DREF Operation

Malawi : Measles Outbreak Response

Measles vaccination session by the Community health action Group volunteer

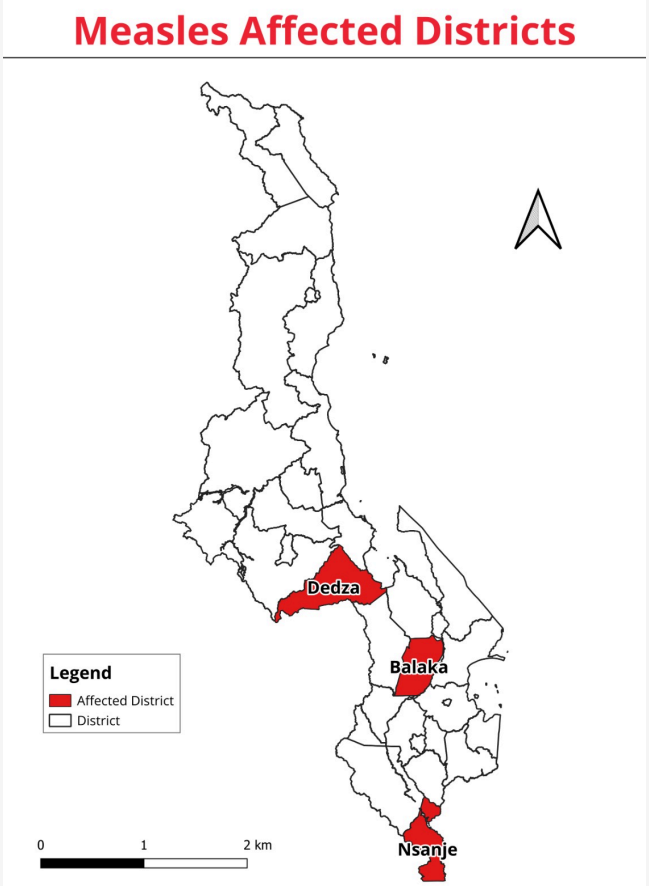
Appeal: **MDRMW027**	Hazard: **Epidemic**	Country: **Malawi**	Type of DREF: **Response**
Crisis Category: Yellow	Event Onset: **Slow**	DREF Allocation: **CHF 288,303**	
Glide Number: -	People Affected: **165,116 people**	People Targeted: **165,116 people**	
Operation Start Date: **30-07-2026**	Operation Timeframe: **3 months**	Operation End Date: **31-10-2026**	DREF Published: **21-08-2026**

Targeted Regions: **Southern Region**

Description of the Event

Date when the trigger was met

20-07-2026



What happened, where and when?

Malawi is experiencing an escalating measles outbreak, with the Ministry of Health reporting 73 measles alerts through the Integrated Disease Surveillance and Response (IDSR) system during Epidemiological Week 27 (29 June to 5 July 2026). The outbreak follows months of sustained transmission that began with sporadic cases earlier in 2026 and has since developed into localized outbreaks in several districts. Cumulatively, Nsanje has reported 211 confirmed and epidemiologically linked cases since February 2026, Dedza has reported 90 confirmed cases since July 2026, and Balaka has reported 82 laboratory-confirmed cases since January 2026. Epidemiological data further indicate that more than 85% of confirmed cases have occurred among children under 15 years of age, while over 70% of cases were either unvaccinated or had an unknown vaccination status, demonstrating significant immunity gaps within affected communities. Continued reporting of new laboratory-confirmed cases indicates ongoing transmission and an increasing risk of expansion to neighbouring districts.

The outbreak is most pronounced in the catchment areas of Comfort and Khwisa health facilities in Balaka District, Golomoti and Kaundu in Dedza District, and Osiyana, Ndamera, Nsanje, and Trinity health facilities in Nsanje District. These areas are experiencing a combination of factors that continue to fuel transmission, including low routine immunization coverage, high numbers of unvaccinated children, delayed health-seeking behaviour, weak community surveillance systems, inadequate risk communication, and widespread misinformation regarding vaccination. In Nsanje, cross-border population movement along the Malawi-Mozambique border has intensified the risk of disease spread, while shortages of trained health workers, volunteers, and operational resources have constrained surveillance and response efforts. In Balaka and Dedza, persistent immunity gaps and delayed case detection are contributing to continued transmission within communities.

The outbreak has generated significant public health and humanitarian impacts. Increasing numbers of suspected and confirmed cases

have placed additional pressure on district health services through heightened demand for surveillance, laboratory testing, case management, contact tracing, and vaccination outreach activities. Children under five years of age remain particularly vulnerable due to low vaccination uptake, malnutrition, and limited access to health services. In some communities, particularly within parts of Nsanje, religious beliefs and vaccine hesitancy have contributed to delayed treatment-seeking and reduced acceptance of vaccination services, increasing the risk of severe illness and preventable deaths. The continued accumulation of susceptible children and ongoing transmission in Balaka, Dedza, and Nsanje indicate a high likelihood of further spread unless urgent interventions are implemented to strengthen outbreak-response vaccination, community engagement, surveillance, and risk communication activities.

Given the epidemiological trends and operational gaps identified, Balaka, Dedza, and Nsanje represent the highest-priority districts for immediate intervention. These districts continue to experience active transmission driven by substantial immunity gaps, weak community-level disease detection and reporting systems, and challenges in reaching at-risk populations with vaccination and health promotion services. Without rapid scale-up of surveillance, community engagement, social mobilization, and immunization activities, there is a significant risk that transmission will intensify within these districts and spread to surrounding areas, resulting in additional morbidity and mortality among vulnerable children and other susceptible populations.

Vacciantion of school going children

Engagement meeting with the volunteers

Figure 1: Nsanje: EPIDEMIC CURVE

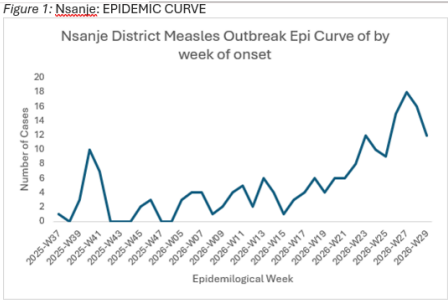
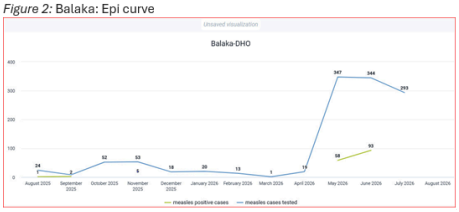
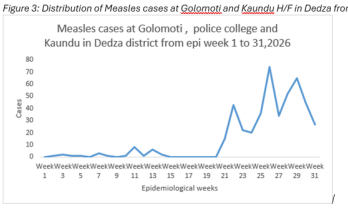


Figure 2: Balaka: Epi curve



epi-curve Balaka and Nsanje

Figure 3: Distribution of Measles cases at Golomoti and Kaundu H/F in Dedza from epi week 1 to 31, 2026



epi-curve Golomoti and Kaundu H/F in Dedza

Scope and Scale

Malawi is facing a significant measles outbreak that has evolved from sporadic cases reported earlier in 2026 into sustained community transmission across several districts. By Epidemiological Week 27, the Ministry of Health had reported 73 measles cases nationally, contributing to a cumulative total of 1,690 suspected measles alerts and 695 laboratory-confirmed measles and rubella cases. The epidemiological trend demonstrates a prolonged outbreak, with cases increasing sharply from Week 21, multiple peaks recorded thereafter, and the highest peak observed in Week 26. Continued reporting of cases through Week 31 indicates that transmission remains active despite ongoing response efforts, highlighting persistent immunity gaps and the risk of further geographic spread. The high laboratory-confirmation rate suggests that transmission is likely more widespread than routine surveillance currently captures.

The outbreak is having substantial impacts on public health, community wellbeing, and health service delivery. Measles is a highly contagious disease that can result in severe complications, including pneumonia, diarrhoea, blindness, malnutrition-related complications, and death, particularly among young children and immunocompromised individuals. The outbreak has increased demand for surveillance, laboratory testing, case investigation, contact tracing, community engagement, and case management services, placing additional pressure on already constrained health systems. Ongoing transmission is occurring in a context of declining routine

immunization performance, with first-dose measles vaccine (MCV1) coverage estimated at 78%, well below the 95% threshold required to achieve and sustain population immunity. Continued dropout between the first and second vaccine doses has contributed to the accumulation of susceptible children and increased the risk of recurrent outbreaks.

The districts of Nsanje, Balaka, and Dedza represent some of the areas at highest risk due to sustained transmission, large numbers of susceptible children, and operational challenges affecting outbreak control. Nsanje has reported more than 200 confirmed and epidemiologically linked cases since February 2026, while Balaka and Dedza have reported 82 and 90 confirmed cases respectively. Transmission remains concentrated in specific health facility catchment areas, including Comfort and Khwisa in Balaka, Golomoti and Kaundu in Dedza, and Osiyana, Ndamera, Nsanje, and Trinity in Nsanje. In these locations, low vaccination coverage, delayed health-seeking behaviour, weak community surveillance systems, vaccine hesitancy, and misinformation continue to undermine response efforts. Cross-border movement in Nsanje further increases the risk of importation and exportation of cases, complicating containment measures.

The populations most affected by the outbreak are children, particularly those under five years of age and those who have missed routine vaccinations. More than 85% of confirmed cases have occurred among children under 15 years of age, while over 70% of cases were reported among individuals who were either unvaccinated or had unknown vaccination status. Children living in remote communities with limited access to health facilities are particularly vulnerable because delays in diagnosis and treatment increase the likelihood of severe complications. Malnourished children face even greater risks, as weakened immunity can lead to more severe disease outcomes and higher mortality.

Other vulnerable groups include people living in underserved rural communities, households with limited access to health information, and populations influenced by misinformation and vaccine hesitancy. In some affected communities, particularly among certain religious groups, misconceptions regarding vaccination and treatment have contributed to delays in seeking health care and low acceptance of immunization services. These social barriers not only increase individual risk but also create clusters of susceptible populations that sustain transmission. Persons with disabilities, elderly caregivers, and households experiencing poverty may also face difficulties accessing health facilities, vaccination services, and accurate health information, further increasing their vulnerability during the outbreak.

Historically, measles outbreaks in Malawi have been associated with immunity gaps, missed vaccination opportunities, and challenges in reaching hard-to-access populations. The current outbreak reflects these long-standing vulnerabilities and demonstrates how reductions in routine immunization coverage can rapidly lead to the accumulation of susceptible individuals. The continued increase in cases despite ongoing response measures indicates that without intensified vaccination, community engagement, surveillance, and social mobilization efforts, affected communities will continue to experience preventable illness, school absenteeism, increased household health expenditures, and avoidable child deaths.

Given the magnitude and trajectory of the outbreak, MRCS intervention remains critical. Through its nationwide volunteer network and strong community presence, MRCS is well positioned to support community-based surveillance, strengthen risk communication and community engagement, address misinformation, and improve vaccine uptake in high-risk districts. Timely action is essential to reduce transmission, close immunity gaps, protect vulnerable children, and prevent further expansion of the outbreak into additional districts.

Source Name	Source Link
1. MoH SitReps on Measles	https://malawiredcross.sharepoint.com/:f:/s/MRCSRepository/IgDofLgQ-BrHQaQx-otiK7XkAata5TdQlH7Ke3BS41f1vtc?e=WOJwrc
2. Recommendation Letter from MoH	https://malawiredcross-my.sharepoint.com/:b:/g/personal/stembo_redcross_mw/IQCStRYQbWPWSIiASKzwSEIEAQ29eNAaXrIfD1FBU1k7NZw?e=lGANKJ
3. District epicurve for measles	https://malawiredcross-my.sharepoint.com/:w:/g/personal/rkufandiko_redcross_mw/IQDMUA9aAb9RQpHEYz_q_be8Adcg34L1glpcpg1ZrMmy24Q?e=BoPzzv

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	**Yes**
Did it affect the same population group?	**Yes**
Did the National Society respond?	**Yes**
Did the National Society request funding form DREF for that event(s)	**No**
If yes, please specify which operation	-

If you have answered yes to all questions above, justify why the use of DREF for a recurrent event, or how this event should not be considered recurrent:

-

Lessons learned:

Malawi experienced a significant measles outbreak in 2024–2025, including major transmission in Lilongwe. During that period, the Malawi Red Cross Society (MRCS) joined the Ministry of Health in supporting the national response, mobilizing volunteers for household sensitization, rumor management, and referral of zero dose children. Funding from the Disaster Relief Emergency Fund (DREF) and partner contributions enabled MRCS to complement government led vaccination campaigns, strengthen risk communication, and provide logistical support in targeted districts. Key lessons learned included the importance of early community engagement to counter misinformation, the need for stronger integration of Mental Health and Psychosocial Support (MHPSS), and the value of systematic community feedback mechanisms to adapt interventions in real time.

In the current outbreak, MRCS is applying these lessons but going further by introducing additional outbreak specific measures that are not part of routine immunization support. Unlike the previous operation, this response integrates WASH, PGI, and National Society Strengthening alongside health interventions, and places stronger emphasis on rumor management, stigma reduction, and after vaccination follow up. Importantly, this requested support is not a replacement for the planned national measles campaign in September 2026, which will deliver over five million doses countrywide. Rather, it addresses the urgent needs that cannot wait for the campaign, including intensified social mobilization, contact tracing, missed children follow up, and support to post campaign mop ups—activities that are normally not funded but are critical to closing immunity gaps and preventing further spread.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	**Yes**
What was the risk level for Child Safeguarding Risk Analysis?:	**Yellow**

Current National Society Actions

Start date of National Society actions

15-06-2026

Health	• Disseminating preventive messaging through social media and community channels. • Supporting MoH with risk communication, community engagement, and rumor

	management. • Producing internal bulletins to keep staff, volunteers, and partners updated. • Participating in national and district coordination meetings with MoH and partners. • Support health workers on contact tracing and referral.
Community Engagement And Accountability	MRCS, through its dedicated volunteers, is actively conducting a range of community engagement activities aimed at strengthening awareness and prevention of diseases at the grassroots level. These activities include: • Door-to-door visits: Volunteers are visiting households to disseminate messages on measles awareness and prevention, ensuring that families receive accurate information directly and can ask questions in a familiar setting • Engagement with community leaders: MRCS ensures that health messages are endorsed and reinforced by trusted voices, increasing acceptance and uptake within communities by engaging with traditional, religious, and local leaders. • Community meetings: Regular meetings are organized to provide platforms for dialogue on disease prevention and health promotion. These gatherings encourage collective responsibility, allow for clarification of misconceptions, and foster community-led solutions.

IFRC Network Actions Related To The Current Event

Secretariat	Provided technical support to the National Society.
Participating National Societies	Participating in Movement coordination meeting providing technical support.

ICRC Actions Related To The Current Event

ICRC has no presence in Malawi, however, the NS connects with ICRC for restoration of family links programming from the ICRC pretoria office.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	Ministry of health is leading the technical implementation of the response through coordination surveillance, case management and contract tracing, sample collection and laboratory analysis, Intensification of routing immunization.
UN or other actors	Both WHO and UNICEF are supporting in strengthening surveillance and outbreak response immunization. These include active case finding, contact tracing, rapid

	notification of suspected cases and data analysis to identify transmission hotspots.

Are there major coordination mechanism in place?

This is a district-level response coordinated through the Public Health Emergency Management Committees (PHEMCs) under the leadership of the respective District Health Offices (DHOs). The PHEMCs serve as the main coordination platform for outbreak response, bringing together government and partner organizations to plan, implement, and monitor interventions through the key response pillars of surveillance and laboratory, vaccination, risk communication and community engagement (RCCE), case management, and logistics and supply chain management.

MRCS participates in the district PHEMCs as an implementing partner, supporting primarily the surveillance and RCCE pillars through community-based surveillance, social mobilization for vaccination campaigns, community engagement, feedback collection, and referral of suspected cases. MRCS does not have a lead or co-lead role but works closely with DHOs to support implementation of district response plans. Key challenges affecting the response include limited outreach resources, shortages of trained personnel and volunteers, transport constraints, and persistent misinformation and vaccine hesitancy within affected communities.

Needs (Gaps) Identified

Health

The measles outbreak has increased the risk of morbidity and mortality among children, particularly those under five years of age and unvaccinated populations. Ongoing transmission is driven by immunity gaps, delayed health-seeking behavior, misinformation, population movement, and limited access to health services. There is an urgent need to strengthen community-based surveillance, risk communication and community engagement, social mobilization for vaccination, early referral and case management, and support to outbreak response activities. Additional resources are required to equip and deploy volunteers, enhance community awareness, support vaccination uptake, and strengthen coordination with health authorities to contain the outbreak and prevent further spread.

Water, Sanitation And Hygiene

Affected communities face significant WASH challenges that increase the risk of measles transmission and secondary infections, including inadequate handwashing facilities in schools and Community-Based Childcare Centres (CBCCs), limited access to soap and water treatment products, and poor adoption of handwashing, household water treatment, and safe water storage practices. These gaps are compounded by insufficient hygiene promotion activities, limited capacity of community volunteers and health workers to deliver behaviour change interventions, weak integration of WASH messaging into vaccination and outbreak response activities, and inadequate community engagement mechanisms to address misinformation, collect feedback, and promote positive health-seeking behaviours. Furthermore, community-based surveillance and outreach systems require strengthening to improve risk communication and support early identification and reporting of public health risks.

Protection, Gender And Inclusion

The measles outbreak presents heightened protection risks for children, particularly unvaccinated children under five years of age, as well as vulnerable groups facing barriers to accessing health information and services. Factors such as disability, geographic isolation, religious beliefs, gender-related barriers, and socioeconomic vulnerability may limit equitable access to vaccination and healthcare. There is a need to ensure that outbreak response activities are inclusive, accessible, safe, and responsive to the needs of all population groups. Malawi Red Cross will integrate Protection, Gender and Inclusion (PGI) approaches across response activities by promoting equitable access to services, strengthening safeguarding and PSEA measures, identifying and addressing barriers to participation, and ensuring community feedback mechanisms are accessible to diverse groups. Special attention will be given to children, persons with disabilities, remote communities, and other at-risk populations to ensure that no one is left behind.

Community Engagement And Accountability

Communities affected by the measles outbreak require access to timely, accurate, and trusted information on disease prevention, vaccination, and healthcare seeking. Persistent misinformation, vaccine hesitancy, and cultural and religious beliefs continue to influence health behaviours and may hinder outbreak control efforts. Strengthened community engagement is needed to build trust, support informed decision-making, promote uptake of vaccination services, encourage early healthcare seeking, and ensure community concerns and feedback are systematically collected and acted upon. Malawi Red Cross volunteers will support two-way communication, community feedback mechanisms, rumour tracking, and community mobilization activities to increase acceptance of outbreak response interventions and reduce transmission of measles.

Any identified gaps/limitations in the assessment

- Limited time and resources to conduct comprehensive public health assessments.
- Convenience sampling of communities due to limited resources.
- Limited community awareness activities done due to financial and human resource constraints.

Assessment Report

Operational Strategy

Overall objective of the operation

The overall objective of this six-month DREF operation is to support the Malawi Ministry of Health in containing and reducing the spread of the ongoing measles outbreak through strengthened Risk Communication and Community Engagement (RCCE), social mobilization for immunization, community-based surveillance, and early detection and referral of suspected cases. The operation will directly reach 165,116 people in affected districts, prioritizing children under five, caregivers, women, persons with disabilities, and underserved communities. Through trained Malawi Red Cross volunteers, the intervention will promote vaccine uptake, address misinformation, improve health-seeking behaviours, and strengthen community participation to reduce measles transmission, morbidity, and mortality.

Operation strategy rationale

The Malawi Red Cross Society (MRCS), in line with its auxiliary role to public authorities is uniquely positioned to complement government efforts by creating awareness, mobilizing communities, strengthening surveillance, and supporting intensified vaccination campaign activities in the 3 targeted districts of Balaka, Dedza, and Nsanje.

Given the immediate risk of continued transmission and severe outcomes among unvaccinated children, MRCS is working with district councils focusing on community-based surveillance (CBS), risk communication and community engagement (RCCE), vaccination supplementary interventions, and support to the planned nationwide measles campaign scheduled from 21 - 26 September 2026, which will target more than five million children, social mobilization for vaccination campaign, and WASH actions. The targeted districts have set aside additional doses to cover the supplementary immunisation activities prior to National MR campaign. The operation will enable MRCS to scale up timely, community-centered interventions to contain transmission and reduce preventable morbidity and mortality. The epi-curve indicates a prolonged and evolving measles outbreak, characterized by a sharp increase in cases from week 21 and multiple subsequent peaks, with the highest peak recorded in week 26. The continued occurrence of cases through week 31, despite fluctuations in weekly case numbers, it indicates ongoing transmission and highlights the need to sustain and strengthen outbreak control measures.

1) Health

Epidemic control: Under the Health component, MRCS will engage a total of 300 volunteers and 30 Community Health Workers (CHWs) across Balaka, Dedza, and Nsanje districts to support community-level measles outbreak response activities. All volunteers and implementing staff will receive orientation on Epidemic Control for Volunteers (ECV) with a focus on measles prevention, detection, referral, and community engagement. Volunteers will work closely with CHWs and District Health Office teams to support reactive vaccination campaigns targeting 38,953 children in the three districts.

Out of the 300 volunteers, 50 trained volunteers will be assigned additional CBS responsibilities and deployed in identified hotspot communities. These volunteers will maintain regular contact with households and work alongside CHWs to identify, report, and refer suspected measles cases and other unusual health events through established surveillance and reporting mechanisms. Furthermore, MRCS will facilitate mentorship and coaching sessions for CBS volunteers and CHWs on Community-Based Surveillance (CBS) and Event-Based Surveillance (EBS), focusing on detection, reporting, verification, referral, and follow-up of suspected cases at community level.

MRCS will support the Ministry of Health's emergency Measles-Rubella (MR) vaccination campaigns in hotspot areas of Nsanje, Dedza, and Balaka districts, guided by district-level vaccination micro plans. The campaigns target 38,953 children and are supported by 41,304 MR vaccine doses made available by the Government for outbreak response. Specifically, the campaigns will target 12,421 children in Nsanje (13,500 doses available), 15,961 children in Dedza (16,381 doses available), and 10,571 children in Balaka (11,423 doses available). The trained 300 volunteers will support the Ministry of Health during intensified and targeted measles vaccination campaigns, including outreach activities in hard-to-reach communities. Their role will be to increase community awareness on measles signs and symptoms, modes of transmission, the importance of early seeking behaviour, and the benefits of vaccination, with particular emphasis on children under five years of age and other at-risk populations. Through these activities community acceptance will be improved which will lead to increased uptake of measles vaccination in the priority districts.

2) RCCE and WASH promotion

Furthermore, under WASH and RCCE component, awareness and necessary messages will be passed to communities using various channels. In parallel, NS will ensure provision of basic WASH services, including WASH supplies, handwashing stations, with associated hygiene promotion activities such as handwashing demonstrations, messages on safe water practices.

- Radio, community messaging, and school peer education will be the basic channels for RCCE activities (Addressing community concerns and reducing the risk of disease transmission.
- In addition, the direct population messages conducted by branches volunteers in communities will be conducted. Include community hygiene campaigns in marketplaces, churches, and mosques, mobile hygiene units at vaccination sites, integration of hygiene promotion into vaccination campaigns, radio and community messaging, and school led peer education (25,000 people) are expected to reach over 250,000 people.

The RCCE and WASH services are expected to complement health interventions to reduce secondary infections, reinforce vaccination uptake, and strengthen community resilience.

Targeting Strategy

Who will be targeted through this operation?

Overall beneficiaries (165,116 people): These are individuals reached through household level interventions in Balaka, Nsanje, and Dedza. The focus is on children under five, unvaccinated and under immunized children, caregivers, pregnant women, vulnerable households, persons with disabilities, female and child headed households, and hard to reach communities. Direct activities include RCCE, social mobilization for vaccination, active case finding, surveillance, referrals, hygiene promotion, and community feedback.

Through mass communication channels, a wider reach of 665,000 people will be reached. This will be made possible through direct household's level activities and large communication and awareness using radio, megaphones, community drama groups but also school-based peer education, hygiene campaigns in public spaces, and integration with vaccination outreach. Indirect beneficiaries benefit from improved awareness, increased vaccination uptake, strengthened surveillance, and enhanced preparedness, even if not directly visited by volunteers. These mass messages may reach at least 665,000 people to reflect both realistic operational capacity and the wider impact of outbreak interventions.

With the direct household's level engagement and the mass media coverage, MRCS aim to scale-up the social mobilisation for the vaccination campaign that is targeting unvaccinated population (Children). As per MoH plan, target in the 3 selected district of MRCS is 38,953 children in identified hotspot areas.

Districts	Target	MR Vaccine Doses Available/Required
Nsanje	12,421	13,500
Dedza	15,961	16,381
Balaka	10,571	11,423
Total	38,953	41,304

Explain the selection criteria for the targeted population

The response will target Households with suspected or confirmed measles cases, children with no vaccination history and communities with low immunization coverage. The selection of the target districts and communities is based on a combination of epidemiological, programmatic, and operational criteria. Epidemiologically, Balaka, Nsanje, and Dedza have reported confirmed measles cases with increasing transmission trends, indicating the need for intensified community-based interventions to interrupt further spread. Programmatically, the selected districts have documented immunity gaps, including low routine immunization coverage, the presence of zero-dose and under-immunized children, and communities with limited demand for vaccination due to misinformation, vaccine hesitancy, and inadequate access to health information. Operationally, priority has been given to remote and hard-to-reach communities, densely populated settlements with increased transmission risk, border and highly mobile populations, and areas with limited access to health services and disease surveillance.

Total Targeted Population

Women	63,537	Rural	-
Girls (under 18)	22,324	Urban	-
Men	58,649	People with disabilities (estimated)	10.4%
Boys (under 18)	20,606		
Total targeted population	165,116		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	Yes
Does your National Society have prevention of sexual exploitation and abuse policy?	Yes
Does your National Society have child protection/child safeguarding policy?	Yes
Does your National Society have whistleblower protection policy?	Yes
Does your National Society have anti-sexual harassment policy?	Yes

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
Response/intervention challenges include: - Coordination challenges: Overlapping roles among partners	This intervention is putting in priority the key gaps but also aligns with other actors ongoing efforts. MRCS will aim at

may cause duplication or gaps if coordination mechanisms are weak. - Surveillance gaps: Weak community-level surveillance could lead to under-reporting and delayed detection of new cases. - WASH limitations: Poor sanitation and hygiene facilities in schools, marketplaces, and health centres may accelerate transmission despite vaccination efforts.	contributing to cover some of these gaps in a coordinated approach with MoH and other stakeholders, ensuring complementary approach to all the deployed resources under various sectors.
Safeguarding risks.	Aligned with safeguarding minimum measures for RCRC intervention, staff and volunteers oriented on safeguarding principles, codes of conduct, and reporting mechanisms will be the one deployed. Safe and accessible feedback and complaint channels will be established to prevent, identify, and respond to any risks of exploitation, abuse, neglect, or harm affecting affected populations.
Equity and inclusion risks: Vulnerable groups (children under five, women, people with disabilities) may be overlooked if PGI measures are not fully integrated.	PGI considerations and standards will be integrated throughout the intervention cycle, including beneficiary identification, planning, implementation, and monitoring, to ensure equitable access and participation of vulnerable groups such as children under five, women, older persons, and people with disabilities. Targeted outreach, community engagement, and disaggregated data collection (by sex, age, and disability) will be used to identify and address barriers to access, ensuring that assistance is provided in a safe, inclusive, and dignified manner.
Operational resource shortages: Limited funding, logistics, and cold chain capacity may delay vaccination campaigns and outreach.	NS is also engaging with Amcross and will keep resource mobilisation to cover emergency needs as relevant based on the trend of the outbreak.
Community resistance: Misinformation, vaccine hesitancy, and low risk perception could undermine uptake of vaccination and health messages.	The community feedback systems, volunteers' engagement with population will inform on the key rumours and belief. On regular basis this will be consolidated to adjust the priority messages at community level using various channels such as volunteers, mass media etc. Right channels of communication will be adapted to communities' preferences. The CEA strategies also ensure community resistance drivers are identified and worked on with relevant tools and with relevant community representatives' involvement.
Volunteer safety concerns: volunteers face exposure risks for their physical and mental wellbeing.	For wellbeing of volunteers (physically and mentally), NS will ensure Frontline have adequate PPE, psychosocial support. An insurance coverage has also been contracted for all the mobilised volunteers.

Please indicate any security and safety concerns for this operation:

No major security and safety concerns in the targeted areas. NS with IFRC support will continue monitor the context (operational and security wise), apply the minimum-security requirements and adjust the intervention and safety measures as relevant.

Has the child safeguarding risk analysis assessment been completed?	No

Planned Intervention

Health

Budget: CHF 92,191
Targeted Persons: 165,116

Indicators

Title	Target
Number of volunteers and HSAs oriented on ECV	330
Number of school-based sessions conducted with age-appropriate materials	30
% of identified affected households receiving MHPSS	90
Number of volunteers trained in MHPSS	90
Number of people reached with health promotion activities	165,116
Number of health workers oriented as vaccinators	150
Number of Community dialogue sessions with leaders and communities	7

Priority Actions

The health component of the operation will realistically reach approximately 250,000–300,000 people, combining direct household level interventions with broader awareness and mobilization activities. Direct interventions include orientation of 300 volunteers and 30 HSAs on epidemic control, mentorship sessions for community health workers to implement CBS/EBS for active case finding, household visits for contact tracing and follow ups among under five children, and provision of MHPSS support to affected households. These activities are expected to directly benefit 40,000–50,000 people across the three targeted districts.

Furthermore, broader outreach will be achieved through social mobilization campaigns, awareness sessions in schools, engagement of caregivers, community leaders, religious leaders, and mother groups, and integration of health messaging into vaccination campaigns. These interventions supported by 300 volunteers and 30 community health workers—are expected to reach 200,000–250,000 people through schools, marketplaces, religious institutions, and community gatherings.

Vaccination Coordination

The Government of Malawi, through the Ministry of Health (MoH), has confirmed that measles vaccines are available and in stock. The National Society (NS) will not procure vaccines but will play a supportive role in mobilization, outreach, and logistical facilitation to ensure that communities access vaccination services. Coordination will be achieved through: Following this alignment, the NS will prioritize the following activities: -

- Conduct orientation of Epidemic Control for Volunteers focusing on measles, targeting 300 volunteer and 30 HSAs and implementing staff in 3 districts.
- Conduct mentorship sessions for volunteers and community health workers to implement CBS/EBS for active case finding - Integrated with ECV Training above.
- Support volunteer during intensified routine & targeted measles vaccinations: 4 weeks of vaccinations per district for 3 districts.
- Conduct household visits and Contact tracing & follow ups on measles cases & vaccination among under 5 children.
- Mobilize and deploy 300 health volunteers & 30 community health workers to create awareness on measles prevention, signs and symptoms, mode of transmission, importance of vaccination among U5 children.
- Conduct social mobilization among at-risk group for intensified routine and vaccination campaign to increase vaccination uptake. -

Integrated with activity above.

- Support awareness in schools for promotion of measles vaccination targeting school health committee, children, and teachers.
- Train and mentor coach volunteers on MHPSS (20 volunteers & 10 HSAs per district).
- Support coach volunteers to provide Mental health and Psycho-social support to deployed volunteers and affected households.
- Support micro-planning of measles response at community level with Caregivers, community leaders, religious leaders, mother groups, local partners & other community structures.
- Support orientation of health workers as Vaccinators in 3 districts.
- Provide logistical support for vaccination in hard-to-reach areas targeting 3 districts.
- Engage stakeholders at Sub-national and district level on Measles response.
- Community dialogue sessions with leaders and communities to address misinformation, build trust, increase accountability, and promote vaccine uptake.
- Conduct 24 interactive radio programs over the three-month DREF implementation period, averaging two programs per week.
- Support airing of radio programs and Jingles on community radios to provide context messages to address rumors and misinformation.
- Support Ministry of health to produce FAQ and key messages.

Water, Sanitation And Hygiene

Budget: CHF 34,483
Targeted Persons: 165,116

Indicators

Title	Target
Number of portable handwashing stations procured	120
Number of volunteers and HSAs trained in hygiene promotion	330
Number of care givers trained in handwashing & household water treatment and safe storage	300
Number of tablet soap procured for vulnerable households and schools	12,000
Number of people reached with WASH interventions	165,116

Priority Actions

The overall WASH reach under this operation is projected at approximately 450,000 people, achieved through a combination of direct service delivery and broader outreach interventions. Supportive direct activities such as soap distribution, the installation of portable handwashing stations in CBCCs and schools (5,000–10,000 people), caregiver training on handwashing and safe water storage (5,000 people), and hygiene promotion delivered by 300 volunteers and 30 community health workers (15,000–20,000 people) will extend the direct reach to an additional 35,000 people. Furthermore, broader outreach interventions including community hygiene campaigns in marketplaces, churches, and mosques (70,000 people), mobile hygiene units at vaccination sites (30,000 people), integration of hygiene promotion into vaccination campaigns (40,000 people), are expected to reach over 350,000 people. Consolidating these figures, the WASH component will realistically reach around 450,000 people in total, ensuring that the target is evidence-based, achievable, and aligned with outbreak-specific needs, while complementing health interventions to reduce secondary infections, reinforce vaccination uptake, and strengthen community resilience. The strategy will ensure that affected communities are actively engaged throughout the response by establishing two-way communication channels that enable people to receive timely, reliable information while providing feedback, raising concerns, and reporting rumors or misinformation. Working closely with the Ministry of Health, community leaders, religious leaders, local media, and trained Malawi Red Cross Society volunteers, the interventions will support risk communication, strengthen community-based surveillance, and ensure that community perspectives inform the ongoing response, ultimately contributing to reduced transmission and improved public confidence in health services.

Specifically, the action will:

- Procure and distribute 120 portable handwashing stations for Community based Care Centers (CBCC) and primary schools.
- Support 300 volunteers and 30 Community Health workers on hygiene promotion including handwashing in communities and schools - integrated with mobilization under health above.
- Train 300 care givers on hand washing and household water treatment and safe storage - These are the focal persons managing the Community health-based child centres (community-based preschools).
- Distribute soap and water treatment tablets to vulnerable households and schools.

Protection, Gender And Inclusion

Budget: CHF 10,978
Targeted Persons: 165,116

Indicators

Title	Target
Number of volunteers trained in Humanitarian Principles and cross cutting issues Gender Protection Inclusion	350
Number of people reached with PGI intervetions and messaging	165,116

Priority Actions

The PGI component of the operation is projected to reach approximately 200,000–250,000 people, combining direct service delivery with broader outreach interventions. Direct activities will include the establishment of safe spaces for women, children, and vulnerable groups, distribution of dignity kits and essential non-food items, and provision of psychosocial support to individuals experiencing stress or trauma during displacement. These interventions are expected to directly benefit 20,000–30,000 people in measles affected and high-risk districts.

Furthermore, broader PGI outreach will be achieved through awareness sessions on protection from sexual exploitation and abuse, community feedback and complaint mechanisms, and integration of PGI messaging into vaccination and hygiene campaigns. These activities delivered by trained volunteers and community health workers are expected to reach 180,000–220,000 people through schools, marketplaces, religious institutions, and community gatherings. The following are the proposed actions:

- Orient 350 volunteers, staff and community health workers on Humanitarian Principles and cross cutting issues Gender Protection Inclusion.
- Ensure inclusion of women, children, persons with disabilities, and marginalized groups in outreach.
- Establish safe referral pathways for vulnerable populations.
- Promote community dialogues to reduce stigma and discrimination.
- Support volunteers to disseminate PGI messages in all the project activities.

Community Engagement And Accountability

Budget: CHF 55,033
Targeted Persons: 165,116

Indicators

Title	Target

Number of staff/volunteers oriented on CEA and CFM	320
Title Number of community engagement & dialogue session conducted with leaders, religious leaders, and other influential leaders to Address misinformation and promote vaccine uptake.	15
Number of districts with complaints and feedback mechanisms activated and operational	3
Number of radio programs and Jingles on community radios produced	20
Number of feedback forms, FAQ, Key messages, Posters printed and distributed	2,400
Number of measles response profiled	1

Priority Actions

The Community Engagement and Accountability (CEA) interventions will strengthen community trust, improve access to accurate information, and promote informed decision-making to increase acceptance and uptake of measles vaccination and other outbreak prevention measures. he following actions will be undertaken:

- Conduct community engagement meetings & dialogue sessions with community leaders, religious leaders, and other influential leaders to Address misinformation and promote vaccine uptake.
- Activate and strengthen Complaints and feedback mechanism focusing on linking digital data systems & 2-way communication channels to close the communication loop.
- Conduct six media engagement meetings, with three meetings in each district targeting local media houses.
- Measles response profiling.
- Print and distribute 2400 feedback forms, FAQ, Key messages, Posters.
- Train volunteers in CEA and complaints and feedback mechanism.

Coordination And Partnerships

Budget: CHF 25,616
Targeted Persons: 30

Indicators

Title	Target
Number of planning/review meetings conducted per district	27
Mumber of joint monitoring visits condcuted	6
Lessons learnt conducted	2

Priority Actions

To strengthen coordination, monitoring, learning, and evidence-based decision-making during the measles response, the operation will support key preparedness and response coordination activities at national and district levels. This will include conducting review meetings and reactivating or strengthening Public Health Emergency Management Committees (PHEMCs) in the three targeted districts to enhance coordination and timely decision-making. The project will facilitate joint supportive monitoring and supervision visits with the Ministry of Health, support stakeholder planning and review meetings, and document lessons learned through district-level and national learning workshops. In addition, the operation will provide technical support to district data clerks in information management,

including data visualization and digital tools to strengthen tracking of measles vaccination activities and overall response performance as outlined below:

- Conduct review meetings and activate and strengthen PHEMC in 3 districts.
- Conduct joint National supportive monitoring and supervision visit with MoH.
- Support planning and review meetings with stakeholders on measles response.
- Lessons Learnt Workshop 1 per district, 1 national.
- Support District data clerks in Information Management, including visual digitalization for measles vaccination and response.

Secretariat Services

Budget: CHF 16,421
Targeted Persons: 7

Indicators

Title	Target
# of IFRC CCD monitoring visits conducted and field reports shared	2
# of Kick off meeting held within 7 days of DREF approval	1

Priority Actions

To ensure effective coordination, compliance, and quality implementation of the DREF operation, IFRC will provide the necessary operational management and technical support throughout the response period. The operation will ensure overall coordination in line with IFRC DREF standards, including the organization of an inception meeting within one week of approval and monthly coordination meetings thereafter. It will support key operational positions, including the PMER Officer and Project Officer, to strengthen planning, monitoring, reporting, and implementation oversight. Technical guidance and compliance support will be provided through the IFRC Country Cluster Delegation, including PMER, finance, and logistics support, to ensure adherence to IFRC policies and DREF requirements.

- Ensure overall operational coordination in line with IFRC DREF standards and policies.
- Convene a kickoff meeting within one week of approval and conduct monthly operational coordination meetings thereafter
- Cover salary costs for essential strategic positions required for effective operation delivery. PMER Officer and Project Officer
- Provide technical and coordination support through the IFRC Country Cluster Delegation (CCD), including PMER, finance, and logistics, in compliance with DREF and IFRC policies.

National Society Strengthening

Budget: CHF 53,581
Targeted Persons: 320

Indicators

Title	Target
Percentage of staff salary contribution covered for key positions	5
Number of volunteers insured	300
Number of visibility materials distributed	469

Priority Actions

To ensure effective implementation, coordination, and accountability of the DREF operation, the project will provide essential operational support to both staff and volunteers. This will include a partial contribution towards the salaries of key personnel responsible for project oversight and coordination, including District Managers for Dedza, Balaka, and Nsanje, as well as the PMER, Finance, and Partnerships Coordinators. Operational efficiency will be strengthened through the hire and servicing of two project vehicles, procurement of Microsoft Office (MS 365) licences and a Power BI licence to enhance communication, data management, analysis, and reporting, as well as the procurement of a laptop, heavy-duty printer, and photocopier to support project documentation and administrative functions. In addition, the operation will provide insurance coverage and visibility materials for volunteers to ensure their safety, identification, and effective participation throughout the measles response.

- Staff salary contribution 5% (District Managers for Dedza, Balaka and Nsanje, PMER Coordinator, Finance Coordinator and Partnership Coordinator).
- Vehicle Hire and Service-2Vehicles.
- ICT Support License (Power BI License).
- Procurement of Laptop.
- Heavy Duty Printer and Photocopier.
- Volunteer Insurance.
- Volunteer visibility.
- Payment for MS License.

About Support Services

How many staff and volunteers will be involved in this operation. Briefly describe their role.

A total of 350 personnel will support the implementation of the operation, comprising 300 Malawi Red Cross Society (MRCS) volunteers and 30 Community Health Workers (HSAs) including staff members at national and district levels. Together, they will ensure effective coordination, implementation, monitoring, and reporting of response activities.
MRCS Volunteers and health workers (330): Volunteers will be the frontline workforce implementing community-based interventions. Their responsibilities will include conducting household visits and mobilizing communities in Risk Communication and Community Engagement (RCCE) activities, mobilizing communities to increase awareness and demand for measles vaccination, supporting active case finding, community-based surveillance, contact tracing, and timely referral of suspected cases to health facilities. They will also facilitate community dialogue sessions, collect community feedback, address rumours and misinformation, promote infection prevention and control practices, and support government-led vaccination campaigns through household sensitization and mobilization.

District Managers: District Managers will provide overall leadership and coordination of the response at district level. They will work closely with District Health Offices to support micro-planning, coordinate volunteer deployment, provide technical supervision, monitor implementation progress, resolve operational challenges, and ensure timely reporting of activities and results.

Planning, Monitoring, Evaluation and Reporting (PMER) Team: The PMER team will oversee monitoring and evaluation of the operation by collecting, validating, analyzing, and reporting programme data. They will track progress against planned targets, support data quality assurance, document lessons learned, prepare operational and donor reports, and facilitate evidence-based decision-making throughout the response.

Finance Team: The Finance team will ensure sound financial management of the operation by overseeing budgeting, fund disbursement, expenditure tracking, and financial reporting. The team will ensure compliance with MRCS and IFRC financial procedures, manage payments for volunteer allowances and operational costs, support procurement processes where required, and maintain accountability and transparency to donors and partners.

National Technical Staff: National Health, WASH, Community Engagement and Accountability (CEA), Protection, Gender and Inclusion (PGI), Communications, Logistics, and Operations staff will provide technical guidance, quality assurance, coordination with the Ministry of Health and partners, capacity building for volunteers, and overall operational oversight to ensure that the response is implemented effectively and in line with IFRC and national standards.

Does your volunteer team reflect the gender, age, and cultural diversity of the people you're helping? What gaps exist in your volunteer team's gender, age, or cultural diversity, and how are you addressing them to ensure inclusive and appropriate support?

Yes. The Malawi Red Cross Society (MRCS) volunteer workforce reflects the gender, age, and cultural diversity of the communities being served. Approximately 60% of the volunteers engaged in this operation are women, ensuring strong representation in community engagement activities, particularly when working with mothers, caregivers, and other groups that may be more receptive to female volunteers. The volunteer teams are drawn from the targeted districts and represent different ethnic groups, cultures, age groups, and local languages, enabling culturally appropriate communication and fostering trust within communities. Volunteers are recruited from the communities where they serve, which strengthens acceptance, facilitates access to hard-to-reach populations, and improves the effectiveness of risk communication, community engagement, and surveillance activities. Teams include both young and experienced volunteers, innovation, and community knowledge. Although the volunteer base is broadly representative, MRCS will continue to address any gaps in diversity by ensuring equitable deployment of male and female volunteers, promoting the participation of youth and persons with disabilities where feasible, and providing orientation on Protection, Gender and Inclusion (PGI), safeguarding, cultural sensitivity, and prevention of sexual exploitation, abuse and harassment (PSEAH). These measures will help ensure that all community members including women, men, children, older persons, persons with disabilities, and other vulnerable groups can access services safely, equitably, and with dignity.

If there is procurement, will it be done by National Society or IFRC?

No major procurement is anticipated under this operation. Any minor procurement required, such as Information, Education and Communication (IEC) materials, volunteer visibility items, hygiene promotion materials, or operational supplies, will be undertaken by MRCS in accordance with the National Society's procurement procedures and the IFRC Procurement Manual to ensure transparency, value for money, and compliance with quality standards. Should unforeseen operational needs arise that require significant procurement, MRCS will coordinate with the IFRC Country Cluster Delegation to determine the most appropriate procurement modality and ensure timely delivery of essential items in support of the response.

How will this operation be monitored?

This operation will be monitored in line with MRCS and IFRC standard monitoring guidelines, which emphasize accountability, transparency, and evidence-based decision making. Monitoring will be conducted through routine field visits, structured reporting, and real-time data collection using digital tools. The Planning, Monitoring, Evaluation and Reporting (PMER) team will lead the process by designing monitoring frameworks, consolidating district reports, and producing situation updates for stakeholders. PMER will also ensure that indicators on vaccination coverage, community engagement, and surveillance are tracked consistently. Meanwhile, volunteer staff will play a frontline role in collecting household-level data, reporting suspected cases, documenting outreach activities, and providing feedback from communities. Together, PMER and volunteers will ensure that the response remains adaptive, inclusive, and aligned with IFRC's accountability standards, while enabling timely corrective actions where gaps are identified.

Please briefly explain the National Societies communication strategy for this operation

The Malawi Red Cross Society (MRCS) will implement its existing communications strategy throughout the operation to ensure the timely dissemination of accurate, consistent, and evidence-based information on the measles outbreak and response activities. All communication activities will be coordinated by the MRCS Communications Coordinator in close collaboration with the Ministry of Health, the IFRC, and other partners to ensure harmonized messaging and alignment with national outbreak communication guidelines.

The communication strategy will support Risk Communication and Community Engagement (RCCE) by promoting key public health messages on measles prevention, the importance of vaccination, early recognition of symptoms, timely healthcare-seeking behavior, and infection prevention practices. Communication products and stories from the field will highlight the role of Malawi Red Cross volunteers in community mobilization, surveillance, and vaccination support while addressing misinformation and vaccine hesitancy through trusted and culturally appropriate channels. The strategy will utilize a combination of local radio, social media platforms, community dialogues, print materials, and human-interest stories to increase public awareness, strengthen community trust, and enhance accountability to

affected populations. Regular documentation of response activities, lessons learned, and success stories will also support donor visibility, resource mobilization, and knowledge sharing throughout the operation.

Budget Overview

IFRC

DREF OPERATION

MDRMW027 - Malawi RC
Measles Response

Operating Budget

Planned Operations	**192,685**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	92,191
Water, Sanitation & Hygiene	34,483
Protection, Gender and Inclusion	10,978
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	55,033
Environmental Sustainability	0
Enabling Approaches	**95,618**
Coordination and Partnerships	25,616
Secretariat Services	16,421
National Society Strengthening	53,581
TOTAL BUDGET	**288,303**

all amounts in Swiss Francs (CHF)

Click here to download the budget file

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Click here for the reference