6 Month OPERATION UPDATE

Malawi, Africa| Cholera Outbreak

Emergency appeal №: MDRMW017 **Emergency appeal launched:** 25/01/2023. **Operational Strategy published:** 04/03/2023	**Glide №:** **EP-2022-000298-MWI**
Operation update #3 **Date of issue:** 31/08/2023	**Timeframe covered by this update:** From 24/01/2023 to 24/07/2023
Operation timeframe: 6 months (24/01/2023 – 30/09/2023)	**Number of people assisted: 4,114,142** people
Funding requirements (CHF): CHF 3,500,00 million through the IFRC Emergency Appeal CHF 5,200,000 million Federation-wide	**DREF amount initially allocated:** CHF 748,286

To date, this Emergency Appeal, which seeks CHF 3,500,000, is 18 per cent funded. Further funding contributions are needed to enable Malawi Red Cross, with the support of the IFRC, to continue Cholera Response as outlined in the Operational Strategy.

MRCS volunteers supporting OCV in Mangochi.

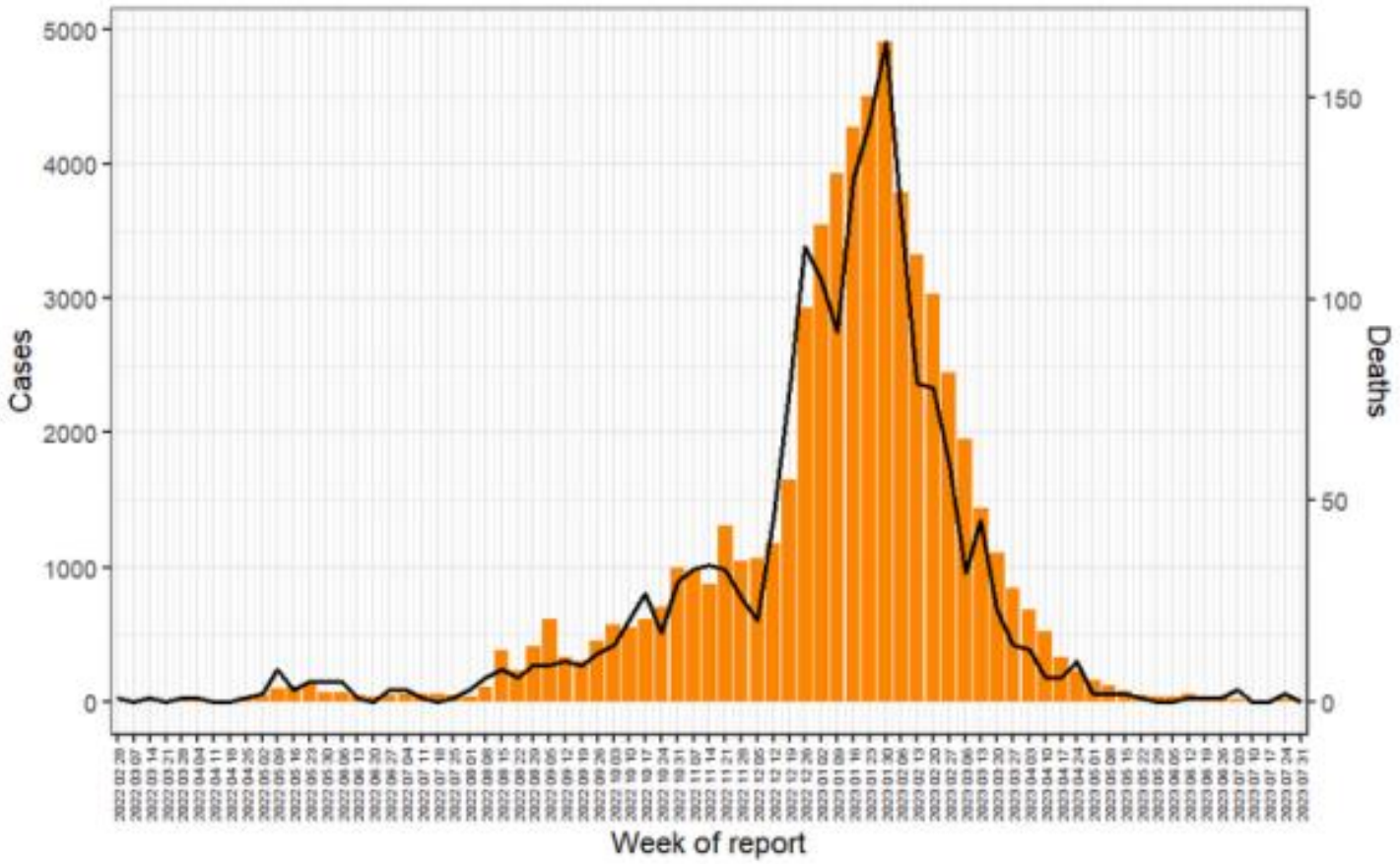
A. SITUATION ANALYSIS

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 4766 cases reported in that month alone. The total number of confirmed cases and deaths as of August 2023 was 58,979 and 1,768, respectively, with a case fatality rate of 13.3%. The Ministry of Health, with support from partners, implemented various interventions to control the outbreak, including oral cholera vaccination (OCV) campaigns, water and sanitation improvement, case management, and social mobilization. The OCV campaigns covered five high-risk districts, reaching 74.4% of the target population. The cholera outbreak trend has shown a significant decline since May 2023, and as of August 2023, only three districts were still reporting sporadic cases.

The presidential taskforce on coronavirus and cholera announced that cholera is no longer a public health emergency as of August 2023.



The 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

DISTRICT	CTU	VILLAGE	CASES	RTD	Culture
Chikwawa	Chipwaila	Jassi	1	Positive	EpiLink
Chikwawa	St Monfort	Sekeni	3	Positive	Positive
Chikwawa	St Monfort	Dzongwe	2	Positive	Positive
Chikwawa	St Monfort	Tomali	1	Positive	Positive
Mangochi	Maganga	Soweto	1	Positive	Positive
Mangochi	Maganga	Matola	1	Positive	Positive
Mangochi	Maganga	Chiphole	1	Positive	Positive
Mangochi	Maganga	Ndamo	3	Positive	Positive

*excludes imported cases from Mozambique

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 seamlessly integrated into MRCS's response projects, facilitated through both MRCS's own initiatives and the Federation Wide Appeal. MRCS has been actively responding to 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 has received essential funding from several significant 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.

The MRCS's effectiveness lies in its robust network of dedicated volunteers and strong branches, which serve as the central pillars of the response efforts. This extensive 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 strategies.

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 streamlines and 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 significant complicating factor in the cholera response, particularly in relation to the exacerbation of the outbreak in the southern region of Malawi. This complication emerged as TCF made landfall in the Southern districts of Malawi 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.

A far-reaching aftermath of TCF was the extensive damage inflicted upon households, leading to heightened concerns about food security and malnutrition. This issue is stressed by the involved interplay between cholera and malnutrition, causing a lot of deaths of under 5 children in the country.

The MRCS Cholera Response operates with a two-fold strategy:

1. The response package aims to reduce morbidity and mortality in affected areas, effectively minimizing the impact of the outbreak.
2. The preventative and preparedness package are geared towards preventing the recurrence and spread of cholera. It also ensures communities are equipped to respond swiftly to new cases.

Trainings and capacity strengthening of volunteers and health workers: Volunteers, staff and health workers were trained in the following capacities. 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.

Risk Communication and Community Engagement: Since the inception of the MRCS Chorela Response, a robust campaign of social mobilization has been underway, facilitated by a team of trained volunteers. Their primary objective is to educate households about effective strategies for Cholera prevention, control, and case management. This educational effort has made a substantial impact, reaching a significant number of individuals across 22 districts.

The campaign has 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 has 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.

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 CTU/CTCs across the country. The 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. However, with support from Qatar RC, Danish Red Cross and UNICEF the MRCS has been able to support the MoH with medical and non-medical supplies for management of Cholera in the CTU/CTCs.

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, Swiss RC, GIZ and UNICEF the MRCS has rehabilitated 88 Boreholes and 128 underway. The IFRC has also supported with construction of 3 boreholes, 2 high yielding boreholes and 20 boreholes (New Water Points) in Salima, Lilongwe, Machinga, Balaka and Nkhatabay. The MRCS has also been supporting 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.

Overview of Red Cross Red Crescent Movement in country:

- The IFRC Secretariat funding is providing interventions in 15 districts. Due to the spread of cases.
- The Swiss RC funded a bilateral cholera response project 421621 which concluded by March 31, 2023. Concurrently, the Swiss Red Cross (SRC) supported the IFRC Emergency Appeal Malawi Cholera Response (MDRMW017) by deploying the CCMC ERU. Post these interventions, the focus is now on cholera prevention and preparedness, with an additional investment of CHF 165'000. This investment aims to enhance cholera prevention at the household level and gradually expand the CCMC unit nationwide, while bolstering MRCS's cholera preparedness. To ensure efficient administration and implementation, this intervention will be seamlessly integrated into the existing, concluded cholera response project 421621.
- Danish Red Cross funded activities continue in Community Resilient Project (COMREP) districts of Mwanza, Chikwawa and Mangochi. The Danish Red Cross has been able to also get funding from Netherland Red Cross and Icelandic Red Cross to scale up the support in Mangochi districts. The DRC+ is also funding 2 High yielding boreholes in Mangochi which will be reticulated and powered by Solar.
- The Qatar Red Cross is supported the MRCS with Cholera Supplies in Lilongwe and Blantyre. The Supplies include, cholera medical supplies, WASH Supplies, IPC supplies and Tents.
- The IFRC Harare Cluster continues to provide technical support during implementation of the Cholera outbreak response by conducting monitoring visits, provision of technical and financial support as well as deployment of surge. The IFRC deployed the following Surge support; CEA Coordinator, PhiE Coordinator, WASH Coordinator, WASH Officer, Communications, and IM.

Overview of non-RCRC actors in country

The most notable humanitarian partners present in the targeted districts are MSF, WHO, GIZ and UNICEF, who have supported with the following interventions including technical support:

- MSF and MRCS collaborated to establish CTUs in Blantyre and Lilongwe, MRCS provided tents for the CTUs while the MSF contributed the technical expertise and supplies for the CTUs.
- UNICEF and MRCS have scaled up the cholera response in the 15 districts of Blantyre, Lilongwe, Mangochi, Dedza, Rumphi, Karonga, Nkhatabay, Nkhotakota, Neno, Mzimba, Machinga, Nsanje, Chikwawa, Salima and Balaka, in the areas of health, nutrition, education, WASH, coordination, social behaviour change, and RCCE.
- MRCS and WHO supported the MoH in development of ORP minimum SOPs.
- WHO has provided technical support in OCV campaign in targeted districts including Lilongwe, Nsanje, Salima Nkhotakota, Kasungu, Nkhatabay, Likoma, Chitipa, Karonga, Rumphi, Zomba, Blantyre, Mzimba South and North from 28 November to 2 December 2022. The vaccination capacity was supported by WHO to Government with 2.9M vaccine provided. The number of administrated vaccines is not yet available.
- WHO continues to support the Malawi Government with Technical support in the Cholera response.
- UNICEF is working with district and partners to support rolling out of Risk Communication and Community Engagement. Provision of mobile latrines in the camps and Installation of prefabricated latrines in 5 camps. UNICEF has also funded MRCS to respond to Cholera in 15 districts.
- MSF supported setting up of CTC at Koche Health Centre in Mangochi and continue provide technical support on case management and IPC in affected districts. Deploy surge teams (Clinical and Nursing) to support the districts in case management in CTUs in the event of upsurge in cases.
- Evidence Action supported implementation of chlorination points at boreholes.

Government Actions

- 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.
- Since the declaration of the outbreak, the Malawi Government through the Ministry of Health, Department of Disaster Management Affairs and Ministry of Water has taken several actions as follows:
- Launched the Tithetse Cholera campaign in all the districts.
- Declaration of the cholera outbreak as a Public Health Emergency by the State President on 5 December 2022
- Call for support to scale up and re-strategize cholera prevention and control activities in the country.
- Established an EOC at Community Health Science Unit (CHSU), where different MoH departments and partners are meeting daily to share updates and plans. MRCS is attending these meetings. Incident Management Team meet to discuss daily situation reports and advise accordingly on interventions for prevention and control of the outbreak.
- Production of daily situation updates.
- Developed a harmonised community feedback form for the Cholera Response.
- Establishment of a Risk Communication and Community Engagement (RCCE) Working Group within the EOC which is led by ministry of health to work on Social Mobilization activities among other social mapping/assessment and community engagement. The group has started developing a Social Behavioural Change and Communication Plan for Cholera. The group is also developing a Crisis Communication Plan with Key Messages on Cholera that will guide Social Mobilization activities for the government and partners. MRCS is a key member of the RCCE group.
- Deployed National Response Team to provide support with surveillance and response.
- Development of Cholera Response plan (underway).

Coordination of actors in country

The MRCS continue to use participatory strategies and approaches. Staff and volunteers are trained in Community based health and First Aid (CBHFA), Community Based Surveillance (CSB), and Community Engagement and Accountability (CEA) and have substantial experience in implementation of health programs including health in emergencies. Such skills are vital and will help MRCS in the fight against this outbreak.

Furthermore, MRCS sits in several technical working groups such as Humanitarian Country Coordination Team (HCT), Incident Management Committees, Surveillance subcommittees, Case management sub committees, ORP technical working group, Health Cluster, WASH cluster, protection cluster as well as Health Emergency Technical Working Group committees. MRCS is thus, well established, and well-connected and enjoys strong partnerships with various movement and non-movement partners. The current engagement of MRCS as outlined above presents the capacities, skills, and the ability to coordinate with different agencies at local, national, and international levels.

Needs analysis

I. Trends in Cholera Cases

The status of the cholera outbreak presents some positive trends. Firstly, there has been a consistent decrease in the number of new cholera cases, indicating a notable reduction in disease transmission. Additionally, the number of cholera-related deaths has also seen a significant decline, dropping from two deaths to zero within the same period. This suggests that the measures and interventions implemented to control cholera have been effective in preventing fatal outcomes.

Furthermore, there is regional progress in addressing the cholera outbreak, particularly in the northern and central parts of the country. These regions have demonstrated success in containing the outbreak, reflecting the effectiveness of containment measures and response efforts. Moreover, a substantial achievement is the fact that twenty-seven (27) districts have reported zero cholera cases for the past 14 days or more. This highlights the success of interventions in several areas and their ability to interrupt cholera transmission.

II. Identified Needs for Cholera Response Operation

To sustain and build upon these positive developments, several key needs have been identified for the cholera response operation:

Firstly, there is a need for sustained surveillance and monitoring to promptly identify and respond to any resurgence or sporadic cases, ensuring that the gains made are maintained. Continuous capacity building is essential, including training programs for healthcare workers and community members in cholera prevention, early detection, and response. As the National Society there is a need to develop a robust Community-based surveillance program that will be able to enables volunteers to identify and report on serious illnesses in the community for rapid detection of possible outbreaks.

Prepositioning of stock, materials and resource allocation remains crucial, with a focus on directing adequate resources, including medical supplies, personnel, and financial support, to areas where cholera cases persist. Support should also be extended to zero-case districts to maintain their status and prevent any potential reintroduction of the disease.

Efforts in risk communication and community engagement should be maintained and reinforced to raise awareness about cholera prevention and control measures within communities. Communities should be actively engaged to promote good hygiene practices, access to clean water, and the early reporting of suspected cases.

Improving access to clean water and sanitation facilities, especially in areas where cholera cases are still being reported, is imperative. Ensuring the availability of safe drinking water sources, improved sanitation facilities and proper waste disposal is essential to prevent contamination.

Effective coordination among all stakeholders involved in the cholera response operation is crucial to ensure a cohesive and effective approach. Collaboration with neighbouring regions or countries should be considered to prevent cross-border transmission. According to Ministry of health Malawi, cross boarder infection is evident in the districts bordering Mozambique and Zambia. In Mchinji, it was realizing that out of 72 cases reported 62 was from Mozambique and 80% of cases came from Sankulani and Nsanje out of the cases reported in the district, 45 were from Mozambique Lilongwe reported an influx of cases coming from Mozambique (over 30 cases in 2 days). Therefore, there is need to support in Cross border collaboration to curb cross border infection.

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. 2 "packages" of activities were developed and deployed within this reporting period and for the rest of March

1. Responsive/ curative activity package: with the aim to reduce morbidity and mortality in areas highly affected by cholera.
2. Preventive/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	• In geographic areas with no or few choleras cases. • Districts Targeted: All other districts (10) 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.).
		• 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

	Support broader coordination and collaboration activities.	• Some lighter work in schools, etc. • BTIT/CATI interventions, when required, by district teams (MRCS&DHO&DOW)

Based on the current trends cases and lessons learnt from the cholera outbreak operation implementation, MRCS also proposes 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.

Will 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 3000 children screened, 510 were MAM and 27 SAM. 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 20HH to max. 50HH) 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 from NRC. 200 volunteers to be trained in the CBS methodology and provide them with the required cell phones and airtime.

C. DETAILED OPERATIONAL REPORT

STRATEGIC SECTORS OF INTERVENTION

Health & Care *(Mental Health and psychosocial support / Community Health / Medical Services)*		Female > 18: **1,133,088**	Female < 18: **1,043,705**
		Male > 18: **991,674**	Male < 18: **945,675**

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 WAS/NFIs	0	2000
	Output 2.2 Mental Health and Psychosocial Support (MHPSS)		

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

	# of volunteers and health workers trained in MHPSS and PGI	900	900

Progress towards outcomes

During the reporting period, 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. This was achieved through 2,165 volunteers who had been trained in Epidemic Control (EPIC, ECV) and Branch Transmission Intervention (BTIT). 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). To carter for the nutritional side of the communities, 553 volunteers have been trained on promotion of good infant and young child feeding practices (IYCF) and nutrition screening.

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 DRC+, 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.

Notably, cash voucher assistance (CVA) wasn't provided during this period due to prioritizing life-saving interventions. Safe burial support and cholera awareness campaigns were omitted due to community acceptance concerns stemming from past experiences with COVID-19. As a result of this development, no volunteers have been trained to support safe burial, consequently no target population has been helped by supporting safe burial.

Lastly, the Community Case Management for Cholera (CCMC) - ERU were 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: **726,853**	Female < 18: **648,976**
Male > 18: **623,016**	Male < 18: **597,057**

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	88	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)	1265	1,500
	# of households in the affected communities provided with 1% stock solution for pot-to-pot chlorination	2,595,902	496,587
	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 mainly key messages to promote personal and community hygiene and provision of 1% stock solution for pot-to-pot chlorination, surpassing our goal (2,199,917 Households) due to increased volunteer engagement amid the escalating cholera outbreak facilitating high demand for the interventions.

MRCS joined efforts with UNICEF to scale up Water, Sanitation, and Hygiene (WASH) efforts to 17 districts, exceeding our target of 15 Districts. Together, 1,265 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.

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.

With Support from Swiss RC, UNICEF, GIZ, and IFRC, MRCS rehabilitated 88 water points, specifically Afridev handpump-equipped boreholes, with 125 more in progress.

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.

Protection, Gender, and Inclusion

Female > 18: **726,853**	Female < 18: **648,976**
Male > 18: **623,016**	Male < 18: **597,057**

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	101%	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: **,133,088**	Female < 18: **1,043,705**

	Male > 18: **991,674**	Male < 18: **945,675**

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	4,114,142 (188%)	2,184,590 (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. This represented a 219% achievement of the target. The MRCS also managed to attend to and resolve 97% of the complaints and feedback that was coming from the communities. this was mainly achieved with the support of 3,951 volunteers carrying out regular activities. Some of the feedback came through 312 dialogue sessions on cholera prevention and treatment that were conducted across the response hotspots.

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 by date of compiling this report. However, all the complaints and feedback will be addressed.

Volunteers utilized a cholera pocket guide to facilitate the delivery of these messages. Cholera Volunteer Handbook[1].pdf

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. These volunteers were equipped with the knowledge to be the locally based responders in case of future outbreaks, representing a response capacity of the MRCS enhanced.
Furthermore, the response also included the participation of 743 community health workers.

Coordination and Partnerships

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

MRCS convenes monthly technical meetings that bring 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 participates in partners coordination meeting with UNICEF monthly.
The government through the Presidential Taskforce on Cholera and COVID-19 continues to lead the cholera outbreak response.
Cholera incident management team meetings are being held once a week by the Ministry of Health together with the partners.
Incident management system response pillars continue to hold their pillar coordination meetings weekly.

Secretariat Services

Objective:	Effective and coordinated disaster response is confirmed.		
Key indicators:	**Indicator**	**Actual**	**Target**
	# of monitoring missions conducted	6	6
	# 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 including Cluster Head of Delegation, Finance Manager, and Security Officer deployed to support set up structures for the Emergency Appeal operations. The support from 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)
4. WASH officer. With a rotation in the Public Health in Emergency Coordinator.

The IFRC deployed communications consultant to document stories for the Cholera work MRCS:
https://shared.ifrc.org/record/_PgI5gMrTKWERUaIwILImILe1
https://shared.ifrc.org/mycollections/index/2652
https://youtu.be/uioYl1NcRyc
IFRC also deployed a 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.

D. FUNDING

The table below summarizes funding received so far under the emergency appeal, funds received through the secretariat and those from bilateral partners.

	Amount raised (CHF)	Coverage (%)	Funding Gap (CHF)	% Gap
Federation Wide Appeal Funding Coverage	2,914,488	56%	2,285,512	44%

Secretarial Appeal Funding Coverage	626,511	18%	3,046,343	82%
Bilateral Appeal Funding Coverage	2,287,977	135%	(587,977)	(35%)

Contact information.

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

At Malawi Red Cross Society

- Chifundo Kalulu, Secretary General; Email: ckalulu@redcross.mw
- Prisca Chisala, Director of Programmes; Email: pchisala@redcross.mw
- 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
- Vivianne Kibon, Operations Coordinator; Email: Vivianne.KIBON@ifrc.org

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:

- Rishi Ramrakha, Head of Africa Regional Logistics Unit; Email: rishi.ramrakha@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: +254 721 486953

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.