DREF Final Report

Comoros Cholera outbreak

Appeal: **MDRKM011**	Total DREF Allocation: **CHF 685,250**	Crisis Category: **Orange**	Hazard: **Epidemic**
Glide Number: **-**	People Affected: **330,000 people**	People Targeted: **330,000 people**	People Assisted: **-**
Event Onset: **Slow**	Operation Start Date: **19-02-2024**	Operational End Date: **-**	Total Operating Timeframe: **11 months**

Targeted Regions: **Grande Comore (Njazidja), Anjouan (Nzwani), Moheli (Mwali)**

IFRC

Description of the Event

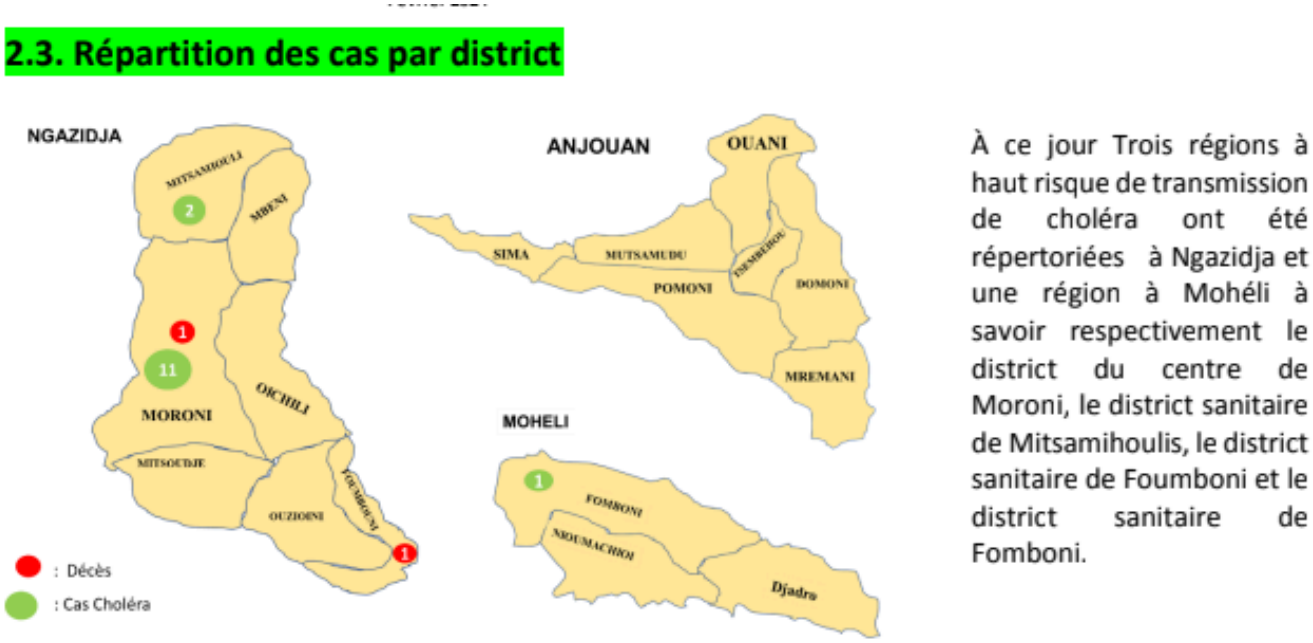


Image 1 : Répartition des cas de choléra selon le district aux Comores, Février 2024 (N=16)

Distribution of cases across the country

Date when the trigger was met

14-09-2024

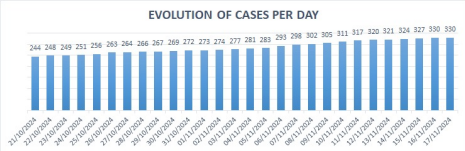
What happened, where and when?

The cholera outbreak in the Union of the Comoros began on 31 January 2024, when a boat from Tanzania arrived in Moroni with a deceased passenger later confirmed to have died of cholera. Following confirmation via rapid diagnostic tests, the Ministry of Health declared an outbreak on 2 February. The disease quickly spread across all three islands, reaching 2,319 cases and 55 deaths by 21 April, with Anjouan emerging as the most affected island.

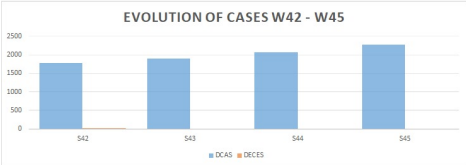
In response, the Government and partners, including the Comoros Red Crescent Society (CRCo), launched a nationwide operation. The CRCo adapted rapidly, expanding its intervention from 3 to 9 months, reaching over 330,000 people with health promotion, WASH, safe burials, and community engagement activities. By July 2024, the epidemic was considered under control, with no new cases reported and a cumulative total of 10,342 cases and 149 deaths.

However, a resurgence occurred on 14 September in Grande Comore, with over 200 new cases and 3 deaths in less than a month. The epicenter shifted back to Anjouan, where contaminated water sources fueled new transmission. CRCo resumed disinfection, awareness, and vaccination efforts, disinfecting 338 households and conducting over 41,000 awareness sessions.

By January 2025, the situation had significantly improved, with new cases declining and transmission largely under control. The CRCo extended the operation to 11 months, reinforcing community-level preparedness, surveillance, and coordination. The operation concluded with strengthened local capacities and key lessons learned for future outbreak responses.



Cases evolution per day



Cases evolution per week

Scope and Scale

The Comoros archipelago consists of three main islands: Grande Comore (Ngazidja), Anjouan (Ndzuani), and Mohéli (Mweli). The cholera epidemic, first declared in February 2024, initially hit Anjouan the hardest, which became the epicentre of the outbreak. Out of the 10,342 total cases and 149 deaths nationwide, Anjouan alone recorded 9,126 cases and 126 deaths, receiving the most attention and resources. While the National Society (CRCo) developed strong operational capacity on Anjouan, this was not mirrored on the other two islands.

Despite their geographical proximity and daily commercial interactions, Grande Comore and Mohéli saw limited benefits from the response in Anjouan. As the epidemic resurged in Grande Comore in September, it quickly spread across 6 of its 7 districts, affecting 274 people with 4 deaths by the end of October. Mohéli, with lower preparedness and coverage, remains highly vulnerable to a new wave.

Several factors contributed to the rapid spread: limited access to safe water, contaminated water sources, low clinical preparedness, lack of knowledge about cholera, community mistrust, and low vaccination coverage. The first national oral cholera vaccination (OCV) campaign reached only 58% of the target population, with significant disparities:

Grande Comore: 40% coverage (170,933 vaccinated of 431,264)

Anjouan: 79% (276,572 of 349,174)

Mohéli: 73% (42,141 of 57,457)

By the end of the year, the total caseload included:

Grande Comore: 635 cases, 15 deaths

Anjouan: 9,126 cases, 126 deaths

Mohéli: 581 cases, 8 deaths
with 10,193 recoveries, and a growing number of affected children (62 cases).

In March 2024, based on increasing case numbers and population exposure, IFRC raised the crisis categorization to Level Orange.

This outbreak also had regional implications. Mayotte, located close to Anjouan, recorded its first imported case on 18 March, followed by 4 more on 11 April. By 19 April, 26 cases had been reported. Given frequent population movement, Madagascar is also considered at risk for cross-border transmission.

National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	No

IFRC Network Actions Related To The Current Event

Secretariat	The Comoros Red Crescent is supported by the IFRC through the IFRC CCD based in Antananarivo, which provides coordination, guidance and technical and financial support. Several meetings and telephone exchanges were organized with the IFRC Delegation based in Madagascar and Nairobi. IFRC Cluster Delegation leads the coordination meetings among the Membership to ensure appropriate support to the NS. In addition to what was shared in the initial DREF operation document, ERU teams were deployed to support the operation. The surge members with different profiles (CEA, WASH, IM, etc.) will also be deployed to support the National Society. The IFRC maintained the support from the Operations Manager to the National Society. This included monitoring the various activities that were not carried out in time and those planned by the emergency teams that were deployed. In addition, it was necessary and important that capacity-building activities were carried out in the National Society so that it would be ready to intervene in such an emergency. The management of the operation's internal and external relations and the monitoring of the operation's budget, in collaboration with the Secretary General, were and remain the responsibility of the field team in collaboration with the IOI cluster. The IFRC preferred to maintain and extend the support from the Operations Manager to the National Society to ensure monitoring the various activities that were not carried out in time and those planned by the emergency teams that were deployed. In addition, it was necessary and important that capacity-building activities were carried out in the National Society so that it would be ready to intervene in such an emergency. The management of the operation's internal and external relations and the monitoring of the operation's budget, in collaboration with the Secretary General, were and remain the responsibility of the field team in collaboration with the IOI cluster.
Participating National Societies	The French Red Cross is present in the country. Supporting Comoros RC, the French Red Cross, in collaboration with the Canadian Red Cross, has deployed a modular ERU team to set up oral rehydration points in Anjouan, train volunteers in PCI in the CTCs and CTUs and train and deploy CBS volunteers. As part of this epidemic, French RC have been working with Comoros Red Crescent by providing: - Technical support for the NS (participation in technical meetings, training for health staff and volunteers). - Support in organizing awareness campaigns via mobile caravans and deployment of village committees in the communities and RCCE. - Logistical support for transporting equipment and volunteers to the CTC. Additionally, French Red Cross support included 3,000 euros allocated for per diems for volunteers dispatched exclusively to Moroni for the Samba Cholera Treatment Center, for early awareness-raising sessions, and the purchase of personal protective equipment (PPE) and other hygiene equipment. Regional Intervention for Indian Ocean Platform (PIROI): PIROI is supporting the NS through: ● Participation in Membership coordination. ● PIROI gave technical support to draft the DREF as well as Human resources according to the NS profile needs. French RC and PIROI provided technical, financial and logistic support as well. PIROI mobilized funds to contribute to purchasing and transporting the water treatment units

	to be used in Anjouan. These units were kept in country for further use when new needs arise.

ICRC Actions Related To The Current Event

ICRC is not present in the country.

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	An inter-ministerial meeting was convened, chaired by the Minister of Health, with the participation of the Secretaries-General from the Ministries of Interior, Civil Service and Islamic Affairs, Education, Transport, Energy and Agriculture, and Finance. The purpose of the meeting was to inform them of the cholera situation and to seek their collaboration in implementing control measures. The Ministry of the Interior supported the search for missing passengers using their passports and provided requisitioned vehicles to assist field teams. In addition, public awareness messages were broadcast via ORTC, the national radio and television. The Ministry of Health initially focused its strategy on establishing Cholera Treatment Centres (CTCs), contact tracing, and community-based interventions using the CATI approach promoted by UNICEF and RCCE. More recently, the Ministry installed triage points at hospital entrances. As a result, all 17 district health facilities in the country were equipped with triage stations that provided initial oral rehydration. The Ministry also promoted an Oral Rehydration Points (ORP) strategy. Through its regional directorates, the Ministry of Health continued to monitor major epidemic-prone outbreaks. During the holiday season, regional entry points were monitored, and travellers were encouraged to get vaccinated. The resurgence of the epidemic on Ngazidja island posed challenges for central authorities. As a result, regional leadership and partners took over the response. On 5 September 2024, following a meeting at the Ministry of Health with CoRC participation, health authorities decided to prepare a second large-scale vaccination phase, similar to the one held in July 2024. Other response activities were led by partners. Since the onset of the epidemic in Ngazidja, regular coordination meetings were held between CoRC and its partners. These meetings ensured partner activities were well monitored, contributing to outcomes such as a 66% recovery rate.
UN or other actors	UNICEF supported the development of the communication plan. WHO took responsibility for increasing the number of SOPs, revising protocols, and providing technical support. Médecins Sans Frontières (MSF) supported the CTCs. During the second wave in Ngazidja, UN agencies including WHO and UNICEF, which have offices in Comoros, worked closely with the government on a daily basis. UNICEF partnered with CoRC to implement the CATI approach. Through this partnership, volunteers were deployed as soon as the outbreak resumed in Ngazidja. CoRC received equipment for water purification, disinfection, and hygiene kit distribution. As part of its support, WHO funded human resources (doctors treating cholera patients at CTCs) and assisted the Ministry in preparing for the second vaccination campaign in Ngazidja.

Are there major coordination mechanism in place?

The following coordination mechanisms were in place:

A working group was established at the central level and on the islands of Anjouan and Mohéli.

Daily meetings were held with partners, coordinated by the Minister of Health, the Inspector General of Health, or the Director General of Health at the national level, and by the Regional Directors of Health on the islands.

A communications unit provided daily updates to the islands and shared situation reports (SITREPs).

A team of health technicians, including doctors and laboratory nurses, worked under the coordination of the Director of Disease Control to care for patients, collect samples, and transmit results.

The OCCOPHARMA structure was identified to supply CTCs with medicines and medical consumables.

Firefighters were identified and trained to transport cholera patients from health facilities or the community to the CTCs.

The Comoros Red Crescent Organization (CRCO) and its volunteer network were mobilized for public awareness activities, disinfection, and the facilitation of safe and dignified burials.

The Comoros Red Crescent (CoRC) played a central role in responding to the epidemic. The National Society was trusted by the Ministry of Health and recognized as the most experienced entity in managing cholera outbreaks. It was therefore highly solicited and expected to take part in numerous interventions. The authorities requested support from CoRC for various activities, including:

Community infection prevention and control (IPC), including disinfection of patients' homes, contacts, schools, and public places.

Public awareness, risk communication, and community engagement (RCCE).

Training of Ministry of Health personnel and volunteers in cholera case management and IPC.

Support in establishing, managing, and maintaining hygiene in cholera treatment centers (CTCs), where CoRC was regarded as the IPC lead.

Support to triage points, including IPC, procurement, and the supply of equipment and oral rehydration salts (ORS).

Logistics related to the local procurement and delivery of medical equipment to CTCs.

Facilitation of safe and dignified cholera burials.

Participation in the UNICEF-supported CATI approach, including contact tracing and interventions in the homes and among the neighbors of cholera patients, with CoRC contributing through RCCE and disinfection activities.

Needs (Gaps) Identified

Health

Anjouan was the initial epicentre and the most severely affected by the epidemic, recording 126 of the total 149 deaths. As a result, it was the first island to benefit from response interventions. However, the activities carried out on Anjouan had minimal to no impact on the neighboring islands of Grande Comores and Moheli, despite their close geographic proximity and strong commercial ties. With the outbreak later emerging in Grande Comores, Moheli became increasingly vulnerable and was at significant risk of experiencing a similar situation.

As of 31 October 2024, a total of 274 individuals had been affected, including four deaths. Despite these concerning figures, the cure rate stood at 66.67%. The rapid spread of the outbreak was attributed to several factors, including limited access to safe drinking water, contamination of water sources, inadequate clinical capacity to manage cholera cases, and low levels of public knowledge about the disease. Community mistrust towards the authorities led to denial of the outbreak, delayed health-seeking behaviors, and numerous community-based deaths. Furthermore, the resurgence of the epidemic was compounded by the low vaccination coverage achieved during the initial campaign. The majority of deaths occurred within the community, underscoring both the lack of access to health services and a reluctance or inability to seek care or referrals. Additional operational constraints included the breakdown of rapid

diagnostic testing (RDT) in Moheli and Anjouan, and the unavailability of cholera beds in Anjouan, despite local stocks being available for manufacturing.

To address these challenges, the extension phase of the operation supported the health interventions of the Comoros Red Crescent (CoRC) and ensured the safety and wellbeing of its volunteers. Volunteer teams trained in psychosocial first aid were established to support both frontline responders and affected communities.

The following key activities were implemented in collaboration with the Ministry of Health and its Regional Health Directorates in Ngazidja (Grande Comores) and Moheli:
- Volunteers were trained and deployed to raise community awareness on preventive measures against endemic, pandemic, and epidemic diseases across the three islands.
- A cadre of volunteer trainers in psychosocial first aid was trained and equipped on all three islands.
- Infection Prevention and Control (IPC) image boxes were produced and utilized by volunteers to facilitate effective community sensitization activities.

Water, Sanitation And Hygiene

WASH is central to the response to cholera. The CoRC has identified the following needs and priority actions:
- Scale up disinfection of patient's and contact's homes.
- Reinforce Infection Prevention and control in CTCs/CTUs and triage points including waste management.
- Provide access to safe water including water treatment for Ndzuani and Mweli that have contaminated water sources, disinfection of water tanks.
- Procurement of essential consumables such as HTH and local bleach to allow production of 2% chlorine solutions.
- Disseminate EHA messages to prevent cholera.
- Ensure all deceased persons receive a safe and cholera burial and increase the acceptability of the process.

WASH activities on the islands of Ngazidja (Grande Comores) and Moheli were initially slow to commence. The first interventions began at the onset of the epidemic in February 2024. However, these activities were soon deprioritized in favor of Anjouan, where the epidemic had escalated rapidly, resulting in significant human casualties. This strategic shift led to the suspension of planned WASH efforts in Ngazidja and Moheli.
The gap in WASH activities was subsequently addressed during the implementation of capacity-building initiatives. These included the establishment of disaster response teams and the training of dignified and safe burial teams to strengthen local emergency preparedness and response capacity.
During the second phase of the epidemic, WASH activities previously undertaken in Anjouan were extended to Ngazidja and Moheli, with adjustments to suit local contexts. Due to the absence of suitable water sources in the districts of Grande Comores, the establishment of a water treatment unit was not pursued. Instead, the focus shifted to community-level interventions. Volunteers were trained to set up Oral Rehydration Points (ORPs), and efforts were made to equip communities with trained personnel to provide accurate information and guidance on Oral Rehydration Therapy (ORT).

Protection, Gender And Inclusion

From the onset of the outbreak, the distribution of reported cases did not align with the overall demographic profile of the population. Individuals in the 15–19 age group, males, and specific vulnerable groups such as students and pregnant women were disproportionately represented among the confirmed cases.
A survey conducted by the Comoros Red Crescent (CoRC), with support from the French Red Cross, further highlighted key disparities. The findings revealed gender-related exposure factors, varying levels of social impact, and significant differences in access to health facilities and WASH infrastructure across different segments of the population.
The assessment also identified the following key needs and gaps:
- Adaptation of interventions and messaging to take into account exposure, knowledge and access to healthcare.
- Mainstreaming PSEA.
- House visits to pregnant women and persons living with disabilities.
- Preventing and responding to a possible surge of GBV.

With this new outbreak upsurge, PGI aspect will be taken into consideration as volunteers have now been trained in PGI.

Community Engagement And Accountability

Multiple partners, including the Comoros Red Crescent (CoRC), were actively involved in Risk Communication and Community Engagement (RCCE) efforts across the three islands. However, raising community awareness remained a significant challenge.
Widespread mistrust, denial of the outbreak, and persistent rumors such as claims that the disease was fabricated undermined public health messaging. Additional fears associated with the main Cholera Treatment Centre (CTC), which had previously been used as a COVID-19 facility, contributed to delayed healthcare-seeking behavior and an increase in community-based deaths.
A survey conducted by CoRC, with support from the French Red Cross, further emphasized these challenges. The findings revealed limited community knowledge and misconceptions about cholera, low adoption of preventive measures, and poor awareness regarding the availability of free treatment services.
The CoRC has identified the following gaps:

- Addressing mistrust, misinformation and rumors in communities.
- Scale up sensitization activities.
- Adapt and disseminate IEC material.
- Scale up group activities.
- Mainstream the community feedback mechanism.

Raising community awareness has been a challenge throughout the cholera response on the three islands. Setting up a feedback system has helped to overcome several problems, including denial of the disease. The CEA pillar was central to the success of the cholera vaccination campaign in the Comoros, and especially in Anjouan. All these actions need to be repeated in Ngazidja and Moheli to support the DRS's communication campaigns. The lack of awareness and denial of the disease in the target areas means that volunteers need to be mobilized to cut off the chain of infection, which is becoming increasingly widespread in Ngazidja. To this end, the following activities should be implemented in this new phase of the epidemic:

- Training and deployment of 60 additional CEA volunteers in the 7 districts of the island of Ngazidja.
- Training and deployment of 30 volunteers to collect, analyze and code community feedback.
- Ensuring the payment of back pay to CREC volunteers in Anjouan.
- Deployment of CEA volunteers previously trained in Mohéli.

Operational Strategy

Overall objective of the operation

The objective of the operation was to support the Ministry of Health (MOH) in limiting the spread of the cholera epidemic across the three islands of the Union of the Comoros over an 11-month period. This objective was pursued through the implementation of integrated health interventions including mental health and psychosocial support, Water, Sanitation and Hygiene (WASH), Protection, Gender and Inclusion (PGI), and Community Engagement and Accountability (CEA) activities. Collectively, these efforts aimed to reduce disease transmission and lower cholera-related mortality.

Operation strategy rationale

This operation aimed to reduce cholera-related morbidity and mortality across the Comoros following the outbreak declared in February 2024. The strategy evolved in response to the shifting epidemiological landscape—first addressing Anjouan, the hardest-hit island, and later adapting to a resurgence in Grande Comore.

Over the 11-month intervention, the Comoros Red Crescent Society (CRCo), with support from IFRC and partners, reached more than 330,000 people with integrated activities in health, WASH, risk communication and community engagement (RCCE), and safe and dignified burials. Major successes included rapid volunteer mobilization, disinfection of over 338 households, delivery of over 41,000 awareness sessions, and strong community feedback mechanisms.

Challenges included unequal resource distribution across islands, community mistrust, low initial vaccination coverage, and limited local capacity in some areas. These informed operational adjustments and reinforced the need for localized preparedness.

As the outbreak came under control by January 2025, CRCo initiated a phased exit strategy. This included handover of remaining activities to local health authorities, reinforcement of community surveillance, and debriefing workshops to capture lessons learned. In coordination with national stakeholders, CRCo is now exploring medium- to long-term resilience-building initiatives, including improved water infrastructure, hygiene promotion, and outbreak preparedness in vulnerable areas.

Targeting Strategy

Who was targeted by this operation?

The overall target population of 330,000 people remained consistent throughout the operation; however, the scope and intensity of activities were progressively adapted and expanded across the three islands—Anjouan, Grande Comore, and Mohéli—in response to the evolving outbreak.

Priority groups targeted during the intervention included:

All confirmed cholera patients and their families,

Contact cases identified through surveillance and CATI interventions,

Communities in affected or high-risk localities,

Health facilities and Cholera Treatment Centres (CTCs), along with their staff,

National Society personnel, including deployed staff and over 3,000 active volunteers,

Vulnerable populations, particularly in areas with low vaccination coverage or poor access to clean water and sanitation.

While direct interventions focused on confirmed cases and their surroundings, the operation also recognized that the entire Comorian population was indirectly affected by the outbreak. Therefore, national-level awareness campaigns, hygiene promotion, and risk communication activities were implemented to support broad community protection and behavior change.

Targeting decisions were continually updated based on epidemiological data, local risk assessments, and community feedback, ensuring a flexible and needs-based approach.

Explain the selection criteria for the targeted population

The selection of sites and targets will be guided by the evolution of the epidemic and information from the authorities' epidemiological bulletins. The National Society will prioritize affected areas, such as Moroni, Foumbouni, and surrounding areas in Ngazidja, as well as Fomboni and surrounding areas in Moheli. The National Society will also consider potential future areas that may be affected by cholera and adjust targets accordingly based on government actions to ensure a complementary response. The direct target is 330,000 people (or 55,000 households), will be reached through sensitization activities, representing 35% of the entire population. Among them, 5,000 suspected cases are targeted for health support, while 2,300 households will undergo disinfection.

Total Assisted Population

Assisted Women	-	Rural	40%
Assisted Girls (under 18)	-	Urban	60%
Assisted Men	-	People with disabilities (estimated)	2%
Assisted Boys (under 18)	-		
Total Assisted Population	-		
Total Targeted Population	330,000		

Risk and Security Considerations (including "management")

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

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

Risk	Mitigation action
Failure of the water and sewerage system	CoRC supported the implementation of WASH interventions, including local chlorine production through electrolysis to ensure a continuous supply for disinfection purposes.
Stock-outs of WASH consumables (e.g. chlorine) and health supplies (e.g. PPE, IV fluids)	The CoRC logistics team actively monitored stock levels. Alerts were issued in advance when supplies were low, allowing for timely replenishment and avoiding stock-outs during critical periods.
Cyclone and rainy season causing flooding and operational delays, with potential to exacerbate the epidemic	The CoRC activated its Flood Contingency Plan. Hygiene promotion campaigns were carried out in at-risk communities, and the situation was closely monitored to enable quick adaptation of the response in case of environmental disruptions.
Public hostility or violence towards service providers	Community awareness sessions were conducted to dispel rumors and misinformation. These efforts helped reduce tensions and foster trust between the public and frontline responders.
Increase of public events and social gatherings (marriage season, Maoulid ceremonies, back to school, etc.).	In anticipation of increased transmission risks due to mass gatherings, preparedness measures were activated. Cholera Alert Teams and Epidemic Disease Surveillance (EDS) volunteers were mobilized. Equipment and consumables were pre-positioned in strategic locations. Risk communication and community engagement (RCCE) activities were intensified to raise public awareness on preventive behaviors.
Health risk for the NS staff in the field	CoRC ensured the safety of its field teams by distributing personal protective equipment (PPE), conducting targeted training sessions, and providing volunteer insurance. In addition, advocacy was conducted to include volunteers in priority vaccination groups once the campaign was initiated.

Please indicate any security and safety concerns for this operation:

- Violent events during epidemics could also increase contamination.
- Contamination of NS staff is a major risk. Infected staff can become sources of transmission in their community. Providing appropriate PPE for the tasks performed by staff, as well as training, will help to mitigate this risk.
- Stigmatization of staff involved in the cholera response (misunderstanding of the disease by the population, rumors and fears), which could lead to violence against them. This risk can be mitigated by Risk Communication and Community Engagement (RCCE).

- Community mistrust/denial may lead to attacks on RCRC staff and volunteers especially when performing cholera burials in communities.	
Has the child safeguarding risk analysis assessment been completed?	No

Implementation

Health

Budget: CHF 166,962
Targeted Persons: 330,000
Assisted Persons: 174,747
Targeted Male: 83,879
Targeted Female: 90,868

Indicators

Title	Target	Actual
# of people reached with health promotion activities	330,000	174,747
# of referrals from ORPs to CTC (Need basis)	0	40
% of cholera burials performed (100%)	100	100
# of ORP set-up or supported	6	6
# of health facilities supported by IPC activities (CTC/triage points)	8	7
Number of people trained to cholera burial	30	30
# of AWD alerts raised by CoRC volunteers	-	40
% of AWD alerts investigated within 24 hours	80	80
% of targeted communities with active CBS reporting/volunteers	100	100

Narrative description of achievements

The cholera outbreak in the Union of the Comoros required a robust and coordinated health response across the three islands. With the support of the IFRC and the French Red Cross (CRF), and in collaboration with national authorities, the Comorian Red Crescent (CRCo) played a central role in delivering health interventions aimed at reducing morbidity, supporting care structures, and enhancing community-level prevention and resilience.

A key achievement was the establishment and operational support of six Oral Rehydration Points (ORPs) across the most affected areas, meeting 100% of the target. These ORPs provided frontline support for dehydration management, infection prevention and control (IPC), and facilitated referrals to Cholera Treatment Centres (CTCs). CRCo volunteers provided sustained daily assistance at both ORPs and CTCs throughout the response period.

- # of ORPs set up or supported: Target 6 / Achieved 6 (100%)
- # of referrals from ORPs to CTCs: 40

Volunteers were comprehensively trained in Community-Based Health (CBH), covering the detection of acute watery diarrhea (AWD), hygiene promotion, water treatment, and IPC. Importantly, 30 volunteers were trained for safe and dignified burials, aligned with both

health protocols and cultural sensitivities. All cholera-related deaths reported during the operation were managed in accordance with these protocols. A total of 154 burials were performed.

- # of people trained in cholera burial: Target 30 / Achieved 30 (100%)
- % of cholera burials performed in compliance with protocol: Target 100% / Achieved 100%

IPC support was extended to five health facilities out of the eight initially targeted. The remaining facility was covered by Medecins Sans Frontieres, in line with joint coordination decisions.

- # of health facilities supported by IPC activities: Target 8 / Achieved 7

CRCo reached 174,747 people through integrated health promotion activities—53% of the 330,000 target. These activities included household visits, school awareness sessions, mobile cinema campaigns, 386 radio broadcasts in local languages, and community dialogues. Although the overall reach fell short due to access constraints during the cyclone season and delays in material replenishment, emphasis was placed on quality and depth of engagement in accessible areas to maximize impact.

- # of people reached through health promotion: Target 330,000 / Achieved 174,747 (53%)

The use of CEA-trained volunteers helped reinforce community understanding and trust, especially in areas with limited access to formal health messaging. CRCo activated its CBS system in affected areas. Volunteers issued 40 AWD alerts, and 80% of these were investigated within 24 hours as targeted.

- # of AWD alerts raised by volunteers: 40
- % of alerts investigated within 24 hours: Target 80% / Achieved 80%

CBS reporting was launched in all targeted communities with consistent reporting maintained in all of them, due to network challenges and volunteer turnover in some remote locations.

- % of targeted communities with active CBS reporting: Target 100% / Achieved 100%

During the national oral cholera vaccination campaign, CRCo volunteers were actively involved in social mobilization, door-to-door awareness-raising, and managing crowd control at vaccination points. Their community embeddedness was crucial in building trust and ensuring high uptake of the vaccine, especially in hotspot areas like Anjouan.

Lessons Learnt

Timely volunteer training and deployment proved vital in the early containment of the outbreak. Training across multiple domains—CBH, IPC, safe burial, oral rehydration—ensured that volunteers were not only first responders but also trusted health educators within their communities.

The mobile cinema approach and radio campaigns were especially effective in reaching remote populations with limited literacy, showing the value of multimedia health promotion. Moreover, the integration of CRCo into national and local health coordination bodies strengthened the alignment of field actions with strategic public health objectives.

Another important lesson was the importance of pre-positioning supplies and ensuring stock availability for health operations. This reduced delays and allowed for a swift scale-up of response.

Challenges

The main health-related challenges included limited infrastructure and workforce capacity, especially in rural health posts. This created gaps in cholera case detection, referral, and follow-up care. Additionally, delayed funding transfers led to interruptions in volunteer activities and medical supply distribution, which temporarily slowed outbreak control in some areas.

Resistance to the recognition of cholera, particularly in the early phase, complicated community engagement and delayed access to care in several regions. Moreover, the lack of incineration facilities for medical waste management posed significant infection control risks, particularly at CTCs.

Moving forward, enhancing community-based disease surveillance, investing in local health infrastructure, and scaling IPC measures across health facilities remain critical to sustaining health gains and improving outbreak preparedness.

Water, Sanitation And Hygiene

Budget: CHF 218,304

Targeted Persons: 330,000
Assisted Persons: 243,936
Targeted Male: 117,089
Targeted Female: 126,847

Indicators

Title	Target	Actual
% or number of homes of infected people and direct neighbor's reported that are disinfected	10,000	40,960
Number of volunteers trained in cholera management	150	599
# of liters of water distributed/day (m3)	80	100
# of water distribution points	10	10

Narrative description of achievements

In response to the cholera outbreak, the Comorian Red Crescent (CRCo), with support from the IFRC and Movement partners, implemented a robust and integrated Water, Sanitation, and Hygiene (WASH) strategy. This strategy aimed to halt disease transmission, protect public health, and promote hygienic practices across affected communities. The response focused on three core pillars: targeted disinfection, safe water provision, and community-based hygiene promotion. On the overall, 243936 people were assisted with WASH activities.

1. Targeted Disinfection of Homes and Public Spaces
A major achievement was the large-scale disinfection of households of confirmed cholera patients and their immediate neighbors, as well as public spaces such as mosques, schools, markets, and Cholera Treatment Centres (CTCs). Trained volunteer teams conducted disinfection activities with high frequency—twice daily in CTCs—adapting to outbreak severity and local caseloads.

# of households (infected + direct neighbors) disinfected:
Target: 10,000 / Achieved: 40,656

This fourfold overachievement resulted from the strategic expansion of disinfection coverage beyond the initial target areas. The CRCo adopted a broader definition of at-risk households and intensified disinfection protocols, especially in urban and high-density settings. Enhanced volunteer mobilization and partnerships with community actors enabled this exceptional scale-up.

To sustain operations, chlorine solutions were locally produced using WATA kits (with a 60-liter capacity), ensuring consistent availability of disinfectant. All teams adhered to stringent Infection Prevention and Control (IPC) protocols to prevent cross-contamination and safeguard both communities and frontline responders.

2. Cholera Management Training for Volunteers
A total of 590 volunteers were trained in cholera prevention and response—significantly exceeding the initial target.

# of volunteers trained in cholera management:
Target: 150 / Achieved: 590 (393%)
(Men: 364; Women: 235)

This extensive training effort covered WASH protocols, IPC, hygiene promotion, water safety, and effective community engagement. Trained volunteers were immediately deployed to support disinfection operations, promote hygiene practices, and facilitate safe water distribution. Their local presence and trust within the community greatly enhanced the acceptability and effectiveness of interventions.

3. Water Distribution and Access
To mitigate the risk of waterborne transmission, the CRCo conducted daily water trucking operations, targeting areas lacking functional water systems or affected by infrastructure breakdowns. On average, 100 cubic meters (100,000 liters) of safe water were distributed each day.

# of liters of water distributed per day (m^3):

Target: 80 / Achieved: 100 (125%)

This overperformance was driven by urgent needs in hotspot areas, particularly on the island of Anjouan. Rapid mobilization of trucks and water tanks, in collaboration with local authorities, enabled sustained water access for vulnerable households and institutions.

In addition, the CRCo established 10 water distribution points, including 1 mobile point to enhance reach and flexibility.

# of water distribution points:
Target: 10 / Achieved: 10 (100%)

This flexible infrastructure approach balanced fixed-point accessibility with mobile delivery solutions, enabling timely water provision in both stable and shifting outbreak zones.

Lessons Learnt

The integration of WASH and RCCE strategies significantly boosted public understanding and adoption of hygiene measures. Disinfection combined with education helped reduce household transmission. The use of local volunteers with cultural knowledge improved compliance with sanitation efforts and reduced resistance to external interventions.

Investing in chlorine production capacity through WATA kits, and ensuring consistent PPE availability, ensured the safety and sustainability of disinfection campaigns. Collaborative planning with the Ministry of Health and partners streamlined WASH operations, including harmonized protocols for CTC sanitation and burial procedures.

The use of a multi-layered approach combining water treatment, hygiene promotion, and sanitation was a key success factor in slowing the spread of cholera.

Challenges

WASH operations faced logistical hurdles, especially in remote regions of Moheli and Anjouan where infrastructure is limited. Transporting disinfection materials and water treatment supplies to these areas often caused delays. In some cases, volunteers had to travel long distances without adequate mobility support.
There were also instances of community resistance to disinfection and safe burial activities, stemming from misinformation or cultural discomfort. Furthermore, the absence of functional medical waste incineration systems at CTCs posed a major infection control risk, requiring temporary alternative methods that were less effective and harder to manage.
To ensure long-term impact, there is a need to invest in permanent community sanitation structures, improve transport capacity for WASH teams, and scale up local chlorine production across all three islands.

Protection, Gender And Inclusion

Budget: CHF 8,946
Targeted Persons: 33,000
Assisted Persons: 33,000
Targeted Male: 15,840
Targeted Female: 17,160

Indicators

Title	Target	Actual
# of volunteers having signed the code of conduct	250	250
# of volunteers having received a PSEA briefing	250	250
# of staff and volunteers briefed on PGI in epidemics	250	190

Narrative description of achievements

As part of the cholera response in the Union of the Comoros, the Comorian Red Crescent (CRCo) systematically mainstreamed Protection, Gender and Inclusion (PGI) across all interventions to ensure equitable access to services and support for all affected individuals, particularly those most vulnerable.

A gender and vulnerability survey was conducted to better understand the barriers faced by women, children, persons with disabilities, and other at-risk groups in accessing health information and services. Based on the findings, tailored training sessions were delivered to volunteers and health workers, focusing on integrating gender-sensitive approaches into community health outreach, safe and dignified burials, and hygiene promotion efforts.

To strengthen accountability and community participation, more than 386 radio broadcasts were aired, and over 19,000 community feedback responses were collected, of which 15,730 were processed—demonstrating a strong commitment to inclusive and responsive programming.

Capacity-building efforts on PGI also yielded concrete results. All 250 targeted volunteers (100%) signed the code of conduct and received a briefing on Protection from Sexual Exploitation and Abuse (PSEA), ensuring they understood their responsibilities and the standards of ethical conduct expected during the response. However, only 190 out of 250 planned personnel and volunteers (76%) were reached with specific briefings on PGI principles. This gap reflects a known structural limitation: PGI, while integrated across training modules, lacks a dedicated budget line, making full coverage challenging. Nonetheless, the transversal nature of PGI allowed its integration into other sessions.

Women leaders played a critical role, particularly in outreach to remote communities. Their leadership helped build trust and increased community engagement in vaccination and hygiene promotion. Focus group discussions held with women and vulnerable groups informed the development of localized action plans, ensuring community priorities were reflected in response activities.

Furthermore, PGI-trained volunteers supported safe burials that were both culturally respectful and health-compliant, addressing families' concerns with empathy and sensitivity, and helping to reduce stigma associated with cholera-related deaths.

Lessons Learnt

The integration of PGI from the early stages of the operation proved to be a key factor in enhancing the overall effectiveness and sustainability of the cholera response. One of the most important lessons was the value of involving marginalized groups, particularly women and people with disabilities, in planning and implementation. Their participation ensured that messages and services were more accessible and better tailored to community needs.
Another key learning was the importance of volunteer protection. Launching the process of volunteer insurance with the support of IFRC emphasized the need to safeguard frontline responders, especially during epidemics. The wide range of communication tools and channels, such as mobile cinema and illustrated leaflets, helped increase reach and understanding, especially in remote or low-literacy communities.

Challenges

Several challenges emerged during the implementation of PGI-related activities. Firstly, the lack of insurance coverage for volunteers created insecurity and led to decreased motivation in some areas. In addition, denial of the disease by certain community members and resistance from some families regarding safe and dignified burials posed operational difficulties.
These barriers impacted the project by slowing the response and potentially contributing to further spread of the disease within households and villages. Delays in the transfer of funds also led to late payment of volunteer and partner organization allowances, reducing the availability of key human resources at critical moments. These challenges underline the importance of early and consistent investment in both community engagement and logistical support to maintain a protective and inclusive response framework.

Community Engagement And Accountability

Budget: CHF 58,575
Targeted Persons: 33,000
Assisted Persons: 33,000
Targeted Male: 15,840
Targeted Female: 17,160

Indicators

Title	Target	Actual
% of community feedback collected and addressed.	90	90
# of people reached through village committees	999	1,000
% of cholera burials occurring without any objection from family or community	100	100

Narrative description of achievements

Community Engagement and Accountability (CEA) was a central pillar of the Comorian Red Crescent's (CRCo) response to the cholera outbreak. Through a participatory, culturally appropriate, and rights-based approach, CRCo ensured that affected populations were not only informed but also actively engaged in shaping the response. This contributed significantly to increased trust, adoption of life-saving behaviors, and reduced resistance to public health measures.

CRCo volunteers collected feedback on a continuous basis through household visits, health promotion sessions, and community dialogues. The feedback included community concerns, rumors, questions, and suggestions on topics such as cholera prevention, case management, vaccine acceptance, and burial practices.

- % of community feedback collected and addressed:

Target: 90% / Achieved: 90% (100%)

All feedback was analyzed and used to refine key messages and adapt operational strategies. The full achievement of this target reflects the effectiveness of the feedback mechanism and the strong coordination between CEA and technical teams in closing the feedback loop, including in remote areas.

CRCo effectively leveraged village committees as key entry points for dialogue, information sharing, and community mobilization. These structures helped facilitate two-way communication and foster local ownership of the response.

- # of people reached via village committees:

Target: 999 / Achieved: 1,000 (100%)

The full target was met thanks to the activation of both pre-existing and newly supported village-level committees. Despite earlier operational challenges—such as competing priorities during outbreak peaks and movement restrictions—CRCo adapted by using hybrid engagement strategies. These included the involvement of community leaders, door-to-door outreach, and public events such as mobile cinema sessions, enabling the response to maintain momentum and community presence.

Safe and Dignified Burial (SDB) practices were implemented in full compliance with public health standards while ensuring respect for cultural and religious customs. CRCo teams worked closely with families and religious leaders to explain procedures and ensure buy-in before conducting any burial.

- % of cholera burials conducted without family or community objection:

Target: 100% / Achieved: 100% (100%)

All cholera-related burials facilitated by CRCo were accepted by the communities, underscoring the strength of early sensitization, the role of trusted local volunteers, and the respectful, transparent manner in which burials were conducted. This also reflects CRCo's ability to address sensitive issues with empathy and effectiveness.

Lessons Learnt

The response confirmed that meaningful community engagement is not just a complementary activity but a core pillar of epidemic response. The CFM allowed the CRCo to remain agile and responsive, while also reinforcing accountability to those affected. Communities were more receptive and cooperative when they were not only recipients of information but contributors to the process.

The success of the mobile cinema and local radio shows how innovative, culturally appropriate communication tools can have powerful reach and resonance. Training volunteers in interpersonal communication also proved essential in building trust and reducing fear and misinformation.

Moreover, integrating feedback loops into decision-making strengthened program relevance and helped overcome resistance to certain health practices, such as safe burials or water chlorination.

Challenges

One of the main challenges was the initial lack of digital tools for recording and analyzing community feedback. This delayed response to some community concerns and required rapid adaptation through manual systems. There were also logistical difficulties in reaching

remote or isolated communities consistently due to poor transport infrastructure.

In certain areas, entrenched beliefs and disease-related stigma led to resistance to some messages or activities. Additionally, volunteer fatigue became a concern as the outbreak persisted, especially in zones with repeated misinformation or high levels of skepticism.

To sustain CEA efforts, there is a need for continued investment in community-based feedback systems, digital tools for real-time data collection, and long-term volunteer engagement strategies, particularly in hard-to-reach areas.

Secretariat Services

Budget: CHF 136,320
Targeted Persons: 266
Assisted Persons: 266
Targeted Male: 138
Targeted Female: 128

Indicators

Title	Target	Actual
# of IFRC monitoring missions conducted	6	4
#of surge deployed	6	6
# of coordination meeting on the intervention	4	24

Narrative description of achievements

Throughout the cholera response operation in the Union of the Comoros, the IFRC Secretariat played a pivotal role in ensuring strategic coordination, technical support, and resource mobilization to reinforce the emergency actions led by the Comorian Red Crescent (CRCo). The Secretariat's interventions were particularly crucial in the island of Anjouan, which was most affected by the outbreak, recording 10,347 cumulative cholera cases, 10,193 recoveries, and 159 deaths between March and July 2024.

To strengthen coordination and response capacity, the Secretariat supported the deployment of six surge personnel (100% of the target achieved) and facilitated the mobilization of 15 Emergency Response Units (ERUs), significantly reinforcing CRCo's operational capabilities. This surge presence enabled rapid scale-up of response activities and technical assistance in critical sectors including WASH, health, and logistics.

A key highlight of the Secretariat's contribution was its leadership in coordinating Movement-wide efforts. Weekly coordination meetings were institutionalized with partners such as the French Red Cross and PIROI. Originally planned at a modest target of four sessions, these meetings reached 24 by the end of the DREF operation—600% of the initial target. The frequency of these sessions (held every Thursday at noon throughout the six-month intervention) proved vital in maintaining coherence across actors and enabling rapid, collective decision-making in a dynamic epidemic context.

Moreover, with the support of the Secretariat, a national coordination cell and three regional coordination cells (one per island) were established. These structures played a central role in harmonizing response strategies, facilitating information flow, and clarifying roles and responsibilities among stakeholders, thereby enhancing accountability and operational efficiency.

In terms of capacity building, the Secretariat backed the rollout of training workshops across Grande Comore, Mohéli, and Anjouan. These efforts led to the formation and deployment of Community Disaster Response Teams (CDRTs) and National Disaster Response Teams (NDRTs), enabling rapid mobilization in affected and hard-to-reach communities.

While six follow-up missions by the IFRC Secretariat were initially planned, only four were conducted (67% achievement). This shortfall was mitigated by the permanent presence of an Operations Manager stationed in the Comoros, who provided continuous technical support and oversight on the ground throughout the operation.

Beyond operational coordination, the Secretariat also provided ongoing assistance in data management, monitoring and evaluation, and financial reporting—strengthening internal systems and boosting donor confidence. The collaboration with the Ministry of Health was further institutionalized through joint field missions and the CRCo's integration into national emergency coordination platforms.

Finally, advocacy and visibility efforts were strengthened through high-level engagements with the Governor of Anjouan, national authorities, and the Indian Ocean Islands Cluster Coordinator. These exchanges helped elevate the visibility of the CRCo, consolidate political support, and position the Movement as a key actor in future epidemic preparedness and response initiatives.

Lessons Learnt

The operation highlighted the importance of maintaining strong and consistent coordination mechanisms between the National Society, the Secretariat, and Movement partners. Weekly coordination meetings and joint planning exercises ensured timely decision-making and reduced duplication of efforts.

One key learning was the strategic value of rapid surge deployments. The presence of surge teams enabled real-time support in hotspot zones and helped build operational capacity. The active participation of the Secretariat in vaccination campaigns and public health advocacy also enhanced the credibility and leadership role of the CRCo within national platforms.

Moreover, embedding technical expertise in areas such as CEA, logistics, and WASH within the CRCo structure significantly improved the coherence and quality of implementation. The ability to adapt support modalities to the evolving context was instrumental in maintaining momentum.

Challenges

Despite the overall success, some challenges hindered Secretariat service delivery. Delays in fund transfers occasionally disrupted activity timelines and caused temporary suspensions in volunteer compensation and local procurement. This affected morale and slowed community-based activities in some areas.

Additionally, the limited logistical infrastructure on the islands, especially in Moheli and Anjouan, created bottlenecks in the distribution of supplies and deployment of technical staff. These constraints called for enhanced prepositioning strategies and improved contingency planning.
Lastly, the evolving nature of the epidemic required agile responses. Balancing coordination duties with direct technical support placed pressure on deployed Secretariat personnel, highlighting the need for scalable surge rosters and flexible support systems.

National Society Strengthening

Budget: CHF 96,143
Targeted Persons: 260
Assisted Persons: 260
Targeted Male: 135
Targeted Female: 125

Indicators

Title	Target	Actual
% of volunteers involved in the operation insured	250	250
# of volunteers trained and deployed	250	250
# of monitoring missions conducted and reported by the HQ	41	41
# Lessons learnt conducted and reported	1	1

Narrative description of achievements

In response to the cholera outbreak, the Comorian Red Crescent (CRCo), with strong support from the IFRC, undertook significant efforts to reinforce both its emergency response capacity and long-term institutional resilience. These efforts contributed to meeting all targets under the National Society Strengthening pillar, reflecting a fully achieved performance across all planned indicators.
A key accomplishment was the training and deployment of 250 volunteers (100%) across the islands of Grande Comore, Mohéli, and Anjouan. These volunteers received comprehensive training in Community-Based Health (CBH), Infection Prevention and Control (IPC), Oral Rehydration Point (ORP) management, Safe and Dignified Burials (SDB), water treatment (UTE), and community feedback mechanisms. This multisectoral approach ensured that CRCo volunteers were well-equipped to respond effectively and with agility to evolving community needs during the outbreak.

Moreover, 100% of the volunteers involved in the operation were insured (250 out of 250), a critical measure to safeguard frontline responders. This achievement not only reflects operational efficiency but also demonstrates the organization's commitment to duty of care and volunteer protection during high-risk health emergencies.
To ensure quality assurance and adaptive management, the CRCo headquarters successfully carried out all 41 planned monitoring missions (100%). These missions enabled real-time supervision, problem-solving, and data-informed decision-making throughout the operation. The strong role played by the Planning, Monitoring, Evaluation, and Reporting (PMER) unit was instrumental in this regard, with the development of tailored tools and reporting mechanisms aligned with IFRC standards.
Institutional learning was also prioritized. A lessons-learned workshop was conducted and documented (100% of target achieved), bringing together CRCo leadership, volunteers, and Movement partners. This participatory event allowed the team to reflect on operational challenges, consolidate best practices, and co-develop strategic recommendations for future epidemic preparedness and response initiatives.
These achievements underscore CRCo's strengthened organizational foundation and enhanced capacity to manage complex health emergencies. The full attainment of all National Society Strengthening targets positions the CRCo as a more effective and trusted actor within the Comorian humanitarian landscape, capable of responding to both immediate crises and long-term public health threats with professionalism, accountability, and resilience.

Lessons Learnt

The operation demonstrated that investing in National Society development is a key enabler for impactful emergency response. Training a large number of volunteers in integrated skills allowed for a versatile and rapid deployment model. The formation of multi-level coordination cells (national and three regional) ensured that field-level implementation was aligned with strategic objectives and evolving needs.

Partnerships with Movement actors proved highly effective in technical capacity-building and joint operational planning. The involvement of CRCo in high-level meetings with government and stakeholders reinforced its advocacy potential and legitimacy as a key responder.
An additional lesson was the importance of institutional memory and standardized systems. The development of a cadre of trained CDRT/NDRT members creates a foundation for future responses beyond this specific outbreak.

Challenges

Despite the progress, the National Society faced several institutional constraints. Delays in funding transfers impacted operational continuity and created frustration among volunteers, whose stipends were sometimes delayed. This had a demotivating effect in the early stages of deployment.

The lack of volunteer insurance at the start of the operation also exposed frontline workers to risks without adequate protection, prompting the urgent launch of a volunteer insurance initiative with IFRC. Furthermore, limited logistical resources, particularly in Mohéli and remote areas of Anjouan, hampered the speed of response and distribution of hygiene kits and medical supplies.

These challenges highlight the ongoing need for structural investments in volunteer welfare, logistics, and financial systems to ensure that the National Society remains agile and responsive in future emergencies.

Financial Report

Selected Parameters			
Reporting Timeframe	2024/2-2025/4	Operation	MDRKM011
Budget Timeframe	2024/2-2025/4	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 29/May/2025

All figures are in Swiss Francs (CHF)

MDRKM011 - Comoros - Cholera Response

Operating Timeframe: 19 Feb 2024 to 31 Jan 2025

I. Summary

Opening Balance	**0**
Funds & Other Income	**685,250**
DREF Response Pillar	685,250
Expenditure	**-670,885**
Closing Balance	**14,365**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash			**0**
PO04 - Health	156,772	55,519	**101,253**
PO05 - Water, Sanitation & Hygiene	199,580	365,979	**-166,399**
PO06 - Protection, Gender and Inclusion	8,400	318	**8,082**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery			**0**
PO10 - Community Engagement and Accountability	55,000	99,122	**-44,122**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**419,752**	**520,938**	**-101,186**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services	133,399	88,077	**45,323**
EA03 - National Society Strengthening	132,098	61,870	**70,227**
Enabling Approaches Total	**265,497**	**149,947**	**115,550**
Grand Total	**685,249**	**670,885**	**14,364**

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Please explain variances (if any)

Explanation of the variances:
At the end of the operation, a remaining balance of 14,364 CHF will be returned to the DREF pot.

- The part of the "PO04 - Health (64%)" was underspent because part of the budget was affected to "PO05 - Water, Sanitation & Hygiene (83%)" activities which were then overspent. More financial needs were focusing on WASH.
- "PO06 - Protection, Gender and Inclusion (96%)" was underspent because it were integrated with "PO10 - Community Engagement and Accountability (80%)" (overspent) activities which was overspent.
- "EA02 - Secretariat Services (33%)" was underspent because most of the budget for surge deployment was funded by NS or ERU

funds.

- Similarly to EA02, "EA03 - National Society Strengthening (53%)" was underspent because most of the budget for volunteer training was funded by ERU and PIROI funds.

Contact Information

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

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Click here for reference

Selected Parameters			
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Budget Timeframe	2024/2-2025/4	Budget	APPROVED

DREF Operation

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MDRKM011 - Comoros - Cholera Response

Operating Timeframe: 19 Feb 2024 to 31 Jan 2025

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
Relief items, Construction, Supplies	**1,519**		**1,519**
Other Supplies & Services	1,519		1,519
Logistics, Transport & Storage		**12,901**	**-12,901**
Storage		255	-255
Distribution & Monitoring		1,449	-1,449
Transport & Vehicles Costs		10,668	-10,668
Logistics Services		528	-528
Personnel	**52,000**	**64,541**	**-12,541**
International Staff	52,000	64,541	-12,541
General Expenditure	**79,880**	**32,240**	**47,640**
Travel	79,880	31,998	47,882
Communications		303	-303
Financial Charges		-61	61
Contributions & Transfers	**510,027**	**520,258**	**-10,231**
National Society Expenses	510,027	520,258	-10,231
Indirect Costs	**41,823**	**40,946**	**877**
Programme & Services Support Recover	41,823	40,946	877
Grand Total	**685,249**	**670,885**	**14,364**