put the communities at the center of the cholera response through:

- ***Strengthening RCCE Coordination and Capacity:*** Ensure that the RCCE IMST is a multisectoral RCCE coordination body that includes representatives from various sectors, such as health, WASH, education, community leaders, NGOs, and civil society. Is well integrated into the functioning of other pillars.
- ***Capacity Strengthening:*** Ensure staff, Community Health Workers, volunteers have the knowledge, understanding and capacity to engage communities effectively: train and provide support to staff, CHW and volunteers. Supporting health system strengthening and robust RCCE interventions.
- ***Evidence-led messaging***: Developing and disseminating a continental message bank and adaptation guide; to localize using rapid social/behavioral insights and community feedback e.g safe excreta disposal including latrine use, safe water/ storage, handwashing etc.
- ***Trusted messengers and channels:*** Establish local partnerships and supply micro-packs (talking points, radio scripts, low-literacy visuals) for CHWs, teachers, faith and community leaders; prioritise IDP/host communities and border districts.
- ***Leverage on Community based Platforms:*** Community mapping and activating the participation of civil society and community-based organizations for the response.
- ***Two-way feedback at scale:*** Provide SOPs, a standard taxonomy, and a reach × harm triage grid for hotlines/IVR, SMS/ WhatsApp, CHW logs, and community committees; mentor IMST focal points to route and close high-risk items within 24-48h.
- ***Accountability to Affected Populations (AAP) :*** Adapt and harmonize minimum AAP standards (accessible information, complaints pathways, safeguarding triggers, minority-language access) and support activating community feedback mechanisms for closing the community feedback loop.
- ***Infodemic Management:*** Support countries in collecting, analyzing, and addressing rumours questions, observations, perceptions, beliefs, related to cholera, ensuring accurate and timely information reaches the public.
- ***Early Warning Communication systems***: Deploy early warning communication system linked to surveillance, to allow a quick effective RCCE response.
- ***Deployments and Surge***: Collaboration with platforms like GOARN and UKPHS, deploy short technical assistance on request and align with EPR and other agencies working in the specific countries.
- ***Collect Social and Behavioral Data Insights:*** Collecting and analyzing social and behavioral data insights through Community Rapid Assessments, behavioural surveys and focus group discussions.

Pillar 3: Surveillance

Strategic Objective:

To rapidly detect, confirm, characterize, and monitor the evolution of an outbreak to inform and guide immediate, effective, and targeted control interventions aimed at interrupting transmission and minimizing morbidity and mortality.

Priority Actions:

- Coordinate with MS to conduct initial in-depth investigation of cholera cases
- Establish multidisciplinary and multisectoral teams at the continental level to investigate, assess risks, identify priority actions, and implement initial control measures
- Establish multisectoral surveillance teams (human and environmental surveillance officers) and establish joint indicators for monitoring surveillance performance
- Disseminate standard surveillance tools (e.g., case definitions, line lists, case investigation forms), for adaptation and ensuring alignment with IDSR.

Category A: High Priority Countries

- Deploy trained surveillance surge staff to support real-time cholera case detection, epidemiological investigation, and field-level data management when necessary. Distribute and contextualize standard surveillance tools (e.g., case definitions, line lists, case investigation forms), ensuring alignment with IDSR and partner tools.
- Provide rapid training and mentorship to national and sub-national surveillance teams on case definitions, alert thresholds, data tools, and outbreak reporting.
- Strengthen case investigation capacity through targeted supervision, mobility support, and standardized protocols, especially in outbreak hotspots.
- Enhance active case finding and verification, with a focus on informal settlements, border areas, and displacement camps.
- Monitor key performance through weekly site reporting audits, completeness and timeliness indicators, and hotspot dashboards.
- Support real-time data collection, cleaning, and analysis, using harmonized templates and shared analysis code to ensure consistent reporting across partners.
- Produce regular continental epidemiological updates and situation reports (daily/weekly), integrating data from health, WASH, and community sources for operational use.
- Coordinate with RCCE teams to integrate community-based surveillance (CBS) for early warning, rumor verification, and timely care-seeking behavior.
- Facilitate cross-border surveillance collaboration, including joint alerts, information exchange, and synchronized investigation protocols in border districts.

Category B: At-Risk/Stable Countries

- Conduct preparedness training for surveillance and RRT staff on cholera-specific case detection, line listing, and event verification tools.
- Conduct surveillance and cholera-specific case detection, line listing, and event verification tools.
- Adapt and pre-position surveillance tools (e.g., line lists, case definitions, investigation forms) in high-risk districts, ensuring readiness for rapid use.

Enhance surveillance readiness by reviewing IDSR functionality and identifying gaps in real-time reporting and alert generation systems (IDSR) while building national capacity for the potential implementation of temporary complementary systems (such as Early Warning Alert and Response System -DHIS2, EWARS and GoData. Build capacity for data management and outbreak analytics, including shared access to analysis dashboards, templates, and visualization tools.

- Strengthen early warning through community-based and event-based surveillance, in close collaboration with RCCE teams, targeting high-risk populations.
- Conduct simulation exercises or joint outbreak drills, especially in border regions or urban PAMIs/hotspots, to test surveillance coordination and data flow.
- Monitor surveillance system functionality regularly (e.g., monthly reviews of alert

responsiveness, data completeness) to ensure early risk signal detection.

- Support development of contingency situation report templates, including pre-filled baseline indicators, response thresholds, and mapping tools.
- Promote information sharing and coordination with neighboring countries, especially in shared watershed or migration corridors and train RRTs rapid case investigation with updated tools, PPE, and SOPs to allow rapid deployment if an alert is triggered.
- Adapt, print, and distribute essential surveillance tools, including case definitions, line list templates, and case investigation forms, to enhance disease monitoring and response efforts
- Conduct comprehensive training on the effective use of surveillance tools, including case definitions, line list templates, and case investigation forms, to enhance the capacity of health workers and community volunteers in MS
- Share surveillance guidelines and support the preparedness of existing national surveillance systems (such as Integrated Disease Surveillance and Response - IDSR) while building national capacity for the potential implementation of temporary complementary systems (such as Early Warning Alert and Response System - EWARS and Go.Data)
- Initiate and strengthen community-based active surveillance and event-based surveillance to enhance disease detection and response capabilities
- Establish or strengthen collaboration and information sharing around cross-border surveillance to enhance disease detection and response across regions.
- Conduct a comprehensive cholera risk assessment and mapping to identify Priority Areas for Mitigation Interventions (PAMIs) and hotspots, prioritizing preparedness and readiness in these critical areas.

Pillar 4: Laboratory Capacity

Strategic Objective

To ensure timely and accurate laboratory confirmation of cholera cases during outbreaks to guide public health response and resource allocation.

Priority Actions

Category A: High Priority Countries

- Rapid deployment of mobile laboratory units and diagnostic kits to outbreak hotspots
- Activate regional reference laboratories to support overwhelmed national systems
- Ensure availability and distribution of RDTs, culture media, and transport media for sample referral.
- Train and deploy surge laboratory personnel to affected areas
- Implement real-time data sharing mechanisms between laboratories and surveillance teams
- Monitor laboratory turnaround times and diagnostic accuracy to ensure quality

Category B: At-Risk/Stable Countries

- Conduct a comprehensive assessment of the continent's laboratory capacity for cholera diagnostics, including identification of gaps and needs, and conduct targeted capacity-building training for MS
- Strengthen national public health laboratories and regional reference laboratories through the provision of equipment, reagents, and training
- Facilitate quality control and External Quality Assurance (EQA) mechanisms in coordination with reference laboratories or WHO collaborating centers to enhance laboratory diagnostics on the continent and MS
- Develop and disseminate standardized cholera diagnostic protocols aligned with WHO and GTFCC guidelines.

- Establish a quality assurance framework including external quality assessments (EQA) and proficiency testing.
- Integrate laboratory data into national and regional surveillance platforms (e.g., DHIS2).
- Build partnerships with relevant organizations for technical support and capacity building.
- Disseminate standardized and GTFCC-recommended guidelines, protocols, and operating procedures for laboratory diagnostics, adapting them based on continental and MS guidelines

Pillar 5: Case Management (including MHPSS) and Infection Prevention and Control (IPC)

Strategic objective

To provide high-quality and comprehensive treatment and holistic care for cholera patients through early establishment of cholera treatment centers (CTC), capacity building, establishment of community Oral Rehydration Points (ORPs) and integration into existing community programmes (CHWs) supported with cholera kits at community, peripheral and central levels and maintain CFR below 1%.

Priority Actions:

Category A: High Priority Countries

- Activate cholera treatment protocols, with immediate establishment or scaling up of Cholera Treatment Centers facilities (CTUs/CTCs) and Oral Rehydration Points (ORPs) in hotspot areas
- Deploy trained HCWs to manage cases based on severity, ensuring prompt administration of oral rehydration salts (ORS) for mild cases and IV fluids and antibiotics for severe cases (including experts to manage critical cases).Train and deploy CHWs to provide and supervise community/ facility establishment of ORPs or other community delivery systems (e.g. CHWs)
- Maintain adequate stocks of essential supplies, including rehydration fluids, antibiotics, IPC materials and nutritional needs.
- Implement strict infection prevention and control (IPC) measures to prevent nosocomial transmission.
- Operationalize clear triage systems, referral mechanisms and transport systems, and case reporting to ensure efficient patient flow and clinical in sentimental sites.
- Incorporate robust MHPSS into the response for communities and responders alike. Build the capacity of HCW and CHW on cholera-related IPC measures to ensure compliance
- Provide IPC supplies and resources
- Monitor and evaluate IPC implementation using rapid assessments during supportive supervision
- Ensuring adherence to IPC best practices at the community level, including households (home-based care) and schools

Category B: At-Risk/Stable Countries

- Capacity building of healthcare workers at all levels on cholera clinical management, infection prevention and control (IPC), and proper use of cholera treatment protocols.
- Conduct an assessment of Health facilities in high-risk areas and strengthen them to ensure they are equipped to handle cholera cases, including the establishment or readiness of Cholera Treatment facilities (CTUs/CTCs) and Oral Rehydration Points (ORPs) in PAMIs Preposition
- Facilitate the mapping of health care facilities (HCFs) among MS to identify gaps in human resources, infrastructure (including isolation and bed capacity), and access to Water, Sanitation, and Hygiene (WASH) services, particularly in the PAMIs
- Provide essential supplies, such as cholera kits to readily be able to deploy at community, peripheral and central level.).

- Establish and maintain a functioning referral system for cholera patients at all healthcare levels to ensure timely and effective treatment in all MS
- Conduct simulation exercises to test response capacity to provide quality clinical care timely during outbreaks.
- Train community health workers to support early detection, referral, and basic case management.
- Conduct a comprehensive mapping of health partners who can support case management activities, including partners for different levels of care such as Cholera Treatment Centers (CTC), Cholera Treatment Units (CTU), and Oral Rehydration Points (ORPs)
- Work with Member States to designate or identify potential sites for cholera treatment facilities in the PAMIs, focus on locations that maximize accessibility, safety, and infection control, while considering both community and operational needs
- Develop, update, and/or adapt cholera case management guidelines and Standard Operating Procedures (SOPs), ensuring they are printed and distributed in all MS for immediate use in response efforts.
- Establish an adequate pool of surge health personnel trained in managing cholera cases, along with a mechanism for rapid deployment or repurposing during outbreaks
- Assess the Infection Prevention and Control (IPC) and Water, Sanitation, and Hygiene (WASH) supply needs in CTCs, CTUs, and ORPs to ensure the availability of essential supplies for safe and hygienic care
- Establish a robust mechanism for monitoring symptom changes in hospitalized patients that may indicate healthcare-associated infections (HAIs).
- Train healthcare workers, support staff, and community health workers on cholera-specific IPC measures
- Integrate cholera IPC training into broader IPC and emergency preparedness curricula
- Develop/update and distribute IPC guidelines and standard operating procedures (SOPs) for cholera
- Health facility assessments in cholera-prone areas for IPC readiness
- Establish or designate isolation areas or Cholera Treatment Centers (CTCs) with proper IPC zoning (clean, contaminated, waste areas)
- Disseminate IPC-focused health education materials to communities in hotspot areas.

Pillar 6: Water, Sanitation and Hygiene (WASH)

Strategic Objective

This plan aims to enhance the readiness and resilience of WASH infrastructure and services against cholera and other waterborne diseases, especially in high-risk communities.

Priority Actions

Category A: High Priority Countries

- Support comprehensive stakeholder mapping for WASH and solid waste management in member states.
- Support and advocate for a strong WASH intersectoral collaborative mechanism in member states.
- Conduct comprehensive preparedness assessments of water and sanitation services, focusing on vulnerable and at-risk populations to identify gaps and inform targeted interventions.
- Support the mapping of existing water sources and supply systems, and identify priority contamination risks that require urgent mitigation to prevent disease transmission.

- Promote the adoption of risk-based approaches for monitoring source water and drinking-water quality by providing essential supplies, technical support, and training to national and local teams.
- Promote and strengthen water treatment supply system in urban settlements for adequate provision of safe water
- Support water quality monitoring systems and surveillance, and mechanisms in member states.
- Support provision of household water treatment materials for the affected population and temporary WASH services during cholera emergencies/outbreaks.
- Build capacity for water-related disease surveillance and outbreak management, including training on risk-based surveillance and emergency management of drinking-water supplies.
- Review and update existing WASH training plans and protocols, with a focus on emergency preparedness and community-level training to ensure local ownership and sustainability.
- Advocate and support improve WASH in health care service provision including eco-friendly waste management and environmental cleaning practices, using tools such as Water and Sanitation for Health Facility Improvement Tool (WASH FIT).
- Support health-care facilities in establishing safe and effective medical waste management systems, ensuring compliance with infection prevention and control standards.
- Support and develop long-term interventions to improve the provision of basic and safely managed WASH services in member states.
- Develop and promote a sustainable financing mechanism for WASH governance, services, and collaborative mechanisms in member states.
- Support the development and implementation of high-impact hygiene and sanitation improvement strategies.
- Advocate for improved access to safe drinking water and sanitation in cholera-prone areas
- Support the provision of safe portable water and basic sanitation services in member states.
- Advocate for the adoption and development of climate-resilient and sustainable safe water supply and sanitation technologies.
- Advocate and support community participation in WASH development actions and interventions.

Pillar 7: Vaccination

Strategic Objective:

Ensure timely, equitable, and high-coverage oral cholera vaccine deployment in response to outbreaks.

Priority Actions:

Category A: High Priority Countries

- Provide oversight support to high-risk countries in accessing OCV through the established ICG mechanism
- Advocate for a targeted multi-sectoral approach to respond to cholera outbreaks, including the using OCV, including the delivery of basic WASH solutions
- Advocate for a continental mechanism to coordinate resource mobilization for OCV deployment on the continent for any costs not covered by existing mechanisms.
- Support the activation of rapid response teams to start vaccination within 10 days of receipt of vaccines
- Support the delivery of OCV alongside hygiene kits and water treatment in high-risk countries to maximize impact.
- Strengthen the deployment of digital tools for live tracking coverage, missed populations, and safety.
- Strengthen monitoring and evaluation of OCV campaigns.

Category B: At-Risk/Stable Countries

- Support countries to update national PAMIs maps and finalize OCV micro-plans
- Engage with countries' regulatory authorities to accelerate pre-clearance processes, cold chain review, and customs protocols for timely OCV deployment
- Train and conduct simulation drills for national OCV rapid deployment teams and healthcare workers in high-risk countries
- Establish a continental vaccine readiness dashboard hosted by the IMST.
- Conduct orientation sessions for Member States, where OCV is not commonly used, on the introduction and use of Oral Cholera Vaccine (OCV) during outbreaks to enhance preparedness and response
- Obtain emergency use approval from the national regulatory authority for the importation and use of Oral Cholera Vaccine (OCV) in countries where OCV is not registered, ensuring rapid access during cholera outbreaks
- Support countries to develop the multi-year plans of action (MYPOA) for preventive OCV, including implementation plans
- Conduct a comprehensive assessment including mapping of available expertise, equipment, infrastructure etc for OCV production on the continent

Pillar 8: Research and Innovation

Strategic Objective

Leverage research and innovation to generate and translate evidence to strengthen data-driven outbreak response, improve risk communication, and optimize logistics during cholera emergencies

Priority Actions:

Category A: High Priority Countries

- Support the development and deployment of innovative tools (e.g., mobile data platforms, GIS mapping) for early detection, case tracking, and hotspot identification
- Conduct rapid behavioral and social science research to tailor risk communication and community engagement strategies to local contexts
- Evaluate the effectiveness of community-based interventions and feedback mechanisms to refine messaging and improve trust
- Study supply chain bottlenecks during emergencies and pilot innovative logistics models to ensure timely delivery of critical supplies.
- Integrate lessons from response-phase research into national cholera control policies and emergency preparedness plans.

Category B: At-Risk/Stable Countries

- Promote community-based participatory research to understand local drivers of cholera transmission and co-design context-specific interventions
- Use research findings to inform and strengthen risk communication strategies and enhance community trust and uptake of cholera control measures.
- Investigate and scale up innovative WASH solutions and hygiene behavior interventions through adaptive research in vulnerable communities.
- Evaluate and optimize the deployment of oral cholera vaccines (OCVs) in high-risk populations through evidence-based approaches.
- Establish research networks to support evidence-informed policy and coordinated cholera response at national and sub-national levels
- Build the capacity of local researchers, academic institutions, and surveillance officers to conduct operational and implementation research on cholera prevention and response.

Pillar 9: Logistics

Strategic Objective

Ensure procurement, delivery, management, and coordination of essential supplies and equipment to sustain preparedness and response activities

Priority Actions

Category A: High Priority Countries

- To minimize duplication of efforts and competition by the humanitarian community, the Logistics pillar will organise regular coordination meetings to support countries that are both in non-humanitarian and humanitarian contexts to evaluate needs and logistics gaps to be filled.
- Monitor stock status of critical medical countermeasures at country level
- Conduct needs assessment (selection, forecasting, quantification) of critical supplies needed for response by MS
- Define the forecasted Medical counter Measures (MCM) needed for short and medium long-term need
- Develop a continental supply strategy of MCM based on zero shortage with consideration to last mile delivery and warehousing
- Enhance resilient supply of medical counter measures through donation management, procurement, stockpiling, pooled procurement and boosting African manufacturing
- Support countries to set up cholera treatment facilities and necessary infrastructure if needed
- Support waste management of medical counter measures supplied
- Support Country central warehouse with additional logistics surge capacity (logisticians, pharmacists)
- Response essential supplies monitoring and coordination:

a) Strengthen continental cholera response supply capacity through a joint supply monitoring and coordination platform that aligns global and regional supply chains, provides partners with real-time intelligence, and safeguards against gaps, duplication, and delays in critical supplies.

- Establish logistics pillar coordination platform
- Establish a supply information gathering system for essential cholera items
- Establish Continental cholera supply monitoring dashboard
- Regularly meet and inform partners to address supply priorities, gaps and potential duplications

b) At country level, the objective will remain the same, but we would eventually add:

Strengthen cholera response supply capacity through a joint supply monitoring and coordination platform that aligns responders supply chains, provides partners with real-time supply data intelligence, and safeguards against gaps, duplication, and delays in critical supplies.

- Establish logistics pillar coordination platform
- Support IMST in the establishment of the response essential supply forecast
- Establish supply upstream and downstream gathering system for essential cholera items
- Establish cholera response supply monitoring dashboard
- Regularly meet an inform partners to address supply priorities, gaps and potential duplications

Category B: At-Risk/Stable Countries

- Procurement and donation management including shipment, customs clearance processes of MCM
- Cold chain gap assessment
- Last mile delivery management of MCM
- Ensure sufficient stockpiling/ of medical countermeasures

Pillar 10: Continuity of Essential Healthcare Services

Strategic Objective

Ensure uninterrupted delivery of critical health services while responding to cholera, particularly for vulnerable populations.

Priority Actions

Category A: High Priority Countries

- Support affected member states to maintain CEHS in 100% of hotspots districts and 100% of Cholera health Centers in the most affected countries
- Reinforce and ensure adequate CEHS staffing levels through task shifting, surge capacity, and workforce protection measures.
- Support country to activate CEHS plans in affected and at-risk health facilities.
- Reorganize patient flow in facilities to separate cholera and non-cholera services and reduce cross-infection.
- Support Member States to Monitor CEHS via key indicators selected, service availability and utilization to detect and address disruptions in real time.

Category B: At-Risk/Stable Countries

- Advocate for member states to include continuity of essential healthcare services plans in the IMS for Cholera response.
- Develop and disseminate CEHS Guide, SOPs for health facilities, and training modules during IMS Cholera response
- Train healthcare managers and staff on CEHS planning and implementation during outbreaks.
- Conduct facility-level risk assessments to identify potential service disruptions during outbreaks.
- Integrate CEHS components (e.g., maternal and child health, immunization, chronic disease care) into national cholera preparedness and response plans.
- Establish CEHS key indicators monitoring system at the national and subnational levels.

Angola received 2,000 life-saving oral cholera vaccines for frontline healthcare workers from the Africa Centres for Disease Control and Prevention (Africa CDC) in March 2025

Resource Requirements (September 2025 – February 2026)

Planning Assumptions for Cholera Preparedness and Response in Africa

Between September 2025 and February 2026, more than 200,000 cases and 6020 deaths due to cholera are expected if the current interventions are maintained. However, with rapid optimal interventions, these numbers are projected to be reduced to 46,764 cases and 418 deaths. The expected number of cholera cases and deaths between September 2025 and February 2026 was estimated using historical surveillance data from the Africa CDC Cholera Database (January 2022–July 2025). A SARIMA model was applied to project future cases, incorporating rainfall patterns, the WASH index, and previous Cholera vaccination coverage for affected Member States. These projections were further refined with scenario-based assumptions (Table 5).

The model suggests that as countries strengthen their surveillance systems, reported cases may initially rise. However, with stronger interventions supported by national and international partners, case numbers are expected to decline over time. Deaths are projected to decrease even more sharply—by as much as 90%—with improved access to timely treatment and response efforts.

Table 4: Cases of cholera expected over the next six months (Sept 2025 to Feb 2026)

Scenario	Description	Total Cases 6months	Total Deaths 6months	Avg Weekly Cases	Peak Weekly Cases	Avg CFR Percent	Intervention Start Week	Cases prevented vs status quo
Status Quo	Current intervention levels are maintained	203,572	6020	7830	10938	3.40	N/A	N/A
Optimal Intervention	Rapid deployment: OCV (90%) + WASH (85%) + Enhanced surveillance	46,764	418	1799	6859	0.89	2	156,808 (77.0%)
Realistic Intervention	Standard deployment: OCV (70%) + WASH (60%) + Basic surveillance	124,457	3494	4787	10798	2.80	4	111,373 (54.7%)
Delayed Intervention	Delayed response: OCV (40%) + WASH (30%) + Limited surveillance	182, 715	4366	7028	10250	2.60	8	15,206 (10.2%)
Worst Case	Reduced interventions + climate stress + conflict	501,424	26884	19286	29728	5.36	N/A	N/A

Table 5: ***Surge patterns of cases in the next six months (September 2025 and February 2026)***

Realistic surveillance surge pattern	Average weekly Cases
Weeks 1-6: 50-70% increase in cases due to enhanced surveillance	8379
Weeks 7 - 12: 20 to 40% Transition period as surveillance stabilizes	7608
Weeks 13-18: Intervention ramp-up with exponential decline	5528
Weeks 19-26: Stabilization at 75-80% reduction	1934

Estimated Number of Oral Cholera Vaccines Needed

To estimate the population at risk of cholera requiring protection through Oral Cholera Vaccination (OCV), we applied Médecins Sans Frontières (MSF) outbreak attack rate parameters: 0.1–2% in rural areas and 1–5% in urban, peri-urban, and informal settlement settings.[1] For conservative planning, the middle value of 3% was used to determine the minimum vaccine requirement. Based on the expected 182,715 cases over the six months and attach rate of 3%, the total population at risk in affected Member States is estimated at approximately 6.1 million individuals. Assuming a target vaccination coverage of 80% and a two-dose approach, the immediate requirement is at least 10 million OCV doses to be implemented in a two-dose strategy. At $1.65/dose for vaccine procurement, $2.8/dose for the vaccine operational cost and technical assistance worth $3,678,303, $48,258,047 is required. Also, the Task Force will need to mobilize an additional $100 million for OCV African manufacturing. This will ensure progress towards a goal linked to cholera elimination by 2030, while remaining outside the six-month emergency envelope.

Estimated Number of Treatment Points Needed

Evidence indicates that among those who develop symptoms, about 80% of the 182,715 cases (146,172 cases) experience mild to moderate illness and can be treated with oral rehydration solution (ORS) at community ORS centers. With the rate of 1 ORS service point for 500 mild/moderate cases, about 311 ORS service (community) points are required. For the remaining 20% of the cases (36,543 cases) that are expected to develop severe disease, about 365 cholera treatment centers (CTCs) are required.[3]

Estimated Number of Oral and IV Fluids Needed

According to WHO guidelines, adults with severe cholera typically require 8–11 liters of Ringer's lactate over the treatment course. Applying this to the projected 36,400 severe cases expected between September 2025 and February 2026 (20% of 182,715 total cases) yields an estimated need of 401,973 liters of IV fluids.

WHO guidelines also indicate that patients with mild to moderate cholera require an average of 8–10 liters of oral rehydration solution (ORS) over the illness course. For the projected

Table 6: Estimated service points by case severity

Case Severity	Proportion of Total Cases	Estimated Number of Cases	Primary Treatment	Estimated Service Points Needed
Severe	15–20%	27,407-36,543	Treatment in cholera treatment centers with IV fluids	275-365 Cholera Treatment Centers (1 CTC per 100 severe cases over the period)
Mild to Moderate	80–85%	146,172-155,308	Oral rehydration solution (ORS) in community or outpatient settings	292-311 ORS Points (1 ORS point per 500 mild/moderate cases)

3 World Health Organization Regional Office for the Eastern Mediterranean. Cholera. Cairo: WHO EMRO; [cited 2025 Aug 12]. Available from: https://www.emro.who.int/health-topics/cholera/cholera.html

155,308 mild/moderate cases expected between September 2025 and February 2026 (80% of 182,715 total cases), this translates to an estimated need of 1.5 million ORS sachets (1 sachet = 1 liter solution).

In the absence of timely and coordinated interventions, the case fatality rate (CFR) could rise above 3%, far exceeding the WHO-recommended threshold of 1% and underscoring the urgent need for action. The projected requirements reflect the combined demand for community and outpatient treatment to prevent progression to severe disease, alongside the capacity needs of cholera treatment centers (CTCs). Ensuring the prompt and adequate supply of both oral rehydration solution (ORS) and Ringer's lactate at this scale is critical to achieving the CFR reduction targets set in the Continental Cholera Response Plan.

Estimated Budget

The effective implementation of the Cholera Preparedness and Response Plan requires adequate and sustained resources to support the priority activities outlined in the strategy. This section outlines the key resource requirements, costing assumptions and funding strategies which are critical for containing ongoing outbreaks, reducing morbidity and mortality, and preventing further spread of cholera across the continent. .

To control the ongoing Cholera outbreak, $231,734,518 is required over the next six months. This plan offers a coordinated, costed roadmap to prevent large-scale loss of life, protect health systems, and reduce cholera transmission across Africa. Donor investment will ensure rapid delivery of essential supplies, surge capacity for health workers, expanded vaccination and WASH interventions, and sustained preparedness in vulnerable countries.

In terms of the response component, $219 million is required in high-risk countries, while $13 million is needed for preparedness in at-risk countries. The response component of the budget has been split into three categories:

- Materials costs (Supplies and equipment (e.g., Ringer's lactate, ORS, PPE, lab reagents, WASH kits):
    - US $57M (20%)..
- Operational costs (Systems and delivery (e.g., transport, warehousing, cold chain, CTC setup, utilities):
    - US $88M (43%).
- Human resources, capacity building and technical assistance - People and expertise (e.g., surge staff, international deployments, national health workers, training workshops, technical guidance):
    - US $74M (37%).

Table 7: Summary of the budget categories

Budget categories	Amount
Response budget	$218,734,518
Preparedness budget	$13,000,000
Total	$231,734,518

The response component is structured across nine strategic pillars to ensure a balanced approach between life-saving interventions and system strengthening. The largest share is allocated to Case Management (31%), reflecting the urgent need to treat patients and reduce mortality, followed by WASH (21%), which addresses the root causes of transmission through safe water and sanitation. Vaccination (16%) is prioritized as a complementary intervention to protect vulnerable populations in high-risk areas. Logistics (10%) and RCCE (10%) are critical enablers of the response, ensuring rapid delivery of supplies and effective community engagement. Laboratory (5%) and Surveillance (3%) underpin timely detection and monitoring of outbreaks, while Coordination and Leadership (2%) ensures partners align around a common strategy. Finally, Research (2%) and Continuity of Essential Services (1%) safeguard learning, adaptation, and resilience within health systems. This allocation reflects a deliberate balance between immediate outbreak control and longer-term capacity building to reduce the impact of future cholera shocks.

The outbreak response budget has been designed to prioritize direct support to affected Member States, with 68% of total resources ($149 million) allocated to country-level interventions such as case management, WASH, vaccination campaigns, logistics, and surveillance. The remaining 40% ($70 million) is directed to international support, ensuring the availability of surge deployments, technical assistance, global supply chains, and coordination across partners. This balance reflects the dual need to empower national systems for frontline response while leveraging international expertise and infrastructure to sustain an effective, continent-wide cholera response.

Table 8: Budget breakdown per pillar and cost category

Pillar	Materials Costs	Operational Costs	Human Resources, Capacity Building and Technical Assistance	Total	Share
Description	Supplies and equipment (e.g., Ringer's lactate, ORS, PPE, lab reagents, WASH kits	Systems and delivery (e.g., transport, warehousing, cold chain, CTC setup, utilities)	People and expertise (e.g., surge staff, international deployments, national health workers, training workshops, technical guidance).		
Coordination and Leadership	$-	$-	$3,678,303	$3,678,303	2%
RCCE	$-	$12,034,176	$7,356,606	$19,390,782	9%
Surveillance	$-	$2,647,519	$3,678,303	$6,325,822	3%
Laboratory	$1,500,000	$601,709	$7,356,606	$9,458,315	4%
Case Management	$14,240,000	$30,085,440	$18,391,516	$62,716,956	29%
WASH	$25,071,200	$2,700,000	$14,713,213	$42,484,413	19%
Logistics	$-	$9,008,667	$11,034,910	$20,043,576	9%
Vaccination	$16,500,000	$28,079,744	$3,678,303	$48,258,047	22%
Research	$-	$2,700,000	$1,471,321	$4,171,321	2%
Continuity of essential services	$-	$-	$2,206,982	$2,206,982	1%
Total	**$57,311,200**	**$87,857,254**	**$73,566,064**	**$218,734,518**	**100%**

Table 9: Response budget breakdown by pillar and type of support

Pillar	Funding for Affected Member States	Funding for International Support	Total
Description	68%	32%	100%
Coordination and Leadership	$2,501,246	$1,177,057	$3,678,303
RCCE	$13,185,732	$6,205,050	$19,390,782
Surveillance	$4,301,559	$2,024,263	$6,325,822
Laboratory	$6,431,654	$3,026,661	$9,458,315
Case Management	$42,647,530	$20,069,426	$62,716,956
WASH	$28,889,401	$13,595,012	$42,484,413
Logistics	$13,629,632	$6,413,944	$20,043,576
Vaccination	$32,815,472	$15,442,575	$48,258,047
Research	$2,836,498	$1,334,823	$4,171,321
Continuity of essential services	$1,500,748	$706,234	$2,206,982
Total	**$148,739,473**	**$69,995,046**	**$218,734,518**

Table 10: Response budget breakdown by High Risk Member States

Category A : High Priority Countries	Budget allocation
Ghana	$3,359,263
Zambia	$3,156,247
Angola	$10,906,602
Sudan	$20,199,007
South Sudan	$30,129,098
Ethiopia	$5,053,249
Uganda	$3,064,944
Malawi	$3,042,364
Zimbabwe	$3,204,417
Mozambique	$4,082,318
Kenya	$3,116,607
Namibia	$3,015,120
Rwanda	$3,058,903
DRC	$20,746,842
Nigeria	$4,372,343
Somalia	$5,562,549
Togo	$3,079,496
Burundi	$3,179,328
Tanzania	$4,003,038
Comoros	$3,016,774
Ivory Coast	$3,130,155
Chad	$3,127,144
Congo Republic	**$3,133,667**
Total	**148,739,473**

(Active cholera transmission / endemic / very high risk)

Table 11: Preparedness budget for at-risk countries

Category B: At-Risk Countries	Preparedness Budget
Benin	$1,000,000
Burkina Faso	$1,000,000
Cameroon	$1,000,000
Central African Republic (CAR)	$1,000,000
Djibouti	$1,000,000
Gabon	$1,000,000
Guinea	$1,000,000
Liberia	$1,000,000
Madagascar	$1,000,000
Mali	$1,000,000
Niger	$1,000,000
Sierra Leone	$1,000,000
South Africa	$1,000,000
Total	**$13,000,000**

(No active cases, but vulnerable due to conditions and bordering high-priority countries)

WHO Response to Cholera Outbreak

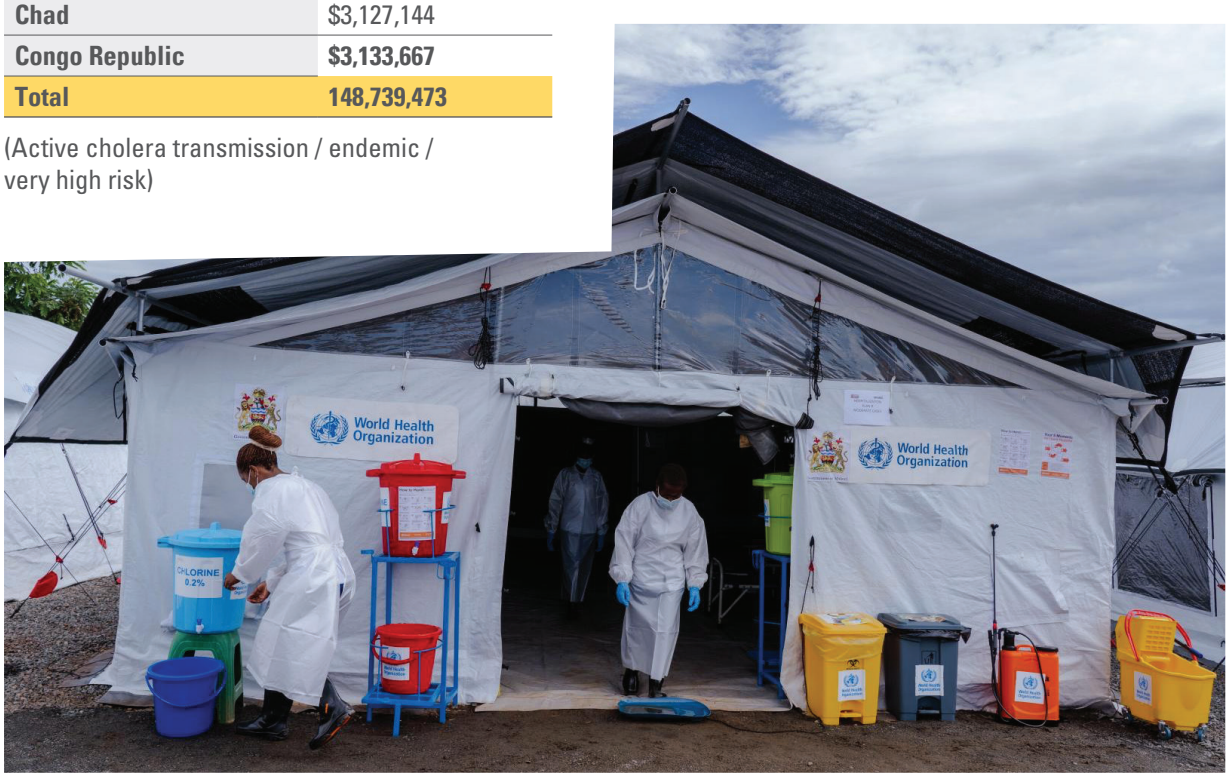


Table 12: Budget breakdown for international support

Pillar	Africa CDC	WHO	UNICEF	WFP	IOM	MSF	IFRC	Total
Description	19%	19%	13%	13%	10%	13%	13%	**100%**
Coordination and Leadership	$223,641	$223,641	$153,017	$153,017	$117,706	$153,017	$153,017	**$1,177,057**
RCCE	$1,178,960	$1,178,960	$806,657	$806,657	$620,505	$806,657	$806,657	**$6,205,050**
Surveillance	$384,610	$384,610	$263,154	$263,154	$202,426	$263,154	$263,154	**$2,024,263**
Laboratory	$575,066	$575,066	$393,466	$393,466	$302,666	$393,466	$393,466	**$3,026,661**
Case Management	$3,813,191	$3,813,191	$2,609,025	$2,609,025	$2,006,943	$2,609,025	$2,609,025	**$20,069,426**
WASH	$2,583,052	$2,583,052	$1,767,352	$1,767,352	$1,359,501	$1,767,352	$1,767,352	**$13,595,012**
Logistics	$1,218,649	$1,218,649	$833,813	$833,813	$641,394	$833,813	$833,813	**$6,413,944**
Vaccination	$2,934,089	$2,934,089	$2,007,535	$2,007,535	$1,544,258	$2,007,535	$2,007,535	**$15,442,575**
Research	$253,616	$253,616	$173,527	$173,527	$133,482	$173,527	$173,527	**$1,334,823**
Continuity of essential services	$134,185	$134,185	$91,810	$91,810	$70,623	$91,810	$91,810	**$706,234**
Total	**$13,299,059**	**$13,299,059**	**$9,099,356**	**$9,099,356**	**$6,999,505**	**$9,099,356**	**$9,099,356**	**$69,995,046**

Implementation of the plan is anchored in a strong partnership of leading health and humanitarian agencies, with allocations reflecting comparative advantages. Africa CDC and WHO will each manage 19% of the total budget, focusing on coordination, surveillance, and technical leadership. UNICEF (18%) leads on RCCE, WASH, and vaccination, while WFP (9%) and IOM (10%) provide critical logistics and operational support. MSF (13%) and IFRC (12%) bring frontline expertise in case management, WASH, and community response. Together, these partners share a budget of $80.9 million, ensuring a coordinated, complementary approach to cholera control across Africa.

Continental IMST Implementation Framework

Overall Coordination and Leadership Structure

The continental cholera response will be jointly coordinated and led by Africa CDC and the World Health Organization (WHO), supported by a network of dedicated technical workstreams—referred to as response pillars—each led by key partners leveraging their unique strengths and expertise. This collaborative structure ensures that all aspects of the response are guided by specialized knowledge and operational capacity.

Africa CDC and WHO will work in close partnership with a broad coalition of stakeholders, including United Nations agencies, non-governmental organizations (NGOs), civil society organizations (CSOs), military humanitarian actors and other technical partners. These stakeholders will be actively engaged within the designated cholera response pillars, ensuring inclusive participation and alignment across all levels of intervention.

In alignment with the Lusaka Agenda and the recent Call-to-Action on Cholera Elimination, the response will be anchored in the "One Team, One Plan, One Budget, and One Monitoring and Evaluation" framework. This approach promotes coherence, operational efficiency, and accountability, enabling a harmonized and results-driven response across the continent.

To operationalize this framework, a Continental Cholera Incident Management Support Team (IMST) has been established and integrated into the existing mpox IMST platform. This integration facilitates seamless coordination, joint decision-making, and effective resource mobilization, while capitalizing on existing infrastructure and lessons learned from previous outbreak responses.

Figure 2: Structure of the Continental Cholera IMST

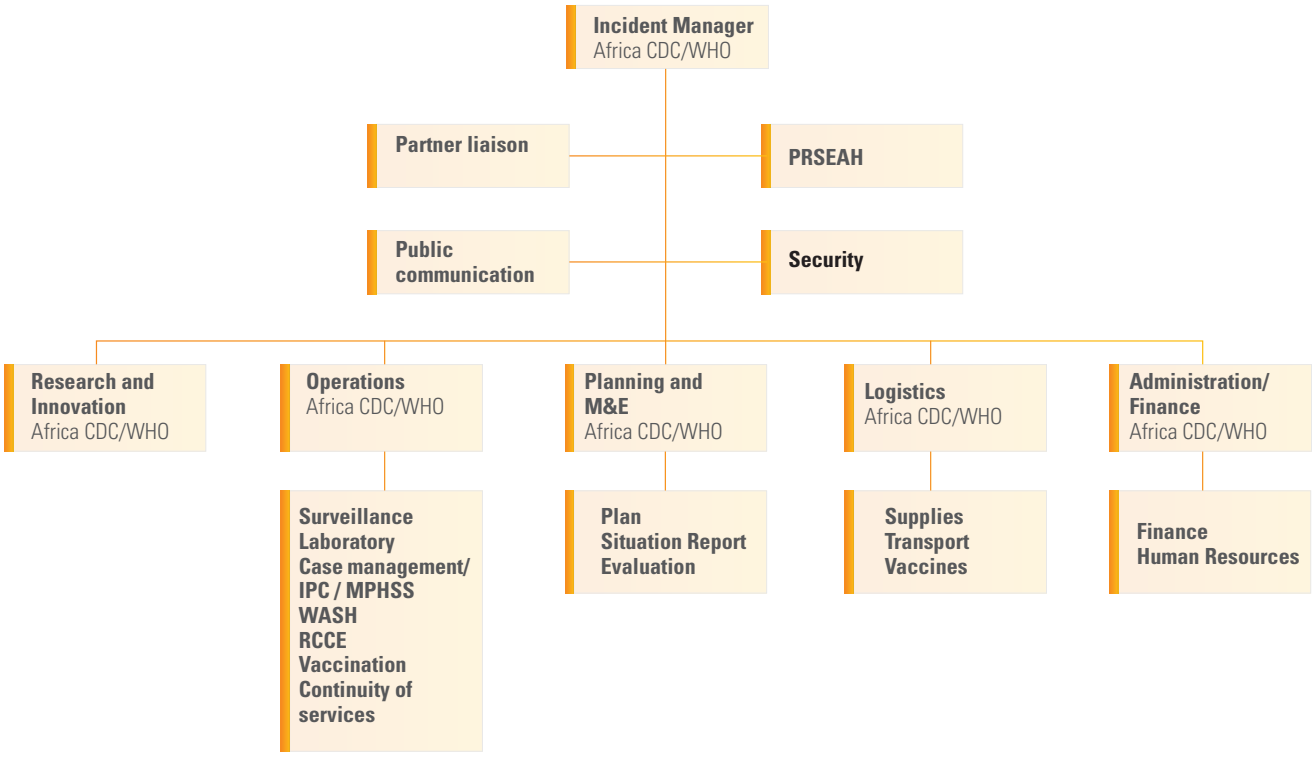


Table 13: Main functions of partners by pillars of response

Pillar	Lead (Africa CDC and/or WHO)	Sub-pillar	Support Partners
Pillar 1: Coordination and leadership	Africa CDC/WHO	Partner/Liaison	Africa CDC
		Public Information	Africa CDC
		PRSEAH	WHO
		Security	WHO
		Planning and M&E	Africa CDC, WHO
Pillar 2: Risk Communication and Community Engagement (RCCE)	Africa CDC/WHO	Community feedback mechanisms	IFRC, UNICEF
		Infodemics	WHO
		Community Engagement	IFRC, UNICEF, WHO
		Risk Communication	Africa CDC, UNICEF, WHO
		Behavioral insights and knowledge management	UNICEF, WHO
		Media	IFRC, UNICEF, USAID
Pillar 3: Surveillance	Africa CDC/WHO	Hotspot mapping and vulnerability assessment	UNICEF
		Community-based surveillance	IFRC
		Data and health information management	HISP, PATH
		Environmental surveillance	Africa CDC, WHO
		Cross-border surveillance and coordination	IOM
Pillar 4: Laboratory Capacity	Africa CDC, WHO	Diagnostics	Africa CDC, FIND, WHO
		Quality Control and Assurance	ASLM, WHO
		Genomic sequencing and bioinformatics	ASLM, WHO
Pillar 5: Case Management and IPC	Africa CDC/WHO	Clinical/Health facilities	Africa CDC, MSF, UNICEF, WHO
		MHPSS	Africa CDC, UNICEF
		Nutrition	WFP
Pillar 6: WASH	Africa CDC/WHO	Health facilities	MSF, WHO
		Community	MSF, UNICEF
		WASH	MSF, UNICEF
Pillar 7: Vaccination	Africa CDC/WHO	Delivery	CDC, GAVI, IFRC, MSF
		Monitoring and evaluation	CDC, GAVI, IFRC, MSF

Pillar	Lead (Africa CDC and/or WHO)	Sub-pillar	Support Partners
Pillar 8: Research and Innovation		Implementation/Operational Research	EDCTP, Wellcome
		Clinical Trials/RandD	CEPI, EDCTP, WHO
		Knowledge management and translation	Africa CDC, WHO
		Ethics and Regulatory	African Regulatory Forum, AVAREF
Pillar 9: Logistics	Africa CDC/WHO	Procurement	Africa CDC, UNICEF, WFP, WHO
		Supply	UNICEF, WFP, WHO
		Health Logistics and Operations	MSF, WFP, WHO
Pillar 10: Continuity of Essential Services	Africa CDC/WHO	National IMST MoH/Strategic level	Africa CDC, Momentum IHR, UNICEF, WFP
		Health facilities/operational level	Africa CDC, Momentum IHR, WFP, UNICEF

Role of the IMST as a Coordinated Response Mechanism

The Incident Management Support Team (IMST), jointly led by Africa CDC and WHO, serves as the central coordination and leadership structure for the continental cholera response. This unified mechanism is designed to ensure strategic coherence, operational efficiency, and evidence-based decision-making across all levels of intervention.

At the core of the IMST is a shared leadership model, with cholera technical leads embedded within key response pillars such as surveillance, laboratory, Infection Prevention and Control (IPC), Case Management, and research. This structure enables seamless integration of expertise and ensures that each pillar is guided by specialized leadership aligned with continental priorities.

The IMST will develop and implement joint standardized guidelines, strategies, and tools, including a comprehensive Continental Cholera Incident Action Plan. These resources will provide a consistent framework for response activities, ensuring that interventions are harmonized across regions and adaptable to local contexts.

Maintaining close interaction with Member States is a cornerstone of the IMST's approach. Through continuous feedback loops, information sharing, and provision of technical guidance, the IMST will support national response teams in real-time, fostering agility and responsiveness in outbreak management.

Capacity building is another key function of the IMST. Tailored training programs, technical assistance, and mentorship will be provided to strengthen national cholera response teams, ensuring that countries are equipped with the skills and tools needed to manage outbreaks effectively.

To promote transparency and learning, the IMST will facilitate regular communication, documentation, and experience sharing among Member States. This includes convening technical exchanges, publishing best practices, and maintaining a centralized knowledge repository.

A harmonized Monitoring and Evaluation (M&E) framework will be jointly developed to track progress, measure impact, and guide adaptive strategies. This framework will ensure accountability and enable data-driven decision-making across all response activities.

In support of innovation and continuous improvement, the IMST will also jointly develop unified research protocols and encourage collaborative publications that reflect the strength of the partnership and contribute to the global cholera knowledge base.

The complementarity of mandates between Africa CDC and WHO is a key strength of this joint IMST. Africa CDC brings deep contextual knowledge, strong relationships with AU Member States, and a proven track record in public health capacity building. WHO contributes normative leadership, global standards, and international coordination. Together, they form a powerful alliance capable of delivering a unified, impactful, and sustainable cholera response across Africa.

Roles and Responsibilities of Member States

As a baseline, all Member States are expected to comply with the International Health Regulations (IHR 2005), follow relevant guidance, and adhere to the standing recommendations currently in effect. These obligations form the foundation for a unified and coordinated approach to the cholera response. Compliance with the IHR ensures consistency across borders and supports collective preparedness and response efforts.

Key considerations include:

- Member States bear the primary responsibility for cholera response within their jurisdictions, including the preparation of a national response plan that specifies resource distribution to facilitate partner coordination and technical assistance.
- As technical support will be provided by partners, Member States must establish and maintain effective collaborative relationships and enabling environments for partner engagement, while also monitoring the support received.
- Member States are required to share relevant epidemiological data with Africa CDC and WHO to inform the response. This includes reporting on Key Performance Indicators (KPIs) as outlined by these organizations.
- Countries must adapt their existing national preparedness and response plans to incorporate transition and legacy components.
- Member States to establish cholera incident management teams

Engagement with WHO, Africa CDC and Partner Organizations

The Cholera Continental Response is anchored in a collaborative framework that brings together Africa CDC, WHO, and a wide range of partner organizations under a unified coordination mechanism. At the heart of this framework is a joint leadership model, with Africa CDC and WHO co-leading the response through a shared Incident Management Support Team (IMST). This co-leadership ensures strategic alignment, facilitates joint decision-making, and promotes transparent communication across all levels of response.

Partner engagement will be actively promoted through regular coordination mechanisms, including weekly technical and strategic meetings. These meetings serve as a platform for harmonizing response planning, aligning resource mobilization efforts, sharing operational updates, and resolving emerging challenges. They also foster a culture of collaboration and accountability among all stakeholders involved.

Roles and responsibilities within the response framework are clearly defined to ensure operational clarity and efficiency. Africa CDC and WHO will provide strategic direction and oversight, while partner organizations—including UN agencies, NGOs, CSOs, and technical institutions—will lead specific response pillars based on their areas of expertise. This structure allows each entity to contribute meaningfully while avoiding duplication of efforts.

By leveraging the comparative advantages of each partner, the coordinated approach maximizes technical expertise, logistical capacity, and resource efficiency. It enables rapid deployment of interventions, strengthens surveillance and laboratory networks, and enhances community engagement. Ultimately, this collaborative model ensures a more agile, effective, and sustainable response to cholera across the continent.

Incident Management Support Team

The Incident Management Support Team (IMST) is Africa's continental effort co-led by Africa CDC and WHO, that collaborates with ministries of Health, regional partners, and global stakeholders to expand vaccination efforts, enhance diagnostic access, and strengthen health system resilience.

https://africacdc.org/download/a-call-to-action-to-end-cholera-outbreaks-and-achieve-cholera-elimination-in-africa-by-2030/taking into account the rainy seasons in sub-saharan Africa usually between August and February. A small number of countries, likely those with ongoing transmission and fragile WASH systems (e.g.,Angola, Sudan, South Sudan, Ethiopia, Mozambique, DRC, Nigeria, Somalia, Burundi, and Tanzania

Monitoring, Evaluation and Accountability

This subsection aims to measure the expected impact of the intervention and assess its effectiveness. It outlines the objectives of the M&E component and describes the methodology that will be used to monitor progress toward the defined goals. This includes a clear statement of purpose and the methodology to apply.

Results-based monitoring

This subsection aims to measure the expected impact of the intervention and assess its effectiveness. It outlines the objectives of the M&E component and describes the methodology that will be used to monitor progress toward the defined goals. This includes a clear statement of purpose and the methodology to apply.

Monitoring of the response plan will be guided by a results-based monitoring approach. This approach recognizes that achieving the overarching goal of the response plan and the objectives set out in the Call to Action is not a linear process. Rather, it involves a complex interplay of interconnected processes and interventions that collectively contribute to the achievement of the desired outcomes and long-term impact, transitioning from inputs to impacts. At each of the results chains, a set of SMART indicators developed and validated by the leadership will be used to track progress of results in the response.

Input and output monitoring will be ensured through a set of reporting tools developed by the IMST that will be adhered to by all stakeholders. Process monitoring will be conducted using specific tools such as the IPC assessment checklist; EPR readiness checklist; and Risk communication checklist among others.

Periodic and ad-hoc joint support supervision visits will be undertaken; and to ensure the correctness, completeness, and timeliness of monitoring data, a series of internal review mechanisms will be used, including weekly and monthly reviews at national, regional and continental levels.

Data collected during the implementation of this plan will be shared with the Continental IMT which has the primary mandate for its monitoring.

Evaluation

The Continental IMST will conduct periodic evaluations of the plan including Intra and After-action review; and accountability forum; among others.

Accountability

Ensuring robust accountability is central to the success and sustainability of the continental cholera response. At both regional and national levels, the finance tracking mechanism used for Mpox will be extended to cholera to uphold financial integrity, operational transparency, and social responsibility throughout the implementation of response activities.

Financial accountability will be maintained through standardized budgeting processes, transparent finance management dashboards, and regular audits. Transparent reporting systems will be established to track the allocation and utilization of resources, ensuring that funds are directed toward high-impact interventions and that donor confidence is sustained.

Operational accountability will be reinforced through performance monitoring frameworks aligned with the “One Monitoring and Evaluation” approach. These frameworks will include clear indicators, timelines, and deliverables for each response pillar. Regular progress reviews, field assessments, and partner reporting will help identify gaps, measure impact, and inform adaptive strategies.

Social accountability will be promoted by engaging communities, civil society organizations (CSOs), and local leaders in the planning, implementation, and evaluation of cholera response activities.

Feedback mechanisms—such as community scorecards, hotlines, and public forums—will be used to ensure that interventions are responsive to local needs and that affected populations have a voice in shaping the response.

Key Performance Indicators (KPIs)

Key performance indicators for the response will be defined and validated into a performance indicator reference sheet by the IMST team. This will include a set of indicators to measure results at each level of the results chain, including process indicators, efficiency to measure how the process of delivering activities science-driven and responsive to local context.

The following KPIs are designed to ensure effective monitoring of the Cholera Preparedness and Response Plan.

Table 14: Key Performance Indicators of the Response Plan

Objective	KPI	Target	Means of verification	Frequency of reporting
Establish a unified and functional coordination mechanism, integrated within the existing mpox IMST (continental and national) and guided by the principles of one team, one plan, one budget, and one monitoring and evaluation framework across continental, regional, national, and subnational levels.	Functional coordination structure established at continental, national, and subnational levels	One at each level	TORs, Reports, meeting and minutes	Monthly
Support and engage communities, including the most vulnerable groups, to promote adherence to key public health measures and ensure access to essential services aimed at reducing cholera transmission, morbidity, mortality, and associated secondary impacts	Percentage increase in public knowledge about Cholera transmission and prevention measures. Level of public knowledge about Cholera transmission and prevention measures. Level of public knowledge about Cholera transmission and prevention measures.	Number of populations reached 90% reach as measured by surveys.	Survey Report	Quarterly
	Percentage of individuals who report practicing recommended measures to protect themselves from Cholera	90%	Survey	Monthly

Objective	KPI	Target	Means of verification	Frequency of reporting
To rapidly detect, confirm, characterize, and monitor the evolution of an outbreak to inform and guide immediate, effective, and targeted control interventions aimed at interrupting transmission and minimizing morbidity and mortality.	Percentage of suspected cases investigated within 24 hours of reporting.	90% of cases investigated within 24 hours	SitRep and weekly epidemic intelligence report	Monthly
	Percentage of Member States established cross border surveillance system	100% of Member States	Surveillance report	Monthly
To ensure timely and accurate laboratory confirmation of cholera cases during outbreaks to guide public health response and resource allocation.	Number of laboratories with functional capacity to conduct Cholera testing	One laboratory per province in 10 high priority countries and at least one national reference laboratory in at risk and other Member States	Laboratory Report	Monthly
To provide high-quality and comprehensive treatment and holistic care for cholera patients through early establishment of cholera treatment centers (CTC), capacity building, establishment of community Oral Rehydration Points (ORPs) supported with cholera kits at community, peripheral and central levels and maintain CFR below 0.5%	Number of engagements, and events to improve cholera case management	Case fatality rate below 1%	Report on CFR	Quarterly
	Number of facilities with staff trained on Cholera case management.			
	Case fatality rate			
To enhance IPC measures in cholera treatment centers and households	Percentage of health facilities supported with IPC	80% of health facilities with strengthened IPC	Assessment report	Quarterly
	% of population in high-risk areas practicing key hygiene behaviors (e.g., handwashing with soap at critical times)	80%	Assessment report	Quarterly

Objective	KPI	Target	Means of verification	Frequency of reporting
Ensure timely, equitable, and high-coverage oral cholera vaccine deployment in response to outbreaks	% of planned OCV campaigns completed as scheduled	80%	Report	Monthly
	Percentage of targeted population and high-risk groups who received at least one dose of OCV	80% of targeted population and high-risk groups are vaccinated	Report	Monthly
Ensure procurement, delivery, management, and coordination of essential supplies and equipment to sustain preparedness and response activities	Percentage of member states that receive at least 80 % of Cholera-related supplies ordered.	80%	Report	Monthly
Leverage research and innovation to generate and translate evidence to strengthen data-driven outbreak response, improve risk communication, and optimize logistics during cholera emergencies	Research coordination mechanism established	A functional continental research coordination mechanism in-place	Report / Publications	Quarterly
Ensure uninterrupted delivery of critical health services while responding to cholera, particularly for vulnerable populations	Percentage of health facilities in each member state that are operational and providing Cholera-related services in hot spots health districts.	80%	Assessment report	Monthly

First Conference on Transdisciplinarity for the Elimination of Cholera in Maputo, Mozambique, on July 29 2025

Annexes

Annex 1: Major Risks and Realistic Mitigations Measures

Risk	Likelihood/Impact	Why it matters	Concrete mitigations
OCV supply gap	High/High	Campaigns slip; reduced impact	Early ICG pre-alerts; prioritize single-dose in hotspots; coordinate donor allocations via IMST dashboard; explore regional fill-finish medium-term.
Funding delays	Med/High	Misses seasonal window	Front-load 60–70% in first 8 weeks; pooled procurement; pre-approved vendor lists; rapid grant instruments.
Last-mile logistics and insecurity	Med/High	Stockouts, low coverage	Use RRTs and mobile CTCs; buffer stocks at sub-national hubs; NGO/IFRC access channels; WFP logistics support.
Weak data sharing and inconsistent KPIs	Med/Med	Poor targeting, late pivots	IMST reporting SOPs; weekly country dashboards; data-use mentorship; cross-border info exchange.
WASH infrastructure gaps	High/ High	Resurgence risk post-response	Package low-cost WASH quick wins with OCV/hygiene kits; facility WASH upgrades using WASH-FIT.
Customs/regulatory bottlenecks	Med/Med	Response slippage	Pre-clearance MOUs; standing exemptions for cholera commodities.

Annex 2: The African Continental Taskforce on Cholera Control

The African Continental Task Force on Cholera Control brings together organizations, economic blocs, institutions across all sectors, and subregional bodies, working alongside the AU Champion on Cholera to ensure effective multisectoral coordination, optimal resource mobilization, and alignment of national and regional efforts toward eliminating cholera in Africa by 2030.

Objectives

1. **Accelerate the implementation of the Global strategy:** Adapt key strategic short and long-term guidance from the GTFCC taking into account the Africa contexts to enhance cholera control and elimination in Africa
2. **Enhance Multisectoral Collaboration and Coordination:** Foster strong partnerships among regional organizations, institutions and countries to enhance cholera control
3. **Enhance advocacy for cholera prevention and control resource mobilization:** Design effective advocacy efforts for increased financial commitment to the long-term cholera prevention and control measures, including considerations to establish a **Cholera Fund** similar to that of Polio
4. **Strengthen cross-border collaboration at regional and subregional levels:** Enhance regional cross-border collaboration and coordination to strengthen regional and subregional cholera preparedness and response to cholera transmission
5. **Encourage Public-Private Partnerships for cholera control:** Foster collaborations with private sector entities to leverage additional funding and technical expertise for cholera prevention and control initiatives, including production of OCV and other cholera supplies within the continent and for research and innovations
6. **Support to Member States:** Develop a mechanism for coordinating tailored technical, human and financial support to national cholera control strategies.
7. **Support to AU Cholera Champion:** The Task Force will accompany the AU Champion on Cholera in his political and strategic activities to strengthen preparedness and response to cholera across AU Member States.

Governance

The Continental Taskforce will:

Include Country representatives from Emergency response, health systems, Water, sanitation and Environment. Developmental partners, technical partners and donors involved in cholera related activities on the continent.

Africa CDC and WHO will:

Serve as the joint secretariat for the Taskforce – Follow up with countries and organize annual meetings with Ministers of health and then Heads of States to provide update on implementation of National Cholera Plans. Status of manufacturing of cholera related supplies on the continent and overview of cholera situation in countries affected by outbreaks.

Operational Framework of the Continental Task Force

The Task Force is designed to create a structured platform for collaboration, streamline decision-making, and enhance the overall response and effective actions to cholera outbreaks across the continent. It shall be country driven with support from organizations and institutions operating in Africa.

The goal of the taskforce shall be to ensure a coordinated, multi-sectoral, and data-driven response. These will be achieved through:

- **Clear command structure**: delineate roles and responsibilities for the continental IMST, regional coordination structures, and national levels incident management systems.
- **Information management**: Establish a robust system for data collection, analysis, and sharing with the continental cholera champion and HoSG as well as global and regional stakeholders to inform decision-making and track progress
- **Resource Mobilization**: Develop effective strategies for resource mobilization and efficient allocation and deployment of human, financial, and material resources across the high-burden areas.
- **Communication**: Regularly update the Head of States and Governments and inform policies, as well as accurate risk communication to the public and stakeholders.
- **Multi-sectoral Coordination**: Engaging ministries of health, water, sanitation, education, local authorities, NGOs, and international partners to achieve the objectives set out in the cholera call-to-action by Head of States and governments.

Leadership and Coordination

Chairperson

The Secretariat will be provided by Africa CDC and the World Health Organization to support Member States and the AU Cholera Champion. Its role will include providing updates on the dynamics and challenges of the cholera response, identifying remaining gaps, preparing the leadership agenda to engage with other Member States and governments, and reporting progress to the AU Assembly.

Secretariat

The Secretariat will be provided by Africa CDC and the World Health Organization to support Member States and the AU Cholera Champion. Its role will include providing updates on the dynamics and challenges of the cholera response, identifying remaining gaps, preparing the leadership agenda to engage with other Member States and governments, and reporting progress to the AU Assembly.

Steering Committee

Comprising representatives from Member States, WHO, Africa CDC, UNICEF, Gavi, IFRC, and other relevant stakeholders. This committee will guide the Task Force's priorities and operational strategies.

Functions of the taskforce

The functions of the Continental Task Force on Cholera Control will mirror the functions of the GTFCC to enhance implementation as close to the Member States as possible.

1. **Collaborative partnerships**

   Foster institutional and operational partnerships at national, regional, and global levels, ensuring that cholera is mainstreamed in multisectoral development initiatives.

2. **Policy and strategic guidance**

   Provide policy advice to align national efforts with regional and global best practices and the objectives of the Regional Framework, 2018—2030, and the Global Roadmap to 2030.

3. **Research and innovation**

   Lead the development of research agendas and the implementation of operational research in Africa, driving innovation in cholera prevention and control.

4. **Technical expertise and assistance**

   Provide tailored technical support to enhance national cholera control strategies and interventions on the continent.

5. **Capacity building**

   Invest in strengthening the skills and capabilities of national teams, enabling them to manage and sustain cholera control programs.

6. **Advocacy and communication**

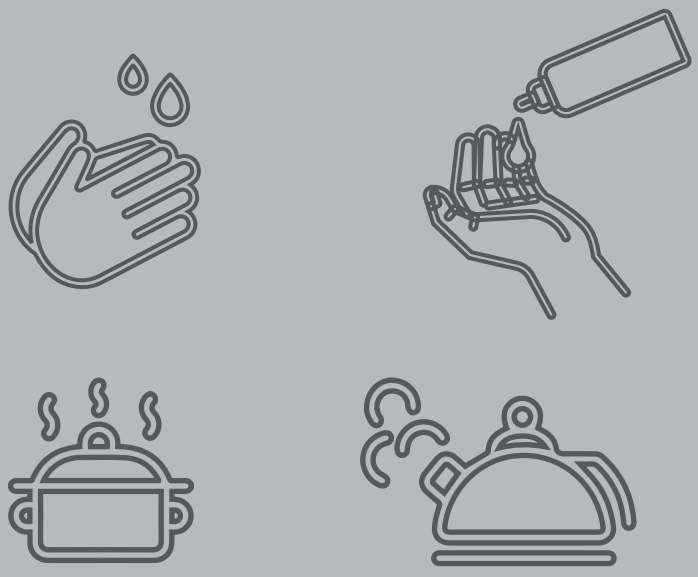
   Support countries in their advocacy efforts, helping to raise awareness and mobilize resources for cholera control initiatives.

7. **Resource mobilization**

   Assist in fundraising and resource management to ensure that countries have the necessary financial support to achieve their cholera elimination goals.

Hand and Food Hygiene:

a key to protecting our citizens from Cholera infection and transmission



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