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OPERATION UPDATE

Country: Malawi Cholera

 International Federation
of Red Cross and Red Crescent Societies

DREF operation n° MDRMW017	Glide number: EP-2022-000298-MWI
Operation update No 1 Date of Issue: 22 December 2022	Timeframe covered by this update: 15 September 2022 to 14 December 2022
Operation start date: 15 September 2022	Operation timeframe: 7 months and end date: 30 April 2023.
Funding requirements: CHF 748,286	DREF amount initially allocated: CHF 392,014
Number of people affected: 12,854 cases countrywide	
Number of people assisted: 432,420 in 4 initial targeted Districts: Nkhatabay, Nkhotakota, Karonga, Mzuzu	Revised Target: 840,227 in 5 Districts: Nkhatabay, Nkhotakota, Karonga, Mzuzu and Salima (new).
Red Cross Red Crescent Movement partners currently actively involved in the operation: IFRC, Swiss and Danish Red Cross Society	
Other partner organizations actively involved in the operation: UNICEF, WHO, and the Malawi Government (Department of Disaster Management Affairs and Ministry of Water DoDMA, MoH, Clusters)	

Summary of major revisions made to emergency plan of action:

Malawi Red Cross Society (MRCS) is publishing this update to inform on the actions since the launch of the operation in September 2022 and update stakeholders on the changes resulting from the deterioration of the context on operational imperative.

This operation update is driven by the worsening of the cholera outbreak which has significantly spread over time in terms of magnitude and geographical area. There has been a 95% increase in the number of cholera cases in November (4,766 confirmed cases) compared to October (2434 confirmed cases). Based on this, on 5 December 2022, the State President declared the 2022 Cholera Outbreak a "Public Health Emergency". As of 5 December, the epidemic included a cumulative total of 11,462 cholera cases with 332 deaths (CFR 2.9%) and **12,854 cases and 47 more deaths on 14 December 2022**. This translates to urgent need to strengthen and expand the response engaged in September.

MRCS will continue to engage the Ministry of Health and DoDMA in implementing immediate and long-term cholera control, response, and preventive measures. The Malawi Government also plans to strengthen the roles of MoH and DoDMA in the next phase of the response. The MRCS additional support will help ensure that lives continue to be saved, and a resilient health system is maintained during and beyond the current outbreak.

The proposed revisions are as below:

- Increasing the target district to five to include Salima from the initial 4: Nkhatabay, Nkhotakota, Karonga and Mzuzu districts. Movement coordination also put in contribution to support Southern districts where outbreak is also spreading.
- Budget is increased from CHF 392,014 to CHF 748,286. Second allocation is CHF 356,272 considering that CHF 226,817 is already implemented by the National Society.
- Scale-up of the MRCS through this DREF include:
 - Extension of the Emergency Response Team from 580 to 796 (580 volunteers and 216 HAS) to improve coverage for interrupting transmission and improving case management of Cholera at community and facility levels in the affected districts. support the MoH led Oral Cholera Vaccination campaign through social mobilization activities in high-risk districts,
 - Deployment of 2 surge profiles to support the technical capacity at National Society and Delegation level, one supported under this DREF and another by regional surge unit.
 - Improvement and extension of case management both at facility and community levels through a provision of oral rehydration therapy - support with the setup of 2 Oral Rehydration Points (ORPs) in each of the 5 districts (for a total of 10 ORPs), district versus 4 (one per four districts), initially planned.

- Support with the setup of a total of 10 CTUs. 4 already in place for which additional material will be provided and 1 new for Salima. This support includes provision of tents and temporary latrines, procurement of infection prevention control materials and provision of Personal Equipment (PPEs) for volunteers and HSAs; Task shifting in health facilities to support nurses to deal with the influx of patients.
- Reinforce the social mobilization and awareness activities by engaging more community leaders and through volunteers and mass communication activities extended to 4 months with more visual material, 15 painting, 50 Van publicity, 1500 airing jingles and IEC to be produced and diffused.
- As a new activity based on the need identified, MRCS will include promotion of the nutrition dietary diversification and breastfeeding for children under 2 as a safe fluid intake in cholera affected areas and safe continuation of breast feeding for mothers suffering from Cholera; infant and young child feeding practices
- Increased support to WASH activities and strengthened water management, access to water and WASH hygiene prevention toward the rainy season with:
 - Ensuring rehabilitation of 25 boreholes instead of 9 initially planned.
 - Support 3 boreholes construction by MoH with Drilling and materials.

MRCS will strengthen the response supervision with dedicated operation coordinator and wash officer to be mobilized to support community health response system strengthening.

A. SITUATION ANALYSIS

Description of the disaster

Malawi is currently experiencing one of its worst cholera outbreaks in years. The first case was registered in Machinga district in the Southern region of Malawi on 2nd March 2022. The Malawi Ministry of Health declared the cholera outbreak on 3rd March 2022, due to the increase in number of confirmed cases. The cholera outbreak, initially limited to the southern part of the country, has now spread throughout the country. All the 29 health districts have reported Cholera cases since the confirmation of the first case this year.

Generally, the outbreak is increasing over time in terms of magnitude and geographical spread. There was a 95% increase in the number of cases in November (4766 cases) compared to October (2434) cases. On 5th December 2022 the State President declared the 2022 Cholera Outbreak as a “Public Health Emergency”. A cumulative total of 11,462 cholera cases including 332 deaths (CFR 2.9%) have been reported in Malawi (Table 1). The Cross-border cases are on the rise, for instance, the 297 cases reported in Nsanje district, 81 (27.3%) represent a cross-border spread from Mozambique, out of 141 cases reported in Likoma district, 60 (42.6%) represent a cross-border spread from Mozambique and Out of the 33 cases reported in Mwanza, 7 (21.2%) represent a cross border spread from Mozambique. From the week 33 at the launch of this operation to the last SITREP, the outbreak has increased as follow:

Table 1: Distribution of cases by district WEEK 33 (launch of the operation) to 5 December 2022.

District	Cumulative cases Week 33	Cumulative cases SITREP 5 th December	
1	Mangochi	1	2589
2	Nkhatabay	349	1473
3	Salima	0	1275
4	Nkhotakota	36	1146
5	Rumphi	0	1003
6	Karonga	0	831
7	Blantyre	500	772
8	Mzimba North	0	463
9	Nsanje	289	298
10	Chikwawa	130	224
11	Lilongwe	1	205
12	Neno	127	189
13	Dedza	0	186

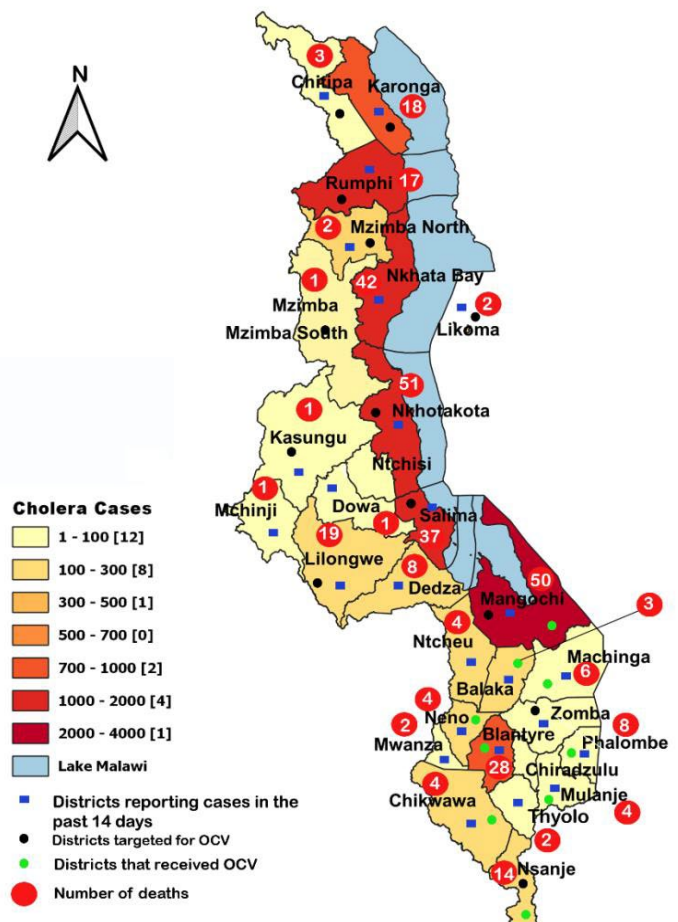
14	Likoma	0	141
15	Ntcheu	0	127
16	Balaka	12	104
17	Chitipa	0	87
18	Machinga	16	81
19	Mulanje	6	54
20	Thyolo	0	49
21	Phalombe	0	44
22	Mwanza	0	33
23	Chiradzulu	5	19
24	Mchinji	0	19
25	Zomba	0	14
26	Dowa	0	13
27	Kasungu	0	10
28	Mzimba South	0	7
29	Ntchisi	0	6
Total		1,467	11,462

According to epi Week 48 report, Mangochi district registered the highest incidence rate at 35 per 10,000 population while Mzimba South, Ntchisi, Chikwawa, Neno, Zomba, Dowa, Likoma, Phalombe, Thyolo, Kasungu and Mwanza district recorded the lowest. On 14 December, a total of 379 deaths (CFR 2.9%) have been registered in Malawi, out of these 59 deaths were at community level (representing 17.8%). The most deaths have been reported in Nkhatakota district with 51 deaths. The outbreak moved along the lake shores and from current evolution, lake areas tend to be the most affected as it has most of the WASH issue driven this deterioration. Also, through fish trade and interaction between fishermen and the communities.

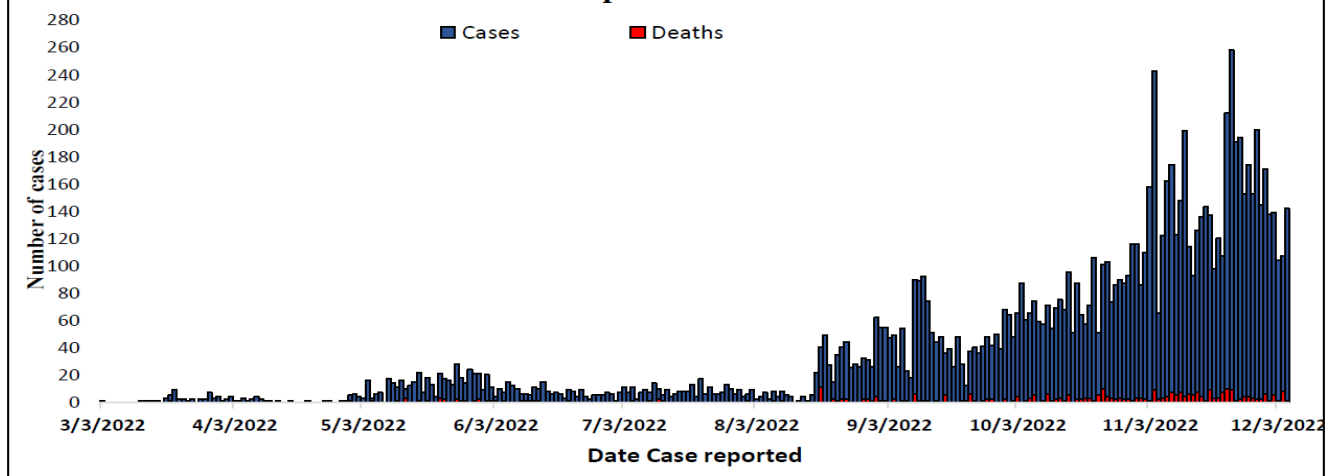
Cholera cases and Deaths by month

Since the beginning of the outbreak, the age group 21 to 30 years is the most affected (25.4%) followed by the 11 to 20 age group (21.9%). Of all the cases, 5,131 are females representing 44.8% and 6,331 are males representing 55.2% of the cases.

MAP OF MALAWI



Malawi Cholera Epi Curve from 3 March to 4 December 2022



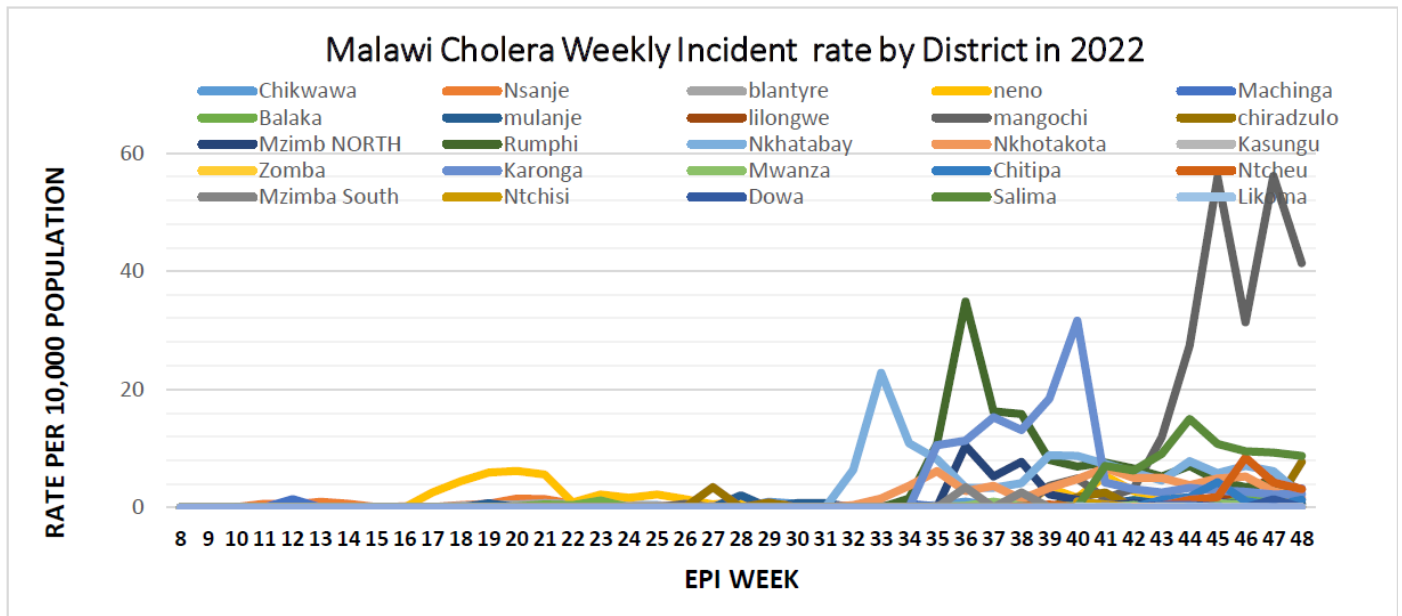


Figure 6. Weekly cholera incident rate by district

Summary of response

Overview of Host National Society

Malawi Red Cross Society (MRCS) continues to support the Cholera response in multiple districts through various funding. To leverage on the response with available funding, these interventions are integrated in the normal MRCS projects and MRCS is also planning to cover WASH prevention with other partners support in anticipation to the floods in flood-prone districts.

In the targeted districts under this DREF, MRCS has been working hand in hand with the District Health Offices in the cholera affected districts by undertaking several activities. The main actions in response include: Risk Communication and Community Engagement (RCCE) at household and community level; Deployment of volunteers to support with active case finding; Oral Cholera Vaccination campaign in high-risk districts (Mangochi); Capacity building and training of Volunteers, health workers, Health Surveillance Assistants Village Health Committees on Cholera Prevention and Control concepts; Provision of critical non-medical cholera prevention and control supplies to cholera treatment centers. These include WASH NFIs; soap, gloves, gumboots, aprons, ORP kits, cholera beds, ORS.

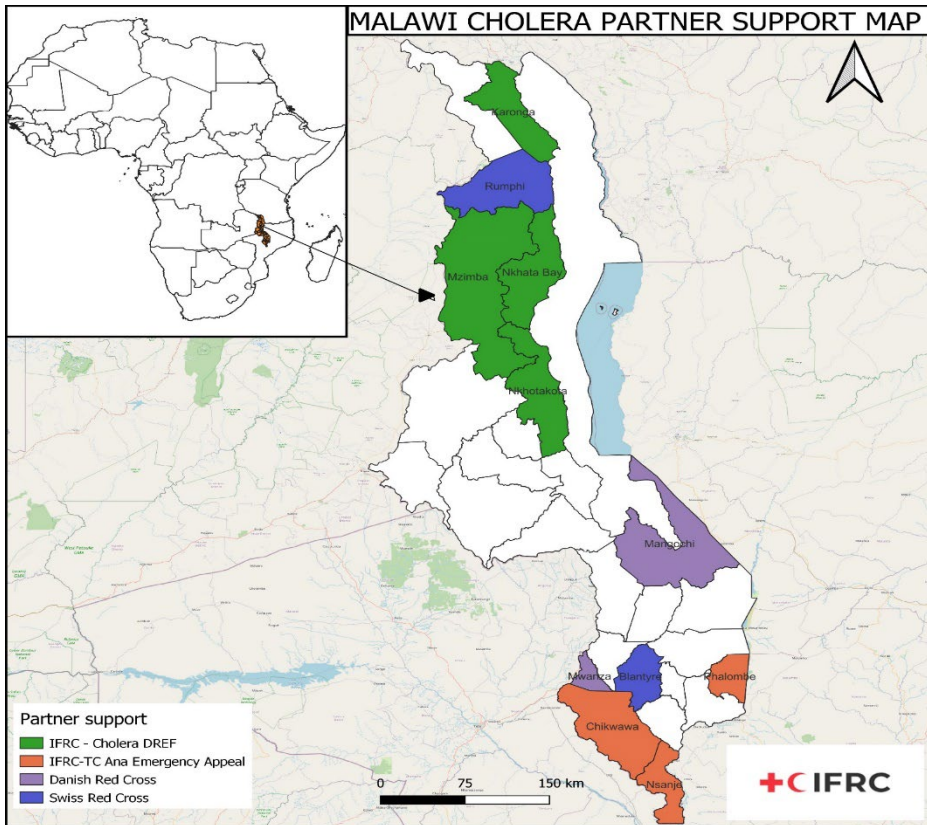
MRCS under this DREF operation has ensured an inception meeting was completed at the launch of the operation. MRCS completed and achieved the following actions from September to 15 December 2022 in the 4 initial targeted districts:

Trainings and capacity strengthening already trained are 419 volunteers and 216 HSAs

- Completed Trainings of 419 Volunteers and 216 HSAs in modules of EPIC package include for a total of 9 days trainings:
 - 100 volunteers and HSAs trained on Epidemic Control for Volunteers (ECV),
 - 200 volunteers and CBS as part of the Epic package (200 (50 + 10 per district) and BTIT (200 (50 +10 per district) for 3 days
 - 400 volunteers (100 per district) plus 80 HSAs trained for 3 days in epidemic prevention and control in CTU. 7 sessions were needed to complete all the trainings in the different districts.
 - Training of 480 volunteers and HSAs (120 per district) in Oral Rehydration Therapy (ORT) and setting up of Oral Rehydration Points (ORP).
 - Train volunteers and HSAs in feedback mechanism (120/district). To be able to identify issues, myths, and misconceptions from their communities

Social mobilisation and awareness reached a total 432,420 people

- Social mobilisation door to door was conducted since October by 400 volunteers for HH visits to educate household members in Cholera prevention, control, and case management. 57,738 people reached.
- Conducted five (4) awareness and message diffusion on cholera activities with the visual support of educational tools procured and distributed to volunteers.



- Provide to ECV volunteers, HAS and branches staff involved with PPE and visibility: pocket guides for Cholera and visibility materials includes t shirts, bibs, bush jackets.
- Mobilisation of 20 supervisors and 200 volunteers (teams of 24 people mobilised per districts) to support active case finding in contribution to the MoH CBS.
- Conducted 160 meetings to engage key stakeholders and communities' traditional and local leaders, Councillors, legislators, and religious leaders. They have also been supportive in inclusion of enactment existence and enforcement of by-laws.
- Supported development and airing of jingles has started and is ongoing
- Conducted Van Publicity sessions 10 sessions/district (Public

Address system through loudspeakers mounted on vehicles) disseminating messages on Cholera – ongoing

- Started the production of banners with Cholera Specific messages (4/district mounted in strategic points).

Support to the case management system

- Conducted WASH assessment and planning for actions with community using IFRC assessment tools “
- Supported Volunteers to provide Oral Rehydration Therapy and OCV (400 volunteers for 10 days) – Partly
- Supported setting up of CTUs (procurement of tents, demarcations tapes/mesh, solar lamps, Chlorine for water treatment to CTU: etc.) to provide isolation space to Cholera patients. – Done
- Procurement and positioning of material to support ORP point established by MoH with ORS, Gloves Heavy Duty, Gloves, gumboots – completed

WASH activities

- Started the rehabilitation/Upgrading of water points and appropriate systems (5 per district).
- Awareness started from October.

At national level, MRCS has a pool of trained National Response Team (NRT) members specialized in different fields, include epidemic response¹ and ready to support the expansion of the response.

Overview of Red Cross Red Crescent Movement in country

- Nkhatabay, Nkhotakota, Mzuzu, Karonga and Salima with DREF funding since the launch of MDRMW015 operation.
- Rumphi, Salima, Blantyre and Mangochi districts through existing programs with movement partners like IFRC, Danish Red Cross, and Swiss Red Cross
- Tropical Storm Ana Emergency Appeal, MRCS through the IFRC TC Ana Appeal contributed to the cholera response in the Phalombe, Nsanje and Chikwawa districts in prevention of and response to any cholera outbreaks. The activities include awareness raising and message dissemination on WASH activities under the appeal. This includes integration of cholera messages in prevention to break transmission chains at household and community level through the Branch Transmission Intervention Team approach.
- Danish Red Cross funded activities in Community Resilient Project (COMREP) districts. With activities such as, Integrated Community Based Health Project (ICBHP), First Aid, Mobile Outreach Clinics and Blood Donor Recruitment (BDR) by integrating message dissemination on cholera in the normal activity implementation.

¹ More details in the EPoA [MDRMW015](#)

The IFRC Harare Cluster 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. This under the current Cholera DREF MDRMW017 that targeted four districts reaching 290,080 people.

The Danish Red Cross and Swiss Red Cross are implementing a Cholera Response, with the aim to contribute to the prevention and control of the Cholera Outbreak in Mangochi, Chikwawa and Mwanza districts targeting 461,061 people for a period of five months (November 2022- March 2023). While Swiss Red Cross is targeting the districts of Rumphi and Blantyre targeting 650,230 people for a period of 4 months (September to December 2022).

Overview of non-RCRC actors in country

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

- WHO has provided technical support in OCV campaign in targeted districts including Lilongwe, Nsanje, Salima Nkhotakota, Kasungu, Nkhatabay, Likoma, Chitipa, Karonga, Rumphi, Zomba, Blantyre, Mzimba South and North from 28 November to 2 December 2022. The vaccination capacity was supported by WHO to Government with 2.9M vaccine provided. The number of administrated vaccines is not yet available.
- WHO continues to support the Malawi Government with Technical support in the Cholera response.
- UNICEF is working with district and partners to support rolling out of Risk Communication and Community Engagement. Provision of mobile latrines in the camps and Installation of prefabricated latrines in 5 camps.
- MSF supported setting up of CTC at Koche Health Centre in Mangochi and continue provide technical support on case management and IPC in affected districts. Deploy surge teams (Clinical and Nursing) to support the districts in case management in CTUs in the event of upsurge in cases
- Evidence Action is testing the implementation of chlorination points at boreholes

Government Actions

Since the declaration of the outbreak, the Malawi Government through the Ministry of Health, Department of Disaster Management Affairs and Ministry of Water has taken several actions as follows:

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

Coordination of actors in country

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

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

Needs analysis, targeting, scenario planning and risk assessment

Needs analysis

Since the onset of the first cases in March, MRCS in alignment with government priorities and plans. At the launch of the operation, the number of cases was 1,736 in 12 districts. 753,869 people were at risk in September 2022.

Since November, there has been a significant increase in the number of cases and high case fatality rate. 11,462 cases countrywide have been registered as of 5 December and 12,854 people on 14 December. The situation is expected to continue deteriorating until the end of the rainy season (November to March). At this stage, the outbreak is reported in all the 29 districts across the nation with only 4 out of the 29 districts have managed to contain the spread so far. This will negatively affect the already overwhelmed national health systems. The country count 11 most affected districts with a worsening trend as detailed below (target in orange):

Districts	05-Oct		05-Nov		05-Dec		14-Dec	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Nkhatabay	840	21	1,168	33	1,473	42	1,492	42
Nkhotakota	430	14	849	41	1,141	51	1,162	51
Salima	-	-	514	7	1,275	37	1,443	41
Blantyre	605	24	659	26	772	28	877	33
Mzuzu	387	1	423	3	463	3	464	2
Karonga	307	6	619	14	831	18	857	21
Nsanje	296	14	297	14	298	14	299	14
Chikwawa	180	4	217	4	224	4	227	4
Neno	140	2	183	4	189	4	189	4
Rumphi	556	10	833	15	1,003	17	1,027	17
Mangochi	-	-	428	12	2,589	50	3,332	65
Cumulative of 29 Districts	3,891	110	6,655	198	11,453	332	12,854	379

Key red flags are as follow:

- Many facilities do not have the PPE materials which pose the risk of Cholera to both Volunteers and the HSAs, as they support at the camp/treatment centres.
- The delay in addressing the risk factors of the outbreak such as provision of safe drinking water especially in the hotspot areas of is leading to increased cases and deaths, thus making it difficult to contain the outbreak
- Wide spreading of the outbreak within a short period of time and the near coming rainy season poses a risk in terms of spreading of the disease

Multiple factors are contributed to this situation and this operation will take it into consideration to scale-up and adapt his response.

Cholera Transmission Risk Factors:

- WASH as driving transmission factor

The main risk factors contributing to the occurrence of new cholera cases are unsafe water source, open defecation, (low latrine usage), poor food hygiene and contact with cholera cases. The areas around the lake tend to be the most affected also due to the presence of large fishing communities in which living, and sanitation conditions are poor, and where safe water availability is scarce. Fishing communities tend to have higher risk of drinking water from the contaminated lake. The Epidemiological report of 5th December shown that 55% of male are affected vs 45% of female aligned with the most exposed group which are fisher men in some districts. Possible increased of fish market and movement during the holiday season could bring more exposure to the already affected communities.

MRCs are cognizant of the sporadic nature of the spread of Cholera across all districts in the country, general poor sanitation across Malawi, and migration of fishermen along the lakeshore from one district to another, posing a threat to increased spread of the outbreak.

As part of the need analysis, MRCs have conducted an assessment with MoH on WASH conditions in November. The outcomes of that being key best practices, red flags, gaps and key recommendations driven the revisions of this operation. WASH capacity of NS and WASH as a driving factor of this outbreak. The rapid assessment recommended supporting the government with materials to drill 3 boreholes in Nkhatabay (Tukombo area). Additionally, there is a need to support provision of shallow wells to the fishing communities; support drilling of boreholes since many people are drawing water from the streams and the lake in the cholera hotspots. There is low latrine coverage in the areas and there is a need to support construction of latrines in these communities as a hygiene promotion initiative. There is a need for awareness raising in the lakeshore communities on dangers of open defecation and innovative ways of constructing latrines along the lakeshore.

ii. Gap of existing response system: inadequate and long-distance health system and response

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). Most of the deaths occurred while in the communities or at health facilities after presenting at the facilities late for treatment. The situation is exerting a lot of pressure on the already constrained health system, which is currently running Polio vaccination campaigns, and managing the impacts of Tropical Cyclones Ana and Gombe as well as the COVID Pandemic.

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. The country is now in lean season where access to food is a big challenge. Also, it was observed that large communities of IDPs (displaced by the cyclone) are still living in floodable areas with very poor access to water and sanitation facilities. They are concentrated mainly in the South, but this situation has badly affected the general health capacity with multiple demands since 2021.

So far, there is limited focus by the districts 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.

Cholera Treatment Units (CTUs) have been set up 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. More material and more CTUs will improve the current case management capacity. This coupled with long distances has contributed to increased case fatality rate and transmissions as most cases get to treatment centres in severe conditions.

iii. Other factors and needs resulting from general context

The Polio outbreak has led to overstretch in the health system. There is a high risk of contamination of primary health care centres. The other risks are related to food insecurity and health challenges emanating from the effects of Tropical Cyclone, COVID 19. The risk of cholera transmission within primary health care centres is higher with greater disruption of essential health service delivery.

Previous responses have indicated that Cholera outbreaks are often associated with myths such as that the outbreak is not Cholera. In Nkhatabay it is related to the mining activities which are taking place in the district. As such, past responses indicate the need of an approach that blends Community Based Surveillance and active case finding, contact tracing, community case management and referral systems for clinical case management at facility level to address the increasing number of cases and a CEA / community engagement approach.

The current technical capacity at NS/ Delegation is also not sufficient to face this level of the epidemic. MRCs are expected support from the Surge regional team.

Collaboration review:

There was good collaboration with the stakeholders (MOH) and other stakeholders at both national and district level at every stage of project implementation starting from planning.

Recommendations from joint monitoring and regional technical health mission streamlined in this update:

The increase in numbers of Cholera deaths in Malawi, ORP has been highly recommended by the MoH and WHO. MRCs are championing the setting up and training Stakeholders in the country.

- The project should continue engaging government stakeholders, communities' leaders and partners in planning and implementation
- The project should continue engagement of volunteers in the project activities
- Need to mainstream Cholera activities in other existing projects in districts MRCS is already implementing projects
- Intensifying community awareness sessions to clear the misconceptions and myths both through engagement meetings, radio programmes, van publicity and other RCCE approaches
- Regular supervisory visits be conducted to backstop the Volunteers and HSAs and ensure the interventions have impact in the prevention and control of the outbreak.

Scenario Planning

Being cognizant of the sporadic nature of the spreading of Cholera across many districts in the country, the initial scenarios must be revised. The possibility of the outbreak to spread to new areas and to deteriorate as per worst case scenario in the EPoA has been reached. The current intervention meet scenario 2 with some aspect of scenario 3. Mitigation measures and responses should be implemented urgently to support the MoH response plan to control and reduce the spread of this epidemy. Therefore, the initial scenario is revised as follow:

Scenario	Humanitarian consequences	Potential response
<p>The best case: the districts have appropriate response mechanism across all the affected communities to contain further spread of the disease. The National emergency is removed by the Government after 1 or 2 months. (Not more than 10 new cases in the next 4 weeks per districts which are confined within the current affected districts) Less than 1% CFR</p>	<ul style="list-style-type: none"> • Administrative level will handle without external support (0-5 Cases) • Improved case management • Decreased incidence and case fatality rate • Coordinated response efforts 	<ul style="list-style-type: none"> • The MRCS support to Government is limited to the activities until February 2023. • Support on response and maintenance of capacity of health authorities, with community interventions to stop and prevent new chain of transmission. • Building on preparedness and lessons learnt. • Community and district will handle the situation using available resources (financial, human and supplies)
<p>Most likely scenario: Capacity of the health system to respond is overstretched, neighboring districts are affected with limited capacity of MoH and partners to deliver WASH, FSH and case management interventions The rainy season comes with risk of further affected of WASH conditions and spread of the disease reach more than 100 cases per months in the current affected districts. The control of the disease become more challenging with more support needed by the Government. CFR is between 1.5% to 3%.</p>	<ul style="list-style-type: none"> • Declaration of state of Public Health Emergency Disaster (6K cases and above). • Administrative level may need external support from local partners (6-20) cases. • Increased morbidity and mortality with a higher Case Fatality Rate (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. 	<ul style="list-style-type: none"> • Facilitate establishment of CTU by MoH with support from partners • Request of additional support on resources. • Supporting in community 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. • Setting up of oral rehydration points • Admission of Oral Cholera Vaccine • Promote Hygiene and conduct WASH prevention to mitigate the worst impact of floods especially in southern districts.

<p>Worst case scenario: Health systems are overwhelmed, and health centers IPC failures increase rate of transmission; nationwide diffusion of the outbreak with Neighboring countries involved. Possible weather events with rainy season accelerate the spread and hamper containment efforts (More than 300 cases which are confined within the district) CFR remain more than 2% and up to 3.5% until April.</p>	<ul style="list-style-type: none"> • The situation escalates and spreads beyond National capacity to respond with increased number of cases and deaths reported in most districts of Malawi. • Other related health issues like malnutrition and other epidemic outbreaks deteriorate because healthcare system is overstretched • Refusal/ denial of the disease • High risk of contamination of primary health care centers with greater disruption of health services continuity. • Neighboring countries affected 	<ul style="list-style-type: none"> • Provision of water points and sanitation facilities • Declaration of Public health emergency • Call for international support. • Mass case management • Request for international support
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Exit strategy

Since the timeframe limitation of the DREF response tool and the development of the above scenario, 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 21st 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.

This Response targets five districts in the Northern and Central districts of Malawi where most of the cases are currently reported. In anticipation of the Rainy season that usually has severe impacts in the Southern districts of Malawi, MRCS anticipate an increase of cholera cases there. Thus, the NS is working with the rest of the movement partners to ensure the effects of the rains on WASH resources including Water Points, Latrines is reduced through safe water, basic sanitation, and good hygiene practices in cholera hotspots. Continued community engagement throughout outbreak response with increased communication regarding potential risks, symptoms of cholera, precautions to take to avoid cholera, when and where to report cases and to seek immediate treatment when symptoms appear. Continuous monitoring of the impacts of the rainy season on the cholera response.

Risk assessment

Malawi is generally a peaceful country. As outlined in the EPoA, risk assessment is continuous as the situation evolve. This operation is assuming that the relative calm being observed will prevail. Below is a summary of key risks and anticipated mitigation measures for the action.

Risks	Potential impact	Probability	Mitigation measures
A possible increase in water and vector borne diseases during the rainy season (November to March)	Significant	Very likely	MRCS to enhance its preparedness for response through procurement and preposition of essential WASH supplies as well as provision of training on Epidemic Control for Volunteers in flood prone districts
MRCS staff and Volunteers getting Cholera due to exposure while delivering services	Moderate	Likely	MRCS to engage with MoH to ensure staff and volunteers receive Cholera vaccine as frontline health workers, orientations and provision of personal protection equipment has been planned and will be provided to all the volunteers before being engaged.
Capacity of the health system to respond is overstretched,	Significant,	Very likely,	Support in case management, addressing gaps in CTUs availability; interventions at community level for

neighboring districts are affected with limited capacity of MoH and partners to deliver WASH and case management interventions			reducing chain of transmission and heightened surveillance for identifying promptly new areas affected. Expected duration of intervention 4-6 months
Rainy season- increased risk of Cholera transmission, poor roads during response	Significant,	Very likely,	Increased efforts to minimize the risk of transmission. MRCS Volunteers to continue supporting interventions in their communities. Radio programs intensified.

B. OPERATIONAL STRATEGY

Overall objective

To contribute to the Prevention and control of the cholera outbreak in Nkhatabay, Nkhotakota, Salima, Karonga and Mzuzu districts targeting 840,227 people for additional period of 4 months (January to April 2023).

The initial target was revised from 753,869 people Nkhatabay, Nkhotakota, Karonga and Mzuzu to 840,227 people to be reached in 5 districts: Nkhatabay, Nkhotakota, Salima, Karonga and Mzuzu. Salima district has been added to the targeted areas because since November there have been a rapid worsening of the situation. 3rd hardest hit district countrywide cumulatively as of 14th December and from last data of 19 December, it is surpassing Mangochi. Some of the Southern districts are covered with some ongoing actions through Danish Red Cross Support (Mangochi), Swiss RC (Blantyre) and IFRC TC Ana EA (Chikwawa). The exit strategy also includes planning to start prevention activities on in the flood's prone southern areas with possible support of other movement partners. Targeted communities include in priority children under 2, pregnant and lactation women, fishing communities, communities along the river, floods prone villages, areas with poor wash conditions...

On the total people to be reached, MRCS has already reached 432,420 people through various activities detailed in the current response section.

Specific Objectives are revised to scale-up the response with main goal being:

- To prevent and control the spread of Cholera Outbreak at the community and facility levels in the affected districts, interrupting the chain of transmission.
- To reduce morbidity and mortality due to cholera by supporting improved cholera case management at facility and community levels in the affected districts.

Outputs:

- MRCS and district health offices have the capacity to prepare for and respond to cholera outbreaks in the targeted areas
- Communities are aware of risk factors and can identify, manage, and timely refer suspected cases to health facilities
- Support community case management and health facility established by MoH
- Increased access to and use of safe water sources
- Decreased open defecation and improved hand washing practices with safe water and soap
- Project Coordination and monitoring are strengthened

Proposed strategy

The In response to the current cholera outbreak in the country and based on the previous experiences, MRCS will focus its response in **interrupting transmission and improving case management of Cholera at community and facility levels** in the affected districts. To interrupt the transmission, the response will keep the initial plan and extend the scope with more human resources and extension of the initial plan as follow:

1. National society capacity is strengthening for this response with Volunteers, HSAs, and regional technical support

Key activities will include the following:

1.1 100 Trainer of Trainers (ToTs) on

- Epidemic Control for Volunteers, BTIT and Community Based Surveillance (CBS) targeting MRCS staff, volunteers and MOH district officials (20 per district).** The TOT will take 5 Days and has not yet been conducted.

- **On Infant & Young Child Feeding Practices (IYFCF), Oral Rehabilitation Therapy (ORT) and setting up of Oral Rehydration Points (ORP) for case management and continuation of breastfeeding in the context of a cholera outbreak.**

These TOTs will be responsible to train a pool of community volunteers, HSAs and stakeholders who will be engaged and tasked to lead the prevention and control interventions at community level. They will ensure cascade on IYFCF, ORT and ORP. Their role will also include monitoring of volunteers to ensure that the support is provided as per standards.

1.2 Train 580 Volunteers and 216 HSAs in

- **Cholera prevention and Control using Epidemic Control for Volunteers, BTIT and Community Based Surveillance (CBS) for 3 days.** The focus will be on equipping volunteers with knowledge and skills in conducting house to house visit in the communities to sensitise the communities on the early signs of Cholera disease and the importance of reporting the risk to relevant health authorities.
- **Social mobilization and administration of Oral Cholera Vaccine for 3 days** the training will be conducted using messages that will be developed together with Ministry Health. They will also be oriented on Oral Cholera vaccine so that they support effectively on awareness during the vaccination campaigns.
- **PGI, PFA for 2 Days** Volunteers will be trained to provide counselling and PFA for the affected households, including households that have lost family members due to cholera or are affected by the cholera and need such kind of support.
- **Infant & Young Child Feeding Practices (IYFCF), Case-area targeted interventions (CATI) approach, Oral Rehabilitation Therapy (ORT) and setting up of Oral Rehydration Points (ORP) for case management and continuation of breastfeeding in the context of a cholera outbreak.** Volunteers will be responsible for supporting Households, ORP and Cholera Treatment Units (CTU) caregivers so that those suffering from cholera do not get malnourished

As the time of this update, All the trainings have already been conducted in the 4 initial districts for 419 volunteers and 216 HSAs and only the additional volunteers and HSAs will be trained in the remaining time. The IYFCF trainings and activities will be started from this update.

1.3 Extend the technical support to the MRCS

A mission has been conducted by the regional public Health in Emergencies coordinator to support MRCS during the first stage of the response. Based on the outcome of this mission, MRCS agreed to reinforce the technical capacity with

- **The deployment of 2 surge profiles in this extension for 2 months: one public health coordinator and 1 wash engineer to cover the main factor of this outbreak.** To ensure proper technical capacity is in place, a community-based surveillance surge deployment with technical knowledge of Cholera Response has been added to the operational strategy for 6 weeks. The surge will support health and wash technical field. They will support the development of SOPs and guide for the ORP integration into the existing government interventions including BITT role out. They will also assist in WASH in emergency technical field.
- **Dedicated staff for the response. The management of this response will require an Operation Coordinator and a WASH coordinator of MRCS.** The operation will partly contribute to the salary of the WASH coordinator, 5 District Coordinators will get a three-month salary contribution too. The operation will lease three vehicles and thus contribute to salary costs for the three drivers for three months. The overall operation will be led by National Society Director of Programs and Operations.

2. Community sensitization on cholera, strengthened case identification and interruption of chain of transmission.

There MRCS would have the component of health promotion as part of EpiC, CEA. The activities include feedback mechanisms and RCCE in its various forms)/ CBS/ BTIT (home spraying of chlorine for cases of diarrhea, etc.). MRCS will ensure deployment of 580 volunteers (400 already deployed) to conduct the following activities:

2.1 Undertake door-to-door visits to deliver targeted information on cholera for 3 days per week for 3 months to reach 50,000 households (300,000 people).

- Procure and provide to volunteers the necessary teaching aids (pocket guides, handbooks for Cholera and posters) and paper CBS forms. MRCS will print Pocket Guides and handbooks and distribute to volunteers for easy understanding and standard delivery of Information as they are conducting SBCC at community level.
- Deployment 580 volunteers for general hygiene promotion and promote hygiene for breastfeeding and complementary feeding of infants and young children (IYCF)
- Volunteers will provide information on the early signs of cholera to enable early detection, educating household members in Cholera prevention, case management and use of sanitary facilities, handling of safe drinking water and hygiene practices. The project will support volunteers with meals and transport refund where possible. These volunteers will reach 50,000 households. HAS and volunteers will also assist in Disinfection of Household with cholera cases and ORPs and CTUs during decommissioning.
- The action shall also ensure that HSAs and volunteers are providing hygiene promotion messages and following up on the usage of the chlorine. volunteers will support communities in identifying and alert on potential further transmission of the outbreak through both paper base and use of smart phones. The Household will be monitored to ensure that IPC protocols are followed to reduce transmission to other households. In severe cases ORP will be established.

2.2 Communities are aware of risk factors and can identify, manage, and timely refer suspected cases to health facilities

- **Support production of 20 jingles in total. Additional 12 to be produced to the 8 already available.** Production of jingles tailor made to local languages jingles with support from the Health Promotion officer. The district shall review the feedback information and develop jingles based on the issues the district needs to address coming out of the feedback mechanism. *Ongoing*
- **Airing of jingles on radio and Van publicity. 75 airing per month per districts for a total of 1500 airtime slots for radio play in 4 months.** From October to November 2022, 684 airing has been done by Radio. The jingles shall be played on the community radios and during Van Publicity Session. *Ongoing*
- **Conduct 50 Van Publicity sessions (10 sessions /district, 1 per month):** The action support in conducting the Mobile van publicity in the targeted district. Firstly, the district stakeholders shall map the targeted hotspot areas and develop an awareness plan including the van publicity session. The Health Promotion Office, Community Health Coordinator, and Information Officer at the district level, shall be the key stakeholders in implementing the action. The action shall include hiring of equipment like, Public Address system, and Genset. 19 sessions already conducted. *Ongoing*.
- **During the Van publicity,** the action shall integrate dissemination of IEC materials, e.g., posters, Flyers, and Cholera leaflets
- **Support 25 Painting of cholera awareness and prevention messages in strategic places. 5 places to be identified per district for painting:** The action shall engage an artist/artisan to paint cholera messages with prevention and control messages in strategic places. From evaluation of community's practices to pay attention of recurrent images. The district shall identify strategic places and develop messages to be printed. 5 places in the district shall be identified and painted. *New activities*
- **Produce 10 banners for awareness raising in public events (2 per districts). The districts of Salima remain to receive the banners as the initial districts have already received.** The banners will be used during awareness raising activities and public events. The banners shall feature MRCS logo and IFRC logo with key messages for awareness raising. To be started from this update. *Ongoing*.
- **Conduct targeted open days focussing on high-risk areas and market days:** The action shall support open-days actions focusing on tailor-made crowd puller activities, i.e., drama, PA systems, Sports, targeting high risk areas and mobile market days, to maximise coverage and reach. *Ongoing*.

2.3 Conduct pot-to-pot chlorination, spraying/disinfection of households by HSAs and volunteers. They will be distributing the 1% stock solution to the targeted households (through direct distribution or through clustered distribution as per MoH guidelines). Volunteers and HAS will also be responsible to ensure that households which had cholera cases are disinfected to break transmission routes. *Ongoing*.

Support to management of cholera patients.

2.4 Support 10 Oral Rehabilitation Point and support ORT; 2 per districts instead of 1 initially planned

- Support volunteers to conduct Oral Rehabilitation Therapy (ORT) in households and setting up of Oral Rehydration Points (ORP) for case management as well as disinfection of households with chlorine.
- Procurement and distribution to the ORP the IPC material for volunteers and HSAs
- Procurement and distribution of ORS, chlorine, disinfection kits and protection.

2.5 Support volunteers to enhance Infection Prevention & Control measures at the Cholera Treatment Units (CTU). 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. CATI (Facility based RRT), HAS and Volunteers will also identify needs for setting up ORP centres at community level in Liaison with Health Facility. Volunteers will be deployed to support IPC in Treatment units through enforcing hygiene and hygiene practices, disinfection of surfaces and transport that is used by the patients e.g., motorcycles, motor vehicles and bicycles and in ORP where they are established to ensure that there is no further transmission of Cholera from patients to guardians.

2.6 Support establishment/operationalization of 10 Cholera Treatment Units. 4 already in place in the initial targeted areas. MRCS will work hand in hand with Rapid Response teams at district and community level to identify the need to establish CTU and proper positioning of the CTUs considering the rainy season. MRCS will provide tents and facilitate construction of temporary latrines. MRCS will also advocate for the establishment of the CTUs gender sensitive. CTU will include emergency latrines with construction material to be provided by MRCS. *Ongoing*

2.7 Support volunteers providing PSS in the CTU and ORP canters.

2.8 Support to the improvement of community water and sanitation systems Conduct WASH KAP Survey. The Action 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 5 districts).

2.9 Latrines will be constructed for the CTU

2.10 Train SHN teachers on hygiene promotion in schools and use of chlorine dispensers the action shall engage SHN Teachers who are the focal persons on hygiene and sanitation in schools to promote the use of treated water by the learners. This will include installation of chlorine dispensers at boreholes in schools. This action will be implemented in consultation with and guidance from Evidence Action.

2.11 Coordinate Evidence Action Staff to orient MRCS staff on installation to orient MRCS staff on installation and use of Chlorine dispensers at Community water source points: The action shall support engagement meeting with stakeholder, Evidence Action to roll out installation of Chlorine dispensers in Water points. After meeting the Stakeholder and MRCS staff shall be deployed to install the Chlorine Dispensers in target communities. MRCS volunteers will support management of chlorine dispensers through reporting when dispensers are empty, refilling and disinfection of boreholes handles.

2.12 Rehabilitation/Upgrading of 25 water points and appropriate systems (5 per district): The action shall support in rehabilitation of broken water points targeting hand pumps and in hot spot areas. 5 water points per district shall be rehabilitated.

2.13 Support 3 boreholes construction by MoH with Drilling and materials.

2.14 The volunteers will also support in pot-to-pot chlorination and disinfection to break transmission at household level.

2.15 Procurement and distribution of water purification tablets – chlorine (496,587 tabs).

3. Project Coordination and monitoring are strengthened

At the launch of this operation, MRCS conducted project inception and induction meeting in the 4 initial targeted districts. The cooperation is improved with this initial phase. Thus, the same will be completed in Salima. The action shall support induction and inception meeting with key stakeholders, district teams and Branch members, to elaborate the DREF actions and orient district staff in implementation modality. The meeting shall invite relevant HQ staff, Districts Staff, MoH, MoWS and Branch.

Following the inception, coordination should be maintained in a regular basis with the following actions:

- 3.1 Conduct joint monitoring and supportive supervision:** The action shall support joint monitoring and supportive supervision at National and District level.
- 3.2 Support coordination meetings at District Level:** the action shall support district level coordination meetings and community level coordination meetings to ensure strengthened coordination collaboration.
- 3.3 Conduct national level review meetings and monitoring with MoH, UNICEF, WHO, MoW and DoDMA:** the action shall support national level meeting with government ministries, UN agencies and non-Movement partners to ensure the response is well coordinated, and create synergies
- 3.4 Conduct lessons learned workshop:** The response shall conduct a lesson learnt workshop to draw lessons for next response and guide the preparedness activities.
- 3.5 NS Management Monitoring & Supportive visits Costs:** This action shall support all the National Society monitoring and supportive supervision.

4. Community engagement and Risk communication.

This will include the following activities:

4.1 Conduct community level engagement meetings that will permit to

- **Identify volunteers and other structures supporting the cholera response. This activity is already completed in the 4 initial target districts and will be completed in January for the Salima district.**
- MRCS will also keep engaging MRCS Division and Subdivisions to identify volunteers who will be engaged in the project. In addition, the community structures such as ADC and VDC will be engaged. This will be 1 Day Meetings per TA in the hot spot areas in each district. The purpose is to call for support of the local leaders to lead in sensitizing their subjects and enforce by-laws.

4.2 Support monthly community engagement meetings with local, influential, and other cholera actors in the cholera targeted areas. Under this activity MRCS will conduct Meetings with Local and influential leaders and other cholera actors in the target areas to call for their action and support. As custodians of culture, Local leaders will be engaged to dispel rumours and discourage practices that may put communities at risk. Staff and volunteers at community level will be tasked to involve community structures as they are implementing activities and be participating in community structure meetings so that they share information and gaps identified.

5. Cross-cutting sectors

5.1. 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.

5.2. 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.

Feedback system like C&F Forms, Toll free lines exists in the 4 old districts and will be put in place in Salima; Other mechanism for feedback include

- Meetings with community leaders and key community and local informant
- Paper based feedback system through volunteers visits in door to door

- Group discussion during the open market discussions
- 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.

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. Frequently Asked Questions (FAQ's) exists in the four old districts and will be developed in Salima 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.

6.0. Operational Support Services

6.1. Human Resources-

Volunteers

Overall, 580 volunteers will be engaged, 216 HSAs in the Cholera operation to support the various sectors. NS need to extend the number of volunteers to extend the coverage at community level.

Volunteers will be all trained in the different modules and used relatively for awareness, social mobilisation, ORP and CTU; Volunteers will be selected from a pool of existing branch volunteers 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 per diems for each deployment.

Districts	Trainers (Health care workers)	Volunteers		HSAs		TOTAL
		Initial	Revised	Initial	Revised	
Nkhatabay,	20	100	120	20	44	164
Nkhotakota,	20	100	120	20	44	164
Karonga,	20	100	120	20	44	164
Mzuzu	20	100	120	20	44	164
Salima (new).	20	0	100	0	40	140
TOTAL	100	400	580	80	216	796

6.2. 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 operation. The lessons learnt session will be built on the previous lessons drawn from other Cholera responses and will include a 2 day debrief of volunteers with the branch development /NSD department as well.

6.3. Communications

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


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. A procurement plan to be developed to ensure timely support to the operation. MRCs has warehouse capacity if needed.

6.6. Logistic, transport and fleet needs

Logistic and procurement: MRCs Logistics and Supply Chain Department will work in close collaboration with the IFRC procedures and guidelines. 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. A procurement plan to be developed to ensure timely support to the operation. MRCs has warehouse capacity if needed.

For fleet, the operation has budgeted costs for hiring of vehicles to ensure transport needs are met during the operation. Since the MRCs started responding, 4 Vehicle were hired (1 per districts) for the operational needs in the branches. The response team will need minimum 3 vehicles to be deployed for the activities and monitoring requirements in the 5 districts for an extended period of 3 months. The MRCs for safety will ensure minimum maintenance is completed for the vehicles mobilised and rent.

C. DETAILED OPERATIONAL PLAN

	<p>Health People reached: 432,420 Male: 198,454 Female: 233, 966</p>	
<p>Health Outcome 4: Transmission of diseases of epidemic cholera potential is reduced</p>		
<p>Health Output 4.4: Transmission is limited through early identification and referral of suspected cases using active case finding.</p>		
Indicators	Target	Actual
% Of targeted population reached with community-based disease control actions (Target: 80%) <i>(Revised target from 753,869 to 840,227)</i>	80% (840,227)	57% (432,420)
#Of Trainers trained on health cholera response <i>(new indicator)</i>	100	0
# Of volunteers & HSAs trained on Health trainings include CBS/RCCE and ECV <i>(Revised target)</i>	580 volunteers & 216 HSAs	419 volunteers and 216 HSAs
# Of people reached with awareness messages on cholera <i>(Revised target from 753,869 to 840,227)</i>	840,227 people	432,420 people
# Of households reached with door-to-door visits <i>(new indicator)</i>	50,000	10,000 (57,738 people)

# Of radio jingles produced (Revised target)	20 radio jingles	8 radio jingles
# Of times radio jingles aired (Revised target)	1500 times	684 times
#of Van publicity conducted (new target)	50	19
# Of mobile messaging sessions conducted (Revised target)	500 sessions	19 sessions
# Of volunteers trained on Infant & Young Child Feeding Practices (IYFCF), (CATI) approach, Oral Rehabilitation Therapy (ORT) (new indicator)	580	0
# Of households reached with messages on IYFCF (new indicator)	50,000	0
# Community Leaders trained on Cholera awareness (Revised target)	510 leaders	510 leaders
# Of community engagement coordination meetings (Revised target to 20)	15	0
# Of volunteers trained/refreshed in feedback mechanism and effective reporting (Revised target)	580 volunteers	419 volunteers 7 10 HSAs
#Of feedback received through door to door visit and treated (New indicator)	TBD	Not yet reported
#Of feedback received through others community meetings and FGD and treated (New indicator)	TBD	Not yet reported
%tage of feedback received that are treated (New indicator)	100%	Not yet reported

Health Output 5.1: Cholera cases are managed in the community, with referral established for severe cases

Indicators	Target	Actual
# Of volunteers & HSAs engaged in ORP management and CTU (Revised target)	580 volunteers & 216 HSAs	419 volunteers and 216 HSAs/HCWs
# Of households supported with IPC materials (new target)	2,000	620
# Of cases identified in the community and referred to CTU by volunteers (100)	TBD	Not yet reported
# Of cases identified in the community and referred to ORP by volunteers (100)	TBD	Not yet reported
# Of ORPs setup and linked with Treatment Centers (Target: 4)	5	Not yet reported
# Of ORPs supported with IPC material and PPEs (Revised target from 4 to 5)	5	Not yet reported
# CTUs setup (Revised target from 4 to 5)	5	Not yet reported
# Of CTUs supported with chlorine and other materials (Revised target from 4 to 5)	5	Not yet reported
#Of people supported with ORT (1000)	1000	Not yet reported
#Of people supported during the CTU activities (1000)	1000	Not yet reported

Progress towards outcomes

During the reporting period 432,420 have been reached with different messages and other community-based actions on cholera prevention and control. MRCS with technical support from the MoH and needs on the ground to prevent the spread of the disease. Awareness sessions were intensified due the escalating cases in the districts resulting the overachievement for the reporting period.

419 volunteers were trained in CBS/RCCE and ECV against a target of 400 volunteers due to the spread of the cholera cases across the districts, more volunteers were required. While 216 HSAs were trained against a target 80, at the request of the

District Health Office to have many health care workers oriented since most of them were not trained in cholera before the outbreak.

- Karonga: 100 (59M, 41F) volunteers & 43 (24M, 19F) HSAs
- Mzuzu: 100 (78,22M) volunteers & 20 (13F, 7M) HSAs
- Nkhatabay: 119 (52M and 67F) volunteers & 71 (47M and 24F) HSAs
- Nkhotakota: 100 [41M, 59F] volunteers & 82 (35M, 47F) HSAs

510 community leaders, councillors, legislators, and religious leaders were trained in cholera awareness against 480 leaders. The over-achievement was because the project wanted to engage as many local leaders as possible since these leaders play critical roles in influencing community behaviour change. In some districts such as Nkhotakota, some local leaders were denying the existence of cholera in their area, so MRCS sought it wise to engage more leaders in the district to help in addressing the myths and misconceptions about the disease.

- Karonga: 5 meetings: 105 (35M, 60F) Community Leaders.
- Mzuzu: 5 meetings: 40 Community Leaders (26M and 14F)
- Nkhatabay: 10 meetings: 60 (48M and 12F) Community Leaders
- Nkhotakota: 6 meetings: 305 (228M, 77F) Community Leaders

The local leaders support in the establishment and make follow-ups on the enforcement of the by-laws. for example, latrine construction as well as handwashing facilities for all latrines

8 jingles (100%) have been produced and aired 684 times for the past 2 months of October and November. Approximately, 432,420 people have been reached with cholera messages through radios as follows.

- Karonga: 2 jingles produced and aired 60 times - 40 680 (11 629M, 29 051F) people reached.
- Mzuzu: 2 jingles produced and 240 aired so far with a reach of 142,340 people (69 345M, 72,995F)
- Nkhatabay: 2 radio jingles produced; 144 radio jingles aired; 130,000 (59,000M and 71,000F) people reached
- Nkhotakota: 2 radio jingles produced and 240 aired; 119,400 (58,480M, 60,920F) people reached
- In Nkhatabay 4 Radio Programmes were also conducted and messages delivered included the cholera preventive measures and referrals to the hospital for any suspected cases in the community

However, CEA activities will have to be enhanced to reach people in areas where radio coverage is minimal. This will also include van publicity and open days to compliment the action.

10 coordination meetings were conducted at community level involving local community structures such as Group Village Heads, Village Heads reaching out to 620 participants out of 1,000 community structures. The underachievement is because the community meetings were designed to start from the high-level community structures trickling down to village level meetings. The community structure meetings are still underway.

- Karonga: 1 meeting involving 64 (45M, 19F) participants
- Mzuzu: 3 meetings involving 35 (8F,28M) participants around Kamwe, Bwengu & Luzi health facilities
- Nkhatabay: 5 meetings involving 425 (182males and 243 females) participants
- Nkhotakota: 2 meetings involving 96 (65M, 31F) participants

Local leaders and community members were engaged to have come to accept that Cholera is indeed real and causing a lot of deaths in the districts. The meeting agreed that one of the ways to contain the same was to make sure that each HH has sanitary facilities in place and continuous adherence to all hygiene and sanitation measures

19 sessions of Van publicity have been conducted so far in the 4 districts reaching to about 229,544 people

- Karonga: 5 sessions; 135,570 (38,764M, 96,836F) people reached
- Mzuzu: 5 sessions; 4 788 (2, 164 M, 2, 624F) people reached
- Nkhatabay: 5 sessions; 5,724 (2,576M 3,148F) people reached
- Nkhotakota: 4 sessions; 83,462 (40,897M, 42,565F) people reached

417 volunteers and 216 HSAs were trained in Oral Rehydration Therapy. They were trained on how to prepare Oral Rehydration Solution (ORS) at community level and give it to cholera suspected patients before referral to the hospital. ORPs were not set up.

- Karonga: 100 (59M, 41F) volunteers & 43 (24M, 19F) HSAs
- Mzuzu: 100 (78,22M) volunteers & 20 (13F, 7M) HSAs
- Nkhatabay: 119 (52M and 67F) volunteers & 71 (47M and 24F) HSAs
- Nkhotakota: 100 [41M, 59F] volunteers & 82 [35M, 47F] HSAs

The volunteers also help health worker at the treatment units in cleaning the surrounding at the camp, and fetching water for use at the camps

419 volunteers were deployed to support social mobilization in the communities for cholera prevention and control through door-to-door visits. So far 57,738 people (11,547 households) have been visited and oriented with cholera prevention messages in the 4 implementation districts

- Karonga: 1046 HHs visited; 5, 230 (2 092M, 3 138F) people reached with cholera prevention messages
- Mzuzu: 301 HHs visited; 1, 508 (722M and 786F) were reached with awareness messages on cholera
- Nkhatabay: 1, 402 HH visited; 7,013 (3,156 males and 3,857 females) people reached with awareness messages on cholera
- Nkhotakota: 8,797 HHs visited; 43,987 (21,150M, 22,837F) people reached

Procurement of Materials and Supplies to support IPC and Case Management (ORS, Chlorine, gloves, gumboots, and facemasks). For each district (10 buckets of 25kgs each, Heavy Duty Glove – 4 pairs, Latex Glove – 1 box, ORS – 100 boxes, Solar Light – 1, Safety fence - 2 rolls)

Key lessons learnt since the start of the operation and best practices:

- Establishment of community by-laws has helped to reduce the spread of cholera in most communities, and this should be scaled up all the communities
- Involvement of MRCS volunteers in the communities is good since they can provide instant feedback, which are addressed through feedback system established. The volunteers are also key in terms of data collection and social mobilisation. The preferred feedback system establish from now are faced to face exchange with communities through focus group discussion, meetings with communities' leaders and key informant in the communities, information collected by volunteers.
- Engagement of community or local leaders is crucial in ensuring the outbreak transmission is interrupted as they act as big change agents and influencers in the communities.
- The involvement of District stakeholders from the start of the project is vital since they can follow all the activities being implemented.



Oral rehydration Point ToT training Session



Volunteer sensitising community on food hygiene



Water, sanitation, and hygiene

People reached: 158,297

Male: 70, 840

Female: 87, 457

WASH Outcome: Immediate reduction in risk of waterborne and water related diseases in targeted communities

Target

Actual

Of WASH assessments

5

4

Of people assisted with water purification tablets and hygiene promotion

496,587

158,297

Of SHN Teachers trained on WASH

150

130

Of Rehabilitated Water points *(New target)*

28

0

Progress towards outcomes

Over 150,000 Households have been assisted with water purification tablets and hygiene promotion chlorine distribution, and support in latrine/ rubbish pit construction. MRCS has been key in distributing HTH and aqua tabs. The water purification chemicals are used for household use as well as in treatment centers. This action will be facilitated through the already existing good coordination between the volunteers and the HSAs.

199 SHN teachers were trained on WASH to promote hygiene in schools. More schools were included as the cases were spreading to various areas.

- Karonga: 40 (20M, 20F)
- Mzuzu: 40 (11M, 31F)
- Nkhatabay: 39 (26M and 13F)
- Nkhotakota: 80 (53M, 27F).

Rehabilitation of water points has not yet been done; Following WASH assessments conducted in all the districts, results indicates that most communities rely on unsafe drinking water sources and there is poor and low sanitation

Enabling approaches



National Society Strengthening

Outcome: Improved NRCS capacity to ensure that necessary ethical and financial systems and structures, and required skills to implement efficiently and effectively	Target	Actual
Output 1: Volunteer's protection and compliance to RCRC principles and SOPs is ensured		
# Of volunteers engaged to support Cholera prevention & Control	580	419
# Of insured volunteers mobilized for this response	580	419
# Of volunteers confirming that they are briefed or have undergo the minimum response standard role, security training for volunteers, code of conduct etc.	580	419
# Of HSAs engaged in the MRCS DREF response	216	216
Output 2: National Societies have the necessary corporate infrastructure and systems in place		
# Of Monitoring visits conducted (include joint monitoring)	14	5
# Of coordination meetings conducted (National and district level)	17	8
# Technical support visits conducted	7	5
# Of NS monitoring missions conducted	6	3
Outcome S2.1: Effective and coordinated international disaster response is ensured		
#Of surge deployed for this intervention	2	0
# Of monitoring and support mission from regional health	1	1
# Of Support and monitoring mission provided by IFRC	3	1
Progress towards outcomes		
<ul style="list-style-type: none"> • 419 volunteers were mobilized and engaged to support awareness on cholera prevention control, out of 400 volunteers. The achievement was high due to spread of the cholera cases across the districts which required engagement of many volunteers. All the volunteers were briefed on the code of conduct and signed volunteer engagement form. The engaged volunteers are under MRCS insurance. • 8 district coordination meetings have been conducted out of 10 meetings. Coordination meetings will be continued for the next phase of funding. • 5 technical visits conducted out of 8 Visits. Under achieved since the activity is on-going. 		

- 3 out of 6 National Society monitoring missions were conducted involving senior management and the Ministry of Health and Ministry of Local government stakeholders.
- Regional Public health in Emergency coordinator has supported the MRCS with an evaluation mission and technical recommendations which have also been integrated to this update. The surges requested will continue this technical support for a more efficient intervention.

D. Financial Report

Budget is revised as follow:

International Federation of Red Cross and Red Crescent Societies all amounts in Swiss Francs (CHF)

DREF OPERATION

APPEAL CODE - MALAWI - MALAWI CHOLERA SUPPORT

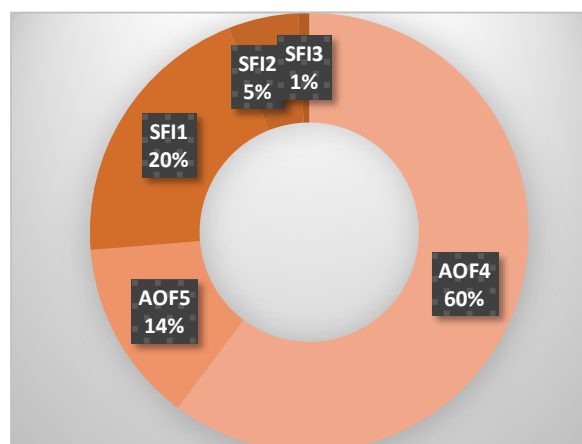
16/12/2022

Budget by Resource

Budget Group	Budget
Water, Sanitation & Hygiene	46,307
Medical & First Aid	68,192
Teaching Materials	9,951
Relief items, Construction, Supplies	124,450
Transport & Vehicles Costs	29,100
Logistics, Transport & Storage	29,100
International Staff	13,950
National Society Staff	72,856
Volunteers	361,361
Personnel	448,167
Workshops & Training	27,508
Workshops & Training	27,508
Travel	21,483
Information & Public Relations	186
Office Costs	2,790
Communications	2,176
Financial Charges	791
Other General Expenses	45,966
General Expenditure	73,391
DIRECT COSTS	702,616
INDIRECT COSTS	45,670
TOTAL BUDGET	748,286

Budget by Area of Intervention

AOF1	Disaster Risk Reduction	
AOF2	Shelter	
AOF3	Livelihoods and Basic Needs	
AOF4	Health	450,717
AOF5	Water, Sanitation and Hygiene	100,850
AOF6	Protection, Gender and Inclusion	
AOF7	Migration	
SF11	Strengthen National Societies	151,724
SF12	Effective International Disaster Management	38,915
SF13	Influence others as leading strategic partners	6,079
SF14	Ensure a strong IFRC	
TOTAL		748,286



Contact information

Reference documents



Click here for:

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

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

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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.

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