



A Malawi Red Cross Society (MRCS) volunteer supporting a cholera treatment unit. Photo: MRCS

Appeal No: MDRMW017	To be assisted: 2,184,590 people	Appeal launched: 24/01/2023
Glide No: <u>EP-2022-000298-MWI</u>	DREF allocated: 1 million CHF	Disaster categorisation: Orange
Operation start date: 24/01/2023	Operation end date: 30/09/2023	

IFRC Secretariat funding requirement: 3.5 million CHF
Federation-wide funding requirement: 5.2 million CHF

TIMELINE



February 2022: First cholera suspect case in Machinga district, southern Malawi.

March 2022: First cholera case confirmed, Ministry of Health (MOH) declared outbreak.

September 2022: IFRC's Disaster Response Emergency Fund (DREF) allocates CHF 392,014 for initial response in Karonga, Mzuzu, Nkhatabay and Nkhotakota districts.

November 2022: Danish Red Cross provides emergency funding for Mangochi, Chikwawa and Mwanza townships; Swiss Red Cross provides funding for Blantyre and Rumphi districts, northern Malawi; and Finnish and Icelandic Red Crosses provide additional funding through Danish Red Cross.

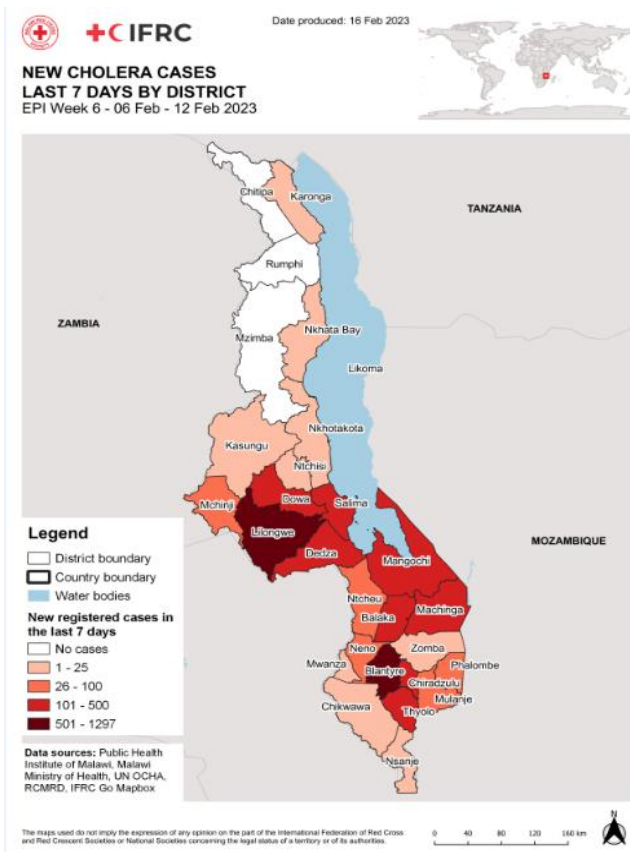
December 2022: President declares the outbreak a public health emergency.

December 2022: Public Health in Emergencies Coordinator from the IFRC Regional Office visits Malawi; scale-up of DREF to CHF 748,286 covering five districts, adding Salima district to the original four.

December 2022: The Presidential Task Force on COVID-19 and Cholera makes a public appeal to organisations and private companies to support the Ministry of Health with supplies.

January 2023: IFRC surge begins. Public Health and WASH Engineer, Logistics and Finance delegates, and IFRC Emergency Response Unit (ERU) for Community Case Management for Cholera (CCMC) deployed.

January 2023: IFRC issues Federation-wide emergency appeal for CHF 5.2 million to cover 2.1 million people.



DESCRIPTION OF THE EVENT

Thus, despite efforts to slow the outbreak, the numbers are rising faster, with a case fatality rate of 3.2%.

Facts and figures (IMT surveillance report Week #5)

- Cumulative 34,355 cases, 1,108 deaths
- By Week 4: 4,261 cases, 120 deaths
- 61 per cent of cases among 10-39 age group
- 32 per cent of deaths in people over 50 (case fatality rate [CFR] 7.4 per cent)
- 56 per cent of cases are among males.

Date	Growth rates	Doubling time
Mar.-Aug. 2022	0.9% (0.6-1.3%)	73 days (range 55-110)
Sept.-Dec. 2022	1.4% (1.2-1.5%)	50 days (45-57)
Jan.-Feb. 2023	2.1% (1.6-2.6%)	32 days (26-42)

In addition to cholera, Malawi is currently affected by COVID-19, polio, and chronic hunger, and the country is just beginning to recover from the effects of tropical storm Ana and Cyclone Gombe, which is straining already limited resources. The rainy season is also exacerbating the growth rate and reduction in doubling time since the rains started in November 2022.

The Ministry of Health is overstretched due to several factors, including:

- the high number of admissions;
- lack of human resources to manage the caseload;
- inadequate cholera treatment units, which necessitates converting some health facilities for the purpose; and
- lack of cholera supplies and inadequate disinfection liquids to stop transmission.

The community health care system has been disrupted as well, and active case finding and surveillance are a challenge, while there is little or no space for the treatment of cholera cases in the community. The general population has also become unsettled by the number of deaths being reported across multiple districts, this compounded by the stress of the rainy season, commonly held myths, misconceptions, and religious beliefs. Delayed health-seeking behaviours only exacerbate the crisis.

Malawi is currently battling its worst cholera outbreak in two decades after the Ministry of Health (MOH) found a case in Machinga district in the southern region of the country, likely in the aftermath of storm Ana and cyclone Gombe. Initially limited to the southern part of the country, the disease has now spread across 29 health districts throughout Malawi, putting at risk over 10 million people including more than 5 million children. On 5 December 2022, the President declared a public health emergency.

Cholera is an extremely virulent disease, spread via contaminated water and food, causing severe acute watery diarrhoea leading to severe dehydration in children and adults alike. It takes between 12 hours and 5 days for an infected person to show symptoms after ingesting contaminated food or water and it can kill within hours if untreated.

The main risk factors of the outbreak are unsafe water, poor sanitation, and lack of hygiene. And due to the high rate of transmission, the disease is now affecting people across multiple geographical areas. Compounding the crisis, communities experiencing high rates of poverty often have limited access to sanitation and are therefore at increased risk of infection.

Based on MRCS scenario planning, the scale of the needs has now reached the worst-case scenario and IFRC is launching this Emergency Appeal for CHF 5.2 million to enable them to scale up the response to reach over 2 million people.

Severity of humanitarian conditions

1. Impact on accessibility, availability, quality, use, and awareness of goods and services.

- The capacity of Malawi MOH has been highly stretched due to the high number of admissions.
- The community health care system has been disrupted.
- The closure of major city and district markets in some locations has affected communities' livelihoods.
- Schools in Blantyre and Lilongwe were closed for two weeks, denying learners access to education as the rest of the country's school calendar was not disrupted.
- Measures aimed at containing the outbreak have also exacerbated hardship in communities already experiencing the impacts of global economic disruptions. These impacts in turn have resulted in limited government resources for scaling up preventive measures.

2. Impact on physical and mental well-being

- The crisis has significantly impacted family cohesion, as family members admitted to

Cholera Treatment Centres (CTCs) or Units (CTUs) have limited contact with their families.

- With over 40,000 cases and close to 1,500 deaths recorded, there are increased need for psychosocial support for families with sick family members or deaths.

3. Risks & vulnerabilities

- Delays in addressing the risk factors of the outbreak, which include access to safe drinking water, sanitation, hygiene, and a better understanding of barriers to health-seeking behaviour, especially in hotspot areas, have contributed to increased cases and deaths.
- COVID-19 has led to some mistrust of the health system, which is now impacting the trust that people have in CTCs and CTUs.
- The wide reach of the outbreak in a short period this early in the rainy season threatens further exacerbation of the situation as the rainy season continues.
- On 19 Jan 2023, health authorities also confirmed a new case of polio in the country, bringing the total number of cases to five since the disease was first confirmed in a patient in Lilongwe in February 2022. In March 2022, IFRC launched a DREF in response to this outbreak ([Malawi - Polio \[MDRMW016\]](#)).
- The rainy season often includes tropical storms from the Indian Ocean and based on long-range forecasts such events will likely bring flooding to central and southern parts of the country. Other risks include COVID-19 and a forecast hunger situation.

CAPACITIES AND RESPONSE

1. National Society response capacity

1.1 National Society capacity and ongoing response

Malawi Red Cross Society

Malawi Red Cross Society (MRCS) is one of the leading humanitarian organisations supporting the public health authorities in the country in the fight against the cholera outbreak since the first case was discovered. This is due to its nationwide reach and a wide network of volunteers. MRCS has 33 branches and a network of more than 72,000 volunteers in all 29 districts of Malawi. Established by Chapter 18:09 of the Laws of Malawi in 1966 (Act 51) as a humanitarian organisation with an established presence across all government administrative districts, MRCS became a member of the International Federation of the Red Cross and Red Crescent Societies in 1971.

With the leadership of a Director of Programmes, the MRCS Programmes unit has three division heads in Health and Social Services, Disaster Management, and PMER. The Head of Health and Social Services leads a technical team of Program Coordinators who have been leading the implementation of key projects including Africa COVID-19, the COMREP Project by the Danish-led Consortium, and the IFRC Emergency Appeal for Tropical Cyclone Ana.

MRCS has a pool of trained emergency specialists who are engaged within 72 hours of a disaster	
Number of staff:	211
Number of volunteers:	72,000
Number of branches:	33

MRCS also sits in several technical working groups such as Humanitarian Country Coordination Team (HCT), Health Cluster, WASH cluster, protection cluster as well as Health Emergency Technical Working Group committees. With these, its ability to be represented and contribute to decisions by key Government mechanisms.

MRCS has a National Response Team (NRT) of 101 members comprising both MRCS staff and volunteers specialised in handling emergencies caused by multiple hazards and this team is ready to support the expansion of the response. The NRT can sit on different platforms with expertise in sharing information for complementarity with relevant structures.

In this response to the cholera outbreak, MRCS continues to work in close coordination with district health offices on Risk Communication and Community Engagement (RCCE) at the household and community levels; deployment of volunteers to provide support with active case finding; contact tracing, community-based surveillance, Infection Prevention and support to oral cholera vaccination campaigns in high-risk districts; capacity building and training of volunteers, community health workers and village health committees on cholera prevention and control modules; and the provision of critical non-medical cholera prevention and control supplies to treatment centres. These include household water-sanitation-hygiene (WASH) items, including soap, gloves, gumboots, aprons, oral rehydration points, and cholera beds.

With the support of partners, MRCS has been able to contribute to the Government's response as follows:

Key Indicators	#
Volunteers and health workers trained and mobilised in active case investigation and surveillance	999
Volunteers trained in RCCE, Epidemic Control, Branch Transmission Intervention, and cholera vaccination	609
Volunteers and health workers trained and mobilised in case management	1,215
Personnel supporting contact tracing and active case finding, gathering information and reporting	4,591
People reached with pot-to-pot chlorination	219,239
Households reached with soap and with water treatment products	5,606
People reached with hygiene promotion activities	105,887
Boreholes drilled and water point committees trained	3
Community engagement meetings to promote early treatment seeking behaviours for diarrhoea	209
People reached by radio, mobile vans and megaphones to support vaccination and hygiene promotion	765,989
People reached through volunteer household visits	805,616
Community sensitisation sessions for cholera vaccination	20
Provided logistical support to MOH in administration of cholera vaccines in hard-to-reach areas	7

1.2 Capacity and response at the national level

The Malawi National Cholera Prevention and Control Plan and the MRCS Cholera Response Plan have been the basis of this Operational Strategy, supporting government efforts to curb the epidemic. Under the leadership of the National Health Cluster, the Public Health Institute of Malawi (PHIM) is coordinating the response. There have been national and district coordination meetings and inter-cluster and technical working group (TWG) meetings in all 29 districts of the country. Management meetings are conducted twice per week as well, focusing on coordination, surveillance, laboratory work, case management, RCCE, and WASH, while partner support is being updated within the 5W matrix.

MOH, MRCS, *Médecins Sans Frontières* (MSF), and other partners are supporting (1) the setting up of tents as CTUs and (2) the procurement and distribution of medical and Infection Prevention and Control (IPC) supplies. Health workers in heavy-burden districts are also receiving capacity building. The Ministry of Water and Sanitation (MOWS) is leading all WASH interventions and coordinating WASH partners, as well as supporting water quality monitoring, drilling of boreholes, and rehabilitation of water points in outbreak hotspots. The World Food Programme (WFP) warehouse is being used for the storage of supplies by different partners.

2. International capacity and response

2.1 Red Cross Red Crescent Movement capacity and response

The IFRC Secretariat will provide technical and financial support to MRCS through the IFRC Harare Cluster Delegation. IFRC will also support coordination within and outside the Movement. It has deployed staff and surge profiles to support Finance, Logistics, Communication, Community Engagement and Accountability (CEA), WASH, and Public Health in Emergencies to work with MRCS.

Partner National Societies (PNSs) in-country have continued to provide bilateral support to MRCS since the start of the response. These are the Danish Red Cross, Finnish Red Cross, Icelandic Red Cross, Italian Red Cross, Qatar Red Crescent, and Swiss Red Cross. All PNSs participate in the coordination meetings that are held in-country and are called upon to contribute their expertise to this response. Currently, the consortium led by Danish Red Cross is supporting Mangochi, Chikwawa, and Mwanza districts while the Swiss Red Cross is supporting Blantyre and Rumphi. Qatar Red Crescent is supporting Lilongwe and Blantyre.

While operationalizing the Agenda for Renewal, MRCS now has a Country Coordination Team to champion the new way of working. The team is made up of:

1. Strategic management group. (MRCS SG, Head of the delegation /cluster IFRC, and HOD PNS).
2. Operational Programme management team (Co-chaired by IFRC Ops Coordinator and MRCS Director of Programmes).
3. Thematic work streams (Health, DM, NSD/OD/PMER, and cross-cutting) with MRCS being thematic leads.

The above coordination teams are now up and running to ensure implementation of the below five expected deliverables under the agenda for renewal with the following current updates.

- Context, needs and situation analysis done in collaboration with partners.
- Country working on Common country support plan.
- Common accountability framework and harmonized resource mobilization strategy
- Common implementation model to be ready by early next year.
- To have an agreed team composition for the 3 working groups at the country level

On a bimonthly basis, the Country Coordination Team completes and updates a planning table and responds on its progress as per the five expected deliverables of the country plan. The bimonthly updates are used to identify actions and follow-up needed by the work streams, working groups, or other stakeholders to support the Country Coordination Teams.

2.2 International Humanitarian Stakeholder capacity and response

Malawi MOH is coordinating the response and holds bi-weekly national task force meetings with all partners, with the participation of Red Cross Red Crescent Movement partners and others, including WHO, UNICEF, and MSF. MRCS will directly collaborate with its different partners including MOH, UNICEF, WHO, and the German International Development Agency (GIZ) among others, as well as with the private sector and any individuals who might be interested to support the response. Currently, MSF and MRCS are collaborating to establish CTUs in Blantyre and Lilongwe. There are also discussions with MSF to conduct mass health promotion in Blantyre and Lilongwe using MRCS volunteers.

In total, UNICEF and MRCS are scaling up the cholera response in the 15 districts of Blantyre, Lilongwe, Mangochi, Dedza, Rumphi, Karonga, Nkhatabay, Nkhosakota, Neno, Mzimba, Machinga, Nsanje, Chikwawa, Salima and Balaka, in the areas of health, nutrition, education, WASH, coordination, social behaviour change, and RCCE. WHO and UNICEF have procured oral rehydration salts (ORS) and are working with MRCS in setting up oral rehydration points (ORPs) in outbreak hotspots.

3. Gaps in the response

Gaps in the response have been identified by MRCS assessment and review of available secondary data as follows:

Social mobilisation and risk communication

- Data show that there is a high awareness of the outbreak and knowledge of cholera overall. However, this is not translating sufficiently into changed behaviour to reduce transmission.
- The general population is very concerned due to the increase in the number of deaths being reported daily across multiple districts, which is being compounded by the rainy season, myths, misconceptions, religious beliefs, and late health-seeking behaviours.
- Community data collected so far are telling us that the level of knowledge on cholera is quite high, but high costs of water tabs, access to clean water, concerns around single-dose vaccines, mistrust of health workers, and concerns about funeral/burial practices are core areas still to be addressed. Thus, RCCE and CEA should focus on working very closely with Health/WASH teams on these issues, and on moving beyond awareness sessions and messaging.
- There is a need for stronger community-based efforts in health and hygiene promotion appropriately addressing barriers to behaviour change and taking into account cultural and traditional requirements.
- There is a need to strengthen community engagement approaches and feedback systems across all interventions, a need to promote community-led actions, and a need to promote the agile adaptation of services and interventions to control the outbreak and regain the trust of affected communities.
- There should be more support for Oral Cholera vaccines (OCV) to dispel the misconception. Some people are still conflating OVC with the COVID vaccine.
- There are lingering issues with trust in healthcare facilities and community engagement, and to overcome this there is a need for better information concerning the treatment offered at CTCs/CTUs.

Improved surveillance

- Active case finding and surveillance are experiencing challenges. Malawi's surveillance system is mainly facility-based, and these health facilities are overwhelmed with the burden of treating cases, which in turn impacts surveillance. To date, no community-based surveillance is in place.

Cholera vaccination

- The lack of sufficient OCV globally makes it very difficult for Malawi to vaccinate its population. On 7 November 2022, Malawi received 2.9 million doses for a single-dose reactive campaign prioritising 15 districts with high cholera case numbers, namely Karonga, Rumphi, Mzimba North, Mzimba South, Likoma, Nkhatabay, Chitipa, Lilongwe, Salima, Nkhosakota, Kasungu, Nsanje, Zomba, Mangochi and Blantyre. Yet this still wasn't enough doses and MOH had to prioritise high-risk areas.
- MOH is in the process of requesting more OCV with the support of WHO.

Nutrition

- Widespread malnutrition could also exacerbate the outbreak. Malawi is now in the lean season when access to food is more challenging. Large communities of internally displaced people (IDPs) from recent cyclones are still living in flood areas with poor access to water and sanitation facilities. They are concentrated mainly in the South, and this situation has impacted the capacity of health services since 2021.

Safe Burial

- Cultural rituals around death and dying may also be helping to spread the disease. For example, family members of people who are dying of, or who have died from, cholera are required to wash the sick or deceased. They then prepare funeral feasts for family and friends very soon after the death, and outbreaks
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of cholera commonly follow these feasts. There is thus a need for more community engagement to improve the safety of burials while ensuring that dignity and traditions are maintained.

Improved case management

- The rapid, widespread outbreak in a short period at the beginning of the rainy season indicates the further rapid spread of the disease.
 - MOH is stretched to the limit (1) due to a lack of human resources to manage the caseload and because of inadequate cholera treatment units, resulting in the conversion of health facilities to cholera treatment units, (2) through lack of cholera supplies and (3) through inadequate supply disinfectants to prevent transmission. This all adds to severe disruption in the community health system.
 - MOH has set up CTs and CTUs in the affected districts, however, the established treatment units are still not adequate to accommodate the increasing number of cases requiring admission, putting pressure on human resources. More materials and more CTUs would thus improve the current case management capacity. This, coupled with the long distances that people have to travel for treatment, has contributed to increased fatalities and transmission, as most cases arrive at treatment centres already in severe condition.
 - Delays in access to facilities result in delayed access to rehydration treatment and by extrapolation lack of community awareness on how to support affected people with ORS. The situation is exerting pressure on the already constrained health system, which is currently running Polio vaccination campaigns and managing the impacts of Tropical Storm Ana and Cyclone Gombe as well the COVID Pandemic.
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Socio-economic hardship

- Closure of major city and district markets in some locations has denied people a source of livelihood, while communities are also then denied a source of the goods and other services necessary to survive.
 - The outbreak has exacerbated hardship in communities already under pressure from global disruptions to supply chains and price increases. This has also limited the resources that government has available to it for the response.
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Mental health

- The crisis has significantly impacted family cohesion, as family members admitted to CTUs have limited contact with their loved ones, more so when admitted family members are the breadwinners. In this crisis, most cases are males and the breadwinners in the Malawian context. There is also evidence of depression among relatives of people who died in CTUs because family members are not allowed to pay their last respects due to strict preventive measures associated with cholera.
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Water and Sanitation

- The main risk factors contributing to new cholera cases are water from unsafe sources, open defecation, low latrine usage, poor food hygiene; and contact with other cholera cases.
 - Low coverage of latrines in rural communities, and the sharing of latrines in high-density urban locations, increase the risk of cholera.
 - Most communities have no alternative sources of safe water, and a lack of water treatment reagents such as HTH has left populations with no option but to continue using these unsafe sources.
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OPERATIONAL CONSTRAINTS

Barrier	Response
The staff is overstretched.	Training, and recruitment of full-time staff. Support MRCS to scale up and provide staff dedicated to the response and manage the files from different partners.
Overstretched logistical capacity.	Recruitment and training of personnel, assessment of warehouses, and continued monitoring of the situation. Use of WFP warehouse.
Stakeholders' limited availability for meetings.	Joint planning and review.
Limited community participation	Effective community engagement.
Unfavorable weather conditions coupled with poor roads make it difficult to deliver supplies to affected populations.	Continue monitoring and contingency replanning
Rising cost of goods and services.	Re-budgeting and consultation with IFRC and partners.

FEDERATION-WIDE APPROACH

The Emergency Appeal is part of a **Federation-wide approach** based on the response priorities of the Malawi Red Cross Society and in consultation with all Federation members contributing to the response. The approach, reflected in this Operational Strategy, will ensure linkages between all response activities (including bilateral activities and activities funded domestically) and will assist to leverage the capacities of all members of the IFRC network in the country, to maximise the collective humanitarian impact.

The Federation-wide funding requirement for this Emergency Appeal comprises all support and funding to be channeled to the Malawi Red Cross Society in the response to the emergency event. This includes the Malawi Red Cross Society's domestic fundraising ask, the fundraising ask of supporting Red Cross and Red Crescent National Societies, and the funding ask of the IFRC secretariat. The overall Federation-wide funding requirement for the MRCS is 5.2 million CHF, of which the IFRC Secretariat funding requirement is 3.5 million CHF.

IFRC Membership Coordination

The IFRC Secretariat will provide technical and financial support to MRCS through the IFRC Harare Cluster Delegation. IFRC will also support good coordination within and outside the Movement. It has deployed staff and surge profiles to support Finance, Logistics, Communication, CEA, WASH, and Public Health in Emergencies to work with MRCS.

Partner National Societies in-country have continued to provide bilateral support to MRCS since the start of the response. These are the Danish Red Cross, Finnish Red Cross, Icelandic Red Cross, Italian Red Cross, Qatar Red Crescent, and Swiss Red Cross. All PNSs participate in the coordination meetings that are held in-country and are called upon to contribute their expertise to this response. Currently, the Danish Red Cross-led consortium is supporting the three districts of Mangochi, Chikwawa, and Mwanza. The Swiss Red Cross is supporting Blantyre and Rumphi, and Qatar Red Crescent is supporting Lilongwe and Blantyre.

The Malawi Red Cross is part of the IFRC network's New Way of Working initiative, which is being piloted in 14 countries. This aims to establish a new model of membership coordination over time to instill thorough change in the way that IFRC networks work together, placing the National Society of the country at the centre. This includes prioritising effective coordination for much greater gains, optimising the power of working as one IFRC by sharing resources, learning and common standards, to ultimately achieve greater impact. Particular attention is given to collective planning to ensure that National Society partners present in country participate in one multi-year country plan, which will ensure that the resources and expertise of the network in country are used in a complementary and efficient way.

The Red Cross in Malawi is being supported by a consortium of in-country participating National Societies. It is led by the **Danish Red Cross**, which works alongside the **Finnish Red Cross**, **Icelandic Red Cross**, **Italian Red Cross**, and **Swiss Red Cross**, while **Netherlands Red Cross** is supports remotely. The consortium supports the National Society with shelter initiatives, *European Civil Protection and Humanitarian Aid Operations (ECHO)* projects, and flood recovery support.

The **Finnish Red Cross** has given its support specifically on the election response and first aid. The **Icelandic Red Cross** has focused on community resilience projects. The **Swiss Red Cross** has supported work on health, water, sanitation, and hygiene, and on blood donor recruitment.

Red Cross Red Crescent Movement coordination

The IFRC Secretariat plays an essential role in ensuring effective coordination across the Movement, through the IFRC Harare Country Cluster Delegation. In this response, both IFRC and ICRC are providing advice on the overall safety and security support to Movement partners. The IFRC Harare Cluster Delegation is in regular coordination

with the ICRC Country Delegation for Zimbabwe, Malawi, and Zambia. Regular meetings are held to make sure there is strong coordination and effective technical support for MRCS, as well as complementarity, to ensure a harmonised response.

External coordination

Malawi's Ministry of Health coordinates daily national task force meetings for partners in this response with the participation of Red Cross Red Crescent Movement partners and other partners, including WHO and UNICEF. The Ministry appreciates the role of MRCS in the cholera response and its participation in cholera technical meetings at the national and district levels.

Partner	Districts supported
Swiss Red Cross	Blantyre/Rumpi
PNS Consortium (Danish, Icelandic, Netherlands, Finnish)	Chikwawa/Mangochi/Mwanza
Qatar Red Crescent	To be confirmed
UNICEF	All 15 target districts

OPERATIONAL STRATEGY

Vision

To contribute to the Government of Malawi's Cholera Response Plan in controlling and reducing the cholera outbreak thereby reducing morbidity and mortality, reaching at least 2 million people from September 2022 to September 2023, focusing on 15 of the most affected districts and vulnerable communities.

MRCS will scale up and expand activities started in the [DREF launch in September 2022](#). It will focus its response on interrupting transmission and improving case management of cholera at the community and facility levels in the affected districts. The core objectives are to:

- prevent and control the spread of cholera at the community and facility levels in the affected districts, interrupting the chain of transmission;
- 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; and
- improve the availability of safe water and sanitation facilities to ensure the use of safe water, basic sanitation, and good hygiene practices in cholera hotspots.

Crosscutting areas

- Community Engagement and Accountability (CEA) and Risk Communication (RCCE)
- Protection, Gender, and Inclusion (PGI)
- National Society Development
- Coordination and Partnerships
- Secretariat Services

Given the risk of the spread of cholera to neighbouring countries, MRCS and IFRC will establish regular cross-border communications, information sharing, and support, which will allow neighbouring Red Cross and Red Crescent National Societies to conduct effective readiness activities and scale up the response, if necessary. At the time of publication, Zambia and Mozambique have been registering new cases.

Anticipated climate-related risks and adjustments in operations

The Malawi [Department of Disaster Management Affairs \(DODMA\) on 2 Feb. 2023](#) highlighted the danger of storm rains, floods, strong winds, hailstorms, and lightning across 27 districts, with some damage to roads, schools, and hospitals. Over 19,000 households, representing approximately 85,536 people, have been affected and the human toll has surpassed 57, and 176 injured. These events have also caused damage to crops, roads, schools, and hospitals, and have ultimately fuelled the rate of transmission by contaminating drinking water and collapsing latrines, which has in turn promoted open defecation. Hospitals have also been damaged or flooded, making it difficult to continue offering care.

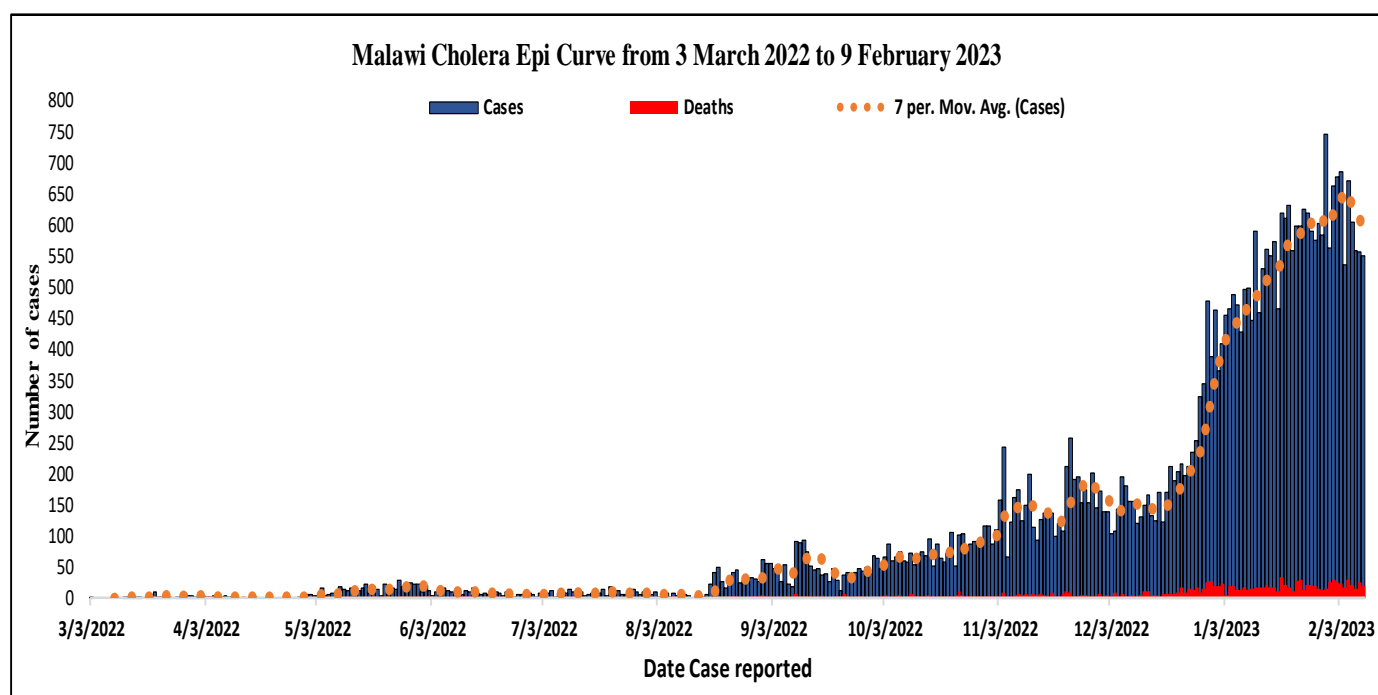
Targeting

1. People to be assisted

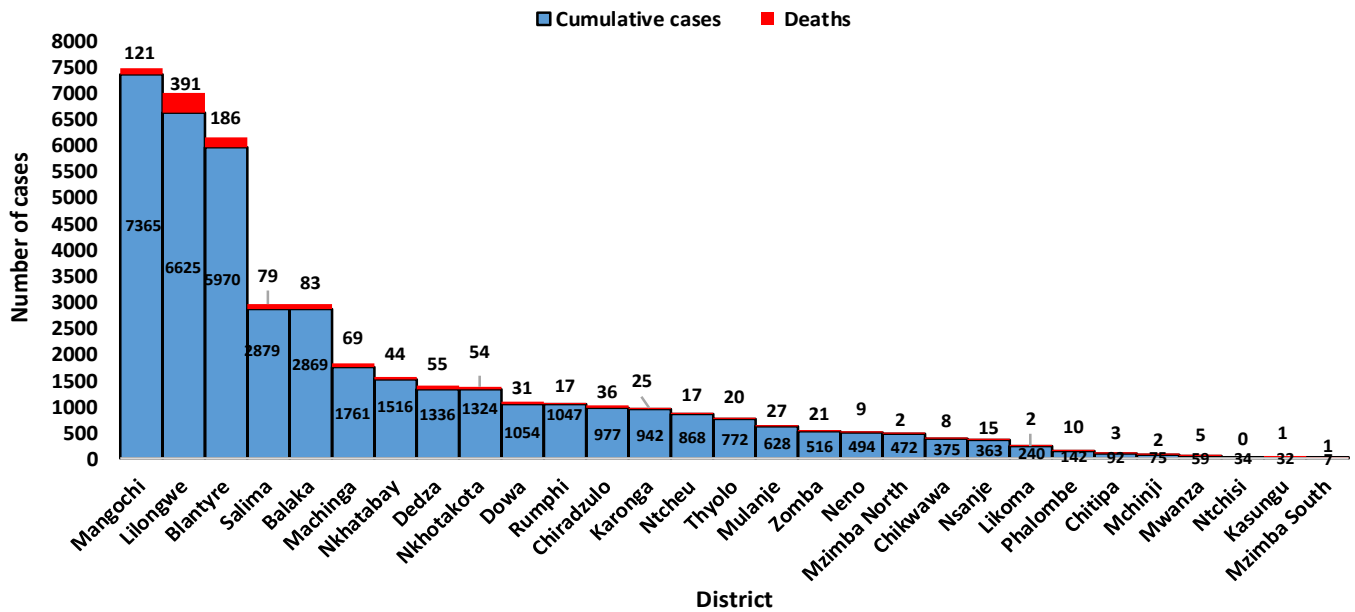
This response aims to scale up activities and geographical area of activities to respond to the increasing cholera caseload. Districts and targeted populations will be prioritised based on the following:

- i. in coordination with MOH and Health Cluster;
- ii. districts with increased numbers of cases and deaths, high CFRs;
- iii. districts with high cholera risk factors contributing to new cases;
- iv. districts registering high numbers of cases (over 20 cases per day) in 14 days;
- v. districts where CTU capacity is limited due to high caseload;
- vi. immediately upon notification of a case in a new area; and
- vii. large numbers of cases coming from a specific area.

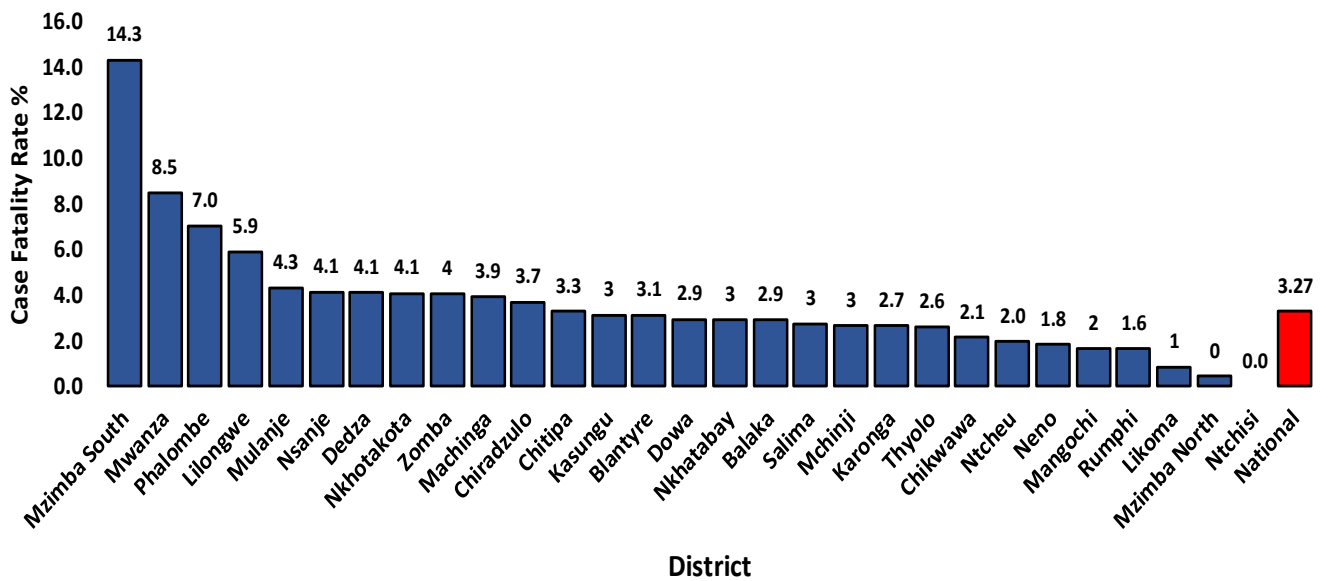
Based on the most recent data, including the following information from MOH surveillance for Week 5:



Malawi Cholera Cases by district

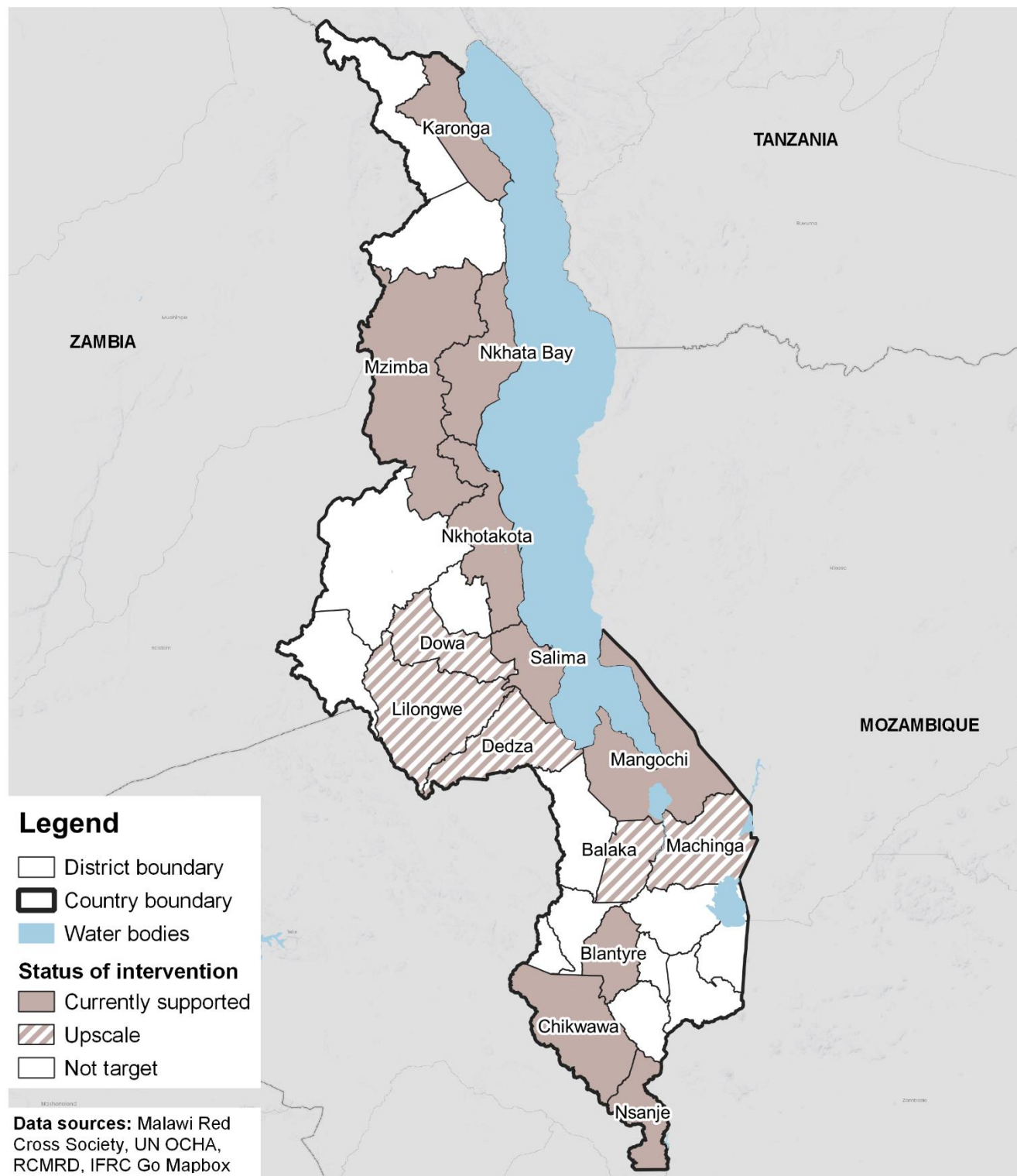


Malawi Cholera CFR per District





CHOLERA DISTRICTS OF INTERVENTION BY MALAWI RED CROSS SOCIETY



The maps used do not imply the expression of any opinion on the part of the International Federation of Red Cross and Red Crescent Societies or National Societies concerning the legal status of a territory or of its authorities.

0 40 80 120 160 km



Interventions will target the most vulnerable affected populations including but not limited to children under 5 and pregnant and lactating women, fishing communities, communities along the rivers and lakeshores, flood-prone villages, areas with poor WASH, and communities bordering Mozambique and Zambia.

Geographic areas included are also expected to change throughout the outbreak based on external factors such as flood rains and resource flows to and from MOH and partners in different locations. Operations will remain flexible:

- The rainy season typically covers January to April, but rains can start in December.
- The hottest months are October and November.
- Currently, 29 districts are affected, but the outbreak is also starting to come under control in Karonga, Nkhatabay, Nkhotakota, and Mzimba, mainly in the North.
- Lilongwe, Blantyre, and Mangochi are still surging, however.
- More support will be needed in Salima, Machinga, Balaka, Cjkwawa, and Nsanje, moving toward the southern part of the country.


To support agility and timeliness of the response, IFRC is supporting MRCS with scenario development based on assessments, secondary data, and mid to long-term forecasts.

2. Considerations for Protection, Gender, and Inclusion (PGI) and Community Engagement and Accountability (CEA)

The Operation will ensure the promotion and participation of both men *and* women and will include persons with disabilities and persons of different age groups, in cholera awareness activities; MRCS will take deliberate action to recruit volunteers with disabilities. Continuous advocacy and dialogue among the different stakeholders will be fostered to ensure that all programmes/sectors mainstream the Dignity, Access, Participation, and Safety (DAPS) approach, ensuring that minimum standards on PGI in emergencies are met based on the identified needs and priorities of humanitarian imperatives on the ground.

MRCS will ensure that all staff and volunteers are briefed on PGI and sign the Code of Conduct, and are briefed on the prevention of and response to sexual exploitation, abuse, and child safeguarding. PGI mainstreaming will be carried out per minimum standards in cholera interventions while ensuring that all the data are disaggregated by sex, age, and disability (SADDD).

PLANNED OPERATIONS

	Health & Care	Female > 18: 611,684	Female < 18: 524,302	CHF 2,470,000
		Male > 18: 524,302	Male < 18: 524,302	Total target: 2,184,590
Objectives:				
<div><div>1.</div><div>Prevent and control the spread of Cholera at the community and facility levels in the affected districts, interrupting the chain of transmission.</div></div> <div><div>2.</div><div>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.</div></div>				
Priority actions:				
<i>Training and mobilisation of volunteers</i>				
<div><div>1.</div><div>On average 100 community volunteers will be trained and mobilised in each of the 15 target districts.</div></div>				

2. Six-hundred volunteers have already been trained on BTIT, Community-based Surveillance (CBS), parts of the epidemic control package, and Oral Rehydration Therapy (ORT), and an additional 900 will be trained in the same way to reach the planned 1,500.
3. Close collaboration with health service assistants (HSAs), of which there will be 400, and the opening of 120 ORPs with 8 volunteers each is envisioned.

1. Prevent and control the spread of cholera at the community and facility levels in the affected districts, interrupting the chain of transmission:

Risk Communication and Community Engagement (RCCE) and Social Mobilisation (aligned with the CEA session below)

1. Volunteers will be trained in RCCE/CEA to build trust in communities, and will also be trained to actively listen and respond to community feedback, (1) to ensure that operations are relevant and (2) to remain updated on the latest feedback trends.
2. Each of the 15 districts will develop its community engagement strategy using a template that addresses specific gaps. Context analysis and community mapping will be carried out to understand the structures, groups, power dynamics, capacities, beliefs, challenges, and needs involved.
3. Partners will adapt strategies and activities based on communities' perceptions, suggestions, and concerns captured through feedback. Based on current assessments, the data collected so far indicate that in some areas, the level of knowledge on cholera is quite high. However, high costs of water purification treatment, access to clean water, concerns around the one-dose vaccine, and concerns about funeral/burial practices remain core areas to be addressed. The RCCE/CEA strategy will focus on working closely with Health/WASH teams on these issues, moving beyond awareness sessions/messaging.
4. Operations will include dialogue meetings with select community leaders as well as bi-weekly engagement with local volunteers, community leaders, faith leaders, and youth. Here, two-way communication that encourages active listening and participatory dialogue with the community will be promoted.
5. Outreach will include sensitisation on cholera through community radio, mobile vans, and megaphones to support vaccination campaigns and hygiene promotion, including phone-in radio sessions for people to share their concerns and ask questions, to address their needs through established feedback mechanisms.
6. A cholera pocket guide for volunteers will be developed along with appropriate information-education-education (IEC) materials for volunteers on household visits, to promote health-seeking behaviours, household water treatment and safe storage, Infant and Young Child Feeding practices (IYCF), and Health & Hygiene information.
7. Through household visits, health promoters will inform communities about the early signs of cholera and the importance of reporting it to health authorities. This will ensure that communities are aware of risk factors and can identify and refer suspected cases to community health workers/health facilities/ORPs on time. Included will be the promotion of ORS as early treatment.

Community-based Surveillance (CBS)

1. As part of routine household visits, volunteers will survey several cases and will report this via supervisor to HSAs and health facilities. This is common practice in all MRCS health projects.
2. Volunteers will take down data on paper and forward that to HSAs.
3. MRCS will work with a smaller group of more experienced volunteers and supervisors in some of the highest-burden districts to pilot Nyss data collection software, to complement data collected by the Government system (facility-based) and in ORPs (see below), and will assist in identifying community transmission hotspots.

For Transmission Interruption

1. Training and mobilising of volunteers in Branch Transmission Intervention Teams (BTIT).
2. Ensuring that upon identification of cholera/diarrhoea, affected households are thoroughly disinfected to reduce the risk of household transmission.
3. Volunteers will be trained and mobilised to support health workers in follow up of cases, early detection of new cases through active case finding and CBS, and support contact tracing.
4. Affected households will be well informed on cholera including transmission routes.
5. MRCS will identify stigmatisation concerns, which will be managed through engagement meetings.

For vaccination

1. Support social mobilisation for upcoming oral vaccination rounds, to create demand and increase uptake of vaccines.

Nutrition-related activities

1. Training and mobilisation of volunteers in the promotion of good IYCF, with nutrition screening.
2. Promotion of IYCF and nutrition screening.
3. Trained volunteers will conduct mass nutrition screening and family mid-upper arm circumference (MUAC), with IYCF counselling in CTUs and communities for children 0-59 months.

Safe Burial

1. Training and mobilisation to support cholera burials, engage the community, and raise awareness on cholera.
2. The affected population is helped by supporting families for cholera burials. Cholera burials are not at the same level as SDBs for viral haemorrhagic fever, e.g., Ebola. However, the bodies of people who have died from cholera must be promptly and safely buried to protect others.
3. Community health workers, such as HSAs, and MRCS volunteers will be trained to provide health and hygiene information and to support concerned families and communities. Burial is a sensitive issue in any community, thus teams will engage communities to ensure that cholera burial protocols are consistent with traditional norms, to avoid compromising safety. They will also collaborate with MOH burial teams on persons without identified families.

Coordination

1. MRCS takes part in the national Cholera Taskforce, attending all meetings and supporting the development and implementation of the National Cholera Outbreak Response Plan.
2. MRCS is an active member of the Health Cluster at the national and district levels.
3. At the community level, MRCS volunteers will coordinate with HSAs, coordinating Primary Health Care Units in communities, village health leadership and coordination structures - including village traditional leadership - and water management committees, which are linked respectively with the Department of Disaster Management Affairs (DODMA) and Ministry of Water and Sanitation (MOWS).
4. MRCS staff participate in RCCE coordination meetings at all levels and confirm that feedback data is discussed and cross-referenced against other data.
5. Monthly coordination meetings with RCCE stakeholders will be conducted, where technical teams will review the feedback collected and develop recommendations. A feedback collection tool will be developed with Health Education Services and partners.
6. MRCS will strengthen coordination and information management through technical surge capacity.

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:

For Case Management


1. MRCS will support improvements in case management of cholera in the community by establishing ORPs.
2. Activities will include training and mobilisation of eight volunteers per ORP, to agree with Government targets.
3. Actions will involve the deployment of ERU with CCMC for four months.
4. MRCS will provide temporary latrines and support the procurement of infection prevention control (IPC) materials, ORS, chlorine, disinfection kits, and Personal Protective Equipment (PPE) for volunteers and HSAs at CTUs.
5. MRCS will extend technical support to MOH through Cholera Emergency Response Units and capacity building for surges (Red Pillar support).

Cash Voucher Assistance (CVA)

1. Operations will include Cash Voucher Assistance (CVA) for the purchase of locally available nutritious food and basic WASH non-food items (NFIs) such as soap, ORS, and buckets for water storage and hand washing, chiefly for lactating mothers and children under 5 that are directly affected by cholera.
2. Once a caregiver/lactating woman or child under 5 has been admitted to a CTU with cholera, they will be registered into a one-off CVA programme.

Mental Health and Psychosocial Support (MHPSS)

1. Mental Health and Psychosocial Support (MHPSS) providers including volunteers, "Mother" groups, health workers, and child protection officers, will be trained to provide services in communities.
2. The Operation will facilitate psychosocial support for family members in situations where a family member is admitted or has passed away.
3. This will include supportive supervision and mentorship sessions with volunteers.

	Water, Sanitation, and Hygiene (WASH)	Female > 18: 611,684	Female < 18: 524,302	CHF 391,000
		Male > 18: 524,302	Male < 18: 524,302	Total target: 2,184,590
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.				
Priority actions:				
<i>Promoting household water treatment and safe storage. Volunteers will be mobilised to conduct pot-to-pot chlorination and distribution of water treatment chemicals including aquatabs.</i>				
<ol style="list-style-type: none">1. Training and mobilisation of volunteers in household water treatment, transport, and safe storage.2. Provision of chlorine to make one stock solution for pot-to-pot chlorination in households. Volunteers will be deployed to scale up chlorination at the point of use and point of source in communities and at institutions.3. Provision of water treatment chemicals including aqua tabs.4. Provision of water storage buckets, jerricans, and soap to affected communities.				

5. Deployment of the Household Water Treatment and Safe Storage (HWTS) Module and ERU pending assessment.
6. Training in the community on the use of HWTS materials at distribution points and other venues.
7. Post-distribution monitoring to promote the correct use of HWTS materials and to determine the need for further distribution.

Contribute to accessing safe water through the construction, rehabilitation, and disinfection of water points.

1. Construction of solar-powered water pumps in Mangochi to contribute to increased access to water for 3,400 people in hotspots.
2. Rehabilitation of water points, including hand pumps, in the 15 target districts.
3. Rehabilitation and upgrade of solar water pumps in health facilities and schools.
4. Disinfecting 100 contaminated water sources.

Water quality monitoring at household and communal water points.

1. Training on water monitoring using field test kits.
2. Provision of test kits and refills. Water quality sampling and testing by water technicians.
3. Use of data to inform decisions on HWTS and water supply rehabilitation.

Facilitate construction of latrines in health facilities and public institutions as a hygiene promotion initiative. Health facilities and schools with wet feeding programmes will be prioritised.

1. Construction of latrines, bath shelters, and handwashing facilities in CTUs.
2. Rehabilitation and de-sludging of pit latrines in health facilities and schools.
3. Training of health workers, teachers, and learners on management of latrines.

Raise awareness on dangers of open defecation and benefits of food hygiene, and advocate for community members to construct latrines.

1. Conduct sensitisation through door-to-door visits in communities.
2. Sanitation promotion in communities, institutions, and public spaces such as markets, including latrine use/management, and proper waste disposal.

Infection Prevention and Control in CTUs and WASH in Communities at schools and public places.

1. Training and mobilisation of volunteers and health workers following IPC guidelines for CTUs in all 15 districts.
2. Reinforce IPC/WASH protocols in CTUs, schools, and strategic public places.
3. Provision of IPC supplies for CTUs, schools, and communities in target districts.
4. Monitoring of CTUs, schools, and communities to determine the need for additional interventions or resources.



**Protection,
Gender and
Inclusion (PGI)**

Female > 18: 611,684

Female < 18: 524,302

CHF 117,000

Male > 18: 524,302

Male < 18: 524,302

**Total target:
2,184,590**

Objective: Communities can identify and respond to the distinct needs of the most vulnerable segments of society, especially disadvantaged and marginalised groups, who are subject to violence, discrimination, and exclusion.

Priority actions:

1. The Operation will ensure the promotion and participation of men and women, including persons with disabilities, and persons of different age groups, in cholera awareness activities.
2. This will include promoting PGI and prevention of stigmatisation of victims of the disease and their families.
3. MRCS will advocate for clear separation of genders in CTUs, adequate lighting around CTUs at night, and gender disaggregation in data.
4. MRCS will mobilise volunteers to strengthen protection of children and women in treatment centres and homes.
5. Operations will ensure continuous dialogue among stakeholders to mainstream Dignity, Access, Participation, and Safety (DAPS) to achieve minimum standards on PGI.
6. Staff and volunteers will identify children without parental care and those experiencing violence and neglect and will enrol them in social welfare.
7. There will be training for volunteers to identify women, men, girls, and boys requiring MHPSS after discharge from CTU to social welfare.
8. Volunteers will receive training in treatment centres on PSEA and GBV risk mitigation, including referrals for survivors to social welfare.
9. Community-based childcare centres and Children's Corners will have to message on cholera prevention and response.
10. MRCS will provide orientation for staff and volunteers on the Code of Conduct and prevention of/response to sexual exploitation and abuse, including child safeguarding.


**Community
Engagement and
Accountability
(CEA)**

Female > 18: 611,684

Female < 18: 524,302

CHF 35,000

Male > 18: 524,302

Male < 18: 524,302

Total target: 2,184,590

Objective: Develop and deploy standardised approaches for community engagement and for collection and use of data to better understand community perspectives.


Priority actions:

1. MRCS will ensure that IFRC CEA tools are tailored to the Malawi context.
2. Community members will be involved as much as possible in planning and throughout the response, to increase their understanding, engagement, and ownership of interventions. This will contribute to reducing the spread of the disease through sharing of reliable information about services and interventions with a focus on the uptake of ORS, use of ORPs, and promotion of health-seeking behaviours; scaling up open and honest communication on selection criteria; and distribution of information through community meetings and door-to-door activities.
3. MRCS will hold consultations with communities to learn their preferences on feedback channels and the type of questions that they would like to have answered.
4. Active feedback systems will be established in strategic places, such as at ORPs and vaccination centres, and feedback will be shared on different platforms at the community, district, and national levels, including technical and sub-technical working groups. This will include harmonisation of feedback collection tools.
5. Feedback and complaints will be collected through community volunteers, community meetings, focus groups, and suggestion boxes, and responses provided through community meetings. Feedback will also be collected during hygiene and health promotion sessions. Trained staff and volunteers will also be available to respond directly to individuals, particularly where the feedback is sensitive. A separate mechanism will be put in place for receiving, managing, and responding to sensitive feedback to give a safe

space to report any sensitive or serious complaints related to corruption, SEA, etc. And these feedback systems will have clear referral pathways.

6. A help desk with a toll-free number will be set up at national headquarters and linked to branches and communities.
7. There will be a CEA surge to support training-of-trainers (TOTs) and the establishment of the feedback mechanisms, with input from information management systems.
8. A frequently asked questions (FAQ) sheet will be developed in collaboration with MOH and shared with volunteers so that they can address common questions, concerns, and beliefs that are seen in the feedback data.

Enabling approaches

	National Society Strengthening	Female > 18: 39,716	Female < 18:	CHF 303,000
		Male > 18: 32,495	Male < 18:	Total target: 72,000 volunteers & 211 Staff

Objective: National Societies are prepared to respond effectively to epidemics/emerging crises, and their auxiliary role in providing humanitarian assistance is well-defined and recognised.

Priority actions:

1. Facilitate capacity building and organisational development to ensure that the National Society has the necessary legal, ethical, and financial foundations, systems, structures, competencies, and capacities to plan and perform.
2. Volunteer duty of care will be emphasised through the appropriate management services, with provision of equipment, training, and an insurance package.
3. Coordination with MRCS on opportunities for capacity building of staff for strengthening their auxiliary, advocacy, and humanitarian diplomacy, particularly in public health emergency preparedness and response for future operations.
4. Facilitating capacity building on response capacity.
5. Epidemic preparedness supplies, fleet, and warehousing.
6. Ensuring that the National Society has the necessary legal, ethical, and financial foundations, systems, policies, strategies, structures, competencies, and capacities to plan and perform.
7. Volunteer management through appropriate management services, provision of equipment, training, and an insurance package.
8. Infrastructure development, communications, fleet, and technical services.

	Coordination and Partnerships	Female > 18: 611,684	Female < 18: 524,302	CHF 33,000
		Male > 18: 524,302	Male < 18: 524,302	Total target: 2,184,590

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

Priority actions:

Membership coordination

1. MRCS is currently receiving support from Danish Red Cross, Swiss Red Cross, Qatar Red Crescent, Kuwait Red Crescent, and IFRC. In-country are IFRC, Danish Red Cross, and Swiss Red Cross.
2. The Danish Red Cross leads the consortium of Iceland, Italy, Belgium, Netherlands, and Finland.
3. Currently, MRCS, IFRC, and partners have agreed on the geographic areas to support within a coordination framework. In line with this framework, the IFRC surge should technically support all districts where MRCS is responding since they will contribute to one MRCS response.
4. MRCS still needs an updated 5W matrix, especially in the districts where it is responding.

Engagement with external partners

1. In its auxiliary role, MRCS will strengthen and add value to coordination at the national and district levels with MOH, DODMA, MOWS, Ministry of Local Government, UNICEF, WHO, MSF, and other organisations.
2. Activities will further facilitate engagement and coordination with PNSs and ICRC in the design of the response, leveraging expertise and resources available through the Red Pillar approach and ensuring alignment with external actors, including government policies and programmes; development actors and UN agencies; and non-governmental organisations (NGOs). GIZ will support the response in Mulanje, Phalombe, and Mangochi
3. MOH has requested support from the Eastern and Southern Africa Region (ESAR)/RCCE Collective Service in strengthening the capacity of country-level partners (including MRCS) through training on the national community feedback mechanism along with face-to-face coaching on how to collect, analyse and act on community feedback. The Collective Service team will provide in-country support in establishing an interagency feedback mechanism to help inform decision-making. The RCCE Collective Service is also in the process of recruiting a national RCCE interagency coordinator, to be hosted by UNICEF, and based in Lilongwe for at least the next six months. MRCS will work closely with this person and has been consulted on recruitment.
4. Bi-monthly district coordination meetings among the Education cluster, WASH cluster, and Health cluster, with a focus on strengthening district-level coordination.

Movement cooperation

1. MRCS, partners, and IFRC coordinate with the ICRC regional office.
2. ICRC has supported MRCS with a one-off donation of PPEs for case management staff.



IFRC Secretariat Services

Female > 18: 611,684

Female < 18: 524,302

CHF 151,000

Male > 18: 524,302

Male < 18: 524,302

Total target: 2,184,590

Objective: Effective and coordinated cholera response is confirmed.

Priority actions:

IFRC Secretariat services

1. IFRC currently has recently signed a status agreement with the Malawi Government on 22nd December 2022. The IFRC has a Cluster Operations Coordinator based in Malawi who is in charge of all IFRC operations which support MRCS. The Harare Cluster Delegation provides full support across finance, logistics, PMER, security, NSD, and technical sectors.
2. IFRC will facilitate an effective Federation-wide response with support from the Harare Cluster Delegation and Africa Regional Office. It will offer its expertise in managing epidemics through the deployment of critical functions as agreed with MRCS and will also equip them with strong risk management and

business continuity plans. Given the risk of spread to neighbouring countries, MRCS and IFRC will establish regular cross-border communication, information sharing, and support, which will allow neighbouring Red Cross and Red Crescent National Societies to conduct effective readiness activities and scale up the response, if necessary.

3. Through the IFRC surge system, regional and global alerts have been issued for coordinators in WASH and Public Health in Emergencies (PHIE), and in RCCE as well. Currently, a PHIE coordinator has been deployed with the support of the German Red Cross and a WASH coordinator is being deployed, also with the support of the German Red Cross. An RCCE coordinator is being deployed with the support of the British Red Cross.
4. The Emergency Response Unit for CCMC has been deployed with support from the Swiss Red Cross and with HR support from the Norwegian, Spanish, and Swedish Red Cross societies.
5. A request for a household water treatment Emergency Response Unit is also under consideration based on the assessment of the needs and capacity in-country.
6. IFRC will take a holistic approach to programming, monitoring, reporting, risk management, information management, external communications, and resource mobilisation.
7. IFRC will facilitate an effective Federation-wide response, with support from the Harare Country Cluster Delegation and Africa Regional Office, and will offer its expertise in managing epidemics through the deployment of critical functions as agreed with the National Society; it will also equip MRCS with strong risk management and business continuity plans.

Risk Management

1. IFRC will provide risk management advice to help the National Society establish the necessary processes and controls.

Communications

1. Communication activities will be conducted to draw attention to and highlight the humanitarian situation and activities related to the Red Cross Viral Hemorrhagic Fevers (VHF) outbreak response, through the development of key messages, press releases, high-quality and compelling photos, video materials, and social media activities that can be used by the media and Federation/Movement partners.

Monitoring & Evaluation (M&E)

1. Develop and launch a Federation-wide Planning, Monitoring, and Reporting framework.
2. Provide PMER support enabling Federation-wide planning, development, and maintenance of sustainable monitoring tools and workflows, supported both internally and Federation-wide, as well as donor reporting, which will contribute to longer-term capacity building of the National Society.
3. Conduct regular monitoring with support from MRCS and IFRC, conduct a mid-term evaluation to assess progress, and formulate recommendations to inform future programming responses. A final evaluation will also be conducted at the end of the Operation.
4. Develop a follow-up mechanism to implement the recommendations from the final evaluation.

Security

1. Active measures must be adopted to reduce the risk of personnel falling victim to crime, violence, health hazards, and road hazards. This includes monitoring the situation and implementing minimum security standards. The National Society's security framework will be applied throughout the Operation to protect personnel and volunteers. IFRC personnel must complete e-learning on security.
2. Area-specific security risk assessments will be conducted and risk mitigation measures will be implemented.
3. The IFRC Regional Security Unit will: conduct security analyses to enable the team to implement risk management measures considering the latest developments; monitor the security environment; provide technical advice; and ensure that any internal/external security incidents or emergencies are immediately and adequately managed and reported to the Regional Director.

Risk management

Risk	Likelihood	Impact	Mitigating actions
Poor participation of affected communities in the response operation	Low	High	Effective community engagement
Non-adherence to finance management procedures	Low	High	Strengthening internal controls, training
Inactivity and or lack of capacity of local branch structures	High	Low	Adequate capacity building and surge
Resurgence of COVID-19	Medium	Medium	Application of specific operational strategies related to prevention, mitigation, and control of COVID-19 will be mainstreamed. This includes ensuring the duty of care and protection of staff and volunteers involved in the response.
National Society capacity is depleted, and they are not able to sustain delivery of humanitarian assistance	Medium	Medium	National Society strengthening will be incorporated to sustain and strengthen the delivery of humanitarian assistance. Provision of Federation-wide management and technical services to supplement the capacities of the host National Societies.

Quality and accountability

MRCS emphasises quality and accountability in implementation of short- and long-term operations, ensuring standard operating procedures and use of implementation guides and manuals, as well as training and supervision.

Key indicator	Target
1.0 Prevent and control the spread of cholera at the community and facility levels in the affected districts, interrupting the chain of transmission	
Output 1.1 Community-based Surveillance (CBS)	
% of active CBS volunteers submitting daily reports	80%
% of alerts investigated within 48hrs by MOH with follow-up by MOH/MRCS	80%
Output 1.2 Transmission Interruption	
% of target population reached with community-based disease control actions	80%
# of volunteers trained in Epidemic Control (EPIC, ECV)	900
# of volunteers trained in Branch Transmission Intervention (BTIT)	900
Output 1.3 Social Mobilisation and RCCE	
% of target population reached with social mobilisation and RCCE activities	2.185m
% of complaints and feedback responded to by the National Society	100%
# of dialogue sessions on cholera prevention and treatment conducted (two-way dialogue for production of community action plans)	240
# of community cinema shows supported in hotspots and schools	1,200
# of volunteers supported to carry out regular activities issued pocket guides	1,500
Output 1.4 Cholera Vaccination	
% of target population vaccinated	100%
# of volunteers trained on vaccination and mobilisation	1,500
Output 1.5 Safe and Dignified Burial	
# of volunteers trained to support safe burial and raise awareness in the context of cholera	100
% of target population helped by supporting families for safe burial	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	1,500

2.0 Reduce morbidity and mortality due to cholera by supporting improved case management in the community (through ORPs) and in CTUs, through IPCs, and provision of tents, in the affected districts	
Output 2.1 Case Management	
# of volunteers in target communities trained in the administration of ORPs	960
# of ORPs established in the targeted communities	120
# of cash voucher assistance (CVA) provided to recovered patients for the purchase of six nutrient-rich food items and basic WAS/NFIs	2,000
Output 2.2 Mental Health and Psychosocial Support (MHPSS)	
# of volunteers and health workers trained in MHPSS and PGI	900
3.0 Improve the availability of safe water and sanitation facilities	
Output 3.1 Contribute to accessing clean and potable water through the construction, rehabilitation, and disinfection of water points	
% of households reached with key messages to promote personal and community hygiene	100%
# of water points rehabilitated in the target communities	100
# of solar water pumps rehabilitated in health facilities and schools in affected communities	10
# of contaminated water sources disinfected in the target communities	100
Output 3.2 Promoting household water treatment and safe storage	
# of volunteers trained in Household Water Treatment and safe Storage (HWTS)	1,500
# of households in the affected communities provided with 1% stock solution for pot-to-pot chlorination	
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 prioritised.	
# of temporary sanitation facilities (latrines, bath shelters and handwashing facilities) constructed and maintained in CTUs	150
# of School Health and Nutrition (SHN) teachers trained in school hygiene and sanitation (latrine management in light of cholera)	300
Output 3.5 Raise awareness on dangers of open defecation and importance of food hygiene, and advocate for community members to construct latrines	
% of households in the target communities sensitised on cholera through door-to-door visits	100%
# of sanitation promotion activities conducted in communities and institutions on latrine use and management, proper waste disposal	150
4.0 Protection, Gender and Inclusion (PGI) thoroughly integrated into the response	
Output 4.1 Promote the practice of PGI, preventing the stigmatisation of victims of the disease and their families	
% of target population reached by PGI activities	100%
% of staff and volunteers oriented on the Code of Conduct, Prevention of and Response to Sexual Exploitation and Abuse (PSEA), and Child Safeguarding	100%
% of volunteers trained to identify women, men, girls and boys requiring MHPSS services after being discharged from CTUs	100%

FUNDING REQUIREMENT

Federation-wide funding requirement*



Federation-wide funding requirement including the National Society domestic target, IFRC Secretariat and the Partner national Society funding requirement:	IFRC Secretariat Funding Requirement in support of the Federation-wide funding ask:
5.2 million CHF	3.5 million CHF

*For more information on Federation-wide funding requirement, refer to Federation-wide Approach

OPERATIONAL STRATEGY

MDRMW017 - MALAWI RED CROSS SOCIETY

MALAWI CHOLERA OUTBREAK

FUNDING REQUIREMENTS

(all amounts in Swiss francs)

Planned Operations	3,013,000
Health	2,470,000
Water, Sanitation & Hygiene (WASH)	391,000
Protection, Gender and Inclusion (PGI)	117,000
Community Engagement and Accountability (CEA)	35,000
Enabling Approaches	487,000
Coordination and Partnerships	33,000
Secretariat Services	151,000
National Society Strengthening	303,000
TOTAL FUNDING REQUIREMENTS	3,500,000

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For In-Kind Donations and Mobilisation table support:

- Rishi Ramrakha, Head of Africa Regional Logistics Unit; Email: rishi.ramrakha@ifrc.org

Reference

□

Click here for:

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