United Nations CERF Central Emergency Response Fund

MALAWI
RAPID RESPONSE
CHOLERA
2023

23-RR-MWI-57751

Rebecca Adda-Dontoh

Resident/Humanitarian Coordinator

PART I – ALLOCATION OVERVIEW

Reporting Process and Consultation Summary:	
Please indicate when the After-Action Review (AAR) was conducted and who participated.	NA
An AAR did not take place as a second disaster, Tropical Cyclone Freddy struck before the end of the cholera response. The same agencies were involved in the response to Cyclone Freddy, which was still underway when the AAR would have taken place. Inputs from recipient agencies were collected during Inter-Sector meetings, bi-laterals, as well as during a Cyclone Freddy Mid-Point review organised by OCHA, and a Cyclone Freddy response AAR organised by government. Recipient agencies were responding to both disasters with activities mostly being implemented in the same locations simultaneously.	
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:

At the start of the rainy season in November 2022, the cholera outbreak that started in March 2022 exponentially increased reaching an average growth rate of 16 percent per week in the first weeks of January 2023. There was an urgent need to address the rapidly deteriorating public health and humanitarian situation. CERF funds enabled agencies and their partners to quickly respond to the needs of the most vulnerable among communities affected not only by the outbreak, but still reeling from the impacts of Tropical Storm Ana and Cyclone Gombe in January and March respectively. CERF allowed agencies to quickly deploy emergency water supply, sanitation, and hygiene to put in place minimum safe conditions to curb the spread of the disease, reducing the risk to public health in many locations. Access to safe water supply, sanitation and hygiene is the single most important factor in prevention and control of cholera transmission. Timely delivery of treatment supplies to health facilities and provision of mobile storage and treatment units in affected communities was made possible by allocation of CERF funding for common logistic services, provided free to health partners including the Ministry of Health. Rapid installation of cholera treatment units and Oral Rehydration Points (ORPs) in hard-to-reach areas was made possible through the common logistics services that included free tents. CERF funds also facilitated a more integrated response across key sectors and partners, strengthening operational coordination for an efficient and effective response to reduce cholera morbidity and mortality. CERF has also been instrumental in promoting localisation through partnership arrangements with recipient agencies and local organisations.

CERF's Added Value:

Cholera CERF funding enabled the UN to support the Government of Malawi to rapidly respond to a time-critical public health emergency through speedy provision of logistics services, treatment supplies and WASH services. The impact of the response, including information and awareness campaigns carried out during the outbreak continued beyond the life of the CERF allocation, as evidenced by the limited number of new cases recorded during flooding caused by Cyclone Freddy in March. Multiple pronged campaigns provided a holistic awareness raising and equipping on cholera prevention and control, GBV, PSEA and malnutrition for maximum impact. Another impact of this allocation is capacity building for future responses to cholera and other health emergencies. For instance, CERF supported the implementation of community based ORPs with development of Standard Operating Procedures (SOPs) and capacity building of community volunteers to manage these posts.

Did CERF funds lead to a <u>fast delivery of assistance</u> to people in need?

Yes ☒ Partially ☐ No ☐

CERF funding was disbursed relatively fast allowing for timely delivery of humanitarian assistance. WFP, for example, was able to very quickly provide common logistics services to partners, including transport, such as the Ministry of Health (MoH), Malawi Red Cross Society, Médecins Sans Frontières (MSF), and the World Health Organisation (WHO) enabling them to provide timely health care to people in need. Provision of mobile storage units was a key component of logistics services that facilitated rapid installation of storage and cholera treatment units including ORPs. With the CERF funds UNICEF was able to quickly activate partnerships to ensure presence on the ground for delivery of lifesaving interventions.

Did CERF funds help respond to <u>time-critical needs</u>?

Yes ☒ Partially ☐ No ☐

A crucial factor of life-saving interventions was availability of vital health and WASH supplies for prevention, control, and treatment of cholera cases. With CERF funding, UNICEF and WHO were able to rapidly procure essential supplies for managing cholera in cholera treatment units and oral rehydration points, contributing to reduced cholera cases and deaths in targeted districts. UNICEF, WHO and UNFPA were able to scale up response in water, sanitation, and hygiene (WASH), health, risk communication and community engagement (RCCE), child protection, and gender-based violence (GBV) sectors, strengthening the response though an integrated, multisectoral time critical approach.

Did CERF <u>improve coordination</u> amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

The cross-sectoral nature of the CERF funded projects facilitated closer coordination and collaboration across different sectors. The need for an integrated, multisectoral approach led humanitarian partners to hold regular coordination meetings to share information

and streamline response operations. As an example of improved coordination, CERF funds enabled UN agencies (WHO, UNICEF), Redcross Society, Save Children, MSF and local Community Based Organizations, humanitarian partners to collaborate in setting up and managing oral rehydration points in target communities, covering different areas to avoid duplication and overlaps, as well as ensure complementarity. The CERF application and prioritisation process also served as a key opportunity to strengthen coordination across recipient UN agencies. Overall intersectoral collaboration under the Humanitarian Country Team (HCT) leadership kickstarted by the cholera allocation has continued during Cyclone Freddy floods response.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

Certain agencies were able to raise additional funds. For example, UNFPA received funds from the Republic of Korea to procure dignity kits. CERF funding served as proof that UNFPA was indeed responding to the needs of adolescent girls and women, and additional resources were required for unmet needs. In the case of WHO, CERF funding was catalytic in mobilizing additional resources from ECHO (EURO 1,542,210), World Bank (USD 9 000,000) and FCDO (GBP 500,000).

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

Attention was paid to gender analysis during the design and implementation of the CERF projects across all sectors. As women and girls are the primary caregivers and household water managers, they were the key focus of cholera response activities. Priority interventions included ensuring access to sufficient and safe water for drinking, cooking and hygiene, and risk communication activities on cholera prevention and treatment. In Malawi, women and girls are considered at higher risk of violence and abuses due to unequal power relations and economic disadvantage. Vulnerability of women and girls increases during disasters. Through this allocation, partners were able to support women and girls with GBV services that integrated psychosocial counselling. UNICEF reached women and girls in hard-to-reach areas tackling gender-based violence through mobile victim support services that included referrals to appropriate services. UNFPA also employed mobile outreach clinics to provide GBV, Sexual Reproductive Health (SRH) and psychosocial support to, mainly, women and girls reaching 72,315 people with GBV services and 10, 645 women and girls with SRH interventions. The projects implemented under this CERF incorporated the principles of diversity, equity, and inclusion approach to ensure better targeting of affected people, particularly people with disabilities (PwD). CERF funded child protection workers were trained to provide case management and protection, with a special focus on persons with disabilities. For example, the UNICEF Nutrition project supported the counselling of caregivers of children with disabilities on feeding and treatment. These children and caregivers were also referred for appropriate support including physiotherapy and livelihood interventions.

Mental Health and Psychosocial Support Services were a vital part of the cholera response, especially for women and girls who had the added burden of caring for sick patients and providing for the household if the alternate or main provider fell ill. Additionally, affected households had to deal with social stigma and taboos associated with cholera. Psychosocial support and the multiple information and awareness campaigns provided much reprieve for affected families during the response.

Funding for support to women and girls in tackling gender-based violence, reproductive health and empowerment should be prioritised and scaled up during CERF prioritisation processes. Funding is often least towards these activities compared to other sector activities. GBV, SRH and empowerment activities for women and girls remain largely underfunded, overshadowed by more prominent sectors

[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.

such as Food Security, WASH and Health. In the cholera response, WASH and Health were prioritised over GBV and SRH, for instance, given their critical role in management and control of a public health emergency that had surpassed any outbreak in the last decade.

Table 1: Allocation Overview (US$)

Total amount required for the humanitarian response	**45,300,000**
CERF	4,300,022
Country-Based Pooled Fund (if applicable)	0
Other (bilateral/multilateral)	11,304,124
Total funding received for the humanitarian response (by source above)	**15,604,146**

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

Agency	Project Code	Sector/Cluster	Amount
UNFPA	23-RR-FPA-006	Protection - Gender-Based Violence	300,000
UNFPA	23-RR-FPA-006	Health - Sexual and Reproductive Health	200,000
UNICEF	23-RR-CEF-008	Water, Sanitation and Hygiene	2,010,000
UNICEF	23-RR-CEF-008	Nutrition	510,000
UNICEF	23-RR-CEF-008	Health	270,000
UNICEF	23-RR-CEF-008	Protection - Child Protection	210,000
WFP	23-RR-WFP-005	Common Services - Logistics	300,011
WHO	23-RR-WHO-008	Health	500,011
Total			**4,300,022**

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

Total funds implemented directly by UN agencies including procurement of relief goods	**3,640,398**
Funds sub-granted to government partners*	243,283
Funds sub-granted to international NGO partners*	135,111
Funds sub-granted to national NGO partners*	281,229
Funds sub-granted to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**659,624**
Total	**4,300,022**

* 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 cholera outbreak in Malawi worsened during the rainy season, with a potential 64,000 to 100,000 cases predicted in the following three months if urgent measures are not taken. The outbreak, declared in March 2022, is the country's largest in two decades, with all 29 districts affected. As of 13 February 2023, there have been 42,957 cumulative cases and 1,399 deaths, resulting in a fatality rate of 3.27%, above the acceptable ratio of 1% set by WHO. As of 31 January 2023, children under the age of 18 have been significantly impacted by the cholera outbreak, accounting for 41% (9,982) of reported cases and 20% (142) of the total deaths. The United Nations and humanitarian partners have called for $45.3 million to provide life-saving aid to people affected by the cholera outbreak in Malawi.

Operational Use of the CERF Allocation and Results:

In escalation to the crisis, the ERC allocated $4.3 million on 23 February 2023 from CERF's Rapid Response window for the immediate commencement of life-saving activities. The proposed response aims to scale up response in the water, sanitation, and hygiene (WASH), health, risk communication and community engagement (RCCE), health, child protection and gender-based violence (GBV) sectors. UNICEF, WHO, and UNFPA are providing essential health supplies and health interventions. UNICEF also strengthens the cholera response through a multisectoral integrated, time-critical approach. The allocation provides humanitarian assistance to 825,792 people, including 202,464 women, 40,575 children, and 75,072 persons with disabilities.

People Directly Reached:

A systematic approach was applied throughout. that considered the highest reach per population group for any of the activities carried out in any location. Additionally, different tools and methods were combined by agencies and partners to calculate people reached and avoid double counting in the assistance of people in need. These include:

I. The Minimum Initial Services Package calculator for SRH and GBV
II. Humanitarian Performance Monitoring (HPM) tool which was used to calculate the total number of beneficiaries reached by specific interventions in WASH, Nutrition and Heath
III. Established cholera health reporting systems that combined different surveillance data tools including an online One Health Surveillance Platform where unique patient identifiers such as age, gender, location among others is recorded.

For the logistics sector, the estimation of direct beneficiaries is not applicable. However, the sector provided storage, including mobile storage units used as cholera treatment units, to four partners – Ministry of Health, WHO, Malawi Red Cross Society and Médecins Sans Frontières (MSF) in key locations. Dedicated transport services ensured over 400MT of medical supplies reached different health facilities in affected communities.

This process was not, however, free of challenges because the number of people tended to fluctuate, and in some cases resulted in lower numbers than original estimates. The number of people reached also shifted as the populations needs changed.

People Indirectly Reached:

At least 996,000 indirect beneficiaries are estimated as being reached through the following activities:

i. Information and awareness raising campaigns.
ii. Distribution of emergency health and WASH Kits, which resulted in improved health condition of affected households.
iii. Logistics services (through delivery of more than 400 MT of essential supplies).

It should however be noted that calculation of indirect reach was challenging in some instances as implementing partners were not able to correctly estimate people reached, particularly regarding information and awareness raising campaigns on specific themes such as family planning, prevention of sexually transmitted infections and prevention of GBV.

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

Sector/Cluster	Planned					Reached				
	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Common Services - Logistics	0	0	0	0	0	0	0	0	0	**0**
Health	72,199	66,835	75,146	69,562	283,742	99,465	82,388	97,576	101,557	**380,996**
Health - Sexual and Reproductive Health	7,846	6,857	8,697	8,600	32,000	3,522	2,878	2,450	1,795	**10,645**
Nutrition	14,175	13,085	15,985	14,755	58,000	42,963	2,959	65,020	56,610	**167,552**
Protection - Child Protection	36,881	0	48,860	50,854	136,595	38,189	36,691	39,747	38,189	**152,816**
Protection - Gender-Based Violence	33,028	28,868	36,613	36,204	134,713	29,692	5,000	30,623	7,000	**72,315**
Water, Sanitation and Hygiene	128,693	123,647	133,946	128,694	514,980	148,560	142,740	154,630	148,560	**594,490**

* 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	0	0
Other affected people	750,718	594,490
Total	**750,718**	**594,490**

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	184,058	148,560	9,256	7,392
Men	160,874	142,740	8,280	6,823
Girls	204,033	154,630	9,635	7,693
Boys	201,753	148,560	8,970	7,102
Total	**750,718**	**594,490**	**36,141**	**29,010**

PART II – PROJECT OVERVIEW

3. PROJECT REPORTS

3.1 Project Report 23-RR-FPA-006

1. Project Information					
Agency:	UNFPA		**Country:**	Malawi	
Sector/cluster:	Protection - Gender-Based Violence Health - Sexual and Reproductive Health		**CERF project code:**	23-RR-FPA-006	
Project title:	Provision of integrated life-saving sexual and reproductive health (SRH) and gender-based violence (GBV) information and services during the Cholera outbreak in Malawi				
Start date:	21/03/2023		**End date:**	20/09/2023	
Project revisions:	No-cost extension ☐		Redeployment of funds ☐	Reprogramming ☐	
Funding	**Total requirement for agency's sector response to current emergency:**				**US$ 1,800,000**
	Total funding received for agency's sector response to current emergency:				**US$ 277,900**
	Amount received from CERF:				**US$ 500,000**
	Total CERF funds sub-granted to implementing partners:				**US$ 240,000**
	Government Partners				US$ 0
	International NGOs				US$ 35,000
	National NGOs				US$ 205,000
	Red Cross/Crescent Organisation				US$ 0

2. Project Results Summary/Overall Performance

During the reporting period of the Cholera response, our implementing partner Family planning association of Malawi (FPAM) conducted 8 District Health Management Team (DHMT) briefing and planning meetings in the districts of Blantyre, Balaka, Machinga, Mangochi aimed at discussing and agreeing on the implementation approach for the planned outreach clinics targeting areas that were most affected by the cholera disasters. All 4 planning meetings were successfully conducted, and corresponding budgets developed by each district. Out of the 5 districts engaged, 4districts were able to start implementation of the cholera response including assisting the clients in cholera treatment centres by March 2023. A total of 30 nurses were recruited to support the cholera response in the affected districts through the Ministry of Health Human resources offices and they provided the services according to government provided protocols. The districts were also provided with health education services that reached a total of 10147 people in the displaced camps and areas. With information pertaining to cholera prevention and ensuring early health seeking behaviours when any diarrhoeal disease affects them.

In terms of GBV prevention and response , UNFPA and its implementing partners which included FOCESE , Foundation for civic Education and Social enhancement, GENET – Girls Empowerment Network and Ministry of Gender conducted outreach activities and dissemination of risk information on GBV through various channels ,72,315 people were directly reached with awareness on GBV, PSEA and the available referral pathways within the camps, but recording at the treatment centres wasn't successful as patronage was not there. 32 service providers were supported to monitor and follow up cases, where 6 cases of GBV were followed and concluded, with one Cholera abuse and use of cost-effective emergency communications with the affected communities to ensure wide outreach and awareness raising on GBV and SEA prevention, both in the communities and Cholera treatment centers in the affected districts reaching over 100,000 people , the existing monitoring and referral mechanisms were strengthened and disseminated to the communities and at Cholera treatment centers,3,000 dignity kits for women and adolescent girls were procured and with the addition of 800 which were already prepositioned, we distributed 3,800 dignity kits to adolescent girls and young women. The dignity kits helped to restore their dignity and resulted in some young women participating in the camp committees and became active responders of the crisis. Safe spaces for women and girls were strengthened and made active to ensure their safety for Systematic and confidential recording of GBV cases, provision of psychological counseling, and clinical management of rape during outreach clinics. A total of 17,813 adolescent girls and young women accessed the safe spaces. A quick reorientation to 300 emergency workers and local gatekeepers, guardians on GBV and PSEA and management standards to strengthen coordination of GBV service provision was done alongside the 32 service providers which were recruited. These supported to follow-up of cases and continued GBV awareness on prevention and response including reporting. Much of the activities were concentrated in Blantyre, Machinga with awareness on GBV and Cholera in Balaka and Mangochi alongside the ongoing programmes. The Cholera response was then done in collaboration with the cyclone response as the cyclone hit districts also had pockets of Cholera. The districts are Mulanje, Chikwawa, Nsanje.

3. Changes and Amendments

The Cholera response was heavily interrupted by the cyclone Freddy that hit the country suddenly with a very heavy blow in February 2023. This changed the response plans as the cholera affected areas were equally affected by the Freddy. The clients for cholera and clients displaced by the cyclone Freddy were mixed up and internally displaced persons increased. This led to the districts deciding in assisting both the cholera affected internally displaced individuals with the cyclone Freddy displaced individuals.

Additionally, the Health protocols were not approved on time by Ministry of health, and they were not disseminated. The funds for the dissemination of the protocols were less than 8% of the total funds, hence were reprogrammed to the training of health workers as per the guidelines which indicated that funds less than 8% can be implemented for other related activity and include in the report.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Protection - Gender-Based Violence									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Returnees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Internally displaced people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Host communities	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Other affected people	33,028	28,868	36,613	36,204	**134,713**	29,692	5,000	30,623	7,000	**72,315**
Total	**33,028**	**28,868**	**36,613**	**36,204**	**134,713**	29,692	5,000	30,623	7,000	**72,315**
People with disabilities (PwD) out of the total										
	33	28	36	36	**133**	**2**	**0**	**4**	**0**	**0**

* 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.

Sector/cluster	Health - Sexual and Reproductive Health									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Returnees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Internally displaced people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Host communities	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Other affected people	7,846	6,857	8,697	8,600	**32,000**	**3522**	**2878**	**2450**	**1795**	**10645**
Total	**7,846**	**6,857**	**8,697**	**8,600**	**32,000**	**3522**	**2878**	**2450**	**1795**	**10645**
People with disabilities (PwD) out of the total										
	8	6	9	9	**32**	**3**	**0**	**4**	**1**	**8**

* 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

The campaigns on cholera reached a total of 100,147 people indirectly with information on prevention of diarrhoel diseases as well as cholera itself. This was coupled with outreach services where the internally displaced persons were able to receive information on Family plannning, prevention of Sexually transmitted infections, prevetnion of GBV,treatement of other ailments and also antenatal clinics.

6. CERF Results Framework

Project objective	This project aims to prevent and response to violence (GBV), Sexual Exploitation and Abuse (SEA) and scale up access to life-saving GBV and SRH information and services in Malawi during the Cholera pandemic
Output 1	Women and adolescents have access to life saving quality GBV and PSEA services that prevent, respond to and mitigate violence

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

Sector/cluster	Protection - Gender-Based Violence			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	PS.2 Number of people receiving GBV psycho-social support and/or GBV case management (Cholera treatment centres in the affected districts)	134,713	72,315	Reports from Implementing partners from their awareness activities and counselling activities
Indicator 1.2	Number of people accessing GBV referral mechanisms at Cholera Treatment Units(CTU).	380	317	These were reached with awareness on GBV, PSEA and the available referral pathways within the camps, but recording at the treatment centres wasn't successful as patronage was not there. 32 service providers were supported to monitor and follow up cases, where 6 cases of GBV were followed and concluded, with one Cholera abuse case where the survivor received Psychosocial support including school fees.
Indicator 1.3	SP.1a Number of menstrual hygiene management kits and/or dignity kits distributed	3,000	3,800	Procurement documents and distribution reports from partners
Indicator 1.4	PS.1a Number of people accessing women- and girl-friendly safe spaces and/or centres	20,000	17,483	Reports from implementing partners
Indicator 1.5	Number of Emergency Responders and gatekeepers benefiting from GBV and PSEA re-orientations	300	300	Training reports both from UNFPA and Partners

Indicator 1.6	Number of dignity kits procured	3000	3,000	Procurement documents from UNFPA
Explanation of output and indicators variance:		The variances especially the low figures were due to the fact that the cholera response was overshadowed with the heavy cyclone disaster. Mostly awareness on Cholera and where to receive treatment was done in collaboration with cyclone GBV prevention messages. Numbers registered are those that received the awareness messages in the camps and communities. Reporting of GBV cases was very minimal, hence the actual referrals done were very few, but a lot of campaigns at all levels were intensified.		

Activities	**Description**	**Implemented by**
Activity 1.1	Conduct outreach activities and dissemination of risk information on GBV through various channels, and use of cost-effective emergency communications with the affected communities to ensure wide outreach and awareness raising on GBV and SEA prevention, both in the communities and Cholera treatment centers in the affected districts	UNFPA, Government and National CSO partners: Ministry of Gender at District Level in collaboration with GENET, and FOCESE
Activity 1.2	Strengthen and revamp existing monitoring and referral mechanisms and disseminate to the communities and at Cholera treatment centers	UNFPA, Government and National CSO partners: Ministry of Gender at District Level in collaboration with GENET, and FOCESE
Activity 1.3	Distribution of dignity kits to women and girls.	UNFPA, Government and National CSO partners: Ministry of Gender at District Level in collaboration with GENET, and FOCESE
Activity 1.4	Strengthen safe spaces for women and girls to ensure their safety for Systematic and confidential recording of GBV cases, provision of psychological counselling, and clinical management of rape.	UNFPA, Government and National CSO partners: Ministry of Gender at District Level in collaboration with GENET, and FOCESE
Activity 1.5	Conduct a quick reorientation of emergency workers and local gatekeepers, guardians on GBV and PSEA and management standards to strengthen coordination of GBV service provision	UNFPA in collaboration with Protection and GBV subcluster stakeholders clustering districts as Training of Trainers, and CSO partners replicating at district level to reach more service providers
Activity 1.6	Procure dignity kits for women and adolescent girls	UNFPA

Output 2	Pregnant women and adolescents have access to life saving quality maternal and neonatal basic emergence care that prevents pregnancy complications and lead to safe delivery by skilled birth attendants to mitigate stillbirths in the Cholera affected districts.			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☒
Sector/cluster	Health - Sexual and Reproductive Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	SP.3 Number of health care providers receiving orientation on the minimum emergency response package for sexual and reproductive health	100	125	Training reports from MOH
Indicator 2.2	Number of adolescent girls, boys, women and men reached with	22,688	15202	Report from the services provided by FPAM

	SRHR services including family planning			
Indicator 2.3	Number of pregnant women and girls referred and receiving basic and comprehensive Maternal Emergency Obstetric care from the affected districts.	7846	3522	Partners reports
Indicator 2.4	Number of nurses midwives and clinician recruited and trained in CTU	25	25	Ministry of Health human resources data base
Indicator 2.5	Number of SRHR protocols in the management of pregnancy printed, rolled out and distributed in the most affected districts	1200	0	Activity was never executed by the Ministry of Health
Indicator 2.6	SP.2a Number of inter-agency emergency reproductive health kits delivered	8	8	Procured, received, and distributed accordingly
Indicator 2.7	Number of SRHR IEC materials for management of Cholera during pregnancy printed	1200	0	Activity was never executed by the Ministry of Health
Indicator 2.8	Number of SRHR IEC materials for management of Cholera during pregnancy printed	1200	0	Activity was never executed by the Ministry of Health
Indicator 2.9	Number of emergency reproductive health kits distributed in the CTU facilities	8	8	Procured, received and distributed accordingly
Explanation of output and indicators variance:		The Cholera program was overshadowed by the cyclone Freddy which led to activity overlap in many districts and the cyclone impact was higher than the cholera outbreak		

Activities	**Description**	**Implemented by**
Activity 2.1	Conduct MISP orientation for 30 services providers per district in 3 most affected districts on Mangochi, Lilongwe, Blantyre.	UNFPA and the Ministry of Health
Activity 2.2	Conduct monthly outreaches supervision and mentorship sessions on SRHR for adolescent girls and women of reproductive age including provision of family planning and maternal health services	Family planning association of Malawi (FPAM), the Ministry of Health and district health management teams.
Activity 2.3	Provide basic and comprehensive Emergency care for pregnant women with cholera.	Recruited nurses under the Ministry of Health
Activity 2.4	Support recruitment of nurses and midwives in CTUs to ensure provision and monitoring of pregnant women with cholera.	The Ministry of Health Human resources team
Activity 2.5	Support printing, rollout and distribution of SRHR protocols for management of pregnant women with cholera.	It was not executed because the Ministry of Health senior management team did not validate the document. The funds were used for training health workers in MISP.
Activity 2.6	Procure International Reproductive Health Kits to save Pregnant women, adolescent girls and youth with SRHR morbidities in the affected districts	UNFPA

Activity 2.7	Print IEC materials on pregnancy care during Cholera	It was not executed because the Ministry of Health concentrated on Cyclone Freddy response as a comprehensive package in the Information Education and Communication packages.
Activity 2.8	Distribute IEC materials on pregnancy care during cholera including antenatal care at operational facilities, hospitals, community clinics and CTU.	It was not executed; instead, the comprehensive package was distributed covering both the cholera response and cyclone Freddy response.
Activity 2.9	Distribute International Reproductive Health Kits (IARHKITS) to save Pregnant women, adolescent girls and youth with SRHR morbidities in the affected districts	UNFPA and the Ministry of Health

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.**

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

Affected People were involved in the implementation as direct beneficiaries of the activities, but also mentors of safe spaces were among the survivors and through the recruitment of local based service providers within the communities and were reached directly with the interventions through the partners. UNFPA and its partners ensured flexibility during implementation and we were able to adjust the dignity kits with an addition of a blanket to protect the girls, lactating and pregnant women to extreme cold weather. Furthermore, service providers and community structures were targeted effectively to protect the rights of women and girls from SEA and restore their dignity.

b. AAP Feedback and Complaint Mechanisms:

UNFPA leverage on existing referral pathways and Community Based Complaint Mechanism that exists at district and local levels, and these were further mapped, reviewed to incorporate the new officers that were not captured where applicable. The Psychosocial counsellors who were trained proved to be a very good referral pathway to the adolescent girls and women.
UNFPA also focussed on increasing communities' awareness on their rights, location and availability of services to report abuse. Through the community outreach and awareness activities, the communities' knowledge on their rights and available services was enhanced. UNFPA through the MHRC gathered information about the perceptions of the affected community in regards to women and girls' access to GBV and SRH services., and this was done during the implementation of cyclone Freddy response. To this end, focus group discussions/ key informant interviews with women of reproductive age including (if permission is granted) adolescent girls were conducted and results from these discussions will be used to help us in our preparedness activities.

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

[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.

[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.

UNFPA facilitated PSEA trainings to the service providers, but also PSEA awareness was an integral part of the awareness activities. UNFPA leveraged on safeguarding officers which were deployed by UNICEF in the districts and oriented them on PSEA before their deployment to the camps. UNFPA and its partners have strict policies and procedures in place that protect victims' privacy as well as to ensure quick and accessible access to GBV related services. These were reinforced through the trainings and awareness through radios which was done by the Implementing partners. Through the support to social workers, they were able to follow up GBV cases and some were concluded. For example in Chikwawa and Nsanje 48 cases were followed up and this included 9 child marriages that were ended. Additionally, this was complemented through UNFPAs implementing partners that handle Community Based Complaints Mechanism and SEA cases such as the National GBV Hotline and the Police emergency line to report and follow up on SEA related complaints.

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

N/A, but all vulnerable people as well as leaving no one behind is the strategy that was followed.

e. People with disabilities (PwD):

From the numbers that were reached, only a few were those with disabilities. This is due to the high magnitude of the cyclone disaster which made it impossible for those with Disabilities to come out from their homes, and consequently, mobility of service providers was also a big challenge.

f. Protection:

All interventions that were done were Protection focused and ensured that Affected People and at-risk groups are at the center of program implementation and monitoring. For example: The dignity kits were distributed right to the affected women and girls and not leaving them at districts to be distributed at another time. Transportation was given up to the camps themselves and not only ending at the district level.

g. Education:

The program executed health education for the internally displaced persons through the outreach clinics and District Health Management teams. A Total of 10147 people were reached with information on prevention of cholera, prevention of unintended pregnancies and treatment on sexually transmitted infections.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	N/A

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$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
Hope and resilience during the disaster	***https://malawi.unfpa.org/en/news/journey-hope-and-resilience-my-experience-cyclone-freddys-response-and-aftermath***

3.2 Project Report 23-RR-CEF-008

1. Project Information			
Agency:	UNICEF	**Country:**	Malawi
Sector/cluster:	Water, Sanitation and Hygiene Nutrition Health Protection - Child Protection	**CERF project code:**	23-RR-CEF-008
Project title:	Accelerated Cholera Response in six 'high burden districts'		
Start date:	01/03/2023	**End date:**	31/08/2023
Project revisions:	No-cost extension ☒	Redeployment of funds ☒	Reprogramming ☐

Funding		
	Total requirement for agency's sector response to current emergency:	**US$ 25,833,128**
	Total funding received for agency's sector response to current emergency:	**US$ 3,000,000**
	Amount received from CERF:	**US$ 3,000,000**
	Total CERF funds sub-granted to implementing partners:	**US$ 419,624**
	Government Partners	US$ 243,283
	International NGOs	US$ 100,111
	National NGOs	US$ 76,229
	Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Health

Responding to the biggest cholera outbreak in Malawi in two decades, through the CERF grant, 400,000 sachets of life-saving Oral Rehydration Salts (ORS) were procured and distributed to Cholera Treatment Centers/Units (CTCs/ CTUs) and Oral Rehydration Points (ORPs) for the treatment of mild to moderate cases of Cholera. UNICEF worked with partners to establish 39 ORPs including 16 in flood-affected districts. Across supported districts, 5,246 persons received care for mild to moderate Cholera corresponding to 26 percent of target. The achievement is low due to a significant decrease in the cholera cases and demand for services from ORPs. Because of this change in the context, UNICEF reprogrammed the project with preapproval from CERF to set up mobile clinics in response to cyclone Freddy effects. The project extended its health emergency response to enhancing primary health care services through Integrated Mobile Health Clinics that brought essential health services closer to people targeting both the camps and the hosting communities in the affected districts, including treatment of diarrheal cases. The project reached 75,996 people through 418 outreach clinics (Nsanje 236, Chikwawa 114, Balaka 39 and Machinga 29). The services provided during the mobile clinics were HIV testing services, Sexual Reproductive Health Services including family planning services (method provision and counselling), overall treatment and management of common infections and illnesses to the affected population, provision of essential services for children under five (including immunization, diagnosis and treatment of malaria, diarrheal, growth monitoring and promotion, acute malnutrition screening and referral, treatment of pneumonia

cases, antenatal and postnatal services). All severe cases that required secondary level of care were referred to nearby health facilities and district hospitals.

WASH

The project reached around 594,490 out of 514,980 targeted people (211,790 M; 303,190 F) in the cholera affected communities with safe water through the provision of chlorine for point-of-use water treatment. This was coupled with hygiene messaging. To monitor household use of the chlorine provided and check whether the water was contaminated, water quality testing was conducted. Two thousand (2,000) tests were done (300 at water sources and 1,700 at households). Samples that were found to be contaminated were disinfected. The water quality testing aided targeted behaviour change messaging with hygiene messaging efforts intensified in areas where the testing revealed some concerns. To verify household use of the provided chlorine, interviews conducted during household visits and focus group discussions. Findings indicated that about 42 out of 50 households per districts (84%) could demonstrate effective treatment of their water to meet the recognized standards for water quality.

A total of 2,000 people (from the above 594,490) has acquired gained access to sanitation through the installation of 62 temporary latrines with handwashing facilities and 5 emergency bath shelter facilities in Internally Displaced People (IDPs) camps. In the targeted camps, hygiene promotion was conducted before the distribution of soap and chlorine. Further, UNICEF constructed 6 new latrines in the schools enabling 1800 learners to access appropriate sanitation facilities enabling the application of Infection Prevention and Control (IPC) protocols.

The project also supported the provision of critical WASH supplies including buckets for water storage and hand washing, tarpaulins for construction of temporary bathroom and toilet facilities and soap for handwashing which were delivered to affected households benefitting 160,457people. Critical WASH supplies were also delivered to Cholera Treatment Centres. In total 95 compared to the 36 targeted Cholera Treatment Centres and schools have been supported with WASH kits and temporary/mobile latrines.

Another major contribution of this CERF project is the roll out of Case Area Targeted Interventions (CATI) for cholera control in cholera hotspot areas which facilitated the provision of a comprehensive package of water, sanitation, and hygiene activities, health surveillance, provision of health services and medical supplies like vaccines and antibiotic chemoprophylaxis. Door-to-door chlorination of water source whenever a cholera case identifies. Specific activities that were conducted as part of the CATI approach included disinfection of homes of the suspected cases (the index houses), provision of WASH supplies (hand washing buckets, soaps and chlorine) to affected and surrounding households, 2 – ways community dialogue sessions on cholera (health talks), water quality testing, and pot to pot chlorination for index houses and all households within a radius of 30 -50 m (approx. 30 households) from the index household. The CATI sessions were integrated with social behaviour change and community-led total sanitation (CLTS) activities.

RCCE

The CERF grant allowed UNICEF to reach over 590,000 people against a target of 750,720 in Lilongwe, Blantyre, Balaka, Machinga, Mangochi and Salima with hand hygiene, sanitation and cholera treatment messages through community dialogues, road shows and door to door visits. Focus group discussions (FGDs) with key community members were conducted to understand the social and behavioural drivers for cholera outbreak in all targeted districts. The findings were used to adapt the risk communication and community engagement (RCCE) advocacy messages.

The grant helped UNICEF to reach out to more than 9.5 million people with community engagement activities such as road shows, engagement meetings with influential leaders, youth clubs, mother care groups, night cinema shows and drama performances. These activities were implemented in cholera and cyclone affected districts. UNICEF also engaged the Health Education Services unit of the Ministry of Health to support district RCCE structure strengthening. The ministry printed and distributed Cholera related communication materials and worked with community radio stations in Chikwawa and Nsanje to produce and air Cholera related jingles and radio programs. RCCE team also supported Case Area Targeted Interventions (CATI) in the Cholera affected districts. Social Behaviour Change (SBC) activities conducted during and after CATI sessions helped to generate demand for use of chlorine at household level.

During the project implementation period, UNICEF rolled out Community Feedback Mechanisms and trained its SBC partners in data collection through use of community feedback mechanism (CFM) tool. Feedback was collected in Cholera and Cyclone Fred affected districts (Nsanje, Chikwawa, Blantyre, Phalombe, Mulanje, Zomba, Balaka Mangochi, Salima and Lilongwe). Throughout the project period, more than 75,000 feedback was collected from community members through community dialogue sessions, Focus Group

Discussions, social listening, and other channels such as observations. The collected feedback was uploaded in the CFM dashboard managed by UNICEF. UNICEF conducted analysis of the feedback received and encouraged SBC partners to close the feedback loop by providing feedback to the communities depending on the urgency of the issue.

SBC partners also supported with building the capacity of district RCCE structures such as District Social Mobilization Committees and District RCCE committees with the aim of coordinating RCCE activities at district level for proper coordination on collection of community feedback. Some districts have integrated RCCE in their district programming.

During the reporting period, more than 80% of the affected population were consulted to solicit their input on the planned RCCE activities. This was done through SBC partners meetings which were conducted at national, district and community levels. At national level, SBC partners participated in weekly RCCE meeting organized by the Ministry of health, health Education Services where partners presented their districts RCCE workplans. At district level, SBC partners conducted meetings with structures such as District Executive Committee and District Health management Teams to brief them and solicit input on their RCCE workplans. At community level, partners conducted meetings with community structures such youth groups, mother groups, traditional and faith leaders to orient them and get their feedback on the planned activities.

Nutrition

Thanks to the CER funding, 121,630 children aged 6 – 59 months were screened for acute malnutrition through UNICEF support to the Ministry of Health (MoH). From the children screened 5,634 children were identified and referred for severe acute malnutrition treatment. Out of those admitted for SAM treatment, 5,175 children were discharged and 5,417 successfully recovered from severe acute malnutrition (SAM) representing a cure rate of 95.5 per cent, 1.4 per cent died, 1.9 per cent defaulted while 1.2 per cent did not respond and were referred for further treatment. The program performance was maintained within the international minimum acceptable SPHERE standard of more than 75 per cent cure rate, less than 10 per cent death rate and less than 15 per cent default rate. UNICEF has ensured availability of lifesaving nutrition supplies through procurement and distribution to the end-user of 5,650 cartons of RUTF). Also, through the CERF project, 1,223 health workers had their knowledge and skills in the management of children with acute malnutrition improved including in the context of cholera. In addition, a total of 45,922 caregivers of children 6-23 months were counselled in optimal maternal, infant, and young child nutrition (MIYCN).

Child Protection

9,718 children benefited from psychosocial first aid activities (PFA) provided by community-based child protection workers in of 180 children's corners. With funding from the CERF project, UNICEF provided tarpaulins to be used for children's recreational activities through which psychosocial support services were provided. UNICEF also equipped the community-based child protection workers with visibility materials and protective wear.

The project also supported Community Child Protection Workers in the Ministry of Gender, Community Development and Social Welfare to provide case management services to victims of violence and neglect in the cholera affected areas. A total of 300 child protection workers were provided with working materials such as gum boots, reflective jackets, whistles, torches, and hardcovers. During the project period, these child protection workers reached 141,718 children with messages on cholera prevention and protection from violence, abuse, exploitation and neglect and reporting mechanisms.

Through support to Malawi Police Service towards mobile victim support services, 251 cases of violence, abuse, exploitation, and neglect were registered. Out of these, 191 were resolved and 60 referred to other protection services. Provision of mobile victim support services involved teams from social welfare, police, health, and judiciary got out to affected communities conducting awareness sessions and providing services to those that require social welfare, police, psychosocial or justice services. In total, the support from CERF reached in total2,177 people who benefitted from GBV risk mitigation and response services.

3. Changes and Amendments

Health

The project aimed to contribute to reducing severe illnesses and case fatality due to Cholera through the identification and management of mild and moderate Cholera cases through Oral Rehydration Points (ORPs) and making referrals of severe cases to the nearest Cholera Treatment Centers (CTC). Malawi consistently registered a downward trend in the number of cholera cases across the country with the

Cholera updates of April, May, and June reporting 23 districts to have controlled the outbreak with only 6 districts reporting new cases occasionally. With this sharp downward trend, UNICEF and the District Health Offices in the initially targeted districts concluded that the initial scope was no longer relevant. Therefore, a request to shift focus from the establishment of Oral Rehydration Points to strengthening mobile clinics offered side by side with diarrhoea diseases management interventions (including distribution of ORS) in Chikwawa, Nsanje, Machinga and Balaka district was initiated.

The implementation of cholera response activities also benefitted from Tropical Cyclone Freddy funding streams and activities which enabled wider reach and coverage than previously planned. Some of the strategies for implementation were therefore adjusted to enable complementarities with other emergency activities.

WASH

The project implementation experienced a sudden change of context in three out of 6 districts (Blantyre, Machinga and Mangochi) due to Cyclone Freddy. The Cyclone Freddy caused huge displacement of people, serious destructions of WASH and health facilities, many water sources were contaminated and people lost their livelihoods resulting in increased food insecurity. The national and subnational government officials were seriously overwhelmed responding to the Cyclone Freddy (floods); and many communities were lacking adequate food, water sanitation and hygiene facilities including WASH Supplies. The cyclone disrupted access to safe water for over 1.3 million people, with 900,000 people requiring urgent services in Malawi. However, the change of context did not change the overall /original plan of the project as cholera response objectives/ activities are similar with floods response interventions. Due to the change of context some activities, such as distribution of WASH supplies and water quality assessment/testing required reassessment and re-registration of new beneficiaries, which resulted in some delays. Through partners' accelerated plans, UNICEF ensured that all planned activities were completed within the project timeframe. The change of context resulted in adaptation of the activities to include support to those who were displaced into camps through mass nutrition screening of children under –five and nutrition messaging in the context of cholera.

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**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Returnees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Internally displaced people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Host communities	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Other affected people	4,998	4,802	5,202	4,998	**20,000**	**22230**	**21357**	**17855**	**14554**	**75996**
Total	**4,998**	**4,802**	**5,202**	**4,998**	**20,000**	**22230**	**21357**	**17855**	**14554**	**75996**
People with disabilities (PwD) out of the total										
	50	48	52	50	**200**	**1899**	**1900**	**1976**	**1824**	**7599**

Sector/cluster	Nutrition									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Returnees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Internally displaced people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Host communities	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Other affected people	14,175	13,085	15,985	14,755	**58,000**	42,963	2,959	65,020	56,610	**167,552**
Total	**14,175**	**13,085**	**15,985**	**14,755**	**58,000**	**42,963**	**2,959**	**65,020**	**56,610**	**167,552**
People with disabilities (PwD) out of the total										

* 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.

	145	139	151	145	**580**	**430**	**30**	**650**	**567**	**1676**

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**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Returnees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Internally displaced people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Host communities	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Other affected people	128,693	123,647	133,946	128,694	**514,980**	148,560	142,740	154,630	148,560	**594,490**
Total	**128,693**	**123,647**	**133,946**	**128,694**	**514,980**	148,560	142,740	154,630	**148,560**	**594,490**
People with disabilities (PwD) out of the total										
	1,287	1,236	1,339	1,287	**5,149**	**1,485**	**1,427**	**1,546**	**1,485**	**5,943**

Sector/cluster	Protection - Child Protection									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Returnees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Internally displaced people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Host communities	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Other affected people	36,881	0	48,860	50,854	**136,595**	38,189	36,691	39,747	38,189	**152,816**
Total	**36,881**	**0**	**48,860**	**50,854**	**136,595**	38,189	36,691	39,747	**38,189**	**152,816**
People with disabilities (PwD) out of the total										

* 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.

	341	0	355	341	**1,037**	**2,673**	**2,568**	**2,782**	**2,673**	**10,697**

* 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

WASH: Through the hygiene promotion campaign more than 500,000 people have indirectly benefited from hygiene messaging Hygiene promotion campaign and media broadcasts.

Health: Through the implementing partner, save the children, UNICEF supported 79 sessions of hygiene promotion campaigns in Chikwawa and Nsanje targeting camps and affected communities. The awareness campaigns aimed to improve hygiene practices by IDPs living in the camps and surrounding communities Cyclone Freddy came at a time when the country was struggling with cholera. The activity reached 329,944 (M:85,459, F:214,902) with messages on hygiene.

Child Protection: Through the Malawi Police service, awareness activities using mobile vans were conducted to mobilise community members to attend mobile victim support unit services. Messages on violence, abuse, exploitation, and prevention of cholera spread were disseminated. Care givers in children's corners were also oriented on cholera prevention who in turn would sensitise children in child friendly spaces. These reached a total of 733,470 people (374,070 females, and 359,400 males) including people from targeted communities and those in surrounding areas.

6. CERF Results Framework

Project objective	Improve early treatment of mild to moderate cholera cases in communities 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	No of Oral Rehydration Points (ORP) set up in the community	33	39	UNICEF SitReps, Monitoring visits, Interim reports, Partners report
Indicator 1.2	H.11 Number of people receiving treatment for acute watery diarrhea (incl. cholera in ORPs)	20,000	75996	UNICEF SitReps, Monitoring visits, Interim reports
Indicator 1.3	No. of PME conducted	6	6	Monitoring visits reports,
Explanation of output and indicators variance:		Due to a downward trend in the number of cholera cases across the country with the Cholera updates of April, May, and June reporting 23 districts, there was a shifting focus from the establishment of Oral Rehydration Points to strengthening mobile clinics offered side by side with diarrhoea diseases management interventions		

Activities	**Description**	**Implemented by**
Activity 1.1	Procurement, freight, and warehousing of Oral Rehydration Solutions for ORPs	UNICEF/District Council/ NGO Partners
Activity 1.2	Distribution of Oral Rehydration Solutions for ORPs	UNICEF/District Council/ NGO Partners
Activity 1.3	Set up Oral rehydration Points (ORPs)	I/NGO partners
Activity 1.4	Joint assessment and periodic monitoring and evaluation of selected districts and Cholera Hotspots on logistics and supplies	UNICEF/District Council/ NGO Partners

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	514,980	594,490	UNICEF SitReps, Monitoring visits, Interim 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	84	Monitoring visits, household visits reports
Indicator 2.3	No of water sources sampled to assess water quality	1,200	2,000	UNICEF SitReps, Monitoring visits, Interim reports
Indicator 2.4	WS.13 Number of communal sanitation facilities (e.g. latrines) and/or communal bathing facilities constructed or rehabilitated (No of temporary latrines installed for hosting communities and in Cholera Treatment Centers)	36	95	UNICEF SitReps, Monitoring visits, Interim reports
Indicator 2.5	No of temporary latrines decommissioned for hosting communities and in Cholera Treatment Centers	36	95	UNICEF SitReps, Monitoring visits, Interim reports
Indicator 2.6	WS.16a Number of people receiving critical WASH supplies (e.g., WASH/hygiene kits)	132,000	160,457	UNICEF SitReps, Monitoring visits, Interim reports
Indicator 2.7	WS.17 Number of people receiving WASH/hygiene messaging	514,980	594,490	UNICEF SitReps, Monitoring visits, Interim reports
Indicator 2.8	AP.3b Percentage of affected people who state that they were consulted on the humanitarian response	80	80	Monitoring visits
Indicator 2.9	Number of people directly reached with risk communication activities on cholera prevention and treatment , involving a 2-way dialogue (focusing on hard to reach and vulnerable with multiple reach for behaviour adoption)	514,980	594,490	UNICEF SitReps, Monitoring visits, Interim reports
Indicator 2.10	Number of people sharing their concerns and asking questions/clarifications for available	75,000	75,000	UNICEF SitReps, Monitoring visits, Interim report

	support services to address their needs through established feedback mechanisms			

Explanation of output and indicators variance:	
	Some targets were slightly exceeded because during Cyclone Freddy, some cholera activities were integrated with Cyclone Freddy (Floods) interventions covered from other funding sources. The savings helped to exceed planned targets. For instance, UNICEF was able to construct and decommissioned 95 communal latrines versus the target of 36 because there was cost sharing of the operational elements (e.g., personnel) between the CERF and other funding sources leaving more available for the procurement of slabs, superstructures. Multiple communication channels such as moonlight cinemas, road shows, community dialogue and radio programme were used to reach people with key life saving messages on cholera. Therefore, the large number of people were able to reached than planned during the period. As most of the interventions were related to the mass reach out.

Activities	Description	Implemented by
Activity 2.1	Procure lifesaving WASH Supplies	UNICEF/District Council/ NGO Partners
Activity 2.2	Ddistribute life WASH supplies (water treatment chemicals, water quality testing kits, water storage containers, Soap, hygiene promotional materials and	UNICEF/District Council/ NGO Partners
Activity 2.3	Treatment (flushing and shock-chlorination) of affected water sources in hosting communities	UNICEF/District Council/ NGO Partners
Activity 2.4	Monitoring of water quality in affected water sources	UNICEF/District Council/ NGO Partners
Activity 2.5	Installation of Emergency latrines in communities and Cholera Treatment Centers	UNICEF/District Council/ NGO Partners
Activity 2.6	De-commissioning of emergency latrines in communities and Cholera Treatment Centers	UNICEF/District Council/ NGO Partners
Activity 2.7	Support to local authorities to perform door-to-door chlorination	UNICEF/District Council/ NGO Partners
Activity 2.8	Support to local authorities in rolling out of Case Area Targeted Intervention (CATI) including door-to-door chlorination	UNICEF/District Council/ NGO Partners
Activity 2.9	Promote hygiene practices and handwashing through door-to-door mobilization of community volunteers	UNICEF/District Council/ NGO Partners
Activity 2.10	Development of Digital job aids to support HSA – Health Surveillance Assistance	UNICEF/District Council/ NGO Partners
Activity 2.11	Community Rapid assessments (including GBV), U-report	UNICEF/District Council/ NGO Partners
Activity 2.12	Strengthen multi-sectoral technical coordination mechanism for RCCE planning and coordination at targeted district councils and national level for evidence-based community engagement interventions with the involvement of communities	UNICEF/MOH/MOI/District Councils
Activity 2.13	Support adaptation/revision of RCCE plans based on community feedback and on various sector intervention areas such prevention and control, WASH, case	UNICEF/MOH/RCCE Sub-committee partners

	management, building trust in cholera treatment centers, early health seeking services and ORPs, OCVs (if available), incorporating or adjusting as per the community feedback	
Activity 2.14	Support to the cholera prevention campaign at district level	UNICEF/District Health Office, CSOs
Activity 2.15	Generate rapid social data on the behavioral and social drivers of cholera transmission using epidemiological and field investigation data to influence behaviour and plan RCCE actions together with the community	UNICEF/Academia, MOH
Activity 2.16	Facilitate RCCE efforts through engagement of youth volunteers, faith leaders, traditional leaders, national social mobilisation committee members, community group leaders for door to door, community dialogue, community conversations and ownership for cholera control in hot spot areas using community actors and influencers.	UNICEF/Youth Council, Norwegian Church AID/Public Affairs Committee, Ministry of Information
Activity 2.17	Strengthen community feedback collection, analysis, information sharing and closing the feedback loop	MOH/RCCE Sub-committee, Malawi Red Cross, Ministry of Information, Youth Council

Output 3	Vulnerable children and women receive lifesaving assistance in respond to cholera related protection risks (mental wellbeing, violence, abuse, exploitation and neglect)			
Was the planned output changed through a reprogramming after the application stage?		Yes ☐	No ☒	
Sector/cluster	Nutrition			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	H.9 Number of people provided with mental health and/or psycho-social support services	6,000	9,169	Protection Sector 5Ws
Indicator 3.2	# People reached through GBV/CP/behavioural change community awareness to promote access to services to respond to incidents of GBV/CP and cholera prevention	50,000	141,718	Protection Sector 5Ws
Indicator 3.3	# of children, parents and primary caregivers at risk provided with risk mitigation, prevention and response interventions	2,000	1,380	Police Activity Report
Explanation of output and indicators variance:		[F In general, more people were reached than planned. This was due to some contributions from implementing partners such as Malawi Police Service who provided adequate staff to provide GBV risk mitigation measures in camps and affected communities. Deployment of social workforce to affected areas also ensured more people are reached with MHPSS services.		

Activities	**Description**	**Implemented by**
Activity 3.1	Provision of non-specialized mental health and psychosocial support services (MHPSS)[1] to children, caregivers and communities affected by cholera	Ministry of Gender, Community Development and Social Welfare

Activity 3.2	Development of life saving messages on child protection for dissemination by all actors responding to cholera	Protection Cluster, Ministry of Gender, Community Development and Social Welfare, Malawi Police Service
Activity 3.3	Orientation of caregivers in CCs and CBCCs on selfcare/proper sanitisation of CCs and CBCCs equipment, alternatives to interactive games and activities, and mitigation strategies for disease transmission	Ministry of Gender, Community Development and Social Welfare
Activity 3.4	Supporting Community Child Protection Workers (CPWs) and Case Managers in provision of identification and assessment of vulnerable children and case management services to children impacted by cholera (disrupted families)	Ministry of Gender, Community Development and Social Welfare
Activity 3.5	Support the orientation of Health Workers on PSEA in CTCs and referral of children and people with specific protection needs to protection service providers (violence and abuse disruption mechanisms, separation of children from caregivers, protection services and referral mechanisms.)	Ministry of Gender, Community Development and Social Welfare, Malawi Red Cross Society
Activity 3.6	Procure and distribute nutrition therapeutic supplies (RUTF, F75, F100 and Zinc)	[Fill in]

Output 4	Prevent and treat malnutrition resulting from the impacts of cholera among vulnerable populations; children under five, pregnant and lactating women			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☐
Sector/cluster	Protection - Child Protection			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 4.1	N.4 Number of people screened for acute malnutrition	99,715	121,630	Partner reports
Indicator 4.2	N.3a Number of people admitted to SAM treatment programme (therapeutic feeding	5,000	5,175	DHIS-2
Indicator 4.3	N.6 Number of people receiving training and/or community awareness sessions on maternal, infant, and young child feeding in emergencies	36,881	45,922	Partner report
Explanation of output and indicators variance:		All targets under indicators (4.1, 4.2, 4.3) were exceeded because of the mass screening exercises conducted in the aftermath of Tropical Cyclone Freddy where more people were reached in camps at a lower cost than initially budgeted		
Activities	**Description**	**Implemented by**		
Activity 4.1	Strengthen management of severe acute malnutrition in the context of Cholera	UNICEF/MoH/District Council		
Activity 4.2	Refresh frontline workers (Nurses, clinicians, HSAs and Homecraft workers) on SAM treatment in the context of cholera	UNICEF/MoH/District Council		

Activity 4.3	Screening children 6-59 months for early detection and referral for treatment of acute malnutrition	UNICEF/MoH/District Council
Activity 4.4	Promote positive social behaviour change to maintain adequate feeding practices among pregnant and lactating women and 0-23 months	UNICEF/MoH/District Council
Activity 4.5	Promote zinc supplementation among affected people to mitigate disease severity	UNICEF/MoH/District Council
Activity 4.6	Procure and distribute nutrition therapeutic supplies (RUTF, F75, F100 and Zinc)	UNICEF/MoH/District Council

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.**

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

Child protection: The protection sector implemented a joint monitoring exercise of the emergency response. This provided an opportunity for the affected population to provide feedback on the response. The results of this feedback are being used in the design of the next response.

Health: The project activities with the principles of diversity, equity, and inclusion approach to ensure better targeting of affected people including patients with disabilities (PwD). Targeted prevention messaging was provided to ensure the protection and safety of adolescent girls and women in the Cholera response. To ensure no one is left behind, women and adolescent girls with disabilities were supported to access emergency supplies including Oral Rehydration Salts (ORS), cholera beds, essential medicine like doxycycline, Interagency emergency health kits (IEHK) kits and infection prevention and control supplies in CTUs and integrated mobile clinics. The supplies were distributed to all people including PWD.

Nutrition: The project design and planning were done based on the needs assessments and consultations with districts and community structures including the District Nutrition Coordination Committees (DNCC), the District Health Management Teams (DHMT), Area Nutrition Coordination Committee (ANCC). In addition, with this support UNICEF conducted review meetings and joint monitoring visits with DNCCs, ANCCs, DHMTs, focus group discussions and the community behaviour tracking tool (CBTTs) to monitor the implementation of the program. The findings from these review meetings helped UNICEF and its partners to provide effective delivery of appropriate life-saving interventions to both children affected by acute malnutrition including people with disabilities. This included strengthening of behaviour change communication messages on maternal infant and young child nutrition (MIYCN) practices to prevent malnutrition.

[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.

[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.

WASH: The cholera response was designed in consultations with local government authorities, implementing partners, representatives from the beneficiary groups and other WASH Cluster partners. The planned activities were guided by reports from the ground from the government, implementing partners, and other WASH Sector partners, whereby life-saving activities were prioritised. Regarding construction of WASH facilities, in the CTCs, camps and communities, several criteria were used such as number of people, access to safe water, risks of cholera outbreak and sanitation coverage in the affected communities. During implementation, UNICEF in close collaboration with implementing partners, government officials (DHO and DWDO), ensured that WASH activities were closely monitored, and quality is effectively controlled. Also, using existing tools and guidelines, UNICEF with its partners monitored the operations and actively consulted the beneficiaries for feedback if there were any complaints/issues with the WASH interventions.

To monitor the response, UNICEF, guided by its Core Commitments for Children in Humanitarian Action and global standards such as the SPHERE standards, through staff at the field level, district officials together with the implementing partners were responsible for feedback and accountability mechanisms integrated into the day-to-day activities. Through different forum such as meetings and FGDs with representatives of beneficiary groups, government authorities and WASH partners; communities were consulted on the services provided as well as the selection of the location of water points and latrines and the feedback on the quality and functioning of those WASH services. Also, partners' performance was monitored through existing systems such as regular programme and financial spot-checks as defined in the Harmonised Approach to Cash Transfers (HACT) Guidelines.

b. AAP Feedback and Complaint Mechanisms:

In child protection, suggestion boxes were placed in the affected communalities. Focal persons were also trained to receive and provide feedback on any complaints and provide referral services to protection services.

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

Suggestion boxes were placed in all emergencies affected areas including schools. Police were trained and empowered to put in place mechanisms for opening these boxes and handling all complaints. All service providers were trained on protection from sexual exploitation and abuse and the reporting mechanisms that can be used. These acted as focal persons for handling cases of sexual exploitation and abuse. Awareness messages were aired on national and community radios on prevention of sexual exploitation and abuse.

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

Through the empowerment of community members especially women and girls through awareness of sexual and gender-based violence, it is expected that the project will stimulate behavioural change towards respect for women and girls. Community members have been empowered to report cases of sexual and gender-based violence through sensitisation on what constitutes violence and abuse and the mechanisms that they can use to report instances of abuse.

e. People with disabilities (PwD):

Child protection workers are trained to provide case management to children and people in need of care and protection including persons with disabilities. Special attention was therefore provided to people with disabilities in the provision of child protection services.

There are important links between disability and malnutrition. Disabilities such as cerebral palsy and cleft palate were some of common disabilities in children with SAM. Caregivers of such children were counselled on the condition and the implication on feeding and treatment. These children and caregivers were also referred for appropriate support including physiotherapy and livelihood interventions.

f. Protection:

UNICEF worked with Malawi Police Service to sensitise affected persons of sexual and gender-based violence and provide GBV risk mitigation and response services. Mobile victim support services were provided at community level to reduce transport costs for community members. Complaints mechanisms were also established in the affected areas through installation of complaints boxes for feedback and reporting of cases of violence, abuse, and exploitation.

g. Education:

Ensuring that children are back to school at any circumstance was a key element considered during the design of the project. Thanks to the CERF Funding, UNICEF constructed 6 new latrines in the schools enabling 1800 learners to access appropriate sanitation facilities thus enabling the application of Infection Prevention and Control (IPC) protocols.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	N/A

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$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
Shielding cyclone survivors from waterborne diseases	https://www.unicef.org/malawi/stories/shielding-cyclone-survivors-waterborne-diseases
UNICEF supporting health facilities with essential supplies and medicines including tents.	https://shorturl.at/eiTW8
UNICEF supports 112,804 people in districts still battling #Cholera by providing safe water.	https://shorturl.at/sCPR7
#UNICEF provides #WASH, child protection and education support at the camp. United Nations CERF	https://shorturl.at/oxVY6
Here are some of the things you can do to stop the further spread of #Cholera. #EndCholera	https://www.facebook.com/UNICEFMw/videos/617645513620779/
UNICEF is supporting Malawi Government to assess damages and respond to children's needs in areas of	https://t.ly/kW1vw

nutrition, education, protection, health, and water, sanitation and hygiene. United Nations CERF	
Machinjiri Township in Blantyre has suffered heavily from the ongoing #cholera outbreak in #Malawi.	https://t.ly/ol_8r
Cholera kills very quickly, but it is easy to avoid and treat. Stop the spread of cholera, drink clean and safe water. #EndCholera #TithetseKolera	https://rb.gy/fqsavz
Prevention is better than cure and this goes for all diseases including #Cholera.	https://rb.gy/zvj1qv
UNICEF supported 112,804 people in districts still battling #Cholera by providing safe water.	https://twitter.com/MalawiUNICEF/status/1697256739375358408
UNICEF Malawi Cholera Flash Update #4	https://shorturl.at/ciDJP

3.3 Project Report 23-RR-WFP-005

1. Project Information			
Agency:	WFP	**Country:**	Malawi
Sector/cluster:	Common Services - Logistics	**CERF project code:**	23-RR-WFP-005
Project title:	Logistics support to the humanitarian community to respond to the Cholera outbreak		
Start date:	03/03/2023	**End date:**	02/09/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding		
	Total requirement for agency's sector response to current emergency:	**US$ 500,000**
	Total funding received for agency's sector response to current emergency:	**US$ 0**
	Amount received from CERF:	**US$ 300,011**
	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 this CERF grant, WFP provided common logistics services for Government and humanitarian partners, including transportation and storage of life-saving Cholera commodities between March and August 2023.

Storage space was provided to four partners, the Ministry of Health (MoH), Malawi Red Cross Society, Médecins Sans Frontières (MSF), and the World Health Organisation (WHO) during the Cholera response. Dedicated transportation for WHO/MoH also provided transport of over 400 mt of medical commodities to affected district hospitals and health centres.

In addition to common logistics services provided, early in the response the Ministry of Health reported that district hospitals and health centres were overrun with Cholera patients and did not have the facilities to accommodate. Given this, mobile storage units, large tents that can be easily mounted, were provided in affected areas to be used as emergency cholera treatment centres. In total 27 mobile storage units were deployed, and more were converted from previous COVID testing centres to support Cholera patients.

3. Changes and Amendments

Not applicable – support provided by CERF was used as planned.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Common Services - Logistics									
	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	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	0	0	0	0	**0**

* 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

The project targeted humanitarian organisations and other key partners to enable the coordination and delivery of critical relief items to support affected populations.

6. CERF Results Framework

Project objective	To support and strengthen the humanitarian community's ability to provide lifesaving supplies to Cholera-affected populations in Malawi.			
Output 1	Fill the identified logistics gaps in response to the Cholera response by providing common logistics services in order to ensure the humanitarian community may reach affected populations.			
Was the planned output changed through a reprogramming after the application stage?		Yes ☐	No ☒	
Sector/cluster	Common Services - Logistics			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	CS.2 Total weight of cargo transported by land, sea or air in MT per project (behalf of health partners)50 MT per month (subject to demand and priorities of the humanitarian communities and Ministry of Health)	300MT	424 mt The variations in transport rates for different delivery points and the fact that WFP utilised own fleet contributed in achieving a larger tonnage than targeted.	Service request tracking
Indicator 1.2	CS.9 Percentage of service requests that have been completed	90% (subject to the demand and priorities of the humanitarian communities and national coordination	100%	Service request tracking
Explanation of output and indicators variance:		N/A		

Activities	**Description**	**Implemented by**
Activity 1.1	Manage a fleet of vehicles for delivery of relief items	WFP
Activity 1.2	Provide dedicated humanitarian common storage space	WFP

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[6] 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.**

[6] 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)[7]:

As the national logistics cluster's end users are humanitarian partners, there is no direct engagement with affected populations. Furthermore, the accountability of the delivery of the ground transport service by WFP and other identified commercial companies with relevant capacity to the humanitarian community for the Cholera response is ensured through logistics cluster coordination meetings and monitoring from WFP staff based in the sub-office and field offices. WFP, via its cooperating partners and field staff in affected areas, ensures that beneficiaries are sensitized on the available Community Feedback and Response Mechanisms (CFRMs) so that they can monitor and report any issues related to the implementation of the activities.

b. AAP Feedback and Complaint Mechanisms:

WFP has several established CFRMs to receive and act on feedback regarding response activities, and in general. For this service provision-focused project beneficiaries can utilise these CFRMs to report inappropriate conduct by drivers or other logistics officers. These include helpline numbers, help desks and suggestion boxes at all distribution points. WFP also has a full-time Risk Management and Compliance Officer who examine any related issues of non-compliance to AAP. Additionally, WFP has an online commodity tracking tool which is used to monitor and track relief items being stored and transported by WFP on behalf of partners. This allows partners to monitor service delivery in real-time from dispatch to distribution alongside WFP and provide immediate feedback on WFP's performance.

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

As noted above, WFP has several established CFRMs to receive and act on feedback regarding response activities, and in general. For this service provision-focused project beneficiaries could utilise these CFRMs to report inappropriate conduct by drivers or other logistics officers. WFP has clear standard operating procedures under the CFRMs on how issues of high priority including SEA are to be handled; this includes high levels of confidentiality and escalation of such cases to the PSEA focal points for follow up. WFP also has a full-time Risk Management and Compliance Officer as well as the PSEA focal points who will examine any related issues of non-compliance to PSEA. Furthermore, prevention of sexual exploitation and abuse (PSEA) commitments is part of the contractor's agreement with external transporters contracted for the response, to ensure demonstrated internal capacity to address and respond to allegations of SEA through their policy and commitments in the agreement.

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

Given its focus on logistics service provision, the project did not directly contribute to gender equality and promotion of empowerment and protection of women, girls and sexual and gender minorities. However, WFP ensures that all actors involved in the implementation of the activities including transporters are oriented on SEA and gender and protection issues. WFP also advocates with the Government and humanitarian partners receiving logistics and transport services for this to be considered in their response activities.

e. People with disabilities (PwD):

Given its focus on logistics service provision, to the extent possible WFP advocates with Government and humanitarian partners receiving logistics support to ensure access to persons with disabilities at distribution sites. WFP field staff also monitors intervention sites to ensure that essential needs of PwD including accessibility and inclusion are considered.

f. Protection:

As indicated above, WFP ensures that key actors involved in the logistics service provision including the transporters, are briefed on humanitarian principles including of protection and dignified assistance. WFP also advocates with the Government and humanitarian partners receiving logistics and transport services for this to be considered in their response activities, for example ensuring that distribution points and times do not lead to protection risks.

g. Education:

[7] 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.

N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?		
Planned	**Achieved**	**Total number of people receiving cash assistance:**
No	No	N/A

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$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
Twitter	https://twitter.com/WFP_Malawi/

That WFP transported over 18,000 tons of food and relief items for the response to Cyclone Freddy in #Malawi.

Thanks to support from @UNCERF @USAIDsaveslives @IcelandDevCoop support to @WFPLogistics.

5 12 457

from #CycloneFreddy and inaccessible by road, @WFP has deployed 2 helicopters to deliver much needed food and medical supplies.

@UNCERF
@IcelandDevCoop

2 20 50 3.9K

@UNCERF has provided a USD 300,000 contribution for @WFP_Malawi to provide logistics support to @MalawiGovt in response to the cholera outbreak in #Malawi.
This is even more important now in light of the #CycloneFreddy with the threat of further spread

4 15 1.4K

3.4 Project Report 23-RR-WHO-008

1. Project Information			
Agency:	WHO	**Country:**	Malawi
Sector/cluster:	Health	**CERF project code:**	23-RR-WHO-008
Project title:	Provision of Life-saving Cholera supplies to 263,742 people in six high-priority and Cholera affected districts in Malawi and enhanced outbreak detection and response.		
Start date:	23/03/2023	**End date:**	22/09/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding		
	Total requirement for agency's sector response to current emergency:	**US$ 11,679,052**
	Total funding received for agency's sector response to current emergency:	**US$ 6,837,880**
	Amount received from CERF:	**US$ 500,011**
	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 this CERF UFE grant, World Health Organization (WHO) and its partners, provided access to essential Cholera supplies to 305,000 people accessing treatment in 10 facilities across six high priority districts including Lilongwe, Blantyre, Balaka, Machinga, Mangochi and Salima. The beneficiaries of these supplies included Women (77,245), Men (61031), boys (79,721) and girls (87003). At least 50,000 litres of ringer's lactate were procured and handed over to Ministry of Health warehouse. To date, 39 246 litres of ringer's lactate have been distributed to the following districts: Lilongwe, Balaka, Blantyre, Machinga, Mangochi, and Salima. Due to the change in epidemiological trend of reported cholera cases, districts that started reporting increased cases between end of February and end April were also included in the distribution lists, which are Mchinji, Zomba, Zomba mental hospital, Dedza, Chikwawa, Ntcheu and Nsanje. A total of 11 968 cases were also treated for Cholera in addition to other acute watery diarrheal diseases (AWD) during the reporting period. Further, this grant allowed WHO and partners to enhance outbreak detection and response at the district level by enforcing timely investigations and response to cholera alerts in the target districts. In total, 115 cholera alerts were received and responded to within 48 hours by the Rapid Response Teams across six priority districts including implementation of community interventions to control local cholera transmission from 23 March to 31 August 2023. Furthermore, more supplies like 10 000 Oral Rehydration Salts sachets were distributed to the Cholera Treatment Units (CTUs), and Oral Rehydration Points (ORPs) in the targeted districts. 5 cholera Investigation kits were procured, 3 laboratory kits, 420 HTH by 25kg buckets were procured and 210 were distributed to Districts for use in CTUs and ORPs for pot-to-pot chlorination. The project allowed for the reduction in number of new cholera cases from over 320 cases/week in March 2023 to under 5 cases per week in August 2023 and deaths reducing from over 15 deaths per week to 0 deaths per week during the same period in the catchment populations, and this was achieved amidst multiple health emergencies in addition to cholera outbreaks, including the aftermath of floods from Cyclone Freddy and the wild poliovirus type 1, which added an additional burden on the health system.

3. Changes and Amendments

There were no changes and amendments made to this agreement. The target was surpassed because CERF funds are catalytic. The Ministry of health was able to ride on that to reach a wider audience. This is inclusive of the CTUs/CTCs as well as ORPs. The interventions 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 allocated to WHO came at a period the cholera cases had just been reported in the Northern region which was becoming the epicentre of the outbreak. Our interventions supported by CERF funding i.e. recruitment of public health surveillance officers, dissemination of IPC job aids and SOPs, establishment of community level cholera rehydration points which had impact on controlling the outbreak in CERF implementing districts compared to others. The interventions 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 ECHO (EURO 1,542,210), World Bank (USD 9 000,000), FCDO (500,000 Pounds), additional funding from CERF (USD 500,011). The funding from these different streams have been 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.

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**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Returnees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Internally displaced people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Host communities	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Other affected people	67,201	62,033	69,944	64,564	**263,742**	**77,235**	**61,031**	**79,721**	**87,003**	**305,000**
Total	**67,201**	**62,033**	**69,944**	**64,564**	**263,742**	**77,235**	**61,031**	**79,721**	**87,003**	**305,000**
People with disabilities (PwD) out of the total										
	7,392	6,823	7,693	7,102	**29,010**	**7,392**	**6,823**	**7,693**	**7,102**	**29,010**

* 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

The indirect beneficiaries involved 996,089 people from communities within the project priority facilities catchment areas in the targeted districts. These benefited from the emergency health kits distributed and the improvement of health conditions of the affected population leading to reduction of transmission of infectious diseases like cholera. The provision of Cholera supplies reduced the cost of health care in the households, indirectly increasing incomes available to households and the household capacity to access other basic needs; sound health conditions of target beneficiaries improved household labour capacity and productivity of direct beneficiaries trickling down benefits to other family members in the form of increased household resources. Finally, a healthy household population enjoyed an environment free from psychosocial distress and mental health reducing the risk of domestic violence among the affected people.

The CERF allocation supported cholera response partly by setting up community-based interventions including the setting up of community based oral rehydration points in the catchment areas of the targeted facilities. These ORPs acted as a hub for information sharing on cholera prevention and interventions to community members, first line of treatment of acute watery diarrheal cases (suspected and confirmed cholera cases) and referral of moderate to severe cases to nearest treatment points. By doing so, the ORPs facilitated early treatment and interruption of transmission potentially to the whole catchment area of the targeted facilities. Secondly, the CERF allocation supported strengthening of surveillance for early detection, case investigation, active case follow-up which happened at community level in the targeted districts. Thus CERF allocation went beyond admissions related to health facilities but rather amongst the communities within the catchment area of the targeted facilities. Therefore, as per 2018 population census and National Statistical Office (NSO) projections, the total populations in the communities where these interventions were implemented and indirectly contributed to the successful control of cholera cases is 996,089 (Source: NSO 2018 census).

6. CERF Results Framework

Project objective	To contribute to the reduction of preventable morbidity and mortality resulting from Cholera outbreak in Malawi through the provision of essential Cholera supplies and enhanced outbreak detection and response at the district level.			
Output 1	Women, men, boys and girls in counties affected by Cholera have equitable and timely access to lifesaving essential Cholera supplies for better management of cases.			
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 of people benefiting from Cholera supplies	263742	305,000	District Health Offices/NSO
Indicator 1.2	H.7 Number of functional health facilities supported(Number of Cholera treatment centres and units supported)	10	10	Project report, Cholera case line list
Indicator 1.3	H.11 Number of people receiving treatment for acute watery diarrhoea (incl. cholera)	263742	305,000	District Health Offices/NSO/Cholera case line list
Explanation of output and indicators variance:		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 higher number of people treated than initially projected. Of note, another activity for the CERF allocation for WHO was supporting the establishment of ORPs to strengthen cholera case management.		

Activities	Description	Implemented by
Activity 1.1	Procurement of essential Cholera supplies to support the response. To address the emergency health needs of responding partners, WHO will procure and make available Cholera Investigation and management kits	WHO
Activity 1.2	Distribution of Cholera supplies to priority locations; In collaboration with the Health Cluster (HC) and Ministry of health, WHO will distribute essential Cholera supplies to Lilongwe, Blantyre, Balaka, Machinga, Mangochi, and Salima which are prioritized locations. 10 facilities (CTCs, CTUs) will be the recipients of the kits. The supplies will be stored in Lilongwe and at the district level where District facilities and health partners will be able to request.	WHO
Activity 1.3	Monitoring and supportive supervision visits to the six districts	WHO

Output 2	Deploy Rapid Response Teams (RRTs) for outbreak detection, prevention and management in priority high-risk locations in 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 2.1	Number of Cholera alert epidemic-prone disease alerts verified and responded to within 48 hours.	90	115	Investigation report
Explanation of output and indicators variance:		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. Noting the high number of cases, the rapid response teams would deploy frequently after notification of a suspected case to conduct case investigation and immediate response activities hence the higher number of alerts investigated.		

Activities	Description	Implemented by
Activity 2.1	Deploy RRTs and technical officers to conduct rapid assessments, risk assessments, alerts, and outbreak investigations at the national and district level including hard to reach locations	WHO

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[8] 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.**

a. Accountability to Affected People (AAP)[9]:

WHO worked with community leaders and partners operating in the project locations to ensure affected people were consulted, informed, participated, and given timely feedback about the project benefits as well as their role during implementation and monitoring. During the implementation phase WHO coordinated with health partners, community structures, the district health department, and community leadership to facilitate the delivery of supplies. The structures provided vital information which guided WHO interventions. Their participation included providing information on needs, community mobilization, technical support, and project monitoring. Project activities were jointly implemented with MoH to ensure the application of national guidelines as well as strengthen the oversight role of the Ministry of Health.

b. AAP Feedback and Complaint Mechanisms:

WHO utilized a combination of mechanisms for feedback, including health information sessions, information boards, community representatives, and meetings to provide two-way feedback to affected people and ensure the needs of the vulnerable population are met. Community leaders and health facility management committees were engaged during monitoring and supervision visits to provide information on supplies received at facilities. Feedback from beneficiaries was analysed at different levels and used for decision-making. Consequently, WHO reintegrated the recommended best practices to increase support for affected people. Where feedback exposes gaps in health programming, WHO designed and implemented remedial actions in line with the needs expressed by the beneficiaries including the provision of clarifications in the case of limited information.

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

WHO has a zero-tolerance policy regarding SEA. SEA allegations would be reported through established community-based complaint mechanisms that are established in high-risk locations in the country and through hotline number numbers availed on PSEA posters. Any cases reported would be investigated following WHO internal procedures on addressing SEA by independent team from headquarters (iOS), which ensures a victim-centred approach, and confidentiality is maintained. Systems are in place for disciplinary action against perpetrators. All WHO staff including surge staff were well trained on WHO SEA policies, reporting mechanisms and whistle blowing mechanism to ensure protection of staff and communities we serve. A consultant at P4 level was deployed through other resources because of the scale of the cholera outbreak. The consultant, WHO country office, and UN focal point engaged beneficiaries on WHO and UN policies and reporting mechanisms.

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

Essential Cholera supplies sites were located close to the sites where the vulnerable population were located so that women, men, boys, and girls could easily access the services without having to walk long distances. All CTCs and CTUs had female clinicians to ensure that victims of GBV could feel free to open up and seek care. Health workers were trained on clinical management of rape to ensure that all survivors get the optimum care. Additionally, WHO ensured that all the supported facilities have safe spaces to facilitate counselling and information sharing with at risk population who need counselling.

e. People with disabilities (PwD):

[8] 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.

[9] 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.

Rapid Response teams were ready to be deployed to the affected districts for emergency response including investigation and response to outbreaks and other public health emergencies. Women, children, and other vulnerable groups were given priority. WHO worked together with community and health facility managers to ensure that PwD, women and girls are supported to safely access the supported health facilities through door-to-door community interventions (i.e. pot to pot chlorination of drinking water, active case search of cases for early detection and interrupt transmission to most vulnerable members of the community), setting up of community based Oral Rehydration Points to ensure first line care is closer to the community serving all including those who may have challenges with accessing health facilities.

f. Protection:

Health facilities that were supported with Cholera supplies were selected with gender and protection considerations to ensure ease of access by key risk populations particularly women and children and at-risk groups. For instance, distance and average walking time were considered in the selection of health facilities and ORPs locations together with the community depending on the density of cholera cases and deaths. The community engagements involved community leaders, who would convene community meetings including women and children as they discussed setting up cholera treatment centres, community based ORPs and other community interventions. By involving those at higher risk, any potential concerns were considered during the implementing period. During these community consultations, the social protection officers within the targeted health facilities were involved to ensure issues of protection of vulnerable and at risk populations are taken into consideration during decision making.

g. Education:

WHO supported risk assessment of schools in the affected districts. As part of this project, WHO ensured RRTs were deployed to conduct rapid risk assessment, investigation and respond to any cluster of cases in the affected districts. WHO also ensured cholera prevention and WASH messaging in schools and school children presenting with cholera symptoms were referred for timely treatment.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	**Achieved**	**Total number of people receiving cash assistance:**
No	No	N/A

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$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
A sustainable approach to cholera prevention	*https://www.afro.who.int/countries/malawi/news/teach-them-young-sustainable-approach-cholera-prevention*
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*

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
23-RR-CEF-008	Water, Sanitation and Hygiene	UNICEF	INGO	$100,111
23-RR-CEF-008	Water, Sanitation and Hygiene	UNICEF	NNGO	$76,229
23-RR-CEF-008	Health	UNICEF	GOV	$17,864
23-RR-CEF-008	Water, Sanitation and Hygiene	UNICEF	GOV	$10,496
23-RR-CEF-008	Water, Sanitation and Hygiene	UNICEF	GOV	$12,841
23-RR-CEF-008	Water, Sanitation and Hygiene	UNICEF	GOV	$2,231
23-RR-CEF-008	Nutrition	UNICEF	GOV	$59,627
23-RR-FPA-006	Nutrition	UNICEF	GOV	$18,115
23-RR-CEF-008	Nutrition	UNICEF	GOV	$27,524
23-RR-CEF-008	Nutrition	UNICEF	GOV	$45,959
23-RR-CEF-008	Nutrition	UNICEF	GOV	$6,914
23-RR-CEF-008	Nutrition	UNICEF	GOV	$28,400
23-RR-CEF-008	Nutrition	UNICEF	GOV	$13,313
23-RR-FPA-006	Sexual and Reproductive Health	UNFPA	NNGO	$65,000
23-RR-FPA-006	Gender-Based Violence	UNFPA	NNGO	$70,000
23-RR-FPA-006	Gender-Based Violence	UNFPA	NNGO	$70,000
23-RR-FPA-006	Gender-Based Violence	UNFPA	INGO	$35,000