IFRC

FINAL OPERATION REPORT

Malawi, Africa| Cholera Outbreak

Volunteer Collecting Cholera Feedback Data in Balaka District

Emergency appeal №: MDRMW017 **First launched on:** 2/01/2023.	**Glide №:** **EP-2022-000298-MWI**
Final report issued on: 24/03/2025	**Timeframe covered by this update:** From 15/09/2022 to 30/09/2023
Operation timeframe: 9 months (24/01/2023 – 30/09/2023)	**Number of people assisted:** 4,780,492 people
Funding coverage (CHF): CHF 3,500,000 through the IFRC Emergency Appeal CHF 5,200,000 Federation-wide	**DREF amount initially allocated:** CHF 1 million

A. SITUATION ANALYSIS

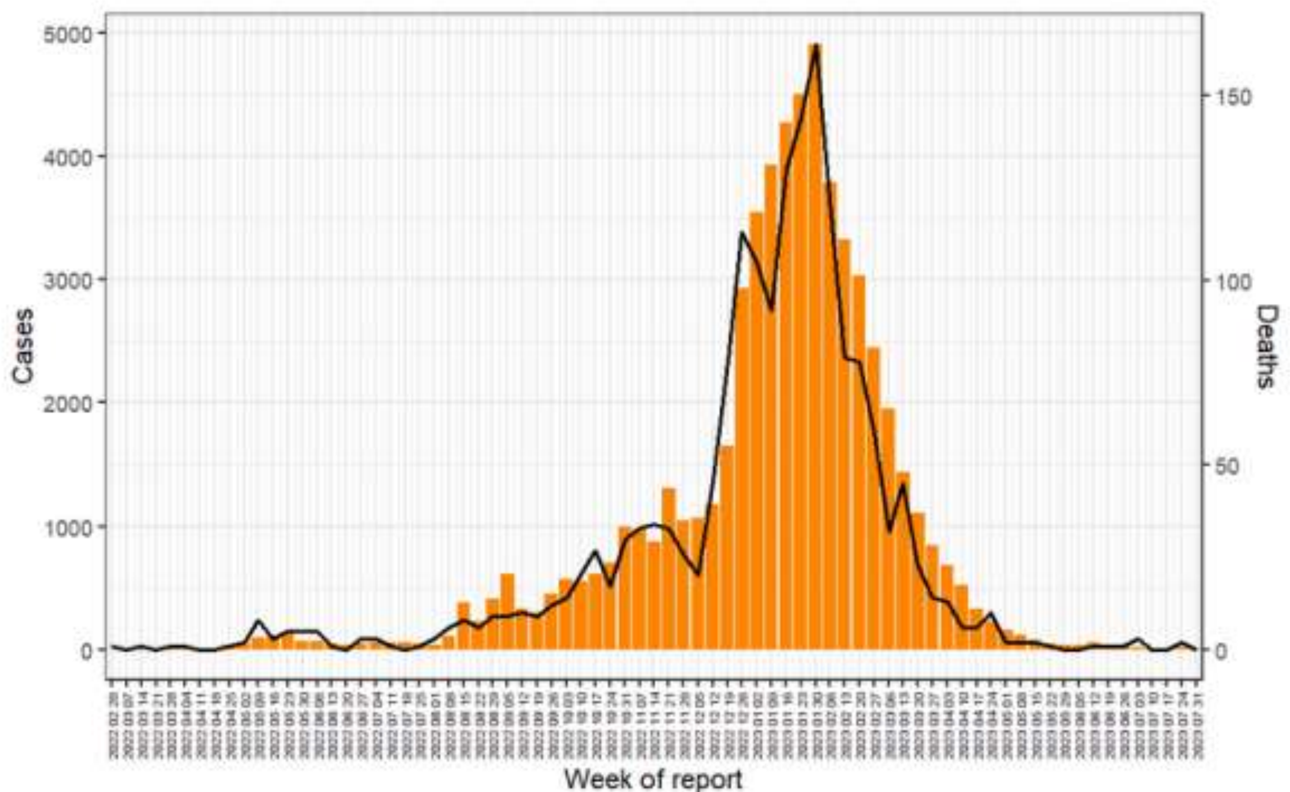
Description of the crisis

Malawi has faced one of its worst cholera outbreaks in years, affecting all 29 health districts in the country. The outbreak started in March 2022 in Machinga district and was declared a public health emergency by the State President in December 2022.

The outbreak was exacerbated by the rainy season of 2022/2023, which increased the transmission of the waterborne disease. The outbreak peaked in November 2022, with 4,766 cases reported in that month alone. The Ministry of Health's epi-week 44 report, released on November 14, 2023, reveals a cumulative case count of 59,088 and a cumulative death toll of 1,769, yielding a 3% case fatality rate. The Ministry of Health, with support from partners, implemented interventions to control the outbreak, including oral cholera vaccination (OCV) campaigns, water and sanitation improvement, case management, and social mobilization.

On 7th November 2023, The Ministry of Health received 2.9 million doses of Oral Cholera Vaccine (OCV). The OCV covered 14 high-risk districts namely Karonga, Rumphi, Mzimba North, Mzimba South, Likoma, Nkhatabay, Chitipa, Lilongwe, Salima, Nkhotakota, Kasungu, Nsanje, Zomba, and Blantyre. The cholera outbreak trend showed a significant decline since May 2023, and as of 30th September 2023, only three districts were still reporting sporadic cases.

It is against this background that the Presidential taskforce on coronavirus and cholera announced that cholera is no longer a public health emergency as of August 2023.



Number of new cases continued to trend downward over the past 23 weeks. Thirteen (13) new cases were reported in the past week (Epi-Week 31), representing a 13.3% decrease in the number of new cases compared to Epi-Week 30

Summary of response

Overview of the host National Society and ongoing response

The Malawi Red Cross Society (MRCS) plays a vital role in supporting the cholera response across numerous districts, utilizing diverse funding sources to effectively address the outbreak. This response is integrated into MRCS's response projects, facilitated through both MRCS's own initiatives and the Federation Wide Appeal. MRCS has been actively responding to the cholera outbreak in 22 districts, namely Karonga, Rumphi, Mzuzu, Nkhatabay, Nkhotakota, Salima, Lilongwe, Dedza, Ntcheu, Balaka, Machinga, Neno, Mwanza, Blantyre, Chikwawa, Thyolo, Mulanje, Phalombe, Chiradzulu, Mangochi, Machinga, and Nsanje.

The MRCS cholera Response received funding from several contributors. The International Federation of Red Cross and Red Crescent Societies (IFRC), Danish Red Cross consortium (Netherlands Red Cross, Icelandic Red Cross), Swiss Red Cross, Qatar Red Crescent, UNICEF, and GIZ. Organisation and companies that donated items for managing cholera are ICRC, Nissan Malawi, Brands Africa Limited and Reckitt Benckiser.

The MRCS's effectiveness lies in its network of dedicated volunteers and branches, which serve as the pillars of the response efforts. This volunteer network is the driving force behind the MRCS's ability to reach affected communities swiftly and efficiently. Furthermore, the MRCS's district staff and headquarters staff significantly contribute to the technical input and successful implementation of the response.

Fundamental aspect of MRCS's effectiveness is its close collaboration with key governmental bodies such as the Ministry of Health and the Ministry of Water and Sanitation. This collaboration enhances the MRCS's efforts, enabling the National Society to effectively exercise its auxiliary role. The partnership with these Ministries not only ensures a more comprehensive and well-coordinated response but also leverages their expertise and resources to address the cholera outbreak in a holistic manner.

The impact of the Tropical Cyclone Freddy (TCF) became a complicating factor in the cholera response, particularly in relation to the exacerbation of the outbreak in the southern region of Malawi as TCF made landfall on March 12, 2023. The timing of TCF's arrival coincided with the peak of the ongoing cholera outbreak, resulting in extensive damage to critical health facilities, as well as essential WASH (Water, Sanitation, and Hygiene) infrastructures.

The aftermath of TCF was also the extensive damage inflicted upon households, leading to heightened concerns about food security and malnutrition. This highlighted the relationship between cholera and malnutrition, with high number of deaths of under 5 children being reported.

Trainings and capacity strengthening of volunteers and health workers.
MRCS used participatory strategies and approaches with staff and volunteers are trained in Community based health and First Aid (CBHFA), Community Based Surveillance (CSB), and Community Engagement and Accountability (CEA) who have substantial experience in implementation of health programs.

A total of 2,165 volunteers and 743 health workers were trained areas including Oral Rehydration Therapy/Points (ORPs), Epidemic Control for Volunteers (ECV), WASH using Branch outbreak Response Teams (BORT), Household Water Treatment & safe storage, mental health and psychosocial support, Nutrition and Screening, Case Management, Infection Prevention Control (IPC), Oral Cholera Vaccine (OCV), Mental Health and Psychosocial Support (MHPS), Case Area targeted interventions (CATI) and Community-based Management for Water Points.

Quality Control and Training volunteers building capacity of MRCS volunteers in ORP in Nsanje District.

Risk Communication and Community Engagement

Since the start of the MRCS chorela response, a robust campaign of social mobilization was implemented, facilitated by a team of trained volunteers. Their primary objective was to educate households about effective strategies for cholera prevention, control, and case management. This has made a substantial impact, reaching a significant number of individuals across 22 districts. The campaign encompassed not only household approachs but also visual aids, radio programs, IEC materials and airing of informative jingles. MRCS promoted two-way dialogue approaches for

instance community engagement meetings, involving local leaders, councilors, legislators, and religious figures. This inclusive approach fostered constructive dialogues about cholera prevention strategies.

The outreach has also incorporated innovative methods such as "van publicity" sessions, which utilized loudspeakers mounted on vehicles to disseminate cholera-related messages, open days and football events. These sessions have been strategically conducted in both cholera hotspots and evacuation camps.

Volunteers, Staff and HSA during a household visit in Lilongwe

Community Case Management for Cholera

The response focused on establishing oral rehydration points in hot spot areas and provision of tents for shelter in the cholera treatment unit and centres (CTU/CTCs) across the country. The Swiss Red Cross CCMC-ERU was deployed to scale up and strengthen the MRCS in community Case management for Cholera. The ORPs were established in the following districts: Nsanje, Chikwawa, Blantyre, Machinga, Balaka, Mangochi, Lilongwe and Salima. With support from Qatar RC, Danish Red Cross and UNICEF, the MRCS supported the MoH with medical and non-medical supplies for management of cholera in the CTU/CTCs.

Oral Rehydration Point in Kauma managed by trained volunteers.

WASH

Several initiatives have been undertaken to enhance water, sanitation, and hygiene (WASH) efforts. These include the rehabilitation and drilling/construction of water points in hotspot areas. With Support from IFRC, Norwegian Red Cross, Swiss Red Cross, GIZ and UNICEF, the MRCS has rehabilitated 216 Boreholes. The IFRC also supported with construction of 23 boreholes (New Water Points) in Salima, Lilongwe, Machinga, Balaka and Nkhatabay. The MRCS supported WASH Assessments, Water Quality Monitoring, distribution of WASH NFIs and water treatment chemicals. The hygiene promotion and community total led sanitation were the common approaches to increase the sanitation coverage and social behaviour change in the hot spots.

Khudzumba Borehole in Machinga before rehabilitation

Khudzumba borehole in Machinga District after rehabilitation by MRCS

Operational risk assessment

Operations risk assessments remain the same as in the Operational Strategy.

B. OPERATIONAL STRATEGY

Update on the strategy

A strategy was developed to ensure quality of work and that gives adequate attention to highly affected areas, while not neglecting preventative/preparedness measures. The technical team developed a scenario planning by looking at the cholera trends. The strategy accounted for different levels activities in different districts.

Two "packages" of activities were developed:

1. Responsive/ curative activity package - with the aim to reduce morbidity and mortality in areas highly affected by cholera.
2. Preventive and preparedness activity package - with the focus to prevent reoccurrence and spread of cholera (new wave) and to ensure preparedness to re-engage early when new cases and targeted response through BTIT and CATI teams.

	Response/Curative	**Preventative/Preparedness**
Purpose	- Reduce morbidity and mortality in areas highly affected by cholera	- Prevent the reoccurrence and spread of cholera (new wave). Ensure preparedness to re-engage early when new cases and targeted response (BTIT, CATI)
Targeting	- In most concerned districts based on the weekly number of cases. - Districts Targeted: Lilongwe, Mangochi (Supported by DRC), Blantyre, Balaka, *Salima, Chikwawa, Nsanje.*	- In geographic areas with no or few choleras cases - Districts Targeted: All other districts (8) included in the Operational strategy
Activities	- ORP Setup in hotspots - Full scale volunteer action around them (BTIT Teams) supporting. - HH ORS distribution - HH Water Treatment (Chlorination & Aqua tabs) Health & hygiene education, CBS and Active case finding, referral and Contact Tracing RCCE/CEA, etc.) - Support broader coordination and collaboration activities	- Reduced intensity of activities of already trained volunteers or staff (e.g., 1 day/week volunteer engagement) - Continuation of HHWT - Light RCCE/CEA package - Continuation of Community activities - Full scale work on any planned WASH Hardware - Some lighter work in schools, etc. - BTIT/CATI interventions, when required, by district teams (MRCS&DHO&DOW).

Based on the cases trends and lessons learnt from the cholera outbreak operation implementation, MRCS also proposed the following complementary interventions, which don't have any budget implication to the Appeal.
To support the districts along the border and ensure cross-border coordination and collaboration to reduce cross boarder infection. According to ministry of health reported out of 74 cases in Mchinji district 62 cases from Mozambique whereas in Nsanje District a total of 45 cases came from Mozambique.

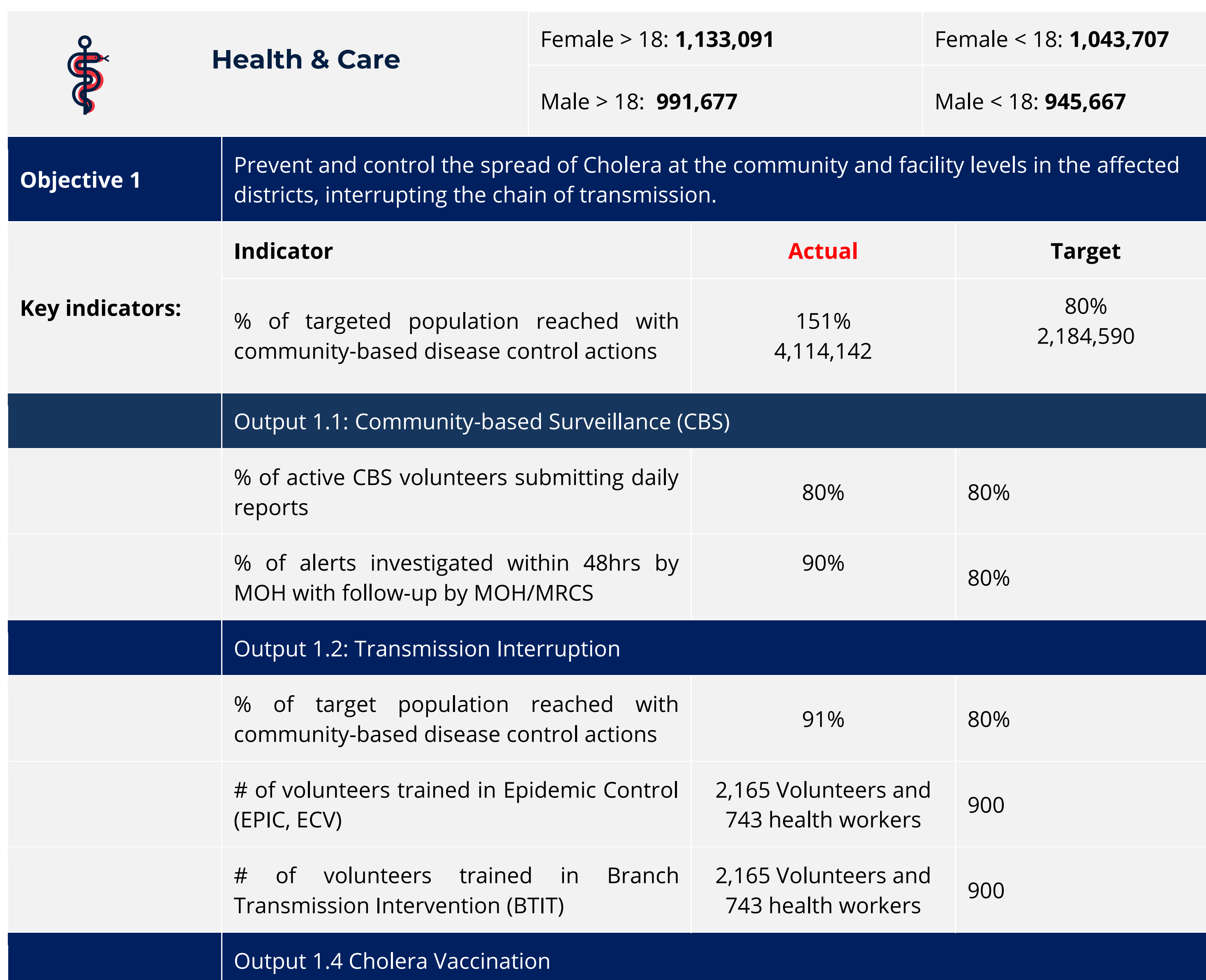
To provide nutrition support through cash transfer targeting pregnant and lactating mothers in Nsanje district.

Based on the assessment conducted after the impact of TC Fredy in Nsanje district, which indicated that children are moving from moderate malnutrition to acute Severe malnutrition. Out of 3,000 children screened, 510 were moderate acute malnutrition and 27 severe acute malnutrition. Therefore, need to support in supplementary feeding program through the cash transfer's budget.

Gearing towards recovery from cholera outbreak response, there will be need to improve surveillance by conducting community-based surveillance in two districts to establish community health surveillance system. Community-based surveillance can reliably pick-up outbreak signals and lead to an early response if there is consistent gathering of data at a sufficiently granular scale at community level (ideally 20 households to max. 50 households) and timely upward transmission of the gathered data. At the regular national cholera IMT meetings there is a need for improved community-based surveillance. An assessment providing more details on the feasibility and scope of the project will be done in collaboration with MRCS and close coordination with the DHO with CBS expert support.

C. DETAILED OPERATIONAL REPORT

STRATEGIC SECTORS OF INTERVENTION



Health & Care	Female > 18: **1,133,091**	Female < 18: **1,043,707**
	Male > 18: **991,677**	Male < 18: **945,667**

Objective 1	Prevent and control the spread of Cholera at the community and facility levels in the affected districts, interrupting the chain of transmission.		
Key indicators:	**Indicator**	**Actual**	**Target**
	% of targeted population reached with community-based disease control actions	151% 4,114,142	80% 2,184,590
	Output 1.1: Community-based Surveillance (CBS)		
	% of active CBS volunteers submitting daily reports	80%	80%
	% of alerts investigated within 48hrs by MOH with follow-up by MOH/MRCS	90%	80%
	Output 1.2: Transmission Interruption		
	% of target population reached with community-based disease control actions	91%	80%
	# of volunteers trained in Epidemic Control (EPIC, ECV)	2,165 Volunteers and 743 health workers	900
	# of volunteers trained in Branch Transmission Intervention (BTIT)	2,165 Volunteers and 743 health workers	900
	Output 1.4 Cholera Vaccination		

	% of target population vaccinated	74.4%[1]	100%
	# of volunteers trained on vaccination and mobilization	540	1,500
	Output 1.5 Safe and Dignified Burial		
	# of volunteers trained to support safe burial and raise awareness in the context of cholera	0	100
	% of target population helped by supporting families for safe burial	0%	100%
	Output 1.6 Nutrition-related Activities		
	# of volunteers trained in the promotion of good infant and young child feeding practices (IYCF) and nutrition screening	553	1,500
Objective 2	Reduce morbidity and mortality due to cholera by supporting improved case management in the community through ORPs and in CTUs, through IPC and provision of tents in the affected districts.		
	Output 2.1 Case Management		
	# of volunteers in target communities trained in the administration of ORPs	405	960
	# of ORPs established in the targeted communities	45	120
	# of cash voucher assistance (CVA) provided to recovered patients for the purchase of six nutrient-rich food items and basic WASH/NFIs	0	2000
	Output 2.2 Mental Health and Psychosocial Support (MHPSS)		
	# of volunteers and health workers trained in MHPSS and PGI	900	900

Progress towards outcomes

A total of **4,114,142 individuals** were reached with health and care interventions, with support from MRCS community volunteers. The targeted population was reached through the household visit by volunteers, Oral Rehydration Points. To prevent and control the spread of Cholera at the community levels in the affected districts, the Branch Transmission Intervention Teams (BTIT) were activated to interrupt the chain of transmission.

[1] https://docs.google.com/spreadsheets/d/e/2PACX-1vSur2gZPLu7fzWOj-9Dg6SQOdmgWKiJiAIv_n6TVwQjJ5_LLiW-qDAhYxLHvnBlsFnTkoejqd_pW8-r/pubhtml?gid=1407186104&single=true

A total of 2,165 volunteers received Level-1 training in Epidemic Preparedness and Response in Communities (EPIC package), focusing on Epidemic Control for Volunteers (ECV), Branch Outbreak Response with focus on WASH, Community Engagement & Accountability (CEA), and Psychosocial First Aid (PFA).

PHiE Coordinator orienting BORT volunteers in Nsanje (L), and volunteers using a pocket guide (R)

Additionally, some volunteers were trained in Level-2 EPIC training, specializing in; - (1) Oral Rehydration Therapy Points (ORT/ORP) and established 45 ORPs - 405 volunteers, (2) Oral cholera vaccine (OCV) - 540 volunteers, (3) Mental Health and Psychosocial Support (MPHSS) Protection, Gender, and Inclusion (PGI) - 900 volunteers.

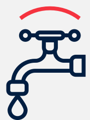
Due to the escalating cholera outbreak which increased in both magnitude and spread, the National Society expanded its response to 17 districts with support from IFRC, Norwegian RC, Danish RC, Swedish RC, Canadian RC, Japanese RC, Monaco RC, Qatar RC, UNICEF, and GIZ. With the Scale up the target was exceeded by 71%, necessitating expanded volunteer engagement and broader population coverage.

The MoH targeted 1,415,497 people for Oral Cholera Vaccine campaign in 5 districts of Dedza, Thyolo, Salima, Mangochi, and Lilongwe. As of the reporting period a total of 1,053,614 people were vaccinated representing 74.4% coverage. Furthermore, MoH is planning to conduct another OCV campaign in September, targeting 428,193 people in 3 districts of Mangochi, Chikwawa and Nsanje.

Volunteer sessions tackling

Cash voucher assistance (CVA) wasn't provided during implementation period due to prioritizing life-saving interventions, and safe burial support and cholera awareness campaigns were omitted due to community acceptance concerns stemming from past experiences with COVID-19.

The Community Case Management for Cholera (CCMC) – ERU was deployed to support the outbreak with the general objective to early respond to a declared cholera outbreak and promptly treat people infected with cholera/acute watery diarrhea at community level with ORS. At the conclusion of the operation, 16 ORPs were established in the heavily affected hotspots of Lilongwe, Mangochi, and Blantyre districts, with 158 volunteers and HSAs trained, including 8 advanced trainers, forming a responsive team for future cholera outbreaks.

	**Water, Sanitation and Hygiene**	Female > 18: 945,987	Female < 18: 562,527
		Male > 18: 345,689	Male < 18: 741,699

Objective:	*Reduce the risk of cholera and other water-borne diseases through improved availability of safe water and sanitation facilities, and through good hygiene practices in cholera hotspots.*
	Output 3.1 Contribute to accessing clean and potable water through the construction, rehabilitation, and disinfection of water points

	Indicator	Actual	Target
Key indicators:	% of households reached with key messages to promote personal and community hygiene	118%	100%
	# of water points rehabilitated in the target communities	216	100
	# of solar water pumps rehabilitated in health facilities and schools in affected communities	0	10
	# of contaminated water sources disinfected in the target communities	193	100
	Output 3.2 Promoting household water treatment and safe storage		
Key indicators:	# of volunteers trained in Household Water Treatment and safe Storage (HWTS)	1,625	1,500
	# of households in the affected communities provided with 1% stock solution for pot-to-pot chlorination	2,595,902	TBD
	Output 3.4 Facilitation of the construction of latrines in health facilities and public institutions as a hygiene promotion initiative. Health facilities and schools with wet feeding programs will be prioritized.		
Key Indicators:	# of temporary sanitation facilities (latrines, bath shelters and handwashing facilities) constructed and maintained in CTUs	386	150
	# of School Health and Nutrition (SHN) teachers trained in school hygiene and sanitation (latrine management considering cholera)	369	300
	Output 3.5 Raise awareness on dangers of open defecation and importance of food hygiene, and advocate for community members to construct latrines		
Key Indicators:	% of households in the target communities sensitized on cholera through door-to-door visits	118%	100%
	# of sanitation promotion activities conducted in communities and institutions on latrine use and management, proper waste disposal	162	150
Progress towards outcomes			

In the reporting period, MRCS reached 2,595,902 households with WASH interventions, surpassing the target due to the increased volunteer engagement amid the escalation of cholera outbreak.

Hygiene and Sanitation Promotion ensuring communities take responsibility of constructing toilets and installing handwashing. The HP volunteers are using the Cards for SBC.

MRCS joined efforts with support from the bilateral and multilateral donors towards the appeal to scale up Water, Sanitation, and Hygiene (WASH) efforts to 17 districts, exceeding the targeted 15 Districts. A total of 1,625 volunteers were trained in Household Water Treatment and Safe Storage (HWTS), aiding over 2.5 million households with 1% stock solution for pot-to-pot chlorination. The Oral Rehydration Points (ORPs) also distributed water treatment chemicals.

Volunteer chlorinating the Water at point of source and using the Pool testers to ensure right dosage for the household water treatment.

MRCS supported 369 schools reaching 591,628 leaners, training School Health and Nutrition (SHN) teachers in hygiene and sanitation, with a cholera focus during school reopening. MRCS rehabilitated 216 Boreholes across 22 districts and drilled 23 new boreholes in 5 districts of Nkhatabay, Lilongwe, Salima, Balaka and Machinga. Solar water pumps rehabilitation in health facilities and schools in affected communities did not take place as borehole rehabilitation was preferred in communities with limited water access where Cholera cases were originating other than schools and/or health facilities. In addiction IFRC drilled 3 boreholes in Nkhatabay and initiated 20 boreholes

in Lilongwe, Salima, Machinga, and Balaka. Furthermore, DRC+ funded 2 solar pumping water schemes in Mangochi for 5,000 households.

Borehole drilling in communities to increase access to clean and safe water.

	Protection, Gender and Inclusion	Female > 18: **1,468,107**	Female < 18: **1,043,707**
		Male > 18: **1,173,234**	Male < 18: **1,095,444**

Objective:	Communities can identify and respond to the distinct needs of the most vulnerable segments of society, especially disadvantaged and marginalized groups, who are subject to violence, discrimination, and exclusion.		
	Indicator	**Actual**	**Target**
Key indicators:	% of target population reached by PGI activities	100%	100%
	% of staff and volunteers oriented on the Code of Conduct, Prevention of and Response to Sexual Exploitation and Abuse (PSEA), and Child Safeguarding	263%	100%
	% of volunteers trained to identify women, men, girls, and boys requiring MHPSS services after being discharged from CTUs	100%	100%

Progress towards outcomes

During the reporting period a total of 3,951 volunteers were engaged and during the trainings they were oriented on the Code of Conduct, Prevention of and Response to Sexual Exploitation and Abuse (PSEA), and Child Safeguarding. 900 volunteers were trained as a specialised in MHPSS since they were deployed in the CTU/CTCs

to support the patients and guardians and advocate for clear separation of genders in CTUs. The increase in the volunteers engaged in the MHPSS was due to increase in the ORPs whereby the volunteers were able to provide PFA services.

	Community Engagement and Accountability	Female > 18: **1,468,107**	Female < 18: **1,043,707**
		Male > 18: **1,173,234**	Male < 18: **1,095,444**

Objective:	Develop and deploy standardized approaches for community engagement, collection, and use of community insights data to better understand community perspectives		
Key indicators:	**Indicator**	**Actual**	**Target**
	% of target population reached with social mobilization and RCCE activities	4,780,492 (219%)	2,185,000 (100%)
	% of complaints and feedback responded to by the National Society	97%	100%
	# of dialogue sessions on cholera prevention and treatment conducted (two-way dialogue for production of community action plans)	312	240
	# of community cinema shows supported in hotspots and schools	43	1,200
	# of volunteers supported to carry out regular activities issued pocket guides	3,951	1,500

Progress towards outcomes

During the reporting period, more than 4.7 million individuals were engaged in Communicating with Communities (CEA) initiatives. The expansion in outreach can be attributed to the integration of the Response program with TC-Freddy and the surge in the number of cases during this period.

Malawi Red Cross Society volunteers prepare to sensitize a community in Mangochi about the risks of contracting cholera and how they can reduce such risks within their community.

The CEA activities leveraged the existing complaints and feedback system in high-priority areas. These activities focused on closing the feedback loop through two-way dialogue sessions. As the volume of feedback collected increased, so did the frequency of these dialogue sessions to ensure that all concerns were addressed. It's worth noting that only 97% of the feedback received responses, primarily due to delays in analyzing the feedback. Volunteers utilized a cholera pocket guide to facilitate the delivery of these messages. [Cholera Volunteer Handbook[1].pdf]

Few cinema shows were conducted because community engagement with key influencers and message dissemination through van publicity and radios were considered to be more effective in cholera prevention.

Influential leaders unite to tackle Cholera - Strategizing for a END CHOLERA campaign.

Enabling approaches

National Society Strengthening

Objective:	*Improved MRCS capacity to ensure that necessary ethical and financial systems and structures, and required skills to implement efficiently and effectively*		
Key indicators:	**Indicator**	**Actual**	**Target**
	# Of volunteers engaged to support cholera prevention & control	3,951	580
	# Of insured volunteers mobilized for this response	3,951	580
	# Of volunteers confirming that they are briefed or have undergone the minimum response standard role, security training for volunteers, code of conduct etc.	3,951	580
	# Of HSAs engaged in the MRCS DREF response	743	216

Progress towards outcomes

A total of 3,951 volunteers were mobilized, insured, and engaged to provide support for the cholera response operation. Each of these volunteers underwent comprehensive briefings, and the completion of minimum response standard role training, security training for volunteers, and adherence to the code of conduct. Furthermore, the response also included the participation of 743 community health workers.

MRCS Volunteers engaged at ORP in Lilongwe district

Coordination and Partnerships

Objective:	*Technical and operational complementarity among IFRC membership, and with ICRC, enhanced through cooperation with external partners.*

MRCS convened monthly technical meetings that brought together the WASH, Health and RCCE thematic areas.

Engagement with external partners:

- MRCS and WHO supported the Ministry of health to formulate the SoPs for the ORPs.
- MRCS participated in partners coordination meetings with UNICEF monthly.
- The government through the Presidential Taskforce on Cholera and COVID-19 continued to lead the cholera outbreak response.

Cholera incident management team meetings were held once a week by the Ministry of Health together with the partners.
Incident management system response pillars continued to hold their pillar coordination meetings weekly.

Secretariat Services

Objective:	Effective and coordinated disaster response is confirmed.		
Key indicators:	**Indicator**	**Actual**	**Target**
	# of surge profiles deployed	6	6
	# of Emergency response Unit Deployed	1	1

IFRC provided coordination through the Cluster Operations Coordinator based in Malawi and all the Cluster office in Harare. Cluster Head of Delegation, Finance Manager, Security Officer deployed to support set up structures for the Emergency Appeal operations.

The Regional Office equally deployed:
1. Regional Operations Coordinator
2. Partnerships and Resource Mobilization
3. Regional RCCE Interagency under the Collective Service

The surge profile deployed were: 1. CEA Coordinator 2. WASH Coordinator 3. PHiE Coordinator (2) and 4. WASH officer with a rotation in the Public Health in Emergency Coordinator.

The IFRC deployed communications consultant to document stories for the MRCS Cholera work as shown on the links below:
https://shared.ifrc.org/record/_PgI5gMrTKWERUaIwILImILe1
https://shared.ifrc.org/mycollections/index/2652
https://youtu.be/uioYI1NcRyc

IFRC also deployed a Swiss RC Community Case Management for Cholera ERU comprising of a Team leader, 2 Epidemiologists, 2 Training and Quality, WASH Officer, Logistics and Finance and Admin staff. The Swedish Red Cross funded the running costs for the Oral Rehydration Points set up by the CCMC ERU.

Lindiwe Ngwira one of the volunteers at an ORP in Lilongwe district captured explaining why she joined volunteerism to help communities have access to locally made Oral Rehydration Solutions (ORS) before being referred to the hospital for Cholera treatment

D. FUNDING

The table below summarizes funding received under the Federation Wide Appeal, funds received through the secretariat and those from bilateral partners. A detailed financial report is also attached.

	Partner	Amount (CHF)	
No.	**Multilateral Through IFRC Secretariat**	**CHF**	**CHF**
1	IFRC - Loan	1,000,000.00	
2	Norwegian RC	178,149.04	
3	Canadian Red Cross	273,900.00	
4	Swedish Red Cross	150,000.00	
5	ECHO	100,262.00	
6	Japanese Red Cross	34,708.00	
7	Monaco Red Cross	9,817.00	
	Multilateral Sub Total		**1,738,836.04**
	Bilateral to Malawi Red Cross		
1	UNICEF	710,831.16	
2	Danish Red Cross	337,553.56	
3	Swiss Red Cross	265,905.00	
4	GIZ	241,638.88	
5	Qatar Red Crescent	164,398.74	
	Bilateral to Malawi Red Cross: Sub Total		**1,720,327.34**
	Total		**3,459,163.38**

Contact information.

For further information, specifically related to this operation please contact:

At Malawi Red Cross Society

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- Dan Banda, Head of Health & Social Services; Email: dbanda@redcross.mw

At IFRC:
IFRC Country Cluster Delegation for Zimbabwe, Zambia, and Malawi

- John Roche, Head of Delegation; Email: john.roche@ifrc.org
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IFRC Regional Office

- Rui Alberto Oliveira, Regional Operations Lead; Email: rui.oliveira@ifrc.org

For IFRC Resource Mobilisation and Pledges support:

- Louise Daintrey, Regional Head of Strategic Engagement and Partnerships; Email: Louise.DAINTREY@ifrc.org

For In-Kind Donations and Mobilisation table support:

- Allan Kilaka Masavah, Head of Africa Regional Logistics Unit; Email: allan.masavah@ifrc.org

For Performance and Accountability support (planning, monitoring, evaluation, and reporting enquiries)

• IFRC Regional Office for Africa Beatrice Atieno OKEYO, Head of PMER &QA,
beatrice.okeyo@ifrc.org , Phone: +254 732 404022

Reference documents

Click here for:

- Emergency Appeal
- Emergency Plan of Action (EPoA)

How we work

All IFRC assistance seeks to adhere the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief, the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable, to **Principles of Humanitarian Action** and **IFRC policies and procedures**. The IFRC's vision is to inspire, encourage, facilitate and always promote all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

Selected Parameters			
Reporting Timeframe	2022/09-2025/01	Operation	MDRMW017
Budget Timeframe	2022/09-2023/09	Budget	APPROVED

Emergency Appeal
FINAL FINANCIAL REPORT

Prepared on 21 Mar 2025

All figures are in Swiss Francs (CHF)

MDRMW017 - Malawi - Cholera

Operating Timeframe: 15 Sep 2022 to 30 Sep 2023; appeal launch date: 23 Jan 2023

I. Emergency Appeal Funding Requirements

Thematic Area Code	Requirements CHF
AOF1 - Disaster risk reduction	0
AOF2 - Shelter	0
AOF3 - Livelihoods and basic needs	0
AOF4 - Health	2,470,000
AOF5 - Water, sanitation and hygiene	391,000
AOF6 - Protection, Gender & Inclusion	117,000
AOF7 - Migration	0
SFI1 - Strenghten National Societies	338,000
SFI2 - Effective international disaster management	33,000
SFI3 - Influence others as leading strategic partners	0
SFI4 - Ensure a strong IFRC	151,000
Total Funding Requirements	**3,500,000**
Donor Response* as per 21 Mar 2025	**738,719**
Appeal Coverage	**21.11%**

II. IFRC Operating Budget Implementation

Thematic Area Code	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction	4,383	4,383	0
AOF2 - Shelter	0	0	0
AOF3 - Livelihoods and basic needs	1,757	1,757	0
AOF4 - Health	351,644	674,652	-323,008
AOF5 - Water, sanitation and hygiene	334,373	589,404	-255,031
AOF6 - Protection, Gender & Inclusion	0	0	0
AOF7 - Migration	0	0	0
SFI1 - Strenghten National Societies	216,951	334,804	-117,852
SFI2 - Effective international disaster management	27,633	32,311	-4,678
SFI3 - Influence others as leading strategic partners	0	0	0
SFI4 - Ensure a strong IFRC	43,298	56,502	-13,204
Grand Total	**980,040**	**1,693,812**	**-713,773**

III. Operating Movement & Closing Balance per 2025/01

Opening Balance	0
Income (includes outstanding DREF Loan per IV.)	1,738,719
Expenditure	-1,693,812
Closing Balance	**44,906**
Deferred Income	0
Funds Available	44,906

IV. DREF Loan

* not included in Donor Response	Loan :	1,000,000	Reimbursed :	0	**Outstanding :**	**1,000,000**

Selected Parameters			
Reporting Timeframe	2022/09-2025/01	Operation	MDRMW017
Budget Timeframe	2022/09-2023/09	Budget	APPROVED

Emergency Appeal
FINAL FINANCIAL REPORT

Prepared on 21 Mar 2025

All figures are in Swiss Francs (CHF)

MDRMW017 - Malawi - Cholera

Operating Timeframe: 15 Sep 2022 to 30 Sep 2023; appeal launch date: 23 Jan 2023

V. Contributions by Donor and Other Income

Opening Balance	**0**

Income Type	**Cash**	**InKind Goods**	**InKind Personnel**	**Other Income**	**TOTAL**	***Deferred Income***
DREF Response Pillar				1,000,000	**1,000,000**	
European Commission - DG ECHO	95,334				**95,334**	
Japanese Red Cross Society	34,934				**34,934**	
Norwegian Red Cross	89,075				**89,075**	
Norwegian Red Cross (from Norwegian Government*)	89,075				**89,075**	
On Line donations	2,042				**2,042**	
Red Cross of Monaco	9,836				**9,836**	
Swedish Red Cross	150,000				**150,000**	
The Canadian Red Cross Society	161,258				**161,258**	
The Canadian Red Cross Society (from Canadian Gov	107,165				**107,165**	
Total Contributions and Other Income	**738,719**	**0**	**0**	**1,000,000**	**1,738,719**	***0***
Total Income and Deferred Income					**1,738,719**	*0*