

OPERATIONS UPDATE

Africa Region | Mpox Appeal



A URCS volunteer engages learners on Mpox at Mirembe Junior school in Wakiso district. Photo credit: Patrick Sebaggala

Emergency appeal №: MDRS1003 Emergency appeal launched: 20/08/2024 Operational Strategy published: 30/09/2024	Glide №: N/A
Operation Update # 05 (16-Month) Date of issue: 31/03/2026	Timeframe covered by this update: 22/08/2024–31/12/2025
Operation timeframe: 21 months (extended until 30 June 2026)	Number of people being assisted: 32 million people
IFRC Secretariat Funding requirement: CHF 30 million Federation-wide funding requirement: CHF 40 million ¹	DREF amount initially allocated: CHF 5 million

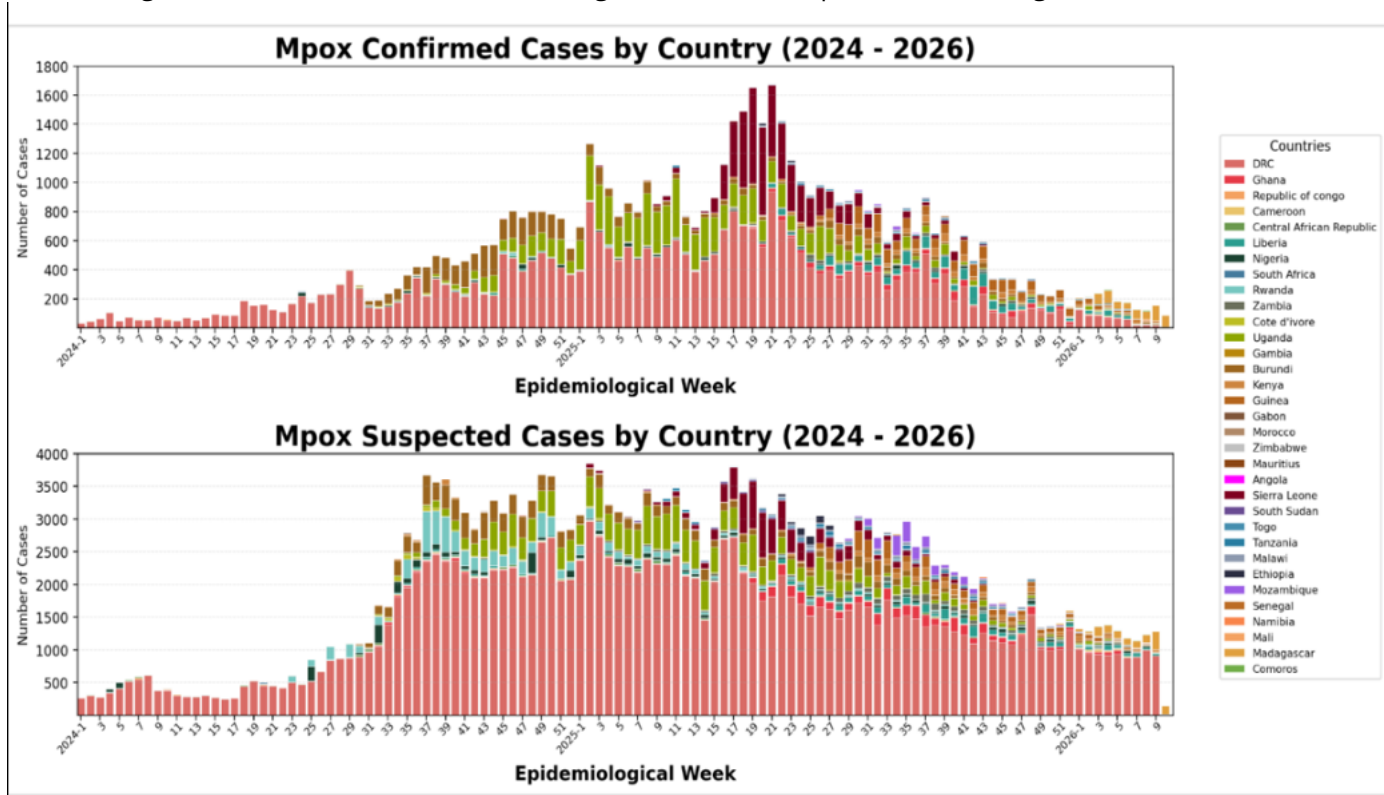
The Mpox Emergency Appeal raised a total of CHF 11,395,048 as of December 2025 against the target of CHF 30 million, including DREF allocation. As of the last Operations update, the funding was reported at approximately 30%, which included a CHF 2,000,000 soft pledge that was not honoured. While no new funding was realised after December 31st, 2025, needs from National Societies to support response leading to constraints as cases continued to escalate. Nonetheless, capacities already established and lessons learned have been ploughed back and sustained mitigation against Mpox.

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 40 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

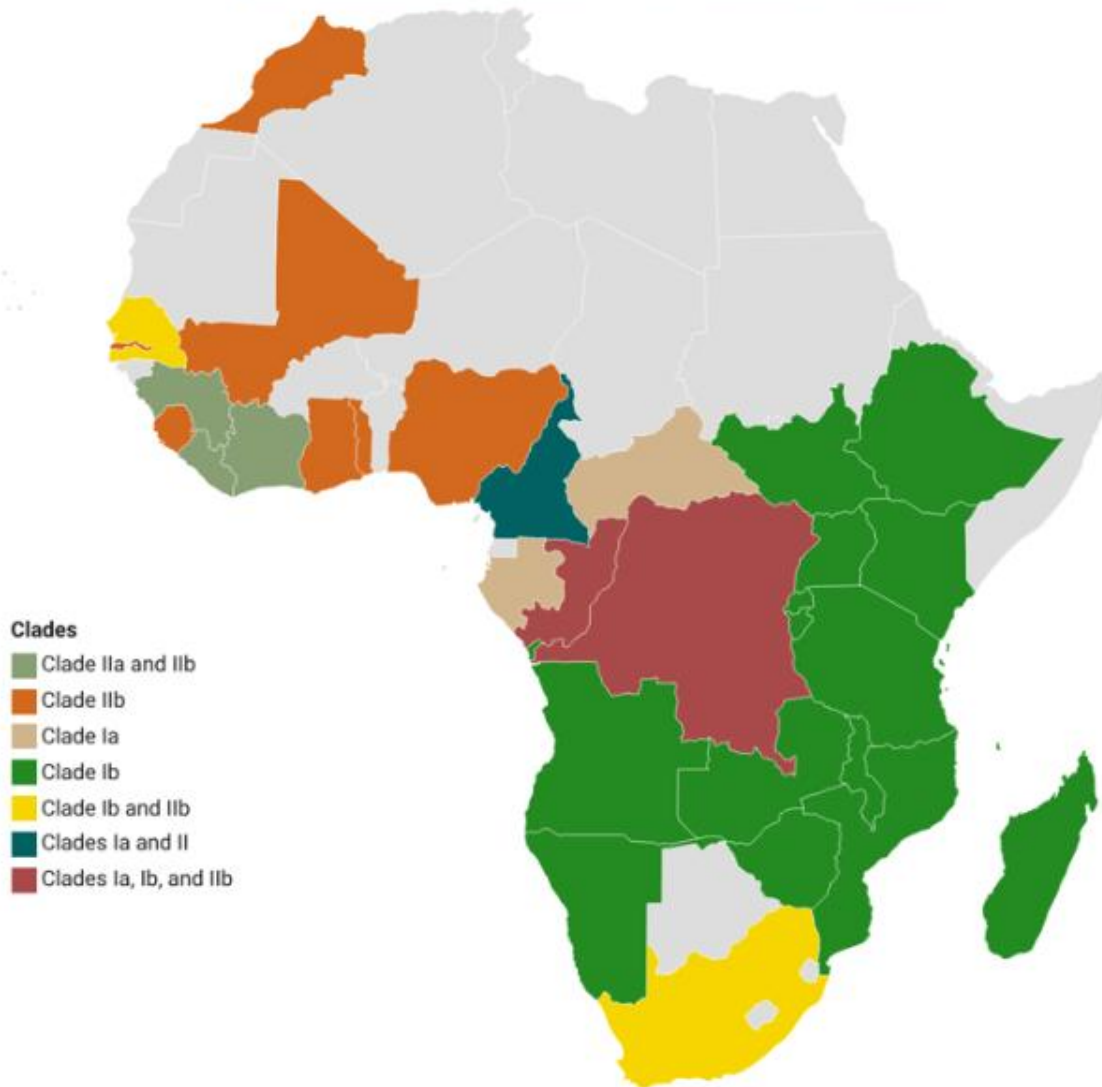
SITUATION ANALYSIS

Description of the crisis

Mpox spread across the Africa continent was initially noted in 2022 and had been within control until 2024 when the spread affected multiple countries and subsequently being declared a Public Health Emergency of International Concern by Africa CDC and WHO. As at the close of 2025, at least 22 countries in Africa had reported cases of Mpox with 21 countries getting assistance. Several strains of the virus causing Mpox were identified with laboratory confirmations. The clades circulating are [Clade I and Clade II](#). Both types spread same way and can be prevented using the same methods. Significant reduction of cases was mostly seen in July and August, and this is attributed to the various interventions put in place. Despite this progress, within the same period, a strong resurgence of cases was observed in Western Africa, in particular Guinea, Togo and Sierra Leone, in Kenya and Tanzania in East Africa and in Malawi and Mozambique in Southern Africa. In the cases reported in Guinea, where at least 942 confirmed cases occurred within a very short time, there seemed to be no clear linkage to the clade 2b that is endemic in Nigeria and the strain common in DRC. The crisis, nonetheless, continues to impact lives and livelihoods negatively. In a review that was done by Africa CDC and WHO following the successful interventions that had been undertaken, the Mpox situation was [reclassified a from Public Health Emergency of Concern to Grade Three Disease Outbreak](#). No further classification has been done since September 2025 but the disease remains to be a threat to the continent with new or recurring infections and hence of interest to governments and partners including the IFRC and National Societies.



Mpox Clade Distribution in Africa 2024 - 2026



Mpox Federation-wide Overview

IFRC Membership Coordination

The IFRC Secretariat has been actively working on renewed membership coordination efforts to promote a strong and active membership engagement for a Federation-wide Mpox response. This coordination aims to identify inter-organization synergies, streamline efforts to support National Societies, and identify the comparative advantages of members—especially those that have medium to longer term engagements across the continent—to work collaboratively and ensure long-term sustainable support to responding National Societies. Ultimately, the outcome of this collaboration is to enhance our collective impact on communities that are impacted and at risk.

Coordination structures and planning and reporting tools are in place both at the country level and at the regional level to support the operationalization of this Federation-wide approach. An example of this is the regional

Membership meetings hosted by the Secretariat to foster discussions on how to best leverage the Membership's strengths in support of the operating National Societies. The Secretariat appreciates the continued support received from movement partners, even in the wake of reduced interest in Mpox that has been observed due to the increasing burden and prolonged nature of the outbreak. All confirmed bilateral contributions have been accounted for under the Federation-wide funding received to date, while indirect contributions are being reported separately to avoid double-counting.

ICRC

Overview of the host National Society and ongoing response

The International Committee of the Red Cross (ICRC) is present in most countries where the Mpox outbreak has been declared. The provisions of the Movement Seville Agreement 2.0 for Strengthening Movement Cooperation and Coordination principles are applied for the ICRC to play its mandate. In outbreak-impacted areas where there is active conflict, the concerned National Society, IFRC and ICRC discuss the most appropriate approach to access the vulnerable or most exposed groups, promoting the safety and security of staff, volunteers and populations. In DRC, which is the most affected country, ICRC is present and has carried out some actions in relation to the Mpox responses, focusing on the South Kivu province in the health districts of Bagira and Nyatende.

Response

1. National Society capacity and ongoing response

The Africa National Societies involved in the Mpox response operation established activities under different adoptive contexts. For countries that were able to start by undertaking preparedness measures with information on how the disease was spreading in the neighbourhood, their efficiency was generally better, albeit with limited resources being available. The National Societies engaged grassroots volunteers, some of whom were already trained in risk communication and community engagement (RCCE) and response in general to highly communicable diseases. The National societies faced a challenge of insufficient resources despite being expected by Governments to play big roles in response to Mpox. Burundi Red Cross, for example, remained as the only partner that was still providing water in Bujumbura to prevent disease spread, yet other partners had either pulled out/or were no longer focusing on Mpox. Nonetheless, the National Societies received accolades from governments and partners for their commitment and sustained efforts. The secretariat continued to support capacity building and deployment of personnel to the neediest areas as it continued to fundraise.

- **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 to enable public adherence to health guidelines. Involvement of trusted community leaders helps in disseminating accurate information and gaining community support for public health measures. Therefore, two-way communication through CEA and RCCE is crucial to ensure a clear direction of actions to be taken to reduce risk.
- **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 building trust, promoting preventive measures, and leveraging 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, contact tracing, and active case finding extends national surveillance systems to communities.
- **Mental health and psychosocial support:** The National Societies working with Ministries of Health and other stakeholders in mental health spheres continued to aid the affected population, mostly from the lessons learnt from COVID-19 and Ebola responses. Call centres for help and physical and psychological First Aid services have remained key in the response operations.
- **Health and hygiene promotion:** Red Cross volunteers implement a variety of health and hygiene promotion activities at the community level in and out of crisis times. This creates a strong foundation to scale and integrate Mpox-related health and hygiene promotion across existing, trusted platforms. Use of customised posters and social media continues to be in use, reaching a high number of audiences on Mpox awareness messaging.
- **Case management and support to vulnerable people:** The communities that were directly affected by Mpox received various services during the response period, which included casualty evacuation of patients to isolation/treatment centres and access to home-based care. The National Societies' teams of volunteers and staff continue to assist in health facilities and provide further assistance to patients past the hospitalization phase.
- **Vaccination:** Vaccination against Mpox has been adopted as a preventive measure among communities that are at high risk, and especially where there is sustained community transmission. The National Societies working with Ministries of Health in their respective countries have been at the forefront in leading these campaigns. As of the close of August, the WHO reported that there are about 6 million doses of Mpox vaccine that have been pledged, while there are 1.5 million doses of MVA-BN vaccines that have been delivered to 12 countries. There are also 3 million doses of the LC16m8 vaccines that have been delivered to DRC. Overall, over 2.2 million doses have been administered in 11 countries.

2. Red Cross Red Crescent Movement capacity and response

The Secretariat cluster teams took over coordination and accountability responsibilities from delegates who were initially deployed to hotspots during the first round of the outbreak. The devolved coordination and flexibility of the majority of the pledges enabled the cluster teams to shift allocations as was necessary to address new outbreaks as the epicentres shifted. Further, this was a big gain in situations where resurgence was experienced, like in Kenya, Tanzania and Malawi, among others. This is on a background of National Societies that have been in response to complex epidemics in previous years, including but not limited to Dengue fever, Ebola Virus Disease and COVID-19, backed up by a strong and skilled workforce of 48 National Societies, 18,000 branches, 14,000 staff and 4 million community volunteers.

Severity of Humanitarian Conditions/Needs analysis

Monkeypox (Mpox) is an infectious disease caused by the Mpox virus. It is caused by 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 painful rash. The rash often begins on the face and then spreads to other parts of the body. The rash progresses to pustules and eventually scabs. Mpox can spread from animals to humans (zoonotic transmission) and from 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. Due to the recent outbreak, DRC has kicked off a fresh vaccination campaign in the eastern province of North Kivu, targeting primarily health workers and frontline responders, contacts of confirmed cases and other at-risk groups to curb the epidemic.

Because one of the modes of transmission for some clades is 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, meanwhile exacerbating an increase in disease transmission rates.

Socio-economic protection

Socio-economic factors also emerged as key determinants for Mpox. Individuals living in underserved communities with limited access to health care or accurate information about Mpox might face increased risk due to delayed diagnosis and access to prevention measures. This particularly applies to DRC, where a considerable proportion of the population lives in internally displaced persons (IDP) camps and informal settlements in tents and overcrowded rooms, hence exposing younger children and women to Mpox due to preexisting poor hygiene conditions.

While the socio-economic impact on families affected by Mpox is considerable due to prolonged times allocated to seeking medical care by travelling, this implies significant economic losses as families must invest in transport, payment of health care services, food, and communication while their daily activities have been partially or totally put on hold because of the disease. This is particularly impactful for women and girls, who act as caregivers. Lessons learned from previous public health crises in Africa, namely COVID-19 and Ebola, have taught us that women and girls are often saddled with primary caregiving duties for those who are sick while still being responsible for the provision of food and water to the family. These burdens are even more pronounced in child and woman-led households.

Health and Care

The main priorities to support the response to Mpox include both stopping continued community transmission as well as providing comprehensive care and support to those infected. While Mpox is an endemic disease in some regions impacted by the current epidemic, its transmission patterns seem to have expanded and shifted during this outbreak, making activities to support active case finding, community-based surveillance, referral mechanisms and contact tracing extremely important to better understand these patterns of transmission and ultimately end community transmission. National Societies have been working in alignment with their national government plans to implement these activities in the most impacted areas. Additional case management support continues to be important, including safe evacuation of patients suspected to have contracted Mpox to health facilities in some locations, food and nutrition support for individuals in isolation and impacted family members, as well as mental health and psychosocial support to those impacted by Mpox.

For any of these interventions to be impactful, effective RCCE is essential. These activities are rolled out together with other health and WASH activities to ensure community needs, capacities, and perspectives remain at the centre of the response. To support these efforts, National Societies have been engaged in risk communication workshops with their respective governments, ensuring visual aids and key messages remain appropriate for the response and continue to work with community leaders, schools, traditional healers and others to facilitate two-way communication and feedback on perceptions of Mpox and relevant response measures.

WASH

Like in most humanitarian emergencies, access to water, sanitation and hygiene is a critical component for the Mpox response and preparedness phases. Through this appeal, the IFRC is supporting hygiene promotion, including access to water and materials critical to enable proper hygiene. Also, the provision of water and hygiene items for management of at-home (home care), and support to health and Mpox treatment facilities has been planned. This will help to promote disinfection and encourage basic hygiene practices amongst the affected communities. Overall, the improvement of WASH services will contribute to breaking the transmission cycles and containment of Mpox.

Operational risk assessment

The spread of Mpox has been steady across many African Countries, now reaching 22 from the initial 12 envisaged at the launch of the appeal. Other emergencies have also occurred alongside this, including conflict and the Ebola outbreak in DRC. It has sometimes been observed that Mpox turned out to be of lower priority, and hence, few resources were allocated. The National Societies have continued to review their plans in line with the respective MOH guidelines and the Africa CDC. Currently, AfCDC has guided that the Mpox response be integrated with other outbreak responses like Cholera, and most National Societies will be working towards the same.

The resurgence of Mpox in countries that were already off the list, highly impacted and high risk, such as DRC, Ghana and Madagascar, clearly points to the need to sustain surveillance and response capacities across the continent.

Vaccination campaigns will also have to be increased despite the inadequacy of the doses needed to support the at-risk population. National Societies will continue to work with the Ministry of Health in their respective countries and adjust strategies to meet the evolving operational needs.

Despite the deficiencies, lessons from Mpox response have borne other mechanisms within the Region on collective Pandemic Preparedness and Response programmes that seek to build long-term capacities to tackle pandemics. The Pandemic Fund of the World Bank has funded the Horn of Africa body (IGAD) to build cross-border collaborations on surveillance and response to pandemics.

A. OPERATIONAL STRATEGY

Update on the strategy

In the previous operation update, indicators for the operation were updated and reported for a few countries and zones. While most activities in the operation have now been completed, IFRC cluster teams and the Region require more time to support capacities at the National Society level to provide accurate and quality reports, considering the number of countries involved in this appeal.

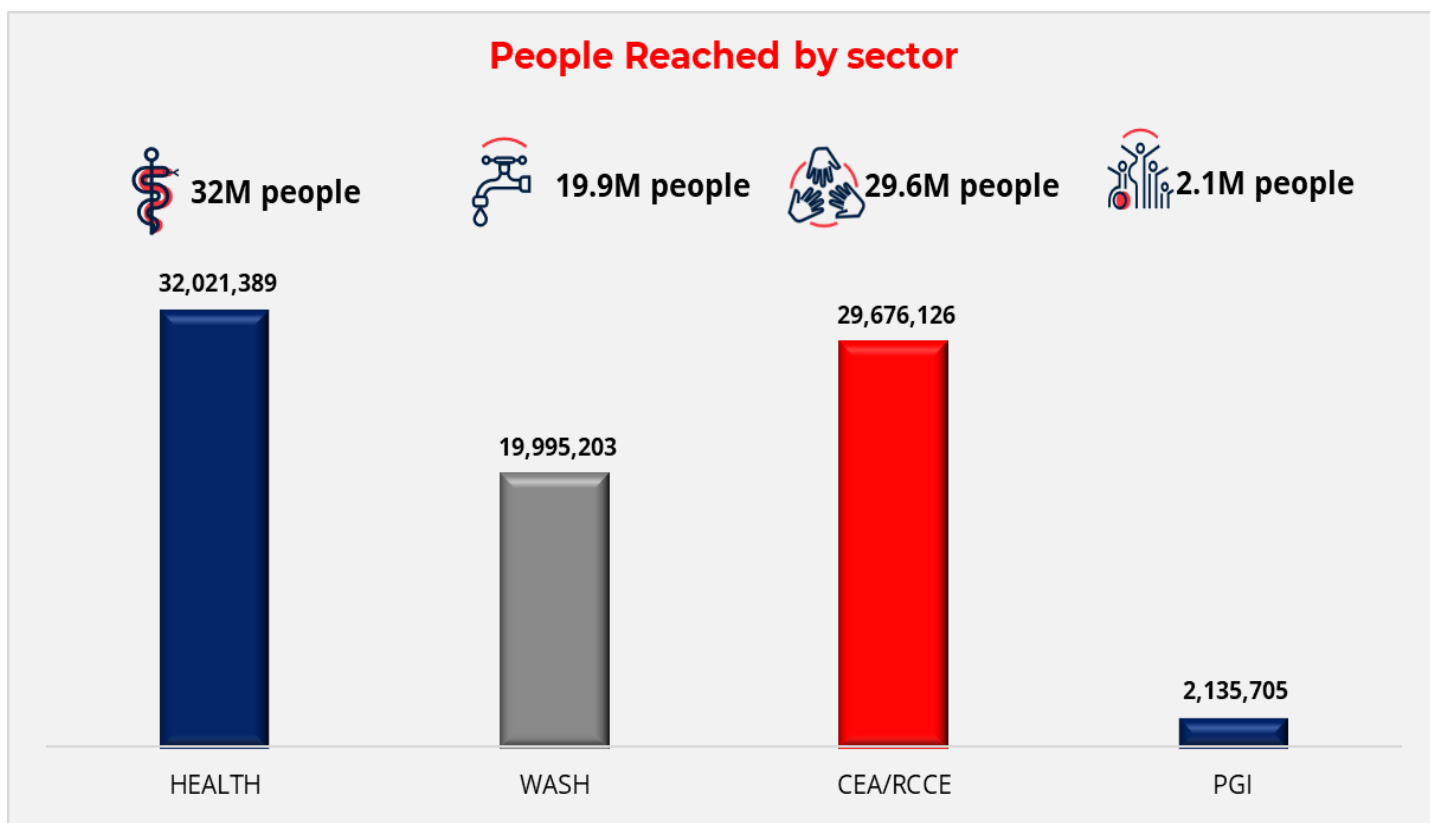
This operation update is proposing an extension of the project period from **31st March 2026 to 30th June 2026** for the purpose of consolidating reports from 21 National Societies that were supported through the appeal.

Rationale:

- This period will enable cluster teams to get verified financial and activity reports from the National Societies.
- complete monitoring and evaluation activities, more so in the countries that have remained in implementation throughout the appeal life.
- The Mpox operation has been heavy, with 21 countries involved. A lot of data has been generated and lessons learnt. During the reporting period, the data generated will be validated to reflect the Federation-wide reach and finally, the closure of the appeal and ensure auditable closure and stocks in the appeal.

B. DETAILED OPERATIONAL REPORT

Regional Overview



Pillar 1: Socio-economic protection

The Mpox outbreak had significant socio-economic implications for families, particularly those with affected breadwinners. The IFRC appeal initially planned to provide multipurpose cash assistance to address urgent needs and support livelihood reintegration through skills enhancement. A dedicated livelihood assessment was also designed to inform these interventions. However, due to funding constraints, socio-economic protection activities could not be prioritized or implemented as planned. Limited cash assistance was provided during the implementation period of the appeal and reflects the deficit in the focus on socio-economic activities in pandemic emergencies. The gap highlights the continued need for investment in resilience-building measures for vulnerable households in future epidemic responses.

Pillar 2: Health and Care (including psychosocial support and RCCE)

Health and care activities provided by Red Cross-National Societies reached or supported slightly **over 32 million people** during the reporting period. Key epidemic control activities across the region include support to disease surveillance systems, including contact tracing and community-based surveillance; RCCE and health promotion;

psychosocial support; support to vaccination campaigns; and support to case management, including patient transport.

An additional **14,399 volunteers received training for community-based surveillance and active case finding** in high-burden countries such as DRC, Uganda, Burundi, Cameroon, Kenya, and Nigeria. Enhanced cross-border surveillance was implemented in the high-burden countries, including Angola, Ethiopia, Rwanda, and Zambia, to curb cross-border transmission. Volunteers were trained in case identification and referral to clinical health facilities. Contacts of affected persons were followed up, identified, and supported to increase IPC measures to avoid further disease spread. Various RCCE and sensitization activities were conducted at the household and community level in all affected countries. RCCE materials were developed in local languages and distributed widely to raise awareness in affected countries. National societies led social mobilization for vaccination in all countries, while PSS activities were received **by more than 700,000 beneficiaries** in Burundi, DRC, Kenya, Tanzania, and Uganda.

The movement's health and care activities are specifically targeting epidemic control, including both prevention of transmission and care for cases. Ambulance services were operated in Uganda and the DRC. Kenya and DRC National Societies supported training and improvement of IPC in their facilities during this reporting period. Key technical coordination structures were in place to ensure lessons learnt and tools sharing across responding National Societies. The IFRC worked closely with technical partners at the continental and country level, linking into the WHO/Africa CDC interagency coordination platform. The IFRC made a significant contribution to the RCCE, surveillance, case management, IPC, and vaccination pillars. The IFRC co-led five webinars covering all pillar activities. National societies were allowed to share experiences and to receive updates on the Mpox protocols as part of capacity building.

Pillar 3: Water, Sanitation and Hygiene

These interventions included improved access to safe water, provision of hygiene items, and hygiene promotion activities targeting individuals and communities affected by or at risk of Mpox infection. WASH interventions played a critical role in reducing transmission risks and strengthening preventive behaviours at the community level. In addition, robust technical coordination mechanisms were established to facilitate peer-to-peer learning, exchange of tools, and harmonization of practices across National Societies, ensuring consistency and quality of WASH response throughout the operation.

Protection, Gender and Inclusion

To strengthen communities' dignity, access, participation and safety in the response, with no one left behind, the team has been able to:

- Develop relevant guidance on how best to ensure protection, gender and inclusion approach strengthens the Mpox response (available in English and French) <https://pgi.ifrc.org/resources/pgi-Mpox-response-english>
- Engage in the GBV working group for East and Southern Africa to enhance collaboration and coordination in Mpox response. The working group has been able to develop a brief on the gendered impacts of Mpox [Impact of Mpox on Women and Girls brief \(GBV AOR\) | Protection, Gender & Inclusion](#)
- One of the major gaps we have in emergency operations, including Mpox, is a lack of gender and diversity analysis to guide the response and recovery. This was also highlighted in the Mpox response, where protection, gender and inclusion actors highlighted the lack of gender and analysis to guide the Mpox response and the lack of sex, age, and disability disaggregated data (SADDD). To address this gap, in January 2025, IFRC, in collaboration with French RC and financial support from the IFRC operations team (PGI and health) conducted the first gender in epidemics training targeting NS (Anglophone) who respond to epidemics, focusing on PGI and health technical colleagues. Twenty-three (23) participants from 12 NS attended to strengthen NS capacity in conducting gender and diversity analysis, including through practical examples and simulations. The NS were able to understand why gender and diversity are critical in epidemics and how to conduct a gender and diversity analysis and to use it to plan the full cycle of the operation. One person from

the Gender in Emergencies group (GIE) presented their experience in conducting gender and diversity analysis, including the recent one they did for the Mpox response, focusing on DRC. NS appreciated the peer-to-peer learning, including from persons outside the movement. The NSs developed action plans, and we continue to work as a team to ensure the action plans are implemented.

- Currently ongoing is the planning for the next gender and epidemics training (francophone). This is a collaboration with Health, CEA and PGI.

PGI had several challenges in the response, as was no budget line included in most NS budgets. We recommended conducting a gender and diversity analysis to guide the operations response plans as the basic minimum in the response, but this was not done.

Community Engagement and Accountability

To enhance National Societies' capacity to respond effectively to the ongoing Mpox outbreak, the IFRC CEA team has closely supported NSs in adapting and refining their Mpox response efforts to reflect the evolving needs and concerns of communities. This support included the following initiatives:

Collecting, responding, and acting on community insights:

- New tools for collecting, managing, and analysing community feedback were developed for NSs. One of which, the Community Feedback Logbook tool, was developed to enable NSs to manage and analyse feedback from multiple epidemic outbreaks to understand if there are significant similarities or differences in community concerns, questions, or beliefs across multiple operations NSs are responding to.
- Of the 23 priority countries, over 10 National Societies have a systematic community feedback mechanism in place, including: Burundi, Rwanda, Angola, Tanzania, Uganda, Kenya, Cameroon, Ivory Coast, Congo, and the Democratic Republic of Congo.
- Weekly "Community Feedback Troubleshooting Sessions" were set up in French and English to strengthen NSs' capacity in collecting, managing, and analysing community feedback. These sessions have been attended by 13 NSs across the region every week.
- NSs were also supported to conduct rapid qualitative assessments (RQAs), which consist of a series of focus group discussions and key informant interviews to better understand the perceptions, knowledge, attitudes and practices communities have on Mpox. At least 3 NSs rolled out RQAs, including Burundi, Rwanda, and Zambia Red Cross.
- Based on findings from community feedback and RQAs, the regional CEA team produced 3 feedback briefs to share real-time community insights and recommendations to address community concerns with NSs, technical colleagues, and externally with RCCE partners. NS were also supported to produce their own in-country feedback briefs, such as Kenya, Cote d'Ivoire, Rwanda, Gabon, Democratic Republic of Congo, Burundi, and Cameroon Red Cross.
- A regional volunteer perception survey was conducted to better understand community concerns, questions, and beliefs around Mpox and response efforts. Over 3,790 RCRC volunteers participated in the survey across 30 NSs.

CEA Capacity Building:

- Regular coordination calls were organised with NSs to provide technical assistance and promote peer learning across countries. These sessions were focused on sharing progress updates, identifying operational challenges, and discussing solutions.
- In-country RCCE and community feedback trainings were rolled out in Rwanda and Burundi. These aimed to build the capacity of NS staff and volunteers to effectively engage with communities, collect and analyse

feedback, and use insights to adapt their response activities. In August 2025, a monitoring visit was conducted in Burundi. Further coaching was provided on coding, analysing, and using community feedback.

Evidence Tracking Framework

- To support evidence-based decision-making, the Collective Service launched an Evidence Tracking Framework (ETF) initiative. This was piloted in Burundi in partnership with the Burundi Red Cross, UNICEF, and MoH. The ETF aims to improve documentation and sharing of lessons learned from coordinated RCCE interventions during emergencies like Mpox.

Coordination

- IFRC has been a core partner of the [RCCE Collective Service](#) since 2020. Through the Collective Service, the IFRC has supported the development of the [Mpox Thematic Kit](#) and tools such as the [Mpox question bank](#) led by the Social Science in Humanitarian Action Platform (SSHAP).
- IFRC has continued to co-lead the ESAR RCCE Technical Working Group, coordinating the regional Mpox RCCE response efforts. In addition, IFRC re-instated the Community Feedback and Social Science Sub-Working Group for the Mpox response (SWG). This is co-chaired with AIRA (WHO) and Anthrologica. Through the SWG, inter-agency feedback tools were adapted for Mpox and shared with country partners. To date, Inter-Agency Community Insights Reports have been developed and shared across regional technical working groups and with partners in the country.
- The IFRC has been a core contributor to the continental IMST coordination discussions and initiatives, including:
 - identification and prioritization of key activities for countries, including Burundi, DRC, Sierra Leone, and Malawi
 - co-developing a joint training on cholera and Mpox for priority countries.
 - supporting the development of a database and key tools, such as the joint cholera and Mpox RCCE guidelines
 - Technical support to ACDC and WHO on drafting key continental and regional RCCE recommendable interventions for end-of-year festivities.
 - Developed and rolled out an Mpox webinar series in English and French with partners. Four webinars addressing different key topics were rolled including stigma and community feedback mechanisms
 - Active support to ACDC on drafting the continental preparedness and response plan for the Mpox outbreak in Africa

Enabling approaches

National Society Strengthening

The presence of National Societies in hotspot areas affected by emergencies is a unique feature that must be nurtured. It gives a comparative advantage to the movement. The ability for a National Society to respond with its own resources depends on its capacities. These capacities are often depleted and hardly get replenished after use from frequent responses. The IFRC secretariat has continuously supported the National Societies in replenishing resources used, increasing human resource capacity through training and generally ensuring that the National Societies are stronger than it was after operations. In the appeal, several NSD support items and mechanisms were included as a contribution towards the goal.






Coordination and Partnerships

Response to epidemics in recent days has been seen to take a new positive dimension. The Africa CDC during the Mpox response took the lead in guiding surveillance, declaration and routine data release on the disease, not to mention the coordination role. Regional bodies like AfCDC will be the future force in the coordination of response. The IFRC has also been very active in the coordination of response, bringing in expertise and presence in affected areas through the National Societies. The Secretariat is committed to maintaining this role and ensuring the work of the National Societies is felt and recognised at the country and regional levels. The National Societies are applauded for being at the table of decision-making with their respective authorities to which they are auxiliary.

Secretariat Services

Due to the exponential nature of Mpox spread at the start and upon declaration by AfCDC and WHO of it being a Public Health Emergency of International Concern, the Secretariat deployed surge teams to epicentre countries to combat the spread of the disease. Most of the human resources deployed remained in service for a period between 3 and 6 months until other long-term resources were available. In doing so, the Secretariat maintained high standards in service delivery and ensured that the National Societies remained relevant and active as per their respective mandate, being auxiliary to authorities. The Secretariat also supported the Continental Incident Management Support Team (IMST) that was chaired by Africa CDC and WHO-Afro. This allowed the Movement to be represented at the highest level of the outbreak response and supported the coordination with other International and Local Partners. Through the IMST, the IFRC secretariat contributed to the development of Mpox Surveillance Strategy 2.0 and dissemination of key information through virtual Webinars. The Secretariat also supported Joint External Evaluation of country capacities' ability for preventing, detecting and responding to outbreak prone disease such mpox in line with International Health Regulations.

National Society Response

 DRC Red Cross Society					
 6,555,470 people reached	 473,466 people reached	 438,256 people reached	 6,457,338 people reached		
Country profile/context <p>The Mpox outbreak has become a major public health concern in the Democratic Republic of Congo (DRC), particularly due to the increasing circulation of the Mpox virus clade I across the country and the wider African region. In 2023, national health authorities reported 14,626 suspected cases and 654 deaths, representing the highest incidence ever recorded in the country. The situation continued in 2024, with 18,078 suspected cases and 610 deaths reported by August, highlighting the persistent and growing scale of the epidemic. The resurgence of Mpox has been accompanied by an expansion of the virus beyond traditionally endemic areas, affecting new provinces and increasing the risk of wider transmission. In addition to its spread within the DRC, the epidemic has also crossed borders, with new human infections attributed to the Clade 1b variant reported for the first time in neighboring countries, including Rwanda, Burundi, Kenya, and Uganda. This regional spread led to renewed international concern and contributed to the declaration of a Public Health Emergency of International Concern in July 2024. In response to the escalating situation, the Government of the DRC developed a national preparedness and response plan, calling on national and international partners to support coordinated efforts to control the epidemic.</p>					

Health

The Mpox outbreak in the Democratic Republic of Congo continues to expand geographically, affecting all 26 provinces. Between 2024 and early 2026, more than **124,352 suspected cases** were reported, with increasing transmission in urban areas and cross-border regions. A new variant (Clade Ib-highly transmissible mainly through sexual ycontact) has contributed to the spread across Central Africa. The DRC RCS mobilized **1,744 trained volunteers** deployed across **44 health zones in 9 provinces** to support community surveillance, case detection, and prevention activities.

Key health achievements include:

- **6,555,470 people reached** through community-based surveillance and health promotion.
- **6,032 community alerts of possible infections were** reported to health authorities, with **5,254 investigated** and **4,919 validated**.
- **26,108 contacts traced** for Mpox cases.
- **763,677 people received psychosocial support**.
- **33 health facilities supported** to strengthen infection prevention and control.
- **139,911 people vaccinated** through community mobilization during vaccination campaigns.
- **1,191,817 condoms distributed** to reduce sexual transmission risks.

The intervention also integrated **One Health approaches**, including surveillance of animal deaths and other epidemic-prone diseases.

Water, Sanitation and Hygiene (WASH)

WASH activities focused on improving hygiene practices and providing infrastructure to prevent the spread of Mpox.

Key achievements:

- **473,466 people reached** through hygiene promotion activities.
- **1,744 volunteers trained** to support WASH activities.
- **5 schools supported** with rainwater harvesting systems (impluviums).
- **24 health facilities equipped** with personal protective equipment and handwashing facilities.
- **312 handwashing stations distributed** in schools, churches, prisons, and public institutions.

Community awareness campaigns promoted proper handwashing techniques and environmental sanitation during the epidemic.

Main challenge: insufficient funding limited the expansion of WASH interventions despite significant community needs.

Risk Communication and Community Engagement (RCCE)

Community engagement was central to the response, focusing on combating misinformation and increasing public awareness.

Key results include:

- **6,457,338 people reached** through RCCE activities such as household visits, community meetings, and public sensitization.
- **383,914 households reached** directly with prevention messages.
- **346 interactive radio programs broadcast** through 18 partner community radio stations across 9 provinces.
- **4,835 community feedback reports collected**, with **2,825 addressed and responded to**.
- **3,308 community meetings** organized to inform populations about the response activities.

These activities helped address rumors, misinformation, and community concerns about Mpox and other health issues.

Protection, Gender and Inclusion (PGI)

The response ensured inclusive engagement of vulnerable and marginalized groups.

Key achievements:

- **438,256 vulnerable individuals reached**, including people living with HIV, pregnant women, sex workers, and displaced populations.
- **1,744 volunteers trained** on protection, gender inclusion standards, prevention of sexual exploitation and abuse, and gender-based violence prevention, mitigation and response.
- **3 gender and diversity analysis conducted** in selected branches.

Efforts emphasized equitable access to information and services while strengthening mechanisms for reporting sensitive feedback.

Livelihood Support (Multipurpose Cash Assistance)

Limited livelihood assistance was provided to affected households.

Key results:

- **191 individuals supported** with livelihood assistance.
- **228 households received multipurpose cash support** or alternative livelihood assistance.

Due to security challenges in conflict areas, some provinces opted to distribute food and agricultural inputs instead of cash.

National Society Capacity Strengthening

The operation significantly strengthened the operational capacity of the Red Cross in the DRC.

Key achievements:

- **1,744 volunteers trained and deployed** across multiple provinces.
- **26 Red Cross branches engaged** in Mpox response activities nationwide.
- Development of a **national Mpox training package** and coordination tools for branches.

Capacity-building workshops and harmonization meetings improved response coordination across provinces.

Coordination and Partnerships

The DRC Red Cross worked closely with the Ministry of Health and international partners including IFRC, ICRC, UNICEF, WHO, Africa CDC and others.

Key coordination actions:

- Participation in **32 government coordination meetings**.
- **36 weekly coordination meetings** between IFRC and the Red Cross branches.
- **60 technical sub-commission meetings** on Mpox response.
- Joint field supervision missions and volunteer training sessions.

These mechanisms strengthened collaboration and aligned the response with national health strategies.

Key Operational Challenges

- **Funding gaps**, limiting the scale of activities.
- **Security challenges and armed conflict** affecting access in eastern provinces.
- **Weak health infrastructure** and lack of logistics for case management.
- **Persistent misinformation and community perceptions** around Mpox.



Burundi Red Cross Society



629,103 people reached



981,059 people reached



5,310 peoples reached



321,685 people reached

The response plan was aligned with the National Response Plan and covered an intervention period of 16 months. It prioritized areas where the National Society (NS) required institutional and operational strengthening. Standard Movement guidelines and tools were applied throughout the response. A surge support mechanism was deployed to strengthen the capacities of teams across the 23 targeted health districts. The EpIC training module was used to deliver most of the required training in health, clinical risk analysis, prevention, and response. Resources were allocated to ensure effective data management, information sharing, and coordination for a timely and evidence-based response. The National Society team also coordinated closely with the International Federation of Red Cross and Red Crescent Societies (IFRC) to monitor sub-regional Mpox trends, enabling a comprehensive risk analysis for Burundi. Appropriate measures were taken based on evolving scenarios and the progression of the outbreak.

1) Health: Reducing the Risk of Transmission

- Strengthening community-based surveillance (CBS) and contact tracing: The CBS system, led by the Ministry of Health and national authorities, contributed to reinforcing surveillance at the community level. The Ministry established contact lists, and volunteers conducted follow-up activities based on these lists. In line with the community case definition, volunteers also reported alerts and supported case follow-up in collaboration with health authorities. A total of 2,415 volunteers were trained using the EpIC module (30 volunteers per health district), supervised by a Community Health Centre (CHC) supervisor.

- Safe transport of suspected and confirmed cases: The National Society relied on its extensive volunteer network for early detection and monitoring of suspected and confirmed cases. In addition, the NS deployed its ambulance services to ensure the safe transport of suspected or confirmed patients, accompanied by Ministry of Health medical teams.

Psychosocial support (PSS) and Psychological First Aid (PFA) training was provided over two days to response teams (20 individuals per district).

2) WASH Intervention: Contributing to the Interruption of Disease Transmission

WASH activities aimed to reduce transmission through improved hygiene and sanitation practices:

- Distribution of disinfectants to households reporting suspected or confirmed cases.
- Improvement of access to Water, Sanitation and Hygiene (WASH) facilities through the installation and monitoring of handwashing stations in public spaces, health facilities, and points of entry.
- Deployment of 20 volunteers per district to ensure systematic monitoring of handwashing stations at all entry points in affected districts and to promote hand hygiene practices
- Community hygiene and disinfection support through the distribution of liquid hand soap.
- Hygiene promotion campaigns conducted in markets, schools, and other public spaces, including demonstrations on safe water treatment and proper handwashing techniques.

In this sector, 690 individuals (667 volunteers and 23 supervisors) received three days of training on WASH in emergencies and Infection Prevention and Control (IPC), representing 20 volunteers per district under the supervision of a Community Coordination Centre (CCC) supervisor.

3) Risk Communication and Community Engagement (RCCE)

Community awareness activities were carried out through door-to-door visits by trained volunteers.

Volunteers disseminated key prevention messages aligned with Ministry of Health guidance, focusing on preventive measures and protective behaviors.

Multiple communication channels and audiovisual tools (including radio and IEC materials) were used. A structured feedback mechanism was also implemented to address misinformation, information gaps, rumors, and community concerns.

A total of 2,415 volunteers were trained in RCCE/CEA and Protection, Gender and Inclusion (PGI) principles.

4) Protection, Gender and Inclusion (PGI)

Inclusive, protective, and gender-sensitive approaches were integrated across all activities to ensure equitable and safe assistance for all population groups within targeted communities. The Emergency Appeal planning and design process assessed and mitigated risks related to discrimination and violence, while promoting meaningful participation of all individuals, regardless of gender, age, disability, or background. The intervention ensured that staff and volunteers understood and applied the Minimum Standards on Protection, Gender and Inclusion across activities. Dedicated briefing sessions were organized along the WASH training for NS staff and volunteers to reinforce these standards reaching 690 people.

Performance Overview

Several indicators were significantly exceeded. This was due to the continued implementation of activities beyond the initially planned scope, as well as updates to the response plan in line with the evolving epidemiological situation.

Additional actions were implemented not only in the initially targeted areas but also more broadly across Burundi, contributing to higher-than-anticipated results.

Photos



Distribution of NFI kits in Cibitoke



Cash distribution in Gitega to people affected by Mpox.



South Sudan Red Cross Society



85,701 people reached

The Mpox outbreak in South Sudan was first detected in February 2025, when the first suspected case was reported in Juba city. The outbreak posed a public health concern, particularly in urban and border areas such as Juba and Nimule, where population movement increases the risk of disease transmission. As an auxiliary to the government, the South Sudan Red Cross (SSRC) worked to bridge gaps in the national health system by supporting preparedness and response activities aimed at preventing the spread of Mpox and strengthening community awareness on prevention measures.

Following the outbreak declaration, the International Federation of Red Cross and Red Crescent Societies (IFRC) released CHF 80,000 from the Mpox Fund to support the SSRC response. The funds enabled the rapid mobilization and deployment of 77 trained volunteers in Juba and Nimule to support prevention and community engagement activities. The response focused primarily on risk communication, hygiene promotion, and community awareness, with the distribution of information, education, and communication materials to support prevention efforts.

Through these interventions, the SSRC conducted community outreach, media engagement, and training of volunteers and community leaders. The operation also organized awareness sessions, distributed hygiene materials, and conducted radio talk shows to ensure widespread dissemination of prevention messages and reduce the risk of further transmission.

Summary of the response

Health and Care

Health and care activities focused on strengthening community awareness and promoting preventive behaviors to reduce the spread of Mpox. The South Sudan Red Cross trained **75 volunteers and 17 community leaders** to support community-level response activities. Volunteers conducted **34 awareness sessions in public and social spaces**, ensuring that communities received accurate information about Mpox transmission, symptoms, and prevention. Overall, **85,701 people were reached through awareness activities**, while **12 radio talk shows** were conducted to extend outreach through mass media. The operation also supported preventive health measures by distributing **1,200 information and education materials, 450 boxes of oral rehydration salts (ORS), 130 sanitizers, and 80 face masks** to support hygiene practices and reduce the risk of infection of Mpox and diarrheal diseases.

Water, Sanitation and Hygiene (WASH)

WASH interventions focused on promoting safe hygiene practices and improving community knowledge about disease prevention. SSRC volunteers conducted community awareness sessions emphasizing **safe drinking water, proper use of latrines, and improved hygiene practices** in affected communities in Juba and Nimule. These awareness activities were integrated into broader community outreach initiatives to reinforce behavior change and encourage communities to adopt preventive hygiene practices during the outbreak. The interventions supported efforts to reduce disease transmission and strengthened community resilience against public health threats.

Protection, Gender and Inclusion (PGI)

Protection, Gender, and Inclusion considerations were integrated into the response to ensure that all community members, including vulnerable groups, had access to information and services related to Mpox prevention. Awareness activities targeted communities broadly to ensure equitable dissemination of prevention messages and support community-wide risk reduction. The approach emphasized inclusiveness and respect for human dignity, ensuring that community outreach activities were accessible to different groups regardless of gender, age, or social status. By engaging community leaders and volunteers, the response sought to ensure that prevention messages reached marginalized groups and contributed to equitable health outcomes.

Community Engagement and Accountability (CEA)

Community engagement was a key component of the Mpox response, focusing on strengthening communication between communities and the South Sudan Red Cross. Volunteers conducted community outreach and awareness sessions in social gathering places, ensuring that communities received timely and accurate information about Mpox prevention and response measures. Radio talk shows and community discussions played an important role in reaching large audiences and addressing community concerns about the disease. These platforms allowed community members to ask questions and receive reliable information, thereby improving trust and encouraging adoption of preventive health practices.

National Society Strengthening

The Mpox response contributed to strengthening the operational capacity of the South Sudan Red Cross. Through the operation, volunteers were trained and deployed to support outbreak preparedness and response activities at the community level. The intervention also emphasized capacity development through training, learning-by-doing approaches, and pre-positioning of essential supplies. These efforts improved the National Society's ability to respond rapidly to public health emergencies and strengthened its role as an auxiliary to the government in the health sector.

Coordination and Partnerships

The South Sudan Red Cross maintained close coordination with the **Ministry of Health and partners** through participation in national coordination mechanisms. SSRC actively participated in the **National Mpox and Cholera Taskforce meetings** at the Public Health Emergency Operations Centre (PHEOC), ensuring alignment of activities with national response strategies. In addition, a Movement coordination task force met regularly to share updates and coordinate activities among Red Cross partners. These coordination mechanisms helped avoid duplication of efforts, strengthened collaboration among stakeholders, and ensured a more efficient response to the Mpox outbreak.



Uganda Red Cross Society



3,184,002 people reached



3,365,636 peoples reached



1,345,782 peoples reached



1,345,782 peoples reached

Description of the Mpox epidemic in Uganda

Uganda confirmed its first two Mpox cases on 24 July 2024, both imported from the neighbouring Democratic Republic of Congo, involving women from border communities in Kasese District. The government officially declared an outbreak on 2 August 2024, shortly before the continental and global escalation of the crisis. On 13 August 2024, Africa Centres for Disease Control and Prevention declared Mpox a Public Health Emergency of Continental Security, followed a day later by the World Health Organization declaring a Public Health Emergency of International Concern due to the rapid spread of the disease in the region. Additional cases soon emerged across the country, including a third confirmed case in Mayuge District. By 25 December 2025, Uganda had recorded 8,404 cases and 51 deaths (0.76% case fatality rate), with infections reported in 83% of districts nationwide.

The Greater Kampala Metropolitan Area, including Kampala, Mukono, and Wakiso, accounted for nearly half of all infections, with Kampala recording the highest number of cases. Other heavily affected districts included Mbarara, Masaka, and Hoima. Epidemiological data showed that men accounted for 56.1% of cases, although infections among women were increasing. Young adults aged 19–39 years represented 59% of all cases, making them the most affected group. During the outbreak, Uganda also faced an additional regional threat when Marburg Virus Disease was declared in neighbouring Rwanda in September 2024. To mitigate cross-border transmission, the Ministry of Health introduced screening measures at several points of entry along borders with the DRC and Rwanda. By late 2025, however, the

epidemiological curve had begun to flatten, with declining weekly case numbers and steps underway to integrate Mpox management into routine healthcare services following the lifting of the international emergency status.

The Government of Uganda led the response through the Ministry of Health using an integrated outbreak management approach supported by national and international partners. A National Mpox Preparedness and Response Plan was developed, and an Incident Management System was activated to coordinate response actions. In support of government efforts, the Uganda Red Cross Society, with assistance from the International Federation of Red Cross and Red Crescent Societies, implemented interventions in several high-risk districts, including Wakiso, Mayuge, Kampala, Jinja, and Mbarara. Activities focused on risk communication and community engagement, community-based surveillance, ambulance services, and coordination with response partners, while screening for Mpox and Marburg Virus Disease was also conducted at key border points of entry. These actions aimed to strengthen early detection, increase community awareness, and support national efforts to control transmission and reduce the social and economic impacts of the outbreak.

Summary of the response

Coordination:

URCS participated in weekly National Task Force meetings organized by the MoH, response pillar meetings (RCCE and surveillance) and District Task Force meetings. This ensured that URCS operations were aligned with the national response plan and accounted for the different needs of the districts.

Risk Communication and Community Engagement (RCCE)

- URCS trained and deployed 239 volunteers to conduct risk communication at the community level through household visits, engaging special groups such as market vendors, transporters (boda-boda riders, truck drivers), casual labourers in informal industrial areas and commercial sex workers. Volunteers also engaged communities through organised group information sessions at places of prayer, schools, and during end-of-year festivities. URCS also used community drives to sensitise communities on Mpox.
- The trained community volunteers reached 61,138 households, and 17,150 group sessions were organized.
- 269,012 people reached through household visits, while 1,345,782 were reached through group information sessions.
- At the 7 Points of Entry (PoEs) 931,419 travellers and local people were reached with health messages, educating them about Mpox and Marburg Virus Disease (MVD). Among those sensitized, 58% were female travellers
- More than 623 schools were reached out to and engaged 544,617 learners (253,801 males, 290,816 females) using the MoH operational guidelines for prevention and control of Mpox in learning institutions. Key focus areas included enhancing school hygiene practices, reducing physical contact and establishing referral systems for suspected cases to nearby health facilities.
- URCS also used other means, such as IEC posters hung in communities, distribution of flyers, among others.

Surveillance (Community-Based Surveillance and Screening at points of entry)

- The trained community volunteers were tasked to work with their communities in identifying community members who present with signs and symptoms similar to Mpox and notify the relevant authorities.
- URCS supported operationalizing of the alert management desk in Wakiso District, and this was through allocating 2 volunteers to manage the district toll-free desk phone. The volunteers received calls from communities about suspected cases, which were forwarded to the District Surveillance Focal Person (DSFP) for follow-up. 248 alerts were received through the alert management desk and 60% were followed up to conclusion
- Of the 239 volunteers, 34 volunteers (25M, 09F) were deployed at seven points of entry to support screening of travellers for Mpox and MVD (during the MVD outbreak period in Rwanda).

- 931,419 people were screened for MVD and Mpox at the seven points of entry in southwestern Uganda. These include inbound travellers, outbound travellers and local people. 57% (n=530,909) were females.

Stakeholder Engagement

- URCS supported district education and health authorities to engage school heads and teachers from Mpox hot spots on how to keep their learners safe. 1,350 teachers (945 males, 405 females) were sensitized on Mpox prevention in schools. These were taken through the MoH operational guidelines for prevention and control of Mpox in learning institutions
- URCS, together with health authorities, engaged 540 religious and community leaders (432M, 108F) and oriented them on Mpox transmission and prevention. These were requested to use their positions of authority and influence to create more awareness about Mpox and encourage community members to report any suspected cases and seek medical care from health facilities.
- URCS, together with health authorities, organised special sessions with groups of people identified as high risk, such as commercial sex workers, market vendors, transporters (including taxi drivers, truck drivers and boda-boda riders). These were taken through the basic facts on Mpox, the risk they face considering their occupation and how they can mitigate the risks to avoid getting infected. 1,191 tax and truck drivers, 18,410 boda-boda riders and 245 commercial sex workers were engaged.

Case Management

- URCS deployed 09 ambulances across different regions to support health authorities in the evacuation of suspected community cases. 3 ambulances were stationed in Kampala to support Kampala Metropolitan Area (includes Kampala city, Wakiso district and Mukono District), 1 in Mbarara, 1 in Luwero, 1 in Jinja, 1 in Soroti, 1 in Masaka and 1 in Nebbi.
- During the reporting period, 803 evacuation requests were received by URCS, with 785 completed (98% fulfilment rate). Eighteen requests were declined either because cases didn't meet the set criteria for evacuation or due to patient refusal to be evacuated (notably in Mbarara City)
- Of all evacuated cases, 85% (n=667) were laboratory-confirmed Mpox cases. Notably, 81% (n=636) of total evacuations were conducted within Kampala Metropolitan Area (KMA) during the reporting period.
- Analysis of evacuated patients revealed a gender disparity (57% male vs. 43% female), with young adults (18-30 years) representing the most affected age group at 51% (n=400) of total evacuations.

Mpox Vaccination

Using community structures (volunteers and VHTs), URCS supported Mpox vaccination in Wakiso district through mobilization of key populations at high risk. Initially, 70,000 doses were allocated in the first phase of vaccination, and 65% of the doses were used. During the second campaign, more than 1,300 high-risk individuals, including sex workers, fishermen, and timber workers, received vaccination against Mpox on the islands of Bussi and Zzinga in Wakiso district.

Photos:



A mobile drive sensitizing communities on Mpx in Wakiso T/C, Wakiso District and a URCS volunteer engaging learners on Mpx at Community Model Primary School Mende S/C-Wakiso District



URCS volunteers engaging boda boda and truck drivers in Mayuge District



Rwanda Red Cross Society



1,162,269 people reached



1,146,394 people reached



3,500 peoples reached



1,162,269 people reached

In August 2024, the Director-General of the World Health Organization declared the resurgence of Mpox a Public Health Emergency of International Concern (PHEIC), following a significant increase in cases in the Democratic Republic of the Congo (DRC) and neighbouring countries. The outbreak was characterized by the emergence of a new Clade 1b variant demonstrating sustained human-to-human transmission and increased cross-border spread. Rwanda, due to its geographic proximity to affected countries and its extensive cross-border mobility, trade routes, tourism activities, and informal border crossings, faced an elevated risk of Mpox importation. Border districts in the Eastern and Northern Provinces were particularly vulnerable, given their shared borders with Uganda, Tanzania, and Burundi, as well as high population density and active commercial corridors. Although national surveillance systems remained operational, the need to strengthen decentralized preparedness, early detection, community-based surveillance, and coordination mechanisms was identified as critical to prevent potential outbreaks and ensure rapid containment.

Health & Care

Health interventions focused on strengthening community epidemic preparedness and response capacity through the establishment of decentralized Joint Emergency Operations Teams (JEOTs). The Rwanda Red Cross successfully established 184 sector-level JEOTs and 12 district JEOTs across the Eastern and Northern Provinces and trained 1,176 JEOT members. These teams were equipped with knowledge on Mpox and Marburg transmission, prevention measures, early detection, community-based surveillance, and risk communication. The initiative strengthened collaboration with district health authorities and created a decentralized response structure capable of improving early detection and coordinated reporting at the community level. Despite logistical challenges such as geographic dispersion and limited time for simulation exercises, the operation demonstrated that decentralized training and gender-inclusive emergency committees improve local ownership, sustainability, and community trust in outbreak response mechanisms.

Water, Sanitation and Hygiene (WASH)

WASH interventions focused on strengthening infection prevention and hygiene awareness in all targeted sectors through training and community outreach activities. A total of 1,176 JEOT members were trained on infection prevention and control (IPC), with 100% demonstrating adequate knowledge during post-training validation. Hygiene awareness activities emphasized safe water handling, handwashing practices, and environmental sanitation as key measures for preventing infectious disease transmission. Volunteers conducted household visits, demonstrations, and community awareness sessions on water treatment methods, safe storage, waste disposal, and critical handwashing practices. While behavior change was strengthened, implementation faced challenges such as limited water access, inconsistent availability of treatment supplies, and cultural habits affecting hygiene practices. Lessons highlighted the importance of practical demonstrations, volunteer engagement, and continuous follow-up to sustain community hygiene behavior change.

Protection, Gender and Inclusion (PGI)

Protection, Gender and Inclusion considerations were integrated to ensure equitable participation and access to preparedness activities, with women representing 52% of members in JEOT committees, exceeding the 30% target. Community outreach activities identified vulnerable groups, including elderly persons living alone, persons with disabilities, women-headed households, low-income families, cross-border traders, and children at higher exposure risk. Volunteers conducted sensitization sessions addressing stigma, misinformation, and equitable access to prevention services while engaging community leaders to promote inclusive participation. Despite challenges such as misinformation, cultural norms, and socio-economic barriers, the intervention demonstrated that targeted messaging, community leadership engagement, and decentralized response structures significantly improve inclusion and trust in public health preparedness initiatives.

Community Engagement and Accountability (CEA)

Community Engagement and Accountability efforts focused on strengthening two-way communication between communities and response actors to improve epidemic preparedness. A total of 1,176 JEOT members were oriented on community-based surveillance and reporting mechanisms, and all 12 targeted districts established structured communication and reporting channels, ensuring effective information flow between communities and authorities. Through community dialogues, household visits, and awareness sessions, volunteers provided prevention information while collecting community feedback and concerns. Although misinformation, stigma, and communication barriers in remote areas posed challenges, the approach improved community trust, increased participation in prevention measures, and strengthened early reporting of suspected cases. Continuous dialogue, accessible feedback mechanisms, and inclusive engagement were identified as key to sustaining community cooperation.

National Society Strengthening

The Mpx response significantly strengthened the institutional capacity of the Rwanda Red Cross Society, particularly at decentralized levels. The operation established 196 emergency structures and engaged 1,176 volunteers within JEOT frameworks across targeted districts, ensuring that all 12 districts had functional emergency response teams. These structures improved coordination with local authorities, strengthened supervision and reporting systems, and enhanced volunteer skills in surveillance, hygiene promotion, and risk communication. While challenges included limited resources at the branch level and volunteer turnover, the intervention demonstrated that decentralized emergency structures and continuous capacity building are critical for improving preparedness and rapid response to public health emergencies.

Coordination and Partnerships

Coordination efforts focused on strengthening collaboration between the Rwanda Red Cross, district authorities, and health institutions. JEOTs served as coordination platforms bringing together volunteers, district officials, and health experts to facilitate information sharing, harmonized planning, and coordinated outbreak response across 12 districts. Regular coordination meetings improved alignment of activities and ensured consistent messaging on prevention measures. Although challenges such as overlapping roles, reporting differences, and logistical constraints occasionally affected efficiency, the response highlighted the importance of clearly defined responsibilities, standardized reporting tools, and strong engagement with local authorities to improve operational effectiveness.



Gabon Red Cross Society



5,546 people reached



5,032 peoples reached



8,094 people reached

The Mpx virus, a zoonotic disease endemic to several Central and West African countries, including Gabon, has seen numerous outbreaks in recent years. On August 22, 2024, the Gabonese government officially declared an Mpx outbreak after identifying six suspected cases and one confirmed case in two provinces: Estuaire and Moyen-Ogooué. Between September and December 2024, the situation evolved toward increased surveillance, with the

number of confirmed cases remaining limited, but suspected cases being closely monitored by the Response Operations Centre. Although the risk of community transmission remained under control, the persistent threat at the borders with Cameroon and the Democratic Republic of the Congo required maintaining a high alert level, prioritizing densely populated urban areas such as Libreville and vulnerable populations such as healthcare workers and children under five. The Gabonese Red Cross (GRC), as a support to public authorities, actively supported the government's efforts to limit the spread of the virus. The Gabonese Red Cross (GRC) activated its response plan to support the government's efforts, focusing on CERC (Community Engagement and Risk Communication), health promotion, isolation and treatment of identified cases, contact tracing, and awareness-raising within affected communities.

The Gabonese Red Cross (GRC), acting as an auxiliary to public authorities, deployed a multidimensional response focused on prevention and early detection. With the mobilization of over 100 volunteers, the GRC conducted intensive awareness campaigns (door-to-door, radio, social media) to combat misinformation and established a community-based surveillance (CBS) system in high-risk areas such as Estuaire and Moyen-Ogooué. On the technical side, the GRC strengthened hygiene measures through community awareness sessions and public handwashing demonstrations, and trained its teams in psychological first aid, thus ensuring a reassuring and effective presence among vulnerable populations.

This intervention was made possible thanks to close coordination with the International Federation of Red Cross and Red Crescent Societies (IFRC), which provided the necessary financial (CHF 150,000), technical, and logistical support, including the deployment of specialized personnel. At the same time, the Gabonese government, through the Ministry of Health and the operations centre, ensured the strategic direction of the national response and clinical care. This synergy between Movement actors and institutional partners (such as WHO and UNICEF) made it possible to contain the outbreak, improve surveillance at points of entry, and stabilize the humanitarian situation despite the coordination challenges encountered on the ground.

Summary of the response

Health & Care

Health and care interventions focused on **mitigating the spread of Mpox through community health promotion, surveillance, and capacity building**. The Gabonese Red Cross trained **100 volunteers in epidemic control** and conducted extensive awareness activities that reached **5,546 people** with health promotion messages on Mpox prevention and care. The operation included EPIC Training of Trainers for **34 participants** from the Red Cross, Ministry of Health, civil society organizations, and community representatives, ensuring broader institutional preparedness. Additional capacity-building activities included **community-based surveillance (CBS) training for trainers and volunteers**, enabling early detection and referral of infectious diseases. Psychosocial preparedness was also strengthened through **Psychological First Aid training for 20 volunteers** and the establishment of the **Henri Dunant Psychosocial Listening and Support Centre**. Despite operational challenges such as tight stakeholder schedules and electricity outages affecting communication, the interventions significantly improved the National Society's preparedness and community-level epidemic response capacity.

Water, Sanitation and Hygiene (WASH)

WASH activities focused on strengthening **hygiene awareness and infection prevention practices** within communities. Volunteers conducted awareness campaigns in several locations, including **Akanda, Owendo, Libreville, Moyen-Ogooué, and Haut-Ogooué**, reaching **5,032 people** with hand hygiene demonstrations and

prevention messages. The activities emphasized practical handwashing techniques, safe water handling, and environmental hygiene to reduce the risk of disease transmission. Educational conferences were also conducted in schools, reaching **1,252 students** with demonstrations and information on Mpox prevention and hygiene practices. The interventions were supported by the distribution of hygiene materials such as **soap, sanitizers, buckets, and personal protective equipment**, which helped reinforce practical behavior change. These activities improved community awareness and strengthened preventive hygiene practices in targeted areas.

Protection, Gender and Inclusion (PGI)

Protection, Gender, and Inclusion principles were integrated across all response activities to ensure **equitable access to information and services for vulnerable groups**. Through awareness sessions, school campaigns, and community outreach, the operation ensured that marginalized groups were included in preparedness activities. Special attention was given to vulnerable populations such as **persons with disabilities, pregnant women, elderly people, and children (5,546)**, who were specifically targeted during awareness campaigns and school-based sessions. Radio programs addressing Mpox risks among pregnant women and other vulnerable groups further expanded outreach. These efforts helped reduce barriers to accessing information and promoted inclusive participation in prevention activities.



Awareness for a person with a disability, CRG



Awareness targeting young women, CRG

Community Engagement and Accountability (CEA)

Community engagement activities focused on strengthening **risk communication, community-based surveillance, and public awareness**. A total of **100 volunteers and 9 supervisors** were deployed across eight districts in Greater Libreville to conduct door-to-door visits, group discussions, and awareness sessions. Through these interventions, **8,094 people** were reached with Mpox prevention messages. Communication strategies also included **radio broadcasts, educational school conferences, digital awareness campaigns, and community dialogues**, which helped broaden outreach and address misinformation. Short educational videos (<https://fb.watch/vrglkweqT9/?mibextid=rS40aB7S9Ucbxw6v>) were disseminated through social media and messaging platforms, while **212 pieces of community feedback** were collected and analysed to inform response strategies. Despite challenges such as delayed materials, insufficient volunteers, and context-specific

communication barriers, the initiative strengthened community awareness and engagement in Mpox prevention efforts.



Awareness sessions through the radio, GRC

National Society Strengthening

The Mpox response contributed significantly to **strengthening the operational and technical capacity of the Gabonese Red Cross**. Staff and volunteers benefited from specialized training programs including **EPIC epidemic response training, community-based surveillance training, and psychological first aid**, improving preparedness for future health emergencies. Operational coordination and field support were also strengthened through improved monitoring, supervision, and reporting mechanisms at branch level. The operation further enhanced logistical capacity through the provision of a **Toyota Land Cruiser** by the IFRC, improving mobility and enabling more efficient field deployment of response teams.

Coordination and Partnerships

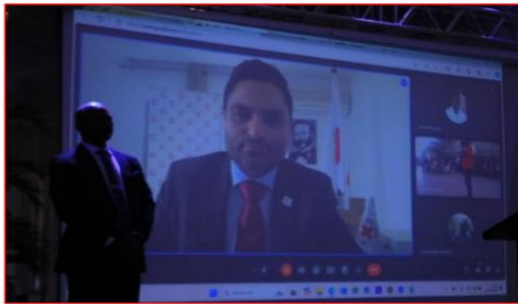
Coordination efforts involved close collaboration between the **Gabonese Red Cross, the Ministry of Health, and international partners** to support national Mpox preparedness and response. The launch of the Mpox appeal brought together more than **80 stakeholders**, including government ministries, civil society organizations, international partners, and diplomatic representatives, to align strategies and mobilize support. Throughout the response, regular coordination meetings were held with national health authorities and partners to review progress, coordinate resources, and harmonize communication strategies. A **lessons-learned workshop** was also organized to review the response and identify improvements for future operations. While coordination challenges with local actors and media were noted, the operation highlighted the importance of clear role definition, stakeholder mapping, and strengthened communication mechanisms for effective epidemic response.



Speech by the National President of the CRG



Speech by the Minister of Health



Speech by Head of IFRC delegation



Family photo

Official launch ceremony chaired by the president of the GRC



Cameroon Red Cross Society



33,967 people reached



12,533 peoples reached



12,533 people reached

The Mpox virus, a zoonotic disease endemic to several Central and West African countries, including Cameroon, has seen numerous outbreaks in recent years. Between January 1, 2024, and January 16, 2025, Cameroon reported 126 suspected Mpox cases, with 114 samples collected (90.5%). Among these, 12 cases were confirmed (10.5%), including one in a monkey in Mefou Park, Mfou Health District, Centre Region (reported on November 27, 2024). Two deaths were recorded among confirmed cases, resulting in a case fatality rate of 16.7%. Additionally, 32 cases of chickenpox (25.4% of suspected cases) were confirmed, with no Mpox-VZV co-infections (Sitrep Mpox No. 6).

The epidemic spread across four regions: Littoral, Northwest, Southwest, and Centre. Young adults aged 20 to 24 were the most affected population, with a marked male predominance (sex ratio of 7 men to 2 women).

Managing this crisis was complex due to the simultaneous identification of virus clades I and II in the territory, as well as the co-circulation of chickenpox, which accounted for 25.4% of suspected cases during the period.

The proximity to the Democratic Republic of Congo (DRC), the epicentre of a new strain, made it an international public health emergency in 2024 by significantly increasing the risks of cross-border transmission

To strengthen Cameroon's preparedness, the International Federation of Red Cross and Red Crescent Societies (IFRC) launched an emergency appeal in August 2024, enabling the Cameroon Red Cross (CRC) to support health authorities in the response, which included training CRC staff and volunteers in community-based surveillance (CBS), essential for the early detection of cases within at-risk communities.

Summary of the Response

Health & Care

The Cameroon Red Cross supported Mpox prevention through community health promotion and strengthened surveillance systems, reaching 33,967 people with Mpox prevention and care information. Awareness sessions were conducted in communities and schools to improve knowledge of transmission, symptoms, and preventive measures. Capacity building was a major component of the response. A Training of Trainers on Community-Based Surveillance (CBS) was conducted for 20 participants, followed by training of 90 volunteers and 9 supervisors across several regions. Through community monitoring, 99 Mpox alerts were reported and 88 referred to the Ministry of Health, supporting early detection. Challenges included weather disruptions, logistical constraints, and difficulties using the digital reporting platform.

Water, Sanitation and Hygiene (WASH)

WASH interventions focused on promoting hygiene practices to reduce disease transmission through community demonstrations and public awareness activities. Volunteers conducted handwashing demonstrations and hygiene promotion sessions in public gathering places such as markets, schools, transport stations, and places of worship. To reinforce behavior change, 50 handwashing stations were installed in targeted localities and regularly maintained by volunteers. In addition, 178 hygiene kits were distributed, including 49 kits to schools and 129 kits to vulnerable households, helping strengthen hygiene practices at both institutional and household levels.

Protection, Gender and Inclusion (PGI)

PGI considerations were integrated across all activities to ensure inclusive access to information and services. Awareness sessions are specifically targeted vulnerable groups, including women, children, and persons with disabilities. Through these efforts, 12,533 people were reached with PGI-sensitive Mpox awareness messages. These activities helped ensure that at-risk populations were included in prevention efforts and had access to essential health information.

Community Engagement and Accountability (CEA)

Community engagement activities were central to the response, with 99 trained volunteers deployed across seven departments to conduct awareness campaigns. Activities included community meetings, mobile cinema

sessions, and localized outreach in markets, schools, churches, and mosques. Overall, 12,533 people were reached with Mpox awareness messages. Communication materials were developed through a national stakeholder workshop, and 350 pieces of community feedback were collected and analysed to address concerns and misinformation about Mpox.



Awareness campaign in a public school in Ambam, CRC



Community Mpox awareness in Golombe, CRC

National Society Strengthening

The operation strengthened the institutional capacity of the Cameroon Red Cross to respond to epidemics. Fourteen staff members were trained as CBS trainers, who subsequently trained volunteers and supervisors in high-risk regions. Additional capacity building included operational research training for 18 staff, enhancing skills in data collection and analysis during health emergencies. The National Society also received two vehicles to support field operations and response activities.

Coordination and Partnerships

The Cameroon Red Cross worked closely with the Ministry of Health and IFRC through the national Incident Management System (IMS), participating in regular coordination meetings to support the Mpox response. The official launch of the Mpox Emergency Appeal in September 2024 brought together national and regional stakeholders to strengthen collaboration and coordination. Leadership engagement, including field missions by the National Society's leadership, helped maintain strong volunteer motivation and partnership coordination throughout the response.



CAR Red Cross Society



11,336 peoples reached



11,336 peoples reached



11,336 peoples reached

Socio-economic protection

In the Central African Republic (CAR), the NS worked to ensure that individuals affected by Mpox were not only medically cared for but also supported with dignity and socio-economic protection during their treatment. At the Mbaïki District Hospital, where a treatment center was established, **15 confirmed patients and 26 suspected cases benefited from daily food and nutritional support over 35 days.** This intervention was essential in ensuring that patients, already burdened by illness and isolation, did not face additional hardships related to nutrition or food security.

Beyond medical and nutritional support, the CAR Red Cross emphasized protecting the dignity and well-being of those affected. A total of **30 dignity kits**, equally distributed between 15 men and 15 women, were provided to patients and suspected cases. These kits included essential hygiene and personal care items, helping individuals maintain a sense of dignity and normalcy during treatment.

Health and care, including psychosocial support and RCCE

CAR RC, in collaboration with the Ministry of Health, placed strong emphasis on building community and institutional capacity to prevent, detect, and respond to Mpox. As part of this, **349 teachers were trained and subsequently briefed their students on Mpox prevention and safe practices.** In parallel, **150 Community Health Workers (CHWs) were trained and actively engaged** in delivering awareness sessions on hand hygiene, RCCE and community-based surveillance. These CHWs also played a vital role in mobilizing communities for vaccination, conducting contact tracing, and referring suspected cases to appropriate care centers.



Preparing trained CHWs before going out into the field for CBS by the MoH

Recognizing the psychological toll of the outbreak, the National Society established an equipped psychosocial first aid room within the country's only Mpox treatment center. To ensure quality services, four trained Red Cross volunteers and one supervisor provided psychosocial first aid to patients and families. During the reporting period, **eight individuals (four men, three women, and one girl) were directly reached with psychosocial care**, helping them to cope with stress, stigma, and anxiety linked to the outbreak. In addition, **20 health personnel received training** in safety and psychosocial support, further strengthening the capacity of the health system to provide holistic care.

This integrated approach, combining prevention, community mobilization, surveillance, and psychosocial care, ensured that Mpox-affected populations in CAR received both medical and emotional support. By engaging teachers, health workers, and volunteers, the Red Cross helped embed lasting knowledge and practices at the community level, strengthening resilience and safeguarding dignity during the outbreak response.



Training participants pose for a group photo



Visit to the Isolation centre in CAR by IFRC and NS leadership

WASH

To strengthen infection prevention and control within the Mpox response, targeted rehabilitation works were carried out at the Mbaiki District Hospital. Specifically, **one (1) toilet block at the case management center was rehabilitated**, providing improved sanitation facilities for patients, caregivers, and health staff. This intervention was guided by the Ministry of Public Health (MSP) and aligned with national standards, ensuring that the rehabilitated facility not only met immediate outbreak response needs but also contributed to sustainable hygiene infrastructure at the hospital.

Additionally, a team of **12 volunteers/hygienists were trained on essential disinfection and sanitation (EDS) procedures and deployed** to provide daily hygiene management within the care center. Their work included regular cleaning and disinfection of patient areas, safe waste disposal, and sensitization of patients and visitors on basic hygiene practices. By reinforcing both the physical infrastructure and human resource capacity, these actions created a safer environment for case management and reduced the risk of secondary infections within the health facility.

PGI

The CAR RC prioritized protection and inclusion as part of the Mpox response, ensuring that interventions upheld dignity, access, participation and safety, and reached marginalized groups with interventions based on their need. A total of **348 National Society staff and volunteers were trained in PGI Minimum Standards**, with a strong focus on Protection from Sexual Exploitation and Abuse (PSEA), child protection, and Sexual and Gender-Based Violence (SGBV). These trainings enhanced the capacity of frontline responders to deliver assistance safely and responsibly, while also reinforcing accountability within the operation.

In addition to capacity building, the NS carried out awareness-raising activities targeting **indigenous Aka/Pygmy populations living in forested areas**, communities often underserved and at higher risk of exclusion during crises. By tailoring outreach to these groups, the National Society helped ensure that vulnerable populations had access to timely, accurate information and were not left behind in the response.

CEA

The NS reached **11,336 people** through CEA activities, ensuring communities were informed, involved, and able to share their concerns. This included training 150 community health workers and Red Cross volunteers on CEA approaches and rolling out RCCE activities that reached 30,089 people with accurate, timely information on Mpox. A Community Feedback Mechanism was established, enabling the collection and processing of feedback from **4,532 households**. Feedback collected ranged from questions, beliefs, and rumors to thanks, suggestions, and requests, helping the Red Cross and partners adapt programming to community needs and strengthen trust in the response.



Kenya Red Cross Society



967,736 people reached



651,946 peoples reached



3,088 peoples reached



967,736 peoples reached

Executive summary

The Mpox outbreak in Kenya was declared on 31 July 2024 following the detection of an imported index case at the Taveta border with Uganda, highlighting the role of cross-border transmission in the spread of the disease. As of 30 January 2026, a total of 994 confirmed cases and 15 deaths had been reported across 38 of 47 counties, with the highest burden observed in urban and transit hubs such as Mombasa and Nairobi. The outbreak affected both men and women almost equally, with the majority of cases linked to local transmission, though some were associated with travel history to neighbouring countries. High population mobility, particularly along border areas and transport corridors, contributed significantly to the geographic spread of the disease.

In response, the Kenya Red Cross Society implemented a comprehensive, multi-sectoral intervention aligned with government efforts, focusing on surveillance, risk communication, vaccination, hygiene promotion, and coordination. The response significantly strengthened early detection and prevention measures, including the screening travellers' during the operation at 26 points of entry. Community engagement efforts reached over 900,000 people—more than double the initial target—while vaccination campaigns surpassed expectations, with over 10,600 individuals vaccinated. Complementary interventions such as contact tracing, hygiene promotion, and volunteer training further contributed to reducing transmission risks and improving community awareness.

Despite these achievements, the operation faced several contextual and operational challenges, including high cross-border mobility, porous entry points, misinformation and vaccine hesitancy, and initial resource gaps due to the rapid expansion of cases beyond targeted areas. These challenges were mitigated through strengthened coordination with the Ministry of Health and partners, expansion of community-based surveillance and RCCE activities, and increased support from partners such as the Norwegian Red Cross. Adaptive strategies, including intensified community engagement, mobile outreach, and cross-border collaboration, enabled KRCS to scale up interventions, address misinformation, and maintain an effective and coordinated response to the evolving outbreak.

Health and care

The Kenya Red Cross Society played a pivotal role in strengthening border health surveillance, community engagement, and early detection systems during the Mpox response. Travelers were screened across 26 Points of Entry, significantly reducing the risk of cross-border transmission. At the community level, KRCS reached more than 900,000 people through Risk Communication and Community Engagement (RCCE) activities, including household visits, school outreach, and media campaigns. These efforts were further expanded through additional partner support, enabling wider geographic coverage and improved public awareness. Complementing this, the Community-Based Surveillance (CBS) system facilitated the reporting of 576 alerts, strengthening early detection and linking communities with health authorities through trained volunteers. KRCS also supported vaccination, contact tracing, and public awareness interventions, contributing to effective outbreak control. A total of 10,697 people were vaccinated, exceeding targets, due to strong community mobilization and improved trust driven by consistent engagement efforts. Contact tracing identified 512 contacts, the majority of whom completed follow-up, enabling timely case detection and interruption of transmission chains. Distribution of information materials and targeted engagement with key influencers such as transport workers, religious leaders, and school authorities further enhanced community acceptance of preventive measures.

Key lessons highlighted the effectiveness of door-to-door engagement, the importance of trusted community leaders in addressing misinformation, and the critical role of CBS in ensuring timely and efficient outbreak response at the community level.

Water, Sanitation and Hygiene (WASH)

KRCS significantly strengthened hygiene promotion and sanitation practices as part of the Mpox response, reaching 651,946 people across nine counties through targeted interventions focused on handwashing, safe water handling, environmental sanitation, and early health-seeking behaviours, particularly in high-risk border and transit communities. To reinforce infection prevention and control measures, KRCS installed 98 handwashing facilities at strategic locations such as border entry points and health facilities and distributed over 1,500 bars of soap to support sustained hygiene practices at community and household levels. Additionally, 238 volunteers were trained in hygiene promotion, equipping them to conduct community outreach, demonstrations, and sensitization activities along high-mobility corridors.

Integrating hygiene promotion into broader RCCE and border screening efforts proved highly effective in expanding outreach, improving message consistency, and driving sustained behaviour change. Continuous engagement, combined with tailored messaging delivered through trusted community structures, helped reduce misinformation, enhance acceptance of preventive measures, and strengthen timely health-seeking behaviours, highlighting the critical role of context-specific hygiene interventions in outbreak response.

RCCE/CEA

The KRCS implemented a comprehensive Risk Communication and Community Engagement (RCCE) strategy that reached over 900,000 people across 26 counties, significantly surpassing initial targets due to expanded support from the Norwegian Red Cross. Using a multi-channel approach, including community forums, door-to-door outreach, school sessions, and mass media, KRCS effectively increased public awareness, promoted preventive behaviours, and strengthened early reporting of suspected cases. Capacity building of 1,112 staff and volunteers ensured consistent and accurate messaging, enhancing community trust and the overall quality of outreach. In parallel, KRCS strengthened accountability through robust Community Engagement and Accountability (CEA) mechanisms, collecting and responding to community feedback via hotlines, radio platforms, and structured dialogue forums.

Regular community review meetings and volunteer feedback sessions enabled adaptive programming, while collaboration with the Ministry of Health and partners supported continuous learning through intra-action reviews. These efforts collectively improved community understanding, addressed misinformation, and reinforced a responsive, community-centred approach to controlling the Mpox outbreak.

PGI

KRCS systematically integrated Protection, Gender, and Inclusion (PGI) into the Mpox response by building the capacity of 271 staff and volunteers on safeguarding, Prevention of Sexual Exploitation and Abuse (PSEA), and inclusive programming to ensure safe, equitable, and accessible services for vulnerable populations. This was complemented by targeted community-level interventions, including psychosocial support and PGI sessions in Busia County, peer-to-peer engagement with high-risk groups such as sex workers and lodging attendants, and the sensitization of 52 community leaders across multiple counties, which strengthened community trust, facilitated local entry, and supported the cascading of accurate Mpox prevention information. These efforts enhanced accountability to affected populations and ensured that interventions were responsive to the needs of women, men, children, and persons with disabilities.

Key lessons highlighted that early and consistent integration of PGI is critical in public health emergencies, as it strengthens safeguarding, improves service quality, reduces exclusion risks, and reinforces community trust, ultimately contributing to a more effective and inclusive outbreak response.

Coordination

The Kenya Red Cross Society ensured a well-coordinated and government-aligned Mpox response through strong engagement at national, county, and cross-border levels. Early in the response, KRCS convened inception meetings with County Health Management Teams across high-burden counties to secure buy-in, clarify roles, and align interventions with local priorities, thereby strengthening ownership and integration within government-led frameworks. At the national level, KRCS actively participated in the Ministry of Health's Incident Management System (IMS) and contributed to strategic discussions, including the IFRC Mid-Term Review, while also engaging in over 30 coordination meetings with partners such as WHO to harmonize approaches, share information, and align technical guidance. Regular review meetings at the sub-national level and weekly RCCE coordination sessions ensured continuous monitoring, adaptive implementation, and consistent community messaging. Additionally, KRCS strengthened cross-border collaboration with Uganda through targeted coordination meetings, enhancing surveillance, information sharing, and joint response efforts at key border points, thereby reinforcing a cohesive and effective regional response.

Gallery of Mpox response interventions in Kenya



Sensitization of trackers at the Malaba One stop border point on March 2025



KRCS Volunteer sensitizing community members on Mpox in Turkana County on May 2025



Mpox sensitization to traders at Kamukunji Market in Nairobi county on June 2025



KRCS Volunteer conducting MPOX sensitization in Busia County on June 2025



Hygiene promotion during Mpox sensitization in Kisumu County on April 2025



Mpox screening at the Busia cross-border point on January 2025



Tanzania Red Cross Society



1,527,513 people reached



1,527,513 people reached



23,695 people reached



1,527,513 people reached

The Mpox outbreak in Africa escalated significantly in 2024, with over 17,000 cases and 500 deaths reported across 12 countries, marking a sharp increase compared to the previous year. The Democratic Republic of the Congo remained the epicentre, accounting for the vast majority of cases, while cross-border transmission expanded into neighbouring countries, including Uganda, Rwanda, Burundi, and Kenya, increasing regional risk. The simultaneous circulation of multiple viral clades, including the more severe and highly transmissible variants, created an unprecedented and complex epidemiological situation. As a result, continental and global health authorities declared Mpox a public health emergency, prompting countries such as Tanzania to activate preparedness and response plans amid growing risk driven by population mobility, urban density, and low risk perception. By mid-2025, Tanzania had reported confirmed cases and widespread exposure risks, particularly in urban and border regions, underscoring the need for early, coordinated intervention.

In response, the Tanzania Red Cross Society (TRCS), in support of the Ministry of Health, implemented a multi-sectoral preparedness and response strategy across 10 regions, focusing on community engagement, surveillance, WASH, mental health, and protection. A total of 330 volunteers were trained to support epidemic response activities, including health promotion, community-based surveillance, and risk communication through diverse channels such as media campaigns, community outreach, and mobile engagement. The response prioritized vulnerable populations and strengthened feedback and accountability mechanisms, including community dialogue platforms and planned hotline systems. Despite operational challenges such as stigma, misinformation, funding constraints, and volunteer fatigue, TRCS adapted through targeted interventions, strong coordination with government and partners, and prioritization of high-risk areas. This approach ensured a responsive, community-centred strategy that enhanced early detection, reduced transmission risks, and strengthened resilience in affected communities.

Health & Care (Community Health, RCCE, MHPSS):

The operation strengthened community health outcomes through large-scale epidemic preparedness and risk communication, reaching **1,527,513 people** (454,432 adult females, 305,329 girls, 488,208 adult males, 279,544 boys) across 10 regions. A total of **330 volunteers were trained and deployed** (target achieved) to deliver integrated health promotion and RCCE interventions, supported by **32 refugee-based sessions, 60 cinema outreaches, 10 radio and TV broadcasts, and 10 public address vehicles**, all meeting planned targets. Behaviour change was reinforced through the distribution of **10,000 IEC materials**, while MHPSS messaging was mainstreamed to address stigma and fear. Despite challenges related to misinformation, logistics, and volunteer sustainability, the intervention demonstrated that combining community-based engagement with mass communication significantly improves reach, trust, and health-seeking behaviour.

Protection, Gender and Inclusion (PGI):

The PGI component ensured inclusive, safe, and accountable programming, reaching **23,695 vulnerable individuals** (7,152 adult females, 4,214 girls, 8,497 adult males, 3,832 boys) through targeted protection mainstreaming. A total of **50 volunteers were trained** on PGI, safeguarding, and PSEA (100% of target), while **5,000 PGI Minimum Standards materials** were produced and distributed to institutionalize protection principles across all operational areas. This strengthened identification and referral of protection risks, reinforced accountability, and ensured adherence to safeguarding standards, including mandatory code of conduct compliance. While stigma, limited community awareness, and resource constraints posed challenges, early integration of PGI and sustained community engagement proved critical support in enhancing trust, reducing discrimination, and improving protection outcomes.

Community Engagement and Accountability (CEA):

CEA efforts focused on strengthening community trust, adaptive communication, and accountability systems through a coordinated, multi-channel approach. A **standardized multimedia SBC package** was developed and adopted (100% achievement), supported by **12 months of engagement with community influencers**, which significantly improved message credibility and uptake. Operational capacity was reinforced through the deployment of **2 CEA volunteers at headquarters**, provision of **6 months of communication support**, and production of **300 visibility materials** to enhance transparency and community recognition. Despite persistent misinformation, low initial risk perception, and funding limitations, the intervention demonstrated that sustained engagement, centralized rumour tracking, and leveraging trusted local leaders are essential for effective behaviour change in public health emergencies.

National Society Strengthening:

The operation enhanced institutional capacity through the mobilization and support of **330 trained and insured volunteers** (100% of the target) and the deployment of **10 regional coordinators** to ensure effective field implementation. Internal and external coordination was strengthened through **47 coordination meetings** between headquarters, branches, and government counterparts, improving operational alignment, information flow, and response efficiency. While scheduling conflicts occasionally affected meeting timelines, the intervention underscored the importance of sustained capacity building and structured coordination mechanisms in ensuring effective and scalable emergency health responses.

Coordination and Partnerships:

Strong coordination and partnerships underpinned the response, with TRCS actively collaborating with the Ministry of Health, WHO, and IFRC to ensure alignment of strategies, surveillance, and interventions. A total of **47 coordination meetings** were conducted (target achieved), enhancing joint planning, data sharing, and harmonization of response efforts across national and sub-national levels. Although overlapping schedules occasionally required adjustments, the experience reaffirmed that consistent multi-stakeholder coordination is critical to achieving coherent, efficient, and impactful public health responses.



Tanzania Red Cross Society volunteers raising Mpox awareness in market places in Zanzibar through RCCE outreach



South African Red Cross Society



24,296 peoples reached



60,970 people reached



79,220 people reached



165,517 people reached

Overview

Between August 2024 and August 2025, South Africa faced sustained public health risks from Mpox, alongside outbreaks of HFMD, cholera, and measles, primarily affecting densely populated urban and peri-urban areas. The WHO declared Mpox a Public Health Emergency of International Concern in August 2024 due to rapid regional spread, and South Africa recorded 35 confirmed Mpox cases and three deaths over the reporting period. Local transmission was evident in Cape Town and Johannesburg, highlighting vulnerabilities from high population density, informal settlements, internal migration, limited WASH infrastructure, and low community awareness, compounded by stigma, delayed care-seeking, and misinformation. Although no national State of Disaster was declared, the government launched targeted surveillance, contact tracing, and an Mpox vaccination campaign in July 2025, emphasizing the need for community engagement, early warning, and behaviour-change interventions.

In response, the South African Red Cross Society (SARCS), in coordination with the Department of Health, NICD, IFRC, and local partners, implemented integrated community-level interventions across all nine provinces, focusing on Gauteng, KwaZulu-Natal, and Western Cape. Key actions included Risk Communication and Community Engagement (RCCE), door-to-door health promotion, Community-Based Surveillance (CBS), WASH station installation, hygiene kit distribution, vaccination demand creation, and Mental Health and Psychosocial Support (MHPSS). Volunteers reached over 160,000 individuals, strengthening early detection, referral systems, and epidemic preparedness. Operational challenges such as stigma, misinformation, limited infrastructure, and concurrent disease outbreaks were mitigated through IPC training, PPE provision, community dialogues, and strengthened referral pathways. Integrated programming addressing health, hygiene, immunisation, protection, and psychosocial needs enhanced community resilience and preparedness for Mpox and other epidemic-prone diseases.

Health & Care:

SARCS deployed 331 trained volunteers across all nine provinces to implement integrated community-based health interventions addressing Mpox and concurrent public health risks, exceeding targets for surveillance and epidemic preparedness activities. Volunteers supported Community-Based Surveillance (CBS), Risk Communication and Community Engagement (RCCE), and referral linkages with Primary Health Care facilities, reaching to individuals with health promotion and epidemic preparedness messaging. Mental Health and Psychosocial Support (MHPSS) services, including Psychological First Aid (PFA), were provided to 24,296 people, addressing fear, stigma, and anxiety associated with infectious disease outbreaks. Activities were integrated with broader public health concerns, including diarrhoeal disease, cholera, measles, and food safety, and supported the national Mpox vaccination rollout by promoting vaccine uptake and addressing misinformation. Lessons learned emphasized the effectiveness of integrated, community-based preparedness approaches for enhancing early detection and resilience to epidemic-prone diseases.

Water, Sanitation and Hygiene (WASH):

A total of 207 volunteers delivered WASH interventions, reaching 3,725 households with handwashing facilities and hygiene materials and 60,970 people with hygiene promotion messaging. Activities focused on preventing disease transmission in high-risk communities, particularly informal settlements and peri-urban areas, while integrating messages on safe water, food handling, and sanitation. WASH interventions supported broader Mpox prevention efforts and concurrent outbreaks of diarrhoeal diseases, cholera, and food safety incidents. Challenges such as limited water availability and inconsistent hygiene practices were mitigated through ongoing community engagement and behaviour-change promotion, highlighting the importance of integrating WASH with epidemic preparedness to enhance community resilience.

Protection, Gender and Inclusion (PGI):

Tailored RCCE campaigns reached 79,220 vulnerable people, while 556 volunteers were trained on PGI standards, PSEA, and SGBV, and 505 from the people reached being staff and volunteers signed Code of Conduct. Community engagement addressed stigma, gendered barriers to healthcare, and protection of children and marginalised groups, ensuring equitable access to information, services, and referral pathways. Lessons learned reinforced the critical importance of embedding PGI principles in epidemic preparedness to improve trust, disclosure, and timely care-seeking behaviour.

Community Engagement and Accountability (CEA):

SARCS trained 399 volunteers on CEA Minimum Standards and conducted 55 community meetings, reaching 165,517 people through RCCE activities. Feedback mechanisms, including Kobo-based Rapid Qualitative Assessments, facilitated community-informed adjustments to messaging and interventions. Coordination with NICD and the Department of Health strengthened responsiveness to emerging misinformation, stigma, and barriers to healthcare access. Findings were documented in the IOA Field Exchange (Vol. 9, Jan 2025) to inform best practices. Lessons highlighted the value of accessible, culturally appropriate feedback channels to maintain trust, improve early reporting of symptoms, and encourage healthcare-seeking behaviours.

National Society Strengthening:

SARCS strengthened institutional readiness by covering 52 branches and supporting 331 staff and volunteers with wellness interventions, surpassing operational targets. Volunteer insurance, stress management, and deployment of the Special Skills Unit (SSU) enhanced technical capacity and surge readiness. The SSU, composed of medical specialists, epidemiologists, and other health professionals, contributed expertise to surveillance, referral pathways, and health response planning. Lessons emphasized the importance of maintaining trained personnel rosters to ensure timely and sustainable community-based epidemic interventions.

Coordination and Partnerships:

SARCS enhanced technical complementarity and response effectiveness through coordination with IFRC, Partner National Societies (e.g., Netherlands Red Cross), ICRC, government structures, civil society organisations, and UN agencies. Engagements strengthened referral pathways, ensured humanitarian access, and expanded outreach to high-risk populations, including MSM and LGBTQI+ communities. Information-sharing platforms, government-led coordination mechanisms, and joint monitoring efforts improved alignment of response strategies. Challenges included stakeholder coordination complexities and information delays, mitigated through regular meetings and

communication channels. Lessons underscored the importance of sustained inter-agency collaboration and integrated Movement coordination for timely, effective epidemic response.



Nigerian Red Cross Society



9,155,749
people reached



9,155,749
people reached



9,155,749 people
reached

Nigeria continues to face a significant Mpox outbreak, declared a Public Health Emergency by the WHO on 14 September 2024. Since the epidemic began in 2017, the country has reported 7,050 suspected cases, 1,611 confirmed cases, and 21 cumulative deaths, with a case fatality rate of 1.2% for 2024. Early 2026 data (epi week 1–6) indicate 281 suspected and 58 confirmed cases, including one death, across 26 states, highlighting a potential escalation of transmission. The outbreak has affected all regions of the country, prompting the Nigeria Centre for Disease Control (NCDC) to activate a multi-sectoral Emergency Operations Centre in November 2024 to coordinate the national response. The Nigerian Red Cross Society (NRCS), in partnership with the NCDC, Ministry of Health, IFRC, and Norwegian Red Cross, has aligned its interventions with the national plan to address Mpox through community-based surveillance, Risk Communication and Community Engagement (RCCE), Water, Sanitation, and Hygiene (WASH), Infection Prevention and Control (IPC), Mental Health and Psychosocial Support (MHPSS), and support to reactive vaccination campaigns.

In response, NRCS mobilized 3,880 volunteers across 23 states to implement integrated community-based interventions. Key actions included door-to-door risk communication and hygiene promotion, active case finding and referral to health facilities, psychoeducation and counselling for affected families, and support to government-led vaccination activities. Volunteers and staff were trained on epidemic preparedness, IPC, and community engagement, while 230 health facilities received IPC materials and PPE. Community feedback mechanisms, including Kobo-based surveys, informed adaptive programming and strengthened trust between communities and health responders. Operational risks such as community resistance, misinformation, and volunteer exposure were mitigated through culturally sensitive engagement, local volunteer deployment, and provision of protective equipment. Overall, NRCS interventions enhanced early detection, strengthened referral pathways, promoted preventive behaviours, and supported government-led efforts to contain the Mpox outbreak nationwide.

Health & Care: NRCS strengthened community and individual health by reaching 2,494,895 households and 9,155,749 individuals with Mpox and hygiene promotion messages, conducting active case search that identified 30,991 suspected cases, and providing PSS services to 393,464 people. A total of 3,880 volunteers were trained and deployed on CBS, PSS-PFA, IPC, and hygiene promotion, supporting 230 health facilities with PPE and IPC materials. Volunteers also supported reactive vaccination campaigns and border surveillance. Integrated community engagement addressed stigma, promoted behavioural change, and strengthened referral pathways to health facilities. The nationwide NTOT and Port Authority training enhanced detection, reporting, and outbreak preparedness across all 36 states and the FCT.

Water, Sanitation and Hygiene (WASH): NRCS reached 9,155,749 individuals with hygiene promotion messages, while 3,880 trained volunteers distributed IPC materials and PPE to 230 health facilities across 23 states. Door-to-door sensitization, public awareness campaigns, and provision of handwashing materials reinforced safe hygiene practices. Staff and volunteers were equipped with masks, hand sanitizers, and chlorine to reduce infection risks. WASH activities were integrated with Mpox prevention to mitigate overlapping public health risks. Community engagement strengthened the adoption of hygiene behaviors and improved preparedness for epidemics.

Protection, Gender and Inclusion (PGI): NRCS ensured protection of vulnerable populations by training and enforcing safeguard measures for 1,380 staff and volunteers (691m and 689f), exceeding the target of 1,372 personnel signing the Code of Conduct and receiving training. Staff and volunteers applied PSEA principles and ethical conduct during outreach, ensuring inclusive, respectful, and confidential service delivery. PGI integration guided interventions to reach marginalized groups and support safe disclosure and access to care for affected populations. Training and supervision reinforced ethical engagement in all operational activities. Lessons learned highlighted the importance of safeguarding measures for effective epidemic response.

Community Engagement and Accountability (CEA): NRCS conducted 96 community meetings and gathered feedback from 20,000 community members to guide programming and messaging. Volunteers carried out targeted advocacy with local leaders, focus group discussions with vulnerable populations, and town-hall meetings with key stakeholders. Community feedback was collected via the Kobo app to inform adaptive risk communication strategies. RCCE activities promoted community trust, ownership, and behavioural change to reduce Mpox transmission and stigma. Engagement efforts enhanced transparency and strengthened the linkage between communities and health services.

National Society Strengthening & Coordination: NRCS trained and deployed 1,240 volunteers on RCCE, hygiene, and health promotion, increasing community-based capacity for epidemic response. The society synchronized operations with national plans through full participation in government-led Mpox coordination meetings and weekly internal EOC reviews. Coordination with NCDC, state ministries, and partners ensured targeted support, avoided duplication, and leveraged resources efficiently. Internal systems reinforced operational oversight, volunteer management, and rapid decision-making. Lessons learned highlighted the value of capacity building and strategic partnerships in epidemic preparedness and response.



Red Cross Society of Cote d'Ivoire



78,160 people reached



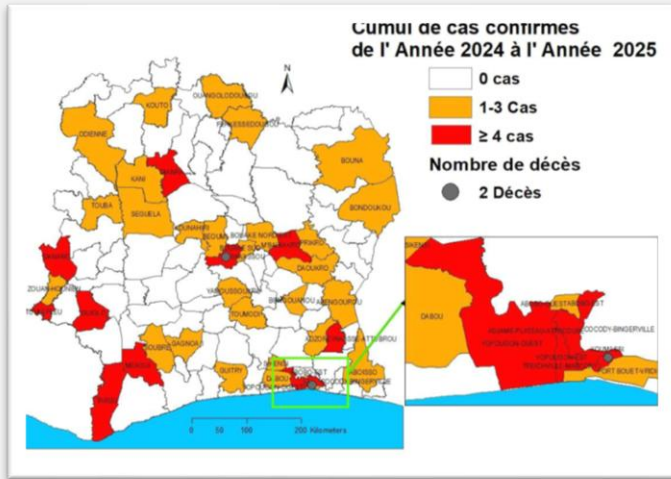
78,160 people reached



78,160 people reached



78,160 people reached



Côte d'Ivoire declared the resurgence of Mpox on 24 July 2024, and since then, the country has continued to report new cases across different regions. The situation remains a concern, with both urban and rural communities affected.

As of 30 August 2025, a total of 801 suspected cases have been reported since the start of the epidemic in 2024, of which 181 have been confirmed positive. In 2025 alone, 304 suspected cases were recorded, including 74 confirmed. The positivity rate stands at 22.6%, pointing to ongoing transmission. Encouragingly, 166 people have recovered (92%), although two deaths have been reported in Koumassi and Sakassou, representing a case fatality rate of just over 1%. At present, there are 13 active cases

under monitoring. Authorities and partners, including the Ivorian Red Cross, continue to strengthen the response. Activities include community awareness campaigns, case investigations and contact tracing, and support for infection prevention in health facilities. Efforts are also underway to tackle misinformation and reduce stigma in affected areas, especially where rumors have delayed treatment-seeking.

While the overall recovery rate is high, the persistence of new cases shows that Mpox is still a public health challenge. Moving forward, continued community engagement, timely case management, and regional coordination will be essential to limit further spread and protect vulnerable families.

In 2025, the country witnessed a resurgence of cases starting from **Week 03**, with almost weekly reports of new cases thereafter. This marked a shift in the outbreak dynamics, as transmission persisted more consistently across districts. The only pause in reporting was observed between **Weeks 13 and 16**, after which cases continued to be documented regularly.

This sustained frequency of reporting in 2025 reflects that the virus remains actively present in communities, reinforcing the importance of ongoing preparedness, community awareness, and rapid case detection. It also highlights the challenges health authorities face in curbing transmission, as periods of low reporting are quickly followed by fresh waves of cases. The trend further underlines the need for strengthened cross-border surveillance and community-level interventions, as the regularity of cases suggests that Mpox could become endemic if response measures are not maintained and expanded.

VACCINATION

Based on the charts below, as part of the national response to the Mpox resurgence, Côte d'Ivoire has set a **target to vaccinate 5,000 people across 42 health districts**, prioritizing frontline health workers, high-risk groups, and affected communities. This effort is aimed at reducing transmission, protecting health staff, and building resilience in communities that have experienced recurrent cases since mid-2024. To date, **335 individuals have been vaccinated, representing 6.7% coverage** against the overall target. While this marks an important first step, the coverage remains significantly below the national objective. Limited vaccine supply, logistical constraints, and the need to build stronger vaccine confidence at the community level have contributed to the slow pace.

Efforts are ongoing to accelerate vaccination through community engagement, mobile outreach campaigns, and coordination with local health authorities, ensuring that vulnerable populations are reached more effectively.

Scaling up vaccination remains a critical pillar in the response strategy to prevent further spread and to complement other prevention measures such as RCCE, surveillance, and case management.

The Mpox epidemic is affecting a large part of the national territory. As part of the response in Côte d'Ivoire, the response is taking place in ten (10) most affected districts to ensure an effective response. Those most at risk are immunocompromised individuals, mainly health professionals and sex workers, pupils and students.

The overall objective of the smallpox response in Côte d'Ivoire is to contribute to the national response and rapid containment of the epidemic. To achieve this, interventions focused on strengthening the capacities of the National Society and volunteers in epidemic prevention and response, taking into account the needs of affected communities through increased participation, engagement, and feedback. The response also prioritized support for affected populations.

Communities will benefit from a safety net approach. Several communication strategies will be deployed to achieve the established objectives. Highlights of this period include:

Health and Care:

To support the government in curbing the spread of Mpox, Côte d'Ivoire RC launched community awareness sessions across all affected districts, with a special focus on encouraging individuals to seek care at the nearest health facility as soon as symptoms appear. These sessions prioritized 10 high-risk localities—including Danané, Yamoussoukro, Abobo, Tabou, Cocody, Bingerville, Yopougon, and Soubré—where the risk of transmission was considered highest. Volunteers played a central role in mobilizing communities, delivering tailored messages on prevention, early detection, and health-seeking behavior. This grassroots approach not only increased public awareness but also strengthened trust between communities and the health system.

At the same time, the National Health Service (NS) ensured that frontline health workers were adequately equipped to manage cases safely by supplying infection prevention and control (IPC) kits to targeted districts. These included infrared thermometers, sterile gloves, face masks, and handwashing kits, all of which are vital to reducing transmission in health facilities and community settings.

Water, sanitation, and hygiene:

Throughout the period, Mpox's WASH program response focused on training volunteers selected in the targeted districts. Following the training and deployment of volunteers, handwashing stations, hydroalcoholic gels, and liquid soaps were distributed to the Sakassou, Yamoussoukro, Danané, and Boundiali branches.

RCCE/CEA

Community engagement and accountability, combined with risk communication, were fully integrated into the Red Cross response in Côte d'Ivoire. The objective is to ensure that communities are well informed and have a say in the actions of implementing actors, to build trust and ownership of the response among the target population. During this period, several key activities were implemented, as detailed below:

- 25 ToT volunteers and 110 volunteers from 10 local committees were selected and trained on AEC.
- Collection of community feedback data during awareness sessions in targeted areas
- Door-to-door and mass awareness campaigns in public places such as markets, schools, bus stops, etc.
- Distribution and display of 2,298 Mpox awareness posters in public and strategic locations in the target districts

PGI approaches and tools were also selected and trained at the CEA to produce interactive radio programs, among other things, to reach a wider audience.

Coordination

Weekly coordination meetings are held regularly, with the Red Cross participating at the national, provincial, and district levels. At the end of each month, local Red Cross committees meet with health district leaders to present and discuss the previous period's outreach reports and define future priorities.



Zambia Red Cross Society



47,701 peoples reached



47,701 peoples reached



47,701 people reached



47,701 people reached



Summary of Response

The Zambia Red Cross Society (ZRCS), in close collaboration with the Ministry of Health (MoH), the Zambia National Public Health Institute (ZNPHI), and the IFRC, has played a pivotal role in strengthening community preparedness and response to Mpox. Leveraging its extensive community-based volunteer network, ZRCS mobilized 300 trained volunteers and 64 MoH supervisors across six hotspot districts to deliver household-level outreach, conduct surveillance, and ensure timely referrals.

Through door-to-door visits, radio programs, mobile public address systems, and community meetings, ZRCS volunteers

reached people with prevention and awareness messages. This grassroots mobilization has been instrumental in countering misinformation, reducing stigma, and promoting early health-seeking behaviours.

To reinforce the health system, 140 frontline health workers in Lusaka and Kitwe were trained in Mpox case management, ensuring standardized, safe care. ZRCS also integrated psychosocial support, stigma reduction, hygiene promotion, and environmental sanitation into its response, while CBS mechanisms enabled timely escalation of alerts to health authorities.

Key results include:

- 149 Mpox cases identified and managed through community-based surveillance and case management.
- **47,701 people** reached with health promotion and WASH messages.
- **47,701 people** supported through PGI interventions, including information, PPE, and dignity materials.

By harmonizing efforts with national coordination mechanisms, ZRCS has reinforced early detection, strengthened surveillance, and safeguarded vulnerable populations. This response highlights ZRCS's strong community presence, technical expertise, and auxiliary role to the government, reaffirming its position as a leading humanitarian actor in Zambia.

Health

Under this pillar, 300 volunteers and 64 Ministry of Health (MoH) supervisors were trained and deployed in epidemic preparedness, community-based surveillance, infection prevention and control (IPC), psychosocial first aid (PFA), and RCCE. Volunteers conducted extensive door-to-door sensitizations, reaching **47,701 people** with Mpox awareness messages. Through CBS, 174 alerts were escalated to health authorities for action. Additionally, 140 health workers in Lusaka and Kitwe received training on Mpox case management, IPC, and psychosocial support. Radio programs and public address campaigns were rolled out in five Copperbelt districts to ensure communities had access to accurate information. PFA was also provided to patients, households, and communities to reduce stigma and build coping mechanisms.

Water, Sanitation and Hygiene (WASH)

Hygiene promotion was integrated into all RCCE activities and household visits. Volunteers actively promoted handwashing, surface disinfection, and safe handling of contaminated materials, while IEC materials with WASH-focused messages in local languages were widely distributed. Overall, **47,701 people** were reached with WASH messages through door-to-door sensitization, radio programs, and mobile PA systems. Volunteers also emphasized environmental sanitation during training sessions and community outreach, contributing to a safer and healthier environment.

Protection, Gender and Inclusion (PGI)

ZRCS identified and addressed risks of stigma and discrimination, especially among individuals with visible Mpox lesions. PGI-sensitive communication was mainstreamed across all RCCE and community meetings. Special efforts were made to engage women, youth, and other vulnerable groups to ensure inclusiveness in the response. Psychosocial counselling was promoted for patients and relatives to help them cope emotionally and mentally. Youth-friendly spaces such as sports gatherings, including football matches and pool table events, were used to engage adolescents, helping to break stigma and promote positive dialogue.



ZRCS communications manager interviewing beneficiaries for Mpox Documentary in Mufulira District

Community Engagement and Accountability

CEA efforts targeted households, reaching **47,701 people** through door-to-door visits, radio broadcasts, public address systems, and distribution of IEC materials, ensuring wide dissemination of Mpox prevention and response information. These outcomes were made possible through the strategic deployment of trained volunteers, collaboration with local authorities, and the use of multiple communication channels to maximize community reach and impact. Volunteers conducted household sensitizations and distributed IEC materials in seven local languages to improve understanding and acceptance. Community meetings and focus group discussions provided platforms for feedback, enabling continuous adaptation of messaging. Trusted leaders—chiefs, councillors, and faith leaders—were engaged to strengthen ownership and credibility of the response. Radio talk shows and mobile PA systems expanded their reach in areas without local stations, such as Kalumbila. Feedback mechanisms were established to track rumors, perceptions, and misinformation, ensuring activities remained responsive to community concerns.



IFRC CEA Officer conducting a community meeting in Chilalabombwe.

Coordination and Partnerships

ZRCS maintained strong coordination with the Ministry of Health (MoH) and the Zambia National Public Health Institute (ZNPPI) throughout the response, supporting surveillance, case management, and RCCE activities. Weekly coordination meetings were held at both national and sub-national levels, ensuring alignment with the Public Health Emergency Operations Centre (PHEOC). The Society also engaged with local authorities, traditional leaders, and civil society partners to facilitate community acceptance and ensure interventions were culturally sensitive. At the regional level, collaboration with the IFRC's Southern Africa Cluster strengthened technical support, resource mobilization, and cross-border preparedness. Globally, the IFRC Secretariat in Geneva provided oversight, accountability mechanisms, and access to Movement-wide resources. This network of partnerships enabled ZRCS to complement government efforts while ensuring a harmonized Red Cross Red Crescent Movement response.



Zimbabwe Red Cross Society



2,400,000 people reached



238,214 peoples reached

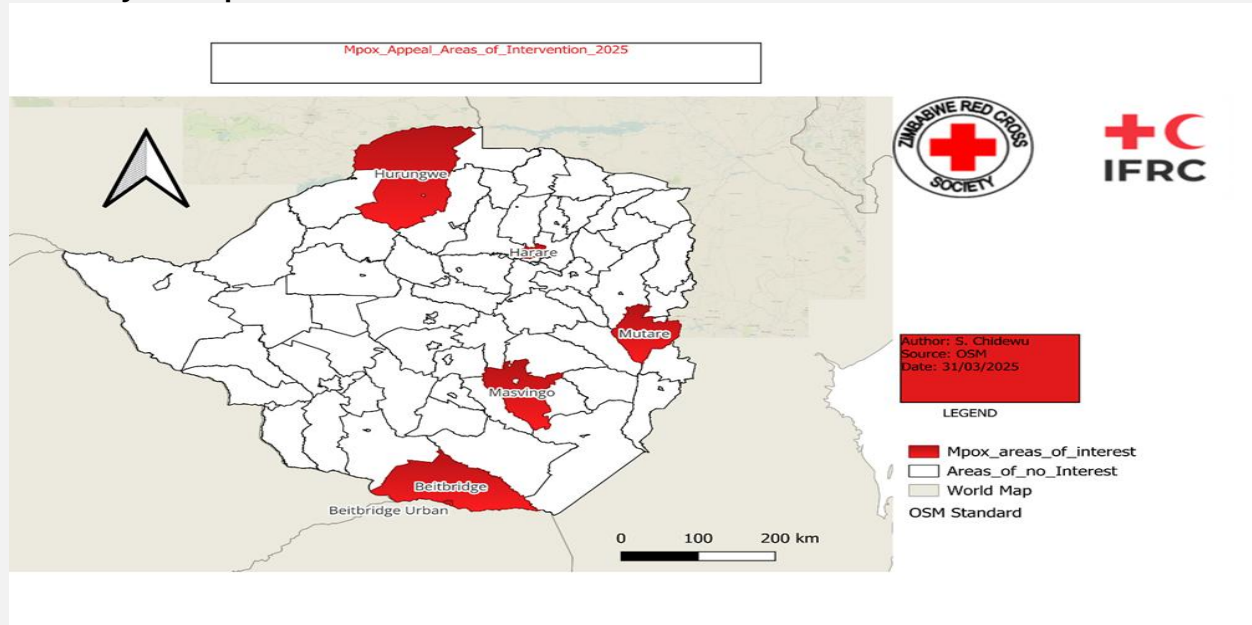


73 people reached



2,400,000 people reached

Summary of Response



HEALTH

Door-to-door health education awareness on Mpox was conducted by Volunteers in Harare, Mutare, Masvingo, Beitbridge and Chirundu. This was done by volunteers who attended PFA and Mpox training to support identifying suspected, reporting, case referral and contact tracing Mpox cases based on the case definition to ensure early detection and early health-seeking behaviours. Community meetings were conducted during Rapid Gender Analysis (RGA) in all implementing districts to get insights into the community's perceptions around Mpox. Volunteers were targeting households for awareness raising, as these would give them a large ground to cover and more reach. Training of Health Care workers who were supporting ZRCS volunteers during the project was done, focusing on IPC and safe waste disposal as a capacity enhancement initiative.



Community members exhibiting IEC material they use for Mpox



Mpox awareness raising in Chirundu

WASH

ZRCS conducted WASH assessments to ascertain areas that would suit and need borehole rehabilitation to improve the water situation in targeted communities. The Mpox project had a niche in Hygiene promotion and would have been difficult to achieve this goal without the promotion of access to clean and safe water. Bush pumps/boreholes were

rehabilitated to ensure a continuous supply of clean and safe water to selected communities in areas of operation. Two boreholes were rehabilitated in Chirundu which serve an estimated population of 246 pupils, 11 Teacher, 414 HHs, 32 tuck shops, and a clinic with a catchment of 1000 HHs from 10 villages, Dip Tank (estimated capacity 15'400 litres per dipping session – once every fortnight), 10 Shops, 5 Churches (Estimation -246+11+32+10+(414x5) + (1000x5) + (5x50) = 7619), in Mutare two boreholes were rehabilitated Zimunya Borehole 100 HHs, 50m from the highway, serves apostolic sect church across the road. Jongwe HHs from zero villages, Dip Tank (estimated capacity 15'400 litres per dipping session – once every fortnight), 10 Shops, 5 Churches. Four handwashing stations were handed over to Kasimure clinic, Nyamakate clinic, Mutoranhanga Secondary and Chirundu clinic, three handwashing stations at Beitbridge Clinic, three handwashing stations in Mutare at Masasi Clinic, Zvipiripiri Clinic and Gutaurare Clinic. One Borehole rehabilitation was done in Masvingo at Makasi primary school, which is estimated to serve 45 households, which around 250 or thereabout individuals and at the school, it provides clean and safe water to 270 pupils and 7 teachers and their families (30).



Community members assisting in borehole rehabilitation



Handwashing stations delivered in Chirundu

Protection, Gender and Inclusion

30 volunteers were trained in gender-based violence (GBV) prevention, mitigation and response, case management and referral pathways as GBV increases during health crises. Volunteers dealing with sensitive issues need to be equipped with relevant skills on how to deal with such matters and to observe the do no harm principles and confidentiality. Role plays were made part of the training to reinforce the theoretical concepts that were delivered.

Community Engagement and Accountability

200 volunteers who were selected and insured to be part of the Mpox project were trained in feedback collection using Kobo during their door-to-door educational awareness raising. Volunteers were interacting with the community daily, and this gave them leverage to collect whatever relevant data or information useful to the project.



Angola Red Cross Society



79,895 people reached



55,155 peoples reached



7,048 peoples reached



1,735 people reached

Country-level updates

On 20 November 2024, the Government of Angola reported two confirmed cases of Mpox in Luanda. The number grew to 8 confirmed cases. The Ministry of Health called for reinforcement of prevention measures and to strengthen epidemiological surveillance at the points of entry for early detection of any cases that may be introduced into the country. The risk of importation of cases to Angola is considered high, given the increase in the number of cases in the Democratic Republic of Congo, with Angola having frequent flights and daily land border crossings and noting the vast border with the Democratic Republic of Congo (DRC), where the disease is endemic. To this extent, the Government created a National Contingency Plan to Control Mpox, a plan drafted in collaboration with various stakeholders, including the Angola Red Cross. The plan also involves mobilization of resources to support the implementation of preparedness and prevention actions in response to the possible introduction of the virus in the country and to interrupt the introduction of the Mpox virus in Angola. By June 2025, cases had remained at 8 confirmed cases.

Overview of the Mpox response in Angola

In support to the National Mpox Contingency Plan, the Angola Red Cross Mpox response operation will focus on the 6 out of the 7 provinces with borders with DRC and the Republic of Congo (excluding Lunda Norte based on current needs and conversations with MoH). These are Uige, Zaire, Lunda Sul, Malanje, Moxico and Cabinda. It also covers Luanda province, containing the capital city and the confirmed cases. The operation mobilized 140 volunteers (20 per province), in districts close to the borders and in Luanda. The operation will aim to mobilize volunteers for health and hygiene promotion and community awareness-raising campaigns in order to contain and prevent the spread of Mpox. As cases stabilized, the operation shifted from response and volunteer mobilization to supporting epidemic preparedness, focusing on activities related to strengthening community-based surveillance and epidemiological data reporting, as well as understanding the knowledge, attitudes and perceptions of Mpox and other diseases in order to best adapt future health operations.

Health and care

A total of 30 Angola Red Cross (CVA) volunteers in Luanda were trained by government health authorities in community health and epidemiological surveillance. In addition, 105 volunteers were identified across six provinces to receive training in health and hygiene promotion in January. These volunteers carried out community-based health and hygiene promotion sessions twice per week until May 2025, when community transmission had stabilized. Although direct Mpox-specific activities were reduced in June, volunteers remained active under the DREF-supported cholera operation, continuing health and hygiene promotion while integrating Mpox prevention messages when relevant.

At the community level, CVA volunteers conducted door-to-door sensitization sessions to reinforce epidemiological surveillance, particularly in provinces with confirmed cases. Messages emphasized safe practices, including avoiding rodents, monkeys, and other wildlife species that may transmit Mpox, and encouraging households to vaccinate their pets. This approach addressed cultural practices in parts of Angola where monkey meat is consumed, and monkeys are kept as pets. CVA strengthened outreach to key populations through its network of peer educators, with a particular focus on sex workers and their partners. Activities concentrated on raising awareness among groups at heightened risk, including truck drivers, moto-taxi operators, and clients frequenting high-contact points such as pensions and nightclubs. To reduce the risk of sexually transmitted infections (STIs), peer educators conducted mobile sensitization sessions and distributed 560 condoms in Zaire Province, reinforcing safe practices and improving access to prevention tools among vulnerable groups.

With support from IFRC, the CVA initiated a CBS feasibility assessment to strengthen and institutionalize its existing system. Progress to date has included consultations with the Ministry of Health to explore alignment with national

surveillance mechanisms, validation exercises with core stakeholders through key informant interviews at CVA headquarters, and a review of existing reporting channels, informal systems, and community dynamics. These achievements represent important first steps toward testing CBS under field conditions, building operational capacity for scale-up, and paving the way for future integration into Angola's national health surveillance framework.

Following the CBS assessment, CVA conducted a 1.5-day training in August 2025 to strengthen internal monitoring and reporting within the epidemiological response. A dedicated workshop brought together 38 (25 male and 13 female) participants from CVA headquarters, IFRC and 11 provincial branches (Bengo, Benguela, Cabinda, Cuanza Sul, Cuanza Norte, Huambo, Luanda, Lunda Sul, Malange, Moxico, Uige, Zaire). The event aimed to streamline data collection tools, clarify roles and responsibilities, improve data quality, feedback mechanisms, and explore opportunities to expand the monitoring system beyond cholera use.

WASH

Volunteers were actively engaged in health and hygiene promotion across several provinces. Their work combined mass sensitization sessions, door-to-door outreach, and practical demonstrations of handwashing and household water treatment. Under the Mpox operation, the budget was insufficient to cater for handwashing facilities; however, the Cholera DREF complemented this by establishing a total of 60 handwashing stations in high-risk areas, accompanied by demonstrations on correct usage. These actions indirectly reached more than 55,000 people with critical messages on safe water handling and hygiene practices. Volunteers also led community clean-up campaigns, particularly around water sources, to reduce contamination risks.

In Zaire Province (Luvo Municipality), volunteers continued household visits and counselling on water treatment and safe latrine use, focusing especially on communities without access to safe water. In Moxico Province, volunteers promoted handwashing through campaigns in markets and door-to-door visits. Across both provinces, children were the primary target group, recognizing their role as change agents within households and schools.



Handwashing demonstration in a school at Moxico

CEA/RCCE

Special attention was given to minority and often marginalized groups, such as refugees and LGBTQ+ communities, through peer educators who helped ensure inclusive outreach and equitable access to prevention messages and services. Contact with community leaders in the selected communities along the border with DR Congo to present the project was also established.

In close collaboration with the Ministry of Health, CVA finalized the IEC materials on Mpox. To ensure accessibility and inclusiveness, these materials were translated into key local languages, Kikongo, Kimbundu, and Lingala, which allowed wider dissemination among the communities.

In March 2025 during the cholera outbreak, CVA with the support of IFRC conducted a KAP survey in 8 communities in Angola (Luanda, Huila, Cuanza Sul e Norte, Bengo, Zaire, Uige e Huambo) with 285 (162 Male, 120 Female and 3 unspecified), respondents, on key topics, such as, water, sanitation, hygiene, cholera, Mpox, information sources and feedback mechanisms. An IFRC PHIE surge was deployed to give support to the National Society.

The KAP survey in Angola (March 2025) revealed critical gaps in water, sanitation, and hygiene: while many households treat their water, irregular supply and unsafe practices persist. Shared and unemptied latrines increase cholera risks, and although 89% recognize personal risk, over half do not see cholera as a community problem. Awareness of the oral cholera vaccine is extremely low, and knowledge of Mpox is almost absent. Radio and TV are the main sources of information, yet most households had not received recent cholera messages, and only 36% knew how to give feedback to the Red Cross.

PGI

Identification and selection of 30 sex worker volunteers (5 per province) who received training to support with peer-to-peer dissemination of Mpox information.

Country-level coordination

CVA has actively engaged in coordination with the Ministry of Health (MINSa) since before the importation of Mpox cases, contributing to national preparedness efforts. At the provincial level, CVA continued strengthening ties with health authorities to define areas where volunteers could support epidemic response, in collaboration with partners such as ANASO, UNICEF, and WHO.

With the onset of the cholera outbreak in January 2025, coordination moved towards joint work-planning with the government and partners, aligning preparedness and response activities. While cholera remained the priority, these platforms also addressed preparedness for other epidemic threats, including Mpox.

At the provincial level, CVA delegations in Cabinda, Malanje, Moxico, Lunda Norte, Zaire, and Uíge actively participated in multisectoral commissions for Mpox response, attending weekly coordination meetings led by provincial health authorities. These meetings brought together local public health services, ANASO, WHO, municipal health directorates, community leaders, and other partners to share information, harmonize approaches, and coordinate volunteer engagement in prevention and response.



Sierra Leone Red Cross Society



93,819 peoples reached



102,707 peoples reached



36,743 peoples reached



258,825 peoples reached

Introduction

Between April and December 2025, Sierra Leone experienced a resurgence of Mpox, with confirmed and suspected cases across all 16 districts, particularly in high-density urban centres and border areas. Vulnerabilities such as limited health information, weak WASH infrastructure, stigma, and misinformation heightened the risk of disease transmission. The Ministry of Health activated national and district-level preparedness mechanisms, with the Sierra Leone Red Cross, supported by IFRC and Finnish Red Cross, implementing a community-based response. The intervention focused on raising awareness, early detection, referral, infection prevention, and building trust between communities and public health authorities.

Trained volunteers conducted household visits, group discussions, and community sensitization, reaching high-risk populations with harmonized messaging on Mpox prevention and hygiene promotion. Psychosocial support was provided to affected families, while engagement with local leaders helped address stigma and misinformation. Community feedback mechanisms informed adaptive programming, and volunteers were equipped with PPE to ensure safety during outreach. The integrated Health, WASH, and Community Engagement approach strengthened local coordination, enhanced volunteer capacity, and improved community resilience and readiness for future outbreaks.

Health & Care: SLRCS reached 93,819 people with Mpox prevention messaging, exceeding the target of 68,040, and trained 480 volunteers and 40 surveillance staff in early detection, contact tracing, psychosocial support, and community-based surveillance using the Nyss platform. Collaboration with MoH and the National Public Health Agency improved data quality, real-time reporting, and integration of community alerts into national systems. Over 3,875 prevention posters and leaflets were distributed, strengthening awareness, early reporting, and public trust.

WASH: Through household visits and community demonstrations, SLRCS promoted handwashing and hygiene practices to 102,707 people, surpassing the 68,040 target. Sanitation interventions in high-risk public spaces reduced exposure to infection, reinforced infection prevention behaviors, and built public confidence. Consistent IPC messaging, coupled with behavior-change communication, ensured sustained hygiene adoption despite challenges such as inconsistent water supply.

Community Engagement & Accountability: SLRCS engaged 258,825 people via community dialogues, household visits, and sessions with 280 local leaders, exceeding the 68,040 target. Activities focused on early case detection, rumour management, stigma reduction, and participatory communication, empowering communities with accurate information. Feedback mechanisms informed adaptive messaging, strengthening trust, ownership, and community-based surveillance.

Coordination & Partnerships: SLRCS maintained full alignment with MoH response plans, conducted joint monitoring with District Health Teams, and collaborated with local councils, community leaders, and IFRC. Regular

data sharing and harmonized messaging improved surveillance, operational quality, and community acceptance. These partnerships enhanced efficiency, reduced duplication, and reinforced trust in public health interventions across targeted districts.



Ghana Red Cross Society



24,894 people reached



20,797 peoples reached



2,869 people reached



23,801 peoples reached

Introduction

In 2024–2025, Ghana experienced an Mpox outbreak with 230 suspected cases across 88 districts, affecting all ages and placing children and immunocompromised individuals at the highest risk. The Ghana Red Cross Society, with IFRC and Ghana Health Service support, deployed 150 volunteers across Western North, Western, and Greater Accra regions to deliver RCCE activities, reaching 117,969 people (78% of the target), distributing 1,000 SBCC materials, and referring 2,560 suspected cases to health facilities. The response prioritized high-risk groups, strengthened early detection and reporting, countered misinformation, and enhanced community-level preparedness for ongoing and future Mpox outbreaks.

Health & Care: A total of 24,894 were reached with RCCE messages promoting self-reporting, care-seeking, and prevention of Mpox, supported by 150 trained volunteers, 1,000 SBCC materials, and 200 branded Red Cross jackets; 2,560 suspected cases were referred to health facilities, while targeted sensitization of 1,753 inmates improved awareness from 26% to 86%, though the vaccination campaign could not be fully supported.

Water, Sanitation, and Hygiene (WASH): The same 20,727 people were reached with hygiene promotion and sanitation interventions through house-to-house visits and community engagement, reinforced with 2,000 PPE items and 10 handwashing facilities; volunteers emphasized handwashing, sanitation, and preventive behaviors to reduce infection risks in affected communities.

Protection, Gender, and Inclusion (PGI): A total of 2,869 from marginalized and high-risk groups, including sex workers, health workers, and settler farmers in border cocoa-growing communities, were engaged in RCCE and preventive messaging, with targeted efforts to reduce cross-border transmission and promote health-seeking behavior.

Community Engagement and Accountability (CEA): The National Society reached 23,801 people through door-to-door visits, FGDs, public education, and Community Information Centers; 15 community feedback mechanisms and two FM stations were used to track concerns, address rumors, and enhance community participation, while volunteers supported local health workers in record-keeping.

National Society Strengthening: Through the operation, GRCS strengthened branch networks, revived inactive volunteers, enhanced visibility, increased membership, and reinforced risk mitigation, early detection, and referral mechanisms; the response contributed to a low case fatality rate of 0.4% (3 deaths/744 cases by October 2025), rising to 0.7% (7 deaths/999 cases) as volunteer intensity reduced, while a contingency plan was developed to ensure ongoing readiness.

Coordination and Partnerships: GRCS, in collaboration with IFRC, Ministry of Health, Ghana Health Service, and community structures, provided RCCE and early detection support, participated in the Interagency Coordination Committee and National RCCE committee, developed SBCC materials with HPD, and ensured effective reporting, volunteer supervision, and technical complementarity across the Mpox response.



Liberia Red Cross Society



52,839 peoples reached



21,228 peoples reached



1,664 people reached



36,121 peoples reached

Background

In 2025, Liberia experienced a nationwide Mpox outbreak, with cases rising from 923 (4 deaths) in September to 1,336 (6 deaths) within two months, affecting nearly 70 districts. The Liberia National Red Cross Society, in coordination with the Ministry of Health, deployed 150 volunteers across five hotspot chapters to conduct door-to-door awareness, school and public sensitization, and community engagement, reaching over 60,000 people and referring suspected cases for care. Volunteers supported the national vaccination campaign, helping more than 20,000 high-risk individuals receive doses while promoting layered prevention measures, including hygiene, early reporting, and safe caregiving. Despite operational challenges in remote areas and persistent misinformation, the response strengthened community trust, improved early detection, reduced stigma, and reinforced Liberia's capacity for ongoing outbreak control and public health resilience.

Health & Care: The Liberia National Red Cross Society (LNRCS) reached 52,839 through Risk Communication and Community Engagement (RCCE), including door-to-door visits, school outreach, and community dialogues. Volunteers delivered culturally appropriate messages on Mpox symptoms, prevention, and early care-seeking, addressing stigma and misinformation. Integrated hygiene and disease prevention messaging promoted behavioural changes such as handwashing, reduced participation in crowded gatherings, and increased healthcare utilization despite logistical and cultural challenges.

Water, Sanitation, and Hygiene (WASH): WASH interventions reached 21,228, focusing on handwashing, sanitation, and hygiene awareness. Volunteers conducted household and school sensitization, established handwashing stations, and promoted waste management, linking WASH practices to Mpox prevention. Challenges

included access to remote areas and cultural barriers, but repeated engagement reinforced sustained behaviour change.

Protection, Gender, and Inclusion (PGI): The project engaged 1,664 marginalized individuals, including sex workers and people living with HIV, to identify protection needs, promote inclusive practices, and encourage equitable access to services. Participatory dialogues strengthened awareness of gender equality and human rights, with women and youth reporting increased empowerment and community engagement despite cultural barriers.

Community Engagement and Accountability (CEA): CEA activities reached 36,121 people, combining household visits, school sessions, and Community Information Centres to strengthen trust, reduce stigma, and encourage early reporting. Volunteers facilitated feedback mechanisms, integrating hygiene and disease prevention messaging with Mpx awareness, resulting in tangible behavioural shifts, including widespread adoption of handwashing practices.

National Society Strengthening: A total of 150 volunteers (67 male, 83 female) were trained in RCCE, symptom recognition, and community engagement. Volunteer-led efforts increased preventive behaviours, vaccination uptake, and early case reporting. Despite logistical and reporting constraints, continuous supervision reinforced skills and community trust, demonstrating the critical role of local volunteers in outbreak response.

Coordination and Partnerships: LNRCS collaborated with two government entities (MoH and NPHIL) and local stakeholders to prioritize hotspot chapters, train volunteers, and distribute IEC materials. Engagement with community leaders strengthened trust, outreach, and vaccination promotion. Coordination challenges, particularly in remote areas and culturally sensitive contexts, were mitigated through sustained communication, reinforcing institutional partnerships and ensuring community-centred, effective response interventions.



Equatorial Guinea Red Cross Society



25,451 peoples reached



3,288 peoples reached



17,148 peoples reached



17,148 peoples reached

As of October 2024, Equatorial Guinea reported 2 suspected Mpx cases and 11 alerts across five provinces, all of which tested negative, with no confirmed cases or fatalities. In response, the Ministry of Health, supported by the Red Cross of Equatorial Guinea (RCEG), intensified surveillance, alert validation, and community sensitization. RCEG trained 120 volunteers across seven localities, distributed leaflets on six priority diseases, including Mpx and Marburg, and conducted awareness campaigns reaching 25,451 people. Building on lessons from the previous Marburg outbreak, these efforts strengthened community engagement and local health capacities. With no confirmed cases, the operation concluded as planned, though limited funding restricted activities to one month.

Health & Care: The Red Cross of Equatorial Guinea (RCEG) implemented community health promotion and risk communication interventions to strengthen holistic health and early detection of Mpx and other priority diseases.

A total of 120 volunteers were trained across seven localities (Luba, Malabo, Bata, Mbini, Mongomo, Riaba, and Evinayong) on six diseases: Mpox, Marburg, Cholera, Measles, Malaria, and Ebola, and deployed to conduct sensitization campaigns. These activities reached 25,451 people, including children, adults, and physically impaired individuals, with tailored messaging on prevention, early detection, and hygiene practices. The initiative increased community awareness, reinforced public health measures, and supported the Ministry of Health in controlling potential cases, though limited resources prevented nationwide coverage.

National Society Strengthening: RCEG strengthened institutional capacity by equipping 120 volunteers, including 7 branch supervisors, with visibility materials (caps and jackets) and training. A cascade training model included one Training of Trainers session in Malabo, followed by eight local-level trainings across targeted communities. Additionally, the headquarters conducted two field monitoring visits to support implementation, address operational challenges, and ensure consistent delivery of outreach activities. These measures enhanced volunteer engagement, local ownership, and visibility of the Red Cross, reinforcing preparedness for future outbreaks.



Congolese Red Cross Society



18,345 people reached



1,776 people reached



25,526 people reached

In the 1st half of 2025, the Congolese Red Cross will carry out activities related to the Mpox call in the localities of Mossaka and Loukoléla, where more than 50 CRC volunteers have been trained on epidemiological surveillance and referral of suspected cases detected. As a reminder, the first cases of Mpox were reported in 2003, more precisely in the department of Likouala. As of June 30, 2025, Congo has accumulated 135 suspected cases and 57 confirmed cases on the national territory and 0 deaths (Sitrep S27).

In response to this outbreak, training sessions for health workers and community members were organized with the support of the CDC. The activities carried out by the volunteers focused more on epidemiological surveillance and mass awareness raising in the neighbourhoods and especially in the fairground market, which are the centres of rapid disease transmission. In addition to epidemiological surveillance and mass awareness-raising, water, hygiene and sanitation activities have been implemented for the well-being of vulnerable populations. In total, Risk Communication and Community Engagement (CRC) actions reached at least **25,526 people**.

Activities were planned under the following pillars: Health, Water, Hygiene, Sanitation, and RCCE. However, due to a lack of funding, activities are currently limited.

Health and care

A total of 75 volunteers (50 men and 25 women) were trained on community-based epidemiological surveillance, psychosocial care (PSS) and were deployed in pairs. The participants are volunteers, health personnel working in Public Health Training, veterinarians/Community Animal Health Workers (ACSAS) and environmental agents. A total of 9734 households were visited during community-based epidemiological surveillance and early detection of Mpox cases. These home visits reached at least **18,345 people**. This also made it possible to detect and report 43 suspected cases (16 men and 27 women), 15 cases were investigated, 11 cases were validated,



Volunteers from CRC Loukoléla conducting epidemiological surveillance

and 9 cases were invalidated. PSS activities were carried out through 120 sessions reaching **1,224 people** through psychosocial and mental health services (**338 men**, 414 women, 202 boys and 270 girls). These people were also affected by the psychosocial support sessions for families who had received a suspected case of Mpox.

Water, sanitation and hygiene

A total of **75 volunteers** have been trained and are active to support IPC/WASH activities in the 3 target health districts with the involvement of community animal health workers, environmental officers and neighbourhood leaders. Their interventions were made through the following activities:

- Organization of 6 sanitation campaigns (evacuation of household waste, channelling of gutters and stagnant water, weeding, etc.) in markets and medical facilities at the rate of 2 campaigns per health district in collaboration with the community.
- Promotion of good hygiene practices based on proper handwashing in **725 households**, including 250 in Oyo, 345 in Mossaka and 130 in Loukolela;
- Disinfection of 60 latrines, including 16 in Oyo, 30 in Mossaka and 14 in Loukolela;
- Provision of hydroalcoholic solutions to the volunteers deployed at the rate of one bottle per week over 2 days of descent for 2 volunteers
- At least **1,776 people** have been reached by WASH activities.

Community Commitment and Accountability

In terms of Community Risk Communication and Engagement (RCCE), awareness data on the risks of the disease present a total of **25,526 people** reached by Mpox messages. These people have been reached through door-to-door outreach activities. In addition, 32 educational talks were held, 6 awareness-raising sessions were held with a megaphone and 6 radio broadcasts. A total of 801 Community feedback was received and dealt with, including 125 questions, 248 rumours, beliefs and observations, 118 suggestions and requests and 310 thanks and encouragement.



Awareness session at the cross-border market in Loukolela

C. FUNDING

As at the end of December 2025, there was CHF 12M (DREF, soft and hard pledges combined) received through Multilateral mechanisms, including CHF 1,104,698 Bilateral contributions. Furthermore, CHF 1,594,338 are mobilized under Other Funding modalities. This includes resources from IFRC or Partner National Societies that were repurposed or reallocated to the Emergency Appeal, for example, through Crisis Modifiers or similar mechanisms.

Federation-wide coverage of project associated with this OP	Amount Raised (CHF)	Coverage %
Total bilateral contributions to FW Appeal	1,104,698	11%
DREF allocation	5,000,000	
Total IFRC hard pledges + in-kind + soft pledges	5,911,274	20%
DREF Allocation	1,000,000	
Total FW contribution (bilateral + IFRC)	12,015,972	30%

Contact information

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

In the IFRC

- **Strategic Lead, Preparedness and Response; and HeOPs for this Appeal:** Rui Oliveira; Phone: +254 780 422 276; Email: rui.oliveira@ifrc.org
- **Manager, Regional Operations, Africa:** Michael Aiyabei; Phone: +254 722 850 484; Email: michael.aiyabei@ifrc.org

For IFRC Resource Mobilization and Pledges support:

- **Head of Strategic Partnerships and Resource Mobilization:** Louise Daintrey-Hall; Phone: +254 110 843 978; Email: louise.daintrey@ifrc.org

For Performance and Accountability support (planning, monitoring, evaluation, and reporting)

- **IFRC Regional Office for Africa** Beatrice Okeyo, Regional Head PMER & QA, email: beatrice.okeyo@ifrc.org, phone: +254732 404022

Reference documents

Click here for:

- [12months Operation Update](#)
- [6 Month Operations Update](#)
- [Operations Strategy](#)
- [Emergency Appeal](#)

How we work

All IFRC assistance seeks to adhere the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief, the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere)** in delivering assistance to the most vulnerable, to **Principles of Humanitarian Action** and **IFRC policies and procedures**. The IFRC's vision is to inspire, encourage, facilitate and promote at all times, all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

Operational Strategy

INTERIM FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2024/08-2026/03	Operation	MDRS1003
Budget Timeframe	2024/08-2026/03	Budget	APPROVED

Prepared on 18 Mar 2026

All figures are in Swiss Francs (CHF)

MDRS1003 - Africa - Regional Mpox Epidemic

Operating Timeframe: 15 Aug 2024 to 31 Mar 2026; appeal launch date: 20 Aug 2024

I. Emergency Appeal Funding Requirements

Total Funding Requirements	30,000,000
Donor Response* as per 18 Mar 2026	7,023,450
Appeal Coverage	23.41%

II. IFRC Operating Budget Implementation

Planned Operations / Enabling Approaches	Op Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items	2,054	6,021	-3,968
PO02 - Livelihoods	0	4,426	-4,426
PO03 - Multi-purpose Cash	39,798	89,625	-49,827
PO04 - Health	3,668,480	3,084,486	583,994
PO05 - Water, Sanitation & Hygiene	663,973	812,715	-148,743
PO06 - Protection, Gender and Inclusion	32,596	43,895	-11,300
PO07 - Education	0	44,018	-44,018
PO08 - Migration	0	0	0
PO09 - Risk Reduction, Climate Adaptation and Recovery	5,971,435	4,846,961	1,124,474
PO10 - Community Engagement and Accountability	491,975	683,314	-191,339
PO11 - Environmental Sustainability	0	8,898	-8,898
Planned Operations Total	10,870,310	9,624,360	1,245,951
EA01 - Coordination and Partnerships	85,079	224,632	-139,552
EA02 - Secretariat Services	596,738	822,982	-226,244
EA03 - National Society Strengthening	1,036,513	483,995	552,518
Enabling Approaches Total	1,718,331	1,531,609	186,722
Grand Total	12,588,641	11,155,969	1,432,672

III. Operating Movement & Closing Balance per 2026/03

Opening Balance	0
Income (includes outstanding DREF Loan per IV.)	11,395,048
Expenditure	-11,155,969
Closing Balance	239,079
Deferred Income	0
Funds Available	239,079

IV. DREF Loan

* not included in Donor Response	Loan :	5,249,111	Reimbursed :	250,000	Outstanding :	4,999,111
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Operational Strategy

INTERIM FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2024/08-2026/03	Operation	MDRS1003
Budget Timeframe	2024/08-2026/03	Budget	APPROVED

Prepared on 18 Mar 2026

All figures are in Swiss Francs (CHF)

MDRS1003 - Africa - Regional Mpox Epidemic

Operating Timeframe: 15 Aug 2024 to 31 Mar 2026; appeal launch date: 20 Aug 2024

V. Contributions by Donor and Other Income

Opening Balance						
						0
Income Type	Cash	InKind Goods	InKind Personnel	Other Income	TOTAL	Deferred Income
Belgian Red Cross (Flanders)	58,711				58,711	
British Red Cross (from British Government*)	1,548,923				1,548,923	
DREF Response Pillar				4,999,111	4,999,111	
European Commission - DG ECHO	186,722				186,722	
Hong Kong Red Cross, Branch of the Red Cross Socie	22,294				22,294	
Japanese Red Cross Society	28,432				28,432	
Luxembourg Government	141,222				141,222	
Norwegian Red Cross (from Norwegian Government*)	1,009,064				1,009,064	
Red Cross of Monaco	18,741				18,741	
Spanish Government	941,591				941,591	
Swedish Red Cross	133,316		12,487		145,803	
Taiwan Red Cross Organisation	8,000				8,000	
The Canadian Red Cross Society	100,000				100,000	
The Canadian Red Cross Society (from Canadian Gov	21,109				21,109	
The Netherlands Red Cross (from Netherlands Govern	645,425				645,425	
United States Government - USAID	1,519,901				1,519,901	
Total Contributions and Other Income	6,383,450	0	12,487	4,999,111	11,395,048	0
Total Income and Deferred Income					11,395,048	0