# EMERGENCY APPEAL

## *OPERATIONAL STRATEGY*

## Africa | Mpox Epidemic

*DRC Red Cross volunteers share health information, promote hygiene measures and conduct community-based surveillance applying the skills learned through USAID's C3 program since 2018 © Alioune Ndiaye/IFRC*

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| Appeal №: **MDRS1003** | To be assisted: **30 million people** | Appeal launched: **20/08/2024** |
| Glide №: | DREF allocated: **CHF 5 million** | Disaster Categorization: **RED** |
| Operation Start date: **20/08/2024** | Operation End date: **30/06/2025** | |

**IFRC Secretariat Funding requirement: CHF 30 million**
**Federation-wide funding requirement: CHF 40 million[1]**

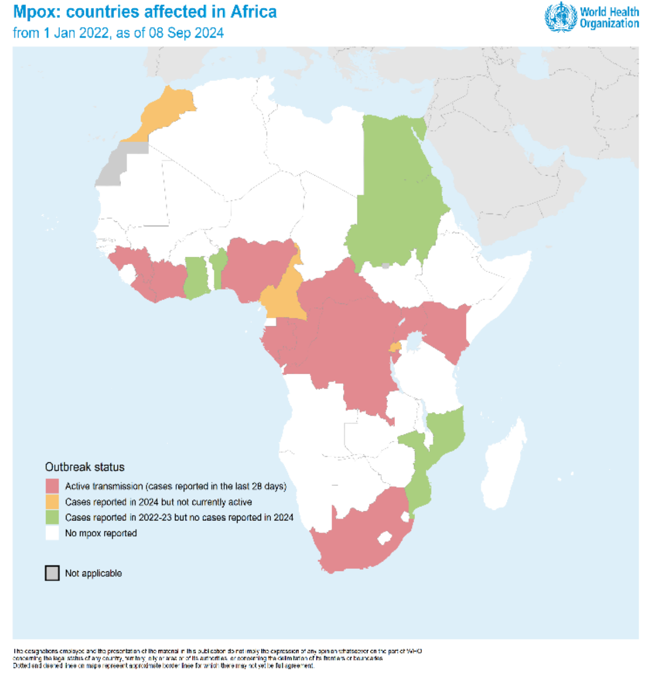
[1] The Federation-wide funding requirement encompasses all financial support to be directed to the National Societies in response to the emergency. It includes the operating National Societies' domestic fundraising requests and the fundraising appeals of supporting Red Cross and Red Crescent National Societies (CHF 10 million), as well as the funding requirements of the IFRC Secretariat (CHF 30 million). This comprehensive approach ensures that all available resources are mobilized to address the urgent humanitarian needs of the affected communities

## TIMELINE

*Trained DRC volunteers sharing important mpox prevention messages through their local radio stations such as Soleil Levant*.

- **April 2022:** Mpox cases are reported in several African countries, including the DRC and Nigeria. The DRC sees a resurgence of cases.
- **June 2022:** The first cases of mpox are detected in neighboring countries of the DRC, such as Uganda and Cameroon, raising concerns of cross-border transmission
- **November 2023:** The African Centre for Disease Control and Prevention (AfCDC) releases a report highlighting ongoing challenges and progress in controlling mpox.
- **March 2024:** An outbreak of mpox in Equateur province (DRC) and the Central African Republic raises concerns. At this stage several African countries continue to report cases: DRC, Cote d'Ivoire, South Africa, Nigeria, Congo Republic, Cameroon
- **April 2024:** DRC Red Cross scales-up the response in the Equateur province with the support from the IFRC
- **July 2024:** A spike in cases in the Eastern DRC (non-endemic mpox area). The new clade is responsible for this outbreak. Cross-border transmission into Uganda, Kenya, Rwanda is confirmed.
- **August 2024: AfCDC declared the mpox epidemic a public health emergency of continental concern. Few days after, WHO declares the epidemic a global threat.** IFRC issues Emergency Appeal for 40M CHF to support 30 million people affected and at risk.

# DESCRIPTION OF THE EVENT




A surge in mpox cases and deaths in 2024 is happening in Africa, with over 25,000 suspect and confirmed cases and 32 confirmed deaths across 15 countries in 2024, representing a 180% and 25% increase in cases and deaths, respectively, in comparison to the same period in 2023. The Democratic Republic of the Congo (DRC) is the epicentre of this epidemic with 90% of the total cases in the Africa region. Cases are in all provinces of the DRC, with multiple clades [2] concurrently appearing in endemic and non-endemic provinces. Cross-border transmission from the eastern provinces of North and South Kivu to neighbouring countries is on the rise, especially into Burundi – now reporting 1,500 cases, but also into Rwanda and Uganda as well as Kenya.

In endemic countries such as Nigeria, Central African Republic, Cameroon and Cote d'Ivoire, outbreaks are slowly expanding or have re-emerged. While the 2022 global epidemic also continues and has expanded into South Africa. This makes it the first time that mpox cases and sustained transmission is reported concurrently in endemic and non-endemic countries and with multiple Clades (Clade 1a, 1b and 2) in different geographical areas.

These developments, linked with an increased risk profile amongst the population due poverty and strained access to health services, almost non-existent supply of vaccines (to respond to mpox), led organisations such as the Africa Centres for Disease Control and Prevention and the World Health Organisation to declare this outbreak a public emergency of continental and international concern. The IFRC joined these organisations in raising the alert through a statement and activated internal coordination mechanisms to enhance preparedness and scale-up response.

The virus is endemic in West and Central Africa, however since 2022 there were outbreaks in countries outside of the endemic areas. In countries with a longer history of mpox, apparent wider population transmission is occurring compared to previous years, with unclear routes. Two different Clades exist: Clade 1 and 2. Clade 1, endemic to Central Africa, has historically been associated with more severe disease and higher mortality rate and has shown higher transmission rates compared to Clade 2. Clade 1a has been present in West and Central Africa for years, while Clade 1b was first identified in September 2023, in Eastern DRC where mpox is not endemic. The new Clade 1b has so far resulted in high caseloads among sex workers and the broader population, including children, and is rapidly spreading to East African countries.

The increasing concern over zoonotic diseases—viruses that spread from animals to humans—has a documented link to climate change and environmental degradation. Key factors contributing to this issue include rising temperatures, deforestation, land clearance, habitat loss, and pollution. The World Health Organization's One Health initiative underscores how environmental changes are impacting wildlife, leading to more frequent interactions between animals and humans, which in turn accelerates the spread of viruses.

Biodiversity decline, driven by ecosystem destruction, can further exacerbate the spread of diseases. Climate change is one driver of this

[2] A clade is a "family" grouping of similar genetic lines or subtypes within a virus.

deterioration, disrupting people's livelihoods, contributing to deforestation and impacting the ecosystem around them. Encroachments on ecosystem boundaries (i.e. through hunting, mining, logging, and agriculture) increases the risk of spillover events of zoonotic diseases like mpox. Supporting a healthy ecosystem and community resilience is essential to reducing the risk for spillover events.

Due to the evolving nature of the new level of transmission of 1a and emerging clade 1b, there are many unknowns and uncertainty among communities impacted by the mpox outbreaks. High levels of uncertainty about an emerging infectious disease can manifest as social anxieties or panic, particularly in areas where there is already stigma against a specific group. Acknowledging the unknowns, focusing on addressing issues of trust and concerns expressed by people will be essential for co-designing responses and actions that are inclusive and adaptable as evidence grows around the current mpox outbreaks.

## Severity of humanitarian conditions

1. **Impact on accessibility, availability and quality of services.**

   Mpox is a viral disease caused by the mpox virus, a species which is related to smallpox although less severe. The disease typically starts with flu-like symptoms such as fever, headache, muscle aches and swollen lymph nodes, followed by a rash. The rash often begins on the face and then spreads to other parts of the body. The rash progresses to pustules and eventually scab. Mpox can spread from animals to humans (zoonotic transmission) and human to human through close contact with the lesions, bodily fluids, respiratory droplets, or contaminated materials like bedding. Supportive care improves outcomes for mpox; outbreaks can be controlled through public health and social measures. Vaccines developed for smallpox are effective in preventing mpox, however smallpox routine vaccination has been discontinued in most countries, and vaccines are in short supply.

   Because of the primary mode of transmission for some clades (forms of sexual contact) there is considerable stigma in most countries. Stigma can spread misinformation about mpox, leading to misunderstandings about its transmission, symptoms, and the importance of timely care. People who fear being stigmatized may avoid seeking medical attention, making it harder to trace and contain the disease, increasing the risk of wider transmission. Discrimination within healthcare settings can discourage people from accessing services. If individuals feel that they will be judged, treated poorly, or denied care, they may choose to avoid healthcare facilities altogether. Stigma and discrimination often disproportionately affect marginalized communities. These groups may already face barriers to care, and stigma can further exacerbate these challenges, leading to underreporting and underdiagnosis.

   Due to potential stigma associated with mpox as well as various measures such as isolation during illness and/or recovery period, those who experience mpox infection may face additional challenges such as loss of livelihoods, missed school days and reduced social capital following infection. Reduced social support structures also puts individuals at greater risk when relying on these systems to support their family or themselves while receiving care (i.e. food, family care, etc.).

2. **Impact on physical and mental well being**

   Mpox has significant mental health and psychosocial consequences due to several factors related to the disease itself, the public health response, and the broader social context. Aspects such as fear and anxiety related to becoming infected, or of the consequences once having contracted the disease, coupled with stigma and discrimination, the disruption of social support for those facing isolation measures, the distress associated with misinformation and uncertainty, or the trauma and grief for those who have lost someone, are some of the reasons why MHPSS will be paramount in the response. Research conducted on cases from the 2022 outbreak confirm mental health morbidity associated with mpox. Early interventions addressing the psychological wellbeing of those individuals and communities affected is of utmost importance, including of staff and volunteers involved in the response.

# CAPACITIES AND RESPONSE

## 1. National Society response capacity

### 1.1 National Society capacity and ongoing response

The IFRC network is the largest humanitarian actor globally. In the Africa Region, its 49 National Societies, 18,000 branches, 14,000 staff and 4 million community volunteers have a long history of responding to crisis and disasters, including health epidemics such as viral haemorrhagic fevers, polio, cholera, dengue and the COVID-19 pandemic. Accumulated years of experience and its reach can make a difference in supporting governments to prevent and stall transmission of the mpox virus. These include:

- **Prevention and Risk Mitigation**: understanding community fears, misconceptions, and practices to create targeted strategies to reduce stigma, counter misinformation and guide the response. Establishing trust through transparent and clear communication is vital for encouraging public adherence to health guidelines. Involvement of trusted community leaders helps in disseminating accurate information and gaining community support for public health measures. Two ways communication is crucial to ensure a clear direction of actions to be taken for positive risk reduction.
- **Community-led preparedness and response**: Local communities bring a critical perspective to emergency response management. Their actions and suggestions should inform risk assessments and action planning conducted with governments and other entities. Communities have local and cultural knowledge of the places where they live that enables them to understand the risks that contribute to health emergencies and how these events could impact them. Involving communities and community-structures in designing and implementing the mpox response is key to build trust, promote preventative measures, leverage local knowledge of exposures, vulnerabilities, and local capacities. This enables communities to develop their unique risk profiles and determine priorities for action at the community level
- **Disease surveillance**: acquired expertise in community-based surveillance, and contact tracing, extend national surveillance systems to communities.
- **Mental Health and Psychosocial Support**: extended networks of support were established during COVID-19 and Ebola responses, support groups and individual sessions, by trained volunteers.
- **Vaccination**: National Societies have expertise in supporting vaccination programmes, including supply chain to remote communities, vaccines awareness, administration and post-vaccination follow up.

Red Cross Red Crescent Societies are engaging with their Ministries of Health prepare and respond to the outbreak. DRC, Burundi, CAR, Nigeria and South African National Societies are in response phase and undertaking various RCCE, health prevention and promotion, and WASH activities, while DRC neighbouring countries, and those with isolated imported cases are engaging in preparedness and response activities.

In DRC, the Red Cross is working in health zones, through funding from USAID and ECHO focusing on three pillars: community-based surveillance, RCCE and MHPSS. Through the Community Epidemic and Pandemic Preparedness Programme, Red Cross has been building health resilience in communities across the country since 2018, equipping them with the knowledge and tools to quickly detect, prevent and respond to disease outbreaks. The DRC Red Cross is now putting this important preparedness work into action through its mpox response.

In Burundi, the Red Cross is working across the country in RCCE, Social and Behavioural Change and WASH activities. In Central African Republic, the Red Cross has activated the network of volunteers trained in the epidemic response from previous outbreaks (Cholera, Ebola and Covid 19) to organize preventive response activities, including health volunteers supporting the Ministry of Health's epidemic treatment centres.

In Cameroon, Kenya, and Uganda, Red Cross volunteers have begun raising awareness on mpox through door-to-door campaigns, and organizing community awareness sessions through focus groups, educating communities on the transmission modes, symptoms, and prevention measures of mpox.

### 1.2 Capacity and response at regional and national level

IFRC is a partner with Africa CDC and World Health Organization on the continental preparedness and response plan, with assigned leadership in the Risk Communication and Community Engagement pillar.

At the regional level, IFRC, World Health Organization, and Africa CDC are undertaking coordinated planning to prioritize countries and National Societies based on outbreak risks, and ensuring the continental plans of the three organizations are aligned. At the country level, specifically in DRC, Republic of Congo, and Burundi, IFRC has deployed additional capacity to support the National Societies coordinate technical alignment with WHO and Africa CDC.

Building on the expertise, experience, lessons learned and best practices from recent public health in emergencies, including Ebola Virus Disease, Marburg virus, Covid-19, and ongoing Mpox outbreaks, the IFRC network is well positioned to ensure a well-coordinated approach to responding this regional and scaled event.

## 2. International capacity and response

### 2.1 Red Cross Red Crescent Movement capacity and response

The IFRC is coordinating and supporting the operation through the Regional Office in Nairobi and the eight country cluster delegations that cover the affected countries. Additional technical surge human resources were deployed to the regional and country levels to support the National Societies.

Renewed efforts are underway by the IFRC to ensure deliberate membership engagement measures and tools are in place to support membership coordination to all partners within the IFRC network. IFRC set-up the foundations to a membership and operational coordination in operations, built of existing country-based coordination mechanisms.

IFRC’s role to support region wide, and country specific coordination amongst the members, and on behalf of the Movement for technical coordination and representation will continue to expand, positioning the Red Cross Red Crescent Movement as a strong institutional partner to Ministries of Health and Governments in pandemic preparedness and response.

This approach is intended to identify inter-organization synergies, identify opportunities to streamline efforts to support NSs, mapping of NSs comparative advantages (especially of those that have medium to longer term engagements across the continent); and for stakeholders to aim to reach efficiencies and economies of scale while working collaboratively within and between components of the RCRC Movement – both in countries impacted by natural disasters; as well as countries impacted by conflict. One important outcome of this collaboration is to strive to increase our overall Collective Impact on impacted communities.

Several participating National Societies are providing support to the affected country National Societies during in enhancing their preparedness and response activities. Below is a mapping of PNS presence by country.

| | Countries by stage | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Stage 3 Established and ongoing transmission | | | | | Stage 2 Imported cases with no established transmission | | | | | | | Stage 1 Strengthen preparedness | |
| PNS | CAR | Burundi | DRC | S. Africa | Nigeria | Rwanda | Uganda | Kenya | Ivory Coast | Congo | Cameroon | Gabon | S. Sudan | Tanzania |
| American RC | | | | | | | | ● | | | | | | |
| Austrian RC | | | | | | ● | ● | | | | | | | |
| Belgian RC | | ● | ● | ● | | ● | ● | | | | | | | |
| British RC | | | | | ● | | | ● | | | | | | |
| Danish RC | | | | | | | | ● | | | | | ● | |
| Finnish RC | | ● | | | | ● | | ● | | | | | ● | |
| French RC | ● | ● | ● | | | | | | | | ● | | | |
| German RC | | | | | | | ● | | | | | | ● | |
| Italian RC | | | | | ● | | | ● | | | ● | | | |
| Japanese RC | | | | | | ● | | | | | | | | |
| Luxembourg RC | | ● | ● | | | | | | | | | | | |
| Netherlands RC | ● | | | | | | ● | | ● | | | | ● | |
| Norwegian RC | | | | | ● | | | ● | | | | | ● | |
| Spanish RC | | ● | ● | | | ● | | | | | | | | ● |
| Swedish RC | | | ● | | | | | | | | | | ● | |
| Swiss RC | | | | | | | | | | | | | ● | |

The ICRC is present in most countries experiencing Mpox, and the provisions of the Movement Seville Agreement 2.0 for Strengthening Movement Cooperation and Coordination principles applied. In outbreak impacted areas where there is active conflict, the concerned National Society, IFRC and ICRC will discuss the most appropriate approach to access the vulnerable or most exposed groups, promoting the safety and security of staff, volunteers and populations.

## 3. Gaps in the response

### Health and Care, including WASH

- **Surveillance**: contact tracing, community-based surveillance, and active case finding need to be bolstered to curb the spread of mpox in communities. These often need specific protocols or guidance to support high risk populations while still maintaining privacy and confidentiality.
- **Health/hygiene promotion**: Targeting health messages and promoting positive behaviour change for mpox depends on tailoring activities and communication to the transmission patterns and potentially Clade type that is circulating, the specific groups affected by the epidemic, and country context around risks and vulnerabilities. Generic mpox messaging is not helpful and causes more confusion in an already complicated situation for countries facing mpox for the first time.
- **Mental health and psychosocial support**: MHPSS interventions are needed to support those who are affected, as well as for the communities who are at higher risk of transmission. Staff and volunteers must also have their mental and psychosocial well-being addressed and catered for.
- **Case management and IPC**: While supportive treatment exists for mpox, it is not always available for general use at local level. In countries with widespread community transmission, health facilities often struggle to provide care, with community case management of non-severe mpox not always approved by Ministries of Health. With mpox expanding to new countries, healthcare workers may require training on case definitions, treatment protocols, IPC procedures, and referral pathways.
- **WASH:** There are critical gaps in the high-risk communities both those in active response and preparedness phases in terms of information on mpox transmission routes and prevention techniques, provision of water and hygiene items for management of at-home care, and support to health and mpox treatment facilities particularly to address disinfection procedures, and to facilitate and encourage basic hygiene practices. Improving WASH services will contribute to breaking the transmission cycles and containment of mpox.
- **RCCE**: Risk Communication and Community Engagement is a large gap in the mpox response to date. IFRC and partners are prioritizing RCCE to ensure information related to mpox and mpox transmission is communicated to the affected populations, ensuring they are well-informed and able to take appropriate action, thereby reducing transmission and increasing the uptake of health-seeking behaviours. Two-way dialogues that engage communities in identifying and mitigating risks will be a priority.

## Community Engagement and Accountability

A community-centred approach that prioritizes trust-building, inclusivity, and sustained dialogue, needs to be in place throughout the response, ensuring that the response is both effective and equitable and to avoid the following foreseen challenges:

- Communities might not be adequately involved in decision-making processes, leading to interventions that do not align with local needs or cultural practices and issues of mistrust.
- Mistrust of public health measures, healthcare systems or government authorities could hinder effective engagement of people and communities in adopting preventative measures, especially if past responses were perceived as inadequate or exploitative.
- Poor understanding of social and cultural context, behavioural drivers and barriers, and lack of a systematic community feedback approach where people are listened to and feedback is acted upon promptly or transparently will hinder tailored approaches to engage communities and counter misinformation and rumours in a timely manner, as well as tailor strategies and course correct the response-based community insights. This can lead to fear, stigma, and resistance to health interventions, and eventually decreased trust in the response efforts by the Red Cross.

## Protection and Inclusion

Mpox outbreak has contributed to several Protection, Gender and Inclusion risks that place affected people at risk of violence, discrimination and exclusion. Some of the gaps identified include.

- **Stigmatization of Affected Populations**: The mpox response has sometimes led to increased stigmatization of certain groups, particularly most at-risk populations. This stigmatization can discourage people from seeking care or reporting symptoms, further exacerbating the outbreak. Different considerations to keep in mind includes avoiding stigmatizing terminologies, acknowledging the risks of at high-risk population, using acceptable language, collaborating with media network to use positive wordings, collecting and sharing survivors' testimonials.

- **Care work**. Burden of care work is on women and girls in families/homes/communities including taking care of sick and they may not be represented in critical spaces where decisions on mpox are being made including in places where accurate information is being shared.

- **Limited Intersectional Analysis**: Many responses to the mpox outbreak have lacked an intersectional approach, failing to consider how overlapping identities (such as gender, race, sexuality, and socioeconomic status) can compound vulnerabilities. An intersectional analysis is essential to understanding and addressing the full range of PGI gaps.

- **Healthcare Access Disparities**: There have been significant disparities in access to mpox-related healthcare services, including testing, vaccination, and treatment. These disparities often affect marginalized groups, such as low-income populations, migrants, internally displaced persons (IDPs) and refugees.

- **Lack of Tailored Public Health Messaging**: Public health messaging about mpox has often not been inclusive or accessible to all groups. For example, information may not be available in all relevant languages or formats, leaving non-native speakers and people with disabilities at a disadvantage.

- **Insufficient Community Involvement**: Communities most affected by the mpox outbreak, particularly marginalized groups, have often been excluded from decision-making processes related to the response. Greater engagement of these communities, including engagement of high-risk communities is essential to ensuring that the response is equitable and effective.

- **Legal and Social Protection**: In many countries, there are insufficient legal and social protection for individuals affected by mpox, particularly those from marginalized groups. This can result in discrimination, harassment, and even violence against those perceived to be at higher risk of contracting the virus.

- **Ethnic and Racial Minorities**: Racial and ethnic minorities often face systemic barriers to healthcare, including access to testing, treatment, and vaccines. In many regions, these communities have been disproportionately affected by the mpox epidemic but have received inadequate attention in the response efforts.
- **Impact on Pregnant Women**: There has been limited research and guidance on the impact of mpox on pregnant women and the potential risks to their unborn children. This gap has resulted in a lack of tailored healthcare responses for this group
- **Data**: Need for disaggregation of data and analysis. At the same time, data protection systems must be looked at to avoid stigmatization.
- **Safeguarding:** Ensure volunteers and staff, as part of the community response, have effective duty of care mechanisms in place and safeguarding measures.

### Socio-Economic Protection

The mpox outbreak has had a significant impact on people's livelihoods in affected regions. Some keyways the outbreak has affected livelihoods include:

- The mpox outbreak may lead to economic disruption, with many businesses facing reduced demand and productivity due to factors like worker absenteeism. This will place millions of livelihoods at risk, especially for those working in the informal economy with limited social protections.
- Mpox has the potential to disrupt food systems, especially in areas where the disease is endemic. Illness, movement restrictions, and disruptions to trade and markets can reduce food availability and access for affected populations.
- Due to some country requirements of isolation in health facilities or at home, support should be considered to ensure livelihood security and/ or food/ nutrition needs are met during times of isolation, care and recovery.
- To maximise intervention efforts, the issue of stigma should be managed. Stigmatization can lead to job loss, social isolation, and barriers to accessing healthcare, social, livelihood and other services. Vulnerable groups, including sex workers and those involved in informal economies, may be less likely to seek care due to stigma or fear of discrimination, which can further exacerbate the outbreak.

## FEDERATION-WIDE APPROACH

The Emergency Appeal is part of a Federation-wide approach, based on the response priorities of the Operating National Society and in consultation with all Federation members contributing to the response. The approach, reflected in this Operational Strategy, will ensure linkages between all response activities (including bilateral activities and activities funded domestically) and will assist to leverage the capacities of all members of the IFRC network in the country, to maximize the collective humanitarian impact.

The Federation-wide funding requirement for this Emergency Appeal comprises all support and funding to be channelled to the impacted National Societies in the response. This includes the National Society's emergency response plan and budget, the fundraising ask of supporting Red Cross and Red Crescent National Societies, and the funding ask of the IFRC secretariat.

At country level, IFRC Delegations are supporting National Societies in the development of their respective country plans, in close consultation with members present in the country. At regional level, operational and technical coordination groups on Health, RCCE, and WASH are underway with the affected National Societies, promoting peer to peer exchange on best practice and evidence.

Since the launch of the Emergency Appeal, the IFRC is organizing regular Operational Membership Coordination meetings with the Participating National Societies active in the affected countries. The meetings serve as a platform to provide updates on the latest developments of the operation as well as to discuss the Federation-wide approach to the response.

As part of the effort to build on existing initiatives and capacity, the IFRC is also closely coordinating with the partners involved in ECHO PPP and USAID implementation to leverage on the epidemic preparedness and response work done under pillar II as well as to consider potential reallocations to the response.

# OPERATIONAL STRATEGY

## Vision

The regional mpox emergency appeal aims to support National Societies in preparing and responding to the mpox epidemic. The operation will focus on two areas: scaling up Health/WASH including RCCE and addressing socio-economic impacts. The operational strategy takes a regional approach to coordinate, manage and operationalize priorities and pillars of support to different National Societies in the region. Based on a risk based approach to the evolving outbreak, and health system capacity in each country, the ultimate goal is to contain the spread of the outbreak while supporting impacted communities to cope and recovery.

The operations are based on a foundation of National Societies preparing for and responding to epidemics in the affected countries. Existing health resilience and disaster risk reduction programmes, as part of the overall climate change adaptation work of the Red Cross and Red Crescent Societies is the foundation for this emergency response. Long term epidemic preparedness programmes supported by ECHO and USAID, will be scaled up during the emergency phase through this Emergency Appeal, and at the conclusion of the emergency phase, mpox recovery and transition activities will be linked back to community health resilience activities.

The regional response will prioritize efforts across three pillars: Preparedness, Readiness and Response:

**PREPAREDNESS**

- Strengthening efforts to prevent, mitigate, and reduce the spread of the virus by scaling-up through community-based advocacy and socialization efforts highlighting various hazards, risks, and vulnerabilities associated with the virus and its' mutations – distinguishable via varying clades. Through the added value of the Red Cross volunteers, Community Engagement and Accountability and Risk Communication and Community Engagement efforts are being scale-up, expanded, and exported to other national societies in a deliberate and intentional way to ensure standardization, and quality control across public health messaging. This is critical – given that misinformation and stigma contribute to mistrust and further marginalization of vulnerable communities and impacted people.

**READINESS**

- National Societies are receiving financial and health technical support to develop Mpox specific Country Response Plans. These are intended to ensure that National Societies have the requisite organizational capacities to respond, based on the mandate from the Ministry of Health, and anticipate potential scale-up activities if the virus continues to spread within their respective geographies.

**RESPONSE**

- National Societies with active cases, and community transition, are responding. IFRC is prioritizing support to specific countries based on exposure vulnerability, spread and risk of cases, National Society response priorities, ability to absorb and scale up implementation with technical support. The responses are in line with Ministry of Health and based on technical guidance from IFRC-World Health Organization-Africa CDC.

Based on the preparedness, readiness and response pillars, National Societies will be supported according to the stage of evolution of the outbreak in each country at any given time.

- **Stage 1 – Countries at heightened risk of case importation**

National Societies in countries under stage 1 will receive resources to develop initial response in coordination with national authorities and provide technical auxiliary support, to develop national mpox contingency plans. Update risk and scenario analysis to include mpox and monitor outbreak trends close to its borders. Define risk mitigation measures and accelerate internal readiness to respond.

- **Stage 2 – Countries with imported cases**

In addition to the activities in stage 1, National Societies in countries under stage 2 will receive support for targeted interventions aimed at isolating and supporting identified cases, identifying contacts, and increasing awareness and readiness in the directly affected area. Initiate staff care protocols for responders. Ensure working relationships with civil society organisations that support high-risk populations or can prepare volunteers to adequately reach these population cohorts.

- **Stage 3 – Established Mpox transmission**

Ensure key elements of stage 1 and 2 are in place. Scale interventions to reach vulnerable and at-risk populations across the affected area (or in geographic area assigned to the National Society as designated in national response plans). Roll-out contingency plans for scenarios of increased transmission, including response activation in the event of spread to new geographic areas. Ensure feedback and ongoing analysis systems are in place to adapt programming over time to changing community needs and epidemic dynamics.

# Targeting

## 1. People to be assisted

- **Most at risk population and Communities**: Based on evolving evidence, groups identified at greatest risk for transmission in particular contexts or clade outbreaks will be prioritized. Currently this includes considerations for children (particularly in outbreaks concerning clade 1a), and those within the 20–40-year age group category (primarily concerning clade 1b and clade 2).
- **Marginalized populations:** Including those who engage in sex work, sexual relations with multiple partners, men who have sex with men, are engaged in the informal economy and others – may be targeted due to misconceptions about the spread of the virus, or may not have access to care due to stigma and discrimination
- **People Living with HIV or are immunocompromised**: Who might face compounded stigma due to their health status and may be at potentially greater risk of contracting mpox.
- **Racial and Ethnic Minorities**: Who may be wrongly associated with the virus, particularly if the virus disproportionately affects specific communities.
- **Migrant Populations**: Or populations who live along transit routes in dense settlements. Migrants especially may face increased stigma due to their transient nature and lack of access to adequate healthcare. Those who live in transit settlements or those who frequent transit routes (i.e. import or truck drivers) may also be at increased risk with reduced access to care due to the transient nature of their work.

## 2. Considerations for protection, gender and inclusion and community engagement and accountability

Protection, gender and inclusion are particularly important cross-cutting concerns in the mpox response due to stigma, assumptions and misinformation regarding the disease. Community engagement and accountability will be mainstreamed throughout the response. Ensuring strong participation and information sharing with affected populations and all stakeholders will be at the core. A crucial focus is also the comprehensive sensitisation and policy dissemination among staff and volunteers of the IFRC and National Societies on PGI, along with

safeguarding practices and adherence to PSEA principles. This equips all concerned parties with the knowledge and skills needed to prevent exacerbating the existing vulnerabilities of affected populations and to avoid inflicting any additional harm.

# PLANNED OPERATIONS

## INTEGRATED ASSISTANCE

| **Socio-economic protection** | Female > 18: **TBD** | Female < 18: **TBD** | **1.2 million CHF** |
|---|---|---|---|
| | Male > 18: **TBD** | Male < 18: **TBD** | **Total target: 50,000** |
| **Objective:** | Enhance socio-economic protection by providing multipurpose cash assistance for immediate needs and supporting livelihood reintegration through skills enhancement for those affected by mpox. | | |
| **Priority Actions:** | • Support affected people and families through a safety net scheme - multipurpose cash (timely, predictable, and regular) to meet immediate needs and covering basic needs while recovering from mpox infections.<br>• Support affected people that have lost livelihoods due to mpox to reintegrate in the labour market of affected people, through skills enhancement and diversification. | | |

## HEALTH AND CARE INCLUDING WATER, SANITATION AND HYGIENE (WASH)

### (MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT / COMMUNITY HEALTH)

| **Health and Care** (*Mental Health and psychosocial support / Community Health / Medical Services)* | Female > 18: **TBD** | Female < 18: **TBD** | **17.8 million CHF** |
|---|---|---|---|
| | Male > 18: **TBD** | Male < 18: **TBD** | **Total target: 30 million** |
| **Objective:** | Strengthen health systems and provide health services through enhanced disease surveillance, community engagement, and continuity of care, ensuring timely detection, testing, and vaccination for at-risk populations. | | |
| **Priority Actions:** | **Disease Surveillance and Case Detection**<br>▪ Support national surveillance systems in the early detection and active finding of suspected cases based on signs and symptoms through community-based surveillance when appropriate, feeding into existing surveillance systems.<br>▪ Identify through national plans and guidelines the clinical care pathways and protocols for screening, triage, isolation, testing, and clinical assessment of suspected | | |

cases of persons with mpox and ensure clinical facilities and personnel are aware of them.

- Activate community-based surveillance for mpox and increase awareness and encourage the use of 'unusual events' or 'clusters of illness' reporting, where CBS is existing. Support contact tracing when appropriate.

**Community-based Health and Hygiene Promotion**

- Implement universal protocols for community-based health and hygiene promotion.
- Engage communities on mpox virus transmission, signs and symptoms, where to access care, and actions to reduce the risk of onward transmission to others (e.g. through ECV, CBHFA).
- Activate, supervise and manage community health volunteers to provide mpox support and coordinate efforts with other risk communication and community engagement approaches to ensure an intensified approach to local needs

**Mental Health and Psychosocial Support**

- Provide MPHSS for people with mpox and community in close contact with those identified as a confirmed case.
- Support people in isolation for the duration of the infectious period through ensuring safe and regular contact with loved ones and connection/referral to appropriate services for additional needs.

**Clinical Care and Infection Prevention and Control**

- Support individuals who have symptoms consistent with mpox to seek testing and care.
- Support Isolation, referral of suspected cases to Health Centres, and provide infection control protocols initiated in the community.

**Paramedical Care and Patient Transport**

- Identify referral pathways for people who require clinical support (e.g. sexual health clinics; health facilities that are welcoming to MSM and/or sex-workers, that is, facilities that provide a welcoming, inclusive and respectful environment for all patients) as relevant.
- Ensure infection control protocol during referral pathways are implemented during transportation.

**Health services for continuity of care in cases of isolation**

- Support individuals who have symptoms consistent with mpox to seek testing and care Isolation to be continued until infection period is over.
- Activate, supervise and manage community health volunteers to provide mpox support.

**Vaccination**

- Engage communities at high risk of exposure in the decision-making process regarding any vaccine roll out.
- Support vaccine roll out through community engagement and last mile activities.

**Management of the Dead**

- Support MOH to develop evidence-informed policies for management of the dead for mpox cases, including at community level.

| | **Risk Communication and Community Engagement**<br>▪ Rapid community assessments to understand knowledge, attitudes, practices, and perceptions to mpox and the overall response<br>▪ Regularly monitor community perceptions, knowledge levels, and behaviour changes related to mpox through surveys, focus group discussions, and interviews to adapt strategies as needed.<br>▪ Develop and disseminate clear, accurate, and culturally sensitive information about mpox, including its symptoms, transmission, prevention, and treatment through trusted platforms like community radio, social media, and face-to-face interactions. Materials should be tailored to local languages, beliefs, and customs. |
|---|---|

| **Water, Sanitation and Hygiene** | Female > 18: **TBD** | Female < 18: **TBD** | **1.7 million CHF** |
|---|---|---|---|
| | Male > 18: **TBD** | Male < 18: **TBD** | **Total target: 50,000** |
| **Objective:** | Improve WASH services in high-risk communities with a focus on providing of essential WASH services for management of at-home care and WASH support targeting health and mpox treatment facilities in affected areas. | | |
| **Priority Actions:** | **1.** Support communities and health centers with establishment, operation and maintenance of handwashing facilities.<br>**2.** Support communities and health centers with improving laundry facilities and actions to reduce the risk of infection.<br>**3.** Align ongoing hygiene promotion activities to address Mpox prevention.<br>**4.** WASH in health centres: Strengthening health and care workers' capacity and resources in infection prevention and control through the provision of training, materials, providing PPE, and handwashing facilities to facilitate handwashing on entry and exit. Toilets and high-touch surfaces should be regularly disinfected with chlorine solution. | | |

# PROTECTION AND PREVENTION

### (PROTECTION, GENDER, AND INCLUSION (PGI), COMMUNITY ENGAGEMENT AND ACCOUNTABILITY (CEA)

| **Community Engagement and Accountability** | Female > 18: **TBD** | Female < 18: **TBD** | **6 million CHF** |
|---|---|---|---|
| | Male > 18: **TBD** | Male < 18: **TBD** | **Total target: 30 million** |

| | |
|---|---|
| **Objective:** | Priority actions are in support of achieving health and care objectives and strategies listed above under RCCE and contribute to accountable integrated assistance.<br><br>Support people and communities to actively participate in the response by promoting safe, healthier practices, facilitating community action, and helping to reduce fear, stigma, and misinformation. |
| **Priority Actions:** | **1.** Engage local leaders, religious figures, and community influencers to gain their support and leverage their influence to encourage health-seeking behaviour and adherence to public health measures<br>**2.** Establish/strengthen Community Feedback Mechanisms for collecting, analysing, and responding to community insights, through regular volunteer's household visits, community meetings, hotlines, and digital platforms.<br>**3.** Establish or strengthen community structures to facilitate dialogue, co-design community-led solutions, ensure local voices are heard and considered in decision-making.<br>**4.** Support and train community volunteers with skills on how to engage effectively with communities, counteract misinformation, and support those affected with adopting preventative measures and lead local actions. |

| **Protection, Gender and Inclusion** | Female > 18: **TBD** | Female < 18: **TBD** | **421,000CHF** |
|---|---|---|---|
| | Male > 18: **TBD** | Male < 18: **TBD** | **Total target: 10 million** |
| **Objective:** | Organize gender and diversity analyses to inform response efforts, ensuring inclusive care and information access for at-risk populations, while strengthening protection, gender, and inclusion measures throughout all project phases. | | |
| **Priority Actions:** | **1.** Conduct gender and diversity analysis to understand the different gender norms and practices within communities that increase vulnerabilities and serve as barriers for most at-risk populations to seek care. The analysis to guide response efforts<br>**2.** Collect and analyse sex, age, and disability disaggregated data (SADDD) to understand how mpox affects different diverse groups to guide response efforts<br>**3.** In collaboration with Health/CEA provide clear, accurate, accessible and culturally sensitive information to the communities to help reduce misinformation, stigma and discrimination.<br>**4.** In collaboration with health and CEA, ensure women and girls including with disabilities and their organizations are included at all levels in preparedness and response including risk analysis and mitigation. This includes ensuring they access accurate information on mpox and safe referral pathways. | | |

5. Ensure that Child Safeguarding and PSEA mechanism are in place and staff and volunteers are sensitized and have signed the code of conduct.
6. Train staff and volunteers involved in the response on the minimum standards for PGI in emergencies including the DAPS principles.
7. Collaborate with other actors and actively participate in protection and GBV sector coordination meetings.
8. Develop standard operating procedures for handling sensitive feedback. In collaboration with Health and CEA teams
9. In collaboration with the health sectors, train health care providers to prevent biased care, ensuring all patients are treated with respect and without discrimination.

# Enabling approaches

| National Society Strengthening | Female > 18: **TBD** | Female < 18: **TBD** | **1.2 million CHF** |
|---|---|---|---|
| | Male > 18: **TBD** | Male < 18: **TBD** | **Total target:** |

**Objective:** National Societies respond effectively to the wide spectrum of evolving crises and their auxiliary role in responding to displacement and disasters are well-defined and prioritised

**Priority Actions:**

1. National Societies enhance their advocacy and their positioning in engaging with stakeholders and authorities for a sustained capacity to coordinate responses at all levels and to position the NS's auxiliary role and increase the humanitarian diplomacy efforts.
2. National Societies re-vitalize National Disaster Response Team and Branch Response Teams.
3. National Societies increase their operational capabilities in the domains of digital transformation and system strengthening, including the establishment of volunteer management systems – where missing – fleet, procurement and logistics management.
4. National Societies provide for duty of care for staff and volunteers (adequate trainings, personal protective equipment, psychosocial support, adequate insurance scheme for deployment) to respond to the specificities of the mpox outbreak while maintaining effective and efficient operational performance.
5. National Society premises that are directly involved in the response, especially health facilities, will be equipped with relevant materials according to the activities they perform and implement infection, prevention and control protocols.

| Coordination and Partnerships | Female > 18: **TBD** | Female < 18: **TBD** | **840,000 CHF** |
|---|---|---|---|
| | Male > 18: **TBD** | Male < 18: **TBD** | **Total target:** |

| | |
|---|---|
| **Objective:** | Technical and operational complementarity among IFRC membership and with the ICRC is enhanced through cooperation with external partners. |
| **Priority Actions:** | **1.** Establish health and multi-sectoral coordination mechanisms to facilitate effective preparedness and response to mpox, including with Ministry of Health and other relevant authorities, humanitarian partners and technical agencies. Ensure RCRC mandate is clear, and relationships are in place for rapid National Society action.<br>**2.** Reactivate and strengthen the RCRC epidemic network (formed during Ebola Virus Disease response) for joint risk analysis and epidemic monitoring, share technical and material resources, engage in advocacy and diplomacy activities with governments and agencies.<br>**3.** Maintain partners up to date about the epidemic, RCRC preparedness and response, in particular developments in difficult to reach communities where the RCRC volunteers are present. |

| **IFRC Secretariat Services** | Female > 18: **TBD** | Female < 18: **TBD** | **639,000 CHF** |
|---|---|---|---|
| | Male > 18: **TBD** | Male < 18: **TBD** | **Total target:** |

| | |
|---|---|
| **Objective:** | The IFRC is working as one organisation, delivering what it promises to National Societies and volunteers, and leveraging the strength of the communities for whom they work as effectively and efficiently as possible |
| **Priority Actions:** | **1.** Technical support: develop and or update relevant technical guidance and materials in the different sectors (Health, CEA, PGI, and others) and ensure proper dissemination among National Societies through different channels.<br>**2.** Coordinate risk management measures across National Societies and through operational coordination with members.<br>**3.** Set-up Federation-wide coordination, including a PMER framework and Information Management services for an efficient use of members resources and expertise, where all engaged and interested National Societies can know where needs and gaps exist.<br>**4.** Surge readiness and deployment: prepare for and deploy experts to support National Societies preparedness and response as required.<br>**5.** Actioning Business Continuity, including duty of care, predict and adapt to changing context, sustaining critical humanitarian operations, risk management and lessons learnt.<br>**6.** The IFRC security plans will apply to all IFRC staff throughout the operation. Area specific Security Risk Assessment will be conducted for any operational area should any IFRC personnel deploy there; risk mitigation measures will be identified and implemented. All IFRC must, and RC/RC staff and volunteers are encouraged, to complete the IFRC Stay Safe e-learning courses. |

| | |
|---|---|
| | **7.** Establish an efficient supply chain system for quality health assets, goods and services as required by National Societies and their governments, when and if the same cannot be efficiently procured in country with the same quality standards.<br>**8.** Humanitarian diplomacy, communication and advocacy: the secretariat, in consultation with its members, will develop advocacy and communication engagement strategies towards external partners and the diplomatic community that enable the work of RCRC Societies in preparing, preventing and responding to the mpox outbreak.<br>**9.** Ensure ongoing lessons are captured, organized and disseminated to National Societies, and periodically organize learning sessions and after-action reviews during different phases of the operation. |

## Risk management

| Risk | Likelihood | Impact | Mitigating actions | Risk level |
|---|---|---|---|---|
| Duty of care to staff and volunteers | High | High | ✓ Mental health and PSS support to staff/volunteers<br>✓ Pre-deployment briefing sessions<br>✓ Staff/volunteers workloads management mechanism including working hours management/staff rotations<br>✓ Deployment of staff/volunteers with relevant skills and expertise<br>✓ Provision of relevant and continuous trainings to staff and volunteers<br>✓ Provision of relevant working tools and equipment<br>✓ Insurance cover for staff/volunteers<br>✓ Volunteers' solidarity funding mechanism | Low |
| Misinformation, resistance to proposed response approaches | High | High | ✓ Application of targeted response strategies to help counter misinformation<br>✓ Transparent and clear communication channels<br>✓ Engagement of trusted community leaders and local communities<br>✓ Establishment of community feedback mechanism<br>✓ Analysis of community feedback, changes in behaviour/perception and continually adapting response strategies | Low |
| Business disruption risk | High | High | ✓ Enhanced documents/records/information management and handover processes<br>✓ Succession planning supported with targeted developmental plans<br>✓ Revision/updating of existing BCPs in line with country risk levels. | Low |

| | | | | |
|---|---|---|---|---|
| Safeguarding risk | High | High | ✓ Implement policies on safeguarding (child safeguarding and prevention and response to sexual exploitation and abuse (PSEA)) including mandatory awareness-raising and training for all staff and volunteers.<br>✓ Sign off on code of conduct and PSEA guidelines by all staff and volunteers as compulsory and priority and that no one should be involved in the operations if they have not been briefed and signed code of conduct<br>✓ Conduct safeguarding self-assessment and implementation of prioritized interventions to address gaps identified.<br>✓ Ensure a working and disseminated safe referral and reporting mechanism- both internally and externally at community level.<br>✓ Establish accountability mechanism at community level and ensuring communities are aware of their rights and obligations on matters safeguarding.<br>✓ Ensure NS have updated child safeguarding risk analysis with action plans to address risks and concerns | Medium |
| Supply chain disruptions and delays in the procurement processes | High | High | ✓ Collaboration with supply chain networks and adapt context.<br>✓ Activate interoperability relationships and networks to optimize and access of existing supplies and resources. | Medium |
| Human resources capacity constraints | High | High | ✓ Carrying out human resources mapping, identification of skills gaps to allow for targeted learning and development programs<br>✓ Business continuity planning and support<br>✓ Support on business continuity planning to guide on aspects such as succession planning on critical positions | Medium |
| Misuse of funding/ fraud/corruption/ integrity issues | High | High | ✓ Implementation of effective oversight mechanism i.e., audit, risk and investigation<br>✓ Trainings and sign offs on fraud and corruption, code of conduct etc<br>✓ Implementation of whistleblower guidelines to report on fraud<br>✓ Investment in financial management capacity building at different levels – IFRC, NS.<br>✓ Budgeting for and implementing financial management systems/automated processes.<br>✓ Spot checks and program monitoring. | High |

| | | | | |
|---|---|---|---|---|
| | | | ✓ Mandatory trainings on fraud and corruption.<br>✓ Resourcing the response with qualified dedicated key personnels. | |
| Delivery risk (quality and timelines) | High | High | ✓ Independent monitoring missions<br>✓ Community feedback and surveys<br>✓ Continuous review, monitoring and re-alignment of the response activities to cater for delays.<br>✓ Oversight and monitoring of performance against work-plan, log frame and budget.<br>✓ Enhanced co-ordination platforms at country, delegation and regional level.<br>✓ Carrying out joint monitoring sessions at country level<br>✓ Establish a joint monitoring and reporting framework. | Medium |

# Quality and accountability

The Appeal is an opportunity to reaffirm the need for a collective picture of the Federation and its membership's contributions in response to the acute crisis and the need to regularly have coherent, consistent, and quality data on agreed indicators.

The IFRC will establish a Federation-wide reporting system to provide information on progress and accountability. The Federation-wide indicator tracking tool will capture contributions across the membership. With support from IM and PMER this information will be displayed in a Federation-wide dashboard to be hosted on the Go platform. The country-teams will lead quarterly reviews of operations for participating countries to discuss implementation, challenges and successes, and ensure that the necessary steps are taken for effective implementation. In addition to the minimum requirement for operational updates, the PMER team will support quarterly updates for this operation. PMER, the Operations team, and other technical teams will collaborate to hire a consultant for a final external evaluation in accordance with the IFRC evaluation framework.

Working alongside National Societies, the IFRC will conduct continuous monitoring at the country level, including a regular update on the operational risk register, ensuring timely adaptation of the operation, and regular reporting on progress in the implementation of the activities. A final evaluation will be conducted at the end of the appeal.

| Sector/Area | Indicators |
|---|---|
| **Socio-economic protection** | # of households that successfully receive multipurpose cash<br>% of households receiving multipurpose cash who were satisfied with the amount received<br># of people reached with livelihoods support |
| **Health and Care** | # of NS supporting CBS or contact tracing for early detection and action<br># of CBS alerts related to mpox escalated to health authorities<br># of RCRC volunteers trained and active in community epidemic preparedness activities (including sensitization, screening, RCCE and referral for treatment)<br># people reached by NS community health promotion<br># of people reached with psychosocial and mental health services |
| **WASH** | # of households reached with handwashing facilities |
| **PGI** | # of volunteers trained on implementing the PGI Minimum Standards, PSEA, and SGBV<br># of staff and volunteers briefed and have signed Code of Conduct<br># of assessments including gender and diversity analysis<br>SOPs on handling sensitive feedback in place |

| | |
|---|---|
| **CEA** | # of volunteers trained on implementing the CEA Minimum Standards, CVA, Health, and WASH<br># of meetings conducted to communicate with communities what is happening in the operation including the selection criteria<br>A functioning feedback mechanism is in place for the operation / programme / whole organisation<br>% of complaints and feedback received and responded to |
| **Enabling Approaches** | **Indicators** |
| **Coordination and Partnerships** | # of response coordination sessions conducted among Movement Partners |
| **National Society Development** | # of insured volunteers |
| **IFRC Secretariat Services** | # of surge personnel involved in supporting the operation<br># of operations coordination, implementation, and reporting sessions conducted |

# FUNDING REQUIREMENT

## Federation-wide funding requirement*

| **Federation Wide Funding Requirement including the National Society domestic target, IFRC Secretariat and the Partner National Society funding requirement** | **IFRC Secretarian Funding Requirement in support of the Federation Wide funding ask** |
|---|---|
| **40 million CHF** | **30 million CHF** |

**For more information on Federation-Wide funding requirement, refer to section: Federation-wide Approach*

## Breakdown of the IFRC secretariat funding requirement

# OPERATING STRATEGY

**MDRS1003 - Africa – Mpox epidemic**

FUNDING REQUIREMENTS

| Planned Operations | 27,265,000 |
|---|---|
| Shelter and Basic Household Items | 0 |
| Livelihoods | 213,000 |
| Multi-purpose Cash | 1,065,000 |
| Health | 17,871,000 |
| Water, Sanitation & Hygiene | 1,704,000 |
| Protection, Gender and Inclusion | 421,000 |
| Community Engagement and Accountability | 5,991,000 |
| Migration | 0 |
| Risk Reduction, Climate Adaptation and Recovery | 0 |
| Environmental Sustainability | 0 |
| **Enabling Approaches** | **2,735,000** |
| Coordination and Partnerships | 840,000 |
| Secretariat Services | 639,000 |
| National Society Strengthening | 1,256,000 |
| **TOTAL FUNDING REQUIREMENTS** | **30,000,000** |

*all amounts in Swiss Francs (CHF)*

# Contact information

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

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Click here for:

- Emergency Appeal