DREF Operational Update

Mpox epidemic emergency response

Mass sensitisation in a school, Antsirabe region, Photo CRM

Appeal: **MDRMG026**	Total DREF Allocation: **CHF 394,995**	Crisis Category: Yellow	Hazard: **Epidemic**
Glide Number: **-**	People Affected: **228 people**	People Targeted: **50,000 people**	
Event Onset: **Sudden**	Operation Start Date: **20-01-2026**	New Operational End Date: **31-07-2026**	Total Operating Timeframe: **6 months**
Reporting Timeframe Start Date: **20-01-2026**		Reporting Timeframe End Date: **31-10-2026**	
Additional Allocation Requested: **0**		Targeted Regions: **Analamanga, Betsiboka, Boeny, Diana, Haute Matsiatra, Alaotra-Mangoro, Melaky, Sofia, Vakinankaratra, Vatovavy-Fitovinany**	

Description of the Event

Volunteers training on Mpox, Photo CRM

Date of event

24-12-2025

What happened, where and when?

Madagascar is experiencing its first documented Mpox epidemic (clade 1b), which began with the detection of the index case on 17 December 2025 (epidemiological week 51). An official alert was issued on 31 December 2025, marking the recognition of a rapidly evolving public health threat and triggering the activation of national coordination and response mechanisms.

In the early phase of the outbreak, the epidemic showed a sharp increase in cases. As of 12 January 2026, a total of 228 cases had been reported, including 24 laboratory-confirmed and 204 suspected cases, with no deaths recorded (case fatality rate: 0%). The outbreak initially originated and was heavily concentrated in the Boeny region, particularly in Mahajanga I district, which accounted for 66% of reported cases at that time. Rapid geographic expansion was observed, with cases reported in 16 of the country's 23 regions, including Analamanga (the capital region), Vakinankaratra, Betsiboka, Diana, and Haute Matsiatra. Epidemiological data indicated sustained community transmission, with a positivity rate of 34.8% and a rapid escalation from 34 cases on 5 January to 228 cases by 12 January 2026.

Since the declaration of the alert, the epidemic has continued to expand significantly. As of mid-April 2026, a cumulative total of 1,574 suspected cases has been reported, including 749 confirmed cases, reflecting sustained transmission and a substantial increase in disease burden. The epidemic remains geographically concentrated in specific regions, with Boeny identified as the epicentre (35.7% of cases), followed by Analamanga (28.2%), Sofia (6.5%), Diana (4.8%) and Atsimo Andrefana (4.1%) highlighting priority areas for targeted interventions. The other areas accounted for 20.7% of the cases combined.

In response, the Government of Madagascar activated the Public Health Emergency Operations Center (PHEOC/COUSP) on 9 January 2026 to coordinate the national response. This includes the establishment of treatment and isolation centres, deployment of contact tracing systems, and strengthening of surveillance mechanisms, including a national hotline (green line 910). Nine technical commissions have been set up to support the response, covering key areas such as surveillance, laboratory, vaccination, case management, infection prevention and control (IPC/WASH), logistics, research, and risk communication and community engagement (RCCE).

A vaccination strategy was also initiated, with 30,000 vaccine doses delivered on 21 February 2026. The vaccination campaign was launched on 5 March 2026, prioritizing frontline health workers and high-risk populations, including sex workers. Vaccination activities have been rolled out across 14 regions, further reinforcing the national response.

In this context, the Malagasy Red Cross, in its auxiliary role to public authorities, has been actively supporting the response through the implementation of this operation.

Despite ongoing efforts by the Government and partners, gaps persist, particularly in risk communication, community engagement, case investigation, and data analysis. This operation is contributing to addressing these gaps, notably through active participation in the RCCE commission and coordination mechanisms.

Disinfection activities in cars park, Photo CRM

Door to door senstization, Photo CRM

Focus group awareness, Photo CRM

Mass sensitization at school, Photo CRM

Scope and Scale

The Mpox epidemic in Madagascar represents an unprecedented public health emergency with significant and evolving impacts on lives, livelihoods, well-being, and the national health system. Since the detection of the first case in December 2025, the outbreak has expanded rapidly both geographically and in magnitude. While initial reports from 12 January 2026 indicated 228 cases across 16 of the country's 23 regions, the situation has deteriorated considerably. As of mid-April 2026, a cumulative total of 1,574 suspected cases, including 749 confirmed cases have been reported, demonstrating sustained and widespread transmission. The epidemic is far from being contained, with continued increases in case numbers and ongoing geographic spread.

The outbreak remains concentrated in specific high-burden regions, with Boeny identified as the epicentre, accounting for 43.7% of reported cases, followed by Analamanga (28.4%), Atsimo Andrefana (5.4%), and Sofia and Diana (4% each). The continued spread toward densely populated urban centres, particularly Antananarivo, significantly increases the risk of rapid transmission amplification. The epidemic's progression along major transport corridors, including the critical Mahajanga–Antananarivo axis, further facilitates the movement of the virus and exposes mobile populations such as traders, transport workers, and maritime crews.

Despite the absence of reported deaths to date, the epidemic is generating substantial indirect impacts. These include:
(1) disruption of livelihoods due to isolation and monitoring measures;
(2) increasing pressure on health infrastructure, including the need for dedicated isolation and treatment capacities;
(3) psychological distress and social stigmatization affecting patients and communities;
(4) economic disruption, particularly in key transport and trade corridors; and
(5) diversion of already limited health resources from other priority health needs, including the ongoing measles response.

Populations most at risk are both geographically and socially defined. Residents of high-transmission areas such as Mahajanga I and

densely populated urban districts of Analamanga face elevated exposure risks. Analamanga, in particular, remains classified as the highest-risk region due to its population density and role as the country's primary mobility hub. The spread in informal settlements further heightens vulnerability due to overcrowding and limited access to health services.

Specific population groups are disproportionately affected or at higher risk of severe outcomes. These include children and adolescents, with cases reported in very young age groups; pregnant women; and healthcare workers, who face increased exposure risks and require continuous training and protection. Immunocompromised individuals, including people living with HIV, are also among priority groups identified for vaccination. Additionally, socioeconomically vulnerable populations—particularly those living in informal settlements—face challenges in adhering to isolation measures due to limited resources. Stigmatized groups, including sex workers and sexual minorities, face compounded vulnerabilities linked to both exposure risk and barriers to accessing care.

The scale of the epidemic is further compounded by structural health system constraints. Madagascar has no prior experience managing Mpox outbreaks, and the response is taking place in a context of multiple concurrent public health challenges. Limited laboratory capacity—initially restricted to a small number of facilities—has affected timely diagnosis, while logistical and supply constraints, including access to personal protective equipment, continue to pose challenges. The ongoing measles epidemic and the legacy of previous health crises, such as COVID-19 and the 2017 plague outbreak, further strain the system. Patterns observed in past epidemics, particularly the rapid spread along transport corridors, are being replicated in the current Mpox outbreak.

Overall, the combination of sustained transmission, geographic expansion, and systemic vulnerabilities indicates that the epidemic remains dynamic and insufficiently controlled, requiring continued and scaled-up response efforts.

Source Information

Source Name	Source Link
1. Situation Report_04.01.2026	https://ifrcorg.sharepoint.com/:b:/s/IOIClusterDelegation-Files/IQDXYNl11jXnSreCbeMzPPG_Aerx0FapQgWyKtJMpq2Mv1I?e=BcW3ZQ
2. Situation Report_12.01.2026	https://ifrcorg.sharepoint.com/:p:/s/IOIClusterDelegation-Files/IQCMZdJqVfOuSK3Jk8iZH9SPAaxLes7fULyhyUUsRwnhf68?e=9dTJds
3. Situation Report_05.01.2026	https://ifrcorg.sharepoint.com/:b:/s/IOIClusterDelegation-Files/IQCGA7xhFAfRTKJSxbVnNqLYARnCt5zMSsei_FdLCFA4oyU?e=9mUbfa
4. Plan de Riposte contre la Mpox	https://ifrcorg.sharepoint.com/:w:/s/IOIClusterDelegation-Files/IQCKAOt6w3rtQbroeXdD0FYgAWEPC6ruAhyOneVFhWb98Io?e=R6alWv

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:

This operations update requests a two-month, non-cost extension to allow the National Society to finalize the procurement process of the items, ensure sufficient time for their distribution, and enable the use and practice of the distributed items. The extension is necessary as the epidemic remains active in the country and the Government's response is still ongoing, making it critical to maintain continuity and effectiveness in programme delivery.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC, through its Indian Ocean Countries Cluster Delegation, is coordinating action among various Movement partners (PIROI, French RC, German RC and Luxemburg RC) to ensure the availability of necessary technical, logistical, and financial support to the National Society for implementing planned activities. Formalized coordination mechanisms, including regular weekly meetings, are fully operational to ensure structured information sharing, joint monitoring of response actions, and effective complementarity among all partners. The IFRC Regional Health Department is fully mobilized to provide continuous technical and strategic support, including guidance, harmonization, and quality assurance of both ongoing and planned response activities.
Participating National Societies	PIROI supports the IFRC in coordination efforts and resource mobilization for the National Society. It has mobilized funds (approximately 100,000 euros) from the Crisis and Support Centre of the French Ministry for Europe and Foreign Affairs (CDCS) to support a two-month response intervention in four priority regions. The intervention prioritizes technical capacity strengthening and the provision of specialized equipment, notably the procurement of PPE, as well as the potential deployment of additional technical personnel and the strengthening of the CRM's community-based surveillance system (NYSS deployment). The DREF operation is designed to strategically complement this funding, establishing an integrated response framework that leverages technical and logistic assets to maximize impact while strictly avoiding operational duplication. German Red Cross does not have specific Mpox response activities underway at this time but remains engaged with the in-country coordination mechanisms and could potentially contribute to response efforts as the situation evolves. Luxembourg Red Cross currently has no ongoing support activities related to Mpox but has indicated its willingness to mobilize resources should funding gaps emerge during the response.

ICRC Actions Related To The Current Event

No ICRC presence in Madagascar.

Other Actors Actions Related To The Current Event

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

Are there major coordination mechanism in place?

1. National Level Coordination
Central COUSP (Emergency Operations Center)
- Lead: Ministry of Public Health, launched 9 January 2026
- Structure: 8 cells (Coordination, Surveillance, Laboratory, Case Management, IPC-WASH, Logistics, Vaccination, RCCE, Research)
- CRM Position: Recognized key partner participating in Surveillance, RCCE, and WASH cells. No formal co-lead role but functions as primary community implementation partner through auxiliary status
BNGRC (National Disaster Management)
- Lead: Multisectoral coordination across government ministries
- CRM Position: Partner through auxiliary status
Health/WASH Cluster
- Co-Leads: WHO and Ministry of Public Health (assumed standard cluster approach)
- CRM Position: Active WASH Cluster participant, contributed to handwashing facility installations

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

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

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

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

Needs (Gaps) Identified

Health

While initial phases of the outbreak placed significant strain on surveillance, laboratory, and case management capacities, the response has since evolved, with improvements observed in case management, including the establishment of isolation and vaccination centres. However, despite these advances, the epidemic remains active and continues to generate significant needs across multiple pillars of the response.

Ongoing Mpox transmission, with an average of 5 to 10 confirmed cases reported every two days and the notification of three deaths, indicates that the outbreak is not yet under control and continues to pose a public health risk. At the same time, the impact of Cyclone Gezani diverted both national attention and partner resources toward emergency response efforts, resulting in reduced operational focus on Mpox and creating critical gaps in the continuity and intensity of response activities.

Significant needs persist in surveillance and community-level detection. While systems are in place, challenges remain in ensuring early identification and referral of cases, particularly among mobile and hard-to-reach populations. Laboratory capacity, although strengthened, continues to face constraints in ensuring timely testing and analysis at decentralized levels, which may delay confirmation and response.

RCCE remains a major gap. Despite localized efforts by some organizations, overall community awareness of Mpox, its transmission, and prevention measures remains insufficient. Misinformation, stigma, and limited understanding of the disease continue to hinder early care-seeking and adherence to public health measures. The Public Health Emergency Operations Center (PHEOC/COUSP) has emphasized the urgent need for rapid assessments of community perceptions, knowledge, and practices to better tailor communication strategies and interventions.

In addition, essential support services for affected individuals remain inadequate. Repeated requests have been made to address gaps in the provision of food and basic needs for patients in isolation centres, which directly impacts adherence to isolation measures and overall well-being. Without adequate support, affected individuals may be unable or unwilling to comply with recommended public health measures, increasing the risk of further transmission.

Water, Sanitation And Hygiene

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

Protection, Gender And Inclusion

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

Community Engagement And Accountability

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

Any identified gaps/limitations in the assessment

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

Operational Strategy

Overall objective of the operation

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

Operation strategy rationale

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

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

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

Methods justification:
The Malagasy Red Cross (MRC) leverages its network of trained local volunteers to ensure trusted, culturally appropriate last-mile delivery, an approach proven effective during Madagascar's 2017 plague and 2020 COVID-19 responses. Digital reporting tools enable real-time data sharing with the national Public Health Emergency Operations Centre (COUSP), strengthening surveillance and operational decision-making, while anti-stigma messaging delivered through fokontany structures and trusted traditional leaders effectively addresses social barriers that limit care-seeking. Accountability to affected populations is ensured through systematic feedback and complaints mechanisms, with information analysed and used to adapt programming, improve response quality, and strengthen community trust and participation.

The operation will integrate a Protection, Gender and Inclusion (PGI) approach to ensure that response actions actively identify and reduce discrimination and address the gender and age specific impacts of the epidemic. The strategy will support community-based child protection awareness, promote safe and dignified access to services, and establish clear referral pathways for protection concerns. Safeguarding principles will be applied throughout the operation to prevent and mitigate risks of sexual exploitation, abuse and harassment, and to ensure safe engagement with affected communities.

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

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

Targeting Strategy

Who will be targeted through this operation?

Target Population: 50,000 people across 10 priority regions
Geographic targeting logic:
The operation targets 10 regions based on official Government risk scores (0-10) using access risk, mobility, population size, and COUSP capacity criteria: Analamanga (10/10 - capital, 2M+ population), Atsinanana (9/10), Diana (9/10), Boeny (7/10 - epicenter with 150/228 cases), Analanjirofo (8/10), Atsimo Andrefana (8/10), SAVA (8/10), Anosy (7/10), Vakinankaratra (6/10 - 19 cases, 59 contacts), and Bongolava (4/10) (Madagascar National Response Plan, January 2026; SitRep 12 January 2026).

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

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

Explain the selection criteria for the targeted population

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

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

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

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

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

Total Targeted Population

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

Risk and Security Considerations (including "management")

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

policy?	
Does your National Society have anti-sexual harassment policy?	**Yes**

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

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

Please indicate any security and safety concerns for this operation:

Volunteer/Staff Safety Risks:
- Infection exposure: Frontline volunteers face transmission risk during household visits, contact tracing, and community mobilization. Mitigation: Comprehensive IPC training for 180 volunteers, adequate PPE provision, clear referral protocols avoiding direct patient contact, daily health monitoring, insurance coverage.

- Stigma-related hostility: Community resistance or aggression toward volunteers perceived as bringing disease or enforcing isolation. Mitigation: Community leader engagement, uniforms/identification, paired volunteer deployment, incident reporting mechanisms.

- Psychosocial strain: Burnout, secondary trauma from witnessing suffering, social stigmatization of volunteers. Mitigation: Regular PSS debriefing sessions, peer support networks, rotation schedules.

Community Safety Risks:
- Rumor-driven violence: False information could trigger mob action against volunteers or suspected cases. Mitigation: Proactive rumor management, transparent communication, police/local authority coordination protocols.
Child safeguarding: Volunteer interaction with minors (28 schools, household visits) requires protection measures. Mitigation: Volunteer vetting, Code of Conduct, two-volunteer rule for child interactions, reporting mechanisms.

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

Has the child safeguarding risk analysis assessment been completed?	Yes

Planned Intervention

Health

Budget: CHF 130,669
Targeted Persons: 50,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of volunteers trained and deployed for active case finding and RCCE activities	180	230
# of daily alerts detected, investigated, and referred through CBS system	30	224
% of identified contacts traced and monitored	100	100
# of isolation/treatment centers receiving technical and material support	3	0
# of volunteers and staff receiving PPE	200	0
# of household contacts receiving home-based monitoring and support	50	98
# of PSS sessions provided to affected individuals, families, volunteers, and healthcare workers	500	268
# of community healthcare workers trained on case management	60	0
# of volunteers trained to provide PSS	30	200
% of monitored households reporting improved psychosocial wellbeing after PSS sessions	70	100
% of volunteers and community health workers who report increased capacity to safely perform epidemic response roles (post training self assessment)	80	0

# of people reached through RCCE campaigns (interpersonal communication, mass media, community sessions)	50,000	51,907
# of IEC materials produced and disseminated (posters, flyers, brochures)	2,000	30,000
% of people reached who demonstrate accurate knowledge of Mpox symptoms, transmission, and prevention (via rapid KAP checks)	80	0

Progress Towards Outcome

During this reporting period, the primary focus was on initiating all procurement processes. Several planned activities depended on the availability of essential materials and equipment, including personal protective equipment (PPE), WASH kits, and disinfection kits.

Bid evaluation sessions have been completed, and selected suppliers were notified within one week following the evaluation process. Delivery of materials is expected within one week after supplier notification, with all items anticipated to be available by the end of April.

In parallel, efforts have focused on strengthening the capacity of 590 volunteers who will support the implementation of key activities, including community awareness, contact tracing, disinfection, focus group discussions, and targeting for WASH kit distribution.

An initial training of focal points (two per district) was conducted in Antananarivo during the week of 9 March. These focal points subsequently facilitated integrated health training for 20 volunteers per district, reaching a total of 200 volunteers, with the support of their respective Regional Health Directorates.

Additional training sessions on Infection Prevention and Control (IPC/WASH) and Psychological First Aid were conducted from 30 March to 22 April, targeting a further cohort of 20 volunteers per district. Clear activity targets have been established at district level to guide implementation.

Capacity strengthening efforts have been carried out in close collaboration with the Ministry of Health, which provided validated training curricula and experienced trainers across the different technical areas.
At present, the operation is entering the phase of consolidating results from awareness-raising activities and collecting community feedback.

Regarding the actual with 0 indicators, this is due to the procurement process which is still ongoing or the data which will be availed prior to KAP survey results.

Water, Sanitation And Hygiene

Budget: CHF 117,662
Targeted Persons: 50,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of handwashing facilities installed at strategic locations (schools, markets, transport hubs, community centers, health facilities)	100	0
# of households of confirmed/suspect cases receiving disinfection and decontamination services	180	100

# of volunteers trained on hygiene promotion, household disinfection, and environmental decontamination protocols	130	200
# of transport vehicles and public spaces receiving systematic environmental disinfection	100	50
# of people reach with hygiene promotion and awareness-raising sessions	50,000	51,907
% of targeted locations where functional handwashing facilities installed are used regularly by community members	70	0
% of targeted population with improved knowledge of hygiene behaviours relevant to Mpox transmission	70	0

Progress Towards Outcome

Implementation of WASH activities is largely dependent (approximately 75%) on the availability of materials and equipment. As such, full implementation will commence following the delivery of supplies to the districts.
However, volunteers have already been trained in IPC/WASH, and hygiene promotion and awareness activities are ongoing.

Regarding the actual with 0 indicators, this is due to the procurement process which is still ongoing or the data which will be availed prior to KAP survey results.

Protection, Gender And Inclusion

Budget: CHF 10,880
Targeted Persons: 50,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of people reached with PGI information (anti-stigma messaging and discrimination prevention Information)	50,000	51,907
# of vulnerable individuals (pregnant women, children, PLHIV, immunocompromised, mobile workers) receiving targeted information and support services	5,000	5,190
# of safe referrals provided	-	224
% of concerns/complaints related to stigma, discrimination, or access barriers reported and addressed within 7 days with documented resolution	100	100

% 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	1	1
# of staff and volunteers trained/briefed on PGI	375	590

Progress Towards Outcome

PGI and Prevention of Sexual Exploitation and Abuse (PSEA) training for volunteers has been conducted, alongside their mobilization to support awareness-raising, communication of referral pathways, and integration of PGI principles across all activities. This training was integrated in all conducted training to ensure all volunteers and staff get required information of PGI approaches.

Regarding the actual with 0 indicators, this is due to the data which will be availed prior to KAP survey results.

Community Engagement And Accountability

Budget: CHF 15,864
Targeted Persons: 50,000
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 CRM volunteers as reliable sources of information	90	0
% of community dialogue sessions, focus group discussions, and community meetings conducted to support community participation	50	177
# of operational decisions or programme adaptations informed by community feedback and documented in coordination meetings or reports	-	4
# of people reached by targeted dialogue sessions and FGD conducted by the trained volunteers	50,000	4,323

Progress Towards Outcome

A standardized CEA approach is being integrated into the operation to ensure community representation and participation throughout the response.

Volunteers have been trained in CEA, and district-level CEA committees are currently being established to support the distribution of

2,500 WASH kits. These committees will collaborate with Malagasy Red Cross teams in beneficiary targeting, validation of distribution lists, and implementation of distributions.

Suggestion boxes are being prepared to support feedback collection during distribution activities. In parallel, volunteers deployed in the field are collecting community feedback using standardized data collection tools. Feedback is processed at branch level to inform ongoing adaptation of the response.

Secretariat Services

Budget: CHF 39,810
Targeted Persons: 5
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of coordination meetings conducted (national, regional, and with Movement partners)	24	16
# of monitoring and supervision missions conducted	2	2
% of planned monitoring missions completed and resulting in timely adaptive management actions	100	70

Progress Towards Outcome

A PHIE coordinator has been deployed for 3 months as part of a Federation-wide surge mechanism of assistance to the operation. This support includes training, validation of procurement requests from the Ministry of Health, provision of technical expertise, and monitoring of implementation.

At the beginning of the epidemics, coordination meetings were held twice a week then shifted to weekly meetings. The PNS and PIROI regularly attend the meetings organized by the HNS, facilitated by the IFRC Cluster Delegation.

National Society Strengthening

Budget: CHF 80,050
Targeted Persons: 12
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of situation reports produced and disseminated	16	12

# monthly progress review conducted	3	3
# of mid-term review and lessons learned workshops conducted	2	0
% of monitoring and supervision missions completed vs planned	100	70
% of evidence of improved preparedness or enhanced CBS/WASH/CEA systems after the operation (documented in lessons learned or mid term review)	20	0

Progress Towards Outcome

A mid-term review workshop was planned for early May. The workshop will bring together district activity leads, Malagasy Red Cross procurement and finance teams, health technical teams, IFRC representatives, and the Ministry of Health.

The results of the KAP survey and awareness-raising activities will be presented, and recommendations will be collected. Implementation challenges will also be discussed.

The main output of this workshop will be a report, including updated micro-planning for the remaining activities of the operation.

About Support Services

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

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

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

Volunteers: 340
- Community-Based Surveillance (180), WASH and RCCE: active case finding using simplified definition, household visits, alert generation, referral to health facilities, contact monitoring support, weekly data reporting, door-to-door sensitization, meetings, anti-stigma messaging, rumor tracking, community feedback collection
- Disinfection Team (130): household/public space decontamination
- PSS Support (30): basic psychological first aid for affected communities

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

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

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

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

Surge personnel has been deployed on a needs-based basis through established IFRC mechanisms, including PIROI and PNSs, to provide specialized technical expertise in emergency health, epidemic response, Community-Based Surveillance, and Psychosocial Support.

Surge delegates will be deployed in time-bound roles to support technical training delivery and provide hands-on technical assistance for field implementation. Deployments will be triggered by operational requirements such as rapid geographic expansion requiring scale-up of volunteer capacity, laboratory bottlenecks necessitating specimen management support, complex coordination demands, or specific requests from government authorities where National Society capacities are insufficient.

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

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

The procurement is underway and the item will be available by mid-May, from then, the NS will implement all activities related to the procured items and equipment.

How will this operation be monitored?

The operation will be monitored through a harmonized framework combining CRM's CBS reporting system (daily volunteer data via mobile platforms - NYSS), weekly operational SitReps tracking outputs against targets, monthly indicator reviews assessing outcomes (% cases detected via CBS, time symptom-to-isolation, population knowledge levels through KAP surveys), and sex/age disaggregated data collection enabling equity analysis, with the dedicated PMER coordinator for data consolidation and dashboard management while Regional Focal Points conduct weekly field spot-checks.

IFRC monitoring will include bi-weekly virtual coordination meetings with CRM leadership, monthly joint field supervision missions to priority regions, assessing quality and accountability, a structured mid-term review at Month 2 evaluating progress and enabling adaptive management, and an end-of-operation lessons learned workshop, with all stakeholders support if complex data challenges emerge or geographic expansion requires enhanced monitoring capacity.

Please briefly explain the National Societies communication strategy for this operation

CRM implements a comprehensive communication and accountability approach combining internal coordination and external engagement. Internal communication is ensured through established WhatsApp groups for volunteers, staff, and Movement partners, regular information sharing, weekly staff briefings, and bi-weekly Movement coordination meetings. External communication leverages multiple channels, including regular public Situation Reports produced by the MoH with CRM contributions, community feedback mechanisms (hotlines, volunteer reporting, and focus group discussions), mass media partnerships (radio broadcasts, television

interviews, and social media campaigns via CRM's official platforms), and transparency measures such as the public display of the NS complaint mechanisms at intervention sites to ensure affected communities can access information and raise concerns.

IFRC supports these efforts through the IOI Cluster Communications Officer, who provides technical guidance to ensure message consistency across the region, coordinates media engagement in the event of international attention, and oversees reporting through the global DREF communication and reporting platforms.

Budget Overview

IFRC

DREF OPERATION

Code - Malagasy Red Cross
Mpox epidemic emergency response

Operating Budget

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

all amounts in Swiss Francs (CHF)

Click here to download the budget file

Contact Information

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

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Click here for the reference