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Emergency Plan of Action (EPoA)
Malawi: Cholera Outbreak

International Federation of Red Cross and Red Crescent Societies

DREF Operation n°	**MDRMW017**	**Glide n°:**	EP-2022-000298-MWI
Date of issue:	17 September, 2022	**Expected timeframe:**	4 months
Operation start date:	15 September, 2022	**Expected end date:**	31 January 2023
Category allocated to the of the disaster or crisis: Yellow			
DREF allocated: CHF 392,014			
Total number of people affected:	1,736 cases	**Number of people to be assisted:**	753,869 people (at risk)
Affected districts:	12 districts	**Targeted districts:**	4 Districts: Nkhatabay, Nkhotakota, Mzuzu and Karonga.
Host National Society presence (n° of volunteers, staff, and branches): Malawi Red Cross Society with 263 members of staff, 74,000 volunteers and 33 branches across the country.			
Red Cross Red Crescent Movement partners actively involved in the operation: International Federation of Red Cross and Red Crescent Societies (IFRC), International Committee of the Red Cross (ICRC), Danish Red Cross, Netherlands Red Cross and Swiss Red Cross			
Other partner organizations actively involved in the operation: Government of Malawi (Ministry of Health), UNICEF and WHO			

A. Situation analysis

Description of the Disaster

Malawi is currently experiencing one of the worst cholera outbreaks in years. The first case was registered in Machinga district in the Southern region of Malawi on 02 March 2022. The Malawi Ministry of Health declared the cholera outbreak on 03 March 2022 after the increase and spread of confirmed cases. The cholera outbreak, initially limited to the southern part of the country, has now spread to Malawi's northern and central regions. Meanwhile, the country continues to register new cholera cases in different parts of the country. As of 31 August 2022, the outbreak had claimed 67 lives with 1,736 cases being registered in 15 districts representing a case fatality rate of 3.85%[1]. So far, the affected districts include Machinga, Nsanje Chikwawa, Blantyre, Mulanje, Neno, Balaka, Lilongwe, Nkhatabay, Nkhotakota, Phalombe, Mangochi, Rumphi, Mzuzu, Balaka. It's also been reported that the cases have started spreading to the neighbouring districts including Mzuzu and Rumphi. Recently, there has been an alarm of sudden increase of cholera cases reported particularly in Nkhatabay and Nkhotakota districts such that on 18 August 2022, the two districts registered 51 new cases with a total of 264 cases of which 25 were admitted. On 20 August 2022, eight people were reported to have died. Laboratory investigations from autopsy samples collected have confirmed that their deaths were as a result of contracting cholera.

[1] *UNICEF and WHO step up efforts to contain Cholera in Malawi and call for additional funds and support*

Below is a summary of cholera statistics table indicating number of weekly cases registered cases per district:

Table: Number of weekly new cholera cases Cumulative cases and case fatality by district (Source: Ministry of Health – Public Health Institute of Malawi: Epidemiology Section

District	Epi wk 27	Epi wk 28	Epi wk 29	Epi wk 30	Epi wk 31	Epi wk 32	Epi wk 33	Cumul. cases	Deaths	CFR (%)	Last reported
Mangochi	0	0	0	0	0	0	0	1	0	0	6.28.22
Lilongwe	0	0	0	0	0	0	0	1	0	0	6.13.22
Chiradzulu	2	0	1	0	0	0	0	5	0	0	7.23.22
Mulanje	0	3	0	1	1	0	0	6	1	17	8.6.22
Machinga	0	3	1	0	0	0	0	16	2	13	7.22.22
Balaka	0	1	0	0	0	0	0	12	3	14	7.12.22
Chikwawa	14	3	9	21	13	1	0	130	1	0.8	8.23.22
Neno	2	4	2	2	0	0	0	127	2	1.6	8.9.22
Nsanje	7	7	11	6	9	0	1	289	14	4.8	7.30.22
Nkhatabay	0	0	0	0	-	-	144	349	11	3.2	8.20.22
Nkhotakota	0	0	0	0	0	8	28	36	3	13	8.22.22
Blantyre	34	27	39	25	13	22	30	500	21	4.2	8.22.22

This year's outbreak is relatively unusual as the cases continue being registered in the dry season of the year and are spread sporadically in several districts across the country which makes the situation less predictable and more difficult to contain. The current outbreak fatality rate is at 3.85% which is higher than the WHO benchmark for cholera epidemics, of case fatality of less than 1%. The high case fatality rate might be attributed to long distances between health facilities and the affected communities which results in delayed access to rehydration treatment and lack of community awareness on how to support the affected people with Oral Rehydration Therapy (ORT).

The Ministry of Health has activated its Emergency Operation Centre (EOC) both at National and districts levels where Incident Management Team (IMT) members meet following an increase in the number of cholera cases in the country. The National EOC which is hosted at the Ministry of Health-Public Health Institute of Malawi, is multi-sectoral and is being coordinated in collaboration with Ministry of Health departments, Ministry of Water and Sanitation, UNICEF, World Health Organization (WHO), Malawi Red Cross Society (MRCS), and other implementing non-Governmental partners.

Summary of the current response

Overview of Host National Society Response Action

Malawi Red Cross Society has 33 Divisions (Branches) and a network of more than 83,000 volunteers countrywide. It is present in all the 29 districts of Malawi. MRCS has previous experience in implementing emergency relief programs throughout the country, with support from various donor partners, Partner National Societies (PNS) and the IFRC through the Disaster Relief Emergency Fund (DREF). This includes DREF operations and IFRC Emergency Appeals in Phalombe, Zomba, Blantyre, Nsanje, Chikwawa, Mangochi, Mulanje, Lilongwe, Salima, Dowa, Mzimba, Mzuzu and Karonga districts.

The Malawi Red Cross Society is one of the leading humanitarian organizations supporting the Government of Malawi in the fight against the cholera outbreak in the country since the first case was registered in March 2022 in Machinga district. In this response, MRCS has been working hand in hand with Ministry of Health which is responsible for providing overall technical coordination. MRCS with its auxiliary role to the Government, trained its staff and volunteers in health emergency operations. The staff and volunteers are trained in Community based health and First Aid (CBHFA), Community Based Surveillance (CSB) with a focus on active case finding, and Community Engagement and Accountability (CEA) and have substantial experience in implementation of health programs including health in emergencies. Such skills are vital and will help MRCS in the fight against this outbreak.

At national level, MRCS has a pool of trained National Disaster Response Team (NDRT) members specialized in different fields such as Health & WASH; Relief support; First Aid; Community Engagement and Accountability; Shelter; Nutrition; Food security & Livelihoods; Protection, Gender & Inclusion; Data management; and Communications. MRCS

has strong experience and qualified staff to conduct this operation with 120 trained NDRT. MRCS has institutionalized Cash and Voucher Assistance (CVA) by implementing cash transfers since 2009. Over this period, the National Society has acquired relevant equipment tools as well as well trained staff and volunteers in the implementation of CVA. MRCS has a full data team which facilitates mobile data management hence, efficient in cash delivery to the affected households.

Malawi Red Cross Society (MRCS) has been supporting in the response to these cases in Nsanje, Chikwawa, Mulanje, Phalombe, Neno and Machinga districts since March 2022 through existing programmes with IFRC Tropical Storm Ana Emergency Appeal (MDRMW015) Appeal and Partner National Societies. The national society's support has been through community mobilization with the help of the MRCS volunteers carrying out disseminations and interventions through door-to-door visits, distribution of buckets and chlorine for handwashing. In addition, the MRCS air relevant jingles on radio stations with key messages to support in awareness raising efforts.

MRCS has already started supporting Nkhatabay and Nkhotakota districts in an effort to curb the spread of the Cholera cases. **MRCS intends to scale up its support to cover Nkhatabay, Nkhotakota, Mzuzu and Karonga districts** following the cholera cases registered since 19 August 2022 in the four districts and following the recent level of mortality and sudden significant increase of cases (Table 1). The rise could result in a catastrophe if immediate emergency support is not provided urgently. There is also a high risk of the disease spreading to the four neighbouring districts along the lake shore of Salima, and Karonga due to the high mobility amongst the fishermen doing both fishing and selling activities as well as regular market interactions amongst the people of Nkhatabay and Nkhotakota Districts that puts them in the "at-risk" population criteria. Blantyre has also been registering a significant number of cases in the country and is considered as one of the targeted districts in this response. In Nkhotakota and Nkhatabay, several Health Centre Catchment areas have been affected including Chintheche, Tukombo, Liwuzi and Kasitu while in Nkhotakota is Matiki and Nkhotakota District Health Office catchment area. Much as Mzuzu has not registered a case, however its proximity to Nkhatabay and also being a city and a northern region business hub, it remains a high risk to cholera burden which justifies its selection. The current Floods Emergency Appeal was not fully funded as a result Blantyre was not prioritized in the response.

In the targeted districts, Malawi Red Cross has been working hand in hand with the District Health Offices in the cholera affected districts by undertaking a number of activities such as Water Sanitation & Hygiene (WASH) activities, active case finding, IFRC CBS in emergency guidelines and Malawi Ministry of Health tools and guidelines as well as Community Engagement & Accountability (CEA) interventions. Approach for the case finding and data management uses paper-based data collection tools later transferred on mobile. In order to leverage on the available projects, these interventions are integrated in the normal MRCS projects such as Community Resilient Project (COMREP), Integrated Community Based Health Project (ICBHP), Scaling Up Nutrition (SUN), First Aid, Mobile Outreach Clinics and Blood Donor Recruitment (BDR). MRCS through the EA Ana and Gombe contributed to the cholera response in the Salima, Nsanje and Chikwawa districts in prevention of and response to any cholera outbreaks. The activities include orientation of volunteers on ORT/ORP; Preposition of ORP Kits; orientation of branches on Branch Transmission Intervention Team and awareness raising and message dissemination on WASH/cholera prevention through breaking transmission chains at household and community level through the Branch Transmission Intervention Team approach.

Furthermore, MRCS sits in a number of technical working groups such as Humanitarian Country Coordination Team (HCT), Health Cluster, WASH cluster, protection cluster as well as Health Emergency Technical Working Group committees. MRCS is thus, well established and well-connected and enjoys strong partnerships with various development partners, partner National Societies and IFRC. The current engagement of MRCS as outlined above presents the capacities, skills and the ability to coordinate with different agencies at local, national and international levels.

Actions taken by MRCS in Responding to the outbreak in Nkhatabay and Nkhotakota

- *Meeting with Nkhatabay and Nkhotakota District Health Offices:* On 15 August 2022, Malawi Red Cross Society (MRCS) held a meeting with the respective district health offices to discuss the confirmed cases and possible partnership in social mobilization and community engagement in the districts regarding the emergence and rise of the diarrhoea cases in the districts. The district health offices also shared on actions done so far and the gaps they have.
- *Deployment of MRCS National Disaster Response Team:* Malawi Red Cross Society deployed a team of NRT members to the affected districts comprising of Wash and Health Specialists, Coordination, Communication

Specialist, Data team and Logistics to support the district health incidence team which is responding to the cholera outbreak.

- Response support of WASH supplies and Tents: MRCS has dispatched the following supplies, tents for ETUs, Tarpaulins, 20 litre Buckets (with and without taps), foldable tables, foldable chairs, and ORP kits to support Nkhatabay and Nkhotakota Districts.
- Mobilisation of volunteers: 60 Volunteers from the hot spot areas (60) have been mobilised and oriented for the multiple tasks including mounting of tents, messaging dissemination, and supporting the HSAs in pot-to-pot Chlorination in targeted villages. The volunteers have been oriented for their specific tasks to enable them to support the community health workers. MRCS is well placed to support social mobilization, community engagement and social and behaviour change communication by taking advantage of its wide and organized network of volunteers and leveraging its auxiliary mandate to the Ministry of Health. Volunteers were inducted before deployment. This ensures that volunteers adhere to the Code of Conduct, understand other key institutional documents i.e., Volunteer Policy, PSEAH policy.
- Cholera Incident management meeting with Ministry of Health and its partners: MRCS attended a meeting chaired by the Minister of Health and the Secretary for Health who updated the partners on the actions implemented in the affected districts and the government plans to scale up the interventions. All relevant sectors such as the Expanded Program on Immunisation section, Health Education Services, Community Engagement section, Environmental Health sections and MRCS also presented their plans in the fight against the virus.
- MRCS has supported the activation of District Level Health Cluster meetings: In this action MRCS helped the two districts to activate their Rapid Response Teams and the District level Health Clusters to support in the coordination of the response and provide technical support to the response.
- Provision of Supplies and construction of temporary latrines: Alongside the deployed team, MRCS has also provided 4 tents for isolation rooms, buckets with taps, soap, HTH, Oral Rehydration Kits and Aqua Tabs.

Overview of Red Cross Red Crescent Movement Actions in country

The IFRC Harare Country Cluster Delegation will continue to provide technical support during implementation of the Cholera outbreak response by conducting induction/reviews with volunteers, monitoring visits, provision of technical and financial support as well as deployment of surge in case the outbreak spreads widely. The IFRC Harare cluster delegation will also continue to support the MRCS on NSD and PMER technical and operational issues. MRCS is working hand in hand with different partners such as a consortium of PNSs led by Danish Red Cross (Icelandic, Italian and Finnish Red Cross), Swiss Red Cross and ICRC to explore synergies for integration into existing activities where they have running programmes.

Overview of non-RCRC actors' actions in country

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

- WHO has provided technical support in the setting of WASH related interventions at the isolation centres and in the affected communities and financial support for the deployment of National Response Team to conduct Rapid Assessments in Nkhatabay and Nkhotakota
- UNICEF is working with district and partners to support start of Risk Communication and Community Engagement

Government Actions

Since the declaration of the outbreak, the Malawi Government through the Ministry of Health has taken a number of actions as follows:

- Established an EOC at Community Health Science Unit (CHSU), where different MoH departments and partners are meeting on a daily basis to share updates and plans. MRCS is attending these meetings. Incident Management Team meet to discuss daily situation reports and advise accordingly on interventions for prevention and control of the outbreak.
- Production daily situation updates
- Establishment of a Risk Communication and Community Engagement (RCCE) Working Group within the EOC which is led by ministry of health to work on Social Mobilization activities among other social mapping/assessment and community engagement. The group has started developing a Social Behavioural Change and Communication Plan for Cholera. The group is also developing a Crisis Communication Plan with Key Messages on Cholera that will guide Social Mobilization activities for the government and partners. MRCS is a key member of the RCCE group.

- Deployed National Response Team to provide support with surveillance and response.
- Development of Cholera Response plan (underway).

Needs analysis, targeting, scenario planning and risk assessment

Needs analysis:
As of 31 August 2022, the outbreak had claimed 67 lives with 1,736 cases being registered in 15 districts representing an overall case fatality rate of 3.85%. So far, the affected districts include Machinga, Nsanje Chikwawa, Blantyre, Mulanje, Neno, Balaka, Lilongwe, Nkhatabay, Nkhotakota, Phalombe, Mangochi, Rumphi, Mzuzu, Balaka. It's also been reported that the cases have started spreading to the neighbouring districts including Mzuzu and Rumphi.

The Rapid Response Teams (RRTs) at national and district levels continue to support surveillance and response mechanisms in the country including in the newly affected districts of Nkhatabay and Nkhotakota districts. The Surveillance investigations conducted in Nkhatabay, and Nkhotakota Districts identified the following as contributing factors to the outbreak:

- Lack of funds and limited human resource to carryout active case search,
- Poor logistics and human resource to carry out community awareness and health education,
- Inadequate SBCC materials such as posters, flyers, and banners,
- Inadequate supply and logistics to carry out Infection prevention and control in treatment centers,
- Open defecation in affected communities,
- Low latrine coverage to as low as 5%,
- Lack of potable drinking water in some rural areas and urban slums,
- Inadequate health facility infrastructure and cholera supplies and equipment for management of patients (Ringer's lactate and ORS),
- Limited number and capacity of human resource for Cholera outbreak detection, investigation, and management,
- Poor and inconsistent reporting from the districts,
- Limited access to drinking water for vulnerable communities have led to poor hygiene and sanitation situation in the affected areas.

So far, the outbreak response has been focused on clinical case management, with very limited focus on behavioural change through risk communication, community awareness creation and sensitization on the key messages to prevent the continuous spread of the disease to avoid future outbreaks.

Six (6) Cholera Treatment Unity (CTUs) have been set by the MoH in the affected districts. However, the established treatment units are not adequate to accommodate the increasing number of cases requiring admission and putting much pressure on human resources. This coupled with long distances has contributed to increased case fatality rates and transmissions as most cases get to treatment centres in severe conditions.

Furthermore, there is limited health facility capacity due to disruption to the health systems and health facilities following tropical cyclone Ana which requires deployments to tents to accommodate patients. Malnutrition could have the potential to escalate cholera burden as cholera is more likely to flourish in places where malnutrition is common.

Scenario planning

Since the operation has a limited timeframe of four (4) months and being cognizant of the sporadic nature of the spreading of Cholera across many districts in the country, general poor sanitation across Malawi, and migration of fishermen along the lakeshore from one district to another, there is possibility of the outbreak to spread to new areas. MRCS operation will be sustained through lobbying for more resources from Malawi Government, PNSs, local resource mobilisation and IFRC to cover costs of the prevailing needs that may still require continued support.

The planned response reflects on the situation and information made available as of 21 August 2022 considering the current situation and required adjustments to contextual changes. Government has called on partners to support the campaign aimed at stopping the spread of Cholera outbreak and control further spread in Malawi. The best scenario is that MRCS will be supported by Government entities where necessary for technical support in the implementation of the planned operation.

Three scenarios have been developed below to guide National Society's response actions, and these include (1) the best-case scenario, (2) the most likely scenario and (3) the worst-case scenario. The current response is based on Scenario 2, which is the most likely scenario. This could be modified in the event of rapid increased of number cases.

Risk assessment

Malawi is generally a peaceful country much as the country has experienced some demonstrations to force government to fulfil its obligations to the people. This operation is assuming that the relative calm being observed will prevail. Regarding the Cholera outbreak, there is a high risk of the outbreak affecting more districts and more people including MRCS volunteers who are part of the affected communities. Proper orientations and provision of personal protection equipment has been planned and will be provided to all the volunteers before being engaged. MRCS volunteers and staff deployed for the operation will be covered by an insurance in line with IFRC regulations. In addition, Security of volunteers will be monitoring to ensure their security during this operation.

Below is a summary of key risks and anticipated mitigation measures for the action.

Scenario	Humanitarian consequences	Potential response
The best case: the districts have appropriate response mechanism across all the affected communities to contain further spread of the disease.	• Improved case management • Decreased incidence and case fatality rate	• Support on response and maintenance of capacity of health authorities, with community interventions to prevent new chain of transmission. Building on preparedness and lessons learnt. Expected duration of intervention 3 months
Most likely scenario: Capacity of the health system to respond is overstretched, neighbouring districts are affected with limited capacity of MoH and partners to deliver WASH and case management interventions	• Increased morbidity and mortality with a higher CFR. • More people are admitted into health facilities and treatment units become overstretched while resources are minimal to contain the spread. • Local disruption of health systems capacity and health service delivery.	• Support in case management, addressing gaps in CTUs availability. • interventions at community level for reducing chain of transmission and heightened surveillance for identifying promptly new areas affected. Expected duration of intervention 4-6 months
Worst case scenario : Health systems are overwhelmed, and health centres IPC failures increase rate of transmission; nationwide diffusion of the outbreak with neighbouring countries involved. Possible weather events accelerate the spread and hamper containment efforts	• The situation escalates and spreads beyond National capacity to respond with increased number of deaths reported in most districts of Malawi. • Other related health issues like malnutrition and other epidemic outbreaks deteriorate because healthcare system is overstretched • Death toll rises • High risk of contamination of primary health care centres with greater disruption of health services continuity. • Neighbouring countries affected.	• MRCS will launch an emergency appeal through the IFRC and request for international surge capacity and possible ERU deployment

Operational Risk Assessment

As a result of the ongoing Tropical Cyclone Emergency Appeal, the Polio DREF, COVID 19 Risks and the forecasted hunger situation in the country, several MRCS operational staff are currently on the field, and some are engaged in other tasks in support to the ongoing interventions in the districts. To mitigate this MRCS will continue to deploy members of trained National Response Teams (NRTs) to the districts (branches) to closely work with District Health Offices in order to close the gap in coordination and monitoring and ensure efficient service delivery in supported districts. Furthermore, MRCS will hire additional staff and increase the number of volunteers recruited to ensure the smooth implementation of the activities.
MRCS will continue to assess potential risk that could impact this operation ahead of the rainy season.

B. Operational strategy

1. Overall objective
To contribute to the control and reduction of the cholera outbreak in Nkhatabay, Nkhotakota, Karonga and Mzuzu districts targeting 753,869 people for a period of 4 months (September to December 2022).

2. Specific Objectives:

a) To prevent and control the spread of Cholera Outbreak at the community and facility levels in the affected districts, interrupting the chain of transmission.

b) To facilitate improved case management of cholera outbreak at facility and community levels in the affected districts.

3. Lessons learnt from previous disease outbreaks
MRCS has been supporting the ministry of health in responding to Cholera outbreaks in the country with support from IFRC, UNICEF and Partner National Societies. During these operations, MRCS has learnt a number of lessons and these include among others (1) Engagement of local leaders is vital in influencing adherence of cholera prevention and control measures by community members, (2) Social mobilization is a critical tool to enhance behaviour change as well as addressing myths and misconceptions, (3) Engagement and training of Volunteers in Community Based Surveillance and Oral Rehydration Therapy reduces transmission and case fatality rate through community case management. (4) Effective Cholera response coordination is vital as it helps in resource and technical leveraging among government, partners, and its stakeholders.

In addition, previous responses have indicated that Cholera outbreaks are often associated with myths such as that the outbreak is not Cholera, but somehow related to the mining activities which are taking place in the district. As such, past responses indicate the need of an approach that blends clinical management to address the increasing number of cases and a CEA / community engagement approach.

4 Proposed strategies

In response to the current cholera outbreak in the country and based on the previous experiences, MRCS will focus its response on **interrupting transmission and improve case management of Cholera at community and facility levels** in the affected districts. In order to interrupt the transmission, the response will facilitate capacity building and deployment of Branch Transmission Intervention Team, support monitoring of the outbreak evolution through active case finding, strengthen community capacity to identify and refer cholera cases through Epidemic Control for Volunteers (ECV), facilitate Risk Communication & Community Engagement (RCCE) at community level and mass media, support the MoH led Oral Cholera Vaccination campaign through social mobilization activities in high risk districts, and promoting hygiene and sanitation for prevention and control of Cholera.
Considering that this is the first cholera response in the targeted areas, usual EPiC training component will be undertaken as separate 3 days sessions each to ensure relevant capacity building. It is the case for ECV, ORP/ORS, CEA during outbreaks/CREC.

The operation will also improve case management both at facility and community levels through provision of oral rehydration therapy and support with the setup of 4 ORPs (whose number and distribution may be adjusted on the basis of the outbreak evolution). This allocation will also support with the setup of 4 CTUs; the purchase of infection prevention control for the CTUs and provision of Personal Equipment (PPEs); task shifting in health facilities to support nurses to deal with the influx of patients; promote the continuation of breast feeding for mothers suffering from Cholera; and hygiene promotion.

A total of 400 volunteers will be engaged and trained and they will be coordinated to shift between community health system strengthening in the context of the cholera outbreak and support to the CTUs and health facilities. 200 of those volunteers will be trained as Branch Transmission Intervention Team (BTIT) and 200 will be trained also on Community Based Surveillance (CBS) to support early active case finding.

5 The following activities will be implemented under structured response:

5.1. Interrupting the transmission

This operation will support the

- Delivery of training as a full EPiC package in fraction of 3 days trainings per sessions (Training sessions for ECV and ORS/ORP, CBS, CEA during outbreaks/CREC, PFA and PGI) and training of BTIT.
- Deployment of volunteers to support BTIT with active case finding as a contribution to the community-based surveillance, promote Epidemic Control for Volunteers (ECV). All team supported by necessary material.
- Facilitate Risk Communication & Community Engagement (RCCE) at community level and through mass media,
- support the implementation of Oral Cholera Vaccination campaign in high-risk districts and promoting hygiene and sanitation for prevention and control of Cholera.

Details of specific activities below from 5.1.1 to 5.1.10:

5.1.1. Train Volunteers in the affected area in Epidemic Control for Volunteers (ECV) in Cholera prevention and Control: 400 (100 per District for 4 districts) volunteers will be trained for 3 days. The training will focus on equipping volunteers with knowledge and skills in conducting house to house visit in the communities in order to sensitise the communities on the early signs of Cholera disease and the importance of reporting the risk to relevant health authorities.

5.1.2. Provide ECV volunteers with tools, pocket guides for Cholera and visibility materials to support disseminating Cholera prevention and control messages including signs and symptoms, risk factors and prevention measures. IFRC ECV Training manual will be used.

5.1.3. Train 200 (50 members per district) Branch members in Branch Transmission Intervention Teams (BTIT): 200 members will be trained with knowledge and skills to facilitate rapid risk assessment of cholera in health facilities and communities to understand origin of diseases and household, identify potential sources of contamination and use the finding s to break transmission in homes and between homes: and in community shared spaces to identify community risk of public water point contamination.

5.1.4. Train staff, volunteers, and stakeholders on Community Based Surveillance. The training will cover 200 volunteers (50 per district). The training will be facilitated using IFRC training manual and guidelines.

Supervisors' trainings have already been conducted by MoH and will not be included here. The only need of training is for volunteers. It was a national training organized in different districts from February to May 2022, covering training of supervisors in the targeted localities. Supervisors for the activities will be taken from the recent trained supervisors by MoH and briefed on the fundamentals of RCRC, CEA and PGI.

5.1.5 Support deployment of volunteers to undertake door-to-door visits to deliver targeted information on cholera: 400 volunteers will be deployed to support house-to-house visits to sensitize communities on the early signs of cholera to enable early detection, educating household members in Cholera prevention, case management and roles they will play in engaging households on availability and use of sanitary facilities, handling of safe drinking water and hygiene practices. Volunteers will be deployed for 3 days per week for 1 month and will be supported with meals and transport refund where possible. These volunteers will reach 40,000 households.

5.1.6. Support 200 Volunteers (50 per district) 3 days per week for 1 month by providing meals and transport refunds to conduct active case finding as a contribution to the MoH CBS in place in collaboration with Health Surveillance Assistants (HSAs).
The trained volunteers will support primary information on case identification while working hand in hand with HSAs who will take samples for further investigation by health authorities on reports of cases meeting the community case definition.
Under this strategy, MRCS will deploy volunteers to support communities in identifying and alert on potential further transmission of the outbreak through both paper base and use of smart phones.

5.1.7. Conduct community engagement meetings with community leaders, Councillors, legislators and religious leaders (120/district= 480) including enactment existence and enforcement of by-laws: The activity will target influential local leaders and community organisation structures in affected areas and their surroundings to discuss with them on the current risks of cholera outbreak. The purpose is to bring to the attention of the local leaders to lead in sensitizing their subjects and enforce by-laws where they exist and formulate where they don't exit.

5.1.8. 100 volunteers per districts for 10 days will be supported in activities of social mobilization ahead of the MoH led OCV campaign in high-risk districts.

5.1.9. Conduct mass media on cholera prevention and control by:

- Support production and airing of jingles: The project will support the development of jingles tailor made to local languages. The process of the development will engage community radio stations in the targeted districts in collaboration with the ministry of health at all levels. The project will then support airing of jingles in different community radios in the hot sport areas for a period of 3 months. Furthermore, phone-in programs will also be supported where the health professionals will engage the communities through radio to address cholera myths and misconceptions. (4/district=16) (2wice/day for 10 days for 4 jingles=80*4=320.
- Conduct Van Publicity sessions 15 sessions/district. Van publicity.
- Production of banners with Cholera Specific messages (4/district mounted in strategic points).\

5.1.10 Monitoring of rumours and collection of feedback on the response

- Train volunteers in feedback mechanism (100/district).
- Procurement of phones for data collection (3/district=12).
- Volunteers collecting feedback data using paper-based form
- Support Feedback data entry, analysis, and reporting

The information collected will be used to adjust the mass media messages/ CEA approach and to monitor community perception of the response

5.2. Improving case management both at facility and community levels

5.2.1. Training of 480 (100 volunteers plus 20 MoH Health Surveillance Assistants (HSAs) per District for 4 districts) for three days in Oral Rehydration Therapy (ORT). The trainings will equip the staff, volunteers and stakeholders the necessary knowledge and skill they require to help to assess dehydration and provide necessary treatment through provision of ORS. The same volunteers will be trained on safe continuation of breastfeeding in the context of a cholera outbreak. ORS training will be integrated as a same package with ECV training.

5.2.2. Support Volunteers to provide Oral Rehydration Therapy.

The response will support the set up and operation of 4 Oral Rehydration Points. This will require a combination of volunteer support, training in above 5.2.1 activities, ensure procurement of necessary supplies 5.2.4 and a ensure sharing of information through the MoH system in place to branches, and partners.

5.2.3. Support setting up of 4 CTUs (tents, demarcations tapes/mesh, solar lumps etc.) to provide isolation space to Cholera patients. The action will be done as a response to the request by the Ministry of Health as there is inadequate treatment space in most health facilities especially those registering high cases on daily basis. This will be aligned with MoH strategy for the clinical case management.

5.2.4. Procurement of materials to support IPC and Case Management (ORS, Chlorine, gloves, gumboots, and facemasks).

5.3 Water, Sanitation and Hygiene

5.3.1. Support WASH assessment and planning for actions with community using IFRC assessment tools (including KAP surveys, sanitary survey, Water points: The WASH assessments shall include KAP Surveys, Water point surveys to establish the WASH gaps both in knowledge and infrastructure and inform on the number of water points requiring rehabilitation. The assessments will also establish the extent of damage of the Water points. The PQL will lead in the KAP surveys while for the water points assessment the Water engineers from the Ministry of Water and Sanitation with the MRCS WASH specialist shall lead the assessments (1 centrally arranged targeting 4 districts).

5.3.2. Train 160 (40 for each district) SHN teachers (School Health and Nutrition teachers in Primary Schools) on WASH: The action will aim at improving School Led Total Sanitation (SLTS), whereby the school health and Nutrition Teachers shall be trained on WASH and SLTS.

5.3.3. Distribute Chlorine for water treatment: The action will ensure that Chlorine for Pot-to-Pot chlorination is available in the district to ensure that households using unsafe water for drinking are treating the water at point of use.
The project will also support pot to pot chlorination by HSAs and volunteers where HSAs and MRCS Volunteers are distributing the 1% stock solution to the targeted households (through direct distribution or through clustered distribution as per MoH guidelines). The action shall also ensure that HSAs and volunteers are providing hygiene promotion messages and following up on the usage of the chlorine.

5.3.4. Rehabilitation/Upgrading of water points and appropriate systems. The action will rehabilitate / upgrade water points and appropriate systems in the affected 4 districts (planned 5 per district, 20 in total).

6.0. Implementation Enablers

6.1. Protection, Gender and Inclusion (PGI)

The operation will ensure the promotion and participation of men and women including persons with disabilities of different age groups in Cholera awareness activities. A continuous dialogue among the different stakeholders will be fostered to ensure all programmes/sectors mainstream DAPS (Dignity, Access, Participation and Safety) approach ensuring the Minimum Standards on Protection, Gender and Inclusion in emergencies are met based on the identified needs and priorities of humanitarian imperatives on the ground. This operation will ensure all staff and volunteers are briefed on the Code of Conduct and on prevention and response to sexual exploitation and abuse and child safeguarding as they implement Cholera interventions. It will ensure all NS, IFRC, PNS staff and volunteers involved have signed the Code of Conduct. PGI mainstreaming will be done per Minimum PGI standards in Cholera interventions while ensuring that all the data that is collected is disaggregated using SADDD.

6.2. Community Engagement and Accountability (CEA)

The MRCS will ensure that the already developed CEA tools, tailored to the Malawi context, are adopted, and used to collect data relevant for planning CEA approaches and activities during implementation, gather community feedback and make sure of the feedback to generate ownership within the community during Cholera operation. Prior to implementation of this DREF, MRCS will conduct consultative meetings with communities aimed at discussing preferences on feedback channels and the type of questions that they would like to have answers on. Meetings will be done with community feedback sessions. The community will initially be accessed and informed through the community leaders, before planning with them on how to engage the wider community including all components including vulnerable groups. A feedback mechanism will be put in place to get the necessary feedback from community members on issues related to the overall Cholera response. This feedback will be shared at different platforms at community, district and national including the technical and sub technical working groups that have been established under the cholera response. The community members in the target areas will be involved as fully as possible in the planning stages and throughout the response to increase their ownership of the response sharing clear information about response activities, selection criteria and distribution processes with communities through community meetings and door to door activities. Feedback and complaints on Cholera interventions will also be collected through community volunteers, community meetings, radios, focus group discussions and suggestion boxes and responses provided through community meetings and on a case-by-case basis where it is a sensitive issue, or a concern shared by one person provided directly to the individual. Frequently Asked Questions (FAQ's) will be developed in collaboration with ministry of health and shared with volunteers so they can address frequent questions, concerns and beliefs that are seen from the feedback data.

As specify in the CEA section, the feedback mechanisms and tools for MRCS are in place or already developed and used. They will need to be further adapted in the areas of the operations. Also, since it's the first cholera operation in these Districts there are CEA and PGI induction and training/refresher to the volunteers during the ECV training.

7.0. Operational Support Services

7.1. Human Resources

Overall, 100 volunteers will be engaged per district in the Cholera operation to support the various sectors. Some of the volunteers will be selected amongst the National Response Team members and will support in assessments, coordination and response. Facilitation for the trainings will be provided by MRCS and Ministry of Health. This will ensure that effective response preparedness and National Society surge capacity mechanism is maintained. Insurance for volunteers is covered in this operation as well as their perdiem for each deployment. The operation will utilise staff from running projects but in districts without a running project, a project officer will be recruited. The overall operation will be led by National Society Director of Programs and Operations.

Supervisors and HAS trained by MoH will be engaged in the response as volunteers' supervisors. They will be briefed as well on principles, CEA and PGI guidance. HAS will act as supervisors and will thus receive RCRC fundamental volunteers briefing with CEA, PGI and movement principal basics. For each activity, supervisors will be selected from the HAS recently trained by MoH.

To ensure proper technical capacity is in place, a NDRT from National society with EPiC and CBS skills will be deployed for the whole duration: 4 months.

7.2. Planning, monitoring evaluation and reporting (PMER)

With the support of the IFRC PMER, the MRCS Planning Quality and Learning department will support the DREF operation for Cholera by providing technical inputs and support to the health department on planning, continuous monitoring, assessment results and information management. They will also support the development and implementation of assessments in this operation. Monitoring reports shall be used to make proper adjustments to the plans and inform on-going actions. IFRC will undertake three technical support visits to the National Society. At the end of the DREF, the PMER team will lead a joint lesson learnt workshop with all stakeholders to document lessons that can be incorporate in future such operations. The lessons learnt session will be built on the previous lessons drawn from other Cholera responses and will include a two day debrief of volunteers with the branch development /NSD department as well.

7.3. Communications

MRCS communication department will ensure the media coverage and visibility of the operation through press article during the implementation, photos, and video documentary. Information related to the operation will also be disseminated through MRCS social media pages.

7.4. Logistics and supply chain

IFRC, working in close collaboration with the MRCS Logistics and Supply Chain Department, will provide technical support in line with operational priorities and IFRC procedures.

7.5. Procurement plans

Local procurement will be carried out in accordance with the IFRC and MRCS standard procurement procedures. Current procurement plans will include procurement of health and WASH items for ORP, material for CTU etc. A procurement plan to be developed to ensure timely support to the operation. MRCS has warehouse capacity if needed.

7.6. Transport and fleet needs

The operation has budgeted costs for local hire of vehicles to ensure transport needs are met during the operation

7.7. Security Environment Review of Malawi

Malawi has a YELLOW security phase all over the country meaning that the risk level from a variety of risk factors is acceptable and normal within the context.

Major cities, including the capital Lilongwe and Mzuzu, experience higher rates of crime compared to the rest of the country, particularly bag-snatching and mugging. The crime level remains at moderate level though. In addition, urban areas are susceptible to sporadic outbreaks of social unrest. Continued economic hardship for the urban poor and widely publicised corruption scandals provide an underlying climate conducive to public protests in the foreseeable future. Precedent shows that any such demonstrations entail the credible risk of violence between protesters and the security forces.

Roads tend to be in poor condition, which, in combination with other factors (e.g. the presence of animals and people on the sides of roads, vehicles traveling after dark without lights), makes for dangerous driving conditions. Road conditions are particularly poor during the country's rainy season, resulting in washouts and potholes. Driving in Malawi can be hazardous. Malawi has one of the highest rates of road accidents on the African continent. Avoid driving after dark.

Relating to safer access concern, one of the main benefits of the MRCS is the nationwide recognition of the National Society. This has made it easy to access affected communities.

To reduce the risk of Red Cross Red Crescent personnel falling victim to crime, violence or road hazards during this operation, active risk mitigation measures must be adopted. This includes situation monitoring and implementation of minimum-security standards. Measures will be communicated to staff and volunteers. IFRC security plans will apply to all IFRC personnel throughout. All RCRC personnel actively involved in the operations must have completed the

respective IFRC security e-learning courses (i.e., Stay Safe Level 1 Fundamentals, Level 2 Personal and Volunteer Security in emergencies, Level 3 Security for Managers).

The Country is MSR (Minimum Security requirements) compliant within the status of non-permanent IFRC presence – having one Expanded Security Welcome Brief document. The team/s to be deployed to Lilongwe under direct guidance of the Regional Security Unit to develop the full MSR pack to maintain set MSR Policy standards while upholding the IFRC Duty of Care principles.

C. Detailed Operational Plan

Health
People targeted: 753,869
Male: 371,808
Female:382,061
Requirements (CHF): 220,745

Needs analysis: With the escalating spread of the disease, prevention of cholera in the affected and neighbouring districts has become critical. Risk communication and health education is required in the targeted areas. In addition, gaps have been identified in identification and management of cases, leading to spread of the disease. Thus, there is need to provide ORPs which will be linked to CTUs to support case management.

Population to be assisted: 753,869 people supported in Nkhatabay, Nkhotakota, Karonga and Mzuzu will be reached.

Programme standards/benchmarks: The operation will seek to meet SPHERE and WHO standards. To ensure equal access to all targeted persons to the support, the operation will also see to meet Minimum standards for protection, gender and inclusion in emergencies

P&B Output Code	**Health Outcome 4: Transmission of diseases of epidemic cholera potential is reduced**																	*% of targeted population reached with community-based disease control actions (Target: 80%)* *# of cases identified in the community and referred to CTU/ORP by volunteers (100)*
	Health Output 4.4: Transmission is limited through early identification and referral of suspected cases using active case finding.																	*# of volunteers & HSAs trained on CBS/RCCE: (120/district= 480 volunteers & 80 HSAs).* *# of people reached with awareness messages on cholera (Target 753,869 people)* *# Community Leaders trained on Cholera awareness (480)* *# of radio jingles produced Target: 10 radio shows)* *# of people in Community structures reached (Target: 10,000).* *# of mobile messaging sessions conducted (Target: 40)*
	Activities planned / Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
AP022	Train Volunteers and HSAs in the affected area using EPIC package in Epidemic Control for Volunteers (ECV) in Cholera prevention and Control: 480 (100 volunteers and 80 HSAs per District for 4 districts)																	
AP022	Train Volunteers and HSAs in the affected area using EPIC package in CBS (200 (50 vols per districts)) and BTIT (200 (50 vols per District for 4 districts)).																	
AP022	Train Volunteers and HSAs in the affected area on ORT and ORP management, 480 (100 volunteers and 80 HSAs per District for 4 districts)																	

AP022	Train 400Volunteers and 80HSAs in IPC in CTUs and safe continuation of breastfeeding. (100 volunteers and 80 HSAs per District for 4 districts)																	
AP021	Material support to HSAs during active case finding																	
AP021	Provide ECV volunteers with tools, pocket guides for Cholera and visibility materials to support disseminating Cholera prevention and control messages including signs and symptoms, risk factors and prevention measures. (Includes t shirts, bibs and bush jackets)																	
AP022	Support 200 Volunteers (50 per district) 3 days per week for 1 month by providing meals and transport refunds to conduct active case finding of cholera in collaboration with HSAs.																	
AP022	Conduct community engagement meetings with community leaders, Councillors, legislators and religious leaders (including enactment existence and enforcement of by-laws. Conducted twice in each district.																	
AP022	Support volunteer to conduct house to house visits to educate household members in Cholera prevention control and case management: 400 Volunteers (100 per district)																	
AP022	Support volunteers to conduct social mobilization for OCV campaign in high-risk district (100 volunteers for 10 days).																	
AP022	Conduct mass media on cholera prevention and control by: - • Support development and airing of jingles. • Conduct public addressing of communities through loudspeakers mounted on vehicles • Production of banners with Cholera Specific messages (4/district mounted in strategic points).																	
AP022	Volunteers collecting feedback data using paper-based form. Support Feedback data entry, analysis and reporting																	
P&B Output Code	**Health Outcome 4: Transmission of diseases of epidemic potential is reduced**																	
	Health Output 5.1: Cholera cases are managed in the community, with referral established for severe cases					*# of volunteers & HSAs engaged in ORP management and CTU (Target: 400 volunteers & 80 HSAs)* *# of ORPs setup and linked with Treatment Centres (Target: 4)* *# of ORPs supported with IPC material and PPEs (Target: 4)* *# CTUs setup (4)* *# of CTUs supported with chlorine and other materials (4)* *#of people supported with ORT (1000)* *#of people supported during the CTU activities (1000)*											
	Activities planned 7 Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
AP022	Training of 480 (100 vols and 20 HSAs per 4 districts) volunteers in Oral Rehydration Therapy (ORP) and setting up of Orla Rehydration Points (ORPs).																	
AP022	Support 400 Volunteers to provide Oral Rehydration Therapy over 10 days																	
AP022	Support setting up of 4 CTUs (tents, demarcations tapes/mesh, solar lumps etc.) to provide isolation space to Cholera patients.																	

AP022	Support setting up of ORPs with material, volunteers deployment and data management																
AP022	Procure and distribute PPE Materials and Supplies to support IPC and Case Management (ORS, Chlorine, gloves, gumboots, and facemasks).																

Water, sanitation and hygiene
People targeted: 493,587
Male: 244,916
Female: 248,671
Requirements (CHF): 43,934

Needs analysis: The rising cholera cases being reported is aggravated by lack of safe drinking water and adequate sanitation facilities. To improve access to water, sanitation, and safe hygiene practices, MRCS will conduct community level campaigns and sensitization on water sanitation and hygiene practices, provide community hygiene promotion to households, strengthening WASH knowledge and best practices. Specific hygiene related activities to support the wider health and hygiene promotion would be carried out in communities identified to be most at risk.

Population to be assisted: 496,587people supported in Nkhatabay, Nkhotakota, Karonga and Mzuzu will be reached.

Programme standards/benchmarks: The operation will seek to meet SPHERE and cluster standards. Community hygiene promotion will be done using the PHAST (Participatory Hygiene and Sanitation Training) approach in the communities in the target states. Operation will also seek to meet the Minimum standards for protection, gender and inclusion in emergencies.

P&B Output Code	**WASH Outcome: Immediate reduction in risk of waterborne and water related diseases in targeted communities**																
																	% Households reached with key messages to promote personal and community hygiene (Target: 100%)
	WASH Output: Hygiene promotion activities which meet Sphere standards in terms of the identification and use of hygiene items provided to target population																*# of WASH assessments: 4 (1 per district)* *# of people assisted with water purification tablets and hygiene promotion (Target: 496,587)* *# of SNH Teachers trained on WASH (Target: 30)* *# of Rehabilitated Water points: 20*
	Activities planned / Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
AP030	Support WASH assessment and planning for actions with community using IFRC assessment tools (including KAP surveys, sanitary survey, Water points).																
AP030	Provision of hygiene promotion messages: The action will ensure that chlorine for																
AP030	Distribution of chlorine for water treatment																
AP030	Pot-to-Pot chlorination is available in the district to ensure that households using unsafe water for drinking are treating the water at point of use.																

AP030	Train SHN teachers on WASH: The action will aim at improving School Led Total Sanitation (SLTS), whereby the school health and Nutrition Teachers shall be trained on WASH and SLTS.																	
AP026	Rehabilitation/Upgrading of water points and appropriate systems. The action will rehabilitate / upgrade water points and appropriate systems in the affected 4 districts.																	

Strategy for implementation

Requirements (CHF): 127,335

P&B Output Code	**Outcome: Improved NRCS capacity to ensure that necessary ethical and financial systems and structures, and required skills to implement efficiently and effectively** **Output: Volunteer's protection and compliance to RCRC principles and SOPs is ensured**					*# of volunteers engaged to support Cholera prevention & Control: 400)* *#of insured volunteers mobilised for this response (400)* *#of volunteers confirming that they are briefed or have undergo the minimum response standard role, security training for volunteers, code of conduct etc (400)*											
	Activities planned / Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
AP040	Insure 400 volunteers (100 per district) supporting the operation.																
AP040	Induction for volunteers engaged on the RCRC Movement and key institutional documents i.e., Code of Conduct, Volunteer Policy, PSEA Policy, safer access and roles and responsibilities.																
P&B Output Code	**Output: National Societies have the necessary corporate infrastructure and systems in place**					*# of NRTs deployed (Target: 4)* *# of Monitoring visits conducted by regional health coordination (target: 01)* *# of coordination meetings conducted (Target: 10)* *# Technical support visits conducted (Target:8)* *# of NS monitoring missions conducted (Target: 6)*											
	Activities planned / Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
AP042	Support Project Inception and Exit meetings																
AP042	Support District Coordination Meetings (WASH, PHEMIC and Health Cluster technical Working Group Meetings).																
AP042	Support Coordination meetings at Community level (review meetings with MRCS Volunteers, HSAs and Community structures).																
AP042	Support National & District Level Monitoring for Cholera interventions																
AP042	Conduct Lessons Learnt Workshop																
P&B Output Code	**Outcome: Effective and coordinated international disaster response is ensured** **Output S2.1.1: Effective and respected surge capacity mechanism is maintained.**							*% target population supported (Target: at least 80%)* *# of IFRC delegation missions conducted (Target: 4)*									
	Activities planned / Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
AP049	IFRC Harare Cluster technical Support and Regional Office through remote and presential monitoring. Include missions (Epidemic Control Officer, CEA Officer and Health Officer)																
AP084	IFRC Malawi Office Technical Support																

Funding Requirements

Overall funding requested for implementation of this operation is **CHF 392,014** as detailed in attached budget, to be spent within a period of four months.

International Federation of Red Cross and Red Crescent Societies

all amounts in Swiss Francs (CHF)

DREF OPERATION

MDRMW017 - MALAWI - CHOLERA

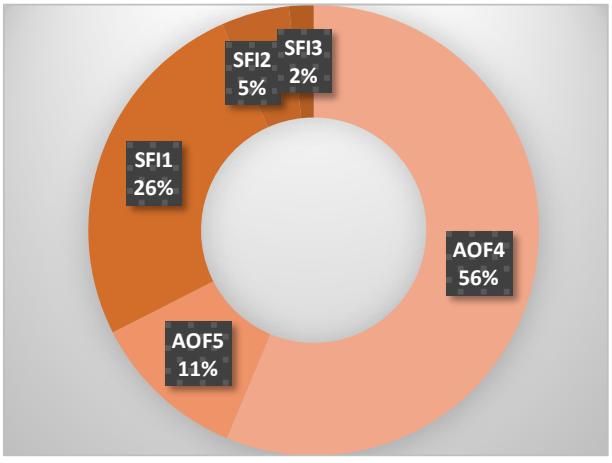
24/08/2022

Budget by Resource

Budget Group	Budget
Shelter - Relief	14,787
Water, Sanitation & Hygiene	29,193
Medical & First Aid	9,263
Teaching Materials	20,615
Relief items, Construction, Supplies	**73,858**
Transport & Vehicles Costs	31,144
Logistics, Transport & Storage	**31,144**
Volunteers	97,626
Personnel	**97,626**
Workshops & Training	66,993
Workshops & Training	**66,993**
Travel	47,465
Information & Public Relations	22,845
Communications	4,836
Financial Charges	3,236
Other General Expenses	20,085
General Expenditure	**98,467**
DIRECT COSTS	368,089
INDIRECT COSTS	23,926
TOTAL BUDGET	**392,014**

Budget by Area of Intervention

AOF1	Disaster Risk Reduction	
AOF2	Shelter	
AOF3	Livelihoods and Basic Needs	
AOF4	Health	220,745
AOF5	Water, Sanitation and Hygiene	43,934
AOF6	Protection, Gender and Inclusion	
AOF7	Migration	
SFI1	Strengthen National Societies	101,237
SFI2	Effective International Disaster Management	19,173
SFI3	Influence others as leading strategic partners	6,925
SFI4	Ensure a strong IFRC	
	TOTAL	**392,014**



Contact information

Reference documents

Click here for:

- Previous Appeals and updates
- Emergency Plan of Action (EPoA)

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How we work:

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

The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:

Save lives, protect livelihoods, and strengthen recovery from disaster and crises.

Enable healthy and safe living.

Promote social inclusion and a culture of non-violence and peace.