SIMPLIFIED EARLY ACTION PROTOCOL

Comoros | Cholera

August 2026

sEAP №: **MDRKM015 sEAP2023KM02**	Total Budget **CHF 210,854**	Readiness: **CHF 74,346**	Prepositioning: **CHF 58945**	Early Action: **CHF 77,563**
People to be assisted: **5,000 People**	EAP Approved: **28/08/2026**	EAP timeframe: **2 Years**	EAP lead time: **21 days**	Activation timeframe: **3 months**
Prioritized geographical areas: 19 localities in Ngazidja, Anjouan and Moheri				

RISK ANALYSIS

Prioritized hazard and its historical impact.

Cholera is the prioritized hazard for this Early Action Protocol (EAP) in Comoros, where it remains a significant public health threat. Comoros, though not cholera-endemic, is highly connected, by sea and air, to East and Central African countries with recurrent cholera outbreaks, notably Tanzania, Mozambique, Kenya, the Democratic Republic of the Congo (DRC), Rwanda, Burundi, and Ethiopia. Between December 2024 and January 2026[1], these seven countries reported a combined 101,351 cases and 2,452 deaths – except for Kenya and Rwanda, whose outbreaks ended in December and November 2025 respectively – all reported had ongoing active cases through January 2026.

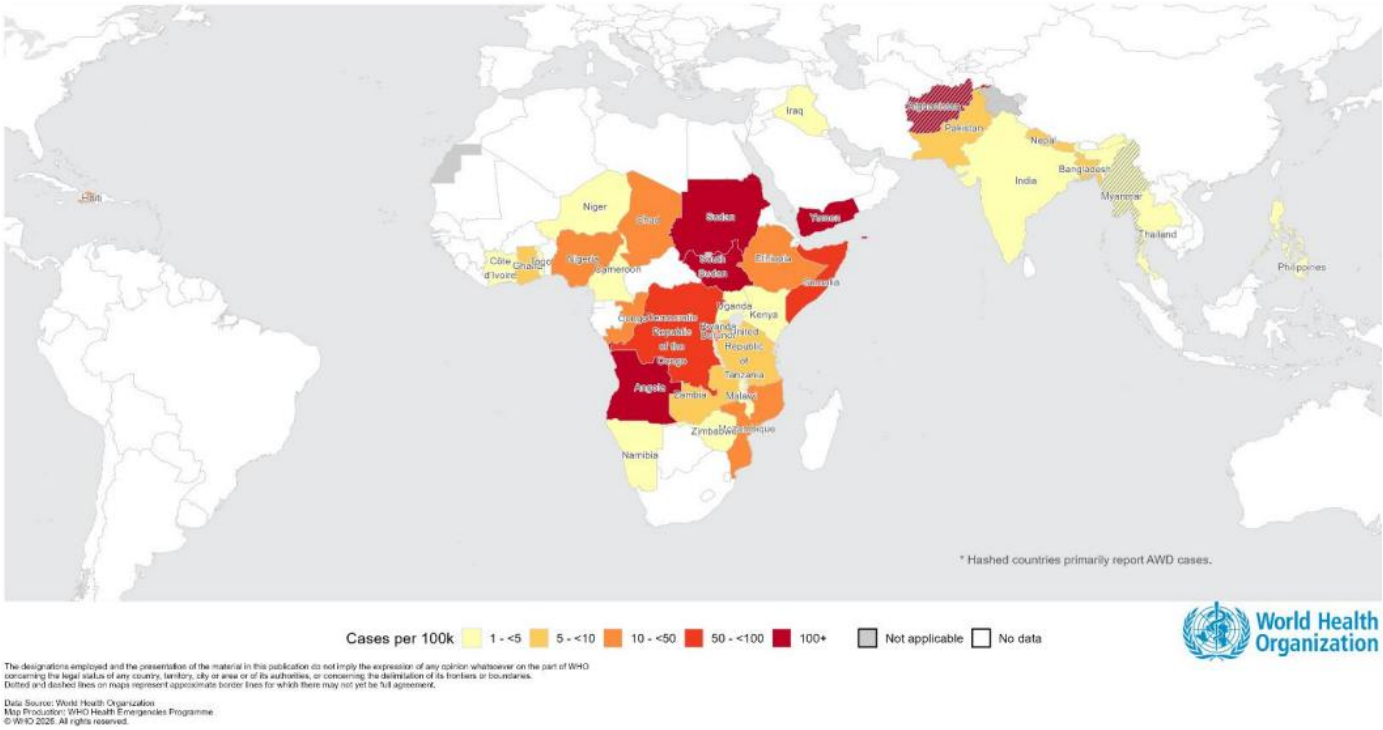


Figure 1: WHO - Cholera and acute watery diarrhoea (AWD) cases per 100 000, 1 January to 28 December 2025

The country's cholera risk is heightened by structural vulnerabilities[2], notably its exposure to multiple hazards whose impacts are amplified by climate change[3]. The principal climate risks facing the Comoros include sea level rise, storm surges, coastal flooding, rising temperatures, and more frequent and intense extreme weather events, alongside the degradation of critical marine ecosystems. Over time, these hazards have evolved from episodic extreme events into a chronic and intensifying multi-hazard regime, characterized by growing variability and the compounding of risks. This transition is evident in both historical trends and future projections of climate variables (see Climate Risk Timeline in Comoros, Annex 1), which indicate a continued escalation in the frequency and severity of extreme events. As a result, climate-related shocks increasingly act as drivers of public health crises, exacerbating vulnerabilities to waterborne diseases such as cholera and other climate-sensitive health risks.

In addition, precarious living conditions affecting parts of the population, together with limited access to essential services (health care, safe water, hygiene, and sanitation), increase the likelihood of deteriorating sanitary and environmental conditions. Taken together, these factors can create environments conducive to the survival,

[1] WHO: Multi-country outbreak of cholera, epidemiological update #33 -27 January 2026
[2] UNDP: Comoros faces water shortages – here's how the small island state is adapting
[3] PANA Comores ; Drought Resilience Profiles - Comoros ; SNRRC - Comores

circulation, and transmission of *Vibrio cholerae*, particularly during periods of water stress, heavy rainfall, flooding, or disruptions to basic services.

Cholera manifests as acute, profuse watery diarrhea, vomiting, and leg cramps, progressing to severe dehydration and death within hours without treatment. Key risk drivers in Comoros include case importation from neighboring countries, seasonal peaks during the rainy season (November–May), and mass gatherings like "Grand Weddings," featuring large crowds and shared meals.

Cholera has been a recurrent threat in Comoros since 1975, with seven major epidemics documented over nearly five decades, underscoring both the severity and the cyclical nature of outbreaks. Critically, Comoros is not cholera-endemic: the majority of documented epidemics has been traced to an imported source, typically introduced via maritime travel, fishing vessels, or population movement from cholera-affected countries in East Africa and the wider Indian Ocean region, before spreading through local transmission once introduced. This importation pattern reflects Comoros' geographic position as a maritime crossroads with high population mobility (commercial shipping, fishing, diaspora travel, and migration to/from Mayotte) rather than the persistence of endemic Vibrio cholerae reservoirs within the country.

Since 1975, the cumulative burden exceeds 29,000 cases and 672 deaths, with an average case fatality rate (CFR) of 3.16%, markedly above the WHO emergency benchmark of 1%. The most recent outbreak, which occurred in 2024, was similarly linked to an imported case – documented as originating from a boat arriving from Tanzania – and coincided with a rainy season marked by severe flooding and significant damage. The floods led to the destruction of essential infrastructure and the contamination of water sources, thereby increasing the risk of spreading cholera and other waterborne diseases. This outbreak was the largest ever recorded in the country, with 11,171 cases and 153 deaths[4]. Vulnerable groups were disproportionately affected, with children under 15 accounting for over 35% of reported cases and 67% of deaths. Beyond the immediate health impacts, cholera outbreaks cause major socioeconomic disruptions, including the closure of markets and businesses, a sharp decline in tourism, and the interruption or deterioration of education services.

[4] WHO: Global Cholera and Acute Watery Diarrhoea (AWD) Dashboard

Since 1975, the country registered seven major epidemics documented over nearly 50 years. The historical data demonstrates both the severity and predictability of cholera outbreaks in the archipelago.

Timeline of major epidemics:

Date	Cases	Deaths	Case Fatality Rate (CFR)	Geographic spread	Key characteristics
1975-76	2,680	239	8.92%	3 islands	First documented major epidemic; left traumatic memory in coastal communities
1998-99	8,480	110	1.30%	Grande Comore (majority), Mohéli	Linked to East Africa regional epidemic; started in M'beni; nosocomial transmission in Moroni hospital
2000-01	3,523	95	2.70%	Grande Comore (90%), Anjouan, Mohéli	Imported from Tanzania - Zanzibar (Dec 2001)
2002-03	1,623	46	2.83%	Grande Comore (<80%), Anjouan, Mohéli	Transmission Feb-Dec 2007; peak during diaspora return (July-Aug) for grand weddings
2007-08	1,559	29	1.86%	Grande Comores (96,4%), Mohéli	Imported from Tanzania - Zanzibar
2024	11,171	153	1.37%	Anjouan (88%), Grande Comore, Mohéli	Most severe epidemic on record; imported from Tanzania (boat arrival Jan 31); unprecedented scale; reached Mayotte (first regional exportation)

Between 1975 and 2024, the country recorded approximately 29,000 cholera cases and 672 deaths, resulting in a critically high average Case Fatality Rate of 3.16%. This hazard is structurally recurrent, returning every 3 to 5 years with attack rates reaching up to 3% of the population during major outbreaks.

Prioritized risks to be addressed by the early actions and their link to the hazard (including timeline)

The EAP prioritizes reducing morbidity and mortality by interrupting cholera's rapid transmission during the critical 7–21-day window. With a historical Case Fatality Rate (CFR) of 3.16%, three interconnected risks amplify the hazard:

1. Rapid water contamination: unprotected sources, relied on by >50% of the population, become immediate amplification points. The actual access to safely managed drinking water remains very low – estimated at under 15% – due to aging and intermittent networks and heavy reliance on stored rainwater without adequate household treatment. Historical evidence from the 1998 M'beni outbreak shows a single contaminated well generated over 100 cases within hours. The critical timeline is:
    - Days 0-3: post-detection, contamination begins
    - Days 4-10: exponential secondary transmission
    - Days 11-21: epidemic peak if unaddressed.
2. Household transmission: lack of hygiene tools and protective knowledge lead to high secondary household attack rates reach, with above 70% of deaths occurring in communities rather than health facilities (2024 data). The critical timeline is:
    - Days 0-5: unsafe practices continue
    - Days 6-15: peak household transmission
    - Days 16-30: third-generation cases
3. High-risk behaviours: disease denial and cultural or large gatherings, including religious events and Grand weddings, can increase the risk of cholera transmission when safe water, sanitation, and

hygiene measures are limited. The 2024 epidemic saw significant community denial [5]hampering response, while the 2007 epidemic peaked during diaspora return for traditional ceremonies[6]. The critical timeline is:

- Days 0-7: denial and misinformation dominate
- Days 8-21: planned high-risk events proceed
- Days 22-45: behavioural regression without sustained messaging.

Describe the selected early actions and explain how they will address the risks and lead to the intended outcomes

Early action selection methodology:

The early actions for cholera preparedness and response were selected through a rigorous, multi-stakeholder process integrating technical workshops between the CoRC, IFRC, French Red Cross, and partners in the health and WASH sectors (Ministry of Health, UNICEF, WHO). This collaborative approach identified cholera-related impacts and risks, prioritized interventions accordingly, and drew upon the National Society's past operational experience.

The selection process was grounded in multiple evidence sources: the National Cholera Preparedness and Response Plan for Comoros[7], community consultations, and CoRC's previous epidemic response experience (notably the COVID 19 response operations, 2024-2025 Cholera DREF operation). Guidance from global and regional frameworks – including the Global Task Force on Cholera Control (GTFCC), WHO and IFRC guidelines, the Continental Cholera Emergency Preparedness and Response Plan for Africa (*by Africa CDC and WHO)* – ensured alignment with best practices and evidence-based approaches.

Four analytical pillars guided the selection:

1. Historical effectiveness analysis: review of interventions deployed during Comoros' seven previous epidemics (1975-2024) identified which actions effectively reduced transmission when implemented early versus late. The evidence is clear: when field actions were rapidly intensified, especially disinfection and community sensitization, the outbreak curve declined soon after. Conversely, when early warnings were disregarded, the consequences were severe. This was especially evident in Anjouan in 2024, where early epidemic response prioritized facility-based case management while community-level interventions remained minimal or absent, thereby driving a rapid escalation of community transmission.
2. Technical feasibility assessment: given the critical constraint of a 7–21-day window between outbreak detection and peak transmission, selected actions were prioritized based on rapid deployability using CoRC's existing capacities: a network of 200+ trained volunteers in diverse health/epidemic topics, and distributed across the three islands, existence of regional warehouses with pre-positioned emergency stocks in the islands, functional community relay systems (Community Health Workers, Civil Society Organizations, religious and community leaders, …) and established coordination mechanisms with the Direction Générale de la Santé (DGS) and the Direction Générale de la Sécurité Civile (DGSC).
3. Vulnerability-focused impact modeling: each action was evaluated for its capacity to protect the most vulnerable populations: children under 15 years (most affected during the 2024's epidemic), pregnant women (at risk of dehydration complications including miscarriage), poor households unable to afford protective supplies, and isolated communities with limited healthcare access. Actions demonstrating disproportionate benefit for these groups were prioritized.
4. Application of "no regrets" principle: recognizing inherent uncertainty in epidemic forecasting, all selected actions must deliver substantial benefits to target populations even if the cholera epidemic does not

[5] Sources: https://www.sciencedirect.com/science/article/abs/pii/S2772743225000236 / https://www.msf.ch/nos-actualites/articles/comment-endiguer-epidemie-cholera-notre-intervention-aux-comores

[6] Source: http://medecinetropicale.free.fr/spe/cholcom.htm

[7] See in annex

materialize or remains limited. Actions were evaluated for broader public health value beyond cholera control, including prevention of other water-borne diseases, strengthening of hygiene infrastructure, and building community resilience.

Overview of selected early actions:

The selected early actions for cholera preparedness and rapid response comprise integrated interventions addressing prevention, detection, case management, and coordination:

1- Enhanced community-based surveillance: early detection through active case finding and rapid alerting, strengthened through the RCRC community-based surveillance platform – **Nyss**.

2- Case management:
- Mapping of hospital centers receiving cholera cases and isolation or treatment sites
- Community Case Management (CCM): establishment of Oral Rehydration Therapy (ORT) corners/points providing Oral Rehydration Solution (ORS).
- Operational support to the treatment facilities with basic materials/equipment, IPC measures, and patient accompaniment, while strengthening referral pathways, ambulance services.
- Provision of oral rehydration corner and point kits

3- Water, Sanitation, And Hygiene (WASH):
- Preventive chlorination of public water points
- Disinfection of community/public latrines
- Community sanitation campaigns and disinfection of public spaces
- Installation of handwashing facilities with provision of consumables at mass gathering sites (mosques, markets, schools, public services)
- Targeted distribution (based on the rapid assessment checklist) of RC-CATargeted I household hygiene and disinfection kit
- Provision of RC-CATI community WASH kit and cholera field volunteer kit

4- Risk Communication and Community Engagement (RCCE): targeted messaging, information and education via diverse channels

a) Communication as a Support Tool
- Develop and pre-test a standardized cholera RCCE package (key messages, IEC materials) in Comorian and French, validated by the Ministry of Health and CoRC
- Identify and pre-position communication channels per locality (community radio, mosque announcements)

b) Communication for Social and Behavioural Change (CSBC)
- Build partnerships with influential community actors (traditional healers, religious leaders, local leaders) to deploy behaviour change messaging
- Deploy door-to-door interpersonal communication on symptom recognition, transmission, and care-seeking pathways

c) Community Participation
- Establish or strengthen community engagement structures (health/WASH committees), ensuring representation of women, youth, and marginalized groups
- Engage community members in co-identifying optimal locations for ORT points, chlorination points, and kit distribution sites, and identification of high-risk households for targeting

d) Community Feedback (Information Channels)
- Establish community feedback and rumour tracking mechanisms with all partners, including standardized tools and referral pathways
- Train volunteers on RCCE and the community feedback mechanism
- Deploy, monitor, and address community feedback through volunteer feedback forms and suggestion boxes at health facilities and community centers

e) Evidence-Based Advocacy

- Compile baseline KAP data, epidemiological trends, and WASH gaps to build an evidence base for advocacy with local authorities
- Use real-time community feedback to advocate with health authorities for rapid correction of misinformation or service gaps

5- Capacity building and coordination:

- Training/refresh for volunteers, health workers and staff on diverse themes (RC-CATI, CBS, CEA, PGI, PSS)
- Provision of personal protective equipment (PPE) for CoRC volunteers and staff
- Establishment of internal and external coordination mechanisms with partners/stakeholders involved in epidemic management
- Development of framework agreement with Ministry of Health defining roles and responsibilities

6- Cross-cutting approaches (integrated into all interventions):

- Protection, Gender, and Inclusion (PGI): ensuring equitable access for women, children, the elderly, persons with disabilities, and marginalized groups; and dignified assistance, with safeguarding principles applied to prevent sexual exploitation, abuse, and harassment.
- Community Engagement and Accountability (CEA): ensuring participatory frameworks and transparent feedback/complaint mechanisms to foster trust. This proactive approach mitigates stigma, corrects misinformation, and systematically addresses the root causes of care avoidance.

By focusing on these integrated early actions, the sEAP aims to mitigate cholera impacts by improving access to safe water, enhancing sanitation facilities, strengthening hygiene practices, and ensuring rapid detection and treatment close to home. These efforts prevent overwhelming health services while ultimately reducing morbidity and mortality among the most vulnerable and at-risk populations, contributing to the broader objective of cholera epidemic control in Comoros. The evidence-based, vulnerability-focused, "no regrets" approach ensures value regardless of epidemic evolution while delivering exceptional protection for those who need it most and cannot access it through any other mechanism.

EARLY ACTION INTERVENTION

Overall objective of the intervention	The overall objective of this protocol is to mitigate cholera outbreaks and interrupt transmission chains to reduce caseload in high-risk areas through targeted, early actions that address the main drivers of transmission. It aims to reduce uncontrolled spread, morbidity, and mortality by rapidly breaking cholera transmission chains from the first warning signs, using a holistic package of measures. The intervention will reach approximately **5,000** people across Grande Comore (Ngazidja), Anjouan (Ndzouani), and Mohéli (Mwali), prioritizing areas identified through epidemiological surveillance and vulnerability mapping, over a 30-day implementation period with intensified prevention activities between Days 3 and 21. The overall implementation timeframe – including readiness, prepositioning and early action – of this sEAP is 2 years.
	The Comoros Red Crescent (CoRC) requests funding for this sEAP to fundamentally shift its operational posture from reactive crisis management to proactive anticipatory action, thereby saving lives through critical time advantages. Current passive health facility-based surveillance systems often detect cases five to seven days after symptom onset, which misses the vital window for prevention; funding this sEAP enables the deployment of Enhanced Community-Based Surveillance using the NYSS digital platform to detect cases within 24 to 48 hours and trigger rapid investigation before widespread transmission occurs. This immediate response is crucial because historical data in

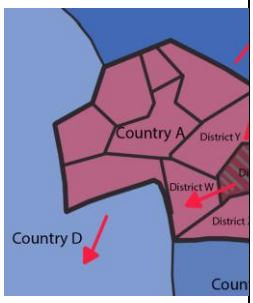
	Comoros indicates that 70%[8] of cholera mortality occurs within communities rather than health facilities, largely due to delayed access to treatment, denial of the disease, asymptomatic cases (80% of infected people) circulating in the community. By establishing community Oral Rehydration Therapy (ORT) corners and points, the CoRC can treat the majority of mild-to-moderate cases locally (70 to 80%), preventing progression to severe dehydration and death while simultaneously reducing the burden on government health facilities by limiting referrals to the smaller proportion of severe cases requiring advanced care. Furthermore, the protocol addresses the primary drivers of the disease by interrupting known transmission chains. Water-borne transmission remains the primary route of cholera spread in Comoros. During the 2024 outbreak, contaminated rivers on Ndzuani (Anjouan) island[9] became significant sources of transmission. Cholera's incubation period of 12 hours to 5 days allows for rapid case generation, with public wells documented as frequent sources of large-scale outbreaks globally. The funding will support low-regret, high-impact actions such as the preventive chlorination of public water points and the distribution of RC-CATI household hygiene and disinfection kit to block this transmission route. Additionally, since epidemics in Comoros have historically been amplified by denial and delayed care-seeking, intensive risk communication is necessary to rapidly alter community risk perception and hygiene behaviors. Finally, this anticipatory approach is justified by the seasonal nature of cholera in Comoros and the exacerbating effects of climate change, where warmer sea temperatures and increased storm intensity create predictable risks that can be mitigated through advanced preparation.
Potential geographical high-risk areas that the EAP would target	This sEAP covers all three islands of the Union of Comoros – Grande Comore, Anjouan, and Mohéli – with interventions concentrated in communities identified as high risk based on historical cholera patterns, vulnerability assessments, and current epidemic surveillance data. The targeting approach applies a geographic prioritization that combines historical hotspot mapping with dynamic surveillance to ensure activities are directed to areas with the highest transmission risk. Communities previously affected during past epidemics are pre-identified as priority zones, while vulnerability mapping integrates WASH risk indicators, such as water source safety, sanitation coverage, population density, poverty levels, and geographic isolation, to capture communities at high risk even without a recent outbreak history. As the epidemic evolves, real-time surveillance information from community surveillance and health facility reporting will guide the allocation of resources to emerging transmission hotspots. All geographic targeting is/will be coordinated with the Ministry of Health, through the Direction Nationale de la Santé, to ensure complementarity with the government response and alignment with official cholera risk mapping. Potential geographical high-risk areas are presented in the table below:

Island	Priority areas & rationale	Specific localities/area covered

[8] Source: UN CERF - 2024 "Comoros: Cholera Outbreak." CERF Allocation Summary 24-RR-COM-64823

[9] Source: IFRC. 2024. "Comoros Cholera Outbreak - DREF Operational Update (MDRKM011)

	Grande Comore (Ngazidja) Target people: **2,000**	**Urban, peri-urban & strategic points** - historical epicenter for 1998, 2007, 2019, and 2024 outbreaks. - high density, informal settlements ("bidonvilles"), entry points for migrants and major transport hubs amplify transmission - seasonal flooding contaminating water sources - key commercial and transport hubs connecting rural areas to the capital	1. Coulée (dense informal settlement) 2. Hamramba (flood-prone) 3. Mitsoudjé 4. Itsandra (fishing community) 5. Hahaya (market) 6. Central market (Volo-volo) 7. Mitsamiouli 8. Oichili	
	Anjouan (Ndzuwani) Target people: **2,000**	**Mutsamudu urban & strategic points** - highest population density in the country - "WASH crisis" in informal settlements and major port entry point facilitate rapid spread - 2024 epidemic: Anjouan was severely affected, particularly Mutsamudu and surrounding areas	1. Mutsamudu Central (Medina) 2. Port Area 3. Hombo (informal settlement) 4. Patsy 5. Lingoni 6. Salamani 7. Central market 8. Ouani (Fishing port)	
	Mohéli (Mwali) Target people: **1,000**	**Fomboni urban and isolated coastal** - capital city, main port entry - limited health services - seasonal flooding contaminating water sources - vulnerable fishing community with distance from health services	1. Fomboni Town Center 2. Fomboni Periphery/Nioumachoua 3. Miringoni	
Which groups of people will be assisted through this operation and what criteria will be used for their selection?	The sEAP targets 5,000 individuals residing in 19 high-risk localities across the country. These localities were selected using a composite risk exposure based on historical outbreaks, WASH vulnerability, population density, and gaps in health system access. Priority vulnerable groups interventions prioritize those at highest risk of severe disease and mortality: • children under 15 (>35% of historical cases) • pregnant and lactating women • economically vulnerable households (income <50,000 KMF) • residents of informal urban settlements, and isolated rural communities Additional focus is placed on fishing communities, market vendors, the elderly, and people with disabilities.			

	A. **Household targeting:** using a community-based participatory approach, households are selected if they meet criterion (i) and/or at least two of the remaining five criteria (ii–vi): i. presence of a suspected or confirmed case within the household ii. residence within a 100–150-meter radius of a suspected or confirmed case iii. presence of high-risk individuals iv. inadequate sanitation conditions and poor hygiene practices v. reliance on unsafe water sources vi. socioeconomic vulnerability The process ensures transparency through volunteer verification, public list validation in coordination with local authorities, and a formal feedback mechanism. **B. Infrastructure targeting:** • 60 water chlorination points are selected based on high user density and proximity to suspected cases. • Up to 24 ORC/ORP are established in areas with health coverage gaps and to deal with the less serious cases in order to reduce stress on health facilities. C. **Universal coverage**: risk communication (RCCE) and community surveillance cover at least 20% of the entire population within the 19 target zones. **D. Protection, Gender, and Inclusion (PGI):** • The strategy integrates PGI by designating women as primary kit recipients and prioritizing female-headed households. • Physical accessibility is ensured for persons with disabilities at all service points, and strict safeguarding measures (PSEA) are enforced to prevent exploitation during distribution.
Trigger(s) statement 	**<u>Scenario A</u>**: Regional alert & seasonal preparedness This represents proactive institutional activation ahead of high-risk periods, aimed at strengthening overall preparedness. This pre-activation does not trigger the disbursement of anticipatory action funds. Its purpose is to accelerate or review preparedness activities already underway or completed. Trigger statement (**ANY ONE** of the following) ▪ A verified report from the General Directorate of Civil Security (DGSC) documenting flash floods affecting water supplier infrastructure and sanitation facilities, thereby creating conditions conducive to the rapid spread of waterborne diseases, particularly acute diarrhoeal diseases. ▪ Official declaration from MoH, WHO (Global Cholera and Acute Watery Diarrhoea Dashboard) or Africa CDC, of a cholera outbreak with **>50** cases reported in the previous 4 weeks in one of the neighboring countries: Tanzania (specifically Zanzibar), Madagascar (specially Mahajanga), Mozambique, Kenya, or Ethiopia, **AND** confirmation of active maritime/air connections with Comoros. ▪ Entry into the July-August seasonal period (Grand Marriage season & diaspora return) **combined with** active cholera transmission reported in at least one neighboring country. **<u>Scenario B</u>**: Early outbreak This activation does trigger the disbursement of anticipatory action funds.

	I. Focus: Rapid containment within the "Golden Window" (time to peak: first 7-21 days) to prevent exponential transmission. II. Trigger statement (**ANY ONE** of the following activates full early actions within 24 hours): ▪ Detection of at least **1** laboratory-confirmed case (RDT/Culture/PCR) **OR** **≥3** suspected cases with an epidemiological link in the same locality within 7 days via community-based surveillance mechanism (NYSS platform – updated daily and managed by the health department coordinator who is responsible for monitoring and escalating the notification and needed action being taken) or weekly epidemic report from the National Epidemiological Surveillance Service – received by the NS every Wednesday. ▪ Detection of at least **1** suspected case at a Point of Entry (via report from the MoH) **OR** a traveler from an active zone presenting acute watery diarrhea within 5 days of arrival – notification via community-based surveillance mechanism (NYSS platform – updated daily and managed by the health department coordinator who is responsible for monitoring and escalating the notification and needed action being taken) or weekly epidemic report from the National Epidemiological Surveillance Service. ▪ Report of **≥2** deaths compatible with cholera (acute watery diarrhea) in the same community within 7 days, via community-based surveillance mechanism (NYSS platform – updated daily and managed by the health department coordinator who is responsible for monitoring and escalating the notification and needed action being taken) or weekly epidemic report from the National Epidemiological Surveillance Service – received by the NS every Wednesday.
Next steps – For National Societies that will be developing a full EAP (Optional).	This sEAP represents CoRC's pilot approach to cholera anticipatory action. As early action for cholera remains a relatively new methodology, CoRC will test this protocol through at least one activation before advancing to a full EAP. This test phase will validate trigger effectiveness, assess intervention impact, identify operational challenges, and generate the evidence needed to justify scale-up.

PLANNED INTERVENTION

	Water, Sanitation and Hygiene	**Budget**	**53,589**
		Targeted persons	5,000

Indicator:

Reason	*Indicator*	*Disaggregate*	*Indicator Calculation*	*Target*
Readiness	*# volunteers trained in RC-CATI response*	*Sex, Age*	***Numerator**: # volunteers trained*	50
Readiness	*% of volunteers who report increased capacity to safely perform RC-CATI response roles (post-training self-assessment)*	*NA*	***Numerator:** # volunteers who demonstrate increased capacity after post-test* ***Denominator:** # volunteers participating in the training*	≥80
Readiness	*% of households in which baseline WASH vulnerability assessments were conducted*	*WASH area Sex, Age, disability*	***Numerator:** # neighbouring HH who were assessed for WASH related needs* ***Denominator:** # neighbouring households in the targeted localities*	≥20%
Prepositioning/Readiness	*% of strategically located, prepositioned WASH supplies at regional level*	*Kit modalities*	***Numerator:** pre-positioned strategically located WASH supplies* ***Denominator:** WASH supplies in the country*	≥80%
Readiness	*# of agreement established and up to date*	*NA*	***Numerator:** # agreement established*	1 at national level
Readiness	*# of SOPs developed/updated and cascaded*	*NA*	***Numerator:** # of SOP cascaded*	4 (RC-CATI, IPC, ORT, and DSB)
Early action	*# people reached with health and hygiene promotion and risk communication*	*Sex, age, disability*	***Numerator:** # people reached with health promotion, hygiene promotion, or risk communication activities*	*5,000*
Early action	*% case / neighbour households assessed for CATI*	*Health Area*	***Numerator:** # case and neighbouring HH who were assessed for CATI-related needs* ***Denominator:** # case and neighbouring households indicated or assigned to RC for CATI*	*≥80%*
Early action	*% case / neighbouring households receiving required package (based on national CATI plans and assessed needs)*	*Health Area*	***Numerator:** # case and neighbouring HH who received full CATI coverage* ***Denominator:** # case and neighbouring households indicated for CATI*	*≥80%*

Annual Readiness activities which are implemented prior to triggers being met as soon as the SEAP is approved.

1. Train 50 volunteers on RC-CATI in the first year. In the second year, provide a refresher training using IFRC e-learning material.
2. Conduct baseline WASH vulnerability assessments / KAP surveys in 19 pre-identified high-risk localities to inform IPC and RCCE activities.
3. Develop / update, and cascade SOPs for RC-CATI, IPC, ORT, and DSB (dignified and safe burial), ensuring full alignment with MoH, UNICEF and WHO protocols.
4. Formalize a framework agreement with the Ministry of Energy, Water, and Hydrocarbons (MEEH) on water sources chlorination protocol.

Pre-positioning activities which are implemented prior to triggers being met as soon as the SEAP is approved. Max 65 % budget	1. Collect, categorize/adapt and print culturally appropriate IEC materials in local languages and French. 2. Pre-position Household Hygiene and Disinfection (HHD) kits, volunteer field kits, ORP and ORC kits and community RC-CATI kits ensuring immediate deployment capacity. 3. Secure appropriate storage facilities on each island.
Prioritized Early Actions:	1. Activate internal coordination mechanisms and ensure active participation in external coordination platforms. 2. Activate community-based hygiene promotion in line with the Well-Prepared Community approach, mobilizing trained and dedicated volunteers to deliver cholera prevention messaging and promote key hygiene practices. 3. Conduct RC-CATI Household and Community rapid assessments in case areas in coordination with the Regional/District Health Authorities, based on Epi-data. 4. Based on RC-CATI assessment findings, deliver emergency WASH interventions at both household and community levels in line with the RC-CATI activity framework ▪ Conduct household disinfection interventions for all families with confirmed/suspect cases and their close contacts, and environmental ▪ Demonstration of water treatment (chlorination of cisterns, HTH tablet use) ▪ Installation of handwashing facilities, including water-soap handwashing devices and alcohol-based hand rub stations (≥60% alcohol) across 3 islands at key high-traffic locations (points of entry, markets, public spaces/mosques, primary & secondary schools) with systematic monitoring to ensure continuous water and soap availability. ▪ Safe water collection and storage promotion. Details of the RC-CATI activities are in annex. 5. Distribute, demonstrate and monitor the use of household hygiene and disinfection kits and consumables. 6. Support IPC and WASH provision at community health facilities were requested by Regional / District Health Authorities: ▪ Installation of handwashing stations at facility entrances and patient areas ▪ Production / provision of chlorine solution for surface disinfection and support with the disinfections ▪ Provision of waste management supplies (bins, waste bags) and installation ▪ Provision of minimum PPE for volunteers supporting IPC and CATI activities 7. Participate in government-led assessments, through the WASH cluster.

	Health & Care	**Budget**	**70,720**
		Targeted persons	5,000

Indicators:

Reason	*Indicator*	*Disaggregate*	*Indicator Calculation*	*Target*
Readiness	*# volunteers trained in ORT and ORP/ORC*	*Age, sex, specific training*	***Numerator**: # volunteers trained*	*60 as part of annual readiness*
Readiness	*% of volunteers who report increased capacity to safely perform ORT response roles (post-training self-assessment)*	*NA*	***Numerator:** # volunteers who demonstrate increased capacity after post-test* ***Denominator:** # volunteers participating in the training*	≥ 80%
Readiness	*# formalized agreements with health authorities at regional and district level*	*NA*	*None*	*Agreements with 3 DRS and 19 district health offices*
Prepositioning / Readiness	*# ORC and ORP kits procured*	*Kit type*	*None*	*19 ORC* *5 ORP*
Early action	*# community awareness raising sessions held on prevention, symptoms and where to access care*	*Awareness raising modality*	***Numerator**: # community awareness raising sessions within a given time period, inclusive of varied awareness raising platforms (mass community outreach, focus group discussions, radio broadcasts, door-to-door campaigns)*	*Varies*
Early action	*% of people reached who demonstrate accurate knowledge of cholera symptoms,* *transmission, and prevention and where to access care (via rapid KAP survey)*	*Knowledge and practice*	***Numerator:** # of respondents who correctly answer a minimum threshold of knowledge / practice questions* ***Denominator:** # of individuals who completed the KAP survey*	≥ *70%*
Early action	*% of IEC materials distributed within information sessions*	*Awareness raising modality*	***Numerator**: # IEC materials distributed* ***Denominato**r: # People reached through information sessions*	≥ *90%*
Early action	*% of CBS volunteers who are active ('zero' reporting, monthly average)*	NA	***Numerator**: # volunteers who submitted a weekly 'zero' report* **Denominator**: *total # CBS volunteers*	*100%*
Early action	*# of case / neighbouring individual receiving PSS*	*Age, sex*	**Numerator**: *# individual reached with PSS*	*Varies*
Early action	*# ORCs (for urban or rural areas) set up*	*NA*	***Numerator**: total # ORCs per targeted communities*	*Up to 19 ORCs – 1 per village experiencing a cholera outbreak*
Early action	*# ORPs (for urban or rural areas) set up*	*NA*	***Numerator**: total # ORPs*	*Up to 5 ORPs, depending on outbreak*

Annual Readiness activities which are implemented prior to triggers being met as soon as the sEAP is validated.

1. Train 60 CoRC staff, volunteers on cholera foundation (including RCC and CBS), ORP/ORC / ORT in the first year. In the second year, provide a refresher training using IFRC e-learning material.
2. Formalize a framework agreement with health authorities at regional and district level, including a clear and appropriate communications protocol on scope of WASH work in the case of an outbreak.
3. Pre-test key messages and IEC materials, via community consultations.
4. Establish framework agreements with local media (radio stations, television, social media,).

Pre-positioning activities Annual	1. Pre-position 19 ORC kits, 5 ORP kits and ensure strategic location. 2. Carry out a comprehensive stock inventory of existing WASH/health items; complete or replace damaged and missing components; assemble supplies into deployment-ready kits. 3. Produce / procure visibility items for volunteers and staff.
Prioritized Early Actions:	1. Conduct community health promotion (HH visits, FGDs, community meetings, work with traditional/religious leaders, mobile cinema and radio programs) especially on awareness of symptoms and need to seek support immediately, in line with the Well-Prepared Community approach. 2. Prepare the setup of Oral Rehydration corners and points (ORC/ORP) auxiliary to community health centers and/or as independent scale up in communities (location, referral pathway, available volunteers). 3. Activate Community volunteers CBS (event surveillance), ORT networks to carry out case finding, treatment and referral. 4. Participate in daily data review meetings with health facilities, and joint supervision with MoH/RoH/DoH. 5. Support OCV campaigns if government has vaccine available to promote vaccine safety and acceptance, engaging religious leaders to address hesitancy and conducting household visits to encourage vaccine uptake.

	Community Engagement and Accountability	**Budget**	**11,837**
		Targeted persons	5,000

Indicator:

Reason	Indicator	Indicator Calculation	Target
Early action	*% of community suggestions and feedback addressed or otherwise acted upon*	*Numerator: # instances where suggestions or feedback were actioned, with communication back to the community* *Denominator: # community suggestions or feedback received through community engagement and feedback mechanisms*	*80%*

Readiness activities	1. Establish or strengthen community engagement structures (health/WASH committees), ensuring representation of women, youth, and marginalized groups. 2. Establish community feedback and rumour tracking mechanisms, in collaboration with all partners. 3. Build partnerships with influential community actors (traditional healers, religious leaders, and local leaders) for behaviour change messages promotion.

	4. Identify and pre-position communication channels per locality (community radio, mosque announcements). 5. Support the training of the 50 CATI volunteers on RCCE and Community feedback mechanism. 6. Support community awareness on pre-positioned HHD kits, ORP and ORC kits and community RC-CATI kits ensuring community capacity building.
Pre-positioning activities	-N/A
Prioritized Early Actions	1. Deploy behaviour change messages through influential community actors and local communication channels. 2. Deploy, monitor and address community feedback and rumour tracking mechanisms: volunteer feedback forms, community suggestion boxes at health facilities and community centers. 3. Hold regular meetings with stakeholders to review community feedback recommendations and actions and ensure that the community stays informed.

-	**Protection, Gender and Inclusion**	**Budget**	**4,143**
		Targeted persons	5,000

Indicator:

Reason	Indicator	Disaggregate	Indicator Calculation	Target
Readiness	*% of volunteers and staff who co*mpleted *PGI, SEAH, and safeguarding principles training sessions and signed the Code of Conduct*	*Age, Sex and Disability*	***Numerator:*** *total # of volunteers and staff who completed the full PGI/SEAH/safeguarding training session and signed the code of conduct* ***Denominator:*** *# of volunteers and staff at Comoros Red Crescent*	*100%*
Early action	*% of concerns/complaints related to stigma, discrimination, or access barriers reported and addressed within 7 days with documented resolution*	*NA*	***Numerator****: # of complaints addressed within 7 days with documented resolution* ***Denominator****: total # of complaints received*	*100%*

Readiness activities	1. Establish confidential reporting mechanisms (toll-free hotline, female focal points, community suggestion boxes) for stigma, discrimination, SEAH (sexual exploitation, abuse and harassment), and safeguarding concerns. 2. Conduct mandatory briefing session for staff and volunteers on PGI, SEAH, and child safeguarding with signature of Code of Conduct and zero-tolerance policy acknowledgment.

Pre-positioning activities	**N/A**
Prioritized Early Actions	1. Disseminate, in collaboration with partners, culturally adapted child protection messages to households, while establishing confidential referral pathways to local service providers.

	Secretariat services	**Budget**	**19,703**
		Targeted persons	-

Indicator:

Reason	Indicator	Indicator Calculation	Target
Early actions	*Joining National level preparedness/EOC meetings, and ensuring RCRC representation within relevant pillars of the response (WASH, RCCE, IPC, etc.)*	*# PH-EOC or EVD MOH/interagency coordination meetings attended* *% response pillars with NS activities with a dedicated NS technical focal point*	*100%*

Readiness activities	1. IFRC technical support mission. 2. Monitor the implementation of preparedness activities.
Prioritized Early Actions:	1. Support coordination with stakeholders and authorities. 2. Support operations management and reporting.

	National Society Strengthening	**Budget**	**50,863**
		Targeted persons	110 new volunteers + 11 staff

Indicator:

Reason	Indicator	Indicator Calculation	Target
Readiness	*Volunteer management system in place*	*# Volunteer management system in place (yes/no)*	*1 functional volunteer management system in place*
Readiness	*% of volunteers insured*	*Numerator: # of volunteers insured* *Denominator: total # of involved in the operation*	*100%*
Readiness	*# of prepositioned items / trained volunteers recorded in the existing database or a new database setup for this purpose*	*# of trained volunteers recorded in database with type of training and contact details* *# items reported and classified in database*	*110 trained volunteers* *19 ORC kits; 5 ORP kits; 100 HHD kits; 20 volunteer field kits; 5 community CATI kits*

Readiness activities	1. Refresher training for NS volunteers and staff on the FBF / AA mechanism. 2. Develop and validate NS contingency plan for cholera. 3. Logistics capacities strengthen (maintenance and vehicle rental). 4. Recruit an AA focal point and a fin-admin officer to carry out the activities. 5. Conduct annual stakeholder coordination meeting. 6. Set up and keep up to date the database for volunteers and logistics.
Prioritized Early Actions:	1. Mobilize the cluster and regional AA teams to support early action and prepare for rapid intervention. 2. Post-distribution monitoring and lessons learned.

CONDITIONS TO DELIVER THE EARLY ACTION

Experience and/or capacity to implement the early actions. Assumptions or minimum conditions needed to deliver on the early actions (including issues to be resolved)	The CoRC serves as a primary auxiliary to public authorities with a proven track record in epidemic response (Cholera 1998, 2007; 2024-2025; COVID-19; Mpox). The NS possesses the specific operational capacity to deliver the proposed early actions: • Volunteer network**:** CoRC maintains a network of trained volunteers across the 19 targeted high-risk zones. These volunteers are experienced in community mobilization with the majority trained in EPiC and will receive complementary training on cholera related topics. • Technical expertise: The NS has demonstrated capacity in **WASH** (management of targeted chlorination points and household disinfection) and Health (establishment and management of ORPs and deploying **NYSS** for community-based surveillance). • Logistics: CoRC manages regional warehouses capable of pre-positioning critical stocks (hygiene kits, chlorine, PPE) to mitigate inter-island logistical delays. **Stop and scale-down mechanism:** • Stop trigger: The EAP mechanism is deactivated when specific pre-established conditions are met, ensuring that resources are used effectively. (i) For ***Scenario A*** (regional alert & seasonal preparedness trigger): If no suspected or confirmed cholera case is detected in targeted localities within ***30 days*** of prevention activation, and the regional alert that prompted activation has been officially lifted – with no cases reported in the implicated neighboring country for **≥*6*** consecutive weeks as confirmed by WHO or national health authority communications – readiness activities will revert to their routine level in accordance with the established operational plan. If, however, a confirmed case is detected during the prevention phase, the mechanism automatically escalates to Scenario 2 activation. (ii) For ***Scenario B*** (early outbreak trigger): If the MoH completes its outbreak investigation and reports zero new suspected or confirmed cases in targeted localities for **≥*3*** consecutive weeks, early action measures are discontinued, and the mechanism returns to baseline preparedness posture. However, if cholera transmission is confirmed to be sustained or escalating beyond the scope and timeframe of early action protocol, the response transitions from anticipatory action to a full emergency response under a separate financing mechanism, such as a DREF Operation or Emergency Appeal, as appropriate. In both scenarios, formal deactivation requires a joint confirmation by CoRC and the MoH, with documented rationale retained for post-activation review. • Scale-down process: Scale-down is graduated across three phases to prevent abrupt operational gaps: (i) Phase 1: active scale-down (days 1–14 following stop trigger confirmation) ○ Personnel: mobilized trained volunteers transitions to enhanced monitoring status; volunteers shift to routine community health programming. ○ Activities: RC-CATI activities and ORT operations are suspended or scaled to on-call status; surveillance continues as a baseline function regardless of activation status.

	○ Logistics: field stocks are inventoried and condition-assessed; items within validity period are retained and pre-positioned for the next risk window; items approaching expiry are reallocated to ongoing health programming or flagged for disposal. (ii) Phase 2: transition to preparedness posture (days 15–45) CoRC conducts a structured post-activation review documenting trigger accuracy, operational performance, and lessons learned for a new re-submission. Trigger monitoring mechanisms remain operational at reduced intensity; any resurgence signal automatically reactivates the relevant scenario.
Red Cross Red Crescent Movement partners, Governmental / other agencies consulted for this simplified EAP	This simplified EAP was developed through a consultative process involving key stakeholders to ensure alignment with the National Cholera Elimination Plan. **Red Cross Red Crescent Movement:** • **Comoros Red Crescent (CoRC):** Lead implementer. • **IFRC:** provides technical guidance on the EAP development and will closely support the NS in the overall implementation of the planned activities, as well as the monitoring of the triggers. • **PIROI (Plateforme d'Intervention Régionale de l'Océan Indien):** provides technical and logistical support to the NS for the implementation of this EAP, while supporting IFRC in coordination and resource mobilization efforts. It will maintain pre-positioned emergency stocks (both in-country and in La Réunion) for immediate deployment and stand ready to provide specialized equipment and technical surge capacity should local capacities be exceeded. • **French RC:** provides permanent technical expertise in epidemic preparedness and will support the NS in national coordination mechanisms. **Governmental Agencies:** • Ministry of Health (MoH): serves as the primary partner at all levels of implementation of this sEAP, including its development, activation, implementation, and monitoring of activities. The MoH, through its Disease Control Directorate (DLM), National Epidemiological Surveillance Service (SNSE), and Health Promotion Directorate (DPS), is one of the primary institutional sources of data underpinning the EAP trigger indicators. A framework agreement to be established between CoRC and the MoH will strengthen collaboration at national and decentralized (region and district) levels and streamline information and data-sharing mechanisms to facilitate timely decision-making. • Ministry of Energy, Water, and Hydrocarbons (MEEH) for water sources chlorination protocol. • ANACM (National Agency for Civil Aviation and Meteorology): consulted for climate/rainfall triggers. • Civil Security (DGSC): coordination for rapid deployment zones. The DGSC remains a primary institutional data source for the EAP trigger indicators. An existing framework agreement between CoRC and the DGSC formally establishes data-sharing and humanitarian coordination arrangements in place in the country. **Other Partners:** • UNICEF: coordination on WASH cluster standards and pre-positioning supply kits and alignment of household-level water treatment and hygiene promotion approaches with cluster-endorsed protocols.

	• WHO: alignment with surveillance protocols and alert thresholds with trigger indicator definitions, and technical guidance on case management guidelines and outbreak investigation procedures informing Scenario activation criteria and informing stand-down decisions through the global cholera and acute watery diarrhoea dashboard. • Africa CDC: Coordination on regional epidemiological intelligence and cross-border outbreak alert systems, supporting the trigger threshold and informing stand-down decisions through continental surveillance data streams.

Contact information

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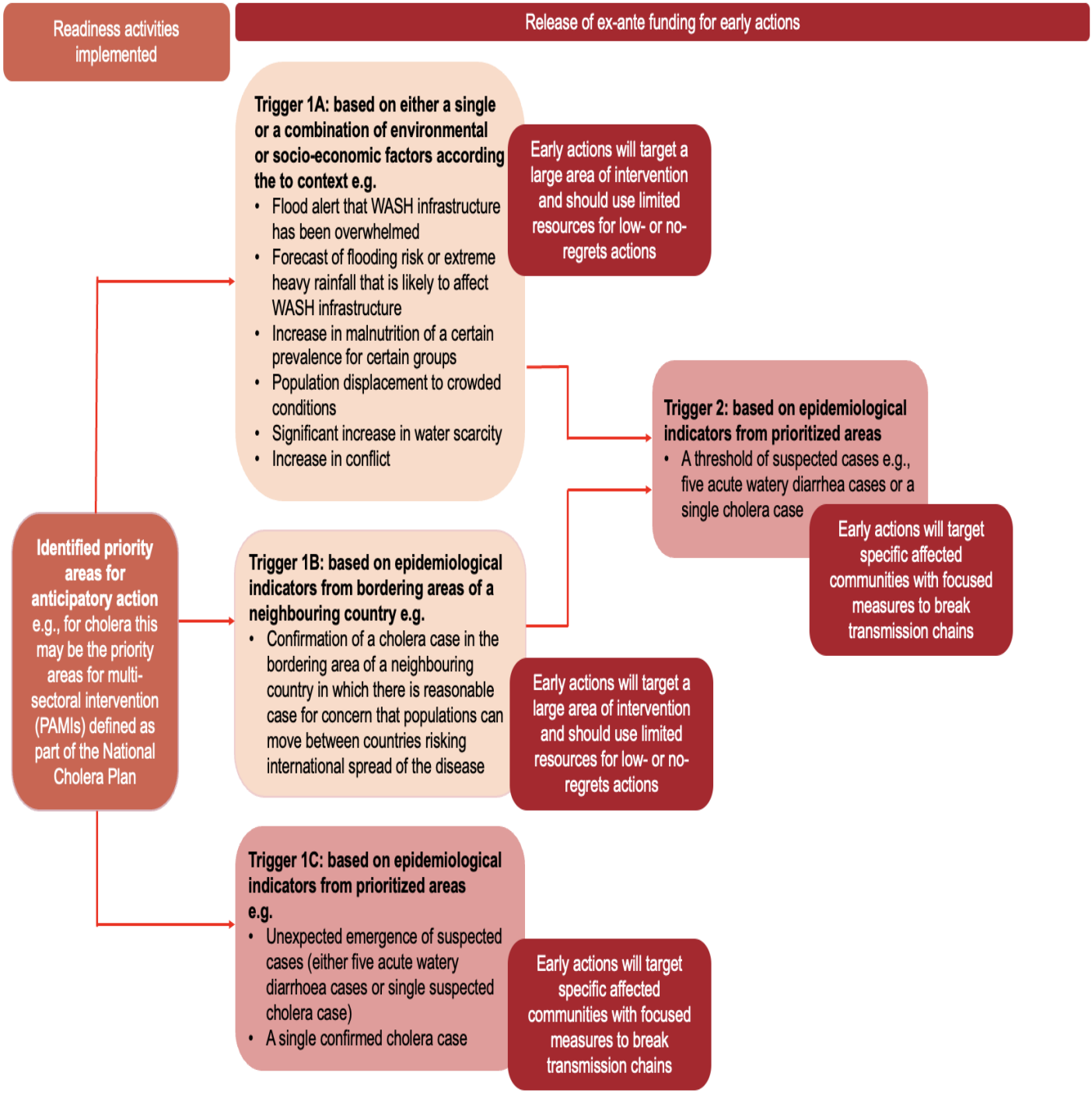
Annex A: Climate Risk Timeline – Comoros (1950–2100)

Period	Main Hazards	Observed Trends	Climatic trend	Key Implications	Sectoral Impacts
1950–1975	Cyclones, seasonal rainfall	Regular cyclones; long wet spells (~50 days); short droughts	Relatively stable climate	Balanced climate conditions	Localized damage to infrastructure; limited disease outbreaks; stable agricultural production
1975–2000	Declining rainfall, variability	Decrease in precipitation; increasing climate variability	Early climate disruption	Emerging pressure on natural resources	Water stress begins; declining crop yields; gradual infrastructure stress
2000–2020	Multi-hazard regime	Temperature rise (~0.22°C/decade); erratic rainfall; drought events	Intensification of climate variability	Increased environmental stress	Flood damage to roads and housing; rise in waterborne diseases; unstable agricultural outputs
2020–2040	Heat, extreme rainfall, flooding	Increase in hot days (~23/year); more intense rainfall; sea level rise	Rapid increase in extreme events	Higher exposure and vulnerability	Higher cholera/diarrheal risks; infrastructure damage; coastal agriculture losses
2040–2070	Extreme heat, heavy rainfall, droughts	Increase in hot nights (~4 months/year); stronger precipitation events	Widespread extreme climate conditions	Persistent stress on water and systems	Heat-related illness; increased malaria/dengue; infrastructure overload; reduced crop productivity
2070–2100	Systemic extreme climate	Up to 100 hot days/year; very frequent extreme rainfall; sea level rise (~0.77 m)	Critical climate regime	Systemic and widespread risks	Severe health crises; risk of infrastructure failure; major agricultural losses and food insecurity

Source: World Bank Climate Risk Country Profile (2025)

Annex B: Schematic on phased triggers



Annex C: RC-CATI methodology

What is Red Cross Red Crescent Case Area Targeted Interventions (RC-CATI)

1. **What is it?**

A methodology that allows better targeting of limited resources to have greatest impact and reduce the transmission of cholera through WASH interventions and disinfection of case households.

2. **How does it work?**

Line lists of CTCs, CTUs, community health facilities, ORPs and ORCs are used to identify where cases are coming from. Teams then move to those areas and carry out household and community level assessments. The assessments guide volunteers to carry out WASH interventions utilizing kits specifically designed for the purpose of putting in place the actions.

3. **What are the key outputs?**

The interventions result in provision of safe water, safe sanitation, safe food and personal hygiene, disinfected case households and greater general awareness in the community. Both household facilities and community spaces are targeted

4. **If done properly what is its impact?**

If done well and followed up the CATI methodology prevents further transmission of the disease within and around the community. It also increases the resilience of the community to cholera

5. **Is there a training for RC-CATI ?**

There is a 4-day training which is very practical and ensures competent use of the rapid assessment and implementation of the interventions

6. **Are there kits? What are the contents and typical costs?**

There are three kits that are used in the implementation of RC-CATI. The ***Household Hygiene and Disinfection Kit*** is given to all case households and some other households where the assessment indicates its need. This kit allows for the disinfection of the households and putting in place of measures that will result in safe water, sanitation and good food and personal hygiene (typical cost 80USD). The ***Volunteer Cholera Kit*** provides various consumables which can be distributed to households such as soap, water treatment products, disinfection products and ORS to allow them to carry out actions where no HHD is provided. The **Community Cholera Kit** will be developed by individual NSs and will consist of items to support safe water, sanitation, hygiene through community facilities and in community spaces. The idea is to source in country and encourage local initiatives.

7. **How is RC-CATI different from other CATI methodologies?**

The permanence of NS branches and the volunteer network within RCRC NSs gives a unique opportunity for continued interaction with communities and the development of greater resilience to cholera outside of an outbreak. This is a means of linking response into preparedness and prevention and is unique to RCRC so that whilst RC CATI does what other CATI teams do it can add both the local knowledge of its CATI team members and continued engagement with communities and it is these which make it distinct.

Annex D: Red Cross Red Crescent Oral Rehydration Response Mechanism

8. What is it?

Training and kits which provide set-ups that allow access to diagnosis of different levels of dehydration, the provision of Oral Rehydration Therapy and onward referral if required. It aims to save lives by provision of diagnosis and treatment to the last mile while at the same time being able to go to scale.

9. How does it work?

It can work at many levels. Two or three trained volunteers may work in their own community setting up an Oral Rehydration Corner (ORC) to provide treatment for community members or those from satellite communities. The volunteers in consultation with community leaders may utilize community infrastructure (empty buildings, latrines) or available items (tables and chairs).

An increase in cases from the area may require the setting up of an Oral Rehydration Point (ORP). This is a stand-alone facility which can provide seating, shade, shelter, sanitation and a good level of IPC. It requires 5 volunteers to make it operational and can cope with up to 30 patients a day. An ORP may also be set up as an annex to an existing health facility, treating the mild cases, allowing the facility to concentrate on the more serious.

Where an outbreak becomes widespread, the ORC/ORP stock of the NS is exhausted and there is a lack of trained volunteers, the NS may call for the deployment of the ERU Community Case Management (Cholera) held by the Swiss RCS. This can quickly train multiple teams of volunteers and provide large numbers of ORP kits allowing for significant scale up.

10. What are the key outputs?

Provision of case management at multiple levels creating a referral pathway that ensures even in the remotest areas there is access to life saving ORT and onwards referral. This in due course will reduce the number of deaths, which in any outbreak tend to be predominantly in the communities.

11. If done properly what is its impact?

If done well and combined with the CATI methodology it can prevent deaths and help target transmission breaking interventions through the utilization of line lists.

12. Is there a training for ORP/ORC ?

A 3-day training which is practical and ensures competent set up of the facilities, diagnosis of dehydration and provision of ORT as well as record keeping of cases and stock keeping.

13. Are there kits? What are the contents and typical costs?

Two complementary kits are used to deliver oral rehydration services at community level: the **Oral Rehydration Corner (ORC) Kit** and the **Oral Rehydration Point (ORP) Kit**.

The **ORC Kit** is designed for deployment by trained volunteer groups within their own and surrounding (satellite) communities. It enables decentralized, last-mile delivery of oral rehydration therapy, particularly in hotspot areas. The kit includes essential components to:

- Produce safe drinking water
- Prepare and administer Oral Rehydration Solution (ORS)
- Facilitate handwashing
- Provide basic consumables and plastics required for ORS preparation

Implementation of an ORC requires communities or volunteers to locally arrange complementary infrastructure, including shelter, latrines, lighting, and furniture. Multiple ORC kits can be distributed or shared across high-burden areas to expand coverage. It is recommended that kit contents serve as a reference list, with procurement carried out locally to ensure contextual appropriateness and cost efficiency.

The **ORP Kit** builds on the ORC model by incorporating enhanced sanitation and infection prevention and control (IPC) measures, along with fully integrated infrastructure components. In addition to all ORC functionalities, it includes:

- Dedicated shelter
- Furniture
- Lighting
- Strengthened sanitation and IPC provisions

The ORP functions as a **self-contained, stand-alone facility**, enabling rapid deployment without reliance on additional local setup. Each unit is compactly packaged on a single Euro pallet (1.5 m × 1.0 m), allowing transport in a standard pickup truck. The estimated cost per ORP unit is approximately USD 2,000.

Annex E: National Cholera Preparedness and Response Plan for Comoros

Plan cholera comores 2024 DLM.doc

Annex F: Kits Required in the Realization of ORP/ORT, RC-CATI and OCV

Kits used in RCRC Training Package 3.do