CERF ALLOCATION REPORT ON THE
USE OF FUNDS AND ACHIEVED RESULTS

MALAWI
RAPID RESPONSE
CHOLERA
2022

22-RR-MWI-55260

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PART I – ALLOCATION OVERVIEW

Reporting Process and Consultation Summary:	
Please indicate when the After-Action Review (AAR) was conducted and who participated.	No After Action Review conducted

The After-Action review was not conduced due to competing priorities. The timeline for this allocation coincided with the onset of Tropical Cyclone Fredy and with all the priorities during this response, the After-Action review was not conducted. As there was a second CERF allocation in 2023 and whose final report is due end of December, the idea is to have a combined After-Action Review for both Cholera allocations and considering that it is WHO and UNICEF who were the main recipients of both these allocations.

Please confirm that the report on the use of CERF funds was discussed with the Humanitarian and/or UN Country Team (HCT/UNCT).	Yes ☒	No ☐
Please confirm that the final version of this report was shared for review with in-country stakeholders (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?	Yes ☒	No ☐

1. STRATEGIC PRIORITIZATION

Statement by the Resident/Humanitarian Coordinator:

Although cholera has been endemic in Malawi since 1998 with seasonal outbreaks reported during the rainy season (November through May), the 2022 outbreak reached unprecedent levels following floods caused by Tropical Storms Ana and Gombe. The consequences of a humanitarian crisis (in this case caused by Cyclone Ana and Gombe) such as disruption of water and sanitation systems, and the displacement of populations towards inadequate and overcrowded camps – increased the risk of cholera transmission. As a result, Malawi faced its deadliest cholera outbreak in recorded history and its largest in the last two decades. The Ministry of Public Health of Malawi notified WHO of a cholera outbreak after laboratory confirmation of a cholera case in Machinga district hospital on 2 March 2022 and an official declaration made on 3 March 2022. As of 28 March 2023, a cumulative total of 56,090 cases had been reported since the onset of the outbreak and all 29 districts. The cumulative number of deaths at this time was 1,712, with a case fatality ratio of 3.1%. The current outbreak surpassed the 2001-2002 epidemic, which was the worst in the country's recent history, that registered 33,000 cases and 1,000 deaths. Although the outbreak was initially limited to the southern part of the country, it spread to all 29 districts of Malawi, including areas that were cholera-free for more than a decade.

Against this backdrop of a health system, which was already overstretched by competing disease outbreaks, including COVID-19 and polio, UNICEF and WHO and supporting the Government of Malawi, implemented an integrated and multi-sectoral life-saving approach including a combination of coordination, surveillance, water, sanitation and hygiene (WASH), health System strengthening, vaccination campaigns, social mobilization and treatment, to control the cholera outbreak and to reduce deaths in districts with the highest number of cholera cases. These included Nkhata Bay, Blantyre, Nsanje, Nkhotakota, Rumphi, Mzimba North, Chikwawa, Neno, and Karonga. CERF enabled partners to conduct massive community awareness campaign and training for health workers, ensuring that Cholera Treatment Centres and Units (CTCs / CTUs) which were fully established and functional. To complement efforts, a robust water quality control measures were implemented. The overall objective of these interventions was to contain the outbreak and prevent its further spread, also considering the imminent start of the rainy season (October and December 2022).

CERF's Added Value:

The allocated CERF funding added value to the cholera response by enabling the UN through UNICEF and WHO to support the Government of Malawi respond to time critical needs of the population affected by the cholera outbreak in the affected districts of Malawi. The allocation improved the coordination between WHO and UNICEF through leveraging and complementing each agency's area of expertise and mandate. The CERF allocation was released in a timely manner when the number of cases where still low. Although the numbers increased, another allocation was made available to response to the exponential increase in cases. Overall, the flexibility of the CERF allowed agencies to re-programme their response according to needs to mitigate the spread of the outbreak. The CERF allocation was the first funding UNICEF received to respond to cholera outbreak, it supported the procurement of cholera supplies like Acute watery diarrhoea kits, tents, oral rehydration solutions and essential medicines for the treatment of cholera cases in the cholera treatment units. It also helped in oral cholera vaccination in one of the hardest hit districts, Mangochi. It had a catalytic effect as it drew attention to the need for such interventions and other partners came in to support including ECHO (Euros 100,000), Latter Day Saints Charities (LDSC) (US$ 500,000), US$300,000 Centers for Disease Control (CDC) and US$400,000 from FCDO. Beyond the immediate humanitarian response, the generated additional funds included components that will contribute to building back better thus building resilience. The BHA grant that UNICEF received grant included construction of water schemes and capacity for water point management; elements whose benefits go beyond the current cholera outbreak.

For WHO, the CERF allocation came at a period the cholera cases had just been reported in the Northern region which was becoming the epicenter of the outbreak. Interventions supported by CERF were catalytic in building community and local leaders' trust and participation allowing implementation of further actions to control the outbreak including end-cholera campaign. The CERF funding was also catalytic

in mobilizing additional resources from DG - ECHO (EURO 1,542,210), World Bank (USD 9 000,000), FCDO (GBP 500,000) including additional CERF (USD 500,011). The funding from these different streams were used to support strengthening capacity of the strained health system in Malawi that will have impact beyond the current cholera response. For instance, procurement and last mile distribution of emergency cholera supplies, capacity building of health workers in emergency response, and strengthening preparedness for future outbreaks and humanitarian events.

Did CERF funds lead to a fast delivery of assistance to people in need?

Yes ☒ Partially ☐ No ☐

As highlighted above, the cholera outbreak that affected Malawi took place against a backdrop of a weakened health system, which was already overstretched by competing disease outbreaks, including COVID-19 and polio. Beyond Cyclones Ana and Gombe in 2022, the country also experienced another cyclone (Tropical Cyclone Freddy) which made its landfall on 12 March 2023. This further compounded the crisis, increasing the risk of a rise in the number of cases. Despite the cyclone, there was not an exponential increase in the number of cases, and this is partly attributed to this CERF allocation which ensured timely procurement of key emergency supplies, active surveillance, contact tracing and management of cases through the establishment treatment units and centres.

Did CERF funds help respond to time-critical needs?

Yes ☒ Partially ☐ No ☐

This allocation provided a timely and integrated multisector (health, and WaSH) cholera response and control in high risk areas in Malawi. As previously highlighted, the outbreak took place in the context of tropical storm Ana (January 2022) and Cyclone Gombe (March 2022) which caused floods leading to the displacement of a population that lacked access to safe water, sanitation, and hygiene. In addition, Tropical Cyclone Freddy also affected the country in March 2023 affecting close to 2 million people. Despite this, the cholera outbreak in the country declined as new cases decreased from 1,427 in week the 3rd week of June to 1,109 in the 4th week (22.3% decrease). New deaths also decreased from 47 in the 3rd week of June to 23 in the 4th week of June (51.1% decrease). As a result, Weekly CFR reduced from 4 per cent at its worst to 0 per cent as of 27 June 2023 in selected districts of CERF, possibly because of the interventions undertaken to support the CTCs and CTUs. The cumulative CFR, although it remained higher than the recommended threshold of 1 per cent , it reduced considerably from the 4 per cent to 2.9 per cent of the end of the CERF project.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

Cholera outbreak provided a valuable opportunity for all relevant partners and implementing partners working in the affected districts to come together. The benefit was maximized through coordination among the different sectors where a costed national cholera response plan has been drafted to manage the outbreak. WHO and other partners supported the implementation of various activities aligned with the plan. Coordination was one of the strongest tools used to control the outbreak at the field level where national and district-level emergency operation centres (EOCs) were operationalized to coordinate the response in collaboration with other health sectors and partners. The CERF allocation allowed both UNICEF and WHO to also support the coordination of and establishment of treatment centres at the district level ensuring regular contact with the lead government coordination Agency (The Cholera Task Force). Thus, overlapping and waste of limited resources was avoided, and complementary actions ensured. Concretely, UNICEF and WHO provided all the essential components required to not only respond to the cholera outbreak, but also mitigate its spread.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

Through the Flash Appeal developed in February 2023, a total of USD45.3 million was requested out of which USD18 million (about 40%) was mobilised. This was the first CERF allocation against the Flash Appeal for cholera and in light on the increase in the number of cases, a second allocation of USD4.3 million was made available in April 2023. Beyond this, UNICEF received additional funding

from DG ECHO (Euros 100,000), Latter Day Saints Charities (LDSC) (US$ 500,000), US$300,000 Centers for Disease Control (CDC) and US$400,000 from FCDO. For WHO, additional resources were mobilised from DG - ECHO (EURO 1,542,210), World Bank (USD 9 000,000), FCDO (GBP 500,000) including additional CERF (USD 500,011). Over and above this allocation, CERF also made available funding to respond the Cyclone Freddy (USD5.5 million), whose risk was closely linked with the impact of the same which caused significant displacement of over 600,000 people. This compounded crisis therefore enabled the revision of a Flash Appeal to include TC Freddy over and above the already existing strategy for the cholera response.

Overall, the CERF allocation had an impact in controlling the current cholera outbreak response but also has built capacity for future responses to cholera and other health emergencies. Beyond the funding, the CERF immediate response included elements that will have lasting effects beyond addressing the immediate needs. For instance, as part of the Case-Area Targeted Intervention (CATI) approach, District Rapid Response Teams (DRRTs) and Facility Rapid Response teams gained knowledge and experience on the CATI approach and how to implement it. The CATI approach has been acknowledged as an effective way of quickly containing and the knowledge and the experiences gained will be used by the teams in future cholera control efforts. In addition, radio listeners groups were trained on community engagement and dissemination of the cholera preventive messages. The radio listeners group members continue to reach out people with door-to-door visits even after the project implementation period and will continue to use these skills to engage with communities in future social mobilisation efforts. Water schemes constructed and capacity for water point management are also elements whose benefits go beyond the current cholera outbreak. CERF supported the implementation of community based Oral Rehydration Points with development of SOPs and capacity building of community volunteers to man these posts. These ORPS served as a community hub for integration of cholera prevention messaging, provision of Chlorine for prevention and provision of ORS. The ORPs have proven critical in the control of the outbreak and reducing number of severe cholera cases and fatalities. This experience will be very useful in the response of future cholera outbreaks by providing timely community access to life saving interventions.

Considerations of the ERC's Underfunded Priority Areas[1]:

Support for Women and Girls

Considering the nature of the response, all priority areas received considerable prioritisation. In view of the key role that women play in their caring roles and frequent contact with water and food, there are specific vulnerabilities which expose them to contracting cholera. These vulnerabilities and barriers include cleaning latrines, fetching and handling water, and preparing raw food. This response targeted women with interventions to empower them with knowledge on cholera prevention and treatment. Community awareness on cholera and hygiene promotion were also done in the communities with men women, boys and girls to address issues of women's restricted movement and multiple roles. Gender Based Violence (GBV) and Sexual Exploitation and Abuse (SEA) awareness campaigns were integrated in cholera prevention and response activities.

Targeting People Living with Disabilities

Being a cholera response, this allocation used an all-inclusive approach for all the cholera affected communities where targeted with all the interventions and this also included people living with disabilities. Since some components of the interventions targeted households that registered cholera cases and their surrounding households, people with disabilities were also targeted and thus also benefited from the interventions. Specifically, the CATI interventions under WASH targeted households that registered cholera cases and their surrounding households. PwD in the targeted households thus also benefited from the interventions. For the Risk communication and Community Engagement, interventions, multiple communication channels were used to reach out to communities with cholera preventive and hygiene related messages. Sign language was included in the visual material to reach people with hearing impairment. Approaches like roadshows and moonlight cinemas, radio programme and loud hailing ensured that both visual and physical disabilities

[1] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

were reached with the messages. In addition, door to door interpersonal communication was used which ensured that people with disabilities were reached with the messages in their homes and through the family members. Under the health response, in providing support to health services and Cholera Treatment Units, PwD received similar treatment and care without discrimination and with dignity as other patients in the CTUs. PwD also equally provided with the oral vaccination.

Education

As there were some schools in the targeted locations for the interventions, activities were designed to ensure that school-going children have access to the school WASH services and hygiene promotion. Specifically, schools in the affected and at-risk communities were targeted soap and hand washing buckets as a way of preventing cholera in the schools and thus prevent learning disruption in the event of cholera outbreaks in the districts.

Protection

Partners recognised the protection risks in cholera contexts including the likelihood of family separation when a parent is taken to a cholera treatment centre (CTC) for treatment and possible death in light of the high number of deaths recorded. Efforts were made to leverage on other humanitarian response projects to mainstream protection. Children in community based childcare centres, parents, and primary caregivers were provided with messaging on cholera prevention and response, community-based mental health and psychosocial support services and child protection services. Children in safe spaces (children's corners) were reached with messaging on cholera prevention and social and behavioural change interventions, Gender-Based Violence in Emergencies (GBViE) and Protection from Sexual Exploitation and Abuse (PSEA).

Table 1: Allocation Overview (US$)

Total amount required for the humanitarian response	**20,000,000**
CERF	1,000,000
Country-Based Pooled Fund (if applicable)	0
Other (bilateral/multilateral)	0
Total funding received for the humanitarian response (by source above)	**1,000,000**

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
UNICEF	22-RR-CEF-063	Water, Sanitation and Hygiene	401,760
UNICEF	22-RR-CEF-063	Health	342,240
WHO	22-RR-WHO-036	Health	256,000
Total			**1,000,000**

Table 3: Breakdown of CERF Funds by Type of Implementation Modality (US$)

Total funds implemented directly by UN agencies including procurement of relief goods	**809,929**
Funds sub-granted to government partners*	28,360
Funds sub-granted to international NGO partners*	85,482
Funds sub-granted to national NGO partners*	76,229
Funds sub-granted to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**190,071**
Total	**1,000,000**

* Figures reported in table 3 are based on the project reports (part II, sections 1) and should be consistent with the sub-grants overview in the annex.

2. OPERATIONAL PRIORITIZATION:

Overview of the Humanitarian Situation

The President of Malawi declared the cholera outbreak a public health emergency on 5 December 2022 and activated the Presidential Task Force (PTF) on COVID-19 and cholera (PTF) to provide overarching coordination for the response. Given the nature of the cholera outbreak, the PTF was expanded to include the Minister of Water. In February 2023, the humanitarian community developed and launched a Flash Appeal in response to the exponential increase the number of cholera cases. The appeal targeted 3.9 million people for a total financial requirement of USD45.3 million. By May 2023, a total of USD18.3 million had been mobilised against the appeal including the USD1 million for this CERF allocation.

A detailed vulnerability mapping across the 29 affected districts carried out by the WASH and Health Sectors, under the leadership of the respective government line ministries. Based on the vulnerability mapping, each district was categorized according to the severity of the outbreak and associated risks. It was then agreed that the Flash Appeal would prioritize response in districts with a high or very high severity score, resulting in a geographic focus on 15 out of the 29 affected districts. This CERF allocation further prioritised nine districts out of those 15 districts which were most affected to include Nkhotakota, Blatyre, Nsanje, Rumphi, Nkhata Bay, Mzimba, Neno, Chikwawa and Karonga.

Operational Use of the CERF Allocation and Results

CERF allocated US $1 million to Malawi from its Rapid Response window to provide a timely and integrated multisector (health and WASH) cholera response and control of community spread in nine districts that had reported the highest number of cases. This CERF allocation allowed UN agencies and partners (government and NGOs) to contribute to the containment of the cholera outbreak reaching a total of 183,704 direct beneficiaries.

Health: The funding enabled UN agencies to reach 172,470 people with health services. For case management, WHO and its partners provided treatment to 5,300 persons, traced 29,236 contacts of cholera patients through active case investigations in communities and reached 170,852 people (92 per cent reach) with the Oral Cholera Vaccine (OVC) (against an initial target of 195,000 people) as a result of a pre-programming of the interventions. An important component in this response was the active case finding for suspected cholera cases in communities in all affected districts. Not only did this help identify cases for treatment, but also brought awareness to the affected communities.

A five-day campaign was implemented in Mangochi which was at the time reporting highest number of cases and deaths. With this allocation, UNICEF supported total of 90 Cholera treatment units (CTUs) which were established against the planned target of 76. WHO established a total of 106 oral rehydration points (ORPs). The establishment of ORPs were set up to bring treatment closer to communities enabling provision of first aid rehydration and timely refer patients to CTUs. In terms of capacity building, WHO deployed four surveillance technical officers to support and scale up surveillance in the targeted districts while I82 healthcare workers were trained on surveillance interventions, and 268 health care workers trained on integrated cholera case management. These trainings were initially planned for participants from the 4 districts. However, as the outbreak was evolving spreading to more neighboring districts, more health care workers from those districts joined in the trainings supported by other partners. This is one area where the CERF allocation was catalytic in resource mobilization at district level and indirectly benefiting more communities than targeted.

The CERF allocation planned to recruit 2 public health surveillance officers per each district that was being supported. The new recruitments were four (4), one based in each of the districts. The funding allocation for the remaining four was used to support public health surveillance officers who were already in place supporting data management, analytics, and field support. These were strategically based at the Public Health Institute of Malawi.

WHO procured 20 containers of Chlorine (HTH) for infection prevention and control (IPC), together with 650 cartons of ORS and Ringer Lactate for life-saving treatment of 2,797 severe cases in the (CTC/Us) for the four districts of Nkhatabay, Nkhotakota, Rumphi and Mzimba North. ORS and clinical supplies for managing severe and moderate cases admitted for care and treatment were also procured. A reprogramming requested was made for inclusion of Ringer Lactate. These efforts contributed to the lowering of the CFR from above 3 per cent to less than 1 per cent in four districts of Nkhata Bay, Rumphi, Nkhotakota and Mzimba North). UNICEF procured and distributed Acute Water Diarrhoea (AWD) kits, Oral Rehydration Solutions (ORS), essential medicine including fluids, rapid diagnostic test kits, and Infection Prevention and Control (IPC) supplies in Cholera Treatment Centers (CTCs) for treatment of cholera cases.

WASH

A total of 182,000 people accessed water chlorination and appropriate sanitation and hygiene services. A total of 89,000 people were reached with water treatment chemicals which includes 112,000 with hygiene kits and hygiene messages. The interventions also supported the construction of 30 latrines in the CTUs and conducted door to door household monitoring in 1,000 households. Results from the household monitoring informed the programme on the water quality. Through the Case Area Targeted Interventions (CATI), and working together with United Purpose, UNICEF provided an integrated package of cholera control interventions including distribution of water treatment chemicals (chlorine and water guards), hygiene promotion and distribution of soap and buckets. The interventions also included water quality monitoring and sanitation promotion both in institutions and communities. A total of 960 people (424 Male and 536 female) from 48 radio listeners group from nine districts were trained and mobilised for cholera prevention door to door actions. A total of 109,800 people were directly reached with messages on hand hygiene and use of chlorine for household level water treatment through community dialogue using cholera preventive cinemas.

People Directly Reached

CERF allocated US $1,000,000 to Malawi from its Rapid Response window in order to provide a timely and integrated multisector (health and WASH) cholera response and control of community spread in nine districts that had reported a significant number of cholera cases in Malawi. This allocation allowed UN agencies and partners to contribute to the containment of the cholera outbreak and reaching a total of 183,704 beneficiaries from 9 of the most affected districts. This included 50,697 women, 47,932 men, 43,446 girls and 41,629 boys in host communities including 19,015 people living with disabilities (5,256 women, 5,067 men, 4,445 girls and 4,247 boys). Of this population, 5,300 people received cholera treatment through the established treatment units. The project initially planned to reach a conservative figure of 25,496 the OCV was scarce, and Malawi was not sure if they will receive OCV allocation from the International Coordinating Group (ICG) for OCV. With strong advocacy from the Malawi government and partners, the country managed to secure doses adequate to vaccinate more people. UNICEF contribution to the total cost of the OCV campaign in Mangochi district was 33 percent which translates to 61,050 people out of the total reach of 170,582 people.

Considering that both UNICEF and WHO were targeting the same districts with complementary interventions, all efforts were made to avoid double counting and using the highest number of people reached in the WASH and the “Others” category. Although an amendment exponentially increased the number of people who benefitted from the OCV, it is again anticipated that this is the same target that benefitted from the other health and WASH interventions.

People Indirectly Reached:

Beyond the interventions that directly benefited the proposed target group. various other initiatives were implemented to ensure that key cholera messaging reached as wide a catchment as possible to contain the outbreak. Working in partnership with Health Education and implementing partners, two million cholera-affected and at-risk people were reached through health promotion. This included a combination of risk communication and community engagement, enhanced surveillance, active case investigation which was integrated with community messaging as well as delivery of chlorine stock solution to households and water collection points in villages. Similarly, from cholera treatment units, cholera cases and their guardians received packages of oral rehydration salt packets and health education

before being discharged from cholera treatment units. A total of 223,657 (100,110 male and 123,547 female) were reached with key lifesaving messages on cholera prevention through door-to-door actions from the radio listeners group members. A total of 12 radio programmes on cholera prevention were produced and broadcasted through 8 community radio stations reaching more than 1 million people across the cholera targeted districts. Around 393,211 (172,617 male and 220,594 female) were reached with hygiene, health seeking and oral rehydration salt use messages through mobile van announcements.

Table 4: Number of People Directly Assisted with CERF Funding by Sector/Cluster*

	Planned					Reached				
Sector/Cluster	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Health	2,878	2,643	2,390	2,339	**10,250**	44,527	42,981	45,981	44,185	**177,674**
Water, Sanitation and Hygiene	46,818	44,982	39,882	38,318	**170,000**	50,271	47,523	43,003	41,203	**182,000**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

Table 5: Total Number of People Directly Assisted with CERF Funding by Category*

Category	Planned	Reached
Refugees	0	0
Returnees	0	0
Internally displaced people	0	0
Host communities	179,320	182,000
Other affected people	930	1,704
Total	**180,250**	**183,704**

Table 6: Total Number of People Directly Assisted with CERF Funding*			**Number of people with disabilities (PwD) out of the total**	
Sex & Age	**Planned**	**Reached**	**Planned**	**Reached**
Women	49,696	50,697	5,150	5200
Men	47,625	47,932	4,948	5000
Girls	42,272	43,446	4,387	4400
Boys	40,657	41,629	4,215	4200
Total	**180,250**	**183,704**	**18,700**	**18,800**

PART II – PROJECT OVERVIEW

3. PROJECT REPORTS

3.1 Project Report 22-RR-CEF-063

1. Project Information

Agency:	UNICEF	**Country:**	Malawi
Sector/cluster:	Water, Sanitation and Hygiene Health	**CERF project code:**	22-RR-CEF-063
Project title:	Integrated Cholera response for Malawi		
Start date:	04/10/2022	**End date:**	03/04/2023
Project revisions:	No-cost extension ☐ Redeployment of funds ☐		Reprogramming ☒

Funding

Total requirement for agency's sector response to current emergency:	**US$ 4,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 744,000**
Total CERF funds sub-granted to implementing partners:	**US$ 190,070.90**
Government Partners	US$ **$28,359.75**
International NGOs	**US$ $85,482.00**
National NGOs (Communication for Development Center)	**US$ 76,229.15**
Red Cross/Crescent Organisation	US$ **0**

2. Project Results Summary/Overall Performance

With the CERF funds, UNICEF supported 90 Cholera treatment units (CTUs) against the planned target of 76, in CERF targeted districts. UNICEF adopted an integrated response covering Health, WASH, and Social Behaviour Change and Communication (SBCC) sectors across nine districts with the highest number of cases (September to February). Key activities for the health component included procurement and distribution of Acute Water Diarrhoea (AWD) kits, Oral Rehydration Solutions (ORS), essential medicine including fluids, rapid diagnostic test kits, and Infection Prevention and Control (IPC) supplies in Cholera Treatment Centers (CTCs) for treatment of cholera cases. UNICEF supported Mangochi district with Oral Cholera Vaccination (OCV) which was then reporting highest number of cases and deaths. Thirty-three (33) percent of the total cost of the Mangochi OCV campaign was covered by the CERF grant. The five days campaign which targeted 185,000 people followed by a mop up, had coverage of 92 percent, reaching 170,582 people. UNICEF supported in microplanning, social mobilization, and provided expert technical support to both national and sub national offices and technical oversight and monitoring during the campaign.

Through the Case Area Targeted Interventions (CATI), in partnership with United Purpose, UNICEF provided an integrated package of cholera control interventions including distribution of water treatment chemicals (chlorine and water guards), hygiene promotion and distribution of soap and buckets. The interventions also included water quality monitoring and sanitation promotion both in institutions and communities. Overall, the programme reached 182, 000 people through different interventions. A total of 89,000 people were reached with water treatment chemicals, 112,000 with hygiene kits and182,000 people with messages. The programme supported the construction of 30 latrines in the CTUs and conducted door to door household monitoring in 1,000 households. Results from the household monitoring informed the programme on the water quality.


Community CATI session in progress

In partnership with Health Education Services, Ministry of Health and Center for Development Communication (CDC), UNICEF supported risk communication and community engagement (RCCE) interventions in Nkhotakota, Salima, Nsanje, Chikawawa, Nkhatabay, Mzimba (North), Karonga, Mwanza and Blantyre districts. The RCCE targeted 350,000 direct beneficiaries and 2 million indirect beneficiaries through door-to-door visits, community dialogue using cholera preventive cinemas, experimental road shows, radio programme and loud hailing.

A total of 960 people (424 Male and 536 female) from 48 radio listeners group from nine districts were trained and mobilised for cholera prevention door to door actions. A total of 223,657 (100,110 male and 123,547 female) were reached with key lifesaving messages on cholera prevention through door-to-door actions from the radio listeners group members.

A total of 12 radio programmes on cholera prevention were produced and broadcasted through 8 community radio stations reaching more than 1 million population across the cholera targeted districts.

Also, 109,800 people were directly reached with messages on hand hygiene and use of chlorine for household level water treatment through community dialogue using cholera preventive cinemas. Around 393,211 (172,617 male and 220,594 female) were indirectly reached with hygiene, health seeking and oral rehydration salt use messages through mobile van announcements.


Community drama performance on cholera prevention in Salima


Community Dialogue Session using cholera preventive cinema in Mzuzu


Community drama performance on cholera prevention in Salima

3. Changes and Amendments

There was a downward revision of quantities of supply items for offshore procurement because of high freight costs, In the meantime, UNICEF distributed cholera supplies that were in its warehouse and some supplies procured locally with the CERF funds, including cholera beds, solar lamps, infection, prevention, and control items like methylated spirit, high-performance tents, and different sizes of gumboots and gloves.

UNICEF requested project amendment to fulfil the request to support the Ministry of Health in expanding the Oral Cholera Vaccine (OCV) campaign to Mangochi district. The campaign started on 5 December with social mobilization activities. The administration of doses commenced on 12 December 2022.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	2,617	2,403	2,173	2,127	**9,320**	42,628	40,956	44,368	42,628	**170,580**
Other affected people	261	240	217	212	**930**	426	409	443	426	**1,704**
Total	**2,878**	**2,643**	**2,390**	**2,339**	**10,250**	**43,054**	**41,365**	**44,811**	**43,054**	**172,284**
People with disabilities (PwD) out of the total										
	255	231	206	201	**893**	426	409	443	426	**1,704**

Sector/cluster	Water, Sanitation and Hygiene									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	46,818	44,982	39,882	38,318	**170,000**	50,271	47,523	43,003	41,203	**182,000**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**46,818**	**44,982**	**39,882**	**38,318**	**170,000**	**50,271**	**47,523**	**43,003**	**41,203**	**182,000**
People with disabilities (PwD) out of the total										
	5,150	4,948	4,387	4,215	**18,700**	5,200	5,000	4,400	4,200	**18,800**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

Around 2 million indirect beneficiaries benefited from risk communication and community engagement (RCCE) interventions through radio programme and loud hailing.

6. CERF Results Framework

Project objective	Treat and contain the ongoing outbreak in Malawi
Output 1	Cholera cases management improved across affected districts

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health

Indicators	Description	Target	Achieved	Source of verification
Indicator 1.1	Cases Fatality Rate (CFR) reduced to below 1 per cent	CFR<1%	2.9%	Public Health Institute of Malawi (PHIM) Dashboard
Indicator 1.2	Attack Rate (AR) reduced to below 1 per cent	AR<1%	0.10%	PHIM data
Indicator 1.3	No. of PME conducted	12	12	Project Monitoring Visit report
Indicator 1.4	H.7 Number of functional health facilities supported (CTUs)	76	90	Delivery consignment
Indicator 1.5	H.4 Number of people vaccinated	25,496	61,050	District OCV report

Explanation of output and indicators variance:	Weekly CFR reduced from 4 per cent at its worst to 0 per cent as of 27 June 2023 in selected districts of CERF, possibly because of the interventions undertaken to support the CTCs. The cumulative CFR, although it remained high, has also reduced considerably from 4per cent to 2.9 per cent of the end of the CERF project. However, it remained higher than the recommended threshold of <1 percent. The project initially planned to reach a conservative figure of 25,496 the OCV was scarce, and Malawi was not sure if they will receive OCV allocation from the International Coordinating Group (ICG) for OCV. With strong advocacy from the Malawi government and partners, the country managed to secure doses adequate to vaccinate more people. UNICEF contribution to the total cost of the OCV campaign in Mangochi district was 33 percent which translates to 61,050 people out of the total reach of 170,582 people

Activities	Description	Implemented by
Activity 1.1	Procurement, freight, warehousing, and distribution of AWD Cholera kits, ORS, essential medicine including fluids, Rapid diagnostic Test Kits, and Infection Prevention and Control (IPC) supplies in Cholera Treatment Centers (CTCs)	UNICEF
Activity 1.2	Procurement, freight, warehousing, and distribution of tents and equipment in CTCs	UNICEF

Activity 1.3	Joint assessment and periodic monitoring and evaluation of selected districts and Cholera Hotspots on logistics and supplies	UNICEF
Activity 1.4	Cholera Treatment units in targeted districts are supported for 24/7 service supplies, (human resources, utilities, IPC)	UNICEF
Activity 1.5	Operational support for OCV campaign in targeted districts	UNICEF/ MOH (District)

Output 2	Cholera Outbreak is effectively contained in targeted districts
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Water, Sanitation and Hygiene

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	WS.6 Number of people accessing sufficient and safe water for drinking, cooking and/or personal hygiene use as per agreed sector standard	80,000	89,000	Partner Reports
Indicator 2.2	WS.19 Percentage of households that can demonstrate effective treatment of their water to meet the recognized standards for water quality	80	82	Partner Reports
Indicator 2.3	No of water sources sampled to assess water quality	1,000	1,000	Partner Reports
Indicator 2.4	WS.13 Number of communal sanitation facilities (e.g. latrines) and/or communal bathing facilities constructed or rehabilitated. (temporary latrines installed for hosting communities and in Cholera Treatment Centers)	30	30	Partner Reports
Indicator 2.5	No of temporary latrines decommissioned for hosting communities and in Cholera Treatment Centers	30	30	Partner Reports
Indicator 2.6	WS.16a Number of people receiving critical WASH supplies (e.g., WASH/hygiene kits)	110,000	112,000	Partner Reports
Indicator 2.7	WS.17 Number of people receiving WASH/hygiene messaging	170,000	182,000	Partner Reports
Indicator 2.8	AP.3b Percentage of affected people who state that they were consulted on the humanitarian response	80	80	Partner Reports

Indicator 2.9	WS.16b Number of WASH/hygiene kits distributed	50	60	Partner Reports
Explanation of output and indicators variance:				

Activities	**Description**	**Implemented by**
Activity 2.1	Procure and distribute water treatment chemicals (mass disinfection)	United Purpose
Activity 2.2	Procure and distribute water storage containers	United Purpose
Activity 2.3	Treatment (flushing and shock-chlorination) of affected water sources in hosting communities	United Purpose
Activity 2.4	Monitoring of water quality in affected water sources	United Purpose
Activity 2.5	Procurement and distribution of water quality kit	United Purpose
Activity 2.6	Installation of Emergency latrines in communities and Cholera Treatment Centers	United Purpose
Activity 2.7	De-commissioning of emergency latrines in communities and Cholera Treatment Centers	United Purpose
Activity 2.8	Procurement and distribution of soap	United Purpose
Activity 2.9	Support local authorities in rolling outdoor-to-door chlorination	United Purpose
Activity 2.10	Support to local authorities to perform door-to-door chlorination	United Purpose
Activity 2.11	Procurement and distribution of hygiene promotion material	United Purpose, Center for Development Communication
Activity 2.12	Support to local authorities in rolling out of Case Area Targeted Intervention (CATI) including door-to-door chlorination	United Purpose
Activity 2.13	Promote hygiene practices and handwashing through door-to-door mobilization of community volunteers	United Purpose, Communication for Development Center
Activity 2.14	Development of Digital job aids to support HSA – Health Surveillance Assistance	United Purpose
Activity 2.15	Community Rapid assessments (including GBV), U-report	United Purpose, Center for Social Research, University of Malawi

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[2] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

[2] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

a. Accountability to Affected People (AAP) [3]:

The marginalised groups were included in the design of the implementation, especially on targets and types of needs based on the population affected. Being a cholera response, all the cholera affected communities were targeted with all the interventions. Distribution of the WASH supplies focussed on the households that registered cholera cases, cholera treatment units and schools with more focus on the most vulnerable and marginalised households and hard to reach communities.

b. AAP Feedback and Complaint Mechanisms:

UNICEF in partnership with WHO and IFRC and under the leadership of Health Education Services, developed standardised online and offline community feedback tools. Altogether 2,467 community feedbacks were collected using U-report, focus group discussion, individual interviews, and community dialogues. The feedbacks were analysed and shared with the district councils and district health offices. Most of the feedbacks were related to the availability and equitable distribution of chlorine, availability of soap, drinking water, management of diapers, and the construction and use of latrines by the communities. The district offices in nine affected districts ensured the availability and distribution of chlorine including community dialogue with the traditional and community leaders to support the latrine construction.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

PSEA is a critical aspect of UNICEF's work and is committed to upholding the highest standards of integrity and ensuring the protection and well-being of the people it serves, especially children and vulnerable populations. Proactive measures have been taken on PSEA within the partner organizations by developing policies, code of conduct. Partner staff were also oriented on PSEA and available complaint mechanism. The online and offline feedback and complaint tool incorporates PSEA related information. The communities were also informed about the suggestion boxes, hotline numbers during community dialogue sessions and through loud hailing in nine targeted districts.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

Women and girls are exposed to cholera due to their caring roles and frequent contact with water and food. Women have specific vulnerabilities and barriers like domestic roles, including cleaning latrines, fetching and handling water, and preparing contaminated raw food. Women also have limited access to information, knowledge and technologies, and there are high illiteracy rates among women as well. The cholera response targeted women with specific interventions to empower them with knowledge on cholera prevention and treatment; community awareness on cholera and hygiene promotion were done in the communities with men women, boys and girls to address issues of women's restricted movement and multiple roles. Messages were provided in local language and pictorial graphics were used to ensure that marginalised women and girls get the messages. MHPSS sessions were provided to affected women and girls to manage their emotional, physical, and socioeconomic challenges during the epidemic. GBV and SEA awareness campaigns were integrated in cholera prevention and response activities.

e. People with disabilities (PwD):

People with disabilities were not explicitly targeted by the interventions. Being a cholera response, all the cholera affected communities were targeted with all the interventions. CATI interventions targeted households that registered cholera cases and their surrounding households. PwD in the targeted households thus also benefited from the interventions.

f. Protection:

Recognising the protection risks in cholera contexts including the risk of accidental family separation when a parent is taken to a cholera treatment centre (CTC) for treatment UNICEF leveraged other humanitarian response projects to mainstream protection. UNICEF included

[3] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

cholera messages, including sensitisation of the protection risks which children face in cholera contexts, in its message dissemination interventions. UNICEF provided children in community based childcare centres, parents, and primary caregivers with messaging on cholera prevention and response, community-based mental health and psychosocial support services and child protection services. Children in safe spaces (children's corners) were reached with messaging on cholera prevention and social and behavioural change interventions, Gender-Based Violence in Emergencies (GBViE) and Protection from Sexual Exploitation and Abuse (PSEA).

Child protection workers were sensitized on the need to monitor and urgently take appropriate action once they become aware of a child(ren) who were separated from his /her parent or caregiver because of cholera. UNICEF also supported community policing initiatives to ensure that mechanisms are available for reporting cases of violence against women and children including from sexual exploitation and abuse.

g. Education:

Schools in the affected and at-risk communities were targeted with WASH supplies including soap and hand washing buckets as a way of preventing cholera in the schools and thus prevent learning disruption in the event of cholera outbreaks in the schools.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	NA

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

N/A

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
NA	NA	US$ 0	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
Shielding cyclone survivors from waterborne diseases	[Insert] https://www.unicef.org/malawi/stories/shielding-cyclone-survivors-waterborne-diseases
Oral rehydration points provide frontline shield in fight against cholera	https://www.unicef.org/malawi/stories/oral-rehydration-points-provide-frontline-shield-fight-against-cholera
Health workers launch pre-emptive attack against cholera Learners bear the brunt of cholera	[https://www.unicef.org/malawi/stories/health-workers-launch-preemptive-attack-cholera https://www.unicef.org/malawi/stories/learners-bear-brunt-cholera

Additional content

- Link to posters of influencers cholera awareness
- Link to content on cholera vaccination campaign
- Link to Mangochi cholera response photos
- Link to cholera videos and b-roll (influencers on cholera awareness)
- Social media links below:
- https://twitter.com/MalawiUNICEF/status/1641075644611145728?s=20
- https://twitter.com/MalawiUNICEF/status/1672175798260776960?s=20
- https://twitter.com/MalawiUNICEF/status/1633015705342824448?s=20
- https://twitter.com/MalawiUNICEF/status/1626642858059898880?s=20
- https://twitter.com/MalawiUNICEF/status/1633125301499592705?s=20
- https://twitter.com/MalawiUNICEF/status/1672175798260776960?s=20
- https://www.facebook.com/UNICEFMw/posts/pfbid0DMNhWZQb15tUaczE8zJb8YXnacTwkgkysH5rNHWN7vLZBPNADBSHEHndERkyxgxml
- https://www.facebook.com/UNICEFMw/posts/pfbid0CcM47wgV4e1gatr4PnJP9s7EU8UK2CoTfLGwbpSQVvvqRScoGjXFDMZFzsSt687Al
- https://www.facebook.com/UNICEFMw/posts/pfbid02samywYHZ2N298qXScHRctr1rD8VALoH7uzry8sfdc3rhuARBbmL9nVkpqJJKK3oil
- https://www.facebook.com/UNICEFMw/posts/pfbid0w3qFie1hkEPXZHGqfC3ej5eoQJR3p2E26AQt4GhTZsKLujMxUYpjrZeMMPfTbPM2l
- https://www.facebook.com/UNICEFMw/posts/pfbid02XHvmQMd55FC6UzFY6BycD5uRgZK2aAYe3q8U2bsadqo9MyQVbovDtww34YhzTa1Sl
- https://www.facebook.com/UNICEFMw/posts/pfbid032jko8uonksNhgCUxNn12gN37qMDUGF1CYmWwqhvR8avYtDvWTzqgYEJqJYyyo7uJl

3.2 Project Report 22-RR-WHO-036

1. Project Information

Agency:	WHO	**Country:**	Malawi
Sector/cluster:	Health	**CERF project code:**	22-RR-WHO-036
Project title:	Support to Strengthen Surveillance and Case Management Response to Cholera Outbreak in Malawi		
Start date:	01/09/2022	**End date:**	28/02/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☒

Funding

Total requirement for agency's sector response to current emergency:	**US$ 5,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 256,000**
Total CERF funds sub-granted to implementing partners:	**US$ 0**
Government Partners	US$ 0
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through the CERF grant, WHO and its partners provided life-saving treatment to 5,300 persons, traced 29,236 contacts of cholera patients through active case investigations in communities to identify cases early and reach them with preventive messages. The CERF allocation aimed at improving surveillance to allow early detection of cholera cases, facilitate contact tracing and active case finding and linking the cases to the nearest post or facility for treatment as holistic spectrum of care. Once a contact is traced and they meet a case definition for cholera, the nearest and most accessible point of care are community based oral rehydration points and these are a hub providing first line treatment hence the indicated number of people treated.

The team managed to establish 106 oral rehydration points (ORPs), deployed 4 surveillance technical officers, conducted 14 supportive supervision visits in the project targeted districts, trained I82 healthcare workers on surveillance interventions, and trained 268 health care workers on integrated cholera case management. The CERF allocation planned to recruit 2 public health surveillance officers per each district that was being supported. The new recruitments were four (4), one based in each of the districts. The funding allocation for the remaining four was used to support public health surveillance officers who were already in place supporting data management, analytics, and field support. These were strategically based at the Public Health Institute of Malawi. For the trainings, these were initially planned for participants from the 4 districts. However, as the outbreak was evolving spreading to more neighboring districts, more health care workers from those districts joined in the trainings supported by other partners. This is one the CERF allocation was catalytic in resource mobilization at district level and indirectly benefiting more communities than targeted.

3,500 cholera case management flow-charts/ job aids and IEC materials were printed and distributed. 20 containers of Chlorine (HTH) for infection prevention and control (IPC) were procured, together with 650 cartons of ORS and Ringer Lactate for life-saving treatment of 2,797 severe cases in the cholera treatment centres/ units (CTC/Us) for the four districts of Nkhatabay, Nkhotakota, Rumphi and Mzimba North. ORS and clinical supplies for managing severe and moderate cases admitted for care and treatment were procured. The ORPS were set up to bring treatment closer to communities enabling provision of first aid rehydration and timely refer patients to CTUs.

These investments resulted into the four districts achieving <1 case fatalty and attack rates of <1 % and transmission interruption (see Appendix included). These investments resulted into a reduction in case fatality rate in these districts from above 3.0 % to figures below 1.0 % (down to 0.1 % in Nkhata Bay, 0.1% in Rumphi, 0.1% in Nkhotakota and 0% in Mzimba North). Similarly, reduction in attack rates from an average of 40.0 per 100,000 to 0.1 per 100,000 population i.e., from 39/100,000 to 0/100,000 in Nkhata Bay, from 5.5/100,000 to 0.0/100,000 in Rumphi, from 4.6/100,000 to 0.5/100,000 in Nkhotakota and from 30/100,000 to 0/100,000 in Mzimba North.

3. Changes and Amendments

Reprogramming was requested for inclusion of Ringer Lactate inclusive of shipping costs. Additionally, prioritization of oral cholera vaccine campaign preparation was undertaken by target districts through October 2022 followed by social mobilization and campaign activities in November 2022 with support for GAVI.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Returnees	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Internally displaced people	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Host communities	1,377	1,323	1,173	1,127	**5,000**	1,473	1,526	1,170	1,131	**5,300**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**1,377**	**1,323**	**1,173**	**1,127**	**5,000**	**1,473**	**1,526**	**1,170**	**1,131**	**5,300**
People with disabilities (PwD) out of the total										
	56	67	45	47	**215**	56	67	45	47	**215**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

An estimated 1,983,770 persons indirectly benefited from the project activities. This was achieved through two-pronged integrated community strategies and case management interventions spanning from CTUs to household levels. Community strategies conducted through enhanced surveillance following the surveillance training resulted in improvements in timely case detection. The active case investigation was integrated with community messaging as well as delivery of chlorine stock solution to households and water collection points in villages. Similarly, from cholera treatment units, cholera cases and their guardians received packages of oral rehydration salt packets and health education before being discharged from cholera treatment units.

6. CERF Results Framework

Project objective	To strengthen surveillance for cholera through capacity building for rapid response teams, timely case investigation, contact and defaulter tracing to interrupt further spread To enhance case management of cholera cases through case management training and mentoring of health care workers, strengthening treatment units for timely management and referral of cases to improve survival
Output 1	Surveillance strengthened for containment of outbreak

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number and gender of surveillance technical support staff at post	4	4	WCO HR plans and reports
Indicator 1.2	CC.1 Number of implementing partner staff receiving training to support programme implementation (health workers trained in surveillance tools)	180	182	Training database
Indicator 1.3	Number of districts reporting data weekly	4 (all targeted districts)	4	Weekly Situation Reports Public Health Institute of Malawi (PHIM), Weekly cholera situation reports, Dashboard link: Microsoft Power BI
Explanation of output and indicators variance:		Additional 2 health care workers were trained with targeted surveillance training at district level based on need during the time of training.		

Activities	**Description**	**Implemented by**
Activity 1.1	Recruit technical support staff	WHO
Activity 1.2	Support operations and supervision of rapid response teams	WHO and MOH
Activity 1.3	Support mentorship and supervision of surveillance activities	WHO and MOH
Activity 1.4	Support capacity building of surveillance and laboratory staff	WHO and MOH

Output 2	Case Management enhanced for improved survival

Was the planned output changed through a reprogramming after the application stage?		Yes ☐	No ☒	
Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	CC.1 Number of implementing partner staff receiving refresher trainings to support programme implementation (health staff trained in cholera guidelines)	180	268	Case Management training database
Indicator 2.2	Number of operational rehydration centers	16	106	Field activity reports
Indicator 2.3	Number supportive supervision visits to treatment centers	14	14	Supervision reports
Explanation of output and indicators variance:		Additional 88 health care workers and were trained based on need as the cholera outbreak evolved within the districts spreading to additional communities that had not previously been affected. Activity 2.1 had aimed to reach implementing partners staff receiving refresher training to support programme implementation (health staff trained in cholera guideline) was implemented by WHO and MOH. As the cholera outbreak was fast spreading in the targeted districts, MOH mobilized additional resources to reach more health care workers during the same sessions. This was more efficient in the context of an outbreak for timely and effective response to control the outbreak and stop transmission to more communities. This was not discussed with CERF as no additional resources were utilized from the WHO allocation.		

Activities	**Description**	**Implemented by**
Activity 2.1	Support refresher training of health staff in cholera guidelines	WHO and MOH
Activity 2.2	Support case management mentorship /supportive supervision	WHO and MOH
Activity 2.3	Print and disseminate cholera treatment guidelines	WHO
Activity 2.4	Support operationalization of rehydration and treatment centers	WHO and MOH

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[4] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

[4] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

a. Accountability to Affected People (AAP) [5]:

Implementation of community integrated interventions inclusive of selection of locations for establishment of ORPs were jointly done through involvement of influential and community leaders enabling community entry followed by village meetings through established and recognized village health committees and area development committees within the structure of district councils. Fishermen beach committees were reached and involved as recognized by the Department of Fisheries and crucial for contact tracing, cholera messaging for early recognition of cholera symptoms for early referral pathways.

b. AAP Feedback and Complaint Mechanisms:

Collaboration with multisectoral groups such as welfare officers at district councils, agricultural extension workers, health facility ombudsman, GBV hotline and One-stop centres that work closely with Malawi Police Services and community referral mechanisms by mother groups linked to the education sector mapped for feedback, complaints and confidentiality and follow-up. Specifically, within Government of Malawi, there are multi-sectoral structures at the district council as well as sectoral structures i.e. in health sector that deals with complains and provide feedback to relevant authorities and sectors. There also exists a multi-sectoral structure which involves a strategic one stop center including – focal person from health sector, Malawi police Service and from the community all based under one office strategically located in district councils. They operate in a wide network of multi-sectoral groups within the government system. For example, social welfare officers who are key focal points for feedback and complaint systems, and serve at the community level to trace victims, conducting needs assessments of reported cases and vulnerabilities. In the health sector, there is an ombudsman located at each health facility who receives and processes complaints regarding access and quality of health care services and provides feedback and recommendations to involved stakeholders and authorities.
There is a gender-based violence (GBV) hotline which is confidential platform for reporting complaints and providing feedback and support. This platform is collaborated by the Ministry of Gender and its partners. Through the Ministry of Education, voluntary mother groups are used to provide support for school going children for reporting complaints and providing feedback. For future interventions, these infrastructures would benefit from additional support to ensure collaborative efforts for outbreak response amongst Government, UN agencies, Partners, CBOs and community structures.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

Prevention and responding to sexual abuse, exploitation, and harassment (PRSEAH) addressed through integration of PRSEAH during health worker trainings, community meeting, reporting mechanisms linked to established government GBV One-stop centres and hotline provided to communities, with monitoring through the common UN agencies network.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The project addressed needs of women and girls, including GBV and empowerment by deliberately reaching out to females to benefit from the capacity building activities especially as they often affected by cholera outbreaks given their care giving roles. The CERF allocation supported community-based interventions including setting up of community based oral rehydration points for timely access to cholera. The ORPs which attracted female volunteers as well as male volunteers. The women and girls, given their care giving roles in these communities, meant they were among primary recipients of the integrated health promotion messaging, thereby improving their health literacy. Further on, with ORPs serving as distribution points for chlorine for water treatment empowered women and girls to render a voice towards solutions for safe water in communities. However, with the role played by males in the affected communities which include male dominated fishing camps, boys and men also benefited from the project activities enabling them to contribute to surveillance activities in the target districts thereby ensuring a gender sensitive response

e. People with disabilities (PwD):

[5] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

This project used an all-inclusive approach during implementation with the aim to accommodate the needs of PWD including women and girls with disabilities such as selection of training venues that enabled accessibility to PWD and ensure their safety. Invitation of participants for capacity building was open to PWD.

f. Protection:

The protection of all persons affected was taken into consideration in the project implementation by ensuring all activities benefited those affected by cholera and also enhance prevention of spread so that others at risk of infection such as contacts were protected through promotion of infection prevention and control measures, early case detection and contact tracing.

g. Education:

Not Applicable

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	Choose an item.	

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

N/A

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
N/A	0	US$ 0	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
In Malawi, community-run Oral Rehydration Points help address cholera deaths	https://www.afro.who.int/photo-story/malawi-community-run-oral-rehydration-points-help-address-cholera-deaths
ORP	https://twitter.com/WHOMalawi/status/1633504837118705665/photo/1
IEC Materials	https://twitter.com/WHOMalawi/status/1641101213960683521/photo/1
Supportive supervision	https://twitter.com/WHOMalawi/status/1583374892309057536/photo/1
Cholera Treatment Centers help save lives in Malawi	https://www.facebook.com/WHOAFRO/videos/741660890959245
Case management mentorship	https://twitter.com/WHOMalawi/status/1588164644794933250/photo/2

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Sector	Agency	Implementing Partner Type	Funds Transferred in USD
22-RR-CEF-063	Water, Sanitation and Hygiene	UNICEF	INGO	$85,482
22-RR-CEF-063	Water, Sanitation and Hygiene	UNICEF	NNGO	$76,229
22-RR-CEF-063	Health	UNICEF	GOV	$17,864
22-RR-CEF-063	Water, Sanitation and Hygiene	UNICEF	GOV	$10,496