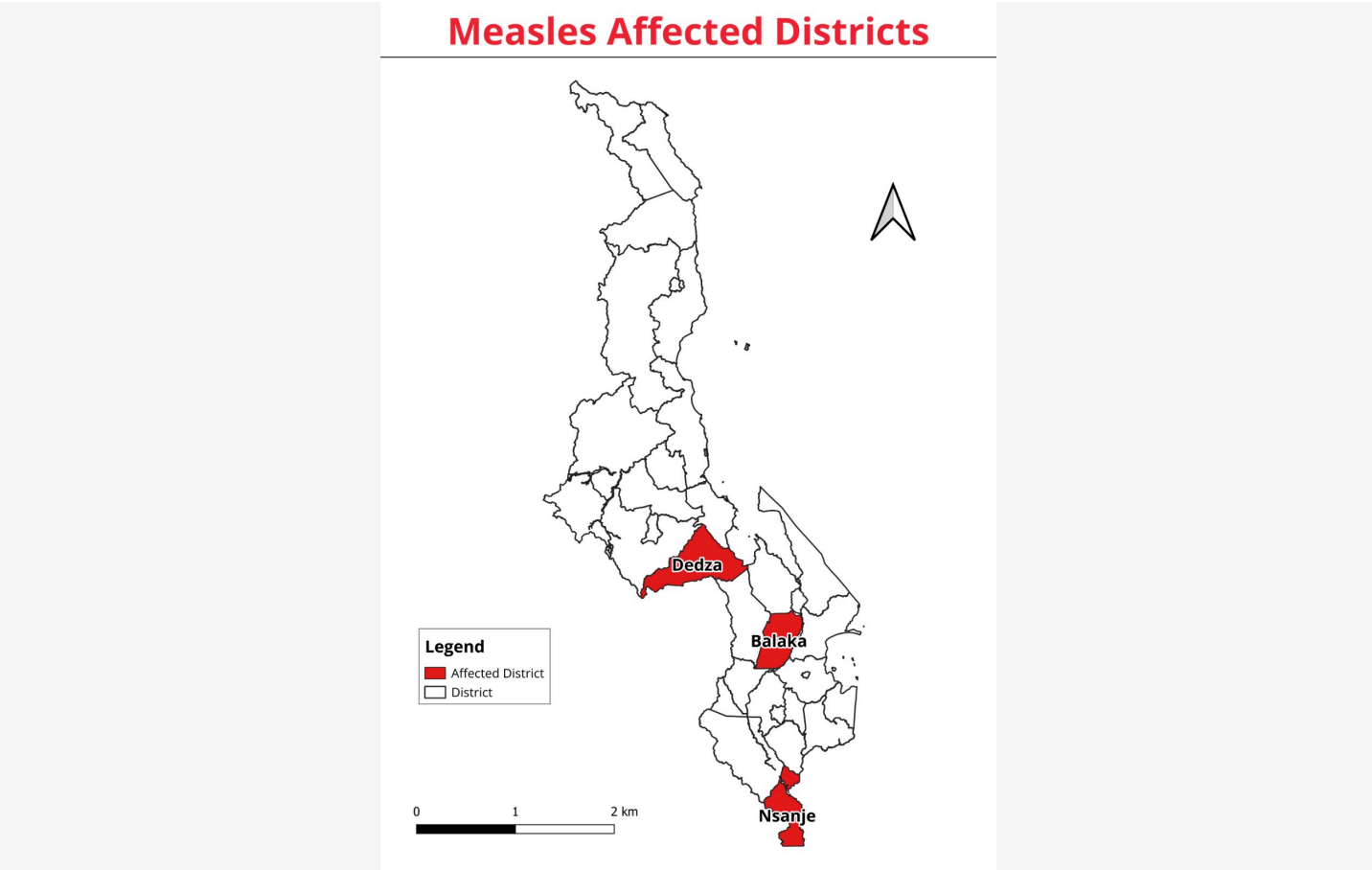




Measles vaccination session by the Community health action Group volunteer

Appeal: MDRMW027	Total DREF Allocation: CHF 288,303	Crisis Category: Yellow	Hazard: Epidemic
Glide Number: -	People Affected: 165,116 people	People Targeted: 165,116 people	
Event Onset: Slow	Operation Start Date: 30-07-2026	New Operational End Date: 30-11-2026	Total Operating Timeframe: 4 months
Reporting Timeframe Start Date: 30-07-2016		Reporting Timeframe End Date: 30-12-2026	
Additional Allocation Requested: -		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.



Volunteer door to door visit



Vaccination in Progress



Training of volunteers in PGI

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 Information

Source Name	Source Link
1. IDSR Epi Bulletin_Week 27_Malawi (2)	https://ifrcorg-my.sharepoint.com/:b:/g/personal/tariro_kamangira_ifrc_org/IQCBedHZIGSMR7E87dwz2iCCAYRJNP-jQFLq5eMwiFQByo0?e=rEdqUJ
2. LETTER TO MRCS_MEASLES SUPPORT REQUEST	https://ifrcorg-my.sharepoint.com/:b:/g/personal/tariro_kamangira_ifrc_org/IQCXHQJEhCrcRleaU8Ne_Y1EAfwBYb1q8dRVkyg7HEpq0Ps?e=xBTMFe
3. Measles epicurve for districts	https://ifrcorg-my.sharepoint.com/:b:/g/personal/tariro_kamangira_ifrc_org/IQBcY0mmyGn4ToGKpEldmwaAAZQITXQNrAulu3QHSeynNmY?e=Rld9fx
4. Nsanje Measles Outbreak Update, 17th July 2026 (1)	https://ifrcorg-my.sharepoint.com/:b:/g/personal/tariro_kamangira_ifrc_org/IQDTkZshUZXR7yAYa9s4G_JAYCaAhDA43DDytva7gDnls8?e=aMUJg5



Summary of Changes

Are you changing the timeframe of the operation	No
Are you changing the operational strategy	No
Are you changing the target population of the operation	No
Are you changing the geographical location	No
Are you making changes to the budget	No
Are you requesting an additional allocation?	No



Please explain the summary of changes and justification:

The project implementation period was scheduled from 30 July to 30 October 2026. Since the process of completing the checklist took longer than expected, approval was received on the 20th of August, MRCS received the funds to MRCS' account on 3 September 2026. This delay resulted in the loss of implementation time for the month of August, thereby compressing the operational window and requiring accelerated activities within the remaining period.

Implementation of interventions also experienced delays due to Malawi's fuel shortages and rapid currency devaluation, which significantly increased transportation and operational costs and disrupted the timely movement of staff, volunteers, and supplies to targeted districts. These external economic challenges affected activity scheduling and procurement processes, necessitating adjustments to implementation timelines while maintaining the planned response objectives.

Activities done

- Conduct orientation of Epidemic Control for Volunteers (ECV) focusing on measles, targeting 330 volunteers and implementing staff in 3 districts.
- Support volunteers during intensified routine and targeted measles vaccinations (4 weeks per district, across 3 districts).
- Conduct household visits, contact tracing, and follow ups on measles cases and vaccination among under 5 children.
- Mobilize and deploy 300 health volunteers and 30 community health workers to raise awareness on measles prevention, signs and symptoms, transmission, and importance of vaccination among under 5 children.
- Support awareness in schools to promote measles vaccination, targeting school health committees, children, and teachers.
- Orient health workers as vaccinators in 3 districts.
- Provide logistical support for vaccination in hard-to-reach areas in 3 districts.
- Engage stakeholders at sub national and district level on measles response.
- Conduct community engagement meetings and dialogue sessions with leaders (community, religious, and other influencers) to address misinformation and promote vaccine uptake.
- Conduct media engagement meetings (6 total: 3 per district with local media houses).
- Profile measles response activities.
- Print and distribute feedback forms, FAQs, key messages, and posters.
- Conduct national supportive monitoring and supervision visits to 3 districts. So far conducted 2 out of the 6 planned visits
- Supported 18 out of the 27 planned planning and review meetings with stakeholders on measles response.
- Train and mentor volunteers on MHPSS (20 volunteers and 10 HSAs per district). This has been partially done. Training has been completed in one of the 3 districts only
- Conduct van publicity and road shows.
- Support airing of radio programs and jingles on community radios to address rumours and misinformation.

Activities not yet done

- Conduct social mobilization among at risk groups to increase vaccination uptake during intensified routine and campaign activities.
- Finalise training and mentoring volunteers on MHPSS (20 volunteers and 10 HSAs per district) in Balaka and dedza districts.
- Support volunteers to provide mental health and psychosocial support to deployed volunteers and affected households.
- Support micro planning of measles response at community level with caregivers, leaders, mother groups, local partners, and community structures.
- Train caregivers (community health-based child centre focal persons) on handwashing, household water treatment, and safe storage.
- Conduct district level engagement and dialogue sessions with community, religious, and other influential leaders to address misinformation and promote vaccine uptake.
- Conduct van publicity and road shows.
- Support Ministry of Health to produce FAQs and key messages.
- Support airing of radio programs and jingles on community radios to address rumours and misinformation.
- Conduct a Lessons Learned workshop.
- Support district data clerks in information management, including digital visualization for measles vaccination and response.
- Conduct national supportive monitoring and supervision visits to 3 districts.
- Profile measles response activities.
- Conduct community engagement meetings and dialogue sessions with leaders to address misinformation and promote vaccine uptake.
- Activate and strengthen complaints and feedback mechanisms, linking digital data systems and two-way communication channels.
- Deliver the procured 120 hand washing stations to the districts.

MRCS is requesting a one month No Cost Extension will allow the NS to complete all the remaining activities. The NS has already absorbed over 66% of funds received and believes the remaining 34% will be absorbed in the next six weeks.



Therefore, MRCS requests a No-Cost Extension (NCE) to finalize the implementation of activities, extending the project end date from 30 October 2026 to 30 November 2026.

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 routine 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.



Operational Strategy

Overall objective of the operation

The overall objective of this four-month DREF operation (August to November 2026) 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
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.
<p>Response/intervention challenges include:</p> <ul style="list-style-type: none"> - Coordination challenges: Overlapping roles among partners 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. 	This intervention is putting in priority the key gaps but also aligns with other actors ongoing efforts. MRCS will aim at 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.
<p>Please indicate any security and safety concerns for this operation:</p> <p>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.</p>	
Has the child safeguarding risk analysis assessment been completed?	No

Planned Intervention



Budget: CHF 92,191
Targeted Persons: 165,116
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of volunteers and HSAs oriented on ECV	330	330
Number of school-based sessions conducted with age-appropriate materials	30	30
% of identified affected households receiving MHPSS	90	60
Number of volunteers trained in MHPSS	90	110
Number of people reached with health promotion activities	165,116	134,890
Number of health workers oriented as vaccinators	150	150
Number of Community dialogue sessions with leaders and communities	7	5

Progress Towards Outcome

- Conducted orientation of Epidemic Control for Volunteers focusing on measles, targeting 300 volunteer and 30 HSAs and implementing staff in 3 districts.
- Conducted mentorship sessions for volunteers and community health workers to implement CBS/EBS for active case finding - Integrated with ECV Training above.
- Trained and mentor coach volunteers on MHPSS (20 volunteers & 10 HSAs per district). This training is ongoing since it has been completed in Nsanje district (110 volunteers and HSAs) only and yet to be finalised in Balaka and Dedza districts
- Support awareness in schools for promotion of measles vaccination targeting school health committee, children, and teachers.
- Supported orientation of health workers as Vaccinators in 3 districts.
- Provided logistical support for vaccination in hard-to-reach areas targeting 3 districts.
- Conducted community dialogue sessions with leaders and communities to address misinformation, build trust, increase accountability, and promote vaccine uptake.



Water, Sanitation And Hygiene

Budget: CHF 34,483

Targeted Persons: 165,116

Targeted Male: -

Targeted Female: -

Indicators

Title	Target	Actual
Number of portable handwashing stations procured	120	120
Number of volunteers and HSAs trained in hygiene promotion	330	330

Number of care givers trained in handwashing & household water treatment and safe storage	300	300
Number of tablet soap procured for vulnerable households and schools	12,000	12,000
Number of people reached with WASH interventions	165,116	134,890

Progress Towards Outcome

- Procurement of 120 portable handwashing stations have been done by the logistics department for Community based Care Centers (CBCC) and primary schools. The items are planned to be delivered to the districts in the coming weeks.
- Supported 300 volunteers and 30 Community Health workers on hygiene promotion including handwashing in communities and schools integrated with mobilization under health above.
- Trained 300 care givers on hand washing and household water treatment and safe storage.
- Procured soap and water treatment tablets to vulnerable households and schools.



Protection, Gender And Inclusion

Budget: CHF 10,978

Targeted Persons: 165,116

Targeted Male: -

Targeted Female: -

Indicators

Title	Target	Actual
Number of volunteers trained in Humanitarian Principles and cross cutting issues Gender Protection Inclusion	350	350
Number of people reached with PGI interventions and messaging	165,116	134,890

Progress Towards Outcome

- Oriented 350 volunteers, staff and community health workers on Humanitarian Principles and cross cutting issues Gender Protection Inclusion.
- Promotion of community dialogues to reduce stigma and discrimination.



Community Engagement And Accountability

Budget: CHF 55,033

Targeted Persons: 165,116

Targeted Male: -

Targeted Female: -

Indicators

Title	Target	Actual
Number of staff/volunteers oriented on CEA and CFM	320	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	12
Number of districts with complaints and feedback mechanisms activated and operational	3	3
Number of radio programs and Jingles on community radios produced	20	13
Number of feedback forms, FAQ, Key messages, Posters printed and distributed	2,400	2,400
Number of measles response profiled	1	0

Progress Towards Outcome

- Conducted community engagement meetings & dialogue sessions with community leaders, religious leaders, and other influential leaders to Address misinformation and promote vaccine uptake.
- Printed and distributed 2400 feedback forms, FAQ, Key messages, Posters.
- Trained volunteers in CEA and complaints and feedback mechanism.



Coordination And Partnerships

Budget: CHF 25,616

Targeted Persons: 30

Targeted Male: -

Targeted Female: -

Indicators

Title	Target	Actual
Number of planning/review meetings conducted per district	27	18
Number of joint monitoring visits conducted	6	2
Lessons learnt conducted	2	0

Progress Towards Outcome

Conducted 2 out of the 6 planned joint National supportive monitoring and supervision visit with MoH and other stakeholders.
Conducted 18 out of 27 planned planning and review meetings with stakeholders. The remaining activities include exit meetings with district and community structures to ensure the sustainability of the interventions.



Secretariat Services

Budget: CHF 16,421

Targeted Persons: 7

Targeted Male: -

Targeted Female: -

Indicators

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

Progress Towards Outcome

Conducted kick off meetings with the stakeholders introducing the project.
Salary support for one month of September.
IFRC supported the DREF launch during the Kickoff meeting.



National Society Strengthening

Budget: CHF 53,581

Targeted Persons: 320

Targeted Male: -

Targeted Female: -

Indicators

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

Progress Towards Outcome

- One month staff salary contribution 5% (District Managers for Dedza, Balaka and Nsanje, PMER Coordinator, Finance Coordinator and Partnership Coordinator).



- Procured 300 Volunteer bibs.

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?

The operation will support the procurement of Information, Education and Communication (IEC) materials, volunteer visibility items, and hygiene promotion supplies. These will be procured by the National Society in line with its procurement procedures and the IFRC Procurement Manual, ensuring transparency, value for money, and compliance with quality standards.

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



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
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all amounts in Swiss Francs (CHF)



Contact Information

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

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