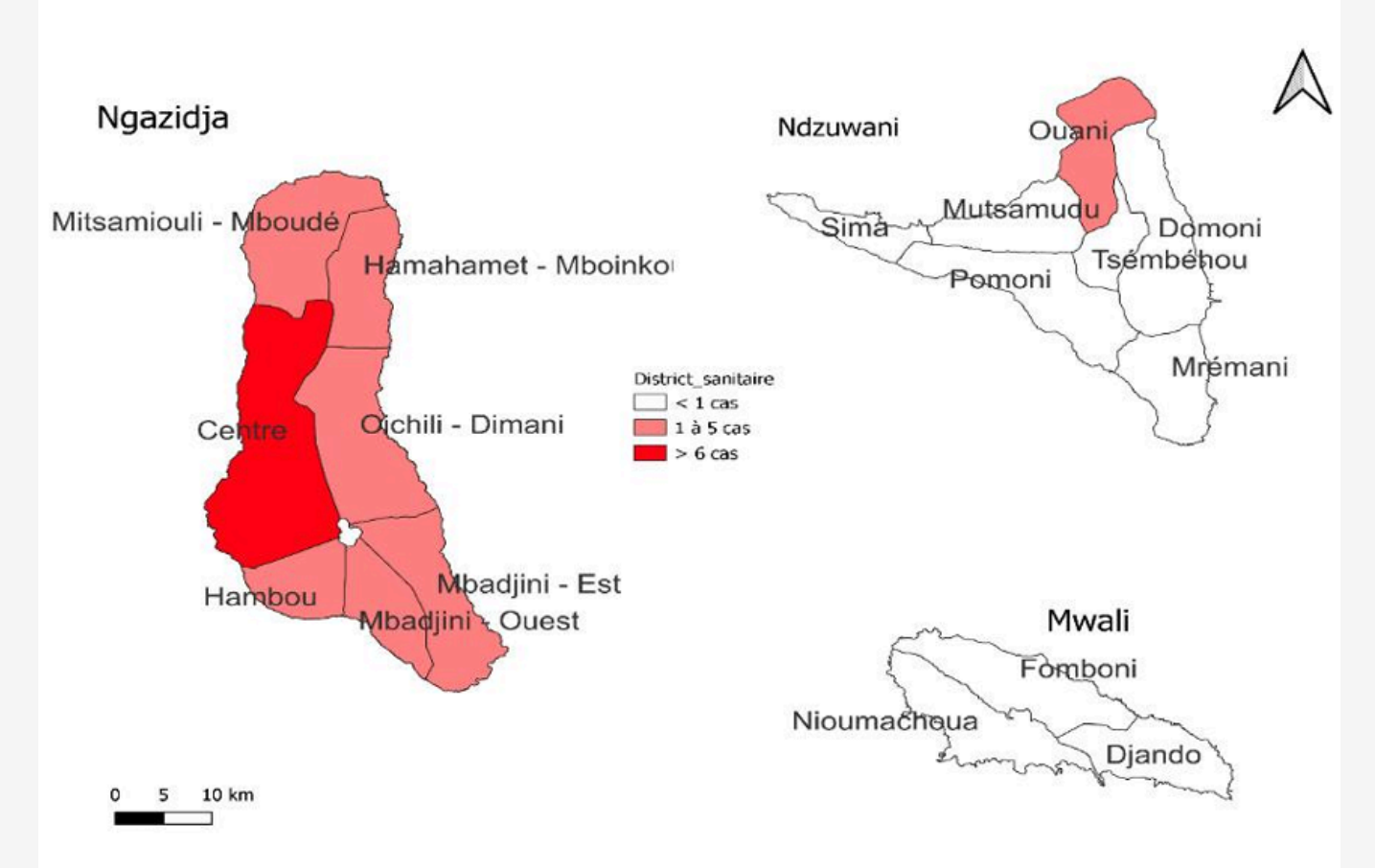
DREF Operational Update

Mpox epidemic emergency response

KAP survey on Mpox - Focus Group Discussion with women in Hambou

Appeal: **MDRKM014**	Total DREF Allocation: **CHF 428,215**	Crisis Category: Yellow	Hazard: **Epidemic**
Glide Number: -	People Affected: **42 people**	People Targeted: **30,000 people**	
Event Onset: **Sudden**	Operation Start Date: **29-01-2026**	New Operational End Date: **31-07-2026**	Total Operating Timeframe: **6 months**
Reporting Timeframe Start Date: **29-01-2026**		Reporting Timeframe End Date: **29-04-2026**	
Additional Allocation Requested: -		Targeted Regions: **Grande Comore (Njazidja), Anjouan (Nzwani), Moheli (Mwali)**	

Description of the Event



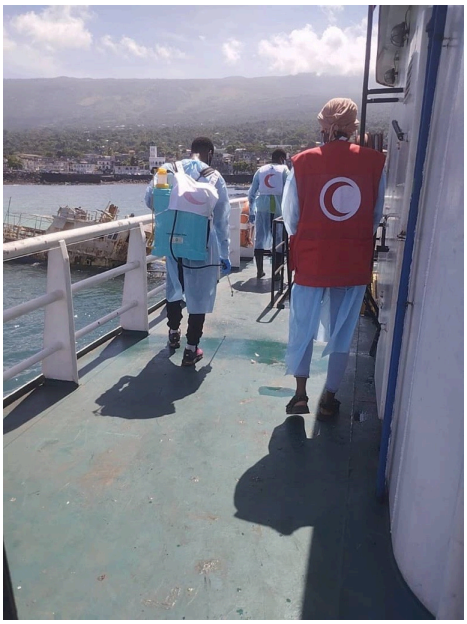
Map of Comoros with geographic distribution of confirmed Mpox cases

Date of event

23-01-2026

What happened, where and when?

On 13 January 2026, the Union of the Comoros declared a national public health emergency following the confirmation of four Mpox (clade Ib) cases on its territory, all imported from Madagascar, where the outbreak remains active with 1,188 confirmed cases and three deaths as of 24 April 2026. The cases were linked to two separate maritime arrivals from Mahajanga to Ngazidja: a vessel arriving on 14 January was associated with three confirmed cases within the same family, while a second vessel arriving on 15 January was linked to a fourth case. All four individuals were initially placed under home surveillance before being transferred on 16 January to the Samba isolation and treatment centre in Moroni. Beyond the imported cases (6 in total as of April 30th), all remaining cases reflect active local community transmission. As of 30 April 2026, a cumulative total of 42 confirmed cases had been reported nationwide - 41 in Ngazidja and 1 in Anjouan.



Disinfection by CoRC volunteers of a boat arriving from Mahajanga - Moroni

Home visit and hygiene kit distribution

Participants at the DREF official launch workshop in Moroni

SIMEX on RCCE during the EPiC training in Moheli

Scope and Scale

As of 30 April 2026, the Union of the Comoros has recorded a cumulative total of 42 confirmed Mpox cases (clade Ib) since the onset of the outbreak. Of these, three cases remain active and are currently hospitalised, while 37 patients have recovered and no deaths have been reported (CFR: 0%). All confirmed cases have presented with moderate clinical severity. The national cumulative attack rate is 4.4 cases per 100,000 population, with transmission heavily concentrated on Ngazidja, which accounts for 97.6% of reported cases across six affected districts (attack rate: 8.6 per 100,000). One confirmed case has been reported in Anjouan, while Mohéli remains unaffected. Epidemiologically, the outbreak shows a marked male predominance (3:1 ratio), with children aged 0–15 years comprising 50% of cases; the median age is 20 years (range: 6 months–68 years).

Beyond its health effects, the outbreak has generated significant humanitarian consequences. The closure of the Samba treatment and isolation center in Moroni on 8 March 2026 - triggered by unpaid health worker allowances - necessitated a shift to home-based case management, substantially increasing household transmission risks. This was particularly evident among young children in overcrowded, resource-constrained households. The suspension of screening activities at points of entry further weakened containment capacity. Livelihood-related constraints have also undermined treatment adherence, with some patients refusing admission or leaving care due to income loss, lack of food provision at facilities, distance from treatment sites and limited social support. Concurrent measles transmission has further complicated community understanding of Mpox, contributing to delayed care-seeking and reduced acceptance of public health measures.

Vulnerability is most pronounced among children aged 0–15 years; residents of densely populated urban and peri-urban settings where effective isolation is not feasible; maritime and port workers exposed through occupational contact with international travelers; and socio-economically marginalized households with limited access to healthcare, hygiene supplies and treatment. Healthcare workers and Comoros Red Crescent volunteers also face elevated occupational exposure. The identification of Foumbouni (Mbadjini-Est, Ngazidja) as a new transmission hotspot signals a geographic expansion of risk beyond the capital area with all the districts in Ngazidja affected.

This first-ever Mpox outbreak in the country has occurred within a context of well-documented systemic vulnerability. Recent public health and climate-related emergencies - including COVID-19, recurrent cholera outbreaks, flooding and cyclones - have exposed persistent gaps in laboratory capacity, infection prevention and control (IPC) supplies, WASH infrastructure and inter-island response logistics. As a small island developing state with strong maritime connectivity to Madagascar and chronic shortages in the health workforce, the Comoros faces an inherently high risk of epidemic amplification. This risk remains acute given continued weekly maritime arrivals from Madagascar, where the outbreak is ongoing, with over 1,188 confirmed cases and three deaths reported as of 24 April 2026.

In response to these compounding challenges, the CoRC adapted its strategy by expanding support for home-based care, including hygiene kit distribution, household decontamination activities and regular psychosocial support. The National Society also engaged in advocacy to facilitate the reopening of the Samba centre, including financial support for health worker remuneration. A major operational milestone was achieved in epidemiological week 16 with the re-operationalisation of the Samba treatment centre and the opening of a new isolation facility in Foumbouni (Mbadjini-Est), marking a return to structured facility-based care and a critical step toward strengthened outbreak control.

In late March 2026, 10,000 doses of the MVA-BN vaccine against Mpox were procured and received in-country. This initial allocation is intended to cover approximately 5,304 priority recipients, including close contacts of confirmed cases, health personnel, including CoRC volunteers engaged in the operation, and other vulnerable individuals. As of 25 April 2026, preliminary vaccine administration has commenced in the Oichili district (Ngazidja), targeting close contacts, ahead of the official campaign launch. The CoRC is actively engaged in vaccination preparedness activities and will participate in the campaign, which is expected to play a critical role in reducing onward virus transmission across the country.

Source Information

Source Name	Source Link
1. Minutes of the Cabinet meeting of January 21, 2026 - Confirmation of Mpox suspects	https://alwatwan.net/politique/conseil-des-ministres-i-mpox-quatre-suspects-plac%C3%A9s-en-quarantaine-%C3%A0-samba-nkuni.html
2. Press briefing by the Minister of Health - Medical confirmation of four cases of Mpox	https://alwatwan.net/sante/mpox-le-minist%C3%A8re-de-la-sant%C3%A9-confirme-quatre-cas-en-provenance-de-madagascar.html

Summary of Changes

Are you changing the timeframe of the operation	**Yes**
Are you changing the operational strategy	**No**
Are you changing the target population of the operation	**No**
Are you changing the geographical location	**No**
Are you making changes to the budget	**No**
Are you requesting an additional allocation?	**No**

Please explain the summary of changes and justification:

The continued persistence of the Mpox epidemic in the Union of the Comoros warrants an operation extension, within an operational environment marked by significant constraints that have limited the overall effectiveness of the response. These include the shift to household-based case management following the closure of the Samba treatment and isolation centre in Moroni; the weakening of health screening mechanisms at points of entry; insufficient adherence to Infection Prevention and Control (IPC) measures in home isolation settings; and the general slowdown of activities during the Ramadan period. These compounding factors have heightened the risk of accelerated community transmission, as reflected in the progression of confirmed cases from 4 at the onset of the operation to 42 to date. Furthermore, the importation risk remains active, given the weekly arrival of travellers from Madagascar, where the outbreak continues to spread. In this context, the Comoros Red Crescent (CoRC) has maintained its operational engagement, implementing the necessary strategic adjustments to preserve the achievement of set objectives. As several critical activities could not be fully completed within the initially planned operational timeframe - owing to the constraints outlined above - additional time is required to consolidate response gains and address remaining operational gaps across all intervention areas.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC, through its Indian Ocean Countries Delegation and country representative, is coordinating the engagement of Movement partners to ensure the availability of appropriate technical, logistical, and financial support to CoRC for the implementation of planned activities. Given the cross-border nature of the outbreak and its direct epidemiological link with the ongoing Mpox outbreak in Madagascar, the IFRC regional cluster is facilitating coordination, coherence, and harmonization of the response across the affected countries. Formal coordination mechanisms are fully operational, including regular weekly coordination meetings between the IFRC, PIROI, and the CoRC. These mechanisms aim to ensure structured information sharing, joint monitoring of response actions, and effective complementarity among all Movement partners. The IFRC regional health department is fully mobilized to provide continuous technical and strategic support to the CoRC. This includes guidance on epidemic preparedness and response protocols, harmonization of approaches with the ongoing response in Madagascar, and quality assurance of both ongoing and planned activities. Technical support also ensures alignment of the response with IFRC regional and global Mpox response guidelines and facilitates access to relevant regional technical resources.
Participating National Societies	PIROI (Indian Ocean Regional Intervention Platform) is supporting the IFRC in coordination and resource mobilisation efforts for the CoRC. PIROI is actively exploring funding opportunities to enable a rapid response, with a focus on strengthening technical capacity, providing specialised equipment, and potential deployment of technical surge capacity. PIROI maintains pre-positioned emergency stocks both in-country and in La Réunion, which can be rapidly mobilised as required to support the timely delivery of essential supplies. The French Red Cross, through its country delegation, remains engaged in national coordination mechanisms and stands ready to provide technical expertise in epidemic preparedness and response, in support of the collective Movement response.

ICRC Actions Related To The Current Event

There is no ICRC presence in Comoros. ICRC maintains liaison with the Movement coordination mechanisms through the IFRC Cluster Delegation and has been informed of the epidemic situation for potential support if protection-related needs emerge.

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	The Government of the Union of the Comoros, through the Ministry of Health, initiated a rapid public health response following the detection of Mpox cases linked to travelers arriving from Mahajanga, Madagascar. Emergency response protocols were immediately activated upon identification of the first four suspected cases. On 23 January 2026, the Minister of Health officially confirmed the four cases during a press briefing and declared a national public health emergency, calling for increased vigilance and mobilization across line ministries, health authorities and civil society partners. Immediate response measures were implemented, including the activation of the Samba Isolation and Treatment Centre in Moroni (Ngazidja) on 16 January 2026 to isolate suspected cases initially placed under home monitoring. As additional cases were identified in Anjouan, authorities rapidly operationalized a second isolation facility on 25 January 2026 to manage two suspected cases arriving from Mahajanga, demonstrating early multi-island response coordination. Standardized treatment and care protocols were applied in both facilities, and clinical management of confirmed cases has, to date, prevented severe outcomes among the nine reported cases. Laboratory diagnostic capacity was made operational on January 21, 2026, following the urgent procurement and receipt of Mpox diagnostic reagents, enabling testing of samples from suspected cases at national level. Surveillance and screening measures were reinforced at major points of entry. Health screening posts were established at ports and airports in Ngazidja and Anjouan, with systematic screening of travelers arriving from affected areas, particularly maritime arrivals from Madagascar. Contact tracing activities are ongoing for all confirmed and suspected cases. Epidemiological investigations are tracing contacts linked to the four initial imported cases as well as the subsequent suspected cases. The identification of three suspected cases in Ngazidja with preliminary indications of secondary transmission has triggered intensified contact identification and follow-up. The Ministry of Health is coordinating the multisectoral response through the activation of emergency coordination structures, including a national crisis cell. Coordination mechanisms include inter-ministerial collaboration (Health, Interior, Transport and Communication), technical working groups focusing on case management and surveillance, and partnerships with civil society organizations, including the Comoros Red Crescent as a key community-level implementing partner. Risk communication and community awareness activities have been initiated, including public statements by the government spokesperson, press briefings by the Ministry of Health, and dissemination of prevention messages through national media channels.
UN or other actors	WHO, in line with its normative mandate, is providing technical guidance to the Ministry of Health on Mpox case definitions, clinical management protocols, infection prevention and control (IPC) standards, and epidemiological surveillance. WHO has confirmed its commitment to support the government's response in close coordination with the Ministry of Health. WHO has made its technical expertise available through the country office, the regional office via the Nairobi hub, and other WHO entities, to support the different pillars of the national response as required. UNICEF is contributing to preparedness and response efforts through support to community-level interventions. Under a UNICEF-funded project implemented by the Comoros Red Crescent, 36 community health workers have been trained and deployed in Ngazidja to support health screening and monitoring at points of entry. This project is expected to be expanded to train additional community health workers in Anjouan and Mohéli. UNICEF also supports the relevant technical working groups and

	contributes to the development and dissemination of IEC materials to strengthen risk communication and community engagement.

Are there major coordination mechanism in place?

1. National-level coordination – Government crisis cell: National coordination is led through the national crisis cell under the authority of the Secretary of the Government. The structure ensures inter-ministerial coordination involving the Ministries of Health, Interior and Transport. CoRC is formally recognized as an auxiliary to the public authorities and is positioned as the primary community-level implementing partner supporting the national response.

2. National-level coordination – Ministry of Health emergency coordination: The Ministry of Health is coordinating the public health response through its emergency coordination mechanisms, ensuring inter-departmental collaboration among technical departments and engagement with technical and financial partners. The CoRC is actively participating in this coordination framework, contributing to surveillance, risk communication and community-based response activities.

3. Island-level coordination – Regional Health Directorates: Response coordination mechanisms have been activated at island level in Ngazidja and Anjouan, under the leadership of the Regional Health Directorates, in close collaboration with district health offices. The CoRC is an active operational partner, deploying volunteers to support response activities across both islands. To date, Mohéli has not yet been fully integrated into active response coordination structures, despite the ongoing risk of case importation through inter-island and maritime movements.

4. Technical coordination – Health cluster and technical working groups: Technical coordination is assumed to be operational under the leadership of the Ministry of Health through the Health cluster and relevant technical working groups. The CoRC contributes to the mapping of IEC tools, adaptation of key messages and sharing of community-based surveillance data. However, coordination platforms for WASH, Protection and Mental Health and Psychosocial Support (MHPSS) have not yet been explicitly activated, representing a gap in the multisectoral response.

5. Movement coordination – IFRC Indian Ocean Cluster: Movement coordination is ensured through the IFRC Indian Ocean Cluster Bureau, with regular weekly coordination calls between the IFRC, PIROI and the CoRC. These mechanisms support information sharing, operational alignment and cross-border coordination with the ongoing Mpox response in Madagascar.

Needs (Gaps) Identified

Health

1. Epidemiological surveillance, diagnostics, and referral: Despite early preparedness measures taken by the authorities, the emergence of this first epidemic, reveals structural constraints. The delayed arrival of diagnostic inputs initially forced suspected cases to remain under home isolation, increasing the risk of intra-household transmission. The centralization of testing capacities (a single national laboratory), combined with inter-island logistical challenges, creates bottlenecks that may delay case confirmation and patient isolation. Surveillance mechanisms remain permeable at informal and secondary points of entry, while community surveillance struggles to cover dispersed or mobile populations. The 21-day contact tracing and monitoring process is hindered by a lack of trained human resources and the absence of digital data management tools. Logistically, sustaining the safe transport of patients - currently provided by the CoRC ambulance service in Ngazidja - imperatively requires the training of Civil Security (COSEP) teams to take over operations and extend this vital mechanism to the other two islands.

2. Clinical management and IPC: Admission capacities are under severe strain, evidenced by the early discharge of patients from the Samba site to free up beds, signaling a risk of rapid saturation should transmission intensify. The quality of care requires immediate strengthening, as health personnel lack prior experience with this specific pathology. It is urgent to deploy intensive training on clinical protocols and IPC, while securing Personal Protective Equipment (PPE) stocks for a sustained response. Regarding CoRC volunteers mobilized on the frontlines in isolation centers, a reinforced support system including continuous training, psychosocial support, and systematic rotation is indispensable to guarantee their safety and prevent burnout.

3. Risk Communication and Community Engagement (RCCE): The current setup (34 health workers and 20 volunteers) offers insufficient geographic coverage given the epidemic's multi-island dynamic, leaving areas like Mohéli island (currently spared but vulnerable) without adequate prevention. A major strategic gap lies in the lack of targeted communication toward high-risk groups identified as potential vectors (maritime workers, inter-island traders, fishermen). A strategic shift is necessary to adapt messages and specifically target these key populations to break transmission chains at critical junctures.

Water, Sanitation And Hygiene

1. Sanitary infrastructure and institutional safety: Major structural constraints in WASH infrastructure are currently compromising the effectiveness of infection prevention measures. Isolation centers face critical challenges, including insufficient handwashing stations and medical waste management systems that require urgent upgrading to prevent nosocomial infection risks for patients and healthcare staff. Simultaneously, hygiene facilities at points of entry, schools, and community gathering sites remain inadequate or require immediate maintenance.

2. Operational capacity and community support: The sustainability of disinfection operations, currently led by CoRC volunteers, is threatened by the imminent depletion of essential consumables (chlorine, soap, disinfectants, PPE). At the household level, families hosting suspected or confirmed cases lack the resources and technical knowledge to ensure safe disinfection, increasing the risk of intra-household transmission. Furthermore, the lack of systematic disinfection of high-risk transmission vectors (public transport, markets, mosques) represents a gap in the community sanitary barrier.

3. Specific vulnerability in the maritime supply chain: A critical gap has been identified in maritime cargo handling. Port workers, lacking adequate PPE and safe handling protocols, face high exposure risks when unloading goods from affected areas. This vulnerability is corroborated by the recent contamination of a suspected case (the 5th case) during cargo retrieval, underscoring the urgent need to target this sector with specific WASH interventions.

Protection, Gender And Inclusion

The outbreak presents significant protection risks compounded by Comoros' small, close-knit island communities, where stigma and social exclusion can severely impact affected individuals and their families. Fear of isolation, economic loss from mandatory quarantine, and discrimination are undermining healthcare-seeking behavior and delaying case detection, with the potential that individuals conceal symptoms or avoid health screening at entry points to evade isolation measures. The three suspected cases in Ngazidja showing evidence of secondary transmission suggest delayed care-seeking, possibly driven by stigma or fear of social consequences.

Vulnerable groups face disproportionate risks that require targeted, inclusive interventions. Children and adolescents are at risk given Madagascar's epidemic pattern showing cases as young as 3 months, yet child-specific protection measures, safeguarding protocols for household visits by volunteers, and age-appropriate messaging are not systematically integrated into response activities. Pregnant women require specialized clinical care and psychosocial support, but pregnancy-specific protocols and safe referral pathways are not yet established. People living with HIV and other immunocompromised individuals face elevated severe disease risk but lack priority surveillance, testing, and clinical management pathways integrated with existing HIV services.

Women face gender-specific vulnerabilities, including caregiving burdens for isolated family members without compensation or support, domestic violence risks during prolonged household isolation, and limited decision-making power regarding health-seeking for themselves and their children. Maritime workers, predominantly male, face occupational exposure without adequate protection or compensation for lost income during isolation periods. Marginalized groups, including men who have sex with men, sex workers, and transgender persons, face dual vulnerabilities of potential elevated exposure and significant barriers to care-seeking due to criminalization, discrimination, and fear of disclosure in conservative island societies.

The elderly and people with disabilities face access barriers to health information, screening services, and isolation facilities that are not designed with accessibility considerations. Economic vulnerability is pervasive, with limited household capacity to absorb income loss during 21-day isolation/monitoring periods, lack of food security support for quarantined families, and absence of livelihood protection mechanisms for informal sector workers who comprise the majority of the archipelago's workforce.

Community Engagement And Accountability

1. Feedback mechanisms and infodemic management: Current accountability mechanisms are limited, lacking systematic platforms for affected populations to report concerns confidentially or influence operational decisions. The absence of a formal rumor tracking system allows unverified information regarding Mpox transmission and treatment to circulate, potentially driving stigmatization and care avoidance. It is imperative to strengthen trust in health actors through transparent communication and demonstrated responsiveness to community feedback.

2. Mobilization of key stakeholders: The engagement of the island-specific community structures (notables, religious leaders, women's and youth groups) remains ad hoc and requires systematic integration into response planning to ensure local ownership. Furthermore, a critical opportunity lies in the mobilization of the private sector, which is currently untapped. Strategic partnerships with maritime transport companies (passenger screening), market associations (hygiene infrastructure), and mobile network operators (SMS campaigns) are essential to extend the reach of prevention messages and secure key economic transmission vectors.

Any identified gaps/limitations in the assessment

The assessment is constrained by the early stage of the outbreak (11 days since initial detection), limiting the availability of robust data to fully characterize the event's dynamics.

- Epidemiological uncertainties: Data gaps in case investigations particularly regarding the cases in Ngazidja and the absence of precise indicators on contact tracing completeness (loss to follow-up rates, total contacts identified) make it difficult to distinguish between contained transmission within contact networks and the onset of established community transmission.
- Surveillance blind spots: Risk assessment remains incomplete regarding Mohéli island and the coverage of secondary and informal maritime points of entry, precluding the exclusion of silent viral circulation via inter island traffic.
- Unmeasured capacities and impacts: The surge capacity of infrastructure (single laboratory, limited PPE stocks) to handle a potential caseload increase remains to be confirmed. Furthermore, the socio-economic (income loss) and psychosocial impacts on isolated households have not yet been quantified, though they occur within a context of pre-existing systemic fragility (limited resources, co-morbidities) that exacerbates population vulnerability.

Operational Strategy

Overall objective of the operation

The operation aims to halt the transmission of Comoros' first Mpox epidemic and prevent geographic expansion across the archipelago by strengthening early detection at entry points and in communities, enhancing infection prevention and control in households and healthcare settings, and ensuring dignified, stigma-free access to health services for 30,000 people across three islands (Ngazidja, Anjouan, Mohéli) through the deployment of 500 trained volunteers over a six-month operational period.

Operation strategy rationale

Operation strategy rationale
The CoRC's operational strategy is calibrated to address the Union of Comoros' first documented Mpox epidemic, originating from maritime importation from the ongoing outbreak in Madagascar (395 cases as of 20 January). With a rapid progression to nine cases across two islands and preliminary evidence of secondary transmission, there is an imminent risk of sustained community spread. Consequently, the operation prioritizes community-level prevention, early detection, and support to isolation facilities - areas where CoRC possesses a demonstrated comparative advantage. As an auxiliary to public authorities, CoRC's intervention is designed to strictly complement the government's clinical and health systems response.

Urgent needs addressed
The operation targets four critical operational gaps:
(1) Incomplete surveillance at secondary maritime points of entry and informal landing sites, which permits continued case importation from Madagascar.
(2) Critical IPC/WASH shortages in households and isolation centers, addressing the risk of nosocomial

infection where secondary transmission is suspected.
(3) Stigma-induced care avoidance, which compromises containment within cohesive island communities.
(4) Geographic vulnerability, particularly in Mohéli, which requires immediate preventive action to forestall importation despite currently having no detected cases.

Strategic priorities rationale
Five priorities align with WHO technical guidance, IFRC epidemic response frameworks, and national response architecture:
1. Community-based surveillance and entry point screening: Expands CoRC's existing deployment of volunteers at major ports to systematically cover secondary maritime entry points, informal boat landings, and fishing communities where most Madagascar-Comoros maritime traffic arrives unscreened. Trained volunteers on EPiC conduct risk communication and education to encourage protective behaviors. In line with the operational plan, CoRC will continue to support community-based surveillance and active case finding through volunteers and community health workers trained in EPiC, active case finding and contact tracing and follow-up. Regarding health screening at points of entry, the CoRC's focus will remain on secondary entry points, with primary points of entry covered by the Ministry of Health.
2. Community Engagement Accountability (CEA): Counters stigma, misinformation, and care avoidance through culturally adapted messaging delivered by trusted community volunteers in local languages. Engages traditional leaders, religious authorities, women's groups, and island-specific community structures to build trust and promote care-seeking.
3. WASH and environmental decontamination: Scales up CoRC's existing disinfection operations to ensure systematic coverage of arriving vessels, households with cases/contacts, isolation facilities, public spaces, and high-risk sites, including markets, transport hubs, and mosques. Installs handwashing facilities at strategic locations and distributes hygiene kit to households with cases.
4. Psychosocial support: Addresses mental health impacts on isolated patients (facing 21-day isolation away from families), monitored contacts experiencing anxiety and social exclusion, healthcare workers and volunteers facing secondary trauma, and communities experiencing collective stress from the first-time epidemic and economic disruption. Psychosocial support services will continue to be provided by the contracted psychologist, recruited at the request of the Ministry of Health and funded through the operation. The service has been highly valued by patients and has demonstrated clear added value in the overall clinical and psychosocial management of confirmed cases.
5. Isolation centers support and health system strengthening: Reinforces CoRC's critical role supporting operational isolation facilities with materials/equipment, IPC, and patient accompaniment, while strengthening referral pathways, ambulance services, and coordination with health authorities.

Methods justification
CoRC leverages its nationwide network of trained volunteers embedded in communities across all three islands (Ngazidja, Anjouan, Moheli) to ensure trusted, culturally appropriate last-mile delivery, proven effective during Comoros' COVID-19 and cholera responses. Integration with CoRC's existing response (70+ volunteers already mobilized) enables immediate scale-up without start-up delays.

Digital reporting tools enable real-time data sharing with national health authorities, strengthening surveillance and operational decision-making. Accountability to affected populations is ensured through systematic community feedback mechanisms. The operation integrates Protection, Gender, and Inclusion (PGI) approaches throughout all activities, with safeguarding principles applied to prevent sexual exploitation, abuse, and harassment.

Over the two-month extension period, the CoRC intends to consolidate and strengthen its response, with a focus on completing pending activities and reinforcing ongoing interventions. These include the replenishment of hygiene kit stocks, the procurement and installation of handwashing facilities, and the strengthening of the community feedback mechanism. Sensitization campaigns will be intensified and expanded to incorporate vaccination messaging, while response strategies will be adjusted in line with the recommendations emerging from the Mpox KAP qualitative survey.

Key contextual factors
Strategy accounts for:
(1) Direct epidemiological linkage to Madagascar's expanding epidemic requiring continuous border surveillance
(2) Small island geography creating both containment opportunities and vulnerabilities (limited health infrastructure, inter-island mobility, supply chain dependencies, critical vulnerability to cyclones, floods, and volcanic eruptions with high coastal population density);
(3) Preliminary evidence of secondary transmission;
(4) Zero historical Mpox experience requiring intensive education and training;
(5) Economic fragility with limited household isolation capacity;
(6) Ongoing cholera risk and endemic diseases (malaria, lymphatic filariasis, Leprosy, ...) creating syndemic context
(7) Cultural factors including strong family networks, gender norms affecting care-seeking, and importance of religious/traditional authorities.

Exit strategy
With the two-month extension granted, the operation will conclude at the end of July 2026 through a phased transition of response functions to national systems and community structures, ensuring continuity of essential services and sustainability of capacity gains achieved. Successful exit will be guided by the following criteria: a sustained decline in newly confirmed cases over consecutive epidemiological weeks; functional treatment and isolation capacity at both national (Samba) and regional level; operational community-based surveillance and contact tracing systems across all three islands; completion of the priority-group MVA-BN vaccination campaign; and fully functional CEA and community feedback mechanisms.

Throughout implementation, close integration between the CoRC and government health authorities has enabled progressive capacity transfer aligned with national epidemic response strategies. At operation closure, community-based surveillance and active case finding, household-level IPC oversight, psychosocial support services, CEA mechanisms and WASH services are expected to be absorbed into existing Ministry of Health systems, community platforms and local authority structures, supported by the trained volunteer and community health worker networks established through the operation.

Should transmission persist or new importation risks emerge at the time of closure, the CoRC - in close coordination with the IFRC and the Ministry of Health - will develop a transition plan to ensure continuity of critical interventions until outbreak control is achieved. Indicative follow-up scenarios include the activation of a follow-on DREF should the scale of transmission warrant additional support; and strengthened regional coordination through PIROI to mobilize additional technical and financial resources. These scenarios remain indicative and will be assessed against the prevailing epidemiological situation and available national response capacity as the end of the operation approaches. In parallel, the CoRC is currently developing a national epidemic contingency plan, which will serve as an additional institutional framework for resource mobilization and response preparedness beyond the scope of this operation.

The skills and knowledge acquired by CoRC volunteers through EPiC, WASH, PSS and CEA training are deliberately anchored at community level, ensuring that gains in epidemic preparedness endure beyond the operational period. The operation will further strengthen the CoRC's institutional capacity through improved volunteer management systems, enhanced inter-island coordination mechanisms, upgraded IPC and WASH protocols, and systematically documented lessons learned - all contributing to the NS's long-term resilience and readiness for future epidemic responses.

Targeting Strategy

Who will be targeted through this operation?

Geographic targeting logic:
The operation targets all three inhabited islands of the Comorian archipelago based on epidemiological risk, population vulnerability, and importation potential:

Ngazidja - Priority level 1
Rationale: Epicenter with 7 of 9 cases, including preliminary evidence of secondary transmission; hosts capital Moroni with the highest population density; primary entry point for both maritime and air traffic from Madagascar.
Target areas: Moroni and surrounding districts, coastal communities receiving boat traffic, markets and transport hubs.
Population: ~15,000 people

Anjouan - Priority level 1
Rationale: 2 confirmed cases detected on 24 January from a vessel arrival from Mahajanga; significant maritime connectivity to Madagascar; high population density.
Target areas: Mutsamudu (capital), secondary ports, coastal fishing communities
Population: ~10,000 people

Mohéli - Priority level 2 (high prevention)
Rationale: No cases detected, but high importation risk via inter-island maritime traffic from Ngazidja and Anjouan, and direct vessels from Madagascar; the smallest island with the most limited health infrastructure.
Target areas: Fomboni (capital), fishing communities, inter-island transport hubs
Population: ~5,000 people.

Although Mohéli has not recorded any confirmed Mpox case to date, interventions on the island remain essential and retain their operational priority. The absence of confirmed cases may reflect the effectiveness of early preventive action and does not diminish the risk of importation, given sustained maritime connectivity with affected islands and Madagascar. Community-based surveillance and risk communication and community engagement (RCCE) remain the primary areas of intervention, aimed at maintaining vigilance, ensuring early detection capacity and sustaining community awareness ahead of any potential case emergence.

Population groups targeted:
1. Maritime and mobile populations (transport workers, traders, fishing communities, passengers)

Why: All confirmed cases linked to maritime arrivals from Mahajanga; 2,000+ travelers from Madagascar currently being monitored; continuous importation risk as long as the Madagascar outbreak persists
How: Active screening at all entry points, RCCE at departure/arrival points, contact tracing, handwashing facilities at 15 port locations, targeted messaging for maritime associations and transport operators

2. Monitored contacts and their households
Why: 21 contacts under active 21-day monitoring as of 25 January; risk of secondary transmission within households
How: Daily home visits by volunteers, household disinfection, PSS support, isolation support for households, stigma reduction messaging
3. Urban high-density communities (Moroni, Mutsamudu)
Why: 7 of 9 cases concentrated in urban Moroni; overcrowding, shared sanitation, and high mobility facilitate rapid transmission
How: Door-to-door sensitization, community dialogue sessions, handwashing stations in public spaces
4. Healthcare workers and volunteers
Why: 70+ CoRC volunteers already deployed face occupational exposure; healthcare workers lack Mpox experience and PPE
How: IPC training, PPE provision for health personnel and volunteers, regular health monitoring, PSS support
5. Children and adolescents
Why: Vulnerable to severe outcomes; schools and congregate youth settings are potential amplification sites; Madagascar's outbreak included cases as young as 3 months
How: School-based handwashing stations, age-appropriate RCCE materials, child safeguarding protocols during household visits, family-based PSS
6. Pregnant women
Why: Risk of severe maternal-fetal complications requiring specialized care
How: Priority surveillance and referral, integration with antenatal care services, specialized PSS, maternal health service coordination
7. Immunocompromised individuals (PLHIV, malnourished, chronic illness)
Why: Elevated risk of severe disease and prolonged viral shedding; require priority clinical care
How: Integration with HIV/TB/chronic disease services, priority PSS, targeted education on vulnerability, confidential screening mechanisms
8. Elderly and people with disabilities
Why: Limited mobility creates barriers to health information and services; higher risk of severe outcomes
How: Home-based surveillance, accessible communication materials, caregiver engagement, priority PSS for isolated individuals
9. Women and economically marginalized populations
Why: Caregiving burdens, limited decision-making power, inability to sustain isolation due to lost income (majority informal sector workforce)
How: Women-led dialogue sessions, support through hygiene kits, engagement of women's groups in RCCE, gender-sensitive messaging
10. Marginalized and stigmatized groups
Why: May face care-seeking barriers due to discrimination; epidemic response must ensure equitable, dignified access
How: Confidential RCCE, peer engagement where culturally appropriate, anti-stigma campaigns, safe reporting mechanisms, and non-discriminatory volunteer training

Vulnerable group approaches:

- Maritime workers: Engagement with transport associations, maritime unions, and port authorities for workplace sensitization and PPE provision.
- Mobile populations: Portable RCCE materials, messaging at transport hubs, cross-border communication
- People with disabilities: Multi-modal communication (visual, audio, simplified language), home-based surveillance, accessible handwashing facilities.
- Elderly: Intergenerational family-based messaging, priority PSS, caregiver training on IPC
- Economically marginalized: Hygiene kit distribution to reduce isolation costs, engagement of informal sector associations.

Target groups remain largely unchanged from those identified. However, strategic adjustments made in response to the evolving epidemiological situation may affect the achievement rates of certain indicators, without compromising the overall attainment of the operation's stated objectives.

Explain the selection criteria for the targeted population

Target populations were selected using three evidence-based criteria: (1) epidemiological risk based on case distribution and transmission patterns, (2) vulnerability to severe outcomes or care barriers, and (3) transmission amplification potential.

1. Epidemiological risk criteria: Geographic concentration prioritizes islands with confirmed cases (Ngazidja: 7 cases, Anjouan: 2 cases) while including Mohéli for preventive interventions given high importation risk. Maritime populations on Madagascar-Comoros routes are prioritized as 100% of cases linked to boat arrivals from Mahajanga, with all ports (principal, secondary, informal landings) targeted as 2,000+ travelers continue arriving. The 21 contacts under active monitoring and their household members receive priority interventions, given the highest probability of secondary transmission.
2. Vulnerability criteria: Age-based vulnerability includes children and the elderly (severe outcome risk). Immunocompromised individuals (PLHIV, malnourished, chronic illness patients) and pregnant women are prioritized for severe disease and complication risks. Marginalized populations facing dual vulnerability - elevated exposure risk plus care-seeking barriers from stigma - are included alongside socioeconomically vulnerable groups (urban informal settlement residents, informal sector workers), unable to sustain isolation with inadequate WASH and limited healthcare access. People with disabilities
are selected for access barriers to health information and services.
3. Transmission amplification criteria: Healthcare workers and volunteers are selected to protect the health system functionality and prevent nosocomial transmission. Urban high-density areas (Moroni, Mutsamudu) are prioritized for rapid amplification potential in densely populated coastal cities. Mobile populations, including maritime workers and inter-island traders, are targeted for their role in geographic spread across the archipelago

Vulnerable group rationale
Vulnerable groups receive priority because they experience:
(1) A higher likelihood of severe disease/death.
(2) Systematic barriers to accessing care.
(3) Compounding vulnerabilities.
(4) Potential for onward transmission. Selection ensures equity by addressing both medical vulnerability and social determinants, preventing outbreaks.

Total Targeted Population

Women	**7,902**	Rural	**30%**
Girls (under 18)	**7,008**	Urban	**70%**
Men	**7,998**	People with disabilities (estimated)	**5%**
Boys (under 18)	**7,092**		
Total targeted population	30,000		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**

Does your National Society have child protection/child safeguarding policy?	**Yes**
Does your National Society have whistleblower protection policy?	**No**
Does your National Society have anti-sexual harassment policy?	**Yes**

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

Risk	Mitigation action
Financial and procurement compliance risks (delay in financial reporting) driven by limited NS capacity and island-specific logistical constraints (delay in procurement).	Leverage ongoing financial system strengthening (supported by a CBF project) to enhance financial management infrastructure and ensure timely reporting Implement a hybrid procurement strategy prioritizing local markets, supported by IFRC / PIROI regional mechanisms for specialized items.
Cyclones, floodings and volcanic activity may disrupt operations, limit access to intervention areas, damage infrastructure, and overwhelm health systems with competing emergencies.	Proactively engage with meteorological services and DGSC to monitor forecasts. Establish contingency stocks on each island. Pre-position volunteers on Anjouan and Mohéli with clear mandates for autonomous operations. Maintain flexible implementation timeline to accommodate weather-related delays.
Risk of sexual exploitation, abuse, and harassment (SEAH) compounded by household visits to isolated families, vulnerable populations facing elevated risk, and power imbalances between volunteers and stressed communities.	Mandatory SEAH and Child Safeguarding training before deployment with signed Code of Conduct. Implement two-volunteer rule for all household visits. Establish confidential reporting mechanisms with clear investigation protocols. Regular supervision and spot-checks. Gender-balanced volunteer teams. Community awareness of complaint mechanisms.
Low passengers screening at points of entry and weak treatment adherence increase the risk of undetected importation and silent household transmission, undermining outbreak control efforts.	Continue community-based surveillance and outreach, strengthen follow-up of contacts and high-risk groups, and support coordination to improve monitoring and screening at points of entry, ensuring early detection and timely referral of suspected cases.
Continue risk of geographic spread through the ongoing local transmission - concentrated on Ngazidja and emerging in new districts - can led to a sustained community transmission	Maintain and strengthen community-level interventions, including active case detection, contact tracing, household-level IPC support and targeted risk communication, to interrupt transmission chains and prevent the formation of new community clusters.
Cultural stigma and religious norms surrounding sexuality discourage disclosure of Mpox symptoms, leading to delayed care-seeking, under-reporting and sustained silent transmission.	Strengthen structured engagement with religious and community leaders to support community mobilisation and trust-building. Integrate Mpox-specific messaging into existing community and religious platforms - particularly mosque-based outreach - to reduce stigma, normalise health-seeking behaviour and promote early disclosure and referral.

Please indicate any security and safety concerns for this operation:

Volunteer/staff safety: Frontline volunteers face infection exposure, stigma-related hostility, and psychosocial strain risks. Mitigation includes comprehensive IPC training, PPE provision, community leader engagement, paired deployment, PSS support, rotation schedules, weather monitoring, and insurance coverage.

Community Safety: Rumor-driven violence, child safeguarding concerns during household visits, and elevated GBV risks from prolonged isolation require proactive rumor management, volunteer vetting, two-volunteer rule for child interactions, gender-balanced teams, and referral pathways to protection services.

Operational security protocols: 24/7 incident reporting line to CoRC coordination, volunteer identification cards and visibility vests, close coordination with local authorities and police, evacuation plans for each island, suspension protocols if security deteriorates, and regular communication schedules for volunteers in remote areas.

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

Planned Intervention

Health

Budget: CHF 199,186
Targeted Persons: 30,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of volunteers trained in Epidemic Preparedness and Response in Community (EPiC) and deployed	390	303
% of daily alerts detected, investigated, and referred through CBS system	80	70
% of identified contacts traced and monitored	100	100
# of isolation/treatment centers receiving technical and material support	3	2
# of volunteers and staff receiving PPE	514	30
# of PSS sessions provided to affected individuals, families, volunteers, and healthcare workers	400	15
# of healthcare workers trained on case management and IPC	50	0
# of Civil Security agents in the 3 islands on safe patient transport protocols	60	0

# of volunteers trained to provide PSS	40	19
% of monitored households reporting improved psychosocial wellbeing after PSS sessions	80	90
% of volunteers, healthcare workers and civil security agents who report increased capacity to safely perform epidemic response roles (post-training self-assessment)	80	100
# of people reached through RCCE campaigns (interpersonal communication, mass media, community sessions)	30,000	39,981
# of IEC materials produced and disseminated (posters, flyers, brochures)	3,000	3,250
% of people reached who demonstrate accurate knowledge of Mpox symptoms, transmission, and prevention (via rapid KAP checks)	70	0
# of volunteers reporting into CBS system	390	109
# of confirmed cased detected via CBS mechanism	-	21

Progress Towards Outcome

In line with the operational plan, 303 volunteers and community health workers were mobilised and trained across the three islands (119 in Ngazidja, 100 in Anjouan and 112 in Mohéli) on the EPiC (Epidemic Preparedness in Communities) methodology and active case finding. Training was delivered across multiple sessions in close collaboration with the relevant technical directorates of the Ministry of Health, and with the support of UNICEF and WHO. Each session was assessed through pre- and post-tests; over 80% of participants demonstrated adequate knowledge retention and the capacity to transmit and apply the skills acquired. Volunteers are deployed to conduct community-based surveillance, active case finding, contact tracing and population sensitization at community level and at points of entry, in an integrated approach and in coordination with health authorities.

Data collected through these activities is reported via the ODK platform established by the Ministry of Health, to which all response partners — including the CoRC — have access, ensuring centralized and streamlined data flow. As of 29 April 2026, 350 alerts had been notified and investigated through the platform, yielding 125 suspect cases, 121 samples collected and 42 confirmed cases (positivity rate: ~33%). Confirmed cases show a 3:1 male-to-female ratio, with 50% of cases among children aged 0–15 years and a median age of 20 years (range: 6 months–68 years).

As of 25 April 2026, CoRC's contribution to the contact tracing system resulted in 244 contacts notified, with a follow-up rate of 93% (226 of 244 contacts successfully followed up).

- Case management support: The CoRC was actively engaged in supporting case management across several areas: ambulance transport of suspected and confirmed cases from their homes to the Samba treatment center in Moroni (25 cases transferred); provision of equipment (mattresses, bedding, pillows, washing machines) and medical supplies to the Samba site; support to the remuneration of medical personnel assigned to the Samba site; and provision of communication and logistical resources to the relevant government technical services overseeing the response.
- Psychosocial support (PSS): A contracted psychologist in Ngazidja — where 97.5% of cases are concentrated and psychosocial needs are most acute — conducted 15 PSP sessions benefiting 10 patients, with a satisfaction rate of 90%. In Anjouan (1 confirmed case to date) and Mohéli (no confirmed cases), 19 volunteers have been trained in PSP and are available to provide services as needed.
- Risk communication and community sensitization: A total of 39,981 people (19,156 men and 20,825 women) were reached through sensitization activities across the three islands, delivered via focus group discussions, community dialogues, door-to-door visits and mosque-based outreach by volunteers. In coordination with the CREC technical working group, IEC materials were developed and the CoRC disseminated 3,250 materials comprising 3,000 leaflets and 250 posters distributed to volunteers across all three islands.

The majority of planned activities under this sector have been initiated and are at varying stages of implementation. Two activities remain pending: training of health personnel, which has been removed from the CoRC scope following its takeover by WHO, and training of ambulance personnel from the General Directorate of Civil Security (DGSC), scheduled for late May 2026. All remaining activities - including community-based surveillance, active contact tracing, logistical support to treatment facilities and psychosocial support - will continue through the end of the extension period.

Water, Sanitation And Hygiene

Budget: CHF 60,350
Targeted Persons: 30,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of volunteers trained on hygiene promotion, household disinfection, and environmental decontamination protocols	75	75
# of people reached with hygiene promotion and awareness-raising sessions	30,000	39,981
# of public spaces receiving systematic environmental disinfection	50	47
# of households of confirmed/suspect cases receiving disinfection and decontamination services	150	23
# of household hygiene kits distributed to isolated families and monitored contacts	100	13
# of handwashing facilities installed at strategic locations (ports, markets, transport hubs, community centers, health facilities, schools)	70	0
% of targeted locations where functional handwashing facilities are used regularly by community members	70	0
% of targeted population with improved knowledge of hygiene behaviors relevant to Mpox transmission	80	0

Progress Towards Outcome

WASH activities during the reporting period covered four main areas: volunteer capacity strengthening, infection prevention and control (IPC), disinfection and decontamination of public spaces and affected households, and hygiene kit distribution.

1. Volunteer capacity strengthening: A total of 75 volunteers were trained or refreshed across the three islands (30 in Ngazidja, 30 in Anjouan and 15 in Mohéli) on practical WASH-based epidemic response techniques. Training covered IPC measures applicable in treatment settings, preparation of chlorine solutions for decontamination and disinfection purposes, correct use and removal of personal protective equipment (PPE), handwashing key moments, and other barrier measures for community-level promotion.
2. Infection Prevention and Control (IPC): IPC support was provided at the Samba and Anjouan treatment centers and at all major points of entry (three airports, three main ports and secondary ports). Volunteers deployed at these sites supported health personnel in temperature screening and passenger data collection for surveillance purposes, as well as chlorine solution preparation and

decontamination of premises, vessels and cargo. Passengers at points of entry additionally received key messages on Mpox prevention and hygiene practices; handwashing stations - supplied by the Ministry of Health - were installed at these sites, with volunteers actively encouraging their use. PPE was provided to all deployed volunteers to ensure safe task execution. Medical waste management at the Samba treatment center was also addressed as part of the IPC response; the CoRC supported the collection and transport of medical waste to an appropriate incineration site, with approximately 96 m^3 of waste safely collected and incinerated.

3. Disinfection and decontamination. Decontamination activities were extended beyond ports and airports to cover the national laboratory, hospital wards where cases were detected, and households of suspected or confirmed cases. As of 25 April 2026, a cumulative total of 47 disinfection sessions had been conducted across treatment sites (Samba and Anjouan), the national laboratory, vessels arriving from Madagascar and Mayotte, and the homes of affected individuals. In partnership with UNICEF, decontamination campaigns were also carried out at market sites as part of the broader epidemic response.
4. Hygiene kit distribution: To support affected households in maintaining adequate hygiene conditions and limiting onward transmission - particularly following the closure of the Samba treatment centre in early March 2026 due to a health workers' strike, which resulted in a shift to home-based case management - hygiene kits were distributed to each household with a confirmed case under home care. A total of 13 hygiene kits were distributed, each comprising a 20-litre tap bucket, 4 bars of soap and 10 strips of 10 Aqualab water purification tablets, sourced from CoRC stock and to be replenished.

The main outstanding activities to be completed are the replenishment of hygiene kits and the procurement and installation of handwashing stations and associated consumables. Ongoing activities include hygiene promotion and sensitization (delivered by EPiC-trained volunteers) and disinfection and decontamination sessions (IPC) across multiple settings, including treatment sites, vessels, public spaces and the households of confirmed cases.

Protection, Gender And Inclusion

Budget: CHF 8,810
Targeted Persons: 30,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of people reached with PGI information (anti-stigma messaging and discrimination prevention information)	30,000	39,981
# of vulnerable individuals (pregnant women, children, PLHIV, immunocompromised, mobile workers) receiving targeted information and support services	2,000	197
# of safe referrals provided to protection services	-	2
% of concerns/complaints related to stigma, discrimination, or access barriers reported and addressed within 7 days with documented resolution	100	70
% of affected individuals reporting reduced stigma or discrimination following targeted PGI and RCCE interventions	90	0
# of community feedback and reporting mechanisms established and functional	3	3

# of staff and volunteers trained/briefed on PGI	514	407

Progress Towards Outcome

During the reporting period, PGI activities focused on four main areas, in line with the operational planning.

1. Volunteer and staff refresher training: The PGI principles, prevention of sexual exploitation and abuse and child protection modules were systematically integrated into the curricula of the three majors training sessions conducted (EPiC, WASH, and PSP), reaching a combined total of 407 volunteers, community health workers and CoRC staff.
2. Community leader engagement: Community leaders were mobilized as key partners in reinforcing health messaging, promoting barrier measure adoption, and combating stigma towards recovered patients and passengers arriving from Madagascar. Their involvement also aims to facilitate case reporting and early health-seeking behavior. Given that sexual transmission represents a primary route of Mpox spread — and that topics related to intimate contact remain socially taboo in the Comorian context — community leader engagement is considered essential, while acknowledging that these actors can themselves occasionally constitute barriers to open communication.
3. Confidential reporting mechanism: Recognizing the limitations of the existing community feedback mechanism in terms of confidentiality, an independent psychologist has been contracted to provide both psychosocial support services and a confidential communication channel for patients, through which appropriate guidance and referrals are facilitated.
4. Community perception and inclusion barriers survey. A qualitative survey on inclusion barriers and community perceptions, led by the Ministry of Health with UNICEF technical and financial support and CoRC participation, yielded the following preliminary findings:
   - Near-universal awareness of Mpox, but with significant knowledge gaps regarding transmission routes, causes and prevention.
   - A marked disconnect between perceived risk and protective behavior: prevention measures are understood primarily through a COVID-19 lens, with Mpox-specific practices less well internalized.
   - Limited visibility of the community response, underlining the need for broader geographic coverage — a challenge given current resource constraint.

   Survey recommendations will inform adjustments to the response strategy.
5. To be noted that certain indicators are designed to be measured at the close of the operation, and dedicated end of operation evaluation is planned.

Community Engagement And Accountability

Budget: CHF 16,664
Targeted Persons: 30,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
% of feedback items received, documented, and responded to through accountability systems	100	100
% of community members reporting trust in CoRC volunteers as reliable sources of information	90	80
# of community dialogue sessions, focus group discussions, and community meetings conducted	40	10
# of operational decisions or programme adaptations informed by community feedback and documented in coordination meetings	-	0

# of people reached by targeted dialogue sessions and FGDs conducted by trained volunteers	30,000	39,981
# of volunteers trained on community feedback coding	12	0
# of community feedback committee meeting or workshop held	90	10
% of recommendations from community meetings implemented	80	0

Progress Towards Outcome

The CEA principles are embedded across all levels of the operation to ensure effectiveness, relevance and respect for affected populations. Key activities during the reporting period are as follows.

- Volunteer and community health worker capacity strengthening: A total of 303 volunteers and community health workers responsible for community-level response activities received CEA training, comprising initial training sessions for new volunteers and refresher sessions for experienced staff. Training covered core CEA principles and the operationalization of the feedback mechanism, equipping volunteers with the skills necessary to promote community participation and adherence to response activities.
- Feedback mechanism and rumor tracking system: The CoRC reactivated its community feedback mechanism at the onset of the outbreak through its decentralized structures, with all available communication channels disseminated to target communities. Community sensitization sessions served as primary collection points for community requests, complaints and rumors, which were systematically reported back through volunteer networks. Field supervision missions provided additional opportunities for direct community feedback collection.
  In coordination with UNICEF and WHO, targeted questions to capture beneficiary feedback on response activities were integrated into the ODK data collection platform, used for both contact tracing and sensitization monitoring. The CoRC's Facebook page has also been actively leveraged as a community engagement and accountability channel, generating interactions on Mpox-related content posted during the reporting period.

The main pending activity currently in preparation is the training of volunteers on feedback coding, scheduled for the first two weeks of May 2026. Additional activities - including community meetings for feedback collection, targeted community dialogues, and the establishment of partnerships with private sector actors are ongoing and will continue throughout the extension period.
To be noted that certain indicators are designed to be measured at the close of the operation, and dedicated end-of-operation evaluations are planned to enable their assessment.

Secretariat Services

Budget: CHF 44,045
Targeted Persons: 30,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of coordination meetings conducted (national, regional, and with Movement partners)	20	12
# of monitoring and supervision missions conducted	4	2
% of planned monitoring missions completed and resulting in timely	100	50

adaptive management actions		

Progress Towards Outcome

The IFRC, through its Indian Ocean Islands Cluster Delegation and its in-country representative based in Moroni, provides continuous technical and financial support to the CoRC in the implementation of the operation. The sustained in-country presence significantly facilitates this support, while ensuring full respect for the respective mandates and prerogatives of each partner.
Under the coordination of the CRCo, regular Movement coordination meetings are convened with all in-country network members - namely the IFRC, PIROI and the French Red Cross. These meetings were held on a weekly basis at the onset of the outbreak and have since shifted to a bi-weekly frequency, reflecting the evolving operational rhythm. Regular field supervision missions are also conducted jointly to support activity implementation, identify operational gaps and provide corrective technical guidance.

National Society Strengthening

Budget: CHF 73,025
Targeted Persons: 30,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of situation reports produced and disseminated	8	9
# of monthly progress reviews conducted	4	2
# of mid-term review and lessons learned workshops conducted	2	0
% of monitoring and supervision missions completed vs. planned	100	50
% of evidence of improved preparedness or enhanced CBS/WASH/CEA systems after operation (documented in lessons learned or end-of-operation review)	40	0
# of monitoring and supervision missions conducted	8	4

Progress Towards Outcome

Following confirmation of the first cases and DREF validation, the CoRC formally launched the operation through a kick-off workshop bringing together representatives of the Ministry of Health at various levels, the French Red Cross (FRC), the IFRC, and CoRC staff and volunteers. Response activities were mobilised immediately thereafter, in line with the operational plan. Key actions undertaken to strengthen the National Society's response capacity during the reporting period include the following.

- A National Epidemic Management Committee was established under the chairmanship of the CoRC National President. The Committee is responsible for overseeing the overall conduct of the response, ensuring operational coherence, and addressing institutional or logistical obstacles that may impede implementation.
- Weekly situation reports have been produced throughout the operation to document the evolving epidemiological situation and the CoRC's response actions. A cumulative total of nine Sitreps have been published to date.
- A total of four field supervision missions have been conducted, including one joint mission with the Minister of Health and the ministerial cabinet to Mohéli. These missions provided an opportunity to assess field-level implementation, identify gaps and refine the operational strategy accordingly.

The CoRC actively participates in the overall coordination of the response in its auxiliary role to the public authorities. In this capacity, the NS is engaged across multiple response fronts through structured coordination arrangements with the Ministry of Health and other partners.

However, the delayed engagement of some partners and the limited resources committed by the government have placed disproportionate operational demands on the NS, whose own resources remain constrained. In order to maximise impact within available capacity, the CoRC will refocus its efforts during the extension period on the areas where its comparative advantage and community presence are most decisive: community mobilisation and engagement, IPC application at treatment sites and in the households of confirmed cases, and psychosocial support to patients and affected families.

About Support Services

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

Total personnel: 514
Staff (14):
Operation Manager: overall coordination, Ministry of Health liaison, strategic oversight. She/he will be supported by the IFRC's operations manager based in the country.
PMER Officer: monitoring, reporting, data management, community engagement, feedback analysis
Finance/Admin Officer: budget management, disbursements, financial reporting, compliance
Logistics Officer: procurement, supply chain management, inventory control
CEA Officer: RCCE coordination, IEC materials production, media engagement, and support social media campaigns
Health and WASH Coordinators (2): technical oversight, CBS protocols, IPC guidance, healthcare worker training coordination
Island Focal Points (3): One per island (Ngazidja, Anjouan, Mohéli) - supervise volunteers, coordinate with island health directorates, support local logistics, ensure quality and accountability
Support staff (4): volunteer manager, drivers, and national warehouse manager

Volunteers: 500
Community-Based Surveillance and RCCE team (390): Active case finding using simplified case definition, household visits to monitored contacts, alert generation and reporting through digital tools, referral to health facilities, weekly data reporting to national surveillance system, door-to-door sensitization, community dialogue sessions, anti-stigma messaging, rumor tracking and reporting, community feedback collection, engagement with traditional/religious leaders
WASH/Disinfection team (75): Household and public space decontamination, vessel disinfection at ports, handwashing facility installation and maintenance monitoring, hygiene promotion demonstrations.
PSS Support team (35): Basic psychological first aid for isolated patients, monitored contacts, healthcare workers, and affected communities; family support sessions; volunteer peer support facilitation.
All volunteers are from the targeted islands, ensuring cultural and linguistic alignment with beneficiary communities.
A volunteer workforce of 500 is necessary for several reasons:

- Island geography and village distribution: As an island nation comprising 332 villages, most of which are coastal, the risk of disease importation and transmission remains constant due to the frequent arrival of boats from Mahajanga (Madagascar) and Mayotte. Passengers arriving through these routes require systematic follow-up.
- High maritime traffic: There are 15 active ports (both primary and secondary) with continuous maritime activity, demanding sustained monitoring and community engagement.
- Geographical constraints: The geographic layout necessitates autonomous, pre-positioned teams on each island to ensure timely response and coordination.
- Health system fragility: The national health system remains fragile and highly dependent on partner support, particularly the Comorian Red Crescent, for community-based surveillance and risk communication. Lessons learned from past epidemics, as well as observations from the onset of the current one, confirm the scale of the needs.
- Operational requirements: For several activities, volunteers must be deployed in pairs, and rotational schedules are required to ensure continuous coverage.

Does your volunteer team reflect the gender, age, and cultural diversity of the people you're helping? What gaps exist in your

volunteer team's gender, age, or cultural diversity, and how are you addressing them to ensure inclusive and appropriate support?

CoRC implements a gender-responsive strategy targeting at least 50% female representation to ensure culturally appropriate access to PSS and home visits for women. The team composition combines youth (60%) with senior volunteers (40%) to maintain credibility within traditional structures, leveraging digital reporting capacity. Deployment is strictly localized by island to navigate specific local dialect variations. To address gaps in the representation of persons with disabilities and stigmatized groups (maritime workers), the operation will consult disability organizations for inclusive messaging and utilize peer-to-peer engagement strategies.

Will surge personnel be deployed? Please provide the role profile needed.

Surge personnel will be deployed on a needs-based basis through established IFRC mechanisms, including PIROI and Partner National Societies (French Red Cross, others), to provide specialized technical expertise in:

- Emergency health/epidemic response specialist: Provides technical guidance on CBS systems, IPC protocols, outbreak investigation, and health system coordination; supports training delivery for healthcare workers and volunteers; strengthens linkages with WHO and Ministry of Health technical structures. each island to ensure timely response and coordination.
- Community Engagement and Accountability (CEA) specialist: Strengthens feedback mechanisms, supports rumor tracking system design, provides training on participatory approaches, and ensures accountability frameworks are operational.

Surge deployments will be time-bound (2 to 8 weeks) to support specific technical needs such as training delivery, system establishment, or capacity building. Deployments will be triggered by:

- Rapid geographic expansion requiring accelerated volunteer training.
- Complex coordination demands as the epidemic evolves.
- Specific technical gaps identified by CoRC or the Ministry of Health.
- Laboratory or clinical management challenges requiring specialized expertise.

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

The operation will utilize a hybrid approach. Local procurement (around 70%), managed by CoRC, covers WASH supplies, IEC materials, and volunteer visibility to ensure rapid deployment (2-3 weeks) and support the local economy. International procurement (around 30%), managed by IFRC/PIROI, covers specialized PPE and medical-grade disinfectants. This leverages PIROI's regional stocks in La Réunion for immediate mobilization while ensuring strict compliance with international quality standards for safety equipment.

How will this operation be monitored?

The operation will be monitored through a comprehensive framework combining real-time data collection, regular supervision, and participatory review mechanisms:

The operation will be monitored through a comprehensive framework combining real-time data collection, regular supervision, and participatory review mechanisms:

1. Real-time digital reporting
   - CBS volunteers report daily alerts, referrals, and community feedback through mobile platform (NYSS).
   - WASH volunteers document disinfection sessions, handwashing facility status, and hygiene kit distribution.
   - Weekly data consolidation by PMER officer into dashboards tracking outputs against targets.
2. Operational monitoring
   - Bi-weekly situation reports tracking epidemiological trends, activity outputs, operational challenges, and adaptive management decisions.
   - Monthly indicator reviews assessing outcomes: % cases detected via surveillance system, contact tracing completeness, population knowledge levels through rapid KAP surveys, handwashing facility functionality, PSS reach and effectiveness.
   - Sex/age/disability disaggregated data collection enabling equity analysis across all activities.
3. Field supervision:
   - Island Focal Points conduct weekly spot-checks of volunteer activities on each island.
   - Bi-monthly CoRC coordination team supervision missions rotating across intervention zones.
   - Joint IFRC-CoRC field monitoring missions assessing quality, accountability, beneficiary satisfaction, and safeguarding compliance.

4. Participatory review:
   - Mid-term review workshop, evaluating progress and enabling adaptive management.
   - End-of-operation lessons learned workshop with all stakeholders documenting successes, challenges, and recommendations for future preparedness.
5. Coordination monitoring:
   - Weekly Movement coordination meetings (IFRC, PIROI, French RC, CoRC) reviewing implementation status, identifying bottlenecks, ensuring complementarity.
   - Daily coordination with the MoH reviewing epidemiological data, surveillance system performance, and response effectiveness.
   - Community feedback mechanisms analyzed weekly to inform operational adjustments.
6. Financial monitoring:
   - Monthly financial reports tracking expenditures against budget lines.
   - Monthly financial spot-checks by IFRC Indian Ocean Cluster.
   - Procurement documentation review, ensuring compliance with IFRC procedures.

Please briefly explain the National Societies communication strategy for this operation

CoRC implements a comprehensive strategy focusing on:
- Internal coordination: rapid information flow via digital tools (WhatsApp) and regular coordination meetings (weekly staff briefings, bi-weekly Movement calls).
- Community engagement: a two-way approach using mass media (Radio, TV, social media) for awareness, and community-based feedback mechanisms (hotlines, focus groups) to track rumors and adapt messaging.
- Accountability: visible complaint mechanisms at intervention sites with a closed feedback loop, ensuring community concerns directly influence operational decisions.
- Regional alignment: technical support from the IFRC and PIROI to ensure consistency with the regional response (Madagascar) and donor reporting standards.

Budget Overview

IFRC

DREF OPERATION

MDRKM014 - Comoros Red Crescent
Mpox epidemic emergency response

Operating Budget

Planned Operations	**303,536**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	212,133
Water, Sanitation & Hygiene	64,273
Protection, Gender and Inclusion	9,383
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	17,747
Environmental Sustainability	0
Enabling Approaches	**124,679**
Coordination and Partnerships	0
Secretariat Services	46,908
National Society Strengthening	77,772
TOTAL BUDGET	**428,215**

all amounts in Swiss Francs (CHF)

Click here to download the budget file

Contact Information

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

National Society contact: Ali Soumaili DANIEL, Secretary General, s.daniel@cr-comores.org, +2693607060

IFRC Appeal Manager:
Papa Moussa Tall, Acting Head of Country Cluster Delegation for the Indian Ocean Islands, papemoussa.tall@ifrc.org, +254727911975

IFRC Project Manager: Abel A. Agbomenou, Manager, Operations, abel.agbomenou@ifrc.org, +261343300213

IFRC focal point for the emergency: Abel A. Agbomenou, Manager Operations, abel.agbomenou@ifrc.org, +261343300213

Media Contact: Susan Nzisa Mbalu, Communications Manager, susan.mbalu@ifrc.org, +254733827654

National Societies' Integrity Focal Point: Saïd ABDOU, Programmes Director, papa_idji@yahoo.fr

Click here for the reference