DREF Operation

Mpox epidemic emergency response

Sanitary barrier in Amboasary Sud – Sampona, supported by the CRM. Source: CRM

Appeal: **MDRMG026**	Hazard: **Epidemic**	Country: **Madagascar**	Type of DREF: **Response**
Crisis Category: Yellow	Event Onset: **Sudden**	DREF Allocation: **CHF 394,995**	
Glide Number: **-**	People Affected: **228 people**	People Targeted: **50,000 people**	
Operation Start Date: **20-01-2026**	Operation Timeframe: **4 months**	Operation End Date: **31-05-2026**	DREF Published: **27-01-2026**

Targeted Regions:
Analamanga, Betsiboka, Boeny, Diana, Haute Matsiatra, Alaotra-Mangoro, Melaky, Sofia, Vakinankaratra, Vatovavy-Fitovinany

Description of the Event

Date of event

24-12-2025

Sanitary barrier in Amboasary Sud – Sampona, supported by the CRM. Source: CRM

What happened, where and when?

Madagascar is experiencing its first documented Mpox epidemic (clade 1b), which began in epidemiological week 51 of 2025 (end-December 2025) and continues as an active outbreak. As of the latest situation report dated 12 January 2026, the country has recorded 228 total cases (24 confirmed by laboratory testing and 204 suspected cases) with zero deaths reported among both confirmed and suspected cases, indicating a case fatality rate of 0% to date. The outbreak originated and remains heavily concentrated in Boeny region, specifically Mahajanga I district, which accounts for 150 of the 228 cases (66% of national burden) with 17 of the 24 laboratory-confirmed cases. Geographic expansion has occurred progressively since the initial detection, with cases now reported across 16 of Madagascar's 23 regions including the capital region Analamanga (16 cases, 2 confirmed), Vakinankaratra (19 cases, 4 confirmed), Betsiboka (6 cases, 1 confirmed), Diana (7 cases), and Haute Matsiatra (10 cases). The epidemic shows evidence of sustained community transmission with a laboratory positivity rate of 34.8% (24 positive results from 69 completed tests out of 106 specimens collected), and a peak occurred on 31 December 2025 with 23 cases reported in a single day. The outbreak timeline shows rapid escalation from 34 cases on 5 January 2026 to 92 cases on 8 January 2026, and subsequently to 228 cases by 12 January 2026, representing a seven-fold increase within one week. On 12 January 2026 alone, 21 new suspected cases were notified (8 in Mahajanga I, 5 in Antananarivo Renivohitra, 4 in Fianarantsoa, 2 in Atsimondrano, 1 each in Ambalavao and Soalala) with 19 specimens collected for testing, demonstrating ongoing active transmission and geographic spread toward high-population urban centers including the capital Antananarivo.
The epidemic has triggered activation of Madagascar's National Emergency Operations Center (COUSP) on 9 January 2026, deployment of treatment and isolation centers across affected regions, establishment of contact tracing systems, and implementation of enhanced surveillance including a green line (910) that has received 273 calls with 9 suspected cases identified through this community reporting mechanism, demonstrating both the severity of the outbreak.

Coordination meeting with health authorities in Mahajanga

Handwashing devices provision to health centers and schools - Mahajanga

Handwashing devices provision to health centers and schools - Mahajanga

Door-to-door awareness campaign in Mahajanga

Scope and Scale

The Mpox epidemic in Madagascar represents an unprecedented public health emergency with substantial negative impacts on lives, livelihoods, well-being, and health infrastructure. According to the Madagascar Ministry of Health Situation Report dated 12 January 2026, the outbreak has affected 228 individuals across 16 of Madagascar's 23 regions, with the epicenter in Boeny region (Mahajanga) accounting for 150 cases (66% of national burden). The epidemic's rapid escalation from 34 cases on 5 January to 228 cases by 12 January demonstrates explosive growth potential. While the zero mortality rate indicates favorable clinical outcomes to date, negative impacts include: (1) disruption of livelihoods for 170 identified contacts under 21-day monitoring; (2) overwhelming of health infrastructure with 25 patients hospitalized in Mahajanga I requiring specialized isolation facilities; (3) psychological and social impacts from stigmatization; (4) economic disruption to the critical Mahajanga-Antananarivo transport corridor; and (5) diversion of limited health resources from routine services including ongoing measles epidemic response.

Populations most likely to experience negative impacts are geographically concentrated and defined by specific vulnerability factors. Residents of Mahajanga I district face highest exposure risk, with 8 new cases reported on 12 January alone. The epidemic's expansion along major transport corridors places mobile populations at elevated risk including traders, transport workers, and maritime crews. Urban populations in high-density areas of Antananarivo face critical vulnerability with 16 notified cases including 5 new cases on 12 January, threatening rapid amplification in densely populated informal neighborhoods. Based on the risk analysis conducted by the Ministry of Health and reflected in the National Response Plan, the Analamanga region is assessed as the highest-risk area (risk score: 10/10), due to its high population density and its role as the country’s primary transport and mobility hub.

Specific vulnerable groups disproportionately affected include children and adolescents (median age 23-23.5 years with cases as young as 3 months, including 2 pediatric cases hospitalized in Mahajanga per SitRep 12 January 2026). Pregnant women face severe vulnerability with at least one confirmed case at 31 weeks gestation hospitalized at CHU Androva. Healthcare workers constitute a high-risk group with 90 healthcare personnel and 30 paramedics requiring intensive training. According to the National Vaccination Strategy documented in the Government National Response Plan (ACTIVITES_PRIORITAIRES, January 2026), immunocompromised individuals including persons living with HIV are prioritized among 208,211 vulnerable persons targeted for vaccination. Socioeconomically marginalized populations including residents of informal settlements lack resources for sustained isolation and face healthcare access barriers. Stigmatized groups including men who have sex with men, transgender persons, and sex workers identified as priority vaccination targets, face dual vulnerabilities of elevated exposure risk and barriers to care-seeking due to discrimination.

Madagascar has no historical experience with Mpox epidemics, as this represents the first documented outbreak in the country's history. However, Madagascar's recent epidemic history provides relevant context. The ongoing concurrent measles epidemic complicates differential diagnosis and strains health resources. The COVID-19 pandemic (2020-2023) demonstrated Madagascar's health system

vulnerabilities including limited laboratory capacity: currently only two laboratories (LA2M and IPM) capable of Mpox testing with 39 of 106 specimens still pending results (SitRep 12 January 2026); and PPE procurement challenges. Cyclical cholera outbreaks have established community familiarity with isolation protocols but also revealed persistent infrastructure deficits. The 2017 plague epidemic demonstrated Madagascar's vulnerability to rapid disease spread along transport corridors with similar geographic patterns emerging in the current Mpox outbreak.

Source Name	Source Link
1. Situation Report_04.01.2026	https://ifrcorg.sharepoint.com/:b:/s/IOIClusterDelegation-Files/IQDXYNl11jXnSreCbeMzPPG_Aerx0FapQgWyKtJMpq2Mv1I?e=BcW3ZQ
2. Situation Report_12.01.2026	https://ifrcorg.sharepoint.com/:p:/s/IOIClusterDelegation-Files/IQCMZdJqVfOuSK3Jk8iZH9SPAaxLes7fULyhyUUsRwnhf68?e=9dTJds
3. Situation Report_05.01.2026	https://ifrcorg.sharepoint.com/:b:/s/IOIClusterDelegation-Files/IQCGA7xhFAfRTKJSxbVnNqLYARnCt5zMSsei_FdLCFA4oyU?e=9mUbfa
4. Plan de Riposte contre la Mpox	https://ifrcorg.sharepoint.com/:w:/s/IOIClusterDelegation-Files/IQCKAOt6w3rtQbroeXdD0FYgAWEPC6ruAhyOneVFhWb98Io?e=R6aIWv

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	No
Did it affect the same population group?	-
Did the National Society respond?	-
Did the National Society request funding form DREF for that event(s)	-
If yes, please specify which operation	-

If you have answered yes to all questions above, justify why the use of DREF for a recurrent event, or how this event should not be considered recurrent:

-

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	Yes
What was the risk level for Child Safeguarding Risk Analysis?:	The current Mpox response presents moderate child safeguarding risks given the operational context. The response (will) involve(s) the deployment 180+ volunteers conducting the planned activities, and direct engagement with families in isolation where children may be present. Additionally, the students who have been directly affected (2), and children in outbreak-affected households may face potential stigma and discrimination. Vulnerable child populations include students, children of health workers, and those living in high-density urban areas targeted for interventions. Given these factors, particularly the scale of community-level volunteer deployment

	with direct child contact through home visits and school-based activities, a specific Child Safeguarding Risk Analysis will be completed using IFRC standard tools, accompanied by comprehensive volunteer vetting, child safeguarding training, clear codes of conduct for household interactions, and robust reporting mechanisms for any safeguarding concerns identified during field operations.

Current National Society Actions

Start date of National Society actions

30-12-2025

Health	To enable early detection and timely reporting of Mpox suspect cases, the NS has mobilised volunteers to support and strengthen the community-based surveillance, complemented by volunteer-supported referral pathways to designated health facilities. Support to health screening at strategic Points of Entry has been provided to reinforce preventive measures, as well as volunteer engagement in sanitary control measures and community-level cordons sanitaires in high-risk locations. RCCE activities aiming to strengthen community awareness (through door-to-door sensitization), trust, and acceptance of public health measures are ongoing through the dissemination of harmonized risk communication messages on Mpox transmission, prevention, and referral pathways.
Water, Sanitation And Hygiene	In support of other response actors, the Malagasy Red Cross deployed volunteers in the Mahajanga district to distribute handwashing facilities and conduct hand hygiene demonstration sessions.
Community Engagement And Accountability	CEA activities ensure the integration of community feedback mechanisms to address rumours, stigma, and misinformation, and to adapt response activities in real time, ensuring accountability to affected populations.
Coordination	The NS actively supports national Mpox preparedness and response through its engagement in the development, presentation, and validation of the National Mpox Response Plan with the Ministry of Health (MoH). It participates on a regular basis in emergency coordination mechanisms alongside the MoH, the National Disaster Management Office (BNGRC), and humanitarian partners, and ensures operational coordination of response activities at regional level in Boeny (Mahajanga). The NS is an active member of the National Emergency Operations Centre (COUSP), relevant technical working groups, and the Health and WASH Clusters, contributing to a coordinated, multisectoral, and complementarity-driven response.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC, through its Indian Ocean Countries Cluster Delegation, is coordinating action among various Movement partners (PIROI, French RC, German RC and Luxemburg RC) to ensure the availability of necessary technical, logistical, and financial support to the National Society for implementing planned activities. Formalized coordination mechanisms, including regular weekly meetings, are fully operational to ensure structured information sharing, joint monitoring of response actions, and effective complementarity among all partners. The IFRC Regional Health Department is fully mobilized to provide continuous technical

	and strategic support, including guidance, harmonization, and quality assurance of both ongoing and planned response activities.
Participating National Societies	PIROI supports the IFRC in coordination efforts and resource mobilization for the National Society. It has mobilized funds (approximately 100,000 euros) from the Crisis and Support Centre of the French Ministry for Europe and Foreign Affairs (CDCS) to support a two-month response intervention in four priority regions. The intervention prioritizes technical capacity strengthening and the provision of specialized equipment, notably the procurement of PPE, as well as the potential deployment of additional technical personnel and the strengthening of the CRM's community-based surveillance system (NYSS deployment). The DREF operation is designed to strategically complement this funding, establishing an integrated response framework that leverages technical and logistic assets to maximize impact while strictly avoiding operational duplication. German Red Cross does not have specific Mpox response activities underway at this time but remains engaged with the in-country coordination mechanisms and could potentially contribute to response efforts as the situation evolves. Luxembourg Red Cross currently has no ongoing support activities related to Mpox but has indicated its willingness to mobilize resources should funding gaps emerge during the response.

ICRC Actions Related To The Current Event

No ICRC presence in Madagascar.

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	The Government of Madagascar, through the Ministry of Public Health, responded rapidly to the outbreak with comprehensive multisectoral interventions. Following laboratory confirmation of five cases on 31 December 2025, Government spokesperson announced activation of a response plan including updates to the National Contingency Plan and mobilization of a coordination and surveillance team, with an emergency Public Health Emergency Operations Center established in Mahajanga to isolate cases, provide treatment, and strengthen health checks at ports and airports. The government established a national response plan covering eight strategic pillars and formally launched the Central COUSP (Emergency Operations Center) on 9 January 2026, with regional COUSP activated in five priority regions: Boeny, Betsiboka, Atsinanana, Menabe, and Vakinankaratra. The Bureau National de Gestion des Risques et des Catastrophes (BNGRC) coordinates the multisectoral response across government ministries and technical partners. Operational documents finalized include the Mpox Contingency Plan (30 December 2025), clinical protocols, and Standard Operating Procedures for infection prevention and control. Immediate response measures included establishing treatment centers with 25 patients currently hospitalized in Mahajanga, contact tracing for 170 contacts across four regions, installing 46 handwashing facilities (28 in schools, 12 at sanitary cordons, 6 at institutions), and deploying sanitary cordons at strategic entry points including Ivato International Airport where 1,110 passengers have been screened (SitRep 12 January 2026; WASH Cluster Report January 2026). The Ministry of Higher Education mandated mask-wearing in all universities and higher education establishments on 4 January 2026. A national hotline (910) was operationalized receiving 273 calls with 9 suspected cases identified, and healthcare worker training intensified with 90 personnel trained on 12 January with plans to train 252 additional workers.

UN or other actors	WHO is providing technical guidance and epidemiological surveillance protocols to the MoH. UNICEF is supporting RCCE activities and capacity strengthening for community health workers. Handwashing facilities distributed by the Malagasy Red Cross in Mahajanga are supplied by UNICEF under an ongoing bilateral partnership with the NS.

Are there major coordination mechanism in place?

1. National Level Coordination

Central COUSP (Emergency Operations Center)
- Lead: Ministry of Public Health, launched 9 January 2026
- Structure: 8 cells (Coordination, Surveillance, Laboratory, Case Management, IPC-WASH, Logistics, Vaccination, RCCE, Research)
- CRM Position: Recognized key partner participating in Surveillance, RCCE, and WASH cells. No formal co-lead role but functions as primary community implementation partner through auxiliary status

BNGRC (National Disaster Management)
- Lead: Multisectoral coordination across government ministries
- CRM Position: Partner through auxiliary status

Health/WASH Cluster
- Co-Leads: WHO and Ministry of Public Health (assumed standard cluster approach)
- CRM Position: Active WASH Cluster participant, contributed to handwashing facility installations

2. Regional Level Coordination

Regional COUSP
- Activated: 5 regions (Boeny, Betsiboka, Atsinanana, Menabe, Vakinankaratra)
- Lead: Regional Health Directorates (DRSP)
- CRM Position: Active participant, particularly strong in Boeny epicenter with volunteer deployment

3. District/Community Level

District Health Services (SDSP)
- Lead: District health offices under DRSP
- CRM Position: District branch coordination with SDSP, no formal co-lead role
- CRM Position: volunteers deployed for CBS, RCCE, PSS activities

4. Sub-Regional Coordination

IFRC IOI Cluster Bureau
- Role: Regional NS coordination (Madagascar, Comoros, Seychelles, Mauritius)
- Mechanism: Weekly coordination calls, cross-border information sharing

5. Key Gaps
- Missing Sectors: No activated Protection Cluster (child safeguarding, GBV), Education Cluster, Mental Health coordination platform, Nutrition integration, or Food Security/Livelihoods support despite 170+ contacts unable to work
- Weak Coordination: District-level mechanisms poorly formalized; One Health platform (human-animal-environment) not structured despite unknown reservoir status.

Needs (Gaps) Identified

Health

The rapid escalation of the epidemic is exceeding existing health system capacities for surveillance, diagnostics, and clinical care, with a high laboratory positivity rate (44.4%) in Madagascar and significant testing backlogs indicating undetected community transmission. Surveillance and referral systems remain weak among highly mobile populations and at informal maritime entry points, while laboratory capacity beyond reference institutions is insufficient to ensure timely testing and epidemiological analysis. Isolation and treatment facilities face capacity and quality constraints, healthcare workers lack adequate IPC training and PPE.

Water, Sanitation And Hygiene

Significant WASH infrastructure and supply gaps undermine infection prevention and control across health facilities, isolation centers, communities, and key transmission points. Existing handwashing facilities are insufficient relative to the outbreak's geographic spread, while shortages of essential WASH supplies and the absence of Mpox-specific IPC-WASH SOPs limit effective implementation. Weak medical waste management, inadequate environmental disinfection of transport and public spaces, and limited household-level WASH support, compounded by high population mobility, continue to heighten transmission risks.

Protection, Gender And Inclusion

The outbreak presents significant protection risks, with stigma and discrimination undermining healthcare-seeking behaviour, delaying diagnosis, and exposing affected individuals and families to social exclusion and violence. Vulnerable groups face disproportionate risks, including pregnant women, people living with HIV and other immunocompromised individuals, children, women affected by gender-based inequalities, and highly mobile populations with limited access to services. Addressing these needs requires inclusive, non-judgemental risk communication delivered through trusted community actors to reduce stigma, promote early care-seeking, and ensure equitable access to prevention and treatment services.

Community Engagement And Accountability

Current risk communication and community engagement efforts are insufficient to match the scale, geographic spread, and mobility-driven transmission dynamics of the outbreak. Limited reach, lack of targeted messaging, weak engagement of trusted community actors, and absence of systematic feedback mechanisms allow misinformation, stigma, and delayed care-seeking to persist. Gaps in accountability, cross-border communication, and engagement of mobile populations, traditional leaders, and the private sector undermine community trust, ownership, and adherence to public health measures.

Any identified gaps/limitations in the assessment

The scale of negative impacts extends beyond direct health outcomes. According to the SitRep 12 January 2026, the 910 hotline received 273 calls (with 9 suspected cases identified), indicating high community anxiety. Health infrastructure strain is evidenced by laboratory systems overwhelmed with only 69 of 106 specimens tested, PPE shortages, and operational budget gaps including restauration costs for patients and healthcare workers cited as major challenges for the Government. The compounding effect of concurrent health emergencies creates a syndemic situation amplifying negative impacts on the most vulnerable populations in a country where 75% of the population lives below the poverty line with limited resilience to absorb epidemic-related shocks.

Operational Strategy

Overall objective of the operation

The operation aims to halt the rapid transmission of Madagascar’s first Mpox epidemic in order to reduce morbidity and prevent further community spread among 50,000 people across 10 priority regions affected by the outbreak, by strengthening active case finding, hygiene promotion, and psychosocial support through the mobilization of 310 trained volunteers, while ensuring safe, dignified, and stigma-free access to essential health services over a four-month operational period.

Operation strategy rationale

The CRM strategy addresses Madagascar's first Mpox epidemic, escalating from 34 to 228 cases within one week (5-12 January 2026) with 34.8% laboratory positivity confirming sustained community transmission. The operation prioritizes community-level early detection and response where the NS has demonstrated comparative advantage, complementing the Government's clinical and health systems response.

Urgent needs addressed:
The operation targets three critical gaps: (1) delayed case detection (current median time symptom-to-isolation exceeds safe thresholds), (2) stigma-driven care avoidance undermining outbreak control, and (3) inadequate infection prevention in households and communities where 90% of transmission occurs outside health facilities.

Strategic priorities rationale:
Five priorities align with WHO and IFRC technical guidance and national response architecture:
1- Deploys trained volunteers for early detection where formal surveillance is weakest: mobile populations, informal settlements, and remote areas.
2- Risk communication counters stigma and misinformation evidenced by 273 hotline calls (70% requiring verification).
3- Psychosocial Support addresses mental health impacts on 170+ monitored contacts, isolated patients, and frontline volunteers.
4- WASH interventions break household transmission chains in high-density urban areas.
5- Health system support strengthens treatment centers managing hospitalized patients.

Methods justification:

The Malagasy Red Cross (MRC) leverages its network of trained local volunteers to ensure trusted, culturally appropriate last-mile delivery, an approach proven effective during Madagascar's 2017 plague and 2020 COVID-19 responses. Digital reporting tools enable real-time data sharing with the national Public Health Emergency Operations Centre (COUSP), strengthening surveillance and operational decision-making, while anti-stigma messaging delivered through fokontany structures and trusted traditional leaders effectively addresses social barriers that limit care-seeking. Accountability to affected populations is ensured through systematic feedback and complaints mechanisms, with information analysed and used to adapt programming, improve response quality, and strengthen community trust and participation.
The operation will integrate a Protection, Gender and Inclusion (PGI) approach to ensure that response actions actively identify and reduce discrimination and address the gender and age specific impacts of the epidemic. The strategy will support community based child protection awareness, promote safe and dignified access to services, and establish clear referral pathways for protection concerns. Safeguarding principles will be applied throughout the operation to prevent and mitigate risks of sexual exploitation, abuse and harassment, and to ensure safe engagement with affected communities.

Key contextual factors:
Strategy accounts for: (1) concurrent measles epidemic straining health resources, (2) limited laboratory capacity (37 of 106 specimens pending), (3) 75% poverty rate limiting household isolation capacity, (4) epicenter in Mahajanga-Antananarivo transport corridor requiring mobile population targeting, (5) zero historical Mpox experience requiring intensive community education.

Exit strategy
The National Society will ensure early and continuous engagement of affected communities throughout the operation to foster ownership and facilitate a smooth transition beyond the implementation phase. Strong integration with government health structures will be maintained to ensure alignment with national epidemic response strategies and continuity of services. As local volunteers are embedded within the communities they serve, the skills, knowledge, and experience gained through the operation will remain at community level, contributing to sustained resilience and long-term added value.

Targeting Strategy

Who will be targeted through this operation?

Target Population: 50,000 people across 10 priority regions
Geographic targeting logic:
The operation targets 10 regions based on official Government risk scores (0-10) using access risk, mobility, population size, and COUSP capacity criteria: Analamanga (10/10 - capital, 2M+ population), Atsinanana (9/10), Diana (9/10), Boeny (7/10 - epicenter with 150/228 cases), Analanjirofo (8/10), Atsimo Andrefana (8/10), SAVA (8/10), Anosy (7/10), Vakinankaratra (6/10 - 19 cases, 59 contacts), and Bongolava (4/10) (Madagascar National Response Plan, January 2026; SitRep 12 January 2026).
Population groups targeted:
1. Mobile Populations (transport workers, traders, maritime crews)
Why: Frequent movement between Mahajanga epicenter and Antananarivo creates transmission vectors along primary commercial corridor
How: active case finding at transport hubs, RCCE at departure/arrival points, handwashing facilities at 12 sanitary cordons
2. Urban high-density communities (informal settlements)
Why: Overcrowding, shared sanitation in Antananarivo/Mahajanga facilitates rapid transmission; Analamanga 10/10 risk score
How: Door-to-door sensitization, 28 school handwashing stations, 2,000 household hygiene kits
3. Community healthcare workers & volunteers
Why: exposure risk to affected people
How: WASH training, PPE provision, psychosocial support, priority vaccination (27,067 national target)
4. Children and adolescents
Why: Median age 23 years, cases as young as 3 months, 2 pediatric cases hospitalized, 2 students at Ambondrona campus
How: School handwashing stations, age-appropriate RCCE, child safeguarding protocols, family-based PSS
5. Pregnant women
Why: 1 confirmed case at 31 weeks gestation demonstrates severe outcome risk
How: Priority surveillance/referral, specialized PSS, maternal health service coordination
6. Immunocompromised (PLHIV, malnourished)
Why: 208,211 vulnerable persons prioritized for vaccination; 47% child malnutrition compounds risk (especially in the Grand South of the country)
How: Integration with HIV/nutrition services, priority PSS, community education on vulnerability
7. Monitored contacts
Why: Under 21-day surveillance (Boeny: 103, Vakinankaratra: 59, Analamanga: 4, Betsiboka: 4) requiring isolation support
How: Daily contact tracing by volunteers seconded to MoH teams, household disinfection, hygiene kits, stigma reduction
8. Marginalized groups (MSM, transgender, sex workers)
Why: Among 208,211 vaccination priorities; face care-seeking barriers due to discrimination
How: Confidential RCCE, peer educators, anti-stigma campaigns, safe reporting mechanisms

Vulnerable group approaches:

- Mobile: Transport association engagement, corridor surveillance, portable RCCE materials, hotline 910 access.
- People with disabilities: Multi-modal communication, home-based CBS, accessible infrastructure
- Elderly: Intergenerational family-based messaging, priority PSS for isolated individuals
- Economically marginalized: hygiene kit distribution

Explain the selection criteria for the targeted population

Selection framework:
Target populations were selected using three evidence-based criteria: (1) epidemiological risk based on confirmed case distribution and contact tracing data, (2) vulnerability to severe outcomes or barriers to care, and (3) transmission potential to amplify outbreak spread.

Epidemiological risk criteria:
Geographic concentration: Regions with confirmed cases (Boeny: 150/228 cases, Analamanga: 16 cases, Vakinankaratra: 19 cases) and high-risk scores (10/10 to 4/10) prioritized based on Government risk matrix
Contact exposure: 170 individuals under active monitoring across 4 regions receive priority interventions
Transmission corridors: Mobile populations on Mahajanga-Antananarivo transport route selected due to movement between epicenter and capital

Vulnerability Criteria:
Age-based vulnerability: Children (median case age 23 years, youngest 3 months, 2 pediatric hospitalizations) and elderly (cases up to 79 years) selected for severe outcome risk
Immunocompromised status: PLHIV and malnourished individuals (47% child malnutrition nationally) prioritized per 208,211 national vaccination target for vulnerable groups
Pregnant women: Selected due to 1 confirmed case at 31 weeks gestation demonstrating maternal-fetal risk
Marginalized populations: MSM, transgender persons, sex workers selected as they face dual vulnerability - elevated exposure risk plus care - seeking barriers from stigma/discrimination
Socioeconomic vulnerability: Urban informal settlement residents selected due to overcrowding, inadequate WASH, inability to sustain isolation (75% national poverty rate)

Transmission amplification criteria:
Healthcare workers: Selected due to nosocomial transmission potential and need to protect health system functionality
Students/congregate settings: 2 hospitalized at Ambondrona campus demonstrates dormitory transmission risk
Urban high-density areas: Analamanga (10/10 risk score) selected for catastrophic amplification potential in 2M+ population

Vulnerable group rationale:
Vulnerable groups receive priority within each geographic zone because they experience: (1) higher likelihood of severe disease/death (children, pregnant women, immunocompromised, elderly), (2) systematic barriers to accessing care (marginalized groups facing stigma, economically marginalized lacking resources for isolation/transport), (3) compounding vulnerabilities (malnourished children, PLHIV), and (4) potential for onward transmission to others (healthcare workers, mobile populations, contacts under monitoring). Selection ensures equity by addressing both medical vulnerability and social determinants preventing outbreak control.

Total Targeted Population

Women	**20,085**	Rural	**35%**
Girls (under 18)	**5,665**	Urban	**65%**
Men	**19,400**	People with disabilities (estimated)	**5%**
Boys (under 18)	**4,850**		
Total targeted population	50,000		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**
Does your National Society have child protection/child safeguarding policy?	**Yes**
Does your National Society have whistleblower protection policy?	**No**
Does your National Society have anti-sexual harassment policy?	**Yes**

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
Risk of non-compliance with IFRC financial management and procurement procedures, including unauthorized budget reallocations and procurement exceeding approved plans, as previously observed during operations. This risk is compounded by weak procurement documentation and limited financial management capacity within the NS, which may result in ineligible expenditures, audit findings, and reputational risks.	A kick-off meeting will be organized to clarify all financial and procurement requirements. The NS will dedicate specific finance and log focal persons during this operation. The cluster will organize follow-up weekly meetings with the NS operation team.
Contextual risk: seasonal cyclone activity and flooding may limit physical access to certain intervention areas and result in delays to the implementation of planned activities.	Proactively engage with all local stakeholders to anticipate access issues and establish contingency plans. Assign specific, measurable, and task-oriented mandates to volunteers in these areas to ensure autonomy and accountability.
Risk of sexual exploitation, abuse, and harassment (SEAH) in community-level operations, compounded by: - Volunteers conducting household visits create multiple SEAH exposure points - Vulnerable populations (children, pregnant women, marginalized / stigmatized groups - MSM, sex worker) face elevated risk and may face coercion or exploitation	- Mandatory training/briefing for volunteers on SEAH and Child Safeguarding before field deployment, with signed Code of Conduct and zero-tolerance policy acknowledgment. - Implement two-volunteer rule for all household visits involving children or vulnerable individuals.

Please indicate any security and safety concerns for this operation:

Volunteer/Staff Safety Risks:
- Infection exposure: Frontline volunteers face transmission risk during household visits, contact tracing, and community mobilization. Mitigation: Comprehensive IPC training for 180 volunteers, adequate PPE provision, clear referral protocols avoiding direct patient contact, daily health monitoring, insurance coverage
- Stigma-related hostility: Community resistance or aggression toward volunteers perceived as bringing disease or enforcing isolation. Mitigation: Community leader engagement, uniforms/identification, paired volunteer deployment, incident reporting mechanisms
- Psychosocial strain: Burnout, secondary trauma from witnessing suffering, social stigmatization of volunteers. Mitigation: Regular PSS debriefing sessions, peer support networks, rotation schedules

Community Safety Risks:
- Rumor-driven violence: False information could trigger mob action against volunteers or suspected cases. Mitigation: Proactive

rumor management, transparent communication, police/local authority coordination protocols.
Child safeguarding: Volunteer interaction with minors (28 schools, household visits) requires protection measures. Mitigation: Volunteer vetting, Code of Conduct, two-volunteer rule for child interactions, reporting mechanisms.

Operational Security Protocols:
- Daily security briefings in high-risk zones
- Volunteer identification cards and visibility vests
- 24/7 incident reporting hotline to CRM coordination
- Close coordination with local authorities
- Evacuation plans for each priority region
- Suspension protocols if security deteriorates

Has the child safeguarding risk analysis assessment been completed?	**Yes**

Planned Intervention

Health

Budget: CHF 122,694
Targeted Persons: 50,000

Indicators

Title	Target
# of volunteers trained and deployed for active case finding and RCCE activities	180
# of daily alerts detected, investigated, and referred through CBS system	30
% of identified contacts traced and monitored	100
# of isolation/treatment centers receiving technical and material support	5
# of volunteers and staff receiving PPE	200
# of household contacts receiving home-based monitoring and support	1
# of PSS sessions provided to affected individuals, families, volunteers, and healthcare workers	500
# of community healthcare workers trained on case management	60
# of volunteers trained to provide PSS	30
% of monitored households reporting improved psychosocial wellbeing after PSS sessions	70
% of volunteers and community health workers who report increased capacity to safely perform epidemic response roles (post training self assessment)	80
# of people reached through RCCE campaigns (interpersonal communication, mass media, community sessions)	50,000

# of IEC materials produced and disseminated (posters, flyers, brochures)	2,000
% of people reached who demonstrate accurate knowledge of Mpox symptoms, transmission, and prevention (via rapid KAP checks)	80

Priority Actions

• Deploy and supervise 180 trained volunteers across 10 priority regions for active case finding, alert generation, rapid community-level referral and RCCE
• Train 30 volunteers on PSS
• Support the MoH contact tracing operations
• Provide technical and material support to 3 isolation/treatment centers and coordination mechanisms with COUSP structures
• Mobilize communities for vaccination campaigns when vaccines become available
• Distribute complete PPE sets to 180 frontline volunteers and support PPE provision to healthcare facility staff in affected regions
• Conduct daily epidemiological monitoring and adaptive response planning based on case trends and positivity rates
• Train 60 community healthcare workers on community case management
• Co-produce and disseminate IEC materials by MRCS, MOH and other stakeholders to ensure technical accuracy, consistency and community acceptability
• Conduct mass media campaigns: radio broadcasts on popular stations, TV spots during prime time, social media campaigns

Water, Sanitation And Hygiene

Budget: CHF 110,443
Targeted Persons: 50,000

Indicators

Title	Target
# of handwashing facilities installed at strategic locations (schools, markets, transport hubs, community centers, health facilities)	100
# of households of confirmed/suspect cases receiving disinfection and decontamination services	180
# of volunteers trained on hygiene promotion, household disinfection, and environmental decontamination protocols	130
# of transport vehicles and public spaces receiving systematic environmental disinfection	100
# of people reach with hygiene promotion and awareness-raising sessions	50,000
% of targeted locations where functional handwashing facilities installed are used regularly by community members	70
% of targeted population with improved knowledge of hygiene behaviours relevant to Mpox transmission	70

Priority Actions

• Install 100 handwashing facilities, including water-soap handwashing devicee and alcohol-based hand rubs (≥60% alcohol) across 10 priority regions at high-traffic locations and conduct systematic monitoring to ensure continuous availability of water and soap
• Train 130 volunteers on hygiene promotion including household disinfection techniques, environmental decontamination of shared spaces, proper PPE use

• Conduct household disinfection interventions for families with confirmed/suspect cases and their close contacts, including surface cleaning, textile treatment, and waste disposal guidance
• Collaborate with local authorities (MoH, transport companies, market management committees, ...) to conduct systematic environmental disinfection of transport vehicles and public spaces to ensure safety of volunteers
• Conduct hygiene promotion and awareness-raising activities among affected populations
• Replenishment of consumables (soap, Alcohol-based hand rubs, and chlorine)

Protection, Gender And Inclusion

Budget: CHF 10,310
Targeted Persons: 50,000

Indicators

Title	Target
# of people reached with PGI information (anti-stigma messaging and discrimination prevention Information)	50,000
# of vulnerable individuals (pregnant women, children, PLHIV, immunocompromised, mobile workers) receiving targeted information and support services	5,000
# of safe referrals provided	-
% of concerns/complaints related to stigma, discrimination, or access barriers reported and addressed within 7 days with documented resolution	100
% of affected individuals reporting reduced stigma or discrimination following targeted PGI and RCCE interventions	90
# of community feedback and reporting mechanisms established and functional	1
# of staff and volunteers trained/briefed on PGI	375

Priority Actions

• Conduct participatory gender analysis in identifying differential Mpox impacts on the affected population and mapping inclusion barriers
• Conduct (or include other training sessions) a mandatory briefing session for all staff and volunteers, with signature of the Code of Conduct
• Integrate anti-stigma messaging into RCCE activities
• Conduct campaigns with traditional leaders, disseminate child protection materials to families, and train volunteers to identify and report child protection and safeguarding concerns
• Map referrals pathways and provide safe referrals
• Establish a confidential reporting mechanisms

Community Engagement And Accountability

Budget: CHF 14,896
Targeted Persons: 50,000

Indicators

Title	Target
% of feedback items received, documented, and responded to through accountability systems	100
% of community members reporting trust in CRM volunteers as reliable sources of information	90
% of community dialogue sessions, focus group discussions, and community meetings conducted to support community participation	50
# of operational decisions or programme adaptations informed by community feedback and documented in coordination meetings or reports	-
# of people reached by targeted dialogue sessions and FGD conducted by the trained volunteers	50,000

Priority Actions

• Establish and disseminate community feedback mechanisms: toll-free hotline, volunteer feedback forms, community suggestion boxes at health facilities and community centers, focus group discussions.
• Deploy rumor tracking system: volunteers report misinformation heard in communities, rapid response team develops corrective messages, distribution through same channels where rumours circulate.
• Partner with private sector: transport operators for vehicle-based messaging and driver training, market associations for vendor information sessions, employers along economic corridors for workplace sensitization.
• Conduct community dialogue sessions, focus group discussions (including with women, youth, and mobile populations) to engage community participation and to address barriers to receiving treatment (fear, stigma and economic loss).
• Integrate community feedback analysis into weekly operational meetings and communicate response adaptations back to communities.

Secretariat Services

Budget: CHF 37,380
Targeted Persons: -

Indicators

Title	Target
# of coordination meetings conducted (national, regional, and with Movement partners)	24
# of monitoring and supervision missions conducted	2
% of planned monitoring missions completed and resulting in timely adaptive management actions	100

Priority Actions

• Provide continuous technical, logistical, and financial support to all four National Societies throughout operation duration.
• Facilitate weekly Movement coordination meetings (11 sessions over 3 months) with participation of IFRC, PIROI, French Red Cross, German Red Cross, Luxembourg Red Cross, and other partners.
• Support the management of the operation including fund disbursement, procurement support, reporting coordination, and compliance monitoring.

• Provide surge capacity support as needed (emergency health, WASH, CEA/RCCE), in coordination with PIROI.
• Organize field supervision missions: regular monitoring visits to intervention zones, joint IFRC-NS supervision ensuring quality and accountability.

National Society Strengthening

Budget: CHF 75,164
Targeted Persons: -

Indicators

Title	Target
# of situation reports produced and disseminated	16
# monthly progress review conducted	3
# of mid-term review and lessons learned workshops conducted	2
% of monitoring and supervision missions completed vs planned	100
% of evidence of improved preparedness or enhanced CBS/WASH/CEA systems after the operation (documented in lessons learned or mid term review)	20

Priority Actions

• Produce and disseminate weekly situation reports (SitReps) documenting: epidemiological trends (cases, deaths, geographic spread), response activities (outputs against targets), operational challenges
• Organize field supervision missions: regular monitoring visits to intervention zones
• Organize mid-term review and end-of-operation lessons learned workshops
• Conduct monthly progress reviews analysing indicator achievement
• Produce final implementation report

About Support Services

How many staff and volunteers will be involved in this operation. Briefly describe their role.

Total personnel: 16
National staff (6):
- Operation Manager: overall coordination, COUSP liaison, strategic oversight
- PMER Coordinator: monitoring, reporting, data management, Community engagement
- Finance/Admin Officer: budget, disbursements
- Logistic Officer: procurement
- Communication Officer: RCCE, IEC materials, media
- Health Coordinator: technical oversight, CBS, IPC protocols

Regional staff (10):
Regional Focal Points - Supervise volunteers, coordinate with Regional COUSP, manage logistics in priority regions

Volunteers: 340
- Community-Based Surveillance (180), WASH and RCCE: active case finding using simplified definition, household visits, alert generation, referral to health facilities, contact monitoring support, weekly data reporting, door-to-door sensitization, meetings, anti-stigma messaging, rumor tracking, community feedback collection

- Disinfection Team (130): household/public space decontamination
- PSS Support (30): basic psychological first aid for affected communities

Does your volunteer team reflect the gender, age, and cultural diversity of the people you're helping? What gaps exist in your volunteer team's gender, age, or cultural diversity, and how are you addressing them to ensure inclusive and appropriate support?

Dedicated volunteers are recruited from the targeted regions, ensuring strong cultural and linguistic alignment with beneficiary communities. The volunteer composition intentionally promotes gender balance, with at least 50% female volunteers to ensure appropriate outreach to vulnerable populations, and combines youth volunteers (aged 18–35) with experienced older volunteers to effectively engage the median affected age group of 23 years.

Will surge personnel be deployed? If yes, please provide the role profile needed.

Yes
Surge personnel will be deployed on a needs-based basis through established IFRC mechanisms, including PIROI and PNSs, to provide specialized technical expertise in emergency health, epidemic response, Community-Based Surveillance, and Psychosocial Support.
Surge delegates will be deployed in time-bound roles to support technical training delivery and provide hands-on technical assistance for field implementation. Deployments will be triggered by operational requirements such as rapid geographic expansion requiring scale-up of volunteer capacity, laboratory bottlenecks necessitating specimen management support, complex coordination demands, or specific requests from government authorities where National Society capacities are insufficient.

If there is procurement, will it be done by National Society or IFRC?

Procurement will be primarily conducted by CRM using local suppliers for handwashing stations, hygiene kits, IEC materials, and operational supplies to ensure rapid delivery and community appropriateness, while specialized PPE procurement will be coordinated by IFRC through PIROI leveraging regional stockpiles and framework agreements with international suppliers to ensure quality standards and economies of scale. All procured items are for direct distribution to beneficiaries (hygiene kits, handwashing stations) and frontline personnel (PPE volunteers and healthcare workers), with CRM's established procurement procedures enabling 2-3 week lead times for local items and PIROI's pre-positioned PPE stocks allowing immediate deployment with replenishment orders processed within 4-6 weeks through existing supply chain mechanisms.

How will this operation be monitored?

The operation will be monitored through a harmonized framework combining CRM's CBS reporting system (daily volunteer data via mobile platforms - NYSS), weekly operational SitReps tracking outputs against targets, monthly indicator reviews assessing outcomes (% cases detected via CBS, time symptom-to-isolation, population knowledge levels through KAP surveys), and sex/age disaggregated data collection enabling equity analysis, with the dedicated PMER coordinator for data consolidation and dashboard management while Regional Focal Points conduct weekly field spot-checks.
IFRC monitoring will include bi-weekly virtual coordination meetings with CRM leadership, monthly joint field supervision missions to priority regions, assessing quality and accountability, a structured mid-term review at Month 2 evaluating progress and enabling adaptive management, and an end-of-operation lessons learned workshop, with all stakeholders support if complex data challenges emerge or geographic expansion requires enhanced monitoring capacity.

Please briefly explain the National Societies communication strategy for this operation

CRM implements a comprehensive communication and accountability approach combining internal coordination and external engagement. Internal communication is ensured through established WhatsApp groups for volunteers, staff, and Movement partners, regular information sharing, weekly staff briefings, and bi-weekly Movement coordination meetings. External communication leverages multiple channels, including regular public Situation Reports produced by the MoH with CRM contributions, community feedback mechanisms (hotlines, volunteer reporting, and focus group discussions), mass media partnerships (radio broadcasts, television interviews, and social media campaigns via CRM's official platforms), and transparency measures such as the public display of the NS complaint mechanisms at intervention sites to ensure affected communities can access information and raise concerns.
IFRC supports these efforts through the IOI Cluster Communications Officer, who provides technical guidance to ensure message

consistency across the region, coordinates media engagement in the event of international attention, and oversees reporting through the global DREF communication and reporting platforms.

Budget Overview

IFRC

DREF OPERATION

Code - Malagasy Red Cross
Mpox epidemic emergency response

Operating Budget

Planned Operations	**275,135**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	130,669
Water, Sanitation & Hygiene	117,622
Protection, Gender and Inclusion	10,980
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	15,864
Environmental Sustainability	0
Enabling Approaches	**119,860**
Coordination and Partnerships	0
Secretariat Services	39,810
National Society Strengthening	80,050
TOTAL BUDGET	**394,995**

all amounts in Swiss Francs (CHF)

Click here to download the budget file

Contact Information

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

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Click here for the reference