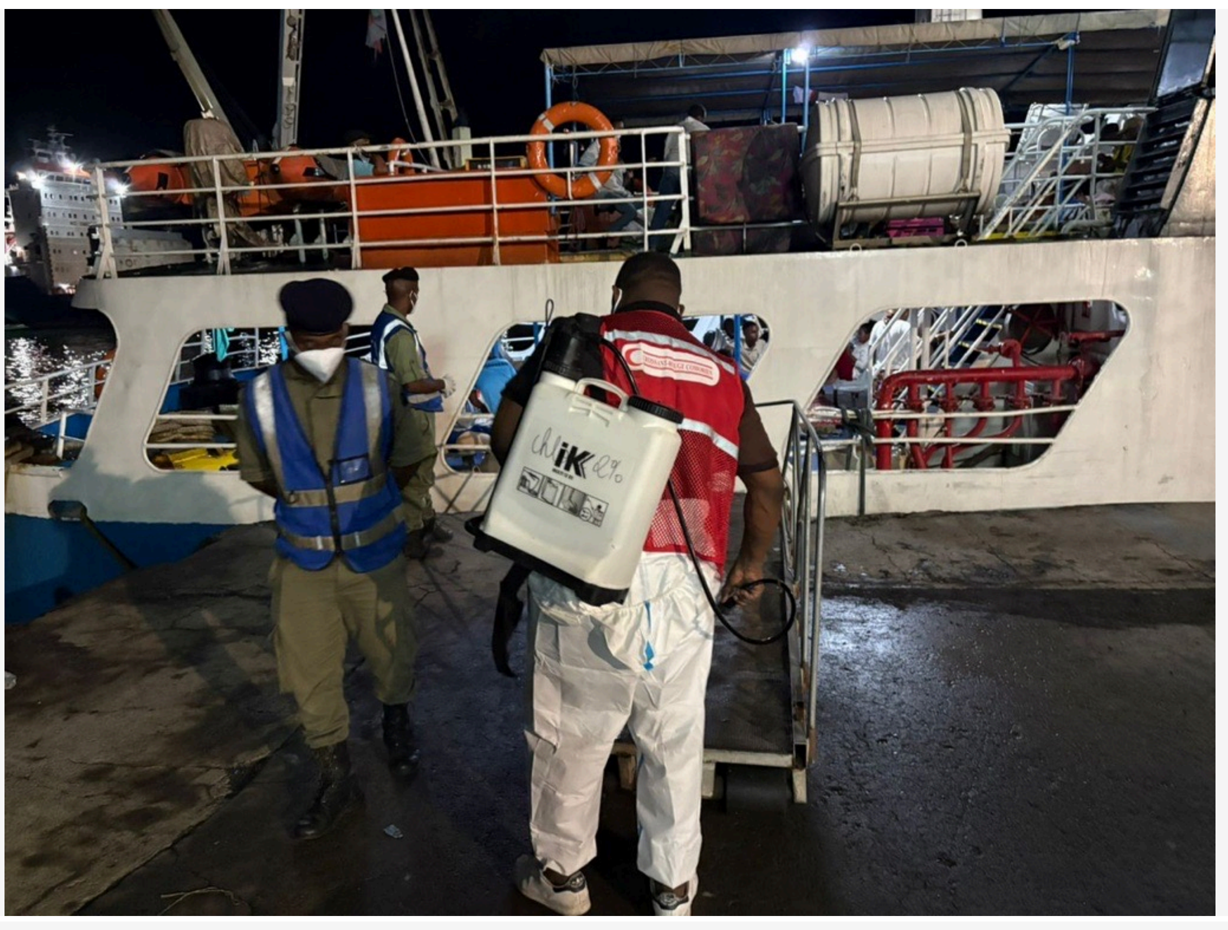
DREF Operation

Mpox epidemic emergency response



A CoRC volunteer disinfecting a maritime vessel at Anjouan's main port

Appeal: **MDRKM014**	Hazard: **Epidemic**	Country: **Comoros**	Type of DREF: **Response**
Crisis Category: **Yellow**	Event Onset: **Sudden**	DREF Allocation: **CHF 428,215**	
Glide Number: **-**	People Affected: **9 people**	People Targeted: **30,000 people**	
Operation Start Date: **29-01-2026**	Operation Timeframe: **4 months**	Operation End Date: **31-05-2026**	DREF Published: **03-02-2026**
Targeted Regions: **Grande Comore (Njazidja), Anjouan (Nzwani), Moheli (Mwali)**			

Description of the Event

Date of event

23-01-2026

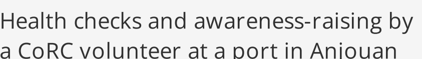
Map of Comoros islands

What happened, where and when?

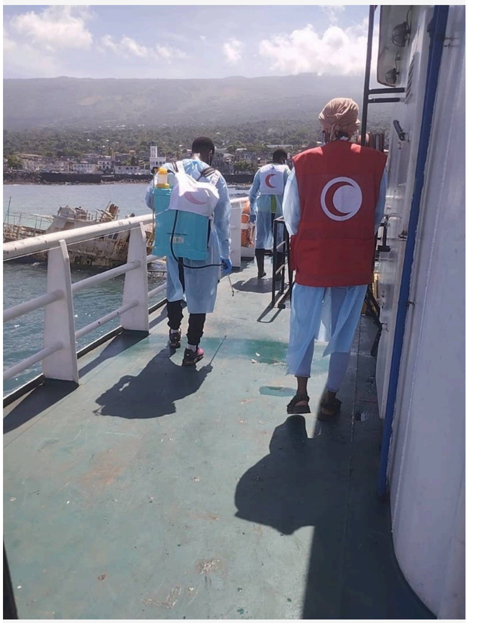
On 21 January 2026, the Council of Ministers announced the detection of four suspected cases of Mpox (monkeypox) in the Union of the Comoros. Following clinical assessment and laboratory confirmation, all four cases were officially identified as positive for Mpox clade 1 on 23 January 2026. During a subsequent press briefing, the Minister of Health declared a national public health emergency and called for heightened vigilance and the mobilisation of all relevant stakeholders.

Epidemiological investigations indicate that the outbreak originated from imported cases arriving by sea from Mahajanga, one of the epicentres of the ongoing Mpox outbreak in Madagascar. As of 20 January 2026, Madagascar had reported a cumulative total of 395 Mpox cases, including 133 confirmed cases. Two separate maritime arrivals from Mahajanga to Ngazidja (Grande Comore) were identified as the source of the confirmed cases. The first vessel arrived on January 14, 2026, and was linked to three confirmed cases belonging to the same family, while the second vessel arrived on 15 January 2026 and was associated with the fourth confirmed case. Upon arrival, all four individuals were initially placed under home surveillance before being transferred on 16 January 2026 to the Samba isolation and treatment centre in Moroni.

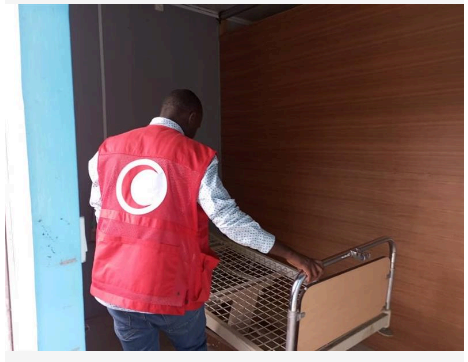
As of 25 January 2026, a total of nine (9) Mpox cases had been reported nationwide, including four confirmed cases. Of these, seven cases were reported in Ngazidja (Moroni) and two cases in Anjouan. The two cases in Anjouan involved individuals who arrived by boat from Mahajanga on the night of 24 January 2026. Investigations into the three suspected cases (locally) in Ngazidja are ongoing; however, preliminary findings suggest potential secondary transmission through direct contact with confirmed cases linked to Madagascar, raising concerns about the risk of community transmission.



Health checks and awareness-raising by a CoRC volunteer at a port in Anjouan



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



Support for the preparation of the Samba isolation and treatment site

Installation of health check point at the port of Moroni

Scope and Scale

The Mpox outbreak in the Union of the Comoros represents a sudden and exceptional public health emergency with a high risk of rapid escalation. As of 25 January 2026, nine Mpox cases have been reported across two islands (Ngazidja and Anjouan), including four laboratory-confirmed cases. This represents a national incidence rate of 1.0 case per 100,000 population. Epidemiological investigations indicate ongoing importation and early secondary transmission, signalling a credible risk of progression towards community transmission in a fragile, multi-island context.

While no fatalities have been reported to date (case fatality rate: 0%), the outbreak poses significant life-saving and time-critical challenges. The national health system has extremely limited surge capacity, particularly for isolation, infection prevention and control (IPC), and case management. The Samba isolation and treatment centre in Moroni has already reached functional capacity, requiring early discharge of clinically improving patients to admit new cases. This situation increases the risk of onward transmission and diversion of scarce resources from essential routine health services in a country with a high communicable disease burden.

The outbreak is also generating acute socio-economic and psychosocial impacts. Individuals under isolation or 21-day medical surveillance face immediate loss of income, while state support remains limited to admitted cases and cannot cover contacts advised to self-isolate at home. In tightly knit island communities, fear, misinformation and stigma are negatively affecting mental well-being and may undermine early reporting and adherence to public health measures. In parallel, the outbreak threatens disruption of critical maritime trade routes between Madagascar and the Comoros, which are essential for food security, livelihoods and national economic stability.

Impacts are geographically concentrated but epidemiologically dynamic. Seven of the nine cases are located in Moroni (Ngazidja), a high-density urban setting with elevated transmission risk, resulting in a localized incidence rate of 1.6 cases per 100,000 population in Grande Comore - 60% higher than the national average. Confirmed cases linked to maritime arrivals from Mahajanga, combined with new suspected cases in Anjouan, demonstrate a persistent risk of importation and inter-island spread, including to Mohéli, driven by routine population mobility.
For regional context: This outbreak occurs while Madagascar continues to report sustained Mpox transmission with 395 cumulative cases (incidence rate: 1.4 per 100,000), creating continuous importation pressure through daily maritime traffic. The proximity and intensity of trade connections mean that without immediate intervention, Comoros risks following Madagascar's trajectory of community transmission.
The most affected and at-risk populations include maritime and port workers exposed through occupational contact, urban residents in high-density neighbourhoods, and mobile populations such as fishermen and inter-island traders. Health care workers and Comoros Red Crescent volunteers face heightened risk due to limited prior experience in Mpox response. Children, pregnant women, immunocompromised individuals (including people living with HIV), and socio-economically marginalised households, particularly in informal settlements, are disproportionately vulnerable due to higher exposure risks and reduced capacity to comply with isolation measures or access timely health care.
This outbreak constitutes the first documented Mpox event in the Comoros, in a context of demonstrated systemic vulnerability. Recent emergencies, including COVID-19, recurrent cholera outbreaks, flooding and cyclone responses, have exposed critical gaps in laboratory capacity (only one functional Mpox testing laboratory), IPC supplies, WASH infrastructure and multi-island response logistics. As a small island developing state with strong dependence on maritime connectivity with Madagascar and chronic shortages of health personnel, the Comoros faces a high risk of rapid epidemic amplification without immediate, coordinated and community-based action.

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

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	**No**
Did it affect the same population group?	**-**
Did the National Society respond?	**-**
Did the National Society request funding form DREF for that event(s)	**-**
If yes, please specify which operation	-

If you have answered yes to all questions above, justify why the use of DREF for a recurrent event, or how this event should not be considered recurrent:

-

Lessons learned:

Comoros has not experienced a previous Mpox epidemic, but CRCo has significant experience responding to COVID-19 (2020-2023) and cholera (recurrent 2019-2025) that directly inform the current operation.
Key lessons applied:
1- Island geography and pre-positioning:
Previous delayed deployment to Anjouan/Mohéli resulted in rapid transmission.
Application: timely volunteer training and deployment proved vital for early outbreak containment.
2- Supply chain resilience:

PPE shortages during COVID-19 due to long international lead times.
Local chlorine production capacity (WATA kits) ensured continuous disinfection operations without stock-outs, critical during supply chain disruptions.
Application: diversified procurement combining local suppliers, PIROI pre-positioned stocks, and multiple international suppliers.
3- Volunteer wellbeing:
Continuous deployment caused burnout and declining quality; volunteers faced community stigmatization.
Application: structured rotation schedules (2-3 days maximum for high-risk roles), mandatory rest, weekly PSS debriefing, and family engagement sessions.
4- Community-based surveillance effectiveness:
Cholera response showed community volunteers identified 70%+ of cases vs. <30% by health facilities.
Application: massive deployment of CBS volunteers as the primary surveillance mechanism.
5- Stigma management:
Families concealed cholera cases fearing isolation, delaying treatment.
Application: anti-stigma campaigns with confidential reporting and dignified treatment messaging.
6- Infrastructure sustainability:
Handwashing stations became non-functional without community ownership.
Application: community management committees for all handwashing facilities with local leaders responsible for monitoring.
7- Community accountability and communication channels diversification
Mobile cinema and radio broadcasts in local languages effectively reached remote, low-literacy populations. Feedback loops (90% of community feedback addressed) strengthened program relevance and countered misinformation.
Application: immediate deployment of mobile cinema, radio campaigns, and IPC image boxes, with systematic community feedback mechanisms to address denial and rumors.
8- Operation management and reporting
Lack of volunteer insurance created insecurity and decreased motivation.
Delays in fund transfers led to late payment of allowances, reducing availability at critical moments.
Delay in mandatory narrative and financial reporting submission.
Application: mandatory kick-off meeting on procedures; all 500 volunteers covered by insurance; dedicated finance focal point ensures timely stipend payments to maintain volunteer motivation and availability.

This systematic integration of 5+ years of epidemic response experience enables CoRC to anticipate challenges, deploy proven approaches, and avoid past mistakes while adapting to the Mpox-specific context.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	**Yes**

Current National Society Actions

Start date of National Society actions

05-01-2026

Health	The Comoros Red Crescent (CoRC), as an auxiliary to public authorities with proven experience in epidemic management (including COVID-19 and cholera), was called upon by the government to support preparedness and response efforts. CoRC has deployed 20 trained volunteers at ports and secondary maritime entry points across Ngazidja and Anjouan to support the installation and operation of health screening posts, conducting passenger temperature checks, symptom screening, and providing prevention messaging to travelers. At the international port, an additional team of volunteers reinforces the health control system. Since January 16, 2026, when the Samba isolation and treatment center in Moroni received the first suspected cases, CoRC has been designated responsible for the preparation and operation of isolation facilities. Two pairs of volunteers (4 volunteers working in rotation) are mobilized to ensure infection prevention and control (IPC) at the Samba site and provide patient accompaniment and support. In Anjouan, eight trained and equipped volunteers perform the same functions at the isolation site opened on 25 January 2026, bringing the total to 12 volunteers supporting isolation center operations across both islands. CoRC provided a briefing to 34 community health workers whom the MoH deployed to support health control activities at entry points and community sensitization efforts. In Ngazidja, the CRCo ambulance service has been officially mobilized by the government

	to ensure safe transport of suspected cases from detection points to isolation facilities, providing critical pre-hospital care and infection control during patient transfers.
Water, Sanitation And Hygiene	CoRC has established systematic environmental disinfection operations at maritime entry points and in affected communities. In Ngazidja, a team of 6 volunteers organized in three pairs works in rotation to conduct disinfection of vessels arriving from Madagascar and Mayotte - the primary importation routes for Mpox cases. The same volunteers conduct household disinfection for families of suspected cases, including surface decontamination, textile treatment, and waste disposal guidance. In Anjouan, 10 volunteers are deployed at the airport and maritime ports (principal and secondary) to conduct similar disinfection activities. As of 22 January 2026, more than twenty disinfection sessions have been completed across Ngazidja and Anjouan, targeting high-risk locations including arriving vessels, households of confirmed and suspected cases, health centers, and public spaces at entry points. The volunteers ensure IPC compliance at the Samba isolation center (Ngazidja) and the Anjouan isolation facility, conducting daily environmental decontamination, waste management, and hygiene monitoring to prevent the transmission of nosocomial infections.
Protection, Gender And Inclusion	CoRC has established an internal coordination cell to oversee the mainstreaming of PGI across all response activities. Training and briefing sessions for staff and deployed volunteers include safeguarding protocols, non-discriminatory approaches to case detection and contact tracing, and procedures for addressing stigma and protecting patient confidentiality. The adaptation of key messages includes anti-stigma content and promotes dignified, respectful treatment of affected individuals and their families.
Community Engagement And Accountability	CoRC volunteers conduct active sensitization campaigns at all major ports and maritime entry points, reaching passengers arriving from Madagascar and other routes with prevention messages adapted to the Comorian context. The NS has contributed to the mapping of existing IEC tools and led the adaptation and updating of key epidemic messages in collaboration with the Ministry of Health, ensuring cultural appropriateness and linguistic accessibility for diverse island populations.
Coordination	CoRC actively participates in government-led coordination platforms, including the national emergency operations structure and the RCCE technical working group. The NS has been instrumental in coordinating the volunteer-led response across two islands (Ngazidja and Anjouan), establishing an internal coordination cell to manage deployment, logistics, and reporting. Weekly coordination meetings are held between CRCR network members, including IFRC, PIROI, and CoRC leadership, to ensure information sharing, resource mobilization, and complementarity of interventions. CoRC contributes epidemiological data from entry point screening, disinfection activities, and isolation center operations to national surveillance systems, supporting evidence-based decision-making by health authorities. The NS's rapid mobilization and deployment of trained volunteers across critical functions - health screening, disinfection, isolation center support, ambulance transport, and community engagement - demonstrates its comparative advantage as the primary community-level implementation partner with nationwide reach across the archipelago's inhabited islands.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC, through its Indian Ocean Countries Delegation and country representative, is coordinating the engagement of Movement partners to ensure the availability of appropriate technical, logistical, and financial support to CoRC for the implementation of planned activities. Given the cross-border nature of the outbreak and its direct epidemiological link with the ongoing Mpox outbreak in Madagascar, the IFRC regional cluster is facilitating coordination, coherence, and harmonisation of the response across the affected countries.

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

ICRC Actions Related To The Current Event

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

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	The Government of the Union of the Comoros, through the Ministry of Health, initiated a rapid public health response following the detection of Mpox cases linked to travelers arriving from Mahajanga, Madagascar. Emergency response protocols were immediately activated upon identification of the first four suspected cases. On 23 January 2026, the Minister of Health officially confirmed the four cases during a press briefing and declared a national public health emergency, calling for increased vigilance and mobilization across line ministries, health authorities and civil society partners. Immediate response measures were implemented, including the activation of the Samba Isolation and Treatment Centre in Moroni (Ngazidja) on 16 January 2026 to isolate suspected cases initially placed under home monitoring. As additional cases were identified in Anjouan, authorities rapidly operationalized a second isolation facility on 25 January 2026 to manage two suspected cases arriving from Mahajanga, demonstrating early multi-island response coordination. Standardized treatment and care protocols were applied in both facilities, and clinical management of confirmed cases has, to date, prevented severe outcomes among the nine reported cases. Laboratory diagnostic capacity was made operational on January 21, 2026, following the urgent procurement and receipt of Mpox diagnostic reagents, enabling testing of samples from suspected cases at national level. Surveillance and screening measures were reinforced at major points of entry. Health screening posts were established at ports and airports in Ngazidja and Anjouan, with systematic screening of travelers arriving from affected areas, particularly maritime arrivals from Madagascar. Contact tracing activities are ongoing for all confirmed and suspected cases. Epidemiological investigations are tracing contacts linked to the four initial imported

	cases as well as the subsequent suspected cases. The identification of three suspected cases in Ngazidja with preliminary indications of secondary transmission has triggered intensified contact identification and follow-up. The Ministry of Health is coordinating the multisectoral response through the activation of emergency coordination structures, including a national crisis cell. Coordination mechanisms include inter-ministerial collaboration (Health, Interior, Transport and Communication), technical working groups focusing on case management and surveillance, and partnerships with civil society organizations, including the Comoros Red Crescent as a key community-level implementing partner. Risk communication and community awareness activities have been initiated, including public statements by the government spokesperson, press briefings by the Ministry of Health, and dissemination of prevention messages through national media channels.
UN or other actors	WHO, in line with its normative mandate, is providing technical guidance to the Ministry of Health on Mpox case definitions, clinical management protocols, infection prevention and control (IPC) standards, and epidemiological surveillance. WHO has confirmed its commitment to support the government's response in close coordination with the Ministry of Health. WHO has made its technical expertise available through the country office, the regional office via the Nairobi hub, and other WHO entities, to support the different pillars of the national response as required. UNICEF is contributing to preparedness and response efforts through support to community-level interventions. Under a UNICEF-funded project implemented by the Comoros Red Crescent, 36 community health workers have been trained and deployed in Ngazidja to support health screening and monitoring at points of entry. This project is expected to be expanded to train additional community health workers in Anjouan and Mohéli. UNICEF also supports the relevant technical working groups and contributes to the development and dissemination of IEC materials to strengthen risk communication and community engagement.

Are there major coordination mechanism in place?

1- National-level coordination – Government crisis cell
National coordination is led through the national crisis cell under the authority of the Secretary of the Government. The structure ensures inter-ministerial coordination involving the Ministries of Health, Interior and Transport. CoRC is formally recognised as an auxiliary to the public authorities and is positioned as the primary community-level implementing partner supporting the national response.
2- National-level coordination – Ministry of Health emergency coordination
The Ministry of Health is coordinating the public health response through its emergency coordination mechanisms, ensuring inter-departmental collaboration among technical departments and engagement with technical and financial partners. The CoRC is actively participating in this coordination framework, contributing to surveillance, risk communication and community-based response activities.
3- Island-level coordination – Regional Health Directorates
Response coordination mechanisms have been activated at island level in Ngazidja and Anjouan, under the leadership of the Regional Health Directorates, in close collaboration with district health offices. The CoRC is an active operational partner, deploying volunteers to support response activities across both islands. To date, Mohéli has not yet been fully integrated into active response coordination structures, despite the ongoing risk of case importation through inter-island and maritime movements.
4- Technical coordination – Health cluster and technical working groups
Technical coordination is assumed to be operational under the leadership of the Ministry of Health through the Health cluster and relevant technical working groups. The CoRC contributes to the mapping of IEC tools, adaptation of key messages, and sharing of community-based surveillance data. However, coordination platforms for WASH, Protection and Mental Health and Psychosocial Support (MHPSS) have not yet been explicitly activated, representing a gap in the multisectoral response.
5- Movement coordination – IFRC Indian Ocean Cluster
Movement coordination is ensured through the IFRC Indian Ocean Cluster Bureau, with regular weekly coordination calls between the IFRC, PIROI and the CoRC. These mechanisms support information sharing, operational alignment and cross-border coordination with the ongoing Mpox response in Madagascar.

Needs (Gaps) Identified

Health

1. Epidemiological surveillance, diagnostics, and referral:
Despite early preparedness measures taken by the authorities, the emergence of this first epidemic reveals structural constraints. The delayed arrival of diagnostic inputs initially forced suspected cases to remain under home isolation, increasing the risk of intra-household transmission. The centralization of testing capacities (a single national laboratory), combined with inter-island logistical challenges, creates bottlenecks that may delay case confirmation and patient isolation. Surveillance mechanisms remain permeable at informal and secondary points of entry, while community surveillance struggles to cover dispersed or mobile populations. The 21-day contact tracing and monitoring process is hindered by a lack of trained human resources and the absence of digital data management tools. Logistically, sustaining the safe transport of patients - currently provided by the CoRC ambulance service in Ngazidja - imperatively requires the training of Civil Security (COSEP) teams to take over operations and extend this vital mechanism to the other two islands.
2. Clinical management and IPC
Admission capacities are under severe strain, evidenced by the early discharge of patients from the Samba site to free up beds, signaling a risk of rapid saturation should transmission intensify. The quality of care requires immediate strengthening, as health personnel lack prior experience with this specific pathology. It is urgent to deploy intensive training on clinical protocols and IPC, while securing Personal Protective Equipment (PPE) stocks for a sustained response. Regarding CoRC volunteers mobilized on the frontlines in isolation centers, a reinforced support system including continuous training, psychosocial support, and systematic rotation is indispensable to guarantee their safety and prevent burnout.
3. Risk Communication and Community Engagement (RCCE)
The current setup (34 health workers and 20 volunteers) offers insufficient geographic coverage given the epidemic's multi-island dynamic, leaving areas like Mohéli island (currently spared but vulnerable) without adequate prevention. A major strategic gap lies in the lack of targeted communication toward high-risk groups identified as potential vectors (maritime workers, inter-island traders, fishermen). A strategic shift is necessary to adapt messages and specifically target these key populations to break transmission chains at critical junctures.

Water, Sanitation And Hygiene

1. Sanitary infrastructure and institutional safety
Major structural constraints in WASH infrastructure are currently compromising the effectiveness of infection prevention measures. Isolation centers face critical challenges, including insufficient handwashing stations and medical waste management systems that require urgent upgrading to prevent nosocomial infection risks for patients and healthcare staff. Simultaneously, hygiene facilities at points of entry, schools, and community gathering sites remain inadequate or require immediate maintenance.
2. Operational capacity and community support
The sustainability of disinfection operations, currently led by CoRC volunteers, is threatened by the imminent depletion of essential consumables (chlorine, soap, disinfectants, PPE). At the household level, families hosting suspected or confirmed cases lack the resources and technical knowledge to ensure safe disinfection, increasing the risk of intra-household transmission. Furthermore, the lack of systematic disinfection of high-risk transmission vectors (public transport, markets, mosques) represents a gap in the community sanitary barrier.
3. Specific vulnerability in the maritime supply chain
A critical gap has been identified in maritime cargo handling. Port workers, lacking adequate PPE and safe handling protocols, face high exposure risks when unloading goods from affected areas. This vulnerability is corroborated by the recent contamination of a suspected case (the 5th case) during cargo retrieval, underscoring the urgent need to target this sector with specific WASH interventions.

Protection, Gender And Inclusion

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

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

Women face gender-specific vulnerabilities, including caregiving burdens for isolated family members without compensation or support, domestic violence risks during prolonged household isolation, and limited decision-making power regarding health-seeking for themselves and their children. Maritime workers, predominantly male, face occupational exposure without adequate protection or compensation for lost income during isolation periods. Marginalized groups, including men who have sex with men, sex workers, and transgender persons, face dual vulnerabilities of potential elevated exposure and significant barriers to care-seeking due to criminalization, discrimination, and fear of disclosure in conservative island societies.
The elderly and people with disabilities face access barriers to health information, screening services, and isolation facilities that are not designed with accessibility considerations. Economic vulnerability is pervasive, with limited household capacity to absorb income loss during 21-day isolation/monitoring periods, lack of food security support for quarantined families, and absence of livelihood protection mechanisms for informal sector workers who comprise the majority of the archipelago's workforce.

Community Engagement And Accountability

1. Feedback mechanisms and infodemic management
Current accountability mechanisms are limited, lacking systematic platforms for affected populations to report concerns confidentially or influence operational decisions. The absence of a formal rumor tracking system allows unverified information regarding Mpox transmission and treatment to circulate, potentially driving stigmatization and care avoidance. It is imperative to strengthen trust in health actors through transparent communication and demonstrated responsiveness to community feedback.
2. Mobilization of key stakeholders
The engagement of the island-specific community structures (notables, religious leaders, women's and youth groups) remains ad hoc and requires systematic integration into response planning to ensure local ownership. Furthermore, a critical opportunity lies in the mobilization of the private sector, which is currently untapped. Strategic partnerships with maritime transport companies (passenger screening), market associations (hygiene infrastructure), and mobile network operators (SMS campaigns) are essential to extend the reach of prevention messages and secure key economic transmission vectors.

Any identified gaps/limitations in the assessment

The assessment is constrained by the early stage of the outbreak (11 days since initial detection), limiting the availability of robust data to fully characterize the event's dynamics.
- Epidemiological uncertainties: Data gaps in case investigations - particularly regarding the cases in Ngazidja - and the absence of precise indicators on contact tracing completeness (loss to follow-up rates, total contacts identified) make it difficult to distinguish between contained transmission within contact networks and the onset of established community transmission.
- Surveillance blind spots: Risk assessment remains incomplete regarding Mohéli island and the coverage of secondary and informal maritime points of entry, precluding the exclusion of silent viral circulation via inter-island traffic.
- Unmeasured capacities and impacts: The surge capacity of infrastructure (single laboratory, limited PPE stocks) to handle a potential caseload increase remains to be confirmed. Furthermore, the socio-economic (income loss) and psychosocial impacts on isolated households have not yet been quantified, though they occur within a context of pre-existing systemic fragility (limited resources, co-morbidities) that exacerbates population vulnerability.

Operational Strategy

Overall objective of the operation

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

Operation strategy rationale

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

Urgent needs addressed

The operation targets four critical operational gaps: (1) Incomplete surveillance at secondary maritime points of entry and informal landing sites, which permits continued case importation from Madagascar; (2) Critical IPC/WASH shortages in households and isolation centers, addressing the risk of nosocomial infection where secondary transmission is suspected; (3) Stigma-induced care avoidance, which compromises containment within cohesive island communities; and (4) Geographic vulnerability, particularly in Mohéli, which requires immediate preventive action to forestall importation despite currently having no detected cases.

Strategic priorities rationale
Five priorities align with WHO technical guidance, IFRC epidemic response frameworks, and national response architecture:
1- Community-based surveillance and entry point screening: Expands CoRC's existing deployment of volunteers at major ports to systematically cover secondary maritime entry points, informal boat landings, and fishing communities where most Madagascar-Comoros maritime traffic arrives unscreened. As of 25 January 2026, 2,000+ travelers from Madagascar and 21 contact cases are currently being monitored. Trained volunteers on EPiC conduct risk communication and education to encourage protective behaviors.
2- Community Engagement Accountability (CEA): Counters stigma, misinformation, and care avoidance through culturally adapted messaging delivered by trusted community volunteers in local languages. Engages traditional leaders, religious authorities, women's groups, and island-specific community structures to build trust and promote care-seeking.
3- WASH and environmental decontamination: Scales up CoRC's existing disinfection operations to ensure systematic coverage of arriving vessels, households with cases/contacts, isolation facilities, public spaces, and high-risk sites, including markets, transport hubs, and mosques. Installs handwashing facilities at strategic locations.
4- Psychosocial support: Addresses mental health impacts on isolated patients (facing 21-day isolation away from families), monitored contacts experiencing anxiety and social exclusion, healthcare workers and volunteers facing secondary trauma, and communities experiencing collective stress from the first-time epidemic and economic disruption.
Isolation centers support and health system strengthening: Reinforces CoRC's critical role supporting operational isolation facilities with materials/equipment, IPC, and patient accompaniment, while strengthening referral pathways, ambulance services, and coordination with health authorities.

Methods justification
CoRC leverages its nationwide network of trained volunteers embedded in communities across all three islands (Ngazidja, Anjouan, Moheli) to ensure trusted, culturally appropriate last-mile delivery, proven effective during Comoros' COVID-19 and cholera responses. Integration with CoRC's existing response (70+ volunteers already mobilized) enables immediate scale-up without start-up delays. Digital reporting tools enable real-time data sharing with national health authorities, strengthening surveillance and operational decision-making. Accountability to affected populations is ensured through systematic community feedback mechanisms. The operation integrates Protection, Gender, and Inclusion (PGI) approaches throughout all activities, with safeguarding principles applied to prevent sexual exploitation, abuse, and harassment.

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

Exit strategy
The operation will ensure early and continuous community engagement throughout the four-month implementation period to foster ownership and facilitate a smooth transition beyond the DREF support. Strong integration with government health structures will maintain alignment with national epidemic response strategies and enable capacity transfer to the MoH systems.
CoRC volunteers are embedded within communities across all three islands, ensuring that skills and knowledge gained remain at community level after the operation conclusion, contributing to sustained epidemic preparedness. The operation will strengthen CoRC's organizational capacity through enhanced volunteer management, improved coordination, upgraded IPC and WASH protocols, and documented lessons learned.
At operation end, surveillance functions introduced into new communities will transition to strengthened MoH systems with CoRC volunteers integrated into routine community health structures, WASH infrastructure handed over to community management committees and local authorities, and PSS and CEA systems institutionalized within health facilities and community platforms. If epidemiological indicators demonstrate sustained transmission or new importation waves at the end of the operation, CoRC will work closely with IFRC and the government to develop a transition plan ensuring continuity of critical interventions until outbreak control is achieved.

Targeting Strategy

Who will be targeted through this operation?

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

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

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

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

Entry points and mobile corridors (across all islands):
All maritime ports (principal and secondary), informal boat landings, fishing harbors, and transport corridors connecting ports to urban centers

Population groups targeted:
1. Maritime and mobile populations (transport workers, traders, fishing communities, passengers)
Why: All confirmed cases linked to maritime arrivals from Mahajanga; 2,000+ travelers from Madagascar currently being monitored; continuous importation risk as long as the Madagascar outbreak persists
How: Active screening at all entry points, RCCE at departure/arrival points, contact tracing, handwashing facilities at 15 port locations, targeted messaging for maritime associations and transport operators
2. Monitored contacts and their households
Why: 21 contacts under active 21-day monitoring as of 25 January; risk of secondary transmission within households
How: Daily home visits by volunteers, household disinfection, PSS support, isolation support for households, stigma reduction messaging
3. Urban high-density communities (Moroni, Mutsamudu)
Why: 7 of 9 cases concentrated in urban Moroni; overcrowding, shared sanitation, and high mobility facilitate rapid transmission
How: Door-to-door sensitization, community dialogue sessions, handwashing stations in public spaces
4. Healthcare workers and volunteers
Why: 70+ CoRC volunteers already deployed face occupational exposure; healthcare workers lack Mpox experience and PPE
How: IPC training, PPE provision for health personnel and volunteers, regular health monitoring, PSS support
5. Children and adolescents
Why: Vulnerable to severe outcomes; schools and congregate youth settings are potential amplification sites; Madagascar's outbreak included cases as young as 3 months
How: School-based handwashing stations, age-appropriate RCCE materials, child safeguarding protocols during household visits, family-based PSS
6. Pregnant women
Why: Risk of severe maternal-fetal complications requiring specialized care
How: Priority surveillance and referral, integration with antenatal care services, specialized PSS, maternal health service coordination
7. Immunocompromised individuals (PLHIV, malnourished, chronic illness)
Why: Elevated risk of severe disease and prolonged viral shedding; require priority clinical care
How: Integration with HIV/TB/chronic disease services, priority PSS, targeted education on vulnerability, confidential screening mechanisms
8. Elderly and people with disabilities
Why: Limited mobility creates barriers to health information and services; higher risk of severe outcomes
How: Home-based surveillance, accessible communication materials, caregiver engagement, priority PSS for isolated individuals
9. Women and economically marginalized populations
Why: Caregiving burdens, limited decision-making power, inability to sustain isolation due to lost income (majority informal sector workforce)
How: Women-led dialogue sessions, support through hygiene kits, engagement of women's groups in RCCE, gender-sensitive messaging
10. Marginalized and stigmatized groups
Why: May face care-seeking barriers due to discrimination; epidemic response must ensure equitable, dignified access
How: Confidential RCCE, peer engagement where culturally appropriate, anti-stigma campaigns, safe reporting mechanisms, and non-discriminatory volunteer training

Vulnerable group approaches:
Maritime workers: Engagement with transport associations, maritime unions, and port authorities for workplace sensitization and PPE provision.
Mobile populations: Portable RCCE materials, messaging at transport hubs, cross-border communication
People with disabilities: Multi-modal communication (visual, audio, simplified language), home-based surveillance, accessible

handwashing facilities
Elderly: Intergenerational family-based messaging, priority PSS, caregiver training on IPC
Economically marginalized: Hygiene kit distribution to reduce isolation costs, engagement of informal sector associations

Explain the selection criteria for the targeted population

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

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

Total Targeted Population

Women	**14,910**	Rural	**30%**
Girls (under 18)	**7,008**	Urban	**70%**
Men	**15,090**	People with disabilities (estimated)	**5%**
Boys (under 18)	**7,092**		
Total targeted population	30,000		

Risk and Security Considerations (including "management")

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

Does your National Society have whistleblower protection policy?	No
Does your National Society have anti-sexual harassment policy?	Yes

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

Risk	Mitigation action
Financial and procurement compliance risks (delay in financial reporting) driven by limited NS capacity and island-specific logistical constraints (delay in procurement).	Leverage ongoing financial system strengthening (supported by a CBF project) to enhance financial management infrastructure and ensure timely reporting Implement a hybrid procurement strategy prioritizing local markets, supported by IFRC / PIROI regional mechanisms for specialized items.
Cyclones, floodings and volcanic activity may disrupt operations, limit access to intervention areas, damage infrastructure, and overwhelm health systems with competing emergencies.	Proactively engage with meteorological services and DGSC to monitor forecasts. Establish contingency stocks on each island. Pre-position volunteers on Anjouan and Mohéli with clear mandates for autonomous operations. Maintain flexible implementation timeline to accommodate weather-related delays.
Risk of sexual exploitation, abuse, and harassment (SEAH) compounded by household visits to isolated families, vulnerable populations facing elevated risk, and power imbalances between volunteers and stressed communities.	Mandatory SEAH and Child Safeguarding training before deployment with signed Code of Conduct. Implement two-volunteer rule for all household visits. Establish confidential reporting mechanisms with clear investigation protocols. Regular supervision and spot-checks. Gender-balanced volunteer teams. Community awareness of complaint mechanisms.

Please indicate any security and safety concerns for this operation:

Volunteer/staff safety: Frontline volunteers face infection exposure, stigma-related hostility, and psychosocial strain risks. Mitigation includes comprehensive IPC training, PPE provision, community leader engagement, paired deployment, PSS support, rotation schedules, weather monitoring, and insurance coverage.
Community Safety: Rumor-driven violence, child safeguarding concerns during household visits, and elevated GBV risks from prolonged isolation require proactive rumor management, volunteer vetting, two-volunteer rule for child interactions, gender-balanced teams, and referral pathways to protection services.
Operational security protocols: 24/7 incident reporting line to CoRC coordination, volunteer identification cards and visibility vests, close coordination with local authorities and police, evacuation plans for each island, suspension protocols if security deteriorates, and regular communication schedules for volunteers in remote areas.

Has the child safeguarding risk analysis assessment been completed?	Yes

Planned Intervention

Budget: CHF 199,186
Targeted Persons: 30,000

Indicators

Title	Target
# of volunteers trained in Epidemic Preparedness and Response in Community (EPiC) and deployed	390
% of daily alerts detected, investigated, and referred through CBS system	80
% of identified contacts traced and monitored	100
# of isolation/treatment centers receiving technical and material support	3
# of volunteers and staff receiving PPE	514
# of PSS sessions provided to affected individuals, families, volunteers, and healthcare workers	400
# of healthcare workers trained on case management and IPC	50
# of Civil Security agents in the 3 islands on safe patient transport protocols	60
# of volunteers trained to provide PSS	40
% of monitored households reporting improved psychosocial wellbeing after PSS sessions	80
% of volunteers, healthcare workers and civil security agents who report increased capacity to safely perform epidemic response roles (post-training self-assessment)	80
# of people reached through RCCE campaigns (interpersonal communication, mass media, community sessions)	30,000
# of IEC materials produced and disseminated (posters, flyers, brochures)	3,000
% of people reached who demonstrate accurate knowledge of Mpox symptoms, transmission, and prevention (via rapid KAP checks)	70
# of volunteers reporting into CBS system	390
# of confirmed cased detected via CBS mechanism	-

Priority Actions

• Train 390 volunteers across 3 islands (Ngazidja, Anjouan, Mohéli) on Epidemic Preparedness and Response in Community (EPiC), with a focus on Mpox.
• Deploy and supervise 390 trained volunteers across 3 islands for active case finding, contact tracing, early detection, rapid community-level referral, and RCCE.
• Train 35 volunteers on PSS to provide support to isolated patients, monitored contacts, healthcare workers, and affected communities.
• Provide technical and material support (PPE, IPC supplies, patient care materials) to 3 isolation/treatment centers (Ngazidja, Anjouan and Mohéli).
• Train 50 healthcare workers on Mpox case management, IPC protocols, and clinical care.
• Train 60 Civil Security (COSEP) agents on safe patient transport protocols, including systematic ambulance disinfection and the management of infectious waste.
• Co-produce and disseminate 3,000 IEC materials with the MoH and partners, ensuring technical accuracy, cultural appropriateness, and linguistic accessibility.

• Conduct mass media campaigns: radio broadcasts, social media campaigns through CoRC platforms, community loudspeaker announcements in partnership with local authorities.

Water, Sanitation And Hygiene

Budget: CHF 60,350
Targeted Persons: 30,000

Indicators

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

Priority Actions

• Train 75 volunteers on hygiene promotion, including household disinfection techniques, environmental decontamination of shared spaces, proper PPE use for disinfection operations, and waste disposal protocols.
• Conduct household disinfection interventions for all families with confirmed/suspect cases and their close contacts, and environmental disinfection of maritime vessels, public transport, markets, and shared spaces.
• Distribute 1,000 household hygiene kits (soap, chlorine solution, buckets, cleaning cloths, waste bags, gloves) to isolated families, monitored contacts, and vulnerable households to support home-based hygiene promotion.
• Conduct hygiene promotion and awareness-raising activities among affected populations with demonstration sessions on handwashing, surface disinfection, and safe waste management.
• Ensure replenishment of consumables (soap, alcohol-based hand rubs, chlorine, gloves, masks, waste bags) throughout the operation duration with buffer stocks on each island.
• Install 70 handwashing facilities, including water-soap handwashing devices and alcohol-based hand rub stations (≥60% alcohol) across 3 islands at high-traffic locations (15 port entry points, 10 markets, 20 public spaces/mosques, 15 schools, 10 health facilities) with systematic monitoring to ensure continuous water and soap availability.

Protection, Gender And Inclusion

Budget: CHF 8,810
Targeted Persons: 30,000

Indicators

Title	Target
# of people reached with PGI information (anti-stigma messaging and discrimination prevention information)	30,000
# of vulnerable individuals (pregnant women, children, PLHIV, immunocompromised, mobile workers) receiving targeted information and support services	2,000
# of safe referrals provided to protection services	-
% of concerns/complaints related to stigma, discrimination, or access barriers reported and addressed within 7 days with documented resolution	100
% of affected individuals reporting reduced stigma or discrimination following targeted PGI and RCCE interventions	90
# of community feedback and reporting mechanisms established and functional	3
# of staff and volunteers trained/briefed on PGI	514

Priority Actions

• Conduct participatory gender analysis identifying differential Mpox impacts on affected populations and mapping inclusion barriers specific to Comorian island context and community perception.
• Conduct mandatory briefing session for all 514 staff and volunteers on PGI, SEAH, and child safeguarding with signature of Code of Conduct and zero-tolerance policy acknowledgment.
• Integrate anti-stigma messaging into all RCCE activities with specific campaigns targeting discrimination against maritime workers, isolated patients, monitored contacts, and their families.
• Conduct campaigns with traditional and religious leaders (imams, community elders, notables) to promote dignified treatment of affected individuals and counter misinformation.
• Establish 3 confidential reporting mechanisms (one per island: toll-free hotline, female focal points, community suggestion boxes) for stigma, discrimination, SEAH, and safeguarding concerns.
• Disseminate, in collaboration with UNICEF, culturally adapted child protection messages to households (specifically those in home isolation), while establishing confidential referral pathways to local service providers.

Community Engagement And Accountability

Budget: CHF 16,664
Targeted Persons: 30,000

Indicators

Title	Target
% of feedback items received, documented, and responded to through accountability systems	100
% of community members reporting trust in CoRC volunteers as reliable sources of information	90
# of community dialogue sessions, focus group discussions, and community	40

meetings conducted	
# of operational decisions or programme adaptations informed by community feedback and documented in coordination meetings	-
# of people reached by targeted dialogue sessions and FGDs conducted by trained volunteers	30,000
# of volunteers trained on community feedback coding	12
# of community feedback committee meeting or workshop held	90
% of recommendations from community meetings implemented	80

Priority Actions

• Establish, disseminate, and monitor community feedback mechanisms: toll-free hotline (separate from government 1717 line), volunteer feedback forms, community suggestion boxes at health facilities and community centers, regular focus group discussions.
• Establish and deploy a rumor tracking system, in collaboration with all partners.
• Partner with private sector actors: maritime transport operators for vessel-based messaging and passenger. information, market associations for vendor sensitization, and employers along economic corridors for workplace awareness.
• Conduct 40 community dialogue sessions and focus group discussions (including with women, youth, maritime workers, traditional leaders, and mobile populations) to engage community participation, identify barriers to care-seeking (fear, stigma, economic loss), and co-design solutions.
• Integrate community feedback analysis into weekly CoRC coordination meetings and communicate response adaptations back to communities through volunteers and community leaders.
• Integrate CEA (community feedback mechanisms) briefings into different training sessions.
• Conduct training for 12 volunteers (4 per island) on community feedback coding.
• Organize regular community feedback committee meetings/workshops to review feedback trends and follow up on recommendations.

Secretariat Services

Budget: CHF 44,045
Targeted Persons: -

Indicators

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

Priority Actions

• Provide continuous technical, logistical, and financial support to CoRC throughout the operation duration through IFRC Indian Ocean Cluster Delegation and the country representative.
• Facilitate weekly Movement coordination meetings with participation of IFRC, PIROI, French Red Cross, and other partners to ensure information sharing, resource mobilization, and complementarity.
• Support operation management, including fund disbursement, procurement support, reporting coordination, compliance monitoring, and quality assurance.
• Provide surge capacity support as needed (emergency health, CEA/RCCE expertise) in coordination with PIROI and French RC.

• Organize joint field supervision/monitoring missions to intervention zones across the 3 islands, ensuring quality, accountability, and adaptive management.
• Support cross-border coordination with the Madagascar Red Cross and IFRC cluster on epidemiological information sharing, harmonized messaging, and regional response coherence.

National Society Strengthening

Budget: CHF 73,025
Targeted Persons: -

Indicators

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

Priority Actions

• Produce and disseminate bi-weekly situation reports documenting: epidemiological trends (cases, deaths, geographic spread), response activities (outputs against targets), operational challenges, and adaptive management decisions.
• Organize field supervision missions: regular monitoring visits to intervention zones on all 3 islands, spot-checks of volunteer activities, quality assurance.
• Organize mid-term review workshop and end-of-operation lessons learned workshop with participation of CoRC, IFRC, PIROI, FRC, MoH, partners, and community representatives.
• Conduct monthly progress reviews, analyzing indicator achievement, budget execution, operational challenges, and planning adjustments.
• Produce final implementation report with comprehensive documentation of activities, results, lessons learned, and recommendations for future epidemic preparedness.
• Strengthen CoRC organizational systems: volunteer management database, expansion of digital CBS reporting tools, IPC protocols, WASH standard operating procedures, CEA feedback mechanisms, and emergency response procedures for sustained capacity beyond the operation.

About Support Services

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

Total personnel: 514
Staff (14):
Operation Manager: overall coordination, Ministry of Health liaison, strategic oversight. She/he will be supported by the IFRC's operations manager based in the country.
PMER Officer: monitoring, reporting, data management, community engagement, feedback analysis
Finance/Admin Officer: budget management, disbursements, financial reporting, compliance
Logistics Officer: procurement, supply chain management, inventory control

CEA Officer: RCCE coordination, IEC materials production, media engagement, and support social media campaigns
Health and WASH Coordinators (2): technical oversight, CBS protocols, IPC guidance, healthcare worker training coordination
Island Focal Points (3): One per island (Ngazidja, Anjouan, Mohéli) - supervise volunteers, coordinate with island health directorates, support local logistics, ensure quality and accountability
Support staff (4): volunteer manager, drivers, and national warehouse manager

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

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

Does your volunteer team reflect the gender, age, and cultural diversity of the people you're helping? What gaps exist in your volunteer team's gender, age, or cultural diversity, and how are you addressing them to ensure inclusive and appropriate support?

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

Will surge personnel be deployed? If yes, please provide the role profile needed.

Yes
Surge personnel will be deployed on a needs-based basis through established IFRC mechanisms, including PIROI and Partner National Societies (French Red Cross, others), to provide specialized technical expertise in:
- Emergency health/epidemic response specialist: Provides technical guidance on CBS systems, IPC protocols, outbreak investigation, and health system coordination; supports training delivery for healthcare workers and volunteers; strengthens linkages with WHO and Ministry of Health technical structures.
- Community Engagement and Accountability (CEA) specialist: Strengthens feedback mechanisms, supports rumor tracking system design, provides training on participatory approaches, and ensures accountability frameworks are operational.

Surge deployments will be time-bound (2 to 8 weeks) to support specific technical needs such as training delivery, system establishment, or capacity building. Deployments will be triggered by:
- Rapid geographic expansion requiring accelerated volunteer training.
- Complex coordination demands as the epidemic evolves.
- Specific technical gaps identified by CoRC or the Ministry of Health.
- Laboratory or clinical management challenges requiring specialized expertise.

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

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

How will this operation be monitored?

The operation will be monitored through a comprehensive framework combining real-time data collection, regular supervision, and participatory review mechanisms:
1. Real-time digital reporting:
- CBS volunteers report daily alerts, referrals, and community feedback through mobile platform (NYSS).
- WASH volunteers document disinfection sessions, handwashing facility status, and hygiene kit distribution.
- Weekly data consolidation by PMER officer into dashboards tracking outputs against targets.

2. Operational monitoring:
- Bi-weekly situation reports tracking epidemiological trends, activity outputs, operational challenges, and adaptive management decisions.
- Monthly indicator reviews assessing outcomes: % cases detected via surveillance system, contact tracing completeness, population knowledge levels through rapid KAP surveys, handwashing facility functionality, PSS reach and effectiveness.
- Sex/age/disability disaggregated data collection enabling equity analysis across all activities.

3. Field supervision:
- Island Focal Points conduct weekly spot-checks of volunteer activities on each island.
- Bi-monthly CoRC coordination team supervision missions rotating across intervention zones.
- Joint IFRC-CoRC field monitoring missions assessing quality, accountability, beneficiary satisfaction, and safeguarding compliance.

4. Participatory review:
- Mid-term review workshop, evaluating progress and enabling adaptive management.
- End-of-operation lessons learned workshop with all stakeholders documenting successes, challenges, and recommendations for future preparedness.

5. Coordination monitoring:
- Weekly Movement coordination meetings (IFRC, PIROI, French RC, CoRC) reviewing implementation status, identifying bottlenecks, ensuring complementarity.
- Daily coordination with the MoH reviewing epidemiological data, surveillance system performance, and response effectiveness.
- Community feedback mechanisms analyzed weekly to inform operational adjustments.

6. Financial monitoring:
- Monthly financial reports tracking expenditures against budget lines.
- Monthly financial spot-checks by IFRC Indian Ocean Cluster.
- Procurement documentation review, ensuring compliance with IFRC procedures.

Please briefly explain the National Societies communication strategy for this operation

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

Budget Overview

DREF OPERATION

MDRKM014 - Comoros Red Crescent
Mpox epidemic emergency response

Operating Budget

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

all amounts in Swiss Francs (CHF)

Internal 1/30/2026 #V2022.01

[Click here to download the budget file]

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Click here for the reference